Promoção da Saúde
DOI: 10.17765/2176-9206.2025v18e12877

Psychoeducation in promoting quality of life for family caregivers of elderly people with dementia

Psicoeducação na promoção de qualidade de vida para cuidadores familiares de pessoa idosa com demência

Evelyn Togni Alves[1*], Camila Mugnai Vieira[2], Ieda Francischetti[3]

[1]Nurse, Master in Health Education in Marília Medical School (SP) Brazil; [2]Psychologist, Postdoctor, Professor at Marília Medical School Post Graduation, Marília (SP) Brazil; [3]Medical Doctor, Postdoctor, Professor at Marília Medical School, Marília (SP) Brazil.

***Corresponding author**: Evelyn Togni Alves – *Email*: evelyntogni@hotmail.com

ABSTRACT
Objective: To analyze the influences of psychoeducation on quality of life of family caregivers of elderly with dementia. **Method:** A quasi-experimental "before-after" study with psychoeducational intervention and quantitative approach was conducted with 56 family caregivers of elderly people with dementia, divided into control (CG) and experimental (EG) groups. The study was approved by the Research Ethics Committee (no. 898.475). The intervention included 12 weekly meetings of 70 minutes over three months. A sociodemographic-cultural questionnaire was administered before the study. To assess outcomes, the Whoqol-bref, Zarit Burden Interview, and Evaluation of the Knowledge of the Caregiver of Elderly People with Dementia were applied before and after the intervention, evaluating: quality of life, physical and emotional burden, and caregiver knowledge. **Results:** Significant improvements in quality of life and knowledge and reductions in burden were observed in the EG. **Conclusion:** Psychoeducation supports caregivers, enhancing self-care and improving care for the elderly.

Keywords: Quality of life. Health Education. Caregivers. Dementia. Aged.

RESUMO
Objetivo: Analisar influências da psicoeducação sobre a qualidade de vida de cuidadores familiares de pessoa idosa com demência. **Método:** Estudo quase-experimental do tipo "antes-depois" com intervenção psicoeducativa e abordagem quantitativa. Participaram 56 cuidadores, divididos em grupo controle e experimental (GE). A intervenção, aprovada pelo Comitê de Ética (nº 898.475), consistiu em 12 encontros semanais de 70 minutos durante três meses. Aplicou-se um questionário sociodemográfico-cultural e os instrumentos Whoqol-bref, Zarit Burden Interview e Avaliação do Conhecimento do Cuidador de Pessoa Idosa com Demência. Avaliaram-se qualidade de vida, sobrecarga física e emocional, e conhecimentos sobre o manejo do idoso. Análises inter e intragrupos compararam os resultados pré e pós-intervenção. **Resultados:** Houve aumento significativo na qualidade de vida e conhecimento dos cuidadores do GE, além de redução na sobrecarga. **Conclusão:** A psicoeducação foi eficaz, influenciando positivamente a qualidade de vida dos cuidadores e promovendo autocuidado e melhor manejo do idoso com demência.

Palavras-chave: Qualidade de vida. Educação em Saúde. Cuidador. Demência. Idoso.

INTRODUCTION

Aging can be defined as a dynamic and progressive process, marked by morphological, functional, biochemical and psychological changes that determine the loss of an individual's ability to adapt to the environment in which they live, with greater vulnerability and incidence of pathological processes that eventually lead to death. The general consequences of aging involve changes in body composition, changes in the balance between energy availability and demand, changes in the signaling networks that maintain homeostasis, and neurodegeneration.[1]

Increased longevity generates transformations that are characterized by an epidemic of chronic and degenerative diseases among the elderly population, with a high presence of various types of dementia.[2] For 20 years, the advance of dementia rates in the elderly population has been a challenge to public health in Europe. The progressive health needs of old people with dementia, added to the emotional impact on their family members (informal caregivers), who must deal with the deterioration of their loved one's overall health, have led them to become ill, weakening their self-care and their health due to psychological and physical overload, financial and social consequences.[3]

A review study conducted between 2008 and 2018 found that approximately 11% of the elderly population in Latin America had some type of dementia.[4] In Brazil, there was a variation in the prevalence rates of dementia from 4.9% to 50%, and in most articles, this rate in urban areas was higher than 10%.[5]

The lack of preparation among informal caregivers is a harsh reality that is difficult to resolve in the short term. Thus, when an individual is affected by dementia, family members are, in 80% of cases, the main caregivers responsible for their full-time care.[6] Studies show significant changes in the health of the elderly caregiver, such as: frailty, loneliness, depression symptoms, fatigue, and stress.[7,8] In surveys carried out, caregivers reported a decrease in their quality of life as the patient required more care, and the caregivers themselves lacked social support. In this sense, the family caregiver needs to be the target of guidance on how to proceed in different situations, receiving pertinent information from a multidisciplinary team, in addition to other forms of supervision and training.[7,8]

