

# Caregiving Styles: A Cognitive and Behavioral Typology Associated With Dementia Family Caregiving

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**Purpose:** An increasing number of elderly individuals are diagnosed with Alzheimer's disease and related disorders (ADRD), many of whom receive daily caregiving from spouse or adult child. Caregiving is a "cultural activity," and as such it is strongly influenced by sociocultural beliefs about caregiving and how it should be enacted. Understanding this thinking–action process has important implications for future research and service. Reasoned action theory provides empirical evidence that attitudes and beliefs, as they are influenced by the social environment, predict intentions to act. In turn, behavioral intentions can reliably predict behaviors. This grounded theory study describes a typology of caregiving styles relevant to family members of an individual with ADRD, where caregiving style is defined as a culturally based pattern in thinking and action. The goal of this study was to characterize the relationship between caregiver intentions and care strategies. **Methods:** Study participants included 97 individuals residing in the Washington, DC, area, who provide daily care for a family member with ADRD. Narrative data were collected from each caregiver during three 1-hr interview sessions. A subset of 30 caregiver–care recipient (CR) dyads was videotaped during typical interactions. **Results:** Four caregiving styles were identified (facilitating, balancing, advocating, and directing), which differ primarily in the intended focus of care and preferred interactions with the CR. **Implications:** The results

provide a foundation for future studies of the relationships between sociocultural context, caregiving styles and strategies, and ensuing outcomes for caregiver–CR dyads.

*Key Words:* Grounded theory, Caregiving–informal, Dementia

The number of individuals with Alzheimer's disease and related disorders (ADRD) is expected to rise precipitously in the next 40 years (DeFries, McGuire, Andresen, Brumback, & Anderson, 2009). In the United States, 5.3 million individuals with ADRD are being cared for by 8.9 million family members (Alzheimer's Association, 2009; U.S. Department of Health and Human Services, 2003), with a projected increase to 11–16 million care recipients (CRs) and 37 million family caregivers by the year 2050 (Hebert, Scherr, Bienias, Bennett, & Evans, 2004; U.S. Department of Health and Human Services, 2003). Caring for someone with ADRD within a family network has both positive and negative effects on the quality of life of the caregiver and CR. The preponderance of mental, physical, and emotional consequences for family caregivers is well documented (DeFries et al., 2009; Pinquart & Sörensen, 2003; Schulz & Martire, 2004). However, caregiving is also reported to be emotionally uplifting for some caregivers (Pinquart & Sörensen, 2003). Donovan and

Corcoran (2010) report that caregivers who perceive themselves as uplifted actively work to promote the positive aspects of care. A wide range of interventions drawing on several conceptual frameworks have targeted caregiver dementia management skills; however, although results are generally positive, effects sizes are small (Pinquart & Sörensen, 2006). These results suggest that the processes by which care is enacted (either naturally or as part of an intervention study) may depend in part on the level at which the caregiver's actions fit his or her existing sociocultural beliefs about caregiving. Sociologists and anthropologists argue that conceptual models of caregiving must incorporate culturally based knowledge, beliefs, meanings, and actions (Ablitt, Jones, & Muers, 2009; Quinn, Clare, & Woods, 2010). To date, studies of the relationships between caregiver characteristics and care processes have been largely limited to quantifiable relationships, such as stress and caregiver characteristics (Able, 1990). As a result, the role of sociocultural context in the caregiving experience and daily care decisions is not well understood. This knowledge gap may hinder development of effective interventions tailored to families' unique needs and preferences for care (Zarit & Femia, 2008).

The goal of this study was to develop a nuanced understanding of what caregivers do and why in the context of their culturally based role. Within a reasoned action framework, a typology of caregiving styles is described, where caregiving style is defined as a pattern of cognitive and behavioral processes. The construct of caregiving style is discussed as a foundation for future research regarding the complex relationships between sociocultural context, daily care decisions, and health outcomes for the caregiver–CR dyad.

