RIASE
REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

THE FAMILY IN CARE OF THEIR ELDERLY: MANAGING THE OVERLOAD AND STRATEGIES FOR COPING WITH DIFFICULTIES

Lisete dos Santos Mendes Mónico - Professor auxiliary at Department of Psychology and of Educational Sciences in Universidade de Coimbra, Portugal

Joana Rita André Custódio - Master in Psychology; Leiria, Portugal

António Antunes Frazão - Professor Auxiliary of ISLA - Instituto Superior de Leiria (Superior Institute of Leiria), Portugal

Pedro Parreira - Assistant Professor of Escola Superior de Enfermagem de Coimbra (Superior Nursing School of Coimbra), Portugal

Sara Correia - PhD, Nurse at Centro Hospitalar Lisboa Norte, Portugal

César Fonseca - Assistant Professor, Universidade de Évora, Portugal

VOL. 3 N.º 2 AUGUST 2017

ABSTRACT

Introduction: Family is considered the main support of the elderly in a situation of dependency. Caregiving often results in overloading, leading to diverse problems.

Aim: To evaluate the self-perception of the family caregiver's overload and the strategies used to provide informal care to the dependent elderly considering their level of dependence.

Method: The sample consisted of 21 children, 16 spouses, and nine other relatives of elderly dependents who responded to the Caregiver's Overload Scale (Sequeira, 2007), the Portuguese version of Caregivers' Assessment Management Index (CAMI, Nolan, Keady, & Grant, 1995) and the Barthel Index (Mahoney & Barthel, 1965).

Results: The Barthel Index showed 34.8% of the elderly as severely dependent and 37.0% as totally dependent. The care most provided respected to medication, hygiene, food, and monitoring. Above 56.5% of the caregivers had an intense overload, both at the objective (impact of care and interpersonal relationship) and subjective (F3-Expectations regarding care and F4-Perceived self-efficacy) levels. The main reason for maintaining caregivers was family/personal obligation (95.7%). Caregivers reasonably assessed the effectiveness of their strategies in dealing with their dependent elderly (CAMI; M = 101.0, SD = 15.0). There was a negative relationship between the perception of the caregiver's overload and the age and health status of the elderly, as well as between the number of strategies used by the caregiver to overcome difficulties and the self-perception of the overload.

Conclusion: The multiplicity of daily tasks performed in support of a family member in a situation of severe dependence translates into situations of intense overload, negatively impacting on care, interpersonal relationship, expectations regarding caring, and perception of self-efficacy of care.

Keywords: Family caregiver; informal caregiver; dependent elderly; overload; *coping* strategies.

INTRODUCTION

The performance of family care to their dependent elderly is a reality that sustains throughout time. Society has overlooked a collection of demographic changes that have altered the prospect of informal care, through the decrease of the number of available family members to provide the necessary cares[1]. The networks of informal support (familiar and neighborly) assure most of the times, the continuation of dependent elderly care, opposing the insufficiency of social and health[2] protection systems.

Therefore, family belongs in the informal network of caregivers and is considered the main cornerstone of support to the elderly in situation of dependence[3,4]. The caregiver in question, most of the times, isn´t chosen of a free and conscious decision, but of circumstance of a familiar relationship and or proximity[2].

With the increase of longevity in the population, the efforts put in the understanding process of aging have a mutual goal: to provide for a good quality of life and increase of well-being of the elderly[5,6]. Dependence often is considered an inevitable consequence of aging. It's a complex fenomenon with several dimensions and causes that may affect every age group. To dependence, we apply the concepts of multi-dimensionality, multi-causality and multi-functionality[7].

The idea of multi-dimensionality indicates that it's a concept that one can extend to numerous domains (physical, psychological, social, amongst others), without being reduces to a single configuration. The multi-causality states several factors – biological, sociological, cultural and economical – that influence the appearance, progression and maintenance of dependency. The notion of multi-functionality means that the dependency may present multiple functions, and may assume, for instance, an adaptive role.

