Psychological Impact of Cancer Surgery

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The problems involved in management of the cancer patient have been radically altered during the past few years by the striking advances in therapeutic techniques. Operative mortalities are being reduced to a minimum. Postoperative medical control has been vastly improved, and operations on patients who not so long ago were considered inoperable are now routine. Not many years ago, the long-term survivor of a cancer operation was considered a unique phenomenon, and therapeutic emphasis was centered on symptomatic management of the terminal cancer patient. Modern therapeutic methods have created an increasingly large army of survivors. It would seem that the problems of the cancer patient would be solved by his survival alone, but unfortunately this is not so. Advances in treatment, like all other advances, have created problems. Unfortunately, the extensive surgery which is necessary for the control of many forms of cancer results in major changes in form and function of various parts of the body. These changes are often disfiguring or mutilating and are not lightly borne by the average patient. They present challenges to his capacity for adaptation in all areas of living, and at times the problems created may appear overwhelming. The result is the therapeutic paradox of patients cured of cancer and clinically well who are able to function only in a very circumscribed way or not at all because the methods necessary for cure have resulted in psychological invalidism.

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Practical Management

Little systematic study has been done on the impact of cancer and the attending surgical procedures to guide the clinician and others associated with him in the practical problem of managing the postoperative cancer patient in his total situation. The Memorial Hospital in New York has established a group to study these problems. This group, consisting of psychiatrists, internists, psychologists, psychiatric social workers, surgeons, and nurses from the various clinical departments of the hospital, has found it advisable to concentrate its attention on certain types of cancer and certain classes of operation. Much of its information is highly particular and has to do with the specific problems met by each patient in the class of operation studied. Nevertheless, certain general conclusions can be drawn which apply to the whole field of cancer and, indeed, to any surgery where serious change in form and function of the body results.

Apparently much of the emphasis in current rehabilitation practices concerned with the psychological management of the patient with any sort of serious disability is misdirected. There seems to be a tacit assumption that the only real problem is the patient's belief that he has problems; therefore, therapeutic effort should be directed toward persuading him that he has no serious problems or at least to minimizing those he does have. This approach, even when fortified by all available clichés, is rarely effective because it is totally unrealistic.

The patient has very real, very immediate problems to solve which must be solved by him, alone or with the help of others. But solved they must be if the individual is to return to his previous ability to function and to emotional peace. It is when these problems are not solved that psychological invalidism occurs.

The approach based on the denial of the existence of problems has an underlying quality of contempt and condemnation for those patients whose problems will not be denied. It describes invalidism in terms of deterioration of moral fiber, of "loss of independence," and of "regression." It fails to recognize that retreat from function is the result of inability to master the problems created by the traumatic event, and that function is resumed when the problems are solved. As a matter of fact, the so-called loss of independence and regression are often necessary to the process of repair. They are to be accepted and not penalized in any way. They are in lieu of more serious disorganizations attendant upon attempts at function without the hope of mastery. The dictum "it's what's left that counts" is true as far as it goes, but it is at least equally true that the loss of a significant body part—an arm, a breast, a stomach, or a rectum—in the mind of the patient calls for a fundamental review of his ability to function normally.

Adjustment to Cancer

One cannot speak of "adjustment" to cancer because this concept is too abstract and general to be meaningful. Each patient must be considered as an individual with a particular type of cancer—an individual who has undergone a particular form of surgery or other therapy. In the first place, there is no special psychology of patients in whom cancer develops. Cancer happens to all types of people: people who are more or less "normal," people who have character neuroses—neurotics, psychotics, and psychopaths. It does not, as far as we know, select particular kinds of emotional problems. Moreover, cancer itself is not a uniform disease. It can vary from a basal cell carcinoma with almost no possibility of mortality to a highly malignant, rapidly growing tumor which can defy all methods of control. Cancer can necessitate the removal of almost any organ in the body, organs which play varying roles in the total life adaptation of the patient. The necessary surgery results in a considerable variation in form and function of the affected organs. One cannot easily separate adaptation to cancer from adaptation to measures needed for its cure. In the vast majority of patients, the threat or fear of cancer is submerged in the problems of adaptation required by the extensive change in form and function produced by surgery.

Adaptations to these procedures are by no means static. Actually adaptations begin with the patient's discovery of something wrong with his health. They progress for better or for worse during the preoperative course, reach a culmination in the crisis of surgery, and then evolve during the postoperative and convalescent period towards the long-range, more or less final resolutions. Moreover, they are not at any time independent of concurrent life situations, but, on the contrary, both concurrent life situations and the patterns of adaptation fundamentally influence each other. Mrs. A., for example, has an abdominal colostomy, that is, an abdominal anus through which she must evacuate her bowel movements and over which she has no voluntary control. She accomplishes this by regular, repeated irrigations. For 12 years she was able to manage these irrigations with almost no spilling and was able to work regularly. But when she came into conflict with her daughter, she developed uncontrollable diarrhea so that she was continually soiling herself. Because of this she had to give up work, became increasingly depressed, and hoped for death. When her emotional and practical problems were straightened out, she was again able to reestablish control over the colostomy and resumed her previous activities.

