

Stereotypes of emotional caregivers and their capacity to absorb information: the views of nurses, stroke carers and the general public

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This study examines the phenomenon of stereotyping informal caregivers' capacity to learn about the condition of stroke victims. Forty-nine nurses, 55 carers and 39 members of the general public gave their opinions on how emotional they considered six hypothetical wives of stroke patients to be and how much information they thought each wife would be able to absorb. Results indicated that nurses were more pessimistic than caregivers in their assessment of how much information could be absorbed, even though these two groups did not differ in their assessment of the emotionality of the wives. Nurses and the general public reported in accordance with the expected stereotype: those rated as being high in emotionality were less likely to absorb information. No such association emerged from the ratings of caregivers. The existence of the stereotype, particularly among health professionals, has serious implications for rehabilitation programmes and caregiver well-being, and provides an explanation for why caregivers sometimes feel neglected in medical settings.

HOME CARE FOR STROKE SURVIVORS

Home care for survivors is widely regarded as a more efficient option than hospital and institutional care, providing a means of controlling spiralling health care expenditures and, at the same time, optimizing rehabilitation and providing greater quality of life for the patient (Mulley & Arie 1978, Vetter 1980, Wade & Hewer 1983, Wright & Robson 1980). Hospitals generally have little to offer stroke survivors in the way of medical treatment after the

acute phase of the illness, and the goals of the staff centre on stroke management and rehabilitation. This slower process of learning to resume as independent a life as possible can be achieved most effectively within the patient's familiar home environment. Furthermore, home care can mean care tailored to the needs of the individual providing greater freedom, privacy and dignity.

In theory, home care is an attractive option. In practice, costs are borne by family members who provide care by the recipients of care. Problems of abuse and neglect among those receiving care have been documented (Godkin *et al.* 1989, Hamilton 1989, Kosberg & Cairl 1986, Pillemer &

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Finkelhor 1989). Reports of caregivers experiencing household disruption and tension, social isolation, inadequate rest, and poor physical and mental health are widespread (Braithwaite 1990, Brocklehurst *et al.* 1981, Grad & Sainsbury 1968, Jones & Vetter 1984, Schulz *et al.* 1988). In the case of carers of stroke patients, anxiety and depression can manifest itself in overprotectiveness of stroke survivors and in attitudes of hopelessness and despair, all of which can jeopardize rehabilitation (Bedsworth & Molen 1982, Kinsella & Duffy 1980, Stroker 1983, Wishnie 1971).

Andrews and Stewart (1979) observed that patients who performed less well at home than in the day hospital had a negative attitude and had carers who had a negative attitude. Brocklehurst *et al.* (1981) compared stroke survivors with and without a chief carer. One year later, dependency was found to be higher in the carer group, an outcome which may be attributable to family overprotectiveness. This explanation has also been proposed by Labi *et al.* (1980) who found that stroke survivors living alone were less likely to lose outside social contacts than those living in a family context.

Support for patients and carers

One recommendation which has frequently been made to counteract these problems is supportive and educational programmes for patients and their families (Dring 1989, Gardner & Stewart 1978, Jarrett 1981, Mongiardi 1987, Overs & Belknap 1967, Stone 1987, Stroker 1983, Wright & Robson 1980). Studies have shown that, through involving families, sharing knowledge and providing information, the rehabilitation of the stroke survivor can be facilitated and the quality of life of their families can be improved (Dzau & Boehme 1978, Hawker 1964). Furthermore, families want information. Molter (1979) found that adequate and honest information was high on the list of needs of relatives of critically ill patients. Similarly, in a study of families' needs in the initial 72 hours in an intensive care setting, Daley (1984) found an over-riding need for information — information about the patient and information that would relieve anxieties. In a study of the coping responses used by wives of patients with myocardial infarction, Nyamathi (1987) concluded that seeking information was an important and useful strategy.

While families may want information and professionals may believe they should have information, many carers suffer from having too little (Gardner & Stewart 1978, Kinsella & Duffy 1980, Mongiardi *et al.* 1987, Sosnowitz 1984). Caregiver characteristics affect the sharing of information. Greater communication is purported to be directed toward families of a higher socio-economic status and

who are better educated (Sosnowitz 1984). Psychological demeanour also appears to be important. In intensive care and coronary care units, Hickey & Lewandowski (1988) found that critical care nurses decreased their involvement with families who exhibited negative behaviour.

Sosnowitz (1984) noted that staff on a neonatal unit assessed parents at a very early stage in terms of whether or not they were 'good' parents, and shared information on this basis. In particular, staff were wary of parents who were not in control emotionally and prone to emotional outbursts. They would keep such parents at a distance and involve them minimally in medical decisions.

