

Cd-Risc Correlates of Well Being Among Formal Caregivers of People With Dementia

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I. INTRODUCTION

A GE, is major risk factor with only 2% cases appearing before the age of 65years. India will have enormous number of older persons in 20yrs and the prevalence of dementia is expected to double every 5 years (Shaji K. S, 2010). The number of caregivers might also increase as the majority of informal caregivers themselves are older. With the increase in the number of diagnosed patients as the caregiving aspect becomes indispensable and this would need more focus on managing the resources related caregiving burnout and their wellbeing (Karlsson et al.2006). Families of elderly in the rural areas used more formal care than in the urban areas. (McAuley et al.2004). Confined capacity in ADL's serves as predictors of formal care (Larsson et al.2006; Liu et al. 2000).

Even though there is research conducted in the area of predictors of the illness, there is a gap in the research field in developing cost effective intervention models for helping or assisting the formal and informal caregivers in managing their stress and adding on to improved psychological wellbeing of the care providers.

Formal caregivers are the trained caregivers who do not have any prior relationship with the patient and are paid for the delivery of care and tend to deliver the essential care aspects to the care recipients either in a home set up as support to the family member or in an institutional setting.

The current training scenario of formal caregivers such that NISD initiative of Geriatric care training at different locations in India, Regional Resource Training Centre also initiates geriatric care training with focus on bedside assistance and a few private organizations has training programs for their caregivers in dementia care. Indeed available training programs helps in imbibing the skills and job knowledge of the formal caregivers, this shall not be helpful in psychological wellbeing of the formal caregivers. These supportive training programs might help in increasing their confidence to work in a dementia care setup and also raises their awareness in management of the patients with dementia. Formal carers focus older adults or people with dementia living alone and are in need of service and care.

II. AIM AND OBJECTIVES

The aim of the present study is to explore the need for mental health promotion intervention in formal caregivers of people with dementia.

The specific objectives of the study are:

O1: To assess formal caregivers in Resilience, Subjective Happiness, Strength use, self-efficacy and coping, well-being and care risk

O2: To examine the relationship among Resilience, Subjective Happiness, Strength use, self-efficacy and coping, well-being and care risk in formal caregivers of people with Dementia.

III. 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.

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. Subjective Happiness Scale:

This Scale developed by Lyubomirsky & Lepper comprises of four items which measure global subjective happiness. The respondents rate four items each rated on a 7 point Likert scales. The total score would range from 4 to 28. SHS is “suited for different age, occupational, linguistic, and cultural groups”.

3. Strength use Scale:

This scale developed by Govindji and Linley comprises of 14-item self-report scale which measures individual strengths use. Each item was rated on a 7-point Likert Scale (Strongly Disagree to Strongly Agree); higher scores are indicative of greater strengths use.

4. 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.

5. The Genral Self-Efficacy Scale :

The general Self-Efficacy Scale developed by Ralf Schwarzer & Matthias Jerusalemis a unidimensional scale with 10 items. The scale is used to asses a general sense of perceived Self-Efficacy. Respondents answer in 4-point Likert scale. The total score would range from 10-40.

6. 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.

7. Care Risk Screen

This scale is developed by Guberman,Keefe,Fancey, Nahmiash and Baryla comprises of 2sections. Section 1 gathers basic information of the caregiver which provides more comprehensive information about the caregiving situation. Section 2 has 12 items, each rated on a 4 – point scale (0-3). Higher the total score greater the risk.

Procedure:

50 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.

Statistical Analysis:

Quantitative analysis was employed for all the measures used. Descriptive statistics such as mean, standard deviation, frequency and percentage is used to analyse sociodemographic data and other variables. Correlation analysis is carried out to find out the relationship among variables.

Result:

Characteristics of the present sample as given below:

Table 1: Distribution of the age of the sample

	Mean	Standard Deviation
Age	27.86	9.56

The mean and Standard Deviation obtained for the sample is 27.86 and 9.56. It is revealed that most of them are very young adults and might have started their career choosing this as their source of income.

Table 2: Distribution of subject with respect to gender

Gender	Frequency	Percentage
Male	5	10%
Female	45	90%

Compared to male, female are more as formal caregivers.

