

Predicting Family Caregiver Psychosocial Functioning in Palliative Care

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Abstract / Background: Health professionals are expected to support family caregivers of patients requiring palliative care. However, there is a dearth of empirical evidence to help clinicians identify caregivers who might be at risk of poor psychosocial functioning. **Purpose:** This secondary analysis of baseline data from a larger study sought to determine if it was possible to predict the psychosocial functioning of family caregivers who were supporting a relative with advanced incurable cancer. **Method:** Data from 35 primary family caregivers obtained at the start of home-based palliative care services and five weeks later was used in the analysis. Instruments to measure caregiver preparedness, competence, mastery, social support, anxiety, and self-efficacy were used. **Results:** Cluster and logistic analyses revealed that self-reported "anxiety" and "competence" subscale total scores at time of commencement of home-based palliative care services were associated with caregivers at risk of lower levels of psychosocial functioning five weeks later. **Conclusions:** This study suggests that it may be possible to identify family caregivers who are at risk for poorer psychosocial functioning. However, replication in a larger sample is required before this screening approach can be recommended for clinical use.

Résumé / Les professionnels de la santé se doivent de soutenir les soignants familiaux qui s'occupent d'un patient nécessitant des soins palliatifs. Cependant, il y a peu de preuves empiriques pouvant aider les cliniciens à identifier ceux parmi ces soignants qui sont à risque d'éprouver des problèmes d'ordre psychologique. **Objectif :** Cette analyse de nature secondaire des résultats d'une étude plus étendue visait à déterminer si l'on pouvait prédire les réactions psychologiques des soignants familiaux devant s'occuper d'un des leurs atteint de cancer avancé. **Méthode :** Les données recueillies auprès de 35 soignants au début des soins palliatifs dispensés à domicile et cinq semaines plus tard ont été à la base de cette analyse. Ainsi on a utilisé des instruments de mesure afin de déterminer l'état de préparation, la compétence et la confiance en soi des soignants dans une telle situation de même que leur niveau d'anxiété, leur efficacité et le support social dont ils jouissaient. **Résultats :** Les analyses logistiques et typologiques ont révélé que les soignants dont les résultats dénotaient un niveau de compétence et d'anxiété plus faibles étaient

ceux qui cinq semaines plus tard étaient à risque de démontrer des problèmes de nature psychologique. **Conclusions :** Cette étude semble indiquer qu'il pourrait être possible d'identifier les soignants à risque d'éprouver des problèmes psychologiques. Cependant, il faudrait faire une étude sur une plus vaste échelle avant que l'on puisse adopter cette approche de dépistage auprès des soignants familiaux.

INTRODUCTION

The fundamental aim of palliative care is to achieve the best quality of life possible for dying patients and for their families (1,2). Assisting the family is a key aspect of palliative care philosophy (3), with patient and family construed as the "unit of care" (4). The family commonly play a central role in home-based palliative care, undertaking tasks such as symptom assessment and management, personal care, and administering medications (5). In so doing, they provide most of the support needed (6-10). Without this contribution, the well-being of most patients in palliative care, and possibly their capacity to stay at home, would be compromised (11). Yet family caregivers commonly report negative psychosocial outcomes (12).

Given the potentially burdensome effects of supporting a relative with advanced disease, we sought to determine whether it would be possible to predict which caregivers might be prone to poor psychosocial functioning.

LITERATURE REVIEW

The physical, emotional, financial, and social effects of caregiving on family members is considerable, with sequelae such as fatigue, insomnia, weight loss, burn-out, and general deterioration in health (5,13-15). Psychological consequences include depression, diminished self-esteem, isolation, and anxiety (16). Social burdens result in restrictions on time and leisure opportunities,

disturbance of routines, and loss of income (13). It is apparent, however, that the principle of family and patient as equals in care provision may not always be upheld and that caregivers do not always receive formal acknowledgment of the centrality of their role from health professionals (11). Research has found that caregivers of advanced cancer patients report a variety of unmet needs, despite input from health care services (13,17–19); it is not yet clear how best to meet these needs (20). In addition, there has been a lack of consensus regarding appropriate instruments for measuring caregiver needs (21), and minimal exploration of these needs over time (22,23). Furthermore, the relationship between physical, psychosocial, and demographic variables and caregiver functioning is under-explored, as are the ways in which positive caregiving experiences might protect against negative psychosocial outcomes (24). Variables such as preparedness, competence, anxiety, mastery, and self-efficacy may be very important in helping caregivers mediate the potential psychosocial burdens of the role of supporting a relative with advanced disease (24).