The condition of health or disease presents clear repercussions in terms of optimism and satisfaction with the life of the elderly, given that the ones who are healthy focus their optimism in beliefs of internality while the elderly who are sick build their optimism in factors of externality[8,9,10]. A dependent person is the one that, during a long period of time, needs help from others to do daily activities, from basic activities regarding personal care to more complex things such as taking medicine, using the phone or prepare meals[11]. This situation of dependency requires help from a caregiver to watch, supervise and support, to provide the necessary cares depending if is a moderate or severe dependency. This is where formal care originates (taken by an institution of health/social[12,13,14] support), or de informal care, usually taken by family members, neighbors or others, in the absence of economic retribution[2,11,12].

Most times, the performance of these cares is done by family, rarely is provided a caregiver from a free process and conscious choice. Or it happens because someone one lives with, was slowly losing autonomy and the support and necessary cares were taken in a natural and economical disinterested way; or someone physically close as victimized by an accident or became a widow or even because the previous caregiver was no longer capable of being so[15,16].

Done in full or part-time, the caregiver of the elderly does a job that usually produces overload or physical, psychological, emotional, social and financial exhaustion[2,11,12,17]. It's

frequent that this overload is analyzed in its objective and subjective[18,19] dimensions, the first of which relating with concrete activities and events, while the second with feelings, attitudes and emotional reactions form the caregiver[20].

A diversity of personal intern and extern resources compete to the adoption of strategies in coping differently[21]. In the first the assets are personal abilities, knowledge about the dependent person, life experience, beliefs and values and the capacity to solve problems, but also the sense of incoherence, self-esteem, optimism and self-efficiency[22]. The efficiency in the coping strategies will be fundamental to the awakening of feeling and positive emotions[23,24]. If so doesn't happen, negative emotions will prevail and lead to the overload and exhaustion to set in[25]. Regarding the exposed, is important to analyze the levels of objective and subjective overload of the family caregivers of the elderly dependent and know the used strategies and perception of efficacy of those in the care given.

METHOD

Sample:

The sample of family caregivers is constituted by 21 children (45,7%), 16 couples (34,8%), 4 daughters-in-law (8,7%), 1 grand-daughter (2.2%), 1 sister-in-law (2.2%) 1 niece (2.2.%) 6 step-daughter (13.0%) are male. Most (n = 35, 76,0%) its between 40-70 years, being the average of 58,41 years (DP = 12,49; 34 to 83 years). Most caregivers (n = 41; 89,1%) are married or live together. Regarding their literary habilitations, 25 (54,3%) attended the 1° CEB, 4 (8.7%) didn´t attend primary school and 2 (4,3%) possess a degree. Professionally speaking, 15 (32,6%) are retired, 14 (30,4%) work full-time and 12 (26,1%) are domestics (work at home).

Measures:

Beside the sociodemographic questionnaire and the collection of questions referring to the given cares and the health condition, we administrated the *Escala de Sobrecarga do Cuidador*[26] (Caregiver's Overload Scale); it showed a coefficient of intern consistency of α = 883. This scale allows the evaluation of the objective and subjective overload of the informal caregiver which includes information about 4 factors: *F1-Impact of the cares* given, which groups the items that reference the overload related with the direct cares given, where the change of the health condition, the high number of cares, the alterations of the social and familiar relations, the lack of time and the physical and mental distress stand out. *F2-Interpersonal Relations*, groups the items that relate the overload between the caregiver and the person dependent of the cares.

These evaluate the interpersonal impact resulting of the relation of the given cares, and are mostly associated to the inter-relational difficulties; *F3-Expectations of the cares*, relates with the giving of relative cares, regarding fears and availability; and *F4-Self-efficacy perception* which relates with the opinion of the caregiver regarding their work performance. Each item is scored in a Likert scale of 5, being that a higher score corresponds to a better perception of the overload, according with the following points: Inferior to 46 No Overloads; Between 46 and 56 Light Overload and Superior to 56 Intense Overload.

The Barthel[27] Index was applied for the diagnose of the degree of commitment from the elderly in their basic day to day activities. This Principle is compost of 10 basic daily activities presented between two to four levels of dependence (the score 0 corresponds to total dependence, being that independence is scored with "5", "10" or "15" points depending with the levels of differentiation). The lower the score the higher is the level of dependence, variating in a way inversely proportional to the level of dependence, floating its global score between 0 and 100 points, depending the following points: 90-100 points – Independent; 60-89 points – Slightly dependent; and <20 points – Totally dependent.

