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Psychosocial palliative care: Patients' preferred intervention medium, target domains, and well-being priorities

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Abstract

Objectives. Although psychological distress in palliative patients has at least an equal or greater impact on the quality of life compared to physical or spiritual distress, there is limited research on contextual factors associated with psychosocial intervention accessibility and relevance. This is the first published study to explore patients' views on psychosocial intervention delivery medium preferences, key biopsychosocial target domains, and well-being priorities during the palliative and end-of-life (EOL) phases.

Methods. Eighty-one palliative patients from a Specialist Palliative Care Service completed a questionnaire, which collected quantitative and qualitative data on preferred mediums for receiving psychosocial interventions, priority biopsychosocial target domains, and well-being priorities during the palliative and EOL phases.

Results. Results showed that an individual in-person was the most preferred medium for receiving psychosocial interventions. Improving quality of life, distressing emotions, and adjusting to the palliative care context were the 3 most frequently endorsed biopsychosocial target domains. Valued living and comfortable living were the key priority well-being themes for the palliative phase, whereas being surrounded by loved ones and comfortable and dignified dying were the priority well-being themes for the EOL phase.

Significance of results. Findings highlight psychosocial interventions as an essential part of a holistic approach to patient-centered care throughout both the palliative and the EOL phases. Results can inform the refinement of existing and the development of new psychosocial interventions, particularly those that target emotional distress, adjustment, and quality of life. Furthermore, in-person treatment delivery remains essential in an evolving digital world.

Introduction

For those living with a palliative illness, the physical, psychosocial, and spiritual domains can contribute independently or jointly to the experience of suffering. As such, modern palliative care aims to embody a multidisciplinary team approach to the treatment of patients with life-threatening illness (Worldwide Palliative Care Alliance 2020). Despite this aim, psychosocial palliative approaches continue to remain secondary to the physical palliative approach (Rodin 2018), with a lack of focus on the contextual factors that may increase their accessibility and relevance for palliative patients (Warth et al. 2019). As psychosocial distress in the form of depression, anxiety, and adjustment disorders are experienced in 29–40% of palliative patients (Mitchell et al. 2011; Yohannes and Alexopoulos 2014), access to effective psychosocial interventions that reduce distress and enhance well-being is essential. Hence, the purpose of this study is to understand the preferred psychosocial intervention delivery mediums, key biopsychosocial target areas, and well-being priorities during the palliative and end-of-life (EOL) phases.

Psychosocial intervention delivery mediums

Palliative care has long prided itself on the provision of a traditional in-person approach within outpatient settings and the patient's place of residence (Hawkins et al. 2020). This in-person approach has persisted for palliative psychosocial interventions despite frequent barriers including severe patient illness, transportation difficulties, and geographical isolation, leading to calls for alternative intervention mediums to be explored (Azuero et al. 2014; Ftanou et al. 2017; Kasl-Godley et al. 2014). Aligned with this, the COVID-19 pandemic has necessitated a rapid transition to telehealth (e.g., phone and videoconferencing) and self-help interventions within palliative care internationally (Dolan et al. 2021).

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Similar to the benefits of telehealth within the mental health sector (Langarizadeh et al. 2017), psychosocial telehealth interventions within palliative care have demonstrated increased quality of care via improved access, greater efficiency, reduced costs, and increased patient satisfaction (Guzman et al. 2020; O'Brien et al. 2008; Rahman et al. 2020). The feasibility and efficacy of self-help interventions specifically for palliative patients are limited. A systematic review and meta-analysis of 25 quantitative studies of non-palliative physical health conditions found that self-help interventions based on a theoretical model (e.g., cognitive behavioral therapy) were effective in improving depression and anxiety symptoms (Matcham et al. 2014).

Although the recent uptake and growing evidence for the efficacy of alternative delivery mediums in the provision of psychosocial palliative care shows promise, telehealth and self-help mediums also have their limitations. For telehealth, this can include poor phone/internet connectivity, technology reluctance or incompatibility with personal devices, and self-consciousness being on video (Guzman et al. 2020). For self-help, the content may not align with the patient's unique experience, and fluctuating health may necessitate more flexibility in the completion of the intervention tasks (Proctor et al. 2018). Patients' preference for in-person, telehealth, or self-help intervention mediums may also influence psychosocial intervention uptake and efficacy. The present study will ask palliative patients about their preferred medium for receiving psychosocial interventions as this is yet to be explored.

