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Thematic Analysis of Coping Strategies and Perceived Social Support Among Cancer Caregivers in India: A Pilot Study

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Abstract

Background: Informal caregiving for individuals with cancer places substantial psychological, emotional, social, and existential demands on family members. Although quantitative instruments measure caregiver burden, coping, and social support, they often fail to capture the subjective meaning-making processes through which caregivers interpret and respond to prolonged illness trajectories.

Objective: This study aimed to explore the lived experiences, coping strategies and perceived social support among caregivers of cancer patients using qualitative thematic analysis within a case series framework.

Methods: A qualitative case series design was employed involving ten caregivers of individuals diagnosed with various types of cancers. Data was derived from ten in-depth narrative case studies incorporating validated measures of coping and perceived social support. An inductive thematic analysis was conducted following Braun and Clarke's six-step approach. Coding was iterative and reflexive, leading to the development of overarching themes.

Results: Six major themes emerged: (1) emotional burden and persistent psychological distress, (2) role overload and life disruption, (3) divergent coping orientations, (4) spirituality as a psychological anchor, (5) unequal distribution of perceived social support, and (6) meaning-making versus helplessness. Caregivers who engaged in problem-focused coping and reported higher levels of social support demonstrated better emotional regulation and resilience. Conversely, avoidant coping and perceived social isolation intensified distress and emotional exhaustion.

Conclusion: Cancer caregiving is a multidimensional and context-dependent experience shaped by coping orientation, perceived social support, cultural norms, and personal meaning-making processes. Qualitative insights reveal psychosocial dynamics that are not fully captured by quantitative scales alone. Tailored psychosocial interventions addressing coping style, social support, and spiritual resources are essential to support caregiver well-being.

Keywords: Cancer caregivers, Coping strategies, Social Support, Qualitative Research, Thematic Analysis

Introduction

Cancer remains one of the leading causes of morbidity and mortality worldwide, with its impact extending far beyond the individual diagnosed with the disease. Advances in detection and treatment have transformed many cancers into chronic conditions, resulting in prolonged treatment trajectories that increasingly rely on informal caregiving provided by family members. Cancer caregivers, often spouses, parents, children, or extended relatives, assume multifaceted roles that encompass physical care, emotional support, financial management, and coordination of health services. While caregiving can be a source of meaning and relational closeness, it also imposes substantial psychological, emotional, social, and economic burdens.

Caregivers of individuals with cancer experience elevated levels of anxiety, depression, emotional distress, sleep disturbances, and impaired quality of life. The unpredictability of disease progression, repeated hospitalizations, treatment side effects, and fear of recurrence or death create a chronic stress environment. Unlike formal

healthcare providers, informal caregivers are rarely trained or systematically supported, yet they are expected to function as constant companions and decision-makers within complex healthcare systems.

Research on cancer caregiving has predominantly relied on quantitative measures to assess caregiver burden, coping strategies, and perceived social support. Instruments such as the Brief COPE and the Multidimensional Scale of Perceived Social Support (MSPSS) have been widely used to capture measurable dimensions of caregiver experience. While these tools are valuable for identifying patterns and correlates, they offer limited insight into how caregivers interpret their experiences, assign meaning to suffering, and navigate emotional and existential challenges.

Qualitative research provides a critical lens for understanding the lived experiences of caregivers by foregrounding personal narratives, contextual influences, and subjective interpretations. In particular, thematic analysis allows researchers to identify recurring patterns of meaning across individual cases while preserving the richness of individual stories. This approach is especially relevant in culturally diverse settings such as India, where caregiving is embedded within familial obligations, gender norms, spiritual beliefs, and socio-economic constraints.

The present study adopts a qualitative case series design to explore coping strategies and perceived social support among caregivers of individuals with cancer. By integrating narrative accounts with structured caregiver briefs, this research aims to illuminate the complex interplay between emotional distress, coping orientation, social support, spirituality, and meaning-making processes. Figure 1 illustrates the caregiver experiences characterised by substantial emotional burden as identified through thematic analysis.