Psychology of the Cancer Patient

In general, the psychology of the cancer patient is the psychology of a person under a special and severe form of stress. Cancer is usually perceived as lethal and as a particularly gruesome form of death. It is almost always intertwined with the necessity for major surgery. Stress of this sort activates childhood and infantile irrational fears as well as

realistic fears. There is a chance of recurrence of cancer. There is a chance of serious postoperative complications and operative death. The fear of some form of mutilation in surgery is very real, and the patient may feel overwhelmed by his anticipation of how seriously handicapped he may be.

The problems inherent in infancy and childhood are all more or less solved by patterns of adaptation related to the specific difficulties experienced. The diagnosis of cancer, the surgical experience, and the residual mutilation or deformity which follows surgery can either threaten or disrupt these adaptational patterns and activate the conflicts which they were designed to resolve. Consequently, many fundamental underlying emotionally charged convictions are brought close to the surface. The notion that mutilation is a form of punishment for sin, or fears of abandonment are common themes. For example, a woman whose mother had interdicted marriage and motherhood for her was subjected to a pelvic exenteration for carcinoma of the cervix uteri. She felt, and stated, that her mother had finally caught up with her and punished her for having married and having a child. Another woman with carcinoma of the breast stated that she had loved her body too much and was being punished.

Indeed, the impact of the experience and the changes produced by surgery may be felt by the patient indirectly and only as a reflection of the change produced in the attitude of some significant family member such as the spouse. The marital partner may be wholly unable to accept the changes in form and function, and consequently reject the patient. Instances have been known in which wives have refused any sexual contact whatever after the husband's operation.

Whenever stress of this sort occurs, it calls forth defensive measures. Such responses are quite characteristic for the individual and are more or less specific for the type of stress. The mechanisms of avoidance and denial are frequently invoked, especially preoperatively. Avoidance is a fairly common mechanism, based on the premise that if one makes something explicit it becomes true, and as long as something is kept out of mind, there is no need to worry about it. Denial is a more forceful rejection of the entire threat; some women have refused to recognize that they have lost a breast or a rectum for a considerable time after the operation. A woman with an extensive pelvic cancer, which was later cured by pelvic exenteration, denied the implication of entrance to three nursing homes for terminal cancer and signed out of all of them on one pretext or another, in order to maintain the denial.

The patient may believe himself overwhelmed by the threat to his safety or to his ability to function and may become seriously depressed. He may show signs of being disorganized; he may be unable to decide on reasonable courses of action. This state of mind is usually accompanied by profound feelings of dejection, a sense of helplessness, a retreat from function, and at times by suicidal thoughts. When a patient is in this anxiety-ridden state, he turns desperately to other people for help and loses his "independence." He seeks advice, consolation, and reassurance from others. He seeks their help in making decisions and in solving problems. It should be emphasized that in the majority of patients depression and concomitant dependence are to be expected, but are only temporary. They can be regarded as a prelude to the process of repair. How temporary they are is dependent upon the amount of help the patient obtains in solving his real life problems, in the reintegration of his primary adaptive mechanisms, and in the restitution of function in the various significant areas of living.

Depression and dependence form the essential core of what is generally referred to as "regression." The patient should not be penalized because of these conditions. Rather, the problems which gave rise to them should be met. The patient may not be able to solve them alone unless he has adequate help, and chronic long-standing depressions, restriction of function, and pathological dependence may persist. Only too often he does not receive adequate help from professional sources and is left wholly on his own or receives from friends and family well-meant but inappropriate advice. Kindness, acceptance, and support, especially from professional persons, have been proved over and over again to be of great significance to the patient. They give him the security

that he needs to face the problems of later resumption of function. It should again be emphasized that marked dependence does not persist for long periods of time except in rare instances. The problems of long-term dependence are, as a rule, few. The majority of patients are content merely to know that there is someone on whom they can rely and with whom they can discuss their problems, even though they do not avail themselves of this privilege for months on end, if at all.

A patient at times attempts to master his difficulties by direct frontal attack, by sheer force of will. This is in effect a form of denial of limitations on his own power. When this process is not guided, it may result in inappropriate solutions which can be bizarre or inefficient, or it can result in failure, with accompanying intense feelings of defeat. As a matter of fact, overly enthusiastic attempts at mastery are closely akin to elation and are often a thin veneer for a very profound depression.

