The Impact of Yoga on Quality of Life and Psychological Distress in Caregivers for Patients With Cancer

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Purpose/Objectives: To assess the effects of a six-week Vinyasa yoga (VY) intervention on caregivers' overall quality of life (QOL) and psychological distress.

Design: A single-group, pre- and post-test pilot study.

Setting: University public recreational facility.

Sample: 12 informal caregivers for patients with cancer.

Methods: Caregivers participated in a six-week VY intervention and completed measures of QOL and psychological distress pre- and postintervention. Program satisfaction was measured with open-ended survey questions.

Main Research Variables: QOL, psychological distress, and program satisfaction.

Findings: Significant improvements were found in the mental component score of overall QOL and in overall psychological distress. Several subdomains of QOL and psychological distress were also improved significantly. Open-ended survey question responses revealed participants perceived physical and mental benefit from the intervention, highlighting improvements in flexibility, core and upper-body strength, balance, breathing, and energy.

Conclusions: Informal caregivers may benefit mentally and physically from participating in VY.

Implications for Nursing: Caregivers of patients with cancer characterize a group worthy of attention, research, and interventions focusing on their healthcare needs.

Key Words: yoga; quality of life; distress; caregiver; cancer

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Cancer statistics and projections indicate that, at some point, the majority of the population will know a close social network member with cancer (Segrin & Badger, 2010). The acute and long-term effects of a cancer diagnosis extend beyond the patient with cancer to social network members, including spouses or partners, immediate family members, and friends (Kim & Given, 2008; Kitrungroter & Cohen, 2006; Northouse et al., 2007). As the prevalence of cancer increases, a greater amount of patients will need to rely on informal caregivers for support from diagnosis into survivorship (Edwards et al., 2002). Cancer survivors with increasingly complex needs are cared for at home at some point during the cancer continuum, and more than half of the care required by survivors is provided by an informal caregiver (Blum & Sherman, 2010).

Informal caregivers are required to meet the multidimensional needs of the survivor, including treatment monitoring; symptom management; emotional, financial, and spiritual support; assistance with personal and instrumental care; transportation to and coordination of medical appointments; administering treatments; and assisting with activities of daily living (Cameron, Shin, Williams, & Stewart, 2004; Given, Given, & Kozachik, 2001; Kim & Schulz, 2008). These responsibilities may adversely affect caregivers who lack adequate resources or are insufficiently prepared for the complex role (Baider, 2011). The physical and psychological toll of caring for a cancer survivor often results in psychological distress that is greater than or equal to the distress experienced by the survivors (Braun, Mikulincer, Rydall, Walsh, & Rodin, 2007; Couper et al., 2006; Grunfeld et al., 2004; Hinnen et al., 2008; Hodges, Humphris, & Macfarlane, 2005; Kim, Kashy, Spillers, & Evans, 2010; Manne et al., 2007; Matthews, 2003; McCorkle, Siefert, Dowd, Robinson, & Pickett, 2007; Mellon, Northouse, & Weiss, 2006; Rabin et al., 2009; Sjövall et al., 2009). Caregivers whose psychosocial needs are not met have reported poorer mental health and quality of life (QOL) (Rivera, 2009).

Caregivers of patients with cancer are a group worthy of attention, research, and interventions focusing on their unique healthcare needs (e.g., psychological and emotional distress, personal care or medical issues, unmet activity needs) (Kim et al., 2010). Because of the evidence regarding the negative effects of caregiving, interventions aimed at improving overall QOL and reducing psychological distress in caregivers are long overdue. Maintaining or improving QOL and reducing the psychological distress of caregivers is important not only for caregivers' health, but also for the caregivers'

ability to provide optimal care, reduce the burden on the healthcare system, and improve the outcomes of patients with cancer and survivors (Van Puymbroeck, Payne, & Hsieh, 2007).

