Quality of Life and Mental Health of Family Members of People in Oncological Treatment

Qualidade de Vida e Saúde Mental de Familiares de Pessoas em Tratamento Oncológico

Calidad de Vida y Salud Mental de Familiares de Personas en Tratamiento Oncológico

RESUMO

Objetivo: Avaliar a qualidade de vida e analisar sua relação com sintomas de ansiedade e depressão em familiares de pessoas em tratamento oncológico. Método: Estudo quantitativo, analítico-descritivo e transversal, realizado com 84 familiares de pacientes em tratamento oncológico em uma unidade de alta complexidade no interior da Bahia. Foram utilizados instrumentos para avaliação da qualidade de vida, ansiedade e depressão. Os dados foram analisados por meio de estatística descritiva e testes de correlação e comparação entre grupos. Resultados: O índice geral de qualidade de vida foi satisfatório, com maior comprometimento nos domínios meio ambiente e psicológico. Sintomas de ansiedade e depressão foram identificados em parcela expressiva dos participantes e apresentaram correlação negativa com todos os domínios da qualidade de vida, especialmente os domínios físico e psicológico. Conclusão: Sintomas de ansiedade e depressão estão associados à pior qualidade de vida dos familiares, evidenciando a necessidade de ações voltadas ao cuidado integral e à saúde mental dessa população.

DESCRITORES: Oncologia; Qualidade de Vida; Ansiedade; Depressão; Cuidadores

ABSTRACT

Objective: To assess quality of life and analyze its relationship with symptoms of anxiety and depression among family members of patients undergoing cancer treatment. **Method:** A quantitative, descriptive-analytical, cross-sectional study was conducted with 84 family members of patients undergoing cancer treatment at a high-complexity facility in the interior of Bahia. Instruments were used to assess quality of life, anxiety, and depression. The data were analyzed using descriptive statistics, correlation tests, and between-group comparisons. **Results:** The overall quality of life index was satisfactory, with greater impairment in the environmental and psychological domains. Symptoms of anxiety and depression were identified in a significant proportion of the participants and showed a negative correlation with all domains of quality of life, especially the physical and psychological domains**. Conclusion:** Symptoms of anxiety and depression are associated with a poorer quality of life among family members, highlighting the need for interventions focused on comprehensive care and mental health for this population.

DESCRIPTORS: Oncology; Quality of Life; Anxiety; Depression; Caregivers

RESUMEN

Objetivo: Evaluar la calidad de vida y analizar su relación con los síntomas de ansiedad y depresión en los familiares de personas en tratamiento oncológico. **Método:** Estudio cuantitativo, analítico-descriptivo y transversal, realizado con 84 familiares de pacientes en tratamiento oncológico en un centro de alta complejidad del interior de Bahía. Se utilizaron instrumentos para evaluar la calidad de vida, la ansiedad y la depresión. Los datos se analizaron mediante estadística descriptiva y pruebas de correlación y comparación entre grupos. **Resultados:** El índice general de calidad de vida fue satisfactorio, con un mayor deterioro en los ámbitos ambiental y psicológico. Se identificaron síntomas de ansiedad y depresión en una parte significativa de los participantes y presentaron una correlación negativa con todos los ámbitos de la calidad de vida, especialmente en los ámbitos físico y psicológico. **Conclusión:** Los síntomas de ansiedad y depresión se asocian a una peor calidad de vida de los familiares, lo que pone de manifiesto la necesidad de medidas orientadas a la atención integral y a la salud mental de esta población.

