DEPENDENCY STRESS AND ITS RELATIONSHIP TO PERCEIVED CAREGIVER ABUSE

BY

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ABSTRACT

The reality of caregivers who perceive themselves to be victims of abuse is a relatively new phenomenon. In an attempt to understand the dynamics of violence within these caregiving relationships, the following study explored the issue and its connection to dependency stress. The objectives of the study were to examine dependencies in those cases where familial caregivers perceived that they were victims of abuse perpetrated by an elder kin. Within that context, it was further hypothesized that the cognitively intact elder, with insight into their dependent state, was more likely to engage in goal directed abusive behaviour. The second objective was to identify factors which were associated with dependency stress in this population.

The study involved a cross-sectional survey design which considered subjects at one point in time. It involved a non-random sample of 20 caregivers from the City of Winnipeg, each interviewed on an in-person, one to one basis. The caregiver interviews consisted of a structured questionnaire, as well as unstructured conversation about individual circumstances.

The sample was obtained using advertisements and professional contacts. Criteria for inclusion in the study were (1) the caregiver must have shared a residence with the elder for sometime during the past three years; (2) the caregiver was required to perform some tasks for the elder so that a degree of dependency was involved; (3) the elder was over 65 years of age; (4) the caregiver was the adult responsible for the household. Dependency issues related to: finances, grooming, household responsibilities and physical needs. Abuse measures were: emotional, refusal, to eat, to take meds, physical and disability.

Data collected from the study was analyzed using crosstabulations, t-test and multiple regression analysis. While not conclusive, the data did suggest that physical disability and financial dependence were positively correlated with the dependent variable of abuse. T-test analysis revealed positive correlations between elders' interference, elders' emotional dependence and elders physical disability to elders without Alzheimers disease.

Given that this study was the first of its kind in the Province of Manitoba, it has provided a basis for larger studies to be planned. Further study in this area is critical to gain a better understanding of the dynamics surrounding dependency stress and its relationship to perceived caregiver abuse.

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INTRODUCTION

"It cannot be disputed that the elderly are often physically, verbally, psychologically, and financially abused. However, the problem can be overemphasized and viewed from only one side" (Goldstein and Blank, 1988, p.89). As Goldstein and Blank suggest, the lives of our elderly are often difficult and complex, and in many cases involve situations of abuse. However, this is only one of the many faces of intrafamilial abuse - another face reveals the situation of the caregivers of our elderly and their perceptions of the treatment they receive from their elder kin. In this context, intrafamilial abuse takes the form of caregivers who perceive themselves to be victims of abuse perpetrated by their elder family members.

Much of the research done in the area of elder mistreatment has focused on the caregiver's mistreatment of the elder, within the context of the generationally inverse family setting. "...The term generational inversion will be used to define families in which an elderly parent is dependent upon the child generation for social, financial, physical or psychological support"

(Steinmetz, 1986, p.49). Little study has been made of elders' abusive behavior directed at family caregivers. Given the complexity of these intrafamilial relations, and the limited knowledge base in this area, the problems of caregivers also deserve consideration.

To view the situation of caregivers who perceive themselves to be victimized by their elder family members in terms of "good and bad people" or a blaming of the victim phenomenon, is to miss its essence. Understanding this type of intrafamilial abuse must involve an examination of the dynamics of perceived dependency stress and its relation to elder mistreatment.

This practicum is a small scale replication of a previous study entitled "Dependency Stress and Elders Abusive Behaviors Towards Family Caregivers" (Stein, 1989). The study, conducted at the University of Delaware, investigated the phenomenon of caregivers who perceive themselves as victims of abuse perpetrated by their elder kin (Appendix 1). Stein interviewed a sample of 104 caregivers who were managing 119 elders. Utilizing a social needs assessment approach, the study focused on issues of dependency stress for adult caregivers.

The aim of the study was to provide a broader context for understanding the dynamics of intrafamilial abuse, both on a clinical and program level. As well, it was hoped that the study, through replication, could provide insight into any differences between the Canadian and American experience.

My own learning objectives were two-fold. First, to gain experience in conducting a social research project. Second, to expand my knowledge and understanding of intrafamilial abuse, particularly as it relates to perceived caregiver abuse.

This practicum report is divided into the following chapters. Chapter 1 reviews the current literature on intrafamilial abuse. Chapter 2 describes the design of the practicum. Research findings are presented in Chapter 3. Chapter 4 contains the discussion of the findings. Implications of the findings are discussed in Chapter 5 and Chapter 6 presents an evaluation of the practicum process and a conclusion.

CHAPTER ONE

LITERATURE REVIEW

Defining The Problem

The "family ideal", or belief in domestic privacy can be traced back to antiquity. This construct involves "...unrelated, but nonetheless distinct ideas about family privacy, conjugal and parental rights and family stability" (Pleck, 1987, p. 87). It supposes that the family is valuable, yet fragile and that government should not interfere with it.

This historic view of the family as a sacrosanct haven for the protection of the individual has been shattered. The fact that this cherished institution has continued to change rapidly has had considerable societal impact over the past three decades.

> Child abuse emerged as a social problem in the 1960's and wife abuse was identified as a major social issue in the 1970's. Similarly, abuse of the elderly has become a topic of interest and concern in the 1980's (Pedrick-Cornell and Gelles, 1982, p. 457).

Today, intrafamilial violence, neglect and mistreatment are recognized as longstanding unfortunate realities of society. Supporting this view, Hudson (1986) suggests that despite glorified images of the nuclear unit, family violence (of all forms) has existed since the beginning of human history.

To accept the historical position that family violence has existed since time immemorial seems dependent on one's definition of abuse. The likelihood of disagreement around notions of abuse and neglect and their applicability to perceived abuse by caregivers from their elder kin, is great given that the concepts are value-laden and emotional.

Supporting this view, Cicirelli notes that "previous attempts at definition have not only involved considerable variation, but also a great deal of ambiguity" (1986, p. 50). He goes on to suggest that,

> Part of the difficulty in defining these terms lies in the fact that abuse and neglect are behaviours not typically observable by others outside the family; thus one must rely on verbal reports after the fact (in cases where there is

> no compelling physical evidence). A further difficulty arises from the great variety of behaviours to be included from physical assault, to exploitation of resources, to neglect. Other considerations are the intentions of the perpetrator to inflict harm or distress on the victim and the seriousness of the effects of abuse. Above and beyond all of these problems, Gelles and Pedrick-Cornell believe that the ultimate source of the difficulty in formulating a satisfactory definition is the varying cultural and subcultural views on the acceptability of certain behaviors (Cicirelli, 1986, p. 50).

Acknowledging the aforementioned difficulties inherent in defining the problem, this practicum report has utilized the definition of abuse put forward by Sociologist Tanya Johnson (1986) which attempts to incorporate all circumstances which may constitute abuse. Although the current literature did not provide a definition of perceived abuse from the perspective of the caregiver, Johnson's broad base work is applicable.

Johnson (1986) proposes a four stage definition:

1) the creation of an intrinsic definition, 2) the development of an extrinsic definition that identifies behavioral manifestations, 3) measurement of the frequency, severity and density of events, and 4) the assessment of the underlying causes of the mistreatment.

Intrinsic Definitions

Johnson's (1986) intrinsic definition of elder mistreatment "is conceptualized as a self or other inflicted suffering unnecessary to the maintenance of the quality of life of the other person" (p. 180). The model suggests an intrinsic definition which requires abstraction; and at times may be more removed from its applied setting. In reality, however, this level of definition must be abstract in order to include all of the circumstances that might constitute abuse. Thus, Johnson attempts to distinguish culturally acceptable abuse such as yelling from pathologic abuse such as physical violence.

Extrinsic Definition

"The extrinsic definition outlines specific behaviors that may be evidence of mistreatment under four categories: physical, psychological, sociological and legal" (Johnson, 1986, p. 180). Much of the research done in this area contains lists of behavioral manifestations or the designation of observable events which include:

1) physical abuse/mistreatment which refers to any bodily harm, contact or injury inflicted by an individual onto another. This form of abuse may include striking, shoving, shaking, beating or sexual assault.

2) psychological abuse/mistreatment which encompasses a range of behaviors that cause emotional stress or injury to an individual.

3) sociological abuse/mistreatment "... represents suffering as a consequence of not being integrated into the primary group setting as a result of the elder's resistance or the coercion on the part of others" (Johnson, 1986, p. 179).

4) legal abuse/mistreatment includes all misappropriations of finances, as well as theft of property or possessions.

Intensity and Density

This component of Johnson's definition assesses the frequency and severity (intensity) of abuse, and measures the various forms of abuse in individual cases (density).

By assessing the degree of intensity and density in cases of abuse, clinicians can attempt to guide their interventive strategies.

Cause and Intent

The final part of Johnson's definition addresses the cause of abuse. She stresses the need to identify the content of the act, as this too will guide in formulating strategies. Intent can be understood as the difference between active abuse or neglect. Neglect (either intentional or unintentional) can be considered an act of omission, or failure to provide some minimal degree of care for another person. This is in contrast to abuse which is considered an act of commission, or an act performed that is harmful to another person.

In reviewing Tanya Johnson's definition of abuse/mistreatment, her framework can be readily applied to situations wherein caregivers perceive themselves as the victims, and define their elder kin as the victimizers. However, to gain further insight into this type of scenario, one must look beyond the definitions of abuse. Consideration must also be given to the global issues surrounding the relationship between helping, caregiving stress, and dependency.

The Helping Relationship in Later Life - Social Exchange Theory

> In the sociological tradition, the help that adult children give to their elderly parents in time of need can be explained in terms of cultural expectations or exchange theory (the need to repay the parent for care and help given in earlier life) (Cicirelli, 1986, p. 55).

Social exchange theory is based upon the assumption that social interaction involves the exchange of rewards and punishments between at least two people. This theory also suggests that all individuals seek to maximize their rewards and minimize their punishments in their relationships with people. Rewards are based upon the positive exchange of goods, services and personal feelings between people. Punishments include the exchange of negative feelings, services and punishing behavior.

If all things were equal, people entering into exchange relationships would receive expected rewards and costs. Homans (1969) asserts that

> ...social interaction occurs according to the laws of "distributive justice" which refers to a

> person's expectations of the rewards due to him and the costs which he may incur - the proportion of his rewards to his costs; that these should be seen to be distributed in a fair ratio to each other (p. 216).

Unfortunately, in many relationships, particularly in the helping context, all things are not equal. Individuals have differing access to resources such as money, power and prestige, as well as differing abilities to provide service. As a result, social exchange relationships are often based on an unbalanced relationship to power. As Dowd (1975) states, "from this perspective, power is synonymous with the dependence of actor A and actor B. It is based on the inability of one of the partners in the social exchange relationship to reciprocate a rewarding behavior (p. 216).

Like many relationships, family ties can be based on the principles of social exchange theory. Cicirelli (1988) suggests three kinds of ties that bind families together, involving the norms of reciprocity, solidarity and role rights and obligations.

"There is ample evidence that relationships between spouses, between parents and children, and between siblings all involve the norm of reciprocity" (Cicirelli, 1988, p. 76). This norm suggests that members of the relationship should experience equal levels of profit and loss. Even in the most intimate family relationships, players expect rewards and resources to flow in both directions, and count on family members to repay acts of kindness and assistance. While the players may attribute these exchanges to family loyalty rather than obligations, the expectations do exist. Given the inherent intimacy of family relationships, players may accept more unequal exchanges or inequities for a longer period of time, but often not indefinitely.

Due to their intimate nature, family relationships also involve connections which include the norm of solidarity. This norm dictates that we provide our loved ones with unconditional support and assistance, without concern for a return on our investment or the emotional distress that giving more than receiving can cause. Unlike other relationships that can be terminated if the solidarity mode goes beyond acceptable limits, familial relations tend to operate in this framework for longer periods of time. Cicirelli (1988) also notes that "it is clear when we operate in the solidarity mode that we are not resentful at the prospect of providing excess rewards and we do not want the recipient of those rewards to experience any guilt as a result of being overbenifited" (p.77).

"Third, family members are bound together by role rights and obligations - a factor that distinguishes family ties from more informal relationships" (Cicirelli, 1988, p.77). The author suggests that some of the familial role obligations are reciprocal, while others are complimentary. However, this distinction is vague, with the possibility that even the players are not aware of the differences.

Accepting the position that family relationships involve at least three distinct ties suggests that it is difficult to determine or account for a particular behavior. This factor is critical in that uncertainty in providing or receiving rewards may generate conflict within the family unit. Cicirelli (1988) notes that "an inappropriate mix of exchange, solidarity and role behaviors is especially destructive if it persists over time..." (p.78).

