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The increasing elderly population is creating a greater need for care providers. Research indicates that while caregiving can be rewarding, it can also generate stress which, in turn, impacts individual well-being. Social support, however, may foster the well-being of persons who are experiencing stressful events.

The purpose of this study was to examine the contribution of perceived social support from close family (siblings, spouse, and children) and background characteristics to well-being for a sample of women caring for mothers who were not cognitively impaired. The sample for this study (N=65) was drawn from a larger five year western Oregon study of women caregivers (Walker, 1986), and included only those women who: participated during the third year of the larger study; were married; and had at least one child and one sibling. Data were collected via face-to-face interviews.

Pearson correlations and multiple regressions were
used to assess the contribution of family support and
background characteristics to well-being. Well-being, as
measured by the CES-D scale, was the dependent variable in
all regressions. The independent variables included the
caregiver's self-reported health, and her perceptions of
support (measured by supportiveness, positivity of contact,
and conflict) from siblings, spouse, and children.
Overall, results from this study indicated that women
caregivers' perceptions of relationships with close family
did impact their well-being. While measures designed to
tap supportiveness and positivity of contact were not
significantly related to well-being, conflict was.
Specifically, conflict with a spouse was associated with
lower well-being. Second to conflict with a spouse,
respondent's health was the strongest predictor of well-
being: poor health was significantly associated with lower
well-being.

In general, recommendations and implications focused
on the need for: (a) repeating this type of research among
other caregiver populations; (b) developing multi-
dimensional measures of family support; (c) services that
provide individuals with positive ways to deal with life-
tensions that foster interpersonal conflict; and (d)
services that target caregivers who are in poor health.

Contribution of Perceived Social Support from Close Family
and Background Characteristics to the Well-Being of Women
Providing Care to Dependent Mothers

by

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CHAPTER I

INTRODUCTION

The increasing elderly population is creating a greater need for caregivers, and a majority of the aging population relies solely on family for supportive services. Research indicates that while providing care to elderly family members can be rewarding, it can also generate stress. This stress may negatively impact an individual's well-being. Social support, however, can protect persons from the negative consequences of stressful events. Thus, it appears important to investigate the contribution of social support to the well-being of individuals providing care to elderly family members. These issues will be explored in greater detail below.

Statement of the Problem and Justification for the Study

An increasing demand for caregiving research is suggested by the growing elderly population. This section illustrates the need for research on caregiving through an exploration of: (a) the increasing need for caregivers; (b) caregiver stress and well-being; and (c) the influence of social support on stress.

An Increasing Need for Caregivers

Both the proportion and number of elderly persons are increasing nationwide. At the beginning of this century less than one out of ten Americans was aged 55 or older, and one in twenty-five was age 65 or older. In 1986 one out of five Americans was at least 55 years old and one in eight was at least 65 years of age (U.S. Senate Special Committee on Aging, American Association of Retired Persons, Federal Council on the Aging & U.S. Administration on Aging, 1988). Today the proportion of persons aged 65 or older has almost tripled to approximately 26 million people. Even more dramatic changes will occur as post-World War II baby boomers reach retirement age. In fact, aged persons of the baby boom cohort will eventually represent about twenty percent of the population, or 59 million people (Davis, 1983).

The state of Oregon reflects the trend of a growing elderly population as well. According to a recent survey (Sales & Marketing Management, 1990), the number of persons aged 65 or older in Oregon showed an 8.5% increase between 1985 (N = 328,078 persons) and 1990 (N = 356,073 persons). Furthermore, the average age for both males and females in Oregon has increased.

As people increase in chronological age they are more prone to physical losses. For example, impaired vision (e.g., cataracts), hearing loss, and decreased physical

mobility (e.g., arthritis, osteoporosis) are commonly associated with growing older (Schwartz, Snyder, & Peterson, 1984). These changes may create the need for assistance, such as the help of a caregiver. The need for caregivers, and therefore the need to understand caregiving, becomes even more evident when one considers that: (a) approximately ninety-five percent of the elderly population are non-institutionalized (DeLaski-Smith, 1985); and (b) nearly 5.1 million of these community dwelling elders need assistance with some aspect of personal care or home management activities in order to live independently (American Association of Retired Persons, 1986). Furthermore, research indicates that the majority of elderly individuals rely solely on family caregivers for supportive services (Stoller, 1983). The duty of caring for an aging individual typically falls upon the spouse. In the absence of a spouse, however, children (Miller, 1981), usually the adult daughter of the elderly individual (Abel, 1986; Callahan, 1987; Troll, 1971), assume caregiving responsibilities.

Caregiver Stress and Well-Being

Research indicates that there are several stresses associated with caregiving, including: (a) negative emotions and feelings; (b) personal and relational strains; and (c) personal sacrifices. Some emotional stresses include anxiety, feelings of being overwhelmed (Robinson &

Thurnher, 1979), feelings of confinement (Robinson &

Thurnher, 1979), and concern from watching a loved one

deteriorate (Abel, 1986, 1989; Robinson & Thurnher, 1979).

Some common feelings may be anger, resentment, depression

(Rivera, Rose, Futterman, Lovett, & Gallagher-Thompson,

1991), frustration, impatience, irritation, helplessness,

and guilt (Cicirelli, 1983). In turn, these feelings may

"spill-over," compromising the care provided to the

dependent elder (e.g., the caregiver may vent these

feelings of frustration when interacting with the care

recipient).

Research suggests that there is a relationship between

stress and well-being. Cicirelli (1983) posited that the

stresses of caregiving can be so severe that the mental or

physical health of the caregiver deteriorates. He studied

parent caregivers and found that most of them reported

feeling physically worn out, emotionally exhausted, and

having parents that were not satisfied with the help given.

The most frequent strains arose from the caregiving

situation itself rather than from secondary sources such as

spouse, children, and job conflicts. On the other hand,

Smith, Smith, and Toseland (1991) studied women who were

parent caregivers and found that a major area of difficulty

for these caregivers was with their relationships with

husbands, siblings, and children.

According to Abel (1989) and Cantor (1983) caregivers may sacrifice personal desires, individuality, and social life to meet the competing demands of dependent elderly family members. This view is supported by Cicirelli (1983) who found that adult children, to some extent, may feel tied down in their daily schedules and have to give up their own social and recreational activities in order to make time to assist their aging parents. The research of Robinson and Thurnher (1979) also suggests that parent caregivers may feel confined because of the unanticipated constraints that come about from the increased dependence of aging parents. Perhaps these caregivers anticipated having time to fulfill missed gratifications during mid-life; but instead, their time became filled with caregiving responsibilities (Robinson & Thurnher, 1979).

In addition, the "sandwich generation" (i.e., adult children who are sandwiched between the financial dependence of their own children and the increasing needs of their aging parents) may be particularly susceptible to the stresses and strains of caregiving. These individuals are faced with a unique set of transitions and responsibilities, including: letting go of youth, coping with children who are still at home, facing the prospect of the "empty nest", and making decisions about caring for their aging parents while coping with their own job demands and spousal commitments (Schwartz, Snyder, & Peterson,

1984). Thus, it is plausible that middle aged caregivers may be especially prone to the multiple role strains of the "sandwich generation" (Brody, 1985; Cantor, 1983).

On the other hand, the research of Rosenthal, Matthews, and Marshall (1989) indicates that "women in the middle" (i.e., women caught between competing demands) are not as prevalent as previously suggested. Rosenthal and colleagues argued that most researchers studying "women in the middle" focus on adult children whose parents need care, thus making it difficult to determine the degree to which current cohorts of middle-aged women in general are "sandwiched." In response to this research gap, Rosenthal et al. studied a representative, random sample of 163 women aged 40 to 69 and found that women aged 40 to 44 had the greatest potential of being caught by competing demands. A closer examination of a subsample of women (n=40), however, revealed that less than one quarter of them (n=9) had been or were involved in parent care, almost half would never be involved in parent care because their parents were deceased (n=18), and about one-third had not yet been involved in providing high levels of parent care (n=13). These conclusions are noteworthy because they: (a) suggest that parent care may not be normative for all middle aged daughters; and (b) reveal that research conclusions may be a function of methodology (e.g., sample selection).

Some researchers posit that caring for an aging parent is particularly stressful when there is a strong bond between the caregiver and care recipient (Brody, 1985; Cantor, 1983). Strong bonds of attachment are likely to exist in the mother-daughter relationship (Baruch & Barnett, 1983). Thus, daughters giving care to their aging mothers may be particularly susceptible to caregiving stress. On the other hand, it should be noted that some research suggests that caregiving can improve the mother-daughter relationship, especially when the daughter is a care manager rather than a care provider (Abel, 1986).

Research indicates caregiver stress and burden may be associated with increased depression for caregivers. This link between caregiver stress and depression has primarily been explored among samples of caregivers to cognitively impaired care recipients. There is a paucity of research, however, exploring the effects of caregiving for elders who are not cognitively impaired (Gallagher, Rose, Rivera, Lovett & Thompson, 1989).

Social Support

The literature suggests that social support may influence how an individual experiences and copes with caregiving related stressors (Brody, 1985; Thoits, 1982). In particular, research indicates that perceived social support can protect persons experiencing negative or stressful events, and may prevent psychological symptoms

such as depression (Arling, 1987; Caplan, 1981; Cohen, Sherrod, & Clark, 1986; Cohen & Wills, 1985; Cooke, Rossmann, McCubbin, & Patterson, 1988; Hirsch, 1980; Zarit, Reever, & Bach-Peterson, 1980). Support from close family may be especially important for fostering well-being (Brody, 1985; Fischer, 1982; Lin et al., 1985; Mutran & Reitzes, 1984).

Social support research provides a framework and rationale for concluding that support from close family is an important predictor of well-being for women caregivers. For example, support from significant others may reduce the impact of stress by promoting a clearer understanding of the stressful situation (Caplan, 1981). Feedback from others may help stressed individuals to develop, implement, and evaluate a sensible plan of action for dealing with the problem. Social support can also reinforce a person's positive self-feeling (Abel, 1989; Cohen & Wills, 1985), assure her that difficult situations can be tolerated (Caplan, 1981), and provide a sense of stability in her life situation (Cohen & Wills, 1985).

On the other hand, close relationships can undermine as well as reinforce the caregiver's well-being (Hirsch & Rapkin, 1986). For example, receiving support from others may bring with it an added burden to reciprocate support (Belle, 1982; Coyne & Bolger, 1990; Goldsteen & Ross, 1989). Furthermore, conflict with significant others may

be a cost that counterbalances the support they give (Abel, 1989).

Summary and Purpose of the Study

The increasing elderly population has created a need for more caregivers (Davis, 1983; Schwartz, Snyder & Peterson, 1984; U.S. Senate Special Committee on Aging, American Association of Retired Persons, Federal Council on the Aging & U.S. Administration on Aging, 1988). In the absence of a spouse, the responsibility of caregiving typically falls upon adult children (Miller, 1981), usually daughters (Abel, 1986; Callahan, 1987: Troll, 1971). A review of the literature indicates that caregivers are exposed to a variety of situations that foster stress (Abel, 1989; Brody, 1985; Cantor, 1983; Cicirelli, 1983; Robinson & Thurnher, 1979; Schwartz, Snyder, & Peterson, 1984; Smith, Smith, & Toseland, 1991), which, in turn, impacts their well-being. Adult daughters caring for elderly mothers may be particularly susceptible to stress (Baruch & Barnett, 1983) due to their close bond with their mothers (Baruch & Barnett, 1983; Brody, 1985; Cantor, 1983), and because of the multiple demands on their time and energy (Brody, 1985; Cantor, 1983).

In addition, the literature suggests that support from close family (e.g., siblings, a spouse, and children) may be particularly important for maintaining the well-being of women care providers (Brody, 1985; Fischer, 1982; Lin,

Woelfel, & Light, 1985): Positive support can enhance well-being, whereas conflict may lower well-being. To date, however, most studies addressing the relationship between social support and the well-being of care providers have focused on persons caring for cognitively impaired elders, with few studies exploring the experiences of caregivers to individuals who are not cognitively impaired (Gallagher, Rose, Rivera, Lovett, & Thompson, 1989). The purpose of this study was to examine the contribution of perceived social support from close family and background characteristics to the well-being (depression) of women providing care to mothers who were not cognitively impaired.

<center>Definition of Terms</center>

Perceived Social Support

Perceived social support refers to the caregiver's perception of how supportive her sibling(s), spouse, and child(ren) had been over the past year. In particular, perceived social support from each family member was assessed using three measures, which included caregiver perceptions of: (a) supportiveness; (b) positivity of contact; and (c) amount of conflict.

Details about these measures can be found in chapter three.

Well-Being

Well-being refers to the caregiver's depression as measured by the Center for Epidemiological Studies Depression Scale

(CES-D, Gatz & Hurwicz, 1990). Details about this measure can be found in chapter three.

CHAPTER II

REVIEW OF LITERATURE

This chapter explores the impact of social support on the well-being (depression) of individuals. Support from close family members (siblings, spouse, and children) may particularly influence how one perceives and copes with caregiving responsibilities.

On one hand, social support from close family may promote well-being and successful coping strategies for caregivers. According to Caplan (1974, p. 6),

> "Significant others help the individual mobilize his [sic] psychological resources and master his emotional burdens; they share his tasks; and they provide him with extra supplies of money, materials, tools, skills, and cognitive guidance to improve his handling of his situation."

Cohen and Wills (1985) suggest that social support may be beneficial because "social networks provide persons with regular positive experiences and a set of stable, socially rewarded roles in the community" (p. 311). This kind of social support may be related to well-being because it provides "positive affect, a sense of predictability and stability in one's life situation, and a recognition of self-worth" (p. 311).

On the other hand, relationships with close family may undermine (as well as reinforce) well-being. Hirsch and Rapkin (1986) suggest that support or rejection from social network members is likely to have a critical effect on role

satisfaction. According to these researchers, social networks may

> "provide or withhold cognitive, emotional, and material assistance that can be used to accomplish role tasks...[and]...either validate or cast into doubt the adequacy of role performance" (p. 1238).

Receiving support may also bring with it an added burden to reciprocate support (Belle, 1982; Coyne & Bolger, 1990; Goldsteen & Ross, 1989), and conflict with significant others may be a cost that counterbalances the support they give (Abel, 1989; Fischer, 1982). Some researchers even argue that negative rather than positive interactions have the strongest impact on well-being (Pagel, Erdly, & Becker, 1987; Rook, 1984).

Research indicates that close family members, especially the caregiver's spouse, children, and siblings, are salient sources of support in times of need (Brody, 1985; Fischer, 1982; Graney, 1985). The following review of literature will examine: (a) the general nature and contributions of social support to well-being; (b) the relationship between support from close family (i.e., siblings, spouse and children) and well-being; and (c) background characteristics that may impact the well-being of daughters providing care to their mothers. The literature is divided into subsections, and each subsection ends with a summary. In addition, an overall summary of "family support" is included at the end of this literature review.

Literature specifically addressing the influence of social support on female caregivers to physically (but not cognitively) impaired mothers is limited (Gallagher, Rose, Rivera, Lovett, & Thompson, 1989). Thus, implications are extrapolated, in part, from the broader literature (e.g., addressing caregiving and social support).

<u>Social Support</u>

Research suggests that personal networks generally protect individuals from many vicissitudes of life (Fischer, 1982). Thus, perceived social support may buffer some of the strains associated with caregiving (Brody, 1985; Thoits, 1982), and may prevent psychological symptoms such as depression (Arling, 1987; Caplan, 1981; Cohen, Sherrod, & Clark, 1986; Hirsch, 1980; Cohen & Wills, 1985; Cooke, Rossmann, McCubbin, & Patterson, 1988). According to Caplan (1981), social support may reduce the impact of stress by promoting a clearer understanding of the stressful situation. In particular, appropriate social support may increase a person's chances of achieving "mastery." Mastery was used to refer to individual behavior that: (a) reduced physiological and psychological manifestations of emotional arousal to tolerable limits; and (b) mobilized the person's internal and external resources.

In addition, feedback from others may help the stressed individual develop, implement, and evaluate a

sensible plan of action for dealing with the problem.

Social support can reinforce an individual's positive self-

feeling and assure her that difficult situations can be

tolerated and that successful outcomes will follow her

actions (Caplan, 1981). The nature of support and the

variety of ways in which it has been examined follows.