Figure 1. Conceptual Model of Caregiver Experience Identified Through Thematic Analysis

The findings seek to inform culturally sensitive psychosocial interventions that support caregiver well-being alongside patient care

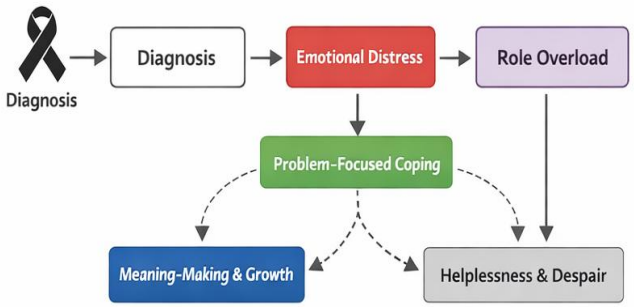
Psychological Burden of Cancer Caregiving

A substantial body of literature documents the psychological toll of cancer caregiving. Caregivers frequently report high levels of anxiety and depressive symptoms, often exceeding those experienced by patients themselves. Emotional distress is influenced by factors such as disease stage, treatment intensity, caregiving duration, and caregiver-patient relationship. Chronic exposure to uncertainty and anticipatory grief can lead to sustained psychological vulnerability.

Studies indicate that caregivers often suppress their own emotional needs while prioritizing patient care, leading to emotional exhaustion and burnout. Caregivers may experience guilt for feeling overwhelmed, helplessness in the face of disease progression, and fear of making incorrect medical decisions. These emotional responses are

compounded in contexts where caregiving is socially expected and rarely acknowledged as labor. Figure 2 illustrates the progressive psychosocial trajectory experienced by caregivers following the diagnosis of cancer .

Figure 2. Thematic Flow Diagram of Caregiver Adaptation



Coping Strategies in Cancer Caregivers

Coping strategies play a central role in shaping caregivers' psychological outcomes. Lazarus and Folkman's transactional model of stress and coping differentiates between problem-focused coping, emotion-focused coping, and avoidance-based strategies. Problem-focused coping involves active efforts to manage stressors through information seeking, planning, and practical problem-solving. Emotion-focused coping aims to regulate emotional responses through expression, acceptance, or spiritual practices. Avoidant coping, including denial and disengagement, may provide short-term relief but is generally associated with poorer psychological outcomes.

Empirical studies suggest that caregivers who predominantly engage in problem-focused coping report lower levels of distress and greater perceived control. Emotion-focused coping demonstrates mixed outcomes, depending on contextual support and emotional resources. In contrast, avoidant coping has been consistently linked to increased anxiety, depression, and caregiver burden.

Perceived Social Support

Perceived social support is a well-established protective factor for psychological well-being. Support may be emotional (empathy, understanding), instrumental (practical assistance), or informational (guidance and advice). The MSPSS conceptualizes support as originating from family, friends, and significant others.

Among cancer caregivers, higher perceived social support is associated with reduced emotional distress, improved coping capacity, and greater resilience. However, support is often unevenly distributed. Caregivers may feel abandoned by extended family or socially isolated due to the demanding nature of caregiving. Cultural norms that position caregiving as a moral duty may further inhibit caregivers from seeking help.

Spirituality and Meaning-Making

Spirituality and religious coping have emerged as salient resources for caregivers, particularly in collectivist and religious societies. Spiritual beliefs can provide a framework for understanding illness, sustaining hope, and tolerating uncertainty. Practices such as prayer, meditation, and religious rituals offer emotional containment and a sense of connection to transcendent sources of meaning.

Meaning-making refers to the process through which individuals reframe adversity, derive purpose from suffering, and integrate challenging experiences into their life narrative. Caregivers who engage in meaning-making

demonstrate greater psychological resilience and acceptance, whereas those who remain fixated on perceived injustice or loss are more likely to experience helplessness and despair.

Gaps in Existing Literature

Despite growing attention to caregiver experiences, several gaps remain. Quantitative studies often overlook contextual and cultural dimensions of caregiving. Moreover, coping and social support are frequently examined in isolation rather than as interrelated processes embedded within lived experience. Qualitative case series can address these gaps by offering nuanced insights into how caregivers navigate emotional, relational, and existential challenges over time.

Methods

Study Design

A qualitative case series design was adopted to explore caregiving experiences in depth. This approach allows for cross-case comparison while preserving individual contextual richness. Thematic analysis was employed as the primary analytic method.

Participants and Data Sources

The study involved ten caregivers of individuals diagnosed with various cancers and consisted of detailed narrative accounts collected through in-depth interviews supplemented with validated assessments of coping strategies and perceived social support.

Caregivers varied in age, gender, relationship to the patient, socio-economic background, and caregiving duration as given in Table 1. This diversity facilitated exploration of common themes across heterogeneous contexts.

