Brief Report

Is Higher Acceptance Associated With Less Anticipatory Grief Among Patients in Palliative Care?

Esther L. Davis, BSc(Hon), Frank P. Deane, PhD, Diploma in Clinical Psychology, MSc, BSc, Geoffrey C.B. Lyons, PhD (Clin Psyc), BSc(Hon), and Gregory D. Barclay, MBBS, FRACGP, FAChPM

School of Psychology and Illawarra Institute for Mental Health (E.L.D., F.P.D.), University of Wollongong, Wollongong NSW, Australia; School of Psychological Sciences (G.C.B.L.), Australian College of Applied Psychology, Sydney NSW, Australia; Graduate School of Medicine (G.D.B.), University of Wollongong, Wollongong NSW, Australia; and Palliative Care Services (G.D.B.), Illawarra Shoalhaven Local Health District, Port Kembla NSW, Australia

Abstract

Context. Patients in palliative care can experience substantial psychological suffering. Acceptance-based interventions from approaches such as Acceptance and Commitment Therapy have demonstrated effectiveness in helping people cope with a range of life challenges. However, there is a dearth of research examining mechanisms of therapeutic change for patients in palliative care.

Objectives. To assess the relationships between acceptance, anticipatory grief, anxiety, and depression among patients in palliative care.

Methods. A cross-sectional survey was verbally administered to inpatients ($N = 73$) receiving palliative care.

Results. Correlations revealed that acceptance had a strong relationship with anticipatory grief, anxiety, and depression. A hierarchical regression analysis on anticipatory grief showed that acceptance was the largest predictor and accounted for an additional 13% of variance in anticipatory grief over and above anxiety and depression.

Conclusion. The present study provides preliminary data suggesting that interventions that target acceptance may be indicated in patients in palliative care. J Pain Symptom Manage 2017;54:120−125.

Key Words

Palliative care, acceptance, grief, anxiety, depression

Introduction

Acceptance and Commitment Therapy (ACT) proposes that a central factor underlying psychopathology is an unwillingness to remain in contact with unwanted private events (e.g., distressing or unpleasant thoughts, feelings, sensations, and memories) and includes attempts to change, avoid, or eliminate these events.[1] This process is known as experiential avoidance, which is the opposite term to our use of acceptance. It leads to a paradoxical increase in the unwanted private events, which ultimately acts to maintain and exacerbate psychological distress.[2,3] Experiential avoidance becomes problematic when it is rigidly applied to unwanted private events and the time and energy spent in avoidance behaviors comes at the expense of pursuing what is important and meaningful in one's life.[4−6] Through acceptance and mindfulness processes, and commitment and behavior change processes, the aim of ACT is to enable individuals to engage in meaningful and fulfilling activities in the presence of whatever unwanted private events may arise.[7] The ability to let thoughts and feelings unfold as they are in the present moment and to adjust values-directed behavior depending on what the situation demands is known as psychological flexibility.[8] It is proposed that psychological flexibility is a

Address correspondence to: Esther L. Davis, BSc(Hon), Illawarra Institute for Mental Health (B22), University of Wollongong, Wollongong, New South Wales 2522, Australia. E-mail: eld458@uowmail.edu.au

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fundamental aspect of psychological health, with its presence corresponding with well-being and its absence implicated in the development of psychopathology.[8]

A recent meta-analytic review showed that ACT is effective in treating a number of psychological disorders, including depression, anxiety, and addiction.[9] Acceptance has consistently been identified as a significant mediator of effects in ACT intervention outcomes.[2,10] Furthermore, experimental studies have shown significant differences in psychological distress and distress tolerance between individuals with high vs. low levels of acceptance or who engage in a suppression (avoidant) vs. acceptance strategy to manage uncomfortable thoughts and feelings.[11]

As a core component of psychological flexibility, acceptance is beneficial in situations involving circumstances that one can exert little or no control over,[12,13] like chronic pain.[14,15] Distressing thoughts and feelings are common and normal for patients in palliative care, and the illness at the center of their difficulties is not going to go away. Acceptance within this context is an active process where the patient acknowledges and opens up to all aspects of their current situation, whether physical or emotional, so as to make the most of the time they have in the present.[16] Theoretically, higher levels of acceptance would be expected to lead to a reduction in psychological suffering by enabling patients to sit with and explore their feelings in a nonjudgmental and curious manner. This would help make the experience of having unwanted feelings more manageable and viewed less negatively, and ultimately less encumbered to engage in what matters most to them. Importantly, the philosophical and theoretical basis of ACT applies to the human condition rather than psychopathology exclusively.[8] Thus, although patients may naturally be distressed at end of life, it is not necessary that they have any particular diagnosis to benefit from intervention focused on increasing acceptance.

Patients in palliative care can experience considerable psychological suffering. The most commonly diagnosed mental health disorder is depression, with estimates of 20%,[17,18] whereas anxiety prevalence is estimated at 14%.[18] Both depression and anxiety have been implicated in pain severity and desire for a hastened death.[19,20] Anticipatory grief occurs in response to impending loss of life as well as loss of identity, function, hopes, and future plans.[21,22] It is associated with anxiety, depression, and hopelessness[23,24] and is implicated in strained communication within families.[21] However, there is a dearth of research investigating anticipatory grief in patients. To the authors' knowledge, no research has investigated psychological processes implicated in the development and maintenance of problematic levels of patient anticipatory grief, such as acceptance. A greater awareness of such clinical correlates would be highly useful in providing more targeted and effective support.

Low et al.[25] conducted the only known study investigating the role of acceptance from an ACT perspective among patients in palliative care. They identified acceptance as sharing a strong negative relationship with psychological distress and that it was a significant predictor. Furthermore, patients who received psychotherapy had significantly higher acceptance scores and the authors concluded that psychological morbidity might be reduced by improving patients' acceptance using ACT.[25] Thus, acceptance in general and acceptance specific to end-of-life issues have the potential to allow patients to live their remaining days less impacted by psychological suffering.

The aim of the present study was to assess the relationships between acceptance with anticipatory grief, anxiety, and depression among patients in palliative care. It is hypothesized that acceptance will be negatively related to anticipatory grief, anxiety, and depression and will be an independent predictor of levels of anticipatory grief over and above anxiety and depression.

Methods

Participants

Participants were patients from two inpatient palliative care units within the South Coast of NSW, Australia. They were recruited between March 2014 and August 2016. To be eligible for participation, patients needed to be aged 18 years or older; diagnosed with a life-limiting illness; recognized by their treating physician as being in the last 6 months of life; identified by clinical staff as physically and mentally willing and able to participate; and have sufficient comprehension of English to be able to understand and complete the study documents.

Measures

Patient sociodemographics and clinical characteristics were obtained from medical records and self-report, including age, gender, marital status, education, ethnicity, religion, and primary medical diagnosis and treatment history.

Acceptance. Acceptance was measured by the Acceptance and Action Questionnaire—II.[26] The AAQ-II contains seven items with statements (e.g., "I'm afraid of my feelings"), which are rated on a seven-point Likert-type scale of 1 (never true) to 7 (always true). We reversed scores so that higher scores indicate greater acceptance. It has demonstrated good reliability and validity in a sample of community