

# The potential role of psychosocial rehabilitation in palliative care

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## Abstract

Palliative care is an approach to incurable and/or severe disease with limited prognosis, aiming to relieve the suffering and improve the quality of life of patients and their families. The existence of psychopathology is common in patients undergoing palliative care, and psychiatric comorbidities, such as depression and anxiety, are frequent and often underdiagnosed. This work constitutes a review of the literature and a reflection on the potential role

of psychosocial rehabilitation in mental health in palliative care. Psychosocial rehabilitation may play a role in the mental health of patients undergoing palliative care, contributing to the minimisation of symptoms, support in daily life activities, the improvement of quality of life and the preparation for death.

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**Keywords:** mental health, palliative care, psychosocial rehabilitation

**Financial and Competing Interests:** No conflict of interests declared

Palliative care is an integrated approach that promotes the quality of life of patients and families who are confronted with the physical, psychosocial and spiritual problems associated with a life-threatening illness.<sup>1</sup>

The palliative patient is not necessarily a terminal patient (estimated prognosis of 3–6 months), or a moribund or agonising patient (estimated prognosis of days or hours).<sup>1</sup>

According to the World Health Organization (WHO) and the National Plan of Palliative Care, palliative care: affirms life and accepts death as a natural process, without trying to delay the process; constitutes a global and holistic approach to the patients suffering from a physical, psychological, social and spiritual point of view; seeks the wellbeing and quality of life of the patient; is centered on the needs of patients and their families, life and death; should not be restricted to terminally ill and agonised patients; and, should be addressed by a multidisciplinary team.<sup>1,2</sup>

The person with a life-threatening illness feels in total pain.<sup>1</sup> Patients with an advanced life-limiting illness experience great suffering, a complex negative state of malaise (bodily, affective, cognitive, spiritual) characterised by feeling threatened and destroyed in the integrity or continuity of their existence, a sensation of powerlessness to face this threat and an exhaustion of their personal and psychosocial resources.<sup>1</sup>

The main sources of suffering in palliative care patients are poorly controlled symptoms, loss of autonomy and dependence on others, alterations in body image, loss of social roles and status, impairment in interpersonal relationships, feelings of abandonment, changes in expectations and future plans, and loss of dignity and meaning of life.<sup>1</sup>

In most cases, palliative patients have severe functional and cognitive limitations requiring support in basic needs, such as hygiene, food, money, medication and mobility, relying on others for daily life activities, with increasing dysfunctionality and psychological repercussions.<sup>2</sup>

According to number 7 of the Administrative Rule 66/2018 in Diário da República (Portugal),<sup>3</sup> a palliative care unit must ensure: permanent medical and nursing care; psychological intervention for patients, relatives and professionals; social intervention and support; support and intervention in mourning; spiritual intervention; complementary examinations; prescription and administration of drugs contained in the National Formulary of Medicines; hygiene, comfort and food; conviviality and leisure; training in palliative care; and, assistance in the area of palliative care for health professionals, namely primary, hospital and continuing healthcare.<sup>3</sup>

Psychosocial rehabilitation can be understood as, ‘a comprehensive and continuous process that provides individuals with disability due to mental illness the opportunity to achieve the greatest possible functioning potential (in the

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hospital and/or community). It is carried out through a set of procedures and a system of residential and occupational support, seeking to give back and develop the instrumental and social skills necessary for autonomy and quality of life – in a global attitude of empowerment, self-determination and recovery' [V Cotovio, Unpublished data].

Therefore, psychosocial rehabilitation may play a role in the mental health and wellbeing of patients undergoing palliative care, contributing to the minimisation of symptoms, support in daily life activities, the improvement of quality of life and the preparation for death.

## Literature search

This work constitutes a literature review on the potential role of psychosocial rehabilitation in mental health in palliative care.

This paper aims to describe and discuss the state of the current science from a theoretical and contextual point of view, providing readers with up-to-date knowledge.

We carried out a search in Pubmed using the keywords “palliative”, “psychosocial” and “rehabilitation”, from 2000 to September 2017. This work was complemented with the consultation of the Portuguese legislation in force on palliative care and psychosocial rehabilitation.

Initially, the abstracts covering the theme under study were included ( $n = 91$ ). Subsequently, works that did not provide clear, explicit, coherent and structured information were excluded ( $n = 43$ ).

