PSYCHIATRIC ASPECTS OF HAEMATOLOGICAL MALIGNANT DISEASE : THE GROOTE SCHUUR EXPERIENCE

RAYMOND BERARD

BSc. M.B.B.Ch.(WITS) D.C.H. (S.A.) M.F.G.P. (S.A.)

F.F.PSYCH (S.A.)

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Department of Psychiatry
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LITERATURE REVIEW

1.1 INTRODUCTION.

The discipline of liaison psychiatry is relatively new particularly in the South African context. The entrance of liaison psychiatry into the domain of oncology began in earnest in the 1950s, and an interest in the psychosocial aspects has mushroomed in the last decade with improved research methodology (1). It currently faces the task of more firmly establishing its role within the entire health care system. Mc Kegney and Beckhardt feel its acceptance by the health care system, and physicians in particular will depend upon scientific demonstration that psychosocial factors influence biologically defined medical illness (2).

2 major research domains appear to have evolved:

cancer control and epidemiology.

psychosocial and psychoneuroimmunology.(1)

According to Holland (1) there are 5 main areas of psychosocial impact on the morbidity and mortality of cancer patients. These are:

1. Lifestyle and behaviours.
2. Social environment.
3. Personality and coping.
4. Affective states/life events.
5. Psychosocial/behavioural interventions.

Systematic research in these areas is providing an increased understanding of the psychosocial needs of cancer patients and the effectiveness of appropriate intervention particularly in terms of relieving unnecessary stress and improving quality of life.

There are an increasing number of papers discussing the role of liaison psychiatry in oncology including the types of problems commonly encountered and the interventions available.(3,4,&5.). Ramirez (3) found that the distribution of patients referred with psychological problems fell into three main categories:

1. Cerebral complications of malignant disease.
2. Coincidental psychiatric disorder.
3. Psychological reaction to malignant disease.

In the latter group there was a high level of Affective Disorder and transient psychological reactions. Ramirez maintained that there was a low rate of referral. The author felt that this was due to the following:

1. An inability of medical staff to recognize psychological morbidity.
2. The low priority given to psychological intervention.
3. A reluctance of patients to disclose their psychiatric morbidity.

Ramsay (4) while agreeing with the above emphasizes the fact that the majority of referrals in his sample presented with an adjustment disorder/problem. The author agrees that physician underreporting is a problem.

The issue of continuity of care is stressed (4).

Meerwein (5) points out a number of important issues when working in this field:

1. It is important for a psychiatrist working in this environment to be cognizant of the fact that one is not in competition with his oncology colleagues. Roles and functions are different.
2. It is important for the Liaison Psychiatrist to emphasize that he views the majority of cancer patients as psychically healthy and that their psychological equilibrium has possibly been disturbed by the onset of the illness.
3. Beware of patients masking the outward expression of their feelings.
4. Cancer patients often regress emotionally as part of their reaction to the illness.
5. The oncology staff may become jealous of the relationship between patient and psychiatrist. It

is important to recognize this perceived threat and confront fears and suspicions.

Exploring psychosocial issues requires a multidisciplinary approach (5). The team includes a psychiatrist, psychologist; psychiatric nurse-clinical specialist and social worker. The training of the psychiatrist allows him to review the interaction of biologic and psychosocial factors in each patient. The unique contribution of the psychologist is in the area of behaviour modification techniques and self -regulatory therapies (relaxation and biofeedback) and neuropsychiatric testing. Many have an additional interest in research methodology. The psychiatric nurse-clinical specialist concentrates her efforts on the nursing staff, helping them to become more objective and provide better care. The social worker is most familiar with community resources and issues involving financial aspects of health care. Hence this member plays and important role in patient rehabilitation. The author feels that the social worker can play a role in therapy particularly family work. Proper training and supervision must be available.

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The author (6) advocates the use of a biopsychosocial database which he feels is the fundamental clinical tool to assure a systematic approach to patient care. This attention to multiple dimensions also ensures that the crucial psychosocial factors will not be discounted by an excessively biomedical viewpoint. Elements that must be included in any basic history are:

past psychiatric history
significant life events
family history
medical history including habits and current medication.

Gonda (7) looks at the psychosocial considerations in the treatment of leukaemia. They are not dissimilar to those inpatients with non-haematological cancer. Modern chemotherapy leads to considerable difficulty in adjusting to treatment-related debility and loss of control. Another concern is the tendency of leukaemia to follow a path of remission and exacerbation which leads to uncertainty about course and outcome. Finally like other malignancies, it is difficult to distinguish the effects of the illness and its treatment from frank depression. The author feels that the following points suggest a mood disorder:

a sense of hopelessness and helplessness.
slowed thinking and speech.

rumination about suicide and unremitting blackness of mood that is not even lightened by previously pleasurable activities.

Psychiatric morbidity is uncommon in patients with cancer. The majority of patients present with adjustment problems associated with their illnes, its investigation or treatment(1). Symptoms (particularly of depression) are often masked. Staff are often unaware of psychological problems which seem to have a low priority in the overall care of the patient with malignant disease.

1.2 THE SOCIOECONOMICALLY DISADVANTAGED.

Poverty is associated with lack of education, unemployment, substandard housing, risk-prompting behaviour and lifestyle, and diminished access to health care (8). According to Freeman all the above contribute to decreased survival. Poor people tend to concentrate on day-to-day survival, often develop a sense of hopelessness and powerlessness, and become socially isolated. Kerner (9) maintains that the gap between interventions for the SED and the middle and upper classes is growing and that the majority of these interventions are researched in this latter group.

Kerner (9) states that the major identifiable preventable risk factors in cancer are smoking, diet and accessibility to screening. The Tobacco Industry targets the SED group which has higher rates of smoking compared with the rest of the population. High bulk foods tend to be unaffordable. Screening is either unavailable or inadequate. Educational programmes are frequently inappropriate and insensitive to the needs of the targetted community.

Improved funding of research in the SED group is a priority.

1.3 MOOD PROBLEMS IN CANCER.

Dean et al (10) feel that the majority of cancer patients have minor affective illness and in his series only 5% required active treatment. They emphasize the stigma attached to psychiatric referral. The authors mention the difficulty distinguishing between appropriate distress and significant depression. They emphasize the importance of previous psychiatric morbidity and the likely predisposition to recurrence.

Dean maintains that adequate social support is important and must be assessed. He feels that psychological assessment is important as active intervention may alter the prognosis.

Massie and Holland (11) in their paper stress that only a small percentage have preexisting affective disorder. They feel that during clinical evaluation it is important to assess if there is a history of previous depressive episodes, family history of depression or suicide, concurrent life stress, and availability of social support.

The authors emphasize that one cannot rely on neurovegetative symptoms as they are commonly associated with the disease process itself.

Peteet (12) describes 3 types of depressive reactions in cancer patients :

the transient stress reaction
the major psychiatric disturbance requiring prompt specialized attention
and a miscellaneous group where charactological, interpersonal and organic factors operate.

He feels that shock, anxious distress, and emotional turmoil at the point of diagnosis; discovery of a worsened prognosis; or loss of valued functions are typical reactions displayed by the cancer patient. These may be accompanied by anger, withdrawal, tearfulness, and insomnia but not typically persisting vegetative symptoms, social withdrawal, or suicidal ideation.

Evans and associates (13) unlike the above feel that Major Depression is common in cancer patients and frequently goes unnoticed and is inadequately treated when diagnosed. The authors then discuss the diagnostic pitfalls particularly the problem of neurovegetative symptoms. They claim that suicidal ideation is uncommon in cancer patients. They also unlike others advocate greater use of antidepressants at full therapeutic doses.

There are certain areas that need to be explored when assessing a cancer patient for depression.

Hopwood and Maguire (14) emphasize the importance of exploring the issue of body image. The effects of malignant disease and the various modes of therapeutic intervention often have a profound effect on the physical appearance of the patient. This may lead to changes in self concept and associated undesirable alterations in behaviour. They explored the effect of breast removal on sexual behaviour. They concluded that patients who fail to adapt to loss of a body part or function as a result of cancer or its treatment seriously compromise their quality of life during survival. This disturbance of body image frequently contributes to the development of an affective disorder.

Another important area that must be explored is the issue of pain. Breithart (15) contends that pain is a feared consequence of cancer. Noyes (16) in his review gives some useful general principles for assessment of pain. He maintains that pain falls into 3 aetiologic categories:

1. Pain caused by the cancer.
2. Pain caused by cancer therapy.
3. Pain unrelated to the cancer or its therapy.

The author emphasizes that it is important to treat pain adequately before diagnosing depression as many of the symptoms associated with chronic pain mimic those of major affective disorder.

