1996

The Relationship Between Spirituality and Depression in Family Caregivers of the Elderly

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THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION IN FAMILY CAREGIVERS OF THE ELDERLY

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A THESIS

Submitted to
Grand Valley State University
in partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN NURSING

Kirkhof School of Nursing

1996

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ABSTRACT

THE RELATIONSHIP BETWEEN SPIRITUALITY AND DEPRESSION IN FAMILY CAREGIVERS OF THE ELDERLY

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The purpose of this study was to examine the relationship between spirituality and depression in family caregivers of the elderly. This study sought to test the following hypothesis: The level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly. A descriptive, correlational design utilizing Neuman's wholistic system theory was used with a convenience sample of 44 family caregivers aged between 32 and 88 years. Self-reporting questionnaires were mailed to clients (identified as caregivers) of a home care agency, a caregiver respite program, and a Parkinson's support group all providing services in Northern Michigan. The Spiritual Perspective Scale (SPS) was utilized to measure spirituality, and the short form of the Geriatric Depression Scale (GDS) was utilized to measure depression.

A Pearson correlation revealed no significant relationship existed between the total SPS scores and the total GDS scores ($r = -.106$, $df = 32$, $p > .05$). Even though this study's results were not statistically significant, the data indicated a trend toward a negative relationship between the variables. Implications for nursing are discussed.

ACKNOWLEDGMENTS

A heartfelt thank you to my chairperson, Katherine Kim, Ph.D., R.N., whose role-modeling of nursing at the highest professional level has been a true inspiration for me. Her endless encouragement and support has meant so much.

Special thanks to Lucille Grimm, Ed.D., R.N.C., Ron Rozema, M.S.W., A.C.S.W., and Linda Scott, M.S.N., R.N., for their expertise and wise counsel.

My deepest appreciation and respect to my husband Denny, who daily demonstrates his spirituality and faith, and to my children; Jennifer, Brian, Matthew and Anna. I couldn't have done it without your love and support.

And lastly, but certainly not least, thank you to my dear friend and mentor, Julie A. Smith, R.N., M.S.N., C.R.R.N., to whom I owe so much.

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CHAPTER 1

INTRODUCTION

By the year 2030, the United States will have an estimated population of 70.2 million people over 65 years old, compared to 32.3 million seniors in 1992 (AARP, 1994). This very large segment of our population will require vast amounts of health care as many of these seniors will be afflicted with at least one and perhaps multiple chronic conditions. This presumption is reinforced by the fact that the prevalence rate of Alzheimer's Disease is an estimated 18.7% of those 75 to 84 years old and 47.2% of those over the age of 85 (Evans, Funkenstein, & Albert, 1989) and that approximately 23% of the older population living in the community have health-related difficulties with one or more activities of daily living (AARP, 1994). Research indicates that families do not abandon their disabled elderly; rather, families provide the vast majority of care and are the key to maintaining the frail elderly in the community, often with extensive personal sacrifice (Brody, 1985; Neundorfer, 1991a). Most informal care for elders in this country is provided by spouses while adult children rank next (Stone, Cafferata, & Sangl, 1986). The average age of all caregivers is over 65 years (Lee, Dwyer, & Coward, 1993), producing multiple scenerios of the elderly caring for the elderly.

Caring for impaired older family members can be extremely stressful, and may lead to problems of burden, role fatigue, deterioration of physical health, and depression (Bull, 1990; Nagai-Jacobson & Burkhardt, 1989; Neundorfer, 1991a; Given, Collins & Given, 1986; Collins, Stommel, Wang, & Given, 1994). Depression is a frequent negative psychological by-product of caregiving (Robinson, 1989), and caregivers are more likely to experience problems with mental health and social participation than with physical health (George, 1986).

Various resources are utilized by individuals to cope with stressful situations within the physical, psychological, sociocultural, developmental and spiritual domains (Neuman, 1989). Literature indicates that as people grow older, spirituality becomes more and more important in maintaining well-being (Brooke, 1987; Nelson, 1990; Young, 1993) and that spiritual integrity helps strengthen one's ability to manage life's challenges and problems while helping to give meaning to life (Eliopoulos, 1987; Heisel & Faulkner, 1982; Young, 1993).

As indicated, family caregiving is frequently stressful, is often attended by depression and not uncommonly affects the caregiver's health. Nurses need to be able to identify and promote all of the positive coping resources of individuals, including the often overlooked spirituality resource (Nagai-Jacobson & Burkhardt, 1989). In previous times, when medicine was lacking of technology, holistic care was the accepted vehicle for healing. The philosophy of holism--healing the mind, body, and spirit--is the foundation of modern medical and nursing practice (Engelking, 1995). The current nursing process provides the model for assessment of and intervention for clients' spiritual needs (Peterson, 1987). Spirituality is an important part of a nursing assessment and offering interventions that help alleviate client and caregiver spiritual distress is necessary to provide wholistic care.

There is a significant amount of nursing literature describing the individual concepts of spirituality and caregiver depression. Available literature examining the relationship between caregiver spirituality and depression is limited to one study by Boland (1990) which is the focus of replication for this current research.

Purpose

The purpose of this study is to examine the relationship between spirituality and depression in family caregivers of the elderly by partially replicating the Boland study of 1990. The examination of this relationship is seen as important to provide a better understanding of the resources available to family caregivers of the elderly.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

Conceptual Framework

Neuman's wholistic systems model (1989) will provide the structure for this study. Neuman's basic underlying assumption is that many known or unknown universal environmental stressors exist, each with it's own potential for disturbing a client's usual stability level. The interrelationship of the parts and subparts to the whole of an individual comprise this wholistic systems model. Client system stability is affected by the interrelationship of multiple variables which determine the amount of resistance an individual has to environmental stress (p. 23) and his/her response to it.

The Neuman Systems Model (Appendix A) depicts five interacting variables of any individual--physiological, psychological, sociocultural, developmental, and spiritual. How these variables function with the internal and external environmental stressors influences an individual's ability to maintain equilibrium of their system at any point and time.

Neuman sees each individual as unique but with innate characteristics common to all. Basic to each individual is a central core, described as the basic structure of the human being, reflecting factors common to all organisms (normal temperature range, genetic structure, response patterns). Surrounding the central core are multiple lines of defense representing different levels of resistance to extra-, inter-, and intrapersonal stressors. These lines of defense are described as the: (a) Flexible lines of defense; which act as a protective buffer preventing or reducing stress invasions into the client's system. They are the furthest from the central core and dynamically filter stressors to reduce their impact on the system. Stressor impact, whether single or multiple, has the potential of reducing the effectiveness of this buffer system (Neuman, 1989, p. 29). (b) The normal lines of defense represent what the client has evolved to over time and

is the usual wellness level. Factors influencing the normal lines of defense are the system variables, coping patterns, life-style factors, developmental and spiritual influences, and cultural considerations (p. 30). These factors are dynamic and system stability depends on the stressor impact and the effectiveness of the other lines of defense and their resistance. Symptoms of caregiver stress, such as depression, may be reduced or alleviated when the normal lines of defense are reinforced by adequate coping patterns and positive spiritual influences. (c) Closest to the basic structure are the lines of resistance which allows the system to reconstitute by reversing the reaction to stressors. When environmental stressors penetrate the normal lines of defense, the lines of resistance are called to action. Physically, this is demonstrated by the immune response and the mobilization of white blood cells in the presence of invading bacteria. Spiritually this is demonstrated by reinforcement of basic values and beliefs that give meaning to existence and purpose of life. Protection of the basic structure' s system integrity is the ultimate goal of the lines of resistance.

