Stress, Role Captivity, and the Cessation of Caregiving*

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Difficulties experienced when caring for an impaired elderly relative, including decisions to place this person in institutional care, are examined as a function of caregiver stress. Three annual interviews were conducted with 555 caregivers to parents or spouses with Alzheimer’s Disease. All patients were initially cared for at home, but 192 were subsequently placed in institutional care and 146 died. Background-contextual factors and disease characteristics have only limited associations with institutionalization. Two secondary stressors—consequences of caregiving that do not directly involve care-related tasks—exert the most proximal impact upon placement: role captivity and economic strain. Role captivity is stable over time when in-home care continues, but institutionalization alleviates this sentiment. The odds of patient death increase substantially following institutionalization, even when health status is controlled. These results illustrate that in-home care may be beneficial for care-recipients, but increase role-related stress for the care provider.

Chronic illness, especially when it entails cognitive degeneration, often exerts a disruptive influence upon ordinary family relations. Perhaps the quintessential example of such disruption occurs among families caring for someone with Alzheimer’s Disease (AD). Typically found among persons of advanced age, AD is a dementia that diminishes memory, impairs cognitive processes, and reduces internal behavioral controls. As these symptoms advance, patients require increased supervision and assistance. The relentless demands associated with AD care may stretch and overwhelm the adaptive capacities of the family. One potential adaptation is to place the AD patient in a long-term care facility.

Yet, even when institutionalization is financially and logistically feasible, only some caregivers pursue this alternative; others do not, even though they face seemingly similar difficult circumstances.

We believe that both the difficult experiences associated with caregiving and decisions to place an impaired relative in institutional care can be understood within the conceptual framework of a stress process. As articulated in reference to caregiving situations (Pearlin et al. 1990), this process is driven by two major types of stressors. The first, primary stressors, is made up of the demands and tasks anchored in daily care: supervising the patient; restraining him or her from potentially harmful actions; performing bodily maintenance tasks, such as bathing, dressing, and feeding the patient, and instrumental tasks, such as paying bills; and, enduring these demands day in and day out. Onerous though these tasks may be in their

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own right, typically other secondary stressors develop or intensify as caregiving continues through time. These secondary stressors do not directly involve the tasks of providing care, but emerge as problems in other social roles, network relations, and feelings about self. Among the secondary stressors commonly experienced by caregivers are economic hardships, family conflicts, constriction of social ties and leisure activities, and friction with work responsibilities or labor force participation (Cantor 1983; George and Gwyther 1986; Pearlín, Turner, and Semple 1989; Scharlach, Sobel, and Roberts 1991; Stone, Cafferata, and Sangl 1987). Other secondary stressors involve painful intrapsychic dislocations, including erosion of a sense of mastery, doubts about one’s competence, and feelings that one has unwittingly become captive of an unwanted role—a dimension of caregiver stress that figures prominently in our analysis (Pearlín et al. 1990). Once established, secondary stressors exist as independent hardships confronted by caregivers. These hardships may generate psychological distress among caregivers, or as we shall demonstrate, hasten institutional placement.

Another, more insidious source of stress is similarly related to but distinct from the demands of daily care—namely, the gradual absorption of a person into a caregiving role. Long before family members became caregivers, they were wives and husbands, daughters and sons—relationships characterized by mutual caring and reciprocal exchanges of affection and assistance. As AD progresses, these qualities, central elements of primary relationships, become less mutual and more unilateral. Thus, caregiver and patient remain husband and wife or parent and child, as they were before, but the core elements of these relationships undergo a metamorphosis of role-related expectations, obligations, and norms as adult autonomy is replaced by patient dependency. Complex family relationships are reorganized, in essence, into a single dominant component, the unilateral provision of care. The sheer restructuring of an important and established relationship is by itself difficult and stressful, independently of the level of daily care needed by the relative (Pearlín 1983; Pearlín and Turner 1987). This restructuring, consequently, may leave one harboring feelings of being held captive by a relationship which resembles only superficially the relationship that once existed.

Thus far, we have deliberately highlighted some of the bleakest features of AD caregiving: the dissipation of cherished elements of the previous relationships between family members and impaired relatives; the constant need for surveillance, control, and assistance; and the spread of secondary stressors into virtually all surrounding roles, spheres of social life, and personal identity. Lacking from this sketch is the considerable variability that exists among AD caregivers. This variability can be observed along two dimensions: first, caregivers differ broadly in the number and intensity of caregiving demands they face; and, second, even when facing similar demands and hardships, caregivers display quite different behavioral and emotional responses. In this report, we shall emphasize the latter. In particular, our analysis will focus on variation in the length of time people provide active care in the home before placing their relatives in formal care institutions. As could be expected, some turn to institutional placement after a relatively limited tenure as caregivers, others continue on as caregivers for many years before placement, and still others adamantly refuse to consider placement at all.

In treating these decisions about continuing care as an outcome of a stress process, we are extending a paradigm that is more typically used to account for variation in the health and emotional well-being of caregivers (e.g., Cantor 1983; Deimling and Bass 1986; Schulz, Visintainer, and Williamson 1990). Yet the severity of caregiving demands are associated as well with decisions to institutionalize. For example, one of the most frequently cited reasons for institutionalization is the burden associated with providing 24-hour care (Chenoweth and Spencer 1986). The impact of these caregiving demands may be dissipated, however, by access to various kinds of psychosocial resources, such as informal social support and self-efficacy (Newman et al. 1990; Romeis 1989; Stoller and Pugliesi 1989). The notion that the magnitude of demands relative to resources is more critical than demand per se echoes themes prominent in stress-buffering models of psychological distress (e.g., Aneshensel forthcoming; Pearlín 1989; Thoits 1984; Pearlín 1985). In the present analysis, therefore, we will examine not only the
stressors experienced by caregivers, but also the ways these stressors combine with psychosocial resources to influence the duration of caregiving.

