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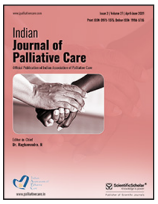

Original Article

Psychological Well-Being amongst Cancer Palliative Care Professionals working in Bengaluru, India

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ABSTRACT

Objectives: Increased levels of psychological distress and burnout in cancer palliative care professionals have implications on their psychological well-being, quality of patient care they provide and for their employing organisations. There is a dearth of studies on psychological well-being with no published study available on psychological well-being amongst cancer palliative care professionals in India. The aim of the present study was to assess psychological well-being amongst cancer palliative care professionals.

Materials and Methods: The study was cross-sectional and quantitative which was carried out at four cancer palliative care centers (one hospice and three hospitals) in Bengaluru city of India. The tools sociodemographic and professional datasheet and psychological well-being (PWB-20) scale were administered with 65 participants (Mean Age = 32.5, SD = 11.78). Purposive sampling method was used to recruit the participants working full-time at respective centers after obtaining permissions and ethical approvals. Descriptive, correlational, and inferential analysis of the quantitative data was carried out based on normality of the distribution.

Results: The results revealed above average levels of self-acceptance and engagement and growth, below average levels of mastery and competence, while average levels of positive relations and PWB (total score). Significant differences in PWB domains based on age ($P < 0.05$) and self-care practices ($P < 0.05$) were seen. Sense of engagement and growth was found to be positively correlated with age and income earned per month ($P = 0.01$).

Conclusion: Findings from the present study suggest that cancer palliative care professionals had moderate levels of PWB with implications in training and future research.

Keywords: Burnout, Cancer, Psychological well-being, Palliative care professionals, Self-care

INTRODUCTION

Professionals working in cancer palliative care settings are exposed to higher levels of stress, suffering, loss, and grief[1,2] which make them vulnerable to psychosocial stress and burnout.[3] Earlier studies have indicated that burnout and compassion fatigue have an adverse impact on professional well-being.[4-6] Quality of patient care has been seen to be impacted by staff well-being[7] while high well-being scores have been seen to be related to less compassion fatigue and burnout in professionals.[4] Being young, being a male, working for a lesser number of hours, undergoing clinical supervision, having satisfaction with one's work environment, and having positive self-judgement are associated with increased well-being.[8,9] A very high secondary traumatic stress and above average levels of burnout in cancer palliative care professionals have been reported earlier.[10] Increased levels of psychological distress and burnout have implications for both well-being of staff and for their employing organisations.

The best-known approach to the understanding of psychological well-being (PWB) is from the movement of positive psychology and positive functioning.[11,12] Although in the west, impact on well-being has been studied but no meaningful utilisation in research can be found because of inconclusive issues surrounding its measurement and conceptualisation.[13] Researches done in the area of well-being have been generally derived from two major perspectives: The hedonic (pleasure and positive affect) and

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eudaimonic approach.[13] Eudaimonia captures the realisation of one's true potentialand congruency of a person's life activities with his/her values and when the individual is holistically or fully engaged.[12,14] Theoretically, PWB has been defined as 'engagement with existential challenges of life' and 'a person's perception about meaning in life.'[15,16] Meaning in life has been seen to be related to work enjoyment and coping in adverse situations.[17,18] Six distinct aspects of human actualisation have been thought to be indicative of eudaimonic well-being: Autonomy, purpose in life, personal growth, positive relatedness, environmental mastery, and self-acceptance (SA).[12]

The concepts of well-being and quality of life (QoL) have followed an intertwined path in health sciences literature.[19] QoL is understood and interpreted differently as it comprises subjective satisfaction and feelings of well-being to physical, occupational, and social functioning.[20] Latha reported that professional caregivers of cancer patients had poor QoL as compared to carers of acquired immune deficiency syndrome (AIDS) patients.[21] There is an immense literature on QoL and the well-being of cancer patients and their informal caregivers; however, to date, we have not come across any published study on PWB in cancer palliative care professionals in India.

