

## Resentment in The Primary Caregiver of A Patient with Dementia in A Mexican Community

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Received: 25 March 2021; Accepted: 12 April 2021

**Citation:** Gutierrez-Herrera RF, Mondragon-Leon MC, Gomez-Gomez C, et al. Resentment in The Primary Caregiver of A Patient with Dementia in A Mexican Community. Int J Psychiatr Res. 2021; 4(2): 1-6.

### ABSTRACT

**Introduction:** Dementia is defined as the progressive deterioration of cognitive abilities; It begins with progressive memory loss, progressing to total cognitive limitation, with behavioral-psychiatric and functional compromise.

Due to deterioration, a caregiver is essential. Reactions to caring can vary considerably, but it is now clear that many caregivers are at risk of psychosocial compromise. Resentment is defined as a persistent feeling of disgust or anger towards someone because they consider it the cause of a certain offense or damage suffered.

**Objective:** Demonstrate the prevalence of resentment in caregivers of patients with dementia.

**Material and methods:** A descriptive cross-sectional study was carried out in 147 primary caregivers of patients with dementia who attended a university hospital. Probability sampling for convenience to people over 18 years of age. Approved by the Institution's Ethics and Research Committees. The resentment scale of Thompson et al. Was applied, with Cronbach's alpha .92.

**Data analysis:** It was done in SPSS version 20 for Windows. Chi2 was used for categorical variables with a value of  $p < 0.05$ .

**Results:** A prevalence of resentment was found in about half of the caregivers. Mostly women, married, university educated, dedicated to the home, of medium socioeconomic level, Catholics, practitioners of their religion, who mainly take care of their mother, 7 days a week with an average of 15 hours a day.

**Conclusions:** About half of the caregivers are resentful. There are factors that are related in favor of the presence of resentment such as occupation and activities related to care and some factors that work against such as attending support groups and being a religious practitioner.

### Keywords

Dementia, Resentment, Caregiver, Burden.

### Introduction

In recent years, the increase in people over the age of 65 has become an unprecedented event in human history [1]. The global demographic transition has resulted in a transformation in the way

they age, fall ill and die populations. This phenomenon, called epidemiological transition, has currently promoted diseases to be more associated with disability and dependency, as is the case with dementias [2].

Dementia is a chronic, neurodegenerative and progressive disease characterized by alterations in cognitive processes, behavior and

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mood; generator of disability and dependence in those who suffer from it [3].

In the world, it affects approximately 10% of people over 65 years of age and half of those over 85 years of age, with a total of 47.5 million people affected and 7.7 million new cases per year [4].

In Latin America, dementia prevalence rates have been reported ranging between 3 and 6% [5]. In Mexico there are some clinical reports on the presence of 500,000 to 700,000 people with dementia, but it is estimated that about 25% of the affected people remain undiagnosed [5].

In the ENSANUT 2012 a prevalence of 7.9% was found throughout Mexico, and for non-dementia cognitive impairment of 7.3%. In both cases, the frequency is higher in women, older subjects, less educated, and in residents of rural areas [6].

In a previous study carried out in Nuevo León in 2006, the prevalence of dementia was 3.5% in adults 60 years of age or older, mild cognitive impairment was found in 30.5% of the population [7].

Dementias can be classified according to multiple criteria, such as: anatomical (based on the injured area), based on its etiology, speed of evolution, age of onset, type of molecular or genetic lesions, in this way the same pathology Insanity can be classified in different ways depending on the perspective from which it is approached [2].

Patients with dementia generate an intense demand for support and assistance due to the functional and cognitive alterations that this entails, most of the time this demand for attention is covered by family and friends [8]. 60% -70% of patients live in the community where 80% of home care is provided by family caregivers [9].

The term primary caregiver refers to the person who most of the time performs support, care and assistance tasks, assumes responsibility for the patient's care; generally, it has a family relationship (spouse, children, siblings) [2].

Most of the primary caregivers are co-residents of these patients, they present problems and needs resulting from stresses related to daily care. According to the Dementia Research Group 10/66 who evaluated the care conditions in 24 cities in developing countries, Latin American cities reported a greater amount of time dedicated to care, caregivers presented a higher degree of overload and morbidity rates psychiatric compared to India and China [10].

Reactions to caring for an elderly person with a disability can vary considerably, but it is now clear that many informal caregivers are at risk of psychosocial compromise [11]. Results from different studies suggest that caring for a patient with dementia affects the mental health of the caregiver due to burden, stress, depression, and anxiety [12-14].

