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Research Paper

Affective States and Life Satisfaction in Cancer Patients

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ABSTRACT

The present study aimed to examine the influence of age, education level, and place of residence on the positive affect, negative affect, and life satisfaction of male cancer patients. The sample consisted of 180 male cancer patients, equally distributed across categories of age (young, middle-aged, and older), education (educated and uneducated), and residence (rural and urban). Participants were administered the Positive and Negative Affect Scale (Watson, Clark, & Tellegen, 1988) and the Satisfaction with Life Scale (Diener et al., 1985). Data were analyzed using three-way Analysis of Variance (3×2×2 ANOVA) followed by Tukey's HSD post hoc tests to examine intergroup differences. Results indicated significant main effects of age and education on positive affect, and of residence on negative affect. Older cancer patients scored significantly higher on positive affect as compared to younger patients. While educated patients reported greater positive affect than uneducated ones. Urban patients showed significantly higher negative affect than rural counterparts. However, no significant effects of age, education, and residence were observed on life satisfaction. Interaction effects of age, education and place of residence were also not significant. These findings suggest that older age and higher education enhance positive emotions. Whereas urban living is associated with greater emotional distress among cancer patients. This study highlights the need for demographically sensitive psychosocial interventions to promote emotional well-being among cancer patients. Younger, uneducated, and urban patients may particularly benefit from psychoeducational and emotional regulation programs to improve coping and quality of life.

Keywords: *Positive affect, negative affect, life satisfaction, age, education, residence, Subjective Well-being*

Subjective Well-being (SWB) is often used as a conceptual umbrella term for a wide array of constructs and measures that reflect some aspect of physical, social or emotional functioning (Gladis, Gosch, Dishuk, & Crits-Christoph, 1999). From this perspective, SWB is one of the several indicators of QOL. Consistent with this assertion, Diener (2006) has redefined SWB as "*an umbrella term for different valuations that people make regarding their lives, the events happening to them, their bodies and minds, and the circumstances in which they live"* (p. 400). This definition shows considerable similarity to world health organization's definition of QOL. As with earlier definitions of SWB, positive and negative feelings are typically included in QOL as a psychological domain. Thus, SWB refers to how people experience the quality of their lives that includes both emotional

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reactions and cognitive judgments. It encompasses moods and emotions as well as evaluations of one's satisfaction with general and specific areas of one's life (Diener, 2000).

Affective States

The affective part is a hedonic evaluation of life guided by emotions and feelings such as the frequency with which people experience pleasant and unpleasant moods in reaction to their lives. Positive affect (PA) refers to the extent to which an individual experiences positive emotional states such as joy, interest, confidence and alertness. Negative affect (NA) refers to the extent to which an individual experiences negative emotional states such as fear, sadness, anger, guilt, contempt and disgust. According to Watson and Clark (1984), each of these emotional dimensions incorporates aspects of self-esteem. Individuals with high PA tend to have a positive self-view, whereas individuals with low PA tend to be insecure and unsure of themselves. Similarly, individuals with high NA tend to have a negative self-view, whereas individuals with low NA tend to be secure and satisfied with their lives. Thus, persons with high self-esteem tend to report high PA and low NA.

Life Satisfaction

The cognitive part of SWB is an information based appraisal of one's satisfaction with life as a whole. Shin and Johnson (1978) defined life satisfaction as "a global assessment of a person's life according to his chosen criteria" (p. 478). The global life satisfaction focuses on the past, present and future levels of life satisfaction. Satisfaction judgments can be general such as "I am satisfied with my life" or specific such as "I am satisfied with my health" These judgments of life, work, marriage, health and other domains can be based on past emotional experiences or present state (Michalos, 1991).

Just as life satisfaction (LS) arises from a judgment made by the person about his life, affect also arises from cognitive appraisals. The emotional system produces hedonic level of SWB which is much more reactive to short term life events. In contrast, LS judgments may take a long term perspective and are more likely to involve a big picture of the person's life. The relationship between LS and affect is likely to be substantial, but it may unlikely to have same correlation. The size of the relation will depend on the time frame of the affect and satisfaction questions, on the degree to which the persons' conscious and unconscious motives differ and on numerous other aspects.

