



**Psychological Adjustment and Coping in Oncology Care:
A Composite Case Analysis**

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Abstract

Advanced cancer presents patients and their families with profound physical, psychological, and existential challenges. This paper presents a composite, anonymized case analysis of a patient undergoing palliative oncology care, focusing on psychological adjustment, coping mechanisms, and family-mediated decision-making. Drawing on clinical reflection and existing literature, the analysis explores the interplay of hope, distress, autonomy, and communication. Ethical considerations related to confidentiality and consent are discussed, and implications for psycho-oncological practice are highlighted.

Keywords: *psycho-oncology, palliative care, psychological adjustment, coping, family dynamics, end-of-life care.*

Introduction

Patients with advanced malignancies face a multidimensional burden that extends well beyond the physical manifestations of their disease. While the physiological consequences of cancer such as pain, fatigue, organ dysfunction, and treatment side effects are evident, the psychological and emotional impact is often profound and complex. Psychological sequelae in oncology commonly include anxiety, depression, demoralization, and existential suffering, which can be compounded by social isolation, role loss, and impaired daily functioning (Grassi & Riba, 2021; Rodin et al., 2015). The unpredictable trajectory of progressive cancer frequently precipitates a heightened sense of uncertainty and lack of control, which exacerbates psychological distress. Patients may experience oscillations between hope for recovery and despair about impending decline, creating a dynamic and often volatile emotional landscape.

The psychological response of patients is intrinsically linked to the social and familial context in which care occurs. Family involvement is particularly central in treatment decision-making, especially in end-of-life scenarios. Families often assume the role of surrogate decision-makers, balancing their desire to protect the patient from emotional harm with the ethical imperative of supporting autonomy (Johnstone & Kanitsaki, 2020). While the presence of family can provide comfort, advocacy, and continuity of care, it can also introduce complexity when familial expectations, beliefs, or protective instincts conflict with the patient's own understanding or desires. Protective behaviors, such as limiting disclosure of prognosis or mediating information, may preserve hope in the short term but can inadvertently contribute to psychological distress, feelings of mistrust, or confusion if patients sense withheld information or perceive inconsistencies in care.

In addition, the interplay between patient and family psychological states can influence clinical outcomes. Elevated stress within the family system has been associated with poorer coping in the patient, increased depressive symptoms, and reduced adherence to treatment recommendations (Kissane, 2015). Conversely, well-informed and emotionally supported family units can enhance resilience, facilitate adaptive coping, and contribute to meaningful end-of-life experiences. The integration of psycho-oncological principles into clinical care emphasizing communication, emotional support, and psychosocial assessment is thus critical to optimizing both patient and family well-being (Grassi et al., 2020).

This paper presents an anonymized, composite case of a patient with advanced gastrointestinal malignancy to examine these dynamics in a clinical context. The case synthesizes observations from multiple patients and interactions, highlighting the interplay of hope, psychological distress, physical symptom burden, and family-mediated decision-making. By analyzing the patient's psychological trajectory alongside family interactions and clinical interventions, the paper aims to elucidate the challenges and strategies inherent in providing holistic, patient-centered, and ethically sound care in palliative oncology settings.

Specifically, this analysis addresses three key dimensions: (1) the psychological adjustment of the patient in the face of progressive disease, symptom burden, and mortality awareness; (2) the role of family involvement and protective instincts in mediating information, treatment choices, and emotional support; and (3) the ethical and clinical implications of balancing patient autonomy with beneficence, particularly when navigating end-of-life decision-making. By reflecting on these domains, the paper provides insights into effective psycho-oncological strategies that can enhance coping, maintain dignity, and support meaningful decision-making for patients and families confronting the challenges of advanced cancer.

Case Narrative

The following case represents an anonymized composite of multiple patients with advanced gastrointestinal malignancies, synthesized to illustrate common psychological, familial, and clinical dynamics in palliative oncology care. All identifiers have been removed, and specific details have been altered to ensure confidentiality while retaining the clinical and psychosocial essence of the patient journey.

Patient Background:

The patient, a middle-aged adult diagnosed with advanced gastrointestinal cancer, initially underwent aggressive oncological treatment, which provided temporary symptom stabilization. Despite periods of physical improvement, the patient experienced intermittent abdominal discomfort and gastrointestinal complications, including intestinal obstruction. The family context included a spouse and a close family

member, both actively involved in care. The spouse assumed a central role in decision-making, motivated by protective instincts and a desire to maintain hope.

