ROLE ADAPTATION IN THE EMPLOYED ADULT FEMALE CAREGIVER FOLLOWING TRANSITIONAL NURSING SUPPORT

A DISSERTATION

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To the Provost of the Graduate School:

I am submitting herewith a dissertation written by Mary Margaret Hortenstine Brackley entitled "Role Adaptation in Employed Female Caregivers Following Transitional Nursing Support." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in nursing.

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We have read this dissertation
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Dedication

I dedicate this volume to my mother, Dorothy, and my daughter, Leila. Together they have taught me to adapt to and love my role of "woman in the middle."

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I wish to express my thanks to my advisors and teachers during the process of conducting my dissertation research. I acknowledge the following:

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Role Adaptation in Employed Adult Female Caregivers Following Transitional Nursing Support

ABSTRACT

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This study addressed the question: Will transition support for midlife women during role transition to caregiver or care manager for their elderly parents lead to role adaptation and decrease role insufficiency? A systematic sample of 30 women between the ages of 30 and 60 was drawn from a pool of employees of a large health science center in the Southwest; their mothers were also asked to volunteer as research subjects. A before-after two group with random assignment design was used to determine the effects of a nurse-led support group on role adaptation of midlife women during role transition. Role adaptation was measured by correlating the scores of mother and daughter pairs on the Brackley Concerns of Aging Scale. The level of role insufficiency was determined by a score on Zung's Self-rating Depression Scale. The independent variables were social support and the nurse-led group. A two-way analysis of covariance

was calculated to test each hypothesis. Hypothesis 1 which predicted a decrease in role insufficiency following transitional nursing support was rejected. Support was found for Hypothesis 2 which specified an increase in role adaptation following transitional nursing support. Alpha was set at $p \leq .05$.

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INTRODUCTION

The family traditionally provides for the care and support of its members. Care of the elderly in this country is no exception (Shanas,1979). According to Butler and Lewis (1982), only 5% of the elderly are confined to institutions; the majority of elderly persons continue to live in the community. Within the age group of 65 years and above, 80% have chronic health problems that require attention (Skipwith,1984). Of those elderly that require outside help with daily survival, most depend on their families for support (Shanas,1979). Spouses and children of those in need usually provide aid as a form of filial responsibility.

Over 80% of all home health care to the elderly, including personal care and medically related services, is provided by family members (USDHEW, 1972). While care of the elderly affects all members of the family, one member is usually identified as the caregiver (Archbold, 1982). If the spouse is alive and well, the caregiving task will become part of that responsibility. When a spouse is unavailable, the adult child, typically a

daughter or daughter-in-law, will assume the role of caregiver or care manager (Archbold, 1982; Brody & Lang, 1982). Caregiving has been identified as a woman's role, and because women generally outlive men, most of the elderly who require help from their children are also female (Brody & Lang, 1982).

In general the dyadic care relationship has been found to satisfy both the caregiver and the care recipient; however when complaints have been voiced, they appear to follow similar patterns. Common areas of complaint have centered around dependency-independency conflicts (Noelker & Poulshock, 1982). The elder care recipients have complained that their caregivers do not listen to them and that they do too much for them.

Caregivers attempt to cope with the caregiving responsibility in different ways. Some have a tendency to isolate the elder to improve efficiency in caregiving (Tonti,1984) while others encourage dependency in the elder. Whereas physical abuse of the elderly in this dependent care situation has not been widely substantiated, some types of neglect have been observed (Rounds, 1984). Lau and Kosberg (1979) found that the neglected elderly were likely to be frail aged females who suffered from chronic illnesses and were cared for by

their sons or daughters. They tended to be physically isolated from others and totally dependent upon the caregiver.

While there is little empirical evidence documenting the effects of caregiving on the elderly parent's welfare, the caregiver role has been identified as highly stressful. Caregivers have been found to sacrifice their leisure time and relaxation (Brody & Lang, 1982), to suffer from symptoms related to guilt, anger, and depression, and to be isolated from their social support systems (Poulshock & Deiming, 1984; Brody & Lang, 1982). Also the caregiving role of midlife women has expanded as changes in family demographics in the last decade have produced greater numbers of young and old dependents (Aizenberg & Harris, 1982). Brody (1981) labeled the middle-aged daughter with multiple responsibilities for the care of dependent children and parents as the "woman in the middle" (p.471).

Clark and Rakowski (1983) summarized published gerontological literature on caregiving tasks, education, and support programs for family caregivers. The authors stated that evaluation data on these programs were flawed in that short-term benefits in the affective domains of caregiving were reported. Published reports on groups

aimed at education and support for caregiving families have lacked controls and relied on post-only questionnaires, anecdotal data, and case studies for evaluation.

Successful professional interventions for elderly clients have included their families as primary caregivers (Cohen, 1983; Clark & Rakowski, 1983; Archbold, 1982). The stressful effects of caregiving on the family can determine the outcome of care (Johnson, 1983). In response to these findings, the professional nurse must learn to diagnose human responses of the caregiving dyad and to prescribe treatments aimed at the elimination of actual or potential health problems related to this situation. Nurses must develop and test care strategies to support families who assume responsibility for the care of the elderly.

Problem of Study

The problem of this study addressed the following question: Will support for midlife women during role transition to caregiver or care manager for their elderly parents lead to role adaptation?

Justification of Problem

At the end of 1981 in the United States there were an estimated 25.6 million people, or 11% of the population, 65 years of age and older (Butler & Lewis, 1982). The cohort from 75 to 85 years is the fastest growing segment of the population. Eighty percent of the elderly have chronic health problems; within this group, the majority receive home care within a family setting. Even though the elderly consume 29% of the nation's expenditure for personal health needs (Pegels, 1981), only 1% of the budgets of the major insurers of the elderly, Medicare and Medicaid, is spent on home health services (Archbold, 1982). When asked their opinion, 85% of the elderly preferred home care (Pegels, 1981); and their families were willing to assume responsibility for the provision of that care (Cantor, 1983). In addition to the above trends, home health care is less expensive to deliver than institutional care. Therefore, health care professionals are obligated to respond to the needs of families with elderly members by developing methods of care that facilitate caregiving and by testing the effectiveness of these interventions (Clark & Rakowski, 1983).

One strategy that has been used to help caregiving

families has been the use of educational programs and support groups. Even though support groups and educational programs have been offered to families by various types of practitioners, these groups have been implemented without empirical evidence to support their use (Clark & Rakowski, 1983, Cohen, 1983). Steuer (1984) posited that while there is little empirical data on the beneficial effects of educational and support groups for caregivers, no data are available on the harmful effects. Among the potential harmful effects of such groups are increased depression, anxiety, and feelings of hopelessness and anger which arise in the caregiver as a result of increased awareness of the situation. Since denial has been identified as the defense mechanism most often used by caregivers in an attempt to adapt to their situations (Steur, 1984), awareness could lead to discomfort.

Before educational and support groups for caregivers gain wide acceptance as a care strategy among professional practitioners, attention must be given to research that will demonstrate the effectiveness of these programs (Clark & Rakowski, 1983). Whereas Clark and Rakowski (1983) reported on eleven such attempts at research and demonstration on education and support

groups for family members, only three of the published reports cited included specific learning objectives, one included pre/post questionnaires, three reported post data only, and the remainder relied on leader observations, anecdotal data, and case studies. The National Support Center for Families of the Aging (FOTA) (1984) used a survey of the United States of America to identify sixty on-going attempts to offer group support and education to families of the elderly. Only one of these groups was involved in evaluation research on the effectiveness of this type of intervention (FOTA, 1984).

Despite the paucity of empirical evidence on the effects of support and education groups available to families of the aging, this intervention continues to surface in the literature (Clark & Rakowski, 1983). In addition to the need for research related to this care strategy, other pertinent topics must be explored to justify the proposed study. These topics are the contemporary issues affecting women over forty and current trends in health care policy.

As of July, 1977, 13.7 million women in the United States were 65 years of age and older, and an additional 22 million were 45-65 years (Block, Davidson, & Gramps, 1981). Together these groups comprised 16% of the United

State population. Among the 13.2 million elderly women in 1975, 91% were white, 7% were black, and 2% were of Hispanic origin. Less than 1% of elderly women in the U.S. were from other minorities (Block et al, 1981). Brody and colleagues (1983) remarked that the U.S. has reached the position with relation to longevity of having as a common occurrence women in their sixties and seventies caring for their ninety year old mothers. The "empty nest" has been filled with aging parents (Block et al, 1981). Little research has been reported that addressed how the caregiving responsibility affected the daughter or what stresses the elderly mother faced in the caregiving relationship (Block et al, 1981). No reports of strategies that focus on the prevention of strains in caregiving prior to their emergence were found in the literature.

In response to escalating costs in health care, public policy makers have moved in recent months to offer incentives to family members who care for their elders at homes. Offering financial incentives to family caregivers is an example of a one-dimensional approach to a multidimensional problem (Cantor, 1983). More evidence on the outcomes of specific interventions is needed before effective policies can be made. This study

investigated the effectiveness of transition support for the adult child during role transition in facilitating adaptation to the role of caregiver or care manager.

Conceptual Framework

The phenomenon investigated in this study was the role transition from adult child to caregiver for the elder parent. Symbolic interactionism and role transition served as the conceptual frameworks, or perspectives, from which the concept of transition support was derived. As the concept was developed actions of the professional nurse which best supported the health and well-being of both the caregiver and the care recipient during role transition became one of the major areas of interest.

The symbolic interactionists, according to Charon (1979), focus on the nature of person to person interactions, thus the interaction itself is used as the unit of study in research. Human beings are viewed as acting in relation to each other; that is, each person takes the other into account, then acts, perceives the other person, interprets the other's response, and acts again. Humans are seen as actors, not merely reactors, thus all behavior is thought to be meaningful.

Fawcett (1984) outlined the characteristics of an

interaction model for nursing as one that includes social acts and relationships, perception, communication, role, and self-concept. Nursing models or theories from this perspective would include actual or potential problems of interpersonal relationships. Intervention strategies would aim to promote optimal socialization (Fawcett, 1984). Socialization, the process whereby a novice learns to function effectively within a social group, is viewed as a lifelong process (Lauer & Handel, 1977).

Maurin (1984) reviewed published literature to determine the six assumptions thought to characterize symbolic interaction. These assumptions are:

1. principles of human social psychological behavior can only be discovered by studying humans;

2. humans are asocial at birth, so they must learn to be social;

3. society existed prior to the individual's existence;

4. humans live in a symbolic as well as physical environment;

5. humans are reflexive, that is they are able to use introspection;

6. humans act as well as react.

Thus the interactional approach focuses on the changing

role relationships and the process of socialization that occurs within families and groups. Any study which involves role transitions within families from this perspective must seek to discover the subject's symbolic world by assuming that person's point of view.

From the symbolic interactionist's vantage point, "symbolic communication with each other is the basis of our socialization, which brings about a shared culture, which allows for understanding each other's acts--what we do is meaningful to each other and cooperative group life is made possible" (Charon, 1979, 55). Therefore, the adult child who anticipates caring for elderly parents must understand the parent's behavior from the parent's perspective in order to assume the role of caregiver or care manager. Learning the role of caregiver or care recipient is a two-way process in which the adult child and the elderly parent are active participants in an interactional process that influences them both (Hurley, 1978).

Support may arise from the person's internal or external environment. That support which surrounds the interaction of role taking and role making during the transition process facilitates change (Meleis, 1975). While support may be symbolic or material, it is always a

function of the individual's perception. Whereas support as a concept was not found in the symbolic interaction literature, it is a concept that fits well into this framework.

A method of concept synthesis described by Walker and Avant (1983) was used to develop the research questions: Will support during role transition lead to role adaptation and prevent role insufficiency. Both inductive and deductive methods of thought were used at various times during the process of concept development. In the deductive phase, the conceptual frameworks of symbolic interactionism, role transition (Burr, 1972), role supplementation (Meleis, 1975), social support (Caplan, 1974), and self-care (Orem, 1971) were used. Personal observations and thoughts about the phenomenon of concern were used inductively at other phases. Together a structure emerged which led to the creation of an operational definition and a design to investigate transition support during role changes.

The concepts of support and role supplementation were synthesized into a concept of transition support. Assumptions based on the relationship of transition support and role transition were derived. Operational definitions were developed.

Concept Synthesis

Walker and Avant (1983) suggested use of concept synthesis as a theory building strategy for generating new ideas where many concepts exist and are used in practice. Many references about types of support are available in published literature, but specific supportive acts are left to individual intuition (Schoenhofer, 1984). Three types of support were explored.

Support. Support is a multidimensional concept which commonly implies adding to endurance and strength of a person or object. Tolsdorf (1976) used support as a function variable, that is, any action that provides assistance to an individual as he or she seeks to meet personal needs or goals. Support may emerge from within the individual, from significant others, or from professional helpers. These three aspects of support are available to the individual in varying amounts as described below.

Self Support (Self-Care). Self-care is a basic function of human life. Self-care is a deliberate action which occurs in two phases (Evans, 1979). The first phase, decision-making, presupposes awareness of a need

and knowledge of ways to satisfy that need. The second phase, action-taking, involves the individual's efforts to attain need satisfaction. Decision-making is an internal process, while action-taking is an external one. Thus basic human needs are satisfied by deliberate action. The individual's ability to take the required action as awareness of a need arises is influenced by personal attributes and environmental conditions (Evans, 1979).

Social Support. Social support is a general feeling or attitude of belonging and being valued by one's social group. This concept has been identified as a buffer to stressful life events in various studies (Gottlieb, 1982). Kahn (1979) identified aspects of social support as:

> interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the affirmation or endorsement of another person's behaviors, perceptions, or expressed views; the giving of symbolic or material aid to another (p. 85).

Affect, affirmation and aid are the attributes of social support (Norbeck, 1981).

Nursing Support. Although support is often verbally discussed in nursing education, there is very little written about nursing support and less research reported on the subject. Schoenhofer (1984) identified and analyzed the concept of support as a legitimate nursing action. Support was defined "a class of nursing assistance whereby resources of the nurse are added to the resources of the client such that the client of nursing is enabled to initiate and successfully carry out action to accomplish a desired health result" (p.219). Thus the desired outcome would guide the nurse in choice of interventions.

According to Corbin and Strauss (1984) when nurses aim the interventions at a desired outcome, they presuppose that the client knows what result is desirable. The professional nurse's responsibility lies in assessing, bringing someone into awareness, and assisting. Therefore the nurse assesses the client, increases awareness, and supports the client toward the desired outcome.

Role Supplementation. Meleis (1975) defined role supplementation as:

> any deliberative process whereby role insufficiency or potential role insufficiency is identified by the role incumbent

> and significant others, and the conditions and strategies of role clarification and role taking are used to develop a preventive or therapeutic intervention to decrease, ameliorate, or prevent role insufficiency (p.267).

Role insufficiency occurs when there is any difficulty, either emotionally or behaviorally, in performance of a role (Meleis, 1975). During times of role transition, like that of becoming caretaker to elder parents, there is a risk of the occurrence of role insufficiency (Meleis, 1975). Role supplementation, according to Meleis (1975), is one form of nursing support available for the professional nurse to use in assisting clients with role transition.

Transition Support. The three-dimensional concept of support in the form of self-care, social support, and role supplementation as a form of nursing support can be combined to form the concept of transition support. Transition support as a nursing intervention is based on the desired outcome of the client. As Corbin and Strauss (1984) point out the nurse uses this support to assess the client, works to increase awareness, and assists as needed. Assistance will vary with the individual needs of each adult child-elder parent dyad.

A concept of transition support to be used by the

professional nurse during role transition was derived in order to clarify and make explicit the relationship among variables to help nurses address the problems inherent in the adult daughter-mother caregiving dyad. The process of transition support during role transition is diagrammed in Figure 1.

