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GENDER AND SERVICE USE ATTITUDES AMONG SPOUSAL CAREGIVERS OF PERSONS WITH DEMENTIA

By

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ABSTRACT

GENDER AND SERVICE USE ATTITUDES AMONG SPOUSAL CAREGIVERS OF PERSONS WITH DEMENTIA

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The purpose of this study was to determine if there were differences in attitudes towards utilization of community services between elderly male and female spousal caregivers. A secondary analysis was done on data obtained from spousal caregiver respondents interviewed during Wave II of the longitudinal study "The Impact of Alzheimer's Disease on Family Caregivers" (Clare Collins, PhD., Principal Investigator, Grant #2R01-MH 417666-02). The only socio-demographic difference noted between the two groups of caregivers was related to caregiver age. Statistical analysis revealed significant differences between husband and wife caregivers in attitudes toward caregiver independence from the service system and confidence in the service system. Implications of the findings for practice and further research are presented.

To Donald and Chad Michael

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Introduction

Background

According to the U.S. Senate Special Committee on Aging 1987-88, it is projected that by the year 2020, when approximately half of the 80 million "baby-boomers" reach the age of 65 years, 20% of the population will fall into this category. The full significance of the growth in the older population requires that morbidity must be considered. The prolongation of survival by increasingly effective medical technology results in a growing number of people living into old age with on-going health problems, most of which are not life-threatening, but chronic diseases resulting in cognitive and functional impairment (Eliopoulos, 1993). As the population over the age of sixty-five increases rapidly, so do the demands placed on the health care delivery system, especially on those health care providers who will need to broaden their understanding of the needs and concerns of this diverse population.

As America's older population continues to grow, the number of people with Alzheimer's Disease and other dementias, will continue to rise. Dementia is a chronic disease characterized by a decline in intellectual functioning severe enough to interfere with a person's normal daily activities and social relationships (National Institute on Aging, 1995). Although there is no agreement on the exact percentage of people with dementia, studies project that after the age of 65, the percentage of affected people approximately doubles with every decade of life (Evans et al., 1990). Although dementia may be the result of multi-infarct dementia, Huntington's Disease or Parkinson's Disease with dementia, Alzheimer's Disease (A.D.) is the most common cause of dementia among older people, affecting 60% of that population (Office of Technology Assessment, 1987). The marked, progressive and irreversible decline in mental functioning, the personality changes and the impairment in judgment creates, over time, the need for continuous care by others. This creates an increasing incidence of caregiving needs and concerns experienced by the elderly and dealt with by their families.

In view of the growth and vulnerability of this population, development of interventional strategies in direct support of family caregivers is becoming an important clinical and policy priority. Physical, emotional and financial burdens, both experienced and perceived, of caring for a family member with dementia are well documented in caregiving literature. Support for caregivers may come from both informal and formal sources. Informal support includes assistance from the individual's family and friends while formal support consists of health care providers and social/community agencies/services. Whether older persons will actually utilize available community services is a function of many motivating and restraining factors in their lives. Frequently identified influences on service use include: access, availability and knowledge of services, demographic characteristics, strength of informal networks and objective and self-defined need; but an understanding of caregiver attitudes on community service use is required (McCaslin, 1988).

Caregiver/Recipient Relationship

The consensus in the literature is that the primary caregiver for impaired elders will generally be a spouse, followed by adult children (Bass & Noelker, 1987; Wilhoite & Buschmann, 1991; Zarit, Todd & Zarit, 1986). In a study of nonspousal caregivers, Stoller (1990), found that helping patterns among caregivers reflected the cultural division of labor based on gender. Research based on gender differences among caregiving spouses suggest that the demands of the caregiver role are experienced differently by men and women (Pruchno & Resch, 1989) and that while husbands and wives participate extensively in caregiving, they differ in the type of care provided and amount of help they receive with caregiving tasks (Enright, 1991).

Gender influences on attitudes toward caregiving may reflect stereotypical male/female role expectations of husbands and wives. There is no evidence that husbands are less likely to take on the caregiving role for their wives, but are more likely to become secondary caregivers, leaving more of the hands-on care to other formal and informal helpers. There is evidence in the research that husbands are more likely to become primary or secondary caregivers than sons (Stone et al, 1987); thus, gender differences among caregivers should not be treated as if they were uniform across all types of caregivers; the caregiver's relationship to the care recipient is an important role characteristic that can modify gender differences (Dwyer & Seccombe, 1991).

Stoller and Cutler (1992) state, "Spouses are the first line of defense in coping with disease and disability" (p. 313). Spouses provide the most consistent, dependable care and tolerate greater disability for longer periods of time with fewer mediating resources and at greater personal cost than any other caregivers (Horowitz, 1985; Motenko, 1988; Stoller, 1992; Stone, Cafferata & Sangl, 1987). Research has purported that spouse caregivers are at great risk for the negative consequences of caregiving: health problems and role overload. During the time of caregiving, these elder spouses sometimes become enmeshed in the dependency demands of their care recipient, resulting in little time for pursuing other interests or meeting their own needs. Elderly caregivers may have their own physical problems that diminish their ability to respond to the increasing demands of caregiving as their spouse's disability increases and they feel a greater obligation to provide care (Barnes, Given & Given, 1992; Lindgren, 1993).

One of the many dimensions that could be problematic for meeting the needs of the spousal dyad is a lack of utilization of the community services, both informal and formal, available to support the caregiving skills of the person expected to provide care. While various motivations and barriers contribute to the pattern of service use, the concept of attitudes toward the utilization of services available has not been adequately studied. Therefore, the focus of this study is to describe the attitudinal differences of caregivers of spouses with dementia toward community service use based on gender.

Review of Literature

Attitudes toward Community Service Utilization among Dementia Caregivers

Community support services are the means by which the formal system can improve care recipient's functioning and enhance caregiver effectiveness. They are not intended to replace the caregiver's or the care recipient's natural support network or areas of independent functioning, but to provide services that cannot be performed by the older adult or his/her informal support system (Maslow, 1990).

Though perceived by providers as important elements in assisting the maintenance of the elderly in the community by promoting the highest level of functioning, enhancing the quality of life for both the care recipient and the caregiver; empirical evidence indicates a pattern of service use where many services were used often by a few caregivers of dementia, while the majority used few services infrequently or not at all (Lawton, Brody & Saperstein, 1989, Stommel, Given & Given, 1990). While this pattern is found in caregiving of the physically impaired (Gwyther, 1988; Stone, Cafferata & Sangl, 1987), it was reported in the studies by Stommel, Given & Given (1990) and Bass, Looman & Ehrlich (1992) that caregivers of family members with dementia used only half as many community services as those caring for the physically impaired. Studies have shown that increased physical disability in the recipient and care-related health changes (need factors) in the caregiver predict the use of formal services and that when services are used by caregivers it is often very late in the caregiving process, when the needs for assistance exceed the resources of the informal network (Noelker & Bass, 1989; Stoller & Cutler, 1993 and Winslow & O'Brien, 1992).

