CONFLICT, STRESS AND COPING IN CARING FOR THE ELDERLY AT HOME: PROPOSAL FOR INTERVENTION

By
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To the loving memories of my father
DECLARATION

This thesis represents original research I conducted between September 1989 and February 1993 in the National Centre for Epidemiology and Population Health, The Australian National University.

Naila Rahman

January 1994
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This thesis is a special tribute to all those fine caregivers who earned my sincerest respect, admiration, and thanks. Many of the caregivers had never before disclosed their life of caring, but when they learned that the purpose of the study was to gain understanding of elder caring and to help the caregivers, their words flowed like a torrent. They relived all this because they hoped that perhaps others could benefit from knowledge of caring. I hope they gained from giving so much.

During the course of this study, countless people assisted in many ways. Even though all of them cannot be mentioned by name, I hope they
understand that I am deeply grateful and thank each of them. Some must be singled out because their contributions were very special. These include Ms. Camilla de Groth Fazakus and Ms. Elizabeth Freeman who provided a support system as well as opportunities for rich and rewarding exchange of ideas.

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Last but by no means least is my spouse Md. Shahidullah, who cheerfully shouldered the major burden of household responsibilities during the long research and writing process and helped in countless other ways, such as by donating his excellent statistical skills, listening carefully, asking provocative questions and introducing new ideas for discussion and exploration. His constant inspiration is a debt that can never be repaid. Amongst all, the greatest gift was his unswerving loyalty and belief that this work was important and deserving of any assistance he could give. Finally I would like to mention the name of my son Shayan whose arrival in September made the writing of my thesis very pleasurable.
This thesis explores the experiences of caregivers caring for an elderly relative at home using qualitative and quantitative methodologies of data collection. Emphasis is particularly placed on conflict. In-depth interviews were conducted to explore the caring experiences of 30 female caregivers, while quantitative methods were employed on 151 caregivers both males and females to identify the predictors of interpersonal conflict and also to test the proposed conceptual model. To get detailed information of the caring situation two new measures were developed: one was a new instrument to quantify interpersonal conflict; the other was the 'Vignette' methodology, which tapped information about the caregivers' sensitivity to conflict and coping with conflict.

All caregivers reported experiencing conflict in their relationship with the elderly person. Caregiving burden, coping strategy, the caregiver's attitude towards caring, the dependency of the elderly person in activities of daily living, predicted most of the conflict. The quantitative data also indicated a two-way interaction between coping strategies and conflict. Conflict was found to divide the caregivers into two groups: adopting adaptive coping and maladaptive coping. Maladaptive coping discriminated between those experiencing high conflict and those experiencing low conflict. Ineffective coping thus led to conflict while high conflict led to ineffective coping. The study concluded with some interventions proposed to reduce the conflict in elder-caregiver relationships.
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CHAPTER 1

INTRODUCTION

In recent years there has been a growing awareness among policy makers of the need to maintain the elderly and disabled in their own homes as long as possible. Increased attention is being given to community care, so that elderly people are able to maintain their independence by living in their own home, being cared for by their family members together with the support of community services. Driven by this ideology of community care, families are encouraged, at least implicitly, to look after their elderly and disabled relatives at home.

As the balance of care for elderly people gradually moves from institutional care to home care, more emphasis is being given to the role of family, friends, and neighbours, the so-called "informal care network" (McLeay Report, 1982). The people providing care are referred to as the informal carers or informal caregivers. Although many elderly people need personal help, or supervision with some aspect of self care, including activities of daily living, the proportion of those requiring help varies with differences in age and vulnerability. In Australia, according to the Carers Survey the proportion of elderly people needing help from a family member is 62 per cent (70.8 per cent males; 54.7 per cent females) ranging from 65 to 69 years, 57.3 per cent (66.5 per cent males; 51.9 per cent females) within the age range 70 to 74 years, and 46.4 per cent (67.1 per cent males, 38.7 per cent females) of those 75 years and over (Australian Bureau of Statistics, 1988). In most of the cases spouses and children,
particularly daughters, are providing the care. Some elderly people, particularly
women over 75, are living alone. Some however do not live with immediate
family and also do not have a carer. It was found that 74 per cent of men have a
carer, compared to only 58 per cent of women. The difference becomes more
pronounced with increasing age: in the age group 75 years and over, 68 per
cent of men and 39 per cent of women had carers. In some cases the elderly
person does not live with the family, but family members are supportive
(Rowland, 1983). To them their elderly relative is a resource and not a burden
(Kendig & McCallum, 1990).

Beginning in the 1980s, researchers started to study the impact on caregivers
which caring for an elderly person has and also how caregivers feel about it.
These were two large-scale surveys, one made as a part of the Ageing and the
Family Project at the Australian National University (Kendig et al., 1983) and a
detailed study emphasizing the factors that had caused carers to give up their
caregiving roles (Rossiter, 1984). A third survey was conducted by Australian
Council on the Ageing and Australian Department of Community Services
(1985). Apart from these surveys two small-scale, more in-depth studies were
conducted: one in Inner Sydney (Eisenberg, 1987), the other in Canberra
(Braithwaite, 1990). Both these smaller studies present a very good picture of
carers and those they care for. The Inner Sydney study included elderly people
living in the community and also in the nursing home, and their carers. The
study was divided into two phases: the carers' study and the elderly people's
study. The design of the first part included both qualitative and quantitative data.
A semi-structured interview schedule was used for the carers and covered
areas of basic demographic and social data such as age, marital status,
housing, income, education, family, friends, holidays etc.; the tasks of caring;
health and recent life events; and feelings about role, self-support services, and
the future. The second phase, which was quantitative, was designed to provide
a physical and social profile of the aged residing in the community as well as in
the nursing home. The findings indicated women carers to be more burdened,
and to show more frustration, anger and despair due to caring for their elderly
relative than men carers. Braithwaite on the other hand interviewed 144 carers
in Canberra to explore the caregiving burden in terms of the caregivers' and the
care receivers' social and psychological characteristics. Results from the
quantitative data indicated that the caregiving burden was the main
consequence of caring which led to some personality disorders, particularly
depression. In a more recent study in South Australia by Kalucy and Baum
(1992), it was reported that though the caregivers received satisfaction from
their caring, a significant proportion of caregivers experienced stress and
restriction of activities.

Some of the problems experienced by the caregivers are due to the disturbance
created by the elderly persons' disability and need for care, one consequence of
which may be change in the balance of individual roles and responsibilities
(Brody & Spark, 1966). Many family members while caring for their elderly
relatives also have their own commitments such as family and work; these
multiple-role involvements in some cases may produce conflict (Goode, 1960;
Marks, 1977). Sometimes during the process of caring, family members find it
hard to meet the needs of the impaired elderly; they are unable to cope with
scarce economic resources. In some cases stressful events and social isolation
exacerbate family conflicts (Pillemer & Wolf, 1986), involving the family, the
elder, and the family's situation (Foulke, 1980), thus affecting family stability
(Brody et al., 1989).

The caregivers thus experience some costs and benefits, burden and stress
during the process of caring. In the later sections of this thesis a description of
the literature on burden, stress, conflict, and coping is given. The conceptual
model outlined in a later section of this chapter was based on work in previous studies, and provides the theoretical contribution of the thesis. However, before discussing the consequences of caring it is necessary to know who the caregivers in general are. For example is it men or women who are mainly involved with the caring? The following section will answer these questions.

1.1 Who Are the Carers?

The existing literature demonstrates that elderly people are cared for by their spouses, children, other relatives, friends, and neighbours (Shanas, 1979; Horowitz & Debrof, 1982; Cantor, 1983; Litwak, 1985; Stephens & Christianson, 1986). Although a variety of people may be involved with the caring, it has been recorded that caregiving is mainly a female responsibility (EOC, 1982; Cantor, 1983; Brody, 1985; Dorvil, 1986); women, rather than men, assume the greater burden of caregiving for the elderly (Wake & Sporakowski, 1972; Lopata, 1979; Troll & Bengtson, 1979; Brody, 1981; Lang & Brody, 1983; Stoller, 1983; Horowitz, 1985a; Houser et al., 1985; Roff & Klemmack, 1986).

Among women caregivers, wives have been found to be the primary caregivers of elderly spouses, while daughters provide more help than sons to elderly parents (Shanas, 1979; Brody, 1981; Cicirelli, 1981; Stoller, 1983; Horowitz, 1985a; Chappell, 1990); in some cases married daughters (Nissel & Bonnerjea, 1982) and in other cases adult daughters and daughters-in-law (Townsend, 1963; Shanas, 1979). Men have been observed to depend substantially on their wives to assist them with looking after parents (Horowitz, 1981). The above findings are supported by Allan (1985: 130):

Just as the bulk of housework and childcare is undertaken by mothers, so too by far the largest portion of routine tending for the elderly is provided by daughters. Support at a daily level is almost
wholly given by women and is defined as an extension of their routine domestic role.

Two Australian studies, by the Australian Bureau of Statistics (1988) and Braithwaite (1990), also have reported women to be the carers of elderly people. Both studies have concentrated on caregivers of people who are 65 years and above. However, when the age of the caregivers was taken into consideration it was found that in the age group 70-74 years and 75 years and over, caregiving was more prevalent among men than women (Australian Bureau of Statistics, 1988: 6).

There have however been various clearly specified explanations for this gender difference. The traditional societal expectation is that strong family concerns are part of the feminine role, and kin keeping tasks are women's responsibilities. Shanas (1979) reports that women have traditionally been the primary caregivers. Others put forward the argument that as women are family-oriented and nurturing, they view their role as a continuation of early responsibilities, and hence are more active helping with tasks of daily living including attending the personal hygiene needs of the care receiver, household tasks and meal preparation (Stoller, 1983; Horowitz, 1985b). Others state that women do the caring in most cases because of their affiliational role in society (Chodorow, 1978) and because they frequently judge themselves according to an ethic of responsibility and care (Gilligan, 1982). However, one possible explanation for the overrepresentation of male caregivers in the Australian Bureau of Statistics (1988) study could be the operational definition of carers. A carer was defined as an adult over 15 years of age, living with the handicapped person and also nominated by the handicapped person to be the main carer. A recently released Australian Bureau of Statistics Family Survey used the families own definition of "caregiving" without a restriction of co-residence. This new survey shows
women as the dominant providers of care except for home maintenance (Australian Bureau of Statistics, 1993).

In summary more women than men have been found to be involved with caring. The next section summarizes the impact caring has on these people.

1.2 The Consequences of Caregiving: Review of the Literature

In describing the impact of caring on caregivers, researchers have used a number of different constructs. Rather than attempt to review the whole caregiving literature as found in psychology, sociology and epidemiology, the following review comments on four main concepts: burden, stress, coping, and conflict. The aim of this review is to describe in detail the caring process as conceptualized in these four constructs.

1.2.1 The Burden Literature

Burden means the problems, difficulties or adverse events which affect the life of the family members who look after an elderly relative. In most literature the concept of burden is synonymous with the effects of caregiving. The term is used to refer to a variety of phenomena related to caregiving. In the literal sense, burden refers to the load borne, the responsibilities carried, or the time and effort required for one person to attend to the needs of another. Burden is thus defined as the extent to which caregivers perceived their emotional or physical health, social life and financial status as suffering as a result of caring for their relative (Zarit et al., 1986). It is widely used to refer to the physical, psychological, emotional, or social problems that can be experienced by family members caring for an impaired older person. It can range from emotional costs...
such as feelings of embarrassment and overload (Thompson & Doll, 1982), to specific changes in caregivers' day-to-day lives such as disruption of daily routine (Fatheringham et al., 1972), financial difficulties, role strain and physical health deterioration (Zarit et al., 1980; Robinson, 1983).

There are many published studies about the family burden experienced by relatives of elderly people. Some of those studies have been conducted to examine the problems of caring for a mentally infirm elderly relative at home (Koopman & Wells, 1979; Gilleard et al., 1982; Greene et al., 1982). Another group of investigators have studied the feelings of burden experienced by family caregivers of demented relatives (Zarit et al., 1980; Chenoweth & Spencer, 1986; Fitting et al., 1986; George & Gwyther, 1986; Gwyther & George, 1986; Scott et al., 1986; Zarit et al., 1986).

In their study of caregivers of dementia patients Fitting et al. (1986) found women caregivers to show more depressive symptoms than the men, with the younger wives feeling more burdened, lonely, and resentful of their roles. However, no significant difference in burden was found for caregiver relatives of demented and depressed patients who were admitted to a geriatric psychiatry inpatient unit (Liptzin et al., 1988). Caregivers who were living with a demented relative experienced more burden than those who were not.

In one study caregiving burden was found to be inversely related to the frequency of family visits to the care provider. However, caregivers perceived the burden from the consequences of providing care on health, psychological well-being, finances, social life and the relationship between the caregiver and the care receiver (Zarit et al., 1980). The elderly person's impairment was not associated with the perception of burden (Zarit et al., 1980; Zarit, 1982). Reece
et al. (1983) concluded that caregivers who lived with the impaired elderly experienced the heaviest burden.

Studying caregiver burden of family members of Alzheimer's disease patients, George and Gwyther (1983) did not observe any association between caregiving and increased physical health or economic problems, but caregiving had its greatest effect upon the dimensions of well-being, especially mental health and social participation. In another study the caregivers found themselves most affected by the demands of care, isolation from friends, embarrassment in public and incomplete information on the progression of Alzheimer's disease and the personality changes of the elderly (Barnes et al., 1981).

Though gender and relationship to the caregiver have been found to have an impact on the caring experience (Fitting & Rabins, 1985; Horowitz, 1985a) the findings regarding the relationship between gender and burden have been less consistent. In a longitudinal study of caregivers, husbands were found to be less burdened than wives (Zarit et al., 1986), but there was no difference in the degree of burden when these people were followed up two years later. Fitting et al. (1986) also found no difference in burden among men and women caring for their demented spouses. However, for younger wives and older husbands the level of burden increased with greater levels of spouse impairment (Fitting et al., 1986; Zarit et al., 1986). Younger caregivers reported that they were more lonely and resentful of their role than older caregivers (Fitting et al., 1986). In their study of spouse-caregivers Steinberg and Shulman (1981) reported that wife caregivers felt burdened by their spouses' dependency while the husbands had problems with the household responsibilities and their spouses' incapacity to interact.
Studies conducted on ethnic groups and in other countries also report some instances of burden. When caregivers of Black and Hispanic dementia patients were compared, the Hispanics reported a greater sense of burden. However, in both Black and Hispanic samples the immediate family members felt more burdened than those who were more distantly or not at all related to the patient, and the burden was greater for women caregivers (Monk et al., 1990). Another caregiving study in two municipalities in Sweden reported similar findings: 60 per cent of the caregivers experienced burden as they had to curtail social contacts (Berg & Holmgren, 1984).

### 1.2.2 The Stress Literature

As the literature on stress is very wide, the following review is restricted to studies on stress of caregivers of elderly people. Although a familiar idea, stress is an elusive concept to define and is not necessarily synonymous with the concept of caregiving burden. As mentioned earlier caregiving burden is the extent to which caregivers perceive their emotional or physical health, social life and financial status as suffering as a result of caring for their relative. On the other hand stress has been defined as "a force, applied to a system, sufficient to cause strain or distortion in the system" (English and English, 1958: 529).

It follows from the definition that stress is dependent on the person's perception of the situation. As it goes, first confronted by a potentially stressful situation, the person engages in a process of primary appraisal. Appraisal refers to how the person evaluates a stressful situation as positive, neutral or negative. If it is negative how harmful, threatening, or challenging is it? (Lazarus & Launier, 1978; Folkman & Lazarus, 1980; McCrae, 1984; Folkman et al., 1986). By the term harm is meant the damage that has been already done, threat represents
the potential for harm, while challenge refers to the potential for some significant gain under difficult conditions. When the person decides what the situation is, the person then engages in a secondary appraisal to determine whether or not the coping abilities and resources will help to overcome the harm or threat and successfully meet the challenge. Stress is thus the blending or balance between these two processes of primary and secondary appraisal.

It has become a matter of increasing concern for policy makers and professionals that stresses experienced in caring for a disabled family member may erode the capacity of families to continue providing needed services. With this view many studies have concentrated on the stress involved in caring for an elderly person. From a number of exploratory studies it is observed that the elderly is the main source of stress to the caregiver. In those cases the elderly person lived with the caregiver, were 75 years and older, and had mental or physical disability (O'Malley et al., 1979; Boydston & McNairn, 1981). Similar observations are reported in a community survey (Wolf et al., 1982). In other studies the major problem of the caregivers was stress which resulted from lack of resources, lack of understanding of the ageing process, and financial problems (Chen et al., 1981; Elderly Abuse Task Force, 1984). Many caregivers experienced a variety of stressors (McLaughlin et al., 1980), of which alcohol abuse and mental illness of the elderly as well as the caregiver were the most important (Dozier, 1984). Others reported role fatigue (Houlihan, 1987), depression (George & Gwyther, 1986), and diminishing quality of relationships between the caregiver and care receiver (Scharlach, 1987) to be the most documented stressors of caring.

Some other sources of stress experienced by the caregivers were the problems associated with odd, dangerous or disruptive behaviour of the elderly (Grad & Sainsbury, 1968); unfavourable relationships between the caregiver and the
elderly (Koopman & Wells, 1979); overdemanding nature, the constant need for attention and supervision from the dependent elderly (Gilleard et al., 1982); the apathetic inactivity of the elderly (Greene et al., 1982); and the quality of the past relationship between the caregiver and the dependent elderly person together with the extent of informal social support the caregivers received (Horowitz, 1981).

Whatever the sources of stress, Brody (1985) recognized caring for an elderly relative to be a 'normative but stressful experience'. The caregivers were reported to experience a variety of stressors. Among various problems experienced by family caregivers are anger, anxiety, guilt and depression (Grad & Sainsbury, 1968; Poulshock & Deimling, 1984; Brody, 1985; George and Gwyther, 1986). It has also been observed that emotional strain is the most dominant effect of caregiving burden (Zarit et al., 1980; Johnson & Catalano, 1981; Horowitz, 1982; Rabins et al., 1982; Cantor, 1983; Brody, 1985). A great amount of depression and conflict has been observed among family members by Zarit et al. (1980); Safford (1980); Lazarus et al. (1981); and Steuer and Clark (1982).

The other types of strain the caregivers experience are strained family relationships, economic strain, and restrictions on time and freedom (Horowitz, 1982). One study reported wife-caregivers to have high rates of hypochondriasis after caring for their disabled spouses (Busse, 1976). Robinson (1983) used the Caregiver Strain Index on caregivers of elderly people who were discharged from hospital after treatment for arteriosclerotic heart disease or hip operation; she found strains, readjustments and disturbances to be the most prominent stressors for the caregivers.
Rabins et al. (1982) found 87 per cent of the caregivers in their study to report fatigue, anger and depression due to caring, while half of the caregivers identified loss of friends and hobbies, and family conflict to be most stressing. On the other hand caregiving stress was found to be associated with the greater involvement of working for the elderly parent (Robinson & Thurner, 1979). In another study the deteriorating memory and behaviour of the patients was found to be a major cause of stress among caregivers of Alzheimer’s Disease patients (Rabins et al., 1982). However, some amount of stress was also experienced by caregivers caring for mothers who were functioning independently. These caregivers reported role strain and unfavourable mother-daughter relationships (Scharlach, 1987).

Studies carried out in other countries demonstrate similar findings. Studies on family caregiving in Sweden revealed instances of personal sacrifice and emotional strain from caring for dementia patients. Some caregivers were found to have psychosomatic illness (Adolfsson et al., 1981); emotional strain (Tornefelt & Johansson, 1988); and symptoms of depression, anxiety and remorse (Winqvist, 1984).

Although caregivers are reported to experience stress, various studies of gender differences among caregivers have demonstrated that women caregivers experienced more stress in the form of depression than did men (Robinson & Thurnher, 1979; Cicerelli, 1981; Noelker & Poulshock, 1982; Cantor, 1983; Johnson, 1983; Horowitz, 1985a; Fitting et al., 1986). In those studies it was not clear, however, whether this reflected their emotional involvement in the caregiver role, different degrees of emotional and task support from others, or modes of responding to indices of depression. Similar results are obtained in another study where female caregivers have been found to be more distressed than a normative sample or male caregivers (e.g. feelings
of depression, anxiety, hostility) (Anthony et al., 1986); daughters and daughters-in-law are the most vulnerable to stress because of their competing commitments (Noelker & Poulshock, 1982). In a case-control study, Haley et al. (1987) found that the caregivers of senile dementia patients were significantly more depressed and had poorer health and quality of life than the non-caregivers. It is thus evident that the stress experienced by caregivers does not follow a coherent pattern although some sources and features of stress have been consistent.

1.2.3 The Coping Literature

Coping has been used as a central term in many studies. It is viewed as a complex amalgam of thoughts and actions (Cohen & Lazarus, 1979). According to some researchers, coping refers to the actions employed by people to reduce the stress they experience (Fleming et al., 1984). It is not a well established and fixed behaviour pattern but changes over time depending on the stressful situation. Some people may cope by becoming angry, feeling guilty or sad or talking it over with a confidant; some may deny the presence of the situation while others may experience some somatic symptoms such as headaches or indigestion. People thus adopt different strategies to cope with the situation.

Coping strategies are the things people do to manage stressful situations. They have been typed as either 'problem-focused' or 'emotion-focused' (Folkman & Lazarus, 1980; Billings & Moos, 1981). Problem-focused coping strategies are those which aim to manage a problem. Emotion-focused strategies, on the other hand, are those which avoid the problem and concentrate on dealing with the emotional suffering experienced over a situation.
The coping strategies have fairly universal application. They help to reduce tension and restore emotional equilibrium (White, 1974; Cohen & Lazarus, 1979); and in many occasions give the caregiver periodic relief from the caregiving situation (Levine et al., 1983; Zarit et al., 1986). However, when coping is viewed across situations it is observed that there may be consistency and variability in the coping mechanisms (Sidle et al., 1969; Moos, 1974). Most families rely on their own resources to cope. Some seek specific treatment programs such as physical therapy and exercise, memory classes and counselling.

People thus use particular coping strategies for particular situations (Coyne et al., 1981; Felton et al., 1984; McCrae, 1984). Some people may show cognitive responses such as reduced ability to concentrate, higher than normal levels of distractability, impaired performance on cognitive tasks (reading, writing), and disruptive or morbid thoughts (Cohen, 1980; Taylor, 1986). Some may react to stressful events by employing one or more of the defence mechanisms, such as minimizing the harm or threat of a stressful event by blocking it from conscious awareness (repression), or engaging in rationalization or projection of blame. In some circumstances stressful events may also result in positive cognitive responses such as learning new ways to cope with or neutralize the stressful event.

In the literature on coping in caregiving, most of the studies have focused on strategies for managing the behaviours of the elderly relatives, along with methods for alleviating the caregivers' emotional stress due to caring for those with Alzheimer's Disease and other forms of dementia. Problem-solving, active self-talk, and consultation-seeking strategies were found to be the most effective coping strategies by caregivers of elderly person suffering from dementia (Levine et al., 1983).
Pratt et al. (1985) found that the most effective coping strategy adopted by caregivers to reduce the burden of caring for old people with Alzheimer's Disease was problem-solving, problem reframing and passivity, and seeking familial and religious support. According to Tonti (1985) caregivers of demented persons undertake two ways of coping with the stress of caring. The over involved or enmeshed caregivers try to take too much control of the demented person's activities, while the under-involved or distanced caregivers cope by deserting the family member.

Chenoweth and Spencer (1986) found that coping ability was affected by the perceived burden of caregiving, whereas Scott et al. (1986) reported socio-emotional support from family members to be positively associated with effective coping with the burden.

The caregivers caring for elderly relatives suffering from dementia, Parkinson's disease, lung disease, and general frailty preferred to manage the situation themselves. This study underscored the importance of a varied repertoire of coping strategies to cope with the stress associated with caring for old people with diverse problems (Barusch, 1988).

Using a modified stress-adaptation framework with husbands, wives and daughters as caregivers of elderly people with Alzheimer's Disease, Quayhagen and Margaret (1988) found that the three groups of caregivers identified similar coping strategies, of which help-seeking was the most commonly used, followed by problem-solving and existential growth, along with blame and fantasy. Minimisation of threat was less frequently used.
Different researchers recommended different coping strategies that might be effective in reducing stress. Of these different approaches, intellectual, social and emotional stimulation was strongly encouraged by Reifker and Wu (1982). However, Siegler and George (1983) found a combination of palliative and instrumental coping strategies to be more effective than a single one, the most effective strategy varying with the type of stress experienced. Zarit et al. (1985) on the other hand recommended retaining the independence and self-sufficiency of the patient by adopting the problem-solving approach.

Thus the coping strategy adopted by the caregiver varies according to the situation. Folkman and Lazarus (1980) state that coping strategies are problem-specific rather than problem-invariant. At certain times the caregiver may rely more heavily on a defensive strategy, and at other times on problem-solving. Thus the coping pattern of the caregiver is likely to change as the situation changes: it is a 'shifting process' (Lazarus, 1983).

Coping arises not only from the stressful situations but also from the personal attitudes and characteristics that shape the stressful situations and are shaped by them. However the existing literature does not distinguish between the coping strategy to reduce caregiving burden and the coping strategy to reduce the stress created by caregiving burden, as it does not establish the relationship between caregiving burden and stress. Sengstock and Liang (1982) and Pillemer and Finkelhor (1988) provide some preliminary evidence of a relationship between stress and abuse. To date, there has been no systematic exploration of the relationship between caregiving burden, stress, conflict and the coping strategy adopted. The present study therefore, focused on specific coping efforts in a single area: conflict.
1.2.4 The Conflict Literature

Beyond burden and stress, conflict is also assumed to be an important variable in helping relationships. As some old people require a great deal of help, the helping relationship often becomes a source of conflict on the part of the caregivers.

Though the concept of 'conflict' has been defined in different ways by different researchers, the definition advanced by Peterson (1983) has been chosen as the most appropriate for the present study. Thus conflict is defined here as 'an interpersonal process that occurs whenever the actions of one person interfere with the actions of another'. According to this definition 'actions' involve verbal and non-verbal actions (e.g., ranging from passive resistance to active aggression), as well as cognitive (e.g., the perception that some other person or entity acts against one's interests) and affective accomplishment (e.g., tension and hostility) of these actions. Conflict can occur in relation to a specific behaviour of one person or the other, to norms or rules governing the two parties, or to personal dispositions (e.g., traits) of one or both.

As family relationships persist over long periods of time, and nearly all are accompanied by conflict in varying degrees, conflict has been considered as simply one of the processes of social interaction (Coser, 1967). However, there have been very few studies on interpersonal conflict in caregivers and the elderly. The sparse literature on conflict comes from U.S. studies which have focused on family violence (Coser, 1967) and abuse of the elderly (Steinman, 1979; Cicirelli, 1981; Steinmetz & Amsden, 1983; Hagestad, 1984; Cicirelli, 1986). There has been no specific study in Australia on conflict and caregiving.
The lack of attention to the study of the endemic conflict in caregiving arises from the implicit preference among most writers for a consensus model of society. The burden and coping concepts are congruent with assumed consensus about caregiving. Conflict in caregiving relations is more problematic since it raises the possibility of a lack of social agreement about caregiving roles. As conflict appears to be normal part of family relationships, interpersonal conflict in the context of family caregiving clearly merits more detailed examination. This study is a step in that direction. In it is explored the relationship between coping strategies, stress, burden and conflict for caregivers to the aged.

1.3 Models of the Caregiving Process

In the previous sections the four constructs, burden, stress, coping and conflict, were discussed to see how they can be used to describe the caring process. The following section describes the inter relationship between these variables in order to develop a multivariate model of the caring process.

In their study Poulshock and Deimling (1984) found a moderate-to-strong empirical link between elders' impairment and the corresponding burden reported by the caregivers. They have given importance to the subjective interpretations of the caregivers as to how they perceive the problems due to caring for an elderly person with both physical and mental impairments. They have proposed an analytic model in which burden played a central role between the elder's impairment and the impact that caregiving had on the life of the caregiver and family life.
Similar findings were also reported in Braithwaite's (1990) study, where in addition to the elderly person's impairments, the caregiver's mental health, daily work load and gender were directly associated with caregiving burden. Based on the proposition that 'caring for someone who is losing skills rather than acquiring them presents a unique set of difficulties to carers which threaten well-being', Braithwaite (1990) has presented a model to guide the analysis of three major types of risk factors: workload; coping strategies and support from others; crisis of decline. In this model burden was used as a particular kind of appraisal: the appraisal that the event is threatening to basic needs. This model also establishes the proposition that caregiving risk factors directly affect burden and indirectly affect symptoms through burden. A schematic diagram of the model is given below.

**Figure 1.1: Source: after Braithwaite, 1990:132**
However, this model cannot be taken further as an explanation of caregiving burden because caregiving burden cannot be treated as the appraisal factor. From caregiving burden a caregiver cannot estimate the value of the caring situation. That is he/she cannot definitely say that caring is threatening to basic needs. Because Braithwaite in her model has likened burden to the stress theorists' notion of the appraisal of an event where the person evaluates a stressful situation as positive, neutral, or negative. In the present study it is expected that the caregiving risk factors will determine which coping strategy the caregiver should undertake to deal with the situation. The caregiver then appraises whether the coping strategy is effective, harmful or threatening. This degree of appraisal will in turn determine whether the caregiver is burdened. Thus it is expected that coping strategy should be the appraisal event and burden the outcome of that coping.

Stoller and Pugliesi (1989) on the other hand have demonstrated that caregiver burden and well-being are both affected by the multiple roles of the caregiver, the caregiver’s work load, the social support received by the caregiver, the relationship to the old person, the living arrangements, the health condition of the old person, and the quality of the caregiver-old person relationship (see Figure 1.2).

In the model it was proposed that multiple roles of the caregivers might have positive and negative effects. For example in some cases caregivers may find competing commitments to be tiring which will affect them negatively, in other cases it may not be harmful if they perceive it to be self-enhancing, which serves as a buffer against caregiving stress. In addition caregivers who receive sufficient social support, have a positive relationship with the elder, and positively assess the old person’s health, are expected to have less burden. On
the other hand it is also hypothesized that daughter-caregivers and those living in the same household are likely to experience greater burden.

Figure 1.2: Source: after Stoller and Pugliesi, 1989: S232

Other Responsibilities of Caregiver
Caregiver is married
Number of children living at home
Caregiver is employed
Number of nonfamilial roles

Level of Assistance Provided
Hours of assistance
Scope of assistance
Hours of personal care
Scope of formal assistance

Support to Caregiver
Socioemotional support
Instrumental support

Other Dimensions of Caregiving Situation
Caregiver is daughter of elder
Shared household
Helper's assessment of elder's health
Quality of elder-helper relationship

It can be postulated that the health of the old person is not the only factor: the health status of the caregiver also demands attention. To have a smooth-running home (especially with an elderly person), all members must function interdependently. Especially the caregiver must be physically fit in order to provide constant care to the elder; physical impairment of the caregiver will make it difficult for him or her to fulfill the elder's demands. Not only will this create an imbalance in caregiving activity, but the caregiver's impairment together with the elder's impairment may multiply the amount of burden. However, this issue was not addressed by Poulshock & Deimling (1984).
Caregivers' unmet needs should also be considered important in contributing to perceived burden. Constant round-the-clock caring may interfere with the caregivers' personal activities, in some cases causing them to quit a job, to disrupt family life, and to lose all sorts of social contacts. Some may still resent having to give up previous work, or the effect on the relationship with spouse, children or siblings. Many may have other needs which because of caring are unmet. These facts give rise to an important question: 'What unmet needs do caregivers have?'. The studies cited above have ignored this issue.

Availability of social support is also assumed to play an important role in caregiving burden. However, the distinction between social support and social-support network must be taken into consideration. Social support refers to the tangible and intangible forms of assistance that individuals receive from informal providers, usually family and friends. The services provided by these people range from financial assistance to the performance of tasks and to the less concrete, but important contribution of emotional support. The support network refers to the configuration of people who provide assistance to the individual such as community-based health and social services. It is thus expected that the caregivers' perceptions of burden will vary depending on the amount of support they get from friends, relatives, neighbours and government agencies. To measure why caregivers receiving identical amounts of assistance differ in their perceptions of the adequacy of that support, both the objective dimensions (size and proximity of the network, number and types of services provided by that network), and subjective dimensions (caregivers' perception of the adequacy and satisfaction) dimensions must be considered.

During the past decade much exploration has been done of the nature, importance and impact of social support in the caregiving role (House, 1981;
Berkman & Breslow, 1983; Cantor, 1983; Aronson et al., 1984). Most of the existing studies on social support have examined the role of formal and informal providers separately, on the basis of the subjective interpretations of the care providers. So far only one study (George, 1987) has examined formal and informal services simultaneously on the basis of subjective and objective dimensions. The results indicated in general that caregivers received very little help from either types of provider. The objective level of support was low and the majority of caregivers perceived the need for more support, and that the relationship of objective and subjective measures is non-significant. This study has a major limitation for my purposes: the study was conducted on caregivers caring for people with Alzheimer's Disease, which is especially difficult.

From the above discussion it appears that caregiving burden may be due to a number of factors such as the caregiver's health, needs, environment and social support. So far the bulk of literature on caregiving has focused only on the burden experienced by the caregivers. An exception is the study by Motenko (1989), who reported that the caregivers experienced feelings of gratification from caring for their impaired relative which in turn was associated with their well-being. Apart from negative aspects of caregiving there are some positive aspects too, such as the feeling of gratification.

Though caring for an elderly person is hard work, takes a lot of time and involves personal and social costs, some caregivers receive needed gratifications and rewards from caring. For some there may be moments of warmth, comfort and pleasure. This belief has been found to be stronger when the caregivers express emotional needs for providing care. The desire to provide care arises from wanting to give comfort and emotional support, expressions of love and affection, companionship, reciprocating past care, and commitment (Graham, 1983; Horowitz, 1985a; Johnson, 1985; Motenko, 1988).
Under such circumstances the same caregiving situation may be burdensome to some while a source of gratification to others.

