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THE IMPACT OF CAREGIVING ON THE MARITAL NEED SATISFACTION OF OLDER WIVES WITH DEPENDENT HUSBANDS

The University of North Carolina at Greensboro PH.D. 1984

THE IMPACT OF CAREGIVING ON THE MARITAL NEED SATISFACTION OF OLDER WIVES WITH DEPENDENT HUSBANDS

by

Audrey Mona McCrory

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Approved by

Vera R. Kinnett
Dissertation Adviser

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

Dissertation Adviser Vera R. Kinnon

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MCCRORY, AUDREY MONA, Ph.D. The Impact of Caregiving on the Marital Need Satisfaction of Older Wives with Dependent Husbands. (1984) Directed by Dr. Vira R. Kivett. 140 pp.

This study investigated the influence of caregiving on the marital need satisfaction (MNS) of older women who were caring for their dependent functionally impaired husbands at home. Comparisons were made with the MNS scores of a group of home-based caregivers and women whose husbands were institutionalized. The influence of the husbands' functional impairment, the wives' caregiving involvement, and the wives' social support on the MNS of only the caregiving women were also investigated.

Drawing upon role theory and humanistic psychology theory, it was hypothesized that caregivers' MNS scores would be significantly lower than those of noncaregivers while certain social and physical characteristics of the women and their husbands were controlled. Three additional hypotheses stated that functional impairment, caregiving involvement, and social support would be significantly related to the caregivers' MNS scores when social and physical variables were again controlled.

Personal interviews using semistructured questionnaires were conducted with 33 caregiving and 30 noncaregiving women (aged 60 and older). The data were analyzed using hierarchical multiple regression analysis. None of the four hypotheses was supported. Only the husbands' functional impairment,

a control variable, explained a significant amount of variance in either caregivers' or noncaregivers' MNS scores ($\underline{B} = -.44$; $\underline{p} < .01$). Both groups had relatively low MNS scores.

Based upon the data it was concluded that MNS is unrelated to the caregiving status; however, the MNS scores of both caregivers and noncaregivers decrease as the husbands' level of functional impairment increases. Social support, health, and socioeconomic status are of no relative importance to the MNS of either caregivers or noncaregivers. Variance in caregiving wives' MNS cannot be explained by functional impairment, caregiving involvement, or social support. Extemporaneous remarks of the respondents indicated that their marital status can be characterized as "long-term marital limbo."

CHAPTER I

INTRODUCTION

Many studies have been made concerning marital satisfaction over the life cycle; however, few have considered the factor of the disabling illness of one spouse during the later years of marriage and the impact of caregiving by the well spouse on the quality of the marital relationship. Some indication of the effect of caregiving on that relationship was provided by a 1981 descriptive study of older women who were caring for their disabled spouses (Crossman, London, & Barry). Many of these women experienced a sense of guilt and emotional and social isolation. Their sexual and affectional needs were also frustrated. Horowitz and Shindelman (1981) in their study of spouses and other relatives engaged in caring for impaired older adults noted that it was the spouse-caregivers who gave evidence of the most deteriorated relationships with these dependents. Evidence is also accumulating from other studies of the negative effects of caregiving on the quality of the marital relationship (Braham, Houser, Cline, & Posner, 1975; Fengler & Goodrich, 1979; Sainsbury & Grad de Alarcon, 1970; Sanford, 1975).

This present study investigated the influence of caregiving on the marital need satisfaction of older wives acting as primary caregivers for their dependent, functionally

impaired husbands in the same household in the community. The marital need satisfaction of caregiving wives and non-caregiving wives whose dependent husbands had been institutionalized were compared. An assessment of the relative influence of social and physical characteristics of the women and their spouses on marital need satisfaction was also made.

Background for the Study

As chronological age advances the incidence of chronic disease and infirmity requiring long-term care becomes more frequent and thus the proportion of those with varying degrees of dependency steadily increases (Gurland, Dean, Gurland, & Cook, 1978). While it is generally assumed that a large proportion of the dependent elderly are institutionalized, in reality only about 5% of those 65 years of age and over do reside in an institution at any one time (Blenkner, Bloom, & Nielsen, 1971). A national probability survey of the non-institutionalized elderly population by Shanas (1979) showed that the proportion of sick and frail older adults residing in the community exceeded that of those who were institutionalized. For example, 3% of that community sample were classified as bedfast, 7% were housebound, and an added 7% experienced difficulty in going out of doors.

The prevalence of mental impairment (to the extent that protective help is required from others) among the community-based elderly population is difficult to estimate. However,

a 1971 review of data from previous studies (Blenkner et al.) concluded that "it is probably safe to say that at least a modicum of mental impairment or behavioral disturbance or both characterizes approximately 15 to 20 percent of the urban aged in the United States today" (p. 485).

Among elderly couples still living together in the community, it is the male partner who is more likely to be dependent. This was illustrated by Shanas' 1979 finding that by far the largest proportion of those who were bedfast or ambulatory (but still in need of help) were married males, two-thirds of whom were being cared for by their spouses. A 1982 community study (Horowitz & Dobrof) also found that those elderly spouses who most frequently functioned as primary caregivers were wives whose husbands were severely impaired. These caregiving wives were most often in their seventies and themselves in fair to poor health, while their caregiving activities involved a broad range of services with an extensive time commitment. This predominance of female caregivers during the later years of marriage is believed to be a result of women's tendency to marry men older than themselves and to have longer life spans (Butler & Lewis, 1973).

Many problems arising from the dependent's behavior are frequently encountered on a day-to-day basis by home-based caregivers. Some behaviors identified by caregivers of the impaired elderly as "most poorly" tolerated included (a) night

wandering and irrational shouting, (b) fecal incontinence, (c) general immobility, and (d) dangerous irresponsibility (Sanford, 1975). The ensuing disturbance of the caregivers' sleep and restriction of social life were also poorly tolerated.

Another problem often associated with home care of the mentally ill elderly is in overcoming the dependent's objections to being helped. Thus "the demented patient may lack the ability to comprehend his or her problem, . . . the depressed patient feels nothing could help, and the paranoid patient is suspicious of everyone including doctors" (Reifler, Cox, & Hanley, 1981, p. 165).

Adverse psychological effects are also often exhibited by patients with chronic physical illnesses. Among these are poor self-esteem and depression stemming from changes in appearance, loss of strength, decreased mobility, and the loss of control of bodily functions. Displacement of anger at being sick is often focused on caregivers (Levy, 1979).

It is not surprising then that long-term care of the chronically ill old person in the home may adversely effect the spouse-caregiver. Horowitz and Dobroff (1982) found increased morbidity among older caregivers' spouses to the extent that 74% reported negative effects on their own physical health. Minimal to extensive stress may also be experienced (Horowitz & Shindelman, 1981). In addition, Gurland

et al. (1978) found that among companions 65 years and older of dependent old people, the frequency of definite depression more than tripled ($p < .05$).

Underlying the thrust of prevailing social policy as it relates to older adults is the widely accepted value judgment that institutionalization should be avoided if at all possible (Gurland et al., 1978). To this end increasing attention is being directed toward assisting community-based sick and frail old people by giving financial aid to relatives who act as caregivers and the expansion and upgrading of formal support services such as homemaker-health aides. Seemingly, added support services would help to alleviate the stress and burden associated with caregiving in the home. Serious doubts as to the efficacy of this approach have been raised by Dunlop (1980), who cited many potential linkage and delivery problems, while Fengler and Goodrich (1979) contended that "it would be erroneous to assume that the best solution for all disabled men is home care by a nondisabled spouse" (p. 178).

Potential Contributions of the Study

Given the fact that the proportion of older men and women is expected to escalate (11.2% in 1980) by the year 2020 to 16% of the total population (Soldo, 1980), there will also be an increased number of older married couples. Studies such as the one proposed which investigate the quality of the marital relationship within the context of spousal caregiving

may help to guide the direction of future social planning as it relates to home-support services and creative solutions to institutional alternatives.

This study may also serve as a stimulus to the future use and development of research instruments which are specifically designed to measure the quality of marital interaction during the later years. Stinnett, Collins, and Montgomery (1970) have pointed out, for example, that there was a virtual lack of such relevant instruments prior to their development of the Marital Need Satisfaction Scale which was used in this study.

Theoretical Foundations for the Study

Three theoretical propositions derived from role theory and one from humanistic psychology together with related studies constituted a basis for the hypotheses of this study.

Role Theory

Role theory is a social psychological interaction theory which describes and analyzes human social interaction. Its foundations lie in the insights of Park, Simmel, Moreno, Linton, and Mead (Turner, 1978).

An integral part of role theory is the concept of "role strain" which was defined by Goode (1960) as the "felt difficulty in fulfilling role obligations" (p. 483). Individuals attempt to reduce role strain to bearable proportions by role

manipulation. This can be accomplished by (a) compartmentalizing or setting aside previous role demands in order to deal with a crisis, (b) delegating role responsibilities to others, (c) eliminating role relationships, and (d) expanding the role system, thereby reducing the level of performance for any one role obligation.

Since an individual's physical and emotional resources are limited, an indefinite expansion of the role system is impossible. Following an initial reduction in role strain as a result of expanding the role system, role strain again increases and is accompanied by worry and anxiety. The increased role strain is caused by a diminished level of role performance. At the same time the rewards (in the form of satisfaction) received from the individual's role partner are outweighed by the costs--worry and anxiety.

Role theory proposition 1. "Role strain begins to increase more rapidly with a larger number of roles than do the corresponding role rewards from alter" (Goode, 1960, p. 487).

A 1967 longitudinal study (Klein, Dean, & Bogdonoff) appears to be related to Goode's concept of role strain. The effects of living with a chronically ill spouse (ages 20-55) on 76 well spouses were investigated by assessing the level of "role tension" prior to and during the long-term illness. Indications of increased role tension during the illness were found among 56% of the well spouses, while a significant positive correlation ($p < .001$) was found between the level of

role tension and the number of symptoms the sick spouse displayed.

Using a descriptive approach, Golodetz, Evans, Heinritz, and Gibson (1969) investigated the family interaction of 59 chronically ill home-based patients, 45 of whom were over 60 years of age. Thirty-three of the caregivers were spouses and many also had significant illnesses. They were generally involved in few outside activities and there was a readily apparent sense of isolation in the households. These authors described the wide range of challenging physical, intellectual, and emotional demands on these caregivers as "impressive," "complex," and "onerous."

The maintenance of a satisfactory affective relationship between a caregiving wife and her dependent spouse may be one important way in which she receives a "reward" or "payment" for the stress associated with the caregiving function. The findings of a 1981 study (Horowitz & Shindelman) for which 203 primary caregivers (9% were spouses) of elderly dependents were interviewed indicated that while 70% of the caregiving spouses found the time spent together prior to the onset of the illness enjoyable, only 17% currently enjoyed the time spent with the dependent. Seventy-eight percent of the caregivers "felt very close" to their spouses before the illness and 64% felt that way at the present time. This was in contrast to the responses of adult offspring who functioned as caregivers, whose feelings of closeness

increased from 51% prior to the onset of the illness to 70% at the present time. These authors suggested that as a result of caregiving the marital relationship suffered the greatest strain because it had occupied a primary place in the spouse-caregiver's life prior to the dependency.

Role theory proposition 2. Delegation of role responsibilities to others reduces role strain (Goode, 1960).

This proposition was derived from Goode (1960). It is related to one form of role manipulation, delegation of role responsibilities to others, which causes reduced role strain.

Sanford (1975) interviewed 50 former "principal supporters" (22 were spouses whose mean age was 74 years) of home-based geriatric dependents who subsequently had been institutionalized. This study sought to identify the problems which had been encountered by these former caregivers and to provide a measure for the degree of their tolerance of these problems. The degree of tolerance was expressed as a percentage with the highest percentage indicating the highest tolerance level. It was found, for example, that 62% of these former caregivers had experienced problems with the dependents' sleep disturbance and 16% were able to tolerate these problems. Of a total of 452 identified problems, 221 were found to be so poorly tolerated that their alleviation was necessary before the dependent would again be accepted in the home. In a presumed effort to reduce role strain, this group of former caregivers

had eliminated their caregiving role relationships by delegating caregiving obligations to an institution.

Community support services can also enable caregiving wives to partially delegate caregiving responsibilities to others. Crossman et al. (1981) investigated the benefits of affordable part-time geriatric home care and overnight respite care to a group of 101 older caregiving wives. Client satisfaction surveys indicated that the highest-ranked response of these women to the benefits of such help concerned their ability to get out of the house. Their overall responses indicated that the services were beneficial because both the dependents and the caregivers had "the opportunity to have periods away from the intense interaction and stresses inherent in their relationship" (p. 469).

Role theory proposition 3. "The quality of alter's role enactment influences ego's satisfaction, and this is a positive linear relationship" (Burr, Leigh, Day, & Constantine, 1979, p. 70).

Burr et al. (1960) asserted that this proposition can be applied to marital relationships. Three studies (Brinley, 1975; Burton, 1971; Nye, 1976) were cited which found that alter's behavior had a greater effect on ego's marital satisfaction than did ego's behavior.

Some factors which may adversely influence the quality of marital role enactment by the dependent husbands in this study are associated with general sick role characteristics. Freud (1949), for example, described the "familiar egoism of

the sick . . . in which the readiness to love, however great, is banished by bodily ailments and suddenly replaced by complete indifference" (pp. 39-40). Lederer (1952) also referred to the behavioral changes which often occur in the sick and are disturbing to friends and relatives. Since individuals with one or more chronic illnesses frequently experience feelings of depression and unworthiness, they tend to lose interest in others, become self-involved, and reject offers of help and support. The side effects of medications may also contribute to the patient's decreased level of awareness (Levy, 1979).

A 1978 probability study (Gurland et al.) investigated the prevalence of depression among community-based older adults. Depressed individuals were characterized in general as irritable, feeling and acting helpless, complaining, demanding of reassurance, hypochondriacal, and apathetic. It was reported that depression severe enough to warrant clinical attention was almost twice as common among those who were dependent as those who were not ($p < .07$). The authors noted that the rates of depression would have been much higher if lesser levels of depression, demoralization, or unhappiness had been used as indicators of depression. The results of multiple regression analysis indicated that depression was significantly related (no significance levels were reported) to dependency and that depression and age combined explained 16% of the variance for predicting dependency.

Human Motivation Theory

Humanistic or "third force" psychology has an underlying basis of existential philosophy, presenting a positive, active, and purposive theoretical model of human beings while focusing on the study of the individual as a whole (Buhler & Allen, 1972). Its major thrust is found in the writings of Goldstein, Maslow, Allport, and Rogers (Shaffer, 1978). A theory of human motivation which falls within the orientation of humanistic psychology was proposed by Maslow in 1943.

The core of Maslow's (1943) theory is that because human beings are "wanting" animals, the organism is dominated by unsatisfied needs. These needs are experienced in a hierarchical manner so that as lower "prepotent" needs are partly or completely satisfied, an innate desire for higher need fulfillment is triggered. Physiological needs such as hunger and thirst are the most prepotent and basic of all human needs. When gratification of physiological needs is achieved, higher safety and stability needs emerge. The attempt to satisfy these needs is demonstrated by the general preference of individuals for familiar rather than unfamiliar things in their environment.

Needs for love, affection, and belongingness emerge as safety needs are satisfied. The concept of love is not synonymous with sex (which is viewed as a purely physiological need) but implies a reciprocal relationship which includes both giving and receiving love. Maslow (1943)

contended that in our society the thwarting of love and affection needs "is the most commonly found core in cases of maladjustment and more severe psychopathology" (p. 161).

The next and higher level of needs are the esteem needs which include self-respect and respect, recognition, and appreciation from other people. Satisfaction of these needs leads to feelings of self-confidence and of being useful and necessary. Thwarting of these needs induces feelings of inferiority, weakness, and helplessness in the individual.

The highest need level, that of "self actualization," refers to the desire for self-fulfillment or the need "to become everything that one is capable of becoming" (Maslow, 1943, p. 163). This level of need satisfaction is ultimately achieved by few individuals.

Human motivation theory proposition 1. Human behavior is motivated by unsatisfied basic needs which are organized in a hierarchy of relative prepotency (Maslow, 1943).

This proposition appears to be related to the concept of "basic marital needs" advanced by Stinnet et al. (1970). Included among the categories of marital needs were (a) love needs (such as receiving expressions of affection from one's spouse), (b) personality fulfillment (receiving help from a spouse in becoming what one is capable of becoming), (c) respect needs (acceptance by a spouse of one's differentness), (d) finding meanings in life (receiving help from one's spouse

in feeling needed), (e) integration of past life experiences (receiving a spouse's recognition for one's past accomplishments), and (f) communication (from one's spouse).

The Marital Need Satisfaction Scale (in which the basic marital needs were incorporated) was developed for a survey (Stinnett et al., 1970) to which 227 older husbands and wives responded. The highest degree of satisfaction was expressed in the marital need category of "love" by both males and females. An indication of the importance of the fulfillment of marital need satisfaction to the emotional well being of these respondents was in the finding of a significant positive correlation ($p < .001$) between marital need satisfaction and morale.

