

OBJECTIVE AND SUBJECTIVE OVERLOAD AND ITS INFLUENCE ON THE MENTAL HEALTH OF PORTUGUESE INFORMAL CAREGIVERS

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Abstract: The 21st century is marked by population aging and as a consequence of this longevity there has been an increase in chronic and/or degenerative diseases typical of advanced ages, which may incapacitate those with them, leading to the need for long-term home care. In this scenario, the informal caregiver emerges, who will have the responsibility of caring for and getting involved in all activities that can guarantee comfort and well-being to the dependent family member. As the task of informal caregiving becomes more demanding, the possibility of caregivers manifesting symptoms of overload, whether objective and/or subjective, increases. There are several studies that point to the negative effects that the task of caring has on the mental health of informal caregivers. Therefore, the main objective of this article was to understand the relationships between objective/subjective overloads and psychopathological symptoms. To carry out this study, we used the Informal Caregiver Burden Assessment Questionnaire-QASCI (Portuguese version adapted from Martins, et. Al, 2003), and the Psychopathological Symptoms Inventory (BSI) (Portuguese version adapted by Canavarro, 2007). The analysis of the data presented is based on statistical inference carried out with the SPSS (Statistical Package for the Social Sciences) application version 20.0 for Windows. In conclusion, this study confirmed the existence of overload, as well as its influence on the mental health of the informal caregivers participating in this sample.

Keywords: Informal Caregiver, Objective/Subjective Burden, Mental Health.

INTRODUCTION

The 21st century has been characterized by an exponential increase in population aging worldwide, with Portugal being a country where this reality is no exception. According to the 2011 census, the country presents a very pronounced and progressive aging pattern, with 19% of the Portuguese population over 65 years old and an average life expectancy at birth of 79 years (INE, 2012).

This context gives rise to the emerging need for long-term healthcare, thus favoring informal care networks (Cruz, Loureiro, Silva, & Fernandes, 2010). According to Neri (2006), the provision of care to elderly and/or disabled people emerges from multiple sources, such as the family nucleus, group of friends, neighbors, members of religious groups or other people in the community, which are designated informal caregivers.

Taking on the task of informal caregiver has an impact on the personal, family, work and social lives of caregivers. They often become vulnerable, presenting some symptoms including: tension, fatigue, frustration, reduced social interaction, depression and reduced self-esteem (Martins, Ribeiro, & Garrett, 2003).

All these physical and psychological phenomena experienced by the informal caregiver while performing their task are called overload in the literature. This concept derives from the English term "burden", and has been used in gerontological literature to describe the negative effects that the task of caring has on the health and well-being of the informal caregiver (Montgomery, Gonyea, & Hooyman, 1985). Although there is no consensus in the literature on the definition of this topic, it is common to find two dimensions associated with this construct: objective/subjective overload (Figueiredo & Sousa, 2008). Objective Overload is associated with the demand for care provided depending on the

severity and type of dependence and behavior of the patient, as well as the consequences or impacts they have on the caregivers' personal, family, social, economic and professional lives (Figueiredo, 2007; Montgomery, Gonye & Hooyman, 1985). Regarding subjective burden, this is related to the emotional repercussions that the demands or problems associated with providing care can bring to the caregiver (Figueiredo & Sousa, 2008). In this sense, objective overload corresponds to the events perceived by caregivers (directly associated with the performance of the caregiver role), while subjective overload is related to the feelings and attitudes arising from the tasks and activities carried out in the care process (Weuve, Boult, & Morishita, 2000 cited by Martins et al., 2003).

It is widely recognized in the literature that the demands and consequences of providing informal care are potentially stressful situations, predisposing the caregiver to the development of feelings of anger, resentment and bitterness, caused by excessive responsibility and deprivation (Pereira, 2011). According to this author, the caregiver can become an intolerant person, easily irritated, bitter at work and in their own home, and can distance themselves emotionally from the person they care for, assuming a stance of coldness and indifference. Overall, studies on this topic highlight the negative effects that objective and subjective overload may have on the health of informal caregivers, mainly affecting their mental health (Martins et al., 2003). In this sense, our study's main objective was to understand the relationship between objective/subjective burdens and psychopathological symptoms perceived by informal caregivers.

PARTICIPANTS

The sample was selected by convenience, consisting of 30 participants from the Cacia Health Center (12 users), Ílhavo Health Center (07 users), Aveiro Health Center (03 users), Social and Parish Center of Santo Antonio de Vagos (02 users), Boa Hora Community Center (03 users) and Association of Friends of Multiple Sclerosis (03 users).

INSTRUMENTS

INFORMAL CAREGIVER BURDEN ASSESSMENT QUESTIONNAIRE-QASCI (PORTUGUESE VERSION ADAPTED BY MARTINS ET AL., 2003)

The QASCI (Martins et al., 2003) is a self-report instrument designed to assess the physical, emotional and social burden of informal caregivers. The QASCI consists of 32 items, distributed across seven dimensions: 1) emotional overload; 2) implications for personal life; 3) financial burden; 4) reactions to demands; 5) effectiveness and control mechanism; 6) family support; 7) satisfaction with the role and family. Satisfactory internal consistency indices were obtained for all these dimensions with the present sample. In this study, the indices of this scale with the respective dimensions had the following results: emotional overload $\alpha=0.630$; Implications on personal life $\alpha=0.866$; Financial burden $\alpha=0.826$; Reactions to demands $\alpha=0.520$; Efficacy and control mechanism $\alpha=0.287$; Family support $\alpha=0.731$; Satisfaction with role and family $\alpha=0.793$.