A study by Lawton, Brody and Saperstein (1989) on the use of respite services for caregivers of Alzheimer's patients found that the impact of the intervention was minimal due to the reluctance of caregivers to seek assistance. The data supported the tendency of many AD patients and their caregivers to become socially isolated and not use the social supports and services that are available. The reluctance of caregivers to seek assistance from community resources can result from various barriers to usage, but attitudes toward caregiving, having a family member with cognitive impairment and the utilization of services are factors that influence the decision.

The influence of caregiver attitudes on the decision to use community services has been cited in anecdotal reports of demonstration projects (Gwyther, 1988; Lawton, Brody, and Saperstein, 1989; Montgomery & Borgatta, 1989) and studies of the elderly (Harel, Noelker and Blake, 1985), where categories of caregiver attitudes reflected: a) attitudes regarding the acceptability of using the formal service system and b) attitudes about the quality of services. Commonly cited attitudes among caregivers with dementia included: 1) the belief, based on ethnic or cultural role expectations, that caregivers should/need to provide all the care required by an impaired relative without the assistance of informal or formal systems; 2) that it is preferable to use assistance from family and friends rather than relying on formal providers, and 3) preferring to be independent of the service system (Collins, King, Given & Given, 1994). Other concerns, based on beliefs/experiences with formal services involve relinquishing control of family concerns to strangers and concern that the quality of the care for the cognitively impaired family member would be appropriate and adequate to meet their special needs (Bass, McCarthy, Eckert & Bichler, 1994; Gwyther, 1988, 1990).

In a retrospective study on utilization of support services by family caregivers to Alzheimer's patients, negative service attitudes were assessed. The first measure, inadequacy of services, reflected respondents agreement that services were not used because someone in the family felt the quality of service was not good (i.e., service providers do not provide good care, cannot be trusted and do not give care as well as the care given by family members). The second measure, denial of the illness, reflected the respondents perceptions that someone in the family avoided the use of services because they did not accept the Alzheimer's disease (i.e. didn't want to admit there was a problem, afraid to find out what was wrong and didn't want person's outside the family knowing about the illness). In the sample of respondents in the Information and Referral Group (I & R), that is directed toward families dealing with earlier stages of the disease, users were more likely to report negative attitudes than the Educational or Support Groups (Bass et al., 1994).

A qualitative study by King, Collins & Liken (1995) identified four themes reflecting attitudes based on beliefs, values and social norms. <u>Family/caregiver sense of obligation</u> was modeled by role behaviors observed within the family unit reflecting how problems were handled and the acceptability of assistance from outside the boundaries of the family. <u>Family/caregiver as owner of the difficulties</u> expressed the belief, especially by spouses, that problems were kept within the family unit and not allowed to become problems for others. In addition, beliefs of the care recipient might out-weigh the beliefs of the caregiver in determining who should provide care. Control of and trust in the quality of care being provided were values expressed by <u>families/caregivers as protectors of vulnerable members</u>. The sense of need to be able to reciprocate for assistance received appeared to define the extent to which assistance was most acceptable from formal or informal sources. In the attitudinal theme of <u>family/caregiver as self-reliant units</u>, the value of independence, not feeling as sense of personal obligation, of taking advantage of others or becoming dependent on outside assistance was expressed. Reciprocity was indicated as a motivation for caregiving within the family unit as a means of "paying back" the recipient for past caring.

Consideration of attitudes constitutes the first step toward an understanding of why people behave they way they do. The consensus among researchers is that attitudes are determined by the beliefs individuals hold about themselves and their environment and the value placed upon them. Norms are also a function of beliefs. Sociologically defined as: "shared rules, guidelines or beliefs that prescribe the behavior appropriate in a given situation or under particular circumstances" (Robertson, 1987, p.62). Norms provide guidelines for individual behavior and reliable expectations for the behavior of others. The function of norms is so culturally important that there is always strong social pressure to conform. In the course of a person's life his experiences lead to the formation of many different beliefs about various objects, actions and events. They may be the result of direct observation, acquired indirectly by accepting information from outside sources or they are self-generated through the inference process (Ajzen & Fishbein, 1980; Robertson, 1987). For purposes of this study, attitudes towards community services will be conceptually defined as those beliefs, values and social norms held by caregivers that influence the decision to utilize formal services.

Gender Influences on Attitudes toward Caregiving

Given, Stommel, Collins, King & Given (1990) state that characteristics of caregivers shown to predict responses to caregiving include age, sex, marital status, physical and mental health status, employment and other role obligations. Including primary caregiver's characteristics into the study of the factors that influence service use expands the potential for understanding use. Gender differences are believed to influence the amount and type of care provided, access to social resources that may alleviate caregiver strain, and appraisal of the caregiving experience (Miller, 1987, 1990; Miller & Cafasso, 1992; Pruchno & Resch, 1989).

Gender differences in attitudes and behavior are the result of pervasive gender role values, beliefs and subjective norms found in our society. These attributes become the stereotypes for masculine and feminine characteristics that tend to be internalized by the person. From these stereotypes emerge assumptions, expectancies and attitudes about gender roles and their enactment (David & Bannon, 1976, O'Neil, 1982). Based on and influenced by economic and social conditions along with technological and medical advances, cohorts/generations may enact gender roles differently.

The current population of elderly spousal caregivers was born in what Sheehy (1995) describes as the "World War II Generation (1914-1929)" (p.27), a period when gender roles were strictly differentiated. Research in the literature proposes that dimensions associated with masculinity: exercising power and control over others, being (and being recognized as) a person of strong will, a leader who will get things done; and strength, toughness and stamina to undertake long, grueling work and endure severe bodily stress, (David & Brannon, 1976; O'Neil, 1982; Solomon, 1982) formed the basis of the male gender role for this generation. Thus men saw life in terms of "missions", approached problems through organization, top-down hierarchies and authority. Shaped by this socialization pattern, men became convinced "they must remain forever strong, virile, the providers for and protectors of their families and without doubts, needs or fears that require expressing feelings" (Sheehy, 1995).

Women were socialized to be kind and caring, obedient and dependent on men or powerful others, responsible, unselfish and to assume the nurturing role for the family. Self-identity was/is connected to domestic and family matters and women seemed to place greater importance on external or interpersonal sources of esteem rather than objective accomplishments. Because of this societal expectation about the appropriate role of women, women tend to feel obligated, and men expect them, to provide care to the recipient (Brody, 1989; Noelker and Bass, 1989).

Some studies have suggested that older women become more instrumental and assertive as they age; focused, more interested in tasks and accomplishments than nurturing: whereas older men become more expressive and show greater interest in nurturing and being nurtured (Gutman, 1994; Sheehy, 1994; Zarit et al., 1986). This does not negate or enhance their roles as caregivers as men and women come to this role from opposing directions. In a study by Miller (1987) the dominant pattern of caregiving appeared to be congruent with previous role behaviors. Female caregiving was viewed as an extension of the nurturing component of their earlier roles as homemaker and care provider. For men, being in charge of another person was an extension of his role as authority figure in the home and at work. While nurturing may be a new experience for some men, taking charge of a situation is not; Miller (1987) found male's assumption of authority, sense of control over a situation and ability to manage/delegate care routines to be an effective enactment of a caregiving role.

