Psychological Care for Patient and Family Facing the Problem Associated with Terminal Illnesses
การดูแลทางจิตวิทยาแก่ผู้ป่วยและครอบครัวของผู้ป่วย ที่กำลังเผชิญกับความเจ็บป่วยระยะสุดท้าย

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Abstract

Death is inevitable. An individual reaches this point in his life through either a sudden or an expected death. People who face expected death usually suffer from terminal illnesses. Terminal illnesses are illnesses caused by chronic, usually incurable diseases, which apparently limit a person's life expectancy. Although it is well accepted that death is a normal process of development, it is quite difficult to accept this fact. This is under the urge of "fear of death instinct". Patients who experience terminal illnesses develop psychological problems as they anticipate death. In order to help ease the patients' pain and worry, as well as to help them cope with the disease, medical institutions and organizations provide the best intervention called, "Terminal Care or Palliative Care". Palliative Care generally provides relief from pain, although not a cure for the illness, a patient undergoing palliative care develops comfort in his situation and readiness to death, when the time comes. Palliative care for the patients and proper interventions for family members are needed. Some of psychological theories and interventions are proposed and discussed in this article.

Keyword: *terminal illness, palliative care, fear of death instinct, psychological intervention*

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บทคัดย่อ

ความตายเป็นสิ่งที่หลีกเลี่ยงไม่พ้น แต่ละบุคคลต้องถึงแก่ความตายไม่อย่างฉับพลันก็อาจเป็นไปตามที่คาดหมายไว้ก่อนหน้า ผู้ที่ต้องเผชิญกับความตายที่คาดหมายไว้ก่อนมักจะเกิดจากการเจ็บป่วยในระยะสุดท้าย ซึ่งอาจมีลักษณะเรื้อรัง จากโรคที่ไม่สามารถรักษาให้หายขาดได้และเป็นเหตุให้มีชีวิตสั้นลง แม้จะเป็นที่รู้กันโดยทั่วไปว่าความตายเป็นกระบวนการส่วนหนึ่งของดำเนินชีวิตมันก็ยากที่จะรับความจริงในข้อนี้ ความกลัวนี้เป็นสัญชาตญาณอย่างหนึ่งของมนุษย์ ผู้ที่กำลังเผชิญกับภาวะความเจ็บป่วยระยะสุดท้ายมักจะมีปัญหาทางจิตใจจากการคาดการณ์ว่าเวลาของความตายใกล้เข้ามาทุกขณะ เพื่อเป็นการช่วยเหลือผู้ป่วยกลุ่มนี้ให้มีความเจ็บปวดและความกังวลน้อยลงและเพื่อช่วยให้ปรับตัวกับภาวะเจ็บป่วยได้ดีขึ้น หน่วยงานด้านการแพทย์และสาธารณสุขจึงจัดหาวิธีที่เหมาะสมและดีที่สุดสำหรับผู้ป่วยโดยเรียกวิธีการนี้ว่า “การดูแลผู้ป่วยระยะสุดท้าย” การดูแลเช่นนี้จะมีลักษณะเป็นความช่วยเหลือให้ผู้ป่วยมีความเจ็บปวดหรือทุกข์ทรมานน้อยลงมากกว่าที่จะมุ่งรักษาหรือแก้ไขอาการ จึงเป็นการช่วยให้ผู้ป่วยมีความรู้สึกผ่อนคลายและเตรียมความพร้อมที่จะเผชิญกับความตายเมื่อถึงเวลานั้น การดูแลผู้ป่วยระยะสุดท้ายร่วมกับการดำเนินกิจกรรมต่างๆ ที่เหมาะสมให้แก่สมาชิกในครอบครัวจึงเป็นสิ่งจำเป็น ในบทความนี้ได้กล่าวถึงทฤษฎีและแนวทางในการดำเนินกิจกรรมต่าง ๆ ทางจิตวิทยาบางประการที่มีความเหมาะสมรวมทั้งแสดงข้อคิดเห็นต่าง ๆ ไว้

คำสำคัญ: *การเจ็บป่วยในระยะสุดท้าย การดูแลผู้ป่วยระยะสุดท้าย สัญชาตญาณของการกลัวความตาย การดำเนินกิจกรรมทางจิตวิทยาที่มีความเหมาะสม*

Introduction to Palliative Care

Terminal illnesses are illnesses caused by chronic, usually incurable diseases, which have the effect of considerably limiting a person’s life expectancy. These include cancer, diabetes, neurological conditions, coronary heart disease and HIV/Aids (Zanni & Browne III, 2010). Terminal illness causes psychological problems related to approaching death (Cramond, 1972; Fine, 2001) as well as to economic difficulties experienced by the patient and his/her family as a result of the illness (Sloan et al., 2017). This is a kind of stress in life. As a living organism, it is inevitable to face death someday. The illness may be sudden and severe and painful or may gradually progress over quite a long time. Death is approaching the patient, but no one can tell us when. Death depends on how serious the progressive stages of the disease are. In order to help the patient to live with less pain and cope with this kind of illness, we try to give the best intervention according to the patient’s social and economic status. This kind of help is known as terminal care or palliative care. This kind of care is designed to make the patient feel comfortable, not to cure the patient. The World Health Organization (WHO) provides help for health professionals by giving advice and training in order to clarify the nature of palliative care and how to handle individual cases. By making these efforts, health professionals can apply their knowledge and understanding in order to

provide better help and care to the patients and their families.

