A Proposed Theoretical Framework
Addressing the Effects of Informal Caregivers on Health-Related Outcomes of Elderly Recipients in Home Health Care

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Purpose  The purpose of this review is to develop a theoretical framework addressing the effects of informal caregivers on health-related outcomes of elderly recipients in home health care.

Methods  The investigator a) reviewed theories and literature related to informal caregiving and health-related outcomes of elderly recipients, b) critiqued the strengths and limitations of these theories and literature for research in this area, and c) developed a new conceptual framework by deductively applying these theories and literature to the effects of informal caregivers on health-related outcomes of elderly recipients in home health care.

Results  Social network theories, social support theories, and the literature on informal caregiving are useful in understanding how informal caregivers affect the outcomes of elderly recipients in home health care. This review synthesizes these theories and literature into a new theoretical framework in order to fully address the effects of informal caregivers on health-related outcomes of elderly recipients in home health care.

Conclusion  The proposed theoretical framework suggests that health-related outcomes of elderly recipients are the result of interactions among types of informal caregivers, the nature of the caregiving relationship, caregiving as a function of such relationships, and the internal processes of the care recipient. [Asian Nursing Research 2007;1(1):23–34]

Key Words  aged, caregiving, home health care, informal caregivers, social support

INTRODUCTION
A number of studies have been conducted to evaluate the outcomes of older adults who receive formal home health care (HHC). However, the research does not consider the potential variability in the outcomes of older adults by informal caregivers. Since a great deal of in-home care is provided by informal caregivers, the development of knowledge about the effects of informal caregivers on the outcomes of elderly recipients is vital. Informal caregiving is provided to older adults in a wide variety of relationships (e.g., spouse, son or daughter, other relatives, or non-relative caregiver)
that can differ tremendously in terms of quantity and quality. Thus, the various informal caregiving relationships may cause differential outcomes in elderly recipients, but there is limited research in this area. In spite of the enormous amount of caregiving literature, research regarding informal caregivers has focused largely on caregiver experiences such as caregivers’ stress and burden (Bakas, Pressler, Johnson, Nauser, & Shaneyfelt, 2006; Nijboer et al., 2000; Pinquart & Sorensen, 2006) and effects of formal HHC services on informal caregivers (Brodaty, Green, & Koschera, 2003; Pinquart & Sorensen, 2006b). Only a few researchers have examined the effects of informal caregivers on the health-related outcomes of elderly recipients. If we are to fully understand the outcomes of elderly recipients in HHC, we need to take into account the effects of the various types of informal caregivers on elderly recipients.

Research is limited due to a lack of theoretical frameworks that may explain how health-related outcomes among elderly recipients are affected by informal caregivers and what variables should be explored. A theoretical understanding is imperative in systematically understanding and evaluating the effects of informal caregivers on the outcomes of elderly recipients. Thus, the purpose of this review is to develop a theoretical framework addressing the effects of informal caregivers on health-related outcomes of elderly recipients in HHC.

METHODS

An electronic database search of MEDLINE (1966 to February 2006), CINAHL (1982 to February 2007), and PsycINFO (1887 to February 2007) was performed. Key terms used were: older adults, aged, home care, home health care, home care services, caregivers, informal caregivers, family caregivers, home nursing, informal care. The search was limited to articles published in English. The inclusion criteria for the studies were: a) reported who the caregivers are; b) reported what health-related outcomes are achieved for the care recipients; c) care recipients are elderly patients (≥ 65); and d) received care in the patient’s home.

The literature was reviewed to identify applicable theories to evaluate the effects of informal caregivers on health-related outcomes of elderly recipients in HHC. Social network theories and social support theories were selected because these theories are predominantly used in the literature and they capture important aspects of adapting to the effects of informal caregivers on the outcomes of the elderly recipients. Analysis and critique of these theories were conducted for use in research on the effects of informal caregivers on the outcomes of the elderly recipients. Simultaneous analysis and critique of the literature on informal caregiving provided several concepts that had the potential to enhance the understanding of the effects of informal caregivers on health-related outcomes of elderly recipients in HHC. These theories and literature were synthesized into a new theoretical framework addressing the effects of informal caregivers on health-related outcomes of elderly recipients in HHC.