Over the past decade social exchange theory has been a popular theoretical framework for explaining elder mistreatment. According to Dowd, the general aging condition can be viewed in the exchange paradigm. In fact, Dowd (1975) suggests that "...as people age, they have less access to power resources and progressively less ability to perform instrumental services" (p.216). Therefore, it can be argued that as one becomes infirm there is a violation of the law of distributive justice - the relationship may become unbalanced, leaving the elder to feel more powerless, dependent and vulnerable. Gelles and Straus (1979), Steinmetz (1986) and Phillips (1986) have all applied social exchange theory to aspects of their research. Much of their research, however, suggests that it is the elderly individual who is more dependent in the exchange relationship. Moving away from this position, Pillemer has charged that social exchange theory has yet to definitively prove that mistreated elders are more dependent than non-mistreated elders. Instead, Pillemer (1985) posits an alternative viewpoint that also rationalizes elder mistreatment within the exchange paradigm. Based on reports from a case control study (1985) Pillemer found that in only a small portion of the cases was the elder excessively dependent. Instead, his research found that in the majority of cases the abuser was more dependent on the elder. Pillemer goes on to argue that abuse arises when the abuser feels powerless and seeks to compensate for lack of control with the resources available - physical/psychological control/violence. In accepting this viewpoint, it can be argued that either the elder or the caregiver can be the abuser, depending on the particular intrafamilial dynamics.

Steinmetz expands on this viewpoint and suggests that abuse may result not due to dependency itself, but rather if it is viewed as stressful by the caregiver. Cantor (1983) supports the aforementioned premise, and posits that emotional dependencies are viewed as much more stressful than those involving physical and financial needs.

Dependencies In Caregiving

A combination of better health, medical advances and the increased use of life-sustaining technology is enabling more people to live beyond their expectations. However, many of these people will be in poor health, have limited financial resources and will be unable to live independently. Not surprisingly, many of these individuals will be cared for by their children who are elderly themselves. These aging caregivers will be responsible for perhaps decades of care for their frail relatives. Meanwhile, both child and parent will be growing more frail and dependent. Even more devastating may be the real possibility that caregiver overload, limited skills necessary to care for elders and variable motivations become precursors to both elder abuse and its other face - caregiver abuse. In this context, variable motivations (or the caregivers reason for entering into the relationship), may involve familial expectations, guilt, financial gain or a variety of other reasons.

Generationally inverse families in which the elderly parent is dependent on the child for social/emotional, financial or physical support are quite present in our society. Unfortunately, "the changes in the roles between those needing care and those providing care may build feelings of resentment and misapprehension in both generations" (Steinmetz, 1988, p.50). "It is possible that while the caregiver may on some level perceive that role reversal is occurring, the elderly parent may not share this perception - a phenomenon labelled asymmetrical transition" (Steinmetz, 1988, p.50). However, it is equally likely that a cognitively intact elder could perceive their dependent status within the caregiving relationship. In these situations, the elder may then seek to dispel the caregiver's perception of them as dependent and the cause of stress by engaging in abusive acts.

Defining Dependency

Dependency has been defined in many different ways in the literature. Cultural perspectives cited by Bleckner (1969) and Clark (1969) view age related dependency as normal and expected, resulting from a permissible life crisis such as illness, loss of spouse and retirement.

Foulke (1980) defines dependency in the following four stages

> The first stage, independence, is characterized by autonomous individuals who exchange favors. The second stage, reciprocal dependency, is characterized by an equal flow of assistance between adult child and parent, but there is some evidence of the elders diminished physical strength and functioning. Asymmetrical dependency, the third stage, is characterized by the parent being more dependent than

> independent and an increasing amount of support and aid being provided by the adult child. The final stage, survival dependency, is one in which the adult child is providing almost total personal care, as well as social/emotional and financial tasks for the elder (p.11).

Although the literature cites numerous ways to define dependency and its stages, what is important in understanding perceived caregiver abuse is the effect of the caregivers perception of the elder's dependence. The caregivers perception of the elders' dependence upon them and its resulting stress for all parties involved has important implications for this growing population. One of the ramifications of this stress is that of perceived caregiver abuse. Certainly, another result of this situation may in fact be more traditional forms of elder mistreatment whereby the stressed caregiver lashes out at the elder care-recipient.

"Intergenerational support systems remain strong and it is the family, not institutions or social service agencies, that still fulfils the major task of caring for the elderly" (Steinmetz, 1988, p. 52). Given this phenomenon there are a number of dependencies which need to be examined in terms of their impact on both the elder and the caregiver. This practicum considered household tasks, personal and health care, mobility, social and emotional support, mental health and financial dependencies and their relationship to perceived caregiver abuse.

The Impact of Stress of Caregiving

The role and lifestyle changes that occur when an elderly family member experiences the transition from independence to dependence can create stress and crisis for all generations. The changing needs of the elder will also signal a redirection of physical energy, time, emotional strength and money from the caregiver, to meet the needs of the individual. Supporting this position, Steinmetz suggests that "when families become generationally inverse, all of the above stressors are experienced by both the elder and the caregiving family members" (Steinmetz, 1988, p. 68).

Given the aforementioned situation, O'Malley, (1979), posits that "when these stressors exceed the tolerance level, family dysfunction in terms of individual disorders or abuse and neglect of the elder or other family members results" (Steinmetz, 1988, p.68).

Cicirelli (1981) notes that the increased amount of time it takes to care for the elder, as well as the lack of privacy involved, usurps time available for the caregiver to fulfil their own needs. As the elder grows more dependent on the immediate family, and experiences a narrowing of their own social network, the caregivers become the centre of the elder's universe. This increased dependency on the caregiver for economic, social, physical and financial support likely increases the stressors for all parties involved.

Steinmetz (1988) also notes that "often considerable resentment by other family members arises when the elder attempts to be the centre of attention and direct all activity" (p. 69). In these situations, Steinmetz (1988) suggests that families attempt to compensate, or restore family balance, by planning specific activities which exclude the elder. Not surprisingly, these activities "...tend to produce further resentment by the elder and conflict over being 'ignored'" (Steinmetz, 1988, p. 69). Once again, this kind of stress, which produces conflict for both the caregiver and the elder, may be a factor in the cognitively intact elder seeking to increase their own power/control over the caregiver by engaging in abusive behaviors. Conversely, the cognitively impaired elders' behavior, which may also be perceived as abusive by the caregiver, may not be demonstrated as a means to increasing their power and control. The impaired elders' behavior may simply be erratic, lacking in insight and perhaps a reflection of their ongoing disease process.

Caregiving For the Chronically Impaired Elder

Providing care for the chronically impaired elder suggests that due to the debilitating nature of their illness, they are no longer able to function independently. The amount of care involved in these situations will often be dictated by the individual's disability. As well, these caregiving scenarios may involve decision making around the elder's living arrangement or various daily activities. In any case, these caregiving situations are usually long term as chronically impaired elders are, at best, not likely to make full recovery, and at worst, terminal. In these cases, caregiving is not only long term, but requires increasing effort and responsibility which create permanent imbalance in the family.

"Permanent imbalance in normal family ties is difficult for both the caregiver and the care recipient"

(Cicirelli, 1988, pp. 79-80). For the caregiver, stress results from the fact that previously acceptable modes of exchange are no longer possible. Despite feelings of distress, caregivers may be unable to relinquish their role as that would violate the norm of solidarity. For the care recipient, the inability to reciprocate in the exchange relationship may generate feelings of guilt, helplessness or even anger.

The aforementioned review of the literature clearly highlights that much of the research done in the area of intrafamilial abuse has been directed at caregivers abuse of the elderly. Abandoning the more traditional focus, Karen Stein (1989) specifically investigated the phenomenon of caregivers who perceived themselves to be victims of abuse perpetrated by their elder family members. Applying the concepts of social exchange theory, Stein has widened the scope of intrafamilial abuse theory by suggesting that "...abuse directed against caregivers is a function of perceived dependency stress; that is, elders who are perceived as dependent and the cause of stress to caregivers may seek to increase their power by engaging in abusive behaviors" (p.1). This practicum further hypothesizes that the cognitively intact elder, with insight into their dependent state, is more likely to engage in this type of goal directed abusive behavior.

In accepting this premise, it is important to distinguish between the reality of the caregivers perceptions from a "blaming of the victim" ideology. On the surface it would seem easy to simply discount the claims of caregivers as being the victims of abuse perpetrated by their elder kin who are often presumed as frail and dependent. Dismissal of this phenomenon is further supported by the overwhelming lack of evidence in the current literature even citing its existence. Instead, the literature generally cites the elder as the victim and the caregiver as the perpetrator. Although researchers do differ on the question of dependency (who is really dependent on whom), the overwhelming message is that the elder is the victim.

To reverse these roles and suggest that at times the caregiver is the victim and the elder is the victimizer is for some a "blaming of the victim".

Blaming of the victim implies that "the stigma that marks the victim and accounts for his victimization is an acquired stigma, a stigma of social, rather than genetic origin" (Ryan, 1971, p.7). Ryan goes on to suggest that blaming the victim serves to concentrate ones

> interests on the defects of the victim, condemn the vague social and environmental stresses that produced the defect (some time ago), and ignore the continuing effect of the victimizing social forces (right now). It is a brilliant ideology for justifying a perverse form of social action designed to change, not society as one might expect, but rather society's victim (Ryan, 1971, p.8).

Traditional, although ageist, understanding of our elderly evoked images of "sweet old ladies and "harmless old men" who cherished their families. The aging process was depicted as peaceful and smooth, spent within the bosom of the extended family.

Current literature has exposed a more realistic account of what individuals may face as they move through the aging process. Issues around retirement, personal loss (in all areas), economic constraint and the like often fill in the "golden years". While for some the latter years are peacefully enjoyable, they are for others, marred by significant pain and loss. Applying the blaming of the victim ideology to the elder perpetrator would be to blame them for behavior caused by social injustices such as ill health, poverty, loss of independence and power.

Possibly it is these social stresses that for some evoke strong images of the elderly as victims. Any attempt to characterize these elderly victims as perpetrators seems not only unfounded in the literature, but socially reprehensible.

For others, dismissing this form of intrafamilial abuse as a "blaming of the victim" phenomenon is just too simplistic. Personality traits, social, physical and economic forces all impact on the behavior of our elderly. To dismiss the abusive acts of the cognitively intact elder kin as beyond their control (emerging from social factors), is to condone behavior which is for other age groups generally unacceptable.

Germane to this practicum is the assumption that perceived caregiver abuse is a legitimate problem, one which highlights another facet of the complex world of intrafamilial abuse.

Researchers must not shy away from exploring this phenomenon for fear of "blaming the victim". For "we can only help the elderly and the people involved in their care if we see the difficulties from all points of view" (Goldstein & Blank, 1988, p.89).

CHAPTER TWO

PRACTICUM DESIGN

The Context

"Canada's society is an aging one. One in ten Canadians is currently over the age of 65" (Podnieks & Pillemer, 1990, p.1). The proportion of Canada's elderly is expected to rise dramatically in the next twenty years. "Statistics Canada estimates that by the year 2000 there will be 3.4 million Canadians over 65 years of age, accounting for nearly twelve percent of the population" (Moore & Thompson, 1987, p.117).

This demographic shift may translate into significant intrafamilial stress given that "it is now widely recognized that the majority of supportive services received by older persons are provided by family members" (George, 1988, p.67).

The literature highlights dependency as a contributing factor towards the abuse of family members. Many elderly have spent a lifetime providing for themselves and their children. They were the ones responsible for the economic and emotional support of the family, and in general making the necessary decisions. For aging parents who reside with their families, those functions have often been taken over by their caregiving children.

This situation may create or even increase feelings of economic powerlessness and dependency in the elder. However, the elder may be reluctant to discuss their feelings, not wanting to appear ungrateful for what they perceive as unnecessary support. Alternatively, if the elder does discuss their feelings, the adult child may brush away their comments with cliches about "doing what's best". To this end, the elders feelings may turn into resentment which manifests itself as abusive behavior (Pillemer & Finklehor, 1985).

As the literature reveals, most studies of intrafamilial abuse, occurring in generationally inverse family settings, focus on the caregivers abuse of the elderly. Much of the conceptual framework applied to these traditional studies has been gleaned from other forms of intrafamilial abuse. For example, researchers have investigated the mistreatment of women and children to develop risk factors for abuse. Stemming from this early work, the elderly are the most recent group to be identified as at risk for mistreatment. To this end, the current literature can be used to form hypotheses relating to families in which the abused is the caregiver and the abuser is the elder. As other researchers have done in the past, Stein utilized traditional literature in the area of elder abuse to support her theory.

When considering the situation of caregivers who perceive themselves to be victims of abuse perpetrated by their elderly family members the following global questions emerge:

1) Is the abuse directed at caregivers a function of perceived dependency stress?

2) Is the perception of financial dependence on the caregiver a greater predictor of abuse directed against caregivers?

These questions are critical and require attention for several reasons. First, as Canada's population ages and fiscal constraints to the health care system increase, the caregivers role will be even more demanding.

Secondly, as increased demands are placed on caregivers, they as well as professionals will require the knowledge and tools necessary to recognize and work with abusive and potentially abusive situations.

Finally, important consideration must be paid to the caregivers of our elderly. Researchers must allow caregivers to express their perceptions of the helping role to understand the phenomenon of intrafamilial abuse. Hopefully, increased knowledge of this problem can lead to pressure being placed on policy makers to create services to meet the needs of this group.

