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IN SICKNESS AND IN HEALTH:
EXAMINING MOTIVATION TO CARE AND INVOLVEMENT
AMONG HUSBANDS AND WIVES
CARING FOR A SPOUSE WITH CANCER

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IN SICKNESS AND IN HEALTH: EXAMINING MOTIVATION TO CARE AND INVOLVEMENT AMONG HUSBANDS AND WIVES CARING FOR A SPOUSE WITH CANCER

By

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ABSTRACT

IN SICKNESS AND IN HEALTH:
EXAMINING MOTIVATION TO CARE AND INVOLVEMENT AMONG HUSBANDS AND WIVES CARING FOR A SPOUSE WITH CANCER

By

Laura Verkest Dwyer

Husband and wife caregivers of cancer patients are compared with respect to their motivation to care and actual care involvement. The main goal of this comparison is to determine whether gender appears to influence caregivers' motivational attitudes and their subsequent involvement in care. Two sources of motivation are distinguished: motivation resulting from values instilled during the socialization process, and motivation derived from the contractual obligation of marriage, i.e. covenant-based motivation. Socialization-based and covenant-based motivation to care are compared regarding their influences on personal care and housework activities of caregivers.

The secondary analysis is based on survey data of 137 cases (72 male, 65 female, mean age = 57) from the first wave of a panel study. Findings reveal that only covenant-based statements are influenced by gender, while involvement appears to be driven mainly by patient dependency. However, greater agreement with covenant-based statements leads husbands to greater involvement in care.

To the memory of my grandparents,

Marguerite M. DeVolder Mortier
October 27, 1980

Albert Mortier
November 1, 1980

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CHAPTER I

INTRODUCTION

It is increasingly common for cancer patients to be cared for in their own homes by members of their families. While women have been the traditional caregivers of their families, men are becoming more involved in homecare, especially for their wives. Thus, to explore the caregiving role of both men and women, this study will focus on examining the influence of gender on husbands' and wives' motivation to care and their level of actual involvement in providing homecare for a spouse with cancer. Furthermore, the aim of this study will be to determine whether strength of motivation to care attitudes can predict level of involvement of husband and wife caregivers.

Background of Problem

Homecare of the chronically ill has become increasingly more common for several reasons. One reason is demographic changes. As the average age of the population increases, chronic care needs increase as well. While it is often necessary to meet acute care needs in a hospital setting, chronic care is mostly provided at home. Another reason is economics. Cost-containment pressures have led to shorter hospital stays and to more patients, both acutely and chronically ill, being cared for in their own homes or in the homes of their family members (Council on Scientific Affairs, 1990). As a result, family members must often provide the kinds of care in the home setting that were typically rendered by health care personnel in an inpatient facility.

Many cancer patients are now receiving treatment on an outpatient basis, whereas a decade ago that treatment may have been administered inpatient. Cancer patients often require intensive treatment and care, and must rely on supportive family and friends to assist them at home. This scenario leaves many families responsible for homecare, most without training or preparation. This trend is likely to continue. According to the American Cancer Society, some 12 million people were under medical care for cancer in the United States in the 1980s. Current projections estimate that about one in three Americans now living will eventually have cancer (A.C.S., 1993).

As the need for homecare continues to increase, the need for a family caregiver in the home increases as well. If women are the traditional carers of the family's sick and dependent this could place a physical and psychological burden on them to fulfill this role. If it is assumed that women will adopt roles as caregiver there may be little incentive for other family members to participate in the care, or for public policy to address homecare as an issue.

Being a "natural" at caring and nurturing could then become a trap for women. There is also a risk that caregiving work will become undervalued as other caring and nurturing activities have, such as the child rearing, cooking and housekeeping women do for their families.

Caregiving work for a cancer patient can be very demanding. The caregiver often supports the cancer patient through recovery from major surgery followed by long aggressive chemotherapy or radiation. Often treatment is followed by periods of remission, sometimes only to be succeeded by exacerbation of the illness and eventual decline. Demands of care might include symptom management resulting from the illness or side effects from treatment, as well as medical emergencies, and adjustment to special diets. In addition to health care related activities, caregivers of cancer patients may also be involved in providing assistance with personal care such as bathing and dressing, and other instrumental activities such as household maintenance, cooking and shopping. With the continued shift toward home management of cancer care, it is important to understand the challenges caregivers face as they assume increasing responsibility for treatment and symptom management, as well as emotional support of the cancer patient (Cassileth & Hamilton, 1979; Given, Dwyer, Vredevoogd, & Given, 1989; Hileman, Lackey, & Hassanein, 1992; Jassak, 1992; Krause, 1993; Northouse, 1984; Oberst, Thomas, Gass, & Ward, 1989; Woods, Lewis, & Ellison, 1989).

As women have been the predominant caregivers in the home, there is no shortage of research published concerning their reactions to the role regarding involvement, depression and burden (Brody, 1981; Cantor, 1983; Finch & Groves, 1983; Noddings, 1984; Sommers, 1985; Stone, Cafferata, & Sangl, 1987). Some recent research has begun to focus on the increasing role of men, as spouses of cancer patients (Northouse, 1988; Northouse & Swain, 1987; Oberst & Scott, 1988; Oberst, Thomas, Gass, & Ward, 1989) and as caregivers, primarily for the elderly (Horowitz, 1985; Kaye & Applegate, 1990; Mathew, Mattocks, & Slatt, 1990; Motenko, 1988; Stoller, 1990; Zarit, Todd, & Zarit, 1986). This study will focus on women and men providing homecare to a spouse with cancer, exploring specifically their motivation to care and level of involvement.

Purpose of the Study

As the need for individuals to commit their time and energy to care for a chronically ill family member in the home continues to increase, it becomes important to study what motivates caregivers in their work. Women have a long history of being the family carer, so it is not surprising to see them so predominant in this role today. Men do not share the same caring history or reputation, yet they are increasingly choosing to accept these roles, particularly when the patient is their wife. Possible motives and justification for continual caregiving include prior socialization to caring roles, and a sense of covenant (i.e. obligation derived from the marriage contract) shared within a relationship.

In addition to assessing motivational factors for caregiving, this study will examine the extent to which husbands and wives are actually involved in care, such as in personal care activities (examples include assisting with bathing, grooming and toileting) and more typical gender role specific housework activities (examples include cooking, laundry and cleaning). Finally, the researcher will determine whether strong agreement with motivational statements actually results in increased levels of involvement in caregiving activities on the part of the caregiver.

Research Questions

The general question addressed in this research is: "How does gender influence responses to motivation to care statements and level of involvement, and how do different types of motivation to care affect the level of involvement among spouse caregivers of cancer patients?" Specifically, this research will address the following questions:

1. Do husband or wife caregivers report stronger agreement with socialization based motives to care?
2. Do husband or wife caregivers report stronger agreement with covenant based motives to care?
3. Are husband or wife caregivers more involved in providing assistance with personal care activities for their spouse with cancer, controlling for functional dependency of the patient?
4. Are husband or wife caregivers more involved in providing assistance with housework activities for their spouse with cancer, controlling for functional dependency of the patient?
5. Does stronger agreement with socialization based or covenant based motives to care among husband and wife caregivers result in increased involvement in caregiving activities overall when functional dependency of the patient is controlled for? (Or do attitudes translate into behaviors?)

Definitions of Variables

The following conceptual definitions will help guide the reader through the selected review of research. For purposes of this study, the terms are defined as follows:

Patient. Patient is defined as the husband or wife identified as having a new or recurrent cancer diagnosis.

Caregiver. Caregiver is defined as the husband or wife who is self-identified as the person who provides the most care for a patient with cancer.

Motivation to care. Motivation to care is defined as the caregiver's self-appraisal of their attitude of commitment to the care situation and patient based on social influences and moral principles. Motivation to care in this study will be measured by two two-item scales constructed for this purpose. The scales assess: 1) socialization-based motivation, in the sense of learned social expectations to care; and 2) covenant-based motivation, referring to the personal solemn promise made by the husband and wife in the marriage vows to care for each other "in sickness and in health."

