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The Depression Situation of Cancer Patients' Relatives in Turkey

*Vedat Isikhan**

Department of Social Work, Hacettepe University, Turkey

Abstract

Purpose: Cancer is a serious illness which lasts from diagnosis until death. The emotional reactions of the relatives of the patient on the illness and their psycho-social difficulties may negatively affect both the treatment of the illness and the relatives' quality of life. It is also important for the relatives to know that the patient receives care of a good quality.

The purpose of this study is to investigate the prevalence of depression levels and the psycho-social factors that affect depression levels of the relatives of the cancer patients.

Patients and Methods: We enrolled 984 relatives of cancer patients from Dr. Abdurrahman Yurtaslan Oncology Training and Research Hospital and Ahmet Andicen Cancer Hospital in Ankara under the Turkish Ministry of Health, between 11 June-11 December in Turkey. In this study, we obtained socio-demographic and some characteristics of both patients and relatives. For the assessment of the psycho-social problems and depression of the relatives, we used the Questionnaire and Beck Depression Inventory (BDI). For statistical analysis of the data t-test and variance analysis (F) were used.

Results: According to BDI scale, relatives had avarage (X: 38,47) depression scores. Data collection tools were administered on 984 relatives of in-patients and statistically significant relationships were found between the following characteristics and depression scores: occupational and income status, closeness to the patient, and need for professional support of the relatives ($p<0.05$).

Conclusion: Cancer is still a great source of fear and it is evident that offering psycho-social support at a professional level in addition to medical treatment will yield more favorable results for both patients and their relatives. Depression was highly prevalent among the relatives in Turkey. All social work interventions aiming at reducing the psychiatric effects of cancer should focus not only on the patient but also on the relatives.

Keywords: Cancer; depression; psycho-social support; relatives; oncology social work; social workers' interventions

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Correspondence:
Vedat Isikhan, Department of Social Work, Hacettepe Universities, Turkey, Tel: 00903122976362; E-mail: visikhan@gmail.com

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Introduction

Cancer is a major problem for the patient and it is also affecting the patient's family and relatives psycho-socially and economically, and thus, it accumulates the interest of many disciplines. It is accepted that it is insufficient to handle the cancer phenomenon, which is so wide in scope, only in terms of the "health problem". The emotional, economic and social problems experienced by the cancer patient during the treatment process cause chronicity of a number of emotions and psychological disturbances such as anxiety and depression in their relatives [1].

Faced with the fact that they suddenly lose a loved one due to cancer, the family member goes into the process of depression known as deprivation, but even though this individual is still alive. The individual remains confronted with any dimension of lack of family members. They may experience different emotions and emotional situations and experiences such as despair, guilt, resentment, denial, fear, confusion, and anger. The response of family members to crying varies according to age, religious belief, ability to cope, support systems, perception of death, and devotion to changes in life [1-5].

After diagnosis, life for the patient and his family may come to a difficult point. Sometimes family members show feelings of resentment, guilt and regret. These responses gradually diminish as a result of the family's illness and compliance with the patient's death [6]. Research shows that cancer affects family and relatives as much as the sick. Dodd et al [7].found that family members

are more concerned about their anxiety than their sickness, that they are concerned with their families, and that patients pay more attention to self-esteem and social independence during the illness. Those who undertake care responsibilities at home may experience too much difficulty while trying to support the patient and other family members.

The literature shows that anxiety and depression are more prevalent among psycho-social problems experienced by cancer patients' relatives [8-13]. However, problems faced by patients' relatives are not only psycho-social. The patients' physical pain, discomfort, additional costs from new treatments, uncertainty and the long duration of illness cause the family and relatives to live in economic conditions. Previous studies have evaluated predictors of caregiver depression, including caregiver characteristics (eg, being female [14-16], being the spouse [15], having poor health [15-16], being old [16].

In his research Fallow field [17] found that patients' relatives had more anxiety and depression than patients. Williams [18] states that family members who take care of their friends spend 4-7 hours each day to complete their tasks. These tasks are carried out daily and are usually performed by a woman working outside or looking after her children. For this reason, the person taking the care is at risk of physical illness due to fatigue, role conflict, social isolation, distress and consequent deterioration of the immune system. In the study by Williams [18], care givers; stated that he has suffered from health problems after his illness, sleep problems, constant fatigue, fatigue, weight change, headache, back pain, muscle tension, indigestion, muscle cramps and serious aches after illness.

