Irwin N. Perr,[1] *M.D.*

Asbestos Exposure and Cancerphobia

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ABSTRACT: In 48 cases of claims of psychic injury due to asbestos exposure, seven were diagnosed as "cancerphobia." Cancerphobia is a concept primarily used in personal injury cases with little support in the medical community. Analysis of standards for phobia indicates that the term is inappropriate for such legal claims. Phobic reactions are avoidant reactions with panic or intense anxiety on exposure to the phobic stimulus. The cases reviewed indicate lack of psychiatric symptomatology, lack of conformance to accepted standards, and insufficient attention to history—medical and otherwise. This clinical review supports the contention of Simon that cancerphobia is not a credible classification. Skepticism is merited where potential damage awards are limited by minimal physical findings with resultant emphasis on claims of illness phobia, an example being exposure to a toxic substance like asbestos, which may be followed, but not necessarily so, by a variety of adverse consequences. Professional persons should be alert to the misuse of medical concepts in such cases.

KEYWORDS: psychiatry, asbestos, cancer, phobia, cancerphobia

Litigation involving asbestosis and its consequences is common; asbestos has been almost ubiquitous in manufacturing, construction, and refining until recently. The well-known physical results of asbestos exposure are exemplified in the review article by Mossman and Gee [*1*]. Serious sequellae can occur as a result of asbestos exposure—mesothelioma, lung cancer, and possibly other cancers. Asbestosis itself can be a serious illness with pulmonary obstructive disease, a condition that can markedly impair function. On the other hand, pleural disorders of various types may be encountered, many of which are relatively benign and without symptomatology.

Because of the importance of asbestos disorders and the possible development of disease years after exposure, complicated litigation has arisen. To put it simply, the issue usually is (1) does the patient have a pulmonary disease?, (2) or another disease related to asbestos?, (3) if a disease is present, was it caused by asbestos?, (4) are there other factors related to the disease, such as smoking, infection, or other toxins?, (5) are other consequences such as cancer present?, (6) if cancer is present, is it related to the asbestos exposure?, (7) if disease is not present, what are the chances of the patient developing such a condition?

These questions must be evaluated by a pulmonary or occupational lung disease specialist. Today the public is well aware of many environmental risks, and unions have been energetic in bringing those issues to the attention of members, active and retired.

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[1]Retired from the Department of Psychiatry and Department of Environmental and Community Medicine, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, Piscataway, NJ.

When a person has a serious condition related to asbestos, such as mesothelioma or chronic pulmonary restrictive disease, the impairment is relatively clear. Where no such condition exists, plaintiffs may seek damages based on the possibility of future injury, a claim that may require some degree of reasonable probability. Liability for a potential disease is quite speculative and therefore such claims may not meet that legal standard.

Other grounds of litigation may be accepted by the courts. On occasion, where there is no particular pulmonary deficit or the reaction to asbestos is questionable, a claimant may plead psychiatric injury for which compensation is merited.

I have previously reviewed 48 cases of asbestos exposure and psychic injury discussing various issues related to such claims [*2*]. In a second article, analysis of the nine cases dealing with alleged post-traumatic stress disorder was presented [*3*].

This paper is directed at the narrow issue of purported cancer phobia (or cancerphobia) as a basis for a claim. Simon [*4*] has reviewed the concept from primarily a legal, theoretical standpoint, noting legal cases in which "cancer phobia" was used with no reference to the issue of asbestos exposure. He states that the word, cancerphobia, is a misnomer because it is not a phobia at all.

Simon states: "The term cancerphobia is full of sound and fury, signifying little of clinical value. It gains some credibility if one is stating that the individual has a phobia of carcinogens, real or perceived, or a phobia of cancer patients because of an irrational fear that one may contract cancer like a contagious disease. However, from a clinical perspective, cancerphobia is largely a mythological term that does not constitute accurate psychiatric diagnostic usage for individuals who manifest significant symptoms of fear of cancer. Thus, its use creates the illusion of the presence of a diagnosable mental disorder, when in fact, none may exist. It makes more sense to merely state that the person has a fear of cancer."

The Concept of Phobia

The concept of phobia raises many semantic and professional issues; therefore clarifying its applicability is important. The word, phobia, has two distinct meanings. The word "phobia" may apply to a fear or to a dislike or to an emotion combining the two concepts—the common lay usage of the term. For example, the words "anglophobe," "francophobe," or "russophobe," refer to individuals who dislike, or even hate, the English, the French, or the Russians. The dislike may have cultural antecedents, may have some basis in reality based on the upbringing, experience or philosophy of the "phobic" person, or it may result from bigotry, individual or institutional. This use of the word is irrelevant to the concepts of disease or disability.

