

Clinical depression while caring for loved ones with breast cancer

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Abstract

Introduction: The period of the cancer patients undergoing treatment is also the most stressful time for their family caregivers. This study aimed to determine the rates of major depressive disorder and dysthymia; and their associated factors in the caregivers during this time.

Methods: One hundred and thirty caregiver–patient dyads attending the oncology centre for breast cancer treatment participated in this cross-sectional study. While the data on the patients' socio-demographic and illness characteristics were obtained from their medical record, the caregivers completed three self-report measures: 1) socio-demography and the caregiving factor questionnaire, 2) Multi-dimensional Perceived Social Support (MSPSS) and 3) Depression, Anxiety and Stress Scale (DASS-21). Subsequently, those with "probable depression" identified from the DASS-21 score were interviewed using The Mini-International Neuropsychiatric Interview (MINI) to obtain the diagnoses of depressive disorders.

Results: Twenty-three of the 130 caregivers (17.69%) were diagnosed to have depressive disorders, where 12.31% ($n = 16$) had major depressive disorder and 5.38% ($n = 7$) had dysthymic disorder. Factors associated with depression include ethnicity, duration of caregiving, the patients' functional status and the caregivers' education level. Logistic regression analysis showed that the patients' functional status ($p < 0.05$, OR = 0.23, CI = 0.06–0.86) and the caregivers' education level ($p < 0.05$, CI = 9.30, CI = 1.82–47.57) were significantly associated with depression in the caregivers attending to breast cancer patients on oncology treatment.

Conclusions: A significant proportion of family caregivers were clinically depressed while caring for their loved ones. Depression in this population is a complex interplay between the patients' factors and the caregivers' factors.

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1. Introduction

When a person is diagnosed with cancer, a gamut of emotions is anticipated to follow as one grieves. Most people need support from the families during this challenging period in the forms of physical help as well as psychosocially [1–3]. However, much work is needed in exploring the extent of severity of emotional burden cancer brings to the family caregivers.

A study by Bambauer [4] found that when patients met criteria for any psychiatric diagnosis, their caregivers were 7.9 times more likely to meet criteria for any psychiatric diagnosis. Similarly, when caregivers developed psychiatric illness, the patients under their care had significant risk of having a psychiatric illness. In a study on the caregivers of recurrent breast cancer patients, Northouse [1] found that the caregivers not only had significantly worse mental health than the general population but also experienced psychological distress far worse than the patients themselves.

The period of time when the cancer patients were undergoing treatment was identified as the most stressful stage of illness for the caregivers [5]. During this period, caregiving tasks may include managing the symptoms of the illness, treatment and its side effects, logistic and financial matter and other daily and household tasks as well as the patients' emotion, for a substantial period of time [6]. Of these tasks, Bakas [7] found that providing

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emotional support and monitoring illness symptoms are the most difficult.

The diagnosis of cancer in family impaired family functioning which in turn, was found to be significantly associated with depression and anxiety in both the patient and caregivers [8,9]. The added responsibility of caring for the ill family results in a shift in the caregiver's life. In addition, the family faced uncertain future as their loved ones suffered from a potentially fatal illness.

While many earlier studies identified high incidence of psychological distress [8,10,11], very few studies used diagnostic tools such as The Mini-International Neuropsychiatric Interview (MINI) and Structured Clinical Interview for the DSM-IV [12] to determine those that require more intensive psychiatric treatment. A few studies identified the psychiatric morbidity in general but did not specifically look at the factors associated with clinical depression in the caregivers [13,14].

In Malaysia, breast cancer is reported to be the most common cancer [15] whereby 1 in 20 women is estimated to suffer from it in their lifetimes [16–18]. Sadly, about half of the cases referred to Kuala Lumpur Hospital for oncologic treatment were reported to be at the later stages of 3 and 4 [19]. Treatment at later stage of illness may demand increased care and support from the caregivers and may increase their vulnerability to depression.

Therefore, this study aimed to determine the rates of depressive disorders in the caregivers during the treatment period of the breast cancer patients. It also examined the factors associated with depression to identify the sub-group of the caregivers who were at risk of depression.

2. Method

2.1. Study setting

The Institute of Radiotherapy and Oncology in Kuala Lumpur Hospital is a major referral centre for oncologic treatment in Malaysia where patients are referred from all over the country. It offers day-care and out-patient services as well as in-patient care. Patients are admitted either for active chemotherapy or radiotherapy treatment, or to receive palliative care. Patients may also be admitted for treatment complications such as lymphoedema and anemia.

2.2. Study design, operational definitions and sample

This is a cross-sectional study on the family caregivers of breast cancer patients who were undergoing oncology treatment either as inpatients or outpatients. Oncology treatment for breast cancer usually comprises of surgery followed by either chemotherapy or radiation therapy and subsequent maintenance therapy with hormonal drugs such as tamoxifen to prevent recurrences. The family caregivers referred to those who were related to the patients either by blood or by marriage, and were identified by the patients as

providing the majority of their unpaid, informal care [1,6,7]). When more than one caregiver was involved, the caregiver providing the most care was selected. The other inclusion criterion is that the caregivers must be able to understand and converse in English or Malay language. Caregivers who were not family members and/or less than 18 years old were excluded because of the relative infrequency of children and adolescents in primary care-giving roles. Moreover, caregiving experience of children and adolescents may differ from adults [13].

2.3. Study procedure

All breast cancer patients who came for treatment during the recruitment period and fulfilled the study inclusion criteria were invited and informed about the study. When the patient agreed to participate and identified the primary caregiver, the consent was obtained from both the patient and the caregiver. The data on the patients were limited to their socio-demography and illness characteristics which were obtained from the patients and their medical record. The caregivers were asked to complete three self-report measures i.e. their socio-demography and the caregiving factors, the Multi-dimensional Perceived Social Support (MSPSS) and Depression, Anxiety and Stress Scale (DASS-21) [20]. Subsequently, those with a score of DASS [20] that meets the cut-off point for stress, anxiety, or depression, which indicates the possibility of depressive disorders, were interviewed to obtain the diagnosis of depressive disorder using MINI.

All data were collected independently and confidentiality was assured.

2.4. Study measures

The patients' sociodemographic data and illness factors included age, gender, ethnicity, marital status, level of education, employment and monthly income, time since the diagnosis of cancer, stage of illness, type of treatment, frequency of treatment and the patients' functional scores using the Eastern Cooperative Oncology Group (ECOG) Performance Status scales, a reliable tool in assessing how cancer affects the patient's daily living abilities [21]. This scores from 0 to 5 whereby score 0 denotes a fully active person, score 1 denotes strenuous physical restriction but ambulatory and able to carry out work of a light or sedentary nature, score 2 denotes ambulatory and capable of all selfcare but unable to carry out any work activities, score 3 denotes limited selfcare capability whereby one is mostly confined to bed or chair, score 4 denotes complete disability and score 5 if one dies [21].

For the caregivers, their socio-demographic questionnaire included age, gender, ethnicity, marital status, educational level, employment status, monthly income, relationship with the patient and presence of medical illness. Data on the caregiving factors obtained included duration of caregiving (either less than 20 hours per week or more), number of

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