Gender Differences in Caregiving Role Strain Among Spouse Caregivers to Frail Older Persons

by

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I would like to dedicate this thesis to my grandmother, Myrtle M. Voris. I hope to grow old as she has.

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Chapter I

This study focuses on the gender of spouse caregivers to impaired older persons and caregiving role strain. The central question to be addressed is: Do elderly husbands or wives perceive more caregiving role strain when caring for their spouse in the home? When elderly persons need assistance to stay in their homes, a majority of this help is provided by their family (Shanas, 1979). This has come to be known as family caregiving. It has been found that caregiving is not performed without consequences. Some of these consequences are negative and have been addressed in the literature (Cantor, 1983; Montgomery, Gonyea, & Hooyman, 1985; Poulshock & Deimling, 1984; Robinson, 1983; Worcester & Quayhagen, 1983; Zarit, Reever, & Bach-Peterson, 1980). Existing studies of the negative consequences of caregiving focus predominantly on wives and daughters because they are the most frequent providers of care. Research on male caregivers, especially elderly husbands, is sparse.

As the elderly population grows, the number of older persons who will need caregiving assistance will increase. Because of the decreasing birth rate and an increase in the number of women employed outside the home, there will be fewer family members available to provide this assistance (Treas, 1977). In light of these demographic trends, one can predict that the number of elderly spouses providing care will increase, warranting additional research attention.

Being male or female determines how one is socialized. The socialization of women in our society prepares them to be caregivers, and society reinforces women's caregiving role throughout their

lifetime. Male socialization generally does not include this caregiving preparation. This assumption, based on the socialization literature, leads to the hypothesis that husbands will perceive more caregiving role strain in performing the caregiving role than wives because they have not been prepared for the role. The perception of caregiving role strain among elderly husbands and wives is the major variable of interest in this study. Because gender and its socialization may have an effect on the nature of the caregiving role performed, and the nature of the caregiving role may effect caregiving role strain, the nature of the role is of interest as an independent and an intervening variable. For this study the nature of the caregiving role will be studied as an intervening variable only.

Knowledge of gender as a variable in caregiving role strain will assist nurses in formulating and targeting appropriate and effective interventions to decrease this caregiving role strain. Interventions to assist family members who are caring for impaired elderly are vital as our health care system strives to keep the ill and elderly in the community.

Review of the Literature

This review of the literature addresses caregiving role strain, the perceived difficulty in fulfilling the caregiving role, among men and women. The nature of the caregiving role, what and how much is done in performing the role, is addressed as an intervening variable between gender and caregiving role strain. Elderly spouse caregivers are the focus of this study, but a review of what is known about strain and nature of the role of other family caregivers has been included due to the scarcity of literature on elderly spouses.

The literature regarding caregiving by families will be briefly reviewed. Then, a study of sex-role self concept in young children and two studies of sex-role acquisition based on the social learning theory will be presented. This will be followed by the main portion of the review which focuses on literature addressing gender differences among family caregivers and role strain. Some pertinent demographic trends will be discussed. What is known about gender and the nature of the caregiving role will be presented and considerable attention will be given to the measurement of caregiving strain.

Family Assistance to Older Persons

Family caregiving occurs when an older family member can no longer perform all the necessary tasks of daily living for him or herself and another person steps in to provide assistance with those tasks. The family provides a major portion of the assistance needed by older people. Shanas (1960) conducted a survey about older persons using a regional probability sample. The design of this study resembled that of the U.S. Census Bureau's population survey. Shanas found that, contrary to popular belief, the American family had not abandoned its elderly members. In this study of 1,734 randomly selected persons 65 and over, and 2,507 randomly selected persons 21 and over, Shanas found that assistance from children increased as the health needs of the older person increased.

In another probability survey of noninstitutionalized elderly, Shanas (1979) documented that a majority of ill and frail elderly in 1975 were living in their own homes or in the homes of family. A substantial portion of elderly in the United States require some type of assistance to stay out of institutions and this assistance is

provided by the family (Shanas, 1979).

These family caregivers bring their gender and the attitudes and behaviors that they have been socialized to possess to the caregiving role. Because men and women are socialized differently, there may be a difference in how they perceive caregiving role strain. Gender socialization may also have an effect on the nature of the role they perform and this may influence their perception of caregiving role strain as well. The gender of the spouse caregiver and its effect on caregiving role strain are the variables of interest in this study. The nature of the role, only as an intervening variable, is of interest as well.

Social Learning Theory and Sex-role Acquisition

In order to understand how gender differences influence the nature of the caregiving role and caregiving role strain, the origin of sex-role acquisition must be examined. In our society men have traditionally been socialized to be independent, autonomous, and the economic provider. Women have traditionally been socialized to be nurturant, supportive, and maternal. Although this traditional socialization may be changing, the population of interest in this study was socialized toward the end of the Victorian era and for the most part have been socialized in the traditional manner. Concern for sex-role stereotyping and its influence on behavior was not a major issue during the childhood socialization of this sample.

There are a variety of theories of sex-role acquisition. Each of the theories have some empirical support, however no one theory can account for all the data and phenomena. A truly comprehensive sex-role acquisition theory would contain elements of all the theories. For

the present study the social learning theory was selected to explain sex-role acquisition as it is the most traditional and probably the most widely accepted of the theories. The theory is based on experimentally verified principles of learning (Mussen, 1969).

This section focuses on social learning theory and sex-role acquisition. Children are socialized into their appropriate sex-roles early in their lives. This was well illustrated in a study by Fauls and Smith (1956), who measured the sex-role self concept of five year olds and their perception of appropriate sex-role activity by the definition of their parents. A sample of 20 boys and 18 girls from middle class families living in the same county were selected for the study. The sex and age of siblings were controlled by selection. A picture interview technique was used. Fauls and Smith found that five year old boys and girls clearly identified with the appropriate sex-role. It is well documented in the literature that children behave in sex appropriate ways and sense that their parents want them to behave in these ways at a very early age.

There is ample evidence that the mechanisms of reinforcement, observation, and imitation shape behavior. The literature in this area is vast and this review will be limited to two classic studies that illustrate children learning their sex-roles.

In a study by Bandura, Ross, and Ross (1961), 72 preschoolers were assigned to one of three experimental conditions. One group viewed an aggressive adult model hitting a Bobo doll, a second group viewed inhibited non-aggressive models, and a control group had no exposure to models. Half of the subjects viewed same-sexed models, the other half viewed opposite-sex models. The subjects were tested

for the amount of nonimitated and imitated aggression without models in a new situation. Bandura et al. found that preschoolers who viewed the aggressive model performed significantly more aggressive behavior, that was unique to the model, than those in the other group. This study illustrates learning by imitation. Spontaneous comments made by the boys demonstrated that they felt this aggressive behavior was inappropriate for the females. Comments by the boys and girls demonstrated their approval of this same behavior for males (Bandura et al.). Even at the preschool level these children sensed what was appropriate male and female behavior.

Wolf's (1975) study reflected learning via reinforcement, observation, and imitation. In this 2x2x3 factorial design study, children illustrated their willingness to imitate the behaviors of same sexed models. A sample of 70 boys and 70 girls, randomly assigned to the treatment conditions, were shown video tapes of children modeling play with sex designated toys and then were observed playing. Wolf found that girls were more willing to touch sex inappropriate toys than boys. This was especially true if the child in the film was female and if the girl was not punished for playing with sex inappropriate toys. Boys played with a sex inappropriate toy less. This was especially true when they had seen the boy in the film punished for doing so and more so if they had seen a girl playing with the toy in the film. It should be mentioned that the sample was a nonprobability homogeneous population and four of the modeled responses in the female films could be considered appropriate male activity while none of the modeled male toy responses were considered appropriate for females (Wolf). This study is of particular interest

because it supports the social learning theory of sex-role acquisition by illustrating the effect of situational variables on social behavior.

The literature regarding sex-role acquisition has focused on children because most theories agree that sex-role identity is established in childhood. There is a body of literature that addresses a reversal of sex-roles during old age. Studies have shown that older women become more tolerant of the egocentric impulses and aggression while older men become more tolerant of their nurturant feelings (Gutmann, 1977).

The role reversal in old age is illustrated in a classic study performed by Neugarten and Gutmann (1958). The Thematic Appreception Technique was used on a subsample of 131 men and women ranging in age from 40 to 70. The larger group was a random sample drawn by area-probability technique stratified by sex, age, and socioeconomic status. The picture used in this study was of four adults, an older couple and a younger couple. The subjects were asked to tell a story about the picture. Neugarten and Gutmann found that the 40 to 54 age group felt the old man was an authority figure. The 55 to 70 year old group felt that the old woman was in the dominant role and the old man was in a submissive role. Additional evidence of the fundamental sex-role change or unisex of old age is found in a cross-cultural, cross-national, cross-ethnic, and rural-urban review of the literature by Gutmann (1977).

It is not known if this fundamental change in sex-roles has an impact on caregiving role strain of elderly caregiving spouses. This unisex of old age does not change how men and women were socialized into their sex-roles early in their lives. Men were socialized to be

independent and autonomous via the social learning process of sex-role acquisition. Women were socialized to be nurturent and supportive via the social learning process of sex-role acquisition. "Societal expectations reinforce the role of mother as caregiver throughout her lifetime" (Crossman, London, & Barry, 1981, p. 466). The social roles of the male have not prepared him as well to care for the ill or to maintain a home. It could be more stressful for males to perform the more traditional female role of caregiving.

Family Relationships and Caregiving Role Strain

Caregiving role strain is the perceived difficulty in fulfilling the caregiving role. It is well documented in the literature that many caregivers who care for the impaired elderly experience negative consequences from performing the caregiving role. Role strain is one of the terms used in referring to these negative consequences of caregiving.

There is disagreement in the literature about who experiences more strain, caregiving spouses or caregiving children. Some see children, who have competing demands, more subject to caregiving strain. Others see elderly spouses, who frequently have health problems themselves, as more subject to strain. It is not the purpose of this review to settle this controversy so three studies with conflicting results will be presented.

Cantor (1983) conducted a descriptive study using a survey, panel design dealing with the impact of caregiving on caregiver's lives. The sample was a nonprobability sample of 111 low income elderly caregivers in New York City. Cantor found that the closer the bond between caregiver and care receiver, the more stressful the caregiving

experience. Cantor concluded that spouses may be the highest risk caregiving group. The validity and reliability of the material used in asking about stress was not established.

The purpose of an exploratory study by Johnson and Catalano (1981), was to compare social support systems of childless and nonchildless elderly. The sample was made up of 167 elderly white Protestants and Catholics who had been recently discharged from a hospital. Of these 167 elderly persons, 28 were childless. Measures of objective supports, quality of help received, and extent of strain were compared for spouse and child caregiving dyads. Content analysis of the subjective experiences was done on open-ended interviews of the persons involved. The investigators found that spouses provided more comprehensive care for a longer period of time with less strain as compared to adult children caregivers. It was the presence of a spouse not a child that prevented institutionalization (Johnson & Catalano).

