

Original Article

The Effectiveness of Emotion Efficacy Therapy on Entrapment and Guilt in Caregivers of the Patients with Dementia

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Abstract

Background and Aim: Considering the growth of the population and the consequent high growth rate of elderly individuals, there is a great need to attend and recognize the problems related to the physical and psychological health of patients with dementia and their caregivers. Therefore, the present study aimed to find the effect of emotion efficacy therapy on entrapment and guilt in caregivers of patients with dementia.

Materials and Methods: It was a quasi-experimental study with a pre-test, post-test, follow-up, and control group. The statistical population of the study included the caregivers of patients with dementia who were referred to neurology clinics in Isfahan in 2022, among whom 30 were selected by purposive sampling, taking into account the inclusion and exclusion criteria and randomly assigned to experimental and control groups each comprising 15 caregivers. The experimental group underwent eight sessions of 90-minute emotion efficacy therapy, and the control group was placed on the waiting list without intervention. The data were collected by Entrapment Scale and Caregiver Guilt Questionnaire and were analyzed by multivariate analysis of covariance.

Results: The results showed that emotion efficacy therapy significantly affected entrapment and guilt in caregivers of patients with dementia ($p < 0.05$). Furthermore, the interaction of the effect of time and group membership was also significant for entrapment (internal, external), guilt (guilt about self-care, guilt about doing wrong by the care recipient, and guilt about not rising to the occasion as caregivers) except for the factor of guilt about having negative feelings towards other people and guilt about neglecting other relatives ($p > 0.05$). It showed that the changes in the pre-test, post-test, and follow-up stages were significant in each group. The level of difference between the groups in the entrapment was 37.4%, and it was 49.3% for the guilt.

Conclusion: Emotion efficacy therapy affects and changes the stimuli and underlying factors, including ineffective beliefs and thoughts; as a result, it can be used to decrease the entrapment and the guilt in the caregivers of patients with dementia.

Keywords: Emotion, Caregivers, Dementia, Entrapment, Guilt

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Introduction

Dementia is a chronic neurological condition characterized by a reduced ability to process thought, and effective cognitive function, especially language, thinking, memory, calculation, understanding, and judgment. It disrupts an individual's ability to continue daily activities (1). Due to the growth of the elderly population worldwide, dementia as an age-related disease has become a major threat to global health (2). Dementia imposes progressive disability and weakness on affected individuals and often follows an unpredictable course. Therefore, it burdens the informal caregivers significantly (3) and negatively affects their financial security, emotional and physical health, and overall quality of life (4). Informal caregivers are a heterogeneous group including spouses, adult children, family members, and others (3) who play a decisive role in providing a suitable environment and quality care for these patients (5). Most patients with dementia are cared for by family caregivers who themselves may have complex problems (6). Therefore, in addition to the costs and some difficulties faced by patients with dementia and their caregivers, entrapment and guilt are among the variables that can affect their health and well-being.

Entrapment, or the feeling of being trapped, is a specific type of thinking and feeling (7). It occurs when a person is stuck in a stressful situation without escape and cannot solve problems (8). If it is due to internal conditions such as thoughts and feelings, it is called internal entrapment, and if it happens due to external and environmental conditions, it is called external entrapment (9). Low level of anxiety and depression in humans causes maladaptive behavior and the inability to reach unattainable resources; however, if these conditions make an individual feel helpless, abnormal behavior is exhibited, and the individual feels no control over social situations (10). Studies revealed a relationship between entrapment and the development and persistence of anxiety disorders (11), depression (7), suicide (12), and guilt (13). Comparison of perception of health, entrapment,

suicidal thoughts, and burden of care in the caregivers of patients with dementia denotes the presence of entrapment and care burden (14). In other words, caring for a patient with dementia leads to caregiver emotional exhaustion, the feeling of guilt, frustration, and shame (15).

Guilt is called a specific and transient understanding of behavior that reflects its judgment and the negative and unfavorable impact of that specific behavior on others (16). The guilt is not only a result of the individual's own negative judgments, but the interpersonal context (relationships with a family member with dementia and others) and the socio-cultural environment (including values) also play a decisive role in explaining the guilt and distress of caregivers. Specific psychotherapeutic interventions that integrate acceptance and self-compassion techniques appear to be potentially effective in reducing the guilt and emotional problems of caregivers, such as depression and anxiety (17). Although the guilt has been recognized in clinical literature and qualitative descriptive studies as an emotion experienced by caregivers (15), it has recently emerged as a core concept in empirical research that focuses on identifying factors leading to negative emotions and burdens in caregivers (18). Few studies focused on examining and analyzing the guilt. Yet, studies revealed a relationship between the guilt and depression, anxiety, stress, and the negative effects of caring for the elderly on the caregiver's mental health (19). The significant relationship between the guilt and high levels of emotions such as distress, depression, the burden of care, anxiety, and less leisure time and activity was reported in studies conducted on the caregivers of patients with dementia (20).

