

[Psychosocial support in palliative care towards women with breast cancer and their families in hospital setting].

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Abstract

Introduction

Cancer is one of the most serious diseases leading to death worldwide. Depression is strongly associated with breast cancer related to strong emotions on the part of family members due to life experience with a patient who has, or has died of breast cancer. Psychosocial support must be provided in order to improve the quality of life for patients and their families. The aim of this study was to describe psychosocial support in palliative care for women with breast cancer and their families in a hospital setting.

Methods

A literature review was used as a method in this study. The authors used PubMed (MeSH) and CINAHL in the research as a database. However, all included articles (n=17) were analyzed separately and evaluated independently.

Results

The results showed that women with breast cancer reported that loss of hair was the most disappointing and frustrating loss. Several women reported that the sense of losing their femininity was due to losing their entire breast and hair loss in connection with the disease. However, the majority of patients reported that what was important was for patients to be informed about their treatment and to be updated regarding their prognosis, because this alleviated the anxiety and depression.

Conclusion

This literature review showed that psychosocial support was very important towards women with breast cancer and their families in palliative care. Pre-existing fear of breast cancer and its treatment have been noticeable with all patients with breast cancer. Emotional pain seemed to have negative impact towards women with breast cancer more than physical pain.

Keywords

Breast cancer; Psychosocial support; Palliative care; Nursing; Family and Literature review.

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I. Introduction

Recently, many studies have focused on cancer diseases. Mortality and morbidity due to cancer have risen significantly worldwide. Women have a higher incidence of breast cancer than men. Breast cancer is two to five times higher in developed countries (high income) compared with developing countries (middle income). People in developed countries have greater awareness of the symptoms, self-assessment and treatment of breast cancer than in developing countries. In 2008, the estimated number of patients with cancer was approximately 12.7 million cases, with 7.6 million deaths worldwide. There were 1.38 million cases of breast cancer, which means 23 percent of the total, and there were a total of 458,000 cases of death due to cancer, which represents 14 percent worldwide (Jemal, Bray, Center, Me, Ward, & Forman, 2011). Depression is strongly associated with breast cancer related to strong emotions on the part of family members due to life experience with a patient who has, or has died of breast cancer. Psychosocial support must be provided in order to improve the quality of life for patients and their families (Gorji, 2012). According to Reed, Simmonds, Haviland, & Corner, (2012), breast cancer should receive more attention at the national or international level, especially for patients in advanced stages.

Palliative care:

The word palliative comes from the Latin word *pallium* which means a cloak or lid. In other word palliative care or philosophy of care is defined as alleviating without cure. It is a method that focuses on improving quality of life for the patients and their families who face problems associated with a life-threatening illness. Furthermore, patients in palliative care may suffer from total pain which includes physical, spiritual and psychosocial pain. The aim of palliative care is to relieve symptoms and other problems such as physical, psychosocial and spiritual aspects. Palliative care can be provided at any age and at any level in the case of life-threatening illness. It is a holistic approach that focuses on patients and their families as the center of care (Becker, 2010; Munck, Fridlund, & Martensson, 2011). Palliative care calls for a high level of professional skills, with special training to ensure quality of care. Furthermore, it can be provided in different settings such as hospitals, hospices and homes. There are four major key concepts in palliative care that aim to cope with patient and family needs (Becker, 2010; Davies & D`arcy, 2013). These are communication, relief of symptoms, multidisciplinary and family needs. Communication is a method of exchanging information, emotions, needs, and preferences. Communication is a complicated process of sending and receiving verbal and non-verbal messages. In addition, it is an essential component of human interactions which allows people to establish, maintain and improve relations with others. It is the core of palliative care, because effective communication helps nurses to identify patient and their family needs (Ronsen & Hanssen, 2009). Relief of symptoms is one of the major cornerstones of palliative care. It focuses on reducing patients' suffering in physical, psychosocial and spiritual terms. The most common symptoms are fatigue, pain, dyspnea, depression, worry, anxiety, problematic family situations and lack of meaning (Becker, 2010).

Multidisciplinary palliative care plays an important role that can lead to improved quality of life. Multidisciplinary care is teamwork cooperation and is regarded as a central component in palliative care

(Jünger, Pestinger, Elsner, Krumm, & Radbruch, 2007). Family is a group of people who share either genetic or legal bonds; family usually involves close relationships such as parents, siblings and cousins. Family in palliative care is a person or a group that is less well-equipped in modern western society to engage with the unprecedented emotional and social desires that caring for dying family member involves (Becker, 2010).

Palliative care in a hospital:

A hospital is a healthcare institution that has an organized multidisciplinary team which offers patients treatment and care. It is equipped with in-patient facilities that aim to provide healthcare services. Usually it works 24 hours per day, seven days per week (Beck, Törnquist, Broström, & Edberg, 2012; World Health Organization [WHO], 2013). Hospital care is similar to hospice care, but healthcare workers in hospitals spend more time with patients than in hospices. In hospitals, a grieving process is essential for families, relatives and friends (Becker, 2010; Davies & D`arcy, 2013).

