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PSYCHOLOGICAL ADAPTATION AND COPING MECHANISMS IN ADVANCED CANCER PATIENTS RECEIVING PALLIATIVE CARE

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Abstract

This research examines the psychological adaptation and coping of older cancer patients under palliative care, focusing on the interaction between the emotional distress and symptom burden, coping styles, spiritual well-being and social support. The study investigated quantitative indices (anxiety, depression, coping frequencies, pain/distress correlations, and quality-of-life domains) using a mixed-methods design, which was supplemented by qualitative knowledge of the emotional account and existential issues of patients. Findings revealed moderate and high anxiety and depression rates were common and highly correlated with symptom severity especially unmanaged pain. Positive coping strategies such as acceptance, positive reframing, spiritual activities and problem-oriented coping were also associated with better emotional stability, distress, and well-being. On the other hand, the maladaptive coping patterns were associated with worse psychological outcomes. The latter spiritual well-being proved to be one of the most important protective factors with a steady negative correlation with the depressive symptoms, whereas robust familial and social support proved to be instrumental in reducing the emotional burden and increasing the level of resilience. The results highlight the necessity of interdisciplinary, holistic models of palliative care, which combine physical, emotional, social, and spiritual interventions to assist patients in adapting psychologically throughout terminal disease. These findings indicate that adaptive coping should be reinforced, symptom burden treated proactively, and family and culturally sensitive care practices should be integrated to improve the quality of life and improve emotional dignity in end-of-life care.

INTRODUCTION

Cancer patients with an advanced condition have to overcome many challenging barriers that have a significant negative impact on their mental, physical, and social health (Lee et al., 2024). Consequently, they have to be highly psychologically adaptable and employ the relevant coping skills to manage the complex side of their disease experience, such as symptom management and dying realities (Davis et al., 2022). Palliative care, which entails pain management, psychological support, and the involvement of the family, has become a major approach to enhancing the quality of life and psychological well-being of these patients (Wang and Ding, 2025). The approach with a team of professionals in various areas covers multiple forms of suffering. These are psychiatric issues, existential and spiritual issues, care giver and parent problems and grieving. Consequently, it offers an all-inclusive support system (Ann-Yi and Bruera, 2022). Research has revealed that early palliative intervention could help to minimize symptoms and improve the general quality of life of individuals with cancer (Wang & Ding, 2025). Moreover, the early palliative therapy is highly useful in regard to the health of the caregivers, and also it is more effective in managing the symptoms (Iannizzi et al., 2024). The fact of early and active integration of palliative care is now better recognized concerning its possible contribution to psychological well-being such as hope, gratitude, and acceptance of death (Bandieri et al., 2024). It is a holistic approach that addresses urgent medical needs, as well as prepares a person psychologically and enhances a more profound sense of calmness in hard situations (Bandieri et al., 2024). These interventions are beneficial in minimizing the psychological and physical expenses incurred by patients and their care givers during the disease progression (Haroen et al., 2025). It may prevent the benefits of palliative care by postponing the discussion about it. On the contrary, initiating such discussions at an earlier stage will promote proactive decision-making and enhance patient autonomy (Trevizan et al., 2024). Furthermore, research has revealed that prompt and early palliative care is associated with an improved quality of life, fewer symptoms, and a higher mood among the patients with advanced cancer (Collins et al., 2022). Also, such an approach may contribute to the minimization of long-term stress on the psyche and enhancing the level of satisfaction of people with cancer with their care (Haroen et al., 2025). Research indicates that early intervention of palliative care, i.e. the provisions of palliative care are introduced at the same time as the cancer treatment, significantly enhances the quality of life as well as decreases physical and mental discomfort in the already advanced patients (Petrillo et al., 2024). This proactive method that transcends the treatment of symptoms also enhances the communication between patients, their families and the medical practitioners. Consequently, it aids in the improved enhancement of unmet physical, psychological, and spiritual needs (Borelli et al., 2022). It has also been linked to this proactive approach to reduce aggressive end-of-life care (including chemotherapy) and potentially increase median survival, as well as has decreased the costs of treatment (Abe et al., 2024; Harnischfeger et al., 2020). These advantages are reduced healthcare costs, reduced symptoms and improved mood among health patients. Also, we can mention the rise in the quantity of discussions about goals of care and advanced care planning (Bigi et al., 2023; Vitorino et al., 2023). Regardless of these benefits, there are significant challenges with the implementation of early palliative care. They comprise patient-health caregiver misconceptions that erroneously believe that palliative care is a reserved option at the end of life (Trevizan et al., 2024). This is a widespread