Palliative Care

According to the definition given by WHO, terminal or palliative care provides relief from pain and other distressing symptoms, supports life and sees dying as a normal process, aims neither to speed up or delay death, incorporates the psychological and spiritual aspects of patient care, provides a support system to aid patients live as actively as possible until death, offers a support system to assist the family cope during the patients illness and in their own bereavement, utilizes a team approach to address the needs of patients and their families, including bereavement counselling, if indicated, will improve quality of life, and may also positively influence the course of illness, and, is applicable early in the course of illness, in conjunction with other therapies that intend to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understanding and manage distressing clinical complications (WHO, 2002). Nowadays, it is already recognized that the focus of palliative care is not only patients' welfare but also includes the considerations of the health and well- being of family members and of the caregivers working with the patient (Sepúlveda, et al., 2002).

Palliative Care for Children

Palliative care for children is defined as the active holistic care of the child's body, mind and spirit. This also involves the provision of support to the family. This process of care starts when illness is diagnosed, and lasts regardless of whether or not a child is being given a treatment directed at the disease. Health providers are ought to evaluate and help lessen a child's physical, psychological, and social suffering. Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources. It can still be successfully implemented despite the limited number of resources. It can be provided in tertiary care facilities, in community health centers and even in children's homes (WHO, 1998).

Hospice and Palliative Care Services

There was a research result done by the Centers for Disease Control and Prevention in 2015 stated that about one-third of Americans, who die each year, die in hospitals (Taylor, 2018). If this was true, the remaining two-third dies at home or some institutions providing the terminal care. In 2017, the total number of patients who died by ten leading causes of death, varied from diseases of heart to septicemia, was 2,067,404 (Centers for Disease Control and Prevention, 2018). Therefore, it will be about 1,378,270 cases who die outside the hospitals. In other words, more than one million three hundred and seventy - eight thousands of cases had the terminal care at home or institutions providing palliative care rather than the hospitals. In Thailand, with less facilities, there should be a higher proportion of patients suffering from final stage of diseases living at home with or without palliative care than in the hospitals or institutions providing palliative care.

It is well accepted that cancer is one of the leading causes of death. Cancer is a life threatening disease. It is quite difficult to treat patient with the later stages of progress of the disease. Furthermore, it takes quite a lot of time and space to take care of the patients with cancer. There is no cure for the later stages of cancer. This is the most difficult time to patients, their relatives, as well as the health professionals. There is a special need to provide positive care rather than to cure for cancer patients. Physicians and nurses together with health professionals need a kind of knowledge for dealing with the end-of-life state patients. It is also necessary to establish a special kind of hospital for the patients suffering from cancer at the end state of life which is called, a hospice. Hospice is a place or an organization that provides care for people who are dying from chronic and fatal diseases.

In the United States, The National Hospice and Palliative Care Organization: NHPCO, founded in 1978. It is an organization for providers and professionals who care for people affected by terminal illnesses. The organization aims to lead and mobilize social change for improved care at the end of life. The services, based on the person centered model for healthcare, provide patients and their family members with comfort, peace, and dignity during most intimate and vulnerable experiences. The organization's members offer several services which includes handling the patient's pain and symptoms, backing-up the patient with the emotional, psychosocial, and spiritual aspects of dying, offering needed drugs, medical equipment and supplies, instructing the family on how to care for the patient, delivering special services like speech and physical therapy when the need calls for, making short-term in patient care obtainable when pain or symptoms become too difficult to treat at home and providing bereavement care and counseling to surviving family and friends (NHPCO, 2012).

In Thailand, there was an evidence given by the Worldwide Palliative Care Alliance (WPCA) in 2011 that Thailand ranked as the Level 3A country. The palliative care was not well supported, the majority of funding was heavily depended on donors. There were very few numbers of hospice palliative care services (Milintangkul, 2015). As the result of that report, a national policy on palliative care was raised led by the National Cancer Control Program for the year 2013-2017. The program was complied considering the guidelines set by the WHO for Effective Programmes: Cancer Control, Knowledge into Action, Palliative Care. Meanwhile, the Ministry of Public Health implemented the Service Plan in the year 2013. Palliative care was brought into the cancer care program in the primary, secondary and holistic care programs. Palliative care developed rapidly in 2014 when the National Health Commission endorsed the three years National Strategic Plan on Health Promotion for Good Death 2014-2016. In May 2014, the WPCA and HO released the "Global Atlas of Palliative Care at the End of Life". This book has been used for making strategic guideline for palliative care development in Thailand. A target of the policy on palliative care development stated that "Palliative care unit should be established in every departmental, regional, general hospitals deployed with at least

one full-time trained nurse as the coordinator and 300 community hospitals to establish the unit by 2016" (Milintangkul, 2015).

Preparation for the End of Life Stage

Life and death come together after conception. When life begins, death begins too, but it waits silently for its turn. Although we have known some limitations of life, like the age expectancy that we will normally die at a certain age limit. However, as a living organism, man has an instinct to preserve his/her life as long as possible. Struggle for life behaviors are easily seen, not only to live but to prevent from pain as well. Therefore, almost all of our behaviors intend to prevent pain and death. For example, breathing, eating, mating, rest and sleeping, fighting and fleeing, are some behaviors of this kind. We try our best to be safe from harm and prolong our life since we were born. It seems that not only to save our life, but to save others' as well. However, according to psychoanalytic theories, with the contradiction of the life and death instincts, sometimes we hurt or kill others just to protect ourselves and to keep our life going on. We sometimes, try to get rid of others from our life. In order to control death instinct, man set up some laws and regulations to save his life and other's life. It is against the laws and regulations to hurt or kill himself and others. These laws and regulations became a part of our religious beliefs that hurting and killing one's self and others are big sins.