PSYCHOPATHOLOGICAL SYMPTOM INVENTORY (BSI) (PORTUGUESE VERSION ADAPTED BY CANAVARRO, 2007)

It is a self-report inventory that assesses nine dimensions of psychopathological symptoms: Somatization; Obsessions Compulsions; Interpersonal sensitivity; Depression; Anxiety; Hostility; Phobic Anxiety; Paranoid Ideation and Psychoticism. Satisfactory internal consistency indices were obtained for all these dimensions with the present sample, we obtained the following results: Somatization $a = 0.758$; Obsessions-Compulsions $a = 0.825$; Interpersonal sensitivity $a = 0.606$; Depression $a = 0.805$; Anxiety $a = 0.785$; Hostility $a = 0.579$; Phobic anxiety $a = 0.423$; Paranoid Ideation $a = 0.793$ and Psychoticism $a = 0.297$.

RESULTS

Of the 30 participants, 23 were female and 7 were male, aged between 14 and 83 years ($M = 60.9$; $SD = 13.8$). Regarding education level, 63.3% have completed the 1st cycle. Regarding professional status, 23.3% are retired, 20% are domestic workers, and 16.7% do not work or are unemployed.

CAREGIVER BURDEN AND MENTAL HEALTH

Regarding the study of the association between caregiver overload and their mental health (assessed through the psychopathological symptomatology inventory – BSI), we found that in relation to the emotional overload dimension, it presents statistically significant positive correlations with the interpersonal sensitivity scale ($rs = .449$; $p < .05$), depression ($rs = .501$; $p < 0.01$), anxiety ($rs = .365$; $p < 0.05$) and hostility ($rs = .402$; $p < 0.05$). Concerning the dimension of implications for personal life, we found statistically significant positive correlations with depression (BSI) ($rs = .374$; $p = 0.05$),

hostility (BSI) ($rs = .376$; $p < 0.05$) and paranoid ideation (BSI) ($rs = .474$; $p < 0.01$). Regarding the financial burden dimension, we found statistically significant positive correlations with the anxiety (BSI) dimension ($rs = .472$; $p < 0.01$) and phobic anxiety (BSI) ($rs = .391$; $p < 0.05$). Finally, regarding the reaction to demands dimension, we found significant correlations with the interpersonal sensitivity (BSI) dimension ($rs = .453$; $p < 0.05$), anxiety ($rs = .419$; $p < 0.05$) and hostility ($rs = .519$; $p < 0.01$) (see table 1).

No significant correlations were found between the remaining overload dimensions and the psychosymptomatology indices assessed.

DISCUSSION

Having as main objective the study of the relationship between types of overload and psychopathological symptoms in informal caregivers, our results suggest the significant presence of positive and moderate correlations between emotional overload and psychosymptomatology associated with interpersonal sensitivity, depression, anxiety and hostility in the caregiver informal. In most of the studies we analyzed, the mental health of informal caregivers focuses on the symptoms of depression and anxiety (Pereira & Mateos, 2006). In this study, in addition to these two symptoms, it was possible to find high scores in the symptoms of interpersonal sensitivity and hostility. Depression and anxiety are still the two main problems revealed by most caregivers (Parks, 2000; Benjamin & Cluff, 2001; Cohen & Eisdorfer, 2001; NCEA, 2002 cited by Figueiredo, 2007). Several authors, including Anthony-Bergstone, Zarit & Gatz (1988), Kinney & Stephens (1989), Schulz & Williamson (1991 cited by Figueiredo, 2007) have shown that depressive symptoms such as sadness, despair, frustration, restlessness, etc., may be

	Emotional Overload	Implications Personal life	Financial burden	Reactions to demands
Interpersonal sensitivity	,449*	,331	,147	,453*
Depression	,501**	,374*	,341	,249
Anxiety	,365*	,354	,472**	,419*
Hostility	,402*	,376*	,057	,519**
Phobic anxiety	,302	,073	,391*	,303
Paranoid ideation	,317	,474**	,189	,330

Table 1. Correlation analyzes between the Informal Caregiver Burden Questionnaire (QASCI) and the Psychopathological Symptom Inventory (BSI)

** $p \leq 0,01$

* $p \leq 0,05$

associated with the progressive deterioration of the family member's health status, the reduction of free time, and the lack of support. Anxiety arises due to constant concern for the health of the family member, one's own health, associated family conflicts, lack of time, etc. These results are in line with or in line with studies by Paúl (2005) and Brito (2000), which also reinforce that the manifestation of these feelings will trigger psychological distress in caregivers, causing symptoms of anxiety and depression. Regarding the dimensions of implications for personal life, financial burden and reactions to demands, the results of this study indicate a significant correlation with the symptoms of interpersonal sensitivity, hostility, phobic anxiety and paranoid ideation. Regarding these aspects, there are few studies that evaluate psychiatric symptoms in a population of informal

caregivers. However, studies by Pereira (2011) suggest that all dimensions of overload are strongly associated with worse mental health among caregivers, negatively interfering with their physical and psychological well-being, a situation that requires greater attention from care professionals. health, in order to enable measures that can mitigate the impacts of overload and promote the health and well-being of caregivers. In conclusion, we can state that the objective and subjective overload to which informal caregivers are subject appears to have a negative effect on the integrity of their mental health. This loss may result in a reduction in their quality of life, with the development of primary and secondary prevention programs that contribute to a better psycho-emotional adjustment of caregivers with the aim of promoting their quality of life and well-being. in general.

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