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Cancer and the Psyche

By K. A. Achte and M. L. Vauhkonen

ABSTRACT

The writers interviewed 100 persons, suffering from cancer, personally in 1965 – 1966 and carried out a follow-up study in 1968. They studied the different attitudes of the patients, when informed about the nature of their illness. They discovered that those in whom the illness followed a rapidly progressive course differ from others in displaying anxiety and aggressiveness. It also appears that prior occurrence of psychic symptoms is a prognostically favourable factor in cases of malignant illness.

INTRODUCTION

Should a patient suffering from cancer be informed as to the true nature of his illness by the physician ? This is an old question, but it is still topical. According to the ethical rules accepted by Finnish physicians, the patient should be informed about the character of his illness. A great deal has been written about this issue, but there are comparatively few psychiatric studies approaching the question from the patient's standpoint.

The writers investigated a series of cancer patients and sought answers to the following questions: Were the patients aware of the nature of their illness? How did they come to know about it? What were the patients' reactions on learning the nature of their illness? What types of psychic symptoms were observable in cancer patients?

The question of how far psychic factors may affect prognosis in

malignant illnesses has interested particularly the representatives of psychosomatic medicine for a long time. In the present study the writers paid attention to the following points related to this question: Does the patient's awareness of the true nature of his illness have a bearing on the prognosis ? How far do the patient's attitudes towards illness and recovery affect the progress of the illness ? And : How far do the psychic symptoms exhibited by the patient correlate with prognosis ?

A SURVEY OF THE LITERATURE INFORMING THE PATIENT ABOUT THE DIAGNOSIS

According to Litin (1960), most patients want to know whether or not they have cancer, and each patient has a legal right to know the truth. Where the patient's past history includes recurrent depressions or paranoid or schizophrenic psychotic episodes, it would be best, Litin feels, not to tell him the truth. It has often been observed, however, that even a rather neurotic person may unexpectedly behave quite maturely in such a situation and show a great deal of strength.

In Hoerr's (1963) opinion truthfulness in the long run is almost always preferable to deception, no matter how kind are the motives prompting the deception. According to him, callousness or brutality in telling a patient is not synonymous with truthfulness and it is always avoidable. If the lesion is hopeless and rapidly progressive, there will be patients, in Hoerr's opinion, who should not be told unless they specifically ask, or have responsibilities to the others, which may be directly affected.

Desjardins (1960) writes as follows : "What the patient is told and how this information is conveyed to him seems to depend largely, if not wholly, on the temperament of the physician himself. Unfortunately, owing to a variety of factors, many physicians seem unable to appreciate the horror and discouragement that the word "cancer" implants in the minds of most patients when they are told that they are affected by any forms of malignancy." In his opinion, the physician ought to have enough time to discuss the matter with the patient, and

he should be able to advance some encouraging points of view. Perhaps the most important point is to avoid using the word "cancer", but to use the word "tumour" instead. For most patients this has a much less sinister connotation.

Wyrsch (1962) felt that the quality and quantity of the patient's spiritual resources were the decisive considerations. Emotionally balanced and intelligent persons could be informed of the malignant nature of their illness with less hesitation than could those lacking these characteristics. Wyrsch also considered it advisable to use the word "tumour" instead of the word "cancer".

Oken (1961) emphasized the importance of encouraging the patient, listening to what the patient wants to say, and letting this determine the approach. A "nothing can be done for you" attitude should be avoided. The physician's own emotions associated with death often make the matter difficult for him.

Erkkilä (1966) emphasized the importance of a listening attitude in the physician caring for a patient with cancer. In his opinion, the physician must answer the patient's direct questions frankly; it would not be compatible with medical ethics to keep any essential fact secret from the patient.

Many other authors have also discussed the question how far a patient should be informed about the malignant nature of his illness and what points should be taken into consideration in informing the patient.

