

A Randomized Controlled Trial of Enhancing Positive Aspects of Caregiving in Thai Dementia Caregivers for Dementia

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Abstract: Strengthening the positive aspects of caregiving for dementia caregivers is necessary to minimize their burden. This Thai study examined the effectiveness of a program for enhancing positive aspects of caregiving and subjective well-being among caregivers of older persons with dementia. Seventy two participants were randomly assigned equally into experimental and control groups. The experimental group received the Program for Enhancing the Positive Aspects of Caregiving while the control group received usual care. The experimental program consisted of caregiving self-efficacy enhancement, exploring spirituality, and increasing perceived social support. Data were collected using the Positive Aspects of Caregiving Questionnaire and the Thai General Well-being Schedule and analyzed using descriptive statistics, and the one-way and two-way repeated measure ANOVA.

Results showed that the program could significantly increase positive aspects of caregiving among the caregivers at 8, 12 and 20 weeks after program implementation. The program could also significantly increase the subjective well-being of the experimental group at all points of measurement. Results of this study suggest that nurses can apply this program to enhance positive aspects of caregiving and subjective well-being for caregivers of older persons with dementia, however further testing of the program is required.

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Introduction

Dementia is a health problem more commonly found in older people. The number of elderly with dementia is expected to be 65.7 million in 2030 and 115.4 million in 2050.¹ As Thailand becomes an aging society, a current population-based survey pointed out that the prevalence of dementia was 12.3%, 8.9% in males and 15% in females. Furthermore, the prevalence of dementia is tripled at 80 years as compared to 60 years.²

Older people with dementia suffer a progressive loss of autonomy in performing basic activities of daily living (ADLs). And they need assistance from

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caregivers, particularly family members, who can provide care for them at home.³ Informal caregivers are key to providing care to people with dementia.

Caregiving is more difficult and puts strain on the caregiver physically and mentally as the disease progresses into moderate and severe stages.¹

Actually caregiving may not be a negative experience; it can generate positive feelings in family members. Understanding the positive aspects of caregiving (PAC) may help clinicians and practitioners work more effectively with caregivers,⁴ and their enhancing positive aspects of caregiving may help protect and enhance caregivers' well-being.⁵ Previously, interventions for most caregivers were offered with the main purpose of reducing the negative impacts of caregiving. However, the outcomes do not last long⁶ due to sustained and unavoidable difficult caregiving experiences.⁷ Therefore, an intervention focused on relieving negative impacts of caregiving may not fit in such situations, while an intervention focusing on enhancing PAC may be appropriate for those caregivers.

Literature review and theoretical framework

Positive aspects of caregiving are positive feelings resulting from caregivers' positive appraisal of their caregiving. Many terms have been used to represent positive aspects of caregiving such as gains⁴ uplift⁸, rewards⁹, life satisfaction⁹, and finding meaning in caregiving.¹⁰ In Thailand, the terms fulfillment, feeling of closeness with the patients, gaining merit, and returning gratitude have been used.¹¹ The positive aspects are strong views of caregiving process. High levels of positive aspects of caregiving may help maintain quality of life for both caregivers and their relatives¹².

Kramer's two-factor adaptation model⁴ provides a set of concepts and propositions exploring positive and negative caregiving outcomes. In this model, there are three primary domains; background and context, intervening processes; and well-being outcomes. The intervening process consists of finding resources for situational appraisal that can be both positive and negative. The caregivers who have adequate resources

for providing care as needed may evaluate their caregiving tasks as positive (challenge).¹³

From literature reviews, resources of positive aspects of caregiving included self-efficacy,⁵ spirituality,¹⁴ religion,¹⁵ familism,¹⁶ coping,¹⁷ and social support.¹⁷ Self-efficacy, spirituality, and social support were main resources that related to enhanced positive outcomes, while other resources were the facilitators for positive appraisal⁴. Self-efficacy refers to caregivers' belief that they can assume personal control over caregiving problems and that they are able to successfully manage caregiving events.⁵ Caregivers of older people with dementia, who have a sense of efficacy, may better control their behavioral problems and be better involved in the uncertainty of such care. They may perceive caregiving as comfortable care and maintain positive views throughout the caregiving process. Spirituality, in the context of caregiving, refers to the interpretation of caregivers on the caregiving experience as the ultimate meaning¹⁸ that can be used to cope with a stressful event,¹⁷ and accept the caregiving problem themselves.¹⁹ Social support can affect the belief and cognitions of caregivers to be able to meet the challenges in their lives.²⁰ Having a chance to share caregiving experiences helps to relieve the pressure of caregiving.²⁰ Caregivers can then cope better with stressful events, increase problem solving abilities, improve the feeling of personal control, and also increase a sense of efficacy in caregiving role.²¹ Therefore, all resources can enhance positive appraisal and positive well-being of caregivers.