From this perspective, there is a notable need to carry out interventions that offer support so that caregivers can improve their management of care for the elderly and for themselves,[9] and psychoeducation, for example, is one of these practices. It consists of an educational intervention that complements pharmacological or psychotherapeutic treatment, being thus recognized as a support strategy to qualify care and improve the quality of life of family caregivers.[10]

This approach is developed in a structured, directive way, focusing on the present, in the search for problem-solving. Following experimental and scientific methods, it is based on the cognitive management of emotions and behaviors. Through it, the person learns about how the processes that characterize the disease of the elderly patient receiving care, being able to identify distorted/dysfunctional behaviors and thoughts that generate distress and suffering.[11,12]

Psychoeducation also allows the learning of multiple functions that are inherent in collective life, such as decision-making, accountability, acceptance of roles, negotiations in the event of disagreements, and establishment of communication channels, among others.[13]

In the search for strategies to better prepare family caregivers for the challenge of caring for elderly people with dementia, with a view to promoting caregiver health, preventing burnout, and ensuring quality care, this study aimed to assess the influences of psychoeducation on the quality of life of family caregivers of elderly people with dementia.

METHODOLOGY

This was a quantitative, cross-sectional, quasi-experimental "before-after"[14] study that encompassed the application of a health education intervention characterized by 12 psychoeducation activities to family caregivers of elderly individuals with dementia. The study included 56 participants who were divided into two groups: control group (CG, $n=14$), whose participants did not receive the intervention during the study period; and experimental group

(EG), whose participants received the intervention. The EG participants (*n*=42) were subdivided into three subgroups of 14 participants each. This was done to respond to the active method of the intervention that requires small groups. The study was approved by the Research Ethics Committee under Consolidated Opinion 898,475, according to Resolution 510/2016 of the Brazilian National Health Council, and the participants signed the Free and Informed Consent Form (FICF),[15]as can be seen in Figure 1.

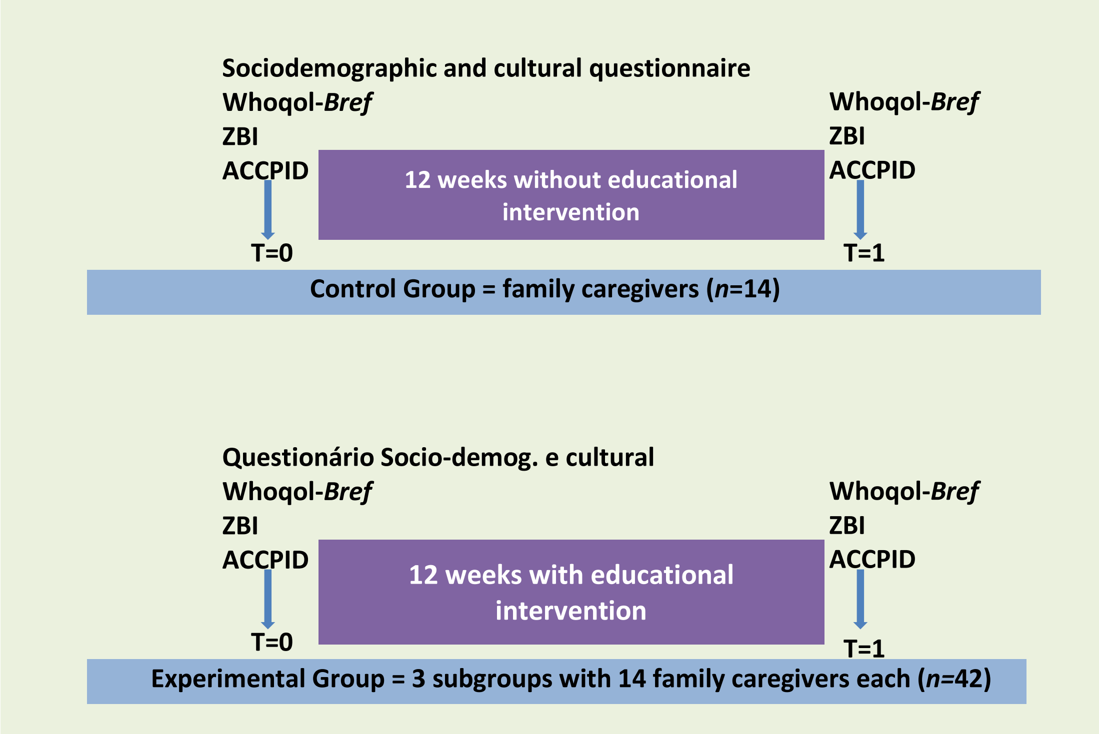

Figure 1. Explanatory drawing on the method
Source: Authors' own work.

