

**THE RELATIONSHIP AMONG THREE MEASURES OF THE POSITIVE ASPECTS OF  
PROVIDING CARE EXPERIENCED BY INFORMAL CAREGIVERS TO SENIORS: CAN  
THEY GET ANY SATISFACTION?**

By

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## **Abstract**

**An investigation of positive aspects (PA) of caregiving was undertaken to determine how three measures differed in relation to one another and how they were related to other variables. Ninety two informal caregivers (mean age=57.27) completed a questionnaire either by phone or mail regarding their age, gender, self-reported health, choice to become a caregiver, availability of relief help, education, task efficacy, total tasks completed, relationship to the care recipient and three measures of the PA: Personal Gain, Task Satisfaction and Caregiving Satisfaction. Results indicated that there were differences between Personal Gain and both other PA measures. More total tasks completed predicted higher Personal Gain. Fewer total tasks completed discriminated between caregivers reporting higher vs lower levels of caregiving satisfaction. Older, self-reported healthier caregivers with high task efficacy and more relief help available discriminated between higher and lower task satisfaction ratings. As well, scores for Task-related Satisfaction and Lawton's Caregiving Satisfaction were closer to their respective scale maximum than were those for Personal Gain.**

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An estimated 90 percent of care to seniors in Canada is provided informally (Angus, Auer, Cloutier, and Albert, 1995). In 1996 “over two million people were providing an average of four to five hours of informal care per week to seniors with long-term health problems” (Keating, Fast, Frederick, Cranswick and Perrier, 1999, p. 103). Recent changes in Canada’s healthcare system and social services have lead to shorter hospital stays and greater use of outpatient treatment (Cranswick, 1997). These changes have in turn increased the responsibility upon Canadian families to provide care to elder family members and friends at home (Cranswick, 1997). Demographic shifts in Canada, such as the projected increase in the elder population, and an increase in life expectancy, highlight the importance of addressing informal caregiving.

Much of the caregiving literature has focused on negative feelings, experiences and outcomes for caregivers. However, the current research will focus on the more positive experiences, feelings and occurrences that may be derived through the role of informal caregiving to seniors. The purpose of the present research was to investigate how three types of positive aspects of providing care were related to one another among a sample of community dwelling individuals who consider themselves to be the primary caregiver to an older adult. The potential predictors of these three measures were also investigated to better understand how the positive aspects relate to one another and to other variables in the caregiving situation. For the purposes of this research, primary caregiver was defined as an individual who considered themselves to be the person who

provided the most care to an older adult. Informal care was considered to be unpaid work completed for an older adult.

### **The Negative Aspects of Providing Care**

The negative consequences of providing care have been referred to within the literature as stress (Pearlin, Mullan, Semple, and Skaff, 1990) burden (Zarit, Reever and Bach-Peterson, 1980), and hassles (Kinney and Stephens, 1989a). The literature indicates that caregiving negatively influences physical health (Haug, Ford, Stange, Noelker, and Gaines, 1999) and health behaviors such as smoking, exercise, and weight maintenance (Burton, Newsom, Schulz, Hirsch, German, 1997). It has also been related to poor sleeping behaviors (Burton et al., 1997; Wilcox and King, 1999). Caregivers have been found to have a higher prevalence of anxiety and affective disorders and greater odds of using mental health services than noncaregivers (Cochrane, Goering, and Rogers, 1997).

In comparison to the multitude of studies that have been conducted on the negative aspects of caregiving, very few studies have been carried out that address the positive aspects of caregiving (Davis, 1992; Kramer, 1997a). This is largely because caregiver research has often been conducted within a stress process framework (Yates, Tennstedt and Chang, 1999). In fact, it has been argued that the focus on the stress model is one of the main reasons that positive aspects have been neglected in caregiver literature (Farran, 1997; Kramer, 1997a; Yates et al., 1999). As a result, caregiving studies have traditionally investigated the difficulties that caregivers encounter and have not always considered the positive aspects experienced in the caregiving role (Stephens, Franks and Townsend, 1994).



Although it is clear that caregiving for an older adult places one at an increased risk for a variety of adverse consequences, research shows that caregivers do in fact report positive feelings associated with their role (Kramer, 1997a). The current study attempted to determine how three measures of the positive aspects were related to one another and also to investigate the significant predictors of these positive aspects. The literature on the positive aspects of caregiving, and evidence to support the necessity of considering these aspects, will be reviewed. Investigations regarding the correlates and predictors of positive aspects to caregiving will then be presented in detail. Finally, specific research questions will be addressed.

### **The Positive Aspects of Providing Care**

Researchers have now realized that in order to fully understand informal caregiving the positive aspects that may be involved when providing care to a senior must be considered (Cohen, Gold, Shulman, and Zuccherro, 1994; Davis, 1992; Dunkin and Anderson-Hanley, 1998; Farran, 1997; Farran, Miller, Kaufman, Donner and Fogg, 1999; Kramer, 1997a, 1997b; Walker, Pratt, and Eddy, 1995). In fact, a recent review of 29 studies on the positive aspects of caregiving by Kramer (1997a) pointed out that much of the variation and individual differences found in caregiver outcomes could be due to the effect that positive appraisals have on the caregiving role. Kramer (1997a) has stated that “lack of attention to the positive dimensions of caregiving seriously skews perceptions of the caregiving experience and limits our ability to enhance theory of caregiver adaptation” (p. 219).

Constructs such as caregiver gain (Kramer, 1997a, 1997b), satisfactions (Dorfman, Holmes, and Berlin, 1996; Lawton, Kleban, Moss, Rovine, and Glicksman,

1989; Lawton, Moss, Kleban, Glicksman, and Rovine, 1991), rewards, uplifts (Kinney and Stephens, 1989a), personal gain (Pearlin et al., 1990), meaning in the role (Farran, 1997; Noonan, Tennstedt, Rebelsky, 1996), and enjoyable aspects (Cohen et al., 1994) have all surfaced in recent caregiving literature to explain the more positive aspects experienced by informal caregivers. For the most part, the above constructs are encompassed in Kramer's (1997b) definition of gain: "any positive affective or practical return that is experienced as a direct result of becoming a caregiver such as the satisfactions, rewards, gratifications, or benefits that are perceived" (p. 240). Thus, this definition will be used in the current study as a term meant to encompass measures that examine the 'positive aspects' of caregiving.

Positive experiences and feelings that arise from the caregiving role are reported by many caregivers (Kramer, 1997a; Miller and Lawton, 1997; Noonan et al., 1996). Stephens et al. (1994) revealed that 100 percent of the caregivers in their study said they felt that caregiving was rewarding because they knew the person they were caring for was well looked after. In the same study, over 80% said they cared for the recipient because they wanted to, not because they had to. Cohen et al. (1994) reported that 55% of caregivers of dementia patients listed at least one enjoyable aspect of caring and Riedel, Fredman, and Langenberg (1998) found that 87% of caregivers in their study reported at least one reward.

Additionally, evidence suggests that caregivers value positive aspects of the relationship they are able to have with the care recipient (Harris, 1998; Noonan et al., 1996; Farran, Kean-Hagerty, Salloway, Kupferer, and Wilken, 1991) and find the relationship rewarding (Hinrichsen, Hernandez, and Pollack, 1992; Walker, Shin, and

Bird, 1990). Caregivers cite feeling closer to the recipient (Schlarch, 1994) and report experiencing a sense of satisfaction from their caregiving role (Hinrichsen et al., 1992; Lawton et al., 1989; Lawton et al., 1991; Riedel et al., 1998).

### **Positive Aspects and Well -Being**

Even though more empirical work must be completed to determine how the positive aspects affect caregivers, research suggests that reports of positive dimensions are related to indicators of well-being. For example, a Canadian study revealed that the number of enjoyable aspects reported by caregivers of dementia patients correlated with lower burden and better health (Cohen et al, 1994). Similarly, Martire, Stephens, and Atienza, (1997) reported that satisfaction in the caregiving role was associated with better physical health, more positive affect, and less depression. Lawton et al. (1991) determined that caregiving satisfaction was related to positive affect and in a multivariate analysis satisfaction was a significant predictor of positive affect. Also, Stephens et al. (1994) reported a significant relationship between the rewarding aspects of the caregiver role and positive affect after controlling for stress experienced in the roles of caregiver, mother, and wife.

Kinney, Stephens, Franks and Norris (1995) found that caregivers who reported more uplifts than hassles also reported significantly less distress and Motenko (1989) revealed that reports of gratifications were correlated with higher general well-being. Braithwaite (1996) determined that those who scored higher on a measure regarding the pleasure derived from the caregiving relationship were more likely to experience positive affect and overall psychological well-being. Pruchno, Michaels, and Potashnik (1990) reported that care recipients were more likely to remain cared for by their spouse in the

community if the dyad had been in a caregiving situation for a longer period of time and if the recipient's caregiver reported deriving satisfaction from caregiving.

The positive aspects of providing care may also help to moderate feelings of burden (Findeis, Larson, Gallo, and Shekleton, 1994). In a recent study, caregivers that reported receiving more rewards from caregiving reported fewer difficulties. Their subjective burden decreased as the number of rewards reported increased (Riedel et al., 1998). As well, Reinardy, Kane, Huck, Call and Shen (1999) reported that satisfactions, such as a sense of achievement and closer family bonds were associated with less subjective burden.

There is also evidence to suggest that the positive aspects of caregiving are important predictors of well-being, even when the level of stress reported by caregivers is taken into consideration. For instance, Martire et al., (1997) determined that despite the amount of stress caregivers reported, caregiving satisfaction predicted better physical health and positive affect. They were able to demonstrate that caregiving satisfaction can predict well-being beyond the effects of the stress experienced in the role of caregiving. Similarly, Riedel et al. (1998) found that, as caregiving rewards increased, subjective burden scores decreased, regardless of the number of difficulties reported by the caregiver.

### **Practical Implications of Studying the Positive Aspects of Caregiving**

Knowing and understanding the dynamics of the positive aspects of caregiving may assist clinicians and practitioners to work more effectively with caregivers, provide important determinants of the quality of care given to older adults (Kramer, 1997a), and benefit theories of adaptation (Miller and Lawton, 1997). Walker et al. (1990) suggest

that caregivers most at risk for low levels of satisfaction may require frequent and costly intervention, whereas caregivers that report caregiving satisfaction may require less frequent and less costly intervention. They reason that service providers with limited funds could potentially use this type of information to distribute services more effectively. For instance, caregivers who report high levels of stress and low levels of satisfaction may be more in need of immediate and extensive formal support.

In spite of the fact that investigations into the positive aspects may allow one to more fully understand the dynamics involved in informal caregiving, research in this area should not undermine the reality that informal caregiving can be detrimental to a caregiver's health. Researchers who pursue this area have been cautioned by Miller and Lawton (1997) to utilize the information carefully. For example, government and policy makers could use this information to argue that informal caregivers to seniors are not in need of services. This type of claim would be very damaging to caregivers that are in need of support and services.

The fact is that not all caregivers report positive aspects and despite positive feelings, some still report more negative effects. For instance, Hinrichsen et al. (1992) reported that caregivers were much less likely to mention rewarding aspects of caregiving than difficulties (51.3% versus 89.3%). Perhaps it is the caregivers that do not experience positive aspects that are in greater need of intervention. However, until more empirical work is completed, it is difficult to determine the profile of a caregiver who experiences positive aspects, and whose feelings of reward and satisfaction contribute to overall well-being, even in the face of adversity.