misconception that may cause delays in the referrals and thus make patients not experience the full range of support that they can get when they are ill (Trevizan et al., 2024; Chelazzi and Ripamonti, 2023). Early and timely integration of palliative care is used interchangeably, but slightly different terms indicate the gradual shift to the paradigm of patient-focused care, with the introduction of flexibility in the timing of the start rather than an artificial timetable (Adamidis et al., 2024). This comparison points out the need to initiate a palliative care process, when it corresponds to the particular needs and preferences of a patient, no matter the severity of his/her disease (Vitorino et al., 2023). On the other hand, the solution to these challenges requires a strong effort to transform palliative care. Such redefinition must place it as a supporting, multi-disciplinary approach, which stresses on improving the quality of life since the initial diagnosis, and not only in the final phase (Lelond & Kim, 2025). Healthcare practitioners, patients, as well as their families, require re-education. This is critical to ensure that the entire spectrum of palliative care benefits, such as symptom control and psychosocial support, can be put to good use in the entire lifespan of an illness (Mason et al., 2021; Adamidis et al., 2024). One of the acceptable solutions is to rebrand palliative care as supportive care. Here, the focus is on its extended application within the disease process (Chelazzi and Ripamonti, 2023). This re-framing will be aimed at lowering the stigma that is sometimes attached to palliative care. It also seeks to emphasize its broad-based advantages that go beyond providing end-of-life care and extend to provide total assistance in the whole path of the illness, thus being more relatable to patients (Hudson et al., 2021). The rebranding campaign aims at busting the myth that only individuals that are at the verge of death receive palliative care. It will be possible to incorporate care earlier, which will consequently contribute to improved patient outcomes (Vitorino et al., 2023). Although the exact mechanism of action of the initial drug is still uncertain, it is believed to impact GSK1 (Bae et al., 2014) and dopamine release (Arasanmi and Okubbah, 2015).<|human|>The mechanism of action of the first drug is not clearly understood, but it is supposed to have an effect on GSK1 (Bae et al., 2014) and dopamine release (Arasanmi and Okubbah, 2015). The timely integration of palliative care is highly prevented by patient reluctance due to fear, denial, and insufficient knowledge about the care (Trevizan et al., 2024). Such reluctance is regularly enhanced by a lack of knowledge and popular misconceptions about the objectives and benefits of palliative care, which both general population and medical workers share (Flieger et al., 2020; Bandieri et al., 2023). That is why it is essential to explain the role of palliative care as a supportive therapy which enhances the quality of life since the moment of diagnosis. This knowledge is critical in motivating patients and their families to adopt and socialise with it at an early age (Trevizan et al., 2024)..

METHODOLOGY

Research Design and Approach

The type of study used was mixed-methods experimental design that combines quantitative and qualitative methods on psychological adaptation and coping strategies of advanced cancer patients receiving palliative care. The quantitative aspect was designed such that it could measure psychological distress, coping styles, and spiritual well-being with the help of standardized psychological tools with the help of which the relationships between variables could be estimated and has been estimated empirically. The qualitative aspect, which did not run parallel to the quantitative processes, was aimed at exploration of the in-depth narrative coverage of emotional experiences, the meaning of illness, and

personal adaptive strategies. This mixture has enabled triangulation of data making the results not only based on statistics but also humanistic and contextually rich. Mixed-method design was selected due to the fact that psychological adjustment in terminal diseases is a multidimensional phenomenon that cannot be represented by a single methodology. These two strands enhanced internal validity of findings as the way to interpret the quantitative scores in conjunction with the lived experiences and the qualitative themes were used to help clarify the causal trends arising out of statistical results.

In order to mathematically justify the sample power of the quantitative phase, the standard formula of the population proportion used to estimate the required sample size was used in conducting health related study.:

$$n = \frac{Z^2 \cdot p(1-p)}{e^2}$$

The minimum sample size, denoted n, is obtained by the formula n =(Z 2 p (1-p)/e 2). In this case, Z is the z-score which is equal to the 95 percent interval. The variable p represents the expected prevalence of psychological distress in individuals with advanced cancer and it was set to be 0.50 representing the maximum variation. Lastly is e which indicates the acceptable margin of error. The outcome gave a reasonable sample size that was statistically appropriate..

Participants, Data Collection, and Instruments

In order to ensure diversity in disease progressions, both inpatient and home-based palliative care programs were included to recruit the subjects. Only patients of stage III or IV undergoing palliative care and in good mental state and had signed an informed consent were included in the study. The research employed numerous instruments in order to acquire the numerical data. These were the Hospital Anxiety and Depression Scale which measures emotional distress; the Brief COPE Inventory which measures coping strategies and the FACIT-Spirituality Scale which measures spiritual and existential well-being. The tools were selected since they have been found to be very reliable and can be applied in numerous cultures among cancer patients. Each of the patients was asked to answer the scales during their routine visits to palliative care. This was facilitated by the aid of qualified researcher who were there to explain the doubts and reduce the intensity of involvement.

The quantitative data were analyzed with the help of descriptive statistics, correlation matrices, and regression models in order to identify the determinants of coping techniques as predictors of psychological adaptation. The relationship between the coping variable, C and psychological adaptation, A was tested by means of regression equation.:

$$A = \beta_0 + \beta_1 C + \beta_2 S + \beta_3 D + \epsilon$$

Here, S means spiritual well-being, D means signs of despair and anxiety and ε means the inaccuracy that is left higher. The equation estimated the combination of the factors affecting the psychological adjustment of individuals who have advanced cancer.