A total of 48 articles (one meta-analysis, 34 original articles, two clinical case articles, eight review articles, two national administrative rules and one economic analysis) and two books (one manual on palliative care and one on psycho-oncology) on the topic were selected for this review.

The review is structured in three parts that aim to address the key psychosocial aspects of palliative care: needs assessment, psychosocial intervention and quality assessment.

## Key psychosocial aspects of palliative care

### Needs assessment

The needs of a person suffering from a serious and irreversible illness are multidimensional, and include physical, psychological, social and spiritual aspects.<sup>1,4,5</sup>

Chronic and advanced disease is complex and often multisymptomatic. In palliative care the most widely used symptom assessment scale is the Edmonton Symptom Assessment System (ESAS). The most recent reviewed version of ESAS comprises eight symptoms (pain, fatigue, dyspnoea, nausea, appetite, drowsiness, depression, anxiety) and a general question on wellbeing.<sup>1</sup>

Pain is an unpleasant sensory and emotional experience associated with tissue damage, actual or potential. The prevalence of pain in the last year of life is 80–90% in patients with cancer and 60–70% in other terminal illnesses. Pain is often underestimated owing to the difficulties of objective measurement. However, pain leads to physical and mental suffering of a human being affecting their decisions and behaviours.<sup>1</sup> Patients with cancer experiencing pain are twice as likely to have a psychiatric complication. The most frequent psychiatric diagnoses in people with pain are adjustment disorders with depressive or mixed mood (69%) and major depression (15%).<sup>6</sup>

Psychological symptoms are frequent in palliative care but are often underdiagnosed. It is common to assume that depression and anxiety represent a natural and understandable reaction to an incurable disease, which may delay or even prevent its adequate treatment.<sup>1</sup>

Depression and anxiety are the most common psychiatric comorbidities in palliative care. In a Canadian National Palliative Care Survey, 381 patients receiving palliative care for cancer were assessed. The prevalence of depressive disorders was 20.7% and that of anxiety disorders was 13.9%, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition diagnostic criteria. Patients with a diagnosed psychiatric disorder were significantly younger, had less functionality, had fewer social networks and had lower participation in religious services.<sup>7</sup>

The wish of the terminally ill to die has been associated with depression and anxiety, but not all patients expressing this desire actually have a psychiatric disorder. A study of patients with cancer receiving palliative care found that the majority of participants (69.5%) had no desire to die. Of those who had this desire, 18.3% expressed occasional transient thoughts and 12.2% reported an apparent genuine desire to die. Of these patients, 52.2% had diagnosed mental disorders and 44.8% had not.<sup>8</sup>

One in three patients with cancer has a moderate-to-high level of emotional distress.<sup>9</sup> Emotional distress has been proposed as the sixth vital sign, and can range from a healthy psychological adaptation to oncological disease to a mental illness.<sup>10</sup> High levels of hopelessness, emotional instability and distortion of self-image are associated with high psychological distress in patients with advanced cancer.<sup>11</sup>

Psychological symptoms may influence physical symptoms. A study of the relationship between depression and the burden of physical symptoms in cancer found that depression was significantly related to the number and severity of physical symptoms.<sup>12</sup>

Social support is another factor that influences the quality of life in patients eligible for palliative care.<sup>13</sup>

Approximately 77% of caregivers of patients with advanced and terminal illness admitted to palliative care also reported

significant distress.<sup>14</sup> In a study of informal caregivers of patients with advanced-stage cancer, almost 52% of participants had at least one psychiatric disorder, with anxiety disorder being the most prevalent condition.<sup>15</sup> About 20% of caregivers develop complicated grief, a syndrome that includes recurrent thoughts and emotional reactions exacerbated in relation to the deceased.<sup>1</sup> Long-term risk factors for complicated grief are a spousal relationship to the patient, the patient's heavy reliance on care, poor family functioning and low levels of optimism.<sup>16</sup> Wives and parents manifest more psychiatric symptomatology than other relatives.<sup>15</sup>

Finally, patients, families and caregivers have spiritual needs. Spirituality is a complex, comprehensive, multidimensional, systemic and integrative personal perspective of human experience, which through processes of questioning, reflection, contemplation, meditation or prayer, looks for possible meanings and purposes of life, feelings of connection and inner peace.<sup>1</sup> Spirituality also reduced distress for patients and caregivers.<sup>17,18</sup> According to two studies, those who believe in life after death have lower levels of distress, anxiety and depression, and despair, since they see life as a ritual of passage.<sup>19,20</sup>