OBJECTIVES

The objectives of the practicum were three-fold:

1) To examine the impact of dependencies in those cases where family caregivers perceive that they are victims of abuse perpetrated by an elder kin;

2) To identify factors that were associated with dependency stress for caregivers;

3) To expand further the literature on this topic.

HYPOTHESES

1) That abuse directed against family caregivers is a function of perceived dependency stress. In other words, elders who are perceived as dependent by their caregivers as well as the cause of stress to their caregivers may seek to increase their power by engaging in abusive behaviors. In this context, it is further hypothesized that the cognitively intact elder, with insight into this

dependent state, is more likely to engage in this type of goal-directed abusive behavior;

2) That the perception of financial dependence by the elder on the caregiver is a greater predictor of mistreatment than is generally revealed in the elder abuse literature.

DESIGN

CROSS-SECTIONAL SURVEY

The design that was used was a cross-sectional survey design. The cross-sectional design is a correlational design that involves a survey of the subjects at one point in time. The design obtains information about individuals' properties and dispositions and then uses various data analysis techniques to compare different sub-groups. The comparisons between sub-groups is statistical and based on correlational techniques (Nachmias, 1981). The practicum examined a non-random sample of caregivers taken from the City of Winnipeg (there were no respondents from the rural areas). At the onset of the meeting, respondents were asked to read and sign a consent form for participating in the study (Appendix 2). Respondents were then asked to complete a basic data form (to provide information on the elder that they cared for (Appendix 3), as well a structured questionnaire (Appendix 4). In addition, the interviewer encouraged the respondents to engage in unstructured conversation about their particular circumstances. The data collected was significant in that it revealed both quantitative and qualitative data regarding the respondents' caregiving experience.

DATA SOURCES

The practicum utilized data from two sources: data base and consumer interviews (caregivers).

Comprehensive demographic/statistical information was collected for every elderly person being cared for by the respondents.

The data was obtained by the caregiver at the onset of each interview. The data collected provided useful information on the elderly care-recipients regarding:

-age of the elder

-gender of the elder

-relationship to the caregiver

-length of caregiving

-where did the elder reside prior to living with the caregiver

-where the elder currently resides

-most common health problems of the elder

-recent hospitalizations

-issues regarding decreased function

SAMPLE

Criteria for inclusion in the study were:

1) The family must have shared a residence with the elder for sometime during the past three years;

2) The adult child was required to perform some tasks for the elder so that a degree of dependency by the elder was involved;

3) The elder was over 65;

4) The caregiver was the adult responsible for the household, such that they were responsible for the day to day operations of maintaining the home.

The sample for the study was selected non-randomly, using advertisements (Appendix 5)and professional contacts (Appendix 6) to gain leads about middle aged children who lived with and were responsible for the care of an elderly family member. All prospective interviewees initially contacted the interviewer by telephone and left their name and phone number on a recorded message. These individuals were then contacted by the interviewer, over the telephone, to explain the study and obtain the participation if they qualified. As well, all participants were assured confidentiality, and were informed that no identifying characteristics would be used in any report of the research findings.

For those callers who did not qualify, the contact was terminated after they were thanked for their interest in participating.

CAREGIVER INTERVIEWS

Caregiver interviews (Appendix 7) were conducted from September 2 - November 29, 1990 inclusive. All interviews were conducted by the researcher on an individual basis with the participants, in the neutral setting of their choice. Two-thirds of the interviews were conducted in the homes of the respondents, with the remaining interviews taking place in local restaurants. On average, each interview took approximately 1 1/2 - 2 hours with each caregiver, with much of the time being used by the qualitative aspects of the meeting. The unstructured conversation not only allowed for some rich qualitative data, but also gave the respondent an opportunity to verbalize their thoughts on the caregiving experience.

The design discussed above was the most appropriate given the time and resource limitations as well as the nature of the study. The correlational and descriptive knowledge levels that were obtained were necessary for a social needs assessment. The cross-sectional survey design was appropriate for obtaining this level of knowledge and for defining the population and its characteristics (Tripodi, 1983). This data began to provide useful insights into the situations of caregivers who perceive that they are victims of abuse perpetrated by their elder family members.

Although the use of a non-random survey posed restrictions to the generalizability of the findings, this type of design was useful to the extent that its results may lead to further scientific study to explore this relatively unknown area in greater detail.

OPERATIONALIZATION OF KEY CONCEPTS

CAREGIVER

Caregiver refers to an adult child who is responsible/required to perform some tasks for an elderly family member so that some degree of dependency on the part of the elder is involved. The caregiver is also the person responsible for the day to day management of the household.

ELDER

Elder refers to an elderly family member, age sixty-five and older, who must have shared a residence with their adult child (caregiver) sometime during the past three years.

DEPENDENCY STRESS (independent variable)

Caregivers were asked to rank the amount of conflict or stress produced by taking on additional responsibilities for the elders welfare. Response categories were: Never bothers me (0), hardly ever bothers me (1), sometimes bothers me (2), usually bothers me (3), and bothers me all the time (4).

Stress could result from the elder being financially dependent (financial), needing help with personal grooming (grooming), being dependent on the caregiver for help with household management such as cooking, cleaning and running errands (household), being physically dependent upon the caregiver due to severe disability (physical), and/or the elder having severe mental disability requiring emotional sustenance and management from the caregiver (emotional).

ABUSE MEASURES (Dependent Variable)

Certain behaviors could be considered abusive if they result in physical harm or cause emotional discomfort and distress. The latter could be caused through such things as deliberate manipulation, public embarrassment, invasion of privacy or the refusal to co-operate in behaviors designed for ones own good. Caregivers were asked how often their parents attempted to obtain control by engaging in behaviors which caused distress. Response categories were never (0), almost never (1), sometimes (2), most of the time (3), and all of the time(4).

Caregiver abuse could result from the elder pouting and withdrawing to their room, yelling at the caregiver and imposing guilt by acting the role of the martyr (emotional), refusing to eat or take medical treatment (refusal), hitting, slapping or throwing objects (physical), using their physical or emotional disability to gain control (Disability), calling police or other help for imagined threats such as being held captive or having their money stolen by the caregiver (embarrass), and manipulating family members and disregarding their privacy (interference).

In addition to the previously discussed measures, caregivers were encouraged to engage in unstructured conversation about their caregiving experience with the researcher. Indeed, these discussions revealed much more about the qualitative aspects of the caregiving experience than the data collected.

ANALYSIS

The data were analyzed using both quantitative and qualitative methods.

The demographic data provided a basic description of the population under study. Frequency counts were used to describe the age, gender, health complications, previous living arrangements and months of receiving care of the care-recipients. A frequency count was also used to describe particular information about the caregivers such as age and gender.

Bivariate analysis was used to highlight the relationship between the abuse measures(dependent variable) and dependency stress (independent variable). As well, crosstabulations were used to examine the relationship between dependent variables and demographics.

Multi-variate analysis was also used. A multiple regression further examined the relationships between specific variables to provide more detail to the results.

The unstructured conversation with the respondents added richness and detail to the quantitative study. This data was organized and compared to the qualitative data to make the results more meaningful.

CHAPTER THREE

RESEARCH FINDINGS

The following chapter presents the research findings gleaned from this study.

When considering these findings, readers must be cognizant of the limitations inherent in the study.

First, the use of a non-random sample limits the generalizability of the research results. Use of this sampling procedure may bias the results of the research such that it may provide an over-estimate or under-estimate of the number of caregivers who perceive themselves as victims of abuse.

The size of the sample, 20 respondents, also severely limits the generalizability and validity of the research findings:

> The degree to which a sample is representative of a population depends on the degree of precision to which the population is specified, the adequacy of the sample, and the heterogeneity of the population. Large samples from well defined homogeneous populations are more likely to be representative than very small samples from vaguely

defined and heteregeneous populations (Tripodi, 1983, p. 92).

Given these limitations, most of the quantitative findings showed no statistical significance, even at the weakest level of testing. Attempts to analyze the statistics with more powerful tests involved the making of assumptions that the data was appropriate for the particular test. This holds true given that "the most powerful tests are those which have the strongest or most extensive assumptions" (Siegel, 1956, p. 19). Due to the limited sample size, certain more powerful tests (T-tests and multiple regression analysis) were performed with the knowledge that the following particular conditions were not satisfied. Seigal (1956) notes that the conditions which must be satisfied to make the T-test the most powerful one, and in fact before any confidence can be placed in any probability statement obtained by the use of a T-test, are at least these:

1. The observations must be independent. That is, the selection of any one case from the population for inclusion in the sample must not bias the chances of any other case for inclusion, and the score which is assigned

to any case must not bias the score which is assigned to any other case.

2. The observations must be drawn from normally distributed populations.

3. These populations must have the same variance.

4. The variables involved must have been measured in at least an interval scale, so that it is possible to use the operations of arithmetic on the scores.

Obviously, "... the fewer or weaker are the assumptions that define a particular model, the less qualifiying we need to do about our decision arrived by the statistical test associated with that model" (Siegel, 1956, p. 19).

Demographic Data

Description of the Caregiver

Of the 31 telephone responses received, 20 caregivers met the criteria for entry into the study. Regarding those who did not meet the criteria, 7 were eliminated due to not actually caring for an elder in their home, 3 were elderly individuals calling to share concerns about circumstances unrelated to the research study, and 1 individual did not follow through after several attempts to arrange an interview.

There were 15 female and 5 male caregivers involved in the study, with 14 individuals actively providing care at the time of the interview. The remaining 6 had already placed their elderly family member in a personal care home at the time when the study was conducted. Of those elders already placed, 2 had since passed away at the care home. The mean age of the caregivers was 57.2 years. The majority of respondents were employed (18 out of 20) during their caregiving role. As well, 19 of these caregivers had 1 or more additional family members in their household during their caregiving experience.

In total, 5 caregivers provided care to their father (4 daughters and 1 son), 9 to their mother (5 daughters and 4 sons), 3 to their mother-in-law (3 daughter-in-laws), 2 to their father-in-law (2 daughter-in-laws) and 1 to their step-mother (1 step-daughter).

The period of caregiving ranged from 4-300 months, with a mean of 60.8 months. Clearly, the caregivers who reported looking after their family member for 25 years has skewed the mean length of caregiving for this sample (Table 1).

Description of the Care-recipient

Caregiving was provided to 20 elders from 20 caregivers. There were 13 female and 7 male care-recipients. The age range was 66 to 90 years, with a mean age of 78.3 years.

The majority of elders (75%) were living independently prior to moving in with a family member. The remainder either lived with a spouse or with another individual (Table 2).

The reported health problems of the elderly were diverse (Table 3). In total, 10 elders were reported to have alzheimers disease (9 females, 1 male). 5 patients were diabetic, 1 had had a heart attack, 4 had cancer, 5 had arthritis, and 6 elders were reported to have other illnesses such as cirrhosis, ulcers, alcohol abuse and depression. Of the total sample, 8 elders were reported to have 2 or more of the aforementioned illnesses. When reviewing these results it is important to note that the reported health status of the elders was based entirely on the perceptions of the caregivers. No documented medical information was requested or obtained to collect this data. To this end, it is possible that other respondents who reported some level of confusion in their elder family member may have also been caring for an individual suffering from the early (possibly undiagnosed) signs of alzheimer type dementia. Therefore, despite half of the sample clearly reporting alzheimers as a medical problem for their elder family member, there may in fact have been more in the sample collected than actually reported.

Caregiver Interviews

Quantitative Results

Crosstabulations were performed to compare scores between the demographic data on the elderly and the abuse variables. No significant positive correlations were found at the .005 level of significance. Crosstabulations were also performed between the abuse variables and dependency stress. Significant positive correlations below the .005 level were found between the following variables:

1) Physical disability and elders imposing guilt (p=.0095).

This relationship suggested that it was the perception of caregivers that the presence of a physical disability in the elder strongly correlated with evoked guilt in the caregiver.

2) Physical disability and the elders' use of their disability to gain control (p=.0466).

This relationship suggested that it was the perception of the caregivers that the presence of a physical disability in the elder strongly correlated with the elders's use of that disability as a means of gaining control.

3) Financial dependence and elders interference (p=.0486).

This relationship suggested that it was the perception of caregivers that those elders who were believed to be financially dependent strongly correlated with their attempts to interfere in family matters.

T-test analysis, looking for the difference between two means, was carried out using demographic and dependent variable data. The study hypothesized that the cognitively intact elder would be more likely to engage in goal directed abusive behavior. T-tests performed between the demographic data around elders with alzheimers and those without the disease, and both the independent and dependent variables, revealed the following significant correlations:

1) Elders interference and elders without alzheimers (t value=2.88) (2 tail probability=.010)

This relationship reveals a correlation which suggests that cognitively intact elders are more often perceived to be interfering in family matters than elders with some level of cognitive impairment.

2) Elders emotional dependence and elders without alzheimers (t value=2.22) (2 tail probability=.039)

In this case, the relationship reveals the caregivers' perception that elders who are mentally clear are more likely to be perceived as emotionally dependent upon their caregivers than those who are dementing.

