The effect of coping strategies on burden among male Alzheimer's caregivers

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THE EFFECT OF COPING STRATEGIES ON BURDEN AMONG MALE ALZHEIMER’S CAREGIVERS

A Thesis

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

in

The School of Social Work

by

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Abstract

The purpose of this study is to examine the coping strategies of an often understudied, growing population of Alzheimer’s disease informal caregivers, male caregivers. Additionally, the current study measured the effects of three styles of coping (task-focused coping, emotional-focused coping, and avoidant-focused coping) on the reported burden of the male AD caregivers. The sample included 138 male AD caregivers. The male AD caregivers in the current study reported moderate to severe burden. Task-focused coping strategies were the most commonly used styles of coping. The use of task-focused coping had no effect on the burden reported by the caregivers in the study. Both emotion-focused and avoidant-focused coping, contributed to increased burden among the male AD caregivers in the study.
Chapter 1: Introduction

The Department of Health and Human Service’s Administration on Aging (2010) estimated that by 2050, older adults, those aged 65 and older, would represent 20% of the population of the United States. The Administration on Aging’s (2010) estimate of 88.5 million older adults by 2050 is double the current number of those aged 65 and older in the United States, and the percentage of older adults is expected to increase by 7%. In Louisiana, the population is aging at a faster rate. The percentage of those 65 and older in Louisiana is expected to rise by 8% by 2030, and to 944,000 people (Administration on Aging, 2010). The rapid aging of Louisiana and the nation’s population highlights a need for research regarding issues and concerns affecting older adults.

Alzheimer’s disease (AD) is a devastating neurological disease that affects every aspect of functioning, including the ability to function physically, mentally, behaviorally, and socially (Alzheimer’s Association, 2011). Additionally, the Alzheimer’s Association identified age as the greatest risk factor for developing AD, and 13% of older adults have been diagnosed with AD in the United States. Because those with AD require assistance to complete everyday tasks such as eating, bathing, and toileting, caregivers must take on this role (Alzheimer’s Association, 2011). The majority of AD caregivers are informal, not paid, family members or friends (Alzheimer’s Association, 2011).

Caregiving burden refers to the multidimensional stress experienced by those providing care to someone with AD (George & Gwyther, 1986), and coping refers to the way in which these caregivers attempt to relieve their stress (Endler & Parker, 1990). The purpose of this thesis is to discuss the effects of coping on the burden of an emerging, understudied population of AD caregivers, male caregivers (Houde, 2002).
This thesis begins with a discussion of previous literature. AD is described, along with its history, diagnosis, scope, and treatment. Then, AD caregiving, burden, and gender differences in burden are discussed. The following section is a description of coping, including Endler and Parker’s (1990) three types of coping strategies: task-focused, emotion-focused, and avoidant focused coping. After the literature review, the Stress Process Model, the theoretical framework, is outlined (Pearlin et al., 1990) along with the research questions and hypotheses. The study methods, including the design, sampling, measures, and data analysis are then discussed. Finally, the results and a discussion of the results, as well as social work implications and study limitations are described.
Chapter 2: Review of Literature

It would be challenging to understand the experiences of Alzheimer’s caregivers without knowledge of the impact of the disease. The following section outlines the history, scope, characteristics, and treatment of Alzheimer’s disease. Additionally, this section also describes AD caregiving, caregiving burden, and the coping strategies used by AD caregivers.

Alzheimer’s Disease

Alzheimer’s disease (AD), which is a debilitating neuropsychological disease that primarily impacts older adults, affects millions of people in the United States (National Institute on Aging, 2009). Additionally, AD is the sixth most frequent cause of death. In Louisiana, 1324 people die per year as a result of Alzheimer’s disease (Xu, Kochanek, Murphy, & Tejada-Vera, 2010). AD, which is characterized by a loss of functioning, is the most frequently diagnosed type of dementia (Alzheimer’s Association, 2011).

A person with AD may require assistance in completing everyday tasks, such as bathing and eating, and treating AD is challenging and costly (Alzheimer’s Association, 2011). The cost of caring for those in the United States with AD is expected to rise sharply over the next 30 years, from $183 billion to $1.1 trillion (Alzheimer’s Association, 2011). The high mortality and rate and rising cost of treatment associated this disease highlights the need for further research, including risk factors, early detection, treatment, and its effect on caregivers (Alzheimer’s Association, 2011).

History of Alzheimer’s Disease. As a psychiatrist, Alois Alzheimer became interested in a 51-year-old patient who suffered a staggering decline in cognitive and motor functioning over a period of 4 ½ years (Small & Cappai, 2006). After his patient’s death in 1906, Alzheimer examined his patient’s brain and found a significant deterioration of brain tissue (Small &
Cappai, 2006). He published a paper on his findings in 1907, pioneering the discovery of the
disorder that would eventually bear his name—Alzheimer’s disease (Small & Cappai, 2006)

**Scope.** The current prevalence of AD in the United States is 5.1 million people (National
Institute on Aging, 2009), but this number will continue to rise as the number of older adults in
the nation increases (National Institute on Aging, 2009). Currently 13% of those over the age of
65 has AD (Alzheimer’s Association, 2011), and the number of adults aged 65 and older is
expected to double within 20 years (Hebert, Scherr, Bienias, Bennett, & Evans, 2003). For each
span of five years over the age of 65, the incidence of AD multiplies times 2, and 93% of those
with AD are over the age of 75 (Herbert et al., 2003). More than two-thirds of people with AD
are women and 85% are white (National Academy on Aging, 2000).

**Defining AD.** The American Psychiatric Association (APA; 2000) stated that AD is a
type of dementia, which is characterized as a loss of cognitive functioning that is a result of a
medical condition or substance use, but the types of dementia are differentiated by their cause, or
etiology. Because it can be difficult to assess the damage of brain cells that is associated with AD
in a living person’s brain, AD must be diagnosed by ruling out the etiologies of other dementia
disorders (APA, 2000).

In order to meet the diagnosis of AD, an individual must demonstrate significant
problems with memory and either problems understanding and speaking language (aphasia),
decreased motor skills (apraxia), problems naming objects (agnosia), or difficulty completing
abstract problems or tasks (impaired executive functioning; APA, 2000). To be diagnosed with
AD, these issues must not be related to any illnesses or substances and cannot be associated with
another mental illness (APA, 2000).
If unusual behaviors are also present, AD can be specified “With Behavioral Disturbance” and if not, “Without Behavioral Disturbance” (APA, 2000, pp. 157-158). Unusual behaviors may include anger, aggression, trouble sleeping, and problems with mood (National Institute on Aging, 2010). Also, two subtypes for the disorder exist (APA, 2000). If diagnostic criteria are met before the individual is age 65, the subtype “With Early Onset” can be applied (APA, 2000, pp. 158). If the criteria are met after age 65, the subtype is “With Late Onset” (APA, 2000, pp. 158). The gradual course of AD typically lasts for 10 years before death (Voisin & Vellas, 2009).