Physical Activity

Researchers have consistently highlighted the value and importance of physical activity (PA), as it has been shown to provide mental and physical health benefits (Warburton, Nicol, & Bredin, 2006). The burden and stress of caregiving has many adverse effects, including reduced QOL, psychological distress (Boyle et al., 2000; Vedhara, Shanks, Anderson, & Lightman, 2000), depression (Pinquart & Sörensen, 2003; Vitaliano, Zhang, & Scanlan, 2003), physical decline (Schulz, Martire, & Klinger, 2005), and neglecting health-promoting behaviors (Collins & Swartz, 2011; Hill, Smith, Fearn, Rydberg, & Oliphant, 2007). Few studies have explored the potential role of PA in addressing the multifaceted health-related needs of this underserved group. Although improving caregivers' QOL and psychological distress with the use of PA interventions has not been a focal point of research, a study has suggested that PA may be the best method to improve QOL (Ulger & Yagli, 2010). In addition, other studies have suggested that part of the negative impact on caregiver health may be because of the reduced probability that caregivers engage in behaviors such as regular PA (Castro, Wilcox, O'Sullivan, Baumann, & King, 2002; Etkin, Prohaska, Connell, Edelman, & Hughes, 2008). Yoga, with its growing popularity and physical and mental health benefits (e.g., stress reduction, improved mood, balance, strength), is a form of PA that may be a useful intervention for caregivers (Lim & Taylor, 2005; McCall, 2007). With that in mind, the authors of the current study designed and implemented a six-week Vinyasa yoga (VY) program to explore its impact on psychological distress and overall QOL in a group of informal caregivers for patients with cancer.

Methods

A single-group, six-week pre- and post-test pilot study was conducted. Pre- and postprogram data included measures of psychological distress, QOL, and subjective program experience. Following approval from the regional Capital Health Research Ethics Board and associated reciprocal agreement with Dalhousie University's research ethics board, participants were recruited via posters placed throughout local healthcare centers and at cancer and caregiver support group locations.

Participants were aged 18–65 years and provided informal, unpaid care to a patient with cancer at the start of the study, self-identified or were identified by a cancer survivor as a primary caregiver, and reported levels of distress sufficient to disrupt their lives (i.e., score of 5 or greater on the 10-point National Comprehensive Cancer Center distress thermometer). Other eligibility criteria included the ability to speak English and willingness not to initiate new or alter existing PA behaviors for the duration of the study. Exclusion criteria included people who had any health concerns that would preclude safe participation in a PA program and those who were older than age 65 years or were pregnant or recently gave birth.

The yoga intervention was conducted at Dalhousie University's public recreational facility twice a week for six weeks for a total of 12 sessions. Caregivers were encouraged to participate in VY for 150 minutes per week (two 75-minute sessions). All yoga sessions included between 25–40 yoga poses derived from the VY method and were taught according to the principles of VY. Each VY session included 5–15 minutes of pranayama (i.e., breathing) exercises and meditation, 50–60 minutes of VY poses, and 4–10 minutes of savasana (i.e., a pose that calms the mind, promotes relaxation, and relieves stress and pressure from the body) (Coulter, 2001; Fraser, 2006; Kaminoff, 2007).

Measures

Self-report demographic information was collected and included age, gender, education level, marital status, annual income, employment status, months in the caregiver role, relationship to patient with cancer or survivor, and previous yoga experience. Study feasibility was assessed by recording overall program attendance. Reasons for absences also were recorded.

The **Profile of Mood States (POMS)** was used to measure psychological distress (McNair, Lorr, & Droppelman, 1971; McNair & Heuchert, 2005). POMS is a 65-item scale, scored on a five-point Likert-type scale ranging from 0 (not at all) to 4 (extremely). POMS measures mood disturbance in six domains (i.e., tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia, and confusion-bewilderment) and yields an overall psychological distress measure, total mood disturbance (TMD). A higher TMD score indicates greater overall psychological distress, and a lower score indicates a lack of or lower amount of psychological distress (McNair et al., 1971; McNair & Heuchert, 2005). The POMS measures state elements; therefore, previous administrations do not influence subsequent administrations, making it an excellent tool for repeated measures. The internal consistency reliability for all POMS scales in the current study was strong, ranging from 0.8–0.93.

The **SF-36®**, version 2.0, was used to measure overall QOL (Osborne & Overbay, 2004). The SF-36 is a multipurpose, 36-item health survey yielding a profile of two health component summary measures, the physical component score (PCS) and the mental component score (MCS), each of which is comprised of four subscales.

PCS subscales include physical functioning, role-physical, bodily pain, and general health. The MCS subscales include vitality, social functioning, role-emotional, and mental health. The two summary scales have been shown to be valid across clinical and general populations from various countries (Ware, Kosinski, & Dewey, 2000). The internal consistency reliability for the summary measures (PCS and MCS) in the current study was strong, ranging from 0.88–0.91. Ware et al. (2000) confirmed the reliability of the eight subscales using estimates of internal consistency and test-retest methods and provided evidence for the construct, criteria, content, concurrent, and predictive validity of the SF-36.

