

ALZHEIMER'S CAREGIVING APPRAISAL

A Thesis

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Social Work

in

The School of Social Work

by

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August 2008

ACKNOWLEDGMENTS

To my committee, Dr. Scott Wilks, Dr. Priscilla (Lilly) Allen, and Dr. Daphne Cain, your dedication to see me thrive and your wisdom and knowledge you so graciously imparted to me has given me an outlook and an experience no classroom could teach. I know that I have accomplished more than most.

To my parents and family, your words of strength and encouragement helped me to push the limits.

To the Alzheimer's Services of the Capital Area, thank you for your support to this project and the services you provide to countless families in the Baton Rouge area.

To my HPC family, your heart and compassion for others comes across in all you do. The friendships I have are immeasurably important to me and no words could express how thankful I am to have each of you in my life.

A very special thank you to Gabby and Kristan, two dear friends who got me interested in social work. Both of you helped me to see that what I wanted to do was possible through this profession. Kristan, I know that our friendship will only continue through the years. Gabby, I realize only now how truly blessed I was to consider you a friend.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	ii
ABSTRACT	v
INTRODUCTION	1
REVIEW OF LITERATURE	7
Cognitive Appraisal	7
Caregiving Appraisal	8
RESEARCH QUESTIONS AND HYPOTHESES	15
METHODS	17
Design and Sampling	17
Measures	17
Data Analyses	20
RESULTS	21
Descriptives	21
Correlations	21
Hypotheses Testing	22
DISCUSSION	24
Reflecting Current Results to Previous Research	24
Implications for the Social Work Profession	26
Limitations	27
Conclusion	28
REFERENCES	29
APPENDIX A: DEMOGRAPHICS	34
APPENDIX B: DESCRIPTIVE RESULTS ON KCSS AND SUMMED SCORES	35
APPENDIX C: DESCRIPTIVE RESULTS ON BRCS AND SUMMED SCORES	36
APPENDIX D: DESCRIPTIVE RESULTS ON CSSS AND SUMMED SCORES	37
APPENDIX E: DESCRIPTIVE RESULTS ON MEIM AND SUMMED SCORES	38
APPENDIX F: DESCRIPTIVE RESULTS ON ATCS AND SUMMED SCORES	39
APPENDIX G: CORRELATIONS FOR DEMOGRAPHICS AND STANDARDIZED MEASURES	40

APPENDIX H: HYPOTHESES TESTING RESULTS	41
APPENDIX I: RESULTS FROM HIEARCHICAL REGRESSION ANALYSIS PREDICTING ATCS SCORES	42
VITA	43

ABSTRACT

The purpose of this study is to contribute to the knowledge base of AD caregiving appraisal by understanding a connection of factors that influence caregiving appraisal. It is important for the profession of social work to understand the complexities which may impact the level of care and/or appraisal. A combination of research questions and hypotheses were devised to determine the influence of each factor and/or a combination of factors on caregiving appraisal. The survey comprises of six sections: demographics and stage of AD, burden, resilience, family strengths, ethnic awareness, and caregiving appraisal. The overall survey was designed by the researcher; yet, each of the subsections, except for demographics and stage of AD, were instruments created by other researchers (Hopkins, Kilik, & Day, 2006; Sinclair & Wallston, 2004; Maton et al., 1996; Ponterotto et al., 2003; Farran, Miller, Kaufman, Donner, and Fogg, 1999). Permission to disseminate the surveys was obtained from the Alzheimer's Services of the Capital Area (Baton Rouge, LA). The sampling frame is all caregivers who attended support groups at the above mentioned program. With the analysis of results it was determined that ethnic identity awareness had a positive and significant correlation to the following: caregiving appraisal and resilience. Also, burden was shown not to have a significant correlation to caregiving appraisal. Furthermore, a positive significant difference was found between mid/moderate stage and late/severe stage on caregiving appraisal. Finally, it was determined that the factors counted for more than half of the variance found in the current study.

INTRODUCTION

In the United States more than 4.5 million people have Alzheimer's disease (AD) (Alzheimer's Disease Research [ADR], (2007), with approximately 7.3 million caregivers (Bohse & Associates, 2001). One out of four U.S. households provides care. Due to the overwhelming number of caregivers, their unique needs and relationships to the care recipient are important to the profession of social work. Several points in the National Association of Social Workers (NASW) *Code of Ethics* (NASW, 1999) expound on this importance. First, social workers are to remain aware of the environmental factors that influence an individual's quality of life. Second, the profession of social work is to enhance the individual's capabilities of addressing her/his needs. Third, the social work profession is to understand the function of culture and how it relates to the individual's perceived strengths of her/his culture within a given society. Thus, with the overwhelming number of caregivers, it is important for the profession of social work to understand the complexities which may impact the level of care and/or appraisal. The caregiver provides care and meets the needs of the care recipient; the social worker needs to understand caregiving appraisal to provide adequate services to the caregiver. The social worker then may understand the environment of the caregiver and may be able to provide more effective counseling to help the caregiver experience caregiving more positively (Berg-Weger, Rubio, & Tebb, 2001).

Before elucidating the complexities of caregiving, an understanding of dementia and AD, a form of dementia, is presented. Dementia is a debilitating disease which affects different areas of the brain (Espino, Jules-Bradley, Johnston & Mouton, 1998; Kaplan, Sadock and Sadock, 2003; Santacruz & Swagerty, 2001). Dementia severely affects memory, judgment, orientation,

and cognition of the individual. Dementia is a combination of symptoms which affects the brain and is not one specified disease (National Institute of Neurological Disorders and Strokes [NINDS], 2007).

Espino et al. compared (1998) dementia to delirium and depression, then explained the differences between the three. Delirium is caused from a general medical condition, substance induced/withdrawal, medication/toxin exposure or a combination of the above. There is a disturbance in the sleep cycle, psychomotor skills, and emotional states; but, delirium is treatable and reversible (Espino et al., 1998). With depression, there is a decrease in pleasure with activities previously enjoyed, appetite has changed, sleep is either non-existent (insomnia) or lengthened (hypersomnia), and the ability to concentrate is affected. The individual has difficulty functioning; but, depression is treatable and reversible. Possibilities of dementia being reversible are slight. There is impairment in the major components of the brain. The memory, thought, problem solving, voluntary movement functions are impaired. Although delirium and dementia can occur simultaneously, the loss of function with dementia cannot be explained by delirium.

Espino et al. (1998) explained two groups of dementia. In the first group, the types which could be reversible are thyroid dysfunction, deficiencies in vitamins and minerals such as B12 and folate, infections like neurosyphilis, uremia, and normal pressure hydrocephalus. The types which are irreversible are vascular dementia, human immunodeficiency virus (HIV), Creutzfeldt-Jakob disease, Huntington's disease, central nervous system trauma, and AD.

According to recent research (Alzheimer's Association [AlzA], 2007a; Wuest, Ericson, & Stern 1994; ADR, 2007), AD deteriorates the brain over a course of time. Before the disease is even diagnosable, the brain cells are attacked and begin to die (AlzA, 2007a). This can occur up

to twenty years before diagnoses. The death of these cells causes deterioration of certain functions. As more cells die, the brain shrinks in size. As the cells of the brain are attacked and shrink, the *care recipient*, or person with AD, loses functions for everyday life. There are seven stages of impairment recognized for these losses (AlzA, 2007a). The progression of AD in the first and second stages includes difficulty with remembering and communication (Shue, Byers, & Graham, 2005). Though there is some difficulty, the care recipient is seen as functioning normally when examined (AlzA, 2007a). The second stage is where mild cognitive failure is apparent. The signs of this stage are the occasional memory lapses, such as forgetting where one placed the keys (AlzA, 2007a). Though AD could be diagnosable during this stage, many may claim the problems are from the normal aging process.

