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Psychosomatic Medicine and Palliative Care

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“In psychosomatic diseases the body takes the voice so that the emotions tell stories through their words that are the symptoms”.

Mejias [1]

Abstract

Psychosomatic medicine (MP) and palliative care are disciplines with history and both are based in the scientific world. Although the psychosomatic diagnosis is exclusionary, it can help palliative care to be more effective. The influence of the psychosomatic in the palliative exists. According to all the bibliography available in the electronic databases, psychosomatic medicine is a biopsychosocial model related to both physical and psychosocial factors, which helps improve the care of patients with advanced cancer in palliative care (improved survival, quality of life, reduces the burden on caregivers). It helps analyze and address psychiatric disorders, as well as in the control of complex symptoms such as life-threatening anxiety, depression or delirium. Therefore, both medical disciplines are related from the beginning and help to the quality of life of terminally ill patients.

Keywords: palliative care, physical factors, quality of life, medical discipline, terminal illness

1. Introduction

The first great historical relationship between both disciplines is referenced by the Paracelsus himself who could inspire centuries later the great Professor Sigmund Freud, since he was the promater of psychotherapy as a science: psychoanalysis, as a part of the birth of medicine itself psychosomatic (MP). This conclusion is understood when reading Dr. Freud's own words about his own condition, that of an oncological disease for 26 years, caused by his smoking habit, of a squamous cell carcinoma of the palate and jaw, which led him to numerous interventions surgical and painful conditions [2, 3]. Although the breaking news pointed to morphine overdose as the immediate cause of death, the fundamental cause was that terminal tumor, which turned off the light of genius in London on 23 September 1939. If palliative care, a later discipline, had been able to intervene, they would have allowed relief from his suffering, from the symptoms that tormented him, and, consequently, a dignified, natural and not accelerated death.

Psychosomatic medicine (PM), coined in 1818 by Heinroth, sought to relate psychosocial variables to psychophysiological changes. Although the first great evolution came from psychoanalysis, from 1965 this orientation changed towards other explanatory theoretical models based on the temporal and evolutionary analysis of the underlying disorder, somatic syndrome, pathogenesis, conflict, neurosis, personality, reliability of the signs, gains (primary and secondary) ..., and thus reach from psychosomatic factors (alexithymia, demoralization, irritability, behavior A), to psychosomatic diseases (according to the Chicago school, chronic with outbreaks) such as high blood pressure, bronchial asthma, peptic ulcer, ulcerative colitis, rheumatoid arthritis, thyrotoxicosis, neurodermatitis.

This medicine “is not a specialty but rather a point of view that applies to all aspects of Medicine and Surgery. It does not mean studying the body less; it means studying the psyche more. It is a reaffirmation of the old principle that the mind and body are one, that they function as interactive and interdependent organs, a principle that has always guided the intelligent practical physician. As a science, psychosomatic medicine aims to discover the precise nature of the relationship between emotions and bodily function. Research in this field is based on the convergence of modern physiological research, as developed by laboratory science and animal experimentation, as well as the discoveries of psychoanalysis, as previously mentioned, both dynamic developments in medicine [4]. It is established from the 1960s of the twentieth century as a multifactorial biopsychosocial model for all disease processes and not only for a group of diseases [5, 6].

The American Board of Medical Specialties recognizes it as the subspecialty of Psychiatry that is dedicated to the diagnosis, treatment and prevention of psychiatric morbidity in medical patients, through psychiatric counseling and the training of health professionals, especially in the hospital context [7]. However, in essence, psychosomatic medicine is multidisciplinary for the evaluation of psychosocial factors involved in individual vulnerability within the disease, holistic clinical care and the integration of psychological interventions with therapeutic, preventive and rehabilitative functions of medical diseases [8].

There are various theories that guide the psychosomatic model in our times, highlighting the complexity of the reality of the problems and the need for an interdisciplinary and multidisciplinary vision. Although it is a way of understanding medicine referring to the concept of disease, it is usually associated in a restricted way with a group of diseases that are variable but superimposable according to many tendencies to the somatoform disorders of DSM-IV-TR, the result of the influence of American origins, where it is equated with the somatopsychic, defined as a psychic alteration that causes organic symptoms through the somatic nervous system (mainly vegetative). The DSM-V criteria for the diagnosis of disorders with somatic symptoms continue to be incomplete because they do not take into account disease behaviors, such as denial of disease or experimental avoidance, which can be very important in the effect on quality of life of patients, for example, in pain, or in palliative care [5, 9].

