Psychiatric Disorders in Patients Who Lost Family Members to Cancer and Asked for Medical Help: Descriptive Analysis of Outpatient Services for Bereaved Families at Japanese Cancer Center Hospital

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Objective: There have been no previous studies about consultation of the bereaved who have lost a loved one to cancer and ask for medical help. The aim of this study was to investigate their basic characteristics and their psychiatric disorders.

Methods: A retrospective study using clinical and background data obtained over 30 months (from April 2007 to September 2009) was conducted at outpatient services for bereaved families at the Department of Psycho-Oncology at Saitama Medical University International Medical Center, Japan.

Results: During the period of investigation, 51 patients underwent consultation. The patients were frequently female (P < 0.0001) and the spouse of the deceased. Regarding the psychiatric diagnoses, major depression was the most common (39%), followed by adjustment disorders (28%).

Conclusions: This study revealed basic characteristics and psychiatric disorders of the bereaved who asked for medical help. Most of the patients were women (86.3%) and 86.3% of them received a psychiatric diagnosis. This information is important for both physicians and psychologists since the bereaved who have lost a loved one to cancer often ask for medical help in clinical settings.

Key words: cancer – bereaved family – consultation – psychiatric diagnosis – retrospective study

INTRODUCTION

Cancer is a disease that is increasing the awareness of mortality among the Japanese. This is due to the fact that one out of three Japanese dies of cancer, which has been the most common cause of death since 1981, and that there has been an increase in the number of fatalities (1). Not only patients but also their family members are affected by cancer. There have been several studies about the psychiatric consultation of cancer patients (2–5) and relatives of cancer patients (6,7) from the view of psycho-oncology. These studies suggest that cancer patients and their families suffer from physical and psychiatric disorders.

If a patient dies, the ‘family of the patient’ becomes a ‘bereaved family’. The death of a person (spouse or close relative, in particular) is a stressful event in life (8). Bereavement, defined as ‘other conditions that may be a focus of clinical attention’ by the Diagnostic and Statistical Manual of Mental Disorders, 4th edn (DSM-IV-TR), of the American Psychiatric Association (9), from a medical viewpoint, is known to cause a variety of physical and mental disorders as well as increased mortality.
A study reported a 40% increase in mortality, of which 75% was due to heart disease, among males aged 54 years or older within 6 months of a wife’s death (10). There has also been a report of increased mortality in females within 3 months of them losing their husbands (11). Other studies have also demonstrated high mortality rates in those who experience the death of a spouse (12,13).

As for physical disorders, there have been reports of heart trouble and high blood pressure, which can increase the risk of many different physical illnesses (14,15).

As for behaviors, around one-third of widows reported drinking alcohol for relief of grief (16), whereas changes in smoking habits and eating habits have also been reported (14).

As for psychiatric and psychological effects, an increased risk of suicide within 1 year of losing a loved one has also been reported (17–19). In a survey of the prevalence of depression after bereavement reported by Clayton et al., 42 and 16% of patients 1 month and 1 year after bereavement met the criteria for depression, respectively. Forty-seven percent of recently bereaved families experienced symptoms meeting the criteria for depression, while this was only 8% at 1 year and 11% overall in a control group, showing that the incidence in bereaved families was very high (20,21). It was also reported that the prevalence of depression in bereaved families was high: 24, 23, 16 and 15% at 2, 7, 13 and 25 months after bereavement, respectively (22). Furthermore, bereavement is one of the most important risk factors for depression among the elderly (23).

As already mentioned, if someone dies, people who were close to the deceased will become vulnerable to a variety of physical and psychological illnesses. Even if they undergo consultations, most patients do not name their distress over the death as a chief complaint to physicians and the relationship between their experience and the illness is often overlooked (24); therefore, appropriate help would not be provided for the bereaved when they need it.

