

Introduction

People living with cancer experience many symptoms both from the disease as well as the treatments. These symptoms are often multiple and complex (Seale & Cartwright 1994) affecting spiritual, emotional and psychosocial aspects of life. The three main symptoms experienced are; pain, dyspnoea and fatigue, which are often distressing for the person and difficult to manage (Curt 2001). Research in palliative care should therefore incorporate the spiritual, emotional and psychosocial components of the person's experience (Field *et al.* 2001) and all three parts of this experience needs to be understood by professionals.

Aim

To explore the effect of spiritual, emotional and psychosocial support within a rehabilitative care approach in relation to three distressing cancer symptoms; pain, dyspnoea and fatigue.

Questions

- ❖ What perceptions do people living with cancer have of their symptoms?
- ❖ How do people living with cancer perceive the spiritual, emotional and psychosocial support they received?
- ❖ What attitudes or beliefs do people living with cancer have about the spiritual, emotional and psychosocial support they received?

Method

A phenomenological orientated psychological approach was used in a cohort with a median age of 66 years to answer two related questions: 'What is the phenomenon that is experienced and lived?' and 'how does it show itself?' Semi-structured interviews of the participants were then transcribed and significant statements were extracted using Colaizzi (1978) methodology. Key themes, which form the basis of the findings, were then derived from the data by categorising words, statements, and phrases according to their similarities and characteristics. The remaining significant statements became the raw data for analysis. The relevance and benefits of the spiritual, emotional and psychosocial support were then identified using quality of life markers established during the data analysis.

Research Findings

Formulated meanings

- 1 **Pre-quality of life**
 - a Quality of life was poor due to a low mood and negative attitude
 - b Negative thoughts led to low self esteem and a sense of abandonment
 - c Quality of life was reduced due to physiological and psychological disabilities
- 2 **Post-quality of life**
 - a Mobility increased with an improvement in health and reduction in pain
 - b Reduction in negative emotions increased ability to do more, alleviating fatigue
 - c Quality of life improved rapidly along with general condition thus positively affecting the individual's whole life
 - d Attending the specialist palliative day care centre added to the individual's quality of life enabling them to achieve more
 - e Being in control of the situation provided the individual with a sense of normality
 - f Quality of life improved through positive attitudes of 'happiness,' 'fitness' and 'lack of worry'

Common themes

- 1 **Participant's negativeness**
 - a. Negative feelings and attitudes arose from isolation producing a sense of abandonment
 - b. The sense of abandonment increased anxiety and stress levels ultimately leading to loss of control
- 2 **Participant's positiveness**
 - a. Positive feelings and attitudes were nurtured through contact with peers and health care professionals producing a sense of unity
 - b. The sense of unity was increased through group activities, communication, enquiry and the ability to express feelings producing a sense of wholeness
- 3 **Participant's individuality**
 - a. The health care professionals acknowledge the participant's individuality through attentive listening and responding to him or her as a valued individual
 - b. The participant perceived the health care professionals treated him or her as a valued individual.
- 4 **Environment's atmosphere**
 - a. Participant's perceived the atmosphere as comforting, secure, stimulating and remedial providing a sense of well-being
 - b. The sense of well-being increased motivation, compliance and a positive change in how the participant perceived their symptoms
- 5 **Therapeutic interventions**
 - a. Therapeutic interventions had a direct effect on the participant's perception of their physiological and psychological well-being
 - b. Participants perceived an overall positive effect on their bodily health with an increase in strength, reduction in pain, fatigue and dyspnoea
- 6 **Rehabilitative care**
 - a. Participants perceived this as subtle treatments that could be accessed when required with an overall accumulative supportive effect
 - b. Treatments opened up opportunities, challenges and the ability to accomplish tasks and therefore provided the participant with a sense of control



Process

A 'simplified' model of research was used as the research framework, which included a 'pre-empirical stage' and an 'empirical stage' (Punch, 2000). This simplified model of research stresses: framing the research in terms of research questions, determining what data are necessary to answer those questions, designing research to collect and analyse those data, using the data (and the results of the data analysis) to answer the questions. The procedure followed Creswell's (1998) data collection circle: locating the site / individual; gaining access and making rapport; purposefully sampling; collecting data; recording information; resolving field issues and sorting data.

Conclusion

This research indicates that the role of the health care professionals in palliative care is to provide hope for individuals facing cancer. Hope in this context is the ability to equip the person with the knowledge that they can achieve more than they thought they could through the use of a variety of therapies and communication skills and so enhance the individual's quality of life.

References

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