

PROSTATE CANCER – PECULIARITIES OF THE PROCESS OF ADAPTATION TO THE DISEASE

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Abstract

Aim. *Psycho-social adaptation to the diagnosis of cancer is a dynamic process, different from one patient to another, depending on many factors (location, stage, treatment, personality of each individual, environment - family, professional background, social-economic-cultural status). The aim of this study is to analyze the process of adaptation of patients with prostate cancer.*

Patients and method. *Thirty six patients diagnosed with prostate cancer, admitted in the Department of Oncology, Palliative Care for Chronic Patients within Chronic Disease Hospital “St. Luke” from Bucharest, Romania, over a period of six months, answered the Illness Cognition Questionnaire (ICQ), in order to assess adaptation to the disease (helplessness, acceptance, perceived benefits).*

Results. *Results of the study showed that feelings of helplessness were expressed at a high level in 22.2% patients, medium level in 55.6% cases and low level 22.2%. The feelings of acceptance were the following: 61.1% of patients had a high level, 33.3% of them a medium level, while only 5.6% had a low level of acceptance. Regarding perceived benefits due to the disease, the following results have been obtained: 22.2% had a high level, 77.8% a medium level and no patient reported low level benefit.*

Conclusion. *The results of this study indicate that patients diagnosed with prostate cancer adapt well to the disease, accept it and even obtain benefits from it.*

Keywords: acceptance, benefits, helplessness, Illness Cognition Questionnaire (ICQ), prostate cancer.

Introduction

Psycho-social adaptation to the diagnosis of cancer is a complex process in which each patient tries to manage emotional stress, disease specific problems and take control over the changes in their own life [1]. It is a dynamic process, different from one patient to another, depending on many factors (location, stage, disease treatment, personality

of each individual, environment – family, professional background, social-economic-cultural status).

Patients who manage to control the changes in their lifestyle and negative feelings caused by disease, and keep their active role through objectives and new meanings, follow the right process of adaptation [2].

In 1976 Weizmann and Worden defined the 100 days after finding out the diagnosis of cancer as an “existential situation”, describing metaphorically the patient’s thoughts and worries and the manner in which the disease will affect

his life [3]. For a satisfactory quality of life, the patients diagnosed with a disease having physical, emotional, social and cultural implications such as neoplasms, undergo a process of cognitive evaluation, in an attempt to adapt to the disease. This is a two-stage process: when a person experiences a stress factor, assesses the level of threat created (primary appraisal). If the stress factor turns out to be a significant threat, the individual will assess his abilities to control the situation and negative emotional reactions (secondary appraisal) [4,5].

Over time, several models of adaptation to chronic disease (including cancer) have been developed. In 1988, starting from the idea that any confrontation with a severe and debilitating disease can catalyze a new development of the individual and his own "rediscovery", Settlege et al. developed a model consisting of three elements: 1) tension and conflict (equivalent to helplessness), 2) resolution (equivalent to acceptance), 3) changes of his own representation (equivalent to beneficence) [6,7].

In 2000 Smart proposed an adaptation model based on emotional and psychological changes of patients: a) shock, b) denial or disbelief, c) depression or bereavement, d) psychological regression to a previous point in life, more positive or "normal", e) anger or personal interview, f) integration and growth. Patients and their families can experience all of these stages, without a "preset order", with different periods of time in each stage [7,8].

In 2007 Moos and Holahan developed a simple model of the adaptation process. According to this model, five groups of factors are associated with results and capabilities of adaptation to the disease (health-related results). The model includes three factors that influence cognitive assessment (personal resources, health-related factors, social and physical context) [9].

Thus, the diagnosis of cancer can mean the individual facing his own vulnerabilities and new concepts

– vulnerability, confrontation and resolution, which can predict the degree of emotional damage after such a diagnosis [3].

During the course of the disease, patients with cancer, including prostate, may face: a change of body image, embarrassment (given by symptoms), change of the social position within the family, impairment of the working capacity, financial loss, difficult physical mobility, social isolation, loss of sexual identity, loss of independence [10]. To these listed above, are added side effects of surgical, hormonal and radiation therapy: loss of libido, erectile dysfunction, changes in body conformation, "hot flashes", extreme fatigability, lethargy, emotional and cognitive changes, osteoporosis, diabetes, and, in case of metastatic prostate cancer, algic syndrome caused by bone damage [11,12].

Patients and methods

Patients diagnosed with advanced locoregional or metastatic prostate cancer, admitted into the Department of Oncology, Palliative Care for Chronic Patients from Chronic Disease Hospital "St. Luke" from Bucharest, over a period of six months, from September 2012 to March 2013, were evaluated using Illness Cognition Questionnaire (ICQ) [13,14]. ICQ is shown in table I. The study was approved by the ethics committee.

