Finding Meaning Through Caregiving: Development of an Instrument for Family Caregivers of Persons with Alzheimer's Disease

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Systematic assessment of the positive aspects of caregiving has been limited by the lack of comprehensive, theoretically based, and psychometrically sound measures. This study developed and tested a measure primarily designed to assess positive aspects and ways that caregivers find meaning through their experience of caring for a person with dementia. The measure has three subscales: Loss/Powerlessness, which identifies difficult aspects of caregiving; Provisional Meaning, which identifies how caregivers find day-to-day meaning; and Ultimate Meaning, which identifies philosophical/religious/spiritual attributions associated with the

experience of caregiving. The measure is useful for understanding the close relationship between both the difficult and positive aspects of caregiving and also may be used to identify a caregiver's strengths in clinical and research settings. © 1999 John Wiley & Sons, Inc. J Clin Psychol 55: 1107–1125, 1999.

Until recently, potential positive effects and means through which caregivers of persons with dementia make sense of their experiences have been largely ignored. Two unanswered questions focus on "why" and "how" caregivers do so well under difficult circumstances. Operationalization of these positive aspects has included constructs such as uplifts (Kinney & Stephens, 1989), caregiving satisfaction and traditional caregiving ideology (Lawton, Kleban, Moss, Rovine, & Glicksman, 1989; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991), personal gain and management of meaning (Pearlin, Mullan, Semple, & Skaff, 1990), postcaregiving rewards (Picot, 1995; Stewart, Archbold, Lee, & Galyen, 1991), and positive feelings toward caregiving (Yamada & Dunkle, 1991). For a more complete discussion of these positive appraisal methods, see Kramer (1997). These positive concepts have been identified as being relevant to both caregiver appraisal, caregiver coping strategies, and potential caregiver outcomes (Kinney & Stephens, 1989; Lawton et al., 1989; Pearlin et al., 1990).

Systematic assessment of these positive aspects of caregiving has been limited by the lack of a comprehensive, theoretically based, and psychometrically sound measure. The availability of such a measure will assist researchers to examine how positive attitudes might influence both the caregiving process and outcomes. Such a measure would also assist clinicians to identify caregiver strengths and design interventions aimed toward supporting and further developing these positive aspects.

Earlier work suggests that existential and stress/adaptation paradigms complement our understanding of how difficult aspects of caregiving simultaneously exist with more positive aspects, such as finding meaning (Farran, 1997; Farran, Keane-Hagerty, Salloway, Kupferer, & Wilken, 1991). Existentialism, a philosophical perspective, is more abstract and addresses such issues as suffering, meaninglessness, nothingness, responsibility, hope, transcendence, and finding meaning (Frankl, 1963, 1978). This perspective was first applied to the experience of caring for persons with dementia by Levine and colleagues (1984) who suggested that caregivers "live in a prison, struggle on a battlefield, and languish in a concentration camp" (p. 222). The stress/adaptation paradigm is more empirically based and, when applied to caregiver research, suggests that the parts, such as stressors, resources, appraisal, and outcomes, can be operationalized; the whole can be represented by corresponding parts; and these parts have a causal relationship (Farran, 1997, p. 251). A combination of these two theoretical perspectives provides a broader basis for interpreting and operationalizing the caregiving experience as outlined in this article.

Theoretical support for the construct "finding meaning," has primarily evolved out of Victor Frankl's (1963, 1978) personal and professional experiences. Early attempts to operationalize the construct of finding meaning from an existential perspective included the Purpose in Life test (Crumbaugh & Maholick, 1969). More recently, Reker and colleagues (Reker, 1992; Reker, Peacock, & Wong, 1987) used a life span perspective to operationalize this construct using the Life Attitude Profile, Sources of Meaning Index,

and Ladder of Life Index. No known caregiver studies, however, have used any of these existentially based measures to examine the positive aspects of caregiving. The construct "finding meaning through caregiving" was initially identified in a preliminary qualitative study of family caregivers of persons with dementia ($N = 94$). Respondents answered a series of open-ended questions, and qualitative analyses identified six major themes (Farran et al., 1991). Using these six major themes and specific wording suggested by caregivers, a 135-item Finding Meaning Through Caregiving Scale (FMTCS) was developed.