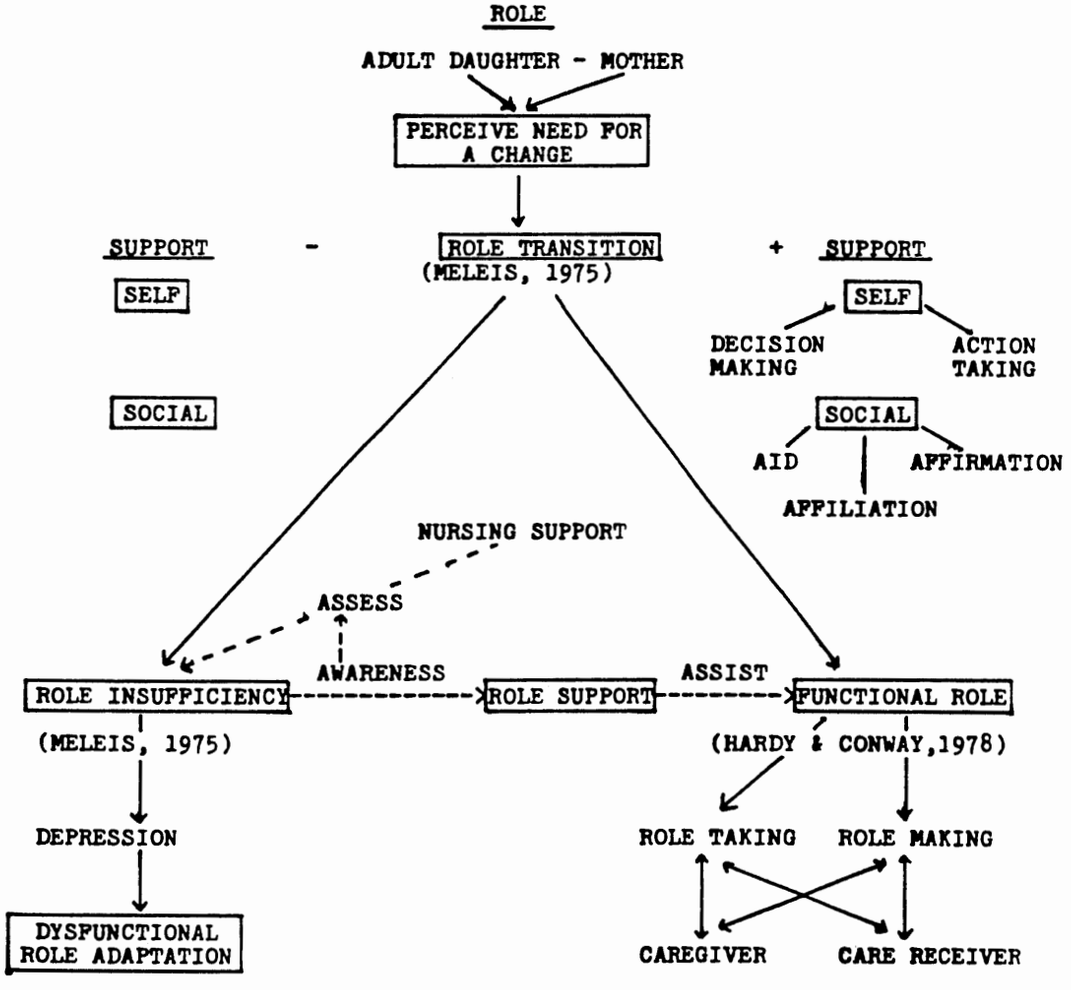

FIGURE 1 - SUPPORT FOR ADULT DAUGHTER DURING ROLE TRANSITION

Summary

A concept of transition support has been developed. Self support, social support, and nursing support in the form of role supplementation were combined to produce a three-dimensional concept of transition. The concept of transition support was developed to facilitate the adult daughter in role adaptation as parents age. The problem of this study was to investigate the following questions: Will transition support for midlife women during role transition to caregiver or care manager for their elderly parents lead to role adaptation? Conversely, the researcher also addressed the question: Will transition support lead to less perceived role insufficiency?

Assumptions

The following assumptions will be used for the study:

1. The role of caregiver contains inherent stress and strain.
2. Role supplementation is a form of nursing support.
3. Role insufficiency will occur during role transition if role adaptation fails to occur.
4. Role taking is indicative of role adaptation.

Hypotheses

The following hypotheses were tested in the study:

1. The adult child who exhibited high levels of social support and who received nursing support in the form of role supplementation will demonstrate less perceived role insufficiency.

2. The adult child who exhibited high levels of social support and who received nursing support in the form of role supplementation will demonstrate higher levels of role adaptation.

Definition of Terms

For the purposes of this study, the following terms will be defined:

1. Role adaptation- involves role taking which is similar to empathy and role making which means creating one's own role (Hardy & Conway, 1978); the ability to develop and implement a new role in a reciprocal process with a significant other. Role adaptation is operationally defined as the correlated scores of the adult daughter-elderly parent dyad on the Concerns of Aging Scale (Brackley, Appendix A, 1985).

2. Role insufficiency- "the perception of role performance as inadequate" by the role incumbent or significant other, "and the behavior and sentiment

associated with such perception while moving in or out of roles" in a health system, "voluntary or involuntary additions or terminations of roles with or without changes in other roles", or "concomitant termination of a role or set of roles and the beginning of a new role or set of roles" (Meleis, 1975, 266). The operational definition of role insufficiency in this study was a score on the Self-rating Depression Scale (Zung, Appendix C, 1972).

3. Role transition- is a change in role relationships, expectations, or abilities; occurs in a reciprocal process in dyads (Meleis, 1975).

4. Transition Support- intrapersonal, interpersonal, or extrapersonal assistance, either material or symbolic, a person receives during a change in role relationships, expectations, or abilities. Transition support includes the following:

A. Role supplementation- is a form of nursing support; a preventive or therapeutic intervention to decrease, eliminate, or prevent role insufficiency (Meleis,1975). Role supplementation is operationally defined as a nurse-led role supplementation group for midlife women anticipating role transition to caregiver (Brackley, Appendix E, 1985).

B. Social support- interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the affirmation or endorsement of another's behavior; the giving of material or symbolic aid (Kahn, 1979). The score on the Norbeck Social Support Questionnaire (Norbeck, Appendix D, 1981) was used to indicate the level of social support.

Limitations

This study had the following limitations:

1. Because all subjects who agreed to participate and who met the criteria were included in the study, the findings of the study cannot be generalized beyond the units sampled.

2. Due to the small sample size, cause and effect cannot be established.

Summary

The effects of transition support on role adaptation of midlife women during role transition to caregiver or care manager for their elderly parents was the problem chosen for study. This chapter also included the justification for the study and the background of the problem. The research questions were outlined and both

theoretical and operational definitions developed. Also limitations and assumptions of the study were made explicit. Hypotheses were stated.

Chapter II contains a review of published literature available on the research question and a survey of appropriate research conducted in the area of parental caregiving in general. Chapter III describes how the data were collected and the actual use of the instruments. Chapter IV contains an analysis of the data, the results of the study, and an interpretation of the findings. A summary of the study, conclusions, implications, and recommendations for future research are included in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

Parent care by adult children has existed since humans began to organize themselves into families. Filial behavior and responsibility toward older relatives has been studied and scrutinized within the last three decades by researchers, practitioners, and social policy makers alike. This chapter reports the findings of those studies and are grouped into the following sections: the nature of parental caregiving, adult daughter-elderly mother interactions, characteristics of role adaptation in the caregiver, characteristics of role insufficiency in the caregiver, and the effects of support on the caregiving relationship.

The Nature of Parental Caregiving

Since the 1963 annual meeting of the Gerontological Society of America, studies and expert opinion have proliferated regarding the myth that American families abandon their elderly members (Brody, 1985). In general, this persistent myth has tended to be refuted (Shanas, 1979). Brody (1985) described parent care as "normative

family stress" (p.21) since families are now providing 80 to 90 % of all services to those persons over 65 years of age, while formal support systems go mostly unused. Moreover, demographic studies suggest that well over 5 million people are at any one time engaged in parent care (Brody, 1985). Today as the American health care system struggles with its transition from an acute care orientation to a chronic care view, adult children are faced with the need to care for older, sicker parents for longer periods of time than seen before. In this section, the structure of caregiving and the interactions between caregiver and receiver were explored.

The structure of caregiving

Johnson and Catalano (1983) described caregiving within the family structure as each member contributing to the tasks necessary for ensuring the welfare of a relative in need of such services. However as many gerontologists have pointed out, one person, typically the wife of an older husband or the daughter or daughter-in-law of an aging couple or widowed mother, usually assumes the majority of caregiving activities (Archbold, 1982; Crossman & Kaljian, 1984; Crossman, London & Barry, 1981; Sommers, 1985). The caregiver may live with the person for whom she cares or she may reside

separately (Soldo & Myllyluoma, 1983; Troll, 1971). In addition, The roles of the caregiver have been separated into those of care provider or care manager (Archbold, 1982). The care provider role is often assumed by a spouse or a child who lives with a parent in need of care. Adult daughters more typically assume the role of care manager when they work outside the home and are financially able (Archbold, 1982; Crossman & Kaljian, 1984).

According to Shanas (1980), 95% of the older people in the United States live in the community, while 5 to 6% are institutionalized. One in three older women was reported to be married and to continue to live with her spouse, in contrast to two in three older men who were in this position; the researcher related this finding to the traditional age differences between husband and wife in this country.

In the same survey, Shanas (1980) found that whereas four of every five people over 65 years of age had children, only 12% of all married and 17% of all unmarried elderly persons lived with their children. In an earlier study, Shanas (1979) reported that 52% of older parents lived within the same household or lived next door or within a few blocks of their adult children.

Three-fourths of all persons with children reported contact with a child on the day of the interview or the day before. Since this review of the literature focused on elderly people with adult children, no discussion of the single elderly population was addressed.

Interactions between caregiver and care receiver

A majority of elderly individuals expressed a desire for health care to be provided by family members if the need arises (Brody, 1985; Brody et al, 1984; Brody et al, 1983; Ory, 1985). In addition, data from two surveys indicated that respondents wished to remain in their own homes for as long as possible (Ory, 1985; Shanas, 1980). When a family attempts to care for a relative in the home setting, it tends to provide certain services. Some of the activities commonly undertaken by family caregivers include the provision of emotional support, mediation with formal support systems, food preparation, shopping, household chores, laundry, personal care, and financial management (Archbold, 1982; Cantor, 1983; Poulshock & Dieming, 1984; Sommers, 1985; Stoller, 1983).

Since the caregiver is reported to give up time usually devoted to leisure, recreation, and other stress reducing activities when caregiving demands become too great (Archbold, 1982; Brody, 1983), stress reactions are

associated with caregiving. Common reactions to the stress of caregiving reported in the literature include depression, social isolation, anxiety, family disruption, guilt, and feelings of burden (Archbold, 1982; Cantor, 1983; Drummond, 1984; Gilhooly, 1984; Poulshock & Deimling, 1984; Zarit et al, 1980).

In summary, families are the major providers of health care and services for older Americans. When the elder person is married, the spouse provides needed services if able; on the other hand if both partners are in ill health or if the parent is widowed or divorced, an adult female child tends to assume the caregiver role. Employed children normally coordinate services, while the unemployed and/or poor child provides direct care. Caregiving tasks, even though time consuming and potentially stressful, are accomplished within the family with or without the use of formal support systems.

Adult Daughter-Elderly Mother Interactions

Published literature describes the relationship between mothers and their offspring from the child's infancy through adolescence. A decline in availability of written materials is apparent beginning with the period of young adulthood and continuing through the end of life. In recent years, researchers have begun to

address the issue of physical and emotional development in old age but have left adulthood and middle-age relatively unexplored.

Fischer (1981) took a developmental approach in discussing transitions in mother-daughter relationships. This researcher identified transition periods of the daughter's adolescence and her transition to marriage and motherhood, and her mother's transition to old age and infirmity. Furthermore the author stated that one should "expect to find negotiations and redefinitions of relationships associated with life-cycle transitions" (p.614). Fischer using a modified family case study approach found that in the daughter's transition to marriage and motherhood, the mother and daughter began to redefine their relative role status, the daughter began to develop a new role perspective of mother, and with the change in family structure from nuclear to extended, mothers and daughters began to renegotiate their interactions.

Brody (1985) criticized a similar view applied to aging developed by Blenkner in 1963 which looked upon parent care as a developmental stage of life labeled "filial maturity" (p.22). In "filial maturity", the adult child develops the capacity to be relied upon by

the aging parent. According to Brody, caring for one's parents is not a developmental stage because "developmental stages are age-linked and parent care is not" (p.22). Furthermore, she stated that old age is variable and does not follow a regular pattern, thus parent care may fall to daughters in their 40s and 50s, or it may begin as early as 30 or as late as 70.

If parent care is not a developmental stage that signals the transition of adult children into old age, and as Brody (1985) pointed out there are "no behavioral norms for this normative life crisis" (p.23), then no single indication of how parent care should be handled by adult children has been identified. Affection and concern for aging parents has been named as the reason adult childern assume caregiving tasks for their aging parents. However Jarrett (1985) refuted the notion that emotional closeness and affection are prerequisites for caring, but instead stated that "kinship obligations" (p.5) are historically a basis for parent care.

If one takes a structural perspective, the family involved in parent care can be described by its position along a disengagement-enmeshment continuum (Johnson & Catalano, 1983; Miller, 1981; Minuchin, 1974). According to Miller (1981) families may form clear boundaries where

each member is neither too close nor too distant for a functional relationship, or the family may become disengaged by forming rigid boundaries that inhibit communication and isolate the aged parent. The other extreme position is an enmeshed family whose members lose their sense of autonomy and their ability to live independently which leads to the aged member losing individualization and a sense of self-worth (Miller, 1981; Tonti & Poulshock, 1984).

Miller (1981) stated that overinvolvement of the adult daughter with the aged parent leads to a weakened bond between daughter and her spouse. In this scenario, family functioning is threatened. In some instances pathological alliances are formed in which mother and daughter form a coalition against the daughter's husband. Miller (1981) pointed out other consequences of blurred intergenerational boundaries as infantilization of the adult child where the child can make no decisions in her life without consulting her mother or infantalization of the parent where the adult child assumes all decision-making for the parent thus placing the aging relative in a dependent role.

In illustration of this structural perspective, Johnson and Catalano (1983) studied 115 individuals 65

years of age and older during hospitalization and 8 months after hospitalization to determine the longitudinal effects of family support of the elderly. Two adaptive techniques, enmeshing and distancing, were used by caregivers. Spouses were more likely to use enmeshment than were adult children. Adult children tended to distance themselves, either physically or psychologically, as time lapsed in the caregiving relationship. In addition, children were more likely to ask for help from formal support systems than were spouses. Other differences between children and spouse caregivers were that children had competing role commitments, while spouses tended to have health problems.

Blurred intergenerational boundaries are but one source of conflict within the caregiving relationship. Rounds (1984) stated that the role of the elderly in modern society, and family characteristics of unresolved conflicts, developmental inadequacies, and burdens caused by the inclusion of the elderly person within the family may lead to conflict that results in elder abuse and neglect. The role of the aged parent may be unclear since most available roles will have been assumed by other family members. Unresolved conflicts include

mother-daughter syndrome, the fallen tyrant, and power reversal (Rounds, 1984; "Abuse of Old People", 1980). Mother-daughter syndrome is similar to the infantilization of the adult child discussed above. In this situation, the daughter is unable to adapt to her mother's decline and anxiety and conflict result.

Rounds (1984) indentified two power conflicts within the family as the fallen tyrant and power reversal of a weak family member. When a powerful member of the family loses dominance, the fallen tyrant occurs. In an attempt to recapture control, the fallen tyrant may resort to manipulation of family members thus creating tension and conflict. The unresolved conflict of power reversal occurs when a previously weak member of the family becomes ill and gains power of the family through inflicting guilt.

In a similar vein, Silverstone and Hyman (1982) stated that family development which leads to successful care and concern for its aged members demands a shift in the balance of responsibility. Recognizing when an aging parent needs help and providing for her or his welfare is not an easy task. In the mother-child relationship, one can expect a move toward independent functioning that does not exist in the adult child-aging parent

relationship. Brody (1985) wrote that "the inevitable shift in the balance of dependence/independence of the elderly parent and the adult child reactivates that child's unresolved conflicts about dependence" (p.23). Developmental family shifts are a potential by-product of all such dynamic interactions among people.

The burden and stress of caregiving has been well documented. Archbold (1982) identified the consequences of direct caregiving as social isolation, lack of privacy, daily irritation created by the situation, marital and sibling conflicts, exhaustion, and physical illness from the demands of heavy physical labor. Archbold pointed out that the care manager often reports lack of time for self, family, and friends, financial drain, and career disruption. However, both types of caregivers were shown to report satisfaction at helping their parents during hard times.

In summary, the interaction between the adult daughter and her aging mother is dictated by their past relationship and its inevitable conflicts, the daughter's present situation, the mother's health, and family supports. As necessitated by circumstance, the mother and daughter renegotiate their relationship and adapt as far as possible to the demands placed upon them.

Affection between generations while nice to have is not the deciding factor in assuming the caregiver role, a sense of family obligation appears more immediate.

Characteristics of Role Adaptation in the Caregiver

Old age does not develop in an orderly pattern as does the growth and development of young children. Brody (1985) wrote that one person at 65 years of age may be incapacitated by physical and mental problems, while another may be totally self-sufficient at age 85. However in the progression to old age, some events may indicate the need for family changes in adapting to the age related problems of a parent. The event may be a new awareness that parents are reaching old age or a crisis, such as a stroke or broken hip, may change the family's functioning (Silverstone & Hyman, 1982). In any case, the adult children begin to realize that their parents need help with daily living.