There is also limited information on how best to support family caregivers (5,20,23), although the specific challenges for health professionals as they attempt to help caregivers have been explicated (25). Systematic study of the role of interventions in addressing caregiver needs is rare (22,26,27). Group interventions have been tried, although individually focused strategies may be more effective to enhance well-being (24,28,29). Intervention studies are proposed to minimize burden and to meet needs (13,22).

Screening methods to identify family caregivers most at risk are required, in order for interventions to be targeted (30,31). While there have been several studies that have explored factors that may be predictive of risk of adverse psychological outcome following bereavement (30–33), few studies have explored factors that may predict psychosocial functioning in family caregivers of patients with advanced cancer at the start of and during the caregiving phase. Higginson and Priest (34) recognized the importance of gathering prospective pre-bereavement caregiver data, and found that family caregivers of younger patients with a recent diagnosis and a relatively short period of receiving palliative care were more likely to have severe anxiety in the weeks preceding the patient's death. A limitation of this study was that ratings were undertaken by health professionals and were not based on family caregivers' own assessment of their anxiety. The authors recommended that

future studies should incorporate more detailed psychological self-report measures.

In summary, family caregivers may be prone to detrimental psychosocial effects and may experience unmet psychosocial needs. Empirically-tested supportive interventions to help caregivers are yet to be developed. At present, there is no method available to identify those family caregivers in greatest need of help over time. Thus, a robust approach for screening family caregivers for psychosocial outcomes is warranted. The current investigation sought to explore whether it is possible to predict family caregiver psychosocial functioning upon admission to home-based palliative care.

METHOD

Sample

The data used for this study constitute a secondary analysis of a larger study involving participants (from Melbourne, Australia) recruited to a randomized controlled trial (RCT) that tested the effectiveness of a psycho-educational intervention for family caregivers of patients receiving home-based palliative care for advanced incurable cancer (35). In total, 106 participants were recruited to the larger study: 52 received standard home-based palliative care services (standard care group) and 54 received these services plus the new intervention (intervention group). Data for the RCT were collected at three time points: within two weeks of commencement of home-based palliative care (Time 1), five weeks later (Time 2), and eight weeks following the patient's death (Time 3). Ethics committee approval was obtained from the University of Melbourne and the participating clinical services.

The aim of the current secondary analyses was to determine whether it was possible to predict which caregivers are in greatest need of supportive interventions over time, based on their profile at entry to palliative care. It was not appropriate to use data obtained from the intervention group for this purpose, because they had already participated in a psycho-educational intervention. Only Time 1 and Time 2 data ($n=35$) were used in the current analyses because insufficient numbers of standard care participants completed assessments at all three data collection points ($n=15$). Participants assessed at Time 1 only did not differ significantly ($p>0.05$) from participants assessed at both Times 1 and 2 on any of the variables used as predictors of psychosocial functioning.

For the current sample of 35 caregivers, two thirds were female (66%; $n=23$). The mean age

of these caregivers was 60.23 years ($SD=12.50$, range: 27–84 years). Almost two-thirds were caring for a spouse, partner, or de facto (62%; $n=21$). The remaining caregivers were caring for a child ($n=7$), friend ($n=3$), parent ($n=1$), sibling ($n=1$) or "other" nonspecified relationship ($n=21$). Over half (57%; $n=20$) the patients were female. The mean age of patients was 66.97 years ($SD=14.92$, range: 34–88 years). The mean performance status (ECOG rating (36)) for patients was 2.71 ($SD=0.86$). As shown in Table 1, few patients were completely physically dependent.

Materials

Participants' responses to six instruments from the suite of nine used in the RCT were used to derive all scale and subscale scores for the current analysis. The composition of all scales and subscales, except the anxiety and depression scales from the Hospital Anxiety and Depression Scale (37), was determined by a principal components analysis of items comprising each instrument. A more detailed account of the scales and these analyses is published elsewhere (38), as is a report of the conceptual framework explaining family caregivers' psychosocial responses and related research variables (24).

The internal consistency reliability of items comprising empirically-derived scales and subscales was estimated using Cronbach's alpha coefficient. Cronbach's alpha coefficients were calculated using responses from the full RCT sample ($n=106$). These are provided below.

Archbold and Stewart's Preparedness for Caregiving Scale was used to assess the preparedness of caregivers participating in this (39,40) study. This scale consists of eight items structured as a five-point Likert-type scale, with response options indexing degree of preparedness ranging from not at all prepared (0) to very well prepared (4). The internal consistency reliability estimate for the scale as measured by Cronbach's alpha was 0.93.

