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QUALITY OF LIFE IN PALLIATIVE CARE

Marta Czerwik-Kulpa^{A,B,C,D,E,F},
Joanna Chylińska^{A,B,D,E}

Department of Medical Psychology, Medical University of Warsaw, Warsaw, Poland

SUMMARY

Background:

This article presents current views on palliative care and its impact on the quality of life (QOL) of cancer patients. On the basis of a literature review, selected predictors of QOL are discussed, such as physical complaints and demographic variables, and the impact of interventions delivered by the palliative team is highlighted. The aim of our study was to determine cancer patients' QOL (in terms of physical and psychological functioning) and its relationship with coping strategies.

Material/ Methods:

Thirty patients referred to the Hospital Support Group at the Department of Palliative Medicine participated in the study. QOL was assessed with the QLQ-C30, and adjustment to cancer was measured with the Mini-Mac (Juszczyński 2001).

Results:

Strong relationships were found between coping with cancer and QOL. Destructive strategies (based on fear and resignation) correlated negatively with almost all aspects of QOL (physical, emotional, cognitive and social), with coefficients varying between -0.80 and -0.46. The strongest relationships were found for Anxiety preoccupation and physical functioning ($r=-0.92$; $p<0.001$). Constructive coping (based on fight and positive re-evaluation) was positively related to cognitive and social functioning ($r=0.56$, $p<0.005$ and $r=0.53$, $p<0.005$, respectively).

Conclusions:

QOL in cancer patients depends not only on good control of somatic symptoms, but also on psychological functioning. Minimizing the physical dysfunction in patients can help to avoid negative coping strategies, based on fear and resignation. An equally important task is to help patients deal with negative emotional states, which inevitably accompany a chronic disease such as cancer.

Key words: cancer, coping strategy, Hospital Support Group, QLQ, MINI-MAC

INTRODUCTION

Defining palliative care

We usually associate palliative care with the end of life. It is commonly believed that doctors suggest it when “there is nothing else they can do,” and that the main (or even only) place where such care can be delivered is the hospice. This state of affairs conforms to a certain extent with the definition of palliative care which the WHO proposed in 1990, which virtually equated hospice care and palliative care. Palliative care was then defined as the complex, active and multi-specialist care of the patient and his/her family during the period when the disease is no longer responding to causal treatment (WHO 1990). Therefore, the key element in this definition was the contrast between causal and palliative treatment. Today, the World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO 2002). Palliative care also:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient’s illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Will enhance quality of life (QOL), and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

One of the consequences of the adoption of this modified definition is to extend the meaning of the term “palliative care,” which no longer refers only to the last, terminal phase of illness, but rather has become an important element of caring for all patients and their families in the face of life-threatening illness. What is more, it may significantly affect the course of illness. According to Jarosz (2005), this last claim may be hard to test empirically, but evidence of the importance of the different elements of palliative care has been reported in the literature. One example is psychological intervention – caring for the psychosocial aspect of the functioning of cancer patients. In a fre-

quently quoted study by Siegel et al. (1989), the survival time of patients with breast cancer who attended support groups where they obtained psychological support doubled compared with patients who only underwent standard biomedical treatment.

QOL of patients in palliative care

It follows from the definition given above that improving the QOL of patients and their families is the essence of palliative care. In addition to survival time, it is now accepted that quality of patient life is the main dependent variable in psycho-oncological research paradigms (Jocham et al. 2009, Majkovicz 2000) and may serve as a measure of the effectiveness of treatment team interventions (Jocham et al. 2009).

The intensity of physical complaints is a frequently reported dimension of QOL in cancer patients. It is worth noting at this point that, on the one hand, researchers treat this variable as a component of QOL, but on the other hand, they treat it as a determinant of other indicators of patients' QOL. A review of the literature on patients in palliative care has shown that the complaints which authors find most frequently (Jocham et al. 2009) are:

- nausea and vomiting (9-51% of patients);
- pain from the malignancy (11-84%);
- breathlessness (21-64%);
- depression and anxiety (27%) .

In a representative Danish sample, Johnsen et al. (2009) found that the most frequent complaints of patients with advanced cancer were:

- fatigue (57%);
- limited social role performance (51%);
- insomnia (48%);
- pain (39%).

One possible modifier of the type and intensity of physical complaints is the type of cancer, and publications supporting this hypothesis are available (Johnsen et al. 2009; Stromgen et al. 2002). However, some researchers (Lundh et al. 2006, Walsh et al. 2000) have found that the exact diagnosis is irrelevant when the cancer is very advanced and there is no difference in intensity of physical symptoms.