The awareness of the need for family roles to changes may cause great concern to all family members. Johnson and Spence (1982) identified the effect of intergenerational roles on family relations. In the family's history, there are patterns of functioning or roles that members adopt in order to ensure their survival within the family. When young, that role is of

a dependent nature and as one grows, independent roles emerge. Parents are normally seen as the cornerstone of the family; they assume the most independent roles. There is comfort in familiar patterns of interaction within any family. As parents age and become more dependent on others for assistance with living, adult children may be uncomfortable assuming the independent role of parent caregiver and conflicts may arise within the caregiver and their family.

The conflicts that arise in caregiving affect women family members most thus caregiving is seen as a woman's issue (Sommers, 1985). Eighty-five percent or more of all caregivers are female (Sommers, 1985); caring appears to be a gender-appropriate role for women (Brody, 1982; Stoller, 1983; Sussman, 1965). Among elderly couples living in their own homes in 1976, over half of the caregivers were wives (Soldo & Myllyluoma, 1983). In the same survey, which used secondary nationally representative data, when the elderly couple lived with others, the wife or daughter assumed the duties of primary caregiver. The daughter assumed secondary caregiver roles in both situations.

Fengler and Goodrich (1979) discovered high stress levels and increased rates of chronic illness in wife

caregivers of disabled spouses. Wives who provide care for their husbands tend to have problems themselves. Stoller (1983) estimated that among elderly couples living alone, over 5% of older caregivers had a moderate need for assistance themselves. Since 80 to 90% of all services, including personal care is given to the elderly by family members, adult children with aging parents may be faced with providing such care. Because women have been identified as primary caregivers and without ignoring the fact that some men assume this role and carry out its functions, the remaining review of the literature will focus on adult daughters and their response to their parents needs for care, mother-daugther role transitions, demographic changes that affect the care of elderly Americans, and the strain associated with caring.

Silverstone and Hyman (1982) described the various ways in which children may respond to their parents' decline. The authors contended that unresolved feelings, such as anger or guilt, often produce behaviors such as withdrawal from the situation, oversolicitousness of parent's situation, faultfinding in other people, denial of parents infirmity, outmoded roleplaying, rebelliousness, blind overinvolvement, and/or

scapegoating. Although family behavior is complex, symbolic interactionism provides a manageable method of veiwing such behavior changes.

From Maurin's (1984) discussion of the theoretical perspective of symbolic interactionism, reactions in the adult child to changes in the aging parents are inseparable. Adaptation to transition in role relationships are interactive and may be characterized by "processes of redefinition and renegotiation" (Fischer, 1981, 614). Role changes experienced by one family member will affect every other member in turn. Redefinition and renegotiation of family structure occur concominantly with changes in role status and role prespective between aging parents and adult daughters.

The adult daughter may have many other conflicting and competing roles with which to contend. Gerontological and family relations research have begun to reflect the burdens the adult daughter may be facing. At midlife, approximately 35 to 40 years of age, the typical adult female in America has been described by Betty Friedan (1981) as a "superwoman". This woman juggles a family, a career, a home, and potentially care of her elderly parents, too. "Role overload" is the term used to illustrate the effects of this juggling act.

Demographic changes have added to the burden of the person Brody (1981) labeled the "the woman in the middle" (p.471). This woman is in her middle years, in the middle generation, and in the middle of competing role demands. Families with aging parents are faced with fewer siblings to assume care for older people, less potential income for elderly to offer their children as a means to secure their help in times of need, the changing role of its women members, and increased longevity of its elderly members. One can readily see the situation as potentially stressful.

Brody (1981) studied the influence of demographic changes on the attitudes about caregiving of the noninstitutionalized elderly and their caregivers. Eighty triads composed of grandmother, mother, and adult grandaughter were drawn through purposive sampling. Middle-generation women had a mean age of 49.1 years, four-fifths were married, 20% were widowed or divorced, 84% had children at home, 20% had a parent living with them. Furthermore, three-fifths were employed outside the home, and more than 20% provided at least one service to their mothers on a continual basis. The sample represented diverse racial, cultural, and socioeconomic sections of society.

All role positions, grandmother, mother, and granddaughter supported filial responsibility toward the elderly. Grandmothers in this sample supported the well-documented desire not to be a burden on their children. All generations endorsed family care for the elderly. Although the middle generation women felt care for aging parents was filial responsibility, they did not choose their children as the best providers of housework and personal-care services for themselves, rather they expressed a preference for purchasing such services in the marketplace (Brody, 1981). Brody speculated that their preferences could have resulted from pressure of multiple responsibilities at the time of the interview and a wish to spare their children from similar stresses.

Whereas the strain of caregiving has been studied for the past two decades, successful caregiving has not been specifically described except in terms of avoiding institutionalization and/or continuing the relationship until the care receiver dies. Through surveys and clinical work, it is known that adult children readily recognize the need for and assume the caregiver role; this is the first step to role adaptation (Shanas, 1979; Sussman, 1965). Successful adaptation to the caregiver role would probably entail the least amount of stress and

increased ability to cope with problems as they arose (Johnson & Catalano, 1983). Sommers (1985) described some personal rewards felt by women caregivers. Some of these rewards included a discovery of an inner strength, a feeling of repayment of a filial obligation, and gaining new knowledge about self and caregiving. Personal growth and a sense of accomplishment as well as a feeling of doing the best job possible were common themes of the experience among caregivers (Jarret, 1985; Ory, 1985; Pierskalla & Heald, 1982; Silverstone & Hyman, 1982).

In summary, no socialization mechanism is available to assist elderly parents and their adult children in adaptation to new roles in later life (Johnson & Bursk, 1977). Role redefinition and renegotiation depend on many variables. Some of these are the changing role of women, previous family functioning, the adult child's response to the need for caregiving, competing roles in the adult child, and attitudes toward help for the aged. More has been written about the burdens of caregiving than personal satisfaction with the role of caregiver. Successful adaptation to the role of caregiver appears to include a sense of accomplishment for a job well done.

Characteristics of Role Insufficiency in the Caregiver

While it is known that most families care for their elderly at home as long as feasible, little empirical knowledge is available about the impact of parent care on the caregiver and family. In this section a body of available literature on the burden of caregiving was explored and role insufficiency in the caregiver was addressed.

The stresses associated with caring for elderly parents has been explored by gerontologists and psychologists alike. The negative consequences, referred to as the burden of caregiving, on the caregiver have been divided into subjective consequences, feelings and attitudes about caregiving, and objective consequences, disruptions or changes in the life of the caregiver due to the demands of the role (Ory, 1985).

Zarit, Reever, and Bach-Peterson (1980) investigated the amount of burden reported by 29 primary caregivers of senile dementia patients on a 25 item self-report instrument. Disruptive characteristics of dementia patients were theorized to be associated with the amount of burden experienced by the caregiver. Spouse and daughter caregivers were analyzed separately to distinguish differences in perceived burden between these

two groups. Zarit and his associates expressed surprise at the finding that feelings of burden were not different for the two groups of caregivers. Furthermore these feelings were not determined by the number of behavior problems exhibited by the dementia patients, instead feelings of burden were correlated with the social supports available to the household. Social supports were specifically determined by the number of visitors to the household other than the caregiver.

One implication of their findings Zarit (1980) and his colleagues identified was that intervention programs aimed at caregiving household should attempt to strengthen informal social supports. Although this study focused on senile dementia elderly patients, the findings suggest that social supports to the older person can benefit the caregiver in the relationship and perhaps prevent premature institutionalization. Investigations of other populations are needed to generalize these findings to other caregiving situations.

In a study of elderly clients and their primary caregivers receiving homemaker services through the New York City Department for the Aging, Cantor (1983) found differences in the type of strain caregivers experienced as determined by their role position to the elder. The

role positions of spouse and adult child caregivers were studied. Spouse caregivers in the study reported financial and physical problems associated with caregiving, while adult children in the role suffered from competing role demands and lack of ability to obtain help for their elder parent. Both groups of caregivers experienced emotional strain in dealing with the elder care receiver. Cantor suggested that solutions to caregiver problems be tailored to the specfic caregiving relationship and include a combination of financial aid, counseling, in-home, and respite services. These findings supported Archbold's (1982) assertion that two types of caregivers exist, direct care providers and care managers; and that each type requires different interventions.

Poulshock and Deimling (1984) attempted to clarify the concept of caregiving burden by using a multidimensional perspective and by suggesting a measurement technique for use in the field. This study was conducted in the 11 counties surrounding and including Cleveland, Ohio. From 2000 referrals to Benjamin Rose Institute, a stratified sample was purposely selected according to geographic location, racial characteristics, and generation configuation of

the household. Approximately 50% of the caregivers were spouses and the remaining caregivers were adult children or children-in-law. Of the children caregivers, 83% were daughters, 9% were sons, and the remaining 8% were daughter-in-laws. The burden and impact on the caregiver were explored in addition to the elder's impairment. Burden was defined as the caregiver's subjective feelings about caregiving. Impact was defined as the objective disruption to the caregiver's family and lifestyle. And elder impairment was divided into physical and mental components.

Poulshock and Deimling (1984) interviewed both the impaired elder and the primary caregiver. The elder person's activities of daily living, sociability, cognitive functioning, and behavior patterns were assessed for levels of impairment. The caregiver's perception of the caregiving burden and the impact on that lifestyle were determined. Additionally the caregiver's mental health as determined by an index for identifying levels of depression was calculated. The indicators were then correlated in various ways and an series of regression equations were done. The results supported the need to separate the caregiver's perceived burden from the impact on lifestyle. Burden had a

substantial effect on impact. Elder impairment and impact are positively correlated with burden. The researchers suggested that the concept of burden be used to describe caregivers subjective perceptions of their problems related to the elder care recepients physical or mental impairment. Burden should then be treated as an intervening variable between impairment and other objective effects of caregiving. Impact should be defined further into a multidimensional concept that includes the effects on the family as well as the caregiving relationship. Poulshock and Deimling further pointed out that depression was associated with both burden and impact, and that it should be viewed as an antecedent or as an intervening variable in caregiving studies. Refinement of these complicated concepts is needed in the area (Poulshock & Deimling, 1984).

Gilhooly (1984) compared characteristics of caregivers of senile dementia patients who lived with the impaired elderly person and with those who reside separately. The patients all attended day hospitals in Scotland. Caregivers living with the patient tended to be older, some were spouses, and the care recepient was more impaired than those living alone. In this exploratory study, the data were collected through

semi-structured interviews. The Kutner Morale scale and the mental health scale of the OARS Multidimensional Functional Assessment Questionnaire were used to assess the caregiver's morale and mental health and an inverse relationship was found. The patient's level of impairment was determined by administration of a mental status questionnaire, a rating given by the interviewer as derived from the caregiver's answers during the interview, and the day hospital staff's ratings of the patient's functioning. In addition, the level of social support was assessed through the interview process. The investigator found that while the morale of caregivers was low, their mental health was good. Sex was the only factor associated with psychological well-being; if the impaired elder was male, the caregiver had lower morale. The relationship of caregivers to recepients was not stated. Furthermore, the researcher found that males caring for impaired wives had higher morale and appeared to be less involved emotionally with their wives' illness than were female caregivers.

Gilhooly (1984) reported that while social support and help from friends did not have a significant effect on morale of the caregiver, presence of a child in the home did tend to improve morale. The researcher also

found that the longer the caregiving relationship, the higher the morale. The investigator attributed this finding to a survival effect of the situation and/or a longer period of time spent in the relationship.

Although published literature about the burden of caregiving on the caregiver is based mainly on case studies and interviews it did suggest several variables related to stressful relationships. These variables include the mental and physical health of both caregiver and care receiver, the family situation, the length of the caregiving relationship, and the presence or absence of informal and formal supports. Caregiving is an interactive process that involves an entire network of people and agencies, but focuses mainly on two people and their role relations, the caregiver and the person in need of care.

A type of caregiving relationship that was the focus of this review of the literature is that of adult daughter caregiver and elderly parent care recepient. The situation in which these two people are involved is an evolving one and requires adaptation and change. Many pitfalls are possible; one of these is the potential for role insufficiency in the caregiver.

Meleis (1975) defined role insufficiency as:

> "the perception of role preformance as inadequate by the self and/or a significant other, and the behavior and sentiment associated with such perception while moving in and out of roles in a social system, voluntary or involuntary additions or terminations of roles with or without changes of other roles, and/or the concomitant termination of a role or set of roles and the beginning of a new role or set of roles" (p.266).

Role insufficiency is usually associated with periods of developmental or situational role transitions. The potential for role insufficiency exists in areas where no socialization process is identified such as the role of parental caregiver. Literature on parent care reflects statements in which daughters express the feeling of not doing enough for their parents. These same daughters often have cared for their parents for months or even years on a twenty-four hour a day basis (Silverstone & Hyman, 1982; Pierskalla & Heald, 1982). Feelings of guilt and depression are common emotions associated with caring for parents (Drummond, 1984; Poulshock & Deimling, 1984; Silverstone & Hyman, 1982).

After a discussion of common problems faced by caregivers such as financial burdens, lack of time for role commitments, health problems, and social isolation, Archbold (1982) called for 1) screening and treatment for stress related health problems in the caregiver, 2) help

in learning how to cope with problems, 3) comprehensive and accurate information and referral services, and 4) social and psychological support. Sommers (1985) added the desirability of women's groups, both traditional and radical, lobbying and demanding help for caregivers to this list. This author stated that as long as women accept the burdens of caregiving without demanding aid, the social policy makers and legislators will be content to let them deliver care. Caregiving must be addressed as a problem of contemporary society.

In summary, caregiving has been shown to be a burden and to have a negative impact on caregivers and their families in some instances. The concepts of burden and impact are complex and need further refinement. Depression appears to be associated with caregiving, and may be an antecedent or intervening factor. Role insufficiency has been defined as one way to label the burden and impact of parent care.

The Effects of Support on the Caregiving Relationship

Most researchers and clinicians in the area of family relations and gerontology suggest that support for the caregiver is one way to ensure quality of care, to prevent premature institutionalization, and to prevent elder abuse and neglect (Archbold, 1982; Clark &

Rowkowski, 1983; Hepburn, 1984; Johnson & Spence, 1982; Steuer, 1984). In this section literature reviewed on various types of support for the caregiver was divided into social support and nursing support.

Social Support

Social support was defined by Kahn (1979) as

> "interpersonal transactions that include one or more of the following: the expression of positive affection of one person to another; the affirmation or endorsement of another person's behavior, perceptions or expressed views; the giving of symbolic or material aid to another" (p. 85).

The concept of social support is multidimensional and there is little agreement among researchers as to how to measure it. Some investigators have focused on the number of people in a social network and the rate of contact among members (Wolf, Breslau, Ford, Ziegler, & Ward, 1983); others tried to describe the quality of the relationships involved in the network (Johnson & Bursk, 1977); and still others attempted to look at the quantity and quality of support systems (Thompson & Walker, 1984).

Most theorists view social support as an extension of attachments formed in infancy and as a precursor to supportive relationships in adulthood (Norbeck, 1981). Social support is further seen by the American Nurses' Association as an "example of personal and environmental

determinants of wellness and health functioning in individuals and families" (Norbeck, 1981, 44). Furthermore, this organization stated that the study of this concept in order to add to the knowledge base of professional nursing is important. Norbeck (1981) has described the importance of social support to nursing practice. According to this author, two types of interventions nurses can develop are based on improving the patient's social support. These are interventions that focus on manipulating the individual's social network to improve their support and/or the provision of direct support or other help to the person experiencing a problem during a specific time.

In the caregiving relationship, the caregiver provides social support to the care recepient (Johnson, 1983; Lilja, 1984; Myers & Drayer, 1979) while concomitantly receiving social support from the care recepient and others in the social network. The smaller the network, the less support that is derived from outside of the relationship. Since it has been reported that caregivers often are isolated from their social support sources, this field of interest appears important for the present discussion.

Nursing Support

Nurses may provide both direct or indirect social support to their clients (Norbeck, 1981). Indirect interventions through manipulation of the client's social support network can be seen when nurses include families in a patient's care or visit in the home to deliver services such as teaching family members to give insulin injections, prepare meals, and other nursing measures (Bogat & Jason, 1983). Rape crisis counseling is an example of direct support required by a specific client situation. Norbeck stated that the duration of support services required and the intensity of services needed are dictated by the client's situation.

The transition from adult daughter to parental caregiver is an example of a situation when a client might need support from a professional nurse. And just as perceived burden and impact are dependent on many variables, support during this transition also is dependent on many variables.

Role Supplementation Group. An intervention that has been used over the last decade to provide support to family caregivers has been support groups. Meleis (1975) suggested use of role supplementation as an intervention that could be used for prevention or treatment of role

insufficiency when anticipating or assuming a new role. Role supplementation was defined by Meleis as: a deliberate process whereby information or experience is conveyed in an effort to increase the awareness of anticipated behavior patterns, sentiments, sensations, and goals involved in each role. Meleis proposed the use of peer groups as an important strategy of role supplementation during role transition. The author also called for descriptive research to identify behavorial manifestations of role insufficiency. She pointed out that these manifestations associated with role transitions may be characterized by anger, hostility, withdrawal, confusion, depression, fatigue and anxiety.