To meet the ethical demands, the CG, after the completion of the project, also received the same psychoeducational intervention as the EG.

Psychoeducation is a constructivist educational approach, governed by meaningful learning, in which the learning process is triggered by an everyday problem and individuals use their prior knowledge to identify the nature of the problems and to formulate questions that allow them to seek new meanings and significance to understand the phenomena encountered.[16]

The psychoeducational intervention occurred through 12 weekly meetings lasting an average of 70 minutes each, over a period of three months. One week prior to the start of the intervention, each participant answered a sociodemographic-cultural questionnaire, developed by the authors, to characterize the participant.

The project was implemented in a public health institution that serves the needs of 1,200,000 inhabitants from 62 municipalities.

The research participants were family caregivers of elderly patients with dementia receiving care in the mental health outpatient clinics of the aforementioned institution for at least one year.

The caregivers included in the study provided care to their family members (patients who were over 60 years old and diagnosed with dementia). Caregivers of patients who, in addition to dementia, had any other associated neuropsychopathology were excluded from the study. Initially, 240 caregivers were selected. Of these, 125 were contacted by telephone, of which 63 caregivers agreed, were available, and met the inclusion criteria to participate in the study. The caregiver was required to be at least 18 years of age and be the main family caregiver of an elderly person with dementia. In the event that the elderly person had more than one caregiver, the caregiver who dedicated the most hours per day in providing care should be selected. The caregiver must have been caring for the elderly person for more than six months, not receiving financial compensation, and not have participated in any similar project, thereby ensuring that they were not formally familiar with the content applied in the intervention and were willing to participate voluntarily in the study. Participants who missed more than 3 meetings or whose elderly family member had been institutionalized, hospitalized due to any pathology, or had died during this period were excluded from the study. Thus, the final number of individuals in the study was 56.

Four questionnaires were administered to all participants before the study, and three questionnaires were administered to all participants after the study. The sociodemographic and cultural questionnaire was administered only before the study began. It was structured, with 14 multiple-choice questions, with the aim of obtaining data (gender, age group, education, marital status, paternity, support network, religion, housing conditions, religion, kinship with the elderly person, existence of collaboration in care, number of hours per day dedicated to care, time spent as a caregiver, and concomitant exercise of formal work) to describe the profile of the caregivers.

The other three questionnaires were administered before and after the educational intervention period: the WHOQOL-BREF (World Health Organization Quality of Life – Brief Version) questionnaire[17] on quality of life, the Zarit Burden Interview (ZBI), on physical and emotional overload[18], and the "Assessment of Knowledge of Caregivers of Elderly People with Dementia" (*"Avaliação do Conhecimento do Cuidador de Pessoa Idosa com Demência" - ACCPID*) questionnaire.

The WHOQOL-BREF is a structured, simplified and easy-to-use questionnaire, organized into 26 questions, with questions 1 and 2 on general quality of life, which are calculated to generate a score independent of the scores of the other domains, called the Overall Quality of Life Index (OQoLI). The instrument has 24 facets distributed across four domains: physical, psychological, social relationships, and environment. The responses to the items present levels of agreement in five increasing (1-5) and decreasing (5-1) levels, the sum of which for the four domains was converted to a maximum score of 100 points (highest perceived quality of life). The rules for applying this instrument require that the interviewee respond individually, based on the last two weeks of their life, judging their quality of life.[17]

The Zarit Burden Scale was translated and validated in Brazil by Scazufca.[19] It is self-administered and has 22 items that assess the perceived impact of the act of caring on one's physical and emotional health, social activities, and financial condition. Responses should be given according to a scale of zero to four (never=0; rarely=1; sometimes=2; often=3; or always=4), where 88 is the greatest burden.

DEVELOPMENT OF THE ASSESSMENT OF KNOWLEDGE OF CAREGIVERS FOR ELDERLY PEOPLE WITH DEMENTIA (ACCPID)

The ACCPID was developed by the author E.T.A. as a structured instrument, consisting of five problem situations, four of which cover the respective domains of the WHOQOL-BREF (Psychological, Physical, Environment, and Social Relations). The last problem situation refers to the meaning that the caregiver assigns to a good "quality of life," as in the WHOQOL-BREF and is configured in the fifth domain.

The development of these problem situations was based on a matrix with the combination of themes related to the needs of the elderly with dementia and the caregiver's burden, considering the references of psychoeducation. Eighteen topics were organized in the five domains. Thus, each problem situation contemplated facets related to the needs of the elderly and the caregiver's burden. For each problem situation, five response options were offered, where one was objectively the most appropriate and validated with one point, while the others were given zero points.

Before its finalization, the ACCPID was submitted to a panel of judges using the Delphi Technique, with three rounds, achieving an agreement rate of over 70% in the responses.[20] Five medical professionals, professors and Masters in the areas of geriatrics or psychiatry participated as panelists. Subsequently, the material was used in a pilot study.