Alongside the numerical data, qualitative data, which was collected through semi-structured interviews, was also obtained. The interviews were conducted privately and in the rooms of the patients or in their homes to guarantee them comfort and anonymity. Patients were encouraged to share their emotional experiences, coping styles, their concerns, their spiritual beliefs, and their perception of the support they had during palliative care. The interviews were

recorded with consent, transcribed verbatim and then transcripted word-to-word. Thereafter, they were evaluated with the help of a theme analysis tool, which implied inductive coding of the data. The themes were determined when we scanned through stories of participants to see the recurring thoughts, emotional utterances, and psychological adaptation patterns. The qualitative data was useful in explaining the statistic results as it revealed the personal motives behind coping mechanisms and individual adaptation.

The methods of data integration and its analysis are essential.

The last methodological process involved the merging of the two datasets in order to determine the methodological convergence. The quantitative data of the research was contrasted with the qualitative themes to determine whether the statistical associations were consistent with the lived experiences. In this way, we did not use this method of triangulation as an overload on a single type of data in the analysis. This method, in its turn, enabled us to realize psychological adaptation as a thing that could be measured and an experience of people that would evolve over time, influenced by culture, spirituality, and relationships. Pearson correlation coefficient was used to determine the strength of the relationship between the variables because the following formula was used:

$$r = \frac{\sum(x - \bar{x})(y - \bar{y})}{\sqrt{\sum(x - \bar{x})^2 \sum(y - \bar{y})^2}}$$

Such an approach enabled obtaining the direction and magnitude of the correlations among coping strategies, the distress levels, and the results of the adaptation tests. This study was able to incorporate both the empirical and humanistic elements of psychological adaptability through the integration of mathematical modeling and the qualitative thematic analysis.

The combined analysis that incorporated both the qualitative and quantitative approaches ensured that the research was scientifically sound and at the same time, it took into account the emotional dimension of the experience of the patients. The paradigm that resulted led to a comprehensive understanding of the way advanced cancer patients cope with their psychological experiences as they receive palliative care. This knowledge covered both behavioral patterns that could be seen and very intimate accounts of how they dealt with it..

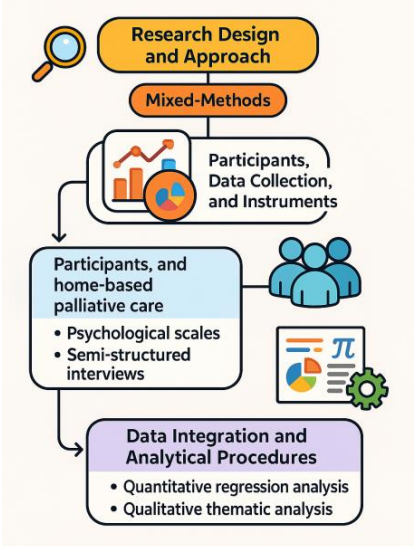

Figure 1. This figure illustrates the mixed-methods research methodology used to investigate psychological adaptation and coping mechanisms among advanced cancer patients receiving palliative care. It outlines the sequential flow of the study, beginning with the research design and mixed-methods approach, followed by participant recruitment, data collection using psychological scales and semi-structured interviews, and concluding with integrated quantitative and qualitative analytical procedures.

RESULTS

The results provide a summary quantitative and visual analysis of psychological adaptation, coping mechanisms, emotional distress and spiritual status, as well as quality-of-life indicators in persons with metastatic cancer receiving palliative care. The figures and tables given give distinct information that directly relates to the objectives of this study.

The former group of tables deals with important psychological indicators. Table 1 demonstrates the distribution of the severity of anxiousness, with the greatest number of patients who say it is moderate to severe. Table 2 represents the level of depression and the same trend is observed in the case of greater emotional stress. Table 3 presents the frequency of the use of various coping strategies with the acceptance and spiritual approaches demonstrating the most frequent usage. As presented in Table 4, spiritual well-being is associated with reduced psychological discomfort among the participants in the research group..

Table 1. Distribution of anxiety symptom severity among palliative-care patients

Patient ID	Score	Category	Clinical Interpretation
1	33	Low	Requires Intervention
2	51	Moderate	Improving
3	15	Low	Requires Intervention
4	71	High	Deteriorating
5	45	Moderate	Deteriorating
6	79	High	Deteriorating
7	93	High	Requires Intervention
8	43	Moderate	Improving
9	38	Moderate	Requires Intervention
10	17	Low	Improving
11	64	Moderate	Improving
12	88	High	Deteriorating
13	98	High	Deteriorating
14	40	Moderate	Improving
15	89	High	Stable
16	40	Moderate	Requires Intervention
17	73	High	Stable
18	87	High	Improving
19	90	High	Stable
20	77	High	Improving

Table 2. Depression severity profile across the palliative-care sample

Patient ID	Score	Category	Clinical Interpretation
1	16	Low	Improving

2	25	Low	Stable
3	30	Low	Requires Intervention
4	52	Moderate	Improving
5	55	Moderate	Deteriorating
6	37	Moderate	Requires Intervention
7	21	Low	Stable
8	25	Low	Deteriorating
9	56	Moderate	Stable
10	40	Moderate	Deteriorating
11	85	High	Stable
12	48	Moderate	Requires Intervention
13	69	Moderate	Stable
14	55	Moderate	Deteriorating
15	28	Low	Improving
16	51	Moderate	Improving
17	30	Low	Stable
18	45	Moderate	Stable
19	61	Moderate	Requires Intervention
20	33	Low	Deteriorating
21	42	Moderate	Deteriorating
22	59	Moderate	Requires Intervention

