

Psychological well-being in palliative care: A systematic review

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Tamara Redondo Elvira¹ ,
Celia Ibáñez del Prado², and
Juan Antonio Cruzado²

Abstract

Objective: To review which are the most influential variables in achieving levels of psychological well-being at the end of life and to verify whether, as certain studies suggest, spirituality, resilience and social support are the pillars on which the psychological well-being construct is based.

Method: A systematic search through the Scopus, Pubmed and PsycInfo electronic databases was carried out using keywords such as: “wellbeing” OR “psychological-well-being” AND “resilience” AND “spirituality” AND “social support” AND “palliative care” and their multiple combinations.

Results: Eleven studies were selected, in which terms such as spiritual well-being, absence of discomfort and quality of life were used in substitution of psychological well-being and a certain consensus was found regarding whether resilience, spirituality and social support are predictive variables of psychological well-being.

Conclusions: Resilience, social support and spirituality are highly relevant variables at the end of life and contribute decisively towards psychological well-being.

Keywords

psychological well-being, resilience, spirituality, social support

¹Department of Psychology, Spanish Association Against Cancer, Guadalajara, Spain

²Faculty of Psychology, Complutense University of Madrid, Madrid, Spain

Corresponding Author:

Celia Ibáñez del Prado, Complutense University of Madrid, Campus de Somosaguas, 28223 – Pozuelo De Alarcón, Madrid, Spain.

Email: ceibanez@ucm.es

Introduction

In recent years, mental health has changed its scope of action, leaving aside the symptom to take more into account the positive aspects that promote psychological well-being (Keyes, 2007; Seligman & Csikszentmihalyi, 2000; World Health Organization, 2005). The same has occurred in the field of Palliative Care, which is based on a health model in which the focus is not only on the patient's difficulties, but also on their skills and resources (Randbruch, Payne & Bercovitch, 2009).

Psychological well-being stems from two well-differentiated perspectives, on the one hand, subjective well-being that comes from the hedonic approach and, on the other, psychological well-being from the eudamonic approach. Subjective well-being articulates its definitions around two axes: the cognitive level assessment that each person makes of his/her own life, related to the term life satisfaction (defined as the discrepancy between expectations regarding one's own life and reality, Diener & Ryan, 2009; Kashdan et al., 2008); and affective evaluation, the balance that arises from contrasting positive and negative affects (Diener et al., 2002). Within the eudamonic perspective, Carol Ryff (1989) became its greatest exponent, coining the term psychological well-being, and defining it as reaching the maximum potential of the person throughout different moments of life, and proposing, in turn, a model with six dimensions: self-acceptance, positive relationships with others, autonomy, environmental mastery, personal growth and purpose in life. These 6 dimensions are concrete and stable indices of well-being (Huta, 2013; Vázquez & Hervás, 2008), which define psychological well-being both theoretically and operationally. In sum, this concept encompasses positive evaluations about oneself, the sense of self-determination, quality relationships with other individuals, as well as the belief that life has a purpose, and each person is capable of efficiently managing their environment while developing as a person (Ryff & Keyes, 1995).

In the field of palliative care, the well-being of the patient depends on various factors that encompass his/her physical, psychological, social and spiritual environments, which are included in the six dimensions of the concept developed by Ryff, as it is necessary to feel good about oneself, accepting one's limitations (self-acceptance); maintaining positive quality relationships (positive relationships with others); having control over the environment (environmental mastery); enhancing individuality and functionality (autonomy); giving meaning to your life (life purpose) and learning (personal growth) (Vázquez & Hervás, 2008). In recent years, scientific literature has focused on spirituality, without forgetting social support and coping skills (Watson et al., 2019).

Spirituality is defined as "the human aspect that refers to the way in which each person seeks and expresses meaning and how he/she lives the connection with the moment, with him/herself, with others and with the significant and the sacred" (Puchalski et al., 2009).

Underlying this definition is the idea that spirituality is a concept inherent to the human being, which emerges from within oneself and manifests itself in each culture (Maté & Juan, 2008). It focuses on harmony with oneself and in relationships, and loving and being loved, as well as on transcendence through hope and the need for belonging (Galiana et al., 2014). Therefore, spirituality plays a very prominent role in the approach to suffering at the end of life, as it is one of the best tools to address it (Barreto et al., 2015; Reig-Ferrer et al., 2015). It is in this stage when the person is forced to face various spiritual needs, which will help him/her find meaning in his/her life, maintaining hope and reaching the acceptance of death, if these needs are addressed effectively (Payás, 2003). Spirituality correlates with lower levels of anxiety and depression (Johnson et al., 2011; McClain et al., 2003; Nelson et al., 2002) and even with a better perception of physical health (Jim et al., 2015), which favors an adequate adjustment to the disease, as well as helps to reinforce psychological functioning (Mystakidou et al., 2008). Spirituality also favors psychological well-being (McClain et al., 2003), improves the patient's quality of life (Bovero et al., 2016; Rippentrop et al., 2006) and reduces emotional distress (Chibnall et al., 2002; Nelson et al., 2002).

