The Emotional Problems of Patients with Bladder Cancer

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Summary

In recent years the quality of survival has become a more dominant factor in our treatment and management of patients with cancer. As a result, it has become necessary to think in terms of a multidisciplinary approach to total rehabilitation. A part of this rehabilitation is of necessity determined by the emotional responses that patients exhibit to their disease and to its treatment. A useful model that has been applied to patients with other diseases and to patients with other types of cancer seems equally applicable to patients with bladder cancer.

In my work with cancer patients I became aware that, after the initial fear of death was dealt with, the patients all responded to their dilemma with stereotyped and predictable responses (emotional patterns of behavior). It was apparent that these responses were determined by the degree to which the patient's life style was altered by the disease and/or treatment.

Introduction

With the current therapeutic modalities of surgery, radiation, and chemotherapy, more and more cancer patients, if not actually cured, are surviving longer. In fact, we can think of many of them as being in an arrested state of the disease. These changing patterns of survival are being reflected in the patient's attitude toward his disease. Whereas the diagnosis of cancer initiates a fear of death in all patients, their knowledge of these changing patterns of cure and survival and their initial response to treatment lead to a rapid denial of the threat of death. In its place they become preoccupied with 1 or all of the following fears: (a) fear of rejection by the spouse, family, and society; (b) fear of invalidism; (c) fear of economic destruction. All of these fears are really related to losses either real or imaginary: loss of love, loss of body image, and loss of security.

Sutherland (2) reported similar observations in 1967. He believes that serious changes in body form and function create stress determined by the specific conscious or unconscious meaning (either real or symbolic) of the sacrificial organ and its function in significant patterns of adaptation. When the patterns of the adaptation are interfered with, there is not only an emotional reaction (anxiety, depression, or both) but also major changes in behavior in the areas of work, sex, and social relations. When the patterns of adaptation are not interfered with, the emotional reaction will be less severe or absent. How good or bad the patterns of adaptation were did not influence the outcome. The most important factor was that, as long as these patterns of adaptation could be maintained, they tended to minimize the impact of change in body form and function. These patterns of adaptation are what I referred to earlier as the life style of the patient, and they function at every age level.

Since the patient must be informed about the nature of the surgery, fears may be precipitated in the preoperative period and lead to rejection of further treatment. There is no question that the patients must be prepared preoperatively, although they often act as though they were not. This preparation may be done by a variety of persons: (a) by the surgeon; (b) by an assistant, such as a nurse or social worker; (c) by a stomal therapist; (d) by other patients. Depending on the type of surgical intervention, I think that all of the aforementioned people should be utilized. This relieves some of the anxiety and distress experienced by the patients and gives them an opportunity to ask questions that may alleviate some of their fears. The postoperative period is the most common time for the fears because, if there are any changes in body form or function, they are not a definite reality. The patient must either adapt or react as the case may be. It is easier to demonstrate this by making use of case histories which we will deal with later.

Patients with bladder cancer who have an ileo-conduit procedure are faced with 2 special problems. They must learn to manage the stoma and its continual threat of leakage, and the male patient must learn to adapt to the resultant sexual impotence. Since there are very few statistical studies in the literature, I have to rely on the impressions of personnel who work with these problems. It is the impression that most patients need about 6 months to adapt to and avoid the problems of leakage. By that time, they should know how often to change the stoma seal and how to develop habit patterns of emptying the bag to achieve maximum safety in avoiding leaks. The adjustment to the sexual impotence will depend on the patient's life situation prior to the surgery. The important variables are his self-image, sexual activity, age, marital status, family support, work situation, and financial security. The fewer of these variables that are interfered with in a negative way, the less will be the patient's problem in adapting to the impotency. Of course, another factor that may intervene is the length of survival which, at times, may be the most important deciding factor of all. In other words, an elderly patient who is not having any sexual activity anyway will be bothered very little by his surgery. On the other hand, when impotence occurs in patients in the younger age group, their ability to adapt to the loss of sexual function depends upon the support they receive from their marital partner, their self-image, their...
financial security, and their work situation. If they are so inclined, the needs of the marital partner can be satisfied by the use of a prosthesis.