Definition

According to Lin, Simeone, Ensel, and Kuo (1979),

social support is "support accessible to an individual

through social ties to other individuals, groups, and the

larger community" (p. 109). Graney (1985) added to this

definition by introducing the concept of "interpersonal

support," suggesting that in order to provide interpersonal

support "a person must often be a 'significant other,'

linked socially through primary group ties such as the

family (especially the spouse and/or children)" (p. 288).

It should be acknowledged, however, that social support is

not limited to family, but can also be provided by

interpersonal ties such as friends.

At face value, this definition of support seems

straightforward. The complex nature of social support,

however, makes it difficult to define. For example, the

definition of social support may vary based upon how it is

measured (e.g., actual instrumental assistance, perceived

emotional support, advice, network size).

Conceptualizations of Social Support

In general, the literature supports two mechanisms through which social support may be related to stress: (a) the stress buffering model--perceived social support is a mechanism which operates in the presence of stress and serves to reduce emotional distress or increase well-being; and (b) the main effect model--an increase in social support will result in increased well-being irrespective of one's pre-existing level of stress (Cohen & Wills, 1985; Cutrona, Russell, & Rose, 1986). A literature review by Cohen and Wills (1985) provided justification for each model depending on how social support was measured. Research supporting the stress buffering model tended to incorporate social support measures that tapped interpersonal resources responsive to the needs elicited by stressful events (e.g., informational support), whereas research using social support measures that addressed the individual's social network integration provided evidence for the main effect model.

The research of Cutrona, Russell, and Rose (1986) lends support for both the main effect and stress buffering models of social support. In a sample of 50 elderly persons, they found that social support was a significant predictor of physical health (main effect model), whereas mental health was related to an interaction of stress and social support (buffering model). While this research does

not specifically address caregivers, it is notable because it illustrates that social support may operate differently (i.e., main effect, stress buffer) depending on the outcome variable (e.g., physical health, mental health).

Types of Support

The literature reveals many types of support that a caregiver can receive. An overall picture of the many types of social support will be developed through reviewing the work of several notable researchers (Cohen & Wills, 1985; Cooke, Rossmann, McCubbin, & Patterson, 1988; Weiss, 1974). Then, original research will be cited to illustrate the importance of various types of social support.

Cooke, Rossmann, McCubbin, and Patterson (1988) interviewed a sample of 22 expectant and first-time parents to provide a better assessment of social support. Interviewees were asked a series of open-ended questions about their sources of support, such as: where their feelings of support came from; what they received from these sources of support; who helped them solve problems; who let them know they were valued; and how the support helped them. Five kinds of support were identified via content analysis of the interviews: (a) emotional support--information which leads one to believe that she is cared for and loved as a person; (b) esteem support--information that leads one to believe that she is valued for who and what he or she does and is; (c) network support--

information that develops a sense of trust and security for belonging to a group to whom one is also obligated; (d) appraisal support--feedback about how one is doing and ideas for resolving difficulties; and (e) altruistic support--information that encourages individual worth because of what she has done for others.

Cohen and Wills (1985) explored the stress buffering and main effects of social support on well-being through a literature review. Of particular interest, they identified four categories of social support that operated as stress buffers: (a) esteem support--value and acceptance of a person for their own worth; (b) informational support--help in defining, understanding, and coping with problematic events; (c) social companionship--spending time with others in leisure activities; and (d) instrumental support--provision of financial aid, material resources, and services.

In addition, Weiss (1974) suggested six different social functions or "provisions" that may be obtained from relationships with others: (a) attachment--a sense of emotional closeness and security; (b) social integration--a sense of belonging to a group of people who share common interests and recreational activities; (c) reassurance of worth--acknowledgment of one's competence and skill; (d) reliable alliance--assurance that one can count on others for assistance under any circumstances, usually obtained

from family members; (e) guidance, advice, and information; and (f) opportunity for nurturance--a sense of responsibility for the well-being of another. Each of these provisions are necessary in order for persons to feel adequately supported and to avoid loneliness. Different provisions, however, may be more crucial at different stages in the life cycle. Furthermore, each provision is usually obtained from a particular kind of relationship, but multiple provisions may be obtained from the same person.

Overall, it appears that the various types of support that a caregiver's family can offer fall into four broad categories: (a) instrumental support--provision of tangible resources and services; (b) cognitive support--advice, information, guidance; (c) esteem support--reassurance of one's worth; and (d) social companionship or integration--a sense of belonging derived from spending time with others who share common interests. Original research addressing each broad category of support will be reviewed here.

Persons who are in poor physical health may be likely targets for instrumental support. Aid to individuals, however, should not be limited to instrumental assistance alone. For example, Arling (1987) studied the relation between life-strain (i.e., physical health problems, economic deprivation) and emotional distress (as measured

by Pfeiffer's [1980] Short Psychiatric Evaluation Schedule)
using a statewide household survey of 2,146 non-
institutionalized older Virginians. This researcher found
that persons with greater sources of strain were more
likely to receive instrumental support (i.e., self-reported
assistance such as advice, shopping, transportation), even
though they had smaller social networks and less social
contact. Additionally, instrumental assistance was
positively related to distress, whereas social contact was
negatively related to distress. This suggests that persons
with reduced personal resources (e.g., poor health) may be
negatively affected by instrumental support when other
types of aid, such as social contact, are not provided as
well.

Cognitive guidance may be a salient source of support
for persons facing major life changes. Hirsch (1980)
examined the influence of natural support systems on coping
with major life changes for a group of undergraduate women
aged 30 or over. Coping was measured using three
indicators of mental health: (a) symptomatology--measured
by Hopkins Symptom Checklist (DeRogatis, Lipman, Rickels,
Uhlenhuth, & Covi, 1974); (b) mood--measured by the Profile
of Mood States (McNair, Lorr, & Droppleman, 1971); and (c)
self-esteem--measured by the evaluation scale of the
Semantic Differential (Osgood, Suci, & Tannenbaum, 1957).
Life change was measured using the Social Readjustment

Rating Scale (Holmes & Masuda, 1974). Hirsch found that helpful support enhanced adaptation to stress. In particular, cognitive guidance (e.g., advice, information) was the most critical type of support for coping with major life changes. The work of Caplan (1981) supports this finding.

Esteem support that reassures the individual may foster well-being. For example, Abel (1989) interviewed a sample of daughters who were caring for their aging mothers and found that caregivers wanted members of their social networks to affirm the value of their endeavor, rather than just help them deal with the problems it provoked.

In addition, the research of Holahan and Holahan (1987) indicates that esteem support (i.e., reassurance of the caregiver's endeavors) can protect caregivers from depression. They interviewed a sample of non-institutionalized, retired university employees aged 65 to 75 years. Several measures were incorporated in this interview including: a self-report measure of qualitative social support (e.g., reassurance), and a five-item self-report depression instrument. Overall, findings revealed that social support was inversely related to depression among elderly individuals. Even though this research does not address a population of parent caregivers, it is important because it suggests that social support can function in reducing depression and increasing well-being.

Finally, social companionship may help to foster well-being for women providing care to their aging mothers. The work of Rook (1987) supports the contention that social companionship plays an important role in sustaining emotional well-being. She used a series of studies to analyze the influence of social interaction on life stress, loneliness, and evaluations by others. Social interaction was measured in two ways: (a) "social support"--social interaction aimed at problem alleviation; and (b) "companionship"--social interaction aimed at providing mutual enjoyment. Overall, findings emphasized the importance of social interactions which provide mutual enjoyment: (a) "companionship" had a main effect on psychological well-being and a buffering effect on minor life stress, whereas "social support" only had a buffering effect on major life stress; (b) "companionship" was the most important predictor of relationship satisfaction and feelings of loneliness; and (c) a deficit of companionship elicited more negative reactions from others than a deficit of social support. This suggests that the underlying goal of social interaction (i.e., social support or companionship) is important in predicting its effect on well-being.

Additionally, the research of Zarit, Reever, and Bach-Peterson (1980) demonstrates the importance of social contact with others. They studied caregivers to elders

with senile dementia and found that increased visits to the
elder by other relatives was associated with decreased
caregiver burden. This suggests that caregiver burden can
be reduced by social support via regular visits from family
and friends (i.e., contact with significant others). These
researchers suggested that primary caregivers would be best
served by interventions that involve other members of the
impaired elder's natural support system.

Importance of Perception

According to House (1981), social support "is likely
to be effective only to the extent [that] it is perceived"
(p. 27). Research highlights the importance of subjective
perceptions rather than objective measures of support and
burden in predicting the well-being of individuals (Cohen
et al., 1986; Graney, 1985; Ishii-Kuntz, 1990; Ward,
Sherman, & LaGory, 1984). For example, Ward et al. (1984)
investigated a sample of 1,185 persons aged 60 and over and
found that perceptions of support (a subjective network
characteristic) were more important than quantity of
support (an objective network characteristic) in
maintaining subjective well-being.

Ishii-Kuntz (1990) provided evidence that subjective
perceptions of relationship quality were more important to
well-being than frequency of interaction (an objective
measure) with one's personal network. She used a national
probability sample to examine the impact of social

interaction on psychological well-being across stages of adulthood (e.g., early adulthood, middle adulthood). Ishii-Kuntz found that the quality of social interactions (as measured by satisfaction with family life and friendship) was positively related to the well-being of adults of all ages. Furthermore, perceptions of interaction rather than frequency of visiting with family and friends impacted the psychological well-being of individuals across the stages of adulthood.

Cohen, Sherrod, and Clark (1986) indirectly highlighted the importance of perceived support in protecting individuals against stressful situations. They conducted a cross-sectional examination of 609 incoming freshmen college students and found that perceived availability of social support provided a buffer against stress. This finding was observed even when personal characteristics such as social anxiety and social competence were controlled. Cohen et al. (1986) concluded that believing that support is available may be sufficient to produce a buffering effect irrespective of ability to mobilize support; but this does not necessarily mean that social skills have no function in the development of support perceptions. Although this research does not address a population of caregiving daughters, it is noteworthy because it stresses the importance of measuring support as it is perceived by respondents. This notion is

supported by research on interpersonal support, suggesting that perceived rather than objective support is what affects outcomes (Graney, 1985; Ishii-Kuntz, 1990; Ward, Sherman, & LaGory, 1984).

A critical literature review by Coyne and Bolger (1990) illustrates the connection between subjective perceptions of support and adaptive outcomes. In particular, they suggest that a person's perception of being involved in a well-functioning relationship may eliminate the need for some explicitly supportive transactions. Suppose a caregiver decides to stop working to meet the increasing needs of her mother. Affirmation from her husband may either support or undermine her, depending on her pre-existing perceptions of him and her relationship with him.

Coyne and Bolger (1990) also posit that much that is helpful occurs in a routine, habitual, and therefore unnoticed fashion. They cite a study suggesting that unnoticed support may be more efficacious. Perhaps this is because noticeable support efforts threaten one's self-esteem and feelings of self-sufficiency. Thus, one's subjective perception of support is important to adaptive outcomes and may influence individual appraisal and coping.

Family as a Source of Social Support

Social support can come from a variety of sources including: a spouse/partner; children; other relatives;

close friends; co-workers; church; community groups; and
professionals (Cooke et al., 1988). Of these, research
suggests that support from close family may be particularly
important (Brody, 1985; Fischer, 1982; Lin, Woelfel, &
Light, 1985; Mutran & Reitzes, 1984). For example, family
may offer aid in the form of financial support (Cicirelli,
1985), decision making (Cicirelli, 1985; Scott, 1983),
socioemotional support (Brody, Hoffman, Kleban, &
Schoonover, 1989), and reinforcement of identity through
shared family history and memories (Cicirelli, 1985).

An extensive study conducted by Fischer (1982)
highlights the importance of family support. He used
interviews to analyze the personal networks of 1,050 adults
living in northern California communities. Respondents
were asked to describe their personal network by naming
people, for example: (a) who cared for their home if they
went out of town; (b) whom they talked with about
decisions; (c) who helped with household tasks; (d) with
whom they discussed personal worries; and (e) whose advice
they considered in making important decisions. Twenty-
three percent of the relationships named by respondents
included close kin (i.e., spouses, parents, children and
siblings). The only other category reaching twenty-three
percent was "just friends." People varied in whom they
turned to and in how they matched particular needs with
particular persons in their networks. Fischer suggested

that people typically have a good time with friends (i.e., sociability), but turn to relatives in times of crisis (e.g., for costly and critical help).

The research of Lin, Woelfel, and Light (1985) also indicated that support from strong ties such as family may be particularly salient in protecting personal well-being. They examined the buffering effect of social support using a sample of 871 males and females aged 18 to 70 years. Lin and colleagues found a positive relationship between experiencing undesirable life events and depressive symptoms. The negative influence of undesirable events was reduced, however, when help was provided by strong (e.g., family) rather than weak ties.

A review of the literature by Brody (1985) revealed that emotional support from spouses, siblings, and children can mitigate caregiver strains. This proposition is supported, in part, by the work of Shanas (1979) which suggested that immediate family of the elderly person (i.e., husbands, wives, and children) is the major source of social support in times of illness. Perhaps Shanas' findings would also hold true for a sample of caregivers who need support in caring for their aging parents.

Finally, the work of Mutran and Reitzes (1984) indirectly highlights the relationship between family support and the well-being of individuals. They explored the effects of family support on the psychological well-

being of the elderly using data from a national survey and found that: (a) elderly parents with more resources received less help, while parents in poor health gave less aid to their children; and (b) exchanges with adult children were more likely to be taken for granted when the respondent's marriage was intact. While this research addressed an elderly population, several implications which apply to caregivers and persons who are not elderly can be extrapolated: (a) support from close family may become more valuable when individual resources decline; and (b) family support may be taken for granted when other supportive relationships are available.

Family Life Cycle Stage

The timing or family life cycle stage of the individual can contribute to the support networks which are available and important to her. Shulman (1975) examined the network structure of adults at various stages in the life cycle and found that single young adults were less likely than older persons to count kin among their closest relationships. Shulman suggested that the major concern of these young persons (during this stage of the life cycle) was to establish a career, seek companionship, and search for a mate; therefore, they associated with persons who shared the same concerns (i.e., more commonly friends than family). On the other hand, older persons became more involved in stable relationships with kin as well as with

friends because they had reached a life stage in which spouse and children were central. Shulman (1975) concluded that close relationships vary with life cycle changes and that "at each stage people tend to establish and sustain networks of relationships geared to the needs and concerns of their particular stage of life" (p. 820).

In addition, the work of Robinson and Thurnher (1979) indicates that the timing of caregiving responsibilities can impact one's well-being. These researchers studied adult children who were caring for their aging parents and found that caregiver stress was related to two primary factors: (a) mental deterioration of the parent; and (b) feelings of confinement on the part of the caregiver. Robinson and Thurnher suggested that the timing of caregiving might contribute to caregiver stress. For example, some of the women in their study had been looking forward to freedom from work and pursuit of favored activities, and men had been looking forward to retirement and extensive travelling. The increased dependence of their parents at this time in life (i.e., "empty nest" stage), however, limited their opportunities to make up for missed gratifications. In turn, greater stress or feelings of confinement might be associated with lower well-being for caregivers.

Negative Side of Support

There is a negative as well as a positive side to social support. For example, high levels of conflict with family may foster low well-being. The work of Strawbridge and Wallhagen (1991) illustrates this point. These researchers studied the impact of conflict on caregivers using a sample of adult children (N=100) who were providing care to frail parents or in-laws. They found that caregivers experiencing family conflict (i.e., a clash or strong feeling of resentment towards a relative in regard to caregiving) reported higher perceptions of burden and poorer mental health than caregivers without family conflict.

In addition, social networks can exacerbate as well as alleviate stress (Abel, 1989). The research of Belle (1982) supports this contention. Belle (1982) conducted an in-depth study of 43 low-income mothers and found that social networks were a burden as well as a source of help. Many mothers reported providing more instrumental and emotional support to others than they received in return. Also, greater network size, propinquity, and interaction levels were associated with higher stress (e.g., worries, upset, and concern) felt by the respondent in regard to her relatives and friends.

The research of Goldsteen and Ross (1989) supported Belle's findings. They studied a sample of 549 mothers of

minor children and found that sharing child care with friends and neighbors increased mothers' perceptions of burden. Perhaps sharing child care responsibilities increased mothers' feelings of obligation to care for their friends and neighbors' children in return. Furthermore, Goldsteen and Ross found that having relatives in the area increased the likelihood that family members would care for one's children. In turn, this increased the mother's perceptions that she could not be alone when she wanted to, which increased burden.