Circumscribing the psychosomatic as a psychological disorder that generates a physical effect, causing some consequence in the body, although practical, would limit our analysis, since psychosomatic medicine as an integrative science, always tries to overcome itself, fleeing from partial or reductionist visions for integrate the manifestations of the biological, psychological, social world in the understanding of the human being, that is, the support of the good doctor or health professional, whose objective is to help the sick person, integrating the humanistic essence. Possibly for this reason, Laín Entralgo, already defined it as *“an orientation of Medicine that is characterized by including in each medical act and in each clinical judgment, the consideration of unconscious emotions that contribute to each patient configuring a sick person in a situation different”*.

Palliative care (PC) is a relatively new field with which a good part of the health system professionals are not familiar, despite its importance. Callahan reminds us in a paradigmatic article in the *New England Journal of Medicine*, that the main goals of today's medicine are not only to diagnose and treat diseases, but also, and equally important, to help die in peace. The English word "care" has its root in the goth term "Kara", which means to grieve, suffer, cry out in pain. The one who really cares must join the other person in his suffering (caring is assisting). Paliar derives from "pallium" (from the Latin "under the Canopy") which means mitigating the violence of certain diseases by making them more bearable. Palliative care is to attend, with the intention of making the patient's coexistence with their disease more comfortable.

Palliative care or "Hospice" care, as they were called from their origin in the fifth century, since they were carried out in hospices, led to the great modern movement in the United Kingdom in the 1960s–1970s of the twentieth century with Cicely Saunders as main figure and after expand to the rest of Europe, North America. The Hospice concept refers more to the physical structure of an organization, and PC would be a special type of care designed to provide well-being and support to patients and their families, in the final stages of a terminal illness (currently called advanced disease). Palliative Medicine from its first steps highlights two important aspects of medical ethics: respect for the weak and evicted, and recognition of the finite nature of curative medicine.

Emphasize that palliative care offers the most basic of the concept of caring, covering the needs of the patient and their family regardless of where they are being cared for or the evolutionary stage of the underlying disease. They affirm life considering death as a normal biological process, that is, the final part of the life process (biography of the subject). Therefore, they seek to preserve the best possible quality of life to the end without accelerating or delaying death. This improvement in the quality of life of patients and their families is achieved by facing the many problems associated with a fatal disease through the prevention and relief of suffering, identifying early, assessing and using adequate treatments for pain and other physical, psychological, social and spritual problems. Its application, when necessary, ranges from the diagnosis of the disease to the death of the patient, continuing with the care of the family in mourning [10, 11].

Determining which diseases are subsidiary to PC is complex, although it is currently based on the well-known McNamara list, the recommendations of the National Hospice Organization (NHO) of 1996 and the NECPAL CCOMS-ICO[®] instrument, which basically includes the following diseases [12–15]:

- Cancer.
- Advanced chronic heart disease.
- Advanced chronic kidney failure.
- Advanced liver failure (liver cirrhosis).
- Advanced lung disease.
- Chronic neurological disease. Highlight:
 - Advanced chronic cerebrovascular disease.
 - Motor neuron disease: amyotrophic lateral sclerosis (ALS).
 - Dementia.

- Advanced Parkinson's disease.
- Advanced Huntington's disease.
- Advanced Alzheimer's disease.
- Persistent vegetative states.
- Geriatric patient with advanced frailty.
- Advanced AIDS.

It is estimated that the need for PC varies between 50 and 90% of patients who die, being higher during the last year of life. In absolute numbers, cases of non-oncology are much more frequent, although the complexity of the cancer is usually greater, which explains at least in part that the scientific experience and clinical practice of tumor-related PC is greater. All health professionals must possess basic knowledge to care for these individuals and families, and in the most complex cases, it is when the Specific Palliative Care Teams or Units must intervene.

A disease is terminal if it has the following criteria:

1. Advanced and incurable and progressive disease, without reasonable possibilities of response to its specific treatment, and with a limited prognosis for life.
2. Presence of intense and changing multifactorial symptoms.
3. Great emotional impact on patients, families and professionals, which generates a great demand for care.
4. Implicit or explicit presence of death.

