EDICIONES
COMPLUTENSE

Cuadernos de **Trabajo Social**
ISSN 1988-8295

ARTÍCULOS

Integration of the combined methodology in the field of Social Sciences and Social Work. An example of practical use in research

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https://dx.doi.org/10.5209/cuts.96781

Enviado: 29/06/2024 • Aceptado: 31/01/2025

ENG Abstract: Research in the field of Social Work is circumscribed to the social sciences and their methodology. Advancing knowledge with rigour and quality involves the use of quantitative and qualitative methods. The combined methodology has made an undeniable contribution to the understanding and knowledge of social phenomena, and its development and implementation is booming. This article presents a study carried out with mixed-methods methodology in a field of social work such as the situation of people with dementia who are cared for at home by family members living with them. The psychosocial adaptation and quality of life of family carers is analysed through a combined data analysis. The results show how the combined methodology makes it possible to delve into the causes and elements that affect care, explain the experiences of the people interviewed and lay the foundations for a recently implemented intervention project. In this way, the use of this methodological practice in the field of social work research is further developed.

Keywords: combined methodology (mixed-methods), Social Work, Social Sciences, practical example, research.

ES Integración de la metodología combinada en el ámbito de las Ciencias Sociales y el Trabajo Social. Ejemplo de uso práctico en investigación

ES Resumen: La investigación en el ámbito del Trabajo Social está circunscrita a las ciencias sociales y su metodología. Avanzar en el conocimiento desde el rigor y la calidad conlleva el uso de métodos cuantitativos y cualitativos. La metodología combinada ha desarrollado una aportación innegable a la comprensión de los fenómenos sociales y al conocimiento de los mismos, estando en auge su desarrollo e implementación. El presente artículo expone un estudio realizado con metodología combinada (mixed-methods) en un ámbito de Trabajo Social como es la situación de personas con demencia atendidas en su domicilio por familiares convivientes. Se analiza la adaptación psicosocial y calidad de vida de familiares cuidadoras a través de un análisis de datos combinado. Los resultados señalan cómo la metodología combinada permite ahondar en las causas y elementos que afectan al cuidado, explicar las vivencias de las personas entrevistadas y sentar las bases de un proyecto de intervención implementado recientemente. De este modo, se profundiza en el uso de esta práctica metodológica en el ámbito de la investigación del Trabajo Social.

Palabras clave: metodología combinada (mixed-methods), Trabajo Social, Ciencias Sociales, ejemplo práctico, investigación.

Sumario: Introduction. Methodology. Results. Conclusions and discussion. Referencies.

Como citar: Lopes-Dos-Santos, M. C. (2025). Integration of the combined methodology in the field of Social Sciences and Social Work. An example of practical use in research. *Cuadernos de Trabajo Social 38(2)*, 281-312. https://dx.doi.org/10.5209/cuts.96781

Introduction

Research in Social Sciences involves validated instruments tested through scientific methodology (Anadón, 2008; Alise & Teddlie, 2010; Erazo, 2011; Brichetto, 2014) that address a complex and changing reality. Consequently, researchers in these fields currently use combined methods of quantitative and qualitative approaches (Plano Clark et al., 2008; Anguera et al., 2020; Forni & De Grande, 2020; Busquets, 2022).

The design of mixed-methods methodology (Campbell & Fiske, 1959; Sieber, 1973; Jick, 1979; Tashakkori & Teddlie, 2004; Creswell & Plano, 2007; Porcino & Verhoef, 2010; Sánchez, 2015; Maxwell, 2016), specifically the triangulation design (Hanson et al., 2005; Greene, 2007; Donolo, 2009; Hueso & Cascant, 2012; Denzin, 1990 & 2012), is determined by the necessary complementarity of quantitative data (Tamayo, 2007; Hernández, 2007; Rodríguez, 2010; Cook & Reichardt, 2011; Monje, 2011) and qualitative data (Morse, 1991; Riba, 2007), which enables integration in data collection, analysis, and interpretation (Sánchez, 2015).

In Social Work, research faces practical limitations. Romero-Martín, Esteban Carbonell, and De Predo (2021), after analyzing 753 Social Work final theses, identified social exclusion (Rodríguez & Facal, 2019) as the most prominent topic, followed by childhood and youth, and education and health (Gartner & Cifuentes, 2001). Furthermore, they highlight the challenges of research related to Social Work (Gutiérrez, Maldonado & Payán, 2014; Teater, 2017), and the limited use of quantitative methodology. However, the drive for research in Social Work, as the foundation for subsequent intervention, reflects a growing interest, challenge, and approach (Rivas, 2007; Álvarez, 2009; Bueno, 2013; Travi, 2014; Falla, Del Pilar & Rodríguez, 2017; Medina & Bohórquez, 2018; Morales & Agrela, 2018; Scarpino & Bertona, 2021).

The study to which this methodology is applied focuses on the home care of dementia by cohabiting family members, primarily related to the care of dependent elderly individuals (Cameron & Moss, 2007; Sarasa, 2003, 2004; Durán, 2005, 2011; Rodríguez, 2011; Abellán, Esparza & Pérez Díaz, 2011; Martín et al., 2014; Serrano & Parra, 2014).

