Chapter 6

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DISCUSSION

INTRODUCTION

This present study on assessment of depression in terminally ill cancer patients was planned with the following objectives.

- To study the socio-demographic profile of the terminally ill cancer patients.
- To assess the family burden of terminally ill cancer patients.
- To study the social support extended by the family members towards the terminally ill cancer patients.
- To study the coping pattern adopted by the terminally ill cancer patients.
- To find out the factors for depression in terminally ill cancer patients.
- To assess specific areas of intervention for the terminally ill cancer patients.

The tools for data collection were administered on 200 terminally ill cancer patients. The unit of study were terminally ill cancer patients in the age group of 20 to 75. The population under study was Amala Cancer Institute and Research Center, Thrissur and Government Medical College Hospital, Mulamkunnathukavu, Thrissur. The following standardized tools were used for the collection of data are:
• Socio-demographic interview schedule (Developed by the researcher).
• Family burden scale (Pai & Kapur 1981)
• Social support interview schedule (families) (Developed by the researcher).
• Coping strategy interview schedule (Developed by the researcher).
• Beck depression inventory (BDI, 1996)

The collected data was analyzed by applying appropriate statistical tests such as mean, percentage, frequency distribution, standard deviation, Chi-square test, correlation coefficient. In the previous chapter of data analysis and interpretation, the tabulated data are statistically analyzed and presented.

SOcio DEMOGRAPHIC DATA

The discussion starts with the socio-demographic details of the terminally ill cancer patients. The tabulated data revealed that majority of the affected patients (56%) are in their terminal stage during their middle age (40-59). In this study it was also observed that a higher percentage of males (54%) and people belonging to the lower strata of the society (54%) were affected with cancer. Cassileth (1985) highlights that incidence of cancer rises steadily with the onset of middle age. Cassileth (1984) Edlund and Sneed (1989) Mor Allen and Matin (1994) states that
young adulthood is extremely stressful for most patients. A study conducted by the American Cancer Society (1990) highlights the findings that among the people with low socio-economic background the incidence of cancer is high.

Taking into consideration the marital status with terminal illness it was statistically identified that 53% of the patients live with their spouse, 38% without their spouse and 9% were single. The dual role, which the spouse of the patient had to shoulder, created additional burden for the patient as well as family members. Lea Baider, Pinnia Ever-Hadani (2003) states that the husbands of cancer patients were highly distressed than their wives and their distress were as high as that of patients of both gender.

The educational status of the respondents revealed from this study is: 43% are illiterate with equal number of males and females, 33.5% have school education, 18.5% have higher secondary education and 13% are graduates. It was found that men were more educated than women. Thus it can be inferred that low level of education has an effect on the awareness about the illness. Study by Obert et al (1989) proved that caregiver in family with low socio-economic status and less education felt threatened towards the illness.

The findings of the study on types of cancer show that 14.5% of the patients have breast cancer, 14% lung cancer of which 89.2% are males, 13.5% stomach cancer (70.3% males), 11.5% throat cancer (73.9% males) and also 8% of them uterus
cancer and 6% bone cancer. The international comparison of AAR with that of PBCRs in India (ICD-10:00-C 96) shows these statistical values incidence-wise as breast cancer ranking first, followed by uterus, stomach, throat cancers etc.

In this present study comparing the type of cancer and the incidence rate in the general population it was found the incidence rate of terminally ill cancer patients in the population are for males lung 22%, stomach 17%, oral 5%, oesophagus 10%, throat cancer 16%, blood 11%, bone 3%, and for females breast 32%, blood 10%, uterus 17%, stomach 9%, oral cancer 4% and lung cancer 3%.

According to the ten leading sites of cancer (2001-2002) among males the incidence rate of cancer are as follows. Lung 12.0%, stomach 11.95%, mouth 7.3%, oesophagus 6.3%, larynx 6.25%, and tongue 5.4%. Among the female patients breast cancer 30.2%, uterus 16.4%, thyroid 6.6%, stomach 4.8%, mouth 4.4% and lung 2.2% respectively.

Studying the reasons for physical discomfort in this study it was found that 74% of the patients suffered from pain, 65% from loss of sleep and 28.5% from nausea. Dorrepaal (1989; Patt (1993) in a study highlights pain to be a major concern for cancer patients, as well as those working with their families and relatives. Barkwell (1991) study proves that the most important determinant of effective coping with cancer pain was the perceived meaning of pain.
Illiteracy is a curse because it stands as a wall in the attainment of knowledge and gathering information about one’s own illness. It, in turn, denies the right to be informed and for information.

