Emotional Crises and Cancer

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Cancer is a hazardous event for both the patient and his physician. To cope, the physician must create a total situation which minimizes the patient’s anxiety, anger and depression and maximizes his ability to respond in adaptive, realistic ways. A good doctor-patient relationship and open lines of communication are essential. Above all, the physician must emphasize probabilities, rather than absolutes, always leaving room for hope.

Because a diagnosis and subsequent treatment for cancer will most likely cause severe stress for the patient and his family, the question frequently arises whether “to tell or not to tell” the patient he has cancer. Several studies have demonstrated that most patients ultimately know their diagnosis and that failure to initially give at least minimally honest feedback impairs communication and makes it more likely that emotional crisis will arise in the future. 1,2

It is also becoming increasingly evident that caring for a cancer patient poses difficult emotional problems for the physician and other health care personnel. 1,3 Recent research at the City of Hope Medical Center indicates that health care personnel rate cancer as stronger, more cruel, more anxiety-provoking, more unfair, less happy and more worthless than even death. 4 Apparently, then, it is generally quite stressful for physicians to inform patients that they have cancer, a recurrence or metastases. Of course, there are many realistic reasons why this situation is stressful, including the high probability that the physician may ultimately be frustrated in his attempt to completely cure the patient.

Faced with this situation, the physician may rationalize that it is easier or more humanitarian, to take a “short term” apparent gain and “spare” the patient the bad news. However, such a tactic involves often unrecognized future risks. Most importantly, it denies reality. The patient has cancer and he must begin to deal with this fact. If the physician cannot at least minimally inform the patient, then with whom is the patient to discuss his diagnosis, his doubts, his fears, his questions regarding treatment? By maintaining a conspiracy of silence, by evading the issue, or by giving false information, future communication with the patient is impaired. This, of course, does not mean that the patient should be informed of all of the facts, such as the total prognosis or his life expectancy. As Hall has pointed out there is a difference between

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"‘the truth and the whole truth. . . .’ The patient will usually inform you of the ‘limits of his capacity to assume . . . the burden of knowledge.’”

Common Emotional Responses to Cancer

The common negative emotional responses aroused by, or associated with cancer are anxiety (fear, dread), anger (frustration, rage) and depression (guilt, despair). Denial of the threatening event, withdrawal, rejection of others, bargaining and, at times, true acceptance may also be seen. Kubler-Ross discusses five phases that the patient may go through: ‘‘not me’’ (denial); ‘‘Why me?’’ (anger); ‘‘Yes, me, but . . .’’ (bargaining for time); ‘‘Yes, me’’ (depression); and, hopefully, near the end, acceptance of the inevitable. She emphasizes that there is immense variability among patients; some may enter and leave one phase a number of times, may never experience more than one or two phases or may skip phases, and so on.

There is little doubt that awareness of having cancer, and its implications, naturally gives rise to negative emotions and defensive behaviors. However, it is often difficult for health care personnel, including physicians, to accept the normal, healthy expression of these emotions. For example, physicians are often upset by denial, even when it is a temporary response which allows the patient to assimilate information at a tolerable rate. The immediate alternative to denial could, in this case, overwhelm the patient and throw him in a state of crisis.

Therefore we must attempt the often difficult task of differentiating between healthy and unhealthy emotional expressions. A useful rule of thumb is: if the emotion significantly impairs the individual’s ability to function—to follow treatment requirements or minimally deal with his day-to-day life—for more than a week or two, it should be considered abnormal. However, it must be noted that an emotion expressed by a patient is not abnormal simply because it is not the way the physician would respond or because it causes discomfort or ‘‘problems’’ for health care personnel. For the patient, these profoundly felt negative emotions have been preceded by a deep investment in living.