DESCRIPTORES: Oncología; Calidad de vida; Ansiedad; Depresión; Cuidadores

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INTRODUCTION

The incidence of cancer in Brazil and worldwide has shown a steady increase in recent decades, emerging as a major public health problem, with an upward trend associated primarily with population aging and demographic transition. In 2022, there were approximately 20 million new cases of cancer worldwide, with a projected significant increase in the coming decades. The World Health Organization (WHO) estimates that cases could reach 35.3 million by 2050 (PAHO, 2024). In this context, caring for people with malignant neoplasms has become an increasingly common reality in families' daily lives, leading to significant changes in family dynamics and requiring a reorganization of daily activities to meet the demands of treatment. Thus, the diagnosis of a serious disease, such as cancer, affects not only the individual who is ill but the entire family, which comes to experience the illness as a shared process (OLIVEIRA et al., 2026; MORAES; SANTANA, 2024).

Cancer is a major public health problem and one of the leading causes of premature death worldwide, especially among people under 70 years of age (INCA, 2020; PAHO, 2024). The cancer treatment journey, in turn, is often marked by multiple side effects, which significantly compromise patients' quality of life (QOL). Recent studies show that the majority of cancer patients—approximately 78.5%—experience adverse effects resulting from treatment, highlighting the high frequency of these manifestations and their impact on the therapeutic experience (DEMILIE et al., 2025; KATTA et al., 2023). Thus, the process involving diagnosis and treatment is recognized as a potentially stressful experience, with repercussions on the biopsychosocial and spiritual dimensions, affecting both the patient and their family members (HOSSEINI et al., 2016; CORDEIRO; SANTOS; ORLANDI, 2021; MILLIRON et al., 2022).

In this regard, although technological advances have expanded the possibilities for prevention, early detection, and treatment, cancer is still frequently associated, in the social imagination, with incurability and the possibility of death, which contributes to the creation of stigmas and feelings of fear related to the disease (OLIVEIRA et al., 2026; GONÇALVES et al., 2024). This perception leads to cancer being experienced as one of the most feared and painful experiences, not only for the patient but also for their family members, impacting emotional, social, and psychological aspects[1,2] . Added to this is the fact that cancer treatments are generally prolonged, invasive, and exhausting, requiring continuous monitoring and causing significant changes in the daily lives of patients and their families[3].

Given this scenario, the central role played by family caregivers in the care process stands out. These individuals take on responsibilities that encompass physical, emotional, informational, and functional support—ranging from assistance with daily activities to accompanying patients to medical appointments and managing symptoms—in addition to contributing to treatment adherence [4,5] . However, despite their importance, attention to the needs of these caregivers is still often neglected. Evidence indicates that family members of cancer patients devote a significant amount of time to caregiving—often more than 20 hours per week—which can result in significant physical and emotional strain [6,7] .

As a result, the burden associated with caregiving negatively impacts the physical, emotional, and psychosocial health of family members, contributing to the emergence of symptoms such as anxiety, fear, uncertainty, guilt, helplessness, and exhaustion [4,7,8] . These conditions can compromise not only the well-being of the family caregiver but also the quality of care provided. Corroborating this scenario, a study identified a high prevalence of symptoms of anxiety (41.5%) and depression (15.4%) among family members of people with cancer, with these conditions being associated with a decline in health-related quality of life [9] .

In addition, mental disorders constitute a major global public health problem, accounting for a significant burden of morbidity and mortality [10,11] . These conditions are influenced by multiple factors, including psychological, social, and contextual aspects, and are often triggered or exacerbated by situations of intense stress, such as a cancer diagnosis. In this context, the hospital environment and the demands of cancer treatment tend to intensify these factors, directly impacting patients and their families [12] .

Thus, there is a clear need to expand scientific research aimed at understanding the quality of life and mental health of family members of people undergoing cancer treatment, given the social relevance of the topic and its impact on comprehensive care. Identifying the factors associated with a reduced quality of life and the development of mental disorders can inform the development of more effective and integrated intervention strategies that address not only the patient but also the family caregiver.

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Thus, the guiding question of this study is: "What is the level of quality of life and its relationship to mental disorders among family members of people with cancer?" The study is justified by the need to deepen our understanding of this topic, which remains under-explored in both national and international literature, thereby contributing to the development of more comprehensive care practices that recognize family members as a fundamental element in the oncology care process.