The aim of the present study was to assess PWB amongst cancer palliative care professionals. The study objectives were (a) to study the levels of PWB amongst professionals working at cancer palliative care centres and (b) to study the relationship of sociodemographic and professional characteristics with PWB amongst professionals working at cancer palliative care centres.

MATERIALS AND METHODS

Sample

The study was cross-sectional, descriptive, and quantitative. The target population for the present study was professionals working as full-time staff at different cancer palliative care centres in Bengaluru city of India. In the absence of any previous study estimates available, a purposive sampling method was followed to recruit 65 participants who gave written informed consent for participation in the study.

Inclusion criteria of the participation were as follows: (i) Professionals (doctor, nurse, counsellor, social worker, psychologist, pharmacist or physiotherapist) working at any cancer palliative care centre in Bengaluru, (ii) professionals involved in direct patient care at cancer palliative care centre, (iii) professionals with work experience in palliative care for at least 6 months (to be able to study the relationship of duration of practice with outcome variables) and (iv) professionals proficient in English or Hindi languages (researchers understood only English and Hindi).

Procedure

The study commenced after taking permission from the four cancer palliative care centres in Bengaluru city and ethical approval taken from the Institute Ethics Committee. A total number of 98 professionals were employed as full-time staff at the time of the study at these four centres. However, 31 did not meet the criteria for the study (English/Hindi languages not known, work experience <6 months, and involved in indirect care). A total of 67 cancer palliative care professionals who met the inclusion criteria were individually contacted (e-mails and phone calls) with the help of coordinators at each centre. Written informed consent for the participation was given by 65 cancer palliative care professionals.

Tools

The tools used were as follows: (1) Sociodemographic and professional datasheet which was developed for the study by the researchers to collect information about sociodemographic details, professional details, and health-related practices have been followed. (2) PWB-20 scale[13] is a 20-item self-report scale which consists of four factor-based subscales with satisfactory reliability and validity which measure SA, mastery, and competence (MC), positive relations (PR) and sense of engagement and growth (EG) (developed through two field trials). Each of the 20 items is rated on a 6-point Likert scale from 1 (strongly disagree) to 6 (strongly agree). The total PWB raw score ranges from 20 to 120. Thus, higher scores, on the whole, indicate a higher PWB. Both total scores and four subscale scores can be calculated. The subscales and total PWB score have shown good internal consistency. The tools and written informed consent were translated and back translated in the Hindi language. However, all the participants were well-versed in the English language and only English versions of the tools including the informed consent form were used in the present study.

Data analysis

Obtained data were analysed using IBM SPSS Statistics for Windows, version 22.0. Armonk, NY: IBM Corp. 2. The data were examined for normality using the Shapiro–Wilk test and Q-Q plots. Descriptive statistics were used to express quantitative variables using mean ± standard deviation and range while qualitative variables using frequency and percentages to describe the data obtained from the tools used. The relationship between PWB scale domains, demographic and professional characteristics was assessed using Spearman's rank-order correlation based on normality of the distribution.

Mann–Whitney U-test (two tailed) was used to examine differences between groups and the subgroups that were formed on the basis of various sociodemographic

variables, professional, health practices, and quantitative measures. Kruskal–Wallis H-test (based on normality of the distribution) was used to examine differences between more than 2 groups formed on the basis of designation type, work experience in palliative care, and age. The significant relationship between PWB scale domains, demographic and professional characteristics was assessed using Spearman's rank-order correlation. P = 0.05 or less was deemed to be statistically significant.

