Family Care of Alzheimer’s Patients: The Role of Gender and Generational Relationship on Caregiver Outcomes

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In this study of 262 individuals caring for victims of Alzheimer’s disease, the time-invariant factors of caregiver gender and generational relationship were analyzed for their negative impacts on caregiving. Caregiving impacts included strain in family relationships, restrictions in social activity, and decline in health. Results indicate that the impacts of caregiving are not distributed uniformly among caregivers but vary according to both caregiver gender and the generational relationship between the caregiver and the care recipient. Caregiver gender influences strain in family relationships and decline in caregiver health; generational relationship affects restrictions in caregiver social activity. To a lesser extent, caregiving involvement is affected by both gender and generational relationship.

Researchers interested in caregiving have paid considerable attention to family members caring for victims of Alzheimer’s disease (for a review of research, see Blieszner & Shiflett, 1990). Especially engaging have been the dual tasks of (a) describing caregiving involvement and impacts (Chesnokweth & Spencer, 1986; Deimling & Bass, 1986) and (b) identifying factors contributing to the differential impacts of caregiving (Barber, 1989, 1993; Barber, Fisher, & Pauley, 1990; Dwyer & Seccombe, 1991).

With regard to the latter, predictor variables generally have included both time-invariant factors (e.g., the dementia patient’s level of impairment) and time-invariant factors (e.g., caregiver gender). This research hypothesized that caregiving consequences would differ when two time-invariant factors—caregiver gender and generational kinship—are simultaneously considered.

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Caregiver gender and generational relationship to the care recipient are admittedly time-worn variables in caregiving research, and their separate effects on the negative impacts of caregiving is well documented. Nevertheless, we focused on these variables because no study could be found wherein the full range of values for both variables had been examined. Unique to this study is the inclusion of both husbands and wives as spousal caregivers and both daughters and sons as filial caregivers. Thus the examination of gender and generational relationship with a constellation of values broader than those in previous research contributes to the extant literature.

Caregiver Gender

A review of the caregiving literature indicates that women and men often confront dissimilar caregiving situations and consequently experience the process and impacts of caregiving differently. Although generalizations are hazardous to assert without qualification, several research findings with regard to the influence of caregiver gender are noted below.

Women are more likely than men to be cast in a primary caregiver role, to experience greater negative caregiving impacts, and to contribute more time and intimacy to caregiving (Young & Kahana, 1989). Among spousal caregivers, men are more likely to be older and in poorer health and to have fewer social supports to aid them in the process of caregiving (Barusch & Spauld, 1989; Stoller, 1992). In terms of caregiving involvement, men and women are provided different types of assistance to care recipients and do so in gender-specific ways (Horowitz, 1985; Stoller, 1988). For example, male caregivers are more likely to provide assistance with home repairs, household chores, and transportation, whereas female caregivers are more apt to help with meal preparation, household cleaning, nursing, and laundry.

Generational Relationship

The majority of caregiving research has centered on adult children caring for aged parents. Spousal caregiving, while recognized, is less prevalent in the literature. One prominent finding is that spousal interactions in the context of spousal caregiving differ substantially from parent-child interactions in the context of filial caregiving (Hess & Soldo, 1985). Hence findings from filial caregiving studies cannot be applied directly to the experience of spousal caregivers.

The marital relationship is fundamentally different from the parent-child relationship in terms of duration, commitment, exchange expectations and
behavior, and history. In actuality, little is reported in the literature regarding how characteristics of the marital dyad affect caregiving (Montgomery & Kosloski, 1994). Studies involving both spousal and filial caregivers show several important distinctions between spousal and filial caregivers in the context of caregiving. These distinctions include differences in age, employment status, type and level of care, and health status. Generally, spousal caregivers are older, less likely to be employed (at least full-time), and more immersed in caregiving as a result of normative expectations associated with the marital bond. Spousal caregivers are engaged in a broader range of caregiving tasks and activities than are filial caregivers, a range that requires greater time commitment. Tennen, McKinlay, and Sullivan (1988) report that spousal caregivers render up to four times the amount (i.e., number of hours of care rendered per week and range of caregiving activities performed) of care provided by nonspousal family caregivers. Lastly, more so than filial caregivers, spousal caregivers commonly shoulder the role of caregiving in the face of their own declining health and increasing frailty.