Caregiving is generally recognized as being stressful. The caregiver's perception of efficacy and adaptive coping strategies are important indicators in maintaining a sense of well being. Tension producing stressors with the potential for causing disequilibrium for the caregiver may be present but may not be experienced as such if the caregiver's lines of defense and/or lines of resistance are capable of providing protection. According to Neuman's theory, the spirituality variable permeates all other system variables and can increase the effectiveness of the flexible line of defense by providing protection from the stressors produced by being a caregiver to an elderly family member. The spirit controls the mind and the mind, consciously or unconsciously, controls the body (Neuman, 1989, p. 29). Utilizing spirituality as an energy resource may foster hope and affect a client's will to live. Optimal system stability can not occur without concurrent spiritual wellness, as it is the essence of wholeness (Dossey, 1989). Based on this assumption one could presume that a

caregiver with significant spirituality would perceive less stress on their system than a counterpart lacking that resource and would demonstrate fewer depressive features. Understanding the impact of spirituality as a resource in helping a client achieve and maintain system integrity is vital to providing wholistic nursing care.

Literature Review

This literature review will examine pertinent information available on two major concepts of this study; (a) spirituality, and (b) caregiver depression. Spirituality will be addressed in section one and caregiver depression in section two. A thorough search of the literature revealed no studies investigating the relationship between spirituality and caregiver depression other than the1990 Boland study. The results of Boland's study, described in section three, showed a significant but moderately weak negative correlation between spirituality and depression in family caregivers of the elderly. Another study investigating the psychological and spiritual well-being in college students (Fehring, Brennan, & Keller, 1987) identified a weak negative correlation between spirituality and depression. Additionally, a study by Nelson (1990), indicated that elderly persons who are more intrinsically oriented to religion experience less depression. Although the results of these studies can not be generalized, they suggest a negative correlation between spirituality and depression. Further research is needed to investigate this correlation.

Spirituality. According to Neuman (1989), a spiritual variable is innate in everyone and permeates all other variables, whether or not it is ever acknowledged or developed. Spirituality is defined by Landrum and associates (1984), as the core of an individual's existence, integrating and transcending the physical, emotional, intellectual and social dimensions. It is concerned with the personal interpretation of life, the inner resources of people and helps one develop a sense of meaning and purpose of life (Ellison, 1983; Heriot, 1992; Nagai-Jacobson & Burkhardt, 1989; Peterson & Nelson, 1987; Reed, 1992; Thomas, 1989). Determining a meaning in life is regarded as

integral to human development and enhancing to health (Fitzpatrick, 1989; Parse, 1981). Further, the meaning of one's life and one's goals help determine health-related practices and values (Thomas, 1989). Although lacking a precise and universally accepted definition, spirituality is a vital force profoundly felt by individuals that influences one's life, health, and behavior (Stuart, Deckro, & Mandle, 1989). Religion is not synonymous with spirituality and refers to an external and more formal expression of values and beliefs (Emblen, 1992). A person's religion is used to express their spirituality, especially when it is connected to God, a Supreme Being, or a universal power.

Providing spiritual care as nurses may mean helping some clients maintain their religious practices and worship, while for others it may mean helping to identify that which holds most meaning in life (Emblen, 1992). Nursing research on spirituality as a health resource for the elderly is still in its infancy. Efforts to build empirical knowledge about the spiritual dimensions of human health have been gaining momentum and increasing awareness of spirituality as a human phenomenon that is relevant to the nursing discipline (Reed, 1992). Conceptual, clinical, and empirical knowledge in nursing indicate that the discipline acknowledges the relevance of spirituality for practice and research (Reed, 1992). Rapidly expanding ethnic and cultural diversity has placed a focus on understanding the variety of healing models that exist, many of which are based on the interconnectedness of the mind, body and spirit (Engelking, 1995). The need for this focus is aptly demonstrated by the fact the World Health Organization reports that 70% of the world's population relies on nonallopathic systems of healing (Krippner, 1995).

Reed (1987) has researched the significance of spirituality among terminally ill adults and in one study two hypotheses were examined; (a) terminally ill hospitalized adults indicate a greater spiritual perspective than nonterminally ill hospitalized adults and healthy non-hospitalized adults, and (b) spiritual perspective is positively related to well-being among terminally ill hospitalized adults. The Spiritual Perspective Scale

(Reed, 1986b) was used to measure the spirituality of the group of 300 participants which were divided into three groups: group 1, terminally ill hospitalized cancer patients who were aware of the terminal nature of their illness; group 2, non-terminally ill hospitalized patients; and group 3, healthy non-hospitalized persons. The ten item Spiritual Perspective Scale (SPS), measured the participants perspectives on the extent to which spirituality infiltrated their lives and their participation in spiritually-related interactions. Additionally, the Index of Well-being Scale (IWB) was used to measure participants' satisfaction with life as it was currently experienced. Results of the study supported the first hypothesis that terminally ill hospitalized adults (group 1) indicated a greater spiritual perspective than either nonterminally ill hospitalized adults (group 2) or healthy non-hospitalized adults (group 3). Individual SPS scores ranged from 1 to 6 and the mean score on the SPS for group 1 was 4.530 (SD = 1.38), for group 2, 4.157 (SD = 1.27) and for group 3, 4.160 (SD = 1.36). A low but significant correlation lent support to the second hypothesis that there is a positive relationship between spiritual perspective and well-being in the terminally ill hospitalized group (group 1). The Pearson product moment correlation was .22 ($p < .02$). Reliability of the SPS in this study was measured by Cronbach's alpha as an estimate of internal consistency. Alpha coefficients ranged from .93 in group 2 to .95 in groups 1 and 3. The three groups were matched on age, gender, years of education, and religious background to minimize the variables that may influence spiritual perspective. With generalization of this study to a like caregiver population, one could extrapolate that spirituality serves as a positive resource during times of extreme stress.

As described by Thomas (1989), inherent spirituality is integral to the treatment approach in Transactional Psychophysiology (TP) where intervention strategies such as biofeedback, relaxation techniques, counseling, exercise and diet modification are used. Thomas described case studies where TP therapeutic dialogue are utilized on clients with hypertension in conjunction with computer-assisted monitoring of blood pressure (BP)

and heart rate (HR). The findings demonstrated a significant relationship between spiritual interventions and a reduction in BP and HR. The clients' reduced BP and HRs were used as teaching tools to help them reevaluate and restructure their lives in a more healthy context. Thomas, through her case studies, helps legitimize the use of wholistic or alternative practices, either as an option or as an adjunct to conventional therapy. The studies demonstrate a way to integrate holism into clinical practice by incorporating nontraditional approaches to disease prevention and management.

Jackson et al. (1978), in a study of black urban elderly individuals, examined the relationship between religiosity and life satisfaction. The authors described intrinsic religiosity as that which "reflects attitudes toward internally rewarding reasons for religious beliefs and church associations" (p. 169). Although labeled "religiosity", their definition appears synonymous with this study's definition of spirituality. In the multiple regression analysis, intrinsic religiosity was a significant predictor of life satisfaction. Heisel and Faulkner (1982) examined a group of 122 urban black respondents ranging in age from 51 to 90 years of age. Results also indicated that high religiosity scores were associated with high scores on personal adjustment and happiness measures; low religiosity scores were associated with feelings of abandonment and loneliness.

Another study by Reed (1992) examined self-transcendence (described as spiritual) and mental health in the oldest-old adults. The sample consisted of 55 independent-living older adults, 80 to 97 years of age. Methodological triangulation was used whereby qualitative data together with quantitative findings were examined. Results of Pearson correlation analysis and matrix analysis of data supported a relationship between self-transcendence and mental health among the oldest old. These findings support a view of mental health in later life that includes the importance of expanding one's conceptual boundaries beyond a preoccupation with physical changes to more inner directed activities (Reed, 1992).

A study by Nelson (1990) sought to determine if there was a relationship between intrinsic and extrinsic religious orientation, depression and self-esteem in the non-institutionalized elderly. A convenience sample of sixty-eight elderly persons who lived in the community and participated in an elderly day care program in a Southwestern city were subjects in this study. Tools of measurement included the Age Universal Religious Orientation Scale which consisted of twenty items divided into two subscales (intrinsic and extrinsic). Measurement of religious orientation was done on a Likert five-point scale. An example of an extrinsic subscale item was, "Although I'm religious, I don't let it affect my daily life", whereas, an example item from the intrinsic subscale was, "My whole approach to life is based on my religion". Alpha coefficients of .73 for the intrinsic subscale and .65 for the extrinsic subscale were reported for this study. Test-retest reliability was reported at .93.