## **Correlates and Predictors of the Positive Aspects**

### **Background and Contextual Variables**

Characteristics of the caregiver may be influential in terms of the caregiving experience and the ultimate consequences faced by caregivers (Dorfman et al., 1996). Some studies have concluded that the age of the caregiver is negatively related to caregiver satisfaction (Johnson, 1998; Kramer, 1993; Picot, 1995), while others have found positive correlations between age and caregiving satisfaction (Orbell and Gillies, 1993; Talkington-Boyer and Snyder, 1994). However, age has not always been related to caregiver satisfaction, nor has it always surfaced as a significant predictor (Dorfman et al., 1996; Kramer, 1997b). Since older adults perform much of the informal care for seniors the clarification of the effect of age is an important one to consider.

Few studies have compared men and women in terms of the positive aspects they report in the caregiving role. This may reflect the fact that the primary caregiver is usually a woman (Keating et al., 1999; Stone, Cafferata, Sangl, 1987). In one of the few studies that looked at gender, Schwarz (1999) determined that men had a more positive appraisal of satisfaction than women did. Conversely, Kinney and Stephens (1989a) revealed that women reported more uplifts. Evidence suggests that this variance may exist because of the differences in the types of tasks for which men and women are typically responsible for. Kramer and Kipnis (1995) found that women were responsible for more intensive types of care, including personal care and hands-on activities. As well,

Ingersoll-Dayton, Starrels, and Dowler (1996) found that compared to men, women provided more social support and home maintenance.

Education has surfaced as a potentially important variable related to the positive aspects experienced by caregivers. In a sample of African American caregivers, Picot (1995) found that younger and more educated caregivers perceived significantly fewer rewards than older less educated caregivers. Kramer (1997b) found that lower caregiver education was a significant predictor of gain in a sample of caregiving husbands. Husbands who appraised the highest levels of gain were those who were less educated. Kramer (1997b) hypothesized that more educated husbands may not find the daily tasks of caregiving stimulating in comparison to the professional role that they held (currently or prior) in the workforce. As a result, they derive less gain from their role as a caregiver than do husbands who are less educated.

The number of tasks that the caregiver is responsible for has also been investigated in relation to the positive aspects of providing care. Researchers have reported that caregivers who report higher levels of satisfaction assist in a greater number of areas (Walker et al., 1990) and are caring for recipients with greater activity of daily living (ADL) impairment (Kramer, 1993; Talkington-Boyer and Snyder, 1994). However, in a longitudinal study by Walker, Acock, Bowman and Li (1996), it was revealed that relative to daughters who experienced little or no change in the amount of help they provided to their mothers, daughters who reported a greater increase in the amount of care they provided, demonstrated a significantly greater decline in caregiver satisfaction over time.

Previous research suggests that the type of relationship (i.e. spouse, child) between the caregiver and the care recipient is an important variable to consider (Lawton et al., 1989). Schwarz (1999) determined that spouses had a more positive appraisal of caregiving in terms of burden and satisfaction than did children. In addition, Lawton et al. (1991) found that in a sample of caregivers to Alzheimers patients, satisfaction led to positive affect in spouse caregivers but not in adult children. In contrast, Hinrichsen et al. (1992), in a study of caregivers to older adults with major depressive disorder, revealed that wives were less likely than sons or daughters to note an improvement in their relationship with the care recipient.

The age and education of the caregiver, the number of tasks they are responsible for, and their relationship to the care recipient have all been identified in previous research as potentially important variables to consider when assessing the positive aspects experienced by caregivers. Various predictors have been identified, however in many of the studies the dependent measure was conceptualized differently. Because the current study included three different measures of the positive aspects, the opportunity exists to determine whether these variables differ depending on the type of positive aspect that is being measured.

### **Internal Resources**

The health of the caregiver, most often measured by self-ratings has been regarded as an internal resource. Skaff, Pearlin and Mullan (1996) contended that health could affect how well caregivers ultimately cope with the demands of their role. However, the existing information on the relationship between these variables is conflicting. Kramer (1997b) determined that better physical health was associated with



less strain and greater gain in caregiving husbands. But in a study of caregiving wives, health did not demonstrate a relationship to caregiving satisfaction (Kramer, 1993). Further, while Lawton et al. (1991) found that health was related to greater burden, less positive affect, and more depression, it was not associated to caregiver satisfaction. The authors concluded from these findings that satisfactions are equally likely for widely varying levels of caregiver health.

Self-efficacy has recently emerged as a potentially important concept in caregiver research, and has been referred to as an internal resource (Kramer, 1997a). The construct of self-efficacy refers to an individual's belief about "their ability to organize and execute courses of action to manage given situations" (Bandura, 1997, p.3). Chou, LaMontagne, and Hepworth (1999) have suggested that caregivers having strong beliefs about their ability to look after their relatives may be better able to look upon their role positively and consequently, experience less burden.

Self-efficacy has been investigated in relation to stress. But the literature that looks at the relationship between positive appraisals and self-efficacy is sparse. Dorfman and colleagues (1996) conducted a unique study in that caregiving satisfaction *and* self-efficacy were analyzed. They found that caregiver efficacy was not related to caregiving satisfaction. However, there were limitations to this study in that single item measures were used to determine both self-efficacy and caregiving satisfaction. It would be useful to examine these two constructs using multi-item measures to determine if a relationship does indeed exist.

## **External Support**

**Social support has been identified as an external support in many studies of caregiving. Researchers have determined that satisfaction with social support positively correlates with the number of enjoyable aspects reported by caregivers (Cohen et al., 1994), and caregiving satisfaction (Talkington-Boyer and Snyder, 1994). Further, Kramer (1993) found that social resources positively correlated with caregiving satisfaction in caregiving wives, and also that social resources were a strong predictor of gain in her study of caregiving husbands (Kramer, 1997b). However, in Dorfman et al.'s (1996) study, the three measures of social support included did not demonstrate a relationship to caregiver satisfaction. Likewise, Lawton et al. (1991) determined that the amount of help received while in the caregiving role did not contribute significantly to caregiving satisfaction.**

**Inconsistent findings regarding social support may be due to the various definitions of social support in the caregiver literature. For example, in Cohen et al.'s (1994) study it was satisfaction with social support that correlated with satisfaction and in Kramer's (1997b) study it was satisfaction with social participation that was operationalized as a social resource. Dorfman et al.'s (1996) study included three different measures of social support, none of which addressed the satisfaction with the type of support available. Rather, the study included indicators of frequency and availability of support such as the number of relatives, friends, and neighbours who provided assistance to the caregiver within the past year.**

## **Rationale for the Present Research**

Why do the positive aspects of informal caregiving not seem to have consistent predictors or correlates? It becomes apparent after reviewing the literature that the various measures used to understand the positive aspects of care could be the source of the variability. For example, some measures assess components of the caregiver's relationship with the recipient while others consider feelings of esteem and inner growth. Cohen et al. (1994) contended that future studies should investigate how different positive aspects correlate with one another. Are the various measures of gain used in the literature related? Do they share similar predictors? The present study investigated three different measures of the positive aspects of providing informal care to seniors. A measure of 'Task-related Satisfaction' was employed to determine if the caregiver found the tasks they complete satisfying. Caregiving satisfaction was measured using Lawton et al.'s (1989) measure of 'Caregiving Satisfaction' which is defined as the positive occurrences that individuals experience as a result of caregiving. A measure of 'Personal Gain' developed by Pearlin et al. (1990) was also used. This measure was developed to identify positive feelings associated with caregiving and reflect what the caregiver has learned about themselves. The inclusion of three different types of positive aspects allowed for the examination of the relationship between these conceptualizations of the positive aspects of providing care.

Secondly, self-efficacy, a variable that has been practically ignored in the caregiver literature (Gallant and Connell, 1998), was investigated in relation to the positive aspects of providing care. Research on self-efficacy in the workforce by Locke, Grederick, Lee, and Bobko (1984) suggests that people who perceive themselves as

having a stronger sense of self-efficacy are more dedicated to accomplishing goals, and also set increased standards in comparison to those who report less perceived self-efficacy. Findings from workforce studies may be relevant considering the parallels between caregiving and being in the workforce (i.e. task-related work, long hours, etc.). However, there are key differences, namely, caregivers are 'working for' a family member or friend and are not being paid monetarily. In light of this, it is possible that self-efficacy may operate entirely differently for informal caregivers. The relationship between self-efficacy and gain was analyzed, addressing the limitations of Dorfman et al.'s (1996) study (explained earlier) by using multi-item measures for both self-efficacy and satisfaction.

And finally, in a review of the literature, Davis (1992) reported that studies indicate that individuals who are expected to become caregivers, when they did not seek out, anticipate, or wish to have the role, have particularly stressful experiences as caregivers. The present study has been designed to investigate how the choice to become a caregiver may affect how one perceives the positive aspects they experience in the role. This variable was included because it has not been previously examined in relation to the positive aspects of caregiving.

Thus, the purpose of this study was to investigate the relationship between three different measures of the positive aspects of providing informal care to seniors. Further, the study sought to determine how caregiver age, gender, education, the number of tasks completed, relationship to the care recipient, choice to become a caregiver, self-rated health, task self-efficacy and availability of relief help from family and friends were related to the various measures of the positive aspects. Specific research questions were

**a) What is the relationship between the three measures of the positive aspects of caregiving: Task-related Satisfaction, Pearlin's Personal Gain, and Lawton's Caregiving Satisfaction?; b) Do the different measures of positive aspects have different predictors?; and c) If so, what is the best combination of variables to predict Task-related Satisfaction, Pearlin's Personal Gain and Lawton's Caregiving Satisfaction?**

**The current research was undertaken in conjunction with a larger research project being conducted by the Centre for Rural and Northern Health Research (CRaNHR) in Sudbury, Ontario. The purpose of the Centre's study was to: a) identify a measure that would assess both objective and subjective workload reported by informal caregivers; b) to identify a measure that was sensitive to changes in workload over time; and c) to determine the most efficient and effective means of data collection (mail survey, phone interview or in-person interview). The present author was one of the research assistants on this project, with particular responsibility for the positive aspects of caregiving. As such, the present author assisted with instrument design and data collection.**

**A questionnaire was developed that addressed both CRaNHR's purpose and the purpose of the current research.**

## CHAPTER II

### Methodology

#### **Participants**

Caregivers to older adults who were aged 60 and over (N=92), from a mid-sized urban city in Northern Ontario and its surrounding area were included in this study. Participants were contacted by randomly calling individuals from the 2000-2001 phone book. A contacted individual was considered to be eligible to become a participant if a) they considered themselves to be the individual who provided the most unpaid care to the senior in question and were thus considered the primary caregiver and b) the care recipient lived either with the caregiver or independently in the community. Primary caregivers to seniors who lived in facilities that provided formal care were not considered eligible.

Caregivers ranged in age from 18 to 86 years (mean=57.52, standard deviation=15.23) and the age of the caregivers was normally distributed. The majority of caregivers were female (79.3%). The sample consisted of 23 caregivers who indicated that they were the spouse of the care recipient (17 females and 6 males), 41 caregivers who indicated being the child of the care recipient (35 females and 6 males), and 28 indicating the 'other' relationship category (21 females and 7 males). In the 'other' category relationship, 4 caregivers were siblings to the recipient, 7 were friends, and 17 did not specify their relationship to the care recipient.