The negative impact of caregiving for both spousal and filial caregivers is well documented in the literature, but differences between them in terms of the specific impacts of caregiving are often unclear, or at least are not easy to interpret. For example, neither Robinson (1983) nor Zauti, Reeves, and Bach-Peterson (1980) found demonstrable differences in burden measures between spousal and filial caregivers. Reeves and Bach-Peterson (1979), however, reported that spousal caregivers experienced significantly more doctors' visits, poorer self-rated health, and lower levels of well-being on mental health measures (e.g., anxiety, depression). These differences persisted even when caregiving age was statistically controlled. Due to multiple work and family roles concurrent with caregiving, filial caregivers appear to experience greater role strain in the provision of caregiving. As Brody (1981) has observed, part-time care, family care, and work often conflict, resulting in competing demands, particularly for daughters, who are described as being “caught in the middle.” Yet to be addressed is whether role strain experienced by adult child caregivers is enduring or transient, although Townend and Noeker (1987) report that filial caregivers seem to adapt over time to the pressures created by the competing demands of caregiving.

In a longitudinal study of factors critical to nursing home placement, Montgomery and Kosloski (1994) reported distinct differences in patterns of caregiving between spousal and filial caregivers, particularly with the onset of the caregiving role and the self-definition of being a caregiver. For spousal caregivers, the onset of caregiving and the process of defining one's self as a caregiver is less abrupt than for filial caregivers. As intuitive as this may be, we emphasize this finding since the length of time a person perceives he or she has served in the caregiver role probably exercises some influence on the differential impact of caregiving between spousal and filial caregivers.

**Gender and Generational Relationship**

Importantly, studies simultaneously addressing gender and generational relationship are rare (e.g., Young & Kahana, 1989). When spousal and filial caregivers are compared, the gender of both groups is not controlled (Montgomery & Kosloski, 1994). Similarly, when female and male caregivers are compared, the generational relationship with the care recipient often is not differentiated (Barusch & Spaid, 1989). We believe this lack of understanding of the role of gender and generation in assessing the impacts of caregiving hinders the refinement of theory building in this area.

Portrayed in Figure 1 is a model emphasizing the role of caregiver gender and generational relationship on caregiving impacts. The model is a streamlined version of a theory of caregiver burden previously developed by Barber (1989). The primary objective of this study was to empirically test this model by separating the effects of the time-invariant factors of gender and generational relationship on three measures of caregiver well-being, while controlling for several time-variant factors that might confound the influence of gender and generation on caregiving impacts. Examples of these latter factors include measures of patient impairment, co-residence with the caregiver, and time spent caring for the patient.

**Hypotheses**

Regarding gender differences in the impact of caregiving, the following hypothesis was tested in the present study:

**Hypothesis 1:** Caregivers will differ in the adverse impact of caregiving such that female caregivers report greater relationship strain, more restrictions in social functioning, and poorer health as a result of caregiving.

We tested the following hypothesis regarding caregiving impact differences due to generational relationship:

**Hypothesis 2:** The adverse impacts of caregiving will differ between spousal and filial caregivers, with filial caregivers reporting the most family relationship strain and spousal caregivers reporting the greatest restriction on social activities.
negative impacts of caregiving. Only in the instance of restrictions on social activity was the generational relationship between caregiver and care recipient an important factor. This is because the marital obligation to provide care for a spouse is more potent in restricting non-caregiving activity than is the filial obligation to care for a parent.

Methods

Data Collection

Data were collected using a mailed questionnaire consisting mostly of closed-ended items. The following information was obtained: demographic characteristics of both the caregiver and the dementia patient, living arrangement that provided the context for caregiving (i.e., intra- vs. interhousehold caregiving), measures of patient impairment, and measures of the impact of caregiving on the well-being of the caregiver.

Procedures for Identifying Caregivers

Forty-two potential sources of caregivers were identified. Sources included diagnostic clinics for cognitive disorders, support groups for caregivers of dementia patients, nursing homes, and adult day care facilities in Colorado, Wyoming, and Washington.

All sources were contacted and asked to provide the names and addresses of persons who were primarily responsible for caring for loved ones afflicted with Alzheimer’s disease. Forty-six sources agreed to furnish names and addresses of caregivers. Two sources (both were caregiver support groups) declined to participate due to confidentiality of lists containing names and addresses of caregivers.