THE RISK OF SUICIDE

Achté et al. (1963) made a study of all the suicides committed in Finland in the years 1954 to 1958. Judging from the death certificates, 0.8 per cent of the persons concerned were affected by cancer. Achté & Vauhkonen (1967) published a paper on the 32 suicides committed in the nonpsychiatric hospitals of Helsinki in 1953 to 1963. Three of these patients had cancer.

Farberow et al. (1963) noted that, irrespective of localization and age, the following findings correlated with the risk of suicide among cancer patients : (1) Emotional stress over and above the physiological aspects of the disease process itself; (2) low tolerance for pain and discomfort; (3) excessively demanding and complaining behaviour with a strong need for attention and reassurence; (4) controlling and directing activity (e.g., insistent request for or directing of treatment and medication); (5) relative alertness and orientation; (6) exhaustion of resources, physical and emotional, including a feeling of a lack of support and attention from family or hospital; and (7) prior and present suicidal threats or attempts.

Litin (1960) held that the suicide rate for cancer patients was not higher than normal. Leshan (1961), on the other hand, was of the opinion that the interrelation between suicide and cancer was quite complicated and in need of further study.

According to the survey published by Baltrusch et al. (1964), the suicide rates were lower for cancer patients than for the general population.

ON EMOTIONAL PROBLEMS IN CANCER PATIENTS

Senescu (1963) writes : "Cancer presents a real and at times most serious threat to the welfare and survival of the human being, one which may overtax the adaptive resources of any or all concerned with the treatment and care of the patient. This threat, however, we regard as being considerably magnified by the fear with which the disease is viewed, a reaction which is by no means confined to the patient alone."

Almost every patient, when he comes to know that he has cancer, reacts more or less intensely to this knowledge, depending on his psychic structure and past experiences (Renneker 1957). According to Litin (1960), three phases are distinguishable in this reaction. First, there is the phase of initial shock with acute feelings of fear and depression. This fortunately is relatively short-lived, sometimes not seen at all because of the fact that the patient has been strongly suspicious

or aware of the fact that he has cancer. This initial shock phase passes relatively rapidly to a second phase which contains early measures dealing with stress and threat to life. This phase is marked by the use of a common and somewhat protective psychological defence : that of denial. The usual form of denial lasts for a relatively short period, only to be quickly brushed aside by reality. In the third phase the patient has gradually attained a new picture of himself with altered perspectives, goals and, at times, behaviour and appearence. This means a long-term successful adjustment to the new realities.

Cobb (1959) classified the emotional problems peculiar to persons with cancer into three groups; (1) anxieties associated with the meaning of cancer for the individual, (2) conflicts arising from the precipitation of a productive adult into an unfamiliar and barren hospital world, and (3) the emotional components of separation from the family, either temporarily through hospitalization or permanently through death.

According to Senescu (1963) it depends upon the doctor's words and attitudes whether emotional complications are avoided or whether such complications will develop.

The psychic symptoms of patients suffering from malignancy have also been described by many other authors.

Most of the writers emphasize the importance of the physician's attitude. A warm protective relationship between doctor and patient minimizes many of the emotional problems.

ON PSYCHIC FACTORS POSSIBLY INFLUENCING THE PROGNOSIS IN MALIGNANT DISEASES

Blumberg et al. (1954) compared the personality traits of cancer patients in whom the illness progressed fast with those of patients in whom the progress of the illness was very slow, discovering significant differences, ascertainable through tests, between the two groups. They found that the patients' anxiety potential was substantially greater and their ability to discharge and to control inward tensions

was substantially less in cases where the illness progressed rapidly, compared with cases where it progressed slowly. They also discovered that prolonged and powerful psychic stress clearly affected the course of the illness.

Herberger (1963) found that difficult psychic stresses during the illness — including the patient's awareness of the fact that he was affected by cancer and iatrogenic errors — could considerably shorten the course of the illness. It also appeared that the progress of the illness was speeded up particularly in cases where the patient was, owing to the difficulties facing him and to his strongly neurotic personality development, unable to handle the burden of his illness adequately and to compensate it.

