Congruence Between Disabled Elders and Their Primary Caregivers

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Purpose: This study examines the extent and independent correlates of congruence between disabled elders and their caregivers on several aspects of the caregiving experience. Design and Methods: Participants were 117 visually impaired elders and their caregivers. Correlational analyses, kappa statistics, and paired t tests were used to examine the extent of congruence. Hierarchical multiple regression analyses identified significant correlates of congruence on four target issues: elder’s functional disability, elder’s adaptation to vision impairment, caregiver’s overprotectiveness, and caregiver’s understanding of the vision problem. Results: Caregivers assessed elders as more disabled and rated themselves as more overprotective than did the elders. Although independent correlates varied by target issue, two domains most consistently influenced congruence across measures: the caregiver’s assessment of the elder’s status and quality of the relationship. Implications: Findings underscore the importance of addressing congruence by target issue, rather than as a global characteristic of the caregiving relationship.

Key Words: Family caregiving, Vision impairment, Caregiving relationships, Disability, Proxy

Congruence may be defined as the level of agreement between two or more individuals in their perceptions, assessments, or beliefs. Many investigators have suggested that congruence (also referred to as consensus, shared relational reality, or shared meaning), within marital and other close relationships, is critically important in maintaining relational quality (Acitelli, 1996; Deal, Wampler, & Halverson, 1992; Duck, 1994). For older, disabled adults, one of their most important relationships, if not the most important, is that with the family member or friend who serves as their primary caregiver. However, because of the many emotional and physical demands associated with caregiving, for both the caregiver and the care recipient, it is also a relationship that is often fraught with stress and susceptible to conflict. A lack of congruence on fundamental components of the caregiving experience may be a major contributor to this stress. Thus, knowledge about the extent of discrepant perspectives can provide important information to better understand variability in the caregiving experience for both the caregiver and care receiver. Given the assumption that no absolute truth exists, it then becomes important to understand such differences by identifying factors that increase or decrease the potential for congruence (Burke et al., 1998). Furthermore, knowledge about the source of incongruence is important in order to understand its psychological and social meaning in the relationship (Acitelli, 1996).

Although congruence is a concept relevant to a variety of issues in caregiving, there has been surprisingly little research that examines questions about the extent and correlates of congruence between older people and their primary caregivers. Furthermore, in addition to helping one to better understand the caregiving relationship, congruence, or the lack thereof, can also have important implications for the quality of the caregiving relationship, and ultimate well-being of both dyad members. For example, it has been found that congruence between caregivers and elders on the latter’s functional and health status is associated with better relationship quality (Fingerman, 1996); other researchers found family congruence on the elder’s functioning to be related to lower caregiver stress (Pruchno, Burant, & Peters, 1997), and spousal congruence on the nature of the caregiving relationship to be associated with greater overall life satisfaction (Chappell & Kuehne, 1998). It is also
likely that incongruence is associated with negative interactions between elders and primary support providers, and much research has demonstrated that negative interactions within dyad relations can indeed have a negative impact on life quality (Okun & Keith, 1998; Reinhardt, 2001; Rook, 1997).

The existing literature on congruence has primarily been concerned with the reliability of caregivers as proxies for the older person in clinical and research interviews (Bassett, Magaziner, & Hebel, 1990; Loewenstein et al., 2001; Long, Sudha, & Mutran, 1998; Magaziner, Bassett, Hebel, & Gruber-Baldini, 1996; Magaziner, Zimmerman, Gruber-Baldini, Hebel, & Fox, 1997; Neumann, Araki, & Guterman, 2000; Rothman, Hedrick, Bulcroft, Hickman, & Rubenstein, 1991; Weinberger et al., 1992; Yip, Wilber, Myrtle, & Grazman, 2001). The focus on proxy reliability, rather than congruence as a more general characteristic of the caregiving relationship, may be attributed to the primary emphasis given to elders with cognitive rather than physical impairments in caregiving research. In such cases, caregivers often become respondents by default and their accuracy in reporting the elder’s status has been the paramount concern guiding most congruence research.