Care recipients ranged in age from 60 to 97 years (mean age=80.45, standard deviation=7.64) and most recipients of care were also female (63%).

## **Measures**

A structured questionnaire was created to examine the aforementioned variables. All items from the questionnaire pertaining to this analysis are included in Appendix A.

Participants were required to provide demographic information including their year of birth, gender, and education. Their education was determined using the education question developed by Statistics Canada for the National Population Health Survey (1998). Due to the nature of the education question utilized in this study categories of education were not easily identifiable. For the purpose of analysis an interval/ratio variable was desirable therefor education was later recoded into three education groups so that a higher number indicated more years of total schooling.

### **Characteristics of the Care Receiver**

The 'Caregiver Interview' (1992) developed by the Margaret Blenkner Research Center, of the Benjamin-Rose Institute, in Cleveland, Ohio was used to determine the number and type of tasks that the caregiver was responsible for performing. The measure addresses six different domains of care:

1. **Personal Care Tasks (i.e. eating, toileting, dressing);**
2. **Supervision Tasks (i.e. stopping by, telephoning regularly);**
3. **Care Management Tasks (i.e. finding out how to get services, making sure the care receiver gets services);**
4. **Daily Living Activities Tasks (i.e. housework, laundry, yard work);**
5. **Emotional Support Tasks (i.e. visiting to provide friendship, listening to him/her talk);**

## **6. Health Care Activities Tasks (i.e. changing bandages, checking pulse, blood pressure).**

The measure is extremely thorough and allows the researcher to determine what specific tasks the caregiver performs for the care receiver.

### **Characteristics of the Caregiver-Care Recipient Dyad**

Participants were asked to indicate their relationship to the care recipient and this variable was recoded to reflect closeness of kin. Caregivers who responded 'other' were considered to be the least close in kin, children the second closest and spouses were considered to be closest in kin. Caregivers were also asked if they had a choice in whether or not to become a caregiver. The possible responses were 'yes they had a choice', or 'no they did not have a choice'.

### **Internal Resources**

Self-rated health of the caregiver was ascertained by asking the caregiver to rate their health as poor, fair, good, very good, or excellent. Mossey and Shapiro (1982) determined that there was a strong correlation between self-rated health and objective measures of health. They stated that "the way a person views [their] health is importantly related to subsequent health outcomes" (p.800).

Self-efficacy is usually applied to one's competence to perform a specific task, therefore caregivers rated how competent they felt performing each of the six types of tasks. For example, they were asked: "When you are helping with activities of daily living how competent do you feel?" Participants answered on a five point Likert Scale with a score of 1 indicating that they felt they were not at all competent with a particular set of tasks and a score of 5 indicating that they felt extremely competent with a set of



tasks. An average score across tasks was taken to represent task efficacy. This measure was meant to improve upon Dorfman et al.'s (1996) single item measure that required caregivers to (mentally) average out their efficacy over tasks.

#### External Resources:

In order to determine the social support available to the caregiver, participants were asked: "Is there someone who could take over your caregiving duties for a few days? A few months?" Scores were coded so that the lowest number indicated that the caregiver had no one to take over their duties and the highest number indicated help was available for a few months.

#### Dependent Measures

The dependent measures in the proposed study are Lawton's Caregiving Satisfaction Scale, Pearlin's measure of Personal Gain and a measure of Task-related Satisfaction. These measures are all aimed at identifying the positive aspects of providing informal care to seniors.

#### Caregiving Satisfaction

Caregiving satisfaction was measured using a sub-scale of the Philadelphia Geriatric Center Caregiving Appraisal Scale, developed by Lawton et al. (1989). The scale, entitled 'Caregiving Satisfaction', consists of five items aimed at determining feelings of satisfaction that caregivers have about helping the care recipient (Lawton et al. 1989). The sub-scale is scored as 1(nearly always), 2(quite frequently), 3(sometimes), 4(rarely), or 5(never), with lower scores indicating more satisfaction. The scores on this measure were recoded so that higher scores indicated a more positive appraisal of

caregiving satisfaction. The items are meant to reflect the benefits of caregiving such as feeling closer to the care receiver, and feeling appreciated by the care recipient.

Kramer's (1997a) review of the literature on the positive aspects of providing care led her to the conclusion that Lawton's measure is one of the most methodologically rigorous measures of caregiving satisfaction. Studies have reported Cronbach alpha's ranging from .7 (Schwartz, 1999) to .81 (Farran et al., 1999). As well, a recent study by Reinardy et al. (1999) provided construct validity for Lawton et al.'s (1989) measure. The researchers determined that many positive appraisals elicited through open-ended questions were similar to the items contained in Lawton et al's (1989) caregiving satisfaction scale.

### **Personal Gain**

Pearlin et al. (1990) report that Personal Gain is a measure designed to reflect "that many people manage to find some inner growth as they face the severe challenges of caregiving" (p. 589). The scale is part of a number of measures, developed by Pearlin and his colleagues (1990) aimed at learning more about caregivers. The questions use a 4-item scale scored as 1(not at all), 2 (just a little), 3(somewhat) or 4 (very much). Higher scores indicate more Personal Gain, meaning that caregivers have learned more about themselves from caregiving. The reliability of this scale, provided by the authors, is 0.76, and Farran et al. (1999) reported a Cronbach alpha internal consistency of .68 for this measure.

## **Task-related Satisfaction**

Task-related satisfaction was obtained by asking caregivers to indicate their satisfaction when performing each of the six types of tasks. For example, caregivers were asked "How satisfied do you feel when helping the care recipient with personal care tasks?" The participant responded to a 5 point Likert scale, where a score of 1 indicated that they were not at all satisfied performing a particular set of tasks and a score of 5 indicated that they were extremely satisfied performing a set of tasks.

## **Procedure**

### **Pilot Study**

After an extensive review of the caregiver literature, a draft of the questionnaire was developed. A pilot study was conducted to evaluate the questionnaire that was initially developed. Ten informal caregivers to seniors filled out the original questionnaire. Some of the caregivers were mailed the survey, and others were interviewed over the phone. Caregivers were encouraged to comment on the questions and the questionnaire was modified accordingly. Consequently, the questionnaire was shortened in length and questions identified as ambiguous were revised.

Caregivers were randomly selected in the 2000-2001 phonebook, and calls were made to determine the respondent's eligibility. Although response rates are not available for the sample used in the current study, the overall response rate for the entire sample collected by CRaNHR (N= 171) was as follows: 7.2% of the 1791 people contacted were eligible but only 3.63% consented to participate.

After being deemed eligible, participants were given the choice between answering the questionnaire over the phone or receiving it by mail. If the caregiver indicated that they would like to answer the questionnaire over the phone, a copy of the informed consent form (see Appendix B) was read to the participant and they consented orally. The telephone interviews ranged in length from 18 to 85 minutes. The average telephone interview lasted 32.98 minutes

If the caregiver indicated that they would like to have a questionnaire sent to them the researcher explained that they would receive a copy of an informed consent form, the questionnaire, and a set of instructions within the next week. The participant was then instructed to send the questionnaire back in the business reply envelope that was provided for them. After mailing out the original survey, a series of reminders were sent out at 2, 4 and 6 week intervals. The total number of days before the questionnaire was sent back and received ranged from 4 to 70 days, while the average time it took was 20.60 days. In total, 47 phone interviews and 45 mail out surveys were completed and analyzed.

### Design and Analysis

Three independent measures of the positive aspects of providing informal care to seniors were investigated. A summary of these measures is presented in Table 1. Nine independent variables were examined as potential predictors. A summary of these measures is presented in Table 2. Included in each table are the question numbers that correspond to each measure in the 'Caregiving Questionnaire' (Appendix A).

Bivariate correlations were examined to determine what independent variables were related to the three measures of the positive aspects of caregiving and to examine the relationship between the three measures of the positive aspects. A factor analysis was

conducted in an attempt to aggregate the nine independent variables into factors. The goal was to decrease the number of independent variables needed in the planned multivariate analyses and to determine possible shared sources of variance. As will be discussed, this attempted aggregation was not successful and the nine variables were retained as separate predictors.

Predictors of Personal Gain were analyzed using a multiple regression analysis, however Task-related Satisfaction and Lawton's Caregiving Satisfaction Scale were both skewed. Consequently, these variables were categorized into extreme groups and analyzed using discriminant function analysis. Finally, a Wilcoxon Sign test was used to determine whether the three measures of satisfaction differed from one another.

Table 1.

### **Summary of Dependent Measures**

(corresponding 'Caregiving Questionnaire' questions indicated in parentheses)

<b>Dependent Measures</b>	<b>Scoring Criteria</b>
<b>Lawton's Caregiving Satisfaction Scale:</b> The positive occurrences that individuals experience as a result of caregiving (#121-125)	The original variable had scores where increasing numbers indicated lower satisfaction. This variable was modified so that increasing numbers indicated higher ratings of satisfaction. The average of the five questions was calculated to represent the participants' score (possible scores: 1 to 5)
<b>Pearlin's Measure of Personal Gain:</b> The positive feelings associated with caregiving and a reflection of what the caregiver has learned about themselves. (#117-120)	The average of the four questions was calculated to represent the participant's Personal Gain Score. Higher scores indicate higher ratings of Personal Gain (possible scores: 1 to 4).
<b>Task-related Satisfaction:</b> A measure of how satisfying the caregiver rates each of six different types of tasks (i.e. Personal Care, Emotional Support Tasks, etc.) (#63,71,78,94, 100,112)	The average of the six different types of tasks was calculated to represent the participants' task satisfaction (possible scores: 1 to 5)

**Table 2.**

**Summary of Independent Measures**

(corresponding 'Caregiving Questionnaire' questions indicated in parentheses)

<b>Independent Measures</b>	<b>Scoring Criteria</b>
Caregiver Age (#1) Gender (#2) Education (# 5-8)	Categories were based on number of years in school. Higher numbers indicate more years of schooling.
Number of tasks the caregiver performs for the care recipient (57-62, 66-70,74-77,81-93,97-99, 103-111)	The total number of the six different types of tasks was calculated. Higher scores indicate the caregiver performs more tasks.
Closeness in relationship to care recipient (#40)	Categories were made such that higher numbers indicate a closer kin relationship to the care recipient.
Choice to become a caregiver to the care recipient (#45)	Yes indicates that they did have a choice and no indicates that they did not have a choice.
Self-rated Health (#13)	Higher numbers indicate higher self-rated health.
Task Efficacy (#65, 73,80,96,102,114)	An average score of the efficacy indicated for each of the six types of tasks was calculated. Higher scores indicate higher task efficacy.
Duration of relief help available from family and friends (#139)	Higher numbers indicate longer duration of help available.

## RESULTS

The data were analyzed using SPSS for Windows, Version 10.0. A summary of the dependent and independent measures is presented in Tables 1 and 2, respectively.

Initial analyses were run to calculate the means and standard deviations for all variables.

The independent measure of total tasks the caregiver indicated responsibility for was skewed (Garg, 1996), however, a square root transformation successfully normalized the distribution. Task efficacy was also recoded into three ordered groups, as the original variable could not successfully be transformed through either square root or logarithmic transformations.

In response to the Lawton Satisfaction Scale and the Task-related Satisfaction questions, a substantial number of caregivers consistently indicated the highest possible rating of satisfaction. Consequently, both of these variables were extremely skewed. Transformations (square root and logarithmic) failed to normalize the data, therefore the variables were categorized. One category included all caregivers that always indicated the maximum level of satisfaction and the other group consisted of caregivers that did not always indicate the maximum.