Clark & Rakowski (1983) reviewed literature related to the use of groups in helping families cope with the demands of caregiving. Eleven reports of interventions that used support groups for caregivers were reviewed by the authors; seven of those groups cited were designed for relatives of noninstitutionalized elderly and were conducted between the years of 1979 through 1982. None of these group offerings had the benefits of a control group; one had pre/post questionnaires of the group's effects. Presently support groups are being used in the clinical setting without benefit of empirical evidence of

their effectiveness (Steuer, 1984).

Summary

Parent care by adult daughters is the most prevalent type of care for the elderly when a spouse is unavailable or unable to assume the role. The caregiver is typically in the middle generation, in her middle years, and has a multiplicity of role demands. Caregiving, while time consuming and potentially stressful, is a role readily assumed by most adult daughters as part of their filial responsibility. The satisfactory development of the caregiving relationship depends on many variables. Among these variables are the past parent-child relationship, the daughter's present situation, the parent's health, and available family supports. Role redefinition and renegotiation are a necessary part of the transition to caregiver. Affection is not a necessary prerequisite to parent care.

No socialization processes exist that dictate an orderly transition to the caregiver-care recepient roles. Successful adaptation to these complimentary roles has not been defined; no normative data exist that describes successful adaptation. Caregiving has been identified as burdensome in some respects. Subjective and objective negative effects, while complex and undefined, were

described in the literature. These effects on caregivers are physical, financial, emotional, social, and mental. Role insufficiency has been defined as one way to view these effects.

Social support has been suggested as a necessary requisite to healthy caregiving. In the past, nurses have used interventions designed to improve social support both directly and through manipulation of the individual's social network. A role supplementation group has been defined as a support strategy to affect a daughter's transition to caregiver.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

An experimental, explanatory, and cross-sectional design was used to examine the effectiveness of transition support for adult children during transition to caregiver/care manager of elderly parents in leading to role adaptation. A two-group before-after design with random assignment to alternate groups was used (Kerlinger,1973). Multiple instruments were employed for data collection to address the two hypotheses: 1)The adult child who exhibited high levels of social support and who received nursing support in the form of role supplementation will demonstrate less perceived role insufficiency and 2)the adult child who exhibited high levels of social support and who received role supplementation as a form of nursing support will demonstrate higher levels of role adaptation. The independent variable, transition support, was assigned to the experimental group. The first dependent variable, role insufficiency, was measured by a score on the Self-rating Depression Scale (SDS). The second dependent

variable, role adaptation, was measured by the Concerns of Aging Scale (CAS).

Setting

An island community, located on the Texas Gulf Coast, which has a population of approximately 70,000 residents served as the setting for this study. A state health science center serves the island residents, as well as state, national, and international clientele. Seven hospitals and 85 outpatient clinics service both inpatients and outpatients. Thirty thousand inpatients are treated each year in 1,200 inpatient beds, while 195,000 outpatient visits are handled and 60,000 emergency cases are seen annually. Seventy-eight hundred people are employed within the health science center.

Population and Sample

A systematic sample of 30 subjects was selected from among the population of female employees at the health science center during August and September, 1985. Participation was on a voluntary basis. The subjects met the following criteria:

1. The adult child and elderly parent lived in separate housing.
2. The adult child was a female over the

age of 30 years.

3. The elder parent was female.

4. Both members of the dyad understood and spoke English.

5. The daughter agreed to attend four group sessions.

Every 75th female name in the health center's employee directory was chosen after a random starting place was selected. Subjects were systematically chosen and mailed a letter which asked for their participation (Appendix E). A reply postcard as well as the investigator's telephone numbers and office room number were included in the letter for volunteers to call or to come for information. When the first subject agreed to participate in the study, a coin was flipped to determine assignment to either the experimental or control group. After this first assignment, other subjects were placed in groups by alternating between experimental or control groups until 30 subjects had been identified. All volunteers were asked to provide their mothers' addresses so that they could be contacted and asked to participate in this research. Mothers were sent a letter via the United States mail that asked them to volunteer as a research subject. When the 30 employees had agreed to

act as subjects for the study, a date was chosen for the group to begin. The control group was offered the group sessions after data collection for the study had been completed.

Protection of Human Subjects

This study adhered to the criteria set forth by the Human Research Review Committee at Texas Woman's University and the Human Rights Committee (Appendix H) at the facility from which the sample was drawn. Each subject was informed regarding the intent to study the relationship of adult women and their mothers. Anonymity, privacy, and confidentiality were maintained throughout the study by coding the questionnaires and avoiding the use of names. A code list was kept locked in the investigator's desk during data collection and destroyed at the end of the study. Potential benefits and negative consequences from participation in the research were outlined in the letter of explanation of the study (Appendix F). These benefits included increased understanding of their needs and those of their mothers as aging occurs. The subjects were told that although emotional discomfort from the nature of the information needed was not anticipated, if it occurred, the group leaders were available for consultation. A subject

consent form was signed by each person who agreed to participate in this research (Appendix G).

Instruments

The Brackley Concerns of Aging Scale, the Norbeck Social Support Questionnaire, role supplementation group, and the Self-rating Depression Scale were used for data collection in the study. A description of each scale and the purpose it served in this study follows.

Brackley Concerns of Aging Scale (CAS)

Since roles are learned in pairs, the role and counterrole (Hurley, 1978), role transition involves a change in both roles. In this study the effects of transition support on role adaptation of the caregiver were assessed. Therefore an instrument that could be used to assess the perception of both the adult child and the elderly parent regarding the caregiving interaction was needed. Since no instruments were available, the Brackley Concerns of Aging Scale (CAS) was developed (see Appendix A).

Following a review of the literature a number of concerns that were expressed by authors about dependency on others in old age were identified. Clark & Rakowski (1983) categorized the dimensions of caregiving into

tasks associated with the caregiver role. These tasks included the areas of direct care, intrapersonal concerns, interpersonal concerns, and interaction with the family and the community (Clark & Rakowski, 1983). The Concerns of Aging items developed for this study were grouped to correspond to the caregiver task categories.

A sample of 8 volunteers served as a subjects for the pretesting of materials. During this phase the list of concerns was submitted to four adult daughters and four elderly mothers for evaluation. The daughters were asked to rate the concerns about dependency on a Likert-type scale from very important to not important at all. Mothers rated the concerns in a similar fashion. All concerns with a neutral to very important rating were retained. The retained list was evaluated for relevance of content by two gerontological nurses and two faculty experts. Comments and suggestions for concerns to be included were requested from all evaluators. Evaluators all concurred that the list included most concerns of the aged that they had encountered.

The completed list of nineteen concerns was then typed on 3" X 5" cards. A typed list of concerns was prepared for daughters and for mothers with columns to be marked "I have discussed this with my mother" and "I have

not discussed this with my mother" or "I have discussed this with my daughter" and "I have not discussed this with my daughter."

In the second phase of instrument development, the set of cards was administered to 4 women in the 45 to 55 year old age bracket with the instructions to rank the cards from most to least important. All subjects repeated the procedure after 30 minutes. A Spearman rank-order correlation of $\underline{r}$ =.80 for the two rankings was determined. Estimates of reliability for internal consistency using Cronbach's Alpha for the eight sets of ranks varied from $\underline{r}$ =.72 to $\underline{r}$ =.85. A Spearman rank-order correlation and a Cronbach's Alpha were calculated for
the mother group as well. A similar range was found.

Norbeck Social Support Questionnaire

The NSSQ (Appendix D) was developed for use by nurses to identify client problems in the clinical area with respect to social support. The average time required to complete the instrument was reported by Norbeck and colleagues (1981) to be 10 minutes; individual times varied from 5 to 20 minutes. The NSSQ consists of a demographic data sheet, a Likert-type scale for social support, and a measurement of loss. The

demographic data sheet includes seven closed ended questions; these items elicit data regarding age, sex, marital status, educational level, ethnic background, religious perference, and participation in religious activities. At the author's request the data sheet was administered as it was designed to the subjects. For example, the answers to religious preference are protestant, Catholic, Jewish, other, and none. After the selections of protestant and other, a space marked "specify" is allocated. The category of religious participation is structured to give the respondent a clear frame of reference from which to answer.

The NSSQ consists of eight questions to be answered in the area of the subject's personal support network. There are twenty-four spaces to list the first name, last initial, and relationship of each person the subject considers supportive; examples are provided for clarity. The subject then rates each person listed in their support network in response to eight questions. The questions measure three variables that when summed are purported to assess social support. These areas are identified as total functional, total network, and total loss; together they compose the three subscales. For example, the subscale affect is based on the question,

"How much does this person make you feel loved and admired?." The subject rates the question from 1 to 5, 1 indicates "not at all" and 5 which indicates "a great deal".

The last question, number nine, is a measure of total loss and is a contingency item. If the respondent answers yes to the question, "During the recent year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason?", information on two additional questions is elicited. The questions ask the number of persons lost and structured responses are supplied. In addition, a Likert-type scale is included that assesses the amount of support lost. These three questions make up the variable of total loss.

Norbeck, Lindsey, and Carrieri (1981) devised several methods of testing the validity of this tool. The NSSQ was tested on two groups of students in its developmental phase. Group one consisted of 75 first year graduate nursing students during their second week of school. Group two was composed of 60 senior nursing students. Subjects were recruited in the classroom; in an effort to avoid coercion, the instructor of the class was not present and did not participate in the research.

Furthermore, the NSSQ was administered to all of the students; subsets of students were given four other instruments, the Marlowe-Crown Social Desirability Scale, the Social support Scale developed by Cohen and Lazarus, the Profile of Mood Status by McNair, Lorr, and Droppleman, and the Life Experiences Survey by Sarason. The Marlowe-Crown Social Desirability Scale was given to assess whether or not answers on the NSSQ were socially desirable responses or were they honest self report? The scores on the NSSQ were then correlated with the aforementioned scale; the correlations varied from $\underline{r}$ =.01 to $\underline{r}$ =.17; the results suggest that the NSSQ is relatively free from social desirability response bias (Norbeck et al, 1981).

Concurrent validity was tested by administering an instrument that is known to measure social support, the Social Support Questionnaire, and correlating its results with the results of the NSSQ. The tool consists of two parts that measure emotional support, informational support, and tangible support. In a study of 100 adults aged 45 to 65 years of age, the tangible and emotional support scales were found to be significant predictors of depression; tangible support was a significant predictor of negative morale. Life stress and social support are

known to be related to depression and morale. Therefore the scale is believed to be a valid measure of social support (Norbeck et al, 1981). According to Norbeck and colleagues, "there are rough parallels between tangible support and aid, informational and affirmation, and emotional support and affect" (p.266). The significant correlations between the two instruments follow the identified strengths and weaknesses of the Cohen and Lazarus scale; tangible support and aid were not related significantly; a negative significant relationship was found between total loss and tangible support ($\underline{r}$ =-.44); a low but significant relationship was found between informational support and affirmation ($\underline{r}$ =.33). Emotional support was related moderately to each subscale of the NSSQ and to the main variables ($\underline{r}$ =.44 to .56) with the exception of total loss. Whereas the reported correlations are low to moderate, they do indicate a significant relationship between the two instruments (n=42).

Construct validity is an assessment of the theory behind the concept, as well as the test itself (Kerlinger, 1973). To determine construct validity, a variable is chosen that is known to be related to the variable of interest; in this case social support is

related to psychiatric symptoms and life stress. Two measures of the related variables were correlated with the NSSQ; the POMS (n=75) and LES (n=33) were not found to be significantly related to the NSSQ. Norbeck and colleagues called for further testing and are at present attempting to validate and provide normative data for the tool. It may be that new measures are needed; perhaps the chosen ones are not good measures of the variables.

The NSSQ was administered to 75 students in group one and one week later 68 of that same group took the test again. Pearson Correlation Coefficients were determined for all pairs of items in the test-retest phase of reliability testing. Each of the items that comprise the subscales, affect, affirmation, and aid, had a high degree of correlation ($\underline{r}$ =.85 to .92, $\underline{p} \leq .0001$). Internal consistency was tested for all items ($\underline{r}$ =.89 to .98, $\underline{p} \leq .0001$), which indicates a high degree of internal consistency.

In conclusion, the NSSQ was found to have high test-retest reliability and internal consistency and to be free from social desirability response bias. Validity has been tested; concurrent validity was found to be moderate when correlated with another questionnaire that purports to measure social support. More testing, with

perhaps different tools, is needed to determine construct validity. However this tool was used in this study because it is logically congruent with the needs of this study.

Role Supplementation Group

A nurse-led support group was developed by the researcher for midlife women with elderly mothers who have the potential need for care in the future. The group met weekly for 1 1/2 hours during an 4-week period. The goals chosen for the group were to:

1) provide the opportunity for role clarification, role taking, role modeling, and role rehearsal.
2) provide information about adult development, the aging process, and available community resources and service.
3) provide a setting to explore and resolve affective aspects of role transition, such as:
   a) guilt
   b) unresolved childhood conflicts
   c) sibling rivalry.
4) encourage daughters to communicate and problem solve with their parents.
5) teach communication skills.

Each group meeting included approximately 30 minutes

of didactic content on a particular topic (Appendix C). Content for the group was developed from the published group outlines found in gerontological literature (Hausman, 1979; Cohen, 1983; Pierskalli & Heald, 1983). The focus for the sessions was group process. The group was co-led by two professional nurses trained in group process. While both nurses hold Master of Science degrees, one had a mental health background and the other's speciality is in gerontology. The co-leaders focused on summarizing themes, identifying strengths and weaknesses, and similarities and differences in the group. Each session provided the opportunity for role taking, role modeling, role rehearsal, and role clarification. Members were encouraged to develop relationships with each other and to support members inside the sessions and outside.

The didactic content (Appendix C) of the group sessions follows:

Week 1:Introduction to group and to the ground rules for group process.

Week 2:Normal adult development.

Physical and psychological aspects of aging.

Week 3:Active listening

Week 4:Listening to the elderly.

Summary and termination.

Self-rating Depression Scale (SDS)

Zung (1974) developed this scale to be used as a measure of depression. The items of the the SDS (Appendix B) were drawn from a large pool of signs and symptoms of depression; no one theory of depression was used as a basis for item development. The measure was tested on 152 inpatients and 73 outpatients (Zung, 1972). Split-half (odd-even) reliability for the SDS was $r = 0.73$ ($p \leq 0.01$). Concurrent validity ($r = 0.70$) was measured by a correlation with the Minnesota Multiphasic Inventory Depression subscale.

The SDS is a 20-item, self-rating scale which contains common characteristics of depression divided into catagories of: affective disturbances, physiological disorders, psychomotor, and psychological disturbances. An item is, "I feel hopeful about the future." Categories that may be checked follow each item with responses of:

1=none or little of the time.

2=some of the time.

3=a good deal of the time.

4=most or all of the time.

A value of 1, 2, 3, or 4 is assigned to the response dependent upon whether or not it has positive or negative wording.

Data Collection

After a systematic sample of 30 subjects was selected, 15 were randomly assigned to experimental group and the remaining 15 composed the control group. Then each elderly mother was sent via the United States Postal Service a deck of Concerns of Aging cards with instructions to place them in their order of importance. In addition, each mother was asked to complete the communication sheet that accompanied the deck by checking the appropriate box. A self-addressed stamped envelope was included in which the completed packet could be returned.

The adult daughters were sent a packet of materials prior to the first group session. The packet included the following items: a cover letter (Appendix F), the CAS deck with communication checklist, the Self-rating Depression Scale, and the Norbeck Social Support Scale. In the cover letter the daughter were thanked for agreeing to attend the sessions and it asked her to complete the questionnaires in the packet. The control group was instructed to return the packet in the enclosed

envelope. The experimental group was asked to bring the questionnaires to the first group session.

The experimental group met weekly for the next four weeks in the Role Supplementation Group led by nurse co-leaders. At the conclusion of the group, experimental and control groups were sent a packet similar to the first, with the exception of the NSSQ, and asked to again complete the questionnaires. Follow-up reminder postcards were made to each subject in an effort increase the rate of return.

After all data were collected from the two groups, instruments were scored and data analyzed. The control group were invited to participate in sessions similar to those the experimental group attended.

Treatment of Data

Data obtained from the demographic data sheet on the NSSQ were analyzed to describe the sample of daughters by using frequency distributions, tables, and measures of central tendency and variablity. The independent variable, role supplementation, was measured at the nominal level of measurement; the experimental group received role supplementation and the control group did not. Social support, the second independent variable, was measured at the ordinal level of measurement, however

in this case it served only as a means to classify subjects. Both dependent variables,the SDS and the CAS deck, yielded ordinal level data. For ordinal data, the median was calculated for the measure of central tendency; the range was reported for a measure of variability.

