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The Relationship Between Marital Satisfaction and Caregiver Burden in Parents Who Care for Adult Children with Development Disabilities

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THE RELATIONSHIP BETWEEN MARITAL SATISFACTION AND CAREGIVER BURDEN IN PARENTS WHO CARE FOR ADULT CHILDREN WITH DEVELOPMENT DISABILITIES

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art.
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Abstract

This study examines the relationship between marital satisfaction and caregiver burden in parents of individuals with mental disabilities. Eighteen couples (18 women and 18 men) completed a demographic questionnaire, the Index of Marital Satisfaction (IMS), and the Caregiver's Burden Scale (CBS). It was hypothesized that there would be a negative correlation between marital satisfaction and caregiver burden. The correlations between the IMS scale and CBS scale were calculated for men and women separately. Findings indicate that the correlation for the IMS scale with the CBS scale for men was not statistically significant (.246). Also, the correlation for the IMS scale and the CBS scale for women was not statistically significant (.177).

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CHAPTER I

INTRODUCTION

Unlike most fathers and mothers, parents of adults with developmental disabilities, such as mental retardation, must continue to maintain active parenting. They remain more on the giving end than the receiving end in this exchange (Essex, 2002). Often, these parents are the primary support for their children and must assist them with almost every aspect of daily living as a result of the special needs that exist. In 1993, Roberto acknowledged that the special needs of sons and daughters with mental retardation may become a source of distress for those who are caregivers (Essex, 2002). It can also be assumed that the special needs of those with other developmental disabilities are a source of distress for those caregivers as well.

In literature, many different terms have been used in reference to the distress experienced by caregivers: caregiver strain, burden, stress, psychological well-being, depression, health, and cost of care (Cousins, Davis, Turnbull, & Playfer, 2002). However, all refer to something difficult to bear emotionally and/or physically. There has been much research on the subject of caregiver burden and its causes. Wright and Aquilino (1998) concluded that providing support to adult children and others in a social network, beside a husband, contributes positively to caregiver burden. Chappell and Reid (2002) found that caregiver burden was effected directly by behavior problems of the recipient, the frequency of getting a break, the self-esteem of the caregiver, and the number of informal hours of care given by the caregiver.

Not only has the causes of caregiver burden been examined, its effects have been studied as well. Seltzer and Li (2000) performed a three-year prospective study with wives and daughters who provided assistance to a husband or parent aged 60 or older because of his aging, illness, or disability with at least one of the following activities of daily living: housework, preparing meals, finances, yard work, shopping, taking medications, getting around inside the house, eating, dressing, bathing, using the toilet, getting in and out of bed, and remembering things. This group was compared to wives who had a husband aged 60 or older, and daughters who had a parent aged 60 or older who were not in need of any care (continuing non-caregivers). Those wives and daughters who became caregivers during the study were also recognized. It was found that wives who became caregivers declined in their participation in leisure activities, assessed their family relations as less favorable, and were less satisfied with their marriage after they entered the role of caregiver than before the transition. In contrast, the continuing non-caregiving wives were relatively stable in these dimensions of social and family life. It was also concluded that continuing caregivers had poorer family relationships than continuing non-caregivers (Seltzer & Li, 2000). Wright and Aquilino (1998) found that providing care to someone with a disability and giving emotional support to members of a social network other than a husband is associated with lower martial satisfaction.

There have been others who examined marital satisfaction in relationship to being a caregiver. Griffore (1997) set out to examine whether satisfaction with marriage or relationship was associated with providing assistance to older family members. He found no significant difference between the level of satisfaction with marriage or relationship among those who assisted older persons and those who did not. Also, the level of marital/relationship satisfaction did not vary significantly with the frequency of care for an older family member. The mean rated satisfaction with marriage/relationship was not significantly different for those who had older persons living with them and those who did not.

Purpose

It has been recognized that caregivers experience burden. It is also concluded that the role of caregiver can conflict with other roles such as wife and husband, possibly effecting marital satisfaction. The purpose of this study was to expand the literature on caregiver burden and marital satisfaction by examining the potential relationship between caregiver burden of the parents of adult children with developmental disabilities and their martial satisfaction.

Statement of Hypothesis

It was hypothesized that there would be a negative correlation between marital satisfaction and caregiver burden. It was believed that marital satisfaction would be lower among those caregivers who have a higher feeling of burden.

CHAPTER II

LITERATURE REVIEW

Definitions of Caregiver Burden

Caregiving is a relationship that takes place between two individuals. A caregiver assumes the responsibility for another, the care recipient. For family members this role is often unpaid and sometimes unexpected. Caregiver burden results from the addition of the caregiving role to already assisting roles (Schene, Tessler, & Gamache, 1994).