The thirty item Geriatric Depression Scale, which had an alpha coefficient of .90 for this study, was used to measure the psychological components of depression. Global self-esteem was measured by the Rosenberg Self-Esteem Scale. Items were answered on a four point scale and included statements such as "I feel useless at times" and "I take a positive attitude toward myself." The instrument had a Cronbach alpha of .74 and test-retest reliability of .85.

The results of this study indicated a significant negative correlation between depression and intrinsic orientation ($r = -.23$, $p = .026$): as depression decreases intrinsic religious orientation increases. As well, the study showed that intrinsic religious orientation was negatively correlated with self-esteem ($r = -.38$, $p = .001$) indicating that as self-esteem scores decreased (positive), intrinsic orientation was increased. Nelson (1990) reported that 69.5% of the participants of this study had high self-esteem, implying that elderly persons with high self-esteem were more intrinsically oriented to religion and less depressed.

Limitations of this study included the participants inconsistent responses when determining intrinsic or extrinsic religious orientation. This continued to be demonstrated even with reversal of wording to nullify the response set bias. Many participants tended to endorse any items that seemed favorable to religion in any sense, suggesting a socially desirable answer. This finding limits the potential for generalizing the study results, but the study does support the use of religion as a positive resource in the lives of the elderly.

The literature indicates that the discipline of nursing recognizes the value of spirituality as a health resource to clients. Target populations for research were varied and included age groups from teenagers to the oldest-old. The studies suggest that those persons with a sense of spirituality have increased satisfaction with life as demonstrated by improved physiological factors (Thomas, 1989), high scores on personal adjustment and happiness measures (Heisel & Faulkner, 1982; Jackson, Bacon, & Peterson, 1978), higher self-esteem, and retained mental health in the oldest of old (Nelson, 1990; Reed, 1992).

Caregiver Depression. "There are more family caregivers providing more care and more difficult care to more older persons over much longer periods of time than ever before" (Brody, 1985, p. 19). The percentage of older persons needing and receiving help with personal care increases sharply with age (AARP, 1994). In 1986 approximately 30% of all persons between the ages of 75 and 84 received help with selected activities of daily living with the percentage increasing to approximately 53% for persons aged 85 and older (AARP, 1994). The majority of caregivers are women and less than 10% report the use of paid services to help with the care (Lee, Dwyer, & Coward, 1993; Neundorfer, 1991a).

Thirty-five per cent of all caregivers are over the age of sixty-five (Lee, Dwyer, & Coward, 1993; Neundorfer, 1991a). Life changes occurring with normal aging (chronic disease, sensory changes, decreased strength and mobility, multiple losses) may decrease

a caregiver's ability to cope during stressful situations, especially if caring for older family members who are impaired with dementia (Zarit, Orr, & Zarit, 1985). The stress of caring for a family member with dementia is well documented (Neundorfer, 1991). The chronic stress of caregiving can result in a significant deterioration of a caregiver's emotional and physical health (Bull, 1990; Schulz, Visintainer, & Williamson, 1990). The presence of depression in caregivers is also well documented (Given, Collins, & Given, 1988; Neunndorfer, 1991a).

A study by Robinson (1989) examined the relationship of caregiver health, past marital adjustment, and social support, noting how these concepts related to depression. Seventy-eight wives who served as primary caregivers to husbands with irreversible memory impairment were surveyed. Four hypotheses were examined:

1. Caregiver received social support was negatively related to caregiver depression.
2. Caregiver past marital adjustment was negatively related to caregiver depression.
3. Caregiver's physical health was negatively related to caregiver depression.
4. Caregiver received social support, past marital adjustment, and health was significantly predictive of caregiver depression. (p. 360)

The participants were recruited through the Alzheimer's Disease and Related Disorders Association, home health agencies, church newsletters, and senior centers surrounding a large midwestern city. The mean age of the participants was 67.5 years. Multiple tools of measurement used in this study included the Louisville Health Scale which measures physical well-being by examining overall health and functional health. Caregivers were asked to rate their health on a four point scale from excellent to poor. Functional health was measured by the caregivers responding to four activity items on a four point scale of never (1), to frequently (4). Internal consistency reliability with alpha coefficients of .82 to .89 were reported. Past marital adjustment was measured by the

Marital Adjustment Test, a fifteen item scale that measures caregivers' marital happiness one year before the onset of the husband's illness.

The Inventory Of Socially Supportive Behavior (ISSB) was used to measure received social support. Caregivers responded to forty questions on how often they received socially supportive behaviors during their caregiving experience. Forty-seven items were measured on a five point scale ranging from not at all (1), to everyday (5). Internal consistency reliability assessment yielded coefficient alphas of .92 and .99. The forty-seven items were examined for various dimensions of social support but because of the small sample, results were only suggestive. Results indicate that the only dimension of social support significantly related to depression was the desire for more social support, ($r = .23$, $p = .039$).

Caregivers' attitudes toward asking for help was measured by a semantic, differential scale where eight bipolar adjectives were used to reflect the caregivers' attitude. A seven point scale, from extremely good to extremely bad, was used to indicate a negative attitude toward help. Results indicated that attitude toward asking for help was significantly related to depression ($r = -.37$, $p = .001$).

The last tool of measurement used in this study was the Center For Epidemiological Studies Depression Scale (CES-D). The CES-D is a twenty item scale which measures frequency of symptoms of depression from rarely (0), to most or all of the time (3). Scores ranged from 0 to 60, with higher scores indicating more depression. Caregivers in this study indicated they felt depressive symptoms "some or a little of the time" reflecting a mean that was higher than the cutoff point for depression.

The first hypothesis, indicating that a negative relationship existed between received social support and depression, was not supported ($r = -.06$, $p = > .05$). The second hypothesis, that a negative relationship existed between past marital adjustment and depression was supported ($r = -.33$, $p = .003$), suggesting that less depression was noted when positive marital adjustment preceded the caregiving role. Total health was

negatively related to depression, (r = -.54, p = .001), giving support to the third hypothesis that a negative relationship existed between caregiver health and depression, or that caregivers with poor physical health are more likely to experience depression. The fourth hypothesis stating that caregiver received social support, past marital adjustment, and health status are significant predictors of caregiver depression was tested using multiple regression. The results supported a strong negative relationship between caregiver health and depression, but received social support was not related to caregiver depression. The findings provided additional evidence that received social support was not related to depression. The hypothesis was partly supported.

Caregiver functional health and the control variable, attitude, were the best predictors of depression. Caregivers with a positive attitude toward asking for support reported significantly less depression. Those with a negative attitude toward help may have viewed caregiving as part of their marital responsibility. The desire for more social support was the only variable significantly related to depression. Desire for more support relates to unmet expectations and thus depression is more likely to occur. More study is needed to determine what effect spirituality has on caregivers' social support, marital adjustment, and attitudes toward asking for support.

Neundorfer (1991b) looked at 60 spouse caregivers of persons with dementia, examining the effects of different coping patterns on physical health, depression, and anxiety. The cognitive theory of stress and coping developed by Lazarus and his colleagues was utilized. The severity of the patient's problems, caregivers' appraisal of the stressfulness of those problems, caregivers' appraisal for their options for managing the caregiving situation and the caregivers' coping efforts were examined for how they impacted physical health, depression, and anxiety.

Results indicated that the severity of the patient's memory and behavior problems were not a significant predictor for any of the caregiver health outcomes. When caregivers' physical health was the dependent variable, caregiver stress related to the

patient's problems was likewise not a significant predictor. Caregiver's appraisal of stress however was a significant predictor of depression and anxiety, partially supporting the hypothesis that caregiver stress is a better predictor of depression and anxiety than patient problems.