Psychiatric morbidity is the most common depressive syndrome in cancer patients and their relatives. Cancer incompatibility and helplessness are the most important factors in the development of depression. Patients and relatives who have an history of emotional disease and a family history of psychiatric illness, alcohol and substance abuse disorders, and lack of social support systems are more at risk for developing depression. In general, the conditions in which the treatment does not show the expected improvement and the general condition worsens are the most critical periods in terms of depression. In another study, patients' relatives were compared before and after the onset of care for their patients, the health status of their relatives before the onset of the illness was better than the health status after the onset of the illness, the most common symptoms of sleep deprivation, weakness, energy, weight and nutrition [19].

In our country, the number of studies on psycho-social problems experienced by cancer patients' relatives is limited [1, 5, 20-21]. When the patient and his / her family are treated as a whole in the psycho-social treatment of cancer, there is information inaccuracy regarding the problems that the patient lives in. It is necessary to identify the problems faced by the patients' relatives and identify them in a scientific way for the social work interventions that will be developed in order to determine the problems experienced by the patients' relatives and to help them overcome this process with the minimal loss.

In summary every crisis that the cancer patient experiences affects the family. Family members are most often affected during diagnosis, at the beginning of a new treatment, during the course of treatment, during recovery of the disease, and during death [21] Cancer experience can cause devastating effects on the social side as well as psychological destruction for the patient's family. For this reason, the primary task and function of the social worker in the oncology clinic should be to empower them in the process of coping with the problems experienced by patients and their relatives. Problem solving initiatives may aim to provide information about patients and their relatives about their illnesses and symptoms, to resolve needs and to share feelings, and to assist in the promotion and use of social resources to patients and their relatives.

Having knowledge about the many causes that can lead to depression can help a better understanding of the difficulties or disabilities of the relatives of the cancer patient. Recognizing the effects of depression on both sides should be considered as complicated as depression is and that it is not caused by the behavior of a single person.

Patıents and Methods

Participant and Data Collection

In this study, socio-demographic characteristics of relatives of cancer patients who were hospitalized, some psycho-social problems they experienced, and the effect of these problems on depression levels tried to be determined. The research was conducted on the relatives of patients who are in-patient treatment between 11 June-11 December in Dr. S.B. Abdurrahman Yurtaslan Onkoloji E. A. Hospital and Ahmet Andicen Cancer Hospital under Turkish Ministry of Health, Ankara, Turkey.

The present study also seeks to determine whether there is a relation between sociodemographic characteristics of the relatives of the patients and their ideas on patients, cancer experience and scores of depression in Turkey.

The following are the hypothesis (questions) of the research:

- Is there a relationship between gender of the relatives and depression scores?
- Is there a relationship between the age groups of relatives and depression scores?
- Is there relationship between marital status of the relatives and depression scores?
- Is there a relationship between education status of the relatives and depression scores?
- Is there a relationship between occupation status of the relatives and depression scores?
- Is there a relationship between income status of the relatives and depression scores?
- Is there a relationship between the closeness of the relatives and depression scores?
- Is there a relationship between need for professional support of relatives and depression scores?
- Is there a relationship between financial problems of relatives and depression scores?
- Is there a relationship between the emotional problems experienced by relatives during care of the patient and depression scores?

Materials and Methods

We constructed a questionnaire booklet that enabled us to examine the impact of cancer on the relatives as well as to examine

Table 1: Socio Demographic Characteristics of Relatives and Mean Scores of Depression.

Socio-demographic Charactarestic	No	%	Std. Deviation	Depression Mean Scores	Test Results
Gender					t-test: ,620
Female	523	53,2	13,124	38,72	
Male	461	46,8	13,760	38,18	
Age Groups					F: 1,128
19-29	185	18,8	12,894	37,71	
30-49	477	48,5	14,310	38,84	
50-59	223	22,7	12,314	38,47	
60 and Over	99	10,1	12,440	38,08	
Marital Status					F: ,483
Married	799	81,2	13,490	38,45	
Single	41	4,2	12,901	36,36	
Widow-Widower	144	14,6	13,210	39,18	
Educational Status					F: 1.168
Illiterate	50	5,1	12,421	35,84	
Literate	38	3,9	12,658	38,39	
Primary School	378	38,4	13,387	38,28	
Secondary School	134	13,6	14,300	38,58	
High School	258	26,2	13,469	38,82	
University	126	12,8	13,188	39,23	
Occupation status					F Test: 1.426 *
Housewife	419	42,6	13,012	38,16	
Worker	104	10,6	14,091	39,19	
Retired	135	13,7	13,230	39,56	
Officer	64	6,5	14,502	39,23	
Self Employment	153	15,5	13,942	37,66	
Not working	54	5,5	14,231	38,31	
Others	55	5,6	12,533	38,27	
Income Status					F Test: 1,549 *
0–357 USD**	167	17,0	13,237	38,19	
358–511 USD	331	33,6	13,043	38,38	
512–766 USD	319	32,4	13,560	38,17	
767 USD and over	167	17,0	14,136	39,47	
Overall	984	100			

* P<0.05

** 1 Turkish Lira = 3,91 USD (2.12.2017)

the relatives' some psycho-social problems and levels of depression.