The Caregiver Competence Scale was used to assess caregivers' perceived adequacy of performance as caregivers (41). This scale comprises four items that are responded to on a four-point Likert scale; degrees of competence range from not at all (0) to very much (3). Internal consistency estimate as measured by Cronbach's alpha coefficient for the competence scale was 0.86.

An abbreviated version of Saranson et al.'s (42) Social Support Questionnaire (SSQ) was used to assess caregivers' perceived levels of support from friends or family. First, where applicable, participants identify an individual who provides support in a specified domain using

Table 1 / PATIENT'S PERFORMANCE STATUS OR ECOG RATING (n=35)

Rating	Frequency	Percentage
Restricted in physically strenuous activity but ambulatory	3	8.6
Ambulatory, capable of self-care, up and about more than 50%	10	28.6
Limited self-care, confined to bed or chair more than 50%	16	45.7
Completely disabled, total confined to bed or chair	6	17.1

a yes/no response format. Next, they indicate their level of satisfaction with the support provided using a six-point Likert-type scale. Levels of satisfaction range from very dissatisfied (1) to very satisfied (6). Cronbach's alpha coefficient for the social support scale was 0.90.

A modified version of Zeiss et al.'s Self-Efficacy Instrument was used to assess caregiver self-efficacy (43). First, participants indicate their ability to undertake specified activities using a yes/no response format. If they respond 'yes' to a specified activity, they then rate their level of confidence to perform that activity from 0% to 100% using a visual analogue scale. Two empirically derived subscales were used for this study: the four-item problem-solving self-efficacy subscale and the three-item respite subscale. Cronbach's alpha for problem solving self-efficacy and respite were 0.92 and 0.80, respectively.

A modified version of Lawton et al.'s Mastery Scale from a caregiving appraisal instrument was used to assess caregivers' perceived ability to manage their caregiving role (44). Items making up this scale are responded to using a five-point Likert-type scale. Participants rate mastery statements from strongly disagree (0) to strongly agree (4). Two empirically derived subscales were used in the current study: the three-item role appraisal subscale and the two-item role proficiency subscale. Cronbach's alpha for role appraisal and role proficiency were 0.70 and 0.56, respectively.

Finally, the Hospital Anxiety and Depression Scale (HADS) was used to screen for clinically significant anxiety and depression (37). This scale consists of 14 items that are responded to using a four-point Likert scale. The anxiety subscale includes all odd numbered items and the depression subscale comprises all even numbered items. The authors recommend a cut-off of 7–8 for probable and of 10–11 for possible cases of anxiety and depression. Cronbach's alpha for the anxiety and depression subscales were 0.85 and 0.84, respectively.

Statistical Analysis

Data were originally entered into Microsoft Excel 2000 then imported into SPSS Version 11.0.0. However, analyses for the current paper were conducted via SPSS Version 12.0.1. Exploratory data analysis was conducted on all items to assess normality. No serious violations were detected. Therefore, subsequent analyses proceeded without transformation of individual items. Note: All scale and subscale scores, excepting the HADS subscales, were calculated by summing individual items and then dividing the total score by the total number of items so that all scores could be interpreted in light of the original scaling method. HADS subscale scores were calculated according to the authors' specifications.

Three major sets of analyses were conducted. First, cluster analysis was performed on seven variables corresponding to the following scale and subscale scores at Time 2: preparedness, competence, social support, problem-solving, respite, role appraisal, and anxiety. The goal of these analyses was to determine whether two relatively distinct profiles of caregiver psychosocial functioning could be identified five weeks after commencement of home-based palliative care services—one high level of psychosocial functioning group and one comparatively lower level of functioning group. The *k*-means approach, which maximizes between-cluster differences and minimizes within-cluster variance (45,46), was used to partition individual cases into a pre-specified (*k*=2) number of clusters.

Second, "level of functioning" group membership, as determined by the *k*-means cluster analysis, was used in a series of multinomial logistic regression analyses to identify those variables based on Time 1 responses that could accurately predict level of psychosocial functioning at Time 2 (47). The goal of these analyses was to determine whether caregivers who were functioning at a comparatively lower level five weeks after the start of home-based palliative care services could be identified at presentation to the service based on self-reported psychosocial characteristics.

