The Management of Pain in Cancer Patients Through Psychological Intervention

S. R. Khan*, Shiveta Gandotra** & Probhjot Kour**

ABSTRACT

This paper presents the efficacy of different psychological interventions which may be used for the management of pain in cancer patients. Cancer-related pain and associated distress significantly challenge the physical and mental well-being of patients with advanced cancer and their families. Cognition, behaviours, and feelings are negatively affected by chronic illness, resulting in an overall diminution of psychic energy, coping, and adaptation. Cognitive-behavioural interventions are uniquely suited to address the most common psychological and emotional problems of patients with advanced cancer and their families. The paper argues that physicians/Oncologists dealing with cancer patients should become aware about the fact that an adjunct to medical care, psychological interventions are also required to reduce the suffering of the patient. Psychological intervention in the form of cognitive-behavioural therapy or any other chosen psychological interventions promote optimal functioning of the individual through cognitive and behavioural restructuring. Physicians/Oncologists dealing with cancer patients should have with them a referral list of Clinical Psychologists and Psychiatrists to whom the patient would be advised to consult beside medical therapeutic treatment.

Key Words: Pain, Cancer, Psychological Intervention, Physical Intervention

Growing criticism from many quarters has shaken the faith of many clinicians in both the effectiveness and efficiency of traditional psychological interventions. Psychological interventions for cancer patients and their families

* Professor of Clinical Psychology, P.G. Department of Psychology, University of Jammu, Jammu-180 006 (J&K).

** Research Scholars, P.G. Department of Psychology, University of Jammu, Jammu-180 006 (J&K).
are time-limited, problem-focused and very practical. The use of Psychological interventions for cancer-pain management has attracted considerable interest, specifically with cancer patients. Mental health care professionals have a vital role to play in improving the quality of life and even the survival time of cancer patients. The rudimentary awareness of psychological principles enables physicians and other health care professionals to understand the types of problems and symptoms that are addressed by psychological interventions. Since patients and families may lack awareness about psychological therapies, informed and confident physicians can frame the referral in the manner that allays resistance and anxiety. Physicians are in a unique and influential position to convey to the patient that problems are a normal part of life, and that there are professionals who are specially trained and able to help them. Patients who cope well and perceive support are more likely to adhere to medical regimens, and as a result they derive greater benefit from cancer treatments.

**Psychological Interventions**

Cognitive-behavioural psychotherapy emerged from the realisation of the limits of strictly defined behavioural therapy. Behavioural therapy is based on the principles of learning derived from the classical studies of Pavlov (1928) and Thorndike (1931). Cognitive–behavioural theorists maintained the significance of learning and conditioning principles, but also recognised a series of very powerful influences that are not readily observable or directly measurable.

The primary focus of this framework is to understand how the individual’s unique mental schema influences learning, interpretations, and behaviours in the phenomenal world. There is an appreciation for the active therapeutic utilisation of responses from the most immediate environment of the patients, which most commonly means the family. In actual clinical practice most cancer patients require a comprehensive psycho-behavioural approach, integrating traditional supportive psychotherapies and cognitive-behavioural interventions (Loscalzo & Jacobson, 1990).

**Psychological Impact of Cancer Related Pain**

*Pain: Understanding its Meaning:* The International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. The pain event is the result of a process involving a multidimensional experience that consists of evolutionary, biological,
physiological, psychological, spiritual and social influences. There are a number of models describing the cancer pain Turk & Feldman (1992), McGuire (1987) and Fernandez (1986). All these models generally integrate the multidimensional characteristics of the definition of pain given above. Pain ultimately destroy and betray the feeling of a unified self and the body.

In humans there is an innate tendency to explore, describe, define and rationalise various happenings in their lives and to interpret their specific “meaning” to them. The general cancer experience and the potential for pain specifically confront the individual with a reality that most people attempt to avoid and deny. The pain experience always has conscious and unconscious meaning to the patient, family and health care team.

