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Psychosocial and Spiritual Model as the Analgesic for Patients with Terminal Illness

IORKOSU, Tyover Samuel
Federal University of Lafia, Nasarawa State, Nigeria

Sadiq Abubakar Mohammed
Maryam Abacha American University, Maradi, Niger Republic

Ishor, Gever David
Associate Professor, Department of Social Work, Federal University of Lafia, Nasarawa State, Nigeria

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Abstract: Terminal illnesses are quite painful and thus require proper attention both from the healthcare personnel and the family. The modern developments in therapeutic and care options in trying to reduce the effects of terminal illness have contributed a lot in the rise of the quality of health care among diagnosed patients. Through the procedure, a person may feel frightened and also anxious. This worry has been documented in patients with life-threatening diseases such as cancer, bubonic plague, or dynamic coronary infarction. Stress in between scientific research and belief are much more frequently revealed in western culture. Terminal illnesses are quite painful and thus require proper attention both from the healthcare personnel and the family. This work tries to figure out how people cope with terminal illnesses, emphasizing the importance of the psychosocial and spiritual model in helping patients who have been diagnosed with these kinds of diseases. It was found that only a small number of patients with terminal illness were receiving support from healthcare personnel. This of course suggests that there is limited availability of psychosocial personnel to handle the emotional and spiritual suffering of patients with terminal illness. In the absence of professional health services, patients may sought the support of family and friends. This work tries to figure out how people cope with terminal illnesses, emphasizing the importance of the psychosocial and spiritual model in helping patients who have been diagnosed with these kinds of diseases.

Keywords: Psychosocial, spiritual, Analgesic, patients, terminal illness

Introduction

Critically unwell patients with the terminal illness are dying alone without the convenience of their family or various other social supports in unmatched numbers. Terminal illnesses like cancer and other malignant diseases account for 25% of all the deaths in industrialized countries and 35% in non industrialized countries (Gurung, 2010). Since the diseases cannot be treated, therapeutic methods have been used to counter the challenges they pose to the society. There have been major developments of new strategies for improving the success rate of therapeutic options in the recent past. Together with these therapeutic methods, the family as the basic unit of the society becomes quite crucial in the management process.

Recently, healthcare groups have actually been flooded with critically ill individuals (Gurung, 2010). Clients isolated for terminal illness like COVID-19 have actually had no contact with their household or liked ones and might have likely experienced death without closure (Crow, 2014). This circumstance highlights concerns concerning individuals' mental as well as spiritual and their families. While palliative care has progressed to sufficiently address these people' demands, the COVID-19 pandemic for instance presents numerous obstacles that compel health care groups to deprioritize these essential aspects of client treatment (Lemire, 2014). The severe acute respiratory syndrome (SARS) episode in 2003 gave us a peek of these obstacles as these people were additionally separated in healthcare facilities. Right here, we review the importance of the psychosocial and spiritual model in terminal illness treatment and also its effects on individuals passing away with terminal illness. Furthermore, we detail an integrative approach to attend to the distinct and holistic requirements of seriously sick clients passing away with terminal illness (Folkman, 2010).

Throughout the swiftly changing and frequently disorderly preliminary actions to the fast increase of people, end-of-life spiritual and mental requirements of people and also their households might have been deprioritized. Many clients with COVID-19 that passed away in healthcare facilities or medical care facilities, specifically in Nigeria, died alone, among complete strangers, unable to be comforted by family members as well as loved ones. This situation intensified as neighborhood health centers were pushed to their limitations serving the influx of critically sick clients while enforcing contact as well as isolation precautions to avoid additional illness spread (Crow, 2014). These strenuous seclusion safety measures straight impacted dying clients and also their loved ones as both events lost their legal rights to correctly observe their end-of-life ceremonies and rituals (Crow, 2014).