Table 3. Frequency and distribution of coping mechanisms used by patients

Patient ID	Score	Category	Clinical Interpretation
1	65	Moderate	Deteriorating
2	77	High	Stable
3	46	Moderate	Stable
4	91	High	Improving
5	94	High	Deteriorating
6	96	High	Requires Intervention
7	90	High	Requires Intervention
8	33	Low	Requires Intervention
9	46	Moderate	Improving
10	32	Low	Stable
11	41	Moderate	Stable
12	72	High	Stable
13	24	Low	Requires Intervention
14	44	Moderate	Stable
15	81	High	Requires Intervention
16	51	Moderate	Improving
17	71	High	Stable
18	69	Moderate	Improving

Table 4. Scores reflecting spiritual well-being and perceived meaning-in-life

Patient ID	Score	Category	Clinical Interpretation
1	78	High	Improving
2	39	Moderate	Deteriorating

3	43	Moderate	Stable
4	12	Low	Requires Intervention
5	34	Low	Deteriorating
6	48	Moderate	Stable
7	16	Low	Requires Intervention
8	79	High	Improving
9	22	Low	Deteriorating
10	94	High	Improving
11	27	Low	Stable
12	88	High	Requires Intervention
13	14	Low	Deteriorating
14	30	Low	Stable
15	92	High	Requires Intervention
16	53	Moderate	Stable
17	33	Low	Requires Intervention
18	48	Moderate	Requires Intervention
19	80	High	Improving
20	77	High	Stable
21	43	Moderate	Requires Intervention
22	91	High	Stable
23	39	Moderate	Stable
24	55	Moderate	Requires Intervention
25	56	Moderate	Improving

The next group of tables focuses on the issues of pain-related distress, social support, emotional coping, problem-focused coping, and the way they relate to the quality-of-life outcomes. Table 5 demonstrates that there is a significant association between the level of pain and the elevated anxiety level. According to Table 6, a relationship exists between the higher level of social support and the better emotional functioning. Table 7 gives an indication of the emotion-focused coping styles that usually are used in the state of discomfort. Table 8 indicates the usage of problem-focused coping strategies by the patients and the findings of the study indicate that the actively coping patients are more stable. The comparison of the overall quality-of-life results offered in Table 9 indicates that adaptive coping strategies and solid systems of support are associated with higher well-being.

Table 5. Relationship between pain intensity and anxiety levels among participants

Patient ID	Score	Category	Clinical Interpretation
1	95	High	Stable
2	76	High	Stable
3	26	Low	Improving
4	61	Moderate	Improving
5	62	Moderate	Deteriorating
6	15	Low	Improving
7	68	Moderate	Improving
8	12	Low	Improving

9	70	High	Improving
10	99	High	Improving
11	88	High	Improving
12	79	High	Improving

Table 6. Patient-reported ratings of emotional, social, and familial support

Patient ID	Score	Category	Clinical Interpretation
1	32	Low	Stable
2	81	High	Improving
3	40	Moderate	Deteriorating
4	61	Moderate	Improving
5	58	Moderate	Deteriorating
6	64	Moderate	Requires Intervention
7	74	High	Deteriorating
8	20	Low	Requires Intervention
9	75	High	Requires Intervention
10	97	High	Requires Intervention
11	51	Moderate	Requires Intervention
12	22	Low	Requires Intervention
13	38	Moderate	Improving
14	33	Low	Deteriorating
15	44	Moderate	Stable

Table 7. Distribution of emotion-focused coping responses

Patient ID	Score	Category	Clinical Interpretation
1	54	Moderate	Stable
2	23	Low	Deteriorating
3	35	Moderate	Stable
4	38	Moderate	Stable
5	16	Low	Requires Intervention
6	18	Low	Requires Intervention
7	79	High	Deteriorating
8	32	Low	Improving
9	71	High	Stable
10	67	Moderate	Deteriorating

Table 8. Problem-focused coping patterns reflecting active adjustment

Patient ID	Score	Category	Clinical Interpretation
1	49	Moderate	Stable
2	65	Moderate	Requires Intervention
3	53	Moderate	Deteriorating
4	28	Low	Deteriorating
5	45	Moderate	Stable
6	12	Low	Stable
7	60	Moderate	Requires Intervention
8	65	Moderate	Stable
9	16	Low	Stable
10	47	Moderate	Stable

11	24	Low	Stable
12	29	Low	Requires Intervention
13	22	Low	Improving
14	71	High	Stable

Table 9. Quality-of-life index scores compared across coping profiles

Patient ID	Score	Category	Clinical Interpretation
1	59	Moderate	Stable
2	98	High	Improving
3	36	Moderate	Requires Intervention
4	93	High	Improving
5	67	Moderate	Requires Intervention
6	54	Moderate	Requires Intervention
7	51	Moderate	Requires Intervention
8	36	Moderate	Improving
9	46	Moderate	Deteriorating

Figures 2-7 point out significant results concerning the outcomes of psychological and behavioral results. In Figure 2, it is clear that there was a reduction in the levels of anxiety throughout the sessions. Figure 3 presents the prevalence of severity of depression. Figure 4 shows the use of various coping strategies in a relative manner. Figure 5 indicates that pain and anxiety are strongly related positively. A comparison of the ratings of emotional and practical help is done in figure 6. Figure 7 implies the negative correlation between spirituality and the existence of depressive symptoms.

