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### RESEARCH ARTICLE

#### THE QUALITY OF LIFE OF BREAST CANCER PATIENTS , EXPERIENCE OF THE MOHAMED 6 CENTER FOR THE TREATMENT OF GYNECOLOGICAL BREAST CANCER

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#### Abstract

**Introduction:** Breast cancer is the most common form of cancer amongst women. It is a serious disease that impacts all aspects of the patient's life and goes beyond that to touch the lives of all their loved ones. This work aims to evaluate the impact cancer has on the lives of our patients and their loved ones, namely: their social, economic and psychological well-being.

**Methodology:** We have conducted a cross-functional study at the Mohamed VI Center of Cancer Prevention and Treatment, between May and July of 2017, leveraging 2 sets of questions, including the Arabic Dialect version of the " quality of life " questionnaire, in its 2 versions: Family and Patient.

**Results:** The average age of the patients' sample was 26-43. Amongst the studied aspects, "fear" was the most negatively impacted; spiritual, physical, and social well- being were the least impacted. 50, 9 % of patients were accompanied, 69, 6 % of companions were females. Amongst the companions, psychological well-being was most negatively impacted.

**Conclusion:** The patients and their companions had their quality of life severely negatively impacted, in all aspects. As such, caring for cancer patients must be done in all-inclusive manner, taking into account their life quality and their loved ones, who are their main source of support during their ordeal.

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#### Introduction:-

Breast cancer is the most common cancer in women worldwide. It accounts for 1.7 million new cases per year and 522,000 deaths per year. Incidence rates vary widely around the world. [1]-[2].

In Morocco, breast cancer has become leading cancer among women. According to the Greater Casablanca Regional Cancer Registry (RCRC), a total of 4,839 cases of breast cancer were recorded during 2008 - 2012. The crude incidence in women was 47 per 100,000 women and the rate standardized to the global population was 49.5 per 100,000 women [3].

Like other developing countries, Morocco is in the middle of an "epidemiological transition". Cancer is now a major health problem with an estimated annual incidence of 35,000 new cases per year, of which only less than half are treated [4]. Moreover, the great difficulty of access to care means that patients are diagnosed most often at advanced stages of the disease.

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The management of this cancer involves several phases from diagnosis to treatment and requires the performance of several complementary examinations that can be costly [5].

Therapeutic means include:

1. Surgery
2. Radiotherapy
3. Systemic treatment: chemotherapy, hormone therapy, and targeted therapy .

Cancer disease and its treatment often have an impact on the psychological state of the patient and those around him. Indeed, cancer is not considered a disease like any other, it represents what a doctor does not want to say to a patient, who does not want to hear it [6-7]. Its prognosis is guarded, marked by a significant morbimortality. In 1955, two American teams attached respectively to the Massachusetts General Hospital and the Memorial Sloan-Kettering Cancer Center published the first prospective studies underlining the specificity of the psychosocial repercussions of cancer and its treatments, and the need for the intervention of mental health professionals [8]. 8] The patient's "well-being" thus became the new challenge in the therapeutic management of cancer. Thus, the growing interest in the psychological, behavioral, and social aspects of cancer led to the emergence in 1975 of psycho-oncology in the United States.

The objective of psycho-oncology is to integrate the psychosocial dimension into the care provided in cancerology, at each stage of treatment and whatever the outcome of the treatment (remission, cure, recurrence, or death) [9-10]. It develops preventive actions for patients and their families systematically screen for psychological difficulties and participates in the coordination of their care. It intervenes with the patient but also with his family. It takes into account the neuropsychological effects of the disease and/or treatments, but also the consequences on lifestyles, thinking, and relationships with others [11].

Another concept that goes hand in hand with psycho-oncology is quality of life.

Quality of life was defined by the WHO in 1994 as "a broad conceptual field, encompassing in a complex way the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and relationship with the specifics of the environment" [12].

Quality of life has become a key issue in current oncology practice. Thanks to the continuous improvement of therapeutic means, more patients are living longer or even recovering. For these patients, the quality of life in general, and in particular the psychological and sexual aspects, are of great importance. Indeed, the occurrence of cancer is a particularly painful event to assume, especially the changes in body image, transformed by the disease and by the treatments, the confrontation with pain and possible death, the constraints linked to the treatments, the disruption of family, professional and social life [13].

In breast cancer, radiation, surgery, chemotherapy, and hormone therapy can have a major impact on patients' quality of life. The learned societies recommend that this measure be included in therapeutic trials. Recommendations on methodology are needed to ensure that these studies provide essential, reliable, relevant, comparable, and clinically useful information. Results from the quality of life studies can be used to better inform patients, improve treatment selection, and improve patient management. [14]–[23]-[24]-[25]

The impact on quality of life is not limited to the patient but extends to family members and caregivers. Indeed, the latter is involved in the emotional support of the patients, as well as in the assistance in the daily activities of life, the communication with health professionals and caregivers, and the management and compliance with treatment.

This involvement, especially if it lasts over time, can cause many problems and affect the quality of life of the patient's family.

They may report problems related to their physical, psychological (stress, depression...), social and economic well-being [26].

The objective of this work was to describe the quality of life of breast cancer patients .

