CHAPTER - II

Review of Relevant Studies
In the light of the discussion made in chapter I, we shall make an evaluation of studies that are indirectly and directly related to the present investigation. It has been established through reliable studies that there are certain ailments including cancer whose onset brings about change in the personality characteristics, and the etiology of many such ailments involves psychological factors.

According to Lachman (1972) there are a wide variety of conditions that, while they are not primarily due to psychological variables are nevertheless believed to be psychologically influenced, i.e., influenced by psychological arousal mediated via emotional stimulation and autonomic nervous mechanism. He has specially mentioned three ailments in this category. They are, cancer, pulmonary TB and coryza. Many cardio-vascular disorders are such in which the major determinants are psychological. Thus in the present research personality characteristics of cancer as visualized by Lachman (1972) have been studied, Levine et al (1978) have brought out records of 100
consecutive hospitalized cancer patients referred for psychiatric consultation brought to light the fact that patients constituted only 5% of those seen by the psychiatry consultation service during the study period. 56% of the referred patients were diagnosed as depressed and 40% as having organic brain disease. Twenty-six of the 100 patients were misdiagnosed by the referring physician as depressed but were classified by the staff psychiatrists as suffering from organic brain syndrome. When referral was studied by primary site of cancer, only patients with breast cancer were referred at a significantly higher than expected rate (p .001). The importance of mental status examination as a routine procedure in all cancer patients is stressed so that an organic brain syndrome will not be missed.

Among all the physical ailments, cancer today is considered as the most fatal and dreaded. In spite of investment of huge amounts of money in the researches on cancer this disease has remained more or less incurable. Effective treatment only postpones death by few
years. The moment a patient becomes aware that he is a victim of cancer, he starts perceiving his end to be a matter of months and at the most few years. The sudden visualizing of death accompanied by death anxiety causes severe psychological disturbance in patient and his attitude toward life and reality undergoes substantial changes. According to Francis (1971) persons who have cancer, suffer from anxiety, regression and depression. Whether the person realistically adapts himself to cancer sooner, later or never or whether he remains fixed in any stage depends not only on his personality characteristics but also on how he perceives his diagnosis and also on the attitudes and competence of the health personnel. According to Picarra (1949) the various groups of people accept the fact that they have cancer in different manners. However the fear of cancer disturbs, all patients with equal intensity and severity. Picarra further points out that after the first shock wears away the patient usually resigns himself to his fate and death is accepted without mental confusion. But in this process several personality characteristics undergo a change. Leshan (1959) after reviewing critically
many studies on psychological aspects of cancer and on psychological characteristics of cancer felt encouraged to develope a concept of a cancer. Some persons, he believes of certain personalities have a predisposition for cancer. Leshan is of the opinion the patient who has cancer has always been concerned with the "establishment of control over things" and is one-sided, rigid, orderly and relatively inflexible.

Typically, according to Leshan, cancer patients develope an emotional attitude of despair after a major traumatic event occurring before the first tumours are noted. This despair involves the convictions that the individual can no longer find satisfactions or meaning in life, it is compounded of expressions of hopelessness and a sense of futility regarding life. In their study Leshan and Reznikoff (1960) indicated psychological factors may be the cause of cancer. More specifically, Leshan and Reznikoff provided data that suggested that early emotional trauma may interact with other factors and thereby play a role in the etiology of a later malignancy.
From the persual of the above case studies a strong case, in favour of psychological factors in the etiology of cancer, is build up. Psychological factors are also associated with cardio-vascular disorders. Firstly, psychological factors play an important role in the causation of cardio-vascular disorders, and secondly, after the onset of such disorders psychological or personality characteristics undergo a change. In the etiology of cancer, however, the evidence in support of a cancer-personality hypothesis is not conclusive, though there is an evidence of psychological factors playing a secondary or minor role in the etiology of cancer. But the review of the literature suggests that there is a strong evidence of psychological or personality characteristics undergoing a traumatic change after the onset of cancer.

