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## The Relationship Between Spirituality and Depression in Family Caregivers of the Elderly

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THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION IN  
FAMILY CAREGIVERS OF THE ELDERLY

By

Cynthia L. Boland

A THESIS

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## ABSTRACT

### THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION IN FAMILY CAREGIVERS OF THE ELDERLY

By

Cynthia L. Boland

The main purpose of this research was to investigate the relationship between spirituality and depression in family caregivers of the elderly. Data for this secondary study came from a caregiver research project conducted by Given and Given (1989). Although the primary study was longitudinal, this study used a cross-sectional, descriptive correlational design. A convenience sample of 191 family caregivers participated. Data on spirituality and depression were obtained by self-administered questionnaires. Spirituality was measured with the Spiritual/Philosophical subscale from the Coping Resources Inventory (Hammer & Marting, 1988). The Center for Epidemiologic Studies Depression Scale (Radloff, 1977) was slightly modified and used to measure depression. The study findings included: (a) a moderately weak negative correlation between the variables of spirituality and depression ( $r = -.2934$ ,  $df = 189$ ,  $p < .001$ ) and (b) the majority of caregivers (62.3%) indicated that spirituality was a consistent resource in their lives. Limitations to the study included the use of a convenience sample and the use of a relatively new subscale to measure spirituality.

## DEDICATION

This thesis is dedicated first of all, to my husband, Ronald, for his positive attitude, his spiritual strength, and his many hours of typing and editing. It is also dedicated to my mother, Donna Perez, for her continual love and encouragement throughout the research process. Without their love and support, this manuscript would not be possible.

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## CHAPTER I

### INTRODUCTION

In 1985, there were 5.2 million elderly persons living in the community with disabilities that affected their ability to carry out daily activities such as dressing, bathing, or eating (Day, 1985). Population projections suggest a marked increase in the actual number of elderly in society, with the greatest increase projected for the over 85 years of age group--those especially vulnerable to problems of ill health and dependency. This population increase and the reduction in federal funds for programs for the elderly will place additional demands on families to provide the caregiving services needed by their aged members (Stoller, 1983).

Family caregiving has inherent strains and conflicts, which, over time, may result in chronic stress for the caregiver (Baldwin, 1988). Chronic stress, which has been described as caregiver burden and strain, can produce a variety of negative caregiver outcomes (Cantor, 1983; Poulschock & Deimling, 1984; Zarit, Reever, & Bach-Peterson, 1980). Caregiver depression is a frequently reported negative outcome related to the stress of caregiving (Baldwin, 1988; Cantor, 1983; Jones & Vetter, 1984).

Individuals use a variety of resources to cope with stressful situations. According to Hammer and Marting (1988) "Coping resources are those resources inherent in individuals that enable them to handle stressors more effectively, to experience fewer or less intense symptoms upon

exposure to a stressor, or to recover faster from exposure" (p. 2). Current research has focused mainly on environmental coping resources such as social support, as a means of mediating stress (Wheaton, 1983). Another category of resources that has been noted in the literature is spiritual resources (Hammer & Marting, 1988). Spirituality is an inner, personal resource that may mediate the effects of caregiver stress and decrease the incidence of depression.

There is a scarcity of research related to the concept of spirituality. The spiritual dimension of man has been referred to as the "ignored dimension" (Soeken & Carson, 1986), but it plays a critical role in determining an individual's overall well-being (Banks, 1980). As Soeken and Carson (1987) have pointed out, spirituality is broader than institutionalized religion in that "It can be considered to be conscious or unconscious beliefs that relate the person to the world and give meaning and definition to existence" (p. 604). Several studies of chronically and terminally ill patients suggest that they use multiple and diverse spiritual coping strategies to deal with the stresses of their illness (Baldree, Murphy & Powers, 1982; Belcher, Dettmore, & Holzemer, 1989; Miller, 1985; O'Brien, 1982; Reed, 1987). Other studies by Miller (1985) and Fehring, Brennan, and Keller (1987) indicate a negative correlation between spiritual well-being (SWB) and the variables of loneliness and depression. Some studies of family caregivers indicate that prayer and spiritual support are important in their ability

to cope and are associated with decreased feelings of burden (Baines, 1984; Pratt, Schmall, Wright, & Cleland, 1985).

No published research studies were found that investigated the relationship of "caregiver" spirituality to depression. Since family caregiving is generally acknowledged as stressful, and it is becoming more necessary and commonplace in our society, nurses must be able to identify and support all the positive resources that a caregiver uses to cope, including those in the spiritual domain. The potential healing force of all aspects of a person's life must be recognized. The purpose of this study is to examine the relationship between spirituality and depression in family caregivers of the elderly.

## CHAPTER II

### REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

#### Review of Literature

No published studies were found that investigated the relationship between spirituality and depression of "caregivers", therefore, the literature review will be divided into three individual sections. The first section will review studies that relate to "spirituality" and focus on the conceptualization of the concept, as well as how it was measured. The study review for this section will include three different types of subjects: (a) chronically ill clients, (b) terminally ill clients, and (c) family caregivers. Section two will investigate studies related to "caregiver depression", and examine the instruments used to measure it. Section three will conclude with a review of the only two studies found which investigated the relationship between spirituality and depression. The subjects for the two studies were college students.

#### Spirituality

Historically, nurses have been concerned with the care of the whole person--body, mind, and spirit. Until recently, the greater focus in nursing has been on the biopsychosocial domain. However, given the increasingly large geriatric population, the prevalence of chronic and terminal illness, the recent impact of devastating diseases such as acquired immunodeficiency syndrome (AIDS), and the growing interest in the search for personal fulfillment and inner

peace, spirituality is becoming an important concept (Belcher, Dettmore, & Holzemer, 1989).

The concept of spirituality is complex. It is necessary to clarify its meaning so that it can serve as a basis for research. Burkhardt (1989) conducted a literature review of the concept of spirituality and found not only this term but also the closely related terms of spirit, spiritual dimension, spiritual well-being, spiritual needs, and religiousness. An analysis of the terms resulted in the descriptive characteristics of spirituality which include: (1) "unfolding mystery" which pertains to one's experience of dealing with mystery or uncertainty in life, discovering and struggling with the meaning and purpose of one's life, and can include a sense of transcendence; (2) "harmonious interconnectedness" which refers to a sense of harmony and connectedness with self, others, and God or Higher Being; and (3) "inner strength" which includes one's inner resources, awareness, consciousness, and sense of sacred source (Burkhardt, 1989).

For the purposes of this study the concept of spirituality will be defined as an innate component of all individuals (Neuman, 1989). It can be viewed as existing on a continuum (Ellison, 1983), ranging from low levels of spirituality to high levels. It affects and is affected by the environment and the biological, psychological, and socio-cultural components that make up individuals. It has the potential to promote purpose and meaning in life, harmony

and connectedness with self, others, God or Higher Being (however this may be defined by the person), and inner strength (Burkhardt, 1989). It is broader than formalized religion, although it may encompass it (Carson, 1989).

Until recently, little has been documented regarding spirituality. The following studies do support its importance as a vital resource for individuals who live with the stresses of chronic or terminal illness, as well as its use as a resource by family caregivers. Two frequent weaknesses noted in many of the studies were (a) the lack of instrument reliability and validity documentation and (b) the use of multiple terms and operational definitions to denote the concept of "spirituality."