## **Patients And Methods:-**

### **Study design and population**

A cross-sectional study was conducted at the Mohammed VI Center for Cancer Control. It was conducted over 18 months from May 2017 to October 2018 involving 660 patients.

Patients were recruited at the consultation and interviewed thoroughly by a physician. Data collection was anonymous.

### **Inclusion criteria**

Adult patients (> 18 years)

Patients with a histologically confirmed diagnosis of any stage of breast cancer for at least six months.

Patients agreeing to participate in the study.

Non-inclusion criteria

Male patients.

Newly diagnosed patients (less than six months).

Patients with severe neuropsychological disorders.

Oral consent was sought. Data collection was anonymous.

### **Data collection**

Patients' quality of life was measured by the Arabic dialect version of the quality of life questionnaire (QoL patient version) (Appendix 1).

The questionnaire contains 45 items divided into five dimensions: "Physical well-being" (7 items), "Psychological well-being" (10 items), "Stress" (7 items), "Fear" (5 items), "Social well-being" (9 items) and "Spiritual well-being" (7 items). Responses to the items are based on a likert scale ranging from 0 to 10.

The Arabic dialect version was obtained after a cross-cultural adaptation process involving two translations and two counter-translations, after syntheses, with a pre-test. The international recommendations were well respected [27].

Patient performance was measured by the Eastern Cooperative Oncology Group (ECOG) [28].

### **Statistical analysis**

Quantitative variables were described by their means and standard deviations and qualitative variables by relative frequencies.

The patients' raw quality of life score was calculated by summing the different responses to the items composing the dimension. A standardized score was calculated and varied from 0 to 100 with 0 correspondings to the worst quality of life and 100 the best.

Quality of life scores was compared by stage or performance status of patients by ANOVA test. The significance level was set at 5%.

The data were analyzed using SPSS 20.0

## **Results:-**

### **1-Sociodemographic characteristics of the study population:**

A total of 660 patients were recruited. The mean age was 43.26 years with a standard deviation of 12.36 years. Approximately 54.5% of the patients were married, the number of children ranged from 0 to 8 with a median of 2. Eighteen percent of the patients were illiterate and 40.9% were housewives. The socioeconomic level was considered low in 62.7% of the population and 22.7% of the patients had social security coverage. Half of the patients (55.5%) were from the greater Casablanca region (Figure 1).

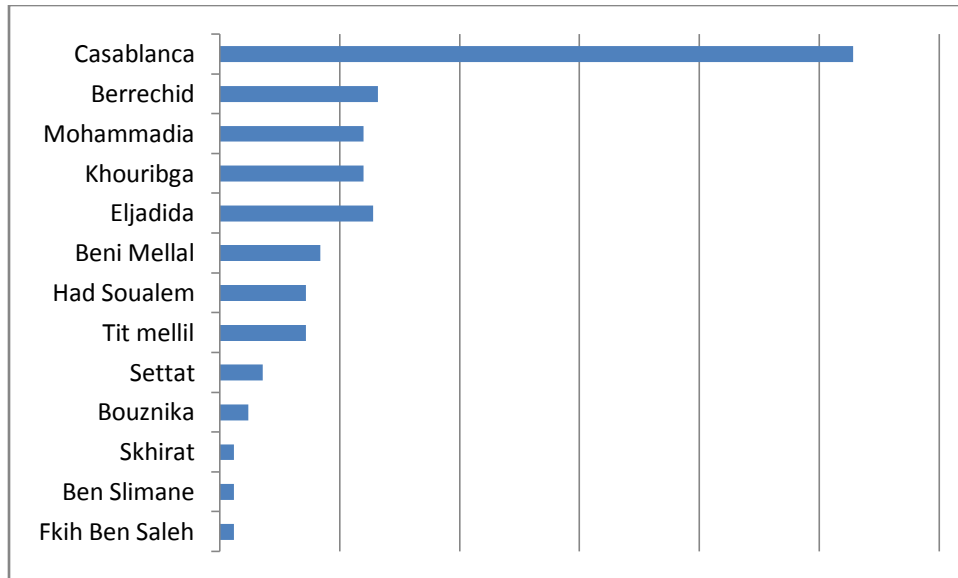


Figure 1:- Distribution of patients by place of residence.

Figure 2:- the stage distribution of the study population

Table 1:- The socio-demographic characteristics.

	Effective	Percentage (%)
Marital status		
Maried		
Single	60	54,5
Divorced	20	18,2
Widow	15	13,6
	15	13,6
Level of study		
Illiterate	20	18,2
Primary	15	13,6
Middle school	25	22,7
College		
University	21	26,4
	29	19,1
Profession		
Housewife	45	40,9
Free profession		
Factory Girl		
official	21	19,1
Retired	31	28,2
Student	9	8,2
	3	2,7
	1	0,9
Perceived socioeconomic level		
Low		
Way	69	62,7
	38	34,5
	3	2,7
Social Security		
Without		
Ramed	32	29,1

AMO	40	36,4
Other insurance	25	22,7
	13	11,8
Current activity		
Not active due to disease		
Not active for other reason	22	20,0
Active	46	41,8
	42	38,2
Number of childrens :	2,62 ( $\pm$ 2,373)	