We also applied the Portuguese version of the Caregivers Assessment Management Index (CAMI)[21,23,28] to get to know the way each caregiver handles perceptional difficulties, which coping mechanism they use and who capable and suited their appear upon several situations. The caregivers should indicate in a scale of Likert from 1 to 4 points if the use or not that way of handling situations and, if so, they also should mention their perception about the degree of efficiency and affectability of the procedure. The many ways of solving the coping problems/strategies can be grouped in 3 categories: Handling with the events/solving of problems, alternative perceptions about the situations and dealing with stress symptoms.

Procedures

After understanding the goals/objectives of the study, the participants were informed of the confidentiality of the data, assuring the anonymity of the answers. Afterwards the codification of the answers the statistic treatment through the computer program "*Statistical Package for Social Sciences*, 22.0 version for *Windows*" was executed.

RESULTS

Considering the *context of the caregivers program* (cf. Table 1), 25 (54.3%) of caregiver live in the same household than the elderly. Regarding time per day in which the care is provided, about half 23 (50.0%) of the caregivers works between 18 and 24. When asked how long they take care of that person, the caregivers indicated values between 0.17 years (2 months) and 30 years, the average being 5.54 years (*DP* = 6.50).

Table 1 - Context of caregiving: Absolut and relative effective.

Variables	Levels	n	%
Live in the same household	No	21	45.7
	Yes	25	54.3
Total			
Time a day caregiving	3 to 6 Hours	13	28.3
	6 to 12 Hours	5	10.9
	12 to 18 Hours	5	10.9
	18 to 24 Hours	23	50.0
Total		46	00.0
How long take care of elderly? (years)	<1	7	15.2
	[1-5]	24	52.2
	[6-10]	7	15.2
	[11-15]	6	13.0
	[16-20]	-	-
	>20	2	4.3
Total		46	0.00
Had you ever taken care of elderly?	No	22	47.8
	Yes	24	52.2
Total		46	00.0
Is so, for how long?	< 6 months	2	4.3
	1 to 2 years	3	6.5
	2 to 3 years	3	6.5
	Over 3 years	16	34.8
Total		24	52.2

The types of care that are more referenced by the caregivers are: medication (95.7%), hygiene, food, companionship and auxiliary help to get to consultations/exams (91.3% respectively), handling bills (80.4%), image care and domestic activities (60.9%). Twenty-four (52.2%) of caregivers receive help and formal support. Out of those, 21 (45.7%) have personal hygiene support, 12 (26.1%) have laundry support and 21 (45.7%) have meal supply's being delivered.

Regarding the perception of the caregivers health condition, 18 (39.1%) categorizes it as good, 17 (37.0%) as weak and 9 (19.6%) as very weak. Only 2 (4.3%) see their health condition as very good. The average is 2.28 (DP = 0.83), which is between weak and good. Twenty-five (54.3%) mention disease.

When asked about why they continued caregiving to the elderly, 44 (95.7%) mention a feeling of personal/familiar obligation, 15 (32.6%) want to avoid institutionalize the elderly and 2 (4.3%) refer the non-existence of institutions available.

On the subject of positive aspects that the caregiver has to provide to the elderly (cf. Table 2), most talks about the positive aspect of caring, while the physical/psychological overload is seen as the negative aspect. Most referred an intense overload.

Table 2 - Positive and Negative aspects at caregiving and overload levels.

Variables	Levels	n	%
Positive Aspects	Positive Aspect when Caring	33	71.7
	Helping the elderly in everyday activities	2	4.3
	Filling obligated to Care	9	19.6
	No Response	2	4.3
Total		46	100.0
Negative Aspects	Physical/Psychological Overload	27	58.7
	Change in personal/family life	13	28.3
	No Response	6	13.0
Total		46	100.0
Levels of Total Overload	No Overload	7	15.2
	Light Overload	13	28.3
	Intense Overload	26	56.5
Total		46	100.0

In the caregivers Overload Scale (cf. Table 3), the higher average refers to the caregiving impact, following the Expectations regarding the care, the interpersonal relation and, at last, the auto-efficiency perception.