However, the background and clinical status of bereaved families of cancer patients who ask for medical help have not previously been reported. It is necessary to describe the profiles of the bereaved who attend outpatient services for the bereaved.

The purpose of the present study was to investigate the characteristics, reasons for consultation and psychiatric disorders in patients who asked for medical help after the death of a loved one with cancer.

PATIENTS AND METHODS

Psychiatric Interventions at Outpatient Services for the Bereaved at Comprehensive Cancer Center, Saitama Medical University International Medical Center

Saitama Medical University (SMU) established a Comprehensive Cancer Center attached to the International Medical Center (IMC) and organized a cancer board. This is the first cancer center affiliated to a university hospital in Japan. The Department of Psycho-Oncology is associated with the cancer board and provides two main services, one for outpatients and one for inpatients. In addition, the Department of Psycho-Oncology provides services for psychologically distressed family members.

As mentioned above, the bereaved are vulnerable to a variety of physical and psychological disorders. Therefore, the International Medical Center, Saitama Medical University (SMUIMC), started an ‘outpatient service for bereaved families’ at the time of its establishment in April 2007, with the aim of alleviating these distresses in the bereaved. This service is designed to ‘help those who have lost a loved one to cancer live a better life’, which is in line with the concept of ‘postvention’ proposed by Schneidman (25), and ‘palliative care’ as defined by the World Health Organization (WHO). WHO has included the following in the objectives for palliative care: to offer a support system to help the family cope during the patient’s illness and in their own bereavement. The provision of palliative care increases as the person nears the end of life and includes support for the family during this entire period. After the patient dies, bereavement counseling for family and friends is also important (26). It provides outpatient services for the bereaved faced with psychological, social, physical and other problems, on the basis of the biopsychosocial model proposed by Engel (27).

The biopsychosocial model evaluates all the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone. This is the first outpatient service for the bereaved that provides psychological and social care and psychiatric treatment in Japan. This service is currently provided by two psychiatrists and two psychologists for those who have lost their spouse, parent, child or sibling to cancer.

Subjects and Procedure

We conducted a retrospective survey of people consulting the outpatient services for the bereaved of SMUIMC for 30 months between April 2007 and September 2009. Bereaved individuals were defined as first-degree relatives (spouse, parents and children) and siblings of the deceased who had died of cancer.

In this investigation, we mainly used patient background data, regarding age, gender, relationship to the deceased, cancer site of the deceased, reason for consultation, the period before consultation and psychiatric diagnosis, stored in databases, as well as we referred to medical records as necessary. Psychiatric diagnoses were evaluated according to DSM-IV-TR (9).

Statistical analyses were conducted using the SPSS 17.0 package. The differences among the data were compared by an analysis of means using \( \chi^2 \) test.

This study was approved by the Institutional Review Board of SMUIMC (08-029).
RESULTS

CHARACTERISTICS OF THE PATIENTS

During the period of investigation, 949 patients consulted the Department of Psycho-Oncology. Of these patients, 51 (5.4%) had relatives who had died of cancer, which had led them to consult bereaved family services. Their ages ranged from 17 to 76 years (mean ± SD: 51.3 ± 14.7; median: 49).

There were 7 males (13.7%) and 44 females (86.3%). There was a significant difference among the consultees between the numbers of males and females (P< 0.0001; Table 1).

The most common relationship to the deceased was as a spouse (n= 26, 51.0%), followed by parent (n= 16, 31.4%), child (n= 7, 13.7%) and a sibling (n= 2, 3.9%).

Among the background characteristics of the patients, the most common cancer site in the deceased was lung (n= 12, 23.5%), followed by pancreas (n= 7, 13.7%) and stomach (n= 6, 11.8%).

CHARACTERISTICS OF CONSULTATION

The most common reason for consultation was distress from the bereavement, which was recognized in 22 patients (62.7%). Seven patients (13.7%) wanted to talk to someone. Five patients (9.8%) needed help because they had trouble with their relatives, friends and neighbors after the death of a loved one. Three patients (5.9%) showed physical and psychiatric symptoms like insomnia and generalized fatigue. Three patients (5.9%) had difficulty in concentrating on their work (Table 2).