For the purpose of this analysis, care recipients were defined as persons ≥ 65 years of age, and who receive care from informal caregivers. Informal caregivers were defined as non-paid individuals who are primarily responsible for providing and/or coordinating care in the home, such as a spouse, offspring, other relative, and non-relative caregivers (friends, neighbors). This analysis considered HHC as the delivery of health and social services provided by formal caregivers in the client’s home. Formal caregivers are paid professionals or paraprofessionals such as nurses, physicians, HHC aides, dietitians, and therapists who provide assessment, education, support, and therapeutic care. HHC includes skilled nursing care, home health aide services, therapeutic treatments such as physical, occupational, and speech language therapies, and other medical social services.

Literature review

Older adults face many health problems as they age. Various kinds of caregiving relationships ensure that older adults can stay at home while requiring health care. Researchers have tried to describe the various types of caregiving relationships. Social network theories, social support theories, and the literature
on informal caregiving have described the caregiving relationships, even though they have conceptualized this relationship in different ways.

**Social network theories**

A social network is defined as “the number, frequency and linkages of contacts with other individuals or groups” (Worcester, 1990, p. 140). Social network theories propose that social interactions between individuals lead to heterogeneous relationships that have different levels of supportiveness (Pierce, Sarason, & Sarason, 1991). There are two main social network theories: task-specific theory and hierarchical-compensatory theory.

**Task-specific theory** categorizes social network groups as primary, informal, and formal groups (Litwak, 1985). According to this theory, each social network has different natures, and because of these different natures of social networks, each network group can optimally manage different tasks (Litwak, 1985; Messeri, Silverstein, & Litwak, 1993). This theory also emphasizes that most people have various needs, and it is necessary for both formal groups and primary/informal groups to cooperate in most areas of life (Messeri et al.). In addition, the provision of aid varies across different relationships even within the primary groups such as spouses, offspring, relatives, and non-relatives. For example, spouses typically live together. Therefore, they continuously have face-to-face contact, and can provide social support over a long period of time. On the other hand, neighbors live close by and primary contact is face-to-face, but unlike spouses, they typically do not provide long-term commitments (Messeri et al.).

**Hierarchical-compensatory theory** focuses on the importance of recipients’ preferences. According to this theory, older adults seeking help have an ordered preference based on “the primacy of the relationship between the caregiver and elderly recipient” (Messeri et al., 1993, p. 123). Older adults prefer the assistance of spouses when they are not available, they turn first to children, second to other relatives, third to friends or neighbors, and last to formal groups (Cantor, 1991; Messeri et al.). The social network can be categorized in a hierarchical-compensatory manner. These hierarchical-compensatory patterns are rooted in past relationships and activated when the older adult needs assistance (Cantor, 1991; Messeri et al.).

**Social support theories**

Uchino conceptualized social support as “the functions that are provided by social relationships” (Uchino, 2004, p. 16). Social support theories have linked the social support provided by social relationships to health outcomes, although each model within social support theory emphasizes different processes. There are two main theories in social support theories: direct effect theories and stress-related theories.

**Direct effect theories** emphasize the benefits of receiving social support based on social identity, social control, or loneliness models (Uchino, 2004). First, according to the social identity model, social support has positive effects on health when individuals are embedded in a social network because it gives individuals meaningful roles that provide self-esteem and increase the meaning of life, which in turn affects the health of support recipients (Thoits, 1983). Second, according to the social control model, social support also has positive effects on health when an individual is embedded in a social network which can place pressure on people to follow healthier behaviors by giving individuals meaningful roles that enhance an obligation to life (Lewis & Rook, 1999). Third, based on a loneliness model, loneliness is related to poor health outcomes because loneliness affects self-esteem, meaning of life, and obligation to life (Stroebe & Stroebe, 1996; Uchino). This, in turn, may result in negative health behaviors such as smoking and the intake of alcohol (Stroebe & Stroebe, 1996). These negative health behaviors consequently affect overall health outcomes for the individual.

