he effective management of many of the health needs of older Americans residing in the community largely depends on the care given by their family members. Family caregivers frequently go to great lengths to avoid the institutionalization of an older family member. Clark and Rakowski note that family caregiving tasks tend to fall in four categories: direct care to the older family member; personal tasks, concerns, and difficulties of the caregiver; interpersonal ties with other family members; and interactions with health care and community networks.

The stresses of caring for a physically or mentally impaired older family member are considerable. Frequently, family caregivers must be continually available, not only providing care and treatment but also supervising the older person’s daily activities, managing resources, and coping with the care receiver’s behavior as well as the physical and emotional strain associated with caregiving tasks and running interference with community resources. Many caregivers also have few respite services and consequently little personal time or opportunity to take vacations or to make future plans. Family caregivers thus experience many unmet needs and low morale.

This article will review literature focusing on stress in family caregivers and will propose a relevant model for nursing intervention.

RELATED LITERATURE
The concept of caregiver burden has attracted the attention of both researchers and professionals. Zarit, Reeves, and Bach-Peterson studied correlates of feelings of burden in the caregivers of community-dwelling older persons with senile dementia to identify sources of caregiver burden and develop interventions to reduce the burden. Specifically, this study examined how feelings of burden in the caregivers were affected by the impairments manifested by the dementia patients and by various characteristics of the home care situation.

In interviewing caregivers, a memory and behavior checklist identified the type and frequency of memory and behavior problems exhibited by the impaired older person. The degree of burden was measured with a self-report inventory, Lawton’s (1971) Physical and Instrumental Activity Daily Living (PADL and IADL) scales determined the functional level of the care receiver with dementia.

Surprisingly, in this study, caregiver burden was not significantly related to any of the variables characterizing the severity of the care receiver’s illness, such as duration, memory and behavior problems, and physical and instrumental activities of daily living. The study demonstrated a significant inverse relationship between family visits and caregiver burden (P<0.05, n=29).

An implication is that an intervention program that increases informal social supports may be effective with caregivers reporting excessive feelings of burden. Limitations of this study were the small sample size and caregivers not reporting what could be considered high levels of burden.

Strategies cited as potentially increasing social support included working with the entire natural support network of the care receiver to assist the primary caregiver and initiating group meetings so that caregivers may share concerns, clarify roles and problems, and develop problem-solving and coping skills. Educating care receivers about the illness and community resources may be useful, as well as facilitating the development of self-help groups. Supportive strategies include providing a supportive counseling rela-
STRESS

Nurses Dealing with Family Members

By Kathryn L. Riffle, PhD

Other investigators stressed the use of group work in facilitating the ability of caregivers to cope with the stresses associated with family caregiving. Cohen4 included work on assertiveness, stress management, communication skills, and information about community resources in a 10-week series of group sessions with family caregivers. No attempt was made to formally assess this group through pre-and post-test measures, although the authors noted that the participants commented positively on the experience.

Hausman5 worked with adults who needed assistance in making important decisions that were comfortable for their parents, their nuclear families, and themselves. He solicited participants, who met for eight sessions of 1.5 hours each, through newspaper notices and letters sent to physicians and service agencies. Group goals were to strike a balance between responsibilities to one's parents, nuclear family, and oneself; make decisions about the extent of one's obligations to the parents; and learn to interact maturely with parents, leaving behind childhood conflicts.

Common issues raised related to the lack of preparation for the caregiving role; the anticipated burden when middle-aged caregiving children were expecting more freedom; fears of aging and death; sibling relationships and resentment toward siblings not perceived as bearing their share of the burden; self-centered behavior of older parents; and problems communicating with relatives and health personnel.

In a post-group evaluation, benefits cited by participants included sharing with others who had similar concerns; evaluating and changing attitudes and beliefs; learning about aging, both personally and in caring for parents; and learning to be more in touch with parents' feelings.

Zarit and Zarit6 suggested that intervention programs to support family members caring for dementia patients in the home have both an assessment and a treatment phase, with the treatment phase including information, problem solving, and support. Such a treatment program would consist of individual counseling, family meetings, and a support group, singly or in combination.

