

PSYCHOLOGICAL REACTION OF PATIENTS WITH TERMINAL ILLNESS

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SYNOPSIS

This paper reports on the psychological reaction of 19 patients with terminal illness. Depression was the main emotional problem in 9 patients, anxiety in 5 patients and 5 other patients had symptoms of depression and anxiety. There was no significant difference between the sexes in degree of depression but women had more symptoms of anxiety ($p < 0.05$). It was also noticed that patients below 50 years experienced more anxiety ($p < 0.05$).

The psychological management of the dying patient is discussed.

INTRODUCTION

One of the most vivid accounts of psychological anguish in a dying patient is depicted in the classic novel, "The Death of Ivan Illych" by Leo Tolstoy. In the management of the dying patient it is increasingly recognised that besides alleviating physical pain it is also equally important to allay psychological discomfort. The psychology of the dying process has been categorised by Kubler-Ross (1) into 5 stages: denial, anger, bargaining, depression and finally acceptance. This has provided a better insight into the psychological defense mechanisms, but it must be emphasised that not all the patients progress through the same stages. The duration of each of the stages varies with patients, and some patients may only go through a brief phase of denial and depression before acceptance. Patients cope with fear or threat in a variety of ways and learn coping skills from previous crises. Their past experiences coupled with external support can modify their reaction to terminal illness.

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In a study of psychiatric consultation in a terminal care unit, Stedeford and Block (2) reported a referral rate of 14 per cent of admissions, and referrals were mainly because of 'abnormal behaviour', depression and anxiety. Hinton found that those under 50 years showed more depression and anxiety (3) and greater distress was noticed in patients with dependent children (4). The study by Craig and Abeloff (5) also emphasised that psychiatric morbidity was common in young patients (particularly women) with cancer.

This paper reports on the psychiatric consultation of terminally-ill patients referred to the Department of Psychological Medicine, Faculty of Medicine, National University of Singapore.

MATERIALS AND METHODS

Not all patients with terminal illness are referred for psychiatric assessment. The majority of patients with minor psychological problems are usually dealt with by their doctors. All referrals were inpatients from a general hospital. The reasons for psychiatric referral were noted and the degree of psychological distress was measured using the Brief Psychiatric Rating Scale (6).

RESULTS

Nineteen patients with terminal illness were referred for psychiatric assessment (Table 1). There were 11 women and 8 men; the youngest patient was 20 and the oldest 67. The diagnoses of these cases were:

- leukemias and lymphomas (9)
- nasopharyngeal carcinoma (2)
- carcinoma of stomach (2)
- carcinoma of colon (2)
- carcinoma of bronchus (2)
- carcinoma of pancreas (2)
- carcinoma of liver (1)

TABLE 1: AGE AND SEX OF PATIENTS WITH TERMINAL ILLNESS

Age Group in years	Sex		Total
	Male	Female	
20-49	4	8	12
50 and above	4	3	7
Total	8	11	19

Table 2 shows the reasons for psychiatric consultation as cited by the referring doctors. The commonest reason was depression. A feeling of depression is not

TABLE 2: REASONS FOR REFERRAL

	Number of patient
Depressed	9
Suicidal tendency	5
Agitated	3
Unco-operative in treatment	2
Total	19

unexpected as the dying person mourns over the impending loss of family and friends. Occasionally guilt feeling may emanate from thoughts of being dependent on relatives and abandoning the family, especially young children. These thoughts together with idea of worthlessness can lead to suicidal intention, as seen in 5 cases. Four had made suicidal attempts by drug overdose (3 patients) and wrist-cutting (1 patient). There were 3 patients referred because they were in an acute anxiety state. The anxiety was due to a fear of pain and of what would happen thereafter. Two patients were non-compliant in treatment and had communication problem with the staff; they were still in the denial stage and appeared to have little knowledge of the illness despite having been provided the information.

In the psychiatric assessment of the mental state, none of the patients manifested any symptom of psychosis. Depression was the main emotional problem in 9 patients, anxiety in 5 patients and 5 other patients had symptoms of both depression and anxiety.

The psychological distress between male and female patients was compared using the Brief Psychiatric Rating Scale (BPRS). Since none of the patients had any psychotic symptoms, these items were excluded in the analysis. The remaining items on the BPRS could be divided into 3 groups: (1) somatic concern — degree of concern over present bodily health, (2) anxiety — including tension and excitement, and (3) depression — including emotional withdrawal, guilt feeling, motor retardation and blunt affect.

As seen in Table 3 there was no significant difference between the sexes in somatic complaints and depressive symptoms but female patients tended to have more symptoms of anxiety ($p < 0.05$).

