

図② Study Day（症状マネジメントを学ぶ）の一場面

に担当することもある。

#### d. 第4ステップ

一人のスタッフとして十分機能できるようになると、指導的立場に立つことが期待される。臨床の場でのリーダーシップの発揮とともに、院内の学習会において、講師役となって他のメンバーを対象に講義をするという体験をもつ。講義を自ら準備し、教えるという行為が学習に対する主体性を育てていく。図②は、Study Dayとよんでいる症状マネジメントを学ぶ院内の学習会で看護師が講師役を務めている一場面である。受講者は看護師だけでなく、テーマに応じて、医師、栄養士、薬剤師、ソーシャルワーカーなども参加し、学びの場を共有する。また、新人オリエンテーション、研修生への講義、さらに、教育研究所主催の外部向けのホスピス講座での講義など、各自の成長にあわせて、それぞれの専門領域に関する講義を担当するようになっていく。

#### e. 第5ステップ

院内のスタッフ同士の学びにとどまらず、近隣病院の医療スタッフを招いて研究会を開催する。各病院からの話題提供、互いの意見交換を通して、学習の場が地域の医療関係者とのネットワークづくりの機会にもなる。また、看護師の場合、この

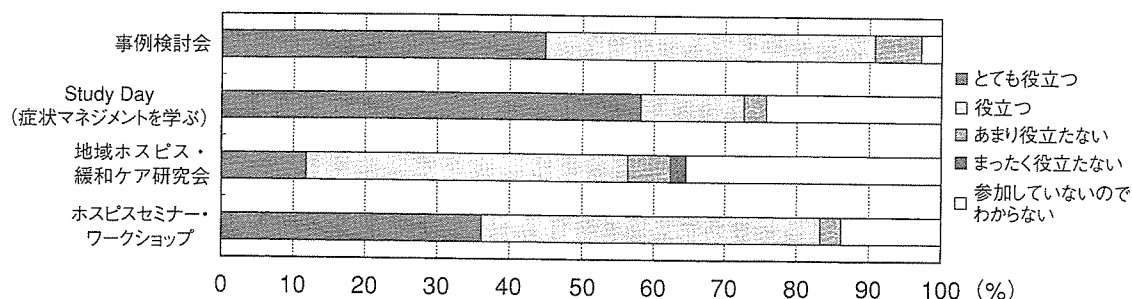
段階になると、訪問看護ステーションにおける在宅ケアの実際を研修する機会が与えられ、地域との連携について実践を通して学ぶこととなる。

こうしたプログラムと並行して、病院に併設されたホスピス教育研究所が年数回、外部から講師を招いてホスピス・緩和ケアに関連したセミナーを開催しており、スタッフは無料で参加できるようになっている。また、外部の研修会や学会に参加することが奨励され、個人の関心や成長レベルにあわせて学会での発表など、研究活動への支援も少しずつおこなわれている。

### 3) 委員会活動を通しての学び

当院における教育プログラムは上述したように、チェックリストを用いての自己学習、講義、ディスカッション、事例検討など、さまざまな形で表①に示した教育テーマを取り上げ、学習を進める方式をとっている。こうした学習とあわせて、院内の委員会活動にも学びの機会があると考えている。

通常、どこの病院でも業務に関するさまざまな専門委員会が設けられていると思われるが、当院でも、専門委員会としては、リンパ浮腫、褥瘡、不安・うつなど、患者のケアに直接関係する委員会、家族・遺族ケアに関する委員会、また、感染



図③ 教育プログラムと日常業務—スタッフによる評価—

予防委員会、薬事委員会や倫理委員会などがある。こうした委員会活動は、日常業務のなかに位置づけられるものであるが、臨床と直結した委員会活動こそ学習のよい機会であり、講義やミーティング以上の効果をもつことがある。

それぞれの委員会は多職種によって構成され、ほとんどのスタッフが何らかの委員会に所属している。各委員会は関係資料を収集し、日常の実践に役立つ提案をし、ケアを推進する役割をもつ。委員会活動を通して、他のメンバーから、その分野のエキスパートとして期待されることは学習への動機づけをさらに高めていくことにつながる。また、委員会が多職種によって構成されていることによって、チーム全体の問題意識が高まるとともに、さまざまな専門職からの発言や情報提供は学習の幅を広げることに役立つ。

#### 4) スタッフによる評価

ここに紹介した教育プログラムについて、スタッフ40名を対象とした質問紙調査をおこなった。そのなかで、さまざまな学習の機会は日常の業務に役立っているかとの問いに対して、31名から回答が得られ、図③に示すような結果が得られた。事例検討会や症状マネジメントを学ぶStudy Dayなどは、臨床に直結したものとして有益であると答えているものが多くみられた。地域の医療関係者との研究会も役立っていると評価しているが、参加できていないのでわからないというものが他に比べて多くなっている。ホスピス

セミナーについては、外部からの講師の話は新鮮で、学びが多いと評価するものが多かった。

教育プログラムに対するチームメンバーの具体的な意見としてはつぎのようなものがあげられた。

- ① ケアをおこなった事例について検討することは意義深い。
- ② 同僚がおこなう講義では、現場で問題になっているテーマが取り上げられるので直接仕事に役立つ。
- ③ 仕事をしながらプレゼンテーションや講義の準備をすることは負担に感じることもある。しかし、発表をおえた後の達成感はとても大きく、学びも多い。
- ④ 多職種と一緒にディスカッションをおこない、他の職種の意見を聞くことは参考になる場合が多い。
- ⑤ 院内のメンバー同士の学びだけでなく、地域の医療関係者と学習の場を共有することは新鮮な体験で、交流の場としても重要である。
- ⑥ さまざまなプログラムがあることは非常に良いと思うが、交代勤務のため、すべてのプログラムに出席できないのが残念である。

#### おわりに—多職種教育の意義と課題—

以上、ホスピスの現場で臨床経験を積みながら学習する教育プログラムについて紹介した。このような学習環境があることは仕事への意欲を増し、教育がチームワークの推進や地域ケアの充実にも重要な役割を果たしていることが確認され

た。また、成人教育として、スタッフの自主性を尊重し、ステップアップを自ら確認していくプログラムであることが、スタッフの学習への意欲を高めているのではないかと思われる。

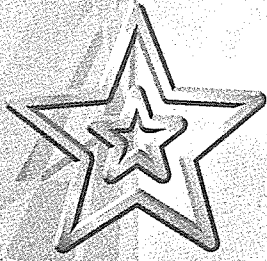
一方いくつかの課題がある。専門分野の異なる多職種が一緒に学ぶとき、知識の差や価値観の違いがあり、それが互いの心理的な緊張感、感情的な衝突を生み、チームワークをかえって悪化させ、崩壊させる危険性もある。互いの違いをむしろ歓迎し、尊重しあう関係を保ちながら教育プログラムを進めていくためには、進行役 (facilitator) が重要な役割をもち、そのような人材をどう育てるかが課題となる。