**Age and stage of the disease:**

The mean age of disease was 2 years with a standard deviation of 1.34. Approximately 42.7% of patients were admitted for stage II. Figure 2 shows the stage distribution of the study population

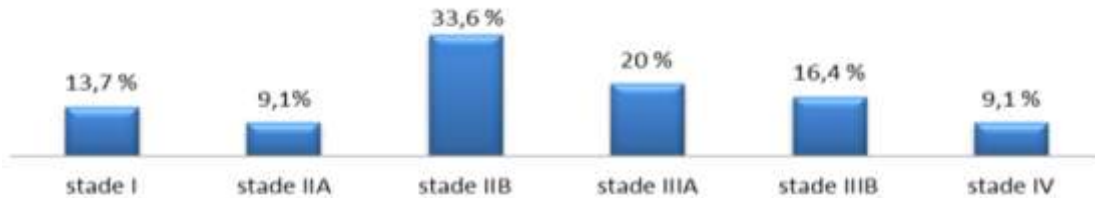


Figure 2. Répartition des patientes selon le stade de la maladie

**Motif of the visit :**

Of the patients included in the study, 28.2% came for a follow-up visit, 12.7% for a chemotherapy session, and 8.2% for palliative care (Figure 3).

■ chimiothérapie   ■ radiothérapie   ■ soins palliatifs   ■ contrôle

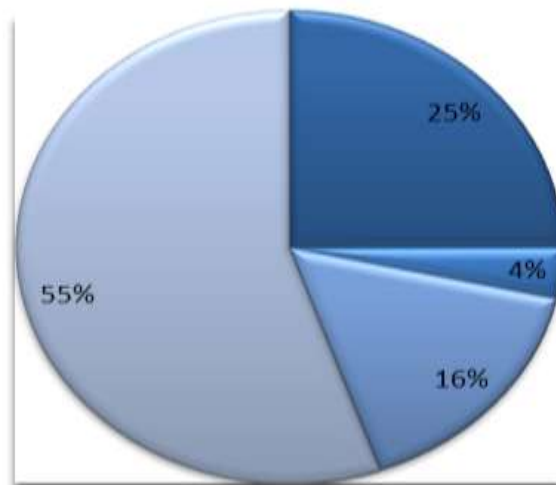
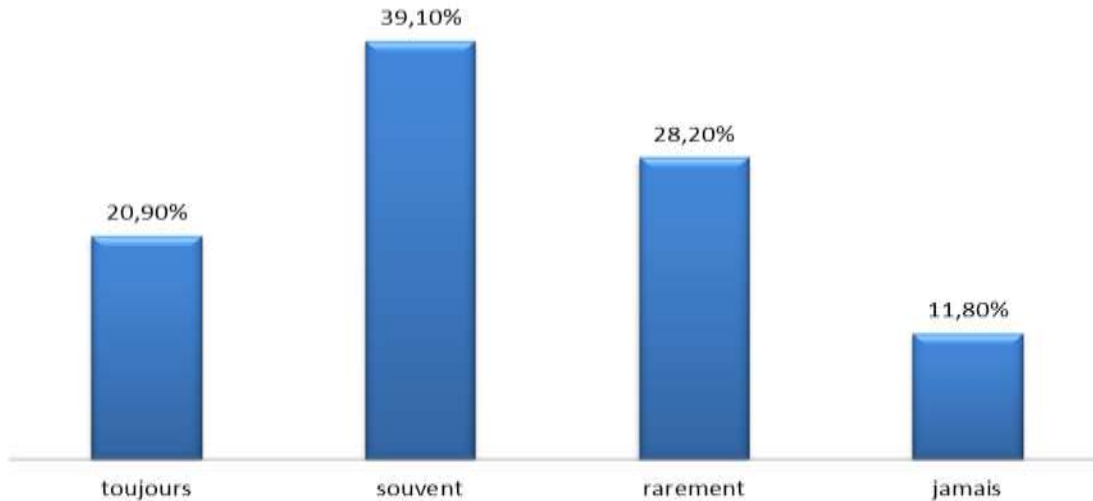


Figure 3:- Distribution of patients by reason for the visit.

