

wellbeing in palliative care

A literature review.

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<p>Abstract:</p> <p>Aim: The increasing population of elderly people with terminal diseases is on a wide spread across Europe thus the question is asked, how can this increasing population of old people with terminal illness live a good quality of life and wellbeing even in their state of medical hopelessness?</p> <p>The objectives of this thesis paper is to find out the factors that affect wellbeing of people who suffering from terminal diseases in palliative care.</p> <p>Research questions: What are the factors that affect wellbeing of an elderly cancer patient in palliative care?</p> <p>What are the interventions that facilitate wellbeing in palliative care of an elderly patient suffering from cancer?</p> <p>Method: literature review through content analysis was employed through the collection of data which was done by extensive database search. The database selection for electronic material was based on availability of full text on the database. The utilization of various database helped in achieving organized and comprehensive information.</p> <p>Results: the factors that affect wellbeing of a cancer patient in palliative care are psychological, physical and social factors. However psychological factors are key factors that cause distress among patient suffering at the end of life, nevertheless these factors can be alleviated or reduced by pharmacological or non-pharmacological interventions.</p> <p>Chat conversation end</p>	
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CONTENTS

1	INTRODUCTION	4
1.1	MOTIVATION	5
1.2	AIM.	5
1.3	RESEARCH QUESTIONS	6
1.4	BACKGROUND	6
1.5	Element of palliative care definition.....	7
1.6	The four main principles	8
1.7	The principle of double effect	10
1.8	Desire theory of wellbeing	11
1.9	Structure	12
1.10	Target group	13
1.11	Task.....	14
1.12	Palliative care and Euthanasia	15
2	Theoretical Frame.....	19
2.1	Physical wellbeing.	20
2.2	Psychological wellbeing.	21
2.3	Emotional wellbeing.....	23
2.4	Spirituality	24
3	METHODOLOGY	25
3.1	Data collection	26
3.2	Presentation of articles	27
3.3	Ethical Consideration.	37
4	RESULTS.....	38
4.1	PSYCHOLOGICAL FACTORS	39
4.2	Physical Factors	42
4.3	Social factors	43
4.4	Interventions.....	44
4.5	Pharmacological interventions.	45
4.6	Non-pharmacological interventions	46
5	Discussions	50
6	References	52

1 INTRODUCTION

The study of palliative care and how it affects wellbeing in people suffering from terminal illness cannot be over emphasized because whether we like it or not everyone will grow old, no matter how scientist try to introduce interventions that reverse the effect of ageing, death is inevitable , growing is certain!.

Palliative care is a sector of healthcare that emphasizes on relieving and averting the suffering of patients. Palliative care is applicable for patients regardless of disease phases especially people suffering from chronic disease and also patients who are approaching the end of life.

Palliative care exploits a multidisciplinary approach to care, which depend on input from health professionals in conveying a plan of care to alleviate suffering in all areas of a patient's life. This multidisciplinary approach permits the palliative care team of health and social professionals to address physical, emotional, spiritual, existential and social alarms that arises as a result of suffering from chronic and incurable ailment.

The efficacy of palliative care measures requires concepts that reveal the specific goals of palliative care, such as enhancing quality of life and wellbeing before death, symptom management, family support and contentment, as well as improving patients' perceptions of purpose and meaning of life

Adverse life events can cause terminal disease, for instance people who live in war prone areas are likely to suffer from life-threatening diseases as a result exposure to toxic fumes. Individuals suffering from terminal diseases are often opposed with the feeling of been a burden to health workers, family and friends. Also a constant reminder of death is imminent; therefore they need a specific care that can provide support in all aspect of their life this is where palliative care and how it affects wellbeing at the end of life comes in as a relevant topic.

1.1 MOTIVATION

The Author chose the topic due to experiences and observations from practical training, in that it seem difficult for elderly people suffering from terminal diseases to experience a state of wellbeing, however some factors are responsible this problem. The health care system are faced with challenges in providing support for elderly people and families who have difficulties in coping with life threatening illness. Most elderly people under agonizing distress that accompanies advance disease with little or no tolerable relief from pain.

The stigmatization and isolation that is attached to people suffering from terminal diseases like Acquired Immune Syndrome (A.i.d.s) is one that is prevalent in some developing countries. The Author once had a friend who was diagnosed of H.i.v A.i.ds, he was deserted by family and friends because his condition became worse.

He suffered isolation until death, now the Question is should anyone be left to die since there is no remedy for their medical condition? If the young man was admitted into a hospice, he probably would have lived longer than he did. I remember before his death, a certain priest from the Roman Catholic Church would go to him and say a few words of prayer, he felt different and appreciated the spiritual support that was given to him, all that ceased when his family decided to take him back to the village where he finally died in isolation, This has motivated the Author to research on the chosen topic.

1.2 AIM.

The increasing population of elderly people with terminal diseases is on a wide spread across Europe thus the question is asked, how can this increasing population of old people with terminal illness live a good quality of life and wellbeing even in their state of medical hopelessness?.

Caring for people at the end of life is not a new practice, but different cultures have different approaches to helping people at the end of their lives. Palliative care aims to make death a pain-free process which includes support, comfort and relief of symptoms, making it possible for people to die with dignity.

Palliative care is a crucial part of treatment, when an individual approaches death and also it proffer treatment of possibly terminal symptoms of adaptable infections. The intent of such treatment is not about curing, however it prolongs life for reasonable periods of time and regenerates quality of life and wellbeing at the end of life.

The aim of palliative care is to affirm life at the end of life and regard death as a normal dying process, therefore the aim of this thesis, is to show that terminally ill patient or elderly can live as active as possible until death if they are given adequate support.

1.3 RESEARCH QUESTIONS

The objectives of this thesis paper is to answer questions that cut-across factors that affect or facilitate wellbeing in palliative care so as to give the reader full insight of what the topic is all about.

What are the factors that affect wellbeing of an elderly cancer patient in palliative care?

What are the interventions that facilitate wellbeing in palliative care of an elderly patient suffering from cancer?

1.4 BACKGROUND

What is palliative care?

In previous research in the field of palliative medicine, there has been confusion as to what to the discipline should be called in that it has seen overlaps terms: hospice care, continuing care, supportive care, end of life care, Thanatology and comfort care were all used. All these terms denote different meanings , although the term palliative care have been generally accepted but this field of health care has not yet seen a consensus on the actual definition of palliative care.

The word palliative was originally used to describe care by Dr. Balfour Mount, the word palliate originates from a Greek word, which translate to cloak, meaning when taking care of someone who is dying, our approach and interventions should be one which is void of experiencing pain and or distress associated with dying, it also means improving the quality of something (T pastrana, S junger et al. 2008 p.1).

According to Oxford dictionary The word palliative means relieving pain without addressing the cause of the situation and care in the concept of health means giving assistance either physically, emotionally, socially and psychologically to people who are incapacitated by illness.

Palliative care does not promise to solve the problem of death, which means it does not prolong or hasten death.

World Health Organization (WHO) Defines palliative care as holistic approach intended to improve quality of life and wellbeing patient and their families facing problems with life threatening illness through prevention and relieve of suffering by means of early identification and faultless assessment and treatment of pain and other problems , physical, psychosocial and spiritual. The National Hospice and Palliative Care Organization (NHPC) defines palliative care as a treatment that enhances comfort and improve the individual's quality of life and wellbeing during the last phase of life. (Stephen R. Connor 2009, p.1).

Palliative care has emerged from a viewpoint of care for dying to an inter-professional field that takes into consideration the quality of life for patients and their families throughout the course of terminal disease, as the discipline develops, there is urgent need for a general and acceptable definition to help regulate clinical care research and development. (David Hui, et al. 2013 p.26)

The diversity of knowledge as to what palliative care should be has made it difficult to select a particular definition for this thesis work, nevertheless there were common fundamental element that were found during the course of study.

1.5 Element of palliative care definition

This sections explains the core element that makes up a proper definition of palliative care .Theoretical principles, structure, Target and Task make up the core element of palliative care.

