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Résumé

Capacité de planification et santé émotionnelle des enfants adultes soignants ayant subi des mauvais traitements dans l'enfance

Margaret England

Le but de cette étude était d'explorer les marqueurs associés aux habitudes en matière de planification et à la santé émotionnelle d'enfants adultes soignants présélectionnés en raison de leurs antécédents de mauvais traitements subis au sein de leur famille. Une grille de décision informationnelle et deux procédures de classification ont été utilisées afin d'organiser et de relier 246 plans écrits élaborés par 50 adultes fournissant presque six heures de soins par jour à un parent atteint de troubles cognitifs. Les résultats ont révélé trois constellations d'approches en matière de planification : une approche concrète centrée sur la personne, une approche instrumentale et une autre alimentée par le chagrin. Les 31 participants adoptant une approche instrumentale en matière de planification étaient beaucoup plus susceptibles que les 17 autres adoptant une approche alimentée par le chagrin de rapporter des expériences d'abandon, de trahison, d'idées de suicide et de consommation d'alcool. Les deux participants dont l'approche était centrée sur la personne présentaient beaucoup moins de réactions émotives et de risques de dégradation de la santé ; de plus, ils n'ont rapporté aucune expérience de détresse ou de stratégies d'adaptation centrées sur l'expression d'une détresse émotionnelle. Les infirmières et infirmiers pourront utiliser ces résultats afin de mettre en évidence et de renforcer les capacités en matière de prise de décision et de soins parentaux des soignants ayant subi des traumatismes dans l'enfance.

Mots clés : prise de décision, santé émotionnelle, enfants adultes, soignants, mauvais traitements, famille d'origine, taxonomie, grille de décision informationnelle

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Planning and Emotional Health of Abused Adult Children Caregivers

Margaret England

The purpose of this study was to explore markers associated with the advance-planning patterns and emotional health of adult child caregivers pre-selected for their history of childhood abuse within the family. An informational decision grid and two classification procedures were used to organize and link 246 written plans of 50 adults providing nearly 6 hours of care per day to a cognitively impaired parent. Results revealed 3 constellations of plans describing hands-on person-centred, instrumental, and grief-based approaches to caregiver planning. The 31 participants taking an instrumental approach to planning were significantly more likely than the 17 taking a grief-driven approach to report experiences of abandonment, betrayal, suicidal ideation, and use of alcohol. The 2 participants taking a person-centred approach reported significantly less emotional arousal and risk for loss of health and did not recount experiences of distress or emotion-focused coping. Nurses can use the findings to highlight and strengthen the decision-making and parental-care capacities of caregivers traumatized in childhood.

Keywords: decision-making, emotional health, adult children, caregivers, abuse, family of origin, taxonomy, informational decision grid

Nearly one fifth of all parental-care situations begin with an adult child's observation of the cognitive decline of a parent (Prescop, Dodge, Morycz, Schulz, & Ganguli, 1999). Initially, adult children are unprepared for caregiving despite their awareness of the eventual need for care (Albert, Moss, & Lawton, 1996). They soon realize that they must not only assist dependent parents with basic activities of daily living over a long period, but also provide care once delivered by nurses with specialized education (Hoffman & Mitchell, 1998). They also learn that they must expend considerable energy and resources arranging for parental care (Brody, 1985; Penning, 1998).

Caregivers of parents typically report varying levels of emotional distress related to critical family events; escalating responsibility; and insufficient skills, knowledge, financial resources, and tolerance for parental care despite strong emotional bonds and the best of intentions (Braithwaite, 1996, 2000). Research indicates that children try emotionally to link their own sense of self with that of a dependent parent in order to cope with critical parental-care events and deprivations that accrue in their own lives because of caregiving (Gottlieb & Gignac, 1996;

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Wackerbarth, 1999). At the same time, at least one in three adult children do not meet the basic challenges of parental care, reporting high levels of caregiver strain and depression (Alspaugh, Zarit, Stephens, Townsend, & Greene, 1999; Dura, Stukenberg, & Kiecolt-Glaser, 1991). Caregivers of parents are more likely than other caregivers to ignore or avoid the emotional implications of care (Fingerman, Gallagher-Thompson, Lovett, & Rose, 1996; Powers, Gallagher-Thompson, & Kraemer, 2002). Such emotion-focused coping suggests that caregivers of parents are at risk for being traumatized by events tied to care.