Caregiver burden can be discussed as both objective and subjective. Data has shown that relationship to care recipient; education and co-residence with the care recipient are significant predictors of objective burden (Hughes, Giobbie-Hurder, Weaver, Kubal, & Henderson, 1999). Jones (1997) identifies the subjective burden for the parent as being related to the perception that the caregiving tasks are needed and the worry about "What will happen when I'm gone." Being blamed and being tired are other elements related to subjective burden. (Jones, 1997). Baronet (2003), while examining the impact of family relations on caregivers' positive and negative appraisal of their caretaking activities, concluded that objective burden is significantly correlated with subjective burden in caregivers. Furthermore, the presence of relationship difficulties between caregiver and the care recipient are associated with higher subjective burden (Baronet, 2003).

Caserta, Lud, and Wright (1996) examined the Caregiver Burden

Inventory (CBI), developed by Novak and Guest, in their search for further evidence for a multidimensional view of burden. The CBI measures five dimensions: time dependence, developmental, physical, social, and emotional burden. Time dependence burden develops from the time demands and restrictions that caregiving can impose on caregivers. Developmental burden describes the caregiver's feelings of being delayed in their development as compared to their peer group. Physical burden refers to the strain associated with demands on the caregiver's physical health, strength, and energy. Social burden refers to the caregiver's feelings of role conflict (Caserta, Lund, & Wright, 1996). Their findings, after studying the instrument, supported the multidimensional view of burden.

Factors Related to Caregiver Burden

Previous studies have shown that factors such as caregiver age, race, and income; relationship of the caregiver to the care recipient; co-residence with the care recipient; disease characteristics of the care recipient; and care needs of the care recipient are associated with higher levels of caregiver burden (Hughes et al., 1999). Hughes, Giobbie-Hurder, Weaver, Kubal, and Henderson (1999) identify studies that conclude that younger caregivers experience greater burden, African-American caregivers express lower levels of caregiver stress, burden, and depression, and caregivers with lower incomes experience greater stress than caregivers with higher incomes.

Gender has been found to have an effect on caregiver burden. Kramer and Kipnis (1995) found that female caregivers reported considerably higher levels of burden than male caregivers. Female caregivers reported significantly more job-caregiving conflicts of being distracted at work and having to use sick leave to fulfill caregiving responsibilities, than male caregivers. Household size was controlled for analysis in this study.

When looking at caregiver burden from a multidimensional view, Caserta, Lund, and Wright (1996) concluded that time dependence burden is strongly associated with issues regarding how much attention the recipient receives from the caregiver. Those who do not derive much satisfaction from their caregiving experience have high emotional burden. Developmental burden is most likely found in caregivers who feel deprived of doing things they want to do and expect to be doing at this point in their lives.

The bond that exists between the primary caregiver and the care receiver is also a factor that can effect caregiver burden. Lowenstein and Gilbar (2000) used the Caregiver Burden Scale, developed by Zarit et al., in their study that compared the perception of the burden of caregiving on the part of elderly cancer patients, their spouse and children. The major finding of this study was that spouses rated the overall burden of caregiving as well as personal strains heavier than the children and the patients themselves. The spouses were the primary caregivers in this study. Lowenstein and Gilbar (2000) reference Cantor's 1983 study that suggest that a closer bond exist between the primary caregiver and the care receiver. For this reason, the spouse is more involved in the caregiving tasks; therefore the burden is perceived heavier (Lowenstein & Gilbar, 2000).

In 1996, Wullschleger, Lund, Caserta, and Wright examined the relationship between caregiving burden and the caregivers' anxiety about there own aging. It was found that greater caregiver burden is associated with greater anxiety about aging on the part of family caregivers. It was also found that the degree of involvement in providing care, patient health, and caregiver satisfaction with support play an important role in caregiver burden (Wullschleger, Lund, Caserta & Wright, 1996).

Caregiver Burden and Mental Illness

In a study in 1994, Schene, Tessler and Gamache revealed that caregiver burden, in relation to severe mental illness, has been studied since the early 1950's. Studies initially began to determine if it was feasible to discharge psychiatric patients into the community. Later, studies were carried out to refine the concept of caregiving, its content, and its underlying structure. Most recently, studies have been conducted to measure (Schene et al., 1994).