Theoretical principles are as follows:

1. The four cardinal principle approach
2. Principles of double effect
3. Desire theory

1.6 The four main principles

This involves the collection of four ethical principles and the claim that all problems in medical ethics can be explained by discussing them in terms of one or more of these principles which are Beneficence, non-Maleficent, respect for patient autonomy and Justice. (Fiona Randell 2009, p.22)

Beneficence

It simply means doing what is right, Care givers are obligated to promote wellbeing in terminally ill patients which means preventing harm and evaluating actions carried out. (Julia M Addington-Hall 2007 p.28).

Beneficence in a palliative care setting means acting in the best interest of patients' fist, and their families. Careers or physicians are expected to lay more emphasis on progressive care for patients with a high risk of death. The responsibility of physicians at some point should extend beyond medical treatment in other to ensure empathetic care during the dying process. During this process the physician's objectives is to reduce pain and distress of patients and their family which is done by providing emotional support and guard the family from financial drain.

Non Maleficence

It means avoiding harm and promoting good, to impose no preventable

Burden on the patient. Although it can be subjected to diverse interpretation and understanding due to the fact the same action carried out by one person

May be interpreted as harmful or helpful depending on the present situation.

For example, when practitioners recommend a particular medication, they must consider the expected advantageous effects with the possible harmful side effects. As a result, health care providers can recommend the medication as being in the best interests of the patient, considering both the potential risks and the expected benefits. In palliative set-

tings physicians must not act divergent to the patient's values, beliefs and perspectives. (DR Narendra Rungta 2010, p.3-4)

Patients Autonomy

Autonomy means the ability of an individual to have self-determination. Physicians must realize that patients have the right to hold views and make choices based on personal beliefs and values. principle of Informed consent is part of autonomy; it involves the ability of an individual to make decisions based on relevant and comprehensive information. It is required that patient who are mentally sound should be allowed to give informed consent.

Confidentiality is also a part of autonomy which gives a patient the right to have control over the amount of medical information he or she wants to disclose. (Julia M Addington-Hall 2007 p.28).

Distributive justice

This principle is most appropriate when resources are expensive or limited and decisions must be made about who will receive these resources. Justice in the context of palliative care means that patients in similar circumstances should receive similar care. Physicians must realize that their duty is to make good use of the material, financial and human resources under their control.

The physician may give treatment and resources to one with a potentially curable condition over another for whom treatment will be ineffective. Another example is if a patient who is mentally sound refuses a treatment that a physician considers to be more helpful than harmful. On the other hand a legal authorized surrogate decision maker may demand that the physician come to a consensus with the patient or medical interventions

that physicians believe are futile and may even be detrimental for the patient health at the end of life.

Sometimes, when principles conflict, it is obvious which principle is most important and must take priority. Sometimes, practitioners are faced with an “ethical dilemma” in which the force of the conflicting principles seems to be equal. In these cases, it may be necessary to confer with the hospital or institution ethics board. (John E Snider & Candice C Gauthier 2008 p.15-16).

1.7 The principle of double effect

The principle of double effect was stipulated according to the moral philosophy of Saint Thomas Aquinas in the 13th century. It is used to ascertain whether an act is ethically acceptable when it has a foreseen bad effect as well as the intended good effect. It has a long history and actually dates back to Saint Thomas Aquinas in the Thirteenth century, so it was not developed with issues of health care ethics in mind!

The principle is multifaceted and its importance is considered only where the foreseen or anticipated bad effect is shortening of life.

According to Fiona Randell (2009, p.23) the principle states that a single act with both good and bad effects is justified if, four conditions are met. Which are

1. The act must be good, or at least morally neutral regardless of its Consequences
2. The means must aim only the good effect. The bad effect can be foreseen, But it must not be anticipated.
3. The good effect must not be achieved by means of the bad effect. For if the Good effect were the direct causal result of the bad effect, the agent would Mean the bad effect in quest of the good effect.
4. The good effect must outweigh the bad effect. The bad effect is ethically Tolerable only if a balanced reason is present that compensates for tolerating the foreseen bad effect.

Ethical illustration of the double effect principle

When trained hospice or palliative care nurses give morphine in order to provide effective symptom management, many readily recognize the possibility of secondarily hastening death. In a palliative setting, the first instinct of a doctor or a nurse is to relieve pain and suffering even if the means or drug administered might eventually shorten life provided the restoration of health cannot be achieved, but the harmful effect must not be the intention for the administration of the medication. (Robert G. Twycross 2003 p.10)

To illustrate the use of the principle we can take the example of oxygen treatment for patients with chronic obstructive pulmonary disease (COPD) and hypercapnic (type II) respiratory failure. Doctors usually are faced with the challenge of regulating the saturation of oxygen to a normal state it is normally considered void because it results in a reduction in respiratory drive with risk of carbon dioxide (CO₂) accumulation, CO₂ narcosis and death.

However, in situations where despite optimal life-prolonging treatment measures the patient is close to death; here the principle justifies the use of low concentration oxygen to increase saturations to a level higher than usually recommended, in order to relieve the symptoms of hypoxia, even if death may occur hours to days earlier because of CO₂ narcosis. The principle does not justify euthanasia because in euthanasia the intention is to cause death, so the bad effect is intended and not merely foreseen. (Fiona Randell 2003, p.24)

1.8 Desire theory of wellbeing

Desire theory recognizes wellbeing as the satisfaction of human desires and also points out the most important part as informed desire which stipulates that desires that are relevant and rational are the ones we give detailed information and reflection. Most people concur with the theory because it is obvious that people do not get satisfaction from de-

sires that are based on ignorance and irrationality. Desire theories highlight the following:

1. What is best for me depends on what i care about and matters which am sovereign
2. Peoples desire can be self-sacrificial in the sense that people can sometimes desire things which are unrealistic and can be destructive to their wellbeing.
3. Desire can be adaptive. When people are faced with difficulties in life, they tend to adapt to possibilities that are available. (Michael, Randy 2008 p.23).

Desire theories stipulates happiness is a matter of getting what you want (Griffin, 1986). Desire theory is considered when what we want is lots of pleasure and little pain. However, hedonism and desire theory and Hedonism often go hand in hand. Hedonism holds that the prevalence of pleasure over pain is the prerequisite for happiness even if this is not what one desires most. Desire theory holds that that realization of a desire have a say to one's happiness in spite of the amount of pleasure or displeasure. (Martin, Royzman 2003)

1.9 Structure

A multifaceted approach is paramount for palliative care settings in that the team requires leadership, coordination, collaboration and effective means of communication is needed to merge different disciplines and services. The pattern of multi-professional team varies but requires an interdisciplinary team of health practitioners, volunteers, nurses, bereavement counselors and clergy men. (T pastrana, S junger et al. 2008 p.5).

Palliative care must be evaluated in other to provide evidence that can be used for assessing and improving quality of care, reveal impending problems that needs urgent attention, clinical support services and also for the general administrative functioning. There are valid quality indicators that required in proper structuring of palliative care, which are: the definition of a palliative care service, accessibility to palliative care, specific infrastructure to deliver palliative care, symptom assessment tools, specific per-

sonnel in palliative care services, documentation methodology of clinical data, evaluation of quality and safety procedures, reporting of clinical activities, and education in palliative care. These quality indicators, are aimed to assess and improve the structural organization of palliative care settings. (W Kathrin, V B Karen et al. 2014 p.2 p.7).

Furthermore, the purpose of evaluation is to enlighten decision-making at policy and operational stages .This differentiates it from predictable research in that it describes how an intervention worked, what impact and what outcomes were accomplished. It then uses these findings to map out strategies and practice implications, as well as options for change and precarious managerial issues.

Clinical evaluation is employed in palliative care settings to assess efficacy of health interventions and treatments .palliative Effectiveness is the level of benefit achieved when services are provided under normal circumstances by average practitioners for typical patients. (National Health Strategy 1991).While considerably research of palliative research assesses efficacy, palliative care evaluation certainly evaluates effectiveness and value. (Carla Cranny, 2004 p.4)

1.10 Target group

Some People have asked questions why palliative care is important since it does not promise life or solutions for people suffering from terminal diseases, but the answer is no one deserves to die in agonizing pain regardless of the situation. when the load of treating an illness outweigh the benefits, the goal of a patient's care may change from curing to comfort so he or she can enjoy the time remaining and achieve personal goals at the end of life. As the patient approaches the end of life, palliative care may extend to involve hospice care but it will be according to the wish of the patient and his or her family.