Biopsychosocial target domains

Unlike the more traditional delivery of psychotherapy via multiple 50-minute consultations over a relatively lengthy period, the provision of psychosocial support within a palliative setting requires a more rapid pace across shorter and fewer sessions (Kasl-Godley et al. 2014). A retrospective chart review of palliative care psychology referrals within a comprehensive cancer center found that 70% of referrals received 1–2 psychology sessions, with the first session being the initial assessment (Ann-Yi et al. 2018). As time is of the essence, having knowledge of the most common biopsychosocial domains for which palliative patients seek assistance will assist researchers to trial targeted interventions to assist clinicians to respond rapidly and effectively.

One such domain is the increasing evidence of an association between palliative psychological distress and loss of life meaning and purpose (Rosenfeld et al. 2017). For this reason, there has been a substantial focus on multiple meaning centered on psychotherapies such as Dignity Therapy, Meaning-Centered Psychotherapy in group and individual formats, and Managing Cancer and Living Meaningfully. However, palliative patient distress is not limited to the existential, and a review of 59 multicomponent palliative care articles by Kozlov et al. (2018) found that “psychosocial support” was the most common description of psychological intervention provided. What is specifically being targeted by this nondescript intervention remains unclear. No published study has asked palliative patients their priority for biopsychosocial domains; hence, this study will obtain a patient-centered perspective on the biopsychosocial domains for which psychosocial assistance is most sought.

Well-being priorities during palliative and EOL phases

Living with a palliative illness is generally divided into 2 phases, the palliative phase where death is not predicted to be imminent and the EOL phase where death is expected within days to a few weeks.

Regarding the palliative phase, a systematic review of 23 quantitative, qualitative, and mixed-methods studies by Sandsdalen et al. (2015) found that patients prioritized living a meaningful life, which consisted of upholding one's sense of self, doing pleasurable activities, engaging within meaningful relationships, and sustaining hope for the future. Health-care professionals, the care environment, and the palliative care organization were also prioritized by patients to assist them in living meaningfully. Regarding the EOL phase, maintaining awareness and engagement in the present moment (i.e., mindfulness), spending time with family and friends, and adequate symptom control were essential priorities for a sample of palliative care inpatients (Romotzky et al. 2019).

The above research suggests that during the palliative phase, the primary priority is living a multifaceted meaningful life, with palliative care services assisting to achieve this. This is consistent with the concept of “double awareness” where death awareness is coupled with an awareness that there remains life to be lived (Rodin and Zimmermann 2008). Once EOL emerges, the priorities narrow, and death awareness becomes the primary foci. A meaningful life is achieved through sustained engagement in meaningful relationships in the present moment, while the provision of palliative care is more focused on symptom control. To our knowledge, no published study has specifically explored different priorities during the palliative and EOL phases within the same cohort. Continuing to clarify differing priorities at different disease stages is important for psychosocial interventions to ensure their relevance and efficacy (Rodin 2013). Hence, in the present study, we ask patients to identify their well-being priorities at the palliative and EOL phases.

The current study

This study has 3 aims. The first is to obtain a palliative patient perspective as to the preferred medium of receiving psychosocial interventions. The second aim is to obtain a palliative patient perspective as to the preferred biopsychosocial target domains. The third aim is to explore the well-being priorities during the palliative and EOL illness phases of a cohort of palliative patients. In view of the lack or absence of prior research on patient's views on psychosocial intervention medium preferences, key biopsychosocial target domains, and well-being priorities, investigation of the corresponding aims is exploratory.

Method

Recruitment and procedures

This research was a component of a larger project conducted within a Specialist Palliative Care Service in Queensland, Australia. This multidisciplinary service provides community and inpatient care for adult patients who have a palliative illness (malignant and non-malignant) with a prognosis of 12 months or less. Palliative patients were recruited by palliative care clinicians (including the principal researcher – clinical psychologist) through multiple points of care including outpatient clinics, community home visits, and inpatient admissions. A summary of the recruitment eligibility criteria is provided in Table 1.