Table 3 - Description of the Caregivers Overload Scale (ESC - Escala de Sobrecarga do Cuidador).

Caregivers Overload Scale	Minimum	Maximum	M	DP
Total of Overload Caregivers	1.51	3.98	2.68	0.55
Objective Overload	1.14	4.22	2.52	0.74
Caregiving Impact	0.64	4.64	2.92	0.93
Interpersonal Relations	1.00	3.80	2.13	0.72
Subjective Overload	1.38	4.25	2.85	0.59
Caregiving Expectations	1.75	5.00	3.87	0.75
Auto-efficiency Perception	1.00	5.00	1.82	0.98

To the levels of evaluation of the total of ways as to how the caregiver faces difficulties (CAMI scale), as we can see in Table 4, most of them have the perception of some efficiency in the used strategies.

Table 4 - Ways the Caregiver Faces Difficulties.

CAMI Scale	Levels	n	%
Perception of efficiency in the ways used to face difficulties	No use of coping strategies	0	0.0
	Perception of some efficiency	38	82.6
	Perception of high efficiency	8	17.4
Total		46	100.0

In Table 5, we will present the main strategies the caregiver uses to overcome their difficulties at taking care of the elderly. Considering a mistake type 1 of 10, we found four significant relationships: a) the global punctuation of the CAMI scale is negatively associated

with the subscale *Interpersonal Relations (Objective Overload)*, indicating that the more strategies the caregiver used to overcome their difficulties at taking care of the elderly, the minor the overload in the interpersonal relation with the elderly (r = -.28, p = .06); b) The strategies regarding the "Dealing with Events/Resolutions of Problems" are associated in a positive way to the "Expectations about Care", indicating that the more strategies at this level bigger are the caregivers expectations referring the cares given to the elderly (r = .25, p = .09); c) The strategies connected to the "Alternative perceptions about the Situation", associate in a negative way with the level of "Objective Overload" (r = -.31, p = .04), designed with the "Interpersonal Relation" (r = -.37, p = .02).

Could the caregivers health condition (1 = very weak to 4 = very good) present any relation with self-perception of ones overload? The calculation of the coefficients of Pearson's correlation shows three relations statistically significant between the caregivers health condition and: 1) the overall of the *Caregivers Overload Scale* (r = -.24, p = .10), 2) the *Caregivers Objective Overload* (r = -.32, p = .06) and, mostly 3) the *Impact of the caregiving to the Caregiver* (r = -.32, p = .03). Therefore, we verify that the caregiver's health condition possesses a considerable influence in the perception he has over the overload regarding the caregiving, being that the better their health condition the least overload they percei-ve. This relation is particularly clear regarding the objective overload, designed to the im-pact of the caregiving, which is minor when the caregiver has a god health condition.

Table 5 - Evaluation Index of the ways the Caregiver handles difficulties (CAMI).

CAMI Scale	Minimum	Maximum	M	DP
Global Score (sum)	76	130	100.98	15.01
Handling the events/resolution of problems	31	52	40.78	5.95
Alternative Perceptions of the situation	30	55	41.91	6.66
Handling symptoms of stress	11	40	18.70	5.88

The Barthel Index displayed 34.8% of elderly as severely dependent and 37.0% as totality dependent. Our goal, now, is check in which way the level of dependence of the elderly correlates with the perception of the caregivers overload. On Table 6, we demonstrate the distribution of effectives in each level of the caregiver overload scale by the diverse degrees of dependence from the elderly in basic everyday activities, according to the Barthel Index (degree do dependence of the elderly).

Table 6 - Distribution of effectives in each level of caregiver overload scale by the diverse degrees of dependence of the elderly according to the Barthel Index.