The result of these solicitations was a composite list of 310 caregivers. Nearly 70% of these caregivers were identified using name and address lists provided by support groups. Two limitations in this sampling strategy are noted. First, there was no reliable means of discerning whether the sources “filtered” names of caregivers prior to forwarding lists to project staff. The request was for mailing lists of all current caregivers, but there was no check on whether staff received only a subset of the caregivers served by the source. It may be that, in some instances, sources forwarded only the names and addresses of caregivers who had given prior permission for their names to be retained, or who were individuals the source felt were most likely to be willing to participate in our study, or both. Second, relying on mailing lists

![Diagram](image-url)

Figure 1. A caregiving impact model emphasizing the time-invariant factors of gender and generation.

Finally, with regard to the interaction of both caregiver gender and generational relationship to the care recipient, the following hypothesis was tested:

**Hypothesis 3:** Of the two time-invariant factors studied (gender and generational relationship), caregiver gender will have the most salient influence on the
made it impossible to ensure that all 510 individuals on the final list were actually primary caregivers for a dementia patient. With regard to this limitation, we attempted to screen out potential respondents who were not caregivers by stating the qualifications for inclusion in the study in the cover letter accompanying each questionnaire. This allowed each person receiving a questionnaire to discern whether he or she qualified for inclusion in the study.

Efforts to maximize response rate included sending one follow-up letter 2 weeks after the initial questionnaire and a second letter 6 weeks later. Of the 322 individuals who returned questionnaires, 24 wrote to indicate they were not eligible to participate in the study (i.e., they reported that another individual was currently fulfilling the primary caregiving role or that the person for whom they had been caring was deceased). An additional 26 caregivers did not return the questionnaire but telephoned to inform project staff they would not be returning the questionnaire because they were ineligible for the reasons mentioned above. If the 50 ineligible caregivers who contacted project staff by letter or phone are counted as responses, the return rate was 68% (348 out of 510). We note that the return rate may be considered conservative in that among those who did not respond at all was an undetermined number of individuals who were not eligible (i.e., they were not currently providing care for a dementia patient) but who did not contact project staff to so inform them.

Among the 298 caregivers who returned completed questionnaires were 106 spousal caregivers (55 wives and 51 husbands) and 156 filial caregivers (121 daughters and 35 sons). The remaining 36 caregivers were friends or siblings. Only responses for 262 spousal and filial caregivers were used in the analyses reported here.

Sample

Caregiver groups. The initial strategy was to divide caregivers into three groups based on gender and generational relationship to the Alzheimer’s disease patient: opposite gender/same generation (all spousal caregivers); opposite gender/different generation (sons caring for mothers and daughters caring for fathers); same gender/different generation (sons caring for fathers and daughters caring for mothers). However, this strategy was abandoned and caregivers were grouped by caregiver status (i.e., whether the respondent was a caregiver, a family caregiver, or a professional caregiver). The final data set included all caregivers who met the qualifications for inclusion in the study.

Table 1. Frequency and Percentage Distributions of Sample in Terms of Gender and Generational Relationship

<table>
<thead>
<tr>
<th>Caregiver Group</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse caregivers</td>
<td>106</td>
<td>40.5</td>
</tr>
<tr>
<td>Group 1: Wives caring for husbands</td>
<td>55</td>
<td>21.0</td>
</tr>
<tr>
<td>Group 2: Husbands caring for wives</td>
<td>51</td>
<td>19.5</td>
</tr>
<tr>
<td>Filial caregivers</td>
<td>156</td>
<td>59.5</td>
</tr>
<tr>
<td>Group 3: Daughters caring for parents</td>
<td>121</td>
<td>46.2</td>
</tr>
<tr>
<td>Daughters caring for mothers</td>
<td>21</td>
<td>8.0</td>
</tr>
<tr>
<td>Daughters caring for fathers</td>
<td>100</td>
<td>38.1</td>
</tr>
<tr>
<td>Group 4: Sons caring for parents</td>
<td>35</td>
<td>13.4</td>
</tr>
<tr>
<td>Sons caring for mothers</td>
<td>10</td>
<td>11.5</td>
</tr>
<tr>
<td>Sons caring for fathers</td>
<td>5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

into four groups: wives caring for husbands (n = 55), husbands caring for wives (n = 51), daughters caring for parents (n = 121), and sons caring for parents (n = 35). In terms of gender and generational relationship, the sample analyzed in this paper is described by the frequency and percentage distributions reported in Table 1.