Individuals with dementia represent the most vulnerable members of the family, due to neurodegeneration (Rodríguez & Sánchez, 2004) that they undergo, the progressive and irreversible loss of functionality, as well as behavioral changes (Gómez, 2001; Azpiazu & Pujol, 2003; Casquero & Selmes, 2003; Bartolomé et al., 2010), which necessarily leads to increasingly continuous (Bofill, 2004) and constant care by the caregiver (Bermejo, 2004). Authors such as Fernández (2020) analyze healthcare Social Work with Alzheimer's patients' families, Fuentes (2014) focuses on Social Work with informal caregivers, and Hernández-Echegaray & Pastor (2020) propose a social intervention methodology with multi-problematic individuals and families, as well as Centenero (2022).

The research objectives of this article are: 1) To determine the psychosocial adaptation of family caregivers to the degenerative process of their relatives with dementia. 2) To determine the quality of life of family caregivers. 3) To understand the experiences of family caregivers in relation to cohabiting with individuals with dementia. As for the hypotheses: 1) The psychosocial adaptation of caregivers will be influenced by various variables such as residential area, family support, income level, household type, and architectural barriers in the home. 2) The quality of life of family caregivers will be determined by good psychosocial adaptation according to the parameters established in the previous point. 3) A key determinant of poor quality of life and poor psychosocial adaptation of caregivers will be the lack of personal development spaces and limited family support.

This research develops the application of mixed-methods methodology in the field of Social Sciences, specifically Social Work in the context of long-term care for dementia patients within the home setting. Changing and highly complex systemic scenarios require the use of parameters that not only address quantitative analysis but also include qualitative aspects that encompass individual and family experiences in coping with a reality of high personal, family, social, healthcare, and economic-structural impact. The contribution of this article to the body of knowledge is grounded in its sociosanitary aspect and the articulation of combined research, offering parameters for subsequent intervention. Following the research, an intervention team was proposed based on the results (professional profiles, areas of action, etc.), which has been implemented in practice, thus providing the necessary knowledge foundations for the development of a practical approach.

Methodology

A mixed-methods methodology was used through a non-probability convenience sampling (McMillan & Schumacher, 2001; Cohen et al., 2003; Lodico et al., 2006; Icart et al., 2006; Porcino & Verhoef, 2010; Sánchez, 2015), as voluntary participation from family caregivers of individuals with dementia in home settings was necessary (a probability sample would have required prior consent from the selected individuals, which could not be guaranteed). The identification of these participants was carried out through direct care professionals in order to establish an access pathway for voluntary participation requests.

Validated questionnaires were used: PAIS-SR (Psychosocial Adaptation to Illness) and QOL-AD (Quality of Life in Alzheimer's disease), along with a semi-structured interview consisting of 8 ad hoc topics.

Quantitative Instruments

The quantitative methodology involves hypothesis testing using a representative sample from the study population (Tamayo, 2007), focusing on facts or causes of a social phenomenon (Rodríguez, 2010) and employing statistical analysis to establish patterns, test theories, and validate or refute hypotheses (Hernández et al., 2010). In this study, the following instruments were used:

1. Sociodemographic Data Sheet: Target variables to establish correlations between the caregiver and factors that interfere with or favor psychosocial adaptation to the illness and quality of life.
2. Psychosocial Adaptation to Illness Scale (PAIS-SR) - Caregiver Self-Reported Version (Derogatis, 1986). A validated scale (Bullinger et al., 1998), also used in the study of the ReNACE program (Portillo et al.,

2012). It consists of 7 sections with a total of 46 items. Each item has 4 response options, scored from 0 to 3 for odd-numbered questions and from 3 to 0 for even-numbered questions. A higher score indicates worse psychosocial adaptation, and vice versa.

3. Quality of Life in Alzheimer's disease Scale (QOL-AD) (Longsdon et al., 1999). A validated scale (Rosas-Carrasco et al., 2010). It consists of 13 items, each scored from 1 to 4. A higher score indicates better quality of life.

The IBM SPSS Statistics[1] program, version 23 from the Public University of Navarra, and R Software, along with the integrated FactoMineR package (Lê, Josse & Husson, 2008) and Coheris SPAD, were used for data analysis. Two types of analyses were performed: factorial analysis (to establish principal components explaining the majority of data variability and their interrelations with sociodemographic variables to obtain potential correlations) (Elosua & Zumbo, 2008; Freiberg et al., 2013), and correspondence analysis (to establish significant relationships between the analyzed variables) (Greenacre, 2008).

Qualitative Instrument

The qualitative methodology involves understanding reality through its natural context, interpreting phenomena based on the meaning attributed to them by the individuals affected and/or involved (Arnoux, 2019; Babbie, 2020). In this study, the following instrument was used:

Semi-structured Interview: It consists of 8 topics with a total of 15 items. All items are open-ended questions that allowed for qualitative assessment. This interview was previously used in the ReNACE project (Portillo et al., 2012), with the term "Parkinson" being replaced by "Dementia" in this study. Additionally, the AQUAD tool was used, an IT instrument for addressing the study of qualitative data (Blasco & Mengual, 2010).

Sample size

The sample size was located in 29 municipalities within the Community of Navarra (rural, semi-rural, and urban areas), distributed across the territory to obtain a representative participation sample from the different geographical zones of the region.

Figure 1. Obtaining the sample from the different areas of the Foral Community of Navarra

Source: Own elaboration.