Results of this study showed that the coping efforts used by spouse caregivers of persons with dementia were factors affecting the impact of giving care. One coping pattern characterized by escape-avoidance, confrontive coping and accepting responsibility (blaming and criticizing oneself for problems), was a significant predictor of caregivers' physical health, anxiety and depression. Less than one quarter of caregivers surveyed reported using these maladaptive coping behaviors.

It seemed that despite the apparent stresses of caring for a spouse with dementia many of the caregivers were managing caregiving without negative effects on their own health. Although this study did not address positive outcomes for caregivers' well-being, it appeared most caregivers were using adaptive coping strategies such as focusing on personal growth, seeing the benefits of caregiving and turning to prayer. Neundorfer recommends that both positive and negative outcomes of caregiving and the factors involved in the process deserve further study.

Neundorfer (1991a) summarized literature about the impact of caregiving on the caregivers' physical and emotional health. She states that caregivers experience higher levels of depression, anxiety, negative affects on their emotional health and are more likely to use psychotropic drugs than the general population (p. 50). Of family caregivers seeking help to increase their coping skills, 46 % had clinical depression (Gallagher, 1989). These health concerns make it imperative for health care professionals to put in place appropriate supportive services before the family reaches a crisis point. Neundorfer (1991a) identifies four coping strategies that have been found to be significantly related to lower burden in caregivers: confidence in problem-solving, reframing the problem, spiritual support, and reliance on extended family (p. 53).

Enhancing a client's sense of well-being through spiritual interventions may help reduce levels of stress by increasing coping mechanisms.

The wear and tear hypothesis of caregiving (the longer care provided, the more psychological strain on caregivers) was examined using panel survey data from 112 adult children providing interhousehold care to an impaired parent (Townsend, Noelker, Deimling, & Bass, 1989). Depression of the caregiver was measured by the Zung Self-Rated Depression Scale with results indicating that children initially reported low levels of depression (M = 38.45), as well as later (M = 36.99) from a potential range of 25 to 100. Positive and negative feelings during the few weeks prior to assessment were measured by the Bradburn Affect Balance Scale. Predominantly positive affect was reported with average scores of Time 1 (M = 7.09) and Time 2 (M = 7.07) utilizing a range from 0-10. A derivation of Klein and Hill's family problem-solving effectiveness model was used to measure how serious, unpredictable, difficult and overwhelming the adult child perceived caregiving to be. Scores covered the entire range from 0 to 21, with the mean stress levels measuring Time 1 (M = 10.88) and Time 2 (M = 10.41) with higher scores representing greater subjective stress.

The quality of the problem solution and the acceptability of the process by which the family arrived at the solution was measured again utilizing Klein and Hill's problem-solving effectiveness model. Three dimensions of caregiving effectiveness were assessed; (a) the respondent's satisfaction with the current care arrangements, (b) satisfaction with how decisions about the elder's care have been made, and (c) the degree to which the respondent's caregiving goals have been achieved. An additive index was created with a range from 1 to 9. A high subjective effectiveness was reported; Time 1 (M = 7.08) and Time 2 (M = 7.36).

Additional analysis examined the amount of change actually occurring in subjective caregiving stress, effectiveness, and depression during the 14-month study. Data revealed variability in adult children's adaptation to caregiving, suggesting

improvement over time rather than deterioration as being the norm. Both subjective stress and perceived effectiveness of caregiving were significant predictors of changes in depression.

Research by Haley and Pardo (1989) helps support findings that depression and caregiver stressors are not significantly related to the duration of caregiving. Further research by Schumacher, Dodd, and Paul (1993) also provides support to the findings that the relationship between caregiver strain and depression is partially explained by the relationship between perceived efficacy of coping strategies and strain. Greater strain was associated with lower coping efficacy. Utilizing spiritual interventions to promote perceived efficacy may assist an individual to reduce their level of strain associated with caregiving.

The literature review on caregiver depression indicates that there are several variables contributing to the presence of depression. It appears that, indeed, depression is a common response to giving care to the elderly. However, the severity of the depression was impacted greatly by such coping mechanisms as spiritual support, prayer, perceived efficacy, adaptation, prior marital adjustment and physical health of the caregiver. The physical condition of the client, memory loss, behavior, and the duration of caregiving, did not seem to have an impact on caregiver depression. The caregiver's appraisal of the stressful situation, rather than the patient's problems, lends credibility to suggesting spiritual interventions as a resource to caregivers of the elderly.

Boland Study. The object of replication for this research is a study done by Boland (1990), which tested the hypothesis: The level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly. This secondary study utilized data from a convenience sample of 191 family caregivers that had responded to questionnaires from a primary longitudinal study conducted by Given and Given (1989). The Boland study used a cross-sectional descriptive correlational design.

Spirituality was measured with the Spiritual / Philosophical subscale from the Coping Resources Inventory (Hammer & Marting, 1988). A modified version of the Center for Epidemiologic Studies Depression Scale (Radloff, 1977) was used to measure caregiver depression. Results of this study identified spirituality as a consistent resource to the majority (62.3%) of caregivers surveyed. There was a significant but moderately weak negative correlation found between spirituality and depression in family caregivers of the elderly, $r = -.2934$, $df = 189$, $p < .001$.

Identified limitations of the Boland study included utilization of the modified CES-D, which had limited testing, as well as utilization of the Spiritual/Philosophical subscale, which was new and had limited validity. Adequate representation of items pertaining to God and religion was felt to be missing from the spiritual assessment tool. The use of a convenience sample was identified as a limitation as well as the use of a cross-sectional research design as opposed to longitudinal collection of data. This limitation was felt to be significant in measuring spirituality and depression as it is not clearly known how a person's beliefs or feelings change over time. Measuring at only one point in time may give an inaccurate picture of the relationship of such subjective variables.

Hypothesis

This study sought to test the following hypothesis: The level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly.

Definition of Terms

Spirituality: a belief that relates a person to the world; giving meaning to existence, a personal quest to find meaning and purpose in life and an attachment to religious values and things of spirit, rather than material or worldly interests (Burkhardt, 1989). Personal views and behaviors that express a sense of relatedness to a transcendent dimension or to something greater than the self (Reed, 1987).

Family caregiver: a primary support person who is cast into the role of being a major source of support and provider of care to a disabled and/or impaired family member with a deficit in a least one activity of daily living (Schulz, Tompkins, & Rau, 1988; Semple, 1992).

Depression: a mood of sadness that consists of feelings of hopelessness and helplessness as well as symptoms of lack of appetite, energy, and rest (Robinson, 1989).

CHAPTER 3

METHODOLOGY

Research Design

This study utilized a descriptive, correlational design to examine the relationship between spirituality and depression in family caregivers of the elderly. Data were obtained from self-reporting questionnaires investigating caregiver demographics, spirituality and depression. Family caregivers were identified by a homecare agency providing services to northwest Michigan, a Caregiver Respite Program, and the Parkinson's Support Group of Northern Michigan.

Setting and Sample

The sampling method used for this study was a convenience sample consisting of forty-four family caregivers. The caregiver inclusion criteria were: (a) Caregivers must be caring for a family member, age sixty or over, with at least one deficit in activities of daily living or instrumental activities of daily living; (b) all subjects were the primary giver of care for their relative; (c) all subjects were able to read, write, speak and understand the English language; (d) all subjects were in a lay capacity only and not professionally associated with an organized religion; and (e) subjects did not have a history of chronic depression or significant mental illness within the past five years.

The settings for data collection were client's or caregiver's homes. Questionnaires were mailed to their place of residence.

A summary of demographic characteristics is presented in Table 1. The majority of the participants were female and were either wives or daughters of the care receiver. The age of the participants ranged from 32 to 88 with a mean of 65.6 years (SD = 12.35). Educational levels of the caregivers ranged from 8 to 23 years of school completed with a mean of 13.6 years (SD = 3.5).