There are factors that affect the well-being of caregivers, for example, the emotional relationship between the responsible relative and the person with dementia, advanced age, unfavorable working conditions and inadequate social support, which increase the risk of presenting health problems for the caregiver and can meaningfully determine whether family care can be maintained or not [2,15-17].

Most caregivers lack social contact and support, thus experiencing feelings of social isolation, which carries a greater risk of affecting the caregiver's emotional health [13,18].

The problematic behavioral and psychological symptoms of dementia, and the burden these symptoms create on the caregiver, are key factors in precipitating the shift from family care to nursing home or other residential care [17,19]. Caregivers are crucial to avoid hospitalization and keep people with dementia in the community, so family members are the cornerstone of the care and support system in all regions of the world [5].

It appears that general behavioral disorders, as well as the caregiver's belief that the recipient's impairments or behaviors were the result of an attempt to "control things or get their own way" are associated with caregiver resentment and depression. Although feelings of resentment and depression are interrelated in caregivers, there are clear differences [19].

Anger and resentment are emotions that caregivers often feel, sometimes leading caregivers to the point of violence [20]. Acts of abuse, both physical and psychological, are predicted primarily by more time spent caring, experiencing a more abusive behavior on the part of the recipients of care and a greater burden [21]. In previous studies, the presence of resentment in caregivers has been described from 41.2% to 62.37% [11,19,20,22,23].

In a previous study it was shown that "Resentment for having to care" was the only statistically predictor of symptoms of anxiety or depression ( $r^2 = .093$ ,  $p = .044$  for anxiety, and  $r^2 = .121$ ,  $p = .041$  for depression) [24].

#### **Associated factors**

Associated factors such as time spent in care, hours per day devoted to care, degree of perceived dependency, and religion have been described. A previous study showed that caregiver resentment is associated with a poor interpersonal relationship ( $r^2 = .78$ ,  $p < .05$ ) (23); co-residency has been described as an indicator for its increase [25].

In a previous study conducted with caring spouses it was found that 41% had ratings on feeling 'resentful of anger' towards the patient in the categories "Often" or "Sometimes". It was shown that the higher the patient's problem score, the greater the anger-resentment in care ( $r^2 = .06$ ,  $p < .001$ ) [20].

The association between general behavioral disturbance ( $r^2 = .68$ ,  $p < .001$ ) and behaviors classified as controlling or manipulative

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( $r_2 = .75, p < .001$ ) confirmed that caregivers can attribute will and purpose to behavioral symptoms dementia, which leads to more frequent resentment [19].

It may be that caregivers make different attributions about behaviors that they recognize as symptomatic of dementia versus behaviors that they view as intentionally manipulative, with the latter resulting in resentment. However, resentment is likely to result not only from attributions that caregivers make about the behavioral symptoms of attention recipients, but also from attributions made about effort, function, and cognitive constructs [19].

Relationship factors prior to illness, patient function, pattern of cognitive decline, caregiver personality, and behavior disorder are likely to play a key role in the attributions that caregivers make to caregiver and caregiver [26].

### Impact of resentment

If providing care is an unchosen activity, anger and resentment can impact the caregiver's overall situation. (24) Caring changes daily responsibilities, social opportunities, and almost every aspect of life, both today and in the future in the caregiver [19].

Caring represents many sacrifices and can lead to feelings of resentment [27]. Results from previous studies indicate that caregivers who resent having to care are susceptible to symptoms of anxiety and depression [23,24].

A relationship has been found between the risk of abuse towards the elderly and certain variables present in the caregiver, such as the burden associated with caring, depression, the internal expression of anger and stress associated with aggressive and provocative behaviors exhibited by the caring person, as well as resentment of care, illness, or caregiver responsibilities [24,28].

Caregivers show more resentment when they attribute caregiving difficulties to something inherent to the care recipient rather than something attributable to the illness [11,23,25].

Previous studies show that as caregiver resentment increases, the quality of informal care decreases [9,22,23,26,29]. Resentment of care has been considered predictors of neglect or mistreatment of the person receiving care [24].

In Mexico, there are no statistics about resentment in caregivers, or the implications that it leads to care and caregivers. It is known that there are not enough formal and informal support networks for the care of chronic diseases, even less if they are degenerative. Neither are their spaces for the detection and attention of violence for these cases [30]. Health providers need to be more sensitive to the activity of caring, particularly how it motivates them [24].

