

Caring for a partner: the impact of resources on caregivers' health in rural and urban Tasmania

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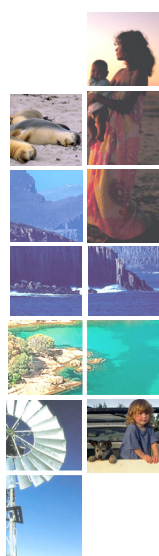
Research has shown that chronic stress significantly impacts on both the physical and mental health status of the caregiver. Depression is an important predictor of health risks, but new evidence suggests additional factors such as social supports through service agencies may alleviate some of the stress involved with caring. However, there is very little research on the role of social supports and their effects on carers health. The research available examines caregiving in general or looks to specific disorder groups to understand the effect on carers health. Caring takes many forms: caring for a child, parent, sibling, grandparent or spouse. Studies recognise that caring for a child places additional stress on the family. Additionally caring for a parent is recognised as placing additional stress on the family network. Little research has investigated the health of the carer in the spousal partnership, and how this role may place additional stress on an aging couple or a young family (eg, in the case of an acquired brain injury). Therefore it is necessary to examine spousal caregivers' psychological health coping in addition to overall well-being to best measure their quality of life.

The aim of this study was to investigate the psychological health of carers and establish any gender or regional differences using a Tasmanian population. It was predicted that females would have higher depression, anxiety and stress scores than males and that personal coping strategies would be better predictors of psychological well-being and life satisfaction than formal supports. A total of 80 participants (40 females and 40 males) with a mean age of 60.83 were recruited for interview from metropolitan, urban and rural regions of Tasmania, via third party organisations.

RESEARCH METHOD

Participants

Inclusion in the study was based on marital status (spouse or defacto) and co-residence. The mean number of years caring for a spouse/partner was 9.88 years ($SD = 8.08$). The disabling conditions of the care recipient were categorised as physical disability (50), mental disability (12), or dual condition including a physical and mental disability (18). A physical disability included such conditions as arthritis, cancer or stroke that affects only motor control. A mental health disability included schizophrenia, PTSD or anxiety disorder. A dual condition included for example, stroke with physical and neurological impairment, or end-stage Alzheimer's Disease where the spouse's physical and psychological functioning is grossly impaired.



Measures

At the interview measures of psychological health and both formal and informal resources were used to assess the impact of caring. Measures used included the following:

The Comprehensive Quality of Life Scale – Adult (ComQol-AS – Cummins, 1991) was administered to measure subjective and objective quality of life, assessing life areas such as Material Well Being, Health, Productivity, Intimacy, Safety, Place in Community and Emotional Well Being.

The Depression Anxiety Stress Scale 42 (DASS – Lovibond & Lovibond, 1995) is a 42 item self-report inventory examining levels of: Depression, Anxiety and Stress.

The General Health Questionnaire (GHQ-60 – Goldberg & Williams, 1969) is a 60-item self-report psychiatric screening instrument to assess aspects of adjustment and felt distress.

The Coping Resources Inventory (CPI – Hammer & Marting, 1987) is a 60-item instrument measuring the personal resources for coping with stress.

Survey questions were incorporated into a demographic information sheet asking such things as gender, age marital status and length of marriage, co-residence with care recipient, length of caring, diagnosis of care recipient, any medical conditions of the carer affecting their ability to care, the type and number of hours per week of formal and informal support they received.

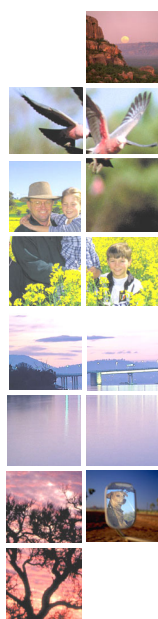
Procedure

Potential participants contacted the researcher and a brief telephone interview established whether the criteria for inclusion were met. Contact details and interview times were established and any general questions regarding the nature of the interview were answered. Interviews took place either in the home of the carer or at a public place of their choosing, such as a community health centre. Confidentiality was assured and participants were also informed that they could ask for an explanation of the interview questions at any time. At the conclusion of the interview participants were debriefed and asked if there were any additional questions or concerns regarding the interview procedure.

Design and analysis

A between-groups design was followed, with between-groups 2 Sex (male/female) and 3 Region (metropolitan/urban/rural) used to explore group differences on four health-related measures (GHQ, DASS, ComQol Importance and Satisfaction) and one measure of coping resources (CRI). Multi-variate analysis of variance (MANOVA) were performed on questionnaire sub-scales and follow-up ANOVAs were conducted to detect where between-groups differences existed.