Stages three through five can last for two to ten years (AlzA, 2007a). Stage three is described by a mild cognitive decline. During this stage, AD can be diagnosed more precisely. The inability to associate name and person and limited short term memory are some examples of the effects of the disease during this stage (AlzA, 2007a). Due to the memory association problems, behavioral changes may occur. Agitation and frustration may be more evident during this stage. The fourth stage is distinguished by a moderate cognitive decline and deficiencies are clearer. In this stage, the care recipient may forget information regarding her/his own past, and her/his ability to complete tasks such as planning meals and paying bills is diminished. Stage five is a decline of moderately severe cognition (AlzA, 2007a). Confusion sets in with time, date, and place, and seasonal wear during this stage.

The sixth and seventh stages of AD can last from one to five years (AlzA, 2007a). The brain has shrunk tremendously and the functions of the individual are limited, if not completely diminished. The sixth stage is severe cognitive decline (AlzA, 2007a). The individual is able to

recall her/his name but most all recollected knowledge is not remembered or remembered incorrectly, and it is during this stage the individual is in need of care with personal hygiene. S/he has the tendency to wander. The seventh stage is very severe cognitive decline (AlzA, 2007a). Speech is unrecognizable; individuals need help with all hygienic needs and mobility. The responsibilities and needs of the AD caregiver increase as the disease progresses.

These seven stages of AD can be fused into three broader categories (AlzA, 2007b; Shue et al., 2005). The early category consists of the first and second stages. The mid/moderate category comprises the third through fifth stages. The late/severe category consists of the sixth and seventh stages.

There are two types of caregivers, formal and informal. Formal caregivers are trained from either a home health agency or other organization, have related education, and are paid for their services (The Medical University of South Carolina, 2007). However, most AD caregivers are not professionals (ADR, 2007; AlzA, 2007a; Bohse & Associates, 2001). There are over seven million informal caregivers in the United States (US). The US population consists of 44.4 million or 21% of unpaid caregivers. The work of informal caregivers is important to the 70% of the 4.5 million care recipients in the US living at home.

The caregiver is understood through who they are and what they do. AD caregivers are described as being typically a female family member who is middle-aged (Hogstel, Curry, & Walker, 2005; Marziali, Donahue, & Crossin, 2005). *Principal* caregiver is a term given to the family member who lives with the care recipient (Wuest et al., 1994). The definition of informal caregiver can also include a friend who cares for the AD care recipient (Li, Morrow-Howell, & Proctor, 2006). For the purpose of this study, the caregiver will be understood as the family member or friend who provides assistance to the AD care recipient. Caregiving could last many

years, depending on the severity and stage of illness. Areas of the caregiver's daily life that may be affected include the caregiver's own daily duties, friendships, and levels of intimacy. As discussed below, caregiver responsibilities may be categorized as (1) social support, (2) emotional support, and (3) assisting in daily life activities (AlzA, 2007b; Marziali et al. 2005; Hogstel et al. 2005; Wuest et al., 1994).

Personality changes can occur within the care recipient. Examples of this behavior can be evident through social withdrawal, easy frustration, and inappropriate friendliness (Santacruz & Swagerty, 2001). The caregiver is often responsible for the care recipient's behavior in public and at home. This is to ensure the care recipient's behavior is appropriate in social settings and potentially encourage a social network.

The caregiver also provides emotional support for the care recipient. Personality changes are not the only influence of care recipient frustrations. Forgetfulness and/or psychiatric needs may also be a concern (Santacruz & Swagerty, 2001). The care recipient's inability to understand spoken or written word, difficulty in finding words, withdrawal and apathy, depression, and insomnia may create difficulty between the caregiver and care recipient. Working through the forgetfulness and difficulties, the caregiver is able to support the care recipient through these emotional difficulties. The support provided can come through helping the care recipient adapt to the changes; to strengthen the relationship between caregiver and care recipient; and to encourage family unity and tradition (Berg-Weger et al., 2001).

The caregiver assists with the day-to-day life activities for the care recipient because, as previously mentioned, AD affects the ability to perform simple tasks. For instance, with memory loss the care recipient may not remember what s/he ate for lunch or even that s/he cooked the meal. Therefore, the caregiver oversees this activity to ensure that the care recipient is receiving

proper nutrition. Fifty percent of caregivers are responsible for medication distribution (Bohse & Associates, 2001). Three out of four are responsible for grocery shopping, transportation (Bohse & Associates, 2001). Sixty six percent handle the finances and do housework (Bohse & Associates, 2001).

The internal perspective of these caregiver activities is known as *caregiving appraisal*. Caregiving appraisal is how the caregiver views the stressors and/or positive aspects of caregiving (Schwarz, 1999). Within the appraisal process, a direct relationship exists between comprehension of caregiving roles/responsibilities and perceived stressors (Schwarz, 1999; & Tennstedt, 1999). Caregiving appraisal can be focused primarily on the psychological aspects which affect the appraisal process (Pot, Deeg, Dyck, & Joncker, 1998). For the current study, AD caregiving appraisal is defined as follows: the caregiver's assessment of her/his actions and effort based on the caregiver's perception of level of care. This perception of level of care is based on a variety of internal and environmental factors. The underlying theory and further conceptualization of caregiving appraisal will follow in the literature review.

The purpose of this study is to contribute to the knowledge base of AD caregiving appraisal by understanding a connection of factors that influence caregiving appraisal. This study of AD caregiving is based on a nomothetic model of understanding. The use of the nomothetic model is to understand an idea or phenomenon in pieces, rather than the whole (Rubin & Babbie, 2005). The social phenomenon in this study is an outcome of caregiving appraisal; the pieces are its factors. The logical flow of this study is deductive: the larger conceptualization of the outcome, its relevant theory, and influencing factors narrows toward the hypothesis, followed by operationalization, data analyses, and reporting of results.

REVIEW OF LITERATURE

Cognitive Appraisal

Cognitive appraisal is a personal judgment based on different situations (Guillet, Hermand & Mullet, 2002). Cognitive appraisal was first studied by Folkman and Lazarus (Gan & Anshel, 2006; Guillet et al., 2002; Kitayama & Masuda, 1995; Skinner & Brewer, 2002). It is a psycho-cognitive process in which the individual needs to accurately assess and characterize the situation (Guillet et al., 2002) and to determine consistency among environmental factors (Skinner & Brewer, 2002).

One element of cognitive appraisal is the person's evaluation of the stressful event. This element can be understood in the appraisal of burden (Guillet et al., 2002; McConaghy & Caltabiano, 2005). Example of an appraisal of a situation being burdensome includes perceived lack of time for self, a perceived level of anxiety, and/or lack of social support. The burden appraisal, therefore, is a cognitive process of the caregiver where s/he must decide if the burden is too great to continue supporting and providing care to the recipient, at least to a certain extent. Further explication of caregiving burden is addressed in the caregiving appraisal context that follows.

Another element of cognitive appraisal is the determination that the person can overcome, prevent or improve the situation (Skinner & Brewer, 2002). This appraisal can be understood through the construct of resilience. Resilience is the ability to appraise the situation and recover, adapt, or transform from the stressor (Neill & Dias, 2001). Resilience is the psychological character which allows the individual to cope with and respond accurately to the stressor (Gan & Anshel, 2006). The cognitive appraisal process includes resilience because it allows the individual to assess the situation and determine an adaptable response to the stressor,

thereby continuing task(s) in stressful situations. Caregiving resilience is expounded upon in the caregiving appraisal subsection that follows.

