Anorexia and Cancer: Psychological Aspects

The Editor interviews:
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Editor: In what forms does anorexia present in the cancer patient, and what is the anorexia-cachexia syndrome?

Dr. Holland: Anorexia and the accompanying weight loss may occur at any stage of illness with variable severity, and it may be related to several causal factors: transient anorexia due to emotional distress at the time of diagnosis; anorexia related to treatment, that is, surgery, chemotherapy or radiation; and anorexia due to the development and progression of the disease. Generally, discomfort, pain and lack of a sense of well-being contribute to an emotionally dysphoric state. A full assessment of the importance of these psychological parameters is difficult in the context of clinical cancer. Yet it is important not to underestimate their possible role in the appearance of anorexia at certain times during illness.

Editor: Is there a psychological component in the cause of anorexia in any of the three areas you mentioned?

Dr. Holland: Transient anorexia may occur in the early stages of cancer, at which time many patients manifest symptoms of emotional distress. During the diagnostic work-up, when the presence or absence of cancer hangs in the balance, the emotional and psychological state of the patient is particularly unsettled. The patient may exhibit anxiety, mood swings, difficulty in concentrating, anorexia and insomnia. Acute emotional distress is an expected response to a situation in which anticipation of a threat to life is present, and anorexia is often prominent in the symptom complex. The physician's actual pronouncement that a serious, life-threatening illness — cancer — has been found results in further psychic insult to the patient, and in an increased concern for his life and body integrity.
Editor: How is the psychological effect of a diagnosis of cancer manifested in the anorexia syndrome?

Dr. Holland: Anorexia occurring at the time of initial diagnosis may be part of the acute emotional response to the physician's evaluation, manifested by disruption of normal sleeping patterns and daily activities. The acceptance of a treatment plan outlined by the physician often helps resolve the turmoil. The patient's feeling that "there is something that can be done for my disease" gives hope and encouragement. The history of a five to 10 pound weight loss at this time may also be related to psychological factors, rather than to early cancer, as is often assumed. Renewed optimism and hope on the patient's part are usually the result of the formation of the physician's plan of action.

Editor: Does surgery often produce anorexia?

Dr. Holland: Operations for cancer, particularly in the gastrointestinal tract, may produce difficulties in taste, swallowing, digestion or absorption that may contribute indirectly to anorexia. Discomfort following eating can cause the patient consciously to refuse to eat, even though he may be hungry. In these patients the technique of intravenous hyperalimentation has been used to support those unable to eat as a result of treatment of the disease. During hyperalimentation the patient may experience hunger and require reassurance that this intake is adequate. In Switzerland, where hyperalimentation has been used in germ-free environments, Haenel and Nagle observed in 1975 that many patients developed a psychological dependence upon the prolonged feeding given through a subclavian-vein catheter. This dependency was sufficient to produce anxiety prior to, at the time of, and even after the removal of the tube. This "umbilical cord syndrome" is similar to that of patients who have been known to become psychologically dependent on equipment such as respirators, and even on treatment environment such as the coronary care unit and laminar air flow rooms. We have noted that patients' anxiety increases upon the termination of both radiotherapy and chemotherapy.

Editor: Are there psychological techniques designed to discourage or prevent such a dependence?

Dr. Holland: A period of "psychological weaning" may be required to lessen anxiety. On the other hand, some patients are eager to remove the catheter. While most patients tolerate the procedure well, monitoring of psychological response is important.

Editor: Is there a connection between anorexia and the psychological state of the patient when chemotherapy or radiation therapy are employed?

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Dr. Holland: Anorexia related to chemotherapy is usually secondary to the nausea and vomiting caused by anti-tumor agents such as Cytoxan, nitrogen mustard, procarbazine, actinomycin D and platinum compounds, to name a few. Radiotherapy also produces anorexia as one of its side-effects. Even when pharmacologic agents are used to control the anorexia, reassurance by the physician and constant support by a nurse who regularly gives the infusions should not be neglected since these are very important in sustaining the patient through repeated episodes of emesis, nausea, and anorexia secondary to chemotherapy or radiation therapy.

Editor: How about anorexia related to recurrence or metastases?

Dr. Holland: When recurrent cancer is diagnosed, anorexia as an emotional response may be expected to occur in the context of general anxiety and depression. Fears of recurrence are usually contained, but they are never far below the surface. Appearance of a new symptom which the physician confirms as recurrent cancer results in a psychic upheaval that is apt to be more disruptive than that suffered at the time of initial diagnosis. The original fears for life are greater and the concern for family and future is intensified. Here again, as a new treatment plan is developed to meet the altered clinical state, the acute emotional disturbance abates.