### *Conceptual Foundation for Caregiving Styles*

The literature on reasoned action is a rich resource for organizing the processes by which individuals make conscious or unconscious decisions about behavior. This empirically tested model assumes a reciprocal relationship between an individual's attitudes, subjective norms, behavioral intentions, and subsequent actions (Ajzen & Fishbein, 1980; Fishbein, 2008). Applied to caregiving, attitudes are beliefs about the definition of good care, responsibility, health, illness, and self-perceptions of skills and abilities. Attitudes are shaped and prioritized through sociocultural influences (such as other people), CR characteristics,

and attributes of the care context (such as competing role demands and available resources). Actual behavior (day-to-day care decisions and strategies) can be predicted from the unique combination of attitudes (beliefs related to care), which are imbued with socially defined meaning and significance reflecting the caregiver's subjective norms. Thus, reasoned action provides an interactive model for describing patterns in beliefs, meanings, and actions that compose the caregiving experience.

The conceptual foundation for this study also draws on occupational science to operationalize caregiving actions as goal-directed, purposeful activities that structure daily life and affect well-being (Zemke & Clark, 1996). Purposeful activities reflect personal, social, cultural, and environmental conditions that are both internal and external to the actor (American Occupational Therapy Association, 1997). For the purposes of this study, caregiver actions are defined as purposeful activities that compose the culturally defined occupation of caregiving.

### *Research Related to Caregiving Styles*

The basis for the construct of caregiving style is rooted in sociology, anthropology, feminism, and family studies. Early literature in women's studies described processes preferred by female caregivers that suggested a pattern of meaning related to an "ethic of care" (Able, 1990, p. 152), suggesting influences from subjective norms. Le Navenec and Vonhof (1996) provide an in-depth overview of a family systems approach to caregiving that emphasizes family members' "behavioral and affective" pattern of response to caregiving (p. 67), or styles of managing. Based on a 1980s longitudinal study of 39 extended families living in western Canada, Le Navenec and Vonhof developed a model of management styles consisting of internal, external, and historical phenomena related to the family. Their model proposes that two dimensions (boundaries and focus) of the family system play a central role in determining styles of management. Conceptually similar to the Navenec and Vonhof study, the present study is conducted within the U.S. health care system, involves only caregiver–CR dyads, is limited to a 2-month time frame, and is a focused, detailed description of everyday purposeful care activities.

### **Design and Methods**

This article describes a grounded theory study of the caregiving styles of 66 spouse caregivers

(NIA R29 AG13019) and 31 filial caregivers (ARDRAF #08-02) of individuals with ADRD who resided in the Washington, DC, area. Narrative data were collected during three 1-hr interviews per caregiver. In addition, 30 randomly selected caregivers were videotaped during a typical interaction with their CR, usually involving meal preparation.

### *Participants*

Eligible individuals for this study self-identified as providing care for at least 1 year to a parent/in-law or spouse with ADRD. Data were collected during different time periods for spouse and filial caregivers (1997–2002 and 2007–2008, respectively). Participants were recruited using print media distributed to local social service, medical, and religious organizations. Newspaper articles helped to recruit 42 participants (43.2%). Study materials were reviewed and approved by the Institutional Review Board at George Washington University.

### *Data Collection*

Interviews were conducted in the caregiver's home at 2-week intervals. Interviewers used a topical interview guide to reflect each component of reasoned action theory: definition of dementia and caregiving (attitude/beliefs), influences on and importance of care decisions (subjective norms), and endorsed daily care strategies (behavioral intentions). Additionally, 30 caregivers consented to videotaping during typical interactions with their CR, thereby providing information about actual behaviors enacted. Interviews and observations were conducted by the principal investigator (PI) and nine trained and certified interviewers. Recordings were professionally transcribed and analyzed using qualitative analysis software (QSR N6).

### *Analytic Approach*

The qualitative analytic approach used in this study is based on grounded theory (Charmaz, 2006; Strauss & Corbin, 1998). Analysis began with the study team (PI and interviewers) developing a group qualitative codebook (Crabtree & Miller, 1992) consisting of initial codes based on the literature and preliminary interview data. The codebook provided a check on the reliability of

codes assigned to the data. This traditional method of assuring accuracy in qualitative research is consistent with interrater reliability strategies in quantitative designs (Crabtree & Miller, 1992; Charmaz, 2006). A codebook was created through a process of reading and discussing interview transcripts to identify and define categories. The interviewers used the codebook to assign codes, which were checked by the PI. When questions, ambiguities, or discrepancies arose, the team reviewed the data and refined the codebook, including definitions. For the remainder of the study, interviewers assigned descriptive codes to new data while the PI conducted higher level analysis, requesting team input during regular monthly meetings.

