

BUILDING ON THE BENEFITS: ASSESSING SATISFACTION AND WELL-BEING IN ELDER CARE*

**CHRISTINE J. JENSEN, MICHAEL FERRARI,
AND JOHN C. CAVANAUGH**

One hundred interviews were conducted with primary caregivers, with 63 held in the home of the caregiver and the remainder conducted in a location convenient to the caregiver. Each participant completed the Caregiver Well-Being Scale (CWB), the Caregiving Uplifts Scale (CUPL), the Caregiving Satisfaction Scale (CSS), and the Center for Epidemiologic Studies Depression Scale (CES-D). Scores on the CWB, the CUPL, and the CSS were significantly higher for caregivers for elders with a primarily physical (e.g., heart disease) rather than a primarily cognitive impairment (e.g., dementia); indicating greater perceived caregiver benefits based on type of care recipient impairment. Little evidence of depressive symptoms was found in either group of caregivers. These findings advance previous research by indicating that caregivers experience satisfaction in their role and the potential for personal fulfillment even when faced with challenging circumstances. The validation of positive experiences and the impact that positive appraisals have on levels of depression are discussed.

Simply put, caregiving is complex. A heavy emphasis has been placed on burden as the primary or only experience of the caregiver. Therefore, the tendency to view caregiving in a negative light exists. Indeed, most studies on elder care have concentrated on burden exclusively, overlooking potential benefits caregivers perceive. Highlighting burdens affiliated with elder care, without acknowledging potential benefits provides an incomplete picture and may be detrimental to aging families. It can set up negative expectations, self-fulfilling prophecies and limit our conceptual treatment of caregiver adjustment and satisfaction.

The burden approach has emerged over the past 20 years describing experiences of family members engaged in elder care. Research has highlighted numerous negative effects associated with the role of elder caregiver including financial strain and detriments to one's health (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995). The scales measuring caregiver burden are exten-

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sive and include: The Burden Interview, Caregiver Strain Index, Caregiving Hassles Scale, and the Screen for Caregiver Burden (Vitaliano, Young, & Russo, 1991). Generally, these scales ask the caregiver to rate the problem behaviors and mood disturbances of the care recipient, and/or evaluate distressing experiences associated with the care situation. Researchers and clinicians are cautioned that these scales, and others like them, are geared towards specific populations (e.g., dementia caregivers) and most appropriate when applied to that population (Vitaliano et al., 1991). In addition, these scales presume burden and do not provide the caregiver the opportunity to disclose rewarding and positive aspects associated with their care situation. Among others, Kramer (1997) has noted the obvious importance of investigating the positive aspects of caregiving. From her reviews of many other elder care studies, she has concluded caregivers not only have wanted to share these aspects but recognition of these reports "increased their feelings of pride in their ability to meet challenges and provided an enhanced sense of meaning and pleasure" (p. 217).

There has been a lack of extensive exploration of benefits in different caregiver—care receiver groups. Caregiver satisfaction has been a focus of research since the late 1980s and early 1990s, and has also been variably referred to as caregiver gain, caregiving uplifts, caregiver meaning, and caregiver well-being (Kinney & Stephens, 1989). Regardless of the terms, however, the belief that caregivers can and do receive some satisfaction from their caregiver role has finally arrived.

Since it is likely that type of care recipient impairment affects positive caregiver appraisals, a brief review of the distinctions being made between caregivers based on care recipient impairment follows. In 1996, the National Alliance for Caregiving and the American Association of Retired Persons completed a phone survey of 1500 caregivers (Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999). Among the findings, analyses showed that dementia caregivers spend more time in caregiving tasks (e.g., providing assistance with ADLs and IADLs) and suffer more negative consequences from their responsibilities (e.g., reduced levels of mental and physical health) (Ory et al., 1999). Comparably less is known about those who provide care for relatives with physical impairments. Ory and her colleagues (1999) hypothesized that caregivers of relatives with physical impairments report lower levels of burden because of their age (e.g., they are more likely to be younger) and presumably greater capability in managing the physical assistance needed (e.g., encouraging the elder's use of supportive equipment such as a walker). In addition, caregivers providing physical assistance are less likely to have to contend with challenging behavior problems prominent in the care recipient with dementia.

In an effort to examine impact of type of impairment, Barusch and Spaid (1996) investigated two groups of spouses, those caring for a spouse with dementia (N = 62) and a physical impairment (N = 62). Barusch and Spaid

noted that spouses of those with dementia reported greater help from social contacts, which may explain the perceptions of experiencing fewer burdens, a perception not consistently reported by other studies (Tower, Kasl, & Moritz, 1997). One potential confound is that spouses, in contrast to others, typically provide care to the most disabled, often involving time-intensive and comprehensive efforts (Cantor, 1983; Horowitz, 1985). Spouses are also more likely to maintain the caregiving role longer. Following from this, it may not be surprising that studies contrasting spousal and parental care have also found spouses to report higher levels of stress and burden (Barusch & Spaid, 1996; George & Gwyther, 1986; Young & Kahana, 1989). However, this experience may, in part, be due to the spousal caregivers being more elderly themselves, and thus dealing with changes related to their own aging (Motenko, 1989; Stephens & Franks, 1999).

A recent study conducted by Ory and her colleagues (1999) at the National Institutes of Health examined differences in those providing care for relatives with dementia versus those providing care for relatives with physical impairments. They found that individuals who provide care to those with physical impairments are slightly younger ($M = 43$ years) than caregivers of those with cognitive deficits ($M = 46.3$ years). They hypothesize that caregivers of relatives with physical impairments report lower levels of burden because they are younger and thus are more capable of managing the physical assistance needed by their relatives. They may also be less likely to have to contend with behavior problems (e.g., wandering, suspicion, screaming) in the care recipient and can encourage the care recipient to utilize supportive devices such as canes, walkers, or wheelchairs that can promote increased mobility. These aides can be helpful to frail older adults, but as frailties grow more severe or are complicated by a fall, or cognitive impairment, more demands will be placed on the caregiver. How family members deal with these impairments not only depends upon the severity of the impairment(s) but also depends upon the familial relationship of the caregiver to the care recipient.