The purpose of this multiphased study was to determine the psychometric properties (reliability, convergent, and discriminant validity) of a measure designed to assess positive aspects and ways caregivers find meaning through their experience of caring for a person with dementia. Study 1 focused on establishing validity of the measure using criterion measures that had a clear existential base. Study 2 focused on establishing validity with stress/adaptation measures commonly used in caregiver research.

STUDY 1: MAIL SURVEY

Method

The purpose of Study 1 was to establish preliminary reliability and validity of a shortened Finding Meaning Through Caregiving Scale (FMTCS). General, as opposed to caregiver-specific, criterion measures were selected for their close association with an existential paradigm.

Participants

A small convenience sample ($N = 46$) of home-based dementia caregivers was recruited from a large midwestern Alzheimer's disease diagnostic and research center. Selection criteria included caregivers whose family member had a diagnosis of dementia, who provided care in their home, and who agreed to participate. Caregivers were contacted by telephone and completed a mail questionnaire once it was determined they were eligible for the study. The FMTCS was completed again one month after entry into the study.

This sample was primarily White (96%), married (91%), and women (71%). Caregivers included wives (40%), husbands (29%), daughters (22%), and other family members (9%). Their average age was 65.53 years ($SD = 9.75$), and their socioeconomic status was primarily middle class (Potential Range: 1 = Lower to 5 = Upper Class; $M = 3$ .42, $SD = .97$). Socioeconomic status was determined using the Hollingshead two-factor Index of Social Position, which is based upon occupational history and education (Hollingshead, 1982).

Measures

Non-Death Grief Experience Inventory-Form B (GEI-B). This 104-item multidimensional measure yields scores on three validity scales, six bereavement scales, and seven research scales. Respondents indicate whether statements are true or false. GEI-B validity has been established with the Minnesota Multiphasic Personality Inventory. The GEI-B has been used to determine grief associated with a variety of situations including divorce and separation, parenting a handicapped child, and institutionalization of aged parents (Sanders, Mauger, & Strong, 1985).

Life Attitude Profile-Revised (LAP-R). This 36-item, multidimensional, self-report scale measures attitudes toward life. A 7-point Likert scale (*strongly disagree* to *strongly agree*) is scored and profiled in six dimensions (purpose, coherence, life control, death acceptance, existential vacuum, and goal seeking) and two composite indices (personal meaning index and life attitude balance index). Validity of the measure has been determined in a series of eight studies using a wide variety of psychological and physical well-being and purpose in life measures. The measure has been normed with young, middle-aged, and older adults and has been used with individuals who have had near-death and out-of-body experiences, following bereavement, with older adults following a reminiscence intervention, and as a predictor of health promotion (Reker, 1992; Reker et al., 1987).

Ladder of Life Index (LOLI). The LOLI consists of a visual three-part ladder that identifies how meaningful life was 5 years ago, presently, and how meaningful it will be 5 years from now. Respondents indicate the level of meaning on each of three ladders from 0–10 (*not meaningful* to *extremely meaningful*). Concurrent validity of the measure has been determined in the same series of studies cited previously (Reker, 1992).

Public and Private Religiosity. This 7-item religiosity measure includes public and private religiosity subscales, identified religious affiliation, frequency of attendance at services, number of known congregation members, self-assessment of religious depth, and how much strength and comfort is derived from religion. Prior research using this measure indicated that public religious involvement protected both men and women against disability, and private religious involvement protected disabled men against depression (Idler & Kasl, 1991, 1992).

Finding Meaning Through Caregiving Scale (FMTCS). The 43-item measure was derived from an initial measure of 135 items developed from caregivers' qualitative responses (Farran et al., 1991). The original 7-point Likert-type rating format asked caregivers to identify their level of agreement with each item (1 [*strongly disagree*] to 7 [*strongly agree*]). A Total Finding Meaning score was derived by reverse scoring Loss/Powerlessness items and then summing the three subscales. The three subscales include:

1. Loss/Powerlessness (LP). The 19-item subscale combines three qualitatively derived themes and reflects caregivers' feelings of loss for their family member, feelings of loss concerning themselves, and feelings of powerlessness associated with caregiving (Farran et al., 1991). Scores for this subscale ranged from 38–125 (Potential Range: 19–133; $M = 91.89$, $SD = 17.21$). Theoretically, these items are supported by existential literature that maintains that suffering, powerlessness, and feelings of loss are a part of finding meaning. One does not deny suffering or feelings of powerlessness but makes personal choices as to how to interpret these difficult experiences (Frankl, 1963, 1978). Although the predominant model for examining responses to the caregiving experience focuses on the stress of caregiving, some authors also suggest that grief is an appropriate paradigm, given the many losses experienced by both the caregiver and his or her impaired family member, but that grief is only one manifestation of the stress associated with caregiving (Bodnar & Kiecolt-Glaser, 1994).