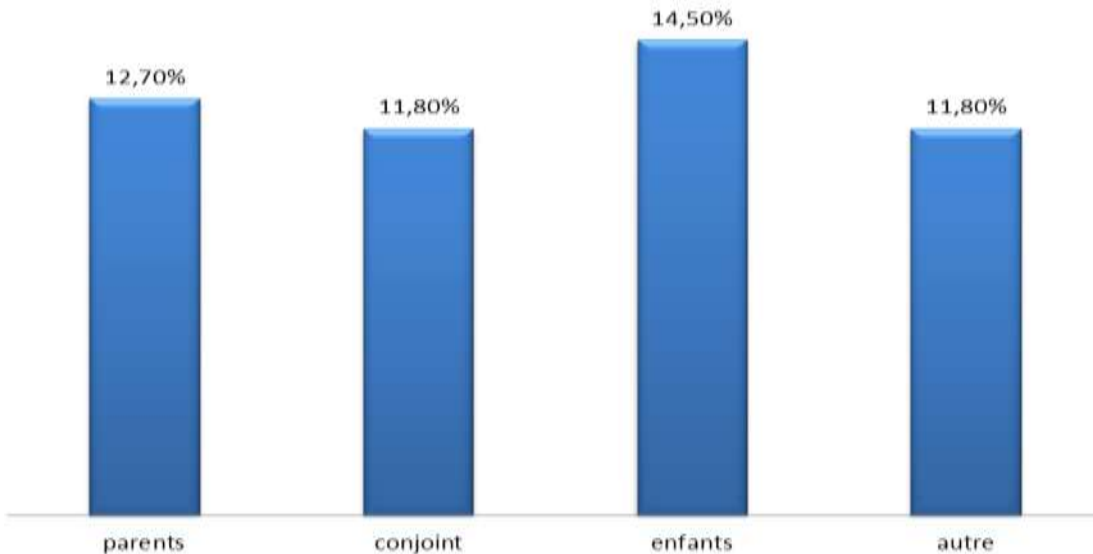
### Accompaniment during consultations

A total of 50.9% of patients were accompanied at the time of the study. 51% reported that they came to the hospital often to always accompanied and 12% of patients were never accompanied. (Figure 4). In 69.1% of the cases, it was always the same person, represented in 14.5% by the children and 12.7% by the parents (Figure 5). In 37.3% of the cases, this same person assisted the patient at home when needed.



**Figure 4. Répartiotn de patientes selon la fréquence de l'accompagnement lors des consultations**

**Figure 4:-** Repartion of patients according to the frequency of support during consultations.



**figure 5. Répartition des accompagnants selon le lien de parenté**

**Figure 5:-** Distribution of accompanying persons according to family relationship.

### ECOG performance score

One-third of patients (33.2%) were bedridden for less than 50% of the day. Figure 6 shows the distribution of patients by ECOG score grades.

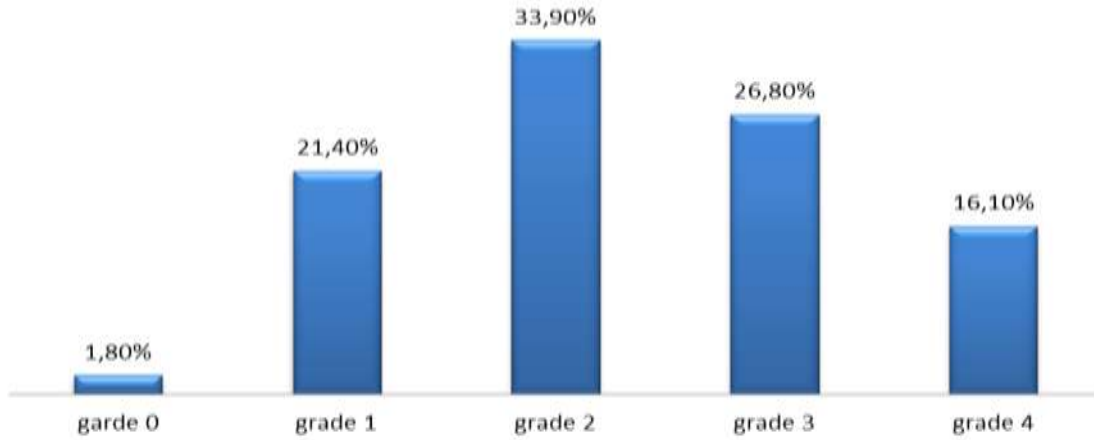


Figure 6. Répartition des patientes selon les stades du score ECOG

Figure 6:- The distribution of patients by ECOG score grades.

**Patient Quality of Life:**

In general, we found good reliability of the scale used for the assessment of the quality of life with a Cronbach's alpha coefficient ranging from 0.57 to 0.81 except for the item concerning the stress related to the disease and the treatment received with a reliability coefficient of 0.32.

The means of the standardized scores of the different dimensions of the QOL questionnaire "patient version" ranged from 15.630.6 to 38.555.0 (Table 2).

When comparing the different scores obtained in the study population according to the stage of the disease, the difference was significant only for the dimension "physical well-being" with a p-value of 0.02 (Figure 10 , 15 ).