A 1972 survey study (Stinnett, Carter, & Montgomery) investigated the perceptions of 408 older husbands and wives (60 to 89 years of age) of their marital relationship. The first-ranked item in response to "the most important factor in achieving marital success" for 48.6% of the respondents was "being in love." When asked to state what they considered the most important characteristic of a successful marriage, "respect" was ranked first by 38.2%.

A descriptive study by Roberts (1979-80) was conducted in which 50 long-married couples (the mean length of marriage to the same spouse was 55.5 years) were each jointly interviewed in an attempt to identify some of the significant elements in long-lasting marriages. Expressive qualities

(such as being kind and understanding) as opposed to instrumental qualities (such as being a good provider or housekeeper) in a spouse were deemed the most important, by all but one respondent. Frequent expressions by these long-married men and women of their continuing need to give and receive affection and to be cherished were also reported. When summarizing the study the author noted that the findings suggested "that love, affection and understanding are needs which continue throughout the life cycle" (p. 270).

In summary, a number of theoretical propositions point toward the hypotheses which were proposed for this study. The propositions from role theory provide an explanation for possible adverse effects on the quality of the marital relationship stemming from the dependent husbands' sick role behavior and the primary caregiving role of the wives, in addition to a rationale for the reduction of these adverse effects. The proposition from Humanistic motivation theory provides a theoretical basis for using the Marital Needs Satisfaction Scale (Stinnett et al., 1970) to assess the quality of the marital relationship of the wives whose husbands are dependent.

Hypotheses

The following hypotheses were proposed for this study:

Hypothesis 1

This hypothesis assessed the influence of caregiving on the marital need satisfaction of wives with dependent

husbands while controlling for the effects of functional impairment, social support, health, socioeconomic status, and caregiving involvement.

H_1: Caregiving wives will have significantly lower marital need satisfaction scores than wives whose husbands are institutionalized when physical and social variables are controlled.

Hypothesis 2

This hypothesis assessed the influence of the dependent husband's functional impairment on the marital need satisfaction of the caregiving wives while controlling for the effects of caregiving involvement and social support.

H_2: There will be an inverse relationship between functional impairment of the dependent home-based husbands and the marital need satisfaction of the caregiving wives when caregiving involvement and social support are controlled.

Hypothesis 3

This hypothesis assessed the influence of caregiving involvement on the marital need satisfaction of the caregiving wives while controlling for the effects of functional impairment and social support.

H_3: There will be an inverse relationship between caregiving involvement and the marital need satisfaction of caregiving wives when functional impairment and social support are controlled.

Hypothesis 4

This hypothesis assessed the influence of the quality of social support received by caregiving wives on their marital need satisfaction while controlling for the effects of functional impairment and caregiving involvement.

H_4: There will be a positive relationship between social support and the marital need satisfaction of the caregiving wives when functional impairment and caregiving involvement are controlled.

Definitions

The following definitions are pertinent to this study. Information on the measurement of these variables is found in Chapter III. References following the definitions refer to other studies which have utilized these variables.

Caregivers. Wives who are the primary providers of a broad range of vital time-consuming services which directly or indirectly support the physical, emotional, social or economic functioning of their home-based dependent husbands (Horowitz & Dobroff, 1982). The fact that these women were primary caregivers was established by a single screening item in the questionnaire.

Caregiving involvement. The level of activity or activities performed by the wives which directly or indirectly supports their dependent husbands' physical, emotional, social, or economic functioning as determined by scores

on the Caregiving Involvement Scale which was constructed for a study of family caregiving to the frail, community-based elderly (Horowitz & Dobroff, 1982).

Dependents. Husbands who are functionally impaired to the extent that direct or indirect supportive services are required from others to enable them to cope with the demands of living in their environment. The withholding of these services would seriously threaten the home-based husbands' continued existence in that environment (Gurland et al., 1978). The presence of this state of dependency will be verified by referral of individual cases from qualified informants in addition to a single screening item in the interview schedule. It was assumed that the institutionalized husbands were dependent.

Functional impairment. The degree to which the dependent husbands are able to physically and socially function in an intact and integrated manner as determined by scores on the Geriatric Rating Scale (Plutchik, Conte, Lieberman, Bakur, Grossman, & Lehrman, 1970).

Health. Wives' subjective evaluations of their own general state of physical well-being as determined by their responses to a single global item (Maddox & Douglass, 1973).

Institution. A private or public facility, commonly referred to as a "nursing home," which specializes in the long-term care of the chronically ill elderly (Libow, 1982).

Marital need satisfaction. Wives' subjective perception of the adequacy with which important psychological needs involved in the marital relationship are fulfilled as determined by scores on the Marital Need Satisfaction Scale (Stinnett et al., 1970). These needs included the areas of "love," "personality fulfillment," "respect," "communication," "finding meanings in life," and "integration of past life experiences."

Older adults. Men and women who are 60 years of age and older. The designation of a specific chronological age for an individual considered "old," "elderly," or "aged" is somewhat arbitrary and varies among studies. For example, Gilford and Bengstron (1977) classified those 55-62 years of age as the "young old," those from 63-69 as "old," and those from 70-90 as the "old-old." Included among those researchers who have classified individuals aged 60 years and above as "older adults," "elderly," or "aged," are Lipman (1961), Stinnett et al. (1970; 1972), and Lee (1978).

Socioeconomic status. An estimate of the wives' position in the social status hierarchy based on scores received on Hollingshead's Two-Factor Index of Social Position (Bonjean, Hill, & McLemore, 1967; Horowitz & Shindelman, 1981).

Social support. Wives' subjective impressions of the quality of the help they were receiving from others. Included was help received from informal sources (family, neighbors, friends) and formal sources (ministers, doctors, home-health

aides, counselors, nurses, etc.). This was determined by a single global item developed for a study by Zarit, Gatz, and Zarit (1981).

Basic Assumptions of the Study

Several basic assumptions are made for this study:

1. The home-based husbands are functionally impaired to the extent that they are dependent, and without the direct or indirect supportive services provided by their caregiving wives, their continued existence at home is threatened or intolerable.

2. The wives whose husbands are home-based are functioning as primary caregivers to their dependent husbands.

3. The institutionalized husbands are functionally impaired to the extent that they are dependent.

Limitations to the Study

Several limitations to the study were acknowledged. Since the sample, consisting of both caregiving and non-caregiving wives with dependent husbands, was obtained by a nonrandom method, the findings were limited in their generalizability. Interviews were conducted only with the wives because it was anticipated that the health problems of many of the husbands would preclude an effective interviewing process. A more complete understanding of the quality of the marital relationship would have been obtained if both members of the marital dyad had been interviewed.

CHAPTER II

REVIEW OF THE LITERATURE

A variety of terms such as marital need satisfaction, marital satisfaction and marital adjustment in addition to marital success, companionship, and integration have been used in research studies concerned with assessing the marital relationship. These terms generally "represent qualitative dimensions and evaluations of the marital relationship" (Burr, 1979, p. 269). This chapter contains a review of studies which evaluated the quality of the marital relationship during the later years in addition to studies related to the possible influence of the wives' caregiving involvement, the dependent husbands' functional impairment, the dependent husbands' institutionalization, the quality of the wives' social support, the wives' health and the wives' socioeconomic status on the quality of the marital relationship during the later years. Whenever possible, this review has focused on findings of studies which relate to older married women.

The Quality of the Marital Relationship During the Later Years

This section contains a review of studies which evaluated the quality of the marital relationship during the later years of marriage. Included among these studies is one by Stinnett, Collins, and Montgomery (1970) in which the Marital Need Satisfaction Scale, used in this study, was developed.

Using the Marital Need Satisfaction Scale (MNS), Stinnett et al. (1970) sought to investigate satisfaction with the fulfillment of certain needs involved in the marital relationship of 227 older husbands and wives who had completed and returned a mailed questionnaire. The questionnaire had been mailed to 418 married couples whose names were obtained from senior center mailing lists throughout the state. Of these 60- through 89-year-old respondents, 51% were females and 49% were males. More than half had been married 40 to 49 years. Some indication of the group's socioeconomic status was revealed by the finding that the greatest proportion of the males (43%) had been in skilled, semi-skilled, and unskilled occupations for the major part of their working lives, while 38% had educational levels of less than high school and 20% had some high school.

The potential range of scores for the MNS scale was 24 to 120, with the highest scores indicating the most favorable perception of the marital relationship. Analysis of variance was used to test the relationship of the following variables to MNS: (a) sex, (b) self-perceived happiness of the marriage, (c) perceptions of whether the marriage had improved or worsened over time, (d) age, (e) occupation of males, (e) number of years married to the present mate, (f) geographic closeness to children, and (g) the perception of whether most marriages improve or worsen over time.

It was found that mean scores for males on the scale ($\bar{X}$ = 101.56) were significantly higher than those for the

females ($\bar{X}$ = 94.88, p = .01). A significant relationship was found between self-perceived happiness of the marriage and MNS scores (p = .001). Those respondents who rated their marriage as very happy (45%) received the most favorable MNS scores. The relationship between perceptions of whether the marriage had improved or worsened over time and MNS scores was also significant (p = .001) and those respondents who stated that their marriage had improved (53%) received the most favorable MNS scores. No significant relationship was found between the respondents' age, primary lifetime occupation of the males, number of years married to the present mate, geographic closeness to children, and perceptions of whether most marriages improve or worsen over time and MNS scores. The researchers also found a significant correlation between the respondents' morale (using the Pearson correlation coefficient to analyze scores for the Life Satisfaction Index-Z) and their MNS scores (p = .001).

The authors stated that the finding of lower MNS scores for the wives in the study may have resulted from the tendency of older wives to be more dependent on their husbands for emotional need fulfillment. This dependency may have fostered greater expectations and thus contributed to a greater awareness of the husbands' inability to fulfill these needs. The importance of the finding that the morale of these older adults was related to MNS was emphasized by the authors since it coincided with findings of earlier studies which were

cited (Barron, 1961; Havighurst & Albrecht, 1953; Kutner, 1956).

Some limitations of Stinnett et al.'s (1970) study include use of a nonrepresentative sample and the source of the sample (senior center mailing lists) since this precluded the participation of home-bound elderly in the study. It is possible that many of those who did not return questionnaires (240 out of 418 contacted) may have had unsuccessful marriages and did not respond for that reason. Additionally, no investigation of the relation of the respondents' state of health to MNS was made. This seems to be an unfortunate omission because the incidence of chronic health problems increases during old age and the health of both spouses may thus be an important variable in studies which investigate the quality of the marital relationship during the later years.

A later survey by Stinnett et al. (1972) investigated the perceptions of 408 older husbands and wives toward their marital relationship by means of a mailed questionnaire to those on senior center mailing lists. Of these predominantly white respondents, 51% were males and 49% were females. The age range for the entire sample was 69 through 89 years. The greatest proportion had less than a high school education (38%). The chief lifetime occupation for 40% of the respondents had been clerical-sales work and 13% had been farmers.

The largest proportion of the respondents appeared to be well satisfied with the quality of their marital relationship

since 45% perceived their marriage as very happy and 49% described it as happy. Perceptions of whether their own marriage had improved or worsened over time appeared to be somewhat divided since while 53% reported that their marriage relationship had improved over time, 40% stated it was just about the same. Judging by their ratings of the marital relationship at the present time, it appeared that most of those whose marriages remained the same had experienced satisfactory relationships throughout the marital career.

An investigation was made of the relation of the respondents' perceptions of their own marital happiness and whether their marriage had improved or worsened over time to morale (using the Life Satisfaction Index-Z). Analysis of the data by means of the chi square test revealed a significant relationship between morale and ratings of marital happiness ($p = .001$) and also between morale and ratings of an improved or worsened marriage ($p = .001$). These findings were consistent with those of Stinnett et al.'s earlier findings (1970). Included among the major problems which these respondents were experiencing were those related to housing (27.5%) which ranked first, poor health (21.2%), and money (20.0%).

The findings of this study indicated that most of these older husbands and wives were well satisfied with the quality of their marriage relationships and that poor health was one of the major problems which they were confronting. The sample

may however, have been biased toward those who were in good health since it was obtained from participants in senior center activities. Another limitation of the study was the use of a nonrepresentative sample.

A similar survey study by McKain (1972) focused on an attempt to evaluate the success of 100 remarriages during old age and to identify the factors which were associated with the success or failure of the marriages. All the spouses had been previously widowed and had then remarried five years before the study took place. At the time of these marriages all the males were at least 65 years old and the women 60 years and older. The authors attempted to secure a statewide random sample of all remarriages among older adults which had taken place five years before (a total of 269 met the specific criteria for age, prior marital status, and place of residence). Since five years had elapsed there was considerable attrition in the sample universe through death, migration, separation, divorce, and illness (a total of 150 couples). Nineteen couples also refused to participate in the study. The author noted that the ultimate sample of 100 couples may have been biased by the absence of a number of unsuccessful marriages.

Interviews were conducted with each couple and evaluations for the "success" of their marriage were based on (a) each respondent's subjective evaluation, (b) the presence or absence of a negative evaluation by one of the spouses (the marriage was then placed in the "doubtful" or "unsuccessful"

category), (c) responses to questions about the spouses' decision-making process, and (d) the interviewer's subjective impression of the marriage. Most of the marriages, based on these criteria, were reported to be successful, 6 were failures, and 20 were described as "mainly successful" but with remaining problems which had to be overcome. No tests for the significance of these findings were reported however.

The relation between life satisfaction (using Life Satisfaction Index scores) and marital success was also investigated. Fifty-seven respondents whose marriages were rated a success had the highest level of life satisfaction scores (21-25) while the scores of only four respondents whose marriages were rated unsuccessful were at this level.

One limitation of this study was that it used a nonrepresentative sample. In addition, the sample appeared to be biased toward successful marriages.

Others have also examined the relation between marital satisfaction and morale. Lee, for example, in a 1978 survey study investigated the effect of morale and other factors on the marital satisfaction of 258 married men and 181 married women (60 years of age and older) who responded to a 28-page mailed questionnaire. The sample was obtained by a two-stage sampling method in which 4,845 households randomly selected from the telephone directory were screened by mail in order to obtain a sample of older married adults. The questionnaire was then mailed to the 1,169 eligible respondents identified

by this method and 870 usable questionnaire were returned (response rate, 74.8%). The sample for which data were ultimately analyzed was considerably reduced because the researcher wanted to examine specific variables.

The hypotheses stated that the respondents' morale would be positively related to marital satisfaction and that this effect would be stronger for wives than for husbands. A 5-item scale with five response categories for each item was used to measure marital satisfaction. The potential range of scores was not reported, but the highest scores for the scale were said to correspond to the highest marital satisfaction. Mean scores for males were 21.7 and 21.0 for females. The effects of morale, age, length of marriage, education, health, and satisfaction with standard of living on marital satisfaction were analyzed by stepwise multiple regression. Bivariate correlations between all the variables were also analyzed using Pearson product-moment correlations.

Significant positive correlations were found between morale and marital satisfaction for males ($r = .38$, $p < .01$) and females ($r = .52$, $p < .01$) with a larger correlation for females. Thus both hypotheses were supported. A significant positive relationship was also found between morale and health ($p < .05$), and between morale and satisfaction with standard of living ($p < .01$) for the females. Marital satisfaction for females was also positively related to health

($p < .05$) and standard of living ($p < .01$). Multiple regression analysis showed that for females the principle explanatory variables for morale were marital satisfaction (52%), health (27%), satisfaction with standard of living (12%), and education (8%).

The finding of a stronger relationship between morale and marital satisfaction for the female respondents was interpreted as an apparent result of the more central role that marriage plays in the "social-life space" of older women, who are as a result more sensitive to the quality of their marital relationship. Men, on the other hand, are "more responsive to the simple presence of a spouse" (p. 137).

In conclusion, studies which have investigated the quality of the marital relationship during the later years generally point toward relatively high levels of satisfaction. Evidence of the significant relationship between morale and marital satisfaction as reported here coincide with the findings of earlier studies.

Caregiving Involvement and the Quality of the Marital Relationship

The following contains a review of research studies which relate to the impact of the older wives' caregiving involvement on their subjective perceptions of the quality of the marital relationship. These studies are concerned with attitudes of caregivers toward elderly dependents and

potential sources and consequences of stress-inducing burden associated with caregiving.

Some inferences can be made as to the effect of living with and caring for an older mentally impaired husband on a wife's marital satisfaction from the findings of a 1970 British study (Sainsbury & Grad de Alarcon) which used a random sample of 119 community-based older adults 65 years of age and older. The effects of the burden associated with caring for these patients, all of whom had a psychiatric illness, were assessed by data obtained from interviews with the closest family member in each home (no differentiation by kin relationship was presented).