Emotions play a major role in the occurrence and intensification of negative states, so the failure to manage emotional reactions effectively increases the probability of emotional problems (21). Given the range of emotional problems in the caregivers of patients with dementia (22), emotion efficacy therapy that is theoretically and contextually grounded aims to assist those with emotion regulation disorders (23). This integrative and trans-diagnostic therapy integrates the components of acceptance and commitment therapy

(ACT), dialectical behavior therapy (DBT), and cognitive-behavioral therapy (CBT) in the form of an exposure-based protocol and two basic trans-diagnostic processes, namely experiential avoidance and distress intolerance increasing emotion efficiency (23). Some researchers believe that emotion dysregulation causes considerable pain and suffering and significantly affects the formation and continuation of emotional disorders, whose main feature is a defect in emotion regulation skills (24). It is designed to teach individuals how to face and experience unpleasant emotions and respond more adaptively (23). It can be an effective intervention in diminishing depression symptoms and strengthening self-care ability in the elderly with depression (25). Few studies have been conducted on the effectiveness of this therapy or its components in treating or improving psychological symptoms and health-oriented behaviors, especially in the elderly and also caregivers of patients with dementia in Iran (25). However, more studies were conducted on psychological well-being (26), treatment adherence (27), and emotion regulation and rumination (28). In general, the effect of emotion efficiency therapy has been investigated on age groups or other variables. Yet, no study has been conducted on the effects of emotion efficacy therapy on entrapment and guilt in caregivers, which highlights the significance of the present research. Given its content, principles, techniques, and basics, emotion efficacy therapy can help deal with the issues and conditions of caregivers of the elderly with dementia. Furthermore, it is required to examine its possible effectiveness in diminishing entrapment and guilt. The reviewed studies clearly showed that the application of this therapy for caregivers of the patient with dementia had not been given enough attention. Therefore, helping the caregivers of the patient with dementia as much as possible through expanding the range of treatments has been one of the major objectives of the present study. Additionally, no study has yet been conducted on determining the effectiveness of emotion efficacy therapy for the caregivers of patients with dementia; therefore, the required and sufficient knowledge and insight about the competitive effects of this treatment with other treatments is nonexistent. The following two questions were posed for the present study. (1)

Does emotion efficacy therapy affect the entrapment of caregivers of patients with dementia? (2) Does emotion efficacy therapy affect the guilt in caregivers of patients with dementia?

Methods

The present study was applied in terms of purpose and quasi-experimental in terms of the method with a pre-test, post-test, follow-up, and control group design. The statistical population included caregivers of patients with dementia in Isfahan in 2022, among whom 30 were selected by purposive sampling and taking into account the inclusion and exclusion criteria and equally and randomly assigned to experimental and control groups. The inclusion criteria were caring for a relative with dementia for at least six months, at least four hours a day (29), not undergoing psychiatric and psychological treatments, and having consent to participate in research. The exclusion criteria were undergoing other psychological interventions besides research intervention or drug therapy, absence of more than two sessions, and unwillingness to participate in research. This study was approved by the Ethics Committee of the Islamic Azad University, Khorasgan branch (IR.IAU.KHUISF.REC.1400.337). The authorization code from the Iranian Registry of Clinical Trials (IRCT) was IRCT20220127053841N1.

Materials

Entrapment Scale

It was used to collect data in the pre-test, post-test, and follow-up stages (7). This scale was developed by Gilbert and Allan. It comprises 16 items and the two sub-scales of internal (1-6) and external (7-16) entrapment. The responses are rated on a five-point Likert scale ranging from 0 to 4, and the total score ranges between 0 and 64. The higher scores indicate a higher entrapment. The internal consistency of the scale was estimated by Cronbach's alpha coefficient, which was 0.93, 0.87, and 0.88 for the whole scale and sub-scales of external and internal entrapment, respectively (7). In Iran, Cronbach's alpha coefficients of the whole scale and external and internal sub-scales were 0.93, 0.90, and 0.89, respectively (30).

