

# CHAPTER 1

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## Coping With Cancer: Patient and Family Issues

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### Introduction

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The psychosocial components of oncology nursing are more diverse and challenging than ever before. Psychosocial concerns and quality-of-life (QOL) issues are rising to the forefront as many patients are living extended lives after treatment. Prior to the 1970s, the success of cancer therapy was determined solely by length of survival and recurrence-free survival (Greer, 1994). Today, advances in technology have made conventional treatments more sophisticated; consequently, patients with cancer accept higher risk and significant deficits to live longer lives.

Simultaneously, family members are challenged because many dimensions of their lives are affected. The burden and strain for families arises from numerous sources, including the physical strain of direct care, financial burdens, work adjustments, emotional adjustments, and managing uncertainty (Archbold, Stewart, Greenlick, & Harvath, 1990; Schumacher, 1995; Yates, 1999).

*Coping* is the ability of patients and family members to adapt functionally to either the immediate distress of diagnosis and treatment or to longer-term adjustments of life changes. Helping patients and family members to cope includes a wide range of supportive strategies, including assisting patients through difficult procedures or therapies to ensure optimum treatment and helping patients and family members to make adjustments to the losses and changes that affect the future quality of their lives.

## 2 Psychosocial Dimensions of Oncology Nursing Care, Second Edition

Medical, psychological, and social factors influence the level of distress experienced by patients and family members (Mermelstein & Lesko, 1992). Medical factors relate to the site and clinical course of the disease, including the type of required treatment and the presence of pain and suffering. Psychological factors reflect the level of disruption of life goals and the ability to modify life plans using coping tactics and emotional maturity. Social factors relate to the availability of support from extended family, friends, coworkers, and healthcare workers.

The psychosocial care of patients suggests a holistic context for healing. It incorporates aspects of healing that are separate from the biologic functioning of organs and organ systems. Individuals do not exist in isolation. Most people have relationships that connect them to a family, a community, and a belief system (spiritual or religious). These bonds are important for healing and should be a part of cancer treatment.

The use of QOL tools to measure the value and outcomes of conventional treatments for cancer is becoming more frequent. Several tools are now available and in use. Ferrans (1990) developed a tool that has become popular in scientific settings. Focusing on QOL domains, the tool examines several components that reflect the psychosocial well-being of patients (see Figure 1-1).

**Figure 1-1. The Psychosocial Needs of Patients With Cancer Based on the Aspects of Quality of Life**

<b>Health and Functioning Domain Components</b>	<b>Socioeconomic Domain Components</b>	<b>Psychological/Spiritual Domain Components</b>	<b>Family Domain Components</b>
<ul style="list-style-type: none"> <li>• Usefulness to others</li> <li>• Physical independence</li> <li>• Responsibilities</li> <li>• Own health</li> <li>• Stress</li> <li>• Leisure activities</li> <li>• Retirement</li> <li>• Travel</li> <li>• Long life</li> <li>• Sex life</li> <li>• Health care</li> <li>• Discomfort/pain</li> </ul>	<ul style="list-style-type: none"> <li>• Standard of living</li> <li>• Financial independence</li> <li>• Home</li> <li>• Job/unemployment</li> <li>• Neighborhood</li> <li>• Conditions in the country of residence</li> <li>• Friends</li> <li>• Emotional support</li> <li>• Education</li> <li>• Influence in government</li> </ul>	<ul style="list-style-type: none"> <li>• Life satisfaction</li> <li>• Happiness</li> <li>• Self</li> <li>• Goals</li> <li>• Peace of mind</li> <li>• Personal appearance</li> <li>• Faith in God</li> <li>• Control over life</li> </ul>	<ul style="list-style-type: none"> <li>• Family happiness</li> <li>• Children</li> <li>• Spouse</li> <li>• Family health</li> </ul>

Note. From "Development of a Quality of Life Index for Patients With Cancer," by C. Ferrans, 1990, *Oncology Nursing Forum*, 17(Suppl. 3), p. 16. Copyright 1990 by Oncology Nursing Society. Adapted with permission.

According to Ferrans (1990), the four major domains that comprise QOL are health and functioning, socioeconomic, psychological/spiritual, and family. The items listed under each of the four domains represent components that are important to a patient's QOL. This particular tool is unique because it defines both the psychological and social needs of patients with cancer and also lists the family as an area of major importance.

This chapter will describe the challenges involved in assisting patients and family members to cope with psychological and social concerns. It will outline appropriate methods of assessment and intervention through the use of skilled communication techniques. Cultural diversity also will be addressed with important suggestions for raising nurses' sensitivity for working with patients and families in the oncology setting.

## **Communication Skills in the Psychosocial Care of Patients With Cancer and Their Families**

Meeting the psychosocial needs of patients with cancer and their family members requires skillful communication. Communication styles can either enhance or become a barrier in the psychosocial care of patients with cancer. Table 1-1 lists communication skills that can be used to enhance nurse-patient interactions. Nurses are in a key position to detect and influence psychosocial distress. Establishing dialogue to identify the patient's true concerns is imperative in assessing patient needs, giving

**Table 1-1. Communication Skills That Enhance the Psychosocial Care of Patients With Cancer**

<b>Skill</b>	<b>Application</b>
Listening with interest and empathy	Use thoughtful silence to encourage the patient to talk. Make and maintain eye contact.
Exploring the patient's feelings (help the patient to put feelings into words)	"Tell me more about feeling out of control."
Validating the patient's feelings	"It must be very difficult to manage all of this—your anger is a normal feeling."
Clarifying misconceptions that may exaggerate fear or isolation	"I'm not sure I understand what is troubling you. Could you explain that further?"
<i>(Continued on next page)</i>	

**Table 1-1. Communication Skills That Enhance the Psychosocial Care of Patients With Cancer (Continued)**

Skill	Application
Inquiring about the patient's response to diagnosis, treatment, and prognosis	"Tell me what you understand about the seriousness of your cancer."
Using questions and comments that encourage open communication	"That sounds interesting; tell me more."
Respecting the patient's views and efforts	"Help me understand what you mean. Your views are important. We will work together on these problems."
Reassuring the patient with realistic hope	"We can help manage your pain and distress" instead of "Don't worry. Everything will be okay."
Summarizing your interactions with the patient and validating mutual understanding	"Let me summarize what we just discussed." (This reinforces your attentiveness to the patient and provides structure for closure to your interaction.)

important information, and intervening to provide symptom management. Understanding and employing these important skills is only one requirement. Nurses also must have a sense of confidence about their ability to communicate (i.e., self-efficacy). Wilkinson (1991) found that nurses who were uncertain about their ability to talk openly were less likely to use interviewing behaviors that increase patient self-disclosure. If communication skills or confidence in them is lacking, nurses may use distancing tactics instead of being active participants in assisting patients and families to cope with social or psychological distress.

Many nurses believe that psychosocial problems are an inevitable consequence of a cancer diagnosis and therefore assume that mentioning these concerns is pointless or that patients and families will disclose problems if they have them. Although most nurses understand the psychosocial concepts of patient and family care, they often carry out only physical duties, such as giving medication, performing procedures, and responding to patients' requests (Peterson, 1988).

Psychological and social problems are unrecognized in 80% of patients who are physically ill (Maguire, 1985). Some potential explanations for this are the belief that talking is not valuable, a sense that concentrating on physical tasks is easier, a fear of unleashing overwhelming emotions, and a fear of coming too close to loss and suffering (Maguire). Nurses who feel anxiety about their own mortality may shield themselves from this issue by using distancing behavior so that they are not subjected

to patients' distress and emotions (Wilkinson, 1991). Fear that eliciting strong emotions will harm rather than help the patient is a commonly held misconception. In addition, nurses may fear that their training has not equipped them to deal with the patient's psychosocial concerns (Parle, Maguire, & Heaven, 1997; Valente & Saunders, 1997).

One of the key psychosocial needs of patients and family members is hope (Lynch & Burnett, 1997). Hope is one of the major modes by which people anticipate the future and mobilize resources to cope with their illness (Kodish & Post, 1995). Hope tempered by reality should be given to all patients, but this does not preclude the need for honesty. Honest disclosure (regarding diagnosis and prognosis) must be balanced by realistic hope. This may be difficult for nurses, especially when either the physician or family members tell them that the patient must not be told the truth.