2. Provisional Meaning (PM). The 19-item subscale focuses on how persons find day-to-day meaning through caregiving. This subscale combines three qualitatively derived themes that focus on caregivers' values concerning positive aspects

about life and caregiving, personal choices, and means by which caregivers find small pleasures in their current situation (Farran et al., 1991). Provisional Meaning scores ranged from 49–131 (Potential Range: 19–133; $M = 102.96$, $SD = 18.31$). Theoretically, these items are supported by existential literature that maintains that persons can find both provisional and ultimate meaning. Provisional meaning refers to those short-term or transitory experiences that give meaning to life. Provisional meaning can be found through such things as day-to-day tasks and relationships. Existential literature also maintains that persons' values are critical to finding meaning, that persons create meaning by making choices, and that each person has responsibility for right action and conduct (Frankl, 1963). More recent caregiving literature has placed greater emphasis on the positive aspects of caregiving that might simultaneously exist with the more stressful aspects (Kramer, 1997).

3. Ultimate Meaning (UM). The 5-item subscale includes responses that focus on a higher power or a religious/spiritual structure. Subscale scores ranged from 5–35 (Potential Range: 5–35; $M = 25.17$, $SD = 8.00$). Existential literature maintains that ultimate meaning is experienced when persons explore deeper philosophical or spiritual meaning in life (Frankl, 1963). More recent caregiving literature suggests that religion, and particularly private aspects of religion such as prayer (Family Caregiving in the US, 1997; Picot, Debane, Namazi, & Wykle, 1997), may play an important role in how caregivers appraise and cope with providing care to their impaired relatives (Lawton et al., 1989, 1991).

The following hypotheses were identified for Study 1:

1.1. Convergent validity of the LP subscale will be established with positive associations between LP and the GEI-B subscales (despair, anger, social isolation, somatization, loss of vigor, physical symptoms, and depersonalization) and the LAP-R existential vacuum and goal-seeking subscales. Discriminant validity will be established by inverse correlations between PM, UM, and Total Meaning and these same GEI-B and LAP-R subscales.

1.2. Convergent validity of the Provisional Meaning subscale will be established with positive relationships between PM and the remaining LAP-R subscales and total scores (purpose, coherence, life control, personal meaning index, and life attitude balance index) and the LOLI. PM discriminant validity will be established with inverse or insignificant relationships between LP and these same LAP-R and LOLI subscales, and lower positive or insignificant relationships between UM and these same subscales.

1.3. Convergent validity of the Ultimate Meaning subscale will be established with positive relationships between UM and the religiosity measures. UM discriminant validity will be established by inverse relationships between LP and these same subscales and lower positive or insignificant relationships between PM and the religiosity subscales.

STUDY 2: SPOUSE CAREGIVER INTERVIEW STUDY

Method

The purpose of this second study was to establish psychometric properties of the FMTCS with a larger caregiver sample, using specific caregiver stress/adaptation measures. This

study was part of a larger cross-sectional study that examined the influence of race and gender on spouse caregivers of cognitively impaired persons (Miller, Campbell, Farran, Kaufman, & Davis, 1995).

Participants

The sample of 215 spouse caregivers included 22 African American men, 55 African American women, 56 White men, and 82 White women. The mean age of the caregivers was 71.67 years ($SD = 8.54$). Average caregiver education was 13.1 years and average years married was 43.6 (Miller et al., 1995).

Measures

The following caregiver-specific measures were used for this study:

Frequency of Behavior Problems Scale. This 28-item measure summarizes the level of behavior problems presented by the impaired family member, including cognitive symptoms such as forgetfulness, misplacing, or losing objects; behavioral symptoms such as wandering, hoarding, or hiding things; aggressive behaviors such as destroying property; and psychiatric symptoms such as paranoia, hallucinations, or delusions (Niederehe & Fruge, 1984). Caregivers indicate how frequently behaviors occur (1 [*never*] to 5 [*every day*]). Cronbach alpha internal consistency with this current sample was .87.