また、多職種教育の意義は大きいですが、つねに全職種が集合する形態では、多面的な視点をもつことができる反面、全体に表面的になりやすい。各専門分野での独自の検討を深め、チームケアにおける自己の役割を見直すなど、単一職種のセッ

ションをもつことも重要である。

学習の成果が臨床にどのように反映されたかを評価することはむずかしい。知識や技術はある程度評価していくことができるとしても、臨床家としての態度をだれが、どのように評価していくか。また、知識・技術・態度が一人のスタッフの総合力として身についたとき、ケアの質の向上へとつながる。その臨床の総合力をどのように評価するのか。さらに、多職種教育の成果は個人レベルだけでなく、チームとしてのケアの向上について評価する必要がある。教育の評価のあり方が今後の大きな課題である。

今回、一施設での教育の試みを紹介したが、一施設完結型の教育プログラムでは、経済的にも教育をおこなう人材の面でも限界がある。同じ地域の他の施設と教育プログラムを共有するなど、教育の面でもネットワークをつくっていくことが必要であると考える。



# 癌患者への告知について

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はじめに

最近、新聞紙上で尊厳死の問題が取り上げられ、なかでも患者への延命処置の意思確認をめぐって論議がなされている。しかし、患者が自分の病状を正確に知らないことには、意思確認をしようにもその判断自体が信頼できるものとはならず、患者への情報提供が何よりも前提となろう。このような患者への情報提供のなかで、一般の医療者にとって一番問題となるのは「告知することであり、とりわけ癌や難病など「悪い知らせ」を伝える場合が典型であろう。そもそも告知の目的は、患者に真実を伝えることによって、患者や家族の理解と協力のもとにその後の検査や治療を円滑に行い、ひいては患者のQOL (quality of life) を高めることにあるが、癌や難病の場合は「治らない」あるいは「死に至る」可能性があることがそれを難しくしている。そこで本稿では、実際の臨床現場でもっとも機会が多く、したがって十分な検討もなされてきた「癌患者への告知」について話を進めていきたい。

なお、わが国において「告知」という言葉は、医療者が患者やその家族に一方的に医療情報を通告するといった、これまでのパターンリズムを反映したニュアンスが強く、インフォームド・コンセントを基盤とした現代の医療にはそぐわなくなってきた。本来は英語の表現から“truth telling” (真実を伝える) や “disclosure” (開示) といった言葉の方が相応しいと考えるが、ここではそうした意味も含めて、一般的に使用されている「告知」という言葉を使用したい。

### 癌告知の現状

2003年9月に行われた毎日新聞の世論調査 (全国の20歳以上の男女4,581人を対象に面接形式で調査)<sup>1)</sup>によれば、癌に罹ったとしたら「治る見込みがあるときは、知らせてほしい」と考えている人が全体の90%、「見込みがないときでも知らせてほしい」という人は73%に上ることがわかった。これを1987年の同調査と比べると、治る見込みがある場合では78%から12ポイント、また見込みがない場合でも59%から14ポイントとそれぞれ上がっている。この背景には、同じ調査で、癌について「治る病気だと思う」と考えている人が28%、「死亡する確率は低くなったと思う」と考えている人は58%と、合わせて86%もの人が克服可能な病気と捉えていることが関係していると考えられる。このように、癌を告知される立場の人の意識は、年々変化してきていることがわかる。

一方、松島ら<sup>2)</sup>は2004年に全国145の中・小規模の一般病院 (平均病床数164.5床) に調査を行い、余命6ヵ月以内の終末期の患者本人への病名告知の達成率は平均45.9%、その家族へのそれは95.8%であり、同じく余命告知となると本人へは26.6%と低く、その家族へは90.8%であったと報告し、告知に関しては家族重視の実態が明らかになった。さらに、尊厳死の論議のなかで一番大切な延命処置の意思確認は本人へは15.2%ときわめて低く、家族へは86.8%とここでも家族の意見が医療行為に反映されていることがわかった。

## 癌の告知の困難さ

PfefferbaumとLevenson<sup>3)</sup>は、患者が本当に必要としている情報と医療者がそう考えている情報との間には相違があることを報告しており、またAndersonら<sup>4)</sup>は、患者が主治医からの情報提供に必ずしも満足していないことを指摘している。とりわけ、癌の告知は医療者が患者の治療をするうえでもっともストレスフルな課題の一つであり、医療者—患者間で情報に対する認識の相違が生じやすい素地がある。その理由としてBeile<sup>5)</sup>は、①医療者がもっとも得意とする「技術的役割」から「患者を支える役割」に移行することの難しさ、②患者から治療の不成功を非難されることへの恐れ、③患者の「希望」を打ち砕く恐れ、④患者が気まずい質問をするのではないかとという恐れ、⑤患者や家族の感情的反応に対処する戦略がないこと、などをあげている。実際、1997年に行われた調査<sup>6)</sup>では、1,557名の医師および3,361名の看護師に対して「死期が迫っている患者の診察に携わって、どんな難しさを感じていますか」との質問をしたところ、医師の69.9%、看護師の56.9%が「患者の病名、病状の説明をすること」を第一位にあげている。

わが国において、癌の告知がなかなか進まない理由として、保坂<sup>7)</sup>は次の3点をあげている。すなわち、①患者側の要因として、「先生にすべてお任せします」という意識が見られることである。これは患者が、他力本願でいることで事実の受け容れを否認する、という心理的防衛機制を使っている可能性が考えられる。つぎに②家族側の要因として、「患者が可哀想だから知らせたくない」という意識が働く。さらに③医療者側の要因として、「告知は患者の希死念慮を強めてしまうから」という懸念が起こる。しかし、この家族や医療者

側の考えの背景には、「患者がどのような反応をするのか、うまく支えられるのかが不安だから、告知しない」という思いが見え隠れしている。そこで医療者側は、患者に代わって家族に情報を伝えることと、家族からの希望を確かめることで、これらの不安を合理化していることが多い。

