

Relationships among Communication Self-Efficacy, Communication Burden, and the Mental Health of the Families of Persons with Aphasia

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Background: The purpose of this study was to elucidate the relationships among communication self-efficacy (SE), communication burden, and the mental health of the families of persons with aphasia using structural equation modeling (SEM). *Methods:* This study examined 110 pairs of persons with aphasia receiving home care and 1 family caregiver per person with aphasia. The survey items for this study consisted of the Communication Self-efficacy Scale, the Communication Burden Scale, the Geriatric Depression Scale—Short Form—Japanese, and the Health-Related Quality of Life: SF-8 Health Survey. The relationships between the constructive concept of “communication self-efficacy” and “communication burden,” and “mental-health status” were analyzed using SEM. *Results:* The results of the SEM analysis revealed that a high communication SE of the families was associated with low burden of communication and good mental-health status. *Conclusions:* Psychoeducational programs that address the communication SE of family caregivers may have the potential to reduce the burden of communication and to improve the mental health of caregivers. These programs could lead to an enhanced quality of life for both persons with aphasia and their families. **Key Words:** Aphasia—family caregiver—communication self-efficacy—communication burden—mental health. © 2015 National Stroke Association. Published by Elsevier Inc. All rights reserved.

Introduction

Aphasia is an acquired language impairment caused by organic brain damage. Persons with aphasia have impairments in all aspects of language modalities including

listening, reading, speaking, and writing. Furthermore, sufficient time and much effort are needed to recover from aphasia, and a complete recovery of language functions is often not obtained. Therefore, aphasia leads to a marked deterioration in the quality of life (QoL) of persons with aphasia.¹⁻⁴

Given the above, a communication environment conducive to coping with aphasia may be necessary to maximize communication skills and to improve the QoL of persons with aphasia. Under these circumstances, family caregivers may struggle to provide a better communication environment for persons with aphasia under their care. However, families often feel very embarrassed and may find it difficult to communicate with persons with aphasia.⁵ The high stress and anxiety levels of family caregivers can negatively influence their care burden and mental health.⁶ In turn, the high care burden and poor mental health of the family caregivers may further deteriorate the communication environment surrounding

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persons with aphasia and disrupt the relationship between persons with aphasia and their families. This situation suggests that in the treatment of aphasia, the emphasis of not only functional training to improve the language impairments in persons with aphasia but also systematic specialized interventions to resolve the psychosocial problems of family caregivers may be important.⁷

To reduce the care burden and to maintain the good mental-health status of family caregivers, it is crucial to increase their stress tolerance during their communication with persons with aphasia and to improve their communication skills. Self-efficacy (SE) is a psychological factor that strongly affects the stress tolerance and communication skills of family caregivers. Bandura⁸ proposed the concept of SE in his social learning theory. SE represents a person's anticipation of the possibility of realizing an action. This factor strongly enhances the motivation for action, improves the learning efficiency, and reduces the levels of depression, anxiety, and sense of disappointment in families.⁹ Therefore, SE is expected to have the potential to improve the care of persons with aphasia. Family caregivers with high SE may be better equipped to understand the linguistic impairments of individuals with aphasia fully and to acquire appropriate communication skills, which are not necessarily easy for ordinary families. Communication SE is an indicator of the families' expectations of "to what extent they can communicate patiently with persons with aphasia." Tatsumi et al¹⁰ created a scale to assess the communication SE (Communication Self-Efficacy Scale [CSES]) of family caregivers. The reliability and validity of CSES have been verified, and its clinical utility has been confirmed. However, the relationships among the CSES, the burden of communication and mental health remain unclear in the family caregivers for persons with aphasia.

The purpose of this study was to verify the relationships among communication SE, communication burden, and the mental health of family caregivers using structural equation modeling (SEM).

Materials and Methods

Participants

This study was conducted in 110 pairs of persons with aphasia receiving home care and 1 caregiver per person with aphasia. The inclusion criteria for persons with aphasia in this study were as follows: (1) age of 30 years or older, (2) aphasia caused by a language-dominant-hemisphere stroke, (3) cohabitation with 1 or more family members at home, (4) attendance at an outpatient clinic, and (5) no history of mental illness. Medical information about the person with aphasia was obtained from the person's speech language pathologist. The severity of aphasia was assessed using the Boston Diagnostic Aphasia

Examination (BDAE) scale (a severity scale graded from 0 to 5). BDAE scores of 4 and 5 were defined as mild aphasia, scores of 2 and 3 were defined as moderate aphasia, and scores of 0 and 1 were defined as severe aphasia.¹¹ For the questionnaire survey for the family caregivers, questionnaires were handed to the family caregivers. The completed questionnaires were then collected on the day of request or within a few days.

Procedures and Assessments

The survey items consisted of the basic characteristics (age, gender, and years of education) of the persons with aphasia and of the family caregivers, the family relationship between the 2 individuals, and the period of care. The CSES was used to assess the SE of communication, the Communication Burden Scale (COM-B) was used to assess the burden of communication,¹² the Geriatric Depression Scale (GDS)-15 was used to assess depression,¹³ and the 8-item Short-Form Health Survey (SF-8) was used to assess the health-related QoL.¹⁴

The CSES is an SE scale consisting of 16 items related to communication with persons with aphasia. To measure the degree of certainty with which respondents believe that they can execute particular communication actions, that is, a sense of "confidence of being able to realize," they are required to rate each item using an 11-point scale, ranging from 0 to 10. A higher total score indicates a higher SE (minimum of 0 to a maximum of 160 points). The reliability and validity of this scale have been verified, and a factor analysis has confirmed that the CSES can be categorized into 3 subscales: consideration of the speech environment, consideration of the confirmation of intent, and consideration of the communication tool. This English version of CSES is given in [Appendix S1](#).

The COM-B is a specialized family care burden scale for the communication disorders of persons with aphasia. It consists of a total of 30 items, and the respondent is required to rate each item using a 5-point scale (1-5 points). A higher total score indicates a heavier care burden (minimum of 0 to a maximum of 150 points). A factor analysis has revealed that the COM-B can be classified into 4 subscales: caregivers' activity restriction, language impairment, cognitive and emotional impairment, and responsibility for household management.

The GDS-15 is a scale for assessing depression (minimum of 0 to a maximum of 15 points). Persons with a score of 11 or higher are assessed as being in a very depressed state, those with a score of 10-6 as having a tendency toward depression, and those with a score of 5 or less as having no tendency toward depression.

The SF-8 is an abridged version of the SF-36, which is a health-related QoL scale. Its reliability and validity have been demonstrated. The assessment is based on mental and physical summary scores that are determined using special scoring software for SF-8.

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