Described in the measurement section of this paper is a study that also addresses this issue. Robinson (1983) found that the relationship of the caregiver to the care receiver was not significantly related to caregiving strain scores. These three studies illustrate the conflicting results of spouse and child caregiving strain studies.

Gender Differences in Caregiving Role Strain

Little is known about how gender influences caregiving role strain. Males make up only a small portion of caregivers as men have a higher incidence of chronic illness and a shorter life expectancy than women. Males more often take on the caregiving role only in the

absence of available others. Consequently, there are few studies of men in caregiving roles. However, several studies have reported gender differences in caregiving and these studies will be presented here. These studies include sons, daughters, wives, and husbands.

Caregiving Role Strain Among Sons and Daughters. A study that explored gender differences and caregiving strain was done on caregiving sons and daughters by Horowitz (1981). Horowitz performed structured interviews with 99 daughters and 32 sons focusing on caregiving involvement and consequences of caregiving when caring for elderly parents. Horowitz found that sons took on the caregiving role only when there was no female sibling alternative and that they perceive the caregiving experience as less stressful than daughters. This continued to be so even when consideration was given to the lesser involvement of sons. The greater stress experienced by daughters was not simply due to their greater involvement. It should be noted that sons received more assistance and support from their spouses than did daughters. This study suggests interesting gender differences in caregiving strain among sons and daughters.

Similar findings were obtained by Robinson and Thurnher (1979) in a study of the perception of 23 sons and 26 daughters caring for their parents. The subjects were drawn from a larger purposive sample in a west coast metropolitan area for a study of social and psychological changes across the adult life course. The initial interview was extensive consisting of rating scales, checklists, structured and open-ended questions. Follow up interviews on two occasions over five years consisted of open-ended questions regarding changes since the previous interview.

Robinson and Thurnher (1979) found that daughters more often perceived the caregiving situation as oppressive. The investigators attributed this to the higher emotional involvement of daughters. The validity and reliability of the interview questions were not established.

A consistent finding of these two studies is that daughters perceive more strain in the caregiving experience than sons. Although spouses, not sons and daughters, are the subjects of the present study, these findings suggest gender differences in the perception of caregiving role strain in an opposite direction to that suggested by the social learning theory and sex-role acquisition.

Caregiving Role Strain Among Wives. The purpose of a paper by Crossman, London, and Barry (1981) was to identify elderly wives caring for disabled husbands as caregivers at risk. Their clinical report described a community based long term care program which included education, respite care, and a support group for wives. Unfortunately, no measure was used before or after the program, so empirical evidence of the program's success was lacking. Only three out of 101 husbands were placed in nursing homes during the study period.

Fengler and Goodrich (1979) also studied a sample of caregiving wives. Their hypothesis was tested using a panel design survey with a nonprobability sample of 12 caregiving wives. They found that husbands and wives scored similarly on a test of life satisfaction, or morale. Wives who scored low on life satisfaction were married to husbands who also scored low on this instrument. The reverse was also found to be true. The validity and reliability of the instrument was

not established. A valuable part of this study was its identification of isolation, loneliness, economic difficulties, and role overload as frequently occurring problems of caregiving wives.

These early studies of caregiving contributed to our knowledge base by identifying some negative consequences of caregiving that were experienced by caregiving wives. Although these studies did not compare husband and wife caregivers, the studies clearly identified wives as caregivers who experience strain.

Caregiving Role Strain Among Spouses. Shanas (1979) found the spouse to be the most frequent provider of care to the bedfast elderly. It has been generally reported in the literature that spouses provide more comprehensive care for longer periods with less formal assistance than other types of caregivers. Spouses have been the focus of several studies, and those studies will be presented here. Unfortunately many of the studies that looked at spouses did not analyze the data according to gender.

Johnson (1983) measured the outcomes of care according to the relationship of the caregiver by analyzing the rate of institutionalization, the subjective dimension of the relationship, level of conflict, level of stress, and the attitudinal response of parent, spouse, and other relative caregivers. Structured and unstructured data were obtained from interviews with 167 families who had an elderly family member recently discharged from two hospitals. The interviews included the care receiver and/or the family caregiver. The subjects were all similar in race and religion to eliminate ethnicity as a variable. Unstructured data were double coded with an 80% agreement level.

Among Johnson's findings were some statistically significant gender differences between spouse caregivers (45% of the sample). Johnson reported that husband caregivers (1/3 of the spouse sample) experienced less strain, although it may be more accurate to say that they reported less strain as no description was given of the strain measurement. The lower strain scores reported by Johnson were thought to be due to the greater level of formal assistance that husband caregivers received (Johnson, 1983).

A study described in the measurement section of this paper performed by Zarit, Reever, and Bach-Peterson (1980) found the level of burden to be similar for husband and wife caregivers who cared for demented spouses.

Although somewhat conflicting, the literature indicates that spouse caregivers are subject to strain. Which caregiving spouse, the husband or wife is more subject to strain is largely unknown due to the lack of research on husband caregivers. Cantor (1983) said "only by decoupling the various groups of caregivers and examining their respective characteristics and strains can we provide intervention modalities which strengthen their individual capacities to assist the elderly in their care" (p. 597). The present study will contribute to the knowledge base in this area.

Gender and Nature of the Role. As described earlier in this paper, the literature indicates that some caregivers are more involved in performing the caregiving role than others. The nature of the role, or what and how much one does in performing the role, certainly has an effect on the caregiver's perception of role strain. The literature on gender and nature of the role will be presented here. This

literature includes sons, daughters, wives, and husbands.

Horowitz (1981), who reported less strain for caregiving sons, found that daughters provided more "hands on" service than sons. This included transportation, household chores, meal preparation, and personal care (i.e., grooming, dressing, and feeding). Assistance with financial management and dealing with bureaucratic organizations did not differ between sons and daughters, nor did the amount of emotional support given.

Horowitz (1981) also found that sons devoted considerably less time to parent caring as compared to daughters. Sons had a limited time and task commitment most often in the area of concrete assistance. Sons more often received help from their wives. Daughters were much less likely to have their husbands involved and appreciated them staying neutral in terms of their involvement with their parents.

Robinson and Thurnher (1979), who reported more caregiving role strain in daughters found that daughters were more often involved in providing complete care than were sons. Sons appeared to have more of an ability to distance themselves from their parents, emotionally and physically. Sons appeared to experience less guilt and more readily accept that they did not have the power to make their parents happier. They more frequently advised their wives not to be overly involved with their own parents. In the five year study period, Robinson and Thurnher found that sons reported they seldom felt responsible for the emotional well being of their parents.

Cantor (1983), who found more strain for female caregivers reported that spouses more than other types of caregivers were involved in providing personal care, shopping, cooking, and housework.

For many of the men this was a reversal of long established roles. Cantor found the females in her sample to be more concerned with the caring situation.

Johnson (1983), who reported less strain for caregiving husbands, found husbands more likely to seek formal assistance regarding care provision than wives. Johnson attributed this finding to the husbands low involvement in domestic activity. She suggested that shared functions between relatives may be more common when males are caregivers.

The nature of the role, what and how much one does, most certainly has an effect on the caregiver's perception of role strain. This will be further discussed in the conceptualization section of this paper.

Measurement of Strain

In order to examine the negative consequences of caregiving (e.g., stress, burden, strain, problems, or adverse effects) of the various types of caregivers, the measurement of these negative consequences must be possible. Currently there are two burden instruments reported in the literature. An instrument that measures degree of burden was developed by Zarit, Reever, and Bach-Peterson (1980), and an instrument that measures objective and subjective burden was developed by Montgomery, Gonyea, and Hooyman (1985). Poulshock and Deimling (1984) have also done research on the concept of burden. Cantor (1983) developed a stress instrument and Robinson (1983) developed a strain index screening tool. Worcester and Quayhagen (1983) adapted some of Lawton's material for a Caregiver Stress Scale. Each defines and measures its concepts differently and all of the instruments are still being subjected to validity and reliability testing. The research in

this area will be reviewed here and will illustrate the complexities of measuring the negative consequences of caregiving.

More methodological work has been done around the concept of burden. Zarit et al. (1980) performed a survey study on a nonrandomized sample of dementia patients to identify sources of burden. The Kahn Mental Status Questionnaire (MSQ), Face Hand Test (FHT), Jacob's et al. mental status test, and Lawton's Physical and Instrumental Activity of Daily Living Scales were administered to 58 caregivers and their care receivers. Only the validity of the MSQ and FHT were addressed in the report of this study. The degree of burden was measured with a 29-item self-report inventory that was based on prior studies and the clinical experience of the investigator. Of the variables considered, Zarit et al. found only the frequency of family visits to have a direct relationship to the caregiver's feeling of burden.

Burden was also the focus of a descriptive survey design study by Montgomery et al. (1985). They examined the relationship between caregiving experience and objective and subjective burden. The subjects were 80 caregivers, mostly adult children, residing in four counties. Objective burden, or the extent of changes in the caregiver's life, was measured using a five point, nine-item inventory. Cronbach's alpha on this inventory was .85. Subjective burden, or the caregiver's attitudes or emotional reactions to the caregiving experience, was measured with a five point, 13-item inventory adapted from the Zarit et al. (1980) inventory. The Cronbach's alpha on this inventory was .86. The extent of caregiving was also assessed.

It was found that income and age of the caregiver were the best

predictors of subjective burden and confining tasks the best predictor of objective burden. Montgomery et al. (1985) concluded that objective burden could be reduced with interventions, but that subjective burden is not likely to be decreased through interventions. The concept of burden and its measurement continues to be studied and discussed in the literature.

Poulshock and Deimling (1984) undertook a study to clarify the concept of caregiving burden. Their sample was purposefully chosen from the Benjamin Rose Institute Survey. The sample was made up of 614 families, half of which were spouses equally divided by gender. The subjects were interviewed using a structured interview schedule which measured elder impairment, effects of caregiving, and subjective burden. Correlational analysis and factor analytic models indicated the importance of differentiating the dimensions of impact, burden, and impairment. The report of this study suggested that the concept of burden refers to subjective perceptions of the caregivers as they relate to the degree of problems regarding mental and physical capability of the care receiver. Poulshock and Deimling also suggested that subjective burden of the caregiver be treated as an intervening measure between impairment and objective caregiver effect indicators. Also suggested was that impact is a multidimensional concept that needs to be defined, and that the caregiver's state of mental health during the interview is reflected in all the measures, and therefore should be thought of as an intervening or antecedent variable.

To learn more about the stress of caregiving to frail elderly, Cantor (1983) asked questions about worry, strain, and the impact of

caregiving of a nonprobability sample of 111 caregivers and care receivers. Health, physical condition, mood, state of mind, finances, and assistance availability were included in the 4-point worry scale. A 3-point strain scale included emotional, physical, and financial concerns. The validity and reliability of these items were not established.