Center for Epidemiological Studies-Depression Scale (CES-D). This 20-item scale is commonly used as a measure of distressed mood in caregiver studies and has a range of 0–60 (Radloff, 1977). Cronbach alpha internal consistency with this current sample was .90.

Global Role Strain. This 7-item measure examines emotional distress specific to caregiving, including confinement, general difficulty, and overall stress because of the obligations of caregiving (Archbold, Stewart, Greenlick, & Horwath, 1990). Cronbach alpha internal consistency with this current sample was .77.

Marital Tension. This 6-item measure examines caregiver perceptions of current tensions that exist in the caregiver's relationship with his or her spouse (Bengston, Rosenthal, & Burton, 1990). Cronbach alpha internal consistency of this measure was .78 with this sample.

Marital Satisfaction. This 5-item measure examines current caregiver perceptions of the positive or meaningful aspects of their spousal relationship (Archbold et al., 1990; Bengston et al., 1990). Cronbach alpha internal consistency with this sample was .81.

Caregiver Satisfaction. This 7-item measure determines caregivers' feelings of satisfaction about helping their spouse (Lawton et al., 1989). The 4-item measure of Personal Gain (Pearlin et al.,1990) identifies their positive feelings associated with caregiving. Cronbach alpha internal consistencies with this sample were .81 and .68, respectively.

Religiosity. This 15-item measure and its associated subscales, religious participation, nonorganized religion, and satisfaction with organized religious support, focuses on caregivers' active religious participation, personal religious beliefs, and satisfaction with

support from their religious community, respectively (Taylor & Chatters, 1986). Cronbach alpha internal consistencies for these subscales were .78, .84, and .90, respectively.

Finding Meaning Through Caregiving Scale (FMTCS). Due to caregiver response patterns in Study 1 and to reduce the amount of caregiver interview time, the 7-point Likert-type response pattern was changed to a 5-point Likert-type scale (1 [*strongly disagree*] to 5 [*strongly agree*]). The final 43-item FMTCS, when self-administered, requires approximately 10–15 minutes for completion. Oral administration is possible, increasing completion time to about 20–25 minutes. To determine the Total Finding Meaning score, Loss/Powerlessness items were reverse scored and the total of all three subscales was summed. In this sample, Total Meaning scores ranged from 76–198 (Potential Range: 43–215; $M = 144.35$, $SD = 19.07$); LP scores, prior to reverse scoring, ranged from 29–91 (Potential Range: 19–95; $M = 64.86$, $SD = 11.45$); PM scores ranged from 45–95 (Potential Range: 19–95, $M = 75.85$, $SD = 8.88$); and UM scores ranged from 5–25 (Potential Range: 5–25; $M = 19.36$, $SD = 4.22$).

The following hypotheses were identified for Study 2:

2.1. Convergent validity of the LP subscale will be established by positive relationships between LP and care-receiver strain measures such as frequency of behavior problems, marital tension, role strain, and caregiver depression (Lawton et al., 1991; Miller et al., 1995). Inverse relationships between these same caregiver measures and PM, UM, and Total Meaning will establish discriminant validity.

2.2. Convergent validity of the PM subscale will be established by positive relationships with marital satisfaction, caregiver satisfaction, and personal gain (Lawton et al., 1989; Miller et al., 1995; Pearlin et al., 1990). Inverse relationships between these same caregiver measures and LP, and weaker positive relationships between these measures and UM, will establish discriminant validity.

2.3. Convergent validity of the UM subscale will be established with positive relationships between UM and religion subscales (Family Caregiving in the US, 1997; Lawton et al., 1989, 1991; Picot et al., 1997). Inverse relationships between these religious measures and LP, and weaker positive relationships between these same measures and PM, will establish discriminant validity.

Results

Analyses were conducted in two stages. The first stage determined the reliability of a shortened version of the FMTCS. The second stage of analyses focused on determining scale validity. Confirmatory factor analysis was conducted, subscale and subscale-to-total correlations, and correlations with existing measures were examined. Because we tested many correlations in this study we used the alpha = .01 criterion for statistical significance to adjust for these multiple tests. This conservative criterion was selected to ensure that we did not overinterpret these data.

