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## The impact of family relations on caregivers' positive and negative appraisal of their caretaking activities

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**Abstract:** This study examined the impact of family support and relationship difficulties between the caregiver and the care recipient on caregivers' satisfaction received from caregiving activities and subjective burden. Ninety-seven individuals caring for a spouse or an adult child with schizophrenia or bipolar disorder participated in the study. Using hierarchical multiple regression analyses, findings showed that relationship difficulties between the caregiver and the care recipient were associated with both satisfaction received from caregiving activities and subjective burden, after the effects of personal, contextual, and stressor variables were controlled. Family support was not associated with caregivers' appraisal of the situation.

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### Full text: Headnote

This study examined the impact of family support and relationship difficulties between the caregiver and the care recipient on caregivers' satisfaction received from caregiving activities and subjective burden. Ninety-seven individuals caring for a spouse or an adult child with schizophrenia or bipolar disorder participated in the study. Using hierarchical multiple regression analyses, findings showed that relationship difficulties between the caregiver and the care recipient were associated with both satisfaction received from caregiving activities and subjective burden, after the effects of personal, contextual, and stressor variables were controlled. Family support was not associated with caregivers' appraisal of the situation.

### Headnote

Key Words: appraisal, caregiver, family, mental illness.

The deinstitutionalization process that began more than 40 years ago resulted in many families having to care for a relative with a severe mental illness such as schizophrenia or bipolar disorder (Cook, Cohler, Pickett, & Beeler, 1997; Thompson, & Doll, 1982). At times, caregiving activities are appraised positively by family members and result in feelings of satisfaction and gratification for the caregiver. At other times, caregiving activities are appraised negatively because they interfere with many aspects of the caregiver's life, such as work, leisure, and social interactions. These disruptions in personal life and the responsibilities associated with the caregiving role often result in a feeling that one is carrying a heavy load, a phenomenon known as subjective burden. In the last two decades, a significant body of research has explored the relationships between different variables and feelings of subjective burden (Magliano et al., 1998; Maurin & Boyd, 1990). In contrast, little research has been conducted on the relationships between the same variables and positive appraisal of caregiving, such as satisfaction received from caregiving activities. There was also little research examining the contribution of family factors, including family support and the quality of the relationship between the caregiver and the care recipient on caregivers' positive and negative appraisal of the caregiving situation, despite the importance of the family environment in the caregiving context. This study was designed to address these issues by clarifying the relationships between certain family factors and caregivers' positive and negative appraisal of their caretaking activities.

### Variables Associated With Appraisal of Caregiving Activities

Among the variables associated with subjective burden, symptomatic behaviors of the person with mental illness are the strongest and most consistently associated with burden (Baronet, 1999; Maurin & Boyd, 1990), suggesting that the more severe the illness is, the more taxing the task of caregiving. Other variables

associated with high subjective burden include shared living arrangements between the caregiver and the care recipient (e.g., Seltzer, Greenberg, Krauss, & Hong, 1997; Solomon & Draine, 1995), caregiver's young age (Greenberg, Kim, & Greenley, 1997; Pickett, Greenley, & Greenberg, 1995), amount of care provided to the relative with mental illness (Greenberg et al., 1997; Pickett et al.), lack of intimacy and family cohesion (Bulger, Wandersman, & Goldman, 1993; Greenberg, Seltzer, & Greenley, 1993), and the presence of conflicts between the caregiver and the care recipient (Bulger et al.; Greenberg et al., 1993). Nonreplicated findings also suggest that support from family members was associated with low subjective burden in caregivers (Biegel, Milligan, Putnam, & Sung, 1994).