Robinson (1983) performed a panel design methodological study to validate questions used to detect strain in caregivers. Of the questions asked, 10 were identified in a previous survey study and 3 were formulated from a literature review. These questions were tested on 85 caregivers. Cronbach's alpha was calculated to assess internal consistency among the items and the reliability coefficient alpha was .86. Construct validity was examined by analyzing the relationship between a number of criterion variables and the Caregiver Strain Index score. Robinson concluded that this index could be used to predict caregivers at risk. It is a screening tool rather than a measurement instrument.

The stress scale used by Worcester and Quayhagen (1983) was not recommended for use (M.I. Worcester, personal communications, June 17, 1984). Worcester wrote that the instrument was in a rough form only. The author's methodological work on stress/strain also continues.

The negative effects of caregiving to the frail elderly are so complex that measurement of these effects is extremely difficult. So many concepts and aspects are present and interacting that accurate measurement of each concept is probably beyond the endurance of the elderly caregiver. The search for a valid and reliable instrument of reasonable length is ongoing.

As there is no existing specific measure of caregiving role strain and current instruments have some methodological problems, the instrument to be used in this study is an interview schedule developed by Archbold and Stewart (1985). This caregiver interview schedule draws from the literature and the existing instruments as well as the clinical experience of the investigators. It measures many dimensions of 18 constructs, one of which is caregiving role strain. The interview schedule is made up of fixed response and open-ended questions. The instrument was reviewed by a panel of experts for construct fit, coverage, and clarity. The data for this study will be obtained from the pilot study of this instrument.

Conclusion

The family is the major source of support for the elderly in times of need and the spouse is a frequent provider of that care. Caregiving wives have been identified as an at risk population of caregivers. Husbands as caregivers have had little attention in the literature. Caregiving can have negative consequences or role strain, especially for spouse caregivers who are usually old and may also have poor health. It is not clear whether there are differences in caregiving role strain based on the gender of spouse caregivers.

Women traditionally, have been socialized via the social learning process into dependent, nurturant roles. Societal expectations reinforce the female role as caregiver even into old age. Men have traditionally been socialized into independent and autonomous roles. The social role of the elderly husband may have left him less prepared to care for an ill wife and maintain a home. Although there is evidence that suggests a sex-role reversal in old age, a male taking

over the female role of caregiving may be subject to more role strain because he has not been socialized to be a caregiver. The problem of exploring this strain is compounded in that there is no ideal instrument to measure caregiving role strain. This study will examine the relationship between gender and caregiving role strain experienced when caring for an elderly spouse in the home. In doing so, one must consider the relationship of gender to nature of the role and the relationship of nature of the role to role strain.

Conceptual Framework

The conceptual framework for this study is based on role theory and gender socialization. Figure 1 shows the hypothetical relationships among gender, socialization, nature of the role, and caregiving role strain. More specifically, gender and its socialization may affect what and how much is done in performing the caregiving role, and how elderly husband and wife caregivers perceive caregiving role strain. This study focuses specifically on the impact that gender and its socialization may have on caregiving role strain of elderly caregiving spouses. The nature of the role is an intervening variable, as well as a variable that may be directly effected by gender. In this study, it will be studied only as an intervening variable.

To understand if there is a relationship between gender and perceived role strain for family caregivers to impaired older persons, gender or sex-role acquisition must be understood. The reader is referred to Wesley and Wesley (1977), for a review of studies that document parents sex typing their children at the moment of birth. These studies show that the description and treatment parents give to

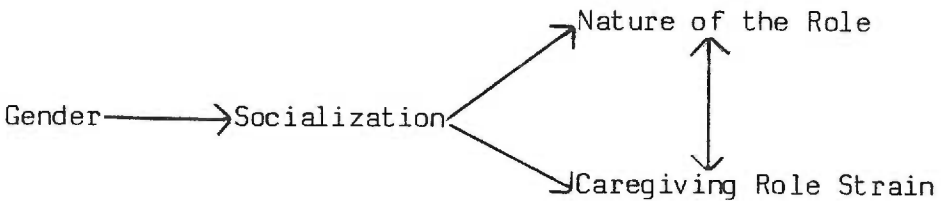

Figure 1. Proposed relationship of gender, socialization, nature of the role, and caregiving role strain.

their newborns is based on preconceived ideas of feminity or masculinity. In their review of the literature, Wesley and Wesley demonstrate that the stereotyping of sex-roles is apparent in many behaviors and attitudes during our life time. This may be changing as people become more aware of sex stereotyping and its effects, but the elderly population in this study have probably experienced the traditional sex-role socialization that is described in the literature.

The present study is based on a conceptualization which includes the social learning theory of sex-role acquisition and various aspects of role theory. Males and females are treated differently from the moment of birth. Generally females are socialized into nurturant, supportive, and maternal roles. These are the characteristics of caregiving roles. Males are usually socialized into independent, autonomous, and economic providing roles. These gender differences in socialization may have an influence on the nature of the role performed by men and women and how they perceive strain in the caregiving role.

Social Learning Theory of Sex-role Acquisition

There are several theories of sex-role acquisition. The theories differ in their ideas about the effects of family, the child, culture, and biology. There are some contrasting views regarding the age that sex-role identity becomes established, but most theories agree that sex-role identity becomes established in a child's preschool years (Brooks-Gunn & Matthews, 1979). In this study, social learning theory will be used to explain sex-role acquisition. Social learning theory views external forces upon children as very influential in the

acquisition of sex-roles. In other words, social learning theorists see sex-role identity as less inevitable, more flexible, and more dependent on the situation rather than genetically determined (Brooks-Gunn & Matthews, 1979). Social learning theory views human behavior as a continuous and reciprocal interaction between behavioral, cognitive, and environmental factors (Bandura, 1977). This theory uses learning principles to explain the acquisition of sex-roles, the most important of which are reinforcement, observation, and imitation (Brooks-Gunn & Matthews, 1979).

Reinforcement encourages or discourages behavior using rewards or punishments. In our society, girls are typically rewarded for showing sensitivity, weakness, and dependence, while boys are rewarded for bravery and independence. Children also learn by watching others. A child learns how and by whom things are done and what the consequences of behavior are by observation. Children observe their parents modeling their own sex-roles in everyday life. The child practices or imitates what he or she has learned and that behavior becomes his or her own (Brooks-Gunn & Matthews, 1979).

Children acquire their sex-roles by selectively observing those whom they share their boyhood or girlhood with and then imitate what they have observed with the intent on maximizing their rewards. A child wants rewards and finds that he or she is rewarded for doing male or female things; consequently he or she wants, and thus acquires, those behaviors and the corresponding sex-role identity. Figure 2 represents the relationships among gender, social learning theory, and adoption of sex-roles. It does not take a young boy long to figure out

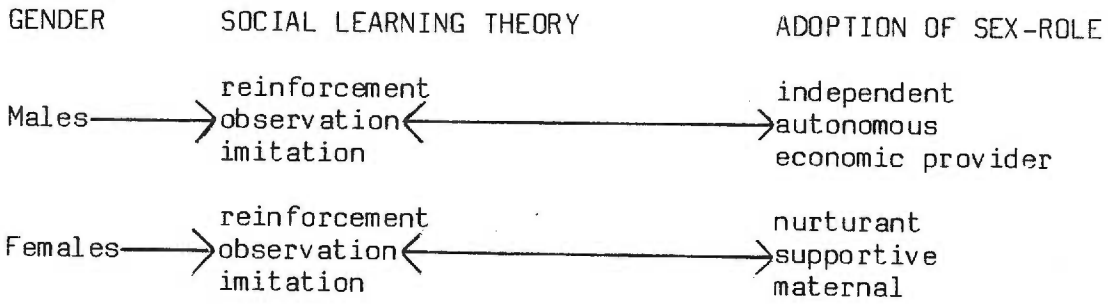

Figure 2. Sex-role acquisition representation.

that he is not supposed to cry if he has been scorned for doing so and has never seen his father cry. The sex-role characteristics displayed by children in this society reflect the sex typing of the culture (Brooks-Gunn & Matthews, 1979).

Male and female traits are acquired not only genetically, but through socialization and the environment. The social learning theory explains the adoption of male and female traits or sex-role acquisition using the learning principles of reinforcement, observation, and imitation. Although gender does not change, there is some evidence in the literature that sex-roles reverse during old age. There are several theories that suggest why this reversal occurs. None of these theories has won universal acceptance. It is not known if this reversal of sex-roles has an impact on caregiving role strain. Gender does not change and the socialization that accompanies gender has already occurred. Gender and its socialization may differentially influence the nature of the caregiving role and the perception of role strain for men and women.

Some of the consequences of caregiving for the caregiver are negative. Documentation of how these negative consequences may be differently perceived by men and women is not abundant in the literature, especially in terms of elderly spouses. Literature on the impact of role reversal is also scarce.

Gender and Socialization for Caregiving

Anticipatory socialization, as defined by Burr, Hill, Nye, and Reiss (1979), is the learning process that takes place for one to understand the attitudes, norms, values, and subtle dimensions of a

role before they actually perform the role. Generally women, by virtue of their socialization, have had anticipatory socialization and experience in the caregiving role prior to old age. They have had repeated opportunities to observe others and perhaps have performed the caregiving role themselves. They understand the values and norms that go along with that role by having observed role models and by practicing and performing these behaviors. An illustration would be a young girl having observed her mother caring for an ill brother or sister and then that child caring for her "ill" doll. In most cases males have not had this anticipatory preparation or experience in the caregiving role during their socialization.

In summary, women have knowledge about the caregiving role before entering the role. Generally, men have not had this anticipatory socialization for caregiving. This difference in socialization of men and women may have a relationship to the nature of the caregiving role that they provide and their perception of role strain. From this perspective one would expect that men would perceive greater caregiving role strain than women in performing the caregiving role.

Socialization and Nature of the Caregiving Role

The nature of the caregiving role is what and how much is done in performing the caregiving role. For example, one caregiver may shampoo the care receiver's hair as part of the caregiving role while another may arrange for someone else to do the shampooing.

Because of the different socialization based on gender, men and women may not be equally prepared to fulfill the caregiving role. Women, the traditional caregivers of our society, have had

socialization for the caregiving role which may have an effect on the nature of the caregiving role that they provide. Men, traditionally have not had socialization for the caregiving role which may influence the nature of the caregiving role that they provide. Past experience and knowledge of the caregiving role may affect the nature of the role. For example, the nature of a role would differ for a long time employee as compared to someone on their first day on the job. Therefore one could conclude that the nature of the caregiving role would be different for men and women.

Caregiving and Role Strain

The theory of role strain is a middle range theory based on common sense and logic (Burr et al., 1979) that is applicable to the caregiving situation. Role strain, stated in Burr et al., is felt difficulty in performing obligations associated with a role. Role strain is the stress created in a person when he or she has difficulty complying with the expectations associated with a role. Roles are integrated sets of social norms (beliefs about how we should behave), that can be recognized as being separate from other sets of norms that make up other roles (Burr et al.). This theory describes negative consequences of performing a role applicable to the caregiving situation.

