Nat. Volatiles & Essent. Oils, 2021; 8(4): 1694-1707

NVEO
Natural Volatiles &
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Efficacy of Psychosocial Interventions for Caregivers – An Umbrella View

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ABSTRACT

Psychosocial intervention can be used in cases of some mental disorders, the cessation of negative behaviors (especially harmful addictions), and in well-being programs. While there are many different therapies with different focuses, educating the person suffering and their family or support system about the condition and treatment approach is key to the success of any psychosocial intervention. Finally, outcomes of psychosocial interventions encompass desired changes in three areas: (1) symptoms, including both physical and mental health symptoms; (2) functioning, or the performance of activities, including but not limited to physical activity, activities of daily living, assigned tasks in school and work, maintaining intimate and peer relationships, raising a family, and involvement in community activities; and (3) well-being, including spirituality, life satisfaction, quality of life, and the promotion of recovery so that individuals "live a self-directed life, and strive to reach their full potential"

KEYWORDS: Psychosocial intervention, negative behaviours, physical and mental health symptoms

INTRODUCTION:

The term "intervention" means "the act or . . . a method of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)" (Merriam-Webster Dictionary) or "acting to intentionally interfere with an affair so to affect its course or issue" (Oxford English Dictionary). These definitions emphasize two constructs—an action and an outcome. Psychosocial interventions capitalize on psychological or social actions to produce change in psychological, social, biological, and/or functional outcomes. CONSORT-SPI emphasizes the construct of mediators, or the ways in which the action leads to an outcome, as a way of distinguishing psychosocial from other interventions, such as medical interventions (Montgomery et al., 2013

Breaking the word down, we see that 'psycho' refers to psychology - the study of human nature or the mind, its functions, and behavior - and 'social' refers to society - groups of people living together with shared laws and organizations. If we put these two ideas together, we can see that psychosocial means how humans interact with and relate to others around them. It focuses on relationships and how humans work in society.

When a person is not interacting with society well, psychosocial intervention may be used to help guide the person back into a healthy state of being. That is the use of non-medicinal means to alter a person's behaviors and relationships with society in order to reduce the impact of the person's disorder or condition. The key to psychosocial intervention is that it does not use pharmaceutical assistance in the endeavor to change a person's behaviors toward a more healthy interaction with society.

Psychosocial intervention can be used in cases of some mental disorders, the cessation of negative behaviors (especially harmful addictions), and in well-being programs. While there are many different therapies with different focuses, educating the person suffering and their family or support system about the condition and treatment approach is key to the success of any psychosocial intervention.

DEFINITION: Psychosocial interventions for mental health and substance use disorders are interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being.