The research of Baronet (1999) consisted of reviewing studies of caregiver burden associated with the care for a mentally ill relative. The resulting pattern of findings were that more objective burden was experienced as a result of tasks related to the caregiving situation than because of the disruptive behaviors of the ill relative. More subjective burden was experienced as a result of disruptive behaviors of the ill relative than because of tasks related to the caregiving situation. The highest objective burden was reported for providing transportation, help in money management, housework and cooking, the need for constant supervision, restriction in caregivers' personal activities and providing financial help. Issues of safety and possible violence of the ill individual towards self and others, excessive demands and high dependency toward caregiver, night disturbances, embarrassing behaviors, symptomatic behaviors, worries about the future, and uncooperative attitudes leading to conflicts and family hardship are items that produce the highest subjective burden (Baronet, 1999).

Findings have shown that burden is significantly higher among parents whose offspring were hospitalized for longer periods of recent time and who rated their offspring as having more unmet needs (Cook, Heller, & Pickett-Schenk, 1999).

In 1999, Schwartz and Gidron (2002) conducted a study with Jewish parents living in Israel and caring for adult children with mental illness. The adult children resided in the home with the parents. It was found that higher levels of objective burden (hardships parents felt their caregiving entailed) and the severity of illness was related to higher levels of subjective burden (mental pain).

Mental Illness versus Developmental Disabilities

Mental illness is an illness that affects or is manifested in a person's brain. It is a condition other than epilepsy, senility, alcoholism or mental deficiency. It may effect the way people think, behave, and interact with others. The term "mental illness" encompasses numerous psychiatric disorders and can vary in severity. Mental illnesses are real illnesses that require and respond well to treatment (American Psychiatric Association, 2003, What is Mental Illness, para. 1).

The term developmental disabilities mean severe, chronic or unending disabilities of a person that is attributed to a mental or physical impairment or combination of mental and physical impairment. A developmental disability is apparent before the person attains the age of twenty-two and is likely to continue indefinitely. The developmental disability results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, mobility, self-direction, capacity of independent living, and economic self-sufficiency. Also, a person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration are reflected (Atlanta Alliance on Developmental Disabilities, 2003, Definition of Developmental Disabilities, para. 1).

Definition of Marital Satisfaction

There have been four recent, important developments regarding marital satisfaction. For one, the idea that factors that lead to marital satisfaction may not be the opposite of those that lead to marital dissatisfaction. Secondly, marital satisfaction should not necessarily be viewed as a continuum. The idea that as satisfaction increase, dissatisfaction increase and vice versa can be a delusion. There has been argument that the two, marital satisfaction and marital satisfaction, should be evaluated independently. The separate evaluation allows for the prediction of different things. Thirdly, marital satisfaction can fluctuate over time. Lastly, marital satisfaction is being looked at in relation to the accessibility of marital satisfaction for individuals and the role of their cognitions. Accessibility refers to that strength of the bond between that couple and their rating of marital satisfaction (Marital Satisfaction, Marital Conflict and Qualities of Successful Marriages, 2003, p. 1). Qualities of a successful and often satisfying marriage are as follows: commitment, honesty, trust, fidelity, responsibility, adaptability, flexibility, tolerance, unselfishness, communication, empathy, sensitivity, admiration, respect, affection, companionship, ability to deal with stress; and shared spirituality, values and philosophy of life (Marital Satisfaction, Marital Conflict and Qualities of Successful Marriages, 2003, p. 7-8). Marital satisfaction is said to decline in the first 2 to 3 years of marriage (Billideau, 1997, ¶ 2).

Factors Effecting Marital Satisfaction

The following are factors that contribute to a happy marriage:

- Pre-marital views and personality types can indicate marital satisfaction in later years.
- Autonomy and relatedness are positively correlated with each other and more significantly to marital satisfaction.
- Parental stage of childlessness has proven to positively influence marital satisfaction for both spouses.

These factors definitely influence marital satisfaction; however, they are not the sole contributors (Billideau, 1997, ¶ 6).

Marital Satisfaction and Assisting Family Members

Griffore (1997) was unable to identify a significant difference in scores on level of satisfaction with marriage or relationship for individuals who assisted older persons and individuals who did not. Levels or satisfaction with marriage or relationship did not significantly vary with frequency of care for an older family member and mean rated satisfaction with marriage relationship was not significantly different for those who had the older person living with them and those who did not (Griffore, 1997).