The course of AD has been identified through three stages: early, moderate, and severe (Voisin & Vellas, 2009). Early AD is characterized by problems with memory and mild disorientation (Voisin & Vellas, 2009). Symptoms of early AD do not impact daily functioning (Voisin & Vellas, 2009). Moderate AD is characterized by aphasia, apraxia, and significant problems with memory (Voisin & Vellas, 2009). These symptoms impact daily functioning, and assistance completing daily tasks is necessary (Voisin & Vellas, 2009). In severe AD, behavioral disturbances are more likely to be present, and language functioning, memory, and motor functioning is severely impaired (Voisin & Vellas, 2009). Assistance with daily living is required, and incontinence may be present (Voisin & Vellas, 2009).

Although the greatest risk factor is increasing age, other risk factors for developing AD include brain injury, genetic history, and problems with the heart and blood vessels (Alzheimer’s Association, 2011). Individuals with a closely related family member who has AD are more likely to have the disease (Mayeux, Sano, Chen, Tatemichi & Stern, 1991), and also, individuals with cardiovascular problems are more likely to have AD (Whitmer et al., 2008). Additionally,
people who have mild to moderate head injuries are at a greater risk for developing AD (Lye & Shores, 2000).

The most recent guidelines for assessing AD were released in April 2011 by the National Institute on Aging and the Alzheimer’s Association. According to the newest guidelines, AD is characterized by the following three stages: Preclinical Stage, Mild Cognitive Impairment, and Alzheimer’s Dementia (National Institute on Aging, 2011).

The Preclinical Stage is defined as the stage before any observable symptoms are present, but there may be a neurological presence of AD (National Institute on Aging, 2011). The National Institute on Aging and the Alzheimer’s Association caution that positron emission tomography (PET) scans and cerebrospinal fluid (CSF) analysis, the technology for assessing AD at this stage, may be unreliable; the Preclinical Stage should only be assessed for the purpose of doing research, not in a clinical setting for diagnosis (National Institute on Aging).

The following stage is called Mild Cognitive Impairment (National Institute on Aging, 2011). In this stage, symptoms of AD are starting to become present, but do not significantly impact functioning (National Institute on Aging, 2011). This stage may be assessed with caution using PET, CSF, and magnetic resonance imaging (MRI) technology (National Institute on Aging, 2011). Neuropsychological testing may also be able assess functioning at this stage (National Institute on Aging).

The last stage of AD is called Alzheimer’s Dementia (National Institute on Aging, 2011). In this stage, decline in cognitive abilities begins to effect functioning in everyday situations (National Institute on Aging, 2011). Significant problems with memory and problems with aphasia, apraxia, agnosia, or executive functioning are present (National Institute on Aging,
Neuropsychological testing may assess the severity of the symptoms (National Institute on Aging, 2011).

**Treating AD**

**Pharmacology Treatment.** Currently, medications cannot stop the progression of AD (Alzheimer’s Association, 2011). Although there are no treatments to stop progression of or prevent AD, medications can make small improvements in AD by slowing the progression of symptoms, such as memory problems, aphasia, and agnosia (Zec & Burkett, 2008). Medications approved by the Food and Drug Administration (FDA) to treat the symptoms of early and moderate stages of AD are cholinesterase inhibitors (Alzheimer’s Association, 2011). The FDA has approved memantine for treating moderate to late stages of AD (Alzheimer’s Association, 2011). These medications are not effective for longer than 12 months, and do not work for 50% of those who try them (Zec & Burkett, 2008). Researchers believe that early detection and engaging in treatment in the Preclinical and Mild Cognitive Impairment stages of AD is key in treating the progression of AD symptoms (Alzheimer’s Association, 2011).

**Behavioral Interventions.** Behavioral management programs have been found effective in treating functional and behavioral symptoms of AD (Terry et al., 2004). In a study by Terry et al., behavioral techniques taught to caregivers were found to decrease depression and improve physical functioning among the people with AD for whom care was given. The effects of the behavioral techniques were even found to be evident two years after the study ended (Terry et al., 2004).

Psychoeducational treatment programs have also been found effective in improving symptoms of AD (Haupt, Karger, & Janner, 2000). Haupt, Karger, and Janner stated that when AD caregivers participate in a psychoeducation group treatment program, perceived anxiety and
agitation of the individual with AD is decreased. The effect of the psychoeducational treatment program lasted for months after the program was completed (Haupt, Karger, & Janner, 2000).

It is currently impossible to slow down the progression of AD with treatment (Alzheimer’s Association, 2011). Some medications can slow the progression of AD symptoms, but this treatment does not work for everyone (Alzheimer’s Association, 2011). Behavioral interventions that can be engaged in by AD caregivers, like behavioral management programs and psychoeducational treatment, may be successful in improving function and mood among those with AD (Terry et al., 2002; Haupt, Karger, & Janner, 2000).

Individuals in the advanced stages of AD require around-the-clock assistance from dedicated caregivers. While paid caregivers provide some of this care, informal caregivers provide the majority of assistance to those with AD in the United States (Alzheimer’s Association, 2011). The population of this study includes male, AD nonprofessional, caregivers. The following section is a discussion on caring for those with AD.

**Alzheimer’s Caregiving**

Of the 5.1 million people with AD in the United States (National Institute on Aging, 2009), 70% are living at home, and less than 10% are assisted with daily living by formal caregivers, or paid caregivers. These are professionals that may include nurses and home-health aids (Alzheimer’s Association, 2011). Family members and friends, or informal caregivers, are the primary caregivers for the vast majority of those with AD (Alzheimer’s Association, 2011).

The majority (56%) of AD caregivers are over the age of 55, and more than half are women (60%). Half of AD caregivers are caring for their spouse and 35% of caregivers are caring for their parent (Metlife Mature Market Institute, 2006). Nearly 67% are living with the care recipient, and AD caregivers average 3 years in providing direct care (Metlife Mature
Market Institute, 2006). Over 40% are employed in addition to providing informal care (Alzheimer’s Association, 2011). The majority of caregivers identify as Caucasian, followed by African American and then Hispanic (Alzheimer’s Association, 2011). In 2010 in Louisiana there were over 200,000 AD caregivers and 80,000 people with AD (Alzheimer’s Association, 2011).

AD caregivers directly assist with activities of daily living (ADL). These ADL include getting out of bed, bathing, getting dressed, eating, and using the restroom. ADL may also include financial planning, housekeeping, and assisting with medication management (Alzheimer’s Association, 2011). Informal caregivers spend nearly 47 hours per week providing direct care (Metlife Mature Market Institute, 2006). AD caregiving, when discussed in this study, will include informal, nonpaid individuals providing assistance in ADL to family members or friends with AD.

