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## Caregiver Wellness Following Interventions Based on Interdisciplinary Geriatric Assessment

Julie A. Smith  
*Grand Valley State University*

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CAREGIVER WELLNESS FOLLOWING INTERVENTIONS  
BASED ON INTERDISCIPLINARY GERIATRIC ASSESSMENT

By

Julie A. Smith

A THESIS

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Thesis Committee Members:

Katherine K. Kim, Ph.D., R.N.

Lucille Grimm, Ed.D., R.N.C.

Ron Rozema, ACSW

## ABSTRACT

### CAREGIVER WELLNESS FOLLOWING INTERVENTIONS BASED ON INTERDISCIPLINARY GERIATRIC ASSESSMENT

By

Julie A. Smith

The study purpose was to examine the effect on interventions based on interdisciplinary geriatric assessment on family caregiver's wellness. A pretest-posttest research design was used, including a sample of 35 family caregivers of frail older adults. Neuman's Systems Model provided the theoretical framework. Care recipients and caregivers were evaluated by an interdisciplinary geriatric team and interventions for that family were developed and implemented. Paired t-tests and Wilcoxon matched-pairs signed rank test were performed to compare scores of pretest and posttest scores on self-rated health, the Burden Interview and Life Satisfaction, before and after the intervention. Results indicated that there was no significant improvement in caregiver wellness, yet the caregiver's physical and psychological wellness were maintained during the 3 month study period. Nursing implications include the need for caregiver assessment and development of a specific plan of care for families.

## Acknowledgements

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## CHAPTER ONE

### INTRODUCTION

A myriad of research is available on the negative effect of caring for the frail older adult on caregiver's physical and psychological wellness. Research indicates that providing care to a disabled family member places physical, emotional and financial demands on caregivers (Evans, Bishop, & Dusley, 1992). Yet, these same family caregivers are the "hidden patients" in geriatric care (Silliman, McGarvey, Raymond, & Fretwell, 1990, p. 462). Comprehensive interdisciplinary geriatric assessment has been demonstrated to be a valuable strategy in improving outcome for frail older adults (American College of Physicians, 1989; Society of General Internal Medicine, 1989; American Geriatric Society, 1989). The National Institutes of Health (Solomon, 1988) have described geriatric assessment as a multidisciplinary approach in which problems are uncovered, described, explained, and services assessed to develop a plan of care. The question should then be asked, what is the effect of interventions that are based on interdisciplinary geriatric assessment on caregiver wellness?

Indications are that families provide the majority of care for their frail and/or disabled older adults. A

Profile of Older Americans (American Association of Retired Persons, 1994) indicated that in 1990 some 67% of non-institutionalized older adults live in a family setting. Additionally, it has been reported that family caregivers are providing between 80% and 90% of medical care, personal care, household maintenance, transportation and shopping for older adults. (Select Committee on Aging, 1988).

Stone, Cafferata, and Sangl (1987) examined data gathered from the 1982 National Long-Term Care Survey and reported that the 1.2 million frail older adults projected to be receiving care at home had a mean score for Activities of Daily Living (ADL's) of 2.2 needs and for Instrumental Activities of Daily Living (IADL's), 5.2, indicating a moderate amount of care required. In this same group 38.4% reported poor health status. Data from Morbidity and Mortality Weekly Report (1990) indicated that most older adults have at least one chronic illness.

Given the abundant evidence of care requirements and the chronic illnesses found in older adults, it is no wonder that caregiving has been described as burden, strain, and stressor (Archbold, Stewart, Greenlick, & Harvath, 1990; Bunting, 1989; Haley & Pardo, 1989; Montgomery, Gonyea, & Hooyman, 1985; Cantor, 1983; Zarit, Reever, & Bach-Peterson, 1980). Yet, Brody (1985) describes caregiving as a normative family stress. Family caregivers continue to provide care to the older adult often at risk to their own physical and psychological wellness.

In recent years, geriatric research has begun to focus on the use of comprehensive geriatric assessment as an effective strategy for improving outcomes for frail older adults (Applegate, Graney, Miller, & Elam, 1991; McVey, Becker, Saltz, Feussner, & Cohen, 1989; Williams, Williams, Zimmer, Hall, & Podgorski, 1987). Yet, this same research offers little in terms of the outcome specific to the family caregiver. In 1987 the National Institutes of Health Consensus Development Conference Statement (Solomon, 1988) identified an area of priority in geriatric assessment to include, "effect on family" (p. 346). Although, "families provide the majority of care to older patients in the home setting and play a critical role in functional recovery following hospitalization, it is surprising that scientific evaluations of geriatric assessment interventions have not included family caregiver wellness" (Silliman et al., 1990, p. 462). To assure preservation of a vital care resource, health care professionals must begin to assess the perceived mental and physical health status of the caregiver.

The purpose of this study is to examine the effect of interventions based on interdisciplinary geriatric assessment on family caregiver's physical and psychological wellness. This study will replicate the work of Silliman, McGarvey, Raymond, and Fretwell (1990).

## CHAPTER TWO

### CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

#### Conceptual Framework

The Neuman Systems Model (1989) provides the conceptual framework for this study (see Appendix A). This model was selected because it is considered "wellness-oriented" (p. 22), based on reaction to stressors within a client system, with the purpose of assisting the nurse to direct and organize appropriate interventions in order to optimize client system stability.

Neuman has identified the client as a complex system in which care must be focused in a holistic approach based on the desire to promote wellness. She has expanded her view of client or client system, "because of respect for newer client, caregiver collaborative relationships" (p. 27) to include individual, family or community. The assumption is then made, that family and family caregivers can be viewed as the client system. For purposes of this study family caregivers are defined as, "interdependent people who engage in tasks aimed at eliminating perceived physiological, psychological, emotional, and/or spiritual burdens of another individual" (Rawlins, 1991, p. 213).

According to Neuman, the client system is represented by a series of rings forming lines of resistance and defense surrounding the basic structure or client system integrity. Therefore, the family caregiver's basic core would be comprised of factors common to all organisms, common survival factors, and unique individual characteristics. Family caregiver stability is focused on protecting the core structure through these various lines.

The three lines, flexible line of defense, normal line of defense, and lines of resistance all have five variables within them. Physiological, psychological, sociocultural, developmental, and spiritual variables are interrelated and determine the nature of the family caregiver system. It is the outermost broken circle, the flexible line of defense, that acts to protect the normal line of resistance for the family caregiver. Ideally, this line of defense would prevent any stressor invasion within the family caregiver client system.

Caregiving is considered a stressor. Neuman has defined stressor as, "any phenomenon that might penetrate both the flexible and normal line of defenses" (p. 50). Multiple stressors identified in caregiving may include: age of the caregiver, income, caregiver's physical and psychological health, care recipients' IADL dependency, behavior and cognitive impairment. Any of these stressors can be, "a tension-producing stimulus that has the potential of causing illness by producing disequilibrium in the body system"

(Ross & Bourbonnais, 1985, p. 201). These same stressors create a reaction with the caregiver system by invading the normal line of defense.

It is the normal line of defense that is considered to be the steady or wellness state of the family caregiver system. Wellness has been defined by Neuman as the optimal system stability in terms of physiological, psychological, sociocultural, developmental and spiritual interacting variables which are at the best possible health state at any given point in time (1989).

Closest to the basic structure of the family caregiver are the lines of resistance. Once stressors have invaded the normal line of defense, lines of resistance ideally work to protect the core structure and facilitate the family caregiver system toward a state of increased wellness.

According to Neuman (1989) the goal of a nursing intervention is to attain or maintain stability and client system integrity. She indicates that an intervention to improve wellness can begin at any point that a stressor is suspected or identified. Interdisciplinary geriatric assessment can be utilized to identify stressors in a family caregiver. It has been defined by the National Institutes of Health as a multidisciplinary assessment, "in which the multiple problems of older persons are uncovered, described, and explained, if possible, and in which the resources and strengths of the persons involved are cataloged, need for service assessed, and a coordinated care plan developed to

focus interventions on the problem" (Solomon, 1988, p. 342). In this context it is used as a secondary prevention intervention which occurs after a stressor reaction, to promote wellness attainment and maintenance by strengthening the internal lines of resistance and thereby protecting the basic structure of the family caregiver.

Utilizing this conceptual framework, a secondary prevention intervention plan of care can be developed, based on an interdisciplinary geriatric assessment of caregivers' physical and psychological wellness. These interventions in turn will improve family caregivers' physiological and psychological wellness (normal line of defense) by strengthening the internal lines of resistance and protecting the basic structure of the caregiver.

#### Review of Literature

In the early 1980s data began to emerge specific to older adult population trends and the increase in longevity. At this same time numerous studies began to investigate the impact of these trends on family caregivers. Early research focused on identification of stress, stressors, and burden to caregivers. By the late 1980s research was beginning to explore the demands of caring for the frail older adult on caregiver wellness and in particular interventions to improve caregiver wellness. It was about this same time that the concept of interdisciplinary geriatric assessment was taking hold. Yet, geriatric literature is extremely limited in terms of the effect of geriatric assessment on

caregiver wellness. Therefore, the review of literature includes studies that explored: (a) caregiver demographics; (b) caregiver stressors; (c) caregiver wellness; and (d) interventions.