RESULTS

Demographic and professional characteristics of the participants

The mean age of the study population was 32.5 years (SD = 11.78) ranging from 18 to 60 years of age. The participants of the study were women (n = 57, 88%), majority falling under 25 years of age (n = 24; 37%) and 29 professionals (45%) earning equal to or <15,000 rupees per month. Duration of practice in palliative care ranged from 6 months to 21 years (M = 3.8 and SD = 3.88). Cases are seen per week (M = 27.5 and SD = 18.04) ranged from five cases to 87 cases depending on the designation and workplace type. The mean number of hours worked daily at the workplace was 8.1 h (SD = 0.83). Workplace type in palliative care included 43 professionals working at a hospice (66%) while 22 working at hospitals (34%). The different professionals as per their designation type comprised 21 nurses (32%), 18 nursing AIDS (28%), 14 doctors (21%), 6 counsellors (9%), 3 social workers (5%), and 3 others (5%; one pastor, one physiotherapist, and one pharmacist). These professionals were grouped into three subgroups after matching their characteristics [Table 1].

Table 1: Demographic and professional details of the participants (n=65).

Demographic variables	***n* (%)**
Age (years), *n* (%)	
<25	24 (37)
25–40	22 (34)
41–60	19 (29)
Gender, *n* (%)	
Female	57 (87)
Male	8 (12)
Income/month, *n* (%)	
<15,000/-	29 (45)
15,000–30,000/-	15 (23)
30,001–50,000/-	14 (21)
>50,000/-	7 (11)
Professional variables	***n* (%)**
Designation type, *n* (%)	
Nurses and nurse AIDS	39 (60)
Counsellors, social workers and pastor	10 (15)
Doctors, physiotherapist and pharmacist	16 (25)
Workplace type, *n* (%)	
Hospice	43 (66)
Hospital	22 (34)
Additional training taken in palliative care, *n* (%)	
Yes	34 (52)
No	31 (48)

Health practices in the participants

In terms of different health, practices followed such as self-care, religious and spiritual practices, 48 participants (74%) reported following self-care practices while 17 participants (26%) did not follow any self-care practices. Religious practices reportedly were followed by 57 participants (87.7%) while the other 8 (12%) did not and 23 participants (34%) reported following spiritual practices while 43 participants (66%) did not do any spiritual practice.

Levels of PWB

On five domains of PWB scale, means and SD were calculated for the study participants. a-e superscripts mentioned in [Table 2] indicate the highest and lowest score which could be obtained on each domain. The mean for PWB total was 87.7 (SD = 12.82), mean score for SA was 20.1 (SD = 2.92), mean score for MC was 20.7 (SD = 6.38), mean score for PR was 20.3 (SD=5.86) and mean score for EG domain was 26.5 (SD = 3.19) [Table 2].

Table 2: Psychological well-being domains summary (n=65).

PWB domains	**Mean**	**SD**
PWB total[a]	87.7	12.82
Self-acceptance[b]	20.1	2.92
Mastery and competence[c]	20.7	6.38
Positive relations[d]	20.3	5.86
Engagement and growth[e]	26.5	3.19

[a]Higher the score, greater the total psychological well-being (score range 20–120). [b]Higher the score, greater the self-acceptance (score range 4–24). [c]Higher the score, greater the mastery and competence (score range 6–36). [d]Higher the score, greater the positive relations (score range 5–30). [e]Higher the score, greater the engagement and growth (score range 5–30)

Relationship of demographic, professional, and health practices related variables with PWB domains

In a correlation between PWB domains and demographic and professional characteristics, it was found that only EG had a significant positive correlation with age (P < 0.05) and income per month (P < 0.01). No significant relationship was seen between any other PWB measures with demographic or professional characteristics [Table 3].

For a better understanding of the relationship between PWB total score, SA, MC, PR, and EG scores with other important study participants' characteristics (age, gender,

Table 3: Relationship of psychological well-being domains with sociodemographic and professional characteristics.