Another factor that is especially relevant in palliative care is resilience, which allows us to focus on the protective factors that facilitate adequate coping with the end of life (Krikorian & Limonero, 2012). Resilience is a dynamic and multidimensional construct that refers to the ability to overcome adversity, recover and emerge stronger from it (Arrebola-Moreno et al., 2014; Grané & Forés, 2008; Ungar, 2011). In the field of palliative care, resilience refers to the patient's ability to face an incurable disease and the problems derived from it, in addition to facing the new perspective posed by a limited life prognosis (Randbruch & Payne, 2009).

Resilience is closely related to spirituality (Fombuena et al., 2016). The most resilient people are capable of experiencing positive emotions during stressful situations, which favors high levels of happiness and interest in their own life (Bonnano, 2004). It is associated with lower levels of emotional distress and higher quality of life (Min et al., 2013; Siebert, 2007), reducing the intensity of stress, anxiety, and depression (Hiew et al., 2000). Ultimately, resilience contributes to an adequate emotional adjustment to the disease process (Baider, 2003).

Regarding social support, it has been fully demonstrated that, when faced with an advanced disease, the patient's social world has the power to alleviate or increase the associated suffering (Garcia-Rueda et al., 2016). Social support can contribute towards acceptance of the disease, while promoting the dignity of the patient (Carter et al., 2004).

Social support is a complex and multidimensional concept that includes qualitative aspects, such as the feeling generated by interpersonal relationships; and quantitative, such as the size of the social network (De la Revilla & Fleitas,

1991). It includes different categories, among the ones that enjoy the most consensus are emotional/informational support, defined as the emotional support and guidance offered; instrumental support, which is characterized by behavior or support material; positive social interaction, which is related to spending time with others and the availability of these to be distracted, have fun, etc.; and affective support, characterized by expressions of love and affection (Costa-Requena et al., 2007; Sherbourne & Stewart, 1991; Tardy, 1985).

All these factors contribute significantly to the relief of suffering, the ultimate goal of palliative care. Suffering can be conceptualized as an experience inherent to the human being, which appears when facing the problems associated with disease, when it is perceived as a threat and for which the patient considers not having sufficient resources to deal with it (Krikorian & Limonero, 2012). For this reason, it is particularly important to define what personal resources are involved in the perception of psychological well-being. However, in the scientific literature there are no studies that show the relationship between these factors. However, research does show that spirituality is not only a necessity at the end of life, but that it becomes a resource to improve emotional well-being, closely linked to resilience and enhanced by social support (Barreto et al., 2015).

The objective of the present study is to review which are the most influential variables in achieving levels of psychological well-being at the end of life and to check whether, as certain studies suggest, spirituality, resilience and social support are the pillars on which the psychological well-being construct is based among the population at the end-of-life.

Method

The review followed the PRISMA model, carrying out an exhaustive search in the SCOPUS, Pubmed and PsycInfo databases, using the following terms in multiple combinations: “well-being” OR “psychological-well-being” AND “resilience” AND “spirituality” AND “social support” AND “palliative care” (Figure 1), during the time period that spans between January 1st, 2010 and December 31st, 2020.

Of the articles found, those that met the inclusion/exclusion criteria listed in Table 1 were selected.

In the first search, 188 articles were obtained, of which the majority were discarded after reading the abstract and objectives, leaving 26 articles. Subsequently, a critical reading of such articles was carried out, selecting 11 articles for the review.

Results

Only research articles published in scientific journals between 2010 and 2020, in English or Spanish, were included in this review, all of them being quantitative.

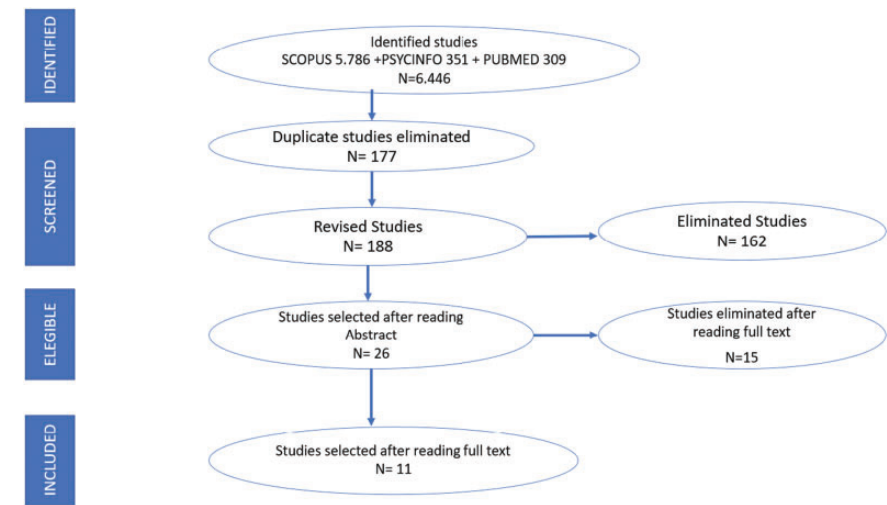


Figure 1. Flowchart.