Table 3: Distribution of the subject with respect to the variables of the study

	High		Low	
	Frequency	Percentage	Frequency	Percentage
Resilience	27	54	23	46
Subjective Happiness	27	54	23	46
Strength use	26	52	24	48
self-efficacy	25	50	25	50
Coping	25	50	25	50
General well-being	25	50	25	50
Caregiver Burden	25	50	25	50
ADL Caregiver Burden	25	50	25	50
care risk	30	60	20	40

In the present sample 54% shows high resilience however 46% shows low resilience which indicates the needs for an intervention.

In subjective happiness 56% of people have obtained high scores where as 46% of them have obtained low scores indicative of increased demand for intervention to enhance subjective happiness.

58% of people reported high use of strength where as 48% of the subjected reported low use of their strength in their daily activities which in turn may impact their resilience and subjective happiness.

50% of the sample similarly obtained high and low scores in the areas of self-efficacy, coping, General wellbeing and Activities of Daily living indicative of caregiver burden. In the present sample 60% shows high care risk where as 40% shows low care risk implying on the need for an intervention in risk reduction.

Table 4: Correlation among Resilience, Subjective Happiness, Strength use, self-efficacy and coping, well-being and care risk in formal caregivers

Variables	Subjective happiness	Strength Use	Coping	General Self efficacy	Basic needs	ADL	CRS
CD-RISC	.691**	.557**	.443**	.753**	.513**	.663**	-.132

**Correlation is significant at the 0.01 level

Table 4 revealed strong positive correlations among Resilience, Subjective Happiness, Strength use, self-efficacy and coping, except well-being in activities of daily living and care risk in formal caregivers. This explains that improvement in Resilience, Subjective Happiness, Strength use, self-efficacy and coping are dependent on each other and an increased score in any one of the variable will directly supplement the other variable. Additionally care-risk and wellbeing in activities of the daily living of the formal caregivers are not significantly related to the other variables in the study which reveals that those variables would act as independently by itself.

IV. DISCUSSION

There is an element of loss in terms of grief, role identity which appears multiple times during the caregiving profession. Might be that sometimes they start contributing more time with the care recipient than their family. This in turn might result in social isolation leading to burnout. Though they are trained, they also lose hope as the disease progress. This professional group is going to be high demand in future as the number of

older people will be more than the adults. Considering these aspects we need to have more training centers in geriatric care and the supervisors of these caregivers should have abundant knowledge about the job so that they are able to help and advice the formal caregivers during a crisis situation. The caregivers should also have continuous training programs as a supportive measure to express their challenges at work which would directly reflect in their resilience and coping with the situation. They should also be made aware of their strengths and weakness and the ways to improvise their strength use and overcome their negativity. The training should also focus on self-reflective measures inducing happiness. To enable in ageing in place and also alleviate the caregiver burden of informal caregivers we need to look at restructuring and novel measures and inspiring solutions to help the frail the older people with dementia. Thus the caregiver wellbeing could be addressed and the sustainability of formal caregivers could be encouraged. Crisis may build stress in the caregiver which could be negatively impacted on the caregiving role leading to attrition and also result distress to the care recipient which enables negative consequences in the family or the institution where the caregiver belongs to. Training module should also have systems were caregivers wellbeing in terms of physical as well as psychological factors are paid attention in a personalized manner and space for organizing ways to deal with these factors are suggested. Care and counseling shall be given to reduce the stress.

Home bound intervention program for people with dementia also to extend helps the caregivers in establishing the rapport with the patients. Disseminating the right amount of information shall help in improvising the caregiving experience. Narrowing the lapse of time between diagnosis and seeking support from formal caregivers helps in identifying the personality traits of the person with dementia in the early phases. This approach helps in enhancing coping skills of the formal caregivers when the physical and cognitive deterioration of the care recipient occurs.

V. IMPLICATION

The results of the study indicates that the resilience, strength us, coping, self-efficacy, and wellbeing factors like basic needs are interrelated to each other and wellbeing in terms of ADL and care risk are independent factors contributing to the wellbeing of the formal caregivers. Increased or decreased proportion of these variables might present positive or negative impact on the caregiver as well as the care recipient. Hence it indicates largely the demand for the need for mental promotion intervention for caregivers.

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