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# A Portrait of Five Undergraduate Students Who Serve as Caregivers While Taking University Courses

**Emily Owens, Carley Ulibarri, Blake D. Karlin**

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The purpose of this study was to identify characteristics specific to adults who are caregivers while taking classes from an institution of higher education. We recruited 5 university attending adults through a subject pool and through announcements in various classes through the university setting. Measures on depression, burden, daily activities, and general background were used to assess the experiences of the participants. Self-reports indicated high levels of self-efficacy with regard to the care process, minimal depression, low to moderate levels of burden, and high resiliency among those surveyed. These results indicate while registered as a full time student (12 credits or more) daily activities remain high, while overall levels for depression and reported burden remain relatively low. This group of providers suggests a desire to continue with current responsibilities of providing care to the family member. More intensive analysis is needed to explain the resilient nature of this group. Degree seeking may provide a buffer from the traditional burden and depression often experienced by other caregivers who are not attending college.

**Keywords:** Caregiving, depression, burden, resiliency, undergraduates

For the past four decades, researchers have focused on the demographic characteristics of caregivers (e.g., gender, age, illness types, relationship aspects, etc.). Evidence suggests that most caregivers are female, a spouse or child of the ill family member(s) that seek support from other family members, and experience personal health problems while providing health care (Bergmann, Foster, Justice & Mathews, 1978; Karlin & Bromley, 1996; Karlin, Weil, & Gould, 2012; Scott & Roberto, 1985). Although a significant amount of psychological research has stemmed from participants found in university/college settings very little data have been collected from adults with experiences surrounding being a caregiver for

family or friends. Of importance is the fact that enrollment in degree-granting institutions has increased dramatically (U.S. Department of Education, 2015). From 1992 to 2012 enrollment increased by 24%. Similar levels of increase have been seen from those between the ages of 18 and 24 and for those over the age of 25. However, the number of students over the age of 25 is expected to rise faster than younger adults, a group who may be raising children or caring for extended family at a high rate. Those students who are committed to enrollment in a degree-granting institution while providing care for a family member may be exposed to levels of stress and time, the average student may not experience. This article sought to identify characteristics specific to adults who take on

the caregiving role while taking classes from an institution of higher education and to begin a discuss on the unique characteristics of these care providers.

### Caregiver Workload

Most people with chronic illnesses are cared for at home by informal caregivers, people who provide unpaid care for family members, friends, and neighbors who are unable to care for themselves (McLennon, Habermann, & Davis, 2010). Caregivers take on a wide range of tasks to ensure that they deliver the best care possible. Informal caregivers not only juggle a normal day-to-day routine, but must also incorporate a secondary workload into their daily lives. According to the Family Caregiver Alliance, more than 1 in 6 Americans working full or part time, report assisting with the care of an elder or disabled family member, relative or friend (2012). The report states that 50% of all caregivers age 18+ who are caring for an individual age 50+ are also employed full-time.

Balancing full time employment, aspects of the individual's personal life, and the challenges associated with being a caregiver result in an increased workload. This workload varies among individuals and according to Juratovac, Morris, Zauszniewski, and Wykle, encompasses parameters of time, difficulty, tasks, demands and ability in the conceptualization of the task (2012). The amount and type of tasks taken on by a caregiver can be determined through instrumental activities of daily living or IADL (Lawton & Brody, 1969). Differentiation between Activities of Daily Living ADL and IADL are prevalent throughout the literature. ADL was originally researched and an instrumented developed by Katz, Ford, Moskowitz, Jackson, and Jaffe (1963). According to Algase and Haesook, ADL is used to refer to the set of skills that constitute the essential abilities to care for oneself and

meet basic needs, which are fundamental to maintaining health and independence (2006). The ADL comprise bathing, dressing, toileting, transferring, continence, and eating, listed in order of increasing severity of disability (LaPlante, 2010). There are however more complex skills that are said to be necessary to maintain independence in the community. This higher-level skill set is distinguished by the use of instrumental activities of daily living or IADL (Algase & Haesook, 2006; Lawton & Brody, 1969). The eight instrumental activities of daily living (IADL), according to LaPlante 2010, include using the phone, grocery shopping, preparing meals, housekeeping, laundering, using transportation, taking medications, and managing finances.

