Impact of a psychoeducational program on three types of caregiver burden among spouses

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Purpose: The purpose of this study was to investigate the extent to which a psychoeducational intervention called “Powerful Tools for Caregivers” (PTC) influences burden of spouse caregivers. Specifically, this study examined whether spouse caregivers who attended PTC exhibited reductions in stress burden, relationship burden, and objective burden compared to a comparison group.

Design and Methods: The 6 week intervention used a self-efficacy framework to train caregivers to focus on self-care, communicate effectively, and manage emotions. This quasi-experimental study included 115 participants from the PTC group and 95 participants from a comparison group. Assessments were completed before and after the intervention for the PTC group and within a 6 week time period for the comparison group.

Results: Analyses using structural equation modeling showed that participants in the PTC group reported significantly lower levels of stress and objective burden than the comparison group. There were no group differences in relationship burden.

Implications: The findings indicate that PTC can be an effective resource for reducing psychological distress and objective burden among spouses caring for disabled partners. Copyright © 2010 John Wiley & Sons, Ltd.

Key words: caregiver intervention; psychoeducational; relationship burden; objective burden

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Introduction

The distressing impact of caregiving on mental and physical health is notable in spouses/partners. Compared to other family members, spouses perform more personal care tasks (Marks \textit{et al.}, 2002) and receive less help (Bedard, Kuzik, Chambers, Molley, Dubois & Lever, 2000). Spouses, especially wives, tend to be the last to relinquish care to professionals and experience more negative effects from caregiving than other family caregivers (Young and Kahana, 1989; Seltzer and Li, 2000).

Psychoeducational programs are one of the most common types of interventions that address caregiver well-being (Sørensen \textit{et al.}, 2002). Many vary in content and format, and have multifaceted curricula offered in 2–3 hours sessions over 4–6 weeks. They cover topics on caregiving roles, care contexts, and skill building. They frequently include group activities that normalize caregiving experiences and build a support
network among participants (Sörensen et al., 2002; Gallagher-Thompson and Coon, 2007). Although benefits of psychoeducational programs are widely touted, there is limited evidence to support positive caregiver outcomes. This may reflect a dearth of well-designed studies and the diversity among caregivers in their need for different types of psychoeducational programs (Gallagher-Thompson and Coon, 2007; Selwood et al., 2007). If psychoeducational programs are to be made widely available, it is important to document their benefits and the segments of the caregiver population that are most apt to benefit from them.

The purpose of this study was to assess the impact of a widely used psychoeducational intervention called “Powerful Tools for Caregivers” (PTC) on spouse caregivers of persons with chronic illnesses (Schmall et al., 2000). PTC is grounded in a self-efficacy model and teaches caregivers to engage in self-care by managing their emotions, communicating effectively, and enhancing their decision-making skills. The premise of PTC is that increased self-efficacy will promote the use of coping behaviors that will, in turn, enhance self-care and well-being among caregivers (Bandura, 1986; Zeiss et al., 1999). PTC was originally targeted to caregivers of persons with Alzheimer’s disease, stroke, and Parkinson’s disease (Kuhn et al., 2003; Boise et al., 2005) but was expanded to other caregivers because self-care needs were relevant. Previous studies using pre-post designs to assess PTC’s impact on spouses and adult-children have documented improvements in self-efficacy, more positive views about the caregiver role, increases in self-care behaviors and decreases in depression, anger, and guilt (Kuhn et al., 2003; Boise et al., 2005). Although Boise et al. (2005) did not examine differences between spouses and adult-children, Kuhn et al. (2003) reported an increase in self-efficacy among both groups, but found that only adult-children reported taking time for themselves and decreases in depressive symptoms. A more recent study of adult-children and spouses who completed PTC documented fewer health risk behaviors and more self-care behaviors (Won et al., 2008).

Only one study examined the hypothesized link between improved self-efficacy and self-care and found that spouses and adult-children who increased self-efficacy over the course of PTC showed increases in self-care and reductions in health risk behaviors (Savundranayagam and Brintnall-Peterson, 2010).