Baltrusch et al. (1963, 1964, 1969) have considered the influence of psychic factors on the course of illness and listed a number of psychic traits that appear to correlate with prognosis.

Several other authors have also discussed the bearing of psychic factors on the course of cancerous illnesses.

RESULTS OF THE PRESENT STUDY : THE SERIES OF PATIENTS AND THE METHODS EMPLOYED

The series of patients consisted of 100 persons affected by cancer and born during this century. All patients had been under treatment either at the Radiological Clinic or Out-patient Clinic of the University of Helsinki Central Hospital or at the Surgical Clinic of the same hospital. Patients more advanced in age were not included, because the possible changes caused by senility or arteriosclerosis were expected to complicate the study of the interrelationships between cancer and the psyche. Employing figures obtained from the Cancer Register, the writers attempted to form a series comprising various types of cancer in proportions corresponding to the annual incidence figures, as computed for men and women separately. Cases on benign cancer of the skin and the lip were, however, to be excluded from the series. It shortly turned out that inclusion of a sufficient number of surgical cases cau-

sed such great technical difficulty that these patients were only included in limited numbers, and other patiens, suffering from other common types of cancer, were included in correspondingly larger numbers. The patients were investigated between June 1, 1965, and September 30, 1966. A follow-up study of the series was carried out in October 1968.

The distribution of the series by location of the cancer was as follows :

Cancer of the respiratory system	38 cases
Cancer of the genito-urinary system	30 cases
Cancer of the breast	17 cases
Cancer of the digestive system	15 cases
Total	100 cases

The sex distribution of the series was as follows : men 47, women 53; and the age distribution was as follows : under 40 years, 7; 40—49 years, 23; 50—59, 47; and 60 years or over, 23 cases.

At the time of the follow-up, in October 1968, 24 of the patients were alive, of whom 7 were men and 17 were women.

The patients were classified into four groups according to the degree of spread as follows : Grade I : the cancer was confined to the tissue of origin; Grade II : the cancer had invaded contiguous structures; Grade III : the cancer had metastasized to regional lymph nodes; and Grade IV : the cancer had metastasized to other parts of the body.

Distribution of patients according to this classification was as follows : Grades I—II : 48 cases; Grade III : 28 cases; and Grade IV:24 cases.

THE PSYCHIATRIC INTERVIEW

The method employed by the writers was the psychiatric interview. In each case the personal psychiatric interview took place with no

other people present; the writers made a point of proceeding discreetly and tactfully, and they were particularly careful not to injure the patient or — where the patient did not realize the character of his illness — not to inform him about it.

Observing due caution, an effort was made to find out whether the patient was aware of the nature of his illness. This was not always easy. The writers tried to proceed tactfully in each case, and they preferred to obtain incomplete information rather than risk upsetting the patient or increasing his anxiety.

The case records of each patient were scrutinized. Moreover, in the case of each patient the staff of the hospital and particularly the nurse in charge of the hospital department in question were interviewed, with the intention of obtaining supplementary information concerning the points listed in the Introduction. Two questions in particular were concentrated on : Was the patient aware of the nature of his illness ? What did his behaviour in the ward reveal in this respect?

The follow-up, which took place at least two years later than the first examination, was intended to secure information on the course of the patient's illness and his present condition, in the light of the clinical records concerning him and additional information was acquired from the physicians who had later cared for the patient and from the population register authorities.