Willoughby and Glidden (1995) explored the relationship between the division of child care and marital satisfaction in couples raising children with disabilities. Data was collected from married couples who were rearing at least one child diagnosed with, or at risk for, a developmental disability. The mean of the score for the division of child care suggested that the fathers participated in less child care activity than the mothers. There was no significant difference in marital satisfaction between mothers and fathers. The father's participation in child care was significantly correlated with marital satisfaction for both the mother and father. The child's level of functioning did not significantly predict marital satisfaction for either parent (Willoughby and Glidden, 1995).

Marital Relationship, Parent-Child Relationship, and the Effects

Many studies have been conducted regarding the effect of the marital relationship on the child and their relationship with the parents. However, little can be found regarding its effect on adult children residing in the household with their parents. Even less can be found regarding the effects on adult children with developmental disabilities residing in the household with their parents. However, it is possible that the findings regarding the effects of the marital satisfaction on children, individuals being cared for, and their relationships may be generalized to this population who are also individuals being cared for. Such studies are as follows:

Shek (1998) studied the relationship between marital quality and child-parent relationship. He defined marital quality by examining marital adjustment and marital satisfaction. Parent-child relational quality and demand was used to examine the parent-child relationship. This study was conducted with 378 Chinese couples over a two-year period. Generally, findings showed that those with better marital quality had a higher level of parent-child relational quality and a lower lever of parent-child relational demands. It was also revealed that those couples who had better marital satisfaction during the first evaluation experienced a better parent-child relationship quality during the second evaluation. Shek's (1998) finding support the thesis that marriage influences parent-child relationships receive more support than the notion that parent-child relationship influences marriage.

Katz and Woodin (2002) examined whether conflict engagement, conflict avoidance, hostility, and hostile detachment in the marriage are associated with differential aspects of child and family adjustment. Their findings suggest that the combination of hostility and detachment within the marital relationship is the most destructive form of marital conflict and is associated with maladjustment throughout many levels of the family system. The level of marital satisfaction or marital violence could not explain these findings. Hostility and detachment in the marital relationship is also related to the couples' ability to parent and co-parent after an argument. The mixture of hostility and withdrawal appear to be the most destructive to the child and family functioning (Katz & Woodin, 2002).

Wang and Crane (2001) examined the relationship between parents' marital satisfaction and depression in the children of that relationship. Their study revealed that the father's scores regarding marital satisfaction, stability, and triangulation has an impact on childhood depression symptoms; however, the mother's does not. They explain these findings by the role in child-rearing practices and differences in conflict resolution. It is believed that a mother, being the primary caretaker, is socially expected to be available for her children regardless of her own problems. They have developed the ability to separate their roles as wives and as mothers, thus excluding the impact of their marital relationship on their role as mother. When a man feels dissatisfied with his marriage, he is more likely to channel his attention and energy outside of the family to his role of family provider. Futhermore, in this study, the nuclear triangulation was found to be an important variable. The father's perception of the triangulation is significantly associated with their child's depression score as well as was moderated by their marital stability. When the father experiences lower marital satisfaction and perceived family triangulation, their child had the highest depression score. The least depression symptoms were shown when triangulation was absent even though marital satisfaction was low (Wang & Crane, 2001).

Kitzmann (2002) examined the effect of martial conflict on children through disruptions in family alliances and parenting. She focused on family variables that may mediate the link between marital conflict and child outcomes. The following is one of the questions that were asked of this study: Were family interactions more disrupted after the conflictual marital exchange than after the pleasant marital exchange? Findings showed less cohesion in family interaction and more unbalanced alliance after a conflictual marital exchange than after the non-conflictual exchange. More families showed balanced alliances after the pleasant marital discussion but disrupted alliances after the conflictual marital discussion. There were no significant mean differences in the level of overall family negativity or overall family warmth in the interactions following the two types of marital discussions (Kitzmann, 2000).

Chapter III

Methods

Participants

Participants were 18 couples (18 women, and 18 men) whose children receive support from a social service agency that services individuals with developmental disabilities. For men, 88.9% (n=16) reported being Caucasian, and 11.1% (n=2) reported being African American. The mean age for men was 57, and 55.29 for women. Also, for women, 88.9% (n=16) reported being Caucasian, and 11.1% (n=2) reported being African American. As for the educational level for men, 5.6% (n=1) reported finishing high school, 27.8% (n=5) reported finishing a two-year college, 22.2% (n=4) reported finishing a four-year college, and 44.4% (n=8) reported attending graduate school. As for the educational level for women, 27.8% (n=8) reported finishing high school, 16.7% (n=3) reported finishing a two-year college, 33.3% (n=6) reported attending a four-year college, and 22.2% (n=4) reported attending graduate school.

