Depressive symptomatology in care-givers of patients with Alzheimer’s disease

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Abstract:

Background: The stress and strain of being an Alzheimer's caregiver can cause physical and mental problems. Nearly half of all Alzheimer's caregivers report that they have suffered from depression at some point, according to the Alzheimer’s Association. The objective of this study was to identify depressive symptoms in caregivers of patients with Alzheimer’s disease.

Method: A descriptive study was carried out in the Department of psychiatry, Pakistan Institute of Medical Sciences (PIMS), Islamabad from May 2010 to September 2010. Thirty caregivers participated in the study. Informed written consent was obtained. The Beck Depressive Inventory (BDI) was used.

Results: 57% of caregivers met criteria for depression. The females scored more on the depressive scale compared to males (Female = 73%, Male = 40%).

Conclusion: Female caregivers are more prone to depression. Caring for the carer is as important as caring for the individual with Alzheimer’s disease.

Key Words: Depressive symptomatology, Care-givers, Alzheimer’s

Introduction

Alzheimer's disease is the most common type of dementia. Alzheimer's disease causes changes in mood and personality (All-on-Depression-Help.com, 2009). Stress, anger, guilt and grief related to care giving can lead to depression. Caregivers can experience depression at any point in the disease process.

Caregiver distress is typically operationalized as caregiver depression or caregiver burden. Caregiver depression is a mood disturbance resulting from the stress of providing care (Fortinsky et al., 2002; Harris et al., 2001), which may be manifested as feelings of loneliness, isolation, fearfulness, and being easily bothered. Caregiver burden is considered “a multidimensional bio-psychosocial reaction resulting from an imbalance of care demands relative to caregivers’ personal time, social roles, physical and emotional states, financial resources, and formal care resources given the other multiple roles they fulfill” (Given et al., 2001, p. 5). Together, caregiver burden and depression may be considered as a general distress response for caregivers. Although there is a great deal of research on correlates of distress for caregivers who are at various points in the care trajectory, little work has been done to assess the impact of providing end-of-life care on the distress of family caregivers of patients with Alzheimer’s disease (Given et al., 2004). This study focused on how Alzheimer disease affects caregiver’s mental health and its association with depressive symptoms.
Method

A descriptive study was carried out in the Department of psychiatry, Pakistan Institute of Medical Sciences (PIMS), Islamabad from May 2010 to September 2010. Fifteen male and fifteen female caregivers participated in the study. Informed written consent was obtained. The Beck Depressive Inventory (BDI) was used.

The data collection questionnaire had demographic information including gender of caregiver, educational status, number of family members, socio-economic status, and caregiver’s relationship with patient and duration of illness.

A standardized scale of depression, the Beck depression inventory (BDI), was used for the assessment of depressive symptoms in care givers.

The statistical package for social sciences (SPSS) was used for data analyses.

Results

Most of the caregivers (51.6%) had more than five family members. The monthly income in the majority (54.8%) of the families was above 10,000 Pakistani rupees. The majority of the care givers (64.5%) are non-spouses. In most (58.1%) the duration of illness was greater than 12 months.

Results of the BDI indicate that the majority of the care givers are depressed due to the illness of their loved ones and their care giving roles and responsibilities (Table 1). It was also found that females are more depressed than males.

<table>
<thead>
<tr>
<th>Carers</th>
<th>Depressed</th>
<th>Not depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>06 (40%)</td>
<td>09</td>
</tr>
<tr>
<td>Female</td>
<td>11 (73%)</td>
<td>04</td>
</tr>
<tr>
<td>Total</td>
<td>17 (56%)</td>
<td>13</td>
</tr>
</tbody>
</table>

Discussion

The study shows that depression is common in caregivers of patients with Alzheimer’s disease.