Bradburn (1969) has initially demonstrated the relative independence of positive and negative affect. He indicated that well-being is critical balance between positive and negative affect. Contrary to common misconception, positive and negative affect can co-occur at the same time in same individual. Carstensen, Pasupathi, Mayr, and Nesselroade (2000) explored age differences in emotional experience over the adult life span and focusing on the frequency, intensity, complexity, and consistency of emotional experience in everyday life. One hundred eighty-four people (age range 18 to 94-years), participated in an experience sampling procedure in which emotions were recorded across a one week period. Age was found to be unrelated to frequency of positive emotional experience. A curvilinear relationship best characterized negative emotional experience. Researchers found U-shaped age differences in NA and reported that NA decreased from age 18 until about age 60 but did not change from age 60 to age 94. Individual factor analyses computed for each participant revealed that age was associated with more differentiated emotional experience. In addition, periods of highly positive emotional experience were more likely to endure among older people and periods of highly negative emotional experience were less stable.

Extensive research in decision making has shown that individuals often fail to retrieve all relevant information when making judgments about LS and often over weight information that happens to be most accessible at the moment of evaluation. Schwarz and Strack (1999) differentiated the influences of information that is made temporarily accessible and information that is chronically accessible on judgments of LS. Evidence indicates that people focus more on information that was made temporarily salient in their evaluations of LS (Smith, Schwarz, Roberts, & Ubel, 2006).

Studies indicate that objective events and emotional responses may change day to day and moment to moment but retrospective recall involves long lasting impressions. People use a host of cognitive shortcuts that includes an evaluation of the best moments and the most recent moments. People are also influenced by prior expectations of how they imagined beforehand the situation would turn out. People have a level of SWB even if they do not consciously think about it, and the psychological system offers virtually a constant evaluation of life events.

People may also form a LS judgment in response to the stressful events. It can be influenced by the memories and life domains which are salient at the time, as well as by what comparison standards are particularly prominent. This reasoning suggests that LS for most people is not likely to be a platonic form, stored in a discrete and simple way; rather, it is a complex judgment which can be altered and updated. As such, it may be subject to the influence of current mood and of situational influences which make certain memories of life domains salient. At the same time, LS judgments are likely to show some stability because many people have made and stored judgments about specific aspects of their lives because the life circumstances on which life judgments are made tend to be stable.

There is evidence that health and SWB may mutually influence each other, as good health tends to be associated with greater happiness. Relationship of health and SWB has been explored with the expectation that illness might reduce the feeling of "wellness" due to experience of discomfort, economic liabilities, functional limitations, and feeling of insecurity (Dubey, 2003). Some research studies demonstrate high well-being with objectively poor health, many other demonstrate low well-being even in the absence of the signs of somatic illness (Mishra, 2009).

A longitudinal study conducted by Brief, Butcher, George, and Link (1993) also failed to find a direct effect of objective health on global LS. Instead, LS was predicted by subjectively interpreted health, which was influenced by objective health condition and NA. However, it is plausible that the global LS of severely ill cancer patients and non patients may differ only slightly (Breetvelt & Van Dam, 1991). One reason for this small difference may depend on cognitive strategies (such as downward comparison) used by cancer patients that induce a positive image of their health condition. Findings indicate that if people find a better way to appraise their health positively, the adverse impact of disease on LS is mitigated. Furthermore, people in poor health conditions downplay the importance of their health when evaluating their global LS. Although adaptation has been one of the most relevant explanation for the weak association between objective health status and SWB, but sometimes adaptation is not fully completed.

The patients diagnosed with cancer subsequently experience a depressed mood and a lack of PA (Helgeson, Snyder, & Seltman, 2004; Stommel, Kurtz, Given, & Given, 2004). Over time, most cancer patients adapt relatively well with their conditions, but certain negative

emotions such as uncertainty and a fear of recurrence may persist in the long term (Schroevers, Ranchor, & Sanderman, 2006). Many cancer patients face continued emotional challenges long after cancer diagnosis and treatment. For some patients, the cancer experience may be akin to other life traumas such as loss of valued life roles and resources that may have the potential to exacerbate long term change in SWB and recalibrate affective set point in a negative direction.