There are three primary entities involved when looking after people with serious diseases. They include the client, their family members, and also the professional healthcare group. In terms of palliative care policy, while some disparity exists amongst the application of methods in Nigeria, medical facility systems should incorporate pain and sign administration, familial support, as well as the communication of objectives and also planning of sophisticated terminal illness care (Lemire, 2014). Inevitably, the emphasis should be on patient quality of life, which may or may not have actually embedded spiritual or spiritual treatment elements. Arya et al. (2020) kept in mind that significant client treatment adjustments need to occur throughout a viral pandemic. For example, boosts in the critical hospital framework, including COVID-19-prepared treatment facilities, equipment, and also employees, are required. Shared choice making, while a core facet of conventional palliative treatment, perhaps catastrophically influenced as a result of public health instructions (traveling and also site visitor constraints), which may consequentially impact the spiritual, mental, psychological, and also social needs of the client as a result of isolation far from their social circle (Lemire, 2014). As an issue of moral consideration, enhanced social communication, common respect between the individual as well as practitioners, and mutual transparency are crucial facets of care. Without a doubt, such values might currently be normally shown in many parts of the world, in which the treatment system is focused more on uniformity than on the stipulation of care services organized with industrial criteria. However, in other contexts, firm adherence to formal protocols for terminal illness care from the point of triage throughout grief is emphasized. Such procedures are understood to allow for the most ideal treatment to be presented, therefore enhancing the lifestyle as well as reducing of passing (Myatra et al., 2014). In such contexts, an extra alternative and integrated vision of efficient end-of-life care may better serve the person's requirements and also assist in emotional closure to the household adhering to the fatality of the person. While taking care of passing away clients is not extraordinary, methods might vary based upon the illness discussion as well as connected challenges (Folkman, 2010). An example of challenging circumstances includes infection devices or hospitals with limited gain access to, isolation safety measures, as well as constraints on after death and burial methods. These procedures were applied throughout extremely infectious epidemics, consisting of the SARS outbreak in 2003 (Lawrence, 2014).

Terminal illnesses are quite painful and thus require proper attention both from the healthcare personnel and the family. Together with explaining certain aspects of terminal illnesses, this work tries to figure out how people cope with terminal illnesses, emphasizing the importance of the psychosocial and spiritual model in helping patients who have been diagnosed with these kinds of diseases.

When an individual is identified with a terminal illness, whether they register for an idea system or not, specific methods are typically followed to guarantee the biopsychosocial and spiritual requirements of individuals as well as their households are met (Lawrence, 2014). These procedures might typically consist of religious rites or customs unique to the particular idea system. In this setup, clients are normally designated a palliative treatment team to collaborate with the person, their household, and the medical care team to focus on a shared-decision making technique (Daneault, 2004). Client's pain administration, comfort, psychological health, religious and also spiritual needs, lawful documentation, and last will, funeral choices all reviewed via a methodical method Richardson, 2014). This allows the healthcare team to cultivate a caring attitude, promote the patient's freedom, regard social or conventional considerations, and also have open communication with the individual and also their family (Daneault, 2004). However, challenges to the provision of alternative patient care were reported to occur during the SARS episode in 2003. These consisted of individual seclusion, quarantine of contacts, limited contact with member of the family, and constraint of contact with the deceased body, making it challenging to observe death rituals as well as funeral rites (Kakuta, Kakikawa,& Chida, 2015). In a quantitative analysis to establish the spiritual as well as psychosocial influences of seclusion, Leong et al. (2004) recognized 4 emergent thematic elements in dealing with the psychosocial and also spiritual obstacles those clients, families, and also medical care employees experienced. They were isolation, the uncertainty of the condition's nature, sufferer taking care of the suffering, and also the disruption of bereavement (Kakuta, Kakikawa,& Chida, 2015). Patients with SARS felt isolated as they experienced a disruption of connectedness, loss of self-confidence, perceived themselves as detainees, and also a loss of health-related decisional freedom. People' family members experienced seclusion as they had restrictions in checking out and also physically getting in touch with their love ones (Kakuta, Kakikawa,& Chida, 2015). The uncertain nature of the condition resulted in the development of clinical depression, stress and anxiety, and also anger among SARS clients, as they did not know whether they needed to prepare to die or not (Duggleby, Williams, Holstlander, Thomas, Cooper, Hallstrom, et al, 2014). When death occurred all of a sudden and also all of a sudden, families lost the opportunity to exchange final words. Families that shed their loved ones to SARS experienced a disruption of grieving as they had to follow state-mandated funeral or cremation practices. Sometimes they were not able to pay their last aspects, really felt an absence of closure, as well as often saw this as an undignified fatality (Leong et al., 2004).