Another barrier to meeting the psychosocial needs of patients and family members is the nurse's own attitudes and beliefs (see Figure 1-2). Nurses may hold cultural and ethical beliefs and attitudes that may lead to stereotyping of patients and families and create barriers to communication. Quality of care delivery may become compromised when patients, their family members, and nurses do not share the same language, ethnicity, value system, or class. Increasing knowledge of cultural perspectives may decrease barriers in communication and increase nurses' ability to meet the psychosocial needs of patients and families (Wright, Cohen, & Caroselli, 1997).

### **Figure 1-2. Beliefs, Attitudes, and Behaviors That Interfere With the Psychosocial Care of Patients With Cancer**

- Discounting or devaluing emotional symptoms
- Believing that talking about sensitive issues with patients takes too much time
- Believing that talking about emotions (or becoming tearful) is detrimental for patients
- Believing that talking about death is taboo
- Believing that there is no hope
- Believing that anger is an unwanted emotion that interferes with patient care
- Labeling (stereotyping) patients as
  - Noncompliant
  - Lazy
  - Manipulative
  - Attention seeking
- Personalizing a patient's anger and becoming defensive or feeling out of control
- Overcompensating to be the "nice nurse"
- Giving false reassurance (e.g., saying, "Don't worry," when you do not know what the patient is worried about)
- Changing the topic/ignoring cues/making jokes (i.e., putting off the patient's true concerns)

*Note.* Based on information from Frost et al., 1997; Heaven & Maguire, 1996; Lovejoy & Matteis, 1997; Maguire, 1985; Parle et al., 1997; Peterson, 1988; Smith & Hart, 1994; Wilkinson, 1991.

Age-related growth and developmental stages are important to consider when communicating with and ensuring quality care for patients with cancer. Erikson (1963) described the normal and evolving social and psychological traumas in the human life cycle. Although the immediate crisis of having cancer may seem to preclude all other issues, nursing assessment and intervention should take normal developmental challenges into account. For example, the communication and care of a child with cancer may require more concrete interventions to promote age-appropriate trust, self-control, guidance, and discipline. Role modeling for the parents of children with cancer will assist them in addressing not only illness behaviors but also normal developmental concerns.

Nurses should be direct about pursuing important information when patients and family members exhibit psychosocial distress. Nurses who show self-confidence and willingness to discuss sensitive concerns are more likely to assist patients and family members in coping. Likewise, patients and family members will be more likely to reveal distressing concerns. Even when the concerns cannot be resolved directly, the opportunity to discuss them may be beneficial (Parle et al., 1997).

Finally, nurses must interview patients and families to evaluate how they have handled stress and crises in the past. Patients and families who have a history of coping successfully with crises can be encouraged to employ strategies that have worked for them in the past. Conversely, if they have used maladaptive coping strategies, nurses can recommend more appropriate alternatives.

## Patient Issues in Coping: Psychological Distress in Patients With Cancer

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Psycho-oncology is the specialized care of the psychological problems that may arise in patients with cancer. The three main concerns in psycho-oncology are depression, anxiety, and neuro-cognitive changes, including delirium. Oncology nurses must understand the range and scope of distress that patients commonly experience to enable them to identify problems and intervene to provide appropriate symptom relief.

Opinions vary widely about the prevalence of psychiatric disorders in patients with cancer, ranging from *all patients* are depressed and need psychiatric intervention to *no one* needs assistance. Estimates indicate that 50% of patients with cancer have a normal adjustment to their illness, and the other 50% demonstrate problems that fall into the category of psychological distress (Derogatis et al., 1983).

Psychological distress in patients with cancer and their families is an expected reaction that may vary from patient to patient. Individuals usu-

ally demonstrate a remarkable ability to adapt to both the cancer diagnosis and the treatment. Understandably, a certain level of distress response accompanies the diagnosis of cancer. The shock, fear, and uncertainties, including fear of pain, suffering, disfigurement, and possible death, are similar for most individuals. Emotional reactions of anger and sadness related to having one's life dramatically interrupted and the need to face the challenge of making meaningful adjustments also are common. These reactions may be troubling but normally are resolved as patients and families are able to renegotiate and balance their lives.

When a patient's reaction or distress interferes with his or her ability to participate in treatment or to function adaptively, immediate intervention may be needed to ensure that the patient receives optimal care.

## Depression

Although depression occurs in 25% of patients with cancer, it frequently is undiagnosed (Massie & Shakin, 1993; Mermelstein & Lesko, 1992; Valente & Saunders, 1997). Nurses have an essential role in the early detection of depression because untreated depression results in higher healthcare costs, decreased compliance, and decreased QOL (Lovejoy & Matteis, 1997).

Patients who are at highest risk for depression include those with an advanced stage of cancer, a history of a previous psychological disorder or alcoholism, increased physical impairment, unmanaged pain, treatment regimens containing certain medications, concurrent illnesses that produce depressive symptoms, or lack of social supports (Shakin & Holland, 1988).

The clinical picture of depression can be divided into two categories: somatic and psychological. The assessment of depression in patients with cancer is different from that in medically healthy individuals. In medically healthy people, the assessment of depression depends heavily on somatic symptoms, such as appetite changes resulting in anorexia and weight loss, insomnia, psychomotor slowing, and poor concentration (see Figure 1-3). However, these symptoms are of little value in the diagnosis of depression in patients with cancer because they may be symptoms of the disease or sequelae

### Figure 1-3. Criteria for Diagnosis of Depression in Medically Healthy Individuals

#### Somatic Symptoms

- Significant weight loss or gain
- Diminished ability to think or concentrate
- Psychomotor retardation or agitation
- Insomnia or hypersomnia
- Fatigue or loss of energy

#### Psychological Symptoms

- Depressed mood, crying spells
- Decreased self-esteem
- Feelings of helplessness and hopelessness
- Diminished interest or pleasure in usual activities (anhedonia)
- Recurrent thoughts of death or suicidal ideation

*Note.* Based on information from American Psychiatric Association, 2000.

of treatment. For patients with cancer, psychological symptoms such as depressed mood, feelings of worthlessness or excessive guilt, diminished interest or pleasure in usual activities, and suicidal thoughts, including a preoccupation with death, are more reliable assessment factors. Skill and experience are required to evaluate the psychological components of depression because they are less obvious than somatic symptoms.

Numerous medications also can produce depressive symptoms (see Table 1-2), but drug-induced depression can be overcome. For example, treatment with interferon (IFN) alfa has been known to place individuals at higher risk for depression, which, in some cases, can result in a discontinuation of therapy. Antidepressant therapy has been shown to be effective in these patients; as a result, they are able to continue to receive therapeutic levels of IFN alfa (Valentine, Meyers, Kling, Richelson, & Hauser, 1998).

Corticosteroids frequently are an important part of cancer therapy, but they can cause psychiatric distress. Wide ranges of mood disturbances occur with steroid use, including an enhanced sense of well-being, emotional lability, euphoria, and depression. The more severe steroid reactions are psychosis and depression with suicidal thoughts.

Patients with constant, uncontrolled pain particularly are prone to depressive symptoms that may include insomnia or demoralization. When pain is a major component of the patient's presentation, appropriate pain management should be instituted before a diagnosis of depression is made.

Nurses need to evaluate depression and suicide potential within the context of what is occurring in the patient's world. For example, a patient with terminal cancer who has lost hope for a treatment to cure his or her condition may be realistic in his or her thinking. Hopelessness that is likely related to psychiatric depression includes pervasiveness, which refers to a theme of hopelessness that penetrates every aspect of the patient's situation, including hopelessness about pain control or living long enough to see a loved one again. A patient may know that he or she is going to die and may acknowledge hopelessness about living but may still maintain reasonable hope for pain control or for living long enough to have a quality visit with family members.