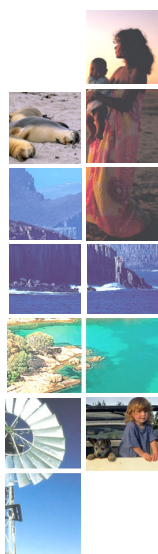
Simple correlations were calculated to identify the strongest predictors of spousal carers* psychological health and quality of life from a large range of potential variables. Separate multiple regression analyses were then performed for outcome



measures including total scores on the General Health Questionnaire and ComQol Total Satisfaction scores for both regional and gender groups.

RESULTS OF STATISTICAL ANALYSES

The results overall supported the expected trends. Significant main effects were found for sex on all questionnaires but effects involving region were not significant. In other words, differences existed between male and female carers, but there were no differences based on whether the participants came from a rural or urban environment. Female carers showed more evidence of psychological distress than did male carers, with higher scores on measures of depression, stress and anxiety. Females also reported less satisfaction with their health than did male carers. Personal coping resources were a significant predictor of psychological health for female caregivers and rural participants. Coping and age appeared to be the best predictors of life satisfaction for both sexes and urban Tasmanians, but not for rural Tasmanians. Personal coping strategies/resources were also the best predictor of both psychological health and life satisfaction, suggesting that coping with caregiver stress was more indicative of intrinsic factors within the individual rather than extrinsic factors such as formal supports.



DISCUSSION OF FINDINGS

Group differences in psychological health

The present study set out first to investigate gender and regional differences in the psychological health and quality of life of spousal caregivers. No significant regional differences were found, but predicted sex differences were found for the present sample. As hypothesised, female caregivers demonstrated higher levels of psychological distress, specifically depression, as well as greater levels of anxiety and stress. These findings are consistent with earlier research, where caregiver wives reported more emotional strain in relation to caregiving, than did caregiver husbands

Subsequent analyses revealed a significant sex difference in the care recipient's type of disability, indicating that female carers were significantly more likely than were male carers in the present sample to be caring for a partner with a mental health condition or dual physical and mental diagnosis. In contrast, males were more likely than females to be caring for a spouse or partner with a physical condition.

These data indicate that female carers in the present sample may indeed be experiencing a greater carer burden than male carers. The disability or condition of the care recipient may reflect the felt distress reported amongst females. The higher number of caregiver wives reporting caring for a partner with a dual diagnosis suggests that they may be experiencing greater losses of emotional supports due to increased caregiver demands and therefore express greater emotional strain.

Explanations for the gender differences in care-recipient condition can be viewed in many ways. Gender role theory has been used to explain the cultural and social expectations placed on husband and wife caregivers. Differences in social or community expectations of the marital relationship may be operating. In other words



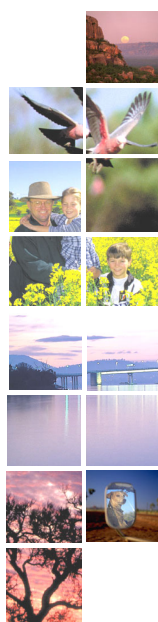
caring for each other “til death to us part” regardless of the practicalities involved might be taken on more readily by females than by male carers who might seek physical respite such as nursing homes to a greater extent than do female carers. Biological differences in the physical capabilities of men and women may also explain the sex differences found in care recipient conditions, with men more able to care for a spouse with a physical condition, due to the need for such activities as lifting and transport.

Alternatively, differences in the strategies used by males and females in coping with stressful situations may explain the sex differences finding. Research suggests that men use practical problem-focused strategies (eg, seeking formal instructional support, seeking options for residential care when needed or scheduling guilt-free time for their own recreation), whilst women use emotion focused strategies such as talking things out or internalising personal blame for their partner’s condition, to reduce stress. Researchers have found that men tended to seek instrumental support (eg, help with housework) whereas women who felt they were expected to cope with both household duties and caring obligations tended to seek emotional rather than instrumental support. The present study suggests differences in the way husbands and wives responded to the stress of caregiving, with male carers using physical strategies such as exercising to reduce stress significantly more than female carers. Additionally, there was a trend for female carers to use emotion-focused coping strategies more than male carers did. Women in this study may have been using strategies that were less effective in reducing burden, while males were using practical and problem-focused strategies that are more effective in reducing stress.

Group differences in quality of life

On a measure of quality of life, female caregivers on average reported significantly lower levels of satisfaction with their physical health than did male caregivers. However, caregiver wives assigned greater importance than did caregiver husbands to family, friends and safety in their lives. A useful theoretical concept explaining this finding could be the notion of domain compensation (Best, Cummins and Lo, 2000). Female caregivers who were less satisfied with their health, may look to family and friends to feel safe and content as a compensation for low satisfaction with health. Male caregivers who were more satisfied with their health than were female caregivers, may not have felt a equivalent need to increase intimacy with family and friends.

