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The effect of the support program on the resilience of female family caregivers of stroke patients: Randomized controlled trial☆,☆☆

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ABSTRACT

Aim: The purpose of the study was to determine the effect of a support program on the resilience of female family caregivers of stroke patients.
Methods: This is a randomized controlled trial. The sample consisted 70 female family caregivers (34 experimental, 36 control group). Data were collected three times (pretest–posttest, follow-up test). Data were collected using the demographical data form, the Family Index of Regenerativity and Adaptation-General.
Results: A significant difference was determined between the experimental and control group's follow-up test scores for relative and friend support, social support and family-coping coherence. A significant difference was determined between the experimental group's mean pretest, posttest and follow-up test scores in terms of family strain, relative and friend support, social support, family coping–coherence, family hardiness and family distress.
Conclusions: These results suggest that the Support Program contributes to the improvement of the components of resilience of family caregivers of stroke patients.

1. Introduction

Stroke is the third leading cause of death and the leading cause of adult disability in the world (Towfighi & Saver, 2011). In Turkey, stroke, with its 15.0% mortality rate, ranks second among the causes of death (Başara, Dirimeşe, Özkan, & Varol, 2007). It also ranks second as the cause of providing care at home in Turkey accounting for 15.4% (Subaşı & Öztek, 2006). Of the patients having suffered stroke, 50% are discharged from the hospital, 20% die or 30% are in need of long-term home or institutional care (Karakurt & Kaşıkçı, 2008). Therefore, stroke patients need emotional, informational and instrumental support provided by family members to maintain their daily life (Schure et al., 2006). Stroke patients usually receive support from the family, spouse or friends (Greenwood & Mackenzie, 2010). Difficulties due to caregiving are not suffered by all caregivers in the same way, which stems from resilience factors such as intra-family communication, social support, spending time with family members, religion, spirituality and loyalty (Jonker & Greeff, 2009).

2. Background

Resilient families can grow stronger from stressful and difficult conditions they face (McCubbin, McCubbin, & Thompson, 2003). Masten (2001) defined resilience as being able to successfully adapt even to high risk conditions and to revert to normal. On the other hand, family members' ability to cope with stressful life cycles in the family and to ensure family cohesion is defined as family resilience (Black & Lobo, 2008). Family resilience is a systemic concept indicating the presence of harmful and beneficial processes that affect the family and the functions of the family members mutually within a specific purpose (Gardner, Huber, Steiner, Vazquez, & Savage, 2008).

It is possible to improve a family's support systems, communication and compliance or other resilience factors through a therapeutic or group intervention program in the family (Schure et al., 2006; Van Den Heuvel, Witte De, Nooyen-Haazen, Sanderman, & Meyboom-De Jong, 2000; Van Den Heuvel et al., 2002). Studies conducted on the issue indicate that families in constant contact with the social environment including their relatives, friends and neighbors have high levels of resilience. In addition, support obtained from social sources such as health services contributes to the family's resilience (Greenwood & Mackenzie, 2010, Simon, Murphy, & Smith, 2005). There are many interventional studies conducted on caregivers of stroke patients. These

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interventional studies have been usually performed through face-to-face interactive personal training, telephone communications, group training or Web based telephone conferences (Grant, Elliott, Weaver, Bartolucci, & Giger, 2002; Oupra, Griffiths, Pryor, & Mott, 2010; Shyu, Chen, Chen, Wang, & Shao, 2008; Steiner et al., 2009). The content of interventions includes provision of information about the disease and stroke, skills training, coping with stress, problem solving and social support (Bakas et al., 2009; Clark, Rubenach, & Winsor, 2003; Grant et al., 2002; Oupra et al., 2010; Pierce, Steiner, Khuder, Govoni, & Horn, 2009; Temizer & Gözüm, 2012; Van Den Heuvel et al., 2000). On the other hand, there is a gap in the research literature related to the studies on meeting multi-dimensional needs of caregivers of stroke patients such as information on stroke, care skills regarding the activities of daily living of the patient provided healthcare, stress-coping methods, problem solving, intra-family interaction and social support.