Caregiver Guilt Questionnaire (CGQ)

It was used to collect data in the pre-test, post-test, and follow-up stages (31). CGQ, developed by Losada et al., comprises 22 items. The responses are rated on a five-point Likert scale from 1 to 5, and the total score ranges between 22 and 110. The higher scores indicate a higher guilt. It includes the five sub-scales of guilt about doing wrong by the care recipient (2, 8, 10, 11, 12, 14, and 20), guilt about not rising to the occasion as caregivers (5, 6, 9, 13, 21, and 22), guilt about self-care (1, 7, 15, and 16), guilt about neglecting other relatives (3 and 4), and guilt about having negative feelings towards other people (19 and 17). Reliability coefficients estimated by Cronbach's alpha were 0.88 for the whole scale and 0.89, 0.76, 0.69, 0.6, and 0.61 for the sub-scales, respectively (31). In Iran, the relationship between occupational stress and guilt was investigated among nurses at Mofid Children's

Intervention

The experimental group underwent emotion efficacy therapy (EET), designed by McKay and West (23). The key coping skills of dialectical behavior therapy are integrated with the components of acceptance, mindfulness, and value clarification processes in acceptance and commitment therapy in the context of emotional exposure of emotion efficacy therapy (23). Emotion efficacy therapy was held in eight sessions, and each lasted 90 minutes. A follow-up session was held 45 days later. The sessions' content is presented in Table 1. The data were analyzed by multivariate analysis of covariance using SPSS23.

Results

The descriptive statistics of the research variables are

Table 1: Sessions and content of emotion efficacy therapy (23).

Session	Content
1	Observation, acceptance, familiarization: greeting and completing questionnaires before treatment, introducing the leader and group members, brief introduction of emotion efficacy therapy and its structure, training on emotions and emotional awareness
2	Mindful acceptance: Emotion surfing, training on brain function in terms of emotion, training and practicing mindful acceptance, introducing emotional avoidance, exposure and practice
3	Values-based action-part one: practicing mindful acceptance and feedback, training about the moment of choice, introducing values-based action, whiteboard exercise with values and emotional barriers, practicing values-based action using imaginary exposure and feedback
4	Values-based action-part two: practicing mindful acceptance and feedback, monsters on a bus exercise, practicing values-based action using imaginary exposure and feedback
5	Mindful coping, body relaxation, and self-soothing: practicing mindful acceptance and feedback, training on mindful coping, introducing body relaxation and self-soothing, practicing body relaxation and self-soothing skills along with emotional exposure and feedback
6	Mindful coping, coping thoughts, and fundamental acceptance: practicing mindful acceptance and feedback, training and practicing coping thoughts using emotional exposure and feedback, training and practicing fundamental acceptance through emotional exposure and feedback
7	Mindful coping, distraction, and rest time: practicing mindful acceptance and feedback, training on distraction and rest time along with imaginary or emotional exposure and feedback, introducing the individual emotion efficacy plan
8	Consolidation, problem-solving, and summarizing: practicing mindful acceptance and feedback, reviewing the emotion efficacy program, receiving feedback and problem-solving, imaginary or emotional confrontation using emotion efficacy therapy skill and receiving feedback, emotion efficacy rating, closing remarks and gratitude
Follow-up	Reviewing and checking exercises and getting feedback

Hospital in Tehran (32), and a positive and significant correlation was found between occupational stress and its dimensions and guilt and its dimensions among nurses ($P < 0.05$).

presented in Table 2. As shown in Table 2, the mean scores of entrapment and guilt variables of the experimental group (emotion efficacy therapy) more greatly decreased in the post-test and follow-up stages

Table 2: Descriptive statistics of the research variables of the two groups and three stages of the research.

Variable		Group	Pre-test		Post-test		Follow-up	
			M	SD	M	SD	M	SD
Entrapment	Total	Experimental	34.87	11.65	25.53	10.85	26.47	8.12
		Control	33.73	12.002	35.07	13.22	34.13	11.43
	Internal	Experimental	14.26	5.37	10.93	3.21	11.00	2.87
		Control	13.06	4.04	14.66	5.23	13.40	3.97
	External	Experimental	20.60	7.13	14.66	6.17	14.80	5.19
		Control	20.66	8.83	20.40	7.55	20.73	7.54
Guilt	Total	Experimental	35.73	9.22	24.53	9.98	24.8	10.54
		Control	33.67	7.47	33.47	7.6	34.87	7.82
	Guilt about not rising to the occasion as caregivers	Experimental	8.13	3.29	6.67	2.32	7	2.03
		Control	7.67	3.18	9.13	3.18	9.07	3.01
	Guilt about neglecting other relatives	Experimental	3.86	2.16	2.6	1.5	2.6	1.4
		Control	3.27	1.53	3.07	1.97	3.26	1.43
	Guilt about doing wrong by the care recipient	Experimental	12.73	5.27	8.2	4.5	7.87	4.55
		Control	12.2	5.9	12.4	4.1	12.8	3.96
	Guilt about self-care	Experimental	6.07	3.21	4	2.39	4.13	2.36
		Control	6.93	2.44	6.67	1.54	6.13	2.13
	Guilt about having negative feelings towards other people	Experimental	4.47	2.06	3	2.64	2.6	2.58
		Control	3.87	2.92	3.66	2.12	4.13	2.72

