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Cancer, disability and dependency. The importance of support networks in cancer patients: perspective from Health Social Work

Alberto García Martín
Universidad de Salamanca
Nuria del Álamo Gómez
Universidad de Salamanca
Eduardo José Fernández Rodríguez
Universidad de Salamanca
Celia Sánchez Gómez
Universidad de Salamanca

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ENG **Abstract.** Cancer is one of the main socio-health problems in the world. The ageing of the Spanish population together with the high survival rates of cancer patients means that the number of centenarians in our country is increasing. The diagnosis and the evolutionary process of the disease generates situations of disability and dependence in the sick patient that affect him or herself, but also the family dynamics. The family is one of the main caregivers of the sick patient, and the role of main caregiver commonly falls on the female gender in the first degree of consanguinity, as is supported by this research. These careers may have an objective and subjective burden in caring for the sick patient. The Dependency Law is insufficient in its application and late in granting aid. The discipline of Social Work must be a guarantor of dignity for the sick patient and the main caregiver, anticipating future events of social needs derived from the oncological disease.

Keywords: social intervention, social services, dependency, support networks, social work.

ES Cáncer, discapacidad y dependencia. La importancia de las redes de apoyo en el paciente con cáncer: perspectiva desde el Trabajo Social Sanitario

Resumen. La enfermedad de cáncer es uno de los principales problemas sociosanitarios en el mundo. El envejecimiento de la población española unido a las altas tasas de supervivencia de pacientes con cáncer hacen que el número de centenarios en nuestro país aumente. El diagnóstico y el proceso evolutivo de la enfermedad genera situaciones de discapacidad y dependencia en el paciente enfermo que afectan a este mismo, pero también a la dinámica familiar . La familia es uno de los principales sustentadores de cuidado del paciente enfermo, el rol de cuidador principal recae comúnmente en género femenino en primer grado de consanguinidad como así lo avala la presente investigación. Estos cuidadores pueden presentar carga objetiva y subjetiva en el cuidado del paciente enfermo. La Ley de Dependencia resulta insuficiente en su aplicación y tardía en la concesión de ayudas. La disciplina de Trabajo Social debe ser garante de dignidad en el paciente enfermo y en el cuidador principal, adelantándose a futuros acontecimientos de necesidades sociales derivadas de la enfermedad oncológica.

Palabras clave: intervención social, servicios sociales, dependencia, redes de apoyo, trabajo social.

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1. Introduction

In recent decades, advances in oncological research have made it possible to increase the survival of cancer patients through new hopeful treatments.

The cancer patient has gradually come to be considered as a being with his or her own identity and biopsychosocial characteristics; thus, being the focus of attention and social intervention from the moment of diagnosis and during the evolutionary process of his or her disease, considering his or her multiple needs.

The total European population is projected to increase, slightly, from 446.8 million at the beginning of 2019, to a maximum of 449.3 million during the period 2026-2029, before falling to 441.9 million in 2050; thus, increasing with this phenomenon the number of centenarians, from 90.5 million at the beginning of 2019, to 129.8 million in 2050 (Pérez, 2018).

The aging of the population is directly related to chronic diseases, including cancer. This fact, added to the high survival rates of patients affected by this disease, makes it necessary to give special consideration to this group and their biopsychosocial needs.

The evolution of the disease generates situations of disability and dependence; it produces loss or anomaly of organs or body parts, functional limitations of the person, limitations in the work or school environment, difficulties in performing activities of daily living, contextual limitations with the social environment, etc. (Abellán and Hidalgo, 2011), which often makes the patient dependent on material support, support from third parties or other professional support.

The disease has a major impact on all areas of the person and their families; it produces a considerable increase in the care needs of the patient's family, modifies family dynamics, as well as roles and responsibilities. The oncology patient unconsciously subjects the family nucleus to modifications in the performance of roles; the patient becomes the nucleus of attention and care, even if hospitalization is involved in the process (Gallo, Niyirhet and Fuentes, 2006).

The family is a basic pillar in the provision of care for the dependent person, but caring for the cancer patient is complex and requires different knowledge, skills and resources (Rodríguez, 2013; Rodríguez and Rihuete, 2011; Giraldo, Zuluaga and Uribe, 2018), thus involving modification of different family habits, changes in schedules, roles, adaptations to daily life and an investment in time directly proportional to the level of disability and dependence of the person to be cared for, the complexity of their care and the length of time they have been suffering from the disease (Rodríguez and Rihuete, 2011).

