

## Quality Of Life among the Caregivers of Persons Living With Cancer

Dr.A.Thirumoorthy<sup>1</sup>, Dr.P.Saraswati Devi<sup>2</sup>, Dr.K.Thennarusu<sup>3</sup>,

<sup>1</sup>Additional Professor, Dept. of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore-29.

<sup>2</sup>Professor & Head, Dept. of Palliative Care & Anesthesiologist, Kidwai Memorial Institute of Oncology (KIDWAI), Bangalore.

<sup>3</sup>Professor, Dept. of Biostatistics, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore-29.

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**Abstract:** The term quality of life (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging also frequently related are concepts such as freedom, human rights, and happiness. However, since happiness is subjective and hard to measure, other measures are generally given priority. It has also been shown that happiness, as much as it can be measured, does not necessarily increase correspondingly with the comfort that results from increasing income. As a result, standard of living should not be taken to be a measure of happiness. The present study consisted of 300 caregivers of persons with cancer was selected based on simple random sampling, and with inclusion and exclusion criteria. Those patients satisfying the inclusion and exclusion criteria and attending both outpatient and inpatient services of cancer specialty hospital in KIDWAI Bangalore, Karnataka were selected randomly. The data was collected from the patients & caregivers of persons living with cancer who fulfill the inclusion/exclusion criteria were taken up for the study after their consent. WHO Quality of Life-BREF was administered to understand quality of life. The interviews and the instruments were administered by research experts. This study concluded that there was poor quality of life found in female caregivers, caregivers who belong to rural domicile, illiterate caregivers, and caregivers not heard about treatment of cancer.

**Key Words:** Cancer, Caregivers Quality of Life,

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### I. Introduction

The term quality of life (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging. Also frequently related are concepts such as freedom, human rights, and happiness. However, since happiness is subjective and hard to measure, other measures are generally given priority. It has also been shown that happiness, as much as it can be measured, does not necessarily increase correspondingly with the comfort that results from increasing income. As a result, standard of living should not be taken to be a measure of happiness.

Also sometimes considered related is the concept of human security, though the latter may be considered at a more basic level, and for all people. (According to ecological economist Robert Costanza). Within the field of healthcare, quality of life is often regarded in terms of how it is negatively affected, on an individual level, a debilitating weakness that is not life-threatening, life-threatening illness that is not terminal, terminal illness, the predictable, natural decline in the health of an elder, an unforeseen mental/physical decline of a loved one, chronic, end-stage disease processes. Researchers at the University of Toronto's Quality of Life Research Unit define quality of life as "The degree to which a person enjoys the important possibilities of his or her life" (UofT). Their Quality of Life Model is based on the categories "being", "belonging", and "becoming", respectively who one is, how one is not connected to one's environment, and whether one achieves one's personal goals, hopes, and aspirations.

### **Caring For A Patient With Cancer Affects The Family Caregiver's Quality Of Life**

Family caregivers usually begin care giving without training and are expected to meet many demands without much help. A caregiver often neglects his or her own quality of life by putting the patient's needs first. Today, many health care providers watch for signs of caregiver distress during the course of the patient's cancer treatment. When caregiver strain affects the quality of care giving, the patient's well-being is also affected. Helping the caregiver also helps the patient.

### **Care Giving Can Affect The Caregiver's Quality Of Life In Many Areas**

The caregiver's well-being is affected in many areas. These include psychological, physical, social, financial, and spiritual.

#### **Psychological Issues**

Psychological distress is the most common effect of care giving on the caregiver's quality of life. Caring for a cancer patient is a difficult and stressful job. Caregiver distress comes from the practical demands of the caregiver role as well the emotional ones, such as seeing the patient suffer. Family members seeing a loved one with cancer may feel as much or more distress than the patient does. Distress is usually worse when the cancer is advanced and the patient is no longer being treated to cure the cancer. Caregivers who have health problems of their own or demands from other parts of their lives may enter the care giving role already overwhelmed. For an older adult caregiver, problems that are a part of aging may make care giving harder to handle. The caregiver's ability to cope with distress may be affected by his or her personality type. Someone who is usually hopeful and positive may cope better with problems of care giving.

