

Chapter 11

Psycho-oncology



Kurt Fritzsche, Sonia Diaz Monsalve, Hamid Afshar Zanjani, Farzad Goli, and Catharina Marika Dobos

Case Study

55-year-old Mr. M. is hospitalized because of an intractable cough. His medical history shows Mr. M. has been smoking an average of 20 cigarettes per day since he was 18 years old and stopped smoking only 5 years ago. He is married, has two adult children, and works as a clerk in a small company.

The chest X-ray and chest CT scan show a mass, and the bronchoscopic biopsy indicates small cell lung cancer. After the examinations he spontaneously says to the doctor: “All these examinations have made me increasingly scared. Four months ago, when I spat blood, I knew: now I have cancer!” (to be continued)

K. Fritzsche (✉) · C. M. Dobos

Department of Psychosomatic Medicine and Psychotherapy, Center for Mental Health, Medical Center - University of Freiburg, Faculty of Medicine, University of Freiburg, Freiburg, Germany

e-mail: kurt.fritzsche@uniklinik-freiburg.de; catharina.marika.dobos@uniklinik-freiburg.de

S. Diaz Monsalve

Department of Psychosomatic Medicine and Psychotherapy, Center for Mental Health, Medical Center - University of Freiburg, Faculty of Medicine, University of Freiburg, Freiburg, Germany

ZMG Centre for Medicine and Society, University of Freiburg, Freiburg, Germany

e-mail: sonia.diaz-monsalve@uniklinik-freiburg.de

H. A. Zanjani

Department of Psychiatry, Medical Faculty, Psychosomatic Research Center, Isfahan University of Medical Sciences, Isfahan, Iran

Noor Hospital, Isfahan, Iran

e-mail: afshar@med.mui.ac.ir

F. Goli

Department of Bioenergy Economy, Energy Medicine University, Mill Valley, CA, USA

Danesh-e Tandorosti Institute, Isfahan, Iran

e-mail: info@iranianhealth.com

Definition

Cancer is a disease which in 50% of the cases is fatal. The treatment is highly stressful both physically and mentally. Generally, a cancer diagnosis triggers anxiety and helplessness, as the disease is often associated with death and dying. The diagnosis is an intrusion into the patient's structure of life which may affect the entire family. The field of psycho-oncology is concerned with the influence of psychological and social factors on the development, course, and coping of oncological diseases and investigates the effectiveness of psychotherapeutic treatment methods to improve the emotional well-being and quality of life of oncological patients.

Relevance

If the extent of stress exceeds the coping ability of patients and their families and affects the mental state and interpersonal relationships of the patient, psychosocial support is necessary. This is the case in 20–50% of all patients with a cancer diagnosis, depending on the type of cancer and the treatment stage. These patients exhibit—at least immediately after the diagnosis—clinically significant symptoms of a mental disorder. The patients mostly show anxiety and depressive symptoms such as rumination, insomnia, and/or physical impairments during radiotherapy and chemotherapy such as pain, nausea, and fatigue.

Theory

Not all causes of cancer are completely explained yet. There are many psychosocial factors that play a role in the development of cancer, including unhealthy behavior (smoking, alcohol consumption, unhealthy diet, exposure to carcinogenic substances at the workplace). Overstraining, loss of attachment and, resulting depressive symptoms lead to the activation of the pituitary adrenal cortex axis and the associated increased release of cortisol. Cortisol in its anti-inflammatory function reduces the gene regulation of cytokines (tumor necrosis factor, interleukin 1, 2, and 6) and the cell activity of T lymphocytes and natural killer cells (NK). Thus, the immune system's defensive function in the formation and elimination of tumor cells is limited. Protective and damaging influences in the development of cancer are no longer in balance. Carcinogenic substances, such as those contained in cigarette smoke or chemical substances, a genetic disposition, radiation, or viruses can develop their harmful effects on the body more easily. In order to prove a connection between psychosocial stress and the development of cancer, studies with very large case numbers and a very long data collection time are necessary. However, the studies currently available do not allow a clear conclusion in one or the other direction.