Little work has been conducted on the variables associated with positive appraisal of caregiving activities in family members caring for a person with a schizophrenia or bipolar disorder. The presence of symptoms in the person with mental illness and low levels of intimacy and cohesion between the caregiver and the person with mental illness were associated with low gratification received from caregiving activities (Bulger et al., 1993; Greenberg et al., 1993). Nonreplicated findings showed that the presence of conflicts between the caregiver and the care recipient was associated with low gratification received from caregiving activities (Bulger et al.). Because of demands on the individual, caregiving for one with severe mental illness can be conceptualized as a life stressor and studied within the context of the stress-process model (Pearlin, Mullan, Semple, & Skaff, 1990). This model suggests that personal characteristics of the caregiver and context of the caregiving situation affect the perception of symptoms of the illness, associated behavioral difficulties in the person with mental illness, and actual caretaking activities provided—all designated as primary stressors. In turn, these primary stressors lead to other problems and hardships, such as disruptions in the caregiver's life routine and interference with his or her activities (secondary stressors). This model also indicates that the effects of these stressors on the caregiver's well-being are counterbalanced by family resources. Based on this model, personal characteristics of the caregiver (i.e., caregiver's age and kinship with the person with mental illness) and contextual variables (i.e., coresidence status) affect the manner in which the caregiver will perceive the symptomatic behaviors of the person with mental illness and associated caretaking activities (primary stressors). In turn, these perceptions will affect the level of hardships and disruptions in the caregiver's life (secondary stressors). The ability of caregivers to process primary and secondary stressors will be influenced by their family environment, including the quality of their relationship with the care recipient and the level of family support, which, in turn, will influence their appraisal of the caregiving situation (subjective burden and satisfaction received from caregiving activities).

#### Objectives of the Study

This study was designed to evaluate the contribution of family support and the quality of the relationship between the caregiver and the care recipient to caregivers' appraisal of the caregiving situation (subjective burden and satisfaction received from caregiving activities), after the effects of certain personal characteristics (caregiver's age and kinship with the person with mental illness), context of the caregiving situation (coresidence status), primary stressors (symptomatic behaviors of the person with mental illness), and secondary stressors (objective burden) were controlled. In addition to increasing our understanding about the role family relations play in the caregiving situation, this study also identifies variables associated with satisfaction received from caregiving activities, a positive form of appraisal that has been neglected in previous research work.

#### Research Hypotheses

**Subjective burden.** It was hypothesized that a low level of family support and a high level of relationship difficulties between the caregiver and the care recipient would be associated with high subjective burden, after the effects of caregiver's young age, shared residence, presence of symptomatic behaviors in the care recipient, and disruptions in the caregiver's life routine were controlled. Kinship with the person with mental illness (being a parent or a spouse of the care recipient) also was included as a personal variable, but no

assumption was made regarding the direction of the relationship with subjective burden.

Satisfaction received from caregiving activities. It also was hypothesized that a low level of family support and a high level of relationship difficulties between the caregiver and the care recipient would relate to a low level of satisfaction received from caregiving activities, after the effects of caregiver's young age, shared residence, presence of symptomatic behaviors in the care recipient, and disruptions in the caregiver's life routine were accounted for in the equation. Again, kinship with the person with mental illness was included as a personal variable, but no assumption was made regarding the direction of the relationship with satisfaction received from caregiving activities.

## Method

### Participants and Procedure

Caregivers were recruited through psychoeducational and support groups for family members of a person with a schizophrenia or bipolar disorder in Edmonton, Alberta, Canada. Caregivers participating in the study were either a parent or a spouse of the person with severe mental illness, and they were self-identified as the family member most involved in caring for that person. They did not provide care in exchange for financial compensation (paid work). After a brief presentation by the researcher at the beginning of group meetings, a number of questionnaires were left with group leaders so caregivers could choose to participate without external pressure. Caregivers who completed and returned the questionnaire were sent \$20. Ninety-seven caregivers completed and returned the questionnaire, approximately 35% of the total number of questionnaires left with group leaders.

### Sample Description

Sixty-three percent ( $n = 97$ ) of the caregivers resided with the care recipients. Most of the caregivers were women (70%) and Caucasian (96%). Most caregivers were parents (69%), and the remaining 31% were spouses of the person with mental illness; their average age was 54 ( $SD = 10$ ). They averaged 14 years of education ( $SD = 3$ ) and reported a mean family income of approximately \$42,500 (Canadian) for 1998. Caregivers residing separate from the care recipient reported a weekly average of 13 hours of involvement in caregiving activities, whereas caregivers residing with the care recipient did not report the number of hours a week they were engaged in caregiving activities. According to information provided by caregivers, care recipients were diagnosed with schizophrenia (42%), bipolar disorder (45%), or another disorder involving the periodic presence of psychotic symptoms (13%).

