British Journal of Psychiatry (1989), **155**, 98–100

Liaison Psychiatry in a Breast Cancer Unit

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"The first 50 referrals to a newly established liaison psychiatry service for the breast cancer unit at Guy's Hospital, London, have been examined. The majority of referrals were for psychological reactions to malignant disease; most of these were mood disturbances. Patients with sustained psychological reactions to their malignant disease were more likely to have had treatment for previous psychiatric illness and to lack a confiding relationship compared with those whose psychological reactions were transient. Teaching doctors and nurses to deal effectively with the transient psychological reactions of patients to their malignant disease is an important task of liaison psychiatry."

The summary quoted above is from an article by Ramirez (1989). The present authors were invited to comment upon the study.

Christine Dean

It is interesting to note that after several decades of research in this area, only 1.7% of breast cancer patients were referred to the new liaison service described in this study; there is considerable agreement that in the first two years following mastectomy and in patients with advanced breast cancer, 25% of women have an affective illness. The low referral rate may be because the illnesses are not very severe, and indeed the liaison psychiatrist in this study considered that only half of the referred women had an illness. Unfortunately, we do not know what factors actually determined referral, because there are no data on the base population of 3000 women.

The psychological morbidity of mastectomy was first described by Renneker & Cutler (1952). In my own research (Dean, 1987), most of the illnesses following mastectomy were found to be minor affective illnesses; a year after mastectomy, only 5% had an illness which a psychiatrist would regard as severe enough to require treatment. Many of the women did not regard themselves as ill and were not keen to be referred to a psychiatrist. Distinguishing between normal distress and illness can be quite difficult – a problem which is also encountered following bereavement, and which does not seem to have been very satisfactorily resolved in the Ramirez study. It would seem undesirable for 25% of women who have breast cancer to be referred to a psychiatrist, thereby adding the stigma of being a psychiatric patient to their already distressing circumstances. The use of a nurse counsellor and referral to a general practitioner would be a much better option in the majority of cases.

It could be thought that the recent moves to treat early cancers with breast conservation rather than mastectomy might remove the need for a counselling service. However, preliminary findings (Fallowfield *et al*, 1986) indicate that women whose breasts are conserved have rates of morbidity as high as women who have a mastectomy; the diagnosis rather than the treatment seems to be the main cause of distress.

As well as the desire to improve the quality of life of cancer patients by treating their psychiatric morbidity, there is recent interest in the fact that psychological factors may play a role in recurrence and death in breast cancer patients. The most influential study in the field of breast cancer is that by Greer's group (Greer *et al*, 1979; Pettingale *et al*, 1985). In an unselected series of 57 women with early breast cancer, they found that those who were coping at three months after operation with an attitude of fighting spirit or denial had a better chance of disease-free survival than those coping with a strategy of hopelessness or helplessness and stoic acceptance. I have myself just completed a study of an unselected series of 127 women with early breast cancer, which found that women who showed much distress before operation and those who coped with an attitude of denial three months after operation both had a greater chance of disease-free survival. This was after physical determinants of outcome, such as histological node status, tumour size, and treatment of the cancer had been taken into account. There have also been studies which have included patients at all stages of the disease. Jensen (1987) found that poor prognosis was associated with reduced expression of negative affect and with an attitude of helplessness and hopelessness; staging at initial diagnosis was controlled for in this study. Hislop *et al* (1987), in a well designed study of 127 patients with breast cancer, found that high extraversion, low anger, and high levels of social contact at home were all related to better survival. On the whole, studies of patients

with advanced breast cancer (Cassileth *et al*, 1985; Holland *et al*, 1986) have found no relationship between psychological factors and survival.

Taking the evidence so far, there does seem to be some support for the view that psychological factors can influence recurrence and survival, particularly in early breast cancer. The consensus appears to be that short-lived distress and expression of negative emotions at the time of diagnosis are associated with a good prognosis, while prolonged apathy and helplessness and hopelessness are associated with a bad prognosis. After the initial adjustment to the cancer, an attitude of fighting spirit or denial is associated with a good prognosis, as is good social support. It is possible that such support facilitates the expression of distress and results in its resolution, producing a more positive response to the cancer and to the resumption of a normal lifestyle. The paper by Dr Ramirez confirms that the patients with a prolonged psychiatric illness were less likely to have a confiding relationship.

There are a few immunological studies which have examined the association between psychological factors and immunological parameters, as this is one way in which psychological factors may be mediated. Levy *et al* (1985) found that when women were assessed within one week of mastectomy, those who were more distressed and maladjusted had higher natural killer cell (NK) activity, and that high NK activity was associated with good outcome in patients with breast cancer. Pettingale *et al* (1981) found that women who were coping with a strategy of denial three months after operation had higher IgM activity than those responding with fighting spirit or stoic acceptance. The group with fighting spirit had significantly lower levels of IgG than those who showed stoic acceptance. They speculate that psychological responses could influence the patient's immune response by increasing non-complement-fixing antibodies (including IgG2 and IgG4), which could act as blocking factors and prevent the destruction of tumour cells or enhance the production of strongly complement-fixing antibodies (of which IgM is one), which would increase destruction of tumour cells.