Reliability

The first stage of data analysis focused on reducing the original 135-item measure to a shorter measure of 43 items with three subscales and establishing test-retest reliability (Study 1). Item reduction was achieved by examining item-to-item, item-to-subscale, and

Table 1
*Finding Meaning Through Caregiving Scale: Cronbach Alpha Internal
Consistency Reliability and Test-Retest Reliability by Study*

| Subscales | Study 1 ($N = 46$) | | Study 2 ($N = 208$) |
	Internal Consistency	Test-Retest*	Internal Consistency
Loss/Powerlessness	.88	.85	.89
Provisional Meaning	.92	.85	.88
Ultimate Meaning	.95	.89	.91
Total Meaning	.91	.80	.91

*Spearman Correlations $p < .0000$.

item-to-total correlations and by conducting internal consistency analyses. The goal was
to derive subscales with an internal consistency reliability of $>.70$, and internal consis-
tency reliability of $>.80$ for the entire measure. Cronbach alpha internal consistency
reliabilities were consistently high for each subscale and for the entire measure in both
Study 1 and 2 (.88 to .95; see Table 1).

Validity

Confirmatory factor analysis. We decided to use confirmatory factor analysis because
we believed that our original subscales had a strong theoretical base. The LISREL 7
program was used to estimate the model based on the scores from 206 participants
(Study 2). Three underlying factors were assumed for the model: *X, Y,* and *Z.* Fit for the
model was adequate with a Goodness of Fit Index (GFI) of .763, $\chi^2 = 1444$, $df = 832$,
and a coefficient of determination of .998. Factor 1 (X) was estimated to be correlated .29
and .14, respectively, with Factor 2 (Y) and Factor 3 (Z). The Factor 2/3 (Y–Z) correla-
tion was estimated to be .55. All of the estimated standardized weights for the final model
are given in Table 2.

Confirmatory factor analysis provided strong support for construct validity of the
three subscales as theoretically derived. Sixteen of the 19 LP subscale items loaded high-
est on Factor 1. All 19 PM subscale items had highest loadings on Factor 2, and all five
UM subscale items loaded highest on Factor 3. Only three LP items (25, 37, 30) had
somewhat higher loadings on Factor 2 (PM). There were two reasons why we chose not
to move these items to Factor 2. The first was that even though the weights were some-
what higher on Factor 2, they were still positively associated with Factor 1. In addition,
inspection of these items indicated that the content of the items was more consistent with
Factor 1. Two of these items focused on wishing (25: "I wish I was free to lead my own
life" and 37: "I wish I could run away") and are viewed as similar to emotion-based
coping strategies that may be associated with loss/powerlessness (Lazarus & Folkman,
1984). The third focused on missing one's job and personal interests (30: "I miss having
given up my job and personal interests"). This item appeared more similar to other items
on LP and appeared more similar to loss (e.g., 18: "I miss our previous social life" and 24:
"I miss not being able to travel").

Factor analysis supported the three theoretically derived subscales but suggested that
some conceptual overlap existed between the LP and PM subscales. The conceptual over-

lap noted in these data is somewhat different than what was expected from data shown in Table 2 where there were close relationships noted between PM and UM (.44 and .58), and in Table 3 where the LAP-R coherence subscale was noted to be more similar to UM than the hypothesized PM. It is possible that the conceptual overlap between the sub-scales may reflect the simultaneous and ongoing nature of feelings of loss/powerlessness and the process of finding meaning. That is, one might experience feelings of loss/powerlessness while experiencing a sense of provisional and ultimate meaning (Frankl, 1963, 1978; Soelle, 1975).

Subscale and Subscale-to-Total Correlations. We used 2-tailed probabilities in Table 3 because a negative correlation between subscales is interpretable. Preliminary analyses revealed that the Pearson's *r* bivariate correlation coefficients and subscale-to-total correlations were consistent across both studies. Expected inverse correlations were noted between LP and PM, UM, and Total Meaning, $r = -.20$ to $-.81$. Expected positive correlations were noted between PM and UM and Total Meaning, $r = .44$ to .81. Correlations between PM and UM suggested some conceptual overlap between these two sub-scales, $r = .44$ and .58. This conceptual overlap is theoretically supported by existential perspectives that suggest that provisional meaning is based upon the values that one holds. If these values are spiritual/religious in nature, a close relationship between provisional and ultimate meaning would be expected (Batson & Ventis, 1982; Frankl, 1963, 1978).