DEFINITION OF THE GROUPS

The four groups were determined based on the Quality of Life (QoL) variable, as this was the main goal of the study. Each group was divided based on the median of 49.3 for QoL obtained from the WHOQOL-BREF results applied to all participants in the pre-test. Thus, seven subjects with results lower than this median and seven with results higher than this median comprised each group, including both the control and the experimental groups in their three subgroups.

To form the EG, the equivalence between the three groups that would undergo the intervention was verified in terms of the Quality of Life variable. The Kruskal-Wallis test[21] was used to calculate the difference between the results of the three subgroups in the WHOQOL instrument at the time of the pre-test. The result considered that, statistically, there was no significant difference ($p=0.54$), thereby demonstrating that they were equivalent before the intervention, being considered a single group.

Subsequently, still in the pre-test phase, the WHOQOL results of the experimental group were compared to those of the control group, using the Mann-Whitney test[21], proving that the two groups did not differ from a statistical standpoint regarding the Quality of Life variable at the time of the pre-test ($p=0.7867$).

After the groups were divided according to the QoL variable, the study and the proposed intervention continued, and after 12 weeks, the data were also collected and processed.

PSYCHOEDUCATIONAL INTERVENTION

Each of the three subgroups of the EG received the psychoeducational intervention, through 12 weekly meetings (with an average duration of 70 minutes each). Each activity addressed the development of knowledge on a central theme: dementia, coping with stress, communication, division of tasks, care for the elderly, therapeutic activities of cognitive stimulation, support networks and legislation, and care for the caregiver and the elderly.

The educational method used consisted of problematization through triggers such as dynamics, videos, texts, and workshops, followed by a dialogue-based presentation. The problematization sought to raise, through people's experiences, the construction of knowledge supported by meaningful learning, with the articulation of skills and abilities. The facilitator's mediation was proactive and led the group, at the end of each meeting, to compose a group summary on the knowledge developed.[13,16]

DATA ANALYSIS

After collection, the data were transcribed to a Microsoft Excel® worksheet, organized in tables and charts according to the type of instrument applied.

The instrument developed to outline the profile of caregivers was organized individually, being treated statistically through absolute and relative percentages.

The WHOQOL-BREF instrument has responses on an intensity scale that varied from "not at all" to "extremely;" the capacity scale, from "not at all" to "completely;" the assessment scale, from "very dissatisfied" to "very satisfied" and "very bad" to "very good;" and the frequency scale varied from "never" to "always." These items had a score from one to five, while questions number 3, 4 and 26 had their scores inverted in the function of 1=5; 2=4; 3=3; 4=2; and 5=1.22. To obtain the total score, each domain was calculated using a syntax, considering the score of said domain, and finally recoded on a measurement scale ranging from zero to 100, with zero being the lowest perception and 100 being the highest perception of the Quality of Life indicator.[23]

The responses on the ZBI burden scale had a score from zero to four, with a minimum value of zero and a maximum of 88. Finally, end a score was obtained by the sum of the points in each question, where the higher and closer to 88, the greater the level of burden, and the lower and closer to zero, the lower the level of burden.[18]

Considering that the ACCPID had five situations that composed the instrument, each question offered five possible answers, with only one correct answer for each item. The ideal answer, chosen based on the consensus of the judges, received a score equivalent to one, while the other answers, considered incorrect, received a score of zero. The score was also summed, with the minimum score being zero and the maximum being five.

The results of all instruments between the pre-test and post-test of the Experimental Group (EG) and the Control Group (CG) were compared (EGxEG and CGxCG) using the Wilcoxon test to determine whether there were statistically significant differences after the intervention in relation to the previous moment.

Additionally, at the post-test moment, the control group was also compared with the experimental group (CGxEG) in order to analyze whether the results were statistically different after the intervention. For this purpose, the Mann-Whitney test was used. These data were analyzed and processed, according to the aforementioned tests, using the GraphPad Instat software program.[24]

RESULTS

The sociodemographic and cultural profile of family caregivers of elderly people with dementia indicated that caregiver are, in their vast majority, female, are the daughter of the elderly person, unemployed, with an average age of 55 years, have completed elementary school, are Catholic, have a partner and children, and are residents of the host city, among other characteristics indicated in Chart 1.