On average, caregivers spend 20.4 hours per week providing care (Juratovac et al., 2012). Those who live with their care recipient spend 39.3 hours per week caring for that person (Family Caregiver Alliance, 2012). This level of time commitment as a caregiver while going to school full time may create extreme demands on the individuals thereby promoting overwhelming burden and depressive symptoms. The ability to commit this amount of time and energy into caring for a family member's needs varies among care providers. Many factors contribute to the extent to which these responsibilities are taken on including age, gender, support levels from other family members, and willingness to sacrifice aspects of their personal life. The student who provides care may have other responsibilities including a job. Among caregivers that work outside the home while caring for a family member or friend, 69% report having to rearrange their work schedule, decrease their hours at the paid employment location or take an unpaid leave in order to meet caregiving responsibilities (Family Caregiver Alliance, 2012).

### Positive Aspects of Providing Care

The impact of being a caregiver affects each individual care provider differently. A pattern in current research tends to focus on negative aspects of being a caregiver of a loved one, although a cursory look at the positive aspects has been addressed. For example, research by Habermann and Davis (2005) suggests that positive aspects of caregiving, such as finding meaning in caregiving, may act as a mediator of psychological well-being. Most caregivers (75%) report that the act of providing personal care contributed significantly to their self-identification as a caregiver and made a positive difference in their lives and in the lives of their family member. Research on caregivers of patients with Alzheimer's disease by Butcher, Holkup, and Buckwalter (2001), found that despite the suffering, loss, sadness, pain, stress, and frustration, most caregivers (78%) report positive aspects of and meaning in the caregiving process. Meaning, for participants in the Butcher et al. study, was found through their commitment to the care recipient, by identifying the positives in caring for another, and by creating moments of joyfulness together. While these positive experiences reported by some care providers may pose differences in individual carers lives, this may not always be the case.

### Depression

Since medical treatments have improved, people diagnosed with cancer are living longer. Due to this extension of life more family members are being relied upon to take on the role of at-home caregiver. Because of the increasing frequency in which family members are assuming this type of role, it is important to look at the psychological effects caregiving may have on an individual. Several areas are of particular interest. Specifically, caregiver depression

needs to be considered. Between 32% and 50% of caregivers experience depressive symptoms at the clinical level (Rivera, 2009). A separate study showed 60% of caregivers under the age of 65 reported symptoms associated with depression (Mystakidou, Tsilika, Parpa, Galanos, & Vlahos, 2007). Caregivers are continually faced with novel tasks. These tasks possess both physical and emotional aspects for the care provider. Caregivers often remain one of very few emotional supports for the family member. While providing emotional support to the family member, some care providers may not receive the necessary individual support required to remain an emotionally individual healthy state.

For some caregivers, this lack of support may lead to depressive symptoms. Reported symptoms of depression in caregivers include fatigue, insomnia, excessive sleep, indecisiveness, and inability to concentrate (Rivera, 2009). These depressive symptoms might make the task of caregiving even more difficult to accomplish (Rivera, 2009). One study in Greece compared depression levels in caregivers of cancer patients, Alzheimer's patients, and people with schizophrenia (Papastavrou, Charalambous, Tsangari, & Karayiannis, 2012). The researchers used the Greek version of the Center of Epidemiological Studies-Depression Scale (CES-D) and had a cutoff score of 16 to be considered moderate and increasing scores indicated higher level of depression. The authors state that in all three groups report high levels of depression. Together, there was a mean depression score of 18.4. However, when considering the individual groups, individuals who were providing care for cancer patients had the highest mean score out of all three groups (20.3) (Papastavrou et al., 2012). This finding suggests that there is some variable about caregiving for a cancer patient that correlates with higher levels of depression.