Husbands and wives cannot easily evade their responsibility for caregiving, confronted by a set of social expectations and obligations concerning support for each other's instrumental and emotional needs, but they may discharge their caregiving responsibilities in ways that reflect gender specific patterns of caring. In this study, it is hypothesized that male and female caregivers will differ in their attitudes towards the use of community services.

Relationship Between Gender and Attitudes toward Community Service Use

Little research has been done to examine the attitudinal differences that may exist within the population of caregivers and the relationship of these attitudes to the inclination to use services.

Some studies found that husband caregivers are likely to receive greater social support and marshal more resources, including additional informal help and formal services, than wife caregivers (Allen, 1994; Stone, Cafferata & Sangl, 1987; Zarit, Todd & Zarit, 1986); while others determined that husbands used only occasional formal and informal assistance (Miller, 1990; Motenko, 1988) and that women were more likely to have informal and formal help assisting them (Chappell, 1989). Research has shown that the caregiver's sex is a factor differentiating which types of service combinations are used: women used formal services to supplement their caregiving, whereas men used formal services to provide care different from what they were providing (Bass, Looman & Ehrlich, 1992).

Despite the discrepancies and inconsistencies in usage patterns between husbands and wives, there is no research literature on why this is so; just speculation that gender and kinship influence the interaction with formal and informal support systems.

Purpose of Study/Research Question

While utilization of community services is acknowledged to be influenced by a multitude of factors, it is not within the scope of this study to investigate all of these variables. The focus of this study and specific research question is " Are there differences in attitudes towards utilization of community services between elderly male and female spousal caregivers?"

Conceptual Framework

The beliefs, values and social norms which make up the attitudes toward family responsibility and community service use are variable and can influence the caregiver's decision to seek assistance with caregiving. The concept of gender/kinship influence on caregiving is closely reflective of the relationship between gender/kinship and attitudes toward community service use.

As a means of understanding and predicting behavior, Azjen & Fishbein (1980) developed the Theory of Reasoned Action. Based on the assumptions that people are rational, make systematic use of information available to them and consider the implications when making decisions about initiating an action/behavior, a person's intention/or volitional choice is the immediate determinant of the that behavior. In order to understand that choice or intention to perform the behavior, the determinants, or the components that influence the decision, must be identified.

Personality characteristics, demographic variables (i.e. sex, age, race, socioeconomic status, religion and education) and social values/perceptions about objects or institutions (i.e. marriage, parenting, social roles) are considered external variables which may form or influence beliefs. These personal beliefs concerning the performance of the behavior involve outcome evaluations and motivations to perform or not perform the behaviors. Attitudes toward the behavior, a judgment that performing the behavior is either "good or bad" involving a perception of social judgment, are based on these beliefs. According to the theory of reasoned action, intention to perform a behavior is a function of attitudes.

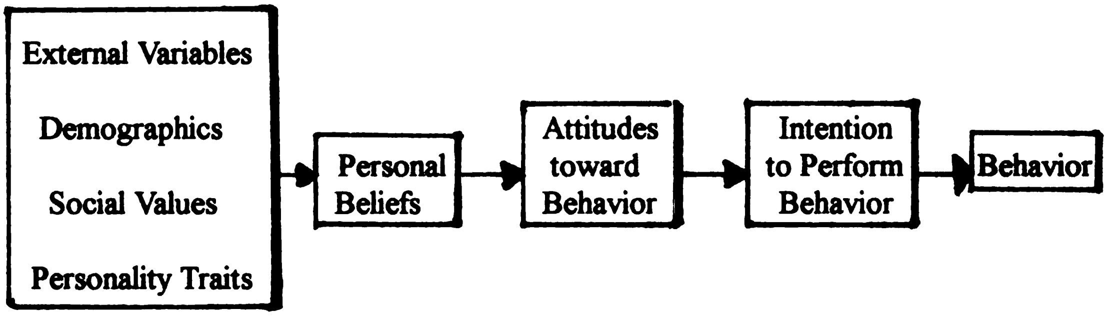

Figure 1-Effects of external variables on behavior (Ajzen & Fishbein, 1980)

This theory emphasizes attitudes toward behaviors rather than toward objects or institutions and can be adapted to help focus the discussion on the influence of gender/kinship on attitudes toward community service utilization. The intention of the author is not to examine these relationships in terms of actual service use.

The adapted model of Azjen & Fishbein's Theory of Reasoned Action reflects the components of the decision-making process.

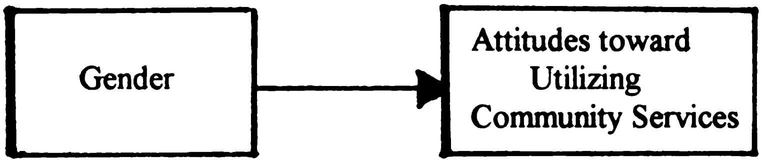

Figure 2-Adaptation of Reasoned Action Model

An individual's perception of husband/wife gender role expectations are the external variables that influence attitudes toward seeking and utilizing community services. For example, a husband who perceives himself as "strong, tough, able to do it alone", one who values his independence, coupled with the perception that society expects a husband to take care of his wife may believe he is totally capable and responsible for providing care and therefore be unwilling or emotionally unable to seek, ask or utilize informal support or community services. In contrast, he may believe that caregiving is primarily a female endeavor and seek assistance from female informal or formal caregivers. Gender/kinship expectations influences beliefs and values; beliefs and values are the determinants of attitudes and subjective norms; and attitudinal differences do result in differences in the intention to utilize community services.

Study Relevance

Whether older persons will actually utilize available community services is a function of many motivating and restraining factors in their lives. As mentioned in the research literature, caregiver's sociodemographic characteristics and attitudes would be predisposing factors toward utilizing community services (Ajzen and Fishbein, 1980, Bass and Noelker, 1987; Given et al., 1990).

Situations in which a husband finds himself to be sole caregiver are likely to become more common in the future, given declining family size, decentralization of the family and increasing proportions of women entering the labor force (Kaye & Applegate, 1990). The issue of utilization of community services to assist in meeting client needs can be pertinent to elderly male spouse caregivers who were socialized in a era of division of labor along gender role lines and live in a society where caregiving is predominantly a female endeavor. Much of the data generated from caregiving research supports gender-role socialization theory, as most of the current cohort of elderly people exhibit traditional attitudes regarding gender roles in the attitudes toward caregiving, division of labor, caregiver burden and actual receipt of community services (Fitting & Rabins, Lucas, & Eastham, 1986; Harris, 1993; Motenko, 1988; Stoller and Cutler; 1992; Stone, Cafferata and Sangl, 1987), but this data does not address caregivers' attitudes toward community services.

The dominant subjects of caregiver research have been women. Community services are planned and developed based on the perceived needs of the clients, thus if interventions are initiated based on current caregiving samples then most of the interventions may be more effective for women than men. Little empirical research has been done to examine the attitudinal and normative differences that may exist within the population of caregivers in relation to the attitudes forming the inclination to use community services and little information is available on the adequacy and appropriateness of informal and formal support services required by the elderly male spouse.