The situation is different regarding investigations into the *course* and *management* of cancer. In the majority of the studies, the following psychosocial stressors have had a negative impact on the quality of life and coping with the cancer diagnosis: depression, anxiety, helplessness and hopelessness, suppression of feelings, and social isolation. Coping styles (see section “[Coping](#)”), such as an active problem-oriented approach to the disease, had a positive influence on coping compared to resignation and withdrawal.

There is no clear evidence to date that psychosocial factors influence the *development of cancer*. However, there are clear indications that psychosocial well-being and certain dysfunctional coping strategies have an influence on the subsequent *management of the disease*.

Symptoms

The mental problems of cancer patients are not fundamentally different from those of patients with other serious physical diseases. It is important to realize that these patients are not primarily mentally ill; rather their mental problems are emotional reactions to the cancer diagnosis, such as anxiety, depression, resentment, and anger. Depending on the type of cancer, 20–50% of patients show symptoms of a mental disorder. In most cases patients show an acute stress reaction with anxiety and depressive symptoms (ICD-10: F 43.0, ICD-10: F 43.2).

The symptoms accumulate during the first weeks after the diagnosis and become less thereafter. In a small number of patients, the symptoms may last for another year or two.

Table 11.1 shows typical emotional reactions and challenges patients may have to deal with in the course of a cancer diagnosis and treatment.

Subjective Disease Theories

In view of the existential threat posed by a cancer diagnosis, patients develop their own ideas about the cause of the disease, its course, and what they can do to cope with it. These “subjective disease theories” are often not in line with or even contradictory to the current scientific view. In a German survey of breast cancer patients, 80% cited the environment, 70% stress, 68% mental problems, 58% fate, and 54% family burdens as the causes of their cancer. Approximately half of all patients see their cancer as a **challenge**, and a third consider it a valuable experience. Only 3–5% see the disease as a personal failure and a punishment

Cancer and Family

A cancer diagnosis is an attack on the entire system of interpersonal relationships surrounding the patient. In addition to the individual’s psychological burden, the cancer diagnosis often leads to a disturbance in the partnership and the whole family dynamic. Some of the negative psychosocial effects of cancer on the social environment are difficulties in talking about feelings and the fear of the progression of the disease in the future, including possible death. Some positive psychosocial

Table 11.1 Mental reactions occurring in the course of a cancer diagnosis and treatment and the patient's upcoming challenges in coping with the disease

Illness phase	Mental reaction	Tasks to be managed by the patient
Diagnosis	Shock, fear	Accepting the diagnosis, coping with intense emotions
	Disbelief, despair, depression	Making a decision regarding treatment
	Anger	Notifying the social environment
Primary treatment phase	Anxiety, depression, loss of control and autonomy	Accepting illness and treatment
	Loss of physical integrity	Coping with treatment side effects
	Loneliness, loss of intimacy, and sexual contacts	Establishment of viable relationships with the treatment team
		Regaining mental and physical self-esteem
Remission	Relief, gratitude	Return to everyday life, living with uncertainty
	Fear of recurrence and metastases, increased awareness of the body	Development of new perspectives on life, returning to work
Recurrence	Shock, anxiety, depression	Accepting uncertainty of the future
	Denial	Accepting the progression of the disease and the likelihood of death
	Loss of hope and trust	Adaptation of the perspective of life to the new situation
	Increased vulnerability	
	Search for meaning, feelings of guilt	
Terminal stage	Fear of death, depression, demoralization	Dealing with death and dying, mourning the loss
	Denial	Accepting your own death
	Loss of control	Accepting the physical decline and the negative prognosis
	Fear of loneliness	Arrangement of family affairs and legal matters and parting from family and friends
	Increasing dependence on doctors and nursing staff	Looking back at your own life, dealing with spiritual issues
	Retreat	
	Anger and resentment	

effects of cancer on the social environment might be stronger family ties and positive changes in relationships to siblings and children. The desire for sexuality and sexual activity decreases in all forms of cancer. The main problems are difficulties in reaching orgasm, lack of sexual desire, pain, and incontinence.