岡崎ら<sup>8)</sup>は、終末期癌患者65名のうち、患者が希望し家族が同意して病名と手術不能な病態にあることの告知を受けた27例と、家族が反対し本人も強い希望を表明しなかったために告知のされていない38例との2群について、精神神経症状や疼痛の出現頻度を比較したところ、両群の間に有意差はなく、むしろ病名告知群の方がいずれの出現頻度も低率であったと報告している。また、同じ65名を疼痛の有無により2群に分け、精神神経症状の出現頻度を比較すると、有痛群28名では46%、無痛群37名では14%と両群間に有意差がみられ、病名告知よりも疼痛の方が精神的負担は大きいのではないかと結論している。このように、告知は患者にとってむしろ有益であるとした報告は多い<sup>9)</sup>。実際、告知を受けない患者は、悪化していく全身状態に対して疑念を抱き、さらには死の恐怖とも1人で戦っていかなければならず、かえって精神状態が不安定となりやすいと考えられよう。こうした点をFletcher<sup>10)</sup>は“*No news is not good news, it is an invitation to fear*”と指摘している。

## 癌告知後の心理的反応

MassieとHolland<sup>11)</sup>は、癌患者の告知後の正常な反応を次の3つの相に分けて説明している。すなわち、第一相は1週間以内に起こる反応（初期反応）で、疑惑あるいは否認、絶望などが中心となる。第二相は1～2週間の間に起こる精神的動揺で、不安、抑うつ気分、集中力低下、食思不

振, 不眠, 日常活動性低下などである。第三相は2週以降にみられるもので, 新しい情報に順応する, 現実の問題に直面する, 楽観的になろうとする, など現実に適応していこうとする段階を指す。すなわち, 患者は病名を聞いて精神的に動揺し, 適応が落ちた状態が一般には2週間前後続き, それから徐々に落ち着いてきて, 自分の身体状態を受け容れ, 今後の治療などに正面きって取り組み始めるようになる。

しかし, 一定期間経っても情緒的に不安定な状態が続き, 生活に支障が出た場合は「適応障害」とされ, さらに長引いたり, 程度が重かったりすると「大うつ病」と診断されることになる。実際, 告知の機会が癌患者の全病期を通じて何回かの段

階があり, それは病名の告知で始まり, 再発の告知, 緩和医療導入への告知, そして余命告知などがあった, それぞれで状況は変わってくる。

#### おわりに

患者への情報提供, とくに癌の告知は, 医療者にとってもっともストレスフルな課題である。しかし, これまでのパターンリズムを基盤とした医療から患者中心の医療へと変化してきた現在において, 患者に検査や治療への理解, 協力を求め, 患者のQOLを高めるためには, いまや「患者に告知をするかどうか」ではなく, 「どのように告知をし, その後患者をどう支えていくか」が重要なのである<sup>5, 12~14)</sup>。

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## Regular Article

# Emotional state and coping style among gynecologic patients undergoing surgery

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### Abstract

The aim of the present study was to investigate changes in emotional state and the relationship between emotional state and demographic/clinical factors and coping style among gynecologic patients undergoing surgery. Using the Japanese version of the Profile of Mood States (POMS), 90 patients (benign disease: 32, malignancy: 58) were examined on three occasions: before surgery, before discharge, and 3 months after discharge. They were also examined using the Coping Inventory for Stressful Situations (CISS) on one occasion before discharge. The scores for the subscales depression, anger, and confusion were the highest after discharge while those for anxiety were the highest before surgery. The average scores of the POMS subscales for all subjects were within the normal range. With regard to the relationship between these emotional states and other factors, multiple regressions showed that the principal determinants of anxiety before surgery were religious belief, psychological symptoms during hospitalization and emotion-oriented (E) coping style; further, it was found that depression after discharge could be explained by chemotherapy, duration of hospitalization, and E coping style. The principal determinants of anger after discharge and vigor before surgery were length of education and E coping style, and severity of disease, chemotherapy, E coping style and task-oriented coping style, respectively. Those of post-discharge fatigue and confusion were length of education, psychological symptoms, and E coping style. In summary it is suggested that the following should be taken into account in patients undergoing gynecologic surgery: anxiety before surgery, depression, anger, and confusion after surgery, including coping styles.

### Key words

Coping Inventory for Stressful Situations (CISS), gynecologic surgery, longitudinal study, Profile of Mood States (POMS).

## INTRODUCTION

Since the 1980s, many studies in the field of psycho-oncology have investigated the relationship between coping style and psychological distress, such as depression, among cancer patients.<sup>1–5</sup> Results have suggested

that focusing on the coping style of patients and attempting to influence coping style might reduce deterioration in the quality of life (QOL). The effects and usefulness of such interventions have therefore been investigated.<sup>6–8</sup> In particular, in addition to psychiatric outcome, the effect of these interventions on prognosis has been reported.<sup>9,10</sup> However, the majority of such studies have focused on patients with breast cancer, and few have investigated the relationship between psychological distress and the coping style of patients with gynecologic cancer.

Patients with gynecologic disease, including cancer, who are undergoing surgery, can be particularly vul-

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nerable to distress associated with damage to self-image, altered sexual function, and loss of fertility,<sup>11-19</sup> in addition to general preoperative stress. Furthermore, approximately 30% of cancer patients are reported to be diagnosed with depression or adjustment disorders.<sup>20,21</sup> We must therefore take into account psychiatric complications among gynecologic cancer patients. Compared to studies conducted in Europe and America, in Japan fewer studies have investigated the perioperative emotional state among gynecologic patients, including those with cancer.

In the present study on gynecologic patients, the aim was to investigate the emotional state in the perioperative period and to ascertain the relationship between emotional state and other factors, including coping style, using self-administered questionnaires. We used the Profile of Mood States (POMS)<sup>22</sup> as a scale for estimating emotional state, and the Coping Inventory for Stressful Situations (CISS)<sup>23</sup> as a scale for coping style. We selected POMS and CISS because these scales are used internationally, and the subjects using these scales are not limited to the members of a particular group such as cancer patients.

We hypothesized that gynecologic patients undergoing surgery are likely to perioperatively exhibit particular psychological symptoms, irrespective of whether or not the patient has cancer. In addition, we hypothesized that the emotional state of the patient is related to their coping style, in particular, the emotion-oriented (E) coping style that has been reported as a maladaptive coping style by many researchers.<sup>24-28</sup> We predicted that there should be timely intervention in gynecologic patients undergoing surgery who exhibit psychological symptoms; further, patient characteristics, including coping styles, should be focused on perioperatively.

## METHODS

### Sample

The subjects consisted of 98 patients who were admitted to the Department of Obstetrics and Gynecology, Tokyo Medical and Dental University Hospital between June 2002 and March 2004 for the surgical treatment of gynecologic disease, including cancer. Patients with cognitive impairment and those undergoing psychiatric treatment were excluded. Two patients did not consent to participate in the study; a further four subsequently withdrew consent or dropped out due to deterioration in physical condition and two patients died before discharge. Consequently, 90 patients (mean age  $\pm$  SD,  $46.9 \pm 13.1$  years) participated in the present study. Of these, 32 were diagnosed

with benign disease (mean age,  $41.0 \pm 11.3$  years) and 58 with malignancy (mean age,  $50.2 \pm 13.0$  years). Patients who dropped out from the study after the first examination day were all cancer patients. There was no difference in the other clinical/demographic factors.