THREE MAIN COMPONENTS IN PSYCHOSOCIAL INTERVENTION

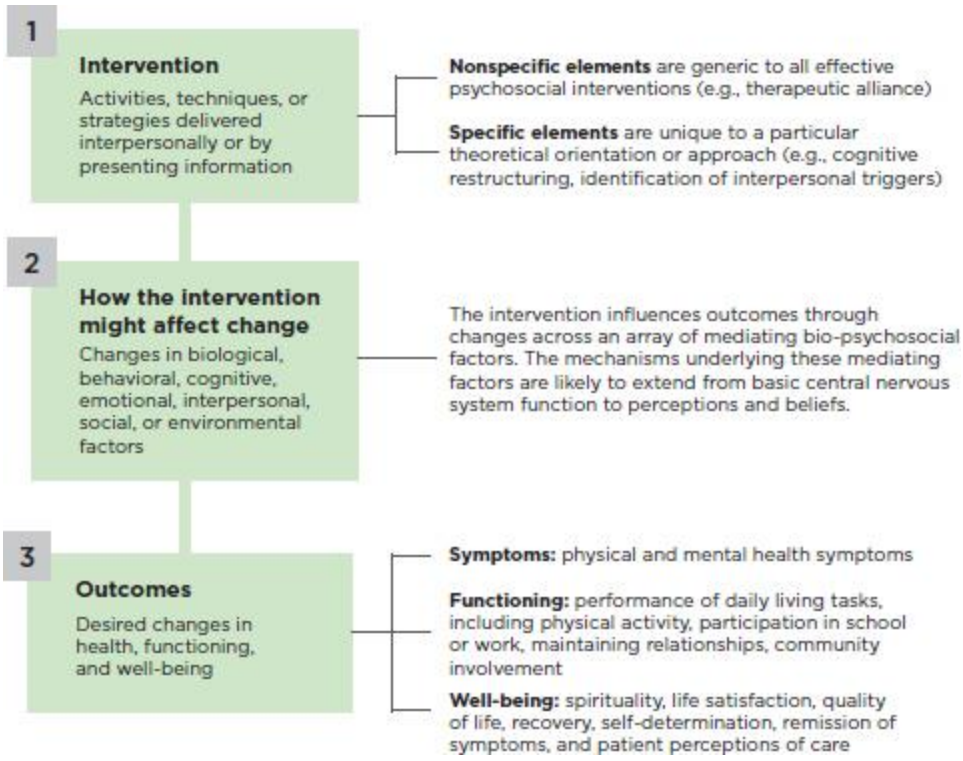


Illustration of the three main concepts in the committee's definition of psychosocial interventions

This definition, illustrated in Figure 1-1, incorporates three main concepts: action, mediators, and outcomes. The action is defined as activities, techniques, or strategies that are delivered interpersonally (i.e., a relationship between a practitioner and a client) or through the presentation of information (e.g., bibliotherapy, Internet-based therapies, biofeedback). The activities, techniques, or strategies are of two types: (1) nonspecific elements that are common to all effective psychosocial interventions, such as the therapeutic alliance, therapist empathy, and the client's hopes and expectations; and (2) specific elements that are tied to a particular theoretical model or psychosocial approach (e.g., communication skills training, exposure tasks for anxiety).

Mediators are the ways in which the action of psychosocial interventions leads to a specific outcome through changes in biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors; these changes explain or mediate the outcome. Notably, these changes are likely to exert their effects through an array of mechanisms in leading to an outcome (Kraemer et al., 2002), and can extend from basic central nervous system function to perceptions and beliefs.

Finally, outcomes of psychosocial interventions encompass desired changes in three areas: (1) symptoms, including both physical and mental health symptoms; (2) functioning, or the performance of activities, including but not limited to physical activity, activities of daily living,

assigned tasks in school and work, maintaining intimate and peer relationships, raising a family, and involvement in community activities; and (3) well-being, including spirituality, life satisfaction, quality of life, and the promotion of recovery so that individuals "live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012a). Psychosocial interventions have broader societal outcomes as well, such as utilization of acute or institutional services and disability costs. However, these outcomes are not the direct focus of the intervention and therefore are not included in the definition here.

Application of Psychosocial Interventions

The committee's definition of psychosocial interventions is applicable across a wide array of settings, formats, providers, and populations.

Settings and Formats

The broad range of settings in which psychosocial interventions are delivered includes outpatient clinics, solo provider offices, primary care clinics, schools, client homes, hospitals and other facilities (including inpatient and partial hospital care), and community settings (e.g., senior services, religious services). Some interventions use a combination of office-based and naturalistic sites, and some are designed for specific environments.

While historically, most psychosocial interventions have been delivered in an interpersonal format with face-to-face contact between provider and client, recent real-time delivery formats include telephone, digital devices, and video conferencing, all of which are called "synchronous" delivery. There are also "asynchronous" delivery formats that include self-guided books (bibliotherapy) and computer/Internet or video delivery, with minimal face-to-face contact between provider and client. Some interventions combine one or more of these options. Formats for psychosocial interventions also include individual, family, group, or milieu, with varying intensity (length of sessions), frequency (how often in a specified time), and duration (length of treatment episode).

Providers

Providers who deliver psychosocial interventions include psychologists, psychiatrists, social workers, counselors/therapists, primary care and other nonpsychiatric physicians, nurses, physical and occupational therapists, religious leaders, lay and peer providers, paraprofessionals and caregivers, and automated providers (e.g., Internet/audio/video-delivered interventions). Combinations of provider options are sometimes used.

Populations

The population targeted by psychosocial interventions is varied. It includes individuals at risk of or experiencing prodromal symptoms of an illness; individuals with acute disorders; individuals in remission, maintenance, or recovery phases of disorders; and individuals who are not ill but are challenged by daily functioning, relationship problems, life events, or psychological adjustment.

