



Case Report

The role of humour and laughter therapy in decreasing caregiver burden among carers of a person living with dementia- A case study

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ABSTRACT

Gibbs (1988)¹ reflective cycle was employed to explore a critical case study involving a senior citizen with dementia and measures to reduce caregiver burden by humour and laughter therapy. This experience highlights key themes of caregiver burden-reduction measures through humour and laughter. This problem is discussed in relation to lack of awareness about measures to reduce caregiver burden arising due to caretaking of a person with dementia. Inclusion of this therapy as a non-pharmacological method of stress management, could be useful in the guidelines for dementia care. Therefore, it is important to include training to all caregivers at home and care home setting to address the issue of caregiver burden.

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1. Introduction

Laughter is the best medicine and it means that one is trying to be happy which is a good way to stop worrying (Cambridge dictionary). Humour and laughter go hand in hand. Humour and laughter are two distinct events that occur together or separately, but are often associated as one. The Oxford English dictionary defines humour as “The quality of action, speech or writing which excites amusement and fun”.

Humour is a multifaceted function that involves cognitive, emotional, behavioural, psycho physiological and social aspects (Tse et.al.2010).² Humour is commonly defined as a stimulus that can help the individual produce laughter (Mora Rippol 2010,³ Tse et.al. 2010). Humour and laughter therapy is beneficial and plays a vital role in reducing stress among caregivers of people living with dementia. Laughter is usually a positive emotion which can occur simultaneously or is provoked by a stimulus. It is always advisable for people living with dementia, their

families, and their caregivers to share happy and share relaxed feelings, because people living with dementia and their carers will be under significant stress, especially in the beginning of the illness. The more is the severity of the illness, the more the strain on everyone in the family. A positive thought, emotion and laughter can help the people living with dementia to cope up with their illness better, improve the immune system and increase the pain threshold and decrease the stress response.

In developing nations like India, Lack of training and understanding of Dementia and its clinical symptoms in the caregivers makes it more challenging for an informal and untrained caregiver causing high level of stress and poor quality of life.

Applying my clinical knowledge of dementia now and recalling the events that happened then, a year ago, I reflect upon the unmet need of addressing the behavioural symptoms, communication skills and stress management techniques which arose among the caregivers, leading to their burnout.

Addressing this issue earlier, through caregiver (humour and laughter therapy session) could have improved the

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quality of life in caregivers.

Using the Gibbs model, I wish to highlight an important issue of caregiver stress management commonly seen due to caretaking in a household setting and will elaborate the importance of laughter and humour in managing the same. Reflection using the Gibbs model, I will explore the benefits of this non-pharmacological management and could be a part of caregiver stress management technique, which if validated, could be suggested for adopting it as a dementia care guideline. Most laughter and smiling, is preserved, in the People living with dementia until the end of the clinical course, even though laughter and smiling as a means of communication is lost during the early stages of the disease. Laughter and smiling associated with pleasant feelings, with the exception of laughing in response to feelings of disharmony, and laughter induced by the release of tension can be used in the caregiver burden management.

2. Objective

To explain the importance of caregiver training using humour and laughter therapy on caregivers' burden, in caretaking, of a person living with dementia.

The critical case study is as per Gibbs model (1988).

3. Description

Mrs A, a person living with dementia, my grandmother, was living in a joint family with caregivers being the members of the family predominantly her sons, Mr B, Mr C & Mr D and daughter-in-law Mrs E. Mr D, Mrs E spent the maximum time with Mrs A as caregivers. Mr D, frequently expressed stress and lost his temper over the repeated spoken behaviour by Mrs A. Following my interview with Mrs E and Mr D, the later expressed a feeling that he had to live with the caregiver stress throughout the life span of Mrs A, but on the contrary Mrs E felt that serving her mother-in-law is a privilege and accepted the behavioural symptoms without even being aware clinically that those were the symptoms of dementia. I allowed Mr D to express his emotions and feelings about caretaking and the difficulties he faced with Mrs A.

3.1. Feelings

Initially as an observer, being a part of the family, I felt these changes in Mrs. A, were due to the ageing process. What I thought was, that there was that there was a significant level of stress in Mr. D, and he expressed it as agitation and anger, which was a way aversion of the feeling due to caregiving. But Mr C is a fun-loving and a cheerful personality who uses humour to turn any serious situation into a happy moment, using a laughter. He made it a point that he visited his ageing mother Mrs A every day, presented a flower to her from our garden, every day. He even made every stressful situation a lighter one by his laughter and his

good sense of humour.

3.2. Evaluation

The positive aspect was that, I was about address the issue of caregiver stress and burden in Mr. D due to caretaking of Mrs A. Humour and laughter was able to address the issue through relevant training and stress management techniques. With the caregivers' point of view, caregiver Mr D, felt like he wished to do more for Mrs A. Mr. D, even felt he could do a better caring job for Mrs A. However, my negative thoughts about the lack of awareness about caregiver stress management made me explore the possible role of imparting caregiver training sessions. Unable to understand the negative symptoms of dementia (agitation, aggression, sleep and mood disturbances), there arose many arguments and conflicts in the family which sometimes had a negative atmosphere at home. Mr D felt that he was overtaxed with responsibilities, that he had no time for himself, and he was losing control of his life. He even felt a sense of anger as Mrs A asked for excessive help requests, felt like discontinuing caregiving and felt like he should give the responsibility to some else.