Various studies have shown that around 30-60% of cancer patients experience pain during active therapy and more than two-thirds of those with advanced disease get pain. Consistent with other studies, Ahles et al. (1983) found that almost two-thirds of patients believed that any increase in pain actually signaled progression of disease. In view of the perception of the public that cancer is painful, it is somewhat surprising that this percentage is not higher. Even the cursory consideration of the role of pain in the perspective of evolution leads to the inevitable consideration that pain often resulted in significant uncontrolled suffering and eventually death.

**Assaults on Psychological health**

Pain is associated with heightened psychological distress and interferes with ability to eat, sleep, think and relations with others. It may be incapacitating and preclude a satisfying quality of life. Pain impairs cognition, concentration and memory. According to Jamison, Sbrocco and Parris (1988), pain stands alone in its ability to gain the active attention of others while demonstrating a sense of being alone and vulnerable. While a patient is experiencing pain, another person inches away is incapable of truly understanding what is so central and undeniable to the patient. Pain overrides the underlying mental schema of the patient. As a result, the patient’s perception is confined to only the most immediate and essential elements of his or her experience. For the person in pain, there is no past or future. The immediate need and goal is to stop or minimise the noxious experience. Pain encompasses and inevitably absorbs the limited psychic energy of the organism.

Cancer patients with pain are more likely to develop a psychiatric disorder, than are cancer patients without significant pain (Derogatis, et al., 1983).
Anxiety, demoralisation, suffering, isolation, anger and depression are especially relevant to cancer-related pain. Pain in the short term provokes anxiety, and over the long term it generates depression and demoralisation. Depression is of great importance because of its ubiquitous nature in patients with far advanced disease. It is significantly related to higher levels of cancer pain, pain is more likely to play a casual role related to depression (Spiegel, Sands & Koopman, 1994). Although overall depression rates for cancer patients are 20% to 25% (Breitbart, 1994), the presence of depression in the advanced cancer patient is quite formidable, with estimations that range, between 50% and 70% (Derogatis, et al., 1983; Razavi, Delvaux & Farvacques, 1990). Anecdotal clinical experience consistently demonstrates that once pain and related distressing physical symptoms are relieved, then suffering, anxiety, depression, demoralisation, and suicidal ideation are ameliorated. Depressed patients globally distort reality and grossly minimise their perceived abilities in managing the demands of the illness and its treatment. Depressed cancer patients with inadequately controlled pain are at increased risk of suicide (Bolund, 1985).

Cancer touches the lives of millions world-wide each year. This is reflected not only in well-publicised mortality statistics but also in the profound though much more difficult to measure-effects of cancer on the health related quality of life, economic status and overall well-being of patients and their families (Lipscomb, et al., 2005). The destructive synergy of unrelieved pain may lead to overwhelming suffering in patients and families, and to a shared sense of hopelessness and helplessness, resulting in the faulty perception that suicide is the patient’s only remaining vestige of control. Within this context, a multimodal approach is essential, combining pharmacology, supportive psychotherapy, and cognitive-behavioural skills training (Massie & Holland, 1990). From a psychological perspective, the focus of care is on promoting compliance with medical regimens, correcting distorted cognitive perceptions, acquiring coping skills to manage physical tension, stress, and pain, and effectively using valuable physical energy to maximise engagement of life.

**Cognitive–behavioural: Perspective**

Cognitive–behavioural methodologies are based on the concept that, if we help people change how they think about their pain, then how they feel, behave, and even perceive noxious sensations will change (Beck, et al., 1979). Originally developed for treating depression, cognitive behavioural methods have been adapted by psychotherapists for the treatment of chronic
pain and cancer pain (Syrjala, Donaldson, Davis, Krippes, & Carr, 1995; Turk, Meichenbaum, & Genest, 1983; Turner, 1982). Moderate to severe pain is often present at diagnosis and during the early stages of cancer treatments in 30% to 45% of patients (Daut & Cleeland, 1982). Cancer pain is present in nearly 75% of cancer patients with advanced disease and in 90% of terminal patients (Daut & Cleeland, 1982). Although a growing body of literature exists concerning the medical aspects and management of cancer pain (Foley, 1985; Patt, 1993), psychological approaches to cancer pain are relatively new treatments that have only recently become available to patients and families.