When assessing the nature of the families' burden, it was found that 28% of the patients required at least some nursing care while 33% required constant care. Nearly half of the old people (44%) demanded what was perceived as "excessive attention and companionship." Sixty-three percent of the close family members who served as informants reported that they themselves had experienced emotional disturbances as a result of worry about the patient. Concern about the patient's behavior was an apparent source of neurotic symptoms (insomnia, headaches, irritability, depression) among approximately 33% of these close family members, while 50% reported restricted social and leisure activities and 36% had disrupted domestic routines. The authors concluded that home-based care of the mentally ill old person clearly takes a heavy physical, emotional, and social toll on families.

Personal interviews were conducted with a random sample of 200 primary caregiving relatives of sick and frail community-based older adults 65 years of age and older for a 1982 study (Horowitz & Dobroff). Eighteen of the caregivers were spouses, 130 were adult children and 52 were other relatives of the older adults. The amount of time devoted to caregiving and overall negative caregiving consequences were measured and analyzed in terms of the kin relationship of the caregiver to the dependent. The findings help to provide a better understanding of the impact of caregiving on the quality of the marital relationship.

An overall measure of the time commitment of caregivers, the Caregiving Involvement Scale (see Chapter III) was developed for this study. It was found that the extent of overall caregiving involvement significantly differed ($p < .001$) according to the kin relationship of the caregivers. Spouse caregivers were most committed and had mean scores of 31 (the potential range of scores was 0-46), while adult children (mean score, 23) and other relatives (mean score, 19) had decreasing levels of involvement. Spouses devoted the most time to caregiving--a minimum of 25 hours a week. Five spouses were actually involved 24 hours a day. The most important ways in which the spouses perceived that they were helping the dependents were emotionally (26%), providing services (36%), and in linkage with other service providers (10%). Fifteen percent of the spouses stated that all tasks were of equal importance.

The most difficult caregiving tasks for the spouses were emotional support (10%) and providing services (31%) such as general household help, personal care, meal preparation, transportation, errands, and financial management. Twenty-one percent stated that no caregiving task was difficult, while 5% found all the caregiving tasks difficult. A contradictory finding was that when asked to state the least difficult caregiving task, 21% of the spouses replied that all the tasks were difficult and that nothing was easy.

The Horowitz and Dobroff study (1982) also measured the degree of overall negative caregiving consequences (using the Caregiving Consequences Scale which was developed in that study) in terms of the kin relationship of the caregiver to the dependent. It was found that the extent of subjectively perceived caregiving consequences differed significantly ($p < .001$) by the relationship of the caregiver, with the highest mean scores representing the most negative consequences. The scores of caregiving relatives ($\bar{X} = 6.3$) indicated that they experienced the least negative caregiving impact which was interpreted as a result of less caregiving involvement and a less intensive kin relationship with the dependent. Caregiving adult children had slightly lower scores ($\bar{X} = 9.8$) than caregiving spouses ($\bar{X} = 10.8$). Sixty-eight percent of the spouses had experienced a "change for the worse" in their general emotional state compared to 52% of caregiving children and 32% of other relatives acting as caregivers. The wife of a stroke victim, for example, described her emotional

decline by saying: "'I don't like my life; I hate it; its changed so terribly. . . . I'm just existing'" (p. 196).

Evidence of deteriorating personal relationships between caregiving spouses and dependents was indicated by the finding that 26% of the spouses reported a change for the worse in how they got along with the dependent, compared to 18% for adult children and 4% for other relatives. Feelings of closeness toward the dependent worsened for 16% of the spouses but improved for 27% of those spouses engaged in caregiving; these feelings worsened for only 2% of caregiving relatives and improved for 41%.

Perceptions of some positive aspects of caregiving among these respondents were also investigated. Twenty-three of the spouses reported positive benefits and of these 70% mentioned one benefit and 5% mentioned two benefits. Only 8% of caregiving relatives reported no positive aspects, 60% reported one and 28% reported two. Benefits for all respondents (no differentiation by kin relationship was given) were primarily in the intrapersonal realm since 56% mentioned experiencing feelings of self-satisfaction in the caregiving relationship. The general findings of the study relating to caregiving consequences, according to the authors, suggested that those caregivers who had a more central past and present kin relationship with the sick and frail older adults (such as in the spousal relationship) had a greater felt responsibility for caregiving and experienced greater stress when performing as caregivers.

A 1978 survey (Teresi, Bennett, & Wilder) helps to provide some insight relating to the quality of the marital relationship of caregivers. This was revealed by the attitudes of 162 randomly selected "key supports" (half of whom were spouses) of home-based dependent and independent elderly. A "key support" was defined as the person whom the elder saw most frequently, turned to in times of trouble, and relied upon most in decision-making. It is quite possible that most of the spouses included among these key supports were caregivers. The general attitude of the key supports toward both the dependent and independent elders was measured by their agreement or disagreement with statements such as "(the elder) often makes people ill-at ease and is hard to be around for long periods of time," "most of the time (the elder) is a burden to family and friends," and "most of the time (the elder) is in good spirits and pleasant to be around." A significant relationship ($p < .001$) was found between attitude of the key support and dependency. For example, 35% of the dependents had key supports who viewed them in a negative manner compared to 13% of the independent elder who were viewed negatively.

The frequency of depression among the independent companions (65 years of age and older) of both dependent and independent older adults, was also compared, although no differentiation by kin status was provided. Depression was found to occur more frequently ($p < .05$) among the companions of those who were dependent.

Danis and Silverstone (1981) investigated the impact of caregiving on the morale of 418 women who functioned as caregivers for an elderly parent or spouse. Two hundred sixty-five were daughters of the dependents (mean age 57 years) and 153 were spouses (mean age 73 years). The entire group of caregivers was subdivided into five groups which consisted of those daughters who lived (1) alone with the parent; (2) with their husband and the parent; (3) with their husband, children, and the parent; and (4) with their children and the parent, in addition to (5) the caregiving spouses.

Analysis of variance revealed a significant difference ($p < .002$) between the five subgroups of women on mean scores for the Zung Depression Scale, with the spouse-caregivers receiving the highest mean scores ($\bar{X} = 1.62$). The findings suggested that the spouses and the group of daughters who lived alone with a dependent parent were most vulnerable to depression. No significant difference was found between the groups of women on the amount of care they provided, the difficulties they encountered in providing care, and the amount of in-home supportive services they received. A significant difference between the groups on the number of coping strategies which they employed ($p = .010$) was found however. The daughters in groups 2 and 3 were most likely to use expressive coping strategies such as crying or anger than either the spouses or the daughters in group 1 (who lived alone with the parent). The daughters in groups

2 and 3 were also most likely to voice negative sentiments about their elderly parent.

The authors' interpretation of these data was based on "triangulating" of problems which they found in the family therapy literature. In this process when stress is present between any two members of a family (such as that between caregivers and dependents), it is relieved by a third family member's diversion of uncomfortable or disturbing emotions. Thus, in the case of the caregiving spouses and the caregiving daughters who lived alone with the dependents there was no opportunity to triangulate or deflect stress-inducing negative emotions which frequently accompany the caregiving context.

In summary, none of the studies which were reviewed have directly investigated the impact of caregiving on the quality of the marital relationship. The studies did however provide a basis for identifying some of the factors inherent in the situational context of caregiving wives which may influence the quality of the marital relationship. The sources of stress stemmed mainly from performance of instrumental and expressive caregiving functions, and the subsequent restriction of social life and disruption of domestic routines. Indications of the frequent occurrence of low morale among caregivers appears to have some bearing on the quality of the marital relationship since studies discussed earlier in this chapter (Lee, 1978; McKain, 1972; Stinnett et al., 1970, 1972) found a relationship between morale and the quality of the marital relationship.

Functional Impairment and the Quality of the Marital Relationship

This section contains a review of studies which help to provide a better understanding of the possible impact of the dependent spouses' functional impairment on the wives' perceptions of their marital relationship. The studies refer to various types and degrees of functional impairment and the accompanying behavioral manifestations and also to the attitudes and responses of both caregiving and noncaregiving wives who cope with their spouses' functional impairment.

The findings from a study by York and Caslyn (1974) furnish a basis for assessing the possible influence of the institutionalized spouses' functional impairmment on the quality of the marital relationship. The purpose of the study was to investigate some of the factors affecting family involvement in nursing homes. Personal interviews were conducted with 76 family members of geriatric patients in three area nursing homes. The sample was a subset of a larger random sample of 116 which had been depleted due to death and other causes. Sixty-four of the family members interviewed were adult children of the patients and the remaining 12 were spouses and other relatives. The mean age of the patients was 81 years and 80% were females. Since public funds were used to provide care for 60 of these patients it can be assumed that this part of the group had a low economic status.

An assessment was made of each patient's behavioral and psychological functioning using the Behavior of Older Patients' Checklist (BOP) and of the patient's level of physical functioning by means of the Physical Capabilities Checklist (PCC). Family visiting patterns were also investigated. It was found that the number of family visits (an average of 12 per month) was unrelated to the amount of the patient's impairment, thus suggesting that family members maintained close ties despite advanced physical or mental deterioration of their aged relative.

A much more significant and problematic issue raised by the findings concerned the quality and enjoyment of these visits by the family. For example, 42% of the families stated that they enjoyed less than half their visits. Enjoyment of visits was unrelated to physical or sensory disabilities but a significant inverse relationship was found between the enjoyment of visits and scores for the PCC self-care disability scale ($p < .05$), impaired cognitive functioning ($p < .05$), and the BOP poor personal appearance scale ($p < .01$). These findings, according to the authors, suggested that the families of those institutionalized older adults who were disheveled and/or confused had less enjoyable visits. Surprisingly, although 30% of these family members reported having the most difficulty in coping with their relatives' mood disturbances (such as social isolation, depression, physical hostility and verbal hostility), this type of behavior was unrelated to the quality and enjoyment of their visits.

The findings of a 1970 study (Sainsbury & Grad de Alarcon) which was previously discussed in this chapter are related to the impact of the behavior of mentally impaired dependent spouses on the quality of the marital relationship of care-giving spouses. When the closest relatives of 119 community-based geriatric patients with various types of psychiatric illnesses were interviewed, the types of behavior considered most worrisome included (a) the patient's being a danger to himself (48%), (b) odd behavior or expressing peculiar ideas (43%), (c) constant restlessness or overtalkativeness during the day (42%), (d) troublesomeness at night (40%), (e) uncooperative and contrary behavior (39%), and (f) hypochondriacal complaints (29%).

The amount of burden experienced by family members was independent of any specific diagnosis. Five behavioral symptoms of these geriatric patients were found, however, to be significantly related to severe burden of the closest family member. These symptoms included aggression, delusions, hallucinations, confusion, and the patient's inability to care for himself (no supportive statistical data were reported). The authors suggested that family members experienced the least negative impact from a patient with neurotic and depressive symptoms, while the demented, bedfast patient interfered drastically with the family's home life.

A survey study by Zarit, Reeves, and Bach-Peterson (1980) is related to the possible impact of dependent spouses' physical and/or mental impairment on the quality of the

caregivers' marital relationship. Personal interviews were conducted with a nonrepresentative sample of 29 primary caregivers (18 spouses and 11 daughters whose ages ranged from 42-82 years) of senile dementia patients whose mean age was 76 years. All but four of the caregivers were women.

The purpose of the study was to measure the caregivers' feelings of burden and to then examine its association with the patient's behavioral variables, duration of the illness and number of visits to the home by other family members. The degree of the caregivers' burden was measured by a 29-item Likert-type scale. The items referred to problems associated with caregiver-dependent relations. Some examples of statements relevant to the marital relationship were: "I wish that my spouse and I had a better relationship," and "I feel nervous or depressed about my interaction with my spouse," and "I feel that my spouse doesn't appreciate what I do for him/her as much as I would like."

The dependents' level of cognitive impairment was measured by the Kahn Mental Status Questionnaire, the Face-Hand Test and by Jacob's 30-item status test. The type and frequency of memory and behavior problems was determined by the 16-item Memory and Behavior Problems Checklist, and Lawton's Physical and Instrumental Activity of Daily Living scales measured functional ability. Analysis of the scores for these tests revealed that the patients had considerable cognitive and behavioral impairment in addition to major deficits in mental status. When instrumental activities of daily living were

measured, two-thirds needed some help, but for activities such as eating, walking, and toileting most were independent.

Contrary to the authors' expectations the levels of reported burden experienced by caregivers were relatively low in view of the fact that the dependents were not mildly impaired or in the early stages of senile dementia. The potential range of scores on the burden interview was 1 through 66 and a mean score of 31 was reported. The authors' expectation that behavior and impairment variables would be correlated with the level of burden was also not supported. Additionally, no significant relationship was found between duration of the patients' illness and burden. Perhaps the most significant finding of this study was that burden was found to be inversely related to the number of visits by family members to the household ($r = -.48$, $p < .05$). The authors noted that previous research studies had found specific behaviors of dependents very troublesome, but the frequency of what would be considered problem behaviors in this sample did not contribute to feelings of burden.

Some limitations of this study are that it used a relatively small nonrepresentative sample of caregivers and that the dependents all had the same diagnosis. Additionally, no information about the reliability and validity of the measure used to rate the caregivers' level of burden was supplied. The authors suggested that although the sample was not representative of all families caring for those with senile

dementia, the problems faced by these caregivers encompassed a wide range of severity and duration of illness.

In summary, the findings of studies relative to functional impairment suggest that certain behavioral manifestations of impaired older adults may have a negative impact on the spousal relationship. This negative impact, however, may be mediated by the support provided by other family members.

Institutionalization and the Quality of the Marital Relationship

This section contains a review of some studies which are germane to the quality of the marital relationship among those wives whose dependent husbands have been institutionalized. These studies do not, however, directly assess the quality of these marital relationships.

The 1974 study by York and Caslyn (previously described in this chapter) investigated the frequency and quality of interaction of family members with their institutionalized elderly relatives. The family members who were interviewed generally maintained their involvement with their aged relative (no differentiation by kin status for data analysis was given) by visiting the nursing home a mean number of 12 times a month. Evidence that family members continued to maintain preinstitutional patterns of involvement was concluded from the observation of a significant relationship between the number of nursing home visits and preplacement telephone contacts ($p < .01$). A substantial proportion of these family

members (42%) did report, however, that they enjoyed less than half their visits. The quality of these visits was unrelated to the type of interaction during the visit (such as talking or participating in activities). One of the major problems related to visiting cited by the family members was that there was so little to do. For example, many visitors simply sat and stared at the patient.

Some positive consequences of long-term institutional care of the elderly were revealed by a 1979 study (Smith & Bengston) whose main purposes were to discover how an elderly parent's nursing home placement affected the child-parent relationship and to identify factors within the nursing home setting which influenced that relationship. Open-ended interviews were conducted over a period of two years with 100 elderly residents (age range 70-92 years) of a 195-bed nursing home and with that adult child (age range 50-71 years) most involved with each resident at the time of placement. The residents of the home were predominantly middle class.

Six types of family relationships following institutionalization were identified. Five were derived from the interviews while the sixth type represented one not encountered in the study but one with which the authors had previous clinical experience. The percentage of family units falling within each category was approximate because in some cases illness of the resident precluded obtaining accurate interview data and so only the adult child was interviewed.

The first type of family relationship for 30% of these respondents was characterized as one having "renewed closeness and strengthened family ties." While a history of affection, respect, frequent contact, and feeling of closeness was suggested between many of the parents and an adult child, these bonds had been seriously strained by the trauma associated with caregiving. Having delegated 24-hour-a-day instrumental tasks of caregiving to the institution, the children felt more free to concentrate on providing the psychosocial and emotional aspects of care and this resulted in strengthened relationships.

The "discovery of new love and affection" was the second category and typified the relationship for 15% of these respondents. The prior parent-adult child relationship among these cases had been based on duty and obligation with an apparent absence of love and affection. Since the nursing home now performed the technical caregiving tasks, interaction was "based on the child wanting to see, to talk, to do for the parent" (p. 441).

The third type of family relationship was described as "continuation of closeness" and included 25% of the respondents. Institutionalization of the parent, for this group, provided a way in which both parent and child could remain independent of one another and still maintain a close personal relationship. Approximately 20% of the respondents were placed in the category described as "continuation of separateness."

The prior relationship had featured little meaningful involvement, and this pattern was continued during the parent's institutionalization. One adult child, for example, reported that while she regularly visited her mother, their time together was not enjoyable and consequently the visits were brief.

"Quantity without quality" best described the fifth type of relationship for 10% of the respondents. While in the past there had been frequent contacts and involvement, unexpressed negative feelings between the parent and child had also been present, and although the child paid frequent visits to the nursing home, neither party enjoyed the time spent together. One way of coping with this situation (employed by both parents and children) was in displacement of anger toward the staff of the nursing home and "negative interactions thus became three-fold among parent, child, and staff members" (p. 443).

No examples among these respondents were found of the sixth type of relationship:"abdication, or using the institution as a dumping ground." The authors noted however that the respondents in some applicable cases may have failed to admit this occurrence or may have been among those unavailable for an interview.