They further noted that assessment skills are crucial in working with the elderly; for example, dementia-like symptoms can be caused by a number of physical problems. They suggested that family caregivers be seen individually before joining support groups since some caregivers are under considerable stress and an individualized counseling strategy may provide immediate relief. These investigators further suggested that support groups for elderly be professionally led since the group process can be non-therapeutic without informed leadership.

Zarit, Todd, and Zarit7 reported a two-year follow-up of 64 men and women caring for spouses to identify factors affecting the course of caregiv-
It is important for nurses to assess the type of care being rendered by the family; a discrepancy in priorities may lead to the nurse being perceived as an adversary rather than an advocate.

was the sum of the cross product of frequency and tolerance ratings for each of the 28 items.

Longitudinal analysis from the 1986 study suggested that the caregivers' ability to tolerate problem behaviors actually increased as the disease progressed, since at the two-year follow-up the cross product scores were lower. Many caregivers explained their responses by noting that they stopped letting the problems bother them and that they had learned to manage problems more effectively. Families in these studies received a low level of both formal and informal support. At the two-year follow-up, the differences in subjective burden between men and women at time 1 (caregiving men reported less burden than women) was not apparent. The researchers suggested that the women changed their coping style, perhaps adopting the more instrumental approach evidenced initially by the men along with a greater tolerance of behavior and memory problems.

Poulshock and Deimling analyzed the concept of caregiving burden from a multidimensional perspective that conceptualizes burden as a mediating force, a subjective filter between the impairment of elders and the impact that caregiving has on the lives of caregivers and their families. The purposive sample of families was stratified into three categories: geographical (40% urban, 40% suburban, 20% rural); racial (25% black, 75% white); and generational (50% one-, 30% two-, and 20% three-generation households). Each household included an impaired elderly relative receiving care assistance from a primary caregiver in the household. The feelings of burden reported by caregivers were linked to the impairment as well as to alteration in objective conditions within the family.

Baines reported that providing diversional and recreational activities for the impaired family member was a major need whereas providing respite services for family caregivers was a corollary need.

Bowers, using a grounded theory approach in studying middle-aged women caring for their aged parents, conducted interviews with 27 parents and 33 of their offspring. Early research questions focused on how one becomes a caregiver, stresses of caregiving, and the experience of caring for an older parent. Later questions focused on the consequences of failed caregiving and strategies for invisible caregiving.

Data analysis revealed five conceptually distinct categories:
- Anticipatory caregiving, where the anticipated needs of parents influence behaviors and decisions, commonly observed when the parent and child were not living together;
- Preventive caregiving, involving more active monitoring than anticipatory caregiving, with activities directed toward preventing injury and physical and mental deterioration;
- Supervisory caregiving, where children are actively involved in monitoring the parent;
- Instrumental caregiving, typically reflecting "hands on" caregiving activities;
- Protective caregiving, focusing around the protection of the parent from threats resulting from inevitable aging changes.

The author comments on the value of nurses assessing the type of caregiving a family member is rendering since a discrepancy in the priorities of the caregiver and nurse may lead to the nurse being perceived as an adversary rather than an advocate.

A number of investigators have examined the unmet needs of family caregivers and the negative impact of such needs on the health and psychosocial well-being of caregivers. Haley et al compared psychosocial and health outcomes for a group of family caregivers of senile dementia patients and matched controls. Caregivers reported significantly more depression, lower life satisfaction, more chronic health problems, more use of prescription medications, and more recent physician visits than did controls. Although objectively controls and caregivers were similar in the number of friends, close relationships, and network contacts, caregivers reported more dissatisfaction with the adequacy of their support network, presumably because of greater need. Significantly fewer caregivers had recent or planned vacations.

Snyder and Keefer examined the health and social needs of disabled, frail adults, primarily those with Alzheimer's disease, multiple sclerosis, and strokes. A self-report measure was used for data collection. A level of disability scale, constructed from the questionnaire, revealed that multiple sclerosis patients had the highest level of disability, followed by Alzheimer's disease and stroke. A statistically significant relationship ($R = .13, P < .10$) was found between the level of disability and the presence of caregiver health problems. Additionally, the longer caregivers had been involved in caregiving, the more likely they would report health problems ($R = .13, P < .10$).