Social scientists note that because caregivers are more likely to be middle-aged, they are involved in many commitments ranging from their career, to their own family, to community organizations. While these individuals may truly feel "caught in the middle," Stephens and Franks (1995) have actually found that possessing multiple roles, particularly for daughters as caregivers, buffers, rather than exacerbates stress levels. Dautzenberg, Diederiks, Philipsen, and Tan (1999) report similar findings with middle-aged daughters ($N = 743$). They found that the additional roles that these daughters performed did not increase their levels of stress or strain. In fact, their findings suggest that, for caregiving daughters, the lack of social roles is associated with distress.

When addressing the issue of positive caregiver appraisals, several researchers interested in caregiving gain have examined how individuals find meaning in their caregiving role (Farran, 1997; Noonan & Tennstedt, 1997). The challenges typically associated with elder care may provide opportunities for

caregivers to discover and create meaning, to see the positive, and to grow personally. Noonan and colleagues (1996) found gratification and satisfaction with the caregiving role, a sense of family reciprocity, friendship that caregiving offered, and commitment to doing “what needs to be done” (p. 313) as predominant themes. In addition, individuals experiencing extremely stressful circumstances may strive to find value and meaning where they feel they have little control (Kahana, Kahana, Harel, & Rosner, 1988). In their investigation of the hassles and uplifts of 60 caregivers of family members with Alzheimer’s disease, Kinney and Stephens (1989) found caregivers spending more time in caregiving reported more uplifts and satisfaction from their helping role. More than 80% of the 110 events listed on the Caregiving Hassles and Uplifts Scale elicited both positive and negative appraisals by caregivers. Of those ADL tasks that were evaluated as hassles (e.g., assistance with walking), most were unrelated to social and psychological distress. Kinney and Stephens (1989) hypothesized that these tasks are more predictable and, to some extent, more controllable than hassles associated with cognitive decline.

Cohen and her colleagues (2002) reported further evidence of positive appraisals in elder care. In a national sample from the Canadian Study of Health and Aging, 73% of caregivers surveyed identified at least one positive aspect about their caregiver role. The researchers found that caregivers who reported positive feelings reported significantly less burden. In addition, participants’ scores on the Center for Epidemiologic Studies—Depression Scale were much lower and self-rated health was higher when positive aspects were considered. Positive aspects reported included: companionship (22.5%), fulfillment (21.8%), enjoyment (12.8%), high quality of life (7.3%), and the meaningfulness of their role (5.9%).

The present investigation was undertaken to explore benefits in caregiving. The purpose of the investigation was threefold. First, care recipient and caregiver characteristics associated with caregiver satisfaction and well-being were identified. Second, differences in caregiver well-being and satisfaction based on care recipient impairment were examined. Third, differences in satisfaction and well-being between adult children and spousal caregivers were examined.

To address the three purposes of the investigation, the following hypotheses were tested. First, certain caregiver characteristics (e.g., receiving assistance from others, caregiver gender) would directly impact caregiver well-being and satisfaction. This hypothesis is based on previous research by Cantor (1983); George and Gwyther (1986); Brody (1990); Dautzenberg and colleagues (1999); Goodman, Zarit, and Steiner (1999), and many others who have explored caregiver characteristics and their influence on caregiver well-being. Second, caregivers of relatives with physical impairments, such as heart disease or diabetes, would report more uplifts, satisfaction, and enhanced well-being than caregivers to elders with cognitive impairments. This hypothesis is predicated on previous research by Barusch and Spaid (1996) and Kinney

and Stephens (1989) who examined differences in caregiver perceptions based on type of care recipient impairment. Finally, spouses would report more uplifts and satisfaction but reduced levels of well-being than adult children caregivers. Although this may appear contradictory, the potential for reduced levels of well-being in spouses pertains to the notion that spousal caregivers are older themselves and their well-being (e.g., sleep, nutrition) as impacted by their own health, is likely affected to a greater extent than with younger caregivers (see Ory et al., 1999, summarized earlier).

Methodology

Participants

One hundred caregivers each completed structured interviews. Participants were recruited from the Mid-Atlantic region of the United States via church newsletters (11% of the sample) referrals made by other participants (11%), social service agencies (37%), local newspapers (6%), and from other individuals familiar with the study (e.g., doctors offices) (35%).

Demographic data for the caregivers are presented in Table 1. The mean age of the caregivers was 59.98 ($SD = 11.56$), range 29 to 82 years. Females accounted for 82% of the participants, with 49% adult daughters, 35% spouses (26 wives, 9 husbands), 9% sons, 3% daughters-in-law and 4% granddaughters or other relatives. The average educational level was 14.6 years, range 3 to 24 years of education ($SD = 3.05$). Caucasians accounted for 85% of the sample, 13% were African American, and one percent Hispanic and Asian American. These demographic characteristics are similar to national estimates (e.g., National Alliance for Caregiving and the AARP, 1987). While 41 caregivers engaged in care for a relative with a primarily cognitive impairment, the remaining 59 assisted a relative with a primarily physical impairment. For purposes of this study, cognitive impairment was defined as functionally significant deficits in mental status including a decline associated with memory, intellectual operations, communication, and reasoning ability. Physical impairment was defined as principal deficits in motor function (e.g., mobility, transfers) and/or other aspects of physical performance, and the absence of significant deficits in the cognitive domain. Participants had been caring for their relative for an average of five years ($SD = 5.14$), ranging from four months to three decades. Caregivers reported an average of 56 hours ($SD = 34.33$) of caregiving per week. Although the interview focused on the care of one family member, 14 participants noted that they simultaneously maintained responsibility for the care of another ill person.

