

## **Patterns of Caregiving Following the Institutionalization of Elderly Husbands**

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Le but de cette étude était de se pencher sur le rôle de dispensatrice de soins assumé par les femmes âgées dont le mari a été placé en établissement de santé. S'inspirant de l'approche interprétative en sociologie et du concept de «carrière» élaborée par Hughes (1971), l'étude se fonde sur un schéma expérimental longitudinal, prospectif et descriptif, alliant les approches quantitative et qualitative. Les données utilisées dans cette analyse ont été puisées dans une étude plus étendue dans laquelle la transition des femmes mariées vers un quasi-veuvage était étudiée sous tous ses aspects, de même que les réactions de ces dernières, suite au placement en établissement de leur conjoint. Des visites fréquentes et une participation croissante aux soins : voilà le mode de vie qui se dégage pour les femmes engagées dans un tel processus. Deux types de prestation des soins se sont dessinés au cours des neuf mois de l'étude, et ils sont caractérisés par des circonstances et des interactions variées. En général, les femmes ayant renoncé à donner certains types de soins s'occupent d'un conjoint atteint dans une large mesure de troubles cognitifs. Elles avaient bon moral et manifestaient peu de symptômes dépressifs; elles s'étaient rapprochées de leur conjoint et se sentaient satisfaites, sous divers aspects, des soins en établissement. De leur côté, les femmes ayant continué à participer de manière intensive à la prestation des soins avaient, pour la plupart, un conjoint souffrant de troubles physiques. Les résultats des tests révélaient chez elles des symptômes de dépression allant de modérés à graves; rien n'avait changé dans leur rapport intime à leur conjoint, et elles s'avouaient insatisfaites, sous certains aspects, des soins en établissement.

The purpose of this study was to examine the caregiving career of older women following the institutionalization of their husbands. Informed by the interpretive perspective in sociology and Hughes's (1971) concept of career, the study employed a longitudinal, prospective, and descriptive design and combined the quantitative and qualitative approaches. The data used in the analysis were drawn from a larger study designed to explore the transition to quasi-widowhood and wives' responses to their husbands' institutionalization. The caregiving career of wives was seen as a pattern of frequent visiting and increasing involvement in the provision of care. Over the nine-month period of the study, two caregiving patterns emerged that were distinguished by a variety of circumstances and interactions. Wives who relinquished aspects of caregiving were more likely

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to be caring for husbands who were, in large measure, cognitively impaired. These wives reported good morale, few symptoms of depression, change in marital closeness, and satisfaction with aspects of institutional care. Wives who continued to be heavily involved in caregiving were more likely to have husbands who were physically impaired. They had depression scores indicative of moderate to severe depression, reported no change in marital closeness, and were dissatisfied with aspects of institutional care.

There is anecdotal and scientific evidence that the provision of care forms a central component of women's lives. Indeed, caregiving can be considered a career that spans the life course of many women, the phases of which are heralded by marriage, the arrival of children, the onset of dependency of parents, the deteriorating health of husbands, and the admission of husbands to long-term care in an institution (Pearlin, 1992; Ross, 1991; Suiter & Pillemer, 1990). While an extensive body of literature focuses on caregiving in later life, the recent literature chronicles the experience of elderly women who provide care to community-dwelling husbands. Less is known about the experience of those who continue to provide care to husbands who have been admitted for long-term institutional care. For these women, the provision of care to their spouse represents a major change in their caregiving career and a first step in the transition to widowhood. Little is known about this phase of their life — the shifts they experience in the provision of care, their emotional responses, and the restructuring of their lives. The purpose of this paper is to examine the caregiving career of elderly wives following admission of husbands for long-term institutional care.

### **Caregiving in Later Life**

Several characteristics of the research literature on caregiving in later life provided direction for this study. With few exceptions, researchers have emphasized the provision of care that occurs prior to the institutionalization of elderly and impaired persons. Their research also focuses on the experience of adult children who provide care to elderly parents (Lichtenberg & Barth, 1989; Mui, 1995; Wolfson, Handfield-Jones, Glass, McClaran, & Keyserlingk, 1993). The experience of spouses, who may be especially vulnerable to the challenges of caregiving because of their own advancing age, particularly wives who continue to provide care to husbands following their admission to an institution for long-term care (Gladstone, 1995; Rosenthal & Dawson, 1991), takes up a very small proportion of the literature on caregiving in later life.

Substantively, researchers, with few exceptions (Aronson, 1991; Bowers, 1988; Guberman, 1992), have focused on the performance of tasks, an approach that may be particularly inappropriate for an activ-

ity dominated by women (Abel, 1990). Caregiving functions do not exist in a vacuum. Rather, they are embedded in personal relationships. Whereas men are likely to take an instrumental approach to caregiving, women are more apt to emphasize the relational aspects of care. Knowledge of both dimensions is necessary for a comprehensive understanding of caregiving (Lewis & Meredith, 1988).