#### Spirituality and Chronically Ill Clients.

Some of the studies have found that spiritual coping strategies are frequently used by individuals who are chronically ill. In a study by Baldree, Murphy and Powers (1982) a descriptive design was used to determine the coping methods commonly used by 35 hemodialysis clients. Coping methods were assessed by the use of a coping scale developed by Jalowiec and Powers (1981) which lists 40 different coping behaviors, both affective and problem-oriented. Subjects were asked to rate each coping method according to degree of use, using a Likert-type scale ranging from "never" to "always." Included among the most frequently identified coping methods were hope, prayer, and trust in God. These methods of coping were classified as affective-oriented,

which was defined as strategies used to manage the emotions accompanying a stressful situation (Baldree et al., 1982). The author suggested further study to explore both the extents to which coping methods are successful and unsuccessful in decreasing the amount of perceived stress (Baldree, et al., 1982).

O'Brien (1982) conducted a study of chronic dialysis patients to examine the possible relationship between religious faith and adjustment to end-stage renal failure and hemodialysis. It was a longitudinal study in which both qualitative and quantitative data were obtained. The variable of "religion" was defined by (a) items that measured religious affiliation and participation in formal religious services, and (b) questions related to the patient's perception of the importance of religious faith in adjustment to renal failure and hemodialysis (O'Brien, 1982). The initial sample consisted of 126 patients, with 63 reinterviewed three years later. Only 26.2 per cent of the initial sample reported that religious beliefs were never relevant in their adjustment to the illness. Those who perceived religious beliefs as more relevant reported higher levels of social functioning, greater compliance with the therapeutic regimen, and lower levels of alienation. After three years, 28.6 percent (18) reported their religious faith to have increased in importance with respect to adjusting to the illness. Only one patient reported a decrease in importance. For the remainder of the sample (69.8% or 44),

the importance of religious faith remained unchanged and essentially positive. The authors suggested that religious faith is a dynamic variable which can have an important influence in helping individuals cope with the chronic stress of long-term illness.

Miller (1983) reported the results of a qualitative study assessing the coping strategies of 56 chronically ill adults with a variety of diseases. The sample consisted of hospitalized adults ranging in age from 20 to 79, with the largest number in the 40 to 69 age group. Twenty-five subjects were men and 31 were women. The intent of the study was to discover as many "effective" coping strategies as possible. Miller reported that the second most frequently used strategy was "enhancing one's spiritual life", second in frequency only to "seeking information" as a coping strategy. Examples given by the patients of "enhancing one's spiritual life" included a renewed faith in God, prayer, a sense of peace and hope resulting from prayer, and feeling God's love (Miller, 1983). Miller (1983) concluded that individuals use a variety of coping strategies to deal with the coping tasks of chronic illness and nurses need to use a holistic nursing approach to be able to identify those strategies that are effective.

There are some studies that have investigated the relationship of spirituality and other research variables. In a study by Miller (1985), the relationship between spiritual well-being (SWB) and loneliness was investigated. The



population consisted of 64 chronically ill adults with rheumatoid arthritis and 64 healthy adults. The purpose of the study was to determine if there was a relationship among the variables, as well as to determine if there was a significant difference in SWB and loneliness between the ill and healthy groups. Spiritual well-being was defined as satisfaction in relationship with God, as well as perception of life as having meaning, and a satisfaction with one's life (Miller, 1985). Spiritual well-being (SWB) was measured with the SWB Scale (Paloutzian & Ellison, 1982) which consists of subscales that measure Existential Well-Being (sense of life purpose and satisfaction) and Religious Well-Being (sense of well-being in relation to God).

The results of the study supported the predicted negative correlation between loneliness and spiritual well-being in both the chronically ill ( $r = -.387$ ,  $df = 126$ ,  $p < .01$ ) and healthy subjects ( $r = -.267$ ,  $df = 126$ ,  $p < .01$ ). Although there was no difference between the groups in the level of existential well-being, those with arthritis reported a significantly higher level of religious well-being. Miller (1985) concluded that "chronic illness may be a factor in stimulating a person's valuing religion, having faith in God, and having a relationship with God" (p. 83).

#### Spirituality and Terminally Ill Clients.

The importance of spirituality to terminally ill clients has been studied by some researchers. Reed (1986 & 1987) conducted two studies investigating the significance

of spirituality for terminally ill adults. Both studies were based upon a life-span developmental theory. In the first study (1986) the purpose was to compare terminally ill with healthy adults for differences in "religiousness". A sense of well-being was also explored. "Religiousness" was defined as the perception of one's beliefs and behaviors that express a sense of relatedness to spiritual dimensions or to something greater than self. The Religious Perspective Scale (RPS) was used to measure the religious beliefs and behaviors that exist in a person's life. The Index of Well-Being (IWB) was used to measure satisfaction with life as it currently is experienced. The sample consisted of 57 healthy adults and 57 ambulatory, non-hospitalized terminally ill cancer patients, who had been matched on four key variables which may influence spiritual perspective: age, gender, education, and religious affiliation (Reed, 1986).

The results of the study supported Reed's (1986) hypothesis that terminally ill adults would report greater religiousness than healthy adults (one tailed  $t$  (112) of 3.11,  $p < .001$ ). There was a significant relationship found between gender (female) and Religious Perspective Scale scores in the terminally ill group ( $r = .47$ ,  $p < .001$ ). A positive relationship was found between religiousness and well-being in the healthy group ( $r = .43$ ,  $p < .001$ ), but not in the terminally ill group. This was an unexpected finding. According to Reed (1986) the lack of relationship could be due to the complex factors that contribute to well-being. Further

research into terminally ill subjects' sense of well-being was suggested, along with further testing of the Religious Perspective Scale (Reed, 1986).

Reed's second study (1987) extended her work on terminally ill patients. In this study the research concept was changed from "religiousness" to "spirituality," although the conceptualization of the concept did not change. The Religious Perspective Scale from the former study was slightly modified, and was renamed the Spiritual Perspective Scale (SPS). The subjects consisted of 300 adults who were divided into three groups and who were matched on the same four variables as the first study. The three study groups consisted of: (1) terminally ill hospitalized cancer patients; (2) non-terminally ill hospitalized patients; and (3) healthy non-hospitalized persons (Reed, 1987).

The results of the study supported the hypothesis that terminally ill hospitalized adults indicate greater spiritual perspective than either of the other two groups. The second hypothesis was also supported which found that there was a positive relationship between spiritual perspective and well-being in the terminally ill hospitalized group ( $r=.22$ ,  $p<.02$ ). The relationship was not significant in Group 2 or 3. Another finding from the study resulted from the addition of an open-ended question appended to the SPS, which investigated the frequency and types of reported recent changes in spiritual views. The majority of those who indicated a change in their spiritual perspective found it

to be in the direction of stronger faith and prayer, and indicated an increase in spiritual beliefs and behaviors (Reed, 1987). The positive enhancement of individuals' spirituality as a result of their illness was also noted by Belcher, Dettmore, and Holzemer (1989) in their study of terminally ill AIDS patients.

#### Spirituality and Caregivers.

The importance of spirituality to family caregivers has been reported in some recent studies. Baines (1984) conducted a descriptive study to determine what stressors were experienced by older family caregivers of physically disabled older adults, and how they coped with these problems. Data were collected from a non-random sample of 50 family caregivers. Both the caregiver and the disabled person were 65 years of age or older. The primary caregivers were interviewed in their homes and the Chronicity Impact and Coping Instrument: Parent Questionnaire was administered. The questionnaire included four sections: (1) demographic data; (2) areas of help needed in providing care; (3) concerns of the caregiver; and (4) methods of coping in the past. The author noted that the results indicated that the majority (64%) of the caregivers' greatest self-concern was not being able to leave the house due to their caregiving responsibilities. When they were asked how they coped with their self-concerns, the majority (74%) indicated that prayer was the primary method of coping. Data from the demographic portion of the questionnaire did reveal that the majority of

caregivers indicated a religious preference, although over half (54%) stated they never had the opportunity to attend religious services (Baines, 1984). A major limitation of this study is that no reliability or validity data about the research instrument were documented.