The findings of this study indicated that the main reason for strengthened family relationships among a substantial segment of these respondents after the parents'

institutionalization was alleviation of preadmission strain which stemmed from dealing with the aged parents' multiple problems. Other factors cited were the parents' improved physical and/or mental condition after placement and their development of new social relationships with other residents of the facility. When less meaningful family relationships were reported, it appeared that long-established patterns of familial interaction continued during the parents' institutionalization.

A caveat with regard to the findings of this study was expressed by these authors stemming from the fact that the nursing home in which the inverviews were conducted appeared to offer an optimal level of care and other services and most of the respondents were well satisfied with the facility. This particular home also actively encouraged family involvement in the nontechnical aspects of caregiving and made visitors feel welcome and comfortable. Thus, the authors pointed out, the effects of institutionalization on the family relationship within another less desirable institutional context may have been less positive.

The findings of the preceding studies, although indirectly related to the quality of the marital relationship, point toward a maintenance and in some cases a strengthening of family relationships when an aged relative is institutionalized. There were also indications that an important contributing factor to strengthened relationships is the assumption of

technical caregiving tasks by the institution which allows the family members to concentrate on expressive interaction with their aged relatives.

Social Support and the Quality of the Marital Relationship

The following studies are related to the influence of social support on the quality of the marital relationships of the wives in this proposed study. Social support of the wives encompasses the quality of the help they receive from both formal and informal sources.

A 1981 descriptive study (Crossman, London, & Barry) reported on the positive consequences of a peer support group, overnight respite care, and home health care among a group of elderly caregiving wives with disabled husbands. All of the couples' incomes were just above the eligibility level for publicly subsidized services. The disabled husbands, most of whom were described as "brain injured," were participants in a geriatric day care program.

The positive consequences of the support received by the wives from their membership in the peer support group included having the opportunity to share common experiences, to explore alternative methods of coping with their husbands' illness and to participate in group problem solving which related to the technical aspects of their caregiving function. Another source of help for these wives was a nurse who helped them in the home with caregiving. The nurse (who visited each

couple for four hours a week) provided more than instrumental assistance since she also served as a much-needed confidante for these women and gave them emotional support.

Positive outcomes were also reported for a "respite care" program during which the disabled husbands were looked after by nurses at the geriatric day care center for periods varying from 24 hours to four full days. The main benefit of this support service reported by the wives was that they were given the opportunity to be away from the "intense interaction and stresses which were inherent in their relationship" (p. 469) with their disabled spouses. A graphic example of the need for and value of these respite services was in the finding that for some caregiving wives it had been three years since they had a vacation, and 12 years for one wife.

Zarit et al. in a 1980 study (described earlier in this chapter) examined the relation of caregivers' feeling of burden to one source of social support--visits from family members. The authors had expected that feelings of burden would be related to the extent and degree of the dependent's behavioral impairment and that the levels of burden experienced by caregivers would be relatively high. These expectations were not confirmed.

The potential range of scores for levels of burden was 1-66, and the mean scores for caregivers fell in the middle range (mean of 31). Visits to the caregiving household by family members were measured quantitatively and no information was gathered about the quality of the visits or

the type of interaction which took place. Adult children visited most often (50 times a month), while grandchildren (2.9 times a month), and siblings (1.3 times a month) visited less frequently.

The frequency of visits by family members was the only factor found to have a significant association with these caregivers' feelings of burden ($r = -.48$, $p < .01$). Thus, caregivers who received more visits from family members reported feeling less burdened. It would appear that visits from family members could provide caregiving wives with not only emotional support but also instrumental aid (although this was not investigated by the authors) and such support could in turn tend to lessen the possible negative effect of caregiving on the marital relationship.

In summary, the literature suggests some positive consequences of the social support received by caregiving wives from formal sources such as peer support groups, overnight respite care and home-health care nurses and from informal sources, exemplified by visits to the household by family members. The data suggest that both types of support may help to optimize the quality of the marital relationship of caregiving wives.

Health and the Quality of the Marital Relationship

This section contains a review of some studies whose findings relate to the influence of older wives' health on the quality of the marital relationship in the proposed

study. All of the studies have used samples of older married adults.

The relationship of health and marital satisfaction among older adults was indicated by a 1977 study (Gilford & Bengston) in which a secondary analysis was performed on data from an earlier probability study by Bengston (1975). A mailed questionnaire was completed by 2,059 respondents. The sample for the 1977 study consisted of 320 married older adults who were categorized as "young old" (age 55-62), "old" (age 63-39), and "old-old" (age 70-90). These respondents were primarily Caucasion with a higher than average education and income.

An evaluation of the respondents' marital satisfaction was made on two general dimensions which referred to positive companionship experiences with a spouse (positive interaction) and to negative feelings from interaction (negative sentiment). The results of stepwise multiple regression analysis indicated a significant relationship between health and the positive interaction dimension of marital satisfaction ($p = .01$) for only the young-old group. No significant relationship was found between health and negative sentiment for any of the three age groups.

A study by Stinnett et al. (1972) which was previously described in this chapter, investigated older adults' perceptions of their marriages. A sample of 408 husbands and wives whose ages ranged from 60 to 89 years was used. While the greatest proportion of these respondents rated their

marriages as very happy (45.4%) or happy (49.5%), 21% reported that poor health was one of the major problems of the present period of their life. No statistical analysis was performed however, to assess the relationship of the state of health of one or both of the spouses to global ratings of satisfaction with marriage.

An earlier (1969) descriptive report of a study by McKain (which was also reported in 1972 and has been discussed earlier in this chapter) referred to the influence of health on the marital relationship. He noted that the health of one-fifth of the elderly spouses had deteriorated during the five years which had elapsed since their remarriages had taken place, and that this occurrence had lowered their chances for a successful marriage. It was found for example that the rate of marital success for those women who had experienced no signs of declining health was 86%, for those with worse health it was 67%, and 58% for those women whose health was definitely poorer. These findings suggested a positive relationship between state of health and marital success, although the findings are not generalizable because of the nonrepresentative sampling procedure.

A study by Lee (1978), previously described, found a significant positive correlation between the self-perceived health of 181 older married female respondents and marital satisfaction. Scores for self-reported health were measured on a 5-point scale with mean scores of 3.8 reported. The

potential range of scores was not supplied.

In summary, available studies have generally suggested that the perceived state of health is positively related to the quality of the marital relationship during old age. This relationship appears to be of particular importance since the incidence of chronic illness tends to increase during the later years of life.

Socioeconomic Status and the Quality of the Marital Relationship

The following studies are related to the association of the quality of the marital relationship and certain aspects of socioeconomic status during the later years of marriage. The respondents in these studies were older adults.

The 1970 study by Stinnett et al. which has been discussed earlier in this chapter investigated the relationship between marital need satisfaction and the occupation of males during the major part of their working lives among a sample of 227 older married adults. No significant association was found between occupation and marital need satisfaction.

Atchley (1979) cited a 1974 study by Veroff and Feld in which it was found that those older married women with the least amount of education were most likely to feel that their marriage was good. This particular finding was used to illustrate one problem in evaluating the quality of the marital relationship by self-report methods, since respondents are most likely to evaluate the marriage as satisfactory when they have few other options.

The findings of Lee's 1978 study are also related to the possible impact of socioeconomic status on the quality of the marital relationship. Lee found a significant positive correlation between the perceived marital satisfaction of a group of married women (60 years and older) and satisfaction with their standard of living ($p < .01$).

The findings of these studies lead to the conclusion that the relation between socioeconomic status and the quality of the marital relation during old age is unclear. Contributing factors to this lack of clarity include the use of different methods to evaluate both socioeconomic status and the quality of the marital relationship.

Summary

This review of the literature concerned the quality of the marital relationship during the later years in addition to the possible impact of a number of factors on that relationship. An attempt was made wherever possible to focus on studies which specifically related to older married women.

The findings of these studies pointed toward moderate to relatively high levels of marital satisfaction during the later years although these findings must be accepted with caution due to methodological problems such as sampling procedures and the failure to assess the impact of important variables. There were indications that caregiving activities may have a negative impact on the marital relations of

spouse-caregivers and that the dependent husbands' functional impairment can in some instances negatively affect the marital relationship of both caregiving and noncaregiving spouses.

Indirect evidence was also found that family relations may be strengthened or at least maintained at the previous level when a dependent spouse is institutionalized. Some positive influences of both formal and informal support services to caregiving spouses were also identified. This review also revealed an indication that the health of older wives was associated with the quality of the marital relationship, while the association between the marital relationship and socio-economic status was unclear.

CHAPTER III

PROCEDURE

The primary purpose of this research was to investigate the influence of caregiving on the marital need satisfaction (MNS) of older women with dependent husbands by comparing the marital need satisfaction of caregiving women with that of women whose dependent husbands were institutionalized. The relative influence of five factors on MNS, namely, (a) the level of husbands' functional impairment, (b) the quality of the wives' social support, (c) the wives' health, (d) the wives' socioeconomic status, and (e) the extent of the wives' caregiving involvement were investigated in addition to the interrelations between these factors.

Design of the Research

These research aims were accomplished by means of a survey study using a "community" and "institutional" version of a structured questionnaire (see Appendix A) with which 63 older women (all of whom were aged 60 and above) with dependent husbands were interviewed. Part of the group of women were primary caregivers to their home-based husbands, while the remainder had institutionalized husbands. The questionnaire contained items included for the purpose of measuring the dependent variable and the independent variables. Additional items, intended for screening, and to

provide a descriptive profile of the sample, were also incorporated in the questionnaire.

Four multiple regression models were constructed to test the hypotheses. The first model was used to determine the influence of the independent variables on the MNS of the caregiving and noncaregiving wives. The second, third, and fourth models were used to determine the influence of three different independent variables on the MNS of only the caregiving wives. A more complete description of these models will be found later.

A nonprobability quota method of sample selection (Buhler, 1967) was employed and therefore those women included in the sample possessed characteristics relevant to the research hypotheses of this study. The sample consisted of a group of 63 married women all of whom were (a) aged 60 and above, (b) residents of Guilford County, (c) capable of maintaining an independent existence in their homes, and (d) wives of men who were dependent. Thirty-three of the wives were functioning as primary caregivers to their dependent husbands who were institutionalized.

A preliminary investigation of possible sample sources was conducted. This was accomplished by interviews with individuals possessing a professional and working knowledge of the Guilford county geriatric population. Included among this group of qualified informants were an outreach director for an aging agency, a group coordinator for an Alzheimer's family support group, public health nurses, social workers,

nursing home administrators, ministers, and church visitors to the homebound. As a result of this investigation it was concluded that the required sample size could be obtained with the cooperation of these informants.

The sample selection was accomplished by assembling from qualified informants an initial pool of names and addresses of approximately 45 caregiving wives who possessed characteristics relative to the research hypotheses listed earlier. The presence of these characteristics, together with a representation of varying levels of the independent variables (functional impairment, social support, health, socioeconomic status, caregiving involvement) among these sample cases, was established by consultation with qualified informants. A second pool of names and addresses of wives with institutionalized husbands whose characteristics (relative to the research hypotheses and independent variables) generally corresponded to those of the initial pool was assembled in the same manner.

The potential respondents were each contacted by a method stipulated by the informants and specific cooperating agencies. That is to say, about half of the respondents were first contacted by a single mailing which included a letter from the informant, an introductory letter from the researcher, and a stamped return postcard (see Appendix B). The signed postcard (giving the respondent's permission to be interviewed) was then returned to the researcher or

to the informant who then provided the researcher with the respondent's name and telephone number. Other informants requested that the researcher contact the potential respondent by phone and solicit the respondent's permission to be interviewed. Each respondent was provided with an introductory letter from the interviewer, and each one also signed an agreement to participate in the study prior to the interview process. The approximate overall refusal rate was 20%.

The majority of interviews with caregivers (81.8%) took place within the respondents' homes, while the remainder were interviewed at their work site or local restaurants. Interviews with noncaregivers were also conducted primarily in their homes (83.3%). Others took place at nursing homes (10.0%) and the remainder at the respondents' work site and a local restaurant. The institutionalized spouses had been placed among 12 different nursing homes within Guilford County.

Description of the Sample

Caregivers

The ages of the 33 caregiving wives ranged from 61 to 84 years (M = 69.2), while wives of the dependent husbands were from 46 to 91 years old (M = 74.6). The racial composition of the group was 78.8% white and 21.2% black. The majority lived in single family dwellings (81.8%), some in condominiums (6.1%),

and others in apartments (6.1%). This group was primarily urban dwelling (72.7%), while 12.1% lived in a rural area and 12.1% in the suburbs. The condition of 81.8% of the dwellings was sound, and 15.2% were deteriorating. (The above data for type of dwelling, area,of residence, and condition of dwelling were unknown for some respondents due to the conditions of the interview.)

Noncaregivers

The age range of the 30 noncaregiving wives was 60 to 85 (M = 72.5) and their husbands ranged in age from 60 to 97 years (M = 76.0). The racial composition of this group was primarily white (83.3%), and the rest (16.7%) were black. Most of the group lived in single family dwellings (73.3%), while others (6.7%) lived in condominiums and apartments (6.7%). Their area of residence was mainly urban (90.0%), while smaller proportions lived in rural (3.3%) and suburban (3.3%) areas. For 73.3% the condition of their dwellings was sound, and 6.7% lived in deteriorating homes. (The above data for type of dwelling, area of residence, and condition of dwelling were unknown for some respondents due to the conditions of the interview.)

Design of the Research Instrument

The following section contains three subsections which describe the pretesting of the instrument and the items contained in the interview schedule. Included in the

first subsection are those items used to measure the dependent and independent variables, while the second describes items included for purposes of screening and providing a descriptive profile of the sample.

Description and Measurement of the Variables

Marital need satisfaction (MNS). The dependent variable was measured by the Likert-type Marital Need Satisfaction Scale (Stinnett et al., 1970). Needs included the areas of love, personality fulfillment, respect, communication, finding meanings in life and integration of past life experiences, with each need category represented by four items.

The four response categories for each item in the MNS scale consisted of "very satisfied," "satisfied," "unsatisfied," and "very unsatisfied." Score responses were coded 1 through 4 respectively, with the highest score indicating the most favorable response and the remaining scores corresponding to decreasing levels of MNS. The item wording and direction of response categories used in the pretest instrument were retained. The potential range of scores was 24 to 96.

The 24-item MNS scale was developed by Stinnett et al. for a 1970 study which used a sample of 227 older husbands and wives whose ages ranged from 60 to 89 years. The first four marital needs used in that study were derived from a factor analysis of Stinnett's Marital Competence Scale (cited in

Stinnett et al., 1970), and the last two were derived from the literature. Convergent reliability was observed by the authors through the finding that those respondents who perceived their marriages as "very happy" and "improving over time" scored significantly higher ($p = .001$) on the scale. Internal consistency was indicated by the observation that each item significantly differentiated ($p = .001$) between those respondents who scored in the upper quartile and those in the lower quartile. A split-half reliability coefficient of .99 was obtained using the Spearman Brown Correlation Formula.

The scale was pretested for the present study using a modified version of the original instrument. One modification concerned reversing the direction of one-half of the response categories (in the original version all were in the same direction) in an attempt to reduce "response set." The wording of each statement was also slightly revised for more appropriate application to the personal interview method of administration and to interviewing only female respondents. Stinnett et al's (1970) five original response categories (which included an "undecided" category) were retained for pretesting.

Pretesting of the scale took place over a period of three days during daytime arts and crafts classes at a local technical institute. The seven classes, from which the sample was obtained, were preselected with the help of the Director of Education because they each contained a large proportion of older women.

All of the married women in each class were asked by the investigator to participate in a confidential study which concerned marital relationships. No specific chronological age requirement for participation was given in order to avoid response bias. Two elderly women and three young adult women refused to participate. A total of 64 questionnaires which contained the 24 MNS Scale items were circulated and then self-administered by 30 women aged 20 through 59 and 34 women aged 60 and above. The 34 returned questionnaires of only the older women were analyzed, and of these, 4 were discarded because responses had not been made to more than 2 items.

The ages of the 30 older women whose completed questionnaires were statistically analyzed ranged from 60 to 73 years with a mean age of 65.2. An indication of the scale's reliability was found through the use of Cronbach's alpha test for internal consistency (.92). Examination of individual item scores for each respondent revealed that the respondents had frequently (an average of three times for each respondent) avoided giving an objective response by resorting to the use of the "Undecided" category. In order to obtain a more accurate assessment of MNS scores this category was eliminated from the present study.

High reliability of the MNS scale was supported by data from the present study which showed the scale to have a Cronbach's alpha of .94 for the caregivers ($\underline{n}$ = 33) and .89 for

noncaregivers (n = 30). The alpha level for the combined group (N = 63) was .94.

Functional impairment. This independent variable was measured by a reduced 22-item version of the Geriatric Rating Scale (GRS) by Plutchik, Conte, Lieberman, Bakur, Grossman, and Lehrman (1970) with the respondents functioning as observer-raters. This version was derived from a 1977 factor analytic study (Smith, Bright, & McCloskey) of GRS scores.