Pain management programs that use cognitive-behavioural principles is worthy of further investigation for patients with chronic cancer-treatment–related pain (Robb, Williams, Duvivier & Newham, 2006).

Affecting, behavioural, motivational and perceptual variables influence the symptoms experienced by patients with advanced cancer. As the focus of attention shifts from aggressive, curative anti-cancer treatments to palliation, the psychological, social, and spiritual needs of the patient and the family become more prominent. Consequently, as an adjunct to medical management, cognitive-behavioural psychotherapeutic techniques emerge as the primary psychological approach for the treatment of these symptoms (Chapman, 1979; Loscalzo & Jacobsen, 1990; Morrow & Dobkin, 1988; Morrow & Morrell, 1982, and Turk, Meichenbaum & Genest, 1983).

Crisis intervention literature suggests that people experience high distress for up to 6 weeks after being diagnosed with a life-threatening disease. After that period, coping responses and resources are engaged more effectively, and distress tends to decrease. The medical complications of advanced disease and resulting emotional reactions can be anticipated, cognitive-behavioural skills can be taught early in the treatment process, so that necessary coping strategies are in place when needed by the patient and family. Although the focus of intervention is primarily on the patient during the diagnostic and treatment phases, increasingly more and more emphasis is shifted to the family as the disease progresses. Spiegel et al., (1994) found that “a family environment with mutually supportive attitudes was associated with less pain.” Cognitive-behavioural skills are helpful in reducing emotional distress, enhancing coping and improving adjustment (Anderson, 1992). Although psychosocial variables such as fear, anxiety, feelings of powerlessness, hopelessness, and depression may exacerbate a patient’s cancer pain experience, the relationship is not causal. Therefore, the maintenance of reality-based conceptualisations maximises coping skills, which can support hope and mastery in the face of uncontrollable factors related to the disease and its treatment.
During the diagnostic and treatment phases, patients and families require ongoing information and support. After the active treatment phase, the patient’s needs shift to acquisition of specific coping skills in the face of having to manage the demands of a harsh and demanding reality. Fishman (1992) brings the territory of advanced disease into sharp relief: “... the challenge for every patient with advanced disease is to cope with disease symptoms and aggressive treatments ... while tolerating the frustration of personal and interpersonal needs and aspirations, without experiencing the self as disintegrating. This challenge is made harder when pain is present because its constant or fluctuating intrusion into consciousness can disrupt normal mental processes and personal activities, weaken the sense of personal control and hence reduce coping efforts.”

Development of Management Plan

Cognitive-behavioural intervention emphasises the role of thinking in the etiology and maintenance of problems. It focuses on the interactions of thoughts, feelings, and behaviours of the patient and family. The technique attempts to modify the patterns of thinking that are believed to contribute to a patient’s problems and may also employ the principles of conditioning and learning to modify problematic behaviours. These processes have the potential to reduce isolating dysfunctional and maladaptive responses that lead to a sense of control and self-efficacy.

Fernandez (1986) has proposed a practical guide for selecting entry points for intervention. This multidimensional model focuses on cognitive, behavioural, and physical components of the pain experience. Once an area or series of areas is identified as being a problem or as having the potential for therapeutic gain, a point or points of entry are established. Although cognitive approaches are used to influence thinking and reasoning about the cancer pain experience, behaviourally interventions are introduced to modify the global cancer pain experience and to teach specific coping strategies. Physical interventions focus on the body and involve any activity that influences what the body experiences.