Lipton & Svarstad (1977) also noted this bias in communication with parents concerning a child's mental retardation. Of the parents perceived as having average emotional adjustment, 55% were given frank and detailed information. None of the parents perceived as being low in emotional adjustment were given such information.

EXPLANATIONS FOR THE NEGLECT OF EMOTIONAL CAREGIVERS

A heavy workload, feelings of inadequacy and lack of knowledge on the part of medical staff have been proposed for limited communication (Bedsworth & Molen 1982, Cassem & Hackett 1972, Dunkel & Eisendrath 1983, Hickey & Lewandowski 1988). Also important are the staff's needs to see patients as clinical problems and maintain detachment (Dunkel & Eisendrath 1983, Hickey & Lewandowski 1988). Sosnowitz (1984) argues that poor information sharing is self-protective. In a neonatal intensive care unit, the emotionality of families threatened the 'detached concern' of staff and distracted attention from patient care. Sosnowitz perceived the neonatal staff as fighting emotional involvement much of the time, linking her observations with those of Scheff (1979):

The more repressed emotion one has accumulated, the less one can tolerate discharge in others, since it disturbs one's own equilibrium.

Avoidance of emotional families appears to be buttressed by a number of assumptions and beliefs about their capacities to deal with the crisis. Lipton & Svarstad (1977) noted that clinicians were genuinely concerned that parents of mentally retarded children were not able to handle the 'bad news'. This belief affected their behaviour. Parents whose emotional adjustment appeared to be below average was less likely to be given information than those who appeared to be emotionally stronger. Parents, on the other

hand, attributed their emotionality to the vagueness of the clinician's communication in the first place.

Apart from beliefs about whether emotional carers can handle bad news, clinicians make judgements about whether emotional carers can absorb information. O'Keefe & Gilliss (1988) have stated that the disorganization that families feel in the coronary care unit is obvious to staff, and families are sometimes too anxious to hear important information about the patient.

Kinsella & Duffy (1980) and Stone (1987) similarly warn against expecting families to participate too much in care in the early stages, since they are unable to retain advice and information. These observations do not sit comfortably with Molter (1979) and Daley's (1984) thesis that information is wanted and needed by families under stress.

THE STUDY

This study examines whether assessment of a caregiver's capacity to absorb information is related to perception of the caregiver's emotional state. The literature suggests that this belief is held by medical staff and is one of several explanations for why emotional caregivers are not fully debriefed on the condition of their relative. Whether it is a stereotype which has emerged as a response to experiences in the medical setting or whether it is a widespread community attitude is unknown. If stereotype is to be rejected anywhere, however, it should be rejected by caregivers themselves. On the basis of the findings of Molter (1979), Daley (1984) and Dzau & Boehme (1978), caregivers may recognize need for information in emotional families and reject notions that they are unable to absorb information. Thus, the stereotype that emotionality affects the capacity to absorb information was examined in three populations — among nursing staff, caregivers and the general public.

METHOD

Design

The hypotheses were investigated by asking all respondents to rate each of six hypothetical carers in terms of their emotionality and their capacity to absorb information. Data were collected by means of a questionnaire comprising six vignettes. Each described the behaviour and appearance of a middle-aged woman visiting her husband in hospital after a stroke. The vignettes were selected from a much longer set tested through a pilot study. The purpose of the pilot study was to find a subset of vignettes for which responses could be combined to produce a 'perception of emotionality' scale and a 'judgement of information

absorption' scale. This strategy was adopted so that ecological validity could be maintained, while ensuring that findings were not context specific. Many factors can be expected to affect assessments of both emotionality and capacity to absorb information.

Other cues may over-ride emotionality in some contexts, but may be of secondary importance in others. Controlling such cues through their exclusion was unacceptable because the vignettes would lose their realistic quality. Ecological validity was achieved through basing the vignettes on descriptions given by nurses of the kinds of carers that they dealt with on a regular basis. At the same time, generalization of results was essential. To ensure that the findings did not reflect the peculiarities of any particular vignette, judgements were made in a series of situations. Responses were then summed over the situations to test the hypothesis that perceptions of emotionality were linked with assessments of how much information could be absorbed by caregivers.

The vignettes

The description of the stroke patient at the beginning of each vignette was the same. Variation was introduced in the description of the behaviours and appearance of the spouse carer as follows:

Mr Jones, aged 50, father of four teenagers, was admitted yesterday evening. He has been diagnosed as having had a stroke. His wife Mary, aged 45 years . . .