Assessment requires listening skills as well as an ability to elicit sensitive information that is crucial to diagnosing depression or determining suicide risk. This area requires careful assessment to determine if the patient is experiencing a clinical depression or if he or she is reacting in a legitimate way to the situation and simply expressing a desire to be in control of an intolerable experience. The description of a patient with cancer who is at risk for suicide might include poor prognosis and advanced disease, uncontrolled pain, disinhibition, and pervasive hopelessness combined with distress about being unable to communicate discomfort to caregivers. Nurses need to be skilled in identifying patients who are at risk and knowing when to consult with psychiatric specialists or provide 24-hour observation care and ongoing assessment of suicide risk.



**Table 1-2. Examples of Drugs That May Cause Depressive Side Effects**

<b>Class of Drug</b>	<b>Drug Name</b>
Analgesics/anti-inflammatory agents	Nonsteroidal anti-inflammatory drugs (e.g., celecoxib) Opiates (e.g., morphine) Skeletal muscle relaxants (e.g., baclofen)
Anticonvulsants	Felbamate Ethosuximide Phenytoin Primidone
Antineoplastics	Alkylating agents (e.g., procarbazine, ifosfamide) Antimetabolites (e.g., azacitidine) Miscellaneous agents (e.g., asparaginase) Plant alkaloids (e.g., vinblastine)
Antiparkinsonian agents	Levodopa Pergolide mesylate
Cardiovascular agents	Clonidine Doxazosin Procainamide Propranolol Verapamil
Hormonal agents	
• Stimulant/replacement/modifying (adrenal)	Glucocorticoids—systemic (e.g., methylprednisolone)
• Stimulant/replacement/modifying (pituitary)	Gonadotropins (e.g., chorionic gonadotropin)
• Stimulant/replacement/modifying (sex hormones)	Anabolic steroids (e.g., danazol, estradiol)
• Suppressant (sex hormones/modifiers)	Antiandrogens (e.g., flutamide)
Immunologic agents	Interferon alfa Interleukin Tumor necrosis factor inhibitors (e.g., etanercept) Other immunomodulators (e.g., natalizumab)
Sedatives/hypnotics	Antianxiety agents (e.g., diazepam) Barbiturates (e.g., phenobarbital) Nonbarbiturates (e.g., ramelteon)
Targeted therapies	Monoclonal antibodies (e.g., cetuximab) Small-molecule inhibitors (e.g., bortezomib)

*Note.* Based on information from Massie & Shakin, 1993; Myers, 2008; Polovich et al., 2009; Spratto & Woods, 2007; U.S. Pharmacopeia, n.d.; Valente et al., 1994.

Cognitive distortions (irrational beliefs) may be present in the depressed patient (e.g., “I’m a failure because I have cancer,” “It’s my fault that I’m sick, and I’d be better off dead,” “I’m a burden; no one should be concerned about me”). Patients with depression also may withdraw, isolate, or behave uncooperatively. These behaviors and distortions in thinking often are unconscious and habitual. Making patients aware of how their negative thinking contributes to depression and poor coping is the first step toward effective intervention. The subsequent steps are helping patients to correct their cognitive distortions, setting practical goals, and praising goals that are well achieved (Valente, Saunders, & Cohen, 1994).

Medications and supportive counseling commonly are used in the treatment of depression in the oncology setting. Antidepressant medica-

tions used in this patient population generally are the same as those used in medically healthy individuals (see Table 1-3). Specific antidepressants are selected depending on the patient’s presenting symptoms. The most commonly prescribed antidepressants are the selective serotonin reuptake inhibitors (SSRIs). The SSRIs have fewer sedative and autonomic side effects than the tricyclic antidepressants and are less lethal in overdose situations (Schwartz, Lander, & Chochinov, 2002). The atypical antidepressant mirtazapine tends to cause increased appetite and paradoxically causes greater sedation at lower doses (Pirl & Roth, 1999). Bupropion is mildly stimulating and may cause gastrointestinal upset, restlessness, and diminished appetite. Doses higher than 300 mg may increase seizure risk (Schwartz et al.).

The use of psychostimulants in low doses may promote a sense of well-being, decrease fatigue, and stimulate appe-

**Table 1-3. Antidepressant Medications That May Be Used in Treating Patients With Cancer**

Drug Category	Drug Name
Central nervous system stimulants	Methylphenidate
Serotonin/norepinephrine reuptake inhibitors	Citalopram
	Duloxetine
	Escitalopram
	Fluoxetine
	Fluvoxamine
	Paroxetine
	Sertraline
	Venlafaxine
Tricyclic antidepressants	Amitriptyline
	Clomipramine
	Desipramine
	Doxepin
	Imipramine
	Nortriptyline
	Protriptyline
Trimipramine	
Other antidepressants	Bupropion
	Maprotiline
	Mirtazapine
	Nefazodone
	Trazodone

*Note.* Based on information from Frazer, 1997; Massie & Shakin, 1993; Spratto & Woods, 2007; U.S. Pharmacopeia, n.d.

tite. The advantages of psychostimulants are their rapid onset of action and their ability to potentiate the analgesic effects of narcotics; therefore, they are considered to be more beneficial than other antidepressants in treating the depressed patient who is terminally ill with a high burden of physical pain.

## **Anxiety**

Anxiety usually is related to the fear that patients with cancer experience. Fear is a normal response and often encompasses the unknown aspects of cancer and its treatment, including fear of death, disability, pain and suffering, and loss or disruption of relationships. Society values people who are independent and self-sufficient; many patients with cancer experience a loss of control and loss of independence that cause them to fear that they will become a burden to their loved ones. Healthcare professionals must be able to distinguish between reasonable expressions of fear and fear that represents an anxiety syndrome requiring intervention. As long as anxiety symptoms do not interfere with treatment or are not intolerable to a patient, no specific interventions from nurses, clergy, physicians, or social workers are required beyond providing reassurance and showing empathy (Holland, 1989).

The distinctions between normal, reactive levels of fear and levels of anxiety that require clinical intervention involve the duration and severity of the symptoms. For example, if anxiety is interfering with treatment compliance, behavioral or pharmacologic interventions may be required. Normal levels of anxiety that may accompany the diagnosis of cancer include shock and irritability, as well as disruption of sleep and appetite. Concentration may be impaired and interfere with the ability to carry out usual daily activities. Fears about cancer treatment and the future impact on QOL may be troubling for patients. These symptoms usually will resolve over a period of several days, especially with the support of healthcare professionals, family, and friends (Massie & Shakin, 1993).

Anxiety in patients with cancer may be divided into three categories: reactive episodes of anxiety related to the stress of cancer and its treatment; chronic anxiety disorders that predate the diagnosis of cancer; and anxiety related to the consequences of medical treatment (see Table 1-4) (Massie & Holland, 1992).

Episodes of stress-related anxiety may occur prior to and during cancer treatment. For example, if a patient feels apprehensive about becoming nauseated before receiving chemotherapy, the anxiety could be considered stress-related (i.e., anticipatory anxiety). Patients commonly experience anticipatory anxiety prior to undergoing tests and procedures or while waiting for test results.

Information about preexisting anxiety disorders is obtained through the patient's history. Disorders may include panic disorder, phobias, generalized anxiety disorder, and post-traumatic stress disorder. Such

**Table 1-4. Types of Anxiety in Patients With Cancer**

Anxiety Type	Examples
Reactive anxiety	<ul style="list-style-type: none"> <li>• Anticipatory anxiety</li> <li>• Fears</li> </ul>
Preexisting anxiety	<ul style="list-style-type: none"> <li>• Generalized anxiety disorder</li> <li>• Panic disorder</li> <li>• Phobias</li> <li>• Post-traumatic stress disorder</li> </ul>
Anxiety related to medical condition	<ul style="list-style-type: none"> <li>• Bleeding</li> <li>• Congestive heart failure</li> <li>• Delirium</li> <li>• Hypocalcemia</li> <li>• Hypoglycemia</li> <li>• Hypoxia</li> <li>• Pulmonary embolus</li> <li>• Sepsis</li> <li>• Medications that cause anxiety                             <ul style="list-style-type: none"> <li>- Neuroleptics</li> <li>- Steroids</li> </ul> </li> <li>• Withdrawal states caused by                             <ul style="list-style-type: none"> <li>- Narcotics</li> <li>- Barbiturates</li> <li>- Alcohol</li> </ul> </li> <li>• Uncontrolled pain</li> </ul>
<p><i>Note.</i> Based on information from Massie &amp; Holland, 1992.</p>	

patients often will have a history of anxiety-related symptoms, such as shortness of breath, chest pain, paresthesia, nausea, and fear of dying. Patients with preexisting disorders usually are taking medications for anxiety and will require careful monitoring of their medical stability and personal and social situations (Massie & Shakin, 1993).