METHODS

Type of Study

A quantitative, analytical-descriptive, cross-sectional study linked to the parent project "QUALITY OF LIFE SCALE FOR FAMILY MEMBERS OF PEOPLE WITH CANCER EQV-FAMC: ADAPTATION OF A GENERIC MEASURE."

Study Location and Period

Conducted at a High-Complexity Oncology Unit (UNACON) located in a city in the interior of Bahia. Data collection took place between September 2022 and January 2023.

Population, sample, and participant selection

The study population consisted of 84 family members of people with cancer undergoing oncological treatment at UNACON. The sample was selected based on convenience/accessibility. Participants were included if they were 18 years of age or older, had a family member undergoing cancer treatment at the unit, lived with and maintained an ongoing relationship with the patient, accompanied the patient through at least one stage of treatment, and agreed to participate in the study by signing the Informed Consent Form (ICF). Family members undergoing medical treatment for mental disorders were excluded.

Study Variables

The variables investigated included sociodemographic and clinical characteristics of family members, as well as scores for quality of life, anxiety, and depression. The sociodemographic variables included age, sex, income, marital status, education level, religion, employment status, and municipality of residence. Clinical and family variables included degree of kinship, living with the ill family member, previous experience with cancer in the family, duration of treatment, patient age, and type of cancer.

Data Collection Instruments

Data collection was conducted using four instruments: a sociodemographic and clinical questionnaire, designed to characterize family members; *the World Health Organization Quality of Life-bref* (WHOQOL-bref) [13], an instrument consisting of 26 questions distributed across the domains of physical health, psychological well-being, social relationships, and the environment, used to assess quality of life. Responses follow a 1–5 *Likert* scale, with scores converted to a scale of 0–100; *the Generalized Anxiety Disorder-7* (GAD-7) [14] , consisting of seven items designed to screen for anxiety symptoms, with a total score ranging from 0 to 21; *Patient Health Questionnaire-9* (PHQ-9) [15] , consisting of nine items to identify depressive symptoms, with a total score ranging from 0 to 27.

Data Collection Procedure

Participants were approached in the clinic's waiting room before or after their family member's treatment. After receiving an explanation of the study's objectives, eligible participants were directed to a private room, where they read and signed the informed consent form and subsequently completed the questionnaires in an interview format. Data collection was conducted by researchers who had been previously trained to standardize the interviews and ensure data reliability.

Data Organization and Analysis

The data were stored in the *Research Electronic Data Capture* (REDCap) system and subsequently exported to the *Statistical Package for the Social Sciences* (SPSS®), version 22.0. In the descriptive analysis, categorical variables were presented as absolute and relative frequencies, while quantitative variables were analyzed using measures of central tendency and dispersion. Data normality was assessed using the *Kolmogorov-Smirnov* test. Given the nonparametric distribution, *Spearman's* correlation coefficient was used to evaluate the correlation between the domains of quality of life and the anxiety and depression scores. For comparisons between independent groups, the *Mann-Whitney* test was applied. A significance level of 5% was adopted.

Ethical Considerations

The study followed the ethical guidelines set forth in Resolutions No. 466/2012 and No. 510/2016 of the National Health Council. All participants signed the informed consent form, guaranteeing anonymity, confidentiality, and the freedom to withdraw from the study at any time. Registered under Research Ethics Committee (CEP) approval number 3,026,668 from the State University of Feira de Santana (UEFS) and the Certificate of Submission for Ethical Review (CAAE) No. 91689518.1.0000.0053.

RESULTS

Characterization of family members and individuals undergoing cancer treatment

A total of 84 family members of

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people undergoing cancer treatment were interviewed. Based on the data extracted during the first stage of data collection—which focused on the sociodemographic characteristics of the family members—it was observed that the majority were female (76.2%), children of the hospitalized patient (56%), with a mean age of 41.3 years (± 12.8), the majority of whom were Catholic (52.4%), married (41.7%), with a high school education (45.2%), employed (34.5%), residing in a city other than where their relative is receiving treatment (53.6%), living with the hospitalized relative (53.6%), and with no prior experience accompanying other relatives undergoing cancer treatment (78.6%).

