Coping styles in elder patients

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Content

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- Age and coping
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Background
Cancer survivors 2013

• Patients diagnosed in 2009 or 2010 with cancer in Germany: estimated relative 5 year survival rate of an average of 61% for men resp. 67% for women (RKI 2013).

• Same trends in all European countries (de Angelis et al Lancet Oncology, 15, 1, p 23 - 34, 2014).

• relative 5 year survival rate depending on cancer site (e.d. rates over 90% for melanoma, testicular or prostate cancer, rates less than 20% for lung, pharynx or pancreas cancer).

• relative 5 year survival rate for prostate cancer: 93% (88-95%).
Cancer survivor (definition)

- Patient after end of treatment with physical, psychosocial or economical issues as a sequelae of cancer and its treatment over the whole life trajectory.
  - < 5 years after diagnosis: survivor
  - > 5 years after diagnosis: long-term survivor

- Patients have to cope with various sequelae affecting quality of life
- Patients have a need for specific after care programs
Distress continuum

Normal distress

- 0-50% normal reactions

Severe distress

- 30-35% subsyndromal
- 15-20% ICD disorders

fear, sorrows, sadness, etc.

depression, anxiety disorders, etc.
Distress in the course of cancer

- Diagnosis
- Therapy
- Rehabilitation
- Aftercare
- Palliative/terminal care
- Recurrence
- Survivors (short – longterm)
# Problem areas experienced by cancer patients and their family members

Cancer is characterized by various distress in all phases of the disease

<table>
<thead>
<tr>
<th>Distress caused by the cancer and its treatment</th>
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<tbody>
<tr>
<td>Invasive treatments, pain, fatigue, disability, psychosomatic symptoms, functional impairments</td>
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<th>Existential and spiritual problems</th>
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<td>Confrontation with one’s own end of life, search for meaning, spiritual, religious, philosophical beliefs and explanations</td>
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<th>Distress caused by family and partnership</th>
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<td>Changes of social roles (family, with friends), communication, sexuality</td>
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<th>Problems of the Health care system</th>
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<td>Inadequate doctor-patient communication, depersonalized treatment, lack of time, lack of information, lack of intimacy</td>
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<th>Social, financial and work distress</th>
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<td>Giving up important social and occupational functions, reemployment, early retirement, social withdrawl, isolation</td>
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Models and concepts of coping
Coping describes the complexity of mental processes to reduce, compensate, handle or sustain existing or expected distress in the context of diseases and their consequences through target-oriented actions with the goal of regaining emotional stability on the following levels:

- Emotional
- Cognitive
- Behavioral
Development of the coping concept

- **Psychoanalysis**
  Concept of defense
  Defense is a protective mechanism and protects the individual from overstrain intrapsychic and unconscious coping processes

- **Stress research**
  Influence of internal regulation processes, assessment and coping processes

- **Behavioral psychology**
  Transactional theory of coping

Defense and coping are understood as processing at the same time and interacting with one another

Various coping strategies can be used simultaneously or consecutively
Coping and influencing variables

Distress
- diagnosis, treatment, side/late effects, recurrence, progress, etc.

Coping
- cognitive
- emotional
- behavioral

Adjustment
- Criteria: Psychological Well being, anxiety, depression, social reIntegration, participation, quality of life, etc.

Mediators:
- Social support
- Personality
- Cultural background

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Further developments of coping concept

- Focus on distress → disorders, adaptation (adjustment)
- Coping as social cognitive transition (Brennan 2001)
- Spirituality and coping (Büssing et al 2008)
- Coping and Self Efficacy (Lee et al 2012, Wolf et al 2004, Merluzzi et al. 2001)
- Empowerment and Coping (Bulsara et al 2006, 2007)
- Patient competence (Weis & Giesler 2009)
coping and age
Age and coping 1

- Regarding disease/treatment variables, younger individuals (patients with colorectal cancer) were more likely to use Rumination, Seeking Social Support, Humour, and Lifestyle Reorganisation than older people (Rinaldi et al 2009).
- In prostate cancer patients aging was related to reduced distress ($r=−0.14$), less anxiety ($r=−0.22$), and increased emotional quality of life ($r=0.16$) (Nelson et al 2009).
- Prostate cancer: aging was associated with greater depressive symptoms ($r=0.18$) controlling for stage of disease, hormone therapy use, time since diagnosis, and social, physical and functional well-being (Nelson et al 2009). The mean depression scores of 5-year cohorts consistently trended upward.
- Younger survivors (breast, endometrium Ca) reported significantly worse adjustment than older survivors (HADS, $p<0.001$): appearance-orientation scale (AOS, body image; $p<0.02$), fear of recurrence ($p<0.001$), distress about long-term treatment-related cancer problems ($p<0.01$) and number of sexual problems attributed to cancer ($p<0.001$). (Kornblith et al 2007)
Age and coping 2

- Younger cancer survivors have been found to be more negatively affected by the cancer experience than older adults, and are more likely to change their resulting behaviors because of it (Eton & Lepore 2002, Bellizi & Blank 2006).

- Older survivors are psychologically resilient and their post-treatment mental health is the same or even better than that of the general population (Blank et al Cancer 2006; Eton & Lepore Psychooncology. 2002; Clough-Gorr et al J Clin Oncol 2007; Deimling et al Psychoncology 2006).

