

# *Understanding Stress in Informal Caregiving*

*Is Burden a Problem of the Individual or of Society?*

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The poor psychological health of caregivers of the frail aged is examined using the stress paradigm and the crises of decline model of caregiving burden. Whereas stress paradigms generally focus on environmental stressors and individual resources, the crises of decline model conceptualizes stress within the social dynamics of the caregiving dyad. Data from a cross-sectional study of 144 caregivers supported both models. Burden was more likely when the primary caregiver experienced degeneration, conflict, enmeshment, unpreparedness, and unwillingness. Minor psychiatric symptoms were explained in part by burden but also by more traditional stressors (supervisory workload) and resources (physical health, self-esteem, mastery, coping strategies, social network availability). Individualistic interventions to relieve burden and symptoms are justifiable on the basis of this study, but with limits to their likely success—limits imposed by family institutions of care in which primary carers lack experience and feel discomfort with degenerative conditions.

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*Studies comparing psychological well-being* in informal caregivers and noncaregivers have tended to show not only greater distress in the caregiving population but also considerable variability in how successfully individuals accommodate and adjust to caregiving responsibilities (R. G. Morris, Morris, and Britton 1988; Schulz, Visintainer, and Williamson 1990). Earlier studies expected that the strain of providing care would be explained by the level of disability of the care receiver (Gilhooly 1984; Zarit, Reeve, and Bach-Peterson 1980).

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Some researchers have been successful in linking patient disability or caregiving workload to poorer caregiver well-being (Deimling and Bass 1986; Morycz 1985; Pearson, Verma, and Nellett 1988; Schulz, Tompkins, and Rau 1988; Stoller and Pugliesi 1989). More commonly, however, little association has been found, leading to the conclusion that stress can only be understood by taking into account other aspects of the caregiving situation (George and Gwyther 1986; Gilhooly 1984; Jenkins, Parham, and Jenkins 1985; R. G. Morris et al. 1988; Pagel, Becker, and Coppel 1985).

To explain caregiving strain and burden, a range of variables have been examined—daily hassles (Kinney and Stephens 1989a), appraisals (Haley, Levine, Brown, and Bartolucci 1987), competing responsibilities (Stoller and Pugliesi 1989), the caregiver-care receiver relationship (L. W. Morris, Morris, and Britton 1988; Young and Kahana 1989), effectiveness (Townsend, Noelker, Deimling, and Bass 1989), coping strategies (Barusch 1988; Haley et al. 1987; Stephens, Norris, Kinney, Ritchie, and Grotz 1988), and social support (Haley et al. 1987; Thompson, Futterman, Gallagher-Thompson, Rose, and Lovett 1993). The caregiving literature has moved increasingly toward stress paradigms to understand the process by which caregivers' well-being suffers as a consequence of providing care at home. Accompanying the popularity of stress paradigms has been the view that objective stressors are not as important as the subjective appraisals and perceptions of those involved (Haley et al. 1987; Jenkins et al. 1985; L. W. Morris et al. 1988; Novak and Guest 1989).

Stress paradigms have three key components. The first is "stress outcome," which has variously been interpreted in caregiving research as burden, life satisfaction, or mental health. The second is "the stressor," or the set of stressors (e.g., moving, death of a loved one, or job loss), that demand adaptation in the individual and that the individual appraises as a challenge, a threat, or a loss. The third key component is "resources." Resources refer to assets that an individual can draw upon to deal with the stressor. The resources may be psychological (stable traits or specific coping strategies), social (friends, family, and community services), or material (money). This basic conceptualization has been elaborated on by Pearlin, Mullan, Semple, and Skaff (1990) to produce a very sophisticated model of the stress process in caregiving: Background and stress context vari-

ables lead to primary stressors and secondary stressors, which lead to secondary role strains, which lead to secondary intrapsychic strains, which lead to outcomes. Mediators in the form of types of resources are shaped by context and background and impinge on the last four stages in the development of a stress reaction.

As this approach has gained momentum, concern has been expressed over its policy implications. At one level, the failure of interventions to alleviate carer stress has aroused puzzlement and frustration (Callahan 1989; Lawton, Brody, and Saperstein 1989; Oktay and Volland 1990). At another level, arguments have been put forward about the inappropriate use of the stress paradigm. Abel (1990) observed that, increasingly, problems are being addressed through offering caregivers stress management programs with the promise that they can increase their capacity to cope with their adversity through personal change. Abel has expressed reservations about the likely effectiveness of such an approach, asserting that stress is inherent in the caregiving role. More important, she argues, is a change in policy direction away from the individual and toward social structure. At present, informal caregiving for older people is largely carried out by women, often with little informal or formal support (Brody 1981, 1985; Ungerson 1987). Instead of eradicating stress, the primary policy objective, according to Abel (1990) and others (Dalley 1988; Ungerson 1987), should be to organize society so that caregiving responsibilities are humanely and justly distributed.

The concern that Abel (1990) raised about the stress paradigm can be extended in two ways. First, the stress approach is weak for planning interventions, in that it removes the notion of agency from the care receiver. The care receiver, or at least personal qualities of the care receiver, are constructed as stressors. This provides a parsimonious solution to fitting caregiving to the stress paradigm. Nevertheless, when the findings are used to plan interventions, the action potential of the care receiver tends to be lost. Family therapists have long advocated a systems approach to the analysis of family problems, emphasizing that interventions must involve all family members, because all have a part to play in the development of dysfunctional relationships (Satir 1967). Within the caregiving context, Montgomery, Stull, and Borgatta (1985) recognized the central role of dyadic interaction across time in the development of burden. The

usefulness of the stress paradigm can be increased if it can be molded to give more explicit recognition to the dynamics of the caregiver-care receiver relationship.

Second, stress paradigms are unable to accommodate the relationship between caregiver and care receiver from a cultural or historical perspective. This is not to suggest that those using the stress paradigm fail to measure the nature of the relationship between caregiver and care receiver. Such measures are frequently taken, but theoretically they are forced into the categories of stressors or resources that exacerbate or ease the stress of caring. Affection, respect, and domination in the caregiving relationship assume special significance when the relationship is an intimate, long-standing, and dynamic one. A similar argument can be made in relation to divorce, child abuse, and codependency. Improved adaptation does not necessarily result from taking the stressor away or changing the stressor, or perceiving the stressor differently. In family contexts, self-identities are based on relationships with other family members. Understanding the stress of one person, the caregiver, requires an understanding of family ties, their traditions and their histories—factors that are not readily accommodated within a paradigm concerned with how an individual deals effectively with a hostile world.

These kinds of criticisms support the importance of the qualitative and anthropological research undertaken on family caregiving (Abel 1990; Gubrium 1988; Graham 1983; Pollitt, O'Connor, and Anderson 1989). Relying on alternative methodologies, however, should not be the only response of stress researchers, given the dominance of stress paradigms in understanding and preventing caregiving problems.

Whereas the focus of the basic stress paradigm on the individual cannot be changed, modifications can be introduced to conceptually disentangle individualistic and environmental parameters from aspects of the caregiver-care receiver relationship that are bound by culture and history. If caregiving stress can be linked to these relational parameters after the individualistic and environmental variables are controlled, there is an empirical basis for further exploring Abel's (1990) contention that there is a certain inevitability about stress in caregiving for the frail aged because of the way in which care is structured in our society.

*DRAWING OUT RELATIONAL  
VARIABLES IN THE STRESS MODEL*

Many different conceptual frameworks have emerged over the past decade for organizing variables that might lead to caregiving burden and poor mental health. The approach followed here has been discussed in detail elsewhere (Braithwaite 1987, 1990, 1992). In terms of independent variables, the main elements of the research model are (a) caregiver workload, (b) caregiver resources of a personal, social, or material kind, and (c) the crises of decline.

