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Will to live in cancer patients receiving palliative care

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Abstract

The will to live is a complex dimension in illness and at the end of life, related to multiple factors. This study aimed to analyze the prevalence of the will to live and associated factors in cancer patients receiving palliative care. The longitudinal study used a structured script for socioepidemiological assessment; the Edmonton Symptom Assessment Scale; the Social Support Scale; the Depression, Anxiety, and Stress Scale; the Herth Hope Scale; and the Analogical Will to Live Scale. It was found that none of the sociodemographic variables influenced the will to live. People who had increased social support in the affective dimension had a reduction in the will to live at T1 (p=0.047); those who had low social interaction had a low will to live at T2 (p=0.011). In terms of hope, those who started with increased scores had a reduction in the will to live from T1 to T2 (p=0.011), but those who maintained high scores at T2 maintained a high will to live (p=0.008).

Keywords: Palliative care. Neoplasms. Social support. Anxiety. Depression. Hope. Volition.

Resumo

Vontade de viver em pacientes com câncer em cuidados paliativos

Vontade de viver é uma dimensão complexa na doença e no final da vida, relacionada a múltiplos fatores. O objetivo do estudo foi analisar a prevalência da vontade de viver e fatores associados em pacientes oncológicos em cuidados paliativos. O estudo longitudinal utilizou roteiro estruturado para avaliação socioepidemiológica; escala de avaliação de sintomas de Edmonton; escala de apoio social; escala de depressão, ansiedade e estresse; escala de esperança de Herth; e escala analógica da vontade de viver. Verificou-se que nenhuma das variáveis sociodemográficas influencia a vontade de viver. Pessoas que apresentaram apoio social aumentado na dimensão afetiva tiveram redução na vontade de viver em T1 (p=0,047); as que apresentaram baixa interação social tiveram baixa vontade de viver em T2 (p=0,011). Na esperança, aqueles que iniciaram com escores aumentados tiveram redução na vontade de viver de T1 para T2 (p=0,011), mas quem manteve escores altos em T2 manteve alta vontade de viver (p=0,008).

Palavras-chave: Cuidados paliativos. Neoplasias. Apoio social. Ansiedade. Depressão. Esperança. Volição.

Resumen

Deseo de vivir en pacientes con cáncer en cuidados paliativos

El deseo de vivir es una dimensión compleja en la enfermedad y al final de la vida, relacionada con múltiples factores. El objetivo del estudio fue analizar la prevalencia del deseo de vivir y los factores asociados en pacientes oncológicos en cuidados paliativos. El estudio longitudinal utilizó un guion estructurado para la evaluación socioepidemiológica; la Escala de Evaluación de Síntomas de Edmonton; la Escala de Apoyo Social; la Escala de Depresión, Ansiedad y Estrés; la Escala de Esperanza de Herth; y la Escala Analógica de Deseo de Vivir. Se verificó que ninguna de las variables sociodemográficas influye en las ganas de vivir. Las personas que presentaban un mayor apoyo social en la dimensión afectiva mostraron una reducción en el deseo de vivir en T1 (p=0,047); las que presentaban una baja interacción social mostraron pocas ganas de vivir en T2 (p=0,011). En cuanto a la esperanza, aquellos que comenzaron con puntuos elevados tuvieron una reducción en el deseo de vivir de T1 a T2 (p=0,011), pero los que mantuvieron puntos altos en T2 mantuvieron uno alto deseo de vivir (p=0,008).

Palabras clave: Cuidados paliativos. Neoplasias. Apoyo social. Ansiedad. Depresión. Esperanza. Volición.

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Research

Palliative care (PC) interventions should be evidence-based and include prevention, early identification and assessment, and management of physical suffering (pain and other symptoms), social needs, and psychological and spiritual distress, while respecting individuals' values and beliefs [1]. In addition, they are applicable and modifiable throughout the course of the disease and according to the patient's needs [2].

For cancer patients in PC, one facet of treatment needs to be focused on controlling physical signs and symptoms, such as pain, fatigue, anorexia, dysphagia, nausea, vomiting, and constipation, among others [3]. These symptoms deteriorate functionality and significantly impact quality of life and should be managed effectively and humanely [4].