After identification by a palliative care clinician, patients were provided with an information sheet, and written consent was obtained. The questionnaire was provided to participants in their preferred format (hard copy or online).

This research was approved by The Prince Charles Hospital Human Research Ethics Committee (HREC/2018/QPCH/43969) and ratified by the University of Queensland HREC.

Table 1. Eligibility criteria

Inclusion criteria	Exclusion criteria
Patient of the Specialist Palliative Care Service	Receiving curative treatment
Adult (18 to 100+ years)	Receiving psychological treatment
All diagnoses eligible	Capacity to consent is impaired
Palliative Care Outcomes Collaboration score:	Palliative Care Outcomes Collaboration score:
Phase: 1	Phase: 2–5
RUG-ADL: 4–10	RUG-ADL: 10+
AKPS: 60 or above	AKPS: 50 or below

Note: The Palliative Care Outcomes Collaboration is an Australian national program, which provides a common language for systematically assessing palliative patients' clinical condition using standardized clinical assessment tools to improve patient outcomes. For further information visit the website: <https://ahsri.uow.edu.au/pcoc/index.html>. RUG-ADL, Resource Utilisation Groups-Activities of Daily Living; AKPS, Australia-modified Karnofsky Performance Status.

Participants

Of the 674 palliative patients screened for study participation, 539 (80%) patients were ineligible due to poor health, currently receiving psychological support, or cognitive impairment. One hundred and thirty-five screened patients met eligibility criteria (20%); however, 35 declined to participate, with the most common reasons being lack of interest or conflict with health-related appointments. One hundred palliative patients provided written consent to participate in the study (15%). Eighty-one completed the questionnaire (12%) with health decline as the primary reason for not commencing the study. Demographic and palliative context data for participants is shown in Table 2.

Measures

The questionnaire obtained information on demographics, as well as in palliative context (e.g., diagnosis and preferred place of death). To explore the preferred medium for receiving psychosocial support, participants were asked to rank 6 delivery mediums on a Likert scale from the most (1) to the least (6) preferred. The 6 delivery mediums were in-person (individual), in-person (group), telephone (voice only), telephone (video and voice), self-directed (booklet), and self-directed (online). To explore biopsychosocial target areas for psychological intervention, participants were asked to endorse areas listed in a 10-item checklist of psychological support areas that they would like to receive support. The 10 psychosocial support areas were improving quality of life, distressing emotions, adjustment to (illness, circumstances, and other), distressing thoughts, non-pharmacological pain management, non-pharmacological sleep strategies, communication and relationship concerns, existential concerns, unhelpful behaviors, and others. Lastly, to investigate palliative patients' well-being priorities, 2 open-ended questions asked participants to list the 3 most important things (i) when living with a palliative illness and (ii) at EOL.

Data analysis

Quantitative data generated by the intervention delivery medium preferences were subjected to mean ranking analysis. The 6 individual delivery mediums were ranked as the grouping of

Table 2. Palliative patient demographic and palliative context variables

Variables	<i>n</i>	%	<i>M</i>	<i>SD</i>	Min.	Max.
Age			69.61	9.83	45	93
Gender						
Male	41	51.25				
Female	40	48.75				
Relationship status						
Single (never married)	5	6.17				
Married/domestic partnership	53	65.43				
Widowed	14	17.28				
Divorced/separated	9	11.11				
Primary carer						
Spouse/partner	49	60.49				
Parent/sibling/child	11	18.51				
Friend/professional carer	7	8.64				
No primary carer	10	12.35				
Place of residence						
Own home	60	74.07				
Rental accommodation	13	16.05				
Family/friend's home	5	6.17				
Residential aged care facility	3	3.70				
Preferred end-of-life location						
Home	43	53.09				
Hospital – general	2	2.47				
Hospital – palliative care unit	26	32.10				
Hospice	6	7.41				
Residential aged care facility	3	3.70				
Unsure	1	1.23				
Time of palliative diagnosis						
At the point of initial diagnosis	38	46.91				
After the period of curative treatment intent	43	53.09				
Years between curative to palliative prognosis			4.78	8.24	0.08	37.17
Years living with a palliative prognosis			1.80	3.61	0.00	21.50

