

## Health services for cancer survivors

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### ABSTRACT

Despite having a higher risk of poor mental health outcomes, spouses of cancer survivors are known to underuse supportive services. The goal of the current study was to ascertain the relationship between cancer survivor's health and use of healthcare and their spouses' use of healthcare for sadness and anxiety. The Medical Expenditure Panel Survey data were utilized in the current observational analysis to identify married people who had had a

cancer-related illness or disability (referred to as "cancer survivors") and to link health and health care use data across spouse dyads. The use of mental health services was indicated in spouses who reported receiving a prescription for an antidepressant, antianxiety drug, or for any type of psychotherapy. With an emphasis on the health and medical needs of the cancer survivor, use correlates were evaluated.

**Key Words:** *Mental health; Caregivers; Sociodemographic; Benzodiazepines; Analgesic*

### INTRODUCTION

The The Medical Expenditure Panel Survey data were utilized in the current observational analysis to identify married people who had had a cancer-related illness or disability (referred to as "cancer survivors and to link health and health care use data across spouse dyads. The use of mental health services was indicated in spouses who reported receiving a prescription for an antidepressant, antianxiety drug, or for any type of psychotherapy. With an emphasis on the health and medical needs of the cancer survivor, use correlates were evaluated. Over the course of the roughly 2.5 years of follow-up, more than 25% of the partners of cancer survivors sought out mental health services. If the cancer survivor reported greater health conditions, spouses were shown to be less likely to receive mental health care, even after controlling for their own predisposing, enabling, and need features. The results of the current study contribute to our understanding of the connections between health outcomes in cancer families and emphasize the value of a family-centered approach to cancer care that supports psychosocial care. Cancer survivors' and their spouses' health and wellbeing are interwoven. The recent study's findings showed that this correlation also applies to mental health services for depression and anxiety.

The likelihood that spouses of cancer patients will seek mental health treatment was found to be lower when Compared to dyads where the survivor reported low distress and depression, higher depressive mood was seen. When a cancer survivor had significant medical demands, their spouses were nearly three times more likely to need

mental health services. If the survivor was also receiving mental health treatment, spouses were almost three times more likely to obtain care. Finding the time, money, or energy to take care of their own well-being may be more difficult for spouses who are providing care. Giving supportive care to one partner, though, might make it easier for the other to get medical attention. The entire family is affected by cancer. Supporting cancer patients is very important for spouses and partners. When spouses are present, they frequently act as the primary caregiver, providing the majority of the emotional, monetary, and/or practical support required by cancer survivors. Like other caregivers, spouses of cancer survivors experience emotional distress and run the risk of negative mental and emotional outcomes. Around 70% of men and 50% of women with cancer are married<sup>1</sup>. The prevalence of anxiety and sadness in spouses can be as high as or higher than the rates among cancer survivors themselves. Even among cancer caregivers with heightened distress, only a minority seek mental health care.<sup>5-10</sup> Spouses of cancer survivors are less likely to seek mental health care than other family members. Our ability to identify caregivers at risk of under treatment, comprehend the mechanisms causing such health care usage, and identify places of intervention will be aided by a better understanding of the correlates of mental health care use (hereinafter referred to as mental health care). The Andersen behavioral model has been expanded upon in the current study to better understand the correlates of mental health care usage. Need characteristics are those that allow for the recognition of the need for treatment, including the presence of

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health conditions, while predisposing characteristics are those that affect the likelihood that a person will seek and receive health care, such as sociodemographic characteristics (e.g., gender). Enabling characteristics are those that facilitate (or hinder) the use of health services, such as insurance coverage.