A major focus of this prior research has been on assessing congruence on functional ability, that is, activities of daily living (ADL), and, to a lesser extent, indicators of psychosocial well-being, such as depressive symptomatology, mental health status, and emotional status. Although most studies find generally good agreement among elders and caregivers in terms of ADL capability, most also find that the family members tend to assess the elder as more disabled than does the elder himself or herself (Epstein et al., 1989; Lyons, Zarit, Sayer, & Whitlatch, 2002; Magaziner et al., 1996, 1997; Matthew, Adamek, & Dunkle, 1993; Neumann et al., 2000; Rothman et al., 1991; Todorov & Kirchner, 2002; Yip et al., 2001; Zanetti, Geroldi, Frisoni, Bianchetti, & Trabucchi, 1999). Interestingly, Kiyak, Teri, and Borson (1994) found this to be true for elders with Alzheimer’s disease, but not for age-matched, nondemented, healthy elders. Higher disability ratings by caregivers have been found to be associated with having a higher caregiving burden (Long et al., 1998; Zanetti et al., 1999), spending more hours in caregiving (Long et al., 1998), not living together (Magaziner et al., 1996; Yip et al., 2001), and being Black (Long et al., 1998). When examined, caregiver depression has not emerged as a significant correlate of caregivers’ higher estimates of disability (Long et al., 1998; Zanetti et al., 1999).

Compared with functional disability, there is less overall agreement between elders and caregivers on mental health indicators (Neumann et al., 2000). The direction of difference, however, is similar, with caregivers reporting the elders as experiencing significantly greater depression and poorer psycho-

**Study Focus and Research Questions**

This study builds on and extends this line of research in elder–caregiver congruence in several ways. First, we go beyond the concern with caregivers as proxies, an approach that implies that there is a “truth” to be discovered. Rather, congruence on a variety of constructs is considered an important characteristic of the caregiving relationship that, in itself, is important to understand in order to fully appreciate the context of caregiving.

Second, our focus is on physically disabled, but cognitively intact, older adults. This group of elders has received somewhat less attention in caregiving research compared with those with cognitive
impairments. In this study, we examine elders who experience age-related vision impairment, one of the most common and potentially disabling chronic conditions of later life. As many as 20% of persons aged 65 and older report some degree of vision impairment, even with their glasses (The Lighthouse Inc., 1995), and it has been identified as the second most prevalent physical impairment among persons aged 65 and older (National Center for Health Statistics [NCHS], 1982). Research has consistently documented the profound consequences of vision impairment for both functional ability and psychological well-being among community-dwelling elders (Branch, Horowitz & Carr, 1989; Carabellesse et al., 1993; Crews & Campbell, 2001; Horowitz & Reinhardt, 2000; Reuben, Silbey, Damesyn, & Moore, 1999; Salive et al., 1994; Wahl, Oswald, & Zimprich, 1999; West et al., 2002). There is also ample evidence that families exhibit significant distress when an older relative becomes visually disabled (Crews & Frey, 1993; Dumas & Sadowsky, 1984; Goodman & Shippy, 2002; Horowitz et al., 1998; Reinhardt & D’Allura, 2000).

Third, in addition to examining congruence on the elders’ functional disability, we also examine congruence on several other, more subjective aspects of the caregiving experience. Specifically, we examine elders’ and caregivers’ perceptions of overprotection by caregivers, the caregiver’s global understanding of what the elder can see and do as a result of his or her vision impairment, and the elder’s adaptation to the vision disability. These issues are especially salient in the case of vision impairment given the pervasive stereotypes regarding the “helplessness” of the blind (The Lighthouse Inc., 1995; Null, 1988). Furthermore, perspectives on overprotection, disease knowledge, and adaptation are also relevant to a diverse range of caregiving situations in which elders experience other common age-related conditions such as arthritis, hip fractures, and stroke.

Fourth, we extend the methodological scope of most prior research on congruence. Specifically, as recommended by Long and colleagues (1998), we examine both caregiver and care-receiver characteristics associated with congruence and use a multivariate approach to identify the most salient variables. Further, on the basis of past congruence research, as well as models used in the study of caregiving outcomes, we conceptualize potential predictors of congruence as falling into five major domains: sociodemographic factors; physical and mental health status of both elder and caregiver; assessment of the elder’s functional and adaptive status; the caregiving context (e.g., help given, appraisals); and the quality of the relationship.