Patients may present with a variety of physical signs or symptoms of anxiety (see Figure 1-4). The decision to intervene with behavioral or pharmacologic therapies is based on the patient's level of distress and ability to participate in treatment or function adaptively. For example, if a patient's fear of needle insertion for a bone marrow biopsy is creating a delay in the procedure, then pharmacologic or behavioral interventions are appropriate.

Behavioral therapies, such as relaxation techniques, may be beneficial for patients who

are experiencing anxiety, especially those who experience anticipatory anxiety prior to tests. Trained staff may teach these simple techniques, or the patient may use a prerecorded relaxation exercise prior to and during procedures. Relaxation, guided imagery, and self-hypnosis techniques require instruction and time to practice and, therefore, are ineffective in some situations. In fact, attempting to instruct patients in these techniques may cause added stress because learning them requires a level of concentration that the patient may not be able to achieve. If a patient's anxiety prevents him or her from using these types of techniques or therapies, other behavioral interventions, such as slow, deep breathing or the creation of a distraction from the anxiety-producing event, may be effective. Medication or a combination of behavioral and pharmacologic therapies should be considered in some cases.

Anxiety that results from a medical cause often is referred to as *organic anxiety*. Of the medical factors that can cause anxiety, the most common are abnormal metabolic states, medication side effects, withdrawal states, and uncontrolled pain (see Table 1-4). The anxiety caused by medical conditions presents similarly to other forms of anxiety (Massie & Shakin, 1993).

The use of antiemetic medications in the cancer setting is quite common and may cause a type of anxiety called *akathisia*. The most common antiemetics that cause akathisia are the dopamine antagonists, such as metoclopramide, prochlorperazine, and haloperidol. The onset of this type of anxiety correlates with the

use of these medications and may be particularly distressing. The patient may complain of a sense of internal restlessness and an inability to sit still. Akathisia may be controlled with benzodiazepines (e.g., lorazepam) or an antiparkinsonian agent (e.g., benztropine). Diphenhydramine also is a popular antidote for akathisia because of its sedating and anticholinergic properties. Patients who have a history of akathisia reactions should have notations made in their treatment plans to avoid use of the causative medications. Using antiemetics that do not cause akathisia may be the best way to prevent this syndrome.

Uncontrolled pain is a common anxiety-producing factor in patients with cancer. The first line of treatment in these cases is the use of analgesics to control pain, followed by a reassessment of anxiety. Anxiety that persists even after pain control is achieved may require other medications or behavioral interventions.

Benzodiazepines are safe and effective in treating both acute and chronic anxiety states in oncology settings. The choice of a benzodiazepine usually is made based on the desired duration of action (see Table 1-5). For tests, procedures, and episodes of brief anxiety, the short-acting benzodiazepines can be used on an as-needed basis. Longer-acting benzodiazepines are preferred for persistent anxiety states. For example, patients who are required to be in isolation for an extended period

**Figure 1-4. Symptoms of Anxiety**

**Appearance and Behavior**

- Flushed face
- Tense, worried expression
- Restlessness
- Sweaty palms
- Diaphoresis
- Irritability
- Tremors
- Difficulty concentrating

**Respiratory**

- Hyperventilation
- Dyspnea
- Feelings of suffocation

**Cardiovascular**

- Palpitations
- Sinus tachycardia
- Elevated systolic blood pressure
- Precordial pain

*Note.* Based on information from Holland, 1989.

**Table 1-5. Commonly Prescribed Medications to Manage Anxiety**

Drug Category	Drug Name
Benzodiazepine	
• Short-acting	Estazolam Flurazepam Midazolam Temazepam Triazolam
• Long-acting	Alprazolam Chlordiazepoxide Clorazepate Diazepam Halazepam Lorazepam Oxazepam Prazepam Quazepam
Nonbenzodiazepine	Zaleplon Zolpidem

*Note.* Based on information from Massie & Shakin, 1993; Spratto & Woods, 2007; U.S. Drug Enforcement Administration, n.d.

of time and experience anxiety as a result of confinement may require long-acting benzodiazepines.

### Neurocognitive Changes

Mental status changes are some of the most troubling conditions that patients with cancer face. Mental status changes vary in severity, but the most acute and life threatening is delirium. Delirium occurs in 25%–40% of patients with cancer at some point during their illness and increases to 85% during the terminal phase of cancer (Zimberg & Berenson, 1990). Nurses play a vital role in identification and assessment of delirium. Although delirium is easily recognized in its most dramatic form, early presentation of milder forms is more difficult to diagnose (see Figure 1-5).

Delirium is characterized by alterations in patients' level of consciousness that may include changes in perception, memory, attention, thinking, psychomotor behavior, emotions, and sleep-wake cycle. These symptoms may fluctuate (i.e., wax and wane) throughout the day or occur abruptly without clear warning (Fleishman, Lesko, & Breitbart, 1993). Patients may appear to be distracted as their thoughts become fragmented and the tone and clarity of speech diminish. Caregivers may observe patients having

**Figure 1-5. Common Behavioral Symptoms Seen in Delirium**

- Disturbance in sleep-wake cycle
- Easily distracted; transient periods of disorientation
- Irritability, anger, being uncooperative
- Withdrawal, refusal to talk to staff or relatives/friends
- Perceptual disturbances
- Illusions, misperceptions (e.g., the folds in the bed sheet may appear to be an animate object)
- Delusions, false beliefs that cannot be corrected by reasoning (e.g., "the chemotherapy is poison")
- Hallucinations, false perceptions, including visual, auditory, and tactile (e.g., sees people or animals in the room that are not there)

*Note.* Based on information from Breitbart & Cohen, 2000; Fleishman et al., 1993.

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difficulty in decision making and being unable to complete tasks. Psychomotor behavior may change to agitation or lethargy or may fluctuate between the two. Short-term memory usually becomes impaired first, followed by long-term memory disturbances.

Patients who are experiencing delirium often may become quiet and withdrawn to compensate for their changing mental status. Patients may appear depressed or anxious and, therefore, be diagnosed with a behavioral or emotional problem. The misdiagnosis of delirium and subsequent treatment for what appears to be depression or anxiety may worsen patients' conditions (Meyers & Scheibel, 1990).

Perceptual disturbances may occur later during the course of delirium and can include hallucinations or illusions. The sleep-wake cycle may be altered as the patient sleeps during the day and stays awake at night (i.e., "sundowning"). During waking hours, the patient may be agitated and unable to rest.

The causes of mental status changes in patients with cancer are related to direct or indirect effects of cancer or its treatment on the central nervous system (see Table 1-6). Direct causes include primary brain tumors and cerebral metastases. An estimated 25% of patients with systemic cancers experience metastatic disease to the brain (Meyers & Scheibel, 1990). The types of symptoms that these patients demonstrate vary according to site and rate of tumor growth.

Of the numerous indirect causes of mental status changes, metabolic abnormalities are the most common and are responsible for many patients being misdiagnosed with depression or anxiety (Goldberg & Cullen, 1987). Patients with cancer who have altered host resistance are prone to infection, including viral, bacterial, and fungal infections. Whereas an overwhelming infection usually presents as a medical emergency, some cases follow a subacute course that produces behavioral and mental status changes. Generalized sepsis followed by shock and multisystem failure also may produce mental status changes and extreme restlessness followed by confusion and irritability. Body temperature always should be checked in patients who exhibit new symptoms of mental status changes.