The sample size and subject selection were subject to the inclusion criteria established beforehand, in accordance with the profile and language proficiency of the researcher (cohabiting family caregivers with a caregiving relationship at home, Spanish, Portuguese, or French speakers, and voluntary participation), as well as access to the sample. Regarding the sample size, it was set at 75 family units (Peduzzi, 1995).

Both questionnaires were administered to the 75 participants, and 60 interviews were conducted (theoretical saturation was reached). Access to the sample was facilitated through the cooperation of professionals from Base Social Services (61) and Health Centers (55).

Data Collection was carried out directly and in person by the researcher: an individualized phone call was made to schedule an appointment (presentation, explanation, and determination of the day, time, and place), followed by presentation (Public University of Navarra ID, information, questionnaires, and interview, official accreditation document, informed consent), and subsequent steps (sociodemographic data, PAIS-SR questionnaire, QOL-AD questionnaire, and interview). Only 15 cases consented to being recorded, while

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[1] Esperanza Bausela Herreras, Department of Philosophy and Educational Sciences, University of León. *Journal of Educational Informatics and Audiovisual Media*, Vol. 2(4), pp. 62–69, 2005

the remaining 45 (N=45) declined for various reasons (privacy, embarrassment, discomfort, feeling of lack of freedom, ongoing legal situations).

In all cases, notes were taken by the interviewer, transcribing responses as literally as possible and highlighting relevant aspects and ideas related to the question posed.

Ethical Approval was obtained from the Ethics Committee of the Public University of Navarra under code PI-025/15.

Quality and Scientific Rigor

This research adheres to the characteristics defined by Guba and Lincoln (1981), as it uses standardized and validated tools, and the study can be replicated in other populations and contexts. In terms of the characteristics defined by Calderón (2002), relevance was ensured by detecting and addressing a scientific gap, and validity was achieved by using standardized and validated tools, allowing for reflexivity (Huberman & Miles, 2000; Cornejo & Salas, 2011; Noreña et al., 2012; Rojas & Osorio, 2017).

Triangulation methodology was used to enhance the validity of the results (Thrumond, 2001; Olsen, 2004; Konecki, 2008; Altrichter et al., 2008; Erazo, 2011; Audrey, 2013; Maxwell, 2016), as it provides a broader understanding of the results.

Results

The results were obtained through the triangulated analysis of quantitative and qualitative data.

Sociodemographic Description of the Sample

The main characteristics of the sample concerning the sociodemographic data collected were: a majority of female caregivers (77.33%), with an average age of 58.2 years. Seventy-two percent were married (none of the 17 men in the sample were married), with an average caregiving duration of 6.06 years. Forty-five percent lived in fully adapted homes, and 33.33% in homes without architectural barriers. In terms of employment status: full-time work (28%) or part-time work (13.34%). Twenty-four percent were housewives, and 22.67% were retired. Regarding education level, 48% had basic education, and 22.66% had university studies. The majority resided in semi-rural areas (69.34%). Concerning salary, there were no significant differences (only 56 responses could be obtained). 74.67% reported having additional income. Household types were divided as follows: couple (33.3%), couple and children (26.67%), and couple, children, and grandchildren (25.33%). The caregivers were primarily daughters (69.33%). Finally, regarding the caregiver's health status, 66.67% did not have any illness.

In general, the caregivers were women, daughters of the cared-for person, without illness, residing in households consisting of couples, couples and children, or couples, children, and grandchildren. They received additional income (besides salary, if any), lived in semi-rural areas, in homes without barriers or fully adapted, had basic education, were married, housewives, retired, or worked full-time or part-time, with an average age of 58 years and an average caregiving duration of 6 years.

Psychosocial Adaptation to the Illness

In relation to the analysis of the PAIS-SR scale, Table 1 presents the values obtained through statistical data analysis regarding the various domains according to the area of residence.

Table 1. Correspondence analysis between the different sections of the PAIS and QOL-AD in their positive aspect with the area of residence in percentages

Residence **Measured domains**	**Urban Area**	**Rural Area**	**Semi-rural Area**
Good health care	40,38	75	43,92
Good domestic environment	38,46	75	28,57
Good family relationships	46,15	43,75	28,57
Good social relationships	28,84	31,25	14,28
Low psychological distress	48,08	87,50	42,86
Good psychosocial adaptation	57,69	93,75	57,14
Good quality of life	42,31	81,25	42,86

Source: Own elaboration.

Section II (labor domain) was removed from the analysis due to only 39 responses being obtained from the sample of 75 participants, thus the values were not representative. The individuals interviewed who were unemployed, retired, or housewives, as well as those in student status or on temporary work incapacity, predominantly did not answer this section since they were not in a labor situation and were unable to respond according to their circumstances. Section IV (sexual relations) was also removed from the analysis because only 14 responses were obtained from the sample of 75 participants, making the values not representative. The other respondents considered this a personal domain they did not wish to be consulted on (Table 2).

Due to the lack of data in these two subscales, intra-scale validation analyses were conducted to assess the impact of removing both sections from the scale. For this purpose, Cronbach's Alpha was calculated to measure internal consistency both with and without the two removed sections, showing that with both sections included, alpha was 0.59, and without them, it was 0.63, indicating an increase in internal consistency upon removal of both sections.