Fourteen open-ended questions were administered in a short survey at the completion of the six-week intervention. The questions were administered to show caregivers' views of the importance of being physically and mentally fit. The questionnaire also collected specific information for the current study, such as participation motives, group composition, and participants' overall satisfaction with the VY program. The open-ended survey included questions such as, "What was your main reason or motivation for attending yoga sessions?" and, "What would you like to see different to make this program a better experience?"

Statistical Analyses

All analyses were conducted using SPSS®, version 19.0. Baseline demographic information, care recipient health profiles, and attendance were analyzed and reported using descriptive statistics and frequencies. The psychological distress and QOL data were scored using the Quick-Score Forms for POMS and QualityMetric Certified Scoring software for SF-36. The data were examined for missing values, assumption violations, and analyzed for outliers (greater than three standard deviation [SD]) (Osborne & Overbay, 2004). The data were checked for normality with histograms, Q-Q plots, skewness and kurtosis calculations, and 5% trimmed means (Price, 2000). Inter-item reliability analysis was performed on the three summary measures (i.e., TMD, PCS, and MCS) and 14 subscales (i.e., six POMS subscales and eight QOL subscales). Measures with an internal reliability of 0.7 or greater were considered acceptable for analyses.

Because of the exploratory nature of this study, the p value was not adjusted for multiple testing. As such, an increased likelihood existed of having made a type 1 error and of having rejected the null hypothesis when it may be true. Exact p values and eta-squared (n^2) effect size are presented for all findings.

A t test was performed to explore the impact of the VY intervention on overall psychological distress. The first t test was performed on the POMS TMD score. Post-hoc explorations of findings were conducted using additional paired samples t tests on each of the 14 subscales from the two tests. To explore the impact of the VY intervention on overall QOL, separate t tests were performed on the summary scales (i.e., PCS and MCS). Responses from the open-ended survey questions were transcribed verbatim from the postintervention questionnaires. A content analysis was conducted with the intent to identify major themes (Hsieh & Shannon, 2005).

Results

Fourteen caregivers expressed an interest in participating in the yoga intervention. All 14 individuals met baseline eligibility criteria and provided informed consent to participate. Although all participants completed pre- and postintervention measures, two participants were able to attend only one VY class and were removed from the final analyses. The remaining 12 participants ranged in age from 19–64 ($\bar{X}$ = 41, SD = 15), included 11 females, and had a mean baseline distress score of 6.5 (SD = 1.6) out of 10 (see Table 1).

Overall attendance was 65% (94 of 144 total sessions attended), with the average participant attending about 8 of 12 classes (SD = 2.1). Reasons for absences included having to work or attend school (n = 14), sickness or physical pain (n = 13), caregiving responsibilities (n = 9), being out of town or on vacation (n = 9), having a previous commitment (n = 2), and having no transportation (n = 1). Reasons for absences for two missed sessions were not reported. One caregiver was out of the country with a patient who was receiving treatment for four yoga sessions.

A significant difference and large effect (n^2 = 0.61) in TMD scores was found from baseline ($\bar{X}$ = 60, SD = 32) to postintervention ($\bar{X}$ = 32.7, SD = 31.7; t(11) = 4.11, p = 0.002, 95% confidence interval [CI] [12.71, 41.96]) (see Table 2). No significant difference was found in the PCS from baseline ($\bar{X}$ = 55.8, SD = 8.2) to postintervention ($\bar{X}$ = 52.6, SD = 8.7; t(11) = 1.62, p = 0.133, 95% CI [–1.15, 7.58], n^2 = 0.19). A significant difference and large effect (n^2 = 0.41) were found in the MCS from baseline ($\bar{X}$ = 34.4, SD = 11.8) to postintervention ($\bar{X}$ = 42.9, SD = 13.6; t(11) = –2.76, p = 0.018, 95% CI [–15.17, –1.71]).