In this study "screening model" was used. The data collection tools applied to relatives between June 11 and December 11 in Ankara in Abdurrahman Yurtaslan Onkoloji E.A. Hospital and Ahmet Andicen Cancer Hospitals through the help of social workers.

Social workers working in these two hospital clinics have explained the aim of the study to the relatives of in-patients with cancer. Each participant was informed, prior to the interview, about the purpose of the study, written informed consent was obtained, and participants were told that they had the right to refuse participation and could withdraw at any time. In the study period, the number of relatives of the patients with cancer was about 1150. The participants were given no special inducement to participate in the study. However, since some relatives were outside of the hospital (at the time of study period), some came to the hospital after working hours, some had problems with their patients and others were against participating in the research. We were not be able to administer the questionnaire to 116 relatives. In sum, data obtained from nine hundred and eight four relatives (n=984) were regarded as valid.

Data were obtained through Beck Depression Inventory (BDI) whose reliability and validity study was made and adapted to our country by Tegin [22] and Hisli [23] and the questionnaire developed by the researchers. A relative is someone involved in the patient's life whether they are a wife, an ex-wife, a husband, an ex-husband, a partner, a parent, a sibling, a child, a friend or any significant others. The term of 'relatives' in our study includes close relatives, such as parents (father or mother), spouses, spouses of children, and friends of in-patients with cancer.

Table 2: Comparison of Mean Depression Scores With Respect to Characteristics of the Patients and Relatives.

Charactarestic	No.	%	Std. Deviation	Mean Score	Test Results
Closeness of the relation					t-test: 1,48 *
Sibling	191	19,4	14,604	38,32	
Parent (father or mother)	455	46,2	12,877	38,84	
Close relative-friend	86	8,7	12,684	34,94	
Spouse	67	6,8	14,800	38,23	
Spouse of child	49	5,0	11,318	36,26	
Unexpressed	136	13,8	13,610	40,58	
Need for professional support					t- test: 2,302 *
Yes	579	58,8	13,430	39,29	
No	405	41,2	13,338	37,29	
Financial problems					t- test: -,960
Yes	658	66,9	13,389	38,18	
No	326	33,1	13,489	39,05	
Emotional problems during care					t-test:,881
Yes	568	57,7	13,762	38,79	
No	416	42,3	12,947	38,03	
Diagnosis					F test: ,724
Lung cancer	506	51,4	13,199	38,00	
Acute Myeloid Leukemia	109	11,1	13,499	38,19	
Acute Lymphoblastic Leukemia	75	7,6	13,827	38,26	
Breast Cancer	38	3,9	13,717	39,13	
Small Cell Cancer	10	1,0	14,363	42,90	
Non Hodgkin's lymphoma	72	7,3	14,447	37,68	
Neuroblastoma	13	1,3	10,789	34,92	
Gastric cancer	37	3,8	12,938	39,64	
Malignant Mesenchymal Tumor	20	2,0	13,677	35,15	
Ewing Sarkom	13	1,3	12,797	40,46	
B Cell Lymphoma	20	2,0	15,527	37,60	
Hair Cell Leukemia	19	1,9	10,781	41,36	
Chronic Lymphoblastic Leukemia	28	2,8	12,239	42,39	
Acute Myeloid Leukemia	24	2,4	15,306	45,29	
Overall	984	100			

* P<0.05

Measures

Questionnaire: The questionnaire has been prepared by researcher taking the purposes of the research into consideration. It includes questions aiming to determine the sociodemographic characteristics of the relatives (gender, age, marital status, education status etc.,) and some characteristics related to the illness and the patient (degree of closeness with the patient, gender of the patient, getting professional help, experiencing financial problems, and emotional problems etc.).

Beck Depression Inventory (BDI): We used the BDI to measure the relatives' level of depression. BDI is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric disorders. BDI was developed in 1961 by Beck. BDI is composed of 21 questions or items, each with 4 possible responses. Each response is assigned a score ranging from zero to three, indicating the severity of the symptom. Individual questions of the BDI assess mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily preoccupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess more physical symptoms [24]. BDI was translated into Turkish and its reliability was recalculated by Tegin [22] and Hisli [23]. Each item scored between 0 and 3. The highest score you can get is 63. (Range = 0-63). The higher the total score, the higher the level of depression or severity.