compared to the pre-test. These differences will be investigated inferentially in the following.

The use of analysis of covariance requires assumption checking, the most important of which is the normality of the distribution of scores, the homogeneity of variances using Levene's test, the homogeneity of the variance-covariance matrix using Box's M test, the normal correlation between the control variables, the homogeneity of the regression slope by the interaction of the pre-test and the independent variable.

The results of the Shapiro-Wilks test to check the normality of the data showed that the assumption of the normality of the distribution of scores of the research variables for the groups is met in the three stages of the study ($p < 0.05$). The results of Levene's homogeneity of variances test in the post-test stage ($P = 0.68$, $F = 0.17$) and follow-up ($P = 0.17$, $F = 1.97$) stages of entrapment and post-test ($P = 0.3$, $F = 1.09$) and follow-up ($P = 0.07$, $F = 3.25$) stages of guilt showed that the assumption of the equality of variances in both variables was met.

The assumption of the regression slope showed that this assumption was met in the following cases: the group interaction test and the pre-test of entrapment ($P = 0.06$, $F = 3.68$) and guilt ($P = 0.58$, $F = 0.3$) and the follow-up stage of entrapment ($P = 0.25$, $F = 1.38$) and guilt

($P = 0.74$, $F = 0.1$). The Box's M test to examine the

homogeneity of the variance-covariance matrices was also met in the following cases: the total scores of entrapment and guilt in the post-test ($M_{\text{box}} = 8.72$, $F = 2.68$, $P = 0.052$) and follow-up stages ($M_{\text{box}} = 2.58$, $F = 0.79$, $P = 0.49$), the dimensions of entrapment in the post-test ($M_{\text{box}} = 7.48$, $F = 2.3$, $P = 0.07$) the follow-up stages ($M_{\text{box}} = 1.14$, $F = 0.35$, $P = 0.78$), and the dimensions of guilt in the post-test ($M_{\text{box}} = 14.86$, $F = 0.79$, $P = 0.68$) and follow-up stages ($M_{\text{box}} = 30.94$, $F = 1.68$, $P = 0.05$). The results of the correlation between the control variables also showed that the correlations were below 0.8 and acceptable.

The results of the multivariate analysis of covariance for research variables in the post-test and follow-up stages are presented in Table 3. In the post-test stage, the pre-test scores of two variables were initially controlled, and the post-test scores were compared in two groups, and the same was conducted for the follow-up stage, i.e., total follow-up scores of two groups were compared after controlling the pre-test scores. Also, the same process was repeated for the dimensions of guilt and entrapment.

The results of the multivariate analysis of covariance for research variables in the post-test and follow-up

Table 3: The total results of the multivariate analysis of covariance for research variables in comparing the effect of emotion efficacy therapy on entrapment and guilt.