The patients were divided into 2 age-groups — those below and above 50 years. As indicated in Table 4 the younger age group had more anxiety symptoms ($p < 0.05$) but there was no difference in somatic complaints and depressive symptoms between the 2 age-groups.

TABLE 3: PSYCHOLOGICAL DISTRESS AND SEX DIFFERENCES

	Items in BPRS		
	Somatic Concern	Anxiety (mean scores \pm s.d.)	Depression
Male (n = 8)	3.0 \pm 0.7	2.3 \pm 1.0	3.3 \pm 0.7
Female (n = 11)	2.8 \pm 0.7	3.5 \pm 0.8	3.0 \pm 0.8
Level of significance t-test	N.S.	$P < 0.05$	N.S.

TABLE 4: PSYCHOLOGICAL DISTRESS AND AGE

Age Groups in years	Items in BPRS		
	Somatic Concern	Anxiety (mean scores \pm s.d.)	Depression
20—49 (n = 12)	2.4 \pm 0.9	3.5 \pm 1.0	3.3 \pm 0.9
50 and above (n = 7)	2.3 \pm 0.9	1.8 \pm 0.9	2.7 \pm 0.8
Level of significance t-test	N.S.	P < 0.05	N.S.

DISCUSSION

The psychological reaction of patients with terminal illness varies with time. The clinical picture depends on when the patients are referred for assessment. In this study the common psychological problems were depression and anxiety. Depressive symptoms were seen in 14 patients, anxiety in 10 patients and 5 patients had symptoms of depression and anxiety. Female patients below the age of 50 had more symptoms of anxiety — this is similar to the previous study by Craig and Abeloff (5). Some of these patients had children and were worried about their future. A few of them knew of the illness only recently and were apprehensive about the prognosis.

Besides the relief of physical distress such as pain or dyspnoea, the aims in management of the dying should be to reduce emotional agony like depression or anxiety, promote self-esteem by encouraging the patient to know that he still has a role in the family and to facilitate mutual support between the patient and relatives. Six severely depressed patients in the study were prescribed antidepressants and 3 with acute anxiety improved with diazepam. There were 10 patients who needed night sedation. But the cornerstone of management rests on good rapport and 'active listening' to facilitate communication — this allows the patient to unbottle pent-up feelings of fear, frustration and bitterness. The trusting relationship permits the patient to ask and clarify issues about the illness. One patient who was un-cooperative in treatment, refused to accept the diagnosis of cancer and discharged herself. In fostering family cohesiveness, the relatives need encouragement to visit the patient regularly to provide support. Weissman and Worden (8) noted that those with less family support were more prone to psychological distress. The dying patient may want to continue to play a role in decision making in the family and not to be left out, although relatives may be reluctant to burden the patient with domestic matters. Sometimes the patient becomes preoccupied with spiritual issues and seeks comfort in religion. Visits from the priests or religious leaders can complement the task of doctors to provide relief.

One of the disturbing issues which confronts doctors in the management of a patient with terminal illness is whether to inform the patient about the diagnosis and prognosis. Hinton (3) pointed out that in spite of the conspiracy of silence, many patients were aware of their fate. Patients are sensitive to the signs of pessimism shrouded in the verbal and non-verbal cues of the doctors. A patient with leukemia sensed the gravity of her illness when a sister from Australia came urgently to see her. A few patients in the study were glad that they were told about the diagnosis because they were able to plan and make arrangements for the family. Saunders (7) cautioned that patients should not be estranged from reality by false assurances. It seems that the major question is not whether to tell but really how, when and what to tell.

Not all the information should be given at the same time. What a particular patient wants to know must be carefully judged as to timing and content. The nature of the illness must be explained in words or language the patient can understand. Not infrequently doctors have difficulty in conveying the message. In medical school, students are taught about their power to cure but terminal illness challenges this image of omnipotence. To overcome this dilemma, doctors may evade a question on dying or may 'intellectualise', meaning that the illness is described in medical jargon like 'malignancy', 'metastasis', microscopic pathology of the disease etc. Sometimes in ward round doctors may limit their contact with them or even avoid them.

As the family faces an imminent loss, the psychology of the mourning process is very much similar to the dying process. There is a brief period of shock or denial, followed by distress even anger and finally the phase of acceptance (9). Seeing the family members serves not only to exchange information about the patient but also allows them to express their grief to someone who understands their predicament. This "anticipatory grief work" may reduce problems during bereavement (10). Not every bereaved person needs counselling but it is, necessary, especially for those at risk, eg. a widowed person living alone or past history of mental illness.

Finally, the psychological management of the dying rest not solely on the doctors but should include nurses, social workers and even religious leaders. Training in counselling will equip them with better skills. Only in problematic cases, as in the patients in the study, should psychiatric consultation be sought.

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