Care Involvement. Care involvement is defined as the frequency and type of caregiving behavior reported by the caregiver. The two categories of care assessed are: 1) personal care activities; and 2) housework activities.

Assumptions

The following assumptions are made in this research:

1. The measurements of motivation to care and care involvement are representative of the sample's experiences over the three months prior to the interview.

2. The instruments are sensitive to the concepts examined in this study.

Limitations

This research has the following limitations:

1. This research concentrates only on a few aspects of the care process and relationship between patient and spouse caregiver. For instance, all possible factors affecting caregiver motivation to care and involvement are not addressed in this study. An example of such a factor is the history of the marital relationship.
2. Since the sample obtained was a convenience sample, the findings of this study are not generalizable to all spouse caregivers of cancer patients.

Overview of Chapters

The presentation of this study is organized into five chapters. Chapter I includes a general background of the problem, purpose of the research, definitions of the variables, assumptions and limitations of this research. In Chapter II, a selected review of research is presented which links this study with the work and ideas of others concerned with gender differences in areas of motivation to care and level of involvement in the cancer care experience. In Chapter III, the research questions are again presented with a description of the methodology used to test them. Data and analyses are presented in Chapter IV. In Chapter V a summary is presented along with a discussion of the findings.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this selective review of the literature is to highlight the theoretical knowledge about motivation to care, and the research knowledge concerning involvement in caregiving, as they are affected by the gender of the caregiving spouses. A discussion of the motivation to care will include influences of gender role socialization and the importance of the covenant within a relationship. This will be followed by a description of cancer patient caregivers' involvement in the homecare routine, including descriptions of activities and how participation among men and women might be expected to vary. Whenever possible, studies will be selected which report the experiences of husband and wife caregivers.

Discussion of Motivation to Care

Traditionally, it has been women as mothers, daughters, wives, sisters and even sisters-in-law who have nursed family members back to health when they were ill (Ehrenreich & English, 1973). Since women tend to be socialized into nurturing roles, they are often viewed by themselves and others as the obvious caretakers in the family realm (Graham, 1983). Gilligan (1982) notes that the motivation to assume this role is instilled during a woman's moral development. Chodorow (1974, 1978) suggests that the nurturer role is assumed initially out of convenience as women are biologically suited to conceive, deliver and nourish babies. Furthermore, Barnett & Baruch (1987) maintain that:

> Central to the traditional roles of wife and mother is the obligation to be available to meet the needs of the family, to be ready to respond whenever someone calls. In addition, wives and mothers are held, and hold themselves, responsible for the well-being of their role partners - their husbands and their children. (p. 133)

It would appear then that women would be more likely than men to see the nurturing role of caregiver as compatible with themselves.

Norms and values concerning marriage in the United States emphasize the obligation of husbands and wives to fulfill each other's instrumental and socio-emotional needs (Johnson, 1985). Motives for providing care to an ill spouse could, of course, vary by individual and marital relationship. While obligation is expected to be an important motivator for caregiving, the influence of discretionary motives, where the caretaker acts by choice and the desire to provide care, could be just as powerful a motivator. Hess and Waring (1978, p. 242) indicate that there has been an "historical erosion" in filial responsibility, and that, for example, discretion now motivates younger generations to care for their elder relatives. Affection and interdependence built over the history of an intimate relationship (such as a marriage) may stimulate an individual to genuinely desire to provide care to their loved one (Walker, Pratt, Shin, Jones, 1990). In fact, Pratt and her associates discovered that daughters caring for their mothers no longer distinguished between obligations and desire to provide care. And Callahan (1985) has written that there may not be any incompatibility between a sense of duty and feelings of affection felt by adult children for their elderly parents.

Women in their mid-life may be reluctant caregivers, however, if they see the decision to provide care less as a choice based on their discretion, and more out of obligation. As Lowenthal, Thurnher, Chirboga, & Associates (1975) pointed out in their study of men and women throughout the life cycle, women traditionally spend a great many of their younger years in the family role as mother, homemaker, and nurturer. In their middle years they are no longer raising small children and move onto other roles, such as those of career women, artists, or other roles which do not require such nurturance of others. Husbands, in contrast, traditionally have spent much of their lives outside the home, working. Lowenthal and her associates

(1975) suggest that husbands in their middle years may welcome a change in focus from work to home, and enjoy this new role as "caregiver." Women on the other hand, may be ready to develop other areas of their lives and see caregiving as an imposition. In a study of spouse caregivers for dementia patients, both husbands and wives expressed a sense of duty and obligation to provide care. However, Fitting, Rabins, Lucas, and Eastham (1986) found that women appeared to feel more constrained than men in their role as caregiver. Reasons given were similar to those highlighted by Lowenthal and associates above.

More has recently been published describing men's experiences as caregivers. Kaye and Applegate (1990) found that a substantial number of men in their study spoke of caregiving as instructive, positively challenging and growth promoting. Their statements of affection suggest that they were motivated by an ethic of caring (Gilligan, 1992), one usually more associated with women, and like the subjects in Motenko's (1988) ethnographic study, these men had found personal gratification, pride, and meaning in their caregiving roles. Somewhat contradictory to this finding, the support group leaders in Motenko's study reported that men in their groups seemed to get more satisfaction from fulfilling vows and obligations than from emotional and affectional aspects of caregiving. This perception is in line with Gilligan's (1982) conclusion that many men are motivated primarily by an ethic of justice and obligation rather than by an ethic of caring. Kaye and Applegate's study participants were selected from caregiver support groups and may represent only a minority of all men in caregiver roles given other research findings that suggest that men tend not to join caregiver support groups.

Most boys and girls are taught to behave in a certain manner appropriate to their gender from very early in their lives. For example, women learn to care for others by role-playing with dolls as children. Socialization defines and supports the gender-role tradition of women's involvement in caregiving. Gender-role attitudes are learned in the socialization process which in turn influence the division of labor (Finley, 1989). Socialization determined behavior differences are less a result of negotiation than of learned gender-roles. The traditional assumption is that strong family concerns are part of the feminine role, and kin-keeping tasks are women's responsibilities.

Given the tradition of gender-role attitudes described above, Finley, Roberts, and Banahan (1988; and Finley, 1989) were surprised to find no gender difference in their research sample in personal <u>attitudes</u> of filial obligation. If women performed caregiving responsibilities simply because they were expected to do so as part of their traditional family role, one would expect a difference in attitudes towards filial obligation between sons and daughters. However, Finley did find that while men <u>feel</u> responsible for taking care of their elderly parents, they do not actually fulfill this responsibility to the extent that women do. It appears then, based on Finley's findings, that it may be the specific caregiving tasks which are gender socialized rather than feelings of obligation to provide care to a family member. In this context, it is important to acknowledge that attitudes do not necessarily result in actions. So there is no inconsistency in finding that men were as likely to report obligatory attitudes as were women, while the extent of involvement in types of activities differed between male and female caregivers.

In a study of sons and daughters caring for their parents, Montgomery and Kamo (1989) suggest that one reason that men may not involve themselves in caregiving tasks to the same extent that women do is that men may be socialized to view certain types of personal care tasks as taboo. For example, one reason hands-on care for a parent such as bathing, dressing, and toileting may be avoided is because assistance with these activities may be viewed as women's domain. Another possible reason may be because the tasks are viewed as inappropriate or taboo behaviors for a son as they border too closely on behaviors that break societal norms regarding incest. On the other hand, intimate bodily contact between spouses would not be considered taboo, despite sex role socialization. Therefore, we would expect greater similarity in caregiving behaviors between husbands and wives than between sons and daughters regarding personal care for the patient.