Pratt, Wright, Schmall, and Cleland (1985) investigated coping strategies used by 240 caregivers of Alzheimer's patients. The relationship of the coping strategies to the caregiver's subjective sense of burden was also studied. The authors indicated that burden scores were negatively correlated ( $r = -.25$ ,  $p < .05$ ) with the external coping strategy of "spiritual support." "Spiritual support" was positively correlated with "reframing", an internal coping strategy which reflects the caregiver's ability to redefine or "reframe" stressful experiences in a way that makes them more manageable. Pratt et al. (1985) concluded that "spiritual support" may allow meaning to be found in the multiple losses that accompany Alzheimer's disease. Although spiritual support was associated with lower burden scores, it is interesting to note that some respondents admitted that the role of caregiver severely tested their religious faith. The anger and frustration felt by some caregivers provoked a spiritual crisis (Pratt et al., 1985).

Wilson (1989) used a constant comparative method to generate a grounded theory explaining the process of family caregiving for a relative with Alzheimer's Dementia (AD). The sample consisted of 20 family caregivers of AD

relatives. After analysis of the data, Wilson reported that the basic psychological problem experienced by the caregiver sample resulted from constant exposure to dilemmas that had only negative alternatives. Spiritual coping strategies were one category of strategies employed to deal with these dilemmas. Most caregivers turned to religious practices, rituals, and beliefs in a higher power for motivation and strength given their decision to take on the caregiving role (Wilson, 1989).

Research about spirituality has been hindered by beliefs that it is a very abstract concept and it is difficult to measure. Keilman (1989) conducted a descriptive study on spirituality involving 278 family caregivers of cancer patients. The purpose of the study was to describe the self-reported expressions of spirituality among the caregivers. It was a secondary analysis of data which came from a large caregiver study conducted by Given and Given (1989b). The data on spirituality and the demographic information were obtained via telephone interviews and self-administered questionnaires. The Spiritual/Philosophical Subscale developed by Hammer and Marting (1988) was used to measure spirituality. Spirituality was defined as the degree to which a person's actions are guided by stable and consistent values derived from religious, familial, or cultural tradition, or from personal philosophy (Hammer & Marting, 1988). According to Keilman (1989) the primary study conclusions were:

1. Family caregivers are able to self-report their expressions of spirituality.
2. The essence of spirituality can be captured through the use of a scale.
3. Spirituality is an important dimension in the lives of family caregivers of individuals with cancer.
4. Spirituality is a dimension of family caregivers that should be assessed (pp. 93-96).

Some limitations noted by the author were the use of a convenience sample and a cross-sectional research design. Recommendations for future research included further testing of the Spiritual/Philosophical subscale, more qualitative studies to better understand the concept of spirituality, and additional family caregiver studies, including those who care for individuals with afflictions other than cancer.

In conclusion, the studies on spirituality which were reviewed included both qualitative and quantitative designs. Some of the studies directly measured spirituality, while others discovered the importance of the concept indirectly. As previously mentioned, many of these studies failed to document reliability or validity of the instruments used to measure spirituality. Also, many different terms and operational definitions were used to denote the concept. There is a scarcity of research on spirituality. However, among the studies cited, spirituality is considered to be an important resource. It should be noted that it has been found to be important not only for individuals with terminal and chronic illness, but also for family caregivers.

#### Depression of Caregivers

Depression is the most common, and one of the most painful mental health problems in the United States

(Saucier, 1984). It is a complex disorder that is noted with more frequency in women, adults over 60 years of age, and those of lower socioeconomic status. It is estimated that between 8 to 20 million people currently suffer from depressive disorders, and 25 percent of the population will require professional treatment during their lives (NIMH, 1982; Maurer, 1986).

Depression is defined as a dysphoric lowering of mood state (McNeil, 1985). It is characterized by loss of interest or pleasure in usual activities, feelings of guilt and worthlessness, and feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance (Radloff, 1977). Depression can vary in duration, degree, and recurrence (Maurer, 1986). It may be conceptualized as a dynamic phenomenon existing on a continuum ranging from mild, transient sadness to a severe psychotic experience (Swanson, 1978). One serious complication of unresolved depression is suicide or a suicide attempt (Saucier, 1984).

Depression is a negative psychological outcome that has been frequently reported in caregiver studies (Baldwin, 1988; Cantor, 1983; Jones & Vetter, 1984). It is interesting to note that family caregivers are at an increased risk for depression. The literature suggests that the majority of family caregivers are older adults and are female (Brody, 1981; Jones & Vetter, 1984; Stone, Cafferata, & Sangl, 1987)



which are two of the variables that are also associated with higher frequencies of depression (Maurer, 1986).

In recent years there have been a large number of studies that have focused on family caregivers. Eleven years ago, Fengler and Goodrich (1979) astutely labeled the spouses of disabled elderly men as the "hidden patients." Much of the recent literature has centered on the strain and burden of the caregiver role. Instruments have been developed that specifically measure the concept of caregiver burden, however, this has lead to limitations for generalizability (George & Gwyther, 1986). George and Gwyther (1986) have suggested the use of general measures of well-being, instead of caregiver burden, which are seen as "opposite sides of the same coin" (p. 253). The use of general well-being measures enables the researcher to identify caregiver outcomes in a multidimensional manner and generalize the results to other populations (George & Gwyther, 1986).

Depression is a general measure of psychological well-being that has recently been studied in the caregiver literature. Pruchno and Resch (1989) interviewed 101 male and 214 female caregivers who were providing care to spouses who were diagnosed with Alzheimer's Disease or a related disorder. One purpose of the study was to compare the mental health of husband and wife caregivers. The Center for Epidemiologic Studies Depression (CES-D) Scale (Radloff, 1977) was used to measure overall level of depression experienced during the past week. This instrument has been found to be

acceptable for use in both the clinical and general populations. It has also been found to be suitable for use with the elderly because of the limited number of items that focus on somatic complaints (Radloff, 1977; Gallagher, Thompson, & Levy, 1980). The authors reported that wives were more depressed and burdened than their husbands, suggesting that the demands of the caregiver role may be experienced differently by men than by women (Pruchno & Resch, 1989).

In a study by Barusch (1988), in-depth interviews were conducted with 89 elderly spouse caregivers. A Coping Inventory developed for the study was used to identify problems confronting each caregiver and to examine coping responses. Lazarus and Folkman's (1984) stress and coping paradigm was used as the framework. The authors reported that caregivers experience a diversity of problems and use a varied array of coping techniques. Within the category of personal/psychological problems investigated by the researchers, the majority of caregivers indicated they experienced generalized anxiety about the future (56%), as well as depression (67%) and loneliness (55%). In managing their depression, caregivers were most inclined to seek help to change the situation. Although they reported moderate success with this approach, caregivers were considerably more satisfied if they could change the situation on their own. Some concern was noted by the authors due to the large

number (16%) who reported they failed to cope with depression (Barusch, 1988).

In a study by Jones and Vetter (1984), 256 family caregivers of the elderly were interviewed. A semi-structured questionnaire was used to establish the type and frequency of assistance provided, levels of stress, and the ways in which the caring affected their own quality of life in terms of social interaction, employment, family, health and mental well-being. Anxiety and depression were the two categories of psychological morbidity that were measured. The measurements were based upon a list of symptoms and signs normally associated with anxiety and depression which were taken from a larger set of questions that had been validated by comparing scores with psychiatric opinion. Many of the caregivers (18%) indicated that they were under a considerable or an unbearable amount of stress. The results indicated that the number of subjects rated as depressed, or anxious, was higher than for the normal population (Jones & Vetter, 1984).