The Canadian Edmonton Symptom Assessment System scale [5], translated and validated into Brazilian Portuguese as the *Escala de Avaliação de Sintomas de Edmonton* (ESAS), is a simple and useful instrument for clinical practice in various settings. This is a tool that uses the patient's report to assess the intensity of symptoms using a numerical visual scale, ranging from 0 (minimum intensity) to 10 points (maximum intensity): pain, tiredness (weakness), shortness of breath, nausea, sadness, anxiety, drowsiness, appetite, and well-being [6].

Physical symptoms can influence the prevalence of anxiety and/or depression symptoms, whether it is the development or worsening of these symptoms [7]. Thus, the Depression, Anxiety, and Stress Scale (DASS), originally developed by Lovibond and Lovibond [8], allows tracking different emotional states in a single instrument. The DASS-21 was adapted and validated for Brazilian Portuguese by Vignola [9] as a self-administered scale, comprising three subscales (one for each emotional state), each with 7 Likert-type items.

In the DASS-21, for each of the 21 items, the person being evaluated must indicate their degree of agreement with what was read in the following options: "Did not apply at all" (0 points), "Applied to some degree, or for a short time" (1 point), "Applied to a considerable degree, or for a good part of the time" (2 points), "Applied a lot, or most of the time" (3 points) [9].

Social support refers to the relationships through which a person receives emotional, affective, and material help to cope with difficult situations, perceiving themselves as cared for, valued, cherished, and loved within the context of the groups to which they belong [10,11]. When patients perceive themselves as important within their social network, they may exhibit better adaptation to the disease, adopt positive behaviors such as adherence to or maintenance of the proposed therapy, have better prognoses, and greater survival [12].

In this context, Sherbourne and Stewart [13] developed a scale to assess and encompass the various dimensions of social support, called the Social Support Scale, to be used in the Medical Outcomes Study, a study with patients with chronic conditions, called MOS-SSS. This scale consists of 19 items originally distributed across five dimensions, covering different aspects of social support (affective, positive social interaction, emotional, informational, and tangible) [14,15].

Based on an initial instruction, the participant must answer: "If you need to, how often do you rely on someone?" selecting one of the five possible answers according to a five-point Likert scale: 0 ("never"), 1 ("rarely"), 2 ("sometimes"), 3 ("almost always"), and 4 ("always"). After the correlation assessment, the authors proposed combining the emotional and informational dimensions into a single subscale [13].

After a cancer diagnosis, it is essential to maintain hope, since the news, usually received as a death sentence, causes intense suffering and can lead to feelings of hopelessness, which negatively affect the prognosis. Balsanelli and Grossi [16] observed that patients who maintained or strengthened their feelings of hope demonstrated greater ability to accept the diagnosis and follow therapeutic recommendations, as well as higher rates of treatment adherence and, consequently, a more positive response to treatment.

To assess hope, there are currently 18 scales, with the Snyder Hope Scale and the Herth Hope Index [17] being the most widely used. The latter index was constructed and validated by Herth [18] and later adapted and validated in Brazil by Sartore [19] under the name *Escala de Esperança de Herth*

(EEH), comprising 12 items and based on three essential components: temporality and future, positive expectancy, and interconnectedness. Thus, it proves valuable as a screening tool [18]. Each item is graded on a 4-point Likert scale, ranging from "strongly disagree" (1) to "strongly agree" (4). The total score ranges from 12 to 48 points, and higher scores indicate a greater level of hope [20].

In studies with patients with advanced cancer, significant correlations were found between will to live and physical symptoms, anxiety, and sense of well-being [21]. The will to live was also found to vary during the course of the disease, possibly, and such fluctuations change as death approaches [22]. Another study found that most patients have a high will to live, even in the proximity of death. However, it also found that a low will to live is directly related to the existence of physical and psychological suffering [23].

In this context, the will to live is considered a complex dimension within the experience of illness and end of life and is related to multiple factors [24]. In the clinic, a single-item instrument to assess the will to live can serve as a starting point for discussing this complex topic and help the multidisciplinary team identify specific areas of intervention.

