

Ovarian Carcinoma: Management of Stress in Patients and Physicians¹

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A discussion of the management of ovarian cancer invariably involves the problems of death and dying faced by the patient, her family, and her physician. This paper attempts to deal with the general fears, anxieties, and problems of terminality, and also places attention on specific issues involved in living with the ongoing disease and its treatments. Focus is on the effects of the disease on the woman's self-image, on her family and relationships, on life outside the hospital, and on her relationship with her attending physician. Specific problems relating to the periods of (1) diagnosis, (2) operative management and treatment, and (3) terminality are discussed. Understanding the psychosocial realities of the patient provides the physician with added insights into methods to assist the patient in adaptation and coping with this ultimately fatal disease.

INTRODUCTION

Ovarian cancer is a disease involving prolonged illness and a usually fatal outcome. The stresses on patient and physician are major. The ways in which the patient responds and adapts to these stresses affect the quality of her remaining life. The adaptation of her physician will have far-reaching effects not only on his care of the patient but also on his own self-image and emotional well-being.

Stresses in ovarian cancer must be understood within the context of organic realities and can be separated into three broad categories: diagnosis, operative management, and treatment and terminality.

DIAGNOSTIC STAGE

In the diagnostic stage, the patient may face a prolonged period of vague, but uncomfortable and, perhaps, frightening symptoms for which no cause can be

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found. Anxiety over her discomfort may be expressed in irritability and mood swings. She may consult several physicians seeking the cause of her symptoms.

The physician faces a diagnostic dilemma which may challenge both medical knowledge and patience. Lennane and Lennane [1] have noted that physicians may overemphasize psychogenic factors in dealing with female patients. If a woman exhibits nervous or anxious behavior, her symptoms are even more likely to be regarded as neurotic. This tendency interferes with the establishment of an early diagnosis, as well as with the formation of a helpful doctor/patient relationship. In addition, physicians may feel pressured both by themselves and by their patients to have an immediate answer to the problem. It may be simpler for the physician to mitigate his own stress by concluding that it is "all in her head" rather than to face the greater stress of not knowing the organic diagnosis.

Also, there is an unfortunately widespread attitude that people with psychogenic symptoms are not entitled to symptomatic relief. Once the patient has been led to believe that her symptoms have no physical basis, she may be reluctant to report more severe symptoms or failures of therapy. Such thoughts as, "I don't want the doctor to think I am crazy," or "I don't want to bother the doctor since it's all in my head anyway," further delay the patient from seeking medical attention. If a question of psychogenic factors arises during a diagnostic work-up, it may be useful to work in collaboration with a psychiatrist until the medical diagnosis becomes clear. A flexible and open-minded approach by the physician during the diagnostic phase will enhance the patient's confidence and trust in his willingness to help her cope with her problems. If a diagnosis of cancer is subsequently made, the doctor/patient relationship will remain intact, whether or not there has been psychiatric intervention.

Communication of the diagnosis of malignancy is stressful for the patient, her family, and her physician. Peck [2] has reported that the most common reactions to a diagnosis of cancer are anxiety, depression, guilt, and anger. Anger is the most difficult aspect with which the physician must deal. Anger may be greatly increased if early symptoms have been ignored or minimized. The physician should understand that the anger is not directed at him personally, but is part of the patient's total response to stress.

A physician may choose to confront the patient with her diagnosis immediately, or may initially allow her some time for denial until she is more able to cope with it. It is usually inadvisable, and often impossible to continue the denial interminably. Diagnostic procedures reinforce the patient's fear and conviction that something serious is wrong with her. As her condition deteriorates, she will neither respect nor appreciate a conspiracy of silence.

To allow the patient to express her feelings about the diagnosis, Kubler-Ross *et al.* [3] use the technique of confronting her with the gravity of the situation: "It is serious . . . what does that mean to you?" Such a question offers the patient the opportunity to discuss her reactions to the disease and to verbalize her fears and fantasies concerning her responsibility in causing her illness and the effect of the illness on others. Such discussion allows the physician to understand the areas of most severe stress and to rectify misconceptions. The physician also reduces his own sense of helplessness as he comforts the patient.