For these reasons, the study of caregiver attitudes towards utilizing services is important to determine if current services are both appropriate and acceptable to both male and female caregivers; to design programs and offer various types of assistance that address the needs and concerns of both male and female caregivers; to identify attitudes that serve as barriers to utilization of services; as well as to develop strategies to promote their usage. Understanding these attitudes can promote effective collaboration between healthcare providers, service providers and the caregivers/care recipients who can benefit from the services offered.

Advanced Practice Nurses in primary care practice are in the position of providing efficient, cost effective health care at the individual and community level. Information regarding attitudes toward utilizing services will guide the provider's counseling and advocacy efforts in support of the caregiver/recipient dyad and assist in the referral to the most appropriate and acceptable community service available. Information concerning clients' attitudes toward community services is invaluable in developing policies and programs, at the local, state and federal levels, for delivering community-based services that are acceptable to caregivers providing care to their spouses with dementia.

Methods

Research Design:

A secondary analysis was conducted on data collected as part of a four year, three wave, longitudinal study (1988-1992) of family caregivers of relatives with dementia who reside in the community (RO1-MH 417666-02, "The Impact of Alzheimer's Disease on Family Caregivers," Principal Investigator-Clare Collins, R.N., Ph.D.). Funded by the National Institute of Mental Health, one aim of the study was to describe community service use patterns of family caregivers of relatives with Alzheimer's Disease and other dementia; including the need for and barriers to use of services. Data for the analysis of gender differences in attitudes towards community service utilization was extracted from this section of the original study.

Present Study

As the data for this study is based on a secondary analysis, the research on the relationship between gender and attitudes toward utilization of community services was developed using a non-experimental, descriptive design. The design is non-experimental in that the independent variable, gender, is a human characteristic not subject to manipulation and the subject under study is not amenable to the other experimental requirements, control and randomization. It is a descriptive study in that the research is more concerned with describing how one variable, gender (independent), is related to another, attitudes toward community services (dependent), than in determining a cause-and-effect relationship.

Sample Procedures:

Original Study

The target population for the original study was family caregivers of relatives with dementia who reside in the community. A convenience sample of family caregivers (n=180) was located through mailings distributed by local chapters of the Alzheimer's Association, the Michigan Association of Adult Day Care Centers and health agencies in southwest Michigan. A cover letter explaining the study and return postcards were sent to Adult Day Care Centers, home health care agencies, and geriatric clinics. Clinicians were asked to distribute information to the families in their agencies. Families interested in participating in the study were asked to return the postcard indicating their name, address and the best time to contact them. A direct mailing was done by the Michigan chapter of the Alzheimer's Association to individuals on their mailing list using the same card back system. In addition, recruitment was enhanced by the use of local radio and television spots and posted information about the study in local libraries and church bulletins. Potential participants were then screened by data collectors to determine if they met the eligibility criteria of the study.

The criteria for entry into the original study by caregiver/patient dyads included the following: 1) the patient was at least 55 years old; 2) the patient was dependent in at least one instrumental activity of daily living (IADL) and one activity of daily living (ADL); 3) the patient had received a diagnosis of Alzheimer's disease or other progressive dementia: 4) the caregiver was self-identified as the family member providing the most care to the relative with dementia; and 5) the patient with dementia was residing in the community at the time of data collection. Participants were involved in the second wave of the original study and all had completed the self-administered booklet.

Present Study

The gender samples (those meeting criteria) was drawn from the original convenience sample and was small and fairly homogeneous. Inclusion in this study of attitudes toward community service use included all of the original criteria, plus the restriction that the caregiver is the care recipient's spouse and that the caregiver is 55 years or older. By narrowing the inclusion criteria, control of extraneous variables was attempted, though it limits the population to which the study can be generalized. Requiring the patient to be living in the community and dependent in ADLs and IADLs supports the reason for caregiving and the possible need to consider community resources. Restriction to caregivers of clients with Alzheimer's disease or dementia and designation as the primary caregivers attempts to control for the variable of whose attitudes are being reflected, as the caregiver in this instance usually makes the decisions. By restricting participation to a specific age group, a cohort influence may be introduced in attempting to control for possible additional extraneous variables that could be introduced by younger caregivers, such as employment, presence of young children and history. Designating the relationship to the care recipient as spouse, generally controls for variables of residence and attitudes based on marital vows.

Data Collection Procedures:

Original Study

Participants were informed that they would be participating in a longitudinal study that would involve several encounters both by telephone and mail. They were told that participation in the study was entirely voluntary and that they could withdraw at any point. Confidentiality was explained to the participant and informed consent was signed.

The subjects enrolled at the second data collection point of the study participated in an extensive telephone interview conducted by a trained research staff member. Interview training procedures are described in Collins, Given, Given and King (1988). In addition, each study participant completed the self-administered booklet containing the Community Service Attitude Inventory (CSAI) which was mailed to them (Appendix A).

Present Study

The use of a secondary data precludes control over data collection procedures. This researcher does not know the content of the interview format or what instructions were given to the participants, in relationship to how they were to respond to the statements on the CSAI, that could have influenced their responses. No mention of respondent's literacy abilities was mentioned.

Prior to any data analysis, the University Committee on Research Involving Human Subjects at Michigan State University approved the use of the identified sample for this study (Appendix B).

Operational Definition of Variables:

In this study attitudes towards community services are operationalized as scores on the five sub-scales of the Community Service Attitudes Inventory (Collins, Stommel, King

& Given, 1991). Caregivers were asked to respond to 25 items that measured five dimensions of attitudes toward community services derived from the research literature and independent data accumulation. The five sub-scales of the CSAI measure: 1) concern for the opinion of others (6 items); 2) confidence in the service system (8 items); 3) caregiver preference for informal care (4 items); 4) belief in caregiver independence (4 items); and 5) acceptance of governmental services (3 items). Answers to the individual items were recorded on a four-point Likert scale for scoring: 1=strongly disagree, 2=disagree, 3=agree and 4=strongly agree.

Gender is operationalized as the sex (male or female) of the caregiver as indicated in the original study data.

Instrumentation:

The instrument utilized to measure the concept of attitudes toward utilization of community services was the CSAI, developed by Collins et al. (1991). It is a summated rating scale composed of five subscales. Internal consistency of the subscales, the best method of assessing the sampling of items which is a source of measurement error, was evaluated by use of Cronbach's alpha and ranged from 0.74 to 0.84. Specifically: 1)concern for the opinion of others (.84); 2) confidence in the service system (.78); 3) caregiver preference for informal care (.78); 4) belief in caregiver independence (.74); and 5) acceptance of governmental services (.74). Reliability coefficients usually range between 0.0 and 1.00. In general, the higher the coefficient the more stable the measure and, in practice, reliability coefficients greater than .70 are considered satisfactory for group-level comparisons, thus the scales have an acceptable levels of internal consistency. (Polit and Hungler, 1995).

