Positive Aspects in Caregiving: An Overlooked Variable in Research*

C.A. Cohen, Sunnybrook Health Science Centre, D. Pushkar Gold, Concordia University, K.I. Shulman and C.A. Zuccher, Sunnybrook Health Science Centre

RÉSUMÉ
Cet article passe en revue les divers concepts et les diverses mesures reliées aux aspects positifs de la prise en charge qui ont fait l’objet d’études antérieures. Il décrit également une mesure simple des «aspects plaisants de la prise en charge» utilisée par un projet longitudinal canadien sur le soin accordé aux patients atteints de démence et résidant dans la communauté. Le taux de fidélité test-retest de cette mesure est significatif, de même que les corrélations avec le fardeau de la prise en charge et la santé du donneur de soins. Cette variable prédit également le désir d’institutionnaliser le bénéficiaire, et ce à trois étapes différentes de la prise en charge, mais ne prédit pas l’institutionnalisation comme telle. Cet article conclut qu’il devrait y avoir davantages de mesures reliées aux aspects positifs de la prise en charge et une meilleure compréhension des interactions entre ces variables et leurs répercussions sur les facteurs principaux liés au patient et au donneur de soins.

ABSTRACT
This paper reviews the different concepts and measures of positive aspects of caregiving that have been used in previous studies. It describes the use of a simple measure of "enjoyable aspects of caregiving" used in a large longitudinal Canadian study of dementia care in the community. The measure attained significant test-retest reliability and significantly correlated with caregiver burden and health. It also predicted caregiver desire to institutionalize the care recipient at three different time periods but not actual institutionalization. The paper calls for greater use of measures related to positive aspects of caregiving and a better understanding of how these measures relate to one another and to outcomes.

* This research was funded by the Ontario Ministry of Health Policy and Research Division, the National Health and Research Development Programme and the Alzheimer Society of Canada.

Key Words: Caregiving, Dementia, Enjoyment.
Mots clés: Aide, démence, plaisir.
Manuscript received September 11, 1992; manuscrit reçu le 11 septembre 1992.
Manuscript accepted February 8, 1994; manuscrit accepté le 8 février 1994.
Requests for reprints should be sent to:/Les demandes de reproduction doivent être adressées à:
Dr. C.A. Cohen
Department of Psychiatry, F307A
Sunnybrook Health Science Centre
2075 Bayview Avenue
Toronto, ON M4N 3M5
Introduction

In recent years a great deal of research has examined the burden experienced by caregivers of dementia patients. Most of this research has been conducted within the theoretical framework provided by stress research. For example, Lazarus and Folkman's (1984) emphasis on the individual's cognitive appraisal of both situational and personal factors as determinants of the level of stress experienced has been influential in developing theories of caregiving burden.

Many global scales have been devised to measure burden (e.g., Zarit, Orr, & Zarit, 1985) and its effects on the caregiver's life. Other studies have conceptualized burden as a multidimensional concept and used a variety of separate measures to document the effects of caregiving on various aspects of the caregiver's life (Cantor, 1983; George & Gwyther, 1986; Haley, Levine, Brown, & Bartolucci, 1987; Lawton, Kleban, Moss, Rovine, & Glicksman, 1989; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991; Pearlin, Mullan, Semple & Skaff, 1990). Many factors have been found to influence the caregiving process including demographic characteristics of the caregiver and care receiver, care receiver impairment, availability and perceived adequacy of social support, and perception of the past relationship (Morris, Morris, & Britton, 1988). The caregiver's coping strategies (Morris et al., 1988; Pearlin et al., 1990), attitude toward caregiving (Cantor, 1983) and reasons for caregiving (Motenko, 1989) have also been found to be important mediating factors in determining the effects of caregiving on the caregiver.

However, individuals differ in their ability to cope with stressors and experience different reactions in chronic stress situations such as caregiving. Some individuals experience positive as well as negative reactions in caregiving situations, yet much less has been written about positive aspects of caregiving and how they influence outcome.