Regarding the clinical characteristics of the family members, 42.9% reported engaging in regular physical activity, and the majority had no comorbidities (64.3%). In addition, 45.2% of family members experienced some form of physical pain, 6.0% had some type of cognitive problem (memory, reasoning, communication), and 2.4% had a psychological problem; 25% reported undergoing some form of medical treatment. Furthermore, there was a predominance of family members with and without anxiety symptoms as assessed by the GAD-7 scale (45.2% and 53.6%, respectively), and twenty-four family members with depressive symptoms (28.6%) and fifty-nine family members without depressive symptoms (70.2%) (Table 1).

Table 1 - Clinical data on family members of patients undergoing cancer treatment at a High-Complexity Unit in Feira de Santana, Bahia, from September 2022 to January 2023 (n=84).

Variables	Yes n (%)	No n (%)
Habits		
Smoking	2 (2,4)	81 (96,4)
Alcohol consumption (until intoxicated)	9 (10,7)	74 (88,1)
Regular physical activity	36 (42,9)	47 (56,0)
Absence of comorbidities	54 (64,3)	30 (35,7)
Comorbidity	18 (21,4)	66 (78,6)
Hypertension	3 (3,6)	81 (96,4)
Diabetes Mellitus	2 (2,4)	82 (97,6)
Heart disease	0	84 (100,0)
Stroke	0	84 (100,0)
Cancer	7 (8,3)	77 (91,7)
Self-reported physical pain	38 (45,2)	45 (53,6)
Self-reported cognitive problems	5 (6,0)	78 (92,9)
Self-reported psychological problems	2 (2,4)	80 (95,2)
Medical treatment	21 (25,0)	62 (73,8)
Anxiety symptoms (GAD-7)	38 (45,2)	45 (53,6)
Depressive symptoms (PHQ-9)	24 (28,6)	59 (70,1)

Source: Data processed by the author.

As for the patients, the majority were female (56%) with a mean age of 57.6 years (± 15.5) and a treatment duration of 19.1 months (± 27.3); breast cancer was the most common type (25%), followed by prostate cancer (15.6%) and colorectal cancer (15.6%).

Quality of life among family members of patients undergoing cancer treatment

The General Quality of Life Index (GQLI) showed an average score of 62.9 (±11.9), indicating a satisfactory quality of life. For item 1, "How would you rate your quality of life?", the score was 3.3 (±0.8), and for item 2, "How satisfied are you with your health?", the score was 3.2 (±0.8). Most family members rated their QoL as "Neither bad nor good" (48.8%). Regarding satisfaction with health, the majority reported being "Neither satisfied nor dissatisfied" (38.1%), while another group reported being "Satisfied" (38.1%).

It was observed that, in the analysis of the mean scores for the items in the Physical domain, item 16—which corresponds to the "Sleep and Rest" facet—had the lowest mean score (3.0); in contrast, items 03, 04, and 15 (which encompass the facets: Pain and Discomfort, Dependence on Medication or Treatments, and Mobility) had the highest scores: 4.0 (±1.2), 3.8 (±1.3), and 3.8 (±1.0), respectively. In terms of the total score, the Physical domain had the highest mean (65.5) among the others.

Items 20 and 22, which pertain to Personal Relationships and Social Support, yielded averages of 3.6 (±1.0) and 3.7 (±1.0), respectively; whereas the "Sexual Activity" facet of item 21 scored 3.5 (±1.0), which was the lowest in the category. "Social Relationships" had a total score of 65.4 (±19.4), second only to the "Physical" domain.