Since everybody loves his/her life, we should find some ways to help others to live as long and as peaceful as possible. A patient may suffer from pain or illness when some kinds of illnesses are chronic, difficult to treat or cannot be treated by present knowledge and technology. How to help this kind of patients to live with the illnesses with less sufferings until death is what health professionals are trying to do. Ditillo (1999) suggested to nurse practitioners that: "As primary care providers, nurse practitioners specialize in facilitating health promotion and disease prevention as well as the optimal management of various disease states throughout the life cycle. Because death is an inevitable part of life, primary care providers need to plan for optimal dying experiences with their patients. By forming partnerships and having open discussions about dying, providers can understand and honor the wishes of their patients and help them to avoid unwanted dying experiences. This is in keeping with a preventive model of care and focuses on the overall well-being of the patient encompasses holistic care and respects patient autonomy" (Ditillo, 1999, p. 243).

Various techniques of health promotion as well as palliative care have been continually invented for the terminal illnesses treatment and care. After rigorous researches on these techniques, the knowledge derived will be transferred from research to practice. There are now a lot of techniques provided for the patients at the end state of life, at different age levels and different kind of illnesses. Physiological, sociological, and psychological techniques are now blended together in order to provide the best palliative care for each specific patient. Therefore, at present, there are several teams of health professionals providing palliative

care with various kinds of interventions. Such team may include physicians, psychiatrists, psychologists, nurses, psychiatric nurses, social workers,physical therapists, occupational therapists, and many other health professionals, necessary for the treatment and intervention (Matzo & Sherman, 2015; Rosser & Walsh, 2014; Balasubramanian et al., 2018). Individual or a single technique is gradually faded away from palliative treatment and care.

Psychological Interventions

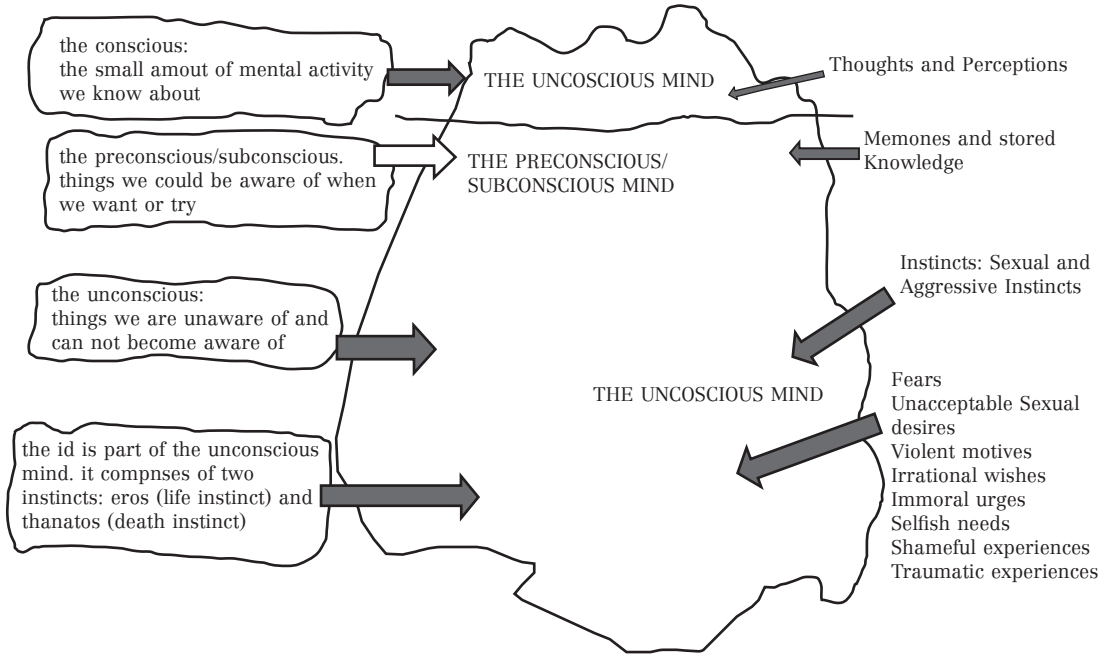
Besides the physiological changes occurring during the progression of the disease, psychological changes like anxiety and depression symptoms usually found in the terminally ill patients and their family members (Fine, 2001). Pharmacological and psychosocial interventions are accepted to be used for treatment of anxiety and depression (Fine, 2001; Widera & Block, 2012; Taylor, 2015; Taylor 2018). However, performing psychological interventions also need some skills to do. Well trained health professionals such as psychologists, psychiatric nurses or counselors should be involved in the palliative care team. There are several psychological theories applied in the treatment processes. Some of them are:

- Psychoanalytic theories
- Humanistic theories
- Cognitive psychotherapy
- Existential psychotherapy and meaning management theory

Psychoanalytic Theories

The original psychoanalytic theories were proposed by Sigmund Freud since 1905. His theory mentioned the topographical model of the mind including the conscious, the subconscious and the unconscious. Besides the stages of the mind, he also mentioned the three essential parts of our personality (the psychic apparatus) including the id, ego and superego. He compared the structure of mind to an iceberg which we can see only a very small part of it above the water while the larger part is hidden under the water. The Ego is a part of personality that a person uses to face with reality or his surroundings. Most part of the ego is in the subconscious or preconscious level. The Superego, which residents in the unconscious level, is the part of the personality which controls a person's behavior to express in a socially accepted way. The Id is the part of personality which tries to support the individual's instincts, the life and death instincts. The Id is in the unconscious level (Nevid, 2003; Balogh, 1971). If the superego cannot control the id, the individual's behaviors will be perceived as immoral, socially unacceptable, bad, and rude. If the superego is too strong, the individual will be too anxious, too much aware of what is right or wrong. The behaviors expressed are somewhat like that of the socalled neurotic behaviors. Either way of personality expressions, the ego will be perceived to be weak or fail to manage conflicts between the id and the superego. A normal person should have a good balance between the id and the superego. However, at certain critical situation, for example, attacked by a thief, the person may fight back (the id) or be placated (the superego). The id or the superego may be stronger than the other during that time. However, after the critical situation is over, the balance between the id and the superego will be

back to normal. The psychodynamic theory believes that psychological problems are rooted in unconscious psychological conflicts which may have occurred since childhood during psychosexual stages of development (McLeod ,2018). Freud proposed that the ego defense mechanisms are mental processes which help a person to cope with strong urges of the instincts, especially the primitive sexual and aggressive impulses which cause the person anxiety. Some of these mechanisms are regression, suppression, repression, conversion reaction, and denial (Nevid, 2003). However, the ego defense mechanisms cannot get rid of the causes of the anxiety. The person thus, suffers from the anxiety from time to time when facing with the arousal situation. Psychoanalysis was designed to make the person gain insight of his/her problems and find a proper way to live without or with less anxiety.