While encouraging, previous studies have not included comparison or control groups, making it difficult to interpret differences over time. Attending to the plight of caregivers by inquiring about their distress could produce salutary effects in the absence of programmatic effects. Moreover, previous studies did not directly examine hypothesized links between increased self-efficacy, changed behaviors, and more distal caregiver outcomes such as caregiver burden. Examining PTC’s influence on burden is important because it is an outcome that is typically assessed in caregiver interventions and therefore, allows for comparisons of this intervention with other psychoeducational interventions (Hebert et al., 2003).

The current study employed a quasi-experimental comparison group design to assess the impact of PTC on three types of burden: stress burden (tension and anxiety stemming from the caregiver role), relationship burden (extent to which the caregiver perceives the care-receiver to be overly demanding and manipulative), and objective burden (infringement of caregiver role on other aspects of caregivers’ lives) (Montgomery et al., 2000). Using multiple forms of burden as outcomes is more informative than using a summary burden score (Gaugler et al., 2000) to assess an intervention’s impact because an intervention may differentially affect each type of burden. What is unknown is whether PTC’s curriculum would lead to decreases in each type of burden. It is hypothesized that PTC empowers caregivers by teaching them coping skills, reframing difficult caregiving situations, and encouraging self-care. In turn, caregivers effectively using these coping behaviors will experience less burden. Specifically, PTC should affect stress burden because the curriculum teaches stress management techniques and fosters the creation of mutually supportive groups. PTC should influence relationship burden because it covers ways to understand care-receivers’ needs via improved communication skills. Finally, PTC should affect objective burden because it teaches caregivers how to find and request help, and to take time for other aspects of their lives. This study was guided by the model depicted in Figure 1. We hypothesized that mean scores for stress burden, relationship burden, and objective burden would be significantly lower in PTC participants than in comparison group participants after controlling for the autoregressive paths for each type of burden.

**METHOD**

**Study design and sample**

A pre-post comparison group design was used to assess the impact of PTC on 115 spouses, who were recruited from PTC classes offered in eight states (California,
Illinois, Iowa, Montana, North Carolina, Oregon, Washington, and Wisconsin) between April 2007 and December 2008. Only 22% of PTC participants withdrew from the study and were excluded from analysis because they did not receive the intervention. Reasons for dropout included declining caregiver or care-receiver health and nursing home placement of care-receivers. The comparison group included 95 spouse caregivers from the League of Experienced Family Caregivers (LEFC), which is a registry of family caregivers who volunteer to share information about their caregiving experiences. Most LEFC members are identified when they seek services or information from provider organizations. Like PTC participants, LEFC members have self-identified as caregivers needing assistance.

Intervention: Powerful Tools for Caregivers

PTC consists of six, 2.5 hours sessions that are conducted weekly by two class leaders. The first session addresses caregiving challenges and self-care. The second week concerns effective stress management, including ways to change negative self-talk to positive self-talk and ways to use relaxation activities daily. In week 3, participants learn and practice effective communication skills. Week 4 emphasizes assertive communication in challenging situations such as dealing with other family members. In week 5, participants learn to listen and identify ways to deal with emotions such as guilt. The last session addresses emotions during life changes and how to manage tough decisions. A unique component of PTC is creating weekly action plans that focus on practicing the “powerful tool/skill” taught in each session. Participants share their action plans with the group and report on their progress in subsequent sessions. They receive encouraging feedback on the implementation of action plans from the group (Schmall et al., 2000).

Data collection

Data collection for PTC and comparison group participants occurred over a period of 21 months. Data were collected from both groups at two points in time by the research team and not by class leaders. PTC participants completed an initial questionnaire before session one and a follow-up questionnaire after session six. Data for LEFC members were drawn from questionnaires completed when they enrolled in LEFC and follow-up questionnaires administered 6 weeks later. Questionnaires included items about demographic information on caregivers and their spouses with chronic illnesses, the care-receiver’s functional status and problem behaviors, and caregiver burden.