Caregiver workload is defined as "the activities in which carers engage and the responsibilities which they accept in order to promote the physical and mental well-being of their dependants" (Braithwaite, 1990, p. 19). Workload involves task-oriented demands such as providing assistance with daily activities, personal care, supervision, and decision making, and social-emotional demands such as acting as a confidant and organizing social activities. Caregiving workload represents the environmental demands of caregiving and is most similar to earlier conceptions of objective burden (Montgomery et al. 1985).

Resources are defined as characteristics of the individual caregiver that enhance or reduce the likelihood of effective responses to the demands of caregiving. Personal resources encompass physical health, personality variables, and coping strategies. Social resources refer to the breadth of the carer's social network, awareness of caregiving support within this network, and use of this support. Material resources cover access to suitable housing and medical supplies and equipment, and are expressed most simply through financial well-being.

The crises of decline are the threats to the caregiver-care receiver relationship that arise from deviations from the cultural norms and expectations of care. The underlying supposition is that individuals learn about family care in western society through raising infants who generally follow well-documented and clearly signposted paths to development and independence. Traditionally, western cultures have expressed pride in individual development and shame in the face of degeneration. Quality care within families is thought to nurture and restore well-being. Tender loving care should, in the mythology of western culture, arrest degeneration. The first crisis, therefore, is

seeing degeneration in the care receiver while accepting responsibility as the primary caregiver. The second crisis is that family carers have not been socialized for the role of caring for those who are degenerating. Most caring experience is with children, in situations where stages of development and childhood problems are anticipated and solutions are shared. In contrast, caregivers of the frail aged often express surprise and feel poorly equipped for their role (Braithwaite 1990). The third crisis, enmeshment in caregiving, involves caregivers directing all their energy toward care receivers who are not coping. When carers are kin, they are more likely to be driven by love, duty, or both to leave no stone unturned to relieve their care receiver's suffering. The fourth crisis for family caregivers is the change in their relationship with the care receiver. When the culture prescribes caregiving as a family concern, caregiving relationships must be superimposed on past relationships that may or may not lend themselves to transformation. Finally, caring for kin restricts choice for both the caregiver and care receiver. Unwillingness to be in a caregiving-care receiving relationship is the fifth crisis of decline. For all five crises of decline, the caregiving-care receiving relationship is threatening to both the caregiver and care receiver, and yet cultural norms and social expectations bind both parties into the relationship.

The crises of decline are actually familiar variables for those involved in caregiver research, but their social relational elements have not been drawn out in this way to set them aside from resources and stressors. Of the five, degeneration is the one that most commonly has been linked with workload and with the objective aspects of care and is less readily recognizable as a relational variable. Yet degeneration that involves loss of control of a psychological and social kind is not divorced from the quality of the care receiver-caregiver relationship. Accentuating such losses is one of the few ways in which care receivers can gain attention and exercise control in their lives (Braithwaite 1990). As Langer and Rodin (1976) have so convincingly demonstrated in institutional settings, behaviors of elderly people are not divorced from their patterns of social interaction with their carers.

Most commonly, the crises of decline variables have been included among impacts or role strains in past research. The present conceptualization does not challenge their relevance to either the impact or role strain constructs. The crises of decline construct, however, is far more

limited in scope than either impact or role strain. First, the crises of decline threaten both the caregiver and the care receiver. What one believes one can do, will do, or should do for the other has to be reassessed by both sides when care and degeneration go hand in hand. In contrast, impacts and role strains are not constructs that are experienced bilaterally.

Second, the crises of decline threaten basic human needs for security and order, belongingness, and self-esteem (Maslow 1954). The family is one of society's bastions for the satisfaction and protection of basic human needs. Degeneration reverses this state of affairs. Individuals experience loss of routine, instability, lack of sleep, and sometimes even food. As caring efforts fail to produce a more favorable outcome, self-esteem is threatened. As the caregiver-care receiver relationship becomes more constrained, distorted, and finite, needs for belongingness become more acute and are less readily satisfied.

The frustration of basic needs for order, stability, loving relationships, and self-esteem as a result of caregiving defines one outcome variable called burden (Maslow 1954, 1962). Whereas this theoretical definition is again more constrained than most other conceptualizations of burden, it is not so different as to be irrelevant to the mainstream caregiving literature. It falls into the category of subjective burden (Montgomery et al. 1985). Poulshock and Deimling (1984) propose a three-dimensional model of impairment, distress over impairment (called burden), and impact. The present conceptualization of burden spans reactions to impairment and impact. It differs most markedly from Poulshock and Deimling's analysis in its emphasis on perceptions of threat rather than feelings of distress. Furthermore, the perceptions of threat must be of a particularly serious kind, affecting basic needs and not more ephemeral aspects of the quality of life. Elsewhere it has been argued that tightening up the definition of burden in this way gives burden greater legitimacy for policy analysis when the needs of competing populations are compared and stringently assessed (Braithwaite 1992).

The crises of decline construct and the concept of burden focus attention on the difficulties of caregiving and care receiving that are embedded in culture and intimate social bonds. Cultural norms locate care in the nuclear family and limit choice for care provision. Cultural experiences and expectations place caregivers and care receivers in

roles that are new and for which both caregivers and care receivers are poorly prepared. Interpersonal relations, expectations, and family history shape the behavior of the caregiver and the care receiver, not necessarily in mutually beneficial ways.

Through placing theoretical importance on the culturally determined context of caregiving, the crises of decline model raises questions that are not dissimilar from those of Abel (1990): Does the solution to caregiving stress lie in the hands of individual carers, or is caregiving stress the problem of a society that is expecting too much of individual family members?

The present study does not seek to provide a definitive answer to this question but rather to open this debate among researchers engaged in using stress paradigms to understand caregiving burden. Specifically, this article examines the importance of the crises of decline variables over and above environmental stressors and the psychological, social, and material resources that the individual caregiver draws upon for self-protection.

#### *TRADITIONAL STRESSORS AND RESOURCES*

In previous applications of the stress paradigm to caregiving, the classic stressor has been the degree of disability in the person being cared for (Lawton, Moss, Kleban, Glicksman, and Rovine 1991). In the present study, the stressor has been operationalized in terms of functional health, that is, the activities of daily living and the personal care provided for the care receiver. In addition, the need for general supervision was included, as was the care receiver's need for assistance with decision making.

Personal resources that have accounted for differences in the way in which people interpret their experiences include self-esteem and mastery, both of which have been associated with resilience to potentially threatening events (Carver, Scheier, and Weintraub 1989; Fleishman 1984; Holahan and Moos 1987; Pagel et al. 1985). A substantial literature documents the role of coping strategies in dealing with stressful situations. Problem-focused coping is generally regarded as more effective than emotion-focused coping (Billings and Moos 1984; Terry 1991), and avoidance strategies have been associated with high stress (Holahan and Moos 1987; Kobasa 1982). A personal resource



that is particularly relevant to giving care is physical health (Grad and Sainsbury 1963; Lawton et al. 1991). Carers with poor physical health might be expected to be more vulnerable to stress.

Social resources were defined in terms of the supportiveness of one's social network (Folkman 1984). The availability of a confidant and of a social network have been recognized as important to personal adjustment and well-being (Cohen and Wills 1985; Poulshock and Deimling 1984). For carers, the ability and willingness to draw upon the support of others is also likely to improve adaptation (Morycz 1985).