Palliative care in hospices:

A hospice is a place that is designed for people who face life-threatening illness. Hospice care includes an expert medical team who are specialized in relieving pain, providing psychosocial support and promoting human dignity. Each patient has right to die without pain. A hospice is an especial unit for dying patients with terminal diseases such as cancer, heart diseases and stroke. In a hospice, care involves providing analgesics to relieve pain and reduce suffering. Hospice care is a day care unit providing a variety of paths for dying patients. Bathing, physiotherapy, and complementary therapies are provided in a hospice (Becker, 2010; Davies & D`arcy, 2013).

Palliative care at home:

Most patients at the end of their lives prefer to die at home with their families, because they feel secure and this protects their dignity. These patients have to be monitored by community nurses who do check-ups and visit patients if necessary (Becker, 2010). Dignity is an intrinsic human value and it is considered the highest level of human values. No individual want his or her dignity to be weakened, because this is an aspect of privacy (Burkhardt & Nathaniel, 2008).

Breast Cancer:

Cancer is one of the most serious diseases leading to death worldwide. It is regarded as the uncontrolled growth and rapid spread of malignant cells in the body. Cancer usually develops and metastasizes to distant sites and can affect all body organs. However, breast cancer is classified as the second highest cause of mortality in women of all ages worldwide (Langhorne, Fulton, & Otto, 2007). According to the Breast Cancer Organization [BCO], (2013), breast cancer can be non-invasive (carcinoma), which means that it does not grow into or invade normal tissues within or beyond the breast. However, it can be invasive, growing into normal, healthy tissues. Moreover, around 85 percent of breast cancers occur in women who do not have a family history of breast cancer. Symptoms are discovered from the patients by self-assessment, although there are a few common symptoms such as breast shape, thickness, swelling and readiness. Furthermore, nipples tend to change color, itch, thicken, turn inward and emit discharges other than milk (Breast Cancer Organization, 2013). Most patients suffer during illness from pain, fatigue and depression, especially in advanced stages (III or IV) where no pharmacological intervention, such as radiation therapy, will be considered (So at el., 2013).

Table 1. Stages of breast cancer (Breast Cancer Organization, 2013)

Stages	Type	(T) Tumor size	(N) Axillary Lymph Node	(M) Metastasis
0	Non-invasive	Not seen	No	No
IA	Invasive	Up to 2cm	No	No
IIA	Invasive	Group of cancer cells, smaller than 2cm	Spread	No
IIB	Invasive	2cm to 5cm	It may spread	No
IIC	Invasive	Larger than 5cm	No spread	No
IIIA	Invasive	Any size	Spread, nodes become attached to each other	No
IIIB	Invasive	Larger than 5cm	Spread	No
IIIC	Invasive	Any size, but cells have spread to skin or chest wall	It may spread	No
IV	No	Any size	Spread along breast bone or above or below collarbone	No
TNM	No	Any size	It may spread	Spread to other organs of the body

Risk factors that may cause breast cancer:

Uncontrollable factors that cannot be changed: e.g. gender, age, race, family history, genetic factors, personal health history, early menstruation and late menopause. Controllable factors: e.g. lack of physical activity, poor diet, being overweight, frequent consumption of alcohol, smoking, chest radiation therapy before the age of 30 and a combined hormone replacement therapy (Breast Cancer Organization, 2013).

Treatment of breast cancer:

Surgery is the main treatment for breast cancer. Chemotherapy can be given in order to alleviate the symptoms. Chemotherapy is often used in conjunction with other cancer treatments, such as radiation therapy or surgery. The aim of chemotherapy and radiation therapy is to reduce the size of the tumor but it may not eliminate the tumor. In addition, hormone therapy is a treatment that can be used to remove hormones and stop cancer cells from growing; Targeted therapy is a treatment that uses drugs or other substances to determine the cancer cells that are to be eliminated without harming normal cells (Breast Cancer Organization, 2013).

Quality of Life:

Quality of life (QoL) is a wide concept that usually involves personal evaluation, either from a positive or negative perspective. It is the level of the individual's satisfaction from what he or she gets from care, including factors that make life worth living (Browall et al., 2008; Van Son, De Vries, Roukema, & Den Oudsten, 2013). QoL can be measured by communicating with the patients and their families to identify needs which lead to such satisfaction (Randall & Downie, 2007). According to Montazeri et al., (2008), quality of life in breast cancer patients can be measured by using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ). This measurement can be done pre-diagnosis, three months after initial treatment and one year after completion of treatment. In addition, this questionnaire contains 30 items that measure five functional scales. These functional scales are physical functioning, role functioning, emotional functioning, cognitive functioning and social functioning.

Health Related Quality of Life:

Health-related quality of life (HRQoL) is a multidimensional concept that usually involves self-reported measures of psychological and physical health. It should be used to evaluate health care implementation. HRQoL is based on a concept of health by measuring health outcome. Health is total physical, mental, and social well-being. HRQoL involves two essential aspects. The first includes functional ability, which means the ability to carry out the acts of self-care and domestic activity. The second aspect includes positive health, which means full efficiency in mind, body and social adjustment (Browall et al., 2008).