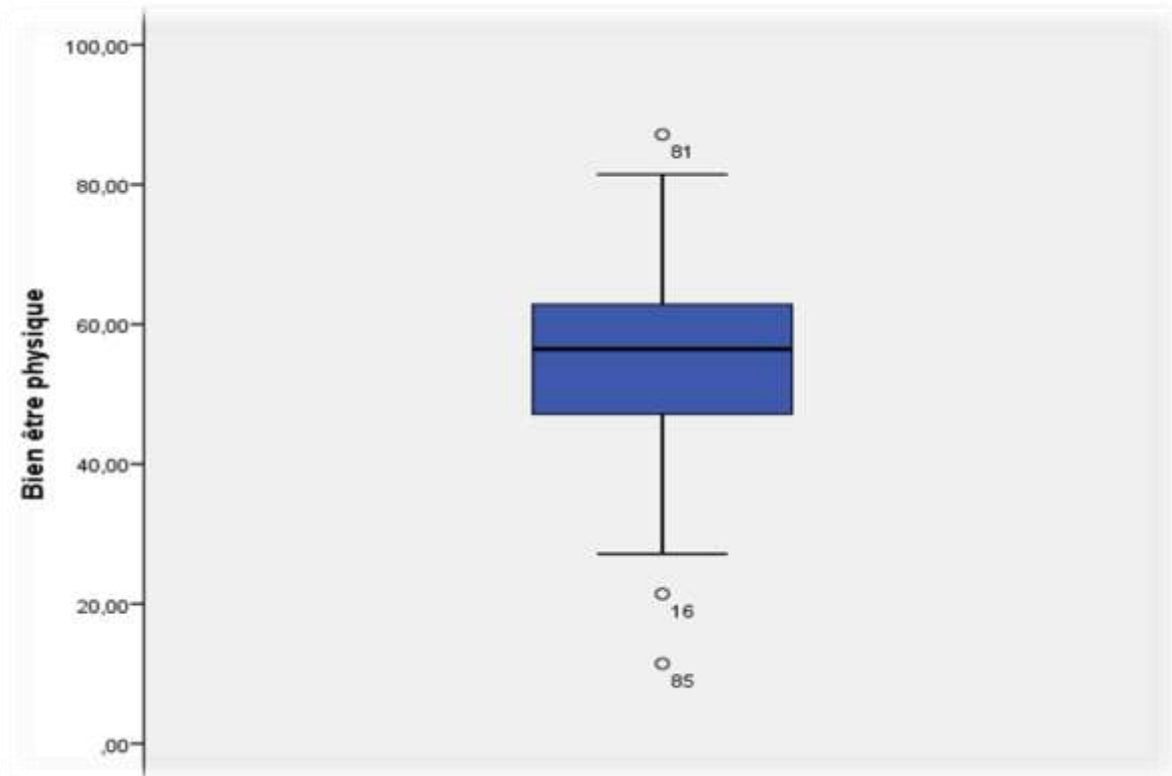


Figure 10:- Description of the "Physical well-being" score.

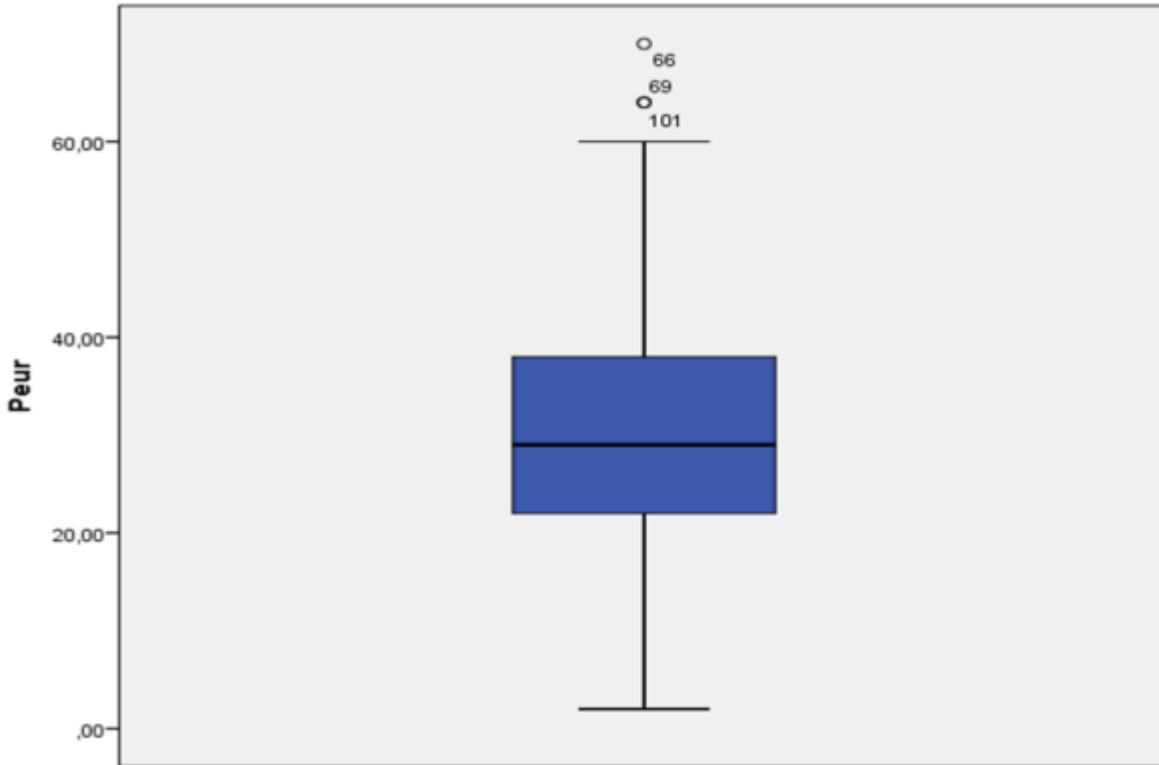


Figure 15:- Description of the fear score.

Table 2:- means of the different dimensions of the QOL questionnaire.