Caregiver characteristics. Caregivers’ average age was 60. Nearly 6 in 10 were filial caregivers, and two thirds were female. The sample was predominately White (95.7%). Twenty-eight percent reported an educational level of 12 years or less.

Using chi-square and one-way analyses of variance, we compared the four caregiver groups on several sociodemographic factors. As depicted in Table 2, caregiver groups differed with respect to employment status, educational level, caregiver age, number of dependents/children, co-residence with the care recipient, marital status, and the age of the care recipient. As might be expected, filial caregivers were more likely to be employed, to have a higher level of education, to be younger in age, to have more dependent children, and to live apart from the care recipient. Additionally, fewer filial caregivers (especially daughters) were married. Both sons and daughters were caring for parents whose average age was 80: 5 years older than the average age of recipients of spousal caregiving.

Characteristics of the Alzheimer’s patient. The mean age of those suffering from dementia was 78.5; Almost 68% were female. About 80% had been clinically diagnosed as having dementia of the Alzheimer’s type.
Table 2. Representative Background Characteristics for Major Caregiver Groups

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Caregiver Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wives (n = 58)</td>
</tr>
<tr>
<td>Race (% White)</td>
<td>95.2</td>
</tr>
<tr>
<td>Marital status (% married)</td>
<td>100.0</td>
</tr>
<tr>
<td>Education (% postsecondary)</td>
<td>61.8</td>
</tr>
<tr>
<td>Employment (% employed)</td>
<td>21.8</td>
</tr>
<tr>
<td>Consistence (% with Alzheimer’s patient)</td>
<td>58.2</td>
</tr>
<tr>
<td>Age of caregiver (mean)</td>
<td>69.9</td>
</tr>
<tr>
<td>Age of dementia patient (mean)</td>
<td>74.2</td>
</tr>
<tr>
<td>Clinical diagnosis of AD (% yes)</td>
<td>90.2</td>
</tr>
<tr>
<td>Number of years since AD diagnosis (mean)</td>
<td>4.1</td>
</tr>
<tr>
<td>Number of dependent children (mean)</td>
<td>.08</td>
</tr>
</tbody>
</table>

NOTE: AD = Alzheimer’s disease. *p < .05, **p < .01, ***p < .001.

The patient’s level of impairment was measured in terms of functional capacity (i.e., the ability to perform activities of daily living), cognitive capacity, disruptive behavior, and social functioning. Scales developed by Poudshock and Deeling (1984) were slightly modified in terms of wording; namely, the phrase “your loved one with dementia” was substituted for the word “relative.”

Functional capacity was measured using a six-item scale that asked the caregiver to rate the patient’s ability to independently perform such activities of daily living (ADL) as eating, dressing/undressing, and personal grooming. The response set for each item was a 3-point scale: (1) not at all to (3) most of the time. Items were coded so that higher scores indicated greater impairment. Cronbach’s alpha was .90.

Items measuring cognitive capacity, disruptive behavior, and social functioning were also rated using the aforementioned 3-point rating set. The scale measuring cognitive capacity consisted of four items: forgetfulness, confusion, hearing/wearing things that are not there, and talking to self. Disruptive behavior was measured using a five-item scale: interfering/giving unsolicited advice, yelling or swearing, demonstrating embarrassing behavior, showing lack of respect for privacy of others, and complaining and criticizing. Social functioning was also measured using a five-item scale: cooperative behavior, friendly and sociable, enjoyable to be around, interesting to talk to, and clean

Table 3. Descriptive Statistics and Reliability Coefficients for Scales Measuring Level of Impairment of the Alzheimer’s Patient

<table>
<thead>
<tr>
<th>Measure of Functional Impairment</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Cronbach’s α</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL capacity</td>
<td>13.53</td>
<td>3.95</td>
<td>.90</td>
</tr>
<tr>
<td>Cognitive capacity</td>
<td>9.77</td>
<td>1.57</td>
<td>.65</td>
</tr>
<tr>
<td>Disruptive behavior</td>
<td>7.98</td>
<td>2.32</td>
<td>.76</td>
</tr>
<tr>
<td>Level of social functioning</td>
<td>9.96</td>
<td>2.51</td>
<td>.70</td>
</tr>
</tbody>
</table>

All higher scores indicate greater impairment.

and most about personal habits. Coefficients of reliability (Cronbach’s alpha) for the three scales were .63, .76, and .70, respectively.