The following diagnoses were made in the benign group: ovarian tumor ( $n = 16$ ), tubo-ovarian abscess ( $n = 10$ ), and other tumors including cervical adenoma ( $n = 6$ ). The diagnoses in the malignant group were as follows: cervical cancer ( $n = 28$ ), cancer of the uterine body ( $n = 12$ ), and ovarian cancer ( $n = 18$ ). The following surgical procedures were performed: laparotomy ( $n = 55$ ), conization ( $n = 19$ ), and adnexectomy ( $n = 16$ ). In the malignant group, tumor extension was classified according to the general classification rules for gynecologic cancer.<sup>29,30</sup> Patients at disease stage 0, I, or II were classified as the early stage group ( $n = 47$ ) and those at stages III or IV as the advanced-stage group ( $n = 11$ ). Table 1 shows the average age, length of education, duration of hospitalization, habitation status, employment status, location of tumor, progress, surgical treatment, and chemotherapy administration in the benign and malignant groups. No cancer patient received chemotherapy and/or radiotherapy after discharge. The two groups exhibited no significant difference in demographic/clinical factors, such as length of education, habitation status, employment status, or surgical treatment. In contrast, significant differences were observed in age, duration of hospitalization, and location of tumor. All patients were informed of their diagnoses before admission, and when the diagnosis was not confirmed preoperatively, the cancer patients were told that the findings were 'suspicious of cancer'. There were five such patients. There was no patient with benign disease in whom cancer was suspected.

### Measures

Following routine admission and stabilization, informed consent was obtained from each patient. Two self-administered questionnaires were used. The patients' emotional state was evaluated using the Japanese version of POMS,<sup>31-33</sup> and coping style was measured using the Japanese version of CISS.<sup>34,35</sup> The POMS questionnaire was administered on three occasions: before surgery, before discharge, and 3 months after discharge. In contrast, CISS was administered only before discharge.

POMS assesses six emotional states: tension-anxiety, depression, anger-hostility, vigor, fatigue, and confusion; a higher score (in the case of vigor, a lower score) indicates a more severe emotional state. These subscales were standardized according to the consecutive studies of Yokoyama and Araki<sup>33</sup>: scores lower

**Table 1.** Sociodemographic subject characteristics

	Benign group ( <i>n</i> = 32)		Malignant group ( <i>n</i> = 58)		d.f./ <i>t</i> , $\chi^2$	<i>P</i>
	Mean/number	SD/%	Mean/number	SD/%		
Age (years)	41.0	11.3	50.2	13.0	d.f. = 88/ <i>t</i> = 3.372	0.0011
Length of education (years)	14.0	1.8	13.0	2.3	d.f. = 88/ <i>t</i> = -1.939	0.0566
Duration of hospitalization (days)	14.0	5.3	28.2	25.4	d.f. = 88/ <i>t</i> = 3.109	0.0025
Habitation status						
Single	6	18.8	12	20.7	d.f. = 2/ $\chi^2$ = 0.438	0.8032
Spouse only	7	21.9	17	29.3		
Others	19	59.4	29	50.0		
Employment status						
Employed	13	40.6	24	41.4	d.f. = 1/ $\chi^2$ = 1.78E-30	>0.999
Unemployed	19	59.4	34	58.6		
Location of tumor						
Uterine cervix	2	6.3	28	48.3	d.f. = 2/ $\chi^2$ = 29.354	<0.0001
Uterine body	1	3.1	12	20.7		
Ovary	29	90.6	18	31.0		
Progress						
Early	NA	NA	47	81.0	NA	NA
Advanced	NA	NA	11	19.0		
Surgical treatment						
Laparotomy	17	53.1	38	65.5	d.f. = 1/ $\chi^2$ = 1.161	0.2812
Conization/others	15	46.9	20	34.5		
Chemotherapy						
(+)/(-)	0/32	0/100	15/43	25.9/74.1	NA	NA

NA, not applicable.

than average + SD (scores are based on data collected from these studies) indicate 'no emotional problem', scores between average + SD and average + 2.4 SD indicate that 'medical attention is advised in the event of symptoms', and scores of average + 2.5 SD or more indicate that 'medical attention is necessary'. In the present study we used standardized scores that were converted from raw scores.

CISS was used to determine the typical coping style of the subjects during the most stressful situations. CISS assesses the following three coping styles: task-oriented (T) coping style, emotion-oriented (E) coping style, and avoidance-oriented (A) coping style, and includes a total of 48 items (16 items for each coping style); a higher score indicates that the coping style is often used. Coping style is defined as the typical cognitive/behavioral pattern adopted most often during stressful situations.<sup>23,34,35</sup> We assumed that although this style might vary depending on the occasion, an individual's coping style is a type of character trait. We therefore assumed that coping style would be more likely to affect emotional state than vice versa. CISS was selected as a measurement of coping style because it is

often used as an international scale, thereby enabling us to compare our findings with those of other studies. Further, the reliability and validity of the Japanese version of CISS have been confirmed, and this scale can be used for both patients with benign disease and cancer patients.

### Statistical analyses

For statistical analysis, the demographic/clinical data between the benign and malignant groups was compared using Student's *t*-test and the  $\chi^2$  test. The change in each POMS subscale score over the three test administration days was analyzed using repeated measures analysis of variance (ANOVA) with post-hoc comparisons (Scheffe's *F*-test; 95% significance). Multiple regressions were subsequently performed by treating the factors (including the CISS scores) significantly related to the POMS scores as independent variables and the POMS scores as dependent variables. This was done in order to assess determinants of the POMS subscale scores exhibiting the greatest deterioration. *P* < 0.05 was considered significant.

## RESULTS

### Emotional states over the three test administration days

On all occasions, the POMS scores for all subjects were within normal range. Significant differences in the tension–anxiety, depression, anger–hostility, and confusion scores were evident across the three test administration days (tension–anxiety:  $F = 9.356$ ,  $P = 0.0001$ ; depression:  $F = 6.819$ ,  $P = 0.0015$ ; anger–hostility:  $F = 15.101$ ,  $P < 0.0001$ ; confusion:  $F = 3.956$ ,  $P = 0.0211$ ). For vigor and fatigue, no significant difference was apparent in the values of the scores over the

study period. In summary, the tension–anxiety score was the highest before surgery, and the depression, anger–hostility, and confusion scores were the highest after discharge (Table 2).

