# Midlife Care Givers: Effectiveness of a Psychoeducational Intervention for Midlife Adults With Parent-Care Responsibilities

Valerie L. Schwiebert and Jane E. Myers

*The purpose of this study was to develop, implement, and evaluate a psychoeducational group intervention that addressed the needs of adult children caring for aging parents. The intervention consisted of four 2-hour sessions and included 70 care givers, 54 to 72 years of age, who were currently caring for a parent 60 years of age or older. A delayed-treatment, control-group design with follow-up after a 4-week interval was used to study three primary variables identified through an extensive literature review as essential for care givers. These included knowledge, care giver burden, and skill development. Skill development did not change following participation, nor did care giver burden variables measured. Significant increases were found at the .05 level for knowledge, overall coping resources, and self-disclosure following group participation.*

Midlife adult children who are responsible for the care of an aging parent often experience conflict between their own needs, the needs of their children, and the needs of their aging parents. At a time when their own children are becoming more independent and there is more time for midlife adult children to devote to the pursuit of their own goals, caring for an increasingly dependent parent may be particularly stressful.

Hence, midlife adult children of aging parents have been called the "sandwich generation" (Miller, 1981). These individuals may experience significant emotional, physical, and financial stresses related to the care-giving role (Cantor, 1983; Cicirelli, 1981). In the absence of respite care, these continuing stresses may become debilitating. Based on projected increases in the older population, the dynamics of family care giving, and the developmental needs of persons in midlife, it is likely that counselors will increasingly be asked to provide assistance to adult children with parent-care responsibilities. Few guidelines for providing counseling interventions for this population exist (Myers, 1989; Myers, Poidevant, & Dean, 1991). To address this need, we developed and evaluated a group counseling intervention to assist midlife adult children in coping with the stresses of providing parent care.

In this article we describe a psychoeducational group intervention based on the needs of adult children caring for aging parents. In addition, the results of a study to evaluate the intervention are presented, using a delayed-treatment, control-group design. The study tested the hypothesis that the intervention would result in knowledge, emotional support, increased knowledge of the aging process, and a perception of enhanced skill development related to care giving. These variables were identified based on an extensive review of the literature in counseling and gerontology and are summarized in the next section.

## COUNSELING NEEDS OF ADULT CHILDREN

The population of persons 65 years of age and older is growing at an increasing rate and is expected to constitute almost 22% of the total population by the year 2030 (United States Administration on Aging, 1989). Approximately one third of older persons are impaired to the extent that they require some form of supportive services to remain living in the community (Brody, 1974; Callahan, Diamond, Giele, & Morris, 1980). Family members provide most (more than 80%) of the needed assistance to impaired older persons (Brody, Davis, Fulcomer, & Jonsen, 1979; Brody, Poulshock, & Mascioachi, 1978). The identity of the primary care giver follows a hierarchical pattern: Care giving is provided by a spouse, if there is one available and capable, and by an adult child (usually a daughter) if there is not (Arling & McAuley, 1983; Cantor, 1983). Approximately 80% of care giving is provided by adult children, most of whom are between 40 and 70 years of age (Brody et al., 1979).

The care-giving relationship is differentiated from typical family exchanges and is defined by the existence of some degree of impairment on the part of the older person, which limits independence and necessitates ongoing assistance (Horowitz, 1985). One of the major challenges that care givers face is the need to balance multiple roles simultaneously and to resolve conflicts between their various roles, such as spouse, parent, worker, and care giver. These conflicts intensify the "generation gap" between adult care givers and their aging parents, which may best be understood within the context of developmental issues (Myers, 1989).

