



Original Article

# Challenges to Family Caregivers in Caring for Gastric Cancer Patients from Perspectives of Family Caregivers, Patients, and Healthcare Providers: A Qualitative Study

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## ABSTRACT

**Objectives:** Cancer affects both patients and their families. Sometimes, the effects of cancer on families are greater than its effects on patients. Family caregivers play significant roles in care for patients with cancer. Nonetheless, the data on the challenges they face in caregiving are limited. The present study explored the perspectives of patients with gastric cancer (GC), their family caregivers, and healthcare providers regarding family caregivers' challenges in caregiving to patients with GC.

**Materials and Methods:** This descriptive exploratory qualitative study was conducted in 2019–2020. Six GC patients, six family caregivers, three physicians, and five nurses took part for a total of twenty participants. Purposive sampling was performed, and data were collected through semi-structured interviews and continued up to data saturation. Conventional content analysis was used for data analysis.

**Results:** Caregivers' challenges in caregiving to patients with GC were grouped into five main categories, namely, lengthy process of GC diagnosis, delivery of bad news, management of physical symptoms, altered relationships, and psychological consequences, and 14 subcategories.

**Conclusion:** Educating the public about the primary symptoms of GC and the importance of timely seeking medical care as well as using culturally appropriate protocols for delivering bad news is recommended. Empowering family caregivers for the effective management of GC symptoms and caregiving-related challenges are also recommended to reduce their caregiver burden.

**Keywords:** Gastric cancer, Family caregivers, Care, Qualitative study, Healthcare

## INTRODUCTION

Cancer is the second leading cause of death in the world.<sup>[1]</sup> The total number of gastric cancer (GC) patients in Iran was 9,786, with 554 cases located in Isfahan Province.<sup>[2]</sup> GC is also the first leading cause of death among Iranian men.<sup>[3]</sup> Patients with GC have a poor prognosis<sup>[4]</sup> and experience a wide range of problems. The physical problems of GC include dyspepsia, heart burn, anorexia, abdominal pain, nausea, vomiting, weight loss, and elimination-related problems.<sup>[5]</sup> In addition to physical problems, acute psychological distress manifested by depression and anxiety is also quite common among patients with GC.<sup>[6]</sup> These patients also have a wide

range of physical, psychological, and educational needs<sup>[6-8]</sup> which are usually fulfilled ineffectively. Unfulfilled needs in these patients negatively affect the different aspects of their quality of life.<sup>[6]</sup>

Care services for patients with GC are mainly community-based due to the development of outpatient care services in recent years, improved survival, and patients' personal preference for receiving care at home.<sup>[9]</sup> Around 80% of home-based care services are provided by family caregivers.<sup>[10]</sup> Home-based caregiving to cancer patients imposes a heavy burden on family caregivers,<sup>[11,12]</sup> particularly after surgical interventions for cancer management.<sup>[7,8]</sup> These

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caregivers need to provide cancer-afflicted patients with a wide range of services such as physical care, symptom monitoring, maintenance of medical equipment, medication administration, and emotional and social support. Meanwhile, they also need to perform household activities such as shopping, childrearing, cooking, washing, and financial management.<sup>[9,13]</sup>

Caregiving to GC patients requires a number of skills for care planning, decision making, problem solving, and professional counselling<sup>[14]</sup> as well as a considerable amount of caregiving-related knowledge.<sup>[15]</sup> Studies have shown that family caregivers are not adequately prepared for home-based caregiving and do not receive adequate education about caregiving before their patients are discharged from hospital.<sup>[13,16]</sup> In addition to a lack of knowledge and limited support, most family caregivers experience an imbalance between their caregiver burden and their own personal needs, which results in many different negative physical, psychological, financial, social, and occupational consequences and negatively affects their quality of life.<sup>[8,9,11,14,17]</sup>

Healthcare providers have an important role in identifying and resolving the challenges faced by family caregivers of cancer patients. Nurses, as health professionals, spend the greatest amount of time with patients and their families. Therefore, they have an especially key role in identifying and addressing social needs, promoting quality of life, decreasing distress, and improving well-being for the family caregivers of cancer patients.<sup>[18,19]</sup>