Cognitive Components

Cognitive impairments, especially delirium, are common in patients with advanced disease (Fleishman & Lesko, 1989) and must be ruled out before attempting to employ cognitive approaches. Cognitive theory asserts that the individual’s appraisal of the situation influences the responses to an event (Beck, 1976). Cognition is significant in that it represents the invisible lens
through which all sensations from the internal and external world are integrated. Distorted appraisal will often result in dysfunctional and bizarre feelings and behaviours. It is within this context that perceptions, thoughts, underlying assumptions, expectations, fears, and fantasies are assessed and, when possible, actively utilised, changed, or accepted.

One of the most significant aspects of this process pertains to the individual’s subjective view of the event itself in relation to the perception of his or her own abilities to rise to the challenge generated by the event (Lazarus, 1991). In the face of advanced disease, it is expected that perceptions and expectations will be negatively affected. The nature of cognition will have an impact on the level of anxiety, suffering, and pain. Negative and self-defeating thoughts will produce a sense of hopelessness and suffering. On the other hand, having a positive attitude and accepting the illness as a challenge (which requires enhancing old skills and learning new skills) will lead to a greater sense of control and competence. For example, a patient may be afraid to become actively involved in psychosocial and physical rehabilitation simply based on the faulty assumption that whenever he or she becomes hopeful or “lets their guard down,” something terrible inevitably happens. This is not an unusual response for patients with advanced cancer. This patient is at high risk for physical deconditioning, depression, and demoralisation. Although this psychological defense may bind the patient’s anxiety, it will also lead to a sense of being immobilised, unable to take action, and feeling victimised.

Suffering is often confused by patients and health care professionals alike. Teaching a patient to effectively discriminate between global emotional experiences—such as suffering, fear, sadness, anxiety, stress, and tension—and pain is important both diagnostically and therapeutically. Pain is usually the result of a specific feeling of sensory or emotional discomfort while suffering, and demoralisation is experienced as a global assault on the integrity of the person (Cassell, 1982). In essence, body parts hurt and people suffer. Although the affective treatment of cancer-related pain is most commonly pharmacologic, the antidote for suffering is control and hope. Teaching a patient how to discriminate between different experiences leads to a sense of self-efficacy, which has been shown to have a significant influence on quality of life (Cunningham, Lockwood & Cunningham, 1981).

**Behavioural Components**

What a patient does in response to being hurt is influenced by his or her past experiences with pain and illness, feedback from the immediate environment, and a personal interpretation of the event. Behaviours that
ultimately meet with rewarding outcomes (for example, reduction of pain or tension, and gaining sympathy) are apt to be repeated. Behavioural responses that are not rewarded are less likely to be repeated and may be eventually extinguished. Therefore, behaviour can be divided into two interdependent realms: (1) social interaction, and (2) physical activity.

Social interaction concerns how the patient perceives and uses people around them. For example, if a patient with head and neck cancer avoids people because it is his or her personality style to do so and or finds it painful and difficult to speak. There is increased likelihood of social isolation with little chance of reinforcement for physical activity and social interaction. The focus of his or her attention will be extremely limited to the most immediate sensory and emotional experiences. Such a limited perspective will lead to withdrawal, anxiety, despair, apathy, depression, and preoccupation with increased pain. This complex interaction would generally lead to the feelings of helplessness. The resultant condition makes adherence to medical procedures more difficult.

**Physical Components**

Realistic physical activity is necessary for all patients. In acute models of pain, activity is usually curtailed by the presence of physical discomfort and the accompanying desire to protect the organism from further abuse, as well as to promote healing. In most forms of chronic nonmalignant pain, physical activity is the primary focus of rehabilitation. For the patient with advanced cancer, physical activity may not be possible and may be contraindicated. In chronic advanced cancer-related pain, lack of activity is often the result of fatigue, asthenia, permanent physical disability, and shortness of breath. Generally, physical activity is important as a basic need for meaningful human interaction because it symbolises life and releases tension and stress while avoiding atrophy and painful muscle spasms.