We must go beyond the confines of the caregiving situation to account for variation in response to the demands of caregiving because these demands take place within the context of very different secondary stressors. One such stressor is of special interest to the present analysis of institutional placement: role captivity, which refers to situations in which people are unwilling incumbents of social roles. The distinguishing characteristic of role captivity is not whether the role is difficult or stressful, but that the role is unwanted (Pearlin 1983; Pearlin and Turner 1987). With regard to caregiving, the demanding responsibilities associated with care matter, but less than the fact that these responsibilities are experienced as obligatory and inescapable, not as voluntary or optional. Although the tension between what one must be and do and what one wants to be and do is experienced individually, its origins may be structural. For example, as we will show below, our findings reveal that adult children are more likely than spousal caregivers to feel captives of caregiving. Spouses, of course, are apt to be elderly, like the AD-patient. Adult children, in contrast, are likely to be at mid-life and often have their own nuclear family and work roles; it is around these roles, in turn, that adult children are likely to have invested their major interests and commitments. When they must withdraw from these interests and commitments, they become vulnerable to a sense of captivity. In such instances, institutionalization may appear as an attractive alternative to providing care at home.

Previous inquiries implicate various socioeconomic and personal characteristics as potentially important antecedents of institutionalization among the elderly. Of course, the logistical availability of appropriate institutional settings (Greene and Ondrich 1990) and financial feasibility make placement possible, although placement often depletes financial resources, leaving the institutionalized economically disadvantaged (Colerick and George 1986; Greenberg and Ginn 1979; Palmore 1976). The risk of institutional placement has been found to be positively associated with patient characteristics, such as advanced age (Branch and Jette 1982; Cohen, Tell, and Wallack 1986; Dolinsky and Rosenwaike 1988; Greene and Ondrich 1990; McCoy and Edwards 1981; Vicente, Wiley, and Carrington 1979), functional impairment (Branch and Jette 1982; Cohen et al. 1986; Greenberg and Ginn 1979; Greene and Ondrich 1990; McCoy and Edwards 1981), the patient’s need for assistance with instrumental activities (Branch and Jette 1982), and the use of formal in-home help (Miller and McFall 1991). Aside from physical limitations, cognitive impairment elevates substantially the risk of placement (Branch and Jette 1982; Greene and Ondrich 1990). Also, there is strong evidence that the availability of help from family members generally reduces the probability of long-term placement (Greenberg and Ginn 1979; Newman et al. 1990).

For example, the chance of placement is elevated among older persons who are unmarried or live alone (Branch and Jette 1982; Cohen et al. 1986; Greene and Ondrich 1990; Palmore 1976; Vicente et al. 1979), in the absence of a spouse or child (Dolinsky and Rosenwaike 1988; McCoy and Edwards 1981; Palmore 1976), and when help from relatives is scarce (Greenberg and Ginn 1979). Indeed, policy analysts generally conclude that the family plays a pivotal role in enabling many impaired elderly who would otherwise be institutionalized to remain in the community (Day 1985; Doty 1986).

This pattern of findings has focused special attention on the role of family caregivers for the cognitively impaired. Among dementia patients, the following behaviors appear to precipitate institutionalization: extreme forgetful behaviors (Pruchno, Michaels, and Potashnik 1990), incontinence, excessive irritability, inability to walk, wandering, hyperactivity, nighttime misbehavior (Knopman et al. 1988), and combative or angry outbursts (Chenoweth and Spencer 1986). Characteristics of caregivers associated with placement of dementia patients include being female, young, employed, and having a high income (Colerick and George 1986). Also, highly stressed or emotionally distressed caregivers appear more disposed to place their impaired relatives (Colerick and George 1986; Lieberman and Kramer 1991), as are caregivers who are themselves in poor physical health (Chenoweth and Spencer 1986). Indeed, several investigators have concluded that caregiver characteristics are more important than patient characteristics to
placement decisions, especially the subjective dimensions of caregiver burden (Colerick and George 1986; Lieberman and Kramer 1991; Zarit, Todd, and Zarit 1986). Contrary to Branch (1984) who argues that placement is predominantly the consequence of medical events, with psychosocial factors playing only an ancillary role.

Confidence in the research findings on placement is constrained, however, by methodological limitations, such as reliance upon small, highly select samples, or secondary analyses of large samples that lack measures of key constructs. A basic problem of longitudinal research in this area flows from the use of characteristics assessed at one arbitrary fixed point in time to predict subsequent institutionalization at a second, arbitrary fixed point in time. This approach is problematic because it fails to account adequately for time-dependency, that is, how long the person has been at risk for placement. For example, some of those who reside in the community at follow-up will eventually enter a long-term care institution. These persons are labeled technically as “right-censored”: they have not been observed long enough to know their ultimate placement status. Also, the common practice of excluding from analysis persons who die without having been placed in an institution is problematic because information about how long these persons resided in the community prior to death is discarded. Parameter estimates may be biased seriously if these censoring problems are ignored in analysis (Singer and Willett 1991). The present study addresses these limitations, at least partially, by using proportional hazard models with time dependent covariates, an analytic technique designed to account for these time-dependency problems.

Variants of this analytic technique have been used recently to describe the risk of institutionalization among the elderly. For example, Liang and Tu (1986) estimate a lifetime probability of entering a nursing home as 29.7 percent. Greene and Ondrich (1990) take a more explanatory approach, using a discrete-time hazard model to assess risk factors for admission to a nursing home, but do not consider characteristics of informal care providers. Several recent studies demonstrate the importance of accounting for variability in periods of observation. First, among primary degenerative dementia pa-

tients, the probability of survival to institutionalization is lower, at least initially, among more advanced cases than among mild cases (Knopman et al. 1988). Second, Pruchno and associates (1990) report that the probability of placement over the next year is highest for those who have provided care for only a short time. Third, Shapiro and Tate (1985) find that time itself affects the relationship of various characteristics to nursing home admissions. Together, these studies indicate that the analysis of antecedents to placement needs to account for the length of time a person has been at risk of placement.

Like previous inquiries, the present study seeks to identify conditions that block, retard, or accelerate institutionalization. Unlike the earlier inquiries, however, we see these conditions not as unrelated “risk factors” — attributes that may predict placement but do not necessarily explain it — but as elements of a stress process that evolves through time. Because of its general theoretical importance to stress processes as well as its empirical power in explaining placement, we give special attention to the construct of role captivity.