Methodologically, researchers have emphasized cross-sectional studies. While this approach may be understandable, given the difficulty of gathering longitudinal data, the snapshot view of caregiving that it provides tends to portray caregiving as a static phenomenon rather than as a process that may shift over time in response to particular or changing circumstances. Studies also tend to be quantitative in nature; an approach that provides little information about the affective and cognitive aspects of caregiving.

Conceptually, the focus on stress, resources, and recovery (George & Gwyther, 1986; Knight, Lutzky, & Macofsky-Urban, 1993; Pearlin, Mullan, Semple, & Skaff, 1990; Williamson & Schulz, 1993; Zarit & Whitlach, 1992) restricts the range of other possible responses to caregiving. While researchers have correlated stress with the degree of intimacy between givers and receivers of care (Cantor, 1983; Miller, 1989), they offer little indication of whether a strong sense of affiliation and attachment simultaneously imbues caregiving with meaning and purpose (Abel, 1989). Any investigation of informal caregiving should understand the motivation to care and the meaning of caregiving as defined by the parties involved.

This study built upon and strived to move beyond previous research on caregiving in later life.

### **Purpose and Objectives**

The purpose of this study was to examine the caregiving careers of elderly women following the admission of their husbands to an institution for long-term care. More specifically, the research was designed to answer the following questions:

- (1) How frequently do wives visit their husbands following admission to an institution for long-term care? Does the frequency of visiting change over time, and, if so, how?
- (2) What caregiving tasks do wives carry out during their visits? Does task performance change over time, and, if so, how?

- (3) What are wives' thoughts and feelings about visiting and task performance?
- (4) Do patterns of caregiving emerge following the institutionalization of husbands?
- (5) How are patterns of caregiving associated with factors of an intrapersonal, interpersonal, and institutional nature?

### **Conceptual Framework**

This study was informed by the interpretive perspective and the concept of career (Hughes, 1971). The interpretive perspective "emphasizes the human capacity to construct and share meaning and the human tendency to attempt to control, through symbolic interaction, situations in keeping with biographically meaningful intentions" (Marshall, 1979, p. 35). The concept of career was useful because of its focus on objective and subjective reality as used in sociological analyses and because it provided a way of looking at the experience of people over time, including the experience of women who provide care to family members. Hughes (p. 137) defines objective career as "a series of statuses and clearly defined offices held throughout the life course, in which there are typical sequences of position, achievement and responsibility." In addition, the concept is congruent with the hypothesis that becoming a caregiver involves a status acquisition similar to other social statuses precipitated by socially recognized events, such as marriage, motherhood, and becoming a professional (Suiter & Pillemer, 1990). Objectively, the notion of career can be seen to incorporate the activities and responsibilities associated with a particular status or position that are carried out and change over time. This study focused on visiting and task performance. Hughes (p. 137) defines subjective career as "the moving perspective in which people see their lives as whole and interpret the meaning of various attributes, actions and the things that happen to them." In other words, the ways in which the objective properties of career are viewed by those persons experiencing them constitute the subjective aspects of career (Marshall, 1980). In this study, feelings and perceptions about visiting and task performance constituted subjective aspects of the caregiving career. This study built on the work of Spence and Lonner (1978-79), Marshall (1980), Martin-Matthews (1980, 1987), Suiter and Pillemer, and Pearlin (1992), who used the interpretive perspective and the concept of career to study motherhood, aging and dying, women's experience of migration, widowhood, and family caregiving, respectively.



## Methods

### *Design*

The data were both quantitative and qualitative and were derived from a larger study that investigated the transition to quasi-widowhood — i.e., “the period of time when women find themselves still married but living alone and in many respects without the mate they once had” (Rosenthal & Dawson, 1991, p. 317). The study was conducted in the Extended Care Department of Sunnybrook Health Science Centre at the University of Toronto. Many patients in the hospital’s 400-bed chronic-care unit were elderly; 90% were male veterans, about half of whom had wives. Patient-related costs were covered by a combination of provincial health insurance and benefits from the federal Department of Veterans’ Affairs. As a result, there were no direct charges to patients and families. The wives of all married male patients admitted to Extended Care (excluding those admitted for intermittent respite care or palliative care) were invited to participate in the study. The design was longitudinal, prospective, and descriptive in nature and involved six interviews over an 18-month period.

