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Psychosocial and Psychological Challenges Faces Women Diagnosed with Cancer

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Psychosocial and Psychological Challenges Facing Women Diagnosed with Cancer

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CERTIFICATE OF APPROVAL

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Psychosocial and Psychological Challenges Facing Women Diagnosed with Cancer

This is to certify that the Capstone Project of

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Abstract

According to the American Cancer Society (2015), there were approximately 231,840 new cases of breast cancer diagnosed with nearly 40,290 deaths related to this type of cancer in 2015. Furthermore, 67,770 new cases of uterine cancer were diagnosed in 2015 with almost 14,270 related deaths from this form of cancer. Research has shown that women diagnosed with cancer also experience psychosocial issues and psychological distress. Through this paper, we will identify specific psychosocial and mental health challenges women face when diagnosed with cancer. Specifically, we will research depression, anxiety and posttraumatic stress disorder (PTSD) and ways in which these psychological factors manifest within the cancer diagnosis. Once these psychosocial issues and psychological distress' are identified, we will research evidenced based therapeutic interventions that can be beneficial in assisting women in processing through their cancer journey throughout many different stages and phases.

Keywords: psychosocial, psychological, depression, anxiety, posttraumatic stress disorder (PTSD), cancer diagnosis, therapeutic interventions

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Psychosocial and Psychological Challenges Facing Women Diagnosed with Cancer

Introduction

Changing psychosocial needs and psychological distress are common challenges women face when diagnosed with cancer. "Psychosocial factors, as well as psychological interventions, have now become issues for study in relationship to cancer onset, quality of life and length of survival" (Straker, 1998, p. 1). Exploring specific psychological and psychosocial factors that interrupt quality of life and well-being of female cancer patients are necessary components of proper treatment and therapeutic intervention for women facing a cancer diagnosis. Understanding these specific factors, and applying the effective treatment and therapeutic interventions will increase the patient's ability to regulate her emotional distress and thus, increase her level of well-being and quality of life throughout her trajectory of cancer diagnosis and treatment. Research has shown that "implementing psychosocial interventions in the early phases of cancer treatment may influence long-term psychological well-being" (Stagl et al., 2015, p. 179). Researching specific evidenced-based interventions used in the treatment of psychosocial and psychological factors related to cancer is essential in delivering efficient intervention and care.

Review of Literature

We begin by defining two key terms that we will examine in depth in this research: distress and health. Pascoe, Neal, Allgar, Selby, and Wright (2004) define distress as:

> An unpleasant experience of an emotional, psychological, or spiritual nature that interferes with the ability to cope with cancer treatment. It extends along a continuum, from common normal feelings of vulnerability, sadness, and fears, to problems that are

> disabling, such as true depression, anxiety, panic, and feeling isolated or in spiritual crisis. (p. 115)

Furthermore, "health is determined not just by biological processes but by people's emotions, behaviors, and social relationships" (Adler & Page, 2008, p. xi). Having a clear understanding of how each of these factors influence emotional and physical health is essential when determining evidenced based therapeutic interventions to effectively treat those women suffering from additional factors influenced by their cancer diagnosis.

Psychosocial Factors

According to Shapiro et al., (2001) "the diagnosis of cancer elicits greater distress than any other disease" (p. 502). Existing psychosocial stressors tend to exacerbate the onset of a cancer diagnosis. According to Nicholas and Veach (2000), "psychosocial adaptation to cancer is the ongoing process of adjustment to the variety of cancer-related life stressors each patient encounters" (p. 206). That is what our research is interested in helping women achieve. Coupled with increased depressive symptoms and other emotional problems common to individuals receiving a cancer diagnosis, additional issues such as lack of information or skills needed to manage the disease, disruptions in work, school, and family, and weakened health have a tendency to increase social distress (Adler & Page, 2008, p. 1). Women newly diagnosed with breast cancer often feel forced to face their mortality. Uncertainty and fear become overwhelming which causes intense psychosocial distress (Shapiro et al., 2001, p. 503). Further, women often blame themselves for their cancer diagnosis. Despite efforts to avoid illness through diet, exercise, and a healthy lifestyle, a cancer diagnosis may leave them feeling at fault (Straker, 1998, p. 6). Annette L. Stanton (2006) recognized that "women diagnosed with cancer experienced an increase in pain and declines in the realms of physical and social function,

vitality, and ability to perform emotional and physical roles" (p. 5132). Similarly, social stigma, isolation, loss of feminine identity, body image and sexuality issues, genetic risks and an overall sense of guilt related to the disease are also psychosocial issues women face throughout their cancer trajectory (Hodgkinson et al., 2007).