Overall, despite some difficulties in finding equivocal means of measuring psychological health in the two gender groups, the sex differences findings in this study suggest that female carers are at a greater risk of negative psychological health effects and express lower satisfaction with their physical health. These effects are brought about by the emotional strain experienced in caring for a spouse/partner with a long-term disability or illness, which may in fact pose great actual burden than that experienced by male carers. These effects may also be linked with differential use of coping strategies and the different cultural and social expectations that accompany different gender roles.



Predictors of psychological health

The second aim of this study was to determine whether extrinsic (environmental) factors or variables intrinsic (personal) to the carer were better predictors of psychological health and life satisfaction. The results from the present study confirmed that personal coping strategies or resources were the strongest predictors of carers' psychological well-being and life satisfaction, despite division of the sample into different gender groups and regions. Moreover, coping strategies more strongly predicted life satisfaction than psychological well-being.

For regional divisions of the sample, coping resources were significantly predictive of carers' psychological well-being, but only for the rural carers. No significant predictors of carers' psychological well-being were identified for the urban group. The strong relationship for the rural group reflects the intrinsic or personal resources that necessitate coping without access to the external supports such as informal or formal assistance.

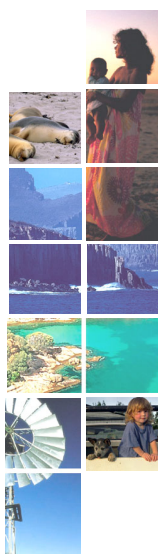
When the sample was divided according to gender, coping resources significantly predicted psychological well-being for female carers but not for male carers. There were no significant predictors among the selected predictors for male carers' psychological well-being. An important finding however, is that an intrinsic factor, personal coping resources was the single significant predictor of female carers' psychological well-being. There is a need for support services to directly address personal strategies that are used by female carers in particular, for coping with the very real stresses in caring for a partner or spouse.

Predictors of life satisfaction

The regression results again confirmed the general finding that personal coping resources was strongest predictor, this time for life satisfaction. Results for the two gender groups were highly similar in the case of life satisfaction. For males however, age was an additional predictor ie. Older males were more likely to express greater life satisfaction.

However, the urban-rural split of the sample again revealed contrasting findings. For urban carers coping resources and age were significant predictors of life satisfaction, ie. the older the carer, and the more personal resources available to them, the greater was their satisfaction with life. However for the rural group there were no significant predictors for life satisfaction amongst the potential predictors selected for this study. Rural carers may simply reflect a shift of subjective perceptions of the caring situation, due in part to the isolated nature of their situation. Therefore variables other than those selected in this study might be more relevant to the prediction of life satisfaction in this group.

Rural Tasmanians not only suffer isolation from medical supports but additionally from family and friends. When a partner is ill and the carer cannot leave the home to shop or visit friends due to lack of available respite or transport, their satisfaction with life will decline. Consequently, they may need to "tap into" whatever resources are available to them. This may explain why the present study did not find a consistent predictor for life satisfaction in the rural group.



ACKNOWLEDGMENTS

We would like to acknowledge the following people and associations for their contributions to this research.

We would like to thank the Carers' Association of Tasmania Inc for whom this research would not have come about without their support and assistance with participant recruitment and media advertisement. We would also like to thank the following state-wide services, organisations and people who provided a great deal of support and assistance with the promotion of this study: Centrelink, Carer Respite Centre, Alzheimer's Association, The Division of General Practitioners, Community Health Nurses, and the many Carer Support Groups whom allowed us to participate in their discussions and promote the study.

PRESENTER

Anne Rutherford-Kitson completed a Bachelor of Arts degree in 1999, and honours in 2001 with the School of Psychology at University of Tasmania. As part of her Honours degree Anne's research project dealt with the subject of spousal carers in Tasmania. The idea for this topic was brought about by research a colleague, Seda Ucereli had previously conducted in 2000 on the health and well-being of carers in rural and remote Tasmania. The study was a questionnaire-style survey assessing carers health within the community. It was found that carers rated their health as worse since their caring role began. The demographics revealed that the majority of carers were couples (in a married relationship) and were suffering poorer health effects such as fatigue and depression.

It was with this knowledge that Anne began the task of assessing this particular target group. International and Australian research indicated that this group had a high risk of negative health outcomes. However, there did not appear to be any Tasmanian research on this group or their health effects. Anne's research attempted to investigate the physical and psychological health effects of spousal carers in the Tasmanian community. As a result of her research Anne now works for the Carers Association of Tasmania Inc and Commonwealth Carer Resource Centre, a state-wide organisation that offers education, training and support for carers in the community who care for a family member or friend who has a disability, chronic illness, mental health illness or who is frail or aged.