Forman (17) agrees with Evans (13) that suicidal ideation is uncommon in cancer patients. The suicide rate amongst these patients is surprisingly low. Forman maintains that the cancer patient who does commit suicide is likely to have been in the late stages of his disease and to have given signals of poor psychologic resources and limited ability to adjust to illness.

Massie and Holland (11) concur stating that there is a higher rate of suicide associated with poor prognosis, prior psychiatric history, and a history of previous attempts or a family history of suicide.

In addition, the recent death of friends or spouse, few social supports, depression (particularly when hopelessness is a key feature), poorly controlled pain, delirium, and recent information about a grave prognosis are significant risk factors.

1.4 STRESS IN THE CANCER PATIENT.

Redd and Jacobsen (18) divide current issues in psychological factors and cancer into 3 categories:

1. The role of psychological factors in disease promotion and progression.
2. The impact of neoplastic disease and its treatment on psychological functioning.
3. The long-term impact of cancer and cancer treatment on the survivor and issues of family bereavement following the death of a cancer patient.

According to the authors psychosocial risk factors include stressors encountered, underlying personality traits or coping styles, and personal habits.

According to Lesko and Holland (19) the normal concerns associated with haematological malignant disease include:

death

dependency on family, spouse, and physician, balanced against the need for independence

disfigurement and changes in body appearance and self image, sometimes in loss or changes in sexual functioning

disability that interferes with achievement of age appropriate tasks in work, school or leisure roles

disruption in interpersonal relationships

discomfort and pain in the later stages of illness

disengagement towards reentry into a near-normal lifestyle (survivorship).

The patient's ability to manage these stressors depends on the following factors:

1. The disease itself. (ie. symptoms, clinical course, type of treatment required, number of relapses.)
2. The level of adjustment, especially prior to medical illness.
3. The threat cancer poses in attaining age appropriate development tasks and goals.
4. The presence of emotionally supportive persons in the patient's environment.
5. Cultural and religious attitudes.
6. The patient's potential for physical and psychological emotional rehabilitation.
7. The patient's personality and coping style.

The authors go on to discuss the 2 most important psychological sequelae in haematological malignancies namely anxiety and depression.

They emphasize situations where acute anxiety is likely to occur in the course of the illness:

while awaiting the diagnosis of cancer
while awaiting procedures
prior to major treatment
while awaiting test results
upon learning of relapse
upon change of treatment
on the anniversary of illness related events.

According to the authors depression is related to stressors with cancer. They also mention the role of medication, biologically determined depression and bipolar illness in the cancer setting.

Weismann (20) in his paper points out that diminished distress improves coping skills, allowing the patient to become a more active participant.

The author describes 2 types of vulnerability namely, dysphoria or dispositional. Dysphoria refers to the affect observed. It relates to the distress or pain the patient is experiencing at the time. Disposition refers to the plight or predicament the patient finds himself in at the time. Assessment of these 2 factors according to the author allows one to reduce the level of stress and improve coping skills.

The importance of adequate assessment of stress in the patient is illustrated in a paper by Irwin (21) who reports an episode of a Brief Reactive Psychosis in a 13 yr. old boy with leukaemia. Increased awareness and better monitoring of the situation could possibly have prevented this outcome.

Ell, Nishimoto et al (22) discuss the issue of survivorship and the importance of quality of life which is gaining more prominence with improved physical treatments and outcome.

They found that the psychological status of patients three or more years after the diagnosis is similar to that found in the general population. However there is a group of patients (approximately 20% to 30%) who continue to experience clinically significant distress and poorer wellbeing long after the diagnosis. Undoubtedly illness-related factors account for ongoing distress among these patients, but psychological factors such as coping resources and life stressors unrelated to cancer are important and may vary over time.

Illness related factors included:

frequency of physical symptomatology
role functioning limitations.

Psychosocial factors included:

personal sense of control
social support
life stressors unrelated to cancer.

The authors conclude that repeated psychological and quality of life assessments are needed to monitor accurately the patient's ongoing adaption.

Donavan and associates (23) emphasize the importance of accurately measuring all domains of life that are impacted by cancer and its treatment. They reiterate the usefulness of a biopsychosocial model.

In the physical domain quality of life is impacted by symptoms, loss of function, and curtailment of activity due to disease process and the physical effects of treatment.

In the psychosocial domain the authors identified 5 major emotional themes:

1. The fear and anxiety generated by the diagnosis and compounded by inadequate communication with caregivers.

2. The loss of personal control associated with the need to be completely dependent on those administering treatment.
3. The uncertainty about outcome.
4. The physician's persistent enthusiasm for cure.
5. The debilitating effects of standard treatments.

Other causes of anxiety include persistence of symptoms, relentless progression of treatment, insecurity when treatment is stopped, having to wait for results of tests, hair loss, alteration in body image, and reduced sexual libido and sexual activity. Other anxieties not directly associated to the illness relate to work, family, unrealized goals, and financial difficulties. The need for clarification about personal responses to the situation are appropriate.

In the social sphere these patients frequently need increased support.

In summary stress is an important factor in cancer in terms of the aetiology of cancer (although unsubstantiated in the human model), the general wellbeing of the patient, particularly in the area of vulnerability and coping ability, and finally its effect on quality of life in the area of survivorship and possible disease outcome.

1.5 MANAGEMENT.

Quality of care has become a central issue in cancer management. Winchester in his paper (24) maintains that quality of care is made up of a number of different components. These include:

1. Competence. The mechanism of achieving and maintaining competence is by certification, recertification and peer review.
2. Care and compassion.
3. Co-ordination of care eg. the multidisciplinary team.
4. Cost effectiveness.
5. Consumerism. What do patients want? Is what they want being delivered? Is it being delivered effectively? Are the patients really in a position to judge what they want and how it is delivered? How are we going to carry out consumer ratings.?

He emphasizes that it is important that we are able to monitor the quality and remember that quality is a by-product of both process and outcome.

According to Wells (25) the care of the patient with malignancy spans 3 broad areas:

1. Prevention and screening.

2. Diagnosis and treatment.
3. Terminal care or the treatment of patients with recurrent or advanced disease.

The above model can be applied to the psychosocial setting. Stam H J; et al (26) and Worden and colleagues (27) show that the options for assessing patients with psychosocial problems involve the following:

1. See every patient following diagnosis. This strategy is expensive and does not acknowledge the fact that some patients cope very well without requiring any special assistance. These patients may have difficult moments eg. at the time of diagnosis or at the time of recurrence, for the most part they require little or no special intervention.
2. screen patients using some reliable, valid, and sensitive assessment instrument to identify those at high risk. The authors are at odds on this approach as Stam et al (26) feel it is expensive. Worden and associates (27) feel that identification of this group allows an effective strategy to be implemented. The main aim of intervention is the relief of distress and the improvement of coping skills.

Worden et al (27) in their study divided patients following screening into 2 groups, viz High emotional distress and Low emotional distress. The aim of intervention in the former was to lower levels of distress, correct deficits in coping, reclaim personal control, and improve morale and self esteem. The intervention group did not have significantly more problems than the low distressed patients, but showed an inability to generate a number of alternate coping strategies and seemed to overuse ineffective strategies.

The results showed that the intervention group with the same level of stress at the time of screening had significantly lower emotional distress at each follow-up assessment.

3. Wait for problems or crises to occur and have patients referred to an available resource. Referral usually takes place at the time that:

a problem is perceived

patients themselves or family request some form of psychosocial assistance

the medical staff perceive or detect problems or a crisis.

Stam and associates (26), Massie and Holland (11), and others discuss the difficulty utilizing the DSM IIIR as a diagnostic tool in this setting. The manual does not take into account the actual process of the illness or its physical management. Stam emphasizes the point that a narrow focus on DSM IIIR categories in psychiatric screening studies misses the fundamental distinction between a chronic illness population and a normal population and attributes greater distress to cancer patients than in fact may exist. Massie (28) and other authors mention its shortcomings particularly in the area of mood disorders with its emphasis on neurovegetative symptoms.

Ford (29) discusses the importance of the multidisciplinary team approach to facilitate proper utilization of available manpower resources to maximize the potential of care.

He also feels that there needs to be a greater emphasis on the availability of community care facilities.