- But: Younger adults with cancer have a higher risk of reporting psychological distress than older adults with cancer (Blank & Bellizi 2008) → older adults tend to underreport psychological distress.

- But: Physical health problems resulting from cancer and its treatment are often exacerbated by coexisting medical conditions which affect more the elderly and can ultimately lead to increased morbidity and mortality (Bellizi et al 2008).
Age and coping in breast cancer women

Findings of a review (Mosher & Danoff-Burg 2005)

• Older women report less psychological distress (anxiety and depressive symptoms)
• Older adults tend to underreport their symptoms and show higher comorbidities
• Potential confounders: general health status, treatment, social and economic factors
• Confounding between distress and coping (mediator or confounder?)
• Non-consistent results over all studies
• Lack of prospective studies
Age and coping: theories

1) Erikson’s psychosocial theory, focusing specifically on increased wisdom in later adulthood;

2) Specific developmental tasks such as shorter time perspective for goals,

2) Different life trajectories and experiences.
Explanations: components of optimal adjustment in later life

- Emotional-regulatory skills
- establishing new goals and life priorities
- adjusting or realigning expectations in spite of losses (function, social networks, independence)

Coping from the systemic perspective
Coping in the context of care system

- Patient-centred communication
- Shared decision making
- Information
- Patients needs assessment and support
- Other Health care Profess.
Research results: impact on patients

Patients, who are satisfied with doctor-patient communication:

... have less problems, cope better
... have lower level of psychological distress
... have higher level of self-efficacy
... show better commitment and adherence to medical therapy
... show better quality of life in the long term

Coping in the context of social system

- Shared and realistic appraisal of distress
- Emotional connection
- Empathic communication

family members

patient

spouse
Coping: patient and partners

- Couples are **conjointly coping** with major stresses (e.g. Coyne & Smith, 1991)
- Effective couple coping is based on partners’ **empathic communication** that develops **emotional connection** and a shared, realistic, and positive appraisal of the stress (Cutrona, 1996) → conjoint coping and mutual support (Coyne & Smith, 1994; DeLongis & O’Brien, 1990)
- Couples use of empathic communication associated with better adjustment to cancer (Manne et al 1999)
- **Psychological interventions** promote couple communication and mutual support and enhance adjustment to cancer diagnosis and treatment (Manne et al 2005; Scott et al., 2004)
- Effects mediated by enhanced emotional communication between the partners and development of active coping and positive cognitive appraisal (Manne et al., 2008)
coping and survival
Coping and the course of the disease

**Coping**
- Fighting spirit, active coping
- Social support

**Course of the disease**
(time to recurrence, survival time)
- Positive
- Negative
- Unclear

- Fatalistic attitude
- Hopelessness/helplessness
- Intrusive thoughts
- Denial, repression
# Coping and the course of cancer

<table>
<thead>
<tr>
<th>Study</th>
<th>Review/Study:</th>
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<tr>
<td>Petticrew et al. 2002</td>
<td>Review: no influence of coping on survival time</td>
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<tr>
<td>Garssen et al. 2004</td>
<td>Review: denial, dissimulation; pos. Influence on course of cancer</td>
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<tr>
<td></td>
<td>helplessness/hopelessness; neg. influence</td>
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<tr>
<td>Falagas et al 2007</td>
<td>Review: Soc. support, denial, dissimulation; pos. Influence</td>
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<tr>
<td></td>
<td>depression; neg. influence</td>
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<tr>
<td>Chida et al 2008</td>
<td>Review: 70% of the studies no effect of coping strategies on survival or mortality</td>
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<tr>
<td>Satin et al 2009</td>
<td>Review: Depression = sign. Influence on mortality, but not on the progress of cancer</td>
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<tr>
<td>Cohen et al 2012</td>
<td>Study: Depression = predictor for survival, explanation:</td>
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<td>dysregulation of HPA axis (Cortisol)</td>
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Coping and somatic course
Hypotheses for explanation

- Direct influence via psycho-neuro-immunological mechanism: stress and depression
  - Maldaptive activation of HPA (hypothalamopituitary-adrenal) axis as a potential mediator for the effect of depression on progress and mortality:
    → Dysregulation der HPA Achse
  - Modulation of cellular immune system linked via pro-inflammatory cytokines (e.d. interleukin 1, 2; tumor necrosis factor-a) and anti-inflammatory cytokines
    → progress of tumor

- Indirect influence via health behavior and compliance:
  - active patient gets better therapy
  - active patient completes standard therapy by better coping with side effects, seeking support etc.
Summary

- Distress and Coping = important concepts in oncology and help for better understanding patients’ psychosocial situation and reactions.
- Patients use a wide range of various coping strategies which are changing over time.
- Defense and denial can be adaptive in the short term, however, in the long term not suitable for adjustment and adaptation.
- Correlation between age and coping/adjustment show heterogeneous results, but overall findings show better adjustment and less psychological distress in older patients.
- There is a lack of prospective longitudinal studies.
- Coping not only an intra-individual process, but also an inter-individual interaction between patient and spouse/family resp. patient and health care providers.
- The influence of coping on the course of the disease is complex; heterogeneous findings and no evidence for a direct influence.
Thank you for your attention!

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