3) Elders physical disability and elders without alzheimers (t value=2.62) (2 tail probability=.018).

This relationship reveals a strong correlation between increased caregiver stress around the elders' physical disability if they were not cognitively impaired. In other words, caregivers in this sample perceived more stress in caring for a physically disabled, but cognitively intact elder than they did from a physically and cognitively impaired elder.

Multiple regression analysis was also performed, but with no significant results.

Tables 4-7 highlight significant quantitative tests run for the research project.

Qualitative Results

The goal of the unstructured conversation was to provide respondents with an opportunity to speak freely about their individual caregiving experiences. For all of the caregivers, the opportunity to express themselves freely was entered into with no apparent hesitation. Clearly, these conversations with the caregivers occupied 90% of the interview time. Most discussions lasted approximately one hour and twenty minutes, with the longest running three hours. Many of the caregivers wept during these discussions, as they recalled particularly painful and frustrating experiences. One of the caregivers who was particularly stressed was visited twice. The second visit was entered into at the request of the caregiver for the researcher to provide the names and resources of people in the community for the individual to contact.

In analyzing the content of these open-ended discussions, several common themes emerged. Firstly , that caregivers did not seem to articulate a strong sense of abuse by their elder family members. Although many articulated feelings of being manipulated, not one caregiver actually stated that they were being actively abused by their elder kin. This was quite interesting given the fact that many respondents expressed significant hostility towards their elder family member stemming from their behaviour.

Case number 20, a middle-aged caregiver who looked after his elderly mother, is an excellent example of this phenomenon. In this situation, the elder came from another province to live with her son, after managing poorly in her apartment. This particular elder was failing to cope due to extensive abuse of alcohol and prescription medication. Shortly after her arrival in Winnipeg, the caregiver reported increased tension in the household due to what he described as his mother's manipulative, deceptive behavior; this included whispering so he could not hear her speaking, eavesdropping on conversations between him and his wife and refusing to eat meals prepared by his wife. He went on to state that he felt his mother's behavior was so destructive that he fantasized about 'tying her to a chair, putting her on the front porch, locking her out and waiting for a social worker to take her away".

Although this male caregiver had hostile feelings towards his mother, at no time did he define her as abusive.

Another general impression which emerged was that of caregivers feeling isolated and strained in their relationships with their spouses. This feeling seemed particularly strong for those individuals who were providing care to an in-law as opposed to a parent.

Case number 18, a female caregiver managing her mother-in-law for eight years, highlighted this general theme. In this situation, the caregiver, who was unemployed, reported assuming total responsibility for her demented mother-in-law. Specifically, she was responsible for assisting the elder with basic activities of daily living, medications, and general supervision - as well as the management of the family home and a child. In this situation, the caregiver reported feelings that her spouse expected her to take on this responsibility due to familial obligation. As well, there was some sense on the part of the caregiver that her lack of employment eased her husband's feelings that the burden would be too onerous. This caregiver, as did others, spoke of resenting the responsibility of physically caring for an elder who was not their parent. "If this was my own mother things would be different". "I would do it because I love her, but with my mother-in-law I have no choice; I can't talk to my husband about this anymore, he doesn't understand how I feel".

This particular situation deteriorated to the point where the caregiver felt so isolated and burdened by her husband's expectations, and lack of assistance, that she had to seek psychiatric help. The caregiver reported that her emotional state was so precarious that she required a hospital psychiatric admission to assist in her recovery.

Another common theme that emerged was the caregiver's general unhappiness with the health care system, particularly around the provision of community based home care support. This type of service provision, often described by the umbrella term "home care", is based in Manitoba Health Services Commission's Continuing Care Program. The program is based on a philosophy of continuing care for elderly people living at home, pre- and-post hospitalizations and through assessment for placement into long term care facilities.

Overall, the Continuing Care Program provides (a) services to support the provision of care at home (Home Care) which include family relief, Respite Care, and Adult Day Care and (b) assessment for personal care home placement.

Home Care can be defined as the co-ordinated delivery of health and social services to meet the needs of individuals who require assistance to remain in their own home. Upon the identification of the individuals needs, short or long term services are organized in order to avoid decreased functioning and to maintain or enhance health. Individuals needs are assessed either in hospitals by Home Care referral nurses or in the community by a Continuing Care Social Worker-Nurse team. The case-co-ordinator, either a Social Worker or Nurse, will act as the main contact for all services provided by Home Care in the community. The case-co-ordinator will continually monitor and assess for changes in the situation or health of the older person and adjust services as appropriate.

Within Manitoba Home Care Services are provided at no cost to the user. However, certain eligibility requirements must exist for older adults to be eligible for service. Elderly individuals are eligible for Home Care when: (a) even with the help of family/friends they would be unable to live at home without additional Home Care Services; (b) with services in place, the individuals ability to remain in the Community will be maintained and deterioration prevented; (c) Home Care provides services to assist family caregivers in maintaining the home environment and thus continue active caregiving; (d) with available Home care Services the elderly individual can be discharged from an acute care hospital (Cooper, 1990).

Discussions seemed to focus on the caregivers feelings around case co-ordinators being inaccessible, unsympathetic, and generally under-serving the care needs of their family members. Caregivers also spoke about not understanding how the system worked or how to make it work for them.

One female caregiver, case number 9, managing her dementing mother-in-law, was receiving service only on the afternoons when she worked. This caregiver tearfully expressed the feeling that the system neither understood nor responded to her needs despite her requests. "I need more help than this, but they don't understand. I would like some time for myself to just get away, not just to go to work. I've asked so many times I don't even know who to talk to anymore".

Guilty feelings around placement seemed to be another commonality amongst caregivers. Despite the hardships of active caregiving, individuals claimed to have very mixed emotions at the time of nursing home placement.

One particular caregiver, case number 14, looking after her demented father stated that she had a great deal of trouble accepting her father's progressively deteriorating cognitive state and eventual need for placement. It was this inability to accept his condition that fuelled her belief that her father did not need a personal care home, but rather her loving care. This caregiver's attempt to manage her father at home led to her buying a larger family dwelling in order for her father to have more room. As a result of her strong convictions and commitment to caring for her father, this caregiver reported refusing to panel her father for personal care home, despite the urgings of the community based social worker. "They don't know him like I do. I can look after him better than any stranger. I promised him I would never put him in a nursing home".

When her father began to display physically violent behavior, this caregiver stated that she reluctantly signed personal care home papers for him. Put on a priority list, her father was placed only four months later. "I've never felt more guilty in my life; I broke my promise to my father, but I had no choice. That was the hardest thing I've ever had to do". Despite having placed her father in a personal care home several months prior to this interview, the caregiver wept as she recounted her feelings of guilt around this difficult life event.

One final theme which seemed to emerge from the qualitative interviews was that the caregiving role was perceived to be one expected of many women who were in the sample. In other words, almost all of the female caregivers, 75% of the entire sample, alluded to a feeling that the job of caregiving was one expected of them. These expectations were felt from siblings and spouses, as well as internally from some caregivers. Some women also alluded to the general stress of being the caregiver not only to an elder family member, but also to their spouse, children, and family home. For those female caregivers who worked, the additional responsibilities of work outside the home seemed to add an additional layer of stress which at times would be intolerable.

In reviewing the cases where this trend emerged, it seemed as though most female caregivers alluded to this phenomenon, either overtly or covertly.

The qualitative results from this study do reveal certain trends in the caregiving experience. These results, as well as the quantitative data will be discussed in the next chapter.

CHAPTER FOUR

DISCUSSION OF THE FINDINGS

The following chapter reviews the quantitative and qualitative research findings obtained from the sample.

The quantitative results gleaned from frequency tests and T-tests will be discussed briefly. With only a very few tests providing statistical significance this portion of the research results cannot be relied upon too heavily. Yet, a larger sample may yield more significant results. It should be clearly noted that despite there limitations, these tests contributed significantly to the author's learning.

Instead, the results of the qualitative data will be examined in greater detail. It is this portion of the study, which has provided the most useful insight into the perceptions of caregivers who feel that they are being abused by their elder family members.

DISCUSSION OF THE QUANTITATIVE RESULTS

It was the perception of caregivers that the presence of a physical disability in the elder was often used by that elder as a means of gaining control. Moreover, those elders with physical disabilities, but without Alzheimers disease, were perceived as more stressful to their caregivers than those with dementia of the Alzheimers type. This relationship suggests that elders cognizant of their physical disability are perceived as more likely to use their handicap as a means of gaining control. This observation is supported by the statistical data.

That the presence of physical disability correlated strongly with evoked guilt in the caregiver also underlies the importance of physical disability as a cause of dependency stress. Such disabled elders would require more physical input from the caregiver. Caregivers unable to provide this input fully may feel guilty and their stress level would be expected to increase. Moreover, the cognitively intact elder could use their physical disability to evoke guilt in a goal-directed manner. Concrete attempts to create guilty feelings on the part of the caregiver may be perceived as an abusive tactic on the part of the elder.

Those elders deemed to be financially dependent by their caregivers were frequently perceived to be interfering in family matters. When considering this relationship, it is important to recognize that it is not known to what extent caregivers' affluence may modulate the relationship between financial dependence and perceived care-recipient interference.

In any case, such elders were less likely to be suffering from Alzheimers disease, suggesting that the interference was goal directed and not random behavior. Financially dependent elders may display behavior viewed by the caregiver to be interfering as an attempt to re-establish a form of control.

Interference by the elder took the form of manipulating family members and not respecting or disregarding their privacy. Such behavior could dissolve a care-recipient's perceived "unified front" against themselves. This dissolution would afford the elder relatively more power and would make individual caregiving positions weaker.

The literature supports a relationship between perceived financial dependence and interference and notes that "a change in status, role loss, deprivation of material goods and resources, and organizational change in family structure and boundary ambiguity can produce stress" (Steinmetz, 1988, p. 68). It is these stressors, experienced not only by the caregiver but also by the care recipient, which may lead the elder to engage in behaviors which are perceived to be interfering.

The absence of Alzheimers disease correlated strongly with several variables including the use of a physical disability to gain control or evoke guilt as described above. Non-Alzheimers disease elders were perceived as more interfering by their caregivers. Moreover, those elders without Alzheimers disease were perceived as more emotionally dependent upon their caregivers than those with the disease.

These limited results do lend support to the research hypothesis that abuse directed against family members is a function of perceived dependency stress. As well, the significant data also supports the premise that the cognitively intact elder, with insight into this dependent state, is more likely to engage in this type of goal directed abusive behavior. These findings are consistent with recent literature citing the impact of stress on the caregiving and care-receiving experience.

Unfortunately, the elders and adult children involved in these stressful caregiving relationships often have less means of resolving conflict when it arises.

The quantitative findings of this study are consistent with the literature which cites that "parents frequently withdrew and pouted, or attempted to manipulate others, impose guilt and use their disabilities to gain control" (Circirelli, 1988, p. 62). Circirelli (1988) elaborates on a second trend which points "... at least for many elderly, towards increasing disinhibition of certain negative behaviors that were repressed or otherwise controlled during earlier years - for example, screaming and yelling, name calling and hitting" (p. 62). Clearly, this type of abusive behavior increases the likelihood of conflict as well as generating negative feelings within the caregiver.

Finally, for those elderly with limited material/financial resources, the literature points to a resulting loss of power that accompanies aging. Cognizant of this, "... parents may increase their efforts to maintain or regain control and authority over adult children, thereby increasing conflict and negative feelings" (Circirelli, 1988, p. 63).

For caregivers, "the unreasonable nature of the parents' demands, numerous behavioral problems, and the physically stressful nature of the around the clock care that is often needed are all contributing factors to a most difficult caregiving situation" (Circirelli, 1988, p. 63).

Adult children who may feel resentful about some of these behavioral manifestations in their elder kin may in fact perceive the elders' behavior as goal directed and abusive.

The quantitative data generated from this study reinforce the reality that caregiving relationships within the family unit are extremely complex. It further points to the reality that the ease or difficulty within which these caregiving relationships evolve is based largely on the perceptions of both the caregiver and the care recipient.

DISCUSSION OF THE QUALITATIVE RESULTS

As previously noted, the qualitative results revealed several trends in the caregiving experience. Clearly, the thoughts and feelings shared by the caregivers in this study provided useful insights into what can be conflict-producing life-experience.

Of interest was a trend on the part of caregivers not to define their elder kin as abusive. Certainly caregivers willingly offered comments of their elders as being manipulative, nuisances, mean, cruel, but not abusive. This is an interesting trend given that the quantitative results showed relationships between physical disability and perceived abuse, as well as financial dependence and abuse. On the surface, this trend may appear to be a reflection of semantics; that in fact caregivers do perceive that they are being abused, but simply have not used that particular choice of expression.

On the other hand, the overwhelming number of caregivers not defining their situation within that framework may be suggestive of other factors. One factor which may hinder the articulation of perceived caregiver abuse may relate to historical family relations and expectations. Within this context, the caregiver may in fact feel abused, but at the same time has internalized this caregiving role as one which is expected of them. For caregivers caught in this dilemma the internalized expectation that they must care for their parent, despite their abusive behavior, may take precedence. As Treas (1977) suggests, the ongoing provision rests upon a delicate balance of sentiments such as affection, gratitude, guilt or desire for parental approval.