Research in the area of trauma indicates that a history of physical or sexual abuse, turmoil in the family of origin, multiple lifetime losses, and recent stressful events are related to poor health status (Leserman, Li, & Drossman, 1998). Research with adult children caregivers who were exposed to childhood victimization or who experienced a recent crisis, for example, reveals that those with weak confidence resources report greater emotional arousal and poorer subjective health than more resourceful caregivers (England, 1997; Fingerman et al., 1996). Those who do not envision outcomes of caregiving very well appear less able to balance care demands (Shyu, Archbold, & Imle, 1998). Thus, it is not surprising that some caregivers of parents report a significant loss of personal mastery the longer they remain in the caregiving role (Skaff, Pearlin, & Mullan, 1996). The implication is that more must be done to assist those at risk for toxic consequences of parental care.

The burden and suffering shared by caregivers of parents, together with a growing social acceptance of caregiver support, provide a window of opportunity for more research into the evolution and treatment of emotional arousal secondary to dependent parental care. Little is known about how adult children, abused in their family of origin, respond to parental-care events. The purpose of this exploratory, descriptive study was to explore markers for emotional distress and coping associated with the perceived health and planning patterns of this population of caregivers.

The findings can inform our understanding of how childhood victimization affects the well-being and decisional capabilities of caregivers of parents and how clinicians might help these caregivers apply decision-making principles to emotional self-care, parental care, and use of informal support. This information will help set the stage for further research on the association of caregiver planning with parental-care involvement and health of adult children caregivers abused in the family of origin. It will help nurses and other service providers appreciate differential patterns of risk among caregivers of parents and how best to target resources and support for this population.

Background

Caregiving within the context of family-of-origin variables is an understudied area of research (Dwyer, Henretta, Coward, & Barton, 1992). A review of databases for nursing, medicine, psychology, and social work, for example, yielded no studies of adult children caregivers specifically reporting on a history of childhood victimization in their family of origin. Yet at least one in four adults report having been emotionally, physically, or sexually abused within their family of origin (Finkelhor, Hotaling, Lewis, & Smith, 1990; Kamsner & McCabe, 2000). Given these figures, it is highly probable that some survivors of childhood abuse within the family will, at some point, provide care to a dependent parent.

Trauma of Abuse

Research reveals that childhood victimization plays a key role in the etiology of chronic distress and existential well-being and ability of the abuse survivors to form or sustain trusting relationships (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Feinauer, Middelton, & Hilton, 2003). Physical abuse, coupled with low family cohesion and exposure to parental violence, has been tied to symptoms of trauma and impaired self-esteem (Draucker, 1996; Kamsner & McCabe, 2000). Signs of trauma are tied to alcohol-related problems in adulthood and use of insecure-attachment behaviours (Caetano, Craig, & Nelson, 2003).

Female survivors of abuse are more likely than members of other female groups to report chronic fatigue or pain and to report depression; they are also likely to report more illness or disability days in bed and more health-related visits to a physician (Ohayon & Schatzberg, 2003; Vertommen, Van Houdenhove, Onghena, Westhoven, & D'Hooghe, 2001). In addition, they are more likely to view day-to-day distress as a catastrophic event and are less likely to maintain positive relationships with an intimate partner (Drossman et al., 2000). Yet, to their credit, hardy abuse survivors compared with their less hardy counterparts exhibit greater creativity, resourcefulness, determination to succeed, and ability to take advantage of opportunities for self-enhancement (DiPalma, 1994; Feinauer, Hilton, & Callahan, 2003).

Decision-Making

Although adult children anticipate the eventuality of care, few make concrete plans for care before a perceived crisis emerges (Soerensen & Zarit, 1996). Planning typically begins with a precipitating event, at which point the person becomes aware of the need to aid a parent in decline, think ahead, and make decisions. It involves anticipation of the need for care, decisions and concrete plans, and role socialization. In theory, parental-care decision-making is most effective when there is a family ethos for resolving family conflicts about the assistance to be given to the parent and when responsibilities and privileges tied to parental care are focused and concentrated in a single family caregiver (Cath, 1972; Owens & Qualls, 1997). Adult children who are less burdened with life events and are more able to communicate, make decisions, and resolve conflicts report less parental-care distress than those who are more burdened with life events, have poorer communication and conflict-resolution skills, and possess less focused decision-making styles (Lieberman & Fisher, 1999).

Research suggests that childhood victimization compromises the development of decisional resources for coping with life events in adulthood (Coffey et al., 1996; Kamsner & McCabe, 2000). An analysis of the concerns and expressed needs of highly distressed caregivers of parents in one study, for example, revealed an accumulation of losses and other problematic life events in the lives of the caregivers, high use of tension-reducing behaviours, and a host of unresolved conflicts with siblings and other family members (England & Tripp-Reimer, 2003); many concerns pointed to a loss of existential well-being and a history of childhood neglect or abuse. Missing from the research, however, are clear descriptions of the day-to-day decision-making of adult children abused in their family of origin. Also missing are clear descriptions of decisions pointing to how the adult children resolved personal needs while engaged in the role of caregiver. Such descriptions could help nurses and other clinicians appreciate differential patterns of risk among caregivers of parents and how best to target resources and support for them.