## Burden

Another factor to consider is caregiver burden. Burden is described as when the demands imbalance other aspects of life including personal time, social roles, financial resources, and physical and emotional state (Francis, Worthington, Kypriotakis & Rose, 2010). One study by Grunfeld et al., found that caregiver burden was the highest predictor of anxiety and depression in caregivers of terminal breast cancer patients (2004). The authors also report that as the cancer progresses, depression and burden levels increase. Another study has also shown that there may be a difference between adult-children caregivers and spousal caregivers of Alzheimer's patients and reported levels of perceived burden (Conde-Sala, Garre-Olmo, Turro-Garriga, Wilalta-Franch & Lopez-Pousa, 2010). Burden appears to be higher in adult-children caregivers than reported by spousal care providers. The authors explain these differences by stating that spouses take caregiving on as a responsibility, whereas caregiving duties tend to disrupt adult-children's lives more, especially for those who are living with their parent. For adult-children living in separate housing greater levels of guilt are often reported.

In burden research, it is important to consider what has been reported for gender differences and caregiver burden. Many studies report no difference between gender and burden. However, there is conflicting data from Gallicchio et al. (2002) who report that female caregivers have higher odds than men to feel a greater level of burden. As well, a study conducted in Spain supports female caregivers reporting higher levels of subjective burden when caring for an elder (del-Pino-Casado, Frias-Osuna, Palomino-Moral & Martinez-Riera, 2012). Finally, Kim, Chang, Rose and Kim report that females have a higher correlation of burden than males when providing care for an individual with dementia (2011).

## Gender

In many studies it has been found that the gender of the caregiver plays a role in the overall experience. Typically, females assume a greater burden for aging parents than males (Finley, 1989). Over time it has been found that this level of responsibility is due mostly to past roles in the house and division of family labor. Although this is indicated, it is not enough to explain gender caregiving differences particularly with young adults who view roles differently than previous generations. As a result, four hypotheses were developed by Finley (1989) to better explain the possible role and time variations reported by female and male care providers.

The first hypothesis is the *time-available hypothesis*. This proposes that the time and other demands outside of caregiving determine the amount of time spent on caregiving. The main factors found to affect the time-available hypothesis are employment, children, and whether or not the caregiver is single or married (Finley, 1989). The second hypothesis is the *socialization/ideology hypothesis*. This proposes that gender role differences learned in the socialization process influence the decision in who is responsible for the caregiving. This traditional assumption is sometimes so strong that the factors mentioned in the other three hypotheses do not have any effect on deciding who will be the caregiver (Finley, 1989).

The third hypothesis is the *external resources hypothesis*. This proposes that external resources, such as education and income, determine who in the family is more qualified as a caregiver and can provide for the ill family member. Although, the family member with more external resources may spend more money on the ill, they may spend less time with them (Finley, 1989). The last hypothesis is the *specialization-of-tasks hypothesis*. This proposes that males and females are assigned certain tasks in

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caregiving to benefit the ill as a whole. Therefore, males who make higher wages are provided with the task of being a source of financial support. Differences often found in pay scale then place females in the primary role of emotional care provider. According to the author, a type of equality is reached when the specialized tasks complement each other. These four hypotheses help explain the process of deciding whether the male or female in the family is the primary caregiver for ill family members.

This study may serve as a starting point to gain further understanding of those primary caregivers who are also students. There has been little to no research published on the caregiver who is also a university student. Perceptions for this group who remain in school, often raising a young family, working full to part-time, as well as experiencing other demands may lead to additional issues (e.g., higher rates of institutionalization of the family member, job related issues, family issues not encountered by other age groups, etc.) not reported by older adults in the caregiving role. Gaining insight into the level of burden, depression, and activities experienced on an average day may provide information to the needs and experiences of these care providers.

### **Institutionalization**

To date, most of the research on institutionalization and the impact on caregivers both before and after placement has primarily focused on care providers of family members with some form of dementia. Typically, findings suggest that institutionalization has not consistently been found to reduce burden for dementia caregivers (McLennon, Haberman, & Davis, 2010). For many caregivers, feelings of anxiety, depression, and loss develop after placement of a loved one.