Loss/Powerlessness Subscale (LP): Convergent and Discriminant Validity. Study 1 examined preliminary convergent and discriminant validity using existentially oriented measures that were not specific to the caregiving experience (Table 4, Hypothesis 1.1). As hypothesized, preliminary convergent validity of LP was established through the positive correlations of each of the GEI-B subscales and the selected LAP-R subscales. Strongest relationships were noted between LP and selected GEI-B subscales (despair, social isolation, loss of vigor, physical symptoms, and depersonalization), $r = .37$ to .51, $p = .01$, and the LAP-R existential vacuum and goal-seeking subscales, $r = .50$ and .51, $p = .01$. Preliminary discriminant validity was established by inverse relationships noted between PM, UM, and Total Meaning and these same subscales, $r = -.36$ to $-.61$, $p = .01$. For these analyses, we used one-tailed probabilities because significant correlation in the nonhypothesized direction would be ignored. Thus, for example, a negative correlation between LP and the GEI-B Despair Scale would be seen as a random result.

Additional analyses to determine LP convergent and discriminant validity were conducted with caregiver stress/adaptation criterion measures in Study 2. It was hypothesized that convergent validity would be further supported if positive relationships between LP and caregiver stress variables were found (frequency of problem behaviors, marital tension, role strain, and caregiver depression; Table 5, Hypothesis 2.1). All of these relationships were confirmed, $r = .38$ to .70, $p = .01$. Discriminant validity was further supported with the inverse relationships found between PM, UM, and Total Meaning and each of these caregiver stress measures, $r = -.28$ to $-.64$, $p = .01$.

Provisional Meaning Subscale (PM): Convergent and Discriminant Validity. Study 1 examined preliminary convergent and discriminant validity using existentially oriented measures that were not specific to the caregiving experience (Table 4, Hypothesis 1.2). Preliminary convergent validity of PM was established when the positive hypothesized relationships were found between PM and the selected LAP-R scales (purpose, coher-

Table 2
Oblique Confirmatory Factor Analysis: Finding Meaning Through Caregiving Scale (Study 2: n = 206)

Items #	Description	Estimated Standardized Weights		
		Factor 1 LP	Factor 2 PM	Factor 3 UM
	Loss/Powerlessness			
L/P1	I miss the communication and companionship that my family member and I had in the past.	.521	—	—
L/P4	I miss the little things my relative and I did together in the past.	.516	—	—
L/P5	I am sad about losing the person I once knew.	.669	—	—
L/P2	I miss my family member's ability to love me as he/she did in the past.	.592	—	−.203
L/P3	I am sad about the mental and physical changes I see in my relative	.500	—	—
L/P12	I miss not having more time for other family members and/or friends.	.510	.176	—
L/P36	I miss my relative's sense of humor.	.664	−.250	—
L/P6	I miss not being able to be spontaneous in my life because of caring for my relative.	.593	—	—
L/P18	I miss our previous social life.	.557	—	—
L/P34	We had goals for the future but they just folded up because of my relative's dementia.	.547	.092	—
L/P31	I feel trapped by my relative's illness.	.506	.288	—
L/P24	I miss not being able to travel.	.484	—	—
L/P7	My situation feels endless.	.481	—	—
L/P41	I feel that the quality of my life has decreased.	.482	.368	—
L/P19	I have no hope; I am clutching at straws.	.418	—	—
L/P13	I wish I were free to lead a life of my own.	.319	—	—
L/P25	I wish I could run away.	.341	.367	—
L/P37	I miss having given up my job or other personal interests to take care of my family member.	.240	.498	—
L/P30		.242	.389	—

Provisional Meaning

Item			
PM22	I am glad I am here to care for my relative.	.751	—	−.199
PM43	Caregiving has made me a stronger and better person.	.703	−.190	—
PM16	Caregiving makes me feel good that I am helping.	.682	—	—
PM33	I would not have chosen the situation I'm in, but I get satisfaction out of providing care.	.643	—	−.175
PM8	I enjoy having my relative with me; I would miss it if he/she were gone.	.633	—	—
PM20	The hugs and "I love you" from my relative make it worth it all.	.582	—	—
PM27	Even though there are difficult things in my life, I look forward to the future.	.576	—	—
PM10	Caring for my relative gives my life a purpose and a sense of meaning.	.559	—	—
PM32	Each year, regardless of the quality, is a blessing.	.558	—	—
PM9	I count my blessings.	.549	—	—
PM28	Caregiving has helped me learn new things about myself.	.510	−.355	.280
PM38	Every day is a blessing	.505	—	—
PM21	I'm a fighter.	.489	—	—
PM15	I am a strong person.	.474	—	.276
PM42	I start each day knowing we will have a beautiful day together.	.410	−.248	—
PM14	I cherish the past memories and experiences that my relative and I have had.	.394	—	—
PM40	I am much stronger than I think.	.369	—	—
PM26	Talking with others who are close to me restores my faith in my own abilities.	.300	—	—
PM39	This is my place; I have to make the best out of it.	.180	—	—