Source: Diagram based on https: //www.simplypsychology.org/Sigmund-Freud.html

Figure 1: *Diagram showing the three structures of mind and their functions according to Freud's theory. Adapted from: https://www.simplypsychology.org/Sigmund-Freud.html*

In the case of chronic and fatal diseases, the patients and their love ones may be urged by the unconscious motives, for example, the fear of death, the wish to live longer, the fear of loss, etc. The fear of death is a matter different from the fact that we all must die (Cramond, 1972).

Some patients and their families may have the unrealistic wishes, beliefs, which leads to negative emotions. It is important to help the patient to live with less fear, and accept the reality of life. Psychologists and healthcare providers will apply the knowledge of the structure of mind as well as the stages of mind to work with the unconscious motives, feelings and emotions, and undesired behaviors in order to make the patient and his/her family members understand and accept the truth of life in order to cope with stressful situations with less negative emotions in a positive way. That is why the psychoanalytic approach is sometimes called "the insight oriented psychotherapy".

The Humanistic Theories

Abraham Maslow (1970) is a well-known humanistic psychologist due to his motivational theory describing the hierarchy of needs. Maslow divided human needs into two categories; the four levels of the first category are referred to as deficiency needs and the second category (top level) encompasses the growth needs or being needs which are known as self-actualization needs. The lowest level of the needs is physiological needs. The second level is safety needs, the third level is love and belongingness needs and the forth level is esteem needs. He proposed that before achieving the growth needs, the basic needs should be, more or less, satisfied step by step from the first level to the fourth level (Maslow, 1987 cited in Mcleod, 2018).

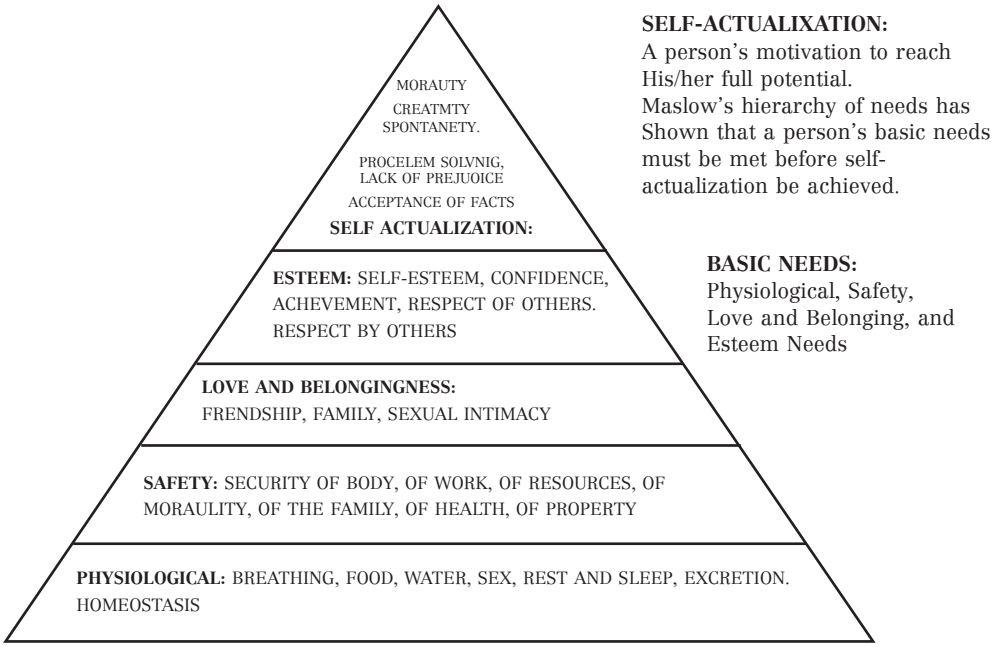


Figure 1: *Figure 2: Diagram representing Maslow's Hierarchy of needs: Adapted from https://whatyourgrief .com/adjustment-after-loss/reprinted from www.timvandevall.com © 2013 Dutch Renaissance Press, LLC.*

Loss is an expected result of a life- threatening disease or terminal illness. It may come sooner or later, when dealing with the end-of-life or receiving palliative care. There are a lot of people who have strong or inadequate emotional tie with others which can be explained by Maslow's hierarchy of needs diagram, the basic needs of love and belongingness. When the symptoms of the disease seem to be progressing, the fear of loss (safety needs) may occur which leads to anxiety and depression. This strong emotion can be easily perceived by others. No matter if it happens to the patient or to the family members, psychological intervention should be given as soon as possible.

Carl Rogers, a prominent humanist, believed that man is naturally positive, forward moving, basically good and self-actualizing. He stressed that every person could "take charge" of life, make decisions, and act on the world. When the person achieves his/her goals, wishes, and desires in life he/she can move into the stage of self-actualizer or becoming fully functioning person (McLeod, 2014). Rogers proposed that the fully functioning person is an ideal and one that people do not ultimately achieve. It is a process of always becoming and changing. Furthermore, a fully functioning person enjoys life thoroughly in all aspects, not only the moment of success (Ivy et al., 1987).