Life-span developmental theories provide a framework for understanding the developmental tasks of both adult children and their aging parents. The tasks of late life include establishing a sense of inner order and self-satisfaction, achieving a sense of ego integrity, adjusting to age-related changes, and dealing with multiple losses (Erikson, 1963; Havighurst, 1972; Neugarten, 1968). Developmental tasks of midlife include taking stock of one's life, setting new goals, and adjusting to a changing time perspective, which results in the realization that life is finite (Havighurst, 1972; Neugarten, 1968). Intimacy and identity issues may also reappear during midlife as well as during later life (Erikson, 1963; Havighurst, 1972; Neugarten, 1968). The developmental tasks of both adult children and aging parents necessitate a turning inward, and a focusing on oneself, in an attempt to assess life changes, the accomplishment of goals, and (it is hoped) the creation of new goals. Both may be concerned about, as well as confused by, physical and emotional changes. Turning inward, adult children and aging parents may have little energy to address each other's concerns. For those adult children involved in providing parent care, however, the developmental issues and changes of later life cannot be ignored. A review of these issues led us to conclude that the counseling needs of adult children caring for aging parents may be categorized in three areas: knowledge, emotional

support, and skill development. Needs that have been identified in the area of knowledge include a need for accurate knowledge of the aging process and knowledge of available community resources (Clark & Rakowski, 1983; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989). Needs identified in the area of emotional support include emotional catharsis, normalization and diffusion of feelings, and reassurance (Altschuler, Jacobs, & Shiode, 1984; Clark & Rakowski, 1983; Cutler, 1985; Dobson & Dobson, 1985; Myers, 1989; Wasow, 1986). Needs related to skill development include increased skills in communication, stress reduction, and coping resources (Johnson & Spence, 1982; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989).

Outcome measures correlated with these three variables have been proposed in the literature. Knowledge has been measured directly in terms of content and comprehension (Johnson & Spence, 1982). Emotional support has been correlated with perceived level of burden (Novak & Guest, 1989; Zarit, 1982; Zarit, Todd, & Zarit, 1986). Skill development in the areas of stress reduction and coping resources has been measured in terms of perceived level of stress and perceived coping resources (Smith, 1989; Wedl, 1986). Based on studies in these areas, it seems that a psychoeducational approach to the needs of adult children may be particularly useful because relevant outcomes are based on information that can be learned. Moreover, theories of adult learning suggest that the adult learner is problem centered, self-directed, interested in learning what has immediate application, and concerned about having control over learning (Brookfield, 1987).

## METHOD

### Participants

The population of interest was midlife adult children with parent-care responsibilities. The sample was defined as persons older than 40 years of age who were caring for at least one parent who was older than 60 years of age. The care giver could not currently be participating in counseling to meet his or her needs related to caring for his or her aging parents.

A total of 70 participants attended all or some of the group sessions; only 51 participants, however, attended all group meetings and completed all of the questionnaires. Thus, only 51 were included for the data analyses. The resulting sample included 7 male care givers (14%) and 44 female care givers (86%), all of whom were White. All were between 54 and 72 years of age, with a mean age of 63.5 years. Of the care givers, 37% reported that they were employed either full time (16%) or part time (21%), and 63% reported that they were unemployed. Only 15 care givers (31%) reported that care giving had affected their employment. Almost one third (29%) of the care givers reported incomes below $16,000 per year, whereas almost half (45%) reported incomes between $16,000 and $26,000 per year.

Approximately 28% of the care givers were married, 10% were single, 31% were divorced, and 31% were widowed. Each care giver reported between 0 and 5 children of their own, the modal value being 2 children. A total of 47 care givers reported no children currently living at home, whereas 4 care givers reported 1 to 2 children currently living with them.

For 41 (80%) of the care givers, the parent receiving assistance was the mother, and for 10 (20%) of the care givers, the parent receiving assistance was the father. Of the care givers, 47% reported that their parent resided in their home, 31% reported that their parent resided in his or her own home, and 22% reported that their parent resided in a setting such as a nursing home or adult congregate living facility. Only 2 of the care givers had ever received counseling.

### Procedure

Participants in the study were recruited through newspaper advertisements, local church bulletin advertisements, the local Area Agency on Aging, and community college leisure course announcements. Potential participants were screened and selected only if they were at least 40 years of age, were currently caring for an aging parent older than 60 years of age, and were not currently receiving counseling. Each participant who met the criteria for inclusion was randomly assigned to one of five treatment groups consisting of 15 participants. The study took place over 7 weeks, with the first two treatment groups receiving the intervention during weeks 1 through 4 and the second two groups serving as control groups during weeks 1 through 4 and then receiving delayed treatment during weeks 4 through 7. Additionally, a fifth treatment group received the intervention during weeks 4 through 7.