Validity is the degree to which an instrument measures what it is supposed to be measuring. The CSAI appears to have face validity in that the questions and categories of the subscales appear to be related to the attitudes in question. This is only pertinent in that the other types of validity, content, criterion-related and construct, have been demonstrated. Content validity, concerned with the sampling adequacy of the content area, was enhanced by the use of focus groups and intensive interviews with individual caregivers to determine prevalent themes/attitudes and use of a panel of experts to analyze the items for representativeness of the construct. Construct validity of the instrument was tested by predicting a relationship between scores on the CSAI scales and two measures of present and past service use of three specific community services (visiting nurses, home-health aides, and adult day care). Predictions were based on: 1) the frequency of current service use (within the 3 months prior to the interview), and 2) the number of these services (0-3) ever used for the care of the individual with dementia. Construct validity of the subscales was identified through use of principle component factor analysis followed by a varimax rotation performed on the selected items (Collins, 1991). All items that met the statistical criteria were further examined for theoretical fit with the subscales. The formation of the five scales resulted from these procedures. Interscale correlations were low, ranging from .11 to .38, suggesting that the scales reflect distinctive attitudes (Collins, 1991; Polit and Hungler, 1995).

The final version of the CSAI is an easily administered, brief (25 item), self-administered instrument using a four-point Likert scale that ranged from strongly agree (1) to strongly disagree (4). Instructions for completing the instrument were given at the beginning and included the caveat that the services considered should include visiting nurses, home health aides or companions, adult day care or family support groups; not hospitals, nursing homes, adult foster care or doctor visits. Examples of statements within the subscales include: People outside my family would think less of me if I used services; I would rather use community services that ask for help from family; and I believe in the idea that families should care for their own and not ask for outside help (Collins, 1991).

Results

The findings described in this section are compiled from the self-reported CSAI questionnaires of 39 male and 80 female spousal caregiver subjects eligible for this study. Tables showing sociodemographic and scale characteristics of the samples and tables giving the results of the data analysis are included.

Sociodemographic Characteristics

This sample of caregivers, drawn from the original study of 182 subjects, were predominantly white (96%), female (67%) and had at least a high school education (82%). The majority of caregivers were unemployed (77%) and caring for a spouse with a diagnosis of Alzheimer's Disease (81%). The average household income was $25,858 and the average caregiver age was 68.5 years. The average years of caregiving was more than five years (Mean=5.5, SD=4.37). Table 1 presents the sociodemographic characteristics of the combined caregiver sample, the male (n=39) and female (n=80) group samples and results of significance testing ($p<.05$). Chi Square tests of significance between the male and female samples revealed no significant difference in the composition of the two groups on the variables of race, education, employment and caregiver recipient diagnosis. T-Tests for the differences in mean caregiver age, income and duration of caregiving between the male and female samples revealed a significant difference in the composition of the groups in regard to age, p=.00. Male spousal caregivers were, on average, four years older than female caregivers.

Table 1 - Demographic Variables for the Male and Female Spousal Samples

Caregiver Characteristics	**Combined Group (n=119)**	**Male Caregivers**	**Female Caregivers**	**Sign. Test for Difference (t-test or Chi-square) p<.05**
Gender	119 (100%)	39 (33%)	80 (67%)	
Caregiver Age (yrs)				
Mean	68.50	70.94	67.32	**p=.00**
SD	7.187	7.38	6.83	
Race				
White	114 (96%)	38 (97%)	76 (95%)	p=.74
Non-white	5 (4%)	1 (3%)	4 (5%)	
Education				
Less than HS	22 (18%)	7 (18%)	15 (19%)	p=.46
High School	78 (66%)	23 (59%)	55 (69%)	
College/Higher	19 (16%)	9 (23%)	10 (12%)	
Employment				
Employed	27 (23%)	11 (28%)	16 (20%)	p=.31
Not Employed	92 (77%)	28 (72%)	64 (80%)	
Household Income				
Mean	25,858	29,529	24,125	p=.08
SD	14,971	17,837	13,194	
Patient Diagnosis				
Alzheimer's Ds.	96 (81%)	32 (82%)	64 (80%)	p=.30
Other	23 (19%)	7 (18%)	16 (20%)	
Duration of Caregiving (yrs)				
Mean	5.45	5.40	5.48	p=.92
SD	4.37	3.46	4.77	

Scale Properties of the Male and Female Spousal Samples

Subscale characteristics are presented in Table 2. Cronbach' Alpha was utilized to determine the internal consistency of the Community Service Attitude Inventory subscales. Polit & Hungler (1995) describe alpha coefficients of .60-.70 as adequate levels of reliability when making group-level comparisons. The coefficient alphas of the subscales for the original sample ranged from 74. to .84.

In the present study of the male and female spousal caregivers, the alpha coefficients for the combined spousal sample was comparable to those of the subscales for the original sample with a range from .71 to .79. Alpha coefficients for the male sample ranged from .52 to .84; while the alpha coefficients for the female sample ranged from .68 to .79, a much more homogeneous grouping and again, comparable to the combined sample and original sample ranges. The coefficient alpha for the subscale Concern for the Opinion of Others was the highest for the female sample and one of the lowest for the male sample (.82, .71). The coefficient alphas on the subscales Preference for Informal Care and Belief in Caregiver Independence were the highest for the male sample (.84, .82), while being the lowest for the female sample (.70, .68). This indicates that these subscales have a high internal consistency reliability in measuring these attitudes and beliefs for this male sample, while the low alpha coefficient (.52) indicates that the subscale Acceptance of Government Services may not be a reliable measure. Though the combined-sample group scale properties were fairly consistent with the original sample, the exception of the subscale Concern for the Opinion of Others (.79 vs .84) the scale properties for the male and female spousal samples exhibited a wider variability. This may indicate that sample size, as well as gender may influence the coefficient alpha. The original sample included caregivers who had relationships to the care recipient, other than spousal; it may be that that factor also causes fluctuations in scale properties. These fluctuations raise questions about the reliability of using the subscales on other population samples.

Table 2 - Scale Characteristicsfor Samples: Caregiver Relationship and Spousal Gender

CSAI Subscales	**Scale Mean***	**SD**	**Scale Range**	**Cronbach's Alpha**	**Interitem Correlation**
Concern for the Opinion					
Total Original Sample	1.71	.41	1.0-4.0	.84	.47
Combined Sample					
Spouses (n=113)	1.72	.36	1.0-2.7	.79	.39
Male	**1.78**	.33	1.0-2.7	.71	.30
Female	**1.69**	.37	1.0-2.7	.82	.43
Confidence in Service					
Total Original Sample	2.77	.37	1.6-4.0	.78	.32
Combined Sample					
Spouses (n=109)	2.76	.36	1.6-4.0	.78	.31
Male	**2.64**	.38	1.6-3.6	.75	.30
Female	**2.82**	.34	2.0-4.0	.78	.30
Informal Care					
Total Original Sample	2.31	.50	1.0-3.8	.78	.47
Combined Sample					
Spouses (n=111)	2.30	.49	1.0-3.8	.76	.44
Male	**2.39**	.52	1.3-3.8	.84	.58
Female	**2.24**	.46	1.0-3.3	.70	.37
Caregiver Independence					
Total Original Sample	2.25	.48	1.0-3.5	.74	.43
Combined Sample					
Spouses (n=110)	2.26	.49	1.0-3.3	.75	.44
Male	**2.45**	.48	1.3-3.3	.82	.54
Female	**2.19**	.47	1.0-3.3	.68	.36
Government Services					
Total Original Sample	2.96	.59	1.3-4.0	.74	.49
Combined Sample					
Spouses (n=111)	2.97	.56	1.7-4.0	.71	.45
Male	**2.85**	.46	1.7-3.7	.52	.27
Female	**3.03**	.61	1.7-4.0	.75	.52