METHODS

Procedures

The data were collected by means of a multiwave panel survey. Three face-to-face interviews were conducted at one-year intervals with a sample of family caregivers for persons suffering from AD or a related dementia. The subject pool consisted of all persons who contacted local Alzheimer’s and Related Disorders Associations (ADRSA) in two sites, the San Francisco Bay Area and Greater Los Angeles. Potential subjects were contacted by telephone to determine their eligibility and willingness to participate in the study. Eligibility was defined as being the primary caregiver to a noninstitutionalized spouse, parent, or parent-in-law suffering from AD or a related dementia; primary caregiver was defined as the family member who spends the most time taking care of the person with AD. Some families placed their relative in institutional care between interviews, and in some families the impaired relative died. However, caregivers were reinterviewed irrespective of whether they
continued to provide in-home care at follow-up. Three separate but overlapping interview schedules were used, tailored to the specific circumstances of in-home care, institutional care, or grief and recovery.

Sample

A total of 555 caregivers participated in the baseline interview, 300 in northern California and 255 in southern California. Of 1,740 persons contacted by phone, over 1,000 did not meet inclusion criteria and another 164 refused to be interviewed. It is not possible to calculate a meaningful response rate because the eligibility of persons who were not contacted is unknown and because some persons refused before eligibility could be ascertained. Thus, the sample should not be construed as representative of all AD caregivers; those without affiliations with formal organizations such as ADRDA, for whatever reason, were not reached. Also, refusals might be more common among some types of caregivers, such as those for whom caregiving is so overwhelming that it inhibits participation, or those for whom interest in the study is minimal because care responsibilities are not problematic. Such selection factors may tend to attenuate observed associations.

The sample is heterogeneous in its demographic characteristics, level of AD patient disability, and duration of care, however, minimizing such concerns. Thus, a slight majority (58.7%) of the sample are spouses of the AD patient, the remainder being adult children. Two-thirds of the caregivers are female. Subjects are distributed uniformly across ages 40 to 70 years, with but a few older or younger than this range. The mean caregiver age is 61.9 years (s.d. = 13.1). The majority of the patients are over 60, with a mean age of 75.4 years (s.d. = 8.7). The sample is predominantly White: Blacks, Hispanics, Asians, and other groups comprise less than one-fifth of the total sample. The vast majority of the caregivers are married; in the case of spousal caregivers, of course, their partner is the AD patient. Annual household incomes range from poverty levels to affluence, with a median income of $27,500. Retirees constitute more than one-third of those interviewed, but full-time workers and homemakers also are well represented. Only two demographic characteristics differed significantly by site: compared to San Francisco, the Los Angeles sample contains a greater percentage of Jewish caregivers and is somewhat less well educated.

Loss of subjects was minimal at both reinterviews, totalling only 11 percent (N = 61) over the three waves from all causes. This rate is quite low, especially given the advanced age of the sample, which contributes to respondent death. The impact of sample attrition is minimized by the use of survival analysis because many subjects have valid transitional data prior to loss-to-follow-up and because the "censoring" function utilizes the maximum available information for others, as described below.

Measures

Start of Care. Several occurrences can signal the start of the care process. For many families, symptom-recognition, the time at which families first recognize that memory and behavior are deviating from established modes, represents the perceived onset of AD. This recognition occurs, of course, well after the true onset of the underlying disease. Diagnosis is a second marker, representing the formal labeling by a clinician of the problematic behavior as an illness. For the individual caregiver, however, the most salient milestone probably is the time at which she or he assumes care-related responsibilities. Survival-time (i.e., time to institutionalization or death) could be counted from any of these milestones, but each provides a distinct vantage point: patient-centered, health care system-centered, and caregiver-centered methods of counting time, respectively. Because our theoretical orientation emphasizes alterations in the relationship between the giver and the recipient of care, the most appropriate start point for our analysis is the initiation of help.

The timing of this event was assessed by asking, "How long ago did you first have to start helping (him/her) do things that (he/she) was no longer able to do for (himself/herself)?" Response categories are: less than 6 months ago, between 6–12 months ago, 1 to 2 years ago, 3 to 5 years ago, 6 to 10 years ago, and 11 or more years ago. For analysis, these responses are scored as the midpoint of the interval.
Family relationships normatively entail caring behavior in everyday interactions. In instances of chronic and progressive impairment, the exchange of care gradually becomes unilateral, making it difficult to date precisely the entrance into the caregiver role. Recall inaccuracy may be particularly pronounced when these transitions occurred long before the baseline interview. Also, the use of categorical rather than continuous time assessment artificially clusters start-of-care times. Consequently, estimates of average survival times must be regarded as approximations. However, it should be noted that errors in the dating of the initiation of caregiving are not likely to be systematic with regard to the timing of the termination of caregiving—the other element used to calculate survival time (see below)—because initiation reports were given at the baseline interview whereas exit transitions (placement and bereavement) occurred after the baseline interview. Thus, recall error in the timing of initial events undoubtedly occurs but is unlikely to bias estimates of the factors affecting survival in the caregiver role.

**Explanatory Variables.** Our analysis is set within a theoretical model aimed at identifying the interrelated conditions under which caregiver stress arises and damages the health and well-being of the caregiver. This model has been articulated recently, along with a detailed description of the measures used to operationalize central constructs (Pearlin et al. 1990). Consequently, we shall only enumerate these measures. Sample items, response categories, and reliability coefficients appear in the appendix.

Three categories of measures figure in our analysis: background and contextual factors; stressors; and stress mediators. Background-contextual factors include sociodemographic characteristics that are measured with standard survey items: age, education, total family income, employment status, and occupation. Attributes of the patient include physical health status rated as (1) poor to (4) excellent; and, (1) hospitalized for a physical and/or mental condition during the past year versus (0) neither. Gender of the caregiver, gender of the patient, and marital status are redundant pieces of information among spousal caregivers. Consequently, the coding for relationship between the caregiver and recipient incorporates this information for the major types of relationships: husband caring for wife (N = 136), wife caring for husband (N = 190), daughter caring for mother (N = 146), and all other parent-child dyads (N = 83).

Two major constellations of stressors are measured, representing what we refer to as primary and secondary stressors. Primary stressors are conditions of potential hardship that flow directly from the needs of the patient and demands of care. Some of these stressors reflect objectively the nature of the caregiving situation, including the cognitive status of the AD patient, problematic behavior, Activities of Daily Living (ADL-depencies), and Instrumental Activities of Daily Living (IADL-dependencies). Other primary stressors reside in the subjective experiences of caregivers, including role overload; relational deprivation—the loss of intimacy, shared goals and activities, and sense of self; and patient resistance to help. The distinguishing feature of secondary stressors is that these circumstances arise beyond the boundaries of the caregiver role, but are generated or exacerbated by the demands of caregiving. These stressors include family conflict; conflicting demands of job and caregiving; economic strain; and, role captivity—being an unwilling, involuntary incumbent of the caregiver role.

