This is to certify that the

thesis entitled

A Descriptive Study to Determine Frequency and
Satisfaction with Instrumental Support Received
By Wives Caring for Disabled Husbands

presented by

Charlene Theresa Lasocki

has been accepted towards fulfillment
of the requirements for

MASTER OF SCIENCE degree in NURSING

Clare Collins PhD, RN.
Major professor

Date 10/24/90

A DESCRIPTIVE STUDY TO DETERMINE FREQUENCY AND SATISFACTION WITH INSTRUMENTAL SUPPORT RECEIVED BY WIVES CARING FOR DISABLED HUSBANDS

By

Charlene T. Lasocki

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN NURSING

College of Nursing

1990

ABSTRACT

A DESCRIPTIVE STUDY TO DETERMINE FREQUENCY AND SATISFACTION WITH INSTRUMENTAL SUPPORT RECEIVED BY WIVES CARING FOR DISABLED HUSBANDS

By

Charlene T. Lasocki

A descriptive, cross-sectional study of 80 caregiving wives ages 52-80 was undertaken, utilizing a sample from a larger longitudinal study by Given and Given (1985). Questionnaires were administered in the home by trained data collectors to gather background data, the frequency of instrumental support provided by family members and friends/neighbors, and their overall degree of satisfaction with support provided. No reliability or validity testing was done on these instruments prior to this study. The results indicated that very limited support was provided to the caregivers, but overall, caregivers were quite satisfied. They were most frequently supported by family and friends spending time keeping their husband company and least likely to receive long-term respite for a weekend or longer. Because of the limitations identified with the instruments used, the correlational analysis must be considered with caution. Recommendations for instrument revision, along with implications for nursing research and practice are presented.

Given, C. & Given, B. (1985). Caregiver responses to managing elderly patients at home. Grant #NIA-1R01 AG08564. Michigan State University, East Lansing, MI. Unpublished manuscript.

ABSTRACT

A DESCRIPTIVE STUDY OF [illegible]
WITH [illegible]
[illegible]

by

Charlene T. L[illegible]

A descriptive, or exploratory study of [illegible] 52 30 [illegible] utilizing a sample from a larger [illegible] study by Olven and Craven (1[illegible]). [illegible] were administered in the home by trained data collectors to gather background data, [illegible] frequency of instrumental support provided by family members and friends/neighbors, and their overall degree of satisfaction with support provided. No reliability or validity testing was done on these instruments prior to this study. The results indicated that very limited support was provided to the caregivers, but [illegible], caregivers [illegible] quite satisfied. They were most frequently [illegible] by family and friends [illegible] least likely to [illegible] for a week or longer. Because of the limitations [illegible] with the instruments used, the correlational analysis must be considered with caution. Recommendations for instrument revision, along with [illegible] for future research and practice [illegible].

Olven, [illegible] (1985). [illegible]
[illegible] Grant #[illegible]
[illegible], East Lansing, MI [illegible]

ACKNOWLEDGMENTS

I would like to thank the members of my committee: Clare Collins, Barbara Given, Sharon King and Jackie Wright. Thank you all for your expertise, patience, and ongoing encouragement which helped to make the completion of this project a reality. Throughout this project, you challenged me to seek out my true potential and for this I am appreciative. A special thank you to Manfred Stommel, the statistician who helped to make the task of data analysis less burdensome and actually enjoyable. I sincerely appreciate Barbara and Charles Given allowing me to utilize part of the data from their caregiver study.

Next I would like to thank all my wonderful friends who heard me speak of this project, only to wonder if it would ever be completed. Well, it is completed and I thank you all for not giving up on me. Thank you for providing me with moral support and the motivation I needed to keep moving along. I cherish each of your friendships very much.

Finally, I wish to thank my family for their continued encouragement throughout this project. To my mother, thank you for your love, patience, and faith in me. These last few years have been difficult for both of us, but I finally accomplished my goal. Your lesson on determination helped me to succeed. To my brothers, Richard and Robert, I thank you both for helping me to obtain the equipment which enabled me to type and print my drafts and final copy in the comforts of my home. Your long distance support and advice were also greatly appreciated.

To everyone who helped me in any way to achieve my goal, I sincerely thank you. I could not have done it alone.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

Growing interest in the elderly population has led to extensive research regarding the aged throughout the world during the past few decades. According to the U.S. Bureau of the Census (1989), 12.2% of Americans were over the age of 65 in 1987 and it is projected that this will increase to 13% in 2000 and 21.8% in 2030. Brotman (1981) projects, through analysis of previous demographic data, the group of 75-84 year olds will increase by 50% and the group over age 85 will increase by 80% from the year 1981-2000. Consequently, health care planning must be tailored to meet the needs of the growing elderly population.

As the population ages there is an increased prevalence of chronic illness. Hooyman & Lustbader (1986) found chronic illness prevents about 18% of the older population from participating in some activities of daily living. These individuals frequently rely on family members as their primary source of help. Between 80% and 90% of personal care for the elderly is provided by families, primarily wives and daughters (Day, 1985).

Stone, Cafferata & Sangl (1987) found that informal caregivers were predominantly female, with a sizable number over the age of 65. Less than 10% of the caregivers reported the use of formal services, with about 33% providing care without any assistance. Also, less than 30% utilized informal sources of support. The support provided to caregivers of the elderly has become a topic of interest since those providing the care have been found to experience a great deal of stress.

The purpose of the following study is to examine the instrumental support provided to caregivers by family and friends/neighbors. The degree to which each caregiver was satisfied is also of interest. Tennstedt, McKinlay & Sullivan (1989) recognized the importance of studying the role of secondary caregivers. The secondary caregiver was that individual who assisted the primary caregiver in providing care to the care-recipient. The primary caregiver is the person who provides majority of the care to the care-recipient. The authors believed that secondary caregivers would provide additional help which would increase the amount of care received by the older person and meet their needs for help more completely. Unfortunately, most studies have focused on the role and activities of the primary caregivers alone with no consideration given to the activities of the secondary caregivers.

The older adults of the 1980's, overall, were more educated, had held jobs and were more financially secure than many of their predecessors. As a result they were more involved in their health care and demanded more personalized care (Schaie, 1980). The older adult of the 1990's will be able, with the help of caregivers, to remain in the community for an extended period of time, in the presence of physical limitations. Consequently, health professionals have developed an interest in who is supporting the elderly and their caregivers and how they are being supported.

Background to the Problem

As life expectancy increases, elderly married couples are remaining together longer. According to Hooyman & Lustbader (1986), one half of the population over age 65 is married and

living with their spouse. Spouses are most frequently identified as the primary caregiver in times of illness or debilitation. If a caregiving situation develops for an elderly couple, the female spouse is more often than not the primary caregiver (Robinson, 1986b).

Wives are caregivers more often than husbands, due to a longer life expectancy of women compared to men. Day (1985), Fengler & Goodrich (1979) and Shanas (1979) found women were most often younger than their spouses leading to a life expectancy averaging 7 to 8 years longer than their male counterparts. Robinson (1986a) found women over the age of 65 to be the fastest growing segment of the population and anticipates 1 out of 14 people to be a woman 65 and older by the year 2000.

These elderly female spouses, when thrust into a caregiving role, are considered by Fengler & Goodrich (1979) to be at risk for physical and emotional problems due to the isolation, loneliness and role overload they experience. These wives may, in many instances, be debilitated themselves making it even more difficult for them to fulfill the role of primary caregiver (Cantor, 1983). Despite the fact that these wives are elderly themselves and have their own health problems with which they must cope, they have marital obligations which they are expected to fulfill.

Apart from the physical burden of caregiving, these women also must deal with the emotional aspects of caring for a husband who may now be quite dependent on them. Zarit, Todd & Zarit (1986) found many wives look to the later years in life for a chance for more personal opportunity and growth and, consequently, they may resent

the role of caregiving. Many also find their husbands' dependency very upsetting. The physical burden of caregiving, along with the emotional strain involved, may lead to the increased risk of health problems for the elderly female spouse caregiver.

In conclusion, it is evident that females in general have accepted a traditional role which has resulted in their being selected as the primary caregivers in many instances. It is a role which many women feel obligated to accept regardless of physical, emotional or financial cost to themselves. The wives of disabled elderly husbands have been found to be under great stress in fulfilling caregiving obligations and are the focus of this study.

Issues in Caregiving Which Influence the Need for Social Support

In order to assist wives in their role as caregivers, it is first important to understand what areas of caregiving put strain on their daily lives. Throughout the literature there are comparisons made between spouses and adult children with regard to the degree of burden associated with specific aspects of the caregiving role (Cantor, 1983; Hooyman & Lustbader, 1986; Soldo & Myllyluoma, 1983).

A few areas where important differences have been found include the degree of isolation from others, the amount of time devoted to continuous caregiving activity, the financial status of the caregiver and the overall level of stress experienced. Zarit, Reever and Bach-Peterson (1980) found the frequency of contact with others outside of the caregiving relationship helped to minimize the burden felt by the caregiver.

The spouse caregiver lives with the care-recipient and, consequently, may have minimal contact with others outside of the

home. The wife frequently feels a sense of duty and obligation to her husband and will forfeit activities outside the home to be with her husband (Fitting, Rabins, Lucas & Eastham, 1986).

Horowitz and Dobrof (1982) found that spouses devoted a significantly greater number of hours to caregiving responsibilities then did other caregivers. Spousal caregivers have continual contact on a day-to-day basis with the care-recipient and feel an obligation to devote any time they can to caring for their husband (Cantor, 1983).

Hooyman & Lustbader (1986) along with Day (1985) and Cantor (1983), discussed the issue of caregivers' finances. Where adult children are willing to sacrifice additional income to assure adequate care for their parents, spousal caregivers fear losing all that they have and, therefore, may be hesitant to spend money to obtain assistance.

Consequently, Hooyman & Lustbader (1986) found wives were hesitant to obtain formal services for which they were required to pay and also unwilling to institutionalize, due to the fear of losing all of their savings. The wives believed the best solution, in their attempt to maintain their savings, was to provide exclusive care for their spouse themselves. This enabled them to fulfill their perceived responsibilities and still maintain a hope of security for the future.

In this review, it is evident that the role of caregiving affects each caregiver in a unique way. Researchers have studied the strain which wives, in particular, experience in fulfilling their role as caregivers.

Fengler & Goodrich (1979) identify these women as "the hidden victims". There is an obvious concern regarding the adequacy of support provided to these women since they are designated the responsibility for caregiving in most instances and are provided minimal, if any, support.

The elderly population is growing rapidly and the need for family caregivers is also likely to grow. In order for caregivers to remain in their roles, health professionals and government officials must recognize their underlying needs and provide adequate assistance. To understand the stressors these individuals encounter, it is important to understand what support is available and whether it is adequate to meet the needs of the caregiver. The next section will focus on the various ways to define social support, the function of social support as a mediator of well-being and the importance of social support in caregiving.

Various Ways to Define Social Support

Social support, as defined by Thoits (1982), is the degree to which an individual's basic social needs are met through interaction with others. In reviewing the literature, it is evident the role of caregiving and the stress it brings about are affected by the various types of support available to the caregiver (Cantor, 1983; Fengler & Goodrich, 1979; George & Gwyther, 1986). Social support is important in minimizing stress, but what exactly is social support? Social support has been defined in many ways by various authors (Cobb, 1976; Diamond & Jones, 1983; Weiss, 1974). One difficulty frequently encountered in the social support literature is the lack of specificity in the operationalization of the concept.

According to House & Kahn (1985), social support can be defined in three general ways. It can first be defined by the existence or quantity of social relationships. Second, it can be defined in terms of the structure of a person's social relationships. Third, social support can be defined in terms of the functional content of relationships.

When defining social support based on the existence or quantity of social support, the frequency of contact with friends and relatives is assessed along with the actual number of relationships that exist between these individuals. Also, information related to marital status and living arrangements as well as membership in any organizations, such as a church or other private group is considered. Evaluating the existence of social support based on these characteristics is relatively objective and concrete. Consequently, many studies are based on this type of data.

When defining social support in terms of the structure of a person's social relationship the emphasis is placed on the characteristics of the social network. These characteristics were best described by Israel (1982) who labeled them as structural and interactional characteristics.

The structural characteristics of the social network include size or range and density. The range is represented by the number of individuals a person is able to either see or speak with at any point in time. The density is the extent to which all the individuals know one another. This is represented by the degree of familiarity between the individuals within the network.

The interactional characteristics identified by Israel (1982)

are as follows: First is content which refers to the meaning individuals give to their relationship such as friend, kin or neighbor. Second is directedness or the extent to which assistance is reciprocated. Third is durability or the extent of stability between individual relationships. Fourth is intensity or the emotional closeness between individuals. Fifth is frequency, the number of interactions between the focal person and the network members. Sixth is dispersion or the ease with which a person can make contact with network members. Seventh is the homogeneity or similarities the network members share such as education level, income level or religious preference.

In summary, to define social support in terms of the structure of a persons social network, there are many characteristics to be considered. There are the two structural characteristics which refer to the actual number of individuals in the network and the degree to which they know one another. Then there are the seven interactional characteristics including content, directedness, extent of stability, intensity, frequency, dispersion and homogeneity. These characteristics refer to the individual relationships within the network, and enable us to describe the support network in greater detail.

When defining social support in terms of the functional content of relationships, emphasis is placed on the type of support directly provided to the individual. This could include affective or emotional support meaning the provision of moral support, caring and love. Functional social support could also refer to instrumental support such as provision of tangible aid or services such as money,

transportation and meal preparation. Another type of support is cognitive support or that which includes advice, feedback or new knowledge and information. A final type of support is that of social outreach or the accessibility to social contacts.

Realistically, when defining social support as it pertains to structure, the existence or quantity of social relationships and the functional content of relationships frequently overlap. Researchers do, however, try to make distinctions between all three dimensions when defining social support.

Social support is most frequently defined in terms of the functional content (House & Kahn, 1985). This specifically relates to the emotional concern for others, as well as the instrumental or tangible aid provided. As noted by Berkman (1983), social networks are the web of social relationships that surround the person and provide the social support defined as the emotional, instrumental or cognitive.

There are two types of networks which provide social support: formal and informal (Cantor, 1983; Goodman, 1986). Support provided by an established agency or organization outside of the home is support provided by a formal network. The services provided by a formal network can be provided either inside or outside of the home and are financially supported either through private pay, insurance or governmental funding.

Sources other than established agencies which provide support are considered informal sources of support. The assistance is usually, but not always, provided without a monetary charge to the caregiver, and is frequently considered a normative obligation.

Contrary to previous beliefs, Cantor (1983) found the informal support network, consisting of friends and family, provided more assistance to caregivers than did formal networks such as hospitals and health care agencies. Stoller & Pugliesi (1988), however, found that as people age their support network may change based on their needs, resulting in more utilization of in-home formal services as a supplement to informal assistance.

In this study, social support will be defined in terms of the functional content. Emphasis will be on the instrumental support provided by the informal network to the caregiver.

Social Support as a Mediator of Well-being

Numerous research studies have focused on the relationship between the availability of social support and its effect on modifying stress and maintaining health (Cobb, 1976; Israel, 1982; Gottlieb, 1981; Lakey & Heller, 1988; Baillie, Norbeck, & Barnes, 1988). There are two major views as to how social support can affect an individuals health and well-being. The first view is that it acts as a buffer in preventing illness and the second view is the theory that social support exerts a direct effect on health and well-being.

The buffering hypotheses described by Gallo (1982) suggests that social support facilitates an individual's ability to cope with a crisis as it develops and helps to minimize the effects of a crisis. Baillie, Norbeck & Barnes (1988) were unable to determine a buffering effect of social support, but noted that although some studies find significant buffering effects for social support many find only main effects.

The direct effect theory, as described by Thoits (1982),

suggests social identity and self evaluation originate in social interaction, which consequently influences a person's sense of well-being. Because social support helps to strengthen and maintain social identity and self-esteem, it may indirectly influence well-being. Therefore, social support can directly affect an individual's state of health and indirectly influence their well-being, independent of a major life change or crisis.

Many researchers have focused on how social support impacts health and well-being. However, it remains unclear which specific aspects of the supportive social relations are responsible for these effects.

Satisfaction to Represent Adequacy

Berkman (cited in Krause, 1987) indicated that the benefits of support may be attributed partly to the feelings of contentment and belonging which may arise from social relationships. Krause (1987) suggested that feelings of contentment did not arise directly from the mere provision of support but were based on subjective evaluations of the adequacy of support received. Furthermore, the feelings of satisfaction with support were believed to arise only if the need for support had been met. Based on this, satisfaction was believed to be a subjective representation of the degree to which adequate support is received.

Determining the best indicator to represent the benefits received by caregivers from their social support networks is of critical importance. There are various factors such as the frequency of support, measures of well-being, and individual perceptions which may be utilized as indicators, but all have varied degrees of

reliability.

Schaefer, Coyne and Lazarus (1981) found the perception of social support to be the best indicator of how helpful a supportive action is to the recipient. Ward, Sherman & LaGory (1984) also noted that whether a person perceives he has adequate social support is more important than determining in an objective sense whether he has enough. Perceptions seem to be the best indicator by which to measure satisfaction with support.

Perceptions of satisfaction with support can represent adequacy of support, but those perceptions may also be influenced by other variables. Vaux & Harrison (1985) and Lyles, King, Given and Given (1989) identified a few of these variables which include past and present levels of support, network size, and closeness of relationships. Controlling for these variables is not within the realm of the present study.

Consequently, knowing the caregivers' perceptions alone will not allow the researcher to have complete understanding of satisfaction related to actual support. It will, however, enable a correlational analyses between the various categories of support and the degree of satisfaction. This will provide a clearer understanding of which supportive functions are most strongly related to an individual's level of satisfaction, with regard to social support, and may ultimately improve their state of well-being.

The Importance of Social Support in Caregiving

Many caregivers who do not want to be the sole source of help have indicated to researchers that it would be beneficial to have

support from outside sources to help relieve some daily responsibilities (Baines, 1984). Wives, on the other hand, tend to be less willing to accept help from others. Wives feel that through the caregiving role they are fulfilling their obligation to their husbands and at times have felt guilty if unable to provide total care to their husbands (Hooyman & Lustbader, 1986).

Another deterrent to accepting assistance relates to financial status, since in most cases neither spouse is working. Wives fear paying for any help since it may disrupt their savings and eventually leave them with nothing. Consequently, they suppress this option for as long as possible.

The assistance most often requested by caregiving wives is respite care. Respite takes the form of someone who comes to stay with the patient so that the caregivers themselves are able to leave for awhile (Baines, 1984; Snyder & Keefe, 1985). Knowing that they have time for themselves is the greatest relief for wives, since frequently they are caregivers twenty-four hours per day. Respite allows them time to be free of complete responsibility, to be among others and be free of the constant stress they experience.

In conclusion, research has shown that women are usually considered the primary caregivers. Wives are most often the primary caregivers followed by daughters, if the wife is disabled, or if the care-recipient is female. The female spouse caregivers, identified as "hidden victims", have been targeted as one of the groups at highest risk for problems because of the minimal support they receive or are willing to utilize.

There are multiple ways in which the caregiving role may place a [illegible] find it difficult to admit [illegible] need help [illegible] tend to be less willing to accept help [illegible]. Wives feel that in the caregiving role they are fulfilling their obligation to their husbands and at times have felt guilty if unable to provide total care to their husbands (Hooyman & Lustbader, 1986).

Another deterrent to accepting assistance relates to finances [illegible] since in most cases neither spouse is working. Many are [illegible] paying for any help since it may interrupt their savings and eventually leave them with nothing. Consequently they attempt to [illegible] as long as possible.

The assistance most often requested by caregiving wives is respite care. Respite takes the form of sitters who come to the home with the patient so that the caregivers themselves are able to [illegible] (Barusch, [illegible]). Knowing that they have time for themselves is the greatest need for wives, [illegible] frequently they are caregivers twenty-four hours per day. [illegible] the responsibility [illegible] of [illegible] the constant stress they experience.

In conclusion, research has shown that women are [illegible] the primary [illegible]. Wives are most often the caregivers followed by daughters [illegible] the wife is [illegible]. The female spouse caregivers [illegible] "hidden victims", have been targeted as one of the groups [illegible] highest risk for problems because of [illegible] they [illegible] willing to utilize.

This [illegible]

strain on an individual's life style. The major concerns noted by wives were the effects caregiving had on their financial status and the amount of time the caregiving role required (Cantor, 1983; Fengler & Goodrich, 1979).

Informal social support from family and friends seems to be the source of support most readily utilized by female spousal caregivers if support is utilized at all (Tennstedt, McKinlay & Sullivan, 1989). Even though much data is available emphasizing the risk of the female spouse caregivers, little has been done to evaluate the type of support most and least frequently available, and how strong the relationship is between the frequency of support provided and the caregiver's degree of satisfaction with support.

Throughout the literature wives have been shown to differ from other caregivers on various issues with regard to support needed, available and utilized in the caregiving role. The area related to support provided by the informal network and the degree of satisfaction with that support is one more area which requires further research. Consequently, it seems reasonable to investigate the type of support wives are receiving, particularly from the informal network, since this seems to be their greatest source of support. Also of importance is the degree to which they are satisfied with the support they are receiving.

Purpose and Significance of Study

The purpose of this study is to identify with what frequency instrumental support is provided by family and friends/neighbors to the female spouse caregivers, to what degree the female spouse

caregivers are satisfied overall with the support provided, and whether there is a relationship between frequency of support provided and degree of satisfaction.

The data collected in this study are measures of the support available from the informal network to caregivers. This is of significance to nursing since Cobb (1976) has found social support to be protective against pathological states in people trying to cope with a great deal of stress, particularly in new roles. Researchers have shown that the female spouse caregivers utilize very few formal services and choose the family as the first source of support when assistance is needed (Snyder & Keefe, 1985; Baines, 1984; Cantor, 1983). Therefore, it is important to understand as much as possible about the support received by caregivers from the informal support group. This can then be added to the already existing knowledge.

The present study will enable health professionals to begin identifying areas in which the informal group does and does not meet the needs of the caregivers. By determining the degree of satisfaction with the support provided, researchers can then begin to identify individuals who are not satisfied and look more closely at the type of support that may be deficient.

Analyzing the informal social support group from this perspective may encourage health professionals and government officials to consider why certain types of assistance are not provided by this group. Further research may then be performed to determine what incentives are needed by the family and friends to enable greater participation on their part.

Since nurses frequently are the caregivers' link to obtaining

assistance when needed, it is very important that nurses identify the support available to the wives through the informal support system and their degree of satisfaction with that support. If wives are unable to receive what they perceive as adequate assistance from this group of friends/neighbors and family, then utilization of support from the formal network may need to be considered in the future.

Montgomery (cited in Theis & Deitrick, 1987) found caregivers did not seek assistance from outside sources until they reached a point of exhaustion or experienced a crisis. To study the utilization of formal services is not within the scope of this project. Therefore, the data obtained will be used only to determine how the informal network could be better utilized to provide assistance.

The data from this study could also be used in the future. A comparison could be made with other caregivers to determine how availability of support differs and whether there are similar correlations between types of support and degree of satisfaction.

Consequently, this research study will be of great significance to nursing research. First, it will provide new knowledge regarding areas of assistance which are not being provided by the informal support system. Second, it will provide a database from which further research can be developed enabling continued growth in this area of research.

Summary

To summarize, the topic of caregiving has taken on great interest over the last decade due to the changes in demographics and

resulting strain on the health care system. Researchers have identified females as the primary group of caregivers, with wives being the most deeply involved in the care of family members in most instances (Sherman, Ward, & LaGory, 1988). Whenever a situation requiring care of an individual arises, women are first to be selected and they feel obligated to assist. This occurs regardless of the already established roles these women may have.

Wives are considered to be at significant risk for health problems, but recognizing the support available to them as well as their satisfaction with the support, may allow health professionals to minimize that risk. Family and friends/neighbors, members of the informal support system, have been identified as the primary providers of support to spouse caregivers.

The informal network can be supported by identifying areas in which assistance may be needed. This will enable the needs of the caregivers to be met. Assistance could be provided through incentives or through direct provision of services. Caregivers and their support network are presently being physically, emotionally and financially over-burdened by their roles. Regardless of the means used to provide assistance, it must be provided if the role of caregiving is to remain in the home.

Research Questions

I. What categories of instrumental support are provided by family members and friends/neighbors to wives who are caregivers?

II. What is the caregivers' overall degree of satisfaction with the support from family members and friends/neighbors?

III. What are the relationships between the categories of instrumental support provided and the overall degree of satisfaction with support?

Definitions of Concepts

The following are definitions of the concepts introduced in the research questions and used throughout the study.

Female Spouse Caregivers (Wives)

A caregiver is a person who provides assistance to an individual in need of help. The female spouse caregiver will be at least 65 years of age and identified as the primary caregiver to her husband. The wife will be living in the same household with the care-recipient. The caregiver will be providing assistance in at least one activity of daily living (ADL) or instrumental activity of daily living (IADL).

Instrumental Support for Caregivers

Instrumental support has been defined by House (1981) as support provided through helping behaviors such as the provision of money or labor. In this study instrumental support will be defined as support provided by family members and friends/neighbors to wives who are functioning as primary caregivers for a disabled elderly husband.

The categories of support to be evaluated will include care related to ADL, the provision of material goods, and the provision of assistance, enabling the caregiver to have more time for the patient and herself. The instrumental support includes helping with physical care during the day and night when needed, providing transportation,

and providing financial assistance or other material goods as needed, such as food and clothing. Another area of support thought to be in greatest demand, the provision of respite for a day or longer, will also be examined (Theis & Deitrick, 1987; Snyder & Keefe, 1985).

Degree of Satisfaction

This study will determine a level of satisfaction based on the caregivers' perceptions. In identifying their degree of satisfaction, it is expected that the individuals' perceptions will reflect the adequacy of support provided. Thus, for purposes of this study satisfaction will be defined as the caregivers' perceptions of the adequacy of support. It will be important to determine the degree to which they are satisfied in order to determine whether the overall support they are receiving is adequate. The level of satisfaction will be a measure of how the caregivers view all informal support provided to them overall. Their perceptions will be measured by a single question with a four point answer scale.

Family Members

Family members are individuals who are related, either through blood, marriage, or adoption, to the caregiver. They will live either with the caregiver, or outside of the caregiver's household.

Friends/Neighbors

Friends/neighbors are individuals who are not blood related or married to family members. They will live within an unspecified distance outside of the caregiver's household and will be self-identified by the caregiving wife.

Overall Support

All support provided by the informal group to the caregiver, including emotional and instrumental support, will be considered when measuring the degree of satisfaction with support provided.

Assumptions

For purposes of this study, the following assumptions were made:

1. The responses to the interview reflect honestly and accurately the individuals' perceptions at that point in time.

2. The questions are sensitive enough to determine level of satisfaction based on quantitative, as well as qualitative aspects of support.

3. The caregivers will be able to differentiate their satisfaction of support provided by family and friends/neighbors.

4. Social support is important to women who are providing care to their disabled husbands.

5. The experience of caregiving affects the potential for receiving social support.

Limitations

The following limitations were identified in this study:

1. The availability of informal support is based on a three month period of time. Therefore, the findings of this study may not reflect the type or frequency of informal support provided at any other time.

2. The sample, though state-wide, was selected based on willingness to participate rather than in a random fashion. Therefore, the research findings may not apply in the same way to

various ethnic groups which were not included in the sample or to wife caregivers in general.

3. Due to the design of the questionnaire, there will be no distinction between support provided by neighbors or friends. They are combined and considered one of the two informal sources of support.

4. The impact of the many extraneous variables, such as the past levels of support and expectations of the support network, on the caregivers degree of satisfaction with support, are not within the scope of this research study.

5. The researcher is limited to using the database as it exists with no recourse to redesigning the study when using secondary data.

6. The degree of satisfaction will be determined with a single item measure.

7. The accuracy of recalling the frequency of support provided may be affected due to the use of retrospective questioning.

Overview of the Chapters

This study is organized into six chapters. Included in Chapter 1 are the background to the study, the purpose for the study, definition of concepts, limitations, and assumptions underlying the study. The concepts relevant to this study are integrated into a conceptual framework upon which the research questions are based in Chapter 2. A review of the literature is presented in Chapter 3 indicating pertinent background information relevant to the research questions and those variables which they address. In Chapter 4, the methodology, design and procedures are explained. A description of the population and setting of the study, data collection procedures,

instruments and method of data analysis are presented. An analysis of the data collected in answering the research questions is presented in Chapter 5. A summary and interpretation of the findings are presented along with recommendations for further research in Chapter 6.

CHAPTER 2: CONCEPTUAL FRAMEWORK

Overview

This chapter will be separated into four sections. The first section will include the steps followed to select the framework most appropriate to guide this study. In the second section an overview of the Kahn & Antonucci (1980) framework is presented including a description of its components and the relationships between components. The third section will include an explanation of how this study's concepts are linked with those in the framework selected. In the fourth section a brief overview of why the study of social support is important to the nursing profession will be presented.