The care of the sick patient is usually assumed by a single person, generally female and usually the result of a direct relationship, mother, wife or older sister who assumes the role of controlling the evolution of the disease (Rodríguez and Rihuete, 2011; Giraldo et al., 2018; López, et al. 2009). This caregiver modifies their routines since caring for the chronic patient has no limits in their "working day" and very often plays other simultaneous roles such as being a mother, father or worker (Sánchez, 2017; Achury, Castaño, Gómez and Guevara, 2011). Other authors have addressed this unequal dedication to caring for sick family members by gender, and the lack of social recognition and economic value that this entails (Duran, 2018), and call for an ethic of care that places it in a prominent place (Camps, 2021).

In an illness of this magnitude, the caregiver puts aside many things that made up his or her life up to that moment in order to care for the sick person. Thus, Moreira and Turrini (2011) show how the caregiver exercises his or her role "motivated by the search for a cure, but affected by disappointments, suffering and workload provided to the patient" (p.3).

The inordinate concern for the fear of something happening to the patient generates an almost complete dedication of the caregiver, often producing isolation, reducing activities that the caregiver himself/herself did in his/her daily life, even reducing or eliminating routines, and becoming a pseudo-prisoner of the care of the sick patient (Moreira and Turrini, 2011).

The quality of life of oncology patients, in their multiple biopsychosocial needs, is determined by the quality of care of the main informal caregiver and, therefore, of the latter's capacity for effective self-care in a disease as complex as cancer. In this context, Health Social Work acts in the face of the different determinants that affect the health of the individual as a point of union between the health system and the social system. Our discipline is also a guarantor of equity in a situation of illness and can provide effective care by studying the social and family context, providing support to both the patient and the family and being responsible within an individualised situation for achieving the maximum quality of life for the sick person (Agulló and Martín, 2020).

For all these reasons, the main objective of this research has been to evaluate the type of informal care provided to cancer patients.

2. Methodology

2.1. Study design

The study carried out was an epidemiological study of a randomised descriptive cross-sectional observational type without replacement, with prevalence of cancer disease in the Complejo Asistencial Universitario de Salamanca.

2.2. Study population

The study population consisted of persons with an anatomopathological diagnosis of cancer, and family members who are in the Medical Oncology Service and who receive outpatient treatment in the

Day Hospital and/or Radiotherapy Oncology Service of the Complejo Asistencial Universitario dede Salamanca.

The sample was duly informed of participation in the study and signed the informed consent form.

2.3. Sample selection criteria

Patients who met the following requirements were included in the study: having an anatomopathological diagnosis of cancer, being an oncology patient at the Complejo Asistencial Universitario de de Salamanca. (España), being over 18 years of age, and agreeing to participate voluntarily in this study.

Participants who met one of the following exclusion criteria were excluded from the study: not signing the informed consent document (even though they had agreed to participate voluntarily in the study), having already been evaluated for this study in a hospital admission or in previous outpatient care, and/or having a cognitive state that does not allow for understanding the study (Mini Mental score of less than 24, synonymous with mild cognitive impairment).

Patients who presented any of the following criteria were withdrawn from the study after their inclusion in the study: express request for withdrawal by the patient's family, even though they had completed the informed consent document, and/or failure to correctly complete any of the assessment instruments required for the study.

2.4. Sample size

In order to calculate the sample size, the following will be taken as a reference:

- **The total population of people diagnosed with cancer disease in the last five years in Spain** is 787,476 people according to data from the Observatory of the Spanish Association Against Cancer in 2019 (Wyman, 2020; Fernández and Del Castillo, 2018).
- **The total population of new diagnoses with cancer disease in Spain** is 275,562 people according to data from the 2019 Observatory of the Spanish Association Against Cancer (Wyman, 2020; Fernández and Del Castillo, 2018).
- **The total population of people diagnosed with cancer disease in the last five years in Castilla y León** is 49,725 people according to data from the 2019 Observatory of the Spanish Association Against Cancer (Wyman, 2020; Fernández and Del Castillo, 2018).
- **The total population of new diagnosed people with cancer disease in Castilla y León** is 17,592 people according to data from the 2019 Observatory of the Spanish Association Against Cancer (Wyman, 2020; Fernández and Del Castillo, 2018).
- **The total population of people diagnosed with cancer disease in the last five years in the province of Salamanca** is 7,043 people according to data from the Observatory of the Spanish Association Against Cancer in 2019 (Wyman, 2020; Fernández and Del Castillo, 2018).

