Emotional Reactions to Having Cancer

Arthur Peck, M.D.

Physicians continually question whether or not to tell a patient he has cancer. Some advise always telling the truth, others never to do so. Perhaps more basic questions, of central importance to the skilled management of the cancer patient, are: how much does the patient already know about his illness and how is he reacting to this knowledge?

Most patients undergo highly specialized diagnostic procedures. With exposure to information on cancer via the mass media, how much do patients glean from the nature of the tests they undergo? What do they conclude from having surgical treatment or radiation therapy?

In an attempt to learn what patients know of their disease and how they integrate this knowledge, 50 out-patients entering the Radiotherapy Clinic of the Mount Sinai Hospital Radiotherapy Service for cancer treatment, between June 1968 and October 1969, were evaluated by a psychiatric interview. All of these patients had previously been seen by several physicians and had undergone diagnostic and therapeutic procedures. They were chosen at random by the chief nurse of the Radiotherapy Clinic from patients newly registered at the clinic.

Method

Patients were told that a study of the problems and attitudes of patients undergoing radiation therapy was in progress and they were asked to see a doctor for this purpose. No one refused to cooperate.

Each patient was interviewed by the author, who identified himself as a psychiatrist interested in the reactions of patients having radiation therapy. He stated that he had no information concerning any individual’s medical condition or treatment and stressed that he was trying to learn from them in order to be of help to others in the future. The author explained that each patient had been chosen at random, and not because a psychiatric consultation was needed.

Structured interviews, lasting 45-90 minutes, covered each patient’s current illness and radiation therapy; past medical, family and brief developmental histories were also obtained. Patients were permitted to volunteer information, ask questions and make suggestions.
A chronologic account of the current illness was sought, stressing the patient's initial observations and reactions, medical contacts and procedures and expectations of the future course of the illness. What doctors said, when and how they explained symptoms, findings, diagnostic procedures, diagnosis and prognosis were all queried.

**Subjects**

1. The youngest patient was 14 years of age, the oldest 80. The average age was 51 years. Most patients were between 40 and 60 years.
2. There were 23 men and 27 women; 39 whites and 11 Negroes.
3. Most of the 41 patients born in the U.S.A. were born in or close to New York City. Most of the nine foreign born were from Europe.
4. Twenty identified themselves as Catholics, 16 as Protestants and 14 as Jews.
5. Thirty-six were married, five had never married, two were divorced and seven had mates who died.
6. Twenty-nine had completed high school. Of these, eight had also completed college and five had completed both college and a graduate school.
7. All 50 patients described themselves as employed, but not working for the duration of their illness. Sixteen were unskilled laborers, 18 were skilled workers, 11 were self-employed professionals, three were housewives and two were students.

The subjects were drawn from an urban population carrying insurance for radiation therapy. This probably explains its predominantly white, native-born, married and well-educated nature. All 50 patients were diagnosed as having cancer. Sites included: 18 cases of cancer of the breast, four of the uterus, two of the ovary, six of the lung, one of the trachea, five of the larynx, four of the gastrointestinal system, two of the urinary tract, and seven of the reticuloendothelial system, including four cases of Hodgkin's disease. One patient had a basal cell carcinoma of the skin.

**Premorbid Psychiatric Status**

Twenty-seven patients were diagnosed as having a psychiatric disorder. In all but one of these patients, the psychiatric disorder antedated the current medical disorder. Only patients with clearly evident symptoms were included as having a psychiatric disorder.

None of these patients was found to be psychotic. One had a paranoid personality, two had passive dependent personalities. One was a homosexual. Two had psychosomatic gastrointestinal reactions. Psychoneurosis was diagnosed in 21 patients (10 had character neuroses, four anxiety neuroses, four hysterical neuroses, two reactive depressions and one a phobic reaction).

Despite the presence of these disorders, none of this group of patients was currently being treated by a psychiatrist; however, six had previously received psychiatric treatment.

**Sources of Information About Current Illness**

In 14 instances, doctors were reported to have frankly informed the patients that they had cancer. No one resented such disclosure, although accounts of how sensitive the doctors were in giving the diagnosis varied from compassionate to callous and indifferent.

The diagnosis was falsified in five cases and each of these patients accepted the diagnosis without question or doubt. The equivocal diagnoses offered to 13 patients usually were not openly questioned, but these patients were left fearing that they might have or develop cancer.

Most patients inferred their diagnosis from associating cancer with the diagnostic and therapeutic procedures they experienced. Biopsy was the procedure most commonly cited as the clue to self-diagnosis. Radiation therapy was also very commonly felt to signal cancer.
Mastectomy was listed as definite evidence of cancer by all of the 18 patients who had had that operation.

Despite the considerable amount of information on cancer written for the public, only one patient gave a booklet on cancer as the source of knowledge that her symptoms indicated cancer.