Levels of Overload Scale	Index of Barthel										Total	
	Independence 90-100 points		Slightly Dependent 60-89 points		Moderately Dependent 40-55 points		Severally Dependent 20-35 points		Totally Dependent < 20 points			
	n	%	n	%	n	%	n	%	n	%	n	%
No Overload	1	2.2	0	0.0	2	4.3	1	2.2	9	6.5	7	15.2
Slight Overload	0	0.0	2	4.3	2	4.3	4	8.7	5	10.9	13	28.3
Intense Overload	1	2.2	4	8.7	1	2.2	44	23.9	9	19.6	26	56.5
Total	2	4.3	6	13.0	5	10.9	16	34.8	17	37.0	46	100.0

The Chi-Squared Test leads to an independence of variables, displaying that the degree of dependence of the elderly doesn't affect significantly the perception of the caregivers overload $\chi 2$ (8) = 8.13, p = .42. Inverting the scale to the Barthel Index (in other words, considering that the scales maximum corresponds to an extreme degree of dependence for de elderly), we proceeded to the calculations of the Pearson coefficients of correlation between the perception regarding the caregivers overload and the dependence scores from the elderly in basic everyday activities.

Although every coefficient is positive, the relation just appeared statistically significant only to the Expectations regarding the care (r = .32, p = .03) of the subscale *Subjective Overload*. We concluded that the elderly dependence only appears in the subjective overload, more specifically at the level of the Caregiving Expectations, higher when the elderly are more dependent.

The seventh table shows the results of the Pearson coefficients of correlation between the *Caregivers Overload Scale* and the CAMI Scale as well as three factors. Regarding the level of significance of $p < .10$, we find four significant relations amongst the strategies used by the caregiver to overcome his difficulties and the self-perception of overload: 1) the global punctuation of the CAMI scale associates negatively with the Interpersonal Relation subscale (objective overload), indicating that the more strategies the caregiver uses to overcome it's difficulties in the caregiving to the elderly there is less interpersonal relations with the elderly; 2) The strategies referring to dealing with Events/Resolutions of Problems associate positively with the Caregiving Expectations indicating that the more strategies at this level the higher are the caregivers expectations regarding the caregiving to the elderly; 3) The alternative Perception strategies about the situation associate in a negative way with the level of objective overload, particularly with the Interpersonal Relation. Higher alternative perceptions regarding the situation lead to a minor objective overload form the caregiver which relates with the interpersonal relation stablished with the elderly.

Table 7 - Coefficients of correlation between the ways the caregiver faces difficulties and the Caregivers Overload Scale.

	Total CAMI		Handling with Events/ Resolutions of problems		Alternative perceptions about the situation		Dealing with the symptoms of stress	
	r	*p*	r	*p*	r	*p*	r	*p*
Caregiver Overload (Global Scale)	-.10	.53	.07	.66	-.21	.16	-.09	.58
Objective Overload	-.19	.20	-.04	.82	**-.31**	.04	-.07	.64
Impact of the Caregiving	-.09	.54	.02	.88	-.21	.16	-.01	.97
Interpersonal Relations	**-.28**	**.06**	-.10	.51	**-.37**	.02	-.14	.37
Subjective Overload	.07	.66	.17	.27	-.01	.97	-.07	.64
Caregiving Expectations	.14	.36	**.25**	**.09**	.04	.82	.02	.87
Self-efficiency Perception	-.03	.86	.01	.96	-.03	.83	-.10	.50

DISCUSSION AND CONCLUSION

In this paper, we analyzed the caregivers overload self-perception and the strategies used for the informal caregiving of dependent elderly in function of their degree of dependence. The daily chores that were executed with family support lead to intense overload in a very high number of caregivers. This overload (physical/psychological) is percept by the family caregiver as the most negative aspect of their job, impacting their interpersonal relation and expectations of the caregiving and the perception of the self-efficiency[2,11,12].

The informal family caregivers disclose the existence of difficulties when facing inherent obstacles regarding the caregiving (perceived only with some efficiency, 83%) and recognized that facing the difficulties of that job went mainly through their capacity of alternative perceptions, for being able to deal with events and solve the problems.

Although the existence of caregivers who appear to have very high overload levels, we also verify, the existence of feelings regarding the caring which are emotionally gratifying, translating in an enriching personal perspective. The personal growth has to be mentioned, as well as the increase of the feeling of accomplishment, the ability to face challenges, the improvement of interpersonal relationships[29], the increase of a meaningful life and self-satisfaction [30].

The social-demographic profile of caregivers indicated the female sex as the predominant (87%), meeting the literary historical, social and cultural role which is attributed to women regarding caring[7,29,31].