Shapiro et al. (2001) identifies three essential psychosocial variables affecting female cancer patients which include loss of control and feelings of helplessness, stress and its negative impact on physical health, and the ability of repression and denial to influence cancer due to dysregulation of the immune system (pp. 504-505). Howell, Fitch and Deane (2003) add "Major challenges include, living with uncertainty, lack of control, fear of the unknown, stigma of cancer, facing death and leaving young children behind" (p. 126). Research by Tallman, Altmaier, and Garcia (2007) reports, "Receiving a cancer diagnosis is often unanticipated. Cancer calls into question one's mortality and the possibility of dying becomes foreseeable and uncontrollable" (p. 481). Understanding how these psychosocial factors intersect with women facing a cancer diagnosis is the first step in treating these patients within the realm of both medical and psychosocial treatment domains.

Potential Barriers

Pascoe et al. (2004) researched potential barriers to female cancer patients receiving support. They found that it was often difficult for patients to express a need for additional support from their physicians. Furthermore, "one in three patients who indicated a need for service had support, 9% of patients who were not offered support and only 22% of patients who were offered support accepted" (p. 439). Perry, Kowalski, and Chang (2007) add, "while patients want their health care providers to inquire about their daily functioning and well-being, health care providers may seldom do so" (p. 3). According to Adler and Page (2008), "many

people living with cancer report that their psychosocial health care needs are not well addressed in their medical care" (p. 5). Effective communication between patient and health care provider is critical so that patients feel comfortable with asking questions of all their health care providers. Cancer patients must be able to understand information about their illness as well as feel safe in asking for clarification when they do not understand. Additionally, it is also important to include any family members that are involved in this communication process (Adler & Page, 2008, p. 159).

Pincus and Patel (2008) report "barriers to psychosocial care are encountered at multiple levels: patient, provider, practice/delivery system, health plan, purchaser, and population/policy" (p. 661). Individuals who lose their jobs due to their cancer diagnosis run the risk of losing their health insurance coverage (Adler & Page, 2008). An additional barrier is the lack of/or inadequacy of health insurance coverage.

> An estimated 8 percent of women with breast cancer are uninsured, or, if patients are insured, there is coverage of mental health services with lower reimbursement levels or placement of mental health services in behavioral health contracts, separate from medical coverage. (Hewitt, Herdman & Holland, 2004, p. 5)

Sadly, cancer affects everyone regardless of marital status, socioeconomic status, employment status or educational achievements. Physicians who have a clear understanding of some of the psychosocial issues women face when diagnosed with cancer and women who are willing to ask for help creates a collaborative environment suitable for positive psychosocial intervention, referral, and medical care.

Psychological Factors

Statistics show that depression, anxiety and PTSD rank high in regards to psychological factors influenced by an unanticipated cancer diagnosis. "Individuals with cancer often exhibit symptoms of psychological distress, including depression, anxiety and symptoms of posttraumatic stress disorder (PTSD)" (Tallman et al., 2007, p. 481). Research by Stafford et al. (2013) reported rates of anxiety (17.7%), depression (32.5%) and combined anxiety and depression (35%) symptoms were highest at diagnoses in breast and gynecological cancer patients compared with all other cancer patients (p. 2072). Thompson & Shear (1998) suggest "Women are especially prone to develop anxiety and depressive disorders; this may be related to reproductive hormones" (p. 241). Identifying psychological factors and examining the negative impact these factors can have on women diagnosed with cancer is the first step in the process of evaluation and treatment.

Depression.

