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ABSTRACT

While research has documented the strengths of the family as a support system to the elderly, there is less understanding of what happens when supports are needed over an extended time. To study family care when support needs persist for a long period, 115 older adults were studied after discharge from the hospital and again about 8 months later. Both structured and unstructured data were collected. Analysis focused on supports defined as family contact and aid, and on the more subjective factors influencing the quality of the supports. The overall results showed that few of the elderly were abandoned by their families, although most were cared for by a primary caregiver rather than the family as a unit. Although a high level of strain was reported, particularly by children who were caregivers, most needs of the elderly were met, and only 17% of the sample were institutionalized. For the group as a whole, the mean functional level had stabilized after 8 months. As a result, family supports declined, even though more patients reported problems with morale and loneliness. A comparison of patients who had achieved independent functioning with those who remained dependent showed that caregivers of dependent patients experienced more strain; more of these families used formal supports. (JAC)

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A Longitudinal Study of Family Supports
to Impaired Elderly

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Abstract

The family supports of 115 individuals 65 years and older were studied after discharge from the hospital and again an average of eight months later. For the group as a whole at Time 2, the mean functional level had stabilized. Most likely as a result, the family supports declined, although more patients reported problems with morale and loneliness. An analysis was also made of those patients who were dependent over the eight month period. In comparisons with those who had achieved independent functioning, it was found that strain was high and more families used formal supports. Adaptive mechanisms to the burdens of care are also described.

A LONGITUDINAL STUDY OF FAMILY SUPPORTS
TO IMPAIRED ELDERLY

While large-scale surveys have documented the strengths of the family as a support system to the elderly (Shanas, 1979a), there is less understanding of what happens to the elderly and their families when supports are needed over time. This paper attempts to add to our understanding of the longitudinal effect of family care when the high needs for supports persist on a more permanent basis. Information on family supports was collected at two points in time: several weeks following discharge from a hospital and again an average of eight months later. Comparisons are made on support variables at these two times and an analysis is made of those elderly who are functionally impaired over this eight-month period. Since this group had high needs for supports, it is possible to identify the dominant patterns of support to a long-term high-needs group and to describe the adaptive strategies used by the caregivers in order to alleviate the strains and burdens of care.

Recent research in social gerontology counters the "myth of family abandonment" by documenting through survey research the frequent contact elderly have with family members and the high incidence of family supports to disabled elderly (Shanas, 1979a; 1979b). While these surveys report high potentials, descriptive studies find high levels of strain in the family and perhaps a "wearing down" or erosion of family supports either because of the high level of stress generated or because of the competing commitments of family members (Brody, 1981; Cantor, 1980; Eggert et al., 1977; Johnson, in press). These latter reports are more consistent with demographic trends which indicate that there are realistic impediments to long-term family supports in terms of the numbers and availability of relatives (Brody, 1981; Treas, 1977, 1981)

While those supports from individual family members are usually referred to under the rubric of "family caregiving", upon closer examination, one finds that the support is extended most often by one family member at a time. In serial order, the spouse functions as the primary caregiver; in the absence of the spouse, the offspring assumes the role; and in the absence of an offspring, another member is responsible (Johnson, in press). Shanas (1979a) has identified this phenomena as the "principle of substitution", inferring that any one person is sufficient to meet the needs of the older person.

Studies using a variety of objective measures of family contact and aid agree with this conclusion. However, the primary caregivers are typically age peers (Cantor, 1980). These individuals usually fulfill the role with little assistance from others even though they may suffer themselves from age-related physical, financial and social limitations (Crossman, London and Barry, 1981; Fengler and Goodrich, 1979; Johnson, in press). Adult children usually remain in contact, but they provide less care to a married parent than to a widowed parent (Johnson, in press). Usually children have realistic impediments which prevent day-to-day care of the dependent parent. Cicirelli (1981) found that offspring actually provide few services, although they exhibit "filial anxiety" in reaction to the possibility of assuming responsibilities. Childless and unmarried older people may turn to siblings or more distant relatives such as nieces, nephews or cousins, but these relatives rarely provide a high level of care (Johnson and Catalano, 1981). Instead they usually function as intermediaries in obtaining needed community services for the patient.

