Stressors and Coping Strategies among Family Caregivers Having Children with Lymphoma at Children’s Cancer Hospital Egypt 57357

RASHA A. ABDEL-RAHMAN, M.Sc. ¹ ; GEHAN M. ISMAIL, D.N.Sc. ² ; HANY A. SAYED, M.D. ³ and HEBA M. SHARAA, D.N.Sc. ⁴

The Departments of Community Health Nursing ¹, ², ⁴, Faculty of Nursing and Pediatric Oncology ³, National Cancer Institute, Cairo University

Abstract

Background: The diagnosis of cancer in children and adolescents is a life-altering event for them as well as their family caregivers. Lymphoma is the third most common childhood cancer.

Aim of this Study: Was to assess the stressors and coping strategies among family caregivers having children with lymphoma. A descriptive exploratory research design was utilized in this study.

Setting: The study was conducted at Children’s Cancer Hospital Egypt 57357, Cairo Governorate. A convenient sample of 100 family Caregivers having children with non Hodgkin’s lymphomas were included in the study. Three tools were utilized in this study. I: Sociodemographic questionnaire; divided into three parts (A) Demographic characteristic of the child with non Hodgkin’s lymphoma, (B) Demographic characteristic of the caregivers, (C) Disease information. II: Stressors scale; this scale was divided into four subscales (physical, psychological, social, and environmental stressors), III: Coping process scale; the scale consisted of 42 items related to emotional and problem focused coping.

Results: Indicated that, the highest mean scores of stressors among family caregivers were related to psychological stressors and the highest mean scores were related to emotional focused coping that is commonly used by family caregivers. A highly statistically significant correlation was found between the caregiver’s total emotional focused coping scores and their total problem focused coping scores, also a highly statistically significant negative correlation was found between the family caregiver’s total stressor scores and their total coping scores. The study concluded that, the majority of the family caregivers were suffering from psychological stressors while, the minority were suffering from physical stressors. For coping strategies used by family caregivers to overcome these stressors, the majority of family caregivers used emotional focused coping than problem focused coping. It is recommended to perform health education program for family caregivers having children with lymphoma to raise their awareness about the disease and the appropriate use of coping strategies to overcome their stressors.

Key Words: Family caregivers – Children – Lymphoma – Stressors – Coping strategies.

Introduction

CANCER diagnosis is never welcomed; it is even more unexpected and difficult when the disease is announced in a child or adolescent. Cancer is the second leading cause of death in the developing world [1]. As the world’s population continues to grow, the burden of cancer will inevitably increase, even if current incidence rates remain the same. More than half of all cancers worldwide are diagnosed in the developing countries, and without intervention, this proportion is predicted to rise in the coming decades. By 2030, there will be almost 21.4 million new cases diagnose annually, and that there will be over 13.2 million deaths from cancer [2]. It is the second most common cause of death among children aged 0-15 years, surpassed only by accidents. Of all childhood cancers, malignant lymphomas [Hodgkin disease (HD) and non-Hodgkin lymphoma (NHL)] rank third in incidence, with an age-standardized incidence rate of 15.5 per million, two thirds are NHL and one third is HD [3].

Lymphoma in children and adolescents comprises a heterogeneous group of malignant diseases of lymphoid tissues. In developed countries, lymphoma is the third most common childhood malignancy following leukemia and brain tumors, accounting for approximately 14% of childhood cancers [4]. A diagnosis of cancer in a child or teenager is a devastating blow to the parents, siblings, and other who love the child. Cancer
creates an instant crisis in the lives of the whole family. The ill child becomes the major focus of family time and attention, and all other concerns are put on hold. Parents should be given detailed information about the diagnosis, treatment plan and make important decisions about their child’s care [8]. Sherwood, Given and Given, (2012) [6] pointed out that, the impact on family can be in the form of increased burden and responsibility of caring for the sick child or adolescent at home, for which families have varying physical and emotional capabilities. Furthermore, as most of medical treatments are delivered during the working hours, there is a potential for increased loss of income for the caregivers in the family leading to financial strain.

All roles and responsibilities of family members must change to accommodate the child’s treatment. Family systems theory asserts what affects one family member affects all family members; thus the system as a whole must rally to fight the child’s cancer together. Family caregivers utilize numerous resources and coping behaviors to fight cancer and maintain emotional stability. Many of these coping behaviors have been identified, such as seeking information, seeking social support, problem solving and relying on religion [7]. Community health nurse can support the family by respecting them and serve as a support by making referrals, providing information about the illness or its management, allowing emotional expression by all family members, and by responding to the emotions when expressed. It is crucial for the nurse to take a long-term view of problems and not to expect all of them to be solved quickly [6].