Reported health problems fell into two categories: negative lifestyle changes (such as the loss of personal time and an inability to plan for the future), and physical problems (such as headaches and back problems). The longer caregivers had been functioning in the role the more likely they were to receive assistance from family or friends. In this study, men believed that
such social services as home nursing assistance, help with housework, and help with transportation would be most helpful, whereas female caregivers most frequently requested help with housework, emotional counseling, support groups, and legal counseling.

Silliman et al.14 compared family caregivers of stroke patients (actual caregivers) with potential family caregivers (those who had family members in a nursing home). They examined the relationships between health effects (general, social, and emotional) and other related factors, such as functional status, duration of caregiving, stressful life events, race, and sex of the caregiver. Although some of these factors demonstrated a significant association with perceived poor general health, their logistic model showed that for social health, three variables (caring for a functionally dependent family member, experiencing other stressful events during the year, and being male) explained 16% of the variance.

For emotional health, the model that explained 21% of the variance contained four variables: functional status, additional life stress, social activity, and help from the family. Caregivers possessing none or one of the risk factors reported emotional ill health only 13% of the time, whereas caregivers possessing two or more risk factors reported emotional distress 53% of the time. Nearly one third of the caregivers (24 out of 78) reported three or four risk factors, and 71% of this group (17 out of 24) reported emotional distress.

Zarit, Anthony, and Boutselis15 argue that an approach to the problems of caregiving that has received relatively little attention involves educating caregivers in stress management techniques. Their clinical experience indicates that caregivers may benefit from individual and family counseling more because they can focus on their own problems longer than they can in a support group, and direct family network interventions can be initiated. In contrast, support groups are more economical, providing the opportunity for a number of participants to learn from group interactions.

The subjects in this study, caregivers of dementia patients, were assigned to either family counseling or a support group. Although showing gains over time, they did not improve significantly more on the dependent variables (burden and psychiatric symptoms) than did subjects on the wait list. The investigators suggest that to be maximally effective, psychoeducational programs may have to provide access to services that offer relief, such as in-home respite or day care. They note that psychoeducational programs are not effective if the pressures or demands that the caregivers face have not been significantly altered.

Greene and Monahan16 examined the institutionalization rate for care receivers when their family caregivers participated in a support and education program. They compared 208 subjects who participated in an education and support program with caregivers who enrolled but later did not attend the program. The program consisted of eight weekly two-hour meetings with three components: a professionally led group discussion to help with negative feelings arising from caregiving as a sense of social isolation; a section focusing on teaching techniques facilitative of the caregiving role, (ie, bathing, turning, medications, social skills useful in interacting with other family members, and content on aging processes); and a session teaching a variety of relaxation techniques.

At the end of the project, all enrolled caregivers were contacted to ascertain whether the older family member had been institutionalized. Eight care receivers from the treatment group (3.8%) and seven from the control group (8.6%) had been institutionalized, a difference statistically significant at the .10 level. When other factors were controlled for, the difference between the treatment and control groups was significant at the .05 level.

A literature review reveals considerable interest in the responses of family members to caring for an older relative. Much of the research focused on the responses of family members to the experience of caring for an older family member with dementia or Alzheimer's disease. Many of these were descriptive, non-hypothesis testing investigations.

Factors contributing to caregiver stress included: impaired elderly/family relationships, secondary to impaired mental health in the older person; depression and manifestations of chronic health problems in the caregivers, such as frequent use of prescription drugs and physician visits; inadequate preparation for the caregiving role; lack of personal and recreational time and inability to plan for future; and inadequate support and respite services.

Strategies suggested for the alleviation of stress in family caregivers encompassed strengthening natural support systems and increasing family visitation; use of groups, including both professionally led and self-help groups; individual and family counseling and teaching; home nursing visits; providing respite services for family; and providing increased recreational diversional opportunities for elderly care receivers.

**NURSING MODEL TO PROVIDE SUPPORT AND ALLEVIATE STRESS IN FAMILY CAREGIVERS**

Much of the literature and research on stress in family caregivers has been written by non-nurses. Similarly, many of the intervention programs have been developed and implemented by non-nurses. Caring for the caregiver, however, is a natural and legitimate interest of the nursing profession. Leininger17

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describes caring generally as involving assistive, supportive, or facilitative acts toward or for another individual or group. Recent literature\textsuperscript{11,18} reveals that nurses are engaged in examining issues related to family caregiving.