Dimensions	Nombre items	Normalized score mean (standard deviation)
Physical well-being	7	55,0 (12,2)
Psychologicalwellbeing	10	34,4 (12,4)
Stress	7	30,6 (10,7)
Fear	5	31,3 (15,8)
Social wellbeing	9	42,5 (10,6)
spiritualwellbeing	7	53,8 (13,8)

### Discussion:-

The socioeconomic level was considered low in 62.7% of our patients, with only 22.7% having social security coverage and 36.4% holding the RAMEd card. One-third of the patients (32%) were illiterate or had a primary level of education and about 45% of the patients were not from the Greater Casablanca region (old division). Half of the patients (51%) were accompanied during this hospital visit. In 69% of the cases, it was the same person who usually accompanied the patient. Accompanying persons were children (14.5%), parents (12.7%), and spouses (11.8%). One in five companions was inactive at the time of the study because of the participants' illness.

About 38% of the accompanied patients were bedridden more than 50% of the day. There was an impact on the quality of life of the patients with scores more degraded for the dimensions "fear" (31.3), "stress" (30.6), and "psychological well-being" (34.4).

The highest scores were for "physical well-being" (55.0) and "spiritual well-being" (53.8).

The impact on the quality of life of family members was almost similar to that of patients with the lowest score for "psychological well-being" (34.0) and the highest for "spiritual well-being" (60.0).

Our study has some limitations, the study of the quality of life of the family members was carried out among the accompanying persons at the time of the survey, which was represented by the person who takes care of the patient at home only in 37% of cases, which may underestimate the impact of the disease on the quality of life of the family members.

However, the assessment of the quality of life for both the patient and the family was carried out using international questionnaires that had demonstrated their validity and had been adapted cross-culturally according to international standards during this study. Reliability was acceptable for five of the six dimensions, with Cronbach's alpha coefficients ranging from 0.6 to 0.8 for the patient version. The internal reliability of the family version was good, with a Cronbach's alpha coefficient of 0.72, but was slightly low for the dimensions "physical well-being" and "social well-being". The significant correlations between the quality of life scores and the patient performance score (ECOG) indicate a good validity of the family version of the Quality of Life scale. The difference in the physical well-being score for stage I patients compared with the others supports the validity of the Patient Quality of Life scale.

Concerning the level of education, 32% of the patients were illiterate (18%) or had a primary level of education (14%). This proportion is close to those reported in other studies, where the proportion of illiteracy could reach 38% [29], [30]. Illiteracy and a low level of education are at the origin of communication difficulties between caregivers and patients.

Indeed, it is difficult to explain to illiterate patients their disease, the side effects of possible treatments, and even less the prognosis. This creates anxiety on the part of both the patient and the physician, who has to take sole responsibility for therapeutic management without the patient being involved. In a study reporting the psychosocial profile of cancer patients in Morocco [31], out of 1000 cases 33% were unaware of their disease and its prognosis. Similarly, some patients adopt attitudes that run counter to the therapeutic project: distancing themselves from treatment cycles, resorting to "traditional medicine" [30]-[32]. There are also misinterpretations such as fear of contagion of the disease, overestimation of the poor prognosis of cancer (9%), or, on the contrary, its underestimation [32].

Furthermore, the results of this study showed the low quality of life scores for all dimensions, with a significant deterioration in the dimensions "fear" and "stress". These results are comparable to those in the literature regarding the presence of psychological distress in women with breast cancer [14], [20], [22], [33], [34]-[45].

Although breast cancer is beginning to be considered as having a "good prognosis", with a 5-year survival rate of more than 80% [46], the real hope of a cure does not prevent the emergence of death anxiety and a feeling of vulnerability [47], which can cause psychological distress in patients.

Cancer is a disease that often evolves quietly, and the brutality of the diagnosis often causes an "existential fracture", a rupture in the balance and the course of a life. From one day to the next, the patient is transformed from a "healthy" person to a "cancer patient". Patients commonly sum it up with this adage: "there is a before and an after to cancer" [48], [49].

The diagnosis of cancer brings the subject into a universe where the words "time", "cancer" and "death" are intimately linked. Their life span seems to depend on a destiny sealed by cancer. The experience of cancer is thus integrated into a painful process of "mourning" marked by the summation of the losses of the illusion of immortality, loss of the ideal of health, loss of physical abilities and well-being, that is to say, the loss of life. This

deprivation of the former identity, the "loss of self" imposed by the disease, thus constitutes a form of existential suffering [49], [50].

The real hope of a cure does not prevent the emergence of death anxiety and a feeling of vulnerability, which can cause psychological distress in patients[47] .

Jimmie C. Holland describes this psychological distress as a temporary or lasting collapse of the patient's psychological defenses, which affects his or her ability to cope effectively with cancer and its management. In most cases, this suffering is to be considered as a necessary stage of adaptation to the disease and the start of treatment [51]-[53]. However, in some cases, this psychological distress alters the patient's adherence to care and compromises the efficiency of cancer treatment [30]. This phenomenon is underestimated by the medical profession, especially as patients do not spontaneously discuss their emotional problems with their oncologist [54], [55]. However, several studies have shown that appropriate psychosocial intervention reduces the cost of treatment and improves patients' quality of life [56], [57].