Statements in the GRS for the present study were modified to the extent that the words "your husband" were substituted for "patient" and those referring to an institutional context were made applicable to a home-based context for interviews with caregiving wives. In addition, two potentially embarrassing items were eliminated. The scoring scheme for the rating category indicating no impairment was 0, while a moderate level of impairment was assigned a score of 1 and a maximum level of impairment was scored 2. The potential range of total scores was 0-44.

The GRS is an observer-rating scale and was developed in a 1970 study (Plutchik et al.) which used a sample of 207 geriatric hospital patients. Statistically significant evidence of its predictive validity was obtained by the finding that it discriminates between mean scores of hospitalized geriatric patients and hospitalized nongeriatric patients ($p < .001$). A correlation of .86 was reported between

psychiatric ratings and GRS scores, indicating convergent validity. The GRS has been adopted for use by the Psychopharmacology Research Branch of the NIMH (according to Smith et al., 1977) and used in a 1974 validation study (Miller & Parachek).

Some criticism of the GRS has been observed. Smith et al. (1977), for example, contended that a major disadvantage of the GRS lay in the fact that it yielded only a total score as a measure of physical and social functioning, thus making it impossible to differentiate specific areas of functioning for clinical and research purposes. Their 1977 factor analytic study of GRS scores used a sample of 370 geriatric patients and yielded three high-loading factors among 24 of the original 28 GRS items. Three specific areas of functional impairment were identified and labeled: (a) Deficits in Activities of Daily Living, (b) Withdrawal/Apathy, and (c) Antisocial Disruptive Behavior. The means for the total scores were 20.8 and 12.2, 1.6, 3.6 for the three factors in the above listed order. The range of total scores was 1-49 and 0-22, 0-11, 0-14 for each of the factors. Internal consistency of the factors was indicated by the finding that the alpha coefficients for each were .90, .75, and .78. A test-retest one year later yielded a reliability coefficient of .63 for the total scores and coefficients of .65, .32, and .63 for the factors.

Several studies report results from use of the GRS. A significant difference ($p < .01$) was found by Smith et al. (1977) between the scores of males and females for the factors Antisocial Disruptive Behavior and Deficits in Activities of Daily Living. This was in contrast to Plutchik et al.'s (1970) earlier finding of no significant difference between males and females using total GRS scores. The difference between the findings of the two studies was interpreted by Smith et al. (1977) as resulting from a "masking" of differences by the use of total GRS scores since "GRS total scores are weighted in terms of the Withdrawal/Apathy factor" (p. 61). George and Bearon (1980) have also stated that although the GRS can be scored by using total scores to indicate an overall measure of impairment or by factor-specific scores, the later method is probably more sensitive. Since the validity and reliability of the revised GRS using total scores has been established (Smith et al., 1977) total functional impairment scores were used to test the hypotheses for this present study.

Social support. The quality of the wives' social support was measured by a single global item derived from Zarit, Gatz, and Zarit (1981). Each respondent was asked: "With regard to the help you are receiving from various sources such as family, neighbors, friends, and ministers, doctors, home-health aides, counselors and so forth--which of the following statements best reflects your current

situation overall?" The four forced-choice responses included (a) I feel overwhelmed and don't know where to turn, (b) I know I could get more help but don't know how to ask, (c) I'm getting some help but could use more, and (d) I'm able to get most of the help I need. The four response categories were coded 1, 2, 3, and 4, respectively.

Justification for the choice of the social support measure came from its use in a 1981 study (Zarit et al.) in which personal interviews were conducted with 22 husbands and wives who functioned as primary caregivers to their spouses, all of whom had senile dementia. These authors were attempting to replicate an earlier study (Zarit, Reever, & Bach-Peterson, 1980) in which a significant inverse relationship ($p < .05$) between caregiver's subjective feelings of "burden" and available social supports was found. In the later study it was found that the best predictor of burden was the quality of social supports.

Health. Health was measured by a single global item in which the following question was posed to each respondent: "How would you rate your health at the present time?" (Maddox & Douglass, 1973). Four forced-choice response options included "excellent," "good," "fair," and "poor." The coding for this self-rating scale consisted of a score of 1 assigned to the lowest subjective health rating and a score of 4 assigned to the highest rating. Other scores fell accordingly.

The utility of using self-rated reports of health in psychosocial studies of older adults has been noted by several authors (George & Bearon, 1980; LaRue, Bank, Jarvik, & Hetland, 1979; Maddox & Douglass, 1973). This stemmed at least in part from the fact that it is often impossible to obtain objective measures of health outside a laboratory setting.

Tissue (1972) interviewed 265 Old Age Assistance recipients who lived in noninstitutional settings and repeated the interviews the following year. An indication of the validity of subjective health ratings was that scores for the first interview significantly correlated with scores for a "functional health index" ($p < .001$) and "number of health problems" ($p < .001$). The first-year ratings of overall health also showed a high degree of association with those of the second year ($p < .001$) which suggested the reliability of the measure. The validity of a self-rating health assessment was also indicated by a 1970 study (LaRue et al.) in which it was found that physicians' ratings based on medical examinations were significantly correlated ($p < .01$) with older respondents' own health ratings.

Socioeconomic status (SES). This variable was measured by Hollingshead's Two-Factor Index of Social Position (cited in Bonjean, Hill, & McLemore, 1967). Respondents were asked to state (a) their husbands' primary lifetime occupation (1 of 7 rank-ordered categories), and (b) their

husbands' level of education (1 of 7 rank-ordered categories). A score ranging from 1 through 7 was then assigned to each respondent for each of the two groups which corresponded to the husband's educational and occupational rank. The occupational score was multipled by 7 and the educational score by 4. The sum of these scores was then used as a basis for placing each respondent in 1 of 5 social class categories, with the lowest scores corresponding to the highest social classes. Coding for these classes was 1 for Class I (scores ranging from 11-17), 2 for Class II (scores ranging from 18-31), 3 for Class III (scores ranging from 32-47), 4 for Class IV (scores ranging from 48-63) and 5 for Class V (scores ranging from 64-77).

Hollingshead's index was used to estimate the respondents' position in the social status hierarchy based on their husbands' educational and occupational attainment since there is evidence that preretirement status attainment factors continue to influence income during old age. For example, a 1976 study (Henretta & Campbell) utilized combined data of the 1962 Occupational Changes in a Generation Survey and the NORC General Social Survey (1973, 1974, 1975) to perform a cohort analysis on the relation of status variables to income during pre- and postretirement years. These authors concluded that "within a cohort, the disruption in sources and amounts of income resulting from retirement of the majority of its members leaves the relation of status variables to income almost untouched" (p. 990).

Caregiving involvement. The 12-item Caregiving Involvement Scale (CIS) by Horowitz and Dobrof (1982) was used to measure the caregiving involvement of the wives whose husbands were home-based and those whose husbands were institutionalized. The scale measured (a) the frequency of contact with the dependent, (b) the amount of time consumed in providing help in a broad range of service areas (transportation, homemaking, cooking, shopping, personal care, health care, financial management, linkage with other service providers), and determined (c) if financial support and emotional support was provided. The first two contact items were each measured by a 7-point scale (0-6), the eight service items were each measured by a 5-point scale (0-4), and the two financial and support items were measured by a 2-point scale (0-1). The scoring scheme for the rating categories of each of the 12 items consisted of a score of 0 denoting no support or assistance and increasingly higher scores corresponding to increasingly higher levels of support or assistance. The potential range of total scores was 0 to 46.

The CIS was developed in a study for which in-depth structured interviews were conducted with 203 individuals who functioned as primary caregivers to frail elderly residents of New York City (Horowitz & Dobrof, 1982). Nine percent of the respondents were spouses with a mean age of 71.4 and they devoted the most time to caregiving responsibilities (a minimum of 35 hours per week). Five spouses reported

spending a mean of 108 hours a week compared to adult children who spent an average of 18 hours a week devoted to caregiving responsibilities. The observed range of total scores was 3 to 43. An internal consistency reliability coefficient of .82 using Cronbach's alpha was obtained. Interviewers' global ratings of "caregiving involvement" were used for a determination of the scale's convergent validity coefficient (.77).

Institutionalized/noninstitutionalized status. This dichotomous independent variable was assigned by the investigator to differentiate those wives with primary caregiving responsibilities in the home and those noncaregiving wives with institutionalized husbands. Since this caregiving status variable consisted of categorical data, it was treated as a "dummy variable" in the statistical analysis and coded "0" for institutionalized and "1" for noninstitutionalized.

Pretesting the Instrument

The instrument was pretested on three respondents, all of whom were caregivers. Pretesting revealed that no problems were encountered in the interpretation of items and that respondents were cooperative during the interview process. As a result, no significant changes were made in the instrument.

Supplementary Questionnaire Items

This section contains a description of the general content of items which were included in the questionnaire in

addition to those used to measure the dependent variable and the independent variables. They were used for screening, and to provide a descriptive profile of the sample.

Items for Both Caregivers and Noncaregivers

1. Wife's age; husband's age
2. Racial group
3. Type of dwelling (single family; apartment, other)
4. Household composition (presence of other(s) and relationship)
5. Number of living adult children (age, sex, geographical proximity, frequency of contact)
6. Physician's description (as reported by the wife) of husband's diagnosis
7. Length of present marriage
8. Perception of whether marriage had improved or worsened over time (better, remained about the same, worse)
9. Self-perceived happiness of marriage (very happy, happy, unhappy)

Items for Noncaregivers

1. Length of home-based caregiving prior to institutionalization
2. Primary reason for institutionalization; primary decision-maker; influence of others in the decision to institutionalize
3. Length of present institutionalization

Items for Caregivers

1. Screening for presence of dependency and identification of primary caregiver
2. Length of caregiving
3. Global feelings about tasks associated with caregiving
4. Feelings about future institutionalization

Administration of the Research Instrument

The collection of data was accomplished by personal interviews with the wives of both home-based and institutionalized dependent men. The interview schedule was read aloud to each wife and her responses recorded by the interviewer in a place where the dependent spouse was not present. The interviews each required approximately 1½ hours.

Statistical Analysis

Four hierarchical multiple regression models were constructed to test the four hypotheses. The first model analyzed data on both the caregiving and noncaregiving respondents. The order of entry of the independent variables was temporally controlled, with the institutionalized/noninstitutionalized variable entered last. The order of entry of the independent variables was controlled in order to eliminate the effects of other independent variables before the effect of the hypothesized predictor variable on MNS was assessed. The second, third, and fourth models

were constructed for only the caregiving wives with the order of entry of the independent variables controlled and based on the same criteria as the first model. When testing the hypotheses using these last three models, those independent variables entered last were functional impairment (Hypothesis 2), caregiving involvement (Hypothesis 3), and social support (Hypothesis 4).

Hypothesis 1 stated that caregiving wives would have significantly lower MNS scores than wives whose husbands were institutionalized when controlling for health and social variables. This hypothesis was tested by examining the relationship between caregiving status and MNS while controlling for and entering in the following order: functional impairment, wives' health, social support, socioeconomic status, and caregiving involvement. This hypothesis was designed to be rejected if no inverse relationship (at the $p < .05$ level of significance) was found between MNS scores and caregiving status as observed through standardized Beta weights.

Hypothesis 2, which stated that there would be an inverse relationship between functional impairment of the dependent home-based husbands and the MNS of the caregiving wives when caregiving involvement and social support were controlled, was tested by examining the relationship between the functional impairment of the home-based husbands and the MNS of the caregiving wives while controlling for and entering in

the following order: caregiving involvement and social support. This hypothesis was designed to be rejected if no significant inverse relationship (at the $p < .05$ level of significance) was found between GRS scores of the home-based husbands and the MNS scores of the caregiving wives as observed through standardized Beta weights.

Hypothesis 3, which stated that there would be an inverse relationship between caregiving involvement and the MNS of caregiving wives when functional impairment and social support were controlled, was tested by examining the relationship between the caregiving involvement of caregiving wives and their MNS while controlling for functional impairment and social support. This hypothesis was designed to be rejected if no significant inverse relationship (at the $p < .05$ level of significance) was found between CIS scores of the caregiving wives and their MNS scores as examined through standardized Beta weights.

Hypothesis 4, which stated that there would be a positive relationship between social support and the MNS of the caregiving wives when functional impairment and caregiving involvement were controlled, was tested by examining the relationship between the social support of the caregiving wives and their MNS while controlling for and entering in the following order: functional impairment and caregiving involvement. This hypothesis was designed to be rejected if no significant positive relationship (at the $p < .05$ level of

significance) was found between social support scores of the caregiving wives and their MNS scores as observed through standardized Beta weights.

CHAPTER IV

ANALYSIS OF THE DATA

This chapter contains the findings from the analysis of data collected by means of semi-structured questionnaires. The questionnaires were administered during personal interviews conducted with 33 older caregiving wives and 30 older noncaregiving wives (whose husbands were institutionalized) of dependents. These findings include (a) general findings, (b) intercorrelations of the dependent and independent variables, and (c) findings related to the four hypotheses.

General Findings

The following section contains findings related to the dependent and independent variables and the marital careers of caregivers and noncaregivers. Also included are findings concerned with the quality of the marital relationship.

The Dependent and Independent Variables

Some general data with regard to the dependent variable, marital need satisfaction, were analyzed. Data were also analyzed for the independent variables socioeconomic status, social support, health, functional impairment, caregiving involvement, and institutionalization/noninstitutionalization.

Marital need satisfaction (MNS). An analysis of the findings of the MNS scores of caregiving wives (Table 1) showed that scores ranged from 32 to 81 (M = 64.42; SD = 11.50). MNS scores for noncaregivers ranged from 24 to 77 (M = 53.77; SD = 17.68). A one-way analysis of variance indicated a significant difference between the two groups of MNS scores, F (1, 61) = 8.18, $p < .01$, with the caregivers having higher mean MNS scores than noncaregivers.

Socioeconomic status (SES). Scores for SES of caregiving wives (Table 1) ranged from 1 to 5 (M = 3.45; SD = 1.17). (The direction of this score was reversed to simplify analysis.) The scores for noncaregivers also ranged from 1 to 5 (M = 3.23; SD = 1.45). The results of a one-way analysis of variance showed no significant difference between the SES of caregivers and noncaregivers.

Social support. Mean scores for caregiving wives for the variable social support ranged from 1 to 4 (M = 3.45; SD = 0.71) (Table 1). Noncaregivers' scores also ranged from 1 to 4 (M = 3.03; SD = 1.16). Analysis of variance showed no significant difference between the scores of the two groups of wives.

Health. Scores of caregiving wives for the health variable (Table 1) showed a range of 1 to 4. The mean score for this group was 2.69 (SD = 1.04). The scores for the health variable for noncaregivers also ranged from 1 to 4, while the mean score was 2.70 (SD = 0.98). No

Table 1

Means, Ranges, Standard Deviations, and F Ratios for Dependent and Independent Variables According to Caregiving Status

Variables	Caregiving Wives			Noncaregiving Wives			F Ratio Between Groups
	Range	M	SD	Range	M	SD	
Dependent							
Marital need satisfaction	32-81	64.42	11.50	24-77	53.77	17.68	8.18*
Independent							
Socioeconomic status	1-5	3.45	1.17	1-5	3.23	1.45	0.44
Wives' social support	1-4	3.45	0.71	1-4	3.03	1.16	3.08
Wives' health	1-4	2.69	1.04	1-4	2.70	0.98	0.00
Husbands' functional impairment	4-29	13.51	5.92	10-41	24.77	7.62	43.22**
Wives' caregiving involvement	29-40	35.91	2.45	1-32	17.30	7.63	176.47**

Note: Caregivers: $n=33$; Noncaregivers, $n=30$

*$p < .01$
**$p < .000$

significant difference was found between the health scores of the two groups of wives as seen through a one-way analysis of variance.

Functional impairment. Scores for the caregiving wives for the variable functional impairment (Table 1) ranged from 4 to 29, with a mean of 13.51 and a standard deviation of 5.92. The range of scores for noncaregivers was 10 to 41 (M = 24.77; SD = 7.62). A one-way analysis of variance indicated a significant difference between the two groups, F (1, 61) = 43.22, p <.000, with the institutionalized husbands having higher mean levels of functional impairment.

Caregiving involvement. The caregiving involvement scores for caregiving wives (Table 1) ranged from 29 to 40 with a mean of 35.91 and a standard deviation of 2.45. Noncaregiving wives' scores ranged from 1 to 32 (M = 17.30; SD = 7.63). A one-way analysis of variance showed a significant difference between the scores for caregivers and noncaregivers for this variable, F (1, 61) = 176.47, p <.000. The caregiving wives had higher mean levels of caregiving involvement than the noncaregivers.

Institutionalized/noninstitutionalized. Supplementary data for this caregiving status variable were also analyzed. This was done for both caregiving and noncaregiving groups.

The length of time the 33 caregiving wives had been functioning as caregivers ranged from 3 weeks to 29 years (M = 6.34 years). Each caregiver was also asked if she had

ever considered institutionalizing her dependent spouse, and 72.7% of the women answered "yes," while 27.3% answered "no."

