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VIETNAMESE AMERICAN MENTAL HEALTH COMMUNITY'S PERSPECTIVES ON A CULTURALLY TAILORED PROGRAM FOR VIETNAMESE AMERICAN DEMENTIA CAREGIVERS



Van Ta Park¹, Khue Nguyen¹, Yvonne Tran¹, Gwen Yeo², Quyen Tiet³, Joyce Suen¹, Dolores Gallagher-Thompson², ¹San Jose State University, San Jose, CA, USA; ²Stanford University School of Medicine, Stanford, CA, USA; ³VA Palo Alto Health Care System, Menlo Park, CA, USA. Contact e-mail: vanmta@alummi.usc.edu

Background: Asian Americans (AA) including Vietnamese Americans (VA) tend to underutilize mental health (MH) services despite the demonstrated need. VA are unique from other AA populations in their predisposition for MH concerns because of the extensive trauma they encountered related to the Vietnam war, their challenging experiences as refugees, and other factors (e.g. low socioeconomic position; limited English language proficiency) that compound their MH risk as caregivers. However, little is known about dementia and caregiving among the rapidly growing VA population, or what should be included in an effective VA caregiver training program to address their MH needs. The objective of this qualitative study was to elicit knowledge and insights from VA mental health (MH) professionals about how to culturally tailor a program to address the MH needs of VA dementia caregivers. **Methods:** Semi-structured interviews were conducted with eight VA MH providers. Participants described a) their professional/personal experiences in the area of Vietnamese MH and/or caregiving; b) unique needs and experiences of VA; c) attitudes toward treatment of elders among Vietnamese persons who immigrated in different waves; and, d) role of acculturation in caregiving. Participants also provided recommendations on how to culturally tailor a program for VA dementia caregivers. Content analysis of their responses was conducted. **Results:** Mean age of the sample was 54.3 (9.5 SD); 75% were female; all were born in Vietnam; 87.5% were very and 12.5% somewhat fluent in Vietnamese; 75% had a graduate degree, and all had worked in MH. Qualitative themes included: a) lack of access to MH services/support; b) different waves of immigration and acculturation levels affect views on MH, treatment, and caregiving; c) need to address caregivers' holistic experiences (mental, physical, social); d) traditional values/beliefs play an important role in caregiving; and, e) the program needs to include spirituality and personal story telling. **Conclusions:** For the program to be acceptable and successful (reduced stress and depression), it needs to consider all aspects of caregivers' health, and incorporate spirituality and Vietnamese cultural values/beliefs, which is significant because there are cultural differences in how Vietnamese families react and care for a family member with dementia.

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CAREGIVER OBJECTIFYING ATTITUDES TOWARD DEMENTIA PATIENTS: CONSEQUENCES FOR CAREGIVER STRAIN AND RELATIONSHIP CLOSENESS



Ali Zahir¹, Julio Rojas-Martinez¹, Winston Chiong², ¹University of California San Francisco, San Francisco, CA, USA; ²University of California, San Francisco, San Francisco, CA, USA. Contact e-mail: ali.zahir@ucsf.edu

Background: Caregivers of patients with dementia are at risk for psychological and physical burden. Adopting a more "objective" attitude towards the patient may be protective (e.g., if associated with less blame and resentment), or alternatively may be deleterious (e.g., if associated with diminished relationship closeness).

Methods: Caregivers of 38 patients with Alzheimer's disease, 76 patients with behavioral variant frontotemporal dementia, 37 patients with semantic variant primary progressive aphasia, and 94 patients with assorted other neurodegenerative syndromes completed a novel questionnaire using different items to measure a hypothesized construct of an objectifying attitude towards patients and patient behaviors. (E.g., "Because my relative has a brain disease, he/she can't fully control the way he/she acts," "While my relative may like or enjoy certain things, he/she no longer understands what is important or unimportant.") Factor analysis was performed to group observed variables into a single latent variable. Structural equation modeling was performed to measure relationships among this latent variable, patient disease severity (Clinical Dementia Rating), caregiver strain (Caregiver Strain Index), and relationship closeness (Relationship Closeness Scale, Noelker 1996, Whitlatch et al, 2001). **Results:** Factor analysis demonstrated that 10 variables were found to reflect a latent factor, interpreted as an objectifying attitude towards the patient. Tests of Cronbach's alpha revealed that the latent factor exhibited high reliability (10 items; $\alpha = .906$) with indication of model fit, $\chi^2(31) = 71.96, p = .001$; CFI = .966, RMSEA = .073. An objectifying attitude by the caregiver mediates the association between disease severity and caregiver strain and negatively influences closeness between the patient and caregiver ($\beta = -0.85, p < .001$) (Figure 1). Structural analysis supported model fit, $\chi^2(58) = 125.74, p < .001$; CFI = .955, RMSEA = .069. **Conclusions:** Caregiver attitudes that treat patients in objectifying terms, rather than as agents, do not protect against caregiver strain and instead mediate the relationship between disease severity and caregiver strain, with negative effects on relationship closeness. These findings may support personhood-based approaches to the ethics of dementia care.