Significance of the study: According to the Leukemia and Lymphoma Society, (2009) [8] out of 10,730 children under the age of 15 years diagnosed with cancer, only 3.7% had HL and 4.2% had NHL. Children with cancer today receive a large part of their treatment at home, which has increased caregiving demands on family members. The intensive and often prolonged treatment can pose problems for family organization, especially if the hospital is far from home. Fear of the child’s death, demands associated with the lengthy treatment process, financial costs and pressures, and negative impact on family relationships can lead to adverse psychosocial outcomes for parents. Clinically, it is important to identify families in need of help to provide interventions [8].

From the field of practice, it was noticed that, caring for a child with cancer is a complex process for the family caregivers. No one can deny that the caregivers play an important role all over the disease process. Also, the presence of children with cancer either at home or at hospital represents a great burden on their parents, not only in the form of physical problems, but also emotional ones. Therefore, the aim of this study was to assess the stressors and coping strategies among family caregivers having children with lymphoma at Children’s Cancer Hospital Egypt 57357.

Subjects and Methods

Research questions:
To fulfill the aim of this study the following research questions were formulated:
Q1: What are the stressors facing family caregivers having children with lymphoma?
Q2: What are the coping strategies used by family caregivers to overcome these stressors?

Research design:
A descriptive exploratory research design was utilized in this study.

Setting of the study:
This study was conducted at Children’s Cancer Hospital Egypt 57357, Cairo Egypt. Newly diagnosed children aged from 1 to 18 years usually come to this hospital as it serves a large number of children which gives the opportunity for capturing family caregivers with different characteristics.

Sample:
A convenient sample of 100 family caregivers having children with NHL was included in the study. Data was collected from February 2013 to June 2013.

Tools of the study:
Three tools were utilized to gather data pertinent to the study, which covered the following areas:
1- Sociodemographic questionnaire divided into three parts:
a- Demographic characteristics of the child; age, sex, education, ranking between their siblings, age at detection and number of brothers and sisters.
b- Demographic characteristics of the caregivers; age, sex, relation to the child, education, place of residence, occupation, marital status, and family income, duration of care per month and presence of another responsible person.
c- Disease information such as history of cancer in the family, presence of another child with cancer in the family, and history of other chronic illnesses in the child.

2- Stressors scale:

This scale derived from Alaedein and Abdelrahman, (2011) from Jordan to measure stressors among family caregivers having children with cancer. Modifications to the scale were done by the investigator after reviewing the related literature. This scale consisted of (40) items divided into four subscales (physical, psychological, social, and environmental stressors). Answer of the scale consisted of 3 points rating scale ranging from (1) Disagree, (2) Agree, to (3) Strongly agree. Validity and reliability of the scale were (0.95 and 0.90) respectively.

3- Coping process scale, (CPS, Ibrahim, 1994):

This scale is a standardized scale developed and tested by (Ibrahim, 1994). Validity and reliability of the scale were (0.90 and 0.80) respectively. The scale consisted of 42 items in the form of 4 points rating scale. Scores on each item in the scale ranged from (1) don’t agree to (4) totally agree. Based upon a comprehensive review in the area of coping, this scale was divided into two main subscales.

a- Problem focused coping included; seeking out information and social support (3 items), positive reinterpretation (5 items), exert of restrain (4 items), denial (3 items) and active coping (3 items).

b- Emotional focused coping included; helplessness (6 items), mental disengagement (5 items), wishful thinking (4 items), turning to religion (3 items) emotional discharge (3 items) and acceptance (3 items).

Ethical and legal consideration:

Based on a wide review of recent literature, stressors scale was modified by the investigator. The tool was evaluated by seven experts in the fields of community health nursing, psychiatric health nursing, pediatric nursing and biostatistics in the Faculty of Nursing, Cairo University to test content validity of all items. Recommended modifications were done. All the research tools for data collection and proposal were submitted to the Ethical Committee in the Faculty of Nursing.