### **Means and Standard Deviations for Dependent and Independent Variables**

The means and standard deviations for the positive aspects measured and potential predictors are presented in Tables 3 and 4, respectively.



**Table 3.**

**Means and Standard Deviations for Dependent Variables**

<b>Variables</b>	<b>Mean</b>	<b>SD</b>	<b>Min</b>	<b>Max</b>
<b>Personal Gain</b>	<b>2.73</b>	<b>0.94</b>	<b>1</b>	<b>4</b>
<b>Task-related Satisfaction</b>	<b>3.98</b>	<b>1.13</b>	<b>1</b>	<b>5</b>
<b>Lawton Caregiving Satisfaction Scale</b>	<b>4.10</b>	<b>0.99</b>	<b>1</b>	<b>5</b>

**Table 4.****Means and Standard Deviations for Independent Variables**

<b>Variables</b>	<b>Mean</b>	<b>SD</b>	<b>Min</b>	<b>Max</b>
Caregiver's Age	57.27	15.23	18	86
Caregiver's Education	1.211	0.80	0	2
Number of Tasks Performed by Caregiver *square rooted	3.80	1.03	1.14	6.00
Closeness in Relationship To Care Receiver	1.95	0.75	1	3
Self-rated Health	3.13	1.03	1	5
Task-efficacy	2.14	0.68	1	3
Duration of Relief Help Available from Family and Friends	1.14	0.78	0	2
Caregiver's Gender	79.3 % female 20.7 % male			
Choice to Become a Caregiver	66 % had a choice 31.5 % did not have a choice			

### **Analysis of the Relationship Among the Dependent Measures**

Nonparametric tests were employed to investigate the relationship among the dependent measures. Lawton's measure was significantly positively correlated to the Task-related Satisfaction scale ( $\rho=.583, p<.001$ ). Higher ratings on Lawton's scale were therefore related to higher ratings on the Task Satisfaction questions. No significant relationship was found between Personal Gain and either of the other two dependent measures.

Wilcoxon Signed Ranks tests were performed to determine if there was a significant responding difference between the three dependent variables. For this analysis all scores were first converted to percent of maximum positive score. Results indicated that there was a significant difference between the Lawton Caregiving Satisfaction Scale and the Personal Gain measure ( $Z=-7.11, p<.001$ ). Participants tended to answer more positively when rating questions on the Lawton Caregiving Satisfaction Scale than they did for the Personal Gain questions (81.99% and 54.50%). As well, there was a significant difference between the Task-related Satisfaction responses and the Personal Gain responses ( $Z=-6.30, p<.001$ ). Again, caregivers tended to answer closer to the maximum for Task-related Satisfaction in comparison to Personal Gain (79.52% and 54.50%, respectively). No significant difference between the Task-related Satisfaction measure and the Lawton Caregiving Satisfaction measure was identified.

### **Analysis of the Predictors of the Positive Aspects**

Pearson correlations between the predictors and Personal Gain revealed that only total tasks the caregiver reported being responsible for ( $r=.37, p<.01$ ) was correlated to

**Personal Gain.** Caregivers who reported higher Personal Gain scores also indicated responsibility for more tasks.

Spearman Rank correlations were used to evaluate relationships for Lawton's Caregiving Satisfaction and Task-related Satisfaction as these dependent measures were skewed. Lawton's Caregiving Satisfaction Scale was mildly positively correlated to choice to become a caregiver ( $\rho=.35, p=0.001$ ) and help available from family and friends ( $\rho=.29, p<0.01$ ). Total number of tasks that the caregiver reported being responsible for was mildly negatively correlated to Lawton's scale ( $\rho=-.233, p<0.01$ ). Caregivers who responded more positively on this scale had a choice to become a caregiver, longer duration of relief help available from family and friends and were responsible for fewer tasks.

Task-related Satisfaction was mildly positively correlated to self-reported health ( $\rho=.33, p<.01$ ), relief help available ( $\rho=.27, p<.01$ ) and moderately positively correlated with task efficacy ( $\rho=.45, p<.01$ ). Task-related Satisfaction was mildly negatively correlated to closeness of relationship to care recipient ( $\rho=-.22, p<.05$ ) and total number of tasks the caregiver reported being responsible for ( $\rho=-.23, p<.05$ ). Caregivers who responded more positively on this measure had higher self-reported health, longer duration of relief help available from family and friends, higher efficacy for tasks, were not as closely related, and were responsible for fewer tasks.

A factor analysis was conducted on the nine potential predictors of caregiver satisfaction to determine whether the independent variables could be aggregated in order to capitalize upon any shared sources of variance. A four-factor structure was found that explained 68.47% of the total variance. After completing a multiple regression analysis

with the four factors they were not found to be significantly predictive. Therefore, the singular predictors were retained and utilized to predict Personal Gain. As well, the factor analysis was a poor one, accounting for only 64% of the common variance.

A stepwise multiple regression analysis was conducted to determine whether caregiver's age, education, gender, self-reported health, choice to become a caregiver, task efficacy, relationship to the care recipient, degree of relief help available and the total number of tasks completed were predictors of Personal Gain scores. The assumptions of linearity, normality of distribution, multicollinearity and no outliers were met for the analysis. Table 4 provides the results of this regression analysis. Only the total tasks that the caregiver reported being responsible for contributed significantly to the prediction of Personal Gain indicated by caregivers ( $F=13.073$ ,  $df=1$ ,  $p=.001$ ). Number of tasks alone predicted 14% of the variance in Personal Gain. Being responsible for more tasks was predictive of higher Personal Gain scores. Univariate correlations revealed that no other criterion variable was significantly correlated to Personal Gain.

**Table 4.**

**Stepwise Regression for Personal Gain**

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<b>Predictor Variable</b>	<b>B</b>	<b>SE B</b>	<b>Beta</b>
<b>Total task responsibility</b>	<b>.36</b>	<b>.10</b>	<b>.38</b>
<b>Constant</b>	<b>1.29</b>	<b>.40</b>	
<b>R</b>	<b>.38</b>		
<b>R Squared</b>	<b>.14</b>		
<b>Adjusted R Squared</b>	<b>.13</b>		

### Lawton Caregiving Satisfaction Scale

The overall averages calculated for the Lawton Caregiving Satisfaction Scale were split into two extreme categories. One group (n=30) included caregivers that always responded with the highest possible satisfaction score on this measure (which would be an average score of 5) and the other group (n=31) consisted of caregivers that did not always respond as such (a possible average score ranging from 1 to 4). In order to maximize the difference between the two groups, caregivers who scored *in between* 4 and 5 were not included in either group. As a result, of the original 92 cases, 22 were eliminated as they did not meet the discriminating group criteria.

Univariate analysis of variance revealed that the relief help available to caregivers, the total number of tasks they are responsible for and whether or not they had a choice to become a caregiver, were all significantly different between the two satisfaction groups created. Those caregivers who had the highest possible satisfaction score had a significantly ( $F(1,59)=7.17, p=.01$ ) higher mean, indicating that this group more often had a choice in whether or not to become a caregiver. (0.80 and 0.40 respectively). They also had a significantly ( $F(1,59)=5.98, p<.05$ ) higher mean on the duration of relief help available, indicating they had more relief help available to them in comparison to the caregivers who were less satisfied (1.33 and 0.87, respectively). As well, the higher satisfaction group had significantly ( $F(1,59)=7.63, p<.01$ ) lower means on total tasks responsible for completing (3.58 and 4.18). The original variable for total tasks completed by the caregiver was skewed and had been transformed (square rooted) prior to analysis. In order to put the mean difference between these groups into

perspective it is useful to look at the original pre-transformed means: 12.82 and 17.47, respectively.

In summary, caregivers who reported the maximal level of satisfaction possible for the Lawton Caregiving Satisfaction scale more often had a choice, had more relief help available to them, and were responsible for fewer tasks.

A discriminant function analysis was used to predict caregiving satisfaction (as measured by Lawton's Caregiving Satisfaction Scale) from caregiver's age, education, gender, self-reported health, choice to become a caregiver, task efficacy, relationship to the care recipient, degree of relief help available and the total number of tasks. One variable, total tasks that the caregiver indicated being responsible for, discriminated between groups. Caregivers that reported responsibility for fewer tasks were more likely to report maximal satisfaction for this scale. The predictive function was found to be significant (Wilk's Lambda= .885, df=1,  $p < .01$ ). Canonical  $R^2$  showed that the function explained approximately 11% of the total variance. The function correctly classified 54.3% of caregivers that always indicated the highest possible rating of satisfaction and 69.7% of caregivers in the less satisfied group. The total number of original grouped cases correctly classified was 61.8%.

### **Task-related Satisfaction**

Caregivers were asked whether they helped with six different domains of care. They answered as follows: 36.96% of caregivers helped with personal care tasks, 80.43% helped with supervision tasks, 67.40% helped with care management, 92.40% helped with daily living activities and emotional support tasks and 58.70% helped with health care tasks. After identifying which tasks they were responsible for, caregivers were



asked to indicate their satisfaction in performing each type of task. Caregivers answered on a 5 point Likert scale ranging from 1, which indicated that they were not satisfied at all, to 5, which indicated that they were extremely satisfied. The mean scores ranged from 3.58 for satisfaction felt when helping with health care activities to 4.07 for satisfaction when helping with daily living activities.

Task-related Satisfaction was also split into two extreme categories. One category (n=22) included those caregivers who always indicated the highest possible rating (extremely satisfied) on each of the six task domains. The other group (n=37) consisted of caregivers who did not always indicate the highest possible rating. Hence, caregivers placed in the always extremely satisfied group had an average score of 5 on this measure. Again, in order to maximize the difference between the groups, caregivers who scored *in between* 4 and 5 were not included. Thus, the caregivers that made up the group that did not always indicate they were maximally satisfied had scores that ranged from 2 to 4. As a result, of the original 92 cases, 24 cases were dropped as they did not meet the discriminating group criteria.

Univariate analysis of variance revealed that task efficacy, self-reported health, relief help available and total tasks responsible for were significantly different between the two satisfaction groups created. Those caregivers who always indicated the highest possible rating of task satisfaction had a significantly ( $F(1,57)=17.865, p<.01$ ) higher mean task efficacy than those in the less satisfied group (2.636 and 1.945, respectively). Caregivers in the always satisfied group had significantly ( $F(1,57)=11.79, p<.01$ ) higher self-reported health than the other group (3.77 and 2.91 respectively). Caregivers in the always satisfied group also had significantly ( $F(1,57)=5.2, p<.05$ ) higher means on relief

help available to them (1.36 and 0.92 respectively). And finally, caregivers who always responded 'extremely satisfied' had a significantly (( $F(1,57)=4.43, p<.05$ ) lower mean score on total tasks responsible for in comparison to the other group (3.5 and 4.05 respectively). The original pre-transformed total task means are: 12.25 tasks and 16.40 tasks, respectively.

In sum, caregivers who always reported being extremely satisfied with all tasks performed were more efficacious about the tasks they performed, healthier, had more relief help available to them from family and friends, and performed fewer tasks than the caregivers who did not always report that they were extremely satisfied.