Closely linked to the aforementioned point is the possibility that caregivers, despite their feelings, may perceive that it is both privately and publicly unpopular to brand their elder kin as abusive. Caregivers may feel that individuals outside their situation will accuse them of being uncaring and insensitive to the needs of their parents. This possibility seems even more real when caregivers are not given either public or private acknowledgement of their feelings. Publicly caregivers do not receive validation, in either the literature or the media at present, that the phenomenon of caregiver abuse even exists. This lack of public support may cause caregivers to question their perception of the situation and in turn, not seek out the private support they need. Undoubtedly, this must be a difficult situation for caregivers who are in fact being abused, but have nowhere to turn for validation, support and assistance.

Another factor which may influence caregivers not to define their situations as abusive may be the fact that they do not feel abused. To this end, the caregiver may feel frustrated and angry with their elder kin, but not abused by them. Once again, individual notions about what constitutes abuse will likely factor into this situation. However, it may simply be that caregivers did not feel the need to define the entire helping relationship as abusive. This may account for the very few quantitative results which were suggestive of abusive situations.

The trend of caregivers feeling isolated and strained in their spousal relationships was quite dominant. Of particular interest were the strong feelings experienced by female caregivers providing assistance to their in-laws as opposed to a parent.

This general theme is suggestive of two separate issues: the assistance provided to the caregiver by their mate, and the helping role as it relates to the in-laws.

Regarding the assistance provided to caregivers by their spouses, respondents in this study reported very little physical help was received. Although some caregivers cited a supportive emotional stance from their mates, most felt isolated and neglected in the area of providing physical care to their elder kin. These scenarios are suggestive of very traditional sex roles whereby the male provides for the family financially, and the female responsibilities involve nurturing both emotionally and physically. The literature supports this trend and notes that "the traditional view of women as being more nurturing, assuming the kin-keeping responsibilities, and having more flexible time.." (Steinmetz, 1988, p. 91) are reasons that females dominate in assuming caregiving responsibilities for elderly parents. Further, "... chores seem to be assigned according to gender, with women performing most social/emotional, housekeeping and personal grooming/health tasks" (Steinmetz, 1988, p. 92). Of interest to note was that despite the presence of other family members in the household, these caregivers felt no direct support or assistance, suggesting that day to day help was lacking.

The study design was based on interviews with caregivers who had assumed the responsibility of caring for an elderly parent. Clearly, though, the term parent is in the eye of the beholder and was defined by respondents in terms of parent-like relationships that had endured over the years. Not surprisingly, "with multiple marriages and women living longer, a caregiver may be faced with simultaneously providing care to a mother, stepmother, and mother-in-law" (Steinmetz, 1988, p. 1984). Keeping with this trend, respondents did define in-laws as parents, but stated that they perceived these helping relationships as much more stressful than caring for their blood parent.

Supporting this phenomenon, the "gerontological literature shows that spouse caregivers, child caregivers and persons less closely related may experience adverse caregiving outcomes" (Young and Kahana, 1989, p. 660).

Despite these adverse effects, Troll et al. (1979) point out that spousal caregiving is a normative expectation of marriage and that in certain circumstances these individuals may be more committed than child caregivers, providing a greater range of assistance and more hours of care. However, the literature also notes that these caregivers " ... may suffer fatigue, health deterioration, anxiety, depression, other mental illness symptomatology, and/or burnout" (Young and Kahana, 1989, p. 661). Sadly echoing the literature, the most extreme example of this kind of in-law caregiving strain was revealed in one sample from this study. The general trend, however, suggests that the relationship between the caregiver and the care recipient may influence the burden felt by the caregiver.

The overwhelming dissatisfaction caregivers felt towards the health care system was another common thread amongst respondents. Caregivers, focused on the provision of home care services, referred to this arm of the system as not responsive to their needs. As previously discussed, caregivers felt that they were not being heard or understood when requesting services for their elder family member. Within this context, caregivers reported their perceptions of professionals as at times unsympathetic and unwilling to stretch or bend with their allocation of resources. Recognizing again the limitations of this data trend due to the small sample size, this phenomenon is suggestive of several issues for the caregiver, the care-recipient and the health care system.

Without specific data regarding the decisions made around service provision for care providers in this sample, it is difficult to assess or substantiate claims that individuals are in fact underserviced. In any case, it is of interest to note that the provision of home care support is viewed by these caregivers as a major component in managing their elder kin. Therefore, any disruption/disagreement to the caregiver's expectations of what assistance is needed is likely to cause significant stress. In this case, it is possible that the home care system may be a dumping ground for the stressed caregiver. Frustrated by not having their perceived needs met by the system, the caregiver may in some circumstances be looking to share their burden of stress by blaming the system.

Equally likely perhaps is the scenario that in some cases the services that were offered were inadequate. For caregivers facing this reality, it is disturbing that there was no verbal acknowledgement of conflict resolution between themselves and the system.

These very strong feelings of inadequate service provision by the health care system may lead to caregivers feeling out of control, and/or unable to adequately cope with these helping relationships. These feelings could possibly lead to caregivers being at physical, emotional, and psychological risk, clearly limiting their ability to deal effectively with an elder already perceived as abusive.

For the elder, inadequate service provision from the community may put them in even more frequent contact with their familial caregiver. Without adequate time away from each other, "stressed out" participants may in fact be more prone to engaging in abusive acts.

Sensing vulnerability on the part of their caregiver, potentially abusive elders may seize the opportunity to lash out at these stressed individuals - thereby increasing their own power and control.

Caregivers who perceive a lack of support from the health care system are in a precarious position. Feeling that there is no professional body to turn to for support both emotionally and physically, these individuals may find the helping relationship overwhelming.

Recognizing that the home care system depends directly upon these familial caregivers to manage elder kin in the community, these negative perceptions will have ramifications for the system as well. Specifically, unsupported or underserviced caregivers may refuse any further caregiving responsibility for their elder kin. Many hospital discharges would not be feasible, for example, without the direct support of a familial caregiver. Alternatively, many established community based caregiving relationships could break down, prompting otherwise preventable hospital admissions. In both case scenarios, providing inadequate home care support to caregiving relationships would have an even larger systems effect by possibly involving acute care facilities.

The negative perception of caregivers regarding the provision of community based home care support has unavoidable ramifications for all potential players. Acknowledging these potential negatives,

> Service providers need to be aware of these differences and the effect that they have on family dynamics. They need to help the elderly accept these new dependent roles and help adult children learn to "parent" their elderly parent. Service providers also need to become more sensitive to the types of services most likely to reduce stress, conflict and abuse (Steinmetz, 1988, p 55).

Respondents from this study did report that services such as housekeeping, bath attendants and meals on wheels were valuable to both themselves and the elder care recipient, but were not enough. This gap in service provision may be suggestive of the caregiver's need for assistance in areas of social/emotional and mental health dependencies. Caregivers clearly articulated the need for more emotional supports regarding services. Future consideration must therefore be given to increasing the services of friendly visitors, day care, sitter services and support groups for adult children who are assuming the care for an elderly parent.

"Few elders welcome the nursing home, and few families are satisfied if they are forced to institutionalize a parent" (Caro, 1986, p. 300). Unfortunately, limited resources both within the family and the community home care service sometimes force such a decision.

Caregivers interviewed during this study revealed that ambivalent or even guilty feelings about placing their elder kin are for many normative. On more than one occasion, caregivers expressed these feelings with tearful, heartfelt emotion.

Caregivers who feel excited yet sad, overburdened yet still willing to give, or even resentful toward their elder kin were represented in this sample. For many, placement, in its global sense, represented a time of both endings and new beginnings.

For some, the long awaited availability of a personal care home bed may signal the end of a very long struggle. Removal of the dependent elder from the caregivers home would ideally restore balance to an often unbalanced exchange relationship. From this point forward, the caregiver could potentially refocus their time and energy as they see fit. No longer bound by the constraints of caregiving, placement would offer these individuals an opportunity to reclaim control over their daily lives.

Alternatively, placing an elder family member into a long term care facility may evoke confusing or negative feeling within the caregiver. For example, the event may be viewed as an end to what some caregivers define as their major purpose or role in life. Recognizing that families provide the bulk of care received by disabled elders, caregivers feeling loss of role at the time of placement should not be viewed as unusual.

Caregivers concerns about losing the helping role may be suggestive of feeling unfulfilled in other areas of their life as well.

Other factors which may impact on the stress of the caregiver at the time of placement may be their own feelings of perceived inadequacy to care for the dependant elder, and in turn projecting these feelings onto extended family members.

Families blame themselves if they give care that is below their own or their relatives expectations. Instead of attributing a portion of their difficulties to the social circumstances that create or exacerbate the problem of caregiving, they feel guilt and self-blame (Spitze & Logan, 1989, p. 108).

Possibly, it is these conflictual feelings that create confusion for caregivers at the time of placement, even if all family members agree that institutional care is needed.

Not surprisingly, caregivers whose elder family member passed away shortly after placement seemed to harbor the most painful memories of the experience.

Discussion of the qualitative data gleaned from this study suggests that for many, caregiving can be a lonely, stressful endeavour. Typically, the responsibility to provide care to elder kin, as well as maintain overall family relations, falls to women. Both the qualitative and quantitative data collected supported the phenonemom of women being the primary caregivers to elder family members.

> One of the most consistent conclusions in the aging literature is the centrality of women in the maintenance of kin networks. Women are socialized to focus more emotional energy on family ties and indeed devote more time and energy to direct care of family members than do men. They are responsible for the variety of tasks known as kinkeeping (Spitze and Logan, 1989, p. 108).

Female respondents sampled in this practicum seemed to frame the concept of kinkeeping as a familial expectation. Consistent with the literature, these female caregivers cited the responsibilities of caregiving to both aging parents and adult children as lonely, isolating and stressful. For many caregivers, stress was produced not only by the physicial demands of caregiving, but by the either spoken or unspoken expectation that she assume the responsibility. As one caregiver stated (case number 16) "My husband expects me to go on like this (caregiving) forever. I don't know how I will manage".

An examination of the possible reasons that women continue to assume this caregiving responsibility is critical to understanding this phenomenon.

It has been argued that the social fabric of our society relies on our ability to nurture the weak and to respond to the needs of intimates (Abel, 1986, p. 485). "The reigning ideology still holds that women are "natural" caregivers, (Abel, 1986, p. 485). In keeping with this belief, families have and still tend to assign primary caregiving responsibilities to daughters or daughter-in-laws rather than a son or son-in-law.

This prevailing ideology of women as the consumate caregiver may be fueled by several factors.

For example "...because women remain concentrated in low-paid and/or part-time jobs, families often view women's salaries as more easily dispensible and their work schedules as more flexible (Abel, 1986, p. 484). Given this perceived flexibility, women are often expected to give up active and fullfilling careers to become the family caregiver and kinkeeper. As one spouse (case number 7) related "I convinced my wife to work only parttime so she could be at home with my mother. My wife likes being at home anyway". Respondents in this sample who continued to work and provide care spoke of the resulting stress as often intolerable.

"The paucity of social services further narrows women's freedom of choice" (Abel, 1986, p. 484). Despite a recent focus on assisting the elderly to remain in the community as long as possible, limited availability of in-home services remains an ongoing problem. As well, widely held beliefs of the supposedly miserable conditions within the "guest home" setting deter many families from considering residential care facilities for elders who require increased support and supervision. These factors, combined with lengthy waiting lists for personal care home beds make a women's choices around whether or not to give care scandalously inadequate. "Thus, many women assume that they have no alternative but to furnish care themselves" (Abel, 1986, p. 485).

These external forces alone, however, cannot entirely explain why women do assume the burden of care for elderly parents.

> Personal explanations of womens willingness to care even for severely impaired patients often focus on the deficiencies of the caregivers. They have been accused of seeking to allay guilt, to

> earn the parental approval that previously had been withheld, or to compensate for failures in the adult realms of love or work. Although such factors may be significant, others may be equally critical (Abel, 1986, p. 485).

Feminist psychoanalytic theories of the women's identity suggests that women feel strongly connected with others. Chodorow (1978), Flax (1978) and Miller (1976) suggest that the women's sense of identity in this society is "affiliational". Expanding on this insight, Gilligan (1982) has suggested that "many women judge themselves according to an ethic of responsibility and care".

When examining the care of elderly parents, it is often a study of the care of mothers by their daughters. The literature documents the rage and ambivilence associated with the mother-daughter relationship but simultaneously notes the centrality of this relationship in the lives of adult women. Authors such as Flax (1978) and Chodorow (1978) also note that issues of separation and independence are problematic for women, particularly in relation to their mothers. Case number 6 highlights this phenomenon with a caregiver feeling so unable to separate herself from her mother that she would come home daily on her lunch hour to be with her. According to Chodorow, women become mothers partly in order to re-create a sense of unity with their own mothers. A similar motivation may well prompt them to care for a mother who is in need".