Selecting a Conceptual Framework

In selecting a conceptual framework to use as a basis for this study, I considered the key concepts and how they were related, as indicated by previous research as well as my own practical experience. The main concepts in this study are female spouse caregiver, instrumental support and degree of satisfaction. The purpose of this investigation was to identify with what frequency instrumental support was provided by family and friends/neighbors to the female spouse caregiver, and to what degree the female spouse caregiver was satisfied with the overall support provided.

Family members are most likely to accept the role as caregiver, due at least in part to a sense of obligation. The female caregiver has been identified as the primary caregiver in most instances (Johnson & Catalano, 1983). Wives most often fulfill this

responsibility when considering elderly couples in a caregiving situation. When compared to husbands who provide care, wives provide a greater percentage of hands-on care, primarily due to the way they were socialized. These women are often under medical care themselves and provide care to their husbands on a 24 hour basis. Thus, these wives are likely to be under considerable stress and strain.

Wives who provide care are under great stress and it is important to know the type and amount of support they are receiving. With this information health professionals may be able to gain a better understanding of the support most frequently and least frequently utilized by caregivers. Further examination of the satisfaction with this support could then be performed.

In the study of support provided to caregivers, there are many dimensions of support which may be considered. When House (1981) examined social support, he concluded that there were four types or functions of support. The four types of support included emotional, instrumental, informational, and appraisal. House & Kahn (1985) suggested that the functional content of social relationships was studied the most often. Their definition of functional support referred to the degree to which the relationships involved emotional concern, instrumental aid, and/or provision of information.

When House & Kahn (1985) studied the domain of social support they identified three criteria by which to examine the functional content of social support. Those criteria included the type of support, the source of support, and the quantity of social support.

In the conceptual framework described by Kahn & Antonucci (1980) the criteria House & Kahn (1985) utilized to examine social support

could also be applied in the examination of the "convoy" characteristics. Kahn & Antonucci (1980) described the convoy as the support network, with emphasis on the type of support provided by specific individuals over the course of life. Kahn & Antonucci's framework could easily be used as a guide to examine specific sources of support which provide specific types of support.

In determining the degree of satisfaction with support, it is likely that the quality of the relationship will be a great influence. Thoits (1982) suggested that quantity and frequency of social contacts alone were not adequate representation of social support. She believed that the actual representation of support resided in the fulfillment of needs which indicates a more qualitative evaluation by the individual receiving support.

Krause (1987) also suggested that feelings of contentment did not arise directly from the mere provision of support, but were based on subjective evaluations of the adequacy of support received. The feelings of satisfaction with support were believed to arise only if the need for support had been met. Therefore, utilizing the degree of satisfaction as a subjective measure allows for the adequacy of support to be determined based on individuals' overall perceptions.

George & Gwyther (1986) suggested that the perceived level of adequacy could be a strong indicator of the caregivers' well-being. They also found the resources available and characteristics of the caregiving situation have the most direct influence on the well-being of the caregiver. Thus, researchers have found a relationship between situational characteristics, adequacy of support, and level of well-being. It is important, therefore, to have a clear could also be applied in the examination of the "convoy" characteristics. Kahn & Antonucci (1980) describe the convoy as the support network, with emphasis on the type of support provided by specific individuals over the course of life. Kahn & Antonucci's framework could easily be used as a guide to examine specific sources of support which provide specific types of support.

In determining the degree of satisfaction with support, it is likely that the quality of the relationship will be a great influence. Tracy (1981) suggested that quantity and frequency of social contacts alone were not adequate representation of social support. She believed that the actual representation of support is based on the fulfillment of needs which indicates a more qualitative evaluation by the individual receiving support.

Krause (1987) also suggested that feelings of contentment did not arise directly from the provision of support, but were based on subjective evaluations of the adequacy of support received. The feelings of satisfaction with support were believed to arise only if the need for support had been met. Therefore, utilizing the degree of satisfaction as a subjective measure allows for the adequacy of support to be determined based on individuals' overall perceptions.

George & Gwyther (1986) suggested that the perceived level of adequacy could be a strong indicator of the caregivers' well being. They also found the resources available and characteristics of the caregiving situation have the most direct influence on the well being of the caregiver. Thus, researchers have found a relationship between [illegible] characteristics, adequacy of support, and level of well being. It is important, therefore, to [illegible] understanding of the support provided to female spouse caregivers, to know who is providing it, and to know whether it is adequate to meet the caregivers needs.

In summary, the focus of this study is on the wives in the caregiving role, to determine the amount of instrumental support provided to them and their level of satisfaction with the support provided. The functional dimension of social support will be evaluated. This dimension of support will be evaluated in terms of the type of support provided to the caregiver, the source of the support, the frequency with which it is provided, and the perceived adequacy of the support. The perceived adequacy of support will be represented by the degree of satisfaction expressed subjectively.

Based on the concepts identified as important to this study, Kahn & Antonucci's framework (1980), linking social support and well-being, was chosen for this study. Prior to selecting this framework a few other models were considered.

Initially, Imogene King's (1981) nursing model was considered along with other nursing models. None of these models, however, were appropriate for displaying the relationship between the support provided to an individual and the perceived satisfaction with that support.

In reviewing other social support models, the one initially considered was developed by Andersen & Newman (1973). This model depicted the relationship between societal conditions, individual characteristics, and the health service system. The emphasis of Andersen & Newman's model was on the factors which influenced a person to obtained support from formal services. The focus of the

present study is on utilization of support from the informal network, with specific emphasis on the source, type, and frequency of support provided. In addition the degree of satisfaction is also of interest.

Based on my review of the conceptual frameworks, Kahn & Antonucci's (1980) was selected. Their framework is based on the central proposition that social support is important to individual well-being throughout the life course, both directly and indirectly buffering the effects of stress.

In the past it was thought that present behaviors and well-being of individuals were strongly dependent on their behavior and well-being of the past. Brim & Kagan (cited in Kahn & Antonucci, 1980), however, have concluded through their studies that individuals have the capacity for change across the life span.

The findings of Brim & Kagan (cited in Kahn & Antonucci, 1980) suggested that researchers must become more aware of present personal and situational factors. The factors to consider include any significant recent events, recognition of transition periods, and awareness of factors which would facilitate successful coping.

In this study one goal was to determine how satisfied the caregiving wives were with the support provided by the informal network. Their level of satisfaction could be an indication of the likelihood of their ability to cope with the situation of caregiving and ability to maintain their state of well-being. Thus, the central proposition of Kahn & Antonucci's framework and the general assumption of this study have a similar focus, maintaining a person's level of well-being.

Framework by Kahn and Antonucci

This section will consist of a description of the Kahn & Antonucci (1980) model and its concepts. An explanation will follow to suggest how the concepts in their model will be related to the concepts identified in this study.

In understanding the framework of Kahn & Antonucci (1980), it is important to remember that they are considering the determinants of individual well-being throughout the course of life. They suggest by their central proposition that the social support needed and the influence it has in helping individuals manage stress will vary throughout the course of life. There are many factors, such as declining family size, increased mobility of family members, and the increased number of women who are employed, which could influence the social support available to individuals today, compared to that available 20 years ago.

Kahn & Antonucci (1980) emphasized the importance of interaction between variables. The individuals identified in a support network are individuals encountered during the participation in various roles throughout life. Thus, as roles change so may the support group, as well as the type of support needed.

Definitions of Concepts

In their framework Kahn & Antonucci (1980) identified a central concept "the convoy", which is influenced by individual and situational factors (see Figure 1). Based on the adequacy of the convoy in providing support, a person's performance in their roles and state of well-being are affected. Following is a description of

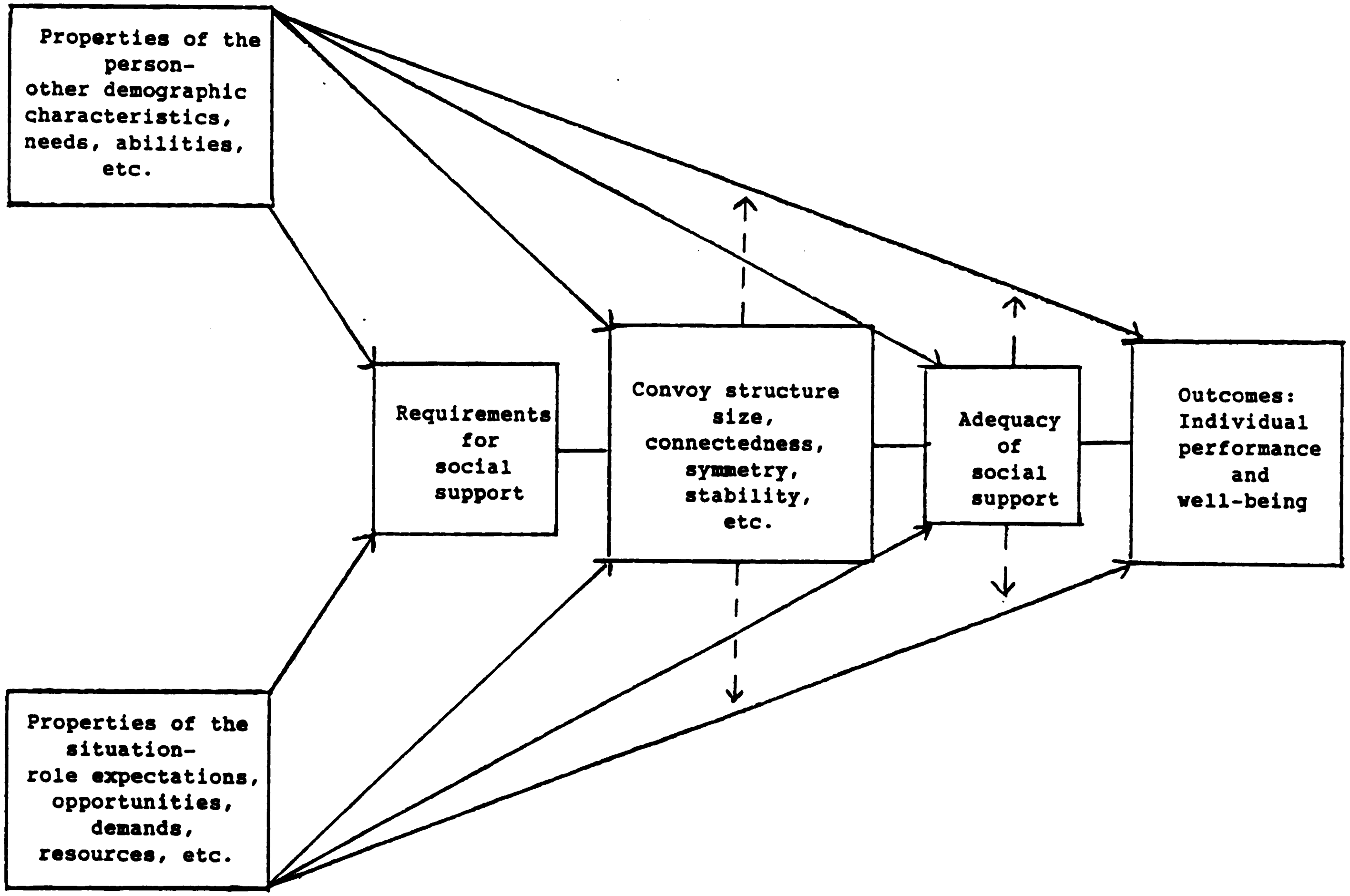


Figure 1. Hypothetical determinants and affects of convoy properties as developed by Kahn & Antonucci (1980).

the components identified in Kahn & Antonucci's (1980) model.

The first two components depicted in the model are the properties of the person and the properties of the situation (see Figure 1). The properties of the person include age along with other demographic characteristics. An individual's perceived need for assistance and abilities to fulfill those needs are also considered as properties of the person.

The properties of the situation include role expectations, opportunities available, demands of others and resources. This component reflects the needs of others, rather than the personal needs of the individual who may provide assistance.

The next component, influenced directly by the personal and situational properties, is the requirements for social support. If an individual has many responsibilities and needs, but does not have the ability to handle them, this will influence whether support is needed and desired.

All these three components will jointly influence the structure of a person's "convoy", the next component of the model (see Figure 1). The convoy is an individual's social network through which support is provided and received. At any point in time an individual's support network will consist of persons on whom he or she relies for support and those who rely on him or her for support. The social network is likely to change as an individual's roles change, due to alterations in the interactions between individuals.

The structure itself consists of family, friends and others who may have become a part of the supportive network at various periods in time. The development of this network is not dependent on an

individual's defined role, but rather on an overlapping of many roles. Thus, this network consists of individuals encountered throughout a person's lifetime and is thought to change as a person's needs for various types of support change.

The convoy can be defined more specifically by identifying the major network properties or by identifying characteristics of the relationship between the focal person and the network members. The major network properties include size, stability, homogeneity, symmetry and connectedness. These properties relate to the structural characteristics of the network as a whole.

The properties of the dyadic links between the focal person and other network members have been identified and defined by Barnes (cited in Kahn & Antonucci, 1980) in his network analysis. The properties analyzed include interaction frequency, type, magnitude, initiative, range, duration and capacity. In whatever manner the convoy is defined, the support provided by its members is of greatest importance.

Social support has been defined differently by many authors. House (1981) defined social support as consisting of four categories of supportive acts namely, emotional (affect, trust, concern), appraisal (affirmation, feedback), informational (advice, suggestions) and instrumental (aid, labor, time).

Kahn & Antonucci (1980) define social support as interpersonal transactions which include one or more of the following elements: affect, affirmation and aid. Through an affective transaction the individual experiences a feeling of being admired, respected or loved. In transactions of affirmation there is an expression of

agreement or acknowledgment regarding the appropriateness of some act or statement of another individual. In addition, transactions are considered supportive when there is a provision of aid. This includes provision of money, information, time and/or goods.

Among these authors there are similarities in the categories of social support but differences in the wording. House (1981) separated informational support from instrumental where as, Kahn & Antonucci (1980) considered them as one category.

Adequacy of support (see Figure 1), the next component of Kahn & Antonucci's (1980) model, is influenced by the personal and situational properties as well as the convoy characteristics. Once the individual can determine his needs based on the specific situation, he can determine if the support available from the convoy is adequate.

How individual's evaluate whether other individuals are supportive or not has only recently become of interest. Kahn & Antonucci (1980) suggested that in order to evaluate adequacy of support, among other things, there must be ways to distinguish between objective and subjective measures of social support. Subjective support refers to adequacy of support as perceived by the person receiving it. How well an individual is able to perform in his roles and maintain a sense of well-being, could be influenced by personal and situational properties as well as the perceived adequacy of support.

Throughout discussion of this model, there is a strong emphasis placed on interaction between variables. An important implication of this interactional relationship is that the model allows for change

throughout the life course, depending on the individual situational and personal factors. This suggests that support could, therefore, be inappropriate if these factors are not considered.

To summarize, based on Kahn & Antonucci's (1980) explanatory framework (see Figure 1) linking social support and well-being throughout the life cycle, the following propositions have been suggested:

1. A person's requirements for support at any given time are determined jointly by properties of the person and of the situation.

2. The structure of a person's convoy is determined jointly by these enduring properties of the person, the situation, and the person's requirements for social support.

3. The adequacy of social support is determined by properties of the convoy, and by personal and situational properties.

4. Well-being and performance in major life roles are determined by adequacy of social support, and by personal and situational properties.

5. The influence of personal and situational factors on performance and well-being is moderated by convoy properties and by the adequacy of social support thus provided.

In conclusion, the convoy or social network is very important to a person's well-being. The social network provides the support which enables the individual to fulfill his many responsibilities. As an individual ages, his responsibilities along with parts of his social network, change. These changes must be considered in order to understand why a person's network may not be able to meet his needs completely.

Cobb (1976) examined the idea that support could influence a person's well-being during periods of acute stress and role change throughout the course of life. Kahn & Antonucci (1980) described the findings of various authors related to the buffering effect of support. Social support is seen as a buffer to help individuals cope with stressful situations and change, thus, enabling them to maintain a good state of health and well-being.

Application of the Model to This Study

The framework developed by Kahn & Antonucci (1980) is an excellent guide for this study (see Figure 2). Even though this researcher did not evaluate the outcome of well-being specifically, the reasons for asking the questions ultimately reflect on the general well-being of the caregiver. In this section an explanation will be provided to suggest how the concepts of this study are related to the concepts identified by Kahn & Antonucci.

Initially Kahn & Antonucci (1980) discussed the importance of considering personal and situational factors (see Figure 2). These factors were important in the development of this study as well. Differences have been identified between various groups of caregivers (Cantor, 1983; Hooyman & Lustbader, 1986). Much of the research has been related to women, but particularly middle-aged women who are caring for their parents. Middle-aged women have been considered to be at risk, in particular, due to role overload as a result of their responsibilities to their family, their career and their parents. Consequently, research in this area has been emphasized.

On the other hand, few researchers have been interested in the

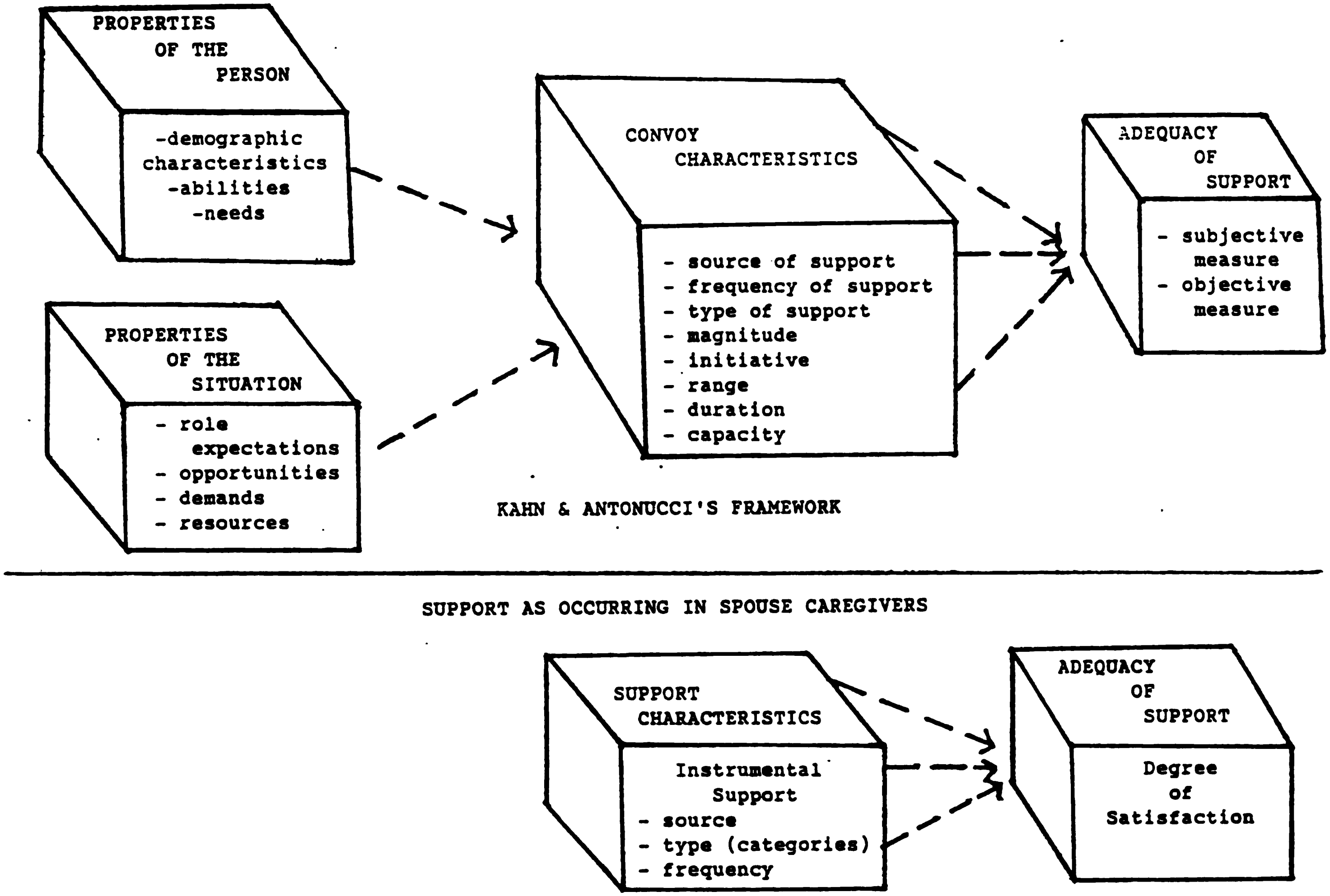


Figure 2. Adaptation of Kahn & Antonucci's framework (1980) to the study.

older female spouse caregiver because they were thought to have fewer responsibilities. Wives now are thought to be at equal or greater risk, because they are trying to do everything on their own, they are more isolated, and have their own health problems to cope with as well (Fengler & Goodrich, 1979). Thus, the need for support is likely to vary based on the personal and situational characteristics.

In the present study the personal and situational characteristics were important, but their influence on the other variables was not a major focus of study. A sample with specific personal and situational properties (elderly female spouse caregivers) was selected for this study. Because no comparison was made between various groups of individuals, the concepts of personal and situational properties were not depicted in the conceptual model representing this study's variables (see Figure 2).

Next, Kahn & Antonucci (1980) described the convoy as the core concept symbolizing the ever changing social network. The general and specific properties of the convoy were defined. They all were considered to be important in determining the adequacy of support. In this study emphasis was not on the major network properties, such as size, connectedness, symmetry, or stability, but rather on the properties of the dyadic links between the focal person, or caregiver, and the informal support group members including family and friends/neighbors. The major structural characteristics of the network as a whole may be influential, but were not considered in this study.

The convoy characteristic of primary interest was the instrumental support provided by the support group to the focal

person, the caregiver. Specific characteristics of the instrumental support provided could influence how an individual may determine their degree of satisfaction with the support. The characteristics of instrumental support considered in this study included the source of support, the type of support, and the frequency with which the support was provided.

Therefore, as depicted (see Figure 2) the overall convoy characteristics of Kahn & Antonucci's model were represented by the specific characteristics of instrumental support provided by the informal support group. Those characteristics included the source (family and friends/neighbors), the type (categories of instrumental support), and the frequency of support (none to almost all the time) provided. Based on the influence of these characteristics, the degree of satisfaction with support was determined.

The last component of Kahn & Antonucci's framework which related to this study was the adequacy of social support (see Figure 2). The researcher's interest with social support revolved around the type of informal support provided and its frequency, but more importantly how the caregiver viewed its adequacy in meeting her needs. Kahn & Antonucci (1980) suggested that the characteristics of the support network and the support provided, could influence an individual's perceptions of the adequacy of support.

Regardless of the support available, if the individual is not satisfied, this then becomes a concern for health professionals. The adequacy of social support may be an indirect way of evaluating the quality of the support provided, based on the perceived satisfaction of the caregiver as a subjective measure. Thus, the adequacy of person, the caregiver. Specific characteristics of the instrumental support provided could influence how an individual may determine their degree of satisfaction with the support. The characteristics of instrumental support considered in this study included the source of support, the type of support, and the frequency with which the support was provided.

Therefore, as depicted (see Figure 2) the overall convoy characteristics of Kahn & Antonucci's model were represented by the specific characteristics of instrumental support provided by the informal support group. These characteristics included the source (family and friends/neighbors), the type (categories of instrumental support), and the frequency of support (none to almost all the time) provided. Based on the influence of these characteristics, the degree of satisfaction with support was determined.

The last component of Kahn & Antonucci's framework which related to this study was the adequacy of social support (see Figure 2). The researcher's interest with social support revolved around the type of informal support provided and its frequency, but more importantly how the caregiver viewed its adequacy in meeting her needs. Kahn & Antonucci (1980) suggested that the characteristics of the support network and the support provided could influence an individual's perceptions of the adequacy of support.

Regardless of the support available, if the individual is not satisfied, this then becomes a concern for health professionals. The adequacy of social support may be an indirect way of evaluating the quality of the support provided, based on the perceived satisfaction of the caregiver as a subjective measure. Thus, the adequacy of support as defined by Kahn & Antonucci was operationalized in this study based on the degree of satisfaction as indicated by the caregiver (see Figure 2).

Unlike Kahn & Antonucci's (1980) framework, the outcome of the present study was to determine if the caregivers were satisfied, and then identify the relationship between satisfaction and frequency of support. Indirectly this information could be used to determine an individual's state of well-being. However, for purposes of this study well-being was not investigated.

In conclusion, Kahn & Antonucci's (1980) framework was an excellent guide to demonstrate the interrelationship among the concepts of this study. The concepts identified, i.e. female spouse caregiver, instrumental support and degree of satisfaction, easily fit into the more general components of Kahn & Antonucci's framework. Overall, with the use of this framework the researcher was able to analyze specific concepts found within the broader components of the chosen framework.

Importance of This Study to Nursing

Social support has always been an important topic to nurses. Many researchers such as Cassel (1976), Cobb (1976), and Norbeck (1988) have found social support to have beneficial effects in helping to maintain an individual's health and state of well-being.

This project will provide nurses with additional information about the adequacy of the support provided to caregiving wives. Nursing professionals have a responsibility to help individuals maintain the best possible health available to them. Therefore, it

is beneficial for nurses to know what support is utilized by caregiving wives and whether the support is adequately meeting their needs.

Norbeck (1981) devised a framework to incorporate social support into clinical practice. The nursing process was applied to the model devised by Kahn & Antonucci (1980). This framework is a helpful guide for nurses who study the importance of social support to individuals at various times in their lives. More discussion of this framework and its benefits to nursing will follow in the implications section of Chapter 6.

Summary

In this chapter, first an explanation was given on the process of selecting a framework to guide this study. Second, a detailed description of Kahn & Antonucci's (1980) framework was presented, including the components and how they relate to one another. Third, an explanation was given incorporating the study concepts into the selected framework. Fourth, the study of social support and its importance to the nursing profession was explained.

The appropriateness of using Kahn & Antonucci's framework as a guide for this study was clearly demonstrated. The interrelationship among the concepts in the study was shown to be very similar to those described in the framework. The review of the literature will be presented in Chapter 3.

CHAPTER 3: REVIEW OF THE LITERATURE

Overview

Researchers have developed an interest in the caregiving role, particularly during the past decade. Due to rigid restrictions on who may and may not remain hospitalized, an increased number of disabled individuals are cared for in their own homes. This has become a growing concern for health professionals who know of the stress and strain experienced with the role of caregiving.

The informal support system, consisting of family and friends/neighbors, has been identified as the primary source of support to caregivers. Support to the caregivers has become of utmost importance in helping to maintain their health status and well-being. Many researchers have studied the effects of social support on well-being, however, few have looked at how individuals view the adequacy of support.

Kahn and Antonucci (1980) suggested that the adequacy of support would influence a person's well-being. A person's well-being could then influence his ability to continue in the role of caregiver. Goodman (1986) noted that it was important to determine what would enable carers to continue caring. Along with knowing the effects of social support on well-being, it is also important to know what support is available and unavailable, and how this correlates with a person's perceived adequacy of support. Information about this relationship will help to better understand what type of assistance most significantly influences a caregiver's level of satisfaction and, therefore, influences their willingness to continue caring.

This literature review will begin with an overview of articles focused on the importance of the informal support network to the caregiver, the instrumental support provided by the informal network, and the limited research available in this area, particularly within the realm of nursing. A selection of articles focusing on the importance of examining perceived satisfaction when studying social support will then be summarized. In conclusion, a review of the literature will be presented on studies designed around the conceptual model developed by Kahn & Antonucci (1980).

Instrumental Support Provided by the Informal Support Network

Various articles have been written on the importance of social support to caregivers and the kind of support provided by the informal support network. Nurses have written articles with a focus on caregiving, but emphasized the importance of understanding the health risks caregivers experience and the need for nurses to continue studying women in the caregiving role.

Since 1986 nurses have become more involved in the study of caregivers and the role of caregiving. Many articles have been theoretical in nature. Very few nurses, however, have done actual research studies to evaluate the kind of support available, the adequacy of support available or the benefit of a supportive intervention.

Bunting (1989) was interested in the health threats caregivers could experience when caring for an elderly relative. She suggested that caregivers were likely to continue caring for the relative, often neglecting their own health care needs. Bunting presented

nursing interventions that could complement and support caregivers in their role.

Phillips (1989) emphasized the importance of considering the elder-caregiver dyad, rather than the elder alone, when providing care. Further examination of the elder-caregiver relationship was recommended to improve the nursing care of the elderly.

Goodman (1986) presented a review of the literature on the role of the family in caring for an elderly relative. She identified who the primary caregivers were, the nature of their responsibilities, and the physical and emotional costs of caring.

