



Feature Article

Personality of the caregiver influences the use of strategies to deal with the behavior of persons with dementia

Graça Melo, PhD^{a,*}, João Maroco, PhD^b, Marta Lima-Basto, PhD^c, Alexandre de Mendonça, PhD^d

^a Escola Superior de Enfermagem de Lisboa, Universidade de Lisboa, Portugal

^b ISPA – Instituto Universitário, Portugal

^c Escola Superior de Enfermagem de Lisboa, Unidade de Investigação & Desenvolvimento em Enfermagem, Universidade de Lisboa, Portugal

^d Laboratório de Neurociências e Serviço de Neurologia, Instituto de Medicina Molecular e Faculdade de Medicina, Universidade de Lisboa, Portugal



ARTICLE INFO

Article history:

Received 25 January 2012

Received in revised form

27 July 2016

Accepted 1 August 2016

Available online 31 August 2016

Keywords:

Caregiver
Dementia
Personality
Behavior
Strategies

ABSTRACT

Personality of family caregiver is an important factor influencing the caregiver's burden, depression and distress. We now hypothesized that the personality is associated with specific strategies used by family caregivers to deal with the behavioral and psychological symptoms of demented relatives (BPSD). Participants were 98 consecutive persons with dementia and their family caregivers. Assessments included: Personality (NEO-FFI), Burden (ZBI), Depression (CES-D), Cognitive Function (MMSE), BPSD (NPI), Distress (NPI-D), and an open question to identify the strategies used by caregivers when faced with BPSD. Caregivers used different strategies to cope with their relatives' behavior: avoiding conflict; confronting; reassuring; orienting; responding coercively; distracting; colluding; medicating and restricting the movements. Extraversion was the only dimension of caregiver's personality that determined the use of caregiver strategies to deal with BPSD. Extroverted caregivers used the "confronting" strategy less often. Caregiver's personality should be taken into account when designing adapted intervention programs.

© 2016 Elsevier Inc. All rights reserved.

Introduction

Behavioral and psychological symptoms of dementia (BPSD) affect the majority of persons with dementia. Recently, a longitudinal study showed the overall frequency of BPSD increased over 3-year period. Approximately 90% of persons with dementia had one or more BPSD and over 50% had one or more clinically significant symptoms. Most (80%) experienced multiple symptoms, and over one-half had 4 or more symptoms at some point in the progression of the disease.¹

There is a growing interest in BPSD as they are responsible for a large share of the suffering of persons with dementia and family caregivers, and strongly determine the caregiver's health,^{2,3} patient's lifestyle and management.⁴ The severity of these symptoms, anti-psychotic medications and caregiver burden predict a shorter time to institutionalization.¹

Conflict of interest: None known.

Name of Institutions at the research was conducted: *Hospital de Santa Maria* (Lisbon) and *MemoClínica* (Lisbon).

* Corresponding author. Escola Superior de Enfermagem de Lisboa, Av. Professor Egas Moniz, 1600-190 Lisboa, Portugal. Fax: +351 21 795 47 29.

E-mail address: graca.melo@esel.pt (G. Melo).

Behavioral and psychological symptoms of dementia are probably related to a complex interplay of psychological, social and biological factors⁵ and should be understood within a dynamic process involving the person with dementia, the family caregiver and their environment. Hall and Buckwalter initially proposed the "Progressively Lowered Stress Threshold" as a conceptual model that explains the interaction of cognitively impaired persons with their environment. According to the model, persons with dementia are increasingly less able to manage stress as disease progresses. The authors described five stressors that increase the BPSD: fatigue; environmental, caregiver or routine changes; misleading or inappropriate stimuli; demands that exceed ability; and physical stressors.⁶ BPSD are known to be more stressful to family caregivers than cognitive or functional decline, because they are felt as the most difficult to manage^{5,7} and have a negative impact on the relationships between the caregiver, person with dementia and family.⁸ Family caregivers differ in their emotional responses to BPSD even when facing similar problems and the caregiver's perception of relatives' problems is more important than problem behavior "per se".⁹ Furthermore, family caregivers respond to BPSD in different ways,¹⁰ and health professionals can use the understanding about individual types of caregivers' responses to best help caregivers to do the tough work of caregiving.

The response of the family caregiver to BPSD is a crucial and modifiable aspect, but there is a little research on this topic. One study described the reactions of six family caregivers to wandering behavior of their demented relatives, showing that the caregivers employed a mixture of reality orientation, diversion, restricting movements, verbal and physical reprimands and psychotropic medication.¹¹ Another study reported the ways in which family caregivers respond to BPSD. The commonest response type was “none” (ignoring the behavior), followed by providing reassurance and diverting attention.¹⁰ On the other hand, verbal and physical reprimands, restriction of movements by locking doors and hiding keys, and dispensing psychotropic medications “as needed” were uncommon. In this study, delusions, sexual disinhibition, physical aggression and verbal disruption presented the greatest difficulties to caregivers. Another study identified three types of family caregiver management strategies, based mainly on how the caregiver accepted the caregiving situation and the dementia-related problems: non-adapting, nurturing and support.⁵ In a recently study, caregivers described on average, fewer than four strategies for managing BPSD. Encouraging activity, utilizing psychotropic medications, identifying triggers, restraining or treating in a paternalistic manner, and meeting physiological needs were the most commonly used strategies.¹² Notably, some caregivers used aspects of different strategies in conjunction.