Statistics: The data was analyzed by the SPSS statistical package, version 16. Depression scores of the relatives were used as dependent variables. Sociodemographic characteristics of the relatives of the patient and their ideas on patients and illness were used as independent variables. This data file is available for further analysis if additional questions arise. For the analysis of the findings, according

to the type of the variables, number and percentage were used and variance analysis and t test were employed. T test was used in order to evaluate the relationship between gender, closeness of the relation, gender of patient, getting professional help, experiencing financial problems, and emotional problems. Variance analysis (F) was used to determine the significance of the relationship between, age groups, marital and educational status, closeness of the relation, occupational status, income status, and depression scores. Minimum acceptable level of significance was set at 0.05.

The ages of relatives were divided into four groups and statistical analyses were carried out. Distribution of the minimum and maximum age and experience were taken into account. As the minimum age was 19 and the maximum was 67, age distribution was divided into four groups, namely under 19-29 ages, 30-49, 50-59 and 60 and over. Least-Significant Difference, among Post Hoc Multiple Difference methods, was used to determine the difference between the groups.

Results: In this part of the study, the questionnaire applied to determine the psycho-social problems of the relatives of cancer patients and the findings obtained by application of the BDI to determine depression levels are included.

Depression Scores of the Relatives

We examined the average depression scores of the cancer patients who were included in the study. It was determined that the relatives of the patients had average 38.47 points, the lowest score was 6 and the highest score was 62. The highest score on the BDI is 63 point. It appears that the patient has a depression score above the average (38.47). In the study of Gozum et al., 53.2% of Turkish cancer patients and 11.8% of their relatives were reported to be depressive [25-26].

The BDI performed in order to determine the severity of the depressive symptoms of the patients was significantly higher compared to the patient relatives. In the study by Gozum et al., [26] the severity of depressive symptoms in Turkish cancer patients was higher compared to the patient relatives. It may be considered that the reason for different rates in different populations is that the general features and patient compositions of these populations are different. Our findings are opposite with results of Gozum et al [26].

The health status of relatives of the patients with cancer before and after care has been compared, with their health being better before the onset of giving care and the most frequent complaints were reported to be sleep problems, weakness, lack of energy, weight and nutrition problems [27-29]. In our study, mean score of depression was found to be 38.47 in the relatives (range 0-63). According to this result, it may be stated that relatives of patients in oncology clinics have depression above the average scores. Our results are inconsistent with those of Grbich et al., [30] Mok et al., [31] and Zakowksi et al [27].

In the evaluation of the sociodemographic characteristics of the relatives of the patients with cancer, it has been established that the majority is female, between the ages of 30-49, married, and graduate of primary school, housewives, and mean income is358-511 USD (Table 1). The majority of the patients' relatives are under the care of their parent (father or mother), need they professional support, they have financial and emotional problems due to illness, and the majority had lung cancer (Table 2).

The aim of this investigation was to establish whether there was a relation between certain characteristics of the relatives and their depression scores. The results obtained and their interpretations are presented below. Undoubtedly, being the relative of a patient with cancer is often very stressful. It is also important for the relative to know that the patient receives care of a good quality. Participation in the care is considered positive by both the patient and the relative. Knowledge about the patient's condition makes it easier for the family to deal with the stresses it faces. Insight into the situation also increases the possibility that members of the family talk with each other and experience intimacy and closeness during the final stages of life [32].

Discussion

As shown in Table 1, the majority of the patients' relatives (53.2%) were female. This result is followed by relatives of the male group with 46.8%. Traditional patriarchal order in Turkey causes women to play an important role in elderly, disabled and patient care, when compared to men. This is in line with the fact that a large proportion of cancer patients' relatives are women. In many studies, those providing care were primarily women e.g. Emanuel et al., [33], but it was also shown that men were active in the care [34]. Female relatives are subjected more to various experiences of the patients such as pain, vomiting, fatigue than male relatives. It has been assumed in this study that this may have an impact on depression scores and first hypothesis was formulated accordingly, namely 'is there a relationship between gender of the relatives and depression scores?' When hypothesis was tested, actually a difference was not found between females and males ($p>0.05$). While the mean depression score of females was 38.72, it was 38.18 in males, with a not statistically significant difference. The reasons for this not significant difference may be that women are constantly caring for the patient as they are mostly housewives as well as being forced to assume some responsibilities of the man they are caring for. As to male patient relatives, they may leave home for some time due to their job, leaving the problems behind as well. Even if it is the woman who is ill, as she keeps up fulfilling her responsibilities at home due to her traditional role, she is under more pressure. Our finding is consistent with the results of Emanuel et al., [33] and Zakowski et al [27]. This result obtained in the research was found to be parallel to "the number of relatives of female patients is more than the number of relatives of male patients" obtained from the research conducted by Isikhan [20]. It can be said that the result of the research is that the relatives of the patients are male or female and they are not affected by the same troubles and the same conditions in the hospital and hospital environment.

