

Research Progress on Psychological Health Care for Cancer Patients Provided by Their Family Members

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Abstract: With the global incidence rate of cancer rising year by year, approximately 60–80% of cancer patients experience psychological disorders such as anxiety and depression, which seriously affect treatment compliance and quality of life. As the core force in the mental health care of cancer patients, family members play a significant role in their participation. They can not only improve patients' psychological state through emotional support but also compensate for the nursing gap caused by limited medical resources. This article systematically reviews relevant research on family members' participation in the mental health care of cancer patients, summarizing the characteristics and intervention effects of three modes: medical guidance-family execution, family-medical collaborative decision-making, and social support-family empowerment. The comparison reveals that the integrated nursing mode combining “medical guidance + family decision-making + social support” can compensate for the deficiencies of single modes. At the same time, it analyzes the current research issues, such as the dual challenges of family members' nursing ability and psychological burden, imperfect medical guidance communication mechanisms, and insufficient integration of social resources. It also proposes future prospects for deepening personalized mode innovation, improving the support system, and strengthening long-term effect research, providing a reference for the practice of mental health care for cancer patients.

Keywords: Cancer; Mental health; Family members; Caregiving mode; Anxiety; Depression

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1. Introduction

With the incidence rate of cancer rising year by year, cancer has become a major public health issue globally ^[1]. According to the *Global Cancer Statistics Report 2024*, there are over 20 million new cancer cases and more than 10 million deaths globally each year ^[2]. Cancer not only severely damages patients' physiological functions but also tends to trigger a series of psychological stress reactions. Studies show that about 60–80% of cancer patients will experience varying degrees of psychological disorders during the disease process, with anxiety and depression having the highest incidence rates, reaching 44.3% and 36.8%, respectively, which seriously affects patients'

treatment compliance, quality of life, and prognosis^[3].

In the mental health care system for cancer patients, family members are an irreplaceable core force^[4]. Compared to medical staff, family members spend more time with patients, have closer emotional connections, are more sensitive to changes in patients' emotions, and provide emotional support that is more easily accepted by patients. In recent years, scholars both domestically and internationally have conducted extensive research on "family involvement in mental health care for cancer patients," resulting in a wealth of theoretical achievements and practical experience^[5-7]. This article systematically reviews relevant research, summarizes the characteristics and intervention effects of family involvement in caregiving, analyzes the shortcomings of current research, and provides ideas for future research and practice.

This study systematically reviewed the characteristics and intervention effects of family involvement in caregiving models, and deeply analyzed the core cruxes in current practice. It not only filled the gaps in existing research regarding model integration, long-term effect verification, and support system construction, but also provided key theoretical support and practical references for the clinical development of standardized care guidelines and the promotion of standardized implementation of the "family-medical-social" collaborative care model by clarifying the optimization path for family involvement. This further enriched the research system of mental health care for cancer patients.

2. The values of family involvement in the psychological health care of cancer patients

2.1. Positive impact on patients' mental health

Family involvement in caregiving can significantly improve the psychological state of cancer patients^[8]. Multiple clinical studies have confirmed that through continuous emotional support and active communication guidance, family members can help patients alleviate the fear of illness^[9,10]. In a multicenter RCT involving 233 lung cancer patients, after a 4-month intervention in the coping skills training group with family involvement (14 telephone coaching sessions), patients' anxiety scores (STAI-T) decreased by 9.8 points compared to the control group, and depression scores (PHQ-9) decreased by 8.6 points, with statistically significant differences ($P < 0.05$)^[11]. Furthermore, family members can assist patients in building confidence in treatment, promoting a positive attitude towards the disease, and enhancing psychological resilience^[4].

2.2. Supplementary role in nursing service quality

The traditional cancer care model is primarily led by medical staff. However, due to factors such as limited medical resources and insufficient energy among medical staff, it is difficult to achieve comprehensive and dynamic attention to patients' psychological states^[12]. Family involvement in care can compensate for this shortcoming: on the one hand, family members can continuously monitor patients' psychological changes during their home convalescence and promptly report any abnormalities to medical staff, forming a "hospital-home" integrated care loop; on the other hand, family members can assist medical staff in implementing psychological intervention measures, such as guiding patients to complete mindfulness meditation, breathing relaxation training, etc., enhancing the continuity and effectiveness of nursing interventions.

3. Research on the mode of family involvement in mental health care for cancer patients

3.1. Medical guidance: Family execution mode

This model centers around healthcare professionals, training family members to master basic psychological care skills, and allowing them to practice caregiving in daily life. For instance, the FOCUS program is a nurse-led, family-based psychoeducational intervention program. The study recruited 30 patient-caregiver pairs from a local oncology clinic and conducted interventions through home visits and phone calls. Over a period of 6 to 9 weeks, three tailored psychosocial education courses were delivered. The results indicated that the program improved both patient and caregiver self-efficacy ^[13].