The previous studies have reported a high prevalence of different problems among the family caregivers of cancer patients. For example, a study in Iran found that all family caregivers had physical, emotional, financial, and informational problems and 97%, 89%, and 74% of them suffered from psychological, financial, and spiritual problems, respectively.<sup>[16]</sup> Another study in Iran showed that family caregivers of cancer patients had unfulfilled needs, mostly in terms of receiving information, attention, and respect from healthcare providers as well as health-related and psychological problems.<sup>[11]</sup> A qualitative study in the United Kingdom into patients' and family caregivers' experiences of living with a jejunostomy feeding tube after surgery for esophagogastric cancer also showed that they suffered from different physical problems, concerns, and problems in daily living.<sup>[20]</sup>

Despite the wealth of studies into the problems and the needs of family caregivers of cancer patients,<sup>[13,21-23]</sup> studies into the experiences of patients with GC and their family caregivers are limited.<sup>[7]</sup> Moreover, family caregivers' needs and problems are context-based and vary according to the immediate social context, values, and family structure.<sup>[11,24]</sup> Therefore, studies of different contexts in this area are needed. Despite

the increasing prevalence of GC in Iran, a literature search showed that no study had yet explored the challenges of family caregivers of GC patients in Iran. Therefore, the present study was conducted to address this gap. This study aimed to explore the perspectives of patients with GC, their family caregivers, and healthcare providers regarding challenges faced by family caregivers in caring for GC patients.

## MATERIALS AND METHODS

### Ethical considerations

The Ethics Committee of Isfahan University of Medical Sciences, Isfahan, Iran, approved this study (IR.MUI.RESEARCH.REC.1397.289). Verbal and written informed consent was obtained from all participants. Participants were ensured of their freedom to voluntarily withdraw from the study, and their data were anonymized using numerical codes.

### Methods

This descriptive exploratory qualitative study was conducted in 2019–2020 in a university-affiliated specialty cancer care hospital in Isfahan, Iran, which provides different cancer care and treatment services including surgery, radiation therapy, and chemotherapy. The study population consisted of patients with GC, their family caregivers, physicians, and nurses in the study setting. Participants were purposively recruited to the study with maximum variation in terms of their age, gender, and work experience. Inclusion criteria for patients were age over 18 years, definite diagnosis of non-metastatic GC based on pathologic findings, history of gastrectomy, awareness of GC diagnosis, agreement for participation, and no affliction with serious physical or cognitive problems which could affect active participation in the study. Inclusion criteria for family caregivers were close kinship with a GC-afflicted patient, active participation in patient care, agreement to participate, and no affliction by serious physical or cognitive problems. Inclusion criteria for physicians and nurses were agreement to participate and work experience of more than 1 year in care delivery to patients with cancer.

Data were collected from October 2019 to January 2020 through in-depth semi-structured interviews, which started with broad questions and continued with pointed questions based on participants' responses to the first questions. [Table 1] gives examples of the interview questions. The time and the place of the interviews were arranged according to the participants' preferences, and the duration of the interviews was 30–60 min. Sampling and data collection were continued to the point of data saturation, that is, when no new data were obtained from the interviews.<sup>[25,26]</sup> Interviews were audio-recorded.

The qualitative content analysis approach proposed by Graneheim and Lundman was used for data

analysis.<sup>[27]</sup> Recorded interviews were transcribed word for word; then, transcripts were perused and meaning units were identified. By definition, meaning units are excerpts from the data which “relate to the same central meaning.” Identified meaning units were condensed, abstracted, and coded. Similar codes were grouped into subcategories, while subcategories were inductively grouped into main categories according to their similarities.

