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LEVEL OF OVERLOADING AND DIFFICULTIES OF INFORMAL CARERS

Carlos Albuquerque (a)*, Catarina Almeida (b), Rosa Martins (c), Ana Andrade (c)
*Corresponding author

(a) CI&DETS - Health School of Viseu - Polytechnic Institute of Viseu, Portugal, cmalbuquerque@gmail.com
(b) ACeS Dão Lafões, Portugal, catarina_silva_almeida@hotmail.com
(c) CI&DETS - Health School of Viseu - Polytechnic Institute of Viseu, Portugal

Abstract

With the increase of life expectancy and the development of chronic diseases, family and friends have a role of extreme importance in the extension of care services. Thus, the main objective of this study is to identify the level of exhaustion and problems that carers can experience and the variables that influence them. This study is characterized as being quantitative, descriptive-correlational, using a non-probabilistic, accidental and convenience sampling, comprising 71 informal caregivers, aged between 30 and 80 years ($\bar{x}$= 53,73; Dp= 12,001), mostly female (64,79%), married (83,2%), village residents (83,2%) and with an average age of 53,73 years (Dp= 12,001). The data collection instruments included the Barthel Index; Smilkstein's Family Apgar Scale; Scale of Social Support; Questionnaire of the Evaluation on the Informal Carer's Overburden and Evaluation Index of Carer's Difficulties. The results displayed that sociodemographic characteristics do not influence the acuity how caregivers experience their exhaustion feelings. Regarding the "family functionality" and "social support"- informal caregivers in families with severe dysfunction and low social support, show higher rates of exhaustion. The higher difficulties were connected to the greater experience of overload by caregivers. The results revealed the existence of crucial factors related to a caregiver's overburden. Hence, the importance of a multidisciplinary approach based on supportive programmes cannot be underestimated - monitoring and giving personalised guidance to these caregivers - highlighting the need to increase the well-being of these people, so they can safely provide essential care to the person they are caring for, preventing at the same time physical and psychological overburden on themselves.

Keywords: Dependent person, informal carer, overburden, difficulties

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1. Introduction

Aging is a demographic reality which is increasing in nowadays societies. Society is changing and life expectancy is also changing markedly throughout developed and developing countries. This increase in the average life expectancy rises the rate of the population over the age of 65, showing that this phenomenon is far from being reversed.

In the past 10 years, an unprecedented increase in the elderly population has been observed in Portugal, currently representing around 19% of the total population, corresponding to an aging index of 129% (Chau, Soares, Fialho & Sacadura, 2012). It is estimated that between 2010 and 2050, Portugal will continue to grow older, with the proportion of elderly people expected to double to 38.9%. As a result, it will be the fourth country in the European Union with the highest percentage of elderly people, only surpassed by Spain (35.6%), Italy (35.3%) and Greece (32.5%) (Sousa, 2009).

Thus, it is observed an associated increase in the prevalence of disabling chronic diseases because of these demographic changes. Until then, we have had a health system based on acute illness paradigms and / or prevention measures which revealed a limited coverage of the national units of continued care services, as well as the lack of an integrated Health and Safety policies to meet both needs.

The changing of social role of women is also a key factor in the paradigm shift in health. Women ceased to be always present at home and to be considered as a traditional caregiver, taking a more active and participative role in society, which led to the need to find answers that could support people in situations of dependency. Rehabilitation and reinsertion, taking into account policies of active aging, are currently some concerns at a global scale. The United Nations Population Fund (UNFPA) and Help Age International (2012) suggest changes in attitudes, policies and practices that may ensure that the elderly person cannot be only seen as a beneficiary of pension plans but as an active participant in the development process, whose rights must be respected. National and local governments, international organizations, communities and civil society themselves must commit to ensure a global effort, adjusting societies to the demographic changes in this century. Investing in aging from birth generates concrete advances, with a positive cost-benefit.

This has led to the need of creating new and sustainable health and social supports tailored to the needs of different groups of people in a situation of dependence and to the different moments and circumstances of the evolution of diseases and social situations and, at the same time, enabling the autonomy and the participation of elderly population.