However, there are a few instances where the researchers have paid attention to the positive aspects of caregiving. Horowitz (1985) included a short section on 'The benefits of caregiving' in his major critical review of caregiving; and Zarit, Reever and Bach-Peterson (1980) included a few positive items in their Burden Interview. These items were handled in a unidimensional fashion along with the negative caregiving attitudes. Considering the caregiver's subjective interpretations of the older person's health to be a positive description of the impaired person, Poulshock and Deimling (1984) developed the Mental Status Measure. In that measure all the eight positive items fell into a single factor 'Sociability', out of which two items referred to the self-rated attributes of the caregivers in response to the elder. Braithwaite (1990) and Levin (1989) also identified a number of positive aspects of caring: in spite of the hard work of caring, this work was rarely the thing the carers saw as the major problem. In none of these studies was there an attempt to examine conceptually and statistically the positive side of caregiving in its own right.

In investigating the positive aspects of caring these studies have failed to give due attention to the question 'why do all carers not derive satisfaction from caring in the same way?'. Some may be happy to be a companion to the older person or care for that person through love and affection but may find the practical tasks of caring relatively tiring and burdensome, or may feel anxious and stressed at the thought of the effect of the caregiving demand on the caregiver's family relationships. On the other hand one may seek the social approval of caring but in turn may be burdened and stressed.
These feelings of satisfaction may be synonymous with the concept of 'uplifts' as given by Lazarus and Folkman (1984). Uplifts are small events that evoke some response of pleasure, affirmation or joy in the person. Caregiving satisfaction may be due to the accumulation of daily caregiving uplifts. However if there is some sort of breakdown in the uplift, a person is likely to experience stress.

This difference in the reaction to caring for an elderly person may be due to the differences in the attitudes of the caregivers. To some caring for an elderly dependent may be a responsibility, while others may perceive it as reciprocation for past affection and care and hence to be nurturing. These perceptions are thought to be shaped by the societal norms and values. Owing to the differences in the norms and expectations of different societies, attitudes towards caring for an elderly person may be different. This will not only help to compare the caregivers and to identify why some are burdened and others are gratified by the caregiving role, but also contribute to identifying the attitudes towards caring for the elderly. It is here that the subjective interpretations of caregivers are important. In order to get detailed information on all these issues the caregivers' perceptions must be taken into account. A person's perception of a situation is often a better predictor of behaviour than objective criteria (Lester, 1968; Neimi, 1974; Steinmetz, 1977).

To date no study has explored the effect of all these factors on caregiving in the same setting, particularly with reference to interpersonal conflict. The Poulshock & Deimling (1984) study was restricted to examining the effect of the elders' impairment on caregiving burden. It also underscored the need to apply the concept of burden to subjective interpretations by caregivers of the elders' different kinds of impairments, both physical and mental.
Though Braithwaite’s (1990) study looked at the concept of caregiving burden more broadly by considering a variety of factors, such as mental health, psychological well-being and demographic measures, it did not address the issues of gratification and conflict.

In summary, although the previous studies have explored various factors, they were studied in isolation. It is expected that caregiving burden is not the only consequence of caring. This study is a first step in combining known predictors and observing interpersonal conflict. Thus one critical aspect of the present study is to observe whether the elder’s health, the caregiver’s health and needs, the living environment and social support lead to caregiving burden, stress or feelings of gratification in the caregivers. An examination is made of interpersonal conflict as a consequence of caring and the predictors of conflict. Identification of predictors of conflict is important in order to develop interventions and also it may have an impact on the policy implications, in the area of caregiving.

1.4 The Proposed Research Model

A careful examination of the caregiving literature shows that caregiving burden is inextricably related to stress and conflict. However various studies have used these concepts according to the nature of the study, giving an impression to the reader that they express the same meaning. An important question still remains: 'Can conflict be considered as the outcome of a coping process?', or 'Do burden and stress due to caregiving have any relationship to conflict?', which has not been systematically studied to date. No other study has examined all the three concepts in one model, to see how each affects the others. The
The present study is thus an effort to consider all of these concepts in one model. The schematic diagram of the model is given in Figure 1.3.

**Figure 1.3: Conceptual Model of Caregiving for the Elderly**

![Schematic Diagram of the Model](image)

The proposed model follows Lazarus and Folkman's Psychological Model of Stress. The paradigm states that a person is likely to experience stress when that person finds out that the coping abilities and resources are not sufficient to overcome the harm, threat, or challenge posed by the external event.

The present model is based on the assumption that a single act cannot constitute coping. There must be a constellation of many acts and thoughts engendered by a complex set of demands that may stretch out over time. A person may have a particular style or pattern of coping, but such styles involve a combination of many acts and thoughts rather than a single one.
As people direct their lives in different ways depending on their differing personal interests, resources and environmental conditions, it is this difference in perceptions of life which generates different meanings and ways of coping in different people. It is thus expected that because of individual differences not all caregivers will react to the same caregiving situation in the same way. These individual differences are also dependent on the socio-demographic characteristics of the person. As people differ at the socio-demographic level (age, sex, education, income, marital status, living arrangements, religion, country of origin) it is expected that they will have different norms and values. These different societal norms and religious expectations are assumed to affect their attitudes towards caring for the elderly.

Not only do the socio-demographic variables shape a person’s attitude but the caregiving context is also assumed to affect the caregiver’s attitude towards caregiving. A favourable attitude towards caregiving is likely to develop when the care receiver and the caregiver have good health, when the living environment is congenial for caregiving, when the caregiver receives sufficient support from family members and social networks, and when the caregiver has fewer needs that are unmet.

It is thus assumed that the socio-demographic characteristics and the caregiving context will directly affect the caregiver’s attitude towards caregiving. Because of these differing attitudes the caregivers will perceive caregiving in different ways: as a burden, stressful, or satisfactory.

However, some burdened caregivers may report feelings of stress, as burden and stress may directly or indirectly affect each other. While caregivers may state that providing certain tasks was stressful, they still may not perceive the overall responsibility as burdensome; and some caregivers may not consider it
stressful to perform these tasks, but the overall responsibility or some untapped aspect of caregiving may result in their feeling a sense of burden in the caregiving role. Not only burdened caregivers are expected to be stressed: caregivers who are satisfied with the caregiving role, who find the overall caregiving context pleasurable and have favourable relationships with the care receiver, may experience certain moments when they are stressed.

Under such circumstances the coping strategy is considered to be the precipitating event when the caregiver will choose a method of coping with the demands posed by the caregiving. Caregivers are most likely to adopt a ‘problem-focused’ strategy if they have positive attitudes towards caregiving. They will then try to manage the problems by dealing with them effectively; confront the situation and carry on; withdraw from the situation (i.e. avoid the old person, get away from caregiving situation etc.); or adopt some other way of dealing with it: talk it over, seek advice from physicians or community workers, consider alternative housing, scream or yell, threaten physical force. On the other hand a caregiver having negative attitudes towards caregiving is likely to revert to the emotion-focused strategy and avoid the problem by suffering from emotional problems.

Whatever coping strategy the caregiver has adopted, the next stage is to appraise that coping strategy. That is, the caregiver will assess whether the preferred coping strategy is effective to deal with the demands of caregiving. It is assumed that caregivers will find satisfaction from the caregiving role if they find the coping strategy to be effective and to be able to overcome difficulties. On the other hand caregivers less confident about their coping abilities and resources to handle the caregiving situation are likely to develop conflicting attitudes towards the care receiver, feelings of burden and stress.
To describe the outcomes more clearly it can be stated that ineffective coping strategies may lead to interpersonal conflict, which is a universal form of social interaction. As the family system is a process of continuous confrontation among its members, to the family members harmony is viewed as problematic rather than normal. Family confrontations may occur from the imbalances, tensions and conflicts of interests due to the caregiving context, which may in turn lead to conflicting attitudes towards the care receiver. In such circumstances conflicts, if they happen, not only may occur on a number of issues, but also will reflect the type of coping strategy undertaken by the caregiver. This means that caregivers coping in an ineffective way will report more conflict, while these severe conflicts may in turn affect the coping ability of the caregivers, making them unable to cope effectively.

4.5 Objective of the Present Study

Thus interpersonal conflict is not an outcome of a single isolated contextual variable, rather the result of multiple factors. All these are the caregivers' subjective interpretations of their coping strategy to some specific caregiving contexts. These caregiving contexts are defined largely by the impairments of the care receiver (physical and mental health), the caregivers' perception of their own health, living environment, and social support (number of networks from which support is sought, availability and satisfaction of support) and the unmet needs of the caregivers. Coping strategy is assumed to play a central role between the contextual variables and the impact it has on the caregiver and interpersonal conflict.

To summarize: the model that has been proposed is one in which the caregiver's attitude towards caring, shaped by socio-demographic variables and contextual variables, will serve as 'inputs' and lead the caregiver to perceive the caring situation as either burdensome, stressful, or satisfactory. Depending on the nature of the caring situation the caregiver will then try to adopt a particular
coping strategy to cope with the situation. Once a coping strategy has been undertaken, the caregiver will assess the quality and worth of that coping strategy. This 'process' of appraising will in turn lead to the outcome variables: it will determine whether the caregiver will have conflicts with the care receiver.

The proposed model is used as a base for examining conflict in the caring relationship, particularly when it comes to caring for elderly relatives in the community. The analysis begins with a description of the contextual variables; next I examine the effect these variables have on the caregivers, and finally, the predictors of interpersonal conflict are examined.

1.5 Objective of the Present Study

This study is about caregivers, how they feel caring for an elderly person and what problems they have. The broad objective of the study is to explore the relationship between conflict and coping strategies, and to examine what other variables are related to conflict and coping strategies.

The specific objectives of the study are as follows:

_ to examine what is related to interpersonal conflict;

_ to examine how caregivers cope with caring;

_ to propose interventions.
1.6 Organization of This Thesis

This chapter has given a review of the literature on caregiving, showing the various kinds of burden, stress, conflict factors, and coping patterns which have been investigated, and suggesting a broader theory of caregiving burden which serves as a framework for the rest of the study. It also delineated the objectives of the present study. Chapter 2 presents the specific research methods used in this thesis involving quantitative and qualitative methods of analysis. The measures used in the study are described in Chapter 3. The development of a methodology employed in the research is laid out in Chapter 4, which contains a discussion of the major focus of the study, interpersonal conflict which has been measured with a psychometric instrument specifically developed for the study. Chapters 5 and 6 are the main analytical chapters. In Chapter 5, quantitative data are analysed in order to identify the predictors of conflict and the different coping patterns based on the different effects of the contextual variables as described in the conceptual model outlined in Chapter 1. The experiences of caring as perceived by the caregivers themselves are outlined in Chapter 6. Chapter 7 is a description of a new methodology, 'Vignettes', aimed to identify the coping patterns with burden and conflict. This methodology is also developed for the study and is a systematic interaction between quantitative and qualitative methods as employed in Chapters 5 and 6. Finally, a summary of the findings and limitations of the present study are discussed and interventions proposed in Chapter 8.
CHAPTER 2

METHODOLOGY

This chapter deals with the design, sample, and sampling procedure. Finally, the methodological issues relevant to the caregiving literature in general, as well as more specifically, methods employed in the present study: measuring instruments and statistical techniques to be employed are discussed in detail.

2.1 Research on Caregiving: the Methodological Limitations

Research on caregiving has considerably enhanced our understanding of a wide variety of consequences of caring for the elderly. It holds the promise for more effective interventions, including the prevention of institutionalization of the elderly. At the same time, however, there are shortcomings in this research.

Research on caregiving has used either the qualitative interviews or quantitative interviews or a combination of both. Information was based on self-reports, gathered by mailed questionnaires, telephone interviews, or personal interviews. This variation in data collection methods makes it difficult to compare the studies and replicate the results (Platt, 1985). For example, although some mail questionnaires and telephone interviews are quite successful they may also produce a poor response rate and data of dubious reliability and validity. Thus they are not to be recommended as preferred methods of obtaining information. Though the self-report inventory is an economical method of data collection, with no threat to validity from interviewer bias, it may not always produce accurate information. For example, in most of the studies on caregiving the sample is to some extent
negatively affected by the caring role. Under such circumstances they are likely to inadequately estimate the magnitude of the caring situation. For example, it is very difficult to measure why caregivers are burdened or stressed. Is it because of their caring role? Or is it that they were themselves burdened and stressed due to other reasons before taking up the task of caring?

The standardized personal interview, though costly, obtains the most complete and valid information (Platt, 1985). The interviewer can in such cases probe for more details and check on inconsistencies in responses. Unless precluded by financial considerations, the personal interview method is found to be effective if it consists of structured questionnaires containing highly defined rating scales, and semi-structured questions allowing the interviewer freedom to make the final ratings (Platt, 1985).

The bulk of research on caregiving has been in the field of mental health (Brown et al., 1972; Thompson & Doll, 1982). Most of the studies have focused on the burden experienced by caregivers of elderly people suffering from dementia (Zarit et al., 1980; Chenoweth & Spencer, 1986; Fitting et al., 1986; George & Gwyther, 1986; Gwyther & George, 1986; Scott et al., 1986; Zarit et al., 1986). Other studies relate to those suffering more specifically from Alzheimer's Disease (George & Gwyther, 1986; Pruchno & Resch, 1989). Only a few studies have focused on the elderly other than Alzheimer's Disease or dementia sufferers (Poulshock & Deimling, 1984; Braithwaite, 1990). Caring is likely to be more difficult when the elderly person suffers significant mental deterioration than when he or she is physically impaired but mentally competent (Sainsbury & Grad, 1970; Poulshock & Deimling, 1984). Thus the findings cannot be generalized to caregivers coping with the demands posed by other kinds of disabilities.
Based on the above observation it is thus argued in this thesis that further progress could be made in understanding caregiving by employing a variety of research methodologies but using the same subjects. Given the multidisciplinary nature of many problems in gerontology, it is suggested here that an interdisciplinary approach to the question of what influences caregiving could advance our understanding, by taking methodologies from psychology, sociology and epidemiology.

With this aim in mind this thesis takes an integrative approach in studying the caring experience of caregivers with particular emphasis on interpersonal conflict. 'Integrative' means using both the qualitative and quantitative methods of information gathering. The qualitative research involved the use of in-depth discussions. In the methodological literature eliciting information from an individual in a relatively unstructured way has been described in various terms such as informal interviewing, strategic informant interviewing (Sjoberg & Nett, 1968), in-depth interviews, flexible discussions (Caldwell et al., 1984). The specific method used in this thesis is a combination of these variations. Since the present study is exploratory an initial set of basic topics of discussion concerning the caring process was developed. Quantitative information gathering included the construction and ordering of relevant questions into a questionnaire and the pre-test and implementation of the questionnaire to a certain number of respondents within the community.

2.2 Design of the Study

In order to evaluate methods for this study, it was necessary to consider the kinds of methods and information which were relevant to the research topic at hand. The following questions formed the background of the selection of
methods for studying the experiences of caregivers: Which sets of methods will be used? How can the advantage of a given method over others be evaluated and justified?

As observed above, various study methods are available for investigation: each contributes distinct benefits to understanding the social world (Ingersoll, 1983). Qualitative research enables the investigator to obtain well-grounded, rich descriptions and explanations of process as it occurs in the local context (Miles & Huberman, 1984). Investigations are committed to seeing the social world from the point of view of the individual actor (Bryman, 1984), where the analysis is based on the participant's understanding and perception of the situation, and the meanings and definitions they provide about the situation together with the frames of reference (Halfpenny, 1979). Typically qualitative research produces a wealth of detailed information about a much smaller number of people and cases. This increases understanding of the cases and situation studied but reduces the ability to generalize. On the other hand quantitative research requires the use of standardized measures so that the varying perspectives and experiences of people can be fitted into a limited number of predetermined response categories to which numbers are assigned. This method enables the researcher to see the reactions of a great many people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data, which gives a broad, generalizable set of findings presented succinctly and parsimoniously.

As qualitative and quantitative methods involve differing strengths and weaknesses, they constitute alternative, but not mutually exclusive, strategies for research (Patton, 1990). However, when used together the weakness inherent in each approach is compensated for by the other. When put in a continuum it can be seen that on one end of the continuum, qualitative
research can be used in an exploratory manner to help define the parameters of a problem area which is then followed by quantitative research. On the other hand, we can begin with quantitative research and use qualitative research to provide interpretation and help understand the meanings that were derived from the quantitative research. In the middle of the spectrum, we can think finally of using the two perspectives concomitantly, which results in independent but simultaneous use of quantitative and qualitative research (Ingersoll, 1983: 6). Such a combination of methodologies in the study of the same phenomenon is known as 'triangulation' (Denzin, 1978: 291). It has further been stated that different methods are appropriate for addressing different kinds of questions, and a 'judicious mix' of qualitative and quantitative methods is most appropriate for community studies (Pelto & Pelto, 1978). As Douglas explains,

> Since all research methods have costs and benefits, and since they differ greatly in their particular costs and benefits, a researcher generally finds it best to use some combination or mixture of the methods (1976: 602)

Based on the above observations this study incorporated over a period of three years both qualitative and quantitative components. These methods suggested a novel strategy of inquiry within the ongoing research project, by obtaining data from open-ended questions and closed-ended interview questions. The data collection involved four phases (see Table 2.1). The first phase was the pilot study conducted in Coffs Harbour in New South Wales on a small group of caregivers outside of the study sample. Second was the quantitative phase where the data were gathered by using structured questions and scales. The third phase consisted of gathering qualitative descriptions of the subject matter by using semi-structured questions. The fourth phase consisted of the use of case scenarios or Vignettes. This was an
attempt to tap the most sensitive issues concerning conflict and coping with conflict.

Table 2.1: Variety of Data Collection Strategies

<table>
<thead>
<tr>
<th>Data Collection Strategy</th>
<th>Sample</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Study</td>
<td>15 Caregivers (male &amp; female)</td>
<td>December 1990</td>
</tr>
<tr>
<td>Structured Interviews</td>
<td>151 Caregivers (male &amp; female)</td>
<td>January-April 1991</td>
</tr>
<tr>
<td>Semi-structured Interviews</td>
<td>30 Female Caregivers</td>
<td>May-June 1991</td>
</tr>
<tr>
<td>Vignettes</td>
<td>30 Female Caregivers</td>
<td>July 1991</td>
</tr>
</tbody>
</table>

The general justification for using diverse methods in this study was that it provided a needed context in which quantitative data could be interpreted and the qualitative components in this research design, among other benefits, allowed for elaboration of answers to structured survey items. Although each level illuminated a different aspect of the caring experience, together they yielded a more complex picture of the consequences of caring for an elderly relative at home. In the present study the qualitative aspect of the design provides depth to the understanding of the caring situation from the carers' point of view, while the quantitative information gathered on different variables (given in the conceptual model outlined in Chapter 1), is used to identify the predictors of conflict. The analysis examines the relationship between the variables and also identifies the predictors of interpersonal conflict. Data on these variables gathered in this investigation are analysed in Chapter 6, to see how they explain the relationship. Further analysis and testing may or
may not lend support to this theoretical perspective, but it provides a new way of examining the issues in this ancient, but newly 'discovered', social problem.

The applicability of this approach has been strengthened by a number of studies carried out in the field of ageing (Marshall, 1981) and also in the social sciences (Jick, 1979). The researchers have treated qualitative and quantitative methodologies as parallel and equal partners, each contributing different information (Kendig, 1986). The combination of methods yields a more rounded, complete picture of the study in question (Kendig, 1986). On the basis of these observations the two methodologies in this study were treated as complementary allies rather than incompatible foes.

2.3 Ethical Concerns

As the study design, presentation, discussion and conclusion are mainly the researcher's, ethical concerns are partly addressed in language and research design. Thus the people in this study are participants and not subjects. They are the people who are caring for an elderly relative at home. All the participants were promised confidentiality and anonymity. To protect the identity of the respondents fictitious names were used. As the effect of being studied may have reverberations on the participants' lives and also those around them, they were encouraged to express their views only as far as they felt comfortable. Emphasis in the interviews lay on eliciting the participants' perception of the caring process which may promote better understanding of the situation and what is required to care for an elderly person. Rather than permitting 'objectivity' in the researcher I attempted to surrender 'objectivity' towards the participants and their experiences. This in turn may have an effect on the participants' management of the caring process, which in fact was also
the purpose of the study. As the researcher works closely with the people in the study, access to intimate and highly personal information is increased, so issues of confidentiality and respect for people in the study become very important.

2.4 Sampling Issues

The sample selection for this study was non-random, since in the general population caregivers experiencing a greater degree of stress and conflict are indistinguishable from those experiencing a relatively lower degree of stress and conflict; thus there are unknown population parameters. Even with random sample selection of caregivers in this society, because of the social undesirability of having a negative experience in caring for an elderly person it seemed highly unlikely that an investigator could expect respondents to answer intensely personal questions frankly and truthfully.

Since it was not possible to have a complete sampling frame for this study, the sampling strategy that has been adopted was one intended to maximize heterogeneity, even though this might produce a sample that is not necessarily representative of any larger population drawn from either a specific setting or more generally. Heterogeneity may be produced by deliberately selecting groups of people whose experience of caring may be influenced by, for instance, age, gender, living condition, or length of caring. This strategy is one that is frequently adopted in qualitative research (Miles & Huberman, 1984) and reflects its different goals and purposes. Although this means that generalisation of findings is limited, the presence of consistent patterns across a heterogeneous sample of reasonable size, especially when studied, has relevance.
2.5 The Participants

For the above mentioned reasons, a purposeful sample was obtained from the Australian Capital Territory (ACT). Owing to the absence of a sampling frame, that is, a register of carers from which a sample could be selected, the most favourable option was to contact carers through the community services; which served as 'go-betweens' between the researcher and the respondents, in this way maintaining client confidentiality. Services include six Community Services in Canberra and the ACT Council on the Ageing (COTA-ACT). The aims of the community services are to provide information, advocacy, referral, assessment, coordination of services, home visits, activities for well-being and lessening of isolation, transport to appointments with doctors, special care and volunteer friendship, visiting, shopping, and bill paying. The ACT Council on the Ageing (COTA-ACT) works with government and the community to make sure that the environment in which the aged people live embodies a full, practical expression of their rights. It is specifically concerned with matters such as housing, financial well-being, security and health. In case of a need it may decide to work from its own resources, or it may work with the community or the government bodies to meet the need.

To maintain client confidentiality the carers were contacted by letter (see Appendix A). This letter was delivered by centre coordinators of the various community services. The carers then contacted the researcher directly, or contacted their particular service agency. In the latter case the names and addresses of those who were interested in participating were forwarded to the researcher so that an interview could be arranged.

Thus the research design for this study entailed the sampling of 151 informal caregivers. The sample size was limited to these 151 as they were the ones
who volunteered and consented to participate after hearing an explanation of the nature of the study (see Appendix A). The informal caregivers are referred to as "carers": people (spouse, child, sibling, grandchild, niece, nephew, or sometimes a close friend) who assume the major responsibility for providing or organizing services, cleaning, shopping, meal preparation, personal care involving bathing, dressing, toileting or mobility, or supervisory care involving regular checks on well-being more than once a day, for a dependent elderly person who is physically or mentally impaired, incontinent, or financially dependent on a family member and incapable of providing care for herself or himself.

Once the caregivers volunteered to participate a list was made of all the participants. The list contained the names and contact address with telephone numbers of the participants. It was in serial order as the caregivers rang the researcher and agreed to participate in the study. After the list was made, out of all 151 caregivers, the first 30 female caregivers were selected for the qualitative phase of the study.

For practical purposes the following groups were excluded from the population: carers for children who are disabled or chronically ill; those caring for elderly dependants residing in institutions such as old people's homes, hostels and hospitals; carers for mentally infirm elderly people; and those who are receiving monetary reimbursement for their caregiving service. These groups were excluded from the study as its main objective was to look into the caring experiences of a sole carer who is the primary caregiver and is living with the elderly person in the same house. Moreover, the elderly people living in hostels and nursing homes are cared for by professionals. As the family members are not full-time carers they may not be confronted with the same problem as those living with an elderly relative at home. Similarly those
receiving monetary reimbursement for their caregiving services are expected to perceive the situation differently from those not getting any payment for their services.

Comparing with the 1988 Australian Bureau of Statistics' sample of Carers of the Handicapped at Home (see Table 2.2), my focused sample did not differ markedly with respect to the basic social demographic variables of gender, marital status, and relationship to care receiver. There was a slight underrepresentation of male carers in the study sample. This comparison suggested that the sampling procedure applied here resulted in the selection of a generally representative sample of carers.

Table 2.2: Comparison of Study Sample (N=151) with Australian Bureau of Statistics Sample

<table>
<thead>
<tr>
<th></th>
<th>ABS(^a)</th>
<th>Study Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex of caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>45.6</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>54.4</td>
<td>68</td>
</tr>
<tr>
<td>Relationship to care receiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wife</td>
<td>40.5</td>
<td>40</td>
</tr>
<tr>
<td>Husband</td>
<td>31.0</td>
<td>30</td>
</tr>
<tr>
<td>Daughter</td>
<td>18.1</td>
<td>20</td>
</tr>
<tr>
<td>Son</td>
<td>4.4</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>6.0</td>
<td>9</td>
</tr>
<tr>
<td>Marital Status of caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>84.8</td>
<td>83</td>
</tr>
<tr>
<td>Separated</td>
<td>1.1</td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
<td>2.6</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td>4.0</td>
<td>8</td>
</tr>
<tr>
<td>Never Married</td>
<td>7.5</td>
<td>1</td>
</tr>
<tr>
<td>Living Together</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In addition to the above, most of the carers were living relatively isolated lives; many had never admitted to anyone before, even to close family members, what was happening between themselves and the care receivers (elderly persons who were being cared for); and a number had never before shared intimate details of their lives with 'strangers'. As a result, the pent-up emotions and unrevealed experiences were able to find a permissive forum for self-revelation that might encourage honesty and full disclosure.

However, it can be stated that the sample was biased by the way that its purpose was described. As this research was about caring experiences, it was possible that only those people who perceived themselves as experiencing some problem chose to volunteer, which may distinguish the results in this study from those of other research on caring for the elderly. It is clear from participants' comments that they joined the study for a variety of reasons. When asked to identify their hopes and reservations about participating in the study, most people gave a mixture of reasons. Out of 151 carers, 57 said that they thought that research on conflict and stress was important, 42 expressed a hope that their experiences might help others and 52 said they joined the study as they thought it would help them to be able to talk about their problems. Almost no concerns were expressed about confidentiality.

2.6 Procedure

In the first phase of data gathering a structured interview with the carer was carried out at the carer's house in the absence of the care receiver. Before the interview began every carer received an explanation of informed consent, and signed a consent form (see Appendix B). In this phase the carers responded to standard questions, which consisted of selected questionnaires and scales.
The interview was one hour long. The questionnaire was filled out by the researcher who, in a face-to-face encounter, asked the questions. This strategy was chosen both for practical and for philosophical reasons. Practically, it would have been difficult for many respondents to fill out the questionnaire, given low educational levels. Philosophically, it was assumed that any social survey data, even where the respondents fill out a questionnaire, result from social interaction. In the case of the questionnaire, the researcher happens to be absent, but there is no less the establishment of a brief social bond for the respondent to agree to fill out and return a questionnaire. The interview was seen as a brief commitment by the respondent to communicate over very sensitive topics. To the extent that a sense of trust could be established within this rapport, it was decided that the data obtained would be more valid and more reliable. The interview was conducted in a way which approached a natural conversation, while of course adhering to the precise wording of questions.

After the structured interview arrangements were made to conduct the semi-structured interviews to gather qualitative data. The interview was standardized from person to person, but carers could explain, digress, and take short breaks throughout the interview, which lasted up to four hours (the shortest were about two and a half hours). All carers were interviewed by the researcher and responded to questions about their perceptions of stress and conflict from their caregiving role, the care receiver's health, the social environment, social support, and their coping patterns. The interview was tape recorded. After this phase the vignettes with a self-addressed pre-paid envelope were left behind with the carer who returned them to the researcher after completion.
2.7 Basic Concepts

Referring back to Figure 1.3 (see Chapter 1: 27) which illustrates a model of the caregiving process, a number of variables have been measured in the present study. These variables were operationalized by numerous items on the survey questionnaire and additional measures developed for the study. The operational definitions of those variables are given in Table 2.3.
### Table 2.3: Study Variables and Their Operational Definitions

<table>
<thead>
<tr>
<th>Variables</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent</strong></td>
<td></td>
</tr>
<tr>
<td>Interpersonal conflict</td>
<td>Conflicting relationship between the caregiver and care receiver</td>
</tr>
<tr>
<td><strong>Independent variables</strong></td>
<td></td>
</tr>
<tr>
<td>Attitude towards caring</td>
<td>The caregiver's perception of who should care for an elderly relative</td>
</tr>
<tr>
<td>Carer's needs</td>
<td>Self-reported unmet needs of the caregiver</td>
</tr>
<tr>
<td>Care receiver's health</td>
<td>Subjective interpretation of the caregiver about whether the care receiver needs assistance with the daily activities such as bathing, dressing, toileting, mobility, continence, and feeding</td>
</tr>
<tr>
<td>(physical)</td>
<td></td>
</tr>
<tr>
<td>(mental health)</td>
<td>Subjective interpretation of the caregiver about the sociability and cognitive behaviour of the care receiver</td>
</tr>
<tr>
<td>Coping strategy</td>
<td></td>
</tr>
<tr>
<td>Caregiver's health</td>
<td>Self-reporting by the caregiver about his/her general health status</td>
</tr>
<tr>
<td>Independent Variables</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Living environment</td>
<td>Perception of the caregiver about the house/apartment and neighbourhood</td>
</tr>
<tr>
<td>Social support (availability)</td>
<td>All the formal help the caregiver gets from the family members, professional service providers, social workers, community workers, and physicians</td>
</tr>
<tr>
<td>(satisfaction)</td>
<td>How much the caregiver is satisfied with this help</td>
</tr>
<tr>
<td>Caregiving burden</td>
<td>The caregiver’s perception of the caring role as tiring and boring</td>
</tr>
<tr>
<td>Stress</td>
<td>The caregiver’s reaction to the disturbing circumstances which produce a state of severe tension, anxiety and depression</td>
</tr>
<tr>
<td>Caregiving satisfaction</td>
<td>The caregiver perceiving the caring role to be pleasurable and comfortable</td>
</tr>
<tr>
<td>Coping strategy</td>
<td>Action employed by the caregiver to reduce the stress he/she experiences</td>
</tr>
</tbody>
</table>

### 2.8 Summary

As mentioned above, the present study used both qualitative and quantitative methodologies to gather data in order to get a complete and comprehensive picture of the carer’s experience of the caring situation especially, when the task is carried out by only one person in the domestic setting. A wide variety
of questionnaires were designed specifically for the study; they are discussed in Chapter 3.

MEASURES

Data from the cohort were obtained by a variety of techniques in order to depict health as well as behavior. The measures used for the study were the 14 structured questions, some unstructured data, physical health, the Behavioral Risk Factor Surveillance System, social support, coping, and socio-economic variables, a series of structured interviews, and the equivalent sensitivity to controls and testing strategies. Detailed descriptions of these measures are given below.

3.1 Standard Measures

A survey questionnaire was designed for the study (see Appendix G). The instrument was devised for several reasons: to gather the maximum demographic information and a wide range of other data, to ease over to gather data on the greatest number of cases possible in the shortest time, and to solicit uniformity of administration and to avoid possible respondent bias from having a standard instrument capable for other researchers to validate the reliability and thereby measure, without any social, economic, or political information with the least possible contamination from other data sources. The respondents were able to respond to questions in privacy and with confidence.
CHAPTER 3

MEASURES

Data from the caregivers were obtained by a variety of techniques in order to obtain depth as well as breadth. The measures used for the study were: (1) structured questions: socio-demographic data, physical health, mental health, stress, burden, social support, conflict, and coping strategy; (2) semi-structured interview; and (3) vignettes: sensitivity to conflict, and coping strategies. Detailed descriptions of these measures are given below.

3.1 Standard Measures

A survey questionnaire was designed for this study (see Appendix C). The instrument was devised for several reasons: to obtain the maximum demographic information and a wide range of other data from the caregiver; to gather data on the greatest number of cases possible in the shortest time, since each in-depth interview required from two to four or more hours; to achieve uniformity of administration and to avoid possible interviewer bias; to have a standard instrument suitable for other researchers to reproduce the study and thereby measure reliability; and to obtain extremely sensitive information with the least possible contamination from social desirability. Since caregivers were able to respond to questions in privacy and with confidentiality.
The questionnaire was piloted and revised once before the final format was adopted. In keeping with the exploratory nature of this study, the questionnaire was comprehensive, detailed, and long. The 24-page instrument included one or more items measuring each of the key variables: health, stress, burden, social support, conflict, and coping strategy. Coded choice-responses were provided for each of the items. Detailed descriptions of each of the variables are given below.

3.1.1 Socio-Demographic Data

In order to gain more detailed information about the caregivers the following socio-demographic information were collected: caregiver's age, gender, marital status, education, annual household income, employment status, care receiver's age, relationship of caregiver to care receiver, living arrangements of caregiver and care receiver, and total duration of caring.

3.1.2 Physical Health

The caregivers' perception of their own health and their care receiver's health was measured in order to assess whether it is the elderly dependant's health status or the caregiver's own disability that has the effect of developing feelings of stress and conflict. The elder-impairment measures are dependency associated with physical illness and mental impairment. The former is represented by responses to the Index of Independence in Activities of Daily Living (Katz, 1987), which is a rating form that is completed by the researcher for the caregiver. It assesses independence in six activities: bathing, dressing, toileting, transferring from bed to chair, continence and feeding. From caregiver's answers the care receiver is rated on a three-point
scale of independence for each activity. After the three-point scale has been translated into a 'dependent-independent' classification, the care receiver's overall dependency is then summarized on a six-point scale that considers the numbers of areas of dependency and their relative importance. Addition of the activities in which the care receiver is dependent, provides the scale which ranges from 0 to 6, i.e., 0=indepenent in all six functions; 6=dependent in all functions (Katz & Akpom, 1976:497).

