

Predicting psychological distress in patients with leukaemia and lymphoma

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Abstract

This study examines the relationship between coping style, quality of life (QOL) and psychological distress in a sample of patients with leukaemia and lymphoma. Fifty-one consecutive in-patients, day cases and haematology out-patient attenders entered the study and completed a 10-item self-report questionnaire, the Hospital Anxiety and Depression Scale (HADS), the Mental Adjustment to Cancer Scale (MACS) and the Schedule for the Evaluation of Individual Quality of Life (SEIQOL). Fifty-one percent of patients reached caseness for moderate distress. Fourteen percent of patients reached caseness for severe distress.

Twenty-seven percent of patients were identified as having adjusted poorly to their diagnosis having low scores on the Fighting Spirit subscale of the MAC and high scores on the Hopeless/Helpless subscale. There was a significant association between patients who scored highly on the HADS and dissatisfaction with the information provided. Use of a logistic regression model showed that those patients most likely to be suffering from severe psychological distress were those with a worse coping style, measured by MAC. The clinical implications of these findings are discussed. © 2003 Elsevier Science Inc. All rights reserved.

Keywords: Lymphoma; Leukaemia; Psychological distress; Coping style; Quality of life

Introduction

Patients undergoing treatment for haematological malignancies suffer from high levels of undetected anxiety and depression [1]. In long-term survivors of leukaemia and lymphomas, high levels of anxiety persist for long periods after chemotherapy when exposed to a reminder of their treatment [2]. Increasingly, very intensive treatments are being proposed especially allergenic or autologous bone marrow transplant (BMT) in young adults. Psychological adaptation to such treatments is highly individual, but a proportion of patients will experience a marked deterioration in quality of life (QOL) and/or will develop clinical depression [3]. Around 35% of patients, during the induction and consolidation phase of treatment, have been found to have high levels of anxiety and depression [4]. In nonhaematological malignancy between 25% and 33% of

cancer patients develop an anxiety disorder or major depression [5], while some studies cite rates of depression at around 50% [6]. The development of depression among cancer patients has been shown to have clear effects on increased amount of pain reported [7] and increases the likelihood of dropping out of treatment [8]. In addition, an association between depression, altered immunity and thus lowered survival rates has been suggested by a number of studies [9,10]. Colon et al. [11] found that depressed mood before bone marrow transplantation in patients with acute leukaemia was one variable that was associated with poor survival outcome. Despite depression being a relatively common and clinically important comorbid illness within this patient group little attention has been paid to those factors that may predict its onset. It would be of value to identify those patients most at risk of developing depression and anxiety so that appropriate interventions can be targeted upon them. Therefore, the present study aimed to identify patient and treatment factors most strongly associated with severe psychological distress with a view to developing preventative therapeutic interventions for those most at risk.

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Method

This study was a cross-sectional descriptive study of consecutive in-patients, day cases and haematology out-patient attenders in the oncology department of the Royal Devon and Exeter Hospital. The study was conducted over a 4-month period in 1998.

For each patient, we obtained from the notes age, sex, diagnosis, time from diagnosis, type of treatment, whether the patient had been in isolation and if so how long. Patients were asked if they lived alone or with a partner. All patients who agreed were seen by one of us (C.M. or K.T.) and a 10-item questionnaire completed covering aspects of their treatment and satisfaction with information given.

Patients were then asked to complete two self-report questionnaires: the Hospital Anxiety and Depression Scale (HADS) [12] and the Mental Adjustment to Cancer Scale (MAC) [13]. The HADS is a 4-point, 14-item self-assessment questionnaire, which has been found to be a reliable and valid method of measuring the severity of psychiatric morbidity in medical patients [14,15]. For screening for distress and probable mild to moderate depression, a total cut-off score of 13 was used. For screening for severe distress and probable major depression, a total cut-off score of 19 was used, based on the work of Razavi et al. [16]. The MACS is a 40-item scale, which is used as a measure of the predominant coping style employed by people with cancer and scores are derived in five domains: Fighting Spirit, Helpless/Hopeless, Anxious Preoccupation, Fatalism and Avoidance. In addition, patients underwent a 10-min semi-structured interview for the administration of a novel QOL measure, the Schedule for the Evaluation of Individual Quality of Life (SEIQOL) [17]. The SEIQOL has been devised as a measure that avoids the imposition of an external value system on individuals when quantifying their QOL. It is a measure that allows patients to describe their lives in terms of those factors, which they consider important and has been shown to be a reliable and valid technique for measuring individual QOL [18].

Comparison of means were conducted using *t* tests or ANOVA as appropriate. Odds ratios were derived from 2×2 tables and for examination of univariate associations. Multivariate analysis was performed using a logistic regression model. In this analysis, three (presence/absence) dummy variables were constructed to represent the categorical treatment variable. Monitoring and oral chemotherapy were combined as the reference category, thereby providing three levels to this variable.

Results

Sociodemographic and clinical characteristics

Fifty-seven patients were approached and six patients declined to be interviewed. The mean age of our study

population was 54 years (S.D. 17.01 years, range 19–79). Thirty-six (70.6%) were male. Most ($n=43$, 84%) were in a relationship.

One-third of patients interviewed were within 6 months of diagnosis (range 1 month to 8 years). In terms of treatment, 7 (13.7%) were being monitored only, 5 were receiving oral chemotherapy, 23 (45%) were receiving out-patient intravenous chemotherapy and 16 (31.4%) were receiving inpatient intravenous chemotherapy. The majority of patients ($n=40$, 78%) were happy with the information they had received about their illness.

Forty-seven percent of patients ($n=24$) had spent time in isolation with the mean total time in isolation being 29 days (range 2 days to 16 weeks). Sixty-three percent ($n=15$) of those who had been in isolation found this tolerable.

HADS scores

Fifty-one percent (26 of 51) of patients reached caseness for distress and probable mild to moderate depression on the HADS using a cut-off total score of 13. Nearly 14% (7 of 51) of patients reached caseness for severe distress and probable major depression on the HADS using a cut-off score of 19.

MAC scores

Twenty-seven percent (14 of 51) of patients reached caseness for poor mental adjustment to their illness. Cases were defined as individuals with a score of 47 or less on the Fighting Spirit subscale in combination with a score of 12 or more on the Helpless/Hopeless subscale (after the work of Watson, Greer and Bliss, 1989) [19].

SEIQOL scores

The mean SEIQOL score was 70.19 (range 20.2–94.3, possible range 0–100). Respondents ($n=26/51$) who were cases on the HADS (HADS > 13) were significantly more likely than noncases to report they were dissatisfied with the information they had received (O.R. = 0.16, C.I. = 0.02–0.97). For cases (HADS > 13), 9 out of 26 patients were dissatisfied with the information provided; for noncases, 2 out of 25 were dissatisfied with the information provided. This association was stronger for those respondents ($n=7/51$) who scored > 19 on the HADS (Fisher two-tailed *P* value = .03). For cases (HADS > 19), 4 out of 7 patients were dissatisfied with the information provided; for noncases, 7 out of 44 patients were dissatisfied with the information provided.

HADS-positive respondents (at a threshold of 19) were significantly more likely to report they wanted more time to talk about their diagnosis and treatment (Fisher two-tailed *P* value = .03); for cases (HADS > 19), 5 out of 7 wanted more time to talk; for noncases, only 12 out of 44 expressed this.

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