Descriptive statistics and reliability coefficients for the scales measuring level of impairment for the dementia patient appear in Table 3. Also noted in the fact that in all instances, higher scores indicate greater impairment.

Comparison of Caregiver Groups by Level of Patient Impairment

In terms of the Alzheimer’s patient’s functional impairment, the context of caregiving for the four groups was generally comparable. The only exceptions were in the areas of cognitive capacity and level of social functioning, and these differences were not significant. Filial caregivers (particularly daughters) were caring for dementia patients with slightly poorer cognitive functioning (M = 10.12) than were spousal caregivers (M = 9.6). Wives being cared for by husbands had higher levels of social functioning (M = 8.9) than did family members cared for by individuals in the three remaining caregiver groups (M = 10.22 for husbands cared for by wives; M = 10.44 for parents cared for by daughters; M = 10.20 for parents cared for by sons).

The Impacts of Caregiving

The impacts of caregiving on the well-being of the caregiver were conceptualized as being multidimensional. Three measures were used: strain in family relationships, restrictions in social activity, and decline in health.

Relationship strain. The Relationship Strain Scale consisted of six items. In each item, the caregiver was presented with a statement regarding the
extent to which there was strain in his or her relationship with others in the family (including the care recipient) as a result of caregiving. Examples of scale items included these: “I feel angry toward my relative,” “My relationship toward my relative makes me feel depressed,” and “I feel that my relative has had a negative effect on my relationships with other family members.” Caregivers were asked to indicate the extent to which they agreed or disagreed with each statement, ranging from (1) strongly agree to (4) strongly disagree. Items were coded so that a high score indicated a high degree of relationship strain. The coefficient of reliability (Cronbach’s alpha) was .86. Deimling and Bass (1986) reported a standardized alpha of .88 for this scale.

Restrictions on social activity. The scale measuring restrictions on the caregiver’s social activity consisted of five items. Each item was rated using a yes-no response scale. Examples of scale items included the following: “Since providing care for your relative, do you visit with family and friends less often?” and “Do you participate in group or social activities less often?” The number of affirmative responses was summed to obtain an overall score for restrictions on social activity, with a higher score indicating greater restriction. The standardized alpha for this scale reported by Deimling and Bass (1986) is .90. In the present study, the coefficient of reliability was .83.

Decline in health. The impact of caregiving on the caregiver’s health was measured using a modified version of a scale developed by Deimling and Bass (1986). The scale consisted of five statements for which the respondent indicated the extent of agreement or disagreement with each statement (1 = strongly agree to 5 = strongly disagree). Examples of scale items included these: “Because of caring for my relative, I seem to get sick more often,” and “I’m bothered more by aches and pains.” In the present study, two additional items were included: “Because of caring for my relative, I seem to be sleeping less,” and “I seem to be eating more (less).” Items were coded so that a high score indicated a negative impact on the caregiver’s health. The standardized alpha for the original scale was reported by Deimling and Bass (1986) to be .90. The alpha for this scale in the present study was also .90.

Descriptive statistics and reliability coefficients for the scales measuring the negative impacts of caregiving appear in Table 4. Also noted is the fact that in all instances, higher scores indicated greater negative impact.

**Data Analysis**

Data were first analyzed for subgroups characterized by caregivers gender and generational relationship. These analyses compared females and males, and spousal and filial caregivers. For the various comparisons, t tests, chi-square, and analysis of variance were used. In running the tests, one-tailed tests were made due to the directionality implied in the hypotheses. Multiple analysis of covariance was subsequently used to disaggregate the factors of gender and generational relationship for the entire sample. Employed as covariates were factors that might confound the influence of gender and generation on caregiving impacts, such as co-residence and the time spent caring for the Alzheimer’s patient.

