



Original Article

# Voices of Resilience: Lived Realities and Challenges of Caregivers for Cancer Patients Receiving Palliative Care – A Qualitative Perspective

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## ABSTRACT

**Objective:** The objective of this study was to explore the lived experiences of family caregivers of cancer patients receiving palliative care in a hospice setting.

**Materials and Methods:** A qualitative phenomenological study was conducted among 15 primary caregivers at a hospice in Chandigarh, India. Participants were selected through purposive sampling. Data were collected through in-depth, face-to-face interviews using a pre-validated interview schedule. Colaizzi's seven-step framework was used for data analysis.

**Results:** The study revealed profound emotional, physical, financial and social challenges experienced by caregivers. Seven major themes emerged: emotional and psychological response to caregiving, physical and lifestyle impact, financial struggles, occupational disruption, spiritual and cultural aspects, social support and barriers and knowledge gaps. These reflect the cumulative burden caregivers carry as they navigate caregiving responsibilities in the end-of-life caregiving context.

**Conclusion:** Caregivers of cancer patients in palliative care face intense and complex challenges that require acknowledgement and structured support. Integrating caregiver-focused interventions into palliative care is essential for holistic, patient and family-centred care.

**Keywords:** Cancer, Caregiver experiences, Hospice, Palliative care, Phenomenology, Qualitative study

## INTRODUCTION

Cancer, a major non-communicable disease, is often associated with death and disability. In its advanced stages, it not only poses a threat to life but also leads to substantial physical and functional decline. Patients in this stage frequently become bedridden, experience profound physical and emotional distress and rely heavily on caregivers for assistance with activities of daily living.<sup>[1]</sup> Cancer remains one of the leading causes of morbidity and mortality worldwide, accounting for approximately 17% of global deaths in 2020.<sup>[2]</sup> In high-income countries, it is the second most common cause of death, following cardiovascular diseases, while in developing countries, such as India, it ranks third. According to the American Cancer Society (GLOBOCAN

2022), the global burden of cancer continues to rise, with an estimated 20 million new cases and 9.7 million cancer-related deaths reported in 2022.<sup>[3]</sup> In India, the prevalence of cancer is significant, with around 2–2.5 million cases, and 700,000–900,000 new cases reported annually. The majority of these patients present at an advanced stage of the disease, contributing to poor prognosis and high mortality rates.<sup>[4]</sup>

The incidence of cancer in Punjab remains a significant concern. According to recent data from the Indian Council of Medical Research-National Cancer Registry Programme, the estimated count of cancer cases has risen from 39,521 in 2021 to 42,288 in 2024, which indicates a 7% increase.<sup>[3]</sup> In data from PGIMER Chandigarh, the cancer cases reported between 2000 and 2010 were 3,000–4,000, which nearly

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doubled between 2011 and 2015 and 5,000–7,000 cases. Punjab accounts for approximately 65% of the total cancer patients in this reported incidence, Haryana follows 20–25% while Himachal Pradesh contributes 10–15%, and patients from other states, such as Uttarakhand, Jammu and Kashmir, make up about 5% of the total cases at PGIMER.<sup>[4]</sup>

Palliative care is an approach that improves the quality of patients and their families by preventing and relieving suffering, whether physical, psychosocial or spiritual. Globally, most patients in need of palliative care have chronic diseases such as cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), acquired immunodeficiency syndrome (5.7%) and diabetes (4.6%). Other conditions such as chronic kidney disease, multiple sclerosis, Parkinsonism, neurological disease and drug-resistant tuberculosis may also require palliative care.<sup>[5]</sup>

In India, palliative care was started as the Shanti Avedna Sadan in Mumbai, a hospice, in 1986, followed by the formation of the Indian Association of Palliative Care in 1994. Despite significant efforts over the years, the reach of palliative care remains limited, currently available to <1% of the people in India.<sup>[6,7]</sup> Barriers include lack of awareness, limited accessibility and inadequate integration into mainstream health services.<sup>[8,9]</sup>