#### **Physical Issues**

Cancer patients often need a lot of physical help during their illness. This is physically demanding for the caregiver, who may need to help the patient with many activities during the day such as:

- Use the toilet.
- Eat.
- Change position in bed.
- Move from one place to another, such as from bed to toilet.
- Use medical equipment.

#### **Social Issues**

Caregivers often have less time to spend with friends and in the community as their days are filled with caring for the cancer patient. If there are problems in the relationship between the caregiver and the patient, the caregiver may feel even more alone.

In the beginning, there may be a lot of support from friends. The caregiver may be able to continue working and keep up work relationships. When cancer care continues for a long time, the caregiver may need to stop working and friends may call or visit less often. Caregivers can find support in other places, such as caregiver groups and cancer organizations, where they can talk with other families. Some caregivers find it helpful to join a support group or talk to a counselor, psychologist, or other mental professional. Others also find it helpful to turn to a leader in their faith or spiritual community.

#### **Money Issues**

There are many financial costs of cancer. Families must pay insurance deductibles, copayments, and for services that are not covered by insurance, such as transportation and home care help. Some caregivers give up their jobs and income so they can stay home with the patient, which makes it harder to pay for everything. Caregivers who work may have less distress if they are able to take leave from work under the Family and Medical Leave Act (FMLA). FMLA applies to businesses with at least 50 employees. It allows employees to take time off from work for their own illness or a relative's serious medical condition without losing their jobs or benefits. Caregivers may take up to 12 weeks of leave.

#### **Spiritual Issues**

Feelings of spiritual well-being may help lower the caregiver's stress. Keeping faith and finding meaning and hope have been shown to decrease the effect of care giving stress on mental health. Spiritual well-being may help some caregivers be more hopeful, find meaning in the cancer experience, and be more accepting of what is. See the PDQ summary on Spirituality in Cancer Care for more information about spirituality and religion in cancer care.

### **WHO QOL BREF Of Caregiver Of Person Living With Cancer**

In a comparison study of quality of life and psychological status of mothers of children with cancer with those of mothers of children without cancer, the general health, vitality, social functioning, and mental health scores were significantly poorer among the mothers of children with cancer as compared with the scores of the mothers of children without cancer (Eyigor, Karapolat, Yesil, & Kantar, 2011). Family caregivers of terminal cancer survivors who received palliative care services in Korea were surveyed for QOL and mental health. Control individuals were selected from participants in the first round of the Fourth Korea National Health and Nutrition Examination Survey and were matched with family caregivers using the propensity score method to optimize comparative analysis. Health related QOL was significantly lower in the caregiver group than in the controls. Caregivers experienced more frequent episodes of depression during the previous year than did controls. Caregiver burden such as “impact on health”, “financial problems”, and “lack of family support” had a negative influence on the health related QOL and mental health. However “disrupted schedule” had a positive influence on the QOL and mental health (Song et al., 2011). Family members of cancer survivors have multiple needs, many of which are not adequately met. Unmet needs may affect psychological distress and QOL. Data was collected from 223 family members to assess needs and unmet needs, QOL, symptoms of anxiety and depression, and the relationship between those variables in different phases of illness. Of the 20 needs assessed twelve important needs were unmet in 40-56 per cent of the sample. The mean number of unmet needs was significantly higher among women than men, other relatives than spouses, younger family members, those currently working and those of survivors with metastatic cancer. The prevalence of anxiety and depression was high and anxiety scores were higher among women than men and both anxiety and depression scores were highest during years 1-5 compared to the first year and more than five years post diagnosis. There was positive relationship between number of important needs and QOL, and between needs met and QOL. Additionally, there was a significant relationship between anxiety and unmet needs. Finally, there was a significant relationship between QOL and symptoms of anxiety and depression. The results support the importance of screening needs and psychological distress among family members of cancer survivors in all phases of illness (Friethriksdottir et al., 2011).