People think of the word Palliative care as preparation of death and Hospice as a place to die. Palliative care is needed because it provides support to people with incurable diseases and their families during the last stages of illness, dying process and bereavement period, it gives some degree of satisfaction in preparation for death through care that is centered on both individual and family needs, palliative and hospice seek to safeguard and encourage prospective for growth and development within individual and families during the last phase of life. (Stephen conor 2009, p.2).

Precisely defining the target group is essential in needs assessment. The target group for palliative care is patients suffering from life-threatening illness and their care givers. Nonetheless, in practice, cancer patients are repeatedly identified as the target group because reasonable empirical data available to facilitate planning. If the palliative settings is perceived as a place that offer service for people dying from cancer then the service will target a specific group and operate in a specific way. This may hinder the necessity for palliative care. A recent Rand Corporation study (Lynn and Adamson 2003) expands the palliative care target group to include frail elderly people at the end of life who are suffering from severe chronic disease. (Carla Cranny, 2004 p.32).

1.11 Task

Palliative care is process that starts from diagnosis, death and bereavement care for families, and it is focused on the needs of patient, families and caregiver. Emphasis should be placed on Patients and families as they the main focus of care rather the cause of illness, cultural and faith differences should be given preference in planning of care, another principle is the obligation to work together through interdisciplinary teams in other to reach a consensus of goals. Interventions of each team members are coordinated and assessed by the palliative care teams in other to develop an all-inclusive plan of care. M. Laporte Matzo & D. Witt Sherman (2005, p.134).

The main focus in palliative care is mainly relieve from pain and symptoms , support system that help patient live active until death and support family bereavement , inte-

gration of psychological and spiritual care (W.H.O). Principles of Symptom Management

It is paramount to remember to consider the patient as a 'whole individual'. Symptoms might be physical or psychological which might have an effect on the patient and family. Thorough Evaluation of symptoms is necessary and also considering the effect of the symptom on the patient's quality of life. Effective communication is essential in discussing treatment options

With patients and their families and also involve them in the planning process. It is important to correct the correctable, as long as the treatment is practical and not overly burdensome, when using drug treatments for persistent symptoms, give frequently only when needed also keep drug treatment as simple as possible, review regularly and adjust treatment.

The consideration of non-pharmacological approaches to help relieve symptoms e.g. simple repositioning, or the use of a TENS machine may help pain; complementary therapies may help psychological distress, although the evidence base for such treatments is not strong, some patients find them helpful. Plan in advance, Good communication is very vital palliative care settings, in that help the care givers to establish patient's wishes for their future care and treatment. Patients may want to document their wishes the Preferred Priorities for Care document (available from www.endoflifecareforadults.nhs.uk) or an Advance Decision to Refuse Treatment might be helpful. (NHS 2012, p.6).

1.12 Palliative care and Euthanasia

The discipline of medicine in conjunction with the society as regards attending to the needs of patients who suffer from agonizing pain, which result into a request for their life to be ended is often discussed. The topic of Euthanasia has been an area of strong deliberation which has resulted in legalization of Euthanasia and assisted suicide In the Netherland. In many other countries, the debate as to whether euthanasia should be le-

galized is currently in view. These advances most times lead to emotional reactions, which has made euthanasia and assisted suicide, a relevant topic in the news.

Euthanasia defined by the Dutch law, is the deliberate ending of a life by the administration of medication by a physician at the explicit request of a patient, this definition has been generally acknowledged and approved in legal regulations in other countries and in research. Nevertheless, some people among patient and caregivers who have different opinion about legally assisted killing, which have led different understanding of what Euthanasia entails, possibly bewildering them as to what is obtainable according to the Dutch law, and surely mystifying the ethical debate. A study that was conducted newly by the Dutch, revealed that quite a lot of citizens considered the use of palliative sedation and the ending of life of severely ill babies to be euthanasia. (Judith AC Rietjens, 2013 p.1)

The Belgian Euthanasia rights was passed into law in 2002, it authorized physicians to deliberately terminate the life of a patient based on patient's request, provided the patient is suffering from a medical condition which is continuously inflicting excruciating physical or mental distress on the patients. In addition all effort to alleviate the serious and irredeemable disorder must have been ineffective before euthanasia will be considered. (Scotsmans and Meulenbergs 2005)

Research has shown that nurses are involved in cases of euthanasia from the moment of request, until the administration stage and further caring for the morning stage. The Belgian law instructs that discussion must be carried out between the physician and the nurse or care giver in order to reach a consensus, because they responsible for the day-to-day care of the patient and are often more closer to the patients sufferings and their family. This is so because opinion of the nurse might facilitate an order which they necessarily do not have a final say. (Joris Gielen, Stef van den Branden et al. 2011 p.2)

The Advancement of palliative care and promoting the authorization of controlled euthanasia and physician assisted suicide are normally regarded as conflicting, due to the following reasons:

First of all, they can be regarded as surrogates in individual cases. Palliative care is presumed to significantly cut down the number of tenacious requests for euthanasia.

In addition, they can be regarded as substitute choices to individual travail at the end of life. The WHO definition of palliative care stipulates that palliative care ‘intends neither to speed up nor postpone death. Palliative care and Euthanasia have some common values which are follows:

Alleviation of Human Suffering.

Palliative care and euthanasia both attach a great deal of importance to alleviation of physical, psychological and existential suffering at the end of life. According to study done in the United States, most patients who experience existential sufferings are more likely to request for Euthanasia. Another point of consensus is that well conducted palliative care can reduce the request for Euthanasia although some people are of the view that not all suffering can be addressed in palliative care.

The consequence of authorizing euthanasia on persons who do not request it is an additional point of argument. Some people are of the view that such legislation would lead to people have distrust towards health care providers, therefore increasing discomfort and suffering. They also of the view that the approval of euthanasia or would wear away empathy that should be expressed to the terminally ill patients.

The conflicting view is that trust can be maintained, by transparency and strict adherence to rules guiding euthanasia with respect to patient choices at the end of life. In addition, authorizing euthanasia can be viewed from the perspective of patient’s choice, in that it does not matter whether the authorization of euthanasia discourages or supports trust in caregivers, it is a matter regarding which realistic data are required.

Avoids reducing patients to biological specimen.

Euthanasia legislation concentrates on the importance of avoiding loss of Autonomy of one’s life while palliative care gives emphasize empathy and also approach caring from a holistic point of view. The significance of caring for the whole individual rather than

for an organ is highlighted, as is the importance of relationship between psychological and physical suffering.

Some people are of the opinion that, the legalization of euthanasia is unsympathetic, concentrating too narrowly on free choice, and displaying inadequate empathy for the suffering of the critically ill, and inadequate interest in the individual making this choice. This has been countered by VE/AS legalization advocates, who reply that empathy has been the root of their concern, and that physician assisted death requires a great deal of emotional contribution

Autonomy of patients at the end of life

It is important for a patient in palliative care settings to choose the situations that will surround his or her death, although there are three points of disparity in this context. The first is the argument as to whether Autonomy embraces the right to choose euthanasia. The second point of disagreement is capacity of terminally ill patient's decision making calls for scrutiny.

Palliative care givers often question the rational thinking of patients who request for euthanasia, they question if they are capable of weighing the options properly. The wish sometimes might be as a result of crises; sometimes the fear of been a financial burden on their family and loved ones, as opposed requesting for assisted killing as a result of unbearable suffering.

Lastly, there is discrepancy on the potential effect of the legalization of euthanasia on the freedom of choice, it is believed by some that there is a possibility that people who are terminally ill will abuse the legislation in that it can lead to excessive pressure to request for euthanasia.

View The worst evil

The probability of a 'good death' is an aim shared by both palliative care givers and advocate for euthanasia legislation. This is conveyed as the campaign for a good death and also helping to treasuring the time that is left in the case of palliative care and also there

is an opportunity to willingly decide to terminate one's life that is not worth living, this applies to the case of euthanasia legalization advocates. These sects have different opinion and outlook as to what a good death should be, nonetheless. The first sect values and accepts a natural death.

