

Review Article

# Predictors and outcomes for caregivers of people with mild cognitive impairment: A systematic literature review

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## Abstract

**Background:** Dementia caregiving is strongly linked to depression, anxiety, and burden in caregivers. Little is known about whether the same holds for people supporting an older person with mild cognitive impairment (MCI). We aim to systematically review the current evidence for negative caregiver outcomes in MCI using Pearlin and colleagues' stress process model as a theoretical framework.

**Methods:** Widely used scientific literature databases were searched using MCI- and caregiver-related terms with "AND" relations. Results were limited to quantitative English language articles published in peer-reviewed journals between 1980 and November 2010.

**Results:** Of the 266 identified articles, six reported relevant depression data on 988 MCI caregivers (73% spouses). The pooled Center for Epidemiologic Studies Depression scale (CES-D) mean score was 12.95 (standard deviation = 6.16). The pooled depression prevalence (i.e., CES-D score  $\geq$  16 or equivalent) was 23%. Two studies compared depression in MCI and dementia caregivers, indicating higher levels in dementia caregivers. Other outcomes, such as burden, stress, or anxiety, were only investigated by individual studies precluding pooling of data. Similarly, pooling of the data on the predictors of caregiver outcomes was impossible because of data heterogeneity. However, descriptive analysis of predictors revealed that Pearlin and colleagues' caregiver stress process model at least partially applies to the MCI context.

**Conclusions:** The studies reviewed were all cross sectional in design, involving clinical samples, thus limiting generalizability. Depression and psychological comorbidity, although not as pronounced as in dementia caregivers, are common complications in MCI caregivers. The long-term course of outcomes in MCI caregivers requires further investigation.

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## Keywords:

Caregiver; Mild cognitive impairment; Depression; Burden; Caregiver outcomes

## 1. Introduction

Mild cognitive impairment (MCI) is defined as cognitive decline beyond normal healthy aging but short of meeting diagnostic criteria for dementia [1–3]. Population-based research shows MCI prevalence rates ranging from 10% to 35% [4–9], with annual incidence rates ranging from 5% to 10% for community-based studies and 10% to 15% in clinical samples [10,11]. Diagnostic criteria for MCI

comprise (i) cognitive complaints (subjective or from a family member), (ii) absence of dementia, (iii) significant change from normal cognitive functioning, and (iv) decline in any area of cognitive function while having (v) preserved overall general functioning (increased difficulties with more complex activities of daily living [ADLs] are acceptable) [3].

The negative impact of dementia caregiving [12–14] and the detrimental effects of cognitive [15], functional [16], and behavioral symptoms of dementia on caregivers, in particular [17], are well established in the literature. Many of those dementia symptoms are already present to a lesser extent in MCI [18,19]. Family members of people with MCI provide

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help and support with more complex instrumental activities of daily living, such as transportation, taking medication, or cooking, for 24 to 28 h/wk [20,21]. As the effects on and contributions of support by family caregivers are a large component of informal costs of dementia [22,23], they are likely to be the drivers of the more modest costs of MCI. Psychological or behavioral symptoms, such as depression, anxiety, and apathy—all linked to burden of care in dementia caregivers [17]—are also common in MCI [24,25]. The reported prevalence of experiencing at least one neuropsychiatric symptom ranges from 43% in population-based studies to 85% in clinical samples [25–28]. However, little is known about the potential impact of those symptoms on family members of a person with MCI.

Family members and friends who support someone with MCI do not necessarily regard themselves as caregivers. However, for the purpose of this review and ease of communication, we will label them as caregivers but acknowledge that they do not necessarily provide care for the person with MCI.

Negative caregiver outcomes have traditionally been viewed as the result of a complex process of multiple interacting stressors and resources or a lack thereof [29,30]; one of the most commonly used caregiver stress models is the “stress process model of Alzheimer’s caregivers’ stress” by Pearlin and colleagues [29]. The “stress process model” consists of four dynamically interacting components: (a) background and context of stress, (b) primary and secondary stressors, (c) mediators of stress, and (d) outcomes or manifestations of stress [29]. Each component is briefly outlined later in the text. The model itself is summarized in Figure 1.