Some researchers have suggested that negative rather than positive interactions have the strongest impact on caregiver depression and network satisfaction. According to Pagel, Erdly, and Becker (1987), "it is primarily the problematic features that cause, maintain, or fail to reduce psychological symptoms" (p. 794). The research of Rook (1984) provided partial support for this view.

Rook (1984) examined the relative impact of positive and negative social outcomes on the well-being of 115 widowed women aged 60 to 89. Well-being was measured using: (a) the Life Satisfaction Index (Neugarten, Havinghurst, & Tobin, 1961); (b) Campbell Converse, and Rodgers' (1976) 9-item Index of Well-Being; and (c) the 4-item UCLA Short-Form Loneliness Scale (Russell, Peplau, & Cutrona, 1980). Supportive social ties were identified by asking respondents to name people to whom they turned for

companionship, emotional support, and instrumental support. Problematic social ties were identified by asking respondents to name people who invaded their privacy, took advantage of them, broke promises to help, and consistently provoked conflicts or feelings of anger. Rook found that negative social interactions had a greater effect on well-being than positive social interactions. Perhaps negative experiences have a greater impact than positive interactions because they are rarer and therefore more salient.

Finally, Coyne and Bolger (1990) reviewed and challenged some general assumptions found in the social support literature. They noted that social support could have "reverse buffer effects," meaning that support may exacerbate the effects of stress in some situations. A possible explanation for this phenomenon was offered: Perhaps persons facing the greatest stress seek and therefore must elicit more support.

Summary

The literature supports the hypothesis that social support may protect the caregiver from some of the strains associated with caregiving (Brody, 1985; Fischer, 1982; Thoits, 1982). For example, social support may help an individual gain mastery in times of stress (Caplan, 1981) and reduce depression among aging individuals (Holahan &

Holahan, 1987). In turn, this may increase well-being (and decrease depression).

Social support can be provided in several forms including: instrumental support, cognitive support, esteem support, emotional support, or social companionship (Cohen & Wills, 1985; Cooke, Rossmann, McCubbin, & Patterson, 1988; Weiss, 1974). Furthermore, research contends that perceived support rather than actual support is particularly important for protecting individuals from the negative consequences of stress, and for fostering well-being (Cohen et al., 1986; Graney, 1985; Ishii-Kuntz, 1990; Ward et al., 1984).

Social support can come from a variety of sources which include family, friends, special groups, and professionals (Cooke et al., 1988). Of these, it appears that support from close family may have an especially important role in fostering well-being (Brody, 1985; Fischer, 1982; Lin et al., 1985; Mutran & Reitzes, 1984). Support from close family may become even more valuable as caregiver resources decline (Mutran & Reitzes, 1984). For example, a caregiver's appreciation of family support may increase as her mother's need for care increases and as her opportunity for social interactions with others decreases.

The family life cycle stage of the caregiver may influence the composition of her network as well as whom she perceives to be the most supportive. Close

relationships vary with life cycle changes in that people tend to establish and sustain relationships geared to the needs and concerns of their particular stage of life (Shulman, 1975).

Finally, it is important to note the negative side of social support. Conflict with persons who also support the caregiver may increase her perceptions of burden and lower her well-being (Strawbridge & Wallhagen, 1991). Thus, negative interactions with individuals in one's support network may counteract the positive effects of the support which they provide (Rook, 1984). Supportive relationships may also increase the caregiver's burden in that receiving support can create an obligation to reciprocate (Belle, 1982; Goldsteen & Ross, 1989). Support (or lack of support) from close family (i.e., siblings, spouse, and children) will be explored in more detail next.

Support from Siblings

Most individuals have living siblings, even in later life (Cicirelli, 1985; Troll, Miller, & Atchley, 1979). The sibling relationship is unique because: (a) it is of long duration (lasting from birth to the death of a sibling); and (b) siblings share a common genetic heritage, a common cultural milieu, and common early experiences within the family (Cicirelli, 1982). According to Cicirelli (1982, 1985), most siblings feel affectionally close and provide psychological support to

each other throughout adulthood and into old age. A smaller proportion of persons, however, feel able to share the intimate details of their lives with siblings, and still fewer consult with siblings about important decisions (Cicirelli, 1985).

In general, siblings can provide emotional support and companionship, and may offer direct aid and services which are especially important in later life (Goetting, 1986). Specifically, siblings can provide support in the form of decision making, boosting morale, homemaking, shopping, home repairs, transportation, respite care, and financial aid (Cicirelli, 1985). Additionally, Scott (1983) studied a sample of 199 community dwelling adults aged 65 to 90 years and found that: (a) siblings (not children or grandchildren) gave and received the most help with important decisions, transportation, and illness; but (b) were less involved in the exchange of assistance than were children.

Research also suggests that siblings are an important source of support in parent caregiving. Overall, it appears that sibling groups mobilize to meet the needs of their aging parents (Matthews & Rosner, 1988). In particular, emotional support and understanding from siblings may be rewarding to parent caregivers (Brody, Hoffman, Kleban, & Schoonover, 1989).

The overriding consensus of research indicates that sibling relationships prevail across the life course and intensify in later life (Bee, 1987; Cicirelli, 1985; Goetting, 1986). A review of the literature suggests that the intensity and closeness of sibling relationships, and therefore the support that siblings provide, can be influenced by several factors: (a) presence or absence of other family relationships, especially ascendent or descendant relatives (e.g., parents or children); (b) marital status; (c) geographic proximity; (d) gender; (e) health of parent and degree of shared parent care; and (f) sibling conflict.

Presence of Other Relatives

The presence of other relatives, particularly ascendants (e.g., parents) or descendants (e.g., children) can mediate the intensity of sibling relationships (Troll, Miller, & Atchley, 1979). Cicirelli (1982) suggests that siblings provide fewer instances of psychological, social, and instrumental support than do other primary relationships (e.g., children, spouse). Research, however, indicates that older persons who are divorced, widowed, childless, or never married may feel especially close to their siblings (Cicirelli, 1985; Troll, 1971). The help of siblings may be especially important when children are not available (Scott, 1983).

Siblings may also find reinforcement of identity
through shared memories and family history, particularly
when older family members begin to pass away (Cicirelli,
1985). Cumming and Schneider (1961) suggested that sibling
relationships become a "substitute" for relationships which
are lost, usually due to death, in later life.

Marital Status

Research indicates that persons who have never married
tend to maintain closer relations with siblings than those
who marry and have children (Cicirelli, 1985; Troll, 1971;
Troll, Miller, Atchley, 1979). In addition, Cicirelli
(1984) suggested that marital disruption (e.g., divorce,
widowhood, remarriage) may limit the adult child's ability
to help an aging parent, and, therefore, siblings may
become a salient source of help by giving additional aid
when necessary.

Geographic Proximity

The work of Lee, Mancini, and Maxwell (1990) suggested
that proximity is one of the most salient factors in
explaining contact between siblings, regardless of whether
or not a parent is still living. According to Cicirelli
(1985) geographic location can be an indicator of emotional
support as well as an indicator of tangible help exchanged
between siblings. For example, siblings who live far apart
may not have the opportunity to exchange emotional support
or aid. Additionally, Adams (1967) found that sibling

interaction was more frequent if one sibling lived near the parents.

Gender

Sibling bonds involving a female are generally stronger than those between two males. The sister-sister sibling bond appears to be strongest, followed by the sister-brother bond, with the brother-brother bond being the least intense of all (Cicirelli, 1985; Troll, 1971).

The work of Lee, Mancini, and Maxwell (1990) suggests that sister-sister pairs have more contact than other sibling combinations. The higher level of contact found between sisters, however, may also provide opportunity for increased conflict. The research of Bedford (1989) helps to illustrate this point. This researcher used the Thematic Apperception Test (Murray, 1943) to explore sibling relationships for a sample of persons with same-sex siblings, a living spouse, and who were either in the child-rearing or empty nest phase. Bedford found that conflict was more prevalent in women's stories about sisters than in men's stories about brothers, perhaps a consequence of the greater intimacy typically found between sisters.

In addition, research suggests that sisters may be more salient sources of support to women caregivers than brothers. For example, Brody, Hoffman, Kleban, and Schoonover (1989) explored the perceived strains and

interactions of caregiving daughters (i.e., daughters caring for their elderly mothers) and their siblings. They found that primary caregivers reported giving the most help and experiencing the most strain, while their brothers perceived the least strain of all in caring for an elderly mother. In particular, brothers: (a) provided the least instrumental help and emotional support to the elderly mother; (b) were least affected emotionally and physically by parent care; and (c) were the least hassled by intersibling interactions. On the other hand, local sisters perceived the same amount of strain as primary caregivers, although these sisters gave less help. Local sisters also evidenced a need for socioemotional support in the caregiving situation, and felt guilty about more matters (e.g., not doing more for their mothers) than did the primary caregivers or brothers.

The research of Matthews and Rosner (1988) supports the notion that daughters are more likely than sons to be personally involved in parent care. They explored shared filial responsibility in caregiving by interviewing 50 pairs of sisters who had at least one elderly parent. Five participation styles used by siblings in parent care were identified: (a) routine--regular assistance to the elderly parent, the core of the parent-care system; (b) backup--not involved in routine provisions, but could be counted on when siblings who were routine caregivers asked for help;

(c) circumscribed--participation that was highly predictable but carefully bounded (e.g., a sibling who routinely called once a week); (d) sporadic--providing services to parents at one's own convenience; and (e) dissociation from filial responsibility--could not be counted on to assist parents. Daughters were most commonly involved in "routine" caregiving, whereas sons/brothers were more likely to be "circumscribed" (e.g., providing help with a specific task such as financial management) or "sporadic" in participation style. Sample, selection, however, might have limited the researchers' ability to identify helpful brothers.

Health of Parent and Degree of Shared Parent Care

Matthews and Rosner (1988) found that parental health affected sibling interactions and relationships. Overall, they found that sibling groups mobilized to meet their parents' needs. When parents' continued independence was threatened by physical or mental changes, siblings were more likely to be in touch to confirm perceptions and to discuss whether or not action was required. Conflict among family members, however, was reported by about half of the participants. In most cases this conflict stemmed from events that occurred before parent caregiving was an issue. Furthermore, conflicts seemed to take a back seat to the more important issue of providing adequate parent care.

The work of Brody et al. (1989) also revealed a connection between parental health and sibling relationships. They found that tension between siblings increased as mothers' needs for care increased. Caregivers and siblings were most troubled by their intersibling parent care interactions when mothers were more difficult to care for, and sibling relationships were most rewarding when mothers needed less help. Brody et al. (1989) also found that socioemotional support from siblings as well as parental health was a salient factor in predicting one's caregiving experience. Finally, research indicates that relations between kin are stronger when their mother is alive, but tend to weaken after her death (Troll, 1971; Troll, Miller & Atchley, 1979).

Sibling Conflict

Increased conflict with siblings due to parent caring may increase the opportunity for conflict and friction, or reawaken feelings of competition (Abel, 1989). In particular, these negative interactions may have a greater impact than positive interactions on the caregiver's well-being and perceptions of support (Pagel et al., 1987; Rook, 1984).

Summary and Implications

Overall, siblings appear to be a salient source of support across the lifespan (Cicirelli, 1985). Siblings can give emotional support, companionship, direct aid,

services (Cicirelli, 1985; Goetting, 1986), financial aid, instrumental support, and help with decision making (Cicirelli, 1985; Matthews & Rosner, 1988). In particular, the lengthy duration of sibling relationships, typically including a common genetic heritage and shared family memories (Cicirelli, 1982), suggests that siblings may provide symbolic as well as tangible sources of support to caregivers.

A review of the literature suggests that siblings are likely to have a greater impact on the caregiver's life when ascendant or descendant family resources are unavailable (Cicirelli, 1985, Mutran & Reitzes, 1984; Troll, 1971). Siblings who live farther away may be limited in their ability to offer practical help (Cicirelli, 1985). Sisters rather than brothers appear to be closer and thus are potentially more salient sources of support for caregivers (Brody et al., 1989; Cicirelli, 1985; Matthews & Rosner, 1988; Troll, 1971). Sibling interaction and support may increase in response to deteriorating parental health (Brody et al., 1989, Matthews & Rosner, 1988), and this support may be more significant to caregivers (and consequently to their well-being) when parental independence is threatened. Finally, conflict with siblings can undermine the caregiver's esteem and well-being. Some research even indicates that negative interactions may have a greater impact than positive

interactions on caregiver perceptions and well-being (Pagel et al., 1987; Rook, 1984).

<div align="center">Support from Spouse</div>

To date, research specifically addressing the relationship between spousal support (or lack of support) and the well-being of parent caregivers is limited. Related literature typically focuses on the relationship between marital satisfaction and well-being for non-caregiving samples, or on the role of spouse support to ill partners. This trend will be reflected in the literature review that follows.

Influence of Support on Caregiving

Intimate support from a husband can protect women under severe stress from becoming depressed (Brown & Harris, 1978). The work of Kerns and Turk (1984) also suggests that spousal support might be an important buffer against depression. They studied a sample of 30 male chronic pain patients and their spouses who had been referred to the Pain Management Program by physicians. Kerns and Turk found that the importance of perceived marital support increased as the range of sources of support declined (with the development and maintenance of a chronic pain problem). It was not the experience of pain, but rather social variables such as the lack of marital support (which may be disrupted as a function of chronic

pain), that were more likely to contribute to the development of depression among chronic pain patients.

The research of Fischer (1982) suggests that a spouse may alleviate some of the burden felt due to the additional role of caregiving. Fischer studied the networks of 1,050 northern Californians and found that women with young children were far more likely than others to say they felt too many demands. Having a spouse, however, moderately reduced feelings of demand.

The research of Hirsch and Rapkin (1986) indicates that a spouse can influence the caregiver's ability to manage the additional role of caregiving via marital satisfaction. They analyzed data from a sample of 235 married female nurses, focusing on marital and job satisfaction as criteria in managing multiple roles. Of particular interest, Hirsch and Rapkin found that mental health was affected more by marital satisfaction than by job satisfaction.

The research of Matthews and Rosner (1988) provides evidence that spousal support is an important determinant of caregiver participation. These researchers conducted interviews with 50 pairs of sisters who had at least one elderly parent and found that the "posture" (or attitude) of a spouse affected how easily an adult child could adopt a particular style of parent care: (a) children with actively supportive spouses were likely to be routinely

involved in providing services to older parents; (b) children with indifferent spouses were likely to be caught between the conflicting demands of their spouse and aging parent(s); and (c) children with antagonistic spouses experienced difficulty in providing routine or back up care for their parents because their spouses were obstacles to caregiving.

Conflict

The work of Webster-Stratton (1989) implies that marital conflict (as well as support) may impact an individual's well-being and perceptions (e.g., perceptions of a dependent family member). She studied a sample of parents with children aged 3 to 7 years. The sample was divided into several subgroups: (a) 42 parents who were maritally supported, as measured by the Marital Adjustment Test (MAT; Locke & Wallace, 1959); (b) 43 parents who were maritally distressed, as measured by the MAT (Locke & Wallace, 1959) or by respondent reports of a history of physical violence or separation within the past 3 months; and (c) 32 single parents. Results revealed a significant relationship between low marital satisfaction/marital distress of mothers and: (a) negative perceptions of child adjustment, as measured by the Child Behavior checklist (Achenbach, & Edelbrock, 1983); and (b) mothers' stress, as measured by the Parenting Stress Index (Abidin, 1983).

Level and Importance of Support

Research indicates that the level and importance of spousal support may change across the lifespan. Depner and Ingersoll-Dayton (1985) suggested that the overall level of marital social support may decrease in later life. These researchers studied conjugal social support using a national random sample of 412 married respondents aged 50 years or more and found that social support was decreasingly prevalent within the marriages of older persons. Several explanations were offered for this interesting finding: (a) perhaps aging couples view life events as challenges confronting them as a unit--thus, a spouse is not seen as a helper, but as someone with whom one faces an event of mutual significance; and (b) since interiority (e.g., a lowered investment in social relationships) appears to increase with age, perhaps the developmental tasks of aging are better met through personal reflection rather than through social support. Depner and Ingersoll-Dayton also argued that their findings implied "constraints in the extent to which older spouses could meet new needs for support and/or alter longstanding patterns of interaction" (p. 766). It is also important to note that Depner and Ingersoll-Dayton's research is just one study, and that there is still much to be explored in this area.