Table 1
Subject Demographic Characteristics (N = 44)

Characteristics	Frequency	Percent
Gender		
Female	30	68.2
Male	14	31.8
Marital Status		
Single	4	9.1
Married	33	75.0
Widowed	2	4.5
Divorced	5	11.4
Health Rating[a]		
Excellent	8	18.2
Very Good	14	31.8
Good	10	22.7
Fair	9	20.5
Poor	2	4.5
Race		
White	44	100.0
Income[b]		
Below $10,000 to $19,999	14	35.0
$20,000 to 39,999	16	40.0
$40,000 to 59,999	5	12.5
Over $60,000	5	12.5

Table 1
Subject Demographic Characteristics (continued)

Characteristics	Frequency	Percent
Caregiver Relationship		
Spouse	22	50.0
Daughter	10	22.7
Son	4	9.1
Daughter-in-law	2	4.5
Sister	3	6.8
Other	3	6.8
Needing Assistance With Activities of Daily Living		
Bathing	37	84.1
Dressing	29	65.9
Toileting	19	43.2
Feeding Self	10	22.7
Transferring	23	52.3
Needing Assistance With Instrumental Activities of Daily Living		
Phone	27	61.4
Traveling	43	97.7
Shopping	37	84.1
Planning/Cooking Meals	39	88.6
Heavy Housework	42	95.5
Taking Medications	38	86.4
Managing Money	39	88.6

[a]One health rating data entry missing

[b]Four income data entries missing

Seventy-five percent of the respondents were married, and seventy-three percent considered themselves to be in good to excellent health. Thirty-five percent of the caregivers annual gross income was below $20,000 and forty percent ranged from $20,000 to $39,999. All were white, and all considered themselves the major provider of care for their family member. The number of years that the caregiver had been providing care ranged from less than one year to 15 years with a mean of 3.98 years (SD = 3.70). The age of the person cared for ranged from 60 to 97 years, with a mean of 79.14 years (SD = 9.53). All care receivers needed assistance with many activities of daily living or instrumental activities of daily living.

Instruments

Screening instruments consisting of demographic data, a spiritual assessment tool and a geriatric depression scale were utilized as instruments of data collection for this study. These instruments were chosen, in part, due to the limitations of the Boland Study (Boland, 1990). Those limitations identified were the use of a relatively new subscale with limited validity to measure spirituality and the utilization of the modified Center for Epidemiologic Studies Depression Scale (CES-D) which had limited testing.

Both of the instruments selected for this study, the Geriatric Depression Scale short form (GDS) and the Spiritual Perspective Scale (SPS), have high degrees of reliability and validity and have been utilized in clinical practice since 1983 and 1987, respectfully. Additionally, in a comparison study, the GDS was found to be a major predictor of depression among the elderly while the CES-D was best in younger subjects (Sheikh & Yesavage, 1986).

The Spiritual Perspective Scale. The 10-item Spiritual Perspective Scale (see Appendix B) measures participants' perceptions of the extent to which they hold certain spiritual views and engage in spiritually-related interactions (Reed, 1986b). The goal of the SPS is to quantify spirituality in a way that is meaningful to adults yet remains easy to administer under various settings and health conditions. Cronbach's alpha estimates the

SPS reliability as being above .90 with little redundancy among items. Criterion-related validity and construct validity has been demonstrated (Reed, 1986b, 1987). The scale has been in use since 1987 and reliability and validity of the instrument has been repeatedly confirmed. In this study the SPS had an alpha coefficient of .90 (KR-20) indicating high reliability. Its ten questions are rated on a six point Likert-type scale with the first four questions being measured by responses ranging from (1) "not at all" to (6) "about once a day". The last six questions are measured by responses ranging from (1) "strongly disagree" to (6) "strongly agree". Scoring is done by measuring the total score from ten to sixty. The instrument can be administered as a questionnaire or in an interview format.

The Geriatric Depression Scale. The Geriatric Depression Scale (see Appendix C) developed by Yesavage et al. (1983) was designed for exclusive use with the elderly (Yesavage, 1992). Its short form was developed in 1986 and consists of fifteen yes or no questions which take approximately five to seven minutes to complete. The yes/no format and ease of administration of the GDS short form is seen as a possible bolster to reliability. Additional choices may lead to greater errors rather than increased sensitivity, as fatigue and poor concentration can interfere with measurement (Sheikh & Yesavage, 1986). Studies comparing the validation of the GDS long and short forms to one another showed that both forms were successful in differentiating depressed from non-depressed subjects with a high correlation ($r = .84$, $p < .001$). The GDS yielded an 84% sensitivity rate and a 95% specificity rate (Sheikh & Yesavage, 1986). The GDS also minimizes inquiries about health concerns which can produce false positive responses. Care was taken in the development of the tool to avoid somatic symptoms that have been found to correlate poorly on total score on depression instruments (Chenitz, Stone, & Salisbury, 1991). The GDS has a high degree of internal consistency and the validity of the instrument has been determined by comparison of total scores with the classification of patients as normal, mildly depressed, or severely depressed (p. 447). It can be

administered as a self-report or as an interview and no special training is required by the individual administering the test. Of the fifteen items, ten questions indicate the presence of depression when answered positively, while five indicate depression when answered negatively. Of a total possible score of fifteen, a score between five and nine suggests the strong probability of depression, and a score of ten is almost always indicative of depression (Sheikh & Yesavage, 1986). Using the data from this study, the reliability of the GDS was examined. A reliability of .78 (KR-20) was obtained.

Demographic Caregiver Data Form. Data collection on the demographics of the caregivers was done on a Demographic Caregiver Data Form (see Appendix D). This form collected information on caregivers regarding age, gender, education level, health, marital status, race, income, relationship to care receiver, and length of time providing care. Also included were questions on past significant clinical depression of the caregiver and whether the caregiver was the primary provider of care to their impaired family member or a member of the clergy. The age, and functional limitations of the care receiver were also addressed.

Data Collection Procedure

Data for this study was collected utilizing self-administered questionnaires that were mailed to potential participant's homes. Written consent (see Appendix E) was obtained from each participant and the researcher indicated on a cover letter (see Appendix F) that confidentiality would be maintained. Questionnaires were mailed to each subject, with a cover letter and two stamped, self-addressed return envelopes. To ensure confidentiality, participants were instructed to return the consent form in one envelope and the questionnaire in the other. A clearly stated deadline date for return was included. To increase respondent rate a follow up postcard was sent if no response was noted within two weeks. The researcher's name and telephone number were included to contact with questions. Prior consent from the Human Research Review

Committee at Grand Valley State University, and from the area agencies and the support group was obtained before data collection.

Eighty-six questionnaires were mailed out to potential participants and fifty-two were returned, yielding a sixty percent response rate. Of the total number of questionnaires returned, forty-four met all of the inclusion criteria of this study.

CHAPTER 4

RESULTS

The purpose of this study was to examine the relationship between spirituality and depression in family caregivers of the elderly. Data analysis was accomplished using the Statistical Package for Social Sciences (SSPS) software.

Hypothesis Testing

This study sought to test the following hypothesis: The level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly. The relationship between the participant's total spirituality and their amount of depression was examined to determine if any significant relationship existed among these variables.

Spirituality was measured on a 6-point Likert scale. Although an ordinal level of measurement, the summated score of spirituality was treated as an interval measure and statistical testing that applied was performed. Depression was measured at an interval level. Computation of descriptive statistics, the mean and standard deviation, were performed. To test the strength and the direction of the relationship between caregiver spirituality and depression, a Pearson Product Moment Correlation Coefficient was calculated. The .05 level of significance was used to evaluate the hypothesis.

Total scores of the Spiritual Perspective Scale (SPS) were used to measure the level of spirituality. These total scores were examined in relationship to the total scores of the Geriatric Depression Scale (GDS). A Pearson correlation revealed no significant relationship existed between the total SPS scores and the total GDS scores ($r = -.106, df = 32, p > .05$). Based on these findings, the hypothesis of the study was rejected.