In caring for their mothers, women may be thrown into intimate contact with the individual they had the most difficulty separating from. Thus, the emotions that may prompt a women to take on a caregiving responsibility also make it an extremely onerous one. For many, caregiving interrupts those activities which help promote a sense of independence and competance in adulthood. As well, the ambivalence of some mothers towards their daughter's independence may aggravate the difficulties of this work.

> But when an adult daughter provides care to her aging mother, the original mother-daughter relationship may not simply be revived; rather, it may be reconstituted. Although caregiving may jeopardize a woman's sense of adulthood, it also can strengthen it (Abel, 1986, p. 487).

Clearly, the experience of caregiving for women is both intensely personal and at times horribly oppressive. It would be wrong to romanticize or downplay the societal expectations placed upon women to assume this kinkeeping responsibility. For caregiving does involve stepping out of one's own personal frame of reference, and entering into another person's reality. Abel (1986) argues that before a woman can care for her parents, she must be able to view them as separate from herself. Further, caregivers must set aside the fantasy that their parents can still protect them. Although development of the caregivers' autonomy and nurturance toward the elder seem counterposed, caregiving can for some lead to maturity and self-development.

While female caregivers do represent the majority of respondents sampled in this practicum, more and more men are also facing the harsh realities of the caregiving role.

CHAPTER FIVE

RECOMMENDATIONS BASED ON THE RESEARCH FINDINGS

This practicum, which studied the phenomenon of caregivers who perceived themselves to be victims of abuse perpetrated by their elder kin, was the first of its kind in Manitoba. The information obtained from the study has important implications for the development of clinical practice, programs and policies regarding caregivers who feel that they are being abused or mistreated by their elderly family members.

While the quantitative results were severely limited due to a small sample size and inherent problems with the methodology, they did suggest some measure of support to the original research questions.

The qualitative results were also suggestive of support for the research hypotheses by providing greater insight into the perceptions of adult caregivers.

When considering the data learned from this study, the following recommendations seem appropriate.

First, it is imperative that attention and recognition be given to the phenomenon of caregiver abuse. It is possible the lack of research, publication and clinical awareness of the phenomenon has left these caregivers feeling isolated and unvalidated in their private struggle. As a result, the possibility of intrafamilial abuse may be increased. If nothing else, there must be recognition of this phenomenon through further expanded research in an effort to greater understand this facet of abuse. As well, increased knowledge and validation of this phenomenon will assist victims, perpetrators, clinicians and program planners in better meeting these individuals needs.

Admittedly, recognition of this phenomenon may be some time down the road. Yet, the results of this study do suggest that there are caregivers who perceive themselves to be in abusive situations at this time. These caregivers have highlighted increased dependence stress relating to elders with physical disability as well as financial dependence. Caregivers also reported increased stress in caring for elders without cognitive impairment, as they perceived the elders abusive actions as deliberate.

Given the existence of this phenomenon as outlined in the research results, it seems timely to call for the development of an initial campaign of education and liaison among caregivers, elders, hospitals and community based home care services. Given the trend toward maintaining the elders' independence in the community as long as possible, both family and professional caregivers must be educated about this phenomenon. Hopefully, increased information regarding this phenomenon can assist institutions and home care in planning more appropirate discharges which will in turn assist the caregiver and elder in reducing the risk factors for caregiver mistreatment through appropriate service provision. Caregivers have clearly stated their need for increased community based service. Education and liaison among these individuals can to some extent alleviate some of the potential risk factors for abuse, while at the same time assisting the caregiver to help maintain the elder in the community as long as possible. Given the fiscal constraints that the provision of continuing care faces, this type of increased service provision is not likely to happen until recognition and collaboration around this phenomenon begin to happen.

In the interim, caregivers who feel abused or mistreated by their elder family members need to have their feelings validated in such a way that there is benefit to both the caregiver and the elder. Support groups may be of benefit in this regard, particularly at this early stage. While support groups do exist for caregivers of cognitively impaired elders through agencies such as the Alzheimers Society, there is no formalized body providing an equivalent service to caregivers of cognitively intact elders who perceive that they are victims of abuse. One possible way of introducing this type of contact may be through a group initially led by a professional with some understanding of this phenomenon. Ideally, this type of early contact could evolve into a self-help group whereby caregivers can take control over the process. Members could specifically tailor these self-help groups to meet the needs of both male and female caregivers by providing a forum for special needs to be met. As well, self-help groups could be instrumental in advocating to program and policy planners around the needs of this client group. This concept, while seemingly straight forward, may be quite difficult to organize and maintain. Attempts at organizing this type of informal network are likely best done through a community based agency already involved and knowledgeable about more traditional caregiving issues.

Further research on this topic is necessary to substantiate the results of this project. Both time and resource limitations had an effect on the sample. Given a longer time frame with which to work and a larger sample, the results would have been strengthened. Despite these factors, the study was a useful pilot project which may provide a basis from which to frame a similar study conducted over a longer period with a larger sample size. As well, the study aided the researcher in meeting both the professional and educational goals set out at the beginning of the practicum.

CHAPTER SIX

EVALUATION AND CONCLUSION

EVALUATION OF THE PRACTICUM PROCESS

The learning objectives that this writer hoped to achieve through the practicum process were two-fold. The first goal was to gain experience in conducting a social research project. The second aim was to expand my knowledge and understanding of intrafamilial abuse, particularly as it related to perceived caregiver abuse. Both were achieved through the practicum process.

Given that the practicum was to be a small scale replication of a previous study (Stein, 1989), this writer assumed that the initial planning stages would flow quite smoothly. Only in retrospect did this writer appreciate the value of conceiving an independent idea for research, rather than replicating another researcher's study. While recognizing the validity and necessity of replicating research studies, this writer did find the task to be both exciting and frustrating.

The opportunity to replicate Stein's project was truly an exciting opportunity, particularly due to the fact that it was research being done in a largely untapped area. However, the "uniqueness" of the project, very limited literature available on the topic, and limited access to the original researcher made the replication process somewhat more difficult. This writer found the most limiting factor to be the sense of a "lack of ownership" over the ideas being considered for replication. Due to limited success in contacting the original researcher, it was at times difficult to rationalize the use of particular questions or steps taken in the original work.

Despite these difficulties, this writer did gain valuable experience in the area of research replication. Through the process, the writer felt more confident and able to critically analyze the research project, and to make recommendations about how the study might be handled differently for future examination. For example, the structured questionnaire used on the study seemed at times not to adequately reflect the feelings of caregivers. Many respondents felt forced to choose a response while acknowledging that it did not truly reflect their situation. To this end, the writer would recommend that the structured questionnaire be used only as a guideline, or reworked to incorporate more appropriate response catagories. The writer would recommend that a larger sample be gathered in order to achieve greater statistical significance, should another researcher use quantitative data gathering techniques. It is this writer's belief, however, that this kind of research can also be done collecting only qualitative data. As this practicum has revealed, the qualitative data provided rich information about the research questions. It is possible that an open-ended approach to studying perceived caregiver abuse, on a larger scale, may reveal even more significant trends.

This writer is grateful to Dr. Stein for allowing her work to be replicated, and in turn, allowing this writer to achieve the goal of gaining experience conducting social research. Hopefully, the experience will be of benefit to the Social Work profession as the writer is now more confident and willing to undertake involvement in future research activities.

Interviews with research subjects proved to be a larger task than was originally expected, which again was a learning experience for the writer. Although the actual interviews were kept as brief as possible, considerable time was spent with each subject. As well, the intensely emotional nature of many of the interviews did prove to be somewhat taxing for both the researcher and subject. Through these struggles, the researcher gained a stronger appreciation of the dynamics around meeting people "on their own turf". Meeting research subjects either in their own home or in the venue of their choice seemed to give respondents a needed element of control in what for many was a difficult emotional experience. As well, it was quickly discovered that the structured questionnaire was an ineffective way to conduct these interviews, Responses were much richer using a more open-ended discussion technique. In the final analysis, the open-ended discussion seemed more comfortable and understandable for the respondents and resulted in more meaningful and indepth responses.

The interviews with respondents were central to assisting the writer in achieving the second goal of expanding the writer's knowledge and understanding of intrafamilial abuse and its relationship to perceived caregiver abuse. The sharing of experiences, thoughts and feelings between the respondents and the researcher provided important and new perspectives around this phenomenon. All of the respondents were found to be open and honest and provided meaningful contributions. This information will hopefully assist in the development of a greater understanding and practice at the clinical level. As well, the information and insight gained through the research adds to the body of knowledge in the field of aging and makes a contribution in an area where little research has been done.

Considerable time was also spent on activities such as contacting media personnel to co-ordinate and follow-up on advertisements, as well as meeting with social workers to discuss the project and gain their co-operation to provide the research information to potential subjects. As a result of this process, as well as the lengthy interviews with respondents, the time factor is more fully recognized by the writer as being important for anticipating the resources required for a study of this nature. The importance of maintaining positive media and professional contacts was essential for accessibility to required information, and for continued assistance and interest in the project. All of the individuals contacted as a result of the project were exceptionally co-operative and truly made the research run more smoothly. There seemed to be a genuine interest in the research topic by this group.

In the final analysis, the practicum experience allowed this writer to achieve goals which had both personal and professional value. On a personal level it helped the writer to achieve a desired academic goal. On a professional level, it helped the writer to achieve a better understanding of caregivers who perceive that they are being abused by their elder kin. This knowledge will also assist the writer on a clinical as well as program/policy development level in making recommendations which truly reflect the needs of this population.

CONCLUSION

This practicum considered the phenomenon of caregivers who perceive themselves to be victims of abuse perpetrated by their elder kin. The study utilized a social needs assessment approach and focused on the issues of dependence stress for adult caregivers. The design proposed and discussed was the most appropriate given the desired level of knowledge and generalizability as well as the resource and time limitations inherent to the study. The results of the study provided a rich profile of this population as well as their needs.

Recommendations for program and policy planning have been made.

The most significant findings of the practicum were reflected in the qualitative interviews with respondents. Several themes emerged that included: a lack of articulation by caregivers that they were actually being abuse, a sense that caregivers felt isolated and strained in their relationships with spouses due to the caregiving role, general dissatisfaction with the home care system, guilty feelings at the time of placement in a personal care home, and finally the issue of caregiving as women's work. Although the research did yield some quantitative results, the validity of the findings were questionable due to the limited sample size.

The research findings suggested a number of implications and recommendations. These included:

1. A call for the recognition and validation of the phenomenon of perceived caregiver abuse through continued research and clincial awareness.
2. Greater networking and liaison between caregivers, institutions and home care in an effort to better service both caregivers and their elder kin.

3. The emergence of community based support groups. Initially, these groups may be led by professionals with clinical knowledge in the area. Ideally, the groups would evolve into self-help groups whereby the caregivers take control over the process. Self-help groups may have tremendous impact both on the level of assisting individual caregivers, but also in advocating to program and policy planners as to the needs of this client group.

4. Individual counselling for caregivers find it difficult to attend or participate in the group process.

My own learning goals including gaining experience in conducting a research project and to better understand the phenomenon of perceived caregiver abuse. The research experience was invaluable and new knowledge was gained from every facet of the study.

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CORRESPONDENT'S PHONE
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January 6, 1990

Ellen Tabisz, Coordinator
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Dear Ellen:

I apologize for the delay in sending you these materials. We are moving into a new building and had already packed many of the materials and files I needed. I only just found the questionnaire! I hope this has not inconvenienced you very much.

I am sending you: 1) The text of the Congress paper that gives more detail about the sample and sample selection, variables and results; 2) selected pages of the questionnaire from which the variables used in the data analysis were obtained; 3) an example of the announcements that were used to help obtain the sample; and 4) the SAS data statement that was used to obtain the study results, and shows how the variables were manipulated.

I have written the names of the variables (as entered into the multiple regression equation) on the questionnaire. Using this as a guide may help you to decipher the data statement. I have highlighted the variables and statements that were used in this analysis. It may help to view these with Table 2 found on p. 11 of the Congress paper.

Although the sampling technique is briefly described on pages 2-3 of the paper, there is additional information that may be of interest to you. Most interviews were conducted in a "neutral" area such as a restaurant or office, as many caregivers did not want the elder to know that she (and sometimes he) was participating in such a study. The interviews themselves were very time consuming. As briefly noted, the interviewers were instructed to engage the caregiver in conversation that would reveal information pertaining to the survey instrument, rather than being asked direct questions on many topics. Based on this conversation, the interviewer would check the response felt to be most accurate.

For example, rather than asking the respondent if it never, hardly ever, sometimes, usually, or always bothered the caregiver that the elder was financially dependent on the family, they would talk about the household financial arrangements. Based on the conversation, the interviewer would decide whether financial dependency was stressful to the caregiver and mark an appropriate response. The tape of the conversation was then given to two others on the grant support staff who were not present at the interview. While listening to the tape, they would also check what they felt would be the appropriate response on the survey instrument. This was a double-check on the interviewer's accuracy; in almost all cases, there was a high degree of agreement.