The elderly population is increasing and the difficulties inherent to care imply identifying who cares for them, where they are cared for and under what conditions. Taking care of a dependent family member generates overload on the caregiver, which affects their

physical and psychosocial health. This study aims to identify the presence of resentment in the caregiver and the predisposing factors in order to plan strategies to prevent and treat it in the future and avoid consequences for the person cared for.

### General objective

Demonstrate the presence of resentment in caregivers of patients with dementia.

### Specific objectives

- Measure the prevalence of resentment in caregivers.
- Describe the sociodemographic factors associated with the presence of resentment.

### Material and methods

**Design:** Descriptive observational study using a questionnaire for caregivers of patients with dementia.

**Universe:** Caregivers of patients with dementia who attend to Family Medicine clinic of at University Hospital who agreed to participate, over 18 years of age. The sampling was non-probabilistic.

**Instrument:** A questionnaire with the following sections was applied: Sociodemographic aspects (Caregiver data and patient data). Resentment scale in the caregiver. Verbal voluntary consent. Resentment: Caregiver Resentment Scale This scale is made up of items from the Zarit burden scale (Zarit et al., 1980) and a resentment scale by Thompson et al. (1995) [25]. It has been widely used in previous studies and has a Cronbach alpha .92. It is a Likert type with a minimum score of 1 and a maximum of 5 in each of the 17 questions [11,17,19,23,24,31].

### Analysis of data

They were captured, processed and analyzed using SPSS version 20 for Windows.

Descriptive statistics were performed with percentages and frequencies for categorical variables.

Square CHI was used for category variables and for the evaluation of the resentment scale, a cut-off point will be established according to the median or it will be evaluated as a continuous variable (the more score, the more resentment).

Pearson's correlation for time of care and the score of the resentment scale.

With a statistical significance value of  $p < .05$ .

### Ethical aspects

The protocol was submitted and approved by the ethics and research committees of the University Hospital with registration code: MF 19-00008. Verbal informed consent was obtained because it did not imply any risk for the caregiver.

### Results

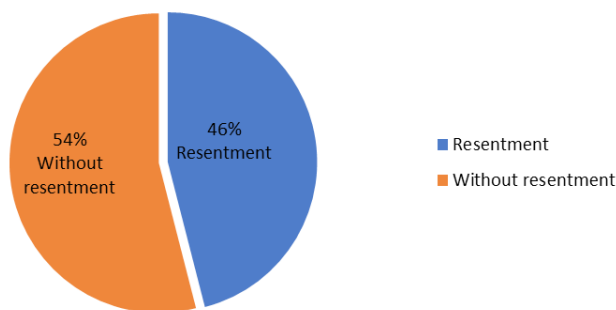
The sociodemographic factors of the caregivers are mostly female, married, university educated, dedicated to the home, of medium socioeconomic status, with a Catholic religion who do practice their religion (Table 1).

**Table 1:** Sociodemographic characteristics of the caregiver.

Variable	f	%
<b>Gender:</b>		
Male	54	36.1
Female	93	63.3
<b>Civil status:</b>		
Single	27	18.4
Married	81	55.1
Divorced	9	6.1
Widower	20	13.6
Separated	10	6.8
<b>Level of education:</b>		
Elementary School	23	15.6
High School	19	12.9
Junior College	19	12.9
Merchant	16	10.9
Technical	12	8.2
College	50	34.0
Posgraduate	8	5.4
<b>Occupation:</b>		
Hogar	53	36.1
Student	2	1.4
Employee	56	38.1
Worker	2	1.4
Merchant	17	11.6
Unemployed	4	6.1
Retired	8	5.4

There was statistical significance related to a greater presence of resentment with: student and merchant occupation, not living in the Monterrey metropolitan area, helping them to dress, transferring the patient, accompanying them to the toilet, the fact that the degree of dementia was not communicated by a health professional, not knowing the degree of dementia or having severe dementia and taking care in the morning (Tables 4-9).

Resentment was found in about half of the caregivers (Graph 1).



