Evaluation of the Psychosocial Characteristics of Gyneacologic Cancer Patients

JİNEKOLOJİK KANSERLİ HASTALARIN PSİKOSOSYAL ÖZELLİKLERİNİN DEĞERLENDİRİLMESİ

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Summary

Objective: We evaluated the psychosocial characteristics of the gyneacological carcinoma patients and, the influence of the sociodemographic characteristics and clinical characteristics of the patients. The results were also evaluated for the applicablity, benefit and correlation to the gyneacologic oncology follow-up practice.

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Material and Methods: This study was designed in a randomised, prospective manner in our clinic in one year period, and 50 carcinoma patients were recruited in the study. Fifty healthy people were also randomly taken as a control group and the same tests were applied. Patients and the control group were applied a semi-structured interview prepared by the investigator to outline the social demographical and other clinical characteristics. "Beck Depression Inventory (BDI)", "Beck Hopelessness Scale (BHS)", "Coopersmith Self-esteem Inventory (CSI)", "The Multidimensional scale of Percieved Social Support (MPSS)", "Percieved Family Support Scale (PFSS)" and "UCLA Loneliness Scale (LS) were applied both to the patients and the control group.

Results: Depressive mood, hopelessness and loneliness were found to be significantly higher; and family and social support and self- esteem were found to be lower when compared with the control group. Also depression and hopelessness scores were found to be significantly higher and self esteem and social support scores were significantly lower in carcinoma patients of low socioeconomic status than avarage socioeconomic status. As the depression score were increased, hopelessness and loneliness scores were found to be increased; and family and social support scores were found to be decreased.

Conclusion: Results showed the importance in delineating the psychosocial characteristics; re-organization of social and family relations; and improvement in life quality had a better effect on the diagnosis and prognosis of the gyneacological carcinoma patients.

Key Words: Gyneacological carcinoma patients, The psychosocial characteristics

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Özet

Amaç: Bu çalısmada jinekolojik kanserli hastaların psikososyal özelliklerinin incelenmesi psikososyal özelliklerinin sosyodemografik ve klinik değişkenlerle ilişkisinin araştırılması ve elde edilen sonuçların jinekolji pratiğine yansıyan taraflarının ortaya konulması amaçlanmıştır.

Çalışmanın Yapıldığı Yer: Kartal Eğitim ve Araştırma Hastanesi Kadın Hastalıkları ve Doğum Kliniği.

Materyal ve Metod: Çalışmaya, Kartal Eğitim ve Araştırma Hastanesi Kadın Hastalıkları ve Doğum Servisine son bir yıl içinde jinekolojik kanser nedeniyle başvuran hastalar içinden rastgele örnekleme yöntemiyle seçilen 50 hasta alındı. Çalışmaya katılım konusunda gönüllü olan sağlıklı bireylerden yine rastgele örnekleme yöntemiyle belirlenen 50 denekle kontrol grubu oluşturuldu. Hastaların sosyodemografik özelliklerini ve bazı klinik özelliklerini sorgulamak amacıyla araştırmacı tarafından geliştirilen yarı yapılandırılmış görüşme formu kullanıldı. Hastalara ve kontrol grubu bireylere Beck Depresyon Ölçeği (BDI), Beck Umutsuzluk Ölçeği (BHS), Coopersmith Benlik Saygısı Envanteri (CSI), Çok Boyutlu Algılanan Sosyal Destek Ölçeği (MPSS), UCLA Yalnızlık skalası (LS) ve Algılanan Aile Desteği Ölçeği (PFSS) uygulandı.

Bulgular: Jinekolojik kanserli hastalarda depresyon, umutsuzluk ve yalnızlık düzeylerinin arttığı, benlik saygılarının düşük , aile desteği ve sosyal destek durumlarının kontrol bireylerinden zayıf olduğu tespit edildi. Öte yandan sosyoekonomik düzeyi düşük olan kanserli hastalarda; depresyon ve umutsuzluk düzeylerinin daha yüksek, benlik saygısının ve sosyal destek puanlarının daha düşük olduğu, depresyon düzeyi arttıkça umutsuzluk ve yalnızlık düzeyininde arttığı, buna karşın aile desteği ve sosyal desteğin azaldığı tespit edilmiştir.

Sonuç: Sonuçlar jinekolojik kanserlerde hastaların psikososyal özelliklerinin ortaya konulmasının, sosyal ve ailesel ilişkilerinin düzenlenmesinin, yaşam kaliteleri ve işlevsel düzeylerinin artırılmasının, tanı ve tedavi aşamalarında önemli olduğunu göstermektedir.

