The Work of Spousal Caregiving of Older Adults with End-Stage Heart Failure

Lisa A. Kitko, RN, PhD, CCRN; and Judith E. Hupcey, EdD, CRNP

ABSTRACT
Heart failure requires complex home management, which is typically performed by a spouse. Yet little is known about the actual “work” of caregiving in individuals with heart failure. The purpose of this study was to describe the types of work manifested in long-term spousal caregiving for older adults across the progression of heart failure. Secondary qualitative analysis was performed of the in-depth serial interview data of 20 spousal caregivers of individuals with heart failure age 62 and older, collected monthly over 12 to 14 months. The work of spousal caregiving impacted all aspects of the lives of spouses and was constant over time and across the course of heart failure. The work of caregiving was always present, even during times of medical stability, but the type of work and intensity varied throughout the course of the illness. Caregivers should be assessed for unmet needs throughout the course of heart failure, not just during the individuals’ exacerbations or hospitalizations. [Journal of Gerontological Nursing, 39(7), 40-47.]
The number of individuals with heart failure is at epidemic proportions, resulting in major clinical, social, and economic problems in the United States. More than 5.7 million Americans are living with heart failure, contributing to more than 270,000 deaths each year (Roger et al., 2012). Improved initial care of individuals with acute coronary events, increased life expectancy, and aging of the Baby Boomer generation are all factors that contribute to the escalation of heart failure diagnoses (Boyd et al., 2011).

There are 65.7 million Americans providing unpaid care for relatives with chronic illnesses at home, with 5% listing heart disease as the main reason for care (Feinberg, Reinhard, Houser, & Choula, 2011). Family members often assume caregiving responsibilities with little preparation for the role and little ongoing support. The AARP estimated the economic value of family caregiving in 2009 at $450 billion, exceeding the total amount spent in 2009 by Medicare ($361 billion) and approaching expenditures for the Medicaid program ($509 billion) (Feinberg et al., 2011).

Individuals with heart failure are medically managed with the goals of symptom reduction, maintenance of clinical stability, and prolonged survival. This complex home medical management is referred to as self-care and is often provided by caregivers who are typically spouses. Self-care for heart failure includes complex management of diet, symptoms, and medications as well as the detection of early signs of heart failure exacerbations (Riegel, Vaughan Dickson, Goldberg, & Deatrick, 2007). The care provided by the family caregiver also includes a combination of physical, practical, and emotional care (Hauser & Kramer, 2004), which changes over the course of the illness and increases in intensity as the care recipient’s health declines (Weitzner, Haley, & Chen, 2000). Self-care management as well as the illness itself can have a dramatic impact on the lives of married couples, as both are occurring concurrently as the couple attempts to live life.

The role of caregiving and managing an illness was aptly conceptualized by Corbin and Strauss (1988) as work and defined as “a set of tasks performed by an individual or couple to carry out a plan of action designed to manage one or more aspects of the illness” (p. 28). The work varies as the illness changes over time, and each type of work has multiple associated tasks. Other than the seminal work by Corbin and Strauss, little is known regarding the work of care giving.

To gain an understanding of the types of work involved in spousal caregiving of older adults across the progression of heart failure, it is imperative to study this phenomenon from the caregiver’s perspective, using methods that address the experience of providing care over time. Identifying the types of work experienced by the caregiver across the course of heart failure is crucial, as health care providers strive to promote self-care in individuals with heart failure. The benefits of social support, such as a spousal caregiver, on improved self-care are well documented (Sayers, Riegel, Pawlowski, Coyne, & Samaha, 2008) but the totality of the experience of not only assisting with self-care but also living with an older spouse with heart failure from the perspective of the caregiver has not been explored. Gaining insight into the experience of not only caring for a spouse but also living with an older spouse with heart failure will provide a more holistic picture of the caregiving experience. Thus, the purpose of this study was to describe the types of work in long-term spousal caregiving across the progressive course of heart failure.

**BACKGROUND**

Caring for a spouse continues to be the most commonly reported care situation for the older adult population (Feinberg et al., 2011). Many caregivers of older adults are older themselves. In fact, the average age of a caregiver who provides care for a person age 65 or older is 63 (Administration on Aging, 2012).

