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Diagnostics and psychological help in anxiodepressive disorder in patients with oncological diseases (literature review)

Relevance: *Anxiety and depression are quite common with cancer diseases. Up to half of all cancer patients show the symptoms of these disorders, which complicate the course and prognosis of the underlying disease. The combination of anxiodepressive disorder with cancer in cancer patients can increase the risk of death from malignant neoplasms and suicide.*

In many cases, anxiety disorders are caused by the emotional reaction to the diagnosis, complex treatment, concern about possible relapses, and the potential threat of death. The possibility of relapse, often observed in patients with malignant disease, significantly increases the risk of developing anxiodepressive disorder. The dependence of the frequency of mental disorders on the severity of the diagnosis of «Cancer» is variable. Meanwhile, the anxiodepressive disorder is often not recognized as a specific pathology that requires special attention and adequate long-term therapy, which leads not only to a chronic outcome of mental disorders but also, possibly, adversely affects the prognosis of cancer.

Purpose of the study: *to review and analyze the literature on the problem of anxiodepressive disorder in psycho-oncology.*

Results: *Particular attention is paid to the aspects of classification and staging of anxiodepressive disorder, to diagnostical issues and the effectiveness of modern methods of psychological assistance for anxiodepressive disorder in cancer patients. The results of using the methods of psychotherapy in the complex treatment of cancer patients are presented.*

Conclusion: *Further investigation of urgent issues of diagnosis, psychotherapy, and prevention of anxiodepressive disorder in cancer patients requires integrated scientific and practical activities of cancer psychologists, psychiatrists, and psychotherapists.*

Keywords: *depression, anxiety, comorbidity, symptoms, anxiodepressive disorder, treatment.*

Introduction: Anxiety and depression are the two most common human responses to stress. They are combined in 23-87% of cases [1]. According to the World Health Organization (WHO), over 300 million people worldwide suffer from these disorders [2]. Anxiodepressive disorder can occur at any age and is associated with a less favorable course compared to anxiety and depression separately.

The studies of the relationship between anxiety and depression follow three conceptual models. The pluralistic model considers depressive and anxiety disorders as separate and fundamentally different disorders. The unitary (unified) model considers these disorders as variants of the same disease, which differ more in quantity than in quality. The combined model addresses exceptional cases when both syndromes are present, distinguishing it from the cases when "pure" anxiety or "pure" depression are present [3].

In cancer patients, anxiety is the main component of their stressful psycho-emotional state. The severity of this symptom serves as the main guideline when assessing the nature and strength of the patient's psychogenic response to the action of the stressor (establishing cancer diagnosis). The peculiarity of the anxiety state is in the fact that it largely determines the patient's internal, subjective attitude to the illness, "the internal picture of the disease" [4].

Depressive disorders in cancer patients have been the subject of research within several decades. Numerous studies have shown several adverse effects of depression, such as increased suicidal risk, decreased quality of life, reduced survival time, poor patient compliance, and increased length of hospital stay [5].

Depressive mood and pathological anxiety are often interrelated. The reduced mood is often combined with anxious tension. The most typical is the simultaneous manifestation of mood disorders and anxiety disorder. Comorbidity is spoken in such cases [6].

Anxiety disorders can be caused by an emotional reaction to the diagnosis, the complicated treatment, the concerns about possible relapses, and the potential threat of death. The possibility of relapse, often observed in patients with a malignant disease, significantly increases the risk of anxiety disorder development. The dependence of the frequency of mental disorders on cancer severity is variable. Moreover, many authors note a decrease in the incidence of depression in the terminal phase, while the incidence of anxiety disorders increases steadily. Both anxiety and depression, which are often in co-morbidity, can affect the progression rate and the mortality rate. More research is required to identify the real impact of anxiety disorders on the cancer course [7].