Conkling (30) feels that if care is defined as comprehensive it must be continuous. The problems associated with the diagnosis and treatment of cancer are multifaceted and sometimes complex. These problems require thoughtful intervention. Failure to understand the issues surrounding the diagnosis and treatment of the cancer patient can greatly inhibit the ability of patients to function normally, to acquire the multiple services necessary to maintain optimal quality of life, and to cope with the ultimate crisis of terminal illness.

The challenge as the author sees it is to ensure continuity of care as patients are diagnosed, enter the acute care setting, progress through that setting, and then move out to home or institutional settings in the community.

Kobasa (31) looked at how patients perceive their care. He states that medical staff significantly affect this perception by their own handling of the situation. In the Memorial Sloane Kettering Study an active stress management programme for staff was shown to significantly improve patient perceptions of the quality of their care.

In terms of assessment Maguire and Faulkner (32) discuss 3 issues which they feel are particularly pertinent in the cancer patient namely: uncertainty, collusion and denial.

Uncertainty often leads to unnecessary worry and confusion both on the part of the patient and family. The ability of the patient to tackle issues improves when one separates out and explores individual concerns.

It is important to acknowledge the collusion and then to explore and validate it. The main effects of a collusion on the patient are increased stress and decreasing communication often leading to a perceived barrier in the relationship. They maintain it is important to break the collusion before it becomes a problem.

Patients use denial when the truth is too painful to bear. Denial should not be challenged unless it is creating serious problems for the patient or relative. According to the authors a useful method is to go over and explore the events leading up to the present time. The patient often oscillates between denial and awareness and one should check for a window.

The main thrust of pharmacological intervention is in the area of organic mental disorder, mood disorder and anxiety. Psychotropics play an important role as an adjunct in the management of pain.

Delirium is not uncommon particularly in the terminal stages of illness. Massie, Holland and Glass (33) feel that the incidence is underreported and that it is common in the terminal stages of cancer. In their sample they report an incidence of 85%. They maintain that it is difficult to isolate a single cause. They emphasize the importance of adequate management to alleviate unnecessary distress to both patient and family. Massie (28) & (33) recommends the use of psychotropics. The author advocates the use of haloperidol. If there are problems with extrapyramidal side effects then one can use either thioridazine or trifluperazine.

The most common psychiatric disorder seen in malignant disease is depression. Prior to starting an antidepressant it should be borne in mind (11&28) that the majority of patients diagnosed as depressed have an adjustment disorder.

In terms of process one should be aware of the patients disease status at the time of assessment. They recommend the use of standard antidepressants including newer agents such as fluoxetine. The authors feel that for reasons that remain unclear depressed cancer patients often show a therapeutic response to a tricyclic at much lower doses.

Massie (28) discusses the Sloane Kettering experience with psychostimulants particularly methylphenidate. The author maintains that these drugs promote a sense of well-being, decrease fatigue, and stimulate appetite in low doses.

Brief mention is made of benzodiazipines particularly the use of alprazolam when anxiety is a component of the depression or adjustment problem.

There is little in the literature concerning the pharmacological management of anxiety. Most anxiety in the cancer setting according to Massie (28) is acute and related to the stress of cancer and its management. Most of the emphasis seems to be in the area of anticipatory nausea and vomiting seen in patients undergoing chemotherapy and radiotherapy. The benzodiazepine lorazepam has been shown to be effective in this setting (34 & 35). In the field of chronic anxiety, standard treatment regimens are used.

It is important to mention the use of psychotropics as adjuvants in the management of pain. Foley (36) and associates (37) discuss an approach to pain management and the use of adjuvant therapy. The authors feel that the antidepressants particularly the tricyclics are the most useful psychotropic drugs in pain management. Of note is the impression that the "analgesic" action comes on earlier and is independent and separate from any antidepressant effect.

Some of the neuroleptic group of drugs eg.thioridazine, are thought to potentiate the action of narcotic analgesics.

Narcotic analgesics can precipitate a delirium particularly when used in high doses and in the debilitated cancer patient. Neuroleptics are useful in the management of this complication.

There is considerable literature on the use of various psychotherapeutic modalities in the area of general medicine. Much is based on case reports and empirical observation.

Linn (38) mentions the importance in dealing with cancer of taking into account the stage of the illness, physical disability, and morbidity associated with cancer treatment. The author briefly looks at the different psychotherapeutic interventions available namely: individual, group, family and behavioural techniques. The type of intervention is often determined by the patients needs at the time of assessment.

Forester and associates (39) looked at an unstructured psychotherapeutic intervention in patients undergoing radiotherapy. This group of patients manifested a marked degree of apprehension, anxiety, depression, and social withdrawal during the course of radiotherapy. The components of the sessions included catharsis, interprative work and education/information. The results in this study showed that patients undergoing psychotherapy showed reduced levels of emotional and physical symptoms.

Kaufmann and workers (40) discuss psychotherapeutic interventions in survivors and maintain that the psychological needs of these patients must be met. They then explore an integrative system of psychotherapy looking at different patient/family needs at different stages of the illness and its management. The authors explore for example the usefulnes of crisis intervention at the time of diagnosis or family therapy particularly when dealing with younger cancer patients.

The two models that have received considerable attention in the literature are crisis intervention and adjuvant psychotherapy developed by Greer and associates (41). Crisis intervention in cancer patients has been developed over a number of years. Campone and colleagues (42) reviewed its impact in the cancer setting over a decade ago. The aim is to direct attention to the problem at hand, restore the individual to precrisis levels of functioning and to elicit adaptive coping mechanisms. The intervention should be time limited, problem focused and allow attainment of specific, situationally appropriate goals.

The authors present a functional model which they feel should focus on:
the unique meaning of cancer to the individual
previous stressful experiences
usual methods of coping
and support systems presently available.

The intervention should focus on:
shaping reality based expectations
adequate information processing
encouraging adaptive behavioural change
integration

assistance with stress resolution leaving the patient with a sense of accomplishment and an internalized sense of control.

Adjuvant psychotherapy APT (41) is an adaptation of the crisis intervention model. The aim is:

to reduce psychological symptoms associated with cancer, particularly depression and anxiety

to improve mental adjustment to cancer by inducing a positive fighting spirit

to promote in patients a sense of personal control over their lives and active participation in the treatment of their cancer

to develop effective coping strategies for dealing with cancer-related problems

to improve communication between patient and his support system

to encourage open expression of feelings, particularly angry and negative feelings.

Sessions are structured hourly over 6 - 12 weeks. The patients are given regular homework assignments to facilitate the learning of new coping skills.

Greer and associates (43&44) developed the concept of fighting spirit and its importance on outcome. Their work seems to demonstrate that APT leads to increased quality of life and improved survival.

Spiegel and associates (45 & 46) using group therapy in a sample of patients with metastatic breast cancer demonstrated improved quality of life and survival as compared with a matched control. They felt that the important factors operating were adequate social support and the effectiveness of group therapy itself in promoting cohesiveness, support and improved coping skills.

Fawzy and colleagues (47, 48 & 49) recently demonstrated the effectiveness of a structured group intervention on a sample of melanoma patients with non metastatic disease. Of note is the fact that, not only did the patients demonstrate improved quality of life by way of decreased levels of distress and improved coping skills but using certain parameters there appeared to be improved immune function. Furthermore the gains seemed to be sustained over a considerable period despite no further intervention.

Bos-Branolte and associates (50) demonstrated the improved psychological status and functioning in patients with cured gynaecological cancers with the introduction of psychological intervention. They emphasize the importance of survivorship and feel this group of patients need more attention.

Peteet and associates (51) look at the concept of support in their paper. They distinguish 4 principal meanings:

1. Comfort. This is supplied in the main by family and friends.
2. Strengthening. This emphasizes the need for adequate structuring in delivering healthcare. The onus of this form of support falls largely on the multidisciplinary team.
3. Maintenance. This involves maintaining the patient in a state of equilibrium and prevention of decompensation.
4. Advocacy. To advocate or promote the patient's interests.

Most authors agree that adequate social support is essential in the management of cancer patients. Goldberg and Wool (52) maintain that it is not enough to mobilize the patient's support system but that to function effectively a member(s) may need psychological intervention.

They looked at a group of spouses in patients with lung cancer. It was felt that well meaning family members may either not know how to offer emotional support or have great difficulty in providing that support. Their study did not substantiate this hypthosis. The experimental group consisted of spouses who received education and were offered support in handling their partners and their illness. No difference between the control and experimental group was found. The authors feel that blanket policies of intervention are time and energy consuming and that adequate screening is essential.