Self-concept is an individual's knowledge of who he or she is. It is active, dynamic and easily changed. It has developed since childhood based on one's own experiences in his/her social situations and motivations. When a person is in a sick role, things may be different. Self-concept may be altered and sometimes may be in conflict. According to Roger's theory of self, there are three components of self-concept (Nevid, 2003):

• Perceived-self or self-image is the result of how a person see himself. It affects the person's psychological health. Because it affects how a person thinks, feels and behaves in his environment and his world.

• Ideal-self is what a person would like to be. It consists of the person's goals and ambitions in life, and is dynamic, keeps on changing according to the context of life.

• Real-self is what a person actually is in his reality.

Self-esteem (Self-worth) comprises what we think about ourselves. Self-esteem has been developed from early childhood and were formed from the interaction of the child with the mother and father and significant persons around him. Any conflict between the real-self and perceived-self or ideal-self, may challenge one's self-esteem. Theperson's negative thoughts or feeling of hopelessness or helplessness might have negative effects on his self-esteem. Depression and anxiety might occur as the results of these kinds of negative thoughts, feelings and poor self-esteem.

A person with low self-esteem may be difficult to accept that life can be painful and unhappy at times. He/she may be defensive and guarded with other people. Thus, some terminal illness or untreatable disease cases do not allow visits by others as a result of these kinds of thoughts.

Rogers: "…We need to be regarded positively by others. We need to feel valued, respected, and treated by affection and loved…." (Rogers, 1951, cited in Ravi,2016).

Terminal illness patients may perceive themselves as hopeless, helpless, weak, being

in bad conditions, worthless, and many other negative thoughts and feelings. Caregivers should be aware of these kinds of thoughts and interact with the patients with warm and unconditioned positive regards. From my experiences, treating the patient with respect as a human being both in verbal and non-verbal communication is a primarily concern in humanistic approaches applied in therapy and counseling.

Cognitive Behavior therapy:

Cognitive Behavior Therapy (CBT) is another approach which was originally proposed by Aaron T. Beck during the year 1960s as cognitive therapy: CT (Beck et al., 1987). Knapp and Beck (2008) stated that thoughts, feelings and behaviors are all connected, and that the way a person perceive and process reality (thinking) determines his/her feelings and behaviors. Since thoughts are at the fringe of awareness that occur spontaneously and rapidly, immediate interpretation of any given situation may occur which is called as automatic thoughts. This kind of thoughts is different from the ordinary flow of thoughts observed in reflective thinking or free association. Cognitive distortions are what Beck tried to make it clear as the source of anxiety and depression. There are different kinds of cognitive distortions. For example, catastrophizing, emotional reasoning, polarization, selective abstraction, mental reality, labeling, and minimization or maximization. Some authors including Beck mentioned that the roots of these distorted automatic interpretations are deeper dysfunctional thoughts called schemas or core beliefs (Knapp & Beck, 2008). According to this explanation, man is depressed because of his automatic negative thoughts. Therefore, to eliminate depression, we should help the patient to change his/her way of thinking which might be wrong as a result of his/her unrealistic beliefs. CBT is suggested to be one of the therapeutic methods for terminal illness patients and family. A diversity of CBT approaches can be organized in three groups. The first one is coping skills therapies which emphasize the development of coping skills to cope with problem situations. The second one is problem-solving therapies which emphasize the development of general strategies to deal with a wide range of personal difficulties. And the third one is restructuring therapies, which emphasize the assumption that emotional problems are results of maladaptive thoughts. The goal of treatment is to reframe the distort thinking and construct new adaptive thoughts (Knapp & Beck, 2008).

According to a cognitive therapist, George Kelly, who proposed his personal construct theory (Kelly, 1963; Knapp & Beck, 2008) which supported Piaget's idea of schemata that the differences between people result from the different ways that each person predicts and interprets events in the world around him/her. Personal constructs, are the ways that each person gathers information, evaluates it, and develops interpretations. Emotions and reactions will be observed later as the results of the interpretations. One well recognized therapeutic approach is rational emotive behavior therapy (REBT) primarily introduced by Albert Ellis as rational emotive therapy (RET) in 1955 which was developed to be rational emotive behavior

therapy in 1962 (Dryden & DiGiuseppe,1990). He emphasized that negative emotions in poor mental health people were caused by getting in the trap of self-defeating beliefs and behaviors. Clearing the client's irrational beliefs and behaviors by using the rational analysis and cognitive reconstruction will help the clients to understand themselves better and then can develop more rational constructs. Another cognitive behavior therapeutic approach is reality therapy introduced by William Glasser in 1965 and his new theory "Choice Theory" in 1998. Glasser (2005) proposed his theory of five basic needs that every human has and needs to be fulfilled. These five needs include the needs to survive, to have the power to achieve his goal, to love and to feel loved in return (the same as Maslow's love and belongingness need), to have freedom of choice, and to be able to have fun and enjoy oneself. However, the negative emotions will occur if the person does not accept his reality. People are easily distracted by the environments; the social environment, the physical environment, and others. They become neglectful of their reality but have the fantasies about things should happen to them. These fantasies are not real. They are making their choices not to be in their reality but in the unreal world which will easily result in suffering as a consequence.

When we feel that the findings of self are conflicting with our personality structure, we have anxiety and negative feelings. If we believe that we are always strong and self-sufficient, when in fact, during the end-of-life period, we are truly weak and we need a lot of help from others, and become more and more dependent. We may feel guilty and shame as well as depressed. It is quite difficult to accept the fact of life that at the end we will die. Cognitive behavior therapy techniques are suggested to be useful interventions to work with this kind of patients (Anderson, Watson, & Davidson, 2008; Knapp & Beck, 2008; Selene, G., Omar, C.F., & Silvia, AP, 2016).