People may describe themselves as phobic about death, illness, taxes, violence, crime, and so forth. Many concerns are reflective of the tensions of life. People do have fears of illness, disability, and death. Often these are real fears; sometimes the fear is exaggerated even if based in reality—for example, fear of AIDS may fit into either category depending on the situation. Anxiety is another term having broad social use and a specific medical meaning; it is commonly a synonym for "nervousness" or tension. More narrowly the medical use of the term refers to an untargeted dread, unrealistic fears, or excessive apprehensive expectations, often associated with physical concomitants such as tachycardia, tremulousness, and dry mouth. Mere obsessional or ruminative thoughts are not to be construed as phobic.

The psychiatric use of the term, phobia, can be clarified by reviewing the evolution of the term. From 1952 to 1968 a phobic reaction was one in which anxiety was detached from an idea or situation and displaced symbolically to a specific fear—such as fears of germs, dirt, closed places, high places, animals. The patient attempts to control anxiety by avoiding the phobic object or situation. From 1968 to 1980 a phobic condition was

one of intense fear of an object or situation which the person consciously recognized as no real danger. Phobias were generally attributed to fears displaced to the phobic object or situation from some other object of which the patient was unaware. In 1980 phobic disorders were characterized by a persistent and irrational fear of a specific object, activity, or situation resulting in avoidance to such exposure. The fear was recognized as excessive or unreasonable. In the DSM-III-R of 1987, the essence of a phobia is the experience of panic (discrete periods of intense fear or discomfort) on confrontation with the dreaded object or situation and the use of avoidance behavior.

Several types of phobic reactions are recognized. In agoraphobia, fear of being in certain places results in discomfort on such exposure. In addition to panic or severe anxiety, a constriction of life function results—often to such a degree that ordinary demands of life like working cannot be met. In social phobia the person reacts to exposure to others. Simple phobia is a fear of a circumscribed stimulus other than these two, with immediate anxiety on exposure. The object is avoided and the person recognizes that the fear is excessive or unreasonable. For example, a woman is so fearful of bees that she stayed inside her home in the summertime and on her mandatory departures would run screaming if a bee were sighted. As a result, her child was often restricted to the home. Thus the phobia was characterized both by symptoms and functional impairment.

The term, cancerphobia, does not conform to this model. While problems such as hypochondiasis (fear of or preoccupation with a disease that one does not have) and adjustment disorder (response to a specific stress) may need to be evaluated, the use of an emotionally laden term such as cancer phobia reflects a non-medical orientation.

The medical literature dealing with "cancer phobia" is sparse. In 1976, Sanborn and Seibert [*5*] used the term cancerphobia as a fear or belief that one has cancer without substantiating medical evidence or in the face of negative medical evidence. This use of the term is different from that implied in the legal cases where the claim is a fear of getting the disease, which would better be described as a hypochondriacal reaction. In 1978, O'Connell [*6*] used the term, cancer phobia, but clarified it as "cancer-related hypochondriasis" in discussing treatment of a woman whose anxiety about cancer "reached uncontrollable or phobic proportions." He also described her preoccupations as obsessive ruminations. Siero, Kok, and Pruyn [*7*] used a different approach in analyzing "fear-arousing" messages or publicity to stimulate people to pay more attention to breast self-examination to combat cancer. They found that "a (realistic) manipulation of seriousness and susceptibility does not bring about a fear of breast cancer."

Viswanathan and Kachur [*8*] described a man who developed agoraphobia with panic attacks after having a five year cure for cancer (embryonal testicular carcinoma).

Various articles deal with emotional reactions to having cancer—a very different matter. Holland [*9*] discussed reasonable fears in relation to actual cancer and problems such as anxiety disorders (reactive anxiety) or adjustment disorders. Cancer patients may have significant problems with poorly controlled pain; Holland discusses the emergence of anxiety with termination of treatment. Silberfarb and Greer [*10*] and Cassidy [*11*] also deal with psychologic problems of the cancer patient.

Padberg [*12*], Larpentier [*13*], Poe [*14*], and Klopovich [*15*] deal with management of fears in relation to cancer in a family or with a specific situation when a fear arises in a family that if one child has cancer another will contract the disease.

None of these articles are directly applicable to these asbestos cases where a diagnosis of cancer phobia was made.