3.1.3 Mental Health

Beyond physical impairment, the mental impairment of elders also has considerable potential for the creation of stress on caregivers. In order to screen this effect two dimensions of mental impairment were found to be the most acceptable. These items were derived from 23 separate items in a factor analytic model with Varimax Rotation (Poulshock & Deimling, 1984: 232). The first factor that was found to be the most suitable for the study was Sociability. This factor contained eight items which tapped the elder's level of cooperativeness, withdrawal, and isolation. The items loaded between 0.49 and 0.70: a low score on this indicator represented a lack of sociability. The second factor measured Cognitive Incapacity. This also contained eight items loading between 0.38 and 0.65 and assessed such aspects of mental impairment as forgetfulness and confusion. The mental health status of the care receiver was based on the caregivers' reports of current behavioural incapacities exhibited by the care receiver at the time of the interview. They were derived from responses to a three-point Likert type scale which ranged from 1 to 3.
3.1.4 Caregiver's Health

The caregivers rated their own health by responding to a single question on an eight-point scale, "How would you rate your overall physical health at the present time: Excellent, Could not be better, Very good, Good, Average, Fair, Not too good, or Not good at all".

3.1.5 Burden

A number of instruments are available to measure burden i.e., the Cost of Care Index (Kosberg & Cairl, 1986; the Burden Interview (Zarit et al., 1986); and the Index of Burden (Braithwaite, 1990). Out of these three well-documented measures the Cost of Care Index has been selected to assess the level of caregiving burden experienced by the caregivers as this index has the factors which I wished to examine.

The Cost of Care Index (CCI) is a case management tool for assessing the potential and actual consequences of caring for an elderly person. It consists of 20 items to measure five dimensions found in the literature to be related to the "costs" of providing care. The five dimensions are: personal and social restrictions (items 1 to 4), physical and emotional health (items 5 to 8), value for care provision (items 9 to 12), care recipient as provocateur (items 13 to 16) and economic costs (items 17 to 20). The index can be either self-administered or researcher/case-manager administered. The caregiver responds to a 4-point Likert scale ranging from 1 to 4.
3.1.6 Social Support

For this variable two sorts of information are gathered: availability of and satisfaction with social support and the most frequently used community services. The Social Support Questionnaire (SSQ) (Sarason, 1987) has been used to assess the caregivers' availability of and satisfaction with social support. The SSQ is a 27-item self-administered scale; each question requires a two-part answer. The caregivers are asked to list the people to whom they could turn and on whom they could rely in specified sets of circumstances (availability); and to rate how satisfied they are with the available support (satisfaction). A maximum of nine persons can be listed as supports for each item, their identity being indicated by their initials and relationship to the caregiver. The satisfaction rating is the same for each item, and uses a six-point scale running from 6, very satisfied, to 1, very dissatisfied. A support score for each item is the number of support persons listed ('the number score'). The mean of these scores across the 27 items gives an overall support score (SSQN). A satisfaction score (SSQS) is based on the mean of the 27 satisfaction scores.

In the second part of this questionnaire, caregivers were asked to state the frequency of use of eight community-based service programs relevant to management of the elderly. These consist of health and social services targeted toward the impaired elderly; these services are generally available in most Australian urban communities. Services specifically designed for memory-impaired old people and their families were not included. The caregivers were asked to report the frequency with which they sought help from each service, with responses to each item ranging from 'never' (code=0) to 'regularly' (code=4). Responses to the eight items were summed to yield a
total scale score which ranged from 0 to 17, with a mean of 8.1 (s.d 3.8). Higher scores represented increased social support.

3.1.7 Stress

Stress was measured by using the 12-item version of the General Health Questionnaire (Goldberg, 1987), which is a self-administered screening instrument. This measure was chosen as a common measure of stress (McDowell & Newell, 1987:139); half of the questions are worded to indicate distress if answered 'yes' and half indicate distress if answered 'no'.

The questionnaire begins with relatively neutral questions, and leads to the more overtly psychiatric items towards the end which ask whether the respondent has recently experienced a particular symptom (like abnormal feelings or thoughts) or type of behaviour. The 12-item version is balanced in terms of 'agreement sets'—that is, half of the questions are worded to indicate illness if answered 'yes' and half indicate illness if answered 'no'. It takes three to four minutes to complete the questionnaire. The items are scored using conventional 0-1-2-3 Likert scores. Any two or three positive answers express the probability of having psychological disturbance.

3.1.8 Coping

Based on the responses of the caregivers during the pilot study 15 items were selected to construct a measure for identifying coping strategies. These items represented the coping strategies adopted by the caregivers in real-life
situation. The items were scored using 1-4 Likert-type format. High score represents worse coping.

3.1.9 Interpersonal Conflict

Owing to the unavailability of an appropriate measure to assess the caregivers' level of conflict a new scale of conflict was developed for this study. The scale was tested on a large group of carers in order to find out the inter-item reliability. Details of the selection of items and the development of the "Scale of Conflict" are given in Chapter 4.

3.2 Semi-Structured Interview

The interview schedule contained 16 questions covering the following areas: circumstances of caring, tolerance of care receiver's disability, competence in caring, relationship with care receiver, family relationships, constraints in caregiving demands, availability of a confidant, decision-making, financial hardships, feeling of stress and interpersonal conflict. The semi-structured questions provided an opportunity for individualized responses. The questionnaire was piloted on a small (n=15) sample in a separate community from the research sample so as to correspond closely to caregivers' usage and the intended meaning. It was written and revised until the final form was reached. The actual questionnaire is given in Appendix D. One of the important features of the questionnaire was to ask important questions in a way that would facilitate internal consistency checks within the questionnaire.

The interview was conducted by the researcher; the entire interview was tape recorded, and notes were taken during the interview. After each interview the tape recorded responses were transcribed by the researcher, then checked
for verification and accuracy, after which the transcribed data were put into a computer software program, 'The Ethnograph' (Seidel et al., 1985:1-1) for coding and analysis. Information about the Ethnograph, the coding procedure and analysis is given in detail in Chapter 6.

3.3 Vignettes

Caregivers' sensitivity to burden and conflict together with coping strategies was assessed by using 'vignettes'. There is no standard vignette in this field to measure coping strategies, therefore three versions of vignettes were constructed (see Appendix E). These vignettes gave a detailed and clear picture of an elderly person's case history; they consisted of stories showing different life situations of the elderly person in different environments. Fifteen caregivers were thought to be sufficient for a pilot group to pretest the vignettes. Chapter 7 gives details on the construction procedure of the vignettes.

3.4 Analysis

A brief description follows of the process of data analysis. The semi-structured interviews were analysed with the help of a computer package, 'Ethnograph', designed for the analysis of text-based data (Seidel et al., 1985:1-1). The data for the quantitative part of the study (standard measures) were interpreted by using SPSSX statistical package which used standard statistical methods. Descriptions and comparisons between caregivers were found to be most suitable for the vignette version of the study.
3.5 Summary

For the qualitative part of the data collection the semi-structured interview schedule and the vignettes were used with 30 female caregivers to gather information about their experiences and perceptions of their caring role. The structured questionnaires consisting of different scales, were applied to 151 caregivers, both male and female. The quantitative information was necessary to perform multivariate analysis in order to identify the predictors of interpersonal conflict from the variables given in the conceptual model outlined in Chapter 1. The later sections of the thesis are devoted to the presentation of the results from the different interviews. However, before going into the analytic sections it is necessary to know more about the 'Scale of Conflict', which was specifically developed for the purposes of the study and is discussed in greater detail in the next chapter.
CHAPTER 4

DEVELOPING A MEASURE OF INTERPERSONAL CONFLICT

This chapter gives a detailed description of the development of a measure for quantifying interpersonal conflict. A measure of this kind was necessary to gather data on conflict quantitatively.

4.1 Definition and Nature of Conflict

As a broad concept, conflict has been defined in various ways. In general terms conflict is defined as 'the opposition of response (behavioural) tendencies within an individual or in different individuals' (English & English, 1958: 110). In Simmel's words (1956) conflict is a universal 'form' that can be seen in all kinds of human relationships. Conflict may also refer to the clash between people of different viewpoints, interests, feelings or actions. In the caring situation caregivers and care receivers may have opposing intentions or wants and hence come up against each other, provoking a crisis.

However, as a process conflict can be either internal or external to an individual or to a group. It can occur at the verbal level (accuse, disagree with, insult, blame, correct, deny or refute each other, disputes, arguments, spats, quarrels etc.); the physical level (hit, push, throw things at each other, shake etc.) the symbolic level (gesture); ideological level (i.e., political parties or
nations); and emotional or intrapsychic level (ambivalence). In many cases communication is usually characterized by a higher tone of voice, the use of cutting words, name calling, aggressive body language, in a conflict situation sometimes leading to such a severe stage that it undermines the relationship.

It is however not necessary that all conflict will be dysfunctional for the relationship, in some cases it may be necessary to maintain the relationship. For example, a person may not find ways to vent hostility and express dissent and hence feel completely crushed. In such a situation the person may show conflict in order to set free the pent-up feelings of hostility. This in turn will help maintain the relationship.

Depending on the various definitions of conflict researchers have organized and classified conflict in different ways. Differentiating between conflict as a means and as an end in itself, conflict is distinguished as realistic and nonrealistic (Simmel, cited in Coser, 1956:49). Explicating the social-psychological similarities and differences among conflicts Deutsch (1973) classified conflict in terms of destructive and constructive conflict. Taking a more formal view of conflicts Rapoport (1960) talked about conflict in terms of fights, games and debates. Trying to distinguish between conflicts occurring in later life (when elderly parents require the support of children) Steinman (1979) classified continuing conflicts (persistent and ongoing conflicts between parents and children); reactivated conflicts (recurrence of unsettled conflicts of the past due to frequent contacts in caring); and new conflicts (usually arising from parents' ageing).

Though the concept 'conflict' has been defined and applied in different ways by different researchers, the definition advanced by Peterson (1983) was chosen to be the most appropriate for the present study. Thus conflict is
defined as 'an interpersonal process that occurs whenever actions of one person interfere with the actions of another' (p. 365). According to this definition 'actions' involve verbal and non-verbal actions (ranging from passive resistance to active aggression), as well as cognitive (the perception that some other person or entity acts against one's interests) and affective accomplishment (tension and hostility) to these actions. Conflict can occur in relation to a specific behaviour of one person or the other, to norms or rules governing the two parties, or to personal dispositions or traits of one or both. However, rather than explaining conflict in terms of 'drives,' 'impulses' or other imputed properties of a single individual, it is appropriate to consider conflict as 'a form of trans-action' (Merton, cited in Coser, 1956: 37). Thus conflict can be understood only as occurring within a pattern of interaction between two or more people where the behaviour takes place in a social situation. And to understand conflict more effectively it is necessary to take into account the interaction between people with close and intimate relationships rather than all social relationships, as a greater degree of interpersonal conflict is likely to occur when the people are deeply involved, and interact with their total personality rather than with only a segment of it.

Thus one explanation of interpersonal conflict can be found in terms of theories of social conflict. Under such circumstances Coser's (1956) and Simmel's (1956) approach is the most appropriate, that conflict will be more intense if the emotional involvement between the people is greater before the conflict and when the individual is deprived in more than one area of life (Dahrendorf, 1959). Thus caregivers who invest most of their time caring for an elderly relative are expected to be emotionally involved, as caring involves a great amount of involvement and the circumstances are longstanding or neverending. On the other hand caregivers who are deprived of their normal life, or of decision-making opportunities, are socially isolated or have financial
problems, are also likely to experience more conflict. Still others who expect to receive most of their gratification from the family, if not successful are likely to experience conflict.

Thus it is expected that the closer the caregiver and care receiver are, the more intense the conflict. Especially where caregivers are the primary caregivers and involved with caring 24 hours a day, where their hostile feelings towards the care receiver are suppressed as there is no other alternative to caring full time, the existing conflict, if it breaks out nevertheless, is likely to threaten the relationship.

Moreover, in the caring situation more intense conflict can be expected when the caregiver has been led to suppress hostile feelings developing from frustration at the care receiver’s demands and expectations of gains due to caring. In many cases instead of a minimal positive affirmation of caregiver’s efforts, there is a total depreciation and denial from the care receiver, that prevents an exchange relationship and fosters a threatening one. Conflict usually occurs over one party’s criticism of or intrusion into the other’s habits or activities. In that case the caregiver may feel resentful at helping because of rejection or alienation from the care receiver.

Conflict may also vary depending on the nature of the issues. It is expected that conflicts concerning the very basis of a relationship may have a different impact from those involving less central issues. In the caring situation conflict over whether the caregiver should have decision making authority, some degree of freedom, social and emotional support from family members, and some time away from full time caring might presumably have a more profound impact on the relationship than a conflict over every-day workload.
No matter what the source of conflict is, it has been observed that several other factors contribute to conflict in the caregiving context when it comes to the parent-child relationship. These are perception of parents' needs (Cicirelli, 1981), perception of parents' traits (Peterson, 1983), and sibling relationship. Children report more conflict when the elderly parents are over-demanding of help that the caregivers perceive to be not so important; when they have negative views of parents' personality traits; and when there is a poor, rivalrous relationship between siblings (Cicirelli, 1986), exacerbated in cases of parent-mediated sibling rivalry in childhood and adolescence. There is also some evidence that a past history of rejection, alienation, argument or other conflict appeared to be the root of interpersonal conflict among adult children with their parents (Simos, 1973).

4.2 Conflict in the Caring Relationship

Whatever the nature and source of conflict only a few gerontological studies have been conducted addressing the issue of interpersonal conflict in the caring relationship. Most of the studies are centred around family relationships involving adult children and parents, intergenerational patterns, and normative family conflict.

Throughout the life cycle family members are expected to provide physical and psychological help to each other, the parents expecting some support (mainly emotional) from children when they reach adolescence. However, this is also the period when conflict between parents and the child begins to develop, especially when the child starts to think about his or her own identity and individuation. As conflict develops between family members from the early stages of life most of the studies have been on the relationship between
parents and adolescents: as a result conflict is viewed as a major issue in parent-adolescent relationships (Montemayor, 1983), especially when the adolescents and parents do not have similar views on issues such as personal description of adolescents; closeness with parents; parental permissiveness; discipline; frequency of talk about educational plans; drugs; and personal problems (Kandel et al., 1968; Faw & Goldsmith, 1980; Jessop, 1981; McKenry et al., 1981); every-day family matters such as school work, social life and help around the house (Csikszentmihalyi & Larson, 1984). The conflicts occur more with mothers than fathers, in many cases between mothers and daughters (Montemayor, 1982).

There is also some evidence that adult children not only experience conflict with parents but they also are often perplexed and irritated by the constraints they perceive from the older generations. In one such study of multigenerational families, family and interpersonal issues were found to be the main source of conflict with grandmothers and general social issues for grandfathers (Hagestad, 1984).

Using data from a large study of three-generation urban American families, Boxer et al. (1986) also studied conflict in intergenerational relations experienced by grandfathers, middle-aged fathers and young-adult sons. Two related levels of analysis were carried out, one between individuals grouped by generational position (grandfather, middle-aged fathers, and young-adult sons) and the other between intergenerational pairs (grandfather-grandson, middle-aged fathers-young-adult sons). In general grandfathers perceived less conflict in relation with their sons and grandsons; only a small group of grandfathers reported conflict in regard to interpersonal relations and life-style issues; fathers and sons experienced conflict over issues dealing with interpersonal relations and life style; while young-adult sons reported more
conflict in areas of work, education, and money. When these groups were examined in pairs or dyads in families, it was found that views on socio-political issues, interpersonal relations and life-style issues were the key factors in grandfathers-middle-aged fathers' conflict. The grandfathers and sons had conflict with issues of work, education, money, socio-political matters, interpersonal relations and life-style; while fathers and young men disagreed in matters concerning work, education, money, interpersonal relations and life-style.

Though conflict with parents continues throughout adult life (Lehr, 1984), it is also recognized that there is some mutual exchange of help between adult children and their elderly parents during this period (Cicirelli, 1986). Little is known about the relationship between adult children and their parents when the parents enter old age and require a great deal of help. One reason for the paucity of research literature is the assumption that as it triggers off strong feelings and recollections in people, it is a difficult theme to approach.

A limited number of studies however have been conducted addressing the issue of conflict between elderly people and their family members. In one such study it has been found that in 64 per cent of the cases the adult children reported some degree of conflict with fathers and 61 per cent with mothers (Cicirelli, 1981). When the frequency of conflict was further examined it was observed that frequent or continual conflicts with fathers accounted for 6 per cent of the cases and 5 per cent in cases of mothers. In the majority of cases the source of conflict was the parent's health and temperament and the children's expectations of the parent's behaviour. In other cases the conflict revolved around the demands of parents, their intrusiveness into the child's life, criticism of the child's behaviour, and the parents behaviour towards each
other (Cicirelli, 1981). Yet in only a low percentage of cases the source of conflict was external matters other than family issues (Cicirelli, 1981).

However, when the caring relationship was taken into account it was found that spouse-caregivers caring for demented elderly people did not experience any normative conflict or tension regardless of full-time caring; adult children caregivers, whether primary caregivers or secondary caregivers, experienced a certain degree of conflict, the conflict occurring between the elderly person in the case of primary caregivers and other family members in the case of secondary caregivers. Daughter-in-law caregivers also experienced similar feelings to adult children (George, 1986).

Though the above studies provide sufficient information on family conflict, at the present time there have been few studies addressing the issue of interpersonal conflict between the caregivers and care receivers who are the primary source of care, and are residing with the care receiver. In addition, when the findings of the previous studies are related to the model given in Chapter 1 it can be seen that none of the existing studies systematically examined contextual issues to gain a better understanding of conflict in the caring relationship. As shown in the model, contextual issues are hypothesized to play a particularly important role in the interpretation of interpersonal conflict as perceived by the carers. The caregiving situation is considered implicitly or explicitly to influence the personal characteristics that are being investigated. These settings typically provide information on the behaviours and cognitive functioning of the elderly person, the consequences of caring on the carers, and the coping patterns. A systematic examination of the above factors will aid in the accurate interpretation of data obtained to measure interpersonal conflict.
In addition, although conflict in family relationships has been used as a variable, in many cases its measurement and application have been inconsistent and in some cases inappropriate for the study of the caring relationship. Most data on conflict among caregivers are generated from responses to open-ended questions and non-specific questions. Although qualitative research using in-depth interviews is helpful and provides rich information, in many cases the findings cannot be generalized. Open-ended questions do not yield unidimensional and internally consistent responses. Hence the issue might be somewhat different for different sorts of caring relationship to the care receiver and living arrangements. The information obtained from open-ended questions cannot ascertain the degree of conflict due to age differences of the carers. In some cases impoverished responses, especially to open-ended questions, can reflect the respondent's fatigue and illness; being tired the respondents may find it difficult to respond to lengthy interviews. As standardized measures cannot be used to interpret open-ended questions it is difficult to establish the reliability and validity of the data. The interview technique using open-ended questions is only one way of making a comprehensive measurement.

As in-depth interviews rely on self-reported data, caregivers really experiencing conflict may under-report or mis-report the actual information. The term 'conflict' may have different meanings for different caregivers and researchers; because of this the operationalization of these factors may reflect differences in conceptualizations. Hence, comparability is low.

In spite of the above limitations a systematic set of questions about these issues may uncover information additional to that normally found through self-report. As well, the information obtained from structured survey questions may be related to the conceptual underpinnings of the research and to qualitative
data obtained in the course of the study. Thus psychometric testing is highly recommended as the reliability and validity of in-depth interviews have seldom been established. As a result the measurement of interpersonal conflict between caregiver and care receiver using fixed response structured questions clearly merits more systematic exploration. The use of more valid measures of this variable with regard to caring also enables the researcher to capture the meaning of the concept taking into account the multidimensional aspect.

4.3 Identification of Items

The empirical literature on family conflict was reviewed in detail in order to identify the most common items representing conflict. In addition the responses to open-ended interview questions on conflict in the pilot study were reviewed very carefully by identifying the themes underlying the caregivers’ responses. Caregivers reported conflict to arise either from the care receiver’s disruptive behaviour pattern or other factors related to caring. A list was made of all these factors. As these were the caregivers’ reports to semi-structured interview questions the validity of the reports has not been established. Twenty items were identified and became the basis for the initial questionnaire: annoyance, resentment, interference with privacy, unappreciative, complaints, demanding, unco-operativeness, rejection, like being with care receiver, disagreements, getting along, hostility, bored with work, furious clashes, getting upset, loss of patience. These 20 items were put into a questionnaire format (Table 4.1) for later validation as a Scale of Conflict.
Table 4.1: The Scale of Conflict Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>I feel annoyed when 'Y' does not want to go to the doctor</td>
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<td>2.</td>
<td>I feel resentful at helping 'Y' all the time</td>
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<td>3.</td>
<td>'Y' interferes with my privacy</td>
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<td>4.</td>
<td>'Y' is unappreciative of what I do</td>
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<td>5.</td>
<td>'Y' complains about things I do</td>
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<td>6.</td>
<td>'Y' asks for more help than he/she needs</td>
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<td>7.</td>
<td>'Y' resists efforts to keep him/her clean</td>
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<td>8.</td>
<td>When 'Y' rejects taking medicine, I do not know what to do</td>
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<td>9.</td>
<td>I like being with 'Y'</td>
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<td>10.</td>
<td>I have disagreements with 'Y'</td>
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<td>11.</td>
<td>I get along alright with 'Y'</td>
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<td>12.</td>
<td>'Y' is hostile towards me</td>
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<td>13.</td>
<td>I am bored or fed up with working at home all day</td>
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<td>14.</td>
<td>I have furious clashes with 'Y'</td>
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<td>15.</td>
<td>It upsets me when 'Y' is irritable and grouchy</td>
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<td>16.</td>
<td>'Y' resists when asked to do things</td>
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<td>17.</td>
<td>I get upset when 'Y' gives me orders</td>
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<td>18.</td>
<td>I find that I lose patience with 'Y'</td>
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<td>19.</td>
<td>'Y' gripes and complains a lot about me</td>
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<td>20.</td>
<td>I feel upset when 'Y' blames me for his/her difficulties.</td>
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</table>

Note: 'Y' is the person who is being cared.

*a*Each item has a Likert-type response category.*
In addition, another section was added for caregivers to mention areas of perceived conflict that might have been missed by the above. This section was dropped out from the final scale as none responded. Conflict was measured by requiring the respondents to respond on a six-point rating scale ranging from 6 (always) to 1 (never). Some of the items were phrased in the opposite direction. Conflict scores ranged from 20 to 120, with most of the scores lying in the middle. The higher the score, the more the perceived levels of interpersonal conflict.

4.4 The Sample

The questionnaire was distributed to a convenience sample of 400 informal caregivers caring for an elderly relative at home through three different sources: A.C.T. Council on the Ageing; Mental Health Resource, Canberra; and Carers Association of N.S.W. Although the sampling frame did not generate a random sample of community caregivers, the sample was large and demographically diverse. A total of 302 respondents returned questionnaires (76%), of which 19 could not be used because of substantial missing data.

The sample of usable questionnaires consisted of 283 informal caregivers, ranging in age from 45 to 72. The mean age was 65.2; 69 per cent were female and 31 per cent were male; 68 per cent were spouses (37 per cent wife and 31 per cent husband), and 32 per cent were daughters; 73 per cent had only primary school education, while the remaining 27 per cent did not go beyond high school.
One hundred and ninety six subjects were married, 15 were single, 32 were divorced, 15 were widowed and 25 were separated from their spouses. The religious distribution included 34 per cent Catholics, 14 per cent Church of England, 12 per cent Protestants, 9 per cent Jews, 13 per cent caregivers indicating other religions (e.g. Spiritualist, Presbyterian), and 18 per cent caregivers who indicated that they subscribed to no religious group (atheist, agnostic).

The care receivers' age ranged from 65 to 93 years, with a mean age of 75.5 years. The duration of caring ranged from three years to 20 years. The majority of caregivers had been providing unpaid assistance for five to 15 years; one-fifth, however had been caring for the elderly person for more than 15 years.

4.5 Analysis

The analysis consisted of three parts. In the first part, the correlation matrix was estimated to examine the interrelationships among items. The matrix of Pearson product moment coefficients for the items is given in Table 4.2. From this correlation matrix the following observations can be made.
Table 4.2: Correlation Matrix for the 20 items for the Scale of Conflict

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<tr>
<th>Items</th>
<th>Q1</th>
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<td>42</td>
<td>56</td>
<td>37</td>
<td>00</td>
<td>48</td>
<td>14</td>
<td>44</td>
<td>34</td>
<td>37</td>
<td>57</td>
<td>46</td>
<td>43</td>
<td>45</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19</td>
<td>40</td>
<td>45</td>
<td>34</td>
<td>56</td>
<td>66</td>
<td>52</td>
<td>44</td>
<td>02</td>
<td>36</td>
<td>08</td>
<td>53</td>
<td>44</td>
<td>13</td>
<td>45</td>
<td>33</td>
<td>56</td>
<td>32</td>
<td>47</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Q20</td>
<td>50</td>
<td>50</td>
<td>44</td>
<td>45</td>
<td>48</td>
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<td>32</td>
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<td>41</td>
<td>20</td>
<td>40</td>
<td>52</td>
<td>39</td>
<td>45</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) Care receivers' disruptive behaviour patterns: interfering with caregivers' privacy, not appreciating caregivers' help, complaining all the time, asking for more help than required, resisting doing things, hostility towards the caregiver, are significantly related to each other. The highest association is found between 'unappreciative' and 'complaining', indicating that these behavioural problems are most related to one another.

(b) Caregivers are annoyed by the disruptive behaviour patterns of the care receiver, and become upset when the care receiver is unappreciative of what has been done, or complains a lot and seeks more help than needed. All these seem to affect the caregivers in such a way that the caregiver does not like to be with the care receiver, is unable to get along well, and hence feels
resentful in caring at all. In this case 'not liking being with care receiver', 'unable to get along', and 'feeling resentful' were highly correlated, indicating that these items are overlapping in content.

(c) The disruptive behaviour pattern of the care receiver has an impact on the caregiver. Specific behaviour patterns, complaining and seeking more help than needed are significantly related to caregivers being upset, indicating that these behaviour patterns add to the feelings other than the care receivers being irritable and grouchy, giving orders and blaming the caregiver.

(d) Specific feelings of being upset, represented by the care receiver being irritable and grouchy, giving orders, and blaming the caregiver for the care receiver's difficulties, were associated with caregivers feeling resentful at providing care.

(e) Caregivers feelings of resentment translate quite directly into some specific outcomes of resentment such as losing patience, and having furious clashes with the care receiver. This is probably due to the perceived pervasiveness of the increasing amount of demands imposed on the caregiver by the care receiver.

In contrast many of the correlations are low (0.1 to 0.3), documenting the independent nature of the items, or that these items have low statistical association in measuring conflict. Still some items have no correlation (0.0) at all, suggesting that 'do not know what to do' and 'bored with work' might assess a different aspect from the rest of the items in the questionnaire. Nevertheless, most of the correlations are found to be positive, indicating that the items are not related inversely but tend to go together to some degree.
For the further refinement of the 20-item scale, item-total correlation was performed to determine how well each item correlated with the total number of items. The analysis indicated that when items were examined individually, items 8, 10, and 13 had low item-total correlations (-0.04 to 0.26); of the three items 8 had the lowest value. From this low correlation it appears that 'not knowing what to do' may assess an aspect other than conflict, compared with the rest of the items in the scale. Because of the low correlations, items 8, 10, and 13 were deleted from further analysis.

The correlation matrix, however, portrays only the gross relationship between each items. It does not clearly indicate which item represents a single dimension with most of the variance. In order to understand more fully the relationship between items it is essential to determine if these items could be reduced to a few principal components that captured most of the variance.

In the second part of the analysis, respondents' ratings on 17 items were subjected to a principal components analysis. The principal components factor analysis of the 17 items identified three factors with an eigenvalue greater than one. The first factor accounted for 49 per cent of the variance, the second accounted for 8 per cent of the variance, the third, 6 per cent.

However, to guard against over-factorizing and to retain a single factor accounting for the highest variance, the scree test was employed. The result of the principal components analysis are depicted in Figure 4.1.
As seen in the figure, the analysis yielded one major principal component with an eigenvalue of 8.29, thus explaining 49 per cent of the variance contained in the responses. The loadings of the items on this principal component (i.e., correlation between each item and principal component) ranged between 0.59 and 0.81. This first factor was considered to be appropriate to represent caregivers' perception of interpersonal conflict, as the next strongest principal component explained only 8 per cent of the variance.
Thus after the principal axis factor analysis with iterations on communalities only one factor was selected to be an adequate representation of conflict. This was then rotated to a varimax criterion for interpretation. Table 4.3 shows the varimax rotated factor structure of the Scale of Conflict.

<table>
<thead>
<tr>
<th>Items</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>0.76</td>
<td>-0.04</td>
<td>0.31</td>
</tr>
<tr>
<td>Q2</td>
<td>0.72</td>
<td>0.41</td>
<td>0.18</td>
</tr>
<tr>
<td>Q3</td>
<td>0.74</td>
<td>0.28</td>
<td>0.01</td>
</tr>
<tr>
<td>Q4</td>
<td>0.71</td>
<td>0.41</td>
<td>0.06</td>
</tr>
<tr>
<td>Q5</td>
<td>0.67</td>
<td>0.37</td>
<td>0.23</td>
</tr>
<tr>
<td>Q6</td>
<td>0.51</td>
<td>0.51</td>
<td>0.28</td>
</tr>
<tr>
<td>Q7</td>
<td>0.53</td>
<td>0.31</td>
<td>0.26</td>
</tr>
<tr>
<td>Q9</td>
<td>0.32</td>
<td>0.76</td>
<td>-0.07</td>
</tr>
<tr>
<td>Q11</td>
<td>0.37</td>
<td>0.74</td>
<td>0.02</td>
</tr>
<tr>
<td>Q12</td>
<td>0.21</td>
<td>0.63</td>
<td>0.26</td>
</tr>
<tr>
<td>Q14</td>
<td>0.22</td>
<td>0.71</td>
<td>0.34</td>
</tr>
<tr>
<td>Q15</td>
<td>0.01</td>
<td>0.64</td>
<td>0.43</td>
</tr>
<tr>
<td>Q16</td>
<td>0.38</td>
<td>0.44</td>
<td>0.52</td>
</tr>
<tr>
<td>Q17</td>
<td>0.23</td>
<td>0.17</td>
<td>0.83</td>
</tr>
<tr>
<td>Q18</td>
<td>0.23</td>
<td>0.53</td>
<td>0.43</td>
</tr>
<tr>
<td>Q19</td>
<td>0.51</td>
<td>0.41</td>
<td>0.28</td>
</tr>
<tr>
<td>Q20</td>
<td>0.61</td>
<td>0.09</td>
<td>0.47</td>
</tr>
</tbody>
</table>

The arbitrary criterion of 0.30 for the significance of factor loadings was used. As a result of varimax rotation one factor was chosen to be appropriate in measuring interpersonal conflict. This factor consisted of 12 items loading between 0.32 and 0.76. It reflected the interpersonal conflict between the caregivers and the care receivers. Of the 12 items, eight items represent the care receivers' disruptive behaviour pattern. The rest reflect the caregivers' feelings about caring and the care receiver.

In addition, to gain more information on the degree of actual correlation between the rotated factors, all the three factors were put into plots. The first graphical representation (Figure: 4.2) shows that items 1, 14, 12, and 17 are
all close to the origin. However, item 1 has a small loading on Factor 2, items 12 and 14 have small loadings on Factor 1, while item 17 has loadings on both factors. All the other items have some loadings on both factors. As a whole the graph does not represent separate clustering of items. The other two plots also provide similar results (Figures 4.3 and 4.4).
Figure 4.2: Comparison of Factor 1 and 2.

Factor 1

15
14
12
18
16
19
7
5
2
4
17
20
Factor 2

Figure 4.3: Comparison of Factor 1 and 3.

Factor 1

17

15
14
12
18
16
6
19
7
5
1
11
9
Factor 3

Figure 4.4: Comparison of Factor 2 and 3.

Factor 2

17

20
16
18
5
15
7
5
6
12
14
2
3
4
11
9
Factor 3
In the final stage eight items were dropped from the original scale. These items are rejection, disagreements, hostility, bored with work, furious clashes, getting upset, and loss of patience. This was because these items had a low factor loading and were thought to assess a concept different from conflict. Thus in its original form the 20-item scale was reduced to 12 items with a single factor known as the General Factor (Table 4.4). This factor is based on the caregiver's report at the time of the survey and was specific to the caregiver-care receiver relationship.

**Reliability**

Chronbach's alpha was calculated to assess internal consistency among items. The reliability coefficient alpha for the 12 items was 0.92, and indicated excellent internal reliability.
Table 4.4: The Scale of Conflict

Caring for an older person involves a large amount of work. In the process of caring, some people may experience problems or feelings of conflict. Here are a number of those problems and feelings. Please indicate the choice which best describes your answer to each question.

Thank you very much for your co-operation.

Note: 'Y' is the person you are caring for.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel annoyed when 'Y' does not want to go to a doctor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>2. I feel resentful at helping 'Y' all the time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>3. 'Y' interferes with my privacy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>4. 'Y' is unappreciative of what I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>5. 'Y' complains about things I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>6. 'Y' asks for more help than he/she needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>7. 'Y' resists efforts to keep him/her clean.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>8. I like being with 'Y'.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>9. I get along alright with 'Y'.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>10. 'Y' resists when asked to do things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>11. 'Y' gripes and complains a lot about me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
<tr>
<td>12. I feel upset when 'Y' blames me for his/her difficulties.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>Very often</td>
<td>Fairly often</td>
<td>Sometimes</td>
<td>Almost never</td>
</tr>
</tbody>
</table>
4.6 Summary

Not only can full-time caring for an elderly relative at home put the caregiver to a considerable amount of strain, but greater emotional involvement may also lead to interpersonal conflict, which may last a long time. This in turn may affect the caring relationship, in some cases making it difficult for the caregiver to cope with the situation. It may be that to relieve the caregiver from this painful situation and to maintain a harmonious relationship in the family, expression of conflict is cathartic. To date all studies measuring conflict have relied heavily on interviews with open-ended questions, information on the validity and reliability of which are lacking.

The scale presented here identifies and measures the degree of interpersonal conflict in elder-caregiver relationships. It is a standard instrument which enables the researcher to detect variation in conflict due to individual differences, relationship to care receiver and length of caring.