## Psychosocial intervention

### Service set up

The general organisation of palliative care should be integrated into the national health system, and the different levels of palliative care must be flexible, dynamic and accessible, with professionals trained in the area and guided according to holistic thinking.<sup>1</sup>

Four levels of palliative care were identified:

1. palliative actions: integration of the principles of palliative care in any service even if not specialised in this kind of care;
2. basic: care provided by primary healthcare professionals or specialists in life-limiting diseases who have good skills and knowledge in palliative care;
3. specialised: care provided by teams whose fundamental and unique activity is the provision of palliative care; and
4. centres of high complexity or excellence: centres for training, research, dissemination and development of palliative care.<sup>1</sup>

At an early stage in the development of palliative care, the services were directed essentially to cancer patients. Following the WHO's changes to the concept of palliative care, focusing on patients' needs rather than their prognosis, the target population for palliative care has become more comprehensive (including people with progressive, chronic illness, acute, severe illness and life-threatening illness with needs of support from third parties).<sup>1</sup>

The WHO has identified several models of action in end-of-life patients. At one extreme, the 'therapeutic obstinacy model' emerged, which comprised attempts to diagnose and

treat until the last moment of life, with scarce possibilities of response and high costs for the patient, family and system. Another model identified was the 'abandonment model', in which after a period of intense search for curative strategies one reaches the point where one considers that there is nothing left to do, 'abandoning' the patient. With the emergence of palliative care, the 'separate model' arose, in which, after a curative approach without success, the patient would move to a palliative approach. With the evolution of palliative care the 'integrated model' emerged, which advocates for decreasing curative and increasing palliative interventions, depending on the evolution of the disease and the needs of patients. Currently, the most recommended model is the 'cooperative model with crisis intervention', a model characterised by permanent collaboration and articulation between curative and palliative measures from the onset of the disease.<sup>1</sup>

The early start of palliative care is increasingly advocated. A study on the early implementation of palliative care concluded that this can improve quality of life and increase the degree of satisfaction of oncology patients with advanced disease and their caregivers.<sup>21</sup>

Four types of palliative phases are described:

1. acute: unexpected development of a problem or exacerbation of an existing problem;
2. deterioration: gradual negative evolution;
3. agonising: patients in which death is imminent; and
4. stability: patients not in any of the other phases listed.<sup>1</sup>

The goals of care depend on which palliative phase the patient is in. In the acute phase symptomatic control is paramount. In the deterioration phase it is important to give information about the disease and to manage the expectations of the patient and family. In the agonising phase the goal of care is focused on maximising comfort. In the stabilisation phase, the objectives are quality of life and the restoration of possible autonomy with adequate social support.<sup>1</sup>

The complexity of the disease and the associated psychosocial complications require a multidisciplinary approach to better meet the needs of end-of-life patients.<sup>6</sup> A palliative care team should basically comprise a doctor, a nurse and a social worker.<sup>1</sup> The importance of other professional categories in palliative care (such as psychologists and physiotherapists) is increasingly recognised.<sup>1</sup> Within the medical category, psychiatry increasingly plays a relevant role in the management of high-intensity psychological problems at the end of life.<sup>22</sup> Palliative care requires a transdisciplinary approach, in which the team formed of a diversity of professionals use a common approach to solve their problems.<sup>1</sup>

In order to test the case management model (a model of care delivery that integrates patient needs according to their specific health issues in a holistic perspective) in specialised palliative care, a study was conducted that concluded that the case manager may contribute to greater collaborative

efficiency among different professionals in palliative care. The results suggest that the case management model relieves some members of the team of organisational and administrative tasks, which allows a greater dedication to the patient with improved quality of care.<sup>23</sup>

However, the care provided does not depend exclusively on the initiative of the professionals themselves, it also depends on the resources available. There are many disparities between countries, especially in Africa and Asia. The austerity policies implemented in Mediterranean countries and Eastern European countries have also had a negative impact on the psychosocial care of patients with cancer.<sup>24</sup>

### **Communication**

Communication is essential for the satisfaction of patients and their families regarding the quality of care. It can establish a relationship of trust, explore expectations and goals for care, report on illness, listen to and validate concerns and needs of patients, and provide a space for conversation about death.<sup>25</sup>