Variable	Level	Test	coefficient	F	Hypothesis df	Error df	P value	Effect Size	Statistical power
Total entrapment & guilt	Post-test	Pillai's Trace	0.814	54.71	2	25	0.001	0.814	1.000
		Wilks Lambda	0.186	54.71	2	25	0.001	0.814	1.000
		Hotelling's Trace	4.37	54.71	2	25	0.001	0.814	1.000
		Roy's Largest Root	4.37	54.71	2	25	0.001	0.814	1.000
	Follow-up	Pillai's Trace	.0679	23.07	2	25	0.001	0.649	1.000
		Wilks Lambda	0.351	23.07	2	25	0.001	0.649	1.000
		Hotelling's Trace	1.84	23.07	2	25	0.001	0.649	1.000
		Roy's Largest Root	1.84	23.07	2	25	0.001	0.649	1.000
dimensions of entrapment	Post-test	Pillai's Trace	0.581	17.33	2	25	0.001	0.581	0.999
		Wilks Lambda	0.419	17.33	2	25	0.001	0.581	0.999
		Hotelling's Trace	1.39	17.33	2	25	0.001	0.581	0.999
		Roy's Largest Root	1.39	17.33	2	25	0.001	0.581	0.999
	Follow-up	Pillai's Trace	0.423	9.16	2	25	0.001	0.423	0.959
		Wilks Lambda	0.577	9.16	2	25	0.001	0.423	0.959
		Hotelling's Trace	0.733	9.16	2	25	0.001	0.423	0.959
		Roy's Largest Root	0.733	9.16	2	25	0.001	0.423	0.959
the dimensions of guilt	Post-test	Pillai's Trace	0.62	6.202	5	19	0.001	0.62	0.977
		Wilks Lambda	0.38	6.202	5	19	0.001	0.62	0.977
		Hotelling's Trace	1.63	6.202	5	19	0.001	0.62	0.977
		Roy's Largest Root	1.63	6.202	5	19	0.001	0.62	0.977
	Follow-up	Pillai's Trace	0.737	10.67	5	19	0.001	0.737	1.000
		Wilks Lambda	0.263	10.67	5	19	0.001	0.737	1.000
		Hotelling's Trace	2.8	10.67	5	19	0.001	0.737	1.000
		Roy's Largest Root	2.8	10.67	5	19	0.001	0.737	1.000

Table 4: The results of the univariate analysis for comparing two groups in the post-test and follow-up stages.

Variable	Level	Sum of Squares	df	Mean Square	F	P value	Effect Size
entrapment	post-test	814.51	1	814.51	33.49	0.001	0.563
	follow-up	526.754	1	526.754	19.32	0.001	0.426
Internal entrapment	post-test	125.694	1	125.694	26.98	0.001	0.509
	follow-up	51.44	1	51.44	7.29	0.01	0.219
External entrapment	post-test	275.55	1	275.55	18.19	0.001	0.412
	follow-up	288.33	1	288.33	15.56	0.001	0.374
guilt	post-test	859.75	1	859.75	59.51	0.001	0.685
	follow-up	1017.05	1	1017.05	35.86	0.001	0.58
Guilt about not rising to the occasion as caregivers	post-test	115.45	1	115.45	17.24	0.001	0.428
	follow-up	128.064	1	128.064	18.13	0.001	0.441
Guilt about neglecting other relatives	post-test	31.71	1	31.71	8.58	0.008	0.272
	follow-up	24.33	1	24.33	6.77	0.016	0.227
Guilt about doing wrong by the care recipient	post-test	43.66	1	43.66	11.24	.003	.0328
	follow-up	21.27	1	21.27	7.52	0.012	0.246
Guilt about self-care	post-test	3.68	1	3.68	1.58	0.221	0.064
	follow-up	4.42	1	4.42	2.29	0.114	0.091
Guilt about having negative feelings towards other people	post-test	6.41	1	6.41	2.04	0.166	0.082
	follow-up	18.66	1	18.66	3.55	0.072	0.134

stages are presented in Table 3. In the post-test stage, the pre-test scores of two variables were initially controlled, and the post-test scores were compared in two groups, and the same was conducted for the

follow-up stage, i.e., total follow-up scores of two groups were compared after controlling the pre-test scores. Also, the same process was repeated for the dimensions of guilt and entrapment.

The results of the univariate analysis for comparing two groups in the post-test and follow-up stages are presented in Table 4.

As shown in Table 4, the difference between the experimental and control groups was not significant for the entrapment, and both internal and external factors in the pre-test stage ($P > 0.05$), but the difference in the post-test and follow-up stages was significant for entrapment and internal and external factors ($P < 0.05$), indicating that the effect of emotion efficacy therapy on improving entrapment and internal and external factors in the post-test was 18%, 16.5%, and 16.3%, respectively. Besides, the effect of emotion efficacy therapy on the variable of entrapment and internal and external factors in the follow-up phase was 15.8%, 11.3%, and 18.5%, respectively.

The findings also showed that the difference between the experimental and control groups in the variable of the guilt and all its factors was not significant in the pre-test stage ($P > 0.05$), but the difference in the post-test and the follow-up stages was significant for the guilt variable and the factors of guilt about self-care, guilt about doing wrong by the care recipient, and guilt about not rising to the occasion as caregivers ($P < 0.05$). However, the difference between the two groups was not significant for guilt about having negative feelings towards other people and guilt about neglecting other relatives ($P > 0.05$). Accordingly, the findings indicated that the effect of emotion efficacy therapy on diminishing the guilt and factors self-care, guilt about doing wrong by the care recipient, and guilt about not rising to the occasion as caregivers was 21.4%, 32%, 20.3%, and 17.4%, respectively. The same values for the follow-up stage were 25.6%, 17.5%, 26.4%, and 14.8%, respectively.