Only two patients considered the frequent and repeated contacts with nurses and radiation therapy technicians as sources of information about their disease. Most patients gave the physicians who examined them as a primary source of information on the diagnosis. Only three patients stated that no doctor had said anything to them about their diagnosis. Five stated that they could not recall what their doctor said.

**Emotional Reactions to Cancer**

While only one patient reacted to his illness by developing a new psychiatric disorder, almost all the others showed emotional responses to it. Anxiety and depression were expected and were found. Yet so were significant degrees of anger and guilt.

Anxiety was the most common response. The only patient who did not show anxiety was a highly devout Jehovah’s Witness who had complete faith that her future was ordained by God. Twenty-two patients had severe anxiety, 19 moderate anxiety and eight mild anxiety.

Depression was the second most common response. (Depression here refers to the affect, not to the clinical disorder *per se.*) These patients appeared sad, felt sad and had lost interest in their usual pursuits. Thirty-seven patients were noted to have a depressed affect (five were judged to be severe, 16 moderate and 16 mild).

Guilt was quite evident in 18 patients: six were highly guilty and felt their own actions had caused them to develop cancer. They did not refer to behavior concerning health care, such as smoking, but to behavior related to the deaths of parents or to sexual acts. Twelve others had a lesser degree of guilt about having cancer.

Overt anger at having cancer was present in 22 patients, who directed their anger at doctors, hospitals and relatives. The 14 most angry patients included 10 who were also the most anxious.

The only patient who developed a full-blown psychiatric disorder in response to having cancer was a 34-year-old nurse’s aide. There was no history of psychopathology until she had a mastectomy. Afterwards, she suffered an acute reactive depression, manifested by severe insomnia, anorexia, anxiety and self-blame. She insisted that she was to blame for developing cancer since she had refused to let her ovaries be removed when she had a hysterectomy (for fibroids) five years previously because she believed that the loss of her ovaries would end her sexual desire and diminish her attractiveness to her husband. Now she felt that her wish to continue to enjoy sex had led to punishment in the form of the loss of another sexual organ, the breast, and possibly in the loss of her life.

In seven instances of this series, pre-existing psychopathology was so great as to determine the manner in which the patient integrated the new illness. Direct anxiety about having cancer was swallowed up in the emotional conflicts previously at work in these patients. For example, a man with paranoid personality was so taken up with the trauma of having been robbed and then accused of complicity in the robbery that the serious symptoms of carcinoma of the colon were minimized. In fact, he attributed his abdominal surgery and the resulting colostomy to “nervous indigestion”
brought on by his encounters with criminals and the police.

Six other patients blamed themselves for developing cancer. For example, a woman who had had primary amenorrhea, hirsutism and undeveloped breasts had urged physicians to give her hormones. She then menstruated, developed breasts, married and had children. Twenty years after hormone treatment she was found to have breast cancer. She insisted that she was to blame, since she had asked for hormones, hormones caused breast cancer, and she had brought cancer upon herself.

**Mechanisms of Defense**

It is interesting to find that 40 of this group of 50 patients did know of their own diagnosis. Each patient was asked what his disease was called and when the recorded clinical diagnoses were later examined, only 10 of them differed from those furnished by the patient. Many patients used medical terms such as carcinoma of the larynx, basal cell carcinoma and Hodgkin's disease. Many used the word cancer.

Most of the patients who failed to learn the nature of their diseases were relatively uneducated. A 14-year-old boy with Hodgkin's disease echoed his parents in referring to it as an infection. An 80-year-old man with giant follicular lymphoma referred to the lump in his groin as a tumor, but did not connect a tumor with cancer. Three foreign-born, poorly educated workers were completely ignorant of the nature of their diseases. A woman from a southern rural background was mystified by her failure to recover from her illness but could not think of any name for it. A truck driver stated that his lung surgery was for an inflammation but could not explain that term.

However, some patients who were well-educated and knowledgeable about cancer also failed to understand that this was their disease. A young woman with recurrent abdominal symptoms requir-
be lethal. Most maintained hope that it would not be lethal for them. A few recognized that they had metastatic disease and that they would die. The others were still well enough medically to warrant the subjective estimate of cure.

Denial is not the only defense mechanism utilized against fears of death, pain, helplessness and disfigurement. For instance, some patients knew they had cancer but displaced most of their anxiety onto another person. To escape the helplessness of not being able to control their own fate, they fixed their concern upon the fate of a loved one. These were persons who had previously assumed much responsibility for the care of their dependents. By continuing to feel this responsibility they avoided the role of being weak and dependent themselves.

Other patients were able to diminish their anxiety about having cancer by equating it to other, less dreaded diseases and injuries which they had previously experienced. Since they had been strong enough to overcome those diseases or injuries, they reduced cancer to a disease they could also overcome. This mechanism might be typified in the statement: "I did it before, so I can do it again."