Studies of interventions for dementia family caregivers focusing on the main resources for positive aspects of caregiving have not been reported in both Western^{22,23} and Asian countries⁷, including Thailand. There is a need for an effective theory-based intervention to enhance the PAC among those caregivers. For this study we designed a program based on Kramer's model⁴ to enhance self-efficacy in caregiving, spirituality context, and perceived social support which were the resources for positive appraisal of caregiving situation. It was expected that the positive aspects of caregiving program (PEPACP) could enhance the caregiver's

positive aspects of caregiving and subjective well-being. Thus the following hypotheses were tested:

Mean scores of PAC and subjective well-being in the experimental group would be significantly higher than that of the control group as measured at 8 weeks, 12 weeks, and 20 weeks, and significantly higher than before receiving the PEPACP plus usual practice.

Method

Design: A randomized control trial (RCT) with two arms pre-post-test.

Sample and Setting: The sample size was estimated using power analysis method for ANOVA. A power of .80, a significance level of .05, and effect size of .40 were estimated from a previous study²¹. To enable one-way analysis, 36 participants per group were required but an additional 20% participants were added to compensate for possible attrition. Therefore, a total of 80 participants were recruited from three secondary medical care hospitals in the central part of

Thailand. These settings had similar care services for dementia caregivers. Prospective participants who met the inclusion criteria were invited to join the study. Inclusion criteria were: aged at least 20 years; being able to speak and read Thai; living with a relative who was diagnosed as having mild to moderate dementia according to the criteria of Mini Mental State Examination-Thai version (MMSE-Thai 2002 score ≤ 22)²⁴; and performing caregiving tasks for at least 4 hours per day. The participants were randomly assigned into two groups, one receiving the EPACP plus usual care and the other receiving only usual care. The program outcomes, PAC and subjective well-being were measured at baseline and at 8, 12, and 20 weeks after completing the intervention. After 20 weeks of data collection, eight participants were excluded from the study, four from each group, due to their inability to attend all intervention sessions and being out of town. The dropout rate was 5%. Therefore, 72 participants completed the study, 36 in both groups (Figure 1).

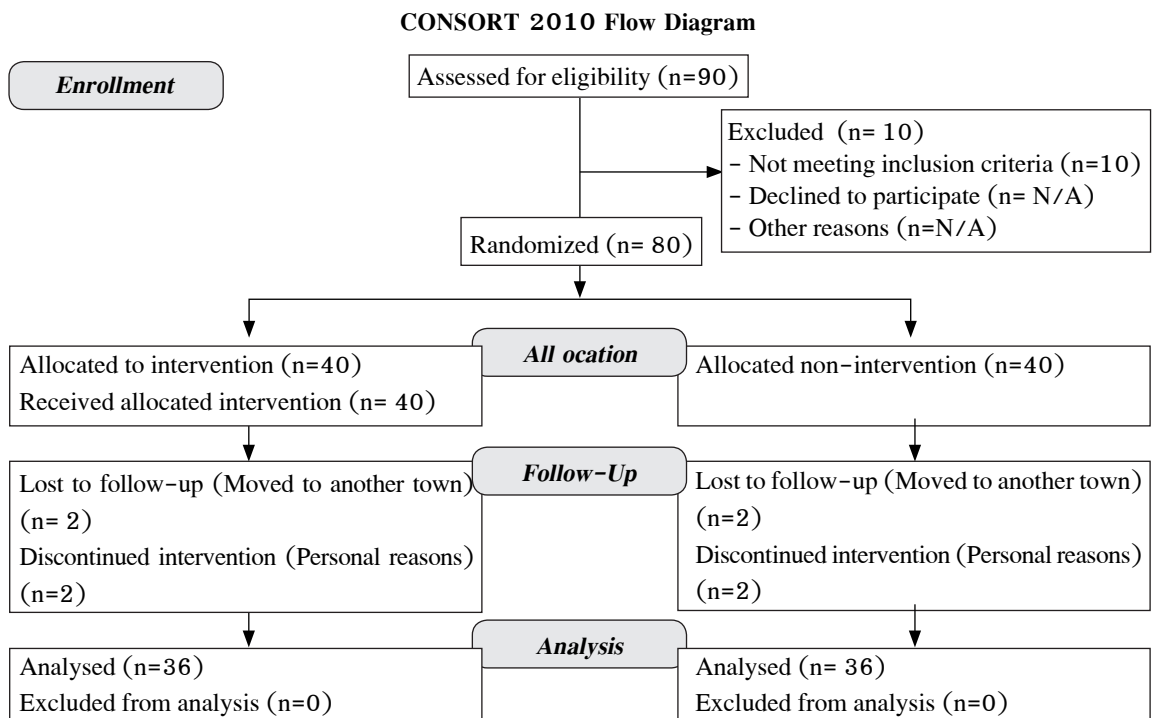


Figure 1 The study flow of participants through each stage of randomized controlled trial

Ethical Consideration: This study was approved by the Research Ethics Committee of the Faculty of Nursing, Chiang Mai University (Full-045-2557). All eligible participants were informed about the objectives and process of the study, the benefits and potential risks, the time required for the study, their rights to privacy, confidentiality, study withdrawal without losing health care service benefits, and were given opportunities to ask questions. All signed a consent form beforehand.