Nursing:

Nursing is a science that focuses on providing care for all patients from a holistic perspective. It is specialized and designed to help people who cannot rely on their own powers. Nursing aims to promote the interaction of health care and ethical care. This is designed to eliminate pain, reduce suffering and promote quality of life (American Nursing Association [ANA], 2013; Burkhardt & Nathaniel, 2008; Pang et al., 2004). Nursing is an independent and collaborative field that provides care for people of all ages and both genders. Nursing is important to prevent illness, and to promote a safer environment, education and research. Nurses have four basic responsibilities which include enhancing health, preventing illness, restoring health, and alleviating suffering (International Council of Nurses [ICN], 2012).

Palliative-care nursing is about helping patients to live with dignity until they die. It does not involve helping patients to die prematurely. Competent palliative-care nursing requires, for example, communication skills, psychosocial skills, teamwork skills, physical skills, life-closure skills and intrapersonal skills (Becker, 2010). Nursing is the care of patients suffering either from natural suffering or from the sources that cause suffering. Nursing is a focus on caring and respect for human dignity and dealing with an individual as a unique person, because individuals have different experiences, different environments, beliefs, values, goals and preferences. Nurses must be advocates in the care process, because sometimes patients have difficulty in finding expression for their feelings (Lynch, Dahlin, & Coakley, 2011).

Patient-centered Care:

Patient-centered care is care through understanding of the needs of patients and their families. It is a companion feature in providing compassionate and arranged care based on respect for the patient's preference, values and needs. Patient-centered care theory focuses on patients and their families who are facing problems in coping with incipient illnesses. Patient-centered care is important in all health care areas, and particularly crucial in breast cancer care. Since chemotherapy and radiation therapy affect patients physically and mentally, self-reliance in the decision-making process becomes problematical. Audio recordings and consultation summaries

were provided during the treatment, because that keeps patients involved in each session in the treatment, and this increases their satisfaction (Belkora, Loth, Volz, & Rugo, 2009).

Psychosocial Support:

Psychosocial support is a concept that includes the emotional, social, and spiritual dimensions of health. Psychosocial care is designed to help people who are having difficulty coping with the emotional problems that can affect health, healthcare and quality of life (Gorman & Sultan, 2008; Matsude, Yamaoka, Tango, Matsuda, & Nishimoto, 2013). Spiritual support is the degree to which a person experiences a connection with a higher power that includes supporting, teaching, healing, protecting and guidance. Spiritual support can be the core of the spirituality-health connection. Spiritual needs can be an important factor for the patient at the end of life. Spiritual support can help the patient to engage in a meditative act (Cobb, Dowrick, & Lloyd-Williams, 2012).

Emotional support is part of psychosocial support in palliative care to encourage patients and their families and show them that you are emotionally involved in their situation. Emotional support is very important for cancer patients' psychological and physical adjustment to their disease. Emotional support can be provided for patients and their families and those who are close to them in this situation. Emotional support includes bereavement care (Gorman & Sultan, 2008). Bereavement care is an aspect of palliative care that aims to support families and those people who are close and important to the patient. Bereavement care can be initiated from the time of diagnosis, during the treatment and after the patient's death (Becker, 2010; Gorman & Sultan, 2008).

Depression, anxiety and stress are the most common consequences of emotional distress. Depression is a serious medical illness that affects the brain. Depression is a common mood disorder among patients with threatening illness that are receiving palliative treatment. The symptoms of depression are perceived as a sign of suffering or weakness for patients in connection with physical disorder associated with low quality of life. Feeling depressed can be a normal reaction to loss, life's struggles or crises. Depression can lead to emotional and physical problems. People with depression usually find it hard to go about their day-to-day activities (Hallford, McCabe, Mellor, Davison, & Goldhammer, 2012).

Anxiety is a general term for mental disorders that cause nervousness, fear, apprehension, and worrying. These disorders can affect the person's feeling and behavior. Anxiety is often caused by stress in our lives, but some people are more vulnerable than others. Anxiety can affect our whole being. The most common physical symptoms as a result of anxiety are nausea, trembling, diarrhea, headache, back pain, tense muscles, sweating, and an increased heart rate (Roth, Cyr, Harle, & Katz, 2013). Stress is the body's or brain's response to a change that needs a physical, emotional, or mental reaction. It can be caused by good or bad experiences. People who have large amounts of stress may become tired, sick and incapable of focusing or thinking, or even suffer mental breakdowns. Often when people feel stressed by something that has happened, their bodies react by releasing adrenaline substance into the blood. Adrenaline gives people more energy which can be good in a situation that calls for immediate reaction. In addition, stress may sometimes be bad if it occurs in an emotional situation and there is no outlet for this extra energy. This may be a problem. Stress can be physical stress, such as fear of something dangerous, or emotional stress, such as worry about your final exam or an interview for a new job (The American Institute of Stress [AIS], 2012). Stress may lead to distress - acute mental stress resulting from life circumstances or mental illness. Distress is common among family members and the loved ones of people suffering from stress (Roth, Cyr, Harle, & Katz, 2013).

Research Problem:

Many studies have demonstrated that a considerable percentage of patients and their families suffer from psychosocial distress due to life-threatening illness caused by cancer. Moreover, cancer not only affects those who have the disease - it is always a family affair. However, there are many factors that affect patients and their families negatively due to life-threatening illness. These factors include depression, anxiety and stress, which require immediate psychosocial support (Lebel, Rosberger, Edger, & Devins, 2008; Siedentopf et al., 2010).