The most common reasons for participating in the yoga study included the desire to relax and de-stress (n = 8), to learn yoga (n = 7), to do something active or participate in PA (n = 5), and to be with other caregivers and have social interaction (n = 5). When asked what physical or mental skills they had learned during the six weeks, the participants most often reported breathing techniques and the use of breath for relaxation (n = 7). All of the participants (n = 12) perceived improvements in their mental or physical well-being during the course of the intervention, noting improvements in flexibility

Table 1. Participant Characteristics (N = 12)

Characteristic	n
Gender	
Female	11
Male	1
Marital status	
Married or common-law marriage	4
Divorced or separated	4
Single or never married	3
Widowed	1
Education level	
High school diploma	2
Some college	1
College degree	3
Technical school degree	1
Some graduate college	2
Graduate degree	3
Annual income ($)	
Less than 10,000	2
10,000–24,999	1
25,000–49,999	3
50,000–74,999	1
75,000–99,999	1
100,000–149,999	1
Declined to respond	3
Employment status	
Full-time (more than 30 hours per week)	6
Part-time (less than 30 hours per week)	1
Unable to work	1
Student	2
Retired	2
Months of caregiving	
1–3	2
4–6	3
7–12	1
13–18	1
19–24	1
25–32	4
Relationship to patient or survivor	
Daughter or son	7
Sister	2
Partner	1
Other	2
Yoga experience	
1–5 classes	2
6–10 classes	2
11–20 classes	3
21–30 classes	2
31–40 classes	–
Greater than 40 classes	3

(n = 5), strength (n = 4), and physical fitness (n = 2). Perceived improvements in mindfulness, focus, and relaxation (n = 2), as well as increased energy (n = 1) , also were noted. Seven participants noted that the program made a difference in how they felt day-to-day.

Discussion

The results of the current study show that participating in a six-week VY intervention was effective in reducing overall psychological distress and improving QOL. The limited impact of the VY intervention on overall physical health may be attributed to the fact that the majority of the participants (n = 7) were meeting or exceeding the Canadian Society for Exercise Physiology's (2012) PA guidelines for achieving health benefits. Therefore, the participants in this study may have been too physically active to experience any substantial physical health benefits in a short period of time. Despite the lack of improvement based on subjective ratings on the QOL measure, most participants (n = 11) reported that they experienced improvements in physical fitness, as noted in the open-ended survey questions. These findings may suggest that physical functioning variables require further examination using objective measures in larger studies using VY interventions in caregivers.

Although the small sample size limited the ability to detect statistical significance, two of the three summary measures (TMD and MCS) had large effects in the intended outcomes, and 11 of the 14 psychological distress and QOL subscales had moderate or large effects in the hypothesized outcomes. The current study's finding are consistent with the results of researchers who found increases in QOL and reductions in psychological distress in healthy and chronically ill populations with the use of yoga interventions (Oken et al., 2006; Pilkington, Kirkwood, Rampes, & Richardson, 2005; Sareen, Kumari, Gajebasia, & Gajebasia, 2007; Woolery, Myers, Sternlieb, & Zeltzer, 2004).

Typically, the spouse or partner of a patient with cancer fulfills the caregiving role. In the current study, however, the majority of the participants (n = 8) were the patient's son or daughter. Some evidence exists that older spouses or partners may be at greater risk of distress or burnout, likely because of age-related physical decline (Pinquart & Sörensen, 2007). However, researchers have noted that caregivers, regardless of relationship to the patient, also are at risk (Segrin & Badger, 2010). Additional research is needed to corroborate the efficacy and feasibility of a VY intervention with caregivers.

Limitations

To the authors' knowledge, the current study is the first to report a significant reduction in overall psychological distress and improvement in overall mental health–related QOL in caregivers of patients with cancer using quantitative, valid, and reliable measures. However, several limitations warrant consideration. A major limitation was the lack of a control or comparison group, which made it difficult to determine whether reductions in overall psychological distress and improvements in overall mental health–related QOL were from VY or other confounding variables. In addition, the small sample size precluded the use of more powerful statistics to explore potential confounding variables. Given the exploratory nature of this study, the p-value