Traditional socialization to gender roles would predict that wives might be more emotionally invested in the spouse-caregiver relationship. However, Pruchno & Resch (1989) discovered in their research that husband caregivers were more highly invested in the marital relationship than were wife caregivers. Informal comments expressed by respondents help to explain these results. For example, husbands, more than wives, were likely to utter comments such as, "She took care of me when I was ill - now it's my turn to take care of her," or, "She did everything for our family, now it's my turn to help." Husbands expressed a greater sense than did wife caregivers that the care they were currently providing to their ill spouses was happily provided. An explanation for this finding might be that men typically have a choice whether to assume the caregiver role, whereas women most often do not. Typically, if a man chooses not to assume the role, a female family member or friend steps in. As dictated by societal and traditional expectations, women seldom are given the same choice. The assumption is that women will naturally assume the role of caregiver in the family. Thus male caregivers in study samples may be more likely to indicate they are very dedicated as they most likely assumed the role by choice.

The assumption that women are "natural" carers is explored by feminine ethicists and can be considered quite controversial. Based, in part, on developments in ethics education, feminist theory, and social psychology, this model describes caring within a feminist perspective of moral development and cultural practices. Women's roles as carers are explored thoroughly by two women philosophers in particular, Carol Gilligan (1982) and Nel Noddings (1984), using what they consider to be a feminine approach to ethics. Both of these thinkers focus on women's purported predisposition to care. Gilligan's and Noddings's morality stresses a person's responsibility to provide care to their family or community members, over their own rights as autonomous individuals. One's relationships matter as much as, if not more than, one's personal ambitions, aspirations, and aims.

While traditional morality, or male-valued morality, is justice based, Noddings (1984) believes that an ethics that emphasizes caring is not only different from, but better than, one that emphasizes justice. Being kind is as important as being fair.

Human caring is a phenomenon and an attitude that expresses our earliest memories of being cared for (Noddings, 1984). Boys and girls experience being cared for by their parents, specifically their mothers. Gilligan (1982) asserts that as children grow up they learn to identify with their same sex parent. Boys learn to differentiate from their mother's nurturing behaviors in favor of more socially acceptable behaviors for boys, including concerns for morality around issues of justice, fairness, rules and rights. Girls identify with their mothers and center their lives around family and friends and are concerned about people's wants, needs, interests and aspirations, and develop what Gilligan refers to as an ethic of caring (Gilligan, 1982). Gilligan has been criticized for linking women with caring and promoting that women care by nature because the implication may be that women should always care no matter the cost to themselves.

Whereas Gilligan thinks that men and women speak different languages of ethics, whereby men speak of rights and women the language of responsibility, Noddings suggests that they come from the same place but need to be reminded, or have their memories refreshed, regarding the value of caring and how to care. However young children are socialized, Noddings is eager to point out that, as a behavior, caring can be learned and cultivated in education and socialization processes of boys as well as of girls. She believes that one cares through methods of receptivity, relatedness, and responsiveness and that these values can be cultivated not only in women but also in men. Noddings expects all individuals to be caring persons who choose to care because they are motivated by feelings such as love, affection, compassion, sympathy and empathy. Noddings's relational ethics of care has been criticized for demanding of all people, but especially women who currently are the carers, a self-sacrificial love, making unreasonable moral demands by expecting caring at all personal costs. As women are most frequently the carers it is in protection of them that this criticism is aimed (Tong, 1993).

Another theorist, Sara Fry (1991), does not distinguish between the different ways in which men and women fulfill needs for care, but rather suggests a model of care that is inherently obligation-oriented which focuses on the moral foundations for care and caring. An obligation model of care highlights aspects of compassion, doing good for others, directed toward the good of an individual. One cares in order to produce some good in a general sense or to create some benefit for another individual. Fry sees obligation as derived from a covenant: i.e. obligation based on the maintenance of fidelity (i.e. faithfulness, devotion, loyalty) in a particular personal relationship. A focus on covenant suggests that personal fidelity is the basis for human caring, rather than human good. Fry (1991) contends that fidelity stems from the covenant made between two individuals when they stand in particular relationship to one another (for example, in marriage). This covenant-oriented obligation model includes elements of compassion, and doing for others, as well as respect for persons and the protection of human dignity. Marriage is ideally a covenant between two individuals with the desire to maintain fidelity in the relationship. Fry suggests that parties in a covenantal relationship are under an obligation to behave in certain ways within the relationship. Thus a spouse is more likely than another family member to become the caregiver for an ill husband or wife.

In summary, the assumption of the marital bond is that it would obligate both partners in the relationship to provide comfort and care to one another in a time of serious illness such as cancer. However, gender socialization, feminine theories on caring, and traditional behavior of both women and men regarding care and nurturance would suggest that a woman might feel a greater sense of obligation to provide care, and thus may be more involved in care, than would a man. This researcher is uncertain whether arguments suggesting women will report greater feelings of obligation and be more involved in care than men, will outweigh the commitment and related obligation implied in a relationship defined by a marital covenant.

Women have had a long tradition of being the family carers and nurturers. Men's roles in these areas are infrequently acknowledged and remained largely undocumented until quite recently. Socialization plays a powerful role in shaping each person's expectation of what their role within their marriage and family should be. Motivation for assuming the role of caregiver could include being socialized to accept the notion that caring is primarily the responsibility of women. Theory cited in this section also suggested that motivation might include: feeling obligated to care for humane reasons just because the individual feels they should, or by a covenant such as marriage, or motivated entirely by choice based on the caregiver's affection and desire to help the one in need.

Some theorists discussed in this section referred to women as "natural" carers. This notion is clearly derived from traditional socialization patterns. If women are indeed "natural" carers, or socialized to believe they are, it would seem then that men might feel it is "unnatural" for them to become a caregiver. Men might feel uncomfortable with the assumption of the caregiving role and might find it difficult to get involved in tasks related to it. The greatest challenge then may come to men who find themselves in a covenant-based relationship (marriage) where the expectation of themselves or from others is to care for their spouse when they have not been socialized to this role and may feel uncomfortable performing the necessary tasks. One would then expect men's involvement in caregiving tasks to be lower than women's because women have presumably been socialized to caring activities throughout their lives. This study will examine men's and women's willingness and commitment to roles as caregivers by asking both husband and wife caregivers about their agreement with socialization based and covenant based motivation to care statements, and compare the motivation to care to the caregiver's level of involvement.

Since all of the caregivers in this study are married to their patients it is possible that marital obligations may lessen gender differences that might be obvious when the caregiver is not a spouse of the care recipient. However, based on a long tradition of women caregiving, this researcher expects that women would express strong agreement with motivation to care statements, particularly socialization based statements. This researcher is less certain about how husband caregivers will respond to the motivation to care statements.

Discussion of Caregiver Involvement

Cancer homecare can require a great deal of the caregiver's time and energy, with demands and involvement varying with the stage of the illness, and the type and frequency of treatment received. Caregivers are often involved in providing transportation to outpatient cancer treatments, rehabilitation efforts, physical care, and assisting the patient's self-care activities in the home. They may also be responsible for medical care activities such as monitoring the signs and symptoms of complications and side-effects, administering medicines through infusaports and I.V. pumps, and managing other complex treatment regimens often involving technical competence (Biegel, Sales, & Schulz, 1991; Cassileth & Hamilton, 1979; Jassak, 1992).

Stetz (1987) identified nine major categories of cancer caregiving demands after interviewing spouses of those diagnosed with advanced cancer. Only 14% of this sample were currently receiving treatment, and the method of treatment varied by patient. The care demand reported most frequently, by 69% of the caregivers, was "managing the physical care, treatment regimen, and imposed changes." Reported care included assisting the ill spouse with activities of daily living and treatment regimens, as well as coping with alterations in the physical and/or emotional state of the ill spouse. Oberst and her associates (1989) interviewed caregivers of cancer patients, a little over half of whom were spouses, receiving radiotherapy. Family caregivers reported spending the most time in providing transportation, giving emotional support, and in performing extra household tasks. The patient's stage of illness was not reported in this study.