Levine (1962) reported a study in which nation-wide quota-controlled sample of 2970 was interviewed concerning grave illness. Six diseases including cancer were rated on a 5-point anxiety x scale and the subjects were questioned about their opinions and
Among the results the following were the mean anxiety ratings: cancer 72, polio 58, cerebral palsy 52, arthritis 50, birth defects 46, tuberculosis 38. Thus out of the patients of all these diseases, cancer patients were found to be most anxiety-ridden and tuberculosis patients, the least. The results are not surprising because cancer still is more or less incurable while tuberculosis is no longer a threat to life.

Hoff (1951) studied neurotic fear of cancer and concluded that cancer propaganda was responsible for spread of cancer neurosis. The author characterizes this form of neurosis as (1) regression (2) irrationality (3) a tendency to repetition, and (4) contamination of the neurosis to the whole personality. Moses and Cividale (1966) found that the fatal disease was an important of the patients condition.

Reznikoff (1954) conducted an exploratory study of some personality trends in the breast cancer patients. This study was conducted on fifty women attending a breast tumour clinic and were given individually, and prior to medical diagnosis, a personal history
questionnaire, a modified, T.A.T., and a especially adopted sentence completion test. These clinical instruments were essentially concerned with eliciting information about the patient's marital experiences and heterosexual relations - the two areas in which breast was thought to be of primary psychological information.

Orbach and Sutherland (1954) conducted a research on acute depressive reactions to surgical treatment for cancer. According to these author depression can be manifested in pre-operative anticipation of the radical surgery or during the immediate post-operative and convalescent period, the anticipated depression being based on expected disruption of character defences essential to the individual's sense of personal worth and acceptability to others and the post-operative coming about when such disruption had actually occurred. Rizzo (1954) conducted few psychological studies of terminal cancer patients with Rorschach Test. The author reports that the Rorschach protocols of 26 terminal cancer patients reflects superficiality, depression, introversion, little will power, brief attention span and low concentration of thinking.
Ferracuti and Rizzo (1955) conducted a study on psychological patterns in terminal cancer cases. The author administered the following tests to the indicated number of terminal cancer patients: Rorschach (50), Rosenzeig P.F. (30), T.O.T. (10), Draw-a-person (20). The results of different projective tests show that no common constant personality type exists in terminal cancer cases. It is possible to demonstrate the presence of some reactive patterns common to most of the subjects, although with different intensity, pointing to a great intra-group variation.

Wheeler, Coldwell (1955) conducted a study on psychological evaluation of women with cancer of the breast and the cervix. This study included three samples (breast, cervix and normal control groups) and these samples were administered Kent scale, Rorschach, Draw-a-person test, Rosenzweig Picture Frustration test and subjected to clinical interview. The authors, however, feel that the trends suggested the early childhood involvement, parental attitudes and sexual attitudes warrant further careful study on the problem.
Cobb (1959) studied the emotional problems of adult cancer patients. The author found 3 major categories of emotional stresses either singly or simultaneously -

(a) anxieties associated with the meaning of cancer to the individual,

(b) conflicts arising from precipitation of a productive adult into an unaccustomed and barren hospital world, and

(c) emotional components of separation from the family, either temporarily by hospitalization or permanently by death.

The author also suggested that a warm, protective relationship between doctor and patients minimized many of the emotional problems.

Neumann (1959) found psychic peculiarities among female cancer patients. The life history data of 50 female cancer patients were compared with those of 30 healthy women from the same geographical area and similar social level. The cancer patients showed a pattern of self sacrifice, care for others, great patience and a
relative lack of concern with personal need, indifference or even repulsion about sexual needs.

Feder (1966) brought to light psychological considerations in the care of cancer patients. The author feels that probably all patients with malignant disease are aware of it to some extent but all deny it. It is important to tell the patient the truth about his condition but not more than he can can bear. The author further feels that frank acceptance and discussion of the illness by the physician reduces anxiety and the fear of death is also minimized. On the other hand failure to obtain emotional discharge may effect the course of illness adversely.

Trentini (1967) after reviewing the American literature concerning psychosomatic relationship in cancer patients suggested that psychological defence mechanism should receive even more attention than the medical pharmalogical surgical and radiological aspects.