- (1) walks confidently up to the nurses' station and places a box of chocolates on the bench, saying: 'These are for the nurses who are caring so well for my husband'. She looks directly at the registered nurse and flashes a smile which displays pearly white teeth. She then proceeds to enquire about her husband's condition.
- (2) stands uncertainly for a moment looking at the nurse: 'May I talk with you? It's nurse, isn't it?' Her face is thin and intelligent. She has dark circles beneath her eyes.
- (3) is discussing her husband's condition with a nurse: 'Yes, well my husband thinks that it is best not to consider the future but take one day at a time, just until he gets over this little spot of trouble.'
- (4) approaches the nurses' station. The pupils of her grey bloodshot eyes are dilated and she breathes rapidly and shallowly. She apologizes for her washed out appearance and mentions she has suffered from a bout of diarrhoea.
- (5) reaches the door of Mr Jones' room. She takes three deep breaths, screws up and relaxes her facial muscles, and enters the sick room, presenting a smiling relaxed face to her husband.

Table 1 Means (standard deviations) on emotionality and information absorption ratings for six vignettes as judged by nurses, stroke carers and the general public

Vignette	Nurses		Stroke carers		General public	
	Emotion	Information	Emotion	Information	Emotion	Information
1	2.08 (0.96)	3.23 (1.27)	2.30 (1.04)	3.48 (1.28)	1.82 (0.85)	3.67 (1.08)
2	3.16 (0.64)	3.69 (0.86)	3.50 (0.83)	3.86 (0.92)	2.90 (0.72)	3.80 (0.80)
3	2.72 (0.90)	2.61 (1.06)	2.45 (0.68)	3.25 (1.03)	2.38 (0.82)	2.87 (0.95)
4	4.00 (0.89)	2.31 (0.87)	4.00 (0.98)	2.93 (1.17)	4.10 (0.53)	2.46 (0.76)
5	3.61 (0.70)	3.33 (1.11)	3.84 (0.60)	3.84 (0.93)	3.33 (0.74)	3.51 (0.97)
6	3.67 (0.62)	3.39 (1.10)	3.71 (0.59)	3.62 (1.02)	3.46 (0.76)	3.28 (0.79)

Table 2 Comparison of means (standard deviations) and F statistics for emotionality and information absorption judgements made by nurses, stroke carers and the general public across six vignettes

Scale	Means (SD)			F (d.f.)
	Nurses	Stroke carers	General public	
Emotionality	19.29 (2.36)	19.78 (2.53)	17.97 (2.64)	6.11 (2,140)**
Information	18.57 (3.64)	20.93 (3.65)	19.59 (2.77)	6.17 (2,140)**

** $P < 0.01$.

(6) refuses to leave Mr Jones' side. She busies herself puffing up his pillows, offering him drinks, arranging the flowers and chatting. Her eyes fill with tears occasionally and she blinks them away quickly.

Following each vignette were two questions — one asking how emotional the respondent considered the carer to be and one asking how much information the carer was likely to be able to absorb given her emotional state. Each judgement was made on a five-point rating scale. The task took approximately 20 minutes to complete.

Subjects

All participants were women: (a) 49 were hospital nurses who were working with stroke patients, (b) 55 were carers attending stroke clubs and (c) 39 were members of the general public who expressed interest in the study but had no experience with stroke patients or their families. They were contacted through a snowballing sampling strategy. All were volunteers.

Procedure

The vignettes were presented to participants in the form of a self-completion questionnaire. Administration was in

small groups wherever possible. Time and transport constraints of participants led to individual administration in some cases and to private self-completion in others.

RESULTS

The mean scores for each of the vignettes on emotionality and information absorption are presented in Table 1. Of particular note is that all three groups ranked the vignettes in the same way on emotionality. The spouse described in Vignette 4 was judged to be the most emotional carer, followed by Vignettes 6, 5, 2 and 3. The spouse described in Vignette 1 was perceived to be the least emotional. Standard deviations on judgements of emotionality were relatively small, suggesting considerable convergence in perceptions of emotionality in each group. The major question, however, is whether these assessments have any systematic influence on judgements of capacity to absorb clinical information.

To ensure generalizability of results across situations and to improve the reliability of the measuring procedure, ratings were summed across the six vignettes on emotionality and information absorption. The alpha reliability coefficients for the six-item emotionality scale and the corresponding information absorption scale were 0.52 and 0.59 respectively over all groups.

The means and standard deviations of the scales for each group are presented in Table 2. A one-way analysis of

variance was used to investigate group differences, first in relation to perceptions of emotionality and, second, in relation to capacity to absorb information. The groups differed significantly in both sets of judgements (see Table 2). The general public perceived the hypothetical caregivers to be less emotional on average than did the nurses ($t(86) = -2.45$, $P < 0.05$) or stroke carers ($t(92) = -3.35$, $P < 0.001$). The nurses perceived the hypothetical caregivers to be less able to absorb information than did the stroke carers ($t(102) = 3.29$, $P < 0.001$).