The family members of patients with Alzheimer experience distress due to care giving roles. This distress has been shown to continue over time and may be exacerbated by changes in the patient’s condition. The emotional impact of providing care is linked to caregiver negotiation of the care giving role, as caregivers may be unfamiliar with the care they must provide and may not be aware of or able to utilize available resources (Given and Given, 1992; Oberst et al., 1989).

The distress resulting from assuming the role of caregiver can be manifested as anxiety, depression, helplessness, burden, and fear (Nijboer et al., 2001; Weitzner et al., 1997; Northouse et al., 1995; Siegel et al., 1991; Blank et al., 1989) and is often related to providing direct care, performing complex medical procedures, coping with disruptions in daily routine, and negotiating the need to provide emotional support to the patient and to other family members. Specifically, caregivers may experience distress from assuming the responsibility for communicating with healthcare professionals, managing symptoms, administering medication, performing medical/nursing treatment and handling patient behavioral problems and emotional reactions (Kurtz et al., 2002; Weitzner et al., 2000; Sarna and McCorkle, 1996; Schumacher, 1996; Schumacher et al., 1995; Kurtz et al., 1995; Laizner et al., 1993; Given and Given, 1991). Caregiver distress may stem from the reprioritization or relinquishment of responsibilities related to childcare and employment, the prioritization of home-care demands, and the negotiation and renegotiation of factors related to familial and generational relationships (Lyons et al., 1999; Weitzner et al., 1999; Sales, 1991). Consistently reported predictors for caregiver distress include caregiver gender (Northouse et al., 2000), level of personal and social support, patient functional status (Stommel et al., 2002; Williamson et al., 1998),
and patient symptom status (Kozachik et al., 2001; Nijboer et al., 2001; Nijboer et al., 2000; Song et al., 1997; Foxall and Gaston - Johannson, 1996; Kurtz et al., 1995; Schultz et al., 1995; Clipp and George, 1993; Given et al., 1993; Schumacher et al., 1993). In general, female caregivers and caregivers with lower levels of personal and social support (Williamson et al., 1998) experience higher levels of distress.

Caregiver distress resulting from the patient’s functional status involves the caregiver’s level of assistance with activities of daily living (ADL): eating, dressing, bathing; and instrumental activities of daily living (IADL: household tasks, shopping, and transportation). Decreases in the patient’s functional status increase the amount of tasks with which the patient requires assistance. Caregivers who must assist with multiple tasks, or with tasks they find difficult or unappealing (such as performing medical procedures at home or toileting) may have higher levels of distress (Kurtz et al., 2002; Given and Given, 1992). Research has shown that providing assistance with both ADLs such as bathing and toileting (Vitaliano et al., 1991), as well as IADLs such as errands or transportation (Gonzalez-Salvador et al., 1999) can increase caregiver distress. The patient’s symptom status (including number, type, and severity of symptoms) can also affect caregiver distress (Given et al., 2001). As patients’ symptom distress increases and results in depressive symptoms and deteriorations in quality of life for the patient (Sama, 1993, 1998; Sama and Brecht, 1997), functional limitations may increase and caregiver responsibilities to help manage symptoms and assist with functional limitations may increase. Patient symptom status requires caregiver assistance not only with recognizing emerging and changing patient symptoms related to the disease and its treatment, but also with the management of those symptoms (Kozachik et al., 2001; Nijboer et al., 1998; Williamson et al., 1998). For the patient with advanced disease, family assistance with symptoms may increase as the patient’s disease progresses and the patient’s health declines. In addition, caregivers have varying emotional reactions to patient symptoms, which can cause distress as the patient’s health declines (Toseland et al., 1995; Carey et al., 1991).

Conclusion

The impact of caring for a relative with Alzheimer’s brings the risks of mental ill health to the carer in the form of emotional stress, depressive symptoms or clinical depression. Being a caregiver is a complex role with many responsibilities. Female gender was a risk factor for caregiver depression. Caring for the carer is as important as caring for the individual with Alzheimer’s disease for a successful outcome in difficult circumstances.

References