All of the groups were conducted by the senior author. The group leader had an educational specialist degree in counselor education with a certificate in gerontology and was a certified rehabilitation counselor.

Evaluation instruments were administered to all groups prior to week 1 of the study. The first treatment groups also completed the instruments at the end of the intervention (week 4) and again at the end of week 7 (follow-up). The delayed-treatment control groups completed the instruments again at week 4, prior to participating in the intervention, and again at week 7, following the intervention. Thus, the delayed-treatment, control-group design provided the advantage of replication as well as evaluation of treatment effectiveness.

### Instruments

Three instruments were used to measure pretest and posttest differences in knowledge, burden, and skill development: (a) the Facts on Aging Quiz–Revised (FAQ-R), (b) the Caregiver Burden Index (CBI), and (c) the Coping Resources Inventory for Stress (CRIS).

*Facts on Aging Quiz–Revised (FAQ-R).* The FAQ-R (Miller & Dodder, 1980) consists of 24 factual statements documented by empirical research (Palmore, 1988). It was designed to assess knowledge of basic physical, mental, and social facts related to aging. Group score reliability is high as shown by the consistency with which comparable educational groups have similar mean scores (Palmore, 1988) and by similar scores on test and retest in control groups (Laner, 1981). Laner (1981) also reported that 46 students in a social gerontology class showed a significant increase in knowledge as measured by the FAQ-R ($\chi^2 = 36.23$, $p < .001$), suggesting that the FAQ-R has content validity.

*Caregiver Burden Index (CBI).* Novak and Guest (1989) developed the CBI as a multidimensional measure of perceived care giver stress. The CBI is a short written instrument composed of five subscales that include Time-Dependence Burden, Developmental Burden, Physical Burden, Social Burden, and Emotional Burden. The CBI subscales and an overall score have internal consistency coefficients ranging from .77 to .85. Content validity has been reported by the authors.

*Coping Resources Inventory for Stress (CRIS).* The fifth edition of the CRIS was developed by Matheny, Curlette, Aycock, Pugh, and Taylor in 1986 (1987) to assess an individual's perceived coping resources. It is a written instrument consisting of 141 items in a true-false format. Scores may be obtained on 11 subscales plus an overall Coping Effectiveness Score (CES). Subscales include Stress Monitoring, Self-Disclosure, Structuring, Social Support, Flexibility, Tension Reduction,

Confidence, Acceptance, Physical Fitness, Wellness, and Problem Solving.

Test-retest reliability time interval on the subscales and the overall coping score ranges from .60 to .87. Internal consistency coefficients are between .73 and .88. Content validity was determined by five independent raters who rated the inventory for adequacy of taxonomy representation. The authors have reported 90% interrater agreement (Matheny et al., 1986).

### Psychoeducational Group Intervention

A psychoeducational counseling intervention was developed comprising four, 2-hour, weekly sessions, each session conducted by the senior author. The format and content of each section is described in the next section (detailed outlines and copies of handouts are available from the senior author).

*Session 1.* The purposes of the first session were to provide information about normal age-related changes, to encourage participants to develop empathy for their aging parents, and to invite participants to consider their own aging (Billings & Moos, 1981; Gallagher, 1985). Specific material covered, using overheads, lecture, and handouts, included age-related physiological changes and the effect of these changes on aging persons (Clark & Rakowski, 1983; McMahon & Ames, 1983; Miller, 1982; Remnet, 1987; Smith, 1989).

*Session 2.* Session 2 focused on improving communication skills within the family by presenting material in a lecture-discussion format, using overhead transparencies and a handout, and demonstrating effective communication skills by using a group exercise.

The second hour of Session 2 focused on family issues by having participants engage in a group discussion of issues such as the relationship between the adult child and the aging parent, the relationship between the adult child caring for the aging parent and siblings, and the adult child's own family. This discussion was initiated by the group leader using stimulus questions such as the following: What is the overall history of the care-giving relationship? Is the care giver a care giver by choice, or was he or she designated care giver by some family member? The purpose of this session was not to give answers and factual information, but to provide participants with emotional support from others in similar circumstances and to help them develop a new framework for thinking about their situation. Through the examination of family dynamics and communication patterns, participants gained a better picture of how these areas were influencing their situation.