As shown in Table 1, a large proportion of the patient relatives (48.5%) were found to be in the 30-49 age groups. Some researchers described that to be a young caregiver [35-37] could increase the difficulties relatives experienced. When age distribution of patient relatives was considered, it was established that those between 19 and 29 (18.8%), to be followed by the largest group of those between 30 and 49 (48.5%). The second hypothesis of our investigation was formulated as follows: 'is there a relation between the age groups of the relatives and depression scores?' However, when it was tested, it turned out that there was no difference between different age groups with regard to depression scores ($p>0.05$). The reason for this may be that relatives are usually spouses and the children of the patient and experiences gained by relatives on cancer illness may be influential. This result is inconsistent with results of Chan and Chan [36], Goldstein et al., [37] Milberg and Strang [38]. According to this result, it can be said that dealing with the situation of the patient

have similar effects in every age group. At the end of the study, it was determined that age groups of the relatives of the patient were not an effective variable on the depression statement.

It has also been assumed that marital status of patient relatives would be influential on their scores. The thirth hypothesis was based on this assumption: 'There is a relation between marital status of relatives and depression scores'. When this hypothesis was tested, no such relation was found (p>005). In our society, being married or single imposes different roles and responsibilities to people. Our results may be attributed to coping methods of patient relatives and personal differences. It may also be that 49% of the attendants of married people are spouses and children while those of single people are mostly friends and acquaintances. This result can be explained by the fact that the majority of patient relatives participating in the research are the patient's spouse and child, or the majority of the patients are friends and relatives of the patient. This result is consistent with the findings of Işıkhan et al [39]. Also this result was found to be parallel to the result obtained by the research done by Isikhan [20], "the majority of which were formed by the number of married patient relatives, followed by the number of single and divorced patient relatives respectively".

Education status is an important variable that may influence the depression scores. It has been established that relatives at low education status find it more difficult to accept the condition of the patient, do not act realistically and hardly grasp issues such as the course and treatment of the illness. As shown in (Table 1), a large majority (38.4%) of the patient's relatives were primary school graduates. Fourth hypothesis of our investigation was hence that 'is there a relation between education status of the relatives and the depression scores?' When the hypothesis was tested, it was, in fact, found that there was no statistically significant relation between education status and depression scores. (p>0.05). Least-Significant Difference, among Post Hoc Multiple Difference methods, was used to determine the difference between groups.

Depression scores of university graduate=39.23 was found to be higher compared to others (illiterate relatives= 35.84, graduate of primary school=38.39, secondary school=38.58, high school=38.82 and). It may be said that the higher the education level, the lower the depression scores. This may be due to the fact that conscious coping mechanisms develop with education and that their social and material means become better. Studies also described that having a lower level of education [40-42] could also increase the difficulties relatives experienced. The education level of the relatives of patients with cancer is important for understanding the behavioral changes of patients during treatment process. It has also been emphasized that low educational level in cancer patients and their relatives is a risk for emotional problems such as anxiety and depression [43]. Our results are in keeping with those of Andershed and Ternestedt [10], Strang et al [44], Link et al [28], Hudson [12] and Winterling et al [45], Andershed [13]. Also, the result of this study is that the majority of the relatives of the patients in the research conducted by Işıkhan [20] were the result of college graduates, then primary school graduates, non-illiterate high school graduates and secondary school graduated relatives respectively. According to the results of the study, it was determined that the educational status was not an effective variable on the depression statements of the relatives of the patients. This study showed that patients' relatives with high educational levels have high depression levels.

When the occupational status of the patient's relatives are examined; (42.6%) of the patients' relatives were housewives. Following this result, 15.5% of the patients' relatives had self-employment, 13.7% were retired, 10.6% were workers, 5.5% did not work any jobs, 6% of them are working in civil servant status and finally 5.6% are in other occupational groups. The majority of patient relatives are composed of housewives. Fifth hypothesis of our investigation was hence that 'is there a relation between occupational status of the relatives and the depression scores?' When the hypothesis was tested, it was, in fact, found that there was a statistically significant relation between occupational status and depression scores. (p<0.05). The highest depression scores were found in employees as civil servants.