Anahtar Kelimeler: Jinekolojik kanser hastaları, Psikososyal Durum

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Even with the most gentle and skilled handling, cancer diagnosis is a traumatic experience for most patients and they react with a typical stress response syndrome (1). To maximize the effectiveness of cancer therapy, the gynecologic oncologist must know his/her patients' characteristics. The effect of psychosocial characteristics

on the therapy and on the prognosis of the cancer patients can not be denied, since delineation of these characteristics gains a great importance. Depressive mood and anxiety, negative changes in self- esteem and personality characteristics, hope- hopelessness, loneliness, personal and family relations, family support and the perception of this support by the carcinoma patient are factors that delineate the quantity and the quality of the help supplied by surgery, radiotherapy and chemotherapy (2-7).

Although there are numerous studies done in our country and in the current medical literature depicting the psychosocial characteristics of the carcinoma patients, this subject is not handled in a systematic manner. Our purposal is that therapy is not complete unless this subject concerning the cancer patients is handled accordingly. Our goal was to evaluate the psychosocial characteristics of the cancer patients with this study thus, we evaluated the depression level, family and social support, hopelessness and loneliness state and self esteem of the patients and the correlation between the clinical characteristics.

Material and Method

This study was conducted in a randomised, prospective manner in our clinic during 01/06/1998 – 31/05/1999, and fifty patients with cancer were recruited in this study. Fifty healthy women were also randomly chosen as a control group and the same tests were applied to them. We looked for the following criterias in every patients recruited in this study.

- Age between 18-75 years
- Literate
- Having the capacity to understand and reply the applied tests

Following criterias were accepted as exclusion criterias:

- Have demantial status acute confutional state, any previous organic psychiatric disease
- Mental retardation
- Taking any of psychoactive drugs
- Central nervious system metastasis

Informed consent has been taken from every patient entering the study and the aim of the study has been explained to them. The control group was also recruited randomly with the same criterias as above. Social and demographical characteristics, gyneacological histories and the therapies applied to the patients have been noted. "Beck Depression Inventory (BDI)", "Beck Hopelessness Scale (BHS)", "Coopersmith Self-esteem Inventory (CSI)", "The Multidimensional scale of Percieved Social Support (MPSS)", "Percieved Family Support Scale (PFSS)" and "UCLA Loneliness Scale (LS)" were applied both to the patients and to the control group (8-12**).** The studies of validity and reliability of these scales were made by the following Turkish authors; Durak, Eker et al., Hisli et al. and Demir et al. (13-16).

Biostatistical tests were done by using chi-square test, t- test, Pearson correlation test, Mann whitney U test, Kruskal Wallis variation analysis test using SPSS 8.0 (Statistic Programs for Social Sciences 8.0) computer program. A p> less than 0.05 value is taken as significant.

Results

The gyneacological cancer patients were 19 - 75 years old with an avarage of 53.4 ± 14.7. Of these 50 patients, 25 were diagnosed with endometrium carcinoma, 17 with ovarian carcinoma, 4 with cervical carcinoma, 4 with vulvar carcinoma. All of these patients were married, with a marriage period ranging in between 1 - 50 years. The avarage marrige period was 29.9 ± 15.4 years. Eight patients (16 %) were in low socioeconomic status, and the rest (84 %) of them were in avarage economic status (If the income of the family was 100 millions TL / per month or lower and 100-300 millions TL/ per month, it's accepted us low socioeconomic status and avarage socioeconomic status respectively). Six patients were diagnosed to be inoperable and surgical intervention was not applied. Radical surgical operation was performed in 38 cases and palliative operation was performed in six of them. The duration of the disease was between 2 - 60 months with an avarage of 20.5 ± 15.7 months. Twentyfour patients were in stage 1, nine patients were in stage 2, 14 patients were in stage 3 and three patients were in stage 4 (Table 1).

The BDI,BHS, MPSS, PFSS, LS, CSI scores of the patients and of the control group and the correlation between the scales of the patients, the scores of the patients' scales according to their social economic status and the correlation between the score of the scales and the duration of the illness are shown in Table 2-5 respectively.

The scores of the scales were compared with each other for the stages of the patients to show whether chemotherapy or radiotherapy has been previously applied or not; or whether the patients are aware of their illness. There was no statistical significance between the groups according to the stage of diseases and the state of applying chemotherapy and/or radiotherapy (Table 6-7).

The patients were divided into two groups, according to their BDI scores, and these scores were compared with the other scales' scores as shown in Table 5.