Socialization and Caregiving Role Strain

It is postulated that gender and its socialization has a relationship to caregiver role strain. Women have had socialization for the caregiving role and would have less difficulty performing the role and complying with the expectations associated with the role.

Consequently, women would experience less role strain. Men, not having had this anticipatory socialization would have more difficulty in performing the role and complying with the caregiving role expectations. Considering role strain theory in terms of the different socialization of the genders, one concludes that men would perceive more role strain in performing the caregiving role than women.

Nature of the Role and Role Strain

Intuitively it seems that what and how much is done in performing the caregiving role, nature of the role, would have an effect on the caregiver's perception of role strain. Although the extent of the relationship between nature of the role and caregiving role strain is not known, it seems logical that nature of the role has an interacting relationship with caregiving role strain. For example, the caregiver who does the shampooing could experience more role strain than the caregiver who arranges for someone else to do the shampoo. The caregiver who does the shampooing and experiences more role strain may then arrange for someone else to perform this task changing the nature of the role. These two variables are interactive.

Summary

Men and women are socialized by the process of social learning to adopt male or female behaviors. Women in our society have had socialization for the caregiving role. Traditional male socialization has not included caregiving. When the elderly are striken with the dependencies of old age, the spouse is the most likely person to provide care. Based on the conceptualization described above, it is expected that the difference in socialization of men and women may have

a relationship to the nature of the caregiving role. It is also expected that the different socialization of men and women has a relationship to caregiving role strain. One also expects caregiving role strain and nature of the role to be related as well.

Conclusion

The exact relationships among gender, socialization, nature of the role, and role strain are not known. Since gender socialization differs, one can speculate that the nature of the role differs for husbands and wives and therefore their perception of role strain differs as well. Based on the conceptualization presented here it is hypothesized that women, with their greater socialization to caregiving roles, would experience less role strain than men who have had little if any preparation for the caregiving role. It is not known if gender is related to nature of the role, but surely nature of the role has an effect on caregiver role strain. The nature of the caregiving role has been found to be different among sons and daughters and caregiving role strain has been found to differ as well. This study will contribute knowledge about the relationships between and among the nature of the caregiving role, role strain, and gender of elderly spouses, an area of research inadequately explored in previous literature.

Chapter II

Methods

Sampling Plan

The subjects for this study came from a sample of 50 caregivers and their care receivers which provided the data for the pretest of an instrument to be used in a study funded by the Division of Nursing, U.S. Public Health Service, entitled "The effects of organized caregiver relief" (Archbold & Stewart, 1985). A subsample of 36 spouses from the pretest sample was used for the present study and includes 20 wives and 16 husbands who are 60 and older. The remainder of the pretest sample was made up of other relatives or friends. A nonprobability sample was obtained to represent a broad range of intensities of caregiving situations. The level of impairment of the care receiver varied from mildly to severely impaired.

The sample was obtained from a Parkinson Clinic that is associated with a local teaching hospital and from recipients of home care from a large health maintenance organization (HMO). The Human Subjects Committee from both institutions approved the study. The Parkinsons Clinic clients received a letter from the nurse practitioner which briefly described the study and invited them to participate by calling one of the principal investigators. A sponsor in the HMO institution served as a contact person and through this sponsor information about the study and the needed subjects was given to the home care staff. The staff then identified potential subjects who were approached by a research assistant. The research assistant invited them in a phone call to participate in the study. The content of that phone

conversation will be described in the procedure section of this paper.

Research Design

This study is descriptive in nature and uses a correlational design. Data were obtained in structured interviews with caregivers and care receivers. The interviews were conducted by one psychologist and five nurse interviewers who interviewed the subjects in pairs. They used a face-to-face structured interview schedule with fixed response and open-ended questions. Interviewer reliability checks were made by comparing the responses of all six interviewers to a taped interview performed by one of the principal investigators.

Measures

For most of the concepts of interest in this study, there are no existing measures having adequate reliability and validity. The interview instrument used in this study, developed by Archbold and Stewart (1985), is based upon the caregiving literature, the conceptual framework for the funded study, existing instruments, responses of 17 caregivers to open-ended interviews, and the clinical experience of the investigators.

Overall the interview instrument contains previously developed standardized composite scales, selected items from existing instruments, and new measures developed for the study where no existing measures were available. The interview for the caregiver was made up of 114 questions and took approximately two hours to complete. The data obtained from specific questions relating to the hypothesis of this study were used in the data analysis.

A pilot testing of the pretest instrument was conducted with eight

caregivers. The pretest used data from 50 family caregivers. Scales were created for the instrument and were analyzed using standard item analysis procedures. Each scale measured a given caregiving variable or dimension of a concept. Table 1 lists the subscales measuring the nature of the role and role strain associated with specific tasks. These were created from question eight of the instrument and show the items that make up each subscale. The responses to question eight provided the data for the present study. After inspection of the frequency distribution for all items was completed, the SPSS reliability program was used to compute Cronbach's coefficient alpha to evaluate the internal consistency of the scales.

Measures of Nature of the Role and Role Strain. Two of the variables of interest in the present study, caregiving role strain related to caregiving tasks and nature of the caregiving role, were measured in question eight of the instrument found in Appendix A. Gender, the third variable of interest, was measured by question 105 which asked the interviewer to indicate the gender of the caregiver, male or female, without asking if obvious or to check the records.

The nature of the caregiving role, or what and how much is done in performing the caregiving role, was measured using the responses to question eight, columns one and four in Appendix A. Caregiving role strain related to specific tasks was measured using responses to questions regarding how hard it was to do specific tasks.

Table 1

Subscales of the Nature of the Caregiving Role constructed from Question Eight

Items	Item Letter[a]
Personal Care	
Assist with bathing or washing	N
Clean up when care receiver soils him/herself	P
Assist with hair care and shampooing.	Q
Have to get up at night to help care receiver	V
Take care of care receiver's dentures	W
Assist with dressing and undressing	BB
Check care receiver's skin and apply lotions	II
Help care receiver to use the toilet or bedpan	PP
Managing Health and Social Service	
Contact health and social service agencies to see if their services are appropriate for care receiver	EE
Get someone from a health or social service agency to come to help care receiver	FF
Make sure that services from agencies continue to come.	GG
Housekeeping	
Do the laundry	F
Prepare or help prepare meals	R
Change dirty bed linens	NN
Clean up after meals	OO
Do light housekeeping for care receiver	VV
Handle Behavior Problems	
Have to handle care receiver's paranoia or suspiciousness.	I
Have to hand care receiver's behavior problem	O
Have to listen and answer repetitive questions	T
Have to watch care receiver in case he/she wanders off	U
Have to remind care receiver who and where he/she is	X
Little Extras	
Sit down and eat with care receiver	S
Read to him/her	HH
Watch television with him/her	MM
Hold care receiver's hand or be physically affectionate	RR
Medically Related	
Change bandages or dressings	A
Give medication or shots	G
Manage care receiver's pain	UU

Table 1 (cont.)

Items	Item Letter
Protection	
Make sure care receiver is safe	C
Assist with walking	D
Protect care receiver from falls	E
Check in on care receiver to make sure he/she is ok.	CC
Transportation	
Do shopping and errands	J
Transport to medical appointments	AA
Transport to friend's homes, meetings, & entertainment events	LL
Financial, Legal, and Health Decision Matters	
Make major decisions about health care	H
Help get legal matters attended to.	Y
Assist with banking and financial matters	DD
Assist with writing checks and paying bills	JJ
Assist in completing necessary forms such as taxes, medicare, social security, or insurance	QQ
Make major financial decisions	SS
Miscellaneous	
Help use the telephone	B
Accompany care receiver on shopping and errands	K
Sit and spend time with care receiver	L
Arrange for care receiver to visit friends.	Z
Items that were Omitted	
Iron and/or mend clothing	M
Fix things and do odd jobs to maintain care receiver's separate dwelling	KK
Manage care receiver's hearing problems	TT

Note: Item letters represent the letter of the item as it appears on the instrument which is located in Appendix A.

The questions which addressed this issue are in columns two and five, located in appendix A.

Table 2 contains the internal consistency reliabilities of the scales created from question eight of the interview schedule. These scales measure the nature of the caregiving role and caregiving role strain for each of eight types of caregiving activities and for miscellaneous and overall categories. The nature of the role and caregiving role strain was divided into direct care role and managed care role. This differentiated caregivers who provided the needed activities themselves from those who had others providing needed activities.

Each of the scales measuring nature of the caregiving role was computed by averaging the no/yes (0/1) responses to the caregiving activities included in that scale. The potential range of scores was .00 to 1.00, reflecting for each scale the proportion of activities that was done by the caregiver. If a caregiver had missing data on one or more activities for a given scale, an average score was computed based on the activities for which valid responses were recorded. This was done as long as the caregiver had valid responses for at least three-fourths of the activities.

The scales that measured caregiving role strain, created from question eight of the caregiver interview, were analyzed using three different methods to yield three different versions of the scales. On version one the caregiver received: a zero when he or she did not perform an activity, 1 if he or she did perform the activity and said

Table 2

Internal Consistency Reliability for Scales Measuring Nature of the Caregiving Role and Caregiving Role Strain

Scale	Direct Care Role	Managed Care Role
Nature of the Role		
Personal care	.81	.78
Managing health and Social Service	DNA[a]	.73
Housekeeping	.87	.05
Handle behavior problems	.70	.13
Little extras	.58	.54
Medical	.21	-.05
Protection	.53	.56
Transportation	.58	.61
Finance/legal/health	.70	.11
Miscellaneous	.26	.15
Overall scale	.81	.54[b]

Scale	Direct Care Role		Managed Care Role	
	Version 1	Version 2	Version 1	Version 2
Caregiving Role Strain				
Personal care	.82	.77	.61	.32
Managing health & Social Service	DNA[a]	DNA[a]	.72	.68
Housekeeping	.80	.72	.24	.33
Handle behavior problems	.68	.64	.09	-.07
Little extras	.58	.48	.43	c
Medical	.35	.42	-.05	c
Protection	.57	.58	.16	-.06
Transportation	.46	.48	.53	.36
Financial/legal/health	.63	.59	-.08	-.11
Miscellaneous	.28	.19	-.03	0.07
Overall scale	.89	.90	.51[b]	.44[d]

Note. Internal consistency reliabilities were not computed for version three.

[a] DNA indicates that the scale did not apply.

[b] Reliability coefficient is based on only 28 of the 42 items because 14 items had zero variance.

[c] Did not compute, these items had zero variance.