Cancer patients have family caregivers who provide care for multiple and varied durations. Levels of involvement in the care depend on the severity of symptoms, treatments required, stage of disease or closeness to death.<sup>[10]</sup> Beyond reducing life expectancy, palliative care imposes considerable burdens that extend beyond patients to their caregivers. Moreover, in a traditional society like India, the family assumes a pivotal role throughout the cancer trajectory, often perceiving the illness not merely as the patient's burden but as a shared familial challenge.<sup>[6]</sup> The term cancer itself leads to shock and fear due to reasons of very high treatment costs and poor chances of survival. The burden associated with cancer treatment often causes severe distress among patients as well as family members. A study conducted among caregivers of advanced cancer patients reported significant psychological burden and distress.<sup>[7]</sup>

Caregiving activities undertaken for people who are at the terminal stage of cancer include self-care assistance, communication, household work, psychological support, feeding, managing financial issues, medical care such as management of patients with pain, administration of medications and therapies such as chest physiotherapy, range of motion exercises and managing infusion lines.<sup>[11,12]</sup>

Despite the crucial role played by caregivers in the end-of-life care of cancer, limited qualitative research exists on their lived experiences, especially in Indian hospice settings. As per the literature review, existing studies have primarily focused on the experiences of caregivers in the home-based palliative care (e.g., Mumbai)<sup>[13]</sup> or in hospital settings (e.g., Bengaluru,

where focus is primarily on patient perspectives rather than caregivers), with only a few addressing hospice-based care specifically.<sup>[14]</sup> This gap in the literature forms the basis for the present study, which aims to explore the lived realities of caregivers within hospice, a setting largely underexplored in India. Understanding the lived experiences of these caregivers is crucial for developing targeted interventions that address their unique challenges and bolster their resilience. By giving voice to caregivers' experiences, this study seeks to uncover the challenges and shed light on their struggles and strengths that can guide future palliative care policies and practices.

### Research problem statement

A phenomenological study was conducted to explore the lived experiences of caregivers of cancer patients receiving palliative care at the hospice, U.T. Chandigarh.

### Objective

The objective of this study was to explore the lived experiences of caregivers of cancer patients receiving palliative care.

## MATERIALS AND METHODS

### Study design and setting

A phenomenological study design was selected to explore the lived experiences of caregivers of cancer patients receiving palliative care at Hospice Chandigarh, which is a palliative care unit run by the Indian Red Cross Society, U.T., in collaboration with the Department of Radiotherapy, PGIMER Chandigarh. The hospice has a capacity of 15 beds and is staffed by a multidisciplinary team of doctors, specialised nurses, counsellors and volunteers. The patient-to-staff ratio is approximately 4:1, ensuring continuous support for both patients and their families. Hospice provides end-of-life care for patients with advanced cancer, in the form of an outpatient clinic, in-home care and inpatient hospice services, ensuring continuous support for both patients and their families. Caregivers are encouraged to stay with the patients during admission, and basic facilities for accommodation and meals are provided. The average duration of stay for patients ranges from a week or 10 days to months, depending on clinical needs and family preferences.

### Study participants

The caregivers of cancer patients receiving palliative care at the hospice, U.T. Chandigarh, were recruited for the study. Those who were willing to participate and able to communicate in Hindi, English or Punjabi were included. Caregivers who were not willing to give consent or who faced difficulties in verbal communication were excluded. This study focused on primary caregivers, such as family members or close relatives, directly involved in the day-to-day care of the patient during hospice stay.

### Sample size and sampling technique

A purposive sampling technique was used to recruit the participants. The sample size was determined based on the principle of data saturation, that is, the point at which no new responses emerged from the interviews. In total, 15 caregivers were included in the study. Caregivers were approached within the hospice, and participation was voluntary. Each participant was given detailed information about the purpose of the study, and informed consent was obtained prior to the interview. Each in-depth interview lasted for 60–90 minutes. The ethical clearance was obtained from the Institutional Ethics Committee of PGIMER, Chandigarh (Ref. No. NK/5157/M.Sc./10). Written informed consent was taken from all participants after explaining the purpose, procedures and nature of the study. Confidentiality and anonymity were ensured throughout.

### Declaration of caregiver's consent

In the form, the participants have given their consent for their information to be used for research purposes. They have understood that their names and identifying details will not be disclosed.