**Stress-related theories** have received the most attention in prior research. These theories focus on the role of social support in stress-related processes. The buffering model of social support predicts that social support is healthy because it buffers the negative effects of stress on health (Cohen & Herbert, 1996). This model suggests that stressors such as bereavement and daily hassles affect health through
In the appraisal process which is a psychological process that can be adjusted by social support (Uchino, 2004). Therefore, based on a buffering model, even when faced with extremely stressful events such as the death of a spouse, social support can help reduce the intensity of the stress response and facilitate coping strategies over the long term (Uchino). On the other hand, according to the stress-prevention model, social support is healthy because social support may prevent people from exposure to potential stressors such as negative life events (Uchino).

**Literature on informal caregiving**

Informal caregiving has been studied by gerontologists, nurses, sociologists, and social workers in order to better understand the care provided by informal caregivers such as family members, friends, or neighbors to older adults or chronically ill individuals.

**The conceptualization of informal caregiving:** Informal caregiving has been defined in many different ways. In most of the literature, informal caregiving has been conceptualized mainly as an activity or a set of tasks to assist physical needs (Swanson et al., 1997), although it is assumed to provide more psychosocial support than the care provided by professionals. Some researchers have noted the lack of a comprehensive definition of informal caregiving, and have attempted to extend the manner in which the concept of informal caregiving is viewed (Archbold, 1982; Bowers, 1987). Bowers’ study reveals five conceptually distinct but overlapping categories of informal caregiving: anticipatory, preventive, supervisory, instrumental and protective. Out of these five categories of informal caregiving, only instrumental caregiving is what has been generally conceptualized as informal caregiving, while the other four types are not included into a conceptualization of informal caregiving. However, informal caregivers believed that the remaining four types of caregiving are as significant as, or even more important, than instrumental caregiving in their caregiving experience.

**Caregiver’s reactions to caregiving:** Many researchers have studied the impact of conducting the caregiving role or tasks on caregivers. Although some researchers reported the positive experience of informal caregivers (Archbold, Stewart, Greenlick, & Harvath, 1990; Cohen, Colantonio, & Vernich, 2002), most researchers have reported a variety of negative impacts that caregiving has imposed on informal caregivers (Robinson, 1997; Schulz & Beach, 1999). These negative impacts, such as emotional, health, social, and financial problems, are conceptualized as caregiver burden or strain (Given & Given, 1991).

Informal caregivers are considered to be at risk due to the health problems of the caregivers themselves. Caregivers, particularly elderly spouses, reported that caregiving negatively affects their physical health (Schulz & Beach, 1999; Vitaliano, Scanlan, Krenz, Schwartz, & Marcovina, 1996). The caregivers’ physical health problems may also be associated with caregiver burden. Schulz and Beach reported that the caregivers experiencing burden had mortality risks 63% higher than non-caregiving controls. However, caregivers who did not experience this burden did not have increased mortality rates.

The relationships between caregivers and care recipients have been considered as a related factor for caregiver burden. Some studies found that spouse caregivers experience higher levels of burden (Nagatomo et al., 1999; Zanetti et al., 1998), while other researchers reported that children or children-in-law caregivers experience higher levels of burden than spouse caregivers (Choi-Kwon, Kim, Kwon, & Kim, 2005; Donaldson, Tarrier, & Burns, 1998; Given et al., 2004). Chumbler, Grimm, Cody, and Beck (2003) examined caregiver burden in diverse caregiving relationships. They found that daughters, sons, wives, and husbands had comparable burden, but they had greater burden than more distant relatives. Thus, studies have revealed mixed findings in terms of levels of burden among family caregivers.