Table 2. Effect of Yoga on QOL and Psychological Distress Measures

			Baseline			Postintervention					
Measure	Range	At Risk	α	$\bar{X}$	SD	α	$\bar{X}$	SD	95% CI	p	n^2
Distress (TMD)	35–120	≥ 69	0.92	60	32	0.93	32.7	31.7	[12.71, 41.96]	0.002	0.61[a]
Tension-anxiety	0–36	≥ 66	0.83	17.6	6	0.86	10.7	5.9	[3.96, 9.88]	0.00	0.71[a]
Depression-dejection	0–60	≥ 23	0.9	18.6	11	0.91	11.8	8.8	[1.10, 12.57]	0.024	0.39[a]
Anger-hostility	0–48	≥ 20	0.92	12.4	9.5	0.91	9	7.4	[–0.44, 7.27]	0.077	0.26[a]
Vigor-activity	0–32	≤ 9	0.89	11.9	5.5	0.8	16.3	5	[–7.74, –0.92]	0.017	0.42[a]
Fatigue-inertia	0–28	≥ 18	0.87	11.7	5.9	0.83	8.8	4.5	[–1.57, 7.41]	0.18	0.16[a]
Confusion-bewilderment	0–28	≥ 13	0.84	11.7	6.2	0.9	8.8	5.7	[1.75, 4.08]	0.00	0.73[a]
QOL (PCS)	–	–	0.88	55.8	8.2	0.86	52.6	8.7	[–1.15, 7.58]	0.133	0.19[a]
Physical-functioning	–	–	0.68	52.1	4.3	0.81	52.3	4.9	[–1.24, 0.89]	0.723	0.01
Role-physical	–	–	0.87	50.5	8.2	0.82	48.7	8.5	[–4.39, 8.06]	0.53	0.04
Bodily-pain	–	–	0.95	48.8	9.4	0.42	47.9	6.9	[–4.86, 6.77]	0.726	0.01
General-health	–	–	0.9	50	10.6	0.78	51.2	7.9	[–3.97, 1.59]	0.366	0.08[b]
QOL (MCS)	–	–	0.89	34.4	11.8	0.91	42.9	13.6	[–15.17, –1.71]	0.018	0.41[a]
Vitality	–	–	0.89	43.5	10.5	0.81	47.4	8.9	[–9.19, 1.39]	0.133	0.19[a]
Social-functioning	–	–	0.74	41.4	9.5	0.79	44.6	9	[–8.40, 2.03]	0.207	0.14[a]
Role-emotional	–	–	0.85	35.5	14.7	0.9	43.6	13.7	[–14.54, –1.65]	0.018	0.41[a]
Mental-health	–	–	0.66	39.4	7.5	0.81	44.1	9.8	[–10.21, 0.83]	0.088	0.24[a]

[a] Represents a large effect (≥ 0.14)
[b] Represents a medium effect (≥ 0.06–0.13)
CI—confidence interval; MCS—mental component score; PCS—physical component score; QOL—quality of life; TMD—total mood disturbance
Note. QOL data are presented as normative data ($\bar{X}$ = 50, SD = 10).
Note. Based on information from Cohen, 1988.

was not adjusted for multiple testing, so the study's findings should be interpreted with caution.

Because of the evident nature of this study, the caregivers who volunteered for the program may be more aware of and recognize the importance of PA and the need to consider their own well-being during times of stress. The use of yoga in the intervention may have contributed to the disproportionately low number of males (n = 1). Swartz and Keir (2007) reported that although exercise was the most preferred form of intervention and stress reduction technique for men and women, only 30% of men (as opposed to 48% of women) chose yoga as one of their stress-reduction or intervention preferences.

Future Research

Given the methodologic limitations of the current study, the results should be regarded as preliminary and treated with caution. The findings from this study provide important information regarding VY as a possible complementary therapy to manage or reduce psychological distress and improve QOL in caregivers, but this area requires additional research. A need exists for the results of the current study to be tested using more rigorous study designs (e.g., using randomized, controlled trials; controlling for multiple testing; controlling for potentially confounding factors) and with larger samples. Additional studies may include same-sex yoga sessions that assess the feasibility and likeability of yoga by both genders. Studies have been underpowered to establish whether interventions result in differential improvement for female caregivers when compared to male caregivers. Research also is needed to understand the differences in psychological distress and QOL outcomes with the use of PA interventions for caregivers' perceived burden, relationship to the patient, and length of caregiving. Assessing caregivers at baseline, during the intervention, and postintervention may be an appropriate method to better understand predictor variables such as financial burden, work disruptions, caregiving responsibilities, disease progression, and bereavement or death. The current study did not include objective measures of physical functioning. Including objective measures would help to assess whether changes in physical functioning are related to reduction in psychological distress, improvement in QOL, and whether VY is comparable to other forms of PA and yoga styles for improving objective components of physical functioning.