Variables to include as possible Time 1 predictors in the logistic regression model were determined based on Pearson's correlation coefficients between Time 2 respite and anxiety subscale scores, and all Time 1 scale and subscale scores. Specifically, all Time 1 variables evidencing a strong and significant relationship with Time 2 respite and anxiety subscale scores ($r > 0.6$, $p < 0.05$) were used as individual predictors in the logistic regression model. For each model tested, the response category was "lower

level of functioning" (coded as 1) and the reference category was "high level of functioning" (coded as 0).

The aim of the final analyses was to develop a potential screening method that could be used in a clinical setting to identify at-risk caregivers—caregivers with comparatively lower levels of psychosocial functioning five weeks post-commencement of services. A mathematical equation based upon regression coefficients is overly complex in terms of both explanation and application. Therefore, multivariate analysis of variance and cross-tabulations were used to determine appropriate cut-off scores relevant to the predictors of Time 2 level of functioning group membership, identified in the preceding analyses. Note: Total scale and subscale scores, rather than averaged total scores, were used in these analyses to ensure any method developed could be easily applied in the clinical setting.

RESULTS

Profiles of Psychosocial Functioning

As indicated previously, *k*-means cluster analysis was used to identify distinct profiles of psychosocial functioning five weeks post-commencement of home-based palliative care. Convergence was achieved after five iterations. The results indicated two relatively distinct groups of participants based on psychosocial functioning: a high level of functioning group and a comparatively lower level of functioning group. The high level of functioning group consisted of 22 participants and the lower level of functioning group consisted of 13 participants. The former group had significantly higher average scores on the preparedness scale and self-efficacy subscales (problem solving and respite), and lower average scores on the anxiety subscale ($p < 0.05$). The final cluster centres, or mean scale and subscale scores for groups, as well as *F*-tests and significance levels are shown in Table 2.

Table 2 / MEANS AND SIGNIFICANCE TESTS FOR PSYCHOSOCIAL SCALES AND SUBSCALES BY LEVEL OF FUNCTIONING GROUP MEMBERSHIP (n=35)

Scale or Subscale	Group		F-test	p-value
	high level of functioning	lower level of functioning		
Preparedness	2.87	2.33	4.00	0.05
Competence	2.50	2.23	2.07	0.16
Social support	4.82	3.79	3.57	0.07
Problem solving	8.60	7.35	8.70	0.008
Respite	7.50	4.08	21.87	<0.0005
Role appraisal	2.71	2.38	1.95	0.17
Anxiety	5.88	11.77	38.40	<0.0005

Table 3 / LOGISTIC REGRESSION ANALYSIS OF LEVEL OF FUNCTIONING GROUP MEMBERSHIP AS A FUNCTION OF PSYCHOSOCIAL VARIABLES (n=35)

Predictor	β	SE β	Wald's χ^2	df	p-value	e^{β} (odds ratio)
Constant	2.55	2.59	0.97	1	0.32	NA
Anxiety	0.22	0.12	3.53	1	0.060	1.25
Competence	-2.30	1.09	4.45	1	0.035	0.10

Predictors of Psychosocial Functioning

The first model fitted expressed level of functioning group membership as a function of five Time 1 variables: competence, problem-solving self-efficacy, role appraisal, anxiety, and depression. Although this model provided a significant improvement over the null model (Likelihood ratio test: $\chi^2(5)=15.5$, $p=0.008$), none of the predictors were significantly and independently related to level of functioning group membership ($p<0.10$). Thus, a second model was fitted using the variables that provided the strongest contributions to the first model.

The second model fitted expressed level of functioning group membership as a function of two Time 1 variables: competence and anxiety. This model provided a significant improvement over the null model (likelihood ratio test: $\chi^2(2)=14.7$, $p=0.001$) and provided an adequate fit to the data (goodness-of-fit test: $\chi^2(29)=27.9$, $p=0.52$) (48). The regression coefficients and other relevant regression statistics are shown in Table 3. According to the Wald criterion, perceived competence as a caregiver at first assessment reliably predicted level of functioning group membership at second assessment ($\chi^2(1)=4.45$, $p=0.035$); in other words, perceived competence was strongly and independently related to level of functioning group membership. Caregiver anxiety at first assessment also provided an independent but weaker contribution ($\chi^2(1)=3.53$, $p=0.060$) to the model.

As shown in Table 4, with the cut-off set at 0.5, the prediction of a high level of functioning caregivers was marginally more accurate than that for lower level of functioning caregivers. This observation was supported by the magnitude of sensitivity (82%) compared to the magnitude of specificity (77%) (48). The overall correction prediction was 80%; this represents an improvement over chance. The goodness of fit of the model was confirmed by an examination of the histogram of estimated probabilities. There was only one low functioning participant with an estimated probability less than 0.25; the other participants had predicted probabilities near 50%.