Giving bad news is an extremely difficult task. More than content itself, the way in which information is transmitted can have repercussions on the patient's reaction. There is evidence that communication training for professionals working with patients with cancer has a beneficial effect on their practice.<sup>26,27</sup>

The incidence of disclosing bad news to a patient increased from 2006 to 2012. The receiver of bad news also changed from family members only, to patients and family members together.<sup>28</sup>

In a study of cancer awareness and the relationship to distress and satisfaction in patients with cancer, most patients were informed about their diagnosis, but this was not the case with their prognosis. Full awareness of their diagnosis and prognosis did not significantly increase emotional distress.<sup>29</sup> The majority of palliative care patients express a desire for a shared decision regarding their treatment.<sup>30</sup>

Another study with patients with cancer found that patients who manifested hopelessness and distress tended to perceive their physicians as being disconnected and less supportive. This points to the importance of the physician-patient relationship in managing emotional distress.<sup>9</sup> In another study, patients reported that, unlike sympathy, empathy and compassion were considered beneficial by patients, compassion being the preferred approach.<sup>31</sup>

Two studies in an intensive care unit also emphasised the importance of effective communication with the family in reducing the psychological symptoms of the patient and the family.<sup>32,33</sup>

### **Psychological interventions**

In order to improve the symptomatology and the quality of life of patients in palliative care, several therapeutic approaches have emerged.

Pain can be addressed by cognitive-behavioural techniques, biofeedback and hypnosis.<sup>6</sup> In a pilot study, patients who received the relaxation intervention by palliative care physicians reported improvements in pain.<sup>34</sup>

Physical symptoms can also condition psychological symptoms that may interfere with the patient's quality of life. A Cochrane study concluded that massage and aromatherapy massage confer short-term benefits on psychological wellbeing. The effect on anxiety and depression is supported by little evidence, and its benefit is limited to 2 weeks after the intervention.<sup>35,36</sup>

Psychotherapy is a strategy for the treatment of depression in patients with cancer. Another Cochrane study concluded that psychotherapy was associated with a significant decrease in the rate of depression in patients with incurable cancer. The evidence, of moderate quality, provided by randomised placebo-controlled trials has suggested that psychotherapy is useful for the treatment of advanced depressive states.<sup>37</sup>

Adjuvant psychological therapy, a cognitive behavioural treatment developed to alleviate cancer-related anxiety and depression, has also been used in emotionally distressed patients with terminal illness.<sup>38</sup>

Several forms of psychotherapeutic intervention have been created to include existential and spiritual dimensions into palliative care:

- Existential psychotherapy: individual or group psychotherapeutic modality that seeks to identify existential conflict (such as freedom, lack of meaning, isolation), dysfunctional defence mechanisms and the destructive influence of self, as well as to alleviate secondary anxiety and to develop coping strategies.<sup>1</sup>
- Logotherapy: therapeutic modality based on the search for meaning of life, which deepens the unique personal existence.<sup>1</sup>
- Group therapy centered on meaning: group modality that promotes personal self-knowledge and search for meaning, peace and life purpose.<sup>1</sup>
- Therapy of dignity: therapeutic modality that explores dignity at the end of life, focusing on physical, psychological, relational, social, cultural and spiritual aspects. This individualised and brief approach invites patients to share important end-of-life issues. These matters will be recorded with the consent of the patient, transcribed and edited in a document as a final legacy that is usually delivered to the family and loved ones.<sup>1,39</sup>

### **Biological interventions**

In order to control the symptoms presented by patients in palliative care, painkillers, antipsychotics, anxiolytics and antidepressants are often used to control pain, psychomotor agitation, anxiety and depression. Some authors argue that some of these interventions are inappropriate in terminally ill patients. There is concern that antipsychotics or sedatives may make the person more sedated or confused.<sup>1</sup>

Management should be carried out on a case-by-case basis, in order to provide the greatest possible comfort in a personalised way.<sup>1,6</sup>

In palliative care, fatigue can be severely debilitating, impacting daily activity and quality of life. Some drugs, such as amantadine, methylphenidate and modafinil, may be beneficial in the treatment of fatigue. A Cochrane review and meta-analysis concluded that in the face of limited evidence, it is not possible to recommend a specific medication for the treatment of fatigue in palliative care.<sup>40</sup>