Demographic variables constitute an important and rather well researched group of predictors of QOL in patients in palliative care. However, findings on the effects of age, sex and family status on QOL are ambiguous (Pachalska 2008). Morita et al. (1999), Lundh et al. (2006) and Walsh (2000) found that young patients report poorer QOL than older patients, and women report poorer QOL than men. On the other hand, a study by Chui et al. (2009) confirmed the effect of age, but not sex. In this study women had higher QOL than men. Family status was also a significant predictor of QOL in this study – married patients scored higher on QOL than other patients. This finding has been corroborated in the literature (King et al. 2000; Sneeuw et al. 2002)

although data contesting the positive effect of marriage on QOL have been reported (cf. Johnsen 2009, Lundh et al. 2006, Owczarek et al. 2006). The authors suggest that a life partner's support acts as a buffer against the adversity of illness. Johnsen et al. (2009), meanwhile, have demonstrated that older age correlates with lower QOL. These writers have interpreted their findings by suggesting that older patients are more likely to have other illnesses as well, and this co-morbidity will contribute additionally to deterioration of physical functioning. These considerable discrepancies in the research findings suggest that it may be necessary to control the effects of additional variables (such as treatment course or duration of illness) and to pay more attention to the precision with which variables are conceptualised and operationalised.

Palliative interventions and QOL

In palliative care QOL is improved by means of bio-psycho-social interventions. Since patients in palliative care have a variety of problems, these problems are usually dealt with by a team of specialists – physician, nurse, psychologist, social worker, chaplain, and sometimes a physiotherapist. Palliative care may take a number of forms. There is home care and inpatient hospice care for adults and children. Some hospitals also have palliative wards and out-patient clinics. One recent novelty in broadly understood palliative care is the creation of Hospital Support Groups in cancer hospitals. These groups care for patients and their families and can bridge the gap between oncological care and palliative care by cooperating in hospital treatment, preparing patients for discharge and ensuring adequate home care. The first Hospital Support Group (HSG) in Poland was established in 2004 at the Department of Palliative Medicine in the Oncology Centre of the M. Skłodowska-Curie Institute in Warsaw. The group consists of specialists in palliative medicine, specially trained nurses, psychologists and a social worker. This is how Jarosz et al. (2010) describe the HSG rationale and goals:

The goal of the Support Group is to treat pain and coexisting symptoms which affect QOL, to provide adjunct treatment by implementing palliative care in all stages of treatment, to lead the patient gently from causal to palliative treatment. These goals are realized by means of consultation, cooperation with the doctor in charge, psychological and social support, organizing spiritual support for patients and their families, educating patients, families and carers, helping to source equipment which facilitates daily functioning, solving problems relating to cancer and its consequences, overcoming myths and superstitions about cancer, suffering and analgesic treatment including prescription of opioids.

A five-year follow-up study of the work of the HSG at the Oncology Centre in Warsaw confirmed the utility of such forms of patient care, and the authors recommended the inclusion of HSGs as indispensable units in the oncology hospital structure (Jarosz et al. 2010).

Another form of palliative-hospice care, the day-care centre, is practically nonexistent in Poland. Other units, such as pain, lymphoedema and wound treatment clinics, also offer palliative care (Buss & Lichodziejewska-Niemierko 2008).

A review of the research on the effectiveness of interventions in terminal-stage cancer patients (Lorenz et al. 2008) found that palliative care can greatly improve QOL. The findings on pain control are the most unequivocal. The available empirical documentation provides indubitable evidence that patients who are given pain control interventions have significantly higher QOL, and gives clear recommendations concerning effective care control treatment (cf. Carr et al. 2002, Jack et al. 2003). The positive effect of control of breathlessness is equally well documented. This symptom is best controlled pharmacologically. Patients' subjective well-being has also been found to improve following stress control and relaxation training by nurses (Brown and Pachalska 2003; Gysels & Higginson 2004).

Palliative care also has documented positive effects on psychological and general QOL. Michiyo and Tatsuya (2010) found improved spiritual well-being in patients following a structured life interview. Dignity therapy, a component of the life history interview, also improved patients' emotional state and enhanced their existential QOL (Chochinov et al. 2005). Lorenz et al. (2008) quote data showing that drug therapy is effective in depressed cancer patients.

The presented findings imply that specific types of palliative intervention, realised at various levels, can significantly improve patients' QOL. There is also empirical evidence that the site where care is rendered may also be important. Melin-Johansson et al. (2010) found a significant increase in psychological, physical, medical and global QOL when patients with advanced cancer were transferred from hospital to palliative home care. Similar findings have been reported by Peters & Sellick (2006), who compared patients in inpatient and home palliative care.

To summarise, the presented findings show that a clear relationship between palliative care and various dimensions of QOL in cancer patients is well documented empirically.

QOL and the needs of patients in palliative care

When discussing the importance of palliative care for QOL in cancer patients one cannot forget about the problem of fit between care and patients' needs. The approach which best complies with the theoretical assumptions and goals of palliative care is the so-called "Warsaw Model" developed at the Oncology Centre in Warsaw (Jarosz & Hilgier 1990), based on the authors' own patient expectation questionnaire. This model stresses the need not only to treat symptoms, but also to satisfy the patient's psychological needs. The model's rationale and the original questionnaire led to the construction of the Patient Expectation and Satisfaction Questionnaire – PESQ (Czerwik & Jarosz 2006). The PESQ is theoretically rooted in Calman's (1984) QOL con-

cept. Calman defines QOL in terms of discrepancy between the individual's expectations and hopes and their level of satisfaction. It is therefore imperative that we understand how patients subjectively evaluate the difference between the ideal situation and the actual situation. This discrepancy largely depends on how well the patient's needs are satisfied. This approach puts the patient in the centre of attention, because the patient knows best what help he/she needs and expects.