Demographic data for the care recipients are presented in Table 2. The mean age of the care recipients was 81.72 ($SD = 8.64$), range 60 to 105 years. Females accounted for 63% of the care recipients. The ethnic breakdown of care recipients mirrored that of the caregivers. With respect to co-residence,

Table 1

Categorical Descriptive Variables for Caregivers

| Variable | n/% | Variable | n/% |
|-----------------------------|-----|-----------------------------------|-----|
| Roles^a | | Race and sex | |
| No other roles | 2 | Caucasian women | 69 |
| One | 9 | Caucasian men | 16 |
| Two-three | 37 | African American women | 11 |
| Four-Five | 37 | African American men | 2 |
| Six or more | 15 | Hispanic women | 1 |
| Marital status | | Asian American women 1 | |
| Married | 74 | Relation to care recipient | |
| Single | 11 | Daughter | 49 |
| Widowed | 7 | Wife | 26 |
| Divorced | 6 | Husband | 9 |
| Cohabiting with partner | 2 | Son | 9 |
| Self-reported health | | Daughter-in-law 3 | |
| Good | 64 | Sister or niece | 3 |
| Excellent | 16 | Granddaughter | 1 |
| Fair or Poor | 20 | Education | |
| Employment | | Less than high school degree | 6 |
| Employed | 46 | Some college | 40 |
| Retired | 45 | Bachelor's degree | 16 |
| Unemployed or housewife | 9 | Post-graduate work | 21 |

Note. Column heading n/% is used because total number of participants was 100, therefore n and % result in same number.

^a Caregivers were asked how many other roles they performed (e.g., mother, volunteer) in addition to their caregiver and employment status.

78 care recipients lived with the caregiver, while the remaining 22 resided in their own home or apartment. Of those care recipients with a physical impairment, heart disease (23.7%), stroke (20.3%), arthritis/frailty (13.6%), and diabetes (10.2%) were reported most commonly. Alzheimer's disease (36.6%), other dementias, including frontal lobe and vascular (31.7%), stroke (17.1%), and memory loss/confusion (12.2%) were reported most commonly by caregivers of relatives with primarily cognitive impairments. Notably caregivers were first asked to identify the care recipient's impairment as primarily cognitive or physical in nature. Then, participants were asked to list the specific impairments, noting which impairment(s) was the primary condition. In formulating their response, caregivers were asked to consider medical diagnoses and other information given by the care recipient's healthcare provider. While comorbidity was a possibility, caregivers were able to categorize their care recipient's impairments as primarily cognitive or physical. Thus, it was possible that a condition (e.g., stroke) was categorized by some caregivers as primarily cognitive and by others as primarily physical.

Procedure

All caregivers responding with an interest in the study were given a brief explanation regarding eligibility.¹ Inclusion criteria were that caregivers self-identified as the current primary caregiver for their relative and that they had been providing regular care for the past three months or longer. The care recipient had to have a probable or definite diagnosis of a cognitive impairment or a physical impairment and be at least 60 years of age. In addition, the care recipients were required to be living in their home or in the home of the caregiver and be receiving minimal formal services (e.g., any outside service that provided more than 12 hours of direct assistance per week and charged a fee for this service).

The majority of interviews (63%) took place in the home of the caregiver, although participants were welcome to select a location most convenient and comfortable to them. Thus, 13 interviews were held at a local senior center or retirement community center, nine took place at a church or library, six were held at the participant's place of work, four were held in a restaurant, one took place at the care recipient's home (e.g., adult daughter who preferred to meet at her mother's home), and the remaining four interviews were conducted over the phone.

Instruments

Data collection began with the caregiver completing a demographic worksheet. The participant then completed four questionnaires with the help of the interviewer. These scales, presented in the interview in the following order, included: The Caregiver Well-Being Scale (Tebb, 1995), The Caregiving

Table 2

| Categorical Descriptive Variables for Care Recipients | | | |
|---|-----|--|-----|
| Variable | n/% | Variable | n/% |
| Living arrangement | | Primary impairment - physical ^b | |
| With caregiver | 78 | Heart condition | 14 |
| Own home/apt. | 22 | Stroke | 12 |
| Primary impairment | | Arthritis/frailty | 8 |
| Physical | 59 | Diabetes | 6 |
| Cognitive | 41 | Use of formal services ^c | |
| Primary impairment – cognitive ^a | | Home healthcare | 56 |
| Alzheimer's disease | 15 | Physical therapy | 38 |
| Other dementia | 13 | Adult daycare | 15 |
| Stroke | 7 | Meals on Wheels | 2 |
| Memory loss/confusion | 5 | | |

Note. Column heading *n/%* is used because total number of participants/care recipients was 100, therefore *n* and % result in same number.

^a Once it was identified that the care recipient's primary impairment was cognitive, the caregiver was asked what the primary diagnosis was and the top four are listed.

^b Once it was identified that the care recipient's primary impairment was physical, the caregiver was asked what the primary diagnosis was and the top four are listed.

^c Caregivers were asked which, if any, formal services, the care recipient had utilized since the participant began needing the caregiver's assistance.

Uplifts Scale (Stephens, Kinney, Franks, & Norris, 1990), The Caregiving Satisfaction Scale (Lawton, Kleban, Moss, Rovine, & Glicksman, 1989; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991), and the Center for Epidemiologic Studies Depression Scale (Radloff, 1977). These scales were utilized because they tap positive appraisals, or the absence of, in caregiving, they each possess appropriate psychometrics, and they are reasonably brief in nature. While they have been validated with adult children and spousal caregivers, these scales have not been used in this combination or used simultaneously in caregiver research to date.

The Caregiver Well-Being Scale. The shortened version of the Caregiver Well-Being (CWB) Scale (Tebb, 1995), consisting of 16 items, was used in this study. The CWB – Revised Shortened Form includes two subscales: Basic needs (BN) and activities of living (AOL), both viewed as critical to caregiver well-being. Each BN and AOL item is rated on a five-point scale from rarely to usually, considering the extent to which the activity has been met over the past three months. The BN subscale consists of items related to self-security and attending to one's physical and emotional needs ($\alpha = .91$, original scale). The AOL subscale consists of items related to time for one's self and

family support ($\alpha = .81$, original scale). Reliability for the full 45-item scale is 0.94, however the psychometrics of the shortened form have yet to be published (Berg-Weger, Rubio, & Tebb, 2000). Reliability coefficients for the current study were: 0.69 for the AOL subscale, 0.69 for the BN subscale, and 0.79 for the 16-item shortened form of the CWB.