The fact that family caregivers are, given the circumstances, mostly "volunteers", makes the informal caregivers mainly assume that their motivations rely on familiar/personal obligation[15,26], which (despise the positive affection being present) won't help in the application of appropriate coping strategies. In fact, the caregivers choice associates mostly to factors like familiar relations, co-living, the caregivers and the elderly's gender and the respecting conditions of the descendants[2,11], as the type of necessary caring, and the condition of the illness will determine the frequency and the intensity to which the care must be applied, influencing the job of the caregiver[26].

Despite the caregivers self-evaluating in a reasonable way about the strategies efficiency they used (we verified a negative relation between the numbers of strategies used to overcome inherent difficulties to the caregiving and the overload felt in the interpersonal relation with the elderly) and the relation between the strategies and the caregivers expectations referent to the caregiving appearing positive, it is important to highlight and develop

alternative perceptions about the situation; clarify the caregiving expectations; promote the development of problematic resolution skills, for the increase and diversification of strategies that lead to the overcoming of caregiving inherent difficulties[2,11,12].

Given that the family and other caregivers belonging to the informal network are considered like an essential supporting cornerstone to the elderly in situations of dependence, it is necessary to study that reality. The promotion of development of skills for the resolution of problems becomes fundamental to the increase and diversity of more strategies that lead to the overcoming of inherent difficulties to the caregiving. This way it will help decrease the objective and subjective overload of the informal caregivers of the elderly.

BIBLIOGRAPHIC REFERENCES

1. Sousa L. The Resource of family formal support; Family, the elderly and the formal caregiver(s). In Sousa L et al., Getting Old as a Family: The Familiar Cares in Old. Porto (PT): Ambar; 2004: 95-141.

2. Custódio J, Mónico LS, Frazão A, Lucas H. Cuidadores informais de idosos: Dos níveis de sobrecarga às formas de enfrentar dificuldades. In Neri de Souza D, Rua M, Teixeira H, Eds. Cuidadores de Pessoas Idosas: Caminhos de mudança. Aveiro (PT), CIDTFF; 2013: 125-129.

3. Figueiredo D. Familiar Cares to the Dependent Elderly. Lisboa (PT): Cadernos Climepsi de Saúde; 2007

4. Figueiredo D, Sousa L. CARE (Caregivers of the Elderly in Europe – Evaluate the needs of the informal Caregivers. Geriatria. 2002; 15 (144): 15-19.

5. Mónico LS. Religiosity and optimism among Portuguese citizens: The effect of religious identity and the mediation by life satisfaction. Journal of Psychology and Social Behavior Research. 2013; 1(4): 105-115. DOI: 10.12966/psbr.10.03.2013

6. Mónico LS, Frazão AA, Clemente DF, Lucas HM. Subjective well-being of elderly in social responses seniors home and home support service. International Journal of Developmental and Educational Psychology. 2012; 1(2): 33-42.

7. Barbosa ALB. Informal Care at the End of Life: Stress and coping in primary and secondary caregivers. [Masters Thesis]. Aveiro (PT): Universidade de Aveiro; 2009. [Quoted in 28 October 2017]. Available in: http://hdl.handle.net/10773/3290.

8. Mónico LS. Religiosity and optimism in ill and healthy elderly. International Journal of Developmental and Educational Psychology. 2012; 1(2): 59-70.

9. Mónico LS. Life Satisfaction, attribution of (in)successes and future expectations: Comparing between elderly and youth. In Santos E, Ferreira JA, Pocinho R, Gaspar JP, Ramalho A, Eds. Transition to retirement: Contributes to the Viseu adaptation. (PT): Psicosoma; 2012: 109-118.

10. Mónico LS. Subjective well-being, attributions and future expectations in the elderly and in the youth. Journal of Psychology and Social Behavior Research. 2013; 1 (3): 81-87. DOI: 10.12966/psbr.08.08.201

11. Custódio JR, Frazão AA, Mónico LS. The Overload and Strategies of coping from the informal caregiver of the dependent elderly. In Pocinho R, Santos E, Ferreira JA, Gaspar JP, Ramalho A, Soeiro D, Silva S, Eds. Getting Old in times of Crisis: Social Responses. Porto (PT): LivPsic; 2012: 93-104.