In the near future, the wide possibilities of predictive diagnostics in the field of oncological disease will additionally challenge the coping resources of affected families. Reliable detection of gene mutation carriers and biomarkers for cancer pre-

disposition will pose questions, such as: “How should these genetic risks and predispositions be communicated within a family?” “Who should talk to children and adolescents who are gene mutation carriers themselves, and when is the right time for that?”.

Children of Parents with Cancer

Having a parent with cancer is an extremely dramatic experience for a child. Depending on their age, children’s reactions can include fear of separation, bed-wetting, thumb-sucking, difficulties in falling asleep, and aggression toward other children but also toward other adult caregivers (in order to relieve the sick parent). Children can also show concentration problems, learning difficulties, rapid decrease in school performance, somatoform symptoms such as headaches or stomach pains, social withdrawal with neglect of friends and hobbies, and physical self-neglect. Younger children often react with behavioral changes, while adolescents might appear cold and uninvolved.

Diagnostic Categories

Of the whole spectrum of mental disorders, the following diagnostic categories are mostly relevant in the context of cancer.

Acute Stress Disorder (ICD-10: F43.0)

An acute stress disorder can develop in response to exceptional physical or mental stress. Acute stress disorder is a transient disorder, which generally subsides within hours or days. The symptoms vary from a feeling of being overwhelmed, narrowing of consciousness, and limited attention to an inability to process stimuli and disorientation. This state may be followed by a further retreat from the social environment, or a state of restlessness and overactivity. Frequently, vegetative signs of panic such as tachycardia, sweating, and blushing occur.

Adjustment Disorder (ICD-10: F43.2)

The symptoms include depressed mood, anxiety, and excessive worrying. In adolescents disturbed socialized conduct may be an additional symptom. Short depressive and anxiety reactions, lasting less than 1 month, are differentiated from longer reactions, lasting up to 2 years.

Fatigue Syndrome

Fatigue is observed as great tiredness, exhaustion, reduced performance, and muscular weakness. It especially affects patients after radiation or chemotherapy. About 30–40% of patients suffer from chronic fatigue even after the cancer treatment has been completed. Fatigue is considered a separate syndrome, even though there is some overlap with depressive symptoms. It probably originates from a complex interaction between the tumor disease, chemo- and radiotherapy, tumor anemia, other secondary diseases, immunological processes, and emotional coping processes.

Frequency

Especially during the first few weeks after being diagnosed with (or learning about the recurrence of) cancer, 30–50% of patients show symptoms of emotional distress. Usually this is an acute stress reaction with anxiety and depressive symptoms (see diagnostic categories). Psychiatric disorders in the strict sense are rare.

Onset and Course

Risk factors for mental decompensation after being diagnosed with cancer include previous and current mental problems (especially depression, alcoholism, earlier suicide attempts), lack of social support, recent experience of separation and/or death, marital or family problems, financial problems, problems at work, previous negative experiences with illness, uncontrollable pain, a poor prognosis, an advanced tumor, and physical and emotional exhaustion.

Coping

Coping is any behavior used by the patient to overcome, alleviate, or accept already existing or expected health-related stressors in an attempt to endure the disease. Patients try to keep feelings of fear, self-esteem impairment, and loss of control within at a tolerable level.