### Measures

Subjective burden was measured using the Burden Assessment Scale (BAS-Subjective section; Reinhard, Gubman, Horwitz, & Minsky, 1994). The BAS is a 19-item scale that evaluates two aspects of caregiving (objective burden and subjective burden). The BAS-Subjective section consists of nine items assessing feelings of embarrassment, guilt about not doing enough and about causing the relative's illness, stigma, resentment, worries about the future and about making things worse, and feeling trapped and upset. Sample items include "I feel trapped by my caregiving role," and "I worry about how my behavior with (name) might be making the illness worse." Items were answered using a 4-point scale, ranging from 1 (not at all) to 4 (a lot). Higher scores indicate higher feelings of subjective burden, and the internal consistency was .80 (alpha).

Satisfaction received from caregiving activities was assessed by the Care Work Satisfaction Scale (Orbell, Hopkins, & Gillies, 1993), a 6-item self-report scale that evaluates the caregiver's appraisal of self-worth gains from caregiving activities. Sample items include "Caring for (name) makes me feel good about myself," and "I find my caring activities rewarding and fulfilling." Items were answered using a 7-point scale, ranging from 1 (strongly agree) to 7 (strongly disagree). High scores indicate a low level of satisfaction received from caregiving activities. Alpha coefficient was .95.

A dichotomous variable was created to record kinship between the caregiver and the care recipient. The kinship variable was coded 0 if the caregiver was a spouse and 1 if the caregiver was a parent. A second dichotomous

variable was created for coresidence status between the caregiver and the person with mental illness; this variable was coded 0 if parties were living apart and 1 if they were residing together. Caregiver's age also was included as a personal characteristic.

Symptomatic behaviors of the person with mental illness were assessed by a modified version of a subscale of the Social Behavioral Assessment Schedule (SBAS; Platt, Weyman, Hirsch, & Hewett, 1980). The 22-item SBAS subscale measures the occurrence of 22 behaviors that are typical of severe mental illness. Sample items include "In the last month, has (name) expressed any strange or unusual ideas?" and "In the last month, has (name) been threatening or abusive toward you or anyone else?" Items were answered on a 3-point scale ranging from 0 (never) to 2 (definitely). Samples of behavior relevant to each item were provided to help caregivers rate the presence and severity of the symptom. For example, for the threatening behavior item, the 3-point scale included the following: 0 (never), 1 (threatening in manner or verbally abusive, but did not strike anybody or cause damage to property), and 2 (hit person or destroyed property). High scores indicate the presence of several disturbing symptoms; the alpha coefficient was .88.

Table 1  
Descriptive Statistics and Intercorrelations Between Study Variables (N = 97)

Variables	1	2	3	4	5	6	7	8	9
1. Coresidence status (shared) <sup>a</sup>	—								
2. Kinship (caregiver is parent) <sup>b</sup>	-.47*	—							
3. Caregiver's age	-.31	.33*	—						
4. Symptomatic behaviors	.00	.15	.05	—					
5. Objective burden	.08	-.13	-.13	.51*	—				
6. Quality of relationship (difficulties)	-.08	.05	.15	.40*	.23	—			
7. Family support	-.12	.15	-.11	-.29	-.27	-.22	—		
8. Subjective burden	-.15	.08	-.02	.42*	.65*	.38*	-.19	—	
9. Satisfaction from caregiving	.04	-.14	-.27	-.37*	-.26	-.56*	.25	-.35	—
%	63	69							
M			54.43	15.03	25.02	26.96	13.91	21.40	24.73
SD			10.40	7.58	7.18	5.87	5.18	5.50	8.90
Alpha				.88	.88	.87	.90	.80	.95

<sup>a</sup>Coresidence status was coded 1 in the context of shared residence and 0 in the context of separate living arrangements. <sup>b</sup>Kinship was coded 1 when the caregiver was the parent of the care recipient and 0 when the caregiver was the spouse of the care recipient.  
\*p < .05. Bonferroni corrections were performed to keep the overall alpha level to .05. Level of significance for each correlation coefficient was .001.