The partnership established between the Ministry of Labour and Social Solidarity (MTSS) and the Ministry of Health enabled the creation and encouragement of multisectoral responses, with the aim of promoting the provision of Health Care and Social Support to all citizens who are dependent, with a commitment on their health condition and in the terminal illness situations, supported by various entities, both public (hospitals, health centres, social security institutions) and social and private institutions (Rede Solidária and Rede Lucrativa), ensured by Governments that will be their main promoter (Mission Unit for Integrated Continuing Care - UMCCI, 2009).

The National Continuing Care Network (RNCCI), created by the Decree-Law 101/2006 No. 108, of June 6, 2006, constitutes the organizational and functional model for the development of this strategy. It represents a new process developed by two sectors with intervention responsibilities in the best interest of the citizens: the National Health Service (SNS) and the Social Security System. The general objective of the RNCCI is "(...) the provision of continuous integrated care to people who, regardless of their age, are in a situation of dependency" (page 4). This Network intends to implement a model of the provision of care adapted to the needs of the citizen and centrered on the user, where it is guaranteed the access to essential care, any time any place and by the most appropriate provider. Through the development of its standards, RNCCI is responsible for reconsider the role of hospitals and for the reinforcement of the primary health care as a fundamental pillar of the SNS. It supports its innovation and must adapt policies to the health needs in the country (UMCCI, 2009).

The RNCCI is therefore aimed at persons in a situation of dependence, regardless of age, who require continued health care and social support of preventive, rehabilitative or palliative natures, provided through inpatient, outpatient and outpatient units, hospital and home teams.

Based on the data presented earlier on the increase in the average life expectancy and, consequently, on the number of elderly people with disabilities associated with aging, as well as the increased incidence of chronic diseases, family and friends play an extremely important role in care needs. This is the core of the informal caregiver who becomes identified as any person, family or not, who is responsible for assisting the dependent person in their daily lives, promoting their quality of life and ensuring that their needs are satisfied. They are the ones who do it informally, without prior professional training, any contractual relationship and without any kind of remuneration.

The word caring "is more than an act; It's an attitude. Therefore, it covers more than a moment of attention, of zeal and care. It represents an attitude of occupation, concern, responsibility and affective involvement with the other "(Boof, 2008, p.33).

Informal caregivers fill the gap in official health services, providing, in European context, about 80% of all care provided to the dependent person. The role played by caregivers is extremely complex and goes beyond helping the person to perform his Basic Daily Life Activities (BDLA's). They assume a role of great responsibility, being often the first ones to detect changes in the person they care for, so they assume themselves as being partners of the health services (Pereira, 2011). The caregiver's choice is essentially related to the personal and family history of the dependent person, as well as in the social and cultural contexts of the dependent person (Sequeira, 2010).

The process of providing informal care is dynamic and quite complex, due to the evolution of the disease, the type of dependency, the family context, the back-up support network, among others.

2. Problem Statement

This study was carried out due to the importance of the role played by all informal caregivers and to the need to alert and sensitize health professionals about the importance of education and training: it urges to alert them about difficulties and facilitate their care. In short, it was decided to develop this study for believing that this is a very current and pertinent thematic area, which can bring to debate and reflection important practical implications not only for the various health professionals but also with probable influences for the whole citizenship. This work does not intend to solve the problem of the overload felt by informal caregivers, however, it is expected to perceive the levels of caregiver overload, as well as the difficulties felt by the caregivers and their determinants.

After diagnosis it is crucial that our intervention focuses on the context of the needs and promotes the well-being and true dignity not only of the caregivers but also of the person who is being cared.

3. Research Questions

Our first aim is to provide answers to our main question: "What are the factors that influence the level of overload and difficulties experienced by the informal caregiver of the dependent person?"

4. Purpose of the Study

The general objective proposed for this study is to know the level of overload and difficulties felt by the person who plays the role of informal caregiver of the dependent person, and subsequently their determinants.