In summary, impaired older people usually have at least one family member to call upon for assistance. A spouse provides the most comprehensive care and a child, while dedicated, is likely to have competing commitments. When an older person must rely on a more distant relative, supports are more perfunctory.

When they must rely solely on an age peer, there is a risk of decreased supports because of the potential health problems of the caregiver.

Most of these studies report stress and conflict in situations demanding day-to-day care. Not surprisingly, the degree of reported stress varies directly with the extent of support which is provided (Cicerelli, 1981). Given these less optimistic findings on the viability of family supports, it appears that different kinship relationships perform different functions and, ideally, the care of an impaired older relative would be better shared among a group of people. In any case, the family caregiver apparently needs a back-up system if strain is to be avoided. Litwak (1980) suggests that specific functions can be performed by the most appropriate category of primary relationship in conjunction with the formal support system. Under this model of shared functioning, the primary concern becomes the degree to which individual older people can mobilize a group of relatives and formal providers who are allocated specific tasks.

Another major question centers on whether reports of contact and aid, indicators which are typically used to evaluate support systems (Schaefer, et al, 1981), actually determine the extent to which these activities meet expressive as well as instrumental needs. Additionally, measures of contact and aid shed little understanding on the processes by which social supports are associated with improved physical and mental health. Since the incidence of contact has been assumed to provide the positive benefits of support, little consideration has been given to the possibility that caregiving produces conflict in the relationship or imposes other costs on the individuals involved. It has been rare for researchers to consider the family as a source of conflict and stress as well as a source of assistance (Schaefer, et al, 1981; Croog, 1979). Certainly the potential for conflict and strain are more likely when family supports are required over a long period of time.

Research on family supports to older psychiatric patients, for example, documents the conflicts, stress and burdens of caregiving (Cath, 1972; Berezin, 1970). The extent to which these findings result from use of clinical populations is difficult to determine since stress is also reported with community samples (Cantor, 1980). While clinical interpretations tend to portray the darker side of relationships, they can also indicate the more dynamic qualities which affect adaptation over time to the burdens of care. For example, longstanding interpersonal problems can reappear in the process (Savitsky and Sharkey, 1973), and the mental health of the caregiver may be adversely affected (Sainsbury and Grad, 1970). The development of hypochondriasis has also been found among older women who care for their disabled spouses (Busse, 1976).

This paper provides objective data on contact and aid to older people over an eight-month period; it also provides an analysis of the more subjective factors influencing the quality of these supports. Social support is defined more broadly here to include not only tangible help and social contact but also relationship variables which are also viewed as influencing the quality of the supports. We assume that the initial aid extended upon discharge from the hospital necessitates readjustments in relationships which are only temporary if the patient's functioning is restored to the level of the pre-hospital period. If there is a period of prolonged dependency, however, one can predict that the dyadic relationship becomes redefined because of the long-term demands placed on it. Thus, it is this latter subgroup which can provide understanding of family supports over time.

Sample Characteristics

The research was conducted with a sample of 167 families in the San Francisco Bay Area between 1978 and 1981. Respondents were selected from lists of

patients 65 years and over in two acute care hospitals, all of whom had at least one family member in the area. At selected intervals, consecutive admissions who met the selection criteria were contacted. The first set of interviews took place two to four weeks after discharge from the hospital, and of these 167, 115 were interviewed eight months later. Lost to the follow-up interviews were 32 elderly who had died, 20 patients or family members who refused to be interviewed, and three who could not be located. The sample at Time 2, 68% of the original group, was similar demographically and in family characteristics to the original sample, so the description of the sample reported below describes those at the first contact.