Those who care for older family members may often become personally depleted because so much energy goes to caring for others that they have no opportunity to care for themselves, nursing aims to assist people in achieving their maximum health potential.

Pender\textsuperscript{19} delineates the role of the nurse in health promotion as facilitating clients in values clarification, self-assessment, goal setting, information acquisition, decision making, planning behavior change, implementing lifestyle modifications, sustaining health-promoting behaviors, and social support building.

Based on the problems and approaches identified above, the author developed a nursing model to serve as a framework for a nurse-directed support program for family caregivers. This model is grounded in a review of the literature and derived from Pender's\textsuperscript{19} conceptualization of the nurse's role in health promotion and Norbeck's\textsuperscript{21} paradigm for providing social support. The proposed nursing model provides support of low, medium, and high intensity and of short, intermediate, and long duration.

The objective of the nurse-directed support program is to alleviate stress in family caregivers. The nurse-directed support program utilizes a three-pronged approach to accomplish this: a weekly series of two-hour meetings with family caregivers, lasting approximately eight weeks to provide an opportunity to ventilate feelings and to teach content relevant to the care of older family members; individualized teaching and counseling sessions with home visits by the nurse and an assessment of the functional status and a diagnosis of the nursing needs of the elderly care receiver; and telephone consultation with the nurse to provide ongoing support to the caregiver.

Norbeck's\textsuperscript{21} social support paradigm calls for assessing properties of both the person and the situation to determine the need for social support. An assessment of particular factors such as marital status, sex, age, culture, religion, and individual differences in abilities, needs, and perspective influences the amount of social support available to a person, as well as the utilization of social support.

A family caregiver who has an elderly spouse, whose grown children have migrated to other sections of the country, and who has experienced the loss of siblings through death probably would have less social support than a middle-aged caregiver with children still living in the family home or siblings in the area.

Age and culture can influence the use of social support. Women are more likely to have support, in the form of a confidant, than men. Middle-class women tend to have more diverse sources of support than working-class women, who tend to rely on family.

An assessment of situational properties is also critical to implementing an appropriate level of support. Norbeck\textsuperscript{21} conceptualizes situational demands for support as being based on the duration and intensity of support required. The Figure shows a model based on Norbeck, adapted for alleviating stress in family caregivers.

As Norbeck\textsuperscript{21} noted, the need for support should be determined by assessing characteristics of both the person and the situation. Scott and Roberts\textsuperscript{22} examined the use of both informal (children, friends) and formal support networks and factors associated with the usage of support systems of the elderly rural poor (mean income $3,555), compared with a group of rural elderly with higher income levels (mean income $13,474). The predictors were background structural variables (ie, sex, race, education, proximity to children) whereas criterion (or network) variables encompassed activities with children, help received from children, involvement with friends, and use of formal services.

Both groups relied heavily on filial support, with proximity to children being a correlate of involvement with children. The type of involvement with children, however, differed with income level: the rural poor relied on their children for both help and social interaction, whereas the higher income rural elderly did not rely on their children as much for help. The study also demonstrated that informal supports were relied on to the exclusion of formal supports when children lived in close proximity; therespondent was of higher socioeconomic status; and the respondent was widowed and lived some distance from children but friend involvement was present.
### FIGURE
MODEL OF A NURSE-DIRECTED SUPPORT PROGRAM TO ALLEVIATE STRESS IN FAMILY CAREGIVERS*

<table>
<thead>
<tr>
<th>Duration of Support Required</th>
<th>Intensity of Support Required</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term</td>
<td>Low</td>
<td>Nurse-directed support groups for family caregivers for sharing feelings and education, lasting six to eight weeks, using Pender’s model for the nurse’s role in health promotion.</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Medium</td>
<td>“Support needed for acute stressors or illness.” Acute illness in elderly care receiver: acute stress experienced by family care-giver. Nurse utilizes crisis-intervention strategies. Individualized teaching and counseling sessions with the family care receiver once or twice a week; emphasis on individualized counseling to alleviate stress.</td>
</tr>
<tr>
<td>Long-term</td>
<td></td>
<td>Ongoing contact with local family caregivers as a self-help group. Use of respite worker weekly to provide personal time and recreation or use of adult day care several times per week; bi-weekly telephone consultation with the nurse. Frequent visits by other family members; other family members assume some of the caregiving tasks. Encouraging use of homemaker services.</td>
</tr>
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</table>


In Pender’s delineation of the nurse’s role in health promotion, the initial phase involves values clarification. As applied to family caregivers, this clarification focuses on family values related to caring for an older person and personal values relative to decisions to assume the caretaking role. Subsequent values-centered discussions are related to valuing self and self-assessment of the need for personal time, socialization, and recreation. Family caregivers may always subliminate their own needs to the needs of others; therefore, the valuing of self needs to be addressed in group meetings.