Caregivers assume an essential role in the self-care of individuals with heart failure. In addition, they monitor patient adherence to the treatment plan, arrange and transport the individual to multiple medical appointments, continually monitor for signs of decompensation, and take on new roles to accommodate the individual’s functional decline (P.C. Clark & Dunbar, 2003; Pattenden, Roberts, & Lewin, 2007). Caregiving consists of not only the observable physical care mentioned above but also an unseen sense of constant surveillance and assessment of health status and needs differentiated as invisible care activities and visible care activities (A.M. Clark et al., 2008).

While providing this critically important care, informal caregivers face significant threats to their own health, including psychological, physical, and financial distress. More than one third of informal caregivers reported fair to poor health (Administration on Aging, 2012). Multiple studies have reported that a care-
giver’s quality of life and health status can decline when caring for an individual with heart failure (Luttik, Jaarsma, Moser, Sanderman, & van Veldhuisen, 2005; Martensson, Dracup, Canary, & Fridlund, 2003; Pressler et al., 2009). Given these health changes, it is not surprising that caregivers have a higher risk of mortality than non-caregivers. In a landmark longitudinal study entitled “The Caregiver Health Effects Study,” Schulz and Beach (1999) found that spousal caregivers who were experiencing strain had mortality risks that were 63% higher than age- and gender-matched individuals who were not caregivers. Compounding the complexity of the caregiving role are the constant challenges faced by the spouse that include not only caring for the individual but maintaining a household and dealing with his or her own preexisting health issues and functional limitations (King & Brassington, 1997).

**METHOD**

**Design**

The purpose of this study was to describe the types of work in long-term spousal caregiving of older adults with end-stage heart failure. Caring for a spouse with heart failure is dynamic in nature with changes occurring over time; therefore, this complex experience is best captured through a longitudinal qualitative inquiry. This secondary analysis was performed as part of a larger longitudinal study investigating the palliative care needs of older adults with heart failure and their spousal caregivers. During the data analysis of the parent study, a new concept of the “work” of caregiving emerged. This work was prominent both during the spouse’s heart failure exacerbation and during times when the spouse was medically stable. This phenomenon has not been well explored in the literature and warranted additional investigation. The results of the larger study of the palliative care needs of care recipients and caregivers have been reported previously (Hupcey, Fenstermacher, Kitko, & Fogg, 2011).

A secondary thematic analysis of the data guided by the principles of grounded theory was employed to explore the experiences of spousal caregiving across the illness trajectory of heart failure. The data generated by using this method are embedded or grounded in the empirical data derived from the interviews with the participants who are acting within the specific social context under study (Strauss & Corbin, 1998).

**Sample**

The sample, from a large tertiary medical center as well as a rural community hospital, both located in central Pennsylvania, included spousal caregivers of older (62 or older) adults with heart failure who participated in the parent study. The inclusion criteria of the parent study were being married and being the primary care provider for a spouse age 62 or older with a diagnosis of heart failure having progressed to the symptomatic stage requiring hospitalization. The original study and the secondary analysis were approved by the institutional review board at the authors’ academic institution and the participating medical centers.

**Data Collection**

The initial interviews of the parent study were performed in person with subsequent interviews scheduled monthly either in person or over the telephone (with the goal of 12 interviews per participant). During the entire data collection period, 20 couples enrolled and were followed between a 1- and 14-month period. Eighteen couples were followed for 12 to 14 months (10 to 12 interviews each); one couple was followed for 1 month due to death, and one couple for 6 months, as they were unable to complete the study due to illness. During each interview, spousal caregivers were interviewed separately from their spouses.

The semistructured interview guide with probes was designed to obtain personal perspectives of caregivers’ lives, experiences, and situations of caring for an older spouse with heart failure. The interview began with the question, “Tell me about your experiences providing care to ________.” This initial interview question was designed to elicit a broad description of the experiences of caring for an older spouse with heart failure. It was expected that caregivers’ responses would provide a full and rich description of the context (everyday life with heart failure), including caregivers’ interpretations of how heart failure affects them personally. The caregivers were asked to relate their experiences freely and to describe what was happening that month. The goal was to capture the dynamic flow of caregiving across the illness progression of heart failure over 12 to 14 months.