According to Calman, one can improve patients' QOL by improving either the actual situation or modifying their expectations to make them more realistic.

Studies of patients in palliative care in hospices (Czerwik & Jarosz 2008) have shown that it is not enough to ensure good symptom control, including cancer pain control, to achieve high QOL. Patients identified the following aspects of QOL as the most important for them:

- need for affiliation (to spend time with significant others, family);
- activity/hobby;
- level of control and information concerning their situation;
- being under the competent and compassionate care of relatives and medical staff.

The researchers also found a significant association between satisfaction of the need for intimacy, self-determination, being informed and being cared for on the one hand, and QOL on the other hand.

Coping strategy and QOL

The most quoted theory of coping with cancer is the theory of Kübler-Ross (1969), which states that the reactions of the patient with cancer evolve with time and with the changing context of the condition. When cancer is first diagnosed, the patient is shocked and takes in the bad news selectively, in a fragmented way. Very acute anxiety, a sense of threat and helplessness are the dominant affects. In extreme cases they may lead to suicide attempts or treatment refusal. Then the patient gradually gets used to the novel situation and integrates his/her self-concept and fantasies about the situation. Defence mechanisms become stronger, the most frequent ones being regression, repression, suppression, withdrawal or isolation from the environment, and turning toward religiousness and religious faith (Kübler-Ross 1979).

Contemporary psycho-oncological research is focusing on the constructive and destructive ways in which patients cope with cancer and is trying to determine which coping strategies facilitate the healing process, facilitate the development of good therapeutic rapport, delay the progression of illness, improve QOL, and help patients to adjust to their difficult life situation. According to Dolinska-Zygmunt (2001), good adjustment to cancer requires acceptance of oneself in one's new situation. She thinks that if patients are to accept their new situation, they must change their personalities. Such change means modifying their value hierarchy, goals and priorities. Patients must look at the world anew, from the perspective of their illness. They must

achieve self-control and self-determination in their new morbid reality. Adequate adjustment also requires cognitive changes, i.e. patients must understand what has changed, who they now are, and what their meaning and goals in life are in the new situation.

Taylor (1983), an American researcher, studied patients who were coping with breast cancer and found that good adjustment to illness is based on positive evaluation of the experience of illness, i.e. the ability to see the good sides of the experience and its secondary gains. To achieve this, the patient must make a cognitive effort. Her search for an answer to the question why she has fallen ill and what will happen now is helpful, even if the answers are unrealistic. When the patient thinks she knows what caused the disease, she can try to control its course, and confidence in her doctors' competence, her own strengths and her capacity to control her symptoms makes her feel better emotionally and improves her QOL (Zagajewska 1984). She begins to process information about herself and her surroundings in ways which enhance her feeling of self-worth. Downward comparisons are also helpful – the ability to see that others who were in a worse condition and whose prognoses were worse than hers managed to recover thanks to their constructive coping strategies.

Current research on ways of coping with cancer, accepting oneself as an ill person, maintaining good QOL despite one's condition and one's struggle with illness, now focuses on various psychological factors which help patients adapt, such as positive re-evaluation, reinterpretation and symbolization of the illness, sense of coherence, optimism, control and social support (Horowitz 1979, Rogers 1980, Krystal 1981). Years of clinical observation have led to the conclusion that confrontation, i.e. explicit expression of negative emotions and thoughts, helps patients to work through their trauma and achieve good adaptation to their illness. Repressive mechanisms such as alexithymia or difficulty recognizing, expressing, verbalizing and defining feelings and inability to experience positive emotions lead to negative consequences of the stressful events.

Many psychologists who work with patients with cancer think that in order to achieve good adjustment patients must not only adopt healthy coping strategies but also be flexible and able to adjust to the changing life situation (Heszen-Niejodek 1991, Krohne 1986, 1992).

The purpose of this study was to determine cancer patients' QOL and identify their coping strategies. It should then be possible to correlate their coping strategies with their QOL understood in terms of physical and psychological functioning, and to recommend directions of action which the therapeutic team should adopt to ensure maximum effectiveness with respect to improved QOL in patients with cancer.

MATERIAL AND METHODS

Participants

The study was conducted on patients representing all the clinical departments at the Oncology Centre who were also in the care of the Hospital Support Group at the department of Palliative Medicine. Patients in all stages of cancer, treated at various clinical departments at the Centre, are referred to the HSG if, for various reasons, they are in great intractable pain, have other persistent somatic symptoms or have psychological symptoms such as depression. The HSG provides analgesic treatment as well as psychological and social support. Patients can be self-referred or referred by the attending physician at their clinic.