As shown in (Table 1), in the income distribution of the patient relatives, 33.6% of the relatives of the patients had an income level between 358 - 511 USD. Following this result, 32.4% of the patients' relatives had a income in the range of 512-766 USD. This result is followed by patient relatives with an income level of 0-357 USD and 767 USD with 17%. It can be said that most of the relatives (n: 750) have income between 358 and 766 USD and have a good income. Sixth hypothesis of our investigation was hence that 'is there a relation between income status of the relatives and the depression scores?' When the hypothesis was tested, it was, in fact, found that there was a statistically significant relation between income status and depression scores (p<0.05). The highest depression scores were found in relatives who have income 767 USD and over (X: 39.47). Isikhan, [20] have reported that in cancer patients the emotional and economic support deficiency are special risk factors for psychosocial symptoms. In our study high levels of depression were found in relatives with low income. The economic power plays also an important role in the struggle against the disease.

Many spouses are plagued by worries about the patients' comfort, emotional responses to the illness, the patients' coming death as well as practical problems. This is an emotionally intense, exhausting, and singular experience, set in a world apart from everyday life pattern. Many relatives become caregivers, some in their own home, which means that they become the person with primary responsibility for providing care for their dying relative [46] and their highest care priority is to give the patient comfort [45]. When the closeness of the relatives with the patient was examined, it was established that the majority were patient's relatives (46.2%) are parents (father or mother). Following this result, it was determined that 19.4% of the patients' relatives were siblings of the patients, 8.7% were close relatives or friends of the patients, 6.8% were spouses and 5% were children. Seventh hypothesis of our investigation was hence that 'Is there a relation between the closeness of the relative and depression scores?' When it was tested, such relation was found (p<0.05). In conclusion, it may be said that cancer influences all members of the family differently. It is thought that in such a chronic and anxiety and fear provoking illness as cancer, spouses are the strongest supporters of the patient in the struggle against the disease and that the attendant family member is usually the spouse. If a member of a family requires treatment as an in-patient or out-patient, it is usually the spouse or parents who accompany the patient. Although there may be conflicts and adverse events in the family, spouse is the most important source of support in the family. In an investigation carried out by Eylen [47], it has been established that of the relatives accompanying the patients, spouse accounts for 42.5%. Our findings are consistent with this result and also with results of Işıkhan et al [39], Andershed and Ternestedt [32] Winterling et al [45], Andershed [13].

Patients' relatives staying in oncology clinics for a short period usually help the patients in procedures of admission to the hospital, drug administration and treatment. As the duration of accompanying the patients is prolonged, relatives face many problems such as not being able to utilize their free time, not having any time for themselves and postponing many things, creating distress in them. Staying in a clinical environment for a long time may lead to the emergence of many problems. It has been reported in the literature that initiation of a new treatment modality and recurrence of the illness increases the duration of hospitalization, having an adverse effect on the patient and the family 58.8% of the relatives of the patient have needed for professional support during the time they are in hospital. Following this, 41.2% of the patients stated that they did not receive any help from any professional in this process. Eighth hypothesis of our investigation was hence that 'is there a relation between need for professional support for the relatives and the depression scores?' When the hypothesis was tested, it was, in fact, found that there was a statistically significant relation between Professional support and depression scores ($p<0.05$). Our findings are in keeping with those of Noone et al [48], Link et al [28] Winterling et al [45], Andershed and Ternestedt [32], found that relatives tried to increase their understanding of the patient's situation by finding out how ill the patient was, how patient viewed his or her situation, and what assistance he or she needed. 'To know' was not only a part of the relatives' involvement, but also a prerequisite for involvement in the light. Relatives are dependent on others; particularly the patient and health care personnel, in obtaining knowledge about the situation, and thereby have the possibility of supporting the patient in a positive way.

Most patients experience social and psychological problems during the treatment process. However, the close proximity of receiving and receiving help may be interpreted as the lack of information about where the patient's relatives get help in the face of social and psychological problems that arise during the treatment process. The other results obtained from the study, 27.7% of the relatives of the patients had received help from doctors and social workers. Later on, 14.9% of the patients stated that they received help from the doctor, 10.9% received help from the nurses, and 2.7% received help from doctors-nurses and social workers. It can be said that the social inadequacy of the social workers and the lack of recognition of the profession due to the inadequacy of the medical staff caused the majority of the helpers from the doctors and nurses who have more frequent contacts with the patients and the social workers to receive the help.

