

*Expert Commentary C*

## CAREGIVER'S ANGER

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Although everybody widely believes that we simply “dump” frail elderly people into nursing homes, numerous studies demonstrate that nursing home residents are more severely ill, older, and less likely to have children or other relatives available to care for them than those living at home.

The growth of interest in family caregivers has been phenomenal. Before the 1980s there were only a few caregiving studies. Now family caregiving studies dominate gerontological meetings and journals all around the world. Despite periodic questioning of the merits and utility of the vast number of publications focused on family caregivers by key scholars in this field, the number of studies of caregiving has not diminished. This interest in caregiving reflects the confluence of social trends that have made caregiving a normative and stressful event in people's lives. Given the essential importance of families in the long-term care, this interest is, without any doubt, necessary. But if we reflect on what we have learned and what might be the direction for future research, we must recognize that much of the research to date has been focused on how much stress is experienced by primary caregivers and which are the factors correlated with this stress. The point that caregiving is stressful for primary caregivers is now well-established. There is great evidence that caregivers feel high levels of burden, depression and anxiety. Nevertheless, we have less evidence about anger feelings experienced by these caregivers. A disproportionate emphasis has been placed on burden and depression, while studies of anger have received minimal attention. We need more primary caregivers studies focused on anger.

We also need to focus on the whole family. Most of what we know about “family” caregiver's anger comes from one person, the primary caregiver. We know other people are often involved in helping, and that increases the involvement of other family members as well as non-kin can be very helpful.

We are in need for longitudinal studies, particularly at the earliest points of providing care. Much of the research on caregiver's anger still involves cross-sectional or very short-

term longitudinal panels. Cross-sectional studies can obscure the sequence of events that lead to the evolution of caregiver's anger. Some of our causal hypotheses may be more complex than we believe. Longitudinal studies that begin near the onset of caregiving could help us more fully understand how experience of anger change over time, and which are the predictors of this emotion.

There is a continuing need for intervention research. Intervention research can lead to practical benefits for caregivers, but it can also be used to test theories about stressors and the processes that contain them. Caregivers' interventions are complex and diverse. The literature has evolved from descriptions of clinical supportive efforts aimed at addressing individual caregiver needs more scientific evaluations of controlled intervention studies. Nevertheless, most qualitative studies report that caregivers find anger intervention programmes helpful, and the results of controlled trials have not produced consistent evidence of benefit.

The grassroots movement that led to formation of the caregiver organizations grew in many cases from community-based support groups, where people with common problems came together to learn from one another and share coping strategies. Much of the early intervention research focused on these groups. When compared to control conditions, people in support groups were found to have modest or no benefit in anger outcomes.

The type of help that most caregivers use is respite services, such as paid homemaker services, part-time Visiting Nursing assistance, or adult day care centers. Results of randomized trial of respite services were minimal. Respite was not helpful to reduce anger. It may be difficult to address individual caregiver needs within group situations or a respite network.

Psychoeducational interventions have also modest therapeutic benefits as measured by global ratings of anger. Generally such interventions offer educational components in a preventive framework, because they operate on the assumption that caregiver's anger is the result of lack of knowledge or learning. Information or knowledge is a necessary requisite for the acquisition of problem solving or behavioural skills, but knowledge alone does not necessarily alleviate anger.

Psychotherapeutic interventions have achieved small to moderate statistically significant effects on anger. These types of interventions apply psychotherapeutic principles to reduce caregiver anger. Most psychotherapeutic interventions follow a cognitive-behavioral approach, where trained professionals may challenge negative thoughts, help caregivers develop problem-solving abilities, and help the caregiver reengage in pleasant activities and positive experience.

Anyone expecting to find a silver bullet solution to alleviating caregiving anger will clearly be disappointed by the intervention literature in caregiving. There is no single, easily implemented and consistently effective method for eliminating the caregiver's anger. This is not surprising given the complexity of the caregiving experience and the variability in caregiver resources. At this point, the most reasonable conclusion is that we need more individually-tailored treatments that take into account a person's care situation, care relationship, and cultural and ethnic background, because these interventions are likely to be more effective than those which are not.

We need clearly articulated, theoretically based interventions with stronger research designs. Most of the interventions targeted to reduce caregiver's anger are fraught with methodological deficiencies that include the use of weak experimental design, problematic sampling and randomization strategies and the use of inadequate measures of anger (i.e.

measures used to detect anger varied widely in their psychometric properties). Many caregivers' anger intervention studies used pre-post designs with a single condition or quasi-experimental designs without random assignment conditions. Although these studies reported positive outcomes, design flaws limited the confidence that could be placed in the findings. Also, the small convenience samples made it difficult draw any definitive conclusions about the effectiveness of intervention programs. Participants are generally volunteer samples, often self-selecting the intervention over an alternative. Nonrandom assignment of participants to intervention and non-intervention groups may lead the more angry caregivers to self-select into the intervention groups. Furthermore, many of the studies involved recruiting participants from a population who was already attending support groups. This raises the question of selection bias.

There are a number of other issues that have not always been considered in the design of anger intervention studies. For example, a) in some studies data collectors have not been kept blind to study hypotheses, b) some studies provide no information about individuals who refuse to participate and those who agree to participate but who drop out before the study is completed, c) some studies don't offer a clear specification of intervention protocols; treatment need to be described, measured and monitored to insure that caregivers are receiving the treatment as prescribed and to permit replication of treatment effects with similar groups of caregivers.

Finally, research and practice on family caregiving needs to continue to consider the social and policy implications. Caregiving is one of the unexpected and still unplanned for consequences of an ageing population. Although policy advocates and policy makers are well aware of caregiving issues it remains one of many competing demands on the public's and government's attention.

Caregiver's anger research has shown a tremendous growth in quality, as well as in breadth and depth. Because of the continued importance of informal caregivers in the lives of frail older people and because the number of frail older adults is increasing rapidly, it is likely that new anger studies will be developed at a rapid pace.