The Group Studied

In a six year period, 48 patients were referred by the defense for psychiatric evaluation of possible psychic injury from asbestos exposure (47 - male, 1 - female). The mean age

was 62.6. Of this group, in 7 a claim of cancer phobia or cancerphobia was made (all male, mean age 58.4). Four were retired, none related to asbestos related disease.

Summary of Cases

(1) A, 62 years old, had been on Social Security disability and a small pension for cardiac disability since 55 following myocardial infarction. He had a history of hypertension. His hospital record for the myocardial infarction noted two packs of cigarettes and 4 to 5 alcoholic drinks a day. His evaluation by his forensic pulmonary specialist three years earlier indicated that A had chronic shortness of breath, productive cough, chest tightness, wheezing, chest pain, and intermittent claudication. A smoking history of 2 and one-half packs a day from age 20 to 55 followed by reduction to one and one-half packs a day was noted. His coronary artery disease was attributed to exposure to "dusts, irritants, and fumes." He was classified as having a cardiac disability of 65%. The examining doctor stated that A did not have asbestosis, but "up to 45% of individuals exposed to asbestos develop cancer." A Ph.D. psychologist described A as depressed, irritated, fearful of succumbing to asbestos, cancer, or heart disease. The psychologist noted that A smoked 2 packs of cigarettes a day, which he attributed to A's "feelings of despair" about his health condition.

The psychologist concluded, "it is my opinion that A lives in constant intense fear that he is or is about to become a cancer victim and that this fear, which we may consider a cancer phobia, derives from the fact of his exposure to the same industrial hazard, namely asbestos dust inhalation, which has led to the illness and death of numerous of his co-workers, many of whom he knew well.

"His phobic condition includes anxiety depression, anhedonia, fearful preoccupation, sleep disruption, and loss of ordinary interests. His range of interests and enjoyment of life is very narrowed due to the preoccupation. The condition also affects his wife who must suffer with her husband's fears and who is very distressed at his unhappy state. We may also say that she is distressed at the possible loss of her husband."

A was seen 19 months later by me. Though edentulous for 20 years, he claimed to eat well though he rarely used his false teeth. He slept well, usually from 11 P.M. to 10 A.M. Occasionally he dreamt about the fellows with whom he worked and spoke of those who died. He denied having had hypertension and stated that his heart did not bother him. The major change from 15 years earlier was that he tired more often. He likes to go to the beach, fishing, boating, and crabbing; he grows vegetables, watches television, and likes to walk in the snow. In the last five years, the only illness for which he was treated was an ear infection. He goes to auctions, is a junk collector, and makes candles.

In interview he was pleasant, relaxed, affable, smiled readily, and displayed a sense of humor, with no anxiety or depression. "He does have some concern about his future health, but this seems to be limited in extent and is quite appropriate." He showed no significant psychological symptom and had no history of seeking help. He was a rather relaxed, well adjusted individual.

(2) B, 59, was evaluated three years earlier and was diagnosed as having shortness of breath with peribronchial scarring. The physician indicated that up to 45% of individuals exposed to asbestos develop cancer. X-ray showed a moderate increase in bronchovascular markings, and pulmonary function tests showed reduction in maximal mid-expiratory flow rate and slightly reduced ventilatory ability. History revealed two prostate operations and a hospitalization for a hand injury. A diabetic, he was not compliant with medication. When hospitalized the year before, no mention of lung impairment was made.

The Ph.D. psychologist had only the internist's report prepared for an attorney. That

letter noted diabetes of five years duration and smoking one and one-half packs a day for 23 years until 15 years earlier. The psychologist reported that the patient denied anything wrong with his sugar control. He had "a chronic fear that he had already developed asbestosis in a latent form." He was described as clinically depressed with fatigue, sleep disruption, curtailment of activities, and a feeling of pessimism. Diagnosis was "Cancer Phobia with chronic anxiety and depression." His loss of sexual enjoyment (inability to get an erection for one year) was related to his depression.

B had two conditions relating to impotence. He was a diabetic under poor control (although impotence is often unrelated to blood sugar level and may even be the first sign of diabetes). In psychiatric evaluation 19 months after the psychologist's examination, B reported impotence of four years duration. He was hospitalized three times for his urinary condition, had a transurethral resection, and then a perineal operation with the implantation of some type of prosthesis (according to B).

When he lifts heavy objects such as tool boxes of 200 lbs., he will spill urine. He showed no abnormalities in mental status review, was jovial, and displayed no evidence of tension or depression. There was some indication of low average intellectual functioning. He was working regularly when he was seen.