Patients were asked to answer the questionnaire in relation to the adaptation to the disease. This measuring instrument includes 18 questions and it consists of three subscales containing six items each. Each subscale measures a dimension, namely helplessness ("the disease controls my life", "the disease makes me feel useless sometimes"), disease acceptance ("I deal with the problems caused by the disease", "I have learned to accept the limitations imposed by the disease") and the benefits resulting from it ("the disease helped me figure out what is most important

Table I. Illness Cognition Questionnaire (ICQ).

To what extent do you agree with the following statements?		Not at all	To little	Largely	Completely
1	Because of my illness I miss the things I like to do most	1	2	3	4
2	I can handle the problems related to my illness	1	2	3	4
3	I have learned to live with my illness	1	2	3	4
4	Dealing with my illness has made me a stronger person	1	2	3	4
5	My illness controls my life	1	2	3	4
6	I have learned a great deal from my illness	1	2	3	4
7	My illness makes me feel useless at times	1	2	3	4
8	My illness had made life more precious to me	1	2	3	4
9	My illness prevents me from doing what I would really like to do	1	2	3	4
10	I have learned to accept the limitations imposed by my illness	1	2	3	4
11	Looking back, I can see that my illness has also brought about some positive changes in my life	1	2	3	4
12	My illness limits me in everything that is important to me	1	2	3	4
13	I can accept my illness well	1	2	3	4
14	I think I can handle the problems related to my illness, even if the illness gets worse	1	2	3	4
15	My illness frequently makes me feel helpless	1	2	3	4
16	My illness has helped me realize what's important in life	1	2	3	4
17	I can cope effectively with my illness	1	2	3	4
18	My illness has taught me to enjoy the moment more	1	2	3	4

in life”, “the disease has brought some positive changes in my life”). Each question had four response scales (1 = not at all; 2 = too little; 3 = largely; 4 = completely), the patient encircling the desired answer. The minimum score is six points and the maximum is 24 points for each subscale [15].

We divided each subscale in 3 levels: low – between 6 and 11 points, medium – between 12 and 17 points, high – between 18 and 24 points. Furthermore, the patients were asked to tell their age and the year when they were diagnosed with prostate cancer.

The purpose and importance of the study were explained to the participants, and the patients signed a written informed consent, in accordance with research law, in which they freely agreed to join this study. The approval from the medical ethical commission of the Palliative Care for Chronic Patients from Chronic Disease Hospital “St. Luke” was obtained.

Data obtained were analyzed using Microsoft Office Excel 2007 and Epi Info 7.

Results

Out of 46 consecutive patients admitted into the Department of Oncology, Palliative Care for Chronic Patients, over a period of six months, 36 patients agreed to answer the questionnaire and were included in the study. Ten patients, out of the total of 46, did not answer the questionnaire: six could not be assessed due to sudden aggravation of the general condition or due to disease-independent reasons and four patients deceased.

Participants in this study were aged between 59 and 89 years, with a mean age of 75 years and were undergoing hormonal therapy with LH-RH inhibitors (Triptorelin or Goserelin or Leuporelin) and antiandrogens (Bicalutamide).

The patients’ distribution according to the year of diagnosis of prostate cancer was: 4 cases (11.1%, 95% CI 3.1-26.1%) in 2008, 2 patients (5.6%, 95% CI 0.7-18.7%) in 2009, 10 cases (27.8%, 95% CI 14.2-45.2%) in 2010, 8 patients (22.2%, 95% CI 10.1-39.2%) in 2011 and the remaining 12 cases (33.3%, 95% CI 18.6-51%) in 2012 (Figure 1).

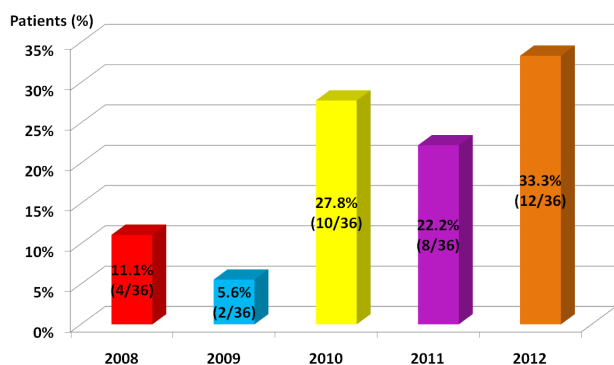


Figure 1. Patients’ distribution according to the year of diagnosis of prostate cancer.

The answers to questions in the questionnaire were interpreted, noticing the feeling of helplessness (Figure 2). Only 8 patients, representing 22.2% (95% CI 10.1-39.2%) experienced a high level of this feeling. Twenty patients, representing 55.6% (95% CI 38.1-72.1%) experienced a medium level. The remaining 8 patients, representing 22.2% (95% CI 10.1-39.2%) had a low level.

