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Measuring positive caregiving experiences in caregivers of nursing home residents with dementia

Dear Editor,

We would like to thank Kajiwara *et al.*¹ for their interest in our study about measuring positive caregiving experiences in family caregivers of nursing home residents with dementia² and their request for more detail on the associations of positive aspects of caregiving with characteristics of the care recipient and family caregiver. We appreciate the recent publications in the international literature on positive caregiving experiences reporting on various instruments developed in Japan.^{3,4}

Regarding associations of positive caregiving experiences with behavioral and psychological symptoms of dementia (BPSD), the relationship between family caregiver and care recipient, and race, it seems that findings depend on covariates such as educational level and religion as explanatory variables. For example, in Roff *et al.*,⁵ independent of race, religiosity was more strongly related to positive aspects of caregiving as measured with the Positive Aspects of Caregiving scale (PAC) than were BPSD, and these authors found that higher religiosity and less BPSD and several other variables partially explained the relationship between race and positive aspects of caregiving. Although highly informative, these findings from the United States may not be generalizable to our countries of Japan and the Netherlands, which have different levels of religiosity and different ethnic backgrounds.

Unfortunately, no data on ethnicity and BPSD were collected in our study. However, the association between positive aspects of caregiving as measured with the PAC and BPSD is not conclusive.^{5–8} Positive caregiving experiences may be (partially) explained as a positive secondary appraisal after the caregiver successfully copes with the BPSD. The relationship between positive caregiving experiences and factors aiding secondary appraisal (e.g. self-efficacy, active dementia management strategies, emotional and social support [services]) support this view.^{8–10}

Unlike Kajiwara *et al.*,⁴ we found no differences in positive caregiving experiences between spouses and adult children, and between spouses and sons/daughters-in-law. However, both studies had a small sample size and they were performed in different settings (community vs. nursing home) and with different questionnaires, thereby limiting comparability. For example, cultural differences, such as in religion or spirituality, caregiving policy and filial responsibility, may also play a role. Higher religiosity is associated with more positive caregiving experiences,^{5,10} while positive religious coping may facilitate the use of meaning-based coping or positive reframing, which increase positive caregiving experiences.⁹ No studies have

investigated the association between positive caregiving experiences and cultural context; it is unclear whether the results of the measurements of positive caregiving experiences take into account the influence of culture and upbringing when reflecting on the experience of caregiving, in particular caregiving for parents.¹⁰ More research is needed with prospective designs and more sophisticated multivariable analyses to further disentangle these matters. Regarding ethnicity or culture, such studies are preferably conducted in parallel in multiple countries and settings (community vs. nursing home).


Most studies have used cross-sectional designs to examine factors related to positive caregiving experiences.⁹ This limits understanding of any causal mechanisms involved. Mediation analyses, preferably using a longitudinal design, can help to unravel the mechanisms underlying associations between caregiver and care-recipient characteristics and positive caregiving experiences. To support family caregivers, support services may help to alleviate caregiver burden but also should use an empowerment approach to stimulate family caregivers' self-efficacy and to equip family caregivers to develop more positive caregiving experiences. The three conditions identified by Yu *et al.*⁹ to enhance positive caregiving experiences (i.e., personal and social affirmation of role fulfilment, effective cognitive emotional regulation, and contexts that stimulate finding meaning in the caregiving process) may provide a useful framework for that.

Author contributions

HS performed the data analyses and drafted the letter to the editor. All authors revised the letter critically for important intellectual content, contributed to and approved the final manuscript.

Disclosure statement

The authors declare no conflict of interest.

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Comment on “Association between habitual coffee consumption and skeletal muscle mass in middle-aged and older Japanese people”

Dear Editor,

We have read the studies of Iwasaka *et al.* investigating the relationship between habitual coffee consumption and sarcopenia in middle-aged and older patients.¹ The authors found that coffee consumption was positively associated with the skeletal muscle mass index independent of inflammation in middle-aged and older Japanese people.¹ The results provide valuable contributions to the literature, but some issues should be considered when evaluating coffee consumption and sarcopenia, particularly in older adults.

Coffee is one of the most consumed beverages worldwide. Its consumption is associated with a variety of lifestyles and health conditions. Many epidemiological studies have shown that coffee consumption decreases the incidence of major causes of death such as heart disease, type 2 diabetes and various types of cancer^{2,3} as well as the risk of neurological and mental illnesses, such as Parkinson's and Alzheimer's diseases.³ Coffee has been the subject of an increasing number of research articles, particularly in recent years, due to its easy accessibility, its consumption in daily life for pleasure, regardless of age in its own, and the detection of many plausible positive effects. In one of the most recently published articles, Iwasaka *et al.* used in their study the “The Short Food Frequency Questionnaire” (FFQ) to obtain information about the dietary status of the participants.⁴ However, it remains in doubt whether patients with cognitive impairment or dementia were included in the exclusion criteria. In addition, one of the limitations of the validation study of “FFQ” is as follows: “It is unknown whether older individuals have the same ability to remember and quantify the frequency of food consumption as middle-aged participants,

because the FFQs cannot evaluate the cognitive and memory functions.” On the other hand, the reliability of hand grip strength is low for older patients with dementia because of the difficulty for judgment and conception, which can cause them to fail and to comprehend and complete tasks fully.⁵ Therefore, if patients with dementia were excluded from the study, it might have been found that muscle strength along with muscle mass was positively affected by coffee consumption. Another issue with the study may be that geriatric depression was not evaluated as a confounding factor. In older people, there is a very close relationship between sarcopenia and depression.⁶ Moreover, those with depression consume less coffee. For example, a study among Korean older adults showed an inverse relationship between coffee consumption and depression.⁷ Therefore, besides the myostatin and autophagy-based mechanisms that Iwasaka *et al.* mentioned in their discussion, there may have been a positive effect on skeletal muscle mass, perhaps because coffee drinkers were less depressed.

To sum up, when the above-mentioned issues are considered in studies on coffee consumption in older people, readers will be able to encounter clearer results.

Disclosure statement

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