Perceptions of the caregiving job may differ for women and men. Researchers have focused on caregivers of the elderly to help them understand more about filial obligation and gender differences in helping behaviors. Horowitz (1985) examined gender differences in a sample of 131 sons and daughters identified as primary caregivers to an aging parent. Horowitz discovered that sons became caregivers by default, usually because a female was unavailable. Sons typically offered less overall assistance to their parents than daughters, particularly in the areas of transportation, household chores, meal preparation, and personal care. For stereotypically male-oriented assistance (e.g., financial help), no significant gender differences in involvement existed. Further support for the predominance of females in the caregiving role is found in the fact that sons frequently enlisted the assistance of their wives when providing care to aged parents.

Researchers consistently indicate that daughters are more likely than sons to assume primary responsibility for parental caregiving in the first place (Stone, Cafferata, & Sangl, 1987). When compared to assistance provided by daughters, researchers (Matthews & Rosner, 1988; Stoller, 1990) found that sons' aid tended to be sporadic. Types of tasks performed also differed. Males were less likely to help with traditionally assigned feminine tasks such as food preparation, laundry, personal care, and routine household chores than their female counterparts (Stone et al., 1987; Stoller, 1990). Stoller notes that while full time employment significantly reduced the number of hours of assistance by sons, it made no change for daughters.

Contrary to the findings along gender lines above, one study's results showed that husbands reported spending more time and performed a greater number of caregiving tasks than did wives (Dwyer & Seccombe, 1991). The researchers suggested that wives are less likely to identify specific tasks as caregiving because of other norms and role expectations. For example, because caring for a spouse is perceived to be part of their marital role more generally, wives might be less apt to attribute these tasks to caregiving than to what is already expected of them in their role as wife. If this were true, however, one should expect wives to report lower caregiving involvement than daughters, but there is no evidence of that.

There are an increasing number of studies exploring the involvement of males as caregivers (Kaye & Applegate, 1990; Mathew, Mattocks, & Slatt, 1990; Motenko, 1988; Stoller, 1990). Consistent with comparisons of men and women caregivers mentioned above, men in these studies tended to be most involved in social support tasks and instrumental daily living tasks, and least involved in personal care.

While both women and men involve themselves in the caregiving tasks for an ill family member, research has consistently found that women remain the predominant caregivers of the ill at home, though men are now more frequently taking on this role. Research shows that involvement in caregiving tasks continues to fall along gender lines (Finley, 1989; Finley, Roberts, and Banahan, 1988; Horowitz, 1985; Stone, Cafferata, & Sangl, 1987; and Stoller, 1990).

The studies mentioned above indicate that men, when involved, are involved to a lesser extent than women when caring for an elderly parent. There were no studies found which compared men's and women's involvement in caregiving tasks when the care recipient was a spouse. This researcher is uncertain based on the literature reviewed whether spouse caregivers in the present study will participate along gender-role lines in the personal care and household activities measured. However, it is expected based on the literature cited above, that regardless of the motivation to be a caregiver, be it a lifetime of socialization to care, or the fulfillment of the covenant shared between husband and wife, that women will be involved in caregiving tasks to a greater extent than men.

Summary

The present study will assess husband and wife caregivers' responses to socialization based and covenant based motivation to care statements in order to determine if the motivation for men and women appears to be different. Husband's and wive's involvement in caregiving activities will be compared to determine whether these spouses adhere to commonly held gender-role assumptions that women are more involved in personal care and housework activities for a care recipient and in general. Lastly, the investigator will determine whether gender and attitudes of agreement with motivation to care statements can predict level of caregiver involvement.

A description of the methodology employed in this research will follow in Chapter III.

CHAPTER III

METHODS AND PROCEDURE

The following chapter will present a description of the research methods, including study design, sampling, data collection, and analysis strategy.

Research Design

In order to describe the relationship between the gender of the spouse caregiver and the attitudes and ethical motives for care and involvement, a secondary analysis of cross-sectional data was conducted. This study was carried out using existing data previously collected by a research team under the direction of Dr. Barbara A. Given and Dr. Charles W. Given, Principal Investigators for the following grants: NCNR, "Family Homecare for Cancer - A Community-Based Model" (#1 R01 NR01915-01) and ACS, "Family Home Care For Cancer Patients" (#PBR-32). Both were one year panel studies. The data reported here, collected between 1988 and 1990, were taken from the first wave of a panel study of family caregivers of new and recurrent cancer patients.

Sample Selection

The researchers identified a convenience sample of patients and their family caregivers in community-based cancer care settings. All families resided in the lower peninsula of Michigan. Subjects were recruited via a card back system and then screened according to clinical, cancer specific, and functional health criteria. The cancer patient/caregiver dyads were selected for screening using the following criteria: adult patients between 20 and 85 years of age; diagnosed with new or recurrent solid tumor or lymphoma; symptomatic or with some physical impairment/ limitation in Activities of Daily Living or Instrumental Activities of Daily Living; and currently under medical treatment for cancer, receiving either chemotherapy or radiation. The primary family caregiver was the person identified as the individual who provides the most care in the home for their family member with cancer.

Subject rights for this study were guaranteed as this investigator conducted a secondary analysis using existing data. Data were presented in aggregate form only and the computerized data files contained no individual identifiers.

For the present study, one hundred thirty-seven married cancer caregivers were drawn from the first wave of the panel study, excluding all non-spouse caregiver dyads and those with a patient who required no assistance in personal care or housework activities.

Data Collection

Data for the major variables under study were collected between 1988 and 1990 via a self-administered mailed questionnaire booklet and a telephone interview to each caregiver. Data were gathered from the caregiver over the telephone by trained research assistants.

Operationalization of Variables

In the following discussion, the major variables under study will be operationally defined. Motivation to care is conceptually defined as the caregivers' self-appraisal of their attitude of commitment to the care situation and patient, based on social influences and moral principles. Motivation to care in this study will be measured by two two-item scales constructed for this purpose. The scales assess: 1) socialization-based motivation as the learned social expectation to care; and 2) covenant-based motivation as the personal solemn promise made by husbands and wives in marriage vows to care for each other "in sickness and in health."

The motivation to care scales are two-item, Likert-type, self-report scales designed to assess attitudes reported by caregivers (Appendix A). These items are taken from an instrument constructed specifically to measure overall caregiver burden. The items selected to measure socialization based motivation to care are the following:

1. At this time in my life, I don't think I should have to be caring for _____. (Score reversed for analysis.)
2. I believe it is my responsibility to care for _____.

Item #1 draws upon a sense of duty, obligation (or their absence), and an assessment of resentment toward the care situation, while #2 overtly evaluates a feeling of responsibility to care for the spouse with cancer. These items clearly seem to refer to a social expectation as the basis of the motivation to provide care. This researcher proposes that caregivers are responding to what they feel is expected of them when answering these questions.

The items chosen to measure covenant based motivation to care are the following:

1. I am doing more for _____ than he/she ever did for me. (Score reversed for analysis.)

2. I will never be able to do enough caregiving to repay _____.

Both of the above items measure to some extent the level of personal affection and emotional investment within the spousal relationship, as well as the desire to provide care for the other. Both items refer explicitly to the care-recipient and appear to reflect the personal solemn promise that is the covenant made between spouses.

Responses to the motivation to care items are measured on a five-point scale describing the extent to which the respondent agrees with the statement where "strongly disagree" was scored as one (1); "disagree" as two (2); "neither agree/disagree" as three (3); "agree" as four (4); and "strongly agree" was scored as five (5). The highest possible score for each of the motivation to care scales would be 10 if responses to both items in the scale were strongly agreed with (score of 5 x 2 items), while the lowest possible score would be 2 for each scale if the respondent strongly disagreed with each statement.

