



A high sense of coherence protects from the burden of caregiving in older spousal caregivers

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ABSTRACT

Objectives: Caregiving is often associated with burden and chronic stress. Sense of coherence (SOC) may help the caregivers in coping with their stress and was identified as a positive factor for health outcomes and quality of life. We aimed to study the links between SOC, burden, depression and positive affects among caregivers of frail older patients.

Methods: Seventy-nine spousal caregivers were recruited via the geriatric outpatient clinic. Data collected: Zarit Burden Inventory, SOC-13, Geriatric Depression Scale, Caregiver Reaction Assessment (CRA), sleep, time of supervision, Katz Index, Global Deterioration Scale and Neuropsychiatric Inventory. Analyses: Caregiver's characteristics were analyzed by burden severity and SOC level. Multivariable logistic regressions were used in order to identify the variable that best predict caregiver burden and high SOC.

Results: The mean age was 79.4 ± 5.3 ; 53% were women. Among care-recipient, 82% had cognitive impairment and the median Katz Index was 3. Caregivers with a high SOC and an older age reported a lower burden (Odds Ratio (OR) 0.18, 95% confidence interval (CI) 0.04–0.65 and OR 0.87, 95% CI 0.76–0.98, respectively). A higher burden was associated with patient functional limitations (OR 8.69, 95% CI 2.28–40.46).

Discussion: Having a high sense of coherence seems to be a protective factor against the burden. To support caregivers, health providers should recognize the expertise of the caregivers and the meaningfulness of this care situation.

1. Introduction

Caring for frail older persons at home represent a high risk of burden for their caregiver, particularly in case of dementia (Schoenmakers, Buntinx, & Delepeleire, 2010).

Zarit defines the burden as all physical, psychological, emotional, social and financial consequences experienced by the caregiver (Zarit, Todd, & Zarit, 1986). Many scales assessing the burden of care have been proposed (Mosquera et al., 2016; Van Durme et al., 2012). Despite the large number of studies identifying factors associated with the caregiver burden, few were interested in the personality of the caregiver. Most have focused on patient characteristics (activities of daily living abilities, cognition, and behavioral disturbances) and caregiving characteristics (Bergvall et al., 2011; Germain et al., 2009).

Moreover, the majority of them assess caregiving as a stressful experience. This narrow vision could be extended by adding potential

resources for the caregivers, such as the sense of coherence, and promoting the positive effects of the caregiving situations, such as self-esteem.

The concept of sense of coherence (SOC) was proposed by A. Antonovsky (Antonovsky, 1987) to explain why some people remain healthy in spite of stressful life situations. His salutogenic theory focused on factors that support human health and well-being rather than on factors that cause disease. He defines SOC as a permanent, but dynamic and reliable feeling. SOC consists of understanding life events (Sense of Comprehensibility), the ability to manage them (Sense of Manageability) and feeling that they have meaning (Sense of Meaningfulness). SOC has been shown to be reliable, valid and cross-culturally applicable (Eriksson & Lindstrom, 2005). The hypothesis of Antonovsky was that with a stronger feeling of coherence, there is a higher probability of remaining healthy. A high SOC allows people to react with flexibility and to activate corresponding resources. Indeed, a high

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SOC has been shown to be a predictor of quality of life (Eriksson & Lindstrom, 2007) as well as a protective factor against mortality (Poppius, Tenkanen, Hakama, Kalimo, & Pitkanen, 2003; Surtees, Wainwright, Luben, Khaw, & Day, 2003) and functional decline, even in a population with a high vulnerability to adverse outcomes (Boeckxstaens et al., 2016). SOC is best described as a continuous process as opposed to a stable personality characteristic (Eriksson & Lindstrom, 2005). It has been suggested that SOC may develop during lifespan and is increasing with age (Nilsson, Leppert, Simonsson, & Starrin, 2010). SOC was generally also higher in men than in women (Nilsson et al., 2010) and inversely associated with depressive symptom (Dezutter, Wiesmann, Apers, & Luyckx, 2013).

There is few literature existing on caregivers' SOC. Some studies have indicated that a higher SOC is associated with a lower burden (Andren & Elmstahl, 2008) and lower distress (Valimaki, Vehvilainen-Julkunen, Pietila, & Pirttila, 2009). So, a caregivers' high SOC might be an individual resource that successfully helps to cope with caregiving. However, caregiver's depression seems also associated with a low sense of coherence and quality of life (Orgeta & Sterzo, 2013; Valimaki et al., 2009).

On the other hand, in 2014, a survey of the National Research Center (USA) found that 83% of caregivers viewed caregiving as a positive experience. This positive affect could potentially protect caregivers against some of the stress-related health outcomes. The Caregiver Reaction Assessment (CRA) (Pascal Antoine & Christophe, 2007) estimates the various aspects of the caregiving situation by considering positive and negative dimensions of the caregiver's reactions.