Stability and Optimism:

Following initial treatment, the patient demonstrated functional independence, including mobility, self-care, and meal participation. During this period, the patient maintained a positive outlook, demonstrating hope for recovery and active engagement with the healthcare team. Psychological resilience appeared high, and the patient expressed confidence in eventual return to normal life. Family members provided emotional support, reinforcing hope while navigating the practicalities of care coordination.

Emerging Complications and Psychological Stress:

Within several weeks, the patient began to experience worsening abdominal pain, edema, and difficulties with swallowing and nutrition. Medical evaluation confirmed persistent intestinal obstruction and declining organ function, rendering surgical intervention unfeasible. The patient's hope for a complete recovery was tested, producing heightened anxiety, frustration, and occasional irritability. Although the patient's optimism persisted, ambivalence and doubts regarding treatment efficacy emerged, reflecting a common oscillation between hope and despair observed in advanced cancer (Rodin et al., 2015).

Family-Mediated Disclosure and Ethical Tensions:

During this period, the patient's spouse requested that the prognosis and severity of disease progression be selectively withheld from the patient to protect emotional well-being. While this approach temporarily maintained the patient's sense of hope, it introduced tension in interactions with healthcare professionals and contributed to occasional mistrust and agitation. Structured counseling sessions were implemented to support family communication and mitigate potential conflict. The clinical team emphasized ethical considerations, balancing the principles of autonomy, beneficence, and non-maleficence, while respecting the spouse's protective role.

Psychological Decline and Crisis:

As physical symptoms intensified manifesting as generalized edema, respiratory difficulties, and declining renal and hepatic function—the patient exhibited signs of psychological distress, including withdrawal, verbal aggression toward nursing staff, and emergent depressive symptoms. Notably, the patient verbalized feelings of hopelessness and suicidal ideation, highlighting the impact of progressive physical decline on emotional well-being. Interventions included increased psycho-oncological support, psychiatric consultation, and

structured routines to reduce agitation and enhance patient engagement. Family counseling continued to mediate information-sharing, aiming to balance patient autonomy with emotional protection.

Transition to Home-Based and Palliative Care:

The patient expressed a strong desire to return home, citing comfort, autonomy, and personal dignity. Clinical discussions facilitated a gradual transition to home-based palliative care, integrating symptom management, nutritional support, and psychosocial interventions. This period highlighted the significance of patient-centered decision-making and the importance of aligning care plans with patient values and preferences. Family involvement remained crucial in supporting adherence to treatment, mitigating emotional distress, and facilitating practical care.

Terminal Phase and End-of-Life Experience:

During the terminal stage, the patient experienced further physiological decline, including worsening organ function, hospital-acquired infections, and reduced mobility. Psychological challenges included episodic hallucinations, delusions, and emotional volatility. Despite these challenges, the presence of family, particularly the spouse, provided emotional stabilization, fostering brief periods of acceptance and peace. Intensive palliative care ensured symptom relief, pain management, and dignity at end-of-life. The patient's final moments were characterized by calm and emotional resolution, reflecting the central role of compassionate care, family presence, and psychosocial support in terminal oncology care.

Key Observations from the Case Narrative:

1. The psychological trajectory illustrated an initial phase of resilience and hope, followed by escalating distress in response to progressive physical deterioration.
2. Family dynamics profoundly influenced patient experience, mediating both support and ethical complexity related to information-sharing.
3. Coping strategies evolved over time, with early adaptive engagement giving way to maladaptive withdrawal and agitation as symptoms worsened.
4. Clinical interventions including structured counseling, psycho-oncological support, and multidisciplinary coordination were critical in managing both physical and psychological challenges.

5. Ethical considerations, particularly balancing patient autonomy with family-mediated protective disclosure, were central to care decisions.

This composite case emphasizes the interconnectedness of physical symptom burden, psychological adjustment, and family-mediated decision-making in advanced oncology. It highlights the need for proactive psychosocial assessment, early intervention, and integration of ethical deliberation in palliative care settings.

