

Effect of Mental Health Promotion Intervention on Well-Being of Formal Caregivers of Patients with Dementia

Ms Sruthi Sivaraman^{1*}, Dr Sherin P Antony²

ABSTRACT

The study aim of to find out the outcome of the mental health promotion intervention program in formal caregivers of patients with Dementia. For this investigation *The Connor-Davidson Resilience scale*, *Brief Cope Inventory*, and *Wellbeing of the caregiver* were used. 18 Formal caregivers of patients with Dementia who belong to 20-35 years of age were selected from different residential care units of Bangalore through purposive sampling and questionnaires were administered after seeking the informed consent. The analysis says that the mean score of ADL in the current study has shown an increase from 72.22 to 84.17. This is an indication that mental promotive intervention program has enabled the formal caregivers to pay more attention to their ADL. This also explains improved well being as ADL is also part of the individuals well being. During the course of the intervention the subjects had mentioned that there is a lack of familial support when they try to put in the effort to change certain things or even in terms of fun activities that would incur financial loss.

Keywords: *Mental Health Promotion Intervention, Well-Being, Caregivers, Patients, Dementia*

It is predicted by the WHO that by 2025 the total number of aged people in developing countries would be highest in developing countries (75%) (ADI, 2010). In light of such an increase it can be argued that there is a need to focus on multiple factors associated with degenerative diseases like dementia. Brookmeyer et al., (2007) contend that the global incidence of this disease is relatively high and that there is an increasing economic burden on the caregivers as well as the state. ADI (2010) further reports that the overall cost of informal and formal caregiving for those affected with dementia is at 604 billion US dollars for 2010, of which 70% incurred in Western Europe and North America. AA (2010) identifies that the promotion of formal caregiving setting while effective in developed nations, is moderate in developing countries. AA (2010) identifies that most people who have dementia are provided care by their caregivers at their homes with 32% of these caregivers provide care for more than 5 years, and 12% provide care for more than 10 years.

¹ (Research Scholar, Dept. of Psychology, Jain University, Bangalore, India)

² (Research Supervisor, Dept. of Psychology, Jain University, Bangalore, India)

*[Responding Author](#)

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Effect of Mental Health Promotion Intervention on Well-Being of Formal Caregivers of Patients with Dementia

Das et al., (2008) identified that dementia linked with Alzheimer's disease is found to have an incidence of 4.7 per 1000 people per year. It is argued that the situation in India is unique due to the transition of an increasing aging population as well as the higher prevalence of non-communicable diseases including stroke and cardiovascular diseases similar to the trends in western countries. Rajkumar et al., (1997) argues that the published literature from India is found to focus on epidemiology and risk factors related to dementia and Alzheimer's with limited focus on associated psychosocial problems. Raina et al., (2010) supports this argument by indicating the need for awareness and psychosocial care rather than just a clinical focus.

On similar lines with this perspective, this research study shall concentrate on a specific and essential aspect of dementia and its effect on the caregiver

Aim:

- To find out the outcome of the mental health promotion intervention program in formal caregivers of patients with Dementia

Objectives:

- To find out the differences in the scores resilience, coping, activities of daily living and basic needs pre and post the mental promotion intervention program for formal caregivers of patients with Dementia.

Hypotheses:

1. There is no significant difference in resilience of formal caregivers of patients with dementia before and after the mental health promotion intervention program
2. There is no significant difference in coping of formal caregivers of patients with dementia before and after the mental health promotion intervention program
3. There is no significant difference in activities of daily living of formal caregivers of patients with dementia before and after the mental health promotion intervention program
4. There is no significant difference in basic needs of formal caregivers of patients with dementia before and after the mental health promotion intervention program

MATERIALS AND METHODS

Study sample: 50 Formal caregivers of patients with Dementia who belonged to 20-35years of age were selected from different residential care units of Bangalore.

Sampling:

Purposive Sampling

Inclusion Criteria:

Male and female caregivers

Age 20-35yrs

People who can comprehend Kannada, Tamil, Malayalam and English

People who has worked as formal caregivers for at least 1 month

People with 7th standard education

Exclusion Criteria:

People who are working in homecare setup

Effect of Mental Health Promotion Intervention on Well-Being of Formal Caregivers of Patients with Dementia

Tools:

1. The Connor-Davidson Resilience scale:

The CD-RISC scale developed by Connor and Davidson comprises of 25 items. Each rated on a 5- point scale (0–4).The total score ranges from 0–100, the higher the score the greater the resilience.

2. Brief Cope Inventory :

This inventory is a brief form of Cope Inventory developed by Carver, Schneider & Weintraub to assess potentially important coping responses with 14 scales with 2 items which is beneficial in health related research. Respondents answer in 4-point Likert scale ranging ‘1- I haven’t been doing this at all’ to ‘4 – I have been doing this a lot’. Higher scores indicate increased utilization of that specific coping strategy.

3. Wellbeing of the caregiver:

The wellbeing scale developed by Susan Tebb is a valid and reliable scale comprising of 45 items. This scale measures caregiver’s wellbeing by assessing the caregiver’s satisfaction with basic human needs and activities of daily living.

Procedure:

18 Formal caregivers of patients with Dementia who belong to 20-35years of age were selected from different residential care units of Bangalore through purposive sampling and questionnaires were administered after seeking the informed consent.

Pre-data were collected. The mental health promotion intervention program was conducted over a period of 2 moths. After a gap of 7 days the post data was collected. The data was subjected to statistical analysis.

Since the data have been tested and fall under normal probability paired t test has been employed to find out the significant differences between the pre and post data.