While the second accepts the possibility for the patient to take strides to die sooner than would naturally have occurred, either by being given or by taking lethal medication. The opinion of chosen aided death as a 'good death' is in contrast to the view of palliative care providers. In accumulation to acceptance of the 'natural' life span and the belief in the sanctity of life that may lie beneath it, some have identified the fear that The ethics of palliative care and euthanasia might gradually be seen as conventional phenomenal that works hand in hand , and cease to be considered as uttermost severity. (Samia A Hurst, Alex Maurun 2006).

2 THEORETICAL FRAME

The author has chosen quality of life in relation to wellness as a framework. In this chapter, definitions and concepts of quality of life will be reviewed. In gerontology research, quality of life includes two separate fields; which are health-related quality of life and environment-based quality of life. The health related quality of life comprises of areas of life which are affected by changes in health. These are facets of life that gets better after a patient has undergone a successful treatment; a major change in health related quality of life is shown by a decline in a particular area of the person's life which leads a health worker to change or modify a medication or treatment. Health related quality of life areas or domains comprises of: daily living activities, mental or emotional wellbeing, social activities and situation of symptoms.

Non-health-related quality of life areas comprises of structures of both the natural and the fashioned surroundings, in addition individual skills and resources. These domains affect health-related quality of life, nonetheless they do not show any improvement with adequate medical treatment. (Albert, Steven M.; Teresi, Jeanne A 2002)

The measures of disease as the sole determining factor for health status are gradually becoming unsatisfactory among health care. Two modules of corresponding criteria of health status measures have developed to bridge the evidence gap of unbiased measures of functional health status and biased measures of health and well-being. These measures are multi-faceted although there are many available articles and research about the measures of quality of life, this phenomenal is yet to see unanimity among researchers about its definition.

The WHO (2006) defines quality of life as personal view of individual position in life in relation to culture and value systems in which they live, and in conjunction to their personal goals and objectives, anticipations, principles and values. Evaluating quality of life require adequate consideration of the level at which people are contented or concerned about the integral part of their life and this analysis will be a highly personalized. (S.M. Skevington , M. Lotfy et al 2006 p.1) .

The concept of quality of life is comprehensive, in that it integrates all aspects of life. Most researches have shown similarities in the defining quality of life as well-being in that it encompasses four areas: quality of life is physical, mental, social and spiritual well-being.

2.1 Physical wellbeing.

Physical well-being is mainly a self-evaluation of abilities of individual to function physically in good health. Living an active life, absent of disease or disability and maintaining a high level of physical functionalities are significant for individuals to evaluate their own physical health and also contribute to individual physical well-being.

Physical activity can be seen by people as a means to achieving to an expected end which are goals in life, however physical activity mostly emanate from achievement of daily living tasks. A decline in physical function will result to reduced physical activity and a succeeding poorer functional capacity will eventually lead to loss of independence. Physical activity has been established to improve elderly people's physical and

mental health and also helps in preservation of independent living. It has been shown that elderly people who are physically active experience improved mental wellbeing such as self-perceptions, reduced anxiety and stress. (Janet Withall, Afroditi Stath. Et al 2014).

Several studies have connected involvement in constant physical activity with a reduced risk for cognitive decline while little or no physical activity are linked to cognitive decline.

Tentative trials of exercise involvements in older adults validate that critical contact to aerobic exercise can lead to temporary development in memory, attention, and reaction time. Although the appliance for the relationship between physical activity and cognitive functioning had not yet been established, numerous researchers have proposed that during behavioral and aerobic training; improved blood flow, increased brain volume, elevations in brain neurotropic factor, and improvements in neurotransmitter systems have been identified.

Quality of life is an inner concept, which is usually defined as a careful assessment of individual satisfaction in relation to one's life. In a review of the literature that observed the relationship between physical activity and quality of life in old age, Rejeski and Mihalko conclude that the evidence strengthens the conclusion that physical activity appears to be positively related with several but not all domains of quality of life. (Wojtek J. Chodzko-Zajko, 2010).

2.2 Psychological wellbeing.

Several research of mental health care has laid more emphasis on treatment of mental illnesses other than prevention. The past few decades has seen several psychological treatments been introduced for mental disorders such as depression and anxiety. Efficiency has been realized for cognitive behavioral therapy, problem-solving therapy and interpersonal therapy, Precautionary and early involvements, to name a few such as coping with depression and anxiety.

World Health Organization stipulates that mental health is more than just the deficiency of mental illness, in that it defines mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. According to the definition, well-being and positive functioning are important factors of mental health. It translates that unhappiness is not subject to people suffering from mental illnesses, it explains that people who suffer from mental disorders can create coping strategies, be happy and enjoy a reasonable quality of life regardless of their mental issues.

Psychological well-being emphasizes on the ideal functioning of individuals and comprises of concepts such as mastery, hope and purpose in life. Several researches have validated the effectiveness of positive psychology interventions such as counting your blessings, practicing kindness, setting individual goals, expressing appreciation and using individual strengths to improve well-being, and also to relieve depressive symptoms. (Linda Bolger, Merel Haverman. Et al 2013 p.2)

Positive psychology is a comprehensive field that entails a diversity of methods and practices that inspire people to realize their individual positive emotions, experiences, and character traits. Positive psychology builds on key concepts of humanistic psychology.

Psychologist Carol Kauffman, director of the Coaching and Positive Psychology Initiative at Harvard's McLean Hospital, highlighted four methods for incorporating the principles of positive psychology into individual or group therapy.

There should be an adjustment in concentrating from negative to positive. It is true that people are inclined to dwell on negative situations or emotions and overlook the positive ones. The therapy should initiate and put into practice interventions that are aimed at shifting attention to more positive sides of life. For instance, patients should be encouraged to have an "I did it" list rather than writing down what needs to be done.

Establishing a language of strength is paramount. Often times physicians, therapists and patients regularly discourse about pain, conflict, and anger. The positive qualities and

individual strength are been overlooked. Psychologist like Kauffman and other practitioners frequently use strength coaching while counselling patients according to a theory that stipulates that people who use their strengths recurrently will function better in life., Kauffman suggest that people should take time identify and ascertain one top strength and use it at least once a day in other to enhance mental abilities.

It is crucial for people to encourage and nurture positivity for themselves and others in order to provide a balance to the negative. Lastly development of strategies that encourages hope is one way to increase individual capability to stand in the face of difficulty in other to overcome challenges in life. When issues are been Broken down into smaller modules it is easy to take it one after the other, Another approach is to recognize skills and coping strategies that would facilitate an individual to overcome a specific problem and also proffering ways that they can be built. (Harvard mental health 2008)

2.3 Emotional wellbeing

The aspect of Emotional well-being in health issues is a significant topic which attracts a lot of alarms in health sector; it affects the physical health, Stress, depression, and anxiety which might result to a lot of physical illnesses comprising digestive disorders, sleep disturbances, and lack of energy.

The process of providing treatment for mental and emotional health issues and caring for the related physical illness can be quite challenging. The stresses of life situations, like caregiving for a sick relative, death of a loved one, managing the tasks of a busy lifestyle, or dealing with a negative addiction can lead to a poor emotional wellbeing. (Harvard mental health 2008).

Emotional wellbeing is defined as a wide concept that consists of both the occurrence of psychological adaptation, positive affect and low levels of negative affect. The concept of affect in the context of wellbeing can be referred to as individual experience which is either positive or negative; effect could also be seen as feeling or emotion. Research has shown that is possible for people to experience improved relationship and better ap-

preciation for life after a cancer treatment. This construct is referred to as Post Traumatic Growth; it is defined as positive psychological change that is experienced as a result of coping with adverse life situations.

Lately, researchers have established that improved post traumatic growth among cancer patient seen in perplexing activities such as dragon boating, motor cycling riding, and scaling as well as leisure activities such as visual art-making. Stress controlling strategies such as reading or acceptance of social relationships and companionship helps to improve emotional well-being (Fredette, 1995; Kroenke et al., 2006).

There are various activities that seem to improve emotional well-being during challenging periods of the disease trajectory. Research has suggested that passion for an activity can influence the way the activity is approached or handled, the activity itself might not boost emotional wellbeing. This implies that passion is a strong factor to consider when trying to improve emotional wellbeing (Shaunna M. Burke, Catherine M. Sabiston ET al.2002 p3-4).