Caregivers. Much of the demographic data on caregivers available today relies upon information analyzed from the National Long-Term Care Survey (LTCS) sponsored by the Department of Health and Human Services (1982). This survey targeted functionally impaired older adults in community settings. Some 6400 participants were identified through the Medicare files. Stone et al. (1987), utilized a component of the LTCS called the Informal Caregivers Survey (ICS) in reporting a profile of caregivers. Data from this probability sample projected that of the 2.2 million caregivers in the United States, females comprised 71.5%, adult daughters 28.9%, wives 22.7%, and husbands 13%.

Additional statistics in this report indicated that the average age of the caregiver was 57.3 years; one-quarter were between 65 and 74; and 10.1% were 75 or older. This has led to the caregiver literature discussing that the young-old are caring for the old-old. Three-quarters of caregivers lived with the care recipient. About 50% of adult caregiver children remained working and 9% reported having to leave their place of employment to provide care.

The Select Committee on Aging (1988) reported many of the same findings. This study noted that close proximity to the older adult appeared to be the major factor in



determining which family member would become the primary caregiver. Seventy percent of all caregivers were married. One-third were employed and reported a middle income bracket.

In data based on the 1990 United States Census Bureau, The Association of Retired Persons (1994) reported that 10.3 million or 81% of older adult men and 10.0 million or 56% of older adult women remain in the family setting. Data continues to suggest that caring for frail older adults remains a primary role for family members.

Caregiver stressors. For the last 15 years many studies have described the negative impact of families caring for dependent relatives. Burden, strain, and stressor are some of the most frequently used terms to describe this phenomena. One of the earliest studies on family caregivers was conducted by Zarit et al. (1980). Family caregivers (N = 29) were interviewed for feelings of perceived burden. Although the mean score of burden (M = 31) was less than the authors expected and the sample size was small, multiple variables of the care recipient were identified and measured. These included: cognitive impairment, memory loss, behavioral problems, functional impairment, duration of illness, and frequency of family visits. Of these variables, only the frequency of visits of other family members had a significant effect on the degree of burden expressed by caregivers ( $r = -.48$ ,  $p < .05$ ), meaning that the greater the frequency of visits by other family members,

the smaller the amount of perceived burden by the caregiver. This study also introduced the Burden Interview (BI) which has become a standard measure for caregiver burden.

Montgomery et al. (1985) examined the relationship between caregiving and subjective and objective burden. Family caregivers (N = 80) participated in structured interviews in the respondent's home. Burden was reported to be measured both objectively and subjectively utilizing an adaptation of the BI. Objective measures however, were a self-rating system of perceived changes such as: time for oneself, money available, health alterations, and amount of energy. In this study subjective and objective burden as they were measured, were found to be correlated ( $r = .34$ ). Additionally, in order, age and income were the best predictors of subjective burden ( $r = .35$ ,  $r = -.32$ ). The authors identified small sample size as a weakness but suggested that interventions may be most beneficial if they were focused on the decrease of objective burden.

In 1985, Pratt, Schmall, Wright, and Cleland surveyed family caregivers (N = 240) of Alzheimer's patients. Mean caregiver burden scores utilizing the BI were 40.08 (SD = 17.9) indicating moderate burden. No significant differences in burden scores were identified in terms of caregiver's sex, income, education, or age. Additionally, no significant differences were noted in the care recipient's residence, specifically community or institutional. Of particular interest in this study were

the burden levels in relationship to the caregiver's health status. Caregivers who reported health as excellent or good had a significantly lower burden score than the caregivers reporting fair or poor health  $F(3, 233) = 9.23, p \leq .01$ . Seventy-nine percent of those surveyed reported caregiving affecting their health. Pratt et al. concluded that health and public agencies must recognize the long-term impact of caregiving on the physical and psychological health of the caregiver.

A convenience sample of 54 family caregivers of demented patients were recruited from community sources for interview and questionnaires in a study by Haley, Levine, Lane-Brown, and Bartolucci (1987). This non-random study identified caregiver stressors including: cognitive impairment, dependency in ADL's and IADL's, memory, and behavioral problems found in the care recipient. Appraisal, coping response and social support were measured. Caregiver outcomes were studied in terms of caregiver's depression (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), life satisfaction (Wood, Wylie, & Sheafer, 1969), and self-reported health. Findings indicated that stressors showed little relationship to the identified variables other than care recipients IADL's dependency and caregiver depression ( $r = .38, p < .01$ ), meaning substantial differences exist in caregivers' response to stress. Problems in this study included a small sample size and sample selection bias.

Bull (1990) identified factors that influenced family caregiver burden and health outcomes at 2 week and 2 month intervals, post-discharge from acute hospital settings. Utilizing a convenience sample (N = 47) of caregivers, a correlational matrix analyzed variables of: income, care recipient's physical health and functional ability, caregiver's physical health, and the size of their social network. Multiple regression analysis revealed that caregiver's functional ability, care recipient's functional ability, and size of the social network were the best predictors of burden at 2 weeks post hospital discharge. Findings at 2 months indicated that income, caregiver's functional ability and care recipient's functional ability were the best predictors of burden.

Two studies that specifically related to caregiver burden assessed at geriatric clinics, were found. The first evaluated caregivers (N = 127) of elderly men at a veterans hospital geriatric referral clinic (Drinka, Smith, & Drinka, 1987). This article was of particular importance in that it began to evaluate how the caregivers' psychological wellness may impact their caregiving abilities. The authors hypothesized that "caregivers of chronically ill, elderly men cope better with physical and cognitive incapacity than with affective symptoms" (p. 522). In a chi-square analysis no significant relationship was found between caregiver depression and patient dementia, yet the presence of

caregivers' depression and burden was positively correlated with patients' depression.

Brown, Potter, and Foster (1990) examined how the inclusion of a measure of caregiver burden in a geriatric assessment could improve the prediction of long-term care services. The authors suggested that the most important factor in determining the use of formal services was caregiver burden. A prospective longitudinal study evaluated caregiver burden (N = 109) at 6 and 12 month intervals as clients and caregivers returned to a geriatric assessment program. A series of logistic regression analyses were performed and, when caregiver burden was added as an independent predictor, the prediction of service use ( $\chi^2 = 5.9$ ,  $p < .02$ ) was greatly improved. By one year 27 subjects had been institutionalized. Unfortunately, attrition of participants (n = 43) over the 1 year time frame skewed the results.

Much research has been conducted on caregiver stressors often with conflicting results. Pearlin, Mullan, Semple, and Skaff (1990) describe caregiver stress as, "not an event or as a unitary phenomenon. It is, instead, a mix of circumstances, experiences, responses, and resources that vary considerably among caregivers and that, consequently, vary in their impact on caregivers' health and behavior" (p. 591). With this in mind the need to assess family caregivers' unique stressors cannot be minimized during a geriatric assessment.

Caregiver Wellness. Wellness is a complex relationship and balance within the physical, psychological, socio-cultural, developmental, and spiritual system of the family caregiver. It has been reported as health, well-being, and wellness (Krause, 1994; Heidrich, 1993; Braithwaite & McGown, 1993; McCarthy-Neundorfer, 1991; Neuman, 1989; George & Gwyther, 1986; Mossey & Shapiro, 1982).

Larson (1978) reviewed research over a 30 year period to determine the overall findings of older Americans' subjective well-being. Perhaps the strongest relationship to a positive subjective well-being in the literature available to Larson was physical health. Other findings indicated that lower socioeconomic status and advancing age tended to decrease subjective well-being. There were no correlations reported between gender and subjective well-being. Race was significant in that white subjects reported greater subjective well-being than non-white. Positive relationships were also found in married subjects and those that had involvement in social activities. Overall, this research indicated that subjective well-being was most strongly related to health, followed by higher socioeconomic status and social interaction.

In 1986 George and Gwyther conducted extensive research examining the impact of caregiving on four categories of wellness: physical health, mental health, social participation, and financial resources. A convenience sample of family caregivers of older adults (N = 510) were

surveyed and compared with random community samples. Scores for self-rated health of caregivers and the random community group were similar, 2.99 and 2.81, respectively. Large discrepancies were seen in the mental health areas between the two groups. When comparing caregivers to the random community group, in order, stress symptoms ( $M = 8.34$ ,  $M = 3.04$ ) were higher in caregivers, while life satisfaction was found to be decreased ( $M = 1.97$ ,  $M = 2.46$ ). Selection bias appeared to be a problem in this study because caregivers were already participants in a family support program and the "norm" comparison group was not clearly identified.