**AD Caregiving Burden.** Friends and family members caring for older adults with AD experience significant stress as a result of the physical, mental, and financial demands associated with the caregiving role. According to the Alzheimer’s Association (2011) over half of caregivers have rated their stress associated with providing care as high or very high. George and Gwyther (1986) stated that caregiver burden is the stress experienced by friends and family members caring for someone with AD. This stress negatively impacts emotional or psychological, physical, financial and social functioning (George & Gwyther). Caregivers providing assistance to older adults with AD who suffer from behavioral disturbances and those who require help with one or more ADL are more likely to report experiencing burden (Robertson, Zarit, Duncan, Rovine, & Femia, 2007).
Evidence of psychological and emotional stress associated with the changing of roles from family or friend to caregiver is considerable (Alzheimer’s Association, 2011; Farcnik & Persyko, 2002; Haley et al., 2005; Yeager, Hyer, Hobbs, & Coyne, 2010). Depression and anxiety are prevalent among caregivers, and as the functional needs of the care recipient and the disease advance, the risk for psychological and emotional stress in the caregiver increases (Wright, Hickey, Buckwalter, Hendrix, & Kelechi, 1999). Depression in caregivers is also correlated with loneliness and social isolation. Compared to caregiving husbands and children, wives of the cared-for are more likely to report loneliness and depression (Beeson, Horton-Deutsch, Farran, Neundorfer, 2000).

In regards to the physical burden associated with providing care for a family member or friend with AD, nearly half (43%) caregivers rated the physical stress they were under as either high or very high (Alzheimer’s Association, 2011). AD caregivers are less likely to participate in self-care than non-caregivers (Alzheimer’s Association, 2004) and are more likely to utilize healthcare resources. It is estimated that the physical and emotional burden caused by caregiving is responsible for a $7.9 billion increase in healthcare (Alzheimer’s Association, 2011). With 20% of caregivers in fair or poor health, nearly 18% have stated that their caregiving duties have negatively impacted their health.

Although many caregivers provide 47 hours weekly in care (Metlife Mature Market Institute, 2006), 44% of caregivers also keep paid part-time and full-time jobs (Alzheimer’s Association, 2011). More than half of employed caregivers reported needing to rearrange work hours in order to meet caregiving and financial duties (Alzheimer’s Association, 2011). As many as 21% of AD caregivers, had to discontinue working (Alzheimer’s Association, 2011).
AD Caregiving and Gender. Although over half of AD caregivers are woman, as many as 40% of caregivers are husbands, sons, or other male family members and friends (Metlife Mature Market Institute, 2006), and the number of male caregivers in the United States is expected to rise (Houde, 2002). The increasing number of male caregivers highlights the need for a discussion on the differing caregiving experiences between male and female AD caregivers.

According to researchers, caregiver gender is a factor that determines severity of caregiver burden. Female AD caregivers are likely to report experiencing more severe levels of burden and depression than male AD caregivers (Campbell et al., 2008; Yeager, Hyer, Hobbs & Coyne, 2010). Female AD caregivers are more likely to experience physical burden, a decline in physical health, as a result as caregiving for a loved one with AD (Barber & Pasley, 1995). Female caregivers are also reported higher levels of tension with other family members as a result of caregiving (Barber & Pasley, 1995). Female caregivers were more likely to be employed outside the home in addition to caregiving and were on average 8.26 years younger than the male AD caregivers in a study by Barber and Pasley (1995).

Harris (1993) stated that men are less likely to report experiencing burden because they may be more likely to use a different coping strategy from females when caregiving. Female caregivers are reportedly less likely than male caregivers to seek additional outside formal or informal assistance with daily tasks, but female caregivers are more likely to participate in support groups (Navaie-Waliser, Spriggs, & Feldman, 2002). A more detailed discussion of gender-related differences in coping strategies among caregivers is present in the following section.

Research regarding gender differences in the kinds of task preformed by male and female caregivers is conflicting. Navaie-Waliser, Spriggs, and Feldman (2002) stated that female
caregivers are more likely to take on traditionally female caregiving tasks, such as hands-on ADL like bathing, feeding, and dressing. Ford, Goode, Barrett, Harrell, and Haley (1997) stated that there is no difference between male and female caregivers regarding the number, kind of tasks performed, and time devoted to completing these tasks. Barber and Pasley (1995) also stated that there is no significant difference in the number of hours spent per week caregiving, the number of years spent caregiving, and the kinds of caregiving tasks completed among male and female AD caregivers.

In a study on male dementia caregivers by Mathews, Mattocks, and Slatt (1990), almost all the caregivers surveyed stated that their desire to provide care was motivated by a feeling of love towards the person receiving care. Some male caregivers also stated that they were motivated by a sense of duty (Mathews et al., 1990). The male caregivers in this study spent on average 7.2 hours providing care and were likely to receive assistance from family members and friends (Mathews et al., 1990). The male caregivers in this study had been providing care for an average of three years (Mathews et al., 1990).

According to Mathews et al. (1990), for many of the male dementia caregivers, this was the first time they had assisted in helping someone complete ADL, such as feeding, bathing, and dressing. The researchers in this study cited the lack of experience with caregiving of males considering taking on the caregiving role as a deterrent to becoming a primary caregiving source (Mathews et al., 1990). Mathews et al. (1990) suggested offering educational classes to men interested in pursuing the caregiving role to encourage the decision to care for a family member or friend with dementia.
Coping

As previously stated, family members and friends providing care for someone with AD experience tremendous stress as a result of taking on the caregiving role (Alzheimer’s Association, 2011; Farncik & Persyko, 2002; Haley et al., 2005; Yeager, Hyer, Hobbs, & Coyne, 2010). Coping is described as strategies used to mitigate or tolerate physical, emotional, or financial stress (Folkman & Lazarus, 1980). Folkman and Lazarus stated that coping strategies might be behavioral, such as problem-solving techniques, or cognitive. Cognitive coping is emotion-focused and involve using psychological approaches to reduce stress, and may include using humor, emotional support, or religion (Folkman & Lazarus, 1980).

Carver and Scheier (1994) stated that the coping strategies an individual uses might be relative to the stages, or phases, of a stressful situation. The researchers stated that a more solution focused coping strategy could be used in the beginning stage of a stressful situation followed by a more emotional coping strategy (Carver & Scheier, 1994). Carver and Scheier also identified the use of more negative coping strategies like denial, disengagement from the stressor, and the use of alcohol (Carver & Scheier, 1994). Coping strategies, for the purpose of this study, will be divided into three types: task-focused, emotion-focused, and avoidance-focused (Endler & Parker, 1990).

Task-focused Coping. Task-focused coping strategies include assessing challenges and problem solving to alleviate stress (Endler & Parker, 1990). Carver, Scheier, and Weintraub (1989) defined this type of coping as attempting to modify the source of stress by using problem solving and planning. Examples of task-focused coping include coming up with a plan to get rid of the problem and thinking of a plan of action (Carver, Scheier, & Weintraub, 1989). Task-focused coping can be effective in reducing burden, and is negatively correlated with depression.
Although this strategy is useful, its effects may be less long lasting when compared with the benefits of emotion-focused coping (Cooper, Katona, Orrell, & Livingston, 2008).