As a comparison to existing literature (Brooke, 1987; Lee, Dwyer, & Coward, 1993; Nelson, 1990; Townsend, Noelker, Deimling, & Bass, 1989; Young, 1993) the sample was then divided into subgroups, comparing age, education levels, and length of time giving care to spirituality and depression using a Pearson correlation (see Table 2). Again, no significant relationship was demonstrated.

Table 2
Correlation's Between Spirituality and Depression by Age, Education, and Length of Caregiving (N = 44)

Groups	n	Correlation Coefficients
Age		
< or = 65 Years	18	-.10
> 65 Years	16	-.08
Education		
< or = 12 Years	17	-.26
> 12 Years	17	-.06
Length of Caregiving		
< or = 5 Years	17	-.26
> 5 Years	17	-.06

Note. All correlation coefficients are not significant at $p < .05$, $df = 32$. Two subjects did not respond to one or more questions on the Spiritual Perspective Scale, and 8 subjects did not respond to one or more questions on the Geriatric Depression Scale.

A review of the variable spirituality revealed that of a total score of 60 on the SPS, the range was from 25.2 to 54.6. The mean was 46.33 (SD = 6.97). Only 2

respondents had scores close to the fiftieth percentile or below, indicating a high level of spirituality among those responding. Table 3 presents the frequencies and percentages of subjects responding to the SPS items.

Table 3
Frequency and Percent of Subjects Responding to Spiritual Perspective Scale Items (N = 44)

	Not at all or about once a year		About once a month or about once a day	
Item	Frequency	%	Frequency	%
1. In talking with your family or friends how often do you mention spiritual matters?[a]	7	16.3	36	83.7
2. How often do you share with others the problems and joys of living according to your spiritual beliefs?[a]	9	20.9	34	79.1
3. How often do you read spiritually-related material?	8	18.2	36	81.8
4. How often do you engage in private prayer or meditation?	1	2.3	43	97.7

Table 3
Frequency and Percent of Subjects Responding to Spiritual Perspective Scale Items (continued)

Item	Disagree or Strongly Disagree		Agree or Strongly Agree	
	Frequency	%	Frequency	%
5. Forgiveness is an important part of my spirituality.	0	0	44	100.0
6. I seek spiritual guidance in making decisions in my everyday life.[a]	2	4.7	41	95.3
7. My spirituality is a significant part of my life.[a]	2	4.7	41	95.3
8. I frequently feel very close to God or a "higher power" in prayer, during public worship, or at important moments in daily life.[b]	5	11.9	37	88.1
9. My spiritual views have had an influence upon my life.[a]	1	2.3	42	97.8
10. My spirituality is especially important to me because it answers many questions about the meaning of life.[a]	2	4.7	41	95.4

[a]One data entry missing.
[b]Two data entries missing.

Of the fifteen items on the GDS, a score between five and nine suggests the strong probability of depression, and a score of ten is almost always indicative of depression. The mean score of respondents was 3.03 (SD = 2.72), indicating an overall low depression score. Scores ranged from 0 to 13.00. Table 4 presents the frequency and percent of subjects responding to the GDS items.

Although the data analysis of this study did not support the hypothesis, the results may indicate a trend toward spirituality and depression having a negative relationship. According to Polit and Hungler (1991, p. 421) interpreting significant relationships between variables of a social or psychological nature (such as spirituality and depression) can be difficult. They suggest that correlation between variables of a psychosocial nature are typically in the .10 to .40 range.

Table 4
Frequency and Percent of Subjects Responding to Geriatric Depression Scale Items (N = 44)

Item	Yes		No	
	n	%	n	%
1. Are you basically satisfied with your life?	37	84.1	7	15.9
2. Have you dropped many of your activities and interests?	25	56.8	19	43.2
3. Do you feel that your life is empty?[a]	4	9.3	39	90.7
4. Do you often get bored?	12	27.3	32	72.7
5. Are you in good spirits most of the time?[a]	36	83.7	7	16.3

Table 4
Frequency and Percent of Subjects Responding to Geriatric Depression Scale Items (continued)

Item	Yes		No	
	n	%	n	%
6. Are you afraid that something bad is going to happen to you?	5	11.4	39	88.6
7. Do you feel happy most of the time?[a]	34	79.1	9	20.9
8. Do you often feel helpless?	12	27.3	32	72.7
9. Do you prefer to stay at home, rather than going out and doing new things?[a]	21	48.8	22	51.2
10. Do you feel you have more problems with memory than most?[b]	7	16.7	35	83.3
11. Do you think that it is wonderful to be alive?[b]	41	97.6	1	2.4
12. Do you feel full of energy?[a]	20	46.5	23	53.5
13. Do you feel pretty worthless the way you are now?[a]	2	4.7	41	95.3
14. Do you feel that your situation is hopeless?	5	11.4	39	88.6
15. Do you think that most people are better off than you are?[a]	2	4.7	41	95.3

[a]One data entry missing
[b]Two data entries missing

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion Related to Hypothesis and Conceptual Framework

The findings of this study did not support the hypothesis that the level of spirituality will be negatively correlated with the level of depression for family caregivers of the elderly. A suggested explanation for this may be the overall high levels of spirituality of the respondents. Neundorfer (1991a) identifies spiritual support as one of four coping strategies that have been found to be significantly related to lower burden in caregivers. If an overall high level of caregiver spirituality existed prior to giving care, then a positive resource was already in place and may have helped reduce the levels of stress leading to caregiver depression.

Comments from respondents in support of this suggestion include: (a) "Jesus is my life. He gives me strength, peace and love to handle one day at a time." (b) "My faith in my maker and my prayers give me the strength I need every day to keep going." (c) "I feel if spirituality was not very important in my daily life, (then) I would become depressed."

According to Neuman's theory, spirituality can increase the effectiveness of the flexible line of defense by providing protection from the stressors produced by being a caregiver to an elderly family member. Based on the above caregiver comments one could presume that a caregiver with significant spirituality would perceive less system stress than a counterpart lacking that resource and would demonstrate fewer depressive features. Since the study group demonstrated overall high levels of spirituality and low levels of depression, this would lead to a less than significant correlation between the two variables of spirituality and depression.

Discussion Related to Other Findings

Results of this study do support the existing literature that spouses and adult children provide the vast majority of informal care (Stone, Cafferata, & Sangl, 1986), that most family caregivers are women, are over the age of 65 years (Lee, Dwyer, & Coward, 1993), and are the key to maintaining the frail elderly in the community (Neundorfer, 1991a). The majority of primary care providers in this study were spouses and adult daughters (72.7%). Caregivers ranged in age from 32 to 88 years with a mean age of 65.6 (SD = 12.35). Sixty-eight percent were female. The ages of the persons cared for ranged from 60 to 97 with a mean age of 79 years (SD = 9.53) and all required assistance with one or more activities of daily living and/or instrumental activities of daily living. Interestingly enough, the literature indicates that as people grow older, spirituality becomes more and more important in maintaining well-being (Brooke, 1987; Nelson, 1990; Young, 1993). However, this study did not demonstrate any significant correlation between spirituality and depression for those whose age was 65 years or less ($r = -.10$, $df = 16$, $p = .68$) compared to those caregivers over the age of 65 years ($r = -.08$, $df = 14$, $p = .77$).

Although statistically not significant, the findings of this study seem to indicate that the relationship between the SPS and the GDS is negatively correlated as predicted. That is, the greater amount of spirituality experienced by the subjects, the less depressed they were. This relationship appears to be stronger for those providing care for more than 5 years ($r = -.06$, $df = 15$, $p = .81$) as compared to those providing care for 5 years or less ($r = -.26$, $df = 15$, $p = .31$). These findings may support the results of Townsend, Noelker, Deimling, and Bass (1989), which suggest that with the utilization of combined resources, adaptation to stressful situations may occur over time.