In her review Goodman (1986) found few researchers had examined what the caregiver wanted, and suggested service provision was not allocated as appropriately as it could be. She recommended further research, particularly from a nursing perspective, to determine what enabled carers to continue caring.

Robinson (1986b) wrote about the importance of nurses in caring for caregivers. She described elderly women caring for their husbands, and their health risks due to the high levels of stress they encounter. Robinson believed the priority for nursing research should be on the care of the elderly. She recognized the urge to minimize institutionalization, and recommended that research be focused on improving the informal and formal community support systems of the elderly.

In her review Robinson (1986b) found only four articles in the nursing literature related to caregiving. The main discipline that seemed interested in family caregiving were individuals in social gerontology. Ironically, they had also mentioned the importance of

nurses role in caregiving.

Preston & Grimes (1987), both registered nurses, recognized the importance of informal support to the elderly, but emphasized the importance of considering individual differences, such as gender and marital status. For their research study a random, stratified, probability sample was selected. The sample consisted of 311 male and 589 female (N=900) elderly individuals in the Northeast. A limitation of this study was that no indication was given whether the individuals in this study were caregivers or required physical care themselves.

The data was gathered through interviews, then cross-tabular analysis along with Chi square testing were performed. The instruments used in the study by Preston & Grimes (1987) were not presented, but sample questions were provided.

The respondents were asked if they received social support in terms of socio-emotional and instrumental aid and whether it was provided by family, friends, or another source of support. They responded as having support (1) or having no support (0). The majority of all the support available to married males was provided by spouses. On the contrary, majority of instrumental aid available to married females was provided by spouses, but socio-emotional support was provided by family. For both unmarried females and males the majority of all support was provided by family.

Preston & Grimes (1987) concluded there were significant differences between the patterns of social support between men and women. Females were found to use help from all sources more than males, with only a 4% use of agency assistance. There were three

likely reasons for this pattern of service use (a) informal help was sufficient, (b) they were too proud, or (c) they did not require the type of assistance offered. These three hypotheses strongly support the importance of studying more closely the informal support network and the support it provides.

Preston & Grimes (1987) helped to demonstrate the importance of studying the elderly and their need for social support on an individual basis. They took into consideration sex and marital status rather than examining the elderly as a homogeneous group of individuals. Preston & Grimes emphasized the need for nurses to help in strengthening the support network of the elderly.

Theis & Deitrick (1987), two registered nurses, investigated the needs of caregivers who provided care to frail elderly individuals in their home. The investigators utilized a self-selected, convenience sample of caregivers living in a midwestern city. The respondents were located through the Visiting Nurses Association. Of the 180 eligible participants, 90 caregivers responded. The caregivers were 51 to 90 years of age and cared primarily for females averaging 75 years of age.

A survey of 29 items was developed for this study. It was utilized to obtain demographic information, the care-recipient's degree of dependency, the kind of services utilized by the caregiver, and services desired by the caregiver. Theis & Deitrick (1987) found a definite desire for more respite care services among the caregivers and that identifying caregivers' needs was important. The authors suggested that other services may have already been provided in a sufficient amount.

There were some definite limitations to the study by Theis & Deitrick (1987). Because the sample was selected from the VNA, it was considered biased. The participants may have already been receiving assistance and would not have been representative of the total needs of the community. The instruments used in the study had limited reliability and validity testing and further testing with a more representative sample was recommended. No actual results were presented related to the type of support utilized or desired. Only a written explanation of the results was provided.

The strengths of the study by Theis & Deitrick (1987) were the use of the Concern scale and Activity scale. Significant correlations were found between items on the two scales indicating some construct validity in the scales.

Nurses have begun to demonstrate an interest in caregiving, but have done very little to investigate specific dimensions of social support. Nurse researchers tend to investigate the social support concept in very broad terms, concentrating on amount and type of support received. There are very few studies which focus on nursing interventions that may help to alter an individual's support status. This is an area in which nurses should have more interest, since a major function of nurses is to be supportive.

There are also very few nursing studies which relate to other studies. There are many isolated studies, each with a different focus, limiting the usefulness of the results. Nurses should use existing research as a base upon which to develop future studies.

Even though nurses have not examined the provision of instrumental support by the informal network in great detail,

researchers in other professional disciplines have done so. A review of articles is presented next emphasizing the importance of the informal network to the spouse caregiver and the kind of support provided, and not provided, by this network.

Hooyman & Lustbader (1986) in their review of the literature, concluded that families provided approximately 80% of in-home care to persons age 75 years of age and older. Initially, most support was financial or emotional, but as the care-recipients' needs increased, the support changed to provision of more concrete daily services. More time and commitment were required but were not always available to the caregiver or their support system.

Day (1985), in her review of the literature, found 45% of the male care-recipients age 65 to 74 years were cared for by their wives, as were 35% of the care-recipients age 75 to 84 years. Most wives were found to bear the burden of caregiving with very little outside help, resulting in loneliness, isolation and exhaustion.

Hooyman & Lustbader (1986), along with Day (1985), were aware of the changing social trends and the increased likelihood of limited availability of informal support persons in the future. According to Day, families are getting smaller resulting in fewer persons to care for the elderly of the family, and people are living longer resulting in older and possibly more dependent elderly requiring care. Day concluded that these factors may affect the availability and willingness of relatives to undertake extensive in-home care. This observation supports the need to evaluate the type of support available from family and friends and to determine whether the support is perceived as adequate.

[illegible] in other professional disciplines have [illegible]. A review [illegible] to present the most [illegible] of the informal network to the spouse caregiver and the kind of support provided, or not provided, by this network.

Hoorman and Clark (1993) in their review of the literature, concluded that families provide approximately 80% of in-home care to persons age 65 years of age and older. Initially, most support was financial or emotional, but as the care-recipients' needs increased, the support changed to provision of more concrete daily service. More formal services were required but were not often available to the [illegible] of their support system.

[illegible], in her review of the literature, [illegible] of the [illegible] 74 years were cared for by their wives, as well as [illegible] of the care [illegible] 65 to 74 years. [illegible] wives were found to bear the burden of caregiving with very little [illegible] resulting in loneliness, isolation and exhaustion.

Hoorman and Clark [illegible], along with Lay [illegible], were aware of [illegible] and the increased likelihood of limited availability of informal support persons in the future. [illegible] resulting in fewer persons to care for the elderly in the family, and people are living longer, resulting in older and possibly more dependent elderly requiring care. They concluded that these factors may affect the availability and willingness of relatives to provide extensive in-home care. This [illegible] the need to evaluate the type of support [illegible] not only [illegible] but to determine whether the support is perceived as adequate.

In their research, Crossman, London & Barry (1981) examined the issues and problems experienced by older women caring for their disabled husbands. A support program through the community was implemented on a trial basis to fulfill the support needs not met by the informal network.

The support program was first developed to be a peer support group, but then was developed into a respite project which incorporated several services, such as adult day care, home care, and extended respite care. Through the support group, wives shared common experiences and explored alternate methods of coping with their problems. The home care program enabled the wives to have a nurse assist them in the home approximately 4 hours per week. If personal care was not needed, the nurse provided companionship and supervision for the patient and emotional support to the wives. The emotional support was a benefit which was not anticipated initially.

Through the overnight respite program, care was provided in a non-institutional setting by nurses on a 24 hour basis. The facility was open Thursday morning through Monday morning. The husbands could stay for 24 hours or the full four days.

The wives were very appreciative of the services provided through the home care and overnight respite programs. These programs enabled the wives to have time to themselves to complete chores and even enabled some to take vacations they had not been able to take in 12 years. Along with the free time available, the wives could also feel confident that their husbands were receiving the care they needed.

The peer support group was helpful by expanding the support

network for the caregivers, allowing them to address needs which could not be met by the other available sources of support. Several of the women had become more assertive and assumed more control in their own lives as a result of the peer support group. The elderly who participated in the program felt very comfortable with the assistance provided, knowing that it was dependable and that they did not have to impose on others.

The authors acknowledged the benefits of having an informal support network, but also made note of areas in which support was lacking. The two biggest concerns were respite care and finances. The described support program provided respite which was frequently unavailable from the informal support system.

Overall, this research was helpful in presenting a formal support program which would help meet caregivers' needs. It provided information regarding the type of support caregivers are lacking, which was consistent with other researcher's findings. The authors emphasized the importance nurses play in helping the elderly obtain the assistance they need. They stressed the benefit of the nurse in providing emotional support to the caregiver.

Topics suggested for further research included the impact of long-term care on the caregiver and an explanation of the factors that influence the caregiver's decision to seek institutional care for their spouse. An initial step in the exploration of these areas is to gain an understanding of the needs of the caregiver and the support utilized.

Snyder & Keefe (1985), both social workers, examined the health problems associated with caregiving, the existence of informal

support systems, the use of formal social services, and the need for additional supportive services. Their sample consisted of 117 caregivers, of whom 3/4 were spouses, who had been participating in caregiver support groups and caregiver workshops. Participants were also contacted through newspapers, newsletters and "senior" publications in the San Francisco area. The sample was selected on a nonrandom, voluntary basis. The disorders most prevalent among the disabled group included Alzheimer's Disease and related disorders (45%). The remaining individuals were afflicted with a variety of physical disabilities.

Only 43% of the caregivers indicated they received help from their informal network, and of those only 28% indicated assistance was consistent. Caregivers did not consider infrequent relief as sufficient assistance with the ongoing responsibilities of caregiving. Of the 117 caregivers, 50% requested that respite be provided on a consistent basis. The caregivers indicated a need for respite care emphasizing longer breaks from caregiving, allowing them to do more than shop or run errands.

A limitation of the study by Snyder & Keefe (1985) was the possibility that the caregivers in the sample were more sophisticated in their knowledge of services available since they lived in an area rich in social services. The caregivers may have had needs different from caregivers in the general population since supportive services were more readily available. The caregivers may have also had greater expectations of the support network.

The findings of Snyder & Keefe's (1985) study were again consistent with other studies, possibly suggesting the inability of

the informal support system to provide assistance related to long-term respite. These findings may suggest that the assistance required was not available or if available, was not provided when needed on a consistent basis.

Throughout the literature it has been suggested that caregivers receive most of their support from the informal support system. Snyder & Keefe (1985) found informal support was not readily utilized and also suggested minimal use of formal services. Their findings may indicate an unwillingness to utilize assistance, no need for assistance or availability of inadequate assistance.

In reviewing the data collection methods, there was no mention of a question allowing respondents to specifically identify in what ways their informal network provided assistance. Therefore, no specific information could be gathered related to the utilization of informal assistance. This was viewed as a limitation since the examination of specific utilization patterns would have been beneficial in helping to strengthen the support network.

In their study, Tennstedt, McKinlay & Sullivan (1989) wanted to determine who the secondary caregivers were and the type and amount of help provided by them. Other questions were addressed but are not relevant to the present review. A random, stratified sample of individuals was selected from the population of eastern Massachusetts. Of the 429 primary caregivers interviewed, 70% were females.

A three-stage field design was used to identify the respondents and collect data. The first stage of data collection consisted of a 10-item index to determine frailty of the care-recipients. The

second stage consisted of survey interviews of the frail elder sample to determine who the primary caregivers were and the type of assistance provided, along with other data. The third stage involved telephone interviews with the primary caregivers. Data regarding the secondary caregivers were collected in these interviews. No further information related to the instruments was provided.

The findings of the study indicated that there was increased involvement of friends and neighbors in the role of secondary caregiver (24%), compared to the 10% fulfilling the role of primary caregiver. Also, nonrelatives were likely to be secondary caregivers not only to distant relatives in the role of primary caregiver, but also to spouses who were primary caregivers. It was suggested that selection of secondary caregivers may not be based on the hierarchy of support members, but rather on availability factors.

Through further evaluation, the type of care provided by secondary caregivers was identified. The secondary caregivers were less involved in personal care and housekeeping, but more involved in areas requiring intermittent help such as transportation and shopping. These findings indicate a supplementary pattern of assistance by the secondary caregiver, rather than a pattern of substitution.

The amount of care provided by the secondary caregiver was strongly related to the relationship of the primary caregiver to the care-recipient. If the primary caregiver was an offspring or relative, the secondary caregiver provided approximately two-thirds as much help as the primary caregiver. However, if the primary caregiver was a spouse, the secondary caregivers were found to second stage [illegible] of survey interviews [illegible] used to determine who the primary caregivers were and the type of assistance provided, along with other data. The third stage involved telephone interviews with the primary caregivers. Data regarding secondary caregivers were collected in these interviews. No further information related to the instruments was provided.

The findings of the study indicated that there was increased involvement of friends and neighbors in the role of secondary caregiver (24% compared to the 10% fulfilling the role of primary caregiver). Also, nonrelatives were likely to be secondary caregivers not only to distant relatives in the role of primary caregiver, but also to spouses who were primary caregivers. It was suggested that selection of secondary caregivers may not be based on the hierarchy of support needs, but rather on availability factors.

Through further analysis, the type of care provided by secondary caregivers was identified. The secondary caregivers were less involved in personal care and housekeeping, but more involved in tasks requiring intermittent help such as transportation and shopping. These findings indicate a supplementary pattern of assistance by the secondary caregiver rather than a pattern of substitution.

The amount of care provided by the secondary caregiver was strongly related to the relationship of the primary caregiver to the care recipient. If the primary caregiver was an offspring or relative, the secondary caregiver provided approximately two thirds as much help as the primary caregiver. However, if the primary caregiver was a spouse, the secondary caregivers were found to provide only 12% of what the spouse provided. Overall, it was suggested that the relationship of the primary caregiver to the elder was more important than the number of caregivers when determining the total amount of care received by the care-recipient.

The sample selection process increased the ability to generalize the findings of the sample to the population. The instruments utilized were not available for critique, however the data obtained were quite detailed and informative. In conclusion, the study helped to document the importance of the informal support network to the primary caregiver and the assistance most likely provided by this network. The researchers also suggested the potential risks to spouse caregivers since limited support is utilized by this group of caregivers in particular.

In summary, review of the literature consistently found the informal support network to be of primary importance to the caregiver. The instrumental support needed, however, was not always available. It is apparent that multiple factors influence the support needed at any point in time, but it seems certain types of support are consistently lacking.

Research by nurses related to elderly wife caregivers is limited but expanding in quantity. Nurses have been encouraged to continue studying spouse caregivers. More specifically, the implementation of intervention studies has been recommended since nurses have the ability to implement a change and follow it through to the point of evaluation.

More specific information is needed on how the informal network provides assistance. Very few studies have examined the assistance

provided by the informal network and the importance of secondary caregivers to the care-recipient.

Barer & Johnson (1990) critiqued the caregiving literature. They identified a major problem in caregiving research which could relate specifically to the issue of spouse caregivers and the type of instrumental support provided, or not provided, to them. Barer & Johnson suggested that it would be easier to evaluate involvement of the caregiver as well as support network if the needs of the recipient could be specifically identified. Caregivers and their use of support could be compared based on specific needs of the care-recipient. Knowing specific information related to care-recipients' needs would enable comparison of findings among care-recipients with similar needs.

Overall, spouse caregivers are becoming the subjects of greater interest among researchers of the 1990's. The intent of this review was to emphasize the importance of studying specific groups of caregivers and to identify the type of instrumental support available and unavailable to them, particularly from the informal support network.

In the present study specific categories of instrumental support were examined. It was determined what support is provided by friends/neighbors and family members to spouse caregivers. Also, the forms of assistance provided most often and least often by these two groups were examined. In the next section of this chapter an overview of the literature will be presented emphasizing the importance of considering the adequacy of support as perceived by the caregiver.

Importance of Examining Satisfaction With Support

A review of the literature focusing on satisfaction with social support will be presented in this section. Very few articles with a focus on caregiver satisfaction were found in review of the literature. Numerous articles were found on caregiving, but the primary focus was usually on availability of support. Often times emphasis was on frequency of support available with little data obtained on the adequacy of the support available.

As previously mentioned the availability of social support to caregivers is important to nurses, since nurses are aware of the benefits to the caregivers' health and well-being. In keeping with the nursing process, an evaluation must be made regarding the adequacy of support available. In this review only one of the articles presented was written by a nurse. Nurses have done little to evaluate caregivers' satisfaction with the support available to them. In the review to follow a summary of articles is presented. The articles will help to emphasize how important it is to consider the degree of satisfaction when studying the availability of social support to caregivers.

Krause (1987) found in his review of the literature, that people have variations in their need for support, and the beneficial effects of support may be attributed in part to feelings of contentment and security. The feelings of contentment were assumed not to arise directly from the mere provision of support, but were based on subjective evaluations of the adequacy of support.

In his cross-sectional study, Krause (1987) randomly selected 351 participants, 65 years of age and older, and conducted face-to

face interviews. Self-reported health was measured with a single-item indicator which had been utilized in a number of previous studies. Social support was measured with a modified version of the Inventory of Socially Supportive Behaviors by Barrera, Sandler & Ramsey (cited in Krause, 1987). The reliability scores ranged from Alpha= .67 to .83 when the scale was subdivided. Depressive symptoms were measured by a scale with a reliability score of Alpha = .86.

Analysis of Krause's (1987) data suggested that the amount of tangible support received by the older adult failed to affect health (Beta = .026), but satisfaction with this support appeared to be an important correlate to health (Beta = .164;p <.01). His findings also showed a significant correlation between satisfaction with emotional support and health (Beta = .218; p <.001) as opposed to frequency of emotional support and health (Beta = .025).

The relationship between the frequency of support and satisfaction with support was also estimated from the analysis performed in this study. The findings of the study by Krause (1987) revealed that the assessments of adequacy of support were made independent of the amount of social support received. The amount of informational and tangible support showed no significant affect on the degree of satisfaction with these support indicators. Krause suggested that a weak association may indicate that an increase in the frequency of support would not necessarily result in an increase in satisfaction with support and that individual variations in support might exist.

Overall, in his study Krause (1987) found the satisfaction with support to be an important determinant of an individual's state of

health. Also in analyzing the relationship between the frequency of support and satisfaction, it was not possible to use one as a determinant of the other. The relationship was found to be more complex and could be influenced by multiple variables, including the nature of the specific stressor confronting the individual.

The random selection and large sample size, along with utilization of reliable instruments were the strengths of this study. The findings of the study were limited by the fact that the data were collected cross-sectionally. This made it difficult to identify whether changes in satisfaction with support preceded changes in health or whether changes in health resulted in the inability to obtain adequate support. Assessing satisfaction with support and health would have been better addressed with longitudinal data.

Ward, Sherman & LaGory (1984) looked at satisfaction among the elderly in general. Most research on the social networks of the elderly have dealt with the quantity, rather than the quality of the relationships. A stratified, representative sample of 1,185 individuals, 60 years and older, was selected from a metropolitan area of New York. The participants were somewhat better educated and healthier than the national data indicated for this population. The purpose of the study was to examine the effect of objective and subjective integration on morale.

Interviews were performed to obtain information related to social ties and support. Both objective and subjective measures of social networks were utilized. Some questions were similar to those used by Cantor and Wellman (cited in Ward, Sherman & LaGory, 1984). The subjective evaluation of well-being was measured by the 17-item

Philadelphia Geriatric Center Morale Scale by Lawton (cited in Ward, Sherman & LaGory).

Strengths of the study included the number of respondents and the sampling process utilized. Also, the use of objective and subjective measures of instrumental support was considered a strength. A limitation was the lack of data related to the quality of support, indicating why support was thought to be adequate.

The findings suggested that respondents had enough support both objectively and subjectively. Most of the respondents (55%) saw or heard regularly from a relative in the area, while only 5% indicated that there was no one they could turn to for instrumental assistance. Majority of the respondents had enough instrumental support (92%) and enough expressive support (95%).

The subjective measures of support were more strongly related to morale than were the objective measures. For example, perceiving that enough instrumental support was available was more strongly related to morale ($r = .23$) than the number of helpers available ($r = .06$). Even though detailed indicators of social support were utilized as measures of support, the quality of support was not adequately investigated. Knowing that enough support was available did not enable the researchers to identify what was meant by this. There was clearly a need for more detailed conceptualization and operationalization of the qualitative aspects of social support, but this was not in the realm of Ward, Sherman & LaGory's (1984) study. The importance of subjective evaluation, however, was emphasized throughout the study.

The instruments used for Ward, Sherman, & LaGory's (1984) study

were a good attempt to indicate the importance of subjective measures. Further development of the instruments are now needed to look at more qualitative aspects. The process of instrument development will be quite involved. This process may be best initiated by allowing individuals to identify why they feel a certain type of support is adequate, however, first adequacy of support must be determined.

Baillie, Norbeck & Barnes (1988) in a study of social support and its interaction with psychological distress, hypothesized that satisfaction with social support would be negatively related to psychological distress. A total of 87 caregivers with a mean age of 52.5 years old were asked to complete a few questionnaires.

Single-item checklists were used to gather demographic information and characteristics of the caregiving situation. The perceived stress and satisfaction with social support were measured by newly developed questions with standardized Alphas = .90 and .84, respectively. Psychological distress was measured by the Profile of Mood States (POMS) developed by McNair, Lorr and Droppleman (cited in Baille, Norbeck & Barnes, 1988).

The researchers found satisfaction with social support was negatively correlated with psychological distress as hypothesized ($r = -.48$; $p < .001$). Because a strong negative correlation was found between satisfaction with support and psychological distress, additional research was recommended to explore factors which may contribute to satisfaction with social support.

A limitation of the study was the use of a voluntary, convenience sample. The ability to generalize the findings to other

individuals, therefore, was limited. The instruments utilized to measure satisfaction and support had high internal consistency reliability, but alterations in the instruments were recommended to validate the study's findings.

In the present study specific factors which might influence satisfaction will not be analyzed. Instead this researcher believed it was important to have a better understanding of how satisfied the elderly caregivers were. After considering the findings of Baille, Norbeck & Barnes (1988), it is important to have some knowledge of satisfaction with support and how it may relate to the support provided, particularly if it could be related to an individual's psychological status.

Vaux & Harrison (1985) wanted to determine what support network characteristics were most likely associated with support satisfaction. Their research project was one of a few attempts to identify what may contribute to a person's satisfaction with support.

A convenience sample of nontraditional women students, ages 30-61, was randomly selected from a Midwestern University. Questionnaires were mailed to each subject with a 50% return rate. Three instruments were administered. The first instrument measured aspects of the social support network, the second measured satisfaction with support and the third instrument measured perceived support. The internal consistency reliability scores for the satisfaction scale (Alpha = .88) and the perceived support scale (Alpha = .91) were very good.

The data analyses were performed using bivariate correlations and hierarchical regression. These techniques were selected because

they complemented one another. Through bivariate correlations, the proportion of close friends and existence of a spouse had the strongest relationship to support perceptions and satisfaction, with correlation coefficients of r = .39 and r = .26, respectively. Network resource variables which were strongly related to satisfaction were closeness (.27), complexity (.28) and density (.34) of relationships. It was also concluded that support network resources rarely account for more than a third of the variance in support satisfaction.

Vaux & Harrison (1985) limited the external validity of their findings somewhat by using a select group of women students. Their assessment of the support networks and the study of support satisfaction and perceptions, however, were more comprehensive than most other studies.

Findings from Vaux & Harrison's study (1985) provided a basis for further research in the area of satisfaction with social support. Researchers were alerted to the multiple factors, such as proportion of close friends and immediate family, closeness of relationships, and presence of a spouse which may influence an individual's degree of satisfaction at any point in time. The study by Vaux & Harrison was an inspiration to examine satisfaction among caregivers even if not at such a comprehensive level.

Scott, Roberto & Hutton (1986) studied 23 primary caregivers of Alzheimer's patients to determine the relationships between the support provided, the satisfaction with support and the level of burden. Also, 19 additional caregivers were interviewed to provide another perspective of the support provided. The focus of the study [illegible] and the [illegible]

[illegible] support [illegible]

[illegible] which were [illegible] related to

[illegible] (19[illegible]), [illegible] density [illegible]

[illegible] also [illegible] that support [illegible]

[illegible] than a third of the [illegible]

[illegible] the [illegible] of the limited sample [illegible] a select group of white students. This [illegible] only of support [illegible] more comprehensive [illegible]

[illegible] Harrison's study (19[illegible]) [illegible] the area of satisfaction with social support [illegible] to the multiple [illegible], such as proportion of close [illegible] and immediate family, [illegible] of relationships [illegible] individual's [illegible] point in time. The study by Vaux & Harrison [illegible] caregivers [illegible] a relative level.

[illegible] & Hutton (19[illegible]) [illegible] primary caregivers [illegible] to determine the relationships between the [illegible] and the level of [illegible] additional caregivers [illegible] of the support [illegible] focus [illegible] the [illegible] was on the instrumental and social-emotional support provided by families to caregivers. It was anticipated that the more adequate the support was for the caregiver the less would be the sense of burden by the caregiver.

The caregivers were selected from one of the author's pool of patients and from a local adult activity center. The caregivers ranged in age from 37 to 80 years, cared for patients with Alzheimer's and were either spouses (87%) or daughters (13%) of the patient.

Open-ended interviews and a battery of instruments were used for the data collection. Two well known instruments were utilized and included Zarit, Reever & Bach-Peterson's 22-item Burden scale, and the Mini-Mental State questionnaire by Folstein, Folstein & McHugh (both cited in Scott, Roberto & Hutton, 1986). The instrumental assistance was assessed by interview and was considered in the list of responses only when both raters obtaining the data listed the same response. The interviews were coded by 2 or 3 raters to insure internal reliability. The questionnaires themselves had reliability and validity scores of .70 or better.

The researchers of the study found financial assistance and physical tasks were provided the least often. The type of assistance appreciated and provided the most frequently included the provision of respite so the caregiver could get out of the house.

Only 19% of the caregivers indicated they did not receive enough help. Those caregivers who were not satisfied indicated visits by family members were infrequent, and that there was a lack of willingness to stay with the patient. Although a few caregivers

indicated support was inadequate, the majority seemed satisfied with the total support received from family members.

Scott, Roberto & Hutton (1986) also found that caregivers who indicated they did not receive enough support, along with those who received more than enough, also indicated high burden scores. The differences in the burden scores were not entirely clear and warranted further investigation.

Because of the convenience sample chosen, the findings could not be generalized to other samples. However, the results provided preliminary evidence suggesting the importance of support to the caregiver. The data collection techniques were very thorough with adequate measures taken to insure reliability.

Fengler & Goodrich (1979) found informal social support to be an influencing factor of life satisfaction. They believed wives were "victims" as much as were their disabled husbands. In their study Fengler & Goodrich (1979) examined the special needs and problems of elderly wives caring for husbands who were disabled.

The sample consisted of male physicians and other health-care workers who had been handicapped and out of work for a period of time. They were recommended for the volunteer workshop but were then randomly assigned to the project and control groups in the Family Study. The information obtained was part of an evaluation study of the volunteer workshop in which these men participated. Part of the evaluation done by Fengler & Goodrich (1979) focused on two groups, the six individuals who scored the highest and six who scored the lowest on a life satisfaction questionnaire, the HLS group and the LLS group, respectively.

Fengler & Goodrich (1979) found the HLS group had support offered freely and frequently, four of the six stating that their children visited more frequently than once a week. In the LLS group not even one of the six could mention the same. The wives in the LLS group identified isolation, loneliness, economic hardship and role overload as the most frequently encountered problems.

In conclusion, their findings suggested that informal instrumental support was beneficial to the well-being of the caregiver, and consequently beneficial to the care-recipient. Even though the men participating in this study were not randomly selected as part of the volunteer workshop, they were still randomly assigned to groups for the Family Study.

The life satisfaction questionnaires suggested that their was a relationship between highly satisfied husbands and wives. Fengler & Goodrich (1979) wanted to identify the factors which could have influenced the scores. Even though the sample size was small (N=12), when the factors which were thought to influence satisfaction were examined, there were definite differences found between the groups. This increased the reliability of the findings. It was suggested that further study is needed to examine support available to various groups of caregivers from informal, as well as formal, sources of support.

Gilhooly (1984) wanted to identify which factors were associated with the psychological well-being of caregivers supporting a dementing relative in the community. She also wanted to determine the relationship between satisfaction with support and well-being.

The sample consisted of 37 caregivers of patients with a primary

diagnosis of senile dementia. The dependent variable, psychological well-being, was measured in two ways, via morale and mental health. The Kutner Morale scale by Kutner, Fanshel, Togo & Langner and the OARS Multidimensional Functional Assessment Questionnaire's `mental health' scale by the Duke University Center for the Study of Aging and Human Development (cited in Gilhooly, 1984) were utilized. There were multiple independent variables in Gilhooly's study (1984) including "satisfaction with help from relatives", which is of interest for purposes of the present study. A 5-point scale ranging from very satisfied (5) to very dissatisfied (1) was used for rating purposes.