Objective burden was measured using the Burden Assessment Scale (BAS-Objective section; Reinhard et al., 1994). The BAS-Objective section consists of 10 items measuring the impact of caregiving on social life, leisure time, finances, time off work, relationships within and outside the household, impact on other family members' needs, life routine, personal plans, and caregivers' capacity to concentrate on their own activities. Sample items include "Missing days at work or school" and "Cutting down on leisure time." Items were answered using a 4-point scale ranging from 1 (not at all) to 4 (a lot). Higher scores indicate higher disruptions in the caregiver's life, and the internal consistency of the objective burden subscale was .88.

Quality of the relationship between the caregiver and the person with mental illness was assessed by the McMaster Family Assessment Device (FAD) General Functioning subscale (Epstein, Baldwin, & Bishop, 1983). This 12-item, self-report subscale evaluates the quality of the relationship with respect to mutual understanding, support, communication, acceptance, sharing, and capacity to agree and to get along with one another. Sample items include "Planning activities with (name) is difficult because we misunderstand each other" and "(Name) and I don't get along well with each other." Items were answered using a 4-point scale ranging from 1 (strongly disagree) to 4 (strongly agree). High scores on the FAD indicate relationship difficulties between the caregiver and the person with mental illness; for this study, the alpha coefficient of the subscale was .87.

Family support was assessed by the Perceived Social Support from Family scale (PSS-Fa; Procidano & Heller, 1983). This 20-item self-report scale assesses perception of moral and emotional support offered by family members other than the person with mental illness. Sample items include "My family gives me the moral support I need" and "I have a deep sharing relationship with a number of members of my family." Statements were answered with yes (1) or no (0). High scores indicate a high level of perceived support from family members, and the alpha coefficient was .92.

## Results

### Correlation Analyses

Intercorrelations, means, and standard deviations of the study variables appear in Table 1. Point biserial

coefficients were computed for correlations between dichotomous variables (coresidence status and kinship between the caregiver and the care recipient) and continuous variables (the other variables included in the study), whereas Pearson coefficients were computed for correlations between the continuous variables. Because 36 correlation coefficients were computed, Bonferroni corrections were performed to reduce the overall probability of making a Type I error. Coefficients with probabilities  $\leq .001$  were considered significant. Symptomatic behaviors, objective burden, and relationship difficulties between the caregiver and the care recipient were significantly correlated with subjective burden in caregivers. Symptomatic behaviors and relationship difficulties also were correlated with satisfaction received from caregiving activities.

#### Regression Analyses

The hypotheses were tested using hierarchical multiple regression analyses for predictor variables of subjective burden and satisfaction received from caregiving activities. Results are presented in Table 2. The first analysis evaluated the prediction of variance in subjective burden by family relation variables after the effects of personal, contextual, and stressor (primary and secondary) variables were controlled. Coresidence status, caregiver's age, kinship with the care recipient, symptomatic behaviors, and objective burden were first entered in the regression equation and accounted for 48% of the variance in subjective burden,  $F(5, 91) = 16.92, p < .001$ . Of these control variables, objective burden was the only variable significantly associated with subjective burden. Relationship difficulties and family support were then entered in a second step and explained an additional 4% of the variance in subjective burden. Although small, the effect of family variables was still significant,  $F\text{-change}(2, 89) = 3.27, p < .05$ . Whereas the presence of relationship difficulties between the caregiver and the care recipient contributed to increase subjective burden in caregivers,  $\beta = .21, p < .01$ , support received from family members other than the person with mental illness did not contribute to reduce subjective burden. The research hypothesis about family variables contributing to subjective burden net of personal, contextual, and stressor variables was partially supported.  $R^2$  for regression was significantly different from zero,  $F(7, 89) = 13.63, p < .001$ . Collectively, the variables explained 52% of the variance in subjective burden.