The more precisely the physician understands the nature of the patient's stress and her manner of coping with it, the more discreetly and judiciously he can manage the combination of analgesics, hypnotics, and psychotropic medications and avoid potentiation and interaction that can lead to toxic states. The elderly and debilitated patients, so commonly seen with ovarian cancer, are more sensitive to medications and require particularly careful management.

THE OPERATIVE STAGE

During the operative stage, the ovarian cancer patient undergoes major stresses including unwelcomed bedrest, intrusion of medical instrumentation strange to her, and changes in body image.

Aerospace studies [4] of young healthy subjects have shown that serious psychobiologic effects may result from prolonged bed rest, with depression, increasing anxiety, and hostility occurring just in anticipation of being confined to bed. These reactions continue throughout the period of bed rest often imposing a cardiac strain comparable to that of physical exertion. Concomitantly, decreased motor-muscular input to the CNS is often accompanied by EEG changes similar to those of severe sensory and perceptual deprivation.

Additional stress arises when daytime sleep patterns alter the amount of deep sleep at night, resulting in inadequate rest. The patient may then be given excessive hypnotic medication at bedtime. Isometric exercises and use of footboards and hand pulleys can prevent disuse atrophy, improve mood, and relieve tension. Adjustment may also be helped by careful monitoring of sleep medications. Whenever possible, a single drug is preferred for managing problems of sleep and anxiety.

The intrusion of foreign objects exacerbates an already stressful situation. Procedures which intrude upon the patient's body and privacy include venesection, iv injections, nasogastric tubes, and paracentesis. Anxiety here can be decreased by a clear and honest explanation of what will be done.

Any surgical procedure produces a highly stressful change in body image and body function [5]. Feelings of mutilation, distortion, and ugliness can cause the patient to interpret these changes as both a loss of integrity and of desirability as a woman. She suffers also from feelings of devaluation and loss of self-esteem, and finally, from depression. Procedures such as colostomy change the patient's physiology drastically and cause even more anxiety. They require more detailed advance explanations [6]. The sight and odor of fecal material coming from her abdomen may cause the patient to feel mutilated, dirty, and foul smelling. She has lost control over a function taught to her as a child as prerequisite to being good, clean, lovable, and acceptable to others. The patient should be allowed to verbalize her negative feelings about these changes. The physician should not feel that she is attacking his expertise. The staff can point out positive aspects, such as that the wound is healing well, or that the colostomy is working for her in maintaining nutrition, health, and life.

It is particularly important that the medical staff be sensitive to the patient's fear of being sexually undesirable. Clarification of her future capacity for sexual function will help the patient maintain her own image of her femininity and allay

fears that the sexually active part of her life may be over. Many patients are, unfortunately, quite ignorant about their bodily functions and their illnesses. Explanations can help them understand what is happening, but may need to be repeated on several occasions, for patients are so stressed initially that they may be unable to integrate the information the first time it is given [7]. Increased knowledge and understanding allow most patients to feel more in control of their lives with concomitant reduction in anxiety.

Pain management during the operative period, as well as at other times, is crucial. Pain itself, or even anticipation of pain, can be the source of anxiety and behavioral changes. Pain also adds to the patient's stress by keeping her from her usual activities. Insofar as it is medically feasible, pain should be controlled at all times. Fear of drug dependence or addiction in this situation is irrelevant. The primary goal is to assist the patient in coping with her illness. The reduction of pain allows her to use her physiologic and psychic energies for recuperation. Once she is assured that her pain can be controlled, the use of additional antianxiety medications may not be required.

TREATMENT STAGE

During rehabilitation from surgery and subsequent treatment, the patient's adjustment is primarily influenced by organic factors. Pain and contingent anxiety may persist. Changes in taste affect appetite and nutrition. Changes in dietary habits resulting from malabsorption or partial obstruction can cause irritability and depression. Changes in bowel or bladder habits affect the patient's personal and social life. Treatment may also result in skin changes including hair loss, eruptions, fibrosis, and scaling. These body image changes may threaten the patient's sense of identity. Decreased libido has been reported with chemotherapeutic agents [8] and can threaten the woman's sense of femininity and desirability.