Kopito-Motenko (1989) suggested in research of older women caring for their husbands ( $N = 50$ ) that wives care for their sick husbands to maintain their own sense of well-being. This assumption was tested in terms of gratification and frustration. Results of this study concluded that wives who were more gratified had a higher sense of well-being ( $r = .43$ ), yet physical health of the caregiver was not appreciably correlated with gratification ( $r = .17$ ,  $p < .01$ ) or frustration ( $r = -.25$ ,  $p < .01$ ). This study is of particular importance in that family caregivers, particularly wives, may feel responsibility to care, yet the emotional frustrations and gratifications are extremely varied in each family situation. Although the sample size was small and the measurement tool for frustration adapted from families of handicapped children, the conclusion that

frustration and gratification may play a role in the long term life satisfaction of the caregiver has relevance in caregiver research.

McCarthy-Neundorfer (1991) hypothesized that caregiver appraisal of stress was a better predictor of physical health, depression and anxiety than the severity of the care recipient's problems. Sixty spouse caregivers were recruited from an Alzheimer's center. Utilizing the Memory and Behavior Problems Checklist (Zarit & Zarit, 1983) their scores were compared with norms of the elderly (Hale, Cochran, & Hedgepeth, 1984). Little variability was noted comparing the two groups in physical health. Depression and anxiety scores of caregivers ( $M = .64$ ,  $SD = .67$ ;  $M = .50$ ,  $SD = .58$ ) were higher than those of the norm group ( $M = .48$ ,  $SD = .55$ ;  $M = .39$ ,  $SD = .47$ ), although these findings were not significant.

Of particular interest in this study were differences noted between wives and husbands: wives reported a significantly greater severity of care recipient's problems ( $M = 60.6$ ,  $SD = 19.3$ ) than did their husbands ( $M = 47.4$ ,  $SD = 28.4$ ,  $t(58) = 2.12$ ,  $p < .05$ ). Husbands reported having significantly better physical health ( $M = 7.9$ ,  $SD = 2.7$ ) than wives ( $M = 9.6$ ,  $SD = 3.4$ ,  $t(58) = 2.11$ ,  $p < .05$ ). Additionally, caregiver age was not associated with physical health but it was negatively associated with depression for both sexes ( $r = -.25$ ,  $p < .05$ ) indicating younger caregivers



had more depression than older caregivers. This study suggested that differences in terms of depression, anxiety and physical health of caregivers may exist between women and men, and among different age groups.

#### Implications for Study

Although literature strongly suggests that the caregiver has significant stressors that can lead to changes in their physical and psychological wellness, there is not conclusive data on which interventions are most effective. One method that has shown modest results has been the use of psychoeducational groups (Gallagher, 1985; Zarit, Anthony, & Boutsellis, 1987) particularly for improving psychological wellness.

Other studies have focused on respite care. These have been difficult to compare in that respite care is operationalized quite differently and can range from 4 hours per week (Mohide et al., 1990) to a 2-week respite stay in a long-term care facility (Burdz, Eaton, & Bond, 1988). In a meta-analytic review of interventions for caregivers, Knight, Lutzky, and Macofsky-Urban (1993) suggested that both psychosocial and respite interventions were moderately effective in decreasing caregiver distress.

Only one study was specifically found to evaluate the intervention of an interdisciplinary geriatric assessment on caregivers' self-reported physical and psychological wellness. Silliman et al. (1990) randomized 142 caregivers of acutely ill hospitalized frail older adults

for this study. The experimental group (n = 69) of family caregivers were studied to see if the assessment and intervention process had any effect on their self-reported physical and emotional health. Findings indicated that at 3 months, the control group was 2.42 times more likely to report poor physical wellness than were the experimental group ( $p < .05$ ). Emotional wellness was not statistically significant ( $p > .05$ ) indicating that interventions may not improve psychological well-being. Overall findings in this study suggest that although findings are modest, family caregivers' well-being may be enhanced if interventions are coupled with geriatric assessment and a care plan process for both the caregiver and care recipient.

As research indicates, caregiver wellness is complex in nature. It is the relationship between the physical and psychological system, as well as the subjective and objective components that determine the caregiver wellness state. Effective strategies to improve caregiver wellness must, therefore, include careful assessment of each of these components, followed by appropriate interventions unique to that caregiver.

#### Definition of Terms

For purposes of this study key concepts will be defined.

1. Family caregivers are defined as family members that, "engage in tasks aimed at eliminating perceived physiological, psychological, emotional, and/or spiritual burdens of another individual" (Rawlins, 1991, p. 213).

2. Care recipient is defined as a person receiving assistance in physical, psychological, emotional, and/or spiritual realms.

3. Stressor is defined as "a tension producing stimuli with the potential for causing disequilibrium" (Neuman, 1989, p. 23).

4. Caregiver wellness is defined as the optimal stability within the physical and psychological system of the caregiver.

5. Interdisciplinary geriatric assessment is defined as "a multidisciplinary evaluation in which the multiple problems of older persons are uncovered, described, and explained, if possible, and in which the resources and strengths of the persons involved are cataloged, need for service assessed, and a coordinated care plan developed to focus interventions on the problem" (Solomon, 1988, p. 342).

6. Older adult is defined as a person aged 65 years or older.

### Hypothesis

The level of physical and psychological wellness of a family caregiver will be greater after an intervention based on interdisciplinary geriatric assessment as compared to those scores before receiving the intervention.

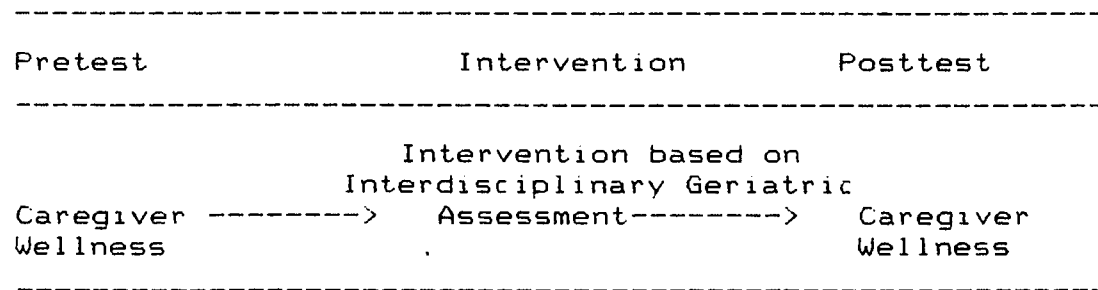
## CHAPTER THREE

### METHODOLOGY

#### Study Design

A one group pre-experimental, pretest-posttest research design (see Figure 1) was used to examine the effect of an interdisciplinary geriatric assessment on caregiver wellness. In this study, data collection took place both before and after the introduction of an intervention but did not compensate for lack of randomization or control group (Polit & Hungler, 1991). At an initial clinic assessment subjects were given a pretest questionnaire regarding their physical and psychological wellness, to be completed at home. Data to study the effect of the intervention based on interdisciplinary geriatric assessment were collected through a posttest questionnaire mailed after a three month interval.

Figure 1. Caregiver wellness using a pretest-posttest one group design.



### Setting and Sample

This study was conducted in a 350-bed northern Michigan acute care hospital outpatient clinic setting during a 9 month period in 1994. On the average, approximately 6-8 family caregivers and care recipients were assessed in the geriatric clinic each month. Frail older adults with complex health care needs were referred to the clinic setting by a primary care physician for comprehensive geriatric assessment and intervention.

The sample selection was a nonprobability convenience group of family caregivers (N = 35) who met the inclusionary criteria and agreed to participate. During this period of time, 56 eligible family caregivers were seen, 35 (63%) agreed to participate, and 35 (100%) completed the study. Demographic data specific to caregivers' characteristics of gender, age, relationship to care recipient, ethnicity, living arrangement, and employment status was gathered and later compared with available national statistics on caregivers (Select Committee on Aging, 1988; Stone et al., 1987).

Inclusionary criteria for this study encompassed both the family caregiver and the care recipient. Caregivers were English speaking, able to read and write, provided the majority of care, and were oriented to time, place and name when screened through a telephone intake process. Care recipients were 65 years or older, required at least moderate assistance with IADL's, and presented with one or

more syndromes that have been defined in geriatric literature as areas that can be improved upon with appropriate interventions.

Caregivers and care recipients self selected into the interdisciplinary geriatric assessment. Because of this, initial analysis included a comparison of study caregivers to available national norms to determine generalizability (see Table 1). In general, the demographic characteristics of study caregivers and the national norm for caregivers were somewhat similar. However, mean age was found to be greater in the family caregiver study ( $M = 63$ ) than in national norm ( $M = 57$ ). The caregiver study also had a larger number of daughters (43%), wives (31%), and husbands (17%) providing care to frail older adults. In this study 77% of daughters and 67% of sons, caring for a parent, were employed outside of the home.