The relationship between positive and negative aspects of caregiving is necessarily a complex one. It is possible that some positive aspects of caregiving act as buffers to reduce the intensity of the burden experienced or mitigate the impact of caregiving stress on health. Alternatively, the positive experiences in caregiving might not be directly correlated with burden or declining health.

In this paper we review the literature related to the positive aspects of caregiving and report on the inclusion of positive or enjoyable aspects of caregiving as a variable in a study which was designed to examine caregivers' decisions regarding institutionalization. The purpose of this aspect of the study was to develop a practical, valid and reliable measure of the positive or enjoyable aspects of the caregiving role. The relation of such a measure to caregivers' negative experiences was then examined. In addition, we aimed to determine the extent to which this measure predicted caregivers' decisions regarding institutionalization and actual institutionalization.
Literature Review

The aspects of caregiving that have been experienced as positive by caregivers have been conceptualized in a variety of ways in the literature. In many studies positive aspects are measured incidentally as part of the more global burden scales; in other studies positive aspects are explicitly defined and measured. This variability relates primarily to the different theoretical frameworks used in exploring the relationship between positive and negative aspects of caregiving.

Poulshock and Deimling (1984) used a multidimensional perspective in measuring burden and its impact on caregivers. They examined three conceptual categories: elder impairment, burden, and impact (negative changes in family relationships and restrictions in caregiver activities). The impact measure included an item explicitly asking if the caregiving relationship provided any pleasure for the caregiver. In addition, several variables in the elder impairment categories measured the sociability of the dependent (i.e. enjoyable to be with). Zarit's original burden scale also included several items asking about the positive aspects of the relationship with the care receiver (Zarit, Reever, & Bach-Peterson, 1980). Subsequent revisions of the burden interview, however, did not include such items (Zarit et al., 1985).

Haley et al. (1987) measured coping responses of caregivers and their strategies for managing stressful situations related to caregiving. Caregiver outcomes included a Life Satisfaction Index which assessed perceived life satisfaction and quality of life for the caregiver. Life satisfaction was best predicted by the availability of social support and satisfaction with social support.

A Caregiving Hassles and Uplifts Scale which included 110 caregiving events to be appraised by the caregiver as a hassle or uplift was developed by Kinney and Stephens (1989). Four categories of events were included: those related to Activities of Daily Living (ADL) tasks; care receiver cognition; care receiver behaviour; and the logistics of caregiving. The most frequently reported uplifts were those related to the behaviour of the care receiver and support from the social network. Significant predictors of uplifts included care receiver behaviour and cognition, time spent on caregiving, caregiver age and sex. Interestingly, ADL and behaviour uplifts were positively correlated with increased depression in caregivers. In general, caregivers who were most intensely involved in caregiving were more likely to appraise caregiving events as satisfying.

A theoretical model which included a measure of uplifts which documented positive components of caregiving was developed by Pruchno, Michaels, and Potashnik (1990). The uplifts were primarily positive responses from the care receiver toward the caregiver, such as being appreciative or grateful for the caregiver's help, or being cheerful. Uplifts were negatively correlated with desire to institutionalize and actual institutionalization of a spouse with dementia.

The relationship between coping, caregiving stress and positive outcomes
of caregiving was examined by Pearlin et al. (1990), working within a theoretical stress orientation. Included as "intrapsychic strains" were two variables designed to assess caregiving competence and personal gain. These were viewed as potentially positive outcomes of the caregiving experience that could be eroded by the primary stressors of caregiving, such as problem behaviour by the care receiver and situational factors such as job-caregiving conflicts. The feeling of being a good caregiver, of having grown as a person, having learned to do things not done before, and having a sense of control were considered potential positive aspects of caregiving.