EXAMPLES OF PSYCHOSOCIAL INTERVENTIONS

Cognitive behavioural therapy

- Includes cognitive, cognitive behavioural and behavioural therapies. Teaches skills in problem-solving, reframing attitudes, e.g. challenging “black and white” thinking, coping with stress and anxiety. Relaxation therapy, guided imagery or cognitive skills might be used in dealing with stressful situations such as particular treatments, or to reduce nausea

associated with chemotherapy. Techniques to enable gradual adaptation might also be included.

- Improvement in emotional distress, coping, anxiety, depression and a psychiatric morbidity; Decrease in nausea, vomiting and insomnia; increase in control over illness.

Supportive psychotherapy

- Encourages the expression of emotions, validates the experiences of the individual, and offers support through empathetic listening and encouragement, and provision of information. Reflects on the strengths of the individual and encourages use of adaptive coping techniques. Sometimes called supportive, existential or supportive-expressive.
- Improvement in mood, coping and physical and functional adjustment.

Group therapy

- Places emphasis on sharing of experiences among patients with a comparable stage of disease. Participants feel that their experiences are validated, and they can contribute in a meaningful way to the well-being of other members of the group. Can use cognitive behavioural or supportive psychotherapy, and include educational and information components.
- Improvement in mood, coping and adjustment, anxiety and depression; positive immune function changes.

Family therapy

- Enhances communication, cohesion and conflict resolution within the family system, including the needs of children. Can use cognitive behavioural or supportive psychotherapy.

Couples therapy

- Targets problems and issues within the couple relationship. Can use cognitive behavioural or supportive psychotherapy.
- Reduces levels of depression and psychological distress. Beneficial in increasing sexual satisfaction.

Telephone counselling

- Provides geographically-isolated patients with an opportunity for cognitive behavioural or supportive psychotherapy interventions. Also useful for providing casework support, e.g. reassurance, information provision and referral.

Other therapies

- Other therapies may include art therapies, e.g. music, painting, reading and poetry, wellness programs, medication, hypnosis, acupuncture, relaxation, exercise, prayer, laughter etc.
- Improvement in mood, coping, anxiety, depression, breathing; Reduction in nausea and pain.

EFFICACY OF PSYCHOSOCIAL INTERVENTIONS FOR CAREGIVERS

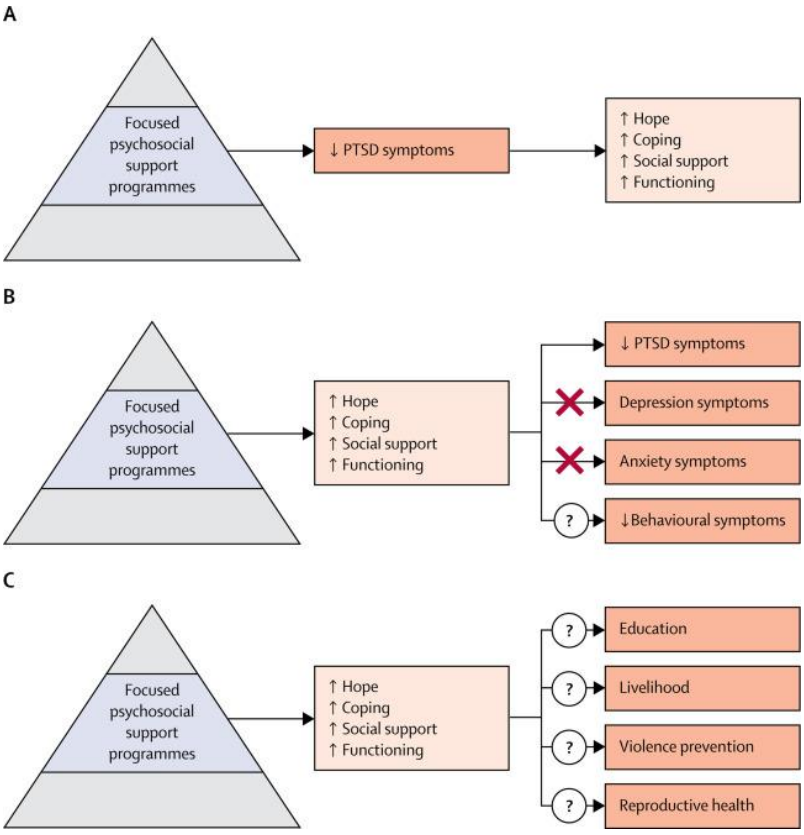
Psychosocial Interventions Are Found to provide benefits in coping skills and social and vocational functioning, as reflected in a greater ability to function independently and an improvement in quality of life