Both structured and unstructured data were collected. The unstructured data were coded by two individuals and an 80% agreement was achieved. In 17% of the cases, the patient alone participated in the interview and in 30%, the patient and a family member were interviewed together; in the remaining 53% the family member alone provided the data. ¹

The mean age of the post-hospitalized individuals was 74.5 with 43 % 75 years of age and over. Fifty-five percent of the patients were female. Of the 49% who were married, 66% were male and 33% female. Females predominated as caregivers, comprising two-thirds of the spouse caregivers and 59% of the offspring caregivers. In regard to household status of the patients, 27% lived alone; 49% lived with an age peer (43% with a spouse and 6% with a sibling); 5% lived with their children in a three-generation household, and 13% lived with children in a two-generation household. After hospitalization 28% of the patients changed these arrangements with 17% entering a nursing home and 11% moving in with a family member. Most of the elderly had been long-term residents of the Bay Area with only 11% having moved here in the past ten years, while one-half had occupied their residence for at least ten years.

In order to control for variation on the basis of ethnic and religious background, sample selection was confined to white Catholics and Protestants of European origin. Twenty percent were foreign born and 47% were Catholic. In education, the sample was evenly distributed, but almost two-thirds of the major wage earners had worked in either skilled or unskilled jobs. Economically, 69% reported no financial problems and only 21% were using Medicaid benefits.

Of those with children, the mean number of living children was 2.5 with 28 having no children. Only 16% of those with children had no child in the area. Because selection criteria excluded minority groups and were confined to those with relatives in the area, these elderly enjoy a more favored position than is generally found (Shanas, 1979b). However, this group is quite impaired; only 19% could perform all of the items on the Activities of Daily Living without help, while another 22% were limited in three or fewer activities. Another 22% were moderately impaired, being unable to perform at least four items; and 36% were severely impaired and required round-the-clock care.

Family Supports Eight Months after Hospitalization

As noted above, the overall findings of this research reports that few elderly are abandoned by their families, although most are cared for by a primary caregiver rather than a family as a unit (Johnson, in press). Although a high level of strain was reported, particularly by children who were caregivers, few of these elderly had their needs go unmet. A family member provided most of the care with little help from formal supports. Given the high level of functional impairment and given the fact that only 17% were institutionalized, the viability of the family support system is validated. Since there is little depth in the family support system in terms of numbers of potential supporters, however, it is useful to examine how it bears up over time.

Among the more important changes over time is the somewhat improved physical status of the group as a whole. This finding can be explained in part by the attrition rates with the deaths of the more impaired patients. Thus, what remains is a somewhat different group whose physical condition is likely to be stabilized. Using the OARS Activities of Daily Living to measure functional ability, we found only one significant change in items between Time 1 and Time 2; there was an increase in the numbers of patients who were ambulatory outside the home. Since this factor is critical for independent living, improvement indicates that more former patients were capable of caring for themselves. (Table One)

Of those 115 subjects contacted after eight months, 22% had been rehospitalized at least once and 9% more than once. Other factors, however, remained relatively stable over this time period. At Time 2, 78% remained in their same living environment. Of the 24 patients who had moved, 17 had moved to more supportive housing (three to institutions and eight to homes of family members). Among the caregivers, children reported no significant events that had occurred which affected their capacity to provide supports (e.g. changes in employment, marital or parental status, health status). However, 17% of the spouse caregivers reported that their own health had declined in the intervening eight months.

While the functional status of the patients and the availability of the family remained much the same, the frequency of contact with members of the family decreases significantly for the sample as a whole (Table One). Although almost three-quarters of the children maintain weekly contact with their parent, 10% had decreased their visits. The same drop in contact is found among relatives with only 19% having weekly contact. Contact with friends

does remain stable over this time period with almost two-thirds having at least weekly visits.