Several scientific studies have shown that the prevalence of psychiatric disorders in the context of cancer is higher than in the general population [58]-[62]. The results usually quoted are those of the American psychologist DEROGATIS et al: Nearly one out of two cancer patients, all locations and all stages combined, present psychopathological disorders according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders. The problems most frequently encountered are mood disorders, anxiety disorders and adjustment disorders [63].

It is important that this psychological suffering is recognized as soon as possible and that the difficulties encountered by patients be identified because unfortunately, this is often not a simple passing phenomenon: a level of distress at a given time is predictive of the level of distress in the future. In the long term, if the patient does not receive the necessary support, there may be adverse consequences on his or her adherence to treatment and chances of survival, the desire for early death is increased [64], [65].

The social well-being of our patients also seem to be degraded, cancer being, first of all, a "long illness", it is under this angle that we can consider sociologically the experience of cancer patients. In addition to the psychological approach, oriented on the individual intrapsychic reactions, it is necessary to focus on the one hand, on the multiple limitations and "deregulations" that the disease entails in social insertion, and on the other hand, on the consequences of cancer from a microsocial point of view, namely the marital situation [66]-[72].

Several writings in the Western literature refer to a "social death" of the cancer patient [73], [74]. The onset of cancer leads to a disruption of the patient's living habits. It implies numerous journeys to the care centers, sometimes with long periods of hospitalization, thus separating the patient from his usual socio-professional and family environment. There is a risk of gradually developing a relational solitude that increases the patient's emotional distress.

The Moroccan patient seems to maintain a strong social bond [75]. Accompanying the cancer patient in his or her misfortune is an opportune moment for the Moroccan family to prove its devotion and attachment to the patient. It is also a duty according to cultural, social, and religious norms. A Moroccan cancer patient throughout his journey solicits the family to accompany him to the hospital. In our study, 50.9% of patients came to their appointment with an accompanying person. This family presence at all times during the illness is an undeniable source of comfort and encouragement which can only optimize the patient's ability to cope with the disease [76], [77].

However, these findings must be qualified, because of the physical constraints generated by advanced cancers. Indeed, our results are consistent with a study carried out at the National Institute of Oncology in Rabat, where nearly 80% of the patients consider that their social activities are limited because of their state of health and the side effects of treatment [78].

In our study, the average "physical well-being" score was 55/100, indicating an alteration of this dimension. This alteration has been reported in several studies, as breast cancer and its treatments break the body unity of the woman who is affected, and the physical well-being of the patients is thus altered [42], [73], [79], [80].

Several treatment strategies are used in the management of breast cancer: surgery, radiotherapy, chemotherapy and finally hormone therapy. Each of these treatments is likely to alter the physical well-being of patients in the short and long term [33], [81] [17], [18], [82], [83].

The major physical sequelae of surgery and radiation therapy are lymphedema (severe, moderate, or moderate), plexopathy (which is brachial plexus neuralgia), rib fracture, soft tissue necrosis, lung disease, cardiac pathology, and limitation of shoulder motion.

Chemotherapy frequently has side effects such as digestive disorders, alopecia, or weight gain [84].

Studies have shown that almost all patients treated with chemotherapy or hormonal therapy for breast cancer have experienced the adverse effects of these treatments [85].

Fatigue is the major component of these adverse effects, as shown by Curt et al. 90% of patients treated with chemotherapy were unable to lead a normal life [86]. Tighe et al. noted that patients described this symptom as "overwhelming" [87].

In two other studies, hormone therapy was described as disabling because of vasomotor disturbances and arthralgia [88] [85].

Pain is a very common symptom of cancer pathologies, especially in the locally advanced or metastatic phase of cancer [89]. This pain is usually related to tumor invasion. However, it can also be induced by the treatments, especially in breast cancer [90]. In this case, it may be post-surgical pain, post-radiation pain, or pain following chemotherapy (mucositis, peripheral neuropathy).

In our study, the physical well-being dimension appears to be the only dimension to be related to the disease stage. These results are comparable to a study conducted in Saudi Arabia where the pathological stage of the disease was found to be an important factor in overall health status and functional well-being [19].

This is probably true because the stage of the disease will determine the therapeutic course that will affect overall health as well as physical functioning: if the disease is detected early, the simplest treatment modality will be chosen.

This result is also in agreement with the study conducted by Lu et al [19], [91].

The "spiritual well-being" dimension had the highest score among the patients in our study. According to the authors, if the traumatic intensity of the cancer pathology remains largely conditioned by the existential threat that it represents, the psychological reactions of the individuals facing cancer are largely influenced by the cultural edifice which guides them. The understanding of the whole emotional dimension surrounding cancer implies a knowledge of the symbolic system and the cultural universe structuring the representation and the meaning of cancer for each individual [92], [93].

Numerous studies, particularly in the West, have highlighted the impact of spirituality in the management of illness, its reinterpretation and, more generally, in the changes it brings about concerning the meaning of life [94], [95].