Coping strategies can be found at the cognitive, emotional, and behavioral level:

1. **Cognitive processing** strategies such as finding subjective explanations for the disease, refusing to believe the diagnosis, and blaming oneself or others for the disease.
2. **Emotions** such as irritability, rumination, sarcasm, quarreling and other moods, and emotions and affects.
3. **Processing on the behavioral level** such as actively tackling upcoming problems, distracting oneself, carefully following medical advice, or social withdrawal. The state of mental well-being during cancer treatment depends on the coping mechanisms that are available to each individual patient. The following coping styles have been found to be helpful in dealing with the disease:
 - An active, confrontational approach to the disease (a so-called fighting spirit)
 - Search for meaning and spirituality
 - Good interpersonal relationships and social support
 - Trust in the doctors

Coping styles that are not helpful:

- Passive acceptance and resignation
- Social withdrawal and isolation
- Helplessness and hopelessness

Studies have shown that using a wide range of coping strategies (according to the situation) enable a better adaptation to the situation than the presence of only one coping strategy.

Practice

Recognition

Indication for psychotherapy/psychosocial care for cancer patients is assessed by the biopsychosocial anamnesis.

Indications for Psychosomatic Basic Care

- Anxiety and depressive reactions after receiving the diagnosis or during the course of the treatment
- Suicidality
- Psycho-vegetative reactions such as nausea, weakness and fatigue, insomnia, and concentration problems (fatigue syndrome)
- Mental impairments (e.g. after surgery)
- Avoiding going outside after face or larynx surgery or after breast surgery
- Changing roles in the family and relationship conflicts
- Physically unexplained pain syndromes persisting for a long time despite treatment
- Posttraumatic stress disorder, for example, after a surgery with many complications

Basic Therapeutic Attitude

There is a very important balance to be kept between hope and acceptance. Hope, as positive anticipation, could promote the psycho-neuro-immunologic system. Without acceptance the anticipation could lead to an anxious and aversive attitude. Acceptance of the reality of a disability and the possibility of dying in the near future is an significant point of coping with cancer, but without hope the confrontation with upcoming disabilities and dying can lead to a passive and fatalistic attitude.

The doctor should accept the behavior of the patient, even if the patient denies his/her disease. Fear, despair, gloom, withdrawal, anger, and rage are all considered adequate responses to the diagnosis. The goal of the therapeutic interventions is for

the patient to be able to better cope with the disease; to eventually regain control of thoughts, feelings, and behavior; and for him/her to develop an overall active and solution-oriented attitude toward the disease.

Basic Interventions

Information and Consultation (Psycho-education)

The first stage includes informing the patients and their families about the disease and the recommended treatment measures. This consultation has the aim of reducing feelings of helplessness and uncertainty due to the lack of knowledge. Information on anxiety and depressive reactions as common reactions to the diagnosis and reassurance on the availability of the doctor as a contact person should be included. Patients should be encouraged to ask questions, to express their thoughts about cancer (subjective theory of disease) and the progression of the disease, and to talk about upsetting thoughts and feelings. These first basic informations should be offered to all patients after cancer diagnosis either as an individual consultation or as part of a group counselling program. It requires the physician to have basic knowledge of psycho-oncology and psychosomatic basic care (an in-depth psychotherapeutic competence is not required). Many patients also benefit from self-help groups.

Specific Measures for Pain, Fatigue, Nausea, and Vomiting

There is a wide range of intervention options to treat pain and fatigue: progressive muscle relaxation, autogenic training, hypnosis, meditation, biofeedback, passive muscle relaxation, and guided imaginations or visualizations. Another common problem of chemotherapy is the anticipatory vomiting and nausea. These side effects follow the rules of classical conditioning and can be treated with a desensitization treatment. The main objective of these symptom-oriented methods is the development of positive associations and pleasant body sensations. The techniques also strengthen mental coping skills and increase feelings of self-control. A combination of progressive muscle relaxation and imaginative techniques has been shown to be effective in reducing pain in mucositis, a very common and painful complication of chemotherapeutic treatment (Syrjala et al. 1992).

Psychotherapeutic Interventions

The physician should inform the patient about psychotherapeutic support services. This includes art therapy, music therapy and imagination therapy, as well as cognitive-behavioral and psychodynamic treatment approaches and person-centered psychotherapy, for individuals or in group settings. Depending on the

patient's problem and personality, individual elements or a combination of treatment methods can be used. In practice, different therapeutic approaches are often combined. A psychotherapeutic intervention is most successful if it is adapted to the patient's needs and his/her individual psychological and social resources.