Hopko et al. (2015) report "Major Depressive Disorder (MDD) is the most common psychiatric disorder among breast cancer patients and is associated with substantial functional impairment" (p. 225). Moreover, Low and Stanton (2015) add, "Women with breast cancer are at increased risk of depression, and the extent to which one's illness disrupts valued activities has correlated with depressive symptoms in women with early stage breast cancer" (p. 89). A diagnosis of cancer tends to interrupt daily routines and social and recreational activities for women. Fear, uncertainty, somatic complaints and increased loneliness replace feelings of hopefulness, happiness and enjoyment of every day (Low & Stanton, 2015). "Breast cancer diagnosis and treatment and the months following primary therapy are stressful times for most women. While many women experience "normal" distress, there is a subset that experience

clinically significant depression that may benefit from specialized psychiatric intervention" (Fann et al., 2008, p. 112).

Clinical depression affects one in four patients diagnosed with cancer. While grieving is a normal response to a cancer diagnosis, some cancer patients find it difficult to move beyond their diagnosis and find themselves dealing with clinical depression. If not properly treated, this diagnosis can have an adverse impact on the patient's cancer treatment plan (American Cancer Society, n.d.). Barrera and Spiegel (2014) add that "classic symptoms of depression such as hopelessness, suicidal ideation, and passive suicidal thoughts are common in women diagnosed with cancer" (p. 32). They continue to say, "Medical staff often rationalizes passive death wishes as a response to the disease and its prognosis rather than a symptom of a treatable co-morbid psychiatric illness" (p. 31).

Women who have pre-existing depressive symptoms, pain or physical limitations are more likely to experience exacerbated depressive symptoms when diagnosed with breast cancer (Hewitt, Herdman, & Holland, 2004). Furthermore, Hewitt et al (2004)'s provision of this information regarding pre-existing depressive symptoms confirms the importance of psychological and psychiatric comorbidities as a factor in adaptation to breast cancer (p. 60). Stafford et al. (2013) found "women with a history of anxiety or depression and those receiving treatment for anxiety or depression at study entry endorsed significantly more anxiety and depression symptoms than their respective counterparts" (p. 2075). This is significant-and-alarming because "patients with major depression as compared with nondepressed persons also have higher rates of unhealthy behaviors such as smoking, a sedentary lifestyle, and overeating" (Adler & Page, 2008, p. 5) – all behaviors that could exacerbate the physical challenges of having cancer. Fann, et al. (2008) agree, finding that "major depression is a frequent but

underrecognized and undertreated condition among breast cancer patients, which causes amplification of physical symptoms, increased functional impairment, and poor treatment adherence" (p. 112).

Anxiety.

According to Lim, Devi, and Ang (2011), "Breast cancer is one of the most common cancers worldwide, and anxiety is a psychological morbidity that is inevitable" (p. 215). Baqutayan (2012) reports that while anxiety is one of the most dominating psychological symptoms among breast cancer patients, it becomes a typical reaction for these cancer patients. Anxiety increases as breast cancer patients process through their cancer trajectory, but it can be a different journey for each cancer patient. It is, therefore, important to note that cancer patients may experience anxiety differently and through various stages of the disease (Baqutayan, 2012). In their study of the course and prevalence of anxiety symptoms in women Stafford et al. (2013) found anxiety symptoms to be at their highest at the time of diagnosis due to fear and shock that observed during this period. Moreover, these researchers found that anxiety symptoms decreased significantly within two months and remained significantly lower than at baseline (p. 2076).

Kate Blackburn (2014) reports on an extensive study performed in Germany, which found "32% of people with cancer experienced some form of clinically relevant mental health challenges, such as anxiety, depressive and adjustment disorders. Moreover, the highest prevalence (42%) was found in breast cancer patients" (Researchers in Germany section para. 2). Price et al. (2010) add, "Psychological morbidity following a diagnosis of cancer is well documented with up to 45% of patients with ovarian cancer experiencing clinically significant

anxiety" (p. S52). In their review of the literature, Thompson and Shear (1998) found seven studies that measured anxiety rates as statistically higher than the general population (p. 245).