Much has been written on the topic of terminal care. Stedeford and workers (53) found that requests for psychiatric consultation in the terminally ill were for:

failure in communication
depression, anxiety or delirium.

Their intervention led firstly to better pain control and diminished depression and anxiety and secondly to improved communication between patient and family with resultant improved support and understanding.

Stedeford (54) in another paper explores the major defensive mechanisms in terminal cancer patients namely denial, displacement, projection and regression. He emphasizes the importance of establishing a good rapport with these patients in order to prevent the establishment of maladaptive defences which may hamper treatment or interfere with patient communication.

The author elaborates on the concept of denial maintaining that it is problematic when it interferes with communication or treatment to the extent that the patient may endure unnecessary pain and suffering.

He explores the concept of hope and the principle of attainable goals. The author feels that the withholding of information about prognosis when a patient is seeking it denies him/her something that is essential if he/she is to do the work of rounding off his/her life in a fulfilling way.

Pasnau and associates (55) look at the role of the physician in bereavement and offer some useful guidelines. In terms of attitude it is important that the physician sees death as inevitable and that it is not an indictment on his/her competence.

They explore the normal reactions of:
shock and disbelief
developing awareness of the loss
and restitution and recovery.

The authors then mention the abnormal bereavement reactions:

1. Overreacting without a real sense of loss.
2. Acquisition of symptoms belonging to the last illness of the deceased.
3. Intensified psychophysiological reactions, including asthma and rheumatoid arthritis.
4. Alterations in relation with friends and relatives.

5. Furious hostility against specific persons (often physicians).
6. Repression of hostility leading to a wooden and formal manner.
7. Activities detrimental to their own social and ecomomic existence.
8. Agitated depression.

They then explore the role of the physician prior to, at the time of, and after the patient's death. They emphasize the importance of availability, awareness and sensitivity to patient and family needs.

1.6 CONCLUSION.

Current thinking advocates adequate psychiatric screening of cancer patients to identify those in need of further assessment and intervention. Screening can also act as a useful method for monitoring patient progress. A biopsychosocial model is recommended as an approach. Adequate assessment is stressed realising the limitations of diagnostic tools such as the DSM IIIR in the cancer setting.

A multidisciplinary team approach is advocated to adequately address the psychosocial needs of the cancer patient.

The plight of the socioeconomically disadvantaged is discussed. Preventative screening and educational programmes are frequently inaccessible or unavailable. Treatment facilities are poor and psychosocial issues often go unaddressed. A plea is made for increased allocation of research funding in this area.

Specific psychiatric diagnostic categories are discussed in some detail. The majority of workers agree that depression is the most common diagnosis encountered in the cancer patient particularly Adjustment Disorder. Diagnostic pitfalls are emphasized particularly in the area of mood disorder where one cannot rely on the neurovegetative symptom component. Adequate control of pain in cancer patients is stressed before one can properly assess mood state.

The significance of stress is discussed at some length and the effect of vulnerability in increasing patient susceptibility to distress and maladaptive coping strategies emphasized.

Pharmacological approaches are discussed. Research literature in the use of psychotropics in oncology appears sparse and firm conclusions are difficult to arrive at. It is suggested that antidepressants can be prescribed at half the dose required in the physically healthy adult population. The use of low dose psychostimulants in the treatment of depression is mentioned. The tricyclic group of antidepressants are regarded as a valuable adjunct in the management of cancer pain. The benzodiazepine lorazepam has been shown to be useful in the area of anticipatory nausea and vomiting in cancer patients undergoing radiotherapy and/or chemotherapy.

In terms of researched psychological intervention the main areas of interest seem to involve crisis intervention, adjuvant psychotherapy and group therapy. Psychological intervention is felt to have a significant impact in the areas of improved quality of life (by way of relieving distress), improving coping strategies and more tentatively, improving outcome in terms of longevity.

The importance of social support is stressed particularly in the areas of diminished psychological morbidity and improved quality of life.

Finally the area of bereavement is explored.

METHODOLOGY

2.1 INTRODUCTION.

A descriptive analysis using the DSM IIIR of patients with haematological malignant disease referred by the Dept. of Haematology, Groote Schuur Hospital was carried out over a 2 year period. These patients were compared with a group of patients referred by the Dept. of Radiotherapy, Groote Schuur Hospital.

All patients interviewed were subjected to a standard psychiatric assessment and then allocated diagnostic categories according to DSM IIIR criteria.

The referral source was unaware that patients assessed were part of a prospective study so as not to bias the sample in any way.

In my role as liaison psychiatrist to the Dept. of Haematology, I actively took part in the intervention strategies designed for each patient assessed.

2.2 AIMS AND HYPOTHESES.

The first aim of the study was to demonstrate the incidence of psychiatric morbidity in patients at Groote Schuur Hospital with haematological malignant disease and assess the usefulness of the DSM IIIR as diagnostic tool in this situation. The hypothesis being that the psychiatric morbidity will follow trends reported elsewhere in the literature and that the DSM IIIR will be of limited value in this setting.

Secondly I compared the patients with haematological cancers to those with non-haematological malignant disease. The underlying hypothesis is that psychiatric morbidity between the 2 groups will be similar.

Thirdly an analysis of the impact of psychiatric intervention in terms of time effectiveness and outcome was carried out. The hypothesis is that psychiatric intervention is time effective and prevents deterioration in terms of psychological morbidity.

2.3 STUDY DESIGN.

The age of the acute leukaemia group and the carcinoma (primary and metastatic) was subjected to non-parametric analysis of variable procedure (Wilcox 2 sample test.). The remainder of the data was subjected to a descriptive analysis using frequency tables because the group sizes were too small.

The only ethical issue to consider was that staff and patients were unaware that these referrals were part of a prospective study. I felt that this might bias the referral sample thereby not accurately reflecting the situation as it exists.

All patients following interview were discussed at clinical meetings with prior patient consent as an educative exercise and to plan management. Confidentiality was respected insomuch as all information the patient wanted withheld from the post-interview clinical meeting was not presented. A new folder on all patients seen was opened and filed separately. I was the only person with ready access to this information and no psychiatric notes were written in the hospital folder.

All patients were allocated a number for the purpose of data analysis and remained anonymous.

2.4 PATIENTS AND METHODS.

The first sample included all patients referred to me personally over a 2 year period for psychiatric assessment by the Dept. of Haematology, Groote Schuur Hospital. The population included both inpatients and outpatients. The referral agent was unaware that these patients were part of a prospective study. All patients were referred for psychiatric assessment by members of the clinical haematological staff.

There was no age or sex restriction on the patients referred to me. Forty three patients with haematological malignant disease were assessed by me for the purpose of this study. The diagnostic categories were as follows:

Acute Leukaemia: 23 patients.
Chronic Leukaemia: 9 patients.
Myeloma: 7 patients.
Lymphoma: 8* patients.

* Four patients with Lymphoma were seen in the Dept. of Radiotherapy.

All patients were subjected to a standard psychiatric diagnostic interview. The identifying data was recorded. The clinical material obtained from the interview was analysed using the DSM III R criteria for diagnosis.

The patients were then divided into 3 groups:

1. No further psychiatric follow up required.

2. Progress monitored by haematological staff and myself at feedback meetings and psychosocial ward rounds. The patients were reassessed by me personally on request.

3. Treatment and progress were monitored by me personally. The patients received psychotropic

medication where indicated, or a non-biological intervention which included:

crisis intervention or brief psychotherapy
couple or family sessions where needed.

At the end of the 2 year period no further referrals were included in the study. Over the next 6 months patients in the study group were seen if referred. At the end of this 6 month period all patients in the sample including those that had died during the study were assessed by way of a folder analysis and discussion with the sister-in-charge and the consultant physician.

The second sample included 19 patients referred to me over a 2 year period by the Dept. of Radiotherapy, Groote Schuur Hospital. All patients were seen on an outpatient basis. The referral agent was unaware that these patients were part of a prospective study. Patients were referred by the clinical staff of the dept. of Radiotherapy.

There was no sex or age restriction placed on patients referred for assessment. All 19 patients assessed had malignant disease.
Lymphoma: 4 patients.
Primary carcinoma: 5 patients.
Metastatic carcinoma: 10 patients.

All patients referred were subjected to a standard psychiatric diagnostic interview. The identifying data was recorded. The clinical material obtained from the interview was analysed using the DSM III R criteria for diagnosis.