There are a limited number of studies which focused on variables which may mediate the stress of caregiving. A study by Baille, Norbeck, and Barnes (1988) not only investigated the stress of the caregiver role and the accompanying level of psychological distress, but also the variable of social support as a potential mediator of stress. The subjects consisted of 87 family caregivers of impaired elderly. Psychological distress was measured with the Profile

of Mood States (POMS). Depression was one of six identifiable mood states that was measured along with anxiety, anger, vigor, fatigue, and confusion. The findings indicated that perceived stress was positively related to psychological distress. Satisfaction with social support was negatively related to psychological distress. The investigators of the study suggested that caregivers who are caring for impaired elderly, who have provided care for an extended time, and who have low social support are at high risk for psychological distress or depression (Baillie, Norbeck & Barnes, 1988).

In conclusion, a limited number of studies investigating caregiver depression were found. The literature indicates a higher incidence of depression in family caregivers than in the general population. One study noted a higher incidence of depression in female caregivers. Another study investigated the role of social support as a variable to mediate the stress of caregiving. A limitation frequently noted from the literature reviewed was the lack of documentation of instrument reliability and validity.

#### Spirituality and Depression

Only two studies were found that investigated both spirituality and depression. Both of the studies were correlational in design and were conducted in 1987 by Fehring, Brennan, and Keller, to investigate the relationship between spirituality and psychological mood states in response to life change in college students. In the first study a

Spiritual Well-Being Scale (SWB), a Religious Life Scale, a Life-Change Index (LCI), and the Beck Depression Inventory (BDI) were administered to 95 freshman nursing students. The SWB scale (Paloutzian & Ellison, 1982) was composed of two sub-scales; a Religious Well-being (RWB) and an Existential Well-being Scale. The Religious Life Scale is made up of 14 items that ranked highest on four dimensions of religiosity in a large study of over 3,000 Mennonites. The instrument was developed as a composite of spiritual maturity (SM). The scale identifies feeling and doing as an expression of religion, rather than beliefs and knowledge. The Beck Depression Inventory (BDI), is a 21-item, self-administered questionnaire. Depression was operationally defined as mood alternations, negative self-concept, regression, vegetative changes, and change in activity. The Life Change Inventory (LCI) was developed as a tool to specifically quantify the readjustment experienced by college students.

In the second study 75 students were randomly chosen from the same private university. Two additional measures, the Profile of Mood States (POMS), and the Spiritual Outlook (SO) Scale, were added to the previous tests. The SO scale measures goals, values, beliefs, commitments, and forgiveness using a 20-item Likert-type scale.

The results of these two studies support the premise that depression in response to life-change is in some way mediated by the individual's sense of spiritual well-being. There was a significant inverse relationship between BDI and

the spiritual variables of SWB (-.46,  $p < .001$ ), EWB (-.60,  $p < .001$ ), and SO (-.45,  $p < .001$ ). For the college students in these studies, mediation was reflected in a purpose and satisfaction in life (EWB) and not in a relationship with God (RWB). The authors suggest that this may reflect the level of spiritual maturity in a young undergraduate population (Fehring et al., 1987).

The two studies were limited because they were replications with subjects from the same undergraduate population. Also, reliability and validity data were not given for the Religious Life Scale, and there was only test-retest reliability scores for the Spiritual Outlook Scale. Recommendations for further research were focused on the examination into the developmental process of spiritual well-being and its role in the stress response, especially with other populations (Fehring et al., 1987).

In summary, after review of the literature it is apparent that there is limited research about spirituality, depression in caregivers, and the relationship of spirituality and depression. The literature does suggest that spirituality is an important resource for individuals who are chronically or terminally ill, as well for family caregivers. Family caregiving has been found to be very stressful, and there is evidence to suggest that it can result in negative psychological outcomes such as depression. The role of caregiver resources as mediators of stress has been investigated to a limited degree.

There are some limitations noted after the review of the literature. One major limitation is the lack of adequate validity and reliability data on several of the instruments used to measure both spirituality and depression. Other limitations are the use of multiple terms to denote "spirituality" and the varied ways in which spirituality is operationally defined in each study. It is therefore difficult to compare the results of the studies. Due to these limitations, as well as the lack of any studies investigating spirituality and depression in caregivers, further research is needed.

#### Conceptual Framework

When elderly family members are no longer able to care for themselves due to the normal physical changes of aging, or chronic illness, it is generally family members who become the caregivers (Shanas, 1979). Research has shown that caregivers experience stress in varying degrees, and that stress seems to be modified by many complex variables (Bunting, 1989). Neuman's wholistic systems model which is based on the concepts of "stress" and "reaction to stress" is an appropriate framework to provide the basis for examining the research question and discussing the implications of the study findings.

Neuman's model (1989) views each person as a unique individual. Each person is described as a multidimensional being; a composite of psychological, physiological, socio-cultural, spiritual, and developmental variables (or parts).

The five variables ideally function harmoniously in relation to internal and external environmental stressor influence (Neuman, 1989).

When individuals take on the caregiver role there are multiple stressors that they encounter. Stressors are defined by Neuman (1989) as "tension producing stimuli with the potential for causing disequilibrium" (p.23). Caregiver stressors include (a) handling increased responsibilities and changes in family roles, (b) uncertainty about the future, (c) personal health needs, (d) social isolation, as well as, (e) facing the reality of aging and eventual death (Archbold, 1980; Cantor, 1983; Corbin, 1988; & Wilson, 1989). Although most caregivers endure great stress, they vary in their reaction and ability to cope successfully (Given, King, Collins, & Given, 1988).

According to Neuman (1989) an individual's reaction to stressors can be partly explained by the individual's unique central core, lines of defense and the lines of resistance. This uniqueness is due to the interrelationship of the five client variables (parts). Neuman defines the central core as the basic structure of the individual which consists of basic survival factors, such as innate or genetic features. The first line of defense is the "flexible line of defense" which acts as a protective buffer system to prevent stressor invasion, and protects the "normal line of defense." The flexible line of defense is the immediate response to a perceived stressor. The second line of defense is the "normal



line of defense" which is defined as "the state to which the client has evolved over time, or the usual wellness level" (Neuman, 1989, p. 30). It serves to maintain equilibrium under normal circumstances. The third line of defense is the lines of resistance. They are defined by Neuman (1989) as internal protection factors that are activated when stressors have penetrated the normal line of defense, causing a reaction or symptomatology. They function to stabilize and return individuals to their normal wellness state, or possibly to a higher level of stability (Neuman, 1989).

When a caregiver's "flexible line of defense" is not capable of protecting and maintaining the normal line of stability from the impact of stressors, then disequilibrium occurs. Depression is a frequently noted psychological reaction to the stress of caregiving that can result from this disequilibrium (Baldwin, 1988). Symptoms of depression may be the result of anger, guilt, fatigue, or feelings of helplessness that can result from the caregiving role (Williams, 1989; Brody, 1985). When the symptoms of depression occur, the internal lines of resistance assist in bringing the individual back to his/her stable condition, or to a higher level of wellness. If this does not happen then more severe symptoms of depression can result and lead to further instability.