A sophisticated model of caregiver well-being was proposed by Lawton et al. (1989), based upon the stress research approach of Lazarus and Folkman (1984). In this model caregiver cognitive appraisal acted as a mediator between the stress of caregiving and the psychological well-being of the caregiver as outcome. Appraisal included caregiving satisfaction, perceived caregiving impact (objective burden), caregiving mastery, caregiving ideology (reasons for caregiving) and subjective caregiving burden. Only subjective burden, caregiving satisfaction and perceived caregiving impact were confirmed empirically as dimensions of caregiving appraisal. Caregiving satisfaction seemed to be separate from the other two factors, but not all nine items in the scale were found to be psychometrically sound. The most sensitive items appeared to be caregiver enjoyment from being with the care receiver, seeing the care receiver happy and feeling closer to him or her because of the caregiving role.

A subsequent paper (Lawton et al., 1991) examined the different pathways through which caregiver appraisal might affect psychological well-being (measured by both positive affect and depression). Spouse caregivers and adult children were examined separately. Caregiver health and social resources did not correlate with caregiving satisfaction. For spouse caregivers, satisfaction did not increase with more caregiving efforts, and satisfaction was not decreased by greater impairment of the care receiver. Caregiver satisfaction was highly positively associated with psychological well-being and negatively associated with caregiver burden. For adult child caregivers, giving more care was associated with both greater satisfaction and greater burden. Contrary to expectation, caregiver satisfaction was not associated with psychological well-being. The authors speculated that the centrality of the spousal role strengthens the association between caregiving satisfaction and well-being.

Social exchange theory has also provided a theoretical framework for caregiving research. Walker and Allen (1991) examined positive aspects of caregiving for physically frail (but not dementing) older women. This study used social exchange theory to study caregiving relationships between mothers and daughters, examining rewards and costs of the relationship to both parties. The dyads were classified in terms of the costs and rewards, areas of conflict and evidence of concern for the other's outcomes. In strong and close relationships described as "intrinsic pairs" (45%) there were many rewards and few costs. The authors encouraged other investigators to ex-
amine positive outcomes in caregiving research.

Caregiver gratification was empirically studied by Motenko (1989). Motenko interviewed 50 wife caregivers of dementia patients at home. Gratification was measured using simple questions asking about the pleasure derived form caregiving, enjoyable aspects of their marriage and enjoyable aspects of having their husband at home. Gratification was correlated with caregiver general well-being, perception of little change in a good marital relationship, and reasons for caring such as love and reciprocity. Gratification did not correlate with care receiver characteristics or length of caregiving.

A review of the literature reveals that positive aspects of caregiving and related concepts have been included in many studies but the definition of the concept and its measurement vary. Four positive aspects seem to have been evaluated in previous studies: caregiver sense of mastery; caregiver enjoyment derived from the present relationship; gratification from caregiving in seeing a desirable outcome such as the care receiver staying at home or appearing happy; and satisfaction derived from the acts of caregiving. Caregiver ideology (reasons for caregiving) may represent yet another aspect but appears to be more difficult to define as a unique and positive aspect of caregiving.

Factors which were found to correlate with positive aspects of caregiving included caregiver demographics, the nature of the previous relationship between the caregiver and care receiver, time spent on caregiving efforts, care receiver variables and perceived adequacy of social support. An inconsistent relationship between positive aspects and caregiver well-being or burden has been reported. Lawton et al. (1989) found that caregiver satisfaction was not strongly related to a summary measure of burden, while Motenko (1989) found that gratification was correlated with caregiver general well-being. Kinney and Stephens (1989) found that ADL and behaviour uplifts correlated with increased depression. Finally, Pruchno et al. (1990) found that uplifts were negatively correlated with desire to institutionalize and actual institutionalization.