Caregiving responsibilities may be eased through financial well-being (Fengler and Goodrich 1979). Resources of a material kind, therefore, were indexed through socioeconomic status and through the carer's ability to meet caregiving expenses.

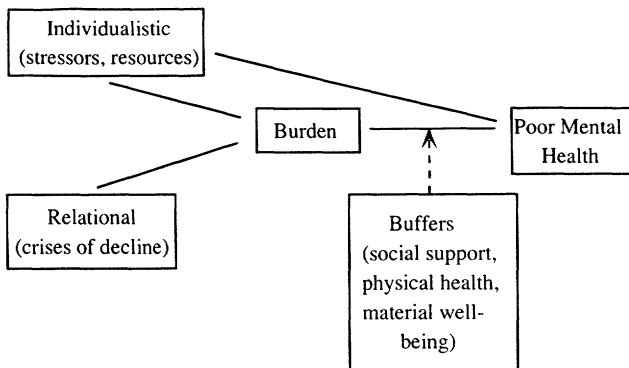
#### *OUTCOME VARIABLES*

In addition to using burden as an outcome variable, this study includes mental health. Others have argued that unless the effects of caregiving on more global indicators of well-being can be demonstrated, concerns about the stress costs of home care lack credibility (Callahan 1989; George and Gwyther 1986).

#### *HYPOTHESIZED CAREGIVING MODEL*

The hypothesized model linking stressors, resources, and the crises of decline to burden (the frustration of basic needs) and mental health encompasses two theoretical perspectives. Following the stress tradition, represented most recently by the models of Pearlin et al. (1990) and Lawton et al. (1991) in the caregiving literature, stressors and resources can be conceptualized as independent variables, burden as an appraisal or secondary stressor, and mental health as an outcome variable. Burden may mediate the relationship between the independent variables and the outcome variable, or the independent variables may directly impact on mental health (see Figure 1).

Within the stress tradition, variables may act as buffers, making the link between stressful experiences and poor adaptation less inevitable for some than for others. Among the most frequently investigated



**Figure 1: A Working Model of Caregiving Stress That Distinguishes Individualistic Stress Parameters from Social Relational Parameters**

buffers is social support. Cohen and Wills (1985) have concluded that under stressful situations, available and appropriate social support may protect the individual from losses to general well-being. In the caregiving context, social support is hypothesized as having a buffering effect between the appraisal variable, burden, and the stress outcome variable, psychiatric symptoms. Other buffering variables that should be considered in this context are self-esteem, physical health, and material well-being. Assets such as these may work in two ways to limit the damage done to carers through frustration of basic needs. They may provide the individual with opportunity to seek temporary relief, and they may provide physical and psychological stamina to endure the frustration longer.

The second theoretical perspective that is incorporated into the model is Maslow's (1962) theory of unsatisfied basic needs. According to Maslow, the satisfaction of basic needs is critical for good health. He describes basic needs as deficiency needs that "must be filled up for health's sake" (p. 21). Thus, from a Maslovian perspective, burden is the forerunner of the poor mental health that has been observed in caregiving populations.

Merging these two perspectives produces the model in Figure 1. Burden, as the perception that basic needs are being frustrated through caregiving, provides the link between them. Burden is the hypothe-

sized outcome of the relational caregiving variables identified as important from the crises of decline model. Burden is also a stress appraisal variable that may be determined by environmental stressors and the resources at the disposal of the individual to deal with a stressful situation. The questions that now need to be answered are as follows:

1. Can burden best be explained through stressors and resources or through the crises of decline?
2. Is poor mental health primarily accounted for by stressors and resources or by burden?
3. According to Maslow, the crises of decline should affect psychological well-being through the frustration of basic needs (burden). From a stress perspective, the crises of decline may work through burden or they may have a direct effect on mental health. Which model best fits the caregiving data?
4. Stress theory assigns a role to buffers interceding between burden and poor mental health. Maslow's theory does not accommodate buffering effects. Again, which conceptualization is most consistent with the data?

### *Data Collection*

#### *SAMPLE*

The data were collected as part of a study of 144 caregivers of clients of either day care centers or community nursing in the city of Canberra, Australia. Caregivers were contacted through these services because they offered the best opportunity for reaching those who had assumed primary and major responsibility for the care of an elderly person. The sample was heterogeneous in terms of the types of care required. The clients suffered from cardiovascular disorders (48%); injury, arthritis, or some other musculoskeletal disorder (36%); impaired mobility through stroke (28%); dementia, memory loss, or disorientation (27%); and gastrointestinal disorders (19%).

Although the sample of caregivers was based on volunteers and was nonrandom, the composition was similar to that reported in previous studies conducted in the United States (Special Committee on Aging,

United States Senate 1987; Stephens and Christianson 1986), Britain (Gilleard 1984; Jones and Vetter 1984), and Australia (Australian Council on the Ageing and the Australian Department of Community Services 1985). Of the 144 caregivers, 75% were women. Ages ranged from 26 to 82 years, with a mean of 58 years ( $SD = 13.04$ ). Care was being provided to a parent or parent-in-law in 51% of cases and to a spouse in 43% of cases. Only 6% of caregivers were caring for other relatives and friends, a somewhat smaller proportion than reported in other research. In comparison with the above studies, the sample overrepresented caregivers who were living with their care receivers (86%) and higher status occupational groups. Thirty-eight percent of families had a breadwinner in a professional or managerial position, 46% in skilled, clerical, or administrative positions, and 17% in skilled and unskilled positions.

#### *PROCEDURE*

Caregivers were contacted by letter, and those who agreed to participate were telephoned by one of three interviewers. Meetings were arranged for a private discussion of their caregiving experiences either at their homes or at the university, depending on their preference. Structured interviewing, interspersed with unstructured discussions, took place over two and sometimes three sessions, each of about 1½ to 2 hours duration. Carers completed a questionnaire that was left with them after the first interview.

#### *MEASURING THE DEPENDENT VARIABLES*

*Burden:* Physiological and safety needs for caregivers involve order, stability, and self-protection. These needs, therefore, were measured by asking caregivers whether they experienced inadequate sleep and rest, poor health, disrupted routine, task incompleteness, and constant interruptions. The frustration of belongingness and love needs was assessed through carers' feelings of divided family loyalties and resentment. Perceptions of one's own inadequate performance as a caregiver constituted threats to self-esteem. Data were scored in terms of the problem being present or absent.

A factor analysis of the 17 burden items produced two factors, one labeled Disruption, the other Inadequacy (see items in appendix). The alpha reliability coefficients for the two scales were .78 and .80, respectively. The correlation between them, although lower than the internal consistency coefficients, was nevertheless moderately strong ( $r = .45, p < .001$ ). The disruption and inadequacy scales showed similar patterns of relationships to indexes of minor psychiatric symptoms (Bedford, Foulds, and Sheffield 1976; Henderson, Byrne, and Duncan-Jones 1981) and to Bradburn's (1969) Affect Scales (see Braithwaite 1990 for further details on validity). Consequently, disruption and inadequacy were combined into one burden scale for subsequent analyses. Scores ranged from 17 to 34 ( $M = 28.38, SD = 4.11$ ), with an alpha reliability coefficient of .84.

*Minor psychiatric symptoms:* Anxiety and depression were assessed using the Delusions-Symptoms-States Inventory (DSSI/sAD; Bedford et al. 1976) and the Four Neurotic Symptoms Index (4-NS; Henderson et al. 1981). On the DSSI/sAD, scores ranged from 0 to 35, with a mean of 7.05 ( $SD = 6.94$ ). On the 4-NS scale, scores ranged from 0 to 4, with a mean of 1.76 ( $SD = 1.36$ ).<sup>1</sup> These measures were used because they had proven to be both reliable and valid indicators of self-reported mental health in an epidemiological study of this community a few years previously (Henderson et al. 1981). Furthermore, the earlier study provided baseline data to show the elevated levels of anxiety and depression in the caregiving population (Braithwaite 1990).