This area of study is as yet in its infancy, but if studies continue to confirm the contribution of psychological factors to outcome, then the role of psychiatric liaison services and counselling will become an important part of the treatment of breast cancers and probably other cancers as well. On the basis of current evidence, it would be necessary to have a counselling service which would allow the patients to express their current distress, would help the patient to marshal good social support, and would refer for psychiatric treatment patients who had persistent apathy, hopelessness, and helplessness.

Penelope Hopwood

Dr Ramirez draws our attention to many important issues in her review of this clinical liaison service. However, she acknowledges one weakness in her paper – the lack of clarity or precision over the definition of psychiatric illness. Although this may seem a glaring fault, I can sympathise with the author because she is reflecting the state of the art in this field. To date, several different criteria have been used to describe psychological morbidity even in well designed, carefully conducted research studies (Morris *et al*, 1977; Devlen *et al*, 1987; Dean, 1987), so where does the pragmatic psychiatrist set the threshold? It may be straightforward to discriminate 'case' depression, but less easy to set the lower limit for 'borderline' depression, particularly when distress is deemed understandable.

A problem in using the 'distress' and 'illness' categories, as described in this paper, is that it is unclear how certain the classification is at the time of assessment, since length/mode of intervention is used to describe it. A firmer basis, including symptom profile, duration of symptoms, and interference with normal function, would need to be applied to any intervention study in these groups of patients.

Dr Ramirez suggests that many of the patients who were referred close in time to receiving bad news had unmet needs. While this may be true, it may also reflect the nature of the referral pattern, since it is possible that medical and nursing staff are more aware of the likelihood of distress in this context, and more likely to pass the buck. She omits to examine the relevance of the quality of doctor–patient communication in this context – an area we know little about. The theory that sensitive, clear communication, delivered with support from the professionals, would result in less distress on behalf of the recipient warrants testing. She is right to consider directing her training skills to the carers who could then deal with this distress, but it is also possible that some transient reactions will resolve without intervention, and research is badly needed to clarify this question. Vulnerability to psychiatric illness, mild or marked, is also an area to which Dr Ramirez correctly draws our attention, and it is interesting that predictive factors begin to emerge, even with these small numbers. However, the literature on this area is still confusing, and more detailed studies are required. What is it about a confiding relationship that is protective? Can patients

be helped to develop such ties when they are absent? Is there a circular relationship – in other words, does depression damage a confiding liaison? How do life events other than the cancer illness interplay in the aetiology of psychological disturbance? We look forward to good research studies from both Dr Ramirez and others to start to answer many of the questions she has raised in this deceptively straightforward account.

References

CASSILETH, B. R., LUSK, E. J., MILLER, D. S., *et al* (1985) Psychosocial correlate of survival in advanced malignant disease? *New England Journal of Medicine*, **312**, 1551–1555.

DEAN, C. (1987) Psychiatric morbidity following mastectomy: preoperative predictors and types of illness. *Journal of Psychosomatic Research*, **31**, 385–392.

DEVLEN, J., PHILLIPS, P. & CROWTHER, D. (1987) Psychological problems associated with the diagnosis and treatment of lymphomas. I. A retrospective study. II. A prospective study. *British Medical Journal*, **295**, 953–954, 955–957.

FALLOWFIELD, L. J., BAUM, M. & MAGUIRE, G. P. (1986) Effects of breast conservation on psychological morbidity associated with diagnosis and treatment of early breast cancer. *British Medical Journal*, **293**, 1331–1334.

GREER, S., MORRIS, T. & PETTINGALE, K. W. (1979) Psychological response to breast cancer: effect on outcome. *Lancet*, *ii*, 785–787.

HISLOP, T. G., WAXLER, N. E., COLDMAN, A. J., *et al* (1987) The prognostic significance of psychosocial factors in women with breast cancer. *Journal of Chronic Diseases*, **40**, 729–735.

HOLLAND, J. C., KORZUN, A. H., TROSS, S., *et al* (1986) Psychosocial factors and disease free survival (DFS) in stage II breast carcinoma. *Psychosocial Aspects of Cancer*, **5**, 237.

JENSEN, M. R. (1987) Psychobiological factors predicting the course of breast cancer. *Journal of Personality*, **55**, 317–342.

LEVY, S. M., HEBERMAN, R. B., MALUISH, A. N., *et al* (1985) Prognostic risk assessment in primary breast cancer by behavioural and immunological parameters. *Health Psychology*, **4**, 99–113.

MORRIS, T., GREER, S. H. & WHITE, P. (1977) Psychological and social adjustment to mastectomy. *Cancer*, **40**, 2381–2387.

PETTINGALE, K. W., MORRIS, T., GREER, S., *et al* (1985) Mental attitudes to cancer: an additional prognostic factor. *Lancet*, *i*, 750.

RAMIREZ, A. J. (1989) Liaison psychiatry in a breast cancer unit. *Journal of the Royal Society of Medicine*, **82**, 15–17.

RENNEKER, R. & CUTLER, M. (1952) Psychological problems of adjustment to cancer of the breast. *Journal of the American Medical Association*, **148**, 833–838.

PETTINGALE, K. W., PHILALITHIS, A., TEE, D. E. H., *et al* (1981) The biological correlates of psychological response to breast cancer. *Journal of Psychosomatic Research*, **25**, 453–458.

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