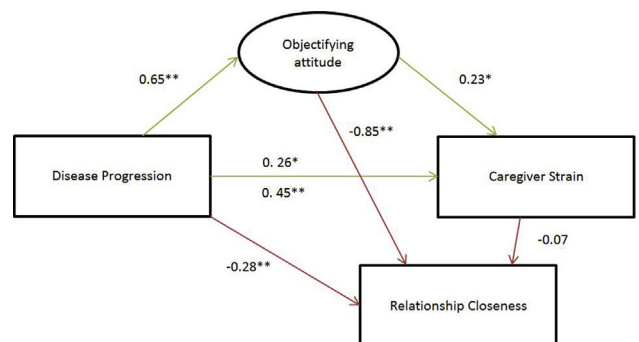


Figure 1. Structural model showing mediation of relationship between disease progression/caregiver strain and negative influence of relationship closeness upon the adoption of an objectifying attitude by a caregiver. Along the path between disease progression and caregiver strain, the value below the arrow shows the total effect, and the value above the arrow shows the direct effect after controlling for the mediator. Asterisks indicate significant paths (* $p < 0.05$, ** $p < 0.001$).

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STAR-C-TELEMEDICINE: ACCESSIBLE CAREGIVER SUPPORT



Allison Lindauer^{1,2}, Deniz Erten-Lyons^{1,3}, Jeffrey Kaye^{1,3,4}, Katherine Mincks^{1,2}, Nora Mattek^{1,3}, Hiroko Dodge^{1,3,4,5}, Linda Teri^{6,7}, ¹Oregon Health & Science University, Portland, OR, USA; ²NIA-Layton Aging and Alzheimer's Disease Center, Portland, OR, USA; ³NIA-Layton Aging & Alzheimer's Disease Center, Portland, OR, USA; ⁴Oregon Center for Aging & Technology (ORCATECH), Portland, OR, USA; ⁵University of Michigan, Ann Arbor, MI, USA; ⁶University of Washington, Seattle, WA, USA;

⁷Northwest Roybal Center, Seattle, WA, USA. Contact e-mail: lindauer@ohsu.edu

Background: Caregiving for persons with Alzheimer’s Disease and Related Dementias (ADRD) can contribute to psychological distress, including depression and burden. Individualized education and support programs can help reduce these negative aspects of caregiving, but stigma, inconvenient meeting times, lack of respite care and transportation challenges interfere with program usage. To address these barriers, professionals are using Internet-based programs (known as “telehealth” or “telemedicine”) to provide support. Many of these options are group-based or automated (without a live interventionist). Of concern, few of the telehealth interventions found in the literature are individually-based interventions tailored to the needs of the caregivers. More options for one-on-one, effective, person-centered telehealth interventions are needed. STAR-C is an example of such an intervention and is well-suited for translation into a direct-to-home telehealth program. The aim of this pilot was to assess the feasibility and acceptability of STAR-C when delivered via direct-to-home telehealth video-conferencing. **Methods:** In this mixed-methods study we administered the 8-week STAR-C intervention via telehealth direct-to-home video-conferencing. This included teaching caregivers about the triggers for bothersome behaviors and how to avoid the triggers. Caregivers were assessed prior to and after the intervention with measures of depression, burden and desire to institutionalize. Qualitative data from the sessions and one focus group provided depth to our findings. **Results:** Of the 16 caregivers enrolled (Tables 1, 2), four withdrew and nine have completed post-intervention testing. None withdrew due to technical difficulties. To date, 100 % of the caregivers who completed STAR-C were satisfied with this telehealth program. There were some easily-resolved technical issues. Quantitative measures show a reduction in burden, depression and desire to institutionalize (significance is unknown due to small sample size) (Table 3). Qualitative findings revealed a positive experience for most caregivers: “It’s been a wonderful tool for me to lean on.” **Conclusions:** These early findings indicate that implementing STAR-C using telehealth technology is an acceptable option for these caregivers, suggesting that this technology can fill a wide gap in caregiver support. More work is needed to successfully translate STAR-C into a telemedicine program; this pilot lays the foundation.