Discussion

The advances in the therapy, understanding the etiology and epidemiology of the cancer are very important

Table 1. Table showing the BDI,BHS, MPSS, PFSS, LS, CSI scores of the patients and the control group

SCALES	PATIENTS	CONTROL	t value	p value
BDI	17.2 ± 13.6	0.8 ± 1.7	8.43	<0.001
BHS	8.9 ± 6.2	0.5 ± 0.7	9.42	<0.001
CSI	51.7 ± 19.3	66.5 ± 9.1	4.88	<0.001
LS	38.8 ±8.3	26.5 ± 5.7	8.61	<0.001
MPSS	59.2 ±14.4	69.1 ± 8.3	4.18	<0.001
PFSS	26.9 ±5.3	33.9± 3.9	7.53	<0.001

Table 2. Table showing the correlation between the scales of the patients (1 =Pearson correlation value insignificant, 2= p> 0.05, 3= p< 0.01)

	BHS	CSI	LS	MPSS	PFSS
BDI	r = 0.56 [2]	r = -0.40 [3]	r = -0.39 [3]	r = -0.42 [3]	r = -0.30 [2]
BHS		r = -0.54 [3]	r = -0.40 [3]	r = -0.48 [3]	r = 0.42 [3]
CSI			r = -21 [1]	r = 0.45 [3]	r = 0.28 [1]
LS				r = -0.40 [3]	r = -0.45 [3]
MPSS					r = 0.49 [3]

Table 3. Table showing the scores of the patients' scales according to the social economic status

SCALES	LOW SOCIO-ECONOMIC STATUS	AVARAGE SOCIO-ECONOMIC STATUS	Z VALUE	P VALUE
BDI	35.6	23.5	-2.14	0.031
BHS	34.9	23.7	-2.00	0.044
CSI	12.3	28.1	-2.80	0.004
LS	27.4	25.1	-0.41	Insignificant
MPSS	14.3	27.1	-2.30	0.021
PFSS	23.4	25.9	-0.45	Insignificant

facts for cancer patients, but the psychosocial results of this illness also carries a great importance (5). Psychiatric disorders like anxiety and depressive mood have been encountered in more than half of the cancer patients in a study conducted by Derogatis and et al. (17). Unluoğlu and Derogatis has also mentioned the reactive increase in morbidity in their study (3,17). Depression has been diagnosed in 5% to 60% of the cancer patients in one series (18). A patient who is faced with a mortal disease feels confused, depressed and experiences denial or even rage against her family members (19). It is not necessary to see all the components in one patient. Medical and surgical therapy, radiotherapy or chemotherapy applied to these patients should be handled with psychosocial approach (3). The effect of the psycosocial approach in the recovery or regression of these patients can not be denied. Without psychiatric intervention, however, cancer patients with anxiety or depression can refuse treatment and can be at risk for suicide.

Table 4. Table showing the correlation between the score of the scales and the duration of the illneess

SCALES	DURATION OF THE ILLNESS
BDI	0.16
BHS	0.20
CSI	-0.21
LS	0.07
MPSS	-0.11
PFSS	-0.30 [1]

We evaluated the psychosocial characteristics of the gyneacologic cancer patients with the above scoring scales (BDI, BHS, MPSS, PFSS, LS, CSI). We evaluated the relation between the psycological well-being and clinical variations like, the awareness of their ilness, socioeconomic status and the stage of the illness. We also evaluated the family and the social support to the patient received and the perception of this support by the patient.

Table 5. Table showing the comparison of the BDI scores wih the other scales' scor

SCALES	BDI<18 (N = 20)	BDI > 18 (N = 22)	t	P
BHS	11,1 ± 5,9	7,4 ± 6,1	3,63	0,042
CSI	48,4 ± 20,1	54,0 ± 18,6	0,99	0,32
LS	41,8 ± 7,3	36,8 ± 8,3	2,17	0,035
MPSS	54,2 ± 17,1	62,6 ± 11,4	2,07	0,043
PFSS	26,4 ± 5,3	27,2 ± 5,3	0,54	0,59

Table 6. The scores the patients according to the stage of CA*

SCALE	STAGE I (n=24)	STAGE II (n=9)	STAGE III (n=14)	STAGE IV (n=3)"	p
BDI	24.6	18.1	30.3	32.0	n.s.
BHS	24.6	22.5	28.3	28.5	n.s.
CBSE	23.6	31.1	23.8	31.0	n.s.
LS	22.6	27.1	28.1	31.5	n.s.
MPSS	26.2	29.0	22.3	16.8	n.s.
PFSS	28.6	21.5	21.5	15.7	n.s.

*Kruskal variation analysis were applied.
n.s.= not significant

Table 7. The scores of ther patients according to the state of taking chemotherapy and/or radiotherapy*

SCALE	Chemotherapy or radiotherapy + (n=28)	Chemotherapy or radiotherapy - (n=22)	t	P
BDI	17.0±13.1	17.5 ± 14.5	0.12	n.s.
BHS	8.8±5.6	8.9 ±7.1	0.34	n.s.
CBSE	52.1±18.6	51.5± 20.5	0.10	n.s.
LS	39.9±7.6	37.3± 8.9	1.12	n.s.
MPSS	59.8±12.8	58.3 ±16.5	0.39	n.s.
PFSS	26.9±5.8	26.8± 4.6	3.68	n.s.