The second regression evaluated the effects of family relations after controlling for personal, contextual, and stressor (primary and secondary) variables in satisfaction received from caregiving activities. Personal, contextual and stressor variables were entered first in the equation and accounted for 24% of the variance in satisfaction received from caregiving activities  $F(5, 91) = 5.64, p < .001$ . Younger caregivers experienced more satisfaction from caregiving activities than did older ones. Relationship difficulties and family support were entered in a second step and explained an additional 16% of the variance in satisfaction received from caregiving activities. The effect of family variables was significant,  $F\text{-change}(2, 89) = 12.38, p < .001$ . Whereas the presence of relationship difficulties between the caregiver and the care recipient contributed to reduce satisfaction received from caregiving activities in caregivers ( $\beta = -.44, p < .001$ ), support received from family members other than the person with mental illness did not contribute to reduce subjective burden ( $\beta = .07, p > .05$ ). The research hypothesis about family variables contributing to satisfaction received from caregiving activities net of personal, contextual, and stressor variables was partially supported,  $F(7, 89) = 8.58, p = .001$ . Overall, the variables explained approximately 40% of the variance in subjective burden.

#### Discussion

This study was designed to determine whether family relation variables, such as relationship difficulties between the caregiver and the care recipient and family support, contributed to the variance explained by caregivers' subjective burden and satisfaction received from caregiving activities, after the effects of personal, contextual, and stressor variables were controlled. Results showed that the presence of relationship difficulties between the caregiver and the care recipient was associated with high subjective burden and low satisfaction received from caregiving activities. In contrast, family support was not associated with either subjective burden or satisfaction received from caregiving activities.

Table 2  
 Summary of Hierarchical Multiple Regression Analyses for Variables Predicting Subjective Burden and Satisfaction in Caregiving (N = 97)

Variables	Subjective Burden			Satisfaction in Caregiving		
	B	SE B	$\beta$	B	SE B	$\beta$
Step 1						
Coresidence status (shared) <sup>a</sup>	-1.74	.99	-.15	-2.12	1.94	-.12
Kinship (caregiver is parent) <sup>b</sup>	1.37	1.06	.12	-3.26	2.07	-.17
Caregiver's age	-.02	.04	-.03	-.21*	.09	-.25
Symptomatic behaviors	.09	.07	.12	-.35	.13	-.30
Objective burden	.47***	.07	.61	-.20	.14	-.16
Step 2						
Relationship difficulties	-.20**	.08	-.21	-.67***	.14	-.44
Family support	-.01	.08	-.01	.11	.15	.07

Note: For regression of subjective burden: adjusted  $R^2 = .48$  for step 1 ( $p < .001$ );  $\Delta R^2 = .04$  for step 2 ( $p < .05$ ). For regression of satisfaction in caregiving:  $R^2 = .24$  for step 1 ( $p < .001$ );  $\Delta R^2 = .16$  for step 2 ( $p < .001$ ).  
<sup>a</sup> $p < .05$ . <sup>b</sup> $p < .01$ . <sup>\*\*\*</sup> $p < .001$ .

The absence of a positive relationship between coresidence status and subjective burden observed here is inconsistent with previous findings. It is possible that the large number of hours of involvement in caregiving activities reported by caregivers living apart from care recipients (approximately 13 hours a week) might contribute to the findings. The difference in level of involvement in caregiving activities between this sample of caregivers and caregivers in other studies that found a positive relationship between shared residence and subjective burden (Seltzer et al., 1997, Solomon & Draine, 1995) could not be evaluated because other studies used different methods to assess level of involvement.

