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Is perceived family support a relevant variable in psychological distress? A sample of prostate and breast cancer couples

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Abstract

Objective: In this cross-sectional pilot study of couples in whom the man was diagnosed with prostate cancer or the woman with breast cancer, the purpose was to identify and compare the variables that characterize couples where both spouses are in high psychological distress with couples where the psychological distress of both spouses is within the normal range. **Methods:** Psychological distress and perception of family support in 574 individuals (118 consecutive prostate cancer patients and their spouses, and 169 randomly selected breast cancer patients and their spouses) were assessed using the Brief Symptom Inventory (BSI) and the Perceived Family Support (PFS) self-report questionnaires. **Results:** Couples experiencing high psychological distress reported lower levels of perceived family support than couples in whom both spouses reported normal levels of psychological distress. **Conclusion:** The findings support the notion that perceived family support is associated with the psychological distress in both patients and spouses.

Keywords: Breast/prostate cancer; Gender; Psychological distress; Spouses and family support

Introduction

Cancer affects not only the patient but also every family member. The data available on psychological factors affecting levels of spouse distress are contradictory, inconclusive, and highly controversial [1,2]. Nonetheless, it is generally accepted that a diagnosis of cancer is a highly distressing event, and between 20% and 30% of cancer patients remain in a distressed state long after the initial diagnosis. State at diagnosis, physical discomfort, and absence of social support show better correlation with psychological distress than with cancer site, though more data on this aspect are available for breast cancer patients and their spouses than for prostate cancer patients and their spouses [3–5].

A recent study showed that female partners have a more accurate understanding of their husbands' experience with prostate cancer than male partners do with their wives' breast cancer experience [6]. In the few studies comparing the psychological distress of prostate cancer patients and their wives, the wives were found to be more concerned about the illness situation than their husbands [7–9].

Studies of patients with a variety of chronic physical disorders have shown that psychological distress and emotional difficulties may be created or exacerbated in a healthy spouse by the partner's dysfunction. The burdens facing healthy spouses include providing care and support for the sick partner, financial difficulties, changes in the normal routine at home, disruption in social and recreational life resulting from the partner's disability, coping with their own and their spouse's emotional distress, and the uncertainty associated with the illness. Each of these stresses may place the healthy spouse at risk of greater psychological distress and physical disorders [10–12]. Furthermore, differences between men's and women's caregiving and patterns of care are often attributed to gender role norms, where care is viewed as an extension of the woman's role, whereas for men it often signifies a new and unfamiliar role [13].

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Married men are most likely to identify a spouse as the person who tries to care for and control their health. Marriage benefits the health of men more than of women, in part because marriage usually provides greater social structure and support for men. It remains to be explained, however, why health-related social support, especially among spouses, is more beneficial for men than for women. Gender-related and marital-status-related differences in health behavior may be closely linked to gender and marital role expectations, especially when the recipient of care and the care provider are clearly defined [14,15]. It is worth pointing out in this connection that, especially for men, the implicit assumption of having a spouse is an indicator of caregiver support and availability [16].

The primary objective of the present pilot study was to identify the variables that characterize couples in whom one of the partners is a cancer patient (the male diagnosed with prostate cancer or the female with breast cancer) and both spouses are experiencing high psychological distress as compared to couples where one of the partners is also a cancer patient and the psychological distress of both spouses is within the normal range. Our assumption is that low perceived family support is a discriminant factor characterizing couples with high levels of psychological distress. Couples reporting high levels of psychological distress reported lower levels of perceived family support than did couples whose psychological distress was within the normal range.

Method

Population

The sample population comprised 574 individuals, 118 of them male cancer patients with their spouses and 169 female cancer patients with their spouses.

The male patients were consecutive cases at Hadassah University Hospital who had been diagnosed with prostate cancer during the years 1995–1998, had received treatment at its Outpatient Department of the Institute of Oncology and Radiotherapy, were free of metastases at the time of the interview, and met the inclusion criteria of this pilot study. Of 153 male patients who fulfilled the criteria for participation (see below), only 118 patients and their spouses (77% of the total sample) agreed to be interviewed. All of the participating male patients had been initially diagnosed 6 months to 4 years earlier with the specific illness of prostatic adenocarcinoma. In most patients the disease was within the medical category of moderate-differentiated adenocarcinoma (T_1a or T_1b) to poor histological differentiation (T_2a or T_2b), and the primary treatment had been local radiation therapy. None of the male patients in the sample had shown evidence of distant metastases or had received hormonal therapy, and all were in remission (NED = no evidence of active disease) at the time of the study.

The female patients were a simple random sample of breast cancer patients at Hadassah University Hospital who were diagnosed during the years 1996–1998, had received treatment at its Outpatient Department of the Institute of Oncology and Radiotherapy, were free of metastases at the time of the interview, and met the inclusion criteria of the study. Of the 211 female patients included in the random sample out of a total of 364 eligible cases, only 169 patients and their spouses (80% of the total sample) agreed to be interviewed. All had been initially diagnosed 6 months to 4 years earlier with breast cancer stage I, II or III, showed no evidence of disseminate and/or active disease at the time of the study, and were receiving no cancer therapy other than tamoxifen.

The response rate of male patients (118/153 = 77%) did not differ significantly from the response rate of the female patients (169/211 = 80%).

No significant differences in age, marital status, education, time of diagnosis and stage of the illness, or scores on the Karnofsky Performance Scale [17] were found between the 35 male patients (23% of the total male patients) or the 42 female patients (20% of the total female patients) who refused to be interviewed and the patients who agreed to participate in the study. The most common reasons given for refusal were that the healthy spouse (especially the partners of the female patients) did not want to be interviewed or that the male patient felt he was healthy and wanted to forget about the past illness.

Inclusion criteria

After receiving approval for the pilot study from the Ethical Review Board of Hadassah University Hospital and the Israel Ministry of Health, we identified and selected the patients by scanning the medical records. To be included in the study, patients had to have received medical care for either prostatic adenocarcinoma or breast cancer at the Institute of Oncology and Radiotherapy of Hadassah University Hospital, and to be without prior diagnosis of other cancers and—to control for comorbidity—any other current or previous chronic or acute psychiatric conditions. Both male and female patients had to have been married or living with a stable partner for more than 15 years, and both patient and partner had to give their signed consent to participate in the study. Other requirements were permanent domicile in Israel for at least 20 years (to control for immigration and acculturation), residence in the Jerusalem area, age between 35 and 85, and ability to complete questionnaires independently.

An experienced research coordinator contacted each couple to explain the purpose of the pilot study. Once both partners had agreed to participate, a clinical psychologist scheduled a home visit to obtain a signed informed consent, conduct a semistructured interview, and administer two self-report questionnaires individually to each partner. No interviews were conducted before at least 6 months after a patient's medical treatment had ended.