*Session 3.* Session 3 focused on stress and time management. The first hour, presented in lecture format with overhead transparencies, included signs and symptoms of stress, varying approaches to reduce stress, and the importance of total wellness and self-care.

The second hour consisted of a discussion of time management techniques, and participants were encouraged to share information related to the effects of stress on their lives and approaches to dealing with it. This portion of the third session, presented in a group discussion format, asked participants to share time management techniques and stress reduction techniques that had worked for them. A handout on progressive relaxation and a practice exercise using progressive relaxation were given.

*Session 4.* Session 4, the final session, began with a discussion of developmental issues related to midlife and late life and was presented in a lecture and group discussion format using overhead transparencies. The Eriksonian issues of midlife, including generativity versus stagnation, and the issues of late life, including ego integrity versus despair, were discussed regarding their impact on relationships between individuals in both life stages.

Following this discussion, information on available community resources to assist older persons was presented, and a handout was given. The remainder of Session 4 consisted of a wrap-up and posttest administration of each of the measures included in the study.

## RESULTS

Group means and standard deviations for each of the instruments (FAQ-R, CBI, and CRIS) for total scores and subscales were tabulated for pretest, posttest, and follow-up administrations. A repeated measures analysis of variance was completed for all scores on all instruments, along with an analysis of covariance (as a result of low $n$ for the follow-up responses). An alpha level of .05 was used to determine statistical significance.

Table 1 provides a summary of means and standard deviations for the three treatment and two control groups on all three variables. This information is provided here to facilitate interpretation of the repeated measures ANOVA and follow-ups.

A repeated measures analysis of variance (ANOVA), for both treatment and control groups across all three measures and three measurement occasions, was conducted. A significant difference was found between the treatment and control groups in knowledge of the aging process, $F(2, 56) = 55.38, 33.57$, $p < .01$, as measured by the FAQ-R. Furthermore, there was an increase in knowledge of the aging process (within-occasion follow-up, posttest and retest $t = 4.46$, $p < .01$) as measured by the FAQ-R following group participation (i.e., the lone significant difference was at the end of week 4). Because the total $N$ was low on the third occasion (follow-up, $N = 8$), a simple analysis of covariance (ANCOVA) was conducted, which was also significant, $F(1, 48) = 52.50, 56.0$, $p < .01$.

No differences were found in care giver burden as measured by the CBI. Additionally, no differences were found for any of the subscales of the CBI following group participation.

A significant difference was found between the treatment and control groups in overall coping effectiveness, $F(2, 56) = 19.26, 7.88$, $p < .01$, as measured by the CRIS. Because the total $N$ was low on the third occasion (follow-up, $N = 8$), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS overall coping effectiveness scores. This analysis was significant, $F(1, 48) = 1628.20, 153.50$, $p < .01$. A repeated measures analysis of variance (ANOVA) resulted in a difference between the treatment and control groups by occasion in overall coping resource effectiveness as measured by the Coping Resource Effectiveness scale (overall coping score) of the CRIS ($p < .05$).

No differences were found on any of the CRIS subscales with the exception of the Self-Disclosure scale. No significant differences were found between the treatment and control groups on the Self-Disclosure scale of the CRIS once the values had been corrected ($p < .05$). Therefore, the results for this scale were equivocal.

In summary, there was a significant increase in knowledge of the aging process following group participation. There was a significant increase in overall coping resource effectiveness following group participation. No significant differences were found in care giver burden or on the subscales of the CBI following group participation. Additionally, no significant differences were found on the subscales of the CRIS. Equivocal results, however, were found for the Self-Disclosure scale of the CRIS.