Chart 1. Characteristics of the family caregiver of an elderly person with dementia and their life context

Characteristics of study participants	**Absolute number (n)**	**Relative number**
Caregiver's gender: female	52	85%
Caregiver's relationship status: elderly person's child	34	59%
Caregiver shares care with other family members	32	56%
Caregiver's personal choice: to care for the elderly person	32	56%
Average age of the caregiver	55 years old	
Caregiver's education level	26	46% attended up to elementary school, of which 27% (7) did not complete it.
Caregiver's marital status	32	56% reported having a partner
Children	52	91% have
Caregiver's religious affiliation	51	90% reported (of which, 50% are Catholic)
Lives with the elderly person (caregiver's housing situation)	40	70%
Unemployed (caregiver's employment situation)	27	47%
Caregiver's main family income	22	39% elderly person's retirement
Total family income	2 to 3 minimum monthly wages	
Time caring for the elderly person	29	51% more than five years
Number of hours/day dedicated to care	40	70%; more than 8h/day
Government assistance to the elderly	9	16% receive some assistance from a social program
Elderly income	51	90% have a pension
Family income considered sufficient	13	23% of caregivers
Caregiver's leisure time	34	59% of caregivers deny leisure activities
Caregiver's place of residence	47	82% city where the study was conducted

Source: Survey data.

The data collected before the start of the study (T=0), related to the WHOQOL-BREF for the CG, were compared with those of the EG (already unified) to assess the Quality of Life variable. Questions 1 and 2 (Q1 and Q2) of the WHOQOL-BREF have values that are independent of the rest of the scale and are related to the subject's self-perception of their Quality of Life and health. Thus, in item "Overall Quality of Life Index (OQoLI)" of Question 1"How would you rate your quality of life?," we obtained:

When we compared the values of the CG with themselves at T=0 (start of the study) and T=1 (12 weeks from the beginning), the results showed p=0.8. That is, there was no statistically significant difference.

Nevertheless, in the same comparison of the EG, the results indicated a statistically significant difference (p=0.01) for the better after the intervention, confirming that, after the intervention, there was an improvement in the self-assessment of the quality of life of these caregivers.

In T1, CG compared to EG, according to Mann-Whitney, the p-value was 0.03, showing an improvement in this perception among those who received the intervention, as seen in Table 1.

Table 1. Results of Question 1 of the WHOQOL instrument in the Control and Experimental Groups at the following moments: T=0 and T=1, comparing the intergroup with the Mann-Whitney test and the intragroup with the Wilcoxon test

Groups	**Moments**	**P-value (pre and post) (CGxCG) and (EGxEG)**	**P-value (CGxEG)**
CG	T0		0.8
	T1	0.5	
EG	T0		
	T1	0.01*	0.03*

Source: Survey data.

Question 2 "How satisfied are you with your health?," in the pre-test, the p-value was not significant (0.68) in EGxCG, also characterizing them as equivalent. In the post-test, the p-value, according to the Mann-Whitney test, was 0.04, considered statistically significant for those who received psychoeducation. The comparison of the results of T=0 and T=1 of the CG indicated p=0.99, and thus, not characterizing a statistically significant difference. In turn, in the EG, at the same moments, the results (p=0.05) indicated a statistically significant difference for the better, confirming the improvement in the self-perception of the health of the caregivers who underwent the intervention, as seen in Table 2.

Table 2. Results of Question 2 of the WHOQOL-BREF instrument in the Control and Experimental Groups at moments T=0 and T=1 in the intergroup comparisonwith the Mann-Whitney test and intragroup comparison with the Wilcoxon test

Groups	**Moments**	**P-value (pre and post) (CGxCG) and (EGxEG)**	**P-value (CGxEG)**
CG	T0		0.68
	T1	0.99	0.04*
EG	T0		
	T1	0.05*	

Source: Survey data.

The results of the overall Quality of Life, regarding the total score of the instrument – i.e., from questions 3 to 26, in the EGxCGcomparison, at T=0 – showed that they were equivalent, as there was no statistically significant difference (p=0.68).

After 12 weeks (T1), the CGxEG comparison was carried out, and the results showed a statistically significant difference (p=0.04) for the better in the group that received the intervention, as seen in Table 3.

Table 3. Comparison between the CG and EG groups of caregivers, using the Mann-Whitney test

Tested Groups	P-values
CG T=0 X EG T=0	0.68
CG T=1 X EG T=1	0.04*

Source: Survey data.

When comparing the CG with itself at T=0 and T=1, the p-value was 0.23, not corresponding to a statistical difference between the two moments, while the EG presented p<0.0001, considered significant from a statistical point of view, as seen in Table 4.

Table 4. Intragroup comparison of caregivers of elderly individuals with dementia at times T=0 and T=1 regarding the Quality of Life variable, according to WHOQOL-BREF, using the Wilcoxon Test

Tested Groups	P-values
CG T=0 X EG T=0	0.23
CG T=1 X EG T=1	<0.0001*

Source: Survey data.

Regarding the results of the ZBI Burden Scale, it was initially verified whether there were statistical differences between them in the pre-test, at T=0, which obtained a p-value of 0.88, thus considering them equivalent at this time. In the post-test, T=1, the p-value was 0.02, i.e., the group that received the intervention showed a decrease in the level of physical and emotional burden.