According to epidemiological studies, almost half of cancer patients show somatogenic, psychogenic, or combined mental disorders [8]. Such combined forms of diseases require an integrated approach to diagnostics and treatment with the involvement of a psychiatrist, a psy-

chotherapist. In practice, a psychiatrist's consultation in an oncology clinic is reduced to the provision of emergency care to patients with distinct psychotic conditions – somatogenic, reactive ones. Border-line disorders are usually not diagnosed and stay ignored [9]. Patients with malignant neoplasms most often have border-line anxiodepressive disorders [10]. The depression of varying severity is detected in 20-30% of cases (1-77%) [11]. Various authors report anxiety symptoms in 24-38% of patients [12]. Besides, anxiety and depression often form mixed conditions presented in 9.3-20.2% of cases of different cancers [13].

Concomitant anxiodepressive disorders have a negative impact on the course and prognosis of the underlying disease. They reduce the compliance to treatment, the efficacy of chemotherapy, inhibit the regression of the tumor process, prevent the restoration of a comorbid level of social adaptation, and increase the likelihood of suicide and early death [14].

Despite the wide occurrence of anxiety and depression in oncological diseases, their detection and therapy remain a challenge mainly because cancer centers do not possess developed algorithms to verify border-line mental diseases and a ready service model to provide psychiatric and psychological care to the patients [15].

Materials and Methods: Anxiodepressive disorder does not have own classification code. ICD-10 attributes it to stress-associated neurotic disorders, as well as somatic disorders. Independent depressive and anxiety disorders are considered mood disorders [16].

Isolated anxiety or depression in cancer patients are manifested by individual symptoms of these affective disorders; in mixed anxiodepressive disorder, these symptoms are combined. The signs of **anxiety disorder** are:

- a sense of panic and fear;
- insomnia;
- increased sweating;
- tingling sensation in arms and legs;
- shortness of breath;
- rapid pulse;
- muscle tension;
- irritability, dizziness, etc.

The signs of **depressive disorder** are:

- mood depression;
- a sense of hopelessness;
- feeling of tiredness;
- lack of desires and interests;
- difficulty in concentrating;
- low self-esteem;
- feeling of guilt;
- futurocracy, etc.

The **three stages** of anxiodepressive disorder are:

I. Increased sensitivity, irritability, minor anxiety, fatigue, insomnia.

II (psychosomatic stage). Somatic manifestations (muscle pains, abdominal pains, chest pains, dizziness, palpitations, etc.), growing anxiety.

III. Intensification of manifestations described in the previous two stages, growing anxiety, decreased self-esteem, apathy for everything, depressed mood.

The detection of affective pathology is complicated by the fact that some symptoms of cancer and depression coincide, such as weight loss, loss of appetite, anergy, and asthenic symptoms. The reasons for underestimating the anxiodepressive states in cancer patients are also the low awareness of patients and their families about the symptoms of mental disorders and the increased risk of their occurrence in cancer pathology [17].

It is important to distinguish between anxiodepressive disorder and individual anxiety and depressive diseases:

- depressive episode - predominantly pronounced depression symptoms;
- generalized anxiety disorder - predominantly pronounced anxiety symptoms;
- somatoform disorder - severe somatic disorders;
- bipolar disorder - alternating phases of mania and depression;
- mental and behavioral disorders caused by alcohol or drug use.

It is worth to remember that the quality of everyday life decreases more significantly in people suffering from anxiodepressive disorder in comparison to independent disorders; their psychosomatic manifestations are more pronounced and the risk of suicidal tendencies is higher [18].

The Depression Scale of the Center for Epidemiologic Studies and the Hospital Anxiety and Depression Scale (HADS) scale are recognized as the most adequate, sensitive, ultrashort instruments for screening and monitoring of anxiodepressive disorders in cancer patients. The analysis of the discriminant validity of HADS has demonstrated its advantage over other psychometric scales [19]. HADS contains two subscales (7 items each) to assess the anxiety and depression symptoms. The manifestation of the severity of symptoms is scored 0 to 21. Score 8 to 10 indicates the presence of border-line anxiety or depression; scores above 10 indicate clinically significant anxiety and depression. HADS is the most convenient self-questionnaire to screen affective and anxiety disorders in somatic patients [20]. The inclusion of this scale into routine examinations of cancer patients can help to diagnose emotional disorders in outpatient and in-patient practice [21].