### *Sample*

Seventy-eight wives were entered into the original study. Attrition was caused primarily by the death of husbands ( $n = 23$ ), discharge home or to an acute-care setting ( $n = 2$ ), or refusals ( $n = 7$ ). Initially, wives were interviewed about their pre-admission situation. Since some researchers suggest that family members usually adjust to a relative’s placement within a year, it was felt that the most turbulent time for these wives would be the six to nine months following their husband’s institutionalization. Consequently, data analysis for this study involved selected variables from three interviews: the background interview conducted at admission, which inquired about the wives’ pre-admission situation, and two process interviews conducted at months one and nine, which inquired about their post-admission situation; this resulted in a time span of nine months. Forty-six wives participated. There were no statistically significant differences on socio-demographic variables between the sub-sample used for this study and the parent sample used for the original study. Respondents were fairly representative in terms of income (Statistics Canada, 1987, p. 22-23) and the proportion born in Canada (Ontario Ministry of Citizenship and Culture, 1981). For the year prior to the study, 24% reported a family income under \$15,000; 34% between \$15,000 and \$19,000; 17% between \$20,000 and \$29,000;

and 24% a family income of \$30,000 or more. The proportion of the sample that was of British ancestry was somewhat higher than that in the Canadian population (Dreiger & Chappell, 1987), although it was similar to that in Ontario (Gerber, 1983).

### Measures

*The demands of caregiving* prior to admission derived from fixed-choice questions about the amount of help husbands required with personal care and instrumental activities of daily living (adapted from Lawton & Brody, 1969). Response categories were: no help needed, some help needed, a great deal of help needed, and unable to do without help. Wives were also asked to identify the main reasons for their husband's institutionalization.

*The Zarit Burden Interview* (Zarit, Reever, & Bach-Peterson, 1980), a widely used measure in social gerontology, was used to measure feelings of burden prior to admission. The reliability for all 29 items resulted in a Cronbach's alpha of 0.94.

*Visiting* was assessed by asking how often wives visited their husbands. The six response categories ranged from every day to once a year or less. Motivation for visiting and feelings about visiting were measured with open-ended questions asking why wives visited as often as they did, how much they enjoyed their visits, and whether they felt a sense of satisfaction with visiting.

*Task performance* was assessed by using a list of 27 items adapted from an inventory developed by Rubin and Shuttlesworth (1983). Each item referred to a task that a wife might perform for her husband, including aspects of grooming, personal care, caring for room and clothing, outings, diet, providing emotional support, maintaining family connectedness, monitoring medical care, providing "extras," enlisting family support, maintaining security, and arranging for counselling. Wives were asked to identify which of the tasks they were performing at each measuring point. An open-ended question asked wives to identify the most important thing they did for their husbands.

*Husbands' health* was assessed by a single-item question asking whether the condition for which the husband had been institutionalized was mental, physical, or both. An open-ended question inquired about other difficulties that had led to the husband's institutionalization.

*Wives' self-rated health* was measured using single-item questions asking them to rate their own health as excellent, good, fair, or poor and

to compare their current health to that of three years earlier as better, the same, or worse.

*Morale* was assessed using a single-item indicator asking whether wives were very happy, pretty happy, or not too happy (Sauer & Warland, 1982).

*Depressive symptomatology* was measured with the widely used Centre for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977). A Cronbach's alpha of 0.90 was achieved.

*Marital closeness* was measured using a single-item question asking wives: "Since your husband entered the hospital, taking everything into consideration, how close is the relationship between you and your husband?" Five response categories were used ranging from extremely close to not close at all. Wives provided additional responses to this question.

*Satisfaction with aspects of institutional care* was measured using three single-item questions. The first asked how well staff were treating their husbands (very, fairly, not too, not at all). The second inquired whether they liked the unit on which their husband resided (very much, fairly well, so-so, not at all). The third asked whether they were satisfied with the overall arrangements (very, fairly, not too, not at all) (Benjamin Rose Study, 1982). Wives also provided responses to these questions.

### *Analysis*

The analysis employed in this study comprised three aspects. Univariate statistics were used initially to examine the distribution of responses to the study variables. The qualitative data were examined for emergent categories and themes (Berg, 1989) reflecting the meaning of messages provided by wives in their comments. Data reduction involved coding and clustering of data. Data reconstruction and synthesis involved identification and verification of patterns and themes. Bivariate analysis, using *t*-tests and Kendall's Tau measure of association, was conducted to examine relationships between intrapersonal, interpersonal, and institutional variables and patterns of caregiving.

### *Findings*

To establish a contextual basis from which to understand wives' post-admission experiences, findings are presented regarding their ages, the duration of their marriages, their self-rated health, the demands of their

caregiving, and their feelings of burden prior to the admission of their husbands.

### *Age of Respondents and Duration of Marriages*

At the time of admission, wives were well on in years. Their mean age was 70 and their modal age, or the most frequently occurring age, was 78. Husbands were on average three years older than their wives. The duration of their marriages ranged from four years to 62 years; however, the vast majority had been married for 40 years or more. Most couples had children and grandchildren.

### *Self-Reported Health*

In tandem with husbands' deteriorating health, wives had to deal with their own medical problems. They were almost evenly divided in their evaluations of their own health, as excellent/good (52%) and fair/poor (48%), at the time of admission. However, when asked to compare their health to what it had been three years prior to admission, a substantial minority (41.3%) felt their health had worsened. Deteriorating health and bad nerves were frequently mentioned as the outcomes of years of caregiving. At the time of admission, the majority of wives (78.4%) reported a wide range of medical problems for which they were receiving treatment.

