

# Emotional support and Palliative care for cancer patients

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**Abstract** - While advancements in cancer therapy have increased concurrently, there is a greater awareness of the various dimensions of misery endured by individuals with cancer and those who care for them. In order to alleviate these suffering, palliative care physicians, researchers, and advocates have spent the last 50 years learning from and alongside cancer patients. As a result, they have become valuable collaborators with oncology physicians. An interdisciplinary team (IDT) approach, in which members from several disciplines work together to alleviate multidimensional pain and suffering and improve quality of life, is beneficial to patients with terminal illnesses in palliative care. Members of the psychosocial team are essential to the palliative care IDT because they offer knowledge of assessment and treatments for psychological distress that have been scientifically proven to work. This presentation will examine the various aspects of psychological discomfort that patients with advanced cancer may encounter. Effective relationships built on emotional attachment serve as the cornerstone of cancer patients' palliative treatment. Given the configurations and environments of palliative care within health systems, training programs on techniques for building emotional bonds can be offered in order to effectively administer palliative care.

**Keywords:** Emotional support, Palliative care, cancer patients

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## INTRODUCTION

One of the most common diseases nowadays, cancer therapy presents a variety of difficulties for medical systems and patients. Global reports indicate that both the number of cancer patients and the disease's annual death rate are rising (Bray et al. 2018). They encounter several physical, mental, psychological, and social issues when they are ill. Palliative care has been planned in various nations in current years to help these patients, give them efficient care, and manage their numerous issues (Hui and Bruera, 2016). The palliative care strategy necessitates a specific structure with procedures in order to accomplish its objectives. The interaction between service recipients (patients) and service providers (care team) is one of the fundamental tenets of effective palliative care. Inattention to this idea could make providing care more challenging (Salmon and Young, 2017). The connection idea enables other crucial elements of palliative care, including interdisciplinary treatment and decision-making (Montgomery et al. 2017). Conversely, a positive relationship linking the patient and the healthcare group leads to the patient being satisfied with the treatment they had and being able to

adjust to having cancer (Cameron and Waterworth, 2014).

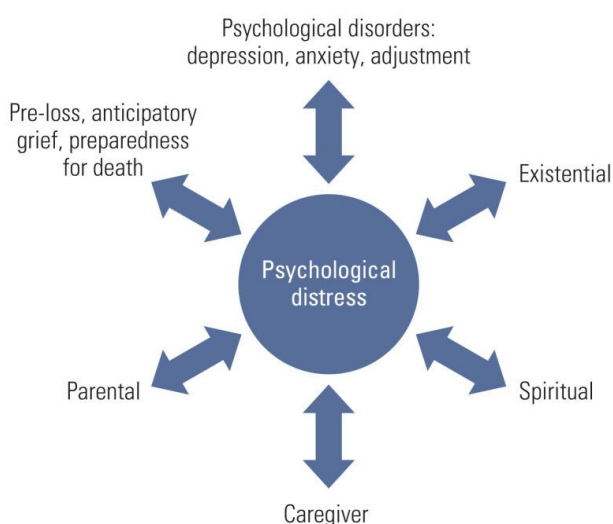
Relationship building has been identified as a critical and significant component of palliative care quality in a number of studies (Nakajima et al. 2015). The care team's communication strategies and skills influence the type and traits of the relationship and assist the caregiver system in overcoming related challenges in the process of building a relationship between patients and the care teams (Brataas et al. 2009). Knowing the characteristics of a process, like a relationship, aids in identifying the nature of the issue and any pertinent difficulties. It can also offer a specific functional framework and aid in the development and structure of that process.

Thus, by fostering a closer relationship between the patient and the care team, the possible goals of care provider systems are met in order to maximize performance. The type of interaction that exists between patients and the care team varies depending on the treatment plan. These characteristics, which include empathy, active listening, establishing a secure space for discussing

death, and outlining the objectives of care, have been mentioned in a few scattered research (Seccareccia et al. 2015). However, studies on the palliative care method have not precisely discovered these features for cancer patients, and the association and its elements have been limited to the patient and a specific subset of the care team, such as doctors. All approaches to care, including palliative care, are contingent upon the specific sector of care and its prevailing cultural norms (Cain et al. 2018). The nature of a care strategy might include a variety of concepts with a wide range of features in different fields.

## ASPECTS OF PSYCHOLOGICAL STRESS AND ITS PREVALENCE

There is a correlation between psychological distress, which can include existential, spiritual, emotional, and social components, and increased physical symptom severity, suffering, and mortality (Krikorian et al. 2014). Research indicates that 64% of the discrepancy in predicts suffering intensity is accounted for by psychological and adjustment issues (Krikorian et al. 2014). It has also been noted that psychosocial symptoms deteriorate as one approaches death. Another study, however, discovered that being close to death was linked to greater levels of existential discomfort, physical symptom weight, and augmented desire to die rather than elevated rates of depression and anxiety disorders. A study that examined samples and discovered that 59.3% of patients receiving palliative care approved it revealed that only 24.5% of cancer outpatients and 16.5% of the general public reported psychological distress (Gao et al. 2010). Please see Figure 1 for an overview of the various types of psychological discomfort that will be discussed in this review.