The following objectives, more specific, were outlined as:

- Determine how the extension of sociodemographic context variables (age, gender) can influence the overload and difficulties felt by informal caregivers of users who are members of Long-term Care and Maintenance Unit (UCCLDM) ;
- Determine the influence that these two variables "family functionality" and "social support" have on the overload and difficulties felt by the informal caregivers of users who are members of UCCLDM.

5. Research Methods

This research is part of a non-experimental, quantitative, cross-sectional, descriptive-correlational study because of the following items: selection of the methodological instrument, nature of the phenomena, object of the research, operationalization of the outlined objectives; teams and other elements (Pestana & Gageiro, 2008). The study's population refers to the informal caregivers of dependent people, that is, people who, for some reason (illness or accident), are not able to satisfy at least one of their BDLAs independently. This sample is constituted by representative elements of the population and it is characterized as being non-probabilistic, accidental and for convenience. In the present study, inclusion criteria were defined as: Age equal or superior to 18 years; Informal caregivers answered to the questionnaire during the first two weeks of hospital admission (UCCLDM); The informal caregiver were the main caregiver of the dependent person, family or not; no remuneration was given for this function; If the informal caregiver was more than one person, their responses would have to be related to the person who is institutionalized in one of the Integrated Continuing Care Units (UCCI) under study; The caregiver would have to care for the dependent person for at least 3 months, being responsible for the essentials of care and not just being an occasional and sporadic caregiver. Of the 71 informal caregivers surveyed, the majority were female (64.79%), married (83.2%), mainly resident in villages (50.7%) and with a mean age of 53.73 years (Dp = 12.001). The most representative age group is between 42 and 62 years old (70.4%).

The data collection instrument included: Sociodemographic File; Barthel Index; Smilkstein Family Apgar Scale; Social Support Scale; Informal Caregiver Overload Assessment Questionnaire (QASCI) and Caregiver Difficulty Assessment Index (CADI).

The research instrument used was a questionnaire, which sought to contemplate the variables in study. Authorization was requested from the presidents of the executive boards of the Long-term Care and Maintenance Units. It was also requested an informed consent to participants in study. The opinion of the ethics committee of the School of Health of Viseu was also requested.

6. Findings

The following results were based on the objectives that guided our study. The association among the variables will be presented next.

6.1. Degree of dependence of the users in BDLA's versus Overload and difficulties of informal care

The stratification of the dependent person's dependency level in informal care allowed to group the users into three levels of dependence: 47 caregivers of users with severe or total dependency (group A); 11 caregivers of people with moderate dependence (group B) and 13 caregivers of independent people or with mild dependence (group C) (see Table 1). By the analysis of variance, there are very significant differences in the factors: Implications in the Life of the Informal Caregiver (H = 11,552, p = .003), Perceived mechanisms of effectiveness and control (H = 9.383, p = .009), the differences revealed significant in the following factors: Financial Overload (H = 7.574, p =, 023) and total QASCI (H = 6.790, P = 0.034). According to the influence of the variable "difficulties experienced by the caregiver", there is a significant effect on the factors: Social Restrictions (H = 16,071, p =, 000); Caring Requirements (H = 13,746, p =, 001); Caring Reactions (H = 11.833, p = .003); Family Support (H = 7.819, p = .020); Professional Support (H = 7.843, p = .020) and total CADI (H = 13.149, p = .001). After application of the Tukey Post-Hoc Test, it was observed that these differences were among groups A and C with a slight significance in the factors "Family Support" and "Professional Support" and a relevant results in the other factors.

Table 01. Kruskal-Wallis test: Overload and difficulties of informal care depending on the degree of dependence of the person

Degree of dependence	**Group A: severe/total dependency**	**Group B: moderate dependency**	**Group C: mild dependence**	**Teste de *Kruskal-Wallis***		**Post-Hoc (Tukey)**
Factors QASCI	**Average rank**	**Average rank**	**Average rank**	***H***	***P***	
Emotional Overload	39,62	24,68	32,50	5,174	,075	
Implications in the Life of the Informal Caregiver	41,89	26,41	22,81	**11,552**	**,003**	**A > B (,047)** **A > C (,006)**
Financial Overload	40,60	30,00	24,46	**7,574**	**,023**	**A > C (,027)**
Reactions to caring requirements	38,09	33,18	30,85	1,505	,471	
Perceived mechanisms of effectiveness and control	41,29	27,41	24,15	**9,383**	**,009**	**A > C (,017)**
Family Support	38,95	34,36	36,73	3,742	,154	
Satisfaction with role and family	37,31	36,91	30,50	1,147	,564	