## DISCUSSION

It seems that the time-limited psychoeducational intervention developed and implemented in the current study was successful in (a) increasing care giver's knowledge of the aging process, (b) increasing care giver's

**TABLE 1**

**Summary of Group Means and Standard Deviations for All Dependent Measures**

| Group | *N* | *M* | *SD* |
|---|---|---|---|
| Facts on Aging Quiz (Revised) | | | |
| Treatment | | | |
| Pretest | 29 | 16.0 | 2.3 |
| Posttest | 29 | 18.6 | 2.2 |
| Follow-up | 8 | 19.0 | 1.8 |
| Control | | | |
| Pretest | 22 | 15.5 | 2.5 |
| Retest | 22 | 14.7 | 2.7 |
| Follow-up | 22 | 18.5 | 2.7 |
| CBI Time Dependence Scale | | | |
| Treatment | | | |
| Pretest | 29 | 4.8 | 4.8 |
| Posttest | 29 | 4.3 | 4.2 |
| Posttest | 8 | 3.9 | 2.9 |
| Control | | | |
| Pretest | 22 | 4.1 | 2.9 |
| Retest | 22 | 4.2 | 2.9 |
| Posttest | 22 | 3.4 | 2.5 |
| CBI Developmental Burden Scale | | | |
| Treatment | | | |
| Pretest | 29 | 5.5 | 4.9 |
| Posttest | 29 | 5.0 | 4.6 |
| Follow-up | 8 | 4.9 | 2.7 |
| Control | | | |
| Pretest | 22 | 5.2 | 3.3 |
| Retest | 22 | 5.0 | 3.2 |
| Posttest | 22 | 4.0 | 2.7 |
| CBI Physical Burden Scale | | | |
| Treatment | | | |
| Pretest | 29 | 5.3 | 3.5 |
| Posttest | 29 | 5.1 | 3.5 |
| Follow-up | 8 | 6.3 | 2.9 |
| Control | | | |
| Pretest | 22 | 4.9 | 3.2 |
| Retest | 22 | 5.2 | 3.2 |
| Posttest | 22 | 4.6 | 2.5 |
| CBI Social Burden Scale | | | |
| Treatment | | | |
| Pretest | 29 | 4.6 | 3.9 |
| Posttest | 29 | 4.2 | 3.4 |
| Follow-up | 8 | 5.8 | 4.6 |
| Control | | | |
| Pretest | 22 | 4.3 | 2.9 |
| Retest | 22 | 4.8 | 3.0 |
| Posttest | 22 | 4.5 | 2.4 |
| CBI Emotional Burden Scale Group | | | |
| Treatment | | | |
| Pretest | 29 | 4.7 | 3.9 |
| Posttest | 29 | 4.0 | 3.2 |
| Follow-up | 8 | 3.3 | 3.9 |
| Control | | | |
| Pretest | 22 | 5.0 | 3.8 |
| Retest | 22 | 4.9 | 3.3 |
| Posttest | 22 | 4.3 | 3.6 |
| CBI Overall Burden Scale | | | |
| Treatment | | | |
| Pretest | 29 | 24.9 | 13.1 |
| Posttest | 29 | 22.7 | 12.2 |
| Follow-up | 8 | 24.1 | 8.0 |
| Control | | | |
| Pretest | 22 | 23.4 | 9.5 |
| Retest | 22 | 24.0 | 10.0 |
| Posttest | 22 | 20.8 | 9.4 |
| CRIS - Stress Monitoring Scale | | | |
| Treatment | | | |
| Pretest | 29 | 68.9 | 33.8 |
| Posttest | 29 | 73.1 | 28.9 |
| Follow-up | 8 | 72.9 | 26.9 |
| Control | | | |
| Pretest | 22 | 74.5 | 26.7 |
| Retest | 22 | 74.8 | 25.8 |
| Posttest | 22 | 78.3 | 22.0 |
| CRIS - Self Disclosure Scale | | | |
| Treatment | | | |
| Pretest | 29 | 70.0 | 25.9 |
| Posttest | 29 | 75.2 | 27.5 |
| Follow-up | 8 | 71.3 | 29.4 |
| Control | | | |
| Pretest | 22 | 68.0 | 31.3 |
| Retest | 22 | 66.8 | 29.8 |
| Posttest | 22 | 70.0 | 28.9 |
| CRIS - Structuring Scale | | | |
| Treatment | | | |
| Pretest | 29 | 75.9 | 23.2 |
| Posttest | 29 | 105.2 | 154.6 |
| Follow-up | 8 | 72.1 | 23.2 |
| Control | | | |
| Pretest | 22 | 78.8 | 16.9 |
| Retest | 22 | 78.5 | 16.3 |
| Posttest | 22 | 80.7 | 16.0 |