The Caregiving Uplifts Scale. Stephens and her colleagues (1990) have defined "uplifts" as those events that make one feel joyful or satisfied. On the Caregiving Uplifts Scale (CUPL), caregivers are asked to rate the 42 statements first, if they happened in the past week ("yes" or "no") and second, if yes, how much of an uplift on a four-point scale ranging from "It Wasn't" to "A Great Deal." For example, the caregiver would respond to "Care recipient cooperating" by noting whether it happened in the past week, and if it happened, then by identifying the extent to which this experience was an uplift. There are five subscales within the CUPL that identify situations that lead to caregiver uplifts. Behavior uplifts ($\alpha = .90$) are defined as those care recipient actions that lead to positive feelings in caregivers, that is, caregiver uplifts, such as "Care recipient leaving things in place." Cognitive uplifts ($\alpha = .89$) include those care recipient mental skills, such as "Care recipient keeping track of things" that lead to caregiver uplifts. Basic ADL uplifts ($\alpha = .81$) include assistance with ADLs, such as "Bathing care recipient." Instrumental ADL uplifts ($\alpha = .78$) include assistance with IADLs, such as "Transporting care recipient to doctor/other places." Finally, social network uplifts ($\alpha = .74$), defined as uplifts from interacting with friends or family, include items such as "Family showing understanding about caregiving." Cronbach's alpha for the full scale is 0.94. Reliability coefficients from this study include: 0.80 for the behavior uplifts subscale, 0.74 for the cognitive uplifts subscale, 0.90 for the basic ADL uplifts subscale, 0.64 for the instrumental ADL uplifts subscale, 0.35 for the social network uplifts subscale, and 0.77 for the 42-item CUPL.²

The Caregiving Satisfaction Scale. The Caregiving Satisfaction Scale (CSS) is a five-item subscale from The Caregiving Appraisals Scale (Lawton et al., 1989; Lawton et al., 1991). Respondents are asked to rate each statement, such as "I really enjoy being with the care recipient" or "Helping the care recipient has made me feel closer to her/him," on a five-point scale ranging from strongly disagree to strongly agree. Higher numbers reflect greater satisfaction from the caregiving situation. Studies of the CSS show Cronbach's alpha coefficients ranging from 0.68 to 0.71. An alpha coefficient of 0.79 was found for this study.

The Center for Epidemiologic Studies Depression Scale. The Center for Epidemiologic Studies Depression Scale (CES-D) is a 20-item self-report measure assessing psychological well-being. Participants are asked to indicate how often they have experienced positive ("I felt depressed.") and negative ("I enjoyed life.") feelings related to depression during the past week. Each item is rated on a four-point scale from "rarely or none of the time" to "most

or all of the time.” Four positive items (“I felt hopeful about the future”) are reverse scored and lack of well-being is indicated by higher scores, with scores of 16 generally serving as the cutoff for depression. This scale took approximately five minutes to complete and has been considered a primary assessment tool of depressive symptoms among adults (Coyle & Roberge, 1992), although “it is not intended for use in making clinical diagnoses” (Haynie, Berg, Johansson, Gatz, & Zarit, 2001, p. 113). Studies of the CES-D show Cronbach’s alpha coefficients ranging from 0.84 to 0.90. The internal consistency coefficient for this study was 0.84. Scores on the CES-D provided a greater understanding of the caregiver’s well-being, while also tapping the more specific dimension of mental health.

Results

Table 3 provides means and standard deviations for each scale. In addition, means and standard deviations are also provided for those individuals caring for a relative with a primarily physical or a primarily cognitive impairment.

An initial step of the data analysis was the calculation of zero-order correlations among the caregiver and care recipient characteristics and the depen-

Table 3

| Measure | All Caregivers | | Physical | | Cognitive | |
|---------|----------------|-----------|----------|-----------|-----------|-----------|
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |
| CWB | 59.88 | 8.55 | 61.61 | 8.41 | 57.40 | 8.23 |
| CWB-AOL | 28.08 | 4.98 | 29.14 | 5.03 | 26.56 | 4.56 |
| CWB-BN | 31.79 | 4.75 | 32.47 | 4.84 | 30.81 | 4.51 |
| CUPL | 50.51 | 17.12 | 54.90 | 14.20 | 44.03 | 19.10 |
| CUPL-BU | 17.26 | 6.67 | 19.12 | 5.97 | 14.53 | 6.76 |
| CUPL-CU | 12.85 | 5.60 | 14.81 | 4.15 | 9.95 | 6.23 |
| CUPL-AU | 6.71 | 5.06 | 6.78 | 4.82 | 6.61 | 5.46 |
| CUPL-IU | 6.94 | 3.55 | 6.86 | 3.28 | 7.05 | 3.94 |
| CUPL-SN | 7.02 | 2.76 | 7.44 | 2.73 | 6.38 | 2.72 |
| CSS | 19.59 | 3.83 | 20.49 | 2.69 | 18.25 | 4.80 |
| CES-D | 10.61 | 7.95 | 10.29 | 7.53 | 11.08 | 8.60 |

Note. CWB = Caregiver Well-Being Scale; CWB-AOL = Activities of Living Subscale; CWB-BN = Basic Needs Subscale; CUPL = Caregiving Uplifts Scale; CUPL-BU = Behavior Uplifts Subscale; CUPL-CU = Cognitive Uplifts Subscale; CUPL-AU = Activities of Daily Living Subscale; CUPL-IU = Instrumental Activities of Daily Living Subscale; CUPL-SN = Social Networks Subscale; CSS = Caregiving Satisfaction Scale; CES-D = Center for Epidemiologic Studies – Depression Scale.

dent variables. These data are presented in Table 4. Prior to addressing the specific hypotheses, it should be noted that, not surprisingly, there was a moderate inverse relationship between the CES-D and the other measures of caregiving appraisal. Also, the CSS was most strongly related ($r = .711^{***}$) with the CUPL, signifying an anticipated possibility that these scales tap similar constructs, and/or are both related in a similar manner to the quality of the reported caregiving relationship.