**Findings**

*Caregiving Impacts: The Effect of Gender*

As proposed in the first hypothesis, there were differences in caregiving impacts by caregiver gender (see Table 5). Female caregivers experienced greater strain in family relationships (M = 13.51) than did male caregivers (M = 10.60). Despite being younger than their male counterparts, female caregivers also reported greater declines in health as a result of caregiving (M = 16.35 for females, compared to M = 14.40 for males).

*Caregiving Impacts: The Effect of Generation*

The second hypothesis predicted that the adverse impacts of caregiving would differ between spousal and filial caregivers, with filial caregivers reporting the most relationship strain and spousal caregivers reporting the greatest restriction on social activities and decline in health. The data reported in Table 5 support this hypothesis. The mean for relationship strain was 13.17 for filial caregivers and 11.53 for spousal caregivers. As for restrictions on social activity and decline in health, spousal caregivers experienced the
Table 5: Comparison of Caregiver Groups. Gender and Generation

<table>
<thead>
<tr>
<th></th>
<th>Female Caregivers (n = 176)</th>
<th>Male Caregivers (n = 96)</th>
<th>Female Elderly Caregivers (n = 108)</th>
<th>Male Elderly Caregivers (n = 56)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean)</td>
<td>57.69***</td>
<td>65.95</td>
<td>72.29***</td>
<td>52.33</td>
</tr>
<tr>
<td>Employment (%)</td>
<td>42.0</td>
<td>36.0</td>
<td>17.0**</td>
<td>65.6</td>
</tr>
<tr>
<td>Clinical diagnosis (%)</td>
<td>91.8</td>
<td>66.4</td>
<td>91.7**</td>
<td>86.3</td>
</tr>
<tr>
<td>Caregiving involvement</td>
<td>Number of hours of care per week (median)</td>
<td>24,35</td>
<td>25,91</td>
<td>37,56**</td>
</tr>
<tr>
<td>Caretaker characteristics (male)</td>
<td>Age</td>
<td>75.42</td>
<td>78.78</td>
<td>74.5**</td>
</tr>
<tr>
<td></td>
<td>ACHL capacity</td>
<td>13.65</td>
<td>14.20</td>
<td>13.83</td>
</tr>
<tr>
<td></td>
<td>Cognitive capacity</td>
<td>9.75</td>
<td>9.83</td>
<td>9.65*</td>
</tr>
<tr>
<td></td>
<td>Disruptive behavior</td>
<td>8.12</td>
<td>7.68</td>
<td>7.77</td>
</tr>
<tr>
<td></td>
<td>Level of social functioning</td>
<td>62.2**</td>
<td>9.29</td>
<td>9.80</td>
</tr>
<tr>
<td>Caregiving impacts (male)</td>
<td>Relationship tension</td>
<td>13.51***</td>
<td>10.60</td>
<td>11.53**</td>
</tr>
<tr>
<td></td>
<td>Restrictions in social activity</td>
<td>3.13</td>
<td>3.20</td>
<td>4.14***</td>
</tr>
<tr>
<td></td>
<td>Decline in health</td>
<td>16.35*</td>
<td>14.40</td>
<td>16.74*</td>
</tr>
</tbody>
</table>

NOTE: ADL = activities of daily living. 
* = higher scores indicate greater impairment. 
** = 0.05. * * = 0.01. * * * = 0.001.

The greatest negative impact (M = 4.14 and M = 16.74, respectively). The difference in restrictions in social activities is not surprising. Compared to filial caregivers, a higher percentage of spousal caregivers lived with the Alzheimer’s patient (61% vs. 18.5%) and required significantly more hours of care per week (37.56 hours vs. 16.24 hours).

Gender and Generational Differences in Caregiving Involvement

Extent of caregiving involvement was determined for the four caregiving groups for several measures of caregiving activity (see Table 6). Members of all caregiving groups had been providing care for approximately 4 years (although sons reported an average of 6 years to the caregiving role). Each caregiving group performed an average of four to five different caregiving tasks weekly. As far as the performance of specific caregiving tasks are concerned, there were no significant differences across the caregiving groups, with four exceptions. The tasks of financial management and telephone checks were more often performed by filial caregivers, whereas yard care and meal preparation were done more frequently by spousal caregivers. The total number of caregiving tasks performed in a given week did not differ across the four groups, but spousal caregivers expended significantly more time performing caregiving tasks (wivrs = 40.21 hours and husbands = 34.69 hours).
hours) thus did filial caregivers (daughters = 18.3 hours and sons = 26.2 hours).