[d] Reliability coefficient is based on only 18 of the 42 items because 24 items had zero variance.

it was easy, 2 if he or she performed the activity and said it was not too hard, 3 if he or she performed the activity and said it was pretty hard, and 4 if he or she performed the activity and said it was very hard. Scores on version one for each of the role strain scales were computed by averaging the 0 to 4 responses for the caregiving activities included in that scale. The potential range of scores for each scale was .00 to 4.00.

On version two of the scale, the truncated version, caregivers who did not perform the activity were assigned a score of one. The caregivers who did not perform the activity were given the same score as caregivers who did the activity and said it was easy. The scores on version two of the scales were computed by averaging and could range from 1.00 to 4.00.

The third version of the role strain scale is also an average. This version yields the average difficulty rating only for tasks a caregiver did. These scores could range from 1.00 to 4.00.

Frequencies were run for the scales measuring nature of the role, direct care and managed care roles. Frequencies were also run for direct and managed care roles for each of the three versions of the scales measuring caregiving role strain. The descriptive statistics are found in Appendix B.

Procedures

The respondents who expressed willingness to participate in the study, or were identified by the home care staff as potential subjects, were contacted by phone by one of the nurse interviewers. The interviewer introduced herself and the study and expressed appreciation

to the Parkinsons Clinic respondents for the caregiver and care receiver's willingness to participate. The potential subjects from the HMO were told that their home care nurse had identified them as possible subjects for a nursing study. It was explained to both groups that the caregiver and care receiver would be interviewed separately in their home by two nurse interviewers. The caregiver interview would last approximately two hours and the care receiver's interview would last about 30 minutes. When indicated, one of the nurse interviewers would stay with the care receiver to minimize worry on the part of the caregiver during the caregiver interview. It was made clear during the phone conversation that a consent form would need to be signed by both participants before the interview could take place and that either participant could end the interview at any time with no adverse consequences. Any questions about the consent form and the study were answered. A date and time for the interview was established at the convenience of the participants. The respondent's address and directions to the home were obtained. The principal investigator's phone number was given in case the appointment needed to be cancelled. A reminder call was made one day before the agreed upon appointment to confirm the interview.

Halfway through the interviewing process, the procedure was modified to include screening questions related to assistance needed by the care receiver in the initial phone call. The respondents were asked if the care receiver needed help with medication administration, walking, shopping, errands, bathing, shampooing, dressing, or household chores. If assistance were not needed in any of these areas,

the respondent was informed that they did not qualify for the present study. They were thanked and asked if they would like their names kept on file for inclusion in some future study. The sample was expanded with subjects obtained through personal contacts of the interviewers.

The interviewers, wearing mid range clothing, had picture identification cards to present upon arrival at the respondent's home. The consent forms (see Appendix C) were reviewed with the caregiver and care receiver and both signatures were obtained. No interview took place without a signed consent except in instances where the care receiver was not able to sign, but agreed to the interview. The caregiver signed for the care receiver in this situation. In situations where the care receiver was unable to participate or consent to the interview, only the caregiver signed the consent. Selected information was then obtained about the care receiver from the caregiver using a proxy interview. Any questions about the study and the interview were answered at this time.

The interviewer explained that separate interview locations were needed for the two interviews and a comfortable position for each was encouraged. The interviewers, nurses or a psychologist, assessed and monitored for symptoms of discomfort, distress, and fatigue throughout the interview. The interview was rescheduled when indicated and support was provided. In most cases the care receiver interview was completed before the caregiver interview. The nurse interviewer stayed with the care receiver until the caregiver interview was completed unless the condition of the care receiver was such that it was not necessary. In these situations, it was explained to the care receiver

that it would be some time before the caregiver interview would be completed and privacy needed to be maintained.

The interviewers attempted to obtain responses which corresponded with the response options for closed-ended questions, but noted when another response was preferred or when an answer was qualified. Items that were reread or rephrased were also noted. Difficulty in responding, confusion, changes in affect, and boredom were noted. Responses to open-ended questions were taken down verbatum when possible.

In most cases the coding and data entry were done by the interviewer who conducted the caregiver interview. Several support staff were trained to code and enter data and did so when necessary. Coding was verified as much as possible by the interviewers who performed the interview.

Analytic Strategies

Differences between husband and wife caregivers in the nature of the caregiving role and role strain were examined using t-tests. The nature of the role was taken into consideration in computing versions 2 and 3 of the role strain scales so that role strain would not simply be a reflection of the nature of the role.

Chapter III

Results and Discussion

The findings of the study will be discussed in this chapter. The sample will be described and the analysis and discussion of the hypothesis will follow.

Sample Description

The husband (N=16) and wife (N=20) caregivers in the sample were very similar. There were no statistically significant differences in age, educational level, number of years living together, number of years caregiving, number of health problems, health compared to others the same age, health compared to one year ago, ability to manage on income, and actual reported income between the husband and wife caregivers.

The mean age for the caregiving husbands was 73.44 years and 71.11 for caregiving wives. The ages ranged from 44 to 87 years with a mean of 73 years. The mean educational level for the husbands was 4.31 and 3.90 for the wives (3=attended high school, 4=completed high school, 5=post high school vocational training). Caregiving husbands lived with their wives a mean of 40.88 years, caregiving wives lived with their husbands a mean of 46.70 years. The range for both groups was from 9 to 62 years. The husbands had been caregiving a mean of 4.79 years and wives 5.96 years., The length of time caregiving ranged from 3 to 4 months to 25 years. Husbands reported a mean of 4.81 health problems and wives reported 5.55. Husbands reported a mean score of 3.19 on health compared to others of the same age and wives reported 3.05 (3=good, 4=excellent). Husbands reported a mean of 3.00 on health

compared to one year ago and wives 3.10 (3=about the same, 4=a little better). Husbands reported a mean of 3.25 on ability to manage on their incomes and wives reported a mean of 3.40 (3=I have enough with a little extra sometimes, 4=I always have money left over.) Husbands reported a mean of 4.87 on income and wives 4.78 (4-$10,000-$14,999, 5=$15,000-$24,999).

There were no statistically significant differences in age, health compared to others the same age, and health compared to one year ago for the care receivers as measured with a *t*-test. There was a statistically significant difference ($p=.03$) in the level of mobility of the care receivers. The care receiving wives were less mobile than care receiving husbands.

The care receiving husbands (N=16) had a mean age of 73.56 years and care receiving wives (N=20) 74.21 years. The age of the care receivers ranged from 44 to 89 years. Care receiving husbands reported a mean score of 2.20 and care receiving wives 2.35 on health compared to others of the same age (2=fair, 3=good). Care receiving husbands reported a mean score of 2.63 and care receiving wives 2.80 on health compared to a year ago (2=a little worse, 3=about the same). Care receiving husbands reported a mean score of 4.30 and care receiving wives a score of 3.31 on mobility (3=I need the help of another person in getting around inside or outside the house, 4=I need the help of some special aid in getting around inside or outside of the house, 5=I do not need the help of person or aid, but have trouble getting around freely).

Findings

There was only one statistically significant difference between caregiving husbands and caregiving wives in the nature of the role as measured with a *t* test. Husbands scored significantly higher than wives (p=.003) on making financial, legal, and health decisions on the nature of the role/direct care scale. Caregiving husbands also reported more difficulty than wives (p=.010) in making decisions about financial, legal, and health care matters on the caregiving role strain/direct care scale, version 1. On the direct care scale measuring caregiving role strain in handling behavior problems, caregiving husbands scored significantly higher than caregiving wives on versions 1 (p=.015), 2 (p=.013), and 3(p=.014). Caregiving husbands scored higher than wives (p=.04) on version 1 of the overall scale of caregiving role strain/direct care scale. Table 3 contains a summary of the comparison of caregiving husbands and caregiving wives on the nature of the role/direct care and managed care scales. Table 4 contains a summary of the comparison of caregiving husbands and wives on versions 1, 2, and 3 of the scales measuring caregiving role strain/direct and managed care.

Discussion

Caregiving husbands made more financial, legal, and health decisions than caregiving wives according to the nature of the role/direct care scale, and version 1 of the caregiving role strain/direct care scale indicated that they perceived this activity to be more stressful than the wives did. It is probable that caregiving husbands made more financial, legal, and health decisions before they began caregiving as

these could be termed masculine tasks. The greater stress that they reported in performing those activities could be a result of their doing more. The caregiving husbands were not asked what about performing these activities was particularly stressful.

Table 3

Comparison of Husbands and Wives on Nature of the Caregiving Role

Type of Caregiving Activities		Mean	SD	t Value	2-tail Probability
Direct Care Scales					
Personal care	Husbands (H)	0.56	0.32	0.48	0.640
	Wives (W)	0.51	0.31		
Housekeeping	H	0.89	0.22	0.24	0.810
	W	0.87	0.26		
Handle behavior problems	H	0.39	0.29	1.96	0.060
	W	0.21	0.26		
Little extras	H	0.75	0.22	0.00	1.000
	W	0.75	0.22		
Medical	H	0.50[a]	0.31	1.43	0.170
	W	0.36[a]	0.21		
Protection	H	0.91	0.20	1.99	0.050
	W	0.74	0.29		
Transportation	H	0.60	0.25	0.62	0.540
	W	0.53	0.40		
Financial/legal/health	H	0.92	0.12	3.28[c]	0.003
	W	0.70	0.26		
Miscellaneous	H	0.48	0.25	-0.04	0.970
	W	0.49	0.28		
Overall	H	0.67	0.12	1.92	0.060
	W	0.58	0.17		
Managed Care Scales					
Personal	H	0.06	0.19	0.91[c]	0.377[c]
	W	0.02	0.05		
Manage Health & Social Service	H	0.04	0.11	1.64	0.110
	W	0.00	0.00		
Housekeeping	H	0.09[b]	0.20	0.76	0.455
	W	0.05	0.11		
Handle behavior problems	H	0.04	0.08	0.74	0.465
	W	0.02	0.06		
Little extras	H	0.05	0.19	-0.06	0.950
	W	0.05	0.10		
Medical	H	0.00[a]	0.00	-1.00	0.327
	W	0.02[a]	0.09		
Protection	H	0.13	0.26	1.29[c]	0.213
	W	0.04	0.09		
Transportation	H	0.19	0.32	0.57	0.574
	W	0.13	0.25		

Table 3 (cont.)

Type of Caregiving Activities		Mean	SD	t Value	2-tail Probability
Financial/legal/health	H	0.13	0.14	0.07	0.948
	W	0.12	0.16		
Miscellaneous	H	0.13	0.18	2.05[c]	0.054
	W	0.03	0.08		
Overall	H	0.09	0.15	0.96[c]	0.353
	W	0.05	0.05		

Note. There are 16 husbands and 20 wives unless otherwise indicated.
[a] These means are based on 14 husbands and 14 wives.
[b] This mean is based on 15 husbands.
[c] These t values were computed using a separate variance estimate.