As my role in the department was consultative unlike the Dept. of Haematology no follow up arrangements were made. A management strategy was devised at a clinical meeting held at the end of the outpatient session. Where necessary patients were referred to the appropriate resource in the Dept. of Psychiatry.

At the end of the 2 year period all patients in the study including those who had died were assessed. This was done by way of a folder analysis and discussion with the relevant attending staff in the Dept. of Radiotherapy.

The following information was documented for each of the subjects:

age
sex
educational status
employment status
previous psychiatric contact
a significant psychological reaction
an Axis 1 diagnosis
type of Axis 1 diagnosis

Axis 3 diagnosis
Pain
Axis 4 diagnosis pre and post diagnosis excluding losses
significant losses prior to diagnosis
use of psychotropics
use of psychological treatment strategies
an analysis of follow up visits in the haematological group
physical outcome
psychological outcome.

For the purpose of understanding elaboration of the content of some these groups is necessary (see appendix 1. p42-45).

APPENDIX 1.

EDUCATIONAL STATUS.

This group was divided as follows:

0 = No formal education.
1 = Primary Education(Sub.A - Std.5.)
2 = Secondary Education(Std.6 - Std 10.)
3 = Tertiary Education(Completed Diploma/Degree course.)

EMPLOYMENT STATUS.

This group was divided as follows:

0 = Gainfully employed.
1 = The patient receives an income either by way of a disability grant or pension.
2 = Unemployment as direct result of the illness.
3 = Unemployment.

SIGNIFICANT PSYCHOLOGICAL REACTION.

This category was introduced for a group of patients who were sufficiently distressed to require psychiatric intervention but did not meet the DSM IIIR criteria for Axis 1 diagnosis. The reaction was an adjustment problem related to a stressor(s).

0 = no reaction.

1 = a significant psychological reaction (SPR.).

AXIS 1 (PSYCHIATRIC DISORDER).

This was divided into 5 main categories:

0. = None.

1. = Organic/structural. This category included all organic brain syndromes both acute (delirium) and chronic (dementia).

2. = Organic/substance. This represents all patients with a substance (eg. alcohol, benzodiazepine, or cannabis.) abuse/dependence diagnosis.

3. = Functional/Mood. This category included all patients with a mood disorder on a non organic or functional basis ie. Major Depression, Bipolar Disorder, and Adjustment Disorder with depressed mood.

4. = Functional/Other. These patients have a disorder which is functional but unrelated to mood (eg. Adjustment Disorder with mixed emotions).

5. = Mixed Organic/Functional - Mood. The category had an organic diagnosis coupled with a major mood disorder eg. Dememtia with Depression.

AXIS 4 (STRESSORS).

A significant psychological stressor(s) involves an event or enduring circumstance which has occurred in the year preceding evaluation and that may have contributed to the following:

1. Development of a new mental disorder.
2. Recurrence of a prior mental disorder.
3. Exacerbation of an existing mental disorder.
4. Development of a significant psychological reaction.

Types of psychosocial stressors to be considered include:

Conjugal (marital and non-marital)
Parenting.
Other interpersonal problems.
Occupational.
Other living circumstances.
Financial.
Legal.
Developmental.
Physical illness or injury.
Family factors.

Of importance is that the DSM IIIR scale for Severity of Psychosocial Stressors defines serious chronic illness in the category of extreme as a psychosocial stressor.

These were assessed as follows:

0.= None.

1.= Significant stressor(s) in the 12 month period prior to psychiatric assessment.

Significant stressors not associated with the Axis 3 diagnosis:

0.= a significant stressor(s) occurring in the 12 month period prior to assessment that remained unaddressed.

1.= a significant new stressor(s) precipitating assessment.

2.= no stressor apparent.

SIGNIFICANT LOSSES.

The significant loss was the death of a family member, relative or very close friend in the 12 month period prior to the diagnosis of cancer.

RESULTS

3.01 AGE.

There was a significant difference between the Acute Leukaemia and the 2 Carcinoma groups ($p < 0.02$.).

	Acute Leukaemia Group	Carcinoma Group
Mean =	39 years	52 years.
Std.Dev.=	17 years	9 years.

3.02 SEX (APPENDIX 2 TABLE 1).

There was no difference between the sexes with an approximate 1:1 ratio throughout the groups (32 males vs.30 females).

3.03 EMPLOYMENT STATUS (APPENDIX 2 TABLE 2&3).

50% of patients were gainfully employed. 23% of the total sample were unemployed with no income as a direct result of their illness.

There appeared to be a trend for increasing educational status to be associated with increasing rates of gainful employment.

3.04 EDUCATIONAL STATUS (APPENDIX 2 TABLE 4).

38% of the total sample had tertiary education and 47% secondary. Therefore 85% of the total sample had exposure to at least some form of secondary education.

There were three patients interviewed who had no formal education. All three were unemployed with no income, secondary to their illness.

3.05 PREVIOUS PSYCHIATRIC CONTACT (APPENDIX 2 TABLE 5).

94% of the total sample had no prior psychological or psychiatric contact.

3.06 SIGNIFICANT PSYCHOLOGICAL REACTION (SPR) NOT CLASSIFIED IN DSM IIIR (APPENDIX 2 TABLE 6).

50% of the sample had a significant psychological reaction (SPR) related to a stressor(s). 13% of these patients were depressed. The majority of patients (37%) in this group presented with a mixed picture. Hence half the sample presented with a psychological reaction requiring some form of psychosocial intervention.

3.07 AXIS 1 PSYCHIATRIC DIAGNOSIS (APPENDIX 2 TABLE 7).

37% of the total sample qualified for an Axis 1 diagnosis. Although sample size is small there is no significant difference between the cancer subgroups.

21% of the total sample had a significant mood disorder. Hence in 57% of the patients presenting with an Axis 1 diagnosis, a significant depression was present either alone or in combination with another psychiatric disorder.

3.08 PAIN AS A MAJOR PRESENTING FACTOR (APPENDIX 2 TABLE 8).

In 94% of the sample pain was not a significant factor. Three of the four patients presenting with pain as a prominent feature had metastatic carcinoma.

3.09 PSYCHOSOCIAL STRESSORS (APPENDIX 2 TABLES 9-12 INCLUSIVE).

47% of the sample had a significant psychosocial stressor(s) in the 12 month period prior to the assessment interview.

18% of the total sample had suffered a major loss within a 12 month period before the diagnosis of cancer.

In 45% of the sample the stressor(s) identified at assessment had gone unnoticed. 40% of the sample presented with a significant precipitant stressor(s) not directly associated with the illness, its treatment or its prognosis. Hence 85% of the sample had stressors not directly associated with the illness, its treatment or prognosis.

The reason for possible lack of overlap in Table 4c is that a significant psychosocial stressor(s) occurred in the 12 month period prior to psychiatric interview, whereas the significant loss(es) occurred in the 12 month period prior to physical diagnosis.

3.10 PSYCHOTROPIC USAGE (APPENDIX 2 TABLES 13&14).

66% of the total sample seen required no psychotropic medication.

Of the remainder, 12 patients (58% of the patients prescribed a psychotropic) were prescribed a tricyclic on its own or in combination with a psychotropic usually a neuroleptic such as haloperidol. This correlates with the 57% presenting with an Axis 1 depressive disorder either on its own or in combination with another psychiatric diagnosis.

Hence antidepressants were the most frequently prescribed psychotropic medication in this sample of cancer patients.

In 89% of the sample no patient was on a benzodiazepine at the time of interview. Of the 7 patients on benzodiazepines:

3 patients were benzodiazepine dependent and were weaned off over a six week period

3 patients were alcohol dependent and it was used for detoxification

in one patient lorazepam was prescribed when necessary sublingually prior to procedures for anxiety.

Hence of the 7 patients requiring a benzodiazepine only one required ongoing medication for a specific indication and this on a dosage regimen controlled by the patient.

<u>3.11 PSYCHOLOGICAL INTERVENTION (APPENDIX 2 TABLE 15).</u>

In the haematological group:

53% of the sample required one visit

30% required between 1 - 4 visits

8 patients of the total sample had 5 or more visits.

Hence 83% of the total sample required less than 5 visits. This figure may be biased by the number of patients that died (18 or 38% in the haematological group). Despite this of the remaining 29 patients only 3 deteriorated and one had a recurrence of a Major Depression, necessitating further psychiatric intervention. This suggests that the initial intervention, at the time of completion of the study was effective in 25 patients or 86% of the haematological patients still alive at the end of the study period.