We addressed two primary research questions in this study:

1. To what extent is there congruence between elders and their primary caregivers on the elder’s functional disability, family overprotection, family understanding of the vision condition, and elder’s adaptation to the vision impairment?

2. What caregiver and care-receiver characteristics represent independent risk factors for greater incongruence on each of these issues?

Methods

Sample

We drew the sample from vision rehabilitation service applicants participating in a larger research–demonstration project, the objectives of which were to design, implement, and evaluate a family-based model of vision rehabilitation. The criteria for participation were age 60 and older, onset of a vision problem at age 55 or older, English speaking, anticipated to be involved in a multiservice rehabilitation program, could identify a primary caregiver, and was sufficiently hearing and cognitively intact to participate in the study. Interviewers conducted preservice interviews with elders, lasting an average of 1 hr, over the telephone. At the conclusion, the interviewers asked elders to identify the “person who helps you the most with the things you need to do.” This person could be a close friend as well as family member, but not a formal helper. Telephone interviews averaging 50 min were conducted with the caregiver. The research reported in this article draws from these preservice baseline data.

In total, we recruited 221 older adults for the evaluation study, representing a response rate of 78%. Because of design elements in the larger study, only 178 of the 221 respondents were asked to give permission to contact a caregiver, of whom 151, or 85%, did so. Seventy-seven percent (n = 117) of the contacted caregivers agreed to participate in an interview. Thus, 117 dyads comprise the sample for this study of congruence.

Approximately two thirds of the visually impaired elders were female (68.4%) and White (66.1%). Only one third (33.3%) were currently married, but 50.4% lived with others rather than alone. Age ranged from 60 to 94 years, with an average of 76.2 years (SD = 8.0). Fifteen percent of the elders were over the age of 85 years. Thirty-seven percent rated their health as either excellent or good, 41.0% rated it as fair, and 22.2% as poor or very poor.

Spouses comprised 29.1% of the caregivers (18.8% wives, 10.3% husbands); one third of the caregivers were adult children (27.4% daughters, 6.8% sons), 20.8% were other relatives (e.g., siblings, cousins, nieces, daughters-in-law), and 16.3% were friends. Age ranged from 40 to 88 years, with an average of 59.7 (SD = 15.8) years. The majority of caregivers were female (78.6%) and two thirds were White (65.0%). Caregivers were generally healthy, with
74.3% rating their health as either excellent or good, 21.4% as fair, and only 4.3% as poor or very poor. Forty-two percent lived with the visually impaired elder.

**Measures**

As noted earlier, we conceptualize variables within five domains.

**Sociodemographic Characteristics.**—Single items tapped age, gender, and race (1 = White, 0 = other races) for both elder and caregiver.

**Physical and Mental Health.**—For self-rated health, each member of the dyad rated his or her own general health on a 5-point scale ranging from **excellent** (5) to **very poor** (1). The mean score was 3.1 for elders (SD = .96) and 3.9 for caregivers (SD = .80). For depressive symptoms, we used the widely excellent (5) to own general health on a 5-point scale ranging from **excellent** (5) to **very poor** (1). The mean score was 3.1 for elders (SD = .96) and 3.9 for caregivers (SD = .80). For depressive symptoms, we used the widely used 20-item Center for Epidemiological Studies–Depression scale (CES-D; Radloff, 1977) to assess the frequency of the respondents’ depressive symptoms in the past week (α = .88 for elders and α = .93 for caregivers). The mean score was 14.6 for elders (SD = 10.88) and 8.2 for caregivers (SD = 10.53).

