CHAPTER V

FINDINGS,
SUGGESTIONS &
CONCLUSIONS
FINDINGS, SUGGESTIONS AND CONCLUSION

The purpose of the study is to focus on the attention on the extend to know about the family interaction pattern and family burden of Alzheimer’s Disease patients. Most of the respondents had low level of family interaction pattern and higher level of family burden. Tools adopted for this study was functional assessment staging, family interaction pattern scale and family burden.

This study was done with Alzheimer’s Disease patients who are registered in ARDSI’S Urban Community Dementia Service Centre located at Cochin. Census method was adopted to collect the data. The ‘t’ test, ‘f’ test was used to found out the differences and ‘chi’ square test and correlation test were used to found out the association. Through these test hypothesis were tested and various major findings were also derived. These are follows.

Hypothesis Accepted: -

1. There is a significant association between leisure time activities of the respondents and family burden.

2. There is a significant association between family burden and sex of the respondents.

3. There is a significant association between educational status of the respondents with regard to family burden.

4. There is a significant association between marital status of the respondents with regard to family burden.

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Student ‘t’ test was applied to test to the above hypothesis

5. There is a significant difference between severity of Alzheimer’s Disease of the respondents with regard to family burden.

‘F’ test was applied to test the above hypothesis.

6. There is a significant association between age of the respondents and opinion about their health.

7. There is a significant association between age of the respondents and severity of Alzheimer’s Disease.

‘Chi-square’ test was applied to test the above hypothesis.

8. There is a significant association between age of the respondents with regard to family burden.

9. There is a significant association between family interaction pattern and family burden of the respondents.

‘Karl Pearson’s co-efficient of correlation’ test was applied to test the above hypothesis.

**Hypothesis Rejected:**

1. There is a significant association between sex of the respondents and opinion about their health.

2. There is a significant association between sex of the respondents and severity of Alzheimer’s Disease.
3. There is a significant association between marital status of the respondents and opinion about their health.

4. There is a significant association between marital status of the respondents and severity of Alzheimer’s Disease.

5. There is a significant association between educational status of the respondents and severity of Alzheimer’s Disease.

6. There is a significant association between previous occupation of the respondents and opinion about their health.

7. There is a significant association between previous occupation of the respondents and severity of Alzheimer’s Disease.

8. There is a significant association between type of family of the respondents and opinion about their health.

9. There is a significant association between type of family of the respondents and severity of Alzheimer’s Disease.

10. There is a significant association between total family income of the respondents and opinion about their health.

11. There is a significant association between the leisure time activities of the respondents and family interaction pattern.

12. There is a significant association between age of the respondents and family interaction pattern.

13. There is a significant association between total family income of the respondents and family interaction pattern.
14. There is a significant association between total family income of the respondents and family burden.

15. There is a significant association between size of the family of the respondents and family interaction pattern.

16. There is a significant association between size of the family of the respondents and family burden.

17. There is a significant association between sex of the respondents and family interaction pattern.

18. There is a significant association between type of family of the respondents and family interaction pattern.

19. There is a significant association between type of family of the respondents and family burden.

20. There is a significant association between educational status of the respondents and family interaction pattern.

21. There is a significant association between marital status of the respondents and family interaction pattern.

22. There is a significant association between severity of Alzheimer’s Disease of the respondents and family interaction pattern.

Socio-demographic Variables: -

Due to reduction in the death rate, 39.1 percent of the respondents were under the age group of 71-80 years. Majority of 60.9 percent of the respondents were females. 46.9 percent of the respondents belong to Muslim religion.
Majority (65.6%) of the respondents were illiterates. Majority (60.9%) of the respondents belong to urban. India is known for its close family ties, therefore 65.6 percent of the respondents come from extended families. Majority 73.4 percent of the respondents were widow/er and only small number of the respondents (26.6%) were married. 43.8 percent of the respondents were under the category of Rs. 5000 and below with regard to their total family monthly income. Good majority (70.3%) of the respondents had no habits. Majority 75 percent of the respondents involving in household activities. 15.6 percent of the respondents were abused physically / verbally / emotionally by their family members.

Findings Related to Health Status

Majority 56.3 percent of the respondents have eye related problems. 42.2 percent of the respondents were suffering from dental problems and diabetes. 37.5 percent of the respondents were suffering from hearing related diseases. 26.6 percent of the respondents have hypertension. 25 percent of the respondents suffering cardiac problems. Majority 57.8 percent of the respondents dissatisfied about their present health condition.

Findings Related to Severity of Alzheimer’s Disease:

7.8 percent of the respondents were suffering from severe Alzheimer’s disease, 15.6 percent of the respondents had moderately severe Alzheimer’s disease, 9.4 percent of the respondents had moderate Alzheimer’s disease and 18.85 percent of the respondents were suffering from mild Alzheimer’s disease.
Family Interaction: -

Most of the respondents had low level of family interaction pattern. With regard to sub-dimensions of family interaction pattern majority of the respondents had low level of leadership, cohesion, role and communication. Age, total family monthly income and size of family were not correlated with family interaction pattern.

Family Burden: -

48.4 percent of the respondents had high level of family burden. Male respondents had higher level of financial burden. With regard to marital status widow / er had higher level of disruption of family leisure. With regard to sub-dimensions of family burden, majority of the respondents had higher level of disruption of family interaction, effect on mental health of others, disruption of family leisure and disruption of routine family activities.