The present scale is an objective way of estimating interpersonal conflict among caregivers caring for the elderly at home. It seems to tap different facets of conflict. The scale can be used to generate quantitative data which enable researchers to emphasize replicability. The use of the scale presents a theoretically based approach to measuring conflict. Summary measures can be developed from the degree of conflict reported by caregivers across the scale. The check list format is easy for respondents to answer and hence provides enhanced reliability.

Though this study reports only early validation of the scale, the high internal reliability of items indicates that this may be a useful instrument for the purposes of research and for screening family caregivers of community-based elderly people. It can be used by researchers and professionals interested in
the wellbeing of the elderly, to assess the effect of interpersonal conflict on caregivers and also to distinguish those who have poor interpersonal relationships from those who do not. The instrument may be useful in designing educational materials for caregivers and also screening caregivers who require more support in the form of respite and counselling. Moreover, it can be used in conjunction with open-ended questions, in the form of either personal interviews or surveys.

As conflict in caring may vary across the caring situation and type of care receiver, researchers wishing to study the degree of conflict on another group may expand the scale by using items suitable for the study. This will allow researchers to make comparisons about the relative difficulty of any caring situation with a somewhat greater degree of confidence. Moreover as the scale is more extensively examined in terms of factor analysis, the approach taken holds promise for further development.

To sum up, the scale seems adequate to measure expressed conflict with various relationships of caregivers and care receivers. It exhibits properties of unidimensionality and holds promise for future work. A validity study on a population similar to but different from those for whom the scale was developed will provide more information on the applicability of the scale.

Limitations

Findings obtained after using this scale have to be viewed as tentative because of the relatively small, purposively selected sample. Also it is unknown whether the finding of the difference between spouse and daughters, men and women, high and low education of the carers is a sample artefact or, perhaps, is indicative of different types of conflict. The importance of the closeness of the relationship with the care recipient cannot be
accurately proved. However, it is not accuracy alone, but the perceived
degree of the carers conflict, that is important in this study. Furthermore, the
scale is not developed to supplement or replace any other scales or
questionnaires measuring conflict. It is constructed mainly for the purpose of
the study and is expected to provide an anchoring point for the interviews.

Relevant to the effects of taking care of an elderly relative has almost been
focused on the sources of burden and stress. It has been recognized that the
memory and behaviour of the elderly person is a major source of care
problems (e.g., Folstein et al., 1982). Despite these researchers findings, no
researcher has yet measured or described conflict associated with
caretaking. Nor has any study attempted to identify the prevalence of conflict in
the caregiving context. This chapter focuses on this issue. Before doing so, a
description of the carers and the nature of caregiving is given.

5.1 A Profile of Caregivers

The analyses presented here refer to a total sample of 232 caregivers with
volunteered for the study (see Chapter 4.2). Table 5.2 presents some key
selection. Table 5.1 shows the demographic characteristics of the
caregivers. The majority of the participants in the sample were females, with
53% of the total sample being carers and 8% being daughters-in-law. However, 99
percenters of the male
Chapter 4 describes a psychometric measure, the Scale of Conflict, for measuring interpersonal conflict among caregivers. This chapter identifies the predictors of conflict, and also the most important predictor of conflict from the variables given in the conceptual model presented in Chapter 1 (see section 1.4, Figure 1.3).

Research into the effects of taking care of an elderly relative has mostly been focused on the sources of burden and stress. It has been reported that the memory and behaviour of the elderly person is a major source of stress (Rabins et al., 1982). Despite these research findings, to my knowledge so far there has been almost no research into the relationship of burden, stress, and coping with conflict. Nor has any study attempted to identify the predictors of conflict in the caregiving context. This chapter focuses on this issue. Before doing so, a description of the caregivers and the nature of caregiving is given.

5.1 A Profile of Caregivers

The analyses presented here refer to a total sample of 151 caregivers who volunteered for this study (see Chapter 2, section 2.5 for details of sample selection). Table 5.1 shows the distribution of key characteristics of the caregivers. The majority of the participants in the survey were female caregivers (68%). Of these female caregivers 40 per cent were wives, with 20 per cent daughters and 8 per cent daughters-in-law. However, 30 per cent of the male...
caregivers were husbands, and only 1 per cent were sons and 1 per cent brothers. The smallness of the proportion of son-caregivers matches the proportion of male caregivers found in larger surveys (see Chapter 2, Table 2.2).

The wives' age ranged from 48 to 86 years and daughters and daughters-in-law from 30 to 77 years; the mean age for the wives was 71.2 years and the daughters 49.2 years. The male caregivers ranged in age from 43 to 90 years with a mean age of 76.4 years.
Table 5.1: Distribution of Caregivers Characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Percentage of Caregivers % (N=151)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>68</td>
</tr>
<tr>
<td><strong>Level of education</strong></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>59</td>
</tr>
<tr>
<td>High school</td>
<td>33</td>
</tr>
<tr>
<td>College or graduate school</td>
<td>8</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>33</td>
</tr>
<tr>
<td>Living together</td>
<td>1</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
<td>5</td>
</tr>
<tr>
<td><strong>Place of birth</strong></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>58</td>
</tr>
<tr>
<td>United Kingdom, Ireland</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
<tr>
<td><strong>Employed status</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>16</td>
</tr>
<tr>
<td>Retired</td>
<td>33</td>
</tr>
<tr>
<td>Pensioner</td>
<td>48</td>
</tr>
<tr>
<td><strong>Annual household income</strong></td>
<td></td>
</tr>
<tr>
<td>$0-$9,999</td>
<td>57</td>
</tr>
<tr>
<td>$10,000-$19,999</td>
<td>38</td>
</tr>
<tr>
<td>$20,000-$29,000</td>
<td>5</td>
</tr>
<tr>
<td>$30,000+</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>37</td>
</tr>
<tr>
<td>Catholic</td>
<td>30</td>
</tr>
<tr>
<td>Jewish</td>
<td>9</td>
</tr>
<tr>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
<tr>
<td><strong>Relationship to care receiver</strong></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>70</td>
</tr>
<tr>
<td>Child</td>
<td>21</td>
</tr>
<tr>
<td>Child-in-law</td>
<td>8</td>
</tr>
<tr>
<td>Grandchild</td>
<td>1</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
</tr>
<tr>
<td>Other relative</td>
<td></td>
</tr>
<tr>
<td><strong>Living arrangement</strong></td>
<td></td>
</tr>
<tr>
<td>Living with care receiver in care receivers house</td>
<td>29</td>
</tr>
<tr>
<td>Care receiver living with caregiver</td>
<td>20</td>
</tr>
<tr>
<td>Living together, joint ownership of house</td>
<td>51</td>
</tr>
<tr>
<td>Living separately</td>
<td>8</td>
</tr>
<tr>
<td><strong>Years caregiving</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 1</td>
<td>2</td>
</tr>
<tr>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>3-5</td>
<td>37</td>
</tr>
<tr>
<td>6 or more</td>
<td>61</td>
</tr>
</tbody>
</table>
Most of the wives and husbands were retired and were pension recipients. Some retired caregivers had their own business and were receiving retirement benefits from this, and others had shares and bonds which helped them to manage financially. The husbands had occupations prior to retirement such as defence service, butchery, carpentry, public service, motor mechanic. Some of the wives had also worked in positions such as teaching, cleaning, secretarial, while the rest were house-wives. Some daughter-caregivers were still employed in part time jobs as cleaners or shop assistants. They were somehow managing to keep on with their work as the pension the care receiver received was not enough to maintain the family. It may be noted that the sample is tilted towards the middle class, as indicated by the educational status. The sample of the present study also reflects the trend with fewer female caregivers having high school education and also college degree or advanced degrees. Neither female nor male caregivers were illiterate or had less than primary school education.

As for marital status, most of the caregivers (126) were married, 12 never married, two were in de facto relationships, four were divorced, and the remaining seven were separated.

In religious affiliation 38 females were Protestants, 32 were Catholics, eight were Jews, seven had other religions and 18 had no religion. Among the male caregivers 18 were Protestants, 13 Catholics, six Jews, and 11 no religion.

The sample also varied in the type of ethnic composition. Most respondents were of Anglo-Irish background, and of these 87 were Australian-born. The rest were migrants, 34 from the United Kingdom and 30 from other parts of Europe. All of those who had migrated to Australia had lived here since their childhood, were educated here and also had worked in some occupation here before retirement.
It was the prerequisite of the research that the care receiver lived with the caregiver. However, there were some variations in the living arrangements. In the majority of the cases (n=77) the care receiver and the caregiver had joint ownership of the house in which they lived. In 44 cases the care receiver owned the house while in the other 29 cases the caregiver owned the house or apartment. In these cases the caregivers were usually the daughters or daughters-in-law. The only exceptional case was one where the care receiver, though living in the same house had separate arrangements under the supervision of the caregiver.

Of the total sample of 151, the daughters (20 %) and daughters-in-law caregivers (8 %) rated their health as very good or excellent. 25 per cent of the male-caregivers rated their health to be average. Many (18.8 %) were suffering from arthritis, diabetes and hypertension and reported that their health condition was not good at all. However, the females were considerably more mobile and able than the males and also felt it easier to look after the care receiver with some assistance. 26 per cent reported that their health was average, 23 per cent were in good health, while 15 per cent did not find their health to be good at all.

5.2 What Caregiving Means

The following section explains in detail what caregiving entails, and the nature of the work undertaken by the carers in this study. The care receivers age ranged from 65 years to 98 years. The duration of caring ranged from three years to 18 years. The majority of carers (57.6%) had been providing unpaid assistance for eight to 12 years, the rest (39.7 %) for six to seven years; 7 per cent however had been caring for the elderly person for more than 15 years.
In many cases, carers had to deal with multiple disabilities. As shown in Table 5.2, majority of the caregivers (31.9%) cared for a person paralysed by stroke, some suffered from multiple sclerosis (9.3%) and cardiac disabilities (11.5%). Some had chronic ailments of old age (28%), of which poor eye vision, diabetes, and loss of hearing were the most common problems. The caregivers had to provide full-time support as these elderly people were less mobile and incapable of self-care.

Table 5.2: Major Problems Identified by Caregivers
(N=151)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Per cent of Caregivers Providing Assistance (N=151)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>31.9</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>9.3</td>
</tr>
<tr>
<td>Cardiac Problem</td>
<td>11.5</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>19.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6.1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3.4</td>
</tr>
<tr>
<td>Arthritis</td>
<td>5.1</td>
</tr>
<tr>
<td>Poor vision</td>
<td>8.3</td>
</tr>
<tr>
<td>Loss of hearing</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Physical health was measured by the Katz Activities of Daily Living (ADL) Scale (see Chapter 3, section 3.1.2). The caregivers were asked: ‘Can the elderly relative you are caring for bathe or shower, dress, toilet, move in and out of bed or chair, control urination or bowel, and feed himself/herself, without assistance, with assistance, or not at all?’ The scores were summed to yield a total score representing the ADL capacity of the elderly. The score ranged from 0 to 6 with a mean of 3.07; s.d. = 2.16. The greater the score the more the dependency.
As shown in Figure 5.1, 35 per cent of caregivers assisted with at least one activity of daily living. A substantial proportion of caregivers (20 %) in the study provided assistance with all the six functions of daily living. It was however interesting to note that 5 per cent of the caregivers did not assist the care receiver with any of the activities. This indicates that these elderly people were physically mobile. However, the carers had to live with their relative and called themselves the carers as the relative did not want to live alone and wanted a family member for companionship and emotional support.

The amount of assistance provided by the caregivers for each activity however varied. The majority of the caregivers (20 %) provided assistance with toileting as the care receivers were unable to control their urination and bowel
movements; some had occasional accidents, while some needed to use a catheter. Apart from these, 16 per cent of the caregivers assisted with dressing and bathing their relative, while only a few (12%) provided help with feeding and moving in and out of bed (11%) (see Figure 5.2).

**Figure 5.2: Percent of Caregivers Assisting Each Activity**

![Bar chart showing percent of caregivers assisting with various activities.](chart.png)

It thus appears that more than half of the caregivers were caring for severely physically impaired relatives. However, examination of the ADL capacity alone does not give the full picture of the nature of caring. To get detailed information it is necessary to take into account the mental health as well as the physical health status of the care receiver. Mental health was measured by two measures of mental impairment having two indicators: a check list of sociability and cognitive incapacity (Poulishock & Deimling, 1984:232) (see Chapter 3, section 3.1.3). As obtained from the data, 56 per cent of male caregivers and 71 per cent of female caregivers found it very difficult to live with a relative who was not interesting to talk to; was not cooperative; not friendly and sociable towards
other people who came to visit; and also not appreciative of the help given by
the caregiver. On the other hand 52 per cent males and 47 per cent females
reported that their relatives were mainly forgetful; had unrealistic fears; and did
things harmful to self and others.

5.3 Analysis

To identify the predictors of conflict the variables burden, stress, care receivers' impairment, caregivers' attitude towards caring, living arrangements, caregiving satisfaction, social support, and coping patterns were used as the independent variables. Regression analysis was carried out for this purpose because this technique allows examination of each of the independent variables to determine their effect on the dependent variable. Before the regression analysis was carried out means and standard deviations of the dependent and independent variables are given. This is followed by simple correlations which were examined to give a picture of the degree or strength of the interrelationships of the variables.
Mean, standard deviation, and range of the variables used in the analysis for all the 151 caregivers are presented in Table 5.3.

Table 5.3: Descriptive Analysis of Dependent and Independent Measures (N=151)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>45.5</td>
<td>16.2</td>
<td>[18-72]</td>
</tr>
<tr>
<td>Burden</td>
<td>52.7</td>
<td>14.7</td>
<td>[23-80]</td>
</tr>
<tr>
<td>Stress</td>
<td>29.9</td>
<td>8.8</td>
<td>[9-45]</td>
</tr>
<tr>
<td>Impairment</td>
<td>31.3</td>
<td>7.2</td>
<td>[17-48]</td>
</tr>
<tr>
<td>ADL</td>
<td>3.1</td>
<td>2.2</td>
<td>[0-6]</td>
</tr>
<tr>
<td>Attitude</td>
<td>10.8</td>
<td>2.4</td>
<td>[3-16]</td>
</tr>
<tr>
<td>Living Condition</td>
<td>13.4</td>
<td>3.9</td>
<td>[4-20]</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>22.9</td>
<td>14.1</td>
<td>[9-54]</td>
</tr>
<tr>
<td>Support</td>
<td>8.1</td>
<td>3.8</td>
<td>[0-17]</td>
</tr>
<tr>
<td>Cope</td>
<td>44.6</td>
<td>5.2</td>
<td>[27-56]</td>
</tr>
</tbody>
</table>

\[See Chapter 3, section 3.1 for explanation of these variables.\]

The mean of a particular variable represents the degree or level of that variable. For example, the mean 45.5 of the dependent variable conflict represents the average degree of conflict experienced by 151 caregivers.

5.3.1 Interpersonal Conflict and Caregiving

Inspection of Table 5.4 gives particular insights into the strength of the relationships among interpersonal conflict and other variables. Conflict was related to variables describing the caregivers' subjective assessment of the caring situation. Some of the correlations were in the expected direction with greater degree of burden associated with greater amount of conflict. The following observations can be made from the correlation matrix.
Table 5.4: Intercorrelations Among Conflict and Other Variables (N=151)

<table>
<thead>
<tr>
<th></th>
<th>Conflict</th>
<th>Burden</th>
<th>Stress</th>
<th>Impair.</th>
<th>Attitude</th>
<th>Living</th>
<th>Satis.</th>
<th>Support</th>
<th>Cope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burden</td>
<td>.906</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>.652</td>
<td>.692</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impair.</td>
<td>.205</td>
<td>.259</td>
<td>.056</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude</td>
<td>.676</td>
<td>.674</td>
<td>.537</td>
<td>-.227</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living</td>
<td>-.418</td>
<td>-.427</td>
<td>-.432</td>
<td>-.036</td>
<td>-.288</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satis.</td>
<td>.442</td>
<td>.406</td>
<td>.441</td>
<td>.036</td>
<td>.287</td>
<td>-.338</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>-.683</td>
<td>-.749</td>
<td>-.603</td>
<td>.275</td>
<td>-.528</td>
<td>.337</td>
<td>-.360</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Cope</td>
<td>-.745</td>
<td>.702</td>
<td>.505</td>
<td>-.164</td>
<td>.483</td>
<td>-.292</td>
<td>.322</td>
<td>-.445</td>
<td>1.000</td>
</tr>
</tbody>
</table>

(a) The strong correlation between burden and conflict (r= 0.90, p<.000) indicated that the more burdened the caregivers were during caring, the more conflict they experienced. This may be more an indicator of the interrelationship of the duration of caring, age of the caregiver and work load, than an indicator that the vulnerability of the care receiver created burden.

(b) A strong correlation between the coping strategies and conflict (r= -.74, p<.000) indicated that the caregivers were unable to manage the repercussions of caregiving stress and burden effectively. They were inclined to negotiate everyday life by learning how to accept the fact of caring and cope with it.

(c) Though the caregivers had a favourable attitude towards caring (r= .68, p<.000), they did not derive any satisfaction from meeting the needs of the care receiver, which increased the distress or disruption in their lives, thus creating conflict.

(d) The greater responsibility for the care of the elderly often led to high levels of caregiver stress. Unable to accept the increased dependency needs of the care receiver many caregivers suffered from depression, anxiety, frustration, helplessness, sleeplessness, lowered morale and emotional exhaustion. The
prevalence of some of these expressed emotions created a great degree of strain on the adaptive capacity of the caregivers, often leading to conflict in the relationship \((r = .65, p < .000)\).

Multiple regression analysis (Table 5.5) indicated that emotional burden was an important variable associated with conflict\(s\). 

(e) The low correlation between mental impairment and conflict \((r = -.20, p < .06)\) perhaps can be explained by the fact that the caregivers were less involved emotionally with the care receivers' impairment. It was interesting to find that the care receivers' unsociability and cognitive incapacity was not associated with conflict. This could be due to the restricted range of mental impairment scores.

In sum most of the independent variables correlated well and in the expected directions. Conflict correlated negatively with coping strategy, availability and satisfaction with social support and living conditions. The correlation matrix showed that the most useful variables for regression analysis were Burden, Stress, Attitude Towards caring, Living Conditions, Availability and Satisfaction with Social Support, and Coping Strategy, because of their stronger correlations with Conflict. The correlation of the rest of the variables with conflict was weak, so these variables have been excluded from further analysis. Overall, the matrix showed interesting features of the data.

5.3.2 Regression Analysis

For the purposes of multiple regression, the variables that had the strongest statistically significant Pearson Product moment correlation coefficients were selected. The variables Burden, Stress, Attitude Towards Caring, Living Conditions, Availability and Satisfaction with Social Support, and Coping Strategy were considered in all the regression analysis. Table 5.5 shows the regression table; variables were entered into the equation on the basis of their
explanatory power, beginning with the one that explained most of variance in the dependent variable.

Multiple regression analysis (Table 5.5) indicated that caregiving burden was an important factor. This variable was positively and significantly related to conflict. One explanation is that the caregivers were not able to deal effectively with the multiple and competing demands imposed on their time and resources. They were ‘overloaded’, which affected their everyday activities. Caregivers who reported being more emotionally, physically, socially and financially ‘burned out’ experienced greater interpersonal conflict. The vulnerability of the care receivers has not been found to create burden, rather the caregivers’ sense of burden was affected by the duration of caring, the age of the caregivers and the daily work load. Those who anticipated being less able to cope with the caregiving demands reported experiencing more conflict.

The other significant caregiving characteristic was the caregivers’ attitude towards caring. This was identified as very important to the caregivers (beta=.882). The strong coefficient indicated that the more negative the attitude toward caring, the more the perceived degree of conflict. In addition coping strategy adopted by the caregivers was also found to be an important predictor although the result showed that the caregivers experienced lower conflict due to worse coping.
Table 5.5: Multiple Regression Predicting Conflict for Male and Female Caregivers (N=151)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Regression Coefficients</th>
<th>Standard Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>32.80</td>
<td>8.50</td>
<td>....</td>
</tr>
<tr>
<td>Burden</td>
<td>.62</td>
<td>.06</td>
<td>.000</td>
</tr>
<tr>
<td>Stress</td>
<td>-.07</td>
<td>.08</td>
<td>.416</td>
</tr>
<tr>
<td>ADL</td>
<td>.74</td>
<td>.29</td>
<td>.013</td>
</tr>
<tr>
<td>Impairment</td>
<td>.11</td>
<td>.13</td>
<td>.427</td>
</tr>
<tr>
<td>Attitude</td>
<td>.88</td>
<td>.28</td>
<td>.002</td>
</tr>
<tr>
<td>Living</td>
<td>-.01</td>
<td>.15</td>
<td>.924</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-.10</td>
<td>.04</td>
<td>.010</td>
</tr>
<tr>
<td>Support</td>
<td>-.12</td>
<td>.20</td>
<td>.565</td>
</tr>
<tr>
<td>Cope</td>
<td>-.65</td>
<td>.13</td>
<td>.000</td>
</tr>
<tr>
<td>R²</td>
<td>.87</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In contrast to the above variables, the presence of caregivers' satisfaction with informal and formal support and the functional impairment of the care receivers in the activities of daily living predicted conflict in the caregiver-care receiver relationship at 0.05 per cent level of significance. Social support mentioned included both informal and professional support. The variables representing support comprised various types of help, including friends, community services, community nurses, home help, meals-on-wheels, and health care services. In addition, given that the predictors were in some cases correlated, stress, mental impairment of the care receiver, availability of social support and living condition, which had previously been noted to mitigate conflict, did not emerge as a significant predictors. The variables presented in Table 5.5 retained their significance when the caregivers' age and education were statistically controlled for. No other variables became significant, suggesting that caregivers' age and education do not play any significant role in predicting conflict.

Sex of caregivers was found to be significant when it was used as the dummy variable in the above model along with interactions effects. This indicates that reasons for experiencing conflict may be different for males and females. So
analyses were done separately. The results are shown in Tables 5.6 and 5.7. From the two Tables it was seen that there was difference among the male and female caregivers as to the predictors of conflict.

Table 5.6: Multiple Regression Predicting Conflict for Female Caregivers (N=102)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Regression Coefficients</th>
<th>Standard Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>48.53</td>
<td>11.54</td>
<td>-----</td>
</tr>
<tr>
<td>Burden</td>
<td>.51</td>
<td>.09</td>
<td>.000</td>
</tr>
<tr>
<td>Stress</td>
<td>.04</td>
<td>.11</td>
<td>.745</td>
</tr>
<tr>
<td>ADL</td>
<td>.96</td>
<td>.38</td>
<td>.012</td>
</tr>
<tr>
<td>Impairment</td>
<td>.06</td>
<td>.17</td>
<td>.722</td>
</tr>
<tr>
<td>Attitude</td>
<td>.84</td>
<td>.35</td>
<td>.017</td>
</tr>
<tr>
<td>Living</td>
<td>.07</td>
<td>.19</td>
<td>.680</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-.04</td>
<td>.06</td>
<td>.498</td>
</tr>
<tr>
<td>Support</td>
<td>-.55</td>
<td>.26</td>
<td>.038</td>
</tr>
<tr>
<td>Cope</td>
<td>-.87</td>
<td>.16</td>
<td>.000</td>
</tr>
</tbody>
</table>

When only female caregivers were considered the predictors of conflict were almost similar to those identified for both sexes (see Table 5.5). The only difference was that in the model of female caregivers the predictor satisfaction with social support loses its significance, whereas the availability of support came out as a significant predictor.
Table 5.7: Multiple Regression Predicting Conflict for Male Caregivers (N=48)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Regression Coefficients</th>
<th>Standard Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-6.47</td>
<td>5.12</td>
<td>----</td>
</tr>
<tr>
<td>Burden</td>
<td>.78</td>
<td>.08</td>
<td>.000</td>
</tr>
<tr>
<td>Stress</td>
<td>-.09</td>
<td>.17</td>
<td>.609</td>
</tr>
<tr>
<td>ADL</td>
<td>-.06</td>
<td>.52</td>
<td>.909</td>
</tr>
<tr>
<td>Impairment</td>
<td>.09</td>
<td>.25</td>
<td>.689</td>
</tr>
<tr>
<td>Attitude</td>
<td>1.63</td>
<td>.39</td>
<td>.002</td>
</tr>
<tr>
<td>Living</td>
<td>.17</td>
<td>.28</td>
<td>.551</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-.24</td>
<td>.06</td>
<td>.005</td>
</tr>
<tr>
<td>Support</td>
<td>.38</td>
<td>.36</td>
<td>.295</td>
</tr>
<tr>
<td>Cope</td>
<td>.33</td>
<td>.24</td>
<td>.170</td>
</tr>
<tr>
<td>R²</td>
<td>.86</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Male caregivers on the other hand identified only three factors: caregiving burden, negative attitude towards caring and satisfaction with social support, to predict conflict. One explanation for this difference may be that compared to females, male caregivers usually receive more support from community services, as being males, they are thought to be less involved with the household work and expected to be less competent in their role as caregivers. In spite of having this advantage they were found to be less satisfied with the support they received.

We also used relationship to caregivers as the dummy variable and tested its effect along with interactions. The effects of wife and daughter-caregivers were found to be significant and separate analyses were done for wife and daughter-caregivers as to the predictors of conflict. Tables 5.8 and 5.9 show the results of the two groups.
Table 5.8: Multiple Regression Predicting Conflict for Wife-Caregivers (N=60)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Regression Coefficients</th>
<th>Standard Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>37.82</td>
<td>9.69</td>
<td>.000</td>
</tr>
<tr>
<td>Burden</td>
<td>.65</td>
<td>.07</td>
<td>.331</td>
</tr>
<tr>
<td>ADL</td>
<td>.57</td>
<td>.62</td>
<td>.989</td>
</tr>
<tr>
<td>Impairment</td>
<td>-.00</td>
<td>.24</td>
<td>.015</td>
</tr>
<tr>
<td>Attitude</td>
<td>.81</td>
<td>.33</td>
<td>.974</td>
</tr>
<tr>
<td>Living</td>
<td>-.01</td>
<td>.38</td>
<td>.001</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-.17</td>
<td>.05</td>
<td>.202</td>
</tr>
<tr>
<td>Support</td>
<td>-.53</td>
<td>.41</td>
<td>.000</td>
</tr>
<tr>
<td>Cope</td>
<td>-.71</td>
<td>.15</td>
<td>.86</td>
</tr>
</tbody>
</table>

R² = .86

Table 5.9: Multiple Regression Predicting Conflict for Daughter-Caregivers (N=30)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Regression Coefficients</th>
<th>Standard Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-1.13</td>
<td>6.31</td>
<td>.000</td>
</tr>
<tr>
<td>Burden</td>
<td>.56</td>
<td>.13</td>
<td>.588</td>
</tr>
<tr>
<td>Stress</td>
<td>.02</td>
<td>.04</td>
<td>.503</td>
</tr>
<tr>
<td>ADL</td>
<td>.03</td>
<td>.05</td>
<td>.329</td>
</tr>
<tr>
<td>Impairment</td>
<td>.04</td>
<td>.08</td>
<td>.001</td>
</tr>
<tr>
<td>Attitude</td>
<td>1.89</td>
<td>.53</td>
<td>.264</td>
</tr>
<tr>
<td>Living</td>
<td>-.03</td>
<td>-.09</td>
<td>.024</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>.07</td>
<td>.18</td>
<td>.374</td>
</tr>
<tr>
<td>Support</td>
<td>-.04</td>
<td>-.07</td>
<td>.335</td>
</tr>
<tr>
<td>Cope</td>
<td>.21</td>
<td>.36</td>
<td>.70</td>
</tr>
</tbody>
</table>

R² = .70

Although both wife and daughter-caregivers reported caregiving burden and attitude towards caring to predict conflict, for wife-caregivers coping strategy was found to be very significant in predicting conflict. This demonstrated that coping was a significant factor in conflict for wives compared to daughter-caregivers.
In summary, together with burden, coping strategy has been found to be an important predictor of conflict. Worse coping or high scores of coping appeared to be related to lower conflict for female caregivers than male caregivers and also for wife-caregivers than daughter-caregivers. However contrary results were obtained for daughter-caregivers who experienced more conflict due to worse coping but this coefficient was not significant. The contradictory result may arise from mixing together effective and ineffective coping in one variable. That is why we split the coping strategies into adaptive (effective) and maladaptive (ineffective). The following section describes in detail the adaptive and maladaptive coping strategies used by the caregivers.

5.3.3 Coping with Interpersonal Conflict

In the present study the responses to each coping item were summed to yield a total score representing the coping of the caregivers. Two indicators of coping were identified: adaptive and maladaptive. Adaptive coping strategies can be referred to as the problem-solving coping strategies where the caregivers reported dealing with the situation in such a way that it did not disturb the care receiver or any other family member. The maladaptive coping strategies on the other hand are emotion focused coping strategies that helped the caregivers to deal with the situation by harming the care receiver. Forty-nine per cent of the caregivers used adaptive coping while the remaining 51 per cent reverted to maladaptive coping strategies to deal with the caring situation. The overall score for all the caregivers ranged from 27 to 56 with a mean of 44.63 and standard deviation of 5.25.

The caregivers listed a handful of coping strategies; the list consisted of items obtained from the responses to the pilot study. The data in Table 5.10 reveal these methods of control.
Table 5.10: Percentage of Caregivers Utilizing Various Coping Strategies

<table>
<thead>
<tr>
<th>Coping Strategies</th>
<th>% of Caregiver (N=151)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk away from the situation</td>
<td>19.2</td>
</tr>
<tr>
<td>Shut yourself in your room for some time out</td>
<td>4.0</td>
</tr>
<tr>
<td>Go for a walk</td>
<td>5.3</td>
</tr>
<tr>
<td>Garden</td>
<td>23.8</td>
</tr>
<tr>
<td>Talk with other people about the situation</td>
<td>4.0</td>
</tr>
<tr>
<td>Be active (sing, read)</td>
<td>4.6</td>
</tr>
<tr>
<td>Cry</td>
<td>37.1</td>
</tr>
<tr>
<td>Scream and yell</td>
<td>57.1</td>
</tr>
<tr>
<td>Threaten care receiver of nursing home placement</td>
<td>39.1</td>
</tr>
<tr>
<td>Argue with care receiver</td>
<td>45.4</td>
</tr>
<tr>
<td>Shake/push care receiver</td>
<td>45.0</td>
</tr>
<tr>
<td>Put care receiver into bed (so that he/she does not bother you)</td>
<td>31.5</td>
</tr>
<tr>
<td>Argue with other family members</td>
<td>42.2</td>
</tr>
<tr>
<td>Pray, read Bible</td>
<td>8.6</td>
</tr>
<tr>
<td>Swear and curse</td>
<td>40.4</td>
</tr>
</tbody>
</table>

Thus it is seen that in an attempt to gain or maintain authority, a variety of coping strategies were used by the caregivers. Screaming was frequently used by a sizeable number of caregivers. Other methods used by caregivers included...
shaking and pushing (45%), arguments with the care receiver and family members (42%), and swearing and cursing (40%). It was interesting to note that the caregivers did not function along accommodative or cooperative lines. They were less likely to utilize active problem-solving behaviours. As a result of conflicting demands, abusive and neglectful methods often became the method of last resort for most of the caregivers.

Once we had identified the various coping strategies adopted by the caregivers it was essential to determine whether these two coping strategies allowed us to make a meaningful distinction between the 73 caregivers adopting adaptive coping and the 78 caregivers adopting maladaptive coping strategies. Discriminant Analysis is particularly well-suited to this research problem as it is a technique for the description and testing of between-group differences. The variables used in the analysis were used to predict the two mutually exclusive groups employing coping strategies (adaptive or maladaptive). The purpose here was not to derive a classification rule for future application, but rather to describe reasons which distinguished the two groups.

5.3.4 Discriminant Analysis

Entering all the nine predictors into the analysis simultaneously resulted in a statistically significant degree of discrimination (Wilks' lambda=0.529; P=0.000), with a mean discriminant score for caregivers employing adaptive coping of -0.906 and for caregivers employing maladaptive coping of 0.968. In analysis of variance terms, with coping strategies as the independent variable and the discriminant score as the dependent variable, caregivers who adopt adaptive coping differ significantly on the discriminant function from those who adopt maladaptive coping. The complement of Wilks's lambda, 'approx'. eta²,
indicates that 47.1 per cent of the total group variability is attributable to the discriminating variables. The relative discriminative ability of each of the predictor variables is given by the absolute value of the standardized discriminant function coefficients shown in Table 5.11.

Table 5.11: Standardized Discriminant Function Coefficients (SDFC) for Predictor Variables Distinguishing Caregivers Adopting Adaptive Coping (N=73) from Those Adopting Maladaptive Coping (N=78)

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>SDFC</th>
<th>Significance</th>
<th>Adaptive Group Mean (s.d)</th>
<th>Maladaptive Group Mean (s.d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>0.903</td>
<td>.000</td>
<td>34.8 (12.5)</td>
<td>56.8 (11.4)</td>
</tr>
<tr>
<td>Burden</td>
<td>0.106</td>
<td>.134</td>
<td>43.8 (11.9)</td>
<td>62.1 (11.3)</td>
</tr>
<tr>
<td>Impairment</td>
<td>0.184</td>
<td>.116</td>
<td>27.4 (6.1)</td>
<td>35.7 (5.8)</td>
</tr>
<tr>
<td>Support</td>
<td>0.120</td>
<td>.065</td>
<td>9.7 (3.6)</td>
<td>6.3 (3.3)</td>
</tr>
<tr>
<td>Stress</td>
<td>-0.081</td>
<td>.574</td>
<td>26.3 (9.0)</td>
<td>33.8 (6.7)</td>
</tr>
<tr>
<td>ADL</td>
<td>-0.699</td>
<td>.001</td>
<td>2.2 (1.8)</td>
<td>3.9 (1.8)</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-0.039</td>
<td>.735</td>
<td>28.4 (15.7)</td>
<td>16.9 (10.1)</td>
</tr>
</tbody>
</table>

The coefficients indicate each variable's net predictive power controlling for all other variables in the model. The significance test associated with each variable's unique contribution is based upon the change in Rao's V when adding this variable last to a model which includes all the other eight variables. The sign of each discriminant function coefficients indicates whether increasing the value of that variable (as scored here) increases or decreases the discriminant function score. Since the group centroid is positive for respondents' maladaptive adaptive coping, but negative for adaptive, all of the predictors except the three
measures are positively associated with persistent use of maladaptive coping strategy.