In regards to the men in this study identifying the developmental disability of their child, 27.8% (n=5) identified their child as being diagnosed with Mild Mental Retardation, 22.2% (n=4) have a child diagnosed with Moderate Mental Retardation, 5.6% (n=1) have a child diagnosed with Educable Mental Retardation, 11.1% (n=2) have a child diagnosed with Borderline Intellectual Functioning, 11.1% (n=2) have a child diagnosed with Down Syndrome, 5.6% (n=1) has a child diagnosed with a learning disability, 11.1% (n=2) have a child diagnosed with ADHD, and 5.6% (n=1) have a child diagnosed with Autism. As for the women, 33.3% (n=6) identified their child as being diagnosed with Mild Mental Retardation, 22.2% (n=4) have a child diagnosed with Moderate Mental Retardation, 5.6% (n=1) have a child diagnosed with Educable Mental Retardation, 11.1% (n=2) have a child diagnosed with Borderline Intellectual Functioning, 11.1% (n=2) have a child diagnosed with Down Syndrome, 11.1% (n=2) have a child diagnosed with ADHD, and 5.6% (n=1) have a child diagnosed with Autism.

Possible sources of sampling bias include the fact that all who participated in the study were volunteers. This was a convenience sample in that the researcher had access to the population who receives support services from a local non-for-profit organization that offers services to individuals with developmental disabilities. The responses of this population may differ from those families who do not receive outside support.

Instruments

The Caregiver's Burden Scale (CBS, Appendix c) is used to measure a caregiver's feeling of burden. The instrument contains a 29-item scale design and was initially designed to measure the feelings of burden experienced by caregivers of elderly person with senile dementia. The items for the CBS were selected based on clinical experience and prior research mentioned by caregivers as problems. The CBS provides the opportunity for a systematic assessment of caregivers' perceptions of burdens (Corcoran & Fischer, 2000).

The CBS was initially studied with 29 elderly people with senile dementia and their 29 primary caregivers. The mean age of the elderly was 76 with 16 males and 13 females. Of the 29 caregivers, only four were male; they had a mean age of 65 years. Respondents were recruited for a research and training center offering services to older persons. The mean score for the total sample of caregivers was 30.8 with a standard deviation of 13.3. For daughters as caregivers, the mean score was 28.3 (SD=14.6) and for spouses as caregivers, the mean score was 32.5 (SD=13.4) (Corcoran & Fischer, 2000).

The CBS is a questionnaire that is scored on a 5-point sliding scale with scores on the items summed for the total scores. Items 14, 16, 20, and 29 are reverse-scored and subtracted from the total. Where the spouse is not the primary caregiver, the term spouse on the CBS can be replaced with the appropriate relationship. Scores range from 0 to 116 (Corcoran & Fischer, 2000).

No data on reliability was reported on this scale. There were no significant correlations between feelings of burden and extent of behavior impairment or duration of illness. There was a low (.48) but significant negative correlation between the CBS and the frequency of family visits, a form of concurrent validity (Corcoran & Fischer, 2000).

The second scale used in this study was the Index of Marital Satisfaction (IMS, Appendix D). The IMS measures problems in the marital relationship. The IMS is a 25-item instrument designed to measure the degree, severity, or magnitude of a problem one spouse or partner has in the martial relationship. The

IMS has two cutting scores. The first is a score of 30 (± 5). Scores below this point indicate absence of a clinically significant problem in this area. Scores above 30 suggest the presence of a significantly significant problem. The second cutting score is 70. Scores above this point nearly always indicate that the clients are experiencing severe stress with a clear possibility that some type of violence could be considered or used to deal with problems (Corcoran & Fischer, 2000).

The IMS respondents who participated in the development of this scale included single and married individuals, clinical and non-clinical populations, high school and college students and non-students. Respondents were primarily Caucasian, but also included Japanese and Chinese Americans, and a smaller number of other ethnic groups. Actual norms are not available (Corcoran & Fischer, 2000).

The IMS is scored by first reverse scoring items 1, 3, 5, 8, 9, 11, 13, 16, 17, 19, 20, 21, and 23, summing these and the remaining scores, subtracting the number of completed items, multiplying this figure by 100, and dividing by the number of items completed times 6. This will produce a range from 0 to 100 with higher scores indicating greater magnitude or severity of problems (Corcoran & Fischer, 2000).