- a. Background and contextual variables include caregiver and patient demographics, social and economic characteristics of the family, and the caregiver’s physical health. Proximity to the patient, duration of the caregiving career, and living arrangements also fall into this category [29].
- b. The model postulates that there are primary and secondary stressors. Primary stressors are mainly disease/dementia related. They put caregivers under pressure and drive the stress process in that they may cause other secondary stressors. Cognitive function and the level of dependence in ADLs as well as behavioral problems in the care recipient are objective indicators of primary stress. In contrast, overload or relational deprivation (i.e., loss of intimacy and shared goals and activities with the patient) are considered subjective indicators of primary stressors [29]. Among secondary stressors, the model differentiates between “role strains” and “intrapsychic strains.” The former represent family conflicts, economic strains, or efforts to combine job and caregiving responsibilities, whereas intrapsychic strains consist of individual characteristics, such as self-esteem, mastery, loss of self, or role captivity.
- c. Coping skills and social support are regarded as mediators of the stress process and engage at several levels in the process [29]. By doing so, they can ameliorate the stress experience or, in case of lacking coping skills or social support, accelerate the stress process.
- d. Outcomes or manifestations of stress constitute the last component of the stress model, and include common psychological symptoms, such as depression,

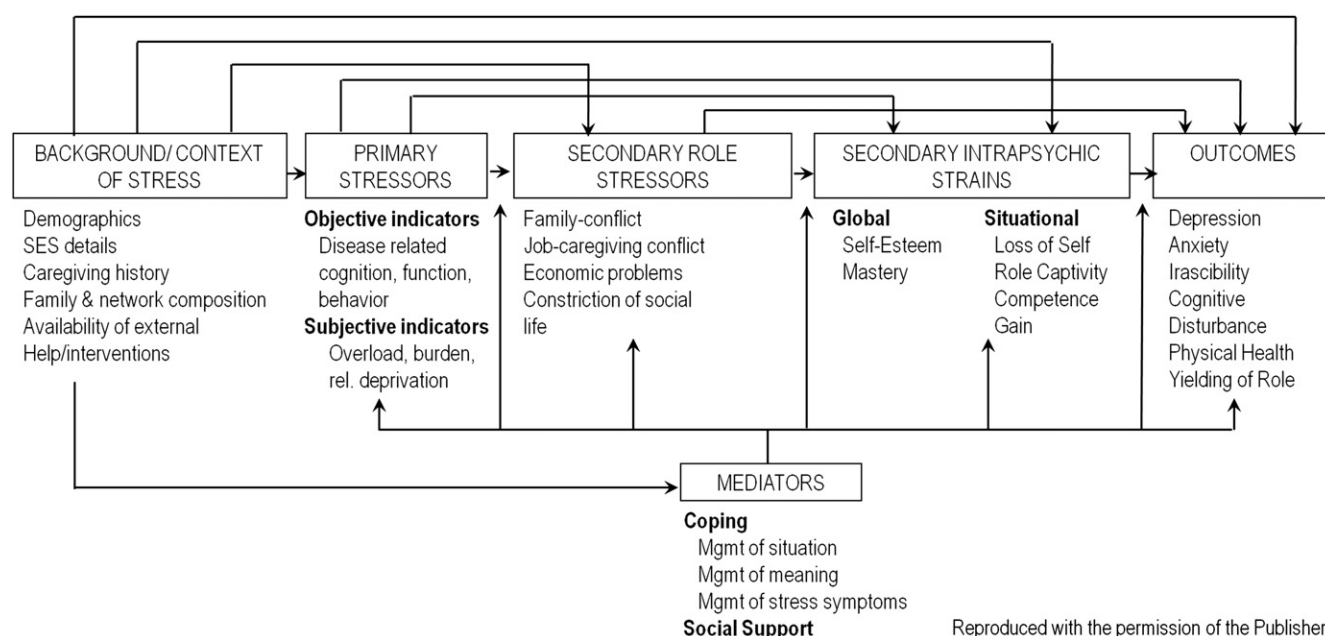


Fig. 1. The stress process model of Alzheimer’s disease caregivers’ stress by Pearlin and colleagues. Abbreviations: Mgmt, management; rel., relational; SES, socioeconomic status.

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