Table 1. Inclusion and Exclusion Criteria Used in the Selection of Articles.

Inclusion criteria
Population: Adults with advanced disease, in palliative care or complex chronic patients.
Language: Spanish or English
Publication date: from 2010 onwards (last 10 years)
Studies in the field of psychological intervention
Articles that refer to psychological well-being in its multiple meanings found across the scientific literature and its predictive variables
Exclusion criteria
Studies regarding caregivers of patients in advanced situations
Studies in children or adolescents
Studies with samples of health professionals

Table 2 presents the analysis of the selected studies that explore psychological well-being and its predictive variables in patients with oncological, chronic, or advanced diseases.

Despite the scope of study, the review is based on large samples of patients, only three of the studies have a sample of less than 100 participants. Vinaccia and Quiceno’s study (2011), with 40 patients, has the smallest sample. However, more than half the studies, a total of 6, have a sample of more than 200 patients, with Gheihman et al.’s study (2016) presenting the largest sample of 341 newly diagnosed leukemia patients.

In relation to the characteristics of the patients, four of the studies have samples with patients at end-of-life (Bovero et al., 2019; Fombuena et al.,

9 **Table 2.** General Characteristics of the Analyzed Studies.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
Sharif et al., 2020 (Malaysia)	n = 145 100% women Mean age: 50.6 (± 9.65) Breast cancer diagnosis Time lapsed from diagnosis: 3 years (± 1.98)	Descriptive cross-sectional study	Spirituality: <i>Beliefs and Value Scale</i> Quality of Life: <i>McGill Quality of Life Questionnaire</i> Hope: <i>Herth Hope Index</i>	With greater spirituality, more hope ($B = 6.345$, $p < 0.001$). With greater spirituality, greater Quality of life ($b = 1.065$, $p < 0.001$). Greater educational level weakens the relationship between spirituality and hope ($b = -1.460$, $p < 0.001$).	Importance of spirituality for perceived health and well-being. Importance of the religious component of spirituality as the sample includes Muslim women. A high educational level reduces the effect of hope on spirituality. Need for individualized spiritual interventions.
Zysberg et al., 2019 (Israel)	n = 72 59% men Mean age: 64.14 (± 14.90) Hemato-oncological diagnosis (78% stage III and IV)	Correlational study	Severity of diagnosis and sociodemographical var.: <i>Clinical history</i> Social support: <i>Duke Social Support Scale</i> Emotional intelligence: <i>Audio Visual Test of Emotional Intelligence</i> Emotional experiences: <i>PANAS questionnaire</i> Quality of Life: <i>McGill</i>	Adequate quality of life predictive model ($\chi^2 = 4.75$; $df = 6$; $p > .05$; CFI = .99; NFI = .99; RMSEA = .02). Negative and positive affect mediates the relationship with Quality of life, Social support, Emotional intelligence, and salary. Positive affect is related to social support (0.50 ; $p \leq 0.04$) Negative affect with social support (-0.27 ; $p \leq 0.04$), emotional	Quality of life as a perception based on emotional response, mediated by personal (emotional intelligence), interpersonal (social support) and demographic (salary) factors. Emotional intelligence as a factor of psychological well-being. People under extreme circumstances (illness)

(continued)

Table 2. Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
			<i>Quality of Life Questionnaire</i>	intelligence (-0.15; $p \leq 0.04$) and salary (0.12; $p \leq 0.04$).	are able to find comfort and value their life in a positive way. Emotional intelligence and social support are protective factors that alleviate negative emotions and contribute towards a better quality of life.
Bovero et al., 2019 (Italy)	n = 235 palliative patients (Karfnosky Performace Status, KPS: 39.72) 52% women Mean age: 68 (range 30-91) Life expectancy mean: 27 days.	Cross-sectional study	Demoralization: <i>Demoralization Scale</i> Depression and Anxiety: <i>HADS</i> Dignity: <i>PDI</i> Spiritual well-being: <i>FACIT – Sp – 12</i> Symptomatology: <i>ESAS</i> Pain: <i>VAS</i>	Negative relationship between the demoraliza- tion syndrome and emo- tional well-being (depression $F = 77.65$; $p < 0.01$; anxiety $F = 48.13$; $p < 0.01$) social support ($F = 16.07$; $p < 0.01$) and also with spiritual well- being ($F = 93.99$; $p < 0.01$). There is no relationship between demoralization and medical variables (physical symptomatology and pain)	Understanding demorali- zation syndrome as the absence of psycholog- ical well-being. It is concluded that there are 5 factors that pre- dict it: “emotional dis- tress and coping difficulties; Loss of meaning and purpose, Uselessness, Feeling of failure and Dysphoria, the first being the most prevalent factor. And as a protective factor, spiritual well-being is found.