(Table One here)

The use of two types of formal supports are reported here: consultation with a physician or social worker for advice on the care of the patient and use of homemaker services. It is apparent that reliance on those professionals who were active at the time of hospitalization declines significantly with the break in the linkage to the acute care system (Table One). However, the proportion using homemaker services remains much the same.

As Table One also indicates, the general stabilization of the support system and the slight improvement in the functional status of the patients after eight months is not accompanied by a general improvement in the patient's mental health. Significantly more patients had problems with low morale and over one-third were reported to be lonely, a proportion which grew twice as large at Time 2.

These changes in patient characteristics and family supports between Time 1 and Time 2 indicate that it was the event of hospitalization which most likely activated the family support system as children and relatives increased their contacts and supports to the patient. With a stabilization or improvement in the patient's health and functional status after eight months, these social contacts declined and old patterns of interaction resumed. Thus, one by-product of improved health is increased social isolation for the older person, and this change was found to be associated with the decline in his or her morale. Since a significant inverse relationship was found between the patient's morale and the numbers of relatives available ($r = -.1889, < .05$), it appears that despite improved functional status, the shrinkage of the social environment has an adverse effect on the older individual.

The data indicate that family members do provide needed help to the older patient, particularly following the crisis of hospitalization. These relatives can be described as a storehouse of resources, available when needed, but after the crisis has passed, former patterns of interaction are re-established. It is possible that relatives other than children are "intimate at a distance" in normal times (Rosenmayr and Kockeis, 1963), and as a consequence the contact after hospitalization is not sustained over time. Relationships with friends fluctuate and are probably situationally defined (Table One). Since the decline in social contact with family members is apparently not compensated by an increase in sociability with friends, the patient becomes more isolated, a phenomenon associated with lowered morale in old age (Liang, et al., 1980).

The High Needs Group at Time 2

Because some patients became more functionally independent over the time of the research, they obviously were less likely to impose strain on the family. In order to control for this variation, the patient's status was categorized by the level of functioning at the follow-up interview. Using the descriptive reports from the respondents, we determined that those who could not function in two or more activities without help would need frequent supports from others. Using this criteria, two groups were identified for comparative purposes: The Independent, who had adequate functioning in eleven to thirteen activities at Time 2 (n= 43, 39%) and the Dependent, who needed help on more than two activities at Time 2 (n= 72, 61%).

In an examination of the 72 patients who were dependent at Time 2, it is first important to note that there is no sharp increase in institutionalization; the proportion remained the same at 21%, although three individuals left a nursing home and three entered one. However, at the follow-up contact

the Dependent were significantly higher users of formal supports; almost one-third used the physician or social worker for advice and almost one-quarter used homemaker services. This proportion is only slightly larger than that for the entire sample as whole at Time 1. On the whole, those who improve in status do not continue to use formal supports, and only two reported that they needed some supports that they were not receiving. In contrast, among the Dependent, 17% reported that they needed some supports that they were going without.

(Table Two here)

In regard to the social network, the high needs of the patients obviously require frequent contact with others, so measures of social contact in Table Two are confined to those contacts taking place daily or several times a week. This group of long-term impaired elderly has one advantage; they have more frequent contact with their children than the healthier group. Presumably, these children continue to respond to the high needs of the parent. Yet the more impaired patients experience the same decline in contact with other relatives found in the entire sample. The greatest contrast between the groups is found in contact with friends; friends are notably less likely to be in contact with the more functionally impaired, a finding which suggests that these relationships are difficult to sustain when one is dependent over time. Given the overall decline in social contacts, it is apparent that the older person and most likely the spouse or child who is the caregiver experience more social isolation.

The change in family supports was evaluated by examining the open-ended discussions with caregivers. Using this measure, it was found that over the eight months the level of family supports remained the same for 42% of the

Dependent Group, a proportion similar to the Independent Group (Table Two). While 21 % of the caregivers had increased their supports to this high-needs group at Time 2, considerably more, 37%, had decreased them. This decrease is compared to the 50% decrease in the Independent Group, an understandable decline. However, one can tentatively suggest that there is an attrition in family supports irrespective of the status of the patient.