As was found by Henderson et al. (1981), the DSSI/sAD and the 4-NS were very highly correlated with each other ( $r = .63, p < .001$ ). Thus the scores on the two symptom measures were combined following the procedure used in the earlier study. Scores were standardized and then added. The combined scores ranged from -2.32 to 5.68 with a mean of .02 ( $SD = 1.81$ ).

#### CRISES OF DECLINE

*Awareness of degeneration.* The caregiver's perception of degeneration was operationally defined as a perception that the care receiver's behavior was departing from the normal social, emotional, and physical functioning of a mature adult. Two measures of degen-

eration were used, one concerned with losses of social-emotional control and one concerned with cognitive impairment.<sup>2</sup> The social-emotional disturbance scale was made up of 11 items representing depressed mood, lack of emotional control, sudden mood change, and socially inappropriate behavior to others ( $\alpha = .87$ ,  $M = 17.94$ ,  $SD = 3.44$ ). The cognitive impairment scale contained 9 items tapping confusion about persons, place, and time; poor knowledge; and poor communication capacity ( $\alpha = .86$ ,  $M = 13.71$ ,  $SD = 2.96$ ). These two scales were correlated with each other ( $r = .48$ ,  $p < .001$ ) and showed similar patterns of relationships to other variables. They were combined, therefore, to form the emotional, social, and cognitive degeneration scale.

It is worthy of comment that the degeneration measure did not require caregivers to compare the care receiver's behavior with behavior at an earlier point in time. The reasons were methodological. Some carers had less detailed knowledge prior to caregiving than did others. Systematic biases in such reports also posed problems. Spouse carers, in particular, are known to deny decrements in performance as a coping response (Pollitt et al. 1989). To capture the essence of degeneration without these methodological problems, items had to represent loss of control of a kind that would not be expected in normal functioning adults. Sufficient qualitative information was available from the interviews to confirm that these abnormal behaviors did reflect decrements in functioning and not lifelong attributes.

*Unpreparedness.* The extent to which carers were unprepared for the caregiving role was assessed through two questions: (a) how much they knew about the care receiver's problems when they began to care (57% knew quite a lot) and (b) how much they had to learn about providing care (51% had things to learn about caregiving). Initial knowledge about the care receiver's problems and having much to learn about caregiving had a correlation of  $-.20$  ( $p < .05$ ) and behaved similarly in preliminary regression analyses. The responses, therefore, were rescored in the same direction and were combined to form the unpreparedness index.

*Enmeshment in caregiving.* Two subjective measures were used: a five-item time constraints scale ( $\alpha = .79$ ,  $M = 9.10$ ,  $SD = 1.41$ ) and a three-item sole responsibility for care scale ( $\alpha = .55$ ,  $M = 5.61$ ,  $SD = .73$ ). For time constraints, carers were asked whether they had missed

out on holidays and outings, had to plan holidays and outings well in advance, had less time to spend with the family, had little time to themselves, and had given up interests, leisure activities, and hobbies. The scale was made up of items that involved sacrifice but that, theoretically, could not be linked to the frustration of basic needs, as the items in the burden scale were.

The sole responsibility scale tapped the absence of psychological relief from caregiving through caregivers' (a) feeling they had total responsibility for the well-being of another person, (b) fearing what would happen if they were unable to provide care, and (c) wondering if the care receiver was all right when they were not with them.

*Past and present interpersonal tensions.* Two measures were used to assess the struggle between caregiver and care receiver for dominance in the caregiving relationship. The first was a retrospective measure designed to capture the degree to which the care receiver dominated the caregiver in the past (prior to the need for care). The measure was a modified version of Parker's (1978) autonomy scale. The eight items used in this context represented the amount of independence the carer had been given by the care receiver in decision making and how much confidence the care receiver had shown in the carer's judgment in the past ( $\alpha = .84$ ,  $M = 24.09$ ,  $SD = 6.01$ ).

The second measure focused on the present relationship between caregiver and care receiver and asked carers about the frequency of differences of opinion with the care receiver. The sample divided evenly across the three response categories: *hardly ever* (1), *sometimes* (2), and *a lot of the time* (3).

The autonomy scale and the conflict item were interrelated ( $r = -.36$ ,  $p < .001$ ). Where the care receiver had dominated the caregiver in the past, expressing little confidence in the person's capacity to solve problems and make decisions, conflict in the caregiving relationship later on was more likely to occur. Preliminary analyses showed autonomy and conflict behaving similarly in relationships with other variables. Thus they were rescored in the same direction, standardized, and combined to form a past and present interpersonal tensions scale.

*Unwillingness to care.* In contexts in which carers do not have alternative forms of care available, lack of choice becomes problematic when carers are unwilling. An index of unwillingness ( $\alpha = .62$ ,

$M = 4.12$ ,  $SD = 1.00$ ) was formed by combining three measures. The first asked carers if their dependents were on a nursing home waiting list and if they would accept the offer of a bed if it were made today. Thirteen percent of carers reported that they were both on a waiting list and would accept a placement immediately. The second measure asked carers how long they intended to provide care. Limitations on how long care would be willingly provided were expressed by 35%. The third question was whether carers were aware of their breaking point, the point beyond which they could not care anymore. A breaking point was acknowledged by 61%.

#### STRESSORS AND RESOURCES

*Workload.* The tasks that needed to be done for care receivers were assessed through three scales measuring personal care, supervision, and decision making.<sup>3,4</sup> All were scored so that increasing magnitude reflected need for greater assistance.

The personal care scale involved 5-point ratings from the caregiver of the level of help required by the care receiver with cutting toenails; combing hair or shaving; dressing or undressing; washing hair; bathing; toileting; getting into or out of bed; sitting, standing, or transferring; walking; feeding; and taking medication ( $\alpha = .87$ ,  $M = 29.78$ ,  $SD = 11.32$ ).

The supervisory workload scale comprised three items scored dichotomously: Was the care receiver left alone unsupervised for a couple of hours (a) during the day or (b) during the night, and (c) could the care receiver use the telephone or call for assistance if no one was on hand ( $\alpha = .54$ ,  $M = 4.57$ ,  $SD = 1.03$ ).

The decision-making scale was made up of five items asking caregivers if the person receiving care made decisions about clothing, food, the daily routine, watching television or listening to the radio, and seeing the doctor ( $\alpha = .68$ ,  $M = 8.95$ ,  $SD = 2.64$ ).

*Personal resources.* The measure of self-esteem, defined as a person's judgment of his or her own worthiness (Coopersmith 1967), was based on the 10-item scale developed by Rosenberg (1965) ( $\alpha = .84$ ,  $M = 40.04$ ,  $SD = 6.64$ ). The scale tapped beliefs about one's worth, competence, and capacity for success.



The mastery scale was intended to gauge the extent to which people believed they had control over their own lives and the difficulties that beset them. This scale was a modified version of that of Pearlin and Schooler (1978), the major change being the balancing of positively and negatively worded items ( $\alpha = .71$ ,  $M = 21.57$ ,  $SD = 4.67$ ).