(continued)

∞ **Table 2.** Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
Kavak et al., 2019 (Turkey)	n = 302 55,7% age ≥ 51 58,4% women Diagnosis of advanced gastrointestinal cancer	Descriptive correlational study	Spirituality: <i>FACIT-Sp-12</i> Resilience: <i>BRCS</i>	Levels of spiritual well-being are high (31.41 ± 4.83) while those of resilience are moderate ($19,17 \pm 4.89$) Positive correlation between spiritual well-being and resilience ($r = 0.88$; $p = 0.000$)	Although the relationship between spirituality and resilience is more than proven, it does not seem that resilient coping is necessary to meet spiritual needs, although it makes it easier to achieve them more quickly.
Soto-Rubio et al., 2018 (Spain)	n = 404 202 patients being cared for in a Palliative Care Unit Mean age: $76,44 (\pm 9.850)$ 68.8% men 202 carers Mean age: $61,46 (\pm 13.521)$ 77.2% women	Cross-sectional study	Functional independence: <i>Barthel's Scale</i> Cognitive state: <i>SPMSQ</i> Emotional state: <i>HADS and DOS</i> Caregiver's Burden: <i>The Caregiver's Burden Scale</i>	Positive correlation between caregiver's burden and the emotional state of the patient without cognitive impairment ($r = 0.23$, $p = 0.007$) and patient with cognitive impairment ($r = 0.29$, $p = 0.005$). The model that predicts the emotional state is relatively acceptable ($\chi^2 = 13.63$, $p = 0.23$. CFI = 0.969, RMSEA = 0.063). It implies that caregiver's burden (0.22; $p = 0.23$) and functional independence of the patient (-0.29 ; $p = 0.23$)	The caregiver's burden and the functional ability of the patient have a decisive influence on the emotional state of the patient, regardless of whether they present cognitive deterioration or not. These two aspects must be taken into account when developing effective psychological interventions, considering it is easier to influence the caregiver's burden than the

(continued)

Table 2. Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
				influence the patient's emotional state.	patient's functionality, as the latter is irreversible at the end-of-life.
Rudilla et al., 2016 (Spain)	n = 70 being cared for in a Palliative Home Care Unit 35 patients in Counseling and 35 in Dignity Therapy 60% men Mean age: 72.14 (\pm 14.29)	Randomized controlled trial with 2 therapeutic groups (Dignity Therapy and Counseling)	Emotional distress: <i>HADS</i> Dignity: <i>PDI</i> Emotional well-being includes: -Resilience (<i>BRCS</i>) -Spirituality (<i>GES</i>) -Social support: <i>Duke-UNC-11 Functional Social Support Questionnaire</i> -Quality of Life: <i>EORTC-QLQ-C30</i>	There are significant differences for both groups in dignity, anxiety, spirituality, and quality of life. Dignity therapy increases levels in depression ($t = -3.736$; $p = 0.001$) and there are no differences in resilience ($t = -1.961$; $p = 0.058$) after intervention. Counseling does not affect depression ($t = -1.652$; $p = 0.108$) and improves resilience ($t = -3.025$; $p = 0.005$). After intervention, better results in anxiety, especially in the counseling group ($t = -2.341$; $p = 0.022$).	The promotion of resilience is more linked to emotional well-being, conceptualized as reducing anxious and depressive symptomatology. Close relationship between spirituality and social support, related to the interpersonal factor of the former.
Gheihman et al., 2016 (Canada)	n = 341 recent diagnosis of leukemia 55.1% men	Longitudinal study	Depressive symptoms: <i>BDI-II</i> Hopelessness: <i>BHS</i> Physical performance:	High scores in depression related to less hope for the future (5.23 ± 5.25 vs. 2.34 ± 2.47 ; $p < 0.0001$), less	Faced with a prognosis of limited life span, hopelessness appears, contributing negatively to

(continued)