Noncaregivers' husbands had been institutionalized for a period of time ranging from 2 months to 6 years ($\underline{M}$ = 1.83 years). All but two of these women had also cared for their husbands at home before their institutional placement. Visiting patterns of noncaregivers to the nursing homes showed that 46.8% visited their spouses every day, while 33.3% visited three to six times a week. The remainder went to visit twice a week (3.3%), once a week (13.3%), and less than once a month (3.3%). The length of this prior caregiving among the 28 women ranged from 2 months to 12 years (M = 3.70). Each noncaregiver was also asked to identify that individual most responsible for the decision to institutionalize her ailing spouse. The primary decision maker for one-half the cases was the wife (50%) and the physician for the remaining half.

The Marital Careers of Caregivers and Noncaregivers

Some supplementary information was also gathered which related to the marital careers of the respondents. These data were analyzed for caregivers and noncaregivers.

Caregivers. Among caregiving wives, six had a former marriage and of these, three had one or more living children

from the marriage. Nine of the caregivers' husbands had also been previously married, and five of these men had one or more living children. The length of time caregiving wives had been married to their present spouses ranged from 9 to 63 years (M = 42 years). Twenty-two of these couples had from one to five living adult children (M = 2.84 children).

Noncaregivers. Interviews with noncaregiving wives indicated that 10 had been previously married. Eight of the respondents had one or more living children from the marriage. Nine of the dependent men also had a prior marriage, and eight had one or more living children. The number of years noncaregiving wives had been married to their present spouse ranged from 4 to 69 years (M = 38.57 years). Eighteen of these couples had from one to five living children (M = 3.03) from their present marriage.

The Quality of the Marital Relationship Prior to the Husbands' Illness

Respondents were asked to assess their marital happiness prior to the onset of the spouses' illness by responses to an item which asked whether the marriage had at that time been very unhappy, unhappy, happy, or very happy. Among the caregivers (n = 32), 93.1% rated their marriage as happy or very happy prior to the illness, while 96.6% of the noncaregivers (n = 30) rated their marriage as happy or very happy at that time.

Intercorrelations of the Dependent and Independent Variables for Caregivers and Noncaregivers

This section contains the results of zero-order correlations between the major dependent and independent variables. The direction, strength, and significance of the relationships are indicated. Correlations for caregiving wives are presented in Table 2 and those for noncaregivers in Table 3.

Intercorrelations Among the Caregiving Group

An analysis of the relationship between the five major independent variables and the dependent variable MNS showed that the only independent variable significantly correlated with MNS was wives' health (.47, $p < .01$). MNS increased as the wives' health levels increased. A significant relationship was found between SES and three other independent variables. These included social support (.48, $p < .01$), wives' health (.62, $p < .000$), and functional impairment (-.39, $p < .03$). As SES increased, both social support and the wives' health increased, and as SES increased, the husbands' level of functional impairment decreased. A significant relationship was also found between social support and wives' health (.40, $p < .03$). As social support increased, the wives' health increased.

Intercorrelations Among the Noncaregiving Group

Functional impairment was the only variable significantly correlated with MNS among the noncaregiving group; (-.48; $p < .01$). As MNS increased, the husbands' level

Table 2

Zero-order Correlations Between Dependent and Independent Variables for Caregivers

Variable	1	2	3	4	5	6
1. Marital need satisfaction	-					
2. Socioeconomic status	.26	-				
3. Wives' social support	.07	.48**	-			
4. Wives' health	.47**	.62***	.40*	-		
5. Husbands' functional impairment	-.19	-.39*	-.04	-.16	-	
6. Wives' caregiving involvement	-.08	.13	.11	.31	-.01	-

Note: n=33

*p <.03
**p <.01
***p <.000

Table 3

Zero-order Correlations Between Dependent and Independent Variables for Noncaregivers

Variable	1	2	3	4	5	6
1. Marital need satisfaction	-					
2. Socioeconomic status	-.04	-				
3. Wives' social support	.15	.09	-			
4. Wives' health	.11	.55**	.43*	-		
5. Husbands' functional impairment	-.48**	-.22	-.21	-.36	-	
6. Wives' caregiving involvement	.08	.21	.05	.33	-.14	-

Note: $n=30$

*$p < .02$
**$p < .01$

of functional impairment decreased. Data in Table 3 show that health was significantly correlated with SES (.55, $p < .01$) and social support (.43, $p < .02$). Thus wives' health increased as SES and social support increased.

Findings Related to the Four Hypotheses

This section contains the findings from hierarchical multiple regression procedures used to test the four hypotheses of the study.

Findings Related to Hypothesis 1

Hypothesis 1 stated that caregiving wives would have significantly lower MNS scores than wives whose husbands were institutionalized when health and social variables were controlled. This hypothesis assessed the influence of caregiving on MNS scores for both caregiving ($n = 33$) and noncaregiving ($n = 30$) wives while controlling for health and social variables.

The overall R^2 for the first model showed that a significant amount of variance was explained by the independent variables ($R^2 = .29$, $p < .003$) (Table 4). Observations of the standardized beta weights showed, however, that only the control variable, functional impairment ($B = -.44$; $p < .01$), accounted for the explained variance. That is, when five of the independent variables were controlled, caregiving status (institutionalized/noninstitutionalized) explained no variance in MNS (caregiving wives did not have significantly

Table 4

Regression of Marital Need Satisfaction upon Caregiving Status While Controlling for Social and Health Variables

Variables	Beta (Standardized)	T Value
Socioeconomic status	-.18	-1.30
Wives' social support	.00	0.04
Wives' health	.27	1.75
Husbands' functional impairment	-.44	-2.83*
Wives' caregiving involvement	-.06	-0.27
Wives' caregiving status (Institutional-noninstitutional)	.10	0.38
R=.54; df=6, 56; R^2=.29**		

Note: N=63 (n=33 caregivers; n=30 noncaregivers)

*$p < .01$
**$p < .003$

lower MNS scores than noncaregivers). As a result, Hypothesis 1 was not supported.

Findings Related to Hypothesis 2

Hypothesis 2 assessed the influence of the husbands' functional impairment on the MNS of only the caregiving wives (n = 33) while controlling for the effects of the wives' caregiving involvement and social support. This hypothesis stated that there would be a significant inverse relationship between functional impairment of the home-based husbands and the MNS of caregiving wives when caregiving and social support were controlled. There was no relationship between impairment and MNS scores even when caregiving involvement and social support were controlled.

The overall R^2 for the second model (Table 5) showed that no significant amount of variance was explained by the independent variables (R^2 = .05, NS), no matter how the independent variables were entered. That is to say, there was no relationship between husbands' functional impairment and the MNS of caregivers. As a result, Hypothesis 2 was not supported.

Findings Related to Hypothesis 3

Hypothesis 3 assessed the influence of caregiving involvement with the MNS of only the caregiving wives (n = 33) while controlling for the effects of functional impairment and social support. This hypothesis stated that there would

Table 5

The Importance of Functional Impairment, Caregiving Involvement, and Social Support to the Marital Need Satisfaction of Caregiving Wives[a]

Independent Variables	Beta	T Value
	Dependent Variables	
	Marital Need Satisfaction	
Caregiving involvement	-.89	-0.48
Social support	.07	0.38
Functional impairment[b]	-.18	-1.02
	Marital Need Satisfaction	
Functional impairment	-.18	-1.02
Social support	.07	0.38
Caregiving involvement[b]	-.09	-0.48
	Marital Need Satisfaction	
Functional impairment	-.18	-1.02
Caregiving involvement	-.09	-0.48
Social support[b]	.07	0.39

Note: n=33

[a] R=.21; df=3, 29; R^2=.05 applies to each model.

[b] Independent variable of interest.

be a significant inverse relationship between caregiving involvement and the MNS of caregiving wives when functional impairment and social support were controlled.

The overall $\underline{R}^2$ for the model (Table 5) indicated that no significant amount of variance was explained by the independent variables ($\underline{R}^2$ = .05, NS). Entry of caregiving involvement explained no significant variance in MNS. No significant relationship was found between caregiving involvement and the MNS of caregivers. As a result, Hypothesis 3 was not supported.

Findings Related to Hypothesis 4

Hypothesis 4 assessed the influence of social support for only the caregiving wives ($\underline{n}$ = 33) on MNS while controlling for the effects of functional impairment and caregiving involvement. This hypothesis stated that there would be a significant positive relationship between social support and MNS of the caregiving wives when functional impairment and caregiving involvement were controlled.

The overall $\underline{R}^2$ for the model (Table 5) indicated that no significant amount of variance was explained by the independent variables ($\underline{R}^2$ = .05, NS). As a result, no significant relationship was observed between social support and MNS for caregivers. It was concluded that Hypothesis 4 was not supported.

Additional analysis was performed to clarify the finding that functional impairment accounted for a significant amount

of explained variance in MNS for combined group scores (H_1) but not for caregivers' scores (H_2; H_3; H_4). An analysis using the same hierarchical regression models employed to test the last three hypotheses was therefore performed on noncaregivers' scores. The findings showed that none of the independent variables used in these equations explained a significant amount of variance in MNS of noncaregiving wives.

CHAPTER V

DISCUSSION, SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter contains a discussion of the findings in addition to summary and conclusions. Recommendations for future research are also made.

Discussion of the Findings

Contrary to expectations, the findings of this study suggested that caring for their dependent husbands at home did not have an overall negative impact on the quality of the marital relationships. That is to say, when the impact of caregiving status on the MNS of the combined caregiving and noncaregiving groups was examined, spousal caregiving appeared to be unrelated to the dependent husbands' fulfillment of the wives' fundamental marital needs. Some possible explanations for the findings of the study were suggested by Horowitz and Dobroff (1982), since the older caregivers in their sample appeared to find intrapersonal compensations for some of the negative consequences of their caregiving experiences. For example, while only one-fourth of the caregiving spouses felt there had been a change for the better in their feelings of closeness toward the dependents, half had experienced no change in their feelings, and less than one-fifth felt there had been a change for the

worse. An important relevant finding was that despite the burdens of caregiving more than half of these caregivers reported one positive caregiving consequence (although each positive consequence represented a small proportion of caregiving spouses). Positive caregiving consequences included feelings of self-satisfaction, feeling needed, freedom from guilt, being appreciated, pleasure in the time spent with the dependent, improvement in the way they now approached life, and bringing the family closer together.

A number of extemporaneous remarks by caregivers in this present study tend to coincide with Horowitz and Dobrof's findings that caregiving brought some spouses closer together. Much of this increased closeness appeared to stem from the dependent spouses' expressions of appreciation to their wives, typified by: "I just couldn't get along without you." Another caregiving wife asserted that her husband put her "high on a pedestal." Two of the caregivers revealed that prior to the husbands' dependency the marital relationship had been very unhappy, since both husbands had "drinking problems." Thus, with the onset of debilitating illnesses, longstanding marital problems were eliminated and these older couples experienced renewed feelings of closeness.

Performance of disagreeable caregiving tasks such as changing husbands' colostomy bags did not appear to impair the marital relationship for some caregivers. One caregiver with this responsibility, for example, indicated that

her husband's illness and the caregiving experience had brought them closer together. She enjoyed taking care of him and remarked: "Anything I can do for him is great," and "I love him, never will I leave him."

Marital Need Satisfaction of Caregivers and Noncaregivers

The finding in this present study that the marital need satisfaction scores of both caregiving and noncaregiving wives were inversely related to their husbands' level of functional impairment appears to contradict the report of a survey study by Zarit et al. (1980) in which caregivers' feelings of burden were assessed. Burden was measured by items which referred to the quality of caregiver-dependent relations when problems resulting from the dependents' functional impairment were encountered. These authors found that caregivers' perceived levels of burden were not correlated with the home-based geriatric patients' behavior and impairment levels, although all the dependents in the study had considerable cognitive and behavioral impairment.

A possible explanation for the contradictory findings of these two studies is that all the dependents in the 1980 study had the same specific diagnosis, senile dementia, whereas those in the present study represented a variety of diagnoses and a wide range for levels and types of functional impairment. Consequently, there was less within-group variance in the 1980 study. Furthermore, a smaller sample of spouse-caregivers (n=18) was used in the 1980 study.

Despite the observations of no significant differences in the marital need satisfaction of caregiving and noncaregiving wives, both groups of women had relatively low MNS scores. The women also appeared to experience numerous negative impacts upon their overall emotional well-being which appeared to stem at least in part from their dependent spouses' behavioral manifestations. Also, many variations could be observed among the women in their coping styles. These observations have important implications for physicians, counselors, educators, and others involved with planning, implementing, and providing services for both caregivers and women whose dependent spouses have been institutionalized.

The negative impact of living with a functionally impaired dependent spouse could be detected in many extemporaneous remarks during the interviewing process by the caregiving wives. For example, negative effects on the quality of the relationship could be observed in the remarks of an obviously bitter caregiver. Her bedfast husband had several severe chronic illnesses. When describing his behavior she said: "He's like a spoiled child--the world revolves around him. He won't even let me crochet when I sit here with him." About the only thing this couple could do together was play a repetitive card game she called "Aggravation."

Caregivers frequently alluded to the loneliness, monotony, and social isolation of their lives. Short periods of time spent away from home to shop for necessities were closely

monitored by their husbands. One caregiver confided that her husband was now easily angered and had become increasingly "more difficult to get along with." With the help of her physician's counseling, however, she no longer felt guilty about sometimes wishing her husband were dead.

As pointed out by the literature, the depressive character of many chronically ill persons further impacts on the quality of life of the independent spouses (Gurland et al., 1978; Lederer, 1952; Levy, 1979; Sanford, 1975). This was illustrated by the 68-year-old wife of a stroke victim. She had been a caregiver for 21 years. While her marriage had been happy prior to her husband's illness, it had become less happy due to his characterological changes. Her formerly extroverted husband was now a "loner" and expressed "no affection" toward her. "I just want him to talk to me," she commented.

Inferences drawn from the literature that coping on a day-to-day basis with the performance of a wide range of complex, demanding, physically exhausting and frequently onerous tasks associated with caregiving (Golodetz et al., 1969) would impair the caregivers' marital need fulfillment were supported to some extent, however, by the interviews. For example, a 64-year-old caregiver described her marriage as very unhappy at the present time. Her responses to the MNS scale indicated general dissatisfaction. She revealed a certain amount of reluctance when voicing negative sentiments

about her husband by averting her eyes from those of the interviewer. Her husband was partially paralyzed as a result of several strokes, and she said, "We don't communicate a lot now. These four walls get pretty old." Physical exhaustion from performance of caregiving tasks and her own poor health were the apparent causes of her stating: "Some days I just can't go on and I go to bed." "You have to actually experience a situation like this to know what I'm going through," said a woman whose husband was very depressed. To alleviate her stress the woman's physician had prescribed tranquilizers for her.

The findings of previous studies (Klein et al., 1967; Sanford, 1975) that a negative impact on the marital relationship in the form of interpersonal conflict and frustration between well and dependent spouses resulting from personality conflicts, the dependents' physically aggressive behavior, inability to communicate, and dangerous irresponsible behavior was supported by the candid remarks of some caregiving wives. One woman, for example, had been caring for her cognitively impaired, incontinent husband for several years. "He has become hateful! He never talks to me. . . . I married for 'better or worse' and this is worse" was the way she described an unhappy marital relationship.

Another caregiving wife of a brain-damaged husband said that she felt as if she were taking care of a child. She sorely missed the fact that since her husband could no longer

express himself in a meaningful way she lacked a confidant. This formerly vigorous man was now a social isolate, unreasonable, stubborn, and appeared to be jealous of the fact that his wife could be up and about while he was unable to leave the house.

Danis and Silverstone (1981) suggested that a viable solution to interpersonal conflicts between caregivers and home-based husbands was the residence of a third person in the home whose presence could help to triangulate stress-inducing problems between the spouses. Since, however, almost all the caregivers interviewed lived alone with their spouses, there was little opportunity to deflect negative emotions.

Strong feelings of antipathy toward their institutionalized husbands could also be observed among a number of non-caregivers. For example, one unhappy older woman had cared for a husband with Parkinson's disease at home for nearly 2 years. Her husband's condition finally had worsened to the extent that his incontinence and physical abuse made her feel "ready to move out of the house." Hostile feelings about her husband, however, were unrelieved by his institutional placement. Among contributing factors were a lack of affection and verbal communication between them which left her feeling "cheated," her "being made to feel guilty" by a daughter's objections to the institutionalization, and the fear that depleted financial reserves would force her to once again become a caregiver.

"We have no marriage now," remarked the tearful, unhappy wife of a cognitively impaired husband. He had been in the nursing home for nearly a year and she visited him every day. She had no outside social activities and keenly felt the loss of her husband's former role in helping and encouraging her.