### Data collection and analysis

Data collection was conducted in a private room within the hospice to ensure a comfortable and confidential environment. Fifteen willing participants were interviewed using a pre-validated, open-ended interview guide. Initial questions focused on general feelings and reasons for becoming a caregiver, such as: 'How are you feeling?', 'How did you feel after knowing that your patient is diagnosed with cancer?' and 'Why did you choose yourself as a caregiver?'. These were followed by deeper probes into caregiving experiences and emotional reactions. Interviews were audio-recorded with informed consent.

Data analysis was conducted in two parts. Quantitative demographic data were processed using descriptive statistics, with assistance from the Statistical Package for the Social Sciences software. The qualitative data were analysed using Colaizzi's method.<sup>[15]</sup> This included reading and re-reading the narratives, identifying and extracting significant statements, developing meaningful interpretations, clustering similar meanings into subthemes, which were further grouped into themes, and formulating an exhaustive description of the phenomenon.

To ensure the credibility and trustworthiness of the data, member checking was carried out by sharing the interpreted themes with a subset of participants to verify whether the findings accurately reflected their experiences. In addition, peer debriefing was used to minimise bias and enhance the rigour of the analysis.

## RESULTS

Table 1 depicts the socio-demographic data of participants. The caregivers ( $n = 15$ ) had a mean age of  $43.9 \pm 13.4$  years,

ranging from 21 to 68 years. The largest proportion (40%) was in the 40–49 years age group, followed by those in the 18–28- and 50–59-year groups (20% each). More than half of the participants were female (53.3%), and the majority were married (73.3%). Regarding education, most caregivers had completed primary or higher education, while 13.3% were illiterate. The occupations of participants varied; one-third were homemakers, and others were engaged in private service (26.7%), daily wage labour (26.7%) or government service (13.3%). Per capita monthly income varied, with over half (53.3%) falling in the Rs 1001–2500 range, and about a quarter (26.7%) in the lowest category (< Rs 1000).

The caregivers were primarily close family members such as spouses (40%), children (26.7%), siblings (26.7%) and parents (13.3%) of the patients. More than half of participants (66.7%) had been providing care for more than 1 year, highlighting the long-term nature of caregiving responsibilities. A few caregivers (13.3%) reported a history of physical or psychological illness, which may have added to their caregiving burden. Significantly, all caregivers (100%) stayed with the patients in the hospice during admission, reflecting the continuous nature of caregiving in this setting.

### Thematic analysis

Seven main themes, as depicted in Table 2, relevant to the research question, were identified, which characterise the family caregiver's experiences: emotional and psychological response to caregiving, physical and lifestyle impact, financial struggles, occupational impact, spiritual and cultural aspects, social support and barriers, reaction of caregiver towards patient's illness and knowledge gaps.

### Description of themes

#### *Theme I: Emotional and psychological response to caregiving*

The caregivers reported significant emotional distress following the diagnosis and during the progression of the patient's illness. Subthemes included denial, despair, anger, acceptance and emotional trauma due to witnessing suffering. One participant reflected, "*The biggest difficulty was when it came to know that there is cancer, it just felt like everything was shattered. And when the second time it was found out that this is the last stage, just understand that we have died a death.*" There had been a severe emotional impact of caregiving, leading to feelings of helplessness, grief and emotional exhaustion. Some caregivers eventually moved towards acceptance, while others struggled in states of fear and hopelessness.

#### *Theme II: Physical and lifestyle impact*

The physical strain of caregiving was reported through the subthemes, including disrupted routines, sleep disturbances, neglect of self-care and emerging health issues. Several

**Table 1:** Socio-demographic profile of the participants (n=15).

Sl. No.	Characteristics	No. of participants (f)
1.	Age (in years)*	
	18–28	03 (20.0)
	29–39	01 (06.7)
	40–49	<b>06 (40.0)</b>
	50–59	03 (20.0)
	60–69	02 (13.3)
2.	Gender	
	Male	07 (46.7)
	Female	<b>08 (53.3)</b>
3.	Marital status	
	Married	<b>11 (73.3)</b>
	Unmarried	03 (20.0)
	Widow/widower	01 (06.7)
4.	Education	
	Illiterate	02 (13.3)
	Primary	<b>06 (40.0)</b>
	Secondary	03 (20.0)
	Graduate or above	04 (26.7)
5.	Occupation	
	Government service	02 (13.3)
	Private service	04 (26.7)
	Daily wage labour	04 (26.7)
	Homemaker	<b>05 (33.3)</b>
6.	Monthly per capita income (INR) <sup>#</sup>	
	<1000	04 (26.7)
	1001–2500	<b>08 (53.3)</b>
	2501–5000	02 (13.3)
	>10,000	01 (06.7)
7.	Relationship with patient	
	Spouse	<b>06 (40.0)</b>
	Children	04 (26.7)
	Siblings	03 (20.0)
	Parents	02 (13.3)
8.	Duration of caregiving	
	3–6 months	02 (13.3)
	7–12 months	03 (20.0)
	More than 1 year	<b>10 (66.7)</b>
9.	History of any illness	
	Yes	02 (13.3)
	No	<b>13 (86.7)</b>
10.	Living with patient in hospice	
	Yes	<b>15 (100.0)</b>
	No	00 (00.0)