Professional and social adjustments also occur during this stage. If a woman has a career or is self-supporting, she may be threatened with the loss of her job and income, which may result in financial stress. Being unable to work also withdraws her from her usual contacts with friends, and her lack of energy may restrain her from her usual social activities. These are major sources of anxiety and frustration.

The patient's family is also under great stress throughout the course of her illness. The husband and adult children should be included in discussions about her course and prognosis. They must also have the opportunity to express, and thus hopefully to dispel, their own fantasies and fears in order to be more helpful and supportive of the patient. Young children are often confused and frightened by their mother's prolonged illness and extended hospitalization. They have their own fantasies based on unfounded fears and myths. Practical help with financial and household management can be provided by social service personnel. Relieving the patient of some of her usual domestic concerns, such as shopping, cooking, and washing, will allow her more energy for coping with the disease and for enjoying the time she has left with her family.

TERMINAL STAGE

In the terminal stage, feelings of helplessness due to loss of control over her life and fear of dying devalue the patient's sense of her personal worth. Most devastating of all, she may fear being abandoned before death. Kubler-Ross [9] has described the emotional stages of dying as denial, anger, bargaining, depression, and acceptance. The physician must learn to recognize these behavioral processes as part of the patient's mourning of and adaptation to her own death. If he regards them as a personal affront to himself, he is likely to become frustrated, angry, or depressed, or to displace his feelings onto other staff members or onto his own family.

In caring for the terminally ill, the physician is required to recognize and understand his own attitudes toward his patient, as well as toward his expectations of his role as a physician more than in any other professional situation [10–12]. There have always been highly demanding cultural and societal expectations of the physician as an omnipotent God-like figure who knows all and can cure all. This burden is heavy to bear. The physician may have his own fantasy of omnipotence and may cause further stress to himself by expectations which are so unrealistically high, that they cause him to react nontherapeutically to those patients who appear to defy his omnipotence not only by failing to be cured, but by dying. A sense of helplessness may lead the doctor to anxiety, and subsequent self-admission of this helplessness may undermine his self-esteem and lead to depression.

The physician may also be forced to recognize the frightening and real human experience shared by all people—that we are all going to die. Doctors and other staff often spend less time with dying patients since they frequently feel helpless when confronted with the imminence of death. They often do not realize the effectiveness of comforting the patient and seem unaware of how much they themselves can learn of life from her. Sharing a universal human experience with the patient will set her at ease and allow her to ask questions which will help her plan realistically for her future and control the remaining portion of her life. She must make a will, settle her business affairs, find guardians for her children, mend “broken fences,” and consolidate her positive relationships and experiences. Speaking with the patient of these matters in a candid and caring way renews her interest in life apart from her terminal illness. It not only reinforces her self-esteem by focusing on her as a living person but also works against the anxiety of abandonment. A feeling of autonomy will help the patient to maintain the self-esteem and dignity that will allow her to adapt to the final stage—death. Although most patients know when they are dying and can verbalize this realization, they also retain hope. The physician can encourage and reinforce the hope that the patient expresses without giving false hope.

Finally, the physician may be the victim of what is often known as “survivor guilt”—feelings of guilt that he will survive and his patient will not. The physician can cope with all these stresses by first realizing that he is not omnipotent, and then by establishing realistic expectations for himself. The role of Healer includes not only the preservation of life but also the alleviation of suffering. It is in the

latter area that the physician can find that he is least helpless. By understanding his own feelings about death, the physician can provide greater support and comfort to the patient and to her family as well.

In conclusion, although ovarian cancer creates considerable stress for both the patient and her physician, adaptive processes exist which will help them both to cope. Ultimately, the physician can see his role as being: "To cure few, to relieve many, and to comfort all" [13].

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