Women diagnosed with cancer face many different biological and psychosocial factors. Biological stressors include pain, tumor burden, reduced physical sensation and comorbid illness. Individuals also experience psychosocial stressors of fear of the unknown, body image, loss of control and changes in life's journey. It is reported that anxiety and depression commonly occur in cancer patients where these biological and psychosocial stressors are already affecting the cancer patient's quality of life (Galloway et al., 2012, p. 2). Lim, Devi, and Ang (2011) write, "Factors that contribute to anxiety in patients with breast cancer can be broadly classified into physical, psychological, social and environmental causes" (p. 216). Physical causes include treatment side effects, hormonal changes, and issues surrounding fertility. Psychological causes encompassed changes in body image and positive and negative feelings about the disease. Social causes include an insufficient support network, lack of sexual interest and sexual dysfunction. Finally, environmental causes include changes in work schedule due to increased doctor visits, which could have an adverse impact on their financial situation.

According to research by Galloway et al. (2012), "Anxiety related to cancer is typically experienced at high rates and intensity until a treatment plan is established. Once a treatment plan has been developed, some women experience a decline in anxiety levels" (pp. 3-4). According to Fann et al. (2008), high rates of anxiety often exist following primary cancer treatment. During this stage of the cancer trajectory patients begin to fear recurrence, and with the loss of medical support and frequent visits to the doctor high rates of anxiety can become more problematic for the patient (p. 113). Anderson and Lutgendorf (1997) also report "a marked increase in death anxiety accompanied by an increased need for reassurance. Along with

the loss of treatment perceived as actively fighting cancer, patients also lose the immediate social support of the medical staff" (p. 224). In their systematic review, Lim, Devi, and Ang (2011) found "the prevalence and intensity of anxiety have been shown to be pronounced among breast cancer women who were undergoing or had experienced one or more of the three treatments. Chemotherapy was shown associated with a higher anxiety level" (p. 215).

Posttraumatic Stress Disorder.

Overall advancement in medical technology creates an environment in which more women who have cancer can survive. Survival rates increase as the ability to treat female cancer patients increases (Alter et al., 1996). "Despite this early interest in cancer-related PTSD, no published data exist regarding the symptom structure of PTSD in survivors of malignant disease" (Cordova, Studts, Hann, Jacobsen, & Andrykowski, 2000, p. 301). Many agree that while a diagnosis and treatment for cancer are traumatic events in one's life, researchers disagree on what psychological symptoms should be expected for someone surviving cancer (Alter et al., 1996, p. 140). Andrykowski and Cordova (1998) add, "While insufficient to merit a diagnosis of PTSD, such symptoms can nevertheless impair quality of life" (p. 190). Alter et al. (1996) reported that some PTSD-like symptoms have been found to limit the ability of survivors of chronic illness to function adequately, particularly intrusiveness, physiologic arousal, and avoidance phenomena (p. 142).

Cordova et al. (2000) in their study "Symptom Structure of PTSD Symptoms Following Breast Cancer" hypothesized that breast-cancer related PTSD symptoms will be explained by three first-order factors: reexperiencing, avoidance/numbing, and arousal (p. 305). Their particular research focused on aligning PTSD-related symptoms experienced by women following a breast cancer diagnosis with the DSM-IV criteria. Researchers found that "rather

than reflecting generalized nonspecific distress, cancer-related PTSD symptoms appear to be dimensionally similar to PTSD as conceptualized in DSM-IV" (Cordova et al., 2000, p. 313). Green et al. (1998) challenged the validity of PTSD symptoms found in breast-cancer survivors and reported that "while it has been established that cancer survivors endorse cancer-related PTSD symptoms, whether these symptoms reflect "true" PTSD has been called into question" (p. 313). Cordova et al. (2000) indicate that alternative models of PTSD specific to cancer-related symptoms should be especially considered as they pertain to avoidance and numbing symptoms (p. 316).