Discussion

Psychological Adjustment and Coping

The composite case vividly illustrates the intricate interplay between hope, distress, and coping in advanced oncology care. Patients facing progressive malignancy often navigate a delicate balance between optimism and despair, particularly as physical deterioration challenges prior assumptions about recovery and control (Kissane, 2015). In the early phase of illness, patients may demonstrate resilience through engagement in daily routines, adherence to treatment regimens, and active participation in self-care, reflecting adaptive coping mechanisms. These behaviors not only support functional independence but also foster a sense of agency and control, which is critical in mitigating psychological distress (Lazarus & Folkman, 1984).

However, the progression of disease often introduces a tipping point where physical discomfort, symptom burden, and loss of autonomy overwhelm coping capacities. In this case, maladaptive coping manifested as withdrawal, irritability, aggression toward healthcare staff, and verbal expressions of hopelessness. These behaviors are consistent with findings in psycho-oncology research, which demonstrate that uncontrolled symptoms, perceived loss of control, and uncertainty about prognosis can precipitate emotional dysregulation, demoralization, and existential distress (Rodin et al., 2015; Breitbart et al., 2018).

Early identification of psychological distress is paramount. Clinicians can utilize standardized screening tools, such as the Hospital Anxiety and Depression Scale (HADS) or the Distress Thermometer, to detect subtle shifts in mood and cognition before they escalate to crises. Integrating both emotion-focused and problem-focused strategies can enhance coping. Emotion-focused interventions, including supportive counseling, mindfulness, and narrative therapy, help patients process feelings of loss and uncertainty. Problem-focused approaches, such as symptom management optimization and structured care planning, empower patients to regain a sense of control over their circumstances. By combining these strategies, healthcare teams can address both the emotional and practical dimensions of illness, thereby improving quality of life even in the context of progressive disease.

Family Dynamics and Decision-Making

Family involvement is a central feature in oncology care, particularly in terminal or high-risk scenarios. Family members frequently assume the role of surrogate decision-makers, balancing protective instincts with the patient's autonomy and right to informed decision-making. In this composite case, the spouse's mediating role in disclosure exemplifies a common ethical and psychological dilemma: withholding information to preserve hope may maintain short-term optimism, yet it risks exacerbating distress if the patient perceives inconsistency in communication or experiences unanticipated deterioration (Johnstone & Kanitsaki, 2020).

Research in psycho-oncology underscores the bidirectional influence between family dynamics and patient psychological adjustment. Emotional distress within family members, such as anxiety, guilt, or anticipatory grief, can amplify the patient's own stress and reduce adaptive coping (Northouse et al., 2012). Conversely, a supportive and informed family unit can enhance resilience, reinforce adherence to care, and provide critical emotional scaffolding. Structured communication protocols, such as the SPIKES model (Baile et al., 2000), are particularly valuable. By providing a stepwise framework for delivering difficult news, clinicians can navigate ethical complexities while maintaining empathy, transparency, and emotional support. These interventions can reduce patient anxiety, minimize conflict, and foster collaborative decision-making, particularly when prognosis and treatment limitations must be discussed.

Ethical Considerations

Ethical reflection is integral to both clinical care and scholarly reporting in oncology. Case studies must navigate confidentiality, informed consent, and the potential for harm. In this scenario, the patient's deceased status and the researcher's separation from the institution necessitated a composite, anonymized approach. By synthesizing multiple observations into a single narrative, the analysis preserves educational and clinical value without compromising privacy or ethical standards (American Psychological Association, 2020).

Beyond publication ethics, the case illuminates broader ethical challenges in clinical practice. Balancing the principles of beneficence, non-maleficence, and autonomy is a persistent concern in palliative care. Protective family behavior, while well-intentioned, can conflict with the patient's right to information and self-determination. Clinicians must navigate these tensions carefully, ensuring that families are supported while the patient retains dignity and agency. Ethical practice also requires vigilance for psychological crises, such as suicidal ideation or self-harm, particularly when patients experience physical decline, isolation, or reduced social support.

Implications for Practice

This composite case highlights several critical implications for psycho-oncological practice and clinical care. First, multidisciplinary collaboration is essential. Oncology teams, psycho-oncologists, psychiatrists, nursing staff, and social workers must coordinate to address the complex interrelations of physical symptoms, psychological distress, and family dynamics. Early integration of psycho-oncological interventions can improve patient adjustment, enhance communication, and prevent escalation of distress.