Measures

Caregiver burden. Burden was measured using the Montgomery et al. (2000) burden measure. Respondents indicated the extent to which an aspect of their life changed due to caregiving by using a response set ranging from 1 (not at all) to 5 (a great deal). Stress burden included five items measuring the affect component of burden such as anxiety and depression. Cronbach’s alpha for stress burden was .91 and .93 for PTC and comparison groups, respectively. Relationship burden included five items assessing the extent to which caregivers perceived care-receivers’ behavior as manipulative and overly demanding. Cronbach’s alpha for relationship burden was .87 and .89 for PTC and comparison groups, respectively. Objective burden included six items assessing the extent to which care demands infringed upon time or privacy that caregivers had for themselves and others. Cronbach’s alpha was .92 and .90 for PTC and comparison groups, respectively.

Covariates. Eight variables reflecting characteristics of caregivers and care-receivers were included as covariates because previous studies have identified them as factors related to burden (Pinquart and Sorensen, 2003). The five variables pertaining to caregivers’ characteristics are gender, education level, employment status, health, and length of caregiving (Table 1).
Caregiver health was measured with a single item asking participants to rate their health using a five point scale. Length of caregiving was measured using five categories: less than 6 months, 6–12 months, 13–24 months, 25 months to less than 5 years, and 5 years or more.

Measures about living arrangement, functional decline, and problem behaviors of care-receivers were also included as covariates (Table 1). Functional status was measured with seven items from the Katz Index of Activities of Daily Living (ADL) scale (McKhann et al., 1984) and nine items from the Instrumental Activities
Structural equation modeling (SEM) using LISREL 8.8 was employed to assess PTC's impact on burden because SEM corrects for measurement error, tests complex models, and explicitly estimates the correlation between independent variables (Rigdon, 2001). Before conducting the SEM analysis, propensity scores were created and included as covariates in the final analyses.

Propensity score analysis. The potential for selection bias is a limitation of quasi-experimental studies that include a comparison group that is not selected through randomization. Differences observed in characteristics of PTC and comparison groups at baseline could influence the outcome variable. For example, female caregivers may be less likely to be employed and also less likely to report being burdened. The inclusion of covariates, therefore, is designed to control for pre-existing differences between PTC and comparison groups in demographic characteristics that might affect the results' validity. The propensity score method balances a set of multiple observed covariates between two groups (Rosenbaum and Rubin, 1983, 1984) by using logistic regression to estimate the probability (propensity score) of belonging to the PTC group given those covariates. Given any value of the propensity score, the PTC and comparison groups will have the same joint distribution in all observed covariates that were used to estimate the propensity score (Rosenbaum and Rubin, 1983; 1984; Rubin, 1997). This method provides a mechanism for assessing whether or not both groups are comparable with respect to the observed covariates after the regression adjustment has been made. The following covariates were included in a logistic regression that predicted classification into treatment status (PTC or comparison): caregiver gender, caregiver education, caregiver employment status, caregiver health, length of caregiving, living arrangement of care-receiver, care-receiver's functional decline, and problem behaviors. The propensity score was used as a covariate in the SEM analyses comparing PTC and comparison groups.

Measurement model. All constructs, except for group and the propensity score, were composed of multiple indicators. The respective indicators for all types of burden included three random parcels with items corresponding to each measure. These parcels contain approximately equal common factor variance (Little et al., 2002). The scale for these constructs was set using the effects-coded method, where the indicator loadings average 1.0 (Little et al., 2006). The error covariances between corresponding time 1 and 2 indicators were freely estimated. Group (a dummy coded latent variable where PTC = 0 and comparison group = 1) and the propensity score were single indicator constructs, which were locally identified by setting the error variance of the indicator to 0 and leaving the factor loading to be estimated.

SEM analysis was conducted using the variance–covariance matrix. Table 2 reports the relationships between indicators and their respective constructs. All indicators loaded significantly onto their corresponding constructs. The amount of variance in each indicator that was accounted for by its latent construct ranged from 0.56 to 0.88. All measured variables were grand-mean centered prior to analyses.

Covariate adjusted test of mean differences between groups. A single group SEM model with a dummy coded latent variable representing both groups was used to perform a covariate controlled test of mean differences in the groups. Time 2 variables were predicted from all control variables and the dummy coded group variable. We estimated the correlation between group and the time 1 variables. The significant regression path from the group variable to the time 2 latent constructs reflects the unique mean difference of groups after controlling for the other effects. The covariate adjusted test was done as a single-group latent variable regression test of the differences at time 2 controlling for the other variables in the model.