When the codebook was fundamentally unchanged for 2 months, the PI transferred coded data to the qualitative software and initiated axial coding. The purpose of axial coding is to develop core codes (central constructs to which all other codes are related) and to define their interrelationships (Charmaz, 2006; Strauss & Corbin, 1998). For this study, the core codes reflected three principal aspects of reasoned action: beliefs, meanings, and actions (Corcoran, 2004).

To focus the analysis on developing a caregiver style typology, selective coding was used to delineate, compare, and contrast the characteristics of each core code. The result was a level of abstraction suggesting emerging concepts that are salient for each participant and yet represented a range of responses. One concept in particular was recognized to fit this description: preferred interactions with the CR. This concept was discussed by each participant; yet, three specific types of interactions were initially noted—joint, parallel, and separate. Consistent with construction of typologies described by Strauss and Corbin (1998), this concept was used in a 3 × 3 matrix to explore the effects of each type of interaction on each of the core categories (beliefs, meanings, and actions). The matrix was created using QSR N6, which also allowed exploration of subcategories across the three types of interaction. One type of interaction (parallel) was split into two separate categories when it became clear that the purpose of the interaction was either to (a) keep the CR busy while the caregiver did something else or (b) allow the caregiver to observe the CR's functional performance. As a result of extensive analysis of data coded at subcategories and sorted in matrices according to the four interaction types, four caregiving styles emerged—facilitating, balancing, advocating, and directing.

The final step of analysis involved categorizing caregivers according to a particular caregiving style. Using a case-based approach, the PI reviewed the entire transcript and then focused on individual responses to four questions that were initially included in every interview to reflect the concepts of reasoned action. Caregivers were asked to describe (a) a typical day and (b) strategies for meeting his or her own needs; these questions allowed caregivers to describe actions used to support quality of life (self and CR). A third question reflected intentions to act in a particular manner by asking participants to advise a fictional caregiver in a vignette who wants to promote CR involvement in an activity. The fourth question asked participants to describe their three top priorities for caregiving, thereby providing a source of data to understand attitudes and beliefs.

The PI subjectively rated each of the four responses for level of consistency (none to high) with each style type based on her understanding of the context for each case and the nuances of each style type. Caregivers were categorized as demonstrating a particular style if at least two questions were rated as highly consistent with that style. Most caregivers (67%) met this criteria and an additional 28% exceeded this cutoff. For the remaining 5% of the sample who fell below the cutoff, scores for the questions related to actions were summed for each style and the highest score determining style assignment.

## Results

### *Description of the Sample*

The majority of participants were White (88.7%;  $n = 86$ ), woman (74.2%;  $n = 72$ ), spouses (68.0%;  $n = 66$ ), providing care for an average of 4.3 ( $SD \pm 3.57$ ) years. All spouses ( $n = 66$ ) and 9 filial caregivers lived with the CR. The remainder of filial caregivers ( $n = 22$ ) lived separately from the CR, who resided in a community residence, assisted living facility, or nursing home.

The average age of CRs was 77.3 years ( $SD \pm 8.8$ ) and the majority had a diagnosis of ADRD (61.9%;  $n = 60$ ). On average, CRs required assistance with 3.2 of 8 possible activities of daily living tasks ( $SD \pm 2.6$ ) and 49 (50.5%) had bowel or bladder incontinence. Thirty-eight (39.2%; including CRs in a nursing home or assisted living) used the services of a home health aide at least once weekly (Table 1).

Table 1. Description of the Sample ( $N = 97$ )