RESULTS

INFORMING THE PATIENT ABOUT THE DIAGNOSIS

1. Diagnosis Spontaneously Revealed to the Patient by the Physician. Forty per cent of the patients in the total series belonged here. In most cases the doctor had told the patient that he was suffering from "cancer" or from a "malignant neoplasm". None of the patients criticized the doctor's frankness per se, but five patients (12 per cent) openly criticized the way in which the doctor had conveyed the information. In another two cases the patient also censured the doctor, though less strongly or openly. Thus a total of seven patients (17 per

cent) found the doctor's way of conveying the information more or less inappropriate. Many a patient expressed the view that the doctor ought to have only revealed the diagnosis gradually, or ought to have given the patient an opportunity to ask for it. Another point on which the patients criticized the doctors was the doctor's habit of not encouraging the patients sufficiently or giving them hope. There were cases where the doctor had spontaneously told the patient that the patient's life was drawing to an end or had stated that the patient would die within this or that length of time; and there were cases where the doctor had stated that the illness was intractable and the situation hopeless. Statements of this kind had been particularly difficult to hear. As the writers saw it, what was criticized in almost every case was the doctor's tactless way of disclosing the information. Another impression was that the patients did not consider it a doctor's self evident duty to inform the patient about a cancer diagnosis spontaneously if the patient did not ask.

Four of the patients (10 per cent) whom the doctor had spontaneously informed about the true nature of their illness displayed a reluctant attitude toward this study. The proportion of the reluctant patients was 16 per cent in the total series.

Three patients in this group (7 per cent) felt dissatisfied and somewhat bitter because the diagnosis had been established too late. The corresponding figure for the total series was 5 per cent.

The group included five patients (12 per cent) who did not realize, at the time of the study, that they were suffering from cancer or a malignant neoplasm, even though they had been told by the doctor The proportion of patients in the total series who were unaware of the nature of their illness was 31 per cent. In most cases this was due to repression, resorted to by the patient in order to avoid seeing the naked anxiety-evoking truth.

Six patients in this group (15 per cent) denied having reacted in any particular way on learning of the diagnosis. Apparently, at least three out of these six patients had resorted to repression from the out-

set or had interpreted the doctor's words in a way agreeable to them. The proportion of such patients in the total series was also 15 per cent.

Judging from the interviews, a large majority of the patients in this group (83 per cent) were satisfied with the doctor's frankness; at least they did not censure it in any way.

A majority of the patients in this group (85 per cent) had felt fear and anxiety on learning that they had cancer. In many cases, however, these feelings were mitigated in a few days or in a few weeks; this was particularly so when the active treatment had begun. Most patients seemed to trust their doctors and the prescribed treatments quite strongly. Almost all of them were inclined to interpret something the doctor had said, or at least the tone in which it had been said, as a sign of a favourable prognosis, which alleviated their anxiety and depression. Many a patient spontaneously stated how important it was for a doctor to give hope even to a seriously ill patient. A vast majority of the patients expected they would be cured under therapy.

2. Diagnosis Frankly Revealed in Response to the Patient's Request. These patients numbered 29 in our series (29 per cent). None of them criticized the doctor for telling them; and all regarded it is important and correct for a doctor to reveal the true nature of the illness to the patient, even where the illness was serious, if the patient inquired.

Two of the patients in this group (7 per cent) had a reluctant attitude toward the study, the corresponding ratio for the total series being 16 per cent. Taking this group as a whole, the patients seemed to relate more naturally to the investigation and the investigator than the rest of the patients did. Eight patients (28 per cent) denied having reacted in any particular way to the information about the nature of their illness. The corresponding ratio for the total series was 15 per cent. The rest of the patients in this group had experienced more or

less intense anxiety, had felt depressed or had manifested some other psychic symptoms.

One patient was dissatisfied because the correct diagnosis had been established at too late a stage, which diminished the probability of cure.