### *Demands of Caregiving*

Husbands' health problems were physical (26%), mental (37%), and both mental and physical (37%). Typically, they were quite dependent on their wives prior to admission. The majority needed a great deal of help with handling finances (94.6%), transportation (91.9%), shopping (83.8%), taking medications (76.7%), and bathing (54%). A substantial minority required a great deal of assistance with grooming (45.9%), dressing and undressing (43.2%), and going to the bathroom (32.4%). Wives reported coping with problems related to falling, incontinence, seizures, dysphasia, memory loss, confusion, wandering, and behaviour of an aggressively disruptive nature, which were the major reasons for the institutionalization.

### *Feelings of Burden*

Wives' scores on the Zarit Burden Interview ranged from a low of 0 to a high of 71, with a mean of 32, indicating a moderate level of burden.



Their accounts confirmed this finding and provided a graphic sense of the desperation they felt during the year prior to their husband's admission. One wife referred to the year as "devastating." "I realized that he would never be the same again and I was constantly tired, worried, and concerned." Wives were generally worn out at the time of admission, after a year of being essentially housebound. One wife said she was tired and didn't know which way to turn. She was both exhausted and overwhelmed. It is within this context that wives continued their involvement in caregiving following the admission of their husband.

### *Post-Admission Experience*

Post-admission data were gathered about the behavioural, cognitive, and affective dimensions of caregiving. As mentioned previously, objective dimensions of the caregiving career were conceptualized as visiting and task performance, subjective dimensions as reasons for and feelings about the provision of care.

### *Visiting*

The pattern of visiting that emerged over the nine-month period was one of consistent and frequent visiting. The vast majority of wives (80%) visited several times a week or daily at the first interview and continued to do so over the nine months. Their reasons for visiting, in descending order of frequency, were: devotion to spouses (78.3%), duty and obligation (54.3%), to provide assistance to husbands (43.5%), to monitor husbands' well-being (41.3%), and to provide assistance to staff (26.1%). Although the majority of wives expressed some degree of satisfaction (80.4%) and enjoyment (67.4%) with visiting, many qualified their responses by stating that these descriptors did not really capture the essence of their visiting experience. Satisfaction with visiting was linked with feeling useful or with their husband's mood and behaviour. The wives who stated emphatically that they did not feel satisfied with their visits attributed their dissatisfaction to feelings of depression or a sense of futility following their visits. Enjoyment was linked with activities carried out while visiting, rather than the visit itself. Wives who clearly did not enjoy visiting expressed serious difficulties communicating and interacting with their husbands, a lack of resources or things to do during the visit, and disagreement with certain practices regarding the provision of care by staff. Just over half of the wives reported other, more negative, emotional responses to visiting. Some of these feelings derived from a sense that they had abandoned their husband to the institution. Others resulted from their husbands' frequent and

repeated requests to return home. Parting was at times problematic and it generated negative feelings. One wife reported that she had to lie to her husband in order to be able to leave, which made leaving dreadful for her.

### *Task Performance*

Wives engaged in a variety of tasks related to personal, instrumental, relational, recreational, and spiritual care (Ross, Rosenthal, & Dawson, forthcoming). At the one-month interview they reported carrying out an average of 9.7 tasks for their husbands, at the nine-month interview an average of 11.3 tasks. The increase in the number of tasks over time, while small, was statistically significant ( $t = 4.37, p = .00$ ). Task performance was further analyzed by using the median (10) number of tasks that wives performed at the one-month interview as a criterion for indicating "high" versus "low" involvement. At both the one-month and nine-month interviews the majority of wives (54% at the one-month interview; 76% at the nine-month interview) were heavily involved in providing care for their husbands. In addition, for a small proportion of wives ( $n = 10$ ) level of involvement increased over time, whereas for the majority of wives ( $n = 36$ ) level of involvement remained the same.

Wives considered visiting to be the most important function they performed for their husbands. They also viewed the provision of love, support, and companionship as important — as well as the fulfilment of specific tasks. In addition, they described the "little things" that staff could not do, but that they could, as reinforcing their husband's individuality and creating a more personalized socio-emotional and living environment for him. Monitoring their husbands' well-being was the task least frequently mentioned. It may be that for them monitoring was such an unconscious or taken-for-granted function that it was not readily articulated in response to an open-ended question.

### *Patterns of Caregiving*

Patterns of caregiving derived from frequency of visiting, level of task performance, and responses at the nine-month point indicated how wives were coping with life on their own and whether they were adjusting to the institutionalization of their husband. Analysis revealed two patterns. At the nine-month point, a little over one third of the wives continued to be heavily involved, both emotionally and behaviourally, in caring for their husbands. For example, one wife stated: "I have no life of my own... I can't start any projects... I can't leave him."

Another said her life continued to revolve around her husband's illness. With one exception, all of these wives visited at least several times a week and continued to feel responsible for the well-being of their husbands. These wives were categorized as "holding on to the past."