Hinton (1973) has also presented a case for the interaction of various personality characteristics and the experience of patient
with cancer. These personality characteristics include incidence
and types of stresses, strains and coping mechanism, sources of
stress as identified as pain, disfigurement concern over the future,
loss of work role, dependency and alienation. Symptoms of strain are
identified as tenseness fear of death, depression aggressiveness,
affect liability, paranoid trends and hypomenia. Coping mechanism
include repressive and minimizing mechanism, denial, acceptance or
despondency and rationalization.

A host of studies related to emotional aspects of reaction to
Cancer have been reported by investigators.

had died of cancer and administered a brevement questionnaire and the
brief symptom inventory 1-4 years after the death of their children.
They were found to have residual levels of grief, few had more
psychiatric symptoms than would be found in a normative population.
Factors that shaped the response to the loss include the prolonged
and debilitating nature of the illness, the sex of the parents and
children, and aspects of the parents-child relationship. Mothers felt that the loss of the child was more painful than did fathers, although they did not grieve more intensely of having more symptoms. A parent-child relationship characterized by negative feelings was related to increased psychiatric symptoms in the bereavement period.

Heinrich, et al (1984) developed the cancer inventory problem situations (CIPS) and evaluated the instrument using 84 cancer patients (mean age 60 years). The CIPS is a self-administered questionnaire designed to assess the type and severity of problem confronted by cancer patients. Ss rated 131 problem statements on a 5-point scale. Results show that Ss had moderate to severe problems in personal care, activity management, involvement with the health care system, work, and interpersonal interactions. For married Ss, sexuality was significantly disrupted.

Schover et al (1984) found that Testicular cancer patients had serious personal and marital problems because their cancer and its treatment reduce their fertilizing capacity and disrupt intimate
relationship at a crucial life stage, (ages 15-34 years). A survey of 121 men (mean age 32 years) treated for non-semivomatomous tumours revealed that 20% had low levels of general activity 10% had erectile dysfunction 6% had difficulty reaching orgasm, and 38% reported decreased orgasmic pleasure. Sexual anxiety related to cancer treatment accounts for much of this dysfunction but orgasmic factors such as hormonal, vascular, or neurologic damage may have also contributed.

Reelick, et al (1984) have found that psychological side effects of mass screening for cervical cancer among 175 women with a positive smear 350 women with a negative smear.

They found that mass screening for cervical cancer caused psychological side effects including tension and depression to occur among Ss with positive smear. However, for the majority of Ss with a positive smear, they were not testing or serious nature.

Nehimkis, et al (1984) 26-18-73 yrs. old advanced cancer patients, 5 oncologies (mean age 39.6 years) and 10 nursing staff members (mean age 39.4 yrs.) ranked in order of importance to patients 14
areas of life changes and loss commonly alluded to in the psychological oncology literature. Findings indicate considerable interpatient variability in what is constituted a major loss, while staff ratings were more consistent but overemphasized certain losses. Medical personnel tended to overrate the importance of pain in cancer patients' experience and undervalue changes in patients' abilities to perform routine household tasks and to engage in leisure activities.

Personality characteristics are also crucial in adjustment and reconciliation after the onset of cancer. This has amply been demonstrated by Weisman and Warden (1976). The authors have brought to light existential plight among 120 newly diagnosed cancer patients. The author considered the first 100 days after the diagnosis as very significant.

According to McCollum (1978) the initial reaction to cancer is typically shock and denial followed by various coping strategies. A surgical or chemotherapeutic period is entered with
concomitant adjustment reactions. The third adjustment period comes after treatment and may involve into a prolonged death crisis which brings difficult change and pressures to the patient and his/her family. If the patient is not terminal, matching 3rd phase, rehabilitation is entered during which emphasis may be placed on adjustment to the physical disabilities that may result from surgical treatment. The role of the rehabilitation counsellor is emphasized during this phase.

One of the most significant aspect of cancer research as regards the etiology of cancer includes findings which give indications of psychological factors in the development of cancer, Nand K. Sah and E. Hasmain (1981) have brought but a summary of the reports that have come largely from the Science Reporter issue of February 1983. They have even ventured to suggest that yogic practices may help curing cancer and much attention has been paid by the Government of India in this regard.
Only recently a German doctor Hammer who developed cancer after death of his son verified his theory psychogenesis of cancer in 500 patients in the University hospitals of Munil, Keil, Rome and Cologne. He believes that cancer is the outward sign of unresolved conflict.