Conceptual Framework for Planning

Rapaport and Orbell (2000) argue that a clinician's ability to integrate an adult child's self-concept and perspective on caregiving is an important consideration for how clinicians might help adult children organize their care decisions. Kasch and Holder (1999) propose the analysis of strategic messages as a framework for this purpose and recommend the use of classification systems for analysing language contained in the decisions of caregivers. The informational decision grid shown in Table 1 provides a framework for the organization and analysis of the language contained in the written plans of caregivers in this study.

Conceptualization of the grid was based upon two critical attributes of planning: goal structure and human need orientation (England, 1996). Goal structure refers to an arrangement of mental actions designed to

Table 1 ***Informational Decision Grid[a] for Organizing the Plans of Adult Children Caregivers***

Goal Structure	**Human Need Orientation**			
Categories of caregiver planning	***Physical and physiological***	***Safety and security***	***Relational***	***Person-enhancing***
Goal state	11	12	13	14
Goal operation	21	22	23	24
Goal strategy	31	32	33	34

[a] The first number of the two-digit classification code in each cell represents the goal structure of a caregiver decision; the second number represents the human need orientation of the decision.

fulfil some trajectory or object of satisfaction. A goal structure represents a cognitive component of planning that can be operationalized at the level of a goal state, goal operation, or goal strategy. A goal state is an awareness of an anticipated state of being or way of acting. A goal operation is a specific intention to act (or not) derived from knowledge, personal values, motivations, or social norms. A goal strategy is a prescription or objective involving deliberative action within a specific time frame or context.

Human need orientation refers to an arrangement of mental actions designed to fulfil some purpose or function for which a goal structure is constructed. It represents a motivational component of planning that can be operationalized at four levels of imminent concern: physical or physiological need, safety and security need, relational need, and self-enhancement need. Table 2 provides examples and classification codes for the decisions of two adult children reporting physical abuse in their family of origin. The first digit of the classification code represents the goal structure of the decisions and the second digit represents the human need orientation of the decision.

The Study

The informational decision grid and rules for classification were used in the study to organize and link up the written plans of the different adult children. Patterns of planning were then tied to parental-care involvement, emotional arousal, distress and coping, and perceived health of the participants. Approval to obtain this information was granted by the Internal Review Board of a large, publicly supported health science centre in the Midwestern region of the United States.

Table 2 *Written Caregiving Plans of Two Adult Children Caregivers Abused in Their Family of Origin*[a]

Written Plans[b]	**Physical or Physiological**	**Safety and Security**	**Relational**	**Person-Enhancing**
Goal state	"For her to gain a little weight" (code 12).			"She will have a good time when I come visit" (code 14).
Goal operation		"Take care that she doesn't trip on anything because she doesn't always watch where she puts her feet" (code 22).	"I will treat her well… better than the way my dad treated her" (code 23). "Encourage the nurses to spend a little chit chat time with her as well" (code 23).	
Goal strategy			"Take her for a stroll in the park this weekend" (code 33). "Ask my sister to help me with Mother's laundry" (code 33).	
Written Plans[c]	**Physical or Physiological**	**Safety and Security**	**Relational**	**Person-Enhancing**
Goal state		"I want to know that he's being fed and bathed" (code 12). "I really can't stand the way [not tolerant] he slobbers all over himself" (code 12).	"I wonder what he'll think after all these years if I told him that I'm beyond caring" (code 13).	
Goal operation	"Obviously, he has to be fed and bathed" (code 21).			
Goal strategy		"Visit the nursing home every 6 months to obtain a report on my father" (code 32).		

[a] The first digit of each two-digit classification code represents the goal structure of the caregiver decision; the second digit represents the human need orientation of the decision.
[b] Hands-on, personal approach to planning. [c] Grief-driven approach to planning.

Sample

Funding for the research allowed for the recruitment of a convenience sample of 50 volunteers from a listing of urban-dwelling adults attending a caregiver support group, limiting the pool of participants to those most likely to voice their concerns and need for help. Self-report criteria for inclusion in the study were that participants be English-speakers reporting a history of victimization in the family of origin and primary responsibility for decisions about the welfare of a cognitively impaired parent.

The sample consisted mostly of high-school-educated (82%), married (76%), employed (90%), Caucasian (88%) women who had been caring for a dependent parent for less than 9 months (Table 3). Two thirds of the participants were firstborn daughters. The dependent parents were mostly mothers (88%) diagnosed with Alzheimer disease (90%) or cerebral vascular disease (10%) resulting in severe confusion and loss of judgement concerning activities of daily living; 14 (28%) resided with the study participant, 12 (24%) resided with a spouse, and the remainder (48%) resided in an institution.