Ultimate Meaning

Item			
UM17	I believe in the power of prayer; without it I couldn't do this.	—	—	.782
UM35	God is good.	—	—	.773
UM29	I have faith that the good Lord has reasons for this.	—	—	.742
UM11	The Lord won't give you more than you can handle.	.288	—	.583
UM23	I believe that the Lord will provide.	—	—	.931

Table 3

Subscale and Subscale-to-Total Pearson's r Correlations by Study

Subscale	Study 1 (*N* = 46)				Study (*N* = 208)			
	LP	PM	UM	TM	LP	PM	UM	TM
Loss/Powerlessness (LP	1.00	—	—	—	1.00	—	—	—
Provisional Meaning (PM)	−.26	1.00	—	—	−.35*	1.00	—	—
Ultimate Meaning (UM)	−.20	.44*	1.00	—	−.23*	.58*	1.00	—
Total Meaning (TM)	−.70*	.81*	.62*	1.00	−.81*	.80*	.63*	1.00

*p < .01 (2-tailed).

ence, life control, personal meaning index, and life attitude balance index; r = .48 to .59, p = .01). PM had the strongest relationship with present meaning on the Ladder of Life Index (LOLI), r = .45, p = .01, suggesting that present provisional meaning may be more relevant than either past or future meaning.

Table 4

Convergent and Discriminate Validity of the Finding Meaning Through Caregiving Scale Using Existentially Oriented Criterion Measures (Pearson's r Correlations) (Study 1: N = 46)

Hypotheses and Measures	FMTCS Subscales			
	LP	PM	UM	Total
1.1. LP Hypotheses				
Grief Experience Inventory-B (GEI-B)				
Despair	.51*	−.40*	−.36*	−.61*
Anger	.34	−.27	−.34	−.42*
Social Isolation	.42*	−.33	−.29	−.44*
Somatization	.29	−.33	−.28	−.44*
Loss of Vigor	.37*	−.32	−.23	−.47*
Physical Symptoms	.37*	−.33	−.12	−.42*
Depersonalization	.41*	−.17	−.26	−.41*
Life Attitude Profile-Revised				
Existential Vacuum	.51*	−.27	−.30	−.50*
Goal Seeking	.50*	−.22	−.32	−.44*
1.2. PM Hypotheses				
Life Attitude Profile-Revised (LAP-R)				
Purpose	−.38*	.55*	.43*	.67*
Coherence	−.43*	.56*	.66*	.73*
Life Control	−.34*	.48*	.16	.50*
Personal Meaning Index	−.43*	.59*	.58*	.74*
Life Attitude Balance Index	−.42*	.55*	.49*	.68*
Ladder of Life Index				
Past Meaning (LOLI)	.12	.16	−.04	.01
Present Meaning	−.40*	.45*	.17	.51*
Future Meaning	−.31*	.34*	.22	.42*
1.3. UM Hypotheses				
Public Religiosity	−.30	.13	.33	.34
Private Religiosity	−.28	.41*	.77*	.58*
Total Religiosity	−.32	.16	.35*	.36*

*p < .01 (1-tailed).

Table 5

Convergent & Discriminant Validity of the Finding Meaning Through Caregiving Scale Using Caregiver Stress/Adaptation Criterion Measures (Pearson's r Correlations) (Study 2: N = 208)

Hypotheses and Measures	FMTCS Subscales			
	LP	PM	UM	Total Scale
2.1. LP Hypotheses				
Problem Behaviors	.44*	−.18	−.12	−.35*
Marital Tension	.38*	−.46*	−.27*	−.49*
Global Role Strain	.70*	−.39*	−.14	−.64*
CES-D	.61*	−.37*	−.28*	−.60*
2.2. PM Hypotheses				
Marital Satisfaction	−.53*	.24*	.13	.46*
Caregiver Satisfaction	−.38*	.64*	.25*	.58*
Personal Gain	−.12	.57*	.26*	.39*
2.3. UM Hypotheses				
Religious Participation	−.22*	.24*	.53*	.37*
Non Organized Religion	−.18*	.49*	.61*	.54*
Satisfaction with Organized Religious Support	−.11	.20*	.24*	.21*

$*p < .01$ (2-tailed).