The readers might be interested knowing the latest and revolutionary theory of cancer. A German doctor now living in Rome, doctor Ryke Greed Hamer, (1982) says it is not pollutant or virusus or genetic predisposition that cause malignant tumours as has been assumed up to now but personal psychological conflicts.

Dr. Hamer has presented his theory as his professional thesis to the Tubingen Medical School. The University is considering the thesis.

Dr. Hamer's research was triggered by the death of his son Dirk in August 1978. He was shot by a descendent of the last Italian
king and died of his wounds four months later. The case was widely publicized at that time. Afterwards, Dr. Hamer developed cancer. He interprets this as the outward sign of an unresolved mental conflict. Dr. Hamer says he verified his theory by examining 300 cases in the university hospitals of Munich, Rome, Keil and Colongne.

Due to his departure from textbook medicine his hospital forced him to resign.

He has summed up his findings in what he calls "iron ruler of cancer". According to this theory there are three criteria for the development of malignant tumors, the first name the "Hamer Sydrome" after his son Dirk. The doctor maintains that cancer occurs on a particular day of severe conflict when the person concerned feels geographically, socially or psychologically massively isolated. The occurrence of the tumor is more likely if the general condition of the patient is poor.

The substance of the conflict determines where the tumor is, the course of illness runs parallel to the course of the conflict.
According to Dr. Hamer’s findings breast cancer is triggered by general human conflicts such as between mother and child while in a man this type of a conflict causes a malignant tumour in the bronchial tubes. Cancer of the cervix is always related to sexual conflicts and lung cancer is caused by fear of death. But, a major element is whether or not cancer develops is not only the conflicts itself, it is also its duration, he points out.

Cancer of the breast is usually noticed after two or three months, cervical cancer after about a year and cancer of the bronchial tubes after 18 months.

Dr. Hamer has evolved the following theory based on research;

"Cancer occurs as a result of a programming mistake of the brain in both man and animals which he describes as a permanent short circuit in the wiring of the brain. This results in the emission of wrong codes that cause cell degeneration. The growth of the tumour ends when the conflict ends".

While much attention has been paid to patient’s emotional
reactions in their overall care, more severe psychiatric morbidity, especially that reflecting impairment of cerebral function, continues to be under-diagnosed. Many of the affected patients could be effectively treated and the quality of their lines improved. Hence mental status examination, including test of cognitive function is regarded as a part of clinical routine for all cancer patients.

Patients reporting or displaying symptoms of depression, organic brain syndrome, paranoid or schizophrenic psychosis, suicidal thoughts, severe anxiety, or any combination thereof, are recommended for psychiatric consultation.

Special attention is paid to impairment of cognitive functions which points to cerebral disorder. Recognition of an organic brain syndrome, it is believed, leads to immediate search for its etiology, which in a patient with cancer is likely to be multifactorial.

Patients displaying marked behaviour pathology, such as agitation, panic, severe depression, excitement and insomnia are supposed to receive appropriate psychotropic drugs. HALOPERIDOL is particularly
suitable for the control of the agitated, restless, and delirious patient and has also been reported useful in the relief of pain. Tricyclic anti-depressants should be used when a depression is severe.

Liaison between psychiatry and ecology is therefore encouraged for the sake of better care of cancer patients. In fact, indecisive studies of occurrence, nature, and severity of psychiatric disorders in various categories of cancer patients are needed.

The studies reviewed above, leave no doubt that some psychological consequences of cancer leading into anxiety and emotional disturbances are inescapable. The finding of the pilot study on the part of this investigator, however, highlights the fact that the impact of cultural factors can become quite noticeable through cross-cultural studies and the fact of transcendence over death, as it was observed in some patients evidently strengthens the idea. However, the investigator was more concerned with furthering the inquiry in order to see the changes in the attitudes of patients
who were in the stage of late malignancy. The methodological requirements for furthering the inquiry are therefore discussed in the next chapter.