Research indicates that decisions to place family members in institutions are based on the burden of being a caregiver (Canam & Acorn, 1999). According to McLennon et al. (2010), informal caregivers have reported a variety of detrimental physical and emotional effects that change their ability to continue care. The challenges of formal employment, providing care, and extended family requirements often become overwhelming resulting in the decision to relinquish at-home care and access formal care services (McLennon et al., 2010). According to Gaugler, Kane, Kane, Clay, and Newcomer (2005), research on the duration of dementia care includes the wear-and-tear hypothesis, which suggests that the longer a caregiver remains in her or his role, the more likely negative outcomes, such as caregiver distress or even care-recipient institutionalization, will occur. Research by McLennon et al., (2010) suggests that the overwhelming task demands have been reported as common reasons for formal care placement in people with dementia as well as the occurrence of some form of crisis. While some care providers search for positive meaning in the caregiving process and ultimately wish to continue caring for their loved one indefinitely, certain aspects pose limitations, forcing more formal care to be introduced.

The purpose of the current study was to identify characteristics specific to adults who take on the caregiving role while remaining a full time university undergraduate student as a starting point toward further discussion on the needs of these providers. Of particular interest were the workload levels, IADL, reported levels of burden, depression, and level of acceptance toward the possibility of institutionalization.

## Methodology

### *Participants*

The current study consists of students enrolled at a western university with an enrollment of approximately 12,000 students (63% female; 37% male). The present study sought to administer inventories to undergraduate students. Five female participants met the criteria for being a primary caregiver of a family member as well as being registered full time as an undergraduate. The ethnic breakdown of the participants was 1 Hispanic and 4 White, non-Hispanic. Participant median age was 30 (range = 19-53). The median number of family members providing care support was 2 (range = 2-9). All but 1 was in their junior (N=2) or senior year (N=2) of school with a mean GPA of 3.46. Yearly income range was \$10,000 to \$39,999. Respondents indicated taking on average 15.4 credits during the current semester (SD=3.9; range = 12-22) with a mean of 20.4 hours per week of providing care. When asked about the average number of graded school assignments completed per week a mean of 4.6 (Median = 4; SD = 3.36; range = 1-10) tasks was reported. Other caregivers provided approximately 8 hours per week of the care on average (Median = 20; range = 0 to 50%) with a mean of 22.2 hours of care per week by the respondent (Median = 21; range = 5 to 40 hours). Between 0 and 6 current extracurricular activities (M = 2.2; SD = 2.68) were listed as something engaged in by participants.

### *Procedures*

There were two methods of data collection for the current study. The first method involved participants who were sought by using the Psychology Department Participant Pool. Additional participants were recruited through various classes with extra credit opportunities for participating in

research during a semester. The current researchers utilized this method of data collection in order to provide a broader sample of participants as well as facilitate ease of data collection throughout the university environment. Approximately 30 minutes was required to complete the study. All participants were presented with a consent form. With the completion of data collection, participants were thanked for their participation and debriefed. Participants were given contact information for the research group in case they had any questions as well as sources of support during the care process. Data cannot be tied to the participant's name to protect individual identity. Numerical values were assigned to participants and at no time has the name or personal information of a participant been associated with their questionnaire. Consent forms and questionnaires are stored on a secure computer with paper and pencil forms kept in locked cabinets located in an office at the institution of higher education.

### *Instrumentation*

Each participant was given a consent form, background and workload surveys, the Zarit Burden Scale, Beck Depression Survey, IADL, and debriefing statement.

***Beck Depression Scale.*** The Beck Depression Inventory was first developed in 1961, then later revised twice into the most recent version, the Beck Depression Inventory II (BDI-II). It is a self-report instrument with 21 questions that is used to identify the presence and severity of depression symptoms as they are classified in the DSM – IV. The 21 items are totaled to give a single score, 0-13 is considered in the minimal range, 14-19 is mild, 20-28 is moderate, and 29-63 is a severe level of depression (Beck, Steer, & Brown, 2006). The BDI-II has been reported as highly reliable regardless of the

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population that is being tested and has a high coefficient alpha of .93 for college students.

**IADL.** The Lawton Instrumental Activities of Daily Living (IADL) Scale took approximately 5-10 minutes to administer. It contains 8 items that are rated with a summary score from 0 (low functioning) to 8 (high functioning). This scale can be administered through an interview or by a written questionnaire. The patient or a caregiver who is familiar with the patient can provide the answers (Lawton & Brody, 1969).