Data Collection: Three instruments were used:

A *Demographic Data Recording Sheet* was developed by the primary investigator (PI) to collect personal data including gender, age, educational level, religion, marital status, current occupation, sufficiency of family income, level of relationship, and duration of care.

The *Positive Aspects of Caregiving Questionnaire* (PACQ), developed by Tarlow¹² measures participants' positive caregiving experience. Because the PACQ had never been used in Thailand, it was translated into Thai by a bilingual expert after getting permission from the authors, then back-translated into English by another bilingual expert, compared with the original English version and examined for cultural appropriateness. This 9-item questionnaire consists of two components: Self-affirmation (e.g., "Made me feel more useful") and Outlook on Life (e.g., "Enabled me to appreciate life more"), concerning the caregiver's mental and affective state regarding their caregiving experience. Participants were asked to rate each item on a 5-point Likert scale ranging from 1 (totally disagree) to 5 (totally agree). A higher total score means higher positive caregiving experience. The reliability coefficient showed an acceptable level of 0.92 and the internal consistency reliability was Cronbach's alpha coefficient of 0.76 in this study.

The *Thai General Well-being Schedule* (TGWS) measures subjective well-being. It was developed by Dupuy²⁵ and was translated into Thai by Hanucharumkul.²⁶

This self-administered questionnaire consists of 18 items, and is used to evaluate individuals' general well-being in six aspects: anxiety, depression, self-control, general health, positive well-being, and vitality. The questionnaire has two parts: Part 1 of 7 positive items (e.g., How have you been feeling in general?) and 7 negative items (e.g., Have you been bothered by nervousness or your "nerves"?), and uses 6-point response scales representing intensity or frequency (1 to 6). Part 2 is composed of 4 items: two positive and two negative, arranged in a linear analog scale ranging from 0 to 10 points (e.g., "How relaxed or tense have you been?"). The total scores range from 0-110, with higher scores indicating a higher level of general well-being: 0-60 refers to severe distress; 61-72 means moderate distress; and 73-110 refers to positive well-being. In this study, the Cronbach's alpha coefficient was 0.88.

The intervention program: In experimental group, they received the EPACP plus usual care. The EPACP was developed based on the Kramer's two-factor adaptation model⁴ and designed to increase caregiving self-efficacy, spirituality, social support, and maintain positive caregiving experiences for family caregiver of the person with dementia. Strategies used included information provision and skill training; exploring spirituality; finding positive events in their lives; mindfulness practice; positive reappraisal activities; and goal setting practice all conducted through group discussions and training. Individual counseling was also given. A dementia caregiving booklet, role model, and video were also used. The program consisted of six groups sessions and one individual session. Three groups of 15 family members met once a week, for 2 hours over 6 weeks. At week 7, the PI offered the individual sessions (see details in **Table 1**). For the control group, participants received only usual care which included health education or suggestions from nurses and other professionals at psychiatric clinics of hospital or at home.

Table 1 The Protocol of Enhancing Positive Aspects of Caregiving Program

Time	Activities
1 st - 2 nd group session (2 hours in each session).	Two lessons were offered by group teaching with a dementia care booklet and group discussions. The contents included 1) knowledge of dementia, 2) assisting the dementia with activities of daily living, and 3) behavioral problem management. Additionally, sharing caregiving experiences, showing role modeling, video, and verbal reinforcement to enhance self-efficacy was provided to the group.
3 rd group session (2 hours).	Group training and discussion were done to enhance the spirituality of caregiver. Meditation training was also offered using strategies such as focusing on the breathing, listening to sermons, sharing Dhamma with a Dhamma specialist, self-evaluation and reflection.
4 th group session (2 hours).	This included continuing meditation training using focused walking, focused breathing techniques, and case studies used to change the interpretation of stressful events. The activities aimed to help caregivers find the good thing out of the bad while providing care.
5 th and 6 th group session (2 hours in each session).	Researcher conducted group training using techniques such as role modeling and selecting the proper strategy for goal setting. Verbal reinforcements to enhance self-efficacy were also given.
7 th individual session	Researcher made telephone calls to provide individual counseling to participants who needed help.

Before starting data collection and to assure data quality, three research assistants (RAs) were trained to collect accurate data by following the study objective, the procedures manual, and the protocol of data collection. At Week 1 (baseline assessment), two instruments were administered by the RAs. At Week 2, the intervention groups started the EPACP plus usual care and the control group received usual care only. All instruments were administered in both groups again at weeks 8, 12, and 20 after the intervention.