Limitations were again related to sample size and the use of a nonrandom sample. Also, the measurement of satisfaction with support was quite general limiting the researcher's ability to obtain information related to the kind of support which resulted in caregiver satisfaction. The utilization of well known instruments to measure morale and mental health were strengths.

Results supported previous research which found frequency of contact with friends and relatives was not significantly correlated with supporters' morale or mental health. However, satisfaction with help received from relatives was significantly correlated with morale ($r = .254$; $p < .10$) and mental health ($r = -.449$; $p < .01$). These findings suggested that the caregivers' "reactions" to help were more important determinants of well-being than the frequency with which help was provided. When trying to predict an individual's state of well-being frequency of support alone was not the best indicator, but a measure of satisfaction was recommended and considered to be an

important variable.

To conclude, it is evident by this review of the literature that little has been done to study the degree of satisfaction with social support, especially by nurses. Most researchers have looked at satisfaction in relationship to well-being and have consistently found when individuals were satisfied with support they were also in a positive state of well-being.

It has been suggested that many factors can influence an individual's degree of satisfaction; consequently, measurement of satisfaction has been cumbersome. Researchers, however, have recognized the influence of satisfaction on well-being and on level of burden and still feel it is important to investigate whether individuals are satisfied and why they are satisfied. Increased satisfaction among caregivers has been related to increased satisfaction among care-recipients.

For purposes of this study, degree of satisfaction was analyzed to determine if there was a relationship between the frequency of support provided and degree of satisfaction. This information will then be helpful in determining what can be offered to increase level of satisfaction and ultimately improve well-being.

The next section will provide an overview of studies in which the social support model, developed by Kahn & Antonucci (1980), was utilized. Through this review, the appropriateness of Kahn & Antonucci's model (1980) for the present study will be presented.

Utilisation of the Kahn & Antonucci Model (1980)

Ingersoll-Dayton & Antonucci (1988) were interested in the perception of reciprocal and nonreciprocal social support among middle-aged and older adults. It was generally believed that social relationships contribute to well-being. However, Wallston, Alagna, DeVellis and DeVellis (cited in Ingersoll-Dayton & Antonucci, 1988) suggested the relationship between social support and positive outcomes may not be as predicted.

In reviewing the literature, Ingersoll-Dayton & Antonucci (1988) found asymmetrical exchanges within an older population resulted in feelings of loneliness and dissatisfaction with social relationships. Their interest was to determine how older individuals perceived their patterns of reciprocity.

The sample consisted of 718 respondents, 50 years of age and older, chosen nonrandomly from a national representative sample of 2,458 households. A cross-sectional study was performed comparing middle-aged and older adults on various issues.

The instruments used included a drawing of three concentric circles to portray those individuals most important in the respondent's life. Questions were asked to obtain information on support provided and received. Then an index was constructed to assess whether or not support was reciprocated. A single-item measure was used to obtain information related to network demand and a 5-point scale was utilized for scoring. General well-being was measured by a single-item measure of life satisfaction and an index of 4 items measuring negative affect.

Limitations of the study included the nonrandom selection of

participants and the mixture of males and females in the sample. It was suggested that gender may influence how an individual views reciprocity of support. A strength of the study was the large sample size.

The results indicated that most individuals (81%) felt relationships were generally reciprocal. However, frequently older adults found themselves in nonreciprocal relationships and experienced less distress when they overbenefited rather than underbenefited. It was suggested that people adopt a life course reciprocity perspective with family members taking into account previous life periods when they did more providing than receiving. Therefore, some balance was eventually achieved.

The differences in the perceptions of nonreciprocity among middle-aged versus older adults, emphasize the importance of considering social support relationships within a life course perspective. Individuals may view satisfaction with support differently depending on who is providing it, friends versus family members.

When evaluating caregiver satisfaction with support it is important to consider the reciprocity of support between the caregivers and the members of the support network. If the caregivers feel they can not reciprocate the support provided to them by family or friends/neighbors, the caregivers may indicate they are satisfied with support provided to them. The caregivers' responses may be influenced by their feelings of appreciation for any support, knowing they can not return the support at the present time.

Antonucci & Akiyama (1987) looked at social networks of older participants and the amount of males and females in the sample. It is suggested that gender may influence how an individual views reciprocity of support. A strength of the study was the large sample size.

The results indicated that most individuals (84%) felt relationships were generally reciprocal. However, frequently older adults found themselves in nonreciprocal relationships and experienced less distress when they overbenefited rather than underbenefited. It was suggested that people adopt a life course reciprocity perspective with family members taking into account previous life periods when they did more providing than receiving. Therefore, some balance was eventually achieved.

The differences in the perceptions of nonreciprocity among middle aged versus older adults, emphasize the importance of considering social support relationships within a life course perspective. Individuals may view satisfaction with support differently depending on who is providing it: friends versus family members.

When evaluating caregiver satisfaction with support it is important to consider the reciprocity of support between the caregivers and the members of the support network. If the caregivers feel they can not reciprocate the support provided to them by family or friends however, the caregivers may indicate they are satisfied with support provided to them. The caregivers' responses may be influenced by their feelings of appreciation for any support, knowing they can not return the support at the present time.

Antonucci & Akiyama (1987) looked at social networks of older adults to determine information on the structural and functional characteristics of the social network. The respondents were separated into three groups by age, and data were obtained on the provision and receipt of support by each group of individuals.

A national probability sample of 718 individuals, age 50 to 95, was selected cross-sectionally. In-home, structured interviews were performed. The hierarchical mapping technique developed by Antonucci (cited in Antonucci & Akiyama, 1987) was utilized to obtain network structure data. Questions related to functional and structural characteristics were asked with reference to the first 10 people listed in the network. The structural characteristics were quite extensive including age, sex, closeness, years known, proximity and frequency of contact. Functional characteristics were limited to the number and type of supportive services provided and received.

The findings suggested no significant difference in size of the network related to the age of the individual. There were differences found, however, related to perceived support reciprocity between the younger and older groups of individuals. The oldest group received about the same amount of support from others as did the younger groups, but provided less support to others than did the younger individuals. This suggests some changes that may occur throughout the life-span which could influence an individual's perceptions of satisfaction.

As people age, the way they view the support from family and friends/neighbors can vary. This is particularly true for elderly caregivers who may require support in their role as caregiver, but are hesitant to accept assistance. Understanding the kind of support

provided to caregivers and whether the support is adequate, may help researchers to begin understanding caregivers' views of support provided. It was suggested that further information be obtained to distinguish support from friends and family.

A strength of the study once again was the sample size and the assessment of multiple structural characteristics. A limitation was the use of a cross-sectional design preventing actual evaluation of changes in provision of support over time. Another limitation was the limited amount of functional data obtained.

Next, a project by Levitt, Antonucci, Clark, Rotton & Finley (1985) was undertaken to analyze the structure of social support and its relation to health, affect and life satisfaction, comparing two samples of the elderly. Focus was on the availability of supportive relationships to residents in the South Miami Beach area in comparison to a national sample. The variation in convoy (support) characteristics was examined along with their relationship to health, affect and life satisfaction.

The South Miami Beach sample of 84 individuals, over the age of 65, was randomly selected from files of a 1977 redevelopment survey of all residents in the area. Personal interviews were conducted to obtain demographic, support and well-being information.

The primary support measure consisted of three concentric circles in which the respondents identified individuals in their support network. This measure was similar to the hierarchical mapping described earlier. Additional questions were then asked to obtain specific information related to the support network. The measures of well-being included the Bradburn Affect Balance Scale by

Bradburn (cited in Levitt, Antonucci, Clark, Rotton, & Finley, 1985), a check-list of health problems, and a global measure of life satisfaction.

Among the Miami Beach (MB) respondents, the correlation between network size and affect suggested that even though the residents were less likely to exchange support with family members compared to the national (N) sample, they did not report more health problems (MB=-.13, N=-.06), or more depression (MB=.34, N=.16). They were, however, less satisfied overall (MB=-.03, N=-.07) with the conditions in which they lived. Consequently, even when the elderly seemed to be coping well with insufficient support they were still likely to be faced with the stress of physical limitations which resulted in overall dissatisfaction.

The data obtained from this study were primarily descriptive with no significance levels established for the comparisons of the two samples examined. Differences between the two samples, however, were marked enough to suggest some general conclusions.

No information on the reliability of the instruments was provided, but some specifics of the instruments were given. The random selection of the sample enables the data to be generalized to some degree in other similar populations.

The present project emphasizes the importance of studying the elderly, particularly those within specific settings or with similar life styles. Among caregivers who may have limited resources of support, it is important to consider whether the support available will help to maintain the caregivers' well-being. With the understanding that satisfaction influences an individual's state of

[illegible]

[illegible] with the context [illegible] clearly [illegible] but they were still likely to be [illegible] which [illegible]

[illegible] were [illegible] the comparison of the [illegible]

[illegible] of the [illegible] were given. The [illegible] of the sample [illegible]

[illegible] or with [illegible] final [illegible] which [illegible] with [illegible] well-being, it is reasonable to plan a study to investigate support utilized by caregivers and whether they are satisfied with the support.

Stoller & Pugliesi (1988) examined the impact of changes in older people's health and functional capacity on the composition of their support networks over time. This study differed from most others in that it was longitudinal.

A probability sample of 173 respondents, age 72 to 80+, with a mean age of 78.1 years was utilized. Data were gathered through personal interviews utilizing an index of network composition which incorporated reports of assistance with Activities of Daily Living. The effectiveness of the networks was operationalized as a two-category variable (same or better) and (worse), constructed from changes in functional status.

The findings indicated that with time the change in networks was usually additive. With time the support previously provided was still utilized, but sometimes additional support was also provided. It was likely that support would be supplementary rather than substitutive.

A pattern of expansion in the network was noted and was consistent with the notion of a convoy of social support as well as a hierarchical pattern beginning with spouse, then moving to children and other family and friends as needed. It was possible that an expansion in the support network did not occur, but activation of sources of support resulted in a change in network composition.

Limitations of the study must be considered when interpreting the results. The sample consisted of individuals who were in

relatively good health. A change in level of disability among sample members could result in different needs of assistance. In evaluation of the change of support over time, several variables were not considered, such as socio-economic status, proximity of adult children, and change in marital status. These variables could influence the change in patterns of assistance.

To have an understanding of support provided to elderly caregivers was believed to be of critical importance in helping to maintain an individual's level of well-being. In the present study it was decided that an investigation of the provision of support was of more value than an investigation of the number of individuals in a support network.

Norbeck (1981) utilized the model developed by Kahn & Antonucci (1980) in a different manner. She demonstrated how nursing could intervene to assist individuals in obtaining the assistance they needed through the life-span to help reduce negative outcomes.

The steps of the nursing process were incorporated into the model to identify where nurses could intervene. The article was very helpful in providing specifics on what nurses could do at each step of the process. This was the only article found incorporating the nursing perspective into the model.

In conclusion, through the review of this literature it was evident that little has been done to evaluate social support networks over time, particularly by nurses. Even though longitudinal studies would be most beneficial, many studies have been cross-sectional and are also beneficial. All the studies reviewed were also focused around the elderly, supporting the notion that knowledge of the

elderly' social support network has become a major issue.

Summary

The first section of the literature review focused on the importance of the informal support network to caregivers. Articles were reviewed to demonstrate in what ways the support network is beneficial to caregivers, ways it may fail to meet the needs of the caregivers, and why this is an important issue for nurses.

The second section of the literature review was focused on the importance of examining satisfaction with social support. Little has been done to evaluate satisfaction with support among caregivers and this review was an attempt to recognize the importance of this issue, particularly for nurses.

The third section of the literature review was included to summarize how the conceptual model chosen for this study has been utilized until now. The model has been utilized to study changes in support networks of the elderly, however, very little research has been done utilizing the nursing perspective.

In Chapter 4 a complete description of the methodology and instrumentation used for this study will be presented. The chapter concludes with an explanation of the statistical analysis to be utilized.

CHAPTER 4: METHODOLOGY AND PROCEDURES

Overview

The purpose of this study is to identify with what frequency instrumental support is provided by family and friends/neighbors to the female spouse caregivers, to what degree the female spouse caregivers are satisfied overall with the support provided, and whether there is a relationship between frequency of support provided and degree of satisfaction. Specific background characteristics with a description of the caregiving situation were obtained to provide information about the sample.

In this chapter the criteria used for selecting the sample are outlined and the data collection procedures are explained. The variables of the study are operationally defined and a description of the instruments is provided. The chapter concludes with an explanation of the statistical analysis to be utilized.

Description of the Research Design

A secondary analysis was performed on data collected as part of a study titled "Caregiver Responses to Managing Elderly Patients at Home". The National Institute on Aging awarded a three-year grant to Dr. Charles W. Given (College of Human Medicine) and Dr. Barbara A. Given (College of Nursing) at Michigan State University in 1985 to study responses of caregivers managing elderly family members at home.

A longitudinal survey was utilized to follow 307 caregivers at five points in time over the period of one year. The main purpose of the research was to examine how the caregiving situation for these

CHAPTER 4: METHODOLOGY AND PROCEDURES

Overview

The [illegible] this [illegible] to identify which factors [illegible] by family and friends [illegible] to the [illegible] of the [illegible] overall with the support provided, and whether there is a relationship between frequency of support provided and [illegible] specific background characteristics with [illegible] of the [illegible] situation were obtained to provide information about the sample.

In this chapter the criteria used in selecting the sample are [illegible] and the data collection procedures are explained. The variables of the study are operationally defined and a description [illegible] is provided. The chapter concludes with an [illegible] of the statistical analyses to be utilized.

Description of the Research Design

A secondary analysis was performed on data collected as part of a study titled "Caregiver Resources to Managing Elderly Patients at Home". [illegible] In [illegible] a three-year grant to Dr. Charles W. Given (College of Human Medicine) and Dr. Barbara A. Given (College of Nursing) at Michigan State University in [illegible] to study [illegible] of caregivers in managing elderly family members at home.

A longitudinal survey was utilized to follow 307 caregivers at three points in time over the period of one year. The main purpose [illegible] was to examine how the caregiving situation [illegible] subjects changed over time.

Specific aims included:

1. To describe how the number and severity of patients' functional, mental and social limitations were related to caregiver involvement and perceived burden of care, and how these are mediated by the economic resources of the patient-caregiver dyad and the functional, mental and social resources of the caregiver.

2. To describe, over time, the interrelationships between patients' limitations and caregivers' health status, their involvement in caregiving, and their perceived burden of care.

3. To describe, over time, how patients' limitations and caregivers' health status, involvement in care, and perceptions of burden predict the amount and type of health care resources utilized and patients' institutionalized.

A retrospective approach was used to collect data from, among others, 80 female spouse caregivers age 52-80. The survey questionnaire was developed to measure the frequency of instrumental support provided and the degree of satisfaction with this support by caregivers. The questionnaire was administered in the caregivers' home by trained data collectors.

Cross-sectional data from Wave 5 of the above study was used in the present descriptive research to determine the frequency with which instrumental support was provided to the female spouse caregiver by family and friends/neighbors. Next, the degree of satisfaction with the support provided was ascertained. Lastly, it was determined whether there was a relationship between the frequency of support provided to the caregiver and their degree of satisfaction

[illegible]

[illegible] the frequency with [illegible]

[illegible] whether there was a relationship between the frequency [illegible] with the support.

Sample

Recruitment of Participants

The target population for this study was caregivers providing care for an impaired elderly family member. The initial sample to be screened was obtained using a variety of sources and methods. The major sources used to locate subjects were health-care agencies. Over 250 agencies agreed to assist in recruitment and of those, 34 were utilized.

The method used to recruit caregiver subjects was a card-back system. This system consisted of a memo sent to individuals inquiring whether they or someone they knew was a family caregiver. If so, they were asked to mail a postpaid card back with information enabling contact by the research staff.

To enhance recruitment and to facilitate networking for the project, extensive public relation activities were conducted. A press release was sent to Michigan newspapers and announcements of the project were published in many organizational newsletters. Additional announcements were made at local and state-wide conferences.

All individuals who responded secondary to agency contact were contacted by the research personnel. Following the response of potential subjects, phone contact was made by the research staff within two weeks.

A total of 815 caregivers were interviewed by trained Clinical Nurse Specialist students for participation in the longitudinal

study. Of this group, 307 caregivers met all criteria for entry into the longitudinal study and became part of a nonrandomized, nonprobability sample. These participants had been caregiving for a mean duration of five years and were themselves in "relatively good health".

The criteria for entry into the study included (a) caregivers who must be caring for a family member over the age of 65, (b) the family member had to be deficit in at least one Activity of Daily Living (e.g. toileting or dressing) or Instrumental Activity of Daily Living (e.g. transportation or food preparation), and (c) the caregiver had to be the acknowledged primary caregiver for their relative.

Sample for Current Analysis

Of the total sample (N=307) analyzed by Given & Given (1985) for their study (Grant #1 R01-AG06584), 80 female spouse caregivers remaining in the study at WAVE 5 were utilized. The spouses included in this study were those continuing to provide care in the home at the last measure of the study.

Data Collection Procedures

Participants were informed by the research staff that the study they were volunteering to participate in was a longitudinal study, which would involve several encounters throughout the year. They were told that answering of any questions was voluntary and they did not have to answer if they preferred not to (Appendix A). Statements of confidentiality were discussed with the participants and an informed consent form was signed (Appendix B).

study. Of this group, 307 caregivers met all criteria for entry into the longitudinal study and became part of a nonrandomized, nonprobability sample. These participants had been caregiving for a mean duration of five years and were themselves in "relatively good health".

The criteria for entry into the study included (a) caregivers who must be caring for a family member over the age of 65, (b) the family member had to be deficit in at least one Activity of Daily Living (e.g. toileting or dressing) or Instrumental Activity of Daily Living (e.g. transportation or food preparation), and (c) the caregiver had to be the acknowledged primary caregiver for their relative.

Sample for Current Analysis

Of the total sample (N=307) analyzed by Given & Given (1985) for their study (Grant #1 R01-AG06584), 80 female spouse caregivers remaining in the study at WAVE 5 were utilized. The spouses included in this study were those continuing to provide care in the home at the last measure of the study.

Data Collection Procedures

Participants were informed by the research staff that the study they were volunteering to participate in was a longitudinal study, which would involve several encounters throughout the year. They were told that answering of any questions was voluntary and they did not have to answer if they preferred not to (Appendix A). Statements of confidentiality were discussed with the participants and an informed consent form was signed (Appendix B).

The majority of the participants received an in-home interview and completed a self-administered booklet upon entry into the study. Participants were then contacted by phone at three, six and nine month intervals and were also asked to complete survey instruments at two of these data collection points.

The secondary data used in this study was the last of five waves of data collected over the period of one year. The fifth wave of data was utilized because, the assistance questionnaire was administered at this point and participants were also asked how satisfied they were with the assistance they were receiving. The collection of the last wave of data took place in the caregivers' home approximately 12 months after the initial contact was made. Some demographic data was collected during the first phase of the longitudinal study and will be presented as it relates to this specific study.

The data used for this study was secondary data collected by a variety of individuals. To help minimize inconsistency in the data collection process, data collectors were required to attend at least two, three-hour training sessions. During the training sessions, questions regarding the study were addressed and a protocol book was explained in detail. Debriefing sessions were also held to discuss problems encountered during specific interview sessions.

To initiate the last phase of the data collection process, a trained data collector contacted the caregiver by phone approximately one week prior to the intended meeting date. In most instances the data collector was the same individual who had previously interviewed the caregiver. A convenient meeting time was identified by the

caregiver.

For the larger research project, questionnaires with a few open-ended items, but primarily closed ended items, were sent to the participants prior to the interviewers going to the caregivers' homes. The caregivers completed the following self-administered questionnaires: (a) the social provisions scale, (b) social resources scale, (c) current feelings of the caregiver, (d) behaviors of the relative, (e) caregivers feelings of how caregiving has impacted his/her life, (f) instrumental activities of daily living of the caregiver, and (g) self-care practices of the caregiver. None of these questionnaires will be utilized in this study.

During the home visit a questionnaire was administered face-to-face by the interviewer to the spouse caregiver. The following information was obtained for purposes of the larger study: (a) background information, (b) physical health of relative, (c) physical health of caregiver, (d) health service utilization by caregiver/relative, (e) amount of assistance provided to caregiver by others, (f) satisfaction with assistance from others, (g) assistance required by relative, (h) spouse finances, and (i) caregiver finances.

The data regarding the (a) background information (Appendix C), (e) the amount of assistance received from others (Appendix D), (f) the caregiver satisfaction with assistance provided (Appendix E) and (g) the amount of assistance required by the relative (Appendix C), were utilized for this study. Prior to any data analysis, the University Committee on Research Involving Human Subjects approved the utilization of the identified sample for this project

(Appendix F).

Operationalization of Variables

Female Spouse Caregiver (Wives)

The caregivers in this study were wives who acknowledged that they were the primary caregiver for husbands who were debilitated. The characteristics of race, age, and employment status were determined as indicated by respondent. Employment status was determined at the first, third and fifth contact.

Care-recipient

The care-recipient was a husband, 65 years of age or older, who was impaired in at least one Activity of Daily Living (ADL) and/or Instrumental Activity of Daily Living (IADL).

Instrumental Support

In this study instrumental support was operationalized by two sets of seven statements which represented behaviors supportive to the caregiver in providing direct assistance in the caregiving role. The caregiver was asked how often assistance had been provided over the past three months, first by family and then by friends/neighbors. Answers were recorded on a four point scale including 1) rarely or none of the time, 2) some of the time, 3) most of the time, and 4) almost or all of the time.

The following list consists of the instrumental support items which were measured.

1. Helps with physical care
2. Keeps relative company
3. Provides care for relative for short period of time (hours)
4. Provides care for relative for longer period of time (days)

5. Has gotten up with relative at night
6. Helps with transportation
7. Helps with provision of money or material goods

Degree of Satisfaction

The variable of satisfaction was operationalized by two separate questions. The caregivers were asked questions to determine overall how satisfied they were with the assistance they were currently receiving from family and then friends/neighbors, to care for their relative. The answers were recorded on a four point Likert scale ranging from 1) very satisfied to 4) very dissatisfied.

Instrumentation

There were three sources of instrumentation utilized in this study: (a) questionnaires to obtain background information about the caregiver and care-recipient (Appendix C), (b) questions to obtain information on the caregiving situation, and (c) an assistance questionnaire developed by Given & Given (1985) from which information regarding social support provided from family and friends/neighbors was elicited (Appendix D). Two single-item questions referring to the degree of satisfaction with the support provided were also included in this questionnaire (Appendix E).

The background information was obtained from questions related to sociodemographic information which included age, and race of caregiver and care-recipient, and employment status of caregiver. The other background information related to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) was obtained from the caregivers responses to questions inquiring about the amount of assistance provided by the caregiver or others to the

elderly person. To determine dependency in ADL they were asked questions such as, "Does you relative need help with eating, or dressing and undressing?" Another included "Does your relative need help with bathing or toileting?" Responses to the questions were (1) yes or (2) no.

An example of a question to measure dependency in IADL is: "Does your relative need help with cooking, arranging transportation, shopping, laundry, housework, or handling of money?" Responses to these questions were also (1) yes or (2) no. An index was calculated by totaling the number of dependencies of the care-recipient that were reported by the caregiver.

Information obtained related to the caregiving situation included duration of care and reason for care. Duration of care was measured by a question which asked the caregiver when she began to provide direct care for the elderly individual. Reasons for care were obtained when the caregivers answered the question, "Was there a specific health problem or illness that led to caregiving? If yes, what?"

Reliability and Validity of Assistance Questionnaire

Reliability

Reliability refers to the degree to which the research instrument produces consistent results or data on repeated use (Wilson, 1989). This is most frequently related to the investigator's ability to standardize the procedure for administering the instrument.

There are three ways to assess reliability. The aspects of the

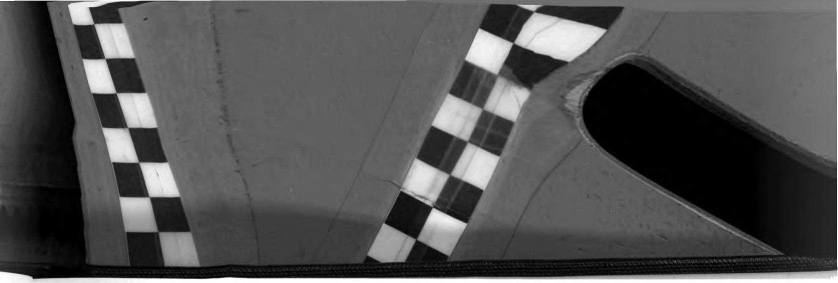
reliability concept most often assessed include stability, internal consistency and equivalence. Stability refers to the extent to which a researcher would get the same results on repeated administrations of an instrument (Polit & Hungler, 1983).

The measure of reliability by internal consistency refers to the degree to which the subparts of the instrument all measure the same dimension or attribute (Polit & Hungler, 1983). Cronbach's Alpha is frequently used because of the ability to measure the intercorrelation of all items in the scale simultaneously. The coefficient can range from 0.0 to 1.0, with the higher values (.7,.8,.9) denoting greater reliability.

Item-total correlations are also considered when determining which items, when eliminated, may help to improve Cronbach's Alpha and thus overall reliability. This is a function to measure the degree of interrelatedness among items in a scale (Woods & Catanzaro, 1988). It consists of a group of single correlations between each item and the total score of the entire instrument.

Equivalence refers to the degree of similarity between two or more forms of an instrument (Woods & Catanzaro, 1988). Having two equivalent forms would be of importance if an instrument was administered on several occasions in a short period of time.

Because the current data set consists of only one cross-sectional wave, stability of the instrument could not be examined. Also, for purposes of the present study there was no need for more than one version of the instrument. Thus, the instrument's reliability was evaluated by determining its internal consistency using Cronbach's Alpha with consideration given to the item-total



correlations. The Alpha coefficients obtained were .77 and .73 indicating sufficient reliability. No previous reliability testing had been done with this instrument.

Validity

Validity is the degree to which an instrument measures what it is expected to measure (Polit & Hungler, 1983). No previous validity testing had been done on the assistance instrument used for this study other than testing for content validity. This questionnaire was initially developed for the purposes of the study undertaken by Given & Given (1985).

The instrument was developed and reviewed by a panel of experts in the field of caregiving. Various alterations were made in the instrument based on the review of the literature as well as interviewer comments. No attempts were made to examine criterion or construct validity. For purposes of the present study no further validity testing was required. Thus, there is limited criteria by which to determine the validity of the instruments utilized in this study, resulting in a limited degree of validity.

Data Summary for Purposes of Analysis

In the statistical analysis descriptive statistics were utilized. The background characteristics for the caregivers (age, race, employment status), the care-recipients (age, race, number of ADL and IADL dependencies), and the caregiving situation (duration of caregiving, primary reason for care) were collected and presented in frequency distribution tables.

To answer the questions, "What categories of support are

provided by family members and friends/neighbors?" descriptive statistics were utilized. A mean frequency score and standard deviation score were determined for each of seven categories of support. One table is presented representing the support from both sources of support, family members and friends/neighbors. The categories are listed in order of frequency of support provided, from most frequent to least frequent.

The caregivers' degree of satisfaction with the overall support received from both sources of support were also presented in a frequency table along with a group mean and standard deviation score. Two group mean and standard deviation scores were presented for the degree of satisfaction with support received, from family and friends/neighbors, respectively.

To determine the relationships between the categories of instrumental support provided and the degree of satisfaction with overall support, the Pearson product-moment correlation (r) was instituted. This statistical method of correlation was selected because of its appropriateness in analyzing the relationship between interval data. Throughout the relationship analysis, the support provided from family members and friends/neighbors was analyzed separately.

Initially, reliability testing was done by evaluating the internal consistency among the categories of support. Cronbach's Alpha was computed to determine the reliability coefficient. Based on the reliability coefficient, it was then determined whether a reliable scale could be developed from the categories of support.

Next, item by item correlations were performed. The mean score

of each category of instrumental support was correlated with the mean score representing the degree of satisfaction to determine a correlation coefficient. These analyses provided information regarding the relationship between the various categories of support and the degree of satisfaction with overall support.

Using the scale developed as a result of the reliability testing, a mean scale score was determined and was then correlated with the mean score representing degree of satisfaction. A final correlation was done to examine the relationship between the support provided by family and friends/neighbors.

Summary

In Chapter IV a discussion of methodology was presented. The major sections of the chapter were:

1. The research is a descriptive study using a survey-type design.

2. The utilization of secondary data was employed and a description of the data collection procedures were presented.

3. The operational definitions of female spouse caregiver, care-recipient, instrumental support and degree of satisfaction were identified.

4. The instruments used included the questions related to the background information, the caregiving situation and the parts of the assistance questionnaire dealing specifically with the categories of support provided and the degree of satisfaction with support overall.