Table 4 / OBSERVED AND PREDICTED FREQUENCIES FOR LEVEL OF FUNCTIONING GROUP MEMBERSHIP (n=35)

Observed Group Membership	Predicted Group Membership		Percent Correct
	high functioning	low functioning	
high functioning	18	4	82
low functioning	3	10	77

Screening for the Clinical Setting

Multivariate analysis of variance was performed with one between-subjects factor group (two levels: high and lower level of functioning at Time 2) and two dependent variables (Time 1 competence and anxiety subscale scores). This analysis was performed to ascertain whether the two groups of caregivers could be clearly differentiated based on their Time 1 anxiety and competence subscale scores.

The analysis revealed a significant main effect of the between-subjects factor group, Pillai's trace statistic=0.34, $F(2,32)=8.2$, $p=0.001$ ($\eta^2=0.34$). The univariate F-test for competence was significant ($F(1,33)=11.6$, $p=0.002$; $\eta^2=0.26$). Compared with the lower level of functioning group, high functioning caregivers reported significantly higher perceived levels of competence as caregivers ($M=7.8$ and $M=10.0$, respectively). The univariate F-test for anxiety scores was also significant ($F(1,33)=9.8$, $p=0.004$; $\eta^2=0.23$). High functioning caregivers reported lower average levels of anxiety than lower level of functioning caregivers ($M=6.7$ and $M=11.5$, respectively).

Next, a cross-tabulation of Time 1 anxiety and competence subscale scores, layered by level of functioning group membership at Time 2, was used to determine approximate cut-off scores. Examination of the cross-tabulations indicated that a substantial proportion of the lower level of functioning participants was correctly classified on the basis of competence scores alone. That is, using a competence score of less than or equal to 8, 85% ($n=11$) of this group were correctly classified. Using this same competence cut-off score, 27% ($n=6$) of the high level of functioning caregivers were incorrectly classified. If a cut-off score of 5 or more on the anxiety mea-

sure is introduced, the proportion of correctly classified lower level of functioning caregivers remains stable, but the proportion of incorrectly classified high level of functioning caregivers is slightly reduced (23%; $n=5$).

Nevertheless, three of these five misclassified high level of functioning caregivers had anxiety scores greater than or equal to 10, which, in and of itself, would warrant further investigation. Table 5 shows the number of caregivers in the lower level of functioning group who were correctly classified on the basis of the above cut-off scores (the total number of correctly classified caregivers is highlighted). Conversely, Table 6 shows the number of caregivers in the high level of functioning group who were incorrectly classified on the basis of the above cut-off scores (the total number of incorrectly classified caregivers is highlighted).

DISCUSSION

Two relatively distinct groups of caregivers were identified at Time 2 based on self-reported psychosocial functioning. Self-reported anxiety and competence subscale scores at commencement of home-based palliative care services were relatively robust predictors of level of functioning five weeks post-commencement of service.

It appears that self-reported anxiety and competence subscale total scores could be used to identify caregivers at risk of lower levels of psychosocial functioning.

For example, if a caregiver obtained: 1) an average competence score of 8 or less, and 2) a total anxiety score of 5 or more at the start of home-based palliative care services, they might be at risk of a lower level of functioning five weeks following their first assessment. Irrespective of caregivers' competence scores, if the HADS indicates concerning levels of anxiety, this would need to be explored in greater detail.

The difference between the average Time 1 anxiety subscale scores of the high and lower level of functioning groups was statistically and clinically significant. The average anxiety score of the high level of functioning group was in the normal range, as indicated by the authors of the HADS (37). In contrast, the average anxiety score of the lower level of functioning group was in the clinical range, indicating concerning/clinical levels of anxiety. Based on this assessment alone, further action is warranted.