Existential Psychotherapy

Yalom a prominent psychiatrist defined Existential psychotherapy as "a dynamic approach to therapy which focuses on concerns that are rooted in the individual's existence" (Yalom, 1980, p.5). He also proposed that existential psychotherapy is a valuable, effective psychotherapeutic paradigm, as rational, as coherent, and as systematic as any other. Existential psychotherapy belongs to what so called "dynamic therapy" because it deals with the specific forces, motives, and negative emotions that interact in the patient. The interaction between the forces and negative emotions is in the unconscious level and leads to internal conflicts of the patient. Therapists need to identify the primary conflicts using the therapeutic assessments like deep reflection, dream analysis, narrative techniques, etc. When using existential psychodynamics, the psychotherapists emphasize on "a conflict that flows from the individual's confrontation with the givens of existence" (Yalom, 1980, p.8). These givens of existence are things within the existence of a person, for example, the person's contexts, the boundaries, and possibilities to do things. He suggested his idea of four facts of life which lead to the "ultimate concerns" consisted of death, freedom, existential

isolation,and meaninglessness. Every person knows that one day he/she will die. There is no exception. However, no one wants to die. The core existential conflict is the tension between the awareness of death and the wish to continue to be. This kind of conflict can occur to the terminal illness patients as well as to the relatives and significant persons. The second ultimate concern is freedom. Freedom is not just being out of other's controls but the responsibility to choose, to do things, to live or even to die by his/her own decision making. The existential isolation refers to the feelings which result from the realization that we cannot ever know exactly how another person experiences the world (Pinel et al., cited in Greenberg et al., 2004). Pinel and her colleague explained that there are two kinds of self. The first one is what we see ourselves. Like looking at a mirror, we can see our face, our body, our dress, etc. It is static. This is self-concept. Another one is different. It keeps on changing according to the situation. We use our senses to perceive the world while another person uses his/hers. The sensations occurring in our body system cause us thoughts, feelings, and emotions. This process is what we call perception or experience. There are a lot of differences among people in sensation and perception. Therefore, we cannot really share our unique experiences to others. We can only share what we think or feel about it. However, no one can understand or experience exactly the sensation or perception the way we do and vice versa. This is a limitation of sharing experiences. The experience which exists to one maybe perceived differently by others. Thus, it is called as existentially isolation. We recognize this phenomena as individual differences. (Greenberg et al., 2004).

Instead of regarding human experiences such as anxiety, alienation and depression as implying the presence of mental illness, existential psychotherapy sees these experiences as natural stages in a normal process of human development and maturation (Yalom, 1980; Lacovou and Weixel-Dixon, 2015). In facilitating this process of development and maturation, existential psychotherapy involves a philosophical exploration of an individual's experiences while stressing the individual's freedom and responsibility to facilitate a higher degree of meaning and well-being in his or her life. (Lacovou & Weixel-Dixon, 2015).

Meaninglessness

Life has some values in itself. After birth, everybody tries so hard in every way to survive. When we were young as a baby, we were too weak and extremely dependent on our parents. Along with developmental processes, we gradually become more physically, socially, psychologically and spiritually mature. We have passed through a lot of obstacles by our abilities, which gradually developed through learning and experiences. We became proud of ourselves, which built up our self-esteem. Because of the development of self-esteem, we perceive ourselves as meaningful persons. It is good for us to be loved by someone and to love someone. Love, belongingness, and self-esteem are needs that are explained in the Maslow's Hierarchy of Needs (Nevid, 2003; McLeod, 2018). Achievement in these basic needs will

lead a person to seek for the meaning of life or self-actualization need. This need approves the existence of one's life. However, when a person is in a sick role or aging, especially caused by terminal illness, self-esteem may be decreased. Because he/she will become more dependent on others. The ability to give is less than to take. The form of interaction with others is changed. As the illness progresses, he/she will become more dependent. When the mobility of body is limited due to the progress of the disease, man becomes totally dependent to others. It is the time that he/she cannot do anything for other but just being a receiver. The meaning of live then, decreases. In order to lessen the sense of meaninglessness as well as to keep the sense of existence, it is important to communicate with the patient at this stage with respect and do whatever possible that can maintain the limited self-help activities in a positive way (yalom, 1980; Stanley et al., 2005).

Death Anxiety

As a fact of group instinct in humans, just like another animals, man prefers to maintain good relationship with others. While the relationship is going on, man has a fear of separation and it leads to separation anxiety. It is quite common to see a child crying after his/her parents say goodbye during the first or second week of school days. Later, he/she will realize that they will meet each other again in the evening crying fades away. Both parties realize that they have to separate from each other just for a while. However, when talking about death, the dying and the people (family and friends) left, may have various kinds of cognitive functions about death. It is different from being away for a period of time. This is a forever departure from a loved one. Since no one knows what life after death will be, everything seems to be uncertain, questionable, unexplainable, and fearful. Because of this kind of uncertainties, man is afraid of death. According to Freudian theories, man has an instinctive fear of death (thanatophobia). Although nowadays scientists may not pay much attention to Freudian theory, they usually refer to terror management theory (TMT) that all humans are instinctively driven toward survival and continued existence, at the same time have knowledge of the inevitability to die (Cicirelli, 2002). This concept is the same as Freud's "life instinct". Death is opposed to the unconscious motive to live. This kind of unconscious urges, leads to death anxiety. The terminal illness patient and the relatives may have this anxiety and thus, interferes their emotions which might be observed as being depressed, irritable, always seeking for help, nervoused, and many other maladaptive behaviors. According to the existential psychology viewpoint, Yalom (2008) stated that every man has the fear of death. This kind of strong feeling interferes with one's enjoyment in life and causes unhappiness, and other negative emotions. One way to cope with this kind of anxiety is to understand and accept the existence of death and live the remaining time in a meaningful manner.