Although sample size is too small to break down further in tabular form, there are several trends in this data which are worth noting. First, almost half of those who maintained the same level of care provided only perfunctory care to the patient in the first place. Furthermore, only two of these 27 caregivers increased their supports to the patient at Time 2. Thus, it seems more difficult for one to increase their care of an older person if some time has elapsed during which other solutions were found.

Second, a spouse is more likely than a child to provide more comprehensive care over this time period and is more likely to continue doing so. Of all those who continue to provide the same level of care or increase it, 62% are spouses and 27% are children. Children, on the other hand, are more likely to turn to formal supports or seek out other family members to assist them.

Turning now to the dimensions of social supports not usually tapped by researchers, correlations were used to identify significant associations between the patients' functional status and measures on the patients' mood and outlook, the conflict they have with their families and the strain experienced by the caregivers. Table Three indicates a cluster of factors which possibly have an adverse effect on social support systems when they must function over time. With the more impaired patients, their mood and outlook is significantly less optimistic than is found in the Independent Group. They also report more economic problems which suggests a source of vulnerability in long-term chronic

conditions. Conflict among family members also is higher with the Dependent Group. The caregivers of the more impaired patients also experience significantly more strain. Finally, somewhat to our surprise, the caregivers of the more impaired are less likely to have problems with their own mood and outlook.

(Table Three here)

Since this finding is not consistent with the negative events also taking place, the interviews with these caregivers with improved morale were examined in order to identify the source of this positive finding. Of the 24 caregivers whose morale had improved, 67% were using some type of formal supports, a much higher proportion than for the entire sample. Thus, with the continued demands upon the caregiver with the long-term dependence of an older family member, there is a tendency to turn to various forms of formal support, probably as a means of ameliorating the increasing strain and conflict which the situation imposes.

Adaptive Mechanisms to Burdens of Care

Given a potentially high-stress situation and the prolonged dependency of the patient, one can predict changes in the patient's status, his or her relationship to the caregiver and the status of the caregiver. In order to identify these and other patterns, an examination was made of not only the objective measures reported in the tables, but also the more subjective changes taking place in the support system as it was revealed in open-ended data. With this procedure, two broad categories of adaptive mechanisms were discernable which suggest how relationships become redefined in a manner which ultimately affects the social support system.

1. Distancing Techniques

In geriatric medicine, the "cascade effect" is sometimes used to de -

scribe a combination of disease conditions and iatrogenic factors which cause a downward spiral of the patient's physical status. For example, a minor ailment might immobilize the individual and, if prolonged, leads to pneumonia, pressure sores and increasingly serious conditions. As these problems interact and become compounded, the decline can become irreversible and it is difficult to restore the patient to independent functioning.

It would seem that a similar process can potentially affect the social situation of some patients, when one singles out significant correlations between the patient's long-term functional status and the variables in the social support system. This cascade effect begins with the patient's status, where the long-term dependency leads to a deterioration in the patient's outlook which, in turn, affects their relationship with the primary caregiver. As more expectations are placed on the relationship, the caregiver finds the responsibilities more difficult to tolerate. This situation is most likely compounded by the increased social isolation that the dyad experiences. In the end, the situation becomes increasingly difficult to tolerate, not only because of the constraints inherent in the patient's physical and mental status, but also because of those negative valences developing in the relationship itself.

Establishing greater physical distance is one option taken by approximately one-third of the sample, most of whom were children. With some older individuals who have long-term impairment, as their psychological resources deteriorate, they become depressed and irritable. Since contacts with friends decline, the individual becomes more dependent upon the family. With their increased dissatisfaction with the support system and with the greater demands they place upon the relationship with the caregiver, conflict between them and the caregiver increases, a factor which frequently has a "ripple effect" to

other relationships in the family. Children might complain about their own mother's distractions in caring for her parent, or spouses might resent the time taken from the marriage. The caregivers also are likely to become more isolated from their usual social activities. All of these factors can affect the caregiver, while the patient is experiencing anger and resentment over his or her helplessness. As the dyadic relationship deteriorates, resistance to providing care can develop and anger and resentment over the responsibilities mount. The possibility of alternatives becomes acceptable and rationalizations serve to alleviate guilt and resistance.