Variables	Age	Income/ month	Number of years in PC	Cases/ week
PWB total	0.13	0.19	0.08	0.07
SA	0.21	0.20	0.13	–0.01
MC	0.04	0.09	–0.09	0.25
PR	–0.02	0.04	0.09	–0.10
EG	**0.29***	**0.34****	0.15	0.16

*P<0.05; **P<0.01 (Spearman's rank-order correlation coefficient). PWB: Psychological well-being, SA: Self-acceptance, MC: Mastery and competence, PR: Positive relations, EG: Engagement and growth, PC: Palliative care

additional training taken, workplace types, duration of work experience, religious practices, spiritual practices, and self-care practices), Mann–Whitney U-test and Kruskal–Wallis H-test were carried out after Shapiro–Wilk normality test.

The comparison between the three groups of participants based on age (in years) showed that professionals having 25–40 years of age had significantly higher EG ($\chi^2 = 6.11$, $P = 0.04$) than the 18–24 years professionals. Participants ($n = 49$) who follow/perform self-care practices had significantly higher PWB total (Z = –3.03, $P = 0.002$), MC (Z = –2.12, $P = 0.03$), PR (Z = –2.27, $P = 0.02$) and EG (Z = –1.97, $P = 0.04$) than participants ($n = 16$) who did not follow/perform any self-care practices. The two groups (who practiced self-care and who did not practice self-care) did not differ significantly on the SA domain. There were no significant differences found on PWB domains based on gender, additional training taken in palliative care, workplace type, duration of work experience, religious practices followed and spiritual practices followed.

DISCUSSION

PWB is an intricate construct. The present study focuses on the eudaimonic approach which focuses on meaning and self-realisation and defines PWB in terms of a person's sense of EG, PR with others, SA, and sense of MC.[12,13]

In the present study, participants obtained an above average score for SA which suggests that majority of the participants held a positive attitude toward themselves. They are most likely to possess a positive attitude toward the self; acknowledge and accept multiple aspects of self, including both good and bad qualities and feel positive about their past. It has been observed earlier that participants with a higher tendency for self-judgement were less compassionate toward both themselves and others, had reduced well-being, and reported greater burnout and compassion fatigue.[4]

On MC, the present study participants obtained a below average score which is indicative of a below average sense of MC in managing the environment and being able to control an array of external activities around. This suggests that the majority of the participants in the present study are more likely to have difficulty in managing everyday affairs and lack a sense of control over external matters in their lives. They may have difficulty in making efforts at managing work demands to accomplish the valued outcomes, dealing with situations, and moulding environments to suit their needs.

Nearly half of the participants have not undergone additional training nor have opportunities for supervision at the workplace, the majority being young and having feelings of not being able to do much for the patients or feeling of unpreparedness to join the field. It has been observed earlier in oncology nurses by Papadatou *et al*.[22] that having a sense of personal control over things that happen in life was found to protect nurses from burnout.

Participants obtained nearly an average score on PR with others, which suggests that participants had moderate levels of warm, satisfying, and trusting personal relationships. Most of them are likely to have average levels of capacity for empathy and intimacy. The ability to love and care can be viewed as a central component of mental health and compassionate caring itself is the main element of palliative care. Most of the participants were having moderate levels of PR which could also be interpreted with the help of Erikson's[23] psychosocial development stage theory. For young and older adults, the achievement of close unions with others (intimacy) and the guidance and direction of others (generativity) would be important as far as the psychosocial stages are concerned. Thus, making efforts to develop and nurture relations with others through investing in relationships, providing support, having empathy, being open to seeking support, and engaging in dialogues to resolve conflicts is important for the life stages of most of the participants. However, the same components could make them vulnerable to developing compassion fatigue. Empathic feelings were observed to be important for deriving satisfaction for the helping professionals, but at the same time seen as a risk factor for compassion fatigue, especially if the individual lacks self-compassionate abilities.[24]

In the present study, participants obtained an above average score for the sense of EG. This finding is indicative of the majority of the participants having an insight into their own potential and being open to new and challenging experiences. They are likely to hold goals and beliefs that support their sense of direction in life and feel that their life has a purpose and meaning. In addition, the majority of the participants seem to have meaningful life goals and a sense of directedness. They may feel that there is meaning to their lives and they hold beliefs that give a purpose in their lives. Earlier studies[7,25,26] have addressed the importance of a sense of meaning and purpose in life to function well as a professional, to be able to provide quality care to the patients. The need to 'actualise' oneself and realise one's potentialities is central to their personal growth.