Nested models. Nested models were created by placing constraints on previous models. This study used the model trimming approach, which begins with a
just-identified model with equal numbers of known variances/covariances relative to unknown parameters (Kline, 1998). Based on modification indices, paths were removed from the hypothesized model until there was a significant chi-square difference signifying that the more parsimonious model provided the best fit to the data.

Evaluating model fit. Maximum likelihood estimation was used because it yields optimal parameter estimates with continuous multivariate normally distributed variables (Jöreskog and Sörbom, 1993). Model fit was evaluated by: chi-square goodness-of-fit index, Bentler-Bonett Non-Normative fit index (NNFI), root mean square error of approximation (RMSEA), and comparative fit index (CFI).

### Results

**Characteristics of study samples**

The demographic characteristics of both groups were generally comparable (Table 1). The average age of caregivers was 71 years in the PTC group and 65 years in the comparison group. The majority of caregivers were wives who comprised 78% of the PTC group and 75% of the comparison group. In both groups, most participants were retired or homemakers and almost 90% of care-receivers lived in the same household as their caregivers. The average age of care-receivers was 75 for the PTC group and 70 years for the comparison groups. According to caregiver self-report assessments, over 80% of care-receivers had cognitive or memory problems, with over half being diagnosed with probable Alzheimer’s disease or dementia.

Differences were observed between both groups on four characteristics. PTC participants had less time in the caregiving role. Although about a third of caregivers in both groups (PTC = 33%; comparison = 26%) had provided care for 2–5 years, almost twice as many comparison group participants (67%) than PTC participants (34%) had provided care for five or more years. The average score for self reported health was higher for PTC participants than comparison participants. PTC participants were less educated and were caring for persons with less functional decline than comparison group participants. The inclusion of propensity scores in the analysis reduces the potential impact of these differences on the observed outcomes. The fit of the logistic regression model was good (C statistic = 0.863) and there was no evidence of heteroscedastic error (Hosmer–Lemeshow statistic p = 0.669). As noted above, propensity scores were

### Table 2 Loading and intercept values, residuals, and $R^2$ values for indicators in hypothesized model

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Equated estimates</th>
<th>Standardized</th>
<th>Loading</th>
<th>θ</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stress Burden Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress1</td>
<td>0.95 (0.02)</td>
<td>0.00 (0.02)</td>
<td>0.88</td>
<td>0.22</td>
<td>0.78</td>
</tr>
<tr>
<td>Stress1b</td>
<td>1.02 (0.02)</td>
<td>0.00 (0.02)</td>
<td>0.94</td>
<td>0.12</td>
<td>0.88</td>
</tr>
<tr>
<td>Stress1c</td>
<td>1.04 (0.03)</td>
<td>−0.00 (0.03)</td>
<td>0.85</td>
<td>0.27</td>
<td>0.73</td>
</tr>
<tr>
<td><strong>Stress Burden Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress2a</td>
<td>0.95 (0.02)</td>
<td>0.00 (0.02)</td>
<td>0.91</td>
<td>0.17</td>
<td>0.83</td>
</tr>
<tr>
<td>Stress2b</td>
<td>1.02 (0.02)</td>
<td>0.00 (0.02)</td>
<td>0.94</td>
<td>0.12</td>
<td>0.88</td>
</tr>
<tr>
<td>Stress2c</td>
<td>1.04 (0.03)</td>
<td>−0.00 (0.03)</td>
<td>0.86</td>
<td>0.26</td>
<td>0.74</td>
</tr>
<tr>
<td><strong>Relationship Burden Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship1a</td>
<td>0.92 (0.03)</td>
<td>0.01 (0.03)</td>
<td>0.83</td>
<td>0.32</td>
<td>0.69</td>
</tr>
<tr>
<td>Relationship1b</td>
<td>1.07 (0.03)</td>
<td>0.00 (0.02)</td>
<td>0.92</td>
<td>0.15</td>
<td>0.85</td>
</tr>
<tr>
<td>Relationship1c</td>
<td>1.02 (0.03)</td>
<td>−0.01 (0.02)</td>
<td>0.84</td>
<td>0.29</td>
<td>0.72</td>
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<tr>
<td><strong>Relationship Burden Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship2a</td>
<td>0.92 (0.03)</td>
<td>0.01 (0.03)</td>
<td>0.75</td>
<td>0.44</td>
<td>0.56</td>
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<tr>
<td>Relationship2b</td>
<td>1.07 (0.03)</td>
<td>0.00 (0.02)</td>
<td>0.91</td>
<td>0.18</td>
<td>0.82</td>
</tr>
<tr>
<td>Relationship2c</td>
<td>1.02 (0.03)</td>
<td>−0.01 (0.02)</td>
<td>0.81</td>
<td>0.35</td>
<td>0.65</td>
</tr>
<tr>
<td><strong>Objective Burden Time 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective1a</td>
<td>0.98 (0.02)</td>
<td>−0.00 (0.02)</td>
<td>0.90</td>
<td>0.19</td>
<td>0.81</td>
</tr>
<tr>
<td>Objective1b</td>
<td>1.01 (0.02)</td>
<td>0.00 (0.02)</td>
<td>0.89</td>
<td>0.21</td>
<td>0.79</td>
</tr>
<tr>
<td>Objective1c</td>
<td>1.01 (0.02)</td>
<td>0.00 (0.02)</td>
<td>0.90</td>
<td>0.19</td>
<td>0.82</td>
</tr>
<tr>
<td><strong>Objective Burden Time 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective2a</td>
<td>0.98 (0.02)</td>
<td>−0.00 (0.02)</td>
<td>0.88</td>
<td>0.22</td>
<td>0.78</td>
</tr>
<tr>
<td>Objective2b</td>
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<td>0.18</td>
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<tr>
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<td>0.00 (0.02)</td>
<td>0.90</td>
<td>0.18</td>
<td>0.82</td>
</tr>
</tbody>
</table>