In this situation, the caregiver is likely to establish greater distance from the patient by transferring the caregiving functions to others. As noted above, such an alternative can improve the outlook of the caregiver.

Establishing psychological distance while maintaining physical proximity is also apparent in some parent-child relationships. Establishing physical distance between them is either not feasible or imposes high emotional costs on a child, usually a daughter. Members of some ethnic groups also impose negative sanctions on children who are unfilial or who break the cardinal rule by placing a parent in a nursing home. Some offspring face high emotional costs to a point that their guilt interferes with their own functioning. In such cases, the caregiving can continue but emotional costs increase.

Many individuals in such a situation, however, find means to establish psychological distance from the parent without resorting to institutionalization. They might enter psychotherapy in order to work through old relational conflicts and, in the process, establish autonomy from the parent. Others consult with friends who face similar situations. In the process, defenses are built up by systems of rationalization. "I have done all I can." Although

the outcome can be institutionalization in some cases, these psychological supports to the caregiver also can enable her to continue to meet the instrumental needs of the parent with minimal emotional commitment. The individual comes to ignore the incidences which bothered her or, in fact, avoids all interactions other than those which provide instrumental supports.

Some caregivers establish more distance from the patient through enlarging the family network. When the dependency of the patient increases and the strain to the caregiver mounts, other family members, if available, are brought into the day-to-day support system. A daughter caring for a widowed mother seeks the help of a sister. Usually among the marrieds, a wife, for example, might become overburdened in providing care. If her health is threatened or the situation becomes intolerable, the help of children who live in the area is enlisted. Sometimes the diagnosis of a terminal illness might be the primary motivation for the children's increased participation. Or in at least four cases, a daughter used this event as an opportunity to move home after a divorce or a loss of a job, and thus also received benefits from the situation. Other children revised their own lives in order to assist, based upon the conclusion that it would be a temporary situation.

This option was used by approximately 12% of the sample, and the outcomes were generally positive. The patient received increased help and the caregiver faced fewer stresses. With shared caregiving, the burdens on the caregiver decreased. With more social involvement through the additional help, their morale generally improved. Those who could also afford more formal supports, such as respite services for the family or housekeeping services, were in an even more favorable situation and undoubtedly would be able to continue this arrangement for some time.

2. Enmeshing Techniques

These techniques are in direct contrast to the distancing techniques described above. As the dependency of the patient persists, the relationship with the caregiver intensifies often to the exclusion of other relationships. For example, the adaptive pattern of social regression is one found among married couples. This strategy involves those dyadic relationships which become socially isolated from others to the extent that other sources of support are excluded. As the needs of the frailer spouse increase, the couple becomes increasingly cut off from others. Usually they have no children nearby, and like most elderly with high impairment, they are not in frequent contact with other relatives and friends. Consequently, they have few whom they can call upon for instrumental help. The healthier one who is caregiver is forced to reduce her contacts outside the home, because no one is available to substitute in the care of the patient. As a consequence, the couple is increasingly forced to turn to each other for the satisfaction of both emotional and instrumental needs. The interdependence which results is reinforced to a point that they are cut off from the outside world and they are less likely to seek formal supports.

We have described this dyadic withdrawal for childless couples (Johnson and Catalano, 1981), but it also applies to some marrieds who are distant from their children and other kinship dyads. Unlike Slater's description of social regression (1963), however, these dyads have few mechanisms available to them to reverse the situation, usually because of their abbreviated social networks. As the needs increase, the interdependence intensifies and the social regression also increases. The risks to this arrangement are primarily in the health of the caregiver; if it deteriorates, the situation is precarious. Only in the event of re-hospitalization might health professionals intervene

and arrange more formal supports.