Spirituality is a client resource that may mediate the stress associated with the caregiving role by influencing the perception of the stressors. It can affect how a person

views life and copes with illness, suffering, and loss (Carson, 1989). Spirituality can positively influence caregivers' perceptions of the situation in several ways. It has the potential for creating meaning and purpose in the caregiver's life, for producing harmony with self, others, and God (as defined by the individual), and for giving the caregiver inner strength to cope (Burkhardt, 1989). Therefore when caregivers are confronted with stressors, their innate spiritual component can interact with the psychological component and mediate negative psychological outcomes, by influencing their perception of the events. Spirituality can play a vital role in protecting the client's "normal stability", and preventing depression from occurring; or it may function to assist them to "reconstitute" to their previous level, or a higher level, if the line of defense is penetrated. Therefore, the spiritual component of individuals can have a mediating influence on the stress of caregiving.

Nurses play an important role in working with family caregivers. According to Neuman (1989) the major concern of nursing is to keep the client system stable; this is done in part through accurate assessment of client stressors, as well as client resources. Spirituality is an innate component of each individual that should not be overlooked. It is necessary for nurses to assess and identify all of the resources that individuals use to cope. It is important to keep in mind that the spiritual dimension may serve as a

resource for purpose, strength, and hope for caregivers and should be supported and reinforced whenever possible.

#### Hypothesis and Research Questions

This study sought to test the following hypothesis: The level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly.

In addition, the following research questions were explored: (1) What percentage of variance in depression is explained by the demographic variables of age and gender, and the independent variable of spirituality?, and (2) What differences are there in age, gender, family relationship, and level of education between family caregivers of the elderly for whom spirituality is, or is not, a consistent resource in their lives?

#### Definition of Terms

The following operational definitions were utilized for this research:

1. Spirituality: the degree to which actions of individuals are guided by stable and consistent values, derived from religious, familial, or cultural traditions or from personal philosophy (Hammer and Marting, 1988). Spirituality was measured using the Spiritual\Philosophical subscale from the Coping Resources Inventory (Hammer and Marting, 1988).

2. Depression: a group of depressive symptoms, and in particular the affective component of depressed mood.

Depression was measured using the modified Center for Epidemiologic Studies Depression Scale (Radloff, 1977).

3. Caregiver: a relative caring for a family member 65 years of age or older who has a deficit in at least one Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL). The caregiver has to be the family member who is acknowledged as the primary caregiver for the relative.

## Chapter III

### METHODOLOGY

#### Research Design

The data for this study came from a larger caregiver study conducted by Given and Given (1989b). A three year grant was awarded for this primary study by the National Institute of Aging, entitled "Caregiver Responses to Managing Elderly Patients at Home" (#R01-AG06584). The primary study used a longitudinal design. Data were collected over a twelve month period and consisted of contacts with participants every three months. The contacts were made through telephone interviews and mailed questionnaires. The primary goal of the funded study was to identify and describe the involvement in care, and perceptions of burden experienced by family members who were managing care of elderly patients in the home.

In the larger caregiver study several variables, including depression, were collected from the subjects at multiple data collection points. However, the data on spirituality were collected only at the last collection point. This study employed a cross-sectional descriptive correlational design which utilized the data on spirituality and depression from the final collection point.

#### Sample

The target population was family caregivers of the elderly. Three hundred and seven caregivers met all criteria for entry into the longitudinal study. The data for the

present study were obtained from a convenience sample of 191 family caregivers who participated in the final data collection, at the twelve month point of the study. Caregiver inclusion criteria were: (a) caregivers had to be caring for a family member over the age of sixty-five, (b) the family member being cared for had to have at least one deficit in Activities of Daily Living or Instrumental Activities of Daily Living, and (c) the caregiver had to be the acknowledged primary caregiver for the relative.

#### Recruitment

Community-agency health care professionals were asked to distribute informational letters and stamped return postcards to interested subjects. Letters included the description and purpose of the study, potential benefits, and the length of time and involvement required for participation. Interested caregivers returned postcards to the M.S.U nursing research office. Follow-up on all postcards was conducted by members of the research staff. A screening questionnaire was administered to the designated caregiver over the telephone to determine eligibility for the study.

#### Method of Data Collection

Approval from the Human Subject Review Committee was obtained prior to data collection. Sociodemographic data were compiled from the screening instrument, interviewer telephone conversation at intake, and a mailed self-administered questionnaire. Data on spirituality and depression were obtained from a self-administered questionnaire booklet

sent out at the final collection point, which was twelve months after the beginning of the study. The booklet contained approximately 150 items which measured multiple caregiver variables. The items measuring spirituality and depression were listed along with items measuring other variables. The sections were not labeled so the caregivers were not aware of the specific concepts under study. Verbal consent was received during screening, and written consent forms (see Appendix A) were mailed to the caregiver and returned with the self-administered questionnaires.

### Instruments

To assess the presence of depressive symptomatology in caregivers of the elderly, a slightly modified version of the Center for Epidemiologic Studies Depression Scale (CES-D) was used (see Appendix B). The original CES-D scale (Radloff, 1977) (see Appendix C) is a short, 20-item self-report instrument developed at the National Institute of Mental Health to measure depressive symptomatology in the general population, with emphasis on the affective component, depressed mood. It consists of 16 statements of depressive symptomatology. Examples of items include: "I did not feel like eating"; "I had crying spells"; and "I felt sad." It also has four positively worded statements such as: "I felt hopeful about the future"; and "I enjoyed life." The positively worded statements were included to break tendencies toward response set, and to assess positive affect (or its absence). Each statement response is scored

on a four-point Likert-type scale ranging from 0-3. The value responses indicate the frequency of occurrence of the symptoms during the past week. The scoring format is: "Rarely or none of the time" (0), "Some or a little of the time" (1), "Occasionally or a moderate amount of time" (2), and "Most or all of the time" (3). The depression score is the sum of the item responses after the four positively worded statements are reverse scored. The potential range of scores for the CES-D is 0 through 60 with a cut off point of  $\geq 16$  used to distinguish those with a sufficient amount of depressive symptomatology that they closely resemble depressed patients in treatment (Radloff, 1977).

The original CES-D scale was modified in two ways for this study. First, rather than having 20 items, one of the four positively worded items, "I was happy," was inadvertently omitted, leaving a total of 19 items. Second, rather than asking about the caregivers frequency of depressive symptomatology in the past week, it asked about the frequency during the past month. The possible range of scores on the modified CES-D was 0 through 57. The cut off point of  $\geq 16$  was maintained from the original scale.

The original CES-D was reported acceptable for use in both clinical and general populations with reliability coefficients above .90 and .85 respectively. It was found to have adequate test-retest repeatability. Validity was established by comparing patterns of correlations with other self-report measures, by making correlations with clinical



ratings of depression, and by identifying relationships with other variables which support its construct validity (Radloff, 1977). The CES-D was also found to be appropriate for measurement of depression in older adults because it contains a minimum number of items (two) that focus on somatic problems, the majority are affective, unlike some other depression scales (Gallagher, Thompson, & Levy, 1980). The alpha coefficient of the modified CES-D for this sample was .91.