* Likert Scale: 1=strongly disagree 2=disagree 3=agree 4=strongly agree
(higher mean scores indicate increased belief in dimension of attitude)

Interscale correlations for both samples were computed to test the degree of relationship between the individual subscales (Tables 3 & 4). Directional changes in the correlations are noted between the two samples with absolute difference ranges from .06 to .64. For example, in the male caregiver sample Concern for the Opinion of Others and Acceptance of Governmental Services are positively correlated (.27), while in the female caregiver sample they are negatively correlated (-.37). Differences in subscale correlations between the male and female spousal caregivers appear to reflect variations based on gender. The male sample showed a more negative correlation between Belief in Caregiver Independence and Confidence in the Service System than did the female sample, while the female spousal sample reflected a strong negative correlation between Acceptance of Government Services and Belief in Caregiver Independence. These findings suggest that the attitude structure between the two groups may be different.

Ranges for the male caregiver sample were from -.62 to .35. For the female caregiver sample, correlations ranged from -.52 to .48. Despite the directional differences, moderate correlations in the male sample subscales Belief in Caregiver Independence and Confidence in Service System (-.62) and the female sample subscales, Belief in Caregiver Independence and Acceptance of Governmental Services (-.52) and Belief in Caregiver Independence and Preference for Informal Care (.48), the over-all low interscale correlations suggest that the subscales do represent distinct attitudes and supports the use of the separate subscale scores to reflect individual attitudes rather than the use of the total CSAI score. Low interscale correlations were found with the original sample (Collins, 1991).

Table 3 - Interscale Correlations of Male Spousal Caregiver Sample

Subscales	Concern	Confidence in Services	Informal Care	Independence	Gov't Services
Concern for the Opinion		-.39	-.00	.35	.27
Confidence in Services			-.08	-.62	.08
Informal Care				.16	-.14
Independence					-.12
Government Services					

Table 4 - Interscale Correlations of Female Spousal Caregiver Sample

Subscales	Concern	Confidence in Services	Informal Care	Independence	Gov't Services
Concern for Opinion		-.33	.23	.30	-.37
Confidence in Services			-.36	-.35	.22
Informal Care				.48	-.28
Independence					-.52
Government Services					

Comparison of Mean Differences on Attitude Subscales

Two-tailed t-tests were utilized to test the significance of the differences between the male and female spousal caregiver samples on the five attitude subscales of the CSAI (see Table 2 for Means and S.D. by subgroup) and were verified by an Analysis of Variance (Table 5). Statistically significant ($p<.05$) differences between the male and female sample groups were found in attitudes related to Confidence in the Service System ($p=.011$) and Belief in Caregiver Independence ($p=.008$). Significantly more male spousal caregivers held the belief of caregiver independence than female caregivers (mean=2.45 vs 2.19); they also had significantly less confidence in the service system (mean=2.64 vs 2.82). Though not statistically significant, the subscale means of the male spousal caregivers suggested more agreement with the attitudes, Concern for the Opinion of Others (mean=1.78 vs. 1.69) and Preference for Informal Care (mean=2.39 vs 2.24) and less belief in Accepting Government Services (mean=2.85 vs 3.03) than the female caregiver sample.

Table 5 -Analysis of Variance: Subscale Scores by Spousal Gender

Source of Variance	**Sum of Squares**	**df**	**Mean Squares**	**F-ratio**	**F-probability**
Concern for Opinion of Others					
Between Groups	.1752	1	.1752	1.3500	.25
Within Groups	14.4038	111	.1298		
Total	14.5790	112			
Confidence in the Service System					
Between Groups	.8207	1	.8207	**6.6565**	**.01**
Within Groups	13.1921	107	.1233		
Total	14.0128	108			
Preference for Informal Care					
Between Groups	.5206	1	.5206	2.2806	.13
Within Groups	24.8792	109	.2282		
Total	25.3998	110			
Belief in Caregiver Independence					
Between Groups	1.7019	1	1.7019	**7.6073**	**.01**
Within Groups	24.1611	108	.2237		
Total	25.8629	109			
Acceptance of Government Services					
Between Groups	.7787	1	.7787	2.4531	.12
Within Groups	34.6002	109	.3174		
Total	35.3789	110			

Analysis of Covariance

ANCOVA was computed next to test for the significance of differences in group means after first adjusting the scores on the dependent variables to control for the effects of age. Age was chosen as the covariate because of a significant difference was noted in the age composition of the male and female spousal samples with male caregivers being older that female caregivers. In addition, chronological age groupings have been shown to produce a cohort effect, theoretically influencing beliefs and attitudes. Further supporting the data from the t-tests and Anova, review of the subscale Confidence in the Service System shows that after controlling for the effects of age, the group/gender effect (main effect) remains significant at the .028 level; the subscale Belief in Caregiver Independence data indicates that the group/gender effect is significant at the .005 level.

The focus of this study and specific research question was " Are there differences in attitudes towards utilization of community services between elderly male and female spousal caregivers?" Gender differences in attitudes towards utilizing community services was demonstrated among husband and wife caregivers with regard to a belief in caregiver independence and attitude of confidence in the service system. No gender differences with regard to a concern for the opinion of others, a preference for informal care or of accepting governmental service were demonstrated.

Table 6 - Analysis of Covariance: Subscale Scores for Gender with Age as a Covariate

Source of Variance	**Sum of Squares**	**df**	**Mean Squares**	**F-ratio**	**F-probability**
Concern for Opinion of Others					
Covariate-Age	.223	1	.223	1.695	.196
Main Effect-Group	.319	1	.319	2.419	.123
Explained	.444	2	.222	1.686	.190
Residual	13.574	103	.132		
Total	14.018	105	.134		
Confidence in Service System					
Covariate-Age	.012	1	.012	.100	.752
Main Effect-Group	.608	1	.608	**4.977**	**.028**
Explained	.612	2	.306	2.507	.086
Residual	12.572	103	.122		
Total	13.184	105	.126		
Preference for Informal Care					
Covariate-Age	.822	1	.822	3.822	.053
Main Effect-Group	.667	1	.667	3.104	.081
Explained	1.217	2	.609	2.831	.064
Residual	22.149	103	.215		
Total	23.366	105	.223		
Belief in Caregiver Independence					
Covariate-Age	.009	1	.009	.040	.843
Main Effect-Group	1.857	1	1.857	**8.093**	**.005**
Explained	1.904	2	.952	4.149	.018
Residual	23.635	103	.229		
Total	25.539	105	.243		
Acceptance of Government Services					
Covariate-Age	15080	1	1.080	3.435	.067
Main Effect-Group	.214	1	.214	.679	.412
Explained	1.590	2	.795	2.530	.085
Residual	32.378	103	.314		
Total	33.969	105	.324		

Discussion

Methodological Limitations

Generalization of these research findings to the clinical setting should be exercised with caution. The use of spousal gender samples, drawn from the convenience sample of the original study, resulted in a small, non-randomized selection of participants which limits the usefulness of study results. The original sample consisted of a group of individuals who had been caregivers for a length of time, were motivated to respond to a request to participate in the study and/or who were already receiving services and were referred to the study. With this bias, they do not represent the entire population of caregivers. The homogeneity among the sample subjects limits generalizability of findings to only those with similar characteristics and who meet similar inclusion criteria. Restricting the caregiver/recipient dyad to 55 years or older may be producing a cohort effect, where the results are not applicable to younger dyads. Probability or random sampling would have been the preferred method to use in this study because it would have increased the variability with the population of caregivers, a larger sample would have allowed for broader use of and interpretation of study findings, and while gender may influence some attitudes towards utilization of community services in this study, a larger, more heterogeneous population may demonstrate different findings.