Another mechanism of adaptation is role entrenchment, a situation in which the caregiver redefines his or her role markedly by enlarging its content and reconceptualizing the costs and benefits accruing from the arrangement. First, caregiving is accepted as a permanent, full-time role which takes precedence over other roles. Second, the caregiver redefines the exchange relationship to exclude some tangible benefits, and instead the individual anticipates the altruistic rewards which enhance his or her self-esteem and sense of competence. Third, the role is viewed as replacing major role losses already experienced, so it is seen as giving new meaning in life. It also permits one to shed auxiliary and perhaps unwanted roles in order to invest one's energies on the patient. As a result, caregiving becomes a way of life to the exclusion of other interests and activities. As long as the individual continues to view the role as a source of such intangible rewards as altruism, the feelings of burdens are minimized.

This technique is used by both spouses and children. With spouses, this redefinition of the role and the total commitment to it can function to replenish the role system which has faced the normal attritions of the aging process (Johnson, in press). Such activities convey a sense of worth and importance which is a positive factor in one's morale. With children, intensifying the role of caring for a parent can be a substitute for a failed marriage, widowhood, or an erratic employment history. It can also be used as a rationalization in an already delayed independence from the parents. Moving home and assuming full-time care can solve their own economic problems or other difficulties in the assumption of full adult status.

Summary and Conclusions

In reviewing the findings of this research, it is apparent that there are no unitary trends on the efficacy of family supports to the elderly as their

needs persist over time. In assessing a group of older people upon discharge from the hospital and again eight months later, we found that the group as a whole either improves or stabilizes. Few dramatic events occur which decrease the potential of the social networks. They have less need for supports and, probably as a consequence, members of their informal support system withdraw their supports and formal supports also decline. While the average older person is able to function more independently, however, they experience more loneliness and discontents, a factor which is most likely associated with their increased social isolation.

In order to identify potential problems in family supports, we omitted those who had re-established independent functioning and were left with a group with high needs (61 % of the Time 2 sample) which had persisted over the time of the research. For this group, the rate of institutionalization remained the same, although there was some increase in the use of formal supports. In comparison to the improved group, these high-needs patients had more contact with their children, although few relatives and friends were involved. Nevertheless, more than a third of the family caregivers had decreased their supports to the patient. Those who were more likely to decrease their supports were those family members who provided only perfunctory care in the first place. Moreover, those individuals who withdrew some supports to the patient were more likely to be children or other relatives, rarely a husband or wife.

In an attempt to determine factors which undermine family supports, significant associations suggest that changes take place over time that alter the relationship between the patient and the caregiver. The persisting poor health and dependence upon others has a detrimental effect on the patient's mood and their satisfaction with the social supports. The relationship with the primary caregiver, in turn, is characterized by more conflict. The

caregivers experience more strain, and most likely as a result, seek more formal supports or help from other family members. One the whole, the morale of these caregivers improves. We have used the analogy of the "cascade effect" to hypothesize a chain of events in which the family decreases its care and transfers the functions to others. These events are observable in approximately one-half of the impaired group.

Since much of the data were descriptive, the adaptive, tension-reducing mechanisms on the part of the caregiver could be identified. Of the two broad types found, one can be described as distancing techniques where the caregiver, usually a child, establishes greater physical or psychological distance from the patient and in the process decreases the supports. In a second mechanism, used primarily by spouses, the relationship between the patient and caregiver becomes intensified. We have labelled this process enmeshing techniques. Some marital dyads experience social regression in which the dyad retreats into the relationship itself and becomes cut off from contact and supports from others. In other situations, the caregiver role becomes more firmly entrenched and redefined to exclude most tangible benefits. As the caregiving role comes to dominate his or her life to the exclusion of competing roles, that individual receives less tangible rewards accruing from such altruism. This maneuver can also substitute for other role losses and can re-establish a dependency situation sought out because of other setbacks in the caregiver's own life situation.