Besides, the standard test methods are also used to diagnose anxiodepressive disorder:

- the Zung scale and the Beck depression questionnaire to detect the presence and severity of the depressive state;
- the Hamilton scale and the Montgomery-Asberg scale (to determine the degree of depression).

Results and Discussion: Cognitive-behavioral psychotherapy is recognized to be the most efficient in anxiodepressive disorders. Its advantages were noted in the treatment of depression in patients with cancer of the breast, gastrointestinal tract, brain, lungs, prostate, lymphoma, in those who received and did not receive radiation therapy [22]. A meta-analysis of six relevant studies of the effect of supportive, cognitive-behavioral and adapted problem-oriented therapy in patients with verified cancer has shown a significant decrease in the severity of depressive symptoms [23].

Rational psychotherapy, for example, in the form of a regular discussion of the problems the patient is facing, individually or in a group of patients with a similar diagnosis, has a significant therapeutic effect. The content of the session is focused on the achievements of modern medicine and the importance of an active role of the patient in achieving the outcome of any treatment [27].

Distraction therapy is widely used, including music therapy, occupational therapy. In a meta-analysis of 30 randomized controlled studies of the impact of music therapy on the psychological state of patients, it decreased pain intensity, the level of anxiety, improved the mood (but did not reduce depressive symptoms), as well as had a positive effect on QOL indicators [28].

The most stable effect is achieved by complex treatment combining psychotropic drug therapy with psychotherapeutic impact [29]. Psychotropic drugs facilitate the contact with a therapist to create conditions for maximum susceptibility of the patient to psycho-correctional work. The choice of specific psychotherapeutic methods and strategies is defined by the patient's personality, the characteristics of his disease, and clinical psychopathological manifestations. In general, cancer patients require regular, lifelong psychotherapeutic treatment [26, 30].

Conclusions: Thus, numerous studies evidence that anxiodepressive disorder remains an acute challenge in psycho-oncology. The frequency of this disorder in malignant neoplasms remains high. At the same time, the classification and stages of anxiodepressive disorder vary significantly depending on a whole range of factors, such as tumor localization, stage, and side effects of treatment.

Diagnostics of anxiodepressive disorders is an essential aspect of the organization of psychological assistance to cancer patients due to a high risk of suicide and a negative impact on the prognosis and the course of the underlying disease. The HSTD self-questionnaire and the standard test methods like the Zung scale, the Beck depression questionnaire, the Hamilton scale, and the Montgomery-Asberg scale are simple public tools for the screening for anxiety and depressive symptoms.

Various approaches to psychological correction of anxiodepressive disorders in cancer diseases are now being developed. A credible criterion of successful psychotherapy is building trust in the therapist and the patient's willingness to comply with all recommendations of the onco-psychologist. However, the primary factor is the patient's desire and intention to understand the cause of his/her disease and make the necessary adjustments.

The scientific literature analysis reveals a whole list of psychological questions still to be resolved in psycho-oncology. Psychological correction of anxiodepressive disorders in cancer patients requires the integration of scientific and practical efforts of onco-psychologists, psychiatrists, and psychotherapists.

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ТҰЖЫРЫМ

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[1]Маңғыстау облысының
Денсаулық сақтау басқармасының облыстық онкологиялық диспансері,
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Онкологиялық аурулары бар пациенттердің үрейлі-депрессивтік бұзылулары кезіндегі диагностика мен психологиялық көмек (әдебиетке шолу)

Өзектілігі: *Үрей мен депрессия онкологиялық аурулар кезінде өте қарапайым құбылыс болып табылады, бұл бұзылулардың симптоматикасы онкологиялық аурулармен ауыратын науқастардың барлығының жартысына дейін көрсетеді және негізгі аурудың барысы мен болжамын ауырлатады. Қатерлі ісік ауруларымен ауыратын науқастарда үрейлі-депрессивтік бұзылулар мен обырды ұштастыра отырып, қатерлі ісіктен және суицидтен қайтыс болу қаупі артуы мүмкін екені белгілі.*