**Assessment of Elder’s Functional and Adaptive Status.**—In terms of time since vision loss, both elders and caregivers responded to this question: “How long have you (has your relative) had problems with your (his or her) vision like you (she or he) are having now that interfere with your (his or her) daily activities?” Responses ranged from 0 to 60, with elders reporting an average onset of 33.9 months ago (SD = 33.3) and caregivers reporting an average of 33.2 months (SD = 32.93). For functional disability, both the elder and caregiver were asked to assess the elder’s disability in ADLs, using a modified version of the Older American Resources and Services (OARS) Multidimensional Functional Assessment Questionnaire (Center for the Study of Aging and Human Development, 1975). This measure assesses 6 personal and 11 instrumental activities of daily living. We added four items to this scale that specifically address functional tasks that may be affected by vision loss (ability to travel outside of walking distance, and ability to identify coins and bills, one’s clothing, and items in the refrigerator or on shelves). Items are assessed on a 4-point rating scale (0 = does with no difficulty to 3 = cannot do without help). Mean ADL scores for elders and caregivers were 19.4 (SD = 9.25) and 22.2 (SD = 10.69), respectively, with alphas of α = .87 for elders and α = .88 for caregivers. We measured adaptation to vision loss by a single item: “Overall, how well would you say you (your relative) have adapted to your (his or her) vision loss?” This item was rated on a 4-point scale (4 = very well to 1 = not at all), with higher ratings reflecting better adaptation. Mean scores for elders and caregivers were 3.1 (SD = 0.68) and 3.0 (SD = 0.81).

**Caregiving Context.**—In terms of the relationship with the elder, we initially created dummy variables for each caregiver category (e.g., spouse, children, other relative, or friend). However, the relatively small sample size limited the number of potential predictors of congruence that we could examine in the multivariate analyses. Further, in our preliminary analyses, we found no significant bivariate relationships between these caregiver relationship variables and the congruence variables. Thus, for subsequent analyses we recoded this variable as kin (84%) versus nonkin (16%), because this distinction was considered conceptually salient to the issue of congruence, as well as empirically related.

We coded the variable of living arrangements as living with (42%) or separately from (58%) the elder. We measured the frequency of ADL help (asked only of caregivers) in terms of the sum of the frequency of help provided by the caregiver in five groups of tasks: kitchen, everyday household activities, paperwork, mobility, and personal care (responses measured on a 7-point Likert scale from 0 = never-needs no help to 6 = everyday; M = 12.9; SD = 9.05). The variable of caregiver worries (asked only of caregivers) consisted of the sum of five items regarding family concern about their relative’s safety in and outside the home, the future, their relative’s emotional state, and how their relative spends his or her social and leisure time (items rated on a 4-point scale from 1 = not at all to 4 = very much; M = .73; M = 15.3; SD = 3.76).

We measured the variable of caregiving appraisals (asked only of caregivers) by using a modified version of the caregiver appraisal scale developed by Lawton, Kleban, Moss, and Glicksman (1989). This scale includes nine items (e.g., “Your social life has suffered because you are helping your . . .”), rated on a 4-point Likert scale (range = 9–36, with high scores indicating more negative appraisals; α = .74, M = 20.8; SD = 6.29).

**Quality of Relationship.**—In terms of relationship closeness, elders and caregivers rated their relationship on a modified Emotional Bondedness Scale (Snow & Crapo, 1982) that includes five items (e.g., “I can count on this person to stand by me”). Two additional items tap overall satisfaction with the relationship and degree of respect. Total scale scores ranged from 7 to 23, with higher scores representing greater closeness. Cronbach’s alpha was α = .75 for elders and α = .83 for caregivers, with means of 21.5 (SD = 1.87) and 20.2 (SD = 3.02) for elders and caregivers, respectively.

We used a two-item scale to assess understanding of vision condition. Each item was rated on a 5-point
scale: “How well do you think your family (you) truly understands what you (your relative) can and cannot see?” and “How well do you think your family (you) truly understands what you (your relative) can and cannot do because of your (his or her) vision problems?” Response categories ranged from 1 = not at all to 5 = completely. The mean score for elders was 7.6 (SD = 2.16) and for caregivers 8.1 (SD = 1.80), with alphas of $\alpha = .85$ and $\alpha = .71$ for elders and caregivers, respectively.

We measured the variable of overprotectiveness by using a single item rated on a 5-point scale: “Because of your (your relative’s) vision problems, does your family (do you) tend to be overprotective (1 = all of the time to 5 = not at all over-protective)?” The mean score was 2.2 for elders (SD = 1.47) and 2.7 for caregivers (SD = 1.47).