Variable	Range	M (SD)
CG age (years)	17–92	63.16 (14.15)
CR age (years)	55–100	77.30 (8.81)
CG education (years)	8–24	15.90 (4.17)
Years providing care	0.5–21	4.32 (3.57)
Total services for CR	0–11	5.04 (3.01)
Total dependence in ADL	0–8	3.27 (2.64)
Variable	Value	Frequency (%)
CG gender	Male	25 (25.8)
	Female	72 (74.2)
CG caring for	Mother (or in-law)	21 (21.6)
	Father (or in-law)	7 (7.2)
	Spouse	66 (68.0)
	Other	3 (3.1)
CG race	White	86 (88.7)
	Black	11 (11.3)
CR diagnosis	Alzheimer's disease	60 (61.9)
	Vascular dementia	24 (24.7)
	Other	2 (2.1)
	Unknown to CG	11 (11.3)
CR lives where	Assisted living facility	7 (7.2)
	Nursing home	3 (3.1)
	Own home, separate from CG	12 (12.4)
	With CG	75 (77.3)
Others living in household?	Yes	34 (35.1)
	No	54 (54.8)
	N/A (institution)	10 (10.1)
CG health	Good–excellent	86 (88.7)
	Fair–poor	11 (11.3)
CR health	Good–excellent	76 (78.4)
	Fair–poor	21 (21.6)
CR incontinent	Yes	49 (50.5)
	No	48 (49.5)
Use of HHA $\geq 1$ time weekly	Yes	38 (39.2)
	No	59 (60.8)

CG = caregiver; CR = care recipient; ADL = activities of daily living; HHA = home health aide; N/A = not applicable.

### *Typology of Style*

Four caregiver styles were identified: facilitating, balancing, advocating, and directing. Table 2 provides information about the distribution of each style, organized by gender and relationship.

**Facilitating.**—Facilitating style caregivers are characterized by a focus on the emotional health of the CR and, if present, the unimpaired parent who lives with the CR. A facilitating style involves promoting one or more of the following: (a) an image of the CR as a productive adult and loving

Table 2. Distribution of Caregiving Styles by Gender and Relationship (*N* = 97)

Relationship	Style	CG gender		Total, <i>n</i> (%)
		Male, <i>n</i> (%)	Female, <i>n</i> (%)	
Filial	Facilitating	1 (1.0)	6 (6.1)	7 (7.2)
	Balancing	2 (2.0)	8 (8.2)	10 (10.3)
	Directing	0	5 (5.1)	5 (5.1)
	Advocating	1 (1.0)	8 (8.2)	9 (9.2)
Spouse	Facilitating	9 (9.2)	15 (15.4)	24 (24.7)
	Balancing	10 (10.3)	17 (17.5)	27 (27.8)
	Directing	0	8 (8.2)	8 (8.2)
	Advocating	2 (2.0)	5 (5.1)	7 (7.2)
	Total	25	72	97

spouse, (b) the CR’s ability to enjoy meaningful activities (to “have a life”—01SHD), or (c) the unimpaired parent’s efforts to provide good care without compromising his or her own health.

A hallmark of a facilitating style is a preference for one-on-one, cooperative activities involving working together (e.g., hobbies, cooking, or gardening) that provide an opportunity for the CR to engage in meaningful past times or a valued past role. Sometimes, the caregiver arranges for someone else to engage the CR, “So, I asked a good friend who is a photographer—and they used to do a lot of photography together—to take him to places like Chincoteague and so on, for bird watching” (38KSJ). The cooperative aspect of the activity assures that the CR is able to safely and successfully engage in the past time because someone is immediately available to seamlessly make up for any performance problems, functioning as 44CDJ says, “. . . like Siamese twins.” This technique was verified in the observation data when caregivers were noted to stand immediately beside the CR to provide instructions, assurance, or hand-over-hand guiding.

A facilitating style includes supporting the emotional health of the CR through reassurance and by avoiding upsetting experiences. One CR got upset when his favorite football team lost so his spouse recorded and played back only winning football games. Caregivers also spoke of using humor, calm voices, and facial expressions purposely to promote an atmosphere of comfort and security.

Some caregivers managed the emotional health of the CR by finding and disseminating selected information to others involved in caregiving (i.e., siblings, unimpaired parent). 13WEE spoke of finding Web-based information that would “. . .

make my point for me.” Information indirectly influenced the emotional health of the CR by directly shaping day-to-day decisions, actions, and attitudes of other caregivers, as verified by 21KET who feels responsible for “Finding out how other people my dad’s [the unimpaired parent] age and older are handling it to pass it along to him. ‘Well, have you tried this?’ Anything I can learn to help him just keep the peace.” When relevant, actions consistent with a facilitating style included attempts to simultaneously address the emotional health of the unimpaired parent as well as the CR, as described by 30DEM:

I think if it is something that is really important to my Dad to be the primary caregiver, he takes a lot of pride in it, it is something he really wants to do for her, he still really loves her so, and it gives him something to do. So I view my function mostly as kind of a background support person, to come in and fine tune things and to try to be pro-active to look ahead at what we need to think about before we are surprised by the next phase.