### Rigor

Trustworthiness was ensured using the confirmability, credibility, dependability, and transferability criteria.<sup>[28]</sup> Confirmability was maintained by recording all research-related activities, and dependability was maintained through data analysis by two of the authors. Credibility was ensured through member- and peer-checking. In member-checking, generated codes were provided to some participants to verify the congruence between the codes and their own experiences. In peer-checking, the co-authors assessed the generated codes and categories and verified the accuracy of data analysis. Transferability was ensured through sampling with maximum variation in terms of participants' characteristics.

## RESULTS

Six patients with GC, six family caregivers, three physicians, and five nurses took part in this study for a total of twenty participants. Further participant characteristics are shown in [Table 2]. After analyzing the interviews, five main categories were extracted: “lengthy process of GC diagnosis,” “delivery of bad news,” “management of physical symptoms,” “altered relationships,” and “psychological consequences.” All categories, subcategories, and some quotes from participants are listed in [Table 3].

**Table 1:** Examples of the interview questions.

Participants	Questions
Patients	Which problems have your caregivers experienced since the diagnosis of your disease? What effects have these problems had on their life? Would you please explain more about this?
Family caregivers	Which problems have you experienced since the diagnosis of GC for your patient? What effects have these problems had on your life? Would you please explain more about this?
Physicians and nurses	Which problems do the family caregivers of patients with GC experience in disease management? What are the effects of these problems on their life? Would you please explain about your experiences in this area?

GC: Gastric cancer

### The lengthy process of GC diagnosis

Participants' experiences showed that patients and family caregivers underwent a lengthy process for receiving the GC diagnosis. They noted that the time interval from the appearance of the first symptoms to the diagnosis of GC had been as long as 1 year in some cases. The three subcategories of this category were “delayed medical care seeking,” “delayed diagnosis by physician,” and “distress induced by frequent medical visits and tests.”

#### *Delayed medical care seeking*

Patients did not take their first gastrointestinal symptoms seriously and referred to a physician with delay due to common symptoms such as nausea and vomiting. They had lost the golden time for diagnosis due to self-treatment, use of herbal remedies, and use of previous experiences in symptom management. They had ultimately referred to a physician when they had found their interventions ineffective.

#### *Delayed diagnosis by physician*

Most patients and family caregivers noted that they had to change doctors several times because of the inability of physicians to manage symptoms and establish a definite diagnosis. Referring to different physicians and performing different diagnostic tests imposed heavy costs on them, as they had to pay the undue costs of the lengthy process of diagnosis.

#### *Distress induced by frequent visits and tests*

Patients had to refer to different physicians due to treatments being ineffective in alleviating their symptoms. Those who lived in small cities had to travel to large cities to undergo tests and wait several weeks for test results. Frequent medical visits, undergoing different tests, delayed diagnosis, and waiting a long time for test results caused them great pain and psychological distress.

#### *Delivery of bad news*

After the lengthy process of establishing a definite diagnosis of GC, family caregivers experienced the challenge of telling the truth to their patients. In Iranian society, healthcare providers sometimes avoid giving diagnosis-related news directly to patients, assigning this responsibility to family members. The three subcategories of this category were “bewilderment after hearing bad news,” “attempt to conceal the truth from the patient,” and “concealing personal emotions from the patient.”

#### *Bewilderment after hearing bad news*

Family caregivers reported that they experienced bewilderment after their patient received a GC diagnosis, and

**Table 2:** Participant characteristics.

Characteristics of participants	Average Age in years (range)	Gender	Months elapsed since diagnosis: Average (range)	Relationship with patient	Work experience (years)
Patients	50.33 (48–52)	Female: 4 Male: 2	7.5 (14-34)		
Family caregivers	40.33 (32–50)	Female: 5 Male: 1	8 (12-31)	Daughter: 1 Son: 1 Wife: 4	
Physicians	43.37 (27–54)	Female: 1 Male: 2			15.9 (3.5–28)
Nurses		Female: 5			