The initial interviews were approximately 45 to 60 minutes in length and the monthly follow-up interviews averaged 30 minutes. The final interview was a summary or exit interview, which lasted approximately 60 minutes. The interviews were digitally recorded and transcribed verbatim. The transcripts were verified against the digital recordings for accuracy. All identifying information was removed from the original transcript.

**Data Analysis**

The identification of conceptual themes was accomplished by a thematic analysis using the tenets of grounded theory in this secondary analysis of the spousal caregivers. The purpose of the analysis was to reduce large amounts of data into meaningful categories then to relate the categories in meaningful ways using an inductive methodology for the thematic analysis. The first stage of the analysis was conducted by reading the complete set of care-
giver interviews for each individual participant across the longitudinal data set. Based on this initial reading, a codebook was developed using an iterative process by the authors who are experienced in qualitative methods and heart failure research. All de-identified, transcribed data were entered into ATLAS.ti version 6.x to organize the analysis. This level of analysis was followed by coding the text across all participants for emergence of themes. Through the analysis process, raw data were converted into concepts or themes. This process occurred until data saturation was reached and no new themes emerged from the data. The trustworthiness of the data was addressed by using the criteria of credibility, dependability, and confirmability (Lincoln & Guba, 1985). All data were collected using the same semistructured interview format. Initial coding was conducted independently followed by member checks among the coders with consensus reached on any disagreements. A detailed audit trail was maintained during all analysis sessions. An expert in heart failure and qualitative methods also participated in the final analysis session by conducting a parallel analysis with consensus reached on any disagreements. A detailed audit trail was maintained during all analysis sessions. An expert in heart failure and qualitative methods also participated in the final analysis session by conducting a parallel analysis with consensus reached on any disagreements.

RESULTS
Demographics
The sample comprised 20 spouses actively involved in the caregiving role of their older adult spouse. Participants ranged in age from 46 to 78 (mean age = 67) at the time of study enrollment. Fourteen were women and 6 were men. Demographic characteristics are summarized in Table 1. All of the care recipients had Stage D heart failure and were in a functional class of 3 or 4 of the New York Heart Association criteria (Criteria Committee for the New York Heart Association, 1994) at the time of enrollment and had multiple hospital admissions for exacerbations during the data collection period.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
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<tbody>
<tr>
<td>Caregiver age (years)</td>
<td>68</td>
<td>67</td>
<td>46 to 78</td>
</tr>
<tr>
<td>Care recipient age (years)</td>
<td>70.5</td>
<td>70</td>
<td>62 to 79</td>
</tr>
<tr>
<td>Years of marriage</td>
<td>45.5</td>
<td>43</td>
<td>6 to 55</td>
</tr>
<tr>
<td>Length of time in caregiving role</td>
<td>4.5 years</td>
<td>4 years</td>
<td>2 months to 9 years</td>
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Major Themes
Six central thematic concepts were identified, all anchored by the core theme of work. The themes associated with the caregiving role were: providing care, navigating the system, maintaining self, managing the household, vigilance, and normalcy. The full data set for each caregiver was analyzed to determine the types of work experienced over the longitudinal course of providing care to a spouse with heart failure. Table 2 presents a summary of exemplary quotes for each theme.

Providing Care. The work of providing care encompassed both the physical and psychological components of care. Physical work included providing assistance with activities of daily living, medication management, documenting daily weights, assessment of incisions, and traveling to physicians’ appointments and hospitalizations. A recurrent theme expressed by spousal caregivers was a description of their role as a “learning process.” This was stated with terms such as planning, patience, and organization.

The psychological aspects encompassed everything the caregiver did to maintain the psychological well-being of his or her spouse with heart failure such as counseling, encouraging, and developing strategies to treat depression. Participants detailed the psychological work that was an integral part of their caregiving role. Many caregivers described how they combated frequent bouts of depression in their spouse with statements such as “I am always trying to talk her into the positive” and “I can sum my role up in three words. I am a cheerleader, drill sergeant, and negotiator.”

Navigating the System. “The system” encompassed any large entity that involved time and work on the part of the spousal caregiver. Systems included complex health care systems, insurance companies, and government institutions as would be necessary for medical disability.