3. Revelation of Diagnosis Unrequested and Apparently Undesired by Patient. These patients numbered 30 (30 per cent). They had never asked the doctor about the nature of their illness, nor had the doctor told them. Six of them (20 per cent) revealed that they nevertheless knew they had cancer. On the other hand, the remaining 80 per cent very probably did not know the nature of their illness, though in certain cases it was impossible to establish beyond doubt whether they did or not. A majority of these patients knew they had a "tumour" or "some kind of tumour"; but apparently, they did not realize the malignant nature of their illness, or at least they did not reveal that they knew. A reluctant attitude toward the study was characteristic of the patients in this group : more or less distinct signs of such an attitude were exhibited by as many as 9 (30 per cent) of them, whereas the corresponding proportion for the total series was 16 per cent. What underlay this attitude was, apparently, fear and anxiety : these patients were afraid of becoming aware of the true nature of their illness. By warding off, or assuming an aggressive attitude toward discussing the matter, these patients were perhaps able to relieve their anxiety.

One patient in this group (3 per cent) expressed dissatisfaction at the diagnosis being too late, the corresponding ratio for the total series being 5 per cent.

4. Patients Apparently Unaware of the Nature of Their Illness. In the total series these patients numbered 31 (31 per cent). Apparently, almost all of them knew they had some kind of tumour, but none used the terms "malignancy" or "cancer" during the interview. The investigators received the impression that they were unaware of the nature of their illness. All seemed to be hopeful of recovery, though this was not absolutely certain in every case. Two had asked

the doctor about the nature of their illness and had been answered frankly. But either they had resorted to repression, or they had been unable to understand the actual nature of the situation. Of the patients who had not asked their doctors about the diagnosis and had not been told by their doctors, 24 (80 per cent) did not know that they had cancer. Five of the patients whom the doctor had informed spontaneously were nevertheless unaware of the situation; they were convinced that the doctor was mistaken or they had repressed the matter altogether.

Finally, there was one case in which it was impossible to find out whether the patient knew the nature of his illness and whether or how he had been informed by the doctor.

Other Points on Which Physicians Were Criticized.

Two per cent of the patients in the total series were dissatisfied, because the physicians they first consulted did not inform them about the actual diagnosis. These were the only patients who were dissatisfied at not learning the cancer diagnosis early.

PSYCHOPATHOLOGICAL SYMPTOMS OBSERVED IN THE PATIENTS

Tenseness, depression and anxiety were the psychic symptoms that were discovered to be of most frequent occurrence. They were found to be present in more than a half of the total patients. Aggressiveness and paranoid attitudes were also quite frequent. A fear of death was present in half of the patients in the series.

Phobic, obsessive or neurotic reactions were not very common. Moreover, where such were observed, the patients had been neurotic previously too and continued to display neurotic symptoms when they were suffering from malignancy. Obviously, neurotic reaction formation of a type encountered in other contexts is not meaningful for the ego here.

A few patients experienced cancer as socially humiliating or

"disgraceful". On the other hand, many patients realized the malignant nature of their illness completely, knew that they were likely to die in the near future but were prepared, reporting that they had not suffered from any subjective psychic complaints either before illness or during it.

None of the patients expressed suicidal thoughts. Nevertheless, one of the male patients later committed suicide.

ON PSYCHIC FACTORS POSSIBLY INFLUENCING THE PROGNOSIS OF MALIGNANT DISEASES

In the follow-up study an attempt was made to give attention in the first place to the influence that psychic factors possibly exerted on the course of the patient's illness. To this end, the set of data was treated statistically, by making use of regression analysis. the results of which will later be published separately. Although the series was comparatively small, including only 100 cases, the findings can be regarded as symptomatic of certain tendencies. The results were, to a large extent, in the same direction as those previously reported concerning larger series (Baltrusch 1969).

Two subgroups of patients were subjected to closer investigation: those who were alive at the time of the follow-up and those whose illness had lasted for less than a year. Each of the two subgroups included 24 patients.

The two subgroups differed clearly in respect of the degree of seriousness of illness : Grade IV tumours were definitely more frequent among the patients who had died (17 per cent) than among those who were alive (4 per cent). However, the corresponding figure for the total series was 24 per cent. The subgroups did not differ significantly as regards how the patients came for treatment, nor did they differ in this respect from the total series.

