American Journal of Biomedical Science & Research

www.biomedgrid.com

ISSN: 2642-1747

Review Article

Role of Palliative Psychiatry in Oncology Patients: New Challenges and Future Perspectives

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To Cite This Article: *Harjot Singh*, Harjot Singh, Harleen Kaur and Paramjot Bindra. Role of Palliative Psychiatry in Oncology Patients: New Challenges and Future Perspectives. Am J Biomed Sci & Res. 2023 20(3) AJBSR.MS.ID.002710,* DOI: 10.34297/AJBSR.2023.20.002710

Received: October 19, 2023; **Published:** October 25, 2023

Review

As per WHO reports forecast that the incidence of cancer will increase by 40% in high-income countries and more than 80% in low-income countries by the year 2030, both mortality and long-term survivorship will be on the rise. However, the role of palliative psychiatry in oncology needs to be reviewed and updated regularly. The implications of the mental health of cancer patients have been repeatedly stressed in the last 40 years as needing attention for holistic care [1].

The epidemiology of psychological distress along with psychiatric disorders in cancer patients was one of the first areas of systematic research in psycho-oncology. Clinically important psychological concepts like stress, trauma, and distress; individual coping strengths, mechanisms, and resources; social and family support; the patient's life cycle phase; medical and psychosocial illness phases; resilience and post-traumatic growth; loss and grief; existential and spiritual dimensions of the patient's cancer care experience; and caregiver support and stresses The financial and social role-function impacts of cancer and its treatment often profoundly adversely affect the patient and caregivers [2,3].

Interventions include the provision of individualized cancer and cancer treatment knowledge, access to educational and support groups, individual supportive psychotherapy, CBT, and existential, meaning, and dignity therapies. Other often personally important services include spiritual care, mind/body stress management training, and exercise/physical therapy or rehabilitation services [4,5].

Only 30% of patients with cancer are reported to receive a psychiatric diagnosis (e.g., major depression, depressive spectrum disorder, stress-related anxiety disorders), while a higher percentage show other clinically relevant psychosocial conditions (e.g., demoralization, health anxiety, irritable mood).1 Mental health problems faced by patients and their families are associated with a reduction in quality of life, impairment in social relationships, longer rehabilitation time, poorer adherence to treatment, abnormal illness behaviour and possibly shorter survival. In advanced cases, these problems are even more often associated with significant psychiatric and psychosocial disorders that target end-of-life care. For these reasons, it has been stated that "it is not possible to provide holistic care without addressing patients' psychosocial health needs" [6].

The Institute of Medicine (IOM) report on delivering high-quality cancer care has outlined five principles of cancer patient care from diagnosis onward: care planning, palliative care, psychosocial support, prevention and management of long-term and late effects, and family or caregiver support [7].

There is increasing recognition of the importance of the role of psychiatry, behavioural healthcare, and spiritual care services in the care of patients at the end of life. Hopefully, future changes in the structure of hospice care and hospice reimbursement will facilitate a broader role for psychiatric oncologists and supportive oncology services in cancer patient hospice care delivery.

Two especially important therapeutic advances concerning the psychosocial care of patients at the end of life include dignity therapy and existential therapy [8-11]. One recent major study found

that early provision of comprehensive palliative care services to patients with advanced lung cancer resulted in extended duration of life as well as improved distress and quality of life [12,13].

However, inequalities exist in the development of psychosocial oncology worldwide. Significant economic constraints within health systems may undermine both monitoring of distress and the process of referral to mental health services and psychiatric treatment.

A new challenge is represented by the debate on euthanasia and physician-assisted death, in which psychiatry and psycho-oncology have a specific role. Also, the implications of cancer screening and treatment among people with severe mental illness are an extremely important part of the psycho-oncology and palliative care agenda.

Today, psycho-oncology and psychiatry in palliative care are recognized as disciplines in themselves, within the wider field of consultation-liaison psychiatry. Many medical student and psychiatry residency programs as well as fellowships in consultation-liaison psychiatry, include clinical rotations in psycho-oncology and palliative care. Screening for distress is now an accepted part of protocols in cancer centers, and there is a growth in research aimed at better understanding on how to screen and provide psychiatric care using evidence-based guidelines and protocols.

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