**Analyses**

Using a methodology similar to that of Pakenham (1998) and Pruchno and colleagues (1997), we calculated congruence variables for each of the four outcomes (ADL, overprotectiveness, understanding, and adaptation) by using absolute difference scores. Absolute difference scores are the positive value of the difference between the caregiver and elder scores. Thus, these scores reflect the magnitude but not the direction of the differences. Congruence scores are unique variables that represent the relative standing of the two original scores of the individuals to each other, and thus they can be completely independent of these original scores. Higher scores reflect greater incongruence on the measure. Descriptive data (range, mean, and standard deviation) on the four congruence variables are presented in Table 1.

We used three types of analyses to assess the extent of congruence between caregiver and elder perspectives on the four measures of interest. First, we examined zero-order correlations to assess the general pattern of association between the dyad’s responses. Second, for categorical variables, we calculated kappa statistics to assess the extent of interrater agreement beyond that attributable to chance. Third, we compared mean scores on each outcome variable for the caregiver and elder, utilizing paired t-tests to identify both significant differences and the direction of any differences.

We examined correlates of congruence in preparation for the multivariate analysis. In order to identify the most salient independent predictors of congruence on each of these measures, we conducted hierarchical linear regression analyses. Because of the relatively small sample size, we needed to be parsimonious in terms of the number of independent variables entered. Therefore, we retained only variables with a bivariate relationship at a significance level of .10 or less for the multivariate analyses. In addition, we assessed independent variables for multicollinearity by examining both intercorrelations and tolerance levels from the regression equations. We entered variables in steps according to their domain.

## Results

### Extent of Congruence

Correlational results indicate that the degree of congruence between elders and caregivers differs, depending on the target measure. There was no relationship between the elder’s and caregiver’s ratings of the caregiver’s understanding of the vision condition ($r = .09$), indicating that the dyad’s responses did not covary consistently on this measure. There was a significant, but modest, association between elder and caregiver responses on both overprotectiveness ($r = .28; p < .01$) and adaptation to vision loss ($r = .21; p < .05$). In contrast, the correlation between ADL disability scores was .60 ($p < .001$). These results are consistent with prior research indicating generally good agreement on objective measures such as functional disability, with less congruence on the more subjective assessments. The kappas for the two categorical congruence variables, which were $\kappa = .01$ for adaptation to vision loss and $\kappa = .17$ for overprotectiveness, confirm the low level of agreement between caregivers and elders on these measures.

Results from the paired t-tests for caregiver and elder mean scores on each of the variables of interest are presented in Table 2.
Caregivers rated the elders as significantly more functionally disabled than did the elders when rating themselves, but also assessed themselves as significantly more overprotective than the elders thought they were. Although neither item reached statistical significance ($p > .10$), caregivers tended to report that they understood the elders’ vision condition better than the elders thought they did, and that the elders were less well adapted to their vision disability than the elders rated themselves.

Finally, it is interesting to note that there is no congruence among congruence variables. That is, intercorrelations of the four congruence variables ranged from .02 to .08, indicating that the extent of congruence on one measure has no relationship to congruence on other aspects of the caregiving situation.

Correlates of Congruence Measures

We examined bivariate correlations to provide an overview of how each domain of independent variables was related to congruence measures. Table 3 presents the elder variables associated with at least one of the congruence variables at the $p < .10$ level, whereas Table 4 does the same for the caregiver variables. Variables that have no bivariate relationship with any of the congruence variables and that do not appear in the tables include the following: age and gender of both members of the dyad, caregiver’s self-rated health, all variables reflecting the elder’s assessment of his or her own condition (i.e., time since onset, ADL disability, and adaptation to vision loss), and the elder’s assessment of emotional closeness with the caregiver.

### Table 3. Significant Correlations of Elder Variables With Congruence Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>ADL</th>
<th>Overprotective</th>
<th>Family Understanding</th>
<th>Adaptation to Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociodemographics</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Race</td>
<td>.03</td>
<td>-.16†</td>
<td>-.23*</td>
<td>.00</td>
</tr>
<tr>
<td>Physical and mental health</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Self-rated health</td>
<td>.03</td>
<td>.00</td>
<td>-.20*</td>
<td>-.05</td>
</tr>
<tr>
<td>Depression</td>
<td>.11</td>
<td>-.13</td>
<td>.15</td>
<td>.17†</td>
</tr>
<tr>
<td>Quality of relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overprotective</td>
<td>-.21*</td>
<td>-.19*</td>
<td>-.18†</td>
<td>.19†</td>
</tr>
<tr>
<td>Family understanding</td>
<td>-.04</td>
<td>.04</td>
<td>-.54**</td>
<td>-.03</td>
</tr>
</tbody>
</table>