\*Mean±standard deviation: 43.93±13.43, Range 21–68 years, <sup>#</sup>Income based on per capita monthly income as per Modified Kuppuswamy Scale

**Table 2:** Themes and subthemes generated from the data.

Sl. No.	Themes emerged	Sub-themes
1.	Emotional and psychological response to caregiving	Denial Despair Anger Acceptance Emotional trauma due to witnessing suffering
2.	Physical and lifestyle impact	Disrupted routines Sleep disturbances Neglect of self-care Emerging health issues
3.	The financial struggles	Treatment-related debt Selling of personal assets Inability to meet familial roles
4.	Occupational impact	Loss of job Missed opportunities for career growth
5.	Spiritual and cultural aspects	Faith in god Superstitious beliefs
6.	Social support and barriers	Lack of support Satisfied with the support received Barriers to help-seeking Lack of trust in other family members
7.	Knowledge gaps	Treatment plans Uncertainty about treatments

caregivers described fatigue, poor nutrition and untreated ailments due to their complete focus on the patient. One caregiver revealed, “*Only 6-grams of haemoglobin is left in my body. Our entire family is suffering. One person is already sick, and we are all dying with him every second.*” The caregiver role also disrupted personal aspirations and daily responsibilities.

### **Theme III: Financial struggles**

One of the most dominant challenges reported by caregivers was economic hardship. Subthemes included treatment-related debt, selling of personal assets, and inability to meet familial roles. One caregiver shared, “*My son is the only one who earns, we have drowned in the debt, so much debt has been incurred on us, what should I tell you? We have borrowed a lot, some from relatives, some on interest. We had some items at home, all were sold, even my daughter-in-law’s jewellery was sold.*” The lack of sufficient support from family members, relatives, friends, or the health care services left them to manage financial resources on their own. In addition to this, many of them have also expressed their grief over missed milestones, like arranging their children’s weddings, due to financial strain.

### **Theme IV: Occupational impact**

Caregiving commitment also had a marked impact on the occupational health of caregivers. The subthemes included

loss of job and missed opportunities for career growth. Some had to discontinue work permanently, while others sacrificed long-term career goals. A caregiver lamented, *“If everything had been fine, I would have studied and worked without worrying. I would have become something by now. But I feel like now I can’t leave her alone. Right now, she needs me the most.”* These verbatim exemplify how caregiving not only deranged their immediate sources of income but also thwarted long-term career development, further escalating the overall burden on caregivers.

#### **Theme V: Spiritual and cultural aspects**

Spirituality played a dual role as a source of strength and confusion. The subthemes included are faith in God and superstitious beliefs. While many relied on faith to cope, others expressed anger towards divine power or attributed the illness to supernatural causes. One caregiver narrated, *“See, we have to keep faith in God, madam. Life is all in His hands. A person lives as long as God has decided, and He will take that life when the time is over.”* Moreover, some participants described superstitious elucidation of the patient’s illness, as a participant said, *“He was completely fine—there was no problem at all. He had lunch, went to the shop, brought some things from the shop, and then a neighbour came over. My husband said the neighbour was staring at him constantly. I told him not to worry, but from that moment, he was uneasy. Later, after lunch, he came back salivating, and the disease began. Sometimes I feel the neighbour might have done something to him. I don’t know if thinking this way is right or wrong.”* Caregivers believed in black magic or the evil eye as the cause of illness, reflecting deep-rooted cultural beliefs influencing caregiving perspectives.