Objectives of Psychotherapeutic Interventions

- Reducing anxiety, despair, and depression in patients and relatives
- Crisis intervention in case of suicidality
- Improving compliance with respect to the medical treatment
- Activating the patient's coping resources
- Teaching behavioral techniques and mental approaches to better manage and accept the disease
- Teaching relaxation techniques to reduce insomnia, pain, nausea, and other physical symptoms
- Breaking the taboo of talking about death and dying

Breaking Bad News

More than 90% of all cancer patients in Western countries want to be informed about the disease and possible treatments. An important component of the conversation is the emotional support in dealing with the information. The doctor should be adequately prepared for this difficult task.

Ineffective strategies like blunt and insensitive (disease-centered) information and kind and sad (emotion-centered) sympathy may make the adjustment process more complex and problematic or even traumatic. In contrast, an empathetic and positive (patient-centered) attitude facilitates adjustment and adherence (Brewin 1991).

The six-step SPIKES protocol by Baile et al. (2000) provides a guideline for delivering bad news to patients with cancer.

1. SETTING UP the Interview

Set the time frame, communicate the objective of the conversation, arrange for some privacy, and ask the patient if he/she would like you to involve a significant other in the interview.

The doctor's checklist:

- Do you have all the test results at hand?
- Do you have a treatment plan? What are the next advised examinations or further diagnostic steps?
- What exactly do I want to tell the patient?
- Where do I want to start?

2. **Assessing the Patient's PERCEPTION**

Before discussing the medical findings, the doctor uses open-ended questions to create an accurate picture of how the patient perceives his medical situation. Based on this information, the doctor can correct misinformation and adjust the bad news to the patient's level of information and understanding.

3. **Obtaining the Patient's INVITATION**

While most patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. Some patients would rather focus on the next treatment steps. To find out about the informational wishes of the patient, doctors can ask questions such as: "Do you want as much information as possible, or are you a person who would rather like to not know everything?"

4. **Giving KNOWLEDGE and Information to the Patient**

Examples of phrases that can be used are: "Unfortunately, I've got some bad news to tell you. Based on the examination, we suspect that you may be suffering from cancer."

5. **Addressing the Patient's EMOTIONS with Empathic Responses**

Conversation techniques that reflect displayed or perceived feelings are helpful. ("You are very sad and confused. I have the impression that you are also angry because you have not been told earlier that it could be cancer.")

For the **emotional support** of patients and their significant others, an orientation toward the following five-stage scheme is helpful:

1. Naming emotions: cautiously, questioningly, as an offer, possibly in the subjunctive.
2. Check your own understanding: continue asking questions, listen carefully, and take breaks.
3. Appreciate the patient's situation and his/her attempt to cope with it: you can show this verbally and nonverbally through facial expressions, changing the sitting position, and possibly touching the patient's hand or arm, if appropriate.
4. Offer serious and feasible support.
5. Inquire more deeply, if the patient is ready for this.

Practical Tip

- Adapt your information to the patients' speech.
- Explain complex information in pictures, and make reference to the patient's everyday experience.
- Do not make the word cancer a taboo, but watch the patient's reaction, and adapt your language according to the reaction.
- Refer to the emotional reactions of the patient and the family members; do not switch immediately to "facts" when emotionally difficult situations arise.

- Silence and pauses with concurrent physical and mental presence are more effective than talking excessively.
- Always leave room for hope. Ensure reliable, competent, and best possible treatment, e.g., against pain. Give the patient the feeling that he/she will not be given up on, but do not raise false hope.
- Check repeatedly whether the patient has understood the information. Inform the patient that he/she can contact the nursing staff or the doctor on duty if needed

6. STRATEGY and SUMMARY

- *Summarize* the conversation.
- Offer *Support* for the following hours and on the way home.
- Ask the patient if he/she is ready to discuss the treatment plan, or set a date for a new appointment. (“If you have no further questions, we can stop here. I can imagine that a lot of questions will come to you later. If you want, we can meet again this evening/tomorrow morning and talk some more about it.”)