Total QASCI	40,51	28,91	25,69	**6,790**	**,034**	**A > C (,049)**
Factors CADI						
Relational problems	39,27	36,18	24,04	5,566	,062	
Social Restrictions	42,26	31,95	16,81	**16,071**	**,000**	**A > C (,000)**
Caring Requirements	42,09	29,86	19,19	**13,746**	**,001**	**A > C (,001)**
Caring Reactions	41,85	27,91	21,69	**11,833**	**,003**	**A > C (,003)**
Family Support	40,79	27,91	25,54	**7,819**	**,020**	**A > C (,038)**
Professional Support	40,72	28,50	25,27	**7,843**	**,020**	**A > C (,033)**
Total CADI	41,77	31,64	18,85	**13,149**	**,001**	**A > C (,001)**

In short, the generality of the obtained results confirms the significant effects of the variable "degree of dependence on BDLA's" on the overload indexes and difficulties of the caregiver. It was verified, with statistically very significant values ($p < 0.01$), that the group consisting of informal caregivers of people with severe or total dependency presented higher rates of overload and difficulties than the group of informal caregivers of people with mild or independent dependence.

6.2. Gender versus Overload and Difficulties

Regarding the influence of the "gender" variable, the Mann Whitney U test results which refer to the indexes of overload and difficulties experienced by informal caregivers (see Table 2), show that in general, male patients do not differ statistically from female subjects according to the different factors of QASCI and CADI, except for the “Social Restrictions” and “Family Support” Factors (p =, 044 and p =, 008, respectively). However, a careful analysis of the data presents that men have a greater perception of overload, in the following factors: Financial Overload; Reactions to the Requirements of Care and Satisfaction with the Role and Family. On the other hand, women present higher levels of overload in the factors: Emotional Overload; Implications in the Life of the Informal Caregiver; Perception of Efficacy and Control Mechanisms and Family Support. Globally, women perceive higher levels of overload than men.

Regarding the perception of difficulties, women experience more difficulties patterns than men in each factors as for the total of the scale.

Table 02. Results of the U Mann Whitney Test: overload and gender-specific difficulties of the caregiver

Sex	**Male**		**Female**		***U de Mann Whitney***		
Factors QASCI	**N**	**Average rank**	**N**	**Average rank**	**U**	**Z**	**p**
Emotional Overload	25	34,16	46	37,00	529,00	-,556	,578
Implications in the Life of the Informal Caregiver	25	35,18	46	36,45	554,50	-,247	,805
Financial Overload	25	37,40	46	35,24	540,00	-,429	,668
Reactions to caring requirements	25	36,86	46	35,24	553,50	-,260	,795
Perceived mechanisms of effectiveness and control	25	35,58	46	36,23	564,50	-,127	,899
Family Support	25	32,54	46	37,88	488,50	-1,054	,292
Satisfaction with role and family	25	36,38	46	35,79	565,50	-,115	,908

Total QASCI	25	34,96	46	36,57	549,00	-,313	,754
Factors CADI							
Relational problems	25	32,90	46	39,63	497,50	-,935	,350
Social Restrictions	**25**	**29,32**	**46**	**39,63**	**408,00**	**-2,016**	**,044**
Caring Requirements	25	30,82	46	38,82	445,50	-1,563	,118
Caring Reactions	25	32,54	46	37,88	488,50	-1,047	,295
Family Support	**25**	**27,28**	**46**	**40,74**	**357,00**	**-2,669**	**,008**
Professional Support	25	31,42	46	38,49	460,50	-1,416	,157
Total CADI	25	29,74	46	39,40	418,50	-1,885	,059