#### **Theme VI: Social support and barriers**

Caregivers’ understanding of support during caregiving varied considerably, involving both the presence and absence of support from family, society and dedicated institutions. This theme encompasses the subthemes: lack of support, satisfaction with received support, barriers to help seeking and lack of trust in others for caregiving. Some caregivers received substantial emotional and logistical help, especially from hospice staff, while others found themselves alone in their endeavour when abandoned by family and community. One participant shared, *“No one in the family came forward to help. My husband was the only son of his parents, with no siblings. Who should we expect support from? Nobody from the family even called to ask how we were. We stood by everyone in their hard times, but when we were in trouble, no one showed up.”* Participants also highlighted barriers to seeking help, deep-seated in cultural beliefs or fear of social stigma. As one participant reflected, *“My brother-in-law offered help, but my brother did not visit. My brother-in-law says I could take money, but how can I accept help from my sister’s house? That would be a sin. I could beg from the world, but I cannot ask*

*my sister’s in-laws for financial help.”* A reappearing notion was a deep mistrust in others’ potential to provide the same level of care as they offer, discouraging seeking help. One caregiver reported, *“If I leave him even for a day with someone else, he will just be lying in bed. No one will care for him like I do. And you need money too—who would come to help without expecting something? What is there to hope for anyone?”*

#### **Theme VII: Knowledge gaps**

Many caregivers experienced perplexity, uncertainty, and at times, had a limited understanding of cancer, palliative care and treatment goals. This theme comprises the subthemes—treatment plans and uncertainty about treatments. This often led to unrealistic expectations, mistrust of medical advice and a reliance on alternative therapies. One caregiver asked, *“I believe if they do surgery, he will recover. But who listens to me? Tell me, can he be cured with surgery or not?”* These misunderstandings fabricated emotional distress and hindered informed decision-making during their caregiving process.

These seven themes express a complex and emotionally charged caregiving journey. They highlight an urgent and crucial need for caregiver support systems, health education and culturally sensitive communication strategies within hospice and palliative care environments.

## **DISCUSSION**

The primary objective of the present study was to explore the lived experiences of caregivers of cancer patients receiving palliative care. The hospice served as the context for data collection rather than the focus of comparative analysis with other care settings. By situating this research in a hospice, however, the study adds to the limited literature on caregiver experiences within institutional palliative care in India.

The findings reveal deep insight into the multifaceted challenges, including emotional distress, physical burden, financial strain, role conflicts and spiritual complexity, a lack of awareness about the nature of the treatment of cancer in the advanced stage. Many caregivers expressed hope that their loved ones might recover if allowed to stay longer in hospice, while others struggled to resolve the reality of terminal illness with their caregiving role. The hospice setting, where caregivers often stay continuously with patients, provides structured medical, psychological and spiritual support. This environment may influence the caregiving experience in ways that differ from home-based or hospital-based care, by easing some practical burdens but also intensifying the emotional strains. These findings highlight the urgent need to address the burden on caregivers and enable them to maintain their lives as usual to protect their overall well-being.

In the current findings, the caregivers reported a range of reactions, including shock, disbelief, denial, anxiety and eventual acceptance. Several participants reported that being informed of the disease’s incurable nature was even more

devastating than the initial diagnosis. These experiences align with existing literature, Sherman *et al.* (2014), where caregivers reported being unprepared for the disease progression and overwhelmed by emotional responses.<sup>[16]</sup>

The caregiving role significantly affected the health behaviour and lifestyle of caregivers. Participants reflected physical symptoms such as fatigue, headaches, muscle pain, appetite disturbances and insomnia. The inability to prioritise their health led to physical and emotional deterioration. These findings resonate with a study by Vitaliano *et al.* (2003), showing that caregiving leads to adverse physical health issues among caregivers.<sup>[17]</sup> Beyond personal neglect, caregivers also reported disruption of family dynamics and parenting responsibilities. Some expressed regret and grief as their children became emotionally neglected or even involved in substance abuse. This highlights the cascading effects of caregiving on the family, extending the understanding of caregiving burden beyond individual health to family-level disintegration. This study also reveals intense self-sacrificing behaviour among caregivers, including the neglect of their own health deterioration. For instance, one caregiver's report of severe anaemia emphasises how personal health crises are often deprioritised in favour of patient care. Similar findings have been reported in existing literature, where caregivers of terminally ill patients experienced significant physical strain and delayed medical attention for their own health.<sup>[13,18]</sup>