Alternatively, the work of Shulman (1975) implies that support from a family member, such as a spouse, may become more important in later life. This researcher examined the network structure of 347 adults (who were selected from a larger study involving a random sample of 845 adults) at various stages in the life cycle. He found that single young adults were less likely to count kin among their closest relationships, whereas older persons became more involved in stable relationships with kin. Shulman suggested that older persons may increase involvement with kin because they have reached a life stage in which spouse and children are central.

Summary and Implications

Overall, research suggests that support from a husband can foster one's well-being (Brown & Harris, 1978; Fischer, 1982; Hirsch & Rapkin, 1986), whereas lack of support may negate one's perceptions and participation in caregiving activities (Matthews & Rosner, 1988; Webster-Stratton, 1989). The intimacy and daily contact typical of marital relationships suggests that the caregiver's perceptions of how supportive her spouse is may be particularly significant in predicting her well-being.

In particular, a husband can: (a) buffer the caregiver against the negative consequences of stress (e.g., depression) (Brown & Harris, 1978; Kerns & Turk, 1984), which may subsequently enhance her perceptions of

satisfaction; and (b) help his wife manage the additional role of caregiving (Fischer, 1982; Hirsch & Rapkin, 1986). The posture a husband takes toward the caregiving activities of his wife is especially important: (a) a husband who provides instrumental and emotional support may ease his wife's burden and enhance her perceptions of self-worth and well-being; (b) the demands of a husband may intensify his wife's burden, conflict with parent care responsibilities, and lower her satisfaction with the situation; and (c) a husband who is antagonistic may be an emotional barrier to the caregiver's ability to provide assistance. In addition, conflict with a spouse may add to the caregiver's stress and negatively impact her perceptions of the care-recipient. Overall, it appears that support (or lack of support) from a spouse may be more significant when the individual reaches a life stage in which the spouse is central (Shulman, 1975), or under conditions which limit the caregiver's contact with pre-existing support networks (Kerns & Turk, 1984).

Support from Children

To date, the majority of research addressing the relationship between parenting and well-being has typically focused on young parents with minor children or elderly parents and their middle-aged children, while studies of parents and their young adult children are scarce (Aquilino

& Supple, 1991). This trend will be reflected in the following review of literature.

A common social myth suggests that older Americans are alienated from their families, and that children no longer help to meet the needs of their aging parents (Brody, 1985; Mancini & Blieszner, 1989). The parent-child relationship does not end with launching, however, but continues throughout life (Bowlby, 1979; Troll, 1971). Research indicates that the majority of aging adults maintain contact with their children and continue to exchange assistance and advice (Mancini & Blieszner, 1989). Thus, most elderly persons are not abandoned, neglected, isolated, or rejected by their adult children (Cicirelli, 1981). While most parent caregivers are probably not elderly themselves, research (such as Cicirelli's, 1981) addressing elderly parents with children is important because it helps to develop an understanding of parent-child relationships in adulthood.

A 1984 study of non-institutionalized older persons found that four of every five older persons had living children. Two-thirds (66%) of these persons lived within 30 minutes of a child, sixty-two percent had weekly visits with children, and seventy-six percent talked on the phone at least once a week with children (American Association of Retired Persons, Administration on Aging, & U.S. Department

of Health and Human Services, 1990). Other research supports the postulation that most older persons have children (Cicirelli, 1983), and that the majority of adult children maintain regular contact with their parents (Cicirelli, 1983; Leigh 1982). Longitudinal research, however, suggests a decrease in parents and children who co-reside and in the number of days per year that parents and children who do not co-reside see each other (Crimmins & Ingegneri, 1990).

Overall, it appears that the parent-child bond is a strong one, and that there is residential propinquity, visiting, and mutual aid between adult children and their parents, and to a lesser extent between siblings and other relatives (Troll, 1971). Adams (1967) found that: (a) relations with parents were closest and most obligatory; (b) relations with friends were highest in value consensus; and (c) relations with siblings came third. The recent research of Hoffman, McManus, and Brackbill (1987) also supports the contention that the parent-child bond is strong, enduring, and includes exchanges of mutual aid.

According to Cantor (1980), the social support system addresses three needs of aging persons: (a) socialization; (b) accomplishing everyday life tasks; and (c) personal assistance in difficult times. Research indicates that adult children can and do meet these needs. Hoffman, McManus, and Brackbill (1987) analyzed data from a sample

of elderly parents and a national sample of parents in
their childbearing years and found that children were most
commonly seen as satisfying parents' needs for love and
companionship and fun and stimulation for both age groups.
Adult children also address needs pertaining to everyday
life tasks and offer support during difficult times
(Mancini & Blieszner, 1989).

A broader review of the literature, however, suggests
that parental perceptions of child supportiveness can
depend on several factors: (a) the context of parenting
and age of child; (b) interaction with children; (c)
gender; (d) child autonomy; (e) reciprocity; (f) personal
resources of the parent; (g) life cycle stage; and (h)
conflict. These factors will be explored in more detail
below.

Context of Parenting and Age of Child

A literature review by Umberson (1989a) and research
(Ross & Huber, 1985; Umberson, 1989b; Umberson & Gove,
1989) suggests that children can have both positive and
negative effects on parents, depending on the context of
well-being under examination. Umberson's (1989a)
literature review revealed that the cost of parenting is
greater when children are young, reside in the parental
home, and when parents are divorced. Of particular
interest, parenting minor children may be stressful and
have a negative impact on parental well-being, while

parenting adult children may be characterized by reciprocity and have a positive effect on well-being.

The work of Umberson and Gove (1989) also supports the notion that children can have both a negative and positive influence on parental well-being. These researchers used data from a national probability survey of 2,246 persons aged 18 and over in the contiguous United States to analyze the influence of children on parental well-being. Several measures of well-being were used: (a) affective well-being--measured by Bradburn's (1969) positive affect scale, a single item measure of life happiness, a seven item measure of depression, and an agitation scale; (b) life satisfaction--measured by asking the respondents how satisfied they were with their own life and with their home life; and (c) life-meaning--measured via a shortened version of Rosenberg's 1965 self-esteem scale, and a measure to assess the degree to which the respondents felt their life lacked purpose and meaning. In particular, they found that parenthood resulted in elevated levels of life-meaning in almost all contexts (i.e., regardless of age of child, whether or not the child resided with them). The costs of parenting were more apparent when children and parents lived in the same residence and when children were under the age of eighteen, whereas the rewards of parenthood outweighed the costs in later life, especially when children were able to maintain independence (e.g.,

financially, in housing) from their parents. Furthermore, even nonparents' levels of well-being on affective and satisfaction measures were usually better than parents living with children or parents with young children.

Another study by Umberson (1989b) indicated that the quality of relationships with children may be more important for parental well-being than the circumstances (e.g., income) of parenting. She investigated how parent-child relationships affected the psychological well-being of parents using a national sample of persons aged 18 and over. Well-being was measured in six ways: (a) positive affect; (b) agitation; (c) psychiatric symptoms; (d) life satisfaction; (e) home life satisfaction; and (f) meaninglessness. Results indicated that the parent-child relationship was not related to parental income, education, and age of the child; but it was related to all six measures of parental well-being.

Finally, the work of Ross and Huber (1985) provides evidence that children have different effects on mothers' psychological well-being under different conditions. For example, the more young children living at home, the more mothers experienced economic hardship. In turn, economic hardship may increase depression. On the other hand, this depression may be counterbalanced in that children may decrease depression because they indicate successful fulfillment of role obligations to women.

Interaction with Children

The work of Aquilino and Supple (1991) indicates that positive interaction with children is related to parental satisfaction. They analyzed data from the 1988 National Survey of Families and Households to determine the influence of children (aged 19 to 34, who were still living at home) on parental satisfaction (for a sample of 851 parents). The majority (70%) of parents indicated that coresident living arrangements worked out very well, whereas only seventeen percent reported dissatisfaction with the presence of a child in their home. Shared activities and enjoyable time spent together were related to positive experiences for parents in coresident living arrangements.

Other research suggests that interaction with children is not necessary for the maintenance of well-being in later life. According to Ward, Sherman, and LaGory (1984), children play a central role in the support network of their parents, yet access to and interaction with children has little relation to subjective well-being. This is supported, in part, by the research of Lee (1979).

Lee (1979) studied a sample of 388 adults and found that the morale of aging parents was not consistently or significantly affected by frequency of contact with children. Additionally, Lee and Ellithorpe (1982) found that contact with children was not related to overall

pleasure or happiness. These research findings may not be true for a sample of caregivers, who may (in fact) come to value their children more as they watch their care receiving parents' lives coming to an end.

Gender

The research of Spitze and Logan (1990) implies that the gender of the caregiver's child may be related to the amount and type of support she receives. These researchers analyzed self-reports from a national sample of parents aged 65 and over. They found that having at least one daughter was important for support via phoning, visiting, and help with daily activities of living, whereas having sons was unrelated to this type of support. Spitze and Logan concluded suggested that perhaps gender norms are too strong to allow sons to help even when daughters are not available.

A review of the literature by Brody (1985) revealed that daughters are the most common helpers for older parents who are caring for impaired spouses. This suggests that daughters may also be the primary helpers to parents who are caregiving for their aging parents. This is supported, in part, by the research of Pruchno (1990).

Pruchno (1990) studied 315 persons who were caregivers to spouses with Alzheimer's Disease and found that even when children were local, most sons and daughters were not involved in providing task assistance (i.e., help with

daily activities of living) to their caregiving parents. Daughters, but not sons, were identified as someone in whom the caregiver could confide. Pruchno suggested that perhaps spouse caregivers substantially under-report the extent to which others are involved in providing care, particularly due to the social belief that "I shouldn't bother the children with my problems."

Child Autonomy

The research of Silverberg and Steinberg (1987) suggests that a child's developing autonomy can influence parental self evaluations and well-being. They explored the relationship between parental well-being and adolescent-parent relationships using a sample of 129 intact families. Parental well-being was measured through: (a) a revised version of Rosenberg's (1965) Self-Esteem Scale; (b) a scale designed to assess midlife identity concerns (referenced in Silverberg & Steinberg, 1987); (c) a general life satisfaction scale developed by Campbell, Converse, and Rodgers (1976); and (d) CES-D (Radloff, 1977). Overall, Silverberg and Steinberg found that parent-adolescent relationships were related to parents' sense of self and well-being. The development of adolescent autonomy intensified identity concerns of same-sex parents, particularly fathers.

Reciprocity

A key dimension of parent-child interaction in adulthood is the system of assistance, advice, and aid that they give to one another (Bee, 1987). In particular, an individual's ability to reciprocate aid and support to children can affect her well-being. For example, Stoller (1985) examined the influence of reciprocity in exchange patterns on well-being for a sample of parents and found that the receipt of help from children was related to depression-like symptoms, whereas provision of help to children was related to well-being. Stoller (1985) suggested that "the inability to reciprocate rather than the need for assistance undermines the morale of the older person" (p. 341). Even though this research pertains to older parents, it does suggest that support may have a negative influence on well-being if the caregiver is unable to reciprocate.

On the other hand, Mutran and Reitzes (1984) examined intergenerational support and well-being. They found no relationship between well-being and exchange of aid for married persons. Help from children, however, reduced negative feelings, whereas giving help to children increased negative feelings for widowed individuals.

Personal Resources

Personal resources of the parent may impact perceptions of and provisions of social support from adult

children. Blieszner and Mancini (1989) suggest that well-educated, healthy, resourceful elderly parents are comfortable with routine interactions with their children and do not expect direct assistance except in extreme circumstances. This suggests that caregivers with more resources may perceive adequate social support whereas those with fewer resources may not, even when level of support is held constant across caregivers.

Life Cycle Stage

Parent-child interaction may vary across the lifespan. For example, Leigh (1982) studied adults across all family life-cycle stages and found a slight decline in frequent contact during the "new parent" stage. The research of Hoffman, McManus, and Brackbill (1987) indicates that the perceived benefits of having children may intensify for parents during later stages of life. They analyzed the satisfactions and dissatisfactions of having children by contrasting a sample of elderly parents with a national sample of parents in their childbearing years. Older parents were more likely than younger parents to report that children filled economic-utility needs and to indicate fewer disadvantages in having children.

The research of Goldsteen and Ross (1989) also supports the proposition that the burden or blessing of having children varies across the life cycle. They studied mother's perceptions of child burden using a sample of 549

women who had at least one minor child living at home.
Findings indicated that mothers experienced their children
as differentially burdensome at different stages in the
life cycle. Younger mothers perceived increased burden
with each additional child, whereas older mothers were less
affected by increasing numbers of children. In particular,
the presence of preschool children tended to make mothers
feel that they could not be alone when they wanted to, thus
increasing their burden.

Conflict

Conflict between parents and their children can affect
parental satisfaction, and thus parental well-being. This
is illustrated in the research of Aquilino and Supple
(1991) who analyzed data from the 1988 National Survey of
Families and Households. They found that conflict with
children was the strongest single predictor of parents'
satisfaction with having their children in the home.
Continued financial dependence on parents for basic needs
increased conflict between parents and children. Aquilino
and Supple concluded by suggesting that parent-child
conflict decreases as children approach full adult status.
In turn, decreased conflict was associated with higher
levels of enjoyable social interaction.

The research of Silverberg and Steinberg (1987)
suggests that conflict with children may have a
particularly significant effect on the well-being of

mothers. These researchers explored the relationship between parental well-being and adolescent-parent relationships using a sample of 129 intact families. They found that parent-adolescent conflict was related to lower life satisfaction for mothers, but not fathers.

Summary and Implications

Overall, the literature suggests that there is a strong bond between parents and their children (Adams, 1967; Cumming & Henry, 1961; Hoffman et al., 1987; Troll, 1971) that continues across the lifespan (Bowlby, 1979; Troll, 1971). Furthermore, research indicates that children can and do meet their parents' needs for socialization (Hoffman et al., 1987), help with everyday life tasks, and offer support in difficult times (Mancini & Blieszner, 1989). Older children (Umberson & Gove, 1989) and daughters (Brody, 1985; Spitze & Logan, 1990; Pruchno, 1990) may be particularly important resources for caregivers.

Several factors, however, can influence the caregiver's perceptions of how supportive children are, consequently influencing her well-being. The presence of dependent minor children in the home may increase perceived costs, whereas perceived rewards of having children may increase under less demanding contexts (e.g., in later life when children require fewer parental resources) (Umberson, 1989a; Umberson & Gove, 1989). So, caregivers may not

perceive young children as significant sources of support, whereas adult children may be seen as providing salient support which consequently may increase the caregiver's well-being. Mothers who have positive interactions with their children may have higher satisfaction than those who do not (Aquilino & Supple, 1991). So, a caregiver may be more likely to perceive children as significant sources of support that enhance her well-being when her interactions with them are positive. Caregivers with more personal resources (e.g., well-educated, healthy) may not expect as much support from children as those with fewer resources (Blieszner & Mancini, 1987). Therefore, caregivers with more resources may not perceive as much support from children as those without resources, even when both sets of caregivers are receiving the same amount of support from their children. The perceived benefits of having children may intensify for parents during later stages of life (Goldsteen & Ross, 1989; McManus & Brackbill, 1987). So, support from children may become more significant as caregivers grow older.

In addition, a child's developing autonomy can influence the caregiver's self evaluations and feelings of well-being (Silverberg & Steinberg, 1987). For example, a child's growing independence may cause the caregiver to re-evaluate her self perceptions and life situation. Furthermore, the caregiver's ability to reciprocate support

given to her is important to the maintenance of positive self perceptions (Stoller, 1985). Thus, a caregiver who is unable to reciprocate help to her children may feel guilty and perceive the dependent elder as a barrier to her ability to reciprocate aid. This may decrease the caregiver's satisfaction and well-being. Finally, conflict with children may decrease caregiver perceptions of support and well-being (Aquilino & Supple, 1991).

<div align="center">Background Characteristics</div>

The literature reveals several background characteristics that may directly or indirectly impact the well-being of women who are providing care to their mothers. In particular, the following caregiver background variables will be explored: (a) age; (b) health of caregiver; (c) education; (d) employment; (e) income; and (f) number of dependent children; and (g) mother's health.