Each hypothesis was tested using inferential statistics. These were :

1. The adult child who exhibited high levels of social support and who received nursing support in the form of role supplementation will demonstrate less perceived role insufficiency. All daughters were separated into the categories of low and high social support by using the middle number of subjects' composite Total Functional scores as the division line. The treatment, Role Supplementation Group, was applied to the experimental group of adult daughters; scores on the SDS were obtained before and after the treatment. The SDS was used as the quantitative measure of role insufficiency. By violating the assumption of continuous data, the hypothesis was tested with a parametric test, the two-way analysis of variance. The decision rule for this hypothesis was to reject if $p \leq .05$.

2.The adult child who exhibited high levels of social support and who received role supplementation as a form of nursing support will demonstrate higher levels of role adaptation. Mean rankings for each concern was computed and used to create summative rank orders. The rankings of adult child and elderly parent were then correlated with the Spearman Rank correlation coefficient, rho, a nonparametric test of relationship. A two-way analysis of covariance was completed by using the difference between mother and daughter scores as a measure of the dependent variable, role adaptation. Social support served as the covariate in this case by using the Total Functional score divided by the number of people listed in the social network.

Both sets of data analysis were conducted. The results were displayed in appropriate tables and frequency distributions. Alpha was set at: $p \leq .05$ for all tests of significance.

Summary

In this chapter the method to be used in the study to collect the data and the manner in which the data were analyzed was described. Two groups of adult child-elderly parent dyads were randomly assigned to experimental and control groups. After demographic data

were collected for both groups, nursing support in the form of role supplementation was given to the experimental group. Postintervention data was collected after the treatment was administered and analyzed according to guidelines set forth in this chapter. The results were tabulated to test the hypotheses of this explanatory, cross-sectional, experimental study. The results were described in Chapter IV of this paper.

CHAPTER IV

ANALYSIS OF DATA

This study was undertaken to determine the effectiveness of a role supplementation group as a method of providing transitional nursing support for adult working women with potential parental care responsibilities. The purpose was to investigate if new information facilitated role transition to parental caregiver. The major hypotheses were:

> Hypothesis 1: the adult child who exhibits high levels of social support and who receives role supplementation as a form of nursing support will demonstrate less perceived role insufficiency and, Hypothesis 2: the adult child who exhibits high levels of social support and who receives role supplementation as a form of nursing support will demonstrate higher levels of role adaptation.

Data were collected from a sample of 30 women who worked at a major health sciences center in a small Southern city. Twenty-two subjects actually completed the study. Descriptive techniques such as frequencies,

means, and standard deviations were used to summarize the demographic variables. Total scores were calculated for the following variables: social support, role insufficiency, and role adaptation. Median scores and the ranges of variation were used to describe the these total scores. Analyses of variance and covariance were used to test the hypotheses.

Description of the Sample

The 22 women who completed the study varied in age from 30 to 60 years with a mean age of 40.18 years and a standard deviation 8.43 years. Ten (45%) of the subjects fell within the 30 to 35 years age bracket. The next largest group 5, (23%) were between the ages of 46 to 50 years (Table 1). Of the 22 women in the sample, 13 (59%) were currently married. The rest of the women 9, (41%) were single never married, divorced, or widowed (Table 1).

Table 1
Characteristics of the Sample on Variables of Age and Marital Status

Characteristic	Frequency	Per Cent
Age		
30-35	10	45%
36-40	3	14%
41-45	2	9%
46-50	5	23%
51-55	1	5%
56-60	1	5%
Total	22	100%
Marital Status		
Married	13	59%
Single	4	18%
Divorced	4	18%
Widowed	1	5%
Total	22	100%

The sample differed from each other on the variables of education and ethnicity. The mean years of education for the sample was 15.72 with a standard deviation of 2.87. Length of education varied among the subjects from 12 to 21 years. Eleven (50%) of the group had obtained a

high school education with some college, while the other eleven (50%) had earned Bachelors and Masters degrees (Table 2). Eighteen (81%) of the sample were caucasian with the rest of the group divided among native American, Black, and hispanic ethnic groups (Table 2).

Table 2
Characteristics of the Sample
on Variables of Education and Ethinicity

Characteristic	Frequency	Per Cent
Education		
12-15	11	50%
16-21	11	50%
Total	22	100%
Ethicity		
Caucasian	18	81%
Black	1	5%
Hispanic	1	5%
Native American	2	9%
Total	22	100%

The following criteria for inclusion in the study were also met. All of the subjects worked full time in the hospitals and colleges of the health sciences center. Each subject lived separately from her mother. All

subjects, mothers and daughters, spoke and read English.

The demographic data were summarized for both experimental and control groups. The mean ages of the experimental and control groups were 42.2 and 38.5 years respectively. Subjects in the experimental group varied in age from 30 to 60 years while control group subjects' ages were from 31 to 50 years. Length of education varied in the experimental group from 12 years to 19 years, while the mean length of education for this group was 15 years. The control group mean for length of education was 15.58 years, with subjects with educational background from 12 to 21 years in length.

Experimental and control groups varied on the characteristics of marital status and ethnicity. Five (50%) of the subjects in the experimental group were married as were 8 (67%) of the control group. The experimental group consisted of more single never married women, while the control group had more divorced members (Table 3).

Table 3
Marital Status of Experimental and Control Groups

Characteristics	Experimental (N=15) f	%	Control (N=15) f	%
Marital Status				
Married	5	50	3	25
Single	3	30	1	8
Divorced	1	10	8	67
Widowed	1	10	0	0
Total	10	100	12	100

Seven (70%) of the experimental and 11 (92%) of the control group members were caucasian. The experimental group contained one (10%) Hispanic and one (10%) Black subject. Both groups included one native American (Table 4).

Table 4
Ethinicity of Experimental and Control Groups

Characteristic	Experimental f	Experimental %	Control f	Control %
Ethinicity				
Caucasian	7	70	11	92
Black	1	10	1	8
Hispanic	1	10	0	0
Native American	1	10	0	0
Total	10	100	12	100

Findings

The scores for social support, role insufficiency, and role adaptation were calculated and statistically analyzed. The median, mode, and range were computed for each variable.

Social Support

Social support is a general feeling or attitude of belonging and being valued by one's social group. The score on the Norbeck Social Support Questionnaire was used to indicate the level of social support for each subject. The Total Functional Variable, a composite score of the aid, affect, and affirmation subscales of the Norbeck Social Support Questionnaire (NSSQ), was used

as the numerical representation of social support in this study. For hypothesis number two, social support was further analyzed to determine the quality of support independent of the number of supporters by dividing the Total Functional Variable by the number of persons in the social network. A similar manipulation of data was suggested by Norbeck and colleagues (1983) who found that composite variable scores should not be used if it is possible that an effect is primarily due to one subscale or its interaction term.

For Total Functional Variable the subjects in this study had a mean score of 284 with scores varying from a low of 78 to to a high of 485 (Table 5).

Table 5
Mean, Low, and High Scores for the NSSQ

Subjects	NSSQ
Total Sample	
M	284
Low	78
High	300
Experimental	
M	195
Low	78
High	450
Control	
M	300
Low	162
High	485

The mean score of the experimental group was 195 while the scores varied from a small social support system of 78 to an extensive system of 450. The mean score of the control group was much higher at 300 and the subjects' scores varied from 162 to 485. The set of persons on whom the subject relies for support is represented by the number of people listed in the Personal Network section of the NSSQ. Study subjects identified an average of 11.95 people in their social networks; the number of supportive persons listed varied from 24 people in the network to 3. The mean score representing the Personal Network of the experimental subjects was 9.9 people with as many as 17 and as few as 3 supportive persons identified. The control group mean for Personal Network was 13.82 while their reported networks varied from 8 to 24 members.

Norbeck and colleagues (1983) reported normative data for males and females in work roles. The mean score for the Total Functional Variable for 89 working women was 281.18 with score variations from 43 to 567. In addition, they reported mean network figures for this same group as 12.39; scores varied from 2 to 20 network members. The study sample (mean=284) for the research project on adaptation to the caregiver role did not

differ greatly from Norbeck's subjects (mean=281) on Total Functional Variable nor on Personal Network scores for Norbeck's sample the network mean was 12.39 for the caregiver sample the mean was 11.95.

When the score for the Total Functional Variable was divided by the number in the network, a truer picture of perceived support was observed. Norbeck and colleagues (1983) stated that support is both a function of quality of support represented by Total Functional Variable score and the number listed in the network represented by the Personal Network score. Therefore, the quality of support independent of the number of supporters must be determined. The quantitative representation of perceived quality of social support for Norbeck's sample was 23.52 and for the caregiver sample it was 22.92. The difference this analysis makes can be seen in the following example. If a subject's Total Functional Variable score is 78, the social support appears very sparse, however if the number of people in the Personal Network is 3, the divided score of 26 indicates one of the higher levels of social support for the group.

Role Adaptation

Role adaptation is a two step process which begins with assuming the role of another person; this part of

the process similar to the concept of empathy. The second step in role adaptation involves creating one's own role through interpretation of the information obtained in the first step of the process. The Brackley Concerns of Aging Scale (CAS) was used to operationally define role adaptation in this study. The CAS is composed of 19 items in which subjects rank each item as to its relative importance from the mother's point of view. The daughter subjects then indicate which items had been discussed with their mothers and the mother subjects indicate items discussed with their daughters (Table 6).

Table 6
Median, Mode, and Range Percentage of Items Discussed on the CAS

	Median	Mode	Range
Total Sample	58	58	26-100
Experimental	58	58	26-100
Control	58	58 79	26- 95

For each mother-daughter pair, three correlation coefficients were calculated. A Spearman Rho for each daughter before and after treatment was calculated, as were coefficients for the pretreatment daughter score

with the mother's score and the postreatment daughter score with the mother's score. Spearman correlation coefficients are displayed in Table 7.

Table 7
Spearman Rank Order Correlation Coefficients for Concerns of Aging Scale

Pre/Post Daughter Scores	Median	Range
All SS	0.637	0.94-.161
Exper.	0.530	0.94-.161
Con	0.676	0.83-.295
Pre Daughter Score with Mother's Ranks		
All SS	0.551	0.825-.075
Exper	0.218	0.614-.075
Control	0.599	0.825-.124
Post Daughter Ranks with Mother's Ranked Concerns		
All SS	0.417	0.730-.022
Exper	0.415	0.641-.040
Control	0.519	0.730-.022

Role Insufficiency

Role insufficiency is the perception that one's performance of a role is inadequate. The Self-rating Depression Scale (SDS) developed by Zung (1965) was used

as the measure of role insufficiency in this study. At the beginning of the study the scores on the SDS for the total sample varied from 38 to 54 with a median score of 45 and a mode of 50 (Table 8).

Table 8
Median, Mode, and Range for SDS

	Median	Mode	Range
Total Sample	45	50	38-54
Experimental	45	42 45	38-53
Control	48	50	41-54

A score of 49 or below on the SDS is considered normal while scores between 50 and 59 are considered to indicate mild or moderate depression (Zung, 1974). At the beginning of this study, seven subjects scored within the mild depression range and at the end of the study, five of the seven scored again in this range. Five of the mildly depressed subjects were included in the control group, while the remaining two were experimental subjects. After treatment, depressed experimental subjects' scores did not change, while among the depressed control subjects one increased, three decreased, and one remained unchanged. Two of the normal control subjects and one of the experimental subjects

became mildly depressed at the end of the study (Table 9).

Table 9
SDS Scores of Depressed Experimental and Control Subjects Pre/Post Treatment

	Pretreatment	Postreatment
Control		
Subject A	50	50
B	52	47
C	50	47
D	43	56
E	48	50
F	54	56
Experimental		
Subject A	45	50
B	53	53
C	50	50

All of the mild to moderate depressed subjects had specific reasons to explain why they were depressed. All refused offers by the researcher for referral to appropriate resources for treatment.

Hypotheses Testing

Two hypotheses were tested for significance. Hypothesis 1 was:

> The adult child who exhibits high levels of social support and who receives nursing support in the form of role supplementation will demonstrate less perceived role insufficiency.

All daughters were separated into the categories of low and high social support by using the median score on the Norbeck Social Support Questionnaire as the division. The treatment, Role Supplementation, was given to the experimental group of adult daughters; scores on the SDS were obtained before and after the treatment. The SDS was used as the quantitative measure of role insufficiency. A two-way analysis of variance with $p \leq .05$ was used to test the hypothesis.

No significant differences in perceived role insufficiency were found between women with high or low levels of social support and between those who received or did not receive role supplementation. A two-way analysis of variance yielded a calculated F value of 0.90 ($p \geq .05$) between the group who had role supplementation and the group who received no role supplementation. Social support, as the source of

variance, produced F =0.90, while the interaction between role supplementation and social support, yielded F =0.11. Thus, no support was found for Hypothesis 1. The small sample size of this study might have failed to produce a significant difference in the finding if one exists. The results are displayed in Table 10.

Table 10
Two-way Analysis of Variance for Role Insufficiency by Group and Level of Social Support

Source of Variance	Sum of Squares	DF	Mean Square	F	Prob
Social Support	8.296	1	8.296	0.90	0.3556
Group	8.296	1	8.296	0.90	0.3556
Interaction	1.024	1	1.024	0.11	0.7429
Error	166.133	18	9.229		

* Significant F =4.41, $p \leq .05$

The second hypothesis was:

2) The adult child who exhibited high levels of social support and who received role supplementation as a form of nursing support will demonstrate higher levels of role adaptation. Mean rankings for each concern were computed and used to create summative rank orders. The rankings of the adult child and the elderly parent were then correlated with the Spearman Rank correlation

coefficient, rho, a nonparametric test of relationship. The rho coefficients were used as the dependent variable in a two-way analysis of covariance. A significant relationship between role adaptation and role supplementation group when social support is viewed as a covariant was discovered as shown in Table 11.

Table 11
Two-way Analysis of Covariance for Role Adaptation by Group

Source of Variance	Sum of Squares	DF	Mean Squares	F	Prob
Group	0.23073	1	0.23073	4.58*	0.049
1st Covar	0.24421	1	0.24421	4.85*	0.044
Error	0.75599	15	0.05040		
R	0.00085	1	0.00085	0.05	0.825
RG	0.00852	1	0.00852	0.50	0.488

* Significant F =4.41

Summary

In summary, the data were calculated and displayed in tables in this chapter. No support was found for the hypothesis of this study which predicted a decrease in role insufficiency following a role supplementation group for working adult women with potential caregiving

responsibilities. If the sample size had been larger, a difference might have been found. A significant relationship was found for role adaptation and role supplementation group as specified in Hypothesis 2. The findings and implications of this study will be explored in Chapter V.

CHAPTER V

SUMMARY OF THE STUDY

In this study the hypotheses under investigation were:

1) The adult child who exhibits high levels of social support and who receives role supplementation as a form of nursing support will demonstrate less perceived role insufficiency;

2) the adult child who exhibits high levels of social support and who receives role supplementation as a form of nursing support will demonstrate higher levels of role adaptation.

The ultimate purpose was to determine the effectiveness of a role supplementation group for facilitating role adaptation and preventing role insufficiency in midlife women faced with care for their elderly parents.

Summary

A random sample of women who were employed at a state health sciences center was selected from the directory of faculty and staff of that institution. The 30 women who met the criteria and agreed to participate

in the study were randomly assigned to experimental and control groups; 22 subjects completed the data collection process. After baseline data collection was completed, ten women assigned to the experimental group attended the role supplementaion group. At the completion of the group experience, all subjects completed the posttest data. No support was discovered for Hypothesis 1 which predicted a decrease in role insufficiency for those subjects who received role supplementation. Support was found for Hypothesis 2 which specified increased levels of role adaptation for women who received role supplementation.

These findings are discussed in the next section.

Discussion of Findings

Midlife women who exhibited high levels of social support and who recieved role supplementation did not have significantly decreased levels of perceived role insufficiency as predicted by Hypothesis 1 in this study. This finding was not unexpected. Even though Steuer (1984) warned of the potential negative effects of raising awareness of the caregiver's plight through educational and support groups, harmful effects of group interventions with caregivers have not been reported in the literature. Steuer (1984) wrote that denial is the

primary defense mechanism caregivers use to continue to meet uncomfortable role demands. When they develop insight into their present situation depression and other harmful effects might occur. Hypothesis 1 of this study was a test of this supposition. Although no significant decrease in role insufficiency was found in the subjects, it should be noted that no significant increase occurred either.

When the effects of social support were removed from the dependent variable role adaptation, the subjects that received role supplementation had higher levels of role adaptation than those subjects who received no role supplementation. Support for Hypothesis 2 was an expected finding both from a theoretical perspective (Meleis, 1975) and from a review of published literature (Pierskalla & Heald, 1982). Meleis (1975) wrote that role supplementation during periods of role transition was one form of nursing support available to nurses in assisting clients with role adaptation. This strategy appears to be effective for the suggested purpose.