So what criteria can we use to establish terminality or advanced disease?. Two types of criteria [1]:

1. General.

- a. Advanced age.
- b. Comorbidity versus vulnerability.
- c. Well-documented disease progression that has generated an increasing need for healthcare. It is established according to:
 - i. Clinical criteria.
 - Independently include advanced cognitive decline.
 - ii. Lab tests.
 - iii. Supplementary tests.
- d. Emergencies or hospital admissions in the last 6 months, associated with:
 - i. Recent functional impairment.
 - ii. Dependency for at least three basic activities of daily life.

e. Nutritional impairment or malnutrition:

- i. Weight loss >10% in the last 6 months.
- ii. Serum albumin <2.5 g/dl.

2. Specific to the disease. Two subgroups:

- a. Cancer: They are mainly based on the histology and staging of the tumor.
- b. No cancer:
 - i. Advanced organic insufficiencies.
 - ii. Advanced degenerative diseases of the central nervous system.

In the case of children, terminality is grouped into four groups:

- 1. Serious potentially curable diseases, such as cancer.
- 2. Progressive diseases without cure such as muscular dystrophy.
- 3. Diseases with premature death with long periods of treatment to promote a normal life, such as cystic fibrosis.
- 4. Non-progressive irreversible diseases, which cause great disability and vulnerability, such as cerebral palsy.

There is an instrument that helps to identify advanced terminal disease and the need for PC, which is the NECPAL CCOMS-ICO[®] instrument for the identification of people in a situation of advanced or terminal chronic disease (oncological or non-oncological) and need for care palliative in Health and Social Services. Its application is aimed at the subsidiary diseases of PC referred to above. Thanks to it, it is possible to detect at a certain moment if the person with an advanced disease requires palliative care, that is, to have quality of life and comfort as a fundamental objective, without ruling out other curative therapeutic measures provided for the clinical and evolutionary state of the subject. Such care is normally welcomed by conventional health resources, and in the most difficult or complex cases, a Specialized Palliative Care Team will intervene [13, 16, 17].

The question in its three aspects: *how much do I have left to live?*; *How much does my loved one have left?*; *how much does my patient have left?*. These are constant questions when faced with a terminal illness in the final phase of life. But this issue is also fundamental for the health professional, since life estimation is fundamental for clinical decision-making and for the proper management of therapies, including communicative ones, such as giving bad news. The possible answer would be made as three questions to answer reflected in **Figure 1** [1, 18, 19]:

- 1. Presence of terminal illness.
- 2. Estimation of life prognosis. There is no single standard method for this due to its complexity. From the study of a multitude of variables, especially in the terminal cancer patient, a multitude of prognostic indices have been designed

Figure 1.
Algorithm for the management of terminal illness, prognosis and last days of life (authorized by the author [1]).

based on laboratory tests, functional status, symptoms, signs and subjective clinical impression of the prognosis. The vital prognosis in non-oncological disease is more difficult to determine, so the need for palliative care will be given by the presence of organic failure and irreversible progressive deterioration with unrelieved suffering. It will be based on the analysis of the functionality of the patient, clinical estimation of the expert professional, present symptoms and laboratory analysis.

3. The third question is the culmination of the person's end of life, in which death comes progressively (as opposed to sudden death). It is the situation of the last days of life or state of pre-agony or agony, which indicates that death is next (between hours and a few days). It would be the last stage of a terminal illness known as the End of Life Phase (FFV). Therefore, it is a phase that precedes death when it occurs gradually (hours, days) with signs that begin with severe asthenia associated with bedriddenness, loss of interest in the surroundings, development of a semi-comatose state, intake limited to liquids or small sips (including total dysphagia), with the inability to take oral medication, it is establishing a very short life prognosis. The treatment is supportive, aimed at intensifying comfort and reducing suffering as much as possible, given that symptoms that cause discomfort to the dying person are frequent, for which fortunately we have effective medications, usually administered subcutaneously (more frequent at home) or intravenous (most often used in hospitals). In the necessary cases, palliative sedation will be applied in order to control the refractory symptoms and alleviate the suffering of the patient.

The great contributions of Palliative Care to Medicine are [1, 10, 19–22]:

1. Accept death as a biological and natural process.
2. Give quality of life to life, helping the patient and the family in their suffering.