**Table 3:** Categories, subcategories and some quotes from participants.

Categories	Subcategories	Quotes from participants
The lengthy process of GC diagnosis	Delayed medical care seeking	“I had much abdominal pain for four years and vomited everything I ate. Primarily, I thought my temperament had become cold. Therefore, I resorted to traditional medicine and used tea with rock candy. After a while, I experienced anorexia and weight loss. Finally, I decided to refer with my daughter to a gastroenterology specialist. After a biopsy, I was diagnosed with GC.” (Patient 3)
	Delayed diagnosis by physician	“All of us experienced considerable stress until the physicians reached a definite diagnosis. About 1.5 years have passed since the beginning of my father’s disease. He underwent many laboratory tests and we paid heavy costs. After a long time, we finally determined that my father has GC.” (Caregiver 5)
	Distress induced by frequent visits and tests	“My husband suddenly experienced weight loss and sometimes had vomiting, abdominal pain and bloody vomiting. We referred to a doctor. They performed many tests and took a biopsy. A cancer diagnosis was established 1 month after the biopsy. We experienced much distress until physicians established the diagnosis.” (Caregiver 1)
Delivery of bad news	Bewilderment after hearing bad news	“When the cancer was diagnosed for my husband, I was bewildered as to how and what to tell him about it so as not to undermine his morale and help him continue treatments. I didn’t know what I had to do.” (Caregiver 3)
	Attempt to conceal the truth from the patient	“A definite diagnosis of cancer had been established for a patient. When we informed her family members, they experienced considerable stress and insisted their mother not be told about the diagnosis. They thought that the best option was not to tell the diagnosis to the patient.” (Nurse 4)
	Concealing one’s own emotions from the patient	“I got terribly upset when I saw the definite diagnosis of cancer. I cried unbeknownst to my husband and avoided showing sadness in his presence. When I told him after several days that we should go to hospital A (which was a specialty centre for cancer care), he realized that he had cancer.” (Caregiver 1)
Management of physical symptoms	Inadequate knowledge about symptom management	“When we took my mother to the emergency ward of the hospital due to the aggravation of her symptoms, the doctor said that my mother’s disease had progressed, and we had to care for her at home. I cried a lot and asked the doctor how I could care for her without knowing anything and having no equipment. I was really frustrated.” (Caregiver 5) “Some caregivers really don’t know how to care for a patient with GC, when they should take their patient to hospital, or when they can care for him/her at home. Consequently, they take their patient to the emergency ward as soon as they observe trivial symptoms. This action causes anxiety and discomfort for both patients and caregivers.” (Nurse 5) “My appetite is not good. I vomit all I eat. I was this way before chemotherapy and got better a while after it. However, vomiting has recently worsened. I have constipation, vomiting, abdominal pain, and bone pain. My son frequently takes me to hospital. I don’t like hospital. I want to be at my home; but we don’t know what we should do at home. We have no option [but to refer to hospital].” (Patient 4)

(Contd...)

**Table 3:** (Continued)

Categories	Subcategories	Quotes from participants
Altered relationships	Pain management	"Because of poor nutrition and cancer-induced obstruction, patients with GC may have continuous nausea, vomiting, anorexia and even pain. As these symptoms frequently occur, patients and their family members need to know how to provide appropriate care; otherwise, the number of hospital visits will increase." (Physician 2)
	Inadequate knowledge about dietary regimen and restrictions	"Patients with GC have many problems. One of the most important issues of these patients is nutritional problems. They have dysphagia and anorexia and prefer not to eat anything due to pain and odynophagia. Family caregivers may reduce the number of patients' meals to reduce symptoms, while this practice worsens the conditions. We need to teach patients and family members about appropriate eating and how to promote comfort." (Nurse 1) "Patients with GC may not tolerate some foods well. For example, the intake of sweet foodstuffs is associated with distension and gastrointestinal irritability. Patients and family caregivers need to know which foods cause these problems. They need to perform feeding in more meals with smaller size. However, patients and caregivers usually don't have adequate knowledge about this." (Physician 1)
	Reduced social interactions	"My husband says he doesn't like to see others. He also remains in the room and locks the door when we have guests, resulting in discomfort for the guests, because they perceive this behaviour as disrespectful. My family and I have a sense of isolation." (Caregiver 3)
	Tensions between patient and family members	"Since he has realized he has cancer, my husband has become impatient. He mistreats the children, shouts at me and the children and doesn't talk to us. The children can't play at home. He is angry and impatient. We can't talk with each other." (Caregiver 1)
	Disturbances in marital and parental relationships	"When my daughter found out that I have cancer, she became very angry, cried continuously, and shouted at her children. Her relationship with her husband was also affected so greatly that her husband decided on a divorce." (Patient 2) "I have frequently witnessed that family caregivers who are alone in caregiving couldn't appropriately perform their parental or spousal tasks, resulting in the destruction of their relationships with their spouse and children as well as the dissatisfaction of their spouse and children." (Nurse 1)
Psychological consequences	Distress due to patient's exhaustion	"I look at my mother and see that she has become thinner and frailer than before. It upsets me and causes me to cry unbeknownst to her. She has lost considerable weight, and this is distressful." (Caregiver 5)
	Distress due to the imminent death of a beloved one	"Whenever I wake up from my husband moaning, I think he is breathing his last breaths. I call him and find that he is still alive. Imagining his early loss has caused me to have no motivation for life." (Caregiver 1)