Another controversial issue is the application of electroconvulsive therapy in palliative care. There are authors who argue that their use should not be completely ruled out and should be considered if it can provide a better quality of life for selected patients.<sup>41</sup>

### Quality assessment

One study suggests that spiritual wellbeing is an important component in the quality of life of patients with advanced cancer. It verified that depression and anxiety were negatively correlated with spiritual wellbeing. Therefore, adequate treatment approaches can reduce suffering and improve quality of life.<sup>17</sup>

In palliative care quality of life is closely related to the quality of death. One study identified 11 main items of a 'good death': preference for a specific death process (such as how, who, where, and when); painless state; religiosity and spirituality; emotional wellbeing; fullness of life; treatment preferences; dignity; family presence; quality of life; relationship with healthcare providers; and other. The three main themes in all groups (patients, family and healthcare providers) were preferences for the dying process (94%), the painless state (81%) and emotional wellbeing (64%). Family members included the fullness of life (80%), quality of life (70%), dignity (70%) and presence of family members (70%) as the main themes. By contrast, religiosity and spirituality was reported more frequently in patients (65%) than in their relatives (50%).<sup>42</sup>

Most patients wish to die at home.<sup>43</sup> This desire may have an impact on the decentralisation of end-of-life care from the hospital environment to the outpatient setting (Domus Model).<sup>44,45</sup>

An economic analysis on healthcare at the end of life found that care by a home-based palliative team was associated with a significant reduction in hospital admission and in the number of emergency room visits in the last 2 weeks of life, as well as a lower risk of dying in the hospital. The results suggest that this approach may meet the patient's desire to reduce healthcare costs.<sup>46</sup>

In order to improve the quality of palliative care, scientific studies are necessary. To evaluate the burden of psychosocial research at the end of life, a study was carried out with patients in palliative care, and it concluded that end-of-life psychosocial research can be performed with terminal patients in an ethical way, since most patients are open to discuss the end of life, and may even benefit from such discussions.<sup>47</sup>

To provide better care to the patient, it is necessary to invest in palliative care training directed to health professionals and caregivers.<sup>26,27,48,49</sup>

### Future directions

Most palliative care patients have some degree of psychosocial disability, manifesting a total or partial reduction in a person's ability to perform activities of daily living in the social, family and professional contexts. The degree of disability is variable, but severity tends to increase as the end of life approaches. This dysfunctionality places people with advanced disease in a situation of disadvantage and dependence. Physical deterioration has significant psychological repercussions that affect a person's quality of life.

Patients are human beings with physical, psychological, social and spiritual needs. Psychosocial rehabilitation as 'the development process of the remaining psychic abilities and of new skills for self-care, activities of daily living, interpersonal relationships, social and professional integration and community participation'<sup>50</sup> may have a role in patients in palliative care.

Finally, integrated psychosocial interventions, targeted towards patients and their families, could allow the reduction of suffering, provide support in basic daily life activities, provide an improvement in quality of life and wellbeing, and aid in preparation for a death with dignity. 