The question of whether or not cancer-related PTSD symptoms meet DSM-IV criteria pales in comparison to the negative impact these symptoms have on the functional ability of women who survived breast cancer (Alter et al., 1996). Andrykowski and Cordova (1998) add, "The presence of avoidance symptoms is likely to translate into an increased likelihood of treatment drop-out or treatment avoidance altogether" (p. 201). Accordingly, "identification of cancer patients at risk for exhibiting PTSD symptoms is important for early intervention efforts" (p. 190). Thus, we emphasize supporting women with cancer diagnoses whether or not they can be considered to have PTSD under DSM-IV guidelines.

Current research provides new statistical data for PTSD symptoms experienced by breast cancer survivors. Statistical reports by Hodgkinson et al. (2007) show nearly one-third (29%) reported clinical levels of anxiety and one-fifth (19%) reported symptoms related to PTSD (p. 381). While maintaining a positive outlook on their cancer diagnosis is essential for psychological health, it is important to recognize that "a diagnosis of breast cancer constitutes a trauma analogous to experiencing a physical assault, accident, or natural disaster" (Spiegel & Riba, 2015, p. 1). Furthermore, Spiegel and Riba (2015) reported that "5-10% of breast cancer

patients met diagnostic criteria for PTSD, which included intrusive thoughts, disbelief, avoidance, inability to sleep, fears, and physiological hyperarousal" (p. 97). These sobering statistics encourage us to continue researching specific symptoms of PTSD and gathering information regarding the negative impact these symptoms have on women diagnosed with cancer.

> The study of PTSD in cancer survivors begins to characterize better the experience of the patient surviving cancer and may also help to clarify our understanding of the experience of trauma. The advantage of conceptualizing the process of dealing with cancer from a PTSD perspective is that it allows for understanding in predicting and treating the psychiatric effects of the illness. (Alter et al., 1996, p. 142)

Through our research, we have identified some psychosocial and psychological factors impacting women faced with a diagnosis of cancer. Understanding and identifying ways to monitor any adverse impact these factors may have on women diagnosed with cancer leads to effective medical, psychosocial and psychological care.

Therapeutic Interventions

Psychosocial distress and psychological challenges often exist throughout the cancer trajectory from diagnosis through survivorship. Therapeutic interventions are an important part of increasing mental and psychosocial health in the life of the cancer patient throughout her lifetime. "These findings reinforce the importance of routine and ongoing psychosocial assessment and intervention" (Hodgkinson et al., 2007, p. 388). We now turn our attention to specific therapeutic interventions designed to help cancer patients transition through their journey of cancer.

Meaning-Making.

According to Lee (2008), "meaning-making coping is a critical mediator between cancer-related distress and psychological well-being and may be the possible mechanism to explain the coexistence of positive and negative psychological states following cancer" (p. 781). Furthermore, she introduces the meaning-making intervention (MMi) which is a strength-based intervention that seeks to help cancer patients identify their strengths and skills so that they can become active participants in their treatment and care (p. 781). Lee (2008) defines three tasks to be completed collaboratively by the patient and clinician:

> (1) To recognize the normative distress and facilitate the grieving process associated with coming to terms with a cancer diagnosis, (2) to avoid forcing an inappropriate and untimely burden on patients to "think positively," and (3) to prepare the patient to gradually confront that which is considered to be more threatening aspects of their particular situation. (p. 782)

These three processes employed together help cancer patients make meaning of their experience thereby increasing their well-being and quality of life.

Managing Cancer and Living Meaningfully (CALM).

Managing Cancer and Living Meaningfully (CALM) is an intervention with relational, attachment, and existential characteristics designed for patients with advanced cancer and used to promote psychological well-being and growth. Lo et al. (2014) describe CALM as a brief, manualized, semi-structured, individual psychotherapy consisting of 3-8 individual sessions delivered over six months with each session lasting 60 minutes (p. 236). Furthermore, four domains are addressed, including symptom management and communication, changes in self and

close relationships, spiritual well-being or the sense of meaning and purpose, and preparing for the future and facing mortality (Lo et al., 2014, p. 3).

Communication-Enhancing Intervention (CCI).