The coping scales were developed specifically for this study and were derived from factor analyzing a set of items that represented the types of coping strategies that carers were known to use and that had meaning in their particular social context (see Braithwaite 1990 for further details). Four coping scales were developed: seeking solutions, reinterpretation and acceptance, avoidance, and withdrawal. The 5-item seeking solutions scale represented problem-focused strategies directed toward controlling the situation through seeking outside assistance and advice ( $\alpha = .65$ ,  $M = 13.66$ ,  $SD = 3.09$ ). Reinterpretation and acceptance brought together 13 items concerned with changing the meaning of the situation and seeking comfort for oneself. The scale represented emotion-focused and cognitive reframing strategies ( $\alpha = .87$ ,  $M = 34.46$ ,  $SD = 8.53$ ). The avoidance scale was made up of 5 items that involved activities that caregivers could use to distract them while in the caregiving role ( $\alpha = .70$ ,  $M = 12.74$ ,  $SD = 3.45$ ). In contrast, the withdrawal scale represented 5 activities for the caregiver that removed them physically from the caregiving situation ( $\alpha = .67$ ,  $M = 11.05$ ,  $SD = 2.83$ ).

The final personal resource variable, caregiver's physical health, was indexed by a 3-point self-rating scale: *good* (3), endorsed by 58%; *fair* (2), by 33%; and *poor* (1), by 9%.

*Social resources.* Two measures of social resources were used: the availability of a social network and assistance with caregiving.<sup>5</sup> The availability of a social network to the caregiver was measured using a shortened version of the Interview Schedule for Social Interaction (ISSI) (Henderson et al. 1981). The scale comprised the following subset of items: (a) how many people do you have contact with in an ordinary week, (b) how many people share common interests with you, (c) how many people could you ask favors of, (d) how many friends do you have who could visit at any time regardless of circumstances, (e) how many friends and relatives do you have who you can talk with freely and frankly, and (f) how many people are there who depend on you particularly for help and advice. The maximum number

of people coded for any item was 7 (Henderson et al. 1981) ( $\alpha = .71$ ,  $M = 26.22$ ,  $SD = 9.26$ ).

Assistance with caregiving was indexed by adding responses to two questions scored dichotomously (1 = *no*, 2 = *yes*): (a) Have you asked for help and received it? (b) Have you been offered help and accepted it? The items had a correlation of .35. The mean of the assistance scale was 3.06 ( $SD = .82$ ).

*Material resources.* The material well-being of the caregiver and care receiver were indexed through the occupational status of the breadwinner of each family. Occupational status was defined in terms of the major breadwinner's long-standing occupation before retirement. The three categories were *high*, professional, managerial; *middle*, sales, clerical, skilled; and *low*, semiskilled, unskilled.

A subjective index of material well-being was the caregiver's assessment of whether there was enough money to meet the care receiver's needs. The vast majority (87%) considered there to be sufficient funds, 4% described the situation as borderline, and 9% reported needing more money.

## Results

Before presenting analyses that regress the outcome variables of burden and mental health on the stressors, resources and the crises of decline, the relationships among the independent and dependent variables at the bivariate level will be examined. Theoretically, relationships were anticipated among the workload variables, the personal and social resource variables, and the crises of decline. Preliminary analyses confirmed these expectations and suggested empirical redundancy in some of the measures. As a result, the number of independent variables carried through to the final analyses was reduced.

Not included in the final analyses are sociodemographic indicators. Previous work has shown that sociodemographic variables account for 3% of the variance in burden and 5% of the variance in mental health (Braithwaite 1990). Standard practice was to enter them as control variables in all regression models. They did not contribute significantly in the final models, nor did their absence affect the contribution of other variables in a significant way. Given the size of

the sample and the importance of maximizing degrees of freedom in the final regression models, sociodemographic variables were omitted.<sup>6</sup> Nevertheless, their bivariate relationships with the dependent variables are reported below.

#### BIVARIATE RELATIONSHIPS

*Sociodemographic correlates.* Burden was significantly higher among younger ( $r = -.16, p < .05$ ) and female caregivers ( $r = .19, p < .05$ ). Minor psychiatric symptoms were higher for carers who were women ( $r = .16, p < .05$ ), who were caring for men ( $r = -.23, p < .01$ ), and who were residing with the care receiver ( $r = .17, p < .05$ ). Spouse carers did not differ from other carers on either burden or symptoms. Nor was care receiver's age related to either dependent variable.

*Crises of decline.* The Pearson product moment correlation coefficients for the six measures representing the crises of decline and the measures of burden and minor psychiatric symptoms are presented in Table 1. All crises of decline variables were significantly related to both burden and symptoms at the bivariate level. Symptoms and burden were more likely to be found among carers who were dealing with degeneration of a social and emotional kind, who had a history of conflict over personal autonomy with the care receiver that continued to characterize the caregiving relationship, who had much to learn about the caregiving role, who had become enmeshed in the role in terms of time and sole responsibility, and who saw themselves as unwilling now or in the future to provide care.

The correlations among the crises of decline variables in Table 1 provide support for the underlying assumption of the crises of decline model that degeneration permeates each of the other problems confronting caregivers and care receivers. When caregivers perceived social and emotional degeneration as high in their care receivers, caregivers reported greater unpreparedness, higher levels of past and present conflict, enmeshment in terms of time<sup>7</sup> and self-definition, and unwillingness and doubt about future capacity to provide home care.

In preliminary analyses, the crises of decline were found to contribute independently to the prediction of burden and symptoms, except in the case of past and present tensions. Consistent with findings in earlier work (Braithwaite 1990, pp. 118-129), the conflict in the

TABLE 1  
Pearson Product Moment Intercorrelations among the Crises  
of Decline Measures, Burden, and Minor Psychiatric Symptoms

<i>Crises of Decline and Outcomes</i>	1	2	3	4	5	6	7
1. Degeneration	—						
2. Unpreparedness	.19*	—					
3. Time constraints enmeshment	.34**	.17*	—				
4. Sole responsibility enmeshment	.30**	.12	.07	—			
5. Past and present tensions	.32**	.16*	.18*	.02	—		
6. Unwillingness	.27**	.08	.12	-.02	.13	—	
7. Burden	.55**	.32**	.51**	.43**	.26**	.34**	—
8. Minor psychiatric symptoms	.29**	.26**	.21**	.20**	.18*	.17*	.43**

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

caregiver-care receiver relationship had no impact on the outcome variables when degeneration was in the regression equation. Consequently, the past and present tensions scale was not included in the analyses presented below.

*Stressors.* Personal care, supervision, and decision making were correlated with each other and with the outcome variables using Pearson product moment correlation coefficients (see Table 2). In general, the workload variables were not strongly related to either burden or minor psychiatric symptoms at the bivariate level, although they were quite strongly related to each other. The exception was the finding of poor mental health among those who undertook high levels of supervision. The question of whether close supervision preceded poor mental health or was a consequence of it remains unanswered from these data.

Preliminary analyses demonstrated that decision making did not add anything above and beyond the other two measures, personal care and supervision. Consequently, this variable was not carried through to the regression analyses reported below.

*Personal resources.* From Table 3, the seven personal resource variables correlated strongly with burden and minor psychiatric symptoms. Burden was lower and mental health higher when carers had high self-esteem and mastery and when they did not try to cope through reinterpretation, acceptance, and avoidance. Good physical health was associated with good mental health, though not with

TABLE 2  
 Pearson Product Moment Intercorrelations among the  
 Workload Measures (Stressors), Burden, and Minor Psychiatric Symptoms

<i>Stressors and Outcomes</i>	<i>1</i>	<i>2</i>	<i>3</i>
1. Personal care	—		
2. Supervision	.48**	—	
3. Decision making	.39**	.32**	—
4. Burden	-.01	.00	.08
5. Minor psychiatric symptoms	.05	.24**	-.02

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

burden. Coping through seeking solutions and withdrawal was related to burden, but not to symptoms, suggesting that these coping strategies may mediate the burden-symptom relationship.