5. Reliability and validity was shown for the assistance questionnaire.

[illegible] category of instrumental support was correlated with the mean [illegible] the degree of satisfaction to determine a [illegible] correlation coefficient. These analyses provided information [illegible] the relationship between the various categories of support and the degree of satisfaction with overall support.

Using the scale developed as a result of the reliability testing, a mean score was determined and was then correlated with the mean score reflecting degree of satisfaction. A final correlation was done to examine the relationship between the support provided by family and friends/neighbors.

Summary

In chapter IV a discussion of methodology was presented. The major sections of the chapter were:

1. The research was a descriptive study using a survey type design.

2. The utilization of secondary data was employed and a description of the data collection procedures were presented.

3. The operational definitions of female spouse caregiver, care-recipient, instrumental support and degree of satisfaction were identified.

4. The instrument used included the questions related to the [illegible] the caregiving situation and the parts of the [illegible] questionnaire dealing specifically with the categories of support provided and the degree of satisfaction with support overall.

5. Reliability and validity was shown for the assistance [illegible]

6. Descriptive statistics with the Pearson product-moment correlation coefficient were utilized for the data analysis.

In Chapter V the data will be presented.

CHAPTER 5: DATA PRESENTATION

Overview

The purpose of this study was to examine the frequency with which certain categories of instrumental support are provided to wife caregivers and to evaluate their overall degree of satisfaction with social support provided to them. This chapter will contain the study's results.

The background characteristics of the participants will be presented along with descriptive data of the caregiving situation. Data to address the research questions will then be presented. The statistical methods employed to present the data include frequency distributions, percentages, measures of central tendency, standard deviations and correlations. A description of the reliability test performed on the "assistance" questionnaire will also be included. A reliable scale of support categories will be presented to enable further statistical testing.

Results

A descriptive study was performed using the subgroup of caregiving wives (N=80) from a larger project undertaken by Given & Given (1985). The questions to be examined are as follows:

1. What categories of instrumental support are provided by family members and friends/neighbors to wives who are caregivers?

2. What is the caregivers' overall degree of satisfaction with the support from family members and friends/neighbors?

3. What are the relationships between the categories of instrumental support provided and the overall degree of satisfaction

with support?

A discussion and interpretation of the results as well as implications of the research findings, will be presented in Chapter 6.

Description of the Study Sample

Background Characteristics of the Participants

Characteristics of the caregivers examined in this study include age, race, and employment status. Characteristics of the care-recipients examined in this study included age, race, and number of dependencies in Activities of Daily Living and Instrumental Activities of Daily Living. The background characteristics of the participants are presented by frequency distributions, means and percentages in Tables 5.1 and 5.2.

AGE. The mean age of the caregivers was 67.5 years. 68% of the caregivers were over the age of 65 years. The care-recipients tended to be approximately 5 years older than the caregivers. The mean age of the care-recipients was 72.9 years. A requirement of this study was that the care-recipient be at least 65 years old.

RACE. The caregivers and care-recipients were matched on this variable. The majority of the caregivers and care-recipients (n=78, 97.5%) were Caucasian. The remaining (n=2, 2.5%) were Black.

EMPLOYMENT STATUS. Of the 80 caregivers 73 (91.2%) were not employed. A total of 7 (8.8%) were either employed part-time or full-time. (see Table 5.1)

Table 5.1: Background Characteristics of the Caregivers and Care-recipients

	Caregivers (N=80)	Care-recipients (N=80)
Age	Mean = 67.5 years Range = 52-80 years Std. Dev. = 5.3 years	Mean = 73 years Range = 64-88 years Std. Dev. = 6.5 years
Race	Caucasian = 78(97.5%) Black = 2(2.5%)	Caucasian = 78(97.5%) Black = 2(2.5%)
Employment Status	Not employed 73(91.2%) Part-time 5(6.3%) Full-time 2(2.5%)	

DEPENDENCY STATUS OF THE CARE-RECIPIENT. The care-recipients required assistance with an average of 5.3 Activities of Daily Living from a total of ten activities. These activities included eating, dressing, bathing, toileting, combing hair or shaving, walking, getting around the house, cleaning following incontinence of urine or stool, and getting in and out of bed. More than half (52.5%) were dependent in at least six to ten activities.

From a total of 6 Instrumental Activities of Daily Living assistance was required with an average of 4.8 as well. These activities included cooking, transportation, shopping, laundry, housework, and handling of money. Furthermore, more than half (55%) were dependent in all six IADL's. Overall, the care-recipients in this sample were quite dependent on their caregivers for both ADL and IADL (see Table 5.2).

Table 5.2: Dependency Status of the Care-recipient Including the Frequency and Percentage of Dependencies

Number of Dependencies		Frequency	Percentage
ADL	0	8	10.0
	1-2	11	13.7
	3-4	12	15.0
	5-6	16	20.0
	7-8	18	22.5
	9-10	15	18.8
Mean = 5.3		80	100.0
Std. Dev. = 3.1			
IADL	0	5	6.3
	1-2	6	7.5
	3-4	11	13.7
	5-6	58	72.5
Mean = 4.8		80	100.0
Std. Dev. = 1.8			

Background Characteristics of the Caregiving Situation

Additional background characteristics are presented to provide a context in which to understand the caregiving situation. These characteristics include duration spent providing care and the primary reason for providing care. The characteristics of the caregiving situation are presented in Table 5.3.

DURATION OF CARE. The largest percentage of caregivers (n=46, 57%) had provided care from 1 to 4 years. The duration of care ranged from 1 to 60 years. The majority of caregivers had provided

Table 5.3: **Background Characteristics of the Caregiving Situation**

Number of Years Caring	Number of Subjects	Percentage
1-2yrs	22	28.0
3-4yrs	24	30.0
5-6yrs	13	16.0
7-8yrs	5	6.0
9-10yrs	3	4.0
11-12yrs	5	6.0
13-14yrs	2	2.0
15-16yrs	2	2.0
20-21yrs	2	2.0
30 yrs	1	1.0
Mean duration = 5.2 yrs	79	100.0

Primary Reason for Care	Frequency
Stroke	29 (36.2%)
Alzheimer's	11 (13.7%)
Parkinson's	9 (11.2%)
Heart Disease	5 (6.3%)
Multiple Sclerosis	3 (3.7%)
Emphysema	3 (3.7%)
Cancer	3 (3.7%)
Other	16 (20.0%)
missing	1 (1.2%)
	80 (100%)

Note. Percentages are rounded to the nearest tenth.

care for less than 6 years with only a few caregivers who had been providing care for an extremely long time. Only one caregiver had provided care for 60 years. Caring for a duration of 3 years was the most frequent response (n=16, 20%).

PRIMARY REASON FOR CARE. Stroke was the most common (n=29, 36.2%) primary reason for care, followed by Alzheimer's (n=11, 13.7%) and Parkinson's Disease (n=9, 11.2%). Other illnesses including heart disease, emphysema, diabetes, cancer, fractured hip, Multiple Sclerosis, paraplegic, and post-op complications were each reported by less than 7% of the sample.

Research Questions

The main purpose of this study was to obtain answers to three questions. The data obtained to answer these questions will now be presented.

Question I

What categories of instrumental support are provided by family members and friends/neighbors to wives who are caregivers?

The categories of instrumental support received from family members and friends/neighbors, along with their mean frequency scores and standard deviations are presented in Table 5.4.

In review of the data, support to the female spouse caregivers from family members and friends/neighbors was found to be very low, if it occurred at all. The mean frequencies of each category of instrumental support received from family members ranged from 1.04 - 1.75 (N= 80). The mean frequencies of each category of instrumental support received from friends/neighbors ranged from 1.00 - 1.47

Table 5.4: Provision of Instrumental Support by Family and Friends/Neighbors

Categories of Support	Family (N=80)		Friends (N=80)	
	M	SD	M	SD
1. Spent time keeping your relative company	1.75	.70	1.47	.68
2. Stayed with your relative so you could do something else for a few hours	1.51	.69	1.29	.60
3. Helped with transportation (for either you or your relative)	1.50	.84	1.29	.66
4. Helped with physical care	1.40	.72	1.25	.65
5. Helped with money or other material goods	1.16	.40	1.06	.29
6. Stayed with your relative so you can take a vacation (for a weekend or longer)	1.07	.38	1.01	.11
7. Gotten up during the night with your relative	1.04	.19	1.00	.00

Note. The response scale of measures consists of (1) Rarely or none of the time (2) some of the time (3) most of the time (4) almost all of the time

(N = 80). The scale of measure used to indicate frequency of support ranged from 1) rarely or none of the time to 4) almost all of the time; thus, the responses suggest that support is quite infrequent.

Caregivers indicated that when support was provided by either family or friends/neighbors, it most often consisted of spending time keeping the care-recipient company. The category of support found to be provided the least often by both family and friends/neighbors was getting up during the night with the care-recipient. The second type of support provided least often by both sources was staying with the care-recipient for a weekend or longer.

The mean scores all seemed quite low on the scale of 1 to 4. The standard deviations were also very small. In review of the various categories of support, 38% to 96% of the caregivers indicated that family members provided support rarely or none of the time. On the contrary, only 0% to 12.5% indicated that any specific category of support was provided either most of the time or almost all of the time.

The categories of support received from friends/neighbors was even lower as noted by 61% to 100% responding "rarely" or "none of the time" with only 0% to 6% who indicated support from any one category was provided most of the time or almost all of the time. There was very little variability among the scores, with majority of the individuals responding rarely or none of the time to all but one category which referred to keeping the relative company.

Each mean score and standard deviation representing support from friends was slightly lower than that from family members. These findings reflect the caregivers' perceptions based on their

utilization of support received from the informal network. The responses do not necessarily reflect the amount of support available to the caregivers from the informal network. Thus, the findings suggest that support from family, as perceived by the caregiver, is utilized a little more frequently and that families vary a little in the support provided to the caregiving family member.

Question II

What is the caregivers' overall degree of satisfaction with the support from family members and friends/neighbors?

The majority of caregivers were either "very satisfied" (n=38, 47%) or "somewhat satisfied" (n=31, 39%) overall with the support they were currently receiving from family members. Only three caregivers were "very dissatisfied" overall with the support they were currently receiving. The mean degree of satisfaction with this source of support was 1.7 (N= 80). The Likert scale used to measure degree of satisfaction ranged from (1) very satisfied to (4) very dissatisfied.

Similar findings, "very satisfied" (n=42, 56%) and "somewhat satisfied" (n=23, 31%), were also found in relation to overall satisfaction with support from friends/neighbors. The mean degree of satisfaction with this source of support was 1.6 (n=75). The mean scores and standard deviations suggest quite limited variability among responses representing satisfaction with support from both friends and family. There were only 15% and 13% of caregivers dissatisfied with support from family and friends, respectively. Caregiver satisfaction with support is presented by frequencies and

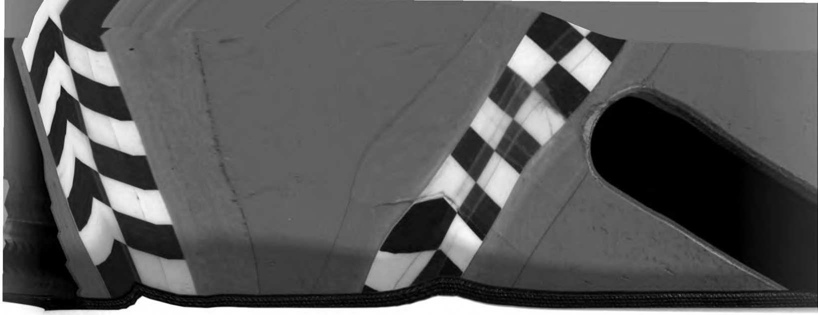


Table 5.5: Degree of Satisfaction with Support

	Family		Friends	
	Frequency	Percentage	Frequency	Percentage
Very Satisfied	38	47	42	56
Somewhat Satisfied	31	39	23	31
Somewhat Dissatisfied	8	10	6	8
Very Dissatisfied	3	4	4	5
	N = 80 Mean = 1.7 Std. Dev. = .80		N = 75 Mean = 1.6 Std. Dev. = .85	

percentages in Table 5.5.

Reliability Testing of the Instrument

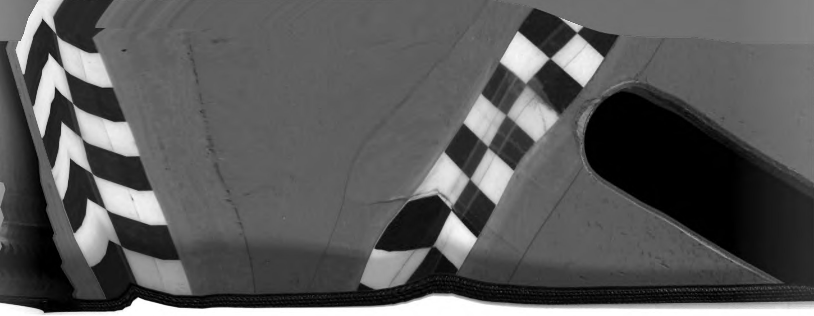
In order for question number three to be answered the reliability of the instrument needed to be addressed. The original instrument for measuring assistance from family and friends/neighbors had nine categories of support, some representing instrumental support and others representing emotional support (Given & Given, 1986). No previous reliability testing had been done on this instrument. Consequently, for purposes of this study the reliability of the instrument was tested by computing the Cronbach Alpha Coefficient.

Two Alpha coefficients were computed, one for the instrument measuring family support and the other for the instrument measuring friends/neighbors support. Woods & Catanzaro (1988) suggested Alpha coefficients between 0.7 and 1.0 indicate adequate internal consistency of an instrument.

In the first computation of internal consistency among the nine categories representing support from family members, an Alpha coefficient of 0.75 was obtained. In measuring the internal-consistency among the categories representing support from friends/neighbors, an Alpha coefficient of 0.73 was obtained. Prior to the latter computation a zero variance was found for the category entitled "gotten up during the night with your relative". Thus, this category was omitted in the computation of the Alpha coefficient representing the questionnaire in relation to support from friends/neighbors.

Based on the low item-total correlation of .1066 between the category entitled "Helped you with money or other material goods" and the other categories in the family support questionnaire, this category along with the above mentioned category were omitted from further Alpha coefficient computations. Thus far the Alpha coefficients were acceptable, but improved slightly with the omission of the two mentioned categories.

A final computation was performed to determine the reliability of the questionnaire consisting of the seven remaining categories. This included the two categories of emotional support. Alpha coefficients of .77 and .73 were computed for the scales measuring family support and friends/neighbors support, respectively. These



reliability coefficients were considered sufficient. In the final statistical correlations to be presented between the mean scale scores representing the support categories and degree of satisfaction, data based on the seven support categories including the categories of emotional support were considered.

The categories of emotional support were included in the final correlations since indirectly the measure of satisfaction also includes this dimension of social support. The categories of emotional support, however, are not included in the item by item correlations.

Question III

What are the relationships between the categories of instrumental support provided and the overall degree of satisfaction with support?

The correlation coefficients and *p* values for the correlations between satisfaction and individual categories of instrumental support are presented in Table 5.6.

Initially, item by item correlations were done between the mean scores of the individual categories of instrumental support and the mean overall degree of satisfaction with support. Categories of emotional support were not considered since they were not the focus of this study. The Pearson product-moment correlation was calculated. Throughout this portion of the analysis, the support provided from family members and friends/neighbors was analyzed separately.

The correlation coefficients representing the relationship between each individual category of instrumental support and degree

Table 5.6: Correlation Coefficients for Individual Categories of Support and Degree of Satisfaction

Categories of Support	Family (N=80) r	p	Friends (n=75)[a] r	p
1. Helped with physical care	-.2273	.021*	-.1801	.061
2. Spent time keeping your relative company	-.2471	.014*	-.3057	.004*
3. Stayed with your relative so you could do something else for a few hours	-.3119	.002*	-.1658	.078
4. Stayed with your relative so you can take a vacation (for a weekend or longer)	-.0083	.471	-.0862	.231
5. Gotten up during the night with your relative	-.1734	.062	--[b]	--
6. Helped with transportation (for either you or your relative)	-.1312	.123	-.2208	.028*
7. Helped you with money or other material goods	-.0039	.486	-.1424	.111

Note. r = Pearson correlation coefficient; p = statistical significance.

[a] Missing five responses

[b] Category had zero variance, correlation not computed.

*_p_ <.05.

of satisfaction with support from family members ranged from r = -.0039 to -.3119 (N=80). A highly significant relationship (r = -.3119, p =.002) was found between overall satisfaction with support and family members staying with the care-recipient so that the caregiver could do something else for a few hours.

The negative correlations reflect the differences in the direction of scoring the two instruments. The scale to measure the degree of satisfaction ranged from 1) very satisfied to 4) very dissatisfied, with a low score representing a high degree of satisfaction. On the other hand, the scale used to measure frequency of support provided ranged from 1) rarely or none of the time to 4) almost all of the time, with a low score representing a low frequency. Thus, a negative correlation means that higher satisfaction is associated with a greater provision of support.

The weakest relationship was found between satisfaction and help with transportation (r = -.1312, p = .123). No relationship was found between satisfaction and the provision of material goods (r = -.0039) or between satisfaction and staying with the care-recipient for a weekend or longer (r =-.0083). Eventually the category entitled "provision of material goods" was eliminated from the final scale of items when the reliability testing was performed.

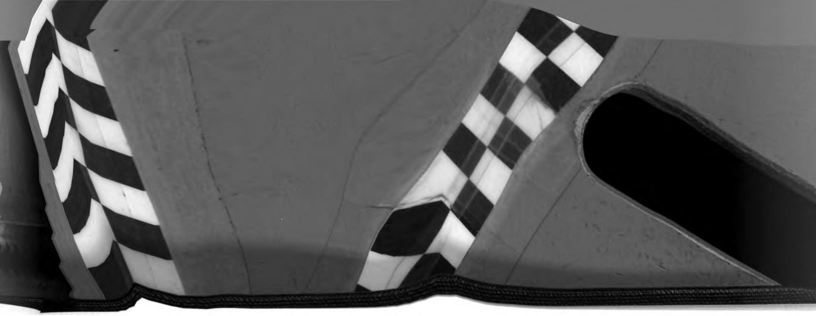
The correlation coefficients representing the relationship between the individual categories of instrumental support and the degree of satisfaction with support from friends/neighbors ranged from r =-.0862 to -.3057 (n = 75). A highly significant relationship (r =.3057, p =.004) was found between overall satisfaction with support and friends/neighbors spending time keeping

the care-recipient company. The weakest relationship (r = -.1424, p =.111) was found between satisfaction and the provision of material goods. There was no relationship found between satisfaction and a friend staying with the relative for a weekend or longer (r = -.0862).

To determine the relationship between the degree of satisfaction with overall support and the scale score representing the combined categories of support, a reliable scale of support was needed. To determine a reliable scale of support categories, the internal consistency of the instruments were examined.

For the original scales utilized in measuring support received from family members and friends/neighbors Cronbach Alpha's = .75 and .73, respectively, were obtained. After the elimination of two categories of support from both the family and friends/neighbors scale Cronbach Alpha's = .77 and .73, respectively, were obtained. The reliability of the instrument measuring support from friends improved only slightly, however the same alterations were made to both scales for the purpose of analysis. The remaining seven categories of support were included in the final correlational computations. These categories included:

1. Helped with physical care.
2. Spent time keeping your relative company.
3. Stayed with your relative so you could do something else for a few hours.
4. Stayed with your relative so you can take a vacation (for a weekend or longer).
5. Given you emotional support or encouragement.



6. Helped with transportation (for either you or your relative).

7. Checked on you to be sure that you were all right.

Using the seven item scale scores and the mean overall satisfaction scores, Pearson product-moment correlation coefficients were determined. Two correlations were computed to represent the relationship between the mean level of satisfaction with support overall and the total mean frequency of support provided by family members and friends/neighbors respectively. The correlation coefficients between satisfaction with support and frequency of support from family was $r=-.42$, $\underline{p} = .000$ and friends/neighbors was $r=-.39$, $\underline{p} = .000$. Both of these were found to be highly significant.

Additional Findings

Once the reliable scale to measure assistance from family and friends was identified, one additional correlation was computed. A correlation was computed between frequency of assistance received from family members and friends/neighbors ($N=80$, $r =.1306$, $\underline{p} =.124$). This result represented a very weak correlation and not a statistically significant result. This result suggested that support from family members or friends/neighbors could not be substituted for one another.

Summary

The caregiver group for this study consisted of 80 wives with an average age of 67 years, caring for their disabled husbands with an average age of 73 years. Majority of the caregivers were Caucasian, unemployed and had provided care for a mean duration of 5 years.

A large percentage of the care-recipients had been diagnosed

with either a stroke or Alzheimer's Disease, which resulted in increased dependence on their wives. On average they required assistance with 5.3 Activities of Daily Living and 4.8 Instrumental Activities of Daily Living.

Overall, instrumental support from family members and friends/neighbors was utilized on a very infrequent basis. The support utilized most frequently consisted of short-term visits with the care-recipient. Caregivers received the least assistance in caring for their husbands during the night. The variability in response was quite low suggesting responses were homogeneous.

Even though assistance was rarely utilized or not utilized at all, the wives indicated that they were quite satisfied with the assistance from both family and friends/neighbors. The standard deviations on this measure also indicated that responses were quite homogeneous.

The Pearson product-moment coefficient was used to represent the relationship between the various categories of support and the wives' degree of satisfaction with that support. The analysis indicated that there was a very weak relationship between satisfaction and help with transportation from family members. On the other hand, there was a weak relationship between satisfaction and the provision of material goods by friends/neighbors. Satisfaction was more likely to be related to a family member caring for the care-recipient for a few hours, or a friend spending time just visiting with the care-recipient.

In this chapter a review of the results was presented. In Chapter 6 interpretation of the results and recommendations will be

presented. Implications for advanced nursing practice and research will also be discussed.

CHAPTER 6: INTERPRETATIONS AND RECOMMENDATIONS

Overview

A descriptive study was conducted using secondary data, to examine the frequency with which specific categories of instrumental support, provided by family and friends, were utilized by wife caregivers. Then an analysis was done to examine the relationship between the utilization of support and degree of satisfaction with support.

The major findings included data that family members and friends spent time keeping the care-recipient company more often than providing any other type of instrumental support. Also, the provision of long-term respite (weekend or longer) was found least often from the same support groups, after elimination of the category titled "gotten up during the night with your relative".

These results suggest that wives caring for their husbands provide majority, if not all, of the direct care with limited involvement from family members and friends. This increases the likelihood that spouse caregivers will provide more care than they are emotionally and physically able to, which may result in an increase in or worsening of their own health problems.

Overall, the wives indicated that they were satisfied with the support that they had received. Multiple variables were suggested to have a possible influence on the measurement of their degree of satisfaction.

The correlation of variables resulted in the following findings. The degree of satisfaction was least likely related to family members

providing material goods and friends providing long-term respite. On the other hand, the degree of satisfaction was most strongly related to the short-term respite received from family, and most strongly related to support from friends when time was spent keeping the care-recipient company. Even though the provision of specific types of instrumental support was minimal, satisfaction was significantly related to specific categories of support.

This chapter will consist of two sections. In the first section an interpretation of the results will be presented in reference to previous research and the conceptual framework selected for this study. The second section will include the implications of the research findings and recommendations for nursing research and practice.

Interpretation of Results

Background Characteristics of the Participants

AGE. The mean age of the caregiver in the present study was 67.5 years with 68% of the sample over the age of 65 years. A requirement for the present study was that the care-recipient be at least 65 years old. Since the study was focused on the spouse caregiver it was expected that the caregiver would be approximately the age of the care-recipient. Therefore, it is not surprising that the caregivers' average age was 67.5 years particularly since wives tend to be slightly younger than their husbands in many instances.

In Fengler & Goodrich's study (1979) the average age of the caregiver was 67 years and in Fitting, Rabins, Lucas & Eastham's study (1986) the average age was 65 years. In the study by Barusch &

Spaid (1989) the mean age of the caregiver was 69 years. Their average was slightly higher then others noted; however, the sample consisted of 70% females and 30% males which may have influenced the age spread.

The mean age of the care-recipient in the present study was 72.9 years with a range of 64 to 86 years. In the study by Fengler & Goodrich (1979) the average age of the husbands was 73 years with a similar range of 65 to 86 years.

In their study, Snyder & Keefe (1985) found the average age of the caregiver to be 60 years and the care-recipient to be 65 years. The age range of both, however, was 28 to 85 years and 22 to 93 years, respectively, with both men and women included. The majority of the studies reviewed included male and female caregivers in the sample with no indication of age breakdown by sex, consequently comparison of this study to others was somewhat difficult.

Overall, when comparing similar studies, the present study's findings are consistent with past studies in regard to age of caregiver and care-recipient. The wife caring for her husband tends to be approximately 5 to 8 years younger than her husband. The differences in mean age tended to vary depending on age limits and/or criteria for the study.

RACE. The individuals in the present study were predominantly Caucasian (97.5%) with wives and husbands matched on this variable. This finding may be an indication of the caregivers who are most likely to make themselves and their role as caregiver known to others. The distribution in this study, however, is not representative of the larger population of the lower Michigan area

where approximately 85% are Caucasian and 13% are Black (U.S. Bureau of the Census, 1988).

The findings of this study are consistent with the studies reviewed for this project. The sample of caregivers were predominantly Caucasian with the second largest group being Black (Cantor, 1983; Baines, 1984; Barusch & Spaid, 1989).

EMPLOYMENT STATUS. A large majority of the caregiver sample (91.2%) were not employed as was to be expected because of their average age. This has been found consistently throughout the literature (Cantor, 1983; Stone, Cafferata & Sangl, 1987; Gilhooly, 1984).

The caregivers in this study were on average 67.5 years old with a large percentage over 65 years old. The national average retirement age is between 62 and 65 years, therefore it was not unlikely that the majority of the caregivers in this study were not employed. This was especially true when knowing the demands of the caregiving role.

CARE-RECIPIENT FUNCTIONAL STATUS. More than half (52.2%) of the care-recipients in this study required assistance in six to ten Activities of Daily Living (ADL). Of a total of ten ADL's, care-recipients needed assistance with an average of 5.3 activities.

In comparison to ADL, there was a greater dependency in Instrumental Activities of Daily Living (IADL) for this sample of care-recipients. Of a total of six IADL's, 55% of the sample required assistance with all six activities. The next highest percentage of individuals requiring assistance was 17.5% (n=14) with dependency in five activities. On the average care-recipients were

found to need assistance with 4.8 IADL's.

Overall, the care-recipients required assistance with at least half the ADL's and/or half the IADL's, on the average. To require this degree of assistance indicated that the care-recipients in this study were quite dependent on their caregivers for daily care. It is also important to consider that men are somewhat socialized to be dependent in IADL's, regardless of physical and/or mental limitations.

The functional status of care-recipients is difficult to compare across studies. Many researchers consider the functional status of the care-recipient, but utilize a number of scoring methods (Gilhooly, 1984; Snyder & Keefe, 1985; Tennstedt, McKinlay & Sullivan, 1989), and a variety of criteria by which to measure functional status.

Barusch & Spaid (1989) measured functional status by level of dependency in ADL tasks and memory and behavior problems. Zarit, Reever & Bach-Peterson (1980) utilized Instrumental Activities of Daily Living and Physical Activities of Daily Living to measure functional status. Stone, Cafferata & Sangl (1987) determined level of dependency based on whether direct assistance or only supervision was required with certain activities.

Consequently, the functional status of a sample is helpful to know when determining the amount of assistance required from the primary caregiver. However, comparisons on this variable between sample groups could be cumbersome.

Background Characteristics of the Caregiving Situation

DURATION OF CARE. The caregivers in the present study have provided care for an average of five years. More than half of the caregivers (57%) have provided care from 1 to 4 years with a range of 1 to 60 years. The mode on this measure was three years. The extreme value of 60 years found in this study may represent a misinterpretation of the question by the caregiver.

The average age of the caregivers was 65.7 years, representing the young-old category of older Americans. It was not unlikely to find majority of the caregivers had provided care for only 3 years. It is likely that with an increase in the caregivers' and care-recipients' ages the number of caregiving years would also increase. However, this could be an issue for further study since many factors, such as cause of illness, caregiver health status and care-recipient's age at onset of illness, could all influence the duration of care.

Barusch (1988) studied spouse caregivers who had been caring for an average of 6 years with a mode of 3 years. Providing care for a duration of three years has been found to be a frequent response among many caregivers. This could suggest a duration of time most tolerated by caregivers and may be influenced by the care-recipient's cause of illness or degree of disability which resulted in the need for care. It must be understood, however, that there are caregivers who have provided care for a much longer duration of time and the factors enabling them to do so are presently being studied by researchers.