Modes of Intervention

If physicians are to deal with difficult emotional behavior, they must know why it occurs. It is no longer sufficient to say that a person behaves in a certain way ‘‘because he is sick, or dying, or tired, or depressed, or angry. . . .’’ Instead, environmental, social, personal-history, physical, hereditary, economic and other factors must be considered in the cause of his current behavior. In addition, it is important to pay close attention to the social and environmental consequences of the patient’s behavior. For example, if the patient is given pain medication only after certain behavior,
he is obviously more likely to behave that way in the future. His pain-related behavior has been reinforced by attention and medication.

There are four general guidelines for dealing with emotional crises:

1. Develop a relationship based on trust, confidence and faith in the physician. A patient who has a quality relationship with his physician shows a more favorable response to treatment, and is generally more cooperative, causes fewer problems and requires less medication for pain or sleep. Iatrogenically-induced sedation, an aspect of the "placebo effect," is well documented and does not require further comment.

2. Maintain open communication. Interviewing techniques are essential to establish an information base and to articulate your relationship with the patient. Be sure to give the patient the time and opportunity to talk and to elaborate on his questions. In general, answer the patient's question—no more and no less. Detailed information which the patient may not understand, or may not want to know, is not necessary.

3. Discuss the probabilities or likelihoods of the disease, or of treatment, rather than talking in terms of absolutes. It is obviously very stressful for the patient to be told definitively when he will die—three months, six months—and the chance of erroneous prediction is high.

4. Maintain hope. While health care personnel are usually most concerned about maintaining hope for a cure of the disease, there are many other kinds of hope which may become equally important to the patient. These include the hope of not being abandoned, very important to patients approaching terminal status; the hope of having pain adequately treated; the hope that families will not unduly suffer; the hope that death will be as easy as possible.

Some Specific Techniques
Several interpersonal and behavioral techniques to help the patient cope with his emotional crisis include: keep the future open; focus on and provide what the patient can still enjoy; find alternative activities which the patient can perform, or alternative ways to perform gratifying activities (including sexual functioning); reward the patient's healthy, adaptive behavior; concentrate on symptoms which can be treated; avoid self-fulfilling prophecies; and involve all available ancillary personnel in a team approach to the patient. It is also very important to deal with the patient's family in an informative, supportive way.

Psychotropic drugs can be of assistance in alleviating or controlling some negative emotions. The minor tranquilizers, such as valium and librium, are useful for treating mild-to-moderate anxiety. The tri-cyclic antidepressants (amitriptyline, etc.) may occasionally be helpful for relieving deep depression, and phenothiazine tranquilizers are very helpful for severe anxiety, and for potentiating analgesics and hypnotics. The patient may also need other drugs for adequate, individualized medication for pain. Often, the staff is reluctant to give adequate analgesics to the dying patient on the basis that "too large a dose" will cause addiction. This is not generally valid, since once the patient knows he
will have adequate pain relief when important, his need for medication will frequently decrease. Abuse of medication is the exception rather than the rule.

Brief psychotherapy, when appropriate or necessary, can also be utilized. A wide variety of brief treatments are now being developed, many of a "crisis intervention" or a "behavior modification" orientation. A "total milieu" approach which accurately assesses the patient’s psychosocial needs and then designs a consistent attitudinal approach can be used with either inpatients or with outpatients. 12

In conclusion, anxiety, grief, depression, anger and denial are the most normal reactions of emotional crisis in the cancer patient. All of these can, to some extent, be resolved by the trust and confidence the patient should have in those who care for him.

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A Look Ahead

Science, as one of man’s highest and greatest intellectual achievements, has had a pervasive and protracted influence on man, his way of life, and his environment. And nowhere has its power for change been so dramatic as in the United States. Most scientists hold that the destructive forces let loose by science can be properly focused and wisely used. Accomplishing these ends necessitates a major effort on the part of science and scientists—an effort dedicated to serving all of society and all of man. And while few can agree on the exact details, all concerned believe that science is indispensable for a future in which man is in reasonable harmony with his physical and social environment.—W. D. McElroy, Ph.D., Chancellor, University of California at San Diego, in Science 175: 349-464, 1972. P. 361.