

This article addresses the question of why respite care is evaluated positively by caregivers, yet is often not used by those considered to be in need of the service. Data from interviews with 144 caregivers in Canberra, Australia, are the basis for examining the relationships between five appraisal dimensions and respite care usage, both in the past and in the future. These data show that use of respite care is higher when the task demands of caregiving are high and when caregivers and care receivers are bound together in dysfunctional caregiving relationships. The factor that is most likely to reduce the likelihood that respite care will be used in the future when past use is controlled is the caregiver's appraisal of an intimate and loving relationship between caregiver and care receiver.

Key Words: Caregiving, Respite care, Social bonds, Appraisal

## Institutional Respite Care: Breaking Chores or Breaking Social Bonds?

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The stress involved in caregiving at home has been widely acknowledged and has given rise to increased numbers of programs to support families engaged in home care (Gallagher, 1985; Gallagher, Lovett, & Zeiss, 1989). Early reviews of home care support programs criticized the absence of quality data to support presumed benefits of greater caregiver well-being and delayed institutionalization (Gallagher, 1985). Subsequent evaluation studies brought a wave of skepticism, suggesting that programs may not be as cost effective and useful as many had hoped (Callahan, 1989; Lawton, Brody, & Saperstein, 1989; Zarit, 1990). More recently, qualified appreciation of intervention programs has been given a boost with more encouraging findings based on different analytical methods and criteria for evaluation (Knight, Lutsky, & Macofsky-Urban, 1993; Kosloski & Montgomery, 1995; Whitlatch, Zarit, & von Eye, 1991).

Through two decades of debate and uncertainty over the effectiveness of programs for caregivers, two findings have held firm. First, caregivers are satisfied, for the most part, with support programs and ask that more be available (Braithwaite, 1986; Callahan, 1989; Gallagher et al., 1989; Lawton et al., 1989; Respite Care Review, Commonwealth Department of Health and Family Services, 1996). Second, services often are not utilized fully, with many elders regarded as most in need not taking advantage of the opportunities available (George, 1988; Gibson, Butkus, Jenkins, Mathur, & Liu, 1996; Lawton et al., 1989; Montgomery & Borgatta, 1989; Oktay & Volland, 1990). Nowhere is this more apparent than in relation to respite care.

This study addresses the issue of why respite care is so often requested and apparently valued by care-

givers, and yet not used by those who appear to have great need (Gibson et al., 1996; Lawton et al., 1989). Upon demonstrating that respite care can be beneficial in delaying institutionalization, Kosloski and Montgomery (1995) express concern that so little is known about why respite care is attractive to some caregivers and not to others and whether some conditions of care enhance the attractiveness of respite services more than others. In an earlier publication, Montgomery and Borgatta (1989) recognized substantive differences between spouses and children in their approach to caregiving: "children end their caregiving careers at about the time spouses begin identifying themselves as caregivers" (p. 463). Such differences between social-demographic groups in their long-term commitment to care and need for outside support are clearly of significance. This article, however, pursues differences by shifting the focus to the social psychological domain where the caregiver's perceptions of needs and circumstance become the critical variables. Insight into the way in which caregivers appraise their situation provides an opportunity to deepen our understanding of why some choose to enter respite care programs and others do not, even when objective caregiving demands justify respite use.

Kosloski and Montgomery (1995) identified three constructs as relevant to the decision to accept a nursing home placement: need, predisposition and enabling factors. The decision to use respite care is comparable to nursing home placement. Need refers to the functional status of the care receiver, the demands made on the caregiver, the physical and mental health of the caregiver, and burden. Predisposition refers to the factors that stop caregivers from taking advantage of respite services. Caregivers may be prevented from using this form of assistance because of their sense of responsibility and duty, the strong emotional ties of love that they share with the care receiver, concern

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that the care receiver would be unhappy, or to maintain privacy and control of their lifestyles. Enabling factors is a term covering issues of cost and availability. In the present study, variation on enabling factors was minimal due to the fact that every attempt was made to ration available respite equally across applicants and major costs were met by the government. This study, therefore, focuses on needs and predispositions as perceived by caregivers. Respite use is expected to be high when caregivers report high need and when they are predisposed to use support to take a break from caregiving.