AIM

The aim of this study was to describe psychosocial support in palliative care for women with breast cancer and their families in a hospital setting.

Questions

- What are the most common psychosocial factors that affect women with breast cancer and their families in palliative care?
- What effect does psychosocial support have for women with breast cancer and their families in palliative care?

II. Methodology

Study Design

Literature review was used as a method in this study. Literature review is defined as a baseline tool to gather information that can be used in a research. It discusses published information either on a certain topic or in a particular subject area in a certain time period. In addition, it may evaluate the sources and advise the reader on the most relevant aspects. It helps either to give a new interpretation of old data or to combine new with old interpretations. Several articles were read and analyzed to find appropriate information for the research (Polit & Beck, 2012).

Data collection

The authors used PubMed and MeSH in the research as a database. PubMed is defined as an online database that can be used in searching for primary articles. This database is described as a bibliographic database containing MEDLINE as an essential source. It is under the auspices of the National Center for Biotechnology Information (NCBI), which is located in the United States. PubMed and MeSH has been used in this study as a research database to narrow the research to specific findings, because it contains valuable articles that can be used in research in this field (Table 2). Cumulative Index to Nursing and Allied Health Literature (CINAHL) database has been also used in this research (Table 3). This is an online database that focuses in nursing and health literature (Polit & Beck, 2012).

Inclusion criteria

The articles selected have been reviewed by experts for approved publication in scientific journals. The search constraint in this literature review included the human being, the English language, women 19 years old and older, the nursing field and primary articles.

Exclusion criteria

Languages other than English, original studies, review articles, books, commercial websites and unreliable sources were excluded.

Table 2. Search process in Pub Med.

Database Date for search	Key words (MeSH)	Identified Articles (hits)	Abstracts reviewed	Articles examined	Articles included
PubMed 131006	Breast cancer AND Psychosocial support	604	12	8	4
PubMed 131008	Breast cancer AND Family	591	20	8	1
PubMed 131010	Breast cancer AND Nursing	337	15	10	2
PubMed 131013	Breast cancer AND Communication	589	12	5	1
PubMed 131015	Early stage breast cancer AND women experience	150	6	5	1
PubMed 1310117	Social problems AND Patients with breast cancer AND relatives	53	6	3	1
PubMed 131017	Quality of life AND breast cancer AND psychology	15	2	2	1
PubMed 131019	Quality of life AND coping in women with breast cancer	250	15	8	1
PubMed 131020	Women With Breast Cancer AND Radiation Therapy AND Depressive symptoms	70	10	4	1
PubMed 1310122	Breast Cancer AND women in Pakistan	42	5	3	1

Table 3. Search process in Cinahl

Database Date for search	Key words	Identified Articles (hits)	Abstracts reviewed	Articles examined	Articles included
Cinahl 131022	Breast cancer AND Quality of life AND Palliative care	33	5	2	1
Cinahl 131025	Women with breast cancer AND anxiety AND depression	87	3	3	1
Cinahl	Effect of spiritual AND breast	2	2	2	1

Data analysis

The selected articles (n=17) were analyzed separately and evaluated independently by the two authors. The authors used color highlighters were used to address the findings that related to the aim. In addition, a small note diary has been used as a reminder of the important points that should be included in the results.

Quality of Study

Classification guide of academic articles and studies regarding quality in both quantitative and qualitative research, modified from Berg, Dencker & Skärsäter (1999) and Willman, Stoltz & Bahtsevani (2006) was used in this study (Appendix 1). The findings of the included articles (n=17) that related to the aim appear in the matrix table (Appendix II). (n=14) articles with graded with high quality (I) and (n=3) articles graded with moderate quality (II). In addition, articles (n=245) with low quality grade were excluded in order to increase the quality of this study. The main focus in the analysis of articles was on the qualification of the researchers, ethical considerations, the attrition rate, who was behind the study, if there was a company supporting the study for commercial purposes, the participants, and whether the environment of the study was appropriate in relation to the topic, such as a hospital setting or hospice. Moreover, credibility and reliability should be presented. Credibility is a standard for evaluating quality and integrity of the study. It refers to the quality of being believable or trustworthy. Validity is the degree to which findings made in the study are reliable and well-founded (Polit & Beck, 2012).

Ethical considerations

The authors selected the articles from PubMed and Cinahl. The selected articles have been reviewed and approved by experts. The authors were careful in their selection of the articles' information and paraphrased it which was designed to eliminate plagiarism, falsification, and fabrication. Thus, the validity and credibility of the research process has been established. Ethical principles were applied in nursing research, such as justice and beneficence. Justice is a very important principle to apply in research because it is essential not to use other person's work without mentioning the reference. Beneficence is also an important principle since the author focuses on maximizing the benefits and minimizing harm to other researchers by using their works without stating the reference (Polit & Beck, 2012).

III. Results

The findings were based on 17 primary articles (Appendix II). These articles focus on psychosocial support in palliative care towards women with breast cancer and their families. The authors presented the results in accordance with the research questions.