The IMS has a mean alpha of .96, indicating excellent internal consistency, and an excellent (low) Standard Error of Measurement of 4.00. The IMS also has excellent short-term stability with a two-hour test-retest correlation of .96. The IMS has excellent concurrent validity, correlating significantly with the Locke-Wallace Marital Adjustment Test. The IMS also has very good known-groups validity discriminating significantly between couples known to have marital problems and those known not to. The IMS also has good construct validity, correlating poorly with measures with which it should not correlate, and correlating significantly with several measures with which it should correlate, such as sexual satisfaction and marital problems (Corcoran & Fischer, 2000).

Procedure

The participants in this study were volunteers. Most of the participants in this study were the parents of individuals receiving support services from a local non-for-profit organization that serves individuals with developmental disabilities. The researcher is an employee of this organization and was given verbal permission to contact parents of individuals in the program that she worked with. Other participants were identified via the researcher's acquaintances outside of the workplace.

All potential participants were initially contacted via phone and given a brief verbal description of the study. They were informed that the study was strictly voluntary and was in no way related to the organization for which the researcher works. If the potential participant voiced interest in participating in the study, a cover letter (Appendix A), two demographic information forms (Appendix B), two CBS (Appendix C), two IMS (Appendix D), and a stamped self-addressed return envelope was mailed. One set of demographic information, the CBS, and IMS was intended for the wife and the other set for the husband. Two weeks after the packet of information was mailed, a reminder letter was sent to the potential participants. This information was mailed to a total of 39 couples (39 men and 39 women).

Each set of scales had corresponding numbers on the bottom of the page. These numbers were used for the sole purpose of matching couples. The identity of all participants remained anonymous.

Chapter IV

Results

The hypothesis of this research was that there would be a correlation between the marital satisfaction and caregiver burden.

To test this hypothesis, we calculated the correlation coefficients between the scores on the IMS scale and the CBS scale for the total sample, and then for the couples. The analysis was conducted with 18 couples. Three women were removed from the sample because their husbands did not complete the surveys. Also, due to extreme scores, two other participants were removed from the sample and their scores were not used in the further analysis.

Descriptive Statistics

The means and standard deviations for the IMS scale and CBS scale for men are listed in Table 1.

Table 1

Means and Standard Deviations for the IMS scale and CBS scale for Men (n=18).

Variable	N	Mean	Median	SD
IMS	18	13.11*	9.00	11.077
CBS	18	35.67**	32.00	16.022

* Possible range from 0-100.

** Possible range from 0-116.

The means and standard deviations for the IMS scale and the CBS scale for women are listed in Table 2.

Table 2

Means and Standard Deviations for the IMS and CBS scale for Women (n=18)

Variable	N	Mean	Median	SD
IMS	18	14.67*	14.34	11.190
CBS	18	39.06**	36.00	14.956

* Possible range 0-100.

** Possible range from 0-116.

The correlations between the IMS scale and CBS scale were calculated for men and women separately. The correlation for the IMS scale with the CBS scale for men was not statistically significant at .246. Also, the correlation for the IMS scale and the CBS scale for women was not statistically significant at .177.

Furthermore, the paired samples correlations were calculated for the couples. The correlation between the IMS scores for husbands and wives was a medium correlation at .357. However, the correlation for the CBS scores for husbands and wives was significant at .632 ($p<.05$).

Paired samples t-test was calculated for the IMS scores and CBS scores. The results demonstrated no significant correlation between the IMS scores for men and women ($t(17) = -.325$, $p = .749$). Also, there was no significant relationship between the CBS scores for men and women ($t(17) = -.872$, $p = .395$).

Chapter V

Discussion

This study found that there is no significant correlation between caregiver burden and marital satisfaction for men. Nor is there a significant correlation between caregiver burden and marital satisfaction for women. Griffore (1997) would agree that caregiver burden does not have a significant effect on marital satisfaction. Griffore looked at marital and relationship satisfaction of individuals assisting older family members. He compared this group with individuals who did not offer assistance to older family members. Griffore (1997) found that there was not a significant difference in scores on the level of satisfaction with marriage and relationship for 193 individuals who assisted older persons and 550 individuals who did not.

There is a medium, but not significant correlation of marital satisfaction for husbands and wives. These findings are consistent with those of Essex. While examining whether affective relationships between parents and their adult children with mental retardation differ by parental gender, Essex (2002) compared mothers and fathers on mean differences in their feelings of affective closeness with their adult children and on the factors associated with those feelings. He found that there were no significant differences between mothers and fathers in instrumental characteristic, their reports of the adult child's behavior problems, or marital satisfaction.

There is no significant correlation between men and women regarding caregiver burden. There is also no significant correlation between men and women regarding marital satisfaction. However, there is a significant positive correlation between husbands and wives for caregiver burden. This meaning that as caregiver burden increases for one spouse, it increased for the other.