Note: SD, standard deviation; Min., minimum; Max., maximum.

the mediums into their respective pairs (in-person, telephone, and self-directed). One-way analysis of variance (ANOVA) with Bonferroni correction applied to post hoc comparisons was performed with the medium pairs, with parametric statistics

Table 3. Palliative patient intervention delivery medium preference

Treatment delivery medium	95% CI			Rank preference ^a					
	Mean rank	LL	UL	1	2	3	4	5	6
Preferences for specific modalities									
In-person (individual)	1.64	1.28	1.99	79.71% (55)	4.35% (3)	5.80% (4)	0.00% (0)	2.90% (2)	7.25% (5)
In-person (group)	3.16	2.85	3.46	5.80% (4)	28.99% (20)	30.43% (21)	17.39% (12)	13.04% (9)	4.35% (3)
Telephone (voice only)	3.77	3.47	4.07	4.35% (3)	5.80% (4)	36.23% (25)	27.54% (19)	14.49% (10)	11.59% (8)
Telephone (video and voice)	3.87	3.53	4.21	5.80% (4)	15.94% (11)	13.04% (9)	28.99% (20)	23.19% (16)	13.04% (9)
Self-directed (booklet)	4.33	3.99	4.67	2.90% (2)	13.04% (9)	10.14% (7)	17.39% (12)	34.78% (24)	21.74% (15)
Self-directed (online)	4.23	3.80	4.66	1.45% (1)	31.88% (22)	4.35% (3)	8.70% (6)	11.59% (8)	42.03% (29)
Preferences for modality groupings									
In-person (individual and group)	2.40	2.13	2.66	85.51% (59)	33.33% (23)	36.23% (25)	17.39% (12)	15.94% (11)	11.59% (8)
Telephone (voice only and video/voice)	3.82	3.59	4.04	10.14% (7)	21.74% (15)	49.28% (34)	56.52% (39)	37.68% (26)	24.64% (17)
Self-directed (booklet and online)	4.28	4.01	4.55	4.35% (3)	44.93% (31)	14.49% (10)	26.09% (18)	46.38% (32)	63.77% (44)

Notes: Italic indicates the highest endorsement for each of the 6 rankings. CI, confidence interval; LL, lower limit; UL, upper limit.
^a1, most preferred; 6, least preferred.

considered robust when applied to ordinal scales and ranked data (Carifio and Perla 2007; Hager 2007; Norman 2010). Quantitative data generated by the endorsement of biopsychosocial target areas were subjected to descriptive analysis including frequencies and percentages of the total number of respondents.

Responses to the open-ended questions asking participants to list the 3 most important things during the palliative and EOL phases were subjected to thematic analysis in accordance with Braun and Clarke's (2006) 6-step process. First, the researcher familiarized himself with the data, which involved reading the data multiple times and documenting recurrent responses and ideas. Second, specific patterns and features of the data were grouped, and initial codes were generated. Third, the relationships between the codes were used to organize them into subthemes, which represented overarching themes. Fourth, overarching themes were reviewed and refined to check for consistency with the respective subthemes and in relation to the entire data set. Fifth, themes and subthemes were defined and labeled. Sixth, the total number and percentage of participants who mentioned a theme were calculated. Two sample responses were selected to illustrate each subtheme within an overarching theme or a theme without subthemes.

Relations between the 3 focal study outcome variables (intervention delivery preferences, biopsychosocial target preferences, and well-being priorities) and the demographic (gender, relationship status, and place of residence) and palliative context (primary carer, preferred EOL location, and time of palliative diagnosis) background variables were examined using chi-square tests. Background variables were recategorized as required to ensure at least 5 participants per group. Given the large number of chi-square tests conducted, a significance level of $p < .01$ was used to reduce the risk of type-I error.

Results

Psychosocial intervention delivery mediums

A total of 69 participants ranked the 6 psychosocial intervention delivery mediums. The percentage of participants ranking each medium and the mean rankings are summarized in Table 3.