When an unimpaired parent or a sibling caregiver does not share the caregiver’s ideas about how care should proceed, the results are often frustrating.

This is what’s frustrating for me. I think if I were the one handling my mother, it would make me more prepared. Because I have no control over what my father’s choosing to do, it is stressing me out, because I have all this information. I know what he should be doing, yet he’s not doing it. It does stress me out. I’m a “ducks in a row,” kind of person. If it was [only] my mom and I had medical power of attorney, I would have my name on a waiting list somewhere for a nursing home just in case. I would have all my powers of attorney in a row now. (21KET)

In sum, a facilitating style is distinguished by cooperative interactions, a reassuring attitude, and dissemination of selected information to optimize the emotional health of the CR. All three of these strategies require a high level of planning, preparation, and direct involvement by the caregiver.

*Balancing.*—A balancing style is characterized by efforts to maintain balance between the needs of the caregiver and CR, preserving quality of life for everyone in the household and avoiding sacrifice on the part of one person for the benefit of another. Thus, caregivers with a balancing style consider the individual in relation to the whole and attempt to meet the needs of each person, at least minimally. This approach helps caregivers to sustain care, as explained by 28COC:

I know she might not think I've done a good job because I haven't done every single thing she's told me or wanted me to do. But, I know that I have done the best job I can without totally losing myself. I remind myself a lot that I have to make sure that I don't lose myself and, that I have to take care of myself.

A balancing style is enacted through use of environmental controls (alarms, intercoms, and baby monitors) to supervise the CR, restrict movement, and avoid or eliminate problems. For example, several caregivers spoke of working in another room while listening to the CR on a baby monitor. Environmental controls may also include modifying items, such as removing knobs on appliances, installing locks, camouflaging doors with curtains or wallpaper, or providing interesting distractions. One caregiver (06REE) set up several appealing puzzles at the kitchen door to distract her husband during meal preparation. Other caregivers used stuffed animals, dolls, toys, or pets to quickly divert attention when needed.

Balancing style caregivers use simple games and pastimes for the CR that require only distant supervision by the caregiver. Favored activities are typically repetitive and highly familiar, including household chores such as sweeping, polishing, and folding. These activities are valued because they are simultaneously easy and can occupy the CR for several minutes. For example, 73KLH commented, "She swept that driveway the whole time I mowed the front lawn. I told her we had the cleanest driveway in the neighborhood." With the CR occupied, caregivers are free to work or relax nearby. In the observation

data, interactions included working in a different room or section while watching the CR's progress. If the CR needed help, the caregiver provided verbal instructions, intervening only if necessary. Thus, this style is characterized by a preference for parallel task interactions, as described by 15GUN, "I can watch a ball game while my wife folds the same towels all day long. She's busy, I'm happy. And that's all that matters right there." In contrast, a facilitating style is characterized by cooperative activities that are meaningful for the CR and require active, direct participation by the caregiver.

Although some caregivers expressed satisfaction with their efforts, a balancing style does require trade-offs. At times, the choices create conflicting feelings, as illustrated by 12ASE in her decision to support her father's wish to live alone despite safety concerns ". . . and so as much as I'm negligent, I also feel like in a way that's good because I'm respecting his wishes, maybe more than I should." The conflict may be in the form of a break with the caregiver's image of the family's past priorities, "We used to spend all our weekends together—the family came first and nothing got in the way of being together. Now I'm just so tired that I have to find time to get out and be alone. If I didn't, we'd both be put away. She doesn't know it's the weekend anyway" (31STJ). Other conflicts typical of a balancing style include pressures associated with managing multiple demanding roles and schedules, "I'm kind of a sandwiched generation. I've got an eight year-old and an eleven year-old, and you know, I'm married. Sometimes I feel like it interferes, like I'm spending too much time over there [at parent's home]. If something happens and I happen to be over there, I'll miss something of theirs" (06PIN). These conflicts were addressed by asking for help from other people ("I do have good help that makes it all possible"—17CRF). Although a facilitating style also includes asking for help from others, these requests are made for a different purpose, typically to provide an enriched experience for the CR. This difference reflects the primary focus of these two styles—emotional health of CR (facilitating) versus balanced attention to needs of caregiver and CR (balancing).