**Gender and Generational Differences in Caregiving Impacts**

Table 7 presents the mean impact scores for the four caregiving groups. In terms of relationship strain, daughters reported the most adverse impact (M = 14.34), followed by wives (M = 12.55). A similar pattern was found for decline in health, with wives reporting the highest score (M = 17.67), followed by daughters (M = 16.36). Restrictions in social activity was greatest for wives (M = 4.18) and husbands (M = 4.09), and least for daughters (M = 2.89) and sons (M = 2.50).

In an attempt to disaggregate the effect of gender and generational relationship on the impact of caregiving, multiple analysis of covariance (MANCOVA) was conducted using caregiver gender and generational relationship (spousal vs. filial) as the independent variables. Dependent variables included strain in family relationships, restrictions in social functioning, and decline in health. Included as covariates were caregiver employment status (employed/not employed), corecision with the Alzheimer’s patient (living or not living with Alzheimer’s patient), hours of care rendered per week to the patient, the age of the caregiver, and two measures of patient impairment (cognitive capacity and social functioning). Results of these analyses are reported in Table 8.

Multivariate effects were significant at p < .01 (Wilks’s lambda = .79). Given the multivariate level of significance, univariate F tests were then conducted to identify which variables were responsible for multivariate effects.

It is important to note that the interaction of gender and generation was not significant, but significant main effects for both gender and generation provide insight into the value of these two variables in assessing the context.
of the negative impacts of caregiving. Considering strain on family (relationships), the main effect of caregiver gender was significant at \( p < .001 \) \( (F_{1,116} = 12.95) \). In terms of restrictions on social activities, the main effect of generational relationship was significant at \( p < .05 \) \( (F_{1,116} = 5.40) \), as was the covariate of hours of care per week \( (p < .001) \). For decline in health, the main effect of caregiver gender was significant at \( p < .001 \) \( (F_{1,116} = 10.97) \), as were the covariates of employment status \( (p < .05) \) and the Alzheimer’s patient’s cognitive capacity \( (p < .05) \).

**Limitations**

Several limitations in the study merit discussion. First, as is the case with most caregiving research, our data collection strategy relied on self-declarations of the participants. In order to participate in the study, the respondent first had to believe himself or herself as a caregiver. This approach is problematic in that filial caregivers are prone to view themselves as caregivers as an earlier point in the caregiving process than are spousal caregivers (Montgomery & Koslowski, 1994). It is suggested that spousal caregivers perceive (if they perceive it at all) the increase in care as a natural part of the marital obligation and are less apt to define caregiving activities as constituting a new role distinct from that of being a spouse. For spousal caregivers, the onset of caregiving (apart from the actual clinical diagnosis of Alzheimer’s disease) is almost imperceptible. The point emphasized here is that the natural histories involved in caregiving are different for spousal and filial caregivers, particularly with regard to the early stages of caregiving, and that this difference is critical in assessing the impacts of caregiving.

Second, the “snapshot” view of caregiving provided by the cross-sectional design used in this study does not permit a clear picture of differences over time in the caregiving experience, either for spousal versus filial caregivers or for female versus male caregivers. As implied earlier, this limitation is particularly glaring with regard to the onset of the caregiving role and the early stages of the caregiving experience. Collecting data from Alzheimer’s support groups, diagnostic clinics, and respite care programs for Alzheimer’s patients was admittedly biased toward the later stages of caregiving. In spite of the findings that caregivers reported approximately the same length of time in the caregiving role (4 years), it is doubtful that this datum accurately portrayed the duration of caregiving for all caregivers.

Third, in an attempt to discern the main effects of gender and generation on caregiving impacts, we employed several time-variant factors as covariates (e.g., measures of the Alzheimer’s patient’s impairment). Even controlling for these factors, differences among caregivers (regardless of gender and generation) may simply reflect differences among the groups on one or more unmeasured variables rather than the presumed predictors. For example, increased coping skills acquired through the course of caregiving may permit a caregiver to absorb some of the negative impacts of caregiving (Buhrer, 1989; Zaut, Todd, & Zaut, 1986). Unless these skills are included as controls, the estimated effect for gender (or generational relationship) may simply reflect the results of the relationship with coping skills.