2.4 Spirituality

Spirituality becomes imminent when an individual experiences emotional stress, physical illness or death. Narayanasamy (2007) report that 'being spiritual' decreases fear of death, increases comfort and enhance a positive viewpoint of death in terminally ill patients. Patients with brain cancer often face challenges with spiritual and existential issues, which is as a result of constant reminder of death which may lead to loss of personality due to the functional and cognitive decline that comes along with terminal disease

Spirituality is referred to as a human occurrence present in all individuals, and it is the essence of our being, it is a quality that enables us to find meaning and purpose in our

lives. The concept of spirituality is wider than religion and relates to all everyone either religious or non-religious orientation (Aline Nixon and Aru Narayanasamy 2010 p.2).

Spiritual needs are categorized by typical expressions of a person's inner being that prompts the quest for meaning in all experiences and an active relationship with self, others and individual values. Spiritual needs can be accomplished through the following: faith, hope, love, trust, meaning and purpose, relationships, forgiveness, creativity and experiences. These factors are expedient t for general well-being in terms of significant existence.

Patients suffering from terminal illnesses at the end of life often experience dissonance of mind, body and spirit. They are often faced with the Feelings of anger, sadness, guilt and anxiety, Despair and hopelessness especially when they experience difficulties arising from challenging circumstances. Patients may feel detached from care givers, family and loved ones as a result of the effect of illness.

Studies about coping strategies recommend that several patients who are suffering from advanced diseases at the end of life specified that they draw strength from their spiritual life. For some, their strength was as a result of an improved faith in God, prayer, a sense of peace. Other approaches were emphasized in meditation, getting love and support from family and friends and an overall review of life. (A Narayanasamy 2007).

3 METHODOLOGY

Research method has been given numerous definitions by various writers with divers point of view nevertheless, they all point to a the same fact that a research is a detailed study or a scientific activity carried out to establish a fact (Rajendar Kumar 2008, p.2), research method used are characterized into two, which are the quantitative research method and the qualitative research method.

The difference between these two methods is that quantitative method involves statistical analysis which relies on numerical evidence to draw conclusion while the qualitative method is generally not concerned with numbers, involves gathering information within

a number of people, the method used to gather qualitative information include observation, informal an in-depth interview and participant observation (A.J Veal 2006,p. 41).

The author adopted content analysis in literature review as a research method. The procedure of reviewing literature helped to comprehend the subject area better and also helped to hypothesize the research problem in a precise manner. The author chose literature review in other to establish if the same method has been adopted by other authors, which procedures have worked well, and what problems might have been encountered.

All this was put into consideration in other to put the author in a better position to choose a method that is proficient in soliciting answers to the research questions. This has increased the author's knowledge in the research spectrum and has enabled the author to read extensively around the subject area.

3.1 Data collection

The method of data collection was done by means of a database search. The database selection for electronic material was based on availability of full text on the database. The utilization of various database helped in achieving organized and comprehensive information.

Here are some of the database that were exploited: Academic Search elite (EBSCO) PubMed Science Direct, Google Scholar and Google books. The Material selection involves collection of literatures that made a significant Contribution to the understanding of the topic the following criterion were used as standard for inclusion and exclusion.

Inclusion Criteria	Exclusion Criteria
Articles with clearly defined scope, severity and relevance.	Articles that was not available in full text.
Articles that had existing relationship between	Articles that had rhetorical-charged language

the theoretical frame and research perspectives.	or tone
Articles that evaluated the literature with relevance to the problem or issue.	Articles that was not available in English Language
Articles that had valid measurements and accurate data which are relevant to the research questions.	Articles that had arguments that could not be broken down logically.
Articles that related specifically to the research question.	Articles that were exclusively based on religious bias.
Articles that contributed to the understanding of the problem of the study, also articles that is useful for practice were included.	

3.2 Presentation of articles

The author adhered strictly to the Arcada rules of data collection, in that articles that was selected was between the years 2004-2014. Although the rule was kind of restrictive in the sense that older articles that had extensive information about the subject matter was discovered, but “to no avail” due to the rule that articles must be ten years old.

Data base	Search phrases	Year range	Result	Selected
Ebsco	Factors affecting Wellbeing in cancer patient.	2012	2	1
Ebsco	Wellbeing in cancer patient	2006-2012	63	4

Ebso	Spiritual wellbeing in cancer patient.	2003	16	1
Pubmed	Effect of spiritual wellbeing on end of life.	2013	63	1
Pubmed	Social determinant of health of cancer patient	2011	6	1
Ebsco	Cancer intervention\ cognitive impairment.	2011	16	1
Google scolar	Psychological wellbeing of cancer patient	2003	18,000	1

The table below, presents the list of articles that were analyzed.

Title	Author	Publication date	results
Receiving Palliative Treatment Moderates the Effect of Age and Gender on Demoralization in Patients with Cancer	Sigrun Vehling Karin Oechsle et al.	03/2013	The interaction identified different relationships between age and demoralization depending on the combination of gender and treatment phase. Demoralization de-

			<p>creased with age only among women receiving palliative treatment and increased with age only among men receiving palliative treatment. Demoralization was not significantly related to age in curative patients.</p>
<p>Predictive Factors for Well-being in Advanced Cancer Patients Referred for Palliative Radiotherapy</p>	<p>K. Lien et al.</p>	<p>08/2012</p>	<p>Elderly Cancer patients often display compound symptom burden as a result of disease advancement, treatment or result of side-effects from medications. The amount and cruelty of symptoms can detrimental to patient's quality of life and well-being thereby hindering their ability to function physically psychologically and socially. Symptom measurement scales are commonly used to assess these concerns and assist patients and health care professionals in making treatment decisions. Symptoms are either physical or psychological:</p>

<p>Quality of life of cancer patients receiving inpatient and home-based palliative care</p>	<p>Louise Peters et al</p>	<p>04/2006</p>	<p>Location of care is one factor that can influence the quality of life and wellbeing of an elderly cancer patient. Home care advantages over institutional care is that home care provides a better bereavement outcome, a supportive family environment and lower cost for health care systems</p>
<p>The benefits of being present: Mindfulness and its role in psychological well-being.</p>	<p>Brown, Kirk Warren; Ryan, Richard M.</p>	<p>04/2003</p>	<p>Mindfulness can be a vital tool in disengaging individuals from spontaneous thoughts, habits, and harmful behavior patterns and this could be an important role in nurturing informed and self-validated behavioral guideline, which has been linked to well-being improvement (Ryan & Deci, 2000). Further, by adding precision and vitality to experience, mindfulness might lead to well-being and happiness in an uninterrupted way. Mindfulness might</p>

			lead to well-being through self-regulated activity and actualization of the simple psychological needs for autonomy self-validated or freely chosen activity), competence, and relatedness.
. Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients	Colleen S McClain, Barry Rosenfeld, William Breitbart	05/2003	Increasing data have shown empirical support for the assumption that spiritual well-being might help to strengthen psychological functioning and adaptation to illness. Results of numerous studies of medically-ill patients have shown a solid relationship between spiritual well-being and comfort with existential concerns and depression. Coward stated that her self-transcendence mediation provided important remunerations for a group of women with breast cancer. During studies of physically healthy individuals, related results have been stated, signify-

			<p>ing that spiritual well-being is a dominant factor of psychological health.</p> <p>Hence, spiritual well-being might shield the effect of depression on desire for suicide, but does not affect the association between depression and hopelessness. due to the fact several religions explicitly forbid suicide, even individuals who are very depressed and are low in spiritual well-being still find it difficult to contemplate suicide as a decision because of their religious principles.</p>
Social Determinants of Health and 5-year Survival of Colorectal Cancer	Mohammad Ali Heidarnia et al.	11/2013	Compared to high socioeconomic status, people living in low socioeconomic status, have poorer health and shorter life (Niu et al., 2010). In low socioeconomic status, there is higher number of diagnoses in later stages and lower survival rate