#### *Appraisals as Indicators of Need and Predisposition to Use Respite Care*

Need and predisposing factors overlap substantially with the domain of caregiving appraisal. Lawton, Kleban, Moss, Rovine, and Glicksman (1989) defined caregiving appraisal as "all cognitive and affective appraisals and reappraisals of the potential stressor and the efficacy of one's coping efforts" (p. P61). In another publication (Braithwaite, 1996), six dimensions of caregiving appraisal were identified in a manner similar to that used by Lawton, Kleban, and colleagues (1989). Five dimensions have counterparts in the Lawton, Kleban, and colleagues (1989) work on dimensions of appraisal and in Guest's (1986) profile of caregiving burden: (a) task load caregiving, (2) a dysfunctional caregiver/care receiver relationship, (3) threat of social captivity, (4) intimacy and love, and (5) caregiver resiliency.

*High task load caregiving* is defined by the provision of personal care, supervision, taking responsibility for many of the decisions surrounding care, and having little informal backup support.

*Dysfunctional caregiving* is defined by caregivers who feel unprepared for their role, who have a continuing history of conflict with the care receiver and who perceive the care receiver as disruptive and as degenerating emotionally, socially, and cognitively. Caregivers in dysfunctional relationships use both active and passive coping strategies, but have a poor prognosis for successful adaptation to caregiving, reporting more minor psychiatric symptoms, lower life satisfaction and resorting to institutional placement sooner than others.

*The threat of social captivity* describes caregiving situations in which the caregiver enjoys an extensive and supportive social network, but where caregiving poses the threat of captivity. High scorers on social captivity receive high levels of support from friends, but their reliance on a range of coping styles suggests that they are actively protecting their previous levels of social engagement outside the caregiving context.

*Intimacy and love* in the caregiving relationship is defined by reciprocity and appreciation in the relationship, by having things to lose should the caregiving relationship end, by being the care receiver's confidant, and by being supported in caregiving in the past. High scorers on intimacy and love were likely to be in better health psychologically and to have higher life satisfaction.

*Caregiver resiliency* reflects a caregiver's inner strength and efficacy defined by personal resources such as high self-esteem, high mastery, good physical health, and emotional stability.

#### *Hypotheses*

Need and the predisposing factors toward service use should manifest themselves in the appraisals that caregivers make of their caregiving situation. Care receivers who need a lot of assistance with activities of daily living and personal care should have caregivers who have high scores on the appraisal dimension of high task load caregiving. Such caregivers are likely to be deprived of the blocks of free time that respite care can offer, and for this reason, are more likely to use respite care services (Berry, Zarit, & Rabatin, 1991).

Also in need of respite are those caregivers who report high levels of subjective stress, show signs of poor mental health, and are unable to manage conflict and emotional, cognitive, and social degeneration in the care receiver. Mental stress of this kind is common in dysfunctional caregiving. For those who appraise their caregiving situation in these terms, respite services should prove attractive as a means of finding temporary relief from continuous mental anguish. A number of studies have linked high levels of subjective distress with intended or actual institutionalization (Braithwaite, 1990; Colerick & George, 1986; McFall & Miller, 1992; Morycz, 1985; Pruchno, Michaels, & Potashnik, 1990).

The quality of the caregiver/care receiver relationship appears to be important as a predisposing factor in institutionalization (Pruchno, Michaels, & Potashnik, 1990). Quality of the relationship is represented in the present study by the appraisal dimension of intimacy and love. Where caregiver and care receiver are devoted to each other, the use of respite care may be difficult because it threatens the caregiver care/receiver bond, albeit temporarily.

The remaining appraisals of social captivity and personal resiliency may be predisposing factors, exerting an influence in favor of or against respite use. Where caregivers see themselves as highly sociable with extensive social obligations that they cannot fulfill, caregivers may take advantage of respite care to increase their freedom from the home. On the other hand, well-networked, sociable caregivers may obtain adequate breaks through the support offered by this network and, therefore, have little use for respite services.

Among resilient caregivers, an argument also can be made for service use being either low or high. Use of respite care could be low because resilient caregivers have their responsibilities sufficiently well under control not to require help. Alternatively, resilient caregivers may use services as a preventive measure to avoid burnout and maintain well-being.