Nearly all participants had been emotionally (98%), physically (30%), or sexually (42%) abused or neglected (22%) while growing up. Eleven (22%) had experienced multiple forms of abuse and seven (14%) acknowledged events in which they had emotionally or physically abused their dependent parent. More than 80% recounted experiences of betrayal, abandonment, being alone in the world, and suicidal ideation. The majority had left home before the age of 18 (78%) and used alcohol (76%) for coping. Of the 13 participants (26%) reporting parasuicide, four had made an attempt within the preceding year.

Measures

Hours of care was defined as a relative amount of time spent performing parental-care tasks and was measured using the revised Caregiver Burden Inventory (England & Roberts, 1996). The CBI is a 27-item instrument that measures engagement in physical, instrumental, and psychosocial tasks of parental care on five-point ordinal rating scales. Adult children completing the CBI average 3 to 5 hours of care per day to a cognitively impaired parent (England, 2000). Coefficient alpha for the CBI is in the range of 0.88 to 0.93. Previous research indicates that data collector/study participant agreement with calculated estimates for hours of care is 0.96 (England & Roberts) — that is, the number of hours of care reported by adult children is equivalent to the hours of care credited to them.

Table 3 ***Background Variables of 50 Adult Children Caregivers Abused in Their Family of Origin***

Variable		***N***	**%**
Gender	Male	5	10
	Female	45	90
Race	Caucasian	44	88
	Black	2	4
	Hispanic	4	8
Birth order	Firstborn	33	66
	Lastborn	7	14
Marital status	Married	38	76
	Not married	12	24
Education	High-school diploma	41	82
	Post-high school	9	18
Employment	Yes, full-time	45	90
	Yes, part-time	2	4
	No	3	6
History of abuse	Emotional	49	98
	Physical	15	30
	Sexual	21	42
	Physical and sexual	11	22
	Neglect	11	22
Indicators of distress	Left home before age 18	39	78
	Being alone in the world	48	96
	Abandonment	41	82
	Betrayal	43	86
	Suicidal ideation	43	86
Indicators of coping	Recounting	46	92
	Use of alcohol	38	76
	Elder abuse	7	14
	Parasuicide	13	26

Emotional arousal was defined as a caregiver's self-report of pleasant and unpleasant feeling states and was measured using the revised Emotional Arousal Scale of the Caregiver Strain Questionnaire (England & Roberts, 1996). The ERS is a six-point ordinal rating scale that measures the extent to which 12 words reflect feeling states associated with a current parental-care situation. Coefficient alpha for items on the ERS is in the range of 0.79 to 0.88.

Perceived health was defined as an adult child's rating of how far he or she is from an ideal state of health or well-being while in the role of filial caregiver (England, 2000). ***Perceived health risk*** was defined as the caregiver's rating of how close he or she is to loss of health or well-being. Both of these variables were measured with single-item, ordinal rating scales. The scales were formatted as a 10-rung ladder and participants were asked to rate their distance from an ideal health state and their risk for loss of health. Average values of perceived health for adult children reporting crises within the previous 6 months are in the range of 6.5 to 6.7.

Caregiver planning was defined as the process of securing a future caregiving situation by integrating concerns, ideas, and values regarding how that situation ought to unfold. Planning consisted of an adult child's written declaration of awareness, intention, or strategy for promoting self-care or the care of a dependent parent, including the physical, security, relational, or person-enhancing orientation of this effort. The construct was operationalized as a set of decision units termed caregiver decisions.

Caregiver decisions were defined as the "most important" outcomes of a planning process pertaining to self-care or parental care. The variable was operationalized as content-substantiated "most important" written plans — that is, the participants were asked to write down, on a Caregiver Planning Form (CarePL), what they considered their most important plans for self-care and parental care in the next 2 weeks, and were then invited to orally describe the meaning of the plans to a nurse and, if they wished, to revise the substance of the plans in order to better reflect their concerns, ideas, or goals.

Procedure

Data were obtained at the site where caregivers attended meetings of a support group led by a doctorally prepared female social worker. Following consent to take part in the study, 50 adult children completed a demographic data form, a survey of dichotomous indicators for distress and coping, and other paper-and-pencil measures for hours of care, emotional arousal, perceived health, and perceived health risk. The participants later took part in a 90-minute interview with a clinical nurse specialist. The interview was scheduled at the convenience of both parties.

During the interview, the nurse queried the participant about concerns and goals for self-care or parental care using communication strategies to elicit ideas and link them together. The participants were asked to discuss their relationship with their dependent parent, their feelings, and their goals and plans for caregiving. They were directed to write down, on the CarePL, and then clarify, their most important plans for caregiving in the next 2 weeks.