Psychosocial factors that affect women with breast cancer and their families

Living with fear, anxiety and depression

According to Arving et al., (2006); Cebeci, Yangin, & Tekeli, (2012); Doumit, Saghir, Huijjer, Kelley, & Nassar, (2010); Huijjer & Abboud, (2012); Obeidat, Dickerson, Homish, Alqaissi, & lally, (2013); Remmers, Holtgrawe, & Pinkert, 2010), women with breast cancer emphasized several losses in body image that include loss of a part of the body (mastectomy), which led to changes in a normal life. The patients reported that loss of hair was the most disappointing and frustrating loss. Although, loss of hair was expected by most of the patients, it was upsetting and distressing. Fear, crying, sadness and anxiety were strongly associated with the consequences of breast cancer's symptoms and the side-effects of treatments. Another side-effect of the women's fear is feeling of guilt, because they were concerned about their daughters' future, which can be affected by genetic predisposition that exists in breast cancer. Moreover, most of the patients in these studies reported that they experienced psychological pain more than physical pain. Another aspect of loss was the breast which has a significant impact on the woman's femininity. The women who underwent total mastectomy wanted to be hidden from other people, because they did not accept their new appearance. Some patients used a piece of cloth or piece of cotton in instead of the breast.

According to Huijjer & Abboud (2012), sadness and nervousness were the most prevalent psychosocial symptoms. In addition, chemotherapy and radiotherapy treatments' side-effects were associated with absence of psychosocial support, due to fatigue and tiredness. In addition, everyday activities were not carried out due to lack of energy (Cebeci et al., 2012). According to Schmid-Buchi, Halfens, Muller, Dassen, & van den Borne (2013), there were differences among patients with unmet needs and patients with met needs, such as less emotional distress, greater secure, stability and a chance to live a new life. The assessment of stress and anxiety is important, because it can help to identify patients' needs at an early stage.

Living with fear due to uncertain outcome

Fear can be due to uncertain outcome of an operation, such as waiting to be operated on, fear of awaking, nausea afterwards and not being operated. The patients have a significant fear of thinking of death in the near future (Remmers et al., 2010). There was a considerable proportion of women with breast cancer concerning about losing of loved ones and treatment difficulties. Several women were frustrated by excessive pity, because it constantly reminded them of their disease. Many patients were open in disclosing their diagnosis to others, because they wanted to maintain their impression as strong, independent and retaining their self-integrity. Some of the patients still experienced shock and disbelief from the moment of diagnosis. In addition, many patients had a depression for several weeks after the diagnosis, which was demonstrated by their inability to sleep, eat, go to work, or take care of children. Silence is another factor has affected women with breast cancer with negative emotions, because of fear of hurting their loved ones. On the other hand, some of these women only informed their loved ones about their diagnosis to reduce stress. Most patients overcome their initial fear, although they still suffer from thinking about their disease in their minds (Obeidat et al., 2013).

Living with fear due to treatments side-effect

Another study showed that several women suffered from fear due to that they did not have a full understanding of the disease and its future consequences. Furthermore, several women reported that the sense of losing their femininity was due to losing their entire breast and hair loss in connection with the disease. Women who had a limited educational level experienced a higher emotionally wrench after diagnosis than those with a higher educational level (Obeidat et al., 2013). The worst aspect of breast cancer treatment was the adverse effects of chemotherapy, because the patient in this period is too weak to perform everyday activities (Lindviksmoen, Hofso, Paul, Miaskowski, Rustoen, 2013). In addition, some women have a higher level of depressive symptoms than other due to a lower level of education, sleep disturbance, having children at home, worry about the outcome of the disease, less support either from family or friends, and less meaning in life (Obeidat et al., 2013).

Self-perception

Many patients stated that they experienced changes in self-perception caused by the effects of the treatments, and thus they found themselves looking at themselves from different viewpoints. Appreciating life was indicated by all patients, because they stated that their health seemed to be more important than when they were healthy (Arving et al., 2006; Cebeci et al., 2012; Doumit et al., 2010; Huijer & Abboud, 2012; Obeidat et al., 2013; Remmers et al., 2010).

Living with cultural beliefs

Another study in Pakistan has shown that lack of awareness, lack of transportation and the expense of travel were the most factors affecting breast cancer examination and treatment. Furthermore, cultural beliefs have a significant impact on women with breast cancer, because male physicians are not allowed to examine women patients. Many patients have been afraid of diagnosis for breast cancer that may lead to divorce by their husband (Raza, Sana, Christopher, & Selhorst, 2012).