Radiotherapy may produce side effects that present as psychiatric symptoms. Generalized depletion and fatigue from radiotherapy may produce secondary effects on mood and attitude (Goldberg & Cullen, 1987). Delayed effects of radiation may occur in patients who have received treatment for head and neck cancers and metastatic brain lesions. These effects may be serious because radiation damage can be progressive and irreversible. Long-term survivors of radiation therapy may develop neurologic deficits, including memory loss, gait disturbance, muscle weakness, and tremor. Children particularly are at risk for long-term effects of radiation therapy because the survival rate with some malignancies is high and length of survival is long. Children may gradually

**Table 1-6. Causes of Neurocognitive Changes in Patients With Cancer**

Cause	Examples
Direct	<ul style="list-style-type: none"> <li>• Leptomeningeal disease</li> <li>• Metastatic disease (lung, breast, melanoma, colon, and prostate)</li> </ul>
Indirect	<ul style="list-style-type: none"> <li>• Chemotherapeutic agents               <ul style="list-style-type: none"> <li>– Alkylating agents                   <ul style="list-style-type: none"> <li>* Altrephine</li> <li>* High-dose cyclophosphamide (when given with total body irradiation)</li> <li>* Ifosfamide</li> </ul> </li> <li>– Antimetabolites                   <ul style="list-style-type: none"> <li>* Azacitidine</li> <li>* Cytarabine (ARA-C)</li> <li>* 5-fluorouracil</li> <li>* Methotrexate</li> <li>* Pentostatin</li> </ul> </li> <li>– Miscellaneous agents                   <ul style="list-style-type: none"> <li>* Asparaginase</li> </ul> </li> </ul> </li> <li>• Biologic agents               <ul style="list-style-type: none"> <li>– Interferon alfa</li> <li>– Interleukins</li> <li>– Aldesleukin</li> </ul> </li> <li>• Targeted therapies               <ul style="list-style-type: none"> <li>– Monoclonal antibodies                   <ul style="list-style-type: none"> <li>* Bevacizumab</li> <li>* Cetuximab</li> </ul> </li> <li>– Small-molecule inhibitors                   <ul style="list-style-type: none"> <li>* Bortezomib</li> </ul> </li> <li>– Miscellaneous biologic response modifiers                   <ul style="list-style-type: none"> <li>* Thalidomide</li> </ul> </li> </ul> </li> <li>• Infection</li> <li>• Metabolic abnormalities               <ul style="list-style-type: none"> <li>– Hepatic failure</li> <li>– Hypercalcemia</li> <li>– Hyponatremia</li> <li>– Hypoxia</li> </ul> </li> <li>• Other drugs               <ul style="list-style-type: none"> <li>– Aminoglycosides</li> <li>– Amphetamines</li> <li>– Analgesics (e.g., nonsteroidal anti-inflammatory drugs, opioids)</li> <li>– Anti-inflammatories (e.g., glucocorticoids, nonsteroidal anti-inflammatory drugs)</li> <li>– Steroids</li> <li>– Sedatives/hypnotics</li> </ul> </li> <li>• Radiation therapy</li> <li>• Withdrawal states</li> </ul>

*Note.* Based on information from Fleishman et al., 1993; Meyers & Scheibel, 1990; Spratto & Woods, 2007; U.S. Pharmacopeia, n.d.



develop learning disabilities and mild to moderate intellectual deficits (Meyers & Scheibel, 1990).

Antineoplastic drugs can cause cognitive changes. Most of these changes are acute and reversible. The newer immunologic agents (IFN and interleukin) work to boost the host immune response to foreign cells, most notably cancer cells. Recent literature reveals that some of these agents produce cognitive side effects that may result in neurologic and psychiatric side effects ranging from subtle impairment that is undetectable by routine examination to acute delirium and psychotic-like behavior (Nail, 2006; Tannock, Ahles, Ganz, & Van Dam, 2004).

Steroid compounds also may cause cognitive and psychiatric changes that range from mild mood disturbances to acute psychosis (Massie & Holland, 1992). Other drugs that patients with cancer may be taking can cause cognitive or psychiatric sequelae. Narcotics, sedatives, and hypnotic agents may cause diminished alertness or confusion, particularly when they are used in older adults or in those with hepatic impairment (Goldberg & Cullen, 1987).

Medications and supportive techniques may assist in decreasing the symptoms brought on by cognitive changes. Commonly used neuroleptic medications include haloperidol and olanzapine. Haloperidol often is the drug of choice in the treatment of delirium (Akechi et al., 1996). Doses as low as 1–3 mg per day may be effective in reducing symptoms. Olanzapine also has been shown to be effective in some clinical trials (Breitbart, Tremblay, & Gibson 2002).

Nurses are in a key position to support patients. Reorienting patients by using calendars and clocks in patients' rooms is a simple strategy. Supporting family caregivers with information about the etiology, progress in treatment, and measures being used to care for the patient are important.

## **Patients Who Are Terminally Ill**

Terminal illness is not a psychiatric disorder itself, but patients who are terminally ill may present with depression, anxiety, or neurocognitive changes, including delirium. Patients with cancer who are in the terminal phase of illness (i.e., life expectancy of three to six months) are uniquely vulnerable to both physical and psychological complications (Breitbart, Levenson, & Passik, 1993). Because these patients may experience a high level of physical distress, such as pain, assessing the psychological symptoms in these patients becomes more difficult.

Depressed mood and sadness may be appropriate responses in the terminally ill. The depression can be related to anticipatory grief of impending loss of life and the personal meaning that these losses have for individual patients. Supportive counseling and antidepressant therapy

are useful in the treatment of the terminally ill. Skilled counselors in this setting should exhibit specific qualities, including active listening, giving supportive verbal feedback, and the ability to elicit conversation about the patient's life and experiences rather than focusing only on death and dying. This requires someone who is comfortable in stimulating interaction and who actively listens with interest rather than presenting as somber and emotionally distant. Nurses who are comfortable with these skills are in a strategic position to carry out these interventions with patients who are terminally ill.

## Family Issues in Coping

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Understanding the psychological distress that patients encounter during their cancer experience will assist nurses in dealing with distress in family members. Patients often say that one of their biggest concerns or fears is the burden placed on their families. Therefore, it is not surprising that family members may experience as much, if not more, distress than the patient with cancer (Mellon, Northouse, & Weiss, 2006). In light of this, nurses are challenged to identify families at risk early in the course of the patient's illness.

The physical and emotional burdens placed on family members may adversely affect the well-being of the entire family unit (see Figure 1-6).

### Figure 1-6. Family Stressors That May Interfere With Coping

- Loss of daily routine
- Loss of the ability to accomplish usual tasks
- Loss of sleep, feeling tired or exhausted
- Loss of confidence in the ability to do all that is needed
- Feeling lonely and isolated (loss of social life)
- Loss of financial security, loss of employment
- Loss of intimacy
- Loss of, or confusion about, meaning in life
- Feeling resentment that this has happened to you and your loved one
- Feeling guilty that you have not done enough
- Medical power of attorney (when patient can no longer make decisions)
  - Helping with treatment decisions
  - Deciding when to stop treatment

Note. Based on information from Miller, 1995; Yates, 1999.

The patient's stage of illness and performance status have a direct impact on each family member's quality of life. Family members are at increased risk for compromised physiologic functioning and health problems (Vitaliano, 1997). Factors that may predict high levels of family distress include concurrent family stressors, conflict between family members, and poor social support.

Concurrent family stressors are quite common and may vary in intensity from one family to another. For example, a family may be in the middle of moving into a new home at the same time a family member is diagnosed with cancer. For one

family, this could pose serious financial distress. Perhaps this family does not have health insurance, and they might lose their new home because of financial depletion. Another family may have the financial and social resources to assist with both supporting the patient through cancer treatments and proceeding with buying and moving into their new home. Other concurrent family stressors might include the recent death of another family member, friend, or pet; loss of employment; medical or psychiatric illness in another family member; and legal problems.

Conflicts between family members are important to assess. Conflict may exist regarding the caregiver role, such as who will fill it or how it will be shared among family members.

Families may have old conflicts or resentments that interplay with the new stress of cancer in the family. In this case, it is important to identify and help families to keep these stressors separate and assist them in finding appropriate resources for resolution. This may require involvement with psychiatric or social service support.