Unfortunately (or fortunately, if one wants to be the first), there is almost nothing in the literature that deals with elders' abusive behaviors toward their family caregivers (see pages one and seven of the paper). A few researchers, notable Karl Pillemer, have done some work indicating a relationship between abuse and financial dependency of the abuser. Pillemer's most recent work indicates that abuse is most directly related to pathological characteristics of the abuser rather than to abuser stress or dependency (I have still not located the particular box in which I filed that paper, but I only have a few more boxes to go--I will send you a copy when I find it). In both cases, the abuser was the caregiver. However, it is possible that similar logic exists when the abuser is the elder.

I would like to repeat that Suzanne Steinmetz designed the study from which this data was taken (see the footnote on page 2 of the paper). The purpose of the study was to examine family dynamics in caregiver families and to investigate the possible causes of caregiver stress and caregiver abuse of the elderly. I was a close working colleague of Dr. Steinmetz before she left the University; she gave me the use of the data for my own analytical purposes and shared the sampling and interviewing techniques used in the original study.

I think that elders' abusive behaviors and the resultant implications for caregiver stress and possible retaliatory abuse is a unique topic. I would very much like to see this topic further explored in Winnipeg, and to serve as a co-investigator. Although I understand you are interested in a replication, I've often thought that better insights might be obtained through the use of additional questions aimed more directly than was possible with the use of Dr. Steinmetz's data. However you choose to conduct your project, I am very willing to give you any assistance you may require.

I hope this is the information you need to get started. Please do not hesitate to call ( ) if you need something else at this point. Best wishes for success in getting this project off the ground.

Sincerely,

Karen F. Stein, Ph.D.
Associate Professor and Director
Clearinghouse on Abuse and Neglect of the Elderly

Appendix 2

CONSENT FORM

This consent form pertains to a city-wide study of families in which an elderly parent lives with a "middle-aged" child.

Information is being sought regarding the rewards and problems of such arrangements and the kinds of services which might help these families.

All identifying information collected in this study will be kept **strictly confidential**, and will not be used in any report of the research findings.

In signing this consent form, I willingly volunteer to participate in Cheryl Bokhaut's 1990 study on dependency stress and retain my right to withdraw without prejudice.

NAME ______________________________

DATE ______________________________

Appendix 3
BASIC DATA FORM

Background Data on the Elderly

A. Age ______
B. Sex ______ (Code 1=Male; Code 2=Female)
C. Relationship to you ______________________________

01 Mother
02 Father
03 Mother-in-law
04 Father-in-law
05 Stepmother
06 Stepfather
07 Aunt
08 Uncle
09 Brother
10 Sister
11 Grandmother
12 Grandfather
13 Great Aunt
14 Great Uncle
15 Other-specify

D. How long has (had) this person lived with you? (converted to months) ______________________________

E. Where did the relative live before moving into your place?
____

F. If relative no longer lives with family, where are they living now?
____

Health Status

A. Has the doctor identified any serious medical problems?

Diabetes ______
Heart Attacks ______
Cancer ______
Alzheimers ______
Strokes ______
Arthritis ______
Other ________________

B. Has your relative been hospitalized in the past year?

Yes_____ No_____

C. Has your relative experienced any problems with diminished physicial functioning?

Yes_____ No_____

If yes, what? ______________________________________

Background on Caregiver

Age ______ Sex ______
Employed while caregiving Yes_____ No_____
One or more additional family members in home during caregiving role? Yes_____ No_____

Appendix 4
RESOLVING PROBLEMS

Card A

I am going to read a list of time which describe methods often used when elderly people refuse to follow doctors or caretakers directions. When you have experienced this problem which of these have you used. Please refer to Card A and give me the number which best describes how often you used this method. (Ask respondent to turn back to Card A)

____ a. talked out
____ b. screamed and yelled
____ c. used physical restraint (i.e., tie in a chair
____ d. forced feeing
____ e. withheld food
____ f. threatened to send to a nursing home
____ g. threatened with physical force
____ h. confined to a room
____ i. hit or slapped to get them to mind
____ j. given medication
____ k. sought the advice of a third party
____ l. found alternative housing (nursing home, other relative)

(When your parent lives (lived) with you....) How often does (did) your parent attempt to do each of the following to maintain control?

____ a. screamed and yelled
____ b. Pout, withdrew to their room
____ e. manipulate family members
____ f. cry (not used)
____ g. hit, slap or throw
____ h. use their physical/ emotional disability to gain control
____ c. refused to eat/spit out food
____ d. refused/spit out medication; refused medical treatment
____ i. calls police or other help for imagined threats (being held captive, money taken, someone after them)
____ j. imposes guilt/act the role of martyr
____ k. doesn't respect privacy/opinion of other family members
____ l. other (please explain)

***Stress**

Card B

Many people find it difficult to provide these extra services for an elderly person because of other family obligations which take time, emotional energy and money. How often do you find it difficult to provide help in each of these areas? Please refer to Card B and give me the number <u>which best describes</u> the <u>amount of conflict or stress produced</u> by taking on these additional responsibilities.

Hand Respondent Card B

____ a. elder financially dependent on family

____ b. elder needs help with personal care

____ c. elder has severe emotional/mental disability

____ g. elder has special needs

____ h. elder is lonely

____ i. elder makes excessive demands (nagging, complains wants a lot of attention)

____ j. household management, cleaning, cooking, running errands

____ d. elder has severe physical disability

____ e. elder is mobile but senile

____ f. elder won't eat

____ k. elder needs transportation

____ l. lack of sufficient room in the house/ privacy

____ m. other (please explain)

Resources (Hand Respondent Card C)

Do you have a relative or relatives who help with the care of your elder?

Yes____ No____

____ no relatives

____ live too far (probe)

____ not close to relative (probe)

____ lost contact (probe)

____ have own serious problems (specify)

I am going to read a list of the kinds of resources that you may have used to help with the care of your relative. Respond either yes or no. If the answer is no, please tell me why by referring to Card. (Give respondent Card D).

<u>Direct Action:</u>

____ a. arranged for in home service

____ b. sought social agency help

____ c. elder was counselled

____ d. family was counselled

____ e. sought help from other family members

____ f. elder placed in institution

____ g. other (please specify)

<u>Emergency Action:</u>

____ a. mecial treatment or hospitalization

____ b. elder sent or placed elsewhere (specify)

____ c. police called in

Card A*

0 Never
1 Almost Never
2 Sometimes
3 Most of the Time
4 All of the Time

Card C

0 No Help
1 Very Little Help
2 Some Help
3 Quite a Bit of Help
4 Always Helps

Card B*

0 Never Bothers Me
1 Hardly Ever Bothers Me
2 Sometimes Bothers Me
3 Usually Bothers Me
4 Bothers Me All The Time

Card D

0 If your answer is no, the reason is because
3 not aware of them
4 not available
5 relative not eligible
6 other family members disagreed with this idea
7 was not necessary
8 other (please specify)

Appendix 5

HELP!

VOLUNTEERS ARE NEEDED

I am conducting a city-wide study of families in which an elderly parent lives with a "middle-aged" child.

I am interested in the rewards and problems of such arrangements and the kinds of services which might help these families.

If you have experienced this kind of family arrangement or know of someone in this situation, we would greatly appreciate hearing from you.

All information is strictly confidential.

Please contact:

Elder Project -

Appendix 6
PROFESSIONAL CONTACTS

News Media

CKND - Public Service Announcements

VPW - Videon Public Access Television

Seniors Today Newspaper

Winnipeg Free Press - Growing Older

Agencies

Age and Opportunity Centre
Alzheimers Society
Elder Abuse Resource Centre
Fort Garry Resource Centre
River Heights Resource Centre
Rupertsland Respite Centre

*Special thanks to all of the Social Workers in the various agencies and institutions who also assisted in distributing information about the research project to their clients and families.

Appendix 7

Synopsis of the Case Scenarios

Case 1

Mrs. B. is a 59 year old caregiver who had been managing her 80 year old father in her home for approximately 25 years. At the time of the interview the elder had already been placed in a personal care home.

Mrs. B. revealed deep feelings of stress and isolation from her spouse and family around her caregiving experience. Defining herself as a "born" caregiver, Mrs. B. stated that she gave so much of herself to her father and her own family, that she lost sight of who she really was. Unhappy that her family could not sense that she was "drowning" in the caregiving role, Mrs. B. states that she began to isolate herself from her significant others. At the time of the research interview, Mrs. B. defined herself as depressed and in need of professional assistance. This was the only research subject to be seen twice, with the second visit used as a time to share referral information with the caregiver.

Case 2

Mr. L age 50, provided care to his 73 year old demented father for approximately 4 years. At the time of the interview Mr. L's father had just been placed in a long term care facility.

Mr. L. presented as bitter and hostile when he related his caregiving experiences. He recounted an abusive upbringing from his parents, but particularly from his father. Estranged for many years, Mr. L. (who lived with his 3 brothers) agreed to take his father in only until alternative accommodations could be found.

Four years later Mr. L. found himself caring for a father who was slowly dementing, and lacking in insight. Unable to convince his siblings that their father needed more care, Mr. L. began to assist the elder with bathing, dressing, meal preparation and banking. All the while, Mr. L. reported feeling tremendous resentment toward his father, but locked into a situation he could not change. Mr. L. reported significant verbal abuse during his caregiving role from all parties involved in the experience.

Case 3

Mr. W. is a 52 year old who has been providing care for his 76 year old demented mother for approximately 10 months. Widowed 7 months ago Mr. W. states that he has been struggling with a caregiving role that was previously assumed by his wife. Still grieving the loss of his wife, Mr. W. states that he has recently began to resent his mother's physical and emotional dependence on him. Feeling the need to "escape" his home situation, Mr. W. has requested increased home care services to benefit his mother and to relieve himself.

Mr. W. states that home care services have not been increased to his satisfaction, and as a result he is frustrated and unhappy even with the services his mother is receiving. Mr. W. states that he feels overwhelmed with his caregiving situation and lacking in the necessary skills to help him cope more successfully. Mr. W. rejected information offered after the research interview on caregiver support groups, as well as grief support.

Case 4

Mrs. L. is a 54 year old providing care to her 76 year old demented mother for approximately 10 months. In this case, Mrs. L. found herself caring for her mother after she was discharged from a hospital on the East Coast. Working part time, Mrs. L. was unsure about managing her mother in Winnipeg, but felt that as an only child this was her responsibility to assume.

Feeling that her husband was unhappy with her decision to take in the elder, Mrs. L. states that he began to withdraw from her both physically and emotionally. As well, Mr. L. refused to provide his mother-in-law with any hands on assistance.

Mrs. L. describes her caregiving experience as being endlessly torn between work, her husband and her mother. Only being serviced by home care during her work hours, Mrs. L. also felt she could not depend on the community to support her struggle. Recognizing that she is having difficulty supporting her mother at home (even with some home care help) and maintaining her marriage, Mrs. L. states that she is building anger and resentment towards her mother. Mrs. L. also states that she feels very ambivalent about the future.

Case 5

Mrs. D. is a 68 year old providing care to her 88 year old mother-in-law for the past 14 months. This caregiver revealed a very difficult situation wherein she provides care to her well functioning mother-in-law and retired alcoholic husband.

Mrs. D. stated that her husband's violent alcoholic outbursts are related to what he feels is her neglectful treatment of his mother. However, the caregiver feels that the mother-in-law is functional enough to live independently and does not require her constant care. Sadly, Mrs. D. hoped that by taking in her mother-in-law it would somehow lessen her husband's drinking and abusive behaviour. Feeling vulnerable and isolated, Mrs. D. now finds herself in a caregiving situation with expectations that can never truly be met in the eyes of her spouse.

Case 6

Mrs. B. is a 54 year old caring for her 72 year old slowly dementing mother for approximately 10 months. This caregiver's main concern involved what she believed was her mothers attempts to manipulate and make her feel guilty. Feeling unable to challenge her mother, Mrs. B. states that she gives in to the elders excessive demands for attention and recognition. Feeling that other family members in the home are better able to distance themselves from the elder, Mrs. B. says that she tends to compensate for what the care-recipient perceives as a lack of attention.

Quite tearful in relating her story, Mrs. B. seemed to feel a lack of understanding from both her husband and children around her inability to separate herself from her mother. In fact, Mrs. B. relates that her family continually tease her about her need to return home to see her mother during her lunch break from work, despite the presence of home care help.

Case 7

Mr. K., age 67, had been providing care for his 85 year old demented mother for 4 years. At the time of the interview the elder had already been placed in a personal care home.

Mr. K. related his caregiving experience as particularly stressful due to his mothers progressive cognitive deterioration. When discussing the difficulties of her daily management, Mr. K. related that his wife probably felt greater stress as she generally cared for his mother. Mr. K. shared that he had convinced his wife to work only part-time so she could be at home with his mother. He did not feel that this was too much to ask of his wife as he felt that she basically enjoyed being at home. Mrs. K. was not home at the time of the interview.