Age

The caregiver's age may impact her need for and perceptions of support, and can directly or indirectly influence her well-being. For example, the physical changes that come with growing older (Schwartz, Snyder, & Peterson, 1984) may limit the caregiver's ability to meet all of her mother's needs, thus producing a greater need for external support. Older caregivers are more likely than younger caregivers to have mothers who are more dependent, while younger care providers may have more role

demands (e.g., dependent children). In turn, this may limit their opportunities for social interaction with persons outside of their immediate family. Thus, support from close family may become more salient for the maintenance of caregiver well-being.

In addition, the work of Arling (1987) suggests that one's needs for and perceptions of social support may change with age. This researcher studied a sample of non-institutionalized older Virginians and found that persons of advanced age had more life strain (i.e., physical health problems, economic deprivation) and reported less social support.

Finally the research of Holahan and Holahan (1987) suggested that social support may be more important in maintaining positive functioning for older caregivers than for younger caregivers. In particular, existing social networks may become especially important with advancing age since there is a general decline in the amount of interaction with social contacts, and in the size and variety of available networks (Lowenthal & Robinson, 1976).

Health of Caregiver

Snyder and Keefe (1985) studied a sample of 117 caregivers and found that almost seventy percent reported that caregiving had negatively affected their health. Reported health problems fell into two categories: (a) physical ailments; and (b) negative lifestyle changes (e.g.

inability to get regular exercise or to make future plans).
In particular, caregivers to persons with higher levels of
disability were more likely to report personal health
problems than caregivers to persons with lower levels of
disability. Lowenthal and Robinson (1985) suggest that ill
health may function to strengthen the kinship network in
terms of frequency of interaction. Poor health has also
been found to be strongly associated with depression (e.g.,
Harris, 1987; Kennedy, Kelman, & Thomas, 1990).

Education

Education is a socio-economic status (SES) factor that
may impact caregiver perceptions of need and support;
therefore, indirectly contributing to her well-being. For
instance, Fischer (1982) studied a sample of 1,050 adults
in northern California and found that educated respondents
relied less on kin than did uneducated respondents.
Perhaps persons with higher levels of education have more
resources (e.g., higher income), and therefore may not
expect support or rely on kin as much as persons with lower
levels of education.

Employment

The increasing participation of women in the labor
force (U.S. Bureau of the Census, 1985; U.S. Bureau of
Labor Statistics, 1984) suggests that employment is an
important variable to consider when analyzing the well-
being of women providing care to their mothers. Employed

caregivers are faced with multiple responsibilities, which, in turn, may influence the amount of support they receive. For example, Brody and Schoonover (1986) found that when caregiving daughters were employed, other persons in the household were more likely to help out with housework/laundry.

Employment may also impact one's interactions with family. The rewards and resources gained through paid work may influence family life and relationships by providing more resources and a more comfortable level of living. Work, however, can absorb the time and energy that would otherwise be allocated to family (Kanter, 1977). Also, satisfactory or unsatisfactory work conditions (e.g., dehumanizing) can "spill-over" into the caregiver's home life and influence her interactions with family members.

Income

Income is another SES factor that may impact an individual's well-being and perceptions of support. According to Edwards and Klemmack (1973), the primary determinant of life satisfaction in older adults is socioeconomic level, with family income being the most important, and perceived health and informal social interaction being the second and third most important factors respectively.

Number of Dependent Children

The presence of dependent children may negatively impact a person's well-being. For instance, the work of Aquilino and Supple (1991) revealed that continued financial dependence on parents for basic needs increased conflict between parents and children. They concluded that parent-child conflict decreases as children approach full adult status. In turn, decreased conflict was associated with higher levels of enjoyable social interaction. The research of Umberson (1989a), and Umberson and Gove (1989) also suggests that parenting minor children may be stressful, increase perceptions of burden, and have a negative impact on parental well-being, while parenting adult children may be characterized by reciprocity and have a positive effect on well-being.

Mother's Health

The caregiver's well-being may be influenced by her mother's health. This idea is supported by the research of Gallagher et al. (1989) who found that increased caregiver depression was associated with dependence of elders with major health problems. Conversely, Zarit, Reever, and Bach-Peterson's (1980) study of caregivers for dementia elders revealed that the extent of cognitive impairment, memory and behavior problems, functional abilities, and duration of illness did not have a significant effect on caregiver burden. The research of Miller, McFall, and

Montgomery (1991) suggests that the caregiver's perception of and response to the care recipient's health, rather than the objective measure of health alone, is what influences the caregiver's experience.

In addition, the research of Miller and McFall (1991) indicates that the health status of the care recipient is related to the amount of help provided to the caregiver. These researchers analyzed data from the 1982-1984 National Long Term Care Survey and the companion 1982 Informal Caregivers Survey. They found that the size and intensity of the caregivers' networks changed in response to the health of elderly care recipients, but not in response to the primary caregivers' level of perceived burden.

Interaction of Background Variables

It is important to note that a combination of background characteristics interacting with each other (rather than isolated characteristics alone) may also impact support given to the caregiver, her perceptions of that support, and subsequent well-being. For example, a review of the literature by Mancini and Blieszner (1989) suggested that older parents who receive high levels of filial support from their children were likely to be female, not married, of low income, and in poor health. Arling (1987) found that women, whites, those living alone, and those with less education had greater sources of

strain. In turn, perhaps these individuals might also require and benefit from higher levels of support.

Finally, Gallagher et al. (1989) found that the relationship of the caregiver to the care-receiver, length of time as a caregiver, annual income, and whether or not the care-receiver was cognitively impaired did not significantly affect caregiver depression rates. Their research did suggest, however, that the presence of a dependent elder with major health problems was associated with increased depression (lower well-being) among caregivers.

Summary

In general, research suggests that caregivers with the following background characteristics may require and perceive a need for more support than caregivers who do not have these characteristics: poor health (Lowenthal & Robinson, 1985; Snyder & Keefe, 1985), low levels of education (Fischer, 1982), low income (Edwards & Klemmack, 1973), highly dependent mothers (Gallagher et al., 1989), dependent minor children (Aquilino & Supple, 1991; Umberson, 1989a; Umberson & Gove, 1989), and advanced age (Arling, 1987). Furthermore, the caregiver's degree of need and/or burden may determine, in part, the social support she receives. In turn, the caregiver's burden (e.g., stress) coupled with the amount of support she

receives can influence her well-being (e.g., satisfaction, depression).

The employment status of the caregiver may also influence her social support network and overall well-being (Kanter, 1977). For example, work can absorb the caregiver's time and energy and increase her role demands. On the other hand, work may offer respite time for the caregiver as well as increase her resources (e.g., income, social network).

Summary of Family Support

Individuals evaluate life experiences based on interactions with significant others (Blumer, 1969; Burr, Leigh, Day, & Constantine, 1979; Caplan, 1974). In particular, close family such as a spouse, siblings, and children may be significant contributors to the well-being of women who are providing care to their mothers (Brody, 1985; Fischer, 1982; Graney, 1985; Lin et al., 1985). Family can offer support in the form of financial support (Cicirelli, 1985), decision making (Cicirelli, 1985; Scott, 1983), socioemotional support (Brody, Hoffman, Kleban, & Schoonover, 1989), and reinforcement of identity through shared family history and symbolic memories (Burr, Leigh, Day, & Constantine, 1979; Cicirelli, 1985; Schvaneveldt, 1981; Stryker, 1959). Several conclusions can be drawn about the relationship between social support from close

family and the well-being of women who are providing care to their mothers.

A Note on Perception

The importance of subjective perceptions rather than objective assessments of social support in predicting an individual's well-being has been established (Cohen et al., 1986; Graney, 1985; House, 1981; Ishii-Kuntz, 1990; Ward, et al., 1984). Caregivers evaluate and perceive their situation based on their interactions with significant persons (Blumer, 1969; Burr et al., 1979; Caplan, 1974).

Perceived Support and Well-Being

Research indicates that individual well-being is positively influenced by support from close family members. In particular, support from siblings, a spouse, or children can enhance feelings of satisfaction (Aquilino & Supple, 1991; Rook, 1987) and protect caregivers from depression (Arling, 1987; Caplan, 1981; Cohen et al., 1986; Hirsch, 1980; Cohen & Wills, 1985; Cooke et al., 1988; Krause, 1986; Kerns & Turk, 1984).

Overall, it appears that adult children, especially daughters, can be significant sources of support, particularly in later life when social and personal resources may be more limited. Support from children may reduce the caregiver's feelings of burden and reaffirm her role, thus increasing perceptions of satisfaction and decreasing feelings of depression. The caregiver's

perceptions of well-being may be negatively influenced,
however, if she is unable to reciprocate to her children,
or if her children (as well as her mother) are dependent on
her.

In the absence of adult children, support from
siblings, especially sisters, may be particularly important
to well-being. The common family heritage and memories
that siblings share across the lifespan confirms the
salience of sibling supportiveness in promoting well-being.
Siblings may be in the best position to give advice and
support when decisions about parental care must be made
(e.g., medical care, nursing home placement). On the other
hand, the caregiver's siblings may be a source of strain.
For example, lack of help or support from siblings may be a
source of irritation and frustration for the caregiver who
finds that she must bear the burden alone.

The intimacy and daily contact typical of marital
relationships suggests that spousal support may be
particularly significant to the caregiver's well-being.
For example, a spouse who supports the caregiver in her
role can provide reaffirmation and ease her burden, thus
increasing feelings of satisfaction and protecting her from
depression. On the other hand, a spouse who is
antagonistic towards the caregiver's duties may undermine
her feelings of worth as a caregiver and add to feelings of
depression.

Finally, it is important to note that support from family members may also bring with it the obligation to reciprocate (Belle, 1982; Coyne & Bolger, 1990; Goldsteen & Ross, 1989). In turn, this may increase the caregiver's burden and decrease her perceptions of well-being. Thus, the psychological costs of personal relations may subtract from their benefits (Fischer, 1982).

Perceived Conflict and Well-Being

Conflict between the caregiver and her family may undermine her feelings of worth (Hirsch & Rapkin, 1986) and may contribute to higher perceptions of burden and poorer mental health (Strawbridge & Wallhagen, 1991). In fact, some research suggests that negative rather than positive social interactions have the strongest impact on well-being (Pagel et al., 1987; Rook, 1984). In particular, conflict with children, siblings, or a spouse may counterbalance the support they give (Belle, 1982).

Research suggests that higher levels of conflict with children are related to lower life satisfaction (Silverberg & Steinberg, 1987) and that less conflict may be associated with more enjoyable social interactions (Aquilino and Supple, 1991). Thus, the amount of conflict which a caregiver has with her child(ren) can impact her well-being.

The distinctive, shared family history of siblings suggests that conflict with siblings may undermine the

caregiver's sense of identity and well-being in making decisions regarding her aging mother. For example, siblings may argue over what type of care is best for their mother and which child should perform what duties.

Finally, the closeness and regular contact typical of marital relationships suggests that conflict with a spouse may continually and directly undermine the caregiver's esteem, satisfaction with her role, and mental well-being (i.e., depression). For example, a spouse who demands a high level of attention and services from his wife may be an obstacle or hostile barrier to her ability to care for her aging mother.

Background Characteristics

The caregiver's background characteristics may impact the amount of help she requires, her perceptions of support, and subsequent well-being. For example, older caregivers, who are likely to have physical limitations themselves, may be more likely to recognize and benefit from the support of close family members than younger caregivers. Caregivers with limited resources (e.g., poor health, low income, fewer years of education) or competing demands (e.g., dependent children) may also place greater value on receiving support. Employment can either be a burden that adds to the caregiver's list of responsibilities, or a blessing that offers respite. Finally, it seems plausible that a caregiver would perceive

support from family members as more valuable if her mother was in poor health, thus requiring more assistance.

Research Question and Hypothesis

Most research addressing the relationship between social support and psychological well-being has focused on the degree to which social support buffers adverse health effects of stressful life events such as bereavement, retirement, relocation, and physical health crises. There is a paucity of research addressing the potential influence of social support upon caregiver well-being, particularly for women providing care to non-cognitively impaired mothers. The proposed study addresses this gap in the literature.

A review of the literature suggests a relationship between perceived social support from and conflict with close family members (siblings, spouse, children) and well-being (i.e., depression). Research also indicates that objective factors (i.e., background characteristics surrounding the caregiving situation) can make an important contribution to the well-being of women care providers. Specifically, the following research question and hypothesis will be used to explore this phenomenon. The direction of the predicted relationship for each set of variables is noted in parenthesis.

Q   Does social support from close family members, in the light of significant background characteristics,

contribute to the well-being of women who provide care to their dependent mothers?

H   There will be a significant relationship between respondents' perceived well-being and:

(a)   Perceived social support from:

   (1)   siblings (positive relationship)

   (2)   spouse (positive relationship)

   (3)   children (positive relationship)

(b)   Background characteristics:

   (1)   age of respondent (negative relationship)

   (2)   health of respondent (positive relationship)

   (3)   education of respondent (positive relationship)

   (4)   employment status of respondent (positive relationship)

   (5)   family income (positive relationship)

   (6)   number of dependent children (negative relationship)

   (7)   mother's health (positive relationship)

CHAPTER III

METHODOLOGY

Background of the Study

The primary objective of this study was to examine the contribution of perceived social support from close family and background characteristics to caregiver well-being. This study was derived from a subset of a larger, five year Western Oregon study of women caring for their aging mothers (Walker, 1986). The sample for the larger study consisted of 222 mother-daughter pairs from rural and urban parts of Western Oregon who volunteered for a study on mother-daughter relationships. At the time of sample selection, mothers were unmarried, aged 65 years or older, lived within 45 miles of their daughters, and showed no signs of cognitive impairments. Sample selection for the larger study included 172 pairs in which the mother had some level of care need provided by the daughter (i.e., dependent mothers). The care provided by daughters ranged anywhere from running errands to providing around-the-clock care for their mothers. The remaining 50 pairs served as the control group for which no care need was present.

The sample for the present study was selected from the group of caregiving women who participated in the third wave of data collection (1989-1990) for the larger study. The third data wave was used for this study because it

incorporated new measures of social support and well-being
that had not been used in the previous data waves. The
number of women interviewed during the third data wave was
smaller than the original year-one sample due to: death of
mothers (5.4%, cumulative); lack of interest or moving out
of state (4.1%); and respondent's illness (.5%). The
sample for this study is described in greater detail below.

The Sample

Sample selection procedures are discussed in this
section. Descriptive statistics (e.g., frequencies) were
used to examine and describe the study sample.

Sample Selection

The sample for this study was selected from the larger
group of women who were interviewed during the third data
wave (1989-1990) of the Parent-Caring Project in Western
Oregon (n=148). The first step in sample selection
involved the exclusion of women who did not have dependent
mothers (23 were excluded). As defined in the research
project, dependent mothers needed assistance in one or more
of the following areas: transportation, housekeeping, meal
preparation, laundry, personal care, or financial aid. The
final step in sample selection entailed eliminating
unmarried women with dependent mothers, or those who did
not have a sibling or child (60 were eliminated). This
group will be referred to as the "smaller kin network"
group. The remaining group of women became the sample for

this study. It included only those who were: (a) caring
for dependent mothers; (b) were married; (c) had at least
one sibling; and (d) had at least one child. This select
group of women will be referred to as the "study sample" or
the "larger kin network" group (n=65). For information
comparing the study sample with the smaller kin network
group see Appendix A.

Description of the Study Sample

As shown in Table 1, the majority of respondents in
the study sample were between age 29 and 54 (57%), in good
health (94%), educated beyond high school (69%), and
employed full-time (60%) or part-time (28%). They had a
mean family income of $38,904, with a median income of
$35,000. Most cared for mothers who were in good health
(62%), and most had dependent children (56%).
Additionally, all of these women were white, and the
majority had at least three children (60%) and at least two
siblings (68%) (see Appendix A).

Sample means and standard deviations for all the
independent and dependent variables can be found in Tables
1 and 2. For instance, most respondents had a mean well-
being of 51 (well-being scores ranged from 0=low to
60=high).