Methodology

The study was originally designed to examine the factors which determine caregiver decision regarding continued maintenance of home care or institutionalization of a dependent with dementia (care receiver). A wide range of caregiver and care receiver variables were examined. In this paper we will only report on variables that have been found in past research to be related to positive aspects in caregiving. These include negative aspects of caregiving (such as burden and health complaints), social variables (such as satisfaction with social support and number of community services used), and situational variables (such as gender and duration of caregiving).

One hundred and ninety-six caregiver dyads were recruited from a wide range of medical and community social agencies. They were assessed every
six months until the care receiver died or was institutionalized, with \( n = 118, 73 \) and \( 37 \) at \( 6, 12 \) and \( 18 \) months respectively. Care receivers had a DSM III diagnosis of dementia for at least one year, resided in the community with no major physical illnesses and had a primary caregiver available to take responsibility for their care. The sample consisted of a wide range of care receivers with dementia and their primary caregivers. Fifty-seven per cent of the caregivers were spouses, 26 per cent were children and 17 per cent were other relatives. The mean age of the caregivers was \( 64.08 \) years and \( 76 \) per cent were women. The mean duration of caregiving at initial assessment was \( 3.28 \) years.

The average age of the care receivers was \( 77.46 \) years and they had a mean Mini-Mental State Exam (Folstein, Folstein, & McHugh, 1975) score of \( 15.11 \). A total of 70 per cent had received a diagnosis of senile dementia of the Alzheimer type, 15 per cent had a diagnosis of multi-infarct dementia, while the others had received a diagnosis of dementia of other etiology or unknown etiology. At the initial assessment, 150 of the 196 caregivers indicated that they were planning to continue maintaining the dependent at home and 46 had decided on institutionalization. At 18 months 37 were still maintaining their dependents at home and 92 had placed their dependents in an institution. The remaining caregivers had been lost to follow-up, but Discriminant Function Analysis showed no difference between dropouts and others on initial measures.

Care receivers were interviewed by a research psychiatrist (C.C.) in their own home. Data collected for each care receiver included age and education and a score on the Mini-Mental State Exam (MMSE) as an indicator of cognitive functioning.

A number of measures were selected to assess the salient caregiver variables, based largely upon the recommendations of Zarit et al. (1985). The caregivers were given a standardized interview approximately two hours long, conducted by a research assistant in the home. Caregiver age, education and duration of caregiving were recorded. Measures used in the study included the General Health Questionnaire (Goldberg, 1978) which assessed physical and psychological health complaints. The Memory and Behaviour Problem Checklist (Zarit, et al., 1985) was used to evaluate caregiver perceptions of patient memory and behaviour problems and the caregiver’s negative emotional reactions to them. The Burden Interview (Zarit, et al., 1985) was used to assess the extent of burden experienced by the caregiver.

The Past Social Interaction Scale (Gilleard, Belford, Gilleard, Gledhill, & Whittick, 1984) was used to evaluate the quality of the prior relationship between caregiver and care receiver. The Social Support Questionnaire (Sarason, Levine, Barham, & Sarason, 1983) measured social support received by the caregiver, indicating the number of supporters and the degree of satisfaction with support received. Caregivers were also asked to indicate how frequently they used social and medical services from a comprehensive list. Finally, they were asked if they had decided to maintain the care receiver in the community or to institutionalize them.
Caregivers were then asked to list what they saw as enjoyable aspects of being a caregiver and their responses were recorded verbatim. Caregivers could give more than one response. After the completion of the interviews, six distinct qualitative categories were derived: none or no enjoyment; having the company of the care receiver; keeping the care receiver at home and preventing institutionalization; feeling a sense of duty; love; and "other". These categories were then used in data analysis treating responses as a continuous variable from "no enjoyment" to multiple categories of enjoyment. This approach was used since it allowed for more sensitive methods of data analysis by including greater variability in responses.