Close to two thirds of the wives were less involved in providing care at the nine-month point. These were categorized as "embracing new realities." One of these wives stated: "It takes time to get used to the changes... I felt that I still had to check on the care that he was getting rather than letting the nurse do it. I've learned to give up some of the control... I now have more freedom." Another wife said: "I'm now a visitor... I don't have the strain or the responsibility any more... I now have more peace of mind... he's being properly taken care of and it's a big relief." These wives engaged in significantly fewer visits and appeared to be coming to terms with their new way of living, compared with those holding on to the past.

### *Factors Associated with Emergent Patterns*

The above data were examined cross-sectionally and longitudinally for similarities and differences that may have led to one caregiving pattern over the other. Wives who were holding on to the past were more likely to be caring for husbands who were physically impaired, whereas those who were embracing new realities were more likely to have husbands who were cognitively impaired ( $Tau = 26., p = .04$ ). Patterns of caregiving also differed on the following variables: change in feelings of marital closeness, depressive symptomatology, morale, and satisfaction with aspects of institutional care (Table 1).

**Marital closeness.** Feelings of marital closeness at each of the measuring points did not distinguish between the patterns of caregiving; however, *change* in marital closeness since admission, either for the better or for the worse, did distinguish between the two patterns. The majority of wives who were embracing new realities said their feelings of closeness to their husbands had changed, either for the better or for the worse; the majority of wives who were holding on to the past reported no change in feelings of closeness ( $Tau = .29, p = .02$ ).

**Depressive symptomatology.** A significantly greater proportion of wives who were holding on to the past had scores indicating symptoms of depression, both at the time of admission ( $Tau C = .38, p = .00$ ) and at the nine-month interview ( $Tau C = .46, p = .00$ ), than wives who were embracing new realities. Furthermore, there was no significant change in their mean CES-D scores over the nine-month period (22.29 at one

**Table 1** *Comparison of Caregiving Patterns on Selected Variables*

	Embracing New Realities N = 29				Holding on to the Past N = 17 <sup>d</sup>			
	Month 1		Month 9		Month 1		Month 9	
	N	%	N	%	N	%	N	%
<b>Change in Marital Closeness*</b>								
Stable			12	41.7			12	70.6
Closer			10	37.9			4	23.5
More distant			6	20.3			1	5.9
<b>Depressive Symptomatology</b>								
0-15 (none)	19	65.5	23	79.3	5	29.4	6	35.3
15-20 (mild)	3	10.3	4	13.8	3	17.6	0	00.0
21-30 (moderate)	6	20.7	1	3.4	5	29.4	4	23.5
31+ (severe)	1	3.4	1	3.4	4	23.5	7	41.2
<b>Morale</b>								
Very happy	3	10.3	4	13.8	0	00.0	0	00.0
Pretty happy	17	58.6	21	72.4	2	11.8	2	12.5
Not too happy	9	31.0	4	13.8	15	88.2	14	87.5
<b>Satisfaction with the Unit</b>								
Very	25	86.2	18	62.0	6	35.2	4	28.6
Fairly	4	13.8	11	37.9	8	47.0	9	64.3
Not really	0	00.0	0	00.0	3	17.6	1	7.1
<b>Satisfaction with Staff</b>								
Very	17	58.6	26	89.6	1	7.1	9	52.9
Fairly	10	34.5	3	10.4	12	85.7	7	41.2
Not really	2	6.9	0	00.0	1	7.1	1	5.9
<b>Satisfaction with Care</b>								
Very	22	75.8	21	72.4	3	17.7	5	29.4
Fairly	5	17.3	6	20.6	13	76.5	7	41.2
Not really	2	6.9	2	6.9	1	5.8	4	29.4
* These data were calculated at the nine-month interview only.								

month and 23.81 at nine months). In contrast, wives who were embracing new realities had mean scores indicating little depressive symptomatology, and their mean scores on the CES-D scale decreased significantly, from 12.72 at the one-month interview to 9.03 at the nine-month interview ( $t = -2.0, p = 0.05$ ).

**Morale.** The findings were somewhat similar with respect to morale. Wives who were holding on to the past scored significantly lower on morale at both interviews than wives who were embracing new realities (Tau C =  $-.54, p = .00$  at one month; Tau C =  $-.69, p = .00$  at nine months). Over 90% of these wives continued to experience low morale nine months following their husband's institutionalization.