Data analysis: Descriptive statistics were used to analyze the participants' demographic characteristics. The Chi-square test and Fisher's exact test were used to examine the differences in demographic data between the participants in the experimental group and the control group at baseline. Two-way repeated measures: ANOVA

was used to examine the difference of positive aspects of caregiving and subjective well-being between experimental and the control group. One-way repeated measures: ANOVA was used to examine the difference of positive aspects of caregiving and subjective well-being in each point measurement in the experimental and control group.

Results

Most of the participants in both groups were female and all were Buddhists. Both groups were also similar in all demographic data at baseline in terms of age, marital status, educational level, occupation, family income, duration for providing care with their relative, and the level of relationship to the person they cared for (see detail in **Table 2**).

Table 2 Demographic Characteristics of the Experimental Group and Control Group

Demographic data	Experimental group		Control group		p-value
	n	%	n	%	
Gender					.257 ^a
Male	6	16.7	10	27.8	
Female	30	83.3	26	72.2	
Age					.187 ^c
M±SD	55.11±13.15		55.66±10.89		
(Range)	(27-83)		(35-76)		
Marital status					.099 ^a
Single	4	11.1	5	13.9	
Married	27	75	30	83.3	
Widowed	5	13.9	-	-	
Divorced	-	-	1	2.8	
Separated	-	-	-	-	
Religion					1.00 ^b
Buddhist	36	100	36	100	
Christian	-	-	-	-	
Muslim	-	-	-	-	
Educational level					.109 ^a
Primary school	13	36.1	21	58.3	
High school	7	19.4	5	13.9	
Diploma	4	11.1	-	-	
Bachelor degree	7	19.4	9	22.2	
Others (Master degree; Doctorate)	5	13.9	2	5.6	
Occupation					.503 ^a
Unemployed	12	33.3	8	22.2	
Farmer/Gardener	7	19.4	12	33.3	
Merchant /Business	5	13.9	4	11.1	
Laborer	3	8.3	5	13.9	
State enterprise employee	-	-	1	2.8	
Others	9	25	6	16.7	
Family income/month					.166 ^a
<1,000 baht (< 30 USD)	-	-	-	-	
1,000-5,000 baht (30-150 USD)	4	11.1	7	19.4	
5,001-10,000 bath (151-300 USD)	9	25	14	38.9	
>10,000 baht (>301 USD)	23	63.9	15	41.7	
Duration for providing care with their relative					.339 ^a
<6 months	6	16.7	2	5.6	
6 months-1 year	2	5.6	3	8.3	
1 to 3 years	16	44.4	15	41.7	
3 to 5 years	7	19.4	13	36.1	

Table 2 Demographic Characteristics of the Experimental Group and Control Group (continued)

Demographic data	Experimental group		Control group		p-value
	n	%	n	%	
>5 years	5	13.9	3	8.3	
Relationship to person cared for:					.667 ^a
Spouse	4	11.1	4	11.1	
Daughter/son	13	39.1	18	50	
Daughter-in-law/Son-in-law	12	33.3	9	25	
Other relatives	7	19.4	5	13.9	

a = Chi-Square, b = Fisher’s Exact test, c= Independent t-test

Positive aspects of caregiving of sample: The mean score of positive aspects of caregiving in the experimental group showed a slight increase from the baseline to weeks 8, 12, and 20. The mean score of control group increased from baseline to week 8, then declined at both weeks 12 and 20. Two-way repeated measures ANOVA showed that the positive aspects of caregiving scores of experimental group were significantly higher than that of the control group (F=33.13, p<.05). There was also a significant interaction between group and time (F=10.21, p<.05) (Table 3) (Figure 2).

The result of one-way repeated measures ANOVA showed that positive aspects of caregiving scores of

the groups were significantly different (F=33.13, p<.000), as were the scores at each point of measurement (F=13.46, p<.000). There was also a significant interaction between group and time. Independent t-test showed that the mean of positive aspects of caregiving scores were statistically significant difference between experimental and control groups at weeks 8, 12, and 20 (Table 3). The multiple pairwise comparisons using the Bonferroni test between each point of measurement showed that the PAC scores in the experimental group increased significantly from baseline to week 8, baseline to week 12, and baseline to week 20 (p<.05) (Table 3).

Table 3 Comparisons of Positive Aspects of Caregiving and Subjective Well-Being between Control Group and the Experimental Group before and after Intervention

Independent variables	Group	Mean (SD)				Effect			
		Baseline	8 weeks	12 weeks	20 weeks	Time		Time x group	
		M (SD)	M (SD)	M (SD)	M (SD)	F ^r	p-value	F ^r	p-value
Positive aspects of caregiving	Experimental	37.11 (5.80)	42.58 (3.20)	43.27 (2.47)	44.08 (1.13)	15.18	.000* ^b	10.21	.000*
	Control	37.19 (6.03)	39.19 (4.52)	37.36 (5.89)	37.75 (3.86)				
Subjective well-being	Experimental	79.44 (11.19)	98.61 (10.8)	98.91 (10.05)	100.27 (9.56)	59.33	.000* ^b	.23	.88
	Control	79.77 (11.02)	100.11 (10.49)	99.80 (11.25)	98.91 (11.23)				

Note. ^r = Two-way repeated measure ANOVA. ^b = Bonferroni. * p < .05.