A stepwise discriminant function analysis was used to predict Task-related Satisfaction from caregiver's age, education, gender, self-reported health, choice to become a caregiver, task efficacy, relationship to the care recipient, degree of relief help available and the total number of tasks. A combination of four variables discriminated between those caregivers in the 'always' extremely satisfied group and those in the 'not always' extremely satisfied group. Older, self-reported healthier caregivers with high task efficacy and more relief help available were predictive of 'always' extremely satisfied group membership. The predictive function was found to be significant (Wilk's  $\Lambda=.53, df=4, p<.01$ ). Canonical  $R^2$  showed that the function explained approximately 46.9% of the total variance. The function correctly classified 73.9% of caregivers that always indicated that they were extremely satisfied and 82.5% of those in the less satisfied group. The total number of original grouped cases correctly classified was 79.4%.

## Discussion

Researchers in the area of caregiving have suggested that the positive aspects of providing care are important to understanding the caregiving experience (for example, Cohen et al., 1994; Walker et al., 1995) and may even aid in explaining the variation found in caregiver outcomes (Kramer, 1997a). This study was designed to investigate the relationship between three different measures of the positive aspects experienced by informal caregivers to seniors. As well, various potential predictors were examined for each of the three measures. The results obtained indicated that the three measures of the positive aspects vary in their relationship to one another and depending on what positive aspect is measured, differential predictors may be found.

### **Discussion of the Relationship Among the Positive Aspects of Providing Care**

The first research question sought to determine the relationship between the three measures of the positive aspects of providing care: Task-related Satisfaction, Pearlin et al's (1990) Personal Gain, and Lawton's Caregiving Satisfaction Scale (1989).

Many caregivers in this study reported experiencing positive aspects from their role. In fact, approximately 30% of caregivers in the study always indicated the highest possible levels of satisfaction for both Task-Related Satisfaction and Lawton's Caregiving Satisfaction measure. Only 15% indicated the highest possible rating for the measure of Personal Gain.

Therefore, consistent with other findings, caregivers in this study did report positive aspects to their role (Riedel et al., 1998; Walker et al., 1996). However, the likelihood of answering positively varied depending on what type of positive aspect was measured. For example, after converting scores to a percentage, the mean percentage

response for Personal Gain was lower than Task-related Satisfaction and Lawton's measure of caregiving satisfaction. A profile of the positive aspects experienced by caregivers in this study would indicate that on average, caregivers reported high levels of satisfaction for the tasks they performed (Task-related Satisfaction) and to the positive occurrences and interactions they had with the care receiver (Lawton's Caregiving Satisfaction Scale). But in comparison to these, they less often reported learning about themselves or having positive feelings associated with their role (Personal Gain). Further, the correlational data indicates that Personal Gain is not related to either of the other two measures. Thus, it is clear that there is something inherently different about feeling as though one has learned something from one's role as a caregiver (Personal Gain) versus feeling satisfied about aspects of one's interactions with the care receiver (Lawton's Caregiving Satisfaction Scale) or feeling satisfied with tasks performed (Task-related Satisfaction). Therefore, if a caregiver feels satisfied with the tasks they perform and aspects of their interactions with the care recipient, this study suggests that it does not necessarily mean that they are learning from the experience or growing as a person. Conversely, it would seem that they could feel as though they are learning from the role, independent of how they may feel about the tasks they complete or components of their relationship with the care receiver.

The recent shift towards analyzing the positive aspects of providing care has resulted in differing definitions and measurements of this construct (Cohen et al., 1994). Cohen et al. (1994) suggested that the relationship between various conceptualizations of the positive aspects be investigated. Further calls to organize this area of literature have been made by Kramer (1997a) who made a distinction between two types of positive

aspects: event and role specific gain. According to Kramer's definition, event specific gain includes appraisals of events or tasks completed in caregiving while role specific gain refers to a more general evaluation of the caregiving role. This conceptualization of the positive aspects would indicate that both the Caregiving Satisfaction Scale and the Personal Gain measure would fall into the same category, that is, role specific gain. However, the results from this study indicate that these two measures are not even related, suggesting that an even finer distinction should be made. The process of organizing this area of literature could be potentially facilitated by investigations that further explain how various positive aspects are related.

The following discussion will highlight the significant predictors found for each positive aspect of providing care. This will further explain the differences found between these three measures.

#### Predictors of the Positive Aspects of Providing Care

The last two research questions for this study sought to determine whether the three measures of the positive aspects had different predictors and if so, what would be the best combination of variables to predict each one? The results indicate that the three measures do indeed have different predictors.

Personal Gain is meant to reflect what caregivers have learned from their role. Pearlin et al. (1990) proposed that Personal Gain is an intrapsychic strain that may be negatively affected by the existence of stress in the role. A review of the literature indicated that the presence of Personal Gain as a measure of the positive aspects of caregiving was not common. Nonetheless, Farran et al. (1999) used Personal Gain to evaluate their newly developed measure of the positive aspects of caregiving. They found

that the Personal Gain questions were most similar to items from their scale that ascertained feelings regarding the caregivers own strengths and abilities. These types of feelings are not captured in the other measures included in this study thus making Personal Gain different by definition from the other measures.

The only significant predictor of Personal Gain was the total number of tasks that the caregiver indicated being responsible for completing. Thus, caregivers reporting higher levels of Personal Gain also reported responsibility for more tasks. This finding is consistent with Kramer's (1993) study of caregiving wives. Her measure of the positive aspects was similar to the measure (Personal Gain) used in the current study as it included rewards of the role such as "feeling increased self-esteem....and feeling useful"(p. 373). She found that caregiving wives whose husbands had greater impairments in activities of daily living reported higher levels of gain.

Because this was not a longitudinal study it is difficult to determine whether caregivers who perform more tasks experience an increase in Personal Gain because they do more *or* whether they are initially more positive about the role and consequently perform more tasks. However, in order to feel that one has learned, it would seem logical to suggest that some type of event or activity would have to be executed in order for the growth and learning to take place. It would be counter-intuitive to suggest that one could derive a sense of learning from their role as a caregiver before they actually became one. As the following discussion will indicate, the lack of a similar relationship between the other measures of gain and number of tasks performed also suggests that it is not an initial positive view of one's role that explains this relationship. Rather it is a growth that

takes place as a result of the tasks performed in the role. It may also be that caregivers highly involved in their role may have more *opportunity* to grow and learn from it.

Lawton's Caregiving Satisfaction Scale is meant to reflect the positive occurrences experienced in the caregiving role. It reflects feelings associated with the caregiver/care-receiver relationship (Farran et al., 1999). It was positively correlated to choice to become a caregiver, duration of help available from family and friends, and it was negatively correlated to number of tasks performed. As well, analysis of variance determined that these same variables were significantly different between those caregivers reporting the highest possible ratings of satisfaction for this measure versus those who did not always report the highest possible rating.

For this measure, caregivers having a choice in terms of becoming a caregiver, who had a longer duration of relief help available from family and friends and were responsible for fewer tasks were more likely to indicate higher satisfaction. Perhaps having a choice might make one feel less resentful towards the care receiver and thus better able to experience positive feelings about the relationship. Chappell and Kuehne (1998) reported that women more often than men express negative affect in the caregiving role and contended that it may be due to men's perceived choice to be a caregiver while women feel that they have more of an obligation to become the caregiver. The findings from the current study do not support this contention as this study did not find that men or women more often reported having a choice about whether or not to become a caregiver, nor, were gender differences for any of the measures of the positive aspects found.

Perceived social support was related to Lawton's measure of caregiving satisfaction in that caregivers who reported that they thought family and friends would take over their caregiving duties for longer periods of time (social support) were also more likely to indicate maximum levels of satisfaction. It would seem reasonable that caregivers having the opportunity to have a 'break' from caregiving may be able to derive a greater sense of satisfaction from their interaction with the care recipient. These results are inconsistent with Dorfman et al's (1996) findings. They reported that social support was not related to caregiving satisfaction. However, Dorfman et al. did not use Lawton's measure of satisfaction, rather a single item asking the caregiver to rate their overall satisfaction with caregiving was employed. They also used a measure of received support as they asked caregivers to indicate the frequency of aid and number of visits and phone calls they received from relatives, friends and neighbours. Thus, a different type of positive aspect *and* a different conceptualization of social support may explain this inconsistency.

Discriminant function analysis revealed that number of tasks performed by the caregiver was the only variable that discriminated between those caregivers always reporting that they were extremely satisfied on Lawton's measure of Caregiving Satisfaction versus those who did not. Unlike Personal Gain, it was caregivers who reported performing *fewer* tasks that consistently indicated the highest possible satisfaction rating. Employing the same scale used in this study, Lawton et al. (1991) found that adult child caregivers who provided more care showed more satisfaction but this relationship did not exist for spouse caregivers in the same study. Spouse and adult child caregivers in the current study did not differ in terms of their scores on Lawton's



**Caregiving Satisfaction Scale. The relationship between the positive aspects and workload has not always been consistent in the literature. Much of the literature reviewed for this study reported that more work equals higher satisfaction (for example, Kramer, 1993; Lawton et al., 1991; Walker et al., 1990). Yet another study reported the opposite finding, both at an initial measurement and longitudinally (Walker et al., 1996). The results of this study suggest that this relationship varies depending on the type of positive aspect assessed. For instance, when Personal Gain is considered, more tasks predict higher scores whereas for Lawton's Caregiving Satisfaction measure it is fewer tasks that predict higher scores.**

**In spite of the fact that the number of tasks completed by caregivers predicted Personal Gain and was a significant discriminator for Lawton's satisfaction measure, it only accounted for 14% of the variance in Personal Gain and 11% of the variance in Lawton's measure. These results indicate that other factors are important in predicting the positive aspects of informal caregiving, and that further research is needed to investigate the possible predictors. Other researchers have suggested that ethnic differences (Kramer, 1997a; Picot, 1995a) may play a role in appraisals of the positive aspects. As well, the type of illness or severity of illness that the care recipient suffers from may affect subsequent appraisals of the caregiving situation.**

**In order to determine Task-related Satisfaction, caregivers were asked if they assisted with personal care, supervision, care management, daily living activities, emotional support and healthcare activities. Caregivers indicated helping with emotional support and daily living tasks most frequently, followed by supervision and care management tasks. The least frequent help was given for health care and personal care**

tasks. For caregivers who always indicated the maximum level of satisfaction for tasks, the highest percentage of these caregivers reported that they were satisfied when helping with daily living activities and emotional support tasks. The lowest percentage reported being satisfied when helping with personal care and healthcare activities. Discriminant analysis revealed a series of variables to be significant discriminators between those who always indicated the maximum level of Task-related Satisfaction and those who did not. Older caregivers, with higher self-reported health, higher task related efficacy, and a longer duration of relief help available from family and friends discriminated between these two groups.

Therefore, according to the results, caregivers who were more efficacious about the tasks they performed were more likely to respond that they were totally satisfied with all tasks they performed. Dorfman et al. (1996) found that caregiver self-efficacy was unrelated to caregiver satisfaction. However, the measures for self-efficacy and satisfaction used in Dorfman et al.'s (1996) study were single-item measures that asked about overall efficacy and satisfaction. A strength of the current study is that caregivers were asked about their efficacy and satisfaction for each of six specific domains of care. Thus caregivers would not be required to mentally average out scores, making the measure used in the current study more valid.