Statement of problem

It was observed that family and friends were a frequent source of support for patient with terminal illness, providing both emotional and practical care giving support; however, a significant proportion of individuals reported having no one to provide them with psychological or spiritual support, and feelings of sadness were very common among patients. Patients frequently reported fears about the future of their children, dying, or being in pain. Researchers have reported that the majority of these patients reported that they solely depended on family or friends for psychological or spiritual support. In Nigeria and many other country, access to psychosocial health professionals is often very limited, with a recent World Health Organization study estimating that at least about 248,000 mental health workers are needed to address the current shortage of health professionals in Nigeria. Many researchers tinted towards assessment of medical care given to people with terminal disease with little regards on the psychosocial and spiritual need of the patients with terminal illness. In other words, the biomedical model focus on the biological aspects of pain management at the expense of the psychosocial or spiritual aspects of the experience. Consequently, there has been a tendency to neglect and undertreat other areas that contribute to the experience of pain and related suffering. This paper therefore set to fill the gap.

Literature

Psychosocial and Spiritual Version for the Treatment of Patients Terminal Illness

A psychosocial-spiritual design is a holistic strategy that acknowledges the interaction between physical, psychological, social, and also spiritual facets to patient care and also person well-being (Alidina, &Tettero, 2010). Patients are taken into consideration as beings-in-relationship, and ailment is regarded as a turbulent force in the biological relationships that can influence all various other relational facets of the person (Alidina, & Tettero, 2010). This holistic version to person treatment concentrates on the intrapersonal interactions of the physique and also the mind-body link and the patient's extra-personal partnerships with the physical atmosphere, household, friends, and neighborhoods. The biopsychosocial-spiritual model is consistently used in the medical setting, particularly in taking care of people passing away from deadly illnesses (McClement, & Chochinov, 2008). The Joint Commission on Certification of Medical Care Organizations (JCAHO) requires spiritual analysis to be part of the patient care strategy. Spirituality places a crucial function at the end-of-life no matter one's faith, as they battle with alienation, loss of self, mercy, self-exploration, look for balance, self-actualization, and tune (Williams, 2006). While the dimension of spiritual care is commonly under- represented in palliative care, several professional standards as well as methods have allowed physicians and doctor to look after individuals holistically (Puchalski, 2001; Puchalski et al., 2009; Delgado-Guay, 2014). However, with the uncertainties, lack of time, and also resources bordering hospitalized individuals with COVID-19, such end-of-life treatment designs are challenging to implement. These aspects may leave passing away clients susceptible to added concern as well as death-related insecurities.

Impact of Faith and Science in Addressing Fears in Patients Terminal Illness

According to the Kübler-Ross model for the stages of despair and dying, end-of-life is marked by a continuum of stages that suggest the process a specific undergoes prior to the approval of his-or-her mortality (Kübler-Ross, 1969). Through the procedure, a person may feel frightened and also anxious. This worry has been documented in patients with life-threatening diseases such as cancer, bubonic plague, or dynamic coronary infarction (McClain-Jacobson et al., 2004). Likely, COVID-19 may also be consisted of in this checklist. Each person's idea system and his-or-her worldview include facets of faith, religion, and also clinical concepts (Folkman, 2010). Stress in between scientific research and belief are much more frequently revealed in western culture. Nevertheless, this may be much less most likely in eastern culture(McClement, & Chochinov, 2008). Some experts question whether tension exists between scientific research and also belief (Barmania & Reiss, 2020), especially in eastern cultures. This was not the situation in the west prior to the better acceptance of Darwin's concepts on evolution came to be mainstream in scientific research. They argue that a scientist may pray for a loved one that could be in an important condition or probably pray for researchers and researchers to find efficient treatment choices for a condition or themselves in a near-death situation (Alidina &, Tettero, 2010). Arguably, several prolific and influential researchers have actually been recorded throughout history that have professed deeply held spiritual or religious beliefs (McClement, & Chochinov, 2008). Lack of belief, reportedly, leaves the person prone to depression and also the fear of fatality. In contrast, properly working confidence in religious beliefs supplied comfort to the individual versus the issues of death.