Table 4

Comparison of Husbands and Wives on Caregiving Role Strain

Type of Caregiving Activities			Mean	SD	t Value	2-tail Probability
Direct Care Scales						
Personal Care Version 1(1)		H	1.13	0.86	0.76	0.226
		W	0.93	0.66		
Version 2(2)		H	1.56	0.59	0.80	0.215
		W	1.43	0.39		
Version 3(3)		H	1.73	0.68	-0.24	0.405
		W	1.78	0.55		
Manage health and Social Service	1	H	0.63	0.80	1.07	0.147
		W	0.33	0.83		
	2	H	1.33	0.52	0.85	0.201
		W	1.18	0.54		
	3	H	1.64	0.95	1.61	0.059
		W	1.23	0.57		
Housekeeping	1	H	1.42	0.63	0.72	0.240
		W	1.29	0.52		
	2	H	1.53	0.49	0.78	0.221
		W	1.42	0.41		
	3	H	1.55	0.48	0.35	0.365
		W	1.49	0.51		
Handle behavior prob.	1	H	1.18	0.94	2.27	0.015
		W	0.56	0.70		
	2	H	1.79	0.67	2.32	0.013
		W	1.35	0.46		
	3	H	2.65	1.07	2.30	0.014
		W	1.84	1.02		
Little extras	1	H	0.97	0.46	0.21	0.417
		W	0.94	0.43		
	2	H	1.22	0.34	0.29	0.386
		W	1.19	0.30		
	3	H	1.30	0.41	0.58	0.282
		W	1.23	0.34		
Medical	1	H	0.93[a]	0.82	1.55	0.067
		W	0.55[a]	0.43		
	2	H	1.43[a]	0.56	1.36	0.093
		W	1.19[a]	0.34		

Table 4 (cont.)

Type of Caregiving Activities			Mean	SD	t Value	2-tail Probability
Medical (cont.)	3	H	1.58[a]	0.70	0.91	0.185
		W	1.35[a]	0.81		
Protection	1	H	1.51	0.63	0.75	0.230
		W	1.35	0.65		
	2	H	1.60	0.55	-0.05	0.480
		W	1.61	0.44		
	3	H	1.65	0.57	-0.60	0.278
		W	1.76	0.56		
Transportation	1	H	1.17[b]	0.76	0.73	0.236
		W	0.96[b]	0.86		
	2	H	1.56[b]	0.70	0.49	0.313
		W	1.46[b]	0.58		
	3	H	1.96[b]	1.03	0.99	0.164
		W	1.66[b]	0.78		
Financial/legal/health	1	H	1.50	0.48	2.45	0.010
		W	1.09	0.52		
	2	H	1.58	0.48	1.48	0.074
		W	1.39	0.31		
	3	H	1.66	0.63	1.03	0.156
		W	1.49	0.36		
Miscellaneous	1	H	0.81	0.58	0.06	0.475
		W	0.80	0.61		
	2	H	1.33	0.45	0.08	0.468
		W	1.32	0.39		
	3	H	1.73	1.05	0.79[c]	0.218
		W	1.50	0.54		
Overall	1	H	1.20	0.45	1.81	0.040
		W	0.96	0.36		
	2	H	1.53	0.38	1.45	0.079
		W	1.38	0.22		
	3	H	1.75	0.49	0.81	0.213
		W	1.64	0.31		
			Managed Care Scales			
Personal care	1	H	0.08	0.20	0.87[c]	0.395
		W	0.03	0.08		
	2	H	1.02	0.06	0.18	0.428
		W	1.01	0.04		

Table 4 (cont.)

Type of Caregiving Activities			Mean	SD	t Value	2-tail Probability
Personal Care (cont.)	3	H	1.13	0.50	0.18	0.428
		W	1.10	0.31		
Manage Health & S.S.	1	H	0.10	0.34	1.38	0.176
		W	0.00	0.00		
	2	H	1.06	0.25	1.12	0.135
		W	1.00	0.00		
	3	H	1.19	0.75	1.12	0.135
		W	1.00	0.00		
Housekeeping	1	H	0.12[d]	0.23	0.33	0.740
		W	0.09[d]	0.24		
	2	H	1.03[d]	0.07	-0.34	0.369
		W	1.04[d]	0.14		
	3	H	1.13[d]	0.34	0.00	0.500
		W	1.13[d]	0.39		
Handle Behavior Prob.	1	H	0.05	0.12	0.00	1.000
		W	0.05	0.18		
	2	H	1.01	0.05	-0.54[c]	0.298
		W	1.03	0.13		
	3	H	1.06	0.25	-0.54[c]	0.298
		W	1.15	0.67		
Little extras	1	H	0.05	0.19	-0.29	0.775
		W	0.06	0.14		
	2	H	1.00	0.00	-0.89	0.190
		W	1.01	0.06		
	3	H	1.00	0.00	-0.89	0.190
		W	1.05	0.22		
Medical	1	H	0.00[a]	0.00	-1.00	0.327
		W	0.02[a]	0.09		
	2	H	1.00[a]	0.00	0.00	0.500
		W	1.00[a]	0.00		
	3	H	1.00[a]	0.00	0.00	0.500
		W	1.00[a]	0.00		
Protection	1	H	0.22	0.38	1.53[c]	0.141
		W	0.06	0.18		
	2	H	1.09	0.22	1.13[c]	0.135
		W	1.03	0.11		
	3	H	1.38	0.89	1.13[c]	0.135
		W	1.10	0.45		

Table 4 (cont.)

Type of Caregiving Activities			Mean	SD	*t* Value	2-tail Probability
Transportation	1	H	0.23	0.38	0.09	0.932
		W	0.22	0.48		
	2	H	1.04	0.11	-0.64[c]	0.264
		W	1.08	0.26		
	3	H	1.09	0.27	-0.27	0.395
		W	1.13	0.39		
Financial/Legal/Health	1	H	0.17	0.22	0.43	0.666
		W	0.14	0.17		
	2	H	1.04	0.13	0.73[c]	0.237
		W	1.02	0.05		
	3	H	1.21	0.75	0.54[c]	0.297
		W	1.10	0.31		
Miscellaneous	1	H	0.16	0.22	1.61	0.116
		W	0.05	0.17		
	2	H	1.03	0.09	0.18	0.428
		W	1.03	0.11		
	3	H	1.13	0.34	0.18	0.428
		W	1.10	0.45		
Overall	1	H	0.12	0.15	0.97	0.339
		W	0.08	0.09		
	2	H	1.03	0.04	0.19	0.426
		W	1.03	0.05		
	3	H	1.45	0.54	1.01	0.160
		W	1.28	0.46		

Note. There are 16 husbands and 20 wives unless otherwise indicated.
[a] These means are based on 14 husbands and 14 wives.
[b] These means are based on 16 husbands and 19 wives.
[c] These *t* values were computed using a separate variance estimate.
[d] These means are based on 15 husbands and 20 wives.

Caregiving husbands reported more strain in handling behavior problems on all three versions of the caregiving role strain/direct care scales which would seem to indicate that this activity is more stressful for caregiving husbands than caregiving wives. One could speculate that typical male socialization did not include handling behavior problems. Stereotypically the mother was responsible for the day-to-day child care and thus any behavior problems. The classic saying, "wait until your father comes home", illustrates the father deciding on the punishment after the behavior has occurred. It is possible that the care receiving wives were more cognitively impaired than care receiving husbands. If this were so, the increased stress of handling behavior problems could have been a result of having more behavior problems to handle. However, because versions 2 and 3 of the role strain scale adjust for the nature of the role, it is unlikely that the higher level of strain for husbands is due only to higher levels of cognitive impairment in their wives.

Caregiving husbands reported more strain overall on version 1 of the caregiving role strain/direct care scale. This could be attributed to caregiving husbands not having been socialized into the caregiving role. This could also be due to their wives being less mobile. Again, the level of cognitive impairment was not known and this could have contributed to increased overall strain. Other unknown factors which could have contributed to the increased overall strain reported by caregiving husbands are the existence of other dependents and or others needing care. Also unknown was how much the caregiving husbands' health problems interfered with caregiving. Although there was not a

statistically significant difference in the number of health problems reported by the spouse caregivers, the problems reported by the two groups may have had a different effect on the difficulty of caregiving. It should be noted that the internal consistency reliability of this scale was .89.

The hypothesis that caregiving husbands perceive more caregiving role strain than caregiving wives was supported, especially when husbands have to handle behavior problems and to a lesser extent make financial, legal, and health decisions. Unlike caregiving sons and daughters, the nature of the caregiving role for husbands and wives in this study is very similar. The only significant difference in the nature of the role was that caregiving husbands made more financial, legal, and health decisions than wives. One might expect from the literature on sons, that caregiving husbands might provide less personal or hands on type activities than caregiving wives. This was not found to be true in this study.

The results of this study do not agree with the findings of Johnson (1982), that husbands perform the caregiving role with less strain than wives. Johnson speculated that the increased use of formal services by husband caregivers may have decreased strain. In the present study sample, six caregiving husbands and four caregiving wives paid for services.

In this study, handling behavior problems was the area which was found to be particularly stressful for caregiving husbands. This has not previously been reported in the literature. Although it may be unfair to compare behavior problems with dementia, Zarit et al. (1980)

found the level of burden to be the same for husbands and wives caring for their demented spouses.

The negative consequences of caregiving (i.e., burden, stress, strain) have been conceptualized and measured differently in these studies using samples that varied widely. Comparisons are difficult and may be misleading. The hypothesis of this study is weakly supported. The results do indicate that caregiving husbands may perceive more caregiving role strain than caregiving wives, especially in the area of handling behavior problems and to a lesser extent in making financial, legal, and health decisions.

Chapter IV

Summary and Recommendations

In this chapter a summary of the study will be followed by a discussion of the limitations of the study. Implications for nursing practice and suggestions for further research will then be presented.

Summary

The number of elderly persons who need some kind of assistance to stay in their homes is increasing. The family has long been the provider of most of this assistance (Shanas, 1960). This family caregiving is not provided without consequences and a number of studies have documented negative consequences to the caregiver as a result of caregiving. With the growing elderly population and changing societal trends there may be fewer family members available to provide caregiving activities. One can predict that the number of caregiving spouses will increase as our health care system strives to keep the ill and elderly in the community.

In the present study the negative consequences of caregiving are referred to as role strain. Caregiving role strain is the caregiver's perception of difficulty of specific caregiving tasks.

The hypothesis that elderly husbands perceive more caregiving role strain in performing the caregiving role than elderly wives was formulated and based on the traditional sex-role socialization of this society. Women have been socialized into the caregiving role and in most cases have actually performed the role prior to old age. The socialization of men has not included the caregiving role nor have most men had the opportunity to perform the role of caregiving. This would

make it more stressful for an elderly husband to be a caregiver than his elderly wife.

Gender socialization is explained in terms of the social learning theory of sex-role acquisition. According to this theory, children observe and imitate the behavior of others in such a way as to derive maximum reward. A child wants rewards and finds that he or she is rewarded for doing male or female things. He or she then acquires the corresponding sex-role identity and behavior. Females become caregivers by this process.