2.1. Conceptual framework

This current study drew on "The Resiliency Model of Family Stress, Adjustment, and Adaptation" (McCubbin & McCubbin, 1996). The resilience model, which places its primary focus on family change and adaptation over time, emerged from studies of war induced family crises (McCubbin et al., 2003). It is a resilience-focused process, with specific focus on several post-crisis or adaptation-oriented elements in an effort to explain the family's behavior and functioning in the process of adaptation. The adaptation process is determined by the pile-up of demands, interacting with the family's vulnerabilities, resources, appraisal processes, social support, patterns of functioning, coping and problem solving, as well as processes that explain the relational processes involved in family adaptation (McCubbin & McCubbin, 1996). Family adaptation is the end product of the family processes in response to the crisis and pile-up of demands. The concept of family adaptation is used to describe a continuum of outcomes reflecting family efforts to achieve a balance in functioning. The positive end of continuum is called bonadaptation, and the negative end of the continuum is maladaptation. As can be seen in Fig. 1, this study entailed those variables related to Mccubbin's resilience model.

2.2. Aim of the study

The purpose of the study was to determine the effect of a support program on the resilience of female family caregivers of stroke patients.

3. Method

3.1. Design

The study utilized a randomized controlled design, with pre-test, post-test and a 6-month follow-up evaluation. Fig. 2 is the CONSORT flow diagram of this study. The target population of the study comprised female family caregivers of stroke patients registered in Denizli State Hospital, Clinic of Home Care Services.

3.2. Sample size

To detect a medium effect size of differences between control and experimental groups at a 0.05 level of significance and the power of 0.80, 26 subjects are normally required in each group (Cohen, 1992). It was decided that both groups should include 40 caregivers considering similar studies and the possibility of caregivers abandoning the study (Oupra et al., 2010; Smith, Egbert, Dellman-Jenkins, Nanna, & Palmieri, 2012; Temizer & Gözüm, 2012). Six caregivers from the experimental group and four caregivers from the control group were excluded from the study due to reasons such as moving to another city, withdrawing from the study and death of stroke patients. Therefore,

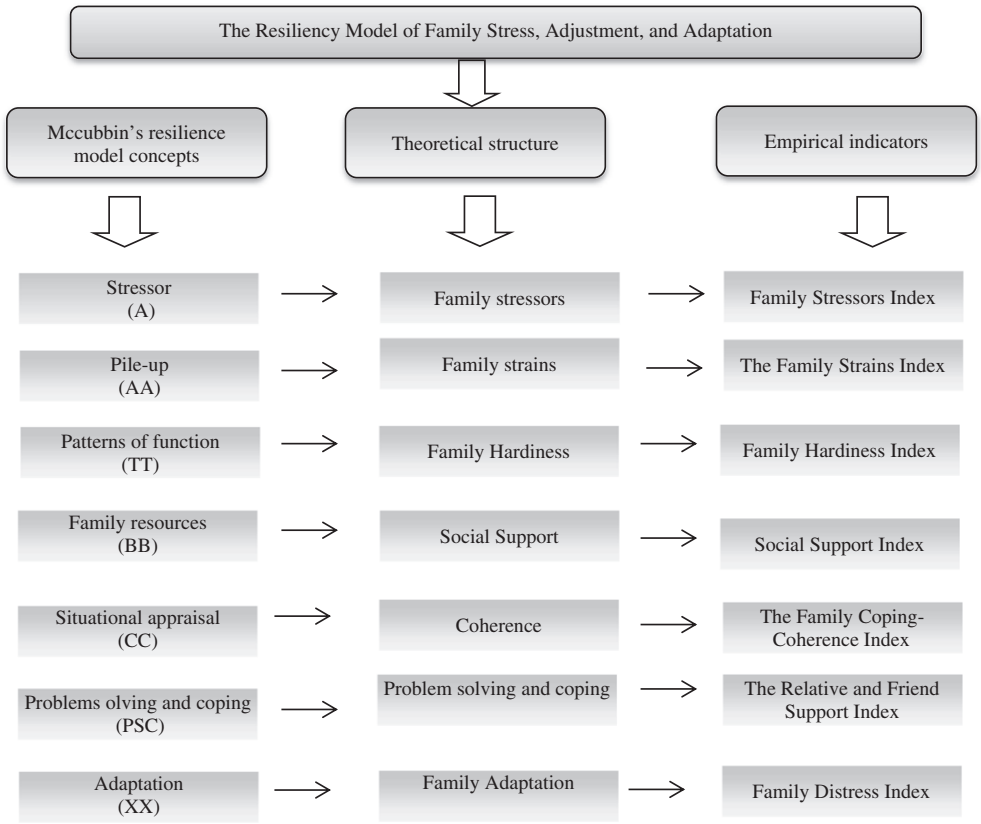

Fig. 1. Conceptual, theoretical, empirical structure of resilience of female family caregivers.