The nurse provided preparatory information about the writing task in order to reduce any uncertainty associated with it. The nurse discussed with the participant dictionary definitions for the terms caregiver, caregiving, planning, important, plans, and decisions. The nurse also shared written examples of plans and decisions that did not pertain to caregiving. The participants were informed that no presumptions would be made about the relative goodness of any plan they wrote down. Also, they were assured that writing a plan for the purposes of the study in no way implied that they could not revise the plan or choose not to follow through with it.

The meaning of "most important" plans for care was clarified orally with the participants once the plans were written down. Points of clarification consisted of identifying the action component (verb) of the plan, the object of the plan (purpose), and the content and context of the plan (situation for planning). The nurse invited the participants to reword their written plans if necessary to better reflect particular concerns or ideas.

At the end of the interview the nurse calculated the number of hours of care per day provided to the parent and confirmed the figure with the participant. The nurse then assigned a two-digit classification code to each written plan generated in the interview and plotted the codes for each plan on an informational decision grid for the participant to reflect on (see Table 2 for examples). Following data collection, the investigator independently assigned a two-digit code to each written plan and content validated the coding with the nurse. One month later, the investigator and the nurse independently recoded the plans with discrepant classification codes and validated these judgements with one another.

Research Questions

1. *What content emerged from classification of adult children's plans for caregiving?* 2. *What patterns of caregiver planning emerged from the organization of adult children's plans?* 3. *Can patterns of caregiver planning be tied to parental care involvement, emotional arousal, distress and coping, and perceived health of adult children?*

Analysis

Two classification procedures were used to organize the participants' most important written plans for caregiving. In the first procedure a two-digit code was assigned to each written plan, the first digit representing the goal structure of the plan and the second digit representing human need orientation of the plan (see Table 2 for examples). In the second procedure an ethnographic software program and typology of decision content were used to further codify the written plans. The purpose was to generate more detailed classes of human concern given one of four basic human need orientations. Codified plans in each category of human need orientation were cross-referenced iteratively with one another and with data from other categories of human need orientation. The purpose was to illuminate meaningful patterns of human concern embedded in the data.

Decision rules to facilitate accurate classification consisted of identifying the verb or action component of each written plan, the intent or object of the plan, the content or theme, and, whenever possible, the context of the plan. The recording of the action component of a plan was meant to facilitate discernment of the overall goal structure of the plan. The recording of the object of the plan was meant to facilitate discernment of the goal operation of the plan. The recording of the content, theme, and context of the plan was meant to facilitate discernment of the specific goal structure and human need orientation of the plan. The rationale for this manner of classification was to achieve an efficient best fit between the meaning of a plan, given the organizing principles for the informational decision grid, and the perspectives of the participants.

Results

The participants had, on average, been caring for a cognitively impaired parent for 8.91 months and were currently providing 5.84 hours of care per day (Table 4). Their respective mean ratings for emotional arousal, perceived health, and risk for loss of health were 40.57 (*SD* = 13.61), 5.85 (*SD* = 1.88), and 7.92 (*SD* = 1.85). The participants reported multiple indicators of distress and emotion-focused coping (Table 3).

Table 4 ***Age, Income, Parental Care, and Perceived Health of 50 Adult Children Caregivers Abused in Their Family of Origin***

Variable	***Range***	***M***	***SD***
Age in years	37–66	51.87	5.69
Annual personal income	$0.00–$70,500	$37,600	$10,776
Parental-care hours/day	1–12	5.84	4.22
Parental-care months	2–46	8.91	7.90
Emotional arousal	23–62	40.57	13.61
Health rating	2–8	5.85	1.88
Health risk	4–10	7.92	1.85
Written plans	1–10	4.92	2.51

Table 5 *Number and Percentage of Written Plans Classified on the Basis of Goal Structure and Human Need Orientation*

Categories of Caregiver Planning	Physical and Physiological		Safety and Security		Relational		Enhancement		Total	
	F	%	*F*	%	*F*	%	*F*	%	*F*	%
Goal state	18	7.3	52	21.1	18	7.3	9	3.7	97	39.4
Goal operation	9	3.7	56	22.8	21	8.6	3	1.2	89	36.3
Goal strategy	5	2.0	49	19.9	5	2.0	1	0.4	60	24.3
Total	32	13.0	157	63.8	44	17.9	13	5.3	246	100.0

Note: Coefficient κ for classifications = 0.79.