Survivors with advanced gastrointestinal, genitourinary, breast, lung or gynecologic cancer, and their caregivers, were recruited from 24 medical oncology clinics for a cluster –randomized trial of early palliative care. Caregivers completed the Caregiver QOL-Cancer scale and the MOS-SF, version 2, and a questionnaire including care-related factors such as hours/day providing care and change in work situation. Of the 191 caregivers, 84 per cent were spouses/partners, 90 per cent cohabited with the survivor. Half were working and 25 per cent had a change in work situation since the survivor’s diagnosis. On multiple regression analysis, better caregiver QOL was associated with better caregiver mental health and survivor physical well-being, and with not providing care for other dependants. Worse caregiver mental health was associated with female caregiver sex, worse survivor emotional well-being, more hours spent caregiving and change in the caregivers’ work situation (Wadhwa et al., 2014). Ambulatory treatment center of a major comprehensive cancer center in the southern United States recruited 194 caregivers of survivors receiving chemotherapy for leukemia, to describe the QOL and well-being of caregivers. Participants completed the Caregiver QOL-Cancer scale, the Caregiver well-being scale, and the Learning Needs Questionnaire. Caregivers identified burden as their most important concern for QOL. Key factors identified with caregiver well-being were expression of feelings and household maintenance. Caregivers identified giving medications and managing the side effects as crucial to learning needs. Communication, positive attitudes, support, and education were important in promoting QOL for the caregivers (Tamayo, Broxson, Munsell, & Cohen, 2010). Caregiver burden may change during different stages of cancer survivors’ cancer trajectory. To compare caregivers of cancer survivors during the curative and a palliative phases with respect to their mental health and health related QOL, a cross sectional descriptive study was carried out. This study combines data from two studies; the first group consists of caregivers of survivors with cancer in the late palliative phase and the second group consists of caregivers of out survivors with cancer who suffer from pain and/ or use analgesics. Based on this material, no significant differences in mental health and health-related QOL were revealed for caregivers of cancer survivors in the palliative and the curative phases, respectively. Neither education level in the caregivers, nor the survivors’ functional status influenced caregivers’ mental health or QOL. Being caregivers of cancer survivors seems to have similar pattern of impact on caregivers’ mental health and QOL regardless of the survivor’s disease stage (Grosv& Valeberg, 2012).

## **II. Scope And Objective**

Family members have been described as co sufferers in the battle against cancer. Cancer is increasingly becoming a chronic disease, which brings considerable needs and problems to both patients and caregivers. Hence the present study will help us in formulating family intervention improve their quality of life of caregivers of persons with cancer. The purpose of the present study was to examine quality of life of caregivers of persons with cancer.

**Objectives**

- To find out the relationship between socio demographic characteristics and Quality of life of caregivers of persons with cancer
- To find out the socio demographic characteristics of persons with cancer and their caregivers such as Socio demographic Data, Family's reaction, Treatment, Family's expectation and Stigma

**III. Research Methodology**

The present study has adopted a descriptive research design to describe the variables associated with various psychosocial aspects of caregivers of persons with cancer. It aims at describing the variables associated with the psychosocial correlates and problems of cancer patients with caregivers due to cancer and its treatments. The variables ranged from socio-demographic details and quality of life. The caregivers of patients diagnosed with cancer (acute, middle or end of life phase of cancer) who are admitted in cancer specialty hospital in KIDWAI (Kidwai Memorial Institute of Oncology) Bangalore. A sample of 300 caregivers of persons with cancer was selected based on simple random sampling, and with inclusion and exclusion criteria. Those patients satisfying the inclusion and exclusion criteria and attending both outpatient and inpatient services of cancer specialty hospital in KIDWAI Bangalore, Karnataka were selected randomly. Based on the pilot information regarding number of inpatient and outpatient at the KIDWAI centers in Bangalore random numbers was taken care of the patient load at the given center. The data was collected from the patients & caregivers of persons living with cancer who fulfill the inclusion/exclusion criteria were taken up for the study after their consent. Hospital registration number during the study period was used to obtain a representative random sample. WHO Quality of Life-BREF was administered to understand the quality of life. The interviews and the instruments were administered by research experts.