*Note: Ns range from 102 to 115. ADL = activities of daily living. $^*p < .05; ^*p < .01; ^*p < .001; ^*p < .10.$

### Table 4. Significant Correlations of Caregiver Variables With Congruence Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>ADL</th>
<th>Overprotective</th>
<th>Family Understanding</th>
<th>Adaptation to Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociodemographics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
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<td>-.13</td>
<td>-.17†</td>
<td>.02</td>
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<tr>
<td>Physical and mental health</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>.07</td>
<td>-.22*</td>
<td>-.01</td>
<td>.26**</td>
</tr>
<tr>
<td>Elder’s functional and adaptive status</td>
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<td></td>
<td></td>
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<tr>
<td>Time since onset of vision</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss</td>
<td>-.18†</td>
<td>-.22*</td>
<td>.05</td>
<td>.06</td>
</tr>
<tr>
<td>ADL</td>
<td>.28**</td>
<td>.09</td>
<td>-.04</td>
<td>.18†</td>
</tr>
<tr>
<td>Adaptation to vision loss</td>
<td>-.16†</td>
<td>.02</td>
<td>.19†</td>
<td>-.32***</td>
</tr>
<tr>
<td>Caregiving context</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kin–nonkin</td>
<td>-.02</td>
<td>.06</td>
<td>-.22*</td>
<td>.03</td>
</tr>
<tr>
<td>Lives with elder</td>
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<td>.01</td>
<td>-.23*</td>
<td>.10</td>
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<td>Frequency of ADL help provided</td>
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<td>.12</td>
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<td>.19*</td>
<td>-.21*</td>
<td>.12</td>
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<td>Caregiving appraisals</td>
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<tr>
<td>Quality of relationship</td>
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<tr>
<td>Relationship closeness</td>
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<td>.14</td>
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<td>-.15</td>
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<tr>
<td>Understanding of vision</td>
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<td>.01</td>
<td>-.22*</td>
<td>.03</td>
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<tr>
<td>Overprotective</td>
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<td>.40***</td>
<td>-.09</td>
<td>.11</td>
</tr>
</tbody>
</table>

*Note: Ns range from 100 to 115. ADL = activities of daily living. $^*p < .05; ^*p < .01; ^*p < .001; ^*p < .10.$
Among the sociodemographic characteristics, only elder race had a significant bivariate relationship with at least one congruence variable; that is, being non-White was associated with greater incongruence on family understanding of the vision condition.

In the physical and mental health domain, elder’s rating of poorer health was also significantly related to greater incongruence in family understanding. Interestingly, higher levels of caregiver depressive symptomatology were significantly associated with less incongruence in perceptions of overprotection, but with greater incongruence in adaptation to vision loss.

As noted earlier, no indicator of the elder’s ratings of his or her own function and adaptive status was related to any of the congruence variables. This was not the case for the caregiver’s perceptions of the elder’s status. That is, less time since the onset of the vision problem from the caregiver’s report was associated with greater incongruence on overprotection. The caregiver’s assessment of the elder as more functionally disabled in ADL was associated with greater ADL incongruence. Similarly, the more poorly the caregiver assessed the elder’s adaptation to vision loss, the greater the incongruence in adaptation.

In terms of the context of the caregiving situation, being a friend rather than relative as well as living apart from, rather than with, the elder were both associated with greater incongruence in understanding of the vision condition, but not with any of the other congruence variables. Providing less caregiving assistance was associated only with greater incongruence in understanding of the vision condition. Interestingly, greater worry about the elder was associated with greater incongruence in perceptions of overprotection, but less incongruence in understanding of the vision condition.

Finally, looking at the bivariate relationships between indicators of relationship quality and the incongruence variables, we see several significant relationships. The elder’s perception of greater overprotectiveness by the caregiver was significantly associated with less incongruence in ADL and overprotection. In addition, the less the elder thought that the family understood his or her vision condition, the greater the incongruence between them in understanding. Whereas the elder’s ratings of relationship quality were not related to congruence on any target, the caregiver’s report of poor relationship quality with the elder was associated with greater ADL incongruence. When the caregiver reported that he or she had a poorer understanding of the vision condition, there was greater incongruence on this indicator; in a similar fashion, when the caregiver perceived himself or herself as more overprotective, incongruence on overprotection was greater.