Relationship of Findings to Previous Research

Boland (1990) reported a significant, but moderately weak, correlation between the variables of spirituality and depression ($r = -.293$, $df = 189$, $p < .001$). The direction of this relationship was consistent with the results reported by Fehring et al. (1987) who found strong inverse relationships between depression and spirituality in college students.

Demographic similarities between this study and Boland's results included a caregiver mean age of 62 years, the percentage of female caregivers was 84.3%, the majority were Caucasian (93.7 %), 78.7% had 12 years or more of education, and 54.4% were caring for their spouses. The major, most significant, difference between demographics of the studies was that the Boland study utilized a much larger sample ($N = 191$). This may explain the significant correlation between variables in the Boland study. Even though this study's results were not statistically significant, the data does indicate a trend toward a negative relationship between the variables.

Limitations and Recommendations

There are certain limitations to this study. Variables that may have influenced the dependent variable of depression were: the amount of social support and extent of family network of the caregiver; educational and socio-economic status of the caregiver; availability of supportive agencies; and health and hardiness of the caregiver. The demonstrated low depression scores may have been related to the caregivers already receiving help from some supportive agency (homecare, support group or caregiver respite), which indicates positive attitudes toward asking for help. This would support the findings of Robinson (1989) that the variable of caregivers' attitudes toward asking for help was significantly negatively related to symptoms of depression ($r = -.37$, $p = .001$).

Internal validity of the research design may have been compromised by recent media emphasis placed on how spirituality positively impacts one's individual health.

Several national news broadcasts and one local newspaper article were featured within months of this study's data collection and may have precipitated some form of social desirability to appear spiritual.

Generalizability of the results to the greater population of caregivers is limited due to the use of a small, convenience sample in a very homogeneous area of northern Michigan where most older residents are white and in a lower middle class socio-economic status. Also, the existing small sample size certainly suffered from a significant amount of missing data. Two subjects did not respond to one or more questions on the Spiritual Perspective Scale, and eight subjects did not respond to one or more questions on the Geriatric Depression Scale. This missing data could have been a contributing factor to the weak correlation's of the variables.

Additional threats to external and internal validity were reduced by utilizing tools that were concise, that have been utilized successfully for many years, and that have a high degree of validity and reliability. However, a noted limitation of the GDS was questions numbered 2, 8, 9, 12. When these questions were answered by caregivers indicating a depressive response, their answers may actually have been a reflection of situational factors as opposed to true depression. As an example question # 2 asks, "Have you dropped many of your activities and interests?" A "yes" answer to this question would be an indicator of depression but it may actually be a reflection of the caregivers inability to participate in activities as he/she once did due to caregiving responsibilities. Taking these factors into consideration when looking at relationships may further weaken the results of this study.

Recommendations would include further studies that compare larger numbers of caregivers, in several geographical settings, to provide a more heterogeneous study group. Further research using a longitudinal design could be useful in strengthening the findings as it is not known how a person's beliefs/ feelings about spirituality and

symptoms of depression may change over time (Boland, 1990). A single measurement may give an inaccurate picture of the relationship of the variables.

Implications for Nursing

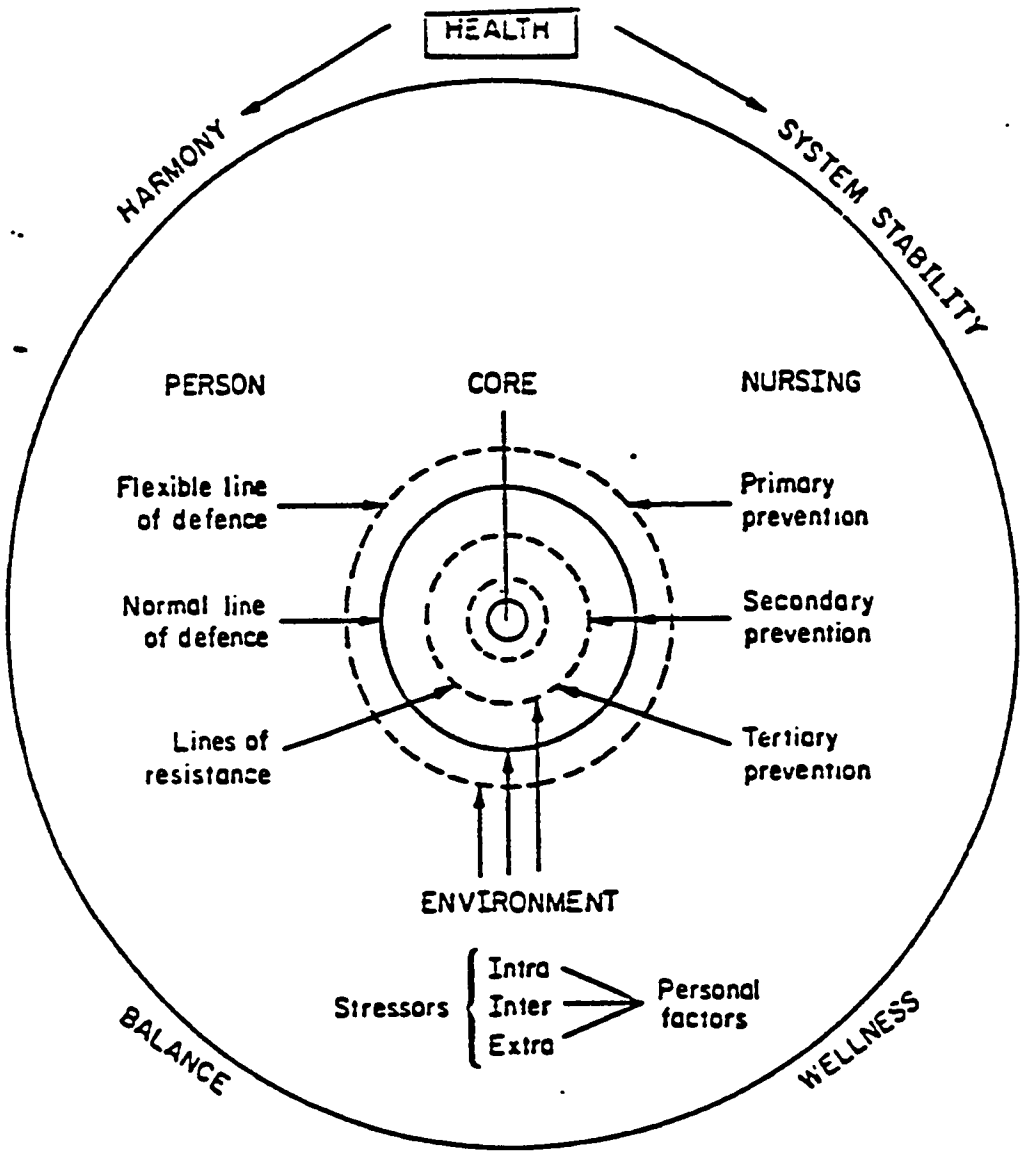
Families as caregivers are key to maintaining the frail elderly in the community and nursing needs to be aware of all of the resources available to support caregivers. Neuman (1989) states that the spiritual variable is innate in everyone and permeates all other variables. For nursing to understand the impact of spirituality as a resource in helping a family caregiver achieve and maintain their system integrity is vital to providing wholistic nursing care. Further research and intervention development would provide a better understanding of the often neglected resource of spirituality as it pertains to family caregivers of the elderly.