Case Study (Continued)

55-year-old Mr. M. was diagnosed with small cell lung cancer. The attending doctor asks the patient whether it would be okay for his wife to join the conversation; the patient agrees, and the doctor invites both into his office.

Before the conversation, the doctor thinks about what exactly she wants to tell Mr. M. and how she would like to phrase the findings so that Mr. M. would still have hope, i.e., offering the possibility of radio- and chemotherapy and telling him that the associated symptoms such as pain and shortness of breath can possibly be treated. She also realizes that she must explain the findings and the treatment to the couple in simple terms. She does not want to share a prognosis, because, on the one hand, she knows from her own experience that they rarely come true and, on the other, she would like to prevent Mr. and Mrs. M. from losing hope.

In the conversation, the doctor tries to communicate the findings in a straightforward manner while remaining objective, yet approachable. She tries to dampen the initial shock, by building confidence in the treatment options. She avoids technical terms and explains the treatment options to the couple and how they work as accurately as possible.

It is difficult for Mr. M. to follow the explanations of the doctor. He feels numb. Toward the end of the conversation, he finally dares to ask whether he will be dying soon. At first, the doctor is surprised about the directness of this question. Through empathetic questioning, she learns about the painful death of a co-worker, who suffered from cancer. Gently, she addresses the fears of the patient and assures him that everything will be done to help him and to avoid unnecessary pain and suffering.

Preparing for Death

Doctor-patient communication becomes difficult when the doctor cannot offer any more treatment options. Feelings of powerlessness and helplessness spread in both the patient and the doctor (“empty hands” syndrome).

“Why don’t the doctors understand the importance of just being there? Why can’t they see that the moment in which they can offer nothing more is the moment in which one needs them most?” (Paula in Yalom 1999)

Hope is usually associated with a positive goal and success orientation, e.g., reduced to the formulation “with favorable prognosis.” It appears treatment failure would rule out hope. Giving hope is an important dimension in creating the doctor-patient relationship. Cancer patients, whose legitimate hope for cure and recovery is disappointed, are not necessarily without hope. When the hope of survival fades, other forms of hope, such as a peaceful death, reconciliation with estranged family members, or wishes like seeing the newborn grandchild become more important. Many dying people show a great calmness, wisdom, and humor in this extreme situation, which amazes the outsider. In order to develop these capabilities, respectful, empathetic attendance is necessary. The dying person needs to feel that he/she is not abandoned. It must be clear to the doctor that he/she will experience an intense, emotional bond to the patient who is preparing for death. Past experience with dying friends, siblings, or parents could possibly be triggered. It is important for the doctor to recognize his/her own “weak points” and vulnerabilities. Doctors who have experienced traumas and loss in their own lives are in the best position to empathize with others and to recognize their own limits. They can best understand what it means to prepare for one’s own death.

Case Study (Continued)

Chemotherapy had to be discontinued after 2 months due to severe side effects such as nausea and vomiting, loss of appetite, weight loss, and poor general condition of the patient. During this time, he was frequently visited by his family doctor as part of an outpatient palliative treatment and was emotionally supported by him. The patient died half a year later with his family present.

Pitfalls

- The doctor continues to talk, even if the patient is no longer receptive.
- There is too much information given at once.
- He/she ignores the patient’s emotional reactions.
- The doctor quickly changes to the factual level, because he/she can no longer take the emotionally stressful situation and feels overwhelmed by the task of caring for the patient long term.