When Lazarus and his colleagues (1981) conducted group sessions with relatives of elderly Alzheimer's patients, they identified three goals the families hoped to achieve. These goals were to find help; to find new

ways of relating to their loved ones; and new ways of coping with problems. The approach used in the role supplementation group in the present study focused on communication and problem solving. Role supplementation was found to be an effective means of increasing understanding between mothers and adult daughters as aging occurs.

Clark and Rakowski (1983) stated that since so few empirical and experimental studies exist, direction is lacking in structuring of educational and support groups. Gaps in published literature identified included lack of an "essential core of content" and an unspecified "crucial time" for such groups (p.641). One independent variable of this project, the role supplementation group, was patterned after groups found in published literature (Cohen, 1983; Clark & Rakowski, 1983) and the content was found effective in facilitating role adaptation. Furthermore, the role supplementation group was presented to women before they adopted the primary caregiver role as a facilitative strategy for role adaptation and it was found to be an effective tool for this purpose.

Conclusions and Implications

Transition support was found to be an effective strategy for facilitating role adaptation in women with

potential parental care responsibilities. Additionally, while role insufficiency was not decreased through the use of transition support, its effects were not increased either. These findings of this study were:

1. Role insufficiency was not decreased in subjects who received role supplementation and who exhibited high levels of social support

2. The level of role adaptation was increased in subjects who received role supplementation.

These findings have implications for theory development and testing.

Implications for Theory Development and Nursing Practice

From a theoretical prespective, the relationship of transition support to role adaptation during role transition was demonstrated. This finding supports the notion that role transition can be anticipated and that transition support can be effective in role adaptation. Furthermore, specific supportive actions of the nurse were identified as those of role supplementation group leader. The fact that increasing awareness through role supplementation did not increase role insufficiency seems relevant, but due to the small sample size further testing with larger samples is necessary before conclusions can be drawn.

With regard to nursing practice, several implications have relevance in the areas of program development and implementation and advocacy. Nurses practicing among the elderly should be aware of their family support systems. These family supporters should be offered support services aimed at decreasing the stresses attached to the caregiving situation. The following recommendations are made for nursing practice:

1. The influence of family support on the care of elderly persons should be included in curricula of nursing schools.
2. Role supplementation groups for families involved in parent care can be implemented by professional nurses. The need for supportive family care will probably increase as the population of persons over 75 years of age increases in the 1990's.

Additional recommendations were derived from working with employed in the role supplementation group:

1. Professional nurses who work with groups of midlife adult women should attempt to educate them about community resources available to them as an adjunct to caregiving. Many resources remain unused because people are unaware of them.
2. Nurses need to raise awareness among industries about

the need for flexible work schedules for women with child and parent care responsibilities.

3. Nurses should lobby for legitimization of family care for the elderly population and improvement of services to families.

Through further research and sensitive practice with families caring for elderly members, nurses can contribute to improved care for such groups and can foster health-promoting relationships among family members.

Recommendations for Further Study

Several recommendations have evolved from the current investigation and are presented as they relate to the research design, analysis of the data, further study, and nursing practice.

1. Develop and test an instrument which more closely measures role adaptation in the role of the caregiver and the counterrole of the care recipient.

2. Develop and test an instrument that predicts role transition awareness in both role partners. Such an instrument should aid in definition of the critical times for nursing interventions aimed at role supplementation.

3. Include role partners, adult daughters and aging mothers, in the same group for role supplementation. To

evaluate impact on role transition and would facilitate improved communication between the caregiver and care recipient.

4. Correlate CAS and SDS scores with demographic characteristics of age, marital status, education, and ethnicity. Patterns may emerge that have predictive value for further research.

5. Replicate the study with a larger sample; minorities, other income groups; and women at the beginning of a caregiving relationship. These replications might lead to predictions of differences among various groups.

6. Repeat the study with mothers and daughters who have been in a caregiving relationship. Validation of content and the effects on caregiving might emerge.

7. Repeat the study with caregivers at various staging of caregiving. The critical time elements might be identified in this manner.

8. Teach the educational portion of the group experience in a four week period, then instruct subjects to practice the skills of active listening for four weeks and meet at the end of that period for reevaluation of learning.

APPENDICES

APPENDIX A

Concerns of Aging

INSTRUCTIONS:The statements that follow are the same statements that you have just arranged in their order of importance to your mother. Please check the box that follows each statement either "yes, my mother and I have discussed her feelings on this topic" or "no, my mother and I have not discussed how she feels about this topic".

Statement	yes	no
My mother wants to:		
Be important to family and friends.	___	___
Have others ask her opinion.	___	___
Maintain her family ties.	___	___
Determine what happens to her.	___	___
Be financially independent.	___	___
Be happy.	___	___
Take care of herself.	___	___
Be healthy.	___	___
Be involved.	___	___
Be satisfied with her life.	___	___
Avoid loneliness.	___	___
Avoid isolation.	___	___
Keep her loved ones.	___	___
Maintain her position in the community.	___	___
Pay her own way.	___	___
Avoid becoming a burden on others.	___	___
Be able to ask her family for help when she needs it.	___	___
Be able to help her family.	___	___
Maintain her level of activity.	___	___

INSTRUCTIONS:The statements that follow are the same statements that you have just arranged in their order of importance to you. Please check the box that follows each statement either "yes, my daughter and I have discussed my feelings on this topic" or "no, my daughter and I have not discussed how I feel about this topic".

Statement	yes	no
It is important for me to:		
Be important to family and friends.	___	___
Have others ask my opinion.	___	___
Maintain my family ties.	___	___
Determine what happens to me.	___	___
Be financially independent.	___	___
Be happy.	___	___
Take care of myself.	___	___
Be healthy.	___	___
Be involved.	___	___
Be satisfied with my life.	___	___
Avoid loneliness.	___	___
Avoid isolation.	___	___
Keep my loved ones.	___	___
Maintain my position in the community.	___	___
Pay my own way.	___	___
Avoid becoming a burden on others.	___	___
Be able to ask my family for help when I need it.	___	___
Be able to help my family.	___	___
Maintain my level of activity.	___	___

APPENDIX B

Self-rating Depression Scale

SELF-RATING DEPRESSION SCALE

Directions: Place an X in the space that most describes you.

	A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex.				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

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APPENDIX C

Role Supplementation Group

Week 1:Introduction to group and to the groundrules for group process.

I. Purpose of session:

A. to introduce subjects to the group

B. to introduce the subjects to each other

C. to agree to some guidelines for the group

D. to begin to establish mutual trust and support

II. Introduction:

A. name tags were given to subjects as they arrived; the co-leaders wore name tags, too

B. the group session began when the leader welcomed the members and asked them to introduce themselves and to briefly describe their relationships with their mothers

C. subjects each spent approximately two minutes introducing themselves and briefly describing the relationship

D. the leader asked for a discussion about groundrules for the group; confidentiality was used as an example of a groundrule. Agreement was reached about group guidelines; these were:

1.subjects agreed to be honest

2.confidentiality would be maintained

3.each subject agreed to attend all sessions

4.group sessions would begin and end on time

III. Content:

A. Woman in the middle

1. population trends- as the quality of our lives has inproved, more and more people are living longer, healthier lives. Women live longer than their male counterparts, therefore there are many more elderly women than elderly men. Chances are that your mothers will live long lives; and chances are at some point you will have to help them with their day to day existence.

2. myth of the "empty nest"- not too long ago magazines and television programs raised the topic of the "empty nest". It was thought that midlife women would have an extended period of time to themselves and husbands. Today, the trend is for adult children to return home because of many factors, school, divorce, unemployment, money. Also, elderly parents may need care. You could be caught in the middle with no time for you. Since all of you work, that leaves even less time just for you.

3. smaller families- also families are smaller than they were at the turn of the century. The trend toward the shrinking family may have left you without brothers or sisters to help with your parents.

IV. Excercise:

A. responsibility tree (see attached)

B. discussion in dyads, then in the group

V. Summary

Week 2:Part 1-Normal adult development

I. Purpose of session:

A. to acquaint the subject to the aging process

B. to continue to develop trust within the group

II. Sharing:

A. each subject was given the opportunity to share what happen in response to the last session

B. group input was solicited

III. Content:

A. film:"Everyone Rides the Carousel, Part III" (Pyramid Films)-
a 23 minutes videotape that illustrates with cartoon figures the developmental tasks of elderly prople according to Eric Erickson.

IV. Group Process:

A. discussed ways in which the film illustrated the subject's mother's aging

Part 2:Death and dying

I. Purpose of session:

A. to explore feelings of grief and loss experienced by not only the subject's aging mother, but also by the subject

B. to facilitate sharing feelings within the group

II. Sharing:

A. discussed new awareness of aging that might have occurred during the week

B. discussed other feelings that have surfaced in the group

III. Content:

A. stages of grief

B. impact of multiple losses

C. physical symptoms of unresolved grief

D. awareness of parental aging as reminder of personal aging

IV. Experience:

A. discussed losses mother's have experienced

B. discussed losses subject's have endured

C. discussed any feelings of loss subject's experienced with regards to the mother

V. Summary

Week 3:Communication Skills

I. Purpose of the session

A. to build skill in active listening

B. to strenghten communication between the adult daughter and the aging mother

II. Content

Chapter II of Help for families of the aging:A small group seminar was covered. The content designated for group members to read was read by the leaders. Audiocassettes selections were played at the places indicated. Group discussion followed the chapter outline (see attached).

Week 4:Active Listening with Elderly Parents

I. Purpose of session

A. to build on the skills identified in the last session

B. to role play active listening to parents

II.Content

Chapter III of Help for families of the aging:A small group seminar was covered. Content to be read by group members was read by the leaders. Audiocassette selections were played at the designated time. Discussion followed the chapter outline (see attached).

The fastest-growing segment of the U.S. population is "85 and above". We are facing a new situation in human history. A generation ago most old people were at the top of a pyramid supported by numbers of sons, daughters, in-laws, and grandchildren. Now many of us find ourselves at the bottom of an inverted pyramid, trying with scant help to hold up several aging relatives. No wonder we feel like we are losing our balance!

My Responsibility Tree *Pencil exercise. 15 min.*

To clarify your personal responsibilities and whom you can call on for help, please complete the exercise on the following page. Here are the directions:

1. Each circle represents an individual. Fill in the name of every person in your family who is presently alive. Draw extra circles to represent step-parents, more aunts and uncles, etc.

2. With a color, underline the name of each person for whose emotional welfare you feel responsible.

3. With the same color, underline the name of each person for whose financial welfare you feel responsible; some names may now have two lines under them.

4. With the same color, underline the name of each person whose daily care is your personal responsibility; some names may now have three lines under them. If you have several minor or unmarried children, you may feel less like the tip of a pyramid than the pickle in a sandwich!

5. With another color, underline the name of each person who shares with you an equal or greater part of any of these responsibilities.

6. For how many people younger than you do you feel responsible? _____

7. For how many people in your own generation or "above" do you feel responsible? _____

8. With how many people do you share this responsibility? _____

You have just completed a picture showing why you are feeling under stress. Given your circumstances, perhaps it would be surprising if you were not. Even if you feel responsible for only one elderly person, you may be carrying that responsibility nearly alone.

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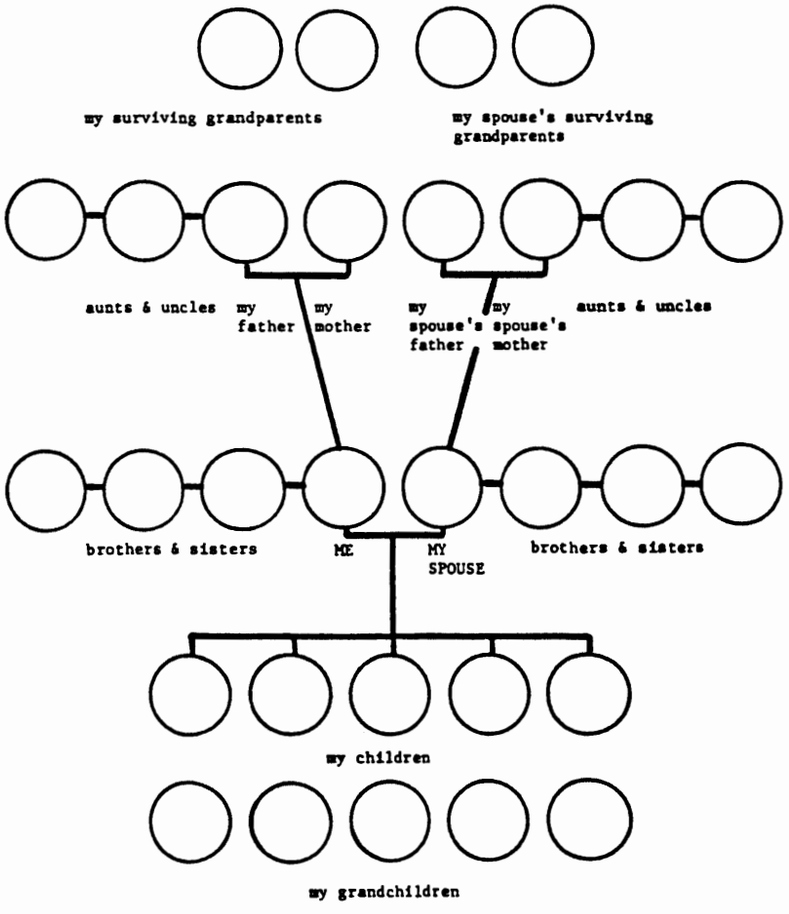
from Help for Families of the Aging
National Support Center for Families of the Aging
P.O. Box 245, Swarthmore, PA 19081

I-3

My Responsibility Tree



II. Learning to Listen

PURPOSE OF THE MEETING

- to continue getting to know each other.
- to learn the skill of Active Listening.

SHARING

5-10 min.

One way to tune people in to how you're feeling is to *tell* them. Would you like to hear how one group sometimes does it?

'Tuning In' *Cassette Selection 2. Please turn on the tape.*

CONTENT

Explanation of Active Listening *Read aloud. 5-10 min.*

First reader

Our task today is to learn the theory of Active Listening, and to begin to practice it. Active Listening is a counseling skill that is helpful to somebody who has a problem. It is a way of reassuring others that you are "there" for them, that you understand what life is like for them right now, that you accept them and are on their side. You cannot, of course, Active Listen someone with whom you are having an argument. While you are arguing you are not on that person's side! Only if you are willing, and able, to set your *own* feelings aside temporarily will you be able to help your friend.

There are times when we need to honor our own feelings and cannot give this attention to another. That's okay, too. Once we possess the skill, we can *decide* when to use it.

The difference between Active Listening and an ordinary conversation is that there is no exchange of views. While Active Listening, you do not respond to your friend's statement with a statement of your own. Instead, you respond by reflecting thoughts

back, so that others become more aware of what they think and feel. That is essentially what each of you did in today's opening exercise. Consequently, you knew that your friends were paying attention; after all, they repeated exactly what had just been said. They couldn't have done that if their minds had been elsewhere, or if they'd been all wrapped up in what *they* were going to say when it was their turn.

Second reader

When you become aware your friend is troubled, begin with Active Listening.

Be Available.

When you want to help a friend, the first thing to do is to make yourself available physically. *Find a quiet place and enough time.* Turn toward your friend until you are *face to face. Lean forward.* Establish *eye contact.* Sometimes it is appropriate to *touch* the other person sympathetically. Let your whole body express your readiness to pay full attention to whatever your friend wants to get off his or her chest.

You could say: "Would you like to tell me about it?"

Third reader

Observe.

Observe your friend. *Focus* on him or her and *resist distractions. Notice* clues to how he or she is feeling. Does he appear tired? Is she blinking back tears? Notice your friend's jaw...hands...voice....

You could say: "You look.....today."

Fourth reader

Listen.

Listen with your heart as well as your ears. *Think* about what life must be like for your friend right now. When you realize that he's doing the best he can in his situation, you'll be able to *be non-judgmental.* Often all that is needed is to *wait quietly, nodding your head.* If he seems stuck, you might want to restate the last idea you heard in an encouraging way. Very skillful listeners are able to paraphrase without adding thoughts of their own, but it is safer for beginners to *repeat exactly* the last few

words their friend said. You may think this will be too "obvious" or that you'll feel silly, but your friend may not really hear his own thoughts and feelings until you do this. Very likely he won't even notice your "technique"; he'll be intent on pinning down his problem. "Oh, so that's what's been bothering me!" It's better not to ask questions, for in so doing you may guide or distract him. Give him the luxury of time to let what is within <u>him</u> come to the surface. This is also much too soon for making suggestions; jumping in to solve the problem will only frustrate your friend. *Avoid giving advice.*

You could say: "To you it seems as if...."
"In other words, you think...."
"I hear you saying that...."

Fifth reader

<u>Respond</u>.

Echo and accept your friend's feelings. Listen with imagination. The actual words may be saying, "I didn't want to go to that picnic anyhow." But the sad face and tone of voice may be indicating disappointment. *Respond to what you perceive the feelings to be.* "You're feeling left out." Respond to the *situation*, too. "You're feeling left out because everyone else has plans for today and you don't." If you're wrong, your friend will tell you. "No, I was just thinking...." *Persevere.* Keep going until you have a good idea what the feelings are. Then *accept* them.