Instrument Limitations

The CSAI represents an initial attempt to measure one aspect of the complex issue of understanding the use of community services by caregivers of individuals. Initial analysis of the psychometric properties of the scales revealed adequate reliability and content validity of the instrument, however further testing is needed. As of this date, the CSAI has been used with a minimal number of caregiver samples. Further testing in clinical settings with more heterogeneous samples of caregivers, including: individuals in different geographical regions, at different stages of caregiving, of different ethnic and cultural backgrounds, of different age cohorts, of various relationships to the care recipient and caregivers of clients with different mental and physical disabilities, would increase the reliability and validity of the instrument and would increase the generalizability of the results obtained. As there have been no previously developed scales to measure attitudes that caregivers may have regarding use of community services, equivalence studies for reliability could not be performed, this also points out that though the instrument is standardized, there are no norms by which to compare the sample measurements. The variability in subscale characteristics between sample groups may limit interpretation of study findings.

Interpretation of Findings

Both the combined sample mean and the mean scores of the male & female spouses do not support the attitudes identified in the ancedotal and qualitative literature on attitudes toward caregiving among dementia caregivers in general (King, Collins and Liken, 1995, Bass et al, 1994, Collins, King, Given & Given, 1994). Spousal caregivers held less of a belief in the opinion of others as to who should be providing care; less of a belief in caregiver independence from the service system; agreed with the attitude of confidence in community services; agreed with the attitude of accepting governmental services; and did not agree with the attitude of preferring to utilize assistance from informal caregivers rather than formal services when there was need. While the data for this sample does not reflect the dementia caregiving attitudes previously mentioned; it does support the findings of other studies of elder spousal caregivers in which both male and female caregivers relinquish some measure of independence, privacy and pride as these concerns become of secondary importance to providing care for an increasingly dependent spouse (Stoller & Cutler, 1992; Stommel, Given & Given, 1990). The attitudes held by this sample may reflect those of elderly caregivers later in the caregiving process (mean=5.45 yrs.), when the needs for assistance exceed their capabilities. The indication of a lack of preference for informal care may reflect the elder spouses' desire not to become a "burden" to their children or friends without the ability to "repay" them (reciprocity). Thus the expression of confidence in the service system and the acceptability of governmental services and the use of services might minimizes the psychological consequences of needing and receiving care, of retaining some measure of control because the dyad is "paying for" or "entitled to" the assistence (Stoller & Cutler, 1992).

Findings from this study indicate there may be gender differences in attitudes towards utilizing community services. Although statistically significant differences were demonstrated among husband and wife caregivers only with regard to a belief in caregiver independence from the service system and the attitude of confidence in the service system, mean differences on the subscales with regard to a concern for the opinion of others, a preference for informal care and of accepting governmental services also suggest a gender influence on attitudes for this spousal sample, controlling for relationship differences.

Differences were found and could be related to gender-based belief/attitudes within the context of the marital relationship. Findings would appear to support the work of those researchers who found the a spouse's role as caregiver was based on gender attitudes and role enactment beliefs, especially for the male spouse. Miller (1987) found that when an elderly spouse cared for a cognitively impaired mate, the dominant pattern appeared to be congruent with previous role behavior.

Male spouses in this study were more likely to support the belief in caregiver independence. This may reflect the traditional attitude/belief held by men that they are the providers and protectors of their families; responsibile for and in control of the situations in which they may find themselves. Gender socialization provided the expectation that males be self-reliant, competent and to keep their weaknesses hidden (Robertson, 1987, p. 324); upholding the male spouses' need for independence and reluctance to ask for assistance. Caring for an impaired spouse may reflect study findings that men become more family oriented and nurturant as they age and the demands of the caregiving role are in harmony with the needs of men (Gutman, 1994; Sheehy, 1994; Miller 1987). Assuming authority and management over dependent wives would be an extension of the husband's role as authority figure in the family and reinforces a sense of control in the home through attritubes such as organization of resources, problem-solving and authoritative decision-making.reminiscent of the workplace. This explanation can be supported by the data that shows male spouses exhibit less confidence in the service system than do female spouses (means=2.64 & 2.82). The male spouse may feel a lack of trust and a loss of control/autonomy/authority over the care of his spouse when dealing with community service personnel; he may have the expectation they will not honor his decisions or follow his directions.

In looking at the statistically significant data from the female spouse perspective, less of a belief in caregiver independence than men may reflect study findings that indicate after the post-parental years a change in the acceptance of total obligation/responsibility for the care of another occurs on the part of women as they become more active/assertive in roles outside of family/home (Gutman, 1994; Sheehy, 1994). Exhibiting more confidence in the service system than men possibly reflects an increased acceptance of the need for assistance to supplement their care in providing for a spouse's needs in order to provide for their own. Therefore, the significant differences between the male and females subjects in this study may be pertinent to understanding the attitudes toward utilization of community services.

Variations of these findings, reflective of the variations in the subscale characteristics, might also be found in other caregiver-care recipient dyads based on gender/relationship (i.e. children vs spouse or daughters vs sons). For example, a spouse may have a different set of attitudes/beliefs than adult children; a wife's belief in the caregiving role may differ from a daughter's attitude, a son's attitude may vary from a husband's. Therefore, the influence of gender may be confounded by the caregiver-care recipient relationship as it reflects various attitude/beliefs and role expectations held by the caregiver.

The Theory of Reasoned Action was developed by Azjen & Fishbein (1980) as a means of understanding and predicting behavior. The premise states that external variables (i.e. personality characteristics, demographic variables and social values/perceptions) influence beliefs/attitudes which may result in the intention to perform a behavior. In this sample of caregivers, the demographic characteristic of gender, in the context of a spousal relationship, appeared to influence the strength of the beliefs/attitudes toward utilizing community services. The decision to utilize services is influenced by a variety of variables, (i.e. cost, availability, need, knowledge of services, social and cultural expectations); the model is useful in that it allows for the wide range of caregiver/care recipient characteristics that would influence and confound beliefs/attitudes when used in the study of other populations. The model illustrates the interactions/possible interactions between the external variables and their relationship to beliefs and attitudes; it does not demonstrate the degree of influence between the concepts. Though presented in a linear fashion, the model would further explain the relationship between attitudes, the intention to perform the behavior and the actual performance of the behavior if a "feed-back" loop between behavior and attitude toward the behavior was included. An experience with performing the behavior, resulting in either a positive or negative result, can influence attitudes toward performing the behavior a second time.