From the perspective of palliative care, the will to live has been little explored in the literature and is directly related to quality palliative care. Measuring the will to live and its related factors may increase professionals' awareness of care needs and improve patient care.

Thus, the objective of this study was to analyze the prevalence of the will to live and its associated factors, whether physical, social, psychological, or spiritual, in cancer patients in PC at a reference hospital for cancer treatment in Ceará.

Method

This is a longitudinal population study, conducted in two periods, designated T1 and T2, in which T1 refers to the first interview and T2 to the second, which occurred three months after the first. Data collection took place at the Haroldo Juaçaba Hospital (HHJ), a reference hospital for cancer treatment in Ceará, specifically at the Corina Parente Outpatient Clinic. Data collection took place between April and October 2023.

For this study, a structured socioepidemiological assessment script was created, with variables such as age, sex, race, origin, marital status, number of children, education, occupation, income, number of household members, who is the household provider, religion, and history of the current illness, which was the first instrument applied in the interview (T1). After this, the ESAS was applied, followed by the MOS-SSS, the DASS-21, the EEH, and finally the *Escala Analógica da Vontade de Viver* (VdV).

The VdV was created for this research based on the findings of Bornet and collaborators [24] to objectively assess the interviewee's self-reported will to live in a score format (1 to 10), in which 1 means little will to live and 10 means high will to live.

In the second interview (T2), the same scales were applied, in the same sequence, except for the socioepidemiological questionnaire. All individuals with a result ≥50% on the Palliative Performance Scale (PPS) were included in the study, provided they had a complete level of consciousness [25].

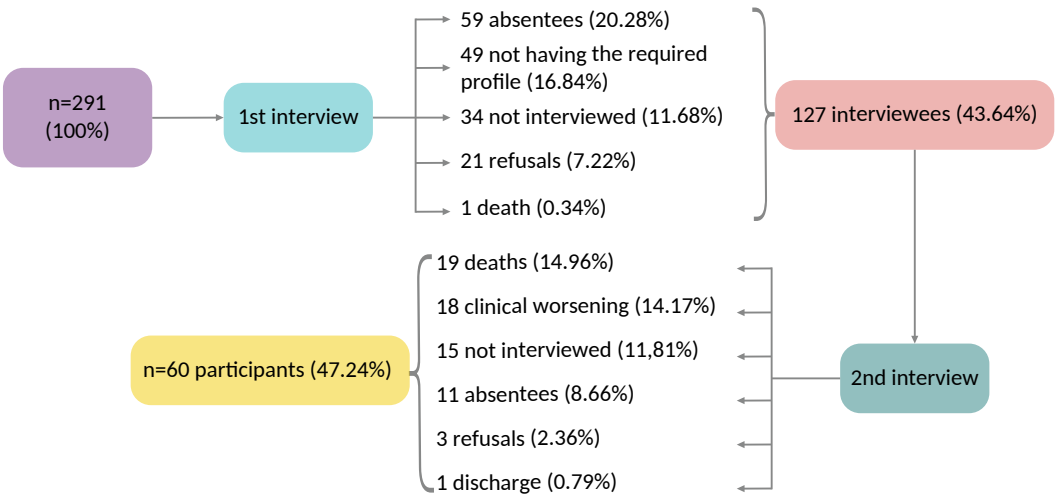
The study population included patients who, during the data collection period, had their first consultation at the Corina Parente Outpatient Clinic, in the pain and palliative care service. These people were referred from various other services at HHJ, such as clinical oncology, oncological surgery, or radiotherapy. In addition, patients referred directly from the screening service to the exclusive palliative care service at the time their medical record was opened were included.

Based on the study by Julião and collaborators [23], which observed that patients who can adapt to the disease have a greater will to live compared to patients who are not (75% versus 35.5%), an estimation was made that the study would require evaluating between 56 and 72 patients to obtain a sample that had between 80% and 90% power and 95% confidence in rejecting the null hypothesis of this study (Fleiss method with continuity correction).