Meaning Management Theory

"Death is the only certainty in life. All living organisms die; there is no exception. However, human beings alone are burdened with the cognitive capacity or be aware of their own inevitable mortality and to fear what may come afterwards. Furthermore, their capacity to reflect on the meaning of life and death creates additional existential anxiety… There is a tacit understanding that sooner or later, we all have to come to terms with our own mortality… The certainty and inevitability of death make its presence felt in every arena of human existence. How we react to the prospect of personal death would have impact on how we live." (Wong, 2012)

The idea of death is such a multifaceted process and broad including psychological, spiritual, societal, and cultural meanings. These meanings therefore bring about important implications for our well-being (Wong et al., 2012).

In 1969 Elisabeth KÜbler-Ross proposed five stages of coping with death including denial, anger, bargaining, depression, and acceptance (Newman, 2004). Various aspects of death and coping mechanisms have been studied after that. One among those was the development of the Death Attitude Profile (Gesser, Wong, & Reker, 1988; Wong, Reker, & Gesser, 1994). It identifies three distinct types of death acceptance: (a) neutral death acceptance-the person sees death is an inevitable end of every life; (b) approach acceptance the person hopes that when death comes, it will send him forth to a better afterlife, and (c) escape acceptance-It is when a person thinks it is better to die than to live this life painfully.

Another assessment is done by Sloan and colleagues, (2017) which aims to assess the meaning in life threatening illness in order to identify distress causing changes that may interfere with the development of meaning and psych-social-spiritual homeostasis. The result would be beneficial for therapist to find an effective way to construct a healing process for the patient.

Wong (2012) proposed that transpersonal religious/ spiritual beliefs for a desirable life are where approach acceptance roots from. After life is not only regarded as a symbolic immortality, clearly because there is what we call spiritual or transcendental reality. Escape acceptance however, perceives life as so painful and miserable that it's not worth the trouble of living. Escape acceptance are sometimes manifested through suicides and assisted suicides. However, the fear of death is opposite. It has its roots in the bases of death anxiety. Examples of causes of death anxiety are thoughts about the uncertainty of death, the final of life, ultimate loss, leaving the love one behind, uncomfortable physical conditions in the last hours of life like difficult to breath, pain, etc.

Wong explains that… if we have lived a meaningful life and achieved ego-integrity, we are able to face death without fear (as cited in Erikson, 1982). Death acceptance is one of the cornerstones for the good life. In the contrary, if we have too many regrets and a profound sense of failure and despair, then death is fearful. Thus, there are two fundamental psychological tasks. The first one is to protect ourselves against the terrors of loss and death and the second one is

to pursue the good life by living meaningfully. Therefore, the meaning of life and the meaning of death are interrelated to each other (Wong, 2008).

Wong explains that the objectives of meaning management is to wisely manage all our oppositional thoughts and feelings. Some examples proposed are: fears and hopes, memories and dreams, hates and loves, regrets and celebrations, doubts and beliefs, and the various meanings we attach to events and people. Therapists need to facilitate the clients to discover the happiness, hope, meaning, fulfillment, and equanimity in the midst of setbacks, sufferings and deaths.

Summary

Psychological distress is common in people facing the stage of the end of life, terminal illness or life- threatening diseases. The common symptoms are anxiety, emotional problems and depression. Palliative care is suggested to be one of the effective ways to help the patient cope with stress. Several techniques applied in palliative care are not for curing or getting rid of the symptoms but to help the patient to live at this stage with less social and psychological problems and pain. Pharmacology, social supports, psychological supports in various forms are among those techniques. However, the most common things should be involved in any kind of palliative care are acceptance and respect the patient as a valuable human being.

I would like to conclude my paper with the following remarks:

As a scientist, what has happened to our lives are facts. They are true under some specific conditions.

As a philosopher, what has happened to our lives are truths. They are true and cannot be changed.

As a clinical psychologist, what has happened to our lives are both facts and truths.

If you are a good reader, you can read between the lines.

If you are a good listener, you can hear the sound of silence the inner voices.

You can make connections with people and understand them by your listening, not by your speaking.

References

Anderson, T, Watson, M, & Davidson, R. (2008). The use of cognitive behavioural therapy techniques for anxiety and depression in hospice patients: a feasibility study. *Palliative Medicine. 7*, 814-821. Retrieved from: http:s//doi.org/10.1177/0269216308095157. Epub2008Aug28.

Balasubramanian, C., Subramanian, M., Balasubramanian, S., Agrawal, A., Raveendran, S. and Kaliaperumal, C. (2018). *"Thanatophobia": Physician's Perspective of Dealing with Patients with Fear of Death". 1*,103-104.doi:10.4103/jnsbm. JNSMB_102_17.

Balogh, P. (1974). *Freud: A Biolographical Introduction.* London: Studio Vista

Beck, A.T., Rush, A.J., Shaw, B.F., and Emery, G. (1987). *Cognitive Therapy of Depression.* New York: Guilford.

Burggraf, V., Kim, K.Y., & Knight, A. L. (2014). *Healthy Aging: Principles and Clinical Practice for Clinicians.* Hong Kong: Wolters Kluwer.

Centers for Disease Control and Prevention. (2018). *Table 7. Leading Causes of death and numbers of deaths,by age:* United States, 1980 and 2017.Retrieved from: https://www.cdc.gov/ nchs/hus/ contents2018.htm#Table_007.

Cramond, W.A. (1972). The Psychological care of patients with terminal illness. *Journal of the Royal College of General Practitioners. 22*, 661-673.