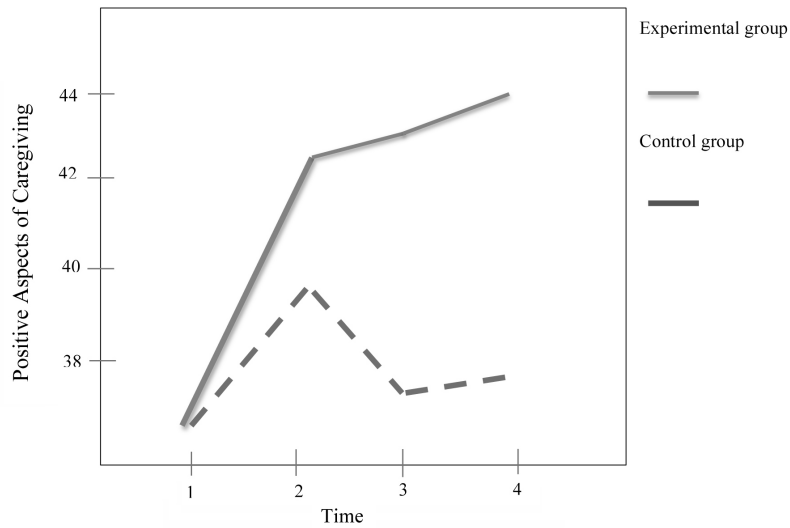


Figure 2 Positive aspects of caregiving

Subjective well-being of sample: At baseline, the scores of subjective well-being in both groups were high with means of 79.44 and 79.77, respectively. In the experimental group the scores increased from baseline at weeks 8, 12, and 20, while the scores of control group increased at week 8, then decreased at weeks 12 and 20. Furthermore, the experimental group had higher scores than the control group at week 20

(Table 3). Two-way repeated measures ANOVA showed that subjective well-being scores of experimental group were not significantly higher than that the control group. However, there was a significant change of subjective well-being scores over time ($F=59.333, p<.05$). It was also noted that the interaction between time and groups was not statistically significant (Table 3) (Figure 3).

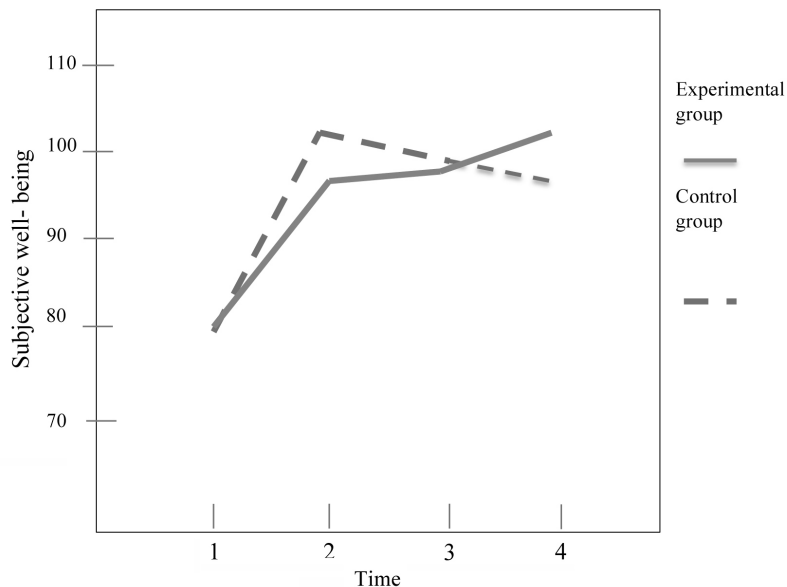


Figure 3 Subjective well-being

Independent t-test showed that the mean of subjective well-being scores was not statistically significant difference between experimental and control groups at weeks 8, 12, and 20 (Table 3). Multiple pairwise comparisons using Bonferroni test between each point of measurement showed that subjective well-being scores of experimental group significantly increased from baseline to 8 weeks, baseline to week 12 but slightly declined at week 20 (Table 3).

Discussion

The result of the EPACP was that caregivers of older persons with dementia in the experimental group had more PAC than those in the control group while subjective well-being score higher than control group at week 20. Furthermore, the experimental group had more positive aspects of caregiving and subjective well-being than before receiving the program. All results indicated that all hypotheses were supported.