After missed appointments, refusals, and exclusion of patients whose profile did not meet the clinical/cognitive requirements for participating in the study in T1, 127 patients were interviewed, representing 43.64% of the total number of patients admitted to the Pain and Palliative Care Clinic (n=291) over approximately 3 months. While the second interview (T2) was conducted with the same participants from T1, starting three months after the first evaluation, there was sample loss due to deaths, worsening of clinical/cognitive condition, refusal to continue in the study, and even discharge from follow-up.

Finally, 60 participants (47.24%) who met the inclusion criteria agreed to be interviewed again. With the appropriate sample size reached, data collection was concluded, and 15 participants (11.81%) were not interviewed (Figure 1).

Figure 1. Graphical representation of the final number of study participants



Source: developed by the authors (2025)

The data were expressed as mean ± standard deviation or as absolute and percentage frequencies. Cronbach's alpha internal consistency coefficients were calculated for each questionnaire and its respective constructs. The mean scores at T1 and T2 were compared using the Wilcoxon test, and the frequencies were compared using Pearson's chi-square test.

In addition, patients were categorized according to whether or not there was a reduction in the will to live at T1 and T2. These data were associated with other clinical-psychosocial variables using the Kruskal-Wallis/Dunn tests. In all analyses performed, a 95% confidence level was adopted. The collected data were tabulated and analyzed using IBM SPSS Statistics for Windows, version 20.0.

The project was submitted to the Ethics Committee on Plataforma Brasil for approval. The study followed the guidelines of Resolution 466/2012 of the National Health Council (CNS) [26].

Results

Sociodemographic, economic, and clinical assessment

Of the 60 participants evaluated, most were aged 50 to 79 years, lived in the capital city, identified as miexd-race, were female, and were married/living with a partner. Most reported having children, living with more than one person, and having attended school, but only at the elementary level. Catholicism predominated among the participants.

The majority (78%) reported not having any employment at the time of the interview. The individual income of 91% of respondents was between 1 and 2 minimum wages, which was also the family income range (85%), and most respondents stated they were not the sole financial provider for their family (68%). Most of the sample reported receiving retirement

benefits (45%), followed by those who reported having government social benefits as their only source of income (36%).

The following cancers were most prevalent in the medical records: breast cancer (20%), gastrointestinal tract cancer (16.7%), prostate cancer (18.3%), and head and neck cancer (11.7%). Half of the sample presented metastases; 35% of the sample had undergone combinations of two cancer treatment modalities (bimodal), with chemotherapy combined with radiotherapy being the most prevalent; another 35% of the sample underwent three or more different types of treatment (trimodal), with the combination of chemotherapy, radiotherapy, and surgery being the most prevalent.

Physical, social, psychological, and spiritual variables

In the overall assessment of will to live, both at T1 (9.32±1.86) and T2 (9.07±2.12), the scores were high (above 9), with a slight reduction at T2, but without a statistical difference (p=0.190). Stratification was also performed to determine who had a reduction, maintenance, or increase in will to live from T1 to T2. Of the 60 participants evaluated, 10 (16.7%) showed a reduction in the will to live from T1 to T2, and 46 (76.7%) maintained a high will to live.

Based on this last analysis of reduction, maintenance, and increase in the will to live, the results of all scales used in the research (ESAS, DASS-21, MOS-SSS, EEH) were evaluated to identify possible associations among variables. Age, sex, race, whether they live in the capital, marital status, whether they have children, number of people they live with, education, religion, working conditions, and income did not significantly influence the reduction in will to live. The same occurred with the clinical characteristics of the sample: type of cancer, presence or absence of metastases, and treatment modalities used did not significantly influence the will to live.

Regarding the ESAS, there was no statistically significant difference in will to live from T1 to T2. As for the DASS-21 scale, symptoms of anxiety, stress, and depression did not influence the variation in will to live from T1 to T2, as there was also no statistical difference.

Regarding the MOS-SSS, subdivided into domains, people who started the study at T1 with a reduced will to live showed increased scores in the affective dimension of social support (p=0.047). At T2, in the assessment of the positive social interaction dimension, people who obtained lower scores also presented a reduction in the will to live (p=0.011), showing an association between the two variables (Table 1).