The sample size (n = …) resulting from the use of formula (Figure 1) using parameter values and confidence levels (Table 1) for qualitative descriptive studies for finite population in health research, has been:

The sample size "n" = 364.33

The different data applied in the formula determine that the optimal result of our study corresponds to a sample size of 365 patients.

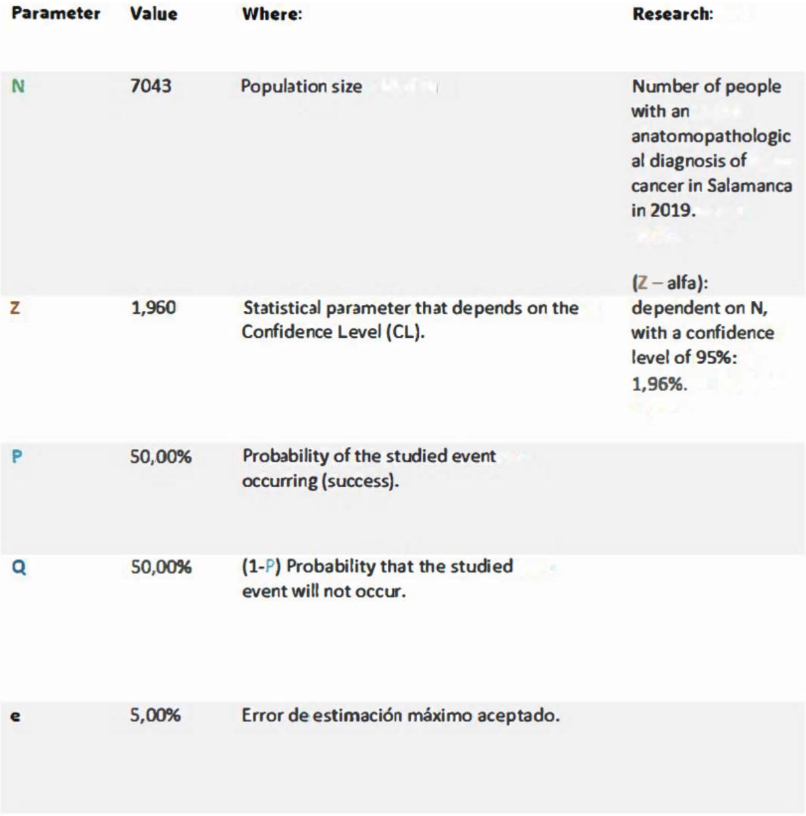
A total of 376 cancer patients were recruited, 4 were excluded and 7 were withdrawn, giving a final total sample size of 365 patients. The sample was balanced with 48.5% male and 51.5% female.

Figure 1. Formula for sample calculation in health research: sampling calculation that is representative for the study.

$$n=\frac{N^{*}Z_{\alpha^{2}}{}^{*}p^{*}q}{e^{2}{}^{*}(N-1)+Z_{\alpha^{2}}{}^{*}p^{*}q}$$

Source: Secretariat of Health of the State of Tabasco, Mexico, 2005.

Table 1. Parameters, values and confidence level of our research.



Parameter	Value	Where:	Research:
N	7043	Population size	Number of people with an anatomopathological diagnosis of cancer in Salamanca in 2019.
Z	1,960	Statistical parameter that depends on the Confidence Level (CL).	(Z – alfa): dependent on N, with a confidence level of 95%: 1,96%.
P	50,00%	Probability of the studied event occurring (success).	
Q	50,00%	(1-P) Probability that the studied event will not occur.	
e	5,00%	Error de estimación máximo aceptado.	

Source: Own elaboration, 2022.

2.5. Data collection

Data collection was carried out by means of a self-completion questionnaire specifically designed for the study, with no time sequence, at a single time for the patient and family member, and on a single occasion.