*Student's t test was applied.
n.s.= not significant

When we compared the six scales between the patients and the control group, the results were statistically significant.

The scales; BDI, BHS, LS; that show the depressive mood, hopelessness and loneliness were high whereas the scales; CSI, PFSS, MPSS; that show the self esteem, family and social support, were lower when compared the gynecologic cancer group to the control group (Table 1). These findings, however show a parellelism with the studies that showed the wide prevalance of psychiatric and reactive disorders in the cancer patients (2-7).

In his study, Unluoğlu had performed BDI and BHS to the cancer patients and had found similar results, high scores in BDI and BHS, as compared with the control group, as in our study (3). On the other hand, self esteem, family and social support scores were found to be low in cancer patients. This might be due to insufficient family and social support. It might also be due to the deficiency of the perception of the family and social support with the depressive and hopeless patients. The latter assumption is far more likely.

We found positive correlation between the hopelessness scores and the family support (Table 2). And this finding is assumed to be due to the family support for the cancer patients. We also found positive correlation between the self esteem and social support. This shows that self esteem of the patients significantly increases as social support increases.

As we searched the correlation between the depressive mood and the self esteem, we found low self esteem as the cardinal finding of depression. Of the 50 patients, 8 (16 %) of them were in low socioeconomic

status, and 42 (84 %) of them were in middle class. Self esteem and social support scores were lower, and BDI and BHS scores were higher in patients with low socioeconomic status (Table 3). Depression and hopelessness were more widespread, self essteem was low, social support was poor in patients with low socioeconomic status.

We also compared the scores of the scales with the duration of the ilness and found that only social support scale showed negative correlation (Table 4). There are two previous studies performed about the relation between family support and the adaptation of the patients to their ilnesses (21,22). In one of these studies, family support increases the adaptation whereas in the latter study it has been ineffective. Our study supports Atkinson's study (16).

We also compared the other variables like the awareness of the patient of her ilnessess, the stage of the carcinoma (Table 6), whether chemotherapy and radiotherapy (Table 7) has been performed, and gyneacological carcinoma types with the scales and we could not find any statistical significance between the above mentioned groups.

It is interesting to observe that there is no difference in BDI and BHS scores when the patients were aware of their ilnessess. We also observed an unexpected finding between the scale scores and the stage of the illness (22), and this might be due to the insufficient number of patients entering the study for the different stages of the carcinoma.

Although it is expected that chemotherapy and radiotherapy side effects increase the depression and hopelessness scores (4,23), we found no increase. This conflict can be interpreted as hope of recovery might neutralize this negative impact. McDaniel et al. has found that gyneacological carcinoma is the third malignancy group that cause depression (6**).** We found no difference in scale scores for the sites of carcinoma. This can be interpreted as gyneacological carcinoma having similar psychosocial affects on the patients.

We divided the patients into two groups according to BDI scores. When we compared the patients having score 18 or more (n=20; 40%) with other patients, we found BHS and LS scores were significantly high and MPSS scores were significantly low in the patients that have BDI scores of 18 or more. These findings well correlate that as depression level increases hopelessness and loneliness increase. Depression and hopelessness are generally seen together.

It is interesting to observe that carcinoma patients have low social support scores. This may be due to the fact that cancer patients might have misinterpreted the social support they received as low, although it was sufficient.

Conclusion

The results of this study is important for documenting the psychosocial characteristics of cancer patients. We observed that depressive mood and state of hopelessness increased in gyneacological carcinoma patients. The feeling of loneliness is excessive. This feeling is merged with depresion and hopelessness feelings. Self esteem of the patients are low. Family and social support are poor. Family members and the social environment have tried to compensate for these negative conditions.

We found that in patients with low socioeconomic status depresion and hopelessnes is more prevalant, self esteem and social support is low.

As the depression, hopelessness and loneliness feeling of these patients increase, family and social support to the patient is decreased, or at least it is perceived to be decreased by the patient.

Psychosocial rehabilitation and psychosocial approaches to the gyneacological carcinoma patients may have a positive affect in the therapy and prognosis of these patients.

Family and social support and the positive perception of these support by the carcinoma patients have a great effect on the self esteem, hopelessness and loneliness feelings they experience. Increments in family and social support to the patients will improve their mental health.

Understanding the psychosocial characteristics of the carcinoma patients will strengthen the doctor patient relationships, and will help with the deontological and ethical issues. It is wise to handle the problems of the patients multidisciplinarily with the psychiatry clinic and to consult a psychiatrist when depression and/or hopelessness emerges or a decrement in family and social support is observed.

We, the clinicians have an important role in providing social support to the patients and to their families, and gyneacologists have a characteristic role in establishing the positive interaction between the patients and their relatives.

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