Patient and family needs

The majority of patients reported that what was important was for patients to be informed about their treatment and to be updated regarding their prognosis, because this alleviated the anxiety and depression (Arving et al., 2006; Cebeci et al., 2012; Doumit et al., 2010; Huijer & Abboud, 2012; Obeidat et al., 2013; Remmer et al., 2010). A considerable percentage of patients suggested that a “*safety net*” was a safe system in which they could be connected to a hospital system to communicate with the healthcare providers (Lafferty et al., 2011). The main requirements of the family are that they want to receive an honest answer to their questions; feeling that someone is taking care of their patients; receiving explanations which can be understood; receiving information about possible side-effects of the treatment; having a contact person on the ward (Pinkert, Holtgräwe, & Remmers, 2013). Patients with breast cancer were completely satisfied with the period of time established in each session to provide psychosocial support. These patients need for external help to understand their needs which can help cope with their emotional distress (Arving et al., 2006). Physical and social impairment in patients with breast cancer required more psychosocial support. In addition, a greater depressive feeling of relative and younger age involved greater needs, including spiritual support (Nizamli, Anoosheh, & Mohammadi, 2011). Most of the patients indicated that the breast cancer nurses (BCNs) were the most appropriate professional they would contact, because BCNs were closer than other professions in their care process (Lafferty, 2011). Accordingly (Remmers et al., 2010) patients preferred to express their feeling and wishes to the nurses and the most important thing was to be taken seriously. Most patients like to be feel security and interest on the part of the nurses. The nurse’s feelings for the patient and their interactions were the most important basis for a good relationship.

What effects does psychosocial support for women with breast cancer and their families have in palliative care?

Many women avoided looking at the mirror, because of the fear of seeing their bodies' disfigurement and loss of physical attractiveness and that was considered as self-coping (Obeidat et al., 2013). Many patients experienced benefit from a feeling of physical relaxation and mental relaxation after the first spiritual healing session during psychosocial support and this increased self-confidence. As a result, emotional stress decreased dramatically (Barlow, Walker, & Lewith, 2013).

Spiritual belief as a coping mechanism

Many patients said that the disease was created by God, and he is the one who has the power to eliminate it. In addition, they were wondering "Why me?" at that particular moment, and they accepted this later on, because the patients' relation with God was connected with great optimism and helpfulness which led to less psychological distress (Cebeci et al., 2012). Patients believed that the disease was a gift from God, encouraging them to rethink their lives and reevaluate their priorities (Obeidat et al., 2013).

All patients reported that they had their own coping mechanism with their disease, which was believe in God. All patients were Muslim, and they performed their worshipping in accordance with the Islamic faith. Moreover, prayer, reading the Quran and counting beads were pursued to achieve the satisfaction which referred to their religion. The patients believed that worshipping was good for the body, healing the disease and surmounting suffering. Reading the Quran, performing prayers and counting beads can help to give strength and happiness (Cebeci et al., 2012).

Communication and quality of life

Two studies showed that breast self-examination (BSE) procedure was not explained clearly, due to lack of communication, and hence most patients were suffering from a delayed diagnosis. Sharing information among the patients helped to reduce psychosocial distress (Cebeci et al., 2012; Raza et al., 2012). Effective communication helped the majority of the patients to reduce stress and depression. In addition, the patients felt more secure and satisfied due to the trustworthiness of the multidisciplinary team as a result of honest communication, and this improved the quality of life. Good communication between the patient and family members was the most important factor that affected the patient. In addition, emotional support was provided by the family members, because patients need to feel that they are not a burden on their families. Most patients want to be near to their families especially during medical treatment, because that makes them feel happy and safe (Coyne et al., 2010; Vogel, Leonhart, & Helmes, 2009). Several patients who were under the treatment of breast cancer at special cancer center had more education and preparation about any possible adverse effects than in the public and the teaching hospitals (Obeidat et al., 2013). According to Witek-Januse et al., (2008); Würtzen et al., (2013) the emotional effect and the rigors during treatment might adversely influence quality of life. This study showed improvement in the quality of life for the patients who participated in a mindfulness-based stress reduction (MBSR) program.

Obviously, social environment, especially with close relatives and friends, was a useful and important factor in reducing distress. Practical support, such as caring for children, shopping and meal preparation was created by the patient's family to avoid being paradox (not being alone). Thus, these roles facilitated mutual support by the women to their families. Younger relatives were required for practical support to cope with their problems (Coyne et al., 2010; Vogel et al., 2009).

IV. Discussion

Method

The literature review was an appropriate method to identify primary articles, and hence the research questions were answered in several recent articles in the period 2006 – 2013. The identified primary articles were from 2006-2013 and come from different countries (Sweden, United Kingdom, Turkey, Australia, Lebanon, Norway, Germany, United States, Pakistan, Jordan, Netherlands, Switzerland, Iran and Denmark) which is important for the generalization of the study results. Most of the studies had performed qualitative interview or used questionnaires which is relevant according to the research questions.

The authors used a literature review (Polit & Beck, 2012) in this study to gain more knowledge about breast cancer and psychosocial support through palliative care in a hospital setting. Lack of knowledge and experience in this field were why the authors have chosen this topic and method, because the authors plan to do further studies with a different methodology design, for example qualitative and quantitative. Inclusion and exclusion criteria were useful to identify specific articles related to the aim. PubMed and CINAHL databases in the research were useful and interesting, because they contain many articles related to the aims and research questions. It was easy to combine two terms to identify specific articles. PubMed was used through the Mesh database to select appropriate terms that connected and related to the aims. On the other hand, CINAHL has a smaller number of articles than PubMed. As a result, most articles were collected from PubMed. The authors encountered a number of difficulties during the database search process, for example combining two terms with

limited hits, In addition, there was the question of how to ensure that articles have information that met the aim and the research questions. Moreover, it was difficult to do the research in a language other than the authors' mother tongue. However, the supervisor and the librarian advised the authors to use several terms as a keywords in the search process. As a result, the authors found limited hits with specific articles.