When comparing the pre- and post-test results of the EG, a significant decrease in burdens was evident (p<0.0001). The CG did not present statistically significant differences (p=0.31), as seen in Table 5.

Table 5. Comparison between the CG and EG groups of caregivers regarding the ZBI,using the Mann-Whitney test (CGxEG) and the Wilcoxon test (CGxCG and EGxEG)

Tested Groups	Moments	P-values
CG X EG	T=0	0.88
CG X EG	T=1	0.02*
CG	T=0 X T=1	0.31
EG	T=0 X T=1	<0.0001*

Source: Survey data.

The educational capacity of the intervention was measured using the ACCPID instrument. In the pre-test, CGxEG did not present statistically significant differences (p=0.67), also indicating equivalence between the groups. After 12 weeks, the EG, which received the intervention, showed a statistically significant difference for the better when compared to the CG at the same time point (p=0.0010), as seen in Table 6.

Table 6. Comparison between the CG and EG groups of caregivers, at T=0 and T=1, regarding the Assessment of Knowledge of Caregivers of Elderly People with Dementia, using the Mann-Whitney test

Tested Groups	Moments	P-values
CG X EG	T=0	0.67
CG X EG	T=1	0.0010*

Source: Survey data.

CONCLUSION

The descriptive characteristics of the profile of family caregivers participating in this study were reported by other authors. Regarding age, the majority were between 40 and 60 years of age, and women were more likely to be caregivers.[25] Regarding the degree of kinship, the data showed equal frequency for daughters and wives, indicating that wives are often the primary caregiver for the elderly, followed by daughters, who are also elderly. Thus, people who are experiencing aging, or who are already elderly, take on the task of caring, even though they may have some change in their functional capacity and even in their health.[25,26]

Financial fragility, the fact that the main income comes from the elderly person's retirement, leads the caregiver to live in the elderly person's home, increasing their commitment to care. The income, acknowledged as "barely sufficient," does not allow for leisure activities, and the long time (years) and high number of hours of care per day do not allow free time for other activities, even with some aid of another family member. Such conditions of social and economic fragility also permeated the findings of Alves et al.[25]

The situation of providing full-time care appears in the literature as one of the main causes of complaints of loneliness and social isolation on the part of caregivers, as well as negatively influencing marital and family relationships due to physical and mental exhaustion and increasing the likelihood of psychiatric morbidity.[26]

The findings on the improvement in quality of life after educational intervention measured by the WHOQOL-BREF, in questions 1 and 2, as well as on the general improvement, corroborate the results of a number of other studies that also developed support, educational, social or welcoming interventions with caregivers of elderly people with dementia, using different strategies, such as weekly or fortnightly sessions, information and support, conversation groups, lectures, and coping strategies.[9,13,27]

The results expressed in Table 4 support the fact that the improvement in the quality of life of the subjects studied in the EG occurred as a result of psychoeducation and not due to some possible event external to it, as the same did not occur with the caregivers in the CG.

According to the results of the ZBI, there was a significant reduction in the burden perceived by caregivers resulting from the care after psychoeducation. The same was described by Arantes et al., in 2019, after an educational intervention conducted at a Psychosocial Care Center.[13]

This result has repercussions on the improvement in the quality of life of these caregivers, as they express benefits in the three spheres studied. This is a construction of learning applied to life and to the improvement of the quality of life of these subjects, following an andragogy-based educational intervention, through an active and reflective method. The construction of meaningful learning that results from the mobilization of internal aspects and the current demands of the learner is capable of providing direct benefits with better management, decision-making, and transformative actions.[28]

The cognitive gains expressed by the ACCPID results reiterate the capacity of the educational intervention to provide caregivers with the apprehension of knowledge applied to their reality. The need and benefits of appropriating this knowledge are also reported in other studies that highlight the importance of family caregivers who have integrated and interdisciplinary information on the patients, the clinical condition, and the care, which should provide them with the tools on how to proceed in the various healthcare situations, while protecting their physical and mental health.[29]The scope of the problem situations used – addressing the elderly, the caregiver's burden, and the physical, psychological, social interactions, environment and quality of life domains, from the perspective of comprehensive care for patients and caregivers – comprises a major contribution in this regard. Thus, expanding the caregiver's knowledge is essential not only to making them feel more secure in their care routine, but also to promoting their own quality of life while improving the quality of care and ensuring better care to the patient.[30]

The psychoeducational intervention proved capable of positively influencing the quality of life of the population studied, and the statistical data regarding the quantification of quality of life were much higher after the intervention when compared to previous results. It also improved caregivers' self-perception regarding their quality of life and health situation.

The study identified the main sociodemographic and cultural characteristics of family caregivers of elderly people with dementia. Additionally, it demonstrated a decrease in physical and emotional overload, as well as an increase in specific knowledge in the participants who received the intervention.