6.3. Age versus Overload and Difficulties

In order to quantify the association between "age" and dependent variables under study (overload and difficulties of the informal caregiver), it was used the Linear Regression as a statistical coefficient, allowing us to perceive the strength and the meaning of the association between the two variables (consider Table 3). Observing the obtained results, based on the level of overload evaluated by the QASCI, it is noticed that there is no statistically significant association in any of the factors of this questionnaire, as well as for its total. Focusing on the analysis of the regression results with reference to the informal caregiver's difficulties evaluated by the CADI, it is verified that these express the existence of very significant associations (p =, 008) between age and the Family Support Factor (r =, 312). The fact that the association is positive indicates that the intensity of the association between these variables is done in the same direction, greater the age greater the difficulties felt in relation to Family Support.

Table 03. Simple linear regression analysis between QASCI and CADI factors and age

Factors QASCI	**r**	**R^2 (%)**	**p**	**t**	**p**
Emotional Overload	,035	0,1	,771	,292	,771
Implications in the Life of the Informal Caregiver	,026	0,1	,828	,219	,828
Financial Overload	,050	0,3	,677	-,418	,677
Reactions to caring requirements	,023	0,1	,846	-,195	,846
Perceived mechanisms of effectiveness and control	,005	0,0	,965	-,044	,965
Family Support	,115	1,3	,341	,958	,341
Satisfaction with role and family	,028	0,1	,817	-,232	,817
Total QASCI	,009	0,0	,940	,075	,940
Factors CADI					
Relational problems	,110	1,2	,362	,918	,362
Social Restrictions	,217	4,7	,069	1,850	,069
Caring Requirements	,153	2,3	,204	1,284	,204
Caring Reactions	,140	2,0	,244	1,176	,244
Family Support	**,312**	**9,7**	**,008**	**2,730**	**,008**
Professional Support	,181	3,3	,130	1,533	,130
Total CADI	,201	4,0	,093	1,704	,093

6.4. Family Functionality versus Overload and Difficulties

By the analysis of the results it can be verified that the variable "family functionality" in general influences the level of overload (see Table 4). The data are statistically significant for the factors: Emotional Overload (H = 17,848, p =, 000), Implications in Informal Caretaker's Life (H = 9.249, p =, 010), Financial Overload (H = 7.108, p (H = 10.529, p = .005), Family Support (H = 21.598, p =, 000) and Satisfaction with Role and Familiarity (H = 9.863, p = 007). All these factors end up influencing the total QASCI (H = 17,295, p =, 000), and for this the differences are located between group A (M = 43,26) and C (M = 23,79, Tukey = , 001) and group B (M = 45.60) and C (M = 23.79, Tukey =, 000), that is, individuals with moderate and severe family dysfunction present higher levels of overload than caregivers who have a highly functional family.

For the factors Emotional Overload and Implications in the Life of the Informal Caregiver, the differences were also found between group A (M = 43.12 and M = 43.05, respectively) and C (M = 23.67, Tukey = 0.001 and M = 27.09, Tukey = 0.015) and group B (M = 45.90 and M = 41.26, respectively) and C (M = 23.67, Tukey =, 000 and M = 27.09, Tukey =, 035, respectively), concluding the same as above. Group B (M = 41.60 and M = 46.02, respectively) and C (M = 28.28, Tukey =, 049 and M = 27.19, Tukey = .003, respectively) show statistically significant Financial Overload Factors and Reactions to Care Requirements, thus, subjects with moderate family dysfunction have higher levels of overload than those who report having a highly functional family.

Regarding Family Support, group A (M = 46.88) presented higher levels of overload when compared to group C (M = 22.55, Tukey =, 000), also group B (M = 43.68), Presented higher values of overload compared to group C (M = 22.55, Tukey =, 000). However, for the factor Satisfaction with paper and the family group A (M = 40.83) reveals higher levels of overload than group B (M = 43.74, Tukey =, 037), as this has higher levels of overload than group C (M = 26.90, Tukey =, 007).