The social and psychological supports are of immense value for the patient during his end stage of life. Lack of psychological support indirectly cause gaps in communication, resulting in strained interpersonal relationship. The partner who has to play a dual role finds it difficult to rise up to the expectation of the patient. This can be assumed as one of the factor that caused depression in patients.

Middle age is a period when every individual has completely experienced the outer world and is in a position to take mature decisions affecting his/her life. It’s a period when an individual starts saving, enjoying life, helping his/her children to establish and leading an emotionally matured and stable life. The onslaught of such a dreadful disease on the life of either one of the spouses causes psychological trauma.

Habits of smoking and use of pan mazala among males are the observed causative factor for the increased cases of lung cancer (14%) among the males. Cases of stomach cancer form 13.5 % of the total sample. Throat cancer, blood cancer, uterus cancer, bone cancer, oral cancer, brain cancer, esophagus cancer and prostrate cancer are the other categories of cancer reported in the study.
Cancer of the lung is common and it has been growing steadily during recent decades. Some cancers start from cancerous cells carried to the lung by blood or lymph circulation. Others begin in the lungs themselves. Medical professionals believe that the increased inhaling of cigarette smoke as the main cause. The increasing use of alcohol, panparag, chemical pesticides on agricultural crops are some of the observed causative factors for lung cancer in the study. Only if changes in life style be made, control of the incidence of cancer is possible.

A vicious killer of women today is breast cancer. Breast cancer may develop without the presences of any know previous disease. At the onset and in the initial stages pain does not accompany it in most cases. At times blood fluid from the nipple, a puckering or dimpling of the skin covering or a lump will appear. By this time, cancer has reached the advanced stage. Pain, as in most other cancers, is comparatively a later manifestation. So it’s not known or given importance. A medical examination using mammogram after the age of 35, for all females will definitely reduce the incidence of breast cancer in the population and also enable early detection.

The physical discomfort manifested by the patients varied according to the type of cancer. However, whatever the case, most of the patients had pain, sleep disturbance and nausea. The unfulfilled desires of the patient took the form of anger and irritation. The physical discomfort of the patients had an indirect effect on the family. The family members should have empathetic
understanding towards the patient in order to lessen the patients sufferings.

One cannot make an inference from the study that cancer is hereditary. Previous studies and articles highlight the effect of environment factors mainly life style changes to have a tremendous influence in causing cancer. If only, each individual see to the safety of his health, can he live a disease free life? Air, water, sound, environment pollution dietary habits, life style are all responsible for cancer.

**FAMILY BURDEN**

The findings of the study highlight that 97% of the terminally ill cancer patients experience moderate to severe level of family burden. Studying the relationship between family income and helping sources in this study, it was observed that as high as 54% of them belong to low income group and 18% of them to high income group. 51.5% use two sources, where as 28.5% use three sources. This study on family burden and helping source depict that the level of burden is severe. 30% patients depend on loans, 74.5% get help from their relatives, 28% from their friends and 15% from their well wishers.

This present study on family burden and sex shows that male patients experience more family burden than females. The traditional ways of division of labour and social role assignment strictly followed in India, the inability to perform daily chores in an effective manner is the main cause of family burden for
majority of the patients. Vess, Moreland and Schewebel (1985) found that families which were adaptable regarding role assignment exhibited greater cohesiveness and competence in illness induced roles.

This study on family burden and marital status shows that the family burden is experienced by both categories of patients, those living with spouse and those living single. On comparing the coefficient variation of the two groups of patients it could be observed that patients living with their spouse experience more family burden than single ones. It could be inferred that the patient living with their spouse has more involvement in family chores than those living single. Lea Baider, Pinna Ever Hadani (2003) studied one of the partner of a cancer patient and found out that even though groups reported more or less similar level of psychological distress, of the spouse affected, male experience more family burden than females.

Oberst and James (1985) in a study of spouses of newly diagnosed patients found that lifestyles disruption was concern over 50% of the spouse. Spouses reported that their employment and house hold schedules were alerted, arrangement for child care changed and social activity curtail.

This study on family burden and duration of illness highlights that the percentage variation based on the average family burden is high in patients living with the illness lesser than or equal to 18 months.
Money is something very much essential. Due to specialization in the field of medicine the expenses incurred for treatment of illness have gone very high. The cost of hospitalization and treatment has shot up incredibly that a common man finds it increasingly difficult to meet the expenses with the money he has saved, unless he is immensely rich or has kept aside a portion of his saving for his bad days. Due to lack of proper employment and financial security people has resorted to more than two or three sources to meet their treatment expenditure. Once an individual is identified as a cancer patient in the initial stage, he has to spend not less than one lakh rupees for chemotherapy, radiation and hospitalization.

