

Title:

Groups of Family Caregivers in Colombia: Profile, Caregiving Ability, and Burden

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Abstract Summary:

The big data is a tendency in research nursing. In this report have experience to have profile family caregivers in Colombia (South America) with simple 1.137 family caregivers analyzed with factor analysis.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to identify the profile family caregivers groups exist in Colombia.	Profile the family caregivers (results to cluster analysis)

The learner will be able to apply to cluster analysis in others research with family caregivers.	The cluster analysis is a new tendency in nursing research and this report will tips to future research with agrupations of sociodemografic variables with other variables to family caring.
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Abstract Text:

Non Communicable Diseases (NCDs) and level of dependence have increased worldwide with more complications. In this regard, the Family Caregiver (FC) emerges to assist this dependence, impacting on status health of caregiver. The Family Caregiver research has focused on caregiver burden profiles and the importance of being a caregiver (Akpan-Idiok *et al.*, 2014). The *Gender* is a variable widely used as significant in relation to caregiver burden, although there are others variables with low relevance, as *Age, Competence, Distress, Physical Health, and Lifestyles* (Crespo & López, 2008).

In Colombia, the research on Family Caregiver of people with a NCD has been developed 15 years ago. The Colombians family caregivers are often female, productive age, with a low education level, and many-hours-per-day and time-in-months caring.

Ngozi Nkongho (2003) proposed the theoretical construct *Caring Ability (CA)*, which includes three dimensions: *Knowledge, Courage, and Patience*. The main topic of this research shows that Latin American family caregivers have low levels of ability caring, specially, with respect to patience.

Zarit (1980) propounded the caregiving burden with respect to three concepts: *impact of caring, self-efficacy expectation* and *dependence* (Zarit, quoted by Breinbauer, Vásquez, Mayanz, Guerra & Millán, 2009). The family caregiver burden in Latin America is low. The burden is associated with education level and caring ability (Carrillo, Chaparro-Díaz & Sánchez-Herrera, 2014; Cerquera-Córdoba, Granados-Latorre & Galvis-Aparicio, 2014; Ocampo *et al.*, 2007; Sánchez *et al.*, 2014; Vega Angarita, Ovallos-Lizcano & Velásquez Ardila, 2012; Ballestas Cueto *et al.*, 2013; Barrera-Ortiz, Sánchez & Carrillo, 2013; Barreto-Osorio, Coral-Ibarra, Campos, Gallardo-Solarte & Ortiz, 2015; Carrillo, Sánchez & Barrera, 2014; Figueroa, 2011; Ortiz-Claro, Lindarte-Clavijo, Jiménez-Sepúlveda & Vega-Angarita, 2013; Sánchez-Herrera, Carrillo y Corredor, 2014).

Review of the literature shows that there are relations between gender and caring ability; between burden and family functionality, and between satisfaction of caregiving and social support. Likewise, there is a relation between burden and female caregiver, and between patient functionality and caring time—in hours and months— (Barreto-Osorio, Coral-Ibarra *et al.*, 2015; Crespo & López, 2008; Andrén & Elmståhl, 2008; Chien, Chan & Monrresse, 2007; Jaracz, Grabowska-Fudala, Górna & Kozubski, 2014; Akpan-Idiok & Anarado, 2014; D'Onofrio *et al.*, 2014; González & Graz, 2004).

Objective: To explore the correlation between socio-demographic variables, caregiver burden and caring ability in a sample of caregivers of people with chronic diseases in Colombia, in order to understand how they establish groups and how data are grouped in accordance with correlation between variables.

Method: Quantitative and descriptive study. The sample consisted of 1,137 family caregivers—the initial sample consisted of 606 caregivers—from the following Colombian regions: Amazonian (17.6%), Andean (61.6%), Caribbean (7.6%), Pacific (12.8%), and Orinoco (0.4%). The inclusion criteria used were: family caregiver of person with NDC; experience as a caregiver at least six months, and to be over 18 years of age. The exclusion criteria used were: difficulty in communicating with other verbally, and patient with critical illness at the moment of the interview.

Instruments used: 1) Characterization record card of the dyad —patient with critical illness- family caregiver— (Chaparro, Sánchez & Carrillo, 2014); 2) Caring Ability Inventory (CAI) (Nkongho, 2003), and Zarit Burden Interview (ZBI) (Breinbauer *et al.*, 2009).

Data was arranged in three stages: training of the interviewers, monitoring of data recording, and control of databases (Universidad Nacional de Colombia, Facultad de Enfermería, Grupo de Cuidado de Enfermería al Paciente Crónico). The selection of study participants was carried out in cooperation with the Red Latinoamericana de Cuidado al Paciente Crónico y la Familia. Participants were located in different observation regional points.

Analysis: A factor analysis and a *k*-means clustering were carried out.

Results: It was found that caregivers were grouped themselves in accordance with their region of origin, in four geographical groups: 1) Andean and Pacific; 2) Andean; 3) Caribbean, and 4) Amazonian. In addition, it was found that each group had its own specific needs of care for the caregiver profiles. The four groups were comprised as follows: *Group 1.* 703 caregivers from Santander, Nariño, Cundinamarca, Boyacá, and Chocó —Colombian Departments. They are female caregivers and they are supported by other caregivers, with a medium education level, without defined occupation, married, and with medium level of religious commitment. They take care of patient since disease diagnosis and they have an intensive burden. *Group 2.* 144 caregivers from central area of country —Andean region— and urban area of Norte de Santander. They are male caregivers, with high level of religious commitment and in common-law marriage. Caregivers of this group have an intensive burden and low caring ability; they take care of patient since disease diagnosis. *Group 3.* 90 caregivers from Caribbean region and rural area — Departments of Cesar, Magdalena, La Guajira and Bolívar. They are female caregivers, with a medium education level, sole family caregivers —that is say, without support of other caregiver—; they take care of patient since disease diagnosis and they have low level of religious commitment. The caring ability of this group is middle and low. *Group 4.* 200 caregivers from Amazonas region —from urban area of Putumayo—, with a low education level, singles, with an occupation and high level of religious commitment. Some of them are supported by other caregivers. It is worth highlighting that they have high caring ability, but they do not report burden.

Conclusion: The groups of the sample reflect the cultural diversity of Colombia and the need to provide continuity to studies that explore socio-cultural factors, which may be able to influence the caring ability and the level of caregiver burden, in accordance with their region of origin.

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