Social support consists of personal friends, extended family members, or community groups that may provide important help for patients and families. Lack of social support, including living alone or not having a confidant, may make coping more difficult. It is important to work with patients and families to maximize their support by engaging these resources. Social service may be able to suggest a cancer support group or counseling to fit each patient's or family member's needs.

Family assessment and history (see Figure 1-7) are important in understanding how coping behaviors manifest during illness (Rolland, 2005). The assessment should include knowledge of family financial and community resources. Past styles of coping may reveal families with dysfunctional patterns and unresolved issues from the past. Subjective indicators of family strain, such as social isolation, feelings of being overloaded, and loss of meaning in life, may require more time-intensive assessment (Matthews, Baker, & Spillers, 2004).

Drawing a genogram of the family unit, including family members and important significant others from the past two to three generations, gives valuable information on what developmental dynamics are currently in play and how the family system reacts in response to stressors. Simply assessing the family as a whole unit gives pertinent information about family functioning but may fail to address particular subsystems that have a life of their own (Wellisch, 2000). Examples of subsystem relationships include the marital relationship, the parent-child relationship, the grandparent-grandchild relationship, and sibling relationships. Consideration of these subsystems will take more time and effort to understand because each of them will have unique interactions and conflicts.

Two relational concepts are important to consider when assessing families and family subsystems: cohesion and adaptability (Cole & Jordan, 1989). Family *cohesion* can be defined as the emotional bonding that exists

### Figure 1-7. Family Coping Assessment and History

- Who constitutes the family unit?
- Draw a two- to three-generation genogram of family members and significant others and where they live.
- What was the role of the patient in the family unit, and how has it changed?
- Describe the relationship of the patient to key members of the family unit prior to the cancer diagnosis.
- Who else in the family unit has care needs or developmental needs (e.g., school-age children, older parents)?
- Have any other losses occurred recently?
- Who does chores around the house? How are tasks divided?
- How does the family unit communicate? How does the family unit solve problems? When there is a tough issue in the family, who brings it up? Who talks to whom?
- Describe the network of support in the community. Discern the climate of support outside the home.
- What is the availability of funds to maintain financial stability?
- Do any of the family members have any emotional problems (e.g., psychiatric history, substance abuse)?
- What is the cultural, ethnic, and religious background of the family unit?
- What are the faith-based rituals and routines of the family unit?
- Assess family members' stress/coping. What are their greatest concerns? Whom do they talk to when they feel burdened?

Note. Based on information from Rolland, 2005; Stetz, 2003; Wellisch, 2000.

among family members (Olson, Russell, & Sprenkle, 1983). Moderate levels of cohesion between family members allow for healthy attachments and optimal functioning. A child with a healthy attachment to a parent allows for a sense of security with the parent and also a sense of safety when exploring new experiences that separate the child from the parent. Two extreme levels of cohesion that may be unhealthy are *enmeshment* and *disengagement* (Minuchin, 1974). In an enmeshed parent-child subsystem, the nurse may observe the child and parent clinging in a way that does not allow the child to experience separateness and growth. The other extreme is disengagement, where the bond within the parent-child subsystem is superficial or absent. Each subsystem within the family may have different levels of cohesion or bonding. It is important for the nurse to find an entry point to offer assistance. For example, the mother-child subsystem may be enmeshed, but the father has disengaged from both the mother and child. The nurse may have difficulty working with the father because of his absence; therefore, the mother may be more accessible for initial intervention, followed by attempts to persuade other family members to be involved.

The second relational concept is *adaptability*, which describes the family's ability to make healthy changes in the face of stress. Adaptability can be understood on a continuum. Low adaptability describes the family that is rigid and has little or no flexibility in making the needed changes

to deal with cancer in the family. These families may require more time and assistance in adjusting to changes in their daily routines. For example, a family that has set rituals for meals may need help to plan meals in a new setting and at different times to accommodate the patient with cancer. The reassurance that important rituals can be maintained with minimal disruption will minimize family distress. Families who have built-in irregularity and fluctuation in their interactions (high adaptability) may experience chaos with stress. These families may require more assistance with building structures and boundaries so that the family is able to function without becoming fragmented. A moderate amount of adaptability allows for both healthy flexibility and structure.

The needs of dependent children of patients with cancer oftentimes are minimized or overlooked. A natural tendency exists for overwhelmed adult patients to protect their dependent children from emotional trauma. Teaching parents how to talk to dependent children may be enough to manage their concerns. Sharing information with children, listening to their questions, and responding to them with truthful answers is essential. Allowing children to express emotions such as anger, sadness, and fear does not worsen the child's anxiety but, on the contrary, may relieve their worst fears. A child's imagination and fantasy about what might be happening can be more traumatic than reality (Beale, Sivesind, & Bruera, 2004). Children often do better if they are allowed to participate with the family in the parent's cancer experience. A specialist in child development or child psychology may be helpful to encourage the nonverbal expression of emotions through art and play therapy.

Another issue for families facing cancer is the need for joint problem solving that involves shared interactions and decision making. For example, family tasks and chores may need to be redistributed. If family members successfully can find solutions to these problems, their anxieties about feeling helpless may be replaced with a sense of empowerment and mastery (Wellisch, 2000).

Figure 1-8 has suggestions for interventions that may be helpful in assisting families to optimize their coping strategies. When families are faced with the stressful situation of having cancer, their usual ways of coping often do not work like before. Families will struggle to redefine their situation to regain control and renew meaning in their life, which in turn makes the cancer experience more tolerable. The nurse may encourage the family to focus their efforts on manageable day-to-day problems rather than spending time trying to solve insurmountable issues.

A family meeting is a supportive structure to educate family members, answer questions, and promote communication with the professional healthcare team. Giving the family information about the patient's diagnosis and prognosis and educating them about when to call for help is important. Although it may be impossible to predict what will happen next, the family may be comforted by knowing what events can happen,

**Figure 1-8. Interventions That Assist Family Members With Coping**

- Help the family to understand the patient’s diagnosis and prognosis.
- Teach the family to mobilize resources early and ask for what they need.
- Encourage family members to take time to grieve losses.
- Help family members to search for meaning.
- Validate the adjustments and behaviors that are working well for the family.
- Encourage the family to build in respite time (personal and recreational); use coping strategies that have worked in the past (e.g., distraction, counseling, support groups).
- If the patient is terminal, educate the family about hospice/palliative care and what to expect as the patient declines.

*Note.* Based on information from Stetz, 2003.

depending on different circumstances. Validating behaviors that the family is doing well helps family members to cope optimally. Offering community resources for support groups and counseling may be helpful for some families. Family members can partner with nurses to meet the needs of the patient with cancer. Appropriate support given to family members will contribute, in turn, to improvements in health outcomes for patients.

## Cultural Diversity

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Working with patients and families in the oncology setting requires sensitivity to diversity, especially within a cultural context. Cultural diversity is increasing in the United States and throughout the world. Attention to cultural competency focuses on providing for the needs of patients and families with differences as well as similarities in beliefs, values, and lifeways (culture) in order to provide culturally congruent and meaningful health care (Campinha-Bacote, 1999; Purnell, 2002). When patients and families feel understood and empowered within their own cultural identity, they are likely to cope in better ways.

The first step to cultural competency is described by Campinha-Bacote (2003) as “cultural desire,” or the nurse’s motivation to become culturally aware and skillful. Without cultural desire, the nurse may find it difficult to engage authentically with patients from unfamiliar cultures. On the other hand, if the nurse is motivated and committed to being culturally competent, he or she is more likely to seek out cultural knowledge and cultural encounters with patients and families (Campinha-Bacote, 2003).