*Advocating.*—An advocating style is distinctive for being vigilant about the CR's well-being and advocating when problems are suspected. The

hallmark of this style is monitoring, observation, and a flexible response, as described by 16RAB:

Before we leave, I check on Mom to see how she's doing. I can tell a lot in the morning. If her shirt's inside out, her speech is slurred. She'll tell me if she slept or not. She'll ask me what I'm doing. She'll tell me if she wants me to do something specific. If I feel that she's perky, then it's just a matter of me going on with my scheduled day. I just call and check on her periodically. If she's not, then I cancel my day and hang out with her.

Advocating style caregivers monitor their CR's need for help and are careful not to provide more assistance or support than is needed at a particular point in time. As 20HIJ says, "It's a daily thing. I'm adjusting to help her . . . It's like a yo-yo. She needs me, but then she doesn't." Monitoring is accomplished by observing the CR's function during normal interactions or during an activity specifically chosen to demonstrate the CR's current status (playing a familiar game so a comparison can be made over time). Facilitating style caregivers also use cooperative activities, although not for the purpose of monitoring function but rather to address the CR's emotional health. Advocating style caregivers also use parallel activities, such as watching the CR play with a grandchild to monitor function. However, the purpose of parallel activities is different from that associated with a balancing style, which is to engage the CR in an activity without the direct involvement of the caregiver.

To monitor function and advocate for the CR, an advocating style often requires that caregivers interact with the CR's formal providers. This may be done to get information, make requests, or assure that staff knows someone is ". . . keeping an eye on things. I ask the aide several questions. I just don't know what those questions are going to be, but I'm just going to let them know that I'm watching. I'm paying attention" (27TIN). Caregivers also call or visit at random times throughout the day to ". . . to make sure that staff is treating her right. I walk in odd times, you know, just to make sure that things are on the up and up there at the facility" (25SAM). Caregivers try to advocate for their family member while not appearing overly demanding. As 18STJ cautions, "You have to step up the interaction. You've got to push it a little more, because you've got somebody, they're unhappy, and you don't like what you're seeing. You don't want to wait. You don't want to be unreasonable, but you just want to move things

along a bit quicker." 10WIB recognizes the nurses' demanding jobs but remains persistent when a problem arises: "I go to the desk and I deal with the nurses. If there's a problem beyond that that I can't take care of one on one, then I'll go higher up, but I don't want to get them in trouble." Her approach works because "I've kind of established a relationship with all the key players that see mom. That's very important. And even with the ones that aren't, you need to let them know who you are and why you're there."

Advocating for the CR also includes caregiver attempts to increase the extent to which staff understand and respect the CR. One caregiver, 11MAJ, brought in pictures and furniture so staff would keep "looking at my mother in a very positive way [in order to] maintain her self-dignity." Of particular importance to this caregiver was displaying "my mother's license as a registered nurse" and a picture of her mother as a captain in the Army Nurse Corps. These choices were made "so that the staff is going to know that they need to be respectful of her, because she did have a position, and she did have accountability and responsibility. We think that was important for us to let them know from the beginning that this was a special person."

Although an advocating style is characterized by a high level of vigilance and flexibility, this is often considered a relief in comparison with providing hands-on care, as described by 10WIB: "I didn't like myself when I did most of the care. I was very unhappy, depressed, and stressed-out. I feel like I could have done a whole lot better than I did for my mom. And now—of course I'm more at peace because somebody else is doing it but then I have the job of making sure they're doing their job. I think she's happier today than she was even ten years ago." Thus, caregivers have traded hands-on care for a care process of consistently monitoring the CR and acting on his or her behalf.