With only two items in each scale, the reliability of the socialization based motivation to care scale is low (alpha = .44), and the reliability of the covenant based motivation to care scale is moderate (alpha = .70). In general, reliability is limited when using scales with only two items because the effect of averaging out measurement errors of individual items usually requires at least 4-5 indicators to measure the same concept. On the other hand, in this secondary analysis, it was not possible to find more items that reflected the desired concepts. In this situation, the researcher is forced to trade-off reliability against face validity.

Care involvement is defined in terms of frequency and type of caregiving behavior reported by the caregiver. The two categories of care assessed are: 1) personal care activities; and 2) housework activities. Involvement is measured by 13 items from the Cornwell Involvement Index, a 22-item telephone administered instrument which inquires about the frequency of assistance required for activities of daily living (ADLs), such as personal care activities, and instrumental activities of daily living (IADLs), including housework activities. For each activity, the respondent is asked whether their spouse needs help with the activity and if so, how frequently the caregiver assists with the activity. The total number of activities requiring assistance by the patient will be reported as well as totals for the activities grouped by type of task (personal care or housework). Caregiver involvement in personal care activities includes help with dressing, bathing, grooming, mouth care, eating, toileting, and cleaning up when the patient is incontinent of urine or stool. Housework activities include shopping, laundry, cooking, heavy and light housework. Responses and scoring values assigned for frequency of involvement in caregiving activities include "once a week or less than once a week" (assigned a value = 1); "several times a week" (3.5); "once a day" (7); "several times a day" (14); and "doesn't help" (0). The highest possible score for the personal care involvement scale would be 112 (score of 14 x 8 items) and the highest score for the housework scale would be 70 (14 x 5 items) representing the number of instances of involvement in each type of caregiving task. The lowest scores for each of these scales would be 0 except that only patients requiring assistance in one or more areas were included for this analysis, bringing the lowest possible score to 1 (requiring assistance in only one area once a week or less). Reliability of both involvement subscales are considered moderate. The alpha for the personal care involvement subscale is .67, and the housework involvement subscale alpha is .59.

Functional dependency of the cancer patient in areas of personal care and housework related activities will be used as a control variable for analysis purposes. A dependency score based on the total number of activities in each of the two categories requiring assistance will be used as a control to investigate variation in caregiver involvement independent of the patient's functional status. Caregivers were asked whether the patient required assistance in areas of personal care and housework, regardless of who provided the assistance. The number of areas where assistance was required was used to factor in functional dependency in the analysis. This measure differs from the involvement measure in that involvement looks (1) only at areas of assistance provided by the caregiving spouse, and (2) is based on the frequency of that assistance, whereas the functional dependency score is simply a count of all areas of assistance required by the patient. The possible range for the dependency score would be 1-13.

Demographic data collected included the caregiver and patient gender and age, and caregiver race, education, employment status, income and religious identification. These will be presented to describe characteristics of the sample under study. The type of cancer and whether patients were undergoing active cancer treatments, were collected to further illustrate the cancer caregiving experience and the patients' likely need for care. These data will be reported as background variables of the sample under study and are intended to be used for descriptive purposes.

The research questions to be tested are as follows:

Research questions

1. Do husband or wife caregivers report stronger agreement with socialization based motives to care?
2. Do husband or wife caregivers report stronger agreement with covenant based motives to care?
3. Are husband or wife caregivers more involved in providing assistance with personal care activities for their spouse with cancer, controlling for functional dependency of the patient?
4. Are husband or wife caregivers more involved in providing assistance with housework activities for their spouse with cancer, controlling for functional dependency of the patient?
5. Does stronger agreement with socialization based or covenant based motives to care among husband and wife caregivers result in increased involvement in caregiving activities overall when functional dependency of the patient is controlled for? (Or do attitudes translate into behaviors?)

The strategy for analysis is described in the next section.

Analysis strategy

The researcher will analyze the variables under study by the following methods. The first stage of the analysis will involve calculating the descriptive statistics which describe the characteristics of the sample, the responses on the major variables (means, standard deviations), frequency distributions, psychometric properties of the major scales used, and the inter-correlations of the major variables and outcome measures utilizing Pearson product-moment correlation coefficient.

The major research questions in this study will be analyzed as follows: oneway analysis of variance (ANOVA) will be used to analyze the association of gender of the caregiver and agreement with motivation to care based statements in two scales: (1) socialization; and (2) covenant. This analysis will be used to test research questions one and two. Analysis of covariance (ANCOVA) will be utilized to determine the relationship between gender and involvement in activities in two involvement subscales: (1) personal care activities; and (2) housework activities. The number of patient functional dependencies in areas of personal care and housework will be used as covariates or control variables in the analysis of each of the relationships. ANCOVA will be used to assess research questions three and four. Multiple regression will then be used to determine whether stronger agreement with socialization based and covenant based motivation to care statements actually result in increased involvement in caregiving activities overall. Spouse caregiver gender and agreement with motivation to care statements will be used along with patient functional dependency as independent variables while caregiver involvement in personal care and housework activities will be considered dependent variables. This procedure will test research question five.

Presentation of data and analysis will follow in the next chapter.

CHAPTER IV

PRESENTATION OF DATA AND ANALYSIS

Overview

In this chapter data analysis and interpretation of the study findings are presented. A description of the sample's demographic characteristics will provide the context for examination of the research problem. Reliability measures and descriptive statistics are presented for the scales used in this study. Data relevant to the study's research questions are presented to examine the strength of the relationships between the variables. Analysis of variance and covariance is used to compare gender scores for the major variables. A regression equation is formulated to examine the variance that can be explained and to derive the standardized beta coefficients.

Sample Characteristics

The sample consisted of 137 caregivers of spouses with cancer, each spouse requiring assistance in at least one activity of daily living. Table 1 presents the socio-demographic characteristics of the subjects, including caregiver age, gender, race, religious identification, education and income. Table 2 presents patient age and gender. Except for gender, the characteristics of the caregivers and patients are not entered into the later analysis, but are presented for description of the study sample.

Table 1. Caregiver Sociodemographic Data

Caregiver Age

$\bar{X}$ = 57
SD = 11
Min. = 23
Max. = 81

Gender	N	%
Male	72	53
Female	65	47
Total	137	100

Race	N	%
Caucasian	132	96
Black	3	2
Asian/Pacific	1	1
Total	136	99

Missing Cases = 1

Education	N	%
Grade School or Less	4	3
Some High School	16	12
High School Graduate	45	33
Some College	47	34
College Graduate	14	10
Graduate/Prof. Degree	11	8
Total	137	100

Religious Identification	N	%
Protestant	83	61
Catholic	36	26
Other	5	4
None	12	9
Total	136	100

Missing Cases = 1

Table 1 (cont'd).

Household Income

$\bar{X}$ = 33,333
SD = 17,459
Min. = 7500
Max. = 60,000 and above

The sample of caregivers consisted of 65 women and 72 men, with a mean age of 57 years (S.D. = 11), with a range from 23 to 81 years. Ninety-six percent of these caregivers were white, 85% graduated from high school, and 52% have some college or higher education experience. The mean age of patients is 58 years (S.D. = 11). All of the respondents resided with their spouses.

Table 2. Patient Sociodemographic Data

Patient Age

$\bar{X}$ = 58
SD = 11
Min. = 22
Max. = 78

Gender	N	%
Male	65	47
Female	72	53
Total	137	100

Disease and Treatment Characteristics of Cancer

Table 3 presents cancer specific data regarding primary tumor site and primary mode of treatment. The cancer related data reveal the most frequent tumor sites to be the female breast (29%), lung (18%), lymphoma (13%), and colon-rectal (11%). These sites reflect the prevalence of reported cancer sites elsewhere in the U.S. (ACS, 1993).

Most patients (94%) were undergoing active treatment for their cancer, the most frequent being chemotherapy (74%).