3.12 PHYSICAL OUTCOME (APPENDIX 2 TABLE 16).

44% of the total sample died during the study period. 50% of the patients were either stable (34%) or in remission (16%). In 6% there was physical deterioration or relapse. This could imply that there was a bias in the sample referred, towards either terminal/preterminal illness, or patients on palliative treatment with no chance of cure. 16% of the total sample were in total remission or disease free at the time of referral.

3.13 PSYCHOLOGICAL OUTCOME (APPENDIX 2 TABLE 17).

In 90% of the sample there was no documented psychological deterioration. Of the remainder, 5 patients deteriorated requiring further psychiatric intervention and one patient had a recurrence of a Major Depressive Disorder, necessitating reintroduction of an antidepressant. There was no clear association between physical and psychological outcome as 4 of these patients were either in a stable physical condition or in remission.

APPENDIX 2: TABLES

TABLE 1. SEX vs AXIS III

	SEX	
AXIS III	M	F
1	13	10
2	7	2
3	2	5
4	2	6
5	2	3
6	6	4
	32 (52%)	30 (48%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

TABLE 2. EMPLOYMENT STATUS vs AXIS III

	Employment			
AXIS III	1	2	3	4
1	12	6	4	1
2	6	1	2	0
3	4	1	2	0
4	2	3	3	0
5	2	0	2	1
6	5	4	1	0
	31 (50%)	15 (24%)	14 (23%)	2 (3%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

EMPLOYMENT STATUS:

1. Gainfully employed
2. Grant/Pension
3. Unemployed due to illness
4. Unemployed

TABLE 3.
EDUCATIONAL STATUS vs EMPLOYMENT STATUS

	Educational Status				
Employment Status	0	1	2	3	Total
1	0	1	15	15	31 (50%)
2	0	2	8	5	15 (24%)
3	3	2	5	4	14 (23%)
4	0	1	1	0	2 (3%)
	3 (5%)	6 (10%)	29 (47%)	24 (38%)	

EMPLOYMENT STATUS:

1. Gainfully employed
2. Grant/Pension
3. Unemployed due to illness
4. Unemployed

EDUCATIONAL STATUS

0. No formal education
1. Primary
2. Secondary
3. Tertiary

TABLE 4. EDUCATIONAL STATUS vs AXIS III

	Educational status			
AXIS III	0	1	2	3
1	1	4	11	7
2	0	0	5	4
3	0	1	2	4
4	0	0	3	5
5	1	0	4	0
6	1	1	4	4
	3 (5%)	6 (9%)	29 (47%)	24 (38%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

EDUCATIONAL STATUS

0. No formal education
1. Primary
2. Secondary
3. Tertiary

TABLE 5.
PREVIOUS PSYCHIATRIC CONTACT vs AXIS III

	Prev. Psych. Contact	
AXIS III	0	1
1	21	2
2	7	2
3	7	0
4	8	0
5	5	0
6	10	0
	58 (94%)	4 (6%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

0. No previous psych.contact
1. Previous psych.contact

TABLE 6
AXIS III vs SIGNIFICANT PSYCHOLOGICAL REACTION (SPR)

	SPR		
AXIS III	0	1	2
1	16	4	3
2	3	0	6
3	2	1	4
4	4	0	3
5	1	1	3
6	5	2	0
	31 (50%)	8 (13%)	23 (37%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

S.P.R.

0. None
1. Mood
2. Mixed

TABLE 7. AXIS I DIAGNOSIS vs AXIS III DIAGNOSIS

	AXIS III						
AXIS I	1	2	3	4	5	6	Total
0	14	6	5	5	3	6	39 (63%)
1	2	1	0	0	0	0	3 (5%)
2	1	0	1	0	2	1	5 (8%)
3	3	1	0	2	0	1	7 (11%)
4	2	0	0	0	0	0	2 (3%)
5	1	1	1	1	0	2	6 (10%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

AXIS I

0. None
2. Organic - structural
3. Functional mood
4. Functional other
5. Mixed organic/functional mood

TABLE 8. PAIN vs AXIS III

	Pain	
AXIS III	0	1
1	23	0
2	9	0
3	7	0
4	8	0
5	4	1
6	7	3
	58 (94%)	4 (6%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

0. No pain
1. Pain as a significant presenting factor

TABLE 9 Significant Stressor in the 12 month period prior to assessment not associated with the Axis III diagnosis

	Signif. Stressor	
AXIS III	0	1
1	13	10
2	6	3
3	3	4
4	2	6
5	3	2
6	6	4
	33 (53%)	29 (47%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

0. No significant stressor
1. Significant stressor occurring in the 12 month period prior to assessment not associated with the Axis III diagnosis

TABLE 10.

Significant loss(es) in the 12 month period prior to the diagnosis of cancer vs Axis III

	Signif. loss	
AXIS III	0	1
1	21	2
2	7	2
3	5	2
4	8	0
5	3	2
6	7	3
Total	51 (82%)	11 (18%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

Significant loss 12 month period prior to diagnosis

0. None
1. Loss

TABLE 11.
Significant Stresses not associated with the Axis III Diagnosis vs Axis III

AXIS III \ Signif. Stressors	0	1	2
1	10	8	5
2	4	3	2
3	4	3	0
4	3	5	0
5	2	2	1
6	5	4	1
	28 (45%)	25 (40%)	9 (15%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

0. Signif. stressor not assoc. with the Axis III diagnosis occuring in the 12 month period prior to assessment that remained unnoticed.
1. Signif. new stressor not associated with the Axis III diagnosis precipitating assessment
2. No stressor apparent

TABLE 12.
Significant Stressors in the 12 mth period prior to assessment vs Significant Losses prior to onset of illness

Signif. Stressor \ Signif. Loss	0	1	Total
0	26	7	33 (53%)
1	25	4	29 (47%)
Total	51 (82%)	11 (18%)	

Signif. Stressor

0. None
1. Signif. stressor within a 12 month period prior to assessment

Signif. Loss

0. None
1. Signif. loss 12 month period prior to diagnosis

TABLE 13. AXIS III DIAGNOSIS vs PSYCHOTROPICS PRESCRIBED

AXIS III	0	1	2	3
1	20	2	1	0
2	6	1	1	1
3	6	0	0	1
4	3	2	1	2
5	3	0	0	2
6	3	3	1	3
Total	41 (66%)	8 (13%)	4 (6%)	9 (15%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

Psychohopic used

0. None
1. Antidepressant
2. Antidepressant & another
3. Another

TABLE 14. BENZODIAZEPINES vs AXIS III

Benzodiazepines

AXIS III	0	1	2	3
1	22	1	0	0
2	9	0	0	0
3	6	0	1	0
4	6	1	0	1
5	4	0	1	0
6	8	1	1	0
	55 (89%)	3 (5%)	3 (5%)	1 (1%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

Benzodiazepines

0. No benzodiazepines prescribed
1. Weaned off group
2. Detoxification group
3. Prescribed with specific indication

TABLE 15. HAEMATOLOGICAL GROUP
No.of visits vs Axis III

	Axis III				
No.of visits	1	2	3	4	Total
1	12	7	3	3	25(53%)
2	8	0	2	4	14(30%)
3	1	0	1	1	3(6%)
4	2	2	1	0	5(11%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma

No: of visits

1. = 1
2. = 2-4
3. = 5-9
4. = 10 or >

TABLE 16
AXIS III DIAGNOSIS vs PHYSICAL OUTCOME

	Physical Outcome			
AXIS III	1	2	3	4
1	11	3	3	6
2	1	0	8	0
3	3	1	1	2
4	3	0	4	1
5	1	0	2	2
6	7	0	3	0
Total	27 (44%)	4 (6%)	21 (34%)	11 (16%)

KEY

AXIS III

1. Acute leukaemia
2. Chronic leukaemia
3. Myeloma
4. Lymphoma
5. Primary carcinoma
6. Metastatic carcinoma

Physical Outcome

1. R.I.P.
2. Relapse/deteriorate
3. Stable
4. Remission

TABLE 17
PSYCHOLOGICAL OUTCOME vs PHYSICAL OUTCOME

Psycholog.outcome

Physical outcome	0	1	2	
1	24	2	0	26 (42%)
2	4	0	0	4 (6%)
3	19	1	1	21 (34%)
4	9	2	0	11 (18%)
	56 (90%)	5 (8%)	1 (2%)	

KEY

Psychological outcome

0. Stable/no change
1. Deterioration
2. Recurrence of an Axis I diagnosis

Physical Outcome

1. R.I.P.
2. Relapse/deteriorate
3. Stable
4. Remission

DISCUSSION

4.01 AGE.

There was a significant age difference between the carcinoma and the leukaemia groups. This is not unexpected as the acute leukaemias tend to be an illness of young to middle aged adults.