The personal resource variables were highly correlated with each other. Preliminary analyses confirmed concerns about multicollinearity with these variables. Thus the minor coping scales of avoidance and withdrawal were eliminated in favor of the major coping scales of reinterpretation and acceptance and seeking solutions. The mastery and self-esteem scales were also highly correlated in this sample ( $r = .57$ ,  $p < .001$ ) and could not be used together in the same regression model. Because mastery showed the most overlap with other measures, this variable was dropped from the following analyses and self-esteem was used instead. It is of note, however, that the analyses reported below were repeated using the mastery variable and produced substantively similar findings.

*Social and material resources.* Table 4 shows a low and expected correlation between socioeconomic status and financial adequacy. Carers who claim to have sufficient money to meet their care receiver's needs are more likely to come from professional and managerial levels than those who do not have sufficient funds. Furthermore, those from higher socioeconomic groups have more extensive interaction networks than those from lower groups.

None of these variables were significantly related to burden. They were, however, significantly linked to minor psychiatric symptoms. Carers with symptoms were more likely to come from low socioeconomic groups and to have a restricted social network.

TABLE 3  
Pearson Product Moment Intercorrelations among the  
Personal Resource Measures, Burden, and Minor Psychiatric Symptoms

<i>Personal Resources and Outcomes</i>	1	2	3	4	5	6	7
1. Self-esteem	—						
2. Mastery	.57**	—					
3. Seeking solutions	.14	.13	—				
4. Reinterpretation and acceptance	-.18*	-.32**	.37**	—			
5. Withdrawal	.10	.21**	.36**	.32**	—		
6. Avoidance	-.08	-.16*	.27**	.49**	.40**	—	
7. Physical health	.04	.34**	-.02	-.16*	.10	-.10	—
8. Burden	-.30**	-.25**	.20**	.40**	.17*	.19*	-.10
9. Minor psychiatric symptoms	-.41**	-.50**	-.06	.37**	-.06	.20**	-.40**

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

TABLE 4  
Pearson Product Moment Intercorrelations among the Social and  
Material Resource Measures, Burden, and Minor Psychiatric Symptoms

<i>Social and Material Resources and Outcomes</i>	1	2	3	4
1. Availability of social network	—			
2. Assistance with caregiving	.12	—		
3. Socioeconomic status	-.18*	.13	—	
4. Financial adequacy	.10	.14	-.17*	—
5. Burden	.10	-.08	.10	-.05
6. Minor psychiatric symptoms	-.21**	-.04	.24**	.04

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

*REGRESSING BURDEN ON STRESSORS,  
RESOURCES, AND CRISES OF DECLINE*

Hierarchical least squares regression analysis was used to test two models: one predicting burden from stressors and resources, and the second predicting burden from stressors, resources, and the crises of decline variables. The standardized regression coefficients for the two models appear in Table 5.

In Model 1, burden was best predicted through two personal resources variables. Burden was likely to be higher when self-esteem was low and when caregivers were adopting an acceptance and reinterpretation coping strategy. This coping strategy comprised items

TABLE 5  
 A Hierarchical Least Squares Regression Model  
 Predicting Burden from Stressors and Resources (Model 1)  
 and from Stressors, Resources, and Crises of Decline (Model 2)

<i>Predictors</i>	<i>Standardized Coefficients</i>	
	<i>Model 1</i>	<i>Model 2</i>
<b>Stressors</b>		
Personal care	.00	-.02
Supervision	-.02	-.08
<b>Resources</b>		
Self-esteem	-.30**	-.06
Seeking solutions	.13	-.03
Reinterpretation and acceptance	.25*	.09
Physical health	-.04	-.07
Availability of social network	.13	.06
Assistance with caregiving	-.10	-.07
Socioeconomic status	.05	.06
Financial adequacy	-.02	-.02
<b>Crises of decline</b>		
Awareness of degeneration		.21**
Unpreparedness		.14*
Time constraints enmeshment		.38**
Sole responsibility enmeshment		.29**
Unwillingness		.19**
Adjusted $R^2$	.18**	.56**

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

such as “telling yourself there are others worse off,” “expressing your feelings,” “accepting hardship because it’s meant to be,” and “telling yourself it isn’t as bad as all that.” Neither the workload variables nor the social and material resource variables contributed to burden.

When the crises of decline variables were added to the regression equation (Model 2), the coefficient of determination ( $R^2$ ) changed from .25 to .61, a substantial and significant change of .36,  $F(5, 105) = 19.90$ ,  $p < .001$ . Burden was best predicted by the four crises of decline variables entered into the equation. Burden was higher for those dealing with cognitive, social, and emotional degeneration; who said they had much to learn about caregiving; who felt they were enmeshed in caregiving both in terms of having sole responsibility and in having no time for anything else; and who could see limits to how much more

care they could provide. The personal resource variables were no longer significant.

*REGRESSING SYMPTOMS ON STRESSORS,  
RESOURCES, CRISES OF DECLINE, AND BURDEN*

When minor psychiatric symptoms were regressed on the crises of decline, stressor, and resource variables, and burden, a different pattern of results emerged. Three models are presented in Table 6, showing variables entered again in a hierarchical fashion. When symptoms of poor mental health is the dependent variable, the stressor and resource variables entered in Model 1 make a significant contribution. Symptoms are more likely to occur when caregivers have constant supervisory responsibilities for the care receiver; when the caregiver's self-esteem, physical health, and social network are poor; and when acceptance and reinterpretation are used to cope with the situation.

When the crises of decline variables are added to this regression equation in Model 2, little change results. The stressor and resource parameters remain dominant and the crises of decline variables are insignificant, although collectively they bring about a significant change in the coefficient of determination, from .46 to .51,  $F(5, 105) = 2.33, p < .05$ .

With the addition of burden in Model 3, a further significant coefficient of determination change of .03 occurs. Burden made a significant contribution net of all other variables. This finding contrasts with the crises of decline variables, none of which had statistically significant regression coefficients, even though collectively, they made a significant contribution. The most likely explanation is overlap between the crises of decline in the variance that they were accounting for. Overlapping relevant variance between these predictors rendered them insignificant individually in the regression equation.

Of importance is the finding in Model 3 that the addition of burden did not weaken the contribution of the stressor and resource variables already in the equation. Supervisory responsibilities, low self-esteem, poor physical health, a restricted social network, and passive coping all contributed significantly to symptoms, as did burden.

One interesting finding in both Models 2 and 3 is the emergence of the second coping strategy, seeking solutions, as a significant predic-



TABLE 6  
 A Hierarchical Least Squares Regression Model Predicting  
 Minor Psychiatric Symptoms from Stressors and Resources  
 (Model 1), from Stressors, Resources, and Crises of Decline (Model 2),  
 and from Stressors, Resources, Crises of Decline, and Burden (Model 3).