The EPACP could significantly increase positive aspects of caregiving. The findings are consistent with the study framework that states the relationship between the intervention and the PAC. Increased PAC resulted from increasing positive appraisal of the caregiving situation. And the EPACP aimed to enhance resources of PAC, self-efficacy of caregiving, spirituality, and social support. These resources were enhanced by using six strategies of the program. For self-efficacy of caregiving, the PI utilized two strategies including information provision and goal setting training. These strategies were conducted by group teaching and discussion. Recent research suggested that information provision could enhance the self-efficacy of caregivers.²⁷ Goal setting training was another strategy that used to enhance caregiving self-efficacy. The goal setting was done through training together with role modeling. Participants learnt about the characteristics of caregiving goals and viewed a video demonstration of this. This strategy encouraged the participants' ability to evaluate

the assisting resources and to categorize caregiving tasks to accomplish their caregiving goals. The result of this intervention could enhance perceived success and role confidence of caregivers and included four sources of self-efficacy: mastery experience, vicarious experience, verbal persuasion, and somatic and emotional states. Caregivers who believe in their own ability, take control over caregiving problems to carry out different activities related to perceive self-efficacy of caregiving¹². Therefore, they could appraise their caregiving tasks as a positive experience.

The EPACP also enhanced the spirituality of caregivers through supporting three strategies: finding positive events in life, positive reappraisal, and mindfulness practice, and these were used to increase positive emotion and confidence in managing daily caregiving problems. The first strategy was developed through group discussion. Participants were asked to share their past and current positive experiences that improved grateful feelings and appreciation for something about themselves. In the second strategy, the participants were motivated to appraise their caregiving tasks, and a video case study encouraged them to think of their own situation positively. The benefits of caregiving tasks, based on Buddhist beliefs, were explained out to the group. In individual discussion, the participants mentioned that they had appraised caregiving tasks positively. The findings of this study were congruent with previous studies that finding spiritual support and benevolent religious appraisal could facilitate the positive reappraisals of care.⁵ Moreover, mindfulness practice was also used to facilitate PAC. The participants were trained to pay attention to the activities of daily living and practice meditation by focusing on breathing. They were also advised to listen to sermons and share Dhamma with the Dhamma expert. Also they had to do self-evaluation and reflection. They could find meaning in life and understand their life through finding out positive reframing every day. Moreover, gratitude was essential feeling to motivate positive views in caregivers.

In Thailand, gratitude is a positive belief¹¹ that strengthens the positive perception of person. This feeling could help participants cope with caregiving tasks.²⁸ They reflected on their feelings towards caregiving, such as the fact that caregiving provides them an opportunity to give something back to their loved ones, made them feel close to the person being cared for, and to feel good. The reflection of the participants showed obvious positive effects on caregiving. Previous studies found that positive cognitive reappraisal is based on family tradition, religious principles, and a desire to require an obligation.²⁹ Moreover, expressing gratitude and blessings can increase positive emotions; and were positively related to positive caregiving.^{29,30}

In this study, perceived social support of the caregivers was also enhanced through information support, instrumental support, emotional support and self-esteem support. Participants received dementia information, individual counseling and telephone call when they were having caregiving problems. All supporting techniques could help participants have confidence to manage their caregiving tasks leading toward a greater caregiving role satisfaction. This perception influenced the participants' positive appraisal that could affect the positive aspects of caregiving²⁸.

For subjective well-being, the experimental group demonstrated significant changes over time from baseline, and we argue resulted from enhancing positive views through all the strategies used. However, a difference between groups was not evident. We found that the control group also demonstrated a higher increase in subjective well-being from baseline to week 12 after program implementation and higher than the experimental group. This finding may be due to an historical effect. During program implementation, the Dementia and Disability Project (DDP) was launched for Thai older people.³¹ The aim of this project was to develop educational strategies and community service programs for nurses to care older persons with dementia and disability. The control group received assistance from nurses and other

providers who gave similar support to that of the PA. A longtime relationship between the caregivers and the nurses made them have higher subjective well-being through getting support. However subjective well-being score of the control group dropped at week 20, while that of experimental group was still increasing. This trend supported the effect of the program that could enhance positive aspects of caregiving, and could also enhance subjective well-being. Most previous studies presented the effectiveness of program for enhancing PAC regarding negative outcomes.^{23, 32} However many studies have not been demonstrated the positive outcomes that this study achieved.

Conclusion and Implications for Nursing Practice

This study demonstrated the EPACP could enhance the PAC and subjective well-being among caregivers of older persons with dementia. Nurses who work in the geriatric clinics and psychiatric clinics can apply the EPACP to Buddhist caregivers by blending participants' beliefs, values, and culture in the program because those factors were found to be related to the individual's positive aspects of caregiving and subjective well-being. For different caregivers, especially those from other religious groups, the program should be tested before applying widely.