Furthermore, with the exception of anger–hostility, no significant difference was apparent in the POMS subscales between the three groups (benign, early stage, advanced-stage groups) across the three test administration days. The anger–hostility score was the lowest in the advanced-stage group and the highest in the benign group ( $F = 4.016$ ,  $P = 0.0220$ ); post-hoc tests showed that there was a significant difference between these two groups with regard to this score.

**Table 2.** POMS subscale scores ( $\pm$ SD) in the three groups (benign, early stage, and advanced-stage) over the three examination days

Subscales	Before surgery	Before discharge	Three months after discharge
<b>Tension-anxiety</b>			
All subjects	47.7 $\pm$ 10.6	42.0 $\pm$ 9.2	43.9 $\pm$ 10.3 <sup>††</sup>
Benign group	49.7 $\pm$ 11.8	42.6 $\pm$ 10.8	45.6 $\pm$ 11.0
Early stage group	46.4 $\pm$ 11.1	42.1 $\pm$ 9.7	44.2 $\pm$ 10.8
Advanced-stage group	48.4 $\pm$ 5.6	39.8 $\pm$ 5.3	38.7 $\pm$ 3.0
<b>Depression</b>			
All subjects	46.3 $\pm$ 9.0	44.0 $\pm$ 6.6	47.8 $\pm$ 10.8 <sup>§</sup>
Benign group	47.2 $\pm$ 8.6	44.8 $\pm$ 7.7	48.2 $\pm$ 10.0
Early stage group	45.4 $\pm$ 8.7	43.8 $\pm$ 6.9	49.0 $\pm$ 12.1
Advanced-stage group	45.8 $\pm$ 5.7	42.5 $\pm$ 3.5	41.7 $\pm$ 2.4
<b>Anger-hostility</b>			
All subjects	42.3 $\pm$ 5.7	40.2 $\pm$ 4.3	44.4 $\pm$ 8.5 <sup>†§</sup>
Benign group	44.8 $\pm$ 5.6	40.2 $\pm$ 3.5	46.4 $\pm$ 8.0
Early stage group	41.3 $\pm$ 5.3	40.1 $\pm$ 4.9	44.5 $\pm$ 9.2
Advanced-stage group	39.1 $\pm$ 1.1	39.0 $\pm$ 1.8	39.2 $\pm$ 2.2
<b>Vigor</b>			
All subjects	48.5 $\pm$ 9.6	51.4 $\pm$ 11.1	51.0 $\pm$ 11.2
Benign group	45.0 $\pm$ 10.5	50.0 $\pm$ 12.5	50.8 $\pm$ 11.6
Early stage group	52.6 $\pm$ 7.7	53.2 $\pm$ 11.2	51.1 $\pm$ 12.1
Advanced-stage group	42.3 $\pm$ 8.1	48.9 $\pm$ 10.9	51.5 $\pm$ 5.3
<b>Fatigue</b>			
All subjects	43.3 $\pm$ 9.1	43.0 $\pm$ 9.6	44.7 $\pm$ 9.7
Benign group	46.1 $\pm$ 9.8	44.0 $\pm$ 11.0	46.8 $\pm$ 10.3
Early stage group	41.0 $\pm$ 7.8	41.4 $\pm$ 8.9	44.6 $\pm$ 9.8
Advanced-stage group	47.9 $\pm$ 9.6	43.3 $\pm$ 9.6	40.5 $\pm$ 6.0
<b>Confusion</b>			
All subjects	44.4 $\pm$ 10.5	42.1 $\pm$ 8.8	45.3 $\pm$ 11.5 <sup>§</sup>
Benign group	46.8 $\pm$ 10.8	42.9 $\pm$ 10.1	46.6 $\pm$ 11.0
Early stage group	42.0 $\pm$ 10.5	40.8 $\pm$ 8.8	46.2 $\pm$ 12.3
Advanced-stage group	45.2 $\pm$ 8.2	43.2 $\pm$ 7.5	37.9 $\pm$ 5.8

<sup>†</sup> Significant differences between before surgery and discharge; <sup>‡</sup> significant differences between before surgery and after discharge; <sup>§</sup> significant differences between before discharge and after discharge.

Two-way analysis of variance (ANOVA) repeated measures.

Multiple comparison was analyzed by Scheffe ( $P < 0.05$ ; Scheffe), between 3 days (before surgery, before discharge, after discharge) for all subjects, and between three groups.

POMS, Profile of Mood States.

Clinically, three patients demonstrated psychological symptoms such as depressed mood from before surgery to before discharge (during hospitalization). One patient was diagnosed with depression before discharge (her gynecologic diagnosis was benign), and the other two patients were diagnosed with adjustment disorder (all had benign disease).

### Relationship between POMS and demographic/clinical parameters

We selected the presurgery tension–anxiety and vigor scores and the post-discharge depression, anger–hostility, fatigue, and confusion scores as dependent variables because these were the highest scores (in the case of vigor, the lowest scores) over the study period.

Next, we performed the following process for selecting the dependent variables for each regression model. First, we analyzed the relationship between POMS and other demographic/clinical factors (continuous variables) including the coping style by using Pearson's correlation test. Second, we analyzed the relationship between POMS and other demographic/clinical factors (nominal variables) by using two-way ANOVA with repeated measures. Third, we confirmed the multicollinearity by analyzing the relationship between the significant demographic/clinical factors (continuous variables) other than POMS by using the

Pearson's correlation test. The following results were obtained.

With regard to the relationship between POMS and clinical parameters, Pearson's correlation test results showed that variables such as CISS scores, age, length of education, and duration of hospitalization were related to the POMS subscale scores (Table 3). The results of two-way ANOVAs with repeated measures showed that variables such as benign/malignant group, religion, chemotherapy, administered during hospitalization, and psychological symptoms during hospitalization were significantly related to the POMS subscales. With regard to the relationship between the significant clinical parameters, including the CISS scores, Pearson's correlation test results indicated significant relationships between the age and duration of hospitalization ( $r = 0.369$ ,  $P = 0.0013$ ), age and length of education ( $r = -0.532$ ,  $P < 0.0001$ ), age and E coping style scores ( $r = -0.313$ ,  $P = 0.0071$ ), duration of hospitalization and length of education ( $r = -0.410$ ,  $P = 0.0003$ ), and E coping style scores and A coping style scores ( $r = 0.320$ ,  $P = 0.0058$ ).