**IV. Result**

**TABLE-1: Socio demographic variables**

Variables	Frequency	Percentage
<b>Gender</b>		
Male	191	63.7%
Female	109	36.3%
<b>Marital status</b>		
Single	57	19.0%
Married	240	80.0%
Divorced	2	0.7%
Separated	1	0.3%
<b>Religion</b>		
Hindu	265	88.3%
Muslim	28	9.3%
Christian	7	2.3%
<b>Domicile</b>		
Rural	185	61.7%
Urban	102	34.0%
Semi-urban	13	4.3%
<b>Educational Qualification</b>		
Illiteracy	40	13.3%
Primary	169	56.3%
Secondary	36	12.0%
Graduate	49	16.3%
<b>Occupation</b>		
Housewife	61	20.3%
Teacher	9	3.0%
Farmer	58	19.3%
Service	3	1.0%
Domestic help	7	2.3%
Business	16	5.3%
Professional	3	1.0%
Others	143	47.7%

The study sample consists of N=191 (63.7%) males and N=109 (36.6%) females,

The distribution of marital status as single, married, divorced, and separated ration was 57:240:2:1 with majority 80% (N = 240) of the caregivers belonging to married category 19% (N = 57) of the caregivers were

unmarried, , 0.7% (N = 2) of the caregivers belonging to divorced category, and the remaining 0.3% (N = 1) of the caregivers were separated.

The distribution of religion of caregivers as Hindu, Islam, Christianity, with a majority of 88.3% (N = 265) of the caregivers followed the Hindu religion, 9.3% (N = 28) of the caregivers followed Islam, and the remaining 2.3% (N = 7) of the caregivers followed Christianity.

The distribution of domicile of caregivers as majority of caregivers hailing from Rural areas (N=185, 61.7 % ), from Urban areas (N=102, 34.0%) and the remaining were 4.3% (N = 13) of the caregivers belonging to semi urban area.

The study sample consists majority of the caregivers were employed in other kinds of work such as auto drivers, tailors and students, 47.7% (N=143), while 20.3% (N=61), were house wife, 19.3% (N=58), were employed in agriculture, 5.3% (N=16), of them had businesses, 3% (N=9), were teachers, 2.3% (N=7), of the caregivers were employed as domestic helps and the remaining 1% (N=3), of the caregivers were employed in the service sector, 1% (N=3), of the caregivers were employed as professionals.

The study sample consists majority of the respondents were completed, their primary level (class 1 to 7<sup>th</sup> standard) 56.3% (N=169), while 16.3 % (N=49), were graduates, 13.3% (N=40), of the respondents were illiterate, 12% (N=36), were completed up to secondary level (Class 8<sup>th</sup> to Class 10<sup>th</sup>) and the remaining 2% (N=6), were completed their post graduate level.

**TABLE-2: Comparison of WHOQOL-BREF scale between male and female**

Variables	Male (n= 191 ) Mean (SD)	Female (n= 109) Mean (SD)	U Score	P value
WHOQOL Physical	20.91(4.38)	17.85(4.73)	-5.239	<0.001**
WHOQOL Psychological	16.34(3.76)	13.66(4.01)	-5.339	<0.001**
WHOQOL Social	5.64 (2.45)	4.82 (2.37)	-3.195	<0.001**
WHOQOL Environmental	20.38 (4.29)	18.53(4.15)	-3.410	<0.001**

Table (2) shows comparison of male and female caregivers of patients with cancer on various domains of quality if life scale. It reveals that male caregivers of patients with cancer had scored significantly high on Physical health, Psychological, Social relationships, and Environment (p < .001), which suggests that male caregivers of patients with cancer had good physical health, psychological health, social relationships and Environment compared to female caregivers of patients with cancer.