Reading abstracts and the selection of results section involved a long-term process to find accurate and relevant information for the aim. A strategy was established by the authors to save time and achieve effective team work. This strategy was based on reading articles separately and evaluating them independently. The authors met and discussed findings several times. Some articles were excluded due to unclear explanation of several points such as the attrition rate, inappropriate participation rate for the study, weak results, wrong information and no valuable information related to the authors' study. Furthermore, some articles contained valuable information but provided no account of ethical considerations, neither consent from the participants nor committee approval to conduct the study.

Some of the studies were conducted with a mixed methodology and therefore the articles' classifications needed description of two classification types. However, the authors planned to use the higher-quality articles to improve the quality of this study. The table process in PubMed was the most complicated aspect for both authors, because sometimes, after the table was prepared, both authors realized that some of the articles were not relevant and should not be included due to the formulated aim and research questions.

Ethical considerations were the essential concern initially in this study, because it is illegal and unfair to take other researchers' works that do not belong to you. Furthermore, the authors were totally agreed and believed that professionalism (to deal as a professional), justice and maleficence are important underlying values that improve the quality of the study. The university facilities were useful in providing a positive environment and working in a good atmosphere. The authors met several times to reread and correct the English versions. Nonetheless, the authors have been working seriously in this study. Furthermore, reliable and trustworthy information can be found in this study which can be useful to in the acquisition of knowledge.

V. Results

This literature review demonstrated that palliative care is very important for all patients with cancer, whether in the early stages or in advanced stages (Arving et al., 2006; Cebeci et al., 2012; Doumit et al., 2010; Huijjer & Abboud, 2012; Obeidat et al., 2013; Remmer et al., 2010). Palliative care focuses on the patients and their families from a holistic viewpoint because many studies have demonstrated that patients with breast cancer have significant impacts from physical, psychosocial, and spiritual factors which affect their families (Arving et al., 2006; Cebeci et al., 2012; Doumit et al., 2010; Huijjer & Abboud, 2012; Obeidat et al., 2013; Remmer et al., 2010). The authors consider that utilitarianism theory is associated with palliative care, because this focuses on the outcomes, regardless of the action, whether good or bad. In addition, patients in palliative care should receive the best possible treatment which may lead to good outcomes. Obviously, multidisciplinary team and family collaboration in palliative care was the main reason for achieving the expected outcomes (Twomey, 2011). In addition, psychosocial support was the most needed factor in intervention, because many studies have proved that psychosocial pain was more problematical than physical pain (Arving et al., 2006; Cebeci et al., 2012; Doumit et al., 2010; Huijjer & Abboud, 2012; Obeidat et al., 2013; Remmer et al., 2010). Relieving the patient's symptoms is important in order to protect their dignity, because each individual has the right to receive the best treatment, regardless of the disease. A multidisciplinary health profession has an important role to play in taking care of patients who suffer from total pain.

Communication can be the crucial key to building a good relationship without exceeding the professionalism framework, because a multidisciplinary team must deal with all patients without bias for anyone. In addition, empathy is important to bear in mind because, most patients with breast cancer have emotional needs, and the health care provider must be strong enough to deal with such patients in a professional manner. Family and close friends are an important part of palliative care because they can help patients emotionally and spiritually. Nonetheless, they should receive honest and clear information about their patient's prognosis in order to increase their awareness (Pinkert et al., 2013).

The authors think that low-income and middle-income countries may lack knowledge regarding breast self-examination (BSE). Furthermore, lack of knowledge can lead to delays in diagnosis which means there is a high chance of having advanced stages of breast cancer. Attending lectures and symposiums which aim to educate people about the controllable risk factors in breast cancer is important in order to reduce the risk of breast cancer. Breast self-examination (BSE) is a very important procedure to discover any breast changes, regardless of where the patient is located. The examination procedures are provided by the social media, breast cancer clinics and hospitals (Cebeci et al., 2012; Raza et al., 2012).

Some barriers may affect the examination, such as language barriers and living at a considerable distance from the nearest hospital. Furthermore, a lower level of education and living in rural areas may effect and delay the diagnosis. A typical symptom in women may cause a delay in diagnosis due to many factors.

These factors include problems of determining the pain location, ignoring their physical symptoms due to home responsibilities and worrying about leaving their children alone (Macleod, Mitchell, Burgess, Macdonald, and Ramirez, 2009).

Quality of life is unique and different among individuals. It is important for the multidisciplinary team to identify patient's needs and their families in order to achieve maximum opportunities of meeting the patient's requirements, which may lead improved quality of life (Browall et al., 2008; Van So et al., 2013). However, some patients have negative views about the concept of quality of life, such as surrender to death. Thus, that may lead to complexity of care. On the other hand, some patients have a positive view, especially if such patients have lived in a positive social environment (Coyne et al., 2010; Vogel et al., 2009). Women with breast cancer prefer to be handled by a BCN, because these women do not want to change a nurse who attended them during the diagnosis. Furthermore, lack of information or misinformation due to unclear endorsement by nurses in communication with patients was the main reason why they did not want to change. However, nurses have more responsibilities than other health professions, because they are the ones who spend a long time with the patients (Lafferty et al., 2011).