In light of the social transformations imposed by population aging and their impacts on families, it was clear that the findings complemented observations by other authors, at both the national and international level, highlighting the importance of an intervention that is able to support the care of patients with dementia.

Similarly, it can be inferred that the lack of specific knowledge on the part of caregivers regarding the physical and mental changes both in themselves and in the patients also directly interferes with the quality of life of the elderly.

In this case, psychoeducation proved to be quite effective in supporting family caregivers and, subsequently, promoting their health and improving the care of the patients with dementia.

The instruments used proved to be reliable for the population assessed. As for the "ACCPID," it is suggested that further studies be conducted in order to increase its reliability, with a larger population and with different survey designs.

A limitation of similar studies may be the lack of caregiver adherence. It is crucial to strengthen the presence of the elderly patients through a prior and joint analysis of the challenges to this participation, making efforts to make it viable. The frequency and location of the meetings should be consistent with the caregivers' routine and with the possibility of assistance from another family member in the care or when the elderly person is receiving outpatient care. The need for transportation should also be assessed.

The good results, low cost and easy application of the psychoeducational intervention suggest its adoption in the health education of caregivers in Primary Care and Psychosocial Care Centers.

REFERENCES

1. Colloca G, Di Capua B, Bellieni A, Fusco D, Ciciarello F, Tagliaferri L, et al. Biological and functional biomarkers of aging: definition, characteristics, and how they can impact everyday cancer treatment. Curr Oncol Rep. 2020 Aug 22;22(11):115. https://doi.org/10.1007/s11912-020-00977-w

2. Atri A. The Alzheimer's Disease Clinical Spectrum: diagnosis and management. Med Clin North Am. 2019 Mar;103(2):263-93. https://doi.org/10.1016/j.mcna.2018.10.009

3. Gonçalves-Pereira M, Verdelho A, Prina M, Marques MJ, Xavier M. How many people live with dementia in Portugal?: a discussion paper of national estimates. Port J Public Health. 2021;39(1):58-68. https://doi.org/10.1159/000516503

4. Zurique Sánchez C, Cadena Sanabria MO, Zurique Sánchez M, Camacho López PA, Sánchez Sanabria M, Hernández SH, et al. Prevalencia de demencia en adultos mayores de América Latina: revisión sistemática. Rev Esp Geriatr Gerontol. 2019;54(6):346-55. https://doi.org/10.1016/j.regg.2018.12.007

5. Laginestra-Silva A, Tuyama FL, Cerceau VR, Mariano TD, Pinheiro HA, Oliveira ML. Prevalência de demências no Brasil: um

estudo de revisão sistemática. Rev Neuroci. 2021;29:1-14. https://doi.org/10.34024/rnc.2021.v29.11377

6. Or R, Kartal A. Influence of caregiver burden on well-being of family member caregivers of older adults. Psychogeriatrics. 2019 Sep;19(5):482-90. https://doi.org/10.1111/psyg.12421

7. Santos-Orlandi AA, Brigola AG, Ottaviani AC, Luchesi BM, Souza ÉN, Moura FG, et al. Elderly caregivers of the elderly: frailty, loneliness and depressive symptoms. Rev Bras Enferm. 2019 Nov;72(suppl 2):88-96. https://doi.org/10.1590/0034-7167-2018-0137

8. Hazzan AA, Dauenhauer J, Follansbee P, Hazzan JO, Allen K, Omobepade I. Family caregiver quality of life and the care provided to older people living with dementia: qualitative analyses of caregiver interviews. BMC Geriatr. 2022 Jan 31;22(1):86. https://doi.org/10.1186/s12877-022-02787-0

9. Alves GC, Peres FS, Silva CM, Friedrich JC, Zucco JV, Macuch RS, et al. Psicoeducação em contextos de saúde mental: uma revisão sistemática. Arq Ciênc Saúde Unipar 2024;28(1):577-92. https://doi.org/10.25110/arqsaude.v28i1.2024-1090

10. Palma LC. Impacto da psicoeducação na sobrecarga do cuidador informal: uma intervenção grupal [dissertação]. Lisboa: Universidade Autónoma de Lisboa, Departamento de Psicologia; 2024. 88 f.

11. Falcão EN, Gomes SP, Duque NC, Rezende VC, Almeida VA, Pereira, BS. Interfaces entre psicoeducação e saúde. Analecta Cent Univ Acad. 2021;7(2).

12. Galdino MM, Silva MC, Lopes GA, Souza GL, Silva MV, Andrade LA. Intervenções psicoeducativas no contexto da saúde: uma revisão narrativa. CGCHS 2022 [acesso em 2024 jun 5];7(2):21. Disponível em: https://periodicos.grupotiradentes.com/cadernohumanas/article/view/10328

13. Arantes DJ, Picasso R, Silva EA. Grupos psicoeducativos com famílias de um Centro de Atenção Psicossocial. Rev Pesqui Prát Psicossociais. 2019;14(2):1-15.