**TABLE-3: Comparison of WHOQOL-BREF scale between single and married**

Variables	Single (n= 59 ) Mean (SD)	Married (n= 241) Mean (SD)	U Score	P value
WHOQOL Physical	22.11 (4.46)	19.23 (4.63)	-4.144	<0.001**
WHOQOL Psychological	16.98 (4.17)	14.97 (3.94)	-3.369	<0.001**
WHOQOL Social	5.52 (2.05)	5.30(2.54)	-1.248	0.212
WHOQOL Environmental	20.18 (4.19)	19.59(4.35)	-0.938	0.348

Table (3) shows comparison of single and married caregivers of patients with cancer on various domains of quality if life scale. It reveals that single caregivers of patients with cancer had scored significantly high on Physical health, and Psychological (p < .001), which suggests that male caregivers of patients with cancer had good physical health and psychological health married caregivers of patients with cancer.

No significant difference was found among other domains such as Social domain, and Environmental domain

**TABLE-4: Comparison of WHOQOL-BREF scale between Hindu and Other Religion**

Variables	Hindu (n= 265) Mean (SD)	Other Religion (n= 35) Mean (SD)	U Score	P value
WHOQOL Physical	19.84 (4.74)	19.48 (4.71)	-0.476	0.634
WHOQOL Psychological	15.40 (4.13)	15.08 (3.48)	-0.442	0.659
WHOQOL Social	5.30 (2.46)	5.68 (2.41)	-1.005	0.315
WHOQOL Environmental	19.74 (4.42)	19.42 (3.54)	-0.334	0.739

Table (4) shows comparison of Hindu and Other Religion caregivers of patients with cancer on various domains of quality if life scale. The result describes the there was no significant difference between the group domains.

**TABLE-5: Comparison of WHOQOL-BREF scale between Rural and Urban/semi urban**

Variables	Rural (n= 185) Mean (SD)	Urban (n= 115) Mean (SD)	U Score	P value
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WHOQOL Physical	19.47 (4.76)	20.33 (4.66)	-1.477	0.140
WHOQOL Psychological	14.91 (4.17)	16.08 (3.77)	-2.388	0.017*
WHOQOL Social	4.88 (2.34)	6.09 (2.46)	-4.429	<0.001**
WHOQOL Environmental	18.82 (4.25)	21.13 (4.07)	-4.504	<0.001**

Table (5) shows comparison of Rural and Urban caregivers of patients with cancer on various domains of quality of life scale. The result describes that urban caregivers had scored statistically significant on Psychological domain, Social domain and Environmental compared to rural caregivers ( $p < 0.001$ ). There was no significant difference found among Physical domain with respect to the rural and urban caregivers living with cancer patients.

**TABLE-6: Comparison of WHOQOL-BREF scale between persons heard about cancer and not heard about the cancer**

Variables	Heard about cancer (n= 208) Mean (SD)	Not heard about cancer (n=92) Mean (SD)	U Score	P value
WHOQOL Physical	20.94 (4.41)	17.21 (4.43)	-6.266	<0.001**
WHOQOL Psychological	16.17(3.89)	13.54 (3.84)	-5.244	<0.001**
WHOQOL Social	5.85 (2.52)	4.20 (1.84)	-5.521	<0.001**
WHOQOL Environmental	20.81 (4.05)	17.21 (3.87)	-6.558	<0.001**

Table (6) shows comparison of the quality of life experienced by the person's heard about cancer and not heard about the caregiver's with cancer patients. There was significant difference with the person's heard about cancer caregivers were greater than the person's not hearing about cancer, which was statistically significant among all the domains such as Physical domain ( $U = -6.266$ ,  $p < 0.001$ ), Psychological domain ( $U = -5.244$ ,  $p < 0.001$ ), Social domain ( $U = -5.521$ ,  $p < 0.001$ ), Environmental domain ( $U = -6.558$ ,  $p < 0.001$ ).