In a past study, Wright and Aquilino (1998) found that providing care to someone with a disability and giving emotional support to members of the social network other than a husband is associated with lower marital satisfaction. This was not true for the population in this study. The mean score for men on the IMS was 13.11. The mean score for the women on the IMS was 14.67. Possible scores range from 1-100. Higher scores indicate a greater degree of dissatisfaction with a marriage. Any score below 30 represents the absence of clinically significant scoring.

Study Limitations

The findings of this study must be viewed in light of several survey limitations. The study was vulnerable to sampling error. The sample was small in number and consisted mostly of families receiving support from a local non-for-profit organization that offer services to individuals with developmental disabilities. The levels of caregiver burden and its effect on marital satisfaction may have been altered if more individuals who are not receiving outside supports were included in the study. Cook, Heller, and Pickett-Schenk (1999) found that support group participation is associated with significantly lower burden when adjusting all other factors. Lastly, all study participants were volunteers.

With one of the returned surveys, the researcher received a letter from a parent. The parent indicated that she was "happy" to fill out the surveys for the study; however she felt that the CBS gave the impression that all children with disabilities are a burden to their parents and families. She stated that this is not case in her life. It is possible that other parents viewed this survey as negative and responded in a way to compensate. This could have produced bias data.

Future Studies

In the future in may be beneficial to examine caregiver burden and its effect on marital satisfaction in relation to other factors. One potential factor to examine is race. Studies have shown that African-American caregivers are significantly more likely than Caucasian or Hispanic caregivers to be providing a higher intensity of care. Compared with Caucasian caregivers, African-American caregivers are significantly less likely to be primary caregivers and to report difficulty with providing care, but are more likely to report having unmet needs with care provision and the experience increased religiosity since becoming a care giver. Similarly, Hispanic caregivers were more likely than Caucasian caregivers to report having unmet needs with care provision, to receive help from formal caregivers, and to experience increased religiosity since becoming a caregiver (Navaie-Waliser, Feldman, Gould, Levine, Kuerbis, & Donelan, 2001). It would be interesting to find out how that race of parents of adult children with disabilities effect the relationship between caregiver burden and marital satisfaction.

It would also be interesting to examine various age groups. Would findings of the effect of caregiver burden and marital satisfaction be different for younger couples as oppose to longer couple?

This study did not take into consideration whether or not the adult children with developmental disabilities lived with the parents or outside of the home. This is another factor that could be examined in relation to caregiver burden and marital satisfaction. Miltiades and Pruchno (2001) conducted a follow up study with 472 mothers who have adult children 22 years of age or older with mental retardation. They found that mothers experienced burden regardless of their living arrangements; however, those whose children were place outside of the home or who did not co-reside with their child, were less burdened. These findings are limited to mothers whose children have some degree of cognitive impairment. Therefore, these results may not generalize to mother with adult children who have developmental disabilities where cognitive limitations are not necessarily a problem. Cerebral palsy would be an example (Miltiades & Pruchno, 2001).

In the United States, there are more than 3 million individuals who have developmental disabilities (Atlanta Alliance on Developmental Disabilities, 2003, Definition of Developmental Disabilities, para. 2). Often, parents are the primary supports for their children. This situation can be both fulfilling and stressful for both parties. In many situations, the stressful aspect of the relationship, in respect to both parties, began to negatively effect other aspects on the involved parties lives. Continued research surrounding individuals with developmental disabilities and the effect of their disabilities on daily existence are needed. Growth can only be accomplished when problems are identified and intervention occurs. Sorensen, Pinquart, and Duberstein (2002) examined how effective interventions are with caregivers. They divided caregiver interventions into two categories: those aimed at reducing the objective amount of care provided by the caregivers and those aimed at improving the caregiver's well being and coping skills. It was concluded that all caregiver interventions taken together produced a significant improvement in the level of caregiver burden. Additional knowledge and understanding of caregiver burden and other issue effecting individuals with developmental disabilities their families are needed.

APPENDIX A

Dear Survey Participants,

I, JuJuane Easter, am a Master level student at Lindenwood University. Currently, I am conducting a study on the marital satisfaction of the caregivers of individuals with mental disabilities. I appreciate your willingness to participate.

Enclosed you will find two sets of questionnaires. There is a set for each spouse. The questionnaires are designed to obtain information regarding perceived level of burden, as well as, perceived level of satisfaction within your martial relationship. It is important to note that your responses will be anonymous and the information you provide will be confidential. This study has been approved by the university's counseling department.