According to Kitayama and Masuda (1982), an individual's foundation for appraisal can be based on her/his understood personal culture. The individual's culture may lead to a conclusion of a situation as stressful that another individual from a culturally different group would not have found stressful (Fry & Grover, 1982). The cognitive appraisal process provides the opportunity to understand culture and the caregiver's appraisal (Fry & Grover, 1982). Again, culture of the caregiver is further explained in the caregiving appraisal subsection that follows.

Summarily, cognitive appraisal is a process that individuals use to assess their abilities in a particular context. A variety of factors can be considered in the cognitive appraisal process. The situation and severity of each factor can impact the appraisal. This process applies to the caregiver as s/he appraises self caregiving skills.

Caregiving Appraisal

Cognitive appraisal is a process the caregiver can utilize to appraise her/his skills, the situation, and the needs and behaviors of the care recipient. The caregiver's appraisal determines which caregiving events, tasks, or situations are stressful (Schwarz, 1999). The caregiver can cognitively appraise her/his efforts to determine efficiency (Kitayama & Masuda, 1982). Thus, well being in a caregiving context is not necessarily controlled by the type or amount of care s/he provides, but how s/he cognitively appraises the caregiving (Tennstedt, 1999). The purpose of caregiving appraisal is to integrate environmental realities and personal interests effectively and efficiently (Pot et al., 1998). Thus, caregiving appraisal is a complex set of factors associated with the caregiver's efforts (Braithwaite, 2000).

Burden. Two primary factors in this study can be fused under the umbrella of caregiving burden. The first factor is the combination of stressors which may cause the caregiver to experience a number of negative physical and emotional symptoms, or *caregiving burden* (McConaghy & Caltabiano, 2005; Pot et al., 1998). Cognitive appraisal can be used to determine a caregiver's level of stress or burden in relation to the care recipient's needs or behavior (Rodney, 2000). This stress may occur because caregiving appraisal focuses primarily on caregiving tasks and not the caregiver's needs (Pot et al., 1998).

The aspects of caregiving burden that may be experienced can include stress and strain, task-oriented and financial-oriented burden (Butler, Turner, Kaye, Ruffin, & Downey, 2005, 2005). Burden may be experienced because of the inability to get personal chores done, constantly being on call, and the unpredictability in scheduling (McConaghy & Caltabiano, 2005). The problems associated with AD in the care recipient may lead to caregiver burden. This burden may be felt when the caregiver is unable to have personal time and lacks the social support needed to provide adequate care. Also, the caregiver's lack of sleep/irregular sleep may also affect the level of care provided. Burden can be viewed as stress. Caregiving can be both emotionally and physically stressful (Tennstedt, 1999). Caregivers may feel the pressures of their caregiving and experience stress and not say anything (Butler et al., 2005).

Caregiving stress may be divided into three subsections: physical, psychological/emotional, and financial (National Alliance for Caregiving & American Association of Retired Persons [NAC & AARP], 2004). The physical stress of caregiving can be caused by increased responsibility of more tasks and the caregiver's own medical problems (NAC & AARP, 2004). Time constraints of increased responsibility can lead to physical stress. This increased responsibility can be connected to the stage of AD and the necessary tasks needed

to ensure quality of life for the care recipient. For example, the physical stress and strain on the caregiver's body may increase as the hygienic needs of the care recipient increases. Also, if the caregiver's own medical problems go untreated this can lead to physical stress (AlzA, 2007).

Emotional stress affects the caregiver the most (NAC & AARP, 2004).

The psychological/emotional stress of the caregiver can be determined by a variety of factors: health, level of burden, and dwelling in same home with care recipient (NAC & AARP, 2004). Taking care of the care recipient is not the caregiver's only responsibility; the caregiver must also take care of her/himself. If not, the caregiver may become isolated or feel emotionally neglected (AlzA, 2007a).

The financial stress of caregiving is experienced through the costs of providing care. The costs a caregiver may face include: prescription drugs, medical treatment, in-home services, personal care supplies, etc. (AlzA, 2007a). The costs can increase, as the disease progresses, to include assisted living or nursing home care. The range of nursing home costs is \$42,000 to \$70,000 a year depending on residential location (AlzA, 2005). Thus, residential location and stage of AD can determine the level of financial stress for the individual. However, resources are available through Insurances like: Medicare, Medigap, Disability Insurance, and Long-term care. Also, assistance is available through Government assistance like: Social Security Disability Income, Supplemental Security Income, and Medicaid. Other forms of assistance may come from personal savings and/or community support (AlzA, 2005).

Another determination of financial stress is the caregiver's level of burden and the caregiver's perception of choice in taking on caregiving responsibilities (NAC & AARP, 2004). Financial stress can be associated with other factors: *caregiver's age, health, and living with the care recipient* (NAC & AARP, 2004). To reduce potential financial burden, the caregiver should

plan in advance (AlzA, 2005; AlzA, 2007b). Planning in advance would require gathering important legal documents (insurance, wills, mortgage, deeds, etc); planning for out-of-pocket expenses (prescriptions, cleaning supplies, safety devices, and medical bills); and researching potential financial resources (Medicare, different insurance, governmental assistance, etc).

The second factor is the effect of the stage of AD on the level of care (AlzA, 2007b). An example is that as the care recipient progresses through AD, the caregiver will provide more hygienic needs. In the early stage, the care recipient may need assistance bathing. For instance, the caregiver sets the temperature of the water and gives the care recipient a choice of when to “wash up.” In the severe stage, the care recipient may need additional assistance. As such, the caregiver installs wall-mounted bars, assists the care recipient getting in/out of shower, and assists in drying off. If the bathtub is difficult to maneuver (i.e. getting in/out), AlzA (2007b) recommends the caregiver install a walk-in bathtub that is easily accessible. Another example is the task of preparing meals. In the early stage, the caregiver may occasionally prepare meals. In the severe/late stage, the care recipient needs her/his meals prepared and fed to her/him. The ability for the care recipient to regulate and determine the temperature of the food and beverages may become increasingly difficult (AlzA, 2007b). Therefore, the caregiver would regulate and determine proper temperature.

As AD progresses into moderate and severe levels, the care recipient becomes more dependent on the caregiver (Shue et al., 2005). The amount of care the caregiver provides reflects the stage of AD within the care recipient. The caregiver’s appraisal of the needs of the care recipient will determine if the caregiver is able to provide the necessary tasks. As dependence increases and the demands of caring expand, the caregiver may decide to institutionalize the care recipient (Daire & Mitcham-Smith, 2006).

Resilience. The next two primary factors are grouped within the category of resilience. The third factor, caregiver resilience, consists of the caregiver's own strength and efficiency (Braithwaite, 2000). Resilience is the ability to appraise a situation and recover, adapt, or transform from the stressor (Neill & Dias, 2001). Resilience is determined by high self esteem, physical health, and emotional stability (Braithwaite, 2000). Though resilience is the ability to adapt, it is also a *protective factor* that helps to alleviate stress (Werner & Smith, 1992). The purpose of protective factors is to guard against risk (Rutter, 1987). Protective factors serve two resilience functions: (1) directly, positively influencing resilience, and (2) indirectly, by minimizing the stressor. Individuals have resilience based on successfully negotiating the protective factors influenced by various environmental situations (Wilks, 2004). A successful negotiation does not mean that the stressor was minimized. The effects of stressors are strongly linked to the individual's ability to cognitively and affectively process their experiences and the result is integrated into their self-concept (Rutter, 1999).