Mediating conditions refer to factors that may influence the impact of stress upon placement decisions; they include social support, self-concept, and caregiver health. Three dimensions of social support are assessed: emotional, care-related, and task-related support. Self-concept is evaluated both as a global sense of mastery and as a situation-specific sense of caregiver competence. Caregiver health is often considered the central dependent or outcome variable in caregiver stress research; here, this domain is treated as mediating the impact of stress upon placement decisions. Our measures of caregiver health are physical health status and psychological distress, encompassing symptoms of depression, anxiety, and irritability. Caregiver distress over the idea of placing their spouse or parent in a formal care institution is the fine mediating factor considered in our analysis.

**Analysis**

The data are analyzed using proportional hazard models with time-dependent covari-
lates for two outcomes: length of time from the start of care until institutionalization, and until death of the AD patient. The data are organized around the timing of transitional events, combining retrospective information on the initiation of care with prospective information on the termination of care. Thus, the duration of care reported at the baseline interview is incremented by time from the baseline interview to institutionalization or to death. For institutionalization, those who did not place their relatives are “censored” at their last interview or upon the death of the AD patient. For bereavement, those who did not lose their relative to death are “censored” at the time of their last interview. Caregivers who placed their relatives and later became bereaved are positive for both exit events; those who neither placed their relatives nor became bereaved are censored for both events. Institutionalization is treated as a risk factor for death.

While some covariates are fixed (e.g., gender), others change over time (e.g., declining cognitive functioning). These time-dependent covariates have Time 1 values for analysis of transitions before the first follow-up and Time 2 values for analysis of transitions after the first follow-up. The updated values, therefore, remain temporally close to transitions that may occur during the next prospective interval. Interactions are modeled as cross-product terms and treated as time-dependent, if appropriate; subgroup analysis also is used to detect contingent relationships. Single covariate models were used to estimate zero-order associations. Three alternate multivariate models were examined: all explanatory variables with statistically significant bivariate associations, and stepwise selection of explanatory variables. These analyses identified the same set of explanatory variables; the stepwise results are presented for simplicity.

Positive regression coefficients indicate an increase in the hazard function, which is equivalent to a negative effect upon survival time. These coefficients also can be interpreted as increasing the probability of event-occurrence at any given time, given no event until that time. The exponential of the regression coefficient can be interpreted as a partial odds ratio, i.e., the multiplicative effect of a unit change in the covariate on the odds of event-occurrence. These transformed values are presented because they are substantively easier to interpret than the linear coefficients for the log-odds.

RESULTS

Initiation of Care

At baseline, the average caregiver had known that something was wrong for about five years and had been providing help for about three years; it had been three and one-half years since the impaired relative first saw a doctor for memory problems, as shown in Table 1. Thus, a considerable lapse in time appears to occur between the initial awareness that something is wrong with a relative’s memory-related behavior and seeking help from a physician or providing help to the relative. There are comparatively few persons in the earliest stages of caregiving, given that an individual must pass through these stages to reach later stages. These distributions indicate that our recruitment strategies were more effective for reaching persons who were

| TABLE 1. Percent Distribution of Time of Occurrence of Initial Events, Time 1 |
|--------------------------|--------------------------|--------------------------|
| Event                    | Symptom Recognition (N = 552) | Physician Contact (N = 526) | Help Provided (N = 552) |
| Time Since Event Occurred| %                        | %                         | %                       |
| Less than 6 months       | 1.3 %                     | 5.5 %                     | 6.0 %                   |
| 6 to 12 months           | 2.2 %                     | 7.6 %                     | 18.5                    |
| 1 to 2 years             | 21.6 %                    | 35.2 %                    | 36.6                    |
| 3 to 5 years             | 37.9 %                    | 30.2 %                    | 31.3                    |
| 6 to 10 years            | 29.5 %                    | 19.2 %                    | 6.9                     |
| 11 or more years         | 7.6 %                     | 2.3 %                     | 0.7                     |
| Mean years ago           | 5.36 %                    | 3.61 %                    | 2.98                    |
| sd                       | 3.95                      | 2.88                      | 2.31                    |
well into their caregiver careers than for those who were just taking up these responsibilities.

The times at which caregivers experienced these three transitions are highly correlated (average $r = .55$), but there is considerable variability in the sequencing of these events. Approximately one in five caregivers noticed something was wrong, started to provide help, and had their relative consult a doctor at about the same point in time (18.5%). More often, noticing something was wrong coincided with contacting a physician, with the caregiver initiating help at a later time (29.6%). Most often, the caregiving experience began with a single transitional event and this event was symptom recognition (37.3%), usually followed by the joint occurrence of consulting a physician and starting to provide help. There were slight generational differences, with spouses more likely than children to begin their caregiver role with multiple rather than single events.

**Transitions in Care Over Time**

At the start of the study, all caregivers occupied a similar status: providing the principal source of care to a noninstitutionalized spouse or parent with AD. This status changed with the passage of time, as caregivers placed their relatives in institutions, experienced the death of their relatives, or encountered both transitions, as illustrated in Figure 1. Over the two years of observations, a total of 192 caregivers, one-third of the original sample, placed their relatives in institutions; about one-third (59) of these persons subsequently became bereaved. During the same period, an additional 87 AD patients died without having been placed in an institution. Thus, the majority (59.6%) of bereaved caregivers ($N = 146$) were providing care to a noninstitutionalized parent or spouse when that person died. Of those placed in a long-term care facility, 30.7 percent died before Time 3, compared to 28.0 percent of those not placed in institutional care prior to Time 3 (exclusive of those lost-to-follow-up). An absolutely greater number of patients died at home than in institutions because more patients resided at home at Time 3 than had been placed in institutions. However, the rate of AD patient death is slightly greater among AD patients in formal institutional care than among those remaining in in-home care.

The median survival time from the start of care is 8.8 years for institutionalization and

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**FIGURE 1. AD Patient Transitions Over Three Interviews (Two Years)**

![Graph of AD patient transitions over three interviews.](image-url)
9.8 years for death. Survival functions decline at fairly uniform rates with the passage of time since the start of care for both alternatives, institutionalization and death.