Issues that relatives need professional help

"We are not the people who stayed here for three days. So we can experience spiritual and physical problems. In addition to these, some rules that very much force us to experience even more trouble. We have illnesses that require high morale. For this reason, sensitive and supportive shoulders will comfort us. We are patients' relatives and, we need support for you and we want it ".

- Financial problems
- Treatment and healing of the patient
- I have been depressed and depressed lately. I need help
- Doctors should not yell at us and our patients and behave more positively
- Accommodation
- My psychology is not good because I am always in hospital
- I experience intense feelings of fear and anxiety
- I feel uncomfortable with the attitudes of doctors and nurses in the hospital and I want this situation corrected
- A lot of bureaucracy
- I feel exhausted and exhausted. I need help
- I need psychological help
- I do not want the cancer statement and photos, brochures to be in the hospital and policlinic. My son does not know his illness, but he knows what cancer means."

The treatment of cancer is a long and tiring process. As patients in our country are usually covered by social security, they do not have to pay many expenses. However, as treatment takes a long time, relatives may experience financial difficulties in coming to the hospital and other problems. In our study, it has been postulated that the majority of relatives are faced with financial problems, influencing their psychological health adversely. As seen in (Table 2), a large majority of patient relatives (66.9%) reported financial problems. 33.1% of the patients' relatives were found not to have financial problems. Cancer disease treatment is expensive. Although all medical treatment cost are covered by the state in Turkey. They can often force family relatives and patient relatives who are accompanying the patient economically. Hence, the nineth hypothesis of the study was formulated as follows: 'There is a relation between the severity of financial problems experienced by relatives and depression scores'. When this hypothesis was tested, a statistically significant relation has not been found between depression scores and financial problems ($p>0.05$). Mean depression score of relatives who have financial difficulties was 38.18 while that of relatives without such problems was 39.05. The fact that patients focus on their illness and themselves may lead the relatives to assume all responsibility and hence to experience financial difficulty. This finding is in agreement with those of Francoeur [49], Milberg and Strang [38], Tsigaroppoulos et al [50].

Vulnerability was illustrated on a scale where burden was defined as vulnerability-increasing factors (care burden, restricted activities, fear, insecurity, loneliness, facing death and lack of support) and capacity as vulnerability-decreasing factors (continuing previous activities, hope, keeping control, satisfaction and good support). Relatives' emotional stress could increase if caregiving caused limitations in valued activities/interests, irrespective of care workload [42,37]. Cancer patients and their relatives mutually try to hide the various problems from each other in order that the other side does not feel sorry. This may lead to communication problems, which may have an adverse effect on the support and help they may give to each other. It is normal for cancer patients to feel sorrowful and mournful due to the illness and changes it causes in life. Yet, this should not be at such a degree that it will prevent the acceptance of the illness and adaptation to treatment. Payne et al., [35] reported that the majority of relatives experienced an above normal level of psychological distress. The fact that relatives are forced to stay away from their close acquaintances when they attend patients and have to spend time continuously with health care personnel and relatives of the other patients may bring about the emergence of some emotional problems.

57.7% of the patients stated that they had emotional problems while they were hospitalized. Following this, 42.3% of the patients' relatives did not show emotional problems during the care of the patients. A chronic disease such as cancer is a common belief that cancer is perceived as a lethal disease, long-term treatment, problems related to the health of the patient during treatment, the patient may experience emotional problems, and it may cause sadness, extreme irritability, stress, anxiety, depression, and so on which can be reflected in daily life with emotional situations. Hence, teenth hypothesis of the study was formulated as follows: 'There is a relation between the emotional problems experienced by relatives and depression scores'. When this hypothesis was tested, a statistically significant relation has been found between depression scores and financial problems ($p>0.05$). Mean depression score of relatives who have emotional problems was 38.79 while that of relatives without such problems was 38.03. Patients' relatives who express emotional problems indicate that the patient is experiencing extreme nervousness, insomnia, impatience, closure, weakness, anxiety, loss of appetite, sadness, vulnerability, shyness, constant crying, deterioration in social relations and hopelessness about the future. This result may be due to the fact that education level of the relatives was high and they had confidence in health care personnel about cancer and its treatment. Our result is compatible with those of Payne [35], Noone et al [48], Zakowkski [27]. This finding is in agreement with those of Hawkins [51], Işıkhan et al [39], Isikhan [20], and Tsigaroppoulos et al [50].

Half of the patients (51.4%) were found to be diagnosed with lung cancer. Following this result, it was found that 9.1% of the patients were acute myeloblastic leukemia patients and 7.6% of them were acute lymphoblastic leukemia patients and 7.3% of them were Non-Hodgkin's lymphoma patients (Table 2).