Data Collection

Data for the larger study were collected annually over
several years. Data for the present study, however, were

**Table 1. Background Characteristics of the Study Sample:
Means, Standard Deviations, and Percentages
(N=65)**

Background Characteristics	Mean	Standard Deviation	Percent
Age	2.23	.95	
29 to 44			27.7
45 to 54			29.2
55 to 64			35.4
65 or older			7.7
Health	4.35	.60	
severely ill			0.0
fairly ill			0.0
not too healthy			6.2
pretty healthy			52.3
very healthy			41.5
Education	2.74	.78	
less than high school			7.7
high school			23.1
1-4 yrs. beyond HS			56.9
5+ yrs. beyond HS			12.3
Employment	1.15	.62	
full-time			60.0
part-time			27.7
unemployed			12.3
Income	2.83	1.25	
less than 24,999			18.8
24,000 to 34,999			21.9
35,000 to 49,999			26.6
50,000 to 74,999			23.4
75,000 or more			9.4
# Dependent Child	.95	1.08	
none			44.6
one			27.7
two			18.5
three			6.2
four			3.1
Mother's Health	2.65	1.00	
poor			17.5
fair			20.6
good			41.3
excellent			20.6

Table 2. Means and Standard Deviations for Perceived Social Support and Well-being (N=65)

Variable	Mean	Standard Deviation
Siblings		
supportiveness	3.37	1.25
positive contact	4.00	.93
conflict	1.69	.84
Spouse		
supportiveness	4.32	.83
positive contact	4.43	.77
conflict	1.83	.68
Children		
supportiveness	4.03	.76
positive contact	4.41	.56
conflict	1.95	.83
Well-Being (measured by the CES-D scale)	51.00	8.47

only collected during the third data wave of the larger study. As previously noted, only data from the third wave was used because it incorporated new measures of social support and well-being that had not been used in previous data waves. Data collection for both the larger and present studies are discussed next.

The Larger Study

Data for the larger study were collected over a five year time period, 1986 to 1991. Yearly face-to-face interviews were conducted with caregiving daughters and their elderly mothers (separately), typically in their homes. At the time of the interview, participants were paid a small amount of money and were asked a series of questions about demographic/background characteristics, caregiving tasks and activities, perceptions of the mothers' health, perceptions of why the daughters help their mothers, perceived decision-making competence of the mother, decisions that had been made for potential future care needs, and perceived conflicting role responsibilities for the daughter. Respondents were also asked to complete paper-and-pencil measures assessing perceived relationship quality between mother and daughter, and the perceived costs and benefits of caregiving and care receiving.

In addition, during the second, third, and fourth data waves each daughter and mother completed a series of telephone interviews over a designated period of time

following the face-to-face interview. Only daughters had telephone interviews during the first wave of the study. During each phone interview, participants were asked to report on the nature of the activities she arranged to do with or for her intergenerational partner, and the amount of time and money devoted to each. Each phone interview typically lasted for five to ten minutes.

In the event that a mother died, daughters were asked to participate in bereavement interviews. During these interviews, daughters were asked questions about the bereavement process and completed paper-and-pencil measures regarding perceived relationship quality (Walker, 1986).

The Present Study

Data for this study were gathered during the third data wave of the larger study (1989-90) via face-to-face interviews. Face-to-face interviews typically lasted for one to two and a half hours. During the interview, each woman responded to all questions prescribed by the larger study (e.g., demographic questions, questions about the mother's health). In addition, daughters (and mothers) completed paper-and-pencil measures assessing feelings over the past week (well-being), and daughters were asked about perceived support from siblings, spouse, and children.

Measures

Face-to-face interviews, including self-report instruments, were used to collect data for the present

study. Measures of the following variables were used for major data analyses: (a) well-being; (b) perceived support, positive contact, and conflict (with siblings, spouse, and children); and (c) respondent background characteristics. Additionally, several measures were used to supplement the major research question and data analyses, including: (a) other demographic characteristics; (b) help from specific persons; and (c) the most supportive person (to the caregiver). A description of each measure is presented next.

Well-Being

Well-being was operationalized using the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) (see Appendix B). This scale consisted of 20 items representing symptoms of depressive disorder. For each item respondents were asked to rate how often they experienced each symptom over the past week on a four point Likert-type scale ranging from 0 (rarely or none of the time) to 3 (most or all of the time). Four items (i.e., 4, 8, 12, and 16) were stated positively and were reverse scored. The total CES-D score is a sum of all items, ranging between 0 to 60, with 0 representing the lowest depression score or the highest well-being. The most common depression cutoff score is 16. For purposes of this study, depression scores were reverse coded so that low scores indicated low well-being and high scores indicated

high well-being. Means and standard deviations for well-being among the study sample can be found in Table 2.

The internal consistency for the complete CES-D scale was tested by Radloff (1977) using a coefficient alpha and the Spearman-Brown, split-halves method. He found that reliability was high in the general population (.85) and even higher in a depressed patient sample (about .90). Test-retest reliabilities were somewhat lower (ranging from .45 to .70). This is to be expected, however, because the CES-D scale was designed to measure current level of symptomatology which may vary over time.

The validity for this scale was also explored by Radloff (1977) through comparing CES-D scores for the general population with CES-D scores for a sample of depressed patients. He found that the CES-D scale differentiated between the general population and depressed patients: Average CES-D scores were significantly higher for patients than for general population samples.

For purposes of this study, the overall depression score will be utilized. From this point on "well-being" will be used to refer to results obtained from analyses using the overall CES-D (depression) scale.

Perceived Social Support

Perceived social support was measured through a series of questions addressing the caregiver's perceptions of social support from siblings, spouse, and children (see

Appendix C). First, respondents answered three questions about social support from siblings. Specifically, they were asked how <u>supportive</u> their sibling(s) had been over the past year. Possible response categories ranged from 1 (not at all) to 5 (totally). Next, respondents were asked how <u>positive</u> their contact with sibling(s) had been over the past year. Possible responses ranged from 1 (very positive) to 5 (very negative). Then, respondents were asked how much <u>conflict</u> with sibling(s) there had been over the past year. Possible responses ranged from 1 (none) to 4 (a great deal). The same three questions were used to assess perceived social support from a spouse and child(ren). Means and standard deviations for perceived social support among the study sample can be found in Table 2.

Responses for supportiveness and positivity of contact were reversed to prevent biased response sets. Prior to all data analyses, however, responses were recoded, as necessary, so that high codes reflected higher levels of supportiveness and positive contact, and low codes indicated lower levels of supportiveness and positive contact.

When measures of supportiveness, positivity of contact, or conflict (with a family member) were highly correlated (i.e., $r < -.5$ or $r > +.5$), they were combined into a single index to avoid multicollinearity problems and

because they appeared to be assessing the same dimension of social support. Indices were created, when appropriate, by summing the standardized scores (Z scores) for the highly correlated measures. In addition, when conflict was highly correlated with measures of supportiveness or positivity of contact, conflict scores were recoded to be consistent with the direction of coding for these measures (i.e., so that higher scores indicated less conflict). Cronbach's Alpha was used to determine the reliability of any index that was created.

Background Characteristics

The following background variables were included in this study: (a) age of respondent; (b) perceived health of respondent; (c) education of respondent, coded as a dummy variable (so that 0=not employed, and 1=employed); (d) employment status of respondent; (e) family income; (f) number of dependent children; and (g) respondent's perception of her mother's health (see Appendix D). These background characteristics were used for descriptive purposes, and were incorporated into the regression analyses if they were significantly correlated with well-being at p < .05.

Other Demographic Characteristics

The respondent's total number of children (sons, daughters), total number of siblings (brothers, sisters), marital status, and race were examined for descriptive

purposes (see Appendix D). These data were used to supplement the major data analyses.

Help Received from Close Family

Help received from specific persons was identified by asking respondents a yes/no question: "Does anyone ever help you to meet your mother's needs for caregiving?" If the respondent answered "yes," then another question was asked: "Who helps you?" (see Appendix E). For purposes of this study, only data pertaining to help from siblings, spouse, and children were analyzed. The data were used to explore the pattern of help to caregivers provided by sisters, brothers, spouses, daughters, and sons.

The Most Supportive Person

Two questions were used to assess the most supportive person to the caregiver. First, each respondent was asked: "Overall, who, if anyone of all the people you know, has been the most supportive of you in the past year?" Second, if the caregiver named a supportive person, then the following question was asked: "What were the most supportive things this individual did for you?" (see Appendix F). The researcher conducted a content analysis on the qualitative responses. Themes of support were identified using responses relating to support from a spouse since respondents most often mentioned a spouse as most supportive.

Identification of Variables

Well-being (measured using the CES-D scale) was the dependent variable for all regression analyses. The independent variables included: (a) perceived support, positive contact, and conflict with siblings, spouse, and children; and (b) background characteristics.

Analyses of the Data

Data were analyzed using SPSS-PC and adhered to the following plan. The most supportive person to the caregiver was examined to set a context for major data analyses. Help received from close family was also explored.

Zero order (Pearson) correlations were conducted for descriptive purposes and to determine if multicollinearity/high correlations (defined prior to data analyses as being $r < -.5$ or $r > +.5$) was a problem among the independent variables to be entered into the regressions. Correlations were also used to demonstrate which of the hypothesized independent variables were significantly correlated ($p < .05$) with the dependent variable, well-being.

Finally, major data analyses involved calculation of three standard multiple regressions designed to assess the contribution of social support from close family (siblings, spouse, and children) and background characteristics to caregiver well-being. Prior to running the regressions,

correlations were used to identify which background characteristics were significantly related to the independent variable (well-being), and therefore would be entered into the regression analyses. In all three regressions well-being was the dependent variable. The level for determining statistical significance was set at $p < .05$ for all appropriate analyses.

CHAPTER IV

RESULTS

Introduction

This study examined the contribution of perceived social support (from siblings, spouse, and children) and background characteristics to the well-being of women providing care to dependent mothers. In this chapter, a brief overview of the study sample, individual reports of the most supportive person, and reports of help received from close family are presented to create a context for major data analyses. Pearson correlations involving background characteristics, perceived social support, and well-being are also explored to determine which variables were correlated with each other and with well-being. Finally, results from regression analyses, designed to explore the contribution of social support and background characteristics to well-being, are discussed.

Description of the Study Sample

Most women in the study sample were: 29 to 54 years old, in good health, educated beyond high school, employed, caring for mothers in good health, and had dependent children. These women had an average family income of $38,904. More details about sample selection and the study sample can be found in chapter three.

The Most Supportive Person

The majority of the sample (63%) reported a spouse as the most supportive person (see Table 3). A content analysis of qualitative responses identified several themes for the most supportive things that spouses did. Responses most often fell into the themes of helping with housework and caregiving (n = 14) and always being there (n = 12) (see Table 4). Appendix G contains all caregiver responses pertaining to the most supportive things that family did.

Second to spouses, daughters were considered to be most supportive (13%) to caregivers (see Table 3). Some of the most supportive things that daughters did for their caregiving mothers included providing love and emotional support and listening (see Table 4 and Appendix G).

No caregiver reported a son or brother to be the most supportive person to her, and only one said that her sister was the most supportive (see Table 3). In this case, the most supportive thing that the sister did for her caregiving sibling was listening (see Table 4 and Appendix G).

Some caregivers reported other individuals as being most supportive. Six percent of the sample mentioned a friend as most supportive, and approximately thirteen percent reported that an "other person" (i.e., someone other than family, a friend, or professional) was most supportive.

Table 3. Most Supportive Person to Caregivers (n=65)

Most Supportive Person	Number	Percent
Mother	2	3.1
Spouse	40	62.5
Sister	1	1.6
Brother	0	0
Daughter	8	12.5
Son	0	0
Other Family Member	1	1.6
Friend	4	6.3
Professional	0	0
Other Person	8	12.5

Table 4. Most Supportive Things that Family Did for Caregivers (n=65)

Themes of Support	Spouse	Daughter	Sister
Helping with housework and caregiving	14	1	0
Always there	12	0	0
Love and emotional support	8	2	0
Listening	6	3	1
Advice/help in making decisions	5	0	0
Other	4	0	0
Uncodeable	1	0	0

Note. Totals may exceed N because some responses could fit into more than one category.

Help Received from Close Family

An exploration of help received from close family was conducted to determine the extent to which spouses, siblings, and children helped caregivers to meet the needs of the care recipient (i.e., the caregiver's mother). Just over half (54%) of the caregivers in the study sample reported that a spouse helped them meet their mother's needs for care. Table 5 shows that most respondents said that their siblings and children did not help.

Background Characteristics

Correlations between background characteristics and well-being were calculated to identify statistically significant background characteristics to be entered into the regression analyses and to determine which variables were correlated with well-being and with each other. Table 6 shows that the respondent's health was the only background characteristic significantly correlated with well-being ($r = .31$). Caregivers who were in better health had higher well-being than those in poorer health. So, caregiver health was the only background variable entered into the regression analyses. Thus, multicollinearity among background characteristics was not present.

Also, the correlation between respondent's age and well-being ($r = .26$) neared statistical significance at $p < .05$). This finding makes sense given that age is no doubt also related to health (see Table 6).

Table 5. Help Received from Close Family

Family Member	Yes--Did Help %	No--Did Not Help %
Spouse (n=59)	54.2	45.8
Sister (n=55)	40.0	60.0
Brother (n=56)	44.6	55.4
Daughter (n=58)	34.5	65.5
Son (n=58)	29.3	70.7

Note. The number of valid cases varies for each cell based on missing cases.

Table 6. Correlations of Background Characteristics and Well-Being

	1	2	3	4	5	6	7	8
1. Age	-----	.12	.07	.10	.13	-.62**	.36*	.26
2. Health		-----	.25	.07	.21	.03	.18	.31*
3. Education			-----	.07	.30	-.15	-.11	-.06
4. Employment				-----	.26	-.10	-.02	.01
5. Income					-----	-.14	.06	-.01
6. Number of Dependent Children						-----	-.15	-.18
7. Mother's Health							-----	.23
8. Well-Being								-----

  * p < .05
** p < .005

As expected, the respondent's age was significantly correlated with her mother's health (r = .36), and number of dependent children (r = -.62). No other background characteristics were significantly correlated with each other (see Table 6).

Perceived Social Support

Correlations between perceived social support and well-being were calculated prior to regression analyses. The only social support measures that were significantly correlated with well-being were those involving conflict with a family member. Significant negative correlations were found between well-being and conflict with siblings (r = -.33), and well-being and conflict with a spouse (r = -.43). Caregivers who perceived less conflict with their siblings and spouse had higher well-being (see Table 7).

Correlations among perceived social support variables revealed that two of the three child social support measures were significantly correlated: child conflict and positivity of contact (r = -.37); and child supportiveness and positivity of contact (r = .31). Higher conflict was associated with less positive contact with children, and higher support was related to more positive contact with children (see Table 7).

All three measures of sibling social support were correlated with each other: sibling supportiveness and

Table 7. Correlations of Perceived Social Support and Well-Being

	1	2	3	4	5	6	7	8	9	10
1. Sibling Conflict	———	-.52**	-.39**	.37*	-.15	-.09	.37*	-.02	-.02	-.33*
2. Sibling Positive Contact		———	.62**	-.48**	.27	.02	-.19	.07	.07	.21
3. Sibling Support- iveness			———	-.37*	.19	.11	-.20	.03	.14	.14
4. Spouse Conflict				———	-.34*	-.40**	.32*	.06	-.09	-.43**
5. Spouse Positive Contact					———	.49**	-.09	.21	.11	.12
6. Spouse Support- iveness						———	.07	.05	.23	.07
7. Child Conflict							———	-.37*	-.18	-.28
8. Child Positive Contact								———	.31*	.02
9. Child Support- iveness									———	.06
10. Well- Being										———

*p < .05
**p < .005

positivity of contact (r = .62); sibling conflict and positivity of contact (r = -.52); and sibling conflict and supportiveness (r = -.39). Higher support was associated with more positive contact with siblings, and more conflict was associated with lower levels of support and less positive contact with siblings (see Table 7).

All three measures of husband social support were also correlated with each other: spouse supportiveness and positivity of contact (r = .49); spouse conflict and positivity of contact (r = -.40); and spouse conflict and supportiveness (r = -.34). Interestingly, conflict with a spouse was also significantly correlated with all three measures of sibling social support (sibling conflict, r = .37; sibling positive contact, r = -.48; sibling supportiveness, r = -.37), and child conflict was negatively correlated with sibling and spouse conflict (see Table 7).

Finally, examination of correlations among perceived social support variables was conducted to determine if multicollinearity existed among the independent variables to be entered into the regressions. For **siblings**, supportiveness and positivity of contact were positively correlated (r = .62), and conflict and positivity of contact were negatively correlated (r = -.52) (see Table 7). These high correlations coupled with the statistically significant negative correlation between sibling conflict

and supportiveness (r = -.39) suggested that all three measures should be combined into a single index, "sibling social support." The reliability, Cronbach's alpha, for this index was .76.