Table 2. Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
	Mean age: 50.16 (\pm 16.02)		KPS Scale Physical symptoms: MSAS Self-esteem: RSES Attachment: ECR-M16 Spiritual well-being: FACIT -Sp -12 Social support: MOS-SSS Communication with healthcare personnel: CARES	self-esteem (32.27 ± 5.13 vs. 36.50 ± 4.38 ; $p < 0.0001$), worse spiritual well-being (21.25 ± 6.67 vs. 27.06 ± 4.35 ; $p < 0.0001$) and greater anxiety related to attachment (3.12 ± 1.54 vs. 2.05 ± 1.03 ; $p < 0.0001$) and worse symptomatic control (all p 's < 0.0001). High scores in hopelessness related to greater depressive symptomatology (17.43 ± 8.73 vs. 8.82 ± 5.43 ; $p < 0.0001$), less self-esteem (29.64 ± 4.96 vs. 36.36 ± 4.24 ; $p < 0.0001$), less perceived social support (71.04 ± 23.61 vs. 86.07 ± 16.08 ; $p < 0.0001$), and worse spiritual well-being.	the emotional well-being of the patient. However, with a good prognosis, hopelessness does not appear, yet depression does. Importance of physical symptomatology, closely related to depression, in the case of leukemia it is derived from medical treatments and not so much with the progression of the disease, therefore, its effect on physical symptomatology is more related to the lack of pleasant activities and social activities. Regardless of the prognosis and the type of illness, spirituality continues to be a protective factor.

(continued)

Table 2. Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
Wang et al., 2016 (China)	n = 227 Hematological diagnosis Mean age: 45.48 (\pm 16.05) 51.5% men	Cross-sectional study	Depressive symptoms: <i>Center for epidemiologic studies depression scale</i> Anxiety symptoms: <i>Zung Self-rating Anxiety Scale</i> Optimism: <i>Life Orientation Scale-Revised</i> Resilience: <i>RS-14</i> Self-efficacy: <i>General Perceived Self-Efficacy Scale</i>	Resilience shows a negative correlation with depression ($\beta = -0.174$, $p < 0.05$). Optimism shows a negative correlation with depression ($\beta = -0.479$, $p < 0.001$) and anxiety ($\beta = -0.393$, $p < 0.001$). Self-efficacy does not show significant relationships with anxiety symptomatology ($\beta = -0.055$, $p > 0.05$) or depressive symptomatology ($\beta = -0.032$, $p > 0.05$).	The positive psychological resources (resilience and optimism) of the patient favor emotional well-being, in this case understood as the absence of anxiety or depression, protecting the patient from the negative effects of the disease.
Fombuena et al., 2016 (Spain)	n = 108 Patients from Palliative Care Units 51.9% women Mean age: 68.09 (± 12.71)	Cross-sectional study	Resilience: <i>BRCS</i> Spirituality: <i>GES</i> Poor symptom control: <i>ESAS</i> Social Support: <i>conceptualized as 1 (living together, care...); 0 (alone)</i> Worry: <i>What worries you the most? 2 categories: Pain,</i>	Good fit of the predictive model of spirituality: $\chi^2 = 35.03$ ($p > 0.05$), CFI = 0.951, GFI = 0.932, SRMR = 0.068, and RMSEA = 0.032. The general spirituality factor is positively predicted by resilience (0.424; $p < 0.05$) and negatively by discomfort related to physical	Resilience, social support, and physical symptoms act as predictor variables of spirituality, the strongest relationship being that of resilience. Spiritual well-being contributes in a decisive way to psychological well-being, with an important presence of

(continued)

Table 2. Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
			<i>Concern About Pain (CAP) and Discomfort Symptoms, Main Discomfort Symptoms, (MDSs).</i>	symptoms (-0.269; $p < 0.05$) and by the social support network (-0.268; $p < 0.05$). However, there is a positive effect of the social support network on the interpersonal dimension of spirituality (0.370; $p < 0.05$).	social support and resilient coping.
Cowlshaw et al., 2013 (Australia)	n = 324 Adults institutionalized in residencies. 53% women Mean age: 80.55 (\pm 4.1)	Longitudinal study	Spirituality: <i>SPS</i> Social support: <i>British Health and Lifestyle Survey</i> Sense of coherence: <i>Orientation of Life Questionnaire</i> Satisfaction with Life: <i>5 items from a longer questionnaire</i> (Campbell et al., 1976)	Spirituality is related to the need for vital meaning ($\beta = 0.11$, $p < 0.05$); which in turn is related to satisfaction with life ($\beta = 0.24$, $p < 0.01$); finding a bidirectional relationship ($\beta = 0.14$, $p < 0.05$). Also, social support predicts satisfaction with life ($\beta = 0.17$, $p < 0.01$)	Satisfaction with life can be conceptualized as the cognitive component of subjective well-being (hedonic perspective). Of the components of spirituality, intrapersonal (search for meaning) is the most determinant when making a positive assessment of life. And in addition, social support also contributes decisively to satisfaction with life.

(continued)

Table 2. Continued.