In the hope scale assessment, people who started the study at T1 with increased hope scores were those who showed a significant reduction in the will to live (p=0.011). At T2, people who had higher hope also maintained a high will to live (p=0.008) (Table 2).

Table 1. Will to live and social support scale

MOSS-SSS	VdV from T1 to T2			*p*-value*
	Reduced	Maintained	Increased	
T1 Tangible dimension	**2.07±0.65**	**3.45±0.51**	**1.50±0.75**	**0.794**
Low	–	4 (8.7)	–	0.577
Medium	3 (30.0)	6 (13.0)	1 (25.0)	–
High	7 (70.0)	36 (78.3)	3 (75.0)	–
T1 Affective dimension	**3.65±1.16**	**2.13±0.31**	**–**	**0.047**
Low	1 (10.0)	1 (2.2)	–	0.075
Medium	4 (40.0)	5 (10.9)	–	–
High	5 (50.0)	40 (87.0)	4 (100.0)	–

continues...

Table 1. Continuation

MOSS-SSS	VdV from T1 to T2			*p*-value*
	Reduced	Maintained	Increased	
T1 Emotional/Informational dimension	**8.89±2.81**	**7.59±1.12**	**4.08±2.04**	**0.559**
Low	1 (10.0)	4 (8.7)	–	0.481
Medium	4 (40.0)	14 (30.4)	3 (75.0)	–
High	5 (50.0)	28 (60.9)	1 (25.0)	–
T1 Social Interaction dimension	**5.24±1.66**	**4.21±0.62**	**1.00±0.50**	**0.369**
Low	1 (10.0)	5 (10.9)	–	0.522
Medium	4 (40.0)	14 (30.4)	–	–
High	5 (50.0)	27 (58.7)	4 (100.0)	–
T2 Tangible dimension	**3.43±1.08**	**3.38±0.50**	**1.00±0.50**	**0.787**
Low	1 (10.0)	3 (6.5)	–	0.846
Medium	1 (10.0)	7 (15.2)	–	–
High	8 (80.0)	36 (78.3)	4 (100.0)	–
T2 Affective dimension	**2.66±0.84**	**1.75±0.26**	**–**	**0.174**
Low	–	–	–	0.341
Medium	3 (30.0)	7 (15.2)	–	–
High	7 (70.0)	39 (84.8)	4 (100.0)	–
T2 Emotional/Informational dimension	**8.95±2.83**	**6.01±0.89**	**2.87±1.44**	**0.160**
Low	2 (20.0)	2 (4.3)	–	0.375
Medium	3 (30.0)	10 (21.7)	1 (25.0)	–
High	5 (50.0)	34 (73.9)	3 (75.0)	–
T2 Social Interaction dimension	**5.84±1.85**	**3.59±0.53**	**1.50±0.75**	**0.189**
Low	4 (40.0)	2 (4.3)	–	0.011
Medium	1 (10.0)	15 (32.6)	2 (50.0)	–
High	5 (50.0)	29 (63.0)	2 (50.0)	–

**: p<0.05, Kruskal-Wallis/Dunn test (mean±SD) or Pearson's chi-square (n, %)*

Table 2. Will to live and hope scale

EEH	VdV from T1 to T2			*p*-value*
	Reduced	Maintained	Increased	
T1 EEH	**7.65±2.42**	**5.48±0.81**	**4.04±2.02**	**0.011**
Decreased	1 (10.0)	–	–	0.002
Normal	2 (20.0)	10 (21.7)	4 (100.0)	–
Increased	7 (70.0)	36 (78.3)	–	–
T2 EEH	**4.37±1.38**	**5.09±0.75**	**4.03±2.02**	**0.008**
Decreased	–	1 (2.2)	–	0.047
Normal	8 (80.0)	13 (28.3)	2 (50.0)	–
Increased	2 (20.0)	32 (69.6)	2 (50.0)	–

**: p<0.05, Kruskal-Wallis/Dunn test (mean±SD) or Pearson's chi-square (n, %).*

Discussion

Regarding sociodemographic variables, most participants were female, with an average age of 65 years, low education, and low income, results similar to those of other studies with cancer patients in palliative care developed in Brazil [27-29].