The mean time between the loved one’s death and the first consultation (period) ranged from 1 to 108 months (mean ± SD: 13.1 ± 22.43 months, Period: mean time between the loved one’s death and the first consultation.

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The mean time between the loved one’s death and the first consultation (period) ranged from 1 to 108 months (n= 51, mean ± SD: 13.1 ± 3.2, median: 5.0), with 24.5% of consultations being carried out within 1 month, 44.9% within the following 12 months and 22.4% within the following 24 months.

PSYCHIATRIC DIAGNOSIS

Psychiatric diagnoses of these patients are summarized in Table 3. Over 80% of the bereaved who consulted ‘outpatient services for the bereaved’ received a psychiatric diagnosis.

Major depression, the most common diagnosis, was observed in 20 patients (39.2%). It was also the most common diagnosis in consultation both within 1 year after the death and over 1 year after the death. There were no significant differences in the ratio of major depression to other psychiatric disorders with regard to the period before the start of consultation (within 1 year after the death and over...
Adjustment disorder was the next most common diagnosis and was observed in 14 patients (27.5%), and bereavement reaction was the third most common and was observed in 6 patients (11.8%). Other psychiatric diagnoses were generalized anxiety disorder (n = 2, 4.0%), post-traumatic stress disorder (PTSD) (n = 1, 2.0%), dissociative amnesia (n = 1, 2.0%) and schizophrenia (n = 1, 2.0%). Seven patients (13.7%) had no diagnosis.

Six patients (11.8%) exhibited the complication of dissociative amnesia during the treatment, with major depression (n = 2, 4.0%), adjustment disorder (n = 2, 4.0%) or bereavement reaction (n = 2, 4.0%). Three patients (5.9%) exhibited the complication of panic disorder during the treatment, with major depression, adjustment disorder and bereavement reaction (data not shown).

### Psychiatric Interventions

Thirty-one patients (60.8%) were treated with medication. The following psychotropic drugs were prescribed: benzodiazepines (n = 8, 15.7%) or antidepressants (n = 8, 15.7%) or, more frequently, the two in combination (benzodiazepines + antidepressants, n = 14, 27.5%). One patient (2.0%) was prescribed antidepressants and neuroleptics (Table 4).

Fourty-three patients (84.3%) received supportive psychotherapy, cognitive behavioral therapy or unstructured counseling as psychological intervention.

### DISCUSSION

This report provides basic information about the bereaved who have lost a loved one to cancer and ask for medical help.

We found that most of the patients who consulted ‘outpatient services for bereaved families’ at SMUIMC were women. Their characteristics are similar to those of individuals in a study of the background characteristics of relatives of cancer patients (6,7). There are several reasons why women tend to consult bereaved family services. The presence of psychosocial problems or distress is predictive of consultation behavior in women, but not in men (28). Men tend to approach the provision of support negatively even though they perceive themselves as being hurt by the death of a loved one (29,30).

The lung was the most common cancer site and the stomach was the third most common cancer site among the deceased patients; this result is consistent with the most common causes of death among men in Japan (1), reflecting the high proportion of female spouses referred to the outpatient clinic for the bereaved, and it is similar to the findings in a study of the relatives of cancer patients (6,7).