Each indicator is a random parcel created from the respective measure.

Impact of Powerful Tools for Caregivers on Burden

Table 3 Statistics for comparison of nested models

<table>
<thead>
<tr>
<th>Model</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$p$</th>
<th>RMSEA (90% CI)</th>
<th>NNFI</th>
<th>CFI</th>
<th>$\Delta\chi^2$</th>
<th>$\Delta df$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement model</td>
<td>234.84</td>
<td>147</td>
<td>&lt;0.01</td>
<td>0.047 (0.0; 0.073)</td>
<td>0.99</td>
<td>0.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypothesized model</td>
<td>247.68</td>
<td>153</td>
<td>&lt;0.01</td>
<td>0.049 (0.035; 0.06)</td>
<td>0.99</td>
<td>0.99</td>
<td>12.83</td>
<td>6</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Final model</td>
<td>247.68</td>
<td>154</td>
<td>&lt;0.01</td>
<td>0.048 (0.034; 0.06)</td>
<td>0.99</td>
<td>0.99</td>
<td>12.84</td>
<td>7</td>
<td>&gt;0.05</td>
</tr>
</tbody>
</table>

included as covariates in the SEM analysis to control for these differences. The correlations for the manifest variables in the hypothesized model are available upon request.

Impact of PTC on burden

Table 3 reports key findings for nested models and includes indices of model fit for analyses of stress burden, relationship burden, and objective burden. The chi-square difference test between measurement and hypothesized structural models indicated a significant loss in fit. When the non-significant path between group and relationship burden at time 2 was removed, the chi-square difference between measurement and final models indicated no significant loss in fit.

Results from the final model are shown in Figure 2. It is important to reiterate that the findings reflect the unique effects of group assignment on stress and objective burden at time 2, after controlling for propensity and burden scores at time 1. We retained non-significant correlations between latent constructs to provide less biased estimates of predicted paths. As predicted, group was a significant predictor of stress and objective burden (standardized coefficient = 0.14 and 0.12, $p < 0.05$, respectively). PTC participants reported significantly lower levels of stress burden and objective burden than comparison group participants. Contrary to our hypothesis, there were no group differences for relationship burden.