**TABLE 1**

**(Continued)**

| Group | N | M | SD |
|---|---|---|---|
| CRIS - Tension Control Scale | | | |
| Treatment | | | |
| Pretest | 29 | 60.8 | 29.4 |
| Posttest | 29 | 67.8 | 28.2 |
| Follow-up | 8 | 61.3 | 29.5 |
| Control | | | |
| Pretest | 22 | 65.2 | 28.9 |
| Retest | 22 | 66.2 | 28.3 |
| Posttest | 22 | 72.2 | 23.7 |
| CRIS - Confidence Scale | | | |
| Treatment | | | |
| Pretest | 29 | 66.1 | 28.1 |
| Posttest | 29 | 66.1 | 30.6 |
| Follow-up | 8 | 54.0 | 32.8 |
| Control | | | |
| Pretest | 22 | 78.5 | 19.1 |
| Retest | 22 | 75.9 | 22.7 |
| Posttest | 22 | 80.5 | 20.8 |
| CRIS - Overall Coping Effectiveness Scale | | | |
| Treatment | | | |
| Pretest | 29 | 68.9 | 19.1 |
| Posttest | 29 | 72.0 | 19.1 |
| Follow-up | 8 | 64.5 | 21.7 |
| Control | | | |
| Pretest | 22 | 72.4 | 15.6 |
| Retest | 22 | 71.9 | 15.6 |
| Posttest | 22 | 77.5 | 13.8 |

*Note.* CBI = Caregiver Burden index. CRIS = Coping Resources Inventory for Stress.

ability to self-disclose, and (c) increasing care giver's overall perception of coping resources. The treatment was not successful in (a) increasing specific coping skills or (b) decreasing the care giver perception of burden. Although impossible to assess directly in this study, it is possible that the psychoeducational intervention may have prevented care givers from experiencing negative changes in burden and specific coping skills, at least during the time of the study. This may be related to the fact that no participants who were included in the final data sample indicated a significant change in the care-giving relationship (positive or negative) while participating in the intervention.

It is possible that specific coping resources could be enhanced and perception of the care giver burden decreased by allowing more time for practice of specific coping and stress management skills. Future interventions could build on the current model to include these emphases. In addition, the inclusion of group and individual counseling could affect care giver perception of burden and coping resources. Many participants in the current intervention expressed a desire to participate in group counseling while participating in the current study. Although this may have been the most beneficial and appropriate way to handle issues that surfaced during the intervention, participants were told that this was not a part of the current study and that they would be referred to additional resources following completion of the study if they so desired. Additionally, they were told that they could be referred for counseling immediately if they believed that was necessary. Only one participant left the group to attend counseling while the group was ongoing.

The results of this study should be considered in terms of possible limitations related to sampling, instrumentation, and response error. Because the sample for the study was restricted to persons in one semirural southern county, the results cannot necessarily be generalized to all adult children caring for aging parents, particularly those residing in large urban areas. Additionally, literature exists that suggests that different cultural groups provide care giving in different ways (Smerglia, Deimling, & Barresi, 1988). It was beyond the scope of this study to include cultural differences; therefore, the results may not be generalized to members of other cultural groups. The inclusion of volunteers as well as self-report measures may also have affected the results in unknown ways. There was no way to control for group dynamics that may be a result of personal characteristics of the group leader. The involvement of the same group leader in this study, however, was intended to make the effects standard across the groups.

## IMPLICATIONS FOR COUNSELORS

Despite the recognition that adult children are the primary care givers to aging parents, there have been relatively few interventions proposed to meet their needs. There have been even fewer studies that have attempted to assess the effectiveness of interventions for adult children caring for aging parents. This study attempted to address both of these areas. The outcomes have implications for counselors working with both adult children and their aging parents, as well as for those engaged in counselor training and research.