Sun, Kosberg, Kaufman, and Leeper (2010) stated that most commonly used task-focused strategies among dementia caregivers included planning (coming up with a strategy) and active coping (actively improving the situation). Male caregivers are more likely to use task-focused coping strategies than female caregivers (Navaie-Waliser, Spriggs, & Feldman, 2002).

**Emotion-focused Coping.** Emotion-focused coping are cognitive strategies used to lessen psychological stress (Endler & Parker, 1990; Folkman & Lazarus, 1980). Examples of emotion-focused coping strategies include attempting to take a positive point-of-view or confiding in a friend (Endler & Parker, 1990). Emotion-focused strategies may also include using religion, humor, or acceptance to lessen the effect of a stressor (Carver et al., 1989). Individuals who are depressed and anxious are more likely to use emotion-focused strategies than task-focused coping strategies (Endler & Parker, 1990). Endler and Parker stated that women are more likely to use emotion-focused coping strategies.

Among caregivers, females are also more likely to use emotion-focused coping strategies (Navaie-Waliser, Spriggs, & Feldman, 2002). In a study of dementia caregivers, the most popular emotion-focused strategies included spiritual coping, emotional growth, and acceptance (Sun et al., 2010). The use of emotion-focused coping strategies in caregivers is negatively correlated with depression among males (Ashley & Kleinpeter, 2002). While both task-focused and emotion-focused coping are effective in reduce caregiver burden and anxiety, those who used emotion-focused coping were less likely to report anxiety one year later (Cooper, Katona,
Emotion-focused coping may be a more long-term solution to burden than task-focused coping (Cooper et al., 2008).

**Avoidant-focused Coping.** An avoidant-focused coping strategy involves purposely not participating in an activity that is related to a stressor to avoid experiencing stress (Endler & Parker, 1990). Iwamoto and Lui (2010) defined avoidant coping strategies as indirectly managing stressors. Those indirect methods may include using alcohol or drugs, denial, or disengagement (Iwamoto & Lui, 2010).

Carver, Scheier, and Weintraub (1989) stated that avoidant coping strategies might be both behavioral and mental. Mental avoidant-focused coping may include daydreaming or watching television in attempt to distract oneself from the stressor (Carver et al., 1989). Behavioral avoidant-focused coping is having a goal in mind to reduce stress but deliberately not taking steps to achieve the goal (Carver et al., 1989). The use of avoidant coping strategies is positively correlated with depression (Mosher & Prelow, 2007), and this positive correlation rings true among AD caregivers as well (Ashley & Kleinpeter, 2002).

Ashley and Kleinpeter (2002) stated that caregivers who used an avoidant coping strategy were far more likely to report symptoms of depression. In a study by Sun et al. (2010), avoidant-focused coping strategies were the least used by dementia caregivers, but mental and behavioral disengagement, denial, and substance abuse were associated with significantly higher burden and decreased life satisfaction. Those who used avoidance-focused coping also reported being in worse health than those using emotion-focused and task-focused coping (Sun et al., 2010). Avoidance-focused coping is not only an ineffective strategy but is associated with negative outcomes (Ashley & Kleinpeter, 2002; Sun et al., 2010).
Chapter 2: Theoretical Framework - The Stress Process Model

The theoretical model referenced in this study is the Stress Process Model and was developed by Pearlin, Mullen, Semple, and Skaff (1990). Pearlin et al introduced this model in a study of stress among 555 non-paid dementia caregivers across the United States. In this study, Pearlin et al (1990) outlined the multiple dimensions of caregiving stress. The Stress Process Model argues that the four major contributing factors to caregiving stress include the caregiver’s background and context, stressors, mediators, and outcomes (Pearlin et al., 1990; see Figure 1).

The caregiver’s background and context as defined in this theoretical model may include factors such as gender, socioeconomic status, ethnicity, age, and biopsychosocial history (Pearlin et al., 1990). As previously stated, gender is related to caregiver stress (Barber & Pasley, 1995). Female caregivers are more likely to report feeling depressed or anxious (Barber & Pasley, 1995). Additionally, age is positively correlated with caregiver burden (Majerovitz, 2007). Those caregivers of lower socioeconomic status and those who are in poor health are also more likely to report significant burden (Majerovitz, 2007).

This model proposes two categories of stressors: primary stressors and secondary stressors (Pearlin et al., 1990). Primary stressors are those directly related to the role of caregiving, such as providing assistance with ADL and supervising the care receivers (Pearlin et al., 1990). Caregivers who care for someone with significant functional impairments require greater assistance with ADL (Bolden & Wicks, 2008). These caregivers are more likely to report significant burden (Bolden & Wicks, 2008). Secondary stressors may include economic or social burden. (Pearlin et al., 1990). In a study by Bookwala and Schulz (2000), caregivers, females especially, reported significant stress related to a decrease in social activities and relationships as
a result of caregiving duties. Increasing financial demands related to caring for someone with dementia are also related to higher levels of burden (Bookwala & Schulz, 2000).

Mediators are variables that may lessen the effect of the stressors, or outcomes. Mediators of stress are also divided into two categories. These include social support and coping (Pearlin et al., 1990). Social support may be obtained from attending a support group or seeking the support of a friend or family member (Pearlin et al., 1990). Caregivers who report higher levels of social support are less likely to report burden (Majervotiz, 2006). Coping strategies, as described above, are strategies to lessen the effect of stress (Lazarus & Folkman, 1980). In the Stress Process Model, the outcomes of caregiving stress in the caregiver may include disturbances in mood (depression or anxiety) or a decline in the physical health. (Pearlin et al., 1990).

![The Stress Process Model](image)

Figure 1. The Stress Process Model (Pearlin et al., 1990).
As previously stated, the Stress Process Model outlines the four contributing factors of stress. These factors include the background and context, primary stressors, secondary stressors, and mediating factors (Pearlin et al., 1990; See Figure 1). In the context of caregiving, background and context refers to the caregiver’s ethnicity, socioeconomic status, gender, and other demographic variables. Primary stressors include the activities associated directly with caregiving, such as feeding and bathing, and secondary stressors may include the negative emotional, social, and economic effects of caregiving. Mediating factors refers to the coping strategies of the caregiver and the social support available. Outcome, as outlined in this model in the caregiving context, is the burden experienced by the caregiver, such as depression and anxiety (Pearlin et al., 1990; See Figure 2).

Figure 2. Stress Process Model in the context of caregiving with burden as the outcome.

