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The informal caregiver's socioeconomic prism and its implications on state of mind

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KEYWORDS
Caregivers;
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Abstract
Introduction: The act of caring for a dependent elderly victim of cerebrovascular accident exerts different impacts on caregivers. Knowledge of their socioeconomic level by health professionals supports the planning and implementation of actions appropriate to the reality of the elderly and their caregivers.
Objective: To determine whether socioeconomic status predicts informal caregivers' state of mind (depression).
Design: Cross-sectional, descriptive study in the Dão Lafões sub-region.
Participants: Non-probabilistic sample of 636 informal caregivers, aged 17-85 years (mean = 50.19 ± 14.30).
Measuring instruments: The Beck Depression Inventory and the Graffar Socioeconomic Level Scale.
Results: We found class III (middle class family/reasonable socioeconomic status) was the most common (40.4%), class IV (upper lower class family/low socioeconomic level) with 37.7%.
A majority of the sample (62.9%) does not have depressive symptoms, with their presence observed in 37.1% of informal caregivers, in which 24.3% are men and 39.6% women.
The results sustain that socioeconomic level ($P = .004$) in the total sample predicts state of mind, inferring that caregivers with poorer socioeconomic status have a worse state of mind.
Conclusions: The evidence found from the research show that informal caregivers with depressive symptoms have a poorer socioeconomic status, so that it is compulsory to consider these variables when planning interventions whose primary focus of attention is aimed at caregivers and elderly cerebrovascular accident victims experiencing situations of transition.

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Introduction

Cerebrovascular accident (CVA) as a nosological entity justifies the relevance of studying the state of mind of informal caregivers of dependent post-stroke elderly people, because the consequences vary and are devastating for the elderly and their families, affecting all aspects of life daily, such as motor skills, speech, emotions, memory and the lack of security that comes from not having the material resources for everyday expenses.

It is also justified because, although the rates of stroke mortality have been declining in Portugal, we are still one of the countries in the European Union with one of the highest mortality rates for this cause of death.[1] On the other hand, the trend towards ever earlier hospital discharges pressures the family to provide care, which it is not often prepared to do or does not feel prepared to do, with consequent physical, psychological and financial overload. This, in turn, endangers the mental health of informal caregivers.

It is known that the family's process of psychologically adapting to the elderly dependent member is complex and generates psychological distress. The sudden or gradual introduction of dependence, the prognosis of the elderly's disease and the resources available for the caregiver to carry out their tasks burdens their physical and psychological endurance.[2]

Therefore, depression emerges as one of the main negative consequences of the informal caregiver's role.[3]

Consequently, the general research question emerged as follows: to what extent does socio-economic level predict the state of mind of informal caregivers?

Thus, assuming the informal caregiver as an integrating part of the family system and the family as a systemic unit with social functions, a privileged space to support life and its members' mental health, determining whether socio-economic status predicts informal caregivers' state of mind (depression) was the aim of this study.

Material and methods

Investigating the state of mind of informal caregivers of dependent elderly members of the household after stroke is justified to the extent that emotional, psychological and physical overload they are subject to has implications for their mental health.

Design

Descriptive and correlational study with cross-sectional data collected in the Dão Lafões Sub-Region integrated in the NUTS III Statistical Territorial Unit in Portugal.

Participants

The sample was based on a total sample of 636 informal caregivers, obtained by a non-probabilistic network sampling technique, also known as snow-ball or chain.[4] The first members of the sample were asked to indicate others who met the eligibility criteria

Inclusion criteria: were defined as: being the main caregiver for over 6 months; cohabiting with the dependent elderly stroke victim; having no previous history of mental illness (depression or other). There was an exclusion criterion defined as: the elderly person having other highly disabling chronic diseases, unless they were secondary problems and/or complications of the CVA.

Formal and ethical procedures

Participation was voluntary with caregivers and the data collection instruments completed by the participants themselves, with the assistance of the researchers, whenever their assistance was requested for this purpose. The ethical principles on which standards of ethical conduct in research are based including the principle of respect for human dignity, the principles of justice and beneficence were taken into consideration. Anonymity and confidentiality were guaranteed in publishing results.[5]

Measuring instruments

The study protocol allowed relevant information to be collected to characterise informal caregivers in relation to personal, social-familial and psychological data. It also allowed us to assess the elderly victim's functional capacity.

We used validated measurement instruments namely, the Graffar Socioeconomic Level Scale[6] and the Beck Depression Inventory.[7]

Each of the 21 items of the Beck Depression Inventory represents a value (0, 1, 2 or 3), the total sum of the 21 statements varying within a range from 0 to 63, allowing depression levels to be differentiated from "absent" to "severe." A score of 12 was considered the cut-off point dividing individuals into depressed and not depressed.

In the study we consider the authors' values as the reference. There are no depressive symptoms when the aggregate of the Beck Depression Inventory is less than 12; there is a mildly depressed state, if values fall between 12 and 17; there is a moderate depressed state, if the score is between 18 and 23; there is a severely depressed state, if the score is greater than or equal to 24.

The mean of the Beck Depression Inventory indices are well centred and accepted as good because all of the items are greater than 0.20, correlating above 0.20 with the overall score when it does not contain the item.[8]

The Cronbach's alpha indices for all items indicated a very good consistency to ranging between 0.919 and 0.926. With reliability index calculated by the halves method, the value was also found to be quite good for the first and second half of the Split-half index (0.89 and 0.867 respectively) and the scale's overall alpha (alpha = 0.926).

The Graffar Scale is a widely used instrument for demographic characteristics in the human and social sciences.[9] The Portuguese version is one of the most widely used social assessment instruments in our country.[6] This scale allows us to measure the socioeconomic status variable in five classes:

- Class I — High upper class family, with a very good socioeconomic level (total score between 5 and 9 points).
- Class II — Lower upper class family, with a good socio-economic level (total score between 10 and 13 points).
- Class III — Middle-class family, with a reasonable socioeconomic level (total score between 14 and 17 points).