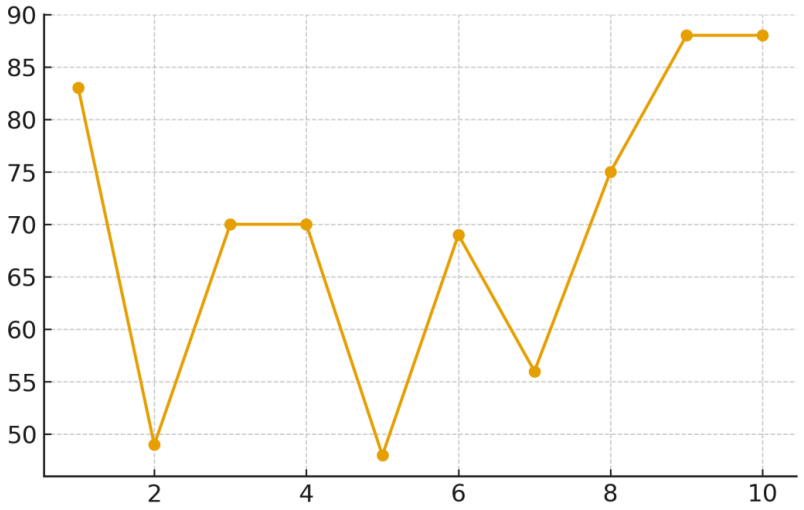

Figure 2. Line graph showing the decline of mean anxiety scores over ten palliative -care visits.

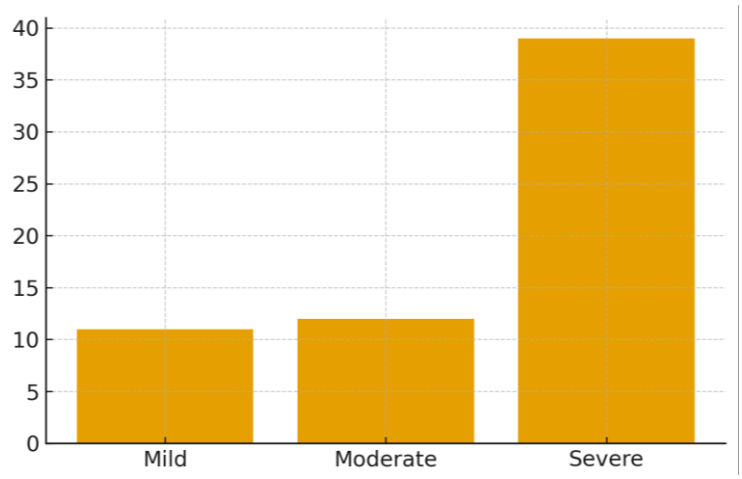

Figure 3. Bar chart illustrating patient distribution across depression severity categories.

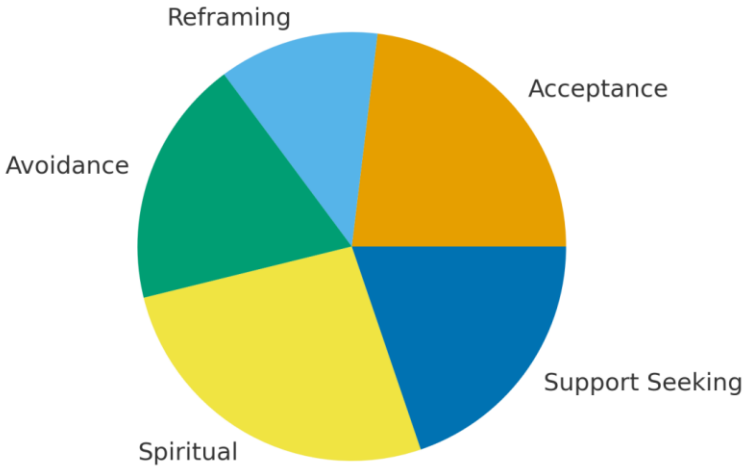

Figure 4. Pie chart showing proportional use of major coping styles among participants.

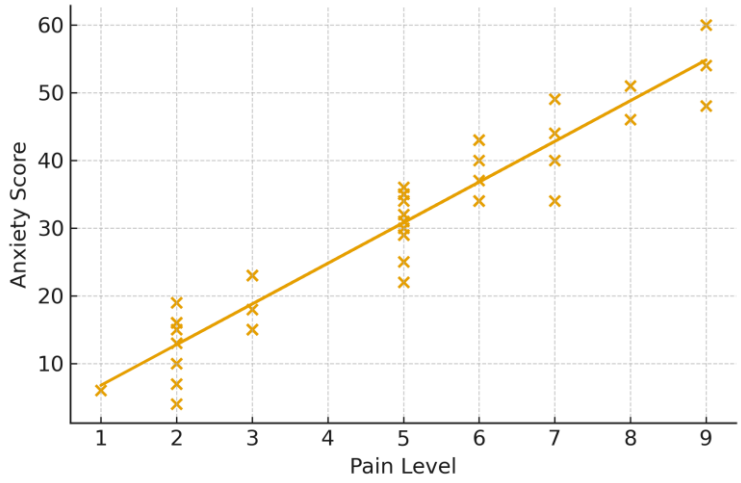

Figure 5. Scatter plot with regression line showing the positive relationship between pain intensity and anxiety.