In India, family ties are strong. When compared to all the other helping source funds received from the well-wishers were quite less. The society has definitely a responsibility towards its members. This we-feeling should be cultivated among the members of the society, so that each one would come forward in helping his fellow human being in pain. This moral obligation, sad to say, is being ignored by very many people.

Another reason observed was, the physical strain of the caretaker. The uncertainty how long this condition is going to last. All these factors have caused separation between the family members and patient.

Thirdly, the atmosphere in the family was found to be dull, quite and interaction and communication was less. The family members have taken the patient as a burden. The relationship
was estranged in most cases. There existed misunderstanding, and the family members hardly communicated with the patient.

Unless the family members are made aware of the truly pathetic condition of the patient and are educated to have an empathetic understanding towards the patient, this state of mind set will not change. This change can be brought about only through social work intervention.

Preferences must always be given to the patient because he/she is the one who is suffering. The feeling that, the patient is cared for and there is someone to shoulder his problem along with him will be of great relief and will enhance family interaction and communication. The feeling of oneness among each others is a feeling of great consolation for every human being especially for a terminally-ill patient, counting down his hours at the evening of the day.

**SOCIAL SUPPORT**

This study on social support and sex reveals that male patients received good social support than female patients.

This study on social support and marital status shows that both categories of patients living with their spouse and living single receive social support from family members. Goldberg and Tull (1983) Vanchon et al (1982) it was found that younger spouses had the most adjustment problem and inspired marital relationship. Spiegal (1989) reported that survival was significantly longer for patients who had been in a support
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group. Bloom and Spiegel (1987) study result indicates that emotional support was strongly related to the patient’s outlook and that greater opportunities for social activity affect both self-perceptions and social functioning and outlook on life.

Promoting healthy relationship between human beings will help in receiving service in times of need. Even though the social support system was strong the patients felt as if they were not given due importance or care. Some of the reasons which can be analyzed for the minimal social support received by the patients are the high expectation of patients while playing the sick role, the inability of the patients to understand their relatives concern, lack of genuine or empathetic approach from the part of relatives, less expressive nature of male spouse.

COPING STRATEGIES

It could be inferred from this present study that 62% terminally ill cancer patients adhered to religious practices to find relief from pain and sufferings. O’ Corner, Wicker and Germiro (1990) conducted a study searching meaning after a diagnosis of cancer found that faith and support proved to be major factors facilitating the search for meaning.

This study compares religion and ventilation the two coping strategies used by patients. On comparing it was found that religious patients did not resort to ventilation and vice versa. If a balance could be maintained between both religious faith and ventilation, a positive self concept could be generated in patients. Being spiritual is the best resort to get away with ill feelings.
Linda & Baner S.M (2003) conducted a study on psycho-spiritual well being and it was shown that patients with an enhanced sense of psycho spiritual well-being are able to cope more effectively with the process of terminal illness and final meaning in the experience.

In this study comparing optimistic and pessimistic attitudes with gender it was observed that majority of males have scored more or less equal score in optimistic as well as pessimistic category. It can be inferred as to male patients are totally confused as to which coping strategy to accept. Among the female the values are high for pessimism indicating, majority of the patients are pessimistic.

According to Scheir and Carver (1985) the disposition of optimism versus pessimism is a dimension of generalized expectancies about the occurrence of good versus bad outcomes in one’s future and is viewed as a stable dispositional characteristic. Optimists and pessimists differ in their coping (Scheir et al 1986) but whether they differ in the matter of participating in treatment decision-making or are predictors for emotional morbidity remains unknown. Taylor et al (1992) studied and found that dispositional optimism is associated with less emotional distress in response to a number of stressors.


Since cancer brings about drastic change in their mood they are totally confused not knowing which coping strategy to use. It could be observed that even the optimistic patients during severe pain used negative coping strategies. Therefore majority of the cancer patients experienced depression.

Most of them were sometimes pessimistic, and went in for suppressing their emotional feeling. They instead expressed their frustration as anger. The pain and mood fluctuation made them a prey to the use of negative coping strategies.