**Zarit Burden Scale.** The Zarit Burden Scale was used to measure perceived burden felt by caregivers (Zarit, Reever, & Bach-Peterson, 1980). These authors report Spearman's rho correlations to be .72 with the global index of burden. Cronbach's alpha = .83 and .89. A test-retest reliability of 0.71 has been reported. The scores for the 22 items are totaled with a possible score range from 0 to 88. A high score correlates with feelings of burden.

**Background Questionnaire and Workload Scale.** The background questionnaire includes items such as: age, gender, caregiver-patient relationship, what illness the participant is providing care, self-efficacy questions and items of resiliency. The Workload Scale is a multi-item scale that collects information on academic, employment, extra curricular, caregiving activities and an overall perception of current workload demands.

### Data Analysis

Before statistical analysis of the survey results, screening of the data was conducted. Data screening for all variables included information in missing data. Additional descriptive statistics are presented in the Results section. Frequency analysis was conducted to identify the rate of

responses to all questions. Participant comments are included in the next section.

### Results

A careful description of participant survey responses serves as the core for this study. Of specific interest were participant levels of burden, depression, resiliency, and independent living skills. The mean burden score for participants was 32.8 (Median = 31, SD = 9.33). With a possible range of 0-88 the actual score range fell between 23 and 43 indicating limited overall burden. Using the Beck Depression Inventory a mean score of 12 was obtained (range = 0-22; SD = 8.51) suggesting most fell into the minimal range for depression. Specifically, three fell into the minimal range (scores of 0, 9, 11), 1 fell into the mild range (score of 18), and 1 fell into moderate range (score of 22). A resiliency mean of 86 (Median = 83, range 75-96) was seen. These scores indicate overall moderate to higher resiliency with respondents. For instrumental activities of daily living the higher the IADL score the greater patient independence indicated. With a possible range of 0 to 8, participant IADL scores ranged between 2 to 6 (Mean = 3.8, SD = 1.64) suggesting variability in the independent living skills encountered. A total score average for perceptions of self-efficacy was 20.4 (range = 1-21).

### Participant Descriptions

An overall description of each participant is provided below in an attempt uncover the general characteristics of these caregivers. Ranges for all surveys are 1-7 unless otherwise indicated below. Qualitative comments are given in support of these self-reported general descriptions.



### ***Participant 1***

A 30 year-old Non-Hispanic, white woman who has never been married cares for a child with autism. This senior has a GPA of 3.82 and makes less than \$19,999 annually. She has never considered institutionalization of her son. She has high self-efficacy. Specifically, the participant reports a strong agreement that she can perform the tasks necessary to be a caregiver, she can perform the tasks that allow her to accomplish her goals as caregiver, and it is important for her to perform the required tasks as caregiver (score of 7 for each). She is taking 12 credit hours, spends 20 hours at school each week, does not hold a paid position, and indicates 5 as her level of difficulty in being a student. The biggest impact on her education as a result of being a care provider is “limited time available for academic work”. She typically has 1 graded task per week and has no one else providing care to this family member. She reports participating in extracurricular activities is difficult with a score of 5 and indicates spending 40 hours per week caring for the family member. She states 1 as the level of difficulty in providing care at the time and 3 as the current perception of her workload (1=limited workload, 7=high workload). Her burden level is 31 (range 0-88), her depression score is 0 (range 0-63), while her IADL score is 3 (range = 0-8). Finally, her total resiliency score was 96 (range 1-96).