Stone, Cafferata & Sangl (1987) studied 500 spouse caregivers

with 44% providing care for 1 to 4 years. With a sample of this size 44% is a large number of caregivers. One fourth of the sample provided care for 5 years or more. Overall, the caregivers in the present study have been providing care for approximately the same, or longer, duration of time in comparison to spouse caregivers in other studies.

PRIMARY REASON FOR CARE. The largest percentage of caregivers in this study were caring for husbands who had a stroke (*n*=29, 36.7%) or had Alzheimer's Disease (*n*=11, 13.9%). Parkinson's Disease was the next most frequent disability identified. Other disabilities were represented, but in smaller frequencies.

Baines (1984) also found the diagnosis of stroke to be the most prevalent among her care-recipients, while Snyder & Keefe (1985) found 48% of their caregivers cared for individuals with Alzheimer's Disease and only 10% cared for those individuals with a stroke. Many studies performed in the past four years have focused on caregivers of Alzheimer's victims (Scott, Roberto, & Hutton, 1986; Barusch, 1988; Lawton, Brody & Saperstein, 1989; Wilson, 1989a). The primary reason for care may influence the level of involvement, the duration of care and consequently the need for various types of support.

Research Questions

This section will consist of the interpretation of the data addressing each of the three research questions separately. The interpretation will include how these findings compare to previous literature and possible explanations for any differences in the

findings. The findings will then be discussed within the context of the conceptual framework selected for this study.

Question I

What categories of instrumental support are provided by family members and friends/neighbors to wives who are caregivers?

In this study limited support by both family members and friends/neighbors was provided in all categories. Only a total of 11 responses indicated that support from family was "almost always" provided and a total of 8 responses, indicating the same from friends/neighbors. These findings suggest that of the categories investigated, very limited support is provided in these areas. It is possible that other support was provided, but was not measured by the questionnaire utilized in this study. The limited assistance provided in the support categories investigated in this study suggests, as did other researchers, that spouse caregivers are at risk for health problems as well as role overload (Ekberg, Griffith, & Foxall, 1986; Fengler & Goodrich, 1979).

The category of support entitled "gotten up during the night with your relative" was least likely to be provided. In a few instances the caregivers in this study ($\underline{n}$=10) indicated that someone else was living with them and their husband; however, the majority of caregivers ($\underline{n}$=69) indicated that they lived alone with their husband. This finding is consistent with Cantor's (1983) findings indicating that in most spousal caregiving situations it is unlikely to find other individuals living in the home. Therefore, it is unlikely that help would be available during the night.

Long-term respite for a weekend or longer was the second least frequent category of assistance provided. The limited availability of long-term respite was expected initially because caregiving wives seemed reluctant to leave their husbands even for short periods of time. Thus, the opportunity for long-term respite was not likely to arise on a regular basis.

Another reason for the limited provision of long-term respite is the possible difficulty individuals of the support network might encounter in their attempt to provide the quality of care provided by the wife. Many individuals may feel they can not adequately manage the care of their relative or friend for a long duration of time and, therefore, hesitate to offer assistance to the caregiver.

The findings of this study are consistent with the findings of Snyder & Keefe (1985) which suggest that respite care is often provided but in amounts too small to be beneficial, thus caregivers request more consistent long-term respite. Many researchers have found caregivers in various caregiving situations frequently request long-term respite (Crossman, London & Barry, 1981; Cantor, 1983; Baines, 1984; Horowitz & Dobrof, 1982; Theis & Deitrick, 1987). Scott, Roberto & Hutton (1986) also found 50% of their caregivers received respite from family members, but indicated that this was an area in which support was still lacking.

On the other hand, the family members and friends/neighbors were found to keep the care-recipient company more often than assisting in any other instrumental activity. Along with the provision of visiting with the care-recipient and providing short-term respite, assistance with transportation followed by help with physical care

were the next most frequent provisions of support by both family and friends.

Because most of the wives in this study lived with their husband, they provided care on a 24 hours a day basis. Even though a few wives had another person living in their household, they provided most of the care themselves because of their feeling of marital responsibility and obligation to their husband. Other individuals were probably more comfortable when they provided other forms of support, such as keeping the relative company or helping with transportation. These supportive actions did not require hands on care, but could suggest that the supportive individual cared for and supported the primary caregiver.

Horowitz & Dobrof, in their final report (1982), mentioned that when help was offered it was usually in small amounts and usually the least-labor intensive, thus not likely to be related to physical care. They also found 52.6% of the spouse caregivers were carrying the responsibility of care completely alone.

Based on the findings of the present study, the spouse caregivers seemed to provide most of the care with limited, if any, help. It is possible that very limited support was actually provided by family and friends as was indicated by these caregivers. However, it is also possible that the caregivers' perceptions reflected their utilization, rather than support that was actually available but not utilized.

Another aspect to consider is that the instrument used in this study may have failed to measure the type of support actually provided to the caregivers, such as emotional, informational, and

formal support. Therefore, the indication of limited provisions of support may not be representative of the support actually provided or received.

Stone, Cafferata & Sangl (1987) along with Tennstedt, McKinlay & Sullivan (1989) have found spouse caregivers to be the least likely to utilize secondary sources of support and, consequently, are the sole providers of care to the majority of married elderly. The findings related to this question are consistent with the previous literature, but were somewhat surprising to this researcher. It was expected, as was found in this study, that family members provided more assistance than friends. However, the degree to which assistance was provided was much lower than was expected, and may have been related to the instrument as mentioned.

When considering this data in the context of the conceptual framework and social support theory, it is suggested that frequency of support can influence adequacy of support and ultimately an individual's well-being. Ward, Sherman & LaGory (1984) along with others, however, have suggested that objective measures of support are not as useful as subjective measures in determining well-being. Therefore, even though the caregiving wives in this study indicated that they received very little support, the actual amount of support received may have no influence on whether the caregivers felt contented or satisfied.

In summary, utilizing objective measures this researcher has found that the spouse caregivers' informal sources of support provided very little, if any, support to the caregivers. When support was provided it was in limited quantities as perceived by the

caregivers, and the tasks requiring the least involvement (i.e. visiting, transportation) were performed most often, while the tasks requiring long-term involvement (i.e. long-term respite, hygiene) were provided the least often. These findings were found to be very consistent with previous research. It was recognized, however, that the results may have reflected the support accepted by the caregivers, rather than the support offered by the support network.

Because objective measures of support are not considered as helpful as subjective measures in determining well-being, the next research question was raised. An explanation is presented of how support as well as other variables can influence an individual's degree of satisfaction with support.

QUESTION II

What is the caregivers' overall degree of satisfaction with the support from family members and friends/neighbors?

Spouse caregivers received very little support from their informal source of support, but indicated they were satisfied with the support they received. This researcher found more than 85% of the caregivers were either "very" or "somewhat satisfied" with the assistance they received from family members and friends/neighbors. The largest percentage of caregivers were "very satisfied" with the assistance from family (47%) as well as from friends (56%).

The caregivers' indication that they were satisfied with the support could not be interpreted to suggest the support was adequate. Their responses could only suggest that they were content with the

support they utilized. The support may or may not have met their needs, but at this point in time they were content.

There are several reasons why the caregivers in this study may have said they were satisfied with the support they were receiving from family and friends. A few reasons to consider when interpreting why the caregivers were satisfied include the caregivers' expectations of the support network, the caregiving situation, the past and present levels of support, the type of support provided and the frequency of support provided.

If caregivers expect more assistance or prefer less, this will influence how they rate their degree of satisfaction with support. Wives may have low expectations of the type and amount of support others should provide, since they frequently view the role of caregiver as an obligation.

It is likely that the caregiving wives along with most individuals would expect more support from family members than from friends. This sense of obligation expected from family members is most likely related to the close bonds felt between the members. Even though individuals have expectations of the kind and frequency of support family members should provide, most individuals do not like to be a burden to others. Therefore, individuals are likely to ask for assistance only when they can not provide the care on their own, and are then grateful for any assistance they receive.

Throughout the literature, wives have been found to be quite independent in providing care, as was also found in the present study. It is likely that the caregivers' degree of satisfaction with the support provided by family and friends reflects their

appreciation for the support provided, rather than their true expectations of the support family and friends should provide.

Scott, Roberto & Hutton (1986) found approximately 80% of their caregivers received enough or more than enough support from their family and, overall, seemed satisfied with the support they received. Their caregivers included spouses as well as children.

Characteristics of the caregiving situation such as the duration of care may have also influenced the caregivers' degree of satisfaction. The caregivers in the present study have provided care for an average of five years. These caregivers are familiar with their role and responsibilities and may feel other individuals can't provide the same quality of care. Because the caregiving wives want the best for their husbands, they strive to do as much as they can without assistance from others. The wives may actually consider help from others to be an imposition on their daily routine, thus assistance from others may not be desired.

Barusch (1988) found veteran caregivers preferred to manage problems on their own. They had their own coping techniques identified which may have resulted in them requiring less assistance. If the need for less support was perceived then less support was preferred. Consequently, the duration of care may be influential in the determination of satisfaction with support.

Perceptions of satisfaction with support may also be influenced by a combination of current levels of support as well as the accumulation of support experienced over a lifetime (Lyles, King, Given & Given, 1989). This is consistent with the proposition suggested by Kahn & Antonucci (1980) that the convoy, or social

network, changes throughout the lifetime. All perceptions related to support may be influenced by what we have experienced in the past as well as the present.

In the present study it was not feasible to examine the type or frequency of support provided in the past. The measure of satisfaction was only intended to measure the caregivers degree of satisfaction at that point in time, however, the researcher was aware of the possible influence of the support provided in the past.

Because many of the caregivers in this study had been providing care for a long period of time, it is likely that they considered all the support they received during their time as a caregiver, when indicating their degree of satisfaction. Consequently, the caregivers' responses to the question of satisfaction may not represent their satisfaction with support at the time of interviewing, but rather a more global impression, possibly resulting in the discrepancy between low support and high satisfaction.

Recall that the subjective measure of satisfaction in this study was expected to reflect the adequacy of support provided. The results of this study could be interpreted to suggest that caregivers are content with the support they received, but could not represent the adequacy of support. A large percent of the caregivers indicated they were very satisfied with the support they received. Along with the factors previously mentioned including caregiver expectations, the caregiving situation, and the influence of past support, there could be other support available which was not measured, for example formal supportive services.

The caregivers were asked to evaluate overall satisfaction which

is quite global and open for individual interpretation. It is possible that having little informal support may be adequate based on the factors mentioned, but if it is not, formal services may be utilized to meet the caregivers' needs. Because the caregivers in this study have provided care for an average of five years, their expectations and abilities to cope with the caregiving situation may have changed over the years. Their positive responses may have been a reflection of all that they have encountered during the years as a caregiver.

No specific conclusions can be made about this data because of the multiple influential factors not measured in this study. However, it can be concluded that the largest percentage of spouse caregivers in this study were very satisfied with the support they received from their informal sources of support. They were also slightly more satisfied with the support they received from friends/neighbors compared to family members.

In much of the support literature, an individual's perception of satisfaction with support is studied in relation to health outcomes (Gilhooly, 1984; Krause, 1987). Rarely are individuals asked how satisfied they are with the support they receive. Because of the difficulty in conceptualizing satisfaction and controlling for the variables which influence it, this researcher now understands why there is a lack of research in this area.

It is difficult to measure an individual's degree of satisfaction with support, because it is subjective and can be influenced by many factors. Individuals may actually find it difficult to suggest that they are dissatisfied, when they truly

appreciate any assistance they receive. It may be more appropriate for the caregiver to identify what further assistance they could use based on their needs, and is a more precise method of determining if the support provided is adequate. This information could be obtained after the caregiver identifies the support presently received from both family and friends. To know what further assistance is needed would enable researchers to compare support which is inadequate across samples, and would generate ideas for future supportive services, whether it be a formal or informal service.

The data collected in relation to this research question can only be interpreted to mean that these caregivers are in fact satisfied, overall, with support. If satisfaction is a subjective means by which to measure adequacy of support, then these caregivers may also feel the support they are receiving is adequate. No further assumptions can be made since the basis upon which the question was answered is unknown. It is possible that the question related to satisfaction was not sensitive enough to measure what it was expected to measure and the four response categories limited precise responses. The response categories did not allow for individual variability among the respondents. The question consisted of the broad term "overall" which could be interpreted differently by each individual and result in inaccurate responses.

It must be understood that the response selected represents the individual's perception at one point in time and could change at any moment. At the time of interviewing there were certain feelings the caregivers experienced and impressions they recalled which may have influenced how they rated their degree of satisfaction with support.

If the caregiver happened to recall an event when a special friend helped with transportation of the caregiver's husband, she would be more inclined to respond in a positive manner. However, recall of a time when a family member refused to come over at a moments notice would have likely resulted in a negative response.

Even though the initial responses related to frequency of support indicated support was limited, when the caregivers were asked, "overall, how satisfied" they were, memories when support was readily available may have been triggered. Consequently, at that point in time when the question was presented as it was, the caregivers' responses may have reflected their perceptions at that moment, but may have also been influenced by past experiences.

In summary, the largest percentage of caregivers indicated that they were satisfied with the support they received from family and friends. There were many factors which could have influenced the caregivers' responses to this question. Some factors characteristic of the caregiver and caregiving situation include the caregivers expectations of support, the duration of care provided, past experiences with support provided by family and friends, and availability of other formal supportive services.

There were also some specific limitations of the questionnaire identified which could have influenced the caregivers' responses. The first limitation was the use of the term "overall" which may have suggested that the caregiver consider support provided now, as well as in the past, when giving their response. This led to the second limitation that the question measured satisfaction with support at that one point in time, but was influenced by the other factors

mentioned which could have actually affected the reliability of the responses.

A third limitation was partially related to the support questionnaire which only allowed for measurement of a few categories of support. If the caregivers only considered these categories of support when expressing their degree of satisfaction, it is possible that they are very satisfied with support in these areas, but not with support in other areas. In actuality this researcher wanted to examine satisfaction with support only related to instrumental support. However, because of the wording of the satisfaction question, the examination of satisfaction with instrumental support alone was not possible.

The fourth limitation of the instrument was having only four broad responses to select from in answering the question. This prevented more precise individual interpretation with regard to the degree of satisfaction. Each caregiver may have responded with different thoughts in mind based on the limitations of the instrument.

Based on the multiple factors which may have influenced the caregivers' responses to the question of satisfaction, the responses must be considered with caution. It is possible that all the caregivers who participated in this study were not as satisfied, as was indicated, with the support they were receiving from family and friends. Therefore, future study with a similar sample, using a modified instrument to measure satisfaction in some manner is recommended. Recommendations for alterations in the instrument are discussed later in this chapter.

QUESTION III

What are the relationships between the categories of instrumental support provided and the overall degree of satisfaction with support?

Initially, an item by item correlation was done between each category of support and degree of satisfaction. The responses for the degree of satisfaction ranged from (1) "very satisfied" to (4) "very dissatisfied". In reviewing the results related to support from family members, three categories were significant at $p<.05$ when correlated with satisfaction. The three categories included helping with physical care (r=-.2273, p=.02), spending time keeping relative company (r=-.2471, p=.01) and staying with the relative for a few hours (r=-.3119, p=.002). These findings suggest that even though these categories of support are provided infrequently, they are related to the caregiver's overall degree of satisfaction with support.

Among the caregivers participating in the present study, when family members helped with physical care of the elderly, kept the elderly relative company or stayed with the relative for a few hours, the caregivers' perceived degree of satisfaction with support was increased. This free time enabled the caregiver to perform other tasks which needed to be completed.

Wives are frequently identified as sole caregivers spending most, if not all, of their 24 hour day caring for their husbands. In some cases the wife is also managing her own health problems. Consequently, it is not surprising that help in any of the categories mentioned would be welcomed.

An elderly wife may not always have the energy required to

provide the physical care needed by her husband, particularly when he is a victim of a stroke, as were one third of this study's care-recipients. The majority of care-recipients were also quite dependent in IADL as well as ADL with almost half of them diagnosed with either a stroke or Alzheimer's. Because of the demanding care and supervision required by these individuals, any short periods of time away from the situation were most likely welcomed by the caregivers.

Krause (1987) studied the relationship between satisfaction with support and various types of support including informational, emotional and tangible support. The only significant relationship was between emotional support and satisfaction (r=-.208, p<.001). Krause's findings are similar to the findings related to the support from friends/neighbors found in the present study. However, since the emphasis in the present study was on instrumental support, the findings related to the emotional support items included in the assistance questionnaire were omitted.

The data related to support from friends/neighbors is different from that related to support from family members. There are two categories that were significant at p<.05 when correlated with satisfaction and these categories were entitled "spent time keeping relative company" (r=-.3057, p=.004), and "helped with transportation" (r= -.2208, p=.028). Horowitz & Dobrof (1982) indicated that less-intensive assistance is likely to be provided by friends/neighbors. This was reflected in the findings of the present study and caregivers have indicated they were satisfied.

Friends/neighbors frequently live close in proximity to the

caregiver and are usually readily available if transportation is needed. Transportation is a service that friends/neighbors often express a willingness to provide, therefore provide it with little resistance when asked. The caregivers in this study identified transportation as the third most frequent category of support provided, but may have felt comfortable asking their friends for assistance with this service when it was needed.

When assistance is not frequently provided, but the caregiver feels comfortable in knowing that the assistance is readily available, the caregiver is likely to indicate a higher degree of satisfaction with that support. This feeling may be part of what was reflected in the caregivers' degree of satisfaction with support discussed in the previous research question.

Following the item by item correlations a reliable scale of support items was developed so that further correlations could be performed. Two items were deleted from the original instrument which resulted in a scale with two items representing emotional support and five items representing instrumental support.

For purposes of the present study the reliable scale as it is now was adequate. However, because of the mixture of emotional and instrumental support categories, it would not be adequate for the study of instrumental support alone in the future. The scale does not incorporate all the dimensions of support, so could not be used to examine support overall either. In future studies this researcher recommends the elimination of the emotional categories of support and the addition of new instrumental support categories. The changes will be discussed further in the last part of this chapter. These

changes were not possible in this study since secondary data was utilized.

Correlations were done between overall satisfaction with support and overall assistance received from family and then friends/neighbors. Both correlations were very significant with p =.000. The correlation coefficients also represented a moderately strong relationship between support from family and satisfaction (r =-.4167) and support from friends and satisfaction (r =-.3872).

Researchers have known that there is a relationship between the amount of support an individual receives and how he/she perceives his/her level of satisfaction. Ward, Sherman and LaGory (1984) found that whether an individual has enough support in an objective sense was not as important to well-being as was their subjective perceptions that they had enough. They suggest that the quality of the support may influence an individual's state of well-being.

In the present study, knowing that support was infrequent raised the question of what other factors affected the caregivers' high degree of satisfaction. This is an area requiring further study and research.

A final correlation was done between the two mean correlations of assistance received from family and from friends (r=.1306, p=.124) and no relationship was found. Based on the differences found between the frequency of assistance provided by family compared to friends/neighbors, this correlation coefficient is not surprising.

Even though not statistically significant, the final correlation is significant to practice. It suggests that assistance from one source of support will not necessarily influence the availability of

support from another source, particularly when studying the instrumental support available to wife caregivers. Also, it is not likely that support from one source could be substituted for support provided by another source. Each source of support is beneficial to the caregiver in its own way. An explanation of how this data can be interpreted in the context of Kahn & Antonucci's framework (1980) follows.

Results As They Apply To Kahn & Antonucci's Framework (1980)

One of the propositions of Kahn & Antonucci's framework (1980) is that adequacy of social support received by an individual is determined by the properties of the convoy as well as situational and personal properties. Therefore, it is suggested that a social network characteristic such as size, but more specifically, type, source and frequency of support received from the network, could influence the degree of satisfaction with support provided.

The findings of the present study are consistent with the propositions suggested by Kahn & Antonucci (1980). Even though not all of the variables in their framework were examined in this study, those variables still influenced each other.

In the present study the sample was pre-selected to consist of female spouse caregivers. This criteria predetermined the properties of the person and the situation to a certain degree. Because the wives were elderly and possibly ill themselves, this increased the likelihood that they may require support in their role as caregivers. Based on these possibilities this researcher was inclined to further evaluate the support provided to this sample of individuals.

The second proposition of Kahn & Antonucci's framework (1980) suggested that the person's support network (convoy) is influenced by the properties of the person and situation as well as the person's requirements for social support. In the present study there is an understanding of some of the personal and situational characteristics which may influence the composition of the support network. However, the requirements for support were not examined. Without determining the needs of the caregivers, it is difficult to assess whether the support network is providing adequate assistance.

The caregivers indicated that very little support was actually provided. It is possible that the support they were receiving was not represented in the assistance questionnaire. On the other hand as previously mentioned, spouse caregivers are frequently identified as sole providers of care and may not be willing to accept assistance. The results of this study may be a representation of the caregivers' unwillingness to accept assistance .

In their third proposition Kahn & Antonucci (1980) suggested that the adequacy of support is determined by the properties of the person and the situation, as well as the convoy. In the present study the adequacy of support was substituted by the evaluation of the caregivers' perceived degree of satisfaction with the support they were receiving. If the caregivers were content with the support provided by the support network they were expected to indicate that they were satisfied. As previously mentioned the caregivers indicated that little support was provided, but they were still quite satisfied. The possible reasons for their responses have previously been discussed.

Kahn & Antonucci's last two propositions were not addressed in the present study. The intent to examine the variables mentioned, however, was to ultimately improve the caregivers' well-being which is included in the final propositions.

To conclude, in the examination of the relationship between satisfaction with support and the frequency of specific types of support, a significant difference was found when comparing the two sources of support. This suggests that satisfaction with support may vary when researchers consider the source of assistance, type of assistance, and frequency with which assistance is provided.

The variables and the results of this study fit appropriately within the framework of Kahn & Antonucci (1980). Even though not all of the variables in their framework were examined, it is reasonable to believe that alterations in the properties of the person and/or situation, such as in the examination of child caregivers, would result in quite different responses to the assistance and satisfaction questionnaires.

Kahn & Antonucci's (1980) framework was selected as a guide for this study because the major concepts of this study fit so closely with the concepts found in their framework. Consideration was given, however, to how concepts from Kahn & Antonucci's framework could be incorporated into a nursing theory. The most appropriate theory to consider was that developed by Imogene King (1981).

King's (1981) theory is very much like Systems theory as is Kahn & Antonucci's (1980). King described three open systems interacting with one another, namely the personal, interpersonal, and social systems. Within the personal system she describes the individuals as

Kahn & Antonucci's last two propositions were not addressed in this present study. The intent to examine the variables mentioned, however, was to ultimately improve the caregivers' well-being which is included in the final propositions.

To conclude, in the examination of the relationship between satisfaction with support and the frequency of specific types of support, a significant difference was found when comparing the two sources of support. This suggests that satisfaction with support may vary when researchers consider the source of assistance, type of assistance, and frequency with which assistance is provided.

The variables and the results of this study fit appropriately within the framework of Kahn & Antonucci (1980). Even though not all of the variables in their framework were examined, it is reasonable to believe that alterations in the properties of the person and/or situation, such as in the examination of child caregivers, would result in quite different responses to the assistance and satisfaction questionnaires.

Kahn & Antonucci's (1980) framework was selected as a guide for this study because the major concepts of this study fit so closely with the concepts found in their framework. Consideration was given, however, to how concepts from Kahn & Antonucci's framework could be incorporated into a nursing theory. The most appropriate theory to consider was that developed by Imogene King (1981).

King's (1981) theory is very much like Systems theory as is Kahn & Antonucci's (1980). King described three open systems interacting with one another, namely the personal, interpersonal, and social systems. Within the personal system she describes the individuals as perceiving, reacting beings. The personal system is influenced by an individual's perceptions of the environment as well as his/her own self-image. This system is very much like what Kahn & Antonucci describe as properties of the person including demographic characteristics and needs, and properties of the situation including roles and demands.

The second system described by King (1981) was the interpersonal system. This system consists of two or more individuals interacting with the personal system. Each individual has a role to fulfill in the interaction process and they communicate both verbally and nonverbally in order to help maintain balance in a situation, minimizing the effects of negative stressors.

The concept of the convoy from Kahn & Antonucci's (1980) framework is very similar to the interpersonal system described by King (1981). The convoy consists of the support network which provides assistance to individuals particularly during stressful periods of the life-cycle. Within the present study, the informal support network could be considered the interpersonal system interacting with the personal system, the caregiver, minimizing the caregiver's stress and enabling her to maintain her role as caregiver.

Another and final concept described by King (1981), which is also considered in the framework by Kahn & Antonucci (1980), is the concept of health. King described health as a continuous adjustment to stressors in the environment through optimum use of one's resources. Illness is defined as an interference or feeling of dissatisfaction. Kahn & Antonucci describe the adequacy of support

and its influence on an individual's well-being. In the present study satisfaction with support was substituted for adequacy of support and was expected to ultimately influence well-being. It could be suggested that the level of satisfaction may depend on the harmony and balance of the environment. Therefore, if caregivers are dissatisfied, alterations in the environment may be required to restore harmony and promote health.

Utilization of King's (1981) theory exclusively for this study would have been complicated, but through this comparison it was demonstrated how closely select concepts could have been operationalized. This comparison also demonstrated similarities between a social support framework and a nursing framework.

Implications and Recommendations

The implications of this research will be addressed in two sections. The two sections include implications and recommendations for nursing research, and implications for advanced nursing practice. The discussion will be directed toward the primary care nurse in advanced practice, specifically the Clinical Nurse Specialist.

Implications for Nursing Research

This section will consist of three parts. The first will focus on the instruments utilized in this study and how they can be used in future research. In the second part of this section a review of the conceptual framework will be presented with an emphasis on the framework's usefulness in this study and how the framework might be used in future studies. The third part of this section will focus on what further research is needed in the area of social support and

satisfaction.

Instruments

The instruments utilized to measure assistance and satisfaction were newly developed for a larger research project by Given & Given (1985). No previous reliability or validity testing had been done on the assistance or satisfaction instrument except in assessing for face validity. Therefore, some changes are recommended prior to their use in future studies, particularly in the study of instrumental support.

The internal consistency of the assistance questionnaire was adequate, but improved when two of the categories were eliminated. Those categories eliminated from the instrument were "gotten up during the night with your relative" and "helped you with money or other material goods". There were also two categories which represented emotional support and were considered part of the reliable scale. Because the emotional categories of support were in the scale, they were seen as limitations to this study since the focus was on instrumental support.

I would recommend substituting the two categories of emotional support, "given you emotional support or encouragement" and "checked on you to be sure you were all right" with two categories representative of instrumental support. A few recommendations include "helping with financial matters, helping with chores around the house, and helping with shopping".

This instrument could be very useful in future studies following the alterations in the support categories. The ability to measure support from various groups such as family members and friends,

separately, enhances this instruments usefulness. The support provided to wives, husbands and children who are caregiving can be examined using this instrument, and administration of the instrument longitudinally may provide more informative data. Further reliability and validity testing is also recommended since it was limited in the present study.

The second part of the instrument measuring satisfaction requires multiple alterations to be of benefit in future projects examining satisfaction with support. The instrument to measure satisfaction should not consider overall satisfaction, but should be directed at satisfaction with instrumental support exclusively.

Future researchers may want to consider more than one question to measure satisfaction, since multiple factors can influence this variable. The satisfaction questionnaire should accompany the revised measurement of support previously discussed. A few suggestions for additional satisfaction questions include, "Based on the support categories mentioned in the previous questionnaire, how satisfied are you with this support currently provided?" also, "Based on your expectations of support from family/friends, how satisfied are you with this support currently provided?". This researcher also recommends a measurement of satisfaction for each category of support rather than a global measure. Separate evaluations for each category of support enables more accurate responses. It may be helpful to expand the 4-point Likert scale to a visual analog scale, whereby individuals could indicate their degree of satisfaction more specifically and help to increase variation among responses.

Once the questions are developed reliability and validity

testing is needed. This will assure consistent results in the measurement of satisfaction regardless of the sample. It will also assure that the questions are measuring what they are expected to measure.

Throughout this study the examination of satisfaction was very cumbersome. It may be more useful to exam the needs of the caregiver and then adequacy of support in meeting those needs. The measurement of the adequacy of support is more specific when examining whether needs are met. If the needs are not met, an additional question must be asked to determine what assistance is still needed.

For the present study this researcher utilized secondary data. Because the instruments were developed and administered by other researchers, the instruments were not quite adequate to measure the variables selected for this study. Future alterations in the instruments were recommended to more accurately measure the variables of instrumental support and satisfaction. Thus, future study of these variables can be implemented with more reliable measures.

The next area related to research implications will consist of a review regarding the use of Kahn & Antonucci's framework (1980) in the study of support provided to elderly caregivers. There are a few studies which incorporated the idea of a "convoy" of social support and were discussed in the literature review.