### Table 1

**DESCRIPTION OF THE STUDY SAMPLE AT ENROLLMENT (N = 20)**

<table>
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<tr>
<th>Variable</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
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<tbody>
<tr>
<td>Caregiver employed outside of home</td>
<td>7 (35)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>18 (90)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>2 (10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>14 (70)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>6 (30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care recipient gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>14 (70)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>6 (30)</td>
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Spousal caregivers spoke of the planning and coordination needed to navigate several health care systems. For those who lived a distance from a tertiary heart failure center, many individuals had their condition managed by a local family physician. These various levels of care required coordinated work on the part of the caregiver. At times, navigating the complex systems became a source of angst for the spousal caregivers.

Caregivers also spoke of the impact of navigating complex systems such as health insurance in the midst of dealing with an ill spouse and its impact on the caregiving role. One couple struggled with the fact that within the year, when the spouse turned 65, he would be dropped from disability and medical insurance through his previous workplace and be switched to Medicare. This switch would then dramatically increase the out-of-pocket expenses for his heart transplant, and the couple was struggling to find a medical supplement that would accept him due to his preexisting condition.

Maintaining Self. This thematic concept encompassed the physical and psychological status of the caregiver and what tactics he or she used to maintain his or her health in the midst of providing spousal care. Many of the caregivers had health issues of their own to deal with in the midst of providing care to their spouse. The caregivers discussed strategies they used to deal with the stresses of providing care including praying, studying the Bible, meeting a friend for coffee, exercising, working on crafts, and babysitting grandchildren. Several of the caregivers required medical interventions for their own health problems but delayed discussing or having them.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Quote</th>
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<tr>
<td>Providing Care</td>
<td>“You have to be organized to do this work. I have a diary with his daily weights and a current list of his meds; I also write down every appointment with every doctor. I have to, he sees so many. When we travel, I also carry my own scale and his most current EKG just to be sure.”</td>
</tr>
<tr>
<td>Navigating the System</td>
<td>“It’s hard because you do not know who to turn to when something is wrong. Like the one local heart doctor we’re going to locally made a comment, ‘How am I going to work with him when I only see him once a year?’ So we feel lost between the two systems and are never sure who to call when we have questions or issues.”</td>
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<td></td>
<td>“This insurance issue is weighing on him considerably since he turns 65 in February. He checked in to possibly changing to another insurance; there is a 6-month waiting period for a condition and if by some wild chance a heart transplant would come up in that period of time we wouldn’t have any insurance for him. See 90% of the problem isn’t with the heart transplant, it’s the financial problems that go along with it.”</td>
</tr>
<tr>
<td>Maintaining Self</td>
<td>“In fact today, I will call the doctor. I have a prolapsed bladder and it’s really bothering me lately and now that he is feeling better, I want to have it surgically corrected.”</td>
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<tr>
<td>Managing the Household</td>
<td>“Well, we are now in the doughnut hole, which means $400 per month for medicine. We will be in the hole for August-December. We are considering a reverse mortgage. And I am considering getting a job and I have always been a housewife, but $400 a month is a lot of extra money on a fixed income.”</td>
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<td></td>
<td>“It’s just something that you do almost unconsciously, but things that require heavy exertion are usually the sticking points in the household because especially with the man, it’s been his domain, you know that’s his role to take care of those things around the house…. He does not deal well with seeing me doing the heavy work, like shoveling, but he knows he cannot do it.”</td>
</tr>
<tr>
<td>Vigilance</td>
<td>“Every morning I put my ear to his chest and listen to his heart. I monitor him very closely and there are days in which I do not feel comfortable leaving for work so those days I work at home. I call every day from work and we have our routine, if I am not aware of anything he had planned for the day, I then immediately call my neighbor to check on him.”</td>
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<tr>
<td></td>
<td>“I used to be able to tell when he was filling up with fluid, he would wheeze. I would hear the wheezing, but now there’s nothing you know. I do not detect anything. So I am much more watchful, I do not let him go anywhere alone. I even sit on the chair by the window and watch him mow the grass.”</td>
</tr>
<tr>
<td>Normalcy</td>
<td>“I would like us to be, to have some kind of normal life.”</td>
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taken care of until their spouse was medically stable.