**Graph 1:** Presence of resentment.

**Table 2:** Resentment and religion.

Resentment	Practitioner		Total	P value
	Yes	No		
Without resentment	66	14	80	.001
Resentment	32	35	67	
Total	98	49	147	

**Table 3:** Resentment and support group.

Resentment	Support group		Total	P value
	Yes	No		
Without resentment	48	32	80	.01
Resentment	27	40	67	
Total	75	72	147	

**Table 4:** Resentment and take the person to the toilet.

Resentment	Toilet		Total	P value
	Yes	No		
Without resentment	41	39	80	.001
Resentment	55	12	67	
Total	96	51	147	

**Table 5:** Resentment and help the person get dressed.

Resentment	Dressing		Total	P value
	Yes	No		
Without resentment	39	41	80	.001
Resentment	55	12	67	
Total	94	53	147	

**Table 6:** Resentment and moving.

Resentment	Moving		Total	P value
	Yes	No		
Without resentment	76	4	80	.003
Resentment	53	14	67	
Total	129	18	147	

**Table 7:** Resentment and level of education.

Resentment	Level of education		Total	P value
	Yes	No		
Without resentment	67	13	80	.01
Resentment	44	23	67	
Total	111	36	147	

**Table 8:** Resentment and degree of dementia.

Resentment	Grado de demencia					Total	P value
	Cognitive impairment	Mild	Modera-te	Severe	Un-known		
Without resentment	5	0	32	9	14	80	.002
Resentment	4	4	10	11	28	67	
Total	9	4	42	20	42	147	

**Table 9:** Resentment and care schedule.

Resentment	Care schedule				Total	P value
	Morning	Evening	Night	All the time		
Without resentment	2	23	4	51	80	.003
Resentment	9	7	4	47	67	
Total	11	30	8	98	147	

Those who help reduce the presence of resentment are: practice your religion, go to a support group (Tables 2 and 3).

The characteristics of the care that we find are that most of the care is provided to the caregiver's mother, it is cared for mainly 24 hours a day, there is help for care mainly from the caregiver's siblings, they do not receive financial remuneration. The activities

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carried out during the care are feeding, bathing, accompanying the bathroom, transferring, mobilizing, helping to dress and changing the patient's diaper. 51% of caregivers go to a support group.

The self-perception of the caregiver regarding her state of health is mainly good, a fifth of the patients report presenting depression.

The sociodemographic characteristics of the patient are a mean age of 79.1 years, female, living with children, with a moderate degree of dementia, not bedridden and without the use of help for ambulation.

## Discussion

Dementia is a disorder that presents cognitive, functional and behavioral impairment that conditions the need for care. Caring for a patient with dementia can have negative consequences on the caregiver, especially in the emotional area.

The reactions to caring for a patient with dementia can be very varied, resentment is one of the emotions related to care and which in turn has been related to a decrease in the quality of care [20,24], which can even reach to violence against the patient [22].

Furthermore, "resentment about having to care" has been linked as a precursor to depression [19] and anxiety [24]. A fifth of the caregivers interviewed suffered from depression, so its detection and treatment is important to avoid further resentment and its consequences.

In relation to resentment in the international literature, mainly in the USA, a prevalence between 41% and 62.3% [11,19,22,26] was found compared to ours, which we found 45.6%. This indicates that resentment is a very frequent feeling in the caregiver, classified as a negative feeling.

The care activities vary from 59.5% to 86.5%, which implies an overload for the caregiver [32] and presents statistical significance mainly in helping them to dress, transfer the patient, accompany them to the toilet.

Compared with the literature in which they describe caregivers with greater resentment [24] and more stressed [32], we found no gender predisposition of the caregiver in the presentation of resentment (Table 6.1).

As family doctors we know that one of the fundamental pillars of family medicine is prevention and since there are no formal interventions in Mexico [30] to prevent or treat the repercussions on the emotional health of the caregiver, it is suggested to study the effect of groups support [25] as prevention or treatment of the presence of resentment. In our analysis, caregivers who attended a support group presented less resentment compared to those who did not attend.

In co-residence, a factor for resentment, we find that 57.8% live with children, 15.6% with a spouse and children, which shows that

the children take care of one of their parents, perhaps as a form of compensation for the care received in childhood.

Some limitations were found in the present study, the studied population was mainly women with a bachelor's education of average socioeconomic status of occupation of housewife, which may not be a representative sample.

## Conclusion

The presence of resentment was found in about half of the primary caregivers of patients with dementia. There are factors that are related in favor of the presence of resentment, such as occupation and activities related to care, and some factors that work against such as attending support groups and being a religious practitioner.

The presence of resentment is a reality, so it is necessary to pay special attention to caregivers to prevent its appearance or treat it and avoid complications.

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