Cancer is still a great source of fear and it is an expected result that it gives rise to many psycho-social and economic problems. Therefore, it is evident that offering psycho-social support at a professional level in addition to medical treatment will yield more favorable results. Professional support should be offered to the patients and their relatives starting from the step of diagnostic procedures in order that the intensity of adverse emotions when they first learn the diagnosis is decreased and healthy coping mechanisms can be developed. The aim of the present study is to investigate the depression of patient relatives who are influenced from treatment process psychologically and in many other ways as much as the patient himself/herself and who try to give support to the care and treatment of the patient.

Our study showed that the mean depression score of relatives was found to be 38.47 (range 0-177). According to this result, relatives of the patients in the oncology clinic do not have high depression scores. It has been established that variables with an effect on depression scores are closeness of the relation (being parent), need for professional support being housewife and mean income between 767 USD and over ($p<0.05$).

It was also seen that 58.8% of the relatives of the patients' have needed for professional support were found to be of great importance. This should be of particular significance for poorly functioning families with a weaker sense of coherence and with a smaller social network, where the experience of security and trust conveyed by the care professional can be the factor that adds to and strengthens the family's resources. Our results also showed that identification of the family's situation and need for support could be easier if the professional's attitude was characterized by respect, openness and collaboration that could thereby inspire trust and security. If we do not care for these family members at this difficult time in their lives, they may well become patients later on. However, it can be said that the collective evidence is unequivocal; good patient care, communication, information and the attitude of the personnel are of decisive importance regarding satisfaction on the part of relatives.

Starting from the onset of the illness, in each important period or stage, relatives of the patient with cancer experience the fear, anxiety and anger related to that period. In our study, it has been observed that relatives try to keep away from the patient with the fear of contracting the disease in addition to other causes.

Relatives experience many contradictory feelings since they want to display a more optimist and cheerful attitude towards the patient although they are very sad meanwhile. Dealing with the care of the patient with cancer may lead the relatives to feel depressed, weaken their immune system and increase the probability of their becoming ill, rendering the family members in need of help themselves.

In brief, each crisis experienced by the cancer patient influences the family and relatives as well. Relatives are affected mostly at diagnosis stage, when a new treatment is instituted, during treatment process and recurrence of the illness and death. The experience of cancer may lead to socially disruptive effects on the patient's family as well as psychologically damaging ones. Therefore, primary function and duty of the social worker employed in oncology clinic should be helping patients and their relatives in coping with the problems they are faced with. Attempts to solve problems may be directed towards providing information about illness and its symptoms, meeting the needs of the relatives and sharing feelings as well as informing the patients and relatives on social resources and helping them to use these resources.

Psycho-social support groups may be planned for the relief of psychological and financial problems experienced by the relatives. Such a group study may contribute to the determination of issues especially relevant to relatives of patient and hence to finding solutions. Moreover, it will also contribute to development of the support of relatives to the patient via becoming more informed and their finding a new source of social support by cooperating with people who have problems in common with them [52,1].

In the professional support offered to relatives, particularly to first degree of relatives, relieving the feeling of loss of a close one and enhancing the positive aspects of the families should be emphasized. Thus, some emotional problems that may be experienced by relatives may be alleviated. Oncology social worker employed at the clinic should prepare an intervention plan in the attempt to solve the problems of relatives of the patients. They must help in the establishment of a healthy communication between relatives and the patient. Professional interventions should stress the potentially strong aspects of the family and the patient in the framework of the empowerment approach.

Oncology social workers have an important role in helping patients and their relatives deal with these kinds of problems. He/she tries to prevent the emergence of psychopathological situations such as anxiety and depression by strengthening the patients' relatives against psycho-social problems by providing economic support, providing patient and patient relatives with resources, counseling and providing psychological support. Thus, social workers facilitate effective participation of cancer patients and their relatives in the

treatment process.

Limitations of the Study

The present study attempted to analyze the place and importance of depressive states of cancer patients 'relatives in Turkey. Qualitative and quantitative studies should be planned to elucidate the activities of social workers in oncology settings, the problems they encounter in offering service, and problems in intrateam harmony. Further studies that will determine the problems experienced by patients and their families are required. Focus groups meetings and the qualitative studies in the oncology clinics are needed planning with the patient, patients' relatives and health personnel that will increase the empathic sensitivity and communicate with each other.

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Author's Disclosure of Potential Conflicts Of Interest

The author (s) indicated no potential conflicts of interest.

Ethical Approval

Permission was obtained from Hacettepe University Ethics Commission in order to be able to practice in the hospitals where the research was carried out.

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