<i>Predictors</i>	<i>Standardized Coefficients</i>		
	<i>Model 1</i>	<i>Model 2</i>	<i>Model 3</i>
<b>Stressors</b>			
Personal care	-.08	-.08	-.08
Supervision	.21**	.19*	.21**
<b>Resources</b>			
Self-esteem	-.28**	-.18*	-.16*
Seeking solutions	-.13	-.22**	-.21**
Reinterpretation and acceptance	.33**	.30**	.27**
Physical health	-.29**	-.30**	-.28**
Availability of social network	-.14	-.16*	-.18*
Assistance with caregiving	.02	.05	.07
Socioeconomic status	.06	.07	.06
Financial adequacy	.14	.13	.13
<b>Crises of decline</b>			
Awareness of degeneration		.10	.04
Unpreparedness		.08	.04
Time constraints enmeshment		.15	.05
Sole responsibility enmeshment		.00	-.07
Unwillingness		.10	.05
<b>Burden</b>			.26*
Adjusted $R^2$	.41**	.43**	.45**

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

tor. The relationship between coping by seeking solutions and having fewer mental health symptoms was masked in Model 1. Burden represents threat, and with heightened burden, the likelihood of using all forms of coping was increased. Thus only when the crises of decline and burden were statistically controlled could the effectiveness of the coping strategies be ascertained. With these controls in place, passive coping remained ineffective, but coping that involved the seeking of solutions proved beneficial to carers. Solution-oriented coping reduced the likelihood of symptoms in the presence of burden. Coping through seeking solutions was very much problem focused and involved discussing problems with others, getting aids and assistance with caring, and seeing difficulties as challenges to be met.

The regression models in Table 5 show that the social-relational variables associated with degeneration in the family caregiving context are stronger predictors of burden than are workload stressors and personal, social, and material resources. The regression models in Table 6, however, tell a different story. Supervisory workload, personal and social resources make a major contribution, even after burden and the crises of decline are controlled. Burden, although accounting for a significant portion of the variance in minor psychiatric symptoms, is only part of the mental health story. These data suggest that poor mental health may be largely an individual problem. Burden, however, can be explained in terms of features of the family caregiving situation.

The final set of analyses to be reported in this article is that which tested for buffering effects. The hypothesis was that the appraisal of burden may not be linked with symptoms in cases where caregivers had resources that offered them protection or resiliency. The resources considered most likely to serve this function were (a) self-esteem, (b) physical health, (c) social network availability, (d) caregiving assistance, (e) socioeconomic status, and (f) financial adequacy.

The buffering hypotheses were tested through adding interaction terms to Model 3 in Table 6. Because the crises of decline did not add to the explained variation after burden was included, these variables were omitted in favor of burden. The interaction terms for (a) Burden  $\times$  Self-esteem, (b) Burden  $\times$  Physical Health, (c) Burden  $\times$  Social Network Availability, (d) Burden  $\times$  Caregiving Assistance, (e) Burden  $\times$  Socioeconomic Status and (f) Burden  $\times$  Financial Adequacy were calculated from standardized scores to reduce problems of multicollinearity between the interaction terms and the predictors. When added individually to the regression equation, the additional variance explained by each interaction term was inconsequential, ranging from 0 to .3%. These analyses support a main effects model without evidence of buffering effects.

### *Discussion*

These data provide support for both individualistic and social-relational explanations of the stress experienced by informal caregiv-

ers, suggesting that the most plausible account depends on whether the outcome variable is caregiving burden or poor mental health.

Individualistic explanations that have come under critical review recently by Abel (1990) continue to attract empirical support when the outcome variable is minor psychiatric symptoms. High symptomatology was found among carers with poor physical health, low self-esteem, a poor sense of mastery, and limited social networks. Where carers tried to cope with their situation through acceptance and reinterpretation, mental health was poor. On the other hand, good mental health was associated with problem-focused coping. These variables have emerged as major predictors of mental health in an enormous number of stress studies, many outside the domain of caregiving.

The first important finding of this study is that these variables remain major predictors of mental health, after the social-relational variables represented by the crises of decline have been controlled. Whereas the social relational variables made a significant contribution collectively to explaining symptoms, these variables did not detract from the individualistic predictors, either through usurping any of their explanatory power or through explaining a larger proportion of the symptom variation.

When the outcome variable was burden rather than minor psychiatric symptoms, a very different picture emerged from this research. Burden, defined as the frustration of basic needs through caregiving, was not explained satisfactorily by the stressor of workload or by the resources that individuals have at their disposal to deal with life's difficulties. Aspects of the caregiving-care receiving relationship that were theoretically connected with the way in which degeneration is perceived in western society dominated both workload and resource variables in the prediction of burden. Awareness of degeneration in the care receiver, caregiver unpreparedness, role enmeshment, unwillingness, and caregiver-care receiver tensions were all strongly intercorrelated and associated with burden. As found previously (Braithwaite 1990), conflict and domination in the caregiving-care receiving relationship influenced burden indirectly through the social, emotional, and cognitive degeneration scale. Where interpersonal tensions in the past and present were high, social, emotional, and cognitive degeneration also was perceived to be high, and this, in turn, was associated with high burden among caregivers.

The third question addressed in this study concerns the role of burden within the hypothesized model in Figure 1. Theoretically, burden is regarded as a variable of central importance. Defined as the degree to which caregiving frustrates basic needs, burden warrants attention both as a threat to mental health and as a threat to human rights (Braithwaite 1992). These data provide empirical support for the contribution of burden to mental health, though not to the exclusion of other variables. Cultural and relational caregiving experiences impact adversely on mental health through undermining the basic needs of the individual, that is, needs for order, security, love, and self-esteem, as Maslow's (1962) theory would suggest. These data are consistent with the thesis that unfulfilled basic needs are at least one of the possible avenues to poor mental health.

Consistent with much of the stress paradigm research is the contribution made by solution-seeking coping in reducing the risk posed by burden to mental health. When levels of burden were controlled, solution seeking was associated with better mental health.

Although these data supported solution coping as a mediating variable, little support was forthcoming for the predicted moderating effects of social status, self-esteem, good health, and social support. In other words, there was no evidence from these analyses that the burden-mental health relationship was weaker for the well resourced than for those with few resources. Whereas this nonsignificant finding was consistent with Maslow's theory of basic need frustration being the precursor of poor mental health, the results conflict with previous work that found evidence of family closeness and available social interaction weakening the burden-symptom relationship (Braithwaite 1990). Two explanations warrant consideration. First, the variance explained by the interaction effects in the earlier study may have been captured by other predictors in the present analyses. The earlier work focused exclusively on the contributions of a variety of social resource variables in explaining caregiver stress. The second explanation is that the ratio of the sample size to the number of predictors in the model may have been too small to ensure sufficient power to adequately test the interaction hypotheses. The issue of whether well-resourced individuals are buffered from the adverse effects of burden on mental health, as the stress paradigm would predict, awaits further investigation.

Before examining the theoretical contribution of this study, the limitations imposed by the cross-sectional nature of these data must be recognized. The model presented in Figure 1 implies causality from left to right in explaining how symptoms emerge as a result of caregiving. Yet the data contain no information about the temporal ordering of events. The study, therefore, can only establish that relationships exist between the major variables in the model. Statistically significant relationships can be considered consistent with the causal theory underlying the model but not sufficient to empirically support theoretical interpretations of cause and effect. Further research is required to establish causal links.

Of particular importance for adequately testing the model outlined in Figure 1 are measures of the psychological variables prior to caregiving. Figure 1 is a simplification of the stress process for caregivers. It is inconceivable that symptoms are not related to burden and other predictor variables in nonrecursive loops. Similar causal paths may be expected between autonomy from parents or partners prior to caregiving, self-esteem, and burden.

Out of such considerations arises an important alternative interpretation of one set of findings in this study. One could argue that depression colors a carer's perception of all facets of life, so much so, that the relationships between crises of decline and burden can be explained in terms of a generalized blackness of outlook. In earlier work, this hypothesis was tested through examining crises-burden relationships while controlling for minor psychiatric symptoms. The relationships were only slightly weakened when the effects of poor mental health were partialled out, leading to rejection of this alternative explanation (Braithwaite 1990). Nevertheless, critiques such as this raise concerns about the collection of data from one informant. Future studies designed to compare environmental stressors, resources, and social-relational variables should incorporate data collection from care receivers and others assisting with care provision.