No evidence exists that suggests an optimal volume, frequency, duration, style, or length of yoga program for improving health. Yoga intervention studies have ranged in duration from four weeks to six months (Lim & Taylor, 2005; Michalsen et al., 2005; Moadel et al., 2007; Oken et al., 2006; Speed-Andrews, Stevinson, Belanger, Mirus, & Courneya, 2010; Swartz & Keir, 2007; Woolery et al., 2004), with 60–90 minute sessions once or twice a week, with or without home-based sessions. Additional

trials assessing response to length of yoga sessions and interventions, as well as specific yoga styles, are required. Although the VY intervention appeared to be an acceptable and enjoyable form of PA intervention in the group of caregivers in the current study, this type of intervention may not be appropriate for all caregivers. In response to the overall satisfaction with breathing and meditation techniques taught during the VY sessions, a more meditative-based yoga program may benefit this population. A VY intervention may be beneficial for certain caregivers if used as an adjunct or complementary intervention to other interventions already offered (e.g., counseling), and not as a replacement for existing psychosocial interventions.

Although several benefits (e.g., learning proper technique, assurance of proper use of props, motivation, socializing) exist in delivering in-person interventions to caregivers, the authors of the current study struggled with recruitment, adherence, and retention (Jacobs et al., 2004; Mant, Carter, Wade, & Winner, 2000; Waldron, Janke, Bechtel, Ramirez, & Cohen, 2013). The development of supervised home-based PA programs has shown promise in facilitating long-term exercise adherence with minimal face-to-face contact (King & Brassington, 1997; Waelde, Thompson, & Gallagher-Thompson, 2004).

The use of a theoretical framework can offer a foundation to build evidence-based interventions. A number of theoretical models exist, but the theory of planned behavior (TPB) (Ajzen, 1991) has received substantial attention in research for health-promoting behaviors. Notably, TPB has guided the majority of the theoretical research on PA, and a number of reviews have shown TPB's concepts to be valuable predictors for explaining exercise behavior in healthy and chronically ill populations (Blanchard, Courneya, Rodgers, & Murnaghan, 2002; Courneya & Friedenreich, 1999; Courneya, Friedenreich, Arthur, & Bobick, 1999; Downs & Hausenblas, 2005; Keats, Culos-Reed, Courneya, & McBride, 2007). Theory-based research can indicate which caregivers may engage in or maintain a particular behavior and how best to tailor interventions to meet the needs of caregivers.

Implications for Nursing

The knowledge gained from the current study can be helpful to nurses. VY may help manage or reduce psychological distress and improve QOL in caregivers. Nursing focuses on providing patients with accurate information to make informed decisions regarding their health. Therefore, nurses can use this information to ensure that caregivers remain healthy enough to continue to provide this irreplaceable and vital care. Nurses can encourage caregivers of patients with cancer to participate in PA interventions, such as VY sessions.

Knowledge Translation

Promoting participation in Vinyasa yoga can help identify additional coping strategies in caregivers for patients with cancer.

Providing anticipatory support and information for what informal caregivers can expect and promoting healthy behaviors can help caregivers maintain psychological health and positive quality of life.

Giving information and psychological support options can help caregivers better manage their caregiving situations.

Caring is the essence of nursing and caregiving. Oncology nurses must recognize caregivers' concerns because caregivers play an important role in the treatment and recovery of patients with cancer. A greater understanding of the impact of cancer on informal caregivers would assist nurses in identifying individuals who are vulnerable to reduced QOL and psychological distress. Nurses also could help develop PA interventions to help decrease the likelihood of heightened psychological distress and reduced QOL.

Conclusions

Studies involving caregivers of patients with cancer have focused on caregiving skills and managing symptoms via therapeutic counseling and information. Few studies have sought to improve a caregiver's overall QOL and psychological distress with the use of PA or yoga. The preliminary data derived from this pilot study provides important information for future research and for healthcare providers working with patients with cancer and their caregivers. Nurses can help caregivers remain physically and mentally healthy by promoting participation in VY.

Because nurses are frequently engaged with informal caregivers, they serve as an important line of contact and source of encouragement and support to assist caregivers in caring for themselves in an effort to remain physically and mentally healthy. The current study provides preliminary evidence that highlights the potential benefits of participating in VY and suggests that the promotion of such activities by nurses may improve the overall psychological well-being and QOL of informal caregivers

Ultimately, the objective is to reach more caregivers of patients with cancer with effective, evidence-based programs, improving not only their own health, but that of the cancer survivors and other family members, as well. Meeting this challenge is critical, and yoga has the ability to reach caregivers of all ages, PA levels, and experience with minimal equipment and costs.

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