To assess spirituality as a resource for family caregivers of the elderly, the Spiritual/Philosophical subscale (see Appendix D) from the Coping Resources Inventory (CRI), developed by Hammer & Marting (1988) was used. The CRI is a 60 item instrument that measures resources in five domains: Cognitive, Social, Emotional, Physical, and Spiritual/Philosophical. The resource domains were established on the basis of experience in conducting stress programs, working with individual clients, and extensive review of the literature on coping resources (Hammer & Marting, 1988). The Spiritual/Philosophical subscale of the CRI consists of 11 items. The response choices are on a four-point Likert-type scale, ranging from 1 through 4. A modification was made for this study and the response choices ranged from 0 through 3. The possible ranges for both scales are (a) 11 through 44 for the original scale and (b) 0 through 33 for the modified scale. According to Hammer and Marting (1988) the higher the scale score, the higher the resource. The

response choices for the subscale were: "Never or rarely", "sometimes", "often" and "always or almost always". Examples of items include: "I accept the mysteries of life and death"; and "My values and beliefs help me to meet daily challenges." Respondents were instructed to circle the answer they felt most described their feeling/belief about each specific item. In development of the instrument, construct validity has been supported by administering it to varied groups of people. Clergy were contacted as content experts to help determine validity. The item-to-scale correlation for the subscale ranged from .34 through .67 with a mean score of .42 (Hammer & Marting, 1988). Moderately high reliability has been demonstrated by a Cronbach's alpha of .80 for a sample of 749 individuals (Hammer & Marting, 1988) and an alpha of .86 for 278 family caregivers of cancer patients (Keilman, 1989). The alpha coefficient for this sample was .83.

Demographic data (see Appendix E) were obtained from the caregivers through telephone interviews and self-report questionnaires. The demographic variables obtained for this study included information about caregiver (a) age, (b) gender, (c) level of education, (d) marital status, (e) family relationship, (f) race , and (g) length of time in caregiver role.

## CHAPTER IV

### RESULTS

#### Sample Characteristics

The sample for which data were analyzed for this study consisted of 191 family caregivers of elderly individuals. The caregivers represent a convenience sample solicited for voluntary participation via community-based health care agencies. The mean age of the sample was 62 (SD 11.57) with a range of 27 through 84 years. One hundred and sixty-one of the subjects were females (84.3%) and 30 were males (15.7%). The majority of the subjects were Caucasian (93.7%), married (81.2%), high school graduates or had some college education (78.7%), and were caring for their spouses (54.4%). The duration of caregiving ranged from 1 to 61 years with a mean of 6.86 years (SD 7.0) See Table 1 for additional demographic characteristics.

The mean scores on the instruments which measured spirituality and depression were calculated for the sample. The mean score on the Spiritual/Philosophical subscale was 23.59 (SD 5.85) with a range of 8 through 33. The mean score on the modified CES-D was 14.49 (SD 8.65) with a range of 0 through 43 (see table 2). The majority (57%) of the subjects scored below 16 on the modified CES-D.

Table 1

Demographic Characteristics

N=191

Variable	N	%
<u>Age</u>		
20-39	10	5.2
40-49	24	12.6
50-59	26	13.6
60-69	77	40.3
70-89	54	28.3
Total	191	100.0
<u>Gender</u>		
Male	30	15.7
Female	161	84.3
Total	191	100.0
<u>Race</u>		
Caucasian	179	93.7
Non-Caucasian	12	6.3
Total	191	100.0
<u>Marital Status</u>		
Single	13	6.8
Married	155	81.2
Divorced, Widowed, or Separated	23	12.1
Total	191	100.1*
<u>Relationship of Care Recipient to Caregiver</u>		
Spouse	105	55.0
Parent	63	33.0
Child	11	5.8
Sibling or Other	12	6.3
Total	191	100.1*
<u>Highest Level of Education</u>		
Less than H. S. Grad.	41	21.2
High School Graduate	43	23.3
Some College	67	34.7
College Graduate	17	8.8
Grad./Prof. Degree	23	11.9
Total	191	99.9*

\*Total does not equal 100.0% due to rounding error.

Table 2

Mean, Standard Deviation, Range, and Pearson Correlation  
for Spirituality and Depression

N=191

Variable	Mean	SD	Range	Spirituality	Depression
<u>Spirituality</u>	23.59	5.85	8-33	-----	-.2934*
<u>Depression</u>	14.49	8.65	0-43	-.2934*	-----

\*1-tailed significance  $p < .001$

### Hypothesis

To determine if there was a relationship between caregiver spirituality and depression a Pearson Product Moment Correlation Coefficient was calculated. The research hypothesis: "The level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly", was supported. A significant, but moderately weak negative correlation was found between the two variables ( $r = -.2934$ ,  $df = 189$ ,  $p < .001$ ). (See Table 2).

### Research Question 1

To answer the first research question: "What percentage of variance in depression is explained by the demographic characteristics of age and gender, and the independent variable of spirituality?", a stepwise multiple regression analysis was computed. Spirituality entered into the regression analysis and accounted for nine percent ( $R^2 = .08943$ ) of the variance in depression. However, the variables of age and gender did not significantly help to explain the variance (see Table 3).

Table 3

### Regression Analysis of Caregiver Depression to Caregiver Spirituality

N=191

Independent Variable	Depression (dependent variable)			
	F	Significance	Multiple R	R Square
<u>Spirituality</u>	18.551	.0000	.29897	.08938

## Research Question 2

The second research question was, "What differences are there in age, gender, family relationship, and level of education between family caregivers of the elderly for whom spirituality is, or is not, a consistent resource in their lives?" To answer the research question, the study sample was divided into two groups. The groups were determined according to their scores on the Spiritual/Philosophical subscale. There were 11 items on the subscale with response choices ranging from 0 "never or rarely" to 3 "always or almost always." The total possible score was 33. The score of 33 was divided in half and those that fell below the halfway point of 17 were placed into Group 1, which indicated that spirituality was not a consistent resource. The subjects that scored 17 or higher were placed into Group 2, which indicated that spirituality was a consistent resource. According to Hammer and Marting (1988) the higher the score the higher the resource .

The two groups were compared for differences in age, gender, family relationship, and level of education. The mean age for Groups 1 and 2 was similar (61 and 63 years respectively). The majority of male (63% or 19) and female (62% or 100) caregivers indicated that spirituality was a consistent resource (Group 2). The majority of Group 1 (87%) and 2 (89%) provided care for their spouse or parent. Both groups were also similar in their level of education. The majority of the subjects in Group 1 (76%) and Group 2

(80%) had a high school education or above. Appropriate univariate statistics were used to identify significant demographic differences between the two groups. However, no significant differences were found.



## Chapter V

### DISCUSSION/ LIMITATIONS/IMPLICATIONS

#### Discussion

There was a significant, but moderately weak negative correlation found between spirituality and depression in family caregivers of the elderly ( $r = -.2934$ ,  $df = 189$ ,  $p < .001$ ). The directionality of this relationship is consistent with the results reported by Fehring et al. (1987) who found strong inverse relationships between depression and several spiritual variables in college students. It is difficult to compare the results between the studies further because different instruments were used to measure spirituality and depression and the subjects in each study represented very different age groups.

Although a negative correlation was found between the variables of spirituality and depression, the correlation was moderately weak. There are some factors that may help to explain the weakness of the relationship between the variables. One factor may be that the Spiritual/Philosophical subscale developed by Hammer and Marting (1988) does not capture enough of the multiple facets of the concept of spirituality. It is a relatively new subscale and consists of only 11 items. Only three items appear to measure the aspect of spirituality that relates to God and religion. The majority of the items measure the concept primarily in a philosophical or existential manner. Although spirituality is broader than formalized religion,

more items may need to be added to capture the religious facet. The majority of family caregivers in the study were over 60 years old, and because of their age possibly had a greater integration of religious beliefs and values (Fehring, Brennan, & Keller, 1987). Further psychometric testing of the subscale is needed.

Another factor which may explain the weak relationship between the variables may be indirectly related to the large number of items that were asked in the original study. The caregivers had approximately 150 items to answer that measured several variables including spirituality and depression. The length of time required to complete the extensive number of items may have affected how accurately the caregivers answered, which may have influenced their final scores on the two research variables.