**Multivariate Findings**

Results of the regressions analyses for ADL, overprotection, understanding, and adaptation congruence as criteria are presented in Tables 5, 6, 7, and 8, respectively.

The six variables considered for the regression on ADL congruence fell into three domains: assessment of the elder’s status, caregiving context, and quality of relationship, with the first and third domains contributing approximately equal amounts of explained variance (12% and 11%, respectively) in ADL congruence. Significant independent relationships emerged between greater incongruence on ADL disability and higher caregiver ratings of elder’s ADL disability, elder’s lower assessment of family overprotectiveness, and caregiver’s poorer rating of relationship closeness. The model significantly explained 23% of the variance. Overall, these results suggest that the more negative caregivers experience...
the caregiving situation in terms of the elder’s disability and their emotional relationship with each other, the more likely there is to be incongruence between the dyad on ADL disability.

In terms of overprotection congruence as the criterion, most variables with a significant bivariate relationship retained their significance in the multivariate analyses. Significant independent correlates of lower overprotection congruence included elder race (being non-White), lower caregiver depression, and assessment of overprotection by both the elder and caregiver. As in the bivariate analyses, these latter assessments worked in contradictory ways, with greater incongruence on overprotection associated with elder’s lower ratings of caregiver overprotection and higher self-ratings by the caregiver. These last two variables were the strongest influences on overprotection congruence, explaining half (17%) of the total variance explained by this model ($R^2 = .34, p < .01$).

Seven variables, representing all five domains, were entered in the analyses with understanding congruence as criterion. Only three variables, however, emerged as significant independent correlates of greater incongruence—elder’s lower self-rated health, being a friend rather than a relative, and the elder’s perception of poorer family understanding of their condition. In total, 41% of the variance was explained in this equation, most of which was accounted for by the last step representing the elder’s perception of family understanding ($R^2 = .28, p < .01$).

Finally, the data in Table 8 indicate that we were least successful in identifying predictors of adaptation congruence, explaining only 14% of the variance. Only the caregiver’s lower rating of the elder’s adaptation emerged as significant in predicting greater incongruence. However, the step containing elder and family depression did result in a significant change in $R^2 (\Delta R^2 = .08, p < .05)$ with the regression coefficient indicating that greater caregiver depression was associated with greater incongruence on adaptation to vision loss.

**Discussion**

This study focused on the extent and predictors of congruence between physically disabled elders and their caregivers on several aspects of the caregiving experience. We recognize that the study is limited by the cross-sectional design and the relatively small sample with a single disability. However, although issues of congruence in perceptions are especially salient in this population because of the many misconceptions about normal versus disease-related vision changes in later life (The Lighthouse Research Institute, 1995), questions about mutual perceptions of disability, adaptation, understanding of the condition, and overprotective behaviors are relevant to a number of other common age-related chronic conditions as well. At the same time, the strengths of the study lie in the examination of multiple congruence measures tapping different constructs, the range of independent variables reflecting both objective and subjective–affective components of the caregiving context, and the inclusion of both caregiver and elder variables as potential predictors of congruence.

Our findings both support and extend those of past investigations in this area in several ways. First, it is clear that congruence is not an either–or characteristic of the caregiving relationship. We found a range of covariation between the elder and caregiver reports on the four measures of interest and a total lack of association among the congruence variables. In a similar fashion to past proxy research, we found relatively good agreement on the more objective measure of functional disability, but much lower levels of congruence on the subjective indicators; namely, the assessment of the elder’s
psychosocial adaptation to his or her vision loss, the family’s understanding of the elder’s vision condition, and the extent of family overprotectiveness. The finding that a dyad may have relatively high congruence on certain indicators and low congruence on others underscores the importance of clearly linking the concept of congruence to a specific target rather than thinking of it as a global characteristic of the caregiving relationship.