The literature also suggests that caregiver burden is related to nursing home admission (Aneshensel, Pearl, Levy-Storms, & Schuler, 2000; Bradley, 2003; Lieberman & Kramer, 1991). For example, Lieberman and Kramer studied patients with dementia and their caregivers, and found that the patient characteristics, such as level of cognitive and medical impairment, did not predict nursing home placement, whereas the caregivers’ characteristics, such as type of caregiver
arrangement, number of family problems, and amount of burden reported by the caregiver, predicted nursing home placement.

**Limitations of theories and the literature**

*Social network theories* suggest that not all types of caregivers are of equal benefit to the mental and physical health of care recipients. In addition, the theories classify the types of informal caregivers and the key concepts related to the nature of caregiving relationships such as availability, familiarity, motivation, and preference (Figure 1). However, social network theories do not specify whether these theories can be applied to both physical and psychosocial support (Friedman, 1993). The effects of social networks can be different based on types of support. Friedman, who tested the hierarchical-compensatory model in older women with heart disease, found that the model appears to offer an explanation for the hierarchy of sources selected for only psychosocial support. In order to understand how informal caregivers affect the outcomes of elderly recipients, the effects need to be specified based on types of caregiving (psychosocial aspects vs. physical aspects). In addition, social network theories do not elucidate the possible mechanism for how the social network affects the outcomes of care recipients (Uchino, 2004). Thus, another theory is needed in order to address these mechanisms.

*Social support theories* are useful to understand the mechanism for how caregiving influences the health of care recipients. These theories also provide the key concepts for mechanisms such as self-esteem, meaning of life, obligation to life, loneliness, stress, health behaviors, and adherence (Figure 1). These theories also explain mechanisms of how these key concepts affect health, including psychological and behavioral processes. However, social support theories focus exclusively on psychological effects. Although these theories reported that physical health can be affected by social support, the physical health is affected through the psychological process, or both psychological and behavioral processes. There is no explanation for how social support directly affects the physiological processes or physical health.

The limitation of social support theories might be related to the conceptualization of social support which emphasizes psychosocial aspects rather than physical aspects. It might not be surprising that social support theories and research on social support show

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**Figure 1.** Factors from theories and the literature.
that social support protects individuals from a multitude of mental health problems, ranging from mild depression to suicidal tendencies (Cohen, Underwood, & Gottlieb, 2000). However, it is less obvious whether and how social support affects physical health. As opposed to social support, caregiving may have a strong influence on the physical health of care recipients. For instance, some caregiving such as administering medications and feeding can directly influence physiological processes and physical health, while social support tends to have an indirect influence on physical health via its psychological process. Thus, in order to understand how informal caregivers affect the outcomes of elderly recipients, the relationship among caregiving for physical needs, physiological process, and physical health must be addressed.

The literature on informal caregiving provides the foundation for the conceptualization of informal caregiving and the acknowledgement that caregiver burden is an important concept within the caregiving relationship (Figure 1). In addition, the literature on informal caregiving informs researchers about what kinds of outcome measures must be included when the effects of informal caregivers on elderly recipients are evaluated. Social network theories and social support theories have investigated mental and physical health. On the other hand, the informal caregiving literature shows that health service utilization is another important outcome measure to consider for understanding the effects of informal caregivers on elderly recipients. However, there are limitations of the literature on informal caregiving for understanding the effects of informal caregivers on elderly recipients in HHC. Researchers have investigated only some types of informal caregivers or have used a proxy of available informal caregivers such as marital status or living arrangements. The incorporation of social network theories for understanding the effects of informal caregivers on the outcomes of elderly recipients will be helpful in solving this limitation in the literature. In addition, informal caregiving studies have not stated the mechanism for the effect of informal caregivers on the outcomes of elderly recipients. The incorporation of social support theories for understanding the phenomenon will be helpful to solve this limitation.