In the event that the patient’s disease progresses, we must be on the alert for signs that the patient is threatened with the fear of death. To understand this we must be acquainted with the normal mourning reaction. When the patient becomes aware that he is inevitably faced with death, the normal mourning process is initiated. As a result, the patient will experience and manifest, in order, the phases of the normal mourning reaction. The first phase of the mourning reaction is denial of the loss. This continues until the patient’s deterioration becomes so obvious that he can no longer ignore it. He next drifts into the second phase which is one of anger which may be directed toward his family, society, his job, his doctor, or other people in the treatment team. Then he sinks into a period of depression and withdrawal which usually persists until death intervenes. One should be alert to the fact that the members of the patient’s family may also go into a normal mourning reaction and manifest the same behavior as the patient. This often creates problems in patient management, but these can be dealt with if the reaction is explained to the family and an effort is made to help the family deal with their grief in an appropriate fashion. Referrals help if the physician does not have the time or inclination to deal with the situation.

Case Histories

**Case 1.** A 52-year-old woman who was the sole supporter of her family, consisting of a husband and 2 dependent children, had for the last 7 years prior to her illness worked as a ward clerk in a hospital. The husband had been a cardiac invalid for several years and was unable to work. The patient enjoyed her job, had adjusted to the disability of her husband over the previous several years, and seemed to have a rather happy life situation. The patient had her bladder surgery in September 1974, and at the time of surgery it was apparent that she already had metastatic disease. Within 6 weeks after surgery, the patient was back on the job and continued to work until July 1975. In the interim, she was treated with chemotherapy because of metastatic disease. In no way did she let this interfere with her returning to a normal life style until July 1975 when she developed the signs and symptoms of bowel obstruction and subsequently required a colostomy. Following that, she began to develop a fistula, her condition rapidly deteriorated, and by the middle of September, 1 year after her original surgery, the patient expired.

**Case 2.** A 29-year-old single male actor, when originally told that he needed surgery, spent approximately 1 month going to a number of different physicians and institutions to ascertain whether or not he needed the surgery. This caused a delay during which he suffered a number of anxiety attacks that necessitated his going to the emergency rooms of several hospitals to seek relief. At the same time, he had been seeing a psychiatrist in another city because of a problem of drug addiction as well as his anxiety. He was offered medication to help control his anxiety attacks, but he refused on the basis that he did not want to become addicted to another drug after having successfully stopped the use of hard drugs; he had been free of them for approximately 5 months at that time. Another problem, when he was initially admitted to the hospital, was that he had developed hepatitis which may or may not have been related to his drug addiction, and the surgery had to be further delayed. It was with a great deal of anxiety that his surgery was performed approximately 1 year ago. Following surgery, he made good use of the personnel associated with the program and freed himself from many anxieties and fears or at least helped to control them by discussing them with both the stomal therapist and the office personnel. At the present time, he is dating women, although some people have raised the question of his sexual identity, and he is very effeminate. His emotional response and his behavior following the surgery have not been noticeably disturbed. There are no signs of depression at the time, and at a recent visit the patient asked about being helped with a prosthesis.

**Case 3.** A 60-year-old male, married and with children, had a very good marital and family relationship prior to his surgery and had a good job with which he was quite happy. He was operated on in January 1975 and from all indications stands a good chance of no recurrence of his illness. He was ready to return to work after about 8 weeks but was told when he returned to work that they could not take him back on the job because of his illness and the nature of his surgery. This was quite a blow to him, but things worsened as that situation developed. Every time he applied for a job he was rejected for the same reason, the nature of his surgery. Within the last 6 months the patient has brought the problem to the attention of the center, and steps have been taken to help him. It seems that the insurance carriers are reluctant to reemploy him because of the possibility of recurrence of his disease. Needless to say, the patient has become mildly depressed because of this situation.