Table 04. Kruskal-Wallis test: overload and difficulties due to family functionality

Family Functionality	**Group A: Severe dysfunction (N=21)**	**Group B: Moderate dysfunction (N=21)**	**Group C: Highly functional (N=29)**	***Teste Kruskal-Wallis***		***Post – Hoc (Tukey)***
Factors QASCI	**Average rank**	**Average rank**	**Average rank**	***H***	***p***	
Emotional Overload	43,12	45,90	23,67	**17,848**	**,000**	**A > C (,001)** **B > C (,000)**
Implications in the Life of the Informal Caregiver	43,05	41,26	27,09	**9,249**	**,010**	**A > C (,015)** **B > C (,035)**
Financial Overload	41,07	41,60	28,28	**7,108**	**,029**	**B > C (,049)**
Reactions to caring requirements	38,14	46,02	27,19	**10,529**	**,005**	**B > C (,003)**
Perceived mechanisms of effectiveness and control	36,90	43,83	29,67	5,860	,053	
Family Support	46,88	43,68	22,55	**21,598**	**,000**	**A > C (,000)** **B > C (,000)**
Satisfaction with role and family	40,83	43,74	26,90	**9,863**	**,007**	**A > B (,037)** **B > C (,009)**
Total QASCI	43,26	45,60	23,79	**17,295**	**,000**	**A > C (,001)** **B > C (,000)**
Factors CADI						
Relational problems	39,86	43,38	27,86	**7,959**	**,019**	**B > C (,020)**
Social Restrictions	43,62	41,74	26,33	**10,915**	**,004**	**A > C (,007)** **B > C (,018)**
Caring Requirements	41,50	41,19	28,26	**6,933**	**,031**	**A > C (,049)**
Caring Reactions	41,90	43,83	26,05	**11,597**	**,003**	**A > C (,013)** **B > C (,005)**
Family Support	44,64	44,38	23,67	**18,094**	**,000**	**A > C (,000)** **B > C (,000)**

Professional Support	43,10	38,86	28,79	**6,779**	**,034**	**A > C (,032)**
Total CADI	43,45	41,74	26,45	**10,579**	**,005**	**A > C (,008)** **B > C (,020)**

Analysing the influence of the variable “difficulties experienced by the caregiver”, it is verified that for all factors and total CADI the data are statistically significant. Thus, regarding Relational Problems factor (H = 7.959, p = 0.019), families with moderate dysfunction (M = 43,38) reported more difficulties than those with highly functional family (M = 27 , 86, Tukey =, 020). Regarding the Social Restrictions factor (H = 10.915, p = .004), the families of group A (M = 43.62) stated that they had more difficulties in caring for the dependent person than the members of group C (M = 26, 33, Tukey =, 007), also the group B elements (M = 41.74), present more difficulties than the caregivers of group C (M = 26,33, Tukey =, 018). In the Caring Requirements, caregivers belonging to families with marked dysfunction (M = 41.50) say they feel more difficulties in care support than those in highly functional families (M = 28,26, Tukey =, 049). As for the second factor, also for the factor Caring Reactions, the elements that constitute group A (M = 41.90), as well as those of group B (M = 43.83), say they experience more difficulties than the elements of group C (M = 26.05, Tukey =, 013 and Tukey =, 005, respectively). The “Family Support” factor reveals that both groups A (M = 44.64) and B (M = 44,38) presented more difficulties patterns than those caregivers with highly functional family, where same significance level was displayed (M = 23.67, Tukey =, 000). Considering the perception of support provided by the professionals, the caregivers inserted in families with marked dysfunction (M = 43,10), expressed more difficulties results about handling care support for the dependent person than the caregivers included in highly functional families (M = 28.79, Tukey =, 032). Finally, regarding the total CADI factor, it was demonstrated that the subjects belonging to groups A (M = 43,45) and B (M = 41,74) have more difficulties than the subjects in group C (M = 26.45 , Tukey =, 008 and Tukey =, 020).

Synthesis: Most of the obtained results confirm the significant effects of the "family functionality" variable on the overload indexes and the caregiver's difficulties. There is a statistically significant difference (p <0.01) between the group of informal caregivers integrated in families with marked dysfunction, as it is perceptible, presenting, in total, higher rates of overload and difficulties than informal caregivers, belonging to highly functional families.