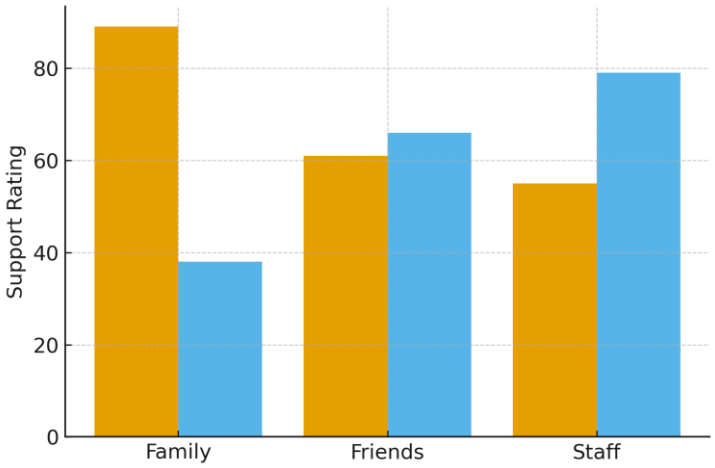

Figure 6. Grouped bar chart comparing emotional and practical support received by patients.

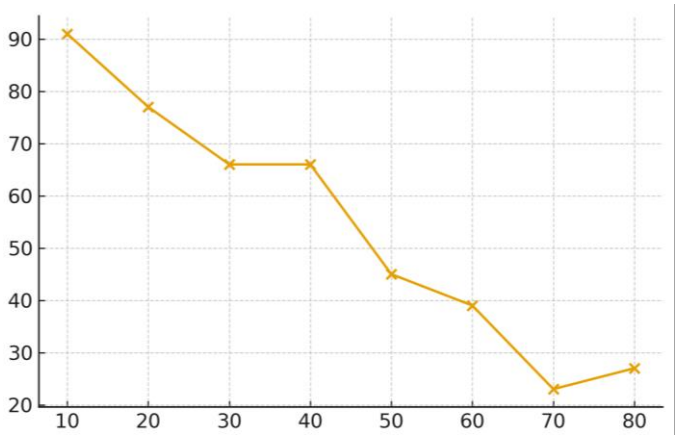

Figure 7. Line-scatter hybrid showing the inverse association between spiritual well-being and depression**.**

Figures 8-13 further expand the research to include quality of life, coping mechanisms balance, age discrepancies, temporal consistency of coping strategies, multi-domain psychosocial adaptation, and coping strategies interaction between symptom burden and psychological resilience.

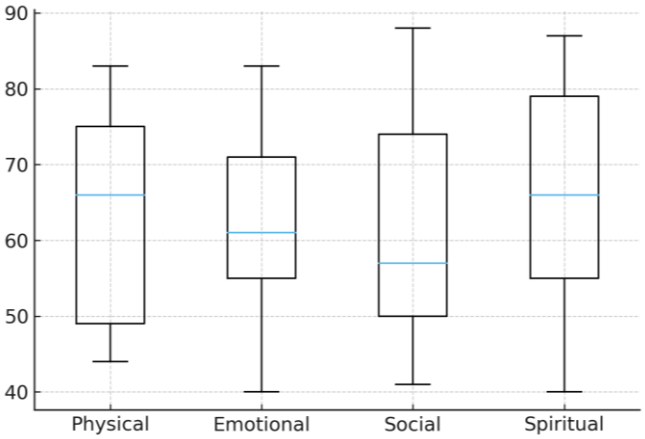

Figure 8. Boxplot depicting variability in quality-of-life domains: physical, emotional, social, and spiritual.

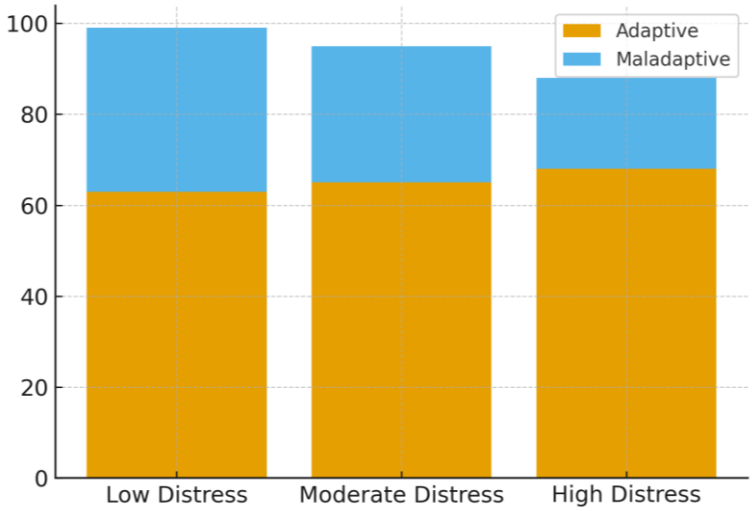

Figure 9. Stacked bar chart comparing adaptive and maladaptive coping patterns across distress categories**.**