Taking these results into account, we attempted multiregression analyses with some combinations of independent variables, and we were able to achieve the most adaptive model (the best combination of the independent variables) for each dependent variable. Table 4 shows the results of those multiple regression

**Table 3.** Variables significantly related to the POMS subscale scores (Pearson's correlation test)

Variables: demographic/clinical factors and coping style(CISS scores)	POMS subscale scores	<i>r</i>	<i>P</i>
CISS scores			
Task-oriented coping style	T-A before discharge	-0.267	0.0249
	V before discharge	0.388	0.0008
	C before discharge	-0.253	0.0344
Emotion-oriented coping style	All POMS scores except for V before discharge	0.263–0.612	<0.0001–0.0278
Avoidance-oriented coping style	T-A after discharge	0.332	0.0048
	D after discharge	0.317	0.0073
	A-H after discharge	0.292	0.0137
	F after discharge	0.267	0.025
	C after discharge	0.315	0.0076
Age	D before surgery	-0.270	0.0236
	A-H before surgery	-0.270	0.0234
	C before surgery	-0.251	0.0357
	D before discharge	-0.300	0.0112
	F after discharge	-0.238	0.0469
Length of education	V before surgery	0.242	0.0434
	C after discharge	0.263	0.0278
Duration of hospitalization	F before discharge	0.259	0.0301

A-H, Anger–Hostility; C, Confusion; CISS, Coping Inventory for Stressful Situations; D, Depression; F, Fatigue; POMS-J, Japanese version of Profile of Mood States; T-A, Tension–Anxiety; V, Vigor.

**Table 4.** Final multiple regression model for predicting POMS scores

Dependent variables	Independent variables	$\beta$	SE	<i>P</i>	$R^2$	<i>F/P</i>
Tension–Anxiety before surgery	Age	0.099	0.124	0.2699	0.270	3.198/0.0024
	Religious beliefs	8.196	0.210	0.0411		
	Severity of disease	–1.794	–0.082	0.4468		
	Chemotherapy	–8.098	–0.289	0.1845		
	Psychiatric symptom	–10.236	–0.263	0.0118		
	Duration of hospitalization	–0.149	–0.306	0.1558		
	Task-oriented coping style	–0.093	–0.121	0.2290		
	Emotion-oriented coping style	0.331	0.332	0.0035		
	Avoidance-oriented coping style	0.051	0.058	0.5706		
Vigor before surgery	Age	0.033	0.045	0.6759	0.324	4.736/<0.0001
	Religious beliefs	–0.567	–0.016	0.8691		
	Severity of disease	5.181	0.260	0.0130		
	Chemotherapy	15.236	0.598	0.0046		
	Psychiatric symptom	0.664	0.019	0.8478		
	Duration of hospitalization	0.105	0.239	0.2437		
	Task-oriented coping style	0.207	0.297	0.0023		
	Emotion-oriented coping style	–0.218	–0.241	0.0206		
	Depression after discharge	Age	0.063	0.075		
Length of education	1.006	0.197	0.1376			
Religious beliefs	3.370	0.093	0.3751			
Severity of disease	2.224	0.097	0.3802			
Chemotherapy	14.300	0.525	0.0178			
Psychiatric symptom	–6.655	–0.171	0.0997			
Duration of hospitalization	0.265	0.565	0.0092			
Task-oriented coping style	–0.089	–0.113	0.2815			
Avoidance-oriented coping style	0.146	0.155	0.1409			
Anger-Hostility after discharge	Age	0.128	0.194	0.1841	0.377	3.517/0.0011
	Length of education	1.160	0.287	0.0459		
	Religious beliefs	1.157	0.040	0.7197		
	Severity of disease	–1.128	–0.062	0.6001		
	Chemotherapy	6.664	0.310	0.1869		
	Psychiatric symptom	–0.547	–0.018	0.8721		
	Duration of hospitalization	0.116	0.314	0.1696		
	Task-oriented coping style	–0.058	–0.093	0.4123		
	Avoidance-oriented coping style	0.107	0.144	0.2036		
Fatigue after discharge	Age	0.057	0.075	0.6070	0.366	3.347/0.0017
	Length of education	1.694	0.366	0.0100		
	Religious beliefs	0.245	0.007	0.9477		
	Severity of disease	–0.731	–0.035	0.7689		
	Chemotherapy	6.743	0.273	0.2474		
	Psychiatric symptom	–9.091	–0.258	0.0238		
	Duration of hospitalization	0.179	0.422	0.0690		
	Task-oriented coping style	–0.013	–0.018	0.8737		
	Avoidance-oriented coping style	0.111	0.130	0.2535		

**Table 4.** *Continued*

Dependent variables	Independent variables	$\beta$	SE	<i>P</i>	<i>R</i> <sup>2</sup>	<i>F/P</i>
Confusion after discharge	Age	0.145	0.160	0.2511	0.429	4.349/0.0001
	Length of education	2.144	0.388	0.0056		
	Religious beliefs	3.322	0.085	0.4327		
	Severity of disease	1.372	0.055	0.6265		
	Chemotherapy	9.375	0.319	0.1570		
	Psychiatric symptom	-10.775	-0.256	0.0183		
	Duration of hospitalization	0.159	0.315	0.1512		
	Task-oriented coping style	-0.090	-0.106	0.3289		
	Emotion-oriented coping style	0.430	0.403	0.0014		
Avoidance-oriented coping style	0.179	0.175	0.1078			

POMS-J, Japanese version of Profile of Mood States.

analyses. Presurgery tension–anxiety scores for non-religious patients were higher than those for religious patients. Presurgery tension–anxiety scores and fatigue/confusion scores after discharge were higher in patients with psychological symptoms than patients without them. Depression scores after discharge and vigor scores before surgery for patients who underwent chemotherapy were lower than those for patients who did not receive chemotherapy. The longer the duration of hospitalization, the higher were the patients' depression scores. The longer the length of education, the higher were the patients' anger–hostility, fatigue, and confusion scores after discharge. Presurgery vigor scores were higher in cancer patients and patients with high T coping style scores than in other patients. Furthermore, presurgery tension–anxiety and vigor, and post-discharge depression, anger–hostility, fatigue, and confusion scores were higher (in the case of vigor, lower) for patients with high E coping style scores than for those with low E coping style scores.

## DISCUSSION

### Change in emotional state over the study period

With regard to changes in emotional state, the present results showed that over the study period, depression and anger changed in a different manner as compared to anxiety. While anxiety was the highest before surgery, depression and anger were maximal 3 months after discharge. High anxiety before surgery might be due to general concerns regarding the surgery itself. In contrast, high depression and anger after discharge might be attributed to psychological distress associated with damage to self-image, altered sexual function, and loss of fertility.<sup>11–19</sup> Such distress appears to be overt after discharge when the patient's physical condition has improved.