Implications for Advanced Nursing Practice and Primary Care

Evaluating research findings for applicability in clinical practice by the APN requires a comparative evaluation of the appropriateness of its applicability to her/his practice. According to Stetler and Marram (1978), this involves determination of substantiating evidence of the study results; the fit of setting and client population; the feasibility of implementing the findings in terms of resources and legal/ethical issues and evaluation of the basis for practice in terms of the theory behind and effectiveness of current intervention strategies and proposed changes. Based on these determinations, decision-making occurs. The APN may choose not to apply the study findings to practice; or to apply the findings in a direct manner, as evidence for change, as a catalyst for the evaluation of current practice or as a model for action. The APN may choose to apply the findings in a cognitive manner, utilizing the findings of the study to enhance understanding of various situations, to analyze the dynamics of practice and/or add the information to her/his theoretical approach to nursing. Due to the limitations of the present study, the APN may choose to apply the findings in a cognitive manner, adding to a theoretical basis of nursing practice and increasing a knowledge base concerned with gender, caregiving, dementia and attitudes toward the utilization of community services.

In view of the growth and vulnerability of the elderly population in regard to dementia, the Advanced Practice Nurse (APN) will need to identify and define her/his role within the health care delivery system in dealing with the issues presented by the elders and their family/support group. The APN, functioning in the roles of advocate, clinician,counselor/collaborator, case manager, educator and consultant, can be effective in influencing the provision of care to a demented patient and in supporting the health and well-being of the caregiver on an individual basis, as well as in developing and supporting efficient, cost effective services at the community level .

Recognition and understanding of any gender differences in attitudes toward caregiving and utilization of community services may assist the APN in developing strategies to promote the most appropriate and acceptable care for both male and female spousal caregivers. This study indicated that there were gender differences in attitudes concerning confidence in the service system and caregiver independence from that service system: suggesting that male spousal caregivers might be less likely to utilize community services and had less confidence in the services than female caregivers. This type of information can be utilized to identify barriers to service utilization and guide the APN's counseling and advocacy efforts in referring to available services. Recognition that men may be less receptive to utilizing community services, especially those that meet the needs of the female caregiver, i.e. emotionally-based support groups vs. task-skill classes, would permit change to occur, encourage development of new/acceptable services promoting both caregiver/care recipient well-being and support the caregiving process/relationship.

Utilizing the CSAI with individual clients entering into or involved in a caregiving situation would enable a APN and the caregiver an insight into attitudes/beliefs that can influence their decisions and behaviors and ultimately affect the effectiveness of the caregiving and the health and well-being of the dyad. A caregiver who resists asking for assistance or utilizing service to the detriment of his/her own health, as well as the well-being of the care recipient, may strongly believe in being or maintaining independence from the system; feel a personal responsiblity for the care; have little confidence in or had bad experiences with the service system; or feel pressured by perceived family and/or societal expectations to be responsible for the care. Reducing the twenty-five questions into a shorter, more open-ended assessment tool would provide more individualized responses. For instance, one could ask: Are you planning on caring for your spouse by yourself (Independence)? If you need assistance who would you ask to provide it

(Informal or Formal Services)? How do you feel about using the community services available in terms of competence, trust and safety (Confidence)? Understanding of these attitudes, along with knowledge of the other factors that may be affecting caregiving decisions, allows the APN information with which to develop strategies for intervention and support that would be appropriate and acceptable to the client within his caregiving framework. Based on the information gathered, the APN can reconsider any past gender bias in regard to attitudes toward caregiving based on stereotypical gender characteristics that could influence the provision of services and educate others in this area to promote a more realistic and acceptable plan of assistance.

Recommendations for Future Research

The limitations of methodology found in this study and the original study from which it was taken, reflect the problems which plague the majority of caregiving research: those related to utilizing small, homogeneous, non-randomized samples. Participants in this study were spouses, over the age of 55 years, middle-class and predominantly white; other relationship dyads and younger cohorts were excluded from the study for control purposes and other racial and ethnic populations were not adequately represented. Further research, with larger samples, for gender differences in attitudes toward utilization of community services among all these groups may provide useful information. The average length of caregiving duration in this study was approx. 5 years and some of the respondents in the sample were already utilizing community services. A longitudinal study of caregivers attitudes toward utilizing services following a population from the beginning of the experience, (before services were needed), through to the end, (the death or institutionalization of the care recipient), may provide a better understanding of attitude differences based on gender, other variables and changes over time.

Research into the effect of gender differences on various issues in caregiving is vast and covers a wide assortment of variable combinations, caregiver distress, burden, type and number or tasks performed, utilization of services. Most examine how the components of caregiving vary by gender but pay little attention to the structural or cultural context influencing the differences. The meaning or significance of gender may change in different cultures or at different points in the caregiving experience. Further research needs to examine the role that gender socialization /role expectations play in assigning meaning to the caregiving experience and how the persistence of these expectations continue to influence the behaviors and decision-making of caregivers, older persons, practitioners and policy makers. Research is needed to examine possible differential effects on men and women of policies directed towards development of health care services, home health care and caregiver support services.

APPENDIX A

Appendix A

Community Service Attitude Inventory

CSAI Subscales

Concern for the opinion of others

People outside my family would think less of me if I used services.

My family would think less of me if I used services for my relative's care.

My family prevents me from using services for my relative.

Families should not use community services to care for a relative with Alzheimer's disease.

I do not want others to know my relative has Alzheimer's disease.

My family supports my use of community services.

Confidence in the service system

People from community services can take care of my relative as well as I can.

I am fearful of having people from community services take care of my relative.

I trust people from community services to take care of my relative.

People from community services would follow my directions in caring for my relative.

It is hard to trust someone from community services to take care of my relative.

People from community services might be better at caring for my relative.

I worry about my safety when someone else is takinfg care of him/her.

Community services might have better ideas about caring for my relative.

Preference for informal care

I would rather use community services than ask for help from my family.

I would rather use community services than ask for help from friends.

I would rather ask my family for help than use community services.

I would rather ask my friends for help than use community services.

Belief in caregiver independence

I am proud of being able to care for my relative with little help from community services.

I believe in the idea that families should care for their own and not ask for outside help.

I think I should care for my relative without help from community services.

I feel good about using community services to help care for my relative.

Acceptance of government services

It is not the government's responsibility to help me find ways to care for my relative.

I would use more services if the government would provide more assistance.

I believe the government should support more community sevices to help families care for persons at home.

APPENDIX B

Appendix B

MICHIGAN STATE
UNIVERSITY

November 25, 1996

TO: Clare Collins
A-129 Life Sciences

RE: IRB#: 96-747
TITLE: GENDER AND SERVICE USE ATTITUDES AMONG SPOUSAL CAREGIVERS OF PERSONS WITH DEMENTIA
REVISION REQUESTED: N/A
CATEGORY: 1-E
APPROVAL DATE: 11/22/96

The University Committee on Research Involving Human Subjects'(UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

PROBLEMS/ CHANGES: Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517)432-1171.

Sincerely,

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Juliann Balcom

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AND
GRADUATE
STUDIES

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LIST OF REFERENCES

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