GC: Gastric cancer

they did not know what or how to tell their patients. Their experiences revealed loneliness, pain, distress, and tension in relaying the diagnosis to their patients.

#### ***Attempt to conceal the truth from the patient***

Family caregivers attempted to conceal the truth from their patients due to the potential negative effects of giving the bad news of cancer on patients' morale and treatment adherence. They had also asked healthcare providers not to tell their patients about the cancer diagnosis.

#### ***Concealing personal emotions from the patient***

As some family caregivers did not inform their patients about the cancer diagnosis, they had to conceal their emotions and

behave normally in the presence of their patients. They noted that they cried unbeknownst to their patient and attempted not to show sadness or grief in their presence, because their patient might realize that their condition was serious. The concealing of emotions from patients caused family caregivers various psychological problems such as distress, strain, frustration, bewilderment, depression, and grief.

#### **Management of physical symptoms**

Patients with GC experience many different physical symptoms of the disease and its treatment, including abdominal pain, nausea, vomiting, extreme fatigue, reduced energy, heartburn, abdominal distension, weakness, and anaemia. Family caregivers faced challenges in managing

these symptoms. The three subcategories of this category were “inadequate knowledge about symptom management,” “pain management,” and “inadequate knowledge about dietary regimen and restrictions.”

#### ***Inadequate knowledge about symptom management***

Participants' experiences showed that most family caregivers did not receive the necessary education about managing GC-related systemic and gastrointestinal symptoms. Such lack of knowledge resulted in frequent requests for medical help, increased health-care costs, increased caregiver burden, and reduced quality of life among family caregivers.

#### ***Pain management***

While pain is one of the most important problems of patients with cancer, afflicted patients and their family caregivers experience challenges in pain management. Participating family caregivers reported that they witnessed their patients' pain and suffered themselves for their inability to manage it. Their inability to effectively manage pain resulted in unnecessary hospital visits and more costs.

#### ***Inadequate knowledge of dietary regimen and restrictions***

In most cases, GC patients should prepare to have a stomach-free life, because they need to eat more meals of a smaller size after surgical removal of the stomach to less frequently experience gastrointestinal problems such as nausea, vomiting, abdominal distension, and pain. Nonetheless, participants' experiences showed that family caregivers received inadequate education, if any, about appropriate dietary regimens for patients with GC and about the management of their patients' nutritional problems. Moreover, symptoms such as post-eating abdominal pain and nausea caused them negative feelings such as fear, discomfort, and inefficiency.

#### ***Altered relationships***

Participants noted that cancer-related consequences affected the interpersonal relationships of afflicted patients and their family caregivers, reduced their interactions with their significant others, and caused problems in their familial relationships. This category had three subcategories, namely, “reduced social interactions,” “tensions between patient and family members” and “disturbances in marital and parental relationships.”