In regard to perceived social support from a **spouse**, measures of supportiveness and positivity of contact were positively correlated at r = .49 (see Table 7), which met the predetermined criterion for a high correlation when rounded to the nearest tenth. Thus, measures of spouse supportiveness and positivity of contact were combined into a single index called "spouse support/positive contact." The reliability, Cronbach's alpha, for this index was .66, a reasonable coefficient given that the index was only composed of two measures. Conflict with a spouse was preserved as a separate measure.

No measures of perceived social support from **children** met the criterion for multicollinearity problems (see Table 7). Therefore, supportiveness, positivity of contact, and conflict with children were maintained as separate measures.

Perceived Social Support and Background Characteristics

Correlations between perceived social support and background characteristics were calculated for descriptive purposes. Table 8 shows that the respondent's age was significantly correlated with the greatest number of perceived social support variables. Respondent's age was

Table 8. Correlations of Perceived Social Support and Background Characteristics

	Sib Cnfl	Sib Pos	Sib Sup	Spou Cnfl	Spou Pos	Spou Sup	Chld Cnfl	Chld Pos	Chld Sup
Age	-.36*	.34*	.37*	-.46**	.22	.11	-.53**	.07	.15
Health	-.23	.29	.16	-.04	.07	-.08	-.13	-.09	-.17
Education	-.09	.08	-.01	.20	-.22	-.30*	-.08	.06	-.10
Employment	-.25	.22	.26	-.09	.03	.15	.09	-.06	-.11
Income	-.18	.11	.26	-.13	.06	.17	.19	-.06	.03
Number of Dependent Children	.20	-.06	-.21	.25	-.03	-.04	.47**	-.18	-.17
Mother's Health	-.18	.32*	.31*	-.39**	.22	.08	-.17	-.02	.14

 * p < .05
** p < .005

Sib Cnfl = perceived conflict with sibling(s)
Sib Pos = perceived positive contact with sibling(s)
Sib Sup = perceived supportiveness of sibling(s)
Spou Cnfl = perceived conflict with spouse
Spou Pos = perceived positive contact with spouse
Spou Sup = perceived supportiveness of spouse
Chld Cnfl = perceived conflict with child(ren)
Chld Pos = perceived positive contact with child(ren)
Chld Sup = perceived supportiveness of child(ren)

correlated with all three measures of perceived social
support from siblings. Being older was associated with
higher supportiveness, more positive contact, and less
conflict with siblings. Respondent's age was also
significantly correlated with the other two measures of
family conflict: Older caregivers had less conflict with
spouses and with children.

The mother's health was significantly correlated with
three measures of perceived social support. Having a
healthier mother was associated with more positive contact
and supportiveness from siblings, and less conflict with a
spouse (see Table 8).

Two other significant correlations were found. There
was a negative correlation between respondent's education
and husband supportiveness (r = -.30), and a positive
relationship between number of dependent children and
conflict with children (r = .47). Having higher education
was associated with lower support from a spouse, and having
fewer dependent children was related to less conflict with
children (see Table 8).

<u>Regression Analyses</u>

Regressions were used to explore the main research
question. Results from these analyses are discussed next.

<u>Perceived Social Support from Sibling(s)</u>

The first regression explored the impact of sibling
social support and caregiver health on caregiver well-

being. The dependent variable in this regression was well-being, and the independent variables included the index of sibling support (i.e., supportiveness, positive contact, and conflict), and respondent's health.

The overall regression equation was significant (p = .0180) with only respondent's health nearing statistical significance (t = 1.9, p = .0609, beta = .243): Better health was associated with higher well-being. The adjusted R^2 was small, indicating that this model accounted for only 9.9% of the variance in well-being. Sibling social support was not significant in the regression (see Table 9).

Perceived Social Support from Spouse

The second regression assessed the contribution of spouse social support and caregiver health to caregiver well-being. The dependent variable for this regression was well-being, and the independent variables included spouse conflict, the index of spouse support (i.e., supportiveness, and positive contact), and respondent's health.

The overall regression was significant (p = .0002). Conflict with a spouse was the most significant predictor of well-being (t = -3.8, p = .0004, beta = -.457), followed by the respondent's health (t = 2.6, p = .0106, beta = .290). Women with higher well-being reported having less conflict with their spouses and were in better health. The

Table 9. Multiple Regression for the Impact of Sibling Support and Caregiver Health on Well-Being

Variables	B	Beta	T
Respondent's Health	3.424	.243	1.911*
Sibling Social Support	.711	.207	1.626
Constant	35.622		4.524**

R^2 = .129

Adjusted R^2 = .099

Multiple R = .360

 * p < .06
** p < .001

Note. Significance of F value for regression equation was p = .0180.

adjusted R^2 indicated that this model accounted for about 24% of the variance in well-being (see Table 10).

Perceived Social Support from Child(ren)

The third regression examined the impact of child social support and caregiver health on caregiver well-being. The dependent variable for this regression was well-being, and the independent variables were supportiveness, positivity of contact, conflict with child(ren), and respondent's health.

The overall regression equation was significant (p = .0289) with respondent's health being the only significant predictor of well-being (t = 2.4, p = .0195, beta = .298). Better health was associated with higher well-being. The adjusted R^2 indicated that this model accounted for only 11% of the variance in well-being (see Table 11).

Summary of Perceived Social Support from Close Family

Overall, regression analyses indicate that health and conflict with a spouse are significant predictors of well-being for women caregivers. Health accounted for a small portion of the variance in well-being: Respondents in better health had higher well-being. Conflict with a spouse was the most important social support measure and the strongest predictor of well-being: Higher conflict with a spouse was associated with lower well-being for caregivers.

Table 10. Multiple Regression for the Impact of Spouse Support and Caregiver Health on Well-Being

Variables	B	Beta	T
Respondent's Health	4.090	.290	2.639*
Spouse Supportiveness/ Positive Contact	-0.428	-.088	-0.722
Spouse Conflict	-5.694	-.457	-3.751**
Constant		43.186	5.776**

R^2 = .277

Adjusted R^2 = .241

Multiple R = .526

* p < .01
** p < .001

<u>Note</u>. Significance of F value for regression equation was p = .0002.

**Table 11. Multiple Regression for the Impact of Child
Support and Caregiver Health on Well-Being**

Variables	B	Beta	T
Respondent's Health	4.226	.298	2.403**
Child Positive Contact	-1.083	-.071	-.526
Child Supportiveness	.941	.084	.656
Child Conflict	-2.526	-.244	-1.858*
Constant	38.257		2.630***

R^2 = .167

Adjusted R^2 = .110

Multiple R = .409

* p < .07
** p < .05
*** p < .01

<u>Note</u>. Significance of F value for regression equation
was p = .0289.

The significant zero-order correlation between conflict with siblings and well-being, and the near significance of child conflict in the third regression suggest that perceptions of conflict with siblings and children may also impact well-being. These variables merit more attention in future research.

Overall Family Support

One final regression determined which of the hypothesized independent variables were the most significant predictors of well-being. Well-being was the dependent variable for this regression, and the independent variables included: (a) an index of overall sibling support (i.e., supportiveness, positive contact, and conflict); (b) an index of spouse support (i.e., supportiveness, and positive contact); (c) conflict with a spouse; (d) supportiveness of children; (e) positive contact with children; (f) conflict with children; and (g) health of the caregiver. It is important to note that this regression model has limitations because many variables are entered into the model given the sample size.

The overall regression was significant (p = .0116) with an adjusted R^2 of .19. Conflict with a spouse was the most significant predictor of well-being (t = -2.8, p = .0077, beta = -.440), followed by the respondent's health (t = 2.3, p = .0241, beta = .295). These results confirmed the findings of earlier analyses. Conflict with a spouse,

followed by the respondent's health, were significant predictors of well-being for a sample of women providing care to non-cognitively impaired mothers (See Table 12).

Table 12. Multiple Regression for the Impact of Family Support on Well-Being

Variables	B	Beta	T
Respondent's Health	4.175	.295	2.323*
Spouse Supportiveness/ Positive Contact	-0.449	-.093	-.665
Child Conflict	-.778	-.076	-.527
Child Supportiveness	.644	.057	.445
Sibling Social Support	-.174	-.050	-.350
Child Positive Contact	.280	.018	.132
Spouse Conflict	-5.971	-.440	-2.771**
Constant	40.952		2.836**

R^2 = .283

Adjusted R^2 = .186

Multiple R = .532

* p < .02
** p < .008

Note. Significance of F value for regression equation was p = .0116.

CHAPTER V

DISCUSSION AND CONCLUSIONS

Summary

A review of the literature indicated that perceived social support can cushion the impact of stressful life events and foster individual well-being (Cohen et al., 1986; Graney, 1985; House, 1981; Ishii-Kuntz, 1990; Ward et al., 1984). This study explored perceptions of social support from close family members (i.e., spouse, siblings, children) and its relation to well-being for a sample of women who provided care to their elderly mothers. The care provided by these women ranged from running errands to providing around-the-clock care. The range of physical health and care needs met by the caregivers in this study is comparable to that of the general population of caregivers for persons who (for the most part) do not suffer from cognitive disorders (Palmore, 1986; Stone, Cafferata, & Sangl, 1987).

The majority of women in this study identified family members as the most supportive people to them. Support, broadly conceived, was related to psychological well-being (as measured by the CES-D scale), especially when a spouse was involved.

This chapter highlights and explores the main results of the present study. The chapter begins with a discussion

and conclusions section, and ends with limitations, recommendations and implications for professionals.

Perceived Support and Positive Contact with Close Family

While some researchers have found a connection between social support and well-being (e.g., Cohen & Wills, 1985), in this study no measures of supportiveness/positivity of contact from close family were significantly related to well-being. Several explanations may account for this result. First, the majority of the sample (83%) had high well-being scores (a score of 45 or higher), with a mean well-being score of 51. The high well-being of respondents might have diminished the ability to detect the impact of supportiveness/positive contact on well-being. Perhaps variance in caregiver perceptions of support from family would have been more apparent among a sample of caregivers who were depressed. Depressed caregivers may report lower levels of support and perceive less satisfaction with support than non-depressed caregivers, even if both groups of caregivers receive the same amount of support (Gallagher et al., 1989; Rivera et al., 1991).

In addition, respondent reports of social support tended to be positively skewed. Perhaps persons in the sample volunteered because they had positive family relationships, or perhaps individuals tended to respond to interview questions in a socially desirable fashion. Alternatively, some research indicates that enjoyable

social interactions are quite common among the general population (e.g., Aquilino & Supple, 1991). Also, since both well-being and perceived support were high in this study, perhaps social support was working.

The health of the caregivers' mothers also provides a partial explanation for the results of this study. Most women in the study sample were providing care to non-cognitively impaired mothers. Perhaps a sample of women experiencing high caregiving demands would have more need for support. That is, caregivers who require more support may perceive less support because they have greater needs for it.

Support from a Spouse

Qualitative data revealed that family members did impact the caregiver's experiences. Of all family members, social support from a spouse appeared to be most important to women who were providing care to their aging mothers. Caregiving women named a spouse more often than anyone else as the "most supportive person." Caregivers commonly described their spouses as helping with housework and caregiving responsibilities, always being there, and providing love and emotional support. For example, one caregiver said of her husband, "...He deals with my mom day in and out like I do." This is consistent with the "active support" posture of a husband described by Matthews and Rosner (1991). Another responded "He is always there to

back me up--gives me advice and always is the person to say 'you're doing great!'"

Other respondents mentioned that their husbands provided emotional support. One caregiver said "He listens to my troubles and tries to solve them if he can..." Another reported "He supports whatever I want to do; [and] encourages me." These findings parallel those of Webster-Stratton (1989) suggesting that the posture a husband takes towards the caregiving activities of his wife is especially important. As shown in this study, husbands can buffer the caregiver against the negative consequences of stress (e.g., depression) (Brown & Harris, 1978; Kerns & Turk, 1984) and help their wives manage the additional role of caregiving (Fischer, 1982; Hirsch & Rapkin, 1986).

Support from Child(ren)

Second to spouses, daughters were regarded as most supportive to women providing care to dependent mothers. Respondents reported that daughters provided emotional support and encouragement, and listened and acted as a sounding board. No respondent mentioned a son as most supportive. This finding is corroborated by other research suggesting that daughters (rather than sons) are particularly important resources for caregivers (Brody, 1985; Spitze & Logan, 1990; Pruchno, 1990).

Additionally, the women in this sample tended be in good health which was also related to well-being. Others

have found that caregivers with many personal resources may not expect much support from children (Blieszner & Mancini, 1987).

Support from Sibling(s)

None of the caregiving women reported a brother as most supportive, and only one caregiver said that a sister was most supportive. The seemingly insignificant contribution of siblings to well-being might be explained by the fact that women in the study sample also had a spouse, children, and mother available to provide support. It has been shown that siblings are less likely to have an impact on the caregiver's life when ascendant or descendant family resources are available (Brody et al., 1989; Cicirelli, 1984, 1985; Matthews & Rosner, 1988; Mutran & Reitzes, 1984; Troll, 1971; Troll et al., 1979).

Perceived Conflict with Close Family

The only social support measure significantly correlated with well-being involved conflict with a family member. The work of Pagel, Erdly, and Becker (1987) emphasizes the significance of conflict suggesting that negative rather than positive interactions have the strongest impact on depression and network satisfaction. Rook (1984) also found that negative social interactions had a greater effect on well-being than positive social interactions.

In addition, Pearson correlations indicated that all three measures of conflict (with siblings, spouse, and children) were positively related. Also, both conflict with a spouse and conflict with siblings were significantly and inversely correlated with well-being. The correlation between conflict with children and well-being, although not significant in the regression, was in the same direction as correlations between conflict with other family members and well-being. These findings suggest a link between well-being and family conflict. The direction of this link, however, is unknown. Thus, it is difficult to determine if conflict predicts low well-being or if low well-being contributes to perceptions of higher conflict. Conflict with close family members is explored in more detail below.

Conflict with a Spouse

Conflict with a spouse was predictive of well-being among women caregivers, even when health of the respondent was controlled for: Higher conflict was associated with lower well-being. The work of Webster-Stratton (1989) suggests that conflict with a spouse may increase the caregiver's stress and negatively impact her well-being. For instance, the demands of a husband may intensify the caregiver's burden, conflict with parent care responsibilities, and lower her satisfaction with the situation. This notion is corroborated by the research of Matthews and Rosner (1991) suggesting that women with

actively supportive spouses are likely to be routinely involved in caregiving, whereas those with antagonistic spouses may experience emotional strain and feel limited in their ability to provide care. Having an indifferent spouse, though, may not impact the caregiver's ability to meet her mother's needs. Moreover, the research of Kleban, Brody, Schoonover, and Hoffman (1989) suggests that spousal conflict may elevate due to the caregiving situation. Almost half the males in their study reported arguing with their wives about caregiving situations. Very few men, however, thought that caregiving had affected their marital relationships detrimentally.

In addition, conflict with a spouse was inversely related to the respondent's age. Older women were less likely than younger women to have conflictual interactions with their husbands. Perhaps individuals in later life have fewer sources of conflict (e.g., children are grown and out of the home), or perhaps marriages with high levels of conflict end in divorce early on.

The potential impact of conflict with a spouse upon aging caregivers is emphasized when combined with previous research suggesting that support (or lack of support) from a spouse may be more significant when the individual reaches a life stage in which the spouse is central (Shulman, 1975), usually in later life, or under conditions

which limit contact with pre-existing support networks (Kerns & Turk, 1984).

Conflict with Child(ren)

Conflict with children was not a significant predictor of well-being. Prior research, however, suggests that conflict with children can impact an individual's well-being (Aquilino & Supple, 1991; Silverberg & Steinberg, 1987). Perhaps the presence of a spouse concealed the potential impact which children had on well-being.

Conflict with Sibling(s)

Conflict with siblings was not a significant predictor of well-being. Prior studies, however, suggest that conflict with siblings can undermine one's esteem and subsequent well-being (Pagel at al., 1987; Rook, 1984). Here, sibling conflict was inversely related to the age of the respondent: Being older was associated with lower levels of conflict. Perhaps the contribution of siblings may not be significant until the caregiver reaches a stage in life when her spouse is no longer available and/or when the long-term family history shared with siblings becomes more meaningful to her (e.g., Cicirelli, 1982).