Table 3. Cancer Specific Data

Primary Tumor Site	N	%
Bladder	1	1
Breast	39	29
Colon/Rectal	15	11
Gastro-intestinal	8	6
Gynecological	7	5
Lung	25	18
Prostate	7	5
Lymphoma	18	13
Head/Neck	2	1
Other	15	11
Total	137	100

Treatment	N	%
Chemotherapy	101	74
Radiation	7	5
Hormone	1	1
Other	6	4
Combination	14	10
None	8	6
Total	137	100

Table 4 shows data on caregivers' duration of involvement in care, reported in months, and reveals that the median duration of care is 9 months. The median in this case is a more accurate measure than the mean, which is 28 months, because the mean reflects the extreme case(s) where a spouse reported "caregiving" for their husband or wife for 40 years.

Table 4. Characteristics of the Cancer Care Experience

Duration of Care (in months)

$\bar{X}$ = 28
Med. = 8
SD = 57
Min. = 1
Max. = 480

The frequency distribution and descriptive statistics for the control variable patient functional dependency are presented in Table 5. Patient functional dependency is the caregiver's report of assistance required of the patient for personal care and housework activities, regardless of who provides the assistance. Specific activities requiring assistance follow in Table 5a. Only patients requiring assistance with one or more activities were included in the study sample. Patients in this sample required assistance for, on average, 2.91 (S.D. 2.01) personal care and/or housework activities. A composite score was computed from the number of activities requiring assistance and entered into the analysis as a control variable.

Table 5. Patient Functional Dependency

# Activities Requiring Assistance	N	%
1	42	31
2	30	22
3	19	14
4	20	15
5	14	10
6	5	4
7	3	2
9	2	1
10	1	.5
11	1	.5
Total	137	100

$\overline{X}$ = 2.91
SD = 2.01
Min. = 1.00
Max. = 11.00

Table 5a. Patient Functional Dependency

Activities Requiring Assistance	N	%
Personal care		
Taking a shower/bath	50	21
Dressing/undressing	48	20
Clean up incontinence-urine	32	13
Clean up incontinence-stool	30	13
Using toilet/bedpan/commode	13	6
Combing hair/shaving	12	5
Mouth care	9	4
Eating	6	3
Housework Activities		
Heavy housework	84	35
Shopping	57	24
Light housework	44	19
Laundry	44	19
Cooking	41	17

Description and Reliability of Measures

The major concepts for this research, motivation to care and caregiver involvement, are each measured by two subscales. The two subscales designed to assess motivation to care include socialization and covenant based motivation to care statements, both of which are two-item scales (see Appendix A). Involvement is measured by two subscales from the Cornwell Involvement Inventory. The personal care activities subscale has eight items and the housework activities subscale has five (see Appendix B).

Reliability coefficients for the caregiver motivation to care and involvement subscale measures are presented in Table 6. Reliability refers to the internal consistency of the scale and the extent to which all the items in the scale are equally good indicators of the concept or attribute in question. Measured by Cronbach's alpha, it is generally understood the higher the coefficient alpha score the stronger the internal consistency of the scale, meaning that the items in the scale are consistently measuring the same concept. When a scale is shown to possess repeatedly high reliability scores it possesses reproducibility and scale scores are less likely to be influenced by error.

The alpha coefficient scores presented in Table 6 reflect low to moderate levels of internal consistency of the measures with the score for the socialization scale being lower than is desirable. However, with only two items in the scale, reliability is bound to be low (Nunnally, 1978). The lower score is defensible in this case, because the subscale was designed conceptually after the data had been collected. Items were chosen from a much larger instrument designed to measure overall caregiver burden. Only four items were found which were related to motivation to care, two of them indicating influence of prior socialization and two items assumed to measure a feeling of covenant within the relationship. Since the items were not originally written on the basis of the conceptual framework employed here, some trade offs between reliability and conceptual validity became inevitable.

Table 6. Reliabilities of Caregiver Motivation to Care and Involvement Subscale Measures

Scale	Items	R	Alpha	N
Motivation to Care				
Socialization	2	.28	.44	137
Covenant	2	.54	.70	137
		Avg R		
Involvement				
Personal Care	8	.21	.67	137
Housework	5	.23	.59	133

Descriptive statistics for the caregiver motivation to care and involvement subscale measures are presented in Table 7. Examination of the motivation to care measures reveals high means and rather small standard deviations indicating that most caregivers are likely to agree or strongly agree that caring for their ill spouse is important to them. Agreement is especially high with the socialization based statements. The standard deviations for the involvement measures are quite large indicating the broad range of caregivers' responses to involvement in care activities. Overall, caregivers more frequently assist with housework than with personal care activities for their ill spouse.

Table 7. Scale Means for Caregiver Motivation to Care and Involvement Subscales Measures

	Mean	S.D.	Items
Motivation to Care (range 1 - 5)			
Socialization	4.35	.65	2
Covenant	3.75	.97	2
Involvement (range 0 - 70)			
Personal Care	8.54	14.56	8
Housework	14.80	16.68	5

Review of the Pearson r linear correlation coefficients for the motivation to care and involvement subscale measures do not reveal significant correlations between the two groups of variables. While the motivation to care scales correlate significantly with each other, these correlations are modest, supporting the contention that covenant based obligations are seen as distinct from socialization based obligations by the caregivers. Please see Table 8.

Table 8. Correlations for Caregiver Motivation to Care and Involvement Subscales Measures

	Social	Covenant	Per Care	Housework
Motivation to Care				
Socialization	1.00	.37**	.06	-.04
Covenant	.37**	1.00	-.17	.00
Involvement				
Personal Care	.06	-.17	1.00	.04
Housework	-.04	.00	.04	1.00

** p < .001

Analysis of Variance

Oneway analysis of variance (ANOVA) is used to determine whether differences in attitudes towards care among gender groups are greater than would be expected by chance.

The first research question in this study was proposed to explore the relationship between gender and socialization based motivation to care statements. The means for husband and wife caregivers and the associated ANOVA tables are presented in Table 9 below.

Research Question #1: Do husband or wife caregivers report stronger agreement with socialization based motivation to care statements?

Table 9. ANOVA Results of Socialization by Caregiver Gender

Group	Mean	S.D.
Men	4.32	.70
Women	4.39	.61

Table 9 (cont'd).

Source of Variation	D.F.	S.S.	M.S.	F Ratio	Prob
Gender Effect	1	.14	.14	.34	.56
Unexplained Variation	135	58.82	.43		
Total	136	58.97			

The results indicate that the mean from the group of husbands does not differ significantly from that of wives in the research sample. Both groups reported strong agreement with the socialization based statements, and the researcher must conclude there is no significant difference in responses of men and women based on the evidence from this sample with regard to attitudes of socialization.

The second research question in this study focused on the relationship between gender and covenant based motivation to care statements.

Research Question #2: Do husband or wife caregivers report stronger agreement with covenant based motivation to care statements?

Table 10. ANOVA Results of Covenant by Caregiver Gender

Group	Mean	S.D.
Men	3.95	.80
Women	3.53	1.09

Table 10 (cont'd).

Source of Variation	D.F.	S.S.	M.S.	F Ratio	Prob.
Gender Effects	1	6.02	6.02	6.63	.01
Unexplained Variation	135	122.52	.90		
Total	136	128.55			

The results indicate significant mean differences between husbands and wives (see Table 10). Based on the F Probability of .01, we know the difference between men and women is significant for the covenant subscale with men expressing, on average, a higher agreement than women that they are motivated by covenant based reasons. However, based on eta squared which assesses the strength of the relationship, only 4.7% of the variation in responses to covenant based statements can be explained by gender.

The third research question in this study addressed the relationship between gender and involvement in personal care activities holding patient functional dependency constant.

Research Question #3: Are husband or wife caregivers more involved in providing assistance with personal care activities for their spouse with cancer, controlling for functional dependency of the patient?