In view of his diabetes and surgical procedures, the attribution of total impotence to "cancer phobia" was unjustified.

(3) In the case of C, 50, a pulmonologist for his employer noted that C had no symptoms, that X-ray was negative, and that pulmonary function was within normal limits. The pulmonary specialist on C's behalf noted no symptoms. C had a 32 year, pack a day smoking history until 15 years previously. Some rales were noted on examination and the X-ray showed minimal bilateral pleural thickening. Pulmonary tests showed a "5%" impairment with diminished small airway flow due to pulmonary asbestosis.

The plaintiff's psychiatrist noted no distress and made a diagnosis of pulmonary asbestosis, pulmonary disability, and psychoneurosis, anxiety reaction with phobic features (cancerphobia).

In my examination, C indicated that he had no problems, slept well, liked skiing, was a car buff. He had not seen a physician for almost three years (other than his own forensic psychiatric examination). He stated that his only worry was whether asbestosis would later bother him. No impairment in functioning was noted. Mental status review showed no abnormality.

(4) D, 40, had some chronic obstructive pulmonary disease with little response to medication. In a brief hospitalization, diagnosis was interstitial pneumonia. Biopsy raised a question of malignancy but this was not confirmed. Final diagnosis was chronic "interstitial pneumonitis and fibrositis,? asbestosis." Earlier pulmonary function tests showed no significant functional deficit. At one point he was a three pack a day smoker. His pulmonologist noted minimal bilateral pleural thickening, interstitial lung changes, with probable asbestosis. A subsequent defense evaluation noted pleural changes and pulmonary function abnormalities attributed to prior pleurisy, chest trauma, smoking and obesity. His psychiatrist made a diagnosis of anxiety reaction with phobic trends (cancerphobia). When seen currently, D complained of arthritis in his knees and shortness of breath on exertion. He had a history of pleurisy at age 18. Mental status review was unexceptional.

(5) E, 67, was hospitalized nine years earlier for hypertension, latent diabetes mellitus, and hypertriglyceridemia and seven years earlier for spastic colitis and hypertension. For a long period he showed X-ray findings of possible pulmonary fibrosis and remained stable; many years earlier he had had periods of mild anxiety and depression. He retired at 63 and was described as active, enjoying retirement, going fishing. E had no particular complaints; he had brought a lawsuit after he was told of the X-ray findings. The plain-

tiff's psychiatrist made a diagnosis of anxiety reaction and phobic reaction (cancerphobia). The psychiatrist defined cancerphobia as a morbid concern about his health. At the current psychiatric evaluation, he indicated that at times he felt short of breath and felt that age was affecting his functioning. He was quite active, worked part-time, was on the City Council where he was Director of Finances, was very energetic in working with agencies helping the elderly and the retarded, and with his church. He had shortness of breath only in bed. He walked 10 to 15 miles a week and stated that he had no concerns (''none really''); he knew that his X-rays remained static, stating, ''Things look good ... I'm satisfied with life just the way it is.'' Mental status review showed no abnormalities.

(6) F, 66, retired, was diagnosed five years earlier as having ''pneumoconiosis, minimal, occupational, asbestosis,'' with no pulmonary impairment. Subsequent medical work-ups were not made available. His psychiatrist made a diagnosis of psychoneurosis, mixed type, anxiety reaction, and phobic reaction (cancerophobia). F indicated that he had not seen a doctor for years; his only complaint was shortness of breath and tiring—since 60. Mental status review revealed no abnormalities.

(7) G, 65, retired, was told that he had asbestosis (X-rays showed bilateral pleural plaques). Pulmonary function tests showed mild decrease in lung capacity. While the pulmonologists disagreed on the cause (one blaming obesity), both felt the findings to be asbestos related.

A Ph.D. psychologist stated that G had shortness of breath, limited activity, dry mouth, hypertension, and drowsiness and that his wife refused to have sex with him because she would get asbestosis. The psychologist stated that dyspnea had denied G of all his former activities and that his life was ''eroded ... by worry.'' G purportedly stated that he had cancer, and the psychologist concluded that he had an ''illness phobia.''

At the current interview G had no complaints. When he walked two miles, he got tired. He enjoyed going to Atlantic City and was economically secure because he and his wife had Social Security. He stated that sex relations had diminished because of his wife's attitude, and she said that it was because he had asbestosis but he knew that that made no sense; he felt that she was no longer interested in sex, a problem that began about 15 years earlier. He was a jovial, affable, pleasant man with a good sense of humor and a positive outlook towards the future. Mental status review was unexceptional.