Family burden positively correlated with age of the respondents. Family burden was not correlated with total family income and size of family of the respondents.

Correlation Between Family Interaction and Family Burden: -

Family interaction positively correlated with disruption of family leisure and effect on physical health of others. Family burden positively correlate with sub-dimensions of family interaction pattern i.e., reinforcement, communication and cohesion. Effect on physical health of others positively correlate with role, communication, cohesion and leadership.
SUGGESTIONS

It is evident that Alzheimer’s Disease is one disability that causes a lot of suffering not only for the sufferer himself, but for his family as well. The presence of Alzheimer’s Disease individual in the family exterts a severe emotional burden on the family, disturbing its harmony and psychological equilibrium.

Suggestions for Interventions

* The rehabilitation has to be individualized, flexible and based on needs of the patients and resources of the family.

* Counseling services are very essential for the elderly in order to help them develop better interaction and adjustment.

* Identify and advocate measures to maintain functional capacity and quality of life in old age.

* An educational programme containing the condition of Alzheimer’s Disease patients, various treatment techniques and the role of the family members in rehabilitating them need to be imparted to family members.

* Raise awareness of the causes and effects of age-related non-communicable diseases.

* Preventive health programs of the government should be improved.
* Consumer education and the development of new skills in daily activity to conserve energy, guard against accidents and protect disabilities will be useful.

* Modifying the behavior of elderly people to promote improved functioning, self-esteem and live a more satisfying life.

* There is a need to work with families to ensure optimum care as well as successful family adaptation approaches to such family intervention should include;

  a) Family education

  b) **Primary caregiver training**

  c) Primary Caregiver counseling

  d) Family social support networking and self-help groups

* The elderly people are in need of love and affection from their family. So the coming generation should be educated to show love and affection towards the elders to solve the emotional conflicts faced by the aged people.

* Governmental / voluntary organizations working on the Alzheimer’s Disease patients should have a family counseling centers should resolve the conflicts occurring in the families.

* Regular and periodical check-up of geriatrician and physician are a must in all Alzheimer’s Disease patients. Intervention based on periodical assessment is essential.
* Adjunct support services (home care services, bedside assistance, and respite care) are encouraged further.

* A supportive environment needs to be established that provides assistance and relief to the vulnerable elderly who are subjected to social isolation, increased dependency, deteriorating family relationship or poor living environment.

* For those who do not enjoy family support adequate, institutional care is established to suit their economic status.

* Geriatric care centres should be established to meet the specific needs of senior citizens.

* Better health care facilities shall be organized for the older persons.

* Old people living in the same area can organize an association for the sake of recreation.

* The involvement of community as an elder care provider be organized and encouraged.

* The elderly have to participate in development and benefit equitably from economic growth. Solidarity has to be built within family, community and institutional structures for inter-generational dependence.

* Promoting physical health from an early age, so that it does not decline rapidly with old age through exercise programs and such like.
* Promoting emotional well being. All people need to be loved and regarded as active members of a caring society. Only then can we age actively and healthily.

* Explore avenues to reduce the impact of urbanization / changing family structure on elders’ lives.

* Prepare schemes to take care of mental health, old age disabilities, caregiving and violence against the elderly.

* Extensive mobilization for associational activities and close community level interaction.

* Promote independence, dignity and purpose for older persons.

* Give them confidence and utilize their wisdom and time for the society.

* Preventing elder abuse, protecting life and property.

* The rights of elders need to be protected, and some kind of aged helpline can be initiated to look into the sufferings of elders.

* A paper of gerontology shall be introduced in all the para-medical courses like social work, psychology, physiotherapy, etc.

* Establish an academy of senior citizens for undertaking activities like research, guidance, publishing useful material and technical library.

* Extend geriatric care up to primary health centres in villages.
**Suggestion for Future Research**

* Research studies in the country lack in some of the ageing problems of widowhood, physically and mentally disabled aged and the most important investigation which needs special attention is studying the aged in their changing family structure.

* Psychosocial problems of the Alzheimer’s Disease patients.

* Future studies can be done on depression, security and insecurity and hopelessness among Alzheimer’s Disease patients.

* Future studies can be done on lifestyles and habits that impact health in old age.
Conclusion:

For the elderly in India, ageing is not a trauma. It is disadvantages that ageing brings with it that is dreaded by them. Otherwise, Indian culture has enough buffers to promote natural acceptance of the process of ageing. If older persons are not to become a liability in old age, prevention has to begin much early in their life cycle. Awareness-building programs, screening for and identification of diseases, improving home care services will add life to years.

Little is known about the capacities of the families, their resources and constraints, in providing care for Alzheimer’s Disease patients. A research based on various issues concerned with families of Alzheimer’s Disease patients may throw some light on how these families can be helped by intervention programs. Research of this nature may help to develop awareness programs in the community with reference to their nature and use.

The Alzheimer’s Disease patient – caregiver relationship had to be maintained in a good manner during this period of life. So it is good on the part of the family of Alzheimer’s Disease patient and the general society to understand their natural changes and try to adapt and make Alzheimer’s patients adjust to each other’s life style and this would aid a healthy Alzheimer’s Disease patient – caregiver relationship which becomes essential for the healthy ageing.