Written Plans

All participants provided written plans for the study; six (12.0%) sought clarification as to whether their plans met the study criteria for planning. Initial classification procedures produced 246 most important written plans for caregiving in the next 2 weeks, an average of 4.92 decisions per adult child. Classification of the goal structure of the plans yielded 97 (39.4%) goal states, 89 (36.3%) goal operations, and 60 (24.3%) goal strategies (Table 5). Corresponding classification of the human need orientation of the decisions yielded 32 (13.0%) plans for physical care, 157 (63.8%) plans for safety and security of the parent, adult child, or other family member, 44 (17.9%) plans pertaining to filial or other relationships, and 13 (5.3%) plans relating to personal enhancement of the parent or adult child. Cohen's (1960) coefficient *k* for inter-rater reproducibility of the two-digit classification codes assigned to the plans was 0.79. Mean percentage agreement for the classifications was 0.97.

Content of Planning

A typology of decision content based on the human need orientation of the participants' plans yielded more detailed description of the plans. Classifications (*n* = 32) with a physical or physiologically orientation described plans detailing participant concerns about health, self-care requisites, and material resources for care. The plans were grouped into 18 goal states, 9 goal operations, and 5 goal strategies, including *"be mindful of her health" (code 11), "feed her" (code 21),* and *"put on her shoes and socks every day" (code 31).*

Classifications (*n* = 157) oriented to safety and security described plans addressing participant concerns with the management of day-to-day events, tasks, or finances; protection of self or the parent; and perceived condition of a parent, situation, or care environment. The plans were grouped into 52 goal states, 56 goal operations, and 49 goal strategies, including *"hope she doesn't burn the house down" (code 12), "lock the doors so that she doesn't wander off" (code 22), "reassure myself that I can cope" (code 22),* and *"talk to the nurses tomorrow about cleaning my mother's wheelchair" (code 31).*

Classifications (*n* = 44) with a relational orientation described plans addressing participant worries, family relationships, reciprocity, and agency. The plans were grouped into 18 goal states, 21 goal operations, and 5 goal strategies, including *"don't argue with Dad about her care" (code 13), "grieve privately so that my children will not worry about me" (code 23), "go with my sister to the nursing home so that she doesn't talk Mother into signing papers" (code 23),* and *"read the Bible to her on Sunday morning" (code 33).*

Table 6 ***Associations of Caregiver Planning With Parental-Care Involvement and Emotional Health of 50 Adult Children Abused in Their Family of Origin***

Planning Pattern	**Person-Centred** $n_1 = 2$		**Instrumental** $n_2 = 31$		**Grief** $n_3 = 17$		**Test of Significance**
Study variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(2,47)*
Parental-care hours/day	5.22	0.77	7.27	5.51	3.31	2.27	4.69
Written plans	5.50	0.53	5.66	3.18	3.50	1.52	5.81
Emotional arousal	25.25	4.56	44.21	14.79	35.73	12.53	7.49
Perceived health	7.45	1.29	5.31	2.06	6.65	1.63	7.61
Perceived health risk	5.34	1.22	8.51	1.57	7.14	2.44	8.17
Indicators of distress and ccoping	*f*	%	*f*	%	*f*	%	Cochran's Q *(2)*
Recounting	0	0.0	31	100.0	15	88.0	31.35
Aloneness	1	50.0	31	100.0	16	94.0	28.13
Abandonment	1	50.0	30	97.0	11	65.0	31.00
Betrayal	0	0.0	29	94.0	14	82.0	29.35
Suicidal ideation	0	0.0	30	97.0	13	76.0	31.58
Parasuicide	0	0.0	9	29.0	4	24.0	9.39
Use of alcohol	0	0.0	29	94.0	9	53.0	34.79

Finally, classifications ($n = 13$) with a person-enhancing orientation described plans concerning personhood or the personal development of a parent, family member, or the participant. The plans were grouped into 9 goal states, 3 goal operations, and 1 goal strategy, including *"try to be all that I can be to my mother" (code 14), "see to it that she is well dressed, like a real person" (code 24), "take my dad fishing once in a while" (code 24), "commend my sister for helping me fight off my dad's advances" (code 24),* and *"talk with the pastor tonight about the songs we want for her funeral" (code 34).*

Patterns of Planning

The organization and linking of participants' plans yielded three hypothetical patterns of caregiver planning. The first pattern, assigned to two adult children, described a hands-on, personal approach to planning. It consisted of providing care or respite, asking a family member for help, acting on behalf of the parent, sharing a relational event with the parent, and attending to the personhood of the parent (e.g., first pattern in Table 2). Plans dealt with taking care, taking precautions, being watchful, and presenting the parent in a positive way. The participants who were assigned this pattern of planning reported significantly less emotional arousal and risk for loss of health than other participants, despite comparable number of hours of parental care (Table 6).