Additional discussion groups include information on the aging processes, physiological and psychosocial changes of aging, and common health, social, and emotional needs of older persons. Group meetings also include home nursing strategies for problems such as senile dementia, confusion, stroke, and incontinence. Such techniques as bathing, feeding, turning, and promoting skill in executing daily activities are demonstrated. Stress management techniques; strategies for developing and strengthening social support systems; discussion of respite services, relevant community agencies, and strategies for accessing support services are also presented during group sessions as a part of information acquisition preliminary to other phases of promoting health and alleviating stress.

Assertiveness training, as a part of a stress management program, may be introduced both in group sessions and in individualized teaching counseling sessions. Problems experienced by caregivers within the family system or in accessing community services may
be improved by learning assertiveness skills.

Other concepts that may be included by the nurse working with family caregivers in counseling sessions are: goal setting relative to the family caregiver’s personal, recreational, and health needs; decision making; planning behavior change; implementing and maintaining lifestyle modification and responses employed by other caregivers:
- Interpersonal learning (through groups caregivers can learn behavioral dynamics and correct distorted perceptions, gaining better understanding of what they are doing and with others, as well as understanding the motivational basis for their behaviors);
- Group cohesiveness (a cohesive group is more accepting and participants more likely to form meaningful relationships within the group); and
- Catharsis (for socially isolated family caregivers the opportunity to express feelings in a sympathetic, accepting atmosphere lessens their anxiety, frustration, and anger and opens the path to constructive problem solving).

Individualized and family counseling or teaching sessions are useful in alleviating caregiver stress. Using Norbeck’s support paradigm, these sessions may be of varying duration and intensity, depending on the nature of complexity and urgency of the problems. Generally, individualized sessions emphasize problem clarification and solution through counseling and teaching strategies. Probably the majority of the counseling sessions occur during home visits by the nurse.

A form of long-term support that is not used frequently is telephone consultation with the nurse. Telephone consultation as a form of support is inexpensive and practically always available. It provides the family caregiver with access to a “primary” nurse, a knowledgeable, accessible, and interested professional ready to discuss concerns, validate strategies, offer guidance and reassurance, and facilitate problem solving.

SUMMARY

Nursing interventions to alleviate stress in family caregivers may be conceptualized as health promotion, for they increase the level of wellness of both the family caregiver and the care recipient. A variety of nursing interventions may be used, including group education and support meetings; individualized counseling and teaching sessions based on home visits and assessment of the functional status of the elderly care receiver; and telephone consultations with the nurse. Support strategies may be conceptualized as being short, intermediate, or long term and of low, medium, or high intensity, depending on characteristics of the client system and the situation.

The establishment of nurse-directed support programs identifies nursing as a primary community health resource for family caregivers, providing a comprehensive holistic approach for meeting the needs of family caregivers and enhancing the level of wellness of both caregivers and elderly care receivers.

REFERENCES

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**Stress**

**KEY POINTS**


1. Family caregivers directly care for the older family member, and network with other family members and health and community agencies.

2. Factors contributing to caregivers' stress include impaired family relationships, depression and chronic health problems, lack of preparation, lack of personal time, and moderate support and respite services.

3. The role of the nurse in health promotion includes values clarification, goal setting, decision making, planning behavior change, and social support building.

4. Support programs may include the conceptualization of support as varying in duration and intensity.

**AUGUST**

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- Back to the Bedside: Teaching on Nursing Rounds
- Loneliness in the Hospitalized Older Adult
- Remember When . . . ? Using Mnemonics to Boost Memory in the Elderly
- Learning After Graduation: Are Nurses Taking Advantage of the Resources?

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