When all nine variables are included in the discriminant model, conflict is clearly the most important predictor of maladaptive coping strategy. A positive response to this variable increases the discriminant function value and contributes to the positive score associated with maladaptive strategy. The discriminant function value also significantly increases with the functional impairment of the care receiver.

The foregoing suggests that the extent to which the coping strategies are reproduced in caring is subject to a wide variety of mediating factors, it is nevertheless an entirely plausible notion that a severe amount of conflict is the main source. All the caregivers reported some amount of conflict in their caring relationship. The overall score of conflict ranged from 18 to 72 with a mean of 45.49 and standard deviation of 16.22. Because of the differences among caregivers and the caring situations caregivers experienced varied amounts of conflict.

Caregivers mentioned a number of factors that contributed to the differences in their experience of conflict. However, discriminant analysis (Table 5.12) indicated that burden due to caring and the functional impairment of the care receivers in the activities of daily living, and the coping strategies used, were mainly associated with high conflict.
Table 5.12: Standardized Discriminant Function Coefficients (SDFC) for Predictor Variables Distinguishing Caregivers Experiencing High Conflict (N=102) from those Experiencing Low Conflict (N=49)

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>SDFC</th>
<th>Significance</th>
<th>High Conflict Mean (s.d)</th>
<th>Low Conflict Mean (s.d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burden</td>
<td>.880</td>
<td>.000</td>
<td>64.9 (8.3)</td>
<td>40.9 (8.6)</td>
</tr>
<tr>
<td>ADL</td>
<td>.813</td>
<td>.000</td>
<td>4.4 (1.9)</td>
<td>1.8 (1.5)</td>
</tr>
<tr>
<td>Cope</td>
<td>.770</td>
<td>.000</td>
<td>60.3 (6.5)</td>
<td>31.2 (7.5)</td>
</tr>
<tr>
<td>Stress</td>
<td>.449</td>
<td>.241</td>
<td>35.7 (5.9)</td>
<td>24.4 (7.5)</td>
</tr>
<tr>
<td>Attitude</td>
<td>.101</td>
<td>.144</td>
<td>19.2 (3.5)</td>
<td>16.3 (2.3)</td>
</tr>
<tr>
<td>Impairment</td>
<td>.003</td>
<td>.574</td>
<td>36.9 (4.2)</td>
<td>26.0 (5.2)</td>
</tr>
<tr>
<td>Living</td>
<td>-.199</td>
<td>.089</td>
<td>5.6 (2.9)</td>
<td>10.4 (3.0)</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>.108</td>
<td>.056</td>
<td>14.9 (8.9)</td>
<td>30.4 (14.0)</td>
</tr>
</tbody>
</table>

A positive response to these variables increased the discriminant function value and contributed to the positive score associated with high conflict. Burden, ADL, and coping correctly classified the caregivers as having either high or low conflict. In contrast, stress from caregiving, care receivers' mental impairment, the caregivers' own attitude toward caring and the current living conditions could not distinguish the caregivers' perceived level of conflict, whereas satisfaction with social support predicted a lower degree of conflict among the caregivers.

Thus the discriminant analysis in the data revealed several factors which significantly differentiated caregivers who reported experiencing high conflict from those who experienced low conflict. Certain of these predictor variables are potentially changeable; others appear to be less malleable.
5.4 Discussion

This chapter makes two contributions to the literature on informal caregivers: first, it describes the causal relationship between the independent and dependent variables as outlined in the model described in Chapter 1. This provides a better understanding of the complex relationship between the caregiver and care receiver in the process of caregiving. As is seen from the regression analysis, among all other possible outcomes of the caregiving situation (e.g. caregiving satisfaction, stress) caregiving burden has been identified as the most important consequence of the caregiving situation. This could be the result of multiple factors such as the physical and mental impairment of the care receivers, the caregivers' perception of their own health, living conditions, the availability of social support, satisfaction with that support, and the unmet needs of the caregiver. The burdened caregivers then try to adopt a means of coping with the pressure and load. It has been observed that in the course of appraising the situation the caregivers find it very difficult to cope with the demands posed by the caregiving context. Such a reaction seems to be acceptable. Previous research also demonstrates that the caregivers' ability to cope with the situation is affected by the burden they perceive (Chenoweth & Spencer, 1986). In such a situation most of the caregivers find the coping strategy to be ineffective to deal with the demands. They become less confident about their coping abilities and resources to handle the caregiving situation and hence experience conflict. However, in the caring situation not only do coping strategies act as a precipitating event in producing conflict, but also a severe amount of conflict may pose a threat to the caregivers' ability to cope. Thus inability to cope with the situation may not only create conflict. The relationship between coping and conflict may also be a vicious circle in which poor coping strategies result in increased conflict and further impede the use of effective coping strategies. Thus from the analysis it could be stated that the
model presented in Chapter 1 provides a background sketch of the complex caregiving process. However, as the idea proceeds a step further from caregiving burden and stress to interpersonal conflict, the model needs to be modified and extended for further empirical testing.

Secondly, the predictors of conflict were identified. The results indicated that the more burdened the caregivers were, and the greater the ADL limitation of the care receivers, the more the caregivers experienced conflict. Specifically, in the regression model it has been found that the more burdened the caregivers were, the more likely they would experience conflict. On the other hand, if the caregivers experienced less stress, there was a lower probability that they would experience conflict. The functional limitation of the care receivers has also been found to create conflict in the relationship. The reason could be that many caregivers often resent satisfying the daily and instrumental needs of the older people, thus they are likely to face more problems as the elders become more dependent on them.

Caregivers' perception of being burdened also reflected their ability to cope. The caregivers overwhelmed with the everyday work load were unable to deal with it effectively. In many cases this would interfere with the regular behaviour and engender feelings of loss of control, annoyance, irritability and discomfort. Their ability to cope was often hampered by the conflict they experienced with the care receiver, which in many cases permanently damaged their relationship. Though some caregivers reported to have used some ways of dealing with the situation by talking the problem with someone; spending sometime gardening; or praying, they found these coping strategies to be inadequate to mitigate the negative impact of conflict they were experiencing. According to them these coping strategies were unlikely to alter their circumstances. This probably resulted in additional stress.
In this case the ability to use problem-solving abilities could be impaired. This finding contradicts to those of Pratt et al., (1985), Quayhagen and Margaret (1988), and Levine et al., (1983) where problem-solving was used as the best coping mechanism by caregivers of elderly people suffering from Dementia and Alzheimer's Disease. Such a difference in the findings could be due to the fact that the care receivers in the study were mentally alert; their involvement in every day activity may produce more arguments and dissention; which may become unbearable for the caregiver. Another reason for such inability to cope could be that the caregivers were not getting enough support from other family members. Support from family members is likely to reduce the amount of burden and conflict as in other studies a positive association has been found between socio-emotional support from family members and effective coping with burden (Scott et al., 1986). Another explanation could be that caregivers with poor coping strategies are likely to encounter more conflict as a result of unresolved problems.

Thus as the conflict increased adaptive coping was likely to be replaced by maladaptive coping strategies. Quite a large number of strategies were reported. A large proportion of those coping items were significantly related to abusive or disruptive interaction. Combative behaviour or angry outbursts were specifically mentioned. The coping strategies thus adopted by the caregivers were not helpful to decrease anxiety and made caregiving less stressful, for which they found it difficult to accept the situation and feel less angry.
5.5 Summary

In summary, although the findings of the study demonstrated that caregivers were experiencing conflict and also finding it hard to cope with it, we have only begun to explore the relationship between interpersonal conflict and other factors affecting caregiving. Although the findings about such exemplary care situations cannot be generalized to all caregivers, the standardized questions focused on the factors giving rise to conflict for this particular sample of caregivers. This made it possible to see the reactions of a great many caregivers to a limited set of questions, thus facilitating comparison and statistical aggregation of the data. This provided additional information that would advance understanding of the caregiving process. More specifically, this Chapter sought to determine the most important predictor of interpersonal conflict, identified how caregivers coped with caring and their consequences.

However, lack of sufficient data hampers the ability to apply more stringent assessment methodologies. We also have limited understanding of the factors that encompass the specific differences among informal and formal caregivers with respect to care. Although, an attempt has been made in this thesis to examine the caring experiences of the caregivers in more details. A small group of female caregivers has been selected for this purpose. The reason for selecting female caregivers is because the literature on caregiving demonstrates women bear the major caring responsibilities. It has also been reported in the literature that women are more burdened and stressed due to caring than the men caregivers. To my knowledge evidence is lacking regarding interpersonal conflict due to caring. Studying conflict among women by using specific questions regarding their caring experiences and consequences would help to broaden our knowledge of the caring situation. The next Chapter will highlight the experiences of women caregivers only.
CHAPTER 6

CARING AS PERCEIVED BY FEMALE CARERS: ANALYSIS OF IN-DEPTH QUALITATIVE INTERVIEWS

In the previous chapter the predictors of conflict were identified together with the coping strategies of 151 male and female caregivers. This chapter gives a detailed description of the caring experiences of female caregivers only. Studying female caregivers will help to improve the understanding of conflict in caring for the elderly by presenting new data and also by taking a fresh look at conflict as perceived by the caregivers themselves. In addition this will also help to confirm and expand the results from regression models given in the previous chapter.

In this phase of the study qualitative methods were employed (see Chapter 2). This approach was taken for two reasons. First, an initial aim was to obtain a general descriptive picture of the caring situation, especially the experiences of the caregivers during the caring process. The goal was to understand the dynamics of caring as perceived by the caregivers themselves. The second reason for employing qualitative methods was to get a sense of how key elements of burden, stress, and conflict were talked about by the caregivers. How did the caregivers perceive and talk about interpersonal conflict? What terms did they use in talking about caring?
6.1 Method

6.1.1 The Sample

Of the 151 caregivers, a subsample of 30 female caregivers was chosen to study in more detail. The sampling procedure is given in Chapter 2 (see section 2.5). These caregivers ranged in age from 30 to 86 years; their mean age was 70.07 years. The sample consisted of approximately half spouses and half daughters, of whom 14 were wives, 14 were daughters, and two were daughters-in-law. Of the respondents, six had only primary education; the majority (13) only some secondary; and 11 had further education and training. Their occupations also varied with a third being in part-time professional work, and the largest category being on pension and old-age benefits. Thus the sample was tilted towards the lower socioeconomic class. The median annual income for the carers' households was A$10,000. The majority of them (24) were married, three were single, two divorced, and one widowed.

The sample also varied in racial and religious composition. Most of them were of Anglo-Irish background: of these 17 were Australian born. The rest who had migrated to Australia were most likely to be from the United Kingdom (8), two were from New Zealand, and one each from Germany, Holland and Poland. The majority had been in Australia for over 20 years, had been educated in Australia and ranged across all occupation and income groups. In terms of religious composition the majority were Protestants (14), the rest being Catholic (8), Jewish (1) and of no religion (7).

The caregivers were caring for an elderly relative at home: the care receivers' ages ranged from 65 to 94 years. The duration of caring ranged from four years to 15 years; the majority of carers had been providing unpaid assistance for four to ten years; one-fifth, however have been caring for the elderly person for more
than ten years. All the caregivers lived in the same household with the care receiver. Only eight of them owned their own houses or apartments, while in the majority of cases the care receiver owned the house.

To indicate whether the caregivers in the sub sample differ from the rest of the sample in background characteristics such as age, education, household income, living condition, and length of caring, the background characteristics are presented in Table 6.1 separately for the two groups. A description of the characteristics of caregivers provides a background for interpretation of the findings.

**Table 6.1: Comparison of Background Characteristics of the Sub sample (N=30) and Remaining Sample (N=121)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sub sample (N=30)</th>
<th>Remaining Sample (N=121)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>62.4</td>
<td>68.0</td>
</tr>
<tr>
<td>Education (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary</td>
<td>20.0</td>
<td>34.7</td>
</tr>
<tr>
<td>high school</td>
<td>43.3</td>
<td>43.0</td>
</tr>
<tr>
<td>college</td>
<td>36.7</td>
<td>22.3</td>
</tr>
<tr>
<td>Annual household income (AUS $)</td>
<td>20854.6</td>
<td>17535.2</td>
</tr>
<tr>
<td>Living condition (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care receiver's house</td>
<td>36.7</td>
<td>27.3</td>
</tr>
<tr>
<td>caregiver's house</td>
<td>26.7</td>
<td>17.4</td>
</tr>
<tr>
<td>joint ownership</td>
<td>36.7</td>
<td>54.5</td>
</tr>
<tr>
<td>Length of caring (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td>....</td>
<td>2.5</td>
</tr>
<tr>
<td>3-5</td>
<td>50.0</td>
<td>37.2</td>
</tr>
<tr>
<td>6 or more</td>
<td>50.0</td>
<td>60.3</td>
</tr>
</tbody>
</table>
Caregivers in the sub sample differed from the remaining sample in terms of background characteristics. Caregivers in the sub sample were younger than those in the remaining sample. The proportion of caregivers with primary school education was 20 per cent in the sub sample compared to 35 per cent in the remaining sample. About 43 per cent of the caregivers of both the groups had high school education. The proportion of caregivers with graduate degree was highest for the sub sample (36 %) indicating that the caregivers in the sub sample were more educated than the rest. Caregivers also varied considerably in terms of annual household income. The caregivers in the sub sample were financially better off than the remaining caregivers. In terms of living arrangement caregivers in the sub sample differed considerably from those in the remaining sample. Compared to the remaining sample a greater percentage of caregivers in the sub sample were either living with their elderly relative in the old persons house or in their own (caregivers) house, lower percentage of caregivers in the sub sample had joint ownership of the house (37 %) than the remaining caregivers (55 %). This difference in the two groups regarding living condition is expected to have a significant effect on the amount of conflict the caregivers experience. However, the two groups did not differ significantly in the duration of caring.

To provide a better understanding of whether the sub sample differed from the total sample when they are divided into groups in terms of the dependent and independent variables, means and standard deviation of the dependent and independent variables are presented in Table 6.2 separately for 30 female caregivers in the sub sample and the rest of the caregivers (N=121).
Table 6.2 Comparison of Sub Sample (N=30) with the Remaining Female Caregivers (N=73) and Male Caregivers (N=48)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sub sample (N=30)</th>
<th>Remaining Sample (N=121)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (S.D)</td>
<td>Females (N=73)</td>
</tr>
<tr>
<td>Conflict</td>
<td>48.6 (14.7)</td>
<td>47.1 (18.1)</td>
</tr>
<tr>
<td>Burden</td>
<td>59.3 (14.2)</td>
<td>57.2 (16.2)</td>
</tr>
<tr>
<td>Stress</td>
<td>31.0 (9.4)</td>
<td>33.8 (7.3)</td>
</tr>
<tr>
<td>Impairment</td>
<td>33.6 (6.5)</td>
<td>31.5 (7.9)</td>
</tr>
<tr>
<td>Attitude</td>
<td>11.3 (1.9)</td>
<td>11.1 (2.6)</td>
</tr>
<tr>
<td>Living</td>
<td>13.4 (3.9)</td>
<td>13.5 (4.0)</td>
</tr>
<tr>
<td>Satis. a</td>
<td>17.3 (12.8)</td>
<td>23.8 (15.1)</td>
</tr>
<tr>
<td>Support</td>
<td>6.2 (3.6)</td>
<td>7.5 (3.6)</td>
</tr>
<tr>
<td>Cope</td>
<td>45.2 (4.4)</td>
<td>43.2 (5.7)</td>
</tr>
</tbody>
</table>

a Satis. = satisfaction with support

Female caregivers of the sub sample found caring more difficult than the rest; they were more burdened, less stressed, less satisfied with the social support they got, unable to cope better, and experienced more conflict. When the remaining 121 caregivers are further divided into 48 males and 73 females caregivers, it was observed that the caregivers in the sub sample not only found caring more difficult than the male caregivers but also than the rest of the female caregivers. Caring was somewhat less threatening to male caregivers who were able to cope better than their female counterparts.

6.1.2 Procedure

Semi-structured interviews were conducted with each of the 30 female caregivers in their homes to elicit data to interpret their experience of caring; a description of the interview schedule is given in Chapter 2. Each interview was
two to four hours in length, was tape-recorded, and subsequently transcribed by the researcher. The transcribed data were arranged in a manner amenable to analysis by the use of the Ethnograph computer program (Seidel et al., 1985: 1-1).

The Ethnograph is designed to assist the researcher in the mechanical aspects of qualitative data analysis; in managing field notes, transcripts, documents etc. The objective of the program is to free the researcher to devote more attention to the interpretative aspects of ethnographic analysis. The two basic parts of the program are the mechanical part, organizing and subdividing the data, and the interpretative part, whereby the researcher decides on ways to organize data into analytical categories and patterns of interrelationships. In addition this program allows the researcher to code, recode, sort and modify the data files into chosen analytical categories. The text can be reviewed and displayed in any order or sequence. Thus it is possible to compare similarly coded sections with each other or with differently coded sections.

The qualitative data for this thesis consisted of both tape-recorded interviews, field notes and responses to three case vignettes (given in Chapter 7). The tape recorded interviews were transcribed, verbatim, into Microsoft Word program, which amounted to approximately 1150 pages, then transferred onto the Ethnograph program for subsequent analysis. An attempt was made to discard inappropriate topics and to add some topics which arose, in many cases spontaneously and unprompted, during the interviews.

After preparing the data the process of coding was carried out. The philosophy behind this process of coding has been taken from the Strauss's Grounded Theory Perspective; detailed explanation of open, axial and selective coding can be found in Strauss (1987: 55-75). The perspective offers a systematic process
of focusing one's interest on a substantive area, where the researcher jointly collects, codes, and analyses the data and decides what data to collect next in order to develop the theoretical explanation as it emerges.

During coding the interviews were read very carefully in order to identify various examples, categories, or subcategories within the text. Then the ideas, concepts and descriptions were noted down in the margin and subsequently entered as casewords in the Ethnograph. Once one interview was coded it was necessary to compare it with previous and subsequent incidents in the same and different groups of informants. Thus the other interviews were also coded in a similar fashion as the constant comparison of the incidents enabled the generation and refinement of explanatory properties of the category (Glaser & Strauss, 1967: 106). After completing the process of coding it was necessary to make an inductive jump to further develop and interrelate the explanatory schema. Under such conditions some generalizations were made. The generalizations acquired from the in-depth discussions formed the basis of the analysis.

6.2 Findings

The analysis aimed to be sensitive to the respondents' subjective interpretations. In order to guide the analysis and to develop categories of processes the following interpretation makes use of the respondents' own words. A composite picture of the dominant and divergent themes that emerge from the interviews with the caregivers is discussed in the following sections. Throughout the following sections, differences between wife and daughter perceptions of caregiving will be highlighted.
6.2.1 How the Carers Feel About Caring: Themes of Caring Experiences

**Stress.** Analysis of the carers' description of the caregiving situation revealed conflict between the caregivers and care receivers. The main cause of such conflict was covered by a theme of stress. Caregivers' statements revealed that caring for an elderly relative is 'very stressful'. The caring situation is not as easy as it sounds but 'very traumatic' and 'impossible'. Wife-caregivers found it easy to compare caring for a child to caring for an elderly person. They went so far as to compare their role as a caregiver for a child and their present caring role. Some of them (n=10) mentioned that caring for a child gives pleasure in a sense that they will grow up, whereas there is no such expectation for an elderly person. In other words there is simply 'no light at the end of the tunnel'. Other explanations were less kindly:

Full time caring is very traumatic and impossible. Caring is not so easy as it first sounds. It is a mystery (69 year-old daughter)

They can see everything from their point, but do not think about you, whether you are sick or tired. This is very stressful and hard to live with (55 year-old wife)

Another carer painted the same picture:

You just go on for ever. It is stretching for ever. You can not see any relief at all. They are like a big shadow all the time hanging over you (65 year-old wife)

In general the carers' perception of the caring situation was that they were on an 'endless' journey which is not pleasurable but like a 'guilt trip'.

On other occasions the caregivers discussed the care receivers' vulnerability as a major source of stress, particularly as the care receivers needed full-time care
or 'assistance' with everything, but showed little concern and interest in others. The care receivers were considered to be egocentric, self centred most of the time, absorbed in their own concerns and needs. What mattered to most caregivers (n=23) were first the disability and illness of the elderly person; and secondly some aspects of their disruptive behaviour pattern, 'stubborn', 'disagreeable', 'wandering', 'irritable', 'complaining', 'demanding', 'uncooperative', and 'negative attitude'. Frustrated and frightened carers often felt guilty and bitter as the ill relative became increasingly dependent. Some (n=13) could not accept illness and thus felt angry, while others (n=10) reacted with fear, anger, and disbelief to what was happening to someone they loved and respected. According to some caregivers they were more or less able to cope with the physical impairment of the care receiver, but the care receivers' mental impairment led to a severe amount of conflict. As one carer said:

You have to tell him to sit down, stand up, you put the food in front of him and rattle the plate and the spoon to make him notice that it is time to eat. Everything is so stressful. That is the time when I just start counting to ten. (57 year-old wife)

Many caregivers also were concerned about financial costs of care. Wife-caregivers had to depend on the age pension, while daughter-caregivers' paid work was interrupted when they had to drop out of the workforce to care for their parent. The sudden transition to a single-income budget led to financial stress. One third said that their level of financial commitment had increased through financing health and social services and trying to meet expenses in the form of special food, clothes and medicine for the care receiver. All of these led to financial worries. However, the need for financial assistance varied among caregivers; depended on the care receivers' dependency and the attitude of the caregivers to the situation.
Caregivers also discussed concern about the future as another source of stress related to their caring situation. For daughters it was focused on the care receiver's condition: 'if he gets worse how am I going to cope?'. While the wife-caregivers were stressed through concern for their own health: 'who is going to care for him if I am gone?, they will put him into a nursing home. I have to keep on my feet to keep him at home' confided a wife-caregiver.

Stress from caring was thus found to be an important issue for the caregivers when they talked about their caring experiences. A significant correlation was also found between stress and conflict when stress was measured quantitatively by using the 12 item version of the General Health Questionnaire (see Chapter 3, section 3.1.7); although the caregivers in the sub sample (N=30) experienced less stress than the remaining caregivers (N=121). However, when the regression analysis was done stress did not appear to be a significant predictor of conflict.

**Feelings of Isolation.** Because of the dependency of the care receiver and constancy of caring many (n=23) caregivers found themselves to be 'isolated'. Both the daughters and the wives reported that they were socially and emotionally isolated; through full-time caring they were restricted in going out. Daughters mentioned the loss of friends and hobbies; some had to give up jobs as shop assistants, office secretaries, or in post offices, restaurants; volunteer work with different community organizations, and leisure activities. All their social contacts were eliminated. The wife-caregivers said that children did not come to visit and spend time with them. They had no one with whom they could freely express their feelings and share their experiences. Emotionally these caregivers were also isolated. They felt that their husbands had lost all their affection, interpersonal sensitivity and empathy, so that the caregivers'
affectional needs were unmet, leaving them frustrated. In particular they reported the greatest need to be for emotional support 'somebody to listen, a shoulder to cry on'.

And here we find age differences. The daughter-caregivers who indicated that they felt isolated were the ones who were least likely to see community and friends. These caregivers reported that they were 'abandoned'. They were unable to maintain phone contacts with family and friends, visit friends, spend time in hobbies or even relaxing. In other words they lost some personal freedom. Loss of privacy, autonomy and sleep was also mentioned. Wife-caregivers resented their inability to attend church and also senior citizens' clubs. Some considered the care receiver's dependency and their own involvement to be the main reason for such isolation. Yet others reported the lack of knowledge on the part of people not involved with the caring situation. As they state:

Friends get hostile and you gradually lose your friends. They will not understand that you have to give this care. (65 year-old wife)

Friends think that you are getting too involved with your situation. It is the carer who feels the burn off not the caree, being abandoned, no one will understand. (59 year-old wife)

According to them instead of getting any sympathy they got 'platitudes' in return. Alternatively, some wife-caregivers, though feeling isolated, had self-imposed a regimen of staying home:

There is no way you can have a social life (68 year-old wife)

If you take them somewhere you are upsetting other people. They (care receiver) are not enjoying because they are mostly out of it. You are not enjoying because you are stressed. It is better to stay at home, do sewing, knitting and see what they are doing. (63 year-old daughter)... were some of the comments.
The caregivers' feeling isolated was also supported by the findings of the quantitative analysis. A significant correlation was found between lack of support and lack of satisfaction with the support. Particularly for females in this sample, lack of support predicted most of the conflict (see Chapter 5, Table 5.6).

*Role reversal.* In other situations feelings of stress developed from the discomfort with change in role and responsibility, what the caregivers called 'role-reversal'. Such a situation was most likely to occur when women shifted from the role of wife or daughter to head of household and took control of all the financial and household management. The stress was more when the daughter was caring for the mother; as one caregiver mentioned:

> She has become so dependent on me that I am now the mother and she is the child. This is very distressing. I find it hard where she has always looked after me, now I have to look after her. Treating a mother like a baby is very stressful. (42 year-old daughter)

Although the caregivers frequently mentioned role reversal during the indepth discussion; that caused stress and conflict, this was not covered in the quantitative analysis.

*Role Conflict.* Another theme that pervaded the comments of the caregivers was that the reason for most of their conflict was having to make a choice between more than one duty. The daughter-caregivers experienced this problem more than the wife-caregivers when they had to choose between their parents and their own spouse and children. Most of these caregivers had their own families, 'their own life to lead'. Full-time caring created an imbalance in the family relationship that produced a question of loyalties. They found the demands of
their various roles competing for their time and energy, and they were easily affected by the hardship of caring, their elders' dependency and loyalty towards their own family. They were put into a dilemma. At a certain stage the caregiving and family pressures became so acute that they experienced 'burnout' symptoms. In some cases the pressures from both sides became so great, they were unable to neglect the parent and walk away, neither could they walk out on their own family. It became impossible for them to keep the situation unobtrusive, by assuming the whole burden of care themselves. This imbalance in loyalties contributed to negative feelings, feelings of guilt, hopelessness and helplessness. This in turn contributed to the cycle of conflict between the caregiver and care receiver. The caregivers in most cases found it difficult to respond to conflict. This in turn led to minimal caregiving effort in many cases, sometimes making it very difficult for the caregivers to control their anger and resentment. As some reported:

I did really go into pieces a few times. I could not control myself. I pushed him, screamed at him, at one stage he fell down and hit himself. (52 year-old wife)

It has turned into a love-hate relationship. For two solid years my husband and I have not gone out of the door together. If you want to do anything you always have to think 'if mum can', 'if mum is alright'. (56 year-old daughter)

I feel very resentful and irritated as I can not get proper sleep. If she is quiet you get up to look and doubt why she is quiet. If she is making a noise you get up to find out why she is making a noise. And when you, your body clock tells you to get up you find that she is still snoring away. At that time you feel if you are honest to say you feel terribly resentful with that she is lying sleeping and she had me awake all night. (72 year-old daughter)

This resentment and unwillingness to provide further care is partly due to the lack of feeling of acceptance by the care receiver. Married daughter-caregivers with children are seen to have responsibilities and burdens of their own. Old parents do not realize these practical necessities which their adult children face.
The expression of love which comes with caring and providing the best for the parents was not seen as an objective for the daughters and daughters-in-law. The caregivers' behaviour can be explained in terms of role obligations: 'it is my duty' 'I have to do it'. These comments demonstrate that daughter-caregivers do not have a strong bond of attachment, rather they are caring only because of commitment or as there is no other 'alternative'. To them expressing love was hindered by lower economic status and subsequent lack of active support given to parents which meant that there was no time to love them, rather 'it has come to a love-hate relationship'; 'I have grown to hate her'. However, despite these perceived obligations which the caregivers have it is surprising that the care receivers do not refrain from requesting and demanding assistance.

The caregivers' experiencing burnout symptoms and resentment and unwillingness to provide further care to the care receiver was also supported by the quantitative analysis. For both the wife and daughter-caregivers caregiving burden and unfavourable attitude towards caring predicted conflict. In many cases it was difficult for them to deal with the conflict. This was particularly true for wife-caregivers who were unable to cope with the situation and hence were confronted with more conflict than the daughter-caregivers (see Chapter 5, Table 5.8).

**Imbalance in Equity.** Analysis of the caregivers' description of the caring situation revealed a theme of imbalance in equity which led to most of the conflict. These caregivers were the only source of care for the elderly; some daughter-caregivers stated that they did not have any one in the family who would take over the caring role. Family members 'do not have the time to be worried about the old who are trailing along behind'. Yet others mentioned that it was their duty and responsibility: 'I have to do it'. In some cases the helping behaviour was governed by cultural norms and expectations. In most of the
cases the elderly parent wanted the eldest daughter to provide care, which in fact was highly supported and appreciated by other family members: 'it has always been in the family'. However, wife-caregivers had different perceptions of their caring role. They found caring to be their primary responsibility rather than mere duty. They treated caring as 'their job' and the suffering of the care receiver as 'a part of themselves who is suffering'. They were ready to continue till the end.

Although they were ready to do the caring, they were tired with the everyday task of caring. They found caring to be a burden (see Chapter 5, Table 5.8 & 5.9). The multiple and competing demands created too much pressure on their time and resources. This not only affected them emotionally and physically but also had an effect on the finances and social life. However, the caregivers were still caring for their relative, as they did not have any other alternative.

Despite realizing that they did not have any alternative to caring both the wife and daughter-caregivers were frequently confronted with the question 'Why me? Why do I have to do the caring? Why not anyone else in the family?'. These questions not only created tension and conflict between the caregiver and care receiver but also affected the caregivers' relationships with other family members. However, it varied between daughter-caregivers and wife-caregivers. According to daughter-caregivers other siblings did not come and visit, and there was no one who could maintain a form of roster to take care of parents when the caregiver became ill. Nevertheless, other siblings were reluctant to admit the presence of a disabled person in the family, for which 'they hardly get along'. On the other hand for wife-caregivers support from children meant a great deal. Although support from children was a very clear example of the emotional well-being of these caregivers they felt that their caring role was not appreciated by their children; they were also disappointed with the amount of
support they got from their children. Such forms of emotional support were only displayed through milestone ceremonies such as Christmas or birthdays; however, rather than criticizing their children the respondents tried to hide their feelings by making excuses:

They do not want a sick dad (65 year-old wife)

We do not see them. His condition upsets them. They also have their own family to look after. I understand that (53 year-old wife)

The hesitancy with which these statements were made clearly illuminated the fact that the elderly parents were in a submissive position and not the central members of their children's families.

Full-time caring made it harder not only to get along with family members, but also for caregivers to confide in their family members. They felt family members did not understand rather felt bothered. The only exceptions were cases where the relatives lived further away, had nothing to do with the caring situation, or in some cases were in the same situation themselves. However, there were some exceptions where some wife-caregivers believed that their relationship with other family members had not been affected in any way by their caring role. This was not because other family members appreciated the role, but because they were all living further away, met only after two or three years, and knew that they would not be bothered by the primary caregiver. Another exceptional and striking reason for such good relationships was that the wife-caregivers performed services for their children that the children would otherwise have had to pay for:

We do not see them. It is just like a contagious disease that they stay away. If they want you to look after their children they will come. At least we are lucky to see them then (57 year-old wife)
This statement indicates that these caregivers were able to have close involvement with their children in exchange for a large amount of free labour: with their free labour they were willing to purchase the affection of their immediate family.

Lack of family support for caregivers was echoed in statements of many carers. No one said that the caring experience had actually drawn the family closer together; rather it was resented by others in the family who denied the problems. In extreme cases the tension on family relationships caused destruction and disintegration of family ties. Other family members did not share in the responsibilities of caring for the ill relative by relieving the primary caregiver of the day-to-day care. Thus from these reports it is quite evident that the caregivers had conflict regarding the amount of labour involving themselves as compared to that involving other family members. In these situations interpersonal conflict not only persists between the caregiver and care receiver but also highlights the dynamics of the broader family network.

Similar findings were also found in the quantitative analysis. A significant correlation was found between conflict and lack of support and satisfaction with support. Lack of support also predicted conflict for female caregivers.

*Imbalance in Norms and Values.* Another theme that was identified in the course of the interview was that the main source of conflict was when the caregivers and care receivers clashed over expectations of norms. The caregivers were caring for an impaired old person, and the nature and extent of the care receivers' disability was so high that the caregivers had to provide a huge amount of care, which not only was long-term but also took a toll of their well-being. As the care receivers were chronically ill there was very little chance of regaining normal functional status, thus they were unable to offer the
caregivers any services. This difference in attitudes and values amplified the conflict.

The conflict experienced by wife-caregivers revolved around a different issue. The wives described their commitments as a means of demonstrating solidarity. The long-term commitment and lack of appreciation in return changed the nature of the relationship. The more intimate relationship now was dominated by exchange principles. These caregivers were unwilling to provide further assistance, without being repaid for the emotional distress. These caregivers were resentful at providing excess help; they did not mind providing constant services to the disabled elderly, neither did that work affect them physically. Rather the daughters and daughters-in-law expected that the continued support they provided to their parents or in-laws should have prompted some form of appreciation from them. The most obvious expressions of appreciation which they observed were by parents towards absent children who returned home for a visit. The lack of any display of appreciation, satisfaction, or rewards available as incentives for good performance (Oakley, 1974), but more expectations from the old people, created an imbalance in the expectation of norms among daughter-caregivers, which made them feel emotionally let down. Because of their excess contributions they experienced anger and resentment:

They wanted us, why should we be grateful for that and have to look after them all our life (78 year-old daughter)

I want to retire and enjoy my retirement. Now I feel that I have given him so much, my life is running out, I do not want to give any more. I would go so far to say there are a lot of women who are widows, but who are so happy. I want to be happy like them (86 year-old wife)

Throughout the discussion opinions of this sort emerged. This was not surprising but nevertheless was a spontaneous topic of discussion. Also
emerging from discussion on the caring relationship is a clear picture of the
difference in the perception of norms and values between the caregivers and
care receivers. These differences created an imbalance in the relationship. In
some cases the problem was so great that the caregivers were unable to deal
with the situation effectively and conflict developed. In addition the caregivers
experience pressure from two potentially competing values: the traditional value
that care of the elderly is a family responsibility and the new value that women
should be free to work outside the home if they wish.