In marked contrast is the view that how people perceive, interpret, recall and actually experience life events may be more critical to their well-being than the nature of the events themselves. The general consensus is that although to some degree objective situational factors (such as income, health and age) influence people's perception of SWB; ultimately, SWB is a subjective phenomenon, with subjective feelings, thoughts, perceptions, and evaluations of the situation even more important than the situation itself (Heller, Watson, & Hies, 2004).

Restoration of Well-Being under Stressful Conditions

The usual SWB maintenance process may become destabilized when people diagnosed with cancer. Diagnosis of cancer are deemed life altering, and for which the person believes he lacks the necessary coping skills that may likely to have adverse impact on domain satisfaction and LS. Parenthetically, the impact on domain satisfaction is based on the assumption that most adverse events differentially affect particular life domains. For instance, cancer symptoms may diminish health satisfaction and in turn, overall life satisfaction (to the extent that health is a central life domain for the individual). However, certain life events hold the potential to exert a cross over effect on multiple life domains. For instance, health threats or loss may adversely affect physical activity and in turn may affect social relationships. More to the present point, facing cancer may affect functioning and satisfaction across multiple life domains such as work, family, social, and other roles may all become disrupted to varying degrees.

Personality variables have also been seen to influence restoration of domain satisfaction and overall life satisfaction both directly and indirectly through cognitive and behavioral routes. More specifically, particular traits may affect how people label life events, perceive their coping efficacy and select coping options. For instance, those with a tendency to have high NA may inclined to respond adversely to problematic life events and hold less favourable view about their coping abilities. In contrary, those with high levels of PA may interpret their circumstances and coping skills in more favourable ways (Lent, 2007). Large inter individual variability has also been found in the emotional reactions to cancer (Stanton & Snider, 1993). Individual differences in psychological and social resources may constitute the main source of variability in SWB in cancer.

The following objectives are formulated for the proposed study-

1. To explore the impact of age, education levels, and place of residence on positive affect of cancer patients.
2. To explore the impact of age, education levels, and place of residence on negative affect of cancer patients.
3. To explore the impact of age, education levels, and place of residence on life satisfaction of cancer patients.

Hypothesis

The following hypothesis have been formulated to empirically validate the objectives of the study-

1. Young age cancer patients (below 40 year age) would score lower on positive affect and life satisfaction and higher on negative affect as compared to middle age (41 to 60 year age) and old age (above 60 year age) cancer patients.
2. Educated cancer patients would score higher on the measures of positive affect, and life satisfaction, and lower on negative affect as compared to uneducated cancer patients.
3. Rural cancer patients would score higher on the measures of positive affect and life satisfaction and lower on negative affect as compared to urban cancer patients.

Sample

The sample of the study comprised 180 male cancer patients. Patients were equally distributed according to the place of residence and level of education. Criteria for inclusion were that the respondents had been diagnosed with cancer and were willing to participate.

Tools

1. **Personal Data Schedule** A semi-structured interview, designed by the researcher, was utilized to collect participants' demographic and cancer-related information. This included age, education, place of residence, household income, stage of cancer, duration of diagnosis, treatment regimen (e.g., chemotherapy, radiation and radio medicine, surgery or lifestyle management), and self-reported complications or comorbidities associated with cancer.
2. **Positive and Negative Affect Scale (PANAS):** The Hindi version of the positive and negative affectivity scale (Watson, Clark and Tellegen, 1988) was applied to assess the affective component of SWB. The PANAS is comprised of two ten-item self-report scales designed to measure positive and negative affectivity. Ratings of 20 mood adjectives are made on a five point scale that includes very slightly or not at all (1), a little (2), moderately (3), quite a bit (4), and extremely (5). The subjects are required to mark one of the five points that they consider the most appropriate in terms of degree of importance for given items. Internal consistency estimates have ranged from 0.86 to 0.90 for the positive affectivity scale and from 0.84 to 0.87 for the negative affectivity scale. Reliability of the scale for the present study was computed by alpha coefficient (Cronbach alpha method) and its value was found to be 0.79.
3. **Satisfaction with Life Measure:** This measure has been developed by Diener, Emmons, Larsen and Griffin (1985) and later revised by Pavot and Diener (1993). This scale consists of 5 items, each to be rated on a seven point scale. The respondents are required to mark one of the seven points that they consider the most appropriate (in terms of degree of importance) for given item. The coefficient alpha for the scale is 0.87 and test-retest reliability is 0.82. In the present study reliability was found satisfactory for scale (Cronbach's Alpha 0.81).