6.5. Social Support versus Overload and Difficulties

Regarding the influence of the variable "social support" on the overload felt by the informal caregiver, it was verified that for all the factors and total of the QASCI index there are statistically significant empirical data. Thus, for the Emotional Overload Factor, it was observed that caregivers who report receiving low social support (M = 61.20) feel a greater overload of care than individuals who receive moderate (M = 34.66, Tukey = , 000) and high social support (M = 20.46, Tukey =, 000).

Also, subjects belonging to group B (M = 34.66) feel more overloaded than those in group C (M = 20.46, Tukey =, 034). Likewise, in the Informal Caretaker Implications in Life Factor, group A (M = 61,25) showed greater overload than group B, with the same level of significance (M = 35.61) and Group C (M = 16.54, Tukey =, 000), also group B (M = 35.61), presented higher levels of overload than group C (M = 16.54, Tukey = .

As for the Financial Overload, the same happens, that is, the group A (M = 57.60) reveals higher levels of overload than group B (M = 36.28, Tukey =, 002) and those of the group (M = 16.88, Tukey =, 000), the subjects in group B also showed higher levels of overload (M = 36.28) than those in group C (M = 16.88, Tukey =).

For the fourth factor, Caring Reactions, caregivers who report receiving low social support from the rear (M = 56.55), present higher levels of overload when compared to caregivers who receive moderate (M = 33.02, Tukey =, 002) and high social support (M = 31.04, Tukey =, 007).

Similar to the previous factor, also in the "Perception of Efficacy and Control Mechanisms" factor, group A (M = 58.90) expressed higher levels of overload than those of group B (M = 34.83, Tukey =, 001) and of group C (M = 21.71, Tukey =, 000). For the factor "Family Support" the same results appeared, that is, the subjects of group A (M = 55.60) show a greater overload in relation to the care of a dependent person than the constituent elements of group B (M = 34, 73, Tukey =, 005) and that of group C (M = 24.83, Tukey =, 001). The Group A (M = 54.85) also disclosed a greater overload compared to those who received moderate social support (M = 34.81, Tukey =, 009) and those who have high social support from the rear (M = 25,17, Tukey =, 001). Thus, for the total QASCI, caregivers with low social support (M = 63,15) express higher levels of overload than those who receive moderate social support (M = 34.64) and high social support (M = 18.92, Tukey =, 000), with the same level of significance. Also, caregivers who receive moderate social support (M = 34.64) show higher levels than those with high social support (M = 18.92, Tukey =, 013).

Table 05. Kruskal-Wallis test: overload and difficulties due to perceived social support

Social Support	**Group A: Low (N=10)**	**Group B: Moderate (N=49)**	**Group C: High (N=12)**	***Teste Kruskal-Wallis***		***Post – Hoc***
Factors QASCI	**Average rank**	**Average rank**	**Average rank**	**H**	**p**	***(Tukey)***
Emotional Overload	61,20	34,66	20,46	**22,125**	**,000**	**A > B (,000)** **A > C (,000)** **B > C (,034)**
Implications in the Life of the Informal Caregiver	61,25	35,61	16,54	**25,723**	**,000**	**A > B (,000)** **A > C (,000)** **B > C (,002)**
Financial Overload	57,60	36,28	16,88	**21,993**	**,000**	**A > B (,002)** **A > C (,000)** **B > C (,002)**
Reactions to caring requirements	56,55	33,02	31,04	**11,699**	**,003**	**A > B (,002)** **A > C (,007)**
Perceived mechanisms of effectiveness and control	58,90	34,83	21,71	**18,439**	**,000**	**A > B (,001)** **A > C (,000)**
Family Support	55,60	34,73	24,83	**13,037**	**,001**	**A > B (,005)** **A > C (,001)**
Satisfaction with role and family	54,85	34,81	25,17	**11,954**	**,003**	**A > B (,009)** **A > C (,001)**
Total QASCI	63,15	34,64	18,92	**25,755**	**,000**	**A > B (,000)** **A > C (,000)** **B > C (,013)**
Factors CADI						
Relational problems	48,80	34,84	30,08	5,008	,082	
Social Restrictions	49,30	36,89	21,29	**10,396**	**,006**	**A > C (,003)**