The same categories of enjoyable aspects of caregiving were used in a similar study undertaken on a similar sample in Montreal, Canada (Reis, Gold, Andres, Markiewicz, & Gauthier, in press). In the Montreal study a sub-sample of 60 cases was coded by a second independent rater and 91 per cent agreement on categorization was achieved. The correlation coefficient between the two raters for the total number of different aspects was \( r = .76, p < .01 \). The number of categories was not correlated with education and socio-economic status as measured by the Blishen Scale, (Blishen & McRoberts, 1976), suggesting that processes associated with education, such as verbal fluency, did not influence the results.

Results

Categories of positive aspects cited were as follows: having the company of the care receiver was given by 19 responses (15%); keeping the care receiver at home by 18 responses (15%); feeling a sense of duty by 10 responses (8%); love by 11 responses (9%); and "other" by 65 responses (52%). At the initial interview, 89 (45%) of caregivers did not list any enjoyable aspects of caregiving. Ninety-two caregivers (47%) listed one enjoyable aspect, 14 caregivers (7%) listed 2 enjoyable aspects, and 1 caregiver listed 3 aspects. These percentages remained generally the same for the four separate assessments.

The nature of the responses classified into the "other" category was widely heterogeneous. Responses included such reasons as feeling satisfied about doing the best one could in providing home care, seeing the care recipient happy, difficulties caused by the placing of the care recipient in an institution, maintaining the gift of life in the family, and feeling good about oneself.

Reliability

The test-retest reliability of the measure was examined. At the six-month follow-up, responses to the question regarding enjoyable aspects were obtained from 119 caregivers, with number of responses correlating at \( r = .28, p < .05 \) with initial responses. At the 12-month follow-up, responses were obtained from 73 caregivers with number of responses correlating at \( r = .43, p < .05 \); and at 18 months responses were obtained from 37 caregivers with number of responses correlating at \( r = .39, p < .05 \).
Table 1
Correlation coefficients for total number of positive caregiving aspects with study variables at four assessments

<table>
<thead>
<tr>
<th>Variables</th>
<th>Initial (n = 196)</th>
<th>6-Month (n = 118)</th>
<th>12-Month (n = 73)</th>
<th>18-Month (n = 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Aspects of Caregiving:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burden(^A)</td>
<td>-.32***</td>
<td>-.31**</td>
<td>-.17</td>
<td>-.36*</td>
</tr>
<tr>
<td>Health</td>
<td>.29***</td>
<td>.33***</td>
<td>.14</td>
<td>.38*</td>
</tr>
<tr>
<td>Caregiver appraisal of patient problems(^A)</td>
<td>-.10</td>
<td>-.28**</td>
<td>-.13</td>
<td>-.20</td>
</tr>
<tr>
<td>Caregiver negative reaction to problems(^A)</td>
<td>-.24***</td>
<td>-.28**</td>
<td>-.30*</td>
<td>-.39*</td>
</tr>
<tr>
<td><strong>Social Variables:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past quality of relationship</td>
<td>.22**</td>
<td>.17*</td>
<td>.37***</td>
<td>.36*</td>
</tr>
<tr>
<td>Social support network</td>
<td>.11</td>
<td>.16</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Satisfaction with support</td>
<td>.25**</td>
<td>.24**</td>
<td>.06</td>
<td>.09</td>
</tr>
<tr>
<td>Services used</td>
<td>.01</td>
<td>-.15</td>
<td>.13</td>
<td>.20</td>
</tr>
<tr>
<td><strong>Situational Variables:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiving duration</td>
<td>-.06</td>
<td>.15</td>
<td>-.08</td>
<td>-.07</td>
</tr>
<tr>
<td>Caregiver age</td>
<td>-.04</td>
<td>-.07</td>
<td>.04</td>
<td>-.23</td>
</tr>
<tr>
<td>Recipient age</td>
<td>.13</td>
<td>.10</td>
<td>.13</td>
<td>.28</td>
</tr>
<tr>
<td>Caregiver gender(^B)</td>
<td>.03</td>
<td>.06</td>
<td>-.13</td>
<td>.04</td>
</tr>
<tr>
<td>Recipient gender</td>
<td>.01</td>
<td>.08</td>
<td>.28*</td>
<td>.65***</td>
</tr>
</tbody>
</table>
Table 1 contd.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Initial $(n = 196)$</th>
<th>6-Month $(n = 118)$</th>
<th>12-Month $(n = 73)$</th>
<th>18-Month $(n = 37)$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situational Variables contd.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver income</td>
<td>-.02</td>
<td>-.03</td>
<td>.34**</td>
<td>.40*</td>
</tr>
<tr>
<td>Caregiver education</td>
<td>.04</td>
<td>.07</td>
<td>.19</td>
<td>.32</td>
</tr>
<tr>
<td>Recipient education</td>
<td>-.01</td>
<td>.07</td>
<td>.04</td>
<td>.18</td>
</tr>
<tr>
<td>MMSE scores</td>
<td>-.05</td>
<td>-.01</td>
<td>.01</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Higher scores indicate more negative appraisal or functioning.