**Stress and Institutionalization**

Whether a family member continues to provide in-home care is influenced strongly by the presence of primary and secondary stressors that impinge upon the caregiver, as shown in Table 2. Several stressors associated individually with substantial elevations in the odds of placement, however, become nonsignificant when considered in combination with other stressors. Thus, problematic behavior, relational deprivation, and patient resistance are no longer significantly related to placement when joined with other stressors. Caregiver psychological distress is the sole mediating variable to attain statistical significance, elevating the risk of placement for the AD patient, but only at the bivariate level. The following variables do not have reliable association with survival time for in-home care in either bivariate or multivariate analysis: patient age and recent hospitalization; caregiver employment status, occupation, race, and health status; type of relationship between patient and caregiver (e.g., parent-child); cognitive status; ADL-dependencies; family conflict; job-caregiver conflict; emotional, care- and task-related social support; caregiver competence; mastery; and placement-distress.

Background-contextual factors exert limited independent effects upon the survival

### TABLE 2. Proportional Hazard Regression Coefficients and Exponentials for Survival to Institutionalization, Time 1 to Time 3

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Bivariate</th>
<th>Multivariate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coefficient (Standard Error)</td>
<td>Exponential</td>
</tr>
<tr>
<td>Family Income (thousands of dollars)</td>
<td>.007* (.003)</td>
<td>1.007</td>
</tr>
<tr>
<td>Caregiver Education (in years)</td>
<td>-.042 (.026)</td>
<td>0.959</td>
</tr>
<tr>
<td>Patient Physical Health Status (1–4)</td>
<td>.149 (.078)</td>
<td>1.161</td>
</tr>
<tr>
<td>Site: Los Angeles (/San Francisco)</td>
<td>.417** (.145)</td>
<td>1.517</td>
</tr>
<tr>
<td>AD Diagnosis (/no)</td>
<td>.386* (.181)</td>
<td>1.472</td>
</tr>
<tr>
<td>Problematic Behavior (1–4)</td>
<td>.405*** (.115)</td>
<td>1.499</td>
</tr>
<tr>
<td>IADL-dependencies (1–4)</td>
<td>.275** (.101)</td>
<td>1.317</td>
</tr>
<tr>
<td>Role Overload (1–4)</td>
<td>.282*** (.082)</td>
<td>1.326</td>
</tr>
<tr>
<td>Relational Deprivation (1–4)</td>
<td>.343** (.116)</td>
<td>1.409</td>
</tr>
<tr>
<td>Patient Resists (/no)</td>
<td>.371** (.145)</td>
<td>1.450</td>
</tr>
<tr>
<td>Economic Strain (just-not enough/ enough)</td>
<td>-.363* (.149)</td>
<td>0.696</td>
</tr>
<tr>
<td>Role Captivity (1–4)</td>
<td>.384*** (.073)</td>
<td>1.468</td>
</tr>
<tr>
<td>Psychological Distress (1–4)</td>
<td>.254* (.108)</td>
<td>1.290</td>
</tr>
</tbody>
</table>

Chi-square (8 d.f.) = 74.16***
Loglikelihood (168 d.f.) = -1015.609***

* Time-dependent covariate.
| Fixed covariate.
| See appendix for code values.
| Test that all regression coefficients equal zero.
| Test that regression model fits the data.
* p <= .05; ** p <= .01; *** p <= .001.
function. The odds of placement increase with income and vary inversely with education, that is, education that is high relative to income. AD patients reside at home longer in San Francisco than Los Angeles, a differential that may be due to site-differences in recruitment. Also, AD patients who are in comparatively good physical health are more likely to be institutionalized than those in poor health.

The degenerative course of AD influences institutionalization primarily through IADL-dependencies and role overload. Cognitive status is correlated with needing assistance with activities of daily living (IADL r = .36; ADL r = .71), but not with problematic behaviors (r = .05). This pattern is consistent with the nature of AD, in that troublesome behavior does not necessarily increase with illness severity (Pruchno and Resch 1989; Zarit et al. 1986). Cognitive status lacks even a bivariate association with placement, however, meaning that any indirect influence on placement via the association of cognitive status with IADL-dependencies, which do hasten placement, is minimal at best. Thus, the severity of cognitive degeneration appears to have virtually no influence upon the placement decisions of caregivers.

The odds of placement decrease considerably when caregivers experience economic strain and increase when care-related responsibilities produce a sense of role captivity (also shown in Table 2). Economic strain does not mediate entirely the impact of income even though economic strain varies inversely with income: high strain and low income each decrease substantially the odds of placement. None of the potential stress-mediating variables is associated independently with the odds of placement. The most proximal independent effects upon placement, then, are the secondary stressors of economic strain and role captivity.

As described previously, caregivers are unlikely to respond uniformly to stress-related circumstances: some caregivers may be impervious to the very occurrences that prompt institutionalization among others. The impact of exposure to care-related stressors may depend upon access to various resources—such as social support, self-concept, or being healthy—even if these resources do not influence directly the risk of institutionalization. Alternately, barriers to placement, such as lack of financial resources, may offset some or all of the impact of care-related stressors in hastening institutionalization. Two strategies were used to assess such conditional relationships: inclusion of sets of product-moment interaction terms between stressors and resources, and stratified analysis within subgroups defined by resources. These stress-modification models were examined for social support, self-concept, psychological distress, placement-distress, and financial feasibility (defined as above/below mean income adjusted for relationship to the patient and site). The number of statistically significant indicators of stress-modification approximates the number expected by chance; multivariate controls for background-contextual factors render these few effects nonsignificant. Thus, there is little empirical evidence that the impact of primary or secondary caregiving stressors on placement is contingent upon these psychosocial factors.

Role Captivity and Institutionalization

Our theoretical model portrayed the psychological distress of caregivers as mediating the impact of primary and secondary stressors, but distress does not exert an independent effect upon institutionalization, as discussed previously. The most proximate effects upon placement derive from secondary stressors, specifically economic strain and role captivity (see Table 2). The function of economic strain in constraining placement options is self-evident. Consequently, we focus upon the extent to which role captivity mediates the impact upon placement of background-contextual factors and primary stressors. This mediating function was assessed by regressing role captivity upon these conceptually antecedent factors (see Table 3).