12. Mónico LS, Custódio JR, Frazão AA. The informal caregiver of dependent elderly: Levels of burden and related variables. International Journal of Developmental and Educational Psychology. 2012; 1(2): 149-160.

13. Clemente DF, Frazão AA, Mónico LS. The Subjective Well-Being in institutionalized and not institutionalized Elderly. In Pocinho R, Santos E, Ferreira JA, Gaspar JP, Ramalho A, Soeiro D, Silva S, Eds. Getting Old in times of Crisis: Social Responses. Porto: LivPsic; 2012: 39-50.

14. Clemente D, Mónico LS, Frazão A, Lucas H. Subjective Well-Being in the 3ª Age: Comparative Study in social responses, home and service of home service. In Neri de Souza D, Rua M, Teixeira H, Eds. Caregivers of the Elderly: Paths for Change. Aveiro (PT): CIDTFF; 2013: 403-408.

15. Sousa L, Figueiredo D, Cerqueira M. Getting Old as a Family. 2ª Ed. Porto (PT): Ambar; 2006.

16. Westphal A. Comparison the quality of life and overload of caregivers of patients with epilepsy for multiple temporal Scleroses and junior myoclonic. Journal Epilepsy Clinical Neurophisiol. 2005; 11 (2): 71-76.

17. Vitalino P, Yong H, Russo J. Is caregiving a risk factor for illness? Current Directions. Psychological Science. 2004; 13 (1): 13-16.

18. Chou KR. Caregiver burden: A concept analysis. J Pediatr Nurs. 2000 Dec; 15(6): 398-407.

19. Sales E. Family burden and quality of life. Quality of life research. 2003; 12(1): 33-41.

20. Aneshensel C, Pearlin L, Mullan J, Zarit S, Whitlatch C. Profiles in caregiving. The unexpected career. San Diego, CA (US): Academic Press; 1995.

21. Nolan M, Grant G, Keady J. Understanding family care: A multidimensional model for caring and coping. Buckingham (UK): Open University Press; 1996.

22. Martz E, Livneh H. Coping with Chronic Illness and Disability: Theoretical, empirical and clinical aspects. New York (US): Springer Publishing Company; 2007.

23. Nolan M, Grant G, Keady J. Assessing the needs of family carers: A guide for practitioners. Brighton (GB): Pavilion Publications; 1998.

24. Noonan AE, Tennstedt SL, Rebelski FG. Making the best of it: Themes of meaning among informal caregivers to the elderly. Journal of Aging Studies. 1996; 10(4): 313-327.

25. Folkman S, Moskowitz JT. Coping: Pitfalls and Promise. Annu Rev Psychol. 2004; 55: 745-74.

26. Sequeira C. Taking Care of Dependent Elderly: Diagnoses and Interventions. Coimbra (PT): Quarteto Editora; 2007.

27. Mahoney FI, Barthel DW. Functional evaluation. The Barthel Index. Md State Med J. 1965 Fev; 14:61-5.

28. Nolan M, Keady J, Grant G. CAMI: A basis for assessment and support with family carers. Br J Nurs. 1995 Jul 27-Aug 9; 4(14):822-6.

29. Ricardete L. Informal Caregivers Overload of Dependent Elderly in the region of Ribeira Grande. [Master's Thesis]. Porto (PT): Universidade do Porto; 2009. [Quoted in 28 October 2017]. Available in: https://repositorio-aberto.up.pt/bitstream/10216/19131/2/ ESCx.pdf

30. Mónico LS. Vulnerability, Old Age and disease: The Effect of Religion in the internal and external optimism. In Santos E, Ferreira JA, Pocinho R, Gaspar JP, Ramalho A, Eds. Transition to retirement: Contributions to the adaptation. Viseu (PT): Psicosoma; 2012: 55-70.

31. Santos, P. (2005). The familiar Caregiver in a household Environment: Physical, Emotional and Social Overload. [Masters Thesis]. Lisboa (PT): Escola Nacional de Saúde Pública; 2005.

Correspondence: lisete.monico@fpce.uc.pt