*Gender is coded: Males = 1; Females = 2.

* $p < .05$; ** $p < .01$; *** $p < .001$. 
Validity
Some data relevant to the construct validity of the measure were also examined for the four assessment periods. Number of responses was examined in relation to negative aspects of caregiving, social aspects, and situational variables. The negative aspects of caregiving included caregiver burden, caregiver health complaints, appraisal of extent of patient cognitive and behavioural problems and caregiver negative emotional reactions to such problems. The social variables included perceived quality of past relationship between caregiver and recipient, number of family and friends providing support to the caregiver, caregiver satisfaction with social support network and total number of community-based services used. The situational variables of the caregiving situation included duration of caregiving, caregiver age, gender, education and income, care recipient gender, education and age, and MMSE scores.

As can be seen in Table 1, number of positive aspects correlated with lower burden scores, better health, and fewer negative reactions to care receiver problems. Caregiver appraisal of lower patient symptomatology correlated significantly with number of positive aspects only at six months. A more favourable appraisal of the quality of the premorbid relationship between the caregiver and care receiver was positively correlated with number of positive aspects. Satisfaction with social support was also correlated with number of positive aspects at initial and six-month assessments. Situational variables did not correlate with number of positive aspects except that at the last two assessments, caregivers with higher incomes and those caring for female recipients reported more positive aspects of caregiving.

One more set of analyses were performed to examine the usefulness of the measure. Discriminant Function Analyses (DFA) were performed on data collected at the first three assessments to determine the role played by number of positive aspects in influencing the decision to continue or end home care. The same 17 negative aspects of caregiving, social support and situational variables described above and positive aspects were entered as predictors. In all three DFAs, a significant function was derived, predicting which caregivers had decided to continue or discontinue home care, \( \chi^2 (18) = 55.40, p < .0001, \chi^2 (18) = 50.24, p < .0001, \) and \( \chi^2 (18) = 36.95, p < .0001 \) at initial, 6-month and 12-month assessments respectively. Number of positive aspects entered significantly into the discriminating function at each assessment \( F = 16.57, p < .0001, F = 22.56, p < .0001, \) and \( F = 4.74, p < .003 \) respectively. The sample size at the fourth assessment was too small to conduct a similar analysis.

DFAs which assessed the efficacy of initial variables to predict actual care receiver status (maintained at home versus institutionalized) at the second, third and fourth assessments produced significant discriminating functions. However, the number of positive aspects of caregiving reported by the caregiver did not enter significantly into these functions. Negative factors such as caregiver burden, health complaints, appraisal of patient problems, negative reactions to such problems and demographic variables entered into
the significant function which predicted actual institutionalization.