Discussion

In seven of 48 cases of claimed psychic injury related to asbestos exposure, the issue of cancer phobia or cancerophobia was raised. Of the seven one had significant pulmonary impairment (D) and one minor impairment (G). None showed any psychiatric symptoms when examined. Examination consisted of review of records, mental status review, and the use of the Rorschach, Thematic Apperception Test (TAT) and test drawings. The Rorschach and TAT demonstrated no gross findings on any of the patients.

In some cases, minimal medical information was available to the examiner for the plaintiff (and in one case reviewed by me). The psychology reports on occasion erroneously interpreted medical data—for example, impotence in the case of B who had both diabetes and two prostate procedures.

The etiology and extent of the lung disorders are not pertinent to this paper; in general, the patients were quite functional. Psychological functioning was good with none demonstrating anxiety or depression. None had had psychiatric treatment or had been referred for such, and current medical treatment was minimal or absent in all.

The data support the conclusion that ''cancer phobia'' or ''cancerophobia'' represents a concept that can be misused and that the application of the concept of phobia is not appropriate when the alleged clinical pictures do not confirm to the current mental health

standards for a diagnosis of phobia. In no case was there any demonstrated psychic impairment. The concept of phobia should be restricted to an irrational fear, usually recognized by the person as unreasonable and commonly directed towards outside circumstances, resulting in an avoidance reaction to prevent anxiety or panic.

Physicians should be aware of loose use of professional language in medicolegal situations where impressive sounding words infer recognized disease entities. Such practices are more likely in psychiatric or psychologic screening when physical findings are minimal or absent, and thus such claims may be more indicative of the manipulations of the legal system and of the use of "expert witnesses" than a reflection of accepted professional practice.

References

[1] Mossman, B. T. and Gee, J. B. L., "Asbestos-Related Diseases," *New England Journal of Medicine*, Vol. 320, 1989, pp. 1721–1730.

[2] Perr, I. N., "Asbestos Exposure and Psychic Injury—A Review of 48 Claims," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 20, 1992, pp. 383–393.

[3] Perr, I. N., "Asbestos Exposure and Post-Traumatic Stress Disorder," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 21, 1993, pp. 331–344.

[4] Simon, R. I., "Cancerphobia: Myth or Malady in Psychic Injury Litigation," *Trauma*, Vol. 29, 1988, pp. 43–60.

[5] Sanborn, D. E. and Seibert, D. J., "Cancerophobic Suicides and History of Cancer," *Psychological Reports*, Vol. 38, 1976, p. 602.

[6] O'Connell, J. M., "Implosive Therapy with Hypnosis in Treatment of Cancer Phobia: A Case Report," *Psychotherapy: Theory, Research, and Practice*, 1978, pp. 15:8–12.

[7] Siero, S., Kok, G., and Pruyn, J., "Effects of Public Education About Breast Cancer and Breast Self-Examination," *Social Science and Medicine*, 1984, pp. 881–884.

[8] Viswanathan, R. and Kachur, E. K., "Development of Agoraphobia After Surviving Cancer," *General Hospital Psychiatry*, 1986, pp. 127–132.

[9] Holland J. C., "Anxiety and Cancer: The Patient and the Family," *Journal of Clinical Psychiatry*, Vol. 50, 1989, pp. 20–25.

[10] Silberfarb, P. M. and Greer, S., "Psychological Concomitants of Cancer: Clinical Aspects," *American Journal of Psychotherapy*, Vol. 36, 1982, pp. 470–478.

[11] Cassidy, S., "Emotional Distress in Terminal Cancer," *Journal of the Royal Society of Medicine*, Vol. 79, 1986, pp. 717–720.

[12] Padberg, R. M., "The Media and Fear of Cancer," *Oncology Nursing Forum*, Vol. 16, 1989, p. 432.

[13] Larpentier, M.,"Family Conferences Reduce Fear by Sharing Information," *Oncology Nursing Forum*, Vol. 16, 1989, p. 430.

[14] Poe, C. M., "A Technological Approach to Reducing Fear: The Tape Recorder," *Oncology Nursing Forum*, Vol. 16, 1989, p. 430.

[15] Klopovich, P., "Coping with Fears of Childhood Cancer," *Oncology Nursing Forum*, Vol. 16, 1989, pp. 431–432.

Address requests for reprints or additional information to
Irwin N. Perr, M.D.
10126 NE 62nd St.
Kirkland, WA 98033