Көптеген жағдайларда үрейлі бұзылулар диагнозға эмоциялық реакциядан, күрделі емнен, мүмкін болатын рецидивтермен немесе өлімнің ықтимал қатерінің алаңдаушылығынан туындайды. Қатерлі аурулармен ауыратын науқастарда рецидивтің болуы үрейлі-депрессивтік бұзылудың даму қаупін едәуір арттыратыны жиі байқалады. Психикалық бұзылулар жиілігінің «Қатерлі ісік» диагнозының ауырлық тереңдігіне тәуелділігі тұрақсыз. Сонымен қатар, үрейлі-депрессивті бұзылуы ерекше назар аударуды және ұзақ адекватты терапияны талап ететін ерекше патология ретінде жиі танылмай, бұл психикалық бұзылулардың созылмалы нәтижесіне ғана емес, мүмкін онкологиялық аурудың болжамына қолайсыз әсер етуі болып табылады.

Мақсаты: *психоонкологиядағы үрейлі-депрессивті бұзылулар проблемасынабайланысты әдебиеттерді шолу және талдау.*

Нәтижелер: *Ерекше назар үрейлі-депрессивтік бұзылудың жіктелуі мен даму аспектілеріне, диагностикасына аударылады, сондай-ақ психологиялық көмек көрсетудің заманауи әдістерінің тиімділігі қатерлі ісікпен ауыратын науқастарда пайда болатын үрейлі-депрессивтік бұзылуда талқыланады. Қатерлі ісік ауруымен ауыратын науқастарды кешенді емдеуде психотерапиялық әсерінің қолдану әдістері нәтижелері келтірілген.*

Қорытынды: *Қатерлі ісік ауруымен ауыратын науқастардың диагностикасын, психотерапиясын және үрейлі-депрессивтік бұзылудың алдын-алудың өзекті мәселелерін одан әрі дамыту онкопсихологтардың, психиатрлардың және психотерапевтердің ғылыми және практикалық қызметінінтеграциясын қажет етеді.*

Түйінді сөздер: *депрессия, үрей, коморбидтті, симптоматика, бұзылу, емдеу.*

АННОТАЦИЯ

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Диагностика и психологическая помощь при тревожно-депрессивном расстройстве у больных онкологическими заболеваниями (обзор литературы)

Актуальность: *Тревоги и депрессии являются достаточно обычным явлением при онкологических заболеваниях. Симптоматику этих расстройств, которые утяжеляют течение и прогноз основного заболевания, проявляют до половины всех больных онкологическими заболеваниями. Известно, что при сочетании тревожно-депрессивного расстройства и рака у больных онкологическими заболеваниями может быть повышен риск смерти от злокачественного новообразования и от суицида.*

Тревожные расстройства во многих случаях вызваны эмоциональной реакцией на диагноз, сложное лечение, озабоченность возможными рецидивами и потенциальной угрозой летального исхода. Возможность рецидива, нередко наблюдаемого у больных злокачественным заболеванием, значительно повышает риск развития тревожно-депрессивного расстройства. Зависимость частоты психических нарушений от глубины тяжести диагноза «Рак» непостоянна. Между тем, тревожно-депрессивное расстройство часто не распознаётся как специфическая патология, требующая особого внимания и длительной адекватной терапии, что ведет не только к хроническому исходу психических нарушений, но и, возможно, неблагоприятно влияет на прогноз онкологического заболевания.

Цель исследования: *провести обзор и анализ литературы по проблеме тревожно-депрессивного расстройства в психоонкологии.*

Результаты: *Особое внимание в литературе уделяется аспектам классификации и стадий развития тревожно-депрессивного расстройства, вопросам диагностики, а также обсуждению эффективности современных методов психологической помощи при тревожно-депрессивном расстройстве, развивающемся у больных онкологическими заболеваниями. Приводятся результаты использования методов психотерапевтического воздействия в комплексном лечении больных онкологическими заболеваниями.*

Заключение: *Дальнейшая разработка актуальных вопросов диагностики, психотерапии и профилактики тревожно-депрессивного расстройства у больных онкологическими заболеваниями требует интеграции научной и практической деятельности онкопсихологов, психиатров, психотерапевтов.*

Ключевые слова: депрессия, тревога, коморбидность, симптоматика, тревожно-депрессивное расстройство, лечение.