An official permission was obtained from the director of the Children’s Cancer Hospital Egypt 57357 to carry out this study, also permission was obtained from the director and the head nurse of outpatient clinic. After explanation of the aim of the study, written informed consent was obtained from all caregivers who agreed to participate in the study. Those who fulfilled the inclusion criteria were included in the study after obtaining their approval. Written informed consent was obtained from the representatives of the caregivers who could not read and write.

Pilot study:

A pilot study was carried out on 10% of the sample size to assess the feasibility of the study, as well as clarity and objectivity of the tools. No modification for the tools was done, so the pilot sample was included in the study.

Statistical analysis:

Data were coded, scored, tabulated and analyzed using the statistical package for the social science (SPSS windows) version 11.5. Numerical data were expressed as mean ±SD and range. Qualitative data were expressed as frequency and percentage. Relations between different numerical variables were tested using person correlation. Probability (p-value) less than 0.05 was considered significant and less than 0.001 was considered as highly significant.

Results

Results of the current study reveals that, 56% of children aged from 2 years to less than 6 years old, while 19% aged from 6 years to less than 10 years old with a mean age of 2.69 ± 1.04 years. Slightly more than three quarters (76%) of them were males. Concerning the children’s education, 29% were at the nursery, while 32% didn’t enroll at schools. Regarding the child’s age at detection of lymphoma, the results reveals that, 49% aged from 2 years to less than 6 years old when the disease was detected, with a mean age of 2.56 ± 1.12 years. Result also shows that, 84% of the children had from 1 to 3 brothers and sisters, while only 16% of children had from 4 to 5 brothers and sisters with a mean 2.16± 1.24 child. The majority (72%) of the children ranked first or second in their families.

Concerning the caregiver’s age, the result illustrates that, 30% of the caregivers aged from 25 years to less than 29 years old, also 30% aged from 30 years to 34 years old, while 25% aged from 35 years to 39 years old with a mean age of 33.3±6.84 years. The result also shows that, 77% of caregivers were females and, 89% were married. Regarding the caregiver’s education, 41% of them had secondary education and 32% had university degree.
Concerning caregiver’s relation to the child, 74% of them were the mothers and 22% were the fathers of the children. Result shows that, 51% of caregivers were living in urban areas. 60% of the caregivers were housewives and 27% were employees. Regarding the family income, 51% of the family caregivers had inconsistence income. Also, 58% of the caregivers were responsible for their children since 1 to 3 months, while 42% were responsible since 4 to 6 months with a mean of 3.2 ± 1.41 months.

Regarding stressors facing family caregivers having children with lymphoma, Table (1) shows, the common stressors facing family caregivers are related to psychological stressors score (68.64 ± 9.766), while the least are related to physical stressors score (6.46 ± 1.482). Table (2) indicates that, the mean scores of emotional focused coping strategies are (70.29 ± 7.469), while the mean scores of problem focused coping are (30.67 ± 8.932).

In relation to problem focused coping, Table (3) reveals that, seeking out information and social support has the highest mean scores (9.03 ± 1.951), while denial has the least mean scores (2.01 ± 1.745) among family caregivers. Regarding emotional focused coping used by family caregivers, Table (4) indicates that, turning to religion has the highest mean scores (11.58 ± 2.184) while emotional discharge has the least mean scores (12.24 ± 1.796).

Table (5) shows a statistically significant negative correlation between the total stressor scores of the family caregivers and their education (p=0.000), also a statistically significant negative correlation is found between the total stressor scores of the family caregivers and their place of residence (p=0.000). For the family caregiver’s income, a statistically significant positive correlation is found between income of the family caregivers and their total stressor scores (p=0.000).

Table (5) also reveals a statistically significant positive correlation between family caregiver’s education and their total coping scores (p=0.000), also a statistically significant positive correlation is found between the total coping scores of the family caregivers and their place of residence (p=0.000). For the family caregiver’s income, a statistically significant negative correlation is revealed between income of the family caregivers and their total coping scores (p=0.012). Table (6) reveals a highly statistically significant negative correlation between the family caregiver’s total stressor scores and their total coping scores (p=0.000).

Table (1): Mean scores of physical, psychosocial and environmental stressors among family caregivers having children with lymphoma (n=100).