Emotionality

The hypothesis linking perceptions of emotionality with expectations about ability to absorb information was tested using Pearson product-moment correlation coefficients: scores on the emotionality scale were related to scores on the information absorption scale. Perceptions of high emotionality were significantly correlated with perceptions of a low capacity to absorb information in the nurse sample ($r = -0.49$, $n = 49$, $P < 0.001$) and the general public sample ($r = -0.44$, $n = 39$, $P < 0.001$). In contrast, stroke carers did not regard capacity to absorb information as dependent on level of emotionality ($r = 0.21$, $n = 55$, NS). In fact, the correlation, though not significant, was in the opposite direction to the others, with judgements of high emotionality tending to accompany judgements of a high capacity to absorb information. When the differences between these correlations were tested for statistical significance, stroke carers differed from both nurses ($z = -2.72$, $P < 0.005$) and the general population ($z = -3.33$, $P < 0.001$). No statistical difference was found between the correlation coefficients describing nurse and general population expectations.

DISCUSSION

These data demonstrate that different groups hold different beliefs about the extent to which emotionality interferes with capacity to absorb information. Across a number of situations, nurses and the general public associated their perceptions of emotional instability with difficulty in absorbing information about the condition and needs of the stroke patient. While nurses and the general public made judgements consistent with the stereotype, the belief was not endorsed by those who had been in the caregiving situation themselves. They did not link emotionality with capacity to absorb information in any systematic way. To investigate their perceptions further, the correlations between emotionality ratings and information absorption ratings for particular situations were examined. None were significant. For this group of stroke carers, emotionality appears to be irrelevant

to their views on capacity to absorb information. Their stance was more compatible with the thesis of Daley (1984) and others, that information is the greatest need of all carers to allay anxieties and uncertainties.

Nurses' and carers' perceptions

Another important finding of this study is the discrepancy in nurses' and carers' perceptions of how much information can be absorbed. Nurses and caregivers perceived the level of emotionality of the wives in the vignettes in the same way. Yet stroke carers were significantly more optimistic about how much hypothetical carers could learn. Nurses were the most pessimistic.

Comparison across samples proved interesting in two other respects. Participants from the general public were not as sensitive to the emotional cues observed by other caregivers and by nurses. Those with greater experience with stroke families inferred greater emotionality from the hypothetical caregiver's behaviour. This difference may be due to some other characteristic which made the general population sample special. Samples were not strictly matched, though comparability was sought through asking caregivers to nominate another person for the general population sample who had not had experience with stroke. At the very least, these group differences raise issues about the subjectivity involved in inferring emotionality in clients.

General public

The finding that the general public viewed emotional carers' capacity to absorb information in much the same way as did nurses is worthy of comment. Group similarities make it unlikely that nurses acquire this belief through their experience in a medical setting. Instead, the data are consistent with the widely heard ultimatum: 'I'll talk to you when you calm down'. Given the more general basis of the stereotype, it may be a widely used rationalization for avoiding involvement with emotional people who threaten one's own emotional equilibrium. This is not to say that the stereotype has no empirical basis. Holding the belief may be an effective strategy employed by nurses and the general population alike to use their time efficiently. Short-term time gains, however, may create long-term problems if families need to be recruited for long-term care and rehabilitation.

Finally, the different perceptions and assumptions of nurse and family carer provide an explanation of carer reports of inadequate communication. These data suggest that the problem arises, at least in part, out of misunderstanding rather than neglect. Carers see their peers as being

more capable of taking in information than do nurses and, unlike nurses and the general public, they see any lack of capacity as being totally unrelated to expressions of distress or level of upset. This study suggests that families may be more satisfied with medical staff and feel better informed, if fewer assumptions were made of caregivers' capacity to absorb information.

Conclusion

Family members want and need information. Both knowledge and anxiety control for family members is accepted as being crucial if effective stroke rehabilitation is to occur; and medical staff want families to assume responsibility for care and rehabilitation as soon as the acute phase of the illness has passed. The belief that emotionality impedes capacity to take in information is a particularly damaging one to hold in this context.

The carers who need most assistance and training for rehabilitation are those who are prone to anxiety and depression. They are likely to be the caregivers with emotional temperaments (Braithwaite 1987, Henderson *et al.* 1981) who risk being considered too unstable to absorb information. Through ignoring their information needs in the crisis situation, both the capacity of these caregivers to assist in rehabilitation and their commitment to doing so can be jeopardized. Emotionality is likely to turn to resentment, negativity and despair if it is not channelled in a more positive and purposeful direction.

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