The multifactorial nature of schizophrenia and the wide-ranging impact of the illness on the patient, their family, carers and healthcare providers mean that clinicians must be prepared to take a holistic approach to treatment. It is widely recognized that a patient's beliefs about their treatment and their experiences of schizophrenia can be very important in determining both attitude towards treatment compliance and behaviour in response to symptoms of the illness and environmental stress. Antipsychotic therapy remains the cornerstone of treatment for schizophrenia. However, there is now growing evidence to support the benefits of non-pharmacological interventions, when used in combination with antipsychotic treatment, in relieving symptoms, improving occupational and social functioning and reducing the risk of relapse. In particular, these interventions appear to provide benefits in coping skills and social and vocational functioning, as reflected in a greater ability to function independently and an improvement in quality of life. Systematic assessment of non-pharmacological therapies in schizophrenia is still a relatively new science, but there is good evidence that psychosocial therapies, such as family intervention therapy, cognitive-behaviour therapy and compliance therapy can markedly change a patient's behaviour and improve adherence to treatment and hence interaction with families, carers and healthcare providers. Psychosocial interventions can be implemented from the first episode of psychosis onwards and can contribute to an improved overall outcome in schizophrenia, to patients being more satisfied with their treatment, and to a better quality of life for the patient and their family. Initial comprehensive assessment will involve regular contact with the patient and opens channels for an ongoing dialogue. It is important that these discussions with the patients and their families and carers not only cover the need for social, emotional and behavioural support but include regular discussion of the acceptability and side-effects of antipsychotic treatment so that problems can be identified and addressed promptly. While the importance of non-pharmacological interventions in improving the quality of patient care is becoming widely accepted, access to psychological, psycho-educational and family support is by no means universal in current clinical practice. It is

important that these services, provided by appropriately trained personnel, are made available to all patients for whom they may be appropriate.

Psychosocial interventions to support the mental health of informal caregivers

Figure Conceptual pathways to frame the role of focused psychosocial support programmes



First, are focused psychosocial support interventions a repackaging of clinical interventions, with the inclusion of psychosocial secondary outcomes—ie, psychiatric symptom improvement mediates improved psychosocial outcomes (figure A)? Framed in this way, focused psychosocial support operates via pathways similar to clinical services, with a range of indirect psychosocial benefits. Purgato and colleagues1 observed that many of the focused psychosocial support interventions evaluated were based on clinical cognitive psychotherapy treatments. However, as clinical interventions, focused psychosocial support has limitations. Depression and anxiety outcomes were not significant compared with waiting list controls, and effects for PTSD were predominantly among older adolescents (15–18 years old; standardised mean difference −0·43, 95% CI −0·63 to −0·23), presumably because of this reliance on cognitive mechanisms. Moreover, the conditions under which focused psychosocial support interventions work favourably—among youth who are not displaced and living with small household sizes—do not represent severe humanitarian emergencies, which are characterised by displacement and large numbers of family members in crowded living conditions.

Psychosocial Interventions Are Found to Reduce Inflammation and Boost Beneficial Immune System Function

A new analysis of 56 randomized clinical trials has concluded that psychosocial interventions can significantly reduce inflammation and enhance beneficial immune system function. It is a finding of considerable significance in light of recent estimates indicating that up to 50% of all deaths worldwide are currently attributable to illnesses that involve inflammation.

Inflammation-related illnesses include physical ailments such as cardiovascular disease, stroke, and certain cancers as well as psychiatric disorders including anxiety, depression, and schizophrenia.

Numerous studies have revealed associations between the functioning of the immune system and a variety of psychosocial factors such as life stress, negative emotions, and social support. But it has not been clear how consistently psychosocial interventions boost immune function, whether these effects differ for different types of interventions, or whether certain individuals benefit more than others. In part, this has to do with differences in studies that have examined these issues.