The preference for the majority of participants (79.71%) was for in-person (individual) delivery. The other 5 delivery mediums have similar but markedly lower levels of support with ordering of ranks from 2 to 6 as follows: in-person (group), telephone (voice only), telephone (video and voice), self-directed (online), and self-directed (booklet).

The intervention delivery mediums were combined into their respective pairs (in-person, telephone, and self-directed), and a mean ranking was calculated for each pair. The highest to lowest mean rankings were in-person, telephone, and self-directed delivery. A one-way ANOVA was conducted with a significant difference found between the medium pairs, $F(2,411) = 58.05$, $p < 0.001$. Post hoc comparisons showed in-person intervention delivery ($M = 2.40$, $SD = 1.57$) to be significantly preferred over both the telephone ($M = 3.82$, $SD = 1.34$) and self-directed ($M = 4.28$, $SD = 1.62$) and that telephone was significantly preferred over self-directed intervention delivery.

Biopsychosocial target domains

A total of 76 participants endorsed one or more biopsychosocial target domains. Most participants (92.11%, $n = 70$) endorsed between 1 and 4 domains and 7.89% ($n = 6$) endorsed 5 to 6 domains. The most frequent number of domains endorsed was 2 at 30.26% ($n = 23$), followed by 23.68% ($n = 18$) endorsing 3 domains and 21.05% ($n = 16$) endorsing 1 domain. As shown in Figure 1, the most frequently endorsed biopsychosocial target domain was improving the quality of life, followed by distressing emotions and adjustment to (illness, circumstance, and other). Regardless of the number of domains the participants endorsed, improving the quality of life was the most frequently endorsed target domain. The least frequently endorsed domains were existential distress, unhelpful behaviors, and others.

Well-being priorities during palliative and EOL phases

A total of 80 participants responded to the request to list the 3 most important things when living with a palliative illness, and of these, 83.75% listed 3, 11.25% listed 2, and 5% listed 1. Responses fell into

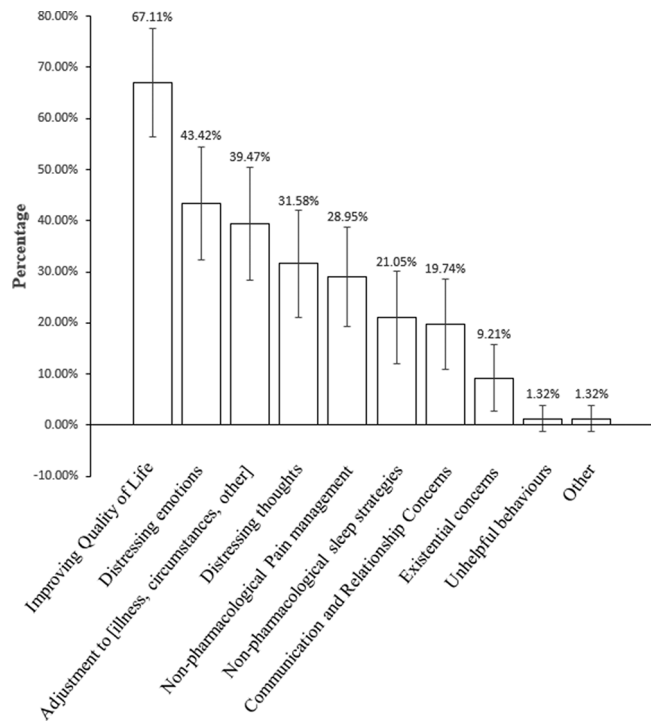


Fig. 1. Biopsychosocial Treatment Priorities.

2 themes. The first theme was valued living ($n = 53$; 66.25%), which consisted of 2 subthemes: (i) time with loved ones ($n = 42$; 79.25%) and (ii) activity engagement ($n = 26$; 49.06%). The second theme was comfortable living ($n = 58$; 72.50%), which consisted of 3 subthemes: (i) pain free ($n = 32$; 55.17%), (ii) mental health ($n = 27$; 46.55%), and (iii) health care ($n = 15$; 25.86%). Theme descriptions and sample responses are outlined in Table 4.