Table 2. Maximum values, mean and standard deviation of the scale PAIS-SR*

Family members (n=75)	Maximum scale value	Mean	Standard deviation
Section I PAIS-SR	24	8,65	3,62
Section III PAIS-SR	24	9,55	5,03
Section V PAIS-SR	15	6,44	4,78
Section VI PAIS-SR	18	10,52	5,36
Section VII PAIS-SR	18	6,64	5,06
Total PAIS-SR**	99	40,79	17,29

*From the analysis of PAIS-SR data, sections II and IV have been excluded due to the lack of data in both, as they were not sufficiently representative, and the entire analysis has been based on the remaining sections.

**Total PAIS-SR excluding the two sections (II and IV) that did not show significant data.

Source: Own elaboration.

Three main factors influencing psychosocial adaptation to caregiving were identified: area of residence, caregiving and distress, and cohabitation.

Quality of Life

The QOL-AD scale does not have sections, so the scores obtained were total scores. This scale was answered in all its items by all participants, yielding the data indicated in Table 3.

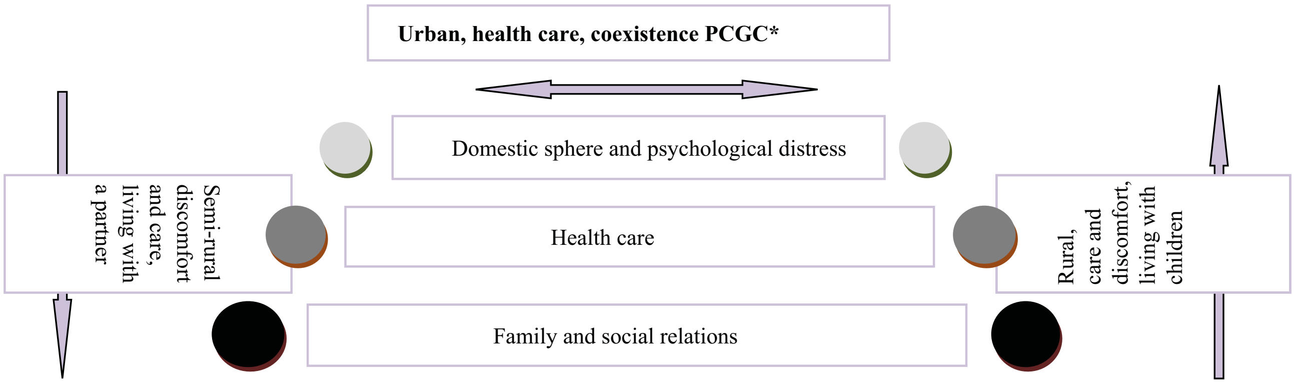
Table 3. Maximum values, mean and standard deviation of the scale QOL-AD

Family members (n=75)	Maximum scale value	Mean	Standard deviation
QQL-AD	52	32,81	6,92

Source: Own elaboration.

The scores obtained in relation to the quality of life of the sample were high, suggesting that participants tended to evaluate this aspect positively.

Figure 2. Visual pyramid of the quantitative aspects from an incidence perspective of the three influencing factors detected



* PCGC: parents, children and grandchildren

Source: Own elaboration.

Qualitative Data Analysis

For data analysis, the content analysis proposed by Miles, Huberman, and Saldaña (2014) and Frankfort-Nachimas and Nachimas (1996) was followed.

- Step 1. Literal transcription of the interviews that had been recorded (a total of 15). For the unrecorded interviews, the data collected in writing was also analyzed.
- Step 2. Three full readings of each interview were conducted (to identify key elements, concepts, and emerging categories, as well as to discard material not relevant to the study).
- Step 3. More focused readings (to specify and refine emerging relevant terms). A data screen was used based on the summaries and notes recorded.
- Step 4. The frequency, structure, behaviors, and strategies were determined, reducing the number of categories found and grouping emerging terms and topics from the interviews.
- Step 5. The final categories and themes were established. Initially, 36 categories emerged, which after a thorough analysis, were defined into 3 categories and 6 themes with their indicators (Table 4).

Table 4: Categories, themes, and indicators identified in the qualitative interviews.

Categorías	**Temas**	**Indicadores/Términos clave**
Coping with Coexistence with the Person with Dementia	Impacts experienced by the caregiver as a result of the initiation of care	– **Self-care: physical and character.** Modifications in personal care, reduced interest in physical appearance, and character changes related to stress and discomfort. – **Deterioration of family relationships** due to lack of support from other family members and maintenance of traditional roles, with women being the primary caregivers.
	Ongoing effects on the caregiver's life	– • **Family disorganization** in terms of organization and coexistence, due to the increase in responsibilities related to caregiving. – **Changes in personal and family life** and absence of personal freedom to pursue one's life project. – **Exhaustion and stress** from the necessary continuity of care for the dependent person without rest.
	Caregiver's adaptation to the degenerative process of the person with the illness	– **A hiatus in the caregiver's own life project** to dedicate themselves to caregiving. – **Dependence of the person with dementia** on the family caregiver. – **Harshness in coexistence** due to the situation being lived. – **Acceptance of the new living conditions** according to the needs of the cared-for person. – **Worsening of the sick person** as a result of a degenerative condition and depersonalization of the person being cared for due to the loss of self-awareness and their life and family history.
Resources Available and/or Necessary for the Caregiver		– **Family members as an internal support system** with other family members. – **Professionals as an external support system** with people and services outside the family unit. – **Personal factors** such as information to understand the disease and maintaining personal activities to have individual spaces for relief and development.