According to Manne et al. (2007), CCI was based on "cognitive-affective-social processing theory" (p. 616). Furthermore, this intervention consists of six, hour-long individual sessions which focused on enhancing coping and support-solicitation skills, evaluating and altering life priorities, and identifying and dealing with emotional reactions to cancer (Manne et al., 2007, p. 618). CCI is a highly structured intervention utilizing homework assignments, coping skills, and cognitive reframing drawn from cognitive-behavioral interventions.

Supportive Counseling (SC).

Supportive counseling encourages emotional expression, supports existing coping behaviors and enhances self-esteem and autonomy (Manne et al., 2007). Also, "therapists use techniques such as reflection, empathy, encouragement, reassurance, validation, clarification and exploration" (p. 616). This particular intervention differs from the CALM intervention in that therapists take on a nondirective and noninterpretive role allowing for a more conversational style approach. Female cancer patients struggling with many different thoughts and emotions could benefit from this type of intervention that seeks to allow the patients to express emotion and find encouragement, empathy, and validation in a safe therapeutic environment.

Cognitive Behavioral Therapy (CBT).

Cognitive behavioral therapy is a widely used therapeutic technique designed to challenge irrational thoughts and beliefs and reframe them into a more effective way to think and behave. CBT interventions can be used when working with women diagnosed with cancer. In our research, we found two different ways CBT was used with women diagnosed with cancer.

Many women experience chronic insomnia comorbid with breast cancer. Cognitive behavioral interventions have been used to help alleviate distress related to insomnia. In their study of 57 women with chronic insomnia comorbid with breast cancer, Tremblay, Savard and Ivers (2009) hypothesized that "sleep improvements at posttreatment and 6-month follow-up would mainly be explained by a reduction of dysfunctional beliefs about sleep and greater adherence to behavioral strategies" (p. 747). These researchers found this hypothesis partly supported, and emphasized the need to "target erroneous beliefs about sleep and poor sleep habits in the treatment of cancer-related insomnia, but also the importance of enhancing patients' expectancies for improvement" (p. 747).

While cognitive-behavioral therapy has been used for cancer patients who have experienced anxiety, it is important to note that some CBT approaches need to be adapted to include additional factors affected by a cancer diagnosis. These include diagnosis worry, disease progression, disability, and death (Greer et al., 2012, p. 1337). Helping women identify any irrational beliefs or cognitive distortions as a result of a cancer diagnosis is essential for reframing these beliefs and distortions into a more productive dialogue and outcome.

Group Therapy.

As previously stated, the most common psychiatric disorders induced or exacerbated by a cancer diagnosis are anxiety and depression. (Spiegel & Riba, 2014, p. 97). Furthermore, "in the initial period of diagnosis and treatment, the term acute stress disorder or PTSD may best describe the psychological problems that may occur" (p. 97). Group therapy provides cancer patients a safe and supportive place to express emotions with like-minded individuals that are experiencing similar concerns. In a group environment patients can take risks and directly confront issues such as death anxiety, grief, and loss within an environment supported by those

who share similar challenges and concerns. Through the group experience patients can role-play and process ways to reorganize life priorities, living life in the present and improving communication with physicians (Spiegel & Riba, 2015).

Conclusion

Our research suggests that psychosocial and psychological factors affect women diagnosed with cancer. Some women can process through their cancer diagnosis without the need for additional support while others experience psychosocial symptoms of living with uncertainty, experiencing loss of control, distorted body image, and sexual dysfunction. Depression, anxiety and PTSD disorders seemed to affect women who are unable to accept or cope with a diagnosis of cancer. Identifying these psychosocial and psychological factors and recognizing the negative impact a cancer diagnosis can have on women's emotional well-being and quality of life is a critical component of providing efficient and effective psychological and medical care. Our research has shown that evidence-based therapeutic interventions within the context of a safe and supportive environment allow space for women to express the many different emotions, fears, and challenges they face as a result of their cancer diagnosis. As technology and medical advancement continue to provide for longer term cancer survival, it is important that research follows suit and seeks to identify innovative ways to help patients learn new skills and interventions so as to increase well-being and quality of life and decrease depressive, anxiety and PTSD symptomology.

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