A total of 75 participants responded to the request to list the 3 most important things at EOL, and of these, 72% listed 3, 17.3% listed 2, and 10.6% listed 1. Responses fell into 2 themes. The first theme was being surrounded by loved ones ($n = 44$; 58.66%). The second theme was comfortable and dignified dying ($n = 68$; 90.66%), which consisted of 3 subthemes: (i) pain free ($n = 42$; 61.76%), (ii) dying preferences ($n = 33$; 48.53%), and (iii) inner peace ($n = 23$; 33.82%). Theme descriptions and sample responses are outlined in Table 5.

Relations between background variables and study outcome variables

Chi-square tests were used to examine relations between the 3 study outcome variables and the background variables. Regarding intervention delivery medium preferences, only the first rank preference data of each of the grouped intervention delivery mediums were examined. Due to the small number of participants who ranked the telephone and self-directed medium groupings, they were merged, leaving 2 groupings for the analysis (in-person and telephone/self-directed). Eight of the 10 biopsychosocial target domains were examined due to 2 domains (“unhelpful behaviors” and “other”) having a single response each. Finally, the 2 well-being priority themes for each of the palliative (valued living and comfortable living) and EOL (surrounded by loved ones, comfortable, and dignified dying) phases were examined. None of the chi-square tests reached the assigned significance level $p < 0.01$,

Table 4. Palliative patients’ palliative phase well-being priorities

Theme/subtheme	n (%)	Sample responses
<i>Theme: valued living</i>		
Engaging in meaningful activities that sustain one’s desired life		
<i>Subtheme: time with loved ones</i>		
Prioritizing time spend with family and friends	42 (79.25)	“Enjoying life with family and friends” “As much time as possible with family” “Family connections”
<i>Subtheme: activity engagement</i>		
Continuing to independently engage in chosen activities	26 (49.06)	“Staying as active as possible” “Getting out in nature and walking everyday” “Able to participate in my hobbies”
<i>Theme: comfortable living</i>		
The experience of minimal physical or emotional discomfort with access to health care to optimize the quality of life		
<i>Subtheme: pain free</i>		
Relief from pain through adequate management and control	32 (55.17)	“To be pain free” “Pain management”
<i>Subtheme: mental health</i>		
Positive emotional state, minimal stress, and mental clarity	27 (46.55)	“Staying positive” “Enjoyment” “Having a clear mind”
<i>Subtheme: health care</i>		
Access to and receipt of health-care services	15 (25.86)	“Support from palliative care unit” “Assistance at home” “Genuine Care”

suggesting that the measured demographic and palliative context variables were unrelated to intervention delivery preferences, biopsychosocial target preferences, and well-being priorities.

Discussion

The 3 aims of the present study were to obtain palliative patients’ perspectives on preferred mediums of receiving psychosocial interventions, priority biopsychosocial target domains, and well-being priorities during the palliative and EOL illness phases. The results related to each of these 3 aims are discussed below.

Psychosocial intervention delivery mediums

Results demonstrated that in-person (individual) was the most preferred medium for receiving psychosocial interventions for palliative patients, with limited differentiation between the remaining 5 intervention delivery mediums based on the mean rank for each one. This finding is noteworthy given the rapid rise and utilization of telehealth due to the COVID-19 pandemic, which has been shown to increase intervention access, efficiency, and satisfaction

Table 5. Palliative patients' EOL phase well-being priorities

Theme/subtheme	n (%)	Sample responses
<i>Theme: surrounded by loved ones</i>	44 (58.66)	"To have people who love me around me"
Having loved ones present including family, friends, and pets		"Close family with me" "Children company" "Having everyone I want around me including the dog"
<i>Theme: comfortable and dignified dying</i>	68 (90.66)	
The experience of minimal physical or emotional discomfort in a chosen environment that respects the patients' dying wishes		
<i>Subtheme: pain free</i>	42 (61.76)	"Dying with no pain"
Relief from pain through adequate management and control		"Free of pain as much as possible"
<i>Subtheme: dying preferences</i>	33 (48.53)	"To have music playing"
Having medical, environmental, and atmosphere desires met		"Not to have tubes coming out of me" "Not prolonged" "Comfortable environment at home"
<i>Subtheme: inner peace</i>	23 (33.82)	"Being at peace"
Achieve a sense of closure and acceptance with life lived and what follows death		"Peace of mind" "Faith in God"

compared with in-person treatment (Langarizadeh et al. 2017), and is likely to become integrated into health systems beyond the pandemic (Hays and Skootsky 2022).