Caregiver's satisfaction with their daily life	Caregiver's satisfaction with their daily life	– **Pity** for the loss of the person as they degenerate and forget their past and life, and **resignation** when accepting this reality as unchangeable. – **Disorientation** from not knowing how to act in relation to caregiving, and **helplessness** from being unable to alter the fact of the pathology. – **Distress** regarding caregiving and how to approach it. – **Fear** of the future and degeneration, of the disease's progression and its consequences on the sick person and the coexistence. – **Anger and frustration** over the situation of coexistence and the degenerative disease.
	Caregiver's satisfaction with their daily life	– **Positive** – **Doubtful** – **Negative**
	Caregiver's satisfaction with their daily life	– **Positive**, when the life analysis is carried out by the caregiver from a global perspective. – **Moderate**, when the life analysis is carried out by the caregiver from the integration of their life trajectory and the start of caregiving to the present moment. – **Negative**, when the life analysis is carried out by the caregiver solely from the present moment.

Source: Own elaboration.

Triangulation

To carry out this integrative process, equivalencies were established between the qualitative and quantitative data based on content similarity (Table 5).

Table 5. Equivalences of qualitative and quantitative data

Evolution of the Process	Equivalence of Quantitative Data
(Topic 1 Interview) Changes in illness and integration	Health care (Section I PAIS-SR)
(Topics 2 and 4 Interview) Changes in illness and influencing factors	Domestic environment (Section III PAIS-SR)
(Topics 2 and 5 Interview) Evolution of the process and changes in illness	Family relationships (Section V PAIS-SR)
(Topics 1 and 2 Interview) Acceptance, adaptation, and integration of the illness	Social relationships (Section VI PAIS-SR)
(Topic 4) Alternatives for illness and integration	Psychological distress (Section VII PAIS-SR)
Alternatives for illness and integration (Topics 3 and 4)	Psychosocial adaptation (Total PAIS-SR)
Life satisfaction (Topic 8)	Quality of life (QOL-AD Questionnaire)

Source: Own elaboration.

Additionally, equivalences were established between terms or concepts emerging from the qualitative data analysis and their percentage relationship with quantitative data, according to the established equivalences. To develop these equivalences and obtain percentage data in the qualitative domain, frequency was used (the number of times a particular term was verbalized in response to the same question was counted).

Coping with living with a person with dementia

The impact indicators (Table 6) identified at both quantitative and qualitative levels involve self-care and deterioration of family relationships, alongside the maintenance of traditional caregiving roles.

Table 6. Indicators of impact on carers.

	Indicators of impact on carers
Self-care: physical and psychological, n (%)	21 (35)
Deterioration of family relationships and maintenance of traditional caregiving roles, n (%)	39 (65)
Total, n (%)	60 (100)

Source: Own elaboration.

The majority of caregivers (65%) have reported a deterioration in family relationships, resulting in another impact, such as the maintenance of traditional caregiving roles.

> *EFMR11: "I had back pain for quite a while. So, we decided to hire someone else."*
> *EFMU019: "With my sister, it was bad. We had many differences and a lot of distance… because when there is a good connection between family members, the situation with the disease becomes more manageable."*

This procedure was similarly followed with the detected impact on family members (Table 7).

Table 7. Indicators of impairment detected by caregivers

	Indicators of caregiver distress
Lack of control and obligations, n (%)	17 (28,3)
Change and lack of freedom, n (%)	31 (51,7)
Exhaustion and stress, n (%)	12 (20)
Total, n (%)	60 (100)

Source: Own elaboration.

Caregivers of family members with dementia have expressed being subjected to a life change that restricts their freedom, creating new and varied responsibilities that disrupt the existing family organization prior to the initiation of caregiving.

> *EFMR11: "Something you already see you won't be able to control in any way."*
> *EFMSR34: "It's a disease that exhausts and stresses."*
> *EFMU42: "I can't do things I'd like to. It's been many years taking care of someone, and you see your life slipping away and you have no alternative."*

Regarding the adaptation of the caregiver (Table 8).

Table 8. Indicators of Adaptation of carers

	Indicators of Adaptation of carers
A parenthesis in their life project, n (%)	8 (13,3)
Dependence of the person with dementia, worsening and depersonalisation, n (%)	14 (23,3)
Acceptance of the new cohabitation conditions, n (%)	9 (15)
Toughness of coexistence, n (%)	23 (38,4)
Ageing process and ignorance of the disease, n (%)	6 (10)
Total, n (%)	60 (100)

Source: Own elaboration.

For all the caregivers interviewed, the caregiving experience has been characterized by changes they have had to face, with 61.7% of them identifying crucial elements in the process.

> *EFMU09: "It's accepting that they will need help and that things will worsen over time."*
> *EFMU12: "Three years of a pause in your life. It's been three years of a pause, three years where you haven't lived the life you wanted. Instead, you've lived the one you had to live, you couldn't choose."*
> *EFMU53: "I have to be attentive as if she were a child, I have to do everything for her, twenty-four hours a day... it's very difficult."*

Available and/or Necessary Resources for the Caregiver

The different strategies were not used in isolation but were intertwined, with two or more strategies being adopted simultaneously. Professional external support and personal resources have been the most utilized in the care of dementia (Table 9).

Table 9. Typology of resources for carers

	Typology of resources for carers
Family members, n (%)	8 (13,3)
Professionals, n (%)	30 (50)
Personals, n (%)	22 (36,7)
Total, n (%)	60 (100)

Source: Own elaboration.