## References

- 1 Barbosa A, Pina PR, Tavares F et al. *Manual de Cuidados Paliativos*. 3rd ed. Lisboa: Faculdade de Medicina da Universidade de Lisboa; 2016.
- 2 Albuquerque E, Cabral AS. *Psico-Oncologia: Temas Fundamentais*. 1st ed. Lisboa: Lidel; 2014.
- 3 Decree Law no 66/2018 of March 6th of the Ministry of Health. Diário da República (Portugal): serie I, No 7 (2018). Access 24 Ago. 2018. <https://dre.pt/web/guest/pesquisa/-/search/114822275/details/maximized>
- 4 Wilson K, Graham I, Viola R et al. Structured interview assessment of symptoms and concerns in palliative care. *Can J Psychiatry* 2004; 49: 350–8.
- 5 Grassi L, Caruso R, Sabato S et al. Psychosocial screening and assessment in oncology and palliative care settings. *Front Psychol* 2015; 5: 1485.
- 6 Gibson C, Lichtenthal W, Berg A et al. Psychologic issues in palliative care. *Anesthesiol Clin* 2006; 24: 61–80.
- 7 Wilson K, Chochinov H, Skirko M et al. Depression and anxiety disorders in palliative cancer care. *J Pain Symptom Manage* 2007; 33: 118–29.
- 8 Wilson K, Dalglish T, Chochinov H et al. Mental disorders and the desire for death in patients receiving palliative care for cancer. *BMJ Support Palliat Care* 2014; 6: 170–7.
- 9 Meggiolaro E, Berardi MA, Andritsch E et al. Cancer patients' emotional distress, coping styles and perception of doctor-patient interaction in European cancer settings. *Palliat Support Care* 2016; 14: 204–11.
- 10 Waller A, Groff SL, Hagen N et al. Characterizing distress, the 6th vital sign, in an oncology pain clinic. *Curr Oncol* 2012; 19: e53–9.
- 11 Diaz-Frutos D, Baca-Garcia E, García-Foncillas J et al. Predictors of psychological distress in advanced cancer patients under palliative treatments. *Eur J Cancer Care (Engl)* 2016; 25: 608–15.
- 12 Fitzgerald P, Lo C, Li M et al. The relationship between depression and physical symptom burden in advanced cancer. *BMJ Support Palliat Care* 2013; 5: 381–8.
- 13 Azevedo C, Pessalacia JDR, Mata LRFD et al. Interface between social support, quality of life and depression in users eligible for palliative care. *Rev Esc Enferm USP* 2017; 51: e03245.
- 14 Costa-Requena G, Cristófol R, Cañete J. Caregivers' morbidity in palliative care unit: predicting by gender, age, burden and self-esteem. *Support Care Cancer* 2012; 20: 1465–70.
- 15 Rumpold T, Schur S, Amering M et al. Informal caregivers of advanced-stage cancer patients: every second is at risk for psychiatric morbidity. *Support Care Cancer* 2016; 24: 1975–82.
- 16 Thomas K, Hudson P, Trauer T et al. Risk factors for developing prolonged grief during bereavement in family carers of cancer patients in palliative care: a longitudinal study. *J Pain Symptom Manage* 2014; 47: 531–41.
- 17 Kandasamy A, Chaturvedi SK, Desai G. Spirituality, distress, depression, anxiety, and quality of life in patients with advanced cancer. *Indian J Cancer* 2011; 48: 55–9.
- 18 Lai C, Luciani M, Mario C et al. Psychological impairments burden and spirituality in caregivers of terminally ill cancer patients. *Eur J Cancer Care (Engl)* 2018; 27: e12674.
- 19 McClain-Jacobson C, Rosenfeld B, Kosinski A et al. Belief in an afterlife, spiritual well-being and end-of-life despair in patients with advanced cancer. *Gen Hosp Psychiatry* 2004; 26: 484–6.
- 20 Testoni I, Sansonetto G, Ronconi L et al. Meaning of life, representation of death, and their association with psychological distress. *Palliat Support Care* 2017; 9: 1–9.
- 21 McDonald J, Swami N, Hannon B et al. Impact of early palliative care on caregivers of patients with advanced cancer: cluster randomised trial. *Ann Oncol* 2017; 28: 163–8.
- 22 Harman SM. Psychiatric and palliative care in the intensive care unit. *Crit Care Clin* 2017; 33: 735–43.
- 23 Strupp J, Dose C, Kuhn U et al. Analysing the impact of a case management model on the specialised palliative care multi-professional team. *Support Care Cancer* 2018; 26: 673–9.
- 24 Grassi L, Fujisawa D, Odyio P et al. Disparities in psychosocial cancer care: a report from the International Federation of Psycho-oncology Societies. *Psychooncology* 2016; 25: 1127–36.
- 25 Seccareccia D, Wentlandt K, Kevork N et al. communication and quality of care on palliative care units: a qualitative study. *J Palliat Med* 2015; 18: 759–64.
- 26 Moore PM, Wilkinson SSM, Rivera Mercado S. Communication skills training for health care professionals working with cancer patients, their families and/or carers. *Cochrane Database Syst Rev* 2003; 2: CD003751.
- 27 Epstein R, Duberstein P, Fenton J et al. Effect of a patient-centered communication intervention on oncologist-patient communication, quality of life, and health care utilization in advanced cancer the VOICE randomized clinical trial. *JAMA Oncol* 2017; 3: 92–100.
- 28 Ichikura K, Matsuda A, Kobayashi M et al. Breaking bad news to cancer patients in palliative care: a comparison of national cross-sectional surveys from 2006 and 2012. *Palliat Support Care* 2015; 13: 1623–30.
- 29 Costantini A, Grassi L, Picardi A et al. Awareness of cancer, satisfaction with care, emotional distress, and adjustment to illness: an Italian multicenter study. *Psychooncology* 2015; 24: 1088–96.
- 30 Belanger E, Rodríguez C, Groleau D. Shared decision-making in palliative care: a systematic mixed studies review using narrative synthesis. *Palliat Med* 2010; 25: 242–61.
- 31 Sinclair S, Beamer K, Hack T et al. Sympathy, empathy, and compassion: a grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliat Med* 2017; 31: 437–47.
- 32 Levin T, Moreno B, Silvester W et al. End-of-life communication in the intensive care unit. *Gen Hosp Psychiatry* 2010; 32: 433–42.
- 33 Curtis J, Treece P, Nielsen E et al. Randomized trial of communication facilitators to reduce family distress and intensity of end-of-life care. *Am J Respir Crit Care Med* 2016; 193: 154–62.
- 34 Pollak K, Lina P, Bilheimer A et al. A brief relaxation intervention for pain delivered by palliative care physicians: a pilot study. *Palliat Med* 2015; 29: 569–70.
- 35 Fellowes D, Barnes K, Wilkinson S. Aromatherapy and massage for symptom relief in patients with cancer. *Cochrane Database Syst Rev* 2004; 2: CD002287.
- 36 Wilkinson S, Love S, Westcombe A et al. Effectiveness of aromatherapy massage in the management of anxiety and depression in patients with cancer: a multicenter randomized controlled trial. *J Clin Oncol* 2007; 25: 532–9.
- 37 Akechi T, Okuyama T, Onishi J et al. Psychotherapy for depression among incurable cancer patients. *Cochrane Database Syst Rev* 2008; 2: CD005537.
- 38 Santos M, Greer S. Adjuvant psychological therapy with a terminally ill patient: a case report. *Behav Cogn Psychother* 1991; 19: 277–80.
- 39 Chochinov H, Krisjanson L, Hack T et al. Dignity in the terminally ill: revisited. *J Palliat Med* 2006; 9: 666–72.
- 40 Mücke M, Mochamat, Cuhls H et al. Pharmacological treatments for fatigue associated with palliative care: executive summary of a Cochrane Collaboration systematic review. *J Cachexia Sarcopenia Muscle* 2016; 7: 23–7.
- 41 Rasmussen K, Richardson J. Electroconvulsive therapy in palliative care. *Am J Hosp Palliat Care* 2011; 28: 375–7.
- 42 Meier E, Gallegos J, Montross-Thomas L et al. Defining a good death (successful dying): literature review and a call for research and public dialogue. *Am J Geriatr Psychiatry* 2016; 24: 261–71.