This fact informed the design of the new analysis, which was published in JAMA Psychiatry. The work was led by 2015 BBRF Young Investigator George Slavich, Ph.D., of the University of California, Los Angeles. His team winnowed 4,621 published studies conducted between 1980 and 2018 to 56 that included a total of 4,060 participants. To qualify, studies had to include assessments of participants' immune system function both before and after they were administered a psychosocial intervention.

Participants in the 56 trials who received psychosocial interventions had various physical and mental health issues: psychiatric disorders including depression and stress, autoimmune disorders, cancer,
HIV, and insomnia.

To determine which interventions might have been more beneficial than others, the team studied eight kinds of psychosocial interventions across the 56 clinical trial: behavior therapy, cognitive therapy, cognitive behavior therapy (CBT), bereavement or supportive therapy, psychoeducation, and other forms of psychotherapy, as well as various combinations of such interventions.

The team also examined how these interventions impacted seven measures of the immune system. These measures included levels of various immune signaling molecules, pro- and anti-inflammatory factors, immune-cell counts, levels of natural killer-cell activity, and viral load. Finally, the researchers assessed nine factors that could have affected the outcome of the trials, including different intervention types, formats, and durations, as well as the age and sex of participants.

The main take-home message of the analysis was that as compared to individuals who were randomly assigned to a control group, those who were randomly assigned to receive a psychosocial intervention exhibited a nearly 15% enhancement in beneficial immune system function, on average, and an 18% decrease in harmful immune system function.

Importantly, these effects were observed to persist for at least 6 months following the end of the psychosocial treatments. The findings did not differ across participants' age or sex, or the length of the intervention, the researchers reported.

The researchers found that the most reliable, beneficial results were found when CBT or multiple or combined psychosocial interventions were used.

The researchers also noted the cost-effectiveness of psychosocial interventions as compared to various forms of drug therapies that are frequently used to treat immune-related illnesses. Savings associated with using psychosocial interventions could be many thousands of dollars annually per case, they said, while generating health benefits that are often comparable to or superior to those associated with pharmacotherapy.

Psychosocial interventions to support the mental health of informal caregivers of persons living with dementia

Informal caregivers of persons living with dementia have an increased risk of adverse mental health effects. It is therefore important to systematically summarize published literature in order to find out which mental health interventions generate effective support for informal caregivers of persons living with dementia. The objective of this study is to conduct a systematic review of intervention content, effectiveness and subgroup differentiation of mental health interventions for informal caregivers of persons with dementia living at home.

Method

We searched four electronic databases (PubMed, PsychINFO, Scopus and CINAHL) and included only methodically high-quality randomized controlled trials (RCTs), published in English or German language between 2009 and 2018. The intervention programmes focused on mental health of family caregivers. A narrative synthesis of the included studies is given.

Results

Forty-eight publications relating to 46 intervention programmes met the inclusion criteria. Burden, depression and quality of life (QoL) are the predominant parameters that were investigated. Twenty-five of forty-six interventions (54.3%) show positive effects on at least one of the outcomes examined. Most often, positive effects are reported for the outcome subjective burden (46.2%). Only six studies explicitly target on a certain subgroup of informal dementia caregivers (13%), whereas all other interventions (87%) target the group as a whole without differentiation.

Conclusion
The most beneficial results were found for cognitive behavioural approaches, especially concerning the reduction of depressive symptoms. Besides this, leisure and physical activity interventions show some good results in reducing subjective caregiver burden. In order to improve effectiveness, research and practice may focus on developing more targeted interventions for special dementia informal caregiver subgroups.

Impact of brief psychosocial intervention on key relatives of patients with schizophrenia

Background: Caregivers of patients with schizophrenia often experience high burden of care and have deterioration in the quality of their life. This study attempted to assess the efficacy of a brief psychosocial intervention (BPI) on the burden of care and quality of life (QOL) of key relatives of patients with schizophrenia and its subsequent effect on QOL of their patients (if any).