Nonetheless, despite telehealth gaining momentum and demonstrating benefits, results of research conducted with general (Predmore et al. 2021) and physical and mental health-care (Rasmussen et al. 2022) populations support the present finding that in-person health care is preferred by most palliative care patients. Furthermore, Predmore et al. also found that in-person health care was the most valued delivery medium with only 3.9% of community adults willing to pay more for telehealth than in-person. As palliative care clinicians take stock of how they provided psychosocial care during the COVID-19 pandemic, in the post-pandemic world patient-centered care must take precedence regardless of the intervention delivery medium used (Sansom-Daly and Bradford 2020). This is especially important in the field of palliative care as palliative patients are a complex population with diverse needs (Cherniwchan 2022).

Biopsychosocial target domains

Consistent with the primary aim of palliative care (Worldwide Palliative Care Alliance 2020), improving quality of life was the most frequently endorsed biopsychosocial target domain for palliative patients. What constitutes quality of life is person-centric;

thus, this finding serves as a reminder of the importance of collaboratively determining meaningful and achievable goals of care that will improve quality of life as perceived by the individual (Milazzo et al. 2020).

Given that depression, anxiety, and adjustment disorders are experienced by 29–40% of palliative patients (Mitchell et al. 2011; Yohannes et al. 2000), and psychological distress has at least an equal or even greater impact on the quality of life compared to physical or spiritual distress in palliative patients (Blinderman et al. 2008; Kutner et al. 2007), it is unsurprising that the second and third most frequently endorsed target domain for which support was sought was distressing emotions and adjustment to [illness, circumstances, and other], respectively. A more surprising finding was that existential concerns were endorsed by less than 10%, particularly given the association between palliative psychosocial distress and loss of life meaning and purpose, and the prominence of meaning-centered psychotherapies for palliative patients (Rosenfeld et al. 2017).

Currently, the evidence supporting the efficacy of psychological interventions in improving psychosocial distress within palliative care is limited (Ftanou et al. 2017). Meaning-centered therapies have demonstrated mixed results (Johnson 2018), and cognitive behavioral therapy (CBT) has been shown to enhance coping when an acceptance-based component has been incorporated (Greer et al. 2012; Wells-Di Gregorio et al. 2019). Research evaluating these interventions has identified acceptance and life meaning as key intervention targets in palliative care. A modern variant of CBT called acceptance and commitment therapy (ACT) directly and indirectly targets acceptance and meaning, respectively, and has been identified as a likely suitable therapy within the palliative context (Angiola and Bowen 2013; Kasl-Godley et al. 2014). In addition, the psychological flexibility framework, which underpins ACT, is a significant predictor of palliative patient distress, death attitudes, and quality of life (Martin and Pakenham 2022). Moreover, ACT has improved the quality of life via effective delivery through a wide range of mediums in health-care contexts, including individual (Feros et al. 2013), groups (Giovannetti et al. 2021), telephone (Hawkes et al. 2014), and online (Lin et al. 2017). Future research should evaluate the utility of ACT in alleviating emotional distress and supporting adjustment for palliative patients.

Well-being priorities during palliative and EOL phases

For the palliative phase, the 2 priority well-being themes valued living and comfortable living were frequently reported by 66.25% and 72.5% of patients, respectively. This finding is consistent with Sandsdalen et al.'s (2015) systematic review of research into palliative patients' prioritization of meaningful living and health-care support. These well-being themes further highlight the competing "double awareness" that palliative patients juggle between life (to be lived) and death (approaching; Rodin and Zimmermann 2008). As indicated in the comfortable living subthemes in the present study, comfort is sought to mitigate the awareness of approaching death by ensuring health care is accessible, one is free from pain, and mental health needs are addressed. This mitigation of death awareness promotes the perception that there is life to be lived, which as indicated by the valued living subthemes involves spending time with loved ones and engaging in valued activities. Targeting these well-being priorities is essential for improved quality of life during the palliative phase, with the absence of valued living and inadequate pain control among the most common reasons for the

experience of intolerable suffering and seeking euthanasia (Health Canada 2021; Hedberg and New 2017).