Cicirelli, V.G. (2002). Fear of Death in Older Adults: Predictions from Terror Management Theory. *Journal of Gerontology: Psychological Sciences. 57*(4), 358-366.

Ditillo, B. A. (1999). Planning for End of Life Care: Pearls for Practice. *Journal of the American academy of Nurse Practitioners.6*,243-248. Retrievedfrom: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1745-7599.1999.tb00572.x

Dryden, W. & DiGiuseppe, R. (1990). *A primer on rational-emotive therapy.* Illinois: Research Press.

Fine, R. L. (2001) Depression, Anxiety, and Delirium in the Terminally Ill Patient, *Baylor University Medical Center Proceedings.2*, 130-133. doi: 10.1080/08998280.2001.11927747

Glasser, W. (2005). *Defining Mental Health as a Public Health Issue: A New Leadership Role for the Helping and Teaching Professions.* Tempe Arizona: William Glasser Institute.

Ivy, A.E., Ivy M.B. & Simek-Downing, L. (1987). *Counseling and Psychotherapy: Integrating skills, theory, and practice.* New Jersey: Prentice-Hall.

Kelly, GA (1963). *A theory of personality: The psychology of personal constructs.* Oxford, England: WW Norton.

Kelly, G. A. (1991). *The Psychology of Personal Constructs: Vol 2.* London: Routledge.

Knapp, P. & Beck A.T. (2008). Cognitive therapy: foundations, conceptual models, applications and research. *Rev Bras Psiquiat, 30*(2), 54-64.

Lacovou, S., & Weixel-Dixon, K. (2015). *Existential therapy: 100 key points and techniques*. London: Routledge.

Matzo, M. & Sherman, D. W. (editors). (2015). *Palliative Care Nursing: Quality Care to the End of Life*. New York: Springer.

McLeod, S. A. (2014). *Carl Rogers*. Retrieved from: https://www.simplypsychology.org/carl-rogers.html

McLeod, S. A. (2018). *Maslow's hierarchy of needs*. Retrieved from: https://www.simply psychology.org /maslow.html

McLeod, S. A. (2018, April, 05). *What are the most interesting ideas of Sigmund Freud?* Retrieved from https://www.simplypsychology.org/Sigmund-Freud.html

Millintangkul, U., (2015). *National Policy on Palliative Care in Thailand*. Retrieved from: https://en.nationalhealth.or.th/wp-content/uploads/2017/11/NationalPolicyPCare2015_09_17-1.pdf

Nevid, J.S. (2003). *Psychology: Concepts and Application*. Boston: Houghton Mifflin

Newman L. (2004). Elisabeth Kübler-Ross. *BMJ : British Medical Journal*, *329*(7466), 627.

Pinel, E.C., Long, A.E., Landau M.J., and Pyszczynski, T. (2004). *I-Sharing, the Problem of Existential Isolation, and Their Implications for Interpersonal and Intergroup Phenomena*. Cited In Greenberg, J., Kole, S.L., & Pyszczynski, T, (2004). Handbook of Experimental Existential Psychotherapy. New York: the Guilford Press.

Ravi, V. (2016). *Advanced Educational Psychology*. Solapur: Laxami Book

Rosser, M. & Walsh, H.C. (2014). *Fundamentals of Palliative Care for Student Nurses*. Singapore: Markono Print Media.

Selene, G., Omar, C.F., & Silvia, AP. (2016). Palliative care, impact of cognitive behavioral therapy to cancer patients. *Procedia Social and Behavioral Sciences. 217*, 1063-1070. https//www.sciencedirect.com

Sepúlveda, C., Marlin, A., Yoshida, T., & Ullrich, A. (2002). Palliative Care: The World Health Organization's Global Perspective. *Journal of Pain and Symptom Management 2*, 91-96. Retrieved from: https://doi.org/10.1016/S0885-3924 (02)00440-2

Sloan, D.H., BrintzenhofeSzoc, K., Kichline, T, Baker, K., Pinzon, JP., Tafe, C., Li, L., Cheng, MJ., & Berger, A. (2017). *An assessment of meaning in life-threatening illness: development of the Healing Experience in All Life Stressors (HEALS)*. Patient Related Outcome Measures. Retrieved from: https://www.dovepress.com/by 58.97.84.66.

Stanley M., Blair K.A., & Beare P. G. (2005). *Gerontological Nursing: Promoting Successful Aging with Older Adults*. 3rd edition. Philadelphia: F. A. Davis

Taylor, S. E. (2015). *Health Psychology*. New York: McGraw-Hill.

Taylor, S. E. (2018). *Health Psychology*. New York: McGraw-Hill.

Widera, E.W. & Block, S.D. (2012). Managing Grief and Depression at the End of Life. *Am Fam Physician,* 86(3), 259-264

Wong, P.T.P. (2008). *Meaning Management Theory and Death Acceptance. In: Tomen, A., Eliason,*

G.T., & Wong P.T.P. (editors). Existential and Spiritual Issues in Death Attitudes. New Jersey: Erlbaum.

Wong, P.T.P. (Ed.). (2012). *The human quest for meaning: theories, research, and applications*. New York: Routledge.

World Health Organization. (1998). *Cancer Pain Relief and Palliative Care in Children*. Geneva: World Health Organization Retrieved from: https://apps.who.int/iris/handle/10665/42001

Yalom, I.D. (1980). *Existential Psychotherapy*. New York: Basic Books

Yalom, I. D. (2008). Staring at the Sun: Overcoming the Terror of Death. *The Humanistic Psychologist, 36*(3), 283–297.

Zanni, G.R. & Browne III, J.D. (2010). Coping with Terminal Illness. *Pharmacy Times*. 2010-08-17. Retrieved from: https://www.pharmacytimes.com/publications/issue/2010/August2010/ CounselingTerminalIllness-0810