Nevertheless, nurses in palliative care are required to listen to their patients more than acting. In addition, most patients with breast cancer want to talk about their life experiences with their disease. Collaboration between families and nurses in palliative care can reduce emotional distress in their patients. As a result, families playing an important part in palliative care, especially for patients with breast cancer, because the relationship between patients and their families leads to a feeling of security that reduces their distress (Coyne et al., 2012).

Patient-centered care emphasizes that the patients and their families who face life-threatening illness should receive the highest quality of care. Hence, the multidisciplinary team should respect the patients' and their families' rights, and protect their dignity. During breast cancer treatment, most patients have mental and physical side-effects due to chemotherapy and radiation therapy that can affect the patient's powers of self-decision. In addition, it was extremely interesting to have consultation summaries and audio recording to support a patient who is unable to decide after the therapy. It is important for nurses and other healthcare providers to support patients' advocacy, and this can also be applied to patients who are unable to make their own decisions (Lynch et al., 2011).

The authors think that all patients with breast cancer need psychosocial support after diagnosis. Some patients have self-coping mechanism that may help to reduce distress. In order to provide high quality emotional support, nurses need to be expert in this field, because it calls for patience and showing interest. Furthermore, the facilities should be well-equipped whether in homes, hospices or hospitals. Most of the findings applied to the similar psychosocial factors associated with patients with breast cancer in various countries, such as fear, anxiety, depression and sadness. In addition, all findings have some differences regarding the level of psychosocial distress with reference to the environment, culture, beliefs, educational level and family support. As a result, nurses are responsible for providing the proper care, based on the patients' and their families' needs in order to achieve high quality care (Arving et al., 2006; Cebeci et al., 2012; Doumit., 2010; Huijer & Abboud, 2012; Obeidat et al., 2013; Remmers et al., 2010).

Their social environment is important for patients with breast cancer, because most patients have negative ideas about death in the near future. People surrounding the patients can reduce the emotional distress, such as the feelings of the people around you (e.g. in Saudi Arabia), where social environment is important for most families from a religious and cultural perspective. In addition, it is noticeable that most families who have patients with breast cancer have less emotional distress, because many convey a sense of being there, with their patients (Saati, 2013).

Based on the authors' experience, fear, anxiety, depression and sadness can increase the risk of having diseases other than breast cancer. Nonetheless, palliative care should encourage and educate the patients to cope with the psychosocial factors caused by breast cancer. The authors totally agreed with many studies that showed that, once a patient receive a diagnosis of any life-threatening illness, many patients believe that the disease comes from God as a reminder of death (Obeidat et al., 2013), and in Saudi Arabia people used to show the power of their faith once they got any disease. A strong normal reaction occurred as a result of fear of death and they believed that God is the only one who can eliminate the disease. In addition, some patients do not believe in psychosocial support due to their strong believe in God, which can be enough to cope with their disease. Some patients pray on their beds in hospital, either verbally or physically, due to treatment of the side-effects. Furthermore, many patients prefer to be alone to spend their time in worshipping. The majority of the life-threatening illness have their own coping mechanism, based on religion (Cebeci et al., 2012; Obeidat et al., 2013). However, the authors wonder about the fate of patients with life-threatening illness who live in low-income countries with high needs of psychosocial support from a global health perspective.

Incidental Findings

The authors think that it is important to find a solution for educating people who live in rural areas to avoid delaying the diagnosis or spreading the disease. People in rural areas may not have enough information about the disease because they prefer to live in the family house where they were born and grew up.

VI. Conclusion

To summarize, this literature review showed that psychosocial support was a very important factor for women with breast cancer and their families in palliative care. Pre-existing fear of breast cancer and its treatment has been noticeable with all patients with breast cancer. Emotional pain has a significant negative impact on women with breast cancer - more than physical pain. Many patients have demonstrated that a self-coping mechanism was one of the most effective strategies for reducing psychosocial distress. In addition, spiritual support played an important part in encouraging patients to perform acts of worship and to pray. Communication was the core of psychosocial support, because effective communication helped the patients and their families to cope with psychosocial distress. Good communication with the family promoted the patient outcome. However, education and providing information to the patients and their families in a treatment plan was supportive in establishing awareness of the treatment and its side effects, hence promoting their ability to take their own decisions. Finally, cultural beliefs seemed to have negative impact on women with breast cancer in rural areas.

Clinical implication

The authors suggest that EORTC QLQ can be useful to apply in Saudi Arabia to determine the level of satisfaction which is associated with quality of life. Effective communication helps to establish a satisfactory conversation so that EORTC QLQ can be applied in a professional manner.

Recommendations for further studies

During the thesis process several new questions have arisen. To interview women with breast cancer in hospital setting in order to identify the effects of psychosocial support during the treatment of breast cancer in different age groups.

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Conflict of Interest

The study was conducted without the involvement of a sponsor. The authors declare that there is no conflict of interest.

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