#### *The Outcome Measures*

Respite care is officially recognized as a set of programs that "allow the carer a break to take a holiday,

devote more time to other family members or for any other reasons such as their own health" (Home and Community Care Programs, Department of Community Services, 1986, p. 1). Respite care is now offered in a variety of forms; it is provided at home or elsewhere and extends from a few hours to a few weeks. At the time these data were collected, options were more limited. Government-funded respite, called Shared Care, was offered within nursing homes and hospitals. Bookings for such care had to be made well in advance. The service was rationed among those who wished to use it so that there was little variability in how often the service was used by caregivers within a certain time period. Furthermore, there was little flexibility in when the service could be used. Shared Care usually extended over a period of a few days to a couple of weeks, temporarily disrupting the caregiver/care receiver relationship to give the caregiver time to pursue other activities.

This study involved two respite care outcome measures. In the first instance, appraisals were related to whether respite had been used already in the course of caregiving. In the second, appraisals were related to whether respite care would be used in the future. Future use represents a behavioral intention rather than actual behavior, and therefore might be considered a weaker outcome. In this context, however, behavioral intentions are considered important. Empirically and theoretically, behavioral intentions are good predictors of actual behavior when individuals are able to choose their course of action (Ajzen, 1991). Intentions for future use of respite are important if respite is to be conceived of not only as a crisis management service, but also as part of a caregiving plan designed to relieve burden and delay institutionalization (Montgomery & Borgatta, 1989). The second research question is to identify the appraisals that predict who believes they will use respite care in the future.

In linking appraisals with respite care use, a question that arises is the degree to which appraisals are typical of particular kinds of disorders in the care receiver, such as dementia. If type of illness and appraisal are interrelated, type of illness may be the factor determining respite use, not appraisal as hypothesized. Theoretically, appraisals have been conceptualized as subjective phenomena that cut across different illness types (Braithwaite, 1990, 1996). Given the importance of this assertion to the argument of this article, appraisals also will be correlated with illness type in order to test their independence.

## Methods

### Sample

An Australian caregiver data set (Braithwaite, 1990) was used to explore the question of the relationship between caregiver appraisals and respite care use. The data were collected through face-to-face interviews with 144 caregivers of clients of the day care centers and the community nurses serving the city of Canberra, Australia. Caregivers were defined as unpaid people who assumed major responsibility for provid-

ing or organizing services on a regular basis for someone incapable of providing for him- or herself. Major responsibility for service provision had to be in at least one of three areas of daily activity (cleaning, shopping, meal preparation) or one of four areas of personal care (washing, dressing, toileting, mobility), or involve regular supervisory care (checks on well-being more than once a day).

The level of dependency of the care receivers was high: Assistance was required by 80% or more of care receivers with each of 11 activities of daily living. The clients suffered from cardiovascular disorders (48%), injury, arthritis, or some other muscular-skeletal disorder (36%), impaired mobility through stroke (28%), dementia, memory loss or disorientation (27%), and gastrointestinal disorders (19%).

Most caregiving relationships involved spouse care (43%) or parent (or parent-in-law) care (51%). The remaining caregivers were supporting grandparents, aunts, ex-husbands, and friends.

Of the spouse caregivers, 59% were women, 10% were employed, only one had a three-generation household, and all but one were living with the person receiving care. Spouse caregivers' mean age was 69 years. Non-spouse caregivers comprised 86% women; 43% were employed, 46% had three-generation households, and 77% cohabitated with the care receiver. The mean age of non-spouse caregivers was 50 years. The sample was disproportionately middle class across both caregiving groups: 38% of caregivers belonged to households where the main income earner was classified as professional or managerial, 46% trade, clerical or sales, and 17% unskilled.

### Procedure

Caregivers were contacted by letter and those who agreed to participate were telephoned by one of three interviewers. Meetings were arranged for a private discussion of their caregiving experiences either at their homes or at the university, depending on their preference. Structured interviewing, interspersed with unstructured discussions, took place over two and sometimes three sessions, each of about one-and-a-half to two hours duration. Caregivers completed a questionnaire that was left with them after the first interview.