### ***Participant 2***

This is a 36 year-old Non-Hispanic, white female who has been married twice and is caring for her mother-in-law who suffers from dementia. There are 9 other family members in the house. This junior has a GPA of 3.04, has a family annual income of less than \$39,999, and does not work beyond school. She has never considered

institutionalization of the family members and also reports all sevens (range 1, low to 7, high) on the self-efficacy scale (can actually perform the task necessary, believes performing these tasks will allow her to accomplish her goals, and it is important for her to perform the tasks necessary to be a caregiver). She is taking 22 credits and reports spending 30 hours a week at school. The participant says the level of difficulty at being a student is 5 (range 1, not difficult to 7, very difficult) and has 10 graded tasks due on average per week. Caregiving has affected her schooling stating, “at times I have missed assignments/due dates because she needs me more”. The mother-in-law’s son also provides care about 20% (5 hours) of the time. A score of 4 (range 1, not difficult to 7, very difficult) was indicated for how difficult it is to work outside the home at this time. She does 4 hours of extracurricular activities (church, volunteer at kids school) and provides a score of 3 on how difficult it is to participate in these extracurricular activities. She spends 20 hours per week providing care with a score of 4 on the difficulty of providing that care. Her workload perception is 6. Her burden level is 25 (range of 0-88), her depression score is 11 (range of 0-63), and gives an IADL score of 5 (range of 0-8). Her total resiliency score was 94 (range of 1-96).

### ***Participant 3***

A 53 year-old female is married and lives with her husband who suffers from dementia. This senior’s GPA is 3.80, has an annual income of less than \$29,999, has never considered institutionalization of the family member, and gives all 7’s on the self-efficacy measure. This participant is registered for 15 credits and spends 11 hours each week at school. She provides a score of 4 on how difficult it is to be a student at this time and has 3 graded tasks per week on average. Caregiving biggest bearing stating,

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“sometimes it is difficult to concentrate when reading is interrupted.” No one else provides for the care of her husband. She indicates a score of 6 on how difficult it is to work outside the home because she cannot be gone that long. She is involved in one extracurricular activity and gives a score of 5 (range 1, not difficult to 7, very difficult) for the difficulty level of participating in this type of activity. She spends 21 hours per week providing care and says the level of difficulty in providing care is 2 (range 1, not difficult to 7, very difficult). Her workload perception is 5 using the same scale. Her reported level of burden is 23 (0-88), her depression score is 9 (range of 0-63), and has an IADL score of 3 (range 0-8). Her total resiliency score was 83 (range 1-96).

***Participant 4***

A 25 year-old female, never married, lives and cares for her father who has colon cancer. Her GPA is 3.68, makes less than \$29,999 annually, works outside the home, and has never considered institutionalization. This participant strongly agrees she is able to perform the tasks necessary to care for the family member (score of 7), strongly believes performing the tasks will allow her to accomplish her goals as caregiver (score of 7), and with a score of 6 believes it is important to perform the tasks as a caregiver. She is enrolled in 15 credits and spends 21 hours per week at school. She stated that it is difficult being a student at this time with a score of 6 (range 1, not difficult to 7, very difficult). She has 4 graded tasks on average per week and the biggest impact caregiving has had on her education is having “less time to study, having poor concentration due to worrying, and missing class for appointments”. The mother of the ill family member also provides 40% of the care. The participant spends 25 hours outside the home working per week and says it is very difficult

to work (range 1, not difficult to 7, very difficult). She had quit her job of 7 years last calendar year to be able to take her father to appointments and for surgeries. She does not participate in any extracurricular activities and said it is very difficult to participate at this time (range 1, not difficult to 7, very difficult). With a score of 5 she indicates it is difficult to provide care at this time and her workload is 7 (range 1, not difficult to 7, very difficult). She provides a score of 43 for burden (range of 0-88), had a score of 18 for depression (range of 0-63), and 6 for IADL (range of 0-8). Her resiliency score was 82 (range of 1-96).

***Participant 5***

A 19 year-old Hispanic female, never married, lives with her sister who had brain cancer and no longer can function independently. She makes less than \$19,999 annually, has a GPA of 3.0, works 12 hours outside the home per week, and has never considered institutionalization. Her self-efficacy score was 6 suggesting a belief she can perform the tasks necessary to be a caregiver, a score of 6 for believing performing the tasks will allow her to accomplish her caregiving goals, and a score of 7 on believing it is important to perform the tasks required to be a caregiver. She is taking 13 credits, spends 20 hours per week at school and indicates a score of 5 (range 1, not difficult to 7, very difficult) for how difficult it is to be a student. She stated having 5 graded tasks per week and says being a care provider has impacted her education by making it “harder to study and really have quiet time for school”. This individual says it is difficult working outside the home with a score of 4 and does not participate in any extracurricular activities. She gives a score of 7 (range 1, not difficult to 7, very difficult) for how difficult it would be to be involved in these types of activities. She spends 25 hours

per week caring for this family member and gives a score of 4 on the difficulty of providing this care. Using the same scale her workload perception was 7. Her level of reported burden was 42 (range of 0-88), her level of depression was 22 (range of 0-63), and her score for IADL was 2 (range of 0-8). An overall resiliency score of 75 (range 1-96) was reported.