			<p>which is correlated to lower access of vulnerable individuals to health care systems. There is correlation between job and 5-year survival of colon cancer. Hazard ratio of patients in manual works was 2.3 times higher than patients in other jobs.</p>
<p>Life review interviews on the spiritual well-being of terminally ill cancer patients</p>	<p>Michiyo Ando , Akira Tsuda and Tatsuya Morita</p>	<p>02/2007</p>	<p>]. A life review interview, hereafter called life review, is a type of reminiscence therapy [4]. It includes various activities of reminiscence, evaluation, and reconstruction of one's life [8]. Reminiscence itself is an activity of life review or reminiscence therapy. The popular life review method [8] consists of six 1-h visits to each client. In this study, we used the Life Review and Experiencing Form [9] as a guide, and the interviewers were instructed to discuss all phases of life in chronological order.</p>

			<p>Wong and Watt [24] found that successful patients who were operationally defined by ratings in mental health, physical health, and adjustment showed significantly more integration (achieved a sense of self-worth or reconciliation with regard to their lives) and instrumental reminiscence (used life reviews as problem-focused coping strategies), and less obsessive reminiscence (stated guilt, bitterness, and despair over their past) than unsuccessful patients.</p>
<p>. Surrender as a form of active acceptance among breast cancer survivors receiving Psycho-Spiritual Integrative Therapy</p>	<p>Lisa Rosequist & Kathleen Wall et al.</p>	<p>06/2012</p>	<p>PSIT is a non-doctrinal psychotherapy that integrates a variety of psychotherapy techniques with a personalized sense of spirituality [14]. Women with primary breast cancer who participated in PSIT showed improvements in general quality of life (QOL) as well as spiritual QOL and</p>

			<p>reduced mood distress [15]. It is informed by stress and coping theory [16], spiritual/religious coping [13, 17], mindfulness [18], and elements of third wave behavioral therapies, especially Acceptance and Commitment Therapy (ACT) [19]. Some of the specific skills taught in the PSIT intervention, including stress reduction, meditation, acceptance, Mindfulness-Based Stress Reduction (MBSR), and passage meditation, have been demonstrated to be helpful for patients with cancer and for chronic stress</p>
<p>Putting Evidence Into Practice</p>	<p>Diane Von Ah et al.</p>	<p>12/2011</p>	<p>This simply involves the use of drugs for example psycho-stimulants as therapy to medical conditions, psycho-stimulants are psychoactive drugs that bring momentary improvements in both psychological or physical functions. It produces a</p>

		<p>range of different effects by augmenting the action of the central and peripheral nervous systems. The effects of a psychostimulant drug, may include enhanced attentiveness, awareness, endurance, productivity, and enthusiasm, improved movement, heart rate, and blood pressure, improved mood and reduced anxiety. However the effect might differ depending on the dosage and substance involved.</p> <p>Attention restoring theories stipulates that environment can influence individual's ability to concentrate and direct attention. According to a study done by Compton and Ronis 2003, it was revealed that those who took part in natural restorative environmental restoration for about 120 minutes of exposure to natural environment per week, had better recovery and ability to direct their</p>
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			attention from pretreatment as compared to the non-intervention group.
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3.3 Ethical Consideration.

The Author wrote what he found in books and articles of Database by adhering to the rules found in the Arcada's thesis guide, to ensure that both the function and the information are not brought into disregard, the Author made sure that the thesis paper is void of personal belief on the subject matter. All sources that was cited in the text were documented in the references.

Articles that were utilized in these thesis paper where carefully checked in other to ensure that the original researcher took into consideration the general standard and proce-

dures that help determine what is morally justifiable. The Author used adequate methodology and ethical guidelines were put in consideration while conducting the study and research process. Information provided by the articles was properly utilized without influencing the findings that was reported.

The information gathered in this thesis paper is open to public view. No new material was collected in this review. The author reviewed the literature in a neutral and objective fashion. The study was strictly based on literature review, there were no observations, interviews or personal studies that was carried out in these thesis paper.

4 RESULTS.

This chapter contains the analysis of findings from literature review which provides answers and interventions to the research questions. The first part of this chapter is divided into three main categories namely psychological factors, physical factors and social factors. The main categories are further divided into sub-categories. While the second part is divided into two main categories which are also divided in sub-categories.

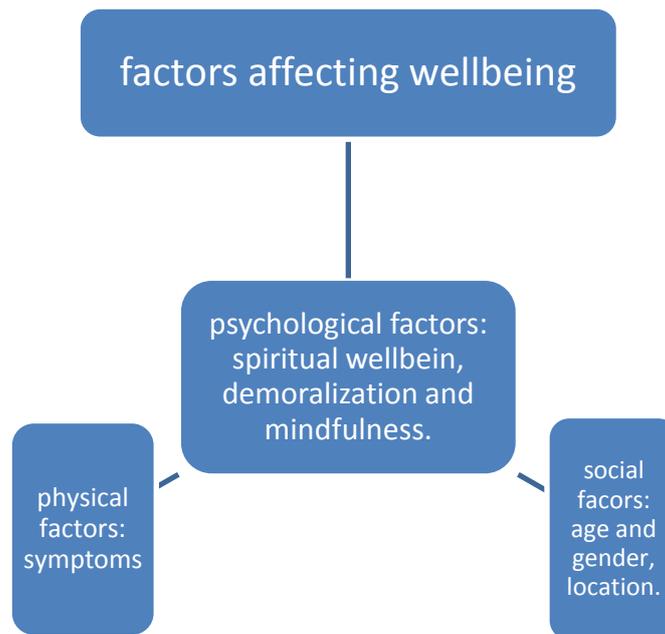


Fig.1

4.1 PSYCHOLOGICAL FACTORS

There are numerous factors that affect wellbeing of cancer patient, but the psychological aspect of life is a broad domain that determines the physical and social aspect of life.

Existential suffering in elderly cancer patients could be linked to the effect of several existential encounters that occur as a result of cancer diagnosis and treatment. The fear of death and dying, fear of losing autonomy, self-esteem, relatedness, and sense of purpose are all related in one way or the other to existential issues. Several Researches have shown that existential suffering is an important element that affects psychological wellbeing of an elderly cancer patient.

Spiritual wellbeing

Increasing data have shown empirical support for the assumption that spiritual wellbeing might help to strengthen psychological functioning and adaptation to illness. Results of numerous studies of medically-ill patients have shown a solid relationship be-

tween spiritual well-being and comfort with existential concerns and depression. Coward stated that her self-transcendence meditation provided important remunerations for a group of women with breast cancer. During studies of physically healthy individuals, related results have been stated, signifying that spiritual well-being is a dominant factor of psychological health.

Hence, spiritual well-being might shield the effect of depression on desire for suicide, but does not affect the association between depression and hopelessness. due to the fact several religions explicitly forbid suicide, even individuals who are very depressed and are low in spiritual well-being still find it difficult to contemplate suicide as a decision because of their religious principles.

Demoralization is a concept that supplies a strong insight for the evaluation of existential suffering in cancer patients. Demoralization according to Clarke and Kissane is defined as a disturbing state of loss of meaning and hopelessness, with cognitions of helplessness and personal failure, subjective incompetence, and social alienation. Demoralization has been basically identified by a captured feeling of “impossibilities” and a consequent feeling of hopelessness. Earlier research which examined predictive factors of demoralization have realized strong associations with physical problems and negative links with social support and partnership. (Sigrun Vehling Karin Oechsle et al. 2003 p.1)

Mindfulness is a theory that has its origins in Buddhist and some other religions where sensible attention and consciousness are seriously practiced. It is defined as the state of being attentive to and aware of what is taking place in the present. It is vital to note that all individuals have the ability to be attentive and to be alert, however the following assumption was made: all individuals varies in their tendency or disposition to be aware and to sustain attention to what is happening in the present, mindful abilities varies within persons, because it can be sharpened or dulled by a variety of factors.

Various researches has establish that the improvement of mindfulness through training enables well-being in all ramifications. Mindfulness can be a vital tool in disengaging

individuals from spontaneous thoughts, habits, and harmful behavior patterns and this could be an important role in nurturing informed and self-validated behavioral guideline, which has been linked to well-being improvement (Ryan & Deci, 2000). Further, by adding precision and vitality to experience, mindfulness might lead to well-being and happiness in an uninterrupted way.