While the Stress Process Model serves as this study’s theoretical framework for understanding caregiving stress, it is important to note that this study is not examining the
mediation effects of coping strategies as the framework suggests. This study will examine only a piece of the Stress Process Model, the effect of caregiving coping strategies on burden. Testing for mediation can be quite challenging (Baron & Kenny, 1986); furthermore, the purpose of this research study is to compare the effect of the independent variables, coping strategies, on the dependent variable, burden, while controlling for demographic and background factors (See Figure 3).

Figure 3. Model of the current study.
Chapter 3: Purpose, Research Questions, and Hypotheses

The purpose of this study is to examine the effect of coping strategies (task-focused, emotion-focused, and avoidant-focused) on burden among male AD caregivers. The following research questions will be examined. The scales mentioned below, the Zarit Burden Interview (ZBI) and The Revised Memory and Behavior Problems Checklist (RMBPC), are discussed further in the Measures section.

1. Among male AD caregivers, what is the likelihood task-focused coping is used?
2. Among male AD caregivers, what is the likelihood emotion-focused coping is used?
3. Among male AD caregivers, what is the likelihood avoidant-focused coping is used?
4. What is the severity of burden experienced by male AD caregivers,
   a. as measured by the ZBI?
   b. as measured by the RMBPC?
5. While controlling for variables, what is the relationship between task-focused coping and the global scores on
   a. the ZBI?
   b. the RMBPC?
6. While controlling for variables, what is the relationship between emotion-focused coping and the global scores on
   a. the ZBI?
   b. the RMBPC?
7. While controlling for variables, what is the relationship between avoidant-focused coping and the global scores on
   a. the ZBI?
b. the RMBPC?

It is hypothesized that among male AD caregivers, the global scores on the task-focused subscale of the Coping Inventory for Task Stress (CITS) will be significantly higher than the global scores on the emotion-focused and avoidant-focused subscales. Additionally, male AD caregivers experience significant burden as measured by the ZBI and RMBPC. Regarding the relationship between coping strategies and burden, the researcher hypothesizes that the use of task-focused and emotion-focused coping strategies has a significant, negative relationship with global scores on the ZBI and RMBPC while the use of avoidant-focused coping strategies has a significant, positive relationship with global scores on the ZBI and RMBPC.
Chapter 4: Methods

Design and Sampling

The data examined in this study was obtained in a previous study by Wilks, Little, Gough, and Spurlock (2011). Based on its status as a secondary data analysis, the current study has been approved by Louisiana State University’s Institutional Review Board.

Data from the original study was collected via survey, using a cross-sectional design. The survey was distributed in two tiers, and participants were offered $10 in exchange for completing the survey (Wilks et al., 2011). In the initial tier, surveys were mailed to nearly 5,000 caregivers in Louisiana who were on the mailing list of a local non-profit, 501(c)3 organization that focuses on assisting those affected by AD (Wilks et al., 2011). The survey contained a cover letter and pre-addressed, stamped envelope. In order to ensure confidentiality, the researchers were never in possession of the mailing list (Wilks et al., 2011). The staff members of the non-profit organization mailed each survey. Of the population of 5,000 caregivers who received the survey, a sample of 566 completed the survey and returned it (Wilks et al., 2011).

In the second tier, the researchers consulted a local expert in the research community with interest and knowledge regarding studying an often-underserved population of caregivers (Wilks et al., 2011) African American AD caregivers (Williams & Barton, 2004). With the help of this community member to reach this population, surveys were distributed to adult day programs, community centers, churches, and home health agencies. In the second tier, 134 surveys were collected (Wilks et al., 2011).
Measures

The thesis will only examine data from the original study that is relevant to the current research questions. This relevant data was obtained using a survey containing the following measures: demographic information, CITS, ZBI, and RMBPC.

The demographic information collected in the survey contained gender, ethnicity, and marital status, which are non-parametric, nominal levels of measurement, and age, a parametric level of measurement. The independent variables, coping strategy, was measured using the CITS, a parametric level of measurement.

The CITS is based on Ender and Parker’s (1990) concept of coping (Matthews & Campbell, 1998). As previously stated, Ender and Parker (1990) divided coping strategies into three types: task-focused, emotion-focused, and avoidant-focused. The CITS is a questionnaire that consists of three subscales that measure the likelihood of use of each coping strategy (Matthews & Campbell, 1998). Each subscale has nine items. Participants are asked to rate each item using a 5-point Likert Scale, with 0 meaning not at all and 4 meaning extremely. Each subscale produces a global score from 0 to 36 (Matthew & Campbell, 1998). A higher global score represents a higher probability that the participant uses the coping strategy (Matthew & Campbell, 1998). In the study by Matthew and Campbell, the Cronbach’s alpha coefficients for the three subscales were between .84 and .86.

The dependent variable, burden, was measured using the shortened ZBI and the frustration subscale of the RMBPC. Both scale are parametric levels of measurement. The shortened ZBI is a 4-item questionnaire that predicts burden among caregivers (Bedard et al., 2001). Each item is measured using a 5-point Likert Scale, with 0 meaning never and 4 meaning nearly always. The scale is interpreted with a global score from 0 to 16. A higher global score
represents a higher likelihood the respondent is experiencing burden (Bedard et al., 2001). The Cronbach’s alpha coefficient for this scale was .78 (Bedard et al., 2001).

The RMBPC is a scale that measures the problem behaviors of the care recipient, as reported by the caregiver (Teri et al., 1992). The scale also measures the caregiver’s reactions to these problem behaviors (Teri et al., 1992). The current study is only interested in interpreting data collected in the RMBPC’s caregiver reaction subscale. The RMBPC is a 24-item scale that measures responses on a 5-point Likert Scale (Teri et al., 1992). In the caregiver’s reaction subscale, respondents are asked to report the degree to which the problem behaviors bother or upset him or her (Teri et al., 1992). The responses range from 0, meaning not at all to 4, meaning extremely. A higher global score indicates that problem behaviors have a more negative effect on the caregiver. The Cronbach’s alpha coefficient for this subscale was .90 (Teri et al., 1992).

**Data Analysis**

**Descriptive Statistics.** The non-parametric data were analyzed using frequency and percentage. Parametric data were reported using mean and standard deviation. These statistics will address research questions one through four.

**Correlations and Regression.** The magnitude and direction of the correlations between coping strategies (task-focused, emotion-focused, avoidant-focused) and burden were reported using Pearson’s $r$. Pearson’s $r$ was reported because the scales used to measure coping strategies and burden all yield parametric levels of measurement. In order to test research questions five through seven, simple linear regression was used, reporting the beta coefficient and its $p$-value. Linear regression was reported because it tests if the independent variable, coping strategy, predicts the dependent variable, burden. $R^2$ was also reported, which describes the degree to which independent variable affects the dependent variable. Additionally, linear regression was
used because the measures of coping strategy and burden are both parametric levels of measurement. The $p$-value threshold was set at .05.
Chapter 5: Results

Descriptive Statistics

Sample Characteristics. Of the 691 caregivers originally surveyed, the current study included 138 male caregivers. The majority of the sample was Caucasian (61.3%, \(n = 84\); 35.8% \(n = 49\)) were African American. Over half of the male caregivers were married (58%, \(n = 80\)). The second most reported marital status was single (18.8%, \(n = 26\)). In the current study, 41.5% \(n = 56\) of the male caregivers surveyed were caring for a parent, and 26.7% \(n = 36\) were caring for a spouse, or partner. Please refer to Table 1 for comprehensive descriptive statistics of the sample population.