Table 11. ANCOVA Results of Involvement in Personal Care by Caregiver Gender

Group	Adjusted Mean
Men	9.15
Women	7.87

Table 11 (cont'd).

Source of Variation	D.F.	S.S.	M.S.	F	Sig.
Covariate					
PT Dep	1	21833.96	21833.96	419.18	.00
Main Effect					
Gender	1	54.46	54.46	1.04	.30
Explained	2	21888.42	10944.21	210.11	.00
Residual	134	6979.60	52.08		
Total	136	28868.02	212.26		

The results from the ANCOVA (see Table 11) indicate that the source of variation in involvement is primarily due to the covariate, patient functional dependency. Husbands and wives do not differ significantly when dependency is taken into consideration (F-Significance = .30), but greater involvement in personal care activities has everything to do with how functionally dependent the spouse is (the covariate accounts for 75.5% of the variation of involvement) and very little to do with gender of the caregiver (<1% of variation in involvement). It may be noted that the adjusted mean for involvement in such activities is higher for men than for women. This difference, however, is well within normal sample fluctuations.

The fourth research question in this study was proposed to explore the relationship between gender and involvement in housework activities holding patient functional dependency constant.

Research Question #4: Are husband or wife caregivers more involved in providing assistance with housework activities for their spouse with cancer, controlling for functional dependency of the patient?

Table 12. ANCOVA Results of Involvement in Housework by Caregiver Gender

Group	Adjusted Mean
Men	14.43
Women	15.19

Source of Variation	D.F.	S.S.	M.S.	F	Sig.
Covariate					
PT Dep	1	25874.02	25874.02	310.03	.00
Main Effect					
Gender	1	15.82	15.82	.19	.66
Explained	2	25889.84	12944.92	155.11	.00
Residual	130	10849.07	83.45		
Total	132	36738.91	278.32		

Once again, the results from the ANCOVA (see Table 12) indicate that the source of variation in the relationship is primarily due to the covariate (accounting for 70.4% of the variation in involvement in housework), patient functional dependency. Husbands and wives do not differ significantly when dependency is taken into consideration. As in the above analysis, greater involvement in housework activities has everything to do with how functionally dependent the spouse is and very little to do with gender of the caregiver. The adjusted mean for involvement in housework activities is only slightly higher for women than for men.

Multiple Regression

The final research question was explored using multiple regression. This technique enabled the researcher to evaluate the simultaneous effect of a limited number of independent variables on the dependent variable involvement. It provides an index of change in the dependent variable per unit change in any of the independent variables in the equation.

In order to create a measure of caregiver involvement that is not confounded by the patients' functional dependency, residual variables were created to represent the variation in personal care and housework involvement, after patient dependency was factored out. The residual variables were then used as the new dependent variables in the regression equations.

Two new variables were created to represent the interaction effects of gender and each of the motivation to care scales, socialization and covenant. These variables representing interaction effects test whether the attitudes rooted in the two different sources of obligation have <u>different</u> effects on actual involvement for male and female caregivers. Tables 13 and 13a present the findings from this analysis.

<u>Research Question #5</u>: Does stronger agreement with motivation to care statements among husband and wife caregivers result in increased involvement in caregiving activities overall when functional dependency of the patient is controlled for?

Table 13. Multiple Regression of Gender, Socialization (Soc), Covenant (Cov), Socialization X Gender, and Covenant X Gender on Residual Personal Care Involvement

Variables	B	S.E. B	Beta	T	Sig.T
Gender*	-14.03	8.61	-.978	-1.63	.10
Soc	-.69	1.39	-.063	-.49	.61
Cov	-.39	1.21	-.053	-.32	.74
Soc X Gender	3.74	2.08	1.167	1.79	.07
Cov X Gender	-1.06	1.49	-.285	-.71	.47
(Constant)	5.13	5.58		.91	.35

Multiple R	.222
R Square	.049
Adjusted R Square	.013
Standard Error	7.143

F = 1.36
Significance F = .24

Table 13a. Multiple Regression of Gender, Socialization (Soc), Covenant (Cov), Socialization X Gender, and Covenant X Gender on Residual Housework Involvement

Variables	B	S.E. B	Beta	T	Sig.T
Gender*	16.26	10.88	.899	1.49	.13
Soc	1.79	1.77	.130	1.01	.31
Cov	2.18	1.54	.235	1.41	.15
Soc X Gender	-.21	2.63	-.054	-.08	.93
Cov X Gender	-3.93	1.88	-.835	-2.08	.03**
(Constant)	-16.66	7.11		-2.34	.02

Multiple R	.254
R Square	.064
Adjusted R Square	.027
Standard Error	8.945

F = 1.75
Significance F = .12

** $p < .05$

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* Gender: 1 = Female; 0 = Male

Earlier regression analysis performed indicated that the only factor explaining caregiver involvement was dependency of the patient. In the above results, where the involvement directly related to patient dependency is factored out and the remaining involvement is a residual score, involvement in personal care and housework activities are left unexplained by individual variables gender ($p = .10$), socialization ($p = .61$) and covenant ($p = .76$). However, the interaction effect of gender with agreement with covenant based motivation to care statements is significantly related to residual involvement in housework activities (beta = -.835; Sig. T = .03). This means that, for male caregivers, the stronger the attitudes rooted in covenant obligations, the greater the involvement, but, for female caregivers, this is <u>not</u> the case. This was the only statistically significant relationship found between all of the tested independent variables and involvement.

Summary of Findings

The data presented above indicate that only the covenant based motivation to care statements were influenced by gender. In that case husband caregivers tended to score higher than wives in this sample. However, gender did not appear to influence overall levels of involvement in personal care and housework activities once the patient's dependency was held constant. Husbands were as likely to become involved in caregiving activities as wives despite stereotypical gender role divisions in labor. The involvement pattern appears to be driven primarily by patient dependency. The one exception to this pattern is the interaction effect of gender and agreement with covenant based motivation to care statements, and involvement in residual housework activities. As result of this, it must be concluded that among male caregivers, greater agreement with covenant statements also leads them to greater involvement, which is not true among women. Thus, wives with greater personal allegiance for their husbands are not more involved than wives with less personal allegiance, whereas among husbands this was an impetus towards greater involvement. Other than the interaction effect between gender and covenant, it must be concluded that neither gender nor the motivation to care scales utilized are good predictors of caregiver involvement. Both techniques employed to control for patient dependency, (1) the use of the patient functional dependency score as a covariate, and (2) the use of a residual involvement variable, showed the same pattern by gender, and by attitude, with the exception mentioned above. Speculations as to why these patterns emerged will be discussed in the concluding chapter.

CHAPTER V

SUMMARY, CONCLUSIONS AND DISCUSSION

Overview

A summary of the present study and research questions addressed will be presented in this chapter. Conclusions derived from the study findings and research implications will be discussed.

Summary of Study

The emphasis of the present study was on the influence of gender on two aspects of caregiving: 1) motivation to care; and 2) involvement in various caregiving activities; and then whether agreement with motivation to care statements would predict increased involvement.

It was the aim of the researcher to determine whether women or men reported stronger agreement with two different types of motivation to care statements. Socialization based statements were expected to elicit stronger agreement from women as women are socialized to be nurturers and carers throughout their lives. The researcher was uncertain, based on the literature reviewed, whether men or women would agree more strongly with covenant based motivation to care statements.

Finally, the researcher was interested in knowing whether attitudes of strong agreement with motivation to care statements actually did translate into greater involvement in caregiving tasks when patient dependency or need was held constant. Essentially the research question would test whether different types of attitudes of commitment to the caregiving situation would translate into increased involvement behavior. These findings will be summarized in the following section.