The majority of the individuals interviewed expressed the need for external resources as support in caring for dementia, followed by personal resources such as engaging in leisure activities and having access to information.

> *EFMU12: "The home care service comes for two hours a day, five days a week. And it does a lot, very, very well for me. It has been a huge relief. That help has saved my life."*
> *EFMU42: "Right now, we have her in a Day Center, which has really been a good, a good decision, so far. It has been a good thing."*
> *EFMU46: "This year I went to that relaxation course, which has been really helpful... to reconsider that you also have to have your own life."*
> *EFVU60: "One of the things I've thought about to avoid being overwhelmed by this situation is to keep my spaces, my tasks, my things... even if it's minimal, because if I only focus on them, I'll end up in a bad place too."*

Life Integration of living with the Person with Dementia

An important aspect has been evaluating how the caregiver has integrated living with dementia into their daily life. Therefore, the feelings generated by the cohabitation situation with the person with dementia, as revealed during the interviews, were analysed.

According to the results obtained, the caregivers' feelings toward the person with dementia have been those of pity and resignation, followed by anger (Table 10).

Table 10. Feelings expressed by caregivers about the caregiving process

	Feelings expressed by caregivers about the caregiving process
Pity and resignation, n (%)	28 (46,7)
Disorientation and powerlessness, n (%)	9 (15)
Anxiety and fear, n (%)	9 (15)
Anger/Rage, n (%)	14 (23,3)
Total, n (%)	60 (100)

Source: Own elaboration.

> *EFMR11: "It made me feel sorry, my mother made me feel very sorry and... I was, well, all of that, taking care of her."*
> *EFMU12: "You find yourself a bit lost, honestly, you're a bit lost because you're not prepared for this."*

> *EFMU49: "Very desperate."*
> *EFVU60: "A little helpless."*
> *EFOMU42: "Sometimes angry, I get really angry."*
> *EFMU046: "It's frustrating, it makes you angry because everything has to depend on... them, I don't know... on their illness."*

Regarding the management of the living situation, the individuals interviewed have stated that they have managed the situation adequately. However, 46.7% have expressed that the management has been unstable or directly negative (Table 11).

Table 11. Assessment of the caregivers' handling of the situation

	Assessment of the caregivers' handling of the situation
Negative, n (%)	9 (15)
Doubtful, n (%)	19 (31,7)
Positive, n (%)	32 (53,3)
Total, n (%)	60 (100)

Source: Own elaboration.

> *EFMU11: "I don't know, I don't know. I think not, that I didn't handle it well."*
> *EFVU60: "Managing is a lot, rather, she manages you, and you just follow trying to respond to what is happening."*
> *EFMSR44: "There are times when I wake up many days and think, 'I'm doing everything well, everything is going well!' and other times when things don't work out."*

According to the results obtained from the interviews conducted, the life satisfaction of the caregivers has largely been regular or poor (Table 12). They particularly mentioned feelings of constraints, lack of freedom, and sadness.

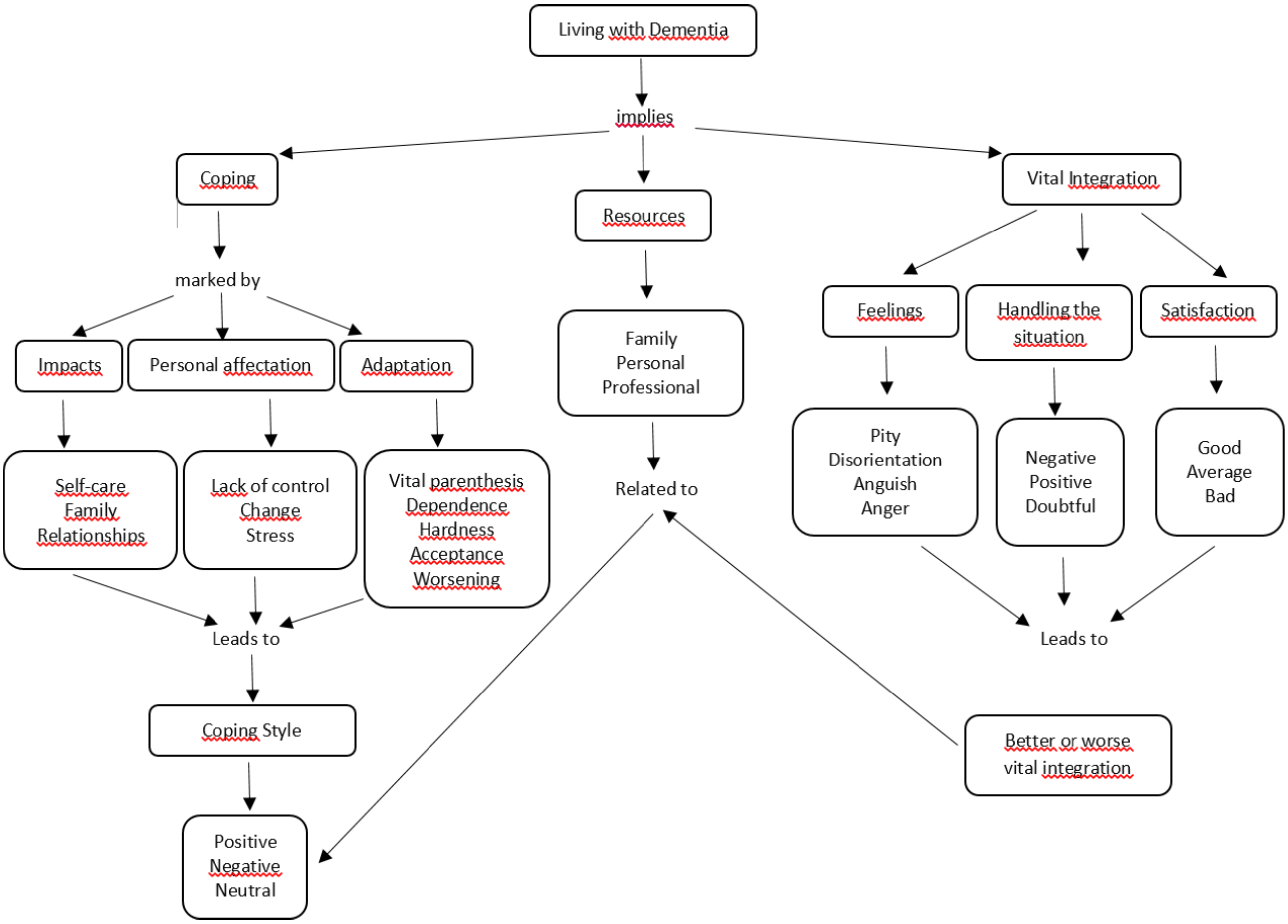
Table 12. Assessment of life satisfaction as perceived by caregivers