Through increased knowledge of community resources and the aging process, provision of emotional support, and development of stress reduction techniques and coping strategies, psychoeducational group interventions can help adult children to better meet their own needs as well as the needs of their aging parents. This is particularly important given that adult children provide most of the care for older persons in the community. Additionally, this type of intervention indirectly benefits older persons by better preparing family care givers to assist them with necessary activities. When aging parents have their needs met, they are able to remain independent and avoid premature institutionalization. By decreasing stress for care givers and enhancing their communication skills, more positive family relationships may result for all family members.

Adult children perform a vital role in society—parent care. As the number of older persons requiring care continues to increase, society will rely heavily on adult children to fill the care-giving role. Because this role is uniformly stressful, the development and implementation of interventions designed to assist adult children in coping with care-giving stresses will become increasingly important. Counselors and counselor educators will need to possess knowledge related to the unique needs of this population and counseling interventions that are effective in meeting these needs.

One important finding of this study related to the needs of adult children is that although surveys have found that adult children caring for aging parents indicate a need for knowledge related to aging, that is only the beginning. Many care givers who participated in the study

indicated a need for group support and group counseling during the course of the intervention. When asked if they would attend a group that was advertised to provide counseling and support, however, they indicated that they would be more likely to attend an educational group than a counseling group.

Another important finding of this study was related to the age of the care givers. The mean age of the care givers was 63.5 years. This meant that participants were caring for aging parents in their 80s and 90s. These ages were significantly higher than was expected based on a review of the literature describing the typical care giver as a midlife adult. Although this finding may be unique to the participants in this particular study, the characteristics of participants in future studies will be important to consider in designing effective interventions.

The intervention developed for this study was found to be effective. Replication of the intervention with groups of adult children of aging parents, particularly those from urban settings and multicultural populations, is needed to establish further the validity of the approach described.

The intervention was not found to be effective in altering care giver burden. Future studies might explore the possibility of modifying the intervention so that the groups evolve into ongoing support groups. Additionally, participants indicated a need and desire for group counseling. Would group procedures be effective in helping to reduce care giver burden? If so, under what circumstances?

These questions and many others can be answered only through future research. Clearly, there is a need for effective interventions to assist adult children in coping with the demands of the care-giving role. The current study is a beginning that can provide a foundation for additional efforts.

## REFERENCES


Altschuler, J., Jacobs, S., & Shiode, D. (1984). Psychodynamic time-limited groups for adult children of aging parents. *American Journal of Orthopsychiatry, 55*(3), 397–404.

Arling, G., & McAuley, W. (1983). The feasibility of public payments for family caregivers. *Gerontologist, 23*, 300–306.

Billings, A., & Moos, R. (1981). The role of coping responses and social resources in attenuating the stress of life events. *Journal of Behavioral Medicine, 4*, 139–157.

Brody, E. (1974). Aging and family personality: A developmental view. *Family Relations, 13*, 23–37.

Brody, E., Davis, L., Fulcomer, M., & Jonsen, P. (1979). *Three generations of women: Comparisons of attitudes and preferences for service providers*. Paper presented at the 32nd Annual Meeting of the Gerontological Society, Washington, DC.

Brody, E., Poulshock, W., & Masciocchi, C. (1978). The family caring unit. *Gerontologist, 18*, 556–561.

Brookfield, S. (1987). *Understanding and facilitating adult learning*. San Francisco, CA: Jossey-Bass.

Callahan, J., Diamond, L., Giele, J., & Morris, R. (1980). Responsibility of the family for their severely disabled elders. *Health Care Financing Review, 1*, 24–48.

Cantor, M. (1983). Strain among caregivers: A study of experience in the United States. *Gerontologist, 23*, 597–604.

Cicirelli, V. (1981). *Helping elderly parents: The role of adult children*. Boston, MA: Auburn House.

Clark, N., & Rakowski, W. (1983). Family caregivers of older adults: Improving helping skills. *Gerontologist, 23*, 637–642.

Cutler, L. (1985). Counseling caregivers. *Generations, 10*(1), 53–57.