Reference	Sample	Method and design	Variables and instruments	Results	Conclusions
Vinaccia & Quicero, 2011 (Colombia)	40 patients diagnosed with COPD. N = 40 COPD Diagnosis 55% women Mean age: 68.9 (± 3.8)	Correlational cross-sectional study	Illness Perception: <i>IPQ-B</i> Resilience: <i>RS-14</i> and <i>CD-RISC2</i> Spirituality: <i>SBI-15R</i> and <i>SCS</i> Quality of Life: <i>Health Questionnaire MOS SF-36</i>	Positive correlations between resilience and mental health ($r = 0.320$; $p < 0.05$). Regarding the linear regression analysis, personal control ($\beta = 0.439$; $t = 3.231$; $p = 0.003$) and the consequences of perception of illness ($\beta = -0.386$; $t = -2.840$; $p = 0.007$) significantly influence quality of life.	Resilience promotes emotional regulation and personal control. However, it is the concerns regarding the disease and its course that negatively influence quality of life.

PANAS: Positive and Negative Affect Schedule; HADS: Hospital Anxiety and Depression; PDI: Patient Dignity Inventory; FACIT - Sp - 12: The Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being; ESAS: Edmonton Symptoms Assessment System; VAS: Visual Analog Scale; BRCS: Brief Resilience Coping Scale (BRS); SPMSQ: Portable Mental Status Questionnaire; DOS: Discomfort Observation Scale; GES: Grupo de Espiritualidad SECPAL (SECPAL Spirituality Group); EORTC - QLQ - C30: EORTC Quality of Life C30 Questionnaire; BDI-II: Beck Depression Inventory-II; BHS: Beck Hopelessness Scale; KPS: Karnofsky Performance Status (KPS) Scale; MSAS: Memorial Symptom Assessment Scale; RSES: Rosenberg Self-Esteem Scale; ECR-M16: Experiences in Close Relationships Inventory; MOS-SSS: Medical Outcomes Study Social Support Survey; CARES: Cancer Rehabilitation Evaluation System Medical Interaction Subscale; SPS: Spirituality Perspective Scale; RS-14: Resilience Scale; IPBQ-B: Disease Perception Questionnaire; CD-RISC2: Connor-Davidson Resilience Scale; SBI-15R: Belief System Inventory; SCS: Scale of Spiritual Coping Strategies

2016; Rudilla et al., 2016; Soto-Rubio et al., 2018); among which, Bovero et al.'s study (2019) set as an inclusion criterion that life expectancy should be less than 4 months and Rudilla et al.'s study (2016) estimated life expectancy to be greater than two weeks. Five of these studies are carried out with cancer patients. Sharif et al.'s study (2020) worked with women diagnosed with breast cancer, while Kavak et al.'s study (2019) presented a sample of patients diagnosed with advanced gastrointestinal cancer; the other three studies obtained samples from haemato-oncological patients (Gheihman et al., 2016; Wang et al., 2016; Zysberg et al., 2019). Finally, the remaining two studies had samples of complex chronic patients diagnosed with COPD (Vinaccia & Quiceno, 2011) and institutionalized in nursing homes (Cowlshaw et al., 2013).

Regarding the design, six of the selected studies present a cross-sectional design (Bovero et al., 2019; Fombuena et al., 2016; Sharif et al., 2020; Soto-Rubio et al., 2018; Vinaccia & Quicero, 2011; Wang et al., 2016); four of the studies have a longitudinal design (Cowlshaw et al., 2013; Gheihman et al., 2016; Kavak et al., 2019; Zysberg et al., 2019). Finally, Rudilla et al.'s study (2016) is a randomized controlled trial of two groups, on the one hand, patients who received a psychological intervention based on Dignity Therapy and on the other, patients who were treated through Counseling.

Assessment of the methodological quality

The assessment of the methodological quality of each study was carried out in a standardized way, using the "Quality Assessment Tool for Quantitative studies (EPHPP, 2008)", designed by "The effective Public Health Practice Project" (National Collaborating Center for Methods and Tools, 2008). The "Quality Assessment Tool for Quantitative Studies (National Collaborating Centre for Methods and Tools, 2008)" is designed to simultaneously evaluate both controlled and uncontrolled studies and includes 8 dimensions or components: "Selection bias"; "study design"; confounding variables "confounders"; "blinding"; "data collection methods"; "withdrawals and dropouts"; Integrity in relation to the intervention (adherence) "intervention integrity"; Analysis of the data "analysis". The last two dimensions do not score, while for the remaining 6, 3 different scores can be awarded: "weak", "moderate" or "strong", where "strong" is the category for a higher quality corresponding to a lower probability of biases (Table 3).

As can be seen in Table 4, of the selected studies, the dimensions that have the greatest robustness are those related to data collection and sample selection. However, the opposite occurs with the "design" dimension, as they are not controlled and randomized groups, it scores as a weak dimension in terms of methodological quality.

Table 3. Quality Assessment tool for Quantitative Studies.