6.3 Summary

In summary, themes of interpersonal conflict emerged during the in-depth
discussions. Some of these themes: feeling of isolation, role conflict, and
imbalance in equity were supported by the quantitative analyses, while some
emerged only in the in-depth discussions. If a conceptual model was to be
drawn only on the basis of the qualitative results, it would be slightly different
from that built up from the quantitative data. One major difference would be that
according to the qualitative data all variables in the caregiving context would
create stress which would lead to conflict in the relationship. Whereas, a model
from the quantitative data would be that the variables such as burden, attitude
of the caregiver towards caregiving, coping strategies (maladaptive),
satisfaction with support, and the functional limitation of the care receiver in
activities of daily living would lead to conflict.

In addition the above discussed themes were also explored in three case
vignettes in order to see whether additional information is obtained about
conflict when the caregivers were distanced from their personal caring
experiences and circumstances of caring. The following chapter gives a
description of the caregivers' sensitivity to conflict as characterised in responses to vignettes.
CHAPTER 7

A VIGNETTE METHODOLOGY FOR IDENTIFYING COPING STRATEGIES

In the previous Chapter, themes of interpersonal conflict that emerged during the in-depth interviews were described. Those themes were also explored in vignettes to see how sensitive the caregivers were to conflict. This chapter provides the background and results of using vignettes for identifying coping strategies among the 30 female caregivers who formed the subsample (see Chapter 2, section 2.5, for sample selection). Special emphasis is given in the vignettes to coping with conflict in the caring relationship as this seems to have a direct effect on the carers and consequently the elderly. In addition the new technique is introduced to gain more insight into the issue of conflict in the caring relationship and also to develop the method by comparison to the different methodologies used in the study. As it was expected that beyond getting information from both qualitative and quantitative data the use of vignette would provide additional insight into the sensitive issue of conflict by bridging the gap between qualitative and quantitative methodologies. This chapter thus traces changes from in-depth qualitative methodologies to the use of hypothetical third parties.

Caregivers are quite ready to admit that they are not always able to cope well with the caring situation and that in some cases there are instances of interpersonal conflict; this readiness is apparent in the conversation of the caregivers during the in-depth interviews. Despite this readiness to admit to
conflict and discussion on coping with conflict, there are many hidden costs of caring. Although caregivers are well aware of the conflict that they may experience, few of them would find it easy to admit that these conflicting attitudes may be expressed in maladaptive coping which may affect caring for the elderly and in turn may lead to severe interpersonal conflict.

Although the sensitive features of caring relationships can be explored effectively by both qualitative and quantitative methods, in some cases answers to sensitive issues may be too complex to be explored by large-scale survey methods. They may also be too sensitive to use in-depth interviews and hence need to be pursued by a different research strategy. It is expected that by distanci

Thus because of the sensitivity of the issue it is argued here that vignettes might be a fruitful research technique. The use of vignettes is considered to be the most appropriate for the study of normative material where the direct and abstracted approach of eliciting responses to specific issues is not possible (Finch, 1987). In this technique, stories of specified circumstances are given, and hypothetical characters are used.
To be non-directive in approach the vignette technique involves various forms in its application. In some cases it may be used as open-ended questions while in other instances the most common form is the application of fixed-choice responses, or fixed-choice response plus an open ended question. The open-ended questions can be comparable to projective techniques where the meaning of the situation in question is defined by the respondents.

As sensitive features of relationships are being explored caution is required in devising questions that are not personally threatening. It is also essential to know how the caregivers cope with the situation in reality or what happens in reality. The questionnaire is constructed so that different elements of a vignette appear also in other questions such as those about coping with the caring situation, arguments and disagreements with the care receiver and so on. By using vignettes the researcher can probably make clear statements only about the particular circumstances specified. In other words the researcher can `tap the general imagery of respondents, but at the expense of some of the more peripheral detail' (West, 1982).

7.1 Use of Vignettes in Different Surveys

The vignette technique has been used as a measuring tool by various American and British survey researchers. Depending on the nature of the studies the application of the technique was rather different. Some of the vignettes were followed by fixed-choice responses while some included a fixed-choice plus an open-ended question. One common element applied in all vignettes was the hypothetical situation, which may be short and simple or longer and complex.
The literature demonstrates occasional use of vignettes as a measuring tool. The number of vignettes used in those studies varied. In a study on beliefs about distributive justice in respect of households' income, fifty vignettes were used in a single interview, and the interviewees' responses were ranked by the researcher on a nine-point scale (Alves and Rossi 1978).

In order to determine the public's perceptions of the severity of child neglect, Ringwalt and Cayne (1989) used 27 vignettes. Respondents were required to rate the severity of each vignette on a five-point scale. O'Toole and Webster (1988) also used 24 vignettes where respondents were required to rank each vignette on a scale of increasing seriousness (1-9) in order to determine the similar and different definitions emerging when people react to behaviours that can be viewed as mistreatment when the object of behaviour is varied (e.g., child, elderly parent, husband, wife). Sixteen vignettes were used by Newman et al. (1987) in their study to examine the influence of patient, service program, and clinical characteristics on judgements of the functioning of treatment recommendations.

Some studies, on the other hand, have used a relatively small number of vignettes. In a study to explore varying levels of public support for different groups of welfare claimants, Cook (1979) used only eight vignettes per interview which were followed up with a fixed set of five questions. A different method was applied in a study conducted to investigate the relationship between traditional or non-traditional sex role attitudes and perception of psychological abuse. Four vignettes were used which reflected marital situations: four typical scenarios of psychological abuse such as economic deprivation, social isolation, social humiliation and verbal battering. All the vignettes were followed by identical statements. In addition a fifth vignette was used. This vignette served as the control vignette in which there was no indication of abuse (DeGregoria,
1987). In these vignettes the aggregate measure of abuse was determined by six descriptive statements, and each vignette was followed by identical statements.

In their study of asserting care preferences advocated by the general public for the care of disabled people, West et al. (1984) used four vignettes which featured a mentally handicapped adolescent; an adult with a physical disability (chronic arthritis); an adult with a psychiatric problem (severe depression); and an elderly physically impaired person (chronic bronchitis) in circumstances requiring a decision to be made about care arrangements. The respondents were asked to select their preferences from six possible options of care arrangements ranging from family and informal care only through domiciliary professional support, community-based professional care, to residential care of a partial or total kind. The chosen option was considered to be the respondent's care preference.

7.2 Case Vignettes Construction

In the present study vignettes were used in a way different from the above-mentioned studies, to gain more insight into the interpersonal conflict and coping strategies adopted by the caregivers to deal with the situation effectively. In particular, three much longer and complex vignettes were used in this study so that elements of each situation are specified in some detail. The vignettes were followed by fixed-choice responses and an open-ended question. This thus allowed for variation in responses elicited between vignettes and the open-ended questions. The use of vignettes in this study builds on two recent studies, a British study, West et al., 1984, and an American study, Newman et al., 1983, which use fixed-choice questions together with open-ended questions. The
technique of altering the circumstances within a single vignette is a distinctive feature of the study in question. The only difference in the present study was that rather than only distancing the judgement requested from the respondent's personal circumstances (Questions come in the form of 'What should these people do next?' rather than 'what would you do next?') in the present study I intended to find whether there was a consensus about the preferred coping strategy and conflicting situations in caring situations, and also to find out what respondents themselves did or would do if they were in similar situations. The fixed-choice responses followed Likert and Guttman scaling. These items were analysed as continuous data. The open-ended questions were categorized to provide answers to the research questions regarding coping and conflict.

Thus a literature review was conducted to determine the types of caregivers' statements that would represent symptoms of conflict and different levels of coping mechanisms. The three cases were then generated from real-life case histories of an impaired elderly person in circumstances requiring care, either living alone or with a family member. The vignettes varied in the amount of conflict with caregivers and also the care provided. As far as possible, the vignette character and the circumstances reflected an instance of a typical situation of this sort. An example which features an old man is reproduced below.

Mr. Brown who is 75 years old had a stroke eight months ago. Since the effect of the stroke Mr. Brown has difficulties with walking, eating, using his hands and fingers, and talking. These problems make it harder for him to look after himself. He needs some assistance with things such as eating, dressing, bathing, going up and down stairs, shopping, preparing meals, etc.

Having read the first section of the story, respondents were then asked which of the several possible care arrangements outlined in the questionnaire should be
adopted as the solution to the problem. In respect of the vignette reproduced above, the options were:

1) To have a paid companion come to live with him
2) To have a relative come to live with him
3) Move into a hostel or nursing home
4) Continue on his own, even though he is having difficulties managing.

The options ranged therefore from family and informal care through community based professional support to total residential care. These care arrangements corresponded to the various packages of community care available to the elderly and could be seen to reflect a continuum of increasing professional and service involvement or conversely decreasing levels of tending by informal carers.

The other two vignettes portrayed an adult son living with elderly parents, and a daughter caring for a father. Thus in this study the vignettes were based on several factors, and most were easy to manipulate. The vignette character was either a male or a female and the circumstances reflected an instance of either a lower or a middle class family. The family situation in the cases portrayed either a supportive or a non-supportive atmosphere. Elderly persons described in the vignettes were considered to have a supportive family if they lived with a family member, or if they were married. Elderly persons who were single and living alone were considered to be living in a non-supportive family situation.

The coping strategies adopted by the caregivers to deal with the situation were determined by identifying how they dealt with the caring situation. Coping was considered to be adaptive if the caregivers were eager to live with and care for the elderly person. Coping was considered to be maladaptive if they did not want to do this, wanted someone else to care for the old or preferred fulltime
residential care. The vignettes also portrayed instances of interpersonal conflict. In these situations conflict persisted if the caregiver and care receiver had arguments, or showed hostility, irritation etc.

Before the vignettes were applied to the study sample they were tested with a pilot sample to identify the extent of interpersonal conflict the caregivers experience, how they cope with the situation, and also how close the cases are to real-life situations. The pilot study was conducted in Coffs Harbour in New South Wales as the caregivers formed a representative group of the caregiver population, a group outside of the study sample. The caregivers volunteered to participate. In order to determine if the cases represented the variables they had been chosen to represent, all the vignettes were rated by 15 caregivers. Fifteen caregivers, ten females and five males, participated in the pilot study. Ages ranged from 42 to 89 years with a mean of 55 years; five were wives, five were husbands, three were daughters and two were daughters-in-law.

In the pilot study, after the in-depth interviews the vignettes and accompanying questions together with pre-paid self-addressed envelopes were left with the respondents, as was a cover letter describing the purpose and procedure. Participants were informed that the study was an attempt to determine kinds of coping strategies and level of conflict. Having read each vignette, respondents were asked which of the several possible options outlined in the questions should be adopted as the solution to the problem. Once the caregivers made a choice they were then asked to respond to an open-ended question about why they had made the choice. Caregivers' preferred choice was selected as the answer to the question.

The pilot study demonstrated that the caregivers were quite sensitive to conflict situations and could not cope very well with them. Hence on the basis of the
pilot study no modifications were made in the vignettes. Testing the three vignettes also proved that for a single interview inclusion of three very complex vignettes was the maximum possible as they made fairly heavy demands on interviewees. Respondents also reported that they enjoyed answering the vignettes, and completion of questionnaires became more than a chore for them.

7.3 The Three Case Vignettes

Three case vignettes were used in the pilot study and subsequently with the main study subsample of 30 female caregivers (see Appendix E). Each of the vignettes demonstrated different caring situations. The case vignettes and the responses generated by each are described below.

*Wife caring for a physically infirm spouse*

This case, as illustrated, involves a typical dilemma facing an exhausted wife who no longer can take on the caring role. A decision must be made about future care arrangements in the knowledge that the wife herself is not getting any younger. Greatest support (n=10) was given to moving into residential care while about one third believed a paid companion to be the most appropriate solution. Most of the carers advocated a care arrangement which involved the dependant being outside the home. There was therefore only limited support for care preferences which implicated the family members as shouldering the major burden. The responses on this occasion did not show any differences between the two situations that was when the carers thought about the carer character in the vignette, and when they thought of themselves in the specific situation. Again, there were no dramatic differences between men and women carers,
although in both cases more women (8) than men opted for permanent residential care, with men rather than women preferring to have a paid companion.

The narrative then moved on and the carers were asked to think about a situation... 'Ruth, who is looking after Mr. Brown, feels tired and exhausted of constant caring, begins to feel angry and resentful, and does not know what to do'. The purpose here was to look at attitudes towards conflict: it was asked what Ruth would think of doing and what the carers themselves would do if they were in that situation. About four-fifths believed that the best option was to threaten Mr. Brown with nursing home placement. The rest were almost all of the opinion that they should live separately for some time and consider visiting occasionally.

Respondents were then asked what they would do if they were in Ruth's condition following her resentment and reaching a stage of breaking point. The answers to this question revealed some striking differences of opinion. The daughters and daughters-in-law believed that they would tell him in a harsh voice that they could not help any more and also threaten to use physical force; while the spouse-caregivers being somewhat more sympathetic believed that they would feel annoyed hearing him call, and if the situation became bad would help him with what he required.

The story ended with Mr. Brown falling down and hurting himself. When asked what they thought of Ruth's behaviour the wives, daughters and daughters-in-law were of the same opinion that they were sympathetic towards Ruth as the caring condition had put too much burden on her personal as well as social life. She was physically and mentally exhausted and was unable to give any more. Hence they thought her behaviour to be understandable, tolerable and
acceptable. The husband-caregivers on the other hand were of different opinion. According to them Ruth could seek help from outside, or take some time off and relax, and they considered her to be uncaring and selfish. In this case we find differences between male and female responses to this question. Women were far more likely than men to opt for some other way of caring; conversely, the men's opinion rested firmly in favour of the caregiver (Ruth) retaining the position of a caregiver.

This vignette featured a couple in their sixties with a history of illness and mental impairment. The male partner usually takes care of his wife. They have an adult son who after losing his job comes to live with the parents.

At this point the carers were asked what would happen to the family relationship. Not surprisingly, there were no differences in response between men and women carers. All of them overwhelmingly stated that as the son had no income there would be financial problems resulting in an unhappy family relationship. They added in response to another section of the story that as time went by the son would have frequent arguments with parents. Eventually a stage would come when he would threaten to use physical force or leave the parents.

As the story proceeded, the situation became worse. William's behaviour became erratic. He misbehaved toward his father and mother. He became so hostile that the parents feared being killed and hence wanted help. When asked what they thought about William's behaviour, all the carers agreed that though William was uncaring towards his parents his behaviour in this situation was
tolerable and understandable. The results clearly indicated that the carers viewed the conflict in the family relationship to be acceptable. As financial concerns were being addressed in the specific vignette, the acceptability of this conflict was noteworthy.

Married daughter caring for a father

This vignette involved a man in his eighties whose arthritis had become so severe that he needed help to maintain personal care. He had a daughter who was married with a son; she lived in close proximity and maintained regular contact. The carers were asked about the care preferences most suitable for Mr. Smith. The most favoured option for him was residential care. According to the carers Mr. Smith’s daughter had her own family to look after and it was impossible to look after both at the same time. With residential care not only would Mr. Smith be better looked after, but it also would be best for his daughter who could visit occasionally.

Having established care preferences, carers were asked about access arrangements by Mr. Smith's daughter. They were asked how often Eva should spend time with her father, and what they would do if they were in that situation. The responses on this occasion showed some differences between the two questions. It was found that the carers exhibited a rather stronger preference for frequent visits (preferably every day) by Eva, whereas, when they were asked about themselves they opted for fortnightly visitation.

The story ended in a dilemma, where Eva had conflict with her husband regarding the care for her father. Her husband not only was unwilling to live with Mr. Smith but also resented Eva spending time with him. A situation had come
where Eva had to make a choice between her family and her father. The only option was to send Mr. Smith into a nursing home.

The carers were asked: What will Eva do, what would you have done? The answers to these questions did not reveal any striking differences of opinion. The carers were in greater agreement here, in that Mr. Smith should be put into residential care. None of them believed that the daughter should bring him into her house. According to them Eva had the right to put him into residential care for his own safety and well-being in the long run. Thus, carers seemed more sensitive to the needs of Eva, even if they were perceived as harmful, and were more open to negotiating a compromise that respected her needs.

The above mentioned vignettes were finally administered to the 30 female caregivers who were selected for the in-depth interviews (given in Chapter 6), so see how they perceived conflict in the caring situation. The following section gives a description of the caregivers' sensitivity to conflict.

### 7.4 Sensitivity to Conflict

In exploring the caregivers' sensitivity to conflict, some themes were identified from the caregivers' responses to vignettes. The important themes that emerged from the vignettes were that caregivers tended to exhibit a greater sensitivity to conflict, felt less guilty about their responsibility and had reached a breaking point in caring. The following section gives a description of those themes.

The majority of the caregivers resented the fact that their lives were tied up in care of the aged. Sometimes these caregivers became so helpless that they lost concentration which in many cases led to accidents on the part of the care
receiver. In these circumstances the caregivers did not feel responsible and did not blame themselves nor feel guilty. For example comments from the caregivers included: 'we have no choice, make the best of a bad job', 'I would have no choice, just do what I could', 'I am not responsible for all the things that happen'.

The majority of the carers (n=27) reported that if they had any other alternative they would definitely not live with the care receiver. Although the differences between wife and daughter caregivers were not very pronounced regarding the preference of care patterns for the elderly, 16 carers reported that the best solution for the 'burnt-out' carers would be to send the care receiver into a nursing home. The remaining 13 thought that instead of having any emotional involvement the best option was to have a paid companion. This would not only relieve the pressure on the caregiver but also enable the care receiver to maintain independence. On the other hand only three opted to live with the care receiver though this situation seemed to pose a true dilemma for them; most of them were, however, uncomfortable with either extreme.

This feeling of resentment and lack of responsibility increased the caregivers' sensitivity to conflict which was evidenced in Vignette 2, where the story included a conflict situation in the son and parent relationship. None of the respondents believed that the son should live with the parents, and one-third were quite clear that living with an elderly relative would definitely damage the family relationship. Comments from the caregivers included: 'He will not get along with his parents'; 'Will have more arguments'; 'Will have financial problems'.

Majority of the wife and daughter caregivers stated that when there was conflict in the family relationship both the parties should try and work things out.
However, most of them were somewhat less likely to think of any viable solution. They felt that in such a situation there was no alternative to taking out their frustration on others. Thus, caregivers seemed to be more sensitive to their own needs. They perceived the conflict situation to be understandable and acceptable rather than harmful, and were not ready to negotiate a compromise that respected the needs of both themselves and the care receiver.

Such a severe amount of conflict had led the caregivers to a breaking point in the caring situation. This was highlighted in Vignette 3 which depicted an overly dependent father. The caregivers were sympathetic toward the caregiver of the story who had a small child and husband to look after. Although the respondents were ready to share the family support they felt their first task was to care for their husband and family. The care receiver must be made to see this, and in fact it would not stop them being a family unit. All of them agreed that they had to have their own life. Lack of some sort of independence had brought them to the end of their tether. 'They have no more to give'. They agreed that they were not eager to continue to meet the excessive demands of the care receiver; they could not carry on any longer. They had to get out of the situation by either having a paid companion to look after the care receiver, someone from the nursing service, home help, meals-on-wheels to call regularly to keep an eye on the elderly person, or if nothing else was available, to put the care receiver into a nursing home.

The data also suggested that caregivers with different types of caring experiences varied in their sensitivity to conflict; this depended on the amount of conflict present in each case. The caregivers thought the vignette situation resembled their own situation, and were sympathetic towards the caregiver character. They perceived the presence of conflict and hence reported dealing with it ineffectively; thus the responses to imagery situations were found to be
related to real-life cases. This can be further explained by the fact that, though the caregivers responded to imaginary situations, they were in fact thinking of conflict and how to deal with it. When confronted with reality this conflict might have been exacerbated and led to ineffective coping responses which were demonstrated in their behaviour. Thus there is an interaction between the imaginary caring situation and that of reality; the cognitive aspect of conflict is translated into behaviour. These behavioural responses to the caring situation were demonstrated in the in-depth discussions (Chapter 6). Especially the caregivers' perception that they were tied to the caring and had no independence was clearly mentioned in the in-depth discussions when the caregivers talked about being isolated from their social life. Feelings of resentment and anger were also frequently demonstrated. The caregivers' comments 'It is my duty, I have to do it' also demonstrates the evidence of lack of responsibility and supports the fact that the caregivers do not feel guilty about their responsibility.

As seen in the vignettes the caregivers had reached a breaking point. They could not carry on any more. This was also mentioned in the in-depth interviews. Particularly the married daughters were affected the most. Their parents' dependency and their loyalty towards their own family created a lot of strain and conflict. Sometimes the pressure was so much that they experienced 'burnout' symptoms. This led to feelings of resentment and minimum caregiving effort. A similar observation was found in the quantitative analysis from the caregivers' responses to coping with conflict. Their (39.1%) preference of threatening the care receiver of nursing home placement clearly demonstrates that they had reached a breaking point.

The caregivers sensitivity to conflict is also supported by the findings from the qualitative and quantitative data. The presence of conflict was frequently
mentioned in the in-depth discussions, particularly when the caregivers were having problem with their various roles; they were the only person to do the caring; and when they could not accept the existing norms and values of elder care. Similarly, when conflict was measured quantitatively it was found that the thirty female caregivers experienced more conflict than the remaining caregivers of the study. The conflict was found to be so severe that in many cases they found it difficult to respond to it. They found it difficult to control their anger and resentment (Chapter 6). Many caregivers (N=78) reported to be unable to deal with the caring situation, and hence adopted maladaptive coping strategies. In order to cope some caregivers screamed and shouted at the care receiver; had arguments with the care receiver and other family members; and pushed the care receiver (see Chapter 5, Table 5.10).

In summary, although there are similarities and dissimilarities in the findings of the three methodologies, the results are related to each other. All of them clearly demonstrate the existence of conflict in the caring situation and the caregivers’ inability to cope with the conflict.

7.5 Summary

The vignettes have been found to be a powerful tool for exploring complex and sensitive issues like conflict in conjunction with the qualitative in-depth interviews and quantitative survey. The data is valuable and reflective of the conflict the caregivers experience, since the closer to real life the cases were, the more generalizable the findings are.

Studying the information obtained on conflict by vignettes also indicates whether it matched or contrasted with that obtained by qualitative interviews. This
provides a better basis for further basic program goals and can be adapted to education or any setting in which coping with conflict is an important part of the caregivers' care for an elderly relative. In addition, the data generated from empirically developed vignettes can be useful in gaining more information on the caring situation, particularly in cases where the caregivers' experiences are taken into account to know their perceived degree of conflict. In such a situation many of the caregivers' perceptions may be susceptible to bias or distortion. For example, with the use of a psychometric instrument, it is easy to determine to what extent the caregiver is experiencing conflict and how much it varies from caregiver to caregiver. When description of conflict depends on the caregiver's perception, as identified through qualitative in-depth interviews, the descriptions given by caregivers can in some cases be distorted by factors that are not related to the actual caring situation. Hence when such data-gathering is involved, the use of vignettes can be helpful in determining whether the conflict experienced is due to other external factors. Moreover, this method, which is known but little employed in conventional research, is a very powerful tool for exploring complex and sensitive topics and may be used in a variety of contexts such as self completion questionnaires and telephone interviews.
CHAPTER 8

CONCLUSION

This chapter reviews the results described in the previous chapters, especially in the context of the conceptual framework. Attempts are made to explain the overall care situation perceived by the caregivers themselves. An explanation is also sought of the predictors of interpersonal conflict by some contextual variables through their relationship with caregiving burden and stress. Finally, salient points are summarized and comments and recommendations offered on the current and future situation of caregiving for the elderly in the community.

8.1 Overview of the Approach

This study of caregiving provides some insights into the experiences by caregivers of their caregiving role. A major purpose of the study was to present the results of a qualitative and quantitative oriented field study on caregiving in a form which could be drawn upon by those engaged in the development of policies and programs. The data set used was from Canberra; it consisted of a structured survey with 151 male and female caregivers and in-depth interviews with 30 female caregivers. On the basis of the findings of this study it is recommended that a variety of conceptual frameworks and methods be applied by social scientists in order to understand the actions of the caregivers. However, researchers too often restrict their theory and methods to a single paradigm. Theoretically one school of thought, structural functionalism, has dominated all the studies in the field of social ageing (Marshall, 1979) for which most of the data have been collected through quantitative methods (Minichiello et al., 1988). However, this thesis demonstrates that much can be gained by combining qualitative and quantitative methodologies: different research
methods are needed just as different theoretical perspectives are needed. All the social phenomena associated with the caregiving process cannot be captured by one single method (Chapter 2).

Thus in order to illuminate different aspects of the caregiving, the study used both qualitative and quantitative methods; the methods were selected because they produced the kind of information which was most relevant to the question being asked. Both the methods were applied to study the caregivers' experiences. In the study, in-depth interviews were used to extract the complex picture of the caregivers' perception of the care situation by identifying specific themes (Chapter 6). The caregivers assigned different meanings to the situation on the basis of their interaction with the care receiver and other family members; this was illustrated in the themes presented in Chapter 6. Interpersonal conflict was determined not solely by the caregivers' social attributes but by how they gave meaning to the situation through their caregiving. Everyday entitlements, obligations, social norms and expectations played a crucial role in determining perceptions of interpersonal conflict or no conflict. Regression analysis in Chapter 5 explored which factors are the predictors of conflict from a number of variables shown in the model proposed in Chapter 1. In this way by synthesizing findings and to produce a more rounded picture of the phenomena under study the thesis has illustrated the value of using multiple methods in a single study.

8.2 Overview of Findings

In the following sections a general description of the overall findings has been given. Then the results are discussed in detail separately for each of the objectives of the study.
As reported in the quantitative analysis the caregivers found certain characteristics of the social environment threatening, especially the emotional, physical, social, and financial burdens of caring, the dependency of the elderly person in activities of daily living, the negative attitude of the caregiver towards caring for an elderly relative, and the lack of satisfaction with the formal and informal support (Chapter 5). In those cases when the threat achieved a particular level the caregivers felt an enduring sense of burden and strain, accompanied by interpersonal conflict (Chapter 6). The perceived conflict which the caregivers experienced was the result not only of the stressful events and circumstances of the caregiving to which the caregiver was exposed, but also of the caregivers' ability or resources to cope with the situation and to resist the effects of stressors (Chapter 5). Thus the caregivers most at risk were those who not only encountered burden due to caregiving, but also had few resources for coping with caring. The present study revealed a high degree of interpersonal conflict among the caregivers (Chapter 5), a situation which was also paralleled by ineffective coping mechanisms (Chapter 5 and Chapter 7).

The female caregivers also spoke about the presence of conflict in their caring relationship (Chapter 6). The difference in attitudes and values between the caregiver and the care receiver concerning care for the elderly was reported to be the important factor behind the conflict. This does not mean that other themes were not mentioned or were unimportant. The caregivers' beliefs that they could not carry on any longer and feelings of isolation were some of the reasons behind conflict. The caregivers not only talked about conflict but also expressed their sensitivity to conflict in their responses to the vignettes (Chapter 7). Their sensitivity to conflict was also heightened by their inability to cope with the situation effectively (Chapter 5). Not only did inability to cope effectively lead to conflict, but severe conflict also paved the way for ineffective coping (Chapter 5). Moreover, the results indicated some diversity in possible interpretations of caregiving between the wife and daughter-caregivers.
8.2.1 First Objective: Factors Related to Conflict

In Chapter 1 three objectives were outlined. The first was to examine what factors were related to conflict. Both the quantitative and qualitative data demonstrated that the caregivers experienced some degree of conflict in their caregiving relationship. A significant relationship existed between some of the independent variables and conflict (Chapter 5). Caregiving burden, coping strategies, and attitude of the caregiver towards care were identified as the important predictors of conflict. The caregivers were reported to be psychologically, socially, emotionally, and financially burdened. They were 'overloaded' which affected their everyday activities, social and recreational activities. The vulnerability of the care receivers has not been found to create burden; rather the caregivers' sense of burden was affected by the duration of the caregiving, the age of the caregivers and the daily work load. Older caregivers were more burdened than the younger ones, and the longer they were caregiving the greater the burden: this affected their coping ability. Rather than trying to cope with the situation effectively and trying to maintain and ensure family solidarity or attachment, the majority engaged in maladaptive coping strategies such as crying, swearing and cursing, screaming and yelling, hitting, and threatening nursing home placement. These communicative behaviours helped the caregivers to express their frustrations in terms of conflict which became a normative everyday event. Moreover, the negative attitudes of the caregivers towards giving care, and lack of affection and satisfaction with it were also found to affect their relationship to the care receiver. However, the variables such as stress, mental impairment of the care receiver, availability of social support, and living conditions which had previously been thought to mitigate conflict, did not emerge as significant predictors of conflict (Chapter 5).

The women caregivers were found to experience problem in caregiving most; this was evident from the themes that have emerged during the in-depth qualitative
discussions (Chapter 6). According to the caregivers the constant caregiving together with the vulnerability of the care receiver created a huge amount of strain which in turn affected their relationship with the care receiver. The wife-caregivers were affected most as their partner relinquished all sorts of affection. Such stress was also aggravated by the limitation of financial funds, due to which the caregivers found it very hard to meet the additional expenses of care; nor could they avail themselves of any community help to relieve them.

The most important reason for conflict as identified in the qualitative study was the caregivers' feeling of isolation; this was a dominant theme of the discussions. The daughter-caregivers faced this problem more than the wife-caregivers: full-time care made them lose all contact with the outside world; they were unable to work or visit friends, and other family members even refrained from contacting them. The caregivers' feeling of isolation increased when they did not get any instrumental, emotional and social support from other family members (i.e., spouse, siblings, children) and relatives. In the absence of kin they had no one who could be drawn upon in a crisis or for long-term hardship (i.e., to take over the caring if the caregiver was sick). Because of the caregivers' lack of social interaction with friends; friends and neighbours were not mentioned as potential sources of support. This posed an obstacle in finding instrumental support. The caregivers were not able to turn to neighbours and to clubs, associations, churches or leisure groups for instrumental support, which was mainly respite care. However in some cases the formal networks were drawn upon particularly for care of the elderly person when the caregiver was sick and unable to provide the care (Chapter 5).

Issues of role reversal and role conflict arose most frequently in the comments of the daughter-caregivers. Much of the conflict emerged when the daughters took over the household responsibility and also the care receiver, leaving the care receiver with minimal decision-making power. The daughters' sudden gain in
responsibility and power was not gladly accepted by the care receiver who once had control over everything, thus leading to tension and conflict. The daughter-caregivers were also confronted with a dilemma of choosing between their own families and the parent; this was not an easy decision to make, creating a lot of tension. Making a choice of caring for the elderly thus created conflict not only with the care receiver but also with the spouse and children. Such a conflict led the caregivers to ask why they should be the only one to look after the old person. They felt the duty should be equally shared by all family members. This lack of concern from other family members created not only resentment towards the care receiver but also conflict with other family members.

Another prominent reason for conflict concerned some emotional aspects of caregiving. What the caregivers wanted was some emotional support from the care receiver in the form of appreciation, love and affection; unfortunately care receivers, instead of expressing some affection and gratitude for the services that they were receiving, showed anger and reproach, while some thought that compared to what they had done for the caregiver they were not getting enough. Owing to the lack of warmth and the negative attitudes, the relationship changed from reciprocity to dependency.

Here I perceived a consistency with the basic assumption of exchange theory which states that the interaction will continue if rewards come equally to both parties, but if not, it will be broken off (Homans, 1961, 1974). However, it is argued that, unlike regular social interaction, intrafamilial relations cannot be broken off easily. As a consequence when family members perceive injustice in a daily interaction, they become angry and resentful. Such perception of anger and resentment was frequently talked about by wife and daughter-caregivers in the in-depth interviews and was also reported to be an acceptable behaviour in their responses to vignettes.
Explanations for this daily irritation could be the differences between the caregiver and care receiver regarding power. Care receivers are likely to be powerless because of dependency; they are likely to lose their feelings of affection, approval, esteem, the sense of security and belonging, to have no opportunity to exercise control, mastery, and competence in their lives. Some care receivers are likely to feel threatened in their traditional status by a more skilful caregiver and resort to physical violence to maintain dominance. On the other hand the caregivers are likely to feel unable to gain sufficient control within their family in any other way, or are not able to gain control of the larger social environment.

In addition, such differences between wives and daughters in the giving of care could also be the result of early socialization. Daughters are traditionally taught to look after the parents resulting in observed behaviour and responsibility. On the basis of this expectation the care receivers believed that they had provided more care to their children than they had been given. They felt their children owed them practical benefits. This condemning attitude provoked conflict within the relationship. The expectation that children would provide comfort and support to their parents particularly in the parents’ old age was not shared by the young caregivers. The concept of ‘parent repayment’ did not exist in their conscience.

Thus conflict arises not only from the severe dependency of the care receiver, and lack of sufficient resources for the caregiver, but also from lack of support from the family network; and the norms and values need by the caregiver and care receiver.
8.2.2 Second Objective: Exploration of Coping with Conflict

The second research objective was to examine how caregivers cope with conflict. The caregivers reported the everyday repercussions of caring to be too much for them to bear, though in order to maintain harmony they had tried their best to deal with it effectively. Finding no other alternative they expressed their frustrations by engaging in ineffective coping strategies. Some of the prominent coping strategies were screaming and yelling at the care receiver, shaking and pushing the care receiver, and having arguments with the care receiver as well as other family members. Some caregivers occasionally swore and cursed about their fate, while others threatened to put the care receiver in a nursing home. Others cried or for some relief put the care receiver to bed to relax. Similar observations were made when the caregivers responded to vignettes (Chapter 7). They were sympathetic to the hypothetical caregiver, and reacted to conflict with resentment and anger. Moreover, they reacted negatively to dealing with conflict and expressed their willingness to find a way out of the situation by opting to place the care receiver in residential care. Not only did some caregivers engage in ineffective coping strategies to deal with conflict, but those unable to deal with the situation were put to considerable strain which exacerbated the conflict (Chapter 5).