Data collection was carried out using a Microsoft Access database created specifically for this study. Statistical analysis was carried out using SPSS version 22.0.

The descriptive statistical analysis was carried out considering the maximum and minimum values obtained for each of the quantitative variables, as well as taking into account the presence of possible outlying values in the box plots. The determination of the outlying values and their consideration or not as part of the study was made through the boxplot, considering the F. Spread distance and classifying the outlying values into three types: adjacent values, close outlying values and distant outlying values. The far distant values have been those that have been determined to be removed from the study in the variables to avoid distortion by maintaining close distant values and adjacent values due to an ecological situation of patient participation in the study.

3. Results

The results show that the mean age of the oncology patient evaluated was 61.62 years (± 13.012), with a gender balance of 48.5% men and 51.5% women. The marital status of the patient was 63.8% married, followed by 14.5% single, 11% separated or divorced and 10.7% widowed.

The average number of treatments the cancer patients underwent was 1.51 treatments (± 0.653), the most important of which were surgery, chemotherapy, radiotherapy, hormone therapy and immunotherapy.

The average number of months that have elapsed for cancer patients since they were diagnosed with cancer was 29.72 months (± 42.032), highlighting the fact that this chronic disease has a long history of active treatments.

The place of residence of the sample was distributed; 55.3% of the oncology patients lived in urban areas and 44.7% lived in rural areas, travelling to receive treatment.

As for the side effects of the treatment, which are one of the main concerns of the patient and family, the following were reported: 1.1% had loss of appetite, 1.6% had nausea, dizziness, vomiting, diarrhoea and/or constipation, 2.7% had fatigue, 5.2% had other different side effects, 9.0% had alopecia, and up to 62.7% of the sample of oncology patients had two or more of these side effects at the same time.

The presence of associated comorbidities after diagnosis, understood as the appearance of several diseases at the same time, produced by the diagnosis and/or treatment itself were: 1.9% had comorbidities related to the genitourinary system, 4.4% had associated comorbidities related to the dermatological system, 6.8% related to the alimentary tract and metabolism, 10.7% related to the skeletal-muscular system, and up to 40.5% had several of these associated comorbidities at the same time after diagnosis.

The mean age of the main caregiver of the oncology patient was 57.19 years (± 14.052), with the female gender being the most represented, with 66.6% women and 33.4% men. The marital status of the main caregiver was 72.9% married, followed by 14% single, 3% separated or divorced, and 2.7% widowed. The degree of relationship of the main caregiver to the patient was 86% first degree, followed by 5.5% second degree and 0.8% a hired caregiver.

Considering the marital status of the cancer patient, the months elapsed since the time of diagnosis, the average number of treatments applied to their pathology and even the place of residence, we can intuit the degree of involvement of the main caregiver, only in biological terms of health care for the sick patient.

The presence of both side effects and associated comorbidities since diagnosis, and the fact that the patients themselves stated that there have been simultaneous side effects and other associated comorbidities, makes us intuit the possible physical limitations suffered since diagnosis and throughout active treatment, involving the main caregiver even more in the care of the patient.

The profile of the caregiver in the sample for the oncology patient was a main caregiver 4.43 years younger than the average age of the patient, female, married, and in the first degree of consanguinity; wife of the cancer patient, or daughter of the patient.

Considering the mean age, 57.19 years, and the standard deviation (± 14.052), we can identify a main caregiver in full capacity and carrying out work activities, who may even be taking care of household chores, family, care of the family environment, etc.

In the words of the World Health Organization [WHO] quoted in Rodríguez and Rihuete (2013), "the primary caregiver is the person in the patient's environment who voluntarily assumes the role of being responsible in its broadest sense and is willing to make decisions for the patient and for the patient and to cover the patient's basic needs directly or indirectly" (p. 136).

These results are similar to those obtained in reference research in the field, such as that of Rodríguez and collaborators (2011), in whose study, carried out on the influence of the dependence of cancer patients on the overload of their careers, they highlight how, of the sample of main careers, 82% corresponded to women, the main link being firstly that of "wife" and, secondly, that of daughter (Rodríguez and Rihuete, 2011). The family situation and the provision of help from it, has an impact as a social determinant on the health of the sick person and can improve personal and social coping with health and illness (Agulló and Martín, 2020).