This concept was expanded to include the idea that the features of the cancer survivor, specifically the survivor's health, functional well-being, and service utilization, also affect the caregiver's involvement in mental health treatment. Care while also impeding caregivers' ability to participate in mental health treatment or affecting the methods in which they provide care. With a focus on the influence of survivor health and health service usage, the current study's objective was to evaluate the correlates of mental health care use among wives of cancer survivors. We predicted that cancer survivors would have lower rates of mental health care usage among their spouses due to weaker health and more use of health services. The findings have significance for providing supportive care to cancer survivors and their families because they will help us understand why some caregivers seek mental health treatment for depression, anxiety, or emotional distress while others do not. The Medical Expenditure Panel Survey (MEPS), an annual household-based survey of the US population, served as the source of the data. Over a 2.5-year period, participants are observed for 5 cycles. The current study linked information from seven MEPS data sets, including the household component, which contains information on demographic and health characteristics, the prescription file, which contains specific information about the medications participants used, the office-based, inpatient, outpatient, and emergency visit files, which contain specific information about participants' medical visits, and the medical conditions files, which compile medical conditions reported by MEPS participants and are coded as truncate. Data from MEPS panels 9 through 21 were combined (2004-2017). In order to find spouses of cancer survivors, we first looked for MEPS members who had cancer in their medical conditions file (excluding nonmelanoma skin cancer and in situ lesions). Then, spousal and household identification numbers were used to link data for married couples. Dyads were disregarded if either spouse's status changed during the MEPS (40 dyads), both participants disclosed having cancer (218 dyads), or if information was proxy provided during any household interview (15 dyads). Then, 312 participants who had missing data were eliminated; the majority of these people had not finished the self-administered questionnaire. Race and/or ethnicity differences between participants who were omitted due to missing data (78% White non-Hispanic in the excluded sample versus 85% in the final sample. The number of health conditions (mean of 2.0 vs 2.2;  $P = .05$ ), employment (56% vs 48% employed;  $P = .04$ ), income (29% vs 19% in the lowest income category;  $P = .01$ ), and self-rated mental and physical health (52% vs 40% reporting fair and/or poor physical health and 40% vs 29% reporting fair and/or poor mental health;  $P = .01$ ) were also significant. The usage of mental health services by the groups was the same. The total number of cases in the final sample was 1882, all of them spouses of cancer survivors. The number of health conditions, self-rated physical and mental health, annualised health care use, and psychological well-being were all considered need criteria. If they had ever had a diagnosis for high blood pressure, coronary heart disease, angina, a heart attack, another type of heart disease, stroke, emphysema, high cholesterol, diabetes,

arthritis, or asthma, subjects were asked. Over all time points, the total number of health problems was calculated (range, 0-11 health conditions). The perception of one's own physical and mental health condition, coded as excellent or very good vs good, fair, or bad, was used to determine one's level of health. In the previous 12 months, subjects stated how many times they had visited a doctor's office for care; 4 or more visits were classified as high health service use. Data on psychological discomfort and a higher than average depressive mood were incorporated in psychological well-being. The Kessler Psychological Suffering Scale was used to assess psychological distress (K6). The six items were scored on a 5-point Likert scale, then the results were added. Scores between 0 and 5 denoted mild to severe distress. Using the 2-item Patient Health Questionnaire, depression was assessed. The responses were scored using a 4-point Likert scale, then added. A high (clinically significant) depressed mood was indicated by a score of three. These scores were combined since there was overlap in the distribution, allowing us to determine whether people had raised depressive mood, low depressive mood with elevated distress, or low depressive mood with low distress. The medical conditions files were reviewed for depression, anxiety, and acute stress diagnosis information.

The number of health issues, self-rated physical and mental health, and restrictions in fundamental activities were among the features of survivors. The number of health conditions, self-rated physical and mental health, limitations in fundamental daily activities (ADLs) or instrumental ADLs, psychological well-being, use of health services, and any use of mental health care, all of which were evaluated as previously mentioned, were considered to be characteristics of survivors. The medical event files classified cancer treatment status as having undergone chemotherapy, radiation, or surgery for cancer or having a prescription for an antineoplastic drug (Cerner Multum MediSource Lexicon class code 20). Calculated were the percentages of spouses of cancer patients who reported receiving any form of mental health treatment. The sample characteristics were evaluated using descriptive statistics (frequency distributions, means), and chi-square or 2-sided Student *t* tests were used to compare those getting mental health care with those who did not. There was no evidence of covariate multicollinearity. Two outcomes were studied using logistic regressions: the usage of mental health services (any vs. none) and the type of treatment (any psychotherapy vs prescription only). In a series of regressions, each outcome was regressed onto sets of the covariates (divided into predisposing, enabling, need, and survivor characteristics), and then the whole model with all of the variables taken into account at once was run. All regressions included a cohort indicator as a panel control (panels 9-14). Panel was taken into account in every regression as a cohort indicator (panels 9-14 or panels 15-21). To make it easier to evaluate the relative predictability of each group of covariates, a generalised coefficient of determination with an adjusted coefficient of determination (pseudo-R<sup>2</sup>) was produced for each model. Sensitivity studies looked at whether the main findings varied among spouses of people with ADL impairments or the entire sample of married MEPS respondents. A second sensitivity study examined the relationship between the prevalence of survivor health issues and their own use of mental health services. The complicated sample frame of the MEPS was taken into account for all analyses using survey weighting, which was carried out using SAS statistical software.

### CONCLUSION

The current study evaluated the factors associated with cancer survivors' spouses' usage of mental health services. The cancer survivor's health conditions, mental health status, and use of health services were discovered to be connected with their partner's use of mental health care, in addition to predisposing, enabling, and need features. To the best of our knowledge, this study is one of the first to show a connection between rates of spousal mental health care use and survivor health and health care use.