- The doctor gives in to the pressure of the patient or the family and prescribes a new chemotherapy cycle, although he/she is not convinced of the indication. In short-term, this calms down the situation but moves all questions related to further tumor growth and the end of life to a time when the course of the disease has worsened and reached a critical state, and there is little time left for the patient to sort out all remaining questions in his/her personal life. It is merely an evasion of answering vital questions by physician, patient, and relatives.

Cooperation

Psychotherapeutic support is appropriate and necessary when the extent of stress exceeds the patient's coping capabilities with detrimental influence on the emotional well-being and social relationships over a longer period. This is the case in about 10–20% of all cancer patients. For these patients, depending on the severity of the psychosocial stress and therapy motivation, there is a need for psychological treatment. Emotionally stressed partners, children, and other persons close to the patient can also be in need of psychotherapeutic help.

Research Evidence

Studies have shown psycho-educative and psychotherapeutic treatment to be efficient in improving the well-being and quality of life of cancer patients. It could also be shown that side effects of chemotherapy, such as pain, nausea, and vomiting, can be influenced by cognitive behavioral therapy and imagination therapy. The influence of psychotherapy on the cancer prognosis has not yet been convincingly demonstrated. In many hospitals, there is a psychiatric and psychosomatic consultation and liaison service which takes over the specialist psychotherapeutic treatment and supports doctors and nurses in learning the basic psychosomatic competences.

Cultural Aspects

Patients of different cultures react differently to the diagnosis of cancer. American patients mostly hold views of adaption and hope. African patients maintain and hold more fatalistic and powerless views. In the Latin American region, breast trauma and certain “bad” behaviors are associated as being risk factors for breast cancer. How cancer and its symptoms are described is subject to the patient's educational level, medical knowledge, and culturally formed beliefs. Chinese describe a depressed mood as “I feel my heart is empty” without any cardiac problem. A

culturally sensitive physician will try to understand the symbolic meaning behind what is said rather than taking the complaint too literal. Furthermore, the patient's relation to the medical team may be different. Japanese patients will try to ask the nurses, whom they feel most comfortable to share their problems with. In Western societies, a person is expected to have an established family physician, but in Asian countries, a patient will shop around for physicians without feeling a commitment to remain with any particular family physician.

Also a wide range of concepts as to whether the physician should inform the patient truthfully about the diagnosis exist. The way to deliver bad news is influenced by cultural aspects (Ong et al. 2002). In many Western countries, oncologists usually inform cancer patients about their cancer diagnosis (Grassi et al. 2000). Studies have shown that 98% of patients would like to know their diagnosis, and 87% of patients would like to receive all available information, both good and bad (Jenkins et al. 2001). The individual wishes of the patient are highly respected. The ethical principle of autonomy supports this approach (Beauchamp and Childress 2001). However, it needs to be pointed out that in the USA and other Western countries, it was not common to practice disclosure of "bad news" about terminal illness prior to the 1960s. Currently, disclosure of medical information to patients is necessary because of the physician's concerns about malpractice lawsuits and the legal requirements to obtain the patient's consent for the treatment. Today cultural views as to whether the physician should truthfully inform the patient about the diagnosis of a life-threatening disease or not still vary from county to country. Patients from different ethnic backgrounds react differently to the disease of cancer. Patients from Western countries mostly hold views of adaption and hope. Patients from Africa and Asia maintain more fatalistic and powerless views.

Asia

For Asian physicians, disclosing diagnosis and prognosis to patients presents a big challenge, because they are confronted with a family-centered model of decision-making (Back and Huak 2005). Accordingly, it is expected that physicians first talk to the family members, who then decide whether the patient should be informed or not. Mostly, it is the task of a senior physician, and it is seen as a sign of competence and respect. If a junior physician or a nurse broke bad news directly to the patients, it would be seen as a breach of trust and might cause dissatisfaction. However, junior physicians and nurses are expected to give more detailed information to patients afterwards, to be in charge of the patient's following treatment and counseling. Most Asian families, however, ask physicians not to reveal the diagnosis and prognosis to patients (Hu et al. 2002). One reason for that might be the fear that the patient might commit suicide out of desperation after finding out about the diagnosis (Tse et al. 2003). This approach places emphasis on keeping patients away from harm and is integrated in the ethical principle of beneficence (Beauchamp and Childress 2001). However, more and more patients in Asia would like to be fully informed, and the right to be informed has been regulated by law. This new development represents a dilemma for oncologists. On the one hand, they must respect the

patients' autonomy, and on the other hand, they need to consider the families' concerns (Wang et al. 2004).