Age of the care recipient in this study ranged from 65 to 93 years with a mean age of 76.3 years. The sample of care recipients included 66% females and 34% males. This same group had a mean for IADL's of 4.9 (range 0 - 7) and a Mini Mental State Exam (MMSE) score range from 7 to 27 ( $M = 18.8$ ), indicating that the average care recipient was found to require moderate assistance with IADL's and had cognitive impairment. In the study by Stone et al. (1982) care recipients had a mean age of 77.7 years and required a moderate amount of care with IADL's ( $M = 5.2$ ).

Table 1

Comparison of Demographic Characteristic of Caregivers and National Norm

Variable	Study Caregivers (N = 35)	National Norm <sup>a</sup> (N = 1,924)
Sex		
Male	26%	28%
Female	74%	72%
Mean age in years	63	57
Relationship to care recipient		
Daughter	43%	29%
Wife	31%	23%
Husband	17%	13%
Son	9%	9%
Other	0%	13%
Ethnicity		
White	100%	80%
Other	0%	20%
Living arrangements		
With care recipient	51%	74%
Not with care recipient	47%	26%
Employment status		
Employed	43%	31%
Unemployed	57%	69%

<sup>a</sup>From "Caregivers of the Frail Elderly: A National Profile" by R. Stone, G. L. Cafferata, and J. Sangl, 1987.

## Instruments

Wellness is more than merely physical health. It is a complex interrelation between physical and psychological wellness. With this in mind, caregiver wellness was operationalized to include measures of subjective physical wellness and psychological wellness that included both measures of perceived stressors/burden and life satisfaction. A questionnaire (see Appendix B) was developed and utilized for both pretest and posttest data collection, incorporating 3 tools to determine physical and psychological wellness: (a) Self-rated health (Ware, Davies-Avery, & Donald, 1978; Mossey & Shapiro, 1982); (b) Burden Interview (Zarit et al., 1980); and (c) Life Satisfaction A (Liang, 1984).

Self-rated health. There have been a number of studies and instruments developed for the purpose of measuring subjective and objective health status. For this study purpose, the 4-point rating scale developed by Mossey et al. (1982) was utilized. This simple format was defined by a single response to questions such as, "compared to others your own age, how do you rate your health?". Self-rated health was scored as: 1, excellent; 2, good; 3, poor; 4, bad. Item number 7 of the Caregiver Questionnaire (see Appendix B) measured self-rated health.

In the early 1960s, physicians reported an actual correlation between objective physicians' rating of physical health and subjective self-rated health (Jeffers & Nichols,



1961; Maddox & Eisdorfer, 1962). Similar findings were also reported by Palmore and Luikart in 1972.

Ware et al. (1978) analyzed 39 various studies of self-rated health and found that ratings of general health perception appeared both reliable and reproducible. Ferraro (1980), in a survey of older persons, reported that self-rating of health was significantly related to objective measures of health.

Mossey et al. (1982) further analyzed this type of rating and compared it with mortality. This study found a 95% confidence interval in predicting mortality. They also reported that although objective health status may change over time, self-rating of health represents a relatively stable perception of the individual. A more recent study by Schoenfeld, Malmrose, Blazer, Gold, and Seeman (1994) reported similar findings particularly with healthy cohorts. Once again, utilizing a 95% confidence interval, subjective self-rated health could predict objective mortality.

Burden Interview. In 1980 Zarit et al. developed a 29 item self-reporting instrument to measure caregiver's "health, psychological well-being, finances, social life and the relationship between the caregiver and the impaired person" (p. 651). Subsequent revisions by Zarit & Zarit (1982) of the Burden Interview has modified the instrument. These 22 questions are found in items 8 - 29 of the Caregiver Questionnaire (see Appendix B) and were designed to measure the impact of a care recipient's disabilities on

the caregiver. Permission to use the BI was obtained (see Appendix C).

This questionnaire was designed to self-administer in a home setting. It was scored as: never (0), rarely (1), sometimes (2), quite frequently (3), and nearly always (4). The total possible score ranged from 0 to 88. Total scores from 0 - 20 indicate little or no burden, 21 - 40 mild to moderate burden, 41 - 60 moderate to severe burden, and 61 - 88 severe burden. Reliability coefficient for internal consistency using Cronbach's alpha has been reported as .88., and test-retest reliability as .71 (Gallagher, Rappaport, Benedict, Lovett, & Silven, 1985). Concurrent validity was assessed using the overall rating scale of burden with Brief Symptom Inventory. Correlation coefficient between these two measures was .71 (Derogatis & Spencer, 1982). Using the data from the present study, reliability coefficient for internal consistency of the BI was evaluated. Cronbach's alphas for the BI pretest and posttest were .93 and .94, respectively.

Life satisfaction. Neugarten, Havinghurst and Tobin developed the Life Satisfaction Index A (LSIA) in 1961. This tool was designed to measure psychological well-being. Throughout the years analysis and modifications have been made on this instrument (Adams, 1969; Wood et al., 1969; Larson, 1978; and Liang, 1984). Utilizing a confirmatory factor analysis, Liang (1984) modified the LSIA. These 11 questions are found in items 30 - 40 of the Caregiver

Questionnaire (see Appendix B) were used to measure life satisfaction. Permission to use the revised version of the LSIA was obtained (see Appendix D). The LSIA is a self-reporting instrument designed to be administered in either a paper-and-pen format or in an interview. Participants were asked to circle either, "agree" (1) or "disagree" (0) in response to general statements about their lives. The total possible score ranged from 0 - 11, with the higher range indicating increased life satisfaction.

Reliability has been reported on the original LSIA (KR = .79). Validity statistics ( $r = .58$ ) correlated the LSIA and the Life Satisfaction Rating (Wylie, 1970). Reliability for internal consistency was evaluated using the data from this study. Reliability coefficient (KR 20) for the pretest and posttest were .71 and .64, respectively. It must also be noted that there has been much criticism in terms of measuring life satisfaction. One of the criticisms is that life satisfaction is not clearly defined and by itself cannot measure subjective well-being (Liang, 1984).

Demographic data specific to the caregiver was obtained in items 1 - 6 on the Caregiver Questionnaire (see Appendix B). These items included: sex, age, relationship to care recipient, living arrangement, educational background, and employment status.

## Procedures

Data for this research was obtained during a nine month period in 1994. Referrals from families, community agencies and physicians, were made to a geriatric assessment clinic for frail older adults with complex health care needs. The nurse researcher identified through a telephone intake screen the primary family caregiver of the older adult, the baseline cognitive status of the caregiver, geriatric syndromes and IADL status of the care recipient (see Appendixes E and F). The care recipient required at least a moderate amount of assistance in IADL's and presented with at least one of the geriatric syndromes outlined on the intake sheet. In addition, care recipients were excluded from the clinic assessment if they met any of the exclusionary criteria. Both inclusionary and exclusionary criteria were based upon geriatric research that supported the effectiveness of geriatric assessment clinics for care recipients.

Upon arrival at the clinic both the care recipient and caregiver were evaluated by an interdisciplinary geriatric team. This team consisted of a physician, geriatric clinical nurse, medical social worker, and clinical pharmacist. Both the care recipient and caregiver were assessed by this team in terms of physiological, psychological, functional, and cognitive wellness. Each team member had developed their own individualized assessment tool (see Appendix G, H and I) The care

recipient received a comprehensive examination; family caregivers were interviewed by all team members.

During the nursing assessment, the family caregivers were asked to participate using a standardized explanation of the research (see Appendix J) and participation form (see Appendix K). Subjects agreeing to participate were given the Caregiver Questionnaire incorporating demographic information, self-rated health, BI and LSIA (see Appendix B). These forms were all in larger print and were condensed only for research presentation. Caregivers were provided with a stamped return envelope.

Following the assessment by all team members, the team met to develop a comprehensive problem list and appropriate interventions for each family. Examples of problems included: (a) social isolation related to care recipient's dependence and (b) impaired home maintenance management. Specific intervention for the identified problems might have been: (a) for the family caregiver experiencing social isolation, respite care, adult daycare, and increase other family members involvement and (b) for the family caregiver experiencing home maintenance, arranging home chore service.

These secondary prevention interventions were evaluated on a weekly basis for one month by the nurse through telephone contact to the family caregiver. It was at this time that modification and re-evaluation took place. At 3 months the Caregiver Questionnaire (see Appendix B)

containing items 7 - 40 was mailed to the family caregiver, once again with a stamped return envelope. In order to increase response rate a telephone contact was made at 2 weeks if the questionnaire had not been returned.

## CHAPTER FOUR

### RESULTS

The purpose of data analysis is to organize and synthesize data, and then to test a research hypothesis (Polit & Hungler, 1991). In this specific study paired t-tests and Wilcoxon matched-pairs signed rank test were used to analyze the hypothesis that the level of physical and psychological wellness of a family caregiver will be greater after an intervention based on interdisciplinary geriatric assessment than reported scores before receiving the intervention. Analysis of data was computed by using the Statistical Package for the Social Science (SPSS) software.