In Brazil, an estimated 483,000 new cases were expected in 2023 (excluding non-melanoma skin cancer), with 49.5% (239,000) in men and 50.5% (244,000) in women. Female breast and prostate cancers each represent approximately 15% of new cases, followed by colorectal cancer (9.4%), trachea, bronchus, and lung cancer (6.7%), stomach cancer (4.4%), and cervical cancer (3.5%) [30]. In this study, the prevalence of breast cancer (20%) and prostate cancer (18%) was higher than expected for the country.

The presence of symptoms, especially pain in its biopsychosocial complexity, has been widely discussed as a determinant of quality of life for patients in PC [31-33]. Other symptoms, such as lack of appetite, dyspnea, depression, anxiety, and lack of well-being, and hospitalization were associated with a statistically significant reduction in survival [34].

This study found no statistical difference between the presence of physical symptoms and the will to live. Most patients maintained (76.7%) or increased (6.7%) a strong desire to live, despite the challenges and burdens faced in the course of approaching death, influenced by multiple physical and psychological aspects, as also described in another study [23].

Social support refers to an individual's perception of the people they can trust and rely on in times of need, and who make them feel cared for and valued [11]. The functional dimensions of social support are: emotional, affective, tangible, informational, and positive social interaction [13].

Specifically exploring the affective dimension on the MOS-SSS scale, the items evaluated are: "that shows love and affection for you," "that gives you a hug," and "that you love and that makes you feel loved," which presented high scores in T1, indicating a high perception of this support by the respondents. However, these people also showed a reduction in the will to live, an unexpected result.

This data showed that the reduction in the will to live occurred even under conditions of increased affective social support at T1, i.e., an increased affective dimension at T1 is a predictor of the reduction in the will to live from T1 to T2. Different results were found by Carvalho and collaborators [35], according to whom women diagnosed with breast cancer reported feelings of anguish, pain, suffering, sadness, and guilt. However, feelings of hope, faith, strength, peace, and the will to live, as well as social support, were also reported as sources of safety, motivation, and coping to continue, although without specifying the dimension.

A situation that may be related to the result found in this research was described in the study carried out by Supiano and collaborators [36], which observed participants concerned about becoming a caregiving burden on their families and friends, or a financial burden, a time commitment, emotional strain from observing the progression of the disease, and imminent death. Hudson and collaborators [21] found that the most common factors associated with the desire to anticipate death appear to be: feeling like a burden to others, loss of autonomy with the progression of the disease (and an associated desire to control the circumstances of death), physical symptoms (such as pain), depression and hopelessness, existential concerns and fear of the future.

The positive social interaction dimension, whose evaluation items are "to have fun together," "with whom to relax," "with whom to distract the mind," "with whom to do pleasant things," had reduced scores in T2 and was associated with a reduction in the will to live. In a study conducted to find out how families organize themselves to cope with cancer and the sick person, most family members reported investing in social life, with activities such as going to the beach and outings, with a predominance of family activities, to offer support to the sick member [37].

However, another study demonstrated a decrease in the functional capacity of individuals with cancer and, as a consequence, greater dependence in performing daily activities.

This reduction occurs due to possible alterations in the cognitive, locomotor, and communication systems caused by the disease or treatment [38]. Due to the loss of functionality resulting from the disease and/or treatment, there was an inferred reduction in the will to live, associated with decreased social interaction.

Depression and anxiety are prevalent disorders in cancer patients, frequently studied and evaluated in different ways and on different scales [39-43]. In clinical practice, there is difficulty in detecting depression in cancer patients, particularly because some somatic symptoms, frequently associated with depression, may result from the cancer itself or even from the treatment. Furthermore, depressive symptoms may be underestimated, mistakenly, because all cancer patients are "understandably depressed" [44].

This study found no significant relationship between symptoms of anxiety, stress, and depression, and the will to live. However, a longitudinal study conducted with elderly (non-cancer patients) found that, at the end of life, weakening of the will to live is a predictor of depressive symptoms, and not the other way around [45]. The life events theory argues that exposure to general life events, particularly negative ones (e.g., a cancer diagnosis), can disrupt the human organism and cause stress. Stress, in turn, initiates physiological and psychological adaptation processes that require investment of substantial personal resources (emotional, physical, behavioral, social, and financial). These significant adaptive demands and continuous efforts can lead to exhaustion and, consequently, physical illness, and the struggle to maintain physical and mental health often results in chronic stress and depression [46].