Second, clinicians should actively monitor both adaptive and maladaptive coping. Adaptive strategies such as engagement in routines, seeking social support, and expressing preferences should be reinforced, while maladaptive responses such as withdrawal, aggression, or hopelessness—require timely intervention. Routine psychological screening, coupled with structured interventions such as counseling, cognitive-behavioral therapy, or existential therapy, can improve patient resilience and quality of life (Breitbart et al., 2018).

Third, family education and counseling are critical. Providing guidance on communication, emotional support, and involvement in care can mitigate maladaptive dynamics and align family expectations with realistic outcomes. Structured discussions about prognosis, treatment options, and patient preferences can reduce conflict, enhance trust, and promote shared decision-making.

Finally, vigilance for psychological crises is crucial. Patients with progressive malignancy are at increased risk of suicidal ideation, self-harm, agitation, and severe withdrawal. Early psychiatric consultation, crisis planning, and continuous support can prevent escalation and ensure patient safety. Interventions should be individualized, taking into account patient values, family context, and cultural considerations, ensuring that care remains patient-centered and ethically sound.

Conclusion

This composite case underscores the multifaceted and dynamic interplay between psychological distress, coping mechanisms, and family-mediated decision-making in the context of advanced oncology care. The case demonstrates that patients with progressive malignancy do not experience illness solely as a physical phenomenon; rather, their emotional, cognitive, and social experiences are inextricably linked to symptom burden, prognosis awareness, and the quality of interpersonal support. Psychological distress, including anxiety, depression, and demoralization, often arises in response to perceived loss of control, uncertainty about the future, and the challenges of navigating complex medical decisions. At the same time, patients exhibit adaptive coping strategies, such as maintaining routines, engaging in social interactions, and relying on supportive family members, which can buffer the impact of illness and foster resilience (Kissane, 2015; Rodin et al., 2015). Family-mediated decision-making, while often protective, introduces both opportunities and challenges. Families can serve as crucial advocates, providing emotional support, ensuring adherence to

treatment, and maintaining continuity of care. However, protective behaviors— such as withholding full disclosure of prognosis—may unintentionally exacerbate distress or reduce trust if the patient perceives inconsistencies or experiences unanticipated deterioration. This case highlights the ethical complexities inherent in balancing patient autonomy, beneficence, and non-maleficence, particularly in palliative and end-of-life contexts. Structured communication frameworks and family counseling are essential strategies to navigate these challenges while preserving the patient’s dignity and sense of agency (Baile et al., 2000; Johnstone & Kanitsaki, 2020).

Importantly, this analysis reinforces the necessity of a multidisciplinary, patient-centered approach in oncology care. Integrating psycho-oncological interventions, nursing support, psychiatric consultation, and medical management ensures that both physical and psychological needs are addressed simultaneously. Early identification of psychological crises, including suicidal ideation, agitation, and withdrawal, allows for timely intervention, which is crucial in mitigating suffering and enhancing quality of life. Moreover, family education and structured involvement are central to promoting collaborative decision-making, reducing conflict, and aligning care with the patient’s values and preferences.

Even in the absence of direct patient data, composite and anonymized case analyses provide significant educational and clinical value. They offer nuanced insights into the interconnections between psychological adjustment, symptom burden, and family dynamics, while upholding ethical standards of confidentiality and respect. Such reflective analyses can guide clinicians in anticipating common psychological and ethical challenges, inform the development of supportive care protocols, and shape training in psycho-oncology practice.

Finally, this case highlights the broader implications for research and clinical innovation in oncology. Understanding how patients and families navigate hope, distress, and decision-making can inform the design of interventions that enhance resilience, improve symptom management, and foster meaningful engagement at the end of life. By emphasizing the integration of emotional, ethical, and social dimensions into oncology care, clinicians and researchers can contribute to the development of holistic, evidence-based approaches that uphold patient dignity, support family functioning, and optimize psychological well-being in the context of terminal illness.

In conclusion, the composite case provides a compelling illustration of the complex psychological and ethical terrain in advanced cancer care. It reinforces the critical importance of proactive psychosocial assessment, transparent communication, family collaboration, and multidisciplinary intervention, demonstrating that these strategies are essential not only for improving patient outcomes but also for ensuring compassionate and ethically sound care at the end of life.

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