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Original Article

Family Relationships and Psychosocial Dysfunction Among Family Caregivers of Patients With Advanced Cancer

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Abstract

Context. Caring for a family member with advanced cancer strains family caregivers. Classification of family types has been shown to identify patients at risk of poor psychosocial function. However, little is known about how family relationships affect caregiver psychosocial function.

Objectives. To investigate family types identified by a cluster analysis and to examine the reproducibility of cluster analyses. We also sought to examine the relationship between family types and caregivers' psychosocial function.

Methods. Data from 622 caregivers of advanced cancer patients (part of the Coping with Cancer Study) were analyzed using Gaussian Mixture Modeling as the primary method to identify family types based on the Family Relationship Index questionnaire. We then examined the relationship between family type and caregiver quality of life (Medical Outcome Survey Short Form), social support (Interpersonal Support Evaluation List), and perceived caregiver burden (Caregiving Burden Scale).

Results. Three family types emerged: low-expressive, detached, and supportive. Analyses of variance with post hoc comparisons showed that caregivers of detached and low-expressive family types experienced lower levels of quality of life and perceived social support in comparison to supportive family types.

Conclusions. The study identified supportive, low-expressive, and detached family types among caregivers of advanced cancer patients. The supportive family type was associated with the best outcomes and detached with the worst. These findings indicate that family function is related to psychosocial function of caregivers of advanced cancer patients. Therefore, paying attention to family support and family members' ability to share feelings and manage conflicts may serve as an important tool to improve psychosocial function in families affected by cancer. J Pain Symptom Manage 2016;■:■–■. © *2016 Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words
Family, cluster analysis, advanced cancer, caregiver mental health, quality of life, social support

Introduction

Family caregivers are important to advanced cancer patients' well-being throughout the course of their illness. Patients depend on caregivers for emotional, financial, and material support; transportation to and from medical appointments and treatment; and assistance with activities of daily living, including dressing and feeding.[1] In the context of advanced illness, caregivers are often providing for patients' medical needs and making decisions about end-of-life care.[2] As a result, caregivers are critically important to the care and well-being of cancer patients.

A substantial body of research has investigated the impact of caregiving on caregiver mental and physical health.[3] Family caregivers of patients with advanced cancer are at increased risk of experiencing poor

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quality of life,[4] depression,[5–7] impaired sleep,[8] and heightened social isolation.[9] Prior research indicates that caregiving is a multifaceted concept in which objective factors such as the number of caregiving tasks and subjective factors such as the motivations behind the care provision may affect caregivers' well-being.[5] For instance, caregivers motivated by autonomous reasons for providing care, such as seeking comfort from being close to others, tend to have higher levels of life satisfaction than caregivers with extrinsic reasons for providing care, such as seeking to avoid disapproval from his or her social group.[10] Family dynamics may influence the motivations behind, and mental health consequences of, caring for a dying family member.

In families of cancer patients, poor family functioning has been associated with increased risk of depression and anxiety.[11,12] In a cross-sectional study of 191 patient-caregiver dyads, lower levels of cohesiveness (family members' involvement in the family), expressiveness (family members' willingness to express their emotions openly), and conflict resolution (family's ability to solve disagreements) predicted depressive symptoms in both lung cancer patients and their caregivers.[13] Previous studies investigating family functioning have shown that cohesiveness is the primary indicator of well-functioning families types.[13–17] However, little is known about the relationship between family function and caregiver burden and well-being.

The Family Relationship Index (FRI)[18] assesses the cohesiveness, expressiveness, and conflict resolution skills of family units. In the field of health psychology, cluster analysis is being used to identify "at risk" groups whose members might benefit from preventative interventions. In relation to the FRI, the cluster solution is generated based on the three FRI subscales (cohesiveness, expressiveness, conflict resolution). Cluster analysis of the FRI has been conducted in American, Japanese, and Australian samples.[14,16,17] The number of components generated from the cluster solutions varies from a three-cluster solution[16] to a five-cluster solution.[12,14,17]

One of the main obstacles to consensus in studies using cluster analyses is the variety of cluster methods being used (i.e., cluster selection method and software package).[19] Inconsistent cluster analysis methodology makes reproducing results difficult. For this reason, we use the same cluster method as used by one the main studies published on this topic—an investigation by Schuler et al. (2014).[17] In addition to validating previous findings, this study will investigate differences in caregiver well-being and caregiving burden across family types.[20–24]

Thus, the present study aims to identify family-type clusters in an American sample of caregivers of terminally ill cancer patients based on the FRI and then to examine the relationship between these clusters and caregiver quality of life, social support, and caregiving burden. Finally, this study aims to examine the reproducibility of cluster analyses. We hypothesize that the cluster model will generate five clusters as in Schuler et al. (2014) given the similarities in the samples and cluster method used.[17] In line with previous research, we hypothesize that caregivers of family types with low levels of cohesiveness will have the most psychosocial dysfunction, whereas caregivers of family types with high levels of cohesiveness will have the least.

Methods

Detailed design and methods for this study have been described elsewhere and are summarized in the following sections.[25]

Sample and Setting

The present study uses data from the Coping with Cancer (CwC1) study.[26] Participants in the CwC1 study were recruited between 2002 and 2008 from outpatient clinics in Connecticut, Massachusetts, New Hampshire, New York, and Texas. Patients who were diagnosed with distant metastasis and disease that was refractory to first-line chemotherapy met the inclusion criteria. Family caregivers were identified by the patients as the person who provided most of their informal care. Caregivers were required to speak English or Spanish. Caregivers younger than 21 years old or with significant cognitive impairment (Short Portable mental Status Questionnaire score ≥6) were excluded.

Procedure

This study was approved by the institutional review board of each site, and all participants provided written informed consent. Patients and caregivers were interviewed separately by trained research staff. Patients were followed from baseline until death (median four months), and caregivers were interviewed at baseline and six months after the patients' death. The present study reports on data collected preloss at the baseline assessment.

Measures

Demographic data included the caregiver's self-reported age, gender, ethnicity, marital status, relationship to the patient, and the patient's self-reported stage of diagnosis, and presence of metastatic disease.

The FRI is a measure of caregiver perception of family functioning, and the scale derived from the short form of the Family Environment Scale.[15] The FRI consists of 12 true/false items divided into three

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