**Satisfaction with aspects of institutional care.** Caregiving patterns were distinguished by satisfaction with the unit (Tau C =  $.56, p = .00$  at one month; Tau C =  $.35, p = .01$  at nine months), satisfaction with the staff (Tau C =  $.34, p = .01$  at one month; Tau C =  $.52, p = .00$  at nine months), and satisfaction with the overall arrangements for care (Tau C =  $.52, p = .00$  at one month; Tau C =  $.42, p = .00$  at nine months). At the nine-month interview the majority of wives who were embracing new realities expressed positive feelings about aspects of institutional care. These feelings were reflected in their comments. One wife stated: "The staff are wonderful...they always have patience...they couldn't do any better." Another commented: "They are friendly and kind to my husband." A third remarked: "The staff do a good job of taking care of him...they deserve a medal." Wives who were holding on to the past, however, were very dissatisfied with the unit on which their husband resided. They were also unhappy with the staff and with the overall care provided. Examples of their comments are: "They certainly don't look after him like I do," "They don't have the time that is needed...they are run off their feet," and "I don't think that they are too crazy about my husband...there are so many changes of nurses and he becomes frightened and then they get angry."

## Discussion

Wives' caregiving career emerged as a pattern of frequent visiting and increasing involvement in task performance. Visiting was both the context within which task performance occurred and a task in itself. Indeed, wives considered visiting to be the most important task they carried out for their husbands. The care they provided served a variety of purposes, including maintaining husbands' sense of personhood, preserving family ties, and redressing the rather impersonal and standardized nature of institutional care.



Over the nine-month period of the study, two patterns of caregiving emerged. The majority of wives relinquished responsibility for aspects of caregiving and began to reshape their lives while living apart from their husbands. They were conceptualized as "embracing new realities." A substantial minority, however, continued to feel responsible for the overall well-being of their husbands and to be heavily involved in the provision of care. They were conceptualized as "holding on to the past." Wives who were embracing new realities experienced fewer symptoms of depression, had better morale, and were generally more satisfied with institutional aspects of care. Wives who were holding on to the past had depression scores indicative of moderate to severe depression. Their morale was poor and they were dissatisfied with many aspects of institutional care.

In interpreting these findings, it is interesting to note that a significantly greater proportion of wives who were embracing new realities had husbands who were cognitively impaired. Many husbands had become merely shells of their former selves, following a process that had occurred over a period of years. As a result, many of these wives felt they had already lost their husbands to illness prior to admission. Following admission, their husbands deteriorated even further, often recognizing the wife as simply another caring person. It may be that for such wives the process of adjustment to a new caregiving relationship begins prior to admission, as marital expectations change. It may be that wives find it easier to relinquish caregiving responsibility when husbands have become totally different personalities, no longer recognizing them nor interacting with them as wives because of the changes associated with mental impairment. Factors of an institutional, intrapersonal, and interpersonal nature also served to distinguish the caregiving patterns.

With respect to aspects of institutional care, wives who were embracing new realities reported satisfaction, for the most part, with the unit, the staff, and the care. Wives who were holding on to the past were generally dissatisfied with care. The association between caregiving patterns and the nature of husbands' impairment may be useful in understanding these findings. It may be that wives who have lost their husbands to mental impairment are more ready to turn over caregiving responsibilities to staff than are wives of husbands with physical impairment. Because of their desire to relinquish responsibility for caregiving, they may view the care provided by others more favourably than those who continue to feel a sense of responsibility for the provision of care. It may also be, however, that because they visit less fre-

quently wives who are embracing new realities have less contact with the institution and less opportunity to be involved in situations that warrant criticism. Wives who are holding on to the past spend more time at the institution and consequently have more opportunity to be involved in care-related situations, which they then may evaluate as less than optimal. For example, several of these wives referred to the shortage of staff in their responses, whereas none of the wives categorized as embracing new realities did so. Wives who were holding on to the past evaluated the staff very specifically and negatively, as opposed to those who were embracing new realities, who used global and positive terms when referring to the staff.

Intrapersonally, the caregiving patterns were distinguished by wives' emotional health as measured by the CES-D depression scale and morale. It must be noted that more depressive symptomatology and lower morale were found in the total sample when compared with what would normally be found in community populations. It seems that the admission of husbands to an institution for long-term care is an emotionally distressing experience for all wives and leads to elevated levels of depressive symptoms in many. George and Gwyther (1986) suggested that it is primarily the characteristics of the caregiving situation that most affect caregiver well-being. This may also be the case with wives of institutionalized husbands. There was a significant and inverse relationship between wives' level of depressive symptoms and their satisfaction with aspects of institutional care. These findings are congruent with and extend those of Brody, Dempsey, and Pruchno (1990), who found that negative perceptions of staff were predictive of depression in adult caregivers of elderly parents who resided in nursing homes. In this study, negative views of the unit, the staff, and the overall arrangements for care were found to be associated with higher depression scores when the total sample was included in the analysis. This relationship, however, did not hold when controlled for the different caregiving patterns. Other factors must be implicated as contributing to the differences in depression scores between the patterns of caregiving. It seems reasonable to suggest that a diminished involvement in caregiving and the embracing of new realities serve to create a distance between wives, and what is for them an emotionally distressing situation. Turning over responsibilities to staff also relieves them of some of the demands of caregiving and allows them to recover from the fatigue associated with high levels of caregiving and to focus on other activities in building a life apart from their husbands. These outcomes may be restorative in nature and thus serve to ameliorate

feelings of depression and poor morale. Wives who hold on to the past and continue their heavy involvement in caregiving are not afforded these opportunities. As well, they are continually confronted with their husband's deteriorating health and requests or demands for assistance with activities of daily living. They are also in frequent contact with other patients, in similar or worse circumstances than their husbands. Continued dissatisfaction with institutional aspects of care might contribute to feelings of emotional distress.