*Directing.*—A directing style is defined by an overall focus on the physical health of the CR, including his or her nutrition, medical routines, and hygiene. For example, 15NIM describes the most important caregiver responsibilities as ". . . taking care of her health, making sure she gets the best medical care and does the right things to take care of herself." The label "directing" reflects a predominant tendency toward maintaining order and certain standards of behavior, perhaps to forestall the effects of dementia. These standards include

good nutrition, exercise, adherence to medical regime, and staying independent. Strategies to enforce these behavioral standards vary, although for the most part they are communicated verbally and reinforced whenever the CR's behavior seems dangerous, unhealthy, or needy. For example, 15NIM does not answer the phone when her mother calls repeatedly because "I guess what I've learned is if I pick up that phone every time, or if I jump and do it, then I'm enabling her . . . basically, I'm rewarding her behavior." Some caregivers adopt a firm tone to convey their conviction that behavior must be adjusted as described by 05ART when her husband falls asleep at the table, "I get angry at him. I say, 'I'm sitting here. You're rude.'" Sometimes this is a departure from past interactions between the CR and caregiver. As described by 02EPB, "The only way I can get him to behave is if I threaten to take him to a nursing home. I hate doing that, but if I use a really stern voice and tell him I can't take care of him anymore, he minds me. We never spoke to each other like that." A directing style can be emotionally difficult for caregivers for this reason but also because CR may have an unforeseen negative response to a firm attitude, as described by 66FOE: "I guess I'm worried that he's going to explode on something that you can't predict. Something is going to magnify and I'll get blamed for things." One way to deal with these emotional difficulties is to manage them internally, as described by a daughter (23RIJ) who increased her own antidepressant medication in order to ". . . deal with things better and not scream at my own family. Cause I was frustrated before [increasing medication]. You know, you go down there and you're happy when you go down there because you've supposedly got their dinner and, you know if something set them off, you might come back in tears. Something little and then you come home and take it out on your family." Another way to deal with these negative emotions includes advice to "Just yell a little bit or go to the piano or do something to get it out. I holler at him! I just holler. I say, Don't bother me" (02EPB). One caregiver (51KAB) commented that the alternative to openly expressing emotions is being ". . . the first Jew to get sainthood. No, I, I think it's unfortunate sometimes my yelling and screaming and getting angry maybe hurts my husband, but it makes me feel a heck of a lot better."

A directing style is partly illustrated by the caregiver's preference for verbal and written directions to communicate with the CR; 66FOE advises

other caregivers to ". . . write things down for them and also realize they can't remember a lot of things so give directions in little bits at a time." 04RIC relies on repetitive verbal communication saying, "I think if you tell her things enough, it will sink in and I don't think some people appreciate how much effort went in to my getting her to remember something, so it's in there." In contrast, a facilitating style of communication includes touching or guiding. Also compared with a facilitating style, a directing style purpose for supporting the CR's leisure activities was to promote interactions with other people (besides the caregiver). These social interactions are perceived as beneficial to the CR, as 02EPB explains were her reasons for taking her husband out shopping: "It's for him! It's not for me because it's very annoying. One day a week when I go shopping he carries the bundles. He likes to see people. And everybody reminds him of someone. 'Oh, he reminds me of this and are you from Pennsylvania?' and things like that."

A directing style does not preclude caregivers from recognizing the importance of other needs besides the CR's physical health but caregivers acknowledged their uncertainty about what aspect of care to prioritize. 04RIC says, "I guess I devote a lot of time to giving her medicine. I'd say some of the things I feel I fail at are providing cognitive mental exercise." Similarly, 15NIM talks about the tension between addressing her mother's emotional needs and reducing helplessness when she says, "I think I'm probably not quite as sympathetic or empathetic as she needs sometimes. Quite frankly I do get irritated with that, but that's probably something that I could do better. She would let you do everything for her. I was thinking maybe I could be better with this, but I don't know if I would be helping her." In response to these internal conflicts and uncertainties, caregivers justify their decisions as the best choices possible under the circumstances ("I think I do the best I can. I just do the best I can. If it doesn't work out, it's not my problem"—24MER) or blame themselves for perceived failures ("I feel like I'm failing. Things are falling through the cracks because of me not being able to keep up with things"—04RIC).

## Discussion

Evidence suggests that care decisions are made and enacted through a dynamic, complex, interrelated set of cognitive, behavioral, and affective



processes. These processes are influenced by a unique set of social and cultural factors and are implemented in the context of a family network. Consistent with this perspective, the purpose of this study was to contribute to the understanding of family caregiving by describing patterns in thinking and action (caregiving styles) associated with the occupation of caring for a family member with ADRD. Four caregiving styles—facilitating, balancing, advocating, and directing—are presented here as a typology. These styles have some characteristics in common but differ primarily in the focus of care and preferred interactions with the CR. This study establishes a foundation for further theory development to examine the extent to which any one caregiver's cognitive and behavioral profile deviates from a primary style type. In fact, caregivers may be found to demonstrate aspects of a secondary style that can best be understood in terms of their relative weight on the dimensions of thinking and acting, much like the dimensions of thinking/feeling and acting/watching used by Kolb (1984) to conceptualize learning styles.