In this study, over 80% of the bereaved who asked for medical help had psychiatric diagnoses. Major depression was the most common psychiatric diagnosis, followed by adjustment disorder. This indicates that most of the bereaved who asked for medical help need psychiatric and/or psychological intervention. Treatment of major depression, especially antidepressant therapy, among the bereaved with bereavement-related depression has been identified as being effective (31). Untreated major depression after bereavement carries the extra burden of prolonging the pain and suffering associated with grief (32). Therefore, more attention should be paid to these diagnoses without dismissing them as ‘reasonable given the circumstances’ (33). Early detection and appropriate recognition of depression in the bereaved should be encouraged. In addition, adjustment disorders are

### Table 3. Psychiatric diagnoses of the patients

<table>
<thead>
<tr>
<th>Psychiatric diagnosis (multiple choices)</th>
<th>Total (n = 51), n (%)</th>
<th>The period before consultation (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0–12 (n = 34), n (%)</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>20 (39.2)</td>
<td>15 (44.1)</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>14 (27.5)</td>
<td>9 (26.5)</td>
</tr>
<tr>
<td>Bereavement reaction</td>
<td>6 (11.8)</td>
<td>5 (14.7)</td>
</tr>
<tr>
<td>Dissociative disorder</td>
<td>1 (2.0)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2 (3.9)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>1 (2.0)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Others</td>
<td>2 (3.9)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>7 (13.7)</td>
<td>4 (11.8)</td>
</tr>
</tbody>
</table>

*Psychiatric diagnosis is defined by DSM-IV (9).

### Table 4. Psychiatric intervention

<table>
<thead>
<tr>
<th>Psychiatric intervention (multiple choices) (n = 51)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotropic medication</td>
<td>31 (60.8)</td>
</tr>
<tr>
<td>Psychological intervention</td>
<td>43 (84.3)</td>
</tr>
</tbody>
</table>

1 year (P = 0.24). Adjustment disorder was the next most common diagnosis and was observed in 14 patients (27.5%), and bereavement reaction was the third most common and was observed in 6 patients (11.8%).

Other psychiatric diagnoses were generalized anxiety disorder (n = 2, 4.0%), post-traumatic stress disorder (PTSD) (n = 1, 2.0%), dissociative amnesia (n = 1, 2.0%) and schizophrenia (n = 1, 2.0%). Seven patients (13.7%) had no diagnosis.

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often responsive to psychological interventions and positive changes in medical status. The distress that these subjects complained at consultation was not only about their loss, but also from another distress that was an offshoot of the death. This might also be a cause of these psychiatric disorders.

Some patients developed dissociative amnesia in addition to other psychiatric symptoms. Dissociative disorder was not recognized in a previous study of the bereaved who had lost a loved one to cancer. Similar symptoms are included in the criteria for the diagnosis of PTSD, such as an inability to recall an important aspect of the trauma (9). However, six patients did not fulfill the diagnostic criteria for PTSD. They suffered from the symptoms of dissociative amnesia because they could not remember certain things even though they wanted to, which could make them grieve even more. Further studies of dissociative amnesia in the bereaved might be required.

This study has several limitations. First, it was only conducted at one institution, the Comprehensive Cancer Center, and so institution bias may be a problem. Second, this study covered only 51 cases where bereaved family services were used. Further studies are necessary to investigate the findings in more detail. Third, this study was a retrospective study. A prospective study is necessary for more detailed investigation.

In conclusion, we investigated basic characteristics and psychiatric disorders among the bereaved who have lost a loved one to cancer and asked for medical help, using the DSM-IV criteria. The observations that most of the patients who consulted ‘outpatient services for the bereaved’ were women and over 85% of the patients received a psychiatric diagnosis are important findings. Almost 40% of the diagnoses involved major depression, which is highly responsive to pharmacologic interventions in psychiatric populations. Additionally, about one-third of the diagnoses were adjustment disorders, which are often responsive to psychological interventions and positive changes in medical status. This information is important for both physicians and psychologists since the bereaved who have lost a loved one to cancer often consult and ask for help in clinical settings. In addition, we have to improve our ability to screen for and recognize these factors among the bereaved at an early stage. The present results revealed that appropriate care is necessary for the bereaved who have lost family members to cancer and ask for medical help, and we have to recognize them in clinical settings.

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Conflict of interest statement
None declared.

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