At baseline, adult-children are more likely than spouses to feel confined by caregiving, a sentiment that also is more pronounced among White than minority caregivers, and younger patients elicit more role captivity than older patients. Several other stressors exacerbate feeling trapped, notably a loss of attachment, troublesome patient behaviors, and excessive caregiving demands. The negative coefficient for ADL-dependencies emerges only in multivariate analysis, apparently representing a beneficial effect of providing assistance to the extent that assis-
TABLE 3. Stepwise Regression Coefficients for Role Captivity at Time 1 through Time 3

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Role Captivity Time 1</th>
<th>Role Captivity Time 2</th>
<th>Role Captivity Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Age</td>
<td>-.010* (.005)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spousal Caregiver (/child)a</td>
<td>-.736*** (.087)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (/else)</td>
<td>.451*** (.102)</td>
<td>.391*** (.100)</td>
<td></td>
</tr>
<tr>
<td>Family Income (thousands of dollars)</td>
<td>- (.002)</td>
<td>-.004* (.065)</td>
<td></td>
</tr>
<tr>
<td>Relational Deprivation (1–4)b</td>
<td>.478*** (.068)</td>
<td>.131* (.065)</td>
<td></td>
</tr>
<tr>
<td>Problematic Behavior (1–4)b</td>
<td>.194** (.069)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role Overload (1–4)b</td>
<td>.153*** (.044)</td>
<td>.117** (.044)</td>
<td></td>
</tr>
<tr>
<td>ADL-dependencies (1–4)b</td>
<td>-.130** (.042)</td>
<td></td>
<td>-.101* (.042)</td>
</tr>
<tr>
<td>IADL-dependencies (1–4)b</td>
<td></td>
<td>-.137** (.051)</td>
<td></td>
</tr>
<tr>
<td>Role Captivity (1–4)b</td>
<td></td>
<td>.537*** (.040)</td>
<td>.152*** (.045)</td>
</tr>
<tr>
<td>Role Captivity, Time 2 (1–4)b</td>
<td></td>
<td></td>
<td>.658*** (.046)</td>
</tr>
<tr>
<td>Patient Institutionalized (/no)c</td>
<td></td>
<td>-.415*** (.092)</td>
<td>-.366*** (.078)</td>
</tr>
</tbody>
</table>

Intercept 1.426 .679 .708

R² 29.091*** 43.287*** 104.395***
d.f. 7,435 7,435 4,344

a Dichotomy used to facilitate stepwise procedure.
b See appendix for code values.
c Patient placed in long-term care facility prior Time 2, or prior to Time 3.
d Test that all regression coefficients equal zero.

*p < .05; **p < .01; ***p < .001.

stance does not also entail other undesirable dimensions of caregiver stress.

Role captivity remains relatively stable over time, as also is shown in Table 3. The major exception to this pattern of stability pertains to the impact of institutionalization, which alleviates role captivity: a sense of role captivity produces its own decline over time in those instances when role captivity prompts institutionalization (see Table 2). Factors that affect both role captivity and institutionalization, therefore, must be interpreted within the context of the effect of placement upon role captivity.

Thus, role captivity at Time 2 is generally exacerbated by role overload, an escalating spiral that is interrupted when overload prompts institutionalization, insofar as placement reduces captivity. Contrastingly, high income alleviates role captivity, especially if these economic resources prompt institutionalization. The same pattern is observed for IADL-dependencies. White caregivers experience not only high but also increasing levels of role captivity. Similarly, the loss of important elements of attachment in the relationship between the caregiver and patient also yields an increasing sense of being enmeshed within the caregiver role.

The ameliorative impact of institutionalization on role captivity is apparent as well at Time 3 (also shown in Table 3). Among the background-contextual and stressor variables considered, ADL-dependencies is the only variable related to long-term change in role captivity. Both previous levels of role captivity are related to this sentiment at the final assessment. Factors that elevate role captivity at Time 1, or contribute to increases observed at Time 2, therefore, contribute to the
maintenance or exacerbation of a high level of role captivity over time.

The reciprocal relationship between role captivity and institutionalization generates several indirect relationships that warrant mention, even though they are of modest magnitude. First, given the powerful role of institutionalization in altering levels of role captivity, any of the factors that prompt institutionalization ultimately contribute indirectly to reductions in role captivity (see Table 2). Second, some factors that lack a direct association with placement nonetheless contribute indirectly to a higher risk of placement via associations with initial levels of role captivity or changes in role captivity over time: being White, caring for a parent or a younger patient, responding to relatively few ADL-dependencies, encountering problematic behavior, and experiencing a loss of relationship. Third, factors that influence both role captivity and placement have indirect effects upon the odds of placement in addition to the direct effects reported in Table 2; for role overload and income these effects are cumulative, but for IADL-dependencies the indirect effects offset somewhat the direct effects on placement. Role captivity, therefore, acts as a conduit, channeling the impact of other aspects of providing care on placement decisions. This sense of entrapment, in turn, is altered by changes in the context of providing care—most critically, exists from the in-home care role.

**Stress, Institutionalization, and Patient Mortality**

Our primary focus concerns institutional placement, but mortality also must be considered because death precludes subsequent placement and because institutional placement may alter the risk of death. While placement and death are very different transitions, these passages are closely intertwined in this population. For this reason, we briefly consider survival to death in the same manner we have considered survival to institutionalization.

Patient characteristics play a minor role at best in survival time relative to institutionalization, but emerge as the prime determinants of time to patient death. As shown in Table 4, the odds of death are increased substantially by poor physical health status, recent hospitalization, cognitive impairment, and advanced age. ADL-dependencies also are associated with increased risk, but are nonsignificant in multivariate analysis. Wives are most likely to become bereaved, suggesting a male mortality disadvantage that persists even when patient health status is controlled statistically. Survival time does not depend upon other demographic variables. Not surprisingly, factors related to the stress of caregivers also have little impact upon the probability of patient death. Although Relational Deprivation is associated with death at the bivariate level, it does not attain statistical significance when patient health status is controlled.

AD patient health status is the only factor shared in common by the survival functions for institutionalization and bereavement; its effects on these outcomes are in opposite directions (see Table 2). At any given time following the start of care, AD patients in good physical health are more likely to be institutionalized but less likely to die than those in poor health.