With respect to the first hypothesis, testing for the impact caregiver characteristics would have on levels of well-being and satisfaction, scores on the depression measure were positively related to the number of caregiving hours per week ($r = .239^*$) and were negatively related to the number of other roles taken on by the caregiver ($r = -.198^*$). The CWB was most strongly related to the caregiver's educational level ($r = .271^{**}$) and to the care recipient's age ($r = .267^{**}$). A positive relationship between the caregiver's age ($r = .266^{**}$) and the CUPL was found, reflecting a tendency of older caregivers reporting more uplifts in their role. An additional correlation to note included the negative relationship between the caregiver's health ($r = -.202^*$) and the number of formal services utilized.

To test both the second and third hypotheses, *MANOVAs* were conducted using care recipient impairment and caregiver relationship as the fixed factors and the scales as the dependent variables. Significant differences based on care recipient impairment were found for the CWB ($F(1, 98) = 6.23, p < .01$), the CSS ($F(1, 97) = 7.84, p < .01$), and the CUPL ($F(1, 97) = 9.67, p < .01$). No significant difference was found for the CES-D when considering the physical or cognitive impairments of the care recipients, thus confirming the absence of depressive symptoms as reported by the participants.

Both spouses and adult children reported higher levels of well-being, as assessed by the CWB, when caring for a relative with a physical limitation than their counterparts caring for a relative with a cognitive limitation. Although the interaction was not statistically significant, the largest difference in means among the scales based on care recipient impairment and the relationship to the care recipient was found with the CUPL. Again, both spouses and adult children reported more uplifts than when the care recipient had a physical impairment than a cognitive impairment. There were no significant differences on the depression measure based on care recipient impairment, caregiver relationship to the caregiver, nor the interaction of these two variables. However, adult children caring for a parent with a cognitive impairment ($M = 12.13$) and spouses caring for a partner with a physical impairment ($M = 11.82$) reported higher levels of depression on the CES-D. This is an interesting pattern when compared to spouses caring for a relative with a cognitive impairment ($M = 9.5$) and adult children caring for a parent with a physical impairment ($M = 9.38$), who reported lower levels of depression on the CES-D.

Further analyses of care recipient impairment (hypothesis 2) were conducted based upon the continuous and categorical variables. Table 5 high-

Table 4

| Correlations Between Caregiver and Care Recipient Characteristics and Total Scale Scores | | | | | | | | | | | | | | |
|--|--------|---------|--------|--------|--------|---------|-------|--------|-------|-------|----------|---------|----------|----|
| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 1. Caregiver age | — | | | | | | | | | | | | | |
| 2. Education | -.178 | — | | | | | | | | | | | | |
| 3. No. of months | -.119 | -.194 | — | | | | | | | | | | | |
| 4. No. of hrs/week | .237* | -.231** | .238* | — | | | | | | | | | | |
| 5. Roles | .126 | -.096 | -.166 | -.039 | — | | | | | | | | | |
| 6. Health | -.105 | .062 | -.187 | -.053 | -.033 | — | | | | | | | | |
| 7. Medications | .354** | -.117 | .004 | .120 | .154 | -.287** | — | | | | | | | |
| 8. Recipient age | .032 | .177 | -.154 | -.236* | .057 | .058 | .078 | — | | | | | | |
| 9. Informal helpers | -.192 | .045 | -.098 | -.109 | .190 | -.138 | .075 | -.096 | — | | | | | |
| 10. Formal services | -.086 | -.035 | .158 | .034 | -.005 | -.202* | .110 | .149 | .107 | — | | | | |
| 11. CWB | .142 | .271** | -.246* | -.253* | .180 | .179 | .036 | .267** | .057 | -.123 | — | | | |
| 12. CUPL | .266** | -.121 | -.046 | .068 | .084 | -.087 | -.057 | .053 | -.063 | .048 | .143 | — | | |
| 13. CSS | .150 | -.065 | -.069 | .024 | .057 | -.111 | .020 | .128 | .022 | .149 | .152 | .711*** | — | |
| 14. CES-D | -.026 | -.160 | -.217 | .239* | -.198* | -.185 | -.031 | -.066 | .034 | -.036 | -.351*** | -.297* | -.355*** | — |

Note. CWB = Caregiver Well-Being Scale; CUPL = Caregiving Uplifts Scale; CSS = Caregiving Satisfaction Scale; CES-D = Center for Epidemiologic Studies – Depression Scale.

* $p < .05$

** $p < .01$

*** $p < .001$

lights the means and standard deviations of the continuous variables for caregivers based on both impairment of and the relationship to the care recipient. Caregivers for those with physical impairments ($M = 1.93$) had more informal helpers ($F(1, 98) = 9.66, p < .01$) than individuals caring for relatives with primarily cognitive impairments ($M = 1.44$). Informal helpers were identified as any relative, friend, or neighbor offering periodic or regular assistance for the needs of the care recipient. Only one significant interaction was found, based on the two primary categories, caregiver relationship and care recipient impairment ($F(1, 98) = 5.86, p < .05$) when considering the number of informal helpers called upon to offer caregiving assistance (see Table 5). Both spouses ($M = 2.0$) and adult children ($M = 1.89$) reported receiving more help when caring for an elder with physical rather than cognitive impairments. Spouses ($M = 0.94$) caring for a relative with a primarily cognitive impairment reported receiving the least amount of assistance, while adult children ($M = 1.76$) caring for a parent with physical needs reported receiving a similar amount of informal assistance as when they cared for a parent with cognitive limitations.

Examining care recipient relationship (fixed factor) as specified in the third hypothesis, there were no significant differences in *MANOVA* found for any of the total scale scores. One subscale of the CUPL, the ADL Uplifts Subscale, did yield a significant difference as spouses ($M = 7.92$) reported more uplifts ($F(1, 97) = 4.02, p < .05$) than adult children caregivers ($M = 5.95$). Also, adult children ($M = 49.22$) reported fewer caregiving hours per week ($F(1, 98) = 5.92, p < .05$) than spouses ($M = 67.68$). Interestingly, adult children ($M = 84.94$ years) were found to be caring for a significantly older relative ($F(1, 98) = 26.94, p < .0001$) than were spousal caregivers ($M = 76.47$ years). In other words, the care recipients who were being cared for by their adult children were nearly nine years older than were the spousal care recipients.