References

1. World Health Organization [internet]. Dementia: a public health priority; C2015 [cited 2016 October 10]. Available from: http://www.who.int/about/licensing/copyright_form/en/index.html
2. National Health Examination Survey Office [Internet]. 2015 [cited 2015 March 3]. Available from: <http://www.hiso.or.th/hiso/report/sreport.php>
3. Dupuis SL, Epp T, Smale B. Caregiver of person with dementia : roles, experience, supports and coping. Ontario: MAREP; 2004.

4. Kramer BJ. Gain in the caregiving experience: Where are we? What next?. *The Gerontologist*. 1997; 32: 218–232.
5. Cheng ST, Chan CW, Lam CW. Short-term Effects of a gain-focused reappraisal intervention for dementia caregivers: A double-blind cluster-randomized controlled trial. *American Association for Geriatric Psychiatry*. 2016; 24: 740–750.
6. Cheung KSL, Lau BHP, Wong PWC, Leung AYM, Lou VWQ, Chan GMY, et al. Multicomponent intervention on enhancing dementia caregiver well-being and reducing behavioral problems among Hong Kong Chinese: A translational study based on REACH II. *International Journal of Geriatric Psychiatry*. 2014; 30(5): 460–469.
7. Cheng ST, Lam CCW, Kwok T, Natalie NSS, Fung AWT. Self-efficacy is associated with less burden and more gains from behavioral problems of Alzheimer's disease in Hong Kong Chinese caregivers. *The Gerontologist*. 2013; 1–10.
8. Donovan ML, Corcoran MA. Description of dementia caregiver uplifts and implications for occupational therapy. *The American Journal of Occupational Therapy*. 2014; 64(4): 590–595. doi: 10.5014/ajot.2010.09064.
9. Cheng ST, Emily PM, Rosanna WL, Lau, Natalie SS, Linda CW, et al. Voices of Alzheimer caregivers on positive aspects of caregiving. *The Gerontologist*. 2016; 56(3): 451–460.
10. Farran CJ, Keane-Hagerty E, Salloway S, Kupferer S, Wilken CS. Finding meaning: An alternative paradigm for Alzheimer's disease caregivers. *The Gerontologist*. 1991; 31: 483–489.
11. Grey RS, Hahn L, Thapsuwan S, Thongcharoenchupong N. Strength and stress : positive and negative impacts on caregivers for older adults in Thailand. *Australasian Journal on Ageing*. 2016; 35(2): 7–12.
12. Tarlow BJ, Wisniewski SR, Belle SH, Rubert M, Ory MG, Gallagher-Thompson D. Positive aspects of caregiving: contributions of the REACH project to the development of new measures for Alzheimer's caregiving. *Research on Aging*. 2004; 26: 429–453.
13. Steffen AM, McKibbin C, Zeiss AM, Gallagher-Thompson D, Bandura A. The revised scale for caregiving self-efficacy: reliability and validity studies. *Journal of Gerontology Series B: Psychological Sciences and Social Sciences*. 2002; 57B: 74–86.
14. Hodge DH, Sun F. Positive feelings of caregiving among Latino Alzheimer's family caregivers: understanding the role of spirituality. *Aging & Mental Health*. 2012; 16(6): 689–698.
15. Lopez J, Lopez-Arrieta J, Crespo M. Factors associated with the positive impact of caring for elderly and dependent relatives. *Archives of Gerontology and Geriatric*. 2005; 41: 81–94.
16. Parveen S, Morrison V, Robinson CA. Does coping mediate the relationship between familism and caregiver outcomes? *Aging & Mental Health*. 2014; 18(2): 255–259.
17. Liu HY, Huang HY. The relationship between family functioning and caregiving appraisal of dementia family caregivers: caregiving self-efficacy as a mediator. *Aging & Mental Health*. 2016; doi: 10.1080/1360 7863.2016.1269148 [Accessed 2 August 2017].
18. Lopez J, Romero-Moreno R, Marquez-González M, Losada A. Spirituality and self-efficacy in dementia family caregiving: trust in God and in yourself. *International Psychogeriatrics*. 2012; 24(12): 1943–1952.
19. Morano CL, King D. Religiosity as a mediator of caregiver well-being: Does ethnicity make a difference?. *Journal of Gerontological Social Work*. 2005; 5(1/2): 69–84.
20. Au A, Lai MK, Lau KM, Pan PC, Lam L, Thompson L, et al. Social support and well-being in dementia family caregivers: The mediating role of self-efficacy. *Aging & Mental Health*. 2009; 15(5): 761–768.
21. Chien LY, Chu H, Guo JL, Liao YM, Chang LI, Chen CH, et al. Caregiver support groups in patients with dementia: a meta-analysis. *International Journal Geriatric Psychiatry*. 2011; 26: 1089–1098.
22. Hilgeman MM, Allen RS, DeCoster J, Burgio LD. Positive aspects of caregiving as a moderator of treatment outcome over 12 months. *Psychology and Aging*. 2007; 22: 361–371.
23. Bolier L, Haverman M, Westerhof GJ, Riper H, Smit F, Bohlmeijer E. Positive psychology interventions: a meta-analysis of randomized controlled studies. *BMC Public Health*. 2013; 13(119): 1471–2458.
24. Institute of Geriatric Medicine. Mini-Mental State Examination-Thai 2002. Thailand: Department of Medical Services, Ministry of Public Health; 2002.
25. Dupuy HJ. The general well-being schedule. In: I. McDowell and C. Newell, editors. *A measuring health: A guide to rating scales and questionnaires*. New York: Oxford University Press; 1977. 125–133.