RESULTS

Given that the phenomenon of how informal caregivers affect the health-related outcomes of elderly recipients in HHC is complicated, social network theories, social support theories, and the literature on informal caregiving cannot fully address the phenomenon but partially explain the phenomenon and its key elements. Thus, these theories and the literature are incorporated into a new theoretical framework which is depicted in Figure 2.

The key concepts in the proposed theoretical framework include type of informal caregivers, nature of the caregiving relationship, caregiving as a function of the relationship, internal processes of a care recipient, and health-related outcomes of elderly recipients. The proposed theoretical framework shows that the nature of the caregiving relationship is influenced by the type of informal caregiver and affects the function of such relationships, caregiving. Health-related outcomes of elderly recipients are the result of the interaction among types of informal caregivers, the nature of the caregiving relationship, caregiving itself, and the internal processes of the care recipient.

Types of informal caregivers

The types of informal caregivers are conceptualized and categorized by task-specific theory, which is one type of social network theory (Figure 1). Based on this theory, the type of informal caregivers can be categorized as spouses, offspring, relatives, and non-relatives such as friends and neighbors. It is hypothesized that each type of caregiver will have a different nature of the caregiving relationship.

Nature of the caregiving relationship

The nature of the caregiving relationship is determined by several factors from the literature on social network theories and informal caregiving (Figure 1). The caregiving relationship is established from past relationships and the history of interactions. Therefore, it is important to consider the nature of the caregiving relationships within an historical context.
Task-specific theory provides the theoretical background for the importance of informal caregivers’ availability in the caregiving relationship. Task-specific theory uses proximity, length of commitment, commonality of lifestyle, and size of the group in order to specify primary groups and informal groups (Messeri et al., 1993). This proposed theoretical framework specifies caregiving rather than social support. In order to specify the nature of each caregiving relationship, this proposed theoretical framework modifies task-specific theory. The concepts of proximity, length of commitment, and size in task-specific theory are combined into the concept of availability because the availability of caregivers, which is a very influential element in the caregiving relationship, is decided based on these factors. Caregivers must be able to provide adequate availability in terms of both density and duration.

Familiarity

The concept of commonality of lifestyle in task-specific theory is included into the concept of familiarity because if caregivers are familiar with care recipients (e.g., lifestyles, behaviors, and characteristics), the commonality of lifestyle might not be very influential on the outcomes of care recipients. In this proposed theoretical framework, the concept of familiarity not only means familiar relationships, but also includes informal caregivers’ knowledge about care recipients. The knowledge about what care recipients want and need is a part of the informal caregivers’ familiarity with care recipients. Informal caregivers become familiar with care recipients’ needs, characteristics, and preferences over time, and thereby, this caregiving relationship becomes more acceptable to care recipients. This familiarity can form during a long-term relationship, and several factors, such as commonality of lifestyles, common culture, and face-to-face contact, can influence this formation.

Motivation

Task-specific theory provides the theoretical background for the importance of informal caregivers’ motivation in the caregiving relationship. Task-specific theory uses type of motivation, division of labor, and level of technical knowledge to specify formal groups (Messeri et al., 1993). From the concepts specifying formal groups in task-specific theory, the type of motivation is the only criteria extracted for this proposed theoretical framework.
because different types of informal caregivers may have different motivations for caregiving.

Care recipients’ preferences
Hierarchical-compensatory theory provides the theoretical background for the importance of care recipients’ preferences. According to this theory, care recipients have different preferences for specific types of informal caregivers. Older adults can experience less psychological damage to their ego systems when they receive help from someone they prefer (Cantor, 1989). Therefore, the preference of care recipients may influence health, specifically mental health.