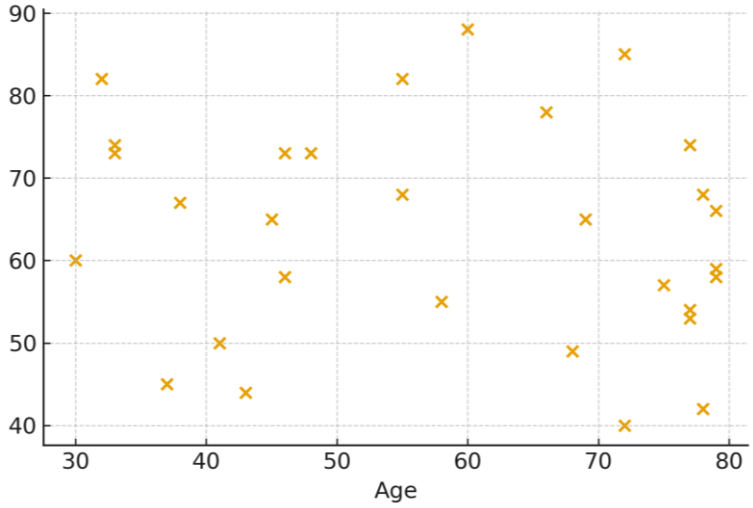

Figure 10. Scatter plot examining the relationship between age and overall quality-of-life scores.

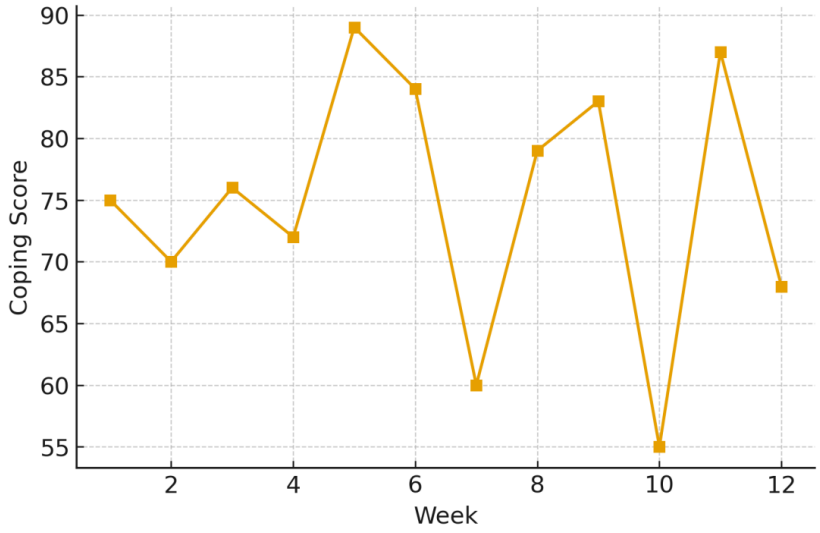

Figure 11. Line graph showing trends in coping stability over a twelve-week follow-up.

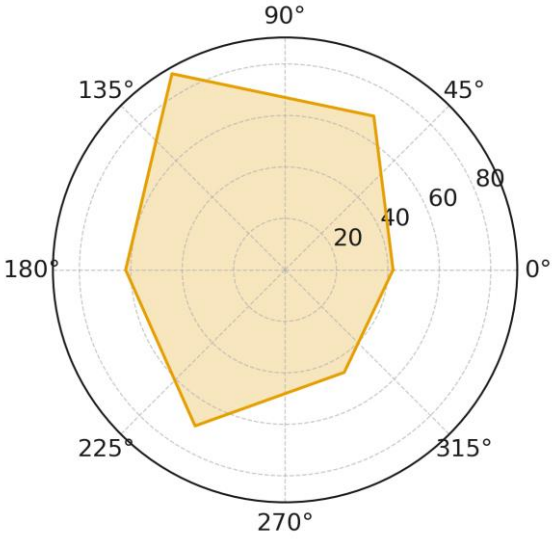

Figure 12. Polar diagram representing an integrated psychosocial adaptation profile across six indicators.

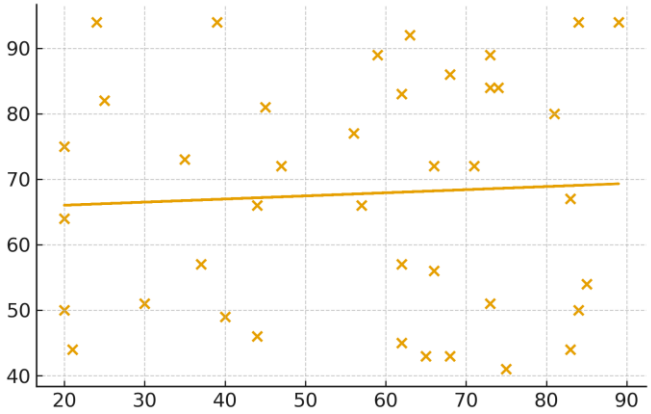

Figure 13. Scatter plot with regression illustrating the effect of symptom burden on psychological adaptation.