### Measures

The appraisal variables were factor scores for five dimensions, derived in an earlier study (Braithwaite, 1996), and representing (1) task load caregiving, (2) dysfunctional caregiving, (3) inner strength and efficacy, (4) intimacy and love, and (5) social captivity. The factor scores were based on a principal components analysis and varimax rotation of a larger set of appraisal items and scales. Factor scores of this kind offer the analytical advantage of partitioning the variance shared by a large set of variables into a smaller set of independent dimensions that are ideal for input into a regression analysis. The disadvantage is that the generalizability of the findings is constrained by the fact that individual variable weights are likely to

be context specific, dependent on the sample and the items in the data set (Gorsuch, 1974).

To ensure that the appraisal measures investigated in this article could be used meaningfully in other contexts, all analyses were replicated with appraisal scales rather than appraisal factor scores. The appraisal scales were constructed through assigning unit weights to variables that had salient loadings (greater than .40) on the five appraisal factors (Gorsuch, 1974). An alpha reliability analysis of these measures was undertaken to ensure that all improved the alpha reliability coefficient for the appraisal scale. Where this was not the case, the measure was dropped. The key variables defining the appraisal factors and comprising the appraisal scales are listed in Table 1, together with their descriptive statistics. Some were multi-item scales, others single items. In order to ensure that measures with a wide range of scores did not contribute disproportionately

to an aggregate appraisal score compared with those with a narrow range, all variables were standardized to a mean of 0 and standard deviation of 1 before being summed.

Use of the respite care service, Shared Care, was assessed along with a number of other services. For each service, caregivers were asked if they had used it (no = 0, yes = 1), if they were satisfied (not completely = 1, satisfied = 2), if they thought their care receiver was satisfied (not completely = 1, satisfied = 2), and if they intended to use the service in the future (no = 0, yes = 1). Qualitative data were also collected on sources of discontent, and why some caregivers would not use the service in the future.

Four sociodemographic variables were used as control variables in the present study: (a) the caregiver's age in years, (b) the caregiver's sex (male = 1, female = 2), (c) whether a spouse was being cared for (2) or was not being cared for (1), and (d) whether the household comprised three generations (2) or fewer than three generations (1).

The medical conditions of care receivers were coded from the open-ended question asking caregivers why they were providing care. Three problems were mentioned by at least 25% of the sample: (a) heart and circulatory problems (42%), (b) stroke (28%), and (c) dementia (27%).

**Table 1. Appraisal Dimensions and Major Defining Variables<sup>a</sup> With Relevant Descriptive Statistics**

Appraisal Scale (Standardized Alpha) <sup>b</sup>	Number of Items	Coeff. Alpha	M (SD)
<b>Task load caregiving (<math>\alpha = .68</math>)</b>			
Personal care	11	.87	29.78 (11.32)
Supervision	3	.54	4.57 (1.03)
Decision making	5	.68	8.95 (2.64)
Absence of backup care	2	.34 <sup>c</sup>	2.90 (.74)
<b>Dysfunctional caregiving (<math>\alpha = .64</math>)</b>			
Acceptance coping	13	.87	34.46 (8.53)
Solutions coping	5	.65	13.66 (3.09)
Interpersonal conflict	1		1.90 (.82)
Cognitive loss (receiver)	9	.86	13.71 (2.96)
Emotional & social loss (receiver)	11	.87	17.94 (3.44)
Time constraints	5	.79	9.10 (1.41)
Lost autonomy in relationship	8	.84	15.91 (6.01)
Unpreparedness	2	.20 <sup>c</sup>	3.49 (1.36)
<b>Threat of social captivity (<math>\alpha = .63</math>)</b>			
Sociability	5	.69	16.57 (4.29)
Availability of confidants (caregiver)	5	.57	9.23 (1.11)
Availability of network (caregiver)	6	.71	26.22 (9.26)
Friend's support	3	.52	7.13 (1.69)
Acceptance coping	13	.87	34.46 (8.53)
Solutions coping	5	.65	13.66 (3.09)
<b>Intimacy and love (<math>\alpha = .58</math>)</b>			
Reciprocity	3	.49	5.98 (1.76)
Number of times caregiver nominates self as confidant	5		2.83 (1.60)
<b>Caregiver resiliency (<math>\alpha = .67</math>)</b>			
Mastery	6	.71	21.57 (4.67)
Self-esteem	10	.84	40.04 (6.64)
Good physical health	1		2.51 (.63)
Emotional stability	15	.83	52.50 (9.97)

<sup>a</sup>In each case, high scores reflect more of the characteristic that the dimension represents.

<sup>b</sup>Standardized alphas are based on the listed component scale scores.