	Selection bias	Design	Cofounding variables	Blinding	Data collection	Withdrawals and dropouts
Sharif et al., 2020	Strong	Weak	Weak	Moderate	Strong	Strong
Zysberg et al., 2019	Strong	Weak	Weak	Moderate	Strong	Weak
Bovero et al., 2019	Strong	Weak	Weak	Weak	Strong	Strong
Kavak et al., 2019	Moderate	Weak	Weak	Moderate	Strong	Strong
Soto-Rubio et al., 2018	Strong	Weak	Weak	Moderate	Strong	Weak
Rudilla et al., 2016	Strong	Strong	Moderate	Moderate	Strong	Strong
Gheihman et al., 2016	Strong	Weak	Weak	Moderate	Strong	Weak
Wang et al., 2016	Moderate	Weak	Weak	Weak	Moderate	Moderate
Fombuena et al., 2016	Moderate	Weak	Weak	Weak	Strong	Weak
Cowlshaw et al., 2013	Strong	Weak	Weak	Weak	Strong	Weak
Vinaccia & Quicero, 2011	Moderate	Weak	Weak	Weak	Strong	Weak

Table 4. % Studies Based on the *Quality Assessment Tool for Quantitative Studies*.

	Strong	Moderate	Weak
Selection bias	63.64%	36.36%	0%
Design	9.09%	0%	90.09%
Cofounding variables	0%	9.09%	90.09%
Blinding	0%	54.54%	45.45%
Data collection	90.09%	9.09%	0%
Withdrwals and dropouts	36.36%	9.09%	54.54%

Discussion

Regarding the initial objective of this review, a certain consensus is observed regarding the predictive variables of psychological well-being; the most prevalent being: resilience (Fombuena et al., 2016; Kavak et al., 2019; Rudilla et al., 2016; Vinaccia & Quiceno, 2011; Wang et al., 2016), spirituality (Bovero et al., 2019; Cowlshaw et al., 2013; Fombuena et al., 2016; Gheihman et al., 2016; Kavak et al., 2019; Rudilla et al., 2016; Sharif et al., 2020; Vinaccia & Quiceno, 2011) and social support (Cowlshaw et al., 2013; Fombuena et al., 2016; Rudilla et al., 2016; Zysberg et al., 2019). Physical functioning also showed its relevance as it is present in all the analyzed studies, however, as with other variables, it is conditioned by the disparity of instruments used to evaluate it.

Resilience, spirituality, and social support become protective factors against anxiety and depressive symptoms, as well as enhancers of psychological well-being. In the case of resilience, it is a fundamental factor (Vinaccia & Quiceno, 2011; Wang et al., 2016) that shows a remarkably close relationship with spirituality (Kavak et al., 2019), and, together with social support, it becomes its predictor (Fombuena et al., 2016; Rudilla et al., 2016). Spirituality also becomes

a protective factor against one of the most prevalent syndromes found in the end-of-life situation, such as the Demoralization Syndrome (Bovero et al., 2019), as well as anxiety and depressive symptoms, also closely related to hope, which positively influences quality of life, social support, and resilience (Gheihman et al., 2016) and even decisively influences, together with social support, in life satisfaction (Cowlshaw et al., 2013). Social support is revealed as a protective factor against negative affect (Zysberg et al., 2019), and even an adequate management of caregiver's burden can positively influence the emotional well-being of the patient (Soto-Rubio et al., 2018).

The rest of the variables that are described as predictors of psychological well-being at the end of life in the analyzed studies are part of the three predictor variables previously considered. Thus, in the case of spirituality, these variables would be hope, sense of dignity and sense of coherence (Benito & Barbero, 2014). Regarding resilience, emotional intelligence (García-Maroto Fernández et al., 2015), self-esteem (Solano et al., 2016), optimism (Thornton et al., 2012), self-efficacy, and in the case of social support, communication (Thompson et al., 2009), social network (Carter et al., 2004; Viel Sirito, 2016) and attachment (Rodin et al., 2007).

Psychological well-being is a complex construct to define and measure. In fact, as can be seen in the articles analyzed in this review, there is no consensus regarding its definition, as none of the definitions can be equated with the more accepted definition of psychological well-being presented by Ryff (1989), as they tend towards three fundamental directions. On the one hand, it is equated with the term quality of life (Rudilla et al., 2016; Sharif et al., 2020; Zysberg et al., 2019), with which it shares the difficulty of definition. There is some consensus in relation to two characteristics of the Quality-of-Life construct. On the one hand, it is a subjective and multidimensional (physical, emotional, social, and spiritual) phenomenon and on the other, in the end-of-life stages, there is a greater deterioration of it, which highlights the reason why it is a term that cannot be equated to well-being as although the quality of life decreases as the physical deterioration increases, well-being follows that rhythm (Vicuña et al., 2002). On the other hand, the most used, the absence of psychological discomfort (Gheihman et al., 2016; Soto-Rubio et al., 2018; Wang et al., 2016), which focuses on anxiety and depression as these are the symptoms more prevalent in palliative patients, their absence indicating good indices of emotional well-being (Barreto et al., 2015), except in the case of Bovero et al.'s study (2019) which places the focus on the absence of Demoralization Syndrome. And, finally, the focus is placed on spiritual well-being (Fombuena et al., 2016; Kavak et al., 2019), when it refers to a sense of purpose, coherence, personal fulfillment and gives meaning to life, which is associated with greater psychological well-being and quality of life, influences them, but they are not equivalent terms (Reig-Ferrer et al., 2015). It should be noted that two of the reviewed studies do not include the definition of well-being within these three predominant lines.

