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The recognition of psychiatric morbidity on a medical oncology ward a single center study

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Abstract

Background: According to the mental elements of cancer, surgeons, radiotherapists, and medical oncologists are increasingly focusing on their patients' quality of life.

Objective: The aim of the study was to evaluate the recognition of psychiatric morbidity on a medical oncology ward.

Methods: The Generalised Health Questionnaire and Standardised Psychiatric Interview were used to assess psychiatric morbidity in a group of 126 patients admitted to a medical oncology unit at the same time. Anxiety and despair were also graded by senior house officers and nurses.

Results: 36 patients (29%) were psychiatrically sick, with affective disorders (29, 23%) predominating. Psychiatric morbidity was linked to feeling moderately or seriously physically unwell, as well as past psychiatric illness, but not to cancer knowledge or a lack of a confiding relationship. The General Health Questionnaire correctly diagnosed 79% of depressive illnesses but had a 34% false positive rate. Mainly 49% of depressive patients were recognized by doctors and nurses; more patients with morbid anxiety (79%) were identified, but only because doctors and nurses presumed most patients were worried.

Conclusion: Patient identification and referral rates for patients with mental morbidity might be significantly improved with training in interviewing skills.

Keywords: psychiatric, morbidity, medical, oncology

Introduction

The psychiatric aspects of cancer pointed out that surgeons, radiotherapists and medical oncologists are increasingly focussing their attention on their patients' quality of life. But advances in the psychological management of patients with cancer will depend upon an accurate knowledge of the psychiatric morbidity associated with specific cancers and their treatments. Mastectomy is associated with a substantial psychiatric morbidity [2, 3] especially when cytotoxic chemotherapy is used as an adjuvant [4, 5]. Colostomy also leads to anxiety and depression [6-7]. But little is known about the effects of other kinds of cancer, surgery or chemotherapy. Moreover, much of the psychiatric morbidity associated with cancer remains unrecognised and untreated [8]. So, a study was undertaken to determine the prevalence of psychiatric morbidity in patients admitted to a medical oncology unit, and the ability of doctors, nurses and a screening instrument to detect it.

Methods

This observational study conducted at Department of oncology, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh. *63* patients (36 male; 27 female) consecutively admitted to the medical oncology unit were included (mean age of 46. I yr). Principal diagnoses included sarcoma 10(16%), myeloma 9(15%), melanoma 9(15%). carcinoma 8(13%), leukaemia 7(10%), Hodgkin's disease 6(10%). non-Hodgkin's lymphoma 6(10%) and other forms of cancer 6(10%). A psychiatrist (A.E.H.) then administered the Standardised Psychiatric Interview to determine if the patient had a psychiatric illness 1121. He did this in ignorance of the General Health Questionnaire score and made a severity rating on a 4 point scale: 0 = no symptoms, 1 = minor symptoms not requiring active treatment; 2 = morbid and clinically important symptoms requiring psychiatric out-patient treatment or intervention by the general practitioner; 3 = severe illness requiring intensive psychiatric help. He made a diagnosis according to I.C.D. criteria and enquired about any previous psychiatric illness in the patient or family, whether the patients had anyone they could confide in (and had confided in them), how physically ill the patient felt subjectively (on a 4 point severity scale), the treatments being given, and any experience of cancer in a close relative.

The senior house officer, ward sister and other members of nursing staff who claimed to know the patient best were asked to rate whether or not morbid anxiety and depression were absent or present to a mild, moderate or severe degree. They were also ignorant of the scores obtained on the General Health Questionnaire and the psychiatrist's judgments. The specialist chemotherapy nurse was asked to complete identical ratings on those patients she had been involved with consistently. All statistical analyses were performed using IBM SPSS Statistics version 24.0 (SPSS Inc., Chicago, IL, USA).

Results

Thirty-six (29%) patients were found to have a psychiatric disorder (Table I). Affective disorders predominated (29, 23%) and were severe in six (5%) patients. Far more (31, 41%) of those 75 patients who said they felt moderately ill or severely ill physically were suffering from a psychiatric disorder compared with 5 (10%) of the 51 patients who considered they were not feeling very ill* ($x2=13.3$, $p<0.001$). A previous history of treatment for 'nerves' by a general practitioner or psychiatrist was commoner in those patients in the psychiatric (6, 17%) than nonpsychiatric (3, 3%) groups ($x1=5.0$, $p<0.05$). Eight (42%) of the 19 patients with melanoma and seven (37%) of those with myeloma had a psychiatric illness compared with rates of 29% or less in those with other forms of cancer. However, these differences were not statistically significant. No association was found between psychiatric morbidity and age, sex, marital status or the presence and use of a confiding tie even when the analysis was restricted to patients with affective disorders. One hundred and three (82%) patients were judged by the psychiatrist to have a good knowledge of the nature of their illness and treatment while 23 (18%) had little awareness. This was consistent with the policy of the unit staff to be honest with patients by explaining that they had a form of cancer, that treatment should shrink the disease, but that a cure is never guaranteed. No relationship was found between the degree of illness awareness and psychiatric morbidity. 79% of those identified by the psychiatrist as suffering from morbid anxiety of moderate to severe degree (Table II) were identified correctly by the doctors and nurses. But the better recognition by the ward sisters and other nursing staff compared with the senior house officers was only obtained at the expense of their diagnosing many normal patients as pathologically anxious. Depressive illness of moderate or severe degree was identified less often and only 49% were recognised (Table III). While nurses other than the sisters and chemotherapy nurse had a better recognition rate, this was only achieved at the cost of a high false positive rate (29, 34%).