The investigator took several steps to assure the rigor and accuracy of the study. First, recruitment was directed at enrolling caregivers who did not regularly receive assistance from professional caregivers who might influence their personal caregiving style. Second, multiple interviewers participated in data collection, analysis, and interpretation, thus ensuring that the results reflected diverse perspectives. Third, use of a codebook added to the accuracy of the study by introducing a continual process of examining, questioning, and monitoring coding decisions and their underlying assumptions. Fourth, for a subset of caregiver participants, interview data were triangulated with direct observations of a caregiver–CR interaction. Finally, 32 (33%) of participants reviewed the study findings and confirmed their accuracy.

Limitations of the study included a disproportionate sample of healthy, White, affluent, suburban residents. This limits the extent to which the study findings can be translated to an ethnically diverse group of caregivers residing in a less affluent or more rural area. Participants were actively involved in daily care tasks for a family member with moderate impairment from ADRD, so findings may not be relevant to other points on the care trajectory. In addition, the short study time frame provides only a snapshot of the participants at a particular point in their caregiving career,

although exposure during that time was extensive. Thus, the study findings do not address patterns in behavioral and cognitive responses over time, under different circumstances, or in other care contexts. Additionally, there are likely to be many different influences on the caregiving process besides those described here. In particular, the literature identifies gender and relationship to CR as relevant to the process and outcomes of caregiving (Barber & Pasley, 1994; Pinquart & Sörensen, 2003). In this study, men are not well represented in the categories of directing style ( $n = 0$ ) and advocating style ( $n = 2$ ). Other factors important to include in future studies of caregiving style potentially include length of time caregiving, adequacy of the support network, and relationship history. Finally, a limitation exists in the subjective nature of the approach to assign caregiver to a particular style (PI rating of four questions based on consistency with a particular style). This approach was not tested and could yield different results in other contexts or by other evaluators. Empirical testing of this caregiving style typology hinges on developing valid and reliable methods for assigning style types to individual caregivers.

Despite these limitations, study findings may help to clarify the diverse responses to specific interventions or to caregiving in general. One potential application of this typology can be found in the role of caregiving style as a moderator in the relationship between an intervention's mechanisms of action and outcomes. In addition, it is reasonable to question whether concepts of caregiving style, personality, and coping are interrelated in a complex dynamic that influences well-being. Knus-sen and colleagues (2008) report that some caregivers successfully cope with responsibilities by maintaining a balanced approach with regular breaks. Two of the caregiving styles reflected these coping strategies. A balancing style included parallel activities and distant supervision to afford the caregiver small amounts of space and time necessary for coping with stressors. Both the balancing and advocating styles reflected an active, problem-solving approach to caregiving that serves as a protective factor for negative health outcomes (Di Mattei et al., 2008). An advocating style also includes strategies to build partnerships with professionals in ADRD care management, an approach promoted by many health professionals to support quality of life for both the caregiver and the CR (Brodaty & Donkin, 2009). Thus, for these two particular caregiving styles, the overall approach

and specific strategies are consistent with conditions reported in the literature as beneficial to caregiver well-being.

The concept of caregiving style provides a future framework for enhancing services to support family caregiving. The caregiving style typology represents a first step in developing a standardized caregiver style inventory that can be used to predict everyday care preferences and service needs. Caregivers may benefit from using such a tool to gain a deeper understanding of their personal care-related needs and preferences. Furthermore, the concept of caregiving styles supports a next generation “personalized” caregiving interventions, which are tailored to the unique circumstances, perspectives, and socio-cultural profile of each caregiver–CR dyad. Evidence suggests that such tailored interventions are more culturally relevant, support healthy behaviors, and reduce health disparities (Campbell & Quintiliani, 2006; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). Because tailored caregiver skill building interventions are designed to reflect the caregiver’s intrinsic attitudes and beliefs, adherence is likely to improve and the likelihood of successful outcome will increase.

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