Women are the main profile to emerge from informal family care. Since ancient times, the tasks of caring for a sick person have been linked and associated with a female gender role, with the peculiarity of its scarce social recognition, possibly related to the low visibility and value assigned to the care tasks performed (Rodríguez, 2013; Rodríguez and Rihuete, 2011; Giraldo, Zuluaga et al., 2018).

Adopting the role of primary caregiver has repercussions on family life and health (Rodríguez and Rihuete, 2011). The new reality means that the caregiver must adapt to different areas: home, friends, family, work, studies, health, etc., which in their failure to adapt to the new reality can cause personal imbalances.

The female primary caregiver is not paid for her care (Rodríguez, 2013; Rodríguez and Rihuete, 2011; Giraldo, Zuluaga et al., 2018) and we may be talking about caring for a person with a disability, high dependency, or incapacity that makes it difficult or impossible for her to carry out her normal life activities or relationships (Rodríguez, 2013; Rodríguez and Rihuete, 2011; Giraldo, Zuluaga et al., 2018). This macro social and economic dimension of the problem has been addressed by the so-called feminist perspective of care. In the words of Razavi (2007), in order to overcome the gender bias, deeply rooted in social protection systems, and to make citizenship truly inclusive, care must become a dimension of citizenship at the level of rights that are equal to those linked to remunerated work.

In cancer patients, care involves a high level of involvement and a great emotional burden; patients may suffer from wear and tear in their disease process, side effects of treatments (nausea, vomiting, dizziness, anaemia, alopecia, etc.), loss of autonomy, loss of the patient's own ability to carry out Activities of Daily Living (ADVD), food needs, hygiene needs, patient mobility, specific care, etc.

In the words of Giraldo, Zuluaga and Uribe (2018) "the caregivers' working day is usually long, most of them provide help for more than five hours and without a specific timetable, in the morning, afternoon and evening. This circumstance generates important changes in the life of caregivers at personal, family, work and social levels. Health problems appear, with a physical and emotional overload that can sometimes lead to the abandonment of the caregiving activity" (p. 91).

3.1. Objective and subjective burden of care in the oncology patient. Primary caregiver burden

The objective burden refers to the characteristics of the patient's care, and the subjective burden refers to the care provided by the main caregiver and the emotional impact of its application.

The objective burden depends on parameters such as the level of dependence of the patient or the patient, the patient's need for care, the difficulty of care, the time required for care, etc.; the subjective part depends on the personal characteristics of the caregiver and how they are affected by or react to the care they must provide (Rodríguez and Rihuete, 2011).

Objective overload corresponds to concrete and visible negative results of the caregiver's role, and subjective overload to the feelings experienced by the caregiver in relation to the evolution of the patient's own illness (Moreira and Turrini, 2011).

We speak of "caregiver syndrome" or "caregiver overload" when there are signs of isolation, loneliness, depressive states, chronic stress, neglect in the caregiver's own care, resulting in osteoarticular problems, chronic mechanical pain, alterations in sleep rhythms, headaches and asthenia, with depressive symptoms being common (López, Orueta et al., 2009; Úbeda, 2009).

The manifestation of this syndrome translates into osteoarticular problems, chronic mechanical pain, alterations in sleep rhythms, headaches and asthenia, and in relation to mental health it can produce anxiety and depression in the form of depressive symptoms (López, Orueta et al., 2009; Úbeda, 2009).

The family member assumes care under his or her own emotions generated by the oncological situation, possibly linked to anguish, anxiety, fear, uncertainty, adding the emotions of the role of main carer, physical exhaustion, insomnia, anxiety, depressive situations, etc., due to the situation of his or her new modified reality.

3.2. Law 39/2006 on the Promotion of Personal Autonomy and Care for dependent persons. A deficient law for the care of oncology patients

Law 39/2006, on the Promotion of Personal Autonomy and Care for Dependent Persons, regulates the assessment of the degree of dependency of users, or in this case, of the sick patient using the Barthel (IB) or Lawton and Brody (LB) indices and/or scales.

These rating scales take into consideration the person's own autonomy, the person's own abilities to perform activities of daily living (ADLV), and give an objective score based on the assessment of each of the items that make up the respective scales.