This is the case of Vinaccia and Quiceno's study (2011), who equate it to the term mental health, while Cowlshaw et al.'s (2013) study uses the term life satisfaction.

This great variability shows the need for an adequate definition of the construct, applicable to the field of palliative care. *A priori*, to reach this consensus, three fundamental characteristics regarding well-being should be considered: it is subjective, it is the person him/herself who makes this assessment; It is variable, depending on the course of the disease and the different needs that arise throughout the process; and it is comprehensive, as it encompasses the physical, psychological, social, and spiritual part of the person (Limonero & Bayés, 1995). And once the term is delimited, it would be important to have a valid instrument that adapts to the characteristics of the patient and that is characterized by brevity, simplicity, by questions appropriate to the level of the patient and that its administration, in itself, is already capable of generating therapeutic effects (García-Rueda et al., 2016). This disparity of instruments used that is observed in the scientific literature makes the analysis of the construct even more difficult.

It should also be noted that the presence of key predictor variables in the achievement of psychological well-being clearly warrants the need for the development of a theoretical model that will serve as a guide in future research to develop one that is completed with the established predictor variables and that can elucidate the possible impact of each of them on this construct. With this model, it would be possible to create a multicomponent psychological treatment to improve the well-being of people who are in the last days of their lives. And, in addition, create a valid measurement instrument that gathers the fundamental predictor variables of said construct.

Among the limitations of the study, the difficulty, on the one hand, to locate studies focused on psychological well-being at the end of life, and on the other, finding studies that focus on protective factors (as the trend is put it on the risk factors) was noteworthy. At the same time, there was great difficulty when defining the psychological well-being variable as such, without using similar or substitute terms, which therefore implies a great disparity in diagnostic tests and difficulty in drawing conclusions. Finally, the absence of a model that serves as a framework for psychological well-being for the end-of-life situation should be noted.

Conclusions

Based on all the articles reviewed, it can be concluded that resilience, social support and spirituality are highly relevant variables at the end of life and contribute decisively to psychological well-being. Another variable that is shown as determinant of well-being in patients in final phase of life is the emotional situation of the caregiver, with studies reflecting that a lower burden of

the main caregiver corresponds to higher levels of emotional well-being in the patient attended. These variables would define the well-being construct, this being one of the primary objectives to be achieved for palliative care intervention.

By focusing on the variables that enhance well-being, despite the situation of intense suffering in which the person is immersed in the end-of-life situation, the psychologist would include his/her intervention within the salutogenic model of current psychology that is proposed for palliative care where attention is paid to protective variables (Moreno & Stanton, 2013; Salmon et al., 1996).

In addition, this review shows the need to review the term psychological well-being, beyond the conceptualization of the absence of psychological discomfort or suffering, as this would not be included within said current approach.

Looking ahead, it is advisable to continue performing studies in this regard, focusing on predictor variables that may be the necessary clue for the creation of an explanatory theoretical model that helps develop effective intervention techniques to improve psychological well-being in patients at the end of life.

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ORCID iD

Tamara Redondo Elvira  <https://orcid.org/0000-0001-5663-6663>

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Author Biographies

Tamara Redondo Elvira, is a PHD candidate at the doctoral program of Psychology and currently serves as psychooncologist in Spanish Association against Cancer. Her research interests pertain issues of palliative care and coping with cancer.

Celia Ibáñez del Prado, PhD, is a clinical psychologist. Professor at the Faculty of Psychology of the Complutense University of Madrid, Spain. His area of research is Psycho-Oncology and Palliative Care. She has served as psychologist in a palliative unit at Virgen de la Poveda Hospital.

Juan Antonio Cruzado, PhD, is a clinical psychologist. Professor of Health Psychology at the Faculty of Psychology of the Complutense University of Madrid, Spain. His area of research is Psycho-Oncology and Palliative Care. He is director of the Master in Psycho-Oncology and Palliative Care at the Complutense University of Madrid, and editor of the journal *Psicooncología* (ISSN 1696-7240).