Fourth, the attempt to describe distributions of effort across caregiving tasks was problematic for spousal caregivers in that many of these tasks are confounded with marital roles and the division of labor between spouses within households (Montgomery & Koslowski, 1994). For example, one member of the marital dyad may have always prepared the meals, managed finances, performed yard maintenance, and so forth. Only help with personal grooming and hygiene may be unambiguously associated with the caregiving role in response to increasing dependency and functional impairment.

**Summary**

The findings of this study are supportive of hypotheses positing that the processes and impacts of caregiving are not distributed uniformly among caregivers but vary according to caregiver gender and the generational relationship between the caregiver and the care recipient. Strain in family relationships, restrictions in social activity, and declines in physical health were not exhibited uniformly among caregivers but varied according to the gender of the caregiver, the generational relationship to the care recipient (spousal versus filial), and the specific family kin relationship (wife, husband, daughter, or son). The theoretical value of the study derives from the finding that our understanding of the impacts of caregiving is sharpened by distinguishing caregiver gender, generational relationship, and specific family kin relation.

The most important finding of the study stems from the simultaneous consideration of caregiver gender and generational relationship. The differences in caregiving involvement and caregiving impacts among the four caregiving groups studied (wives caring for husbands, husbands caring for wives, daughters caring for parents, and sons caring for parents) indicate that gender and generational relationship need to be distinguished. Efforts to consider either without controlling for the other may mask important findings. This point is illustrated in our finding that whereas wives and daughters caring for...
a dementia patient provide similar types of care and both experience adverse impacts, these two caregiver groups do not experience the same negative outcomes. Daughters grapple with strain in family relationships, whereas wives confront restrictions in social activity.

Female caregivers (wives and daughters) were the most affected groups in our study. Perhaps this was a product of the fact that more women (42%) than men (36.8%) were employed. Trying to balance work (even part-time) and caregiving responsibilities probably created situations wherein there was considerable strain and conflict with the caregiving role.

In confirming hypotheses based on gender and generation, this study supports the need for multiple component models of caregiving that include the time-invariant factors of caregiver gender and generational relationship between caregiver and care recipient. When combined with time-variant factors such as patient impairment and caregiver involvement, a more complete picture of the caregiving enterprise results. Of particular value is identifying caregivers deemed to be at risk for experiencing negative impacts of caregiving. Examples here include daughters who are at risk for relationship strain, and wives at risk for restrictions in social activities.

Implications for Practice

The implicit assumptions underlying some intervention programs are that caregivers are a homogeneous group and that members of this group experience caregiving in similar ways. The results of this study suggest that such assumptions need to be carefully examined in the design and implementation of programs to help caregivers. Interventions may need to be tailored for different caregiver needs based on gender and generational relationship. For example, interventions that would best serve daughters caring for aging parents include strategies to reduce strain in family relationships, whereas spousal caregivers would be better served by interventions addressing spousal restriction on social activities.

Further, intervention programs centered on support groups may be less viable for filial caregivers who often confront the task of balancing multiple roles. Support groups may serve filial caregivers well initially, providing them with useful information and an opportunity to share feelings and experiences, but over time, competing demands of work, family, and caregiving may make regular attendance at support groups an added burden. For spousal caregivers, on the other hand, attending support groups may provide a much needed social outlet for the restricted lifestyle that the demands of spousal caregiving often impose.

References


Future Research

What our work does not provide is a dynamic picture of the impacts of caregiving over time, nor does it permit a glimpse of the positive or adaptive outcomes of caregiving. Thus we cannot determine which groups of caregivers burn out over time or which groups successfully adapt to the caregiving role. These and similar time-related issues can be addressed only through longitudinal studies. Cross-sectional investigations such as ours provide only a snapshot of caregiving at a particular point in time but do not enable us to say anything about the future. How will the care recipients fare? How will the caregivers react? Our results indicate that different groups of caregivers experience different degrees of strain and that over time some groups may suffer greater strain than others. Further, some caregivers will cope better than others, and some will need more support than others. Thus, different types of interventions may be needed for different groups of caregivers. Future research should address these issues and help us understand better the impact of caregiving on the caregivers and care recipients.


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