4.02 SEX.

There was no difference between the sexes in terms of referral.

4.03 EMPLOYMENT STATUS.

Approximately half the patients were gainfully employed at the time of assessment. The majority of these patients had a matriculation or tertiary qualification.

The above findings may have been the result of referral bias. However it is likely that other factors may have contributed to this association viz -:

This group were primarily white collar workers who had a more sedentary form of employment coupled with greater employer support and better benefits. The employer was able to exercise greater flexibility in terms of job description and time allocation. The individual was also protected by benefits such as medical aid, and employment assurance.

Although the level of unemployment in S.A. is at present high, there needs to be greater company awareness of the plight of the blue collar worker. Future planning needs to take this into account.

Maintaining employment is an important part of patient rehabilitation and gives the individual a sense of independence and purpose. It often acts as a useful source of distraction and social support making patients less dependent on family and community resources.

4.04 EDUCATIONAL STATUS.

As shown by the results over 80% of the sample had some form of secondary education or more. This is by no means representative of the general hospital community, even taking into account that most patients with malignant disease requiring radiotherapy and /or chemotherapy are treated by Groote Schuur Hospital, as there is no equivalent oncology service in the private sector.

Possible reasons for this discrepancy are that:

1. People with higher education are better able to communicate their distress verbally.
2. The majority of professional staff are either English or Afrikaans speaking, creating a language barrier particularly for Xhosa speaking patients.

3. The majority of poorly educated come from the Xhosa language group.
4. Cultural differences where some groups do not see it as a right to demand attention by enquiring about their wellbeing, or voicing their distress in any way.
5. Insufficient effort made on the part of professional staff to enquire into the wellbeing of this group of patients?
6. The socially disadvantaged are less informed about their rights, about facilities available for both treatment and rehabilitation and about the accessibility of community facilities available eg. National Cancer Association.
7. The socially disadvantaged in this study have diminished access to health care, particularly with recent rapid urbanization and associated poor infrastructure.
8. The escalating costs of health care even for the indigent population with the current State drive towards privatisation.

Certainly more attention needs to be given to this area of patient management as many are surely needlessly suffering. These results reflect the findings of such workers as Kerner (9). Professional training should involve intiatives such as:

language classes in Xhosa

greater understanding of traditional norms and values
greater awareness of the needs of the underpriviledged.

The authorities must consider the introduction of translators, greater utilization of traditional healers, more involvement of existing community resources, and greater accessibility and affordability of services.

4.05 AXIS 1 PSYCHIATRIC DIAGNOSIS.

Of the total sample 63% had no Axis 1 diagnosis.

The majority of patients presenting with an Axis 1 diagnosis presented with a mood disorder (21% of the total sample). This group was equally divided between those with a functional mood disorder (n=7) and those and with a mixed presentation of an organic disorder either structural or substance in origin with an associated functional mood disorder (n=6).

Three of the 6 patients presenting with Major Depressive Disorder had a recurrence of an existing disorder. Hence 3 patients of the total sample presented with a single episode major depression associated with their malignant disease. The remaining 7 patients presented with an Adjustment Disorder with depressed mood.

Hence in this study the incidence of Major Depression associated with malignant disease was uncommon (n=3).

The majority of patients with emotional problems occurring during the course of their malignant disease presented with adjustment disorder or adjustment problems, the latter not classified in the DSM IIIR. These findings are consistent with those of other workers in the field (10 & 11).

Of the total sample 19% (n=12) had an organic component. In 7 patients this was related to a substance abuse/dependence problem predating the diagnosis of cancer.

Of those presenting with a structural organic diagnosis (n=5), 3 patients had a delirium. This latter condition not infrequently goes unnoticed by physicians particularly in the early phases when the main features centre around behavioural changes.

Of interest was a 21 year old male who presented with all the features of Post Traumatic Stress Disorder. In view of this finding he was transferred to a 12 week programme in a Psychotherapeutic Milieu Unit for adolescents and young adults for further assessment and treatment.

As with others working in the field the shortcomings of the DSM IIIR as a diagnostic tool particularly in the area of mood disorder became apparent (11,26,&28). One could not rely on the neurovegetative symptoms, such as anorexia and weight loss, as they frequently were related to the patient's underlying physical condition or treatment. The manual does not take into account the fact that a period of depression is to be expected and appropriate when for instance there is relapse of his/her illness. It is important to monitor patients at junctures such as these and watch for a persistence in depressive symptomatology. The manual does not take cognizance of the effect of treatment such as the discomfort or disfigurement associated with some forms of chemotherapy.

Disfigurement was a theme with most patients interviewed although the study design did not take this issue specifically into account. For example hair loss in the patient, particularly female, during chemotherapy had a major impact and not infrequently appeared to cause the patient more concern than the illness itself.

In the sample of patients interviewed suicidal ideation was never a major symptom except in one patient who was preterminal and on an antidepressant at the time of assessment for a recurrent major depressive disorder. When questioned most either denied suicidal ideation or admitted to vague suicidal feelings. One can only speculate as to the reason for this. Possibly this formed part of their overall denial as a defense mechanism against a perceived life threatening situation. Another factor could be the will to live or survive as part of a normal reaction to the illness.

4.06 SIGNIFICANT PSYCHOLOGICAL REACTION (SPR) NOT CLASSIFIED IN DSM IIIR.

Of the total sample 50% presented with a significant psychological reaction (SPR) or adjustment problem, not classified in the DSMIIIR. In 26% of these patients the primary change was depressed mood.

Although the majority of patients may not fulfil the DSM IIIR criteria for an Axis 1 psychiatric disorder they are sufficiently distressed to warrant some form of intervention. I feel that many of these patients go unnoticed and hence suffer unnecessarily. This is an important area for training staff as the symptoms and signs are not that obvious and underlying distress is often masked by problems associated with their malignant disease. Collateral from family is frequently useful in these situations and assists one in monitoring change.

4.08 STRESSORS.

Of note was that 47% of the sample had a significant stressor(s) in the 12 month period prior to the assessment interview. Aside from this another 18% suffered a major loss 12 months prior to the diagnosis. Sadly the majority of these stressors went unnoticed and hence were additional to the stressors normally associated with the investigation, diagnosis, management, and outcome of the illness.

The above finding is of concern. Although many authors discuss the issue of disease related stress very little is discussed about stressors not associated with the illness or the impact of cumulative stress.

Training in this area is sadly lacking with attending staff frequently focussing their attention on the tasks at hand which are usually disease or physical management related.

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This study showed the situation is unsatisfactory as 40% of the sample presented with a significant stressor(s) not with their illness or its prognosis. The fact that the vast majority of these stressors go unnoticed only adds to the patient's distress and increases their vulnerability to major psychopathology.

This was a situation where a multiaxial approach such as adopted by the DSM IIIR is useful. It allows one to take a more holistic view of the situation and particularly address the needs of the individual patient. Of note is that the manual accords a serious chronic illness the status of an extreme stressor. I think this is important to bear in mind when one is carrying out an assessment because it draws attention to the underlying vulnerability to stress present in each every cancer patient.

4.09 PSYCHOTROPIC USAGE.

The majority of patients seen required no psychopharmacologic intervention (66%). Of those requiring medication most were placed on an antidepressant.

One should be circumspect before prescribing an antidepressant for a number of reasons mentioned below:

1. Prior to using an antidepressant one must be sure of the diagnosis. This is often a difficult task in this group of patients because many of the symptoms

encountered could be related to their underlying malignant disease. One cannot rely on neurovegetative symptoms as in physically healthy adults. It is often wise, if uncertain, to delay antidepressants until after one or two follow up visits.

2. One must exclude pain as a contaminating factor in cancer patients. Pain control is essential before one can make an adequate assessment of the patient's mood status.

3. Compliance is a major factor when prescibing psychotropics to cancer patients. Experience has shown that there is often a lot of resistance initially to starting medication. This is partly due to the stigma attached to psychiatric morbidity and the underlying denial of the problem. Adequate compliance is improved by devoting sufficient time to discussing mode of action of the product used and side effects.