Table 1
STAR-C-TM Demographics (n = 15: 1 withdrawal prior to data collection)

Caregivers	
Age (mean, SD, range)	63, 11.6, 30-74
Sex, (% women)	67%
Race (% white)	93%
Number of years caregiving (mean, SD, range)	3.8, 2.4, 0.5-8
Care-recipients	
Age (mean, SD, range)	70, 5.8, 61-82
Sex, (% women)	47%
Race (% white)	93%
Number of years with dementia (mean, SD, range)	2.9, 2.3, 0.5-8
Montreal Cognitive Assessment (n = 13)	13.6, 8, 0-26
Both	
Distance from OHSU, miles (mean, range)	45, 3-154
Income, (% reported. “I can’t make ends meet)	6%

Table 2
STAR-C-TM Enrollment and Feasibility

Enrolled	16
Withdrawn	4
Completed	9
Intervention active (pending)	3
Set-up time (mean, range)	32, 10-120
Intervention time (mean, range)	46, 23-63

Table 3
STAR-C Telemedicine Pre-Post Measures

Measures	Pre (n=9)	Post (n=9)
Revised Memory and Behavior Problem Checklist (RMBPC) Frequency Total	47.2 [29 - 69]	43.3 [28 - 56]
RMBPC Reaction Total	32.7 [10 - 59]	26.4 [6 - 54]
Screen for Caregiver Burden (SCB) Objective Total	12 [7- 19]	11.1 [8 - 18]
SCB Subjective Total	40.2 [28 - 58]	36.9 [28 - 46]
Desire to Institutionalize Question 6	1.3 [1 - 2]	1.1 [1 - 2]
Center for Epidemiologic Studies Depression Scale Total	17.3 [4 - 38]	15.7 [0 - 36]
Modified Conflicts Tactics Scale Response	11%	0%

P2-510 WITHDRAWN

P2-511 AN EVIDENCE-BASED TECHNOLOGICAL CAREGIVER SKILLBUILDING INTERVENTION FOR DEMENTIA FAMILY CAREGIVERS: PILOT STUDY



Carol J. Farran¹, Peter Zurawski², **Ben Remor Inventor¹**, Janie Urbanic¹, Olimpia Paun¹, ¹Rush University College of Nursing, Chicago, IL, USA; ²Grand Marketing Solutions, Libertyville, IL, USA. Contact e-mail: Ben_Inventor@rush.edu

Background: Family caregiving is a growing public health concern and caregivers of persons with Alzheimer’s disease or other related dementias (ADRD) need appropriate, timely, and ongoing education and support to successfully meet their caregiving responsibilities. Well-designed interventions can significantly reduce risk concerning caregiver mental and physical health, and improve care recipient outcomes. Few interventions are translated into everyday practice; and most rely on in-person, professionally-led delivery methods, making them inaccessible to many family caregivers. **Methods:** The product developed and tested in this pilot study included six evidence-based Caregiver Skill Building Intervention (CSBI) modules, available via a web-based online format for ADRD caregivers. On-demand interactive training modules made up an integrated web-based product that taught family caregiver skills concerning how to care for their impaired family member. Product strengths include: a) an evidence-based intervention, developed from a prior group-based randomized clinical trial (RCT); b) a focus on caregiver management skill, rather than merely teaching facts; c) an interactive approach, enabling caregivers to apply information to realistic scenarios and receive immediate feedback to their responses; d) content which addresses key caregiving topics; and e) a convenient approach, available 24 hours/day/ 7 days/week from any location with internet access. The project enrolled 100 family caregivers and established