#### Analysis of Research Hypothesis

Physical health was analyzed by collecting data in an ordinal measure during the pretest and 3 months later in a posttest. Since a 4-point rating scale was utilized, a Wilcoxon matched-pairs signed rank test was performed to compare pretest and posttest scores (see Table 2). Physical health was not found to be statistically significant ( $p > .05$ ), yet 24 (69%) caregivers reported maintenance of a excellent to good health range.

The Select Committee on Aging (1988) has reported that nationally one-quarter of caregivers reported excellent

health and one third of this population reported fair or poor health. In this study 34.3% and 25.7% reported excellent health pretest and posttest respectively. Unlike the national results, only 8.6% on the pretest and 5.7% on the posttest reported fair or poor health.

Table 2

Comparison of Pretest and Posttest Physical Health<sup>a</sup>

Mean Rank	Cases (N = 35)
1.77	4 - Ranks
1.87	7 + Ranks
	24 Ties
2-tailed p = .549	

<sup>a</sup>Wilcoxon matched-pairs signed test.

To measure psychological wellness, two instruments, the Burden Interview (BI) and Life Satisfaction Index A (LSIA) were used to analyze pretest and posttest scores following interdisciplinary geriatric assessment. Table 3 presents the results of the paired t-test for comparison of burden. Although burden scores reported by the caregivers before and after the intervention were not statistically significant ( $p > .05$ ), the ratings remained in a mild to moderate range at a 3 month interval.



Table 3

Paired T-Test for Comparison of Pretest and Posttest Burden

	Mean	SD	df	t	p
Pretest Burden Interview (N = 35)	30.06	16.12	34	.79	.437
Posttest Burden Interview (N = 35)	31.31	16.74			

Results of the LSIA data analysis indicated a slight decrease in posttest score although not significant ( $p > .05$ ). In general, caregivers reported being satisfied with life both at the pretest and in posttest follow-up (see Table 4).

Table 4

Paired T-Test for Comparison of Life Satisfaction

	Mean	SD	df	t	p
Pretest LSIA (N = 35)	7.97	2.36	34	1.65	.108
Posttest LSIA (N = 35)	7.29	2.19			

## CHAPTER FIVE

### DISCUSSION AND IMPLICATIONS

#### Discussion

This study specifically examined the physical and psychological wellness of family caregivers following interventions based on interdisciplinary geriatric assessment of both the caregiver and the frail older adult care recipient. Although no statistically significant findings were uncovered, both physical and psychological wellness of the caregiver continued to be maintained over the three months study period. These findings were not consistent with those reported by Silliman et al. (1990). Finding of that study indicated that family caregivers, at a 3 month follow-up, had significant improvement in self-reported health and psychological health was slightly better although not statistically significant.

Brown et al. (1990) suggested that evaluation of caregivers burden during geriatric assessment could be a predictor for long-term care placement of the care recipient. In a study by Drinka et al. (1987), findings indicated that neither dementia nor dependency in activities of daily living were statistically associated with caregiver depression or burden. This study supported

their findings in that care recipients, on the average had some dementia and required moderate assistance with IADL's, yet caregivers continued to report only mild to moderate burden. Clearly, many more studies are needed to determine the effect on caregivers following interventions based on interdisciplinary geriatric assessment.

The use of geriatric assessment to evaluate not only frail older adults, but their caregivers, is a relatively new concept. Comprehensive interdisciplinary geriatric assessment has been demonstrated to be of benefit to care recipients in reducing mortality, morbidity, use of emergency rooms and inappropriate use of long-term care. (Boult, Boult, Murphy, Ebbitt, Luptak, Kane, 1994; Thomas, Brahan, & Haywood, 1993; Altkorn, Ramsdell, Jackson, & Renvall, 1991). Yet, scant research is available in terms of impact on caregiver wellness.

Given the complex nature of studying caregivers and limited available data on effective interventions for caregiver wellness, it is not surprising that in this research, findings were statistically insignificant. Yet, maintaining wellness over a 3 month period cannot be minimized given the myriad of stressors caregivers encounter. Their caregiving responsibilities extend over long periods. The health status of the frail older adults they care for is tenuous at best. Pearlin, Mullan, Semple, and Skaff (1990) suggested that stressors found in caregiving are comprised of multifaceted primary

and secondary stressors. They conclude that caregiver stressors are a variety of "circumstances, experiences responses and resources that vary considerably among caregivers and that, consequently, vary in their impact on caregiver's health and behavior (p. 591).

Neuman's Systems Model supports the multiple stressors Pearlin et al. (1990) describes. Multiple variable such as physiological, psychological, sociocultural, developmental and spiritual factors are interrelated and determine caregiver wellness. Stressors of caregiving cause a reaction within the caregiver system. Interventions based on interdisciplinary geriatric assessment in turn act as a secondary prevention intervention. The strengthening of the normal line of defense is therefore varied among the caregivers. One must begin to ask what can be done in a geriatric assessment to accurately identify caregiver stressors and how do we develop unique interventions to improve physical and psychological wellness?

#### Application to Practice

Throughout our lives most of us will be called upon to be family caregivers. Many of us will find ourselves as the primary caregiver for an elderly spouse or parent. Indeed the research-based knowledge on caregivers has proliferated over the last ten years as we identify the growing number of family caregivers. Unfortunately, "there is neither

agreement nor conclusive results concerning the most effective interventions for these stressed family members" (Whitlatch, Zarit, & von Eye, 1991, p. 9).

Atkinson (1992) called upon nurses to make a greater contribution in supporting caregivers. Yet, nursing research has lagged behind in specific interventions that may enhance the physical and psychological wellness of caregivers. Nurses can play a pivotal role in geriatric assessment. It is here that we can assess and uncover problems a caregiver may encounter. Problems can then be identified and described, allowing for formulation of interventions specific to that caregiver and care recipient.

#### Limitations

Selection of subjects is especially problematic in gerontological research because, "diversity that exists among elderly people increases with age, owing to the effects of varied life events, environments and resources" (Bowsher, Bramlett, Burnside, & Gueldner, 1993, p. 874). With this in mind, certain limitations need to be discussed specific to this research project.

Several threats to validity need to be discussed in this design selection. Internal validity is threatened in a number of ways. Maturation threat needs to be particularly discussed in that over a three month period with interventions, caregiver wellness was expected to improve. However, the complex care needs of older adults cannot be predicted. Examples of maturational threats

include caregiver fatigue and increased care recipient dependency. Selection bias was a problem in this study because clients are self selected into the geriatric assessment clinic. Therefore, the study lacked randomization and a control group. This poses a lack of control and no available comparison group. In addition, the collection of data over a three month period and use of a pretest-posttest tool may have influenced the overall test effect.

Representativeness of the sample was jeopardized by a small sample size from one setting. Measures were taken to analyze the generalizability by comparing study caregivers and national norms. Two other issues should be mentioned in terms of external validity. Geriatric assessment was a new treatment approach to caring for older adults in the specific geographic area lending itself to novelty effect. The role of the nurse cannot be minimized in terms of experimenter effect as telephone contact was ongoing throughout the 3 month follow-up.

One must also review the tools specifically utilized in this study. Both physical and psychological wellness are driven subjectively and objectively. Were the instruments selected sensitive enough to note changes in physical and psychological wellness? In addition, questions regarding the instruments efficiency and redundancy should be raised.

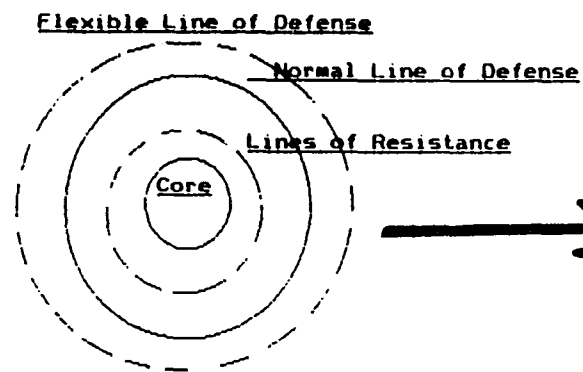
### Future Research Suggestions

Despite over 20 years in caregiver research, much is still unknown in terms of the most effective interventions to improve caregiver wellness. Often studies have been contradictory. Yet, as the population continues to age, wellness of caregivers must become a priority in health care research.

Geriatric assessment and it's value for the caregiver and care recipient also remains nebulous. Nurses, however play a leadership role in care of older adults. Nursing research should focus on the variety of chronic illnesses seen in older adults and on the development of effective interventions specific to these. In addition, there is room to explore expansion of home care and community services that geriatric teams could utilize as plans of care are developed. Finally, nurses must become a strong voice in our profession to advocate for family caregivers and prioritize research for our aging population.