The second planning pattern, assigned to 31 adult children, described an instrumental, task-oriented approach to planning that addressed resources for caregiving, sense of security, and taking things step by step. Plans included custodial aspects of care and the appropriateness of the environment for care. Some plans addressed assessment of the health, safety, or functional status of the parent or caregiver, while others suggested a tit-for-tat manner of relating within the family. Plans for achieving personal security included *"need to cope" (code 12), "get a grip on myself" (code 12),* and *"be in control" (code 12).* Plans for relational security included *"make sure that we all do things equally" (code 22), "don't want him bothering the children" (code 12), "she's better off being in a nursing home" (code 12), "[I] long for stability in the family" (code 12),* and *"have nothing to do with him [Dad]" (code 22).*

The participants who were assigned an instrumental pattern of planning reported high scores for emotional arousal and risk for loss of health (Table 6). According to the nurse interviewer, these participants had engaged in particularly repetitive, negative narratives of distress and urgency or showed an inability to engage in the usual activities of daily living because of caregiving. Most reported experiences of aloneness, abandonment, betrayal, suicidal ideation, and use of alcohol. All had left home before the age of 18 and four had attempted suicide within the previous year.

The third planning pattern, assigned to 17 adult children, described grieving that illuminated elements of suffering and concern for the personal welfare of the caregiver, parent, or another family member. More than half of the plans falling into this pattern were written in the form of goal states. Issues tied to the goal states included loss of mastery, freedom from threat, conservation of energy, and needing help. Some plans dealt with distress, separation, or control of the filial relationship, while others dealt with memories, meaning in life, or a parent's legacy (e.g., second pattern in Table 2). The participants who were assigned this pattern of planning reported experiences of aloneness, abandonment, betrayal, suicidal ideation, and use of alcohol (Table 6). They also reported high scores for emotional arousal and risk for loss of health, but the scores were not as high as those of the participants who were assigned an instrumental pattern of planning (Table 6).

Discussion

This exploratory study was developed to identify markers tied to emotional health and planning patterns of adult children caregivers with a history of victimization in their family of origin. Given the expectations and complexity of long-term care in the case of a cognitively impaired parent, it is not surprising that the participants spent nearly 6 hours per day, on average, on tasks associated with parental care. Their written plans homed in on issues of safety and security more than on other aspects of care, a finding consistent with the results of previous research (England, 1994). At the same time, the participants generated 40% fewer relational plans and fewer plans for physical or person-enhancing care than found in previous research. The absence of physical and relational plans may be linked with the residence of the dependent parent and the fact that some parents retained sufficient long-term memory to permit self-care. It is also possible that some adult children preferred not to engage in physical or person-enhancing parental care because of ambivalence with role-reversing or physically intimate aspects of such care. It is possible that these caregivers, given their history of childhood victimization, did not have sufficient reciprocity, interpersonal boundaries, or tolerance for close engagement with a parent.

The participants in this study generated 70% more goal states than those in previous research (England, 1994), and in the process they sacrificed a focus on the development of goal operations. While the participants clearly had concerns about and hopes for themselves and their parents, they may not have been sufficiently mindful, resilient, or confident to consistently develop plans on the basis of knowledge, values, or norms for self-care or parental care. According to crisis theory, upset individuals with a narrowed perceptual field and high concentration of goal states for planning are at increased risk for failure to thrive in their situation, and thus may need help with practical aspects of planning (Roberts & Dziegielewski, 1995).

The procedures used to organize and link the plans of the different participants yielded person-centred, instrumental, and grief-based patterns of planning among the adult children in the study. Two of the participants who were assigned a person-centred pattern of planning differed from the other participants in that they reported significantly better perceived health and did not recount negative indicators of abuse or emotion-focused coping. Their plans incorporated three levels of abstraction and a range of human needs suggesting a practical, flexible understanding of how to meet particular caregiving challenges. It is possible that these participants had somehow reconciled conflicts tied to their family of origin, developed more affiliation with their dependent parent, and derived more positive meaning from the caregiving situation. According to cognitive appraisal theory (McCarthy, Mejia, & Liu, 2000), this rather holistic conceptualization of caregiving plans is likely the result of how the caregivers deconstructed and reconstructed their situation and their emotional responses.

The 31 adult children who were assigned an instrumental pattern of planning reported the highest scores for emotional arousal and risk for loss of health. They also provided explicit oral accounts of abuse, trauma, and emotion-focused coping, including alcohol use, elder abuse, and parasuicide. Their plans were consistent with their oral reports, alluding to negative appraisals of caregiving, intrusive experiences, and use of palliative or avoidance strategies for coping. Their plans, however, lacked general coherence and did not lead to corresponding practical plans to resolve concerns about personal or relational insecurities. These findings suggest that many participants were engaged in passive or reactive decision-making and did not have sufficient resources to fulfil important desires. It is possible that chaotic circumstances and abuse within the family of origin had predisposed these persons to view caregiving as an ill-fated endeavour, and to reduce their ability or willingness to make definitive plans, especially for a parent who had contributed to their abuse.