Among the items in the Psychological domain, item 05, "Positive Feelings," had the lowest mean (3.0), while items 06, 11, and 19—relating to

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the facets of Spirituality, Religion, and Personal Beliefs; Body image and appearance; and Self-esteem—achieved the highest scores and, consequently, a higher level of QoL: 4.0 (±0.8); 3.9 (±1.1); and 3.7 (±0.9), respectively. In terms of its total score, it showed one of the highest averages (64.3), second only to the Physical and Social domains as previously mentioned among the domains, thus indicating a moderate level of QoL.

The "Financial Resources" facet, assessed by item 12, and the "Participation and/or Opportunities for Recreation/Leisure" facet, assessed by item 14, both had the lowest averages, at 2.6 (±0.9), In contrast, item 09, which assesses the Physical Environment (pollution/noise/traffic/climate), followed by item 23 (Home Environment), had scores of 3.5 (±1.0) and 3.7 (±0.9), respectively; these two were the highest scores in this domain. The total score for the Environment domain had the lowest mean (54.4) among the other domains, and consequently indicated that families have a lower quality of life in this regard.

Table 2 shows the correlation between the WHOQOL-bref domains and the scores on the anxiety (GAD-7) and depression (PHQ-9) assessment scales, as measured by *Spearman's* correlation.

It was observed that a weak but significant negative correlation was found between the Physical domain and the GAD-7 score (r = -0.36; p-value = 0.001), followed by the correlation between the Psychological domain and the GAD-7 score (r = -0.34; p-value = 0.001), indicating that the higher these anxiety scores are among family members, the more their QoL in the Physical and Psychological domains tends to be impaired. In addition, the Social and Environmental domains showed a moderate negative but significant correlation (r = -0.29; p-value = 0.006 and r= -0.26; p-value = 0.017).

The Physical and Psychological domains, on the other hand, showed strong and significant negative correlations (r = -0.55 and p-value = 0.000, and r = -0.51 and p-value = 0.000, respectively) with the PHQ-9 score, thus confirming that the higher the PHQ-9 scores—that is, the more depressive symptoms family members exhibit—the lower the QoL scores in the Physical and Psychological domains, thus indicating a negative impact on these individuals' QoL.

Table 2 – Correlations* between GAD-7 and PHQ-9 scores and WHOQOL-bref domain scores, according to family members of individuals undergoing cancer treatment, Feira de Santana, Bahia, September 2022 to January 2023 (n = 83).

Domains	Anxiety r (p)	Depression r (p)
Physical	-0.36 (0.001)	-0.55 (0.000)
Social Relationships	-0.29 (0.006)	-0.27 (0.014)
Psychological	-0.34 (0.001)	-0.51 (0.000)
Environment	-0.26 (0.017)	-0.36 (0.001)

*: The correlation is significant at the 0.01 level (p-value = 0.05).

SOURCE: Data processed by the author.

Table 3 shows the quality of life scores for the group of family members with GAD scores above 10 points, suggesting anxiety symptoms, and the QoL scores for the group of family members with scores below 9, indicating no anxiety symptoms.

When analyzing the difference between the groups (family members with anxiety symptoms vs. family members without anxiety symptoms), it is observed that in the Physical domain, family members without anxiety symptoms had the highest average QoL score (61.4) and a p-value of 0.025, indicating a significant difference between the two groups. Furthermore, in the Environmental domain, a mean of 54.1 (±15.8) was observed; this was the domain with the lowest mean, indicating that family members with anxiety symptoms tend to have their QoL in the Environmental domain impaired. However, it was not possible to identify a significant difference between the groups (p-value = 0.155).

Table 3 - Mean and standard deviation of the WHOQOL-bref and GAD-7 domains, as reported by family members of cancer patients, Feira de Santana, Bahia, September 2022 through January 2023 (n=83).