#### ***Reduced social interactions***

Affliction of a family member with GC isolated the whole family and reduced their social interactions and relationships with relatives. Moreover, cancer caused patients problems such as impatience and willingness to

self-isolate, resulting in the restriction of the relationships of other family members.

#### ***Tensions between patient and family members***

Participants' experiences showed that the affliction of a parent by cancer resulted in the negligence of the other parent and particularly the children and undermined their morale. Moreover, patient's anger and aggression caused discomfort for family members. Nonetheless, family members attempted to provide the patient with calmness, even at the cost of preventing children from playing.

#### ***Disturbances in marital and parental relationships***

Caregiving to a family member with GC significantly affected caregivers' relationships with their spouses. Engaging in caregiving, heavy caregiver burden and fatigue had reduced their emotional and sexual relationships and resulted in their inattention to their children. Some family caregivers were even at risk for divorce.

#### ***Psychological consequences***

Cancer and its complications cause strain, distress, and concerns for caregivers. The two subcategories of this category were “distress due to patient's exhaustion” and “distress due to the imminent death of a loved one.”

#### ***Distress due to patient's exhaustion***

Family caregivers did their best to provide care and comfort to their patients. Nonetheless, they witnessed the progressive exhaustion of their patients and experienced extreme distress themselves.

#### ***Distress due to the imminent death of a beloved one***

Family caregivers reported continuous fear and concern over losing their loved ones. Caregiving with fear of a patient's death caused them tension and mental problems such as depression.

## **DISCUSSION**

This study explored the perspectives of patients with GC, their family caregivers, and healthcare providers regarding the challenges faced by family caregivers in caring for patients with GC.

The lengthy process of GC diagnosis was a major challenge for family caregivers. GC is usually diagnosed in its advanced stages and has a poor prognosis due to metastasis and old age at the time of diagnosis. A main reason for delayed GC diagnosis is that patients are usually asymptomatic<sup>[4]</sup> or have unspecific symptoms in the first stages of the disease.<sup>[29]</sup> Most

patients do not take their symptoms seriously and attempt to manage them using herbal remedies or over-the-counter medications; thus, they seek medical care with a delay. The use of herbal products has a long history in Iran.<sup>[30]</sup> Historical evidence confirms that people in almost all cultures use herbal remedies for the management of gastrointestinal problems such as distension, nausea, vomiting, diarrhoea, constipation, and dyspepsia.<sup>[31]</sup> Delayed medical care seeking is accompanied in most cases by a long interval for performing diagnostic testing and establishing a diagnosis. This long time can be incredibly stressful and impose heavy costs for both patients and family caregivers, particularly for those in small cities who need to refer to healthcare settings in large cities. Different studies have confirmed that the family caregivers of patients with cancer have financial problems mostly due to the lack of an efficient financial support system for paying the heavy costs of cancer diagnosis and management as well as patients' and even their caregivers' loss of employment.<sup>[8,14,23]</sup>

The findings also revealed that family caregivers experienced bewilderment after hearing about the cancer diagnosis, attempted to conceal the truth from their patients and concealed their own emotions from their patients. Like many other Asian and Middle Eastern countries, cancer-related news is given to family members instead of patients, yet most family members may prefer not to give the news to their patients because they think that such news will cause their patients despair, suffering, and hasten their death.<sup>[32]</sup> Similarly, giving cancer-related news has a family-centred pattern in China, where 98% of physicians primarily give such news to family members, and 82% avoid giving the news to patients if their family members do not agree with informing patients.<sup>[33]</sup> Different studies have recommended strategies for modifying this family-centred approach and supporting patients' rights to know about their disease. One of these strategies is to consult patients and families about their willingness to receive good or bad news about the diagnosis.<sup>[33,34]</sup> It is important to strongly support family members during the stressful period after giving them cancer-related news. Moreover, healthcare providers' use of culturally appropriate communication protocols for giving bad news about cancer to patients can reduce the challenges of caregiving among family caregivers.<sup>[35]</sup>