"Survivors," tired of fighting for existence and aware of the short life they have ahead of them, may begin to wonder if such a life is still worthwhile, an uncertainty that undermines their will to live. Such feelings can cause increasing apathy towards the world around them and a loss of motivation to continue living, as well as symptoms of passive suicidal ideation. Symptoms of this type lead to persistent withdrawal from regular social and health activities, even from previously pleasurable ones. Changes in daily behavior exacerbate the decline in health and function, which can further accelerate people's loss of interest in life and intensify the main symptoms of depression, including feelings of emptiness and apathy. Ultimately, this process can lead to pathological depression syndrome and loss of the will to live. Given this, maintaining a strong and stable will to live can protect people from declines in their mental health [45].

The fear of mortality among people with cancer is a significant element that permeates their experiences from the moment of diagnosis and influences their perspective and hope throughout the treatment process. The feeling of lack of control over one's own life, combined with the fear of death, compromises adaptive resources and undermines expectations regarding the future [47]. In contrast, characteristics observed in a study by Li and collaborators [48] that can lead to increased levels of hope are age less than or equal to 45 years, religious beliefs, and reporting of milder symptom burdens.

In this study, participants who started with higher hope scores showed a reduction in the will to live at T2, an unexpected finding. A different, but related, situation occurred in a study conducted in Türkyie [47], which observed that, with the increase in the educational level of the participants, the average scores of the hope subscales also increased, which may have contributed to improving the feeling of uncertainty, learning coping behaviors, investigating, and reading articles about the disease. In another longitudinal study [49], hope was not diminished after engagement in advance care planning, and may even be increased, i.e., having "difficult" conversations with patients can make them more comfortable and safer.

Hope often arises from a negative circumstance in which the probability of a given outcome is low, but highly important to the individual, such as remission or cure of a patient with advanced cancer. Although maintaining hope at higher levels yields proven benefits, both physical and psychological, it can also increase the likelihood that the patient will exhibit biases, such as motivated reasoning, self-deception, optimism, and superiority. This can also lead to overtreatment and regret [50].

In T2, people with higher hope scores also maintained a high will to live, and hope must be fostered and sustained at the end of life. In general, patients who feel they have more control over themselves at the end of life showed increased levels of hope [51,52]. Discussing end-of-life care, or even completing advance directives, can be an effective way for patients to gain the additional control needed to foster hope at the end of life [49].

Limitations

This study was conducted in a single hospital and over a specific period of time. Therefore, the characteristics of the study site and the social and cultural conditions of that period and population may have influenced the results in ways that are not generalizable. The follow-up period between assessments T1 and T2 was relatively short. It may not have been sufficient to capture significant changes in will to live and other variables of interest over time.

Multivariate analysis models combined with qualitative methods might provide additional insights into the patterns of association among the variables studied, thereby improving understanding of the data. Further studies in this area are needed, given the scarcity of publications on the subject.

Final considerations

Among participants, the will to live was high at both T1 and T2, with a slight reduction in scores at T2, but without statistical difference. From T1 to T2, 16.7% of those surveyed showed a reduction in their will to live, but 76.7% maintained a high will to live. The will to live was not found to be influenced from T1 to T2 by any of the variables studied: age, sex, race, housing, marital status, children, education, religion, work and income, type of cancer, metastases, or treatment modalities.

The ESAS assessment of physical symptoms was not significantly related to changes in the will to live. Participants who reported increased social support in the affective dimension showed a reduction in the will to live at T1, and those who reported low social interaction also showed low will to live at T2. The assessment of depression, anxiety, and stress by the DASS-21 was not significantly related to changes in the will to live.

Finally, it is noteworthy that people who started the study with increased hope scores had a reduction in the will to live from T1 to T2, and those who maintained increased hope scores at T2 also maintained a high will to live.

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