In Morocco, where Islam is the predominant religion, this impact was evaluated by ERRIHANI et al. on a series of 1600 Muslim patients treated and followed up at the National Institute of Oncology in Rabat (all cancers combined). This study identified two groups of patients: practicing believers (49%) and non-practicing (51%) [30]. The experience of the occurrence of cancer varied according to the degree of practice. In the non-practicing group, the main feeling reported was that of guilt; the patient systematically thought that he was a "bad" Muslim and feared "divine punishment". In 95% of cases, this way of thinking led to the practice of religion, often with extremism.

In some cases, these practices were against the doctor's recommendations (fasting and pilgrimage during chemotherapy).

In the group of religious patients, cancer represented a divine test (in the Koran, it is stipulated that God tests the best of his faithful to reward them), and therefore there was an acceptance of the disease, even pride in having been chosen and tested by God. In both groups of patients, new religious behaviors were found: in particular clothing, in the case of women (wearing the veil in 68% of cases, 32% keeping it only during the chemotherapy cycles because of alopecia, and the others permanently). This notion of veiling after the discovery of cancer was also found in a cohort of 600 breast cancer patients. Other patients treated themselves with herbs and foods recommended by the Qur'an (honey, nigella seeds, etc.), and even struggled with illiteracy to read the Qur'an and invoke the good Lord [29].

The role of religion as a refuge for the cancer patient is a mechanism that is frequently found in Muslim countries, but is not specific to them. Studies in Western Christian populations also reveal the power of religion to alleviate the distress and despair of patients by allowing them to accept the disease as their God-given fate. Religious support is thus beneficial overall for the quality of life of patients, especially in overcoming anxiety and depression [94], [96]-[98].

**Conclusion:-**

The quality of life-related to the health of patients was degraded in all its dimensions. Thus, the management of breast cancer patients must be global and holistic, taking into account the quality of life of the patients and their families, who are the main source of support during this ordeal. Psychological support is necessary, as well as good communication between health care personnel and patients and their families.

**ECOG indicator:**

**ECOG measure:**

Fully functional. Capable of all tasks, exactly as before illness with no exception.

Functioning very well. Can do everything, the same way she could before diagnosis without any exceptions.

Can not perform hard tasks, but can move and perform light tasks (light house work)

2. Incapable of doing challenging work, but mobile and capable of easy work (non-demanding work at home).

Doesn't need bed rest, and capable of taking care of herself fully, but not capable of doing any work.

Capable of standing up 50% of the time she is awake.

Able of getting out of bed, and able of caring for herself, but can not perform any work. Can stand up half of her awake time.

Partially able to take care of herself. Needs to lay or sit down more than 40% of the time she is up.

Can care for herself a bit. Stays in bed or on a chair more than 40% of her awake time.

Completely incapable of caring for herself. Always laying or sitting down.

Can not take care of herself at all. Needs to stay in bed or on a chair all the time.

We would like to know how the disease affected this woman from your family. Please answer with 1 to 10 depending on your current status.

We are interested in the impact of your female relative's illness. Please provide an answer on a scale of 1 to 10 based on your situation.

How big of a problem is the following?

How problematic is the following?

Fatigue.

Tiredness.

Changes in appetite.

Appetite variations.

Pain and burning.

Aches and discomfort.

Sleep disorder.

Changes in sleep patterns.

Overall quality of life.

Life satisfaction.

Happiness.

Content.

Do you feel in control of your life?

Level of life control.

Are you satisfied with your life?

Life fulfillment.

Can you concentrate?

Ability to focus.

Are you helpful?

How useful do you feel?

How hard was it to discover your relative's illness?

Was the disease's diagnosis difficult to accept?

How hard was your relative's treatment?

Was the medication difficult?

How hard was the time between the beginning and end of your relative's treatment?

Was it difficult between the first and last part of the medication?

How anxious are you?

What's your anxiety level?

How depressed are you?

What's your level of depression?

How fearful are you that your relative might get another cancer?

Are you concerned about another cancer affecting your relative?

How fearful are you that your relative's cancer may return?

Are you concerned about the comeback of your relative's cancer?

How fearful are you that cancer may affect other areas in your relative's body?

Are you concerned about cancer hitting other organs in your relative?

Can you assess your psychological comfort?

How psychologically comfortable are you?

How hard was it for your family to discover your relative's illness?

Was the disease's diagnosis difficult to accept for your family?

How fearful are you about your relative's future?

Are you concerned about the future of your relative?

How much did your relative's treatment affect your personal relations?

How big of an impact did the medication of your relative have on your personal relationships?

How much did your relative's treatment affect your sexual life?

How big of an impact did the medication of your relative have on your sexual relationships?

How much did your relative's treatment affect your work?

How big of an impact did the medication of your relative have on your professional life?

How much did your relative's treatment affect your work inside the house?

How big of an impact did the medication of your relative have on your domestic work?

How much did your relative's treatment affect your distance with others?

How big of an impact did the medication of your relative have on your closeness with people around you?

How much did your relative's treatment affect your financial situation?

How big of an impact did the medication of your relative have on you financially?

Do you have any objectives or reasons to live?

What are your objectives and motivations to stay alive?

How optimistic are you?

What's the level of your optimism?

How spiritually comfortable are you?

Can you assess your spiritual comfort?

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