3. To confront the symptoms from a practical and decisive point of view so that their control allows helping the patient to have the greatest possible well-being, regardless of the evolutionary stage of their disease. It is common to confuse pain (*“Unpleasant sensory and emotional experience, associated with actual or potential tissue damage, or described in terms of such damage”*, defined in 1979 by the International Association for the study of pain or IASP) and suffering (grief). In Palliative Care there are 56 definitions of suffering, showing that although there are deficiencies in its definition, its relevance in the deep personal anguish it causes, especially in the last year of life, makes the person more vulnerable. Its most frequent causes are pain, dyspnea, delirium and depression.
4. Communication and emotional coping skills (especially for bad news, trustworthy therapeutic relationship acquisition or emotional ventilation).

Psycho-oncology (term that is related to Psychosomatic Medicine and Palliative Care) studies the impact of cancer on the psychological function of patients and their families. It arises, among other influences, from the PM as a need to respond to the needs of the cancer patient, from which the PC has tried to benefit. Its evolution has been possible thanks to the sustained advancement of multiple disciplines such as Oncology (Medical and Radiotherapy), Epidemiology, Surgery, Immunology, Genetics, Endocrinology, Sociology and Bioethics, among others, providing updated assistance protocols comprehensive for terminally ill patients in the Palliative Care Units. This development has clearly contributed to the development of the psychological and psychiatric aspects linked to cancer. Thus, as we have reiterated, it contributes to a better quality of life for cancer patients from the initial impact of the diagnosis. Adjustment disorders, related major depressive disorder, and acute confusional syndrome (delirium) are common. There are effective treatment protocols for such adapted pathologies in each region [23, 24].

Psychosomatic physicians can play an important role in the field of cancer treatment through psycho-oncological activities such as psychological support after receiving bad news, before and/or after surgery and in chemotherapy cycles to control delirium associate [25].

Within the biopsychosocial framework and from the knowledge coming from the Psycho-oncology and the PC, one of the great problems is addressed which is the *Pact or Conspiracy of Silence*. This is usually defined as an agreement, implicit or explicit, between family members, relatives and health professionals, to hide or distort information about the patient's diagnostic, prognostic and/or therapeutic situation, in order to avoid the suffering of facing the end of your own life. This information deficit is regarding not only the diagnosis, but also and above all the prognosis. Only between 15 and 21% of people at the end of their lives know their diagnosis and prognosis, being the most important factor when communicating the diagnosis the fear of negative repercussions that may result from the communication of the real state of the patient [11, 26].

The idea behind this chapter is that PM and PC are related disciplines. I am pleased to find, albeit to a much lesser extent than we would like, that there is an attempt to verify this interrelation. For example, in Romania, how life experiences imprint the possible relationship of somatic effects in terminal diseases, especially cancer [27] or as a professional paradigm of life, represented in Dr. Arthur H. Schmale, who advocated the relationship between PC, PM, and Psychosocial Oncology [28].

2. Relationship study (PM and PC)

The first known article that related both concepts in an indirect way was van der Valk [29], since he commented on the psychological aspects of palliative treatment of malignant tumors with a small psychosomatic veneer. In that same year, H. Zalce in the medical journal *Gaceta de México*, spoke in a shallow way when referring to the scarce training of doctors in the therapeutic management of advanced cancer. Geriatrician Dr. A. Verwoerd, from the Southern American Medical Association, began to relate a little more, almost unintentionally, the importance of both, in reference to palliative care in the communication process, especially the bad news, becoming from the early 70s, a promoter of Counseling and of the psychological stress responses of physical illnesses, that is, he traveled from palliative to Psychosomatic Medicine, to finish the last third of his career focusing on study of sexual behavior [30–32].

It is in May 1965, when the German B. Staehelin, deals specifically with Psychosomatic Medicine (PM) and Palliative Care (CP) in a German magazine [33]. It showed that an adequate psychosomatic approach helped physicians to better treat patients with advanced cancer, subsidiaries of Palliative Care (PC).

The relevant aspects of this research that show the concern of Psychosomatic Medicine in Palliative Care and its interrelation, contain the following eight thematic pillars (summarized in **Table 1**):

1. Psychosomatic medicine is based on a biopsychosocial model related to physical and psychosocial factors, with many similar points of view in General Medicine, Psychosomatic Medicine and Palliative Care [35]. Thus, the PM also helps cancer survivors as psychosocial support services [34].
2. Psychosomatic medicine helps physicians to improve the care of patients with advanced cancer in palliative care [33], to get better the satisfaction of their own illness and at the same time helps to reduce the overload of professionals in palliative care that cares for patients and their families [35].