Iran

Cancer is the third leading cause of death in Iran. The increase in cancer incidence is one of the most critical challenges for the Iranian health-care system. Recent epidemiologic data show an age-standardized incidence rate (ASR) of about 142 per 100,000 inhabitants. It is estimated that there will be 100,000–110,000 new cases per year (Global Cancer Observatory 2019).

Several studies conducted in Iran demonstrated that cancer is a taboo subject, and the word cancer, as well as other indicative terms, were rarely used in daily communication. A climate of nondisclosure predominated as patients were the last to know their diagnosis, they were unaware of their prognosis, and family members and physicians employed strategies to conceal this information. The mutual concern of patients, family members, and physicians was the main reason that a cancer diagnosis is not discussed (Zamanzadeh et al. 2011).

Along with improvements in curative care (using advanced methods in diagnosis and treatment) palliative and supportive care including psycho-oncology is also improving in Iran (Rassouli and Sajjadi 2016; World Health Organization 2017; Khanali Mojen 2017). Qualified care for cancer patients, their families, and health-care providers is needed starting on the first days after diagnosis and this need poses a high demand on Iranian health-care providers (Omidvari 2016; Rouhollahi et al. 2014). Many clinical and health psychologists are studying and working in Iran, and most of the oncology hospitals need skilled psychologists to work with oncologists and palliative specialists.

Some of the essential skills in psycho-oncology include disclosing bad news, communication skills, a meaning-centered approach, spiritual care for some, and attending the decision-making process of the patient and family. The attitude toward cancer is very much influenced by culture and needs experience and expertise (Jünger et al. 2010; Jünger and Payne 2011; Scheidt et al. 2017; Ehsani et al. 2016; Ahmadifaraz et al. 2015). Currently, relatively good palliative care and psycho-oncology settings are found in Isfahan City, which includes the University Psycho-oncology Clinic, the University Pain Clinic, and a consultation and liaison service for inpatients. Palliative and psycho-oncological care is also provided by non-government organizations (NGO) in a Cancer Prevention and Control Center (MACSA), in Isfahan and Tehran. MACSA services are provided by the hospital outpatient clinic and ward, home care network, cancer rehabilitation center, hospice, call center, and cancer supportive social network, which has been developed over the past 5 years (MACSA 2019).

Regarding the high number of cancer patients and number of interested psychologists, recently, a culture-based and adaptive psycho-oncology educational program is being established by a joint program between the Department of Psychosomatic Medicine and Psychotherapy of Freiburg University, Germany, and the Psychosomatic Research Center of the Isfahan University of Medical Sciences, Iran.

Latin America

In most Latin American countries, cancer is highly stigmatized and viewed as a “death sentence,” with a culture of silence and fatalism implying that there is no treatment that can change the outcome of death. Given income inequalities and the weak health-care infrastructure, the treatment options are often limited. Perceptions of cancer (cause and treatment) vary with educational and social background and access to early detection and treatment services.

A research group of 98 doctors established in Cuba has shown that in case of serious illness, communication between doctor and patient takes place in an active-passive or a top-down paternalistic approach. In this mode there is a preference for not communicating bad news to the patient and avoiding talking about the facts of the illness. Also, among others, lack of empathy and mutual trust in the communication process was found, as well as lack of exploration on what the patient already knew about the illness and what the patient wanted to know. This study revealed that a great number of doctors surveyed did not have adequate communication skills (Martinez and Trujilo 2009).

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