RESULTS

Variables	Test	Mean (n=18)	SD	t
Resilience	Pre	71.28	14.81	1.531
	Post	63.44	12.12	
Coping	Pre	69.44	14.26	0.4
	Post	71.39	10.80	
Basic needs	Pre	73.17	7.49	1.351
	Post	79.06	13.80	
ADL	Pre	72.22	9.08	2.265*
	Post	84.17	15.00	

**p < .01, *p<.05

The analyzed data indicates that there is no significant difference in resilience after the mental health promotion program for formal caregivers of patients with dementia. This reveals that the intervention may not have influenced in enhancing the resilience factor in formal caregivers of people with dementia.

Effect of Mental Health Promotion Intervention on Well-Being of Formal Caregivers of Patients with Dementia

The analysis indicates that coping and basic needs of the formal caregivers does not show a significant difference after the intervention program. This shows that the intervention has not positively influenced their optimistic coping styles assessed by the inventory.

The data presents that the mental health promotion intervention has shown significant difference at .05 level in the activities of daily living of the formal caregivers of patients with dementia. This identifies the influence of the intervention in well being of the formal carers of patients with dementia.

DISCUSSION

The mean score of ADL in the current study has shown an increase from 72.22 to 84.17. This is an indication that mental promotive intervention program has enabled the formal caregivers to pay more attention to their ADL. This also explains improved well being as ADL is also part of the individuals well being. During the course of the intervention the subjects had mentioned that there is a lack of familial support when they try to put in the effort to change certain things or even in terms of fun activities that would incur financial loss.

During the follow up sessions they had also mentioned as coworkers they try to appreciate each other and participate in group exercise and take time for reflective thinking to change situations and alter the consequences of situations around them. It was also observed during the course that participants had taken extra efforts for enhancing their appearance and pleasantness in the work routine. They also stated active participation in the household chores and efforts to improve their living environment which was hardly paid attention to before the intervention. They were also keen on attending social events as they realized catching up or socialization made them happier and recovered the lost bonds of family and friends. The intervention had helped them to make a better choice about their well being as it had also explained strength use as part of the program. Empowering caregivers with more such program shall arise as the need of the hour as it helps the institution in sustaining integrity when the prevalence rate of the dementia drastically increasing, to arise inquisitiveness in the carers about their future and the need to look after themselves. This could be beneficial to the care recipient also as the carer tends to take extreme care in managing the care risk because of which the mean score of the resilience could have also come down as they were more aware of their risk and ideally learning to master the skills of mental health promotion for their well being.

As a consequence of the irreversible degenerative characteristics of dementia, much of the existing caregiving research documents stressful negative caregiving experiences. Long-term caregiving of people with Alzheimer's has been correlated with a number of negative physical, psychological, emotional, social and financial problems for families and other informal caregivers (Gainey and Payne, 2006 and George and Gwyther, 1986).

In a 4-year longitudinal study for instance, caregivers had a 63% higher mortality risk than non-caregivers (Schultz and Beach, 1999), as well as more depression (Pinquart and Sorensen, 2003 and Schulz and Sherwood, 2008), decreased employment rates (AA, 2010), and increased poverty risks in women (Wakabayashi and Donato, 2006). These problems may in turn lead to elder abuse, lower quality of provided care (Gainey and Payne, 2006), or termination of the caregiving situation due to caregiver burnout (Bedard et al., 2001 and Chenier, 1997). Spousal caregivers can have more negative experiences than other informal

Effect of Mental Health Promotion Intervention on Well-Being of Formal Caregivers of Patients with Dementia

or formal caregivers, because the caregivers themselves are older adults and may have multiple chronic diseases of their own (George and Gwyther, 1986). Spousal caregivers have also been found to report higher levels of loneliness and depression than adult children caregivers (Beeson, 2003 and Bergman-Evans, 1994).

Some of the caregivers who are spouses explain a sense of being disconnected from the spouse who suffers from dementia. This results in an accumulated loss of meaning in the life that they lead. In some of the cases, the recipient who receives care becomes highly violent and tough to control or slowly develops other behavioral issues in due course. Nevertheless, many of the people who provide care pursue their duty for long periods of time, with some of them even pursuing their responsibilities for more than five years.

According to Pearlin et al. (1990), the other caregiver factors that could contribute to negative feelings in caregivers are the personality of the caregiver, beliefs that he or she has, observed resources, how they handle situational overloads, anger and finally fatigue. For instance, some of the people who provide care tend to feel caught in turmoil when they try to provide care, which is defined as “role captivity”. Moreover, the context factors of care giving consist of lack of social or external resources and lack of familial support.

Edwards et al., (2002) had studied about 202 caregivers through the cross-section of the database. It had both employed and unemployed care providers (i.e. both study and control groups). The outcome depression (CES-D 20 item) cut-off was found to be 16. However, there was no difference in the depression scores between the study and control groups. The other factors that were studied were only correlations and no features of the caregivers were addressed. It is therefore argued that a significant effort has been undertaken to understand the impact on the caregiver. However, no significant understanding of the psychosocial well being has been examined from the Indian context.

IMPLICATIONS

- There is a need to examine the role of support that is extended to the care giver and the mutual relationship between the care giver and the patient. This should be merged with high measures of preparedness which could balance the impacts of high role strains on formal carers even when the demand for caregiving is extremely high.
- There is a need to examine the role of wellbeing as part of the dyad relationship as the Indian social structure promotes the caring of the elderly. This balance helps understand the impact of the care receiver’s cognitive functions on the care providers’ role stress.
- The social demographic factors are a critical aspect of the caregiver’s role stress which tends to alleviate the strain observed in these roles.

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Effect of Mental Health Promotion Intervention on Well-Being of Formal Caregivers of Patients with Dementia

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Conflict of Interest

There is no conflict of interest.

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