As mentioned in the previous chapter, the variable of spirituality was found to account for nine percent of the variance in depression. Although spirituality appears to explain only a small amount of the variance in depression, it should not be ignored. Perhaps this resource gives caregivers purpose, hope, and meaning in the caregiver role. It may influence their perception of the stressors they encounter and allow them to handle them more effectively. The resource of spirituality, combined with the other resources that family caregivers utilize, may enable some caregivers to continue caring for their elderly family member in spite of multiple stressors. This supports Neuman's (1989) model

of "stress" and "reaction to stress", in which she theorizes that it is the combination of variables (psychological, physiological, sociocultural, developmental, and spiritual) working together at the various levels of defense, that maintain human beings in a state of equilibrium, or assists them to reconstitute to a higher level in the face of both internal and external stressors. All of the resources that individuals utilize must be identified. It is most likely the total summative strength of these resources that gives caregivers the ability to cope with the chronic stress that caregiving can bring.

It is unclear why the demographic variables of age and gender did not help to explain the variance in caregiver depression. In the general population, higher incidences of depression have been found in individuals over 60 and those who are female (Mauer, 1986). Perhaps there are other variables that were not investigated in this study that may help to better explain the variance in depression for family caregivers. Some of the variables may be (a) length of time in the caregiving role, (b) health status of the caregiver, (c) income, and (d) perceived social support.

It is interesting to note that there were no significant differences found between family caregivers for whom spirituality was a consistent resource and those for whom it was not. Perhaps this can be explained in part because of the limitation in variability among the sample. The majority of the subjects were female, Caucasian, and well

educated. This may have resulted from the use of a convenience sample. It is not known how the inclusion of more males, more subjects from other races, and more individuals with less education may have influenced the results.

Another interesting finding is that the majority of the subjects (57%) scored below the cut off point of 16 on the modified CES-D. According to Radloff (1977), this indicates that the majority of subjects did not have a sufficient amount of depressive symptomatology to resemble depressed clients in treatment. However, the mean score of the sample (14.49) does approach the scale cut off of 16. Although the majority of the sample did not appear to be notably depressed at the time of data collection, it is unknown how this may change over time.

One major finding of importance is that the majority of the subjects (62.3%), both male and female, indicated that spirituality was a consistent resource in their lives. This was suggested by scores of 17 and above on the Spiritual/Philosophical Subscale. For the purposes of the study, the range of scores from 17 through 33 was used to represent a higher number of responses to the items in the "often" and "always or almost always" categories. A closer evaluation of the subscale items is needed to determine if some of the items are more heavily weighted than others. It is possible that lower scores may also indicate a consistent use of spirituality. However, the findings are significant because it seems to clearly suggest that spirituality does exist as

a resource and that spirituality can be expressed and measured. The importance of spirituality among caregivers in this study extends the findings noted earlier (Baines, 1984; Keilman, 1989; Pratt, et al., 1985; Wilson, 1989).

#### Limitations

There are several areas which present possible limitations to the present study. The use of the modified CES-D is one limitation. Modifications to the original CES-D included the omission of the positively worded item "I was happy", and the measurement of subjects' frequency of depressive symptoms over the past month, rather than the past week. The original CES-D had been subjected to rigorous testing and had demonstrated high reliability and validity (Radloff, 1977). Although the modified CES-D demonstrated high internal consistency (Cronbach's alpha .91) for this sample, further testing is necessary. The validity of the modified instrument was not investigated in the original study. It is unknown how the modifications to the original CES-D may have affected its ability to measure depression.

Another limitation of the study was the use of the Spiritual/Philosophical subscale developed by Hammer and Marting (1988). The subscale is relatively new and consists of only 11 items. The items appear to heavily concentrate on the philosophical/existential facet of spirituality. The subscale seems to lack an adequate representation of items on the facet of spirituality that pertains to God and religion. Although clergy were utilized as "content experts" in

the development of the scale, it is unknown what the religious backgrounds of the clergy were, and how many clergy actually were involved. Input from a diverse selection of clergy, as well as philosophers, may provide an additional perspective. Although internal consistency for this sample was found to be moderately high for the subscale (coefficient alpha .83) further testing with different samples, as well as the same sample over time, needs to be continued. Also, the subscale has been found to have a low item-to-scale correlation that ranged from .34 through .67 with a mean score of .42 (Hammer & Marting, 1988). Further investigation into the validity of the subscale needs to be continued.

The use of a convenience sample is yet another limitation of the study because it decreases the generalizability of the study results to the greater population of caregivers. The sample in this study is skewed toward those family caregivers who have a high level of education and are Caucasian. It is not known to what extent individuals who chose not to be part of the study may have influenced the results.

The use of a cross-sectional research design in which the variables are measured at only one point in time is another limitation to the study. It is not known how a person's beliefs/feelings about spirituality, and symptoms of depression may change over time. It is also important to determine whether other variables or situations during the

caregiver experience decrease or increase the resource of spirituality. Some studies suggest that an individual's spirituality can be enhanced or strengthened during prolonged stressful situations (Belcher, Dettmore, & Holzemer, 1989; O'Brien, 1982; Reed, 1987). Thus, the measurement of spirituality and depression at only point in time may have given an inaccurate picture of the relationship of the variables.

#### Nursing Implications

The study found a moderately weak negative correlation between spirituality and depression in family caregivers. Also, an interesting finding was that the majority of family caregivers indicated that spirituality was a consistent resource in their lives. For these reasons, it is essential that the spiritual dimension of individuals not be neglected when assessing the needs and resources of caregivers. It is assumed that the spiritual dimension exists in all individuals. For some people it may be a very important resource, for others it may not be. A wholistic approach to patient care demands that nurses assess not only the physical, psychological, and social domains, but also the spiritual domain.

There is a need for nursing educators to integrate the spiritual dimension into the basic nursing curricula. This should entail more than information regarding various formalized religious groups, because spirituality is broader than this. It is important that the spiritual dimension of

individuals be addressed not only in the theory component of the course, but also as part of the clinical component. Nurses need to be taught how to assess the spiritual dimension just as they do the other dimensions of human beings.

#### Recommendations for Further Research

The need for further research investigating spirituality is apparent, given the dearth of studies that were found. Specifically, additional research needs to be conducted investigating the relationship of spirituality and depression in family caregivers. Future research should utilize instruments with adequate reliability and validity data. This would provide statistical information that could be interpreted with greater confidence. Several studies in the literature review lacked documentation of instrument reliability and validity.

There is a need for longitudinal studies to determine the changes that may, or may not occur over time between the variables of spirituality and depression. Also, future studies should utilize caregivers obtained from a variety of settings to provide a more representative sample of the caregiver population. This study used caregivers obtained through contacts with community health care agencies resulting in a sample in which the majority of caregivers were Caucasian and had a high level of education. This may or may not have influenced the outcomes of this study.

To better understand the variance in depression in family caregivers, spirituality, as well other caregiver



variables not measured in this study should be investigated. Some of the variables should be (a) length of time in the caregiving role, (b) income, (c) perceived social support, and (d) health of the caregiver. Depression is a frequently reported negative outcome of caregiving that cannot be ignored. According to George and Gwyther (1986) it is the characteristics of the caregiving situation, as well as the resources available to the caregiver, that most directly affects caregiver well-being.

Another recommendation would be to limit the number of items on the research instrument. The primary study questionnaire consisted of approximately 150 items that measured multiple variables, including spirituality and depression. If only spirituality and depression were measured this would result in a short 30-item questionnaire which would be more manageable. Perhaps a short social desirability scale could also be added to help determine if individuals answer the questions related to how they actually believe, or how they think they are expected to answer.