## Discussion

According to Juratovac, Morris, Zauszniewski, and Wykle (2012) caregiving encompasses parameters of time, task difficulty, task demands and perceptions of caregiving ability in the conceptualization of the overall caregiving task. In support of these findings participants for the current study had a workload that averaged 15.4 credits, spend 20.4 hours per week taking classes and studying, have an average of 4.6 graded assignments per week, and report a mean of 22.2 hours providing care per week. A total mean self-efficacy score of 20.4 (range 1-21) was reported by participants indicating high perceptions in being able to accomplish whatever is necessary while in the role of caregiver, believing completing the caregiving tasks will help them reach any individuals goals while in the role, and that it is very important to perform the tasks as caregiver.

Research provided by the Family Caregiver Alliance (2012) showed that 69% of informal caregivers report having to rearrange their work schedules, work fewer hours, or take an unpaid leave of absence from their jobs in order to provide care for their loved one. For the current care providers only one worked in a paid position beyond school and caregiving. All receive some form of financial assistance through federal grants and loans. This type of financial support may be an antecedent condition for them being able to take on the role of care provider.

Research done by del-Pino-Casado et al., 2012; Kim et al., 2011; and Gallicchio et al., 2002 found females report higher levels of burden than males while providing care. Unfortunately, all participants in the current study were female meaning no comparisons were possible. Further consideration on a possible gender gap may be warranted. The current institution where data collection occurred has a larger number of female students (63%) thereby influencing those caregivers available to be surveyed.

Research by McLennon et al., 2010 suggests that the overwhelming task demands have been reported as common reasons for formal care placement in people with dementia as well as indicating high crisis experiences. Because of the additional demands of being a college student (e.g., course work, social life demands, employment), the authors suggest that this group of caregivers might report a high level of acceptance for institutionalization of an ill family member. However, none of this study's respondents reported having considered any form of institutionalization of the ill family member.

Mystakidou et al. (2007) found that 60% of caregivers under the age of 65 report symptoms of depression. Four of the participants fell at the minimal or mild range for depression. Only 1 fell at the moderate depression level. Participants reported minimal to moderate levels of burden and high levels of resiliency. Further analysis is needed to clarify the resilient nature of these caregivers. Seeking a degree of higher education may server as a buffer from the burden and depression reported by caregivers who are most often cited in provider research, those 65 years and older.

Overall, the participants indicated not having enough time to study, missing assignments, and due dates as a result of being a caregiver. Respondents were taking a full load of credits, spending more than 20

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hours per week taking classes, had approximately 4-5 graded assignments due per week, and spent more than 20 hours per week providing care. Even with this workload, these care providers reported high levels of self-efficacy with regard to the care process, had minimal depression, indicated minimal to moderate levels of burden, and were highly resilient overall.

### Limitations

Due to a lack of male caregivers, this study could not examine potential gender differences for the variables of interest. It should be noted that the current study was focused more on a general description of caregivers who are also enrolled full time in a degree awarding institution of higher learning rather than group comparison. Sample size was small and does not warrant a full range of quantitative analysis; however, participant comments are reported in support of participant self-descriptions.

### Conclusions

This study contributes to the literature on caregiving by beginning the discussion on the experiences and characteristics of those who do not fit the traditional caregiver description of someone over the age of 65 and retired. With regard to future research more intensive analysis is needed to explain the resilient nature of this group of care providers. Degree seeking may provide a buffer from the traditional burden and depression often experienced by other caregivers who are not attending college. More research is needed to understand the immediate and long-term impact of providing care as a full time, degree-seeking adult.

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