<sup>c</sup>A Pearson correlation coefficient is reported in cases where the variable comprises two items.

## Results

### *Descriptive Statistics and Correlations*

Shared Care had been used by 30% of caregiver/care receiver dyads. Of the caregivers who had used the service, satisfaction was high (67%), although most reported that their care receivers had expressed some dissatisfaction (71%). When the question of future use was raised, 36% of all caregivers said that they intended to use Shared Care in the future.

Before relating past and future respite use (dependent variables) to appraisals (independent variables), both sets of variables were correlated with background sociodemographic characteristics and medical conditions (see Tables 2 and 3). In Table 2, correlations are reported for appraisals measured as factor scores and, in parentheses, as scale scores. By and large, factor and scale scores on the appraisal variables produced comparable results, and unless specified otherwise, interpretations will focus on factor score coefficients.

From Table 2, caregivers who reported a high task load component in their work were more likely to be a spouse and to be older. High task load caregiving was more common in cases in which the care receiver was afflicted by stroke or dementia.

Dysfunctional caregiving relationships were not characteristic of any particular sociodemographic group, but there was a tendency for dysfunctional relationships to emerge more strongly when the receiver suffered from dementia.

Sociodemographic links were strong in relation to appraisals of looming social captivity. This threat was felt most strongly by women caring for someone other

**Table 2. Correlations of Sociodemographic Characteristics and Care Receiver's Medical Condition With Appraisal Factor Scores (Appraisal Scale Scores)**

Background Variables	Task Load	Dysfunctional	Social Captivity	Intimacy and Love	Caregiver Resiliency
Caregiver's age	.18* (.16)	-.06 (-.08)	-.16 (-.16)	.08 (.04)	.09 (.09)
Caregiver's sex	.01 (.00)	.12 (.15)	.27** (.29**)	-.09 (-.09)	-.05 (-.03)
Spouse caregiving	.28** (.26**)	-.10 (-.07)	-.20* (-.17*)	.09 (.03)	-.06 (-.04)
Three-generation household	-.16 (-.16)	.06 (.08)	.22** (.21*)	-.16 (-.05)	.01 (.03)
Heart, circulatory	-.12 (-.14)	.01 (.02)	.13 (.11)	.05 (.02)	.08 (.03)
Stroke	.23** (.19*)	-.10 (-.07)	-.04 (-.05)	-.04 (.01)	-.10 (-.03)
Dementia	.23** (.25**)	.18* (.13)	-.06 (-.02)	-.08 (-.01)	-.02 (-.07)

\* $p < .05$ ; \*\* $p < .01$ .

than a spouse in three-generation households. Caregivers who felt threatened by social captivity were not found disproportionately among the three most common illness groups.

The remaining appraisals of intimacy and love and caregiver resiliency were related to neither sociodemographic characteristics nor the medical condition of the care receiver.

Table 3 shows the correlations of the background variables (sociodemographic characteristics and medical conditions) with the dependent variables of past and future respite use. Past use of respite care was higher for women than for men. Caregivers who nominated themselves as future users were more likely to be women, to have three generation households, to be younger, and to be caring for someone other than a spouse. Future use was also anticipated more often by caregivers of dementia sufferers.

All four sociodemographic variables were related to both independent and dependent variables, and therefore will be used as control variables in the logistic regression analyses reported below. Overall, appraisals and respite use did not overlap substantially with illness conditions. Significant correlations emerged in cases where they might be expected: Care to stroke or dementia sufferers was associated with caregiver perceptions of high task load demand, dementia sufferers were more likely to be involved in dysfunctional relationships, and their caregivers were more likely to expect to use Shared Care in the future. These correlations did not affect the nature of the relationships between the independent and dependent variables,

and therefore will not be used as control variables in the final set of analyses.

In order to test the hypotheses of this study, the respite usage variables, both past and present, were correlated with the appraisals (see Table 4). As in Table 2, the appraisal variables are represented as factor scores and, in parentheses, scale scores. Past use was more likely to be found among those caregivers with a high task load, and by those in dysfunctional caregiving relationships. Those threatened by social captivity were also more likely to have used respite care when calculations were based on scale scores rather than factor scores.