Discussion

The present study aimed to find the effect of emotion efficacy therapy on entrapment and guilt in caregivers of patients with dementia. The findings demonstrated the significant effect of the treatment for the caregivers of patients with dementia regarding the effect of time and group membership on entrapment (internal and external). No study has yet investigated its effect on the caregivers of patients with dementia. For this reason, the findings are compared with those

that examined the effectiveness of one of the fundamental components and constituents of the two treatment methods used in the research, such as acceptance and commitment-based therapy or dialectical behavior therapy in different statistical samples. However, the findings of the present study are somewhat in line with the findings of Griffiths et al. (33), Abdi et al. (25), and ZareieFaskhudi et al. (34). In explaining these findings, as previous research revealed, a treatment aiming for trans-diagnostic factors or underlying stimuli is more efficacious (35). Using the five components of emotion efficacy therapy, i.e., awareness, mindful acceptance, values-based actions, mindfully coping, and practicing skills based on exposure, therapy seekers learn to expand their choices facing emotions and establish a new relationship with their emotions instead of ineffective and incompatible reactions. Furthermore, they learn how to correctly respond to thoughts and emotions in an emotionally active state, which, in turn, reduces incompatible and ineffective thoughts and emotions (23). Accordingly, emotions such as entrapment are also affected by trans-diagnostic mechanisms, targeting the intolerance of significant distress, high emotional avoidance, and high rumination/worry (repeated negative thoughts), which play the most prominent role in emotional dysregulation (36). New adaptive strategies and establishing new relationships with emotions prevent suffering by accepting pain (37), and caregivers can perform their difficult tasks with less burden and more acceptance, hope, peace, and presence using mindfulness techniques proposed in this treatment. The mechanisms through which caregivers' concentration of attention increases cause higher levels of mindfulness and quality of life and lower levels of anxiety, depression, and entrapment (33). The component of values, which can motivate and guide change, is more prominent in emotion efficacy therapy. Regarding the insignificant finding for the component of internal entrapment, it seems that under the influence of the wide range of techniques learned in this treatment, participants could not clearly distinguish their emotions, and only the effect on the external entrapment was more manifested by the movement in the path of values. No Iranian study has yet been conducted on the effectiveness of emotion efficacy therapy on the guilt and its factors in caregivers of

patients with dementia. The findings of the present study indicated its effectiveness on the guilt and all its factors except for guilt about having negative feelings towards other people and guilt about neglecting other relatives.

In explaining these findings, it can be stated that emotion efficacy therapy includes components of acceptance and commitment therapy (ACT), dialectical behavior therapy, and mindfulness techniques (23). Therefore, the findings are somewhat consistent with Gallego-Alberto et al. (18), Owen et al. (15), and Dolatshad et al. (32). The guilt occurs when an individual cannot regulate emotion and tolerate distress (38). The emergence of accepting and performing actions and choosing them based on values alters negative evaluations and ineffective thoughts and beliefs, including feelings of guilt, guilt about self-care, guilt about doing wrong by the care recipient, and guilt about not rising to the occasion as caregivers. With this change in belief, the individual feels capable of facing them. As a result, the guilt is diminished through reducing psychological distress, increasing acceptance, commitment to action, and confronting problems and inappropriate beliefs. On the other hand, research results indicated that dialectical behavior therapy is also effective in reducing the guilt (39). Therefore, since emotion efficacy therapy affects negative evaluations and ineffective beliefs, it can affect the occurrence of guilt-arousing issues.

Among the limitations of this study, we can state that it was cross-sectional and conducted in Isfahan and that the effectiveness of emotion efficacy therapy was not compared with other treatment methods. Also, the caregivers of patients with dementia were examined in this study, so conducting other studies on other samples and at other time points is suggested. It is also suggested to conduct a study to compare formal and informal caregivers.

Conclusion

In general, emotion efficacy therapy had a significant effect on entrapment and the guilt in the caregivers of the elderly with dementia in the post-test stage, which sustained into the follow-up stage. So, this therapeutic technique diminished entrapment and guilt in

caregivers of patients with dementia.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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