8.2.3 Third Objective: Suggested Interventions to Deal with Conflict

As discussed in the previous sections this study reported that caregivers to experience significant amount of conflict due to caregiving, a common expression of which was repressed fear, anger, resentment and continued hostility. Because of this the caregivers had reached such a stage that more supportive conversation with confidants or diversion in social performances could not help them to resolve the feelings of hostility and anger. In addition, there is no single service or programmatic
formula that can alleviate the plight of the caregivers. In such situations some intervention strategies would be helpful to detect conflict in the caring situation and bring some relief to the caregivers before the condition becomes too bad. The intervention programs described below address the third objective of the study and also the gap revealed by this study.

In Canberra there are support groups for caregivers whose dependants are suffering from specific illnesses, such as Parkinson's Disease, Alzheimer's Disease and AIDS. The ACT Council on the Ageing is the only one open to all caregivers irrespective of the condition they are dealing with. As there is only one support group many caregivers, particularly those not living close by and having transport problems, are unable to join. They are thus unable to articulate and share difficult and painful experiences. At home they do not have the opportunity to constructively ventilate their feelings and to experience a sense of solidarity and social connectedness. More support groups for caregivers of frail elderly are essential as they have been found to be effective (Silverman & Brahce, 1979; Crossman et al., 1981; Brahce, 1983; Greene & Monahan, 1989; Toseland et al., 1989). Carefully planned clinical trials are needed to evaluate the quality and effectiveness of the existing support groups.

The conflict may also be reactivated from childhood and adolescence; under such circumstances it is also necessary to go into the caregivers' past. Counselling programs are necessary where the caregivers will get information and support before they are involved with the caring role. Mental-health counselling services with teaching oriented sessions need to be bolstered, so that the caregivers are given help to develop the understanding and skills necessary for caring for an elderly person. This will strengthen an existing bond by helping to resolve conflicts between the caregiver and the care receiver.
Since its inception in 1985 the Home and Community Care (HACC) have been improving their services. There has been a growth in the number and range of services available, there has been increasing emphasis on provision of a flexible and coordinated range of services, and the care options available to individuals has been expanded. In addition to the HACC services more in-service education programs should be formulated to evaluate the caregivers' situation and also their behaviour as well as the care receivers' behaviour. These programs should provide training to the caregivers so that they learn techniques and information useful to their role and also develop social skills in dealing with care receivers and other family members.

One of the main reasons for conflict is the difference between the caregiver and the care receiver about the values and expectations of care for the elderly. Such conflict can be resolved through educational programs giving information about societal values and expectations regarding care for the elderly. Both the caregivers and the care receivers should be able to participate. Guide-lines must be set about appropriate norms to be observed by both the caregiver and the care receiver.

Much of the conflict will be resolved if the primary caregivers get some support from other family members; the care for the elderly person should ideally be equally shared by the family members. Specific strategies can help to achieve family team care. Small workshops can demonstrate the role of each member of the family regarding the care and support of the elderly. They can get information about ageing and caregiving. The caregivers will also be able to discuss long pent-up feelings with the family members. Family counselling can also help to explore in greater depth personal, relational or situational issues related to caregiving.

Caregivers face practical problems of lack of knowledge regarding caregiving techniques and community resource utilization. Most of the caregivers are unaware
of the services and supports which exist in the community; others may feel that the programs would not benefit them, thus it is a great challenge to get the information to them. Many of the crises would have been avoided if the caregivers had known how to care for someone who is bedridden, and all sorts of practical things about caring, especially physical skills training in such areas as moving, lifting, bathing, and medication administration. Better information campaigns should be organized using the educational system and the non-formal channels of communication including the mass media so that caregivers do not have to rely only on health and social services to obtain information.

Peer support is very important, particularly where the caregivers can talk about their problem and release tension. To do so it is necessary to link carers with one another within a neighbourhood. Carers looking after an elderly relative in the same neighbourhood can help each other in times of crisis, can provide respite when required. Many caregivers are not ready to confront deeply personal issues in a group; in such cases the caregivers will also get the opportunity to talk to someone. This will help them to relieve the tension and stress, and they will also get directions and new ideas of how to cope. The community services should look into this matter and take the initiative to explore more neighbourhood networking.

There should be a case management system for monitoring caregivers and the services they need and are using. Case management is offered by the Aged Care Assessment Team (ACAT) and the Home and Community Care (HACC) particularly in the Community Options Program. These assessments are mostly done when the care provided by the caregiver is not sufficient for the elderly person. But caregivers do not only need help when the condition is desperate. Conflict may persist from the beginning of the caring. There is always a hidden problem of conflict. It is essential to detect it before it gets too bad. It is also necessary to identify the caregivers who do not attend groups so that they are encouraged to join. Under such conditions the
general practitioners should be targeted to detect the caregivers of their elderly patients and train them to detect conflict in the caring situation.

Recent policy and service planning efforts have encouraged the development of interventions that support family care, such as respite care. However, the existing six hours a week home-based care for the elderly is very expensive, so that many caregivers are unable to avail themselves of the service. It is necessary to develop a home-care system that can reduce burden and family conflict without incurring unreasonable costs. Moreover, the existing respite care should be more flexible. The caregivers should be able to get 24-hour respite care which fits their needs. Finally, carefully planned clinical research are needed to evaluate the quality and effectiveness of different types of respite care versus permanent institutional care.

8.3 Conflict and Caregiving: Discussion of the Different Methodologies

It is clearly demonstrated from the above discussion of the findings that conflict occurs in the caring relationship. The following section describes how the findings from the three different methodologies fit into the conceptual model (Chapter 1, section 1.4).

As mentioned earlier (Chapter 2) the three methodologies: quantitative, qualitative, and vignettes were used in this thesis to explore the complex relationship between the caregiver and the care receiver in the process of caregiving. The conceptual model reproduced below (described in details in Chapter 1) provided a background sketch of the complex caregiving process, and was used as a guide for the analysis.
All the variables outlined in the model were covered in the quantitative survey. From the above mentioned variables burden, coping strategy, attitude of the caregiver towards the care receiver, and the ADL limitation of the care receiver were identified as the most important predictors of conflict.

The experiences of caregivers were explored in the in-depth qualitative interviews. Stress was a frequently mentioned theme in the interviews. The other themes that emerged in the interviews were: the caregivers experienced a change in their role responsibility; had to make a choice between their family and caregiving; received no support from family members; and had problems in accepting the traditional norms and values of parent care.

The vignette methodology provided additional information on the caregivers' sensitivity to conflict. Only the variables conflict and coping strategies were covered in the three case scenarios. Three themes were identified from the caregivers'
responses to the vignettes. The caregivers were found to be sensitive to conflict, they did not feel guilty from not being able to provide sufficient care to the care receiver, and finally mentioned that they had reached a breaking point and could not carry on any longer with the caregiving.

Therefore, themes emerging from the in-depth interviews and vignettes were not outlined as variables in the model and hence were not covered in the survey questionnaire. In the in-depth interviews the caregivers were able to describe their experiences in their own words and talked about the concepts of burden, stress and conflict as they understood and perceived them. Whereas, in the quantitative survey they had to respond to some structured questions that had predetermined answers. This did not permit them to talk about the different concepts in their own words. This suggests that the model could be further developed which requires to include all the variables studied under the three methodologies. Hence it is recommended that in future study some open-ended questions to be included into the survey questionnaire to capture those narrative accounts of caregiving experiences which are likely to be missed by the close-ended questions. The variable(s) resulting from the open-ended questions would then be included into the model along with the input variables (see Figure 8.1). Inclusion of such variables in the model would be necessary to obtain fuller description of conflict in the caring relationship.

In summary, although both the quantitative and qualitative methodologies report some differences in the caregivers' perception of the caregiving situation, and the model needs further development, the data in general demonstrate the presence of conflict which is maintained by ineffective coping strategies. In addition, the detailed in-depth interviews and responses to vignettes did provide information about the perceptions by wife and daughter-caregivers of their caring situations, what happens during the caring and the meanings they attach to these acts, although the small
number of caregivers (n=30) for these sections of the study permit only guarded
generalization of the results.

The quantitative data also offered strong support to that obtained by in-depth
interviews and vignettes. It helped to gauge the depth and breadth of caregivers’
experiences and feelings. This demonstrated that not only did conflict in the caring
relationship yield to explanation through qualitative methodology, but each
contributed elements that become in effect, building blocks to knowledge.

8.4 Limitations of the Study and Suggestions for Further Research

Although the greatest strength of the present study is the exploration of conflict in
the caring relationship by using a variety of methodologies, there are some
shortcomings that need to be addressed. The following section describes those
limitations and also gives some suggestions for further research.

To satisfy the fundamental assumption of most statistical techniques, the ideal
would have been to select a random sample. However, given the selection
procedure used the sample obtained was non-random. The participants
volunteered to join the study. The sampling strategy was constrained by the lack of
a suitable sampling frame, and by time and budget considerations. Nevertheless,
non-random sampling has been used in many sociological studies (Balswick &
Balkwell, 1978; Cullen et al., 1979; Bardo & Bardo, 1980; Day, 1985), where the
respondents volunteered to participate (Cullen et al., 1979; Ramu & Tavuchis,
1986).

It has been argued by many researchers such as Muthan and Joreskog (1983) that
in any attempt to estimate population parameters from a non-random sample there
is a likelihood of 'selectivity' problems; but the purpose of this thesis is to look at a social process rather than to make statistical generalizations from the data. The results of the study should not necessarily be considered representative of what might have been discovered had a more representative sample been studied; as a consequence the conclusions drawn should be interpreted with caution. However, the sampling technique used is compatible with qualitative data analysis which aims to explore themes rather than test hypotheses statistically.

Another shortcoming of this research is the obvious problem of technique. Some of these variables, especially the situational variables, could be operationalized in ways more consistent with the notion of perceived conflict. Similarly, measures of social support, burden and stress could be refined considerably. Different measures should be used for different respondent groups. Moreover, the effect of different culture is thought to be an important factor in describing the caring relationship (Synak, 1989; Albert, 1990; Goodman, 1990; McCallum & Gelfand, 1990). As the sample of the study was homogeneous the issue of culture has not been addressed. Taking the present research and replicating in different cultures could provide more insight into the issue of conflict and coping with conflict. It is hoped that future researchers will take up these tasks.

On the basis of quantitative results, the effect of social support has been found to be different for male and female caregivers. Future work should focus mainly on social support among different groups of caregivers. The existing social support should be evaluated for testing the hypothesis that social support would be more important for female caregivers than male caregivers.

It is also useful at this point to examine explicitly some of the shortcomings of the model proposed here. The model does not depend on some subjective notion of stress and burden, but rather is conceptualized in much broader terms. The
experience of conflict grew out of a complex set of interactions among social and psychological facts. Many models were formulated in a study of caregiver burden (Stoller & Pugliesi, 1989; Braithwaite, 1990). Now the model appears to predict interpersonal conflict; this parallels Cassel's (1976) concept of 'generalized susceptibility', that psychosocial processes create a general risk for all outcomes. On the other hand given differences in care it seems likely that situational factors influence the experiences of the caregivers that can result either in conflict which is consciously or unconsciously experienced or some other parameter which is mostly outside conscious awareness. In other words, this model needs the incorporation of another set of variables to help explain why some people experience conflict and others end up with some other problems.

Finally the model proposed here needs to be cross validated with another sample. Obviously, the potential exists no matter how robust this model is for explaining conflict and the caring relationship. Yet it is necessary to know whether the process operates in other care situations. The only way to determine how this process operates is to carry out more research, but research of a particular kind. The research must be sensitive to the community studied, and must be explicitly comparative in its orientation, in both an intracultural and a cross-cultural sense. Only by adopting this broad perspective will research be able to explain the elder-caregiver relationship in greater detail.

8.5 Concluding Remarks

At the conclusion of the long process of reviewing the literature, designing the study, developing the questionnaire, conducting the investigation, analysing the data, and writing this thesis, there are feelings of both accomplishment and satisfaction as well as recognition of ways all of these steps might have been improved.
This study is an attempt to fill the gap in our understanding of the caregiving situation giving particular emphasis to interpersonal conflict. The study offers insights into the elder-caregiver relationship and points to areas that require further investigation. The study has examined interpersonal conflict in the caregiving relationship, an area of inquiry not previously given adequate attention. Much valuable information was gathered directly and indirectly through a variety of techniques from the caregivers who were either spouses, offspring, or siblings of old people. The statistical tests of analysis helped to describe the interaction of the key variables. By examining and analysing both qualitative and quantitative data gathered in this study, a greater depth of understanding has been gained than if the study had relied entirely on one or other. The employment of a variety of research techniques provided a rich data base of both ‘hard’ and ‘soft’ data (Bernard, 1974:23) so that they complement each other by filling in the gaps in understanding. Based on the data accumulated by all methodologies, the researcher is convinced that strong and sufficient evidence was gathered to explore the idea that the caregivers experienced some degree of interpersonal conflict.

Caregivers reporting a sense of conflict had a greater potential for using abusive or neglectful behaviours. A strong association between conflict and coping was found. Given the comparable length of caregiving, it appeared that caregivers were trying to cope with a precipitous decline in the care receivers’ abilities in addition to a more insidious onset. Commitment to family made it difficult to leave the caring situation. Especially, financial and affective commitments made it hard for the caregivers to leave the care receiver even though they were burdened and were unable to carry on with the care process. Emotional involvements also characterized most caregivers, and it appeared that this high emotional involvement was a cause of most of the conflict.
There was an incongruency between authority and power. The unequal status of authority and power created most of the conflict as the care receivers usually claimed the superordinate position of authority, but lacked the power to have that authority obeyed. Above all certain characteristics of families (e.g., the amount of time the family members spent together, the intensity of their involvement, the fact that they had impinging activities and needs) in many cases made them ripe for conflict.

This study showed that conflict is best understood as arising from a particular social process. These results also demonstrated the utility of understanding the caring situation in these terms. Finally, it is hoped that this research, along with a few related studies, will help to form a new basis for the study of caregiving with an emphasis mainly on conflict. Interventions directed at improving the elder-caregiver relationship will affect the overall caring situation and reduce conflict. It is a great challenge for the society and the policy makers to help these vulnerable people so that any other caregiver does not have to say

I have given so much all my life. I can not give any more. When I go out I see so many widows. They are so happy. I wish I could be a widow like them.
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APPENDIX A
(Letter to the caregivers from the researcher explaining the purpose of the study)

Dear Caregivers,

I am enrolled in a PhD project in the National Centre for Epidemiology and Population Health (NCER) at the Australian National University (ANU). My project is about understanding conflict in intimate relationships and how caregivers of those with dementia may experience it. I am writing to explain the purpose of the study and to invite you to participate. If you agree, I will provide you with more information about the study and explain the process of joining.

In order to work on this project, we need to work with caregivers of people who have dementia. We are interested in understanding how caregivers manage stress and make decisions about care. We will use qualitative methods to gather information from caregivers about their experiences and challenges. The study will be conducted in accordance with ethical guidelines and will be reviewed by the Human Research Ethics Committee.

I am keen to conduct this project and would be very grateful for your cooperation. If you are interested in participating, please feel free to contact me to discuss the study in more detail. I am happy to answer any questions you may have.

Thank you for considering this opportunity. I look forward to hearing from you.

Yours sincerely,

[Researcher's Name]
Dear Carers,

I am enrolled in PhD work in the National Centre for Epidemiology and Population Health (NCEPH), at the Australian National University (ANU), in Canberra.

I am planning to do research work on carer conflict in families. Caring for dependent older people involves a large amount of work and we are only just beginning to study the pressures that it creates. In the process of caring, some people may experience problems or conflict. It is the causes and consequences of this conflict from caring for an elderly person at home, that is of most interest to me. If we clearly know what sort of problems or conflict the carers face, we can take up the issue to the government so that policies are made to provide more support and facilities to the carers. In my research I am interested in talking to a wide range of carers, not only those who find their daily caring role stressful. I want to identify the causes of conflict and to find out what interventions help to relieve it.

In order to work in this area I need to work with carers (at least 100 carers or more) to identify the causes of conflict and think about and evaluate interventions. All this will be within the strict National Health and Medical Research Council guidelines.

I am most anxious to discuss this project with you and to take your advice on practical things that can be done in situations of caring for the elderly at home. In this respect I will be glad to talk with each of you individually.

An interview will be carried out either in my office or in your houses wherever you wish to have it. The interview will be one to one and a half hours long. I will do the interview myself. If you do not want to talk in front of your family we can meet at any place. Each carer will be interviewed individually.
I will ask you some questions about the conflict you are experiencing from the caregiving role, the carees health and your own health, the social environment around you, whether you are receiving any formal support and how you cope with your problems or what do you do to have a better life. You can talk freely. And if you think you do not want to answer a question you are free to do that.

After finishing all the interviews I will let you know about the outcome of the study. I hope that all the carers in Australia will be benefited from this study.

I will be very delighted if you all volunteer to participate in my study. If you are eager to talk to me please contact me. My phone number is (06) 249 5605.

Thank you for your attention.

Yours sincerely,

Naila Rahman
FORM OF CONSENT TO PARTICIPATE IN RESEARCH PROJECT:

I, .............................................. (Name)
of ......................................................... (Occupation)
hereby consent to taking part in a research project entitled Copper, Silver and Gold in Caring for the Elderly at Home. Proposal for intervention.
The procedure will involve completing questionnaires.
I understand that I can refuse to take part in the project, or withdraw from it at any time.
I also understand that all my responses will be kept confidential.
I agree after considering all the above factors to participate in the project.

_________________________ Date

Signed

APPENDIX B
(Consent forms)
FORM OF CONSENT TO PARTICIPATE IN RESEARCH PROJECT, A1

I, ............................................ (name)
of..................................................
................................................(address)

hereby consent to taking part in a research project entitled Conflict, Stress and Coping in Caring for the Elderly at Home: Proposal for Intervention.

The procedure will involve completing questionnaires.

I understand that I can refuse to take part in this project, or withdraw from it at any time.

I also understand that all my responses will be kept confidential.

I agree after considering all the above factors to participate in the project.

Signed: ......................... Date: .............
FORM OF CONSENT TO PARTICIPATE IN RESEARCH PROJECT, A2

I, .................................... (name)
of ........................................
........................................... (address)

agree to let Naila Rahman, a PhD student from the National Centre for Epidemiology and Population Health at the Australian National University, ask me questions about the conflict I experience due to caring for my elderly relative at home.

The procedure will involve an interview in my home.

I have been made aware that the interview may cause me some stress.

I understand that the interview will be tape recorded and realise that I can ask for the interviewing or taping to be stopped at any time.

I also understand that I can refuse to take part in the project, or withdraw from it at any time.

I agree after considering all the above factors to participate in the project. My decision to take part in the study will not affect the caregiving pattern or my relationship with the care receiver.

I understand that whatever I say will be kept confidential.

Signed: ........................ Date: .............
APPENDIX C
(Structured questionnaire)
CARERS SURVEY

THIS QUESTIONNAIRE CONSISTS OF QUESTIONS ABOUT CARING FOR YOUR ELDERLY RELATIVE. THE ANSWERS WILL HELP ME IN DEVELOPING MY RESEARCH AND GREATLY ASSIST MY UNDERSTANDING OF YOUR CAREGIVING SITUATION. I WILL READ OUT THE QUESTIONS. IT IS IMPORTANT THAT YOU TRY TO ANSWER ALL THE QUESTIONS. THIS QUESTIONNAIRE WILL BE TREATED ANONYMously AND CONFIDENTIALLY.
I would like to ask some questions about your age, education and so on to help me know you better. Please try to be as accurate as possible.

What year were you born? ______

How much schooling did you complete?
- Primary school only
- High school only
- Some college or graduate school

Are you:
- Single
- Married
- Living together
- Widowed
- Divorced
- Separated

Where were you born?
- Australia
- U.K., Ireland
- Other Specify ______

Are you:
- Employed
- Unemployed
- Retired
- Pensioner
What is your household income in a year?

- $0 - $9,999
- $10,000 - $19,999
- $20,000 - $29,999
- $30,000 +

What is your religion?

- Protestant
- Catholic
- Jewish
- None
- Other (Specify)

Is the person you are caring for your:

- Spouse
- Parent
- Grandparent
- Sibling
- Friend
- Other relative

How old is your spouse/parent/sibling/relative?

Are you:

- Living with care receiver in care receiver's house
- Care receiver living with you
- Living together, joint ownership of house
- Living separately
For how many years have you been caring?

Less than 1  
1-2  
3-5  
6 or more

I am now going to ask some questions about how you feel about caring for your spouse/parent/sibling/relative. For each question, I will read all choices. Please choose the ONE statement which best describes your own attitude.

1. Some people say that they take care of an elderly person more because they want to, than out of a sense of duty. How much does this apply to you?

   Very frequently 6  
   Frequently 5  
   Sometimes 4  
   Once in a while 3  
   Almost never 2  
   Never 1

2. How often do you feel that you would rather do something else apart from caring for the care receiver?

   Very frequently 6  
   Frequently 5  
   Sometimes 4  
   Once in a while 3  
   Almost never 2  
   Never 1

3. How often do you feel resentful of other relatives who could but who do not do things for the care receiver?

   Very frequently 6  
   Frequently 5  
   Sometimes 4  
   Once in a while 3  
   Almost never 2  
   Never 1
4. Who do you think should take the responsibility of caring for an elderly person? Rank in order of most to least responsibility from 1 (most responsible) to 6 (least responsible)

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<thead>
<tr>
<th></th>
<th>Rank</th>
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<tbody>
<tr>
<td>Spouse</td>
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<td>Daughter</td>
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<td>Son</td>
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<tr>
<td>Daughter-in-law</td>
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<tr>
<td>Sibling</td>
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<tr>
<td>Other relative</td>
<td>6</td>
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5. Do you think there is someone else who should have taken the responsibility?

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<td>Yes</td>
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<td>No</td>
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If yes, Who?

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<tr>
<td>Your spouse</td>
<td>1</td>
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<tr>
<td>Your other sibling</td>
<td>2</td>
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<tr>
<td>Any other relative</td>
<td>3</td>
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<td>Service providers</td>
<td>4</td>
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6. How satisfied are you with caring for your spouse/parent/sibling/relative?

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<td>Extremely satisfied</td>
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<tr>
<td>Satisfied</td>
<td>4</td>
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<tr>
<td>Somewhat satisfied</td>
<td>3</td>
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<tr>
<td>Unsatisfied</td>
<td>2</td>
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<tr>
<td>Extremely unsatisfied</td>
<td>1</td>
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6. How important are the following reasons for you taking care of the care receiver? Rank in order of importance from 1 (most important) to 5 (least important).

- Because it is your duty
- Because of family traditions
- Because of religious principles
- Because it is an opportunity to repay the care receiver for what he/she had done for you when you were young
- Because it will provide a good model for your own children to follow

Now I would like to know what you think of your spouse/parent/sibling/relative. Do you think he/she is:

1. Interesting to talk to
   1 Not at all
   2 Somewhat
   3 A great deal

2. Enjoyable to be with
   1 Not at all
   2 Somewhat
   3 A great deal

3. Friendly and sociable toward people
   1 Not at all
   2 Somewhat
   3 A great deal
4. Seems interested in things

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<th>Not at all</th>
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5. Cooperative

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6. Clean or neat about self

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7. Appreciative or grateful for help

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8. Withdawn or unresponsive

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And now I would like to ask you about some things that people need to do as a part of their daily lives. I would like to know if the person you are caring for can do these activities without any help at all, or if he/she needs some help to do them, or if he/she can not do them at all.
### Bathing—either sponge bath; tub bath, or shower

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<tr>
<td><strong>Receives no assistance</strong>&lt;br&gt;(gets in and out of tub by self if tub is usual means of bathing)</td>
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<tr>
<td><strong>Receives assistance in bathing only one part of the body</strong>&lt;br&gt;(such as back or a leg)</td>
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<tr>
<td><strong>Receives assistance in bathing more than one part of the body</strong>&lt;br&gt;(or not bathed)</td>
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### Dressing—gets clothes from closets and drawers—including underclothes, outer garments and using fasteners (including braces if worn)

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<th>D</th>
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</thead>
<tbody>
<tr>
<td><strong>Gets clothes and gets completely dressed without assistance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gets clothes and gets dressed without assistance except for assistance in tying shoes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Toileting—going to the “toilet room” for bowel and urine elimination; cleaning self after elimination, and arranging clothes

<table>
<thead>
<tr>
<th></th>
<th>D</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goes to “toilet room,” cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Receives assistance in going to “toilet room” or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doesn’t go to room termed “toilet” for the elimination process</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mobility---

I

Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)

D

Moves in and out of bed or chair with assistance

D

Doesn't get out of bed

Continence---

I

Controls urination and bowel movement completely by self

D

Has occasional "accidents"

D

Supervision helps keep urine or bowel control; or catheter is used; or is incontinent

Feeding---

I

Feeds self without assistance

I

Feeds self except for getting assistance in cutting meat or buttering bread

D

Receives total assistance in feeding
Independent in all six functions
Independent in all but one function
Independent in all but bathing and one additional function
Independent in all but bathing, dressing and one additional function
Independent in all but bathing, dressing, going to toilet and one additional function
Independent in all but bathing, dressing, going to toilet, mobility and one additional function
Dependent in all six functions

I have just asked you about the physical problems your spouse/parent/sibling/relative has. Now I would like to know if the person you are caring for has any memory difficulties. Is your/does your spouse/parent/sibling/relative

1. Confused
   1 Not at all
   2 Somewhat
   3 A great deal

2. Forgetful
   1 Not at all
   2 Somewhat
   3 A great deal

3. Hears or sees things that are not there
   1 Not at all
   2 Somewhat
   3 A great deal

4. Wanders inside the house
   1 Not at all
   2 Somewhat
   3 A great deal
5. Has unrealistic fears

1. Not at all
2. Somewhat
3. A great deal

6. Talks or mumbles to self

1. Not at all
2. Somewhat
3. A great deal

7. Repeats self

1. Not at all
2. Somewhat
3. A great deal

8. Does things harmful to self and others

1. Not at all
2. Somewhat
3. A great deal

Now I would like to know about your own health. How would you rate your health at the present time:

- Excellent
- Could not be better
- Very good
- Good
- Average
- Fair
- Not too good
- Not good at all

Choose the one that best describes your health.
The following questions are about your living condition. Would you say that your present living condition is:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very bad</td>
<td>1</td>
</tr>
<tr>
<td>Bad</td>
<td>2</td>
</tr>
<tr>
<td>Average</td>
<td>3</td>
</tr>
<tr>
<td>Good</td>
<td>4</td>
</tr>
<tr>
<td>Very good</td>
<td>5</td>
</tr>
</tbody>
</table>

2) How much do you like the neighbourhood?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat</td>
<td>2</td>
</tr>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
</tbody>
</table>

3) How much do you like living in this house/ apartment?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat</td>
<td>2</td>
</tr>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
</tbody>
</table>

4) With things as they are now, would you like to move

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Let's turn now to the help and support you get from your friends and relatives. The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, give me a list of all the people you know, excluding yourself, whom you can count on for help or support in the manner described (card shown to respondent with an example). Give the person's initials and their relationship to you (see example). Do not list more than one person next to each of the letters beneath the question.

For the second part, please tell me how satisfied you are with the overall support you have.

If you have no support for a question, check the words "No one," but still rate your level of satisfaction. Do not list more than nine persons per question.
1. Whom can you really count on to listen to you when you need to talk?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>4)</th>
<th>7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied are you with this support?

- Very satisfied 6
- Fairly satisfied 5
- A little satisfied 4
- A little dissatisfied 3
- Fairly dissatisfied 2
- Very dissatisfied 1

2. Whom can you talk with frankly, without having to watch what you say?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>4)</th>
<th>7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied are you with this support?

- Very satisfied 6
- Fairly satisfied 5
- A little satisfied 4
- A little dissatisfied 3
- Fairly dissatisfied 2
- Very dissatisfied 1

3. Whom can you really count on to distract you from worries when you feel under stress?

<table>
<thead>
<tr>
<th>No one</th>
<th>1)</th>
<th>4)</th>
<th>7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How satisfied are you with this support?

- Very satisfied 6
- Fairly satisfied 5
- A little satisfied 4
- A little dissatisfied 3
- Fairly dissatisfied 2
- Very dissatisfied 1
4. Whom can you really count on to be dependable when you need help?
No one

How satisfied are you with this support?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>6</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>5</td>
</tr>
<tr>
<td>A little satisfied</td>
<td>4</td>
</tr>
<tr>
<td>A little dissatisfied</td>
<td>3</td>
</tr>
<tr>
<td>Fairly dissatisfied</td>
<td>2</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
</tr>
</tbody>
</table>

5. Whom can you count on to listen openly and uncritically to your innermost feelings?
No one

How satisfied are you with this support?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>6</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>5</td>
</tr>
<tr>
<td>A little satisfied</td>
<td>4</td>
</tr>
<tr>
<td>A little dissatisfied</td>
<td>3</td>
</tr>
<tr>
<td>Fairly dissatisfied</td>
<td>2</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
</tr>
</tbody>
</table>

6. Who will comfort you when you need it by holding you in their arms?
No one

How satisfied are you with this support?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>6</td>
</tr>
<tr>
<td>Fairly satisfied</td>
<td>5</td>
</tr>
<tr>
<td>A little satisfied</td>
<td>4</td>
</tr>
<tr>
<td>A little dissatisfied</td>
<td>3</td>
</tr>
<tr>
<td>Fairly dissatisfied</td>
<td>2</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
</tr>
</tbody>
</table>
7. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

No one 1) 4) 7)  
2) 5) 8)  
3) 6) 9)

How satisfied are you with this support?

Very satisfied 6  
Fairly satisfied 5  
A little satisfied 4  
A little dissatisfied 3  
Fairly dissatisfied 2  
Very dissatisfied 1

8. Whom can you count on to console you when you are very upset?

No one 1) 4) 7)  
2) 5) 8)  
3) 6) 9)

How satisfied are you with this support?

Very satisfied 6  
Fairly satisfied 5  
A little satisfied 4  
A little dissatisfied 3  
Fairly dissatisfied 2  
Very dissatisfied 1

9. Whom can you really count on to support you in major decisions you make?

No one 1) 4) 7)  
2) 5) 8)  
3) 6) 9)

How satisfied are you with this support?

Very satisfied 6  
Fairly satisfied 5  
A little satisfied 4  
A little dissatisfied 3  
Fairly dissatisfied 2  
Very dissatisfied 1
Here is a list of eight community-based service programs for elderly people. How often (during the last year) did you receive support from each of these services.

1. Adult Day Care Services

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

2. Meals-on wheels

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

3. Visiting Nurses Services

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

4. Home Help

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

5. Respite Services

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

6. Mobil Rehabilitation Unit (supply of aids such as wheel chairs, shower rails etc)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>
7. Medical Practitioner

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

8. Mental Health Counselling

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once in a while</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Regularly</td>
<td>3</td>
</tr>
</tbody>
</table>

I am now going to ask you some questions about the things you are facing/ will face due to caring for your elderly spouse/parent/sibling/relative. Please choose one statement that you think best describes your problem.

1. I feel that my elderly relative is (will be) an overly demanding person to care for.

   Strongly Agree 4
   Agree           3
   Disagree        2
   Strongly Disagree 1

2. I feel that caring for my elderly relative puts (will put) a strain on family relationships.

   Strongly Agree 4
   Agree           3
   Disagree        2
   Strongly Disagree 1

3. I feel that caring for my elderly relative disrupts (will disrupt) my routine in my home.

   Strongly Agree 4
   Agree           3
   Disagree        2
   Strongly Disagree 1
4. I feel that caring for my elderly relative interferes (will interfere) with my friends or friends of my family coming to my home.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

5. I feel that caring for my elderly relative has negatively affected (will negatively affect) my family’s or my physical health.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

6. I feel that caring for my elderly relative has negatively affected (will negatively affect) my appetite.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

7. I feel that caring for my elderly relative has caused me (will cause me) to be physically fatigued.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

8. I feel that caring for my elderly relative has caused me (will cause me) to become anxious.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

9. I feel that meeting the psychological needs of my elderly relative for feeling wanted and important is not (will not be) worth the effort.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>
10. I feel that meeting the health needs of my elderly relative is not (will not be) worth the effort.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

11. I feel that meeting the daily needs of my elderly relative is not (will not be) worth the effort.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

12. I feel that meeting the social needs of my elderly relative for companionship is not (will not be) worth the effort.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

13. I feel that my elderly relative is (will be) an overly demanding person to care for.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

14. I feel that my elderly relative tries (will try) to manipulate me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

15. I feel that caring for my elderly relative has caused (will cause) my family and me much aggravation.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
16. I feel that my elderly relative makes (will make) unnecessary requests of me for care.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

17. I feel that caring for my elderly relative is causing me (will cause me) to dip into savings meant for other things.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

18. I feel that my family and I must give up (will have to give up) necessities because of the expense to care for my elderly relative.