The two subgroups differed quite substantially in regard to how the patients had been informed concerning their illness, as well as in the extent to which they were aware of the true nature of their illness.

Forty-two per cent of the patients in the subgroup of those who had died soon had not asked the doctor about the nature of their illness, nor had they been informed about it at any stage. Of those who were alive, no more than 17 per cent belonged to this category. The corresponding proportion in the total series was 30 percent. Of the patients who died shortly, 50 per cent were not aware of the nature of their illness. The corresponding proportion for the subgroup that were alive was only 17 per cent. These findings suggest that the patients whose illness progresses rapidly and leads to death in a short length of time tend to repress the anxiety-evoking reality of their illness more actively, compared with other patients, either by refusing to acquire information about the illness or by warding off the truth revealed to them.

None of the patients in either subgroup had apparently lost an appetite for life. Nevertheless, it was clearly observed that patients in the subgroup where the illness shortly led to death were considerably much less strongly clinging to life, compared with the patients in the other subgroup and with the total series. It is hard to believe that this difference would solely have been due to a difference in the degree of gravity of the illness; instead, it appears likely that, if "life has lost its taste", this fact tends to diminish the person's general ability to resist illness and, in consequence, to shorten his life.

Depression, anxiety and tension were discovered to be of more frequent occurrence in the subgroup of patients who died soon than in the subgroup of those who were alive. Only in the case of the occurrence of depression, however, was the difference between the two subgroups statistically significant.

The patients whose illness was rapidly progressing appeared to be clearly more passive and dependent, on an average, than those in the subgroup that was alive at the time of the follow-up or those in the total series. A similar finding has previously been reported by Baltrusch et al. Abuse of alcohol and/or drugs was definitely more frequent in the first (17 per cent) than in the second subgroup (4 per cent). The proportion of abusers in the total series was 9 per cent.

Weakness of self-esteem was in evidence in the first subgroup somewhat more frequently (33 per cent) than in the second subgroup (21 per cent). Paranoid trends, on the other hand, were approximately equally frequent in both.

Thirty-eight per cent of the patients in the total series had exhibited psychic symptoms prior to the development of the malignant tumour. The proportion was the same for the patients who died within a year. In contrast, the corresponding figure for the subgroup of those who were alive at the time of the follow-up was 54 per cent. Baltrusch et al. have made a similar observation in their studies. Thus it seems obvious that the occurrence of psychic symptoms prior to the development of a malignant tumour is a prognostically favourable factor.

A very interesting finding was the frequent occurrence of aggressiveness in the subgroup where the illness led fast to death. Of the patients in the total series, 39 per cent displayed aggressiveness. The corresponding figure for the subgroup of those who were alive at the time of the follow-up was 17 per cent, whereas the proportion of aggressive patients in the other subgroup was 58 per cent. The differences were highly significant statistically. How far aggressiveness can be regarded as a prognostically unfavourable factor cannot be ascertained within the framework of this study. It seems obvious, however, that patients in whom the illness progresses rapidly resort to aggressiveness as a means to repress the anxiety caused by the illness more often than other patients.

Patients in the subgroup where the duration of the illness was short were clearly more hopeless regarding recovery than were the patients in the other subgroup. A fear of death was also a definitely more common finding in the former than in the latter subgroup. Obviously, hopelessness and a fear of death are factors associated with an unfavourable prognosis. It would seem that their frequent occurrence in the first subgroup was not explicable solely on the basis of the gravity of the illness; on the contrary, it appears likely that hopeless-

ness is a factor that tends to reduce the patients capacity to resist the illness.

DISCUSSION

It is doubtful whether a physician is right in invariably following an "either or" principle. Telling the truth presupposes both an ability to listen to the patient and psychological insight. It is hardly advisable to hasten to tell the patient that he has cancer, if unasked. Even when the patient inquires about the diagnosis, it may be preferable to speak of a "tumour" or, if the patient wants to have more detailed information, of a "malignan tumour" rather than cancer. However, professional ethics oblige the physician to answer the patient's question.