The frequency of depression among the companions of home-based geriatric patients (Gurland et al., 1976), together with reports (Horowitz & Dobrof, 1982) that over two-thirds of spouse caregivers had experienced a change for the worse in their general emotional state and that more than half had experienced a change for the worse in feelings about the dependents were also factors which had been expected to preclude caregivers' marital need satisfaction. Although the overall effect of physical health of caregivers did not negatively impact their MNS, a majority of the caregivers interviewed stated that they were depressed and many also exhibited overt signs of depression. Some said they cried a lot, while others were worried, anxious, and agitated. One very independent, outspoken 84-year-old caregiver credited her strong religious faith as the source of her ability to cope with her constant worries. She said her husband didn't understand her problems and that she found it "hard to reach him." Other caregivers appeared to be ambivalent about their marital relationships. For example, the 74-year-old wife of a stroke victim was generally satisfied with her

husband's ability to fulfill her marital needs "because he's sick and I understand . . . but I'm really not all that satisfied." She also felt that his illness had brought them closer, since he seemed to appreciate what she did for him. "We just try to get along the best we can. My health is poor due to nerves," she explained.

Overt signs of depression, however, were also found among many of the noncaregiving women. Some women said that the fact that their husbands were in a nursing home depressed them. The physician of one 74-year-old woman, for example, had prescribed "tension pills" although many sleepless nights were still spent worrying about the high cost of her spouse's medications. This marital relationship appeared to typify the category of "renewed closeness and strengthened family ties" upon institutionalization noted by Smith and Bengston (1979). General satisfaction with marital need fulfillment seemed to stem from an understanding attitude about the characteriological consequences of her spouse's debilitating stroke: "I don't tell him my troubles, he's not capable of taking them. . . . I try to pacify him. I quiet him down and smooth his head," and then "he kisses me and I kiss him goodbye." A plaintive note, however, was added with the observation that "I wish I could still take care of him at home and we could be together."

Another obviously depressed 80-year-old noncaregiver stated: "He thought I was his mother last week," when attempting to describe the change in her marital relationship.

Her own state of health was very poor, and yet she visited her husband for over 3 hours every day. Their marital relationship had deteriorated as a result of his characterological changes which included violent and threatening behavior. "He's not the same person--he was a fine Christian man. It would be best for all if God would take him quickly," she said. This woman was also very fearful about her own future since she was now threatened with the loss of her modest home due to the high cost of her husband's care at the nursing home. Contributing to the present financial distress of another former caregiver was the fact that before institutionalization her cognitively impaired husband had depleted their savings through "unwise" investments and also had literally "buried money in the garbage can."

Extemporaneous remarks of both caregivers and noncaregivers suggested that, for a significant group their husbands' dependent status impacted strongly on the quality of the marital relationship, with the women placed in a state of "long-term marital limbo." That is to say, interviews with both caregivers and noncaregivers suggested that changes in the marital relationship caused by their spouses' long-term debilitating illnesses led to the wives' feeling as if they were no longer really married. A few openly admitted that they wished their husbands would die, and the ambiguity of their marital state would then be resolved.

The state of "long-term marital limbo" appeared to be more keenly felt by those among the noncaregiving group. In

addition to the fact that spouses in this group had higher levels of functional impairment, another contributing factor may be that these women were no longer residing in the same home with their spouses. Thus, although they were still married, there was a literal and permanent separation from their spouses. All of the women continued to cope, albeit in different ways, with a lengthy and extremely demanding crisis situation caused by their spouses' long-term illnesses. They appeared to be demonstrating their adherence to the traditional marriage vows of "in sickness and in health."

Institutional Visiting Patterns of Noncaregivers

The frequency of visits with institutionalized spouses relate to the findings of a 1977 study (York & Caslyn). Frequent visits by women in the present study to the nursing homes confirmed the 1974 findings that family members maintain close ties despite advanced physical and/or mental deterioration of their aged relative. The noncaregivers' motivation for repeated visits with their husbands varied, however. A few said they went to the nursing home only because they felt it was their duty, and they appeared to have emotionally "distanced" themselves from their spouses. One such 65-year-old woman described how she now attempted to live "the best life possible" and pointed with some pride to the fact that she gave dinner parties in her home for friends. She had cared for her husband at home for 6 years and he had been institutionalized for 2 years. "I live for the day when I will be free and this is past history," she said.

A contrasting and more prevalent attitude was expressed by another woman who not only visited her husband each day, but stayed with him for the entire day. Her visits appeared to be prompted, at least in part, by feelings of satisfaction derived from feeling needed. "I'm the only one who cares about him. He appreciates my help and it makes me happy to be with him," was the way she explained her feelings. The enforced separation from their husbands appeared to distress many of these wives, and they expressed a compelling need to visit their husbands at the nursing homes.

Theoretical Implications of the Study

The relation of the findings of this study to the theoretical propositions which formed a basis for the hypotheses are presented below:

> Role theory proposition 1. "Role strain begins to increase more rapidly with a larger number of roles than do the corresponding role rewards from alter" (Goode, 1960, p. 487).

The findings of this study appear to support in part those of Klein et al. (1972) in which a significant positive relationship was found between the levels of caregivers' role tension (or role strain) and the number of symptoms displayed by the sick spouse. Many of the caregivers and noncaregivers stated that they were worried and anxious which suggested that they were experiencing role strain, although this study did not attempt to evaluate the mental health of the wives. It is, however, possible to speculate that as the levels of

the dependent spouses' functional impairment increased, their ability to "reward" their wives by expressions of love, affection, and gratitude decreased. At the same time, both caregiving and noncaregiving spouses had assumed primary responsibility for aspects of their lives which formerly had been performed by the husbands, in addition to continuation of their more traditional responsibilities.

This role theory proposition was supported by the findings of the study in which both caregivers and noncaregivers experienced role strain as a result of role reversal and their consequent assumption of additional obligations for which they were unprepared. This very apparent role reversal appeared to upset and distress the women. Legal and financial matters appeared to provoke the most anxiety. The cohort of women interviewed represented more traditional forms of marital relationships, in which the husband was the "head" of the family and as a consequence the wives were generally uninformed about financial and legal affairs since the husbands had been responsible for primary decision-making in these areas. Husbands' levels of functional impairment were also observed to interfere with their ability to reward their wives for the assumption of additional roles caused by role reversal.

Role theory proposition 2. Delegation of role responsibilities to others reduces role strain (Goode, 1960).

This proposition derived from Goode (1960) speaks to one form of role manipulation which reduces role strain--delegation of role obligations to others. The proposition can best be related to those former caregiving wives who had delegated the responsibilities for care of their husbands to an institution in an attempt to reduce role strain, caused by their inability to continue performing caregiving tasks in a satisfactory manner.

Former caregiving women described how they had derived a sense of satisfaction and a feeling of being needed from the caregiving experience. The feelings of satisfaction appeared to be unrelated to the performance of disagreeable, physically exhausting tasks and the women's confinement in the home. Among apparent sources of satisfaction within the context of spousal caregiving were fulfillment of nurturance needs, adherence to an internalized norm commitment to care for their ailing husbands, and the approval of significant others or "third parties" (such as their adult children, other relatives, and friends) who believed that it was the wives' role obligation to perform home-based caregiving.

Wives of many of the noncaregivers appeared to be defensive and to harbor feelings of guilt about having institutionalized their spouses, since they were no longer conforming to their internalized sense of duty to care for their husbands. Furthermore, the women's adult children and others overtly expressed disapproval at the dependent spouses'

institutional placement. Additionally, the institution had now assumed primary responsibility for instrumental task performance from which the women asserted they had derived a sense of satisfaction. These former caregivers had as a consequence lost their positively sanctioned and satisfying role as caregivers.

In an apparent attempt to compensate for role loss many of the women visited their husbands very often and stayed for prolonged periods of time. (Indeed, physicians had advised some to limit the number of times they visited, prompted by their concern for the women's own physical and emotional well-being). During the time spent at the nursing home the wives performed those instrumental tasks which were permitted by the rules of the particular institution. Other wives arranged to have their spouses placed in scarce and costly private rooms, which they could ill afford.

In sum, interviews with noncaregiving wives indicated that for many, delegation of caregiving obligations to an institution did not reduce role strain. The women appeared to overcompensate for the loss of normatively sanctioned role obligations which in turn produced role strain.

> Role theory proposition 3. "The quality of alter's role enactment influences ego's satisfaction, and this is a positive linear relationship" (Burr et al., 1979, p. 70).

The findings of the study tend to support this proposition. That is to say, the quality of the wives' marital need

fulfillment decreased as the husbands' levels of functional impairment increased. Husbands with higher levels of functional impairment exhibited more adverse characterological changes, while others were unable to communicate with their wives in a meaningful way. These characteristics thus impeded the husbands' ability to fulfill both caregiving and noncaregiving wives' marital need satisfaction.

> Human motivation theory proposition 1. Human behavior is motivated by unsatisfied basic needs which are organized in a hierarchy of relative prepotency" (Maslow, 1943).

This proposition from Maslow provided a theoretical basis for using the MNS scale in the study to assess the quality of the marital relationships of those wives who were interviewed. A basic supposition of the study was that the scale measured the wives' subjective perceptions of their husbands' fulfillment of fundamental marital needs in the areas of love, personality fulfillment, respect, communication, finding meanings in life, and integration of past life experiences.

It would appear that the incidence of chronic long-term illness of one spouse and the ensuing dependency caused by that illness has important implications for the quality of the marriage of the well spouse during later life. The findings of this study suggested that the level of the dependent husbands' functional impairment influenced their wives' fundamental marital need satisfaction. That is to say, the

wives' marital need satisfaction decreased as the dependent husbands' level of functional impairment increased.

Summary

The purpose of this study was to investigate the influence of caregiving on the marital need satisfaction of older women with dependent husbands. Comparisons were made for marital need satisfaction scores between caregiving women and those of women whose husbands had been institutionalized, while controlling for the effects of certain social and physical characteristics of the women and their husbands. The influence of functional impairment, caregiving involvement, and social support on the MNS of only the caregiving women was also investigated while again controlling for the effects of social and physical factors.

The 63 older women aged 60 and over composing the sample of caregivers (n=33) and noncaregivers (n=30) were secured with the assistance of informants with a working professional knowledge of the Guilford County geriatric population. The data were obtained during personal interviews by the use of semi-structured questionnaires. The questionnaires were administered only to the wives because, as had been anticipated, the state of health of many of the dependent husbands precluded an effective interviewing process. The findings of this study were therefore based on the subjective perceptions of 33 caregiving and 30 noncaregiving women.

The results of the study showed similarities between the mean ages of both caregiving and noncaregiving wives and also between the home-based and institutionalized husbands, although wide age spans were represented among each group. Both home-based and caregiving groups were primarily white. Although the majority of respondents within each group resided in single family dwellings in an urban area of Guilford County, similar small proportions of rural and suburban county residents were present within each group. Observed mean SES levels for the entire sample fell between the second and third class levels for Hollingshead's (Bonjean et al., 1967) 5-level status classification. No significant difference for SES was found between the two groups and all status levels were represented.

General similarities between caregiving and noncaregiving respondents were also observed for mean number of years married, percentage with living offspring, and mean number of living children. Length of marriage was also similar between groups with the average being around 40 years. The quality of the marital relationship of both groups prior to the onset of their spouses' illness also closely corresponded since similar large proportions of both groups rated their marriages as happy or very happy at that time. No significant differences were found between caregivers and noncaregivers for subjective perceptions of the quality of social support they were receiving from others. Mean levels

fell between the third and fourth levels of social support of a possible four levels. Subjective ratings of health for both groups of women also closely corresponded. Mean scores indicated that both groups' self-rated health generally fell between fair and good, although all levels of health were represented.

A wide range of MNS levels was observed within each group, but greater variability was found for noncaregivers' satisfaction. Both groups had relatively low MNS scores, however. As might be expected, institutionalized husbands had significantly higher levels of functional impairment compared to the home-based husbands. Greater variability also was observed for levels of impairment among the institutionalized husbands. The majority of all the dependent husbands had more than one chronic disease and a variety of specific diagnoses was represented.

Caregiving wives had significantly higher levels of caregiving involvement than wives whose husbands were institutionalized, although greater variability was found among noncaregivers' scores. The majority of noncaregivers kept in close touch with their institutionalized spouses by frequent and often lengthy visits to the nursing homes. Supplementary data showed that wives of home-based husbands had been caregivers for an average of 6 years, although a wide range of time devoted to caregiving was represented among the group. Home-based husbands appeared to be at some risk for institutionalization since a majority of their wives had

considered institutionalizing them. All but two of the wives of men who were institutionalized also had been caregivers for a mean length of 3.7 years. Their husbands had been institutionalized a mean number of 1.8 years. Fifty percent of these wives had been the primary person responsible for the decision to institutionalize their spouses, while physicians had assumed that responsibility for the remainder.

The data did not support the four hypotheses of the study. Hypothesis 1, which stated that the MNS of caregivers would be significantly lower than noncaregivers when certain social and physical characteristics were controlled, was not supported. Functional impairment, a control variable, explained a significant amount of variance in MNS for caregivers and noncaregivers. Marital need satisfaction decreased as functional impairment of husbands increased. An earlier univariate analysis, however, did show that MNS scores for caregivers were significantly higher than those for noncaregivers when other variables were not controlled.

Hypotheses 2, 3, and 4 investigated the impact of functional impairment, caregiving involvement, and social support on the MNS of only the caregiving wives while controling for certain social and physical characteristics of the wives and their husbands. These hypotheses were not supported by the data. That is to say, differences in the MNS of caregiving wives could not be explained by the husbands' functional impairment, the wives' caregiving involvement, or the wives'

social support when social and physical characteristics were considered.

Functional impairment would appear to account for differences in an initial description of differences in the means of MNS scores. Analysis of MNS scores for all respondents showed, for example, that differences in MNS between caregiving and noncaregiving groups could be observed. These differences, however, could not be seen when functional impairment of husbands was considered.

Zero-order correlations showed that only functional impairment was related to the MNS of the noncaregiving group, while only health was related to the MNS of the caregivers. These data suggest that the higher levels of functional impairment and larger within-group variability among these scores for the institutionalized husbands accounted for the influence of functional impairment on MNS for all respondents.

Conclusions

Based upon the findings of this study, the following conclusions may be made regarding the marital need satisfaction of older women with dependent husbands.

1. Although differences were observed on marital need satisfaction between wives who were caring for their dependent husbands at home and those whose dependent husbands were institutionalized, these differences were eliminated when social and physical

characteristics were controlled. Both groups had low MNS scores which may be why there was no difference.

2. The marital need satisfaction of both caregiving and noncaregiving wives is influenced by their dependent husband's level of functional impairment. Marital need satisfaction decreases as the husbands' level of functional impairment increases.
3. Differences in caregiving wives' marital need satisfaction cannot be explained by the husbands' functional impairment, the wives' caregiving involvement, or the wives' social support.
4. Social support, health, and socioeconomic status appear to be of no relative importance to the marital need satisfaction of either caregiving or noncaregiving wives.
5. The ambiguity of the wives' marital status could be characterized as a state of "long-term marital limbo."

Suggestions for Future Research

1. Added research attention, using representative samples, should be focused on situational factors which may impact on the quality of the marital relationship during the later years. Emphasis should be placed in particular on the impact of the functional impairment of one spouse on the quality of the relationship on differing situational contexts.

2. Attention should also be directed toward the development of valid and reliable scales which are designed specifically to measure the quality of the marital relationship during the later years and for administration to older adults.

3. The design of research studies directed toward older adults should be of a cross-sequential nature. An advantage of such a design for a sample using older adults is that it would differentiate between age cohorts. That is to say, comparisons could be made between the "young old," the "old," and the "very old" groups of older adults.

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APPENDIX A

COMMUNITY VERSION OF QUESTIONNAIRE

AND

INSTITUTIONAL VERSION OF QUESTIONNAIRE

Community Version of Questionnaire

Respondent's Number _____

Version of Scale: Community

Respondent's Name_____
Last First Middle

Address_____

Interview Site_____

Date Interview Completed_____

Record of Calls and Callbacks			
Calls Phone Personal	Date	Time Start-End	What Happened (General Reaction)

Questionnaire completed_____ Questionnaire Incomplete_____

Number of Unanswered Items_____ List these items_____

Name of Interviewer_____

Statements to be Completed by Interviewer:

1. Respondent's race: white___(1), black___(2), other___(3)
   Describe_____
2. Type of dwelling: single family___(1), apartment___(2), condominium___(3), trailer___(4), other___(5)
   Describe_____
3. Location: rural ___(1), urban___(2), suburban___(3), other ___(4). Describe_____
4. Condition of dwelling: sound ___(1), deteriorating ___(2), dilapidated ___(3).

TO BE READ ALOUD TO EACH RESPONDENT

Hello, I'm _____(Display ID). I'm here to keep the appointment that was made for a personal interview with you. As you know, a research study is being conducted at The University of North Carolina at Greensboro in the Department of Child Development and Family Relations. In connection with this study we are interviewing older married women whose husbands are sick or disabled. We are concentrating on some of the problems and concerns which are sometimes faced when one's husband becomes ill during the later years of life. We sincerely believe that the knowledge we gain from talking with you will help other women who may someday be in the same position.