It is clear from this material that family supports play a major role in maintaining older people in the community. There are, however, points of vulnerability as needs for supports persist over time. Children with their competing commitments and spouses with their own health risks, in combination with the increased social isolation of the patient and caregiver, can make the long-term

care of an older person vulnerable. If these problems are identified as they differentially affect various categories of relatives and if supplemental supports are made readily available, the breakdown in family supports could possibly be forestalled.

TABLE ONE

Comparison of Support Variables at Discharge from Hospital
and Eight Months later

(by percentage)

n= 115

	Time 1 Post-discharge	Time 2 8 months later	Significance
<u>Contact with family</u> (weekly or more often)			
Children	83	73	$\chi^2=93.966$, df28 \leq .0001
Relatives	29	19	$\chi^2=78.749$, df45 \leq .002
Friends	61	63	n.s.
<u>Use of Physician or Social Worker</u>			
	55	34	$\chi^2=23.995$, df2 \leq .0001
<u>Use of Homemaker Services</u>			
	21	19	n.s.
<u>High Strain Reported *</u>			
	3	35	$\chi^2=21.36$, df 3 \leq .001
<u>Patients with Low Morale *</u>			
	27	38	$\chi^2=20.756$, df2 \leq .001
<u>Patients Reported to be Lonely</u>			
	17	34	$\chi^2=28.158$, df6 \leq .0001
<u>Functional Status</u>			
Independent	30	39	n.s.
Dependent	70	61	n.s.

* Measures on strain and moral were derived from a series of open-ended questions on the respondents' mood and outlook and their reports on the effect the illness and need for caregiving had on daily life. These responses were coded by two individuals and an 80% agreement level was reached.

TABLE TWO

Comparisons of Patients' Level of Dependence at Time 2
by Social Support Variables

(by percentage)

n = 115

	Independent (n=43)	Dependent (n=72)	Significance
<u>Family Contact</u> (Daily or Several Times a week)			
Children	53	81	r = -.1725, $\leq .03$
Relatives	21	21	n.s.
Friends	57	25	r = .2538, $\leq .0009$
<u>Changes in</u> <u>Family Supports</u>			
Increased	5	21	
The same	45	42	
Decreased	50	37	n.s.
<u>Use of Physician</u> <u>or Social Worker</u>	7	31	$\chi^2 = 18.362, df 3, \leq .0004$
<u>Use of Homemaker</u> <u>Services</u>	12	23	n.s.

TABLE THREE

Comparisons of Patients' Level of Dependence at Time 2
by Relationship Variables

(by percentage)

n = 115.

	Independent	Dependent	Significance*
<u>Patients with Poor Outlook</u>	20	52	$r = .2109, \leq .009$
<u>Economic Problems</u>	32	59	$r = .2661, \leq .0008$
<u>Caregiver Strain</u>	11	48	$r = .245, \leq .009$
<u>Conflict between Patient and Caregiver</u>	14	24	$r = .1675, \leq .05$
<u>Caregiver's Mood and Outlook Worse</u>	62	46	$r = -.1924, \leq .02$

* Kendall's Tau B Correlation Coefficients

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Footnote

1 This variation in the category of respondent resulted from the hospital's rules on access to the patient which required that the patient be contacted first. Some patients wanted to be interviewed alone rather than referring us on to a family member. These patients interviewed on the whole had better health and a higher level of functioning than those where a family member was interviewed alone. Correspondingly, this group received fewer family supports. In order to analyze these combined effects, an analysis of variance was performed to examine the effects of the level of functioning (OARS Activity of Daily Living) by who reported on specific variables. In all variables reported here, the level of functioning accounted for significantly more variation than the category of respondent.