The third category was related to the management of physical symptoms. Patients with GC experience many different physical problems due to cancer and its treatments. Most of these problems can be managed by providing education to patients and family caregivers. The current findings showed that patients and family caregivers referred to hospital with the occurrence of any problem, because they had limited knowledge about cancer-related issues and their management and had received limited education in this

area. This practice increased caregiver burden and costs. In line with this finding, a previous study reported that most family caregivers had serious problems in managing the side effects of chemotherapy and expected healthcare providers to provide them with more information about them.<sup>[36]</sup> Another challenge was coping with dietary modifications after gastrectomy, because these patients need to adopt a new eating style after surgery which entails restrictions in the type and quality of foods. Moreover, the meaning of symptoms and problems changes in these patients. For example, nausea may happen as a symptom of fullness.<sup>[37]</sup> Inattention to nutritional problems can lead to anxiety, despair, dissatisfaction with recovery, and low quality of life among patients.<sup>[38]</sup> Given the significant effects of nutritional problems on patients with cancer and their family caregivers, an interdisciplinary rehabilitation team is necessary for supporting these patients.<sup>[37,39]</sup> This team should assess and identify patients' nutritional needs from the first post-gastrectomy days and provide the necessary education to these patients and their family caregivers to improve their ability to cope with their nutritional problems.

The fourth main category was altered familial and social relationships. Role multiplicity, psychological tensions, financial problems, lack of support, and limited informational support by healthcare providers can negatively affect caregivers' relationships. In most cases, family caregivers need to simultaneously care for their patients and their own parents or children. Moreover, some caregivers avoid engaging in recreational activities because they feel shameful and guilty when they see that their patients cannot enjoy these activities.<sup>[18]</sup> Most family caregivers also need to seriously restrict their own social lives due to their heavy caregiver burden and the heavy risk of transmitting infection to their patients. Some caregivers may even lose their employment due to their heavy caregiver burden.<sup>[36]</sup> The added burden of caregiving considerably affects the familial and social relationships of caregivers and leads to their social isolation.<sup>[40]</sup> One study showed that 60.6% of the caregivers of cancer patients had no free time for themselves, and 84.9% of them had problems in their relationships with their patients.<sup>[41]</sup> Therefore, an interdisciplinary approach is necessary to identify and fulfill the psychological, emotional, and social needs of these caregivers and provide them with culturally-appropriate support.<sup>[13,18,19]</sup> Such support by peers and relatives can help them better cope with their care-related physical and mental tensions and better accept their new roles.<sup>[36]</sup>

Providing care to patients with GC leads to different psychological consequences such as depression, anxiety, grief, and despair for family caregivers. The current findings showed that family caregivers were seriously concerned with the gradual exhaustion of their patients and the likelihood

of their imminent death. These problems are particularly prevalent among the family caregivers of patients with GC due to the poor prognosis of the disease. A former study also reported uncertainty over future caused by poor prognosis and functional impairments as the main challenge of most family caregivers.<sup>[22]</sup> Psychological needs are among the most important and most neglected needs of the caregivers of cancer patients. Therefore, healthcare providers need to pay close attention to the psychological needs of both patients and their caregivers and provide them with strong psychological support.<sup>[11]</sup>

## CONCLUSION

Family caregivers of patients with GC experience many different challenges. They need to immediately seek specialized medical help when their patients' symptoms are persistent and use culturally appropriate truth-telling protocols. Moreover, healthcare providers need to provide them with adequate information about the management of their patients' physical symptoms and a healthy dietary regimen for their patients. Professional empowerment programs for caregivers can also reduce their problems and challenges.

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## Author contributions

Conception and design: all authors. Conducting the study: FT and SEF. Data gathering: SAF, AM and MT. Interpreting and analysing data: FT, SEF and ME. Original drafting of the article: SEF, ME, and FT. Review and final approval of the article: all authors.

## Declaration of patient consent

Patient's consent not required as there are no patients in this study.

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## Conflicts of interest

There are no conflicts of interest.

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