Informal caregiver’s burden
The associations between the type of informal caregivers and informal caregivers’ burden have been reported. For instance, researchers have reported that spouse caregivers experience less role strain than daughter caregivers because daughter caregivers experience reversed roles, and have more difficulty in meeting reciprocal expectations (Johnson & Catalano, 1983; King, Atienza, Castro, & Collins, 2002). These role strains cause daughter caregivers to take on a greater burden, which might negatively affect the health of care recipients.

Caregiving
Caregiving is a concept that encompasses a multitude of domains including physical and psychosocial. Unfortunately, the psychosocial aspects of caregiving have not been adequately conceptualized in the current literature. Although physical assistance is an important aspect in caregiving, the current conceptualization of caregiving, to concentrate only on physical assistance, is a partial and incomplete view and risks neglecting those psychosocial aspects which may be central to care recipients and caregivers. It should be emphasized that informal caregivers provide both psychosocial support and direct care related to illness and aging. Thus, in this proposed theoretical framework, caregiving is defined as psychosocial support as well as direct care related to illness and aging for care recipients provided by an informal caregiver in the care recipients’ home.

Internal processes of a care recipient
Social support theories are adapted in order to explain the mechanism between caregiving and the outcomes of elderly recipients. Caregiving affects care recipients’ health through: a) psychological processes such as a strong sense of self-esteem, greater meaning of life, more positive obligation to life, less loneliness, and less stress; b) behavioral processes such as health behaviors and adherence; and c) physiological processes such as cardiovascular, neuroendocrine, and immune function (Thoits, 1983; Uchino, 2004).

Psychosocial support and direct care provided by informal caregivers will influence care recipients through different processes. Since these care recipients’ psychological, behavioral, and physiological processes influence one another, either psychosocial support or direct care can influence both care recipients’ mental and physical health. However, care recipients’ psychological processes might directly influence care recipients’ mental health without directly influencing care recipients’ behavioral and/or physiological processes. In addition, care recipients’ physiological processes might directly influence care recipients’ physical health without directly influencing care recipients’ psychological and/or behavioral processes. These processes are all interrelated. Psychosocial support will primarily have an effect on the psychological processes, and then influence a care recipient’s mental health. Likewise, psychosocial support also can affect a care recipient’s physical health by behavioral processes that are influenced by psychological processes. On the other hand, direct care related to illness and aging will primarily have an effect on physiological processes, and then influence a care recipient’s physical health (Figure 2).

The discrepancy between received care and perceived care can occur due to the internal processes of a care recipient, especially the psychological process. Namely, received care may be perceived differently based on self-esteem or level of stress. Thus, care recipients who are depressed or who have low self-esteem may have a higher discrepancy between received care and perceived care.
Health-related outcomes of care recipients

Social network theories and social support theories have investigated mental and physical health. However, the informal caregiving literature shows that health service utilization such as hospitalization and nursing home admission is another important outcome measure to consider in order to understand the effects of informal caregivers on the outcomes of care recipients.

DISCUSSION

The proposed theoretical framework suggests that the type of informal caregivers influences the nature of the caregiving relationship which, in turn, affects the function of such caregiving relationships, caregiving. The quality of the caregiving relationship can be considered high if the caregiving relationship is characterized as being highly available, exhibiting a familiarity between caregivers and care recipients, motivated by affection, having a preferred caregiver, and having few burdens. Similarly, the quality of caregiving is considered high if the caregiving comprises a high quality of psychosocial support and direct care related to illness and aging. Thus, for caregiving to be optimum, a psychosocial dimension must be incorporated with the dimension of direct caregiving.