Although physical activity may be limited for the debilitated patient, any activity that is promoted should be as meaningful and rewarding to the patient as possible. Relatively low-energy activities, such as scheduling former work colleagues over for lunch or communicating by way of recorded audiotapes can increase energy and instill a sense of motivation and hope. For example, if a patient has decreased physical activity and uses chronic illness behaviours (guarding, limping, moaning) to communicate to gain support from the immediate environment, these self-limiting behaviours will minimise the availability of existing resources. As a result, the patient is more likely to become prematurely
debilitated and dependent. Similarly, chronic illness behaviours often alienate family and health care professionals, who may view the patient as exaggerating his or her helplessness and not really wanting help. Out of frustration, attention is displaced to some area where a sense of control seems possible. Quite often under these circumstances, conflicts related to the use of narcotic analgesics will surface as patients, families, and staff each try to regain a sense of control. Feelings of powerlessness, anger, and frustration replace those of encouragement, support, and acceptance.

Weissman and Haddox (1989) describe the destructive process of “pseudo-addiction” in which hospital staff reinforce “drug seeking behaviours” by withholding pain relief until the patient manifests significant emotional and physical distress (for example, moaning, groveling, crying, or regressive manipulative behaviours) and then labeling the patient as psychologically dependent or addicted. This downward spiraling process, in which everyone loses, results in conditioned maladaptive responses (such as chronic illness behaviour, powerlessness, and humiliation) that have significant negative implications for other areas of cancer care and treatment.

Overall, the palliative care patient is in a unique position to significantly benefit from cognitive-behavioural interventions, because the focus of care is often on symptom management and quality of life concerns. At a time when there is a natural propensity for introspection and self-absorption, working with patients to provide them with a model in which they can gain a deeper appreciation for their cognition, behaviours, and emotions can be an empowering experience in itself.

**Psychological Services: Introduction and Location**

Communication with hospital-based departments of social work, psychiatry, or Clinical psychology is often the most efficient course of action. It is best to start locally, when seeking to identify an appropriate mental health professional. Although health care settings vary greatly (whether in an individual physician’s office or in a tertiary care hospital), social workers, psycho-oncologists, clinical and counselors, psychologists, and psychiatric nurses who specialise in oncology are generally available.

When introducing cognitive-behavioural interventions to the patient and family, physicians are often at a loss as how to introduce the referral. Attending to psychological and emotional concerns may seem out of place within a clinical context. It is suggested that the physician use the following statement: *Coping with cancer is a major challenge. We have professional staff that can help you to get through this experience. Here is the name and...*
telephone number of the person I would like you to contact. I will let them know you will be calling them.

The following list outlines some of the best ways to ensure that patients and families will effectively utilise psychological services:

1. Mention at the first office visit that, along with medical services, psychological care is also a necessary part of their care.
2. Emphasise that physical and mental health cannot be separated, and that you care about the quality of life of both the patient and family.
3. State that at the end of the first visit you will provide them with the name and telephone number of a psychological services provider.
4. At subsequent visits or telephone conversations, ask if the patient and family are satisfied with the psychological services available to them.

Cognitive-Behavioural Interventions

Cognitive Behavioural Interventions are effective for symptoms control and reduction of suffering in cancer pain patients. It gives the patient a sense of control and to develop coping skills to deal with disease and its symptoms. Interventions introduced early in the course of illness are more likely to succeed because they can be practiced by patients while they have sufficient strength and energy.

CBT for chronic pain management involves modifying negative thoughts related to pain (e.g., this pain is going to kill me, I’m worthless because of the pain, I can’t cope with this pain) and on increasing a person’s activity level and productive functioning. This approach for pain management has been shown to be highly effective in promoting positive cognitive and behavioural changes in individuals with chronic pain.

Cognitive Interventions

Cognitive interventions have several techniques; a brief sketch of these techniques is given below:

*Cognitive restructuring* is the process of redefining of some or all aspects of the patient’s interpretation of the noxious or threatening experience, resulting in decreased distress, anxiety, and hopelessness. Applications include acute or chronic pain, anticipatory reactions, anticipatory nausea and vomiting besides anxiety, and stress (Goldfried, 1979).