Another useful defense mechanism is identification with the physician. In contrast to the patient, the physician has an active role toward disease. In the patient's eyes the physician understands the illness and takes up weapons against it. The patient remains passive, depending upon others to take care of him, to fight his battle. When independent persons are sick, they become anxious about having to be passive and to depend upon others. If such patients can identify with the physician's active fight against disease, much of their anxiety is lost.

Still another common mechanism of defense against anxiety was to attribute special powers to physicians. Many patients referred to the wonderful advances in medicine and to the powerful ma-

chines and drugs now in use against cancer. A corollary of this defense was to rationalize that intricate, expensive techniques requiring scarce, highly skilled professionals' time and effort would certainly not be used to treat them if their prognosis was poor. This rationalization was used by well-educated, sophisticated patients as well as by those with little knowledge.

**Suicide**

A persistent cause of concern in caring for patients with cancer is the danger of suicide. Many physicians fear that the danger is increased by informing a patient of the diagnosis. Some fear this to such an extent that they refuse to tell any cancer patients the nature of their illness.

But it is of interest that in this series, where so many patients knew they had cancer, no patient admitted an attempt at suicide, and only four patients had suicidal thoughts. These suicidal ideas ranged from an explicit statement of continued, firm suicidal intent to placing such thoughts completely in the past.

**Discussion**

This study demonstrates that there is much more to patients' reactions to cancer than simply resorting to massive denial. With 80 percent of patients able to name their own diagnosis in this study, complete denial of having cancer is clearly not the most common reaction. What is denied by most patients is not having cancer, but the probability of death from cancer. Patient after patient gave his medical diagnosis correctly but described himself as only temporarily away from his work. They knew that radiation therapy treatments might not cure cancer but spoke of it in their own cases as preventive medicine, as "insurance" against recurrence.

Adaptational psychodynamics⁵ offer a useful frame of reference for under-
standing the situation of patients with cancer. This illness is an overwhelming threat to the individual, in the face of which he feels helpless. To regain some feeling of mastery over himself, the individual resorts to previously established patterns of adaptation to overcome feelings of helplessness.

The most frequent such pattern is dependency—to turn to others for protection. As in any serious illness, patients with cancer become dependent upon their physicians. Those in this study amply demonstrated this, some in undisguised form, some rationalizing it as entrusting themselves to experts in the fight against cancer. It is implicit in the unwillingness of such patients to judge their physicians objectively or to compare one physician to another in terms of competence or personality. It is also responsible for their reluctance to question their physicians about the management of their illness.

Some patients do not accept the dependent role and try to continue to have others dependent on them. Such patients are particularly difficult to manage when their illness becomes disabling and they are forced to become physically dependent on others.

Many patients were angry at having developed cancer and directed this feeling toward relatives, doctors and hospitals. The angriest patients were also the most anxious. Their anger, partly a manifestation of their inability to accept dependency, may disguise their need for help if misunderstood by physicians.

The recurrent question of whether to tell the patient he has cancer seems almost academic in the light of the finding that 80 percent of these patients already knew their own diagnosis. Emphasis should shift to understanding how the patient is integrating his existing knowledge of his diagnosis.

Only by learning the patient’s life history and personality can the physician properly evaluate the patient’s integration of his having cancer. It is time consuming to do so, but only by spending time with the patient can the physician know how to manage him during his lengthy, perhaps fatal illness. Sixteen of these patients saw close relatives die of cancer. How can such patients be skillfully managed if this key fact is not uncovered?

Yet it is not easy to get this important information. Most patients are so dependent upon physicians that they do not ask to speak with them. They fear that the busy physician will resent their taking up his time, that he would be annoyed at having to answer “silly” questions. Even an open invitation to ask questions will not break through such timidity, unless it is preceded by sincere interest in the patient as shown in the doctor’s manner and in his willingness to spend time to get to know the patient as an individual.

Once the physician knows his patient well enough to see how he is reacting to having cancer, he can make an informed judgment on how to manage him. This includes deciding what to tell the patient initially and at every phase of his illness and being consistent in the execution of such decisions.

There is another important aspect to the physician’s management of patients with cancer. He must be in touch with his own feelings about the patient and aware of his own reactions to the disease itself, to treatment and to his own role as the physician of the patient with cancer. If too troubled by anxiety about his own health or the well-being of his own family, a physician will not be able to learn the patients’ emotional reactions to the disease. In such instances, physicians tend to defend themselves by involuntary aloofness from patients, or by rigid stereotyped management of all patients with cancer. Sometimes anxiety within the physician leads him to excessive wordiness, circumlocution, omissions and untruths when he is forced to talk to
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cancer patients. If, however, the physician's own reactions to cancer are understood and accepted, he can individualize his approach to his cancer patients. He can let the patient lead in any discussion of diagnosis. He can clarify misconceptions by simple clear statements. He can take the time to know his patient as a human being and relate to him, not avoid him. The patient benefits by a decrease of anxiety and depression; the physician benefits in the preservation of his ability to be of help to the patient, even when he finds himself unable to cure the disease.

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