A social network may provide the individual the protective resources necessary to recognize her/his resilience. The caregiver may gain social support when amongst other caregivers (Marziali et al, 2005), including other family members and those in support groups. Thus, the fourth factor is that the caregiver often receives support and strength from family (Shulman, 2005). Family strengths may also be seen in the relationship between caregiver and care recipient, if related. The individual's perception of her/his role in the family may lend understanding to the appraisal of a given function (Shulman, 2005). Family support can provide benefits to the caregiver that is not available to a formal caregiver.

Families are an aspect of the social network which provided support for the caregiver (Wuest, Ericson, & Stern, 1993). This social network of the family extends to friends,

neighbors, and other individuals that provide emotional support, advice, role models, help in solving problems, and material assistance (Zigler & Black, 1989). Through social relationships, empowerment can be experienced by some caregivers (Berg-Weger et al., 2001). This network provides the caregiver with resources and the ability to pursue needed and available outside resources. It is important to note that the caregiver's culture, particularly race, class and ethnicity, may enhance or limit access to social networks (Cantor, 1989). The family is a beneficial social network to the caregiver and deserves research attention.

Ethnic Identity Awareness. A fifth factor considers the effect of caregivers being culturally aware (Crawley, 2005). For the purpose of this study, culture is the understanding of one's traditions, customs, beliefs, attitudes and prejudices. A caregiver's cultural self-awareness may improve the level of care (Kleiman, 2006) and, thus, needs to be examined. Cultural awareness is based on perception of a given situation within the realm of customs, values, and norms of the group (McCabe, 2006). Culture can be the interpretive-tool used by the individual through personal judgment to cognitively appraise a situation (Kitayama & Masuda, 1982).

Ethnic identity is the perceptions, cognitions, and emotions based on understanding of one's own culture (Ponterotto, Gretchen, Utsey, Stracuzzi, and Saya, Jr., 2003). Ethnic identity may also mean how culture impacts the ability to care (Daire & Mitcham-Smith, 2006). Thus in the present context, ethnic identity is the caregiver's ability to recognize her/his culture and how it impacts the ability to care. Ethnic identity awareness is a process an individual may utilize to understand her/his life experiences based on the impact and meaning s/he has attributed to those experiences (Kleiman, 2006). Daire and Mitcham-Smith (2006) researched the impact of family culture on the caregiver's ability to benefit from caregiving. They stated that level of care could be impacted by ethnic identity awareness of the caregiver's ethnicity. Three examples provide

explanation of this impact. The first is African-American culture. This culture supports family caregiving. In fact, the responsibilities are shared and the support system includes: spouse, children, and extended family (Daire & Mitcham Smith, 2006). The second is Japanese culture. This culture has a respect for elders and has a value of not imposing burden on others. Therefore, the Japanese family caregiver, typically the eldest son's wife, usually does not seek help outside of the family. Latino culture, the third culture, places the family in the center. This culture has a larger support network which includes the community. All of these ethnic dynamics may impact the caregiving appraisal process. Yet, little research has been done on the benefits of ethnic self awareness for non-practitioners. Social workers are ethically bound to understand culture and to be culturally competent; but informal caregivers are not bound by these same ethics. Therefore, research in the area of caregiver cultural competence is scarce. The connection between culture and the caregiver's appraisal is integral because as culture changes, the caregiver's appraisal of role can also change (Braithwaite, 2000).

Understanding the connection of factors that influence caregiving appraisal may help to contribute to the knowledge base of AD caregiving appraisal. As seen above, the caregiving appraisal process can include three broad areas in the cognitive appraisal process (Braithwaite, 2000; Kitayama & Masuda, 1995; Neill & Dias, 2001; Pot et al., 1998; Schwarz, 1999): burden, resilience, and culture. These three broad areas are comprised of the following: caregiving burden, stage of AD, resilience, family strength, and culture (specifically, ethnic identity awareness).

RESEARCH QUESTIONS AND HYPOTHESES

This study's purpose was to contribute a nomothetic understanding to the knowledge base of AD caregiving appraisal, a topic with insufficient research. Based on aggregate data from a sample of Alzheimer's caregivers, the following empirical, descriptive research questions were comprised:

- R1. What is the caregiver's perceived level of burden?
- R2. What is the care recipient's stage of AD?
- R3. What is the caregiver's perceived level of resilience?
- R4. What is the caregiver's perceived level of family strengths?
- R5. What is the caregiver's perceived level of ethnic identity awareness?
- R6. What is the caregiver's perceived level of caregiving appraisal?

From the above mentioned questions, five bivariate hypotheses were formed.

H1: The caregiver's perceived sense of caregiving burden significantly influences her/his appraisal of the caregiving situation.

H2: The care recipient's stage of AD significantly influences the caregiver's appraisal of her/his caregiving situation.

H3: The caregiver's resilience significantly influences her/his appraisal of the caregiving situation.

H4: The caregiver's perceived sense of family strengths significantly influences the appraisal of the caregiving situation.

H5: The caregiver's perceived sense of ethnic identity awareness significantly influences the appraisal of the caregiving situation.

Next, research questions were formed by using the three broad categories of caregiving appraisal, as previously outlined. These categories are stress, resilience, and culture.

R7. Is burden, categorically as the interaction of burden and stage of AD, positively related to caregiver's appraisal?

R8. Is resilience, categorically as the combination (interaction) of the constructs of family strengths and resilience, positively related to caregiver's appraisal?

Because the category of cultural awareness contains only one factor in this study, this question was covered above in H5.

METHODS

Design and Sampling

The research design is cross-sectional. This means that data from a cross section of the population is taken at one specified time to study a specific phenomenon (Rubin & Babbie, 2005). The survey comprises of six sections: demographics and stage of AD, burden, resilience, family strengths, ethnic identity awareness, and caregiving appraisal. The overall survey was designed by the researcher; yet, each of the subsections, except for demographics and stage of AD, were instruments created by other researchers (Hopkins, Kilik, & Day, 2006; Sinclair & Wallston, 2004; Maton et al., 1996; Ponterotto et al., 2003; Farran, Miller, Kaufman, Donner, and Fogg, 1999). Permission to disseminate the surveys was obtained from the Alzheimer's Services of the Capital Area (Baton Rouge, LA). Surveys were given to the program director to give to the support group facilitators. The facilitators disseminated the surveys to the caregivers. The population of interest is those caregivers under the auspice of the above mentioned programs. When the surveys were completed, the facilitator returned the surveys to the program director who will return them to the researcher. The sampling frame is all caregivers who attend support groups at the above mentioned program. Prior to the data collection phase, permission was obtained from the Louisiana State University Institutional Review Board, IRB # 2779.

Measures

The overall instrument is a self report survey. This survey is comprised of six sections.

Demographics. Seven demographic factors, each with nonparametric data except age, were considered in this study. Three standard questions were solicited age, gender, and marital status. Ethnicity was considered with the following responses: *American Indian/Alaska Native, Pacific Islander, African American/Black, White, Asian, or Hispanic/Latina (o), and Other.*

Relation to care recipient was asked with the following responses: *spouse, child, sibling, other relative, friend, or other*. Level of health was considered with the following responses: *poor, fair, good, very good, or excellent* (Rapp, Shumaker, Schmidt, Naughton, & Anderson, 1997).