Table 1. Sociodemographic and Clinical Characteristics of Caregiver–Patient Dyads (N = 10)

Case	Caregiver (Relationship / Age)	Patient (Age)	Cancer Type	Care Setting	Socio-Economic Context	Duration of Caregiving	Perceived Social Support
1	Male, Husband (40s)	34	Breast cancer	Urban hospital	Middle income	~2 years	High
2	Female, Mother (40s)	32	Colon cancer	Urban hospital	Middle income	~3 years	Low–Moderate
3	Female, Wife (60)	64	Pancreatic cancer	Urban hospital	Middle income	~1 year	Low

4	Female, Daughter (34)	63	Renal cell carcinoma	Semi-urban	Middle income	~4 years	High
5	Female, Wife (56)	59	Colorectal cancer	Urban tertiary care	Govt employee	~4 years	Moderate
6	Female, Mother (32)	5	Rhabdomyosarcoma	Rural hospital	Low income	~2 years	High
7	Female, Daughter (32)	55	Uterine cancer	Urban hospital	Middle income	~1 year	High
8	Male, Nephew (36)	56	Stage IV ovarian cancer	Urban private care	High income	~1 year	Low
9	Parents (28, 30)	2	Retinoblastoma	Urban tertiary care	High income	~1 year	High
10	Male, Father (40)	15	Blood cancer	Urban tertiary care	High income	~1 year	High

Data collection and Analysis

Cancer caregivers in the waiting area of hospitals in Delhi and the National Capital Region were directly approached to collect the data for this study. Participants were given a study information sheet to explain the purpose of the study and their contribution in the study. After giving the information about study, consent was received from participants to use the data for research purposes. Before interviewing the caregivers and asking questions, a rapport was established with them and they were assured about the confidentiality of data.

Data analysis followed Braun and Clarke's six-step thematic analysis framework: familiarization, initial code generation, theme searching, theme review, theme definition and naming, and report production. Coding was inductive and semantic, focusing on explicit meanings within the data. Reflexive memo-writing supported analytic depth and rigor.

Trustworthiness

Credibility was enhanced through prolonged engagement with the data and iterative coding. Dependability was supported by maintaining an audit trail documenting analytic decisions. Confirmability was addressed through reflexive awareness of researcher assumptions. Thick descriptions were provided to facilitate transferability.

Results

Based on the interview, a coding sheet was developed and six overarching themes emerged from the analysis.

Table 2 outlines the coding framework generated through thematic analysis illustrating the development of code categories, initial codes and underlying conceptual focus derived through participants' responses.

Table 2. Coding Framework Used in Inductive Thematic Analysis

Code Category	Initial Codes	Conceptual Focus
Emotional Distress	Anxiety, fear, sadness, guilt, anger, helplessness	Psychological burden
Role Strain	Job loss, caregiver overload, multitasking, sacrifice	Role disruption
Coping Orientation	Planning, acceptance, denial, withdrawal	Stress regulation
Spiritual Coping	Prayer, faith, religious rituals	Meaning and resilience
Social Support	Family help, spousal support, abandonment	Interpersonal resources
Meaning Apprisal	Hope, resilience, fatalism, injustice	Cognitive interpretation

Table 3 illustrates the major themes and corresponding subthemes emerged through thematic analysis of participants' responses.

Table 3. Themes and Subthemes Derived From Thematic Analysis

Major Theme	Subthemes	Representative Case Examples
Emotional burden and persistent psychological distress	Anxiety, anticipatory grief, guilt	Cases 1, 2, 3, 8
Role overload and life disruption	Employment loss, family conflict	Cases 4, 5
Divergent coping orientations	Problem-focused, emotion-focused, avoidant	All cases

Spirituality as psychological anchor	Faith reliance, surrender, hope	Cases 1, 4, 6, 10
Unequal distribution of social support	Strong support vs isolation	Cases 2, 3, 8
Meaning-making versus helplessness	Resilience vs despair	Cases 4 vs 2

Table 4 provides a conceptual mapping of coping strategies to psychological outcomes, highlighting the relationship between coping styles, observed behaviour patterns and associated emotional outcomes among participants.

Table 4. Mapping of Coping Strategies to Psychological Outcomes

Coping Style	**Observed Behaviors**	**Emotional Outcome**
Problem-focused	Information seeking, planning, advocacy	Better emotional regulation
Emotion-focused	Crying, prayer, emotional expression	Mixed outcomes
Avoidant	Denial, withdrawal, distraction	Heightened distress

Table 5 presents verbatim quotes from participants that illustrate and substantiate major themes identified through thematic analysis.