Future respite use was related significantly to the same appraisals as past usage with one additional predictor. The intention to use respite in the future was acknowledged by caregivers who reported high task load, a dysfunctional relationship and threat from social captivity (scale scores only). From Table 4, the newly emerging appraisal that lessened the likelihood of respite use in the future was intimacy and love in the caregiving/care receiving relationship.

#### Logistic Regression Analyses

In order to determine the relative importance of appraisal and sociodemographic variables in predicting the dichotomous variable, respite care usage, logistic regression models were tested. These analyses relied upon appraisal variables as factor scores because they afforded the advantage of predictors that were statistically independent. Following previous practice, the analyses were replicated using appraisal scale scores. The findings did not change substantively, and therefore are not reported below.

In the first analysis predicting whether respite care

**Table 3. Correlations of Sociodemographic Characteristics and Care Receiver's Medical Condition With Past and Future Use of Respite Care**

Background Variables	Respite Past Use	Respite Future Use
Caregiver's age	-.13	-.18*
Caregiver's sex	.28**	.24**
Spouse caregiving	-.09	-.20*
Three-generation household	.16	.23**
Heart, circulatory	-.11	-.14
Stroke	.05	.02
Dementia	.16	.29**

\* $p < .05$ ; \*\* $p < .01$ .

**Table 4. Correlations of Past and Future Use of Respite Care With Appraisal Factor Scores (Appraisal Scale Scores)**

Predictors	Past Use	Future Use
Task load caregiving	.26** (.28**)	.20* (.24**)
Dysfunctional caregiving	.30** (.28**)	.21* (.20*)
Threat of social captivity	.11 (.18*)	.10 (.18*)
Intimacy and love	-.12 (-.16)	-.29** (-.31**)
Caregiver resiliency	.02 (-.09)	-.05 (.03)

\* $p < .05$ ; \*\* $p < .01$ .

had been used in the past (see Table 5), the control variables (age, sex, spouse care, three generations) were entered first. The sociodemographic variables improved prediction significantly compared to the null model in which all coefficients apart from the constant are assigned the value of zero ( $\chi^2 = 14.53, p < .01$ ). In the second model (see Table 5), the appraisal variables were added. As a block, the appraisal variables significantly improved prediction above the level achieved with the sociodemographic variables ( $\chi^2 = 27.06, p < .001$ ). From Table 5, the probability of having used respite care in the past was higher for caregivers who were women, who faced high task demands in terms of physical care, and who were in dysfunctional caregiving relationships.

When these same variables were used to predict future use, a similar pattern of results emerged (see Table 6). The sociodemographic variables improved prediction significantly above the null model ( $\chi^2 = 11.580, p < .05$ ), and the appraisal variables improved the model further ( $\chi^2 = 24.12, p < .001$ ). The likelihood of expecting to use respite care in the future was higher for women (although this relationship became nonsignificant when the appraisal variables were included), those with high task demands, and those in dysfunctional caregiving relationships. The likelihood of using respite care in the future, however, dropped significantly when the caregiver/care receiver relationship was characterized by intimacy and love.

These findings raised a further question: Would intimacy and love remain important after controlling for previous experience with respite care? At the bivariate level, past use and future use were strongly correlated ( $r = .54, p < .01$ ), suggesting that future use may be accounted for by past use, rendering appraisals unimportant.

**Table 5. Parameter Estimates (B) for Sociodemographic Control Variables and Factor Score Appraisals in Two Logistic Regression Models Differentiating Users and Non-users of Respite Care**

Predictors	Past Respite Care User B Coefficients	
	Model 1	Model 2
<b>Control Variables</b>		
Caregiver's age	-.02	-.03
Caregiver's sex	1.80**	1.70*
Spouse caregiving	.71	.50
Three-generation household	.53	.34
<b>Appraisal Variables</b>		
Task load caregiving		.81**
Dysfunctional caregiving		.89**
Caregiver resiliency		.09
Threat of social captivity		.18
Intimacy and love		-.31
$G^2$	151.24	124.18
$df$	130	125
% cases correctly predicted in final model		75

\* $p < .05$ ; \*\* $p < .01$ .