Interpersonally, the caregiving patterns were distinguished by change in feelings of marital closeness. These feelings remained stable for the majority of wives who held on to the past and changed for the majority of wives who embraced new realities. Continuity in feelings of marital closeness was also related to feelings that they were still married. It seems reasonable to suggest that those who perceived little change in marital closeness over time continued to hold the same expectations regarding their responsibility for the provision of care and thus continued their heavy involvement in caregiving following admission.

### *Limitations of the Study*

Implications of the study must be considered within the context of its limitations. Generalization of the results beyond the study population is limited by the non-random sampling design and the size of the sample. The approach to analysis of the numeric data assumed that parametric tests are generally robust to violations of normality (Polit, 1996). Nevertheless, some researchers would argue that if the assumptions for such tests are not met, then non-parametric tests should be selected. Although the exploratory and correlational nature of the analysis rendered the attribution of causation problematic, insight into the direction of influence was provided by wives' qualitative responses. Generalization of the results beyond the study population was also limited by the nature of the setting from which the respondents were drawn. The life course of wives whose husbands have served in the Canadian armed forces and for whom the experience of war has touched their lives in a very personal way can be expected to differ from that of other wives. Nevertheless, findings from this longitudinal study should be regarded as transferable; it is likely that other wives who continue to provide care to husbands following their admission for long-term care will identify similar experiences and responses.

### ***Implications for Nursing***

The significance of this research lies partly in the identification of behavioural and affective changes that occur over time and that may signal the increasing vulnerability and potential for breakdown in elderly wives coping with the institutionalization of their husbands. It also lies in the need to recognize elderly wives as both clients of and resources to the institution, and in the development of strategies that will assist in their adjustment to the new realities of their caregiving careers. At a more global level, a better understanding of the informal health-care system and its relationship to the formal system is essential if each is to maximize this relationship, only improving the delivery of health care to people in their later years.

Over time, some wives are better able to cope with their new realities than others. Nurses need to be observant of and responsive to signs of depression, low morale, and dissatisfaction with institutional aspects of care as indicators of distress. Wives who are having difficulty with the institutionalization of their husbands and its consequences may view caregiving as a way of coping, albeit an unsuccessful one. They require support in learning to turn over responsibility for care to health-care workers. Nursing strategies that result in the provision of care to husbands that is both technically and interpersonally excellent may infuse wives with confidence in the system and allow them to concentrate on other aspects of their lives rather than on the provision of care. Nevertheless, wives who wish to and are able to remain involved with caring for their husbands should be encouraged to do so in whatever ways are conducive to the maintenance of positive and health-promoting caregiving and marital relationships.

### **Conclusion**

This longitudinal study of the caregiving careers of elderly wives revealed the different directions that their lives can take following the institutionalization of their husbands. Further research employing larger samples, from a variety of sites, and a longer time period will more definitively examine the experience of continuing to provide care to elderly husbands within an institutional setting. Such research should inform the development of strategies to ensure that the health and well-being of elderly wives, who are themselves experiencing the health and social consequences of advancing age, is not compromised because of the continuation of their caregiving career.

## References

- Abel, E. (1989). The ambiguities of social support: Adult daughters caring for frail elderly parents. *Journal of Aging Studies*, 3, 211-230.
- Abel, E. (1990). Daughters caring for elderly parents. In J. Gubrium & Andrea Sankar (Eds.), *The home care experience*. Newbury Park, CA: Sage.
- Aronson, J. (1991). Dutiful daughters and undemanding mothers: Contrasting images of giving and receiving care in middle and later life. In C. Baines, P. Evans, & S. Neysmith (Eds.), *Women's caring: Feminist perspectives on social welfare*. Toronto: McClelland & Stewart.
- Benjamin Rose Study (1982). *Problem solving effectiveness and caregiving elders*. Cleveland: Benjamin Rose Institute.
- Berg, B.L. (1989). *Qualitative research methods for the social sciences*. Toronto: Allyn & Bacon.
- Bowers, B. (1988). Family perceptions of care in a nursing home. *Gerontologist*, 28(3), 361-368.
- Brody, E., Dempsey, N., & Pruchno, R. (1990). Mental health of sons and daughters of the institutionalized aged. *Gerontologist*, 30, 212-219.
- Cantor, M. (1983). Strain among caregivers: A study of experience in the United States. *Gerontologist*, 23(6), 597-604.
- Dreiger, L., & Chappell, N. (1987). *Aging and ethnicity: Toward an interface*. Toronto: Butterworths.
- George, L., & Gwyther, L. (1986). Caregiver well-being: A multidimensional examination of family caregivers of demented adults. *Gerontologist*, 26(3), 253-259.
- Gerber, L. (1983). Ethnicity still matters: Socio-demographic profiles of the ethnic elderly in Ontario. *Canadian Ethnic Studies*, 15, 60-80.
- Gladstone, J. (1995). Feelings of elderly married persons living in long-term care institutions. *Ageing and Society*, 15, 493-515.
- Guberman, N. (1992). Women as caregivers: Why do they care? *Gerontologist*, 32(5), 607-717.
- Hughes, E. (1971). Cycles, turning points, and careers. In E.C. Hughes (Ed.), *The sociological eye*. New York: Aldine Atherton.
- Knight, B., Lutzky, S., & Macofsky-Urban, F. (1993). A meta analytic review of interventions for caregiver distress: Recommendations for future resesarch. *Gerontologist*, 33(2), 240-249.
- Lawton, P., & Brody, E. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *Gerontologist*, 9, 179-186.
- Lewis, J., & Meredith, B. (1988). Daughters caring for mothers: The experience of caring and implications for professional helpers. *Ageing and Society*, 8, 1-21.
- Lichtenberg, P., & Barth, J. (1989). The dynamic process of caregiving in elderly spouses: A look at longitudinal care reports. *Clinical Gerontology*, 9(1), 31-44.