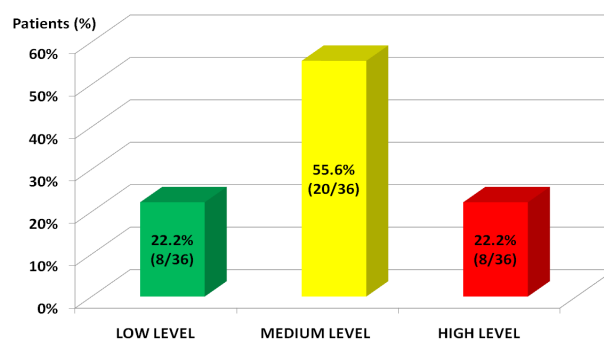


Figure 2. Helplessness feelings according to level.

With regard to the feelings of acceptance of the disease, the results of the study showed that 22 patients, representing 61.1% (95% CI 43.5-76.9%) had a high level of acceptance, 12 patients, representing 33.3% (95% CI 18.6-51%) had a medium level, while only 2 patients, accounting for 5.6% (95% CI 0.7-18.7%) had low level of acceptance (Figure 3).

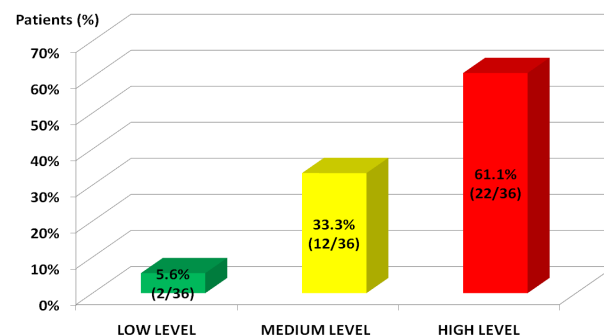


Figure 3. Acceptance feelings according to level.

As regards the benefits obtained due to the disease, the study showed that all patients experienced these feelings, 8 patients, representing 22.2% (95% CI 10.1-39.2%), having a high level and 28 patients, representing 77.8% (95% CI 60.8-89.9%), reporting a medium level (Figure 4). No patient had low benefit.

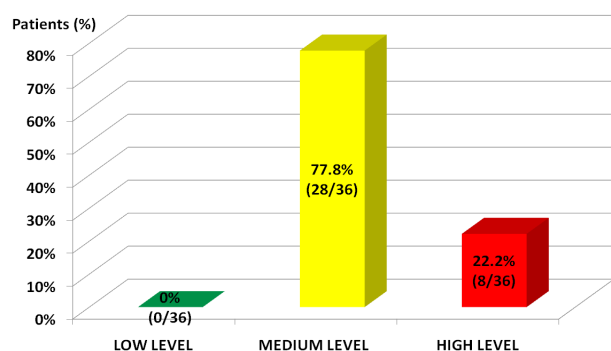


Figure 4. Feelings of benefits perceived according to level.

Discussion

ICQ [13,14] is used to assess patients with long-term diseases. ICQ is free for doctors and researchers [16]. It assess helplessness, by summing the points from items 1, 5, 7, 9, 12 and 15, acceptance, by adding together the scores from items 2, 3, 10, 13, 14 and 17 and perceived benefits are calculated by summing items 4, 6, 8, 11, 16 and 18. During the first phase of any life-threatening disease patients may experience helplessness, which is an emphasizing tool that helps patients to cope with the new situation. Acceptance minimizes negative charge and benefits adds a positive meaning to the disease [16]. It is stated that helplessness is a maladaptive function, acceptance is an adaptive function and perceived benefits is a positive adaptive function [13,14,16].

The clinical usefulness of ICQ was supported in various groups of patients [15].

No patient from the present study showed a low level of benefits, which means that throughout the outcome of the disease, they had a lot to learn from the disease, life became a lot more precious, they learned to enjoy more the present moment.

A comparison between results of this study and results of another study carried out within the Department of Oncology, Palliative Care for Chronic Patients, which included cancer patients regardless of location [17] was performed. The results showed that patients with prostate cancer had high and medium levels of beneficence feelings significantly increased compared with patients with cancer regardless of location (100% versus 84.42%). Regarding feelings of acceptance, high and medium levels account for 94.44% in patients with prostate cancer, compared to 71.42% in patients with cancer, regardless of location. Regarding the feeling of helplessness, high and medium level are quite similar in patients with prostate cancer and in those with cancer in any locations (77.78% versus 81.82%).

This high grade of acceptance and relative good response to the disease may be explained by the advanced age of patients included in this study. The mean age was 75 years and patients' age varied from 59 to 89 years.

Nevertheless these results may also be due to long evolution of the prostate cancer and the favorable results of treatments carried out.

Psychological adaptation of patients with prostate cancer is a complex process, which depends on the patient's personality, way in which the patient relates to the new changes occurring in his life, learning from this experience, understanding that by dealing with the disease he can become stronger, and for whom life becomes more precious.

Cognitive rehabilitation treatment improves cognitive function and quality of life, diminishes psychosocial distress, helps family and social insertion and increases satisfaction with the treatment [18].

Conclusions

Patients diagnosed with prostate cancer adapt well to the disease, accept it and even obtain benefits from it.

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