Second, this study provides support for variability in the direction of incongruence. Our data are consistent with prior research indicating that caregivers tend to more negatively assess the elders’ ADL capability and emotional status compared with the elders’ assessment of themselves. Furthermore, in regard to their own attitudes and behaviors, we found that caregivers evaluate themselves more positively than do the elders, in that they tend to think they understand the elders’ vision condition better than the elders think they do. However, when it comes to perceptions of overprotectiveness, caregivers tend to more negatively self-evaluate themselves as being more overprotective toward the elder than the elder thinks they are. This finding is consistent with those reported by Horowitz, Silverstone, and Reinhardt (1991) in a study of autonomy issues within family-caregiving relationships that also drew on dyadic data. That is, family members tended to respond to potentially conflictual situations with greater sensitivity to autonomy concerns in later life than did their disabled elder relatives. The latter gave greater importance to health and safety concerns than to retaining decision-making or behavioral autonomy. Thus, in terms of the current study’s data, we would argue that behaviors that caregivers define as being overprotective are not similarly defined as such by the elder, which, as a result, leads to incongruence in ratings.

Third, our findings suggest that there is not only variability in the degree and direction of congruence depending on the target issue but also variability in the predictors of congruence across constructs. For example, in the multivariate analyses, the caregiver’s assessment of the elder’s ADL disability was significant only in understanding ADL incongruence, not for any of the other congruence measures. Similarly, being a family member versus being a friend emerged as important for understanding of vision condition congruence, but it did not play a role in congruence on the other outcomes. Interestingly, we found that caregiver depression was related to two of the congruence measures, but in different directions. That is, a lower level of caregiver depression was associated with greater incongruence on overprotection ratings, but with less incongruence in assessments of the elder’s adaptation to vision loss. Thus, some of the inconsistent findings regarding correlates of congruence identified in prior research may be a function of differences in the target question.

Fourth, although specific variables associated with each of the congruence measures varied, some common patterns did emerge. We find that sociodemographic characteristics, such as age and gender, were not strong influences on congruence. Similarly, the elders’ assessment of their own status (i.e., time since onset, ADL ability, and adaptation to vision loss) was not significant in understanding congruence, supporting Chappell and Kuehne’s (1998) conclusion that it is the caregivers’ rather than the care receivers’ characteristics that are the strongest determinants of congruence. Lastly, it appears two domains emerge as most consistent in influencing congruence across measures; namely, the caregiver’s assessment of elder status and the quality of the relationship. Variables in the latter domain, especially, reflect more subjective and affective aspects of the caregiving relationship.

Although these results require replication with other samples of disabled elders, we can draw some tentative implications for practice and future research. First, in situations when a caregiver is called upon to represent the wishes and interests of the disabled elder, it is important for health-care providers to understand how specific characteristics of each member of the dyad can influence how well the caregiver would be in agreement with the elder’s perspective, depending on the issue to be addressed. As our data indicate, caregiver depression and negative appraisals of the caregiving relationship can negatively influence congruence on some, but not all, domains. Second, caregiving relationships can sometimes be fraught with a great deal of tension and conflict, and caregivers and care receivers in these situations often come to the attention of service organizations and clinicians. As Burke and colleagues (1998) noted, discrepancies between elders and caregivers can be troubling to the clinician who is attempting to develop treatment and service plans. However, it would be ill advised to look for a single truth because differences in perception, rather than objective fact, typically define incongruence. Instead of a barrier to treatment, the existence of incongruence may be best approached as a primary target for intervention. Lack of congruence in a caregiving relationship may be the cause or consequence of negative interactions between caregiver and care receiver. This is a question that we simply do not have the data yet to address and that remains a critical question for future research. In either case, however, the very fact that incongruence exists provides important clinical information that can be used to facilitate communication between the dyad (Kristjanson et al., 1998).

Clearly, additional research attention to issues of congruence in caregiving relationships is needed for us to more fully understand the causes and consequences of this phenomenon across different constructs. Studies with larger, more diverse samples of elders are needed, as are longitudinal designs that
can track consistency and change in congruence over time as a function of changing caregiving circumstances. What is most important is that research is needed to examine the consequences of incongruence in terms of how it influences both general well-being among elders and their caregivers and plays a role in influencing outcomes of service and rehabilitation interventions for disabled elders, which typically depend on the active involvement and understanding of family members.

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