The finding that healthier caregivers were more likely to be maximally satisfied is consistent with other findings (Kramer, 1997b; Riedel et al., 1998). Kramer (1997b) reported that caregiving husbands in better health reported more gain. If an individual is healthier they may find the tasks less difficult and thus able to derive a sense of satisfaction from performing them. On the contrary, if someone is not in good health they

may be less likely to always find tasks satisfying because the performance of tasks would be more taxing and strenuous. This contention is also supported by the fact that caregivers in this study who were less satisfied with tasks also reported less task efficacy, that is, lower feelings of competence to perform tasks. It should be noted that it could also be that doing tasks could have led to poorer health for some caregivers and thus resulted in them having to decrease the number of tasks they assist with. A longitudinal study would have to be conducted to determine the direction of this relationship.

Health was not related to either Personal Gain or Lawton's Caregiving Satisfaction Scale, a finding that is supported by previous studies (Lawton et al., 1991, Kramer, 1993). Lawton et al. (1991) reported that satisfaction was likely for varying health status of caregivers. The present study indicates that this may be true for certain types of positive aspects such as Personal Gain or Caregiving Satisfaction (Lawton's measure) but it does not seem to be true for Task-related Satisfaction. It may be that caregivers who are in poor health still experience the positive occurrences and feelings that come as a result of caregiving. For example, feeling appreciated by the care recipient. But doing the actual tasks may be more demanding for an individual in poor health, less enjoyable and perhaps even painful if it involves physical work such as lifting. For these reasons, a caregiver in poor health may not find satisfaction in completing the tasks but may still potentially feel satisfaction with aspects of the interaction between themselves and the care recipient.

Caregivers in this study ranged in age from 18 to 86. Older caregivers were more likely to report that they were always satisfied with tasks they performed. Although some literature has found that younger caregivers report more rewards associated with their

role (Riedel et al., 1998) rewards in the role may be very different than the current study's measure of satisfaction with types of tasks. It may be that older caregivers are more likely to be retired without the pressure of handling outside employment and thus may have more time to complete the tasks. As well, they may find the task work more satisfying because it gives them a sense of purpose.

The only other measure found in the existing literature that approximated Task-related Satisfaction was Kinney and Stephen's "Caregiving Hassles and Uplifts Scale" (Kinney and Stephens, 1989a;1989b;1995). They asked caregivers to rate daily events and tasks they perform as uplifts or hassles. Not one study could be found that specifically assessed Task-related Satisfaction, which is surprising considering that the tasks performed by caregivers are such an integral part of their role. In the current study, significant differences between satisfaction for each kind of task were not found. However, a single-item was used to assess each domain of task satisfaction. The value of Task-related Satisfaction should be further investigated to determine if there are differences in how caregivers perceive their satisfaction with various types of tasks and how this perception ultimately affects the caregiving situation.

The relationship between Task-related Satisfaction and task efficacy also deserves further attention. Although self-efficacy has been postulated to be a potentially important variable in the caregiver burden literature (Chou et al., 1999; Solomon and Draine, 1995) its relationship to the positive aspects of caregiving is less clear. The current study found that caregivers who report high levels of task efficacy also report higher levels of Task-related Satisfaction. This suggests that increasing caregiver's feelings of competence about performing certain tasks may result in an increase in Task-related Satisfaction.

**Bandura (1982) has suggested that a person's perception of their ability to handle stressful situations may affect task accomplishment and also assist in explaining how long one will continue in the face of adversity. In the present study caregivers indicated that they were least efficacious about performing healthcare activities. This section included such things as changing bandages, helping with special exercises and using medical equipment. From a practical perspective, it may be useful to know what tasks caregivers do not feel competent performing, as it may be with these tasks that they could use the most assistance.**

**The findings of this study highlight the importance of considering more than one type of positive aspect experienced in the caregiving role. If the current study had only employed Lawton's Caregiving Satisfaction Scale, the results would indicate that highly satisfied caregivers indicate performing fewer tasks. However, if Personal Gain were investigated then one would have concluded that performing more tasks could increase the positive aspects of caregiving. Further, if one were to measure only Task-related Satisfaction one would have concluded that although tasks completed was correlated with Task-related Satisfaction it could not significantly discriminate between caregivers who were highly satisfied and those who were not. Similarly, if one did not include a measure of Task-related Satisfaction then the relationship between health and the positive aspects would have been found to be unrelated. This may be untrue as the results suggest that health may play a role in the satisfaction that caregivers derive from one of the most salient features of their role: task performance.**

**As well, the relationship between the positive aspects and social support varied considerably as social support was related to both Lawton's Caregiving Satisfaction and**

**Task-related Satisfaction, but not to Personal Gain. It seems that one's perception of availability of family and friends to assist may in turn make it more likely that the caregiver will experience certain types of positive aspects. However, Personal Gain is seemingly more intrinsic and could therefore be less affected by resources that are available outside of the caregiver's immediate situation (i.e. family and friends). Personal Gain may be something that is felt internally as a result of one's role, independent of how other people may contribute to the caregiving experience. It is surprising that Personal Gain was not affected by internal feeling states such as self-efficacy, a variable typically regarded as an internal resource.**

**The difficulty with measuring the positive aspects and social support is that a wide variety of measures have been used to quantify social support in the literature. Future research should determine what facets of social support (i.e. perceived versus received social support) are most predictive of the positive aspects of caregiving and then which ones most affect caregiver outcomes such as increased health and well-being. In order to improve the caregiving situation, service providers need to know what supports can help caregivers cope more effectively with their role. It would also be constructive to investigate formal support use to determine how it relates to the positive aspects experienced in the caregiving role.**

**It seems reasonable to suggest that one goal of caregiver research is to identify at-risk caregivers and develop the most effective interventions. Effective interventions could be aimed at increasing the caregiver's ability to cope with their role, maintaining or increasing well-being, and avoiding the early institutionalization of care recipients. The question then becomes, which positive aspects are most related to these goals? Are**

caregivers who feel more competent and satisfied with the tasks they perform less likely to institutionalize the care recipient? Or is it caregivers who feel as though they have learned and are gaining something valuable from their role who are most likely to keep the care recipient at home? The answers to these questions must be addressed in order for the positive aspects of caregiving to be considered a valuable concept to service providers and government.

Further investigation of Personal Gain may also be of special interest to service providers. Findings from this study suggest that caregivers who complete more tasks experience more Personal Gain. If so, then agencies that work with caregivers may find it helpful to further validate feelings of growth and learning in the role. However, this suggestion is somewhat premature until the relationship between Personal Gain and outcome measures for caregivers is established. For example, if Personal Gain is not related to well-being then perhaps it is not an aspect of caregiving that is crucial to maintaining or increasing well-being. However, if Personal Gain is positively related to well-being indicators then those who work with caregivers may benefit from an understanding of how to facilitate feelings of personal growth and learning.

### **Strengths and Weaknesses**

The strength of the current study is the collection of data using volunteers from a random sample. The method of data collection was unique in that most other studies have typically obtained information by recruiting caregivers from existing support groups or from agencies that provide formal services. It has been suggested that these caregivers may be different as they have already recognized their need for service and support to manage and cope with their role (Kramer, 1997a). Kramer (1997a) has pointed out that

one of the problems with literature in this area is the reliance on convenience samples. Caregivers for this study were contacted randomly from a telephone book therefore increasing the chance that the experiences and feelings of the average caregiver are represented by the results.

Although the means of data collection may be regarded as a strength to this study, it is also problematic because the range of care provided by caregivers in this study was quite large. Some caregivers indicated that they spent 6 hours a week providing care while others indicated providing care 24 hours a day. The current study was also limited in that the medical conditions of the care recipients were not ascertained. This information could potentially explain some of the existing variance in all three positive aspects of care. Differences may exist that are typical to a particular type of caregiver (i.e. dementia) and these differences would not be detected in this study. Finally, the measure used to assess closeness of relationship is flawed in that it is a purely anthropological measure. A better indication of closeness of relationship might have involved asking the caregiver to rate how close they felt to the care recipient.

A potential confound to the results obtained regarding positive aspects is response bias. In a post-hoc analysis, the likelihood of this was assessed by comparing the two groups of caregivers on Task-related Satisfaction and Lawton's Caregiving Satisfaction (always satisfied versus less satisfied), based on whether participants had agreed to be interviewed over the phone or chose to have the survey mailed to their home. Differences with respect to both Task-related satisfaction (Chi-Squared (1,67)=4.75,  $p < .05$ ) and Lawton's measure (Chi-Squared (1,68)=6.39,  $p < .05$ ) were found between these two groups. For Task-related Satisfaction, participants who chose a phone interview



responded significantly more positively than participants who chose a mail out survey did. An even number of caregivers who were interviewed over the phone responded that they were always satisfied and less satisfied (17 in both groups). However, in the mail-out interview the ratio was 3:1 in that more caregivers responded less positively if they were in this group. For Lawton's Caregiving Satisfaction Scale, more participants in the phone interview group indicated that they were always satisfied rather than less satisfied (23 vs 14) while the ratio for mail out survey participants was roughly 1:2 as caregivers who filled out the mail-out survey were more likely to indicate that they were less satisfied (10 vs 23). These findings suggest that contact with the interviewer throughout the duration of the survey (phone) may have biased participants to answer more positively. However, caregivers who chose the mail survey also reported that they were responsible for significantly more tasks than those who agreed to a phone interview were. Considering that caregivers who completed more tasks also reported lower levels of both Task-related Satisfaction and Lawton's measure, it seems more likely that task responsibility and not response bias is responsible for responding differences.

### **Conclusion**

Inconsistent findings regarding caregiving and the positive aspects experienced may be due to the various conceptualizations of this measure used in the literature (Kramer, 1997a). In this study alone, three measures of the positive aspects of providing care demonstrated differential relationships to other variables and to one another. According to the results, the development of a theory addressing the positive aspects that could potentially guide this area of research should consider that there are different aspects to the positive dimensions of providing care that should be considered. As

evidenced from this study, considering only one positive aspect may not reveal the entirety of caregiving and the positive aspects experienced in this role. The definition and conceptualization of the positive aspects included in any study may result in different predictors and relationships that would consequently be postulated to be important. Perhaps a single multi-dimensional measure should be developed to begin to address how various positive experiences and feelings about the caregiving role are interrelated and how they ultimately affect outcome measures such as caregiver well-being.

This study should be considered only the beginning of the exploration into how different positive aspects are related to one another. Further research is also needed to determine how various positive aspects are related to measures of burden. Kramer (1997b) found that the predictors for gain and strain were differential suggesting that this relationship is not reciprocal. Riedel et al. (1998) reported that caregiving rewards reduced the caregiver's level of burden suggesting that the positive aspects may mediate this relationship. The current study found that three measures of the positive aspects were different therefore each type of positive aspect may indeed have a different relationship to existing measures of burden.