**DEPRESSION**

This study on coping and depression show that 62% of the patients adopted religious practice, in order to cope with their illness. 35.5% of them were optimistic in their approach and
38.5% of them were ready to face life as it comes. 28% adopted ventilation as better mean of coping. A study by Christian Rosenfeld et al (2002) highlights the impact of spirituality and religion on depression in terminally ill patients.

This study comparing gender with depression shows that 63% of the patients experience severe depression of which 53.88% are males. It can be inferred from the above values that depression was observed more in males. The reason for this finding might be because males have a tendency to suppress their feelings. It was also observed from the study on cancer and age that all these patients are affected during their middle age group. Holland (1984) explains that social support mainly plays a buffering role in reducing the stress caused by the disease. Giese-Davis (2000) found that a good relationship with spouses or patient was important to assist women to cope with breast cancer.

This study on coping pattern and the level of depression shows that patients who adopted good coping felt less depressed than those who adhered to moderate or no coping. David B. Callan (1989) on a study on hope and coping in men and women with cancer found that there is no significant relationship between hope and coping.

This study on depression and income indicates that nearly 46% experience severe depression of which 44.2% belong to middle income group, 31.1% to the low income group and 7.5% to the high income group of which 45% experienced moderate depression, 35.5% belongs to middle and low income
groups. In general, it can be inferred that irrespective of economic status all the three classes of people experience depression, but differed according to the levels of social support, economic status held and coping strategies used.

This study on depression and age shows that there is no significant difference between the aged and young people considering depression. Harvey Max Chochinov, Keith G Wilson (1997) conducted a screening for depression in terminally ill cancer patients. It was noticed that depression is a common problem in older adults and medically ill patients and often goes unrecognized.

This present study on the relationship between depression and marital status of the terminally ill cancer patients, it was observed through statistical analysis that the patients who were single experienced more psycho-social depression.

This study on depression and duration of illness among cancer patients shows that the patients on their early months of identification experience more depression compared to patients those who are living with the illness for quite some years..

On the whole, most of the terminally ill cancer patients irrespective of the coping strategies used experience severe depression. The pain and mood fluctuation experienced by patients can be considered as a major cause for depression. On comparing the three groups of people, it is found that it is the middle-income group patients experience more depression.
Patients who received constant social support from their families also experienced severe depression. The findings indicate that the cause of depression is multifarious and it cannot be attributed to a single factor.

When the patients feel they are a burden to the society more was the depression experienced. When relationship is disturbed, walls are built, instead of bridges. Strengthening relationship should be of paramount importance in any effort to lessen the level of depression in terminally-ill patients.

Man is a social animal and no individual can be happy in a life of isolation. Every individual longs for company of others to share his/her joys and sorrows in the journey of life. Having someone near to share ones painful experiences is a great solace for every one. Oncology social worker should divert their attention more on the patients who are single and has no one to be at their side in times of distress. Ventilation of their hearts grief will definitely help them to see life more positively and challenging. It would also help them lead a peaceful life amidst adversity.

It may be concluded that all patient who are suffering from terminally ill cancer experience depression and it varies slightly in degree. It implies that there is variation experienced by patients in their early period of identification when compared to the patients who are living with the illness for quite some years. Lack of definite diagnostic criteria for depression is a real problem. This has been supported by
researchers. Koeing et al, Derogalis et al and Evans et al (1986) reported in their studies, the absence of define diagnostic criteria for depression.

**OBSERVATION**

Using indirect method in the course of the study certain information on the attitude of patients and their immediate care taker regarding euthanasia was collected.

The findings of the present study highlights that patients and relatives were against the concept of euthanasia. 69.5% of patients and 69% of their relatives were against this concept. This reveals that family ties are stronger in India.

Maria E. Suarez-Amazor et al (2002) conducted a study on terminally ill cancer to assess the attitude of patients towards euthanasia and physician assisted suicide. The finding of the study proves that 69% of the patients were for the concept of euthanasia. This can be taken as the difference in attitude towards life of the people in the developed countries to that of developing countries. Value for life was viewed differently in different cultures.

**VERIFICATION OF HYPOTHESIS**

There exist a significant relationship between the age and depression experienced by the terminally ill cancer patients.

The Pearson’s coefficient of correlation obtained indicates a weak or no relationship among the variables. Hence it can be concluded that all the terminally ill irrespective of their age experience depression.
There exist a significant relationship between the family burden and depression experienced by the terminally ill cancer patients.

There exist a moderate positive correlation between the family burden and depression among the terminally ill cancer patients. Depression increases with an increase in family burden. So family burden is a factor of depression among the terminally ill cancer patients.

