Psychological issues facing women with gynaecological cancer

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With the diagnosis of gynaecological cancer and the treatments involved, women not only face life threatening implications, but also unique problems involving

- the loss of reproductive organs, infertility and menopause,
- sexuality and body image concerns.

The general aims of psychological interventions in the oncology setting are:

- increasing morale, self-esteem and coping ability.
- decreasing distress
- enhancing the individual's sense of personal control during their illness;
- helping the patient to bring about some resolution of the practical problems being faced
- explaining common emotional responses to a cancer diagnosis;
- enhancing quality of life through support.

Women diagnosed with gynaecological cancer commonly present with anxiety, depression, stress and adjustment issues, sexuality and body image issues, and interpersonal problems.

The prevalence of long-term psychological distress is variable, ranging from 20-60 per cent according to the few available estimates.**1** This variability is related to:

- medical factors such as stage of illness at time of diagnosis
- treatment offered
- course of the cancer (and the presence of difficult symptoms such as pain)
- psychological factors such as prior adjustment, coping ability, emotional maturity and the ability to make major adjustments to life goals
- social factors, particularly levels of support

Critical psychological time points along the disease continuum

Diagnostic phase

This is the period when acute psychological symptoms begin to occur.

This stage is characterised by emotional upheaval, shock and disbelief, with mixed symptoms of anxiety and depression.

While most people with cancer will experience minor or transient symptoms of anxiety and depression, 12-30 per cent will develop more severe problems that require specialised psychological and pharmacological treatments.**2**

Symptoms associated with anxiety may include heightened physical arousal, sleep disturbances, impaired concentration and decision making.

More severe reactions include panic episodes, pervasive and generalised worry and post traumatic stress reactions.

Patients who are diagnosed with a poor prognosis and high disease burden are especially vulnerable to psychological distress, and high rates of depression.**1**

Treatment phase

Undergoing treatment generally has a significant impact on a patient's quality of life—spending long hours in hospital clinics & giving up their normal day-to-day activities.

This phase is characterised by anxiety and depressed mood, & is often accompanied by distressing side effects, including treatment phobias, & persistent concerns about the effectiveness of treatment and prognosis.

Recurrence of disease

Psychological distress may become more intense at this stage, with one half of patients being clinically depressed at some point during advanced disease. Recurrence of disease is associated with psychiatric disorders in up to 50 per cent of women with breast cancer.**3**

Major psychological issues resulting from gynaecological cancer

Gynaecological cancer places the patient at high risk of developing:

- Sexual and body image problems—body image problems may occur, for example, as a response to lymphoedema, or coping with a stoma.
- Infertility and associated grief.
- Hormonal dysfunction & premature menopause occurring after bilateral salping (oophorectomy) with resulting psychosexual problems.
- Interpersonal problems—possible changes in the relationship with partner & family because of an increase in distress experienced

Rates of sexual dysfunction in women with gynaecological cancer range from 20-80 per cent.**4**
Sexual problems for women with gynaecological cancers typically include reduced libido, dyspareunia, diminished lubrication and orgasmic dysfunction and the effects of severe menopausal or disease related symptoms.

Specific difficulties associated with dyspareunia include vaginal irritation, reduced vaginal lubrication, vaginal stenosis, altered sensation and shortening of the vagina.

Loss of libido may follow any cancer treatment.
It is a common side effect and difficult to treat, because it may be a response to stress, it may reflect endocrine changes or a psychological response to treatment.
Reduced libido is often a result of:

- Treatment-related effects, particularly nausea and fatigue
- anxiety and depression
- body image problems / feelings of loss of femininity and self esteem
- fears about the consequences of sexual activity in relation to gynaecological cancer
- interpersonal / relationship difficulties—response of partner to changes

Burdened by the side effects of treatment, medications and anxieties about how they or their partner may respond, first attempts at sexual intimacy following treatment may be difficult or unsuccessful.

Patients and their partners will therefore benefit from discussions about the impact of treatment on sexuality from diagnosis onwards.

Impact of gynaecological cancer treatments

Surgery

Radical hysterectomy or total abdominal hysterectomy and bilateral salping-oophorectomy result in premature menopause for many women and consequent psychosexual problems.

Profound psychosexual difficulties are common in young women who have been deprived of the ability to complete their childbearing because of surgery.

Other more radical, disfiguring surgery—such as vulvectomy or pelvic exenteration involving the removal of bodily parts important to femininity and sexuality, may have emotionally traumatic effects

Radiotherapy and chemotherapy

In addition to the general side effects of radiotherapy, external beam radiation to the pelvis may alter gastrointestinal, bladder & sexual function
The specific effects of intracavitary brachytherapy are significant for women with gynaecological cancer, resulting in vaginal stenosis, dyspareunia and long term sexual difficulties.**5**

Patients often experience persistent levels of distress and fatigue throughout treatment with chemotherapy. They are often left with body image problems such as hair loss and loss of confidence and self esteem.

Completion of treatment

Remission can also present difficulties as patients begin to resume previous activities, regain their personal identity and renew relationships.
They may also experience sexuality and body image problems & often fear that sexual activity may produce a recurrence of their disease.

Psychological issues and recurrence of disease

Psychological issues surrounding completion of treatment include anxiety about perceived loss of support from the treatment team, and fears of recurrence of disease. Residual anxiety about recurrence of disease and fears surrounding routine check ups may last for many years after diagnosis.

The diagnosis of recurrence challenges people in confronting their mortality more than at any other stage of the cancer experience, with greater levels of distress & concerns about a poorer prognosis

A diagnosis of recurrence was found to be related to an increase in levels of stress and associated psychiatric disorders in up to 50 per cent of women with breast cancer.**6, 3**

Psychological assessment and interventions

Psychological assessment is important in order to:

- identify and document high risk psychological factors
- identify high risk disease characteristics
- assess general psychological functioning
- identify specific clinical issues such as the presence of anxiety and depression

Effective psychological interventions include sexuality information and education.
Medical interventions include the use of HRT, vaginal dilators, pelvic floor interventions and rehabilitative surgery, involving the creation of a neo vagina in appropriate patients.
Specific psychosexual interventions include:

- information on disease, treatment modality, physical changes and sexual functioning
- encouraging patients to broaden their sexual repertoire by exploring new forms of sexual expression
- efforts to manage dyspareunia
- and improving communication between patient and partner.

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