**Managing the Household.** This theme encompassed the work required to maintain finances, the impact the spousal illness had on the employment of the caregiver, changing roles of the household necessitated by the spouse’s inability to maintain previous roles secondary to heart failure, discussions of not being able to maintain their current residence, and how caregivers mobilized help to keep the household going throughout the course of their spouse’s heart failure. Many of the caregivers spoke of the financial impact of heart failure and how this was one more area of “work” they had to address to maintain their marriage and lives together. The theme of managing the household also encompassed the changing roles of the caregiver due to their spouse’s inability to carry out previous roles. For some caregivers, this required assuming new household tasks that were previously done by the spouse.

**Vigilance.** Vigilance was the constant awareness that traversed across the illness progression of heart failure despite the patient’s medical condition. The work of vigilance was the constant monitoring and watchfulness on the part of the caregiver that occurred even in the most stable of times.

For participants who still maintained employment, the work of vigilance took on a heightened awareness, as they had to leave their spouse alone for periods of time. The work of vigilance was evident even in those caregivers who did not leave the home for employment.

**Normalcy.** Normalcy included all of the work by the caregiver to establish some type of routine or normal everyday life in light of the spouse’s heart failure. It encompassed activities such as flexible planning, anticipating the needs of the spouse, planning for the future, and negotiating.

Normalcy, as with all of the other themes, changed in tandem with individuals as they experienced illness exacerbations as well as medical stability over the course of heart failure. For the caregivers, normal was reframed in the context of accepting the chronic nature of heart failure, as evidenced by this caregiver’s comment: “I know he will never get better, but we have to figure out how to live our lives with this.”

If the spouse was in a stable phase of the heart failure trajectory, the caregivers worked to re-establish normal routines that existed prior to the illness or occurred during a more medically stable time. Caregivers were also prepared for sudden and unplanned changes to normalcy as the unpredictable course of heart failure would change. In many cases, when these changes occurred the caregivers quietly dealt with them. As one caregiver said, “Nothing is certain, and I would never let him see how it upsets me that our life has changed so much.”

**Work.** The theme that captured the totality of the caregiving experience was work. This work occurs not only during times of exacerbations but also during times of medical stability. The type of work dynamically changes based on the condition of the spouse throughout the progressive course of heart failure. Caregiving is a complex process, as the management of self-care of a spouse occurs simultaneously with managing one’s personal life, resulting in significant changes in all aspects of the everyday lives of these couples.

**DISCUSSION**

Capturing the work of caregivers over time permitted the exploration of themes that dynamically changed in response to the progression of heart failure. The importance of the various types of work changed based on the spouse’s illness trajectory. During times of exacerbation, caregivers adopted a “day-to-day” outlook and concentrated on the medical needs of their spouses. During times of medical stability, the types of work at the forefront of the discussions ranged from maintaining the household, scheduling and coordinating appointments, returning to work, and assuming new roles that their spouses were unable to complete due to heart failure. Previous research supports the changing and responsive experience of the caregiver based on the changing course of the individual’s illness (Hupcey, Fenstermacher, Kitko, & Penrod, 2010). Each of the six identified work themes support the premise of a process or interaction between the spouses in the context of heart failure. The findings support existing research that caregiving is much more comprehensive than the visible tasks and includes invisible tasks (A.M. Clark et al., 2008).

The busy caregiving schedule or perceived lack of support may result in the caregiver neglecting his or her own self-care. Shaw et al. (1997) reported a similar finding of reluctance among caregivers to schedule hospital care at times when the spouse appeared to have the greatest caregiving needs. This finding has important implications for health care providers and speaks volumes for the necessity to embrace caregivers as coproviders and corecipients of care.

Consistent with the literature, in times of relative stability the participants spoke of their attempts to foster more independence and maintain normalcy in the care recipient (Houldin, 2007; Pickens, O’Reilly, & Sharp, 2010). It is often during these times of medical stability that the work of the spousal caregiver goes unnoticed by health care providers.

Understanding the caregiving role has remained underdeveloped, especially in exploration of the complexities of chronic disease management. The findings of this study provide a theoretical explanation of the work involved in providing care to a spouse with heart failure over time during periods of exacerbation as well as medical stability. The results
KEYPOINTS

1 Spousal caregivers play an important role in the self-care of the care recipient, but the totality of the experience of not only assisting with self-care but also living with an older spouse with heart failure from the perspective of the caregiver has not been explored.