Summary of Findings

Analysis of the data used to investigate the relationships between variables of interest allowed the researcher to conclude that gender was not a good predictor of motivational attitudes among married caregivers of spouse cancer patients. A weak relationship did emerge between gender and covenant based motivation to care statements where men's responses were in somewhat stronger agreement than women's with the statements. While the strength of this relationship was weak, the findings could be attributed to feelings of personal affection and gratitude towards the spouse, measured by the covenant based statements. Given the likely self-selection of male caregivers, one would expect this sentiment to be more widespread among men than women providing care.

Gender was also not a good predictor of the level of involvement. The results indicated that most involvement was directly due to the patients' needs. Once patient dependency was controlled for, men were just as likely to provide personal care and do housework as women who were caregivers. Involvement therefore appears to be related to how sick the patient is, i.e. the patient's functional dependency, or possibly other unmeasured variables, but not associated to the gender of the caregiver in this sample.

Agreement with socialization or covenant based motivation to care statements were generally not good predictors of involvement. Here, again, patient dependency appeared to be significantly related to involvement but attitudes of motivation did not. The only exception was found with husband caregivers who strongly agreed with covenant based statements. For these caregivers, stronger agreement led to greater involvement, which was a pattern not found to be true for women. Thus it appears that for women, personal allegiance to their husband does not affect their involvement, but men's involvement <u>is</u> conditional upon personal affection for their wife.

Discussion of Findings

An interest in women's traditional roles as the family carer and nurturer led this researcher to question whether wives would feel more obligated to provide cancer care for their ill husbands than husbands for their wives. Familiarity with Horowitz's research (1985) concerning gender and extent of caregiver involvement prompted interest in whether conclusions that women caregivers do more personal care and housework for the dependent patient than men caregivers could also apply to spouse caregivers.

As the results of this study indicated, men in this sample of caregivers were highly motivated, committed and every bit as involved in the care for their ill spouses as were wives. One possible explanation for the strong devotion and involvement of men may be the self-selection of men who choose to be caregivers. This researcher would like to argue that since society does not expect that men will be carers, men are left to choose whether or not they will accept that role. Women do not have the same luxury. They are expected to care for ill family members with a life-long history of caring for their infants, sick children and even elderly parents. When a husband falls ill there is little question as to who will be the caregiver since it is a "natural role" for women to assume. In the reverse situation, a husband may choose to be his wife's caregiver if he feels compelled perhaps by affection, the covenant of marriage vows taken, or to repay her for years of caring for him and their children. If he chooses not to assume the role, it will likely go to a female family member such as a daughter or sister.

The scale utilized to measure motivation to care in this study included a limited assessment of the motivation behind the decision to care. A more comprehensive assessment could include issues regarding motivation for caring, as well as sense of past socialization to caregiving, perceptions of the commitment within the marriage, history of the relationship, and marital satisfaction. It seems all of these factors could potentially determine how the caregiver might feel about the importance of assuming such a demanding role.

Regarding husband caregivers' high involvement in housework activities, it is possible that men overreported their activities and that women underreported theirs. Particularly in the age group studied (average age was 57 years among caregivers), women have spent most of their lives within the household and may think of housework activities as their job regardless of whether their husband was ill. Women may have interpreted the questions to ask whether their work has increased in each area because of their husband's illness. Men who are doing many of the housework activities regularly for the first time in their lives as result of their wife's illness might report with more accuracy (or possibly overreport) the activities they are involved in and the frequency of their involvement.

It is encouraging to see a group of men so committed and involved in caregiving. Hopefully a new generation of men will grow up realizing that women are not the only ones who can participate in nurturing and caring activities. Socializing only women to be carers is dangerous for them as well as for men. Carol Gilligan has been criticized for insinuating that women are biologically and socially predetermined to be carers. It is important to realize that the assumption that women are "natural" caregivers can be a trap, and a physical and psychological burden for women, and simultaneously a disadvantage for men. Men must be encouraged and taught how to provide care, the way women are, by their mothers, as well as by example by their fathers or other prominent men in their lives. It is also important for women to be able to choose, as men do now, whether or not they wish to assume a role as caregiver for another. Women should not feel it is expected of them to be caregivers, just because they are women and that is what women do, any more than men should be expected to be caregivers just because they are men. Rather, in an ideal world, women would have the same autonomy to choose whether to assume this role as men have, and at the same time, both women and men would see that caregiving is valued and vital work and have the desire to provide care when needed.

Implications for Future Research

If the researcher had the opportunity to design a comprehensive instrument to measure more adequately the concepts of socialization and covenant bases for motivation to provide caregiving to an ill spouse, this instrument would have more items testing each concept in order to reduce the chance for error and increase the validity and reliability of the measurement scales.

A more comprehensive instrument measuring the sociological basis for motivation to care might include an assessment of whether the caregiver believes that caring activities are "women's work" or whether women are "natural carers." It would also be important to assess whether the responsibility to care is an expectation as result of the role as spouse, or because of a religious or moral code that guides the caregiver's decisions, or perhaps because the caregiver is a woman and has learned to believe it is her job to care for an ill family member.

Covenant based motivation to care could be measured more comprehensively if an assessment of the quality of the caregiver's marital relationship, personal affection toward their spouse, marital satisfaction, and meaning of their marriage vows/covenant was included. It would also be imperative to ask whether the caregiver is caring for their spouse because of a personal commitment or because of the societal expectation as result of the marriage vows exchanged.

In light of the findings in the present study regarding the assumed choice that male caregivers seemed to experience in whether to accept the role, it seems important to assess how much choice the spouse actually felt they had in making the decision to take on the caregiver role in order to determine whether men indeed did have greater freedom than women to pass along the caregiving responsibility to someone else. Caregivers could also be queried about whether there was anyone else who could have become the primary caregiver if they were unable or had chosen not to assume the role.

Finally, if designing a new study, this researcher would limit analyses to include only those who had been caregiving for one year or less so that all participants would be relatively new to the caregiving routine and responsibilities, and the motivation leading to the decision to provide care could be recalled from the recent past.

Summary

The present study explored the relationships between gender, motivation to care and involvement in caregiving tasks in an effort to compare how husbands and wives responded in the role as caregiver. Findings from this research reveal that husbands and wives caring for a spouse with cancer were both dedicated and involved when patient need required. Men as a group were very committed and highly motivated as caregivers. This may be indicative of the self-selection of male caregivers. Those men who chose to be caregivers were very dedicated to the role. It is likely that men who did not feel the same dedication chose not to be their wives' primary caregiver, passing that role on to another family member. Women reported a wider range of responses to the motivation to care statements than did men, indicating that whether or not they felt highly committed to their spouse, they were likely to become caregivers anyway.

APPENDICES

APPENDIX A

MOTIVATION TO CARE SCALES

I. Socialization based motivation to care

1. At this time in my life, I don't think I should have to be caring for _____. (R)
2. I believe it is my responsibility to care for _____.

alpha = .44

II. Covenant based motivation to care

1. I am doing more for _____ than he/she ever did for me. (R)
2. I will never be able to do enough caregiving to repay _____.

alpha = .70

5 point scale:
1 = Strongly Disagree
2 = Disagree
3 = Neither Agree Nor Disagree
4 = Agree
5 = Strongly Agree

(R) indicates that item was reversed for analysis purposes.

APPENDIX B

CORNWELL INVOLVEMENT SCALES

How frequently do you help your relative (spouse) with the following activities? (Number of times in one week)

1 = Once a week or less
3.5 = Several times a week (2-6)
7 = Once a day
14 = Several times a day
0 = Doesn't help with this activity

Personal Care Activities (ADL)

1. Dressing and undressing
2. Combing hair or shaving
3. Taking a shower or bath
4. Using the toilet, bedpan or commode
5. Eating
6. Mouth care
7. Clean up when incontinent of urine
8. Clean up when incontinent of stool

alpha = .67

Housework Activities (IADL)

1. Shopping
2. Heavy housework
3. Light housework
4. Laundry
5. Cooking

alpha = .59

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