**Table 6. Parameter Estimates (B) for Sociodemographic Control Variables and Factor Score Appraisals in Two Logistic Regression Models Differentiating Users and Non-users of Respite Care in the Future**

Predictors	Future Respite Care User B Coefficients	
	Model 1	Model 2
<b>Control Variables</b>		
Caregiver's age	.00	.00
Caregiver's sex	1.10*	1.03
Spouse caregiving	-.29	-.78
Three-generation household	.66	.44
<b>Appraisal Variables</b>		
Task load caregiving		.74**
Dysfunctional caregiving		.49**
Caregiver resiliency		.23
Threat of social captivity		.00
Intimacy and love		-.69**
$G^2$	148.84	124.72
$df$	117	112
% cases correctly predicted in final model		75

\*This variable failed to reach statistical significance when scale scores were used instead of factor scores.

\* $p < .05$ ; \*\* $p < .01$ .

In a third set of logistic regressions, past use was added as a control variable, and as expected, its contribution was significant (see Table 7). Prediction was still improved by the addition of the appraisal variables ( $\chi^2 = 11.93, p < .05$ ). In this case, however, the only appraisal factor to have an effect was intimacy and love. Past use increased the likelihood of

**Table 7. Parameter Estimates (B) for Sociodemographic Control Variables, Past Use and Appraisals in Three Logistic Regression Models Differentiating Users and Non-users of Respite Care in the Future**

Predictors	Future Respite Care User B Coefficients		
	Model 1	Model 2	Model 3
<b>Control Variables</b>			
Caregiver's age	.00	.00	.00
Caregiver's sex	1.10*	.41	.53
Spouse caregiving	-.29	-.77	-.93
Three-generation household	.66	.35	.24
Past respite care user		2.50**	2.21**
<b>Appraisal Variables</b>			
Task load caregiving			.53
Dysfunctional caregiving			.18
Caregiver resiliency			.29
Threat of social captivity			-.03
Intimacy and love			-.66*
$G^2$	148.84	118.29	106.36
$df$	117	116	111
% cases correctly predicted in final model			80

\* $p < .05$ ; \*\* $p < .01$ .

future use, while intimacy and love reduced the likelihood of future use.

## Discussion

These findings are supportive of need and predisposition as explanatory concepts in models of service use. Furthermore, in the caregiving context where there are so many needs and predispositions to consider, a limited number of broadly defined appraisal dimensions have proven useful in understanding who uses institutional respite care and who does not.

Appraisals reflecting the physical demands and the mental strains of caregiving predicted both past and future respite usage as hypothesized. Appraisals of social captivity, only in analyses involving scale scores, also indicated past and present respite patterns. In contrast, caregivers who were resilient were neither more nor less likely to turn to Shared Care. Those with an intimate and loving relationship with their care receiver, however, responded to the use of Shared Care in the future with greater reluctance than others, even when past use was controlled.

When sociodemographic factors were considered conjointly, the strongest correlate of respite care use was gender. The finding that female caregivers were more likely to have had experience with Shared Care is consistent with national data on respite care usage (Gibson et al., 1996). In this sample, greater reliance on respite by female caregivers was not due to their shouldering more intensive physical and emotional demands. Furthermore, the greater usage could not be explained by the fact that women reported greater subjective burden than men (Braithwaite, 1990). Perhaps the practice of greater respite use among women has its origins in the social organization of care with women being part of more cohesive care networks (e.g., knowing others who used respite care, having aged care workers as part of their supportive networks). Further research is required to understand the reasons that underlie the greater tendency of women to use institutional respite.

The greater likelihood of respite use in caregiving dyads with high task demands is reassuring from the perspective of those concerned with the appropriate targeting of respite services. Caregivers with care receivers who are highly dependent use respite more than those with care receivers who are more independent. Caregivers with high task demands were also more likely to be without backup and to be spouse caregivers. The care receivers with high task demands were more likely to have been affected by dementia or stroke. Overall, the use of government respite by high scorers on this dimension appears to answer a legitimate need for assistance that is not being met informally.

Respite for caregivers in dysfunctional relationships provides relief from a situation that threatens caregiver's well-being in a fundamental way. High scorers on dysfunctional caregiving were slightly more likely to be caring for dementia patients, although the overlap was not substantial. The profile of dysfunctional caregiving involves caregivers dealing with cognitive,

social, and emotional degeneration, experiencing conflict with the care receiver, being unprepared for the role, being unable to manage time and meet other obligations, and experiencing poor mental health. The fact that such caregiver/care receiver relationships had a history of conflict suggests that respite can at best break the cycle in many cases. Caregiver's stress reactions are likely to reemerge when caregiving resumes. This would explain why high scorers on dysfunctional caregiving sought earlier institutional placement (Braithwaite, 1996) in spite of being users of respite services.