Stage of AD responses are the following: *early stage* (noticeable memory loss or other cognitive deficits, yet the person can compensate and function independently); *mid-stage or moderate* (mental abilities decline; personality changes; physical problems develop so that the person becomes more dependent); and *late stage or severe* (complete deterioration of personality; loss of bodily functions requires total dependence on others) (Forest Pharmaceuticals, Inc., 2007). The remaining items came from standardized measures with parametric data, except for the Kingston Caregiver Stress Scale (burden) whose properties are under review in this study.

Burden. The burden measure used in this survey is the Kingston Caregiver Stress Scale (KCSS; Hopkins, Kilik, & Day, 2006). This is a self report scale for informal caregivers to measure perceived stress in the current situation. The KCSS has 10-items with a 5-point Likert response format. Answers range from “*no stress*” to “*extreme stress*”. Higher scores indicate possible higher stress. The measure was broken down into three subsections: caregiving issues, family issues, and financial issues. “Have you noticed any changes in your social life?” is an example of a caregiving issues question (Hopkins et al., 2006). An example of a family issues question is, “Are you having any conflicts within your family over the amount of support you are receiving in providing care?” “Are you having any financial difficulties associated with caregiving?” is asked to ascertain financial issues. This measure is under investigation in the current study, to establish validity and reliability.

Resilience. Sinclair and Wallston (2004), created the Brief Resilient Coping Scale. This is a self report scale to measure resilient coping behavior. The measure contains 4 items. Responses range from “*does describe me*” to “*does not describe me*” on a 4-point Likert response format. Higher scores indicate higher resilience, with the range of scores being from 4 to 16. An example of questions asked follows: “I believe I can grow in positive ways by dealing with difficult situations,” (Sinclair and Wallston, 2004).

Family Strengths. Maton et al. (1996) studied specifically how ethnic differences are attributed to social support. The instrument used to measure support is the Cultural Specificity of Support Sources developed by Maton et al. (1996). This is a 10-item instrument with responses ranging from “strongly agree” to “strongly disagree” on a 5-point Likert Scale. Scores range from 10-50 with higher scores representing higher perceived support. A sample of the questions asked is: “I rely on my family for emotional support,” (Maton et al., 1996).

Ethnic Identity Awareness. Ponterotto et al. (2003) examined the strengths and limitations of the Multigroup Ethnic Identity Measure (MEIM). To iterate, ethnic identity is the process of developing perceptions, cognitions, and emotions based on one’s understanding of ethnic identity. The MEIM was designed to measure ethnic identity. This is a 15-item instrument using a 4-point Likert scale for items 1-12; items 13-15 are demographic items and are redundant in this study. Responses range from “*strongly disagree*” to “*strongly agree*”. Overall scores range from 12-48. A strong ethnic identity is representative of a higher score. An example of the questions asked is: “I participate in cultural practices of my own group, such as special food, music, or customs” (Ponterotto et al., 2003). This measure has a reliability coefficient above .80 (Ponterotto et al., 2003).

Caregiving Appraisal. Farran et al. (1999) developed the Attitudes toward Caregiving Scale to measure the positive attributes and benefits of caregiving. This is a 43-item instrument using a 5-point Likert response format. Responses range from “*strongly agree*” to “*strongly disagree*”. Score range is 43-215, with higher scores indicating a higher level of caregiving appraisal. The scale is comprised of three sub-sections: Loss/Powerlessness (LP); Provisional Meaning (PM); and Ultimate Meaning (UM). The LP sub-section is omitted because items wholly relate to caregiving burden, which is already tested by the KCSS. An example of a PM statement is: “Caregiving makes me feel good that I am helping” (Farran et al., 1999). The PM reliability is .88 (Farran et al., 1999). An example of an UM statement is: “I believe in the power of prayer; without it I couldn’t do this” (Farran et al., 1999). The UM has a reliability score .91 (Farran et al., 1999). The overall reliability score for the Attitudes toward Caregiving Scale is .91 (Farran et al., 1999).

Data Analyses

All non-parametric data will be reported by frequency and percentages (Rubin & Babbie, 2005). All parametric data, including demographics and standardized measures, will be reported by central tendency and dispersion. Such data will address research questions 1-6.

Strength of bivariate associations among the primary factors (caregiving burden, stage of AD, resilience, family strengths, and ethnic awareness) and caregiving appraisal will be reported with Pearson’s product-moment correlation coefficients (Rubin & Babbie, 2005).

Testing for all hypotheses was performed using linear regression analysis. This type of analysis was also conducted with the final two research questions. Finally, multiple (hierarchical) regression analysis was conducted on these aforementioned hypotheses to observe the composite influence of all factors on the appraisal outcome.

RESULTS

Descriptives

The frequency of gender was 82.9% female. The main two ethnicities reported were White (70.7%) and African American/Black (17.1%). The majority of caregivers reported a marital status of married (61.0%); with never married and divorced (single) both at (14.6%). Most caregivers were the care recipient's child (46.3%) or the spouse (26.8%). The majority of caregiver's reported good to excellent health (good, 43.9%; very good, 24.4%; and excellent, 24.4%). The predominant caregiving role reported was informal (75.6%). The formal caregiving role reported at 19.5%. There following was reported by caregivers; early stage was reported at 36.6% and late stage/severe reported at 34.1%. The average age of the caregiver was 60.2. See Appendix A for complete demographic statistics.

The respondents' average score on the burden scale was 24 ($SD = 6.90$), with an adequate amount of reliability (Cronbach's $\alpha = .75$). The average score for respondents on the resilience scale was 12.7 ($SD = 2.62$), with a satisfactory amount of reliability (Cronbach's $\alpha = .83$). The overall average score on the support scale was 37.6 ($SD = 10.87$), and an adequate amount of reliability (Cronbach's $\alpha = .79$). The respondents' average score on the ethnic awareness scale was 36.3 ($SD = 8.88$), and a satisfactory amount of reliability (Cronbach's $\alpha = .77$). The average respondents' score was 107.4 on the caregiving scale ($SD = 12.48$), with an adequate amount of reliability (Cronbach's $\alpha = .76$). Appendices B-F reveal complete descriptive statistics on the KCSS, BRCS, CSSS, MEIM, and ATCS.

Correlations

Ethnicity had a significant correlation to the caregiving scale (Spearman's $r = -.40$; $p < .05$). Two correlations were found to the relationship of the care recipient, caregiving role

(Spearman's $r = .65$; $p < .01$), and stage of Alzheimer's (Spearman's $r = .40$; $p < .05$). Health had correlations to the following: support scale (Spearman's $r = .32$; $p < .05$), and resilience scale (Spearman's $r = .40$; $p < .05$). Caregiving role and stage of Alzheimer's had a significant correlation (Spearman's $r = .43$; $p < .01$). The stress scale and the support scale had a significant correlation (Pearson's $r = -.35$; $p < .05$). The support scale had a significant correlation to the following: caregiving scale (Pearson's $r = .47$ $p < .01$); and, resilience scale (Pearson's $r = .36$; $p < .05$). The ethnic awareness scale has significant correlation to the caregiving scale (Pearson's $r = .48$; $p < .01$) and, resilience scale (Pearson's $r = .36$; $p < .05$). The final significant correlation was found between the caregiving scale and the resilience scale (Pearson's $r = .61$; $p < .01$). For a complete list of the correlational statistics see Appendix G.