Table 1. Descriptive statistics of sample characteristics.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Valid %</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>35.8</td>
<td>49</td>
</tr>
<tr>
<td>Hispanic/Latina(o)</td>
<td>0.7</td>
<td>1</td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>61.3</td>
<td>84</td>
</tr>
<tr>
<td>Other</td>
<td>2.2</td>
<td>3</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single (never married)</td>
<td>18.8</td>
<td>26</td>
</tr>
<tr>
<td>Divorced</td>
<td>13.8</td>
<td>19</td>
</tr>
<tr>
<td>Married</td>
<td>58.0</td>
<td>80</td>
</tr>
<tr>
<td>Widowed</td>
<td>9.4</td>
<td>13</td>
</tr>
<tr>
<td>Relationship to care recipient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse/partner</td>
<td>26.7</td>
<td>36</td>
</tr>
<tr>
<td>Child</td>
<td>41.5</td>
<td>56</td>
</tr>
<tr>
<td>Grandchild</td>
<td>11.1</td>
<td>15</td>
</tr>
<tr>
<td>Sibling</td>
<td>3.7</td>
<td>5</td>
</tr>
<tr>
<td>Friend</td>
<td>3.7</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>13.3</td>
<td>18</td>
</tr>
</tbody>
</table>

Primary Variables. The average global scores on the CITS subscales are as follows: task-focused \((M = 20.1, SD = 4.3)\), emotion-focused \((M = 12.6, SD = 6.6)\), and avoidance-focused \((M = 9.13, SD = 5.5)\). The average global score on the ZBI was 12.1 \((SD = 3.1)\), and the average global score on the reaction subscale of the RMBPC was 32.8 \((SD = 23.6)\).
Table 2. Descriptive statistics of global scores of measures.

<table>
<thead>
<tr>
<th>Measures</th>
<th>(n)</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITS Task Coping</td>
<td>132</td>
<td>20.1</td>
<td>4.3</td>
</tr>
<tr>
<td>CITS Emotion Coping</td>
<td>131</td>
<td>12.6</td>
<td>6.6</td>
</tr>
<tr>
<td>CITS Avoidance Coping</td>
<td>128</td>
<td>9.1</td>
<td>5.4</td>
</tr>
<tr>
<td>ZBI</td>
<td>136</td>
<td>12.1</td>
<td>3.1</td>
</tr>
<tr>
<td>RMBPC Reaction Subscale</td>
<td>95</td>
<td>32.8</td>
<td>23.6</td>
</tr>
</tbody>
</table>

Correlations

Global scores on the reactions subscale of the RMBPC were significantly correlated with global scores on the ZBI ($r = .48, p < .01$). Scores on this subscale of the RMBPC were significantly correlated with global scores on the emotion-focused ($r = .59, p < .01$) and avoidant-focused ($r = .58, p < .01$) subscales of the CITS. Scores on this subscale of the ZBI were also significantly correlated with global scores on the emotion-focused ($r = .52, p < .01$) and avoidant-focused ($r = .23, p = .01$) subscales of the CITS. Global scores on the emotion-focused subscale of the CITS and the avoidance-focused subscale were correlated ($r = .52, p < .01$). Please refer to Table 2 for a comprehensive list of correlations of the primary variables.

Table 3. Correlations of global scores of measures with significance.

<table>
<thead>
<tr>
<th></th>
<th>RMBPC</th>
<th>ZBI</th>
<th>CITS-Task</th>
<th>CITS-Emotion</th>
<th>CITS-Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMBPC</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZBI</td>
<td>.480**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITS- Task</td>
<td>-.054</td>
<td>-.053</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITS- Emotion</td>
<td>.594**</td>
<td>.520**</td>
<td>.058</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CITS- Avoidance</td>
<td>.584**</td>
<td>.226**</td>
<td>.104</td>
<td>.521**</td>
<td>1</td>
</tr>
</tbody>
</table>

* Significance of <.05
** Significance of <.01

Regression

The global score on the ZBI significantly regressed the emotion-focused subscale on the CITS ($\beta = .52; p < .01$). With the inclusion of the demographic variables in the regression models, the regression of the outcome remained statistically significant ($\beta = .53; p = < .01$). In the stepwise regression model, no demographic variables showed statistical significance.
The global score on the ZBI also significantly regressed the avoidant-focused subscale on the CITS ($\beta = .23; p = .01$). Additionally, with the inclusion of the demographic variables the regression was statistically significant ($\beta = .28; p = < .05$). No demographic variables showed statistical significance.

The global score on the reaction subscale of the RMBPC significantly regressed the emotion-focused subscale of the CITS ($\beta = .59; p = < .01$). This regression was also statistically significant with the inclusion of the demographic variables ($\beta = .59; p = < .01$). None of the demographic variables measured showed statistical significance.

The global score on the reaction subscale of the RMBPC significantly regressed the avoidant-focused subscale of the CITS ($\beta = .59; p = < .01$). With the inclusion of demographic variables, the regression remained significant ($\beta = .58; p = < .01$). No demographic variables were significantly significant. See Tables 3-8 for a comprehensive description of the regression models.

### Table 4. Stepwise regression model of ZBI with task-coping and demographic factors.

<table>
<thead>
<tr>
<th></th>
<th>$\beta$</th>
<th>$p$-value</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITS-Task</td>
<td>-.035</td>
<td>.694</td>
<td>.001</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITS-Task</td>
<td>-.027</td>
<td>.765</td>
<td>.014</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.118</td>
<td>.232</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>.025</td>
<td>.796</td>
<td></td>
</tr>
<tr>
<td>Relationship to care recipient</td>
<td>.025</td>
<td>.786</td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5. Stepwise regression model of ZBI with emotion-coping and demographic factors.

<table>
<thead>
<tr>
<th></th>
<th>$\beta$</th>
<th>$p$-value</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITS-Emotion</td>
<td>.523</td>
<td>&lt; .01</td>
<td>.267</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITS-Emotion</td>
<td>.527</td>
<td>&lt; .01</td>
<td>.270</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.135</td>
<td>.099</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>.016</td>
<td>.845</td>
<td></td>
</tr>
<tr>
<td>Relationship to care recipient</td>
<td>.003</td>
<td>.968</td>
<td></td>
</tr>
</tbody>
</table>

**R^2 Δ** .020

Table 6. Stepwise regression model of ZBI with avoidant-coping and demographic factors.