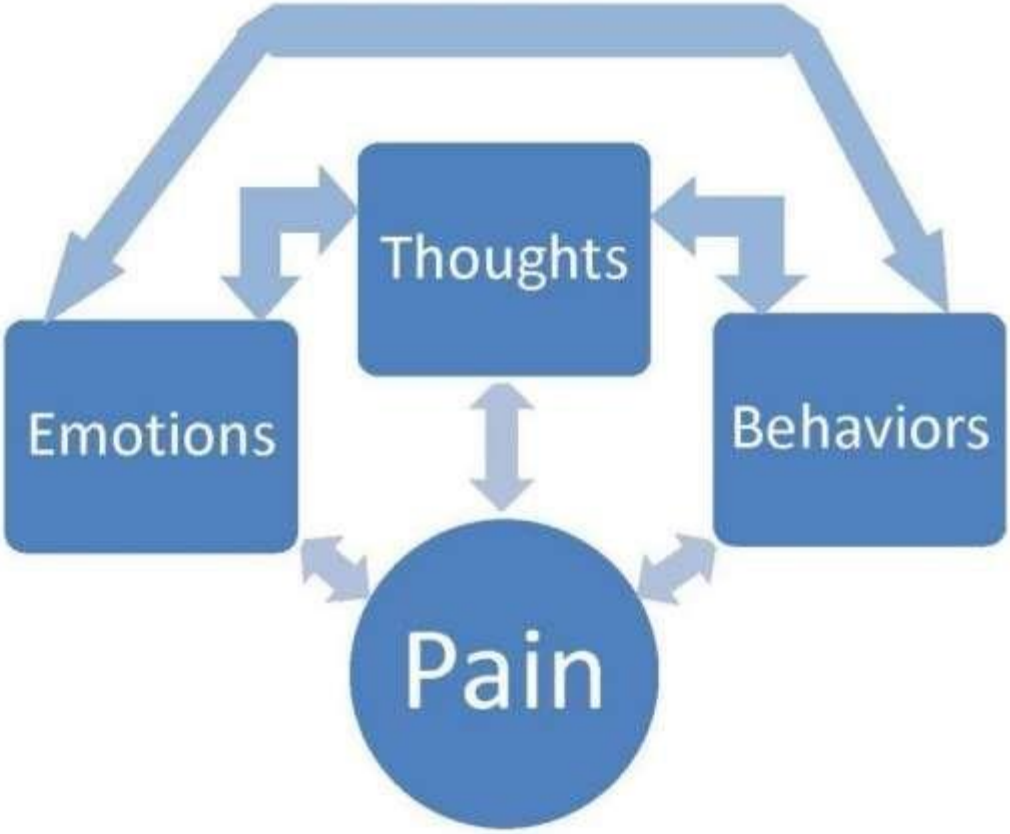
Attending to the psychosocial and Spiritual Needs of Clients Dying with Covid-19

There are a number of actions that health care teams can take to properly manage the psychosocial and also spiritual requirements of seriously unwell patients with COVID-19 (McClement, & Chochinov, 2008). The most critical action is to boost sychronisation initiatives with hospital palliative treatment groups towards an integrative care strategy throughout this pandemic. This method will certainly help effectively address most terminal illness patients by the experts. An empirical research study performed at a New York City medical center dealing with people with COVID-19 showed that the participation of palliative care groups considerably enhanced end-of-life treatment (Folkman, 2010). Palliative treatment teams fostered individual freedom helping to clarify as well as carry out innovative regulations more effectively (Alidina &, Tettero, 2010). While isolation precautions as well as minimal sources may be barriers, remote assistance from these end-of-life experts can be just as or more reliable, as they can consult much more individuals (Duggleby, Williams, Holstlander, Thomas, Cooper, Hallstrom, et al, 2014). The second crucial procedure is to review end-of-life plans with seriously unwell clients and also their families really early in the hospitalization process (Alidina &, Tettero, 2010). While death is not a certainty at the time of hospitalization for COVD-19, given the erratic nature of the disease diagnosis, this assists prepare patients for a likely result (Folkman, 2010). This action will certainly allow clients as well as their households to consider crucial spiritual facets, including forgiveness, life after death, and offer time for closure. Third, the more comprehensive use of video clip conferencing modern technologies is a just as crucial useful application that can facilitate a sense of digital connectedness in between people alone as well as their households (Alidina &, Tettero, 2010). Virtual conferences can aid eliminate the physical distance as well as visitation barriers to provide even more call time with their enjoyed ones. Integrating this with very early discussions about end-of-life strategies will guide households to have significant spiritual conversations before the death of their liked one (Alidina &, Tettero, 2010). Hospitals looking after individuals with COVID-19 can promote this by boosting the access to such technology as well as building them right into isolated COVID-19 systems. Finally, increasing common decision-making opportunities as well as including family members in person care choices will certainly address their problems and create a clear post-COVID-19 exit strategy (Folkman, 2010).

This method will certainly cover patient results, consisting of total recovery, debilitating conditions, longer-term treatment, and the death of the patient. All these action steps work synergistically towards the typical objective of resolving the mental and also spiritual needs of clients passing away in isolation (Alidina & Tettero, 2010). An integrative technique incorporating these four actions in scientific setups will certainly help with all natural take care of patients dying with COVID-19 as well as their households.