Further psychometric evaluation of the Spiritual/Philosophical subscale is needed. Additional research is necessary to determine how the subscale relates to scores on various other instruments that measure the concept. A factor analysis of the subscale may be helpful to examine which items best reflect each facet that comprises the concept of spirituality. The subscale is relatively new and needs further evaluation and possible revision.

Additional research is also needed to investigate the relationship between spirituality and other caregiver variables. This research was limited only to the study of spirituality and depression. Although a correlation was found between the variables, it was moderately weak. Perhaps there are other caregiver variables which are affected more by the resource of spirituality than depression.

In conclusion, this study supports the premise that caregiver depression is in some way affected by an individual's spirituality. A significant, but moderately weak negative correlation was found between the two variables. This negative correlation is consistent with the research findings purported by Fehring et al. (1987). Another important finding was that the majority (62.3%) of family caregivers, both male and female, reported spirituality was a consistent resource in their lives. Family caregiving has become more commonplace in our society, and it is becoming more necessary for family members to be the primary care providers for their aged family members. It is important that nurses identify all of the resources that caregivers use to cope with the potentially stressful role of caregiving. A wholistic approach to nursing practice is necessary in order to identify the bio-psycho-social resources of caregivers, as well as the frequently neglected resource of spirituality. The outcomes of this study have contributed to a better understanding of spirituality among caregivers of the elderly. Further research needs to be conducted to provide

the empirical knowledge base that is necessary to develop a clearer understanding of how the concept of spirituality operates in individual's lives.

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APPENDIX A

Family Caregiver Study Consent Form

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MICHIGAN STATE UNIVERSITY  
Family Caregiver Study

CONSENT FORM

The study in which we are asking you to participate is designed to learn more about the ways in which caring for an older family member affects the person providing care.

Over the next year, family caregivers will be interviewed by a member of the Family Caregiver Study research staff three times (at intake, six months, and at one-year). This interview will take approximately one and one-half hours to complete. Caregivers will be asked to complete written questionnaires and to answer questions asked by the interviewer. They will also be asked to report, each three months during the year, on any health care services used.

If you are willing to participate, please read and sign the following statement:

1. I have freely consented to take part in a study of caregivers and their patients conducted by the College of Nursing and the Department of Family Practice, College of Human Medicine, at Michigan State University.
2. The study has been described and explained to me and I understand what my participation will involve.
3. I understand that participating in this study is voluntary.
4. I understand that I can withdraw from participating at any time.
5. I understand that the results of the study will be treated in strict confidence and, should they be published, my name will remain anonymous. I understand that within these restrictions, results can, upon request, be made available to me.
6. I understand that no immediate benefits will result from taking part in this study, but am aware that my responses may add to the understanding of health care professionals of the experience of being responsible for an older family member.

I, \_\_\_\_\_, state that I understand what is required of me as a participant and agree to take part in this study.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(signature)

APPENDIX B

MODIFIED CENTER FOR EPIDEMIOLOGIC STUDIES  
DEPRESSION SCALE (CES-D)

MODIFIED CENTER FOR EPIDEMIOLOGIC STUDIES  
DEPRESSION SCALE (CES-D)

These next questions are about how you feel, and how things have been with you mostly within the past month.

For each question, read the statement then circle the one answer that comes closest to the way you have been feeling during the past month. There are no right or wrong answers. Do not spend too much time on any one statement.

DURING THE PAST MONTH, HOW MUCH OF THE TIME...

1. were you bothered by things that usually don't bother you?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

2. have you not felt like eating; had a poor appetite?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

3. have you felt that you could not off the blues, even with the help from family or friends?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

4. have you felt that you were just as good as other people?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

5. have you had trouble keeping your mind on what you were doing?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

6. have you felt depressed?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

7. have you felt that everything you did was an effort?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

DURING THE PAST MONTH, HOW MUCH OF THE TIME...

8. have you felt hopeful about the future?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

9. have you thought your life has been a failure?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

10. have you felt fearful?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

11. has your sleep been restless?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

12. have you talked less than usual?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

13. have you felt lonely?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

14. were people unfriendly?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

15. have you enjoyed life?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

16. have you had crying spells?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

17. have you felt sad?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

18. have you felt people disliked you?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------



19. could you not get "going"?

ALMOST ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	RARELY OR NONE OF THE TIME
---------------------------	---------------------	---------------------	-------------------------------

Coding:

0 = Rarely or None of the Time  
1 = Some or A Little of the Time  
2 = Occasionally or a Moderate Amount of Time  
3 = Most or All of the Time

\*Modifications on the instrument were made by Given and  
Given (1989).

**APPENDIX C**

**CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE**

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CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE

INSTRUCTIONS FOR QUESTIONS: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

- 0 = Rarely or none of the time (less than 1 day)
- 1 = Some or a little of the time (1-2 days)
- 2 = Occasionally or a moderate amount of time (3-4 days)
- 3 = Most of all of the time (5-7 days)

During the past week:

- 1. I was bothered by things that usually don't bother me.
- 2. I did not feel like eating; my appetite was poor.
- 3. I felt that I could not shake off the blues even with the help of my family or friends.
- 4. I felt that I was just as good as other people.
- 5. I had trouble keeping my mind on what I was doing.
- 6. I felt depressed.
- 7. I felt that everything I did was an effort.
- 8. I felt hopeful about the future.
- 9. I thought my life had been a failure.
- 10. I felt fearful.
- 11. My sleep was restless.
- 12. I was happy.
- 13. I talked less than usual.
- 14. I felt lonely.
- 15. People were unfriendly.
- 16. I enjoyed life.
- 17. I had crying spells.
- 18. I felt sad.
- 19. I felt that people dislike me.
- 20. I could not get "going."

APPENDIX D

SPIRITUAL/PHILOSOPHICAL SUBSCALE

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**PLEASE NOTE**

**Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.**

**Appendix D, 57-58**

**University Microfilms International**

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**APPENDIX E**

**DEMOGRAPHIC CAREGIVER DATA FORM**

\*DEMOGRAPHIC CAREGIVER DATA FORM

1. What is your date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/date/year
2. How far did you go in school? Did you complete:  
\_\_\_\_ Grade school or less  
\_\_\_\_ Some high school  
\_\_\_\_ High school  
\_\_\_\_ Some college or technical training  
\_\_\_\_ Graduate or professional school  
(post baccalaureate degree)
3. What is your marital status?  
\_\_\_\_ Single, never married  
\_\_\_\_ Married  
\_\_\_\_ Widowed  
\_\_\_\_ Separated  
\_\_\_\_ Divorced  
\_\_\_\_ Other (Please specify\_\_\_\_\_)
4. What is your race? Are you:  
\_\_\_\_ Caucasian  
\_\_\_\_ Black  
\_\_\_\_ Hispanic  
\_\_\_\_ American Indian  
\_\_\_\_ Oriental/Pacific Islander  
\_\_\_\_ Other (please specify\_\_\_\_\_)

5. What is your relationship to the person you provide care for?

\_\_\_ Spouse

\_\_\_ Parent

\_\_\_ Daughter (in-law)/ son (in-law)

\_\_\_ Brother (in-law/ sister (in-law)

\_\_\_ Other (please specify\_\_\_\_\_)

6. What is the length of time you have been providing care for your family member?

Years\_\_\_\_\_ Months\_\_\_\_\_

\* This is only a portion of the demographic data that was collected during the original caregiver study by Given and Given (1989).



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