	Assessment of life satisfaction as perceived by caregivers
Good, n (%)	22 (36,7)
Regular, n (%)	23 (38,3)
Poor, n (%)	15 (25)
Total, n (%)	60 (100)

Source: Own elaboration.

In the following conceptual map in Figure 2, the interrelation of the categories and subcategories emerging from the qualitative analysis can be observed.

Figure 2. Conceptual map of the interrelation between categories and themes emerged from the qualitative analysis.



Source: Own elaboration.

Equivalence of Quantitative and Qualitative Results

For the triangulation of results, equivalences between the qualitative and quantitative data have been established (Table 13).

Table 13. Correspondences between qualitative and quantitative data in relation to the concepts derived from the analysis of interviews

Concepts derived from the analysis of interview data	**Equivalence of qualitative data**	**Equivalence of quantitative data**
Inadequate health care, fatigue, and psychological stress	Evolution of the Process *(Topic 1 – Interview)*	Health Care (Section I PAIS-SR)
Duties, difficulties in cohabitation, and interdependence	Changes Related to Illness and Integration *(Topics 2 and 4 – Interview)*	Domestic Environment (Section III PAIS-SR)
Deterioration of family relationships	Changes Related to Illness and Influencing Factors *(Topics 2 and 5 – Interview*	Family Relationships (Section V PAIS-SR)
Lack of freedom, suspended life	Progression of the Illness Process and Disease-Related Changes (*Topics* 1 and 2 – Interview)	Social Relationships (Section VI PAIS-SR)
Feelings of pity, resignation, helplessness, anger, rage, distress, and fear	Acceptance, Adaptation, and Integration of the Illness (*Topic* 4)	Psychological Distress (Section VII PAIS-SR)

Concepts derived from the analysis of interview data	**Equivalence of qualitative data**	**Equivalence of quantitative data**
Negative coping and adaptation	Illness-Related Alternatives and Integration (*Topics* 3 and 4)	Psychosocial Adjustment (Total Score PAIS-SR)
Moderate to poor life satisfaction	Life Satisfaction (*Topic* 8)	Quality of Life (QQL-AD Questionnaire)

Source: Own elaboration.

Subsequently, percentage equivalencies were calculated in relation to the concepts that emerged from the interviews and their frequency of occurrence across the different topics and sections of the questionnaires, in order to assess their incidence and similarity in both quantitative and qualitative data types (Table 14).

Table 14. Equivalence between Terms or Concepts Emerging from the Interview Analysis and Their Percentage Correspondences as Measured in the Qualitative and Quantitative Data Analysis

Concepts Emerging from the Interview Analysis	**Equivalence of qualitative data %**	**Equivalence of quantitative data %**
Poor health care, exhaustion, and stress	35	50,90
Obligations, difficult coexistence, and interdependence	38,4	54,67
Deterioration of family relationships	65	59,40
Lack of freedom, suspended life	51,7	72
Feelings of pity, resignation, helplessness, anger, rage, distress, and fear	46,7	43,63
Negative coping and adaptation	40	35,25
Moderate or poor life satisfaction	58,3	50,67