<table>
<thead>
<tr>
<th>Subscales of stressors</th>
<th>Max mean</th>
<th>Total sample (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical stressors</td>
<td></td>
<td>1.46±.727</td>
</tr>
<tr>
<td>Psychological stressors</td>
<td>72</td>
<td>68.64±9.766</td>
</tr>
<tr>
<td>Social stressors</td>
<td>21</td>
<td>9.58±2.307</td>
</tr>
<tr>
<td>Environmental stressors</td>
<td>21</td>
<td>6.46±1.482</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>86.14±14.282</td>
</tr>
</tbody>
</table>

Table (2): Mean scores of coping strategies among family caregivers having children with lymphoma (n=100).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total sample (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean±SD</td>
</tr>
<tr>
<td>Problem focused coping</td>
<td>30.67±8.932</td>
</tr>
<tr>
<td>Emotional focused coping</td>
<td>70.29±7.469</td>
</tr>
<tr>
<td>Total</td>
<td>100.96±16.401</td>
</tr>
</tbody>
</table>

Table (3): Mean scores of problem focused coping strategies used by family caregivers having children with lymphoma (n=100).

<table>
<thead>
<tr>
<th>Subscales of problem focused coping</th>
<th>Max mean</th>
<th>Total sample (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking out information and social support</td>
<td>12</td>
<td>9.03±1.951</td>
</tr>
<tr>
<td>Positive reinterpretation</td>
<td>20</td>
<td>10.54±1.264</td>
</tr>
<tr>
<td>Exerctise of restrain</td>
<td>16</td>
<td>7.37±2.440</td>
</tr>
<tr>
<td>Denial</td>
<td>12</td>
<td>2.01±1.745</td>
</tr>
<tr>
<td>Active coping</td>
<td>12</td>
<td>2.16±1.532</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>30.67±8.932</td>
</tr>
</tbody>
</table>

Table (4): Mean scores of emotional focused coping strategies used by family caregivers having children with lymphoma (n=100).

<table>
<thead>
<tr>
<th>Subscales of emotional focused coping</th>
<th>Max mean</th>
<th>Total sample (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helplessness</td>
<td>24</td>
<td>12. 24±1.854</td>
</tr>
<tr>
<td>Mental disengagement</td>
<td>20</td>
<td>10.40±2.132</td>
</tr>
<tr>
<td>Wishful thinking</td>
<td>16</td>
<td>14.15±2.840</td>
</tr>
<tr>
<td>Turning to religion</td>
<td>12</td>
<td>11.58±2.184</td>
</tr>
<tr>
<td>Emotional discharge</td>
<td>12</td>
<td>11. 31±1.796</td>
</tr>
<tr>
<td>Acceptance</td>
<td>12</td>
<td>10. 61±1.651</td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>70.29±7.469</td>
</tr>
</tbody>
</table>
which reported that, NHL is more likely to occur in younger children.

The current study showed that, the majority of the children had from 1 to 3 brothers and sisters. These results were consistent with the study done by Kohlsdorf and Costa Junior, [12] who conduct a study on 44 caregivers at pediatric oncology centers in Brasil and found that, the majority of them had from one to three siblings living with the child. Regarding the child rank in the family the study showed that, the majority were first or second child in their families. These findings were in agreement with Kohlsdorf and Costa Junior, [12] who found that, more than half of the children (53%) were the first-born child.

Regarding the caregiver’s age, the current study illustrated that, more than one quarter of the caregivers aged from 25 to 29 years old, also more than one quarter of the caregivers aged from 30 to 34 years. These results contradicted the study done by Elizete, Maria, Mariano, Dulce and Angélica, [13] conducted a study on 32 caregivers taking care of children with cancer in Brazil, and found that, the majority of the caregivers’ age was 35 years. The difference between the two studies could be related to the sample selection or may be related to the different in age of mirage in Egypt.

The current study indicated that, the majority of the family caregivers were females and the majorities were the mothers of the children. These results were supported by many studies as Scarpelli et al., [14] who conducted a study on family caregivers of children with cancer at pediatric Hematology/Oncology centers in Brazil, and found that most of family caregivers were females and mothers of their children. Also Anne et al., [15] conducted a study on 500 caregivers in Canadian pediatric oncology centers to assess caregiving demands in parents of children with cancer (include lymphoma) and found the majority of family caregivers were females and mothers of their children. From the investigator point of view, mothers are the primary caregivers for any sick child in the family and they carry most of responsibilities, while fathers do not have enough time to provide care as they spend most of time working outside home. In addition mothers usually assume the role of primary caregiver and become emotionally involved while fathers act as money providers and tend to distance themselves emotionally from the situation.