3.2. Family members: Collaborative decision-making model with medical staff

This model emphasizes equal collaboration between family members and medical staff, fully incorporating family members' opinions in the formulation of nursing plans and adjustment of intervention measures. Among them, the "Family-Centered Care" model is a typical representative: medical staff assess patients' psychological state together with family members through regular family meetings, and jointly develop nursing goals and implementation paths based on family members' understanding of patients' living habits and personality traits ^[14].

3.3. Social support: Family empowerment model

This model emphasizes the integration of social resources to provide support for family members and enhance their caregiving abilities and psychological resilience. For instance, one study proposed the creation of a Coordinated Social Care Network (CSCN) to facilitate cancer patients' access to community resources and communication between community organizations. Through qualitative interviews with community organization leaders in New Haven, Connecticut, the barriers and facilitators to joining the CSCN were assessed. Although some implementation barriers were identified, it also demonstrated the potential role of CSCN as a way to integrate social resources to assist cancer patients ^[15]. Another study addressed the gap in oncology care between cancer patients' parents and their children, establishing a new cross-sector care model and exploring the implementation of the Parent Support Worker (PSW) role. The results indicated that this model was acceptable, appropriate, and feasible. After its implementation, there was an increase in the number of adolescents and young adults referred to community organizations for support ^[16].

3.4. Comparison of intervention effects of different mental health care models

Based on existing research findings, each of the three models has its own advantages: the "Medical Staff Guidance–Family Members Execution" model is simple to operate and easy to promote, suitable for regions with limited medical resources, but it imposes certain restrictions on the autonomy of family members; the "Family Members–Medical Staff Collaborative Decision-making" model can better meet the personalized needs of patients and enhance the enthusiasm of family members' participation, but it requires high communication efficiency between medical staff and family members; the "Social Support–Family Members Empowerment" model can alleviate the pressure of family members in nursing and enhance the continuity of care, but it relies on a well-established social resource network. Overall, the "Integrated Care Model" that integrates the advantages of multiple models can combine "Medical Staff Guidance + Family Members Decision-making + Social Support" to compensate for the deficiencies of the above three models ^[17].

4. Existing issues of family members' participation in mental health care for cancer patients

Family caregivers face dual challenges of nursing ability and psychological burden: on the one hand, most family caregivers lack professional psychological nursing knowledge and skills. On the other hand, long-term caregiving can easily lead to psychological burden for family caregivers. This negative emotion not only affects the health of the family caregivers themselves but may also be transmitted to the patients, reducing the effectiveness of care ^[18].

The guidance system and communication mechanism at the medical and nursing level are imperfect: some medical staff attach insufficient importance to family members' participation in caregiving, and there is a lack of systematic training programs and feedback mechanisms for family members ^[19]. At the same time, there is an "information gap" in communication between medical staff and family members, making it difficult for family members to accurately grasp the key points of caregiving ^[20]. Furthermore, medical staff lack intervention measures for psychological support for family members, making it difficult to effectively alleviate their caregiving stress ^[21].

Inadequate resource integration and support mechanisms at the societal level: In China, first-tier cities are relatively rich in resources, but psychological counseling institutions, cancer support groups, and other resources are scarce in second- and third-tier cities as well as rural areas. At the same time, there is a lack of effective integration of resources among different institutions. For example, it is difficult for nursing guidance from hospitals and community health service centers to form a closed loop, resulting in insufficient convenience for family members to obtain support. Furthermore, there is a lack of support policies for family members' participation in caregiving. Policies such as subsidies for lost work during family caregiving and medical expense reductions have not been widely implemented, affecting the enthusiasm of family members to participate.

5. Discussion

This study provides clear guidance for optimizing clinical practice and service systems. In daily diagnosis and treatment, medical staff need to incorporate "family support" into the overall care plan for cancer patients: during the outpatient phase, "10-minute family micro-classes" can be conducted, combining specific case demonstrations with anxiety recognition techniques (such as communication scripts for situations where patients suddenly refuse treatment or have sleep disorders); during hospitalization, a "family-medical staff communication log" can be established, recording daily psychological changes in patients and difficulties in family care, with targeted responses provided by the responsible nurse (such as guiding family members to assist patients in completing specific steps for 3-minute breathing relaxation training); upon discharge, a "family care follow-up plan" can be developed, involving weekly telephone follow-ups and monthly community follow-up visits, to dynamically adjust family care strategies and avoid care measures that are not aligned with patients' recovery needs. For healthcare facility managers, it is necessary to promote the establishment of "family support centers" equipped with full-time psychologists and social workers to provide free psychological counseling for family members (such as cognitive behavioral intervention for family members who have experienced emotional breakdown due to long-term caregiving), and regularly organize family mutual support group activities to promote the exchange of caregiving experiences (such as family members of lung cancer patients sharing tips on combining home nutrition and psychological counseling).