Table 1: Psychiatry Diagnosis

Diagnosis	Moderately severe	Severe	Total
Depression	2	0	2
Anxiety state	9	6	15
Toxic confusional state	1	3	4
Dementia	0	2	2

Table 2: Diagnostic agreement with psychiatrist by other professionals: anxiety state

	Anxiety state present					Anxiety state absent				
	No. rated	Agree		Disagree		No. rated	Agree		Disagree	
		n	%	n	%		n	%	n	%
Doctors	13	7	56	6	44	37	30	82	7	18
Sisters	12	11	96	1	4	40	14	35	26	65
Other nurses	13	9	84	4	20	43	18	42	25	58

Table 3: Diagnostic Agreement with Psychiatrist by other professionals: Depression

	Depression present					Depression absent				
	No. rated	Agree		Disagree		No. rated	Agree		Disagree	
		n	%	n	%		n	%	n	%
Doctors	12	5	40	7	60	37	34	91	3	9
Sisters	12	6	50	6	50	40	31	79	9	21
Other nurses	13	8	63	5	37	43	29	66	15	34

Discussion

The psychological morbidity was considerable and equivalent to that reported in cancer patients undergoing mastectomy, colostomy, or lymphoma therapy [13], as well as in those suffering from severe physical illness [11]. It was discovered to be linked to patients' subjective assessments of their own disease. Because of their perspectives, patients with melanoma and myeloma may have a greater occurrence. Melanomas are frequently visible to patients, but myelomas cause significant bone pain. Both are infamous for being sluggish to respond to first treatment. Whereas steroids are known to increase mental morbidity, the patients' testimony also included chemotherapy and radiation. Because their depressed symptoms occurred within a few hours after therapy, some felt that these drugs had a direct influence on brain activity. Other testimony described how the treatment's toxicity caused patients to become increasingly anxious and despondent. In a British Medical Journal editorial, Diana Brinkley addressed this critical issue.

Whitlock [14] has charged psychiatric studies of cancer patients of neglecting to account for inherited predisposition, despite the fact that only one-sixth of those with mental morbidity had previously experienced psychiatric disorder. The pressures of being diagnosed with and treated for cancer appeared to be sufficient to trigger onset in the remaining patients. Given its obvious protective effects in emotional illnesses [15], the absence of a link to the presence and use of a confiding bond is puzzling. Perhaps a tie is only required when there is a problem with one's body image.

The rate of psychiatric referral and treatment was higher than is usually found in medical and surgical wards [11]. Most patients appeared to respond to treatment with anxiolytic drugs, antidepressants or supportive psychotherapy, but their precise role has still to be determined. Those affective disorders which require and respond to such treatment have also to be distinguished from those which remit spontaneously. The failure to recognise and treat half of those with psychiatric problems may reflect these uncertainties. It clearly represents a general problem among cancer patients.

The undetected morbidity cannot be attributed to an indifference to psychological aspects since the oncologists initiated this study because they were concerned about their patients' quality of life. Instead it stemmed, in part at least, from assumptions that patients who became anxious or depressed would disclose this. Like general practitioners, few of the doctors or nurses actively and routinely enquired about the psychological impact of the cancer and its treatment [16]. They said they were reluctant to probe because they might be asked awkward questions like 'How long have I got?' or be faced with strong emotions which they could not handle. Moreover, tuning in too often to their patients: suffering might impair their own functioning.

Systematic monitoring of patients' psychological adjustment is obviously required. The General Health Questionnaire would identify four in every five patients needing help but at the cost of assessing psychiatrically a third of those who are adapting well. Moreover, some patients disliked items 56 to 60 concerned with feeling suicidal or very low. Seven items [1-4, 16, 26, 29] measure physical wellbeing and could be as much affected by cancer and its treatment as by anxiety or depression. Their exclusion reduced the false positive rate

to 22% without affecting specificity. Raising the cutoff point might also sharpen identification. Further studies are required to determine which items of the GHQ best discriminate between cases and non-cases.

It is commonly considered that specialized nurses notice the majority of their patients' issues, whether they are physical, social, or psychological in character; nevertheless, our specialist chemotherapy nurse performed no better than her peers. This is hardly unexpected given that undergraduate and postgraduate education does not assure that they are prepared with the necessary interviewing abilities. When expert nurses are taught these abilities through practice, audiotape playback, and performance evaluation, they can identify and refer 76 percent of patients who need care, compared to 33 percent in this research [17]. Such training must take into account physicians' and nurses' concerns about delving too deeply and their own emotional survival, as well as demonstrate that openness regarding diagnosis and treatment does not appear to hamper psychological adjustment as long as patients acknowledge they want this information.

Limitation of the study

The present study had some limitations. Larger number of population is needed for better evaluation.

Conclusion

Patient identification and referral rates for patients with mental morbidity might be significantly improved with training in interviewing skills.

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