Editor: Is the relationship the same in the case of advanced cancer?

Dr. Holland: The anorexia-cachexia syndrome of advanced cancer poses perplexing questions about etiology. Anorexia may frequently be a presenting symptom in advanced cancer, but the reasons for its presence are unclear. It has been proposed that several metabolic routes may disrupt the feeding-satiety centers of the hypothalamus, producing either decreased hunger or inappropriate satiety. However, the influence of the neoplastic process, either directly on taste or on the hypothalamus, is not clear. A psychogenic basis is sometimes proposed for this syndrome, on the assumption that depression produces the anorexia and profound weight loss. Data do not exist to support this assumption.

One could reasonably question whether clinical depression, with its vegetative symptom of anorexia, could represent a significant psychological etiology of the anorexia-cachexia syndrome.

Editor: What is the basis for the assumption that anorectic cancer patients suffer from "clinical depression"?

Dr. Holland: Data collected on self-reported depression in cancer patients has been compared with the depressive symptoms of other groups. Ninety-seven patients hospitalized with advanced neoplasms at Roswell Park Memorial Institute were assessed by means of the well-known Beck Depression Inventory, and their responses were compared with those of 66 of their next-of-kin and 99 patients...
without significant physical illness who had been hospitalized for depression resulting in a suicide attempt. The results showed that patients with cancer scored in the same low range as their next-of-kin on scale items rating such non-physical symptoms of depression as feelings of worthlessness, loss of self-esteem, pessimism, guilt, and suicidal ideas. All of these items were found to be high in the "psychiatric" depressed population. The depressive symptoms on which the cancer patients scored as high as the suicide attempt patients were the physical symptoms of depression, which are also physical symptoms of advanced cancer: anorexia, weight loss, insomnia, easy fatigability, loss of libido and loss of interest in usual activities. The data on the Beck scales support an etiology other than a psychological state of depression for the anorexia of advanced neoplasm. The symptoms of anorexia and weight loss in the cancer patients were not associated with feelings of guilt, worthlessness, or hopelessness, but were associated with other physical symptoms such as insomnia and fatigability. The conclusion is that total scores on depression scales devised for psychiatric or "clinical" populations are meaningless for patients with serious physical illness and that vegetative signs of depression, when present alone, are not an adequate basis for diagnosis of clinical depression.

**Editor:** Are you suggesting that the anorexia of advanced cancer is essentially "non-psychological"?

**Dr. Holland:** Yes. Cancer patients typically display few of the psychological characteristics by which clinical depression is likely to be diagnosed in psychiatric patients. Furthermore, cancer patients usually do not respond to tricyclic antidepressants with anywhere near the 30 percent frequency seen in patients with psychiatric depression. Thus, standard treatments geared toward psychotic depression are neither appropriate nor beneficial to the anorectic patient. A better term to describe the emotional distress of the patient with advanced malignant disease may be "emotional dysphoria of life-threatening illness," avoiding use of the abused term of depression.

On the other hand, while the anorexia syndrome is presumed to be largely metabolic in origin, psychological techniques oriented toward its particular symptoms may nonetheless be useful in its treatment. Two promising areas of intervention are the use of psychopharmacological agents such as Cyproheptadine or THC, the active ingredient in marijuana, and manipulation of the social environment.

**Editor:** What psychosocial techniques can be used in the nutritional management of the cancer patient with anorexia?

**Dr. Holland:** Basic considerations are the patient's food preferences and the presentation and serving of food in the most palatable form. Special attention to the ambiance associated with eating in the
hospital and at home is needed. When it is possible, planning for the patient to share dinners with family members and perhaps for the serving of favorite wines adds some of the social aspects that many healthy individuals associate with a pleasant meal. Some of the success of St. Christopher’s Hospice in London appears to be due to the encouragement of maximal social interaction with family members, especially around meals.

Although operant conditioning, in which rewards such as exercise, visits and passes are made contingent upon weight gain, has been successfully used in anorexia nervosa patients, it is difficult to see how these techniques could be used for the physically ill. The use of self-hypnosis in managing children with cancer has been reported by LaBaw as resulting in children achieving more rest, less anxiety, better food and fluid intake, and less anticipatory anxiety and vomiting prior to treatment. Further exploration of these techniques, particularly the utilization of group participation, may prove useful in children and possibly in adults.

Editor: Thank you, Dr. Holland.

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