The theoretical contributions of this article are twofold. The first area involves the conceptual separation of the social-relational crises of decline variables as a set of predictors of burden. The crises of decline were theoretically and empirically interconnected by the proposition that degeneration in intimate caring relationships throws both caregiver and care receiver into a novel and threatening relation-

ship. Caregivers are likely to feel ill prepared, enmeshed in the role, and unable to continue care, and they are at risk of revisiting past conflicts and inviting new ones. These crises are different from the workload demands placed on caregivers that fit the category of objective stressors and the resources that caregivers can draw on to help them adapt to their new situation. This article argues that the conceptual separation of social-relational variables within stress paradigms is not only possible but is useful as a means of understanding the stress process and, ultimately, of addressing the issue of whether policy should be directed more toward changing the individual or more toward changing the social structure of care in our society.

The theoretical insights that can be gained from the separation of the social relational variables can be demonstrated through comparing the empirical findings predicting burden with the conclusions from intervention studies to relieve burden. Many caregiving studies verify the importance of the social relational variables discussed in this article (Hasseltus 1988; Kinney and Stephens 1989a, 1989b; Miller, McFall, and Montgomery 1991; L. W. Morris et al. 1988; R. G. Morris et al. 1988; Scharlach 1987; Townsend et al. 1989; Young and Kahana 1989). Yet, in general, there has not been explicit recognition that these variables may constrain the effectiveness of interventions that seek to reduce workload or increase resources. In an evaluation of respite care, Lawton, Brody et al. (1989) expressed surprise at the way in which carers with high need failed to take advantage of the respite service available to them. Similar frustration has been expressed by Oktay and Volland (1990), who found that carers were always too tired in spite of additional help. Among other things, they suggest looking at the psychology of midlife women for an explanation. Individualistic accounts such as this disguise the social explanations that this study has highlighted. In response to Oktay and Volland, watching irreversible degeneration of a family member is emotionally exhausting and no amount of help can relieve carers from this drain on their much needed energies. Thus it is not surprising that carers are always tired. In response to Lawton, Brody et al., the caregiving relationship is an intense one and cannot be equated with a hostile stressor that the caregiver can turn his or her back on at the first opportunity. Care in our society takes place within intimate relationships: Timing, shared understandings, empathy, and trust between caregiver and receiver are

important aspects of when respite care can be used beneficially and when it cannot. These factors fluctuate in the caregiving dyad, not always in sympathy with the availability of respite care (Braithwaite 1986).

The second theoretical contribution of this study concerns the definition of appraisal. Stress theorists have classified appraisals broadly as challenges, threats, and losses. Lawton, Kleban, Moss, Rovine, and Glicksman (1989) have argued that the conceptualization of appraisal needs further development and, most important, needs to be distinguished from other perceptions involved in the stress process. This study focuses on a particular type of appraisal that defines threat in terms of frustration of basic needs. These needs have wide theoretical acceptance as scientific constructs and they have wide acceptance in society as legitimate concerns in formulating law and social policy. In this study, caregivers were required to say whether these basic needs were frustrated through caregiving. Close informants could have answered these questions equally well, thereby providing a means for examining the precursors to burden using data from different sources. The concept of basic needs may prove to be a useful starting point for more clearly defining the component of threat in the appraisal process.

In terms of the caregiving/well-being relationship, this study confirms opportunities for intervention, while signaling limitations. The findings show that individual interventions to increase the resources of caregivers and to prepare caregiving dyads for what lies ahead remain viable and important options of support. Equally apparent is the fact that interventions cannot compensate for the threat of degeneration, nor can they, en masse, turn destructive caregiving-care receiving relationships into mutually supportive ones. Consequently, burden may be an intractable problem in some informal caregiving contexts.

Further research is clearly required with more refined instruments, with samples that are larger, and where cultural background can be systematically varied. At the same time, these findings do not justify complacency in dealing with burden. They take a small step toward challenging the wisdom of applying pressure to intense, fragile, and often damaging informal caregiving relationships through glorifying family care and limiting options for shared community care. It may be timely to take up Abel's (1990) challenge and seriously consider ways

in which the provision of care in our society can be radically restructured, more equitably shared, and varied to meet the needs of different caregivers and care receivers.

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## APPENDIX

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### Disruption

1. Having to constantly be on call to assist the person you are caring for
2. Being unable to get your household chores done
3. Having to change your plans at the last minute
4. Being unable to get enough sleep
5. Being unable to rest when ill yourself
6. Having health problems as a result of caregiving
7. Not being able to do your job as well as you would like
8. Not having a regular daily routine

### Inadequacy

9. Feeling that you cannot get on top of all the things you have to do
  10. Losing patience with the person you are caring for
  11. Feeling that you are not doing anything as well as you should
  12. Feeling guilty about what you have or have not done for the person you are caring for
  13. Feeling resentment at what has happened to the person you are caring for
  14. Feeling divided loyalties between the person you are caring for and other members of your family
  15. Feeling you have lost control over your life
  16. Feeling that you do not understand the nature of the other person's illness
  17. Feeling resentment that this has happened to you
- 

## NOTES

1. The 4-NS was developed by Henderson, Byrne, and Duncan-Jones (1981) and asked respondents if, in the last month, they had suffered from any one of 13 symptoms. The number of yes responses to 4 of these symptoms—*anxiety, depression, irritability, and nervousness*—constituted the respondent's 4-NS score.

2. A physical deterioration scale comprising three items measuring *incontinence and immobility* ( $\alpha = .71$ ,  $M = 4.73$ ,  $SD = 1.13$ ) was included in the original study (Braithwaite 1990) but



was consistently dominated by cognitive, emotional, and social impairment. Thus it was not included in the analyses presented in this article.

3. Measures were also taken of the tasks that caregivers did for care receivers. Empirically, the overlap was substantial (see Braithwaite 1990). Theoretically, work demand was considered superior to work actually done by the caregiver, for two reasons. First, the basic stress model requires a measure of environmental demand and not response to demand. Second, carers may assume responsibility for a task being done even though they do not do it themselves. Responsibility is part of the demands of caregiving.

4. Caregivers also indicated whether the care receiver required help with the following activities of daily living: shopping, major meal preparation, minor meal preparation, cleaning, laundry, ironing, and handling finances ( $\alpha = .74$ ,  $M = 13.28$ ,  $SD = 1.30$ ). The overwhelming majority of care receivers required help with these tasks (see Braithwaite 1990 for further details). Thus the scale was not included in the present analyses.

5. The availability to caregivers of a confidant was also measured using a shortened version of the Interview Schedule for Social Interaction (ISSI; Henderson et al. 1981). Respondents were asked if they had a particular person who (a) you feel you can lean on, (b) you feel very close to, (c) shares your happiness with you, (d) shares your most private feelings, and (e) gives you a hug ( $\alpha = .57$ ,  $M = 9.23$ ,  $SD = 1.11$ ). Respondents varied little on this scale, with most reporting having a confidant. For this reason, the measure has not been included in the present analyses (see Braithwaite 1990 for further details).

6. For further details of the relationships of the sociodemographic variables to the independent and dependent variables, see Braithwaite (1990).

7. The correlation between burden and time constraints enmeshment is high because of the very strong link for this sample between disruption that frustrates basic needs and general disruption. The correlation would not necessarily be this high in a sample that was less burdened.

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