						B > C (,038)
Caring Requirements	45,35	37,16	23,46	6,671	,063	
Caring Reactions	49,20	37,23	19,96	**11,631**	**,003**	**A > C (,002)** **B > C (,017)**
Family Support	45,00	37,14	23,83	**6,436**	**,040**	**A > C (,037)**
Professional Support	52,00	35,91	23,04	**11,341**	**,003**	**A > B (,040)** **A > C (,002)**
Total CADI	48,65	36,73	22,46	**8,991**	**,011**	**A > C (,007)**

Regarding the influence of the same variable on the difficulties experienced by caregivers, empirically tested data are statistically significant for the following factors: Social Restrictions (H = 10.396, p = .006), Caring Reactions (H = 11.631 Family Support (H = 6.436, p = .040), Professional Support (H = 11.341, p = .003) and total CADI (H = 8.991, p = .011). Concerning the "Social Restrictions" factor, it can be marked that caregivers with low social support (M = 49.3) and moderate social support (M = 36.89) present greater difficulties than those receiving high social support (M = 21, 29, Tukey =, 003 and Tukey =, 038, respectively). Similar results were attained in the factor "Reactions to Care", that is, groups A (M = 49,20) and B (M = 37,23) report greater difficulties than the subjects of group C (M = 19.96, Tukey =, 002 and Tukey =, 017, respectively). In the "Family Support" factor, caregivers with low social support (M = 45.00) express more difficulties than those receiving high social support (M = 23.83, Tukey =, 037). Regarding "Professional Support", caregivers in group A (M = 52.00) reveal greater difficulties in caring for a dependent person than those included in group B (M = 35.91, Tukey =, 040) and those in group C (M = 23.04, Tukey =, 002). Even though all factors do not show statistically significant data, yet for total CADI, it was noted that caregivers with low social support (M = 48.65) divulge more difficulties in caring than caregivers with high social support (M = 22.46, Tukey =, 007).

Synthesis: Most of the results confirm the significant effects of the variable "Social Support" on the overload indexes and difficulties of the caregiver. It was verified, with statistically significant values ($p < 0.01$), that the group of informal caregivers integrated in families with low and moderate social support experience higher rates of overload and difficulties than those who have a high social support.

7. Conclusion

This study exposes that the health of informal caregivers is one of the factors which promotes a decrease in the experience of burden and adversities, which intensifies the importance of formal support. Thus, it will be attained a systematic and structured intervention between the different formal and informal agents, i.e., those responsible for medical, nursing, social, emotional and economic support to informal caregivers and their dependent relatives. This support should be provided by a multidisciplinary team that must outline strategies with the informal caregiver, promoting training and so improving the quality of life of the caregiver and their dependent relatives. In this way, it is essential to raise awareness among professionals and disseminate the profile of the caregiver most likely to trigger overload so that health professionals do not only care for the users but also keep a close eye on the informal caregiver above all their difficulties. For this to happen, they are required simple and unbureaucratized services, with an integrated perspective, involving services to support the basic activities of daily life as health aspects (medical and nursing, rehabilitation, psychology, occupational therapy, among others), that can be activated when the identification of caregivers, who need support, is made.

The health professionals should have at his disposal means that allow them to diagnose and be prepared to these situations. It would be interesting to create a multidisciplinary team bureau responsible for informal caregivers needs. This measure will allow to decrease the levels of overload and the integration of caregivers into the health system and their early follow-up. This bureau should be massively publicized and easy to access.

In short, the results revealed the existence of determinants for the caregiver's overload, hence the importance of a multidisciplinary approach based on programs of support, follow-up and differentiated orientation of these caregivers when emphasizing the need to increase the welfare index of these people. These measures will provide an essential care to the caregiver while, at the same time, it will prevent physical and psychological overloads that are harmful for their health. We believe that general nursing and rehabilitation nursing will have an important role here to foster and develop.

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