You could say: "I can see that you feel really...."
"You feel...."
"You feel..... because...."
"Is there anything else?"
"I can understand that...."
"I feel.....too when...."
"I don't blame you for feeling...."

Sixth reader

At this point most of us have to bite our tongues to keep from saying, "Why don't you to go the movies? Or invite Cynthia over? Or bake some cookies?"

When a friend is in pain, we're hurting too, and we have a stake in feeling like Successful Helpers. *Don't jump in with advice! Listen!* It's okay for people to have problems. They grow by handling them.

You may be thinking, "Oh. Is that all there is to it?" Well, of course sometimes the problem-solving process goes on from here. Active Listening is only the first step. It is the necessary first step, and it is *hard!* Some of us have been trying to learn this skill for two years and still haven't mastered it! It is so different from the way we "normally" interact with people. We are to be deeply and completely involved with another person--and voice no opinions!

Caution: Please don't jump to conclusions: "Oh, I know what the problem is; that happened to me last year." Expectations can color the way we listen, so that we miss hearing what is really going on. Even asking a question can *direct* a friend's thoughts instead of *revealing* them.

Active Listening Checklist *Read page II-5 silently. 2-3 min.*

'Eavesdropping' *Cassette Selection 3.*

Keep an eye on the checklist as Sue tells her neighbors about one of those common hassles of daily life.

Rating Connie and Alice as Listeners *Pencil exercise 5-10 min.*

If you picked role play A as the more helpful version, you're right. After talking things over with Connie, Sue understood her feelings and problem better. Her conversation with Alice just left her baffled.

Now please rewind Selection 3 and listen to role play A again. Then turn off the cassette and put a plus (+) in column A of the Checklist for every part of the skill you think Connie used.

Replay role play B and put a plus (+) in column B for every part of the skill Alice used.

You may want to talk over your decisions, or glance at Appendix C to see how one of us completed this exercise.

Active Listening Checklist

Did I:	A Connie	B Alice	C	D	E
Make myself available?					
Find a quiet place, enough time?	___	___	___	___	___
Sit face to face?	___	___	___	___	___
Lean forward?	___	___	___	___	___
Make eye contact?	___	___	___	___	___
Touch?	___	___	___	___	___
Observe?					
Focus on my friend?	___	___	___	___	___
Resist distractions?	___	___	___	___	___
Notice body language, tone of voice?.	___	___	___	___	___
Listen?					
Think about what I was hearing?	___	___	___	___	___
Remain non-judgmental?	___	___	___	___	___
Nod Head? Wait quietly?	___	___	___	___	___
Repeat key words or ideas?	___	___	___	___	___
Avoid giving advice?	___	___	___	___	___
Respond?					
Respond to perceived feelings?	___	___	___	___	___
Respond to feelings *and* reasons?	___	___	___	___	___
Persevere?	___	___	___	___	___
Accept?	___	___	___	___	___

By accepting him *where he is*, you enable your friend to go on to other steps of the problem-solving process.

Practicing the Skill of Active Listening *Read aloud. 1-2 min.*

Active Listening is the basic skill used in this seminar. After all, who needs a sympathetic ear more than we do? We will practice today with ordinary problems from daily life, leaving the more emotionally-charged situations with our parents for later.

The basic principle is to be alert to recognize when your friend has a problem and to respond, not from where *you* are, but from where *he* or *she* is.

Practicing the Skill of Active Listening *Pencil exercise. 5-10 min.*

Here are some sample "openers" that might tip you off to the presence of a problem. Check the Active Listening response you would make.

1. Friend: "I don't know what to do. I'd love to apply for that teaching job that was advertised in the Packet—it's a wonderful opportunity—but Joe says a woman's place is in the home."

Listener:

___(a) "Well, for heaven's sake, he ought to be glad you're willing to work; it's great to have two paychecks in the family."

___(b) "You're uncertain about whether or not to apply for that job, even though it appeals to you, because you think Joe might object."

___(c) "Well, *I* never thought a woman should go back to work until her kids are in junior high."

* * *

2. Friend: "My boss says if I won't work Friday nights he'll have to consider giving my job to someone else."

Listener:

___(a) "You sound worried you might lose your job."

___(b) "That man makes me mad! It's time you looked for another position."

___(c) "What's so bad about working Friday nights? You'd still have Saturday nights free."

* * *

3. Friend: "I went to the doctor today and he told me the results of some tests I took last week."

Listener:

___(a) "You go to Dr. Benson, don't you. Is he any good?"

___(b) "Medicine can do wonderful things these days, but the bills are out of sight. It cost us $300 just for Jeannie's wisdom teeth."

___(c) "Do you want to talk about it?"

* * *

When everyone has finished, please read aloud the following Answers and Explanations.

1. I hope you checked response (b). It tells your friend you know how she feels (uncertain) and why (because she'd like the job but Joe might object). It opens the door to further exploration of the subject. Response (a) is certainly coming from where *you* are, not where *she* is. Response (c) is extremely judgmental and would completely block your friend from solving her own problem in her own way.

2. Response (a) is right on target. You accept that your friend is worried and you take the reason seriously. Response (b) jumps the gun; it lays a solution on your friend before he's had time to figure out what the problem is. Response (c) even tells him how he ought to feel about the situation!

3. Response (c) is the only one that acknowledges that your friend might be struggling with a problem. It's a low-key declaration that you are *there* for him if he wants to accept your invitation. What do you bet Listener (c) turned toward his friend, leaned forward, and concentrated on his face; maybe he could tell by the tone of voice that his friend was troubled. Probably Listener (a) kept filing her fingernails and Listener (b) lit a cigarette!

Practicing with Each Other *Triads. 30-50 min.*

You have been observing listeners, noticing whether or not they meet the needs of their friends. Now we want you to divide up into groups of three. (If there are only four or five of you, stay together; if there are six, make two groups; if nine, three groups, etc.) Take turns being the CLIENT (the friend with the problem), the LISTENER, and the COACH(ES).

Everyone should get one turn to be a CLIENT, one turn to be a LISTENER, and one or more turns to be a COACH.

Here's what to do:

CLIENT: Talk about a problem from daily life, one that has nothing to do with aging. It can be a real problem with your kids, your job, or the auto mechanic. Or it can be a made-up one.

LISTENER: Practice Active Listening. You may consult the Checklist before you begin.

COACH(ES): Watch the *listener*, not the client. Do not try to help solve the problem. Do not say anything. (You are permitted to point to a phrase on the checklist.) Your task is to watch the participants and observe whether or not the listener is Active Listening correctly. After four minutes (use a watch or timer) stop the practice and allow the listener to ask for feedback. "Was I leaning forward?" "Was I repeating key words or ideas?" "Anything else?"

Please don't be shy about making suggestions. This skill is difficult at first, and it's no favor to let your friend practice incorrectly. You'll have your turn to receive help, too.

Allow the listening to resume and continue for four more minutes, during which the listener practices with your suggestions in mind.

As each listener finishes a turn, give him or her a minute to fill out column C of the Checklist. Give yourselves a plus (+) for every part of the skill you remembered at least once.

HOW DID IT GO?

Group Discussion. 5-15 min.

Were you able to resist giving advice? It's easy to get "hooked" and feel compelled to offer your superior wisdom, isn't it?

Were you able to stay within time expectations? Takes some self-discipline, doesn't it?

How did it feel to be listened to and know you weren't going to be swamped with opinions and suggestions? Nice, eh?

For homework, practice recognizing when people have problems. Practice Active Listening. Jot down any results you'd like to share.

AFFIRMATION

Read aloud in unison.

We are receptive to new skills and insights.

LETTER

Just to read in private.

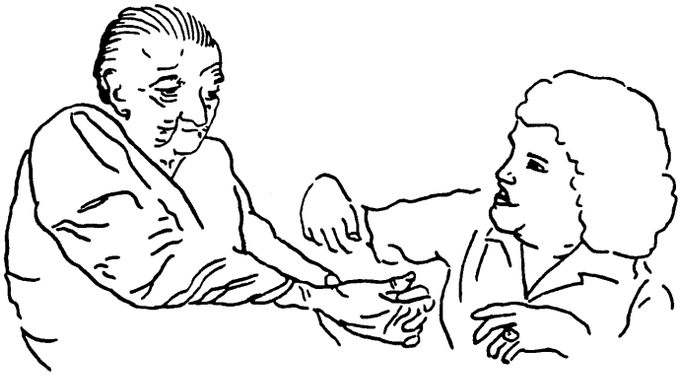
"Although it seems simple (you only have to recognize problems, not solve them), Active Listening isn't easy. In fact, it's hard work to submerge your own views and care completely about another's.

"Nobody can be expected to Active Listen every problem anyone else has! It's a skill that's available when you have the time, the energy, and the desire to help. You have every right to *choose* whether and when to make that gift to someone.

II-10

"It turns out that Active Listening is a wonderful way to get along better with your spouse, your kids, your taxi driver, your boss--even yourself. Yes, I find out what *I* am feeling when I write in my Journal and reread what I say!

"I feel more secure in the world now that I know Active Listening. I'll never have to be lonely and isolated again. Even when I'm an old lady in a nursing home, I'll be able to connect with *somebody*."



III. Listening to the Elderly

PURPOSE OF THE MEETING

- to learn how to show love to our elderly relatives by listening to them and accepting their feelings.
- to consider the importance of touching.
- to get a better understanding of each other's situations.

SHARING

5-10 min.

What happened when you tried Active Listening during the week?

Has anything else come up you'd like to share?

CONTENT

It's Hard to Active Listen Our Parents *Read aloud. 2-3 min.*

Given enough money, it would theoretically be possible to hire somebody to do almost anything for our parents. Almost, but not quite. Nobody else can be *us* for our parents. Nobody else can give them *our* love and *our* moral support.

In the nature of things, old people sustain many losses. Our elderly relatives may have lost jobs, homes, spouses, friends, even their health. They are going to feel sad some of the time--maybe most of the time. If we allow ourselves to empathize with their feelings, it can be pretty painful, especially if we believe we ought to make them happy.

On the other hand, if we avoid facing their feelings, who else in the world can they count on to understand and care?

To Active Listen our parents in their sadness, it is necessary to overcome our own discomfort and pain. When Bea visits her mother in the nursing home and her mother says, "Take me home. I want to go home!" Bea's impulse is to reply out of her own defensiveness, "Now, Mama, you know the doctor says you need to be here.

Besides, I can't take proper care of you at home. I can't even lift you."

Do you think for one minute Bea's mother is going to reply, "Oh, yeah, that's right. I am bedridden and incontinent, aren't I?" Not on your tintype! She's an old lady, sick, and living among strangers. She feels life has stopped. She feels unloved and worthless. She doesn't *want* to understand Bea's problems with the situation. She wants Bea to understand *hers*.

'Visiting Mama' *Cassette Selection 4.*

One way to learn how to respond to the elderly is to practice with each other. Please turn on the cassette and listen to an example. Later in the lesson you will have a chance to practice this way, too.

Expressing Love to the Elderly *Read aloud. 3-5 min.*

First reader

Bea's temptation was to respond out of her own exasperation. But her mother needed Bea to respond to *her* feeling. An Active Listening response to "I want to go home, " might be, "You really want to go home, don't you? I know." At least there's no temptation for Bea to problem-solve for her mother. There really isn't any solution.

What, then, can Bea do to comfort her mother? Probably the most important thing is just to *be there* for her. It would be easier for Bea to distract herself by talking to her mother's roommate, fussing with the flowers, or having a conversation with the nursing assistant--anything rather than paying attention to her mother's pain. But Bea's full attention is what her mother needs, especially when she's feeling scared and cranky. When Bea takes her hand, looks her in the eye, and repeats word for word, her mother knows she's been heard; she's *sure* Bea *understands*.

Second reader

Physical affection is another gift Bea can offer. As the other senses dim, touching becomes more important to old people. Even in families who have never been particularly demonstrative, hugging, kissing, and hand-holding can become immensely valuable

means of showing love to the elderly. If touching is not in your relative's present range of behavior, you will have to be the one to initiate it. You may be rebuffed a few times. Hang in there! Almost all older people come to appreciate love expressed through physical contact. When you sit facing your mother and take her hand, it helps her focus on you. You may even find, to your surprise, that she covers your hand with her other one and hangs on for dear life! People *need* affectionate touching; it's emotional vitamins. Don't you, yourself, love to hug a sleepy baby or pet a kitten?

Third reader

If this is a new idea to you and your relative, you might want to begin by brushing her hair or offering an arm when walking together. Many an older person who ambulates perfectly well enjoys the excuse to take an arm or hold your hand. It comforts her that, for the moment at least, she's really "got" you.

You, on the other hand, may find the feeling of "being got" unbearable. When we are under severe emotional pressure from our parent, we can't *stand* being "clutched". We're feeling too clutched already! In that case, experiment with a shoulder rub. You'll be in control and able to back away when you want to.

We're not telling you that you *have* to touch your parent. There may be reasons why you cringe. The last thing we want to do is lay another burden on you. Maybe you just don't have the inner resources to respond to that need right now. As you continue working through these lessons, and as you begin to regain control of your life, we hope you'll try touching as a very effective way of showing love to your aging relative.

'Responding to the Elderly, Part I' *Cassette Selection 5.*

Please turn on the cassette. The elderly people you'll hear agreed to share their thoughts with you who are studying these lessons. They are speaking, not from scripts, but from their own loving hearts.

III-4

Active Listening the Elderly *Read aloud. 4-6 min.*

First reader

As you heard Selection 5, were you aware of how *little* the listener spoke? She said, "mmmh" and "oh" and "really". She chuckled. Once she interrupted (thereby proving that you don't have to master the skill perfectly to be effective). She didn't say much. It wasn't necessary.

If she *had* guided the interviews--by asking questions, for example--she probably wouldn't have found out what was really on the speakers' minds.

These interviews proved somewhat surprising to Jane. In each instance, she had asked the speaker to talk about what life is like for him or her right now. Except for June, whose memory is weak, what she got was some attention to the present mixed with a lot of reminiscing. Apparently, when one is old and still alert, the past is as interesting as the present. And why not? One theory even suggests that Life Review is an important task of old age. Isn't it wonderful that we, as listeners, can facilitate it--and enrich ourselves at the same time!

Second reader

A side effect of the interviewing was that Jane found herself *appreciating* the speakers on new levels. She'd never known Edna as a young mother. Suddenly she was picturing her with a bossy live-in mother and four children--including twins! The two of them *connected* as they never had before, and Jane found she admired, respected, and loved Edna in a new way.

And what a gift Jane's mother-in-law gave her when she said, "Oh, you're wonderful." June can't remember much any more, but she felt supported and understood, and she was kind enough to say so.

Third reader

One of our nurturing impulses is to protect both our children and our aging loved ones from sorrow or unpleasantness. We think we are avoiding talking about loss and death for *their* sakes. Sometimes, however, loss and death are, in fact, part of their experience. They may need to retell what happened and share what it means to them. Months after the event they may open their hearts, and we may find ourselves participating deeply, intimately in their interpretation of life. Learning to share such moments of closeness blesses us beyond measure.

'Responding to the Elderly, Part II' *Cassette Selection 6.*

Because recording conditions were poor, and because the speaker's voice dropped when he spoke from the heart, we've transcribed the last selection here:

"Well, I miss my wife so much. Dear Dorothy! She was a wonderful woman."

"Mm-hmmm....yeah. It's been kinda lonesome with her gone, hasn't it?"

"Oh, yes. Yes. Yes. But I'm glad she didn't have to suffer any longer in the condition she was in...at the time. She...she died on New Year's Eve of 1980 and that was the time when we had that....well, all over the country, that flu or virus epidemic. And we were quarantined here, and I had...."

"You were sick, weren't you?"

"Yes, about three weeks, two weeks anyway, and I was in bed. I couldn't go to see her at the last...."

"Oh."

"And..."

"That was too bad."

"I never saw her after...even after she died. So...."

"You never got your chance to really say good-bye."

"No...no."

"Mm-hmmm."

"I had been going to see her three times a day...and...always, in the evening, she liked me to rub her forehead. She said, 'I'm sure that even when I was dying I would recognize your hand on my forehead,' and..."

"Oh."

"I never had a chance."

"But your hand wasn't able to be there."

"No....no."

Listening to Each Others' Parents *Read aloud. Triads. 20-30 min.*

Do you remember how you practiced Active Listening in Triads last week? (See page II-8.) You will do a similar exercise now, except that you will play the part of your own aging relative and your friend will play "you".

There are two reasons for this exercise. One is that it gives each of you "hands on" practice in Active Listening the elderly. Remember you are to keep going until you get an idea what the real feeling is, then accept it.