Discussion

PTC was developed to promote caregivers’ well-being by equipping them with knowledge and skills to cope with their roles. Results from previous studies of PTC that have used a pre-post design have documented improvement in self-efficacy and self-care among participants. The current study’s findings add to, and strengthen in three ways, the evidence that affirms PTC’s merits. First, we used a quasi-experimental study design that included a comparison group and analyses procedures that controlled for differences between treatment and comparison groups to provide stronger evidence of PTC’s merits. Second, by focusing on distal outcomes of caregiver burden, this study demonstrated that PTC’s benefits extend beyond influencing self-efficacy and self-care to improvements in more global indicators of well-being. Third, the findings advance our understanding of types of burden that PTC influences. The mixed results regarding the impact of PTC on burden raise questions about which aspects of PTC’s curriculum are linked with decreases in objective burden and stress burden, and why PTC did not affect relationship burden. Although speculative, an examination of PTC’s content affords plausible hypotheses that might account for the mixed results.

PTC participation may have led to less stress burden because many elements of the curriculum targeted stress management. The curriculum was purposefully designed to enhance self-efficacy by providing caregivers with permission to engage in self-care and tools for acting on this permission. In session two, PTC’s curriculum helps caregivers to identify and manage stress. Participants also learned stress management and relaxation techniques during each session and were encouraged to practice them between sessions using action plans (Savundranayagam and Brintnall-Peterson, 2010).
Objective burden occurs when caregiving responsibilities leave individuals with little time for themselves or other aspects of their lives (Montgomery et al., 2000), making them feel trapped in their caregiver role. The segments of PTC’s curriculum that focus on giving permission for self-care, communication, and implementation of action plans may lead to reduced objective burden. PTC participants were given permission to seek help and taught how to communicate with family members and professionals about caregiving issues. They were taught how to request and access help. With newly acquired skills and greater knowledge of services, caregivers are more apt to use assistance from others and thereby reduce the responsibilities that they had previously viewed as an infringement on their time and relationships with other family members.

Unlike the positive link between PTC participation and stress and objective burden, PTC participation did not influence relationship burden. There are two plausible explanations for this finding. First, PTC’s curriculum does not include extensive content that is directly focused on the caregiver—care–receiver relationship. PTC’s content on communication is focused primarily on communication with professionals and other family members, which is qualitatively different from communication issues involving care–receivers, especially those with dementia who comprised over half of the study sample. PTC’s curriculum does not include information about or demonstrate intensive skills that are often required to communicate with persons with dementia. It is therefore not surprising that relationship burden would not be directly affected by PTC. A second plausible explanation involves the fact that most PTC participants in this study were long-term caregivers. Almost two thirds (66.3%) of PTC participants provided care for over 2 years. Half of these participants provided care for more than 5 years. Caregiving is a journey of constant change and variable length. More intense responsibilities fall on caregivers at later phases of this journey, when care–receivers are more dependent. Not all caregivers are willing or able to continue as caregivers when responsibilities become increasingly demanding. Long-term caregivers tend to be the most committed and, as a group, more homogenous. They may have low levels of relationship burden that cannot realistically be lowered by any intervention. Consequently, the absence of a link between PTC participation and relationship burden may reflect the generally low level of relationship burden reported by study participants, which left little room for improvement. Perhaps caregivers who experience strained relationships with care–receivers tend to opt out of the caregiving role and are less likely to seek help or enroll in psychoeducational groups.

Limitations and future research

The findings from this study are encouraging in that they demonstrate the potential for psychoeducational programs to address stress burden and objective burden. The study’s strengths include using a comparison group, propensity scores to control for potential baseline group differences, and SEM to simultaneously assess PTC’s impact on three types of burden. However, the lack of random assignment to treatment and comparison groups leaves open the potential for selection bias and the possibility that there were differences in unobserved factors that might influence the outcomes. The field would benefit from a study that employed a randomized control group design.

Future research is needed on characteristics of caregivers who are likely to benefit the most from PTC. It is well-known that there are significant differences in the caregiving experience for spouses and adult-children. Future research could also benefit from expanding the sample to be more culturally diverse. Finally, most PTC participants provided care for two or more years, reflecting the prevailing pattern of service use among spouses who generally do not seek help early in their caregiving journey. These long-term caregivers may also experience lower levels of relationship burden. Future studies could attempt to include individuals in earlier phases of caregiving and then examine the impact of PTC on different types of burden.

Conflicts of interest

None declared.
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