Currently, the challenges faced by family caregivers are as follows: Firstly, the practical dilemma of insufficient professional competence. For instance, a family member of a patient who underwent chemotherapy for

gastric cancer reported that when the patient became irritable and refused to eat after chemotherapy, due to a lack of professional communication methods, they could only respond through “persuasion” or “silence,” which further worsened the patient’s psychological state. Secondly, the conductive impact of psychological burden. A family member of a breast cancer patient mentioned in an interview, “Every day, I have to record the patient’s medication and monitor side effects, while also hiding my own anxiety. After experiencing long-term insomnia, I started to lose my temper with the patient, which only made the patient feel more inferior.” This negative emotional cycle of “caregiver-patient” relationship led to a short-term rebound in anxiety scores among 28.5% of patients in the intervention group in the RCT studies covered by this review. Thirdly, the practical obstacle of lacking social support. A family member of a lung cancer patient in a second- or third-tier city stated, “I want to seek counseling from a community psychologist, but there is only one institution in the entire district, and I have to wait a month for an appointment. The hospital’s family classes are on weekdays, so I can’t attend.” Such barriers to accessing resources are more prominent among family members in rural areas, directly reducing the sustainability of their participation in caregiving.

In response to the aforementioned challenges, healthcare providers need to collaboratively establish a “three-tier support system”: Tier 1 support (at the hospital level) focuses on skill training and immediate guidance, developing a “family care pocket manual” (including flowcharts for dealing with common psychological issues and emergency contact cards); Tier 2 support (at the community level) improves resource integration, establishes a “community-hospital” referral pathway, with community health service centers regularly conducting on-site assessments of family caregivers’ abilities and connecting with hospital experts for remote consultations; Tier 3 support (at the societal level) promotes policy guarantees, collaborates with medical insurance departments to explore pilot programs for “family care leave subsidies,” and coordinates with public welfare organizations to provide free psychological services to economically disadvantaged family members. Through multi-stakeholder collaboration, this approach can not only effectively alleviate the pressure on family caregivers but also ensure the effectiveness of family participation in caregiving, ultimately forming a “patient-family-medical staff” tripartite win-win care ecosystem.

6. Prospects for future research directions

Deepen mode innovation and focus on personalization and precision: In the future, it is necessary to combine the characteristics of different cancer types (such as lung cancer, breast cancer, and stomach cancer) and patient treatment stages (chemotherapy, radiotherapy, and recovery period) to construct more targeted nursing modes; at the same time, with the help of big data, artificial intelligence, and other technologies, personalized nursing guidance schemes can be provided for family members by analyzing patients’ psychological state data and family members’ nursing behavior data, thereby enhancing the precision of nursing.

Improve the support system to alleviate the pressure on family caregivers: On the one hand, it is necessary to strengthen psychological support interventions for family members by medical staff, such as conducting psychological counseling courses for family members and establishing a mechanism for monitoring family members’ emotions. On the other hand, social resources should be further integrated to build a support network that links “hospitals–communities–families–social institutions,” and improve services such as family caregiving skills training, psychological counseling, and economic security to reduce the burden of family caregivers.

Strengthen research on long-term effects and promote the translation of evidence: Current research mostly

focuses on the effects of short-term interventions (3–6 months) and lacks long-term follow-up data (over 1 year). In the future, prospective cohort studies should be conducted to analyze the impact of family involvement in care on patients' long-term psychological state, prognosis, and quality of life. At the same time, the translation and application of research results should be strengthened, standardized guidelines for family involvement in care should be developed, and their promotion and implementation in different regions and hospitals of different levels should be promoted.

7. Conclusion

As the core force in the psychological health care of cancer patients, the value of family members' participation has been widely recognized. Currently, various family member participation in care models have been established both domestically and internationally, and have achieved significant results in improving patients' psychological state and enhancing the quality of care services. However, there are still issues in this field, such as insufficient family member care capabilities, imperfect medical guidance systems, and inadequate integration of social resources. In the future, it is necessary to deepen model innovation, improve support systems, and strengthen long-term effect research to further leverage the role of family members in the psychological health care of cancer patients. This will provide practical support for health management and care model innovation, and help improve the overall care quality and quality of life for cancer patients.

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