<table>
<thead>
<tr>
<th>Step</th>
<th>β</th>
<th>p-value</th>
<th>R^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>CITS-Avoidant</td>
<td>.233</td>
<td>.009</td>
</tr>
<tr>
<td>Step 2</td>
<td>CITS-Avoidant</td>
<td>.276</td>
<td>.003</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>.159</td>
<td>.108</td>
</tr>
<tr>
<td></td>
<td>Marital Status</td>
<td>.012</td>
<td>.904</td>
</tr>
<tr>
<td></td>
<td>Relationship to care recipient</td>
<td>.001</td>
<td>.995</td>
</tr>
<tr>
<td>R^2 Δ</td>
<td></td>
<td></td>
<td>.025</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>.140</th>
<th>.196</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td>.072</td>
<td>.440</td>
</tr>
<tr>
<td>Relationship to care recipient</td>
<td>.029</td>
<td>.731</td>
</tr>
</tbody>
</table>

**R^2 Δ** .028

Table 7. Stepwise regression model of RMBPC with task-coping and demographic factors.

<table>
<thead>
<tr>
<th>Step</th>
<th>β</th>
<th>p-value</th>
<th>R^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>CITS-Task</td>
<td>-.025</td>
<td>.810</td>
</tr>
<tr>
<td>Step 2</td>
<td>CITS-Task</td>
<td>-.050</td>
<td>.643</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>.140</td>
<td>.233</td>
</tr>
<tr>
<td></td>
<td>Marital Status</td>
<td>.070</td>
<td>.542</td>
</tr>
<tr>
<td></td>
<td>Relationship to care recipient</td>
<td>.036</td>
<td>.732</td>
</tr>
<tr>
<td>R^2 Δ</td>
<td></td>
<td></td>
<td>.033</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>.120</th>
<th>.196</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td>.072</td>
<td>.440</td>
</tr>
<tr>
<td>Relationship to care recipient</td>
<td>.029</td>
<td>.731</td>
</tr>
</tbody>
</table>

**R^2 Δ** .028

Table 8. Stepwise regression model of RMBPC with emotion-coping and demographic factors.

<table>
<thead>
<tr>
<th>Step</th>
<th>β</th>
<th>p-value</th>
<th>R^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>CITS-Emotion</td>
<td>.585</td>
<td>.000</td>
</tr>
<tr>
<td>Step 2</td>
<td>CITS-Emotion</td>
<td>.586</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>.120</td>
<td>.196</td>
</tr>
<tr>
<td></td>
<td>Marital Status</td>
<td>.072</td>
<td>.440</td>
</tr>
<tr>
<td></td>
<td>Relationship to care recipient</td>
<td>.029</td>
<td>.731</td>
</tr>
<tr>
<td>R^2 Δ</td>
<td></td>
<td></td>
<td>.028</td>
</tr>
</tbody>
</table>
Table 9. Stepwise regression model of RMBPC with avoidant-coping and demographic factors.

<table>
<thead>
<tr>
<th>Step 1</th>
<th></th>
<th>β</th>
<th>p-value</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CITS-Avoidant</td>
<td>.594</td>
<td>.000</td>
<td>.346</td>
</tr>
<tr>
<td>Step 2</td>
<td>CITS- Avoidant</td>
<td>.582</td>
<td>.000</td>
<td>.327</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>.039</td>
<td>.695</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marital Status</td>
<td>.038</td>
<td>.691</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relationship to care recipient</td>
<td>.012</td>
<td>.892</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R² Δ</td>
<td></td>
<td>.004</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 6: Discussion

Review of Results

The purpose of this study was to examine the effects of coping strategies on burden among an often understudied and growing population of dementia caregivers, male informal caregivers. The typical caregiver in this study’s sample was a Caucasian, married male who is caring for a parent with Alzheimer’s disease. The marital status, ethnicity, and relation to the care recipient of the participants in this sample are consistent with the general population of caregivers in the United States. Among caregivers in the United States, 70% are Caucasian, and in the current study, 61% of the sample was Caucasian (Alzheimer’s Association, 2011). African Americans represented a greater proportion of caregivers in the current study, 36%, than in the national population, 15% (Alzheimer’s Association, 2011).

The majority (42%) of the current sample is the son of the care recipient. This percentage of the sample is consistent with previous research (Winter, Gitlin, & Dennis, 2011). Finally, 66% of the population of caregivers in the United States is married, and 58% of the current sample was married. With the exception of gender, this sample is representative of the population of informal AD caregivers in the United States.

In response to research questions one through three, the likelihood that task-focused, emotion-focused, and avoidant-focused coping are used, the most common coping strategy used by the caregivers in this study was task-focused, followed by emotion-focused. Avoidance-focused coping strategy was the least used by the sample. These findings are consistent with past research, which suggests that male caregivers are most likely to use task-focused coping strategies and avoidant-focused strategies the least (Navaie-Waliser, Spriggs, & Feldman, 2002).
Next, research question four is regarding the severity of burden experienced by male caregivers. The caregivers in this study reported experiencing a moderate to high level of burden.

The following section is a discussion of research questions five through seven, which are regarding the relationships between burden and each coping strategy. Those who reported higher levels of burden were significantly more likely to use avoidant- and emotion-focused strategies. These results are in line with those of Endler and Parker (1990), who found the use of emotion and avoidant-focused coping to be related to higher anxiety and depression. The stepwise regression analysis indicated that emotion-focused coping strategies strongly influenced global scores on the ZBI and the reaction subscale of the RMBPC. On all stepwise regression models, the inclusion of the demographic variables resulted in a minimal change in effect size.

As previously stated, researchers have found task-focused coping to be the most popular coping strategy among male AD caregivers (Navaie-Waliser, Spriggs, & Feldman, 2002). While there was no surprise that task-focused coping was the most popular strategy among the population of caregivers in the current study, the relationship between this strategy and burden in the study was unexpected (Navaie-Waliser, Spriggs, & Feldman, 2002). The use of task-focused coping was not associated with decreased levels of burden. In fact, task-focused coping had no effect on burden among this sample. This finding contrasted previous research that found a significant inverse relationship between task-focused coping and negative outcomes (Endler & Parker, 1990). In the current study, the use of task-focused coping did not significantly influence reported burden among male AD caregivers. Participants with higher levels of burden were more likely to use emotion-focused and avoidant-focused coping.

In the current study, it was hypothesized that task-focused coping would be the most common coping strategy among this sample of caregivers. This hypothesis was supported. Task-
focused was used most frequently, followed by emotion-focused and avoidant-focused coping strategies. Next, the current researcher anticipated that the sample would report significant levels of burden, and this hypothesis was also supported. The male caregivers in this study reported high levels of burden. It was also expected that the use of task-focused coping would have a significant, negative relationship with burden. This hypothesis was not supported. There was no specific relationship between task-focused coping and burden. The current researcher expected that emotion-focused coping would have a significant, negative relationship with burden. This hypothesis was not supported. Emotion-focused coping had a significant relationship with burden, but the direction was positive. As emotion-focused coping increased, burden increased. Finally, it was anticipated that the use of avoidant-focused coping would have a significant, positive relationship with burden. This hypothesis was supported. As the use of avoidant-focused coping increased, burden increased.