- 43 Hales S, Chiu A, Husain A et al. the quality of dying and death in cancer and its relationship to palliative care and place of death. *J Pain Symptom Manage* 2014; 48: 839–51.
- 44 Pivodic L, Harding R, Calanzani N et al. Home care by general practitioners for cancer patients in the last 3 months of life: an epidemiological study of quality and associated factors. *Palliat Med* 2016; 30: 64–74.
- 45 Nordly M, Benthien K, Maase H et al. The DOMUS study protocol: a randomized clinical trial of accelerated transition from oncological treatment to specialized palliative care at home. *BMC Palliat Care* 2014; 13: 44.
- 46 Pham B, Krahn M. End-of-life care interventions: an economic analysis. *Ont Health Technol Assess Ser* 2014; 14: 1–70.
- 47 Pessin H, Galietta M, Nelson C et al. Burden and benefit of psychosocial research at the end of life. *J Palliat Med* 2008; 11: 627–32.
- 48 Glendon R, Hodges B. End-of-life care education for psychiatric residents: attitudes, preparedness, and conceptualizations of dignity. *Acad Psychiatry* 2009; 33: 451–6.
- 49 Hendrix C, Bailey DE, Steinhauser KE et al. Effects of enhanced caregiver training program on cancer caregiver's self-efficacy, preparedness, and psychological well-being. *Support Care Cancer* 2016; 24: 327–36.
- 50 Decree Law no 8/2010 of January 28th of the Ministry of Health. Diário da República (Portugal): serie I, No 2 (2010). Access 24 Ago. 2018. <https://dre.pt/pesquisa/-/search/616776/details/maximized>