In this context, we evaluated the associations between SOC, positive affects, depression and the burden experienced by older caregivers.

2. Design and methods

This was a cross sectional analysis of data from a cohort study of older spousal caregivers focusing on caregivers' health.

2.1. Participants (caregivers)

Caregivers were recruited from March 2015 until May 2016 via the geriatric outpatient's clinic and memory center at the University Hospital in Namur, and with the help of general practitioners and home nurses. The inclusion criteria were more than 70 years of age and living at home with a spouse with either a cognitive deficit (score more than 3/7 on the global deterioration scale (Reisberg B, 1982 Reisberg, de Leon & Crook, 1982)) or functional decline (a minimum dependence of 1 activity of daily living). Caregivers were met at their home in the morning. All provided written informed consent that was approved by the CHU UCL Namur Institutional Review Board (NUB: BO39201422799).

2.2. Socio-demographic data of caregivers

We collected data on the caregiver demographic characteristics, including age, sex, educational level and income level. Socioeconomic status was constructed as suggested by Cockerham (Cockerham, 2007). A total score for the socioeconomic status was calculated as the sum of education (primary school = 1; unfinished secondary education = 2; secondary education = 3; higher education = 4), income (difficult = 1; easy = 2) and past occupation (worker-farmer-unemployed = 1; craftsman-self-employed = 2; employee-officer = 3; manager-liberal profession = 5)

2.3. Medical data of caregivers

The presence of comorbidities was evaluated with the Charlson Comorbidity Index (Charlson, Pompei, Ales, & MacKenzie, 1987). The short physical performance battery (Guralnik et al., 1994) was used to

assess the lower extremity function. It includes balance (ability to stand in tandem positions), gait speed (time to walk 4 m) and strength (time to rise from a chair and return to the seated position 5 times). Nutrition was assessed with the Mini Nutritional Assessment-short form (Kaiser et al., 2009), frailty phenotype was assessed with the definition of L. Fried (Fried et al., 2001) and cognitive status was assessed with the clock drawing test.

2.4. Psychosocial data of caregivers

Caregivers were asked to complete a set of four self-report questionnaires when we visited them at home. The CRA consists of 24 items in five subscales: self-esteem, lack of family support, financial problems, disrupted schedule and health problems. Responses are represented on a Likert-type scale and response options range from 1 = strongly disagree to 5 = strongly agree. A higher score on the caregiver's self-esteem subscale indicates a more positive reaction to caregiving, while higher scores on the other four subscales indicate greater negative effects.

Caregiver burden was measured using the Zarit Burden Interview (ZBI) (Zarit et al., 1986), which consists of 22 self-report items. Each item is scored on a 5-point, Likert-type scale ranging from 'never' to 'nearly always present'. Total scores range from 0 to 88 with higher scores indicating a higher perceived burden.

The Sense of Coherence Scale (SOC-13), a 7-point Likert-type scale, was used to estimate the caregiver's SOC. A systematic review of the validity and reliability of the shorter SOC-13 scale (Eriksson & Lindstrom, 2005) showed that it is generally acceptable among older people. SOC seems to be a health promoting resource, which strengthens the resilience and develops a positive subjective state of health. We determined the quartiles of the total score and divided the participants into a high-SOC group (highest quartile) and a medium-low SOC group.

We finally assessed depressive symptoms with the Geriatric Depression Scale-15 (GDS) (Leshner & Berryhill, 1994).

We also collected the following information on the caregiving situation: the time spent giving care or supervision and the duration as caregivers. Finally, we asked them about the quality of their sleep (sleep duration, more or less than 8 h and perturbation of sleep, yes/no) and the gratitude of their spouse ("Do you feel that your caring efforts are appreciated by your spouse?")

2.5. Medical data of care-recipient

Concerning the care-recipient, the presence of functional impairment was evaluated with the Katz Index (Katz, 1983) on a 6-point scale with lower scores indicating greater dependence. People with dementia were screened for behavioral disturbances with the Neuropsychiatric Index (Cummings et al., 1994; Kaufer et al., 2000) and the severity of dementia was rated with the Global Deterioration Scale (Reisberg B, 1982). All data for the care-recipient were completed by their caregivers. The history of the dependency and the evolution of the cognitive function were also evaluated as far as possible.

2.6. Statistical analyses

Continuous variables were summarized using means and standard deviation (SD) or median with the association P_{25} and P_{75} , depending on the normality of the distribution. Categorical variables were summarized using the frequencies and percentages. The burden was dichotomized into "low burden" (< 25/88 points) and "high burden" (> 24/88). This cut-off score has significant predictive validity for identifying caregivers who have a risk of depression (Schreiner, Morimoto, Arai, & Zarit, 2006). Variables were compared between the group of caregivers with low or high burden using a Student's *t*-test or Chi-square test, as appropriate. Correlations between the

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