The most dominant theme reported in this study was the financial burden. Caregivers often develop financial security to meet the expenses of medication, transportation and hospice services. This finding mirrors the study by Zafar *et al.* (2013), indicating that families caring for cancer patients experience financial toxicity.<sup>[19]</sup> Several caregivers reported that they had to quit jobs, suspend education or give up personal goals to meet caregiving demands. These patterns are consistent with a study by Reinhard *et al.* (2008), showing caregiving adversely affects employment, career trajectories and financial independence.<sup>[20]</sup> In the present study, a unique observation was the duality of spiritual response. While faith in the divine offered strength to many, several caregivers expressed anger at God. Caregivers frequently engaged in rituals, prayers and used indigenous medicines, believing they brought relief or peace to the patient. This is consistent with findings by Puchalski *et al.* (2014), who noted that spirituality can enhance meaning-making and resilience in palliative care.<sup>[21]</sup> However, beliefs in supernatural powers, for example, black magic, reflect deep-rooted cultural frameworks influencing caregiver belief systems, contemplating a need for culturally sensitive health education.

Support from extended family, friends and other networks varied widely. While some caregivers received considerable help, others experienced social isolation, stigma or lack of assistance. These findings align with the study by Northouse *et al.* (2012), who emphasise the importance of a robust social

support system and that inadequate social support increases caregiver distress and impairs coping.<sup>[22]</sup> The findings in the present study also highlight the dual distrust experienced by caregivers towards their families and the medical system, resulting in social withdrawal and caregiver isolation. Many believed that others would not offer the same level of care, while some feared cultural judgment for accepting help.

Many caregivers reported limited understanding of cancer and its progression, palliative care and treatment plans. This lack of knowledge often contributed to distress and confusion. These findings are supported by Hudson and Payne (2011), who brought to the fore that knowledge deficits in caregivers hinder care planning and increase anxiety.<sup>[18]</sup> The present study also highlights that there was widespread turmoil among caregivers regarding the nature of care being provided at the hospice. Many caregivers misunderstood palliative care as curative. They associated symptom relief with recovery and believed an extended hospice stay could result in disease remission. This misinterpretation reveals a crucial gap in communication and points to the need for clear and repeated explanation of palliative goals.

#### Limitations of the study

Some of the caregivers were not willing to participate in the study as they did not want their conversation to be recorded, and another limitation was the interview itself; the requirement of time for each participant to talk for nearly 60–90 min was perceived as a burden for recruitment in this study.

#### Recommendations

Based on the findings of this study, the following recommendations are made to enhance the support for family caregivers of cancer patients in palliative care:

Future studies should be done to assess the perceptions and determinants of quality of life among caregivers of cancer patients at the end of life. Understanding these perceptions can help develop targeted interventions to improve their well-being

Regular counselling sessions and emotional support groups should be established within hospice settings to help caregivers manage stress and emotional exhaustion

Caregivers' training programs, such as symptom management, communication strategies and self-care, should be integrated into hospice care protocols

More qualitative and mixed-method studies should be conducted in other geographic and cultural hospice settings across India to deepen understanding and improve caregiver-focused palliative care policies.

#### CONCLUSION

This study contributes new insights into the caregiver literature in palliative cancer care, revealing the multidimensional challenges they face. While emotional and

physical distress among caregivers is well established, this study uniquely highlights the underreported dimensions, such as (i) the cultural tension between spiritual hope and superstitious fear, (ii) the profound disruption of family roles leading to intergenerational stress and (iii) persistent misunderstandings of palliative care as curative, even in a hospice setting. The physical self-neglect and dual distrust in both healthcare systems and family networks uncover that caregiving is not only burdensome but deeply isolating. The findings from the study suggest the need for more culturally sensitive communication, family-inclusive education and caregiver-focused interventions in palliative care. Care for the caregiver is not optional; it is essential.

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**Ethical approval:** The research/study was approved by the Institutional Review Board at the Institutional Ethics Committee of PGIMER, Chandigarh, approval number NK/5157/M.Sc./10, dated 2nd April 2019.

**Declaration of participant consent:** The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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