The total score for PWB was found to be average, which suggests that the majority of the participants seem to have moderate levels of positive psychological functioning. This finding needs to be seen in the light of studies that have indicated that burnout and compassion fatigue have an adverse impact on professionals' well-being.[4-6]

The comparison based on age (in years) showed that professionals in the present study belonging to 25–40 years of age, and 40 years and above had a significantly higher sense of EG in comparison to professionals in the 18–24 years age group. This would mean participants in the age range of 25–40 years would have a better sense of EG than participants of any other age group. The high sense of EG in the group of age range 25–40 years could be understood in terms of their attainment of identity development and maturity to be able to seek purpose and meaning in their life goals as per Erikson's theory[23] of psychosocial development. Furthermore, 25–40 years would be the most productive period between mid-life crisis/afternoon of life (above 40 years) and identity development/morning of life (around 18–20 years) as per Jung's[27] interpretation of youth and ageing. In addition to these explanations, being 50 years or lesser has been observed to be linked to better well-being in professionals.[8]

Professionals who reported carrying out self-care practices (activities undertaken with the intention of enhancing health, preventing disease, limiting illness, and restoring health) were observed to have better overall PWB, MC, PR, and sense of EG, as compared to those who did not engage in any self-care practices. The findings from the present study are in accordance with several studies which suggested that engagement in self-care practices promoted better well-being of the professionals.[4,25,28-31]

In addition, self-care has been defined differently by different researchers as it involves three components: Inner/spiritual care, social care, and personal care.[2] Personal care usually involves physical or pleasurable activities. Further, no significant differences were observed on any of the PWB domains among professionals who practice religious and spiritual strategies for self-care and those who do not practice it at all. This finding is contrary to findings of a larger systematic review of 850 studies that involved professionals providing mental healthcare and stated that the higher levels of religious involvement were associated positively with indicators of PWB (life satisfaction, positive affect, happiness, and higher morale).[32]

In a correlation between PWB measures and demographic and work-related characteristics [Table 3], it was found that only EG had a significant positive correlation with age; and EG also had a significant positive correlation with income per month. These findings indicate that having goals and beliefs that support meaningfulness of life and a sense of direction and purpose in life increase with increasing age and better salary provided from the workplace. In some studies, carried out on different populations, zero-order correlations have been observed between income and well-being frequently in the vicinity of 0.10–0.20.[33,34] Similarly, in the present study, income per month was seen to have no significant correlations in the vicinity of 0.04–0.20 except for the EG domain.

While this is the first known study on PWB amongst cancer palliative care professionals in India, it is limited by its small sample size and having participants who were fluent in English or Hindi languages and working in Bengaluru city. More sample size with diversity could have added to the generalisability of the results. Furthermore, the levels of PWB were assessed cross-sectionally using only one scale, there is a possibility that an individual's assessment of his/her perceptions can change overtime due to individual work-related conditions.

This is an initial attempt toward understanding the PWB amongst cancer palliative care professionals. Similar studies are required in other parts of India to explore the construct better. More studies are needed to understand the relationship between PWB and self-care practices. The impact of better PWB on the quality of patient care could be explored and ways to enhance PWB could be studied.

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CONCLUSION

Findings from the present study suggest that professionals working at cancer palliative care centres experience moderate levels of PWB suggestive of positive psychological functioning. This also suggests the need to develop relevant psychological interventions which could target enhancing PWB in cancer palliative care professionals.

Declaration of patient consent

Patient's consent not required as there are no patients in this study.

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Conflicts of interest

There are no conflicts of interest.

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