Regarding the EOL phase, 2 priority well-being themes emerged, being surrounded by loved ones and comfortable and dignified dying, and were reported by 58.66% and 90.66%, respectively. These themes are consistent with those identified in Romotzky et al.'s (2019) study for the EOL phase, spending time with family and friends and adequate symptom control. With regards to symptom control, being pain free was the specific symptom, which formed a subtheme within the overarching well-being theme of comfortable and dignified dying in the present study. This theme, however, also included 2 additional subthemes of having dying preferences met and achieving inner peace. Ensuring that patients' dying preferences are identified, respected, and achieved can be facilitated through the process of advance care planning (ACP; Detering et al. 2010), which has been shown to improve the quality of EOL care (Brinkman-Stoppelenburg et al. 2014). As inner peace was described by patients to involve an acceptance of life lived and the afterlife, supporting this priority for patients may involve spiritual care such as that provided by the patient's chosen spiritual leader and/or the utilization of psychological therapies.

ACT is well suited to addressing the themes in both phases. Research on advanced cancer patients has demonstrated improvements in mental health, symptom severity and interference, and quality of life following ACT intervention (Hulbert-Williams et al. 2021; Mosher et al. 2018; Rost et al. 2012). Increased rates of ACP completion have also been demonstrated following an ACT intervention with advanced cancer patients with comorbid depression and anxiety (Arch et al. 2020). Lastly, ACT has been described as having "an inherently and wordlessly spiritual quality to it" (Hayes and Lillis 2012, p. 153), with psychological flexibility processes such as acceptance, present moment awareness and values aligning with various spiritual traditions (e.g., Buddhism), and being relevant in the alleviation of spiritual struggles associated with achieving inner peace (Karekla and Constantinou 2010; Santiago and Gall 2016).

Limitations

This study had several limitations. First, generalizability of findings is limited by convenience sampling via a single Specialist Palliative Care Service, which typically treats individuals with more complex clinical presentations. Furthermore, as eligibility criteria limited participants to those with stable disease, the findings are restricted to a subsample of a complex palliative care population who were not acutely unwell at the time of participation. To obtain a more representative palliative care sample, future research could sample across multiple palliative care services. Second, no qualitative data were gathered on patients' preferred psychosocial intervention mediums. Such data would likely enable the identification of factors influencing the selection of in-person intervention medium preferences. Future research should investigate the enablers and barriers for all intervention mediums. Third, patients were limited to providing up to 3 well-being priorities, which may have limited the range of priorities identified. Future research could provide an open-ended response, which permits as many priorities as each patient desires.

Conclusion

Patients' perspectives on the contextual factors associated with psychosocial intervention accessibility and relevance have not historically been prioritized in palliative care research. The inherently uncertain and likely limited timeframes available to assist

an often-complex patient population create an impetus to ensure the most relevant psychosocial needs are the primary focus, and interventions are provided via the most suited medium. Findings from this study show that psychosocial interventions for palliative care patients should prioritize individual in-person delivery mediums, target quality of life, emotional distress, and adjustment, and attend to well-being priority themes that are prominent within the palliative (e.g., valued living) and EOL phases (e.g., comfortable and dignified dying). These findings can inform the refinement of existing and the development of new psychosocial interventions. Emerging data suggest that ACT should be explored as a possible psychosocial intervention pathway in palliative care. ACT-informed interventions have the potential to target key palliative psychosocial issues identified in this study and to be provided across a range of intervention mediums. Overall, the findings from this study demonstrate the importance of psychosocial care in conjunction with physical and spiritual domains throughout the entire palliative care journey and the necessity that all care in its delivery and content is patient-centered.

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