- Marshall, V.W. (1979). No exit: A symbolic interactionist perspective on aging. *International Journal of Aging and Human Development*, 9(4), 345-358.
- Marshall, V.W. (1980). *Last chapters: A sociology of aging and dying*. Monterey, CA: Brooks Cole.
- Martin-Matthews, A. (1980). *Wives' experience of relocation: Status passage and the moving career*. Unpublished Ph.D. dissertation, McMaster University, Hamilton, Ontario.
- Martin-Matthews, A. (1987). Widowhood as an expectable life event. In V.W. Marshall (Ed.), *Aging in Canada: Social perspectives* (2nd ed., pp. 343-366). Markham, ON: Fitzhenry & Whiteside.
- Miller, B. (1989). Adult children's perceptions of caregiver stress and satisfaction. *Journal of Applied Gerontology*, 8, 275-293.
- Mui, A.C. (1995). Caring for frail elderly parents. *Gerontologist*, 35(1), 94-102.
- Ontario Ministry of Citizenship and Culture. (1981). *Mother tongue atlas of Metropolitan Toronto* (Vol. 2). Toronto: Author.
- Pearlin, L. (1992). The career of caregivers. *Gerontologist*, 32(5), 647.
- Pearlin, L., Mullan, J., Semple, S., & Skaff, M. (1990). Caregiving and the stress process: An overview of concepts and their measures. *Gerontologist*, 30(5), 583-594.
- Polit, D. (1996). *Data analysis and statistics for nursing*. Philadelphia: Lippincott.
- Radloff, L. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Rosenthal, C., & Dawson, P. (1991). Wives of institutionalized elderly men: The first stage in the transition to quasi-widowhood. *Journal of Aging and Health*, 3(3), 315-334.
- Ross, M. (1991). Spousal caregiving in later life: An objective and subjective career. *Health Care for Women International*, 12, 123-135.
- Ross, M., Rosenthal, C., & Dawson, P. (forthcoming). Caregiving in the institutional setting: Task performance. *Canadian Journal on Aging*.
- Rubin, A., & Shuttlesworth, G. (1983). Engaging families as support resources in nursing home care: Ambiguity in the subdivision of tasks. *Gerontologist*, 23(6), 632-636.
- Sauer, W., & Warland, R. (1982). Morale and life satisfaction. In D. Mangen & W. Peterson (Eds.), *Research instruments in social gerontology* (Vol. 1). Minneapolis: University of Minnesota Press.
- Spence, D., & Lonner, T. (1978-79). Career set: A resource through transitions and crises. *International Journal of Aging and Human Development*, 9, 51-65.
- Statistics Canada. (1987). *Family income: Census families*. Ottawa: Ministry of Supply and Services.
- Suiter, J., & Pillemer, K. (1990). Framework for studying social support and well-being. In S. Stahl (Ed.), *The legacy of longevity* (pp. 310-321). Newbury Park, CA: Sage.

- Williamson, G., & Schulz, R. (1993). Coping with specific stressors in Alzheimer's disease caregiving. *Gerontologist*, 33(6), 747-755.
- Wolfson, C., Handfield-Jones, R., Glass, K., McClaran, J., & Keyserlingk, E. (1993). Adult children's perceptions of their responsibilities to provide care for dependent elderly parents. *Gerontologist*, 33(3), 315-323.
- Zarit, S., Reever, K., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *Gerontologist*, 20(6), 649-655.
- Zarit, S., & Whitlach, C. (1992). Institutional placement: Phases of the transition. *Gerontologist*, 32(5), 665-672.

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