Concerning family caregiver’s education, the current study showed that, the majority of them had secondary education, while more than one third of them had university education. These results were supported by LeLe et al., [16] who conducted a study on the hidden impact of child-

Table (5): Correlation between the total family caregiver’s stressor scores and coping scores and their education, place of residence and income (n=100).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total stressors</th>
<th>Total coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>−0.635</td>
<td>0.000**</td>
</tr>
<tr>
<td>Place of residence</td>
<td>−0.587</td>
<td>0.000**</td>
</tr>
<tr>
<td>Income</td>
<td>0.575</td>
<td>−0.0251 0.012*</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Table (6): Correlation between the total stressor scores of the caregivers and their total coping scores (n=100).

<table>
<thead>
<tr>
<th>Variables</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total stressors</td>
<td>−0.348</td>
<td>0.000**</td>
</tr>
<tr>
<td>Total coping</td>
<td>0.075</td>
<td>0.000**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).

Discussion

Family caregivers of children diagnosed with cancer confront a multitude of cancer-related stressors, including threat to their child’s life, repeated hospitalizations and clinic visits, caring for other family members, and alteration of roles and responsibilities [9], so the present study aimed at assess the stressors and coping strategies among family caregivers having children with lymphoma at Children’s Cancer Hospital Egypt 57357.

Results of children characteristics with NHL presented in the current study revealed that, more than half of children aged from 2-6 years old, while only three of them had less than 2 years old. These findings were in agreement with American Cancer Society, [4] which reported that, NHL is more common in older children than in younger ones. Regarding the sex of the child, results of the current study indicated that, the majority of children were males. These findings were in agreement with North American Association of Central Cancer Registries, [10] and American Cancer Society, [4] which reported that, the incidence rates of NHL are much higher in boys than in girls.

Concerning the child’s age at diagnosis, approximately half of children aged from 2 to 6 years old, while only few number of children aged from 14 to 18 years old at diagnosis of NHL. These results were consistent with American Cancer Society, [4] and National Cancer Institute, [11] which reported that, NHL is more likely to occur in younger children.
hood cancer on the family in Singapore and found the highest level of education achieved for the parent or caregivers was primary/secondary school (40%) and undergraduate (39%). From the investigator point of view, early marriage of Egyptian females may be an obstacle for them to join higher education.

Regarding marital status, the current study also showed that, the majority of family caregivers were married. These results were in agreement with Al-Jauissy, [17] who conducted a study on 82 caregivers at outpatient chemotherapy clinic in Jordan and revealed that, the majority of the family caregivers were married. Also Elizabeth et al., [18] who conduct a study on 73 parental caregivers to assess physiological and psychological stress among parents of childhood cancer and brain tumor survivors in USA revealed that, the majority of the family caregivers were married and have another children and responsible for the whole family.

Concerning the place of residence, current study showed that, approximately half of the caregivers were living in urban areas and almost half were living in rural areas. This result was in agreement with the study done by the National Alliance for Caregiving [19], who conduct study on family caregivers caring for children with special needs in USA, and indicated that, caregivers were equally distributed among urban and rural areas. But this result contradicted the study done by Al-Jauissy [17], who conducted a study on Jordan caregivers and found that, most of caregivers were coming from rural areas. The difference between the studies could be related to the sample selection at the time of data collection, also the hospital of 57357 served people from all parts of Egypt.

A statistically significant negative correlation was found between family caregiver’s stressors and their education and place of residence. Also a statistically significant positive correlation was found between family caregiver’s education and place of residence and their coping strategies. These results contradicted with Greening and Stoppelbein, [20] Klassen et al., [21] who conducted study at pediatric oncology setting to assess caregiving experience of parents of children with cancer and found no significant correlations between coping and personal characteristics of the caregivers which was related to place of origin, gender and monthly income.

It seems possible that, this difference between the studies could be related to the sample selection and cultural difference. Also this result could be true as in the early stages of the treatment socio-demographic characteristics of the family caregivers influence the experience of stressors and the adoption of coping strategies, so adequate support both during diagnosis phase and the early stages of the treatment was important, which may influence the adoption of certain coping strategies over others.

Regarding the family caregiver’s work, results revealed that, almost two third of caregivers were housewives, while slightly more than one quarter were employees. These results were in agreement with Elizete et al., [13] who conducted a study on caregivers and found that, 65.6% were housewives due to the presence of a child with cancer. This result contradicted with National Alliance for Caregiving [19], which reported about two third of caregivers were employed while caring for their relative or children. From the investigator point of view this difference between the studies could be related to the sample selection and cultural difference.