Usefulness of Kahn & Antonucci's Framework

For the present study this framework was helpful in understanding the relationship between the use of social support and the degree of satisfaction with support. The presence of social testing is needed. This will assure consistent results in the measurement of satisfaction regardless of the sample. It will also assure that the questions are measuring what they are expected to measure.

Throughout this study the examination of satisfaction was very cumbersome. It may be more useful to exam the needs of the caregiver and then adequacy of support in meeting those needs. The measurement of the adequacy of support is more specific when examining whether needs are met. If the needs are not met, an additional question may be asked to determine what assistance is still needed.

For the present study this researcher utilized secondary data. Because the instruments were developed and administered by other researchers, the instruments were not quite adequate to measure the variables selected for this study. Future alterations in the instruments were recommended to more accurately measure the variables of instrumental support and satisfaction. Thus, future studies of these variables can be implemented with more reliable measures.

The next area related to research implications will consist of a review regarding the use of Kahn & Antonucci's framework (1980) in the study of support provided to elderly caregivers. There are a few studies which incorporated the idea of a "convoy" of social support and were discussed in the literature review.

Usefulness of Kahn & Antonucci's Framework

For the present study this framework was helpful in understanding the relationship between the use of social support and the degree of satisfaction with support. The presence of social support and the degree of satisfaction with the support were expected to influence the caregivers' well-being, which is the ultimate goal in the provision of support, particularly within the realm of nursing.

The framework Kahn & Antonucci (1980) developed was an excellent guide for this study. The concepts selected to be investigated in this study fit appropriately within the framework selected. In an earlier chapter this researcher noted that not all of the concepts discussed by Kahn & Antonucci were examined in the present study. The study of the other concepts described by Kahn & Antonucci were not within the realm of this project, but could be of interest in future studies related to the topic of instrumental support. Recommendations of how Kahn & Antonucci's framework could be utilized more completely will now be presented.

The properties of the person and situation were of importance in the present study, but did not become concepts of major focus. The sample group was predetermined and consisted of a homogeneous group with regard to sex, marital status and role, thus no comparisons could be made in relation to this variable.

The next concept described by Kahn & Antonucci (1980) was the requirement of support. This concept was not examined in the present study, but could easily be examined in future studies. The caregivers could be asked to identify their primary concerns and needs. A list of possible responses could be developed to allow easier scoring of the responses. Based on the identified needs, the provision of support could then be evaluated.

Kahn & Antonucci (1980) described the convoy as the next concept support and the degree of [illegible] with the support were [illegible] [illegible] the [illegible] in the [illegible] in the provision of support, particularly within the realm of nursing.

The framework Kahn & Antonucci (1980) developed was an excellent guide for this study. The concepts selected to be investigated in this study fit appropriately within the framework selected. In an earlier chapter this researcher noted that not all of the concepts discussed by Kahn & Antonucci were examined in the present study. The study of the other concepts described by Kahn & Antonucci was not within the realm of this project, but could be of interest in future studies related to the topic of instrumental support. Recommendations of how Kahn & Antonucci's framework could be [illegible] methodologically will now be presented.

The properties of the person and situation were of importance in the present study, but did not become concepts of major focus. The sample group was predetermined and consisted of a homogeneous group with regard to sex, marital status and role, thus no comparisons could be made in relation to this variable.

The next concept described by Kahn & Antonucci (1980) was the requirement of support. This concept was not examined in the present study, but could easily be examined in future studies. The caregiver could be asked to identify their primary concerns and needs. A list of possible responses could be developed to allow content analysis of the responses. Based on the identified needs, the provision of support could then be evaluated.

[illegible] & Antonucci [illegible] the convoy [illegible] in their framework and emphasized the ability for it to change throughout life. In the present study a very limited part of the convoy was investigated. Emphasis was on a specific type of support, but the source was evaluated in a very general manner. To utilize this framework as it was developed to be used, more specific aspects of the "convoy" or support network must be examined.

A critical area to examine within the network are the individuals who are considered the immediate network. It is possible that the caregiving wives are quite involved in their role and may have a very limited support network from which they can obtain assistance. This could influence how much support they receive and could also influence their level of satisfaction. How could the caregivers be dissatisfied with network members who do not exist?

It is also important to have the caregivers identify other sources of support, such as members of a formal network of support. These additional sources of support can affect the degree of satisfaction with the informal network, if it supplements the support not provided by the informal network. Having an alternate source of support may leave the caregivers with an overall feeling of satisfaction which may overcome any feelings of dissatisfaction.

Knowing who is in the support network is important, but it is also helpful to know how long the individuals have been a part of the network. Veteran members may be more helpful in a crisis and may enhance the overall network. Caregivers may consider the presence of a veteran member vital, enabling them to maintain their role as caregiver.

A comparison of change in network members over time would be a [illegible] adequately, but it to change [illegible]

[illegible]

[illegible] was [illegible] on a specific type of [illegible] but the source was evaluated in a very general manner. To utilize this framework as it was developed to be used, more specific aspects of the "convoy" or support network must be examined.

A critical area to examine within the network are the individuals who are considered the immediate network. It is possible that the caregiving wives are quite involved in their role and may have a very limited support network from which they can obtain assistance. This could influence how much support they receive and could also influence their level of satisfaction. How could the caregivers be dissatisfied with network members who do not exist?

It is also important to have the caregivers identify other sources of support, such as members of a formal network of support. These additional sources of support can affect the degree of satisfaction with the informal network, if it supplements the support not provided by the informal network. Having an alternate source of support may leave the caregivers with an overall feeling of satisfaction which may overcome any feelings of dissatisfaction.

Knowing who is in the support network is important, but it is also helpful to know how long the individuals have been a part of the network. Veteran members may be more helpful in a crisis and may [illegible] the [illegible] network. Caregivers may consider the presence of a veteran member vital, enabling them to maintain their role as caregiver.

A comparison of change in network members over time would be a valuable observation in a longitudinal study focused on instrumental support and satisfaction. The affect of change on satisfaction could be quite interesting.

There are many aspects of the support network that could be examined. Only a few aspects emphasized throughout the discussion of Kahn & Antonucci's (1980) framework, were found to be of special importance when considering the use of the framework in the study of social support and its affect on well-being. The aspects of interest, as discussed, include the network members, their relationship and degree of closeness to the caregiver and the pattern of change in the network over time.

The main proposition of Kahn & Antonucci's framework (1980) is that throughout the course of life an individual's support network will change, but so may their need for various types of support. Alteration in these two variables will consequently influence whether the support is adequate to meet an individual's needs. The framework suggests the use of a longitudinal study to examine the alterations in these variables over time.

Unfortunately, because of time and cost to develop longitudinal studies, very few have been conducted. It would be helpful to have more cross-sectional studies focused on individuals of various ages, specifically wives caring for husbands. A comparison across the course of life could then be attempted. This would give researchers a better perspective of how the provision of support may change and how the degree of satisfaction with support could be altered.

A benefit to using this framework is that it can be used for cross-sectional or longitudinal studies and still be a useful guide.

valuable observation in a longitudinal study focused on the [illegible] support and satisfaction. The affect of change on satisfaction could be quite interesting.

There are many aspects of the support network that could be examined. Only a few aspects emphasized throughout the discussion of Kahn & Antonucci's (1980) framework, were found to be of special importance when considering the use of the framework in the study of social support and its affect on well-being. The aspects of interest, as discussed, include the network members, their relationship and degree of closeness to the caregiver and the pattern of change in the network over time.

The main proposition of Kahn & Antonucci's framework (1980) is that throughout the course of life an individual's support network will change, but so may their need for various types of support. Alteration in these two variables will consequently influence whether the support is adequate to meet an individual's needs. The framework suggests the use of a longitudinal study to examine the alterations in these variables over time.

Unfortunately, because of time and cost to develop longitudinal studies, very few have been conducted. It would be helpful to have more cross-sectional studies focused on individuals of various ages, specifically wives caring for husbands. A comparison across the course of life could then be attempted. This would give researchers a better perspective of how the provision of support may change and how the degree of satisfaction with support could be altered.

A benefit to using this framework is that it can be used for cross-sectional or longitudinal studies and still be a useful guide.

There are multiple variables to consider which allow for a variety of projects to be developed. The framework by Kahn & Antonucci (1980) can be useful for the Clinical Nurse Specialist in the future study of support and satisfaction since, like nurses, Kahn & Antonucci consider an individual as a whole including his/her past and present as well as his/her personal and situational characteristics.

In her article Norbeck (1981) explained how Kahn & Antonucci's framework (1980) could be utilized to incorporate the study of social support into nursing practice. The incorporation of the four steps of the nursing process, assessment, planning, intervention and evaluation, into the framework will now be presented.

In their framework Kahn & Antonucci (1980) propose that the properties of the person and of the situation jointly determine an individual's need for social support as well as the actual support provided. The assessment process involves determining whether the actual support provided meets the needs of an individual.

The Clinical Nurse Specialist begins the assessment process by first identifying possible needs of the caregiver. This information can be anticipated based on previous research findings as well as actual clinical experience.

During an interview with the wife, the Clinical Nurse Specialist can identify the wife's weaknesses and strengths in the caregiving role. The Clinical Nurse Specialist can identify what coping behaviors the caregiver previously used and what resources she has had available to her on a consistent basis. It would also be useful to explore the caregiver's past experiences with seeking assistance from others.

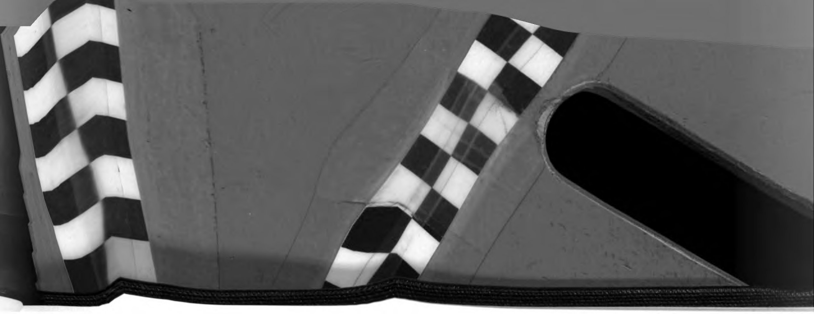
there are multiple variables to consider which allow for a variety of concepts to be developed. The framework by Kahn & Antonucci (1980) is useful for the Clinical Nurse Specialist in the future study of support and satisfaction since, like nurses, Kahn & Antonucci consider an individual as a whole including his/her past and present as well as his/her personal and situational characteristics.

In her article Norbeck (1981) explained how Kahn & Antonucci's framework (1980) could be utilized to incorporate the study of social support into nursing practice. The incorporation of the four steps of the nursing process, assessment, planning, intervention and evaluation, into the framework will now be presented.

In their framework Kahn & Antonucci (1980) propose that the properties of the person and of the situation jointly determine an individual's need for social support as well as the actual support provided. The assessment process involves determining whether the actual support provided meets the needs of an individual.

The Clinical Nurse Specialist begins the assessment process by first identifying possible needs of the caregiver. This information can be anticipated based on previous research findings as well as actual clinical experience.

During an interview with the wife, the Clinical Nurse Specialist can identify the wife's weaknesses and strengths in the caregiving role. The Clinical Nurse Specialist can identify what coping behaviors the caregiver previously used and what resources she has had available to her on a consistent basis. It would also be useful to explore the caregiver's past experiences with seeking assistance from others.



After reviewing the needs and resources, it is important to assess whether, according to the caregiver, they complement one another. If the wife indicates the assistance is inadequate, further planning is required to facilitate the caregiver.

The plans for change must include the caregiver, the care-recipient if possible, and any family or support network members who participate actively in the caregiving role. If support is inadequate, planning is needed to identify ways to alter the situation or improve the support network in order to meet the need for support.

The Clinical Nurse Specialist along with the caregiver and others identified, must determine a plan to help meet their needs adequately. If more respite is needed, the family and caregiver should discuss the alternatives, with the Clinical Nurse Specialist as the facilitator. Recommendations can be offered by the nurse, but they can only be implemented by the caregiver and her support network.

If the help is not provided by the informal support system, the support required by the caregiver must be obtained from other sources. Likewise, if support is adequate, planning may be required to determine what long-term help is needed to maintain the support.

Intervention, the next step in the nursing process, involves efforts to enhance the capacity of the social support system to provide support. It is recommended that this be done with minimal disruption to, or alteration of the support network, unless the network is found to be pathological. The intervention can involve the support network available or result in use of supplemental

After reviewing the needs and resources, it is important to assess whether, according to the caregiver, they complement one another. If the wife indicates the assistance is inadequate, further planning is required to facilitate the caregiver.

The plans for change must include the caregiver, the care-recipient if possible, and any family or support network members who participate actively in the caregiving role. If support is inadequate, planning is needed to identify ways to alter the situation or improve the support network in order to meet the need for support.

The Clinical Nurse Specialist along with the caregiver and others identified, must determine a plan to help meet their needs adequately. If more respite is needed, the family and caregiver should discuss the alternatives, with the Clinical Nurse Specialist as the facilitator. Recommendations can be offered by the nurse, but they can only be implemented by the caregiver and her support network.

If the help is not provided by the informal support system, the support required by the caregiver must be obtained from other sources. Likewise, if support is adequate, planning may be required to determine what long-term help is needed to maintain the support.

Intervention, the next step in the nursing process, involves efforts to enhance the capacity of the social support system to provide support. It is recommended that this be done with minimal disruption to, or alteration of the support network, unless the network is found to be pathological. The intervention can involve the support network available or result in use of supplemental support from other sources, depending on the need of the individual.

The Clinical Nurse Specialist functions as a facilitator in the intervention step of the nursing process as well. She should encourage the caregiver's participation to the maximum. The Clinical Nurse Specialist is responsible for coordinating the services required by the caregiver. The services to be coordinated include the referral to home health agencies and home care supply companies. The caregiver can be informed of what would best meet their needs such as a bathtub rail or a portable phone, but must initiate the actual purchase of aids or assistance on their own, when possible. This allows them to maintain their independence with the guidance of a professional person.

Evaluation, the final step in the nursing process, involves evaluation of the actual outcome. The evaluation also includes examination of the intervention and planning methods to determine if they were appropriate to produce the expected outcome. Other variables related to person and situation may also be discovered through evaluation.

After an established period of time such as three to six months, the Clinical Nurse Specialist should contact the caregiver to determine the status of the caregiving situation. At that time the Clinical Nurse Specialist, along with the caregiver, should reevaluate the changes implemented to determine their effectiveness in meeting the needs of the caregiver. If more time is needed to complete errands or more assistance is needed to help with physical care, new plans should be devised. Plans should be devised collaboratively between the caregiver and the health care agency with [illegible] need [illegible] the individual [illegible] of the nursing process as well. The [illegible] the caregiver's participation to the maximum. The Clinical Nurse Specialist is responsible for coordinating the services required by the caregiver. The services to be coordinated include the referral to home health agencies and home care supply companies. The caregiver should be informed of what would best meet their needs such as a hospital bed or a portable phone, but must initiate the actual purchase of aids or assistance on their own, when possible. This allows them to maintain their independence with the guidance of a professional person.

Evaluation, the final step in the nursing process, involves evaluation of the actual outcome. The evaluation also includes examination of the intervention and planning methods to determine if they were appropriate to produce the expected outcome. Other variables related to person and situation may also be discovered through evaluation.

After an established period of time such as three to six months, the Clinical Nurse Specialist should contact the caregiver to determine the status of the caregiving situation. At that time the Clinical Nurse Specialist, along with the caregiver, should evaluate the changes implemented to determine their effectiveness in meeting the needs of the caregiver. If more time is needed to complete errands or more assistance is needed to help with physical care, new plans should be devised. Plans should be devised [illegible] between the caregiver and the health care agency with

the Clinical Nurse Specialist again facilitating the contact when needed.

Norbeck (1981), in her discussion of this framework, considers the four steps of the nursing process as well as the four components included in most nursing practice theories - person, environment, health and nursing actions. Norbeck has shown how closely this framework represents what nursing theorists have been emphasizing for years. Consequently, utilization of this framework in future nursing research is recommended.

Kahn & Antonucci's framework (1980) could also be used as a guide in a Geriatric Assessment setting, such as the one in which this researcher works. In the evaluation of an individual's social support network, it is important to consider all the variables mentioned, including the personal and situational characteristics and the need for support. This information can be the basis upon which additional support is provided if thought to be necessary.

Use of this framework as a guide could prevent inappropriate recommendations of support to caregivers not willing to utilize specific types of support. An example is a caregiver who is quite meticulous in her chores around the house and would be very frustrated with a housekeeper coming to her home weekly. Knowing some of her personal characteristics, can help in the identification of appropriate and inappropriate assistance. The implications and recommendations for future areas of study related to the topic of social support and satisfaction are presented next.

Clinical Nurse Specialist as a facilitator using the context when needed.

Norbeck (1981) in her discussion of that framework, considers the four steps of the nursing process as well as the four components included in most nursing practice theories - person, environment, health and nursing actions. Norbeck has shown how closely this framework reflects what nursing theorists have been emphasizing for years. Consequently, utilization of this framework in future nursing research is recommended.

Kahn & Antonucci's framework (1980) could also be used as a guide in a Geriatric Assessment setting, such as the one in which this researcher works. In the evaluation of an individual's social support network, it is important to consider all the variables mentioned, including the personal and situational characteristics and the need for support. This information can be the basis upon which additional support is provided if thought to be necessary.

Use of this framework as a guide could prevent inappropriate recommendations of support to caregivers not willing to utilize specific types of support. An example is a caregiver who is quite meticulous in her care around the house and would be very frustrated with a housekeeper coming to her home weekly. Knowing some of her personal characteristics, can help in the identification of appropriate and inappropriate assistance. The implications and recommendations for future areas of study related to the topic of social support and satisfaction are presented next.

Future Areas of Study

The present study was descriptive as are many other studies performed in the areas of caregiving and social support. As was recommended by Zarit (1989) and Stewart (1989), there is a need for more projects involving interventions. The Clinical Nurse Specialist has the ability to implement an intervention technique and then evaluate its effectiveness in altering the dependent variable.

The Clinical Nurse Specialist has the ability to develop a program to instruct caregivers and family members on the provision of physical care, such as bathing, repositioning, transferring, and feeding of dependent individuals. For caregivers who have family members who are unable to help with care due to lack of ability, an instructional program may be helpful. It could instill confidence in family members who are willing to participate, but are uncomfortable with the caregiving role.

After providing the program, the Clinical Nurse Specialist can then evaluate whether the program had an influence on the increased participation of other family members in the role of caregiving. This information could be obtained from the primary caregivers themselves.

In the present study because wives on average were satisfied, it would be difficult to evaluate a change if additional support was provided. When a more reliable instrument of satisfaction and assistance is utilized, it is possible that the responses would have greater variability. Implementation of an intervention could then be useful in promoting a positive change. Of course other variables influencing the perception of satisfaction would also need to be

considered.

The literature review stimulated interest in other areas requiring research as well. There is a growing interest regarding caregivers and the adequacy of support in meeting their needs. An additional dimension of interest should be on the simultaneous evaluation of the care-recipients and their views regarding adequacy of support (Barer & Johnson, 1990).

Through the literature it was also suggested that emphasis be placed on the whole support network, rather than just on the primary caregiver (Tennstedt, McKinlay & Sullivan, 1989; Barer & Johnson, 1990). The Clinical Nurse Specialist should recognize the secondary caregivers and their impact on the primary caregiver's role. In the present study the researcher began to examine the effects of the secondary caregiver's assistance on the primary caregiver's degree of satisfaction with support. This is only the beginning to understanding all the variables which may influence adequacy of support and satisfaction.

The strong relationship between frequency of support and satisfaction is consistent with most previous research and is of particular interest. They have both been shown to be related, but in the present study in particular because support was so low and satisfaction so high, the influence of other factors seems important.

Based on the results mentioned, further studies are recommended to examine whether similar findings occur with other spouses. Then a comparison to other caregivers is recommended to determine if they also receive support infrequently but indicate they are very satisfied. It may also be of interest to compare elderly individuals [illegible] interest in other areas of nursing research as well. There is a growing interest regarding caregivers and the adequacy of support in meeting their needs. An additional dimension of interest should be on the simultaneous evaluation of the care recipients and their views regarding adequacy of support (Farran & Johnson, 1990).

Through the literature it was also suggested that emphasis be placed on the whole support network, rather than just on the primary caregiver (Tennstedt, McKinlay & Sullivan, 1989; Farran & Johnson, 1990). The Clinical Nurse Specialist should recognize the secondary caregivers and their impact on the primary caregiver's role. In the present study, the researcher began to examine the effects of the secondary caregiver's assistance on the primary caregiver's degree of satisfaction with support. This is only the beginning to understanding all the variables which may influence adequacy of support and satisfaction.

The strong relationship between frequency of support and satisfaction is consistent with most previous research and is of particular interest. They have both been shown to be related but in the present study in particular because support was so low and satisfaction so high, the influence of such factors seems important.

Based on the results mentioned, further studies are recommended [illegible] similar findings occur with other spouses. Then a comparison to other caregivers is recommended to determine if they also receive support infrequently but indicate they are very satisfied. It may also be of interest to compare elderly individuals other than caregivers to determine if results vary. This may help to narrow the list of factors which influence the degree of satisfaction with social support. Knowledge of the factors which have the greatest impact on satisfaction can be useful in the provision of adequate support.

Other recommendations include evaluating other primary caregivers such as other wives, husbands and children, utilizing the modified instrument previously discussed. Then a comparison of the caregivers with regard to support provided and satisfaction with the various support provided would be of interest.

Next, a study is recommended to investigate the support provided by the informal network versus the formal network followed by an examination of the satisfaction with the support. It would be interesting to know whether utilizing both sources of support has any influence on degree of satisfaction with support and whether the caregiver believes the two sources complement each other or substitute for one another.

More longitudinal studies would be helpful to enable comparison of changes over time. However, further descriptive cross-sectional studies utilizing the same instrument in its revised and expanded format would be useful for comparison purposes as well.

Once it can be determined which factors may have the most positive influence on an individual's level of satisfaction, an intervention can then be implemented. The Clinical Nurse Specialist could be part of the planning, the implementation, as well as the evaluation process previously discussed.

Implications for Nursing Practice

The findings of this study also have implications for nursing practice. In this study wives utilized very little support from family and friends. However, when examined further the wives were quite satisfied with the assistance they were receiving.

To the Clinical Nurse Specialist, particularly in her roles as assessor, planner and counselor, these findings are important. As a Clinical Nurse Specialist working in a Geriatric Assessment Clinic it is important to identify who is in the patient's and caregiver's support network and what assistance is provided.

The patient is of primary interest in the program, however the caregiver and other support providers become a secondary concern. The patient's well-being often depends on the physical and emotional status of the caregiver.

The Clinical Nurse Specialist must assess what support is available to the caregiver, but must also identify whether the patient's needs are adequately met. Knowing the female spouse caregivers in the present study utilized limited support but were satisfied, raises concern whether the patient's needs were adequately met. There is also concern that the type of support needed by the caregiver may not have been the type examined in this study, therefore no final conclusions could be made. It would be nice to assume if the caregiver is satisfied, then no further assistance is needed. Review of the literature, however, has shown that multiple factors can influence an individual's feelings of satisfaction. Therefore, satisfaction may not be a true indication that the patient's needs are adequately met.

The Clinical Nurse Specialist in his/her role as an assessor must consider the findings of the present study. There are major concerns regarding caregivers and the stress they encounter, however when in a clinical situation the patient is of primary concern and must be considered first when fulfillment of needs is examined.

The Clinical Nurse Specialist as planner could use the findings of this study as a basis for developing plans of care for the patient while also benefiting the caregivers. As a primary care provider the Clinical Nurse Specialist has a responsibility to care for an individual in a comprehensive manner. The responsibility includes the consideration of all variables which may influence the individual's state of well-being. When an individual is the patient of a caregiving dyad it is very important for the Clinical Nurse Specialist to recognize the needs of both the patient and caregiver. Because the caregiver's health and well-being could be a major factor in the patient's health status, the plan of care must include the needs of the caregiver as well.

When an individual is the caregiver of a caregiving dyad the Clinical Nurse Specialist must consider the strain of caregiving. As a Clinical Nurse Specialist in Gynecology this issue becomes of greater concern everyday, particularly since females are the primary source of caregiving in our country today. Consideration of the possibility that a patient may have the role of caregiver among other roles should be of primary importance for a Clinical Nurse Specialist in the primary care setting. This is especially true since the stress caregiving women encounter may be a primary influential factor in the development of future health problems.

The Clinical Nurse Specialist in his/her role as researcher must consider the findings of the present study. There are major concerns regarding caregivers and the stress they encounter, however when in a clinical situation the patient is of primary concern and must be considered first when fulfillment of needs is examined.

The Clinical Nurse Specialist as planner could use the findings of this study as a basis for developing plans of care for the patient while also benefiting the caregivers. As a primary care provider the Clinical Nurse Specialist has a responsibility to care for an individual in a comprehensive manner. The responsibility includes the consideration of all variables which may influence the individual's state of well-being. When an individual is the patient of a caregiving dyad it is very important for the Clinical Nurse Specialist to recognize the needs of both the patient and caregiver. Because the caregiver's health and well-being could be a major factor in the patient's health status, the plan of care must include the needs of the caregiver as well.

When an individual is the caregiver of a caregiving dyad the Clinical Nurse Specialist must consider the strain of caregiving. As a Clinical Nurse Specialist in Gynecology this issue becomes of greater concern everyday particularly since females are the primary source of caregiving in our country today. Consideration of the possibility that a patient may have the role of caregiver, among other roles, should be of primary importance for a Clinical Nurse Specialist in the primary care setting. This is especially true in the area of caregiving when encountered may be a primary initial factor in the development of future health problems.

The Clinical Nurse Specialist as a counselor could also benefit from the information obtained from the present study. When counseling a caregiver on ways to obtain assistance, knowing the kinds of support likely to be unavailable from the informal network can be helpful. Researchers have found family members to be the best source of assistance to spouse caregivers, but the assistance may consist of limited involvement in physical care.

As a Clinical Nurse Specialist in a Geriatric Assessment clinic the role of counselor becomes very important. The caregiver is allowed time to verbalize concerns openly and is then encouraged to use any problem-solving skills available.

In the present study the caregivers were satisfied with assistance. This may be true for other caregivers as well, but they should be encouraged to evaluate their caregiving situation and express any concerns they may have. Initially many caregivers may feel confident in their role. With access to counseling they may find that they could benefit from utilization of other resources, whether from the informal or formal support network.

Summary

In this chapter an interpretation of the results was presented followed by a discussion of the implications to nursing research and practice. Within the section on results it was stated that the characteristics of this sample are representative of majority of caregivers previously studied. The caregivers may not, however, represent the overall caregiving population due to the self-selection process utilized in recruiting participants.

Through this study female spouse caregivers were found to receive most support from family and friends by them keeping their husband company. Long-term respite care was available least often. These findings are consistent with previous studies.

Overall, support was provided at very limited intervals, however caregivers were still found to be satisfied with the assistance provided. The literature has indicated there are multiple factors which could influence an individual's perception of satisfaction. Therefore, measurement of satisfaction must be utilized with caution.

There were limitations found with the instrument used in this study and several recommendations were made. Following is a summary of those recommendations along with recommendations for future nursing research and nursing practice.

Summary of Recommendations

Instrument

1. Further reliability and validity testing.

2. Specific rather than global questions to measure satisfaction.

3. An assistance instrument which measures only one dimension of support such as instrumental or emotional support, not both.

4. An instrument to measure adequacy of support, rather than satisfaction.

5. Use of a visual analog scale to increase response accuracy.

Future Areas of Research

1. Projects involving interventions to provide supportive services followed by a measurement of change in satisfaction or

adequacy in meeting needs.

2. Evaluate care-recipient satisfaction simultaneously with caregiver satisfaction.

3. More studies focused on secondary caregivers and their impact on the primary caregiver's role.

4. Comparison studies between different groups of caregivers to examine support provided and their degree of satisfaction with support.

5. Project to examine both informal and formal support available and determine whether they are related to satisfaction.

6. Descriptive studies utilizing the revised instrument would be beneficial initially for comparison.

7. Longitudinal studies are recommended to compare change of support utilized over time.

8. Examination of other concepts within Kahn & Antonucci's (1980) framework such as the need for support and specific network characteristics.

9. Specific network characteristics to consider include network members, length of time as a member, and the change of the network membership over time.

10. Further study on the availability of informal and formal support and how they are used to complement or substitute for one another.

Practice

1. When examining a care-recipient the Clinical Nurse Specialist must consider the needs of the caregivers and means to assist them in

their role as caregivers.

2. The Clinical Nurse Specialist must consider the role of caregiver when assessing their clients. This may influence the client's state of health.