Procedure

In this study first of all rapport has been established with the participants then purpose of the study was explained. When it was found that particular participant is convinced to participate in the study, the necessary instructions were given to participate in the study. All participants were assured of the confidentiality of their responses.

RESULTS

Since the sample of cancer patient represented diverse age group (young, middle aged and old), education (educated and uneducated group) and place of residence (rural and urban), thus the study focused on the effect of age, education and residence on positive affect, negative affect, and life satisfaction. To test the impact of demographics (e.g., age, education, place of residence) on positive affect, negative affect, and life satisfaction, a 3×2×2 design was implicated and three way ANOVA was performed. The obtained data were analysed in terms of means, standard deviations and Univariate Analysis of Variance (ANOVA). The study focuses on the assessment and differences in positive affect, negative affect, and life satisfaction of cancer patients.

Effects of Age Groups (Younger, Middle aged and Older), Education level and Rural-Urban Area on Positive Affect, Negative Affect, and Life Satisfaction in Cancer Patients.

To examine the impact of age (younger, middle age and older), education (educated-uneducated) and residence (rural-urban) on SWB of cancer patients 3×2×2 ANOVA has been performed. Further, Tucky's HSD Post Hoc test was applied for comparing the three age groups, namely 28 to 40 years (younger group), 41 to 60 years (middle aged group) and 61 to 70 years (older group). The mean, SD, F-ratio and Tucky's HSD Post Hoc test score on different measures of SWB are given from Table 1 to Table 5.

Table 1 Mean and SD of Groups on Positive Affect, Negative Affect and Life Satisfaction Measures

Age	Positive Affect							
	Rural				Urban			
	Educated		Uneducated		Educated		Uneducated	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Younger Group	23.31	4.23	22.18	5.89	26.13	5.59	23.09	5.22
Middle aged Group	25.58	6.43	24.15	5.46	28.42	6.43	25.59	7.01
Older Group	27.00	8.12	26.35	5.62	28.60	6.12	26.56	8.65
Negative Affect								
Younger Group	29.92	8.43	26.24	7.13	29.38	6.99	35.00	6.02
Middle aged Group	27.08	9.88	27.65	7.82	32.37	6.96	33.29	8.31
Older Group	29.83	10.12	29.15	8.34	27.80	7.31	29.22	8.38
Life Satisfaction								
Younger Group	17.31	4.29	18.24	4.49	18.29	5.16	19.00	4.56
Middle aged Group	19.42	3.92	20.05	5.27	21.21	3.97	17.29	5.19
Older Group	20.17	4.59	20.54	4.67	19.00	5.03	17.89	4.14

Table 2 Composite Mean and SD of Groups on Positive Affect, Negative Affect and Life Satisfaction

Variable	Positive affect		Negative affect		Life satisfaction	
	Mean	SD	Mean	SD	Mean	SD
Younger Group	24.02	5.51	29.62	7.57	18.20	4.65
Middle aged Group	25.96	6.39	30.28	8.38	19.57	4.82
Older Group	26.28	6.17	28.88	8.24	19.66	4.69
Rural	24.79	6.02	28.29	8.37	19.45	4.66
Urban	26.08	6.13	30.90	7.55	18.86	4.84
Educated	26.47	6.11	29.48	8.01	19.22	4.66
Uneducated	24.40	5.93	29.71	8.14	19.09	4.85

Table 3 ANOVA outcomes on Positive Affect, Negative Affect and Life Satisfaction

		Positive affect		Negative affect		Life satisfaction	
Sources of Variations	**d. f**	**MS**	**F**	**MS**	**F**	**MS**	**F**
Age	2	179.84	4.74**	24.14	.38	30.94	1.39
Education	1	155.61	4.09*	21.87	.35	7.16	.32
Residence	1	121.07	3.19	370.83	5.91*	11.53	.52
Age × Education	2	28.20	.07	1.32	.021	23.63	1.07
Age × Residence	1	6.22	.16	170.91	2.72	28.09	1.27
Education × Residence	2	27.67	.73	174.14	2.77	49.10	2.22
Age × Education × Residence	2	.32	.008	85.90	1.37	19.49	.88
Error	188	37.97		62.79		22.17	
Total	199						