In order to qualify for the study, patients had to be able to fill in the questionnaires themselves. They also filled in an information sheet, but this was not included in the statistical analysis. All patients were over 18 years old, gave their informed consent to participate and were told that the study was anonymous and the results would only be reported in anonymous compilations. The study was conducted between September 2009 and May 2010. All in all, 30 patients aged 21-56 participated.

Instruments

Quality of life was assessed with the QLQ-C30 and psychological adjustment to cancer was assessed with the Mini-MAC.

QLQ-C30

The QLQ-C30, developed by EORTC, adopts a multidimensional approach to the evaluation of patients' QOL by including items enquiring about the effect of illness on the patient's functioning in various spheres of life, and asking him/her to rate the effect of symptoms on functioning in these various spheres. The authorized Polish version of the questionnaire was used in the present study. The QLQ-C30 measures the following aspects of QOL:

- physical functioning;
- emotional functioning;
- fatigue;
- nausea and vomiting;
- pain;
- breathlessness;
- sleep disorders;
- loss of appetite;
- constipation;
- general, subjective QOL.

Most items are rated on a 4-point Likert scale. Reliability (Cronbach alpha) ranges from 0.60 to 0.81 for the functional scales and from 0.52 to 0.86 for the symptom scales.

Mini-MAC

The Mini-Mac is a very good measure of patient strategies. It was adapted for use in Poland by Z. Juczyński (2001). The Mini-Mental Adjustment to Cancer Scale (Mini-MAC) is a self-report measure. It has 29 items, for which patients rate their condition. The scale measures four major coping strategies: anxious preoccupation, fighting spirit, helplessness/hopelessness and positive re-evaluation. Due to the strong inter-correlations between anxious preoccupation and helplessness/hopelessness, and between fighting spirit and positive re-evaluation, two styles of coping with cancer have been proposed – the constructive style, a composite score based on fighting spirit and positive re-evaluation scores, and the destructive style, a composite score based on anxious preoccupation and helplessness/hopelessness scores. Cronbach alpha for the scales ranges from 0.87 to 0.90.

The Mini-MAC can be used in psycho-oncology to assess patients' adjustment to illness, but it can also be used to monitor changes in patient adjustment during treatment and rehabilitation.

RESULTS

In order to determine the relations between strategies of coping with cancer and QOL, patient attitudes and strategies were correlated with the QLQ C30 scale scores. The correlation coefficients are shown in Table 1.

Table 1. Correlations between coping strategies of cancer patients and the QOL

		MINI-MAC					
		ANX	FGHT	HLP	POS	CON	DES
QLQ C30	Physical	-0.92***	0.49**	-0.53***	-0.1	0.33	-0.80***
	Role	0.02	0.22	0.3	0.03	0.18	0.18
	Emotional	-0.75***	0.25	-0.57***	0.22	0.27	-0.73***
	Cognitive	-0.63***	0.50***	-0.66***	0.46*	0.56***	-0.71***
	Social	-0.62***	0.58***	-0.2	0.22	0.53***	-0.46*

* p<0.05

** p<0.01

*** p<0.005

Abbreviations

ANX	Anxious Preoccupation
FGHT	Fighting Spirit
HLP	Helplessness/hopelessness
POS	Positive Re-evaluation
CON	Constructive Style
DES	Destructive Style
Physical	Physical Functioning
Role	Role Functioning
Emotional	Emotional Functioning
Cognitive	Cognitive Functioning
Social	Social Functioning

As we can see, a number of correlations point to a relationship between coping strategies and attitudes toward cancer and various aspects of patients' QOL. The most powerful relations are presented in the following figures and then discussed more thoroughly. The figures show not only the test scores but also the trends which emerged from the linear and multinomial goodness of fit analyses (R^2).

As we see in Figure 1, the lower the ratings of physical functioning, the higher the anxious preoccupation scores. This relationship is almost linear, suggesting that loss of good physical functioning due to illness translates directly into anxiety in the patient.

In Figure 2 we see a negative correlation between emotional functioning and anxious preoccupation.

Figures 3 and 4 show us how the level of anxious and destructive attitudes coincides with patients' cognitive functioning. As we can see, when the