Another essential component to becoming culturally competent is self-reflection. Self-analysis of one’s own beliefs, values, and lifeways will prepare the nurse to understand and relate to others more genuinely (see Figure 1-9). For example, a nurse from the North American cul-

**Figure 1-9. Cultural Diversity Self-Analysis**

- What is the cultural identity that you most closely identify with?
- What values were you taught when growing up?
- How were you affected by the first encounter that you had with someone from a different culture? Different race? Different sexual identity?
- How were men and women treated differently or similarly in your cultural group?
- How do your feelings change when you find out a person abuses prescription medicine, alcohol, or illegal drugs?
- What cultural differences in others do you find most difficult to accept? What differences do you find to be easier to accept?
- How did food affect your life within your household when you were growing up?
- How do you feel when you are on an elevator with a person of a different race?
- If you had to be at an appointment at 3 pm, what would be your arrival time?
- Have you met an individual who has been incarcerated? How did that make you feel?
- How old were you when you met someone with a terminal diagnosis? How did this affect you?
- Do you recall the first time that you saw a person or met someone with a physical or mental disability and how that made you feel? How is that different from how you feel now?

*Note.* Based on information from Jenko & Moffitt, 2006.

ture might explore values from that culture, such as the importance of money, freedom of choice, or the right to privacy. Other cultures are not likely to place the same importance on these North American values. With successful self-analysis, nurses will recognize strengths and weaknesses intrinsic in their points of view. A conscious awareness of one's own cultural values may enable nurses to overcome barriers in the care of patients and families from other cultures (Gray & Thomas, 2005; Jenko & Moffitt, 2006).

Understanding a number of common assumptions about culture in the nursing literature is important (see Figure 1-10). These assumptions will help oncology nurses to broaden their awareness and understanding of cultural diversity. One of the key assumptions is that culture is dynamic and ever changing. Because of this, the nurse is in an ongoing learning process as culture and diversity change over time. Another important assumption is that healthcare outcomes will be improved when patients and families, regardless of culture, are coparticipants in decision making about goals, plans, and interventions of care (Purnell, 2002).

Purnell (2002) described 12 cultural domains that are germane to the study of cultural diversity (see Figure 1-11). Each domain holds important information about understanding the cultural diversity of patients and families. Purnell's model was selected because it is comprehensive, provides a structure for nurses to learn about various cultures, and can be applied to any culture worldwide. The model also allows for sensitivity to differences within the same culture. Even patients/families from

**Figure 1-10. Assumptions About Culture**

- Culture is learned and not genetic.
- One culture is not better than another culture; they are just different.
- Differences exist between, within, and among cultures.
- Any person can identify with multiple cultural groups.
- Culture influences one's interpretation and response to health care.
- All people have the right to be respected for their uniqueness and cultural heritage.
- Nurses who are culturally competent will improve the care of their patients.
- When patients and families participate in decisions about their care, healthcare outcomes are improved.
- Culture is a dynamic and ever-changing process.
- Learning culture is an ongoing process and develops in many ways, primarily through cultural encounters.
- With cultural awareness, prejudices and biases can be minimized.

*Note.* Based on information from Campinha-Bacote, 1999; Gray & Thomas, 2005; Purnell, 2002.

**Figure 1-11. Purnell's 12 Domains**

1. Overview/heritage—country of origin, reason for emigration, economics, political affiliation, educational level, occupation
2. Communication—dominant language, willingness to share thoughts and emotions, eye contact, touch, form of greeting, clock versus social time
3. Family roles and organizations—gender roles, developmental tasks of children, roles of extended family members, social status, alternative lifestyles, child-rearing practices
4. Workforce issues—autonomy, gender roles
5. Biocultural ecology—biologic variations: skin color, physical differences, heredity, genetics, and differences in how the body metabolizes drugs
6. High-risk health behaviors—the use of alcohol, tobacco, and recreational drugs; physical inactivity; high-risk sexual practices; at-risk behaviors (e.g., nonuse of seatbelts and helmets)
7. Nutrition—having enough food, meaning of food, food choices, rituals
8. Pregnancy and childbearing practices—fertility practices, views toward pregnancy, methods of birth control, birthing, and postpartum treatment
9. Death rituals—how the culture views death, rituals, burial practices, bereavement practices
10. Spirituality—religious practices, use of prayer, individual sources of strength, behaviors that give meaning to life
11. Healthcare practices—focus on acute or preventive, individual responsibility for health, self-medicating practices, views about mental illness, organ donation, organ transplantation, one's response to pain and the sick role
12. Healthcare practitioners—status of, use of, gender of practitioner may have significance

*Note.* Based on information from Purnell, 2002.



the same culture may have striking differences. For example, spirituality within the same culture may vary from a defined religious faith to other individual sources of strength, such as the beauty and wonder of nature and evolution.

Cultural diversity can be challenging for the conscientious oncology nurse. Rather than categorizing patients and families based on false assumptions or stereotypes, understanding individuality and variation is important. Cultural desire, critical self-analysis of one's own cultural influences, understanding common assumptions about cultural diversity, and applying Purnell's 12 cultural domains will help oncology nurses to provide sensitive quality care to patients and families.

## Summary

The psychosocial needs of patients with cancer are closely tied to each individual's perception of quality of life. Quality of life cannot be discerned without understanding the patient's relationship to family and community. Diversity, including beliefs, values, and cultural practices, also plays an important part in shaping quality-of-life outcomes for patients and their families.

The most common psychiatric problems seen in the oncology setting are depression, anxiety, and neurocognitive changes, including delirium. Each of these problems requires the nurse to accurately assess and intervene using skillful communication. Establishing and maintaining dialogue is critical to the assessment of and intervention in psychosocial problems in patients with cancer and their family members. Experience in helpful communication techniques equips nurses to meet the psychosocial needs of these patients and families. The nurses' knowledge of cultural diversity also plays an important role in communication.

Nurses are in a strategic position to assess and intervene in the psychosocial needs of patients with cancer and their family members. Oncology nurses must understand and assess the level of distress in patients and families and be able to intervene to provide symptom relief and guidance to enhance an extended quality of life.

## References

Akechi, T., Uchitomi, Y., Okamura, H., Fukue, M., Kagaya, A., Nishida, A., et al. (1996). Usage of haloperidol for delirium in cancer patients. *Supportive Care in Cancer*, 4(5), 390-392.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

- Archbold, P.G., Stewart, B.J., Greenlick, M.R., & Harvath, T. (1990). Mutuality and preparedness as predictors of caregiver role strain. *Research in Nursing and Health*, 13(6), 375-384.
- Beale, E.A., Sivesind, D., & Bruera, E. (2004). Parents dying of cancer and their children. *Palliative and Supportive Care*, 2(4), 387-393.
- Breitbart, W., Levenson, J.A., & Passik, S.D. (1993). Terminally ill cancer patients. In W. Breitbart & J. Holland (Eds.), *Psychiatric aspects of symptom management in cancer patients* (pp. 173-230). Washington, DC: American Psychiatric Press.
- Breitbart, W., Tremblay, A., & Gibson, C. (2002). An open trial of olanzapine for the treatment of delirium in hospitalized cancer patients. *Psychosomatics*, 43(3), 175-182.
- Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38(5), 203-207.
- Campinha-Bacote, J. (2003). The spiritual key to cultural competence. *Journal of Christian Nursing*, 20(3), 20-22.
- Cole, D., & Jordan, A. (1989). Assessment of cohesion and adaptability in component family dyads: A question of convergent and discriminant validity. *Journal of Counseling Psychology*, 36(4), 456-463.
- Derogatis, L.R., Morrow, G.R., Fetting, J., Penman, D., Piasetsky, S., Schmale, A.M., et al. (1983). The prevalence of psychiatric disorders among cancer patients. *JAMA*, 249(6), 751-757.
- Erikson, E.H. (1963). *Childhood and society* (2nd ed.). New York: Norton.
- Ferrans, C.E. (1990). Development of a quality of life index for patients with cancer. *Oncology Nursing Forum*, 17(Suppl. 3), 15-21.
- Fleishman, S., Lesko, L., & Breitbart, W. (1993). Treatment of organic mental disorders in cancer patients. In W. Breitbart & J. Holland (Eds.), *Psychiatric aspects of symptom management in cancer patients* (pp. 23-47). Washington, DC: American Psychiatric Press.
- Frazer, A. (1997). Antidepressants. *Journal of Clinical Psychiatry*, 58(Suppl. 6), 9-25.
- Frost, M.H., Brueggen, C., & Mangan, M. (1997). Intervening with the psychosocial needs of patients and families: Perceived importance and skill level. *Cancer Nursing*, 20(5), 350-358.
- Goldberg, R.J., & Cullen, L.O. (1987). The psychiatrist's role in cancer care. *Cancer Surveys*, 6(3), 417-437.
- Gray, D.P., & Thomas, D. (2005). Critical analysis of "culture" in nursing literature: Implications for nursing education in the United States. *Annual Review of Nursing Education*, 3, 249-270.
- Greer, S. (1994). Psycho-oncology: Its aims, achievements and future tasks. *Psycho-Oncology*, 3(2), 87-101.
- Heaven, C.M., & Maguire, P. (1996). Training hospice nurses to elicit patient concerns. *Journal of Advanced Nursing*, 23(2), 280-286.
- Holland, J.C. (1989). Anxiety and cancer: The patient and the family. *Journal of Clinical Psychiatry*, 50(Suppl.), 20-25.
- Jenko, M., & Moffitt, S.R. (2006). Transcultural nursing principles. *Journal of Hospice and Palliative Nursing*, 8(3), 172-180.
- Kodish, E., & Post, S.G. (1995). Oncology and hope. *Journal of Clinical Oncology*, 13(7), 1817-1822.
- Lovejoy, N.C., & Matteis, M. (1997). Cognitive-behavioral interventions to manage depression in patients with cancer: Research and theoretical initiatives. *Cancer Nursing*, 20(3), 155-167.
- Lynch, A., & Burnett, C. (1997). Ethical dimensions and communication issues in nursing patients with advanced metastatic cancer. *Annals of the New York Academy of Sciences*, 809, 172-178.