The items taken into account when assessing the patient's dependency are: personal care, domestic activities, essential mobility, ability to recognise people and objects, ability to orientate, understand and carry out simple orders or tasks, etc. They also consider the use of prostheses, ortheses, technical aids, use of different orthopaedic material, as well as the consideration of architectural barriers in the person's usual environment.

Oncology patients in the evolutionary process of their disease present different functional problems, and it is important to have information, knowledge and possible application for the dependency process if required; the bureaucratic process takes time and the patient's needs may increase in order in a few months as their evolutionary phase progresses (Elena and Rodríguez, 2007).

It is possible that in the evolutionary process of the disease we may encounter a metastatic process. When we talk about metastasis, we refer to a frequent complication of cancer and a common event in advanced tumours; any type of cancer has the potential to metastasise (Sánchez, 2007).

Although in initial stages the metastasis may be hidden, in most cases with its diagnosis we can assimilate to the disease the characteristic of incurable and end up with incapacitating pain, pathological fractures, nerve compression syndromes or hypercalcaemia, having to make use of a dependency procedure among other needs (Sánchez, 2007).

Asthenia is also another of the factors easily reproduced as a symptom in a diagnosed patient; Feliu and Belda-Iniesta (2007) state that "with a prevalence of between 60% and 90% depending on the diagnostic criteria, the stage of the disease and the treatment administered, it deteriorates the quality of life of the patient and their relatives, with physical, psychological, social, economic and occupational repercussions" (p. 444).

There are many factors that can have an impact on the triggering of the patient's limitations; therefore, we must be foresighted as far as possible in order to be able to take the appropriate steps in the consideration of the application for disability-dependency.

The degrees of dependency that can be recognised in these situations are (Servicios Sociales de Castilla y León, 2022; Boletín Oficial del Estado [BOE], 2011):

- Grade III or Great dependency: the person needs help to carry out basic activities of daily living at least several times a day having a total loss of autonomy. He/she needs to have a person for support on a continuous basis or has a general need for support for his/her autonomy.
- Degree II or Severe Dependency: the person needs help to carry out the basic activities of daily living but does not permanently require a carer figure. Nor does he/she need general or extensive support for his/her autonomy.
- Degree I or Moderate Dependency: the person needs help to carry out basic activities of daily living at least once a day or needs intermittent or limited support for personal autonomy.

The recognition of the degree entails the granting of the following benefits and/or service through the public network of social services (SS.SS) of the Autonomous Community of public ownership and/or through duly accredited private subsidised services (Riquelme Olivares, 2015):

- Service for the prevention of situations of dependency.
- Service for the promotion of personal autonomy.
- Teleassistance service.
- Home help service.
- Day center.
- Night center.

- Residential center.
- Financial benefit for care in the family environment.
- Financial benefit for personal assistance.
- Financial benefit linked to the purchase of a service.

We must do a harsh criticism of two fundamental aspects of this Law; on the one hand, the time taken to grant it and, on the other hand, its effectiveness in the application of the response through resources.

Firstly, regarding the time taken to grant it and its excessive bureaucratisation, we must be objective regarding oncology patients; and the fact is that, on many occasions, the situation of dependency is due to the diagnosis and a rapid and unexpected evolution, generating great physical limitations that require rapid responses, and cannot wait for the interminable application and concession procedures that the Law implies.

Home help often arrives late, and the same happens with residential centers where, if the patient is in an advanced stage of the disease, he or she cannot wait, needing means and resources to guarantee a minimum of dignity.

Secondly, the granting/activation of the resource is not coherent with the real need of the oncology patient; the home help granted does not cover the real need in number of hours of the sick patient and family, having to resort to contracting complementary formal support, informal family support or even formal, non-legalised support, i.e., not registered with Social Security.

We take the affirmation of Casas-Martín (2022) about the Dependency Law in hospitals and how he affirms that the system, at state level, is deficient and obsolete, both in that dependency often arises from one day to the next and as a matter of dignity and even survival. Social services are configured according to where you live, and bureaucratisation slows down the activation of the resource (Casas-Martín, 2022).