Younger caregivers reported increased satisfaction received from caregiving activities. These findings are surprising, because the literature suggests that young age in parent and sibling caregivers typically is associated with increased subjective burden (Greenberg et al., 1997; Pickett et al., 1995). However, studies that assessed the effects of age on subjective burden did so with a sample of caregivers who were parents or siblings of the care recipient. Here, spouses were included, involving a relationship of a different nature. It is possible that kinship with the care recipient might affect the relationship between age and caregiver appraisal. Results of this study failed to support a direct association between symptomatic behaviors of the care recipient and subjective burden in the caregiver. It is possible that the inclusion of objective burden as a stressor variable has altered the relationship usually observed between symptomatic behaviors and subjective burden. Conceptually, one would assume that when care recipients exhibit a large number of behavior problems, caregivers and the family are likely to experience more disruptions. In turn, this may lead to greater feelings of subjective burden. To test this hypothesis, a hierarchical regression of subjective burden was conducted in which symptomatic behaviors were entered in the first step, and then objective burden was entered on the subsequent step (the results are not presented here). The change in the standardized regression coefficients of symptomatic behaviors affecting subjective burden is consistent with this explanation.

Because most caregiving activities involve an interaction between the caregiver and the care recipient, it was hypothesized that the quality of their relationship would influence caregivers' appraisal of their involvement in caretaking. The findings supported this hypothesis and were consistent with nonreplicated findings in the literature that found similar associations between specific aspects of the relationship (i.e., conflicts, intimacy and cohesion), subjective burden, and caregiver gratification (Bulger et al., 1993; Greenberg et al., 1993). Although measures used by these authors focused on specific aspects of the relationship between the caregiver and the care recipient, the measure used here yielded a global evaluation of the quality of that relationship with respect to mutual understanding, support, communication, acceptance, sharing, and capacity to agree and to get along with one another.

Family support was not related to subjective burden or satisfaction received from caregiving activities. The inclusion of family support was based on the assumption that the large amount of time consumed by caregiving would likely isolate caregivers from other social contacts and activities and therefore would contribute to increasing the importance of the family environment. Because these participants had sought support from an external source, it is possible that they did not perceive the support offered by family members as effective in fulfilling their needs and in alleviating their feelings of burden. Another possible explanation involves the need for an extended social network; because caregivers are already highly devoted to a family member (Spaniol,

1987), their feelings of burden might be reduced by their ability to get involved in "something different" and with people from the "outside world." Results from an exploratory study (Spaniol, 1987) noted that caregivers mentioned involvement in outside activities, engaging in meaningful work away from home, making efforts to maintain a normal family life, and belonging to a support group as successful coping strategies.

There are several important limitations to this study, including (a) the generalizability of the study findings, (b) the response rate of study participants, (c) the small sample size, and (d) the issue of shared methods variance in the measurement of objective and subjective burden. Findings of the present study represent the experience of caregivers who were members of support and psychoeducational groups; they do not necessarily represent the experience of all caregivers of a family member with a severe mental illness. Caution should be exercised when generalizing these findings to other caregivers, because differences between support group members and nonmembers are noted. Support group members tend to be predominately Caucasian and have higher levels of education and income than do nonmembers (Lefley, 1996). Also, members who return surveys are mostly Caucasian, female, middle class, and educated and are usually the parent of the care recipient (Mannion, Meisel, Solomon, & Draine, 1996). Thus, it is possible that caregivers who participated in the study differed from those caregivers who did not participate with regard to their experience in caregiving. Such differences between caregivers should be kept in mind when generalizing these findings to other caregivers.

Also, caregivers participated in the study on a voluntary basis, and approximately 35% of questionnaires left in the care of support group leaders were completed and returned. Although this is consistent with the rate of return reported in the research literature (Mannion et al., 1996), it is possible that caregivers who volunteered to participate in the study differed with regard to their experience in caregiving from those who decided not to participate.

The number of participants ( $n = 97$ ) was sufficient to obtain a desirable power to detect relationships between variables. The effect size of family variables on appraisal of the caregiving situation, after the effects of personal and stressor variables were accounted for, varied between .12 and .35 for subjective burden and between .05 and .55 for caregiver gratification (Bulger et al., 1993; Greenberg et al., 1993). For purposes of power calculations, an expected  $R^2$  of .15 was used. Using the formula suggested by Cohen (1988),  $n[R^2 / (1 - R^2)]$ , a lambda value of 17 was obtained. Given the number of independent variables included in regression analyses (7), an alpha value of .05, and the obtained lambda value, Cohen's power tables indicated a power level of .83 for the statistical analyses. However, the sample size remained below the ideal ratio of 20 times more research participants than the number of independent variables (Tabachnick & Fidell, 1989). The ideal number of research participants would have been 140 for these analyses.