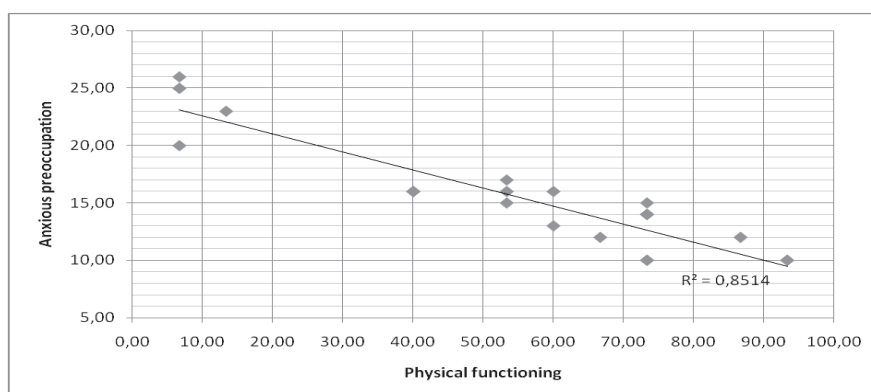


Figure 1. Anxious preoccupation and physical functioning

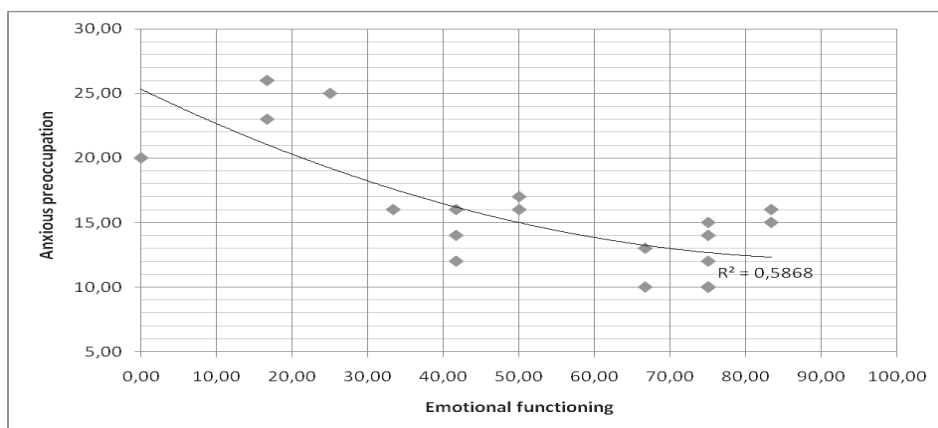


Figure 2. Anxious preoccupation and emotional functioning

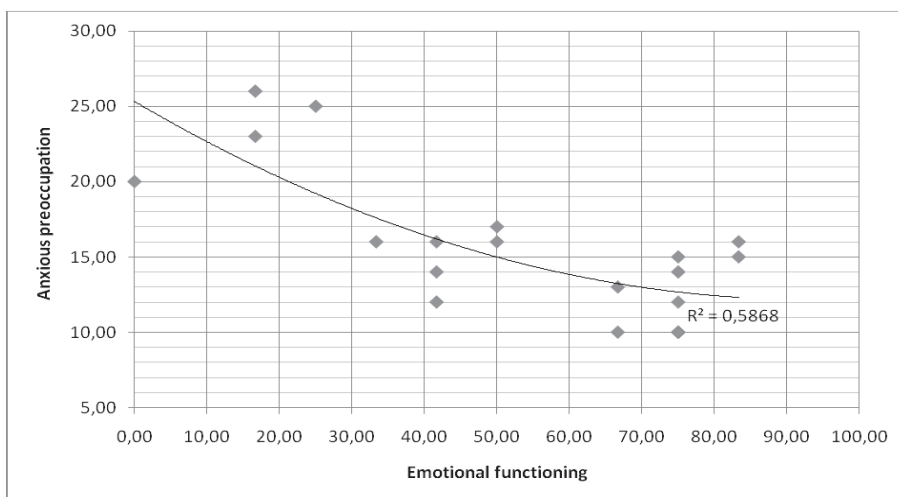


Figure 3. Anxious preoccupation and cognitive functioning

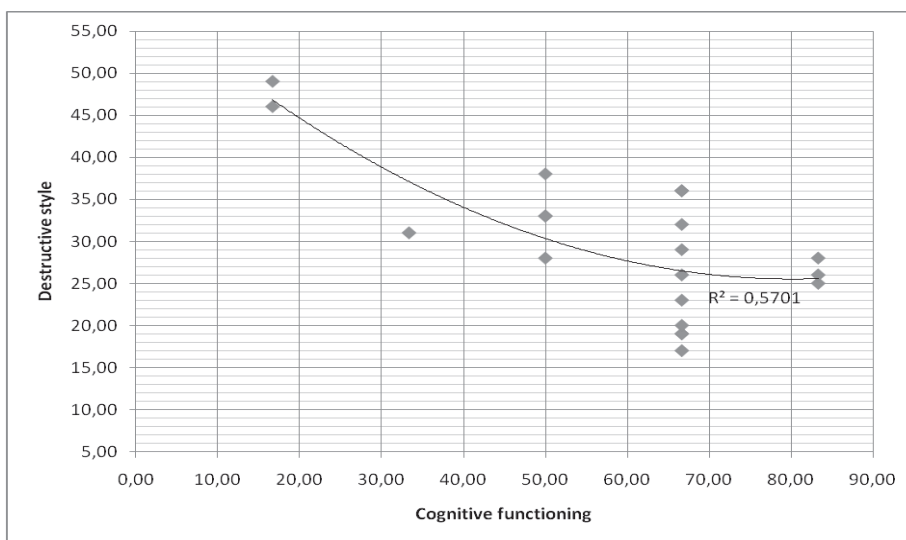


Figure 4. Destructive style and cognitive functioning

patients' cognitive skills are good, they are less likely to adopt destructive coping strategies such as anxious preoccupation.