In summary, future research should investigate how different positive aspects of providing care to a senior are related to outcomes such as caregiver well-being and institutionalization of the care recipient. What positive aspects are most influential in terms of affecting outcomes for caregivers? The answer to this question may then lead to the development of a theory and a unifying measure that could assess the most influential positive aspects in caregivers. Knowing and understanding how various positive aspects affect the caregiving situation will aid in the eventual development of measures that can

**effectively assess the needs of caregivers and ultimately help caregivers cope with their role and increase positive feelings and experiences related to caregiving.**

## References

- Angus, D.E., Auer, L., Cloutier, J.E., & Albert, T. (1995). Sustainable health care for Canada. In Keating, N., Fast, J. & Cranswick, K. & Perrier, C. (1999). Eldercare in Canada: Context, Content and Consequences. Catalogue no. 89-570-XPE. Ottawa: Statistics Canada.
- Bandura, A. (1997). Self-efficacy: The Exercise of Control. New York: Freeman.
- Bandura, A. (1982). Self-efficacy mechanism in human agency. American Psychologist, *37*, 122-147.
- Benjamin Rose Institute (1992). Service Use by Impaired Elderly and Informal Caregivers: Caregiver Interview. The Margaret Blenkner Research Center of the Benjamin Rose Institute, Cleveland, Ohio.
- Braithwaite, V. (1996). Between stressors and outcomes: Can we simplify caregiving process variables? The Gerontologist, *36*(1), 42-53.
- Burton, L.C., Newsom, J.T., Schulz, R., Hirsch, C.H., & German, P.S. (1997). Preventive health behaviors among spousal caregivers. Preventive Medicine, *26*, 162-169.
- Chappell, N.L. & Kuehne, V. (1998). Congruence among husband and wife caregivers. Journal of Aging Studies, *12*(3), 239-254.
- Chou, K., LaMontagne, L. & Hepworth, J. (1999). Burden experienced by caregivers of relatives with dementia in Taiwan. Nursing Research, *48*(4), 206-214.
- Cochrane, J., Goering, P. & Rogers, J. (1997). The mental health of informal caregivers in Ontario: An epidemiological survey. American Journal of Public Health, *87*(12), 2002-2007.
- Cohen, C.A., Gold, D.P., Shulman, K.I., & Zuccherro, C.A. (1994). Positive aspects in caregiving: An overlooked variable in research. Canadian Journal of Aging, *13*, 378-391.
- Cranswick, K. (1997). Canada's caregivers. Canadian Social Trends. Catalogue no. 11-008-XPE.
- Davis, L. (1992). Building a science of caring for caregivers. Family and Community Health, *15*(2), 1-9.
- Dorfman, L., Holmes, C., & Berlin, K. (1996). Wife caregivers of frail elderly veterans: Correlates of caregiver satisfaction and caregiver strain. Family Relations, *45*, 46-55.

- Dunkin, J., & Anderson-Hanley, C. (1998). Dementia caregiver burden: A review of the literature and guidelines for assessment and intervention. Neurology, 51(1), S53-S60.
- Farran, C., Miller, B., Kaufman, J., Donner, E., & Fogg, L. (1999). Finding meaning through caregiving: Development of an instrument for family caregivers of persons with Alzheimers disease. Journal of Clinical Psychology, 55(9), 1107-1125.
- Farran, C. (1997). Theoretical perspectives concerning positive aspects of caring for elderly persons with dementia: Stress/adaptation and existentialism. The Gerontologist, 37(2), 250-256.
- Farran, C., Keane-Hagerty, E., Salloway, S., Kupferer, S., & Wilken, C. (1991). Finding meaning: An alternative paradigm for Alzheimers disease family caregivers. The Gerontologist, 31(4), 483-489.
- Findeis, A., Larson, J.L., Gallo, A., & Shekleton, M. (1994). Caring for individuals using home ventilators: An appraisal by family caregivers. Rehabilitation Nursing, 19, 6-11.
- Gallant, M., & Connell, C. (1998). The stress process among dementia spouse caregivers. Research on Aging, 20(3), 267-297.
- Garg, R. (1996). Computing via Spss: A Practical Approach. Laurentian University: Sudbury, ON (unpublished handout).
- Harris, P. (1998). Listening to caregiving sons: Misunderstood realities. The Gerontologist, 38(3), 342-352.
- Haug, M., Ford, A., Stange, K., Noelker, L., & Gaines, A. (1999). Effect of giving care on caregivers health. Research on Aging, 21(4), 515-5-38.
- Hinrichsen, G.A., Hernandez, N.A., & Pollock, S. (1992). Difficulties and rewards in family care of the depressed older adult. The Gerontologist, 32, 486-492.
- Ingersoll-Dayton, B., Starrels, M., & Dowler, D. (1996). Caregiving for parents and parents-in-law: Is gender important? The Gerontologist, 36(4), 483-491.
- Johnson, P. (1998). Rural stroke caregivers: A qualitative study of the positive and negative response to the caregiver role. Topics in Stroke Rehabilitation, 5(3), 51.
- Keating, N., Fast, J., Frederick, J., Cranswick, K., & Perrier, C. (1999). Eldercare in Canada: Context, Content and Consequences. Catalogue no. 89-570-XPE. Ottawa: Statistics Canada.

- Kinney, J., & Stephens, M. (1989a). Hassles and uplifts of giving care to a family member with dementia. Psychology and Aging, 4(4), 402-408.
- Kinney, J., & Stephens, M. (1989b). Caregiving hassles scale: Assessing the daily hassles of caring for a family member with dementia. The Gerontologist, 29, 328-332.
- Kinney, J.M., Stephens, M.A., Franks, M.M., & Norris, V.K. (1995). Stresses and satisfactions of family caregivers to older stroke patients. The Journal of Applied Gerontology, 14(1), 3-21.
- Kramer, B. (1997a). Gain in the caregiving experience: Where are we? What next? The Gerontologist, 37(2), 218-232.
- Kramer, B. (1997b). Differential predictors of strain and gain among husbands caring for wives with dementia. The Gerontologist, 37(2), 239-249.
- Kramer, B. (1993). Marital history and prior relationship as predictors of positive and negative outcomes among wife caregivers. Family Relations, 42, 367-375.
- Kramer, B., & Kipnis, S. (1995). Eldercare and work-role conflict: Toward an understanding of gender differences in caregiver burden. The Gerontologist, 35(3), 340-348.
- Lawton, M., Kleban, M., Moss, M., Rovine, M., & Glicksman, A. (1989). Measuring caregiving appraisal. Journal of Gerontology: Psychological Sciences, 44(3), P61-P71.
- Lawton, M., Moss, M., Kleban, M., Glicksman, A., & Rovine, M. (1991). A two-factor model of caregiving appraisal and psychological well-being. Journal of Gerontology: Psychological Sciences, 46(4), P181-P189.
- Locke, E.A., Frederick, E., Lee, C., & Bobko, P. (1984). Effect of self-efficacy, goals and task strategies on task performance. Journal of Applied Psychology, 69, 241-251.
- Martire, L., Stephens, M., & Atienza, A. (1997). The interplay of work and caregiving: Relationships between role satisfaction, role involvement, and caregivers well-being. Journal of Gerontology: Social Sciences, 52B(5), S279-S289.
- Miller, B., & Lawton, M. (1997). Introduction: Finding balance in caregiver research. The Gerontologist, 37(2), 216-217.
- Mossey, J., & Shapiro, E. (1982). Self-rated health: A predictor of mortality among the elderly. American Journal of Public Health, 72(8), 800-808.
- Motenko, A. (1989). The frustrations, gratifications, and well-being of dementia caregivers. The Gerontologist, 29(2), 166-172.

- Noonan, A., Tennstedt, S., & Rebelsky, F. (1996). Making the best of it: Themes of meaning among informal caregivers to the elderly. Journal of Aging Studies, 10(4), 313-327.
- Orbell, S., & Gillies, B. (1993). Factors associated with informal carers preference not to be involved in caring. The Irish Journal of Psychology, 14, 99-109.
- Pearlin, L., Mullan, J. Semple, S., & Skaff, M. (1990). Caregiving and the stress process: An overview of concepts and their measures. The Gerontologist, 30(5), 583-594.
- Picot, S. (1995). Rewards, costs, and coping of African American caregivers. Nursing Research, 44(3), 147-152.
- Pruchno, R., Michaels, J., & Potashnik, S. (1990). Predictors of institutionalization among Alzheimer disease victims with caregiving spouses. Journal of Gerontology: Social Sciences, 45(6), S259-S266.
- Reinardy, J.R., Kane, R.A., Huck, S., Call, K., Shen, C. (1999). Beyond burden: Two ways of looking at caregiving burden. Research on Aging 21(1), 106-127
- Riedel, S., Fredman, L., & Langenberg, P. (1998). Associations among caregiving difficulties, burden, and rewards in caregivers to older post-rehabilitation patients. Journal of Gerontology: Psychological Sciences, 53B(3), P165-P174.
- Scharlach, A. (1994). Caregiving and employment: Competing or complementary roles? The Gerontologist, 34(3), 378-385.
- Schwarz, K. (1999). A study of the relationship of caregiving appraisal to depressive symptomatology and home care utilization. Journal of Community Health Nursing, 16(2), 95-108.
- Skaff, M., Pearlin, L., & Mullan, J. (1996). Transitions in the caregiving career: Effects on sense of mastery. Psychology and Aging, 11(2), 247-257.
- Solomon, P. & Draine, J. (1995). Subjective burden among family members of mentally ill adults: Relation to stress, coping, and adaptation. American Journal of Orthopsychiatric, 65(3), 419-427.
- Stephens, M., Franks, M., & Townsend, A. (1994). Stress and rewards in women s multiple roles: The case of women in the middle. Psychology and Aging, 9(1), 45-52.
- Stone, R., Cafferata, G., & Sangl, J. (1987). Caregivers of the frail elderly: A national profile. The Gerontologist, 27, 616-626.
- Talkington-Boyer, S., & Snyder, D. (1994). Assessing impact on family caregivers to Alzheimer s disease patients. The American Journal of Family Therapy, 22(1), 57-66.

Walker, A., Shin, H., & Bird, D. (1990). Perceptions of relationship change and caregiver satisfaction. Family Relations, 39, 147-152.

Walker, A., Acock, A., Bowman, S. & Li, F. (1996). Amount of care given and caregiving satisfaction: A latent growth curve analysis. Journal of Gerontology: Psychological Sciences, 51B(3), P130-142.

Walker, A. Pratt, C., & Eddy, L.(1995). Informal caregiving to aging family members. Family Relations, 44, 402-411.

Wilcox, S., & King, A.C. (1999). Sleep complaints in older women who are family caregivers. Journal of Gerontology: Psychological Sciences, 54(1), P12-P22.

Yates, M., Tennstedt, S., and Chang, B. (1999). Contributors to and mediators of psychological well-being for informal caregivers. Journal of Gerontology: Psychological Sciences, 54(1), P12-P22

Zarit, S., Reever, K., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. The Gerontologist, 20(6), 649-655.



## **APPENDICES**

**Appendix A**  
**Caregiving Questionnaire**

**A. In the first section, we will ask you some questions about yourself.**

1. What is your year of birth? : \_\_\_\_\_

2. Are you: Male  Female

5. Excluding kindergarten, how many years of elementary and high school have you successfully completed?

No schooling - *Please go to Question 9.*

1 to 5 years

6 years

7 years

8 years

9 years

10 years

11 years

12 years

13 years

6. Have you graduated from high school?

Yes

No

7. Have you ever attended any other kind of school such as a university, community college, business school, trade or vocational school, CEGEP or other post-secondary institution?

Yes

No – *Please go to Question 9.*

8. What is the highest level of education that you have ever attained? *Please check the most appropriate answer.*

Some – Trade, Technical or Vocational School, or Business College

Some – Community College, CEGEP, or Nursing School

Some – University

Diploma or Certificate from – Trade, Technical or Vocational School, or Business College

Diploma or Certificate from – Community College, CEGEP, or Nursing School

Bachelor's or Undergraduate Degree, or Teacher's College (e.g., B.A., B.Sc., LL.B.)