## APPENDICES





### INTERVENTION

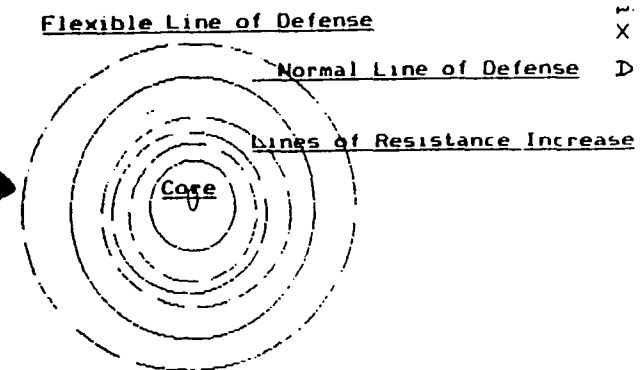
Interdisciplinary  
Geriatric  
Assessment

A) Comprehensive  
Assessment of the  
care recipient

B) Comprehensive  
Assessment of the  
caregiver -  
Physical and  
Psychological  
Wellness



Secondary Prevention  
Intervention



## Appendix B

### CAREGIVER QUESTIONNAIRE

You are being asked to participate in a study of caregivers seen at the Geriatric Assessment Clinic. An initial questionnaire will be given to you today. You are asked to take it home, complete it, and mail in the envelope provided. Please mail it back in the envelope provided. In 3 months you will receive a similar questionnaire that you will also be asked to mail in the envelope provided. PLEASE ANSWER ALL OF THE QUESTIONS COMPLETELY so the information can be utilized for research.

You may be assured of complete confidentiality. The questionnaire has an identification number for mailing purposes only. Your participation is voluntary so you may withdraw from this study at any time.

This study is being conducted by Julie Smith R.N. B.S.N. If you have any questions she can be contacted at the following number: (616) 935-6650 or (616) 879-3959.

Direction: Please put a check mark in the response that best describes you.

- \_\_\_1. Sex [1] Male [2] Female
- \_\_\_2. How old are you? \_\_\_\_\_
- \_\_\_3. What is your relationship to the person you care for?  
[1] spouse  
[2] child  
[3] friend  
[4] other
- \_\_\_4. Are you living with the person you care for?  
[1] yes  
[2] no
- \_\_\_5. How far did you go in school?  
[1] 0-4 years [5] Post high school, business or trade school  
[2] 5-8 years [6] 1-3 years of college  
[3] High school (incomplete) [7] 4 years of college  
[4] High school (complete) [8] Post graduate education
- \_\_\_6. Do you work outside of the home?  
[1] yes  
[2] no
- \_\_\_7. Compared to others your own age, how do you rate your health?  
[1] excellent  
[2] good  
[3] poor  
[4] bad

Caregiver Identification Number: \_\_\_\_\_

# CAREGIVER QUESTIONNAIRE

2

INSTRUCTIONS: The following is a list of statements which reflects how people sometimes feel when taking care of another person. After each statement indicate how often you feel that way: never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers. Circle each of your answers. Please do not leave any unanswered

- \_\_\_8. Do you feel that your relative asks for more help than he/she needs?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_\_9. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_10. Do you feel stressed between caring for you relative and trying to meet other responsibilities for your family or work?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_11. Do you feel embarrassed over your relative's behavior?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_12. Do you feel angry when you are around you relative?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_13. Do you feel that your relative currently affects your relationship with other family members in a negative way?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_14. Are you afraid of what the future holds for your relative?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_15. Do you feel your relative is dependent upon you?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_16. Do you feel strained when your are around your relative?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_17. Do you feel your health has suffered because of your involvement with your relative?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always
- \_\_18. Do you feel that you don't have as much privacy as you would like because of your relative?
- Never      Rarely      Sometimes      Quite Frequently      Nearly Always

# CAREGIVER QUESTIONNAIRE

3

- \_\_19. Do you feel that your social life has suffered because you are caring for your relative?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_20. Do you feel uncomfortable about having friends over because of your relative?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_21. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_22. Do you feel that you don't have enough money to care for your relative in addition to the rest of your expenses?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_23. Do you feel that you will be unable to take care of your relative much longer?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_24. Do you feel you have lost control of your life since your relative's illness?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_25. Do you wish you could leave the care of your relative to someone else?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_26. Do you feel uncertain about what to do about your relative?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_27. Do you feel you should be doing more for your relative?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_28. Do you feel you could do a better job caring for your relative?
- Never Rarely Sometimes Quite Frequently Nearly Always
- \_\_29. Overall, how burdened do you feel in caring for your relative?
- Not at All A Little Moderately Quite a Bit Extremely

CAREGIVER QUESTIONNAIRE

4

Here are some statements about life in general that people feel differently about. Would you read each statement in the list and, if you agree with it circle "agree". If you do not agree, circle "disagree". Please leave no statements unanswered.

\_\_30. I have gotten more of the breaks in life than most of the people I know.

Agree

Disagree

\_\_31. I am just as happy as when I was younger.

Agree

Disagree

\_\_32. My life could be happier than it is now.

Agree

Disagree

\_\_33. These are the best years of my life.

Agree

Disagree

\_\_34. Most of the things I do are boring or monotonous.

Agree

Disagree

\_\_35. I expect some interesting and pleasant things to happen to me in the future.

Agree

Disagree

\_\_36. The things I do are as interesting to me as they ever were.

Agree

Disagree

\_\_37. I feel old and tired.

Agree

Disagree

\_\_38. As I look back on my life, I am fairly well satisfied.

Agree

Disagree

\_\_39. I would not change my past life, even if I could.

Agree

Disagree

\_\_40. I've gotten pretty much what I expect out of life.

Agree

Disagree

Thank you for your help

Caregiver Identification Number \_\_\_\_\_

## Appendix C

PENNSTATE



Gerontology Center  
College of Health and Human Development

(H14) RC-1711

The Pennsylvania State University  
210 Henderson Building South  
University Park, PA 16802-1000

Dear Colleague:

Thank you for your interest in The Memory and Behavior Problems Checklist and The Burden Interview. The enclosed booklet includes descriptions of the measures, psychometric information, and a brief bibliography. You are welcome to use these instruments or parts of them in your research and to make copies of them for that purpose, with appropriate citation of the source in any papers or reports you prepare.

If you do use these measures, we would appreciate learning of your results.

Sincerely,

Steven H. Zarit, Ph.D.

Judy M. Zarit, Ph.D.

An Equal Opportunity University

Appendix D

## Institute of Gerontology



The University of Michigan  
300 North Ingalls  
Ann Arbor, Michigan 48106-2007  
Telephone: (313) 764-3493  
Fax: (313) 936-2118

Richard C. Adelman, Ph.D.  
Director and Professor of Biological Chemistry

August 29, 1994

Julie Smith  
10785 Sperry  
Fife Lake, MI 49633

Dear Ms. Smith:

This letter is to verify that Julie Smith has my permission to use my revised version of Neugarten's LSI-A scale in her doctoral work. Enclosed are reprints of articles related to the LSIA. Best wishes on your dissertation.

Sincerely,

Jersey Liang  
Professor, School of Public Health  
Research Scientist and Associate Director,  
Institute of Gerontology

JL/jmb

Appendix E

GERIATRIC ASSESSMENT CLINIC

INTAKE SCREENING FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_ Sex: [M] [F]  
Telephone: \_\_\_\_\_ Marital Status: M-W-S-D  
Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Contact Address/Telephone (if different from above): \_\_\_\_\_  
\_\_\_\_\_

Significant Medical Problems: \_\_\_\_\_  
\_\_\_\_\_

IADL Rating \_\_\_\_\_ (number responses indicating dependency or requiring assistance)

Degree of Impairment: None\_\_ Mild\_\_ Moderate\_\_ Severe\_\_  
( 0 ) (1-2) (3-4) (5-6)  
Complete\_\_  
( 7 )

Inclusionary Criteria (circle those appropriate to client)

Does the client have one of the following complaints:

- a. reported/suspected elder abuse      k. recent bereavement
- b. ECF or acute care in past 3 mo.      l. impaired mobility
- c. history of falls  $\geq$  LOC      m. impaired affect
- d. urinary incontinence      n. impaired cognition
- e. "failure to thrive"
- f. malnutrition (recent appetite chg. or wt. loss)
- g. polypharmacy( $\geq$ 7 meds including prn's)
- h. unstable/unsuitable living arrangement
- i. absence of able caregiver or caregiver stress
- j. proven or perceived need for services



## GERIATRIC ASSESSMENT CLINIC

## INTAKE SCREENING FORM

Exclusionary Criteria	Yes	No
Terminal illness (life expectancy < 6 months)		
Physician diagnosis of probable Alzheimer's Disease		
Current recognized or untreated substance abuse (severely curtailing evaluation/therapeutic efforts)		
Medically unstable (needing inpatient admission)		
Inevitable ECF placement		
Too healthy/too functionally intact		

Comments:

Intake Recommendation: Recommended \_\_\_\_\_ Not recommended \_\_\_\_\_

\_\_\_\_\_  
Signature/title

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date reviewed

Action: Appointment made \_\_\_\_\_ Appointment not made \_\_\_\_\_

Date of scheduled appointment \_\_\_\_\_

Appendix F  
Instrumental Activities of Daily Living (IADL'S)