Case 8

Mrs. C. age 60, has been providing care to her 81 year old mother for the past 16 months. Suffering from severe arthritis, Mrs. C. states that it is becoming increasingly more difficult to care for her mother who had a stroke within the past year. Heavily dependent on home care as well as extended family support, Mrs. C. states that it is still not enough. She expressed significant hostility toward her "well" siblings for not assuming part of the burden of her mother's care (Mrs. C. has 3 brothers and 1 sister in Winnipeg). This caregiver also felt frustrated with home care around both the hours of care her mother was receiving as well as the length of time it was taking for the elder to be placed. At the time of the interview the elder has been panelled for only 4 months.

Case 9

Mrs. L., age 65, has been providing care for her 85 year old demented mother-in-law for approximately 4 months.

As highlighted in the text, Mrs. L. felt great frustration toward home care for only providing services during the hours that she worked. Mrs. L. felt misunderstood by the system, and resentful for the lack of time she had to herself. Despite understanding her mother-in-laws cognitive deterioration, Mrs. L. stated that she felt anger towards the elder for needing so much care.

Case 10

Mr. L., age 50 and single, has been providing care to his 67 year old mother for approximately 5 years. In his caregiving role, Mr. L. has assumed responsibility (while working full-time) for both his mothers physical and emotional care. Suffering from a long history of depression, alcohol abuse and cancer, the elder has significant daily care needs.

Mr. L. reports that he has refused any offer of home care help, as he feels that his mother would be negatively affected by strangers coming into the home. Feeling greatly burdened by her care needs, yet convinced that outside help is not the answer, Mr. L. finds himself in a self-described depressive state. Unable to distance himself from his mother (she goes on his daily work deliveries with him) he feels lonely, isolated and unfulfilled. Mr. L. does have one sister who he reports is also alcoholic and uninvolved with his mothers care.

Case 11

Mrs. R., age 61, has been providing care to her 84 year old father for approximately three years.

Mrs. R's caregiving experience seemed to reflect some negative as well as positive aspects. For example, Mrs. R. expressed stress around her fathers gradual deterioration over the past few years. She tearfully related anecdotes of her fathers previous personality and compared it to his present limitations.

On a more positive note, this respondent shared some positive feels relating to the support she receives from her spouse and children around her caregiving role. This caregiver stated that she was comfortable in her caregiving role and would try to maintain her father at home as long as possible.

Case 12

Mrs. S., age 61, had been caring for her 83 year old father for approximately 7 years. At the time of the interview the elder had already been placed in a personal care home.

This caregivers main stressors seemed to involve perceived expectations of being "supermom" to her spouse, one adult child living at home with a degenerative muscular disorder and her father. While feeling verbal support for her spouse, Mrs. S. spoke of her endless days caring for others with no physical help from her mate. She did, however, feel some relief from the home care help her father received in the form of attendants, and a day program.

Case 13

Ms. R., age 68, has been caring for her 90 year old demented mother for the past 12 years. Ms. R. also lives with her 73 year old sister. Both of these caregivers were never married and had always shared a residence.

Ms. R. maintained a strong supportive stance regarding her caregiving role. While at times acknowledging that it can be stressful, Ms. R. felt supported by her sister in caring for their mother. Despite a description of limited outside interests or activities, this caregiver steadfastly maintained no strong concerns around providing active physical care to her mother.

Case 14

Mrs. D., age 54, had managed her 80 year old father at home for approximately 3 years. The elder had already been placed in a long term facility at the time of the research interview.

As outlined in the text, Mrs. D's stressors centred around her inability to accept her father's progressive cognitive deterioration. Further, she expressed strong feelings of guilt around his placement. Believing that she could always care for her father, Mrs. D. promised him she would never place him in a personal care home. However, when the elder became violent, Mrs. D. could no longer safely manage him at home. Not surprisingly, the decision to place her father was fraught with guilt and confusion.

Case 15

Ms. M., age 55, has been managing her 73 year old demented mother for approximately 25 years.

This interview was quite brief as the caregiver presented with what seemed to be mild cognitive limitations as well. What she did share was that 3 siblings lived in the family home (duplex), but that she provided physical care and supervision to her mother. No home care support was going into the situation to assist with the elders behavioral management. The researcher was unable to ascertain what other family support this caregiver received.

Case 16

Mrs. C., age 57, has been caregiving to her 79 year old father-in-law for 7 months. The elder was discharged from hospital to their home after he suffered a moderate stroke with some recovery.

Mrs. C. tearfully related that she felt uninvolved in the decision to take the elder into her home. She reports that her husband made the decision unilaterally and assumed she would provide care to the elder when she was not working.

This caregiver expressed great resentment in having this "burden" placed on her. She states that caring for her father-in-law is particularly stressful due to the fact that she never got along well with him in the past. Despite her feelings, Mrs. C. states that her husband expects her to continue in this role as long as necessary. Mrs. C. is unsure as to how she will continue to cope.

<u>Case 17</u>

Mrs. D., age 54, has been caregiving to her 72 year old father-in-law for 4 years.

Still working full-time, Mrs. D. relies on daily home care to assist with his toileting, medications and supervision. While relating the stressors involved with having to care for her dependent father-in-law Mrs. D. seemed to distance herself from him emotionally. She reported feeling no strong emotions toward the elder, and thus was able to care for him in an unemotional fashion.

Mrs. D. did receive help from her husband and children on a daily basis.

<u>Case 18</u>

Mrs. S., age 50, provided care to her 70 year old demented mother-in-law for 8 years. The elder had already been placed in a personal care home at the time of the interview.

Mrs. S. reported assuming total responsibility for her mothers care. She stated that her husband "expected" her to take on this role due to familial obligation. As well, Mrs. S. sensed that her husband did not view the caregiving role as too onerous since she was not employed outside the home.

Mrs. S. clearly articulated feelings of resentment in having to care for an elder who was not her parent. Sadly, she felt she could not share her feelings with her husband around this issue. Mrs. S. stated that she became so isolated and burdened that she eventually had to seek psychiatric assistance.

Case 19

Mrs. Y., age 65, has been caring for her 87 year old dementing step-mother for the past 11 months. Expressing a life long commitment to her stepmother, Mrs. Y. sees her caregiving role as both obligatory and willingly done.

Retired only 2 months at the time of the interview, Mrs. Y. states that full-time caregiving is a greater task that she had imagined. However, she expressed very strong love for her stepmother, since her childhood, and saw caregiving as an opportunity to "say thank-you". Mrs. Y. related receiving some emotional support from her husband, but no physical help with the care of her step-mother. Mrs. Y. stated that she understood why her husband would be uncomfortable helping with the elder, and that "it was really her responsibility anyway".

Case 20

Mr. B. age 50, has been providing care to his 66 year old mother for 3 1/2 years.

As outlined in the text, this elder came to live with her son from another province, after managing poorly in her apartment. The elders decreased ability to cope was resulting from her extensive abuse of alcohol and prescription medications.

Mr. B. described his mother's behaviour as manipulative, deceptive and destructive. This caregiver related a hostile fantasy of tying his mother to a chair, locking her outside, and waiting for her to be "taken away". Mr. B. also expressed strong resentment toward the health care system for their inability to "help her quit drinking and pill-taking", or to place her in an appropriate facility.

Table 1
Demographic Characteristics of the Caregivers

Characteristic	**Frequency**
Sex	
Male	5 (25%)
Female	15 (75%)
Age	
50-55	10 (50%)
57-61	5 (25%)
62-70	5 (25%)
Employment During Caregiving	
Employed	18 (90%)
Unemployed	2 (10%)
Relationship to Care-Recipient	
Father (4 daughters; 1 son)	5 (25%)
Mother (5 daughters; 4 sons)	9 (45%)
Father-in-law (2 daughter in laws)	2 (10%)
Mother-in-law (3 daughter in laws)	3 (15%)
Step-mother (1 step daughter)	1 (5%)

Table 2
Demographic Characteristics of the Care Recipients

Characteristic	**Frequency**
Sex	
Male	7 (35%)
Female	13 (65%)
Age	
66-72 years	5 (25%)
73-83 years	9 (45%)
84-90 years	6 (30%)
Months of Receiving Care	
4-11 months	6 (30%)
14-48 months	8 (40%)
60-300 months	6 (30%)
Previous Living Arrangements	
Independent	15 (75%)
Other	5 (25%)

Table 3
Reported Health Problems of the Care Recipient

Illness	**Male**	**Female**	**Total**
Diabetes	3	2	5 (25%)
Heart Attack	1	0	1 (5%)
Cancer	1	3	4 (20%)
Alzheimers	1	9	10 (50%)
Stroke	4	1	5 (25%)
Arthritis	3	2	5 (25%)
Other	4	2	6 (30%)

Table 4
Quantitative Test Results Crosstabulations

Dependent Variable	by	Independent Variable	Significance at .05
Dep Emotional		Financial Dependence	.3240
Dep Emotional		Personal Help	.4284
Dep Emotional		Household Management	.6316
Dep Emotional		Physical Disability	.3271
Dep Emotional		Emotional Disability	.5035
Dep Refusal		Financial Dependence	.9038
Dep Refusal		Personal help	.0854
Dep Refusal		Household Management	.4491
Dep Refusal		Physical Disability	.3908
Dep Refusal		Emotional Disability	.7241
Hit/Slap/Throw		Financial Dependence	.2071
Hit/Slap/Throw		Personal Help	.2898
Hit/Slap/Throw		Household Management	.6377
Hit/Slap/Throw		Physical Disability	.4753
Hit/Slap/Throw		Emotional Disability	.4214
Use Dis. for Control		Financial Dependence	.7102
Use Dis. for Control		Personal Help	.4362
Use Dis. for Control		Household Management	.3497
Use Dis. for Control		Physical Disability	.0466*
Use Dis. for Control		Emotional Disability	.1182
Impose Guilt		Financial Dependence	.5903
Impose Guilt		Personal Help	.0760
Impose Guilt		Household Management	.6339
Impose Guilt		Physical Disability	.0095*
Impose Guilt		Emotional Disability	.4078
Dep Interference		Financial Dependence	.0486*
Dep Interference		Personal Help	.5188
Dep Interference		Household Management	.5346
Dep Interference		Physical Disability	.5140
Dep Interference		Emotional Disability	.7663

Table 5
Quantitative Test Results Crosstabulations

Dependent Variable	**by**	**Demographics**	**Significance at .05**
Dep Emotional		Respondent Sex	.5535
Dep Emotional		Elder Age	.2473
Dep Emotional		Elder Gender	.2945
Dep Emotional		Months of Residence	.0608
Dep Refusal		Respondent Sex	.7113
Dep Refusal		Elder Age	.6457
Dep Refusal		Elder Gender	.1729
Dep Refusal		Months of Residence	.5184
Hit/Slap/Throw		Respondent Sex	.1085
Hit/Slap/Throw		Elder Age	.4685
Hit/Slap/Throw		Elder Gender	.3300
Hit/Slap/Throw		Months of REsidence	.6706
Use Dis. for Control		Respondent Sex	.1328
Use Dis. for Control		Elder Age	.3571
Use Dis. for Control		Elder Gender	.1167
Use Dis. for Control		Months of Residence	.1996
Impose Guilt		Respondent Sex	.1801
Impose Guilt		Elder Age	.6013
Impose Guilt		Elder Gender	.0857
Impose Guilt		Months of Residence	.2017
Dep Interference		Respondent Sex	.1334
Dep Interference		Elder Age	.3490
Dep Interference		Elder Gender	.0594
Dep Interference		Months of Resident	.2703

Table 6
Quantitative Test Results Crosstabulations

Dependent Variable	by	Alzheimers	Significance at .05
Dep Emotional		**Alzheimers**	**.3832**
Dep Refusal		**Alzheimers**	**.3546**
Hit/Slap/Throw		**Alzheimers**	**.1439**
Use Dis. for Control		**Alzheimers**	**.1183**
Impose Guilt		**Alzheimers**	**.1753**
Dep Interference		**Alzheimers**	**.1013**

Independent Variable	by	Alzheimers	Significance at .05
Personal Help		Alzheimers	.2917
Household Management		Alzheimers	.7190
Physical Disability		Alzheimers	.0866
Emotional Disability		Alzheimers	.6444

Table 7
T-Tests

Dependent Variable	**by**	**Alzheimers**	**2-Tail Probability .05**
Dep Emotional		Alzheimers	.039*
Dep Refusal		Alzheimers	.286
Hit/Slap/Throw		Alzheimers	.288
Use Dis. for Control		Alzheimers	.054
Impose Guilt		Alzheimers	.051
Dep Interference		Alzheimers	.010*

Independent Variable	**by**	**Alzheimers**	**2-Tail Probability .05**
Personal Help		Alzheimers	.637
Household Management		Alzheimers	.861
Physical Disability		Alzheimers	.018*
Emotional Disability		Alzheimers	.458

Dependent Variable	**by**	**Respondent Sex**	**2-Tail Probability .05**
Dep Emotional		Respondent Sex	.258
Dep Refusal		Respondent Sex	.664
Hit/Slap/Throw		Respondent Sex	No variance
Use Dis. for Control		Respondent Sex	.202
Impose Guilt		Respondent Sex	.085
Dep Interference		Respondent Sex	.317