Mindfulness might lead to well-being through self-regulated activity and actualization of the simple psychological needs for autonomy self-validated or freely chosen activity), competence, and relatedness. This means, awareness enhances attention that encourages “standing up” to basic needs, makes an individual to regulate behavior in a way and manner that accomplishes such needs, mindfulness may enhance well-being through association with a higher entity or ideal moment-to-moment experiences. A current experiment by LeBel and Dube (2001) established that individuals whose attention was concentrated on the sensory experience of eating chocolate stated that they experience more pleasure than individuals engaged in an interference task while eating chocolate

Attention is a process of directing conscious awareness and providing intensified sensitivity to a limited range of experience (Westen, 1999). In practicality, awareness and attention are interwoven. Attention and awareness are moderately constant features of normal functioning, mindfulness can be regarded as a boosted attention to an awareness of existing experience or current reality. Biofeedback research has since revealed that attention can be a vital element in decreasing harmful somatic disorders or indicators of illness.

Greater scorers on the Mindfulness Attention Awareness Scale (MAAS) are likely to be more receptive to innermost experiences and are more mindful of their obvious behavior, they are more in harmony with their emotional conditions and able to modify them, they also tend to fulfill simple psychological needs. Equally, such individuals are less likely to be self-conscious, socially anxious, and contemplative compared to the individuals who scored low

According to results presented by clinical intervention, the study indicated that greater levels of mindfulness were associated to reduce levels of mood disturbance and stress before and after the MBSR intervention. Upturn in mindfulness during the intervention projected decreases predictive factors of psychological disturbance. These associations among the MAAS and the outcomes were realized after checking for the impacts of fatigue and pain. Such results propose that the scale can be useful to the study of well-being in cancer patients. (Kirk Warren Brown and Richard M. Ryan 2003)

4.2 Physical Factors

Elderly Cancer patients often display compound symptom burden as a result of disease advancement, treatment or result of side-effects from medications. The amount and cruelty of symptoms can be detrimental to patient's quality of life and wellbeing thereby hindering their ability to function physically psychologically and socially. Symptom measurement scales are commonly used to assess these concerns and assist patients and health care professionals in making treatment decisions. Symptoms are either physical or psychological:

Physical symptoms are pain, loss of appetite, fatigue, nausea and drowsiness. Managing symptoms can be very challenging to medical practitioner as they may spring out from various factors. For instance, fatigue in elderly cancer patients might be experienced as a result of cancer treatments, or medications used in managing other symptoms, such as pain.

In a recent study aimed at comparing symptoms of palliative cancer patients with their medication profiles, Reichmann et al stated that the high percentage of patients complaining of fatigue (63%) was perhaps related to the percentage of patients treated using opioids for pain relief (67%). This shows the equilibrium between controlling symptoms which cause distress and introduction of new prescriptions that intensify other symptoms.

Psychological symptoms

The incidence of psychological symptoms, such as depression, may obscure assessments as they have been revealed to intensify physical symptoms. By recognizing the utmost important symptoms resulting to well-being, management approaches can be enhanced. Level of anxiety and depression has been measured as gauges of psychological health using the Hospital Anxiety and Depression Scale (HADS: Zigmond& Snaith 1983). The HADS is a self-report scale which is made up of two subscales, each with seven items rated on a 4-point scale. The HADS has been re-counted to be an effective and dependable measure of depression and anxiety in a wide range of cancer groups, comprising of elderly patients with advanced cancer involving inpatient and home-based palliative care.

Edmonton Symptom Assessment System (ESAS) is an interesting tool which offers a measurement of a patient's overall comfort relating to physical and psychological aspects. Several interpretations of the tool exist from an individual sense of well-being including physical, psychological, social and spiritual aspects' to patient understandings relating to general health and the answer to the question 'How do you feel now?'

4.3 Social factors

Comparison between people living in high and low socioeconomic status have shown that people living in low socioeconomic status, have poorer health and shorter life. In low socioeconomic status, there are increased amount of diagnoses in advanced stages and lower survival rate which is as a result of low accessibility to health care systems.

Research has shown that unemployment and unsteady income reduces the survival of colon cancer since job type defines the income, it is an indicator of social level, it has operational role in socioeconomic status and its relationship with survival reveals the position of socioeconomic status in 5-year survival of colon cancer.

According to its level of relevance, job type is seen as the strongest factor that determines survival rate after treatment. During this study, there were associations between

City, region, residency and 5-year survival which made it clear that the differences was due to different socioeconomic factors in different city regions.

Age and Gender differences.

Psychological wellbeing as regards age and gender differences is the ability to tolerate or face the reality of death and still maintain a sense of meaning from personal values. Younger women consciousness of a limited prognosis may sometimes lead to a failure to shift focus toward new sources of hope and meaning thus increasing the risk of demoralization. On the other hand, male gender role expectation of endurance and self-reliance has been proposed to explain the distraction coping strategies in men although gender differences increases with age.

According to (Sigrun Vehling et al) demoralization was found to be higher in women aged 61 or younger who were receiving palliative treatment compare to their male counterpart. Younger age has been linked to some helpless situation like cancer, greater interference with role functioning and less coping experience from adverse life effect. Socialization effect has been shown to be the most relevant factor in increased distress in female patient, also

Location of care is one factor that can influence the quality of life and wellbeing of an elderly cancer patient. Home care advantages over institutional care is that home care provides a better bereavement outcome, a supportive family environment and lower cost for health care systems

4.4 Interventions.

The word intervention is a compound word which is defined as the progressive or step by step restoration to consciousness of earlier experiences which can be re-evaluated with the objective of undertaking and incorporating past conflicts, hence giving new meaning to one's life (Michiyo Ando et al. 2007). In the section of the thesis the intervention for the factors that affect elderly cancer patient has been divided into two major categories namely pharmacological and non-pharmacological interventions.

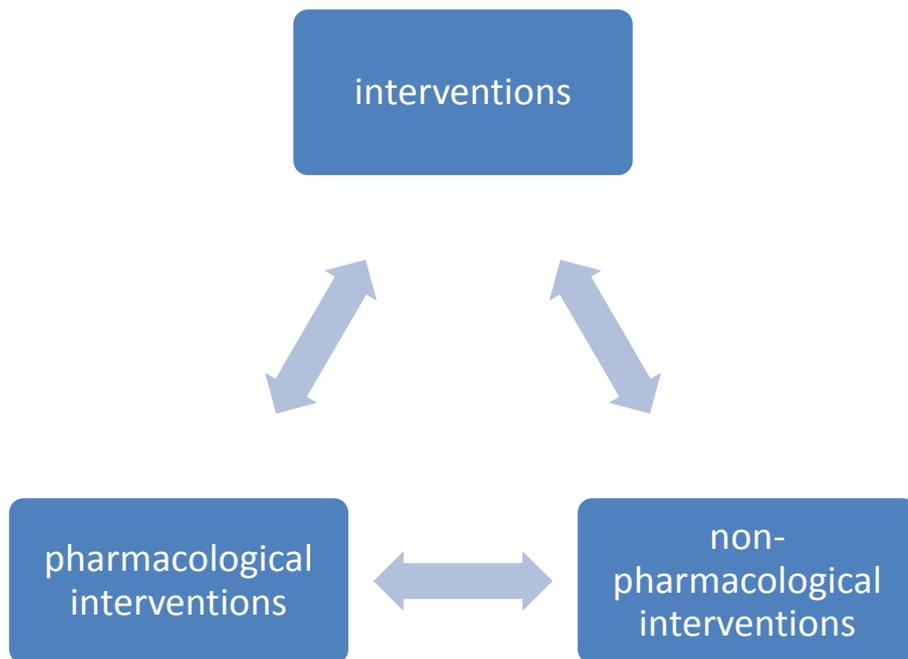


Fig.2

4.5 Pharmacological interventions.

This simply involves the use of drugs for example psycho-stimulants as therapy to medical conditions, psycho-stimulant are psychoactive drugs that bring momentary improvements in both psychological and physical functions. It produces a range of different effects by augmenting the action of the central and peripheral nervous systems. The effects of a psycho-stimulant drug, may include enhanced attentiveness, awareness, endurance, productivity, and enthusiasm, improved movement, heart rate, and blood pressure, improved mood and reduced anxiety. However the effect might differ depending on the dosage and substance involved.