4. The choice of antidepressant is important in this group of patients because of possible undesirable effects associated with their illness and its treatment. These must be borne in mind. This area requires more research but some general principles should be adhered to when starting a product:

gradual increase of the dose to a therapeutic level suitable for that individual remembering that the majority of cancer patients respond to a dosage less than that used in the physically healthy adult population. My experience is that patients with prior Major Depression may need full therapeutic doses as in the healthy adult population,

attempt to avoid products with anticholinergic properties because this may aggravate already unpleasant side effects the patient is experiencing. Patients are frequently on antiemetics such as prochlorpromazine while undergoing chemotherapy and/or radiotherapy and most have anticholinergic side effects. Patients on narcotic analgesia may already be constipated and this will only add to their discomfort.

cardiotoxicity should be borne in mind before prescribing an antidepressant particularly the tricyclic group. One should enquire into the cardiac status of the patient and document the physical medication prescribed particularly chemotherapeutic agents (eg. cyclophosphamide) which have known cardiotoxic side effects.

the patient's progress must be adequately monitored especially in the initial stages of therapy. It should be emphasized that drug treatment is not a substitute for listening, counselling, or psychotherapy.

Antidepressants are useful in the area of pain control particularly the tricyclic group. The mode of action in this setting is thought to be unrelated to their antidepressant effect. Where appropriately used antidepressants can be a useful adjunct to treatment of pain.

The benzodiazepine, lorazepam has been shown to effective in the area of anticipatory nausea and vomiting associated with chemotherapy and/or radiotherapy (34&35). The usefulness of these agents in anticipatory anxiety needs to be further researched eg. in the area of investigatory procedures such as bone marrow aspiration.

These products should not be prescribed without adequate supervision and monitoring. The dosage should be titrated to meet individual needs and the locus of control in terms of usage should be left wherever possible with the patient.

4.10 PSYCHOLOGICAL INTERVENTION.

Comments in this part of the discussion will only include those patients seen in the Dept. of Haematology. Of interest was that only half the sample required more than one visit. Of the sample 83% required less than 5 visits.

It is important because it demonstrates that assessment and intervention is time effective and that the vast majority of these patients do not return for further follow up.

Firstly the majority of patients with malignant disease are psychologically well-adjusted individuals. They are confronted by a major stressor in terms of a life threatening disease often compounded by superadded stressors not associated directly with their illness. In the study population most patients benefitted from a crisis type of intervention concentrating on the issues at hand. There was a cognitive bias to this form of input which was frequently educative and orientated towards problem solving. Only 17% of the sample required more than 5 visits. It was my feeling clinically that these patients benefitted from this brief psychotherapeutic intervention. This was manifest by improved symtomatology and better functioning in their lives both in the occupational and interpersonal sphere, especially with regard to intimate relationships.

Secondly if staff are adequately trained in assessing problems and instituting management strategies much patient suffering can effectively be alleviated. Coupled with this will be the advantage of decreased patient vulnerability and hence less likliehood of developing serious psychiatric morbidity.

Thirdly staff will require adequate support in handling these problems. This is an area where the Liaison Psychiatrist can be utilized in organising feedback meetings which assist the staff in monitoring, managing, educating and supporting patients. Personally I have found these feedback meetings useful in increasing medical staff awareness and introducing a forum for discussion which is both educative and supportive. It also allows the staff to explore issues beyond the narrow confines of the biomedical model and hence develop a more holistic and frequently more realistic awareness of the patient's plight.

The area of staff support needs considerable investigation. Little energy is devoted to this area and most reports are ancecdotal. Proper staffing of units such as Radiotherapy Outpatients or the Haematology High Care Unit should be a priority with adequate cover in case of illness or leave. Enforced periods of leave and regular appraisal of working conditions such as hours worked and call rosters are mandatory. The introduction of support programmes is essential such as staff groups and stress management. These programmes must be directed at all levels of staff. Appropriate education programmes are imperative.

Burn out is a common phenomenon in this area. Sadly for the most part it goes unnoticed by the hospital authorities. (unpublished data.) Hospital personnel and administrative teams need greater awareness in this area of patient care including education about the demands on staff. Large outpatient loads are all too common in the oncology setting with inadequate staffing.

Greater emphasis needs to be placed on the multidisciplinary team. This facilitates a coordinated management strategy. It also allows the patient to benefit from a broader range of opinion and therapeutic skills.

Screening techniques which can be administered by attendant staff need to be developed. This would help in preventing unnecessary intervention delays and patient suffering and also allow one to monitor patient progress.

4.11 PHYSICAL OUTCOME.

As mentioned previously 44% of the sample died during the study period. Those remaining were either in a stable condition or in remission. As no physical parameters were measured it is not possible to discuss the impact of psychiatric intervention on physical morbidity or longevity.

4.12 PSYCHOLOGICAL OUTCOME.

Five patients deteriorated psychologically during the study. This followed initial assessment/intervention including a 6 month period after completion of the study. One of these patients had a recurrence of a Major Depression which responded to the reintroduction of an antidepressant.

It is difficult to interpret the significance of this result and one can only speculate:

initial assessment/intervention addressed the problem successfully

the exposure of the issue heightened awareness of patient, staff and support system

there was improved patient monitoring by staff and the support system

there was improved communication between the parties involved

there was greater patient acceptability and hence an increased feeling of containment, and improved readiness to utilize the service.

4.13 CONCLUSION.

The poor representation of the socially disadvantaged (although the sample size is small) is a matter of concern. A number of reasons have been put forward in the discussion but underpining all these is an urgent need to investigate this discrepancy. This could have a major impact on these disadvantaged members of the community.

The incidence of major psychiatric morbidity appears to be no higher than that in the general population. The onset of malignant disease seems in some cases to lead to a recurrence of existing psychopathology. The majority of patients in the sample analysed presented with an adjustment problem or disorder. The DSM IIIR demonstrated its limitation as a diagnostic instrument particularly in the area of mood disorder where there is considerable overlap between psychiatric symptoms and the disease itself. It also does not make allowance for the effect of the disease process in cancer or its treatment.

Of concern is the incidence of significant stressors predating the onset of malignant disease (including loss) which frequently go unaddressed. Staff appear to concentrate on the definable stressors associated with the diagnosis, investigation, management and outcome. I personally feel the whole entity of cumulative stress needs to be addressed in the cancer setting. The area is important not only in the alleviation of unnecessary suffering in these patients but to diminish their vulnerability and predisposition to psychiatric morbidity. I feel the DSM IIIR is useful in this area as it draws attention to the underlying vulnerability of the cancer patient and makes one aware of stressors outside of the immediate implications of the disease process and its treatment.

Psychotropic usage in this patient population must be judicious. Prior to prescription, the following must be assessed:

past psychiatric morbidity including family history of psychiatric illness
the influence of pain
underlying stressors.

One must choose agents which are effective but at the same time do not add to the distress and physical suffering of the patient. Understanding side effect profiles of products used is important in this area as most cancer patients are on a number of physical agents at any one time; hence polypharmacy is the rule rather than the exception.

This study demonstrated that psychological intervention is cost effective and does not overburden already stressed staff. The majority of psychological interventions required under 5 follow up visits. These interventions were often helpful in alleviating suffering, assisting support systems and improving staff-patient communication and compliance.

This area could be better served by the development and introduction of reliable and valid screening questionaires which could be administered by attendant medical staff. These could identify problems and assist with ongoing monitoring of patient progress.

There is an urgent need to focus on staff issues. There needs to be ongoing input in this area to increase awareness and ability in dealing with psychosocial problems. Educational input should be formal by way of seminars and tutorials and informal by using feedback sessions, psychosocial ward rounds, and discussion groups.

A multidisciplinary team approach needs to be developed to allow for more comprehensive patient management.

A neglected area is staff support where one could offer staff groups and adequate training before entering the field of oncology. Management awareness is vital in this area.

Psychosocial oncology is developing into a recognized discipline. The literature in this area is increasing and a solid body of well-researched knowledge is becoming available. The field has done much to enlighten the oncologist in the deficiencies of modern cancer care. It has highlighted the impact of the illness and its treatment on the patient and attendant psychosocial concerns. I think it has led to a more realistic appraisal of management strategies and takes the individual needs of each patient into account.

It would appear that the problems confronting others are not dissimilar to the Groote Schuur setting. Of urgent need in our setting is increased awareness of the plight of the socially disadvantaged and the implementation of appropriate strategies to confront these issues including communication with the affected communities, increased awareness and attention to psychosocial needs, and improved staffing and staff education and support.

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