Master's Degree (e.g., M.A., M.Sc., M.Ed.)

Degree in Medicine, Dentistry, Veterinary Medicine or Optometry (M.D., D.D.S., D.M.D., D.V.M., O.D.)

Earned Doctorate (e.g., Ph.D., D.Sc., D.Ed.)

Other – Please specify: \_\_\_\_\_

**B. In this next section, we will ask you some questions about your daily life, your health and your leisure activities.**

13. In general, would you say your health is: (Please circle the appropriate answer)

1                      2                      3                      4                      5  
Poor                  Fair                  Good                  Very Good          Excellent

**C. In this section, we will ask you some questions about the person you are caring for. We refer to this person as the care receiver.**

40. What is your relationship to the care receiver? Are you their...

- Spouse
- Child
- Sibling
- Other Relative (e.g., cousin, aunt, niece,...)
- Friend
- Other, please specify: \_\_\_\_\_

45. Which of the following best describes how you became a caregiver?

- I had a choice in whether or not to become a caregiver.
  - ↳ If you had a choice, did you feel pressure to make the choice?
    - Yes, there was pressure to make the choice.
    - No, there was no pressure to make the choice.
- I did not have a choice in whether or not to become a caregiver.

46. What is the care receiver's year of birth?: \_\_\_\_\_  I don't know

47. Is the care receiver: Male  Female

**D. In this section, we will ask questions about the work involved in caring for the care receiver.**

Please read the instructions carefully.

For the following section, we ask whether or not the care receiver has gotten help for different things. If the care receiver has gotten help with a task or activity, we ask that you check the boxes of **all people** who have helped. If the care receiver did **not** get any help, simply check the "No one has helped with this" box and move to the next task or activity.

Here is an example.

During the past 4 weeks, did the care receiver get help from anyone with:

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
Dressing or undressing?		✓		✓

In this example, the care receiver gets help from professionals and the primary caregiver (you) with dressing or undressing. If the care receiver did not get help with dressing or undressing, only the "No one has helped with this" box would be checked.

Please answer the following questions using this format.

Following each section of tasks, we will ask you how satisfying and how stressful it was for you to complete those tasks. Also, we ask how competent you felt in doing those tasks. Please select the answer that best describes your situation.

**During the past 4 weeks, did the care receiver get help from anyone with the following Personal Care tasks:**

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
57. Eating, including cutting food or buttering bread?				
58. Toileting, including getting to the bathroom in time, being reminded to go to the bathroom, or cleaning him/herself?				
59. Dressing or Undressing?				
60. Cutting fingernails or toenails?				
61. Washing or bathing him/herself?				
62. Getting in or out of the tub or shower?				

***If you have not helped with any of these Personal Care tasks, please go to Question 66.***

**When you are helping with the Personal Care tasks listed above...**

	Not at all			Extremely	
63. How <b>satisfied</b> do you feel?	1	2	3	4	5
64. How <b>stressed</b> do you feel?	1	2	3	4	5
65. How <b>competent</b> do you feel?	1	2	3	4	5

During the past 4 weeks, did anyone have to perform any of the following Supervision tasks:

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
66. Stay with the care receiver because he/she couldn't be left alone?				
67. Stop by to make sure the care receiver was all right?				
68. Telephone regularly to make sure the care receiver was all right?				
69. Be there while the care receiver carried out his/her daily activities?				
70. Be available to come over in case the care receiver needed help?				

***if you have not helped with any of these Supervision tasks, please go to Question 74.***

When you are helping with the Supervision tasks listed above...

	Not at all			Extremely	
71.. How <b>satisfied</b> do you feel?	1	2	3	4	5
72. How <b>stressed</b> do you feel?	1	2	3	4	5
73. How <b>competent</b> do you feel?	1	2	3	4	5

**During the past 4 weeks, did the care receiver get help from anyone with any of the following Care Management tasks:**

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
74. Making decisions about using services including health, social, legal or financial services?				
75. Finding out how to get services or arranging for services?				
76. Making sure that the care receiver got the services he/she was supposed to get?				
77. Completing the forms necessary to arrange for services or get services paid for?				

***If you have not helped with any of these Care Management tasks, please go to Question 81.***

**When you are helping with the Care Management tasks listed above...**

	Not at all					Extremely				
78. How <b>satisfied</b> do you feel?	1	2	3	4	5	1	2	3	4	5
79. How <b>stressed</b> do you feel?	1	2	3	4	5	1	2	3	4	5
80. How <b>competent</b> do you feel?	1	2	3	4	5	1	2	3	4	5



**During the past 4 weeks, did anyone help the care receiver with any of the following Daily Living Activities:**

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
81. Use the telephone, including looking up or dialing numbers, or answering the phone?				
82. By preparing, serving, or providing meals for him/her, or taking him/her out?				
83. Do light housework, such as vacuuming or dusting?				
84. Do laundry, including getting the clothes to the laundry area?				
85. Do his/her banking and keep track of his/her money?				
86. Do the shopping?				
87. By accompanying him/her to appointments because he/she can't handle it alone?				
88. By driving him/her places or helping him/her use public transportation?				
89. Do heavy housework, such as washing windows or scrubbing floors?				
90. Do outside maintenance on his/her home, do yard work or shovel snow?				
91. With legal matters?				
92. Walk around inside the house?				
93. Walk around outside the house?				

***If you have not helped with any of these Daily Living Activities, please go to Question 97.***

**When you are helping with the Daily Living Activities listed above...**

	Not at all		Extremely		
94. How <b>satisfied</b> do you feel?	1	2	3	4	5
95. How <b>stressed</b> do you feel?	1	2	3	4	5
96. How <b>competent</b> do you feel?	1	2	3	4	5

**During the past 4 weeks, did the care receiver have anyone who gave them**

**Emotional Support:**

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
97. Listened to him/her talk About things that are important to him/her?				
98. Visited to provide friendship or companionship?				
99. Counselling or advised him/her about things that concern him/her?				

***If you have not given any Emotional Support, please go to Question 103.***

When you are giving Emotional Support, as listed above...

	Not at all					Extremely
100. How <b>satisfied</b> do you feel?	1	2	3	4	5	
101. How <b>stressed</b> do you feel?	1	2	3	4	5	
102. How <b>competent</b> do you feel?	1	2	3	4	5	

**During the past 4 weeks, did the care receiver get help from anyone with any of the following Health Care Activities:**

	No one has helped with this.	I have helped with this.	Family members, friends, neighbours or volunteers have helped with this.	A professional or someone who is hired has helped with this.
103. Advice or instructions on his/her health care?				
104. Caring for a colostomy or catheter?				
105. Getting medical equipment, supplies, or medications?				
106. Changing bandages or dressings?				
107. Checking pulse, blood pressure, respiration or glucose level?				
108. Using medical equipment, supplies, or medications?				
109. Special exercises?				
110. Injections, IV therapy, tube feedings or other special medical needs?				
111. Any other healthcare activity? Please specify:				

***If you have not helped with any of these Health Care Activities, please go to Question 115.***

**When you are helping with the Health Care Activities listed above...**

	Not at all			Extremely	
112. How <b>satisfied</b> do you feel?	1	2	3	4	5
113. How <b>stressed</b> do you feel?	1	2	3	4	5
114. How <b>competent</b> do you feel?	1	2	3	4	5

**E. In the following section, we will ask you questions about how your caregiving affects you.**

*For questions 117 to 125, please circle the most appropriate answer.*

	Not at all	Just a little	Somewhat	Very much
117. How much have you become more aware of your inner strengths?	1	2	3	4
118. How much have you become more self-confident?	1	2	3	4
119. How much have you grown as a person?	1	2	3	4
120. How much have you learned to do things you didn't do before?	1	2	3	4

**How often do you feel...**

	Nearly Always	Quite Frequently	Sometimes	Rarely	Never
121. You really enjoy being with the care receiver?	1	2	3	4	5
122. That the care receiver shows real appreciation of what you do for him/her?	1	2	3	4	5
123. That the care receiver's pleasure over some little things gives you pleasure?	1	2	3	4	5
124. Helping the care receiver has made you feel closer to him/her?	1	2	3	4	5
125. Taking responsibility for the care receiver gives your self-esteem a boost?	1	2	3	4	5

139. Do you have family and/or friends who could take over your caregiving duties for...

- A few days?       Yes       No  
 A few weeks?     Yes       No

**APPENDIX B  
CONSENT FORM**

## **Consent Form**

**The Change Foundation and the Centre for Rural and Northern Health Research(CRaNHR), a research center based at Laurentian University, are jointly conducting a study on the changes in informal caregiving over time. The investigators believe that this study will be important in helping to create better and more comprehensive health and social policy for informal caregivers.**

**I realize that this study involves my filling out the attached questionnaire at two times in the next year (now and in 6 to 10 months), and that it will take approximately 20 minutes of my time to complete the questionnaire. As well, I realize that the researchers will attempt to link the information contained in both questionnaires by assigning me an identification number. I understand that the identification number on the questionnaire is for the sole purpose of being able to match my questionnaires, so that the researchers may see if any changes have occurred in my caregiving situation. I know that once the information from both questionnaires has been examined that the identification number will be deleted. No name will appear in the database.**

**I know that any information provided will be kept strictly confidential. The information provided will only be used to evaluate changes in informal caregiving over time and for research purposes only. The information that I provide will not be released to other individuals or organizations. This study had passed the ethics review at Laurentian University.**

**I know that my participation in this study is entirely voluntary, and that my decision to take part or not to take part in this study will not affect me in any way. I have the right to withdraw at any time or to refuse to answer any question that I do not feel comfortable answering.**

**If I have any questions about this study, I can contact Dr. Alan Salmoni of Laurentian University at (705) 675-1151 (ext 1046), or Dr. Raymond Pong of CRaNHR at (705) 675-1151 (ext. 4357).**

**I agree to participate in this study (to fill out the questionnaire at both times) and I have received a copy of this consent form. I have been assured that my identity will not be revealed while this study is being conducted or when the study is published. I have also been assured that the information I have provided will be used for the purpose of researching changes in caregiving over time.**

\_\_\_\_\_  
**Subject's Name (please print)**

\_\_\_\_\_  
**(Identification Code)**

\_\_\_\_\_  
**Subject's Signature**

\_\_\_\_\_  
**Date**

v

## **Appendix C**

### **Table of Spearman Rank Order Correlations Between Independent Variables**

**Table of Spearman Rank Order Correlations Between Independent Variables**

Variable	1	2	3	4	5	6	7	8	9
1 Age	—								
2 Gender	.43	—							
3 Self-reported health	-.21* (N=90)	.08	—						
4 Choice to become a caregiver	-.11	-.17	.18	—					
5 Caregiver education	-.32** (N=88)	.03	.40** (N=90)	.00	—				
6 Availability of help from family and friends	-.18	.07	.06	.22* (N=87)	-.07	—			
7 Task Efficacy	-.22* (N=89)	.15	.16	.06	.24* (89)	.03	—		
8 Closeness of kin relationship to care recipient	.51** (N=90)	.00	-.03	-.01	-.02	-.23* (N=89)	-.21* (N=91)	—	
9 Tasks the caregiver indicated responsibility for completing	.07	-.12	-.10	-.24* (N=90)	.16	-.43** (N=89)	-.05	.31** (N=92)	—

\*p < .05; \*\* p < .01