It is the responsibility of the multidisciplinary team, and in particular the social worker, to identify the biopsychosocial needs of the sick patient and the family at an early stage, thus enabling their application to avoid future bureaucratic delays at the time when the resource is imminently needed.

3.3. The Social Worker in professional intervention in the provision of resources for oncology patients

Social Work is the professional discipline that intervenes in different contexts in different situations of need or problem, promoting the growth of the individual, groups and/or communities. Thus, the term Social Work is used to refer to both the discipline and the professional activity that aims to develop social welfare, because of overcoming situations that generate real or potential social discomfort (Conde, 1998).

The Social Worker, in the professional intervention, must consider the importance of social relationships, personal networks and support groups; we can affirm that there is a positive relationship between social support and individual well-being also called resilient factors that exert positive effects on people's health (Bravo and Fernandez, 2003; Lara, Navarro and Navarrete, 2004).

Taking into consideration the document prepared by the International Federation of Social Workers (IFSW) for its definition of Social Work in 2014, we highlight how the mission of the discipline of Social Work is to develop potential, trying not to fall into dysfunction, facilitating participation in society, families and communities (Garcia, 2020).

One of the key aspects in professional intervention is the consideration of the person as a whole, as a set of perfectly related and interconnected parts; in this sense in our professional intervention we advocate the consideration of the person as a biopsychosocial systemic entity, not only constituted by the visible biological part, but by a compendium of psychosocial summations; being the sum of the biological part, the social part and the psychological part the one that differentiates, completely, a person from another.

The person, within the conception as a system, is not a solitary, isolated, withdrawn, abandoned element, but has an "interacting" character, he does not remain isolated. Immersed in a multitude of systems, he intervenes directly or indirectly by emitting feedback, thus shaping his being and his being itself.

At this point we recall Mary Richmond, who considered social problems from a global perspective, gathering different evidence of the social fabric of the person himself, in relation to others and inserted in the community, always respecting its peculiarities, and establishing an appropriate intervention plan (Richmond, 1917).

In this sense, as Social Workers, we must promote a correct identification of the informal or formal support networks in the reality of the oncology patient in order to mitigate possible negative effects of overload, both in the sick patient in whom they are exercised and in the main caregiver as well as in the person who performs it.

In the broadest sense of professional intervention, we should advocate providing in advance sufficient information about institutionalized and non-institutionalized resources, existing forms of care and social support for the person in a situation of dependency, thus being guarantors of protection for the oncology patient and his or her main caregiver.

Also, to exercise a continuous and insistent claim regarding the Dependency Law, shortening bureaucratic times for oncology patients and their families who need it so that they can cover their needs, providing a timely and effective response, promoting their human dignity.

4. Conclusions

The oncological disease generates situations of disability and dependence in the cancer patient, which, therefore, entail the involvement of the patient, but also of the entire family, assuming different care roles.

The family is one of the most fundamental pillars in the provision of care to a dependent person, but the care provided to the cancer patient is complex in its knowledge, specific in its application, requires skills and attention to both public and private resources.

Throughout this study and the literature review, we have seen how the care of the cancer patient commonly falls to a female, generally in the first degree of consanguinity, assuming a role often imposed by culture, generating situations of objective and subjective burden, i.e., overload of the main caregiver.

Law 39/2006, on the Promotion of Personal Autonomy and Care for Dependent Persons, is insufficient in the provision of services to meet the multiple needs of cancer patients. It is not a guarantor resource in the provision of services to solve urgent needs and it is slow in its public concession.

Our professional discipline emerges with a luminous transforming character, as a pretension of change in people, groups, communities, and even in legislation and public policies, being thus defined social workers, in many occasions, as the real agents of change.

In our professional work we focus on the functioning of different people in their social reality of their different situations and events in search of social welfare, and is that, we are workers of the need/problem situations that affect the normal functionality of individuals and / or families.

Thus, Social Workers must start from the epicenter of the oncology patient considering their biological situation, evaluating, identifying and issuing specific social diagnoses anticipating future needs arising from the oncological process taking into account the importance of support networks that can configure the social reality of the person facilitating the management of possible public and/or private resources.

It is our obligation to promote the quality of life of the sick patient, but also of the main caregiver in predisposition to assume such care, so our discipline is a guarantor of dignity throughout the process, for both parties.

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