*Coping statements* are silent or spoken distractive statements on which the patient focuses in order to manage, master, or reinterpret a noxious or
threatening situation or experience. Applications include acute or chronic pain, anxiety, and panic (Beck, 1984, 1997; Fernandez, 1986).

_Distraction consists_ of active or passive cognitive, behavioural, and physical techniques designed to inhibit awareness of pain or distress. Applications are anticipatory anxiety reactions, nausea and vomiting, acute and chronic pain, treatment-related phobias, insomnia, and obsessional thinking (McKaul & Malott, 1984; Redd, Jacobson & Die-Trill et al., 1987).

_Passive relaxation techniques are_ the active engagement of the patient’s imaginative processes that are most often related to a directed and controlled dissociative process. Applications include nausea and vomiting, acute or chronic pain, anxiety, and panic (Barber, 1986; Erickson, 1959, and McGuire, 1987).

_Thought stopping is_ a series of techniques specifically designed to redirect or minimise obsessional preoccupations. It may be applied in cases of anticipatory reactions, obsessional thinking, nausea, vomiting, anxiety, and stress (Cormier & Cormier, 1985).

**Behavioural Interventions**

_Management of social contingencies involves_ responses, most commonly by family members, that reinforce or inhibit specific behaviours exhibited by the patient. Applications include acute or chronic pain behaviours, anticipatory nausea and vomiting, anxiety or stress, aversive medical treatments, and family support (Fordyce, 1976; Jay, Elliot, Katz & Siegel, 1987).

_Modeling is_ the overt or covert demonstration of effective behaviours designed to be replicated by the patient. Applications include pain behaviours, anxiety, stress, chronic illness behaviour, social skills training, problem solving, and assertiveness training (Bandura, 1969, 1971).

_Shaping is_ the process of reinforcing specific responses that successively approximate the desired outcome, skill, or behaviour.

_Stress inoculation is_ a package of behavioural techniques aimed at fostering more adaptive responses in anticipation of stressful situations and events. Applications include anxiety, acute pain, and aversive medical treatments (Meichenbaum, 1985, Meichenbaum & Cameron, 1983, Postlethwaite, Stirling, & Peck, 1986, Weissman & Haddox, 1989).

_Systematic desensitisation utilises_ relaxation or distraction paired with a hierarchy of anxiety-arousing stimuli presented through mental imagery or in vivo, resulting in control of fear. A step-by-step procedure, individuals learn to react calmly instead of with intense fear to the subjects or situations they

*Time outs* are defined short periods in which the patient is deprived of social interaction because of specific maladaptive reactions. Applications include panic, anxiety, and provocative behaviour (Bandura, 1939, Leitenberg, Agras, Butz & Vincze, 1971).

**Physical Interventions**

*Graded task assignments* are a hierarchy of cognitive, behavioural, and physical tasks that are partialised and sequentially performed to achieve identified goals.

Applications include phobias, social interaction, up-time (enhancing physical activity), health behaviours, pain, and stress (Spiegel, Sands & Koopman, 1984).

*Pain diaries* are time-limited or continuous written or audio-taped chronicles that the patient maintains to describe specific characteristics associated with pain or distress.

Applications include assessment, identification of problems, existential concerns, monitoring of progress, distraction, and insight (Turk & Feldman, 1992).

*Progressive muscle relaxation* is achieved by systematically tensing and relaxing specific muscle groups and by controlled deep breathing, resulting in inhibition of sympathetic activity in the peripheral nervous system (Jacobson, 1938). Applications may include nausea and vomiting, stress or anxiety, acute or chronic pain and insomnia (Bernstein & Borkovec, 1973).