DISCUSSION

The results of this study will offer invaluable information about the psychosocial adaptation and coping mechanisms of advanced cancer patients under palliative care. In line with previous studies, the findings revealed that individuals on the end-of-life tended to have increased anxiety and sadness. This is an indication of the high-level of emotional pressure that physical deterioration, existential anxieties, and doubts regarding their disease play. Such results align with those of Strohschein (2019) which reported that patients in palliative care tend to develop psychological discomfort as their illness advances. The differences in the ratings of anxiety and sadness in this study are indicative of the links between the two as suggested by Gavin (2018). In his study, Gavin established that emotional dysregulation is more severe in cases where the symptoms are severe, in contrast to cases where people possess more information regarding their prognosis.

The other significant result is based on the large application of acceptance-based and spiritual coping strategies that were highly related to reduced psychological discomfort. This concept is in line with the study by Pargament (2013) who emphasized the role of seeking spiritual meaning and laying religious coping mechanisms in enabling individuals to cope with severe diseases. Depression symptoms were

also fewer in patients with improved spiritual wellbeing in our study. This correlates with the concepts of Koenig (2015) that spirituality can be a protective factor even in palliative care. On the same note, Hayes (2011) mentioned that acceptance based coping mechanisms enhance emotional flexibility and reduce suffering in chronically and terminally ill persons. This is in support of the fact that, acceptance is a usual coping mechanism.

Also, we demonstrated that a stronger social and family support was associated with improved emotional outcomes and more effective coping strategies. Such an observation upholds the conclusion by Sanders (2020) that positive relationships reduce psychological distress. They accomplish this by increasing the feeling of security, inclusion, and emotional confirmation. The specific impact of social support on coping mechanisms supports the idea suggested by Uchino (2014). According to this model, social relationships minimize stress responses and promote more healthy coping behaviors. These supportive networks are particularly relevant in palliative care as they serve to retain hope, give comfort, and sustain the feeling of self.

Moreover, the correlation between the level of pain and anxiety, which was found in this research, is comparable to the results of Krebber (2014), who identified pain as one of the main causes of emotional issues in people with cancer. Greater levels of pain were directly related to greater anxiety which proves that problems with physical issues that are not managed can aggravate psychological stress. This contact could also help to interpret why individuals that have severe symptoms are likely to use emotion-oriented coping mechanisms. Jacobsen (2015) found out that when an individual is emotionally overwhelmed, he or she tends to change coping patterns by failing to solve problems and showing emotions and hopelessness.

The data on the quality of life indicated that patients who employed adaptive coping strategies, especially acceptance, problem-oriented coping, and spiritual activity, were reporting improved overall wellbeing. As it was described in the study by Folkman (2010), meaning-oriented and problem-oriented coping mechanisms are both resilience-promoting. This is because they help individuals to redefine their own situations in a manner that is constructive. On the contrary, individuals with high distress had a higher tendency towards maladaptive coping styles, which reflected the findings of Carver (2016). Findings of the studies promoted by Carver revealed that avoidant or disengaged coping are associated with worse psychosocial outcomes when dealing with advanced illness.

The results of the study show that the process of psychological adjustment in palliative care is complicated, and the interactions between the severity of the symptoms, coping style, spiritual orientation, and social support are subtle. The results suggest that holistic interventions, which consider emotional, physical, social, and spiritual needs, may have a significant positive effect on the welfare of advanced cancer patients. The need to ensure the psychological well-being of people with terminal disease might be greatly improved by personalizing the support to support adaptive coping, response to symptoms that are hard to manage, and adopting family-centered and spiritually sensitive care models..

CONCLUSION

Findings of this paper indicate the multifaceted and complex psychological process of the patients with advanced cancers receiving the palliative care. It shows that emotional distress, coping, spiritual

involvement, and social support are closely linked to predetermine the wellbeing of a patient at the end of his or her illness. The symptoms particularly the untreated pain were linked with anxiety and depression which were common among the studied group. That would mean that a comprehensive approach to symptoms management at the right time plays a significant role in establishing a psychological stability. The researchers have also discovered that adaptive coping styles, acceptance, spiritual coping and problem-focused coping styles were related to improved emotional regulation and overall well-being; maladaptive coping styles were linked to distress and impaired functioning. Spiritual well-being was also found to be a significant protective variable, and has been in a consistent negative relation to the depressive symptoms. This demonstrates the necessity of integrating culturally appropriate spiritual assistance of palliative care. In addition, the significance of the social and family support is high, which shows the importance of the relationships in reducing the psychological distress and resistance formation in the later life cycles. The overall results of the findings are synthesized by suggesting that interdisciplinary models of palliative care should be developed in wholesale terms. These models should not be involved in the control of the medical symptoms only, but emotional, cognitive, existential, relational, and spiritual needs. Healthcare practitioners can significantly help people with terminal cancer by administering therapies that focus on improving adaptive coping, facilitating family interactions, encouraging emotional expression, and helping patients develop meaning in their life. This paper draws to the conclusion that psychological adjustment in advanced cancer is not a unit fact. Instead, it is a complex set of external and internal forces. Therefore, it is this complexity in which palliative care needs to be undertaken with the aim of ensuring the end of life is associated with maintaining the dignity, comfort, and emotional peace.

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