Client Name: \_\_\_\_\_ Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

1. Telephone

- I: able to look up numbers, dial, receive and make calls without help
- A: able to answer phone or dial operator in an emergency but needs special phone or help in getting number or dialing
- D: unable to use telephone

2. Traveling

- I: able to drive own car or travel alone in bus or taxi
- A: able to travel but not alone
- D: unable to travel

3. Shopping

- I: able to take care of all shopping with transportation provided
- A: able to shop but not alone
- D: unable to shop

4. Preparing meal

- I: able to plan and cook full meals
- A: able to prepare light foods but unable to cook full meals alone
- D: unable to prepare any meals

5. Housework

- I: able to do heavy housework (e.g. scrub floors)
- A: unable to do light housework, but needs help with heavy task
- D: unable to do any housework

6. Medication

- I: able to take medication in the right dose at the right time
- A: able to take medication but needs reminding or someone to prepare it
- D: unable to take medications

7. Money

- I: able to manage buying needs, writes checks, pays bills
- A: able to manage daily buying needs but needs help managing checkbook, paying bills
- D: unable to manage money

IADL Rating

None (0)\_\_\_\_ Mild (1-2)\_\_\_\_ Moderate (3-4)\_\_\_\_ Severe (5-6)\_\_\_\_ Complete (7)\_\_\_\_

I = Independent A = Assisted D = Dependent

Score Either Assisted or Dependent as one (1).

Appendix G

MUNSON MEDICAL CENTER-GERIATRIC ASSESSMENT CLINIC  
OLDER ADULT HEALTH ASSESSMENT-NURSING

Client Name:\_\_\_\_\_ Date of Evaluation:\_\_\_\_\_

Name Preference:\_\_\_\_\_ Sex:\_\_\_\_\_ DOB:\_\_\_\_\_ Age:\_\_\_\_\_

Client's expectation for care: \_\_\_\_\_

Caregiver expectation for care: \_\_\_\_\_

Description of usual health, activities, and current treatment:\_\_\_\_\_

Perception of past health care service (acceptability and unacceptability of services): \_\_\_\_\_

Client for your age would you say in general , your health is:

Excellent [3]    Good [2]    Poor [1]    Bad [0]

MEDICAL HISTORY

(Check positive findings and indicate date of onset)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA	<input type="checkbox"/> Kidney/Prostate	
<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Myocardial Infarct	<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Pulmonary disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ulcers
<input type="checkbox"/> TIA's	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Falls/Fractures	
<input type="checkbox"/> Rheumatoid or Osteoarthritis	<input type="checkbox"/> Osteoporosis		

Primary diagnosis:\_\_\_\_\_

Comments:\_\_\_\_\_

Past hospitalizations in the last 3 years: \_\_\_\_\_

### Current Medications

Allergies: \_\_\_\_\_ Drug \_\_\_\_\_ Food \_\_\_\_\_ Contact \_\_\_\_\_ Seasonal  
 Allergic Reaction: \_\_\_\_\_

Current Meds	dose	route	adm. time	indication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

### VITAL SIGNS

Temp: \_\_\_\_\_ Resp. \_\_\_\_\_ B/P Stand \_\_\_\_\_  
 Radial rate (R/L) \_\_\_\_\_ Sit \_\_\_\_\_  
 Apical rate \_\_\_\_\_ Supine \_\_\_\_\_

### NUTRITION ASSESSMENT

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Average weight  
 throughout life \_\_\_\_\_  
 Compare to last 3 months: \_\_\_\_\_ gain \_\_\_\_\_ loss \_\_\_\_\_ stable  
 Reason client perceives weight change: \_\_\_\_\_

Diet: \_\_\_\_\_ Eating Pattern: \_\_\_\_\_ Fluid Intake: \_\_\_\_\_  
 Appetite: \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor Caffeine intake: \_\_\_\_\_  
 Alcohol Intake: \_\_\_\_\_ No Difficulty: \_\_\_\_\_  
 Indigestion: \_\_\_\_\_ Dysphagia: \_\_\_\_\_ Nausea: \_\_\_\_\_  
 Vomiting: \_\_\_\_\_ Enteral Feedings: \_\_\_\_\_  
 Vitamins/Minerals: \_\_\_\_\_ Supplements: \_\_\_\_\_  
 Any assistive devices required for feeding or meal prep: \_\_\_\_\_

\_\_\_\_\_ Dentures (upper/lower) Do they fit: \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Last dental exam: \_\_\_\_\_  
 Describe your meals today: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### INTEGUMENTARY ASSESSMENT

\_\_\_\_\_ No difficulty \_\_\_\_\_ Dry \_\_\_\_\_ Oily \_\_\_\_\_ Rash \_\_\_\_\_ Moles  
 \_\_\_\_\_ Callus/Bunions \_\_\_\_\_ Temperature intolerance \_\_\_\_\_ Chills  
 \_\_\_\_\_ Night sweats \_\_\_\_\_ Fever  
 \_\_\_\_\_ Sores/Ulcers(location/size)  
 \_\_\_\_\_ Discoloration(location/size)  
 \_\_\_\_\_ Bruises(location/size)  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### ACTIVITY/REST ASSESSMENT

Katz ADL \_\_\_\_\_ IADL \_\_\_\_\_ Performance Scale \_\_\_\_\_  
 Describe a typical day: \_\_\_\_\_  
 Describe sleeping/nap: \_\_\_\_\_  
 \_\_\_No difficulty \_\_\_Difficulty sleeping \_\_\_Difficulty staying awake  
 \_\_\_Snore \_\_\_Wanders \_\_\_Confusion at night  
 \_\_\_Sedatives \_\_\_Restraints  
 Do you have a telephone? \_\_\_Yes \_\_\_No  
 Can you use it? \_\_\_Yes \_\_\_No Are emergency no. posted? \_\_\_Yes \_\_\_No  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### MUSCULOSKELETAL

Tinette Balance and Gait Evaluation \_\_\_\_\_  
 \_\_\_No difficulty \_\_\_Arthritis \_\_\_Immobile \_\_\_Contractures  
 \_\_\_Calcium intake \_\_\_History of falls \_\_\_Stiffness  
 Do you typically exercise: \_\_\_\_\_  
 Are you [active] [somewhat active] [inactive]  
 Any assistive devices for self care or mobility: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### TRANSPORTATION

Do you drive? \_\_\_Yes \_\_\_No  
 Do you have access to transportation? \_\_\_\_\_  
 Handicap permit \_\_\_Yes \_\_\_No Seat belt \_\_\_Yes \_\_\_No  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### ELIMINATION ASSESSMENT

##### GASTROINTESTINAL

Describe bowel Pattern: \_\_\_\_\_  
 \_\_\_No difficulty \_\_\_Abdominal pain \_\_\_Melena \_\_\_Constipation  
 \_\_\_Diarrhea \_\_\_Incontinence \_\_\_Recent change in habit  
 \_\_\_Ostomy \_\_\_Enema \_\_\_Laxative  
 \_\_\_Hemorrhoids  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

##### GENITOURINARY/REPRODUCTIVE

Describe bladder pattern: \_\_\_\_\_  
 \_\_\_No difficulty \_\_\_Incontinence (recent onset, chronic, \_\_\_per wk)  
 \_\_\_Stress incontinence \_\_\_Dribbling \_\_\_Nocturia \_\_\_Urgency  
 \_\_\_Painful urination \_\_\_Hematuria \_\_\_Frequency \_\_\_Infections  
 \_\_\_Hesitancy \_\_\_Catheter use \_\_\_Pads/Diapers \_\_\_Impotence  
 \_\_\_Sexually active \_\_\_Monthly breast exam  
 \_\_\_Monthly scrotal exam  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SENSATION/COMMUNICATION ASSESSMENT

VISION

Pupils \_\_\_\_\_  
Snellen \_\_\_\_\_

Do you have trouble seeing? \_\_\_\_\_  
Last Exam: \_\_\_\_\_

HEARING

Do you have trouble hearing? \_\_\_\_\_  
Last Exam: \_\_\_\_\_

SMELL/TASTE

Have you noticed any problem with smell or taste? \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COGNITIVE/AFFECTIVE ASSESSMENT

\*MMSE \_\_\_\_\_  
\*Do you notice any problem with thinking or thought process?  
(client) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Do you notice any problem with thinking or thought process?  
(caregiver) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have there been any behavior problems? (caregiver describe)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SAFETY/COMFORT ASSESSMENT

Environmental Assessment \_\_\_\_\_ Risk Factors for Falls \_\_\_\_\_

Do you have pain? \_\_ Yes \_\_ No Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rate your pain 0-1-2-3-4-5-6-7-8-9-10

\*Who do you live with? (name) \_\_\_\_\_  
\*Who is your major helper? (name) \_\_\_\_\_  
\*Any problems with living arrangement? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Problems identified:

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Expected outcome:

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NURSING PLAN OF CARE/RECOMMENDED ACTION

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Source of data: \_\_\_\_\_

Informants reliability \_\_\_\_\_

Signature/title \_\_\_\_\_

1/94  
GAC.2

Appendix H

GERIATRIC ASSESSMENT CLINIC  
MUNSON MEDICAL CENTER

MENTAL HEALTH ASSESSMENT

Date of Evaluation: \_\_\_\_\_ Length: \_\_\_\_\_

Place: \_\_\_\_\_ Evaluator: \_\_\_\_\_

I. IDENTIFYING INFORMATION

Client Name: \_\_\_\_\_

Current Living Situation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

II. SURROGATE DECISION MAKER

Representative Payee:                      Yes                      No

Conservator:                                  Yes                      No

GUARDIAN:                                    Yes                      No

POA:    Yes                      No

DPOA:    Yes                      No

DPOA Medical:                              Yes                      No

Comments: \_\_\_\_\_

III. FINANCIAL ASSESSMENT

Results of the FINANCIAL ASSESSMENT FORM section A:

Are there current financial problems indicated?