Cognitive, behavioural, and physical skills are taught to both patients and families and are practised until a sense of mastery is attained. Patients and families need not believe in the interventions for them to be effective; they simply need to do them. Interventions included education, relaxation, exercise training, and goal setting. A variety of outcomes were examined to assess general fitness, psychological distress, coping success, activities of daily living, and pain report (Robb, Williams, Duvivier & Newham, 2006).

**Relaxation Exercises**

Relaxation exercises are used to achieve mental and physical comfort, and they represent the most utilised and studied cognitive-behavioural intervention. Relaxation also enables patients and family members to experience
some degree of control over their physiologic and emotional reactions. The sense of well-being created by relaxation permits patients to receive much-needed rest and may distract them during painful treatments and acute periods of pain. Patients are usually taught relaxation first, because it is easy to learn and does not require much physical effort. For patients who are depressed, demoralised, fatigued, or regressed, timing the relaxation exercise with the onset of analgesia may serve to enhance their self-confidence. Sample relaxation exercises are readily available and range from simple physical relaxation techniques (Benson, 1975) to more complex models utilising therapeutic stories, metaphors, and imagery (Erickson, 1959).

**Barriers and Limitations of Cognitive-Behavioural Approaches in Palliative Care**

Patients and families need not believe in cognitive-behavioural interventions for them to be effective. At a minimum, an accepting attitude will increase the likelihood of their use. However, there are circumstances in which cognitive-behavioural interventions may be contraindicated or are less likely to be helpful or effective.

Delirium, dementia, overwhelming pain, acute nausea and vomiting, and untreated psychiatric symptoms can significantly compromise patients’ ability to benefit from these interventions. Although audiotapes and relaxation exercises can be soothing for patients who are delirious, the use of non-reality based imagery can be disorienting. Overwhelming pain consumes attention and makes it almost impossible to effectively engage any patient. A patient and family who are coerced to accept psychological assistance are much less likely to learn and practice the exercises and skills necessary for maximal benefit. At the same time, however, some patients and families find cognitive-behavioural approaches to be less intrusive than traditional psychological approaches.

Without question, the most salient barrier to appropriate psychological interventions is an absence of referral for these services. Generally, health care professionals are reluctant to call in mental health providers, and the reasons for this are many. The unfortunate outcome, however, is that patients and families simply do not receive the expert psychological assistance they have a right to receive.

**Conclusion**

Psychological intervention in the form of Cognitive-behaviour therapy or any other chosen Psychological intervention, promotes optimal functioning of
the individual though cognitive and behavioural restructuring. It would encourage patient to actively engage in the activities that may help to control or minimise symptoms of pain and motivate him/her to acquire specific skills that may increase self-efficacy and hope which may in turn results into a better quality of life. Therapeutic factors that are particularly relevant for individuals with cancer are catharsis, altruism, identification, interpersonal learning, instillation of hope and existential factors. Although extremely valuable, cognitive-behavioural interventions are always integrated with and should never be a substitute for appropriate and comprehensive medical management (Cleeland, 1987; Cleeland, 1984, and Loscalzo, 1985). Cancer-related pain and associated distress significantly challenge the physical and mental well-being of patients with advanced cancer and their families. As patient demands require greater vigilance in the management of noxious symptoms, families have a parallel need for emotional support and the acquisition of coping skills. Under ideal circumstances, coping skills are taught to the patient and family when psychic and physical energy are relatively high. Consequently, these skills should be incorporated into the early phases of care, prior to advanced disease or the final stages of the illness. Cognition, behaviours, and feelings are negatively affected by chronic illness, resulting in an overall diminution of psychic energy, coping, and adaptation. Patients frequently manifest symptoms and maladaptive behaviours that require specialised interventions to restore a sense of focus and control. Cognitive-behavioural interventions are uniquely suited to address the most common psychological and emotional problems of patients with advanced cancer and their families. As an adjunct to medical care, cognitive-behavioural interventions promote optimal functioning through the encouragement of active participation in the control of symptoms and acquisition of specific skills that increase self-efficacy and hope.

REFERENCES