APPENDICES

APPENDIX A

NEUMAN SYSTEMS MODEL

Appendix A
Neuman Systems Model



APPENDIX B

SPIRITUAL PERSPECTIVE SCALE

APPENDIX C

GERIATRIC DEPRESSION SCALE

Appendix C
Geriatric Depression Scale

GDS

CIRCLE THE BEST ANSWER FOR HOW YOU FELT OVER THE PAST WEEK :

1. ARE YOU BASICALLY SATISFIED WITH YOUR LIFE?.....YES / NO
2. HAVE YOU DROPPED MANY OF YOUR ACTIVITIES AND INTERESTS? .....YES / NO
3. DO YOU FEEL THAT YOUR LIFE IS EMPTY? .....YES / NO
4. DO YOU OFTEN GET BORED? .....YES / NO
5. ARE YOU IN GOOD SPIRITS MOST OF THE TIME? .....YES / NO
6. ARE YOU AFRAID THAT SOMETHING BAD IS GOING TO HAPPEN TO YOU? .....YES / NO
7. DO YOU FEEL HAPPY MOST OF THE TIME? .....YES / NO
8. DO YOU OFTEN FEEL HELPLESS? .....YES / NO
9. DO YOU PREFER TO STAY AT HOME, RATHER THAN GOING OUT AND DOING NEW THINGS? .....YES / NO
10. DO YOU FEEL YOU HAVE MORE PROBLEMS WITH MEMORY THAN MOST? .....YES / NO
11. DO YOU THINK IT IS WONDERFUL TO BE ALIVE? .....YES / NO
12. DO YOU FEEL FULL OF ENERGY? .....YES / NO
13. DO YOU FEEL PRETTY WORTHLESS THE WAY YOU ARE NOW?....YES / NO
14. DO YOU FEEL THAT YOUR SITUATION IS HOPELESS? .....YES / NO
15. DO YOU THINK THAT MOST PEOPLE ARE BETTER OFF THAN YOU ARE? .....YES / NO

APPENDIX D

DEMOGRAPHIC CAREGIVER DATA FORM

Appendix D
Demographic Caregiver Data Form

DEMOGRAPHIC CAREGIVER DATA FORM

ID # _____

I. How old are you ? _____ (in years)

II. How many years of school have you completed ? _____ (in years)

III. Compared to other people your age, how would you rate your health? Would you say that your health presently is:

1. ____ excellent
2. ____ very good
3. ____ good
4. ____ fair
5. ____ poor

IV. What is your marital status?

1. ____ Single
2. ____ Married
3. ____ Widowed
4. ____ Separated
5. ____ Divorced
6. ____ Other (please specify)_____

V. What is your race? Are you:

1. ____ White
2. ____ Black
3. ____ Hispanic
4. ____ Native American Indian
5. ____ Asian/Pacific Islander
6. ____ Other (please specify)_____

VI. What was the range of your family's gross annual income last year?

1. ____ under $10,000
2. ____ $10,000 to 19,999
3. ____ $20,000 to 29,999
4. ____ $30,000 to 39,999
5. ____ $40,000 to 49,999
6. ____ $50,000 to 59,999
7. ____ over $60,000

VII. What is your relationship to the person you provide care for?

1. ____ Spouse
2. ____ Daughter
3. ____ Son
4. ____ Daughter- in-law
5. ____ Son-in-law
6. ____ Sister
7. ____ Brother
8. ____ Sister-in-law
9. ____ Brother-in-law
10. ____ Other (please specify)_____

VIII. How old is the person that you provide care for? _____(in years)

IX. Does the person that you provide care for need assistance with:

1. ____ bathing
2. ____ dressing
3. ____ toileting
4. ____ feeding self
5. ____ transferring to a chair or walking

X. Does the person you provide care for need assistance with:

1. ____ answering or dialing the telephone
2. ____ traveling (unable to drive own car or travel alone on bus or taxi)
3. ____ shopping (if transportation is provided)
4. ____ planning and cooking meals
5. ____ heavy housework (cleaning floors)
6. ____ taking the right medication at the right time
7. ____ managing money, buying needs, writing checks, paying bills

XI. Are you a major provider of care to your impaired family member?

1. ____ yes
2. ____ no

XII. What is the length of time you have been providing care for your family member?

number of years _____ number of months _____

XIII. Have you been treated for a significant clinical depression or severe mental illness within the past 5 years?

1. ____ yes 2. no ____

XIV. Are you a member of the clergy?

1. ____ yes
2. ____ no

XV. Are you:

1. ____ male
2. ____ female

APPENDIX E

INFORMED CONSENT

Appendix E
Informed Consent

FAMILY CAREGIVER STUDY
CONSENT FORM

The study in which you are being asked to participate is designed to learn more about the ways in which caring for an older family member affects the person providing care. It is being conducted by Mary Jean Chappel, RN, a graduate nursing student at Grand Valley State University. Family caregivers will be asked to complete written questionnaires and return them to Mrs. Chappel in a self-addressed stamped envelope.

If you are willing to participate, please read and sign the following statement:

1. I have freely consented to take part in a study of caregivers conducted by Mary J. Chappel, RN, which is being done to meet partial requirements of her masters of nursing thesis through Grand Valley State University.

2. I understand that participating in this study is voluntary.

3. I understand that I can withdraw from participating at any time.

4. I understand that the results of the study will be treated in strict confidence and, should they be published, my name will remain anonymous. I understand that within these restrictions, results can, upon request, be made available to me.

5. I understand that I can call Mary Jean Chappel at 616-275-6380, or the chair of the Grand Valley State University Human Research Review Committee at 616-895-2472 with any questions I may have about this study.

6. I understand that no immediate benefits will result from taking part in this study, but am aware that my responses may add to the understanding of health care professionals of the experience of being responsible for an older family member.

I,_____, state that I understand what is required of me as a participant and agree to take part in this study.

Signed_____ Date _____
signature

PLEASE RETURN THIS FORM BY: _____

APPENDIX F

COVER LETTER

Appendix F
Cover Letter

January 4, 1996

Dear Caregiver;

I am a graduate nursing student at Grand Valley State University completing my masters thesis. Part of my thesis research includes surveying caregivers and what resources they utilize in their every day lives.

You have been identified as a caregiver of a family member. I would very much appreciate you taking a few moments to fill out the enclosed questionnaires and return them to me in the included stamped envelopes as soon as possible. To ensure your confidentiality please return the signed consent form separately.

Thank you in advance for your time and participation in this project.

Mary J. Chappel, R.N.

APPENDIX G

PERMISSION LETTERS

Appendix G
Permission Letters

AGING CLINICAL RESEARCH CENTER
FOR THE STUDY OF SENILE DEMENTIA
Jerome A. Yesavage, MD, Director

Palo Alto VA Medical Center
3801 Miranda Avenue, 151Y
Palo Alto, California 94804

To whom it may concern:

Thank you for your interest in the Geriatric Depression Scale. I have no objection to your use of the scale as it is in the public domain.

Jerome A. Yesavage, MD
Professor of Psychiatry & Behavioral Sciences
Stanford University

Request Form

I request permission to copy the Spiritual Perspective Scale (SPS) for use in my research entitled,

The Relationship Between Spirituality and Depression in Family Caregivers of the Elderly

In exchange for this permission, I agree to submit to Dr. Reed a copy of the following:

1. An abstract of my study purpose, framework, and findings, especially which includes the correlations between the SPS scale scores and any other measures used in my study. (This will be used by Dr. Reed to assess construct validity).
2. The reliability coefficient as computed on the scale from my sample (Cronbach's alpha).
3. A copy of the one-page scoring sheet for each subject tested or #4.
4. A computer printout listing the data requested (See #3) and data coding dictionary (to decipher coded data).

Any other information or findings that could be helpful in assessing the reliability or validity of the instrument would be greatly appreciated (e.g. problems with items, comments from subjects, other findings).

These data will be used to establish a normative data base for clinical populations. No other use will be made of the data submitted. Credit will be given to me in reports of normative statistics that make use of the data I submitted for pooled analyses.

[redacted]
(Signature)

Position and Full Address 10263 Harmony Drive
Interlochen, MI 49643

Permission is hereby granted to copy the SPS for use in the research described above.

[redacted]
Pamela G. Reed

[redacted]
(Date)

Please send two signed copies of this form, and a stamped, self-addressed envelope to:

Pamela G. Reed, Ph.D., R.N.
College of Nursing
University of Arizona
Tucson, Arizona 85721

LIST OF REFERENCES

LIST OF REFERENCES

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