There is some evidence that sex-roles may reverse in later life. There is evidence that males become more tolerant of their nurturant feelings and women become more tolerant of their aggressiveness in later years. This does not alter the socialization process which has already taken place. Elderly husbands are less prepared to perform the role of caregiving.

Studies on elderly caregiving spouses are not overly abundant in the literature. Daughters are more frequent providers of care and have been the focus of more research than spouses. Many of the studies that included spouses did not analyze their data according to gender, so little is known about elderly husband caregivers.

The sample for the present study, a subsample from a larger study, was made up of 16 caregiving husbands and 20 caregiving wives who were 60 or older. They were interviewed using an instrument developed by Archbold and Stewart (1985), made up of previously standardized composite scales, selected items from existing instruments, and new measures developed for the larger study. Data from one portion of the

instrument was analyzed for the present study.

It was found that caregiving husbands performed more financial, legal, and health decisions than caregiving wives. This was the only difference in the nature of the role provided by these spouse caregivers. Caregiving husbands reported that these activities and handling behavior problems were significantly more difficult than reported by caregiving wives on three different scoring versions of the scale measuring difficulty of handling behavior problems. The results of this study suggest that elderly caregiving husbands who make more financial, legal, and health decisions and especially those who handle behavior problems should be closely monitored for role strain.

Limitations

Limitations of this study include its small, nonprobability sample. Many of the subjects were self selected. The majority of the sample was obtained through agencies, so the use of services may be over represented and the level of care receiver impairment may be very high. The length of the instrument may have prevented caregivers who were extremely stressed in terms of time and energy from expressing interest in participating. The home care staff identification of potential subjects may have increased the homogeneity of the sample. Some gender differences may not have been detected due to the low reliability of some of the scales. The instrument used in this study was only in its pretest phase.

Some information that was not considered in this study includes the presence of other dependents and others who receive care from the caregiver. The care receivers level of cognitive impairment was not

explored. The area of managing hearing problems was omitted from the scales, so this data is not represented in the present study.

Implications for Nursing

Because the hypothesis of the study was only weakly supported, the conclusion that interventions should be targeted toward caregiving husbands because they perceive more caregiving role strain cannot be made. However, this study indicates that elderly husband caregivers who have to handle behavior problems and to a lesser extent make more financial, legal, and health decisions may perceive more caregiving role strain. Perhaps it can be concluded that caregiving husbands who perform these activities should be more closely monitored for strain and possible need for intervention.

Suggestions for Future Research

Replication of this study using a larger sample of probability origin would strengthen the study. Further use and refinement of the instrument is needed.

The addition of information about dependents and others receiving care as well as cognitive level of the care receiver should be helpful to anyone wishing to further explore this area. Management of a hearing problem and its effect on caregiving role strain would be an interesting study in itself.

Topics of interest related to this study include: the exploration of the lesser involvement of sons when caregiving, role reversal, sex-roles and aging, and the area of older adult development. It would be of interest to discover who helped spouse caregivers and determine if there is a relationship to the gender of the caregiver.

It would be interesting to ask caregivers of all ages if their gender is helpful in caregiving and why. Comparing the socialization of caregivers of various ages and role strain may also provide some insight. A follow up study might include specific questions about making financial, legal, and health decisions and handling behavior problems and what about these activities is particularly difficult.

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1. Do you (READ TYPE OF HELP FROM LIST) for (CARE RECEIVER)

2. (IF YES) How hard is it for you to do that? (READ OPTIONS)

3. Does anyone else help out in this way? Who helps out? (READ CHOICES)

4. Do you have to arrange for this help or do they just do it on their own?

5. (IF YES) How hard is it for you to arrange to have someone else do this? (READ CHOICES)

TYPE OF HELP	Column 1 DO YOU DO?		Column 2 HOW HARD TO DO?				Column 3 DOES ANYONE ELSE HELP?					Column 4 ARRANGE HELP FROM OTHERS?		Column 5 HOW HARD TO ARRANGE?			
Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
A. Change bandages or dressings....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
B. Help (CARE REC.) when he/she wants to use the telephone.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
C. Watch (CARE REC.) and make sure he/she is safe...	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
D. Assist(CARE REC.) with walking.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
E. Protect(CARE REC.) from falls.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
F. Do the laundry...	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

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Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
G. Give(CARE REC.) medications or shots.....	0	1	1	2	3	4	No	OR	FR	N	J	0	1	1	2	3	4
H. Make major decisions about health care.....	0	1	1	2	3	4	No	OR	FR	N	J	0	1	1	2	3	4
I. Have to handle (CARE REC.)'s paranoia or suspiciousness	0	1	1	2	3	4	No	OR	FR	N	J	0	1	1	2	3	4
J. Do shopping and errands.....	0	1	1	2	3	4	No	OR	FR	N	J	0	1	1	2	3	4
K. Accompany (CARE REC.) as he/she does shopping and errands.....	0	1	1	2	3	4	No	OR	FR	N	J	0	1	1	2	3	4
L. Sit and spend time with (CARE REC.)	0	1	1	2	3	4	No	OR	FR	N	J	0	1	1	2	3	4

1. Do you (READ TYPE OF HELP FROM LIST) for (CARE RECEIVER)

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Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
M. Iron and/or mend clothes.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
N. Assist with bathing or washing.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
O. Have to handle (CARE REC.)'s behavior problems.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
P. Clean up when (CARE REC.) soils him/herself.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
Q. Assist with hair care and shampooing.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
R. Prepare or help prepare meals....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

1. Do you (READ TYPE OF HELP FROM LIST) for (CARE RECEIVER)

2. (IF YES) How hard is it for you to do that? (READ OPTIONS)

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Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
S. Sit down and eat with (CARE REC.).....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
T. Have to listen and answer repetitive questions that (CARE REC.) asks.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
U. Have to watch (CARE REC.) in case he/she wanders off.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
V. Have to get up at night to help (CARE REC.).....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
W. Take care of (CARE REC.)'s dentures.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
X. Have to remind (CARE REC.) who he/she is and where he/she is..	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

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2. (IF YES) How hard is it for you to do that? (READ OPTIONS)

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TYPE OF HELP	Column 1 DO YOU DO?		Column 2 HOW HARD TO DO?				Column 3 DOES ANYONE ELSE HELP?					Column 4 ARRANGE HELP FROM OTHERS?		Column 5 HOW HARD TO ARRANGE?			
Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
Y. Help to get legal matters attended to.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
Z. Arrange for (CARE REC.) to visit friends....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
AA. Transport to medical appointments....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
BB. Assist with dressing and undressing.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
CC. Check in on (CARE REC.) to make sure he/she is ok.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
DD. Assist with banking and financial matters.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

1. Do you (READ TYPE OF HELP FROM LIST) for (CARE RECEIVER)

2. (IF YES) How hard is it for you to do that? (READ OPTIONS)

3. Does anyone else help out in this way? Who helps out? (READ CHOICES)

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Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
EE. Contact health and social service agencies to see if their services are appropriate for (CARE REC.).....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
FF. Get someone from a health or social service agency to come to help (CARE REC.)	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
GG. Make sure that services from agencies continue to come.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
HH. Read to him/her..	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
II. Check (CARE REC.)'s skin and apply lotions.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
JJ. Assist with writing checks and paying bills.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

1. Do you (READ TYPE OF HELP FROM LIST) for (CARE RECEIVER)

2. (IF YES) How hard is it for you to do that? (READ OPTIONS)

3. Does anyone else help out in this way? Who helps out? (READ CHOICES)

4. Do you have to arrange for this help or do they just do it on their own?

5. (IF YES) How hard is it for you to arrange to have someone else do this? (READ CHOICES)

TYPE OF HELP	Column 1 DO YOU DO?		Column 2 HOW HARD TO DO?				Column 3 DOES ANYONE ELSE HELP?					Column 4 ARRANGE HELP FROM OTHERS?		Column 5 HOW HARD TO ARRANGE?			
Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
KK. "Fix" things and do odd jobs to maintain (CARE REC.) separate dwelling.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
LL. Transport to friends' homes, meetings and entertainment events.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
MM. Watch T.V. with him/her.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
NN. Change dirty bed linens.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
OO. Clean up after meals, do dishes.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
PP. Help (CARE REC.) to use the toilet or bedpan.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

1. Do you (READ TYPE OF HELP FROM LIST) for (CARE RECEIVER)

2. (IF YES) How hard is it for you to do that? (READ OPTIONS)

3. Does anyone else help out in this way? Who helps out? (READ CHOICES)

4. Do you have to arrange for this help or do they just do it on their own?

5. (IF YES) How hard is it for you to arrange to have someone else do this? (READ CHOICES)

TYPE OF HELP	Column 1 DO YOU DO?		Column 2 HOW HARD TO DO?				Column 3 DOES ANYONE ELSE HELP?					Column 4 ARRANGE HELP FROM OTHERS?		Column 5 HOW HARD TO ARRANGE?			
Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGH-BORS N	SOMEONE WHOSE JOB IT IS J		NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
QQ. Assist in completing necessary forms, such as taxes, medicare, Soc. Sec. or insurance....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
RR. Hold (CARE REC.)'s hand or be physically affectionate.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4
SS. Make major financial decisions.....	0	1	1	2	3	4	No OR	FR	N	J		0	1	1	2	3	4

TYPE OF HELP	Column 1 DO YOU DO?		Column 2 HOW HARD TO DO?				Column 3 DOES ANYONE ELSE HELP?				Column 4 ARRANGE HELP FROM OTHERS?		Column 5 HOW HARD TO ARRANGE?			
Do you _____for	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4	ANOTHER RELATIVE OR	FRIEND FR	NEIGHBOR N	SOMEONE WHOSE JOB IT IS J	NO 0	YES 1	EASY 1	NOT TOO HARD 2	PRETTY HARD 3	VERY HARD 4
TT. Manage (CARE REC) hearing problems...	0	1	1	2	3	4	No OR	FR	N	J	0	1	1	2	3	4
UU Manage (CARE REC) pain...	0	1	1	2	3	4	No OR	FR	N	J	0	1	1	2	3	4
VV Do light house keeping for (CARE REC)...	0	1	1	2	3	4	No OR	FR	N	J	0	1	1	2	3	4

WW Is there anything missing from this list?.._____

_____

Appendix B

Table B-1

Descriptive Statistics for Scales Measuring Nature of the Caregiving Role

Type of Caregiving Activity	Mean	SD	Median
Direct Care Scales			
Personal Care	0.54	0.31	0.56
Manage Health and Social Service	0.21	0.34	0.08
Housekeeping	0.88	0.24	0.99
Handle Behavior Problems	0.29	0.28	0.24
Little Extras	0.75	0.22	0.77
Medical[a]	0.43	0.27	0.41
Protection	0.81	0.26	0.90
Transportation	0.57	0.34	0.58
Financial/legal/health	0.80	0.24	0.85
Miscellaneous	0.49	0.26	0.49
Overall	0.62	0.16	0.64
Managed Care Scales			
Personal care	0.04	0.13	0.01
Manage Health and Social Service	0.02	0.08	0.01
Housekeeping[b]	0.07	0.15	0.03
Handle behavior problems	0.03	0.07	0.02
Little extras	0.05	0.14	0.02
Medical[a]	0.01	0.06	0.01
Protection	0.08	0.19	0.04
Transportation	0.16	0.28	0.06
Financial/legal/health	0.12	0.15	0.12
Miscellaneous	0.07	0.14	0.04
Overall	0.07	0.10	0.05

Note. Total number of cases = 36 unless noted otherwise.
[a] Number of missing cases = 8.
[b] Number of missing cases = 1.