Dexamethylphenidate, Modafinil and Methylphenidate (DMPH and MPH) are stimulants are used in major treatments and management of attention deficit and hyperactive disorder. Several studies have indicated that a daily dose of 10mg given to patient with chronic cancer, revealed improvement in alertness, attention, memory and psychomotor functions.

Donepezil is an acetylcholinesterase inhibitor that is used in treating mild dementia, according to Shaw et al. 2006 which re-counted that improvement in cognitive functions and mood was experienced by patients suffering from brain tumor when Donepezil was administered.

4.6 Non-pharmacological interventions

This involves the use of complementary and alternatives to medicine or alternative medicines. Several interventions have observed that the introduction of vitamin E and Natural Restorative Environmental Interventions resulted in improved cognitive function. According to Chan et al patients who received 1000 international units of vitamin E twice daily over a period of one year demonstrated verbal and visual memory, nevertheless other studies have notified that high dosage of vitamin E can lead to death.

Exercise

The amalgamation of exercise and psycho-educational program with various aspect of quality of life and cognition, reported improvement in visual attention, motor speed and flexibility. The exercise sessions was supervised by a physiotherapist with inclusion of aerobics, endurance and strength training.

Natural restorative intervention.

Attention restoring theories stipulates that environment can influence individual's ability to concentrate and direct attention. According to a study done by Comprich and Ronis 2003, it was revealed that those who took part in natural restorative environmental restoration for about 120 minutes of exposure to natural environment per week, had better

recovery and ability to direct their attention from pretreatment as compared to the non-intervention group.

Cognitive training programs.

This has been defined as any intervention intended at improving, preserving or restoring psychological functions through recurrent and regulated task which pose an intrinsic problem or perceptual challenge (Sitzer, Twamley & Jeste 2006. p.75).

Several studies have premeditated the effectiveness of cognitive training among which is Ferguson et al 1997, who examined a subset of older adults who were diagnosed with cancer within a community. Cognitive training interventions were targeted towards improving memory and attention. Improvement was found in attention, psychomotor functions and verbal memory.

Psycho-spiritual integrative therapy.

Effective coping approaches are centered on willingness to accept the numerous changes that come along with cancer, changes might be physical, emotional, psychological and existential. Elderly patients suffering from cancer might experience existential worries which might lead to a desire to search for meaning, coping strategies that encompass an active approach in the direction of a specific stressor, like social support, active acceptance, and intense pursuit towards regaining autonomy, may speed up recovery by promoting and encouraging an optimistic perception.

Psycho-spiritual integrative therapy is a concept of psychotherapy that incorporates a variation of techniques with an individualized perception of spirituality. It was recorded that Women with breast cancer who partook in psycho-spiritual integrative therapy exhibited improvements in overall quality of life, spiritual wellbeing and mood distress.

The concept of PSIT has been enlightened by stress and coping theory, spiritual coping, mindfulness and Acceptance Therapy. Several of the specific skills that are imparted in the PSIT intervention, which comprises of stress management, acceptance, Mindfulness and channel meditation, have been proved to be effective for patients with cancer and long-lasting stress.

Acceptance is usually described in psychological research as a phenomena that: creates perception about oneself thereby forming a direct empirical basis for human spirituality, a transcendent sense of self, utilizes an opening that response to life stressors and also boost an appealing coping style. Active acceptance play a vital role in the psychological adjustment to breast cancer which may contribute to the development of an consenting psychological perception that has been notified to be favorable in adapting to chronic sickness.

Objectives of Psycho-Spiritual Integrative Therapy

The goals and objectives of this therapy include helping persons with cancer to achieve their life goes and improving their Quality of life and wellbeing. Meditation and stress reduction enables the therapeutic process as well as provide explicit abilities to prompt enhanced physical and psychological wellbeing. The procedure of PSIT begins with recognizing individual purpose or set goals for one's life which for a lot of people is spiritual.

The Practice of acceptance and psychological "coping strategies" empowers patients to accept and change the personal elements that hinder the actualization of their set goals. Additionally, in PSIT, the practice of openness to a personal sense of the sacred is encouraged to enable calmness and to strengthen an obligation to living and actualization of a distinct purposeful life.

PSIT emboldens an open-minded acceptance and acknowledgement of sensations, cognitions, and emotions. The acceptance process utilizes spirituality to modify the obstructing belief patterns that inhibit the achievement of their life purpose. This spiritual coping strategy is particularly useful in encouraging individuals to accept declining of functional abilities, un-manageable aspects of life and mortality.

Several researchers have established that spirituality has an affirmative impact on coping with psychological and physical health encounters. Acceptance in relation to Psycho-spiritual integrative therapy may increase calmness, sense of purpose, optimism, quality of life and wellbeing. (Lisa Rosequist & Kathleen Wall ET al.2006).

Life review therapy.

A life review, is sort of reminiscence therapy. It comprises of several activities of reminiscence, assessment, and rebuilding of one's life. Wong and Watt establish that patients who were successful in life review therapy; achieved a sense of self-worth, reconciliation with respect to their lives, instrumental reminiscence, less obsessive reminiscence compared to the unsuccessful patients. (Michiyo Ando et al. p.2)

Life review therapy can be in form of interview process which involves a constructive life assessment interview which could be presented as follows: review of childhood, adolescence, adult life, and current situation, the most impressive events in childhood and present feeling as regards review of impressive events.

Three dimensions in life review therapy in relation to enhanced spiritual wellbeing.

Positive view of life" might be the willingness to keep hope alive which may result to active coping style, which may reduce psychosomatic suffering.

Pleasure in daily activities

Pleasure in day-to-day activities is a significant factor in cognitive behavior therapy. Patients might forget the distress caused by ailment and can live in the moment while doing pleasurable activities. Greer and Moorey notified day to day life activities that are not hampered by disease should be prioritized.

Good human relationships

Good human relationships" is well thought-out to be an essential factor because patients who have good human relationships usually don't feel lonely and also support others. Generativists is an important concept in psychotherapy for terminally ill cancer patients in that it enables patient have a sense of continuity among generations. Balanced

Evaluation of life

Balanced evaluation is also an important factor, provided the life review strategy function therapeutically. Life review is considered to be effective when a patient is able to

keep good and bad memories in a state of equilibrium. The importance of “Balanced evaluation” is in harmony with the results signifying that life reviews are successful when the type of memories is “integrative”.

5 DISCUSSIONS

The sturdy of wellbeing in palliative care is relative to the concept of quality of life. However, quality of life emphasizes measures and structures of health that must be taking into consideration in other for an individual to have a quality of health and life, several researches have been developed in these area.

However in this sturdy, emphasizes has been on the feeling of wellbeing from both patients and caregivers point of view as regards health structure and measures that are put in place in other to bring about contentment.

According to David Hui ET al.2013 wellbeing in the area of palliative care has developed from caring for a dying patient, to an interdisciplinary that takes into consideration the quality of life of both patient and their families from the commencement of disease to the final stage and furthermore provision of emotional support in cases of bereavement.

Wellbeing in palliative care can be achieved if the goal is to alleviate or reduce pain and distress that accompanies cancer or any other terminal diseases. However it has been “brought to light” that managing symptoms can be challenging due to the fact these symptoms springs out from various factors.

Wellbeing in palliative care can be achieved if care givers imbibe the four main principles of palliative care which have been discoursed extensively in chapter one. The four principles are rules and concept that guide the caregiver in other to carry out actions and decisions that must be in the patient’s interest and also taking into consideration the prevailing situation at any given time.

According to findings of this research paper, it is safe to say that psychological factors are key factors when researching about wellbeing and palliative care, if the psychological aspect of life is well taken care of, the physical and social outcomes will be positive.

Lastly wellbeing can be achieved in palliative care of cancer patient by adopting health proven interventions weather pharmacological on non-pharmacological. It was noted that physical and psychological functions can be improved by the administration of psycho-active drugs.

Non-pharmacological interventions: exercise, Natural restorative program, Cognitive training and psycho-spiritual integrative therapy have all proven to enhance psychological wellbeing, however further research is needed in other to “bring to light” new and established interventions that foster wellbeing in the study of palliative care.

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