

Nutritional Problems and the Cancer Patient Psychosocial Considerations

by Susan Blacker, M.S.W., L.C.S.W.-C

Fifteen to 40 percent of patients with cancer develop problems with nutrition early in the course of their illness,¹ and substantial weight loss is experienced by more than 50 percent of patients undergoing cancer treatment.² For many, a diagnosis of cancer brings an altered relationship with food, eating, and body weight. In turn, a diagnosis of cancer can lead to high levels of concern and anxiety about food consumption and maintaining weight early

in the course of illness. Patients and their caregivers should be educated about eating problems early on, since concerns about eating may arise or be exacerbated once treatment begins.

An interdisciplinary team approach to nutritional care must include a psychological assessment as well as support and education for the patient and family. Caregiver support should be encouraged, and family involvement valued.

All team members must be sensitive to the potential for distress related to eating problems and to the fact that intervention requires the individual to engage in behavioral change. Dietary habits are influenced by many variables, including level of health consciousness, attitudes, personal taste preferences, cultural influences, and learned behaviors. Behavioral change is a complex process under any life circumstance. Helping patients and caregivers to identify barriers to making changes must be part of initial and follow-up assessments. Dialogue and structured problem-solving with the food preparer can be very effective.³ Education is a key intervention and should be provided to both the patient and caregivers to minimize distress, maximize coping and control, and allow them to participate fully in care. Relevant and appropriately written materials can be extremely useful and serve to reinforce the teaching provided by the team.⁴

The team must also be aware that more invasive nutritional interventions (forced oral, enteral, or total parenteral nutrition) can negatively affect the patient's self-image, including the sense of control over one's body, and may lead to feelings of failure for the patient or the caregiver. Artificial feeding

"Before I was diagnosed with cancer, I never really thought about what I ate, when I ate, or how I ate.

Now I worry every time I eat. And I worry even more if I don't feel like eating."

—Linda, 43, undergoing chemotherapy for lung cancer



Susan Blacker, left, discusses the importance of preparing family caregivers.

may result in increased demands on the patient's caregiver. Here again, appropriate education of the patient or primary caregiver is essential. A home health care nurse can ensure that the patient/caregiver is properly using equipment and is educated about potential problems.³ However, the expense of these interventions and the financial burden they place on those who may not have comprehensive insurance coverage must be considered.

When assessing the patient who has cancer and eating problems, the team should consider potential psychological and social variables. Depression and anxiety are common symptoms in patients with cancer. Although the literature on the prevalence of depression and anxiety among patients with cancer varies, many clinicians assert that patients who are hospitalized and those who experience distressing symptoms (such as pain) or who have advanced cancer are more likely to be depressed.⁶ The diagnosis of depression and anxiety in cancer patients is complicated by the reality that many patients experience somatic symptoms (e.g., anorexia, weight loss, abdominal distress) not related to psychological problems. Clinicians, therefore, must look closely at the cognitive symptoms of depression and anxiety to accurately diagnose the problem.^{5,6} Both depression and anxiety must be addressed and treated; psychological distress should not be considered an unavoidable consequence of a cancer diagnosis.⁶

Social isolation may also be a contributing factor to poor nutrition. The patient who lives alone with minimal social supports is potentially at increased risk. Physically managing the task of shopping for food or preparing meals may be difficult. Those patients without a committed primary caregiver may lack the encouragement and monitoring that are useful when special dietary guidelines must be adopted. As part of a global assessment, the team should review the patient's social supports and then consider referrals to agencies that may be able to assist those requiring home-based assistance. The team's social worker can be valuable in assessing and developing a plan to manage these psychological, social, and financial problems.

ISSUES OF ADVANCED CANCER

Cancer cachexia and anorexia are closely associated with the dying process. At the end of life, patients may develop additional symptoms (such as weakness, shortness of breath, pain, or nausea and vomiting) further complicating the individual's difficulties with eating or swallowing. While decreased intake and appetite are common and expected at the end of life, family members may be frightened and confused seeing their loved one's deteriorating condition.

Often the impact of eating difficulties for the patient's family members is not acknowledged. Within most families, feeding a loved one when he or she is ill is an expression of love and caring. When a patient cannot eat, caregivers often experience a sense of helplessness and even desperation. The perception of the patient being able to eat but declining to do so can become a source of conflict in the caregiver-patient relationship.

Often when this conflict and distress arise, family members raise questions about invasive nutritional interventions that can be offered. The limitations and prob-

lems of artificial nutrition for patients with advanced cancer are well documented.^{1,2,5,7} Patients with advanced cancer are not likely to benefit from the use of either a feeding tube or parenteral nutrition.⁵ Because the patient or family may find it difficult to accept this lack of an alternative, caring and skillful communication and explanation by members of the oncology care team are required. Compassionate dialogue at earlier points in the disease process will help the patient and family adapt.

A CASE STUDY

Addressing nutritional problems at the end of life is a complex process. The following case highlights the impact of family perceptions, emotional responses, and the influence of past experiences on the decision-making process and coping. The importance of patient-family and team-patient-family communication is underscored, as is the importance of patient *and* family education about cancer cachexia and anorexia and the role of support.

Robert G., a 58-year-old man, was admitted to the hospital for intractable nausea and vomiting. Eight days later he was unresponsive and dying from metastatic colon cancer. His family members angrily asked his nurse: "Why isn't he being fed? How can you starve him like this?" This reaction surprised her, as he obviously had been struggling with his symptoms of advanced cancer for some time.

Robert's nurse spoke with his caregivers and learned that they suspected that he had not informed his family of the extent of his cancer prior to this hospitalization. He and his physician had also never discussed his thoughts, worries, or wishes about the end of his life. Robert had always come to his appointments alone, even when he was visibly not feeling well.

The social worker learned that Robert's wife had been very concerned about his weight loss. She had been encouraging him to eat and preparing only his favorite meals. He dismissed her concerns and even became angry with her at times. She felt helpless and now, seeing him wasted and unable to respond, blamed herself. Their three adult children were equally frustrated and perceived that their father was wasting away without appropriate nutritional intervention.

At the beginning of his hospitalization, Robert had clearly told his physician that he did not want his life to be prolonged by any means, including invasive nutritional interventions. Unfortunately, he did not discuss his wishes with his family, and slipped from consciousness two days later, further complicating the situation.

The team (physician, nurse, social worker, and dietician) met to decide how to optimally support Robert's family. They held a family meeting to provide them with an opportunity to receive information about his cancer, how it had progressed, and an explanation of the symptoms they had noticed. They shared information about their father's expressed wishes about his code status and nutrition and explained that the decision was in keeping with good palliative and supportive care. Robert's wife expressed enormous relief when the team explained that Robert's lack of appetite was normal and that even if he had eaten more or received invasive nutritional support, it would not have changed the outcome of his disease.

Robert died, comfortably, surrounded by his family, two days later.

After Robert's death, the team identified a number of areas that could have been addressed to provide interventions earlier in his care. These included: 1) initiating earlier discussions with him and his family members about his advancing cancer and what symptoms to expect, including cachexia and anorexia; 2) encouraging him to articulate his wishes and concerns to his health care team and his family, including those related to artificial nutrition and hydration; 3) making attempts to educate Robert about the importance of involving his family and offering support and education for them; and 4) referring Robert to a hospice program. 📄

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