The 17 adult children who were assigned a grief-based pattern of planning reported significantly fewer plans and hours of parental care than the other participants. More than 50% of their plans were in the form of goal states that addressed desires to ameliorate relational concerns and suffering. Their failure to link desires with specific planning suggests that they were less able than other participants to translate ideas into practical solutions to problems, or were more caught up in their inability to commit resources to parental care.

Interestingly, the adult children who were assigned an instrumental or grief-based pattern of planning were similar to one another in that they had high scores for emotional arousal and perceived risk for loss of health, a finding that is consistent with their accounts of aloneness, abandonment, betrayal, suicidal ideation, and use of alcohol (Table 6). At the same time, the emotional arousal and perceived health scores of the grief-based planners were significantly lower than those of the instrumental planners, but higher than those of adult children in other research (England, 1994). It is possible that grief-based planners were more prepared than instrumental planners, but less so than secure caregivers, to face conflicts and losses accrued from their role within the family.

In theory, grieving provides an avenue for individuals to relinquish harmful affect and re-contextualize relationships within the family of origin (Fingerman, 1997). Thus, grieving can provide adult survivors of childhood abuse avenues for becoming more attuned to their own needs, capacities, and purposes in life. Nevertheless, it must be noted that while a combination of high arousal, grief-based planning, and low involvement with parental care might conserve well-being in the short term, it may not ensure effective parental care and resolution of concerns in the long run.

Conclusions and Implications

The findings from this study indicate that many adult children victimized in their family of origin do not form patterns of planning that can sustain emotional health or effective parental care over the long term. Compared to the plans of caregivers of parents in previous research (England, 1994), those of the participants in this study were linked with significantly fewer goal operations in general and fewer relational and person-enhancing plans in particular. These more abstract, task-oriented and security-oriented plans are associated with significantly greater emotional arousal and perceived risk for loss of health. This combination of variables points to difficult relationships with dependent parents and insecurity concerning how adult children might effect change while in the role of caregiver. The implication is that highly aroused adult children need to modify the structure of their plans. These caregivers might also modify or supplement goal states and concentrated instrumental planning with more holistic, person-centred approaches.

In theory, individuals moderate their emotional distress according to how they conceptualize emotions and decisions for self-management

(McCarthy et al., 2000). When individuals understand how decisions are connected with memory and emotional sense experience, they are more likely to intuit meaning from their efforts and plan accordingly. The findings from this study suggest that many adult children victimized in their family of origin do not have sufficient memories and emotional sense experience to intuit meaningful plans for self-care and parental care. It is likely that the inner resources and affiliation of the caregivers are not potent enough to offset the burdens of parental care. The implication is that these caregivers need critical supportive care to enhance their meaningful engagement with and tolerance for caregiving.

Given the prevalence and long-term negative consequences of childhood victimization, nurses need to increase their ability to recognize and respond to survivors of abuse. An important goal of nursing, then, is to sustain partnerships with survivors of abuse that foster perceptions of worth, mastery, competence, and control. By doing so, nursing can affirm and accommodate the needs of survivors and avoid contributing to the root causes of their sense of abandonment, betrayal, or alienation (Gallant, Beaulieu, & Carnevale, 2002; Nolan, 2001). Nurses should consider caregivers of parents as experts in their own needs and affirm their inherent decision-making capabilities. Nurses can encourage caregivers who have been abused in the family of origin to recall, acknowledge, and re-contextualize traumatic incidents so that they can reclaim a sense of self as well as a purpose for caregiving. In addition, they should commend the caregivers for having the courage to care and help them access and use informal means of support.

Implementation of study procedures suggests that caregivers of parents can tolerate plan-writing and discourse on their present parental-care situation. The effort of participants to make visible their concerns and desires in the form of written plans demonstrates well that adult children can take reasoned action to change their situation. It appears that plan-writing and discourse can offer caregivers a value-added opportunity to make coherent plans and at the same time negotiate conflicts connected with the family of origin. Insertion of their written plans into an informational grid can assure these caregivers of the validity of their needs and desires.

Future Directions

The findings suggest that informational decision grids and plan-writing can help caregivers victimized in their family of origin to conceptualize reasoned actions for emotional self-care, parental care, and use of informal support. Future research should examine the efficacy of these heuristic decisional aids for case finding and decision support. In addition, it should target more particularized narratives from caregivers abused in childhood in order to more fully reveal the meaning of caregiving for this population. Such research would set the stage for formal validation of a decision-support intervention for this population.

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