The enclosed questionnaires should be filled out independently and returned separately. DO NOT PUT YOUR NAME ON THE QUESTIONNAIRES. You will notice a numerical code (i.e. 001, 002, etc.) on the bottom of each questionnaires. These codes are used solely to match couples not to identify participates.

I realize that your schedule is busy and your time is valuable. However, I hope that you will take 15–20 minutes to complete the questionnaires and return them within two weeks of your receipt. I have provided you with two stamped, self-addressed return envelopes for your convenience.

Thank you in advance for your participation. Upon the completion of the study, all participates will receive a summary of the results. If you have any questions regarding the study, please feel free to contact me at (314) 741-7949.

Thanks Again,

JuJuane Easter
Professional Counseling Student
Lindenwood University

APPENDIX B

DEMOGRAPHIC INFORMATION

Please complete the following information.

Sex:	Male/Female
Ethnicity:	Caucasian/African-American/Hispanic/Other
Age:	_____
Education Level:	High School/2-year college/4-year college/graduate school
# of years married:	_____

Child's Diagnosis (i.e. mental retardation (mild, moderate, or severe), borderline intellectual functioning, schizophrenia, etc.)

____

APPENDIX C

CBS

The following is a list of statements which reflect how people sometimes feel when taking care of another person. In the space beside each statement, please indicate how often you feel that way using the following scale:

0 = Never
1 = Rarely
2 = Sometimes
3 = Quite frequently
4 = Nearly always

1. _____Feel resentful of other relatives who could but do not do things for my child.
2. _____I feel that my child makes requests which I perceive to be over and above what he/she needs
3. _____Because of my involvement with my child, I don't have enough time for myself.
4. _____I feel stressed between trying to give to my child as well as to other family responsibilities, job, etc.
5. _____I feel embarrassed over my child's behavior.
6. _____I feel guilty about my interactions with my child.
7. _____I feel that I don't do as much for my child as I could or should.
8. _____I feel angry about my interactions with my child.
9. _____I feel that in the past, I haven't done as much for my child as I could have or should have.
10. _____I feel nervous or depressed about my interactions with my child.
11. _____I feel that my child currently affects my relationships with other family members and friends in a negative way.
12. _____I feel resentful about my interaction with my child.

13. _____I am afraid of what the future holds for my child.

14. _____I feel pleased about my interactions with my child.

15. _____It's painful to watch my child grow older.

16. _____I feel useful in my interactions with my child.

17. _____I feel my child is dependent.

18. _____I feel strained in my interaction with my child.

19. _____I feel that my health has suffered because of my involvement with my child.

20. _____I feel that I am contributing to the well-being of my child.

21. _____I feel that the present situation with my child doesn't allow me as much privacy as I like.

22. _____I feel that my social life has suffered because of my involvement with my child.

23. _____I wish that my child and I had a better relationship.

24. _____I feel that my child doesn't appreciate what I do for him/her as much as I would like.

25. _____I feel uncomfortable when I have friends over.

26. _____I feel that my child tries to manipulate me.

27. _____I feel that my child seems to expect me to take care of him/her as if I were the only one he/she could depend on.

28. _____I feel that I don't have enough money to support my child in addition to the rest of our expenses.

29. _____I feel that I would like to be able to provide more money to support my child than I am able to now.

APPENDIX D

IMS

This questionnaire is designed to measure the degree of satisfaction you have with your present marriage. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. _____My partner is affectionate enough.

2. _____My partner treats me badly.

3. _____My partner really cares for me.

4. _____I feel that I would not choose the same partner if I had it to do over again.

5. _____I feel that I can trust my partner.

6. _____I feel that our relationship is breaking up.

7. _____My partner really doesn't understand me.

8. _____I feel that our relationship is a good one.

9. _____Ours is a very happy relationship.

10. _____Our life together is dull.

11. _____We have a lot of fun together.

12. _____My partner does not confide in me.

13. _____Ours is a very close relationship.

14. _____I feel that I cannot rely on my partner.

15. _____I feel that we do not have enough interests in common.

16. _____We manage arguments and disagreements very well.

17. _____We do a good job of managing our finances.

18. _____I feel that I should never have married my partner.

19. _____My partner and I get alone very well together.

20. _____Our relationship is very stable.

21. _____My partner is a real comfort to me.

22. _____I feel that I no longer care for my partner.

23. _____I feel that the future looks bright for our relationship.

24. _____I feel that our relationship is empty.

25. _____I feel there is no excitement in our relationship.

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