YES

NO

Comments: \_\_\_\_\_

IV. PRESENTING PROBLEM

Client's Chief Complaint: \_\_\_\_\_

Other (i.e. professionals) \_\_\_\_\_



V. FAMILY/SOCIAL HISTORY

Where were you born and raised? Tell me about your parents.  
Were they nice people? What did they do for a living?

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How many siblings did you have? \_\_\_\_\_

How many do you have now? \_\_\_\_\_

Where are you in the birth order? \_\_\_\_\_

Comments: \_\_\_\_\_

Did you have a good childhood? \_\_\_\_\_

Marriage date(s). Date of deaths. Cause of death. Children  
with locations. What did you and your spouse do for a living?

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Grade completed? \_\_\_\_\_

Do you have close supportive friends that you have regular  
contact with? \_\_\_\_\_

Any evidence of physical, sexual, financial abuse or neglect?

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Alcohol use:    Yes                      No                      MAST-G score: \_\_\_\_\_

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Other: \_\_\_\_\_

Family A & D use: \_\_\_\_\_

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GERIATRIC ASSESSMENT CLINIC  
FAMILY/SOCIAL HISTORY  
Continued  
page 3

INTERESTS/HOBBIES:

What were your past and what are your current interests  
(include spiritual)?

LOSSES/TRAUMAS/STRESSES:

GENOGRAM:

VI. PREVIOUS MENTAL HEALTH SERVICES

# of Hospitalizations: \_\_\_\_\_ Date of First: \_\_\_\_\_  
Date of Last: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_  
Mental Status Report: (appearance, activity, speech, mood,  
affect, thought content, thought processes, perceptual  
disturbances, judgement, insight) \_\_\_\_\_

\_\_\_\_\_  
Depression Scale Score: \_\_\_\_\_  
Comments: \_\_\_\_\_

VII. SELF CONCEPT

How do you feel about yourself? \_\_\_\_\_

\_\_\_\_\_  
Describe your personal strengths and limitations. \_\_\_\_\_

VIII. GOALS

What are your goals; what do you hope for? \_\_\_\_\_

\_\_\_\_\_  
Caregiver goals: \_\_\_\_\_

GERIATRIC ASSESSMENT CLINIC  
Mental Health Assessment  
page 5

IX. SUMMARY

ROLE PERFORMANCE

Home/Family: \_\_\_\_\_

Community/Friends/Church/Leisure: \_\_\_\_\_

Financial: \_\_\_\_\_

Strengths: \_\_\_\_\_

Weaknesses: \_\_\_\_\_

Needs: \_\_\_\_\_

Recommendations: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Appendix I  
MMC GAC MEDICATION HISTORY FORM

Client Name \_\_\_\_\_ Age (DOB) \_\_\_\_\_ Sex \_\_\_\_\_  
 Date of Evaluation \_\_\_\_\_ Phone interview \_\_\_\_\_ GAC interview \_\_\_\_\_  
 Allergies \_\_\_\_\_ ADR's \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Insurance Coverage \_\_\_\_\_  
 Pharmacy (Name and Phone Number) \_\_\_\_\_

Past Medical and Surgical History

Vaccination History

Pneumococcal \_\_\_\_\_

Tetanus/Diptheria \_\_\_\_\_

Influenza \_\_\_\_\_

Current Prescribed Medications

NAME	REGIMEN	INDICATION	START OF TX

### Current Non-Prescription Medications

CLASS	PRODUCT(S)	DOSE & FREQUENCY
Analgesics and Antipyretics		
Cough/Cold Preps		
Allergy Preps		
Laxatives, Stool Softeners, Enemas		
Vitamins and Minerals		
Dietary Supplements (Ensure, etc.)		
Hemorrhoidal Preps		
Eye Drops		
Inhalers (Nasal and Oral)		
Creams, Salves, Ointments, Sprays		

### PROBLEM IDENTIFICATION/PATIENT ASSESSMENT

#### Therapeutic Problems

- ☐ 1. Duplication (therapeutic, or chemical class)
- ☐ 2. Inappropriate dose, regimen, timing.
- ☐ 3. Inappropriate PRN (efficacy, toxicity, dependency)
- ☐ 4. Side effects, ADRs, allergies
- ☐ 5. Drug-Disease Interactions
- ☐ 6. Drug-Drug Interactions (inc ETOH)

#### Medication Usage Problems

- ☐ 7. Compliance problems/need for aids
- ☐ 8. Counseling/Inadequate medication knowledge
- ☐ 9. Financial concerns
- ☐ 10. Use of multiple prescribers/pharmacies
- ☐ 11. Demanding dosage forms (Oph, Inj, Inh, oversized)
- ☐ 12. Selection/usage of OTCs

### DESCRIPTION OF PROBLEMS

PROBLEM NUMBER	MEDICATION(S) INVOLVED	DESCRIPTION

Time required for problem identification/assessment process: \_\_\_\_\_ min

### PROBLEM RESOLUTION

#### Pharmacist Actions

- [ ] Patient contacted:       \_\_ In-person   \_\_ By phone   \_\_ Other:
- [ ] Family member/caregiver: \_\_ In-person   \_\_ By phone   \_\_ Other:
- [ ] Prescriber contacted:    \_\_ By phone    \_\_ In writing  
     Prescriber contact resulted in:  
     \_\_RX DAW    \_\_RX changed and dispensed    \_\_RX not dispensed

PHARMACIST ACTION(S)	MEDICATIONS INVOLVED	DESCRIPTION
<input type="checkbox"/> Provided counseling		
<input type="checkbox"/> Provided patient education materials		
<input type="checkbox"/> Provided compliance/ administra- tion aids		
<input type="checkbox"/> Modified dosing times		
<input type="checkbox"/> Advised OTC selection		
<input type="checkbox"/> Other		

Time spent resolving Problem(s): \_\_\_\_\_ min

Pharmacist \_\_\_\_\_ Date \_\_\_\_\_



## Appendix J

### Caregiver Script

-----, you are being asked to participate in a study of caregiver wellness. You will be sent home today with a questionnaire that you can return to the clinic in the stamped envelope provided. Every two week you can expect a call from the clinic nurse to discuss you and your ----- follow-up recommendations from the clinic. In 3 months you will receive a similar questionnaire. Once again you can send it back to the clinic in the stamped envelope provided.

You may be assured of complete confidentiality. Your participation is voluntary so you may withdraw at any time. If you have any questions you can contact the clinic.

## Appendix K

### INFORMATION AND INFORMED CONSENT FOR RESEARCH PARTICIPANTS

The study in which you are being asked to participate is titled "Caregiver Wellness". The purpose of this research is to evaluate types of caregivers' stressors on their overall wellness.

As a participant you are being asked to give permission to the researcher to gather information directly from you by filling out 2 brief questionnaires. The nurse researcher will contact you by telephone prior to you receiving each questionnaire to answer any questions.

The questionnaires will take about 10 minutes to complete and will be sent to you about 3 months apart. The questionnaires will have a self-addressed, stamped envelope for convenient return.

You may be assured of complete confidentiality. The questionnaire has an identification number for mailing purposes only. This is so that the nurse researcher may check your name off the mailing list when your questionnaire is returned. Your name will never be placed on the questionnaire. The data gathered from these questionnaires may be released to nursing scientific literature.

It is not expected that this study will lead to physical, emotional, or financial cost to you. The personal benefit is also limited to you. The results of this study will help to determine what might be helpful to improve caregiver wellness.

Your participation in this study is voluntary and you may withdraw from this study at any time.

This study is being conducted by Julie Smith R.N., B.S.N. She is a graduate nursing student at Grand Valley State University. If you have any questions she can be contacted at the following number 935-6650 or a message left at 879-3959.

I have read and understand the information presented above. I consent, of my free will, to participate in the study.

-----  
Participant/date

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