- Maguire, P. (1985). For debate: Barriers to psychological care of the dying. *BMJ (Clinical Research Edition)*, 291(6510), 1711-1713.
- Massie, M., & Shakin, E. (1993). Management of depression and anxiety in cancer patients. In W. Breitbart & J. Holland (Eds.), *Psychiatric aspects of symptom management in cancer patients* (pp. 1-21). Washington, DC: American Psychiatric Press.
- Massie, M.J., & Holland, J.C. (1992). The cancer patient with pain: Psychiatric complications and their management. *Journal of Pain and Symptom Management*, 7(2), 99-109.
- Matthews, B.A., Baker, F., & Spillers, R.L. (2004). Family caregivers' quality of life: Influence of health protective stance and emotional strain. *Psychology and Health*, 19(5), 625-641.
- Mellon, S., Northouse, L.L., & Weiss, L.K. (2006). A population-based study of the quality of life of cancer survivors and their family caregivers. *Cancer Nursing*, 29(2), 120-131.
- Mermelstein, H.T., & Lesko, L. (1992). Depression in patients with cancer. *Psycho-Oncology*, 1(4), 199-215.
- Meyers, C.A., & Scheibel, R.S. (1990). Early detection and diagnosis of neurobehavioral disorders associated with cancer and its treatment. *Oncology*, 4(7), 115-122.
- Miller, S.M. (1995). Monitoring versus blunting styles of coping with cancer influence the information patients want and need about their disease. Implications for cancer screening and management. *Cancer*, 76(2), 167-177.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Myers, J.S. (2008). Proinflammatory cytokines and sickness behavior: Implications for depression and cancer-related symptoms. *Oncology Nursing Forum*, 35(5), 802-807.
- Nail, L.M. (2006). Cognitive changes in cancer survivors: Cancer and cancer treatment often cause cognitive deficits, but no guidelines exist for screening or treatment. *American Journal of Nursing*, 106(Suppl. 3), 48-54.
- Olson, D.H., Russell, C.S., & Sprenkle, D.H. (1983). Circumplex model of marital and family systems: VI. Theoretical update. *Family Process*, 22(1), 69-83.
- Parle, M., Maguire, P., & Heaven, C. (1997). The development of a training model to improve health professionals' skills, self-efficacy and outcome expectancies when communicating with cancer patients. *Social Science and Medicine*, 44(2), 231-240.
- Peterson, M. (1988). The norms and values held by three groups of nurses concerning psychosocial nursing practice. *International Journal of Nursing Studies*, 25(2), 85-103.
- Pirl, W.F., & Roth, A.J. (1999). Diagnosis and treatment of depression in cancer patients. *Oncology*, 13(9), 1293-1301.
- Polovich, M., Whitford, J.M., & Olsen, M. (Eds.). (2009). *Chemotherapy and biotherapy guidelines and recommendations for practice* (3rd ed.). Pittsburgh, PA: Oncology Nursing Society.
- Purnell, L. (2002). The Purnell Model for cultural competence. *Journal of Transcultural Nursing*, 13(3), 193-196.
- Rolland, J.S. (2005). Cancer and the family: An integrative model. *Cancer*, 104(Suppl. 11), 2584-2595.
- Schumacher, K.L. (1995). Family caregiver role acquisition: Role making through situated interaction. *Scholarly Inquiry for Nursing Practice*, 9(3), 211-229.
- Schwartz, L., Lander, M., & Chochinov, H.M. (2002). Current management of depression in cancer patients. *Oncology*, 16(8), 1102-1110.
- Shakin, E.J., & Holland, J. (1988). Depression and pancreatic cancer. *Journal of Pain and Symptom Management*, 3(4), 194-198.
- Smith, M.E., & Hart, G. (1994). Nurses' responses to patient anger: From disconnecting to connecting. *Journal of Advanced Nursing*, 20(4), 643-651.

- Spratto, G.R., & Woods, A.L. (2007). *2008 PDR nurse's drug handbook*. Montvale, NJ: Thomson Healthcare.
- Stetz, K.M. (2003). Quality of life in families experiencing cancer. In C.R. King & P.S. Hinds (Eds.), *Quality of life: From nursing and patient perspectives. Theory, research, practice* (2nd ed., pp. 219-237). Sudbury, MA: Jones and Bartlett.
- Tannock, I.F., Ahles, T.A., Ganz, P.A., & Van Dam, F.S. (2004). Cognitive impairment associated with chemotherapy for cancer: Report of a workshop. *Journal of Clinical Oncology*, 22(11), 2233-2239.
- U.S. Drug Enforcement Administration. (n.d.). *Benzodiazepines*. Retrieved March 13, 2009, from <http://www.usdoj.gov/dea/concern/benzodiazepines.html>
- U.S. Pharmacopeia. (n.d.). *USP drug list table V 4.0*. Retrieved March 9, 2009, from <http://www.usp.org/pdf/EN/mmg/drugListTableV4.0.pdf>
- Valente, S.M., & Saunders, J.M. (1997). Diagnosis and treatment of major depression among people with cancer. *Cancer Nursing*, 20(3), 168-177.
- Valente, S.M., Saunders, J.M., & Cohen, M.Z. (1994). Evaluating depression among patients with cancer. *Cancer Practice*, 2(1), 65-71.
- Valentine, A.D., Meyers, C.A., Kling, M.A., Richelson, E., & Hauser, P. (1998). Mood and cognitive side effects of interferon-alpha therapy. *Seminars in Oncology*, 25(Suppl. 1), 39-47.
- Vitaliano, P.P. (1997). Physiological and physical concomitants of caregiving: Introduction. *Annals of Behavioral Medicine*, 19(2), 75-77.
- Wellisch, D.K. (2000). Family issues and palliative care. In H.M. Chochinov & W. Breitbart (Eds.), *Handbook of psychiatry in palliative medicine* (pp. 275-289). New York: Oxford University Press.
- Wilkinson, S. (1991). Factors which influence how nurses communicate with cancer patients. *Journal of Advanced Nursing*, 16(6), 677-688.
- Wright, F., Cohen, S., & Caroselli, C. (1997). Diverse decisions: How culture affects ethical decision making. *Critical Care Nursing Clinics of North America*, 9(1), 63-74.
- Yates, P. (1999). Family coping: Issues and challenges for cancer nursing. *Cancer Nursing*, 22(1), 63-71.
- Zimberg, M., & Berenson, S. (1990). Delirium in patients with cancer: Nursing assessment and intervention. *Oncology Nursing Forum*, 17(4), 529-538.