Table 5. Selected Verbatim Quotes Supporting Major Themes

Theme	**Illustrative Quote**
Emotional distress	"I am helpless watching his pain; it never leaves my mind."
Role overload	"I left my job because there was no one else to care for him."
Coping orientation	"I decided to learn everything about the disease so I could help."
Spirituality	"Prayer gives me strength when nothing else works."

Social support	"No one asks how I am coping; they only ask about the patient."
Meaning-making	"This journey changed me; I am stronger now."

Six major themes which emerged through thematic analysis were (1) emotional burden and persistent psychological distress, (2) role overload and life disruption, (3) divergent coping orientations, (4) spirituality as a psychological anchor, (5) unequal distribution of perceived social support, and (6) meaning-making versus helplessness

Theme 1: Emotional Burden and Persistent Psychological Distress

Caregivers consistently described intense emotional distress marked by anxiety, sadness, guilt, and helplessness. Many articulated a sense of constant vigilance and emotional exhaustion. Mothers and spouses reported particularly high levels of distress, often expressing self-blame and anticipatory grief.

A caregiver stated, "I feel helpless watching him suffer. Every day I ask myself if I am doing enough, if I missed something important."

Theme 2: Role Overload and Life Disruption

Caregiving resulted in significant role strain and life disruption. Several caregivers reported resigning from employment, neglecting personal health, and sacrificing social relationships. Managing multiple dependents alongside caregiving intensified stress, particularly in financially constrained households.

Theme 3: Divergent Coping Orientations

Caregivers demonstrated three primary coping trajectories.

Problem-focused coping involved active engagement with healthcare providers, information seeking, and structured planning. These caregivers reported a greater sense of agency.

Emotion-focused coping included emotional expression, crying, and seeking comfort through prayer or conversation. Outcomes varied depending on support availability.

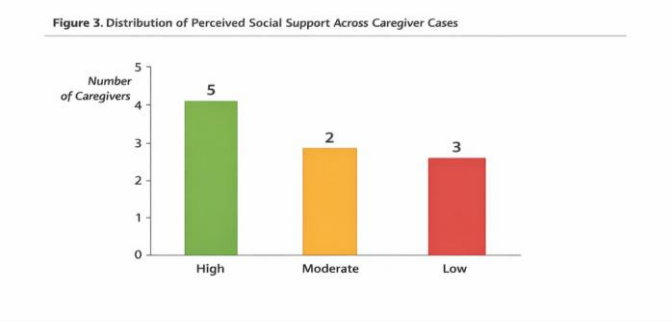
Avoidant coping, characterized by denial and emotional withdrawal, was associated with heightened distress.

Theme 4: Spirituality as a Psychological Anchor

Spiritual beliefs emerged as a powerful source of resilience. Caregivers described prayer and religious rituals as providing emotional stability and meaning. Spirituality facilitated acceptance and a sense of shared burden with a higher power.

Theme 5: Unequal Distribution of Social Support

Perceived social support varied markedly. Five number of caregivers reported strong family involvement, two caregivers had moderate social support while three caregivers experienced isolation and abandonment. Lack of support exacerbated emotional exhaustion and reliance on avoidant coping.



Theme 6: Meaning-Making Versus Helplessness

Caregivers differed in their cognitive appraisal of caregiving. Those who reframed adversity as meaningful demonstrated resilience, whereas others remained fixated on loss and injustice, leading to despair.

Figures 1-3 present the conceptual model of experiences of caregivers identified through thematic analysis, flow diagram of caregivers adaptation and distribution of perceived social support across caregiver cases, collectively illustrating psychological experiences, adaptive processes and support patterns among caregivers.

Discussion

This study highlights the complex interplay between coping orientation, perceived social support, spirituality, and emotional adjustment among cancer caregivers. Problem-focused coping and strong support networks functioned as protective factors, while avoidant coping and social isolation intensified distress. Cultural expectations surrounding caregiving influenced emotional expression and help-seeking behaviors.

Implications for Practice

Routine psychological screening of caregivers and interventions targeting maladaptive coping and strengthening social support systems are essential for the well being of caregivers. Further,integrating spirituality-informed care may enhance cultural relevance and effectiveness.

Limitations

The small sample size and cultural specificity limit generalizability. Longitudinal research is needed to examine changes over time.

Conclusion

Cancer caregiving is an emotionally complex and deeply contextual experience. Qualitative thematic analysis reveals psychosocial dynamics that remain hidden in quantitative assessments. Tailored, culturally sensitive psychosocial interventions are necessary to support caregiver well-being and sustain informal care systems.

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