Domains	Family members with anxiety symptoms (n=38)		Family members without anxiety symptoms (n=45)		p-value*
	$\bar{x}$	SD	$\bar{x}$	SD	
Physical	61.4	16.1	68.9	11.8	0.025
Social Relationships	60.3	21.3	69.7	16.9	0.058
Psychological	60.9	15.5	67.1	12.8	0.100
Environment	54.1	15.8	58.5	11.6	0.155

*: p-value <0.05, Mann-Whitney test.

Source: Data processed by the author.

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Analysis of QoL scores among family members with positive and negative symptoms of depression revealed that, in most domains, there were significant differences between the groups.

In the group of family members with depressive symptoms, the following means were observed: Physical domain (55.8; p-value = 0.000), Psychological domain (54.5; p-value = 0.000), and Environment domain (51.2; p-value = 0.030), with the latter being the lowest, indicating that family members with depressive symptoms tend to have their Environment domain of QoL impaired (Table 4).

In the Social Relationships domain, the score was 59.0 and the p-value was 0.107, revealing that there was no significant difference between the groups; however, the score in the group of family members without depressive symptoms showed an average difference of approximately 9 points, indicating a statistical discrepancy. This discrepancy was likely due to the influence of the small sample size.

Table 4 - Mean and standard deviation of the WHOQOL-bref and PHQ-9 domains, according to family members of individuals undergoing cancer treatment, Feira de Santana, Bahia, September 2022 to January 2023 (n=83).

Domains	Family members with depressive symptoms (n=24)		Family members without depressive symptoms (n=59)		p-value*
	$\bar{x}$	SD	$\bar{x}$	SD	
Physical	55.8	15.1	69.4	12.1	0.000
Social	59.0	20.9	68.0	18.4	0.107
Psychological	54.5	14.6	68.3	12.2	0.000
Environment	51.2	15.6	58.6	12.5	0.030

* <0.05, Mann-Whitney test.

Source: Data processed by the author.

DISCUSSION

Cancer has a significant impact not only on the life of the person with the disease but also on the physical, emotional, and social health of family members involved in caregiving, especially those who assume the role of primary caregiver [16,17] . Recent studies show that family caregivers experience high levels of psychological distress, emotional overload, and impaired quality of life (QOL), particularly in the face of changes imposed by the treatment regimen and the ongoing demands of care [18] .

The predominance of female family members observed in this study is consistent with evidence from previous research, which indicates that women are primarily responsible for supporting and caring for family members who are ill [16,19,20] . The literature indicates that sociocultural factors related to gender roles lead women—primarily wives and daughters—to assume the majority of responsibility for family care, making them more vulnerable to physical and emotional overload [8,20] .

The "Environment" domain showed the greatest impairment of QoL, suggesting a direct influence of socioeconomic conditions, access to health services, transportation, and leisure opportunities on family members' well-being. These findings corroborate previous studies that identified a significant financial impact resulting from cancer treatment, including expenses related to food, medications, transportation, and time off work [21,22] .

Furthermore, the limitation of leisure activities observed in this study supports previous findings showing that family caregivers often reduce or abandon opportunities for self-care and recreation due to their ongoing dedication to the patient. This context contributes to the impairment of social life and well-being, since feelings of excessive responsibility and guilt when prioritizing personal needs can lead to social isolation and a more negative perception of quality of life [22,23] . Another factor that can compromise family members' quality of life relates to difficulties in accessing health care services. The indirect costs of treatment, combined with the need for frequent and often prolonged travel, represent an additional source of physical, emotional, and financial strain, particularly among families in situations of greater socioeconomic vulnerability [8] .

The psychological domain showed significant impairment, indicating considerable emotional distress among family members. Reduced life satisfaction and difficulty concentrating among family caregivers, fear of disease progression, uncertainty regarding the prognosis, and constant concern for the ill family member contribute to the onset of anxiety, sadness, distress, and a sense of helplessness [22,23,24] . Another relevant aspect concerns the difficulty family members have in practicing self-care. The burden of responsibilities and the focus on the patient's care contribute to the neglect of their own physical and emotional needs, including a lack of physical activity, sleep disturbances, and reduced rest time. Studies show that family caregivers are at greater risk of physical exhaustion and psychological distress, especially when they have a weak social support network [19,20] .