Several limitations of this study are noteworthy. The first limitation relates to this being a secondary analysis of an existing data set and, thus, not all variables of predictive value were included a priori. Results from cluster analyses

Table 5 / CROSS-TABULATION OF COMPETENCE AND ANXIETY CUT-OFF SCORES FOR LOWER LEVEL OF FUNCTIONING GROUP (n=13)

	Competence >8.0	Competence <8.0
Anxiety <5.0	0	0
Anxiety >5.0	11	2

Table 6 / CROSS-TABULATION OF COMPETENCE AND ANXIETY CUT-OFF SCORES FOR HIGH LEVEL OF FUNCTIONING GROUP (n=22)

	Competence >8.0	Competence <8.0
Anxiety <5.0	1	6
Anxiety >5.0	5	10

are not readily generalized to larger populations because clustering methods are not supported by extensive statistical reasoning (45); therefore, the current solutions require validation in larger samples. Unfortunately, "no definitive test exists to determine if true clustering is present in the data" (49, p.130); nonetheless, testing clusters against predictions from available theory may assist future research to validate empirically generated solutions. An additional limitation was that patient variables related to psychosocial functioning were not measured. It is expected that patients' responses to their circumstances are likely to influence caregiver reactions; hence, these data should be collected in future studies.

It must be emphasized that the screening method outlined above is not sufficiently developed for use in the clinical setting. The solutions presented here should be regarded as explorations and descriptions, such that these solutions require replication and further testing in a larger sample. It should also be acknowledged that any screening method would need to be followed by a more detailed interview with at-risk caregivers. Furthermore, the relevance of other predictors of psychosocial distress (e.g., history of alcohol abuse, psychiatric problems, being single) such as those identified in patients with cancer might be worthy of exploration (50).

Research studies to address these limitations are required. In addition, studies should be extended to later in the caregiving experience and should include the bereavement period. Researchers and clinicians also need to be mindful that, while efficacious strategies for screening for depression in palliative care patients are warranted (51,52), screening methods for family caregivers are also needed. It would also be advantageous if variables that predict psychosocial functioning are tested in populations of caregivers who are caring for a relative with advanced

cancer, but not necessarily at the palliative care stage. In order for interventions to be relevant and efficacious a suitable time frame is required so they can be implemented appropriately. Leaving interventions to at risk caregivers of people confronting death in several weeks or months will potentially compromise their usefulness.

CONCLUSION

This study sought to determine if it was possible to predict the psychosocial functioning of family caregivers who were supporting a relative with advanced cancer. The results indicate that self-reported anxiety and competence subscale total scores upon commencement of home-based palliative care might be used to identify caregivers at risk of lower levels of psychosocial functioning. However, this screening approach needs to be replicated with larger, prospective samples before its clinical utility can be claimed. Other variables related to psychosocial functioning should also be considered in subsequent studies.

Health professionals working in palliative care are expected to meet standards for supporting family caregivers (1,2,53,54). Identifying strategies for determining caregivers at risk of psychosocial distress is a priority. Without research initiatives in this area, interventions may not be specifically directed at those who need them most.

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Peter L Hudson, Karla Hayman-White, Sanchia Aranda, Linda J Kristjanson. Journal of Palliative Care. Toronto: Autumn 2006. Vol 22, Iss. 3; pg. 133, 9 pgs

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Full Text (5546 words)

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[Headnote]

Abstract / Background: Health professionals are expected to support family caregivers of patients requiring palliative care. However, there is a dearth of empirical evidence to help clinicians identify caregivers who might be at risk of poor psychosocial functioning. Purpose: This secondary analysis of baseline data from a larger study sought to determine if it was possible to predict the psychosocial functioning of family caregivers who were supporting a relative with advanced incurable cancer. Method: Data from 35 primary family caregivers obtained at the start of home-based palliative care services and five weeks later was used in the analysis. Instruments to measure caregiver preparedness, competence, mastery, social support, anxiety, and self-efficacy were used. Results: Cluster and logistic analyses revealed that self-reported "anxiety" and "competence" subscale total scores at time of commencement of home-based palliative care services were associated with caregivers at risk of lower levels of psychosocial functioning five weeks later. Conclusions: This study suggests that it may be possible to identify family caregivers who are at risk for poorer psychosocial functioning. However, replication in a larger sample is required before this screening approach can be recommended for clinical use.

Résumé / Les professionnels de la santé se doivent de soutenir les soignants familiaux qui s'occupent d'un patient nécessitant des soins palliatifs. Cependant, il y a peu de preuves empiriques pouvant aider les cliniciens à identifier ceux parmi ces soignants qui sont à risque d'éprouver des problèmes d'ordre psychologique. Objectif: Cette analyse de nature secondaire des résultats d'une étude plus étendue visait à déterminer si l'on pouvait prédire les réactions psychologiques des soignants familiaux devant s'occuper d'un des leurs atteint de cancer avancé. Méthode : Les données recueillies auprès de 35 soignants au début des soins palliatifs dispensés à domicile et cinq semaines plus