The logistic regression analyses failed to produce evidence of high respite use among caregivers who fear social captivity or who vary in emotional resiliency without experiencing high physical and emotional caregiving demands. These findings allay concerns of excessive use of respite care among those whose needs are not legitimate. Indeed, the opposite picture emerges. Those who were deserving of this kind of assistance were likely to be dissuaded from using it because of the close bond they had with the care receiver. These findings offer one explanation for why caregivers in need may want the service to be available, but never use it. Caregivers who score high on love and intimacy may not want freedom from the chores of caregiving, if it means that the social bond between caregiver and care receiver is placed at risk. They would rather soldier on, doing things as best they can with the social bond intact and with the assurance that respite care is available in a crisis. These findings support Montgomery and Borgatta's (1989) conclusion that "the woodwork effect," whereby all eligible clients come out of the woodwork and overload the system, is unlikely to pose a problem for caregiving programs. Rather, the problem is identifying eligible families early enough in the caregiving experience to shape future behavior.

The negative relationship between intimacy and love and likely future use is the most important finding of this article, particularly in light of the absence of intimacy and love as a significant predictor of past use. One way of interpreting this pattern of results is through recognizing that past use captures unforeseeable events, whereas future use does not. Past use of respite care will incorporate planned as well as unplanned emergency respite. Where respite care is a form of crisis management, intimacy and love is unlikely to be an important predictor of use. In contrast, future use of respite represents planned use by the caregiver. In these circumstances, intimacy and love is more likely to emerge as a significant predictor.

A second interpretation of the importance of intimacy and love in predicting future use, but not past use, is that caregivers' future intentions are shaped by past experiences. Although caregivers were generally satisfied with Shared Care, the majority of care receivers expressed some reservations to their caregivers. The suitability of the institutional environment caused concern, as did the care receivers' reactions to being away from home (Braithwaite, 1986). Caregivers sharing close intimate relationships with their care receivers may put the interests of the other ahead of



their own in considering future use. In cases where the relationship is not supportive and intimate, caregivers may be more likely to opt for the opposite strategy, risk straining the social bond, and take the break that respite care offers.

Whether the "deterrent effect" of intimacy and love disappears as the quality of the service improves is difficult to predict. Possibly the effect is less marked when the context for respite care changes. Many caregivers now use respite that is short term and home based, conditions under which the impediments to separation may be less potent. At the same time, more recent data suggest that even with a greater variety of options at their disposal, caregivers are reluctant to use the services that they ask to have in place (Gibson et al., 1996; Rhys Hearn, Hewitt, Lindsay-Smith, Barratt, Hendrie, & McCarthy, 1996). Respite care may fall into the category of a necessary, but underutilized service. Caregivers may need to know respite is there to give them a sense of security, but they may only be able to bring themselves to use it when they reach their breaking point.

The conclusions drawn in this article are constrained by the limitations of the sample on which the data were based. No claims can be made that those interviewed were representative of all caregivers. What is more, conclusions from any cross-sectional study of respite care must be seen as bound by time and culture. Institutions of care are in a state of change, with the growing realization that sharing the care of frail aged and disabled members of society is in the interests of both carers and care receivers. As part of this process, the norms followed by future generations of caregivers in different cultural settings are likely to be constantly evolving in ways that escape recognition in the static picture captured by the data presented in this article. As the sharing of care becomes a more accepted mode of operation in the community, support for respite care, in increasingly innovative forms, might be expected to increase.

Even so, the findings of the present study raise concerns about whether the strength of the social bond between caregiver and care receiver has been underestimated in planning for formal support for informal care, and particularly in program evaluation. Love and the expectations that go with it do not disappear when caregivers become overloaded with demands from their care receivers. How they decide to deal with their distressing situation is not going to mirror the decision process of the disinterested policy analyst who relies on rational calculations of unmet needs and resources available. As long as a significant proportion of care in our society takes place within intimate relationships, shared understandings, empathy, timing, and trust between caregiver and care receiver will be critical elements in determining when respite care can be used beneficially and when it cannot.

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