Table B-2

Descriptive Statistics for Scales Measuring Caregiving Role Strain

Type of Caregiving Activity	Mean			Standard Deviation			Median		
Direct Care Scales									
Version	1	2	3	1	2	3	1	2	3
Personal care	1.02	1.49	1.76	0.75	0.48	0.60	0.88	1.37	1.76
Manage Health and Social Service	0.46	1.25	1.41	0.82	0.53	0.78	0.08	1.06	1.03
Housekeeping	1.35	1.47	1.52	0.57	0.45	0.49	1.24	1.28	1.36
Handle behavior problems	0.83	1.54	2.20	0.86	0.60	1.10	0.70	1.37	2.03
Little extras	0.95	1.20	1.26	0.43	0.32	0.37	0.84	1.09	1.03
Medical[a]	0.74	1.31	1.45	0.67	0.47	0.76	0.50	1.11	1.04
Protection	1.42	1.61	1.71	0.64	0.48	0.56	1.29	1.53	1.69
Transportation[b]	1.06	1.51	1.79	0.81	0.63	0.90	0.94	1.30	1.54
Financial/legal/health	1.27	1.47	1.57	0.54	0.40	0.50	1.18	1.37	1.51
Miscellaneous	0.81	1.32	1.60	0.59	0.41	0.80	0.73	1.22	1.42
Overall	1.07	1.45	1.69	0.41	0.30	0.40	1.05	1.39	1.67
Managed Care Scales									
Personal care	0.05	1.01	1.11	0.15	0.05	0.40	0.01	1.01	1.05
Manage health and Social Service	0.05	1.03	1.08	0.23	0.17	0.50	0.01	1.01	1.04
Housekeeping[b]	0.10	1.03	1.13	0.23	0.11	0.37	0.03	1.01	1.03
Handle behavior problems	0.05	1.02	1.11	0.15	0.11	0.52	0.02	1.01	1.03
Little extras	0.06	1.01	1.03	0.16	0.04	0.17	0.20	1.00	1.01
Medical[a]	0.01	1.00	1.00	0.06	0.00	0.00	0.01	1.00	1.00
Protection	0.13	1.06	1.22	0.29	0.17	0.68	0.04	1.02	1.06
Transportation	0.22	1.07	1.11	0.43	0.21	0.34	0.06	1.02	1.03
Financial/legal/health	0.15	1.03	1.15	0.19	0.09	0.54	0.14	1.01	0.30
Miscellaneous	0.10	1.03	1.11	0.20	0.10	0.40	0.04	1.01	1.05
Overall	0.10	1.03	1.35	0.12	0.05	0.50	0.05	1.00	1.03

Note. Total number of cases = 36 unless noted otherwise.
[a] Number of missing cases = 8.
[b] Number of missing cases = 1.

APPENDIX C

THE OREGON HEALTH SCIENCES UNIVERSITY

INFORMED CONSENT

INVESTIGATION: THE EFFECTS OF ORGANIZED CAREGIVER RELIEF SERVICES (PRETEST PHASE)

INVESTIGATORS: PATRICIA G. ARCHBOLD, RN, DNSc PHONE: 503-225-8297
BARBARA STEWART, PH.D. PHONE: 503-225-7796
PROFESSORS
SCHOOL OF NURSING
THE OREGON HEALTH SCIENCES UNIVERSITY

PATRICIA ARCHBOLD AND BARBARA STEWART, FACULTY MEMBERS AT THE SCHOOL OF NURSING, THE OREGON HEALTH SCIENCES UNIVERSITY, AND CO-INVESTIGATORS AT THE KAISER PERMANENTE MEDICAL CARE PROGRAM HEALTH SERVICES RESEARCH CENTER, ARE CONDUCTING A STUDY OF CAREGIVING TO OLDER CARE RECEIVERS.

IF WE AGREE TO PARTICIPATE IN THE STUDY, THE FOLLOWING WILL HAPPEN:

1) THE CARE RECEIVER WILL ANSWER QUESTIONS IN ONE INTERVIEW SESSION APPROXIMATELY ONE HALF HOUR LONG.
2) THE CAREGIVER WILL ANSWER QUESTIONS IN ONE INTERVIEW SESSION. THIS INTERVIEW SESSION WILL REQUIRE APPROXIMATELY ONE AND A HALF TO TWO HOURS. NEITHER THE CAREGIVER NOR CARE RECEIVER WILL HAVE ACCESS TO THE INTERVIEW RESPONSES OF THE OTHER.

THE INTERVIEWS WILL BE RECORDED IN WRITING. THE RECORDINGS WILL BE HANDLED IN A MANNER TO ENSURE CONFIDENTIALITY. ANY PUBLICATIONS FROM THIS STUDY WILL INCLUDE THE NECESSARY PRECAUTIONS TO PROTECT OUR IDENTITY.

PARTICIPATING IN THE STUDY MAY NOT BENEFIT US DIRECTLY, BUT MAY BENEFIT OTHER PEOPLE IN THE FUTURE. SOME OF THE QUESTIONS MAY TOUCH ON PAINFUL EXPERIENCES WHICH MAY BE UPSETTING TO US. WE MAY REFUSE TO ANSWER INDIVIDUAL QUESTIONS, OR MAY DISCONTINUE THE INTERVIEW AT ANY TIME WITHOUT AFFECTING OUR CARE AT THE KAISER PERMANENTE MEDICAL CARE PROGRAM OR THE OREGON HEALTH SCIENCES UNIVERSITY.

CRS/PABS/TH/5/25/85

IF WE HAVE COMMENTS OR QUESTIONS ABOUT PARTICIPATING IN THIS STUDY WE SHOULD CONTACT THE INVESTIGATORS.

WE UNDERSTAND THAT IT IS NOT THE POLICY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OR ANY OTHER AGENCY FUNDING THE RESEARCH PROJECT IN WHICH WE ARE PARTICIPATING TO COMPENSATE OR PROVIDE MEDICAL TREATMENT FOR HUMAN SUBJECTS IN THE EVENT THE RESEARCH RESULTS IN PHYSICAL INJURY. THE UNIVERSITY OF OREGON HEALTH SCIENCES CENTER, AS AN AGENCY OF THE STATE, IS COVERED BY THE STATE LIABILITY FUND. IF WE SUFFER ANY INJURY FROM THE RESEARCH PROJECT, COMPENSATION WOULD BE AVAILABLE ONLY IF WE ESTABLISH THAT THE INJURY OCCURRED THROUGH THE FAULT OF THE CENTER, ITS OFFICERS, OR EMPLOYEES. IF WE HAVE FURTHER QUESTIONS, WE CAN CALL DR. MICHAEL BAIRD, M.D. AT 255-8014.

_____I HAVE READ WHAT IS WRITTEN ABOVE AND AGREE TO BE IN THE STUDY.

_____I HAVE HAD READ TO ME WHAT IS WRITTEN ABOVE AND AGREE TO BE IN THE STUDY.

CAREGIVER	DATE	CARE RECEIVER	DATE

CRS/PABS/TH/5/25/85

THE OREGON HEALTH SCIENCES UNIVERSITY

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THE INTERVIEWS WILL BE RECORDED IN WRITING. THE RECORDINGS WILL BE HANDLED IN A MANNER TO ENSURE CONFIDENTIALITY. ANY PUBLICATIONS FROM THIS STUDY WILL INCLUDE THE NECESSARY PRECAUTIONS TO PROTECT OUR IDENTITY.

PARTICIPATING IN THE STUDY MAY NOT BENEFIT US DIRECTLY, BUT MAY BENEFIT OTHER PEOPLE IN THE FUTURE. SOME OF THE QUESTIONS MAY TOUCH ON PAINFUL EXPERIENCES WHICH MAY BE UPSETTING TO US. WE MAY REFUSE TO ANSWER INDIVIDUAL QUESTIONS, OR MAY DISCONTINUE THE INTERVIEW AT ANY TIME WITHOUT AFFECTING OUR CARE AT THE KAISER PERMANENTE MEDICAL CARE PROGRAM OR THE OREGON HEALTH SCIENCES UNIVERSITY.

IF WE HAVE COMMENTS OR QUESTIONS ABOUT PARTICIPATING IN THIS STUDY, WE SHOULD FIRST CONTACT THE INVESTIGATORS. IF WE HAVE FURTHER QUESTIONS ABOUT THIS RESEARCH, OUR RIGHTS AND RESPONSIBILITIES AS SUBJECTS, OR ABOUT RESEARCH-RELATED INJURIES, WE MAY CONTACT M. R. GREENLICK, PH.D., VICE PRESIDENT FOR RESEARCH, KAISER FOUNDATION HOSPITALS AT 233-5631.

_____ I HAVE READ WHAT IS WRITTEN ABOVE AND AGREE TO BE IN THE STUDY.

_____ I HAVE HAD READ TO ME WHAT IS WRITTEN ABOVE AND AGREE TO BE IN THE STUDY.

_____		_____	
CAREGIVER	DATE	CARE RECEIVER	DATE

PA/TDB 6/12/85

AN ABSTRACT OF THE THESIS OF

MAGGIE DONIUS R.N., B.S.N.

For the Master of Nursing

Date of Receiving this Degree:

Title: Gender Differences in Caregiving Role Strain Among Spouse Caregivers to Frail Older Persons

This paper addresses a gap in the literature regarding gender differences among elderly spouse caregivers. A descriptive study of the relationship between gender and caregiving role strain of elderly husbands and wives caring for their spouses in the home was undertaken with the nature of the role viewed as an intervening variable. A nonprobability sample was made up of caregivers, 20 wives and 16 husbands who were 60 and older. A structured interview schedule which took approximately two hours to complete was administered by a team of five nurses and one psychologist. T-tests were used to examine the difference between husband and wife caregivers on the nature of the role and caregiving role strain. The nature of the role did not differ significantly ($p<.05$) except in the area of husbands making more financial, legal, and health decisions than wives. Caregiving role strain was significantly higher for husbands in that same area as well as on a scale measuring overall strain. Husbands scored higher than wives on three different versions of a scale that measured strain of handling behavior problems. Elderly caregiving husbands who are handling behavior problems may be especially prone to strain and should be monitored more closely for need of intervention.