Preliminary discriminant validity of PM was established when the hypothesized inverse relationships were found between LP and these LAP-R scales, $r = -.34$ to $-.43$, $p = .01$. Preliminary discriminant validity between PM and UM was supported with weaker correlations between UM and four out of the five LAP-R scales (purpose, life control, personal meaning index, and life attitude balance) and insignificant relationships for all LOLI subscales. However, the relationship between UM and the LAP-R coherence subscale was somewhat higher than the relationship between PM and coherence, $r = .66$ and .56, $p = .01$, respectively, and the relationships between PM and UM and the personal meaning index were similar (.59 and .58, respectively). Closer examination of selected coherence subscale items suggests why this might be true as four out of the eight items appear to be similar to UM (viz., "I am aware of an all powerful and consuming purpose in my life," "I have a philosophy of life that gives my existence significance," "I have a framework that allows me to understand life," and "I have a clear understanding of the ultimate meaning of life"). The similar strength of relationships between PM and UM and the personal meaning index is likely due to the fact that this index combines both the purpose and coherence subscales.

Additional studies of convergent and discriminant validity were conducted with caregiver stress/adaptation criterion measures in Study 2. It was hypothesized that convergent validity would be further supported if positive relationships between PM and caregiver positive variables were found (marital satisfaction, caregiver satisfaction, and personal gain; Table 5, Hypothesis 2.2). All of these relationships were confirmed, $r = .24$ to .64, $p = .01$). It is possible that the relationship between PM and marital satisfaction is weaker than caregiver satisfaction and personal gain because the latter two are more global positive measures. Marital satisfaction is a more specific indicator and is often thought to be lower in spouses of persons with dementia because of the more limited reciprocity in the relationship (Wright & Aquilino, 1998). PM discriminant validity was further supported with the inverse relationships found between LP and these same caregiver measures, $r = -.38$ to $-.53$, $p = .01$, and the insignificant or weaker relationships found between UM and these caregiver variables, $r = .25$ to .26, $p = .01$.

Ultimate Meaning Subscale (UM): Convergent and Discriminant Validity. Study 1
examined preliminary convergent and discriminant validity using existentially oriented
measures that were not specific to the caregiving experience (Table 4, Hypothesis 1.3).
Preliminary convergent validity of UM was established when the positive hypothesized
relationships were found between UM and the religiosity measures, $r = .35$ to $.77$, $p =$
.01. UM had the strongest relationship with private religiosity, $r = .77$, $p = .01$. Prelim-
inary discriminant validity of UM was established when the hypothesized but nonsignif-
icant inverse relationships were found between LP and these religiosity subscales, $r =$
$-.28$ to $-.32$, $p = .05$. Preliminary discriminant validity between UM and PM was
supported by insignificant or weaker correlations between PM and each of these religi-
osity subscales, $r = .13$ to $.41$.

Additional studies of convergent and discriminant validity were conducted in
Study 2 with religiosity measures commonly used in caregiver studies. It was hypoth-
esized that convergent validity would be further supported if positive relationships were
found between UM and these religious subscales (religious participation, nonorganized
religion, and satisfaction with organized religious support; Table 5, Hypothesis 2.3). All
of these relationships were confirmed, $r = .24$ to $.61$, $p = .01$. UM discriminant validity
was further supported with the inverse relationships found between LP and these same
religiosity measures, $r = -.11$ to $-.22$; and the weaker positive relationships found
between PM and these religious subscales, $r = .20$ to $.49$, $p = .01$. Of note in both Study
1 and 2 is that UM had the strongest positive relationships with a more personal religi-
osity (Study 1, Table 4, private religiosity $r = .77$, and Study 2, Table 5, nonorganized
religion, $r = .61$.

Discussion

This multistage research study traces the development of the Finding Meaning Through
Caregiving Scale (FMTCS) from an initial qualitative study through two successive quan-
titative studies. The measure is easy to use, easy to score, and may be used in self-report
or interview settings. Results support the use of the FMTCS as a measure of both positive
and more difficult aspects that caregivers may experience while caring for