Contribution of Background Characteristics to Well-Being

Respondent's health was the only background characteristic significantly associated with well-being. Caregivers who were in better health had higher well-being. Research supports this finding, suggesting that there is a

direct relationship between physical health and mental
health (e.g., Harris, 1987; Kennedy et al., 1990).

Other Notable Findings

Interestingly, all three measures of perceived support
from siblings (supportiveness, positive contact, and
conflict) were correlated, while only two measures of
support from a spouse (i.e., supportiveness, positive
contact), and no measures of support from children were
correlated. A possible explanation for this finding is
that married women with children may not be as intimate
with siblings, and therefore perceive both positive and
negative sibling interactions along one dimension, or as a
single block. On the other hand, positive and negative
interactions in more intimate relationships, such as with a
spouse (or children), can be experienced separately. This
view is supported, in part, by research suggesting that
siblings may have a stronger impact on the caregiver's life
when ascendant or descendant family resources are not
available (Cicirelli, 1985, Mutran & Reitzes, 1984; Troll,
1971).

Correlations suggested that having a healthier mother
was associated with more supportiveness and positive
contact with siblings, and less conflict with a spouse.
These findings are supported, in part, by previous
research. Brody et al. (1989) found that sibling
relationships were most rewarding when mothers needed less

help. It also seems plausible that having a healthier mother would be associated with fewer caregiving-related demands, therefore reducing the chances of conflict between the woman's role as a caregiver and her role as a wife.

Limitations, Recommendations, and Implications

As with all research, this study has some limitations. The design of this study was non-experimental. Therefore, cause-effect relationships could not be identified and extraneous variables could not be controlled. For example, a negative relationship between support and well-being might mean that depressed persons seek more support and perceive less support (Gallagher et al., 1989), or that depression contributes to perceptions of little positive support (Rivera et al., 1991).

The sample used for this study was highly restrictive. It excluded spouses, sons, in-laws, siblings, grandchildren, and neighbors who were caregivers. It included only married caregiving daughters who had at least one sibling and one child. Also, caregivers to institutionalized or cognitively impaired individuals were not included. Thus, the ability to generalize from the results is limited. Research on social support for caregivers should be repeated with different samples so as to explore the relationship between support and well-being more broadly. Similarly, this additional research would provide a more complete picture of the contributions of the

caregiver's support network, including friends and neighbors, to well-being.

Perceived support from siblings, a spouse, and children was measured generally, that is types of support were not assessed. Thus, it was not possible to determine what type of support (e.g., emotional, instrumental) was most important to caregivers, or which sibling (e.g., brother or sister) or child was the most influential source of support. Perhaps the contribution of support from siblings and children would have been more apparent if additional measures of support had been used. Future research should include measures that are sensitive to/designed to detect the different types of support, and the individual persons providing that support. Inclusion of responses from the persons giving support to the caregiver might also provide important information and help to verify the actual extent that family members help and support caregivers.

Most women in this study had high well-being scores (low depression), a trait which might have limited the ability to explore the impact of support on well-being. Future research might include samples of caregivers who are experiencing high stress, or compare the experiences of depressed and non-depressed caregivers.

Overall, the results of this study suggest that perceptions of conflict with a spouse is associated with lower well-being (higher depression) among women providing

care to dependent mothers. This finding is supported by research suggesting that negative rather than positive interactions have the strongest impact on caregiver depression and network satisfaction (Pagel, Erdly, & Becker, 1987; Rook, 1984). This proposes a need for intervention programs that teach family members constructive ways to interact and deal with life tensions which foster conflict. It also recommends that future researchers give special attention to the impact of family conflict on caregiver well-being.

In addition, this study revealed that poor health was predictive of low well-being. Thus, caregivers who are in poor health are likely targets for intervention. Respite services and educational workshops focusing on reframing life situations could be targeted at these women. For instance, workshops might focus on giving caregivers "permission" to give up or to share a role that has traditionally been the responsibility of women.

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APPENDICES

APPENDIX A

Comparison of the Study Sample and
Smaller Kin Network Group

Comparison of the Study Sample and Smaller Kin Network Group

Overall, the study sample, the group with a larger kin network, did not appear to be considerably different from the group of caregivers who were not included in the study, those who had a smaller kin network. For example, the majority of women in both groups had mothers who were in good health (see Appendix Table A1), and the majority of women were white (see Appendix Table A2). Several slight trends, however, are noteworthy. As expected, women in the study sample appeared to be younger and had dependent children. Caregivers with smaller kin networks appeared to have slightly more education and were more likely to be employed. As expected, because of their marital status, the smaller kin network group were in lower income brackets than women in the study sample, those with larger kin networks (see Appendix Table A1). Additionally, women in the study sample appeared to have more siblings and children, partially an outcome of the sample selection design. All women in the study sample were married (a criteria for sample selection), whereas the smaller kin network group included both married and divorced or widowed women (see Appendix Table A2).

Appendix Table A1. Background Characteristics of the Study Sample and Smaller Kin Network Group

Background Characteristics	Study Sample: Larger Kin Network Group (N=65) %	Not in the Study: Smaller Kin Network Group (N=60) %
Age		
29 to 44	27.7	20.7
45 to 54	29.2	31.0
55 to 64	35.4	32.8
65 or older	7.7	15.5
Health		
severely ill	0.0	0.0
fairly ill	0.0	1.7
not too healthy	6.2	10.0
pretty healthy	52.3	53.3
very healthy	41.5	35.0
Education		
less than HS	7.7	1.7
high school	23.1	21.7
1-4 yrs beyond HS	56.9	60.0
5+ yrs beyond HS	12.3	16.7
Employment		
full-time	60.0	65.0
part-time	27.7	26.7
unemployed	12.3	8.3
Income		
less than 24,999	18.8	48.3
25,000 to 34,999	21.9	18.3
35,000 to 49,999	26.6	16.7
50,000 to 74,999	23.4	13.3
75,000 or more	9.4	3.3
# Dependent Childrn		
none	44.6	58.9
one	27.7	28.6
two	18.5	7.1
three	6.2	5.4
four	3.1	0.0
Mother's Health		
poor	17.5	15.3
fair	20.6	22.0
good	41.3	39.0
excellent	20.6	23.7

Appendix Table A2.   Other Demographic Characteristics of the Study Sample and Smaller Kin Network Group

Other Demographic Characteristics	Study Sample: Larger Kin Network Group (N=65) %	Not in the Study: Smaller Kin Network Group (N=60) %
Number of Children		
none	0	21.7
one	12.3	11.7
two	27.7	25.0
three	29.2	26.7
four	15.4	10.0
five or more	15.4	5.0
Number of Sons		
none	15.4	30.0
one	35.4	36.7
two	38.5	28.3
three	9.2	3.3
four or more	1.5	1.7
Number of Daughters		
none	13.8	40.0
one	44.6	35.0
two	21.5	16.7
three	10.8	5.0
four or more	9.2	3.3
Number of Siblings		
none	0	41.7
one	32.3	25.0
two	27.7	8.3
three	18.5	13.3
four	13.8	6.7
five or more	7.7	5.0
Number of Brothers		
none	24.6	50.0
one	36.9	31.7
two	27.7	15.0
three	4.6	3.3
four or more	6.2	0.0
Number of Sisters		
none	29.2	65.0
one	43.1	18.3
two	13.8	8.3
three	9.2	3.3
four or more	4.6	5.0

Appendix Table A2 (cont.). Other Demographic Characteristics of the Study Sample and Smaller Kin Network Group

Other Demographic Characteristics	Study Sample: Larger Kin Network Group (N=65) %	Not in the Study: Smaller Kin Network Group (N=60) %
Marital Status		
widowed	0	18.3
separated	0	3.3
divorced	0	33.3
never married	0	10.0
married--1st mar.	83.1	25.0
married--2nd mar.	12.3	10.0
married--3+ times	4.6	0.0
Race		
White	100.0	96.7
Black	0.0	1.7
other	0.0	1.7

APPENDIX B

Well-Being

DAUGHTER'S FEELINGS/BEHAVIORS IN THE PAST WEEK

Tell me how often--if at all--you have felt this way IN THE PAST WEEK.

		NEVER 1	1-2 DAYS 2	3-4 DAYS 3	5-7 DAYS 4
1.	I was bothered by things that don't usually bother me.	____	____	____	____
2.	I didn't feel like eating.	____	____	____	____
3.	I felt that I couldn't shake the blues, even with help from my friends and family.	____	____	____	____
4.	I had trouble keeping my mind on what I was doing.	____	____	____	____
5.	I felt I was as good as other people.	____	____	____	____
6.	I felt depressed.	____	____	____	____
7.	I felt everything was an effort.	____	____	____	____
8.	I felt hopeful about the future.	____	____	____	____
9.	I thought my life was a failure.	____	____	____	____
10.	I felt fearful.	____	____	____	____
11.	My sleep was restless.	____	____	____	____
12.	I was happy.	____	____	____	____
13.	I talked less than usual.	____	____	____	____
14.	I felt lonely.	____	____	____	____
15.	People were unfriendly.	____	____	____	____
16.	I enjoyed life.	____	____	____	____
17.	I had crying spells.	____	____	____	____
18.	I felt sad.	____	____	____	____
19.	I felt people disliked me.	____	____	____	____
20.	I couldn't "get going."	____	____	____	____

APPENDIX C

Perceived Social Support

Perceived Social Support

(a)   siblings

Overall, how supportive have your brother(s) and/or
sister(s) been of you in the past year?
1 = not at all
2 = a little
3 = somewhat
4 = very
5 = totally
6 = not applicable

In the past year, how positive would you say that your
contact with your brother(s) and/or sister(s) has
been?
1 = very positive
2 = positive
3 = neutral
4 = negative
5 = very negative
6 = not applicable

In your contact with your brothers and/or sister in
the past year, how much conflict would you say there
has been?
1 = none
2 = a little
3 = a moderate amount
4 = a great deal
5 = not applicable

(b)   spouse

Overall, how supportive would you say your
spouse/partner has been of you in the last year?
1 = not at all
2 = a little
3 = somewhat
4 = very
5 = totally
6 = not applicable

In the past year, how positive would you say that your
contact with your spouse/partner has been?
1 = very positive
2 = positive
3 = neutral
4 = negative
5 = very negative
6 = not applicable

Perceived Social Support (cont.)

In your contact with your spouse/partner in the past
year, how much conflict would you say there has been?
1 = none
2 = a little
3 = a moderate amount
4 = a great deal
5 = not applicable

(c) children

Overall, how supportive would you say your child(ren)
has (have) been of you in the last year?
1 = not at all
2 = a little
3 = somewhat
4 = very
5 = totally
6 = not applicable

In the past year, how positive would you say that your
contact with your child(ren) has been?
1 = very positive
2 = positive
3 = neutral
4 = negative
5 = very negative
6 = not applicable

In your contact with your child(ren) in the past year,
how much conflict would you say there has been?
1 = none
2 = a little
3 = a moderate amount
4 = a great deal
5 = not applicable

APPENDIX D

Background and Demographic Characteristics

Background and Demographic Characteristics

<u>Background Characteristics</u>

(a)   age of respondent (collected in the first data wave)

When were you born?

(b)   health of respondent

How would you describe your own health?
1 = very healthy
2 = pretty healthy
3 = not too healthy
4 = fairly ill
5 = severely ill

(c)   education of respondent

At what grade did you stop going to school?
e.g., 12 = high school

(d)   employment status of respondent

Are you currently employed?
1 = yes
2 = no
3 = student

(e)   family income

What was your approximate family income last year?

(f)   number of dependent children

How many children are financially dependent on you?
[rewording of original question]

(g)   mother's health

In general, how would you describe your mother's
health right now?
1 = poor
2 = fair
3 = good
4 = excellent

<u>Other Demographic Characteristics</u>

(a)   number of children

How many children do you have?   _____
[rewording of original question]
_____ Number of sons
_____ Number of daughters

(b)   number of siblings

How many brothers and sisters do you have, if any?
_____ Number of brothers
_____ Number of sisters

(c)   marital status of respondent

What is your current marital status?
1 = married--1st marriage
2 = separated
3 = divorced
4 = deserted
5 = married--2nd marriage
6 = widowed
7 = other

(d)   respondent's race

What is your racial background?
1=White
2=Black
3=Indian/Native American
4=Asian
5=Hispanic
6=Other

APPENDIX E

Help Received from Close Family

Help Received from Close Family

Does anyone ever help you to meet your mother's needs for caregiving? [If yes] Who helps you?

1 = yes
2 = no
3 = not applicable

_____ Sister(s)
_____ Brother(s)
_____ Spouse
_____ Daughter(s)
_____ Son(s)
_____ Daughter's neighbors
_____ Mother's neighbors
_____ Daughter's friends
_____ Mother's friends
_____ Other relatives
_____ Formal services
_____ No help

APPENDIX F

The Most Supportive Person

The Most Supportive Person

Overall, who, if anyone of all the people you know, has been the most supportive of you in the past year?

```
 1 = mother
 2 = partner [spouse]
 3 = sister
 4 = brother
 5 = son
 6 = daughter
 7 = other family member
 8 = friend
 9 = professional
10 = other
11 = no one
```

[If applicable] What were the most supportive things this individual did for you?

APPENDIX G

Caregiver Responses:

Most Supportive Things that Close Family Did

SPOUSE as Most Supportive Person

* He is always there to back me up--gives me advice and always is the person to say "you're doing great!" Puts up with good and bad--doesn't emphasize the bad.

* Being there for me--emotional support! Also doing physical things (i.e., making dinner, dishes).

* Good listener. I talk things over with him.

* He just loves me for who I am. He is not demanding.

* He helps me make decision regarding my mother. He's always there for both of us.

* He listens to my troubles and tries to solve them if he can. We together all the time. He's always there.

* Opening our home. He is so good to her. He has such a good relationship with her, and I admire him for it.

* He does everything. Helps with the housework, helps with mother.

* Will frequently go and get mom, I don't like to drive.

* He listens and lets me blow off steam.

* Willing to take on the expense for my mother if need be.

* All I have to do is suggest something and he does it.

* He backs me in everything that I do.

* His concern for my health.

* Cause he's so involved with all the problems.

* He is always right there helping me, and never complains about it.

* His attitude..."freedom to be me."

* Just doing things together that we enjoy; he's more and more supportive of my mother--not as big of a conflict.

* Encouragement in school and in being a human being; listens; shares; confides; understands about my mother...in my decision about raising children.

SPOUSE as Most Supportive Person (cont.)

* He's always there; totally dependable, loving, and has a great sense of humor. A neat man.

* He always listens to me. He pitched in when we moved mom.

* He loves me no matter what; understanding; gives me a lot of personal freedom to let me work things out.

* Moral/emotional support.

* He's very understanding.

* He's here with me. He deals with my mom day in and out like I do.

* He's always there; listens to me; we talk a lot; he doesn't complain about my mother being there.

* Lets me be and do what I want; supports coming to see mom; gives advice; leaves me alone when I want to be alone; it there.

* He supports whatever I want to do; encourages me.

* The things he does do--his own ironing. He doesn't cross me when I make decisions. He usually doesn't try to [?] any decisions I make. He's my best friend.

* He always puts my desires before his/ supports anything I want to do; puts up with my relatives when they come to visit.

* We're just best friends.

* He's always there when needed.

* He came home with a dozen roses! He's always aware of how I feel.

* Always there to help with what needs to be done.

* He's there for me if I need him.

* Helps when needed; suggests inviting mom out with them sometimes.

* Everything.

* Takes me everyplace I want to go; just helps me out.

SPOUSE as Most Supportive Person (cont.)

*   Helps with the bills, helps with driving, emotional support.

*   Did a lot more for himself when mother was living with them. Insisted wife take time for herself. Helped mom move to retirement home, and sell her belongings.

DAUGHTER as Most Supportive Person

*   A lot of emotional support. She and her family just pitch in. I know that if I needed her, she would be there.

*   She says "you are my best friend." Acts like she thinks I'm OK.

*   She is very into relationships.

*   Tells me what a wonderful grandma I am.

*   She lets me vent when I need to vent.

*   Can talk with her, she can understand.

*   Encouraged me--served as a sounding board. Supportive with mother.

SISTER as Most Supportive Person

*   Listened.