14. Martins VL, Ponte CM. A redação acadêmica: dicas para uma boa escrita. In: Ponte CM, Gurgel MH, Lopes LS. Manual prático para a produção acadêmica. Fortaleza (CE): Unichristus; 2021. p. 109-16.

15. Brasil. Ministério da Saúde. Resolução nº 510/CNS, de 7 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais cujos procedimentos metodológicos envolvam a utilização de dados diretamente obtidos com os participantes ou de informações identificáveis ou que possam acarretar riscos maiores do que os existentes na vida cotidiana. Diário Oficial da União, Brasília, 24 maio 2016. Seção 1:44.

16. Luchesi BM, Lara EM, Santos MA, organizadoras. Guia prático de introdução às metodologias ativas de aprendizagem. Campo Grande (MS): Editora UFMS; 2022.

17. Iriawan J, Shabrina GN, Taufan A, Zulqarnain MA. Quality of life level description of elderly patients with hypertension using instruments WHOQOL-BREF. Adv Health Sci Res. 24 Jul 2021;37:187-92. https://doi.org/10.2991/ahsr.k.210723.045

18. Zarit SH, Zarit JM. The memory and behaviour problems checklist and the burden interview. Pennsylvania: Pennsylvania State University; 1983.

19. Scazufca M. Versão brasileira da escala Burden Interview para avaliação de sobrecarga em cuidadores de indivíduos com doenças mentais. Rev Bras Psiquiatr. 2002;24(1):12-7. https://doi.org/10.1590/S1516-44462002000100006

20. Zarili TF, Castanheira ER, Nunes LO, Sanine PR, Carrapato JF, Machado DF, et al. Técnica Delphi no processo de validação do Questionário de Avaliação da Atenção Básica (QualiAB) para aplicação nacional. Saúde Soc. 2021;30(2):e190505. https://doi.org/10.1590/S0104-12902021190505

21. Lapa LD. Testes estatísticos: breves reflexões. In: Sá P, Costa AP, Moreira A, coordenadores. Reflexões em torno de Metodologias de Investigação: recolha de dados. Aveiro: Universidade de Aveiro Editora; 2021. p. 73-86.

22. Zanei SS. Análise dos instrumentos de avaliação de qualidade de vida WHOQUOL-bref e SF-36: confiabilidade, validade e concordância entre pacientes de Unidades Terapia Intensiva e seus familiares [tese]. São Paulo (SP): Universidade de São Paulo; 2006. 135 f.

23. The World Health Organization Quality of Life assessment (WHOQOL): position paper from the World Health Organization. Soc Sci Med. 1995 Nov;41(10):1403-9. https://doi.org/10.1016/0277-9536(95)00112-k

24. GraphPad. InStat versão 3.1 para Windows 10. San Diego: GraphPad Software; 2022.

25. Alves BS, Oliveira AS, Santana ES, Chaves RN, Marinho MS, Reis LA. Caracterização dos cuidadores informais de idosos dependentes quanto aos aspectos demográficos e de saúde. Rev Saúde Col UEFS. 2019;9:113-8. https://doi.org/10.13102/rscdauefs.v9i0.3684

26. Diogo MJ, Ceolim MF, Cintra FA. Orientações para idosas que cuidam de idosos no domicílio: relato de experiência. Rev Esc Enferm USP. 2005;39(1):97-102. https://doi.org/10.1590/S0080-62342005000100013

27. Oliveira WS, Silva TB. Centro-dia para idosos e psicoeducação: intervenções no grupo de profissionais cuidadores e na sua relação com as pessoas idosas. Rev Kairós. 2020:23(3):89-109. https://doi.org/10.23925/2176-901X.2020v23i3p89-109

28. Pereira JC, Monte LR, Souto CC, Carvalho AH, Teixeira LS, Renovato RD, et al. Metodologias Ativas e Aprendizagem Significativa: Processo Educativo no Ensino em Saúde. Rev Ensino Educ Ciênc Hum. 2021;22(1):11-9. https://doi.org/10.17921/2447-8733.2021v22n1p11-19

29. Uhm KE, Jung H, Woo MW, Kwon HE, Oh-Park M, Lee BR, et al. Influence of preparedness on caregiver burden, depression, and quality of life in caregivers of people with disabilities. Front Public Health. 2023 Jul 26;11:1153588. https://doi.org/10.3389/fpubh.2023.1153588

30. Nascimento HG, Figueiredo AE. Demência, familiares cuidadores e serviços de saúde: o cuidado de si e do outro. Ciênc Saúde Coletiva. 2019;24(4):1381-92. https://doi.org/10.1590/1413-81232018244.01212019

Received: 17 june. 2024
Accepted: 08 aug. 2024