Lastly, the issue of shared methods variance in the measurement of objective and subjective burden should be considered. Because objective and subjective burden were assessed using different items from the same scale, part of the correlation between these two constructs is likely due to shared methods variance. Although factor analyses of the scale suggest distinct dimensions for objective and subjective burden, it remains difficult to determine the extent to which the large correlation reflects a causal process or is due to shared methods variance.

#### Implications of the Study

These findings have important implications for counselors and mental health professionals working in the field of severe mental illness. To date, interventions designed for caregivers and family members have typically been psychoeducational in nature and have focused on teaching caregivers how to manage symptoms and disruptive behaviors of the care recipient. This approach was consistent with the existing body of literature on caregiving that identified symptoms of the illness and objective burden as major determinants of subjective burden. Findings of this study suggest that caregiving involves feelings of satisfaction as well as burden and that the quality of the relationship between the caregiver and the person with mental illness affects the caregiver's appraisal of the situation above and beyond the effects of the illness and the caregiving activities. Thus,

interventions designed for caregivers might be improved by a shift in attention from burden alone to a broader approach that also addresses satisfaction and the caregiver-care recipient relationship.

Following discharge from a psychiatric hospital, community support services offered by mental health professionals often are provided on an individual basis to the care recipient. Given the role and responsibility of the caregiver in maintaining the person with mental illness in the community, regular inclusion of the caregiver in follow-up sessions would provide much needed information about the care recipient's condition and functioning to members of the treatment team, as well as provide professionals with the opportunity to detect and address relationship difficulties between the caregiver and the care recipient. One would expect that interventions that improve the quality of family relationships might result in improved quality of life and wellbeing outcomes for all members and might contribute to reduce the likelihood of a relapse for the care recipient.

In a meta-analysis of the effects of family interventions on relative's burden, Cuijpers (1999) found that family interventions had positive effects on the relationship between family members and the person with mental illness, family functioning, relatives' burden, and psychological distress. Cuijpers' findings are consistent with those of this study and suggest that addressing problems and conflicts between the care recipient and family members may reduce psychological distress and improve well-being in the parties involved. Because of the small number of studies involved in the meta-analysis and the variety of characterizing measures used and services provided, Cuijpers was not able to specify which elements of family interventions were responsible for the positive outcomes. However, he reported that interventions involving more than 12 sessions yielded larger effects than did interventions of shorter duration. One may assume that a larger number of sessions would allow family members not only to identify the nature and source of conflicts, but also to work through these conflicts with the support of a professional. Thus, follow-up services in severe mental illness could be improved by including psychologists, marital counselors, or family therapists as integral members of the treatment team. These findings suggest that although most of the variance in subjective burden was explained by indicators of stress, stressor and relationship variables accounted for a similar amount of variance in satisfaction received from caregiving activities. Therefore, relationship difficulties between the caregiver and the care recipient appear to have a larger impact on caregivers satisfaction than they do on their feelings of burden. Although interventions targeting the quality of the relationship between the caregiver and the care recipient might not have a huge impact on the taxing aspects of caregivers' activities, such interventions may provide the opportunity to appraise the situation more positively, which may, in turn, help caregivers to accept and cope better with the demands and responsibilities associated with caregiving.

Also, clinical interventions designed to provide respite care and instrumental help to caregivers, especially in times of exacerbation of symptoms, would likely be helpful in reducing the amount of care required from the caregiver during an acute period of the illness and would be helpful in providing an opportunity for family life to return to a less disruptive level of functioning. By reducing objective burden, respite care and instrumental help would contribute to reduce subjective burden in caregivers. These services were implemented on a large scale for caregivers for older persons with cognitive impairment and were found helpful in alleviating caregiver burden (Aneshensel, Pearlin, Mullan, Zarit, &Whitlatch, 1995).

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