Bio-Psycho-Social-Spiritual Model of Pain

The first person that describe the biopsychosocial model of people with terminal illness was George Engel in 1989. This model quickly became the gold standard through which mental health physicians conceptualized and treated their patients however, the process of adoption was significantly slower among biomedical personnel. The model is beyond the Cartesian dualism that separates the “physical” from the “mental” experience. Conceptualizations that incorporate the bio-psycho-social model can explain how individuals may experience pain without an identified physiologic etiology or how they may experience differing pain levels compared with other individuals within the context of a recognized disease or injury process (Engel, 1989). The bio-psycho-social model encompasses interactions among medical, mental health (including the patient’s cognitive appraisals of his or her medical status), and sociological factors and how these affect a patient’s general well-being.



How People Cope with Terminal Illness

The modern developments in therapeutic and care options in trying to reduce the effects of terminal illness have contributed a lot in the rise of the quality of health care among diagnosed patients (American Cancer Society, 2010). The quality of analgesic therapy has continued to increase especially in reducing pains caused by terminal diseases such as cancer (Klaschik, 2003). Therapeutic and care giving strategies have come in handy to help alliviate the negative impacts of these illnesses to friends, patients, and family members (Larsen, & Lubkin, 2006).

It is important to point out that counseling services have also contributed much in aiding patients and family members handle with the situation (Klaschik, 2003).. Spiritually, the religious societies, clergy men can be of valuable help because most religions believe that there is life after death (Larsen, & Lubkin, 2006). Thus, by giving the patient some hope of life after their death, it reduces the suffering of these terminally ill patients. In other dimension, in non religious families, professional counselors can be consulted to aid the patient and their families handle with the situation in a manner that will not include a lot of psychosocial factors like emotions.

Reducing the Pains Caused By Terminal Illness

Reducing the pains is done by pain management methods. In cancer patients, the use of both invasive and non-invasive method is commonly used. The destruction measures are becoming more uncommon because of their side effects. Intravenous and subcutaneous administration of drugs is also pretty common in treating cancerous situations (Klaschik, 2003). Coping is another way of handling with this situation (Dennis, 2009). Coping in this regards includes anything people do to manage problems or emotional responses whether successful or not. Coping helps in dealing with stressful situations of the terminal illness. Hence, it can be utilised to reduce the pains of the patient (Gurung, 2010). A person finding out that they are HIV positive or has test results showing cancer, can experience a surge of fear and anxiety and is therefore driven to cope with these feelings.

The person may deny the results of the test or not want to talk about it for some time. Thus, emotional-focus-coping is the name given to these mental or behavioral methods of dealing with the feelings resulting from the stress (Dennis, 2009). Problem focused and emotional focused approaches of dealing with these pains can be quite effective especially in the hospice service providers (Singh, 2010).

Conclusion

This study sheds light on psychosocial and spiritual model for patients with a terminal illness, their loved ones, and their physicians. The attributes of scientific method focus initially on cure, then shift toward prolonging survival, and then to improving quality of life. As the illness advances, this hope might evolve into a form of acceptance or, conversely, give way to despair, phenomena that can alternate over time in either direction. This study also highlights the need to avoid oversimplifications, both in clinical interactions and in research, as it provides valuable insights from both the clinical and research perspectives. Families and physicians clearly need to maintain some degree of hope in their patients while remaining as realistic as possible, even if this balance is tenuous. It is pertinent for health personnel to understand and remember that psychosocial and spirituality is a dynamic phenomenon to which they must be adapted in attending to patient with terminal illness.

Recommendations

1. Supportive counseling by the health care workers should be provided to patients who have been diagnosed with terminal illnesses. The stressful effects of stigma should be reduced so that the lives of the patients can be bearable. Thus, special care should be given to such patients.
2. Furthermore, spirituality via the use of clergy should be utilized to facilitate development of coping with realities. Reminiscence and life review situations can be of great help in identifying and emulating past coping skills that are considered successful.
3. Terminal ill patients are to be encouraged to mend damaged relationships, forgive and be forgiven and also encouraged to openly express their emotions and give a farewell to other relationships. Care givers should work closely with dying patients so that their goals can be achieved. The patients should also be encouraged to explain what they most want thereby giving the caregivers an ample time in achieving their desirablegoals.

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