**p ≤ .05, **p ≤ .01*

Effects of Age, Education and Residence on Positive Affect

The mean scores of different groups on positive affect are given in Table 3. The mean score of the older patients group is higher than the middle aged and younger group. The mean score of the urban group is higher than the rural group. The mean score of educated group is generally higher than the uneducated group.

Table 5 shows that the main effects of age (F= 4.74, p<0.01) and education (F = 4.09, p <.05) to be significant on positive affect. Results indicate that older (61 to 74 years) group (M = 26.28, SD = 6.17) scored significantly higher than the middle aged (M = 25.96, SD = 6.39) and younger groups (M = 24.02, SD = 5.51) on positive affect.

Tucky's HSD Post Hoc test was used to examine the differences among the three age groups (Table 6). Results reveal that older group significantly differ to younger group on positive affect according to Tucky's HSD Post Hoc test. The other intergroup differences, i.e., between younger and middle aged group, and between middle aged group and older group were not significant. Educated group (M = 26.73, SD =6.25) scored significantly higher than the uneducated group (M = 24.73, SD =6.22). The main effect of residence was not significant. Although the urban group (M = 26.67, SD =6.46) scored higher than rural groups (M = 24.79, SD =6.02). No one interaction of age, education and residence was found to be significant for positive affect.

Table 4 Tucky's HSD Post Hoc test for effect of Age on Positive Affect

	Positive affect		
	Younger Group	**Middle aged Group**	**Older Group**
Group Means	24.02	25.96	27.16
Younger Group	-	1.94	3.14*
Middle aged Group	-	-	1.20
Older Group	**-**	**-**	**-**

**p ≤ .05*

Effects of Age, Education and Residence on Negative Affect

The mean and SD obtained by different groups on negative affect are given in Table 3. The mean score of the older group is higher than the middle aged and younger groups. The mean scores of the urban group are higher than the rural group. The mean scores of educated and uneducated groups are approximately similar.

Analysis of variance (Table 5) revealed the main effects of residence ($F = 5.91$, $df = 2,198$, $p < .05$) to be significant on negative affect. The urban group scored ($M = 30.90$) significantly higher than the rural group ($M = 28.29$). The main effects of age and education were not found to be significant. Although the middle aged group ($M = 30.28$) scored higher than the younger ($M = 29.62$) and older group ($M = 28.88$), and uneducated ($M = 29.71$) group scored higher than the educated group ($M = 29.48$), but these differences were not significant. The interaction effects of age, education and residence were not found to be significant.

Effects of Age, Education and Residence on Life Satisfaction

The mean and SD of groups on life satisfaction are given in Table 3. The mean score of the older group is higher than the middle aged and younger group. The mean score of the rural group is higher than the urban group. The mean scores of educated and uneducated groups are approximately similar.

Table 5 shows that neither the main effects of age, education and residence nor the interaction effect of age, education and residence found to be significant for life satisfaction. However, older group ($M = 19.66$) scored higher than the middle aged ($M = 19.57$) and younger group ($M = 18.20$). The mean scores of the rural group ($M = 19.45$) is higher than the urban group ($M = 18.86$). The mean scores of educated group ($M = 19.16$) is higher than uneducated group ($M = 19.09$).

DISCUSSION

The present study sought to investigate the influence of age, education level, and place of residence on positive affect, negative affect, and life satisfaction among male cancer patients. Using a 3×2×2 factorial design, the results revealed distinct demographic influences on affective and cognitive aspects of subjective well-being (SWB).

Impact of Age on Positive and Negative Affect and Life Satisfaction

The findings revealed a significant effect of age on positive affect, with older cancer patients (above 60 years) showing significantly higher positive affect compared to younger patients (below 40 years). Tukey's post hoc test further confirmed that the older group differed significantly from the younger group. These results partially support the first hypothesis, which predicted lower positive affect and life satisfaction and higher negative affect among younger patients.