26. Hanucharurnkul S, Intarasombut P, Putwatana P. Daily hassles, Sense of coherence, general well-being among nursing faculty members of university. *Journal of Nursing*. 1989; 38(3): 169-190. [in Thai].
27. Chenoweth L, Stein-Parbury J, White D, McNeill G, Jeon YH, Zaratan B. Coaching in self-efficacy improves care responses, health and well-being in dementia carers: a pre/post-test/follow-up study. *BMC Health Services Research*. 2016; 16:1-16.
28. Hi-Po Lau B, Cheng C. Gratitude and coping among familial caregivers of persons with dementia. *Aging & Mental Health*. 2017; 21(4): 445-453.
29. HEO GJ. Religious coping, Positive aspects of caregiving, and social support among Alzheimer's disease caregivers. *Clinical Gerontologist*. 2014; 37: 368-385.
30. Lambert NM, Fincham FD, Stillman TF. Gratitude and depressive symptoms: The role of positive reframing and positive emotion. *Cognition and emotion*. 2012; 1-19.
31. Senanarong V, Harnphadungkit K, Pongvarin N, Vannasaeng S, Chongwisal S, Chakorn T, et al. The dementia and disability project in Thai elderly: rational, design, methodology and early results. *BMC Neurology*. 2013; 13(3): Available from: doi: 10.1186/1471-2377-13-3 [Accessed 24 August 2017].
32. Cheng ST, Lau RWL, Mak EPM, Ng NSS, Lam LCW, Fung HH. Benefit-finding and effect on caregiver depression: A double-blind randomized controlled trial. *Journal of Consulting and Clinical Psychology*. 2017; 85(5): 521-529.

การวิจัยเชิงทดลองแบบสุ่มของการส่งเสริมมุมมองด้านบวกในการดูแลของผู้ดูแลผู้สูงอายุภาวะสมองเสื่อมไทย

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บทคัดย่อ: การส่งเสริมมุมมองด้านบวกในการดูแลมีความจำเป็นสำหรับผู้ดูแลผู้สูงอายุภาวะสมองเสื่อม การวิจัยเชิงทดลองนี้มุ่งที่จะทดสอบประสิทธิผลของโปรแกรมสำหรับส่งเสริมมุมมองด้านบวกต่อการดูแลและความพึงพอใจในชีวิตของผู้ดูแลผู้สูงอายุภาวะสมองเสื่อม กลุ่มตัวอย่างจำนวน 72 คน ถูกสุ่มเข้ากลุ่มทดลองและกลุ่มควบคุมในจำนวนเท่ากัน กลุ่มทดลองได้รับโปรแกรมการเสริมสร้างมุมมองด้านบวก กลุ่มควบคุมได้รับการดูแลตามปกติ โปรแกรมประกอบด้วย การเพิ่มสมรรถนะแห่งตน การค้นหาภาวะทางจิตวิญญาณ และการส่งเสริมการรับรู้การสนับสนุนทางสังคม เก็บข้อมูลโดยใช้แบบวัดมุมมองด้านบวกในการดูแล และแบบประเมินความพึงพอใจในชีวิตโดยทั่วไป วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนา การวิเคราะห์ความแปรปรวนแบบทางเดียวและการวิเคราะห์ความแปรปรวนแบบสองทาง

ผลการทดลองพบว่า โปรแกรมการส่งเสริมมุมมองด้านบวกเพิ่มมุมมองด้านบวกของผู้ดูแลผู้สูงอายุภาวะสมองเสื่อมอย่างมีนัยสำคัญทางสถิติที่สัปดาห์ที่ 8, 12 และ 20 ภายหลังได้รับโปรแกรม โปรแกรมสามารถเพิ่มความพึงพอใจในชีวิตของกลุ่มทดลองอย่างมีนัยสำคัญทางสถิติทุกระยะเวลาของการวัด ผลการศึกษานี้ชี้ให้เห็นว่า พยาบาลสามารถใช้โปรแกรมนี้เพื่อเพิ่มมุมมองด้านบวกในการดูแลและความพึงพอใจในชีวิตของผู้ดูแลผู้สูงอายุที่มีภาวะสมองเสื่อม

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คำสำคัญ : การส่งเสริมมุมมองด้านบวก ผู้ดูแล ผู้สูงอายุ ภาวะสมองเสื่อม

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