Hypotheses Testing

Referring to H1, the influence on caregiving appraisal by caregiver burden was not significant ($\beta = -.25$, $p > .05$). Referring to H2, the influence of stage of AD on caregiving appraisal was significant ($F = 4.37$, $p < .05$). Post hoc analysis using the Bonferroni method showed a positive significant difference between mid stage/moderate and late stage/severe on the caregiving appraisal outcome ($t = 13.26$; $p < .05$). The influence on caregiving appraisal from resilience, referring to H3, was positive and significant ($\beta = .61$, $p < .01$). There was positive and had a significant influence regarding H4, by caregiver family strengths on caregiving appraisal ($\beta = .47$, $p < .01$). There was a positive influence on caregiving appraisal by ethnic identity awareness, referring to H5 was significant ($\beta = .48$, $p < .01$). There was significant influence, referring to R7, on caregiving appraisal from the negative interaction of burden and stage of AD ($\beta = -.06$, $p < .01$). Finally, in reference to R8, there was a positive significant

influence on caregiving appraisal from the construct of family strengths and resilience ($\beta = .59, p < .01$). See Appendix H for a complete list of the hypothesis statistics.

Finally, the hierarchical regression results were conducted through a step process to analyze the effects of the different independent variables on caregiving appraisal. The determination of factors was decided based on lowest to highest strength found in the correlations with appraisal, yet, placing demographics first. The following indicates the order used: demographics; stage of AD; burden scale; ethnicity scale; support scale; and resilience scale. Two factors showed significance when included in the hierarchical process. These are the ethnicity scale ($\beta = .413, r^2 = .431, p < .05$); and the support scale ($\beta = .537, r^2 = .552, p < .05$). Finally, all factors, including demographics, accounted for 62% of the variation in caregiving appraisal scores. Appendix I shows the statistics from the hierarchical regression analysis.

DISCUSSION

Reflecting Current Results to Previous Research

According to previous research, the five factors were determined to have an influence on caregiving appraisal (Cantor, 1989; Fry & Grover, 1982; Hogstel, Curry, & Walker, 2005; Marziali, Donahue, & Crossin, 2005; Ponterotto et al., 2003; Rodney, 2000). However, the influence of the factors had not been determined in conjunction with each other. This study took from previous research and combined the factors to determine the individual and combined influence on caregiving appraisal. As a result, it was determined that the factors counted for more than half of the variance found in the current study. The following is a breakdown of how each factor influenced caregiving appraisal.

The research indicated that most caregivers were female and age 60. Previous research also concluded similar findings (Hogstel, Curry, & Walker, 2005; Marziali, Donahue, & Crossin, 2005). Furthermore, the sample provided similar findings in regards to the type of care; informal care was either the child or spouse of the care recipient. Previous research explained the importance of informal caregiving (AARP, 2005; ADR, 2007; AlzA, 2007; Bohse & Associates, 2001). There are over 7 million informal caregivers in the United States (US). The work of informal caregivers is important to the 70% of the 4.5 million care recipients in the US living at home (AARP, 2005; ADR, 2007; AlzA, 2007; Bohse & Associates, 2001).

In the current study, caregivers reported a moderate amount of burden. Burden had a negative influence on caregiving appraisal, but was not significant. With further analysis of the stage of AD, it was found that a majority of caregivers reported the care recipient having early stage or late stage/severe of AD. Also, considering the combination of burden and stage of AD and the reported negative correlation, this compares to previous research (Rodney, 2000).

Previous research indicated the following about burden and its relation to the stage of AD: as the stage of AD progresses towards late stage/severe the caregiver will potentially experience more burden because of the increased responsibilities in taking care of the person with AD (AlzA, 2007; Rodney, 2000). In regard to early stage, a caregiver taking on the responsibility of care during this stage may experience similar burden to the late stage/severe caregiver because of the complexities of taking on the responsibility of being a caregiver. At the beginning, the caregiver may experience burden because of the uncertainty in her/his skills, then as the care recipient progresses through the stages, the caregiver potentially becomes more confident in her/his skills. Yet, when the care recipient reaches late stage/severe the required skills change and the responsibilities are increased due to the overwhelming needs of the care recipient (AlzA, 2007). These inferences are suggested based on the research where positive significant correlations were found with the relationship to the care recipient and with the caregiving role.

A high level of resilience was reported by caregivers. A majority of caregivers reported a high amount of social support which had a significant positive correlation to resilience. The sample also indicated good to excellent health. Braithwaite (2000) indicated that high physical health was a characteristic that provided the caregiver with strength and efficiency to have resilience. As indicated by previous research, spousal/mate support and external support systems was a protective factor (Marziali et al., 2005; Werner & Smith, 1992; Zigler & Black, 1989). Therefore, the current research is supported by previous research where family strengths had a significant negative correlation to burden.

There is a positive significant correlation between the response on the ethnic identity awareness scale and the level of resilience; therefore, it may be possible that ethnic identity awareness is a protective factor. Werner and Smith (1992) indicated that protective factors are

resources that enhance the individual's level of resilience. As indicated by previous research, the caregiver's culture may help her/him to access or limit access to social networks and resources (Cantor, 1989). The ethnicity of the caregivers did have a significant correlation to caregiving appraisal.

A caregiver can determine the efficiency of skills provided based on her/his caregiving appraisal (Kitayama & Masuda, 1982; Tennstedt, 1999). This means that based on the effects of the independent variables on caregiving appraisal, the following conclusions can be drawn. First, two factors had a positive significant correlation to caregiving appraisal: ethnic identity awareness and family strengths. This finding of ethnic identity is supported by previous research indicating that it could be a source of strength (Ponterotto et al., 2003). Second, burden had a negative correlation to the caregiving appraisal scale. All other factors influenced the caregiving appraisal scale positively; however, they were not significant in the relationship.

Implications for the Social Work Profession

The social work professional based on the Code of Ethics is to understand the environmental factors, to enhance the individual's capabilities of addressing her/his needs, and to understand the function of culture and how it relates to the individual's perceived strengths of her/his culture within a given society (NASW, 1999). The caregiver provides care and meets the needs of the care recipient; and the social worker who understands caregiving appraisal may be able to provide adequate services to the caregiver. The social worker may then understand the environment of the caregiver and be able to provide more effective counseling to help the caregiver experience caregiving more positively (Berg-Weger, Rubio, & Tebb, 2001).

Previous research supports the current findings (Daire & Mitcham-Smith, 2006; Fry & Grover, 1982; Kitayama & Masuda, 1982; Kleiman, 2006). Daire and Mitcham-Smith (2006)

researched the impact of family culture on the caregiver's ability to benefit from caregiving and concluded that the level of care may be impacted by the self-awareness of the caregiver's ethnicity. Another study concluded that an individual's culture may be the determining factor which indicates an event not stressful (Fry & Grover, 1982). Kitayama and Masuda (1982) indicated that through personal judgment, ethnic awareness became the tool used to appraise a situation. Kleiman (2006) concluded that an improvement in the level of care could be based on the caregiver's ethnic self-awareness.

Current research indicates that a caregiver who is more aware of her/his ethnicity and has a higher level of resilience is more likely to have a higher level of caregiving appraisal. Thus, if a social worker can help a caregiver become more aware of her/his ethnic identity, then the caregiver may have a higher likelihood for a higher perceived level of caregiving and level of resilience.

Limitations

Also important to the profession of social work is the understanding of the limitations of social work research (NASW, 1999). Due to the small size of the sample many of the inferences drawn from the current research are limited and not conclusive. The current research was proposed to a particular local agency using those caregivers who are in support groups, the research does not include caregivers who are not in the agency's offered support groups or affiliated with this agency. Future research needs to include members from rural areas and those not connected to agencies' support groups, yet not eliminate the current population.

