most difficult symptom for you to manage?; What triggers the symptom?; How do you deal with the symptom when it occurs?; Why the symptom bothers?; and What education would be helpful for you? Among BPSD, agitation, aggressive behavior, and apathy were excluded from the interview topic because they were confirmed in the study conducted in 2013. Data were analyzed using content analysis. The difficult BPSD that family caregivers experienced were identified as suspicion, delusion, hallucination, wandering, depression, refusal to care, inappropriate elimination, and inappropriate eating. Most of respondents answered that they first scolded, hit, or argued with the patient when BPSD occurred and wanted to know how to effectively manage the patient's BPSD. The findings suggest that education is necessary for improving family caregivers' competencies to handle BPSD. The education should be comprehensive enough to make caregivers acquire general attitudes towards the persons with dementia as well as specific skills for managing BPSD.

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PSYCHOLOGICAL DIMENSIONS AND SOC AMONG ELDERLY PRIMARY CAREGIVERS PROVIDING HOME CARE FOR ELDERLY

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Objective: The present study surveyed the elderly primary caregivers providing home-based care for elderly individuals in local regions of Japan in order to determine whether psychological dimensions and sense of coherence (SOC) differed according to age group.

Methods: The subjects were 67 pairs comprised of elderly individuals aged ≥65 years undergoing home care and their primary caregivers aged ≥65 years. The survey items consisted of primary caregiver attributes, Barthel Index (BI), psychological dimensions (mental health; CES-D8), feeling of caregiving burden (J-ZBI), general self-efficacy (GSES), life satisfaction (LSI-K), and SOC (SOC13-5). For comparison, primary caregiver responses were scored and classified into two age groups: 65–74 years and ≥75 years. The survey was designed to avoid any potential ethical issues.

Results: SOC was significantly higher among primary caregivers aged ≥75 years than those aged 65–74 years. Positive correlations between GSES, LSI-K and SOC were recognized in both age groups. A negative correlation in the J-ZBI, CES-D8 and SOC scores was only seen among the primary caregivers aged ≥75 years.

Discussion: Primary caregivers who had a high SOC score exhibited a high level of general self-efficacy and life satisfaction. The results also suggested that primary caregivers aged ≥75 years who had a high SOC score had a low feeling of caregiving burden and a high level of mental health. Primary caregivers aged ≥75 years had a higher SOC than their 65–74 year-old counterparts, suggesting that a high level of SOC is important in continuing to provide care.

FACTORS RELATED TO MENTAL HEALTH OF ELDER FAMILY CAREGIVERS IN DEMENTIA CARE

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In dementia care, elder caregivers increase recently and it's necessary to consider support according to the age of the caregivers. In this study, the degree of mental health and factor were investigated to consider the appropriate support to the family caregivers. A questionnaire survey was conducted with family caregivers that are caregiving dementia persons at home. Analysis objectives were 81 persons (20 males, 61 females), and age average was 62.91±10.66 years (range 33–88) . In this study, the WHO-Five Well-Being Index (WHO-5-J), The Erikson Psychosocial Stage Inventory (EPSI) and perceptions about the self of the participants were assessed. Among 81 caregivers, more than 65-years-old persons (elder group) were 32, and less than 65-years-old persons (younger group) were 49. The younger group scored the high points more than the elder group for the total score of WHO-5-J that is index of mental health (t(79)=2.26, p<.05). In the elder group, when caregivers recognized of own as “I am I, myself” (t(29)=2.99, p<.01), the total score of WHO-5-J and identity subscale score of EPSI (t(29)=2.19, p<.05) were high points compared with the caregivers who are not recognized. The significant difference wasn’t admitted for the younger group. The difference in the nursing environment wasn’t admitted about the degree of mental health and own recognition. In dementia care, it is suggested that the support to maintain or promote the self-identity is needed for the elder family caregivers.

SESSION 3615 (POSTER)

FAMILY, INTERGENERATIONAL, AND CAREGIVING ISSUES

LIFE AFTER CARE: ROLE AND IDENTITY TRANSITION AND FAMILY CAREGIVING

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Framed by an idealist ontology and relational constructionist perspective (Blakie 2010), this qualitative study explores how family carers experience role and identity transition as they progress from ‘family member’ to ‘family carer’, to ‘post-carer’, with the latter reflecting the cessation of the caring role as the individual being cared for moves to or dies in a care home or dies at home. Such transitions approximate cumulative rites of passage (Van Gennep 1960, Turner 1969) comprising identity rebuilding and present practical and emotional challenges for family carers. In line with Barnhart and Penaloza (2013), we characterize family caring as a dynamic and situated, socially constructed group phenomenon, where the assisting functions of family, friends, and paid service providers create a family caring ensemble (FCE). Depth interviews were conducted with eight family carers, four females and four males, who had experienced loss in relation to their family caregiving role. Emergent