3. Plans of care must be considered with the role of caregiver in mind, if it applies.

4. The Clinical Nurse Specialist must make caregivers aware of resources available.

5. The Clinical Nurse Specialist must counsel the caregivers as well as families on the ways they can obtain and provide assistance.

Conclusion

The present study sample was self-selected and nonrandomized resulting in a nongeneralizable sample. The descriptive findings can be used as a base upon which the Clinical Nurse Specialist can add data as other groups of caregivers are studied. The findings have no direct application to practice, but as described by Stetler & Marram (1976) they have a cognitive application. This suggests that knowledge from this study may be used to enhance understanding of other caregiving situations which may result in future alterations within the practice of nursing.

APPENDIX A

APPENDIX A

Informed Consent Procedure

Before we get started, I would like to take some time to explain what will be involved in taking part in this study and to answer questions you may have about taking part.

Basically, over the course of the year, there will be two home visits which will be arranged at your convenience as well as several telephone calls and mailed questionnaires.

There are some other things that are important for me to let you know about relative to taking part in this study.

One thing is that taking part in the study will not change the health care or services that you are now receiving. The study does not provide any services and cannot arrange for services for you.

Also, if your situation should change during the year so that you are no longer helping your relative, we would still like to maintain contact and ask questions of you.

It is important for you to know that all of your responses during the course of the study are anonymous and confidential. Your name and anything which would identify you personally will be kept separate from the answers you give. Neither your name nor the name of your family member will be given out to anyone else or used in any written reports of the study at any time.

We want you to be aware that taking part in the study is voluntary and you are free to withdraw from the study at any time without consequence.

Do you have any questions about taking part in the study?

I have a written consent form with me that I would like to have you sign. I'll leave one copy of the consent form for you to keep and take one copy to keep with the records of the research study.

IF SUBJECT DOES NOT WISH TO SIGN FORM, LEAVE THEM A COPY AND PROCEED WITH THE INTERVIEW. INCLUDE THIS INFORMATION ON THE INTERVIEWER ASSESSMENT.

APPENDIX B

APPENDIX B

MICHIGAN STATE UNIVERSITY
Family Caregiver Study

CONSENT FORM

The study in which we are asking you to participate is designed to learn more about the ways in which caring for an older family member affects the person providing the care.

Over the next year, family caregivers will be interviewed by a member of the Family Caregiver Study research staff three times (at intake, six months, and at one year). Each interview will take approximately one and one-half hours to complete. Caregivers will be asked to complete written questionnaires and to answer questions asked by the interviewer. They will also be asked to report, each three months during the year, on any health care services used.

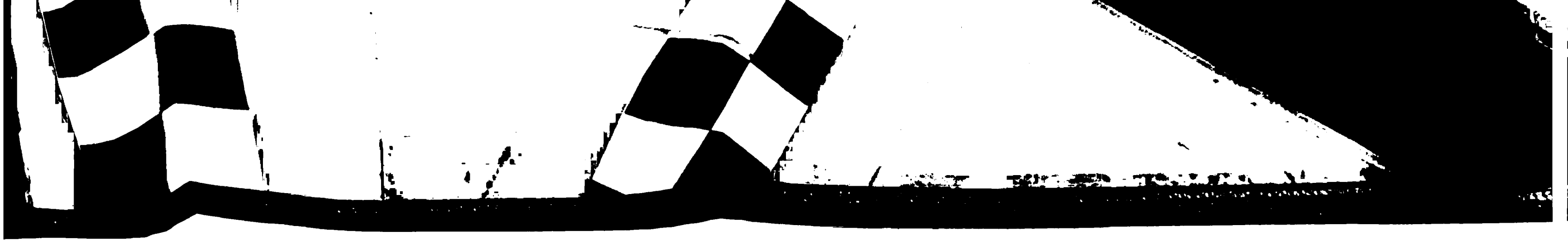
If you are willing to participate, please read and sign the following statement:

1. I have freely consented to take part in a study of caregivers and their patients conducted by the College of Nursing and the Department of Family Practice, College of Human Medicine, at Michigan State University.
2. The study has been described and explained to me and I understand what my participation will involve.
3. I understand that participating in this study is voluntary.
4. I understand that I can withdraw from participating at any time.
5. I understand that the results of the study will be treated in strict confidence and, should they be published, my name will remain anonymous. I understand that within these restrictions, results can, upon request, be made available to me.
6. I understand that no immediate benefits will result from taking part in this study, but am aware that my responses may add to the understanding of health care professionals of the experience of being responsible for an older family member.

I,_____________________, state that I understand what is required of me as a participant and agree to take part in this study.

Signed _________________________ Date _________________________
(Signature)

APPENDIX C



APPENDIX C

BACKGROUND INFORMATION OF CAREGIVER, CARE-RECIPIENT AND CAREGIVING SITUATION

CAREGIVER INFORMATION: Please answer the following questions about yourself as the caregiver.

2. What is your date of birth?: _____/____/_____
month/date/year

3. What is your race? (Check one, optional)

_____ Caucasian
_____ Black
_____ Hispanic
_____ American Indian
_____ Oriental/Asian/Pacific Islander
_____ Other (Please specify __________)

Caregiver Employment

1. Are you currently employed for pay? (Check)

_____ NO _____ YES Are you employed: Full-time _______
Part-time _______

CARE-RECIPIENT INFORMATION: Please answer the following questions about your relative as the care-recipient.

1. What is the date of birth of your relative?: ______/____/_____
month/date/year

2. What is the race of your relative? (Check one, optional)
INTERVIEWER CONFIRM RACE IF RELATIVE IS NOT PRESENT

_____ Caucasian
_____ Black
_____ Hispanic
_____ American Indian
_____ Oriental/Asian/Pacific Islander
_____ Other (Please specify)___________

Assistance Required By Relative

In the next set of questions, I am going to ask you about the kinds of assistance required by your relative. For each activity I will ask whether your relative requires assistance. Please respond either YES or NO to each question.

A. Questions related to ACTIVITIES OF DAILY LIVING

1. Does your relative need help with eating?

YES ____ (1) NO ____ (2)

2. Does your relative need help with dressing and undressing?

YES ____ (1) NO ____ (2)

3. Does your relative need help with combing hair or shaving?

YES ____ (1) NO ____ (2)

4. Does your relative need help with taking a shower or bath?

YES ____ (1) NO ____ (2)

5. Does your relative need help with using toilet, bedpan or commode?

YES ____ (1) NO ____ (2)

6. Does your relative need help with walking?

YES ____ (1) NO ____ (2)

7. Does your relative need help with getting around the house?

YES ____ (1) NO ____ (2)

8. Does your relative need help with getting in and out of bed?

YES ____ (1) NO ____ (2)

22. Does your relative need help to be cleaned up when incontinent of urine?

YES ____ (1) NO ____ (2)

24. Does your relative need help to be cleaned up when incontinent of stool?

YES ____ (1) NO ____ (2)

B. Questions related to INSTRUMENTAL ACTIVITIES OF DAILY LIVING

9. Does your relative need help with shopping?

(1)____ YES
(2)____ NO

10. Does your relative need help with housework?

(1)____ YES
(2)____ NO

11. Does your relative need help with laundry?

(1)____ YES
(2)____ NO

12. Does your relative need help with cooking?

(1)____ YES
(2)____ NO

13. Does your relative need help with handling his/her own money?

(1)____ YES
(2)____ NO

14. Does your relative need help with arranging his/her own transportation?

(1)____ YES
(2)____ NO

BACKGROUND INFORMATION OF CAREGIVING SITUATION

13. When did you begin to provide direct care for this person? (WRITE IN NUMBER OF YEARS AND MONTHS)

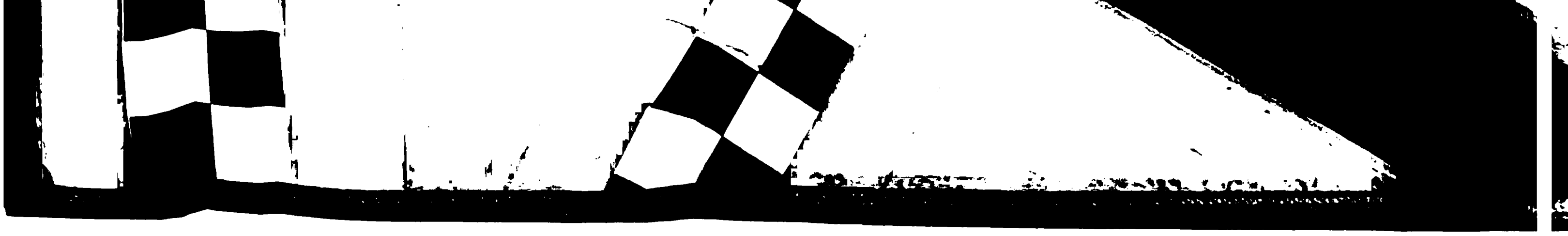
______ Years ______ Months

14. Was there a specific health problem or illness that led to caregiving?

____ YES ____ NO

If YES, what?____

APPENDIX D



APPENDIX D

ASSISTANCE RECEIVED BY CAREGIVER FROM FAMILY AND FRIENDS/NEIGHBORS

The questions that I have just asked are about assistance that you receive through <u>agencies.</u> Now I'm going to ask you questions about the assistance that you receive from <u>other</u> <u>people</u> to care for your relative. By other people, I mean friends or relatives whether you pay them or not.

For the next set of questions, I would like you to pick one of four categories of answers. You can choose from "RARELY OR NONE OF THE TIME," "SOME OF THE TIME," "MOST OF THE TIME" or "ALMOST ALL OF THE TIME."

1. How often, over the past three months, HAS ANYONE IN YOUR FAMILY given you assistance in the following ways?

Assistance Category	Rarely or none of time (1)	Some of the time (2)	Most of the time (3)	Almost all of the time (4)
a. Helped with physical care.				
b. Spent time keeping your relative company.				
c. Stayed with your relative so you could do something else for a few hours.				
d. Stayed with your relative so you can take a vacation (for a weekend or longer)				
e. Gotten up during the night with your relative.				
f. Given you emotional support or encouragement.				
g. Helped with transportation (for either you or your relative).				
h. Helped you with money or other material goods.				
i. Checked on you to be sure that you were all right.				

ASSISTANCE RECEIVED BY CAREGIVER FROM FAMILY AND FRIENDS/NEIGHBORS

The questions that I have just asked are about [illegible] that you receive through agencies. Now I'm going to ask you questions about the assistance that you receive from other people to care for your relative. By other people, I mean friends or relatives whether you pay them or not.

For the next set of questions I would like you to pick one of four categories of answers. You can choose from "RARELY OR NONE OF THE TIME," "SOME OF THE TIME," "MOST OF THE TIME" or "ALL OR MOST OF THE TIME."

1 How often, over the past three months, has ANYONE IN YOUR [illegible] given you assistance in the following ways?

Assistance Category	Rarely or none of the time (1)	Some of the time (2)	Most of the time (3)	All or most of the time (4)
a. Helped with physical care.				
b. Spent time keeping your relative company.				
c. Stayed with your relative so you could do something else for a few hours.				
d. Stayed with your relative so you can take a vacation (for a weekend or longer).				
e. Gotten up during the night with your relative.				
f. Given you [illegible] support or encouragement.				
g. Helped with transportation (for either you or your relative).				
h. Helped you with money or other material goods.				
i. Checked on you to make sure that you were all right				

For the next set of questions, I would like you to pick one of four categories of answers. You can choose from "RARELY OR NONE OF THE TIME," "SOME OF THE TIME," "MOST OF THE TIME" or "ALMOST ALL OF THE TIME."

1. How often, over the past three months, have FRIENDS OR NEIGHBORS (not relatives) given you assistance in the following ways?

Assistance Category	Rarely or none of time (1)	Some of the time (2)	Most of the time (3)	Almost all of the time (4)
a. Helped with physical care.				
b. Spent time keeping your relative company.				
c. Stayed with your relative so you could do something else for a few hours.				
d. Stayed with your relative so you can take a vacation (for a weekend or longer)				
e. Gotten up during the night with your relative.				
f. Given you emotional support or encouragement.				
g. Helped with transportation (for either you or your relative).				
h. Helped you with money or other material goods.				
i. Checked on you to be sure that you were all right.				

[illegible]

[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

APPENDIX E

APPENDIX E

SATISFACTION WITH SUPPORT FROM OTHERS

2. Overall, how satisfied are you with the assistance you are currently receiving from FAMILY to care for your relative? Are you...

_____ Very Satisfied (1)　_____ Somewhat Dissatisfied (3)

_____ Somewhat Satisfied (2)　_____ Very Dissatisfied (4)

3. Overall, how satisfied are you with the assistance you are currently receiving from FRIENDS or NEIGHBORS to care for your relative? Are you...

_____ Very Satisfied (1)　_____ Somewhat Dissatisfied (3)

_____ Somewhat Satisfied (2)　_____ Very Dissatisfied (4)

APPENDIX F

MIC

UNIVE
HUMA
206 BE
(517) 3

Ap

Ch
96
Al

De

R

T
r
p

Y
C
U

MICHIGAN STATE UNIVERSITY

UNIVERSITY COMMITTEE ON RESEARCH INVOLVING
HUMAN SUBJECTS (UCRIHS)
206 BERKEY HALL
(517) 353-9738

EAST LANSING • MICHIGAN • 48824-1111

April 17, 1990 **IRB# 90-154**

Charlene Lasocki
9637 Quandt
Allen Park, MI 48101

Dear Ms. Lasocki:

RE: "DESCRIPTIVE STUDY TO DETERMINE FREQUENCY AND SATISFACTION WITH INSTRUMENTAL SUPPORT RECEIVED BY WIVES CARING FOR DISABLED HUSBANDS **IRB# 90-154**"

The above project is exempt from full UCRIHS review. I have reviewed the proposed research protocol and find that the rights and welfare of human subjects appear to be protected. You have approval to conduct the research.

You are reminded that UCRIHS approval is valid for one calendar year. If you plan to continue this project beyond one year, please make provisions for obtaining appropriate UCRIHS approval one month prior to April 17, 1991.

Any changes in procedures involving human subjects must be reviewed by UCRIHS prior to initiation of the change. UCRIHS must also be notified promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

Thank you for bringing this project to our attention. If we can be of any future help, please do not hesitate to let us know.

Sincerely,

John K. Hudzik, Ph.D.
Chair, UCRIHS

JKH/sar

cc: C. Collins

LIST OF REFERENCES

List of References

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. The Milbank Memorial Fund Quarterly, 51, 95-124.

Antonucci, T. C., & Akiyama, H. (1987). Social networks in adult life and a preliminary examination of the convoy model. Journal of Gerontology, 42(5), 519-527.

Baille, V., Norbeck, J. S., & Barnes, L. A. (1988). Stress, social support, and psychological distress of family caregivers of the elderly. Nursing Research, 37(4), 217-222.

Baines, E. (1984). Caregiver stress in the older adult. Journal of Community Health Nursing, 1, 257-263.

Barer, B. M., & Johnson, C. L. (1990). A critique of the caregiving literature. The Gerontologist, 30(1), 26-29.

Barusch, A. S. (1988). Problems and coping strategies of elderly spouse caregivers. The Gerontologist, 28(5), 677-685.

Barusch, A. S., & Spaid, W. M. (1989). Gender differences in caregiving: Why do wives report greater burden. The Gerontologist, 29(5), 667-676.

Berkman, L. F. (1983, December). The assessment of social networks and social support in the elderly. Journal of the American Geriatrics Society, 31(12), 743-749.

Brotman, H. B. (1981). The aging society: A demographic view. Aging, nos. 315-316, 2-5.

Bunting, S. M. (1989). Stress on caregivers of the elderly. Advances in Nursing Science, 11(2), 63-73.

Cantor, M. (1983). Strain among caregivers: A study of experience in the United States. The Gerontologist, 23(6), 597-604.

Cassel, J. (1976). The contribution of the social environment to host resistance. American Journal of Epidemiology, 104(2), 107-123.

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38(5), 300-314.

Crossman, L., London, C., & Barry, C. (1981). Older women caring for disabled spouses: A model for supportive services. The Gerontologist, 21(5), 464-470.

Day, A. (1985). Who cares? Demographic trends challenge family care for the elderly. *Population Trends and Public Policy, 9*, 1-17.

Dimond, M., & Jones, S. (1983). Social support: A review and theoretical integration. In P. Chinn (Ed.), *Advances in nursing theory development* (pp. 235-249). Rockville, MD: Aspen Systems Corporation.

Ekberg, J. Y., Griffith, N. F., & Foxall, M. J. (1986). Spouse burnout syndrome. *Journal of Advanced Nursing, 11*, 161-165.

Fengler, A. P., & Goodrich, N. (1979). Wives of elderly disabled men: The hidden patients. *The Gerontologist, 19*(2), 175-183.

Fitting, M., Rabins, P., Lucas, M., & Eastham, J. (1986). Caregivers for dementia patients: A comparison of husbands and wives. *The Gerontologist, 26*, 248-252.

Gallo, F. (1982). The effects of social support networks on the health of the elderly. *Social Work Health Care, 8*(2), 65-74.

George, L., & Gwyther, L. (1986). Caregiver well-being: A multidimensional examination of family caregivers of demented adults. *The Gerontologist, 26*(3), 253-259.

Gilhooly, M. L. (1984). The impact of caregiving on caregivers: Factors associated with the psychological well-being of people supporting a dementing relative in the community. *British Journal of Medical Psychology, 57*, 35-44.

Given, C., & Given, B. (1985). *Caregiver responses to managing elderly patients at home.* Grant #NIA-1R01 AG08564. Michigan State University, East Lansing, MI. Unpublished manuscript.

Goodman C. (1986). Research on the informal carer: A selected literature review. *Journal of Advanced Nursing, 11*, 705-712.

Gottlieb, B. H. (1981). Preventive interventions involving social networks and social support. In B. H. Gottlieb (Ed.), *Social networks and social support* (pp. 201-232). Beverly Hills: Sage Publishing.

Hooyman, N., & Lustbader, W. (1986). *Taking Care: Supporting older people and their families*. New York: The Free Press.

Horowitz, A., & Dobrof, R. (1982). *The role of families in providing long-term care to the frail and chronically ill elderly living in the community.* (Final Report, Health Care Financing Administration, Grant No. 18-P-97541/2-02). New York: Brookdale Center on Aging.

House, J. S. (1981). The nature of social support. In J. S. House *Work stress and social support* (pp. 13-40). Reading: Addison-Wesley.

[illegible] (19[illegible]). [illegible] for the elderly. [illegible]

[illegible], M., & [illegible] (19[illegible]). [illegible] social support: A review of theoretical [illegible]. In [illegible] (Ed.), [illegible] elderly [illegible] (pp. 2[illegible]-43). Rockville, MD: Aspen [illegible] Corporation.

[illegible], J. Y., Griffith, N. [illegible], & Ford, M. J. ([illegible]). Burnout syndrome. Journal of Advanced Nursing, 11, [illegible]

Fengler, A. P., & Goodrich, N. (1979). Wives of elderly disabled men: The hidden patients. The Gerontologist, 19(2), 175-183.

Fitting, M., Rabins, P., Lucas, M. J., & Eastham, J. (1986). Caregivers for dementia patients: A comparison of husbands and wives. The Gerontologist, 26, 248-252.

Gallo, F. (1982). The effects of social support networks on the health of the elderly. Social Work in Health Care, 8(2), 65-74.

George, L., & Gwyther, L. (1986). Caregiver well-being: A multidimensional examination of family caregivers of demented adults. The Gerontologist, 26(3), 253-259.

Gilhooly, M. L. (1984). The impact of care-giving on care-givers: Factors associated with the psychological well-being of people supporting a dementing relative in the community. British Journal of Medical Psychology, 57, 35-44.

Given, C., & Given, B. (1985). Caregiver responses to managing elderly patients at home. (Grant #NIA-1RO1 AG06584). Michigan State University, East Lansing, MI. Unpublished manuscript.

Goodman, C. (1986). Research on the informal carer: A selected literature review. Journal of Advanced Nursing, 11, 705-712.

Gottlieb, B. H. (1981). Preventive interventions involving social networks and social support. In B. H. Gottlieb (Ed.), Social networks and social support (pp. 201-232). Beverly Hills: Sage Publishing.

Hooyman, N., & Lustbader, W. (1986). Taking care: Supporting older people and their families. New York: The Free Press.

Horowitz, A., & Dobrof, R. (1982). The role of families in providing long-term care to the frail and chronically ill elderly living in the community. (Final Report, Health Care Financing Administration, Grant No. 18-P-97541/2-02). New York: Brookdale Center on Aging.

House, J. S. (1981). The nature of social support. In J. S. House, Work stress and social support (pp. 13-40). Reading: Addison-Wesley.

House, J. S., & Kahn, R. L. (1985). Measures and concepts of social support. In S. Cohen & S. L. Syme (Eds.), Social support and health, (pp. 83-107). Orlando: Academic Press, Inc.

Ingersoll-Dayton, B., & Antonucci, T. C. (1988). Reciprocal and nonreciprocal social support: Contrasting sides of intimate relationships. Journal of Gerontology, 43(3), 565-573.

Israel, B. (1982). Social networks and health status: Linking theory, research, and practice. Patient Counseling and Health Education, 4(2), 65-79.

Johnson, C., & Catalano, D. (1983). A longitudinal study of family supports to impaired elderly. The Gerontologist, 23, 612-618.

Kahn R. L., & Antonucci, T. C. (1980). Convoys over the life course: Attachment, roles, and social support. In P. B. Baltes and O. G. Brim (Eds.), Life-span development and behavior, Vol. 3 (pp. 253-286). New York: Academic Press.

King, I. (1981). A theory for nursing. New York: John Wiley and Sons.

Krause, N. (1987). Satisfaction with social support and self-rated health in older adults. The Gerontologist, 27(3), 301-308.

Lakey, B., & Heller, K. (1988). Social support from a friend, perceived support, and social problem solving. American Journal of Community Psychology, 16(6), 811-824.

Lawton, M. P., Brody, E. M., & Saperstein, A. R. (1989). A controlled study of respite service for caregivers of alzheimer's patients. The Gerontologist, 29(1), 8-16.

Levitt, M. J., Antonucci, T. C., Clark, M. C., Rotton, J., & Finley, G. E. (1985). Social support and well-being: Preliminary indicators based on two samples of the elderly. International Journal of Aging and Human Development, 21(1), 61-77.

Lyles, J., King, S., Given, B. A., & Given, C. W. (1989). Social interaction, instrumental support and family caregiver perception of support. Manuscript submitted for publication, College of Human Medicine, Department of Family Practice, Michigan State University.

Norbeck, J. S. (1981). Social support: A model for clinical research and application. Advances in Nursing Science, 3, 43-59.

Norbeck, J. S. (1988). Social support. Annual Review of Nursing Research, 6, 85-110.

Phillips, L. R. (1989). Elder-family caregiver relationships: Determining appropriate nursing interventions. Nursing Clinics of North America, 24(3), 795-807.

Polit, D., & Hungler, B. (1983). Nursing research principles and methods (2nd ed.). Philadelphia: J. B. Lippincott Company.

Preston, D., & Grimes, J. (1987). A study of differences in social support. Journal of Gerontological Nursing, 13(2), 36-40.

Robinson, K. (1986a). Older women: A literature review. Journal of Advanced Nursing, 11, 153-160.

Robinson, K. (1986b). Older women and caregiving. Nursing Success Today, 3(10), 28-33.

Schaefer, C., Coyne, J. C., & Lazarus, R. (1981). The health related functions of social support. Journal of Behavioral Medicine, 4, 381-406.

Schaie, K. W. (1980, August). America's elderly in the coming decade. In K. W. Schaie, America's elderly in the coming decade. Address to the annual meeting of the American Society of Hospital Social Work Directors, Denver.

Scott, J. P., Roberts, K. A., & Hutton, J. T. (1986). Families of alzheimer's victims: Family support to the caregivers. Journal of the American Geriatrics Society, 34, 348-354.

Shanas, E. (1979). The family as a social support system in old age. The Gerontologist, 19, 169-174.

Sherman, S., Ward, R., & LaGory, M. (1988, March-April). Women as caregivers of the elderly: Instrumental and expressive support. Social Work, 164-167.

Snyder, B., & Keefe, K. (1985). The unmet needs of family caregivers for frail and disabled adults. Social Work in Health Care, 10, 1-14.

Soldo, B. J., & Myllyluoma, J. (1983). Caregivers who live with dependent elderly. The Gerontologist, 23(6), 605-611.

Stetler, C. B., & Marram, G. (1976). Evaluating research findings for applicability in practice. Nursing Outlook, 24(9), 559-564.

Stewart, M. J. (1989). Social support intervention studies: A review and prospectus of nursing contributions. International Journal of Nursing Studies, 26(2), 93-114.

Stoller, E. P., & Pugliesi, K. L. (1988). Informal networks of community-based elderly. Research on Aging, 10(4), 499-516.

Stone, R., Cafferata, G. L. & Sangl, J. (1987). Caregivers of the frail elderly: A national profile. The Gerontologist, 27, 616-626.

Tennstedt, S. L., McKinlay, J. B., & Sullivan, L. M. (1989). Informal care for frail elders: The role of secondary caregivers. The Gerontologist, 29(5), 677-683.

Theis, S., & Deitrick, E. (1987). Respite care: A community needs survey. Journal of Community Health Nursing, 4(2), 85-92.

Thoits, P. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. Journal of Health and Social Behavior, 23, 145-149.

U. S. Bureau of the Census (1988). U. S. Department of the Commerce. County and city data book, Washington, DC: U.S. Government Printing Office.

U. S. Bureau of the Census (1989, January). U. S. Department of the Commerce. Current population reports: Projections of the population of the United States by age, sex, and race, 1988-2080 (Series P-25, No. 1018), Washington, DC: U.S. Government Printing Office.

Vaux, A., & Harrison, D. (1985). Support network characteristics associated with support satisfaction and perceived support. American Journal of Community Psychology, 13(3), 245-268.

Ward, R. A., Sherman, S. R., & LaGory, M. (1984). Subjective network assessments and subjective well-being. Journal of Gerontology, 39(1), 93-101.

Weiss, R. (1974). The provisions of social relationships. In E. Rubin (Ed.), Doing unto others. Englewood cliffs, NJ: Prentice-Hall.

Wilson, H. S. (1989a). Family caregiving for a relative with alzheimer's dementia: Coping with negative choices. Nursing Research, 38(2), 94-98.

Wilson, H. S. (1989b). Research in nursing (2nd ed.). Redwood City, CA: Addison-Wesley Publishing Co.

Woods, N. F., & Catanzaro, M. (1988). Nursing research: Theory and practice. St. Louis: The C. V. Mosby Co.

Zarit, S. H. (1989). Do we need another "stress and caregiving" study? The Gerontologist, 29, 147-148.

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

Zarit, S. H., Todd, P. A., & Zarit, J. M. (1986). Subjective burden of husbands and wives as caregivers: A longitudinal study. The Gerontologist, 26(3), 260-266.

Tennstedt, S. L., McKinlay, J. B., & Sullivan, L. M. (1989). Informal care for frail elders: The role of secondary caregivers. The Gerontologist, 29(5), 677-683.

Theis, S., & [illegible] (19[illegible]). [illegible] survey. Journal of Community Health Nursing, 4 [illegible]

Thoits, P. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. Journal of Health and Social Behavior, 23, 145-159.

U. S. Bureau of the Census (1988). U. S. Department of the [illegible] County and city data book, Washington, DC: U.S. Government Printing Office.

U. S. Bureau of the Census (1989, January). U. S. Department of Commerce. Current population reports: Projections of the population of the United States by age, sex, and race: 1988 to 2080 (Series P-25, No. 1018). Washington, DC: U. S. Government Printing Office.

Vaux, A., & Harrison, D. (1985). Support network characteristics associated with support satisfaction and perceived support. American Journal of Community Psychology, 13(3), 245-268.

Ward, R. A., Sherman, S. R., & LaGory, M. (1984). Subjective network assessments and subjective well-being. Journal of Gerontology, 39(1), 93-101.

Weiss, R. (1974). The provisions of social relationships. In Z. Rubin (Ed.), Doing unto others. Englewood Cliffs, NJ: Prentice-Hall.

Wilson, H. S. (1989a). Family caregiving for a relative with Alzheimer's dementia: Coping with negative choices. Nursing Research, 38(2), 94-98.

Wilson, H. S. (1989b). Research in nursing (2nd ed.). Redwood City, CA: Addison-Wesley Publishing Co.

Woods, N. F., & Catanzaro, M. (1988). Nursing research: Theory and practice. St. Louis: The C. V. Mosby Co.

Zarit, S. H. (1989). Do we need another "stress and caregiving" study? The Gerontologist, 29, 147-148.

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

Zarit, S. H., Todd, P. A., & Zarit, J. M. (1986). Subjective burden of husbands and wives as caregivers: A longitudinal study. The Gerontologist, 26(3), 260-266.