Regarding the duration of taking care of the child, this study showed that, the majority of the caregivers were responsible for caring for their children from 1 to 3 months, while more than one third was responsible from 4 to 6 months. These results contradicted with Vrijmoet-Wiersma et al., [22] who indicated that family caregivers often provide care over several years where two-thirds of them were providing care for a year or more. Also Elizete et al., [13] who conduct study on caregivers found that, the mean time of care for the child exceeded one year. The difference between the studies could be related to the sample selection in every study and the type of cancer being studied.

Regarding stressors facing family caregivers having children with lymphoma, the current study showed that, the majority of them reported higher level of psychological stressors, while the minority suffered from physical environmental stressors. These results were in agreement with the study done by Vrijmoet-Wiersma et al., [22] who found the higher levels of parental stressors on the pediatric oncology setting were related to higher levels of psychological stressors. Also Kazak et al., [23] found that, following a child’s cancer diagnosis, parents experience intense psychological stressors as a result of invasive medical procedures, fears about the child’s future health status, and hospitalization. Another study done by Long and Marsland, [9] on family adjustment to childhood cancer found that, caregivers of children diagnosed with cancer confront a multitude of cancer-related stressors,
including threat to their child’s life, repeated hospitalizations and clinic visits, caring for other family members, and alteration of roles and responsibilities.

Also Miedema, Easley, Fortin, Hamilton and Mathews [24] found that, parents where psychologically affected by their child’s diagnosis, time since diagnosis, side effects of treatment and child’s health status. Additionally, parents have reported burden in their employment and financial status, their family relationships, caring for the other children and guilt feelings sometimes. In contrast to the study results, LeLe et al., [16] who conduct a study on the hidden impact of childhood cancer on the family in Singapore found that, the highest impact was perceived as familial/social stressors, followed by financial stressors. From the investigator point of view, the difference between the studies could be related to the sample selection and cultural difference, also being treated on free payment hospital decrease the financial burden on caregivers (Question one answered).

In relation to coping strategies used by family caregivers, results indicated that, the majority of the family caregivers were using emotional focused coping more often than problem focused coping. These results were supported by Kohlsdorf and Costa Junior, [12] who found that, the main coping strategies used by family caregivers were based on emotional focused coping strategies 4.13 ±0.53 followed by problem focused coping strategies 3.85±0.60. From the investigator point of view, family caregivers responsible for sick child tend to use emotion-focused coping strategies most of the times as a way to manage their stress in the form of spiritual and religious rituals as a source of reassurance (Question two answered).

The current study revealed a highly statistically significant negative correlation between the family caregiver’s total stressor scores and their total coping scores. This finding contradicting the study done by Kohlsdorf and Costa Junior [12] and Greening & Stoppelbein [20] , who conducted a study at pediatric oncology setting to assess caregiving experience of parents of children with cancer and found a statistically significant positive correlation between the coping strategies and the level of stressors and anxiety among caregivers.

In conclusion: The present study concluded that, the majority of the family caregivers suffered from psychological stressors while, the minority suffered from physical stressors. For coping strategies used by family caregivers to overcome these stressors, the majority of them used emotional focused coping more frequent than problem focused coping.

Recommendations:

In the light of the findings of this study, the following recommendations were suggested:

1- Perform health education program for family caregivers having children with lymphoma to raise their awareness about the disease and the appropriate use of coping strategies to overcome their stressors.

2- New protocol of care for caregivers having children with lymphoma to help them coping with their stressors.

References


أدوات البحث:
تم جمع البيانات الخاصة بهذه الرسالة باستخدام ثلاثة أدوات كالتالي:
1- استمارة البيانات الديموغرافية والتي تشمل على أسلوب لمعرفة (السن، الجنس، مستوى التعليم، الوظيفة ….) الخ
2- مقياس الضغوط النفسية، أعد بواسطة (علاء الدين وبيدر محسن) في الأردن، وقد تم العمليات باللغة العربية مع الثقافة المصرية
3- قسم إلى أربع عناصر ضغط جسدي، ضغط نفسي، ضغط اجتماعي وضغوط بيئية.
4- مقياس معيقات شمل الضغوط، أعد بواسطة (إبراهيم 1994).