The repercussions of cancer ex-

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tend beyond the physical and clinical spheres, also affecting aspects related to intimacy, sexuality, and interpersonal relationships. The emotional burden and changes resulting from the illness and treatment process can reduce emotional closeness between partners and compromise the quality of social relationships, contributing to a poorer perception of quality of life among family caregivers [8,23].

Although the Physical domain had the highest scores, the persistence of sleep- and fatigue-related impairments suggests that the demands of caregiving may negatively impact family members' physical health. Changes in sleep patterns, exhaustion, and reduced energy for daily activities have frequently been described among caregivers, reflecting the cumulative impact of caregiving demands and emotional burnout [22,23,25].

Additionally, the association between lower quality-of-life scores and higher levels of anxiety and depression reinforces the close relationship between psychological distress and overall well-being. This finding aligns with evidence pointing to a high prevalence of anxiety and depressive symptoms among family members of cancer patients, highlighting the need for psychological support strategies aimed not only at the patient but also at their family support network [19].

The most significant association was observed between depressive symptoms and the physical domain of quality of life, suggesting that emotional distress may directly affect physical well-being, functional capacity, and sleep quality. Evidence from the literature indicates that the psychological impact of long-term caregiving promotes the emergence of somatic symptoms and contributes to a worsening of caregivers' overall health [20,24]. Furthermore, studies indicate that family members of cancer patients may experience levels of emotional distress equal to or even greater than those of the patients themselves, especially due to uncertainties related to the disease's progression, the risk of recurrence, and the possibility of losing a loved one [20,24]. The persistence of unmet emotional and psychological needs has also been associated with increased psychological distress and a poorer quality of life for these individuals [24].

In light of these findings, it is essential to expand multidisciplinary care for family members, recognizing them as active participants in the therapeutic process. Strategies such as psychological support, support groups, discussion circles, health education initiatives, and strengthening communication among the healthcare team, the patient, and the family can help reduce emotional strain, promote a healthier approach to coping with illness, and improve caregivers' quality of life.

CONCLUSION

This study achieved its objective by assessing quality of life and analyzing its relationship with symptoms of anxiety and depression among family members of individuals undergoing cancer treatment. The results demonstrated that, although participants reported an overall level of quality of life considered satisfactory, significant impairments were identified in specific dimensions, particularly in the Environmental and Psychological domains. In addition, a high frequency of anxiety and depression symptoms was observed, which were associated with lower quality-of-life scores, highlighting the close relationship between psychological distress and the well-being of these family members.

The findings showed that higher levels of anxiety and depression were associated with lower quality-of-life scores across all domains assessed, with a particularly significant impact of depressive symptoms on the physical and psychological domains. It was also found that family members with symptoms of anxiety and depression had worse quality-of-life indicators compared to those without these symptoms, reinforcing the negative influence of emotional distress on the health and daily lives of caregivers.

Thus, the study highlights the need to recognize family members as individuals who also require attention in the context of cancer care, considering the emotional, physical, social, and environmental repercussions resulting from a family member's illness and treatment. The results point to the importance of implementing multidisciplinary strategies focused on providing support, monitoring mental health, and promoting quality of life for this population, thereby fostering a more comprehensive approach to care.

Notable limitations include the cross-sectional design, which makes it impossible to establish causal relationships between the variables under investigation; the use of a convenience sample; and the sample size, all of which are factors that may limit the generalizability of the results. In this regard, we recommend conducting longitudinal studies with larger and more diverse samples to deepen our understanding of the factors associated with the quality of life and mental health of family members. In addition, future research could explore coping strategies, protective factors, and interventions aimed at promoting the mental health and well-being of these individuals throughout the cancer treatment journey.

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