2 Research shows that the “work” performed by spousal caregivers occurred not only during times of exacerbations but also during times of medical stability. The themes associated with the caregiving role were: providing care, navigating the system, maintaining self, managing the household, vigilance, and normalcy.

3 Nurses can assess and recognize cues in the clinical encounters during times of exacerbations and medical stability that could lead to specific needs-driven interventions for the care recipient as well as the spousal caregiver.

also add a unique perspective to the extant body of literature on spousal caregivers of individuals with heart failure. Descriptions of the changes over time provide a global view of the various types of work manifested by the caregiver that occurred throughout the progression of heart failure and how the types of work change based on the older spouses’ changing course of illness.

STUDY STRENGTHS AND LIMITATIONS
A limitation of the study was the homogenous sample—the majority of participants were Caucasian female spouses. Future studies involving spouses from various ethnic and racial backgrounds in the context of heart failure would add meaningful data to help provide culturally sensitive care. In addition, all participants reported a happy and lengthy marriage. Literature suggests that prior marital satisfaction may play a role in caregiver attitude and burden; thus, it is recommended that future studies include participants with more varied marital backgrounds (Goldstein, Atkins, Landau, Brown, & Leigh, 2006; Seltzer & Li, 2000). However, the types of work identified in this study were consistent with the findings of other caregiving studies in heart failure.

A strength of this study was the longitudinal design, as it enabled the researchers to capture the dynamic nature of the heart failure trajectory over a 12- to 14-month time frame and allowed in-depth exploration of the work of caregiving. The findings provide the basis for future research on the development of an intervention study implementing strategies directed specifically to the predominant type of work manifested by the caregiver at a specific point in the heart failure trajectory.

CLINICAL IMPLICATIONS FOR GERIATRIC NURSES
Although the caregivers were committed to their role, they did so from a limited clinical or formal knowledge base and were frequently seeking sources of information. There is a growing body of research on the need for caregiver support as well as involvement in heart failure disease management programs (A.M. Clark et al., 2010; Riegel et al., 2009). Given, Sherwood, and Given (2008) found that providing caregivers with information about managing individuals’ symptoms can help alleviate the uncertainty regarding decision making in the home setting. Evangelista et al. (2002) reported that when a caregiver’s needs are met via ongoing communication and interventions designed to address the caregivers’ ability to perform the caregiving tasks associated with heart failure, his or her emotional well-being is improved, which is an independent predictor of patient emotional well-being. These findings suggest that support should focus on increasing the caregivers’ understanding of the condition and its management. Health care professionals who care for an older adult with heart failure could significantly impact the experience for both the caregiver and spouse by acknowledging the various types of work involved in caregiving in addition to the self-care management. The results of this study demonstrate that the needs of the couples, especially the caregiver, require more than a brief contact with the health care provider. Health care providers should recognize cues in the clinical encounters that could lead to specific needs-driven interventions.

CONCLUSION
This article adds additional insights currently not explicited in the literature of the constant work required by caregivers as they assist with heart failure care, not only in times of exacerbations but also in times of medical stability. The findings of this study illustrate that the caregiver moves with the spouse during the course of the illness, and when there is an exacerbation or instability the needs of the caregiver escalate in tandem with those of the spouse but may be manifested in different ways. The needs of the caregiver are just as significant as the medical needs of the care recipient and occur throughout the entire course of the illness even dur-
ing times of medical stability. This heightened awareness of the specific and changing needs of the caregiver, especially the older caregiver, is expected to inform nursing intervention and supports the development of future research and implementation of evidence-based practice to promote the benefits of self-care.

REFERENCES


ABOUT THE AUTHORS

Dr. Kitko is Assistant Professor and Dr. Hupcey is Dean for Graduate Education, School of Nursing, The Pennsylvania State University, University Park, Pennsylvania.

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Address correspondence to Lisa A. Kitko, RN, PhD, CCRN, Assistant Professor, The Pennsylvania State University, School of Nursing, 201 Health and Human Development East, University Park, PA 16802; e-mail: lah150@psu.edu.

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