As we can see in Figure 5, within the range 0-50%, better social functioning goes with less intense anxiety. This pattern confirms the well-known cliché that lonely people are more afraid. However, we also see that the intensity of anxious preoccupation increases again when social functioning is superior (> 50%). This result may be caused by a measurement error

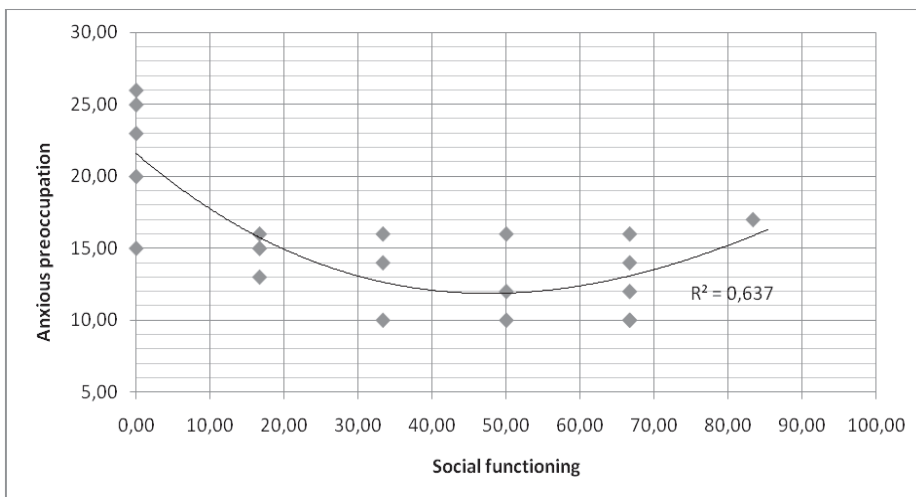


Figure 5. Anxious preoccupation and social functioning

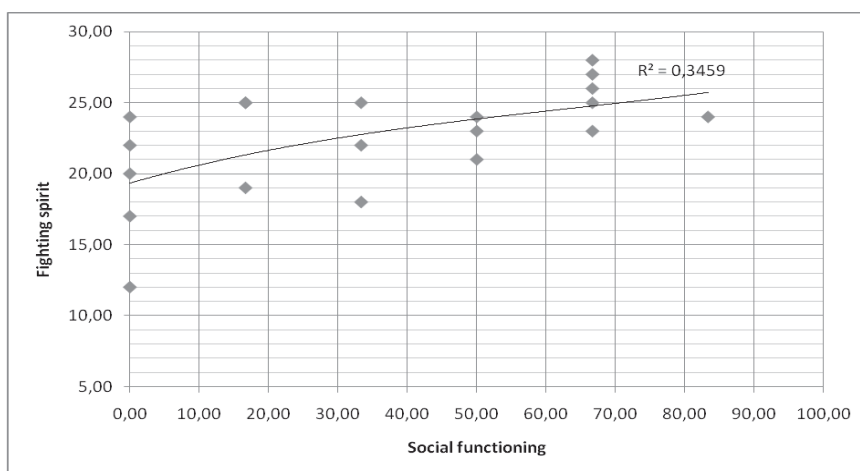


Figure 6. Fighting spirit and social functioning

because the pattern was only found in one patient. Another interpretation would be that when the patient meets many people who express their fear and compassion, this may aggravate his/her own fears and apprehensions.

As we can see in Figure 6, social support and fighting spirit go together.

Figure 7 illustrates the strong correlation between poor physical functioning due to illness and adoption of destructive coping strategies.

As we can see in Figure 8, when the patient's psychological functioning deteriorates this is reflected in the choice of destructive coping strategies.