**TABLE-7: Comparison of WHOQOL-BREF scale between caregivers of cancer patients underwent surgery and other modes of treatment**

Variables	Surgery (n= 261) Mean (SD)	Other treatment (n=39) Mean (SD)	U Score	P value
WHOQOL Physical	19.94 (4.72)	18.84 (4.80)	-1.507	0.132
WHOQOL Psychological	15.42 (4.012)	14.94 (4.40)	-0.692	0.489
WHOQOL Social	5.41 (2.49)	4.948 (2.17)	-1.016	0.309
WHOQOL Environmental	19.88 (4.34)	18.56 (4.10)	-1.615	0.106

Table 7 shows the quality of life experienced by the caregivers of cancer patients underwent surgery and other modes of treatment. The result describes that there was no significant difference between the group domains.

**TABLE-8: Comparison of WHOQOL-BREF scale between caregivers according to education**

Variables	Illiterate (n=40) Mean (SD)	Primary (n=169) Mean (SD)	Secondary (n=36) Mean (SD)	Graduate (n=55) Mean (SD)	U Score	P value
WHOQOL Physical	15.12 (3.54)	19.64 (4.31)	22.19 (4.93)	22.10 (3.99)	60.540	<0.001**
WHOQOL Psychological	11.87 (3.47)	14.97 (3.51)	17.69 (4.14)	17.60 (3.83)	59.477	<0.001**
WHOQOL Social	3.70 (1.52)	4.99 (2.30)	6.41 (2.45)	6.94 (2.36)	55.475	<0.001**
WHOQOL Environmental	16.30 (3.26)	19.33 (3.92)	21.58 (4.67)	22.10 (4.06)	47.364	<0.001**

ANOVA U test was used to compare the quality of life experienced by caregivers of cancer patient's qualification. There was significant difference with the secondary caregivers of cancer patients were greater than other qualification such as illiterate, primary, graduate caregivers of cancer patients which was statistically significant in following domains such as Physical domain ( $U = 60.540$ ,  $p < 0.001$ ), Psychological domain ( $U = 59.477$ ,  $p < 0.001$ ), ( $U = -5.521$ ,  $p < 0.001$ ).

Social domain of graduate caregiver of cancer patients were greater than other qualification such as illiterate, primary, secondary caregivers of cancer patients which was statistically significant ( $U = 55.475$ ,  $p < 0.001$ ).

Environmental domain of graduate caregiver of cancer patients were greater than other qualification such as illiterate, primary, secondary caregivers of cancer patients which was statistically significant ( $U=47.364$ ,  $p<0.001$ ).

## **V. Discussion**

Family caregivers are essential partners in the delivery of complex health care services and this case exemplifies the associated caregiver burden and stress during cancer treatment. Unlike professional caregivers such as physicians and nurses, informal caregivers, typically family members or friends, provide care to individuals with a variety of conditions, most commonly advanced age, dementia, and cancer (NAC,2009)

### **Discussion Of Methodology**

The distribution of marital status as single, married, divorced, and separated ration was 57:240:2:1 with majority 80% ( $N = 240$ ) of the caregivers belonging to married category 19% ( $N = 57$ ) of the caregivers were unmarried and this finding matched with a study done by Malathi et al(2014), and also 0.7% ( $N = 2$ ) of the caregivers belonging to divorced category, and the remaining 0.3% ( $N = 1$ ) of the caregivers were separated. The distribution of religion of caregivers as Hindu, Islam, Christianity, with a majority of 88.3% ( $N = 265$ ) of the caregivers followed the Hindu religion, 9.3% ( $N = 28$ ) of the caregivers followed Islam, and the remaining 2.3% ( $N = 7$ ) of the caregivers followed Christianity and this finding matched with previous study done by Malathi et al (2014). The current study also have found that majority of caregivers hailing from Rural areas ( $N=185$ , 61.7 %) compared to Urban areas ( $N=102$ , 34.0%) and the remaining were 4.3% ( $N = 13$ ) of the caregivers belonging to semi urban area again this finding matched with Malathi et al (2014) found the similar result.