The social support received by the terminally ill cancer patients is significantly related to the level of depression.

Social support had nothing to do with depression. It is a temporary relief the patients get when social support is extended. The irrecoverable state of the illness induced fear of death in them and patients thus face severe depression irrespective of the social support received.

The relationship between depression and adoption of coping strategies among the terminally ill cancer patients are significant.

Pearson’s coefficient of correlation obtained indicates a negative correlation between the variables. It can be concluded that the patients who adopt good coping felt less depressed than those patients who adopted moderate coping or no coping.
IMPLICATION OF THE STUDY

The study implicates the need for psycho-social intervention in three main areas.

1. Field of palliative care.
2. Social work programmes and training.
3. Social work research.

**Intervention in the field of palliative care.**

Effective practice of the social work methods like casework and group work is imperative as the study highlights the need for both individual and group interventions in palliative care and has observed its effectiveness in reducing the level of depression among patients and their caretakers.

Considering the high demand for palliative care services in the country, policy changes need to be made incorporating services of the service providers. Relative cost effectiveness of various methodologies needs to be tried out and evaluated.

**Interventions in the field of social work programmes and training.**

The need for social work training in the field of palliative care is another area of intervention. Social work students should be given an exposure to such high risk areas and should to be made to understand the importance of practice in such areas. For this purpose changes in social work curriculum itself may be required to include practice oriented education programmes.
Also, placement of students in palliative care centers will help the trainees to develop interest in this area and enhance their knowledge about palliative care and its principles. Trainings is essential not only for students but also for the staff working in these centers. As the findings of the study show that the majority of the patients experience severe depression it should be taken as the felt-need of the patients and appropriate intervention strategies should be planned to cater to the need of the patient, recognizing the right of the patient to live a happy life and die a peaceful death.

Training for the staff can be planned at three different levels.

1. Psychiatric- social work training for the social workers in the palliative care centers.

2. General orientation programmes for staff-general, spiritual and subject specific.

3. Advanced training for the professionals in knowledge enhancement.

The curriculum for the three types of training may be different depending upon the educational qualification of the staff as well as their designation. However, general orientation is meant for all the staff.

Knowledge about various mental health problems, early identification and prevention, treatment and psychosocial management, rehabilitation, child and adolescent mental health problems, substance abuse and promotion of positive mental
health would be some of the areas that need to be essentially covered in psychiatric social work training for the social workers in palliative care centers.

General orientation programmes may include building up of counselling skills (active listening, empathy, non-possessive warmth, effective communication skills, genuineness, in human relationships, unconditional positive regard etc), healthy lifestyle, and cover such areas as problem solving and effective interpersonal communication. Spiritual orientation to the staff would be effective as it include components like spiritual intelligence (belief in higher forces, compassion and ‘big picture’ concept), love, empathy, humor, and sense of gratitude to oneself and also to the fellow beings. It helps the person to internalize values of life and skills in communication, which results in improving the quality of work. Spiritual education also aims at reducing introspectiveness and increasing ‘other-centeredness. The aim of such an orientation is to enhance the knowledge of the staff and also to enable them to provide support to their fellow workers in developing a better relationship with their patients without actually personalizing the patient’s problems. Subject specific orientations should cover areas like mental health problems, and activities such as like stress management programmes, life skills education, personality development programmes and various other areas related to staff development and welfare.
Each professional in the palliative care centre needs to be an expert in their field and hence advanced training for the physicians, nursing staff, social workers and other professionals are essential to update their knowledge in the field and make them more effective and efficient in their work.

**Interventions in the field of social work research**

There is a dearth of studies in this field, especially in the Indian context, and hence more psycho-social oriented studies needs to be conducted among the patients and staff in order to understand the various problems in the concern field. Interventions need to be planned based on the empirical evidence obtained through research studies. Not only students, but practitioners also need to contribute to the field of information. Hence the problem has to be identified at the grass root level and more research studies leading to effective intervention programmes have to be conducted at this crucial point. An Indian study by (Chandra et al, 1996) also points the important of further research studies in this area to highlight the need for addressing these issues by professionals in the field.

The level depression as evidenced in the study, can cause considerable distress and lead to poor adjustment and quality of life in patients. The results are significant. They highlight the need for action in preventing depression among the patients. Palliative care needs of the society are increasing. Social workers who are sensitive to the needs of the community, need to understand the importance of the problem and take effective
steps in the preventive aspects. The findings also emphasize the need for early identification of the depression, so as to achieve better results from the programmes for the patients, and to ameliorate the sufferings of the patients’ problems. Several studies have indicated that the degree of dysfunction which may affect the overall performance of the patient. Also, the study emphasis the need for suitable depression management programmes that may help to improve the quality of life of the terminally ill cancer patients.