Another limitation of the study is the possible implications of the Hawthorne effect. Merrett (2006) concluded that the Hawthorne effect occurred when subjects of a study changed their behavior because the researcher was present. The effect was thought to happen because the

subjects received more attention and therefore, their behavior changed (Merrett, 2006). Thus, any attention given to the subjects was seen as positive and the results were positive. Since the caregivers who responded were participating in a support group where the facilitator handed out the surveys, the caregiver may have felt they needed to respond a particular way.

Conclusion

The purpose of this study was to contribute to the knowledge base of AD caregiving appraisal by understanding a connection of factors that influence it. As indicated previously the factors for this project were chosen because of previous studies findings of significance to caregiving appraisal. Therefore, the 62% of variance indicated that each of the factors does contribute to a caregiver's appraisal. It is hoped that this study has provided a basis for further research regarding caregiving appraisal; especially in regards to ethnic identity awareness. Also hoped for is that the work and research to understand the dynamics between the social work profession and those caregivers of person's with AD would be further researched.

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APPENDIX A: DEMOGRAPHICS

Demographics (N = 41)

Variable	Valid % (n)	<i>M</i> (<i>SD</i>)	Median
Gender			
<i>Female</i>	85.0 (34)		
<i>Male</i>	15.0 (6)		
Ethnicity			
<i>African American/Black</i>	17.5 (7)		
<i>Asian</i>	2.5 (1)		
<i>Pacific Islander</i>	2.5 (1)		
<i>White</i>	72.5 (29)		
<i>Other</i>	5.0 (2)		
Marital status			
<i>Never Married</i>	14.6 (6)		
<i>Married</i>	61.0 (25)		
<i>Divorced (single)</i>	14.6 (6)		
<i>Widowed</i>	7.3 (3)		
<i>Cohabiting (unmarried)</i>	2.4 (1)		
Relationship to care recipient			
<i>Spouse</i>	28.2 (11)		
<i>Child</i>	48.7 (19)		
<i>Sibling</i>	0.0		
<i>Other relative</i>	2.6 (1)		
<i>Friend</i>	2.6 (1)		
<i>Other</i>	17.9 (7)		
Health			
<i>Poor</i>	2.4 (1)		
<i>Fair</i>	4.9 (2)		
<i>Good</i>	43.9 (18)		
<i>Very good</i>	24.4 (10)		
<i>Excellent</i>	24.4 (10)		
Caregiving Role			
<i>Informal</i>	75.6 (31)		
<i>Formal</i>	19.5 (8)		
<i>Other</i>	4.9 (2)		
Stage of Alzheimer's			
<i>Early stage</i>	36.6 (15)		
<i>Mid stage/moderate</i>	29.3 (12)		
<i>Late stage/severe</i>	34.1 (14)		
Age		60.2 (<i>SD</i> = 14.14)	61.0

APPENDIX B: DESCRIPTIVE RESULTS ON KCSS AND SUMMED SCORES

Descriptive Results on KCSS and Summed Scores (N = 41, Cronbach's $\alpha = .75$)

Item	<i>M</i>	<i>SD</i>	Median	Range
1. Overworked	2.9	1.07	3.0	1 – 5
2. Relationship	2.4	1.17	2.0	1 – 5
3. Social life	2.6	1.24	2.5	1 – 5
4. Commitments	2.6	1.34	2.0	1 – 5
5. Responsibilities	2.5	1.20	2.0	1 – 4
6. Ability	2.3	1.15	2.0	1 – 4
7. Future needs	3.2	1.08	3.0	1 – 5
8. Decisions	1.8	0.92	2.0	1 – 4
9. Support received	1.9	0.97	2.0	1 – 4
10. Finances	2.1	1.26	2.0	1 – 5
Overall	24.0	6.90	23.0	10 – 40

Abbreviation:

KCSS: *Kingston Caregiver Stress Scale*

APPENDIX C: DESCRIPTIVE RESULTS ON BRCS AND SUMMED SCORES

Descriptive Results on BRCS and Summed Scores (N = 41, Cronbach's $\alpha = .83$)

Item	<i>M</i>	<i>SD</i>	Median	Range
1. Creative ways	3.4	0.59	3.0	2 – 4
2. Control my reaction	3.1	0.71	3.0	2 – 4
3. Dealing w/ difficult situations	3.3	0.66	3.0	2 – 4
4. Replace losses	3.3	0.69	3.0	1 – 4
Overall	12.7	2.62	12.0	5 – 16

Abbreviation

BRCS: *Brief Resilient Coping Scale*

APPENDIX D: DESCRIPTIVE RESULTS ON CSSS AND SUMMED SCORES

Descriptive Results on CSSS and Summed Scores (N = 41, Cronbach's $\alpha = .79$)

Item	<i>M</i>	<i>I</i>	Median	Range
1. Moral support	3.9	1.23	4.0	1 – 5
2. How to do things	3.8	1.09	4.0	2 – 5
3. Family/hearing what I think	3.7	1.21	4.0	1 – 5
4. Family/share interests	3.7	1.16	4.0	1 – 5
5. Emotional support	4.0	1.09	4.0	1 – 5
6. Family member I go to	4.1	1.06	4.0	1 – 5
7. Family & I very open	3.9	1.14	4.0	2 – 5
8. Family sensitive to my needs	3.7	1.16	4.0	1 – 5
9. Family/solve problems	3.7	1.07	4.0	2 – 5
10. Deep sharing relationship	3.9	1.17	4.0	1 – 5
Overall	37.6	10.87	39.0	3 – 50

Abbreviation

CSSS: *Cultural Specificity of Support Sources*

APPENDIX E: DESCRIPTIVE RESULTS ON MEIM AND SUMMED SCORES

Descriptive Results on MEIM and Summed Scores (N = 41, Cronbach's $\alpha = .77$)

Item	<i>M</i>	<i>SD</i>	Median	Range
1. Find out more	2.8	1.02	3.0	1 – 4
2. Active in organizations	2.6	1.00	2.5	1 – 5
3. Clear sense	3.4	0.70	3.5	2 – 5
4. Life affected by membership	2.7	0.98	2.5	1 – 4
5. Happy member	3.4	0.68	3.0	2 – 5
6. Strong sense	3.3	0.67	3.0	2 – 5
7. Understand ethnic membership	3.4	0.63	3.0	2 – 5
8. Talked to other people	2.9	0.85	3.0	1 – 4
9. Pride in ethnic group	3.4	0.69	3.0	2 – 5
10. Participate in cultural practices	3.1	0.86	3.0	1 – 4
11. Strong attachment	3.3	0.80	3.0	1 – 5
12. Feel good about background	3.4	0.60	3.0	2 – 5
Overall	36.3	8.88	36.0	4 – 56

Abbreviation

MEIM: *Multigroup Ethnic Identity Measure*

APPENDIX F: DESCRIPTIVE RESULTS ON ATCS AND SUMMED SCORES

Descriptive Results on ATCS and Summed Scores (N = 41, Cronbach's $\alpha = .76$)