On the other hand, Mrs. E (daughter-in-law) of Mrs A, is a mentally strong, stable and euthymic personality who did her duty of caregiving, religiously and with empathy. Despite her willingness to serve her mother-in-law, she was not professionally trained for caregiving and understanding the symptoms of dementia. Hence an intervention needed to be designed and tailored to meet the specific needs of caregiving in Mrs E and Mr D.

3.3. Analysis

Among the two individuals who were caregiving, Mr D had a will to do more for Mrs A, but lack of awareness, continued stress due to long hours of caregiving and unable to handle the stress at times made him a vulnerable caregiver who was susceptible to emotional and psychological burnout and in the long run decreased the quality of life of Mr D. Mr. D also reported more burden in social relationship, incompetence and dependence. It is mainly due to lack of time to maintain social relationship after his working hours and caring for Mrs. A, whereas, Mrs E felt pressurised in areas of expectation, dependence and management due to the responsibilities towards the other members of the family while caring for Mrs. A. Mrs E was emotionally stronger and empathetic in comparison to Mr. D, and thus less prone for burnout. Despite the additional responsibilities of home related household chores, Mrs E thought that caregiving was also her responsibility and was mentally prepared for caregiving, unlike Mr. D. who at times felt it was a burden apart from his work outside home.

4. Discussion

4.1. Based on the quality of relationship with the caregiver

Important aspect of caregiver burden is the association between the quality of relationship with the caregiver and the receiver (Gupta, 2009).⁴ Studies suggest that emotional bonding and closeness between the caregiver and care receiver is an important aspect, explaining the level of caregiver burden (Spaid & Barusch, 1994).⁵ Stoller & Pugliesi (1989)⁶ suggested that, having a positive relationship with care receivers were unlikely to develop burden, despite the high level of burden due to caregiving. The poorer the quality of relationship between the caregiver and the receiver, the more is the caregiver burden (Koerner, Kenyon, & Shirai, 2009;⁷ Gupta, 2009), which were the exact findings in our study, too.

4.2. Gender

In Indian families, caregiving predominantly is the primary responsibility of women (primarily daughter-in-law) and it is they who experience more burden than the male caregivers (Kahn, McGill, & Bianchi, 2011;⁸ Miller, Lynda, & Cafasso, 1992;⁹ Navaie-Waliser, Spriggs, & Feldman, 2002).¹⁰ This was opposite to the findings in our study, where the male caregiver Mr D had more burden as he was more eager to provide care to Mrs. A and overburdened himself for the sake of caregiving.

4.3. Multirole involvement by the caregiver

Multiple roles played by caregivers may lead to exhaustion of time, energy and resources. According to the scarcity hypothesis by (Goode 1960)¹¹ more the roles involved by caregivers, the more is the exhaustion of time and energy, thus likelihood of more burden. This is also based on the ability of the caregiver to handle this exhaustion which was exactly what happened in our case study, where Mrs E was well-prepared to handle all the responsibilities of caregiving but Mr D was not.

4.4. Sense of humour and laughter on caregiving

Humour and laughter strengthens the interpersonal relationship between the family members (Francis 1994).¹² The role of Mr C, who had a positive sense of humour, united all the family members and strengthen the interpersonal relationship between all the members of the family.

4.5. Role of caregiver training sessions

To prevent negative symptoms and decrease the negative consequences of caregiving, various interventional programs are suggested with an aim to strengthen caregiver

skills, knowledge about the spectrum of the changes in dementia, and the caregivers own care (Bourgeois.et al).¹³

5. Conclusion

The outcome obtained of this case study using caregiver training sessions, helped in significant reduction of stress. Our case study concluded that humour should be included introduced slowly as it may evoke a strong defence mechanism in the person whom it is being addressed to. Hence it has to be used carefully and needs to be addressed and accepted by the people living with dementia and the caregivers in a positive note.

Laughter is enjoyed by everyone, but a misjudged humour is taken in a negative sense, would be offensive. Though laughter is always positive, humour can provoke a mixed response. Thus, using it appropriately, especially in a tensed situation and taking it

Sportively by the caregivers is always beneficial.

5.1. Action plan

In order to be prepared for similar situations in the future, it is advisable for the caregivers to undergo training about the clinical symptoms of Dementia. Training about appropriate usage of humour in tense situations in the management of caregiver stress. Sharing of caregiving, equally among all the members of the family, so that there is no burden of caregiving on a single caregiver. Regular training sessions by ex-caregivers for prevention and management of caregiver stress and burden. Laughter therapy sessions for the person living with dementia, as it will ease the negative symptoms of dementia. Training of caregivers by trained professionals about the appropriate usage of humour in tense situations.

5.2. Overall conclusion

Humour and laughter therapy, is beneficial for reducing caregiver burden and stress if used appropriately. Women have better ability to manage caregiver stress than male caregivers. Thus, the positive aspects of humour and laughter are reflected more, than the negative aspects and hence it could be adopted as a non-pharmacological method of stress management among caregiver's in the caregiving.

Our observations concluded that humour should be generally introduced to the caregivers, slowly, as humour can also be used as a defence mechanism in an adverse setting, and has a greater value if it is properly addressed and accepted in caregivers of dementia.

6. Source of Funding

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7. Conflict of Interest

None.

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