Psychosomatic medicine deals with relevant aspects in improving the survival of cancer patients. An aging population, advances in diagnosis and treatment, have led to a rapidly growing population of people affected by cancer. People live longer after a cancer diagnosis, tolerating more advanced and even aggressive treatments more and better than in times past. In the evolution of tumors, there is an impact on the quality of life, with a psychological repercussion, where Psychiatry, Psychology, Psychotherapy, Mental Health Services, in short, provide tools to all professionals (doctors, nurses, social workers, physiotherapists, psychologists, trained volunteers, etc.), who have contact with these patients and their families, many medical specialties: Medical Oncology, Radiation Oncology, Internal Medicine, Primary Care, Psychiatry, Pediatric, Emergency Medicine, other medical and/or surgical specialties (Cardiology, Dermatology, Endocrine, Nephrology, Pulmonology, Neurology, Rheumatology, Gynecology, General, Digestive, Cardiovascular, Neurosurgery, Traumatology, Maxillo-facial, Otorhinolaryngology, Ophthalmology, Urology). Therefore, the increase in life expectancy in cancer has increased interest for its impact on psychosocial problems and quality of life, rather than just focusing on longevity [37].

Psychiatry has been collaborating more and more with the above all hospitable services of palliative care, although there is much to improve because it is not a general trend [36].

Thematic area	Relevant ideas	Featured authors
1. Biopsychosocial model	<ul style="list-style-type: none"> • Psychosocial support 	[34] [35]
2. Improved care in PC (especially advanced cancer)	<ul style="list-style-type: none"> • Decreased load • Improved survival • Impact on quality of life • Psychiatry (area of work to be developed) 	[33] [35] [36] [37]
3. Analysis of psychiatric disorders in cancer patients in PC	<ul style="list-style-type: none"> • Early detection • Specific derivation • Psychosocial suffering • Psychosocial interview • Disorders: <ul style="list-style-type: none"> ◦ Adaptive (anxiety, depression) ◦ Delirium 	[38] [39] [37] [40]
4. Bad news communication	<ul style="list-style-type: none"> • Kübler-Ross phases • Psychosomatic symptoms • Denial, anger, negotiation, depression, acceptance 	[41] [37]
5. Symptom control (especially in terminal cancer)	<ul style="list-style-type: none"> • Life distress • Cancer as a stressful life event • Impaired quality of life • Fatigue by compassion of professionals • Depression in cancer • Anorexia in cancer 	[42] [37] [43] [44] [45]
6. Psychotherapy to patients and family (basic concepts)	<ul style="list-style-type: none"> • Anxiety before death • Chronic pain 	[46] [47] [48] [49] [50]
7. Psychotherapeutic interventions	<ul style="list-style-type: none"> • Emotional Support • Psychoeducation • Cognitive-behavioral (self-regulation) • Individual <ul style="list-style-type: none"> ◦ Mindfulness ◦ Counseling ◦ Meditation and hypnosis ◦ Others • Group • Specific 	[51] [52] [37] [53] [54]

Thematic area	Relevant ideas	Featured authors
8. Others aspects of interest	• Non-cancer PC	[55]
	• Pediatric PC	[49]
	• Caregivers (overload)	[56]
	• Anxiety about death and relationships	[57]
	• Assessment and perception of health care received	[58]
	• Place of exitus	[59]
	• Attention to grief	[50]
		[60]

Table 1.
Thematic summary of Psychosomatic Medicine in Palliative Care.

3. The psychosomatic spectrum analyzes psychiatric disorders in cancer patients and very sensitively when they are also subsidiaries of palliative care. A double operational advantage is provided: teaching professionals to detect the most common problems in order to address them and specifically refer experts (psychiatrists, physiotherapists, psychologists,...) when it'd been necessary [37, 38].

A fundamental question is to measure the presence of mental disorders. There are many different variables that act as factors on individual vulnerability (for example, life events, chronic stress, well-being and health attitudes) and the psychosocial correlates of medical illness (for example, psychiatric disorders, psychological symptoms, disease behavior, quality of life,...), which are possibly involved not only in classic psychiatric disorders, but more broadly in psychosocial suffering in cancer and in Palliative Care. There are many studies, so we summarize the highlights of this analysis [37–40]:

- The specific psychosocial interview with diagnostic criteria for psychosomatic research (known as Diagnostic Criteria for Psychosomatic Research or DCPR) represents a way to detect and evaluate emotional distress, anxiety, depression, wrong coping, dysfunctional attachment and other dimensions psychosocial. Intercultural problems, such as language, ethnicity, race, and religion, are also discussed as possible factors influencing perception of the disease in patients and families (another important aspects may be survival mechanisms and the psychological response to cancer diagnosis).
- Psychiatric disorders can be found in up to 47% of cancer patients. In some cases they are direct responses to this disease, in others it acts as a trigger or enhancer.
- Psychiatric disorders depend mainly on individual factors. In cancer the most frequent are:
 - Adaptive disorder (68%) with depressed and/or anxious mood. It's a response to a vital stressor that produces harmful interference in the social role. It requires a follow-up to differentiate it from depressive or anxiety disorders.
 - Others (10–34%): major depression, anxiety disorders, delirium or acute confusional syndrome (more frequent in the last days of life).

- In specific types of cancer, for example prostate cancer, depression is more frequent in the elderly and anxiety in young adults.
4. People diagnosed with cancer, their families and close friends experience normalized responses, such as those derived from the impact as bad news of having a tumor (knowledge of diagnosis and/or prognosis), initially described by Elizabeth Kübler-Ross in 1969, in the following phases where psychosomatic phenomenology stands out [37, 41]:
- *Denial (Phase I)*. It's an isolation phase as a defense mechanism against the perception of the disease and its consequences. The information received produces an emotional impact, which requires progressive and usually adaptive elaboration. Therefore, if it's maintained throughout the disease process, it becomes a difficult pathology to treat. The most convenient attitude on the part of professionals is respect, trying to combat it with patience and delicacy, without reinforcing denial with lies. Communication skills are essential.
 - *Fury or anger (Phase II)*. It's characterized by outrage and the fight against the inevitable, looking for guilty people. Anger is a feeling that appears at the perception of injustice due to illness. It's important that this fury directed at oneself, the family for not having cared for the patient, friends, work environment, superior forces (like God), but especially towards the health workers, the doctor who did not detect the pathology, the tests that took time to carry out, the medication that was not effective,... It's essential to know that this is not a personal attack, so the professional should not judge or participate in the confrontation. Self-blame involves extra suffering.
 - *Negotiation (looking for a pact: Phase III)*. It's a pact that faces reality but looks for the possibility of improvement, cure or even miracle. Pacts are made with a supreme being (in our culture it would be God), others and oneself. The attitude towards this phase will have to be formed by tolerance, respect, without prejudices. The patient can seek relief in other complementary or less conventional therapies, so an integrative and communicative medicine should be promoted. Dialog is specially important to face this phase.
 - *Depression (Phase IV)*. The disease progresses and cannot escape from reality, adopting different attitudes: crying, sadness, indifference, isolation,... Although it's a very hard phase for the family and the health workers, it can be an adaptive mechanism and the beginning of acceptance. That is why we must maximize communication skills, knowing how to be active listening, managing silences and promoting emotional expression.
 - *Acceptance (Phase V)*. After the depression phase, the inevitability progression of the disease and the physical-psychological exhaustion, can reach a degree of acceptance of reality, entering a state of serenity, tranquility and inner peace that's always recommended, although not always possible. Spiritual needs take on greater importance at this time, and farewells are important to close life cycles and unfinished situations.

These phases do not always appear all of them nor do they have to be consecutive. Each person has a phase rhythm, so that for example one person can be angry (Phase II) throughout the disease process and another can come directly to acceptance.

5. The importance of recognizing and addressing symptoms is the principle on which PC are based. PM brings its vision to some of the more complex symptoms to treat.

- In the process of oncological disease, psychological or vital anguish (valued through emotional reactions, physical restrictions, communication deficits, negative social reactions, pain and gastrointestinal symptoms) has a prominent psychosomatic role, the origin of which emanates from the four main actors involved in the palliative disease process [37, 42]:

- Patient.
- Family.
- Health professionals.
- Society and culture.

Understanding these factors allows professionals involved in cancer to better assess the patient and adapt therapies in a more personalized way, also helping their families, because cancer is a stressful life event (SLE), tumor pathology involves a change of life throughout the family, especially when the patient is a child, in addition to developmental problems and cognitive disorders, behavioral changes (including schooling), financial difficulties... Young adults fight especially for the changes that the disease implies in the work and in their social or personal relationships. The elderly focus on the challenge of aging and cancer.

Therefore, the psychological and social care of cancer patients is part of quality medical care, and training professionals in diagnostic (test, questionnaires...) and therapeutic techniques (psychotherapy, pharmacology...) are priority needs.