**Implications to Social Work**

While the majority of AD caregivers are female, a rising number of males are taking on a caregiving role, and studies examining this population are limited (Houde, 2002). In a literature review regarding male AD caregiving conducted by Houde (2002), the majority of articles featuring this population had either a low sample size or were qualitative. Additionally, as previously discussed, researchers have suggested that female and male caregivers have differing caregiving experiences (Campbell et al., 2008; Endler & Parker, 1990; Navaie-Waliser, Spriggs, & Feldman, 2002; Yeager, Hyer, Hobbs, & Coyne, 2010). The unique aspects of this population and the dearth of literature examining the male caregiving experience highlight a need for further examination.
The purpose of this study was to contribute to the limited understanding of this population: male AD caregivers. The current study confirms that this population is likely to report significant burden. While research suggests that female caregivers are more likely to report burden (Campbell et al., 2008; Yeager, Hyer, Hobbs, & Coyne, 2010), male caregivers in this study also experienced significant burden. Social workers in the field and social work educators should be encouraged to address the needs of this vulnerable population, burdened male caregivers.

Clinicians might assess male caregivers for burden and help the caregivers identify maladaptive coping strategies. According to the results of the current study, emotion-focused coping and avoidant-focused coping may contribute to negative outcomes. Although task-focused coping was not associated with decreased burden in the current study, task-focused coping is historically the most effective among this population of caregivers (Navaie-Waliser, Spriggs, & Feldman, 2002). Rather than engage in emotion- and avoidant-focused coping, male caregivers could be encouraged to engage in more task-focused coping, such as planning, problem solving, and active coping. Social workers are encouraged to assess caregivers for the use of avoidant-focused coping. In a study by Sun et al. (2010), avoidant-focused coping was associated with increased physical burden in addition to emotional, financial, and social burden. According to this study, maladaptive coping strategies have a significant effect on male caregiver’s reported burden.

With this awareness, social work clinicians can challenge these strategies and attempt to improve caregiving outcomes among this growing population. Sanders, Marwit, Meuser, and Harrington (2007) suggested challenging maladaptive coping strategies by identifying dysfunctional thinking and helping clients to reframe these thoughts. Additionally, Sanders et al.
(2007) stated that clinicians might discuss self-care with their caregiver clients to discourage the use of negative self-care strategies, such as substance abuse.

Mathews et al. (1990) stated that for many male dementia caregivers, taking on an AD caregiving role was their first experience assisting someone with ADL, such as feeding, bathing, and dressing. Mathews et al. (1990) suggested that new male caregivers taking on this role might benefit from education and support with these tasks. Zarit and Femia (2008) identified several aspects associated with effective interventions for AD caregivers. These characteristics include a combined psychological and educational approach and a multidimensional perspective (Zarit & Femia, 2008). The intervention should be tailored to address the caregiver’s specific needs and stressors and should be flexible to fit the caregiver throughout the treatment (Zarit & Femia, 2008). An intervention, which considers male caregiver’s unique experiences, might be ideal for this population. Further examination in research regarding effective interventions and the experiences of male caregivers would be valuable in order to truly serve this burdened group of caregivers.

**Limitations and Future Research**

There were several limitations in the current study. First, the participants were recruited using convenience sampling. The caregivers in this study were recruited from a local Alzheimer’s services organization, so they had previously sought services from this organization. Because the participants had already used the organization or may currently be participating in supportive services, they may not be representative of the general population of caregivers in Louisiana. The caregivers recruited though this organization may represent an overly burdened population, or others may be already making efforts to reduce their burden. Ideally, future
studies regarding this population of caregivers should utilize random sampling, rather than convenience sampling via an Alzheimer’s support organization.

Next, the sample size was relatively small considering the survey was mailed to approximately 5,000 caregivers. Of the 691 caregivers who completed the survey, only 138 were male. In future studies, the researchers should focus recruiting on targeting this population specifically. To truly understand the male caregiving experience, future studies should aim to sample a larger number of male caregivers.

Finally, the overwhelming majority of the participants in the current study identified as Caucasian and African American. Only one participant in the current study identified as Hispanic/Latina(o), and three participants answered with the category other. Similarly to how the current study utilized a local community expert to recruit African American participants, future studies would benefit from obtaining a more diverse sample of participants.
Chapter 7: Conclusion

The purpose of this thesis is to examine coping strategies and their effect on burden among an under-examined population, male AD caregivers. AD, a progressive and debilitating neurophysiological disease, is affecting a growing number of individuals and families. Currently, there are no medications or interventions that stop the progression of this deadly, devastating disease. As the nation ages, the incidence of AD will increase, and there will be a further demand for resources to assist those with AD. The millions who care for a friend, family member, or loved one with AD experience significant physical, mental, emotional, and social burden. This burden is costly, and many AD caregivers suffer from depression, anxiety, and social isolation. As the demand for resources to support those with AD increase, so will the need for support among AD caregivers.

To reduce the negative outcomes associated with high levels of burden, caregivers use different styles of coping. Coping can be cognitive or behavioral. The current study examined three coping strategies: task-focused, emotion-focused, and avoidant-focused. Task-focused was the mostly commonly used coping strategy among the male caregivers in this study, and although the use of this strategy was not associated with lower levels of burden in the current study, past researchers have identified this style of coping as the most effective for male caregivers. Emotion-focused and avoidant-focused coping were found to have a positive effect on burden. The male caregivers who reported higher levels of burden engaged in emotion- and avoidant-focused coping.

Social work clinicians can help male AD caregivers by paying special attention to identify those who are experiencing significant burden, as they may be less likely to seek support. Additionally, social work clinicians can identify maladaptive coping strategies and
encourage task-focused coping. Because the experiences of male AD caregivers may differ from female caregivers, social work educators and researchers should pay special attention to this growing population. This researcher hopes that the current study contributes to much needed knowledge regarding this especially vulnerable population of caregivers.
References


Vita

Lauren McKinsey Lovelace is from Houma, Louisiana, where she graduated from Terrebonne High School in 2003. She earned a Bachelor of Science in psychology with a minor in sociology from Louisiana State University in 2008. Lauren will obtain her Master in Social Work in May 2012. As a social work graduate student, she obtained field experience from internship placements at Capital Area Human Services District – Child and Adolescent Response Team and Baton Rouge General Medical Center – Behavioral Health Unit. She co-presented her thesis research in “Recognizing Resilience: Hartford Study Examining Coping among Alzheimer’s Caregivers” with Dr. Scott E. Wilks at the 19th Annual Alzheimer’s Education Conference.