No doubt, many factors influence the reciprocal nature of the interaction between persons with dementia and their caregivers, and the perception of the effectiveness of this interaction. Among these factors, caregivers’ personality could be particularly relevant to determining the type of caregivers’ response to their relatives’ behavior problems, because personality characteristics affect the processes that individuals use to appraise stressful events and predispose them to cope in certain ways when they confront these events.^{13,14} Caregivers with higher levels of neuroticism more often reported non-adapting approaches to manage BPSD, namely emotion-focused and not problem-focused coping strategies.^{5,15} In a previous study, we showed that the personality of the caregiver is an important factor for determining the caregiver’s depression and burden, and can also indirectly influence the caregiver’s distress related to BPSD.¹⁶

The role of health professionals who are knowledgeable and skilled in dementia care is a key factor in providing education, targeted information and individual and support groups to family caregivers.¹⁷ In this way, the personality of family caregiver could be an important feature in designing specific individual support and psycho-education interventions that reflect individual uniqueness and wholeness. This would help family caregivers to understand and cope with their relatives’ behavior problems, improving the level of care, decreasing the use of anti-psychotic medication, and promoting the quality of life of both patients with dementia and caregivers.

The purpose of this study was to test the hypothesis that personality is associated with specific strategies used by family caregivers to deal with the behavioral and psychological symptoms of persons with dementia.

Material and methods

Type of study

A cross-sectional design was used to determine the association between personality traits and specific strategies used, in the previous month, by family caregivers to deal with BPSD.

Participants

The participants were dyads (family caregiver – person with dementia), consecutively recruited at a Dementia Outpatient Clinic. Requirements for participation were living at home, the family caregivers should have been in the caregiving role for a minimum of 6 months, and have spent at least 2 hours per day caring for the relative. The *family caregiver* was any relative, partner, friend or neighbor who had a significant personal relationship with, and was most responsible for day-to-day decisions and care of the patient, and not financially compensated for services. Participants with dementia must fulfill the DSM-IV-TR diagnostic criteria.¹⁸ All persons with dementia underwent a standard assessment protocol, including clinical history, neurological examination, neuropsychological testing, laboratory evaluation, and brain imaging, according to Knopman et al.¹⁹ Family caregivers with abnormal Mini-Mental Status Examination (MMSE), severe deafness or another communication problem or recent disease that could influence the responses were excluded.

One hundred and ten family caregiver – person with dementia dyads were approached and all agreed to participate in the study. Five cases were excluded for the following reasons pertaining to caregivers: refusal of home visit, severe deafness, bipolar disorder, cognitive deficit (low MMSE score), widowhood a month ago, and recent diagnosis of leukemia. Seven cases were excluded because the tape recordings of the answers to the open question were lost. Thus, the participants were 98 family caregiver – person with dementia dyads.

Data collection

The questionnaires were administered to the caregivers in a face-to-face interview at home, without the presence of the person with dementia. In all cases, the interviews were conducted by the same trained nurse. The average time of the interviews was 100 ± 21 min. The project was approved by the Research Ethics Committee of the *Hospital de Santa Maria*, Lisbon. Written informed consent was obtained from all participants, after full explanation of the procedures.

Evaluation of persons with dementia and family caregivers

Sociodemographic variables (age, gender, education level, type of relationship and living together) were registered during the interview with the family caregivers.

The *Mini-Mental Status Examination*^{20,21} is one of the most widely used screening instruments for dementia, and provides a total score ranging from 0 to 30, with lower scores indicative of greater cognitive impairment. It was administered to the patients to obtain an overall level of current cognitive function, and to caregivers to rule out significant cognitive deficits. The normative cut-off values of dementia screening, adjusted to the education of the Portuguese population, were considered: abnormal values were ≤ 22 (1–11 years of education) and ≤ 27 (more than 11 years of education).²¹ These cut-off values adjusted to education levels were similar to those found in other studies (see, for instance, Ostrosky-Solis et al.²²; Uhlmann and Larson,²³ for the effect of education on MMSE cut-off scores).

Evaluation of persons with dementia

The stage of dementia was evaluated, by the family caregiver, with the *Global Deterioration Scale* (GDS),^{24,25} a well-established scale used to measure the severity of functional and cognitive

Download English Version:

<https://daneshyari.com/en/article/5567877>

Download Persian Version:

<https://daneshyari.com/article/5567877>

[Daneshyari.com](https://daneshyari.com)