- Burnout and compassion fatigue of health professionals who care for cancer patients can have two major problems for themselves: professional and personal damage and the negative repercussion on patient care and on the work environment in general [37].
- Depression in cancer patients is a frequent symptom. PM tries to study its relationship with age, where it seems that there is an inverse relationship, improving depression with increasing age or senescence [43]. Likewise, it has helped to show the negative impact of depression on cancer, measured by quality-adjusted life year. That is, if depression exists, life is shorter and with loss of quality [44].
- Anorexia is one of the most frequent symptoms in patients with terminal cancer. It's characterized by a lack of appetite, where treatment is very limited, especially with corticotherapy and antiestrogens [45].

6. The PM investigates relevant aspects of psychotherapy in Palliative Care.

- It's common for the family to hide both what they know and their negative emotions (anxiety, fear, sadness ...) to the cancer patient's dying [49]. It's shown that this process also influences caregivers [50].

- The presence of chronic pain in general (whether oncological or non-oncological), and particularly in terminal illnesses, should benefit from psychological therapies applied, both for seniors, adults and children [46–48].

7. The types of recommended psychotherapeutic interventions that have shown improvement in the quality of life, anxiety and distress of cancer patients are short-term therapies, aimed at supporting and helping in their anxiety and stress crises. Obviously, these therapies often require psychotropic drugs to control symptoms, especially anxiety, depression, negative thoughts, conduct disorders, etc. Therefore, the following are included as types of recommended therapies [37, 51–54]:

- *Emotional support to the patient and caregivers* (essential treatment). Through like-minded thinking (empathy), a comprehensive and integrative vision of personal life can be provided, transferring a coherent, real and meaningful hope.
- *Psychoeducation*. It can be carried out by other members of the health team, and helps to know the disease, its natural evolution...
- *Cognitive and behavioral therapies*, especially self-regulation (for example, relaxation exercises, distraction tools, rehearsal of dreaded events, suggestion ...). They are especially effective in pain, fatigue and post-chemotherapy emetic syndrome, especially if they are done preventively.
- *Individual psychotherapy*. Are included:
 - Mindfulness: effective technique especially for anxiety and depression. It's popular on PC because is widely used in professionals' self-care. It's a person-centered therapy, based on meditation and compassion, to reduce anxiety and strengthen resilience and motivation.
 - Counseling: therapy that helps especially in the existential crisis of a tumor, especially if it's advanced. It's about guiding and advising from empathetic listening to be able to handle negative thoughts and the emotions that are generated. It's a therapy frequently followed in PC, applicable to patients, family and health personnel.
 - Meditation and hypnosis: neuropsychobiological management of stress and anxiety, although it has also been used for difficult pain, nausea and vomiting.
 - Others: psychotherapy focused on meaning, therapy for preserving dignity ...
- *Group psychotherapy*. Its objective is to educate, guide and reduce social isolation. Couples and family therapy are included. A very important example is group therapy for caregivers of patients with long survival.
- *Specific treatment implemented by specialists in Mental Health Systems* (Psychotherapy, Psychopharmacology, other interventions such as psychological support, among others...). This type of intervention is formally requested in appropriate situations where patients face challenges, especially

during active cancer treatment, survival, and in the worst case, end of life. However, there are disparities in criteria regarding these assumptions given that in clinical practice the cases are not always the same. Therefore, psychosomatic medicine tries to emphasize what are the most frequent stages in palliative care, in order to provide the best care for patients with severe cancer.