Finally, with respect to testing the third hypothesis, a variety of factors impacting the caregiver—care receiver relationship were evaluated including co-residence, and gender and employment status of caregiver. When considering mean scores on the well-being measure, a significant interaction was found ($F(1, 98) = 5.20, p < .05$) based on caregiver gender and relationship to the care recipient. Husbands ($M = 55.31$) had the lowest scores, with wives ($M = 60.52$) reporting a slightly higher level of well-being. Adult daughters ($M = 59.55$) reported somewhat lower levels of well-being when compared to adult sons ($M = 64.33$). A significant interaction was also found ($F(1, 97) = 5.90, p < .05$) when considering these caregiver characteristics and mean scores on the CES-D. Again, husbands ($M = 14.78$) appeared to be most impacted by their caregiving responsibilities, as their depression scores were markedly higher than any of the other caregivers. Daughters ($M = 11.17$) reported the next highest level, with wives ($M = 9.62$) reporting slightly lower levels. Interestingly, sons ($M = 6.33$) reported the lowest levels of depression. A score of 16 or higher is usually considered an indication of an individual's risk for

Table 5

| Caregiver and Care Recipient Variable Means for All Caregivers and Based on Care Recipient Impairment and Caregiver Relationship | | | | | | | | | | |
|--|----------------|-----------|----------|-----------|-----------|-----------|----------|-----------|----------------|-----------|
| Variable | All Caregivers | | Physical | | Cognitive | | Spouses | | Adult Children | |
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |
| Caregiver | | | | | | | | | | |
| Age | 59.98 | 11.56 | 60.98 | 11.45 | 58.54 | 11.71 | 70.29 | 8.20 | 53.66 | 8.33 |
| Caregiver | | | | | | | | | | |
| Education | 14.63 | 3.05 | 14.47 | 3.02 | 14.85 | 3.12 | 13.83 | 2.47 | 15.11 | 3.28 |
| Recipient | | | | | | | | | | |
| Age | 81.72 | 8.64 | 83.05 | 8.62 | 79.80 | 8.41 | 76.47 | 7.35 | 84.94 | 7.79 |
| No. of | | | | | | | | | | |
| Months | 66.98 | 61.65 | 60.18 | 56.0 | 76.76 | 68.51 | 62.01 | 47.77 | 70.02 | 68.99 |
| No. of | | | | | | | | | | |
| Hrs/Week | 56.24 | 34.33 | 51.71 | 34.53 | 62.75 | 33.38 | 67.68 | 35.13 | 49.22 | 32.13 |
| Caregiver | | | | | | | | | | |
| Roles | 3.70 | 1.80 | 3.88 | 1.64 | 3.44 | 2.0 | 3.95 | 1.66 | 3.55 | 1.88 |
| Informal | | | | | | | | | | |
| Helpers | 1.73 | .97 | 1.93 | .96 | 1.44 | .92 | 1.55 | 1.06 | 1.84 | .91 |
| Formal | | | | | | | | | | |
| Services | 1.47 | .94 | 1.58 | 1.21 | 1.32 | .85 | 1.42 | .98 | 1.50 | .92 |
| Caregiver | | | | | | | | | | |
| Medications | 1.64 | 1.19 | 1.69 | 1.21 | 1.55 | 1.18 | 2.08 | 1.12 | 1.36 | 1.16 |
| Caregiver | | | | | | | | | | |
| Health ^a | 2.94 | .65 | 2.92 | .62 | 2.98 | .69 | 2.84 | .55 | 3.00 | .70 |

^a Caregiver Health was rated by each caregiver as 1 = Poor, 2 = Fair, 3 = Good, and 4 = Excellent.

depression, and on average, caregivers' scores were well under this level at 10.61. Also, out of the 18 male participants, nine were sons and nine were husbands; therefore, whether these differences would exist in a larger sample of males is not known.

Differences were found based upon co-residence of the care recipient with the caregiver. If the care recipient resided with the caregiver, the caregiver (*M*

= 61.73 years) was older ($F(1, 98) = 9.05, p < .01$) than if the recipient lived in his/her own home ($M = 53.77$ years), likely resulting from the number of spouses present in this study. In addition, the caregiver ($M = 62.99$) reported providing more care hours per week ($F(1, 98) = 15.77, p < .0001$) than if the care recipient resided in his/her own home ($M = 32.30$ hours per week). Interestingly, the health of the caregivers was better if the care recipient resided with them ($F(1, 98) = 4.33, p < .05$).

Based upon the employment status of the caregivers, scores on the well-being measure were significantly higher ($F(1, 98) = 4.30, p < .05$) for retired caregivers ($M = 61.73$) compared to employed caregivers ($M = 58.37$). Individuals who were retired ($M = 65.27$) provided more hours of care per week ($F(1, 98) = 5.95, p < .05$) than employed caregivers ($M = 48.85$). Retired caregivers ($M = 2.0$) noted taking more prescription medications ($F(1, 98) = 8.27, p < .01$) than employed individuals ($M = 1.33$), although there were no differences in self-reported health.

Summary of Results

There was little indication of depression regardless of caregiver—care receiver relationship or care recipient impairment; however, husbands appeared to be most impacted by their caregiving responsibilities, as their depression scores were higher than any of the other caregivers. There was a moderate inverse relationship between the depression measure and the other measures of caregiving appraisal. There was a strong positive relationship between the satisfaction and uplifts measures, signifying an anticipated possibility that these scales tap similar constructs. Also, a positive relationship between the caregiver's age and the uplifts scale was found, reflecting a tendency of older caregivers reporting more uplifts in their role. A variety of interactions were reported. Significant differences based on care recipient impairment were found for the well-being measure, the satisfaction scale, and the uplifts scale. Although no significant differences were found for any of the total scale scores when examining care recipient relationship, both spouses and adult children reported receiving more help when caring for an elder with a primarily physical rather than a primarily cognitive impairment.