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Coefficient (Standard Error)</th>
<th>Exponential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Age(^a)</td>
<td>.044(^***) (.012)</td>
<td>1.045</td>
</tr>
<tr>
<td>Patient Physical Health Status (1–4)(^b)(^c)</td>
<td>-.197(^*) (.083)</td>
<td>.821</td>
</tr>
<tr>
<td>Recent Hospitalization (/no)(^a)</td>
<td>.636(^***) (.176)</td>
<td>1.888</td>
</tr>
<tr>
<td>Cognitive Status (1–4)(^b)(^c)</td>
<td>.611(^***) (.102)</td>
<td>1.842</td>
</tr>
<tr>
<td>Relationship to Patient (/else)(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>.355 (.306)</td>
<td>1.426</td>
</tr>
<tr>
<td>Wife</td>
<td>.734(^**) (.279)</td>
<td>2.084</td>
</tr>
<tr>
<td>Daughter of Mother</td>
<td>-.019 (.284)</td>
<td>.981</td>
</tr>
<tr>
<td>Patient Institutionalized (/no)(^a)</td>
<td>.742(^***) (.173)</td>
<td>2.100</td>
</tr>
</tbody>
</table>

Chi-square\(^d\) (8 d.f.) = 97.60\(^***\)
Loglikelihood\(^d\) (133 d.f.) = -769.560\(^***\)

\(^a\) Time-dependent covariate.
\(^b\) Fixed covariate.
\(^c\) See appendix for code values.
\(^d\) Test that all regression coefficients equal zero.
\(^e\) Test that regression model fits the data.
\(*\) p ≤ .05; \(^**\) p ≤ .01; \(^***\) p ≤ .001.
However, caregivers who institutionalize their relatives are more likely to become bereaved than those whose relatives continue to reside within the community. The zero-order odds of AD patient death approximately double following institutionalization, an elevation in risk that is virtually unchanged when health status is controlled (also shown in Table 4).

DISCUSSION

Our analysis of caregiving and institutionalization illustrates quite clearly the oftentimes competing and conflicting interests of family members (cf. Mirowsky 1985). Specifically, the cessation of in-home care reduces role-related stress among caregivers, but care-recipients who are institutionalized are more likely to die than those who remain at home. Whatever the underlying reasons for this increase in mortality, many caregivers believe that in-home family care is superior to institutionalized care and continue to provide such care long after it is in their own best interests to cease (Colerick and George 1986). It is evident that, under present conditions, the interests of caregivers and their impaired relatives are not equally served by in-home care or institutional placement. We can surmise that in many households this dilemma only adds to the anguish and burdens of having a parent or spouse with AD.

Our finding that AD patients in comparatively good physical health are most likely to be placed goes against the grain of conventional wisdom, given that frail health typically is associated with an increased risk of institutionalization among the general population of older persons. Several considerations may account for this seemingly anomalous finding. First, our measure of physical health status relies upon the subjective perceptions of the caregiver, which may be inaccurate. For example, our annual assessments may not have detected precipitous declines in health status that both necessitate institutionalization and result in death. However, we do not believe that measurement limitations account for the association between being healthy and being institutionalized. Fair or poor health ratings on the same measure are associated with an increased risk of mortality, suggesting that the caregiver’s subjective assessment does indeed provide a valid indicator of the AD patient’s health.

Second, the combination of cognitive impairment and physical disability presents unique considerations for long-term care facilities. Specifically, care demands are likely to be more pronounced than for either type of impairment singly, making treatment especially difficult and costly: two care demands for the price of one. These circumstances may generate selective admission criteria. Third, caregivers may have special incentives to seek placement for physically fit but cognitively impaired relatives. For example, informal caregivers may selectively place dementia patients because they are less able to control the difficult behavior of patients who are robust than those who are frail. Finally, caregivers might hesitate to place a relative whom they perceive as too frail to survive the dislocations that accompany institutionalization. Whatever the explanations for this finding, there are probably mutually reinforcing dispositions on the parts of both institutions and caregivers that increase the chances of early placement of the physically fit dementia patient.

In this regard, we need to comment as well upon the substantial increase in the risk of death following placement. As we just discussed, this increment cannot be attributed to poor initial health among those who are institutionalized, for they tend to be healthier than those remaining at home. Moreover, the differential in mortality persists when health status is controlled statistically. Institutionalization, then, appears to hasten patient death; alternately, both institutionalization and death may be a function of some factor other than those examined here. We cannot empirically evaluate alternate explanations because crucial information lies outside the boundaries of the present study. Yet, we do not want to suggest increased mortality is an inevitable consequence of placement. Instead, this elevation in risk may reflect more on the quality of institutional care than on the transitional event of placement per se. At any rate, our findings add to the urgency of addressing quality of care issues.

Our analysis of caregiving as a specific instance of chronic stress has several general implications for models of stress processes. For example, the reduction of caregiver stress following institutionalization is consistent with the findings of Wheaton (1990) that the
level of prior stress encountered within a social role determines whether exits from the role are stress-provoking or stress-reducing. Also, research on social support typically focuses upon the recipient of support, often demonstrating a beneficial influence on psychological well-being. Here we see that the provision of social support—in the form of family caregiving—is not without cost, generating or exacerbating stressful circumstances for the provider of care. Assessment of the health effects of long-term social support for problems that are essentially irreversible, therefore, should count benefits and deficits for both parties (cf. Schulz et al. 1987).

Placement may be seen as an effort to cope with a complex and enveloping life-situation that inherently resists ameliorative actions. Caregivers cannot change the degenerative course of AD or the dependencies that surface along the way. Placement represents, in effect, attempts to manage the situation, a type of coping aimed at removing the source of stress—in contrast to managing the meaning of the situation or alleviating symptoms of distress produced by the situation (Pearlin and Aneshensel 1986; Pearlin and Schooler 1978). Although the criterion usually employed to judge the efficacy of coping actions is how well the action relieves the actor of psychological distress, there are multiple standards for evaluating coping effectiveness (cf. Menaghan and Merves 1984). Our results highlight one standard, the reduction of role-related stress. By this criterion, placement would appear to be an effective response to a difficult and intractable situation.