**Figure 1. Aspects of psychological distress (Ann and Bruera 2022)**

### PSYCHOLOGICAL DISORDERS

Disparities in the operational definition of distress, measurement methods, and methodological challenges account for the variable occurrence rates of

distress in samples from palliative care and cancer (Walker et al. 2013). Among 9,000 cancer patients in a large sample, the prevalence of distress was 35.1%, with the greatest rates found in patients with lung cancer (43.4%) and gynecological tumors (29.5%) (Zabora et al. 2001). Anxiety disorders (11.5%) and adjustment disorders (11%) were found to be the most common mental disorders among cancer patients (31.8%) in a huge epidemiological study that assessed mental disorders using a standardized clinical interview with a 4-week prevalence (Mehnert et al. 2014). Similarly, a meta-analysis of studies that performed systematic, in-depth clinical interviews with cancer patients found that 32% of all samples satisfied the criteria for a mental health concern (Singer et al. 2010).

In a meta-analysis of research on palliative care, rates of adjustment disorders (15.4%), anxiety disorders (9.8%), and combined mild and severe depression (24.6%) were found to be slightly lower than the overall rates for mood disorders. According to certain studies, there is a greater level of distress as death approaches (Seow et al. 2021). This meta-analysis did not reveal any statistically significant differences between palliative care and non-palliative care settings, despite the fact that 30 to 40% of patients had a combination of mental health concerns (Mitchell et al. 2011).

Patients with advanced disease experience depression at rates ranging from 23% to 58%, with a higher prevalence in advanced stages of the disease (Potash and Breitbart, 2002). Independent of caregiver type, functional level, treatment status, and survival duration, there was a significant correlation between the severity of depression and amplified physical symptoms, symptom distress, and symptom cruelty (Fitzgerald et al. 2015). According to a meta-analysis evaluation, depression in cancer patients was linked to a higher death rate (Satin et al. 2009).

### EXISTENTIAL ANXIETY

Apart from psychiatric illnesses, existential discomfort can also be experienced by cancer patients and caregivers who are nearing the end of their lives. The literature on palliative care presents a considerable issue because different concepts and terminology have been utilized interchangeably (Boston et al. 2011). In a broad sense, existential pain is suffering brought on by problems with "personal integrity, identity, or an unfulfilled past, as well as problems with future concerns like meaninglessness, futility, death, and religious worries" (LeMay and Wilson, 2008). Clinical presentations of existential anguish have been classified into four broad areas (Satrang et al. 2004). First, there is the concept of freedom, which holds that everyone has a choice and that someone may feel distressed if they have guilt, unresolved conflict, or regret prior choices. The second is meaning, which can be upsetting if someone is wondering, looking, or has lost their sense of purpose in life or in

themselves. Isolation, or feeling cut off from or abandoned by the greater community, comes in third. The fourth and last topic is death or mortality, which covers separation from loved ones, the afterlife, and anxiety and fear of dying (Satrang et al. 2004).

The idea of demoralization is one such existential suffering that has acquired traction in the literature on palliative care. Terminal patients have been shown to exhibit demoralization, which is characterized as a spectrum that starts with minor loss of confidence or disheartenment and progresses to depression, despair, and finally full-blown demoralization syndrome (Clarke and Kissane, 2002). Demoralization, which is defined as low morale in situations where one's principles, morals, or principles are in jeopardy, has been seen in healthcare workers under extreme stress that is difficult to handle (Gabel, 2013).

**SPIRITUAL DISTRESS**

Another aspect of distress that needs to be properly identified and attended to by palliative care providers is spiritual distress, which is supported by about 25% of cancer patients (Schultz et al. 2017). When conducting a psychological assessment, psychologists in particular should include the patient's spiritual needs in order to have a deeper understanding of the patient's beliefs, values, spiritual history, suffering, and needs (Rego and Nunes, 2019). Comprehending the worldview and coping mechanisms of a patient via their spirituality can aid in tailoring therapies such as psychotherapy and working in conjunction with spiritual care experts to address the patient's spiritual needs.

**CAREGIVER DISTRESS**

Palliative care not only relieves patients' suffering but also offers psychosocial support to family members, particularly caregivers, who bear the weight of providing care for a loved one, especially as their time is running out. This is done in a holistic and family-centered manner. Distress experienced by cancer patients and caregivers was positively correlated, according to a meta-analysis study (Hodges et al. 2005). In a recent study, 96% of family caregivers for patients with advanced cancer acknowledged experiencing clinically significant discomfort, with 43% reporting moderate to severe anxiety and 41% reporting depression (Ullrich et al. 2017). This research provides evidence that the requirements and difficulties faced by caregivers grow as a patient approaches death and occasionally may even exceed those of the patient who is terminally ill (Martin et al. 2016).

