

Communication skills for caregivers who work with patients under palliative treatments

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Editorial

Palliative care (PC) is offered to patients who have diseases such as oncological and non-oncological chronic degenerative diseases; in addition to neurological, pulmonary, cardiovascular, renal, and infectious problems, such as Acquired Immune Deficiency Syndrome (AIDS). When they are not institutionalized, these patients receive health care, commonly, in their homes, with their family. The latter must be understood in its broadest definition, extending to people with emotional ties, members of the community, that is, the social support of the sick person, including the caregiver.¹

The act of caring for a sick person is complex since the family's adaptation to the weakness of the disease is permeated with uncertainty. The patient rarely chooses who will monitor their general and health needs daily. Therefore, the person who assumes responsibility for PC tends to have low self-esteem, zeal due to guilt or the need to repair something from the past and few life goals.²

The process by which a person becomes a designated caregiver for a sick person is varied, but there is a tendency for those individuals in the community to have little expectation of personal fulfillment and who harbor a feeling of pity or compensation for what they consider to be failures. In your relationship, before the establishment of the disease or the situation that led to the need for care. There is not always a balanced division of responsibilities between family members.¹

In general, care is the responsibility of a single person who, over time, tends to distance themselves from other family members and get less support. The physical and emotional intensity that the caregiver-ill person relationship demands often overloads the caregiver. It is common to see caregivers experiencing a worsening quality of life, neglecting their own health and lack of leisure activities. This situation requires attention from the multidisciplinary Primary Health Care team, mainly in relation to communication with the caregiver,² to establish preventive care.

Communicating, as mentioned by the philosopher Nietzsche,³ is losing the singular, it is becoming common. It thus constitutes the basis of care. During consultations, health professionals are recommended to adopt a proactive emotional style, when there is a record of the sentimental tone in the consultation, without letting themselves be carried away by the negative emotions they receive. With emotional competence in communication, it is important to be able to counteract omnipotence or an exhausting, pessimistic or negative climate, manifesting the opposite behavior to that of the person, instead of having a reactive sensitive style, which acts in a similar way to the stimulus it receives.

The companion should initially be considered an important source of information, and it is recommended to involve him or her in shared decision-making. Thus, the family and community doctor can demonstrate greater openness and interest in the doubts and opinions of the person assisting, to consider the joint plan. Furthermore, it is recommended, in cases where it is necessary to communicate difficult

news, that the doctor demonstrates confidence and communicates the information assertively, avoiding words with a high emotional content. Leaving the caregiver comfortable to cry is important so that they can express their emotions, if they wish, and not appear to feel relieved.

The literature even suggests that issues related to Spirituality be addressed, as a form of support and coping, in the assessment of positive spiritual religious coping to confer resilience and, in the case of negative coping, to prevent such habits and beliefs from harming or alienating the people in the treatment.⁴ Support, for both patients and caregivers, must promote comfort and respect the needs of both, through an appropriate approach, diagnosing, intervening, and evaluating Spirituality.⁵ This approach allows, through more effective communication, self-reflection and self-awareness about death and its meaning, generating recognition of fear in the face of death and greater empathy.⁶

It is important that the professional assists in making decisions shared with the caregiver. To this end, the following steps are suggested, through the construction of ecomaps: (i) define the problem, which must be specified by the professional, taking into account their perceptions and those of the person when making a decision; (ii) transmit confidence, making it clear that different health professionals may not have the same opinion about which therapeutic option is the best; (iii) address issues related to spirituality, obtaining data that investigate physical, psychosocial aspects and existential/spiritual expectations and preferences/desires; (iv) summarize the options, describing one or more therapeutic alternatives and, if relevant, the consequence of not treating; (v) check understanding, making sure the person understands the options; (vi) explore conceptions, evoking the person's concerns and expectations about the clinical condition, possible treatment options and their consequences; (vii) investigate the caregiver's acceptance, checking whether they agree with the shared decision process and identify their role in the interaction; (viii) involve the caregiver, committing them to the decision-making

process; (ix) delay, if necessary, reviewing the caregiver's needs and preferences, including the opinion of other people in the family; (x) review the agreements, carefully examining the decisions and cultural competence of the patient and his assistant.^{7,8}

In meetings with the caregiver, paying attention to the latter, it is important that the family doctor diagnoses the current situation, mental health and/or prolonged grief and proposes effective intervention plans. The most common psychopathologies identified in PC companions are depression and anxiety, for which the prescription of psychotherapy and mood stabilizers are effective.

Grief, on the other hand, corresponds to a specific emotional state, which begins with the threat or rupture of an emotional bond and is characterized as a period of coping with the pain of the loss of a presumed relationship. If such a condition is identified, when managing it, it is important not to reduce the experience of it to pathological aspects. The initial approach must include restoring resilience and ensuring longitudinal and comprehensive care, using social support, such as religiosity. To this end, the use of the ecomaps family approach tool is effective in identifying the main foundation points, in each case, for the reframing and relief of post-loss suffering.⁹

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Conflicts of interest

The author declares there is no conflict of interest.

References

- Lichtenfels P, Santos MHS, Fernandes EO. *O Cuidado do Paciente Idoso*. In: Duncan BB, et al., editors. *Medicina ambulatorial: condutas de atenção primária baseadas em evidências*. 4ª ed. Porto Alegre: Artmed; 2013.
- Hudson PL, Remedios C, Thomas K. A systematic review of psychosocial interventions for family carers of palliative care patients. *BMC Palliat Care*. 2010;5(9):17.
- Nietzsche FW. *A gaia ciência*. São Paulo: Companhia das Letras, 2012. p. 181.
- De Jesus GT, Freitas FG, Bispo, DBS, et al. The role of spirituality in the context of palliative care. Research. *Society and Development*. 2023;12(1):e19812139531.
- Vianna MLGDES, Souza W. A Espiritualidade dos cuidadores informais de pacientes em cuidados paliativos: uma reflexão bioética na perspectiva da alteridade. *Estudos Teológicos*. 2017;57(2):401–413.
- Best M, Leget C, Goodhead A, et al. An EAPC white paper on multi-disciplinary education for spiritual care in palliative care. *BMC Palliative Care*. 2020;19(1):9.
- Gómez-Batiste X, Connor S. *Building Integrated Palliative Care Programs and Services*. Chair of Palliative Care. WHO Collaborating Centre Public Health Palliative Care Programmes. Worldwide Hospice Palliative Care Alliance. Liberduplex. 2017. p. 384.
- Wawrzynski SE, Alderfer MA, Kvistad W, et al. The social networks and social supports of siblings of children with Cancer. *Children (Basel)*. 2022;9(1):113.
- Collares MF, Lichtenfels P, Santos MHS. Abordagem da Morte e do Luto. In: Duncan BB, et al., editors. *Medicina ambulatorial: condutas de atenção primária baseadas em evidências*. 4ª ed. Porto Alegre: Artmed; 2013.