The belief that one has sustained a serious injury, often held by patients who have had extensive surgery, is usually associated with considerable resentment which, unfortunately, has no logical object. The physician is often seen unconsciously, or at the margin of awareness, as the injuring agent, but he is also regarded as too powerful or too necessary to offend. Consequently, resentment is often misdirected toward persons in the immediate environment—on nurses and social workers or on members of the family. Resentment is usually manifested by querulousness, a demanding attitude, complaints, and other manifestations of hostility. It often includes feelings of being the victim of others' hostility and, indeed, may be frankly paranoid. Irritating as this state is to those who handle the patient, it should be regarded as a part of the normal process of repair, although at times a miscarried process. When the anger and resentment can be vented and worked through, they do not persist as a permanent adaptive pattern.

The social worker is in a peculiarly advantageous position to aid the patient in his struggles to resume function. She can determine the real limitations imposed by the circumstances of the surgery and other therapy. She can mobilize community resources for the benefit of the patient or his family. Her training in case work has taught her the proper approach to the emotionally disturbed patient. She can accept the patient's dependence and help him voice the resentments and fears on which his dependence is based. She can interpret his needs to his family and other important persons in his environment. She can strengthen or repair significant interpersonal and family relationships. Moreover, she can interpret to the physician and the surgeon the needs, both material and emotional, that the patient may have. Her professional status makes her an authoritative source of reassurance. Her training in meeting people's needs and helping them to solve practical problems makes her a very valuable ally for the patient in his struggle to resume his previous life.

Adaptation of the Patient

The surgical experience itself is probably crucial to the long-range adaptation of the patient. In the first place, a fairly large percentage of patients regard any major surgery as having a high probability of being fatal, or at least mutilating. Frequently, the extensive removal of body parts, especially of organs significant to the patient, is believed to be incompatible with health or vitality. When this conviction exists, surgery is approached with a keen expectation of serious injury, signaled by anxiety, confusion, and sometimes despair. It is when the expectation of injury becomes changed postoperatively into a belief that serious injury has taken place that problems of hypochondriasis and depression are most severe. The individual believes himself too enfeebled or frail to resume his premorbid functioning; consequently there is restriction of function, frequently in all areas of living. Unless these feelings are dealt with adequately when they manifest themselves, depression and invalidism may be permanent. As one patient said, "I have lost confidence in my body."

As yet no means are available to predict which patients will do well psychologically and which ones will not. No reasonable prediction can be made preoperatively that the patient fits into some particular diagnostic classification. As a matter of fact, neurotic or

psychotic mechanisms may be an asset in the total situation. When they are not disrupted, such mechanisms may shield the patient from the impact of the experience or enable him to resume function with little difficulty. A schizophrenic boy who underwent an amputation of the arm and shoulder for a bone tumor had little trouble in accepting this disability because it remained peripheral to his central problems of his own sexuality and his mother. No prediction can be made on the basis of gross adaptation, such as the fact that the patient seems to be a "well-balanced individual and a solid citizen." The physician must know exactly how this experience will integrate with or disrupt the patient's major patterns of adaptation. This is usually far too subtle to be determined before the event. Moreover, the final adaptation cannot easily be predicted on the amount of preoperative anxiety alone.

It has not been possible to develop instruments or tests to differentiate sharply between those who need help and those who do not. All patients who undergo major surgery with serious change in form and function such as that used routinely to manage and control cancer need help at some time in their course, particularly around the time of surgery.

Summary

The problems to be met in managing the cancer patient today are quite different from those of a few years ago. Operations which were considered impossible a short time ago are now routine, and postoperative care has been much improved.

All types of people have cancer. Each patient must be considered in the light of his individual problems; each one must make his own adjustment to the circumstances of his particular kind of cancer and its treatment.

No prediction can be made preoperatively of how the patient will react to surgical experience. No instruments or tests have been developed to differentiate sharply between those who will need help and those who will not.

The psychology of the cancer patient is the psychology of a person under a special and severe form of stress in which many fundamental underlying emotionally charged convictions are brought to the surface. Stresses are often met postoperatively by avoidance or denial, or depression and dependence may develop which the patient may not be able to overcome without help. Such problems can best be met by professional persons. The social worker is in a very advantageous position to aid the patient in his effort to resume normal functioning following surgery.

Psychosocial Aspects of Cancer

Two papers in this series, in addition to those appearing in this issue, were published in the October 1952 issue of *Public Health Reports:*

Professional attitudes and terminal care, by Charles S. Cameron, pp. 955–959.

Typical patient and family attitudes, by Addie Thomas, pp. 960–962.

A fifth article will be published at an early date.