However, as with most coping, placement must be judged not only by its effects on the actor, but also its effects on others, in this instance, within the role set of caregiver and care-recipient. Here, judgments about the efficacy of placement must be tempered because caregivers derive relief from placement, but patients confront elevated mortality risks. Thus, coping that serves one person well may be injurious to others. Caregiving for AD, we submit, helps to reveal some of the limitations with current asocial and individualistic conceptualizations of the nature of coping.

We turn now to role captivity, a construct that is the analytic cornerstone of this paper. Its prominence is deserved for two reasons. First, it is a potent condition that contributes to placement and also is sharply reduced as a consequence of placement. Second, although role captivity has been somewhat overlooked in stress research, there is reason to believe that its presence is widespread in people’s social experience. Its ubiquity stems from the fact that people commonly find themselves incumbents of roles and statuses that they did not seek or that they sought but later discover are unwanted. This circumstance can be observed among the unemployed who want to work; homemakers who would prefer to be in the labor force and vice versa; the childless who desperately want parenthood; and so on (Pearlin 1975). The “over-socialized” conception of societal members assumes that we learn to want what we must do, to seek the roles in which we eventually become incumbents. However accurate this portrayal is in general, it does not describe the fates of numbers of reluctant or rebellious social actors. It certainly is not consistent with the experiences of many caregivers.

Caregiving is not something people typically are socialized to desire, seek, or expect. Confronted with a need for care, many wives, husbands, daughters, and sons step forward to become caregivers. Others, however, find themselves responding more to powerful cultural expectations than to inner imperatives. Often people become caregivers by default: because they are women, not employed outside of the home, happen to live close by, and so on. Certainly there are people who initially are reluctant or resentful who later become dedicated to the role; correspondingly, there are those who start out committed, but whose motivation wanes under the load. Regardless of the particular scenario by which one is channeled into the role, there are caregivers who become unwilling incumbents. Being captive of the role, we submit, can be better testimony to powerlessness in shaping one’s own fate, a condition conducive to stress.

Finally, most research into social stress focuses upon the health and well-being of the person exposed to stress. Here we illustrate that stress processes are consequential as well for other health-relevant outcomes, institutional placement in this instance. We have argued elsewhere (Aneshensel forthcoming; Aneshensel, Rutter, and Lachnerbruch 1991; Pearl 1989) that conclusions regarding social stress processes have been constrained artificially by an exclusive emphasis upon a
narrow range of mental health outcomes. Based upon our findings here, we conclude that a wider net should be cast in seeking to identify the consequences of exposure to social stress.

NOTES

1. Eight respondents lost-to-follow-up after the AD patient died between Time 1 and Time 2 are not shown in Figure 1.

2. Whether the AD patient lives with the caregiver also presents problems of redundancy insofar as spousal caregivers and patients live together. Of persons caring for parents, 60.7 percent live with the AD patient. Living arrangement is not associated with the odds of placement, however, in bivariate or multivariate analysis and hence is excluded from our discussion of relationship.

3. Mean time from starting to provide help to the baseline assessment is shorter for Los Angeles than San Francisco respondents (2.54 vs. 3.35 years; t=4.20; p<.001). Because more caregivers were recruited early in their careers in Los Angeles than San Francisco, the Los Angeles caregivers had more opportunity to “fail” early. The site difference in institution- alization cannot be attributed to the higher percentage of Jewish caregivers in Los Angeles because religion is not significantly related to the odds of placement in bivariate or multivariate analysis.

APPENDIX

Measures

Primary Stressors (seven measures).

Cognitive status of the AD patient—difficulty with seven tasks (e.g., remember words) scored (0) not at all difficult to (4) can’t do at all (alpha = .84).

Problematic behavior—how often the caregiver has to deal with 14 troublesome behaviors (e.g., swearing, clinging) rated (1) no days to (4) 5 or more days for the past week (alpha = .78).

ADL-dependencies—seven activities of daily living (e.g., eating) weighted from (1) not at all to (4) completely dependent (alpha = .91).

IADL-dependencies—eight instrumental activities of daily living (e.g., handling money) with the same categories as ADL-dependencies (alpha = .82).

Role overload—three demanding situations (e.g., exhausted at night) rated (1) not at all to (4) completely describing the caregiver (alpha = .78).

Relational deprivation—eight items assessing loss of intimacy, shared activities, and sense of self rated (1) not at all to (4) completely lost in the relationship with the AD patient (alpha = .81).

Resistance—a single item, the patient makes it very difficult by resisting help (yes/no).

Secondary Stressors (four measures).

Family conflict—12 disagreements concerning treatment of the patient and the caregiver (e.g., disagreement about the patient’s capabilities) rated (1) no disagreement to (4) quite a bit of disagreement (alpha = .90).

Job-caregiver conflict—five items regarding stress at work (e.g., care-related calls interrupt work) rated (1) strongly disagree to (4) strongly agree (alpha = .75).

Economic strain—a single item, “In general how do your family finances work out at the end of the month?”, scored as (1) not enough or just enough to make ends meet versus (0) some money left over.

Role captivity—three items concerning a sense of entrapment (wish you were free to lead a life of your own, feel trapped by your relative’s illness, and wish you could just run away) rated as describing the caregiver (1) not at all to (4) very much (alpha = .83).

Mediating-Moderating Conditions (eight measures).

Caregiver competence—four ratings of self as a caregiver (e.g., competent) scored (1) not at all to (4) very much (alpha = .74).

Mastery—seven items assessing a sense of self efficacy (e.g., I can do just about anything I really set my mind to do) rated (a) strongly disagree to (4) strongly agree (alpha = .75).

Emotional support—seven items tapping socioemo- tional support (e.g., you have someone you can trust) scored (1) strongly disagree to (4) strongly agree (alpha = .81).

Care-related support—a single item of receives about the amount of help needed with things like bathing or dressing the patient.

Task-related support: a single item of receives about the amount of help needed with things like shopping or other household chores. For both instrumental support measures, the alternative is receiving less help than needed or not needing help; these alternatives are not distinguished because too few respondents stated that they did not need either type of assistance.

Placement-distress—a single item of thinking about the possibility of placing the patient makes the caregiver feel very distressed versus fairly, just a little, or not at all upset. Caregiver physical health status—a single item rating of health as (1) poor to (4) excellent.

Psychological Distress—17 symptoms of depression, anxiety, and irritability from the Hopkins Symptom Checklist rated as present (1) no days to (4) 5 or more days for the past week (alpha = .91).
REFERENCES


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