Item	<i>M</i>	<i>SD</i>	Median	Range
1. Enjoy having relative	4.5	0.80	5.0	2 – 5
2. Count my blessings	4.7	0.48	5.0	4 – 5
3. Gives my life purpose	4.0	1.04	4.0	1 – 5
4. Lord won't give more	4.2	0.99	4.0	1 – 5
5. Past memories & experiences	4.7	0.66	5.0	2 – 5
6. Strong person	4.5	0.68	5.0	3 – 5
7. Feel good that helping	4.3	0.83	5.0	2 – 5
8. Believe in the power of prayer	4.5	0.64	5.0	3 – 5
9. Hugs & "I love you"	4.5	0.71	5.0	2 – 5
10. A fighter	4.5	0.68	5.0	3 – 5
11. Care for my relative	4.5	0.64	5.0	3 – 5
12. The Lord will provide	4.5	0.68	5.0	3 – 5
13. My faith in my own abilities	4.5	0.75	5.0	2 – 5
14. Look forward to the future	4.5	0.60	5.0	3 – 5
15. Learn new things about myself	4.5	0.60	5.0	3 – 5
16. Faith that the Lord has a reason	4.3	0.85	4.0	1 – 5
17. Each year a blessing	4.5	0.68	5.0	2 – 5
18. Satisfaction providing care	4.2	0.83	4.0	2 – 5
19. God is good	4.5	0.60	5.0	3 – 5
20. Run away	2.2	1.23	2.0	1 – 5
21. Every day a blessing	4.6	0.50	5.0	4 – 5
22. My place	4.4	0.55	4.0	3 – 5
23. Much stronger than I think	4.5	0.60	5.0	3 – 5
24. A beautiful day together	4.0	0.82	4.0	2 – 5
25. Stronger & better person	4.4	0.77	4.5	2 – 5
Overall	107.4	12.48	109.0	80–124

Abbreviation

ATCS: *Attitudes toward Caregiving Scale*

APPENDIX G: CORRELATIONS FOR DEMOGRAPHICS AND STANDARDIZED MEASURES

Correlations for Demographics and Standardized Measures (N = 41)

Item	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Gender	--												
2. Ethnicity	.06	--											
3. Marital status	.18	.05	--										
4. Relationship to care recipient	.01	.29	.02	--									
5. Age	.20	.04	.10	.31	--								
6. Health	.16	.28	.10	.06	.04	--							
7. Caregiving role	.06	.27	.08	.65**	.19	.10	--						
8. Stage of Alzheimer's	.09	.27	.18	.40*	.17	.01	.43**	--					
9. KCSS	.02	.01	.08	.10	-.13	.19	.21	-.05	--				
10. CSSS	.17	.05	.14	.17	.29	.32*	.03	.02	-.35*	--			
11. MEIM	.15	.02	.04	.03	.14	.07	.03	-.28	-.21	.28	--		
12. ATCS	.14	-.40*	.07	.20	-.01	.12	.28	.14	-.25	.47**	.48**	--	
13. BRCS	.06	.08	.05	.03	-.10	.40*	.01	.05	-.17	.36*	.36*	.61**	--

* $p < .05$, ** $p < .01$

Note: Bivariate correlations among items 5, 9, 10, 11, 12, & 13 are reported with Pearson's r ; all other bivariate correlations are reported with Spearman's r .

Abbreviations

KCSS: *Kingston Caregiver Stress Scale*

CSSS: *Cultural Specificity of Support Sources*

MEIM: *Multigroup Ethnic Identity Measure*

ATCS: *Attitudes Toward Caregiving Scale*

BRCS: *Brief Resilience Coping Scale*

APPENDIX H: HYPOTHESES TESTING RESULTS

Hypotheses Testing Results.

Hypotheses/Question	Test Statistic	Significance
H1 KCSS→ATCS	$\beta = -.25$	$p = .12$
H2 AD stage→ATCS	$F = 4.37$	$p < .05$
H3 BRCS→ATCS	$\beta = .61$	$p < .01$
H4 CSSS→ATCS	$\beta = .47$	$p < .01$
H5 MEIM→ATCS	$\beta = .48$	$p < .01$
R7 KCSS x AD stage→ATCS	$\beta = -.06$	$p < .01$
R8 BRCS x CSSS→ATCS	$\beta = .59$	$p < .01$

Abbreviations:

KCSS: *Kingston Caregiver Stress Scale*
 CSSS: *Cultural Specificity of Support Sources*
 MEIM: *Multigroup Ethnic Identity Measure*
 ATCS: *Attitudes Toward Caregiving Scale*
 BRCS: *Brief Resilience Coping Scale*

**APPENDIX I: RESULTS FROM HIERARCHICAL REGRESSION
ANALYSIS PREDICTING ATCS SCORES**

Results from Hierarchical Regression Analysis Predicting ATCS Scores

	<i>R</i> ² composite	<i>B</i>	<i>t</i>	Beta
Step 1				
Demographics	.236	4.976	.830	.236
Step 2				
Stage of Alzheimer's	.236	.044	.015	.003
Step 3				
KCSS	.299	-.538	-1.501	-.291
Step 4				
MEIM	.431	.553	2.365	.413*
Step 5				
CSSS	.552	.739	2.482	.537*
Step 6				
BRCS	.617	1.534	1.944	.333

* *p* < .05

Abbreviations:

KCSS: *Kingston Caregiver Stress Scale*

CSSS: *Cultural Specificity of Support Sources*

MEIM: *Multigroup Ethnic Identity Measure*

ATCS: *Attitudes Toward Caregiving Scale*

BRCS: *Brief Resilience Coping Scale*

VITA

Andre' Fortier was born to Adrian and Margaret Fortier in November, 1980. She graduated for St. Amant High School in 1998. The next ten years of her life would be a journey through life, education, and travel. She began her educational journey at Southeastern Louisiana University where she spent one year and then transferred to Louisiana State University, A&M (LSU). It was at LSU where all of her journeys would soon intersect. In September of 1999, what she considers one of her most important decisions in life, she became a Christian. In the spring semester of 2000, she decided to major in sociology, criminology. Also, she went to Mexico with the campus's Baptist Collegiate Ministry.

In August of 2001, she moved to Roanoke, Virginia, to pursue a different type of education, ministry. While in Virginia, she travelled with classmates who went into high schools and taught character and integrity to the students. She was able to volunteer at the local Boy's and Girls Club, and two nursing homes in the area. Also, in the summer of 2003, after completion of the two year program, she went with a team to Abaco Island, Bahamas, to work with and assist the people in a leadership conference. In August of 2003, she returned to LSU to finish her studies in sociology. Also, she declared a second major in philosophy, religious studies. The next two years of her life would consist of school, two jobs, and participating in various outreaches sponsored by Healing Place Church. She graduated in December 2005 with two degrees.

Before graduating, she always knew that she wanted to further her education. She had the desire to link both of her degrees, and advocate for individuals through politics and the court systems. So she began looking and with the help of two close friends she decided to apply to the LSU School of Social Work. In August of 2006, Andre' entered the LSU School of Social

Work's full time program. Her first year internship was at the Capital Area Family Violence Intervention Center, Inc., Battered Woman's shelter, where she assisted in intake and assessments, the crisis line, and court services. Also, it was in her first semester that she decided to consider doing the thesis option rather than comps. In the spring semester, she chose her committee and began the process of research. Due to her research focus in gerontology, she was invited to join Sigma Phi Omega, an organization focused in gerontology. Also, she became a member of the National Association of Social Workers, the professional organization for social work. In April 2007, she was offered a job from her internship to work in the courts of East and West Feliciana Parishes as a Court Advocate.

In August 2007, she returned to classes and her second year internship was at the National Association of Social Workers - Louisiana Chapter. Here she learned the dynamics of conference planning, legislative advocacy, and grant writing. In October, she had the opportunity to travel with Healing Place's college ministry to Sicily and Italy to assist in a leadership conference. In January 2008, she accepted a research position to evaluate a faith-based abstinence program in the Baton Rouge area. After graduation, her plans are to move to England and work as a credentialed social worker.