Discussion

This study set out to illuminate some of the lesser known and less appreciated aspects of elder care; that caregivers can and often do characterize their experiences as satisfying and uplifting. It adds to the knowledge base offered by others (e.g., Cohen et al., 2002; Cohen, Gold, Shulman, & Zuccherro, 1994; Stephens et al., 1990) further debunking the myth that caring is “hardly reciprocal and only rarely rewarding” (Nolan, Grant, & Keady, 1996, p. 146).

Of those studies that have investigated caregiver benefit or satisfaction, they have generally done so by including these more “positive” variables as mediators, while still considering stress or burden as the *ultimate* outcome. The impetus for this study began by asking “why can’t caregiver benefit or satisfaction be an outcome in and of itself?” This study clearly demonstrated that caregivers do perceive rewards and gratification in their role. They reported enjoyment in their ability to provide this type of personal care and emotional support. Furthermore, many reported that the family member receiving care has shown significant health improvements due to their attention and detail to the care.

It should also be noted that very low scores on the depression measure ($M = 10.6$, where 16 is the cutoff score for a diagnosis of depression) were found for caregivers, even though the length of care, measured in months and in hours per week, was well above national averages, i.e. 30–35 hours per week (see Tennstedt, 1999). Therefore, little indication of depression was present regardless of the caregiver relationship to the care recipient or the type of care recipient impairment. In addition, the more roles an individual had, outside of caregiving, the lower the scores on the depression measure. The variable “multiple roles” has been examined as both a buffer and a mediator of more stressful outcomes. Stephens and Franks (1995) and Dautzenberg and his colleagues (1999) have reported that adult daughters who possess multiple roles have found these additional “identities” (e.g., mother, spouse, employee, church member) a source of beneficial support buffering against increased stress levels. In this study, caregivers who held several roles, in addition to caregiving, reduced their likelihood of depression, offering further evidence that multiple roles can indeed mediate the negative outcomes routinely found in elder care.

In the present study, there are several important factors related to care recipient impairment to consider. First, caregivers for those with cognitive deficits reported many hours of care ($M = 62.75$). Most caregiver studies (e.g., Administration on Aging, 2001; Tennstedt, 1999) have reported that informal caregivers, for both those with physical and cognitive limitations, provide an average of 30–35 hours of care per week. The average of this sample was twice that amount. This may be due to care recipients who were in advanced stages of dementia and thus, needed more “round-the-clock” care, as attested by many caregivers. This difference may also be attributed to methodological differences in how information concerning the number of caregiving hours per week was gathered. Also, those providing care to a relative with a primarily cognitive impairment reported caring for an average of 16 months longer and 11 hours more per week than those caring for a relative with a primarily physical impairment. This lengthy duration of caregiving implies that this sample of caregivers was caring for very frail elders and was clearly dedicated to remaining in this caregiving role.

The “relationship” of the caregiver to the care recipient appears to have less of an impact on the caregiver’s perceptions of the experience as positive

when compared to the impact the type of impairment has on these perceptions. No significant difference was found between caregiver relationship and the measures of well-being, uplifts, satisfaction, or depression; however, there is little disagreement that adult children and spouses have different caregiving experiences. Adult children are more likely to have care responsibilities for both younger and older family members. They are also more likely to be employed, thus stretching their time and resources.

With respect to gender, very few differences were found between male and female caregivers and their perceptions of their role as rewarding. However, when considering the interaction of gender and the caregiver's "relationship" to the care recipient, significant differences emerged both with the depression measure and the well-being measure. In this study, husbands reported higher levels of depression than wives, adult daughters and adult sons, with sons reporting a very low level. Husbands reported the lowest levels on the well-being measure, with sons reporting the highest, and the wives and daughters scoring very similarly and falling in between these two levels. With females accounting for 82% of the sample, true gender differences may have been difficult to detect. Caregiver studies continue to reflect U.S. demographics, with women outnumbering men in all categories at 65 years of age and older (U.S. Census, 2000). However, with regards to the sons' depression scores, two additional factors are worth considering. It may have been that these sons felt uncomfortable disclosing their real feelings in the interview, as items inquired about episodes of crying and feeling sad. Or, it may simply be that these sons were secure and confident in their role and thus found the questions on the depression measure and well-being measure were less applicable to them. In addition, husbands who are primary caregivers for their wives are likely to be older and thus their own health may have played a part in these results.

When examining the impact of informal assistance, 89% of the caregivers reported receiving assistance from their friends or family at least occasionally since the caregiving began. Furthermore, spouses caring for a relative with a physical impairment reported more informal help than adult children caring for a parent with physical needs. Spouses caring for a relative with a cognitive impairment reported the least amount of informal assistance, when they may be the very individuals who need the most assistance, particularly if their spouse is in an advanced stage of dementia or Parkinson's disease. Also, caregivers for elderly relatives tend to express their desire to handle the personal care without the assistance of either informal or formal support (Nolan et al., 1996) and from this sample, caregivers indicated that no one else could provide the level of care that they were providing. Barusch and Spaid (1996) found spouses of those with dementia reported more assistance from social contacts, which may explain the perceptions of experiencing less burden, a perception not consistently reported by other studies (Tower, Kasl, & Moritz, 1997).

Limitations

Addressing several limitations with respect to this study are in order. First, this study has limited statistical power due to the small sample size, particularly with respect to subsamples (e.g. spouses). Second, to some extent, these data are cross-sectional (comparing adult children and spouses), thus limiting our understanding of caregiver perceptions over the long term. Some days or weeks may be more challenging or rewarding than others. In addition, the scales had different periods of time (e.g., the past week, the past three months) the caregiver was asked to consider.³ Some caregivers reported “you got me on a good week” noting they would have had different responses had time of measurement been different. In this respect, a longitudinal design would have been better suited to capture these experiences.

Third, findings from this study reflect the perceptions and experiences of caregivers who responded to the study announcement. Therefore, caregivers were not randomly chosen, thus limiting generalizability to other informal caregivers. In addition, the educational level of the participants and their access to resources (e.g., city and state of residence) may have played a part in their positive feelings. The majority of participants (94%) had at least some college education. College-educated individuals are more likely to take better care of their health (Pincus, Callahan, & Burkhauser, 1987), are more likely to reside in communities with accessible resources, and thus, may feel more confident in their role.