تم أخذ الموافقة الرسمية لتنفيذ هذا البحث من لجنة أخلاقيات البحث العلمي كلية التمريض جامعة القاهرة، وتم الحصول على إذن رسمي من مستشفى سرطان الأطفال ٧٤ لتنفيذ هذه الدراسة. وأخيراً بعد سرح الهدف من الدراسة تم أخذ موافقة كتابية وشفاف من مقدمي الرعاية الأساسية للأطفال سرطان الدم الاليوبائية.

النتائج الرئيسية للبحث:

أظهرت النتائج الرئيسية لهذه الدراسة أن:
• في مقدمي الرعاية الأساسية (٢٠٪) تقع في الفئة العمرية بين ٢٥ إلى ٤٠ سنة ٣٠٪ ونسبة منسهم تتراوح بين (١٨٤±٣٢٣٪) 
• أن أغلبيتهم (٣٣٪) كانوا من أصل وترقبهم أصولهم على تعليم ثانوي بينما ثلثهم حاصلاً على تعليم جامعي. كما أوضحت الدراسة أن أكثر من ثلاثة أرباع (٣٩٪) من العينات كانوا أمراء الأطفال ومتزوجين.
• بالنسبة للأطفال المصابين بسرطان الدم الاليوبائي، فإن أكثر من نصفهم (٥١٪) عين في الفئة العمرية بين ٢ إل ٤ سنوات ونسبة متوسط أعمار تتراوح بين (١٨٤±٣٢٣٪) من الذكور، فيما يقل يقل فئات الأطفال (٣٩٪) من الأطفال في مرحلة الطفولة. 
• بالنسبة للضغط النفسي التي تواجه مقدمي الرعاية الأساسية لهذه الأطفال فقد أوضحت الدراسة أن كل عينة تعاني من ضغوط نفسية، جسمانية، واجتماعية وبيئية، وقد أغلبية عينة البحث تجلي بعض من الضغوط النفسية التي يمثلها في (الخوف من المستقبل، الخوف من فقدان الطلب، عدم القبول، القلق والقلق، وقفة في الطلب……).
• بالنسبة لاستراتيجيات التكيف فقد أوضحت الدراسة أن أغلبيه مقدمي الرعاية الأساسية يستخدمون طريقة التكيف عن طريق التعامل مع الافعالات التي تنتج من المنشأة النفسية.
• أوضح الدراسة أن هناك دلالة إحصائية بين درجة تعليم الطفل والضغط النفسي التي تواجه مقدمي الرعاية الأساسية، كما وجد أن هناك دلالة إحصائية بين سن الطفل واستراتيجيات التكيف لدى مقدمي الرعاية الأساسية.
• وجد أن هناك دلالة إحصائية قوية بين درجة تعليم، محل أزمة مقدمي الرعاية الأساسية بين استراتيجيات التكيف لديهم.
• ويشمل العلاقة بين الضغوط النفسية واستراتيجيات التكيف وجد أن هناك دلالة إحصائية قوية ولكن سلبية بين ضغوط النفسية واستراتيجيات التكيف لدى مقدمي الرعاية الأساسية.
• أوضح الدراسة أيضًا أن هناك دلالة إحصائية قوية بين التكيف عن طريق التعامل مع المشكلة والتكيف عن طريق التعامل مع الافعالات التي تنتج من المشكلة نفسها.

الآراء:
• في ضوء النتائج التي توصلت إليها هذه الدراسة قد أوصت الدراسة بما يلي:
• إجراء نماذج تقنية بواسطة ممرضة صحة المجتمع لمقدمي الرعاية الأساسية لتشجيعهم على الاستفادة ومعرفة المزيد عن استراتيجيات التكيف.
• وتقديم أيضاً النصائح اللازمة للتنفيذ هذه الاستراتيجيات.
• نظم برنامج تدريب لجميع مقدمي الرعاية الأساسية للأطفال وباقي مخبراء السرطان وذكروا بالجهات المعنيين.
• تزويد مقدمي الرعاية الإسارية بالطرق المختلفة للتخفيف من الضغوط النفسية التي يمر بها من الممارسة.
• رفع الوعي لدى ممرضات أورام الأطفال لمساعدتهم على تقديم الرعاية الإسارية للأطفال المصابين بالسرطان بالتكيف الفعال مع الضغوط التي يعانون منها.