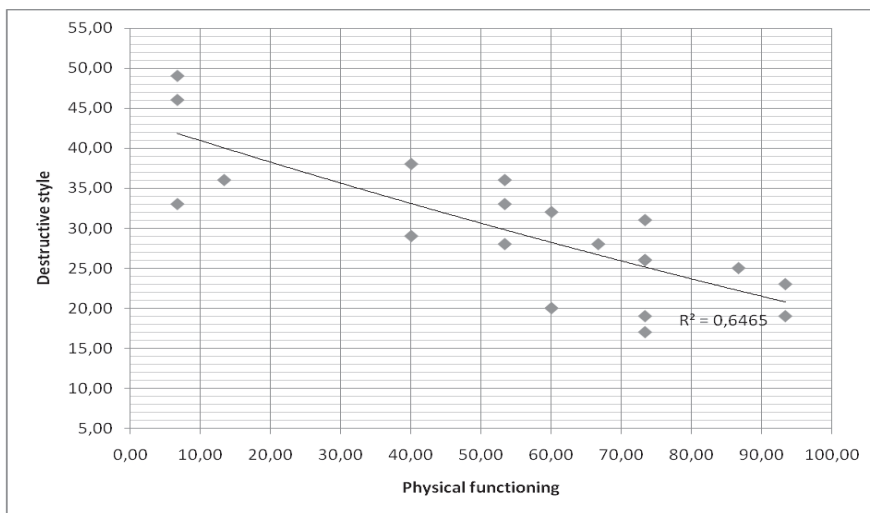


Figure 7. Destructive style and physical functioning

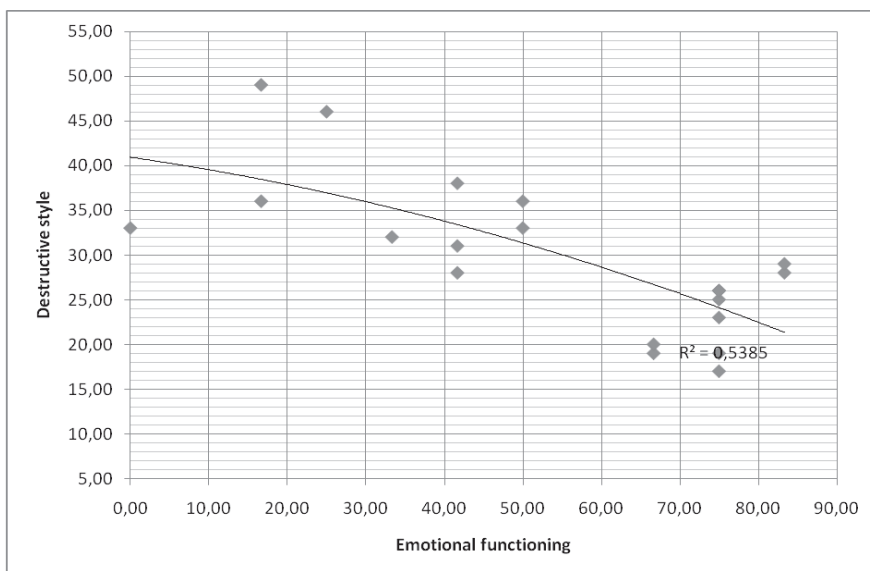


Figure 8. Destructive style and emotional functioning

DISCUSSION

Anxious preoccupation and physical functioning

In this study, the more positively patients rated their physical functioning, the less likely they were to manifest anxious attitudes. This suggests that by rehabilitating patients and improving their fitness we can considerably allevi-

ate their anxiety. Another factor which greatly contributes to patients' perceived QOL is social help, such as providing rehabilitation equipment that increases mobility and functioning despite disability. If the patient's condition makes physical rehabilitation impossible, adequate psychological support will go a long way to reduce anxiety. Existing research has shown that a comprehensive, multi-disciplinary approach should be the gold standard in palliative care.

Anxious preoccupation and emotional functioning

Ensuring psychological comfort can greatly reduce the patient's fear of illness and hospitalisation. Our data, demonstrating a negative correlation between emotional functioning and anxious preoccupation, show how important it is to provide patients, especially oncological patients, with psychological and social support. The patient's emotions have a significant effect on the course of treatment and prognosis, and so it is wrong to ignore them when assessing and treating the patient. In patients who are chronically ill, and this includes patients with cancer, we often find chronic anxiety associated with health and uncertain prognosis (Dolińska-Zygmunt 2001). Such patients often present a specific pattern of emotional expression, i.e. a façade of emotional numbness and calmness hides a real emotional turmoil of rebellion, anger and resentment. Chronically ill patients often have trouble identifying and verbalising their emotional states. This difficulty probably results from years of treatment in strictly medical terms, from the perspective of somatic complaints – the standard approach until recently. The staff would limit their interest to the patient's well-being in a purely physical sense but omit his/her psychological state. There is now ample evidence that this model of medical care leads to a learned pattern of behaviour. If no one asks, the patient will not tell, and so it is very important to pay attention in good patient care to non-verbal cues. These will supply a great deal of valuable information, particularly about the patient's emotional state. Frequently, the only manifestation of anxiety and negative emotion is resistance to various aspects of therapy, entitlement etc. That is why our understanding of the chronically ill patient's specific, unique ways of experiencing and expressing affect is the key to adequate treatment of the primary illness and the accompanying anxiety (Czerwik & Jarosz 2008).

Anxious preoccupation, destructive coping strategies and cognitive functioning

The results presented here show a negative correlation between the intensity of anxious preoccupation and destructive coping strategies on the one hand and cognitive functioning on the other hand. Greater awareness reduces the patient's anxiety, but we must remember that everyone has his/her own individual level of information which will ensure psychological comfort, and that there are numerous barriers resulting, among other things, from the

patient's mental state, which will prevent adequate intake of essential information. Two broad groups of patients can be distinguished: monitors and blunterners. The first group consists of patients who want to know as much as possible about their illness and treatment because this makes them feel better and more psychologically comfortable ("I would rather know where I stand"). On the other hand, blunterners want to know as little as possible because too much information would be more than they can cope with mentally, would be threatening and provoke anxiety ("I would rather not know what's going to happen to me and not think about it, what will be, will be"). Our results suggest that when treating cancer patients one really must know what sort of information the patient needs and can process. All members of the medical staff who have chronic patients under their care should take this aspect of individual differences into consideration. They should also assess the patient's emotional state correctly because acute anxiety is detrimental to cognitive functioning. This will help to prevent the still frequent situation when physicians, for a variety of reasons, do not inform patients optimally about their health and prognoses, leading to uncertainty and negative emotions in the patients. Subsequently, this will influence negatively future doctor-patient relations and lead to further disinformation and mutual exacerbation of anxiety. The reasons for the patient's current attitude have to be individually assessed in each case so as to avoid needless misunderstandings in communication. This is an indispensable aspect of good cooperation in the treatment process.