Older adults' higher positive affect can be explained through Socioemotional Selectivity Theory (Carstensen, Isaacowitz, & Charles, 1999), which posits that as individuals age, they shift focus toward emotionally meaningful goals and experiences, thereby enhancing positive affect despite health adversities. In contrast, younger cancer patients are likely to perceive their diagnosis as a major threat to identity, goals, and future prospects, resulting in more distress and reduced positive emotions (Mosher & Danoff-Burg, 2005).

Although the effect of age on negative affect and life satisfaction was not statistically significant, mean comparisons suggested that older patients reported slightly higher life satisfaction and lower negative affect. This pattern aligns with the notion that emotional resilience and acceptance coping increase with age, even when objective health declines (Charles & Carstensen, 2010). Nonetheless, cancer-related suffering, treatment burden, and existential concerns may have constrained the expected age-related gains in subjective well-being.

Impact of Education Level on Affective States and Life Satisfaction

The study found a significant main effect of education on positive affect, with educated cancer patients scoring higher than their uneducated counterparts. However, education did not significantly influence negative affect or life satisfaction. This result partially supports the second hypothesis and suggests that educational attainment may enhance emotional well-being by fostering cognitive understanding, perceived control, and effective coping (Helgeson & Tomich, 2005).

Educated patients are more likely to seek information, communicate effectively with healthcare providers, and adhere to treatment regimens, all of which may contribute to greater optimism and adjustment (Morrison et al., 2012). The absence of a significant education effect on life satisfaction, however, suggests that when facing a severe illness, overall life evaluation may depend more on existential acceptance, spirituality, and family support than on cognitive or social status-related variables.

Impact of Place of Residence on Positive Affect, Negative Affect and Life Satisfaction

A significant main effect of residence was found for negative affect, with urban cancer patients reporting significantly higher negative affect than rural patients. This finding partially supports the third hypothesis, confirming that rural patients exhibit relatively lower distress. However, positive affect and life satisfaction did not differ significantly between rural and urban participants.

The heightened negative affect among urban patients may stem from greater social isolation, competitive lifestyle, and limited emotional support in urban settings. Conversely, rural communities typically provide stronger social cohesion, family bonding, and shared coping mechanisms, which can buffer psychological distress (Chandran, Thirumoorthy, & Sivakumar, 2018). Moreover, rural individuals may rely more on religious and spiritual coping, enhancing resilience in the face of illness.

Interaction Effects of Age, Education, and Residence

No significant interaction effects were observed among age, education, and residence on any of the dependent variables. This indicates that these demographic variables independently influence emotional outcomes rather than in combination. Thus, age and education independently enhance positive affect, while residence independently predicts negative affect.

Overall, the findings indicate that older age and higher education predict higher positive affect, while urban residence predicts higher negative affect among male cancer patients. Life satisfaction appeared relatively stable across groups, suggesting that it may be influenced by broader psychosocial factors such as social support, spiritual acceptance, and disease adaptation rather than demographic characteristics alone.

These findings have meaningful clinical and psychosocial implications. Younger and urban cancer patients, who are more prone to distress, may benefit from targeted psychosocial interventions, such as cognitive-behavioral therapy (CBT), mindfulness-based stress reduction (MBSR), and social support enhancement programs. Uneducated patients may require psychoeducational counselling to improve health literacy and emotional adjustment. The results emphasize the need for demographically sensitive psychosocial care models within oncology treatment frameworks.

CONCLUSION

In conclusion, the present study highlights that older and educated cancer patients experience higher positive affect, while urban patients tend to experience higher negative affect. Life satisfaction, however, remains relatively unaffected by demographic variations. These findings underscore the complex interplay of personal and contextual factors in shaping emotional adjustment to cancer and call for comprehensive, individualized psychosocial interventions to enhance quality of life among cancer patients. While the study offers valuable insights, several limitations must be acknowledged. The sample included only male patients, limiting generalizability across gender. Cancer type, stage, and treatment duration were not controlled, which may have influenced the affective responses.

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Conflict of Interest

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