None of the patients in the present series actually criticized the physicians adversely for their frankness. Instead, the patients criticized the doctors who did not give them any hope or informed them of the nature of the illness sadistically. Therepeutic nihilism — no matter how realistic — increases the patient's anxiety, makes him aggressive toward the physician and perhaps makes his attitudes toward the further treatment negativistic. It depends upon the physician's attitude whether the patient develops emotional complications; or at the least the physician's attitude can increase or diminish such complications.

The defence mechanism that cancer patients most frequently em-other defence mechanisms are resorted to increasingly. Denial may sometimes assume psychotic forms.

Paranoid symptoms and aggressive or hypomanic traits work for the avoidance and channelling of anxiety. The frequent occurrence of aggressiveness in the subgroup where the illness led shortly to death was an interesting finding. How far aggressiveness can be considered a prognostically unfavourable factor cannot be ascertained within the framework of the present study. It seems obvious ,in any case, that in instances where the illness runs a rapidly progressive course, the patient

is inclined to resort to aggressiveness, in an attempt to word off anxiety, more often than in other cases.

Death, as an absolute end of life, transcends our experience. Investigations concerning death and opinions about it contain a great deal of knowledge of what death is not. We can take death as a fact, but it is hardly likely that anybody can see his own death as an absolute end-point of all that exists. Freud (1915) states that, in our unconscious, our attitude toward death is the same as that of pre-historic man; in our unconscious we do not believe in our own death but act as if we were immortal.

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الموجـــــــــز

مرض السرطان والنفس

أجرى الباحثان مقابلة شـــــخصية مع مائة من المصابين بالسرطان فى الفترة ما بين ١٩٦٥ و ١٩٦٦ واجريا متابعة لهم فى عام ١٩٦٨ م . درس الباحثان المواقف المختلفة للمرضى عند معرفتهم بطبيعة مرضهم ووجـــدا ان هؤلاء الذين يتطور مرضهم بشكل سريع وخطير يختلفون عن الآخرين حيث انهم اكثر عرضة للاصابة بالقلق واظهار العدوانية . كما رجحا ان وجـــود اعراض نفســـية قبل الاصابة بالسرطان له نتائج افضل على تطور المرض الخبيث .

ABSTRAIT

Le Cancer et le Psychisme

Les auteurs ont interviewé personnellement 100 patients souffrants du cancer. Ils ont étudié les attitudes différentes des patients quand ils étaient informés qu'ils souffraient du cancer.

Les résultats suggèrent que les patients chez qui la maladie progressait rapidement avaient des tendances d'aggression et d'anxiété.

L'apparition ultérieure de symptômes psychiques est un facteur favorable dans le pronostic des cas de maladies malignes.

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Anxiety : A Concomitant of Some Psychiatric Disorders (A Psychophysiological Approach)

By A. Seif El-Dawla, A. Okasha, A. Sadek, A. Hamed and F. Lotaief

ABSTRACT

This is a study of the emotion anxiety and its presence in association with other psychiatric disorders. It is based on the detection of the physiological high level of arousal known to exist in anxiety. Patients were chosen from the outpatient clinic at Ain Shams university hospital.

Patients had a consistently lower alpha time per cent, higher basic skin conductivity level and a slower rate of habituation than controls. Also they had higher neuroticism and lower extraversion scores and showed a less stress-basal difference upon stimulation. Physiological measures could not support reactive-endogenous dichotomy in depression. Moreover, depressed patients did not differ from other patients as regards anxiety. Patients with obsessive-compulsive neurosis came on the top of the list of arousal.

The authors suggested to view anxiety not as a pure disease on its own, rather, a heterogeneous cluster of symptoms.

INTRODUCTION

Anxiety is the commonest psychiatric disorder and probably the most widespread medical illness and is a component of various psy-