Methods: A total of 66 patients and their key relatives were included in the study. Patients were assessed for psychopathology (by applying Positive and Negative Syndrome Scale and World Health Organization QOL scale [WHOQOL-BREF]) and relatives were assessed on Burden Assessment Schedule and WHOQOL scale (WHOQOL-100). Thirty-three patients and their key relatives were randomly allocated to BPI group and nonspecific control intervention group.

Results: There was a statistically significant reduction in burden of care (P = 0.004) and improvement in QOL of relatives (P = 0.024) as well as in QOL scores of patients (P = 0.0028) in the BPI group.

Conclusion: BPI is associated with a significant improvement in QOL as well as burden of care of key relatives of patients with schizophrenia, which, in turn, results in improvement in QOL of their patients.

Community-based psychosocial interventions for people with schizophrenia

Background
There is consensus that the treatment of schizophrenia should combine anti-psychotic medication and psychosocial interventions in order to address complex social, economic and health needs. It is recommended that family therapy or support; community-based rehabilitation; and/or self-help and support groups should be provided for people with schizophrenia in low and middle-income countries. The effectiveness of community-based psychosocial interventions in these settings is unclear.

Methods
Studies evaluating community-based psychosocial interventions for people with schizophrenia were identified through database searching up to April 2016. Randomised controlled trials were included if they compared the intervention group with a control group receiving treatment as

usual including medication. Only studies set in low and middle-income countries were included. Random effects meta-analyses were performed separately for each intervention type.

Results

Eleven randomised controlled trials in five middle-income countries were identified, with a total of 1580 participants. The content of included interventions varied from single-faceted psychoeducational interventions, to multi-component rehabilitation-focused interventions, to case management interventions. A third of the included studies did not incorporate any community involvement in the intervention. The quality of evidence was often low. Amongst the seven studies that reported on symptom severity up to 18 months post intervention, the pooled standardised mean difference (SMD) across all intervention types was 0.95 (95% CI 0.28, 1.61; P 0.005; I 2 = 95%; n = 862), representing a strong effect. A strong effect on symptom severity remained after excluding two studies with a high risk of bias (SMD 0.80; 95% CI 0.07, 1.53; P 0.03; I 2 = 94%; n = 676). Community-based psychosocial interventions may also have beneficial impacts on functioning (SMD 1.12; 95% CI 0.25, 2.00; P 0.01; I 2 = 94%; n = 511) and reducing hospital readmissions (SMD 0.68; 95% CI 0.27, 1.09; P 0.001; I2 = 33%; n = 167).

Conclusion

The limited evidence from low and middle-income countries supports the feasibility and effectiveness of community-based psychosocial interventions for schizophrenia, even in the absence of community mobilization. Community-based psychosocial interventions should therefore be provided in these settings as an adjuvant service in addition to facility-based care for people with schizophrenia.

Effectiveness of Psychoeducation and Mutual Support Group Program for Family Caregivers

Schizophrenia is a disruptive and distressing illness, not only for the person affected but also for family members. Family intervention, particularly in a group format using a diverse range of modalities, is thought to effectively satisfy the informational needs of families and enhance their coping abilities when caring for a relative with schizophrenia, and thus reduce a patient's relapse from illness. This study tested the hypothesis that participants in a family psychoeducation and mutual support group would demonstrate significant improvements in levels of patient and family functioningand shorter duration of re-hospitalization than families in routine care. A randomized controlled trial was conducted witha sample of 68 Chinese families of schizophrenia sufferers in Hong Kong, who were randomly assigned to either a familypsychoeducation and support group (n = 34), or a routine care group (n = 34). The interventions were delivered at twopsychiatric outpatient clinics over a nine-month period. Results of multivariate analyses of variance test indicated that thepsychoeducation and support group reported greater improvements on family and patient functioning and shorter lengthsof patient hospitalizations at the two post-tests (one month and one year after completion of the intervention), comparedwith the routine

care group. The findings substantiate that within a Chinese context, psychoeducation and mutual supportgroup intervention can effectively help families care for a mentally ill relative.

Conclusion

Interventions are, on average, successful in alleviating burden and depression, increasing general subjective well-being, and increasing caregiving ability/knowledge. The majority of these effects persist after an average of 7 months post intervention. Providing psychoeducational interventions, psychotherapy, and a combination of several of these interventions, as is done in multicomponent approaches, is most effective for improving caregiver well-being in the short term**.**

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