The other reason for the exercise is that it gives each of you a chance to share just what it is you're trying to cope with. When your friends "see" your parent (as enacted by you) it will absolutely solidify their support of you!

Divide again into small groups, going with the people you know the least. Each group should have one "Parent", one "Adult Child", and one or more "Observers".

With timer or watch in hand, the Observer is to watch the Child for two minutes, then stop the practice and allow the Child to ask for feedback and coaching. Then let the listening resume and watch it for two more minutes.

Before you begin, refer again to the Active Listening Checklist on page II-5. As each Child finishes his or her turn, give him a minute to fill out Column D of the Checklist. Give yourselves a plus (+) for every part of the skill you remembered at least once.

Take turns so that each person gets a chance to play all three parts.

HOW DID IT GO?

Group Discussion. 15-20 min.

Did you get a better idea of what others in your triad are dealing with? Would you be willing to trade situations?

Did you have an almost irresistable urge to stop Active Listening or Observing and give advice, to solve each other's problems? It is hard to give our friends the luxury of experiencing their own pain when we are experiencing it with them, isn't it?

Were you able to communicate understanding and caring to the old person? Did you have to force yourself to do it? Did you have to set aside some of your own feelings?

How did you feel towards your own parent as you were portraying him or her? Did the thought cross your mind that some day *you'll* be that old?

For homework, try Active Listening your aging relative. Experiment a little with touching and see what happens....

AFFIRMATION

Read aloud in unison.

We are open to learning new ways of relating to the elderly.

LETTERS

Read to yourself when you need a little encouragement.

"Eva has been delivering Meals on Wheels. Once a month, instead of taking the meals to people's homes, they bring the elderly together for a "birthday dinner". On one occasion, as Eva was helping Mrs. Jackson into the building, the older woman said, 'You know me well enough by now to call me Millie.'

"'Well,' replied Eva, 'in that case I know you well enough to do this....' and she gave her a big hug.

"To Eva's dismay, Millie Jackson began to cry. The tears ran down her cheeks.

"'Oh. I'm sorry...I didn't mean to hurt you.'

"'Oh, no, my dear. You didn't hurt me. But that's the first hug I've had since my husband died four years ago....'"

* * *

"Sonia came back to the group and reported, 'I finally got up the nerve to touch my mother. She didn't seem to respond at all. But it felt awfully good to *me*.'"

APPENDIX D

Norbeck Social Support Questionnaire

SOCIAL SUPPORT QUESTIONNAIRE

PLEASE READ ALL DIRECTIONS ON THIS PAGE BEFORE STARTING.

Please list each significant person in your life on the right. Consider all the persons who provide personal support for you or who are important to you.

Use only first names or initials, and then indicate the relationship, as in the following example:

Example:

	First Name or Initials	Relationship
1.	MARY T.	FRIEND
2.	BOB	BROTHER
3.	M.T.	MOTHER
4.	SAM	FRIEND
5.	MRS. R.	NEIGHBOR

etc.

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

- spouse or partner
- family members or relatives
- friends
- work or school associates
- neighbors
- health care providers
- counselor or therapist
- minister/priest/rabbi
- other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

© 1980 by Jane S. Norbeck, D.N.Sc.
University of California, San Francisco
Revised 1982

For each person you listed, please answer the following questions by writing in the number that applies.

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 1: How much does this person make you feel liked or loved?	Question 2: How much does this person make you feel respected or admired?
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____
9. _____	9. _____
10. _____	10. _____
11. _____	11. _____
12. _____	12. _____
13. _____	13. _____
14. _____	14. _____
15. _____	15. _____
16. _____	16. _____
17. _____	17. _____
18. _____	18. _____
19. _____	19. _____
20. _____	20. _____
21. _____	21. _____
22. _____	22. _____
23. _____	23. _____
24. _____	24. _____

GO ON TO NEXT PAGE

[7-9] [10-12]

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 3:

How much can you confide in this person?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[13-15]

Question 4:

How much does this person agree with or support your actions or thoughts?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[16-18]

GO ON TO NEXT PAGE

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 5:

If you needed to borrow $10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[19-21]

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

[22-24]

GO ON TO NEXT PAGE

Number _____ [1-4]
Date _____

Question 7:

How long have you known this person?

1 = less than 6 months
2 = 6 to 12 months
3 = 1 to 2 years
4 = 2 to 5 years
5 = more than 5 years

Question 8:

How frequently do you usually have contact with this person? (Phone calls, visits, or letters)

5 = daily
4 = weekly
3 = monthly
2 = a few times a year
1 = once a year or less

PERSONAL NETWORK

	First Name or Initials	Relationship			
1.			[25]	[32]	
2.			[26]	[33]	
3.			[27]	[34]	
4.			[28]	[35]	
5.			[29]	[36]	
6.			[30]	[37]	
7.			[31]	[38]	
8.			[32]	[39]	
9.			[33]	[40]	
10.			[34]	[41]	
11.			[35]	[42]	
12.			[36]	[43]	
13.			[37]	[44]	
14.			[38]	[45]	
15.			[39]	[46]	
16.			[40]	[47]	
17.			[41]	[48]	
18.			[42]	[49]	
19.			[43]	[50]	
20.			[44]	[51]	
21.			[45]	[52]	
22.			[46]	[53]	
23.			[47]	[54]	
24.			[48]	[55]	

[25-27] *PLEASE BE SURE YOU HAVE RATED EACH PERSON ON EVERY QUESTION. GO ON TO THE LAST PAGE.* [28-30] [5-6]

9. During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason? [57]

_____ 0. No
_____ 1. Yes

IF YES:

9a. Please indicate the number of persons from each category who are *no longer available* to you.

_____ spouse or partner	[58]	
_____ family members or relatives	[59-60]	
_____ friends	[61-62]	
_____ work or school associates	[63-64]	
_____ neighbors	[65-66]	
_____ health care providers	[67]	
_____ counselor or therapist	[68]	
_____ minister/priest/rabbi	[69]	
_____ other (specify) _____	[70]	[71-72]

9b. Overall, how much of your support was provided by these people who are no longer available to you? [73]

_____ 0. none at all
_____ 1. a little
_____ 2. a moderate amount
_____ 3. quite a bit
_____ 4. a great deal

Number _____

APPENDIX B

To enable us to compare the results of this study with people from different groups and situations, we would like some additional information about your background. Please complete the following items.

1. AGE _____ [5-6]

2. SEX [7]
   _____ 1. male
   _____ 2. female

3. MARITAL STATUS [8]
   _____ 1. single, never married
   _____ 2. married
   _____ 3. divorced or separated
   _____ 4. widowed

4. EDUCATIONAL LEVEL [9-10]
   What is the highest grade of regular school that you completed? (Circle one)

Grade School								High School				College				Graduate School					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

5. ETHNIC BACKGROUND [11]
   _____ 1. Asian
   _____ 2. Black
   _____ 3. Caucasian
   _____ 4. Hispanic
   _____ 5. Native American
   _____ 6. Other (Specify) _____

6. RELIGIOUS PREFERENCE [12]
   _____ 1. Protestant (Specify) _____
   _____ 2. Catholic
   _____ 3. Jewish
   _____ 4. Other (Specify) _____
   _____ 5. None

7. PARTICIPATION IN RELIGIOUS ACTIVITIES [13]
   _____ 1. Inactive
   _____ 2. Infrequent Participation (1-2 times a year)
   _____ 3. Occasional Participation (about monthly)
   _____ 4. Regular Participation (weekly)

Beverly A. Hall, R.N., Ph.D
Chair
School of Nursing
Department of Mental Health and
Community Nursing
Room N505-Y
San Francisco, California 94143
(415) 666-1504

University of California, San Francisco . . . A Health Sciences Campus

April 5, 1984

Margaret H. Brackley, M.S., R.N.
Route #1, Box 166C8
Galveston, Texas 77551

Dear Ms. Brackley:

Enclosed is the copy of the revised Norbeck Social Support Questionnaire and complete scoring instructions that you requested.

The initial testing and description of the NSSQ was reported in the September/October, 1981 issue of Nursing Research. The January/February, 1983 issue of Nursing Research presents normative data with employed adults, further testing of the instrument's stability and sensitivity, and construct, concurrent, and predictive validity.

A form for requesting permission to use the NSSQ is in Appendix A of the scoring instructions. Should you have additional questions about the use of the NSSQ, please feel free to contact me.

Thank you for your interest in the NSSQ.

Sincerely,
Jane S. Norbeck

Jane S. Norbeck, R.N., D.N.Sc.
Associate Professor

JSN:rl

Enclosures

WILLIAM W.K. ZUNG, M.D.
Professor of Psychiatry
Duke University Medical Center

March 15, 1985

Margaret Brackley
408 Pine Mills Drive
League City, TX 77573

Dear Ms. Brackley:

Per your letter of request dated (undated, received on 3/14/85), you have my permission to use the following scale(s) for the limited and specific purpose of your research as outlined in your letter. This permission good for one time, in English only. Rights granted are nonexclusive. You must include the credit line on all applicable forms and manuscripts where the requested scale(s) is used:

WZ Self-rating Depression Scale (SDS)
© W. Zung, 1965, 1974. All rights reserved.
Reproduced with the permission of the author.

WZ Depression Status Inventory (DSI)
© W. Zung, 1975. All rights reserved.
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____ Self-rating Anxiety Scale (SAS)
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____ Anxiety Status Inventory (ASI)
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____ Self-rating Psychiatric Inventory List (SPIL)
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____ Interviewer-rated Psychiatric Inventory List (IPIL)
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____ Self-rating Pain and Distress Scale (PAD)
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On completion of your project, you agree to send me a copy of your final result and findings, in the form of a report, preprint, or published paper.

Sincerely, William Zung

VETERANS ADMINISTRATION HOSPITAL, DURHAM, NORTH CAROLINA 27705, *U.S.A.*
TELEPHONE: 919 286-0411

APPENDIX E

First Letter to Subjects

(Address)

Dear (Name):

Because you are an employee of the University of Texas Medical Branch, you have been chosen to participate in a research project on women and their relationships with their mothers. You must meet the following criteria to be in the study:

1. you must be at least 30 years old
2. your mother must agree to participate in the study by answering and returning a short questionnaire that will be mailed to her home
3. both you and your mother must speak and read English
4. you and your mother must live separately.

If you satisfy the above requirements and you agree to help me with this study, you will be asked to participate in one of two ways. You could be asked to either answer and return 3 questionnaires mailed to you or you might be offered the opportunity to attend an educational seminar for daughters to learn about and to discuss aging mothers. This free 6-hour seminar will be held on the UTMB campus on a weekend day and will be fun as well as educational.

If you are chosen to answer questionnaires only, the seminar will be offered to you in the Fall or Spring at your convenience. I really hope that you are interested in my study. If you are, either sign the enclosed postcard and drop it in the campus mail or call me at 761-1181 (days) or (713)334-4231 (collect) in the evenings. Thank you for reading this letter and for your help.

Sincerely,

Margaret H. Brackley, MS, RNC
Assistant Professor
School of Nursing

APPENDIX F

Coverletter to Subjects

Dear (Insert Study Subject's Name):
Allow me to thank you again for agreeing to participate in the research project on adult daughters and their mothers. Your help in this research study is of vital importance to the future care of families with aging members.

Enclosed are three research instruments for you to complete at your convenience. Do not place your name anywhere on the sheets of paper. On the top of the first page there is a space labeled number, please choose and write in the space a number that you and your mother will use on the questionnaires, for example your birthdate or the last three digits of your phone number. Please tell your mother the number you have chosen so that she may use it on her questionnaires also. The "Norbeck Social Support Questionnaire" consists of some questions about you and then some on how you see other people supporting you on a day to day basis. It should take you about 10 minutes to complete the questionnaire. The "Concerns of Aging Scale" has two parts, one is a deck of cards to stack in the way your mother would stack them and the other is a checklist about whether or not you have talked to your mother about each card. The deck and checklist should also take about 10 minutes to complete. The third instrument is a short questionnaire about your feelings. This one should take less time to complete than either of the other two.

Because your name will not appear anywhere on the instruments, your identity can not be revealed. I can assure you that anything you share during this research study will be held in the strictest of confidence, even from your mother. After you have completed the questionnaires, please place them in the stamped, self-addressed envelope and return to me. Please try to answer all questions as only completed questionnaires can be used. Please return your questionnaires within one week .

Thank you for you help in this matter. I will be contacting you in approximately eight weeks for the second set of questionnaires. After that time, a date will be set for you to attend the group for adult daughters of aging mothers, if you so desire.

Sincerely,
Margaret H. Brackley, MS, RN, C

APPENDIX G

Consent Form

SUBJECT CONSENT

I have been asked to participate as a subject in the research project entitled Support for Midlife Women during Transition to Parental Caregiver under the direction of Margaret H. Brackley, R.N., M.S., C.

The purpose of this study is to determine if a nurse-led support group for women who may assume the role of caregiver or care manager for their elderly parents will help in adapting to this new role.

I understand that I may be asked to participate in one of the following two ways in this study, I could be asked to either answer several questionnaires mailed to me at my home or I might be offered the opportunity to attend an educational and support group for daughters to learn about and to discuss their relationships with their aging mothers. I understand that the sessions will be held on the UTMB campus weekly for eight weeks and that the sessions will last 1 1/2 hours each time. If I am chosen to answer questionnaires only, I understand that the group sessions will offered to me in the Fall or Spring at a convenient time.

The direct benefits to me include the opportunity to clarify the relationship that I now have with my mother, to learn skills that will help me help my mother as she ages, and to learn about normal aging.

The potential risks from participation in the study are the possiblity of emotional discomfort and/or loss of confidentiality from group discussions during a support group. In order to protect against emotional discomfort, all discussions will take place on a voluntary basis. All participants in the support group will be asked not to discuss what is said in the sessions with persons outside the group. Confidentiality will be protected by you choosing a three digit number for you and your mother to use for identification on the questionnaires both of you will be asked to complete. Your name will not appear on any document and the list of subjects with your name and address on it will be kept in a locked drawer to which only the investigator has access. This list will be destroyed at the conclusion of this study.

1. I understand that informed consent is required of all persons in this project.

2. The principle and alternate procedures, including the experimental procedures in this project, have been identified and explained to me in language that I can understand.

3. The risks and discomforts from the procedures have been explained to me.

4. The expected benefits from the procedures have been explained to me.

5. An offer has been made to answer any questions that I may have about these procedures. If I have any questions before, during or after the study, I may contact Ms. Brackley at (409) 761-1181.

6. I have been told that I may stop my participation in this project at any time without any ill effects on me.

7. I have been told that the University of Texas Medical Branch at Galveston and Texas Woman's University, like virtually all other universities in the United States, do not have a mechanism for compensation of the injured research subject. Therefore, I understand that I cannot look to any such mechanism to receive financial remuneration for any such injuries resulting from my participation in this project. If physical injury occurs as a direct result of this research, emergency treatment which is available to the general public will be available to me. UTMB, TWU, or Ms. Brackley cannot assume financial responsibilities or liability for the expenses of such treatment.

I voluntarily agree to participate as a subject in the above named project.

Date	Signature of Subject
Date	Signature of Witness
Date	Signature of Project Director

APPENDIX H

Agency Permission for Conducting the Study

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE University of Texas Medical Branch

GRANTS TO Margaret H. Brackley, M.S.,R.N.,C. Ph.D.
a student enrolled in a program of nursing leading to a ~~Master~~'s Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Role Adaptation in the Adult Female Caregiver following Transistional Nursing Support

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 1/15/87

Signature of Agency Personnel

Signature of Student

Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

/bc

The University of Texas Medical Branch at Galveston

Medical School
Graduate School of Biomedical Sciences
School of Allied Health Sciences
School of Nursing

Marine Biomedical Institute
Institute for the Medical Humanities
UTMB Hospitals at Galveston

June 17, 1985

M E M O R A N D U M

TO: Margaret H. Brackley, M.S., R.N./Dr. Helen Ptak
Doctoral Candidate, TWU/School of Nursing

FROM: Marjorie Forster
Director of Sponsored Programs-Academic

SUBJECT: OSP # 85-144

Under the Institutional Review Board's mechanism for reviewing minimal risk protocols, your project OSP # 85-144 entitled "Support for Midlife Women During Transition to Parental Caregivers" has been approved on June 13, 1985. I am, therefore, pleased to inform you that you may proceed with this project effective immediately.

Project Directors of approved projects are responsible for reporting to the Institutional Review Board any unanticipated adverse reactions observed during the conduct of the project as all as any severe or serious side effects whether anticipated or unanticipated.

Should your project require modification which alters the risk to the subject or the method of obtaining informed consent, the project must be reevaluated by the Institutional Review Board before the modification is initiated.

Completed subject consents should be maintained in the designated place for at least three years after the termination of the project. A copy of the completed consent document should be offered to the subject.

MF/nh

Attached is the revised subject consent form with the date of IRB approval. Please use this copy of the revised consent form with the IRB approval date and make additional copies as they are needed.

Attachment

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