Caregiver Wellness

Summary of Study Results

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Introduction

An estimated 2.6 million frontline direct caregivers provide approximately 75% to 80% of hands-on long-term care for the elderly and persons suffering from disabilities in the United States (National Clearinghouse on the Direct Care Workforce, 2006). Frontline direct caregivers include (a) nursing assistants, (b) home health aides, (c) personal home care aides, and (d) family caregivers, who assist elderly and/or disabled clients with activities of daily living (ADLs) such as dressing, bathing, and grooming.

The growth in number of the aging population and changes in the health care industry have resulted in an increased need for frontline direct caregivers to provide home- and community-based services (HCBS; Paraprofessional Healthcare Institute, 2008; Yamada, 2002). Projected increases in the demand for frontline direct caregivers can be attributed to expansions in HCBS, through which care is provided in the home, rather than in a long-term care facility. According to the Paraprofessional Healthcare Institute (2008), between 2006 and 2016, providing personal care and home health care will be among the fastest-growing occupations in the United States. For example, by the year 2016, the number of HCBS caregivers is expected to exceed the number of long-term care facility workers by nearly two to one (Paraprofessional Healthcare Institute, 2008).

Purpose of the Study

The purpose of this study was to examine relationships among mental health risks, physical health risks, social networks, stress, and job satisfaction, as reported by frontline direct caregivers of the elderly and disabled in the United States. It was postulated that (a) social networks, stress, and job satisfaction would exert an influence on mental health risks; (b) social networks, stress, and job satisfaction would exert an influence on physical health risks; and (c) that there would be a statistically significant relationship among mental and physical health risks, stress, social networks, and job satisfaction. Perceptions of recent turnover among frontline direct caregivers were also explored in order to identify why professional frontline direct caregivers leave their jobs.

Study Sample

A predictive correlational Internet survey research design was undertaken with a
convenience sample of 515 frontline direct caregivers. Survey respondents were primarily family caregivers ($N = 381$), who were married. The majority of respondents were white women aged 40-75.

**Results**

In this study, frontline direct caregivers of the elderly and disabled reported high levels of stress, poor social networks, low levels of job satisfaction, poor physical health, and poor mental health. Results from this study were congruent with the literature, which noted that frontline direct caregivers have limited social interactions, and poor physiological and physical health as a result of their caregiving (Mannion, 2008; Pinquart & Sorensen, 2006; Love, Street, Harris, & Lowe, 2005). Researchers have also linked an individual’s poor psychological health to alterations in the immune system and as a contributing factor to increasing an individual’s susceptibility to infections and disease (Kalb & Raymond, 2004; Lemonick, 2004; Mannion, 2008; Pinquart & Sorensen, 2006). Therefore, it was not surprising that stress and job satisfaction were weakly associated with poor mental health among frontline direct caregivers. However, it was interesting to find that job satisfaction, stress, and social networking did not significantly contribute to physical health risks among frontline direct caregivers. Rather, the findings from this study suggest that stress, social networks, and job satisfaction might be better predictors of mental health than physical health among frontline direct caregivers of the elderly and disabled.

In addition, stress scores were significantly lower among trained frontline caregivers compared to stress scores among non trained frontline direct caregivers. These findings suggest that training might be an intervention to reduce stress among frontline direct caregivers of the elderly.

Another significant finding was that social networks among frontline direct caregivers varied significantly based on whether the caregiver received training, the type of caregiver, and the diagnosis of the care receiver. Trained caregivers’ social network scores were significantly higher than the scores among nontrained caregivers. Additionally, family caregivers reported smaller social networks than professional caregivers. Finally, frontline direct caregivers of loved ones with diabetes reported larger social networks than individuals caring for a loved one with any other diagnosis. These findings were significant because the strength of social networks is believed to have positive health-related outcomes (Lubben, 1988).
Implications for Practitioners

Issues of access to care, cost, supports, and the identification of applicable theories to explore and provide solutions to these challenges among frontline direct caregivers are paramount to practitioners in the health care field. Practitioners in the health care field may be able to utilize the results of this study to better understand mental and physical health risks, stress, social networks, job satisfaction, and turnover among frontline direct caregivers of the elderly and disabled.

It would be of great interest to researchers, policy makers, and health care practitioners to better understand which variables contribute to and/or predict poor physical health among frontline direct caregivers of the elderly and disabled.

The following paragraphs describe two important implications for practice: (a) access to training and (b) health care coverage for frontline direct caregivers.

Training

Frontline direct caregivers were reported to experience a variety of internal and external stressors as a result of their caregiving-related duties (Amirkhanyan & Wolf, 2006; Gainly & Payne, 2006; Gillen & Chung, 2005; Hartke et al., 2006). Training has been identified as a possible intervention to reduce stress among frontline direct caregivers (Institute for the Future of Aging Services, 2007). Researchers acknowledge that there is a wide variation of training required for frontline direct caregivers (National Clearinghouse on the Direct Care Workforce, 2006); for example, the Institute of Medicine (2008) found that some frontline direct caregivers receive 75 hours of training while others receive no training at all. Increased frailty of the elderly and disabled and the pressure of having to be self-reliant for caregiving duties were among major stresses reported by frontline direct caregivers of the elderly and disabled.

Caregiver training may also be effective in helping direct caregivers care for individuals with complex medical conditions. This study found that frontline direct caregivers with caregiver related training report lower stress and higher social network scores than frontline direct caregivers who did not have caregiver related training. These findings could be used in practice to help health care providers implement caregiver training as an intervention to reduce stress and increase social networks among frontline direct caregivers of the elderly and disabled.

Access to health care

A growing concern among frontline direct caregivers is the lack of access to health care. Home-based frontline direct caregivers are less likely than the average worker to have health care coverage (McDonald & Bridges, 2008;...
Of the 455 participants answering the question about access to health care, 145 (32%) were not eligible for health care coverage. The lack of health benefits and the pressure of having to provide care for the elderly and disabled could negatively impact the health and well-being of frontline direct caregivers, as was evidenced in the low physical health scores among study participants. Lack of access to health care among frontline direct caregivers of the elderly is a vitally important health care issue. Without adequate health care coverage, many frontline direct caregivers are only one illness from financial ruin (McDonald & Bridges, 2008).

Conclusion

In summary, the purpose of this study was to examine relationships among mental health risks, physical health risks, social networks, stress, and job satisfaction, as reported by frontline direct caregivers of the elderly and disabled in the United States. Little empirical research exists on the relationships among mental health risks, physical health risks, social networks, stress, and job satisfaction among frontline direct caregivers of the elderly and disabled. This study reveals the importance of training in the reduction of stress and for enhancing social networks among frontline direct caregivers and the need for increased access to health care. These findings could be used in practice to help health care providers implement caregiver training as an intervention to reduce stress and increase social networks among frontline direct caregivers of the elderly and disabled. Caregiver training may also be effective in helping caregivers navigate through the health care system to care for individuals with complex medical conditions and provide timely access to pertinent information to better support them in their caregiving journey.

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Full study results can be accessed at:

www.mycaregiverwellness.org
or www.caregiversupportservices.org
References