Previously, we investigated the psychological state of gastrointestinal patients (including cancer patients) undergoing surgery. We found that depression increased from before surgery to before discharge and had not recovered to presurgery levels 6 months after discharge; but the scores for anxiety did not change over the study period.<sup>36</sup> Although it is evident that patients with gastrointestinal disease differ from those with gynecologic disease in terms of parameters such as gender and physical status, the two studies showed similar results with regard to the following two points: (i) depression changed significantly over the study period; and (ii) the changing pattern of anxiety was different from that of depression. In conclusion, we should focus on the timely initiation of treatment or care to gynecologic patients. For example, we should communicate to patients with gynecologic disease taking into account their anxiety, and offer preoperative orientation and explanation about surgery. Furthermore, follow-up psychological examinations should be carried out by skilled experts to evaluate patient deteriorated emotional states such as depression, anger, and confusion. The routine psychological screening test carried out during follow up after discharge might be useful.

### Incidence of psychiatric disease and the level of emotional state over the study period

All the POMS average scores for all subjects were within the standard range for each subscale on all test administration days. Furthermore, only three of 90 subjects had psychological symptoms warranting psychiatric diagnosis. Hence, the morbidity rate was relatively low at 3.3% when compared with findings from previous studies that investigated psychiatric morbidity rates among cancer patients.

Using the Center for Epidemiologic Studies Depression Scale (CES-D) and the State–Trait Anxiety Inven-

tory (STAI) as depression/anxiety evaluation scales, Bodurka-Bevers *et al.* investigated depression and anxiety among patients with ovarian cancer (26% of subjects had early stage cancer, 74% had advanced-stage cancer, and 49% were undergoing active treatment).<sup>37</sup> They reported that scores exceeded the threshold for depression in 21% of all subjects and scores for anxiety exceeded 75% of the average scores in 29% of all subjects. In the present study, the fact that the POMS average scores were all within the normal range might be explained by differences in the measurements used and the inclusion of subjects with benign tumors and the fact that patients with early stage disease outnumbered those with advanced-stage disease in the present study. In contrast, our study showed that the emotional status of advanced-stage patients was not different from that of benign and early stage patients. This contradiction might be because there were only a few advanced-stage patients in the present study and their physical condition was not severe.

Next, Tanaka *et al.* reported that 29.2% of gynecologic cancer patients who had been informed of their diagnosis were diagnosed with psychiatric diseases within 1 week of being given the diagnosis.<sup>38</sup> In the present study, preoperative tests were administered some weeks after the patients were informed of their diagnosis; this might contribute to differences between the Tanaka *et al.* findings and those of the present study.

We now discuss our findings that there was no difference in most POMS subscale scores between the benign, early stage, and advanced-stage groups and the finding that the anger–hostility score was higher in the benign group than in the advanced-stage group. As for the former observation, the physical condition of the advanced-stage patients in the present study was not severe. Additionally, Lutgendorf *et al.* investigated QOL and mood in women with gynecologic cancer at an initial clinic visit and after 1 year by using FACT (measuring QOL) and POMS.<sup>39</sup> They reported that QOL and mood improved among the early stage and regionally advanced oncology patients and that there was no significant difference between the two patient groups in the level of and change in mood over time. Their finding is consistent with the present findings. Irrespective of whether the patients have cancer or whether their cancer is at an early or at an advanced stage, most distress common to all gynecologic patients undergoing surgery might be associated with concerns other than surgery, cancer, and the disease itself. Furthermore, as for the second finding (that the anger–hostility score was found to be higher in the benign group than in the advanced-stage group), we did not obtain the same results in proceeding studies in gynecologic patients.

However, because gynecologic patients with benign diseases have no fear of cancer, that is, they are not severely anxious, feelings such as anger and hostility might be exhibited to a greater extent by these patients than by cancer patients. In fact, through clinical experience in gynecologic wards we confirmed that strong negative emotions such as fear and anxiety often prevail over anger and hostility.

### Relationship between emotional state and demographic/clinical parameters

Anxiety before surgery was related to religious beliefs and to the E coping style. In crisis situations, patients with religious beliefs might experience less stress than non-religious patients. Jarvis *et al.* examined the relationship between religious practice and psychological distress in a culturally diverse urban population, and confirmed that attendance at religious services was related to lower levels of distress.<sup>40</sup> Salsman *et al.* investigated the relationship between religiousness and adjustment (distress and life satisfaction) and between spirituality and adjustment; they reported that intrinsic religiousness and prayer fulfillment are related to life satisfaction, and that life satisfaction is mediated by optimism and social support.<sup>41</sup>

Moreover, it appears plausible that patients exhibiting psychological symptoms during hospitalization are more likely to feel anxiety, fatigue, and confusion after discharge than those who do not exhibit psychological symptoms. It also appears plausible that patients who underwent long hospitalization stays were more depressed after discharge than those who underwent a short hospitalization. With regard to the finding that scores for anger, fatigue, and confusion after discharge were lower among patients with short-term education, many previous studies showed that gynecologic patients are more likely to suffer from distress associated with loss of female identity and self-image than that resulting from the disease itself.<sup>11–19</sup> The cognitive scheme against such distress might be related to the length of education. However, this scheme is assumed to be different from coping styles because the length of education affected patient mood after discharge independently of coping styles. In contrast, it is unclear why vigor scores before surgery were higher for cancer patients than for patients with benign diseases, and why depression scores after discharge were lower for patients who underwent chemotherapy than for those who did not.

Corney *et al.* investigated psychological and sexual distress among patients with uterine and vulval cancer undergoing surgery by using interview methods incorporating HADS.<sup>42</sup> They reported that anxiety was not

related to age or surgical methods and sexual problems were significantly related to the anxiety level. In addition Greimel and Freidl investigated daily living and psychological well-being among gynecologic cancer patients perioperatively; they reported that the scores were not significantly related to age, tumor location, or disease progression.<sup>43</sup> Therefore, although we cannot make a simple comparison, their findings regarding age, tumor location, surgical methods, and disease progression appear to be consistent with the present findings.

### Relationship between emotional status and coping style

After the multicollinearity in the regression model was considered, the present findings suggested that anxiety and vigor before surgery and depression, anger, fatigue, and confusion after discharge depend on the individual's coping style. In particular, the E coping style had a great influence on all emotional states. Previous studies using CISS have reported that among the various population, the E coping style is related to negative psychological states, personality, or psychiatric pathology.<sup>24-28</sup> Some studies have also reported that the T coping style is related to positive personality traits.<sup>27,28</sup> These findings are similar to those of the present study. From the standpoint of optimizing mental health and promoting comprehensive patient care, concrete strategies should focus on the coping style of gynecologic patients, particularly the E coping style. Patients who cope emotionally should be enrolled in a psychoeducational program focusing on adjusting coping style.