**FUTURE DIRECTIONS**

Since this study is one among a small series, so far conducted to explore the depression in terminally ill cancer patients. More research is needed in this field across centers and different population groups with larger sample size. More in-depth studies are required to probe more elaborately into the psychological, cultural and social dimensions of the problem. Case studies are to be given more importance as it helps in looking at the problem in an individualized manner for better results and effectiveness.

More intervention-based studies showing to assess the impact of short-term and long-term effects of stress management programmes, personality development programmes and life skills education development programmes are suggested.
SOCIAL WORK INTERVENTION METHODS

The two most important social work methods which are of use while dealing with the terminally ill cancer patients are social casework and social group work. They have been explained below.

Social case work method

In social casework method, the principles of casework, various approaches have to be integrated into the psycho-social intervention package. The basic aspects which need to be added are.

1. Crisis intervention
2. Client Centered Approaches.
3. Problem solving Approaches.

The social casework activities, which have to be integrated into the intervention package are social skills training, individual psycho-education, channelizing the coping strategies, strengthening the ego of the patient to face reality and providing basic supportive work like the creation of a social platform for ventilation, counselling, reassurance, strengthening the faith in the religion they believe etc. Since the study is not an intervention study the researcher could only provide supportive service in between the data collection sessions which itself proved immediate change in the patient’s outlook. It is beyond
doubts that if these above maintained services could be provided most salutary changes would result there from which would prove immensely helpful in alleviating the agony and distress of cancer victims and their families and in facing both life and death with equal courage and equanimity.

**Social group work method**

Social group work included basic group work principles, methods and applications. Use of these will be beneficial to the patient and relatives group.

1. Family centered counselling & Guidance
2. Family oriented Psycho-education
3. Social support through strengthening, buffering and connecting.
4. Support groups so as to benefit during times of emergencies and referrals.

**Therapeutic intervention**

The main aims of using therapeutic strategies are

1. To reduce anxiety, depression and other psychiatric symptoms.
2. To improve psychological adjustment to cancer by inducing a positive fighting spirits.
3. To promote in the patients a sense of personal control over their lives and active participation in the treatment of their illness.
4. To develop effective coping strategy for dealing with cancer-related problems.

5. To improve communication between the patient and the family and friends.

6. To encourage open expression of feelings particularly anger and other negative feelings.

7. To help family members realize their family burden and try other means to overcome it.

CONCLUSION

On evaluating the present study on a comparison with the past studies the former is found to support the conclusion of the latter that at the middle age people are more vulnerable to cancer and that the incidence of cancer rises steadily with the onset of middle age. The present as well as past studies agree on the point that dual role played by the couple is the major cause of family burden. It is revealed that husbands are more distressed than their wives. The majority of the terminally ill cancer patients on whom the present studies were conducted were less than SSLC educated. This was supported by Obert et al (1989) study. The finding of the present study that breast cancer is at a higher rate in the population corroborates with the results of the study conducted by (ICD-10:00-C 96). The conclusion drawn from this study that the incidence of cancer in the low income group reinforces the findings of the study conducted by The American Cancer Society. Pain is a marked feature of the
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distress. Hipowski, Barkwell, Dorrepaal, Patt in their study have expressed the same view that family interactions are poor can be noticed in the study by Bloom and Spiegel. Male patients are exhibiting more family burden than females. Vess, Moreland, Scjewebel say that families which are adaptable regarding role assignments exhibit greater competence in illness induced roles.

Case studies support the fact that lack of medical information as one of the cause for depression. This finding is supported by Christ(1987), Housts et al(1984), and Schag et al(1994) that unmet need of the patients were for information.

In summing up the findings of the current study and the past studies it could be said that all terminally ill cancer patients experience depression in different degrees irrespective of their age and gender.

The cause for depression is multi-farious and one cannot ascribe at a particular cause for it. The factors responsible for depression observed in the study were financial constraint, physical discomforts mainly pain and lack of sound sleep, lack of proper use of coping strategies, feeling of being a burden to others, lowered work efficiency etc. It can be concluded that if only psychotropic medication be safely and effectively used in the palliative care of terminally ill cancer patients will they be of use in helping these patients to live ahead.