Fighting spirit and social functioning

Our results corroborate those of other researchers: social support can mobilize the patient to fight consistently and perseveringly with his/her illness and is a great help for the medical staff who care for chronic patients. Time and again, it has been observed in clinical practice that social support has a positive effect on the patient's physical and psychological wellbeing. Patients who have social support and feel important and needed cope better with persistent cancer therapy, have fewer adverse effects and suffer less pain, and they respond more favourably to analgesic treatment. These observations attest to the usefulness of seeking help from volunteers and other social support groups. They help us to see how important it is to allow the ill person to function in society at every stage of illness and avoid compartmentalizing him/her in the role of patient whose duty it is to comply with medical orders. We must remember that before they fell ill, patients were part of society and they continue to be parts of society now they are ill. They play many roles and this also affects their bio-psycho-social condition and the course of treatment. The medical staff must see the human being first and then the patient. This will help to develop co-operation based on partnership, patient trust, greater acceptance of treatment and motivation to get well.

Destructive coping strategies and physical and emotional functioning

We found a powerful correlation between deteriorated physical and emotional functioning on the one hand and frequency of destructive coping strategies on the other hand. Physical dysfunction is the easiest type of dysfunction for patients to notice and they feel that it is important for all aspects of their lives. Most patients experiencing negative emotions, especially if these emotions are chronic, develop destructive coping styles focused on emotions rather than the real problem. Frequent destructive attitudes on oncologic wards include rebellion, resentment, anger, flight into helplessness and dependency, and explicit or implicit resistance. Family support, empathy from the medical staff as well as professional psychological assistance from the hospital psychologist all help to prevent these destructive attitudes (Czerwik & Jarosz 2008). Minimizing the negative effects of illness on physical functioning also helps to prevent the development of negative attitudes and strategies.

CONCLUSIONS

The data we collected and the correlations we found lend themselves to the following conclusions:

- Coping strategies based on fear and resignation (destructive strategies) correlate negatively with QOL in all its functional aspects except social functioning.
- Coping strategies based on fight and positive re-evaluation (constructive strategies) correlate positively with subjective perception of QOL but they correlate negatively with QOL calculated from symptoms.
- Cancer diagnosis is a source of great psychological stress for patients and their families. One of the reasons for this is that cancer evokes many negative emotions, such as anxiety, fear and depression. The patient may or may not be aware of the negative emotions which accompany his/her condition. Sometimes all we can see are multiple defence mechanisms, such as repression. Negative emotional experience should not be seen as something completely negative, however. Negative feelings are a natural companion of adaptation to illness and may eventually lead to better functioning and reduction of internal tension and distress. Psychological therapy should aim at helping patients to cope with the destructive states and emotions which inevitably accompany chronic disease.

Quality of life in cancer patients depends not only on good control of somatic symptoms, but is also largely a function of the patient's psychological state and subjective wellbeing. Thanks to the development of modern medicine it is now possible to control pain and alleviate other somatic symptoms. This way, factors which used to be major predictors of QOL are not so important any longer because available methods of care minimize their effects on patients' lives. As physical symptoms are controlled, the psycho-

logical state becomes most important and QOL depends to a great extent on the provision of psychosocial support which is adjusted to the patient's current situation and subjective needs.

Numerous clinical studies have demonstrated that it is not possible to adopt one and only one care procedure for all cancer patients. It is necessary to assess the coping strategies, defence mechanisms and preferred patterns of behaviour which the patient uses to cope with the illness. It is also necessary to identify possible anxiety and depressive disorders due to the stress of illness and treatment, as well as all other barriers to adaptation to illness. Questionnaires specially constructed for cancer patients, as well as experience in working with such patients, can be a great help. It is also essential that the caring team identifies patients' needs and expectations so that they can be satisfied, and therefore the feeling of deprivation is reduced as far as possible. Also, we need to minimize entitlement with respect to needs and expectations which cannot be satisfied.

Our knowledge of the patients' psychological state, the obstacles with which they are struggling, and their needs and expectations will help us to assist them in their psychological adaptation to cancer and, consequentially, to function better and experience less distress and internal tension.

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Address for correspondence:

Marta Czerwik-Kulpa
Department of Medical Psychology, Medical University of Warsaw
ul. Żwirki i Wigury 81A
02-109 Warszawa, Poland
Email: marta_czerwik@o2.pl
Phone: +48509713604