Finally, the care recipient was present during some of the interviews. When the interview was scheduled, the caregiver was informed that the questions would be asked in a one-on-one setting, between the researcher and the primary caregiver. However, it appears that this setting is not always a realistic one for caregivers when the care recipient resides with them. Thus, the issue of the lack of respite for these caregivers remains critical and could have affected the accuracy of the data gathered.

Practical Implications

This study highlights the strong desire that caregivers possess to be acknowledged for both the positive and negative feelings they hold about their role. The low levels of depression reported in this group of caregivers are worthy of further exploration. Indeed, there may be a link between optimistic attitudes, increased feelings of satisfaction, and reduced levels of depression. Factors related to optimism and similar personality traits may be important predictors of positive appraisals and/or lower levels of depression.

Although Cohen and her colleagues (2002) found co-residence was significantly related to elevated depression scores, the findings from this study offer support in favor of the benefits associated with co-residence between the caregiver and care recipient. When care recipients co-resided with the

caregivers, caregivers were much more likely to report their own health as "good" or "excellent" compared to those caregivers who lived separately from the care recipient. Also, there were no differences in depression scores based on co-residence.

This study also brings forward the importance of communication; a dimension critical in understanding family interaction. In this study, communication, or the lack of, arose as an important aspect distinguishing caregivers for elders with cognitive impairments from those caring for elders with physical impairments. Teaching communication strategies to families involved in care for an elder with cognitive limitations (e.g., dementia, stroke) might reduce the stresses associated with this provision of care. Cavanaugh and his colleagues (1989) examined the ways in which caregivers provide instructions to assist the elder care recipient in completing tasks. The caregivers for individuals with dementia provided significantly more concrete explicit directions, including location and form or shape instructions, on the Block Design subtest from the Wechsler Adult Intelligence Scale (WAIS-R), than the comparison dyads. The caregivers also incorporated more aspects of feedback and motivation in their directions. Therefore, it appears that many caregivers are already equipped with the knowledge and desire for communication and continued research in this area can foster these skills to enhance communication.

IADLs and ADLs are fairly easy to measure because behaviors can be counted, but less obvious activities, such as emotional support, should not go unnoticed. Although emotional support, advice, and companionship are more challenging variables to measure, they are also reported as the most common forms of exchange in these care arrangements (Eggebeen, 1993). "When included in the inventory of services, emotional support emerges as the most universal caregiving task, engaged in by almost every caregiver" (Horowitz, 1985; p. 203). In addition, both Horowitz and Cicirelli (1983) found that regardless of the time and hands-on care given, the caregiver identified the provision of emotional support as the "most important and most critical type of assistance offered to their frail relative" (Horowitz, 1985, p. 203). Therefore, in addition to the impact being able to communicate with the care recipient has on the caregiver's perceptions, the value placed on being able to offer emotional support is great. Caregivers who perceive their offering of emotional support to go unappreciated or without acknowledgement may be more likely to disclose negative appraisals of their situation.

In conclusion, the aim of this study was not to develop an overarching conceptual model of the rewards of caregiving; however, those models presented by Pearlin (1999) and Aneshensel and colleagues (1995) may be helpful in providing direction for studies examining predictors of positive appraisal. In addition, future studies of caregiver satisfaction would build upon longitudinal designs as found in the research of Roth, Haley, Owen, Clay, and Goode (2001), and Goodman, Zarit, and Steiner (1999). Those individuals who main-

tain feelings of satisfaction and well-being, through the ups and downs, will prove most interesting to study. As family caregivers progress from the initial period of care, possibly following a crisis situation, a period of adjustment may occur where information and resources are gathered. This adjustment phase may be followed by burnout as the research clearly shows elder care involves daily tasks that can become consuming and exhaustive. However, a rebound phase may follow this burnout period, whereby a renewed commitment to provide this intimate level of care occurs, as long as the caregiver is able and confident in the quality of care he/she can provide. Therefore, levels of depression are likely to rise and fall throughout the caregiving experience. It is possible then that the group of caregivers who participated in this study reported many positive and satisfying experiences associated with a phase of adjustment or rebound. Increased awareness and understanding of satisfaction in caregiving is important in order to both support current caregivers and to promote and empower future generations of caregivers to seek fulfillment and personal growth from their caregiving experiences.

Biographical Notes

Corresponding author: Christine J. Jensen, Center for Public Policy Research, The College of William and Mary, P.O. Box 8795, Williamsburg, Virginia 23187-8795. E-mail: cjjens@wm.edu

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Christine J. Jensen, Ph.D., is research manager with the Center for Public Policy Research at the College of William & Mary. Christine received her BA and MA in Psychology from Roanoke College and Radford University, respectively, and her PhD in Family Studies from the University of Delaware. Christine is active with the Alzheimer's Association and is a member of the American Psychological Association and the Gerontological Society of America.

Michael Ferrari, Ph.D., received his BA in psychology from SUNY at Stony Brook. He earned his MS and PhD degrees in psychology from Rutgers University and completed a post-doctoral fellowship in clinical neuropsychology at Johns Hopkins School of Medicine. He is an Associate Professor at the University of Delaware in the Departments of Individual and Family Studies and Psychology. Other areas of recent research have included the pharmacotherapy of Alzheimer's disease and the effects of Stroke on life adaptation.

John C. Cavanaugh, Ph.D., is President of the University of West Florida. He received his BA in psychology with high honors from the University of Delaware, and his MA and PhD degrees in psychology from the University of Notre Dame. John is a Fellow of the American Psychological Association and the Gerontological Society of America, and a Charter Fellow of the American Psychological Society. He is author or coauthor of 10 books and nearly 70 articles and chapters on topics in aging and teaching.

Notes

1. It should be noted that there were an additional 26 caregivers who contacted the first author who were ineligible (e.g., relative resided in a long-term care facility or was deceased) or unable (e.g., time constraints) to participate.

2. The reliability coefficient for the total scale was calculated based on the total subscale scores rather than the 42 individual items, because at least one participant did not rate at least one of each of the 42 items.
3. To avoid confusion during the interview, participants were handed a 5" x 8" card to follow along as the researcher read the items.

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