I am going to ask you a series of questions which will help us in our research study. If you do not wish to respond to any question please feel free to tell me and you will not be pressured to do so. In addition, I want to assure you that everything we discuss is very confidential and that your name will not be associated with this research study. We believe that your responses will be of great value and are very grateful for your cooperation.

Do you have any questions before we begin? (Make note of questions) (Allow time for questions)_____

Now make yourself comfortable and we'll begin.

First of all, I'm going to ask you some questions about your family.

5. How many years have you and your husband been married?

   _____ years.

6. Were you ever married before? yes_____; no_____

If woman has been married before, ask:

7. Do you have any living children from your previous marriage(s)?

   yes_____; no_____

If "yes," ask questions number 8 and 9 and list in box below:

8. What are their ages and sex?

9. How often does each child come to visit you?

____ every day (6)
____ several times a week (5)
____ once a week (4)
____ several times a month (3)
____ several times a year (2)
____ every few years (1)
____ never (0)

10. How far away does each child live? same county (3), same state (2), out of state (1)?

Wife's Children from Previous Marriage(s)

Age of Child	Sex of Child	Visiting Pattern	Distance

11. Has your husband been married before? yes____; no_____

If the husband has been married before, ask:

12. Does your husband have any living children from his previous marriage(s)? yes_____; no_____

If "yes," ask questions 13 and 14 and list in box below:

13. What are their ages and sex?

14. How often does each child come to visit you and your husband?

____ every day (6)
____ several times a week (5)
____ once a week (4)
____ several times a month (3)
____ several times a year (2)
____ every few years (1)
____ never (0)

15. How far away does each child live? same county (3), same state (2), out of state (1)?

Husband's Children from Previous Marriage(s)

Age of Child	Sex of Child	Visiting Pattern	Distance

16. Do you and your husband have living children?

yes_____; no_____

If "yes," ask questions 17 and 18 and list in box below:

17. What are their ages and sex?

18. How often does each child come to visit?

____ every day (6)
____ several times a week (5)
____ once a week (4)
____ several times a month (3)
____ several times a year (2)
____ every few years (1)
____ never (0)

19. How far away does each child live? same county (3), same state (2), out of state (1)?

Age of Child	Sex of Child	Visiting Pattern	Distance

Note comments about children's visits _____

_____

_____

20. What was your main occupation before you were married?

_____

21. Since you have been married, have you worked outside of the home? yes____; no_____ If "yes," ask question #22

22. What was your main occupation outside the home?

_____

23. Are you working now? yes_____; no_____

If "yes," ask: full_____ or part-time?_____

24. Could you please tell me the year in which you were born? _____

25. How far did you go in school? _____

26. What has been your husband's main occupation?_____

27. How far did he go in school?_____

28. In what year was he born?_____

29. Does anyone else live here with you and your husband? yes_____; no_____

If "yes," ask question #30

30. Who else lives here, that is, could you tell me the person's relationship to you and your husband?

List _____

What is the approximate age of this person (or persons)?

_____

31. How would you rate your general health at the present time? Would you say it is excellent ____(4), good ____(3), fair____(2), or poor____(1)?

32. How would you rate your husband's general health at the present time? Would you say it is excellent____(4), good____(3), fair____(2), or poor____(1)?

33. How does your doctor explain and describe your husband's health problems?

Interviewer try to arrive at diagnosis

34. What particular person is most responsible for your husband's care here at home?_____

35. Do you receive help in caring for your husband here at home from your children, friends or other relatives?
yes_____; no_____

If "yes," ask questions #36, 37, 38

36. Could you tell me the relationship and sex of this person or persons?

List in box below: Male or Female; Child, relative or friend

37. Would you say that you receive very much help (4), a moderate amount (3), a little help (2), or very little help (1) from this person or persons?

List number in box below for each person

38. What kind of help do you receive from each of these (or this person)?

List in box below

Relationship Friend, Child, Relative	Sex (male or female	Quantity of (1-4) Help	Kind of Help
1.			
2.			
3.			
4.			

Interviewer note any comments about help received in care-giving from children, relatives, and friends:

39. Do you receive help in caring for your husband from any professional sources in the community such as home-health aides, day care services, etc. yes _____; no_____

If "yes," ask questions #40, 41, 42

40. What are the sources of this help?

List in box below

41. What kind of help do you receive (from each)?

List in box below

42. Would you say that you receive very much help (4), much help (3), a little help (2), or very little help (1) from each source?

List in box

Source of Help	Kind of Help	Amount of Help (1-4)
1.		
2.		
3.		

List any comments about help from professional sources

_____

_____

43. Without the help your husband receives from you and from others, do you believe he could remain here at home?

yes _____; no_____

Now I am going to ask you some questions about your marital relationship.

44. When thinking back over the years you and your husband have been married, do you feel that your marriage has improved or worsened over time? For example, is your marriage better____(4), about the same____(3), worse____(2), or very much worse_____(1)?

45. Would you say that at the present time your marriage is very happy ____(4), happy____(3), unhappy____(2), or very unhappy____(1)?

Now I would like to ask you some questions about how satisfied you are with your husband's performance of certain marriage roles at the present time. After each question I will ask you if you are very satisfied, satisfied, unsatisfied, or very unsatisfied. How satisfied are you with your husband in:

Check one

46. How satisfied are you with your husband in his providing you with a feeling of security? Very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

47. How satisfied are you with your husband in his expressing affection toward you? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

48. How satisfied are you with your husband in his giving you an optimistic feeling toward life? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

49. How satisfied are you with your husband in his expressing a feeling of being emotionally close to you? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

50. How satisfied with your husband are you in his bringing out your best qualities? Are you very unsatified (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

51. How satisfied are you with your husband in his helping you to become a more interesting person? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

52. How satisfied are you with your husband in his helping you to continue to develop your personality? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

53. At the present time, how satisfied are you with your husband in his helping you to achieve your individual potential (become what you are capable of becoming)? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

54. How satisfied are you with your husband in his being a good listener? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

55. How satisfied are you with your husband in giving you encouragement when you are discouraged? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

56. How satisfied are you with your husband in his acceptance of your differentness (whatever it may be)? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

57. How satisfied are you with your husband in his avoiding habits which annoy you? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

58. How satisfied are you with your husband in his letting you know how he really feels about something? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

59. How satisfied are you with your husband in his trying to find satisfactory solutions to your disagreements? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

60. At the present time how satisfied are you with your husband in his expressing disagreement with you honestly and openly? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

61. How satisfied are you with your husband in his letting you know when he is displeased with you? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

62. How satisfied are you with your husband in his helping you to feel that life has meaning? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

63. How satisfied are you with your husband in his helping you to feel needed? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

64. How satisfied are you with your husband in his helping you to feel that your life is serving a purpose? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

65. How satisfied are you with your husband in his helping you to feel satisfaction and pleasure in your daily activities? Are you very satisfied (4), satisfied (3), unsatisfied (2), or very unsatisfied (1)?

66. How satisfied are you with your husband in his giving you recognition for your past accomplishments? Are you very unsatisfied (1), unsatisfied (2), satisfied (3),or very satisfied (4)?

67. How satisfied are you with your husband in his helping you to feel that your life has been important? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

68. How satisfied are you with your husband in his helping you to accept your past life experiences as good and rewarding? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

69. How satisfied are you with your husband in his helping you to accept yourself despite your shortcomings? Are you very unsatisfied (1), unsatisfied (2), satisfied (3), or very satisfied (4)?

Note any comments made by the wife during the preceding questions about her satisfaction with her husband's role performance.

Now I would like to ask you some questions about the amount of time you spend doing things with and for your husband:

70. Score 6 for caregivers.

71. Score 6 for caregivers.

72. Do you ever help your husband by taking him to clinics, church, or other places? How often do you do this?

At least one time a day ____(4)
One time a week ____(3)
One time a month ____(2)
Less than one time a month ____(1)
Doesn't help at all ____(0)

73. Do you help your husband with housekeeping chores such as cleaning, doing his laundry, etc.? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____(3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

74. Do you ever prepare meals for your husband? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____(3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

75. Do you ever help your husband by shopping for his food and other items or by running other personal errands for him? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____(3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

76. Do you ever help your husband with personal care, that is, with bathing, dressing, feeding or toilet care? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____(3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

77. Do you ever help your husband with health care (such as giving medications, changing bandages, taking blood pressure, or supervising physical exercises)? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____(3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

78. Do you ever help your husband manage his money? (for example: doing banking and paying bills)? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____(3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

79. Do you help your husband by dealing with the agencies or people from whom your husband receives services or by getting information from other services (for example: medicaid, medicare, department of social services, counselors, home-health aides, nurses, physicians, therapists, etc.)? How much time do you spend doing this?

At least one hour a day ____(4)
One hour a week ____ (3)
One hour a month ____(2)
Less than one hour a month ____(1)
Doesn't help at all ____(0)

80. Do you help your husband financially by giving money or paying for his food, clothing, or medical expenses?

Yes ___(1); No_____(0)

81. Do you help your husband by just talking to him when he has had a personal or family problem or when he is feeling generally depressed?

Yes ___(1); No____(0)

Now I would like to ask you some questions which relate to your husband's general condition. I am going to read a list of things which deal with your husband's behavior and also with his ability to perform various activities at the present time. Some of these occur with certain illnesses and may or may not apply to your husband.

82. When your husband is eating does he require (or need) no assistance (0), a little assistance (1), or considerable assistance (2)?

83. Is your husband ever incontinent, that is, does he have trouble controlling his bladder and/or his bowels? never (0), sometimes (1), or often (2)?

84. When he is bathing or dressing, does your husband need: no assistance (0), some assistance (1), or assistance (2)?

85. Will your hysband fall from his bed or chair unless protected by side rails (or some other restraint? never (0), sometimes (1), or often (2)?

86. With regard to walking, does your husband show: no difficulty (0), need assistance (1), or does he not walk at all (2)?

87. Is your husband's sight, with or without glasses: apparently normal (0), somewhat impaired (1), or extremely poor (2)?

88. When other people are present, does your husband do things which are embarrassing to you? never (0), sometimes (1), or often (2)?

89. Is your husband confused? almost never (0), sometimes (1), or often (2)?

90. Does your husband know the name of more than one friend or relative (0), only one friend or relative (1), or no friends or relatives (2)?

91. Does your husband communicate well enough to make himself understood by speaking, gesturing, or nodding? almost always (0), sometimes (1), or almost never (2)?

92. Does your husband react or respond to his own name? almost always (0), sometimes (1), or almost never (2)?

93. Does your husband play games or have hobbies? often (0), sometimes (1), or almost never (2)?

94. Does your husband read books or magazines? often (0), sometimes (1), or almost never (2)?

95. Does your husband begin conversations with other people? often (0), sometimes (1), or almost never (2)?

96. Is your husband willing to do things which are asked of him? often (0), sometimes (1), or almost never (2)?

97. Does your husband help with chores around the house? often (0), sometimes (1), or almost never (2)?

98. With regard to friends in town, does your husband have several friends (0), just one friend (1), or no friends (2)?

99. Does your husband talk to other people? often (0), sometimes (1), or almost never (2)?

Some illnesses are accompanied by various types of disturbing behavior. The following statements with regard to your husband's behavior, may or may not apply to him:

100. Does your husband break or destroy things on purpose? That is, does he tear up things such as magazines, books, clothing, or sheets or break furniture? never (0), sometimes (1), or often (2)?

101. Does your husband make disturbing noises such as shouting, yelling, or moaning? never (0), sometimes (1), or often (2)?

102. Does your husband threaten to harm you or other people? never (0), sometimes (1), or often (2)?

103. Does your husband try to harm you or other people? never (0), sometimes (1), or often (2)?

104. Thinking back to before your husband became ill, how would you describe your marital relationship? At that time would you say it was: very happy ____(4), happy ____(3), unhappy ____(2), or very unhappy ____(1)?

105. Could you tell me some of the ways in which your husband's illness may have affected your marital relationship?_____

_____

106. Which of the following statements best reflects your current situation overall (with regard to the help you are now receiving from others)? I feel overwhelmed and don't know where to turn ____(1), I know I could get more help but don't know how to ask ____(2), I'm getting some help but could use more ____(3), or I'm able to get most of the help I need ____(4)? (includes help from relatives, friends, doctors, home-health aides, counselors and all other sources)

107. What tasks associated with caring for your husband do you find most satisfying?_____

_____

108. What tasks associated with caring for your husband do you find least satisfying?

_____

109. What is the length of time that you have been taking care of your husband during this present illness?

_____

110. During the time that your husband has been ill, have you ever thought about placing him in a nursing home?

yes____; no_____

111. Could you briefly explain why you feel this way?

_____

_____

112. If it were possible for you to receive some more help here at home in caring for your husband, what kind of help would you <u>most</u> like to receive?

_____

113. Can you think of any other kind of help that you would like to have?

_____

<u>I have no more formal questions to ask you and I want to tell you how very much I appreciate your patience and cooperation. I would, however, like to give you an opportunity to add any comments if you wish to do so.</u>

_____

_____

_____

Interviewer: please note if there was any hesitancy on the part of the respondent to answer any particular item or items. Note if any reason was given._____

_____

_____

Institutional Version of the Questionnaire

The following modifications were made in the institutional version of the questionnaire:

1. Items # 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 107, 108, and 109 were worded in the past tense to apply to the respondents' prior home-based caregiving performance.

2. Items 70 and 71 were worded in the following manner:

   #70. How often do you usually speak to your husband over the telephone?

   At least one time a day____(6)
   Several times a week (3-6)____(5)
   Twice a week ____(4)
   Once a week ____(3)
   Once every two weeks ____(2)
   Once a month ____(1)
   Less than once a month ____(0)

   #71. How often do you see or visit with your husband?

   At least one time a day ____(6)
   Several times a week (3-6) ____(5)
   Twice a week ____(4)
   Once a week ____(3)
   Once every two weeks ____(2)
   Once a month ____(1)
   Less than once a month ____(0)

3. The following items were added to the institutional version:

   How long has your husband been in the nursing home?_____
   Was the state of your husband's health such that you needed to take care of him at home before he entered the nursing home? yes_____; no_____
   For how long a time did you care for him at home?_____
   What person had most of the responsibility for his care at home?_____
   List any comments:_____
   _____

What was the chief reason for your husband's entering the nursing home?_____
What person was most responsible for making that decision?_____
Were there any other persons involved in that decision-making? yes_____; no_____
If "yes" ask: Could you identify this person(s)?

_____

Could you tell me some of the ways your husband's residence at the nursing home may have affected your marital relationship?_____

_____

Could you tell me some things associated with your husband's residence at the nursing home which give you a sense of satisfaction?_____

_____

Could you tell me some things which are associated with your husband's residence at the nursing home which give you a sense of dissatisfaction?_____

_____

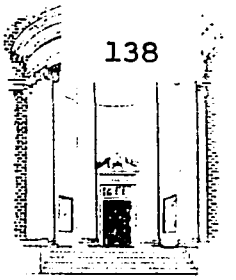
4. For Item 97 the phrase "chores around the nursing home" was used to replace "chores around the house."

5. Items #110, 111, 112, and 113 were omitted from the institutional version of the questionnaire.

APPENDIX B

LETTER FROM INFORMANT, LETTER FROM RESEARCHER, AND POSTCARD

THE UNIVERSITY OF NORTH CAROLINA
AT GREENSBORO



School of Home Economics

July 1, 1983

Dear friend,

I am a doctoral candidate at the University of North Carolina at Greensboro in the Department of Child Development and Family Relations, a mother of four and a grandmother of three. I am conducting a research study in which older women whose husbands are sick or disabled will be interviewed. The purpose of the study is to gain insight into some of the problems and concerns encountered by wives of dependent husbands. The knowledge which is gained will be useful in helping other women who may someday be in the same position.

The information from these interviews will be confidential in the sense that the names of women interviewed will not be used in the interpretation of the results or in any other way. The interviews will take about one and one-half hours to complete.

A stamped postcard is enclosed. If you are willing to participate in this study, please fill it out and return it at your earliest convenience. Upon request, you will receive a summary of the results of this research study. The results, in turn, may be useful to you.

If you have any questions, please contact me at 292-0265. Your help and participation in this important research project will be very much appreciated.

Sincerely,

Audrey M. McCrory

Suggested Enclosure from Cooperating Agency

Dear _____

We recognize the value of a study such as the one which is being conducted at UNC-G by Mrs. McCrory. The results of her study will provide valuable information about the problems and concerns of older women who have sick or disabled husbands. Your permission to take part in the study must be obtained, however, before you can be interviewed.

Postcard

I would like to take part in the research study being conducted at UNC-G by Mrs. Audrey McCrory. I understand that all information obtained from me is confidential, that my name will not be used in the interpretation of the results or in any other way, and that I may refrain from answering a specific question if I so desire. I will be expecting to receive a call to set up an appointment for an interview.

Name_____Date_____

Phone_____ Please send me a summary of the results of the study_____.