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

19. I feel that my family and I cannot (will not be able to) afford those little extras because of the expense to care for my elderly relative.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Strongly Agree</td>
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<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
</tr>
</tbody>
</table>

20. I feel that caring for my elderly relative is (will be) too expensive.

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<table>
<thead>
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<tbody>
<tr>
<td>Strongly Agree</td>
<td>4</td>
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<tr>
<td>Agree</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>1</td>
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</tbody>
</table>

Now I would like to know if you feel stressed due to caring for your spouse/parent/sibling/relative. Have you recently:

1.- been able to concentrate on whatever you’re doing?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Better than usual</td>
<td>0</td>
</tr>
<tr>
<td>Same as usual</td>
<td>1</td>
</tr>
<tr>
<td>Less than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much more than usual</td>
<td>3</td>
</tr>
</tbody>
</table>
2. - lost much sleep over worry?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>No more than usual</td>
<td>1</td>
</tr>
<tr>
<td>Rather more than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much more than usual</td>
<td>3</td>
</tr>
</tbody>
</table>

3. - felt that you are playing a useful part in things?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>More so than usual</td>
<td>0</td>
</tr>
<tr>
<td>Same as usual</td>
<td>1</td>
</tr>
<tr>
<td>Less useful than Usual</td>
<td>2</td>
</tr>
<tr>
<td>Much less useful</td>
<td>3</td>
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</tbody>
</table>

4. - felt capable of making decisions about things?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>More so than usual</td>
<td>0</td>
</tr>
<tr>
<td>Same as usual</td>
<td>1</td>
</tr>
<tr>
<td>Less so than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much less capable</td>
<td>3</td>
</tr>
</tbody>
</table>

5. - felt constantly under strain?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>No more than usual</td>
<td>1</td>
</tr>
<tr>
<td>Rather more than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much more than usual</td>
<td>3</td>
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</tbody>
</table>

6. - felt you could not overcome your difficulties

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>No more than usual</td>
<td>1</td>
</tr>
<tr>
<td>Rather more than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much more than usual</td>
<td>3</td>
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</tbody>
</table>

7. - been able to enjoy your normal day-to-day activities?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Same as usual</td>
<td>1</td>
</tr>
<tr>
<td>Less so than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much less than usual</td>
<td>3</td>
</tr>
</tbody>
</table>

8. - been able to face up to your problems?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>More so than usual</td>
<td>0</td>
</tr>
<tr>
<td>Same as usual</td>
<td>1</td>
</tr>
<tr>
<td>Less able than usual</td>
<td>2</td>
</tr>
<tr>
<td>Much less able</td>
<td>3</td>
</tr>
</tbody>
</table>
9. - been feeling unhappy and depressed?

Not at all 0
No more than usual 1
Rather more than usual 2
Much more than usual 3

10. - been losing confidence in yourself?

Not at all 0
No more than usual 1
Rather more than usual 2
Much more than usual 3

11. - been thinking of yourself as a worthless person?

Not at all 0
No more than usual 1
Rather more than usual 2
Much more than usual 3

12. - been feeling reasonably happy, all things considered?

More so than usual 0
About same as usual 1
Less so than usual 2
Much less than usual 3

13. - felt that life is entirely hopeless?

Not at all 0
No more than usual 1
Rather more than usual 2
Much more than usual 3

14. - been wondering what will happen to care receiver if you became ill?

Not at all 0
No more than usual 1
Rather more than usual 2
Much more than usual 3

15. - been worrying what would happen if you were in the position care receiver is now?

Not at all 0
No more than usual 1
Rather more than usual 2
Much more than usual 3

We know that caring for a dependent older person involves a large amount of work. In the process of caring, some people may experience
problems or feelings of conflict. Here are a number of those problems and feelings. Please indicate the choice which best describes your answer to each question.

Note: 'Y' is the person who you are caring for.

1. I feel annoyed when 'Y' does not want to go to a doctor.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>6</td>
</tr>
<tr>
<td>Very often</td>
<td>5</td>
</tr>
<tr>
<td>Fairly often</td>
<td>4</td>
</tr>
<tr>
<td>Sometimes</td>
<td>3</td>
</tr>
<tr>
<td>Almost never</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</tbody>
</table>

2. I feel resentful at helping 'Y' all the time.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>6</td>
</tr>
<tr>
<td>Very often</td>
<td>5</td>
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<td>Fairly often</td>
<td>4</td>
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<td>Sometimes</td>
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<tr>
<td>Almost never</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</table>

3. 'Y' interferes with my privacy.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
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<td>Almost never</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</tbody>
</table>

4. 'Y' is unappreciative of what I do.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>6</td>
</tr>
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<td>Sometimes</td>
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<tr>
<td>Almost never</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</tbody>
</table>

5. 'Y' complains about things I do.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
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</tr>
<tr>
<td>Very often</td>
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<tr>
<td>Fairly often</td>
<td>4</td>
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<tr>
<td>Sometimes</td>
<td>3</td>
</tr>
<tr>
<td>Almost never</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
</tr>
</tbody>
</table>
6. 'Y' asks for more help than he/she needs.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very often</th>
<th>Fairly often</th>
<th>Sometimes</th>
<th>Almost never</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

7. 'Y' resists efforts to keep him/her clean.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very often</th>
<th>Fairly often</th>
<th>Sometimes</th>
<th>Almost never</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

8. I like being with 'Y'.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very often</th>
<th>Fairly often</th>
<th>Sometimes</th>
<th>Almost never</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

9. I get along alright with 'Y'.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very often</th>
<th>Fairly often</th>
<th>Sometimes</th>
<th>Almost never</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

10. 'Y' resists when asked to do things.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Very often</th>
<th>Fairly often</th>
<th>Sometimes</th>
<th>Almost never</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
11. 'Y' gripes and complains a lot about me.

Always 6
Very often 5
Fairly often 4
Sometimes 3
Almost never 2
Never 1

12. I feel upset when 'Y' blames me for his/her difficulties.

Always 6
Very often 5
Fairly often 4
Sometimes 3
Almost never 2
Never 1

Here are some things that caregivers do to make caregiving easier for themselves. When things go badly in your caring, how often do you:

1. Walk away from the situation

   Very often 4
   Fairly often 3
   Once in a while 2
   Never 1

2. Shut yourself in your room for some time out

   Very often 4
   Fairly often 3
   Once in a while 2
   Never 1

3. Go for a walk

   Very often 4
   Fairly often 3
   Once in a while 2
   Never 1

4. Garden

   Very often 4
   Fairly often 3
   Once in a while 2
   Never 1
5. Talk with other people about the situation

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</table>

6. Be active (sing, read)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
<td>2</td>
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<tr>
<td>Never</td>
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</table>

7. Cry

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
<td>2</td>
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<tr>
<td>Never</td>
<td>1</td>
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</table>

8. Scream and yell

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
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<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
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<tr>
<td>Never</td>
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9. Threaten care receiver of nursing home placement

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</table>

10. Argue with care receiver

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
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<tr>
<td>Once in a while</td>
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<td>Never</td>
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</table>

11. Shake/push care receiver

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
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<tr>
<td>Once in a while</td>
<td>2</td>
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<tr>
<td>Never</td>
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</table>
12. Put care receiver into bed (so that he/she does not bother you)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
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<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
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</tr>
<tr>
<td>Once in a while</td>
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<tr>
<td>Never</td>
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</table>

13. Argue with other family members

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
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</table>

14. Pray, read Bible

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
</tr>
<tr>
<td>Fairly often</td>
<td>3</td>
</tr>
<tr>
<td>Once in a while</td>
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</tr>
<tr>
<td>Never</td>
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</table>

15. Swear and curse

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
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<tr>
<td>Fairly often</td>
<td>3</td>
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<tr>
<td>Once in a while</td>
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<td>Never</td>
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</table>

THANK YOU FOR YOUR TIME AND EFFORT
APPENDIX D
(Semi-structured interview schedule)
QUESTIONS FOR SEMI-STRUCTURED INTERVIEW

1. As we know caring for an elderly person involves great amount of work. In the course of caring some people may feel stressed while others may feel happy. How do you feel caring for your spouse/parent/sibling/relative?

2. What are the things in caring that make you feel uncomfortable?

3. Is the amount of work involved in caring for your relative a big burden for you?

4. What difference has caring for your spouse/parent/sibling/relative made to your family? Has it affected the way you get along with your spouse/children/sibling/parents?

5. Is there anybody to whom you can confide when you have any problems?

6. Are there times when you have arguments or disagreements, or get irritated with each other? What causes the disagreements usually? Examples.

7. Think back to the time before you started caring. How was your relationship to the care receiver. Did you have arguments?

8. Are there times when you feel you cannot carry on any longer?

9. When you are stressed how do you manage things?

10. Do you get any support from the local health services or the local council services? Are you satisfied with that help?

11. During your course of caring for your spouse/parent/sibling/relative do you think that there are some things you need are still unmet?

12. You are caring for your spouse/parent/sibling/relative. Do you think that some other person in the family could care for your spouse/parent/sibling/relative?

13. If your relative has a fall or hurts himself/herself as a result of your caring how would you feel? What would you do?

14. What do you think of a situation where a caregiver suffering from stress related problems abuses/ misbehaves with the care receiver. What do you think should be done to help the caregiver.

15. According to you what will be the breaking point beyond which you think you can not care for your relative at home. He/she has to be put into a nursing home?

16. Though caregiving is difficult and exhausting, are there times when you find caring for your spouse/parent/sibling/relative as comforting and pleasurable?
DEAR RESPONDENTS,

I AM TRYING TO GET SOME IDEA ABOUT HOW CAREGIVERScope WITH THE SITUATION WHILE CARING FOR AN ELDERLY RELATIVE AT HOME AND WHAT KINDS OF THINGS ARE LIKELY TO HAPPEN IN THE CAREGIVING SITUATION THAT MIGHT AFFECT THE CAREGIVER’S RELATIONSHIP TO THE CARE RECEIVER. I WOULD ALSO LIKE TO HEAR YOUR IDEAS ON HOW IT MIGHT BE POSSIBLE TO RESOLVE CAREGIVING FROM CONFLICT AND HELP THEM TOcope BETTER WITH THE SITUATION.

THIS QUESTIONNAIRE WILL BE TREATED ANONYMOUSLY AND CONFIDENTIALLY. PLEASE READ EACH SECTION CAREFULLY AND TRY TO ANSWER ALL THE QUESTIONS. IF YOU HAVE COMPLETED IT IN THE RETURN ENVELOPE.

THANK YOU FOR YOUR COOPERATION.

APPENDIX E
(Vignette questionnaire)
DEAR RESPONDENTS,

I AM TRYING TO GET SOME IDEA ABOUT HOW CARERS COPE WITH THE SITUATION WHILE CARING FOR AN ELDERLY RELATIVE AT HOME AND WHAT KINDS OF THINGS ARE LIKELY TO HAPPEN IN THE CAREGIVING SITUATION THAT MIGHT AFFECT THE CAREGIVER'S RELATIONSHIP TO THE CARE RECEIVER. I WOULD ALSO LIKE TO HEAR YOUR IDEAS ON HOW IT MIGHT BE POSSIBLE TO RELIEVE CARERS FROM CONFLICT AND HELP THEM TO COPE BETTER WITH THE SITUATION.

THIS QUESTIONNAIRE WILL BE TREATED ANONYMOUSLY AND CONFIDENTIALLY. PLEASE READ EACH SECTION CAREFULLY AND TRY TO ANSWER ALL THE QUESTIONS. WHEN YOU HAVE COMPLETED SEAL IT IN THE RETURN ENVELOPE PROVIDED.

THANK YOU FOR YOUR COOPERATION.
CASE 1

1.1) Mr. Brown, who is 75 years old, had a stroke eight months ago. Since the effect of the stroke, Mr. Brown has difficulties with walking, eating, using his hands and fingers, and talking. These problems make it hard for him to look after himself. He needs some assistance with things such as eating, dressing, bathing, going up and down stairs, shopping, preparing meals, etc.

1) Imagine that you have met Mr. Brown. What do you think would be best for him: (tick one).

1) To have a paid companion come to live with him;
2) To have a relative come to live with him;
3) Move into a hostel or nursing home
4) Continue on his own, even though he is having difficulties managing?

Why?

Q2. Whatever your real position as a caregiver, imagine for a moment that you are Mr. Brown's spouse/daughter/son/brother/sister/relative, how would you feel about living with him?

1) Happy to live with him;
2) Very happy to live with him;
3) Undecided about what I should do;
4) Will have to live with him, if there is no other alternative;
5) Not happy to live with him;
6) Definitely would not live with him.
1.2) Mr. Brown is looked after by his wife Ruth (55). Ruth enjoys doing things for her husband, and taking care of him. After Mr. Brown's stroke she has been his constant companion and is helping him in every way. However, over the last two months, Ruth has been feeling tired, life has become monotonous and boring to her, and constant caring for her husband has made her lose all contact with her friends and social life. As a result she has become resentful towards her husband and has begun to feel angry, trapped and burdened by having to care for her husband all by herself. She is lost in despair and does not know what to do. But she tries to think of a way to manage the situation.

Q 1. In this situation what will Ruth think of doing? (tick one).

1) Carry on as the way things are;
2) Talk out the problem with Mr. Brown’s physician;
3) Talk out the problem with a social worker;
4) Threaten to send Mr. Brown to a nursing home;
5) Consider visiting occasionally but live in a separate flat.

Q 2. If you were in Ruth's situation what would you do? (tick one).

1) Carry on as things are;
2) Talk out the problem with Mr. Brown’s physician;
3) Talk out the problem with a social worker;
4) Threaten to send Mr. Brown to a nursing home;
5) Consider visiting occasionally but live in a separate flat.

Why?
1.3) Let's see what happens to Ruth. One night while Ruth is reading, Mr. Brown calls out, asking for help to go to the toilet. It has been a long day, Ruth is tired, and she thought she finally had the old man settled for the night. This request is the last straw: she has reached breaking point.

Q 1. Imagine yourself being in Ruth's situation. What do you think you would do in this situation? (tick one)

1) Feel annoyed hearing him call;
2) Hold Mr. Brown carefully and take him to the toilet;
3) Ignore Mr. Brown's call and keep on reading;
4) Tell him in a harsh voice that you cannot help him;
5) Threaten to use physical force;
6) Tell him not to worry, and you will be with him;
7) Thinking that you are the only one he has, get up happily to see what he wants.

1.4) Ruth then got up from the couch and took hold of Mr. Brown's hand. With the old man leaning on her Ruth pulls Mr. Brown forward.

Do you consider Ruth's behaviour to be (tick one)

Bearable
Understandable
Tolerable
Uncaring
Acceptable
Selfish
Other, Specify__________
1.5) Ruth supports Mr. Brown and gradually takes him to the toilet. As it has been a long day and Ruth is very tired, for a while she forgets to hold her husband. Mr. Brown loses his balance and has a fall.

Do you consider Ruth’s behaviour to be(tick one)

Bearable
Understandable
Tolerable
Uncaring
Acceptable
Selfish
Other, Specify

1.6) Hearing the sound of a fall Ruth rushes into the toilet and finds Mr. Brown on the floor. At first she blames her husband for not being careful and hurting himself.

Do you consider Ruth’s behaviour to be(tick one)

Bearable
Understandable
Tolerable
Uncaring
Acceptable
Selfish
Other, Specify

Q.1. What would you have done if you found Mr. Brown lying on the floor?
1.7) Ruth quickly gets hold of Mr. Brown and carefully helps him to get up. She slowly drags him into the bedroom and helps him to get into bed. As Mr. Brown had hit the wall he has a bruised left arm. Ruth looks at the arm and tells Mr. Brown not to worry about it. She also tells him that if required she will call in the doctor in the morning.

Do you consider Ruth's behaviour to be(tick one)

Bearable
Understandable
Tolerable
Uncaring
Acceptable
Selfish
Other, Specify

Q.1. How would you have felt when Mr. Brown hurt himself?

Q 2. What would you have done if you were in this situation?
CASE 2

2.1) Mr. Block, a 68 year old retired public servant lives with his 60 year old wife in a small but attractive house in a pleasant suburban neighbourhood. Mrs. Block is frail, has epilepsy and severe emotional problems and cannot work. Mr. Block’s health is deteriorating, but he can still manage, and can drive a car. He takes care of his wife and also does all the shopping, cooking and cleaning. They have a son named William who is 45 years old. William is single, lives alone in a different suburb and is a clerk in a private firm. Everything is going well for William until one day he gets laid off from work due to the firm’s closing down. William is awarded no severance pay or any other support from his office. At this he becomes very shocked and suffers a nervous breakdown. Mr. Block brings William home to live with him. As William is totally bankrupt he contributes no money to the household, and is entirely financially dependent on his parents.

Q 1. What will happen to the family relationship now?

1) Mr. and Mrs. Block will be very happy to have their son living with them;

2) Mr. Block will worry about his son’s future;

3) As William has no income there will be financial problems in the family;

4) William will not get along well with his parents;

5) William will be happy to depend on his parents.

Q 2. How can this problem be resolved?
2.2) William's unemployment and financial dependence gradually makes him more troublesome. It becomes harder to get along with him. He occasionally requests money from his father. Soon these requests become demands and are made more and more frequently. Getting annoyed Mr. Block asks William to look for a job. This proposal makes William more irritable towards his father.

Q 1. What do you think William will do? He will(tick one)

1) Talk out the problem with his father and try to come to a solution;
2) Look for another job;
3) Have more arguments with parents;
4) Threaten to use physical force;
5) Threaten to leave parents

Q 2. Can you suggest any way that will help William cope with the situation?

2.3) As time passes William's behaviour becomes erratic, and he shouts at his parents. He bangs the door, tries to knock the door down, starts kicking things around.
Q.1. For a moment imagine yourself in William's position. What would you have done?

2.4) He taunts his father and assaults him by hitting him. One day he knocks his father down the front stairs. William not only mistreats his father but also his disabled mother.

Do you consider William's behaviour to be(tick one)

- Bearable
- Understandable
- Tolerable
- Uncaring
- Acceptable
- Selfish
- Other, Specify________

Why?
2.5) William also has arguments with his mother. He never listens to what she says. Sometimes he threatens to leave her.

Do you consider William's behaviour to be (tick one)

- Bearable
- Understandable
- Tolerable
- Uncaring
- Acceptable
- Selfish

Other, Specify

2.6) The situation becomes worse by day. Mr. Block can not figure out what to do. He and his wife are very frightened. They fear that their son might kill them. Mr. and Mrs. Block are very hurt. They want to get out of this situation. They really want help.

Q.1.) What do you think should be done to help Mr. and Mrs. Block?
CASE 3

3.1) Mr. Smith is now 85 years of age. He has been widowed for six years. He lives alone in his own home where he has lived for the last 30 years. Mr. Smith's house is dirty with little furniture. There is a hospital bed in the dining space and a walker in the corner. Mr. Smith is short, stocky and barrel-chested. He wears finely tailored, good quality clothes, but they are unbuttoned, dirty, and dishevelled. He feels that he should have good living arrangements but he cannot make ends meet on the $291.70 fortnightly he receives from Social Security. He perceives himself as an extremely impoverished man, who is badly in need of social support.

1) In your opinion what sort of social support should Mr. Smith get?

2) What arrangements should be made so that Mr. Smith can look after himself?

3.2) Mr. Smith has a number of physical impairments. He has had high blood pressure and heart problem for 35 years and diabetes for 12 years. He has used a walker since he had a stroke 3 years ago and has kidney trouble. He gets around the house easily but does not go outside often because his legs are
too weak. He has a full set of dentures but does not wear them because they are too big. He has a number of medications, but he does not understand some of his medications and what they are for, so does not take them regularly. Because of all these problems Mr. Smith sees his life filled with deprivation and disability. Some times he feels frustrated, desperate and defeated.

Q 1. What do you think would be best for Mr. Smith (tick one)

   a) To have a paid companion come to live with him
   b) To have a relative come to live with him
   c) Move into a hostel or nursing home
   d) Continue on his own, even though he is having difficulties?

Q 2. Whatever your real position as a caregiver, imagine for a moment that you are Mr. Smith's son/daughter/spouse/relative. Under these circumstances what would you have done? (tick one)

   1) Have Mr. Smith come to live with you;
   2) Move in with Mr. Smith and renovate the house;
   3) Arrange for a paid companion to live with him;
   4) Arrange for a relative to live with him;
   5) Arrange for him to live in a nursing home or a hostel.

3.3) Mr. Smith has a daughter named Eva. Eva lives 20km away with her husband and a two year old son. Mr. Smith depends on his daughter for emotional support, as well as for some specific work such as cleaning the house, shopping and transportation to the doctor. Eva manages to visit weekly and to phone almost daily.
1) Do you find Eva's support for her father to be sufficient? (circle one)

Yes  No

Why?

2) How often should Eva spend time with her father? (tick one).
   1) Make her father live with her;
   2) She should move in with her father;
   3) Visit him every day;
   4) Visit him twice a day;
   5) Visit him once a fortnight;
   6) Visit him once a month;
   7) Should not bother about him.

3) Imagine that you have a father like Mr. Smith. How often would you have visited him? (tick one)
   1) Once a day;
   2) Once a week;
   3) Once a fortnight;
   4) Once a month;
   5) Whenever you have time.

3.4) But the problem is with Mr. Smith. Though he has a loving and supportive family he feels "lost" all the time and complains about living alone.
1) Mr. Smith can overcome this feeling only if (tick one)

1) Eva comes to live with him;

2) He goes to live with Eva;

3) A social worker comes and spends some time with him;

4) His physician calls in more frequently;

5) Moves into a nursing home or hostel where he can have company.

3.5) Eva also feels that she should do more for her father, but she also has her own family to look after. Eva’s husband is not willing to live with Mr. Smith in the same house because they wouldn’t have any privacy. He resents the time Eva spends with her father. Eva finds herself in a dilemma being forced to choose between her family and her father. She thinks about putting her father in a nursing home, but this makes her feel guilty.

1) What will Eva do? (tick one)

1) Bring Mr. Smith to live with her;

2) Ignore her husband’s resentments and spend more time with her father;

3) Have a paid companion to live with Mr. Smith

4) Send Mr. Smith to live in a nursing home/ hostel.

Q 2. What would you have done if you were in Eva’s place? (tick one)

1) Bring Mr. Smith to live with you;

2) Ignore family problems and spend more time with him;

3) Visit him regularly;

4) Have a paid companion to live with him;

5) Put him into a nursing home.

6) Other, specify __________________________
Q 3. Imagine yourself as Eva's husband. What would you do to help Eva solve her problem?
APPENDIX F

(A copy of the published paper derived from Chapter 5 of this thesis)
CONFLICT AND CAREGIVING:
TESTING A SOCIAL-PSYCHOLOGICAL MODEL
N. Rahman

ABSTRACT
Interpersonal conflict in the caring relationship and coping with conflict were explored in a survey of 151 informal caregivers of the elderly. Burden, maladaptive coping strategies and the functional limitation of the elderly person were found to be significant predictors of conflict. A two-way relationship between conflict and maladaptive coping was indicated. Caregivers experiencing severe amounts of conflict dealt with the situation by using maladaptive coping strategies. Maladaptive coping strategies often lead to abusive behaviour which in turn aggravates the degree of conflict.

INTRODUCTION
Interpersonal conflict is expected to be a pervasive, even if sometimes minor, aspect of caring for a dependent elderly person. This is especially true when the caregivers are involved with caring 24 hours a day, and when their hostile feelings towards the care recipient are suppressed because of a lack of respite from full-time caring. Although interpersonal conflict is expected in aged care, the literature on elderly caregiving is replete with the reports of the other impacts that caregiving has: caregiving burden (Cantor 1980; Zarr et al. 1980, 1986; Chenoweth & Spencer 1986; Fitting et al. 1986; Brainwaite 1990) and stress (Grad & Samsbury 1968, George & Gwyther 1983, 1986; Gilleard 1984). There has been no specific study in Australia on conflict and coping in the caregiving situation. This paper therefore examines the relationships between conflict and other features of caregiving, in particular, coping strategies among caregivers for the elderly.

METHOD
Sample
Caregivers in Canberra were contacted by a letter distributed to them through the Council on the Ageing (ACT). One hundred and fifty-one informal caregivers volunteered to participate in the study. The majority were female caregivers (68%). Of these female caregivers, 40 per cent were wives, with 20 per cent daughters and 8 per cent daughters-in-law. Of the male caregivers 30 per cent were husbands; sons and brother caregivers comprised only one per cent. The mean age for the wives was 71.2 years, the daughters 49.2 years, and the males 76.4 years.

The caregivers were caring for an elderly relative between the age of 65 years and 98 years. The majority of caregivers (57.6%) had been providing unpaid assistance for eight to 12 years, seven per cent had been caring for the elderly person for more than 15 years, and the rest for six to seven years. Caregivers had to deal with people suffering multiple disabilities. Thirty-two per cent of the caregivers cared for a person paralysed by stroke, some suffering from multiple sclerosis (9.3%) and cardiac disabilities (11.5%). Some cared for those suffering from chronic ailments of old age (28%), of which poor vision, diabetes and loss of hearing were the most common problems. They had to provide full-time support as these elderly people were less mobile and incapable of self-care.

Questionnaire
A one hour survey questionnaire was piloted and revised before the final form was adopted. It included one or more items measuring each of the key variables: health, stress, burden, social support, conflict and coping strategy. Detailed descriptions of each of the variables are given below:

Socio-demographic data: The socio-demographic information collected was: caregiver's age, gender, marital status, education, annual household income and employment status, care receiver's age, relationship of caregiver to care receiver, living arrangements of caregiver and care receiver and total duration of caring.

Physical health: The physical health of the care receiver was measured by responses to the Index of Independence in Activities of Daily Living (Katz 1987), completed by the researcher for the caregiver, assessing independence in six activities: bathing, dressing, toileting, transferring from bed to chair, continence and feeding.

Mental health: The items to measure mental health of the care receiver were selected from 23 separate items in a factor analytic model with Varimax Rotation (Poulishock & Demling 1984: 232). These items were based on the caregivers' reports of current behavioural incapacities, particularly sociability and cognitive incapacity exhibited by the care receiver at the time of the interview. The items were derived from responses to a three-point Likert type scale which ranged from 1 to 3. The care receivers' mental impairment scores ranged from 17 to 48, with a mean of 31.3 (s.d. 7.2)

Caregiver's health: The caregivers rated their own health by responding to a single question on an eight-point scale, "How would you rate your overall physical health at the present time: excellent, could not be better, very good, good, average, fair, not too good, or not good at all?"

Burden: The Cost of Care Index (CCI) assessing Australian Journal on Ageing, Vol. 12, No. 4
the potential and actual consequences of caring for an elderly person (Kosberg & Carl 1986) was used to measure burden. It consists of 20 items measuring five dimensions: personal and social restrictions, physical and emotional health, value for care provision, care recipient as provocateur and economic costs. The carer responds to a four-point Likert scale ranging from 1 to 4. Caregivers' burden scores ranged from a lowest cost of 23 to high cost of 80, with a mean of 52.7 (s.d. 14.7).

Social support: For this variable two sorts of information were gathered: availability of, and satisfaction with, social support and the most frequently used community services. The Social Support Questionnaire (SSQ) (Sarason 1987) has been used to assess the caregivers' availability of, and satisfaction with, social support. The scores ranged from a minimum of 9 to a maximum of 54; the mean was 22.9 (s.d. 14.1).

In the second part of this questionnaire, caregivers were asked to state the frequency of use of eight community-based service programs relevant to management of the elderly. These consist of health and social services targeted toward the impaired elderly and are generally available in most Australian urban communities. The score ranged from 0 to 17, with a mean of 8.1 (s.d. 3.8).

Stress: Stress was measured by using the 12-item version of the General Health Questionnaire (Goldberg 1987), which is a self-administered screening instrument. The items are scored using conventional 0-1-2-3 Likert scores. Any two or three positive answers express the probability of having psychological disturbance. The caregivers' scores ranged from 9 to 45, with a mean 29.9 (s.d. 8.8).

Coping: Based on the responses of the caregivers during the pilot study, 15 items were selected to construct a measure for identifying coping strategies. These items represented the coping strategies adopted by the caregivers in real-life situation. The items were scored using 1-4 Likert-type format. The coping scores of the caregivers in the study ranged from 27 to 56, with a mean of 44.6 (s.d. 5.2).

Interpersonal conflict: Owing to the unavailability of an appropriate measure to assess the caregivers' level of conflict a new scale of conflict was developed for this study. Factor analysis was used to select the items measuring conflict. The scale was piloted on a large group of carers in Sydney. The scale consists of 12 four-point Likert-type items with good internal consistency (alpha = 0.92). The conflict scores of the caregivers ranged from 18 to 72, with a mean of 45.5 (s.d. 16.2).

**RESULTS**

All correlations between the independent variables and the dependent variable conflict were in the expected direction with greater degree of burden (r=0.90, p<.000) and ineffective coping (r=-0.74).

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The presence of caregivers' satisfaction with informal and formal support and the functional impairment of the care receivers in the activities of daily living were also significant. Stress, mental impairment of the care receiver, availability of social support and living conditions, which had previously been noted to mitigate conflict, did not emerge as significant predictors. Caregivers' age and education do not play any significant role in predicting conflict.

The results for separate analyses for men and women are shown in Tables 2 and 3. There were differences among the male and female caregivers in the predictors of conflict.

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When only female caregivers were considered the predictors of conflict were similar to those identified for both sexes (see Table 1). The only differences were that satisfaction with social support loses its significance, whereas the availability of support came out as a significant predictor.
Table 3. STEPWISE MULTIPLE REGRESSIONS PREDICTING CONFLICT FOR MALE CAREGIVERS (N=48)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Regression Coefficients</th>
<th>Standard Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>6.47</td>
<td>5.12</td>
<td>0.00</td>
</tr>
<tr>
<td>Burden</td>
<td>7.8</td>
<td>0.83</td>
<td>0.01</td>
</tr>
<tr>
<td>Attitude</td>
<td>1.85</td>
<td>0.39</td>
<td>0.02</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>2.2</td>
<td>0.66</td>
<td>0.05</td>
</tr>
<tr>
<td>R</td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The model for male caregivers identified only three significant factors: caregiving burden, negative attitude towards caring and satisfaction with social support.

Coping with Interpersonal Conflict

The caregivers listed a handful of coping strategies to deal with the conflict in order to maintain authority. The data in Table 4 reveal these methods of coping.

Table 4. PERCENTAGE OF CAREGIVERS UTILIZING VARIOUS COPING STRATEGIES (N=151)

<table>
<thead>
<tr>
<th>Coping Strategies</th>
<th>% of Caregivers (N=151)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk away from the situation</td>
<td>19.2</td>
</tr>
<tr>
<td>Shut yourself in your room for some time</td>
<td>4.0</td>
</tr>
<tr>
<td>Go for a walk</td>
<td>5.3</td>
</tr>
<tr>
<td>Garden</td>
<td>23.8</td>
</tr>
<tr>
<td>Talk with other people about the situation</td>
<td>4.0</td>
</tr>
<tr>
<td>Be active (sing, read)</td>
<td>4.6</td>
</tr>
<tr>
<td>Cry</td>
<td>37.1</td>
</tr>
<tr>
<td>Scream and yell</td>
<td>57.1</td>
</tr>
<tr>
<td>Threaten care receiver of nursing home</td>
<td>39.1</td>
</tr>
<tr>
<td>Placement</td>
<td>43.4</td>
</tr>
<tr>
<td>Argument with care receiver</td>
<td>45.0</td>
</tr>
<tr>
<td>Shout/push care receiver</td>
<td>45.0</td>
</tr>
<tr>
<td>Put care receiver into bed (so that he/she does not bother you)</td>
<td>31.5</td>
</tr>
<tr>
<td>Argue with other family members</td>
<td>42.2</td>
</tr>
<tr>
<td>Pray, read Bible</td>
<td>8.6</td>
</tr>
<tr>
<td>Swear and curse</td>
<td>40.4</td>
</tr>
</tbody>
</table>

Screaming was frequently used by a sizeable number of caregivers. Other methods used by caregivers included shaking and pushing (45%), arguments with the care receiver and family members (42%) and swearing and cursing (40%). It was interesting to note that the caregivers did not function along accommodative or cooperative lines. They were less likely to utilize active problem-solving behaviours. As a result of conflicting demands, abusive and neglectful methods often became the method of last resort for most of the caregivers.

These coping strategies were classified into adaptive and maladaptive. Adaptive coping strategies were those in which the caregivers reported dealing with the situation in such a way that it did not disturb the care receiver or any other family member (e.g. walking away from the situation, reading the Bible, talking with others, etc.). The maladaptive coping strategies on the other hand helped the caregivers to deal with the situation by harming the care receiver (e.g. swearing/pushing, swearing and cursing, etc.). Data indicated 49 percent of the caregivers to use adaptive coping while the remaining 51 percent reverted to maladaptive coping strategies.

Whether these two coping strategies allow us to make a meaningful distinction between the 73 caregivers adopting adaptive coping and the 78 caregivers adopting maladaptive coping strategies was examined in Discriminant Analysis. The variables used in the analysis were used to predict the two mutually exclusive groups employing coping strategies (adaptive or maladaptive). The purpose here was not to derive a classification rule for future application, but rather to describe reasons which distinguished the two groups.

When all nine variables are included in the discriminant model, conflict is clearly the most important predictor of maladaptive coping strategy. A positive response to this variable increases the discriminant function value and contributes to the positive score associated with maladaptive strategy. The discriminant function value also significantly increases with the functional impairment of the care receiver.

DISCUSSION

As is seen from the analysis, among all other possible outcomes of the caregiving situation (e.g. caregiving satisfaction, stress) caregiving burden has been identified as the most important predictor of conflict in the caregiving situation. Caregivers were overloaded, not able to deal effectively with the multiple and competing demands imposed on their time and resources which affected their everyday activities.

In addition to burden the functional limitation of the care receivers has been found to create conflict in the relationship. Caregivers often resent satisfying the daily and instrumental needs of the older people, thus they face more problems as the elders become more dependent on them.

The burdened caregivers adopt a means of coping with the pressure and load. Caregivers found it very difficult to cope with the demands posed by the caregiving context and most of them reported the coping strategy to be ineffective to deal with the demands.

As conflict increases, adaptive coping is replaced by maladaptive coping strategies. The ability to use problem-solving abilities is impaired; or it may be that
those with poor coping strategies are likely to encounter more conflict as a result of unresolved problems. The relationship may also be a vicious circle in which poor coping strategies result in increased conflict and further impede the use of effective coping strategies.

In conclusion, the typical coping mechanisms adopted by the caregivers actually increased anxiety and made caregiving more not less stressful. The caregivers did not cope adaptively with the situation and feel less anxious. Combative behaviour or angry outbursts were specifically mentioned, and lack of support from family and friends made it hard to cope with the multitude of problems. Such outcome is likely to occur in any form of social interaction, particularly when one party is dependent on the other.

While the study shows that conflict is present in most caring situations, this does not necessarily lead to abusive behaviour. Thus as we proceed a step further from caring burden and stress to interpersonal conflict, the theoretical model needs to be modified and extended by further empirical testing. In particular, interventions that enhance more adaptive coping need to be developed and evaluated.

Maht Rahman is a PhD student and researcher at the National Centre for Epidemiology and Population Health at the Australian National University.

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