**Case 4.** A 55-year-old male is married and has 2 daughters, one of whom is still living at home. He owns an automobile agency and has a very close relationship with his wife. Prior to surgery, he was very anxious and upset because of the things that he had been told concerning the problems that people have with such surgery. To allay some of these fears everybody mentioned earlier in the paper talked to this patient including one of the patients who had had a satisfactory recovery from such surgery. In addition, his wife was very supportive and talked to him extensively and quite freely about her attitude about the sexual problems and the other problems with which he would be faced. Since his surgery, he has made a good adjustment to his stoma, he goes out very often with his wife and daughter, and he has continued to be very active in sailing, which is his greatest recreational pursuit. In addition, it is believed that he stands a very good chance of having no recurrence of his disease. The patient had his original surgery in March 1976 and is doing extremely well.

**Case 5.** A 61-year-old black male developed a number of complications during his recovery from surgery. He is married to a woman almost 20 years his junior and had made many threats about self-destruction rather than living with what he foresaw as almost impossible handicaps. The patient has been in the hospital for almost 3 months at this...
time, having had a complicating bowel obstruction, followed by a stroke. During convalescence from these, the patient lost a great deal of weight because the patient was throwing his food away in a suicidal gesture. Even now he remains depressed, hostile, and negative in his general attitude towards himself and his disease. He still has a long way to go to achieve even a minimal adjustment to his life situation.

Discussion

Each of the case histories presented in the previous paragraphs demonstrates the existence of the types of emotional reactions and behaviors mentioned in the Introduction.

Case 1. This case demonstrates what happens when a patient is quickly returned to a former life style. She was returned to her former job and position in her family in about 6 weeks. We can see that her pattern of adaptation was not interfered with until shortly before she died. She did very well relative to emotional or behavioral problems because she was able to return to exactly the same functions that she performed prior to the treatment of her illness. She began to have difficulty only when the complications of obstruction and fistula formation occurred. Fortunately, this lasted for only 2 months and the period of disruption was thus very brief.

Case 2. Here we have a young male whose major problems would be adapting to the stoma and coping with his loss of normal sexual potency. He did exhibit much anxiety and reluctance to undergo the surgery as demonstrated by the 1-month delay while he tried to find someone who would tell him that the surgery was not necessary. However, when the inevitable occurred he was able to accept the surgery and to deal with his anxiety by keeping close contact with the people on the treatment team. His ability to adapt had been very good and, as a result, he has, within 1 year of surgery, started dating again and has developed an interest in a prosthetic procedure.

Case 3. In this instance, the patient made a good adjustment emotionally and otherwise to his surgical intervention. However, because of lack of cooperation at the place where he worked and the lack of cooperation from other places where he sought employment, he was pushed into a depression because of the threat of loss of economic security. One can understand that, in a man of this age, to be forced into an invalid role could be disconcerting. He is currently being advised regarding his potential for rehabilitation by the Division of Vocational Rehabilitation operated by the State.

Case 4. This 55-year-old male, who had magnificent support from his wife and family and who was able to return to his normal work situation and his normal extracurricular avocation of sailing, has done very well. He leads an active social life and is very close to his wife and daughter. His wife had spent a great deal of time talking to him about the adjustment that both will have to make to his sexual impotence and has been very supportive in helping to overcome some of his feelings about it. In spite of preoperative problems, proper handling made his postoperative recovery unremarkable.

Case 5. This case demonstrates some of the more complicated problems that can arise depending on the previous life situation of the individual. We have a marked disparity in the ages of the parties concerned. We have the fact that the patient had complications of his surgery that contributed to suicidal behavior, which further stressed his recovery. This patient still remains depressed and adamant about his dislike for his current life situation. This indicates that he has a very poor self-image and that he is threatened as far as his sexual activity is concerned. He is markedly concerned about his wife’s youth and what will happen to her sexual needs in their future relationship. All of these plus the morbidity that he had following surgery have contributed to the production of a moderately severe depression. The depression can be managed if further physical recovery is less traumatic. A great deal will also depend on how well his relationship with his wife is maintained.

It is apparent that the emotional reactions of patients to bladder cancer can be quite varied, but with proper knowledge and with proper management the patients’ adverse emotional reaction and behavior can be managed satisfactorily. This is essential if we are able to get the patient back to his normal life style.

References

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