Discussion

The results of this study indicate that even a simple measure of positive aspects in caregiving can achieve significant test-retest reliability, correlate in meaningful ways with other salient caregiving variables and be useful in predicting the decision regarding home care. However, the measure of positive aspects correlated at a low level across time and was clearly less stable than measures of burden or impaired health of caregivers (Gold, Cohen, Shulman, Andres, Etezadi, & Zuchero, under review). In part, such lack of consistency across time could reflect the need for further development of the measure, particularly in the development of more refined and complex categories of response. Such refinement would facilitate comparison across studies which is difficult at present because of the variability in defining and measuring this concept.

The enjoyable aspects listed by caregivers in this study included those related to the relationship itself and the desire to see positive outcomes for the care receiver. Two aspects which were more closely related to caregiver ideology or reasons for caregiving were sense of duty and love, which overlap with those identified in the other studies reviewed. Caregiver sense of mastery and satisfaction with caregiving activities were not identified as frequently in this study as in others. However, some responses of this type were included in the "other" category. In this study the "other" category consisted of a wide variety of responses which would benefit from further clarification.

The number of enjoyable aspects of caregiving correlated with two important caregiver variables, namely burden and health, albeit at a low level. Similar to other findings, positive aspects in caregiving in this study correlated with perceived adequacy of social support, quality of past relationship and negative caregiver reactions to care receiver behavioural problems. These findings support the idea that positive aspects mitigate the negative effects of burden and stress in caregiving.

Situational variables were not significantly related to positive aspects until the last two assessments, when caregiver socio-economic factors and care recipient gender emerged as significant correlates. This may be partially explained by the fact that the situation of providing home care for a dementing individual is itself unstable and consequently, different situational aspects may become more or less stable with time.

The finding that female care receivers engender more positive aspects of caregiving should be replicated and explored. Perhaps females become more amenable to caregiver directions or are physically easier to manage as they become more impaired. Similarly, the role of higher levels of income, and possibly education, in leading to more positive experiences in caregiving should be specified. Although service use did not correlate with positive aspects, it is possible that additional financial resources provided other
benefits, such as more time away that might have eased the caregiving situation.

In this study, positive aspects also significantly predicted desire to institutionalize the care receiver, but not actual institutionalization. In part, this finding replicates the work of Pruchno et al. (1990). Actual end of home care has frequently been found to be precipitated by changes in care receiver functioning and changes in caregiver functioning or family situation, (Gold, Reis, Markiewicz, & Andres, under review). Thus, experiencing few if any positive aspects in caregiving might signal reduced commitment to home care, but it appears that the actual move to institutional care is determined largely by negative and situational factors.

There clearly are limitations in the use of enjoyment as a variable in our study. The question regarding enjoyment was asked very soon after caregivers were queried about their level of agreement with various "reasons" for caregiving, such as duty, religious or moral beliefs or family insistence. Placing the questions in this order may have prompted caregivers to list "reasons" for caregiving when asked to provide examples of aspects of the situation which they enjoy.

From this study and others, it is clear that we have more to learn about positive aspects of caregiving. Indeed, only 55 per cent of caregivers in this study spontaneously cited any positive aspects. Examining additional variables such as intrapsychic factors and personality traits may provide some insight into these differences amongst caregivers.

The act of caregiving has a specific meaning for each caregiver and various aspects of the task may meet different psychological needs. O'Connor (1993) has discussed similar concepts using a "self" psychology perspective, hypothesizing that if caregiving meets the psychological needs of the caregiver it may be perceived as less burdensome. Similarly, some caregivers may be more likely to experience positive affective states due to their personality traits, such as extraversion (Costa & McCrae, 1984), or their ability to view situations as challenging rather than stressful (Kobassa, 1979).

Future studies should address a number of issues. How can we define and measure positive aspects of the caregiving process more consistently across studies? How do different positive aspects correlate with one another? How do positive outcomes relate to different personality traits of the caregivers? Ultimately, a better understanding of these questions may offer valuable insights into the caregiving process and outcomes such as psychological well-being, service use and rate of institutionalization.

References