8. The PM has been concerned with other topics of interest in PC, less recognized but important, which would be:

- Palliative care in non-cancer patients, such as Phase IV and V advanced chronic kidney disease (end-stage renal disease). The stress of hemodialysis has a negative impact on the mental health of the patients. Spiritual well-being can be a great predictor of mental health, psychological distress, sleep disturbance, and psychosomatic complaints [63].
- Palliative care in the pediatric age. Pathological behaviors produce symptoms, functional deterioration and difficulty in therapeutic coping. For this reason, integrated models of behavioral health care have been implemented to promote resilience (adaptability of a living being against a disturbing agent or an adverse state or situation) in: Oncology, PC, pain, Neuropsychiatry, Cystic Fibrosis and Transplants. This psychosomatic treatment helps the child comprehensively and effectively and reduces costs derived from tests and hospitalizations of pathologies such as asthma [58].
- Caregivers and family. Throughout the chapter, we have emphasized the importance of the role of the family. We highlight the following studies:
 - a. In relatives of patients with cerebral malignancy, it's found that financial support in most cases does not exist, and that there is an increased risk of psychosomatic problems such as anxiety or depression. Caregivers worsen care overload, quality of life and mental state [55].
 - b. Caregiver burden is often a difficulty in increasing family satisfaction in end-of-life care at home. A caregiver burden-centered home care model could improve end-of-life experiences for patients and family caregivers [59].
 - c. Death anxiety can produce negative emotions that hinder the search for meaning in family members and in dying patients themselves with advanced or metastatic cancer. A study qualitative to highlight on these aspects investigated the relationship of a couple of patients diagnosed with melanoma along 6 months, revealing how the image of the relationship and its nature changed in a complex way, especially in aspects of care patterns, closeness, distance regulation and the communication process between each couple. Thus, 50% of the patients and their partners hid negative emotions to avoid worries in the other person (this phenomenon is more frequent in Latin and South American cultures). And yet in those who did not hide these emotions, changes continued to appear in the relationship. Using a scale such as the Death and Dying Distress Scale (DADDS) in the sessions, it was shown in this work how the score depended on the knowledge and reflective capacity of one's own death. Consequently, when anxiety is very high, high-intensity emotions dominate and hinder the search for meaning in their death

process. On the contrary, if anxiety is low, there is more psychological preparation for death without the need to reflect on it. It's shown that this process influences both patients and their caregivers [49, 50, 56].

- d. The majority of caregivers who lose loved ones in PC Units are satisfied with the behavior of doctors in the face of death, integrating professionalism and friendliness, being these factors most commonly associated with caregivers'satisfaction health care [60].
- e. The place of exitus can have an effect on the grief of caregivers, where generally the quality of death is better at home or in Hospice compared to acute care hospitals. The most frequent causes of hospital admission are pain and dyspnea because they are the ones that generate the most stress in the whole family, including the dying sick [50, 57].
- f. Family grief care is a reflection of the continuity of care before and after the death of the patient. After death (usually months and more in couples), depression, insufficient social support and decreased physical activity are frequent. Fluent communication, especially before death, helps reduce depression and complicated grief, improving coping and the quality of life of the dying person's death [61, 62].

3. Conclusions

1. In the last 15 years, there has been an increase in electronic literature on PM and PC (especially scientific books and papers). Even so, there is "a lot of bibliographic noise" as in any search for information (large number of duplications, documents unrelated to search criteria, etc.), that make analysis of the relationship more difficult, in this case than usual of both medical disciplines. This is mainly due to the fact that the close relationship with the PM has not been accepted internationally in PC.
2. Currently, the psychosomatic diagnosis is by exclusion, largely because Evidence-Based Medicine is based on the need to explain the existence of a palpable or visible substrate of the disease. It's probable that functional imaging tests (nuclear magnetic resonance imaging and others), will demonstrate the organic substrate of many diseases understood today as "mental".
3. Mental illness is one of the most striking complications in terminal illnesses, which could have the same or greater prognostic impact than the tumor stage, the leukocyte formula, the presence of symptoms such as delirium, dyspnea or cachexia, among others.
4. The influence of the psychosomatic world is objectified in the increase of electronic scientific resources in recent years. It's striking how from the oriental culture, mainly from Japan, the largest studies in reference to both disciplines of knowledge have come in last years, although this phenomenon is increasing more and more in all areas of research in Medicine.
5. There is an influence of the PM on the PC, reflected to a lesser extent than the real one in the scientific literature, where Palliative Care in general as a

discipline has not recognized this contribution. In the most professional in PC the PM is applied, although its deep association is unknown. Many aspects collected in the research in this chapter support the experience of palliative care professionals (the suffering of patients and relatives, the concern to protect the other from the disease and its consequences ...). More research is needed to help patients, families and healthcare professionals.

6. The PM provides insight in Psychiatry for specific disorders, but also, in its breadth, it can be useful for any discipline such as cancer or PC.
7. To reach the soul of a person (understood as the essence that defines each person against the rest), according to their nature, the health professional must know how to be a psychotherapist. Because this way you will be able to treat from the symptoms of the body, the emotions or from the thought. Although these three structures are the great summary of what a human being can explain, the reality is always more complicated, where good human relations would be a great bridge with the person who suffers to help them.

Note

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