Each key concept in the proposed framework needs to be measured. For example, the quality of caregiving can be assessed by the QUALCARE Scale (Phillips, Morrison, & Chae, 1990a, 1990b), and caregiver burden can be measured by the Caregiver Burden Inventory (Novak & Guest, 1989). In terms of health-related outcomes of care recipients, the Geriatric Depression Scale (GDS) (Yesavage et al., 1982) can be used for measuring depressive symptoms, and the Katz ADL index (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963) can be employed for measuring the physical health of elderly recipients. These are examples in which other instruments can be applicable to the model. With continued research, many other instruments could be developed. Furthermore, the proposed theoretical framework needs to be tested by empirical studies. For example, the association between the quality of caregiving as measured by the QUALCARE Scale and the depressive symptoms of elderly recipients as measured by the GDS can be tested.

The proposed theoretical framework elucidates the key elements influencing the health-related outcomes of elderly recipients. This framework shows that health care providers need to assess both the nature of the caregiving relationship and the caregiving itself in order to provide effective interventions. The most suitable intervention must consider whether the caregiving deficiency is due to the absence of caregivers, the nature of the caregiving relationship, or a quality of caregiving. If care recipients do not receive appropriate care from informal caregivers because of an inappropriate caregiving relationship, the interventions targeting improvement to the caregiver’s skill and knowledge will not be effective because the interventions will not change the fundamental problem. This theoretical framework will be helpful in terms of assessing these problems and designing appropriate interventions based on the aforementioned problems.

If the caregiving deficiency is due to the absence of informal caregivers and the older adult has a potential informal caregiver, health care providers should consider developing caregiving relationships and testing interventions aimed at maintaining supportive caregiving relationships throughout the long term. However, if the care recipient does not have an available informal caregiver, the interventions may be to supplement the role of informal caregivers with formal HHC. A caregiving deficiency due to the nature of the caregiving relationship would lead to interventions to increase the quality of the existing relationship through increasing the caregiver’s availability, familiarity between the caregiver and care recipient, motivation of affection, or considering the care recipient’s preference and decreasing the caregiver’s burden. A caregiving deficiency related to the nature of the caregiving relationship can be addressed by mobilization of informal and formal support systems such as support groups and respite care services, respectively.

Even when a caregiver is present and the nature of the caregiving relationship is optimal, the outcomes of
care recipients can be affected by the caregiving itself. This deficiency can be addressed through education and development of caregiving skills. Deficiency in different educational domains (psychosocial support vs. direct care) needs to be addressed by different educational interventions. For example, if the caregivers do not know how they can effectively provide psychosocial support to the patients, the education needs to be focused on effective psychosocial support.

Researchers have measured caregiving by either the structures of informal caregivers (e.g., the presence of caregiver, types of caregivers, or living arrangement) or the function those informal caregivers may serve (e.g., provision of ADL or IADL). However, it appears an appropriate strategy to measure both the caregiving structure and the caregiving function in order to know the whole picture of caregiving. This proposed theoretical framework, incorporating these two perspectives, will increase the understanding of both the structural and functional aspects of caregiving. Furthermore, this theoretical framework will help to integrate the existing literature that separates these domains, and facilitate the development of effective interventions based on these perspectives.

The proposed conceptual framework is an initial step in addressing the effects of informal caregivers on the health-related outcomes of elderly recipients in HHC. This proposed conceptual framework assumes that, on average, caregiving positively affects the health of older adults. The possibility exists for negative effects of informal caregivers on care recipients, and researchers need to be aware of these negative effects. Taking into account the negative effects of caregivers can serve to refine this proposed conceptual framework. The social structural environment should also be considered for addressing the effects of informal caregivers on health-related outcomes of elderly recipients. The social structural environment in which care recipients, caregivers, and caregiving relationships between them are affected has not been sufficiently integrated in this proposed conceptual framework. Culture, race/ethnicity, gender, and socioeconomic status are of particular concern, which can refine this proposed conceptual framework in the future. In spite of these limitations, the proposed theoretical framework indicates what variables should be explored, and provides direction for future studies of interrelationships among these variables in order to improve health-related outcomes of care recipients in HHC. Thus, the framework described here offers a map for intervention and research on caregiving for care recipients in HHC.

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REFERENCES


In Informal Caregivers