### **Comparison BetweenWHOQOL-BREF Scale And Dependent Variables**

Mann-Whitney U test was used to compare the quality of life experienced by the male and female caregivers of patients with cancer. It reveals that male caregivers of patients with cancer had scored significantly high on Physical health, Psychological, Social relationships, and Environment ( $p < .001$ ), which suggests that male caregivers of patients with cancer had good physical health, psychological health, social relationships and Environment compared to female caregivers of patients with cancer. The present study finding matched with Paul et al (2015) study findings, examined gender differences in mental health (Patient Health Questionnaire-9, Satisfaction with Life Scale, Rosenberg Self-Esteem Scale, State-Trait Anxiety Inventory, and Zarit Burden Inventory), health-related quality of life (HRQOL; Short Form-36), and social support (Interpersonal Support Evaluation List-12) in 81 (66.7% women) Mexican MS caregivers. Results. As compared to men caregivers, women had lower mental health, HRQOL, and social support. This was partially explained by women caregivers providing care for nearly twice as many hours/week as men (79.28 versus 48.48), and for nearly three times as many months (66.31 versus 24.30, ).It also reveals that single caregivers of patients with cancer had scored significantly high on Physical health, and Psychological ( $p < .001$ ), which suggests that male caregivers of patients with cancer had good physical health and psychological health married caregivers of patients with cancer. The result describes that urban caregivers had scored statistically significant on Psychological domain, Social domain and Environmental compared to rural caregivers ( $p<0.001$ ). There was no significant difference found among Physical domain with respect to the rural and urban caregivers living with cancer patients. The present finding is matched with a study done by Caregiving In Rural America(2007) Although they are less likely to be employed than their urban counterparts, more than half of rural caregivers (54%) reported working full-time or part-time during the period in which they were providing care. In order to provide care, 56% of rural caregivers had to make workplace accommodations, such as take time off and/or leave their job early; 18% took a leave of absence; 8% went from full-time to part-time employment; 4% turned down a promotion; 3% took early retirement; 5% lost some job benefits; and 7% gave up work entirely. Rural caregivers are less likely to use most formal services that might support them in their caregiving efforts. Twenty-two percent of rural caregivers report using an aide or nurse through an agency or service, while 25% of urban and 24% of suburban caregivers do so. Only 8% of rural caregivers report using other paid help (i.e., besides an aide, housekeeper, or nurse), while 16% of urban and 13% of suburban caregivers do so. Only 29% of rural caregivers are likely to use transportation services, while 38% of urban and 34% of suburban caregivers do so. There was significant difference with the person's heard about cancer caregivers were greater than the person's not hearing about cancer, which was statistically significant among all the domains such as Physical domain ( $U= -6.266$ ,  $p<0.001$ ), Psychological domain ( $U=-5.244$ ,  $p<0.001$ ), Social domain ( $U=-5.521$ ,  $p<0.001$ ), Environmental domain ( $U=-6.558$ ,  $p<0.001$ ).There was significant differs with the secondary caregivers of cancer patients were greater than other qualification such as illiterate, primary, graduate caregivers of cancer patients which was statistically significant were found following domains such as Physical domain ( $U=60.540$ ,  $p<0.001$ ), Psychological domain( $U=59.477$ ,  $p<0.001$ ), ( $U=-5.521$ ,  $p<0.001$ ). this study finding matched with Alptekin (2010) According to caregivers, patients needed assistance for one or more daily living activities. Caregivers'

higher age, unemployment status, female gender, low education level, their own diagnosed health problems, care duration above 18 months, and having difficulties to continue social activities had negative effects on their quality of life. Cancer patients' families are also affected from cancer. We may suggest that including caregivers in the context of home care and universalizing home care programs can reduce caregivers' burden.

## **VI. Conclusion**

This study concluded that there was poor quality of life were found in female caregivers, caregivers who belong to rural domicile, illiterate caregivers, and caregivers not heard about treatment of cancer. As quality of life is vital issue not only for patients themselves but also for caregivers. So, it is imperative to design suitable intervention strategies to enhance the quality of life and other psychosocial issues of caregivers of patients living with cancer.

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