### CONCLUSION

The present study clarified perioperative changes in the emotional state in gynecologic patients undergoing surgery, and the relationship between these and multiple related factors. In particular, the findings showed that there are not many differences between the mood of patients with benign disease and those with cancer. Additionally, the findings elucidated the characteristics of subjects who should receive more clinical attention. However, although we were able to identify these characteristics, it is difficult to extrapolate these findings into concrete methods for care or intervention for characteristics such as the physical condition of patients, types of treatments, and patient background such as educational length. In contrast, with regard to coping style, it is not impossible to prompt patients to alter their cognitive style and to urge them to use a more adaptive style through therapy such as psychoe-

ducational group therapy. Furthermore, considering that almost all the psychological variables studied changed over the perioperative period, it can be concluded that timely intervention taking into account individual treatment conditions and situations is important.

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# 中・小規模の一般病院における がん告知の実態調査

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## 中・小規模の一般病院における がん告知の実態調査

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【要約】 全国の中・小規模の一般病院（50床以上300床未満）の中から無作為抽出した2,397病院に質問紙を送付し、医師を対象に担当がん患者への告知をめぐる対応等の実態調査を行った（回収率21.4%）。担当患者に占めるがん患者の割合が1割未満とする医師は44.7%であり、自らが最初の病名告知をした患者が、担当がん患者の中に占める割合が5割以上という医師は44.3%、1割未満という医師は28.5%、半数以上の医師は、自らが告知したがん患者数よりもそうでない患者数のほうが多かった。一方、8割近い医師があえて未告知にしている患者割合を3割未満としていた。最初の告知対象者は「家族」が最も多く、担当患者の中に占めるがん患者割合の高い医師ほど告知率は高く、告知全般の実施率が高い医師ほど、最初の病名告知の対象は本人が多かった。また、望ましい告知方法が告知後の望ましい対応よりもよりルーチン化されており、告知方法の水準は医師個人によってある程度一貫していた。

### はじめに

わが国の終末期がん医療においては、ホスピスや緩和ケア病棟、在宅緩和ケアといった環境下で亡くなる患者数よりも、一般病院で亡くなる患者数のほうがはるかに多い。また近年は、欧米並みにがんの病名告知も浸透してきたとの報告<sup>1-3)</sup>を散見するが、その多くはがんに特化した治療施設や大学病院での実態を示したものがほとんどである。しかし、がんの診断・検査や初期治療は別と

しても、その後の治療や緩和医療的処置の多くを提供している一般病院、特に中・小規模の一般病院における告知については明らかにされていない。

本研究では、中・小規模の一般病院における臨床医が、日常どのくらいの割合でがん患者を担当し、患者ないしその家族への、病名をはじめとする一連の告知をいかなる頻度で、どのように実施しているのか、また、その後の対応など、告知をめぐるがん患者およびその家族へのかかわりの実態を把握するとともに、告知のあり方に関連する諸因子を明らかにすることを目的とした。

### 研究対象と方法

「病院要覧2003-2004年版」<sup>4)</sup>に記載されている全国9,239の病院から、50床以上300床未満の一般病院という条件で無作為抽出した2,397病院に、

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調査依頼書、医師対象の質問紙、返送用封筒を一式として各院長宛で郵送した。質問紙は、担当がん患者の割合、告知の実施状況、その後の対応等について尋ねた設問など33項目から構成されており、当該病院で最も担当がん患者の多い医師に回答していただくよう依頼した。なお、倫理面の配慮として、無記名での回収を原則とし、質問紙には病院ないし個人が特定されるような設問を含まないようにした。質問紙作成の具体的な手続きであるが、まず研究者間の話し合いで、本研究の目的に沿った上記設問群を決定し、次に群ごとの設問を文献等<sup>5-9)</sup>を参照しながら検討した。

データ解析は記述統計を中心としたが、設問回答肢のおおよそは順位尺度として扱えるよう作成したことから、各設問結果間の相関をSpearman順位相関係数にて評価するとともに、その一般化可能性を検定した。

## 結 果

2,397病院に郵送したうち、返送件数は510病院、513件(回収率:21.4%)であり、有効回答数は504件(有効回答者数:21.0%)であった。病院の平均病床数は138.6 ± 81.5床、臨床医の性別は男性が488名(96.8%)、年代は40歳代と50歳代で73.8%を占めていた。臨床医としての経験年数は、最も多いのが20年以上30年未満群(43.8%)で、次が同数で10年以上20年未満群と30年以上40年未満群であった(それぞれ23.2%)。その他、対象者の属性等はTable 1に示した。

### 1. 担当がん患者の割合と告知の実態

担当患者に占めるがん患者の割合は、1割未満とする医師が44.7%であるのに対し、5割以上とする医師は15.6%にすぎなかった(Fig. 1)。自ら最初の「病名」告知をしたがん患者割合が担当がん患者の5割以上と答えた医師は44.3%、1割未満と答えた医師は28.5%であった。結局、55.7%の医師において、自らが告知していない患者数が、自ら告知した患者数よりも多かった(Fig. 2)。一方、78.8%の医師が、何らかの理由であえて本人に未(病名)告知にしている割合は、担当がん患者の3

Table 1. 対象者の属性 (n = 504)

		名	%
性 別	男性	488	96.8
	女性	16	3.2
年 代	30歳未満	2	0.4
	30歳代	34	6.7
	40歳代	169	33.5
	50歳代	203	40.3
	60歳代	70	13.9
	70歳以上	26	5.2
経験年数	5年未満	2	0.4
	5～10年	10	2.0
	10～20年	117	23.2
	20～30年	221	43.8
	30～40年	117	23.2
	40年以上	37	7.3
都道府県	北海道	36	7.1
	東北	41	8.1
	関東	122	24.2
	信越・北陸	29	5.8
	東海	39	7.7
	近畿	87	17.3
	中国	52	10.3
	四国	20	4.0
	九州	77	15.3
	沖縄	1	0.2
所属する科	内科	210	41.7
	外科	267	53.0
	内・外科	11	2.2
	緩和ケア・ホスピス	16	3.2

割に満たないと回答した(Fig. 3)。

次に、自らが最初の「再発」告知をした患者の割合となると、42.4%の医師が担当がん患者の1割未満にしか自らが再発告知を行っていないとし、一方で32.5%の医師は、担当がん患者の5割以上に自らが再発告知を行ったと回答した(Fig. 4)。自らが最初の「がんの積極的治療(抗がん剤の使用など)中止」を告知した患者の割合については、担当がん患者の1割未満という医師が61.6%、半数以上という医師は13.1%にすぎなかった(Fig. 5)。自らが最初の「余命」告知をした患者の割合もほぼ同じで、1割未満という医師が67.1%であるのに対し、5割以上という医師は10.0%にすぎなかった(Fig. 6)。また、すでに他院で「病名」告