**PARENTAL DISTRESS**

Treating patients with advanced cancer who have small children is one area of focus for palliative care psychosocial specialists. Having children has been linked to increased anxiety, depression, and a lower quality of life in cancer patients, especially as they age

(Park et al. 2016). Anxiety and despair in patients with metastatic disease were primarily predicted by parenting worries. According to numerous studies, parents are worried about how their illness and death will affect their little children, that they won't be able to care for their children while receiving treatment because of physical restrictions, and that they won't be able to adequately tell their kids about their diagnosis and prognosis (Park et al. 2019). According to Nilsson et al. (2009), parents of young children with terminal cancer are less likely to start advanced care planning and are more inclined to favor aggressive therapy over palliative care.

**EVALUATION AND SCREENING FOR PSYCHOLOGICAL DISTRESS**

Early psychological assistance may prevent "normal" adjustment from becoming diagnosable disorders, much like the need for early palliative care. Because of this, a number of national requirements have mandated that all cancer patients receive integrated psychosocial care as well as routine screening for psychological distress.

After a member of the psychosocial team has identified distress during the screening process, a thorough psychological assessment can be useful in determining appropriate, empirically validated psychological interventions to personalize treatment for each patient and family during the initial clinical interview. A clinical interview should cover the following topics: coping mechanisms, spirituality, sense of purpose, past substance abuse, psychiatric history, social and familial history, current family and living situation, including dysfunction in the family, current mood symptoms, including intensity, frequency, and duration to determine whether the patient meets criteria for psychological disorder, and suicide risk assessment.

**Table 1 Commonly used screening and assessment instruments in palliative care contexts**

Name	Measures	Format	Population
ESAS: Edmonton Symptom Assessment System (Hui and Bruera, 2017)	Symptoms of total, psychological, spiritual, and physical well-being	Patient, family, or staff self-report, with a score of 0–10—10 being the worst	Palliative care patients, caregivers
CAMPAS-R: Cambridge Palliative Assessment Schedule (Ewing et al. 2004)	Physical, emotional, and caregiver anxiety symptoms	Self-report, validated symptoms reported online with an indication of intensity and subsequent degree of disruption to daily activities or problematic	Home palliative care patients
MSAS: Memorial Symptom Assessment Scale (Portenoy et al. 1994)	Symptoms both psychological and physical that affect life quality	Self-report, validated symptoms scored on a 4-point categorization scale for severity, frequency, and distress	Palliative care patients



MDAS: Memorial Delirium Assessment Scale (Breitbart et al. 1997)	Level of delirium symptoms severity	4-point rating system for clinicians	Cancer patients
IPOS: Integrated Palliative Care Outcome Scale (Murtagh et al. 2019)	Issues relating to the body, mind, and soul; communication needs, especially with family; and practical assistance	patient or proxy self-report using a 5-point Likert scale	Palliative patients
HADS: Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983)	Depression and Anxiety	Five-point self-report Adults on a Likert scale	Medically ill
DS-II: Demoralization Scale-II (Robinson et al. 2016)	Demoralization	Self-report scale: 0 = never, 1 = occasionally, 2 = frequently	Palliative patients

## CONCLUSION

Given the importance of psychological issues resulting from cancer diagnosis and treatment, a thorough assessment of symptoms and psychosocial requirements is crucial in oncology and palliative care settings. Since it is not possible to properly evaluate every patient, guidelines have been put in place to make it easier to screen for distress and psychosocial symptoms and requirements as part of standard good clinical practice. Evaluation is seen as a follow-up strategy for those exhibiting observable signs or requirements. A number of dimensions beyond those that come from a typical psychiatric interview should be taken into particular consideration.

Furthermore, it is important to recognize that some diagnostic levels in consultation psychiatry, psychosomatic medicine, and subsequently psychosocial oncology are related to one another rather than antagonistic: The three types of diagnoses are the nosologically-oriented clinical diagnosis, the interpersonally-oriented dynamic-interpersonal diagnosis (e.g., DSM, ICD), the genetically-oriented historically-oriented diagnosis (e.g., coping mechanisms, social support, early experiences, psychological factors, and social forces involved in the presentation of the patient's symptoms, vulnerabilities, and strengths), and the psychologically-oriented dynamic-interpersonal diagnosis (Wise, 1986). These methods are part of the assessment process and should take into account many factors in the particular contexts of cancer and palliative care, consultation-liaison psychiatry, and psychosomatic medicine. Comprehending the multitude of variables is very vital. In addition to the psychosocial correlates of medical disease, such as psychological symptoms, illness behavior, and quality of life (QoL), which may be linked to both "classical" psychiatric disorders and more widespread psychosocial suffering, these include life events, chronic stress and allostatic load, well-being, and health attitudes (Fava and Sonino, 2005).

Thus, as part of routine care in oncology and palliative care settings, it is important to take into account the role of screening for distress (e.g., DT, ESAS, and other psychometric questionnaires), associated with a more focused assessment of other psychosocial dimensions related to cancer diagnosis and treatment (e.g., attachment, coping, DCPR).

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