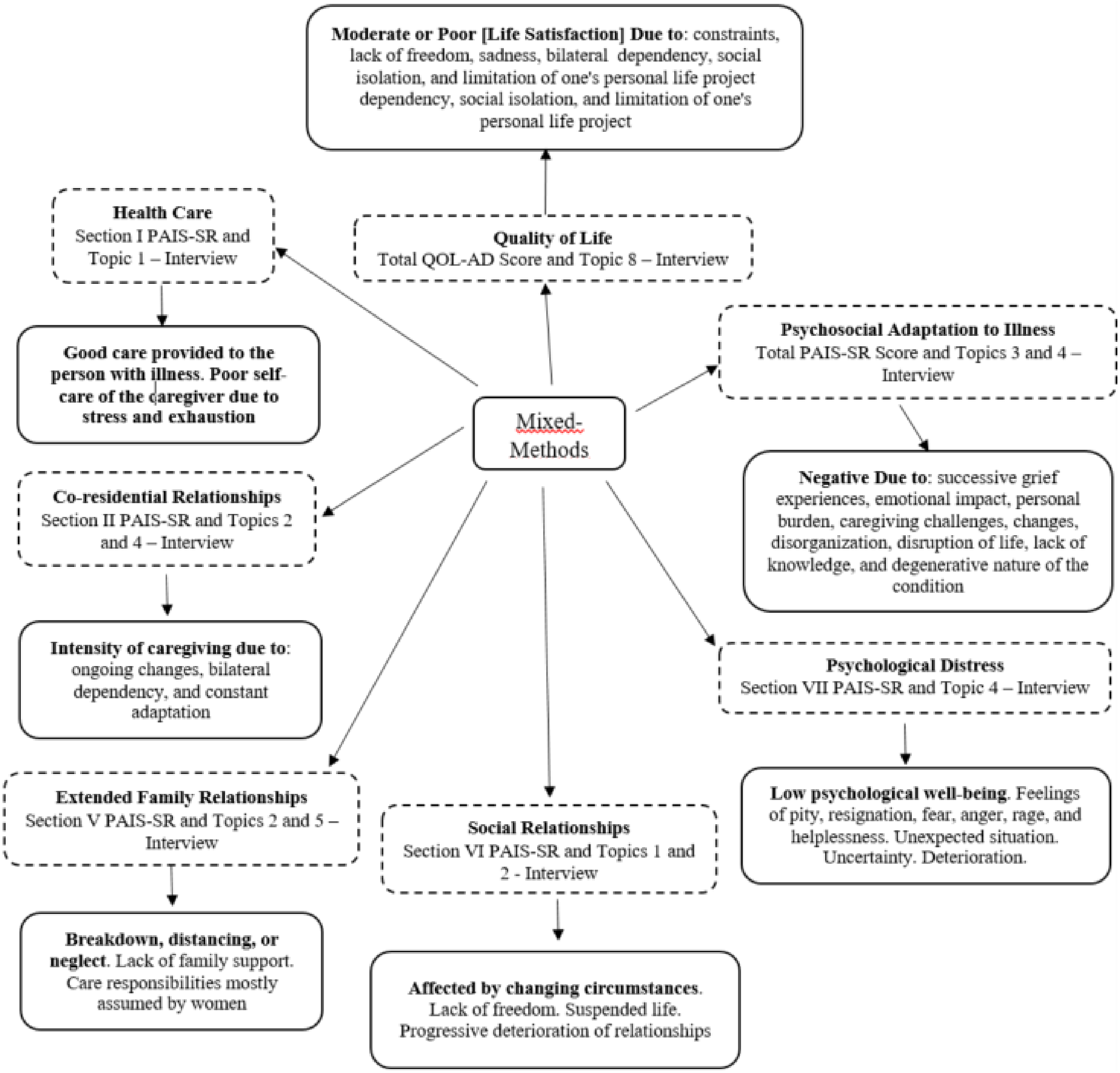
Source: Own elaboration.

By triangulating the results from the different sections of the PAIS-SR questionnaire and the QOL-AD questionnaire with the qualitative data from the semi-structured interview, it can be observed that they significantly correlate in both parameters:

1. Health care (Section I PAIS-SR and Topic 1 Interview).
2. Co-habitation relationships (Section II PAIS-SR and Topics 2 and 4 Interview).
3. Family relationships (Section V PAIS-SR and Topics 2 and 5 Interview).
4. Social relationships (Section VI PAIS-SR and Topics 1 and 2 Interview).
5. Psychological distress (Section VII PAIS-SR and Topic 4 Interview).
6. Psychosocial adaptation to the disease (Total PAIS-SR and Topics 3 and 4 Interview).
7. Overall quality of life (QOL-AD Questionnaire and Topic 8 Interview).

Figure 3 highlights the key points of the triangulation process:

Figure 3. Conceptual Map of the Key Points Identified in the Triangulation Process of the Mixed-Methods Methodology



Source: Own elaboration.

Finally, it can be stated that the profile defined through the quantitative data is corroborated by the qualitative data, since, as indicated in the triangulation, the integration of both data converged on the same aspects and results.

Conclusions and Discussion

In Social Work and other social sciences related to social and family intervention, the triangulation method is useful and precise for addressing family models and interpersonal interaction. However, authors such as Kurten, Brimmel, Klein, and Hutter (2022) observe in their analysis of 1,406 articles published in the *European Journal of Social Work*, *British Journal of Social Work*, and *Research on Social Work Practice* between 2016 and 2020, that only 6% use combined methodology. This is an issue that impacts the ability to provide integrated meaning to the obtained data.

Given the complexity of the social fabric and the coexistence of individuals, triangulation in the social sciences explains the richness of human behavior (Cohen, Manion, and Morrison, 2003) and establishes regularities in research data (O'Donoghue and Punch, 2003), as observed in the process carried out and the results obtained. This study has contributed to the development of combined methodology in the field of Social Sciences, particularly Social Work, providing a complementary perspective on a current issue and helping to establish the scientific knowledge base for practical application through a multidisciplinary intervention team project for context-based care.

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