Dobson, J., & Dobson, R. (1985). The sandwich generation: Dealing with aging parents. *Journal of Counseling and Development, 63*, 572–574.

Erikson, E. (1963). *Childhood and society*. New York: Norton.

Gallagher, D. (1985). Intervention strategies to assist caregivers of frail elders. In C. Eisdorfer (Ed.), *Annual review of gerontology and geriatrics* (pp. 194–246). New York: Springer.

Havighurst, R. (1972). *Developmental tasks and education* (3rd ed.). New York: David McKay.

Horowitz, A. (1985). Family caregiving to the frail elderly. In C. Eisdorfer (Ed.), *Annual review of gerontology and geriatrics* (pp. 194–246). New York: Springer.

Johnson, E., & Spence, D. (1982). Adult children and their aging parents: An intervention program. *Family Relations, 31*, 115–121.

Lauer, M. (1981). Palmore's facts on aging quiz: Does it measure learning? *Gerontology and Geriatrics Education, 2*, 3–7.

Matheny, K., Curlette, W., Aycock, D., Pugh, J., & Taylor, H. (1987). *Coping Resources Inventory for Stress*. Atlanta, GA: Health Prisms.

McMahon, B., & Ames, B. (1983). Educational programming for midlife adults with parent-caring responsibilities. *Educational Gerontology, 9*, 377–387.

Miller, D. (1981). The sandwich generation: Adult children of the aging. *Social Work, 26*, 419–423.

Miller, D. (1982). Aging parents and their middle-age children. *Educational Horizons, 50*, 179–183.

Miller, D., & Dodder, R. (1980). A review of Palmore's facts on aging quiz. *Gerontologist, 20*, 673–679.

Myers, J. (1988). The mid/late life generation gap: Adult children with aging parents. *Journal of Counseling and Development, 66*, 331–335.

Myers, J. E. (1989). *Adult children and aging parents*. Alexandria, VA: American Association for Counseling and Development.

Myers, J. E., Poidevant, L., & Dean, L. (1991). Group work with older persons and their caregivers: A review of the literature. *The Journal for Specialists in Group Work, 16*, 197–205.

Neugarten, B. (1968). The awareness of middle age. In B. Neugarten (Ed.), *Middle age and aging*. Chicago, IL: University of Chicago Press.

Novak, M., & Guest, C. (1989). Caregiver response to Alzheimer's disease. *International Journal of Aging and Human Development, 28*, 67–79.

Palmore, E. (1988). *Facts on aging quiz: A handbook of uses and results*. New York: Springer.

Retonet, V. (1987). How adult children respond to role transitions in the lives of their aging parents. *Educational Gerontology, 13*, 341–355.

Smerglia, V., Deimling, G., & Barresi, C. (1988). Black/White comparisons in helping and decision-making networks of impaired elderly. *Family Relations, 37*, 305–309.

Smith, K. (1989). Serving the sandwich generation: Working with adult children of aging parents. *Journal of Independent Social Work, 3*, 79–94.

United States Administration on Aging. (1989). *A profile of older Americans*. Washington, DC: Author.

Wasow, M. (1986). Support groups for family caregivers of patients with Alzheimer's disease. *Social Work, 31*(2), 93–97.

Wedl, L. (1986). *Stress coping resources and their relationship to life satisfaction among older persons*. Doctoral dissertation, Ohio University, Athens.

Zarit, J. (1982). Predictors of burden and distress for caregivers of senile dementia patients (Unpublished dissertation, University of Southern California). *Dissertation Abstracts International, 43*, 03B.

Zarit, S., Todd, P., & Zarit, J. (1986). Subjective burden of husbands and wives as caregivers: A longitudinal study. *Gerontologist, 26*, 260–266.



***Valerie L. Schwiebert*** *is an assistant professor in the Department of Educational Psychology, Counseling, and Special Education at Northern Illinois University, DeKalb.* ***Jane E. Myers*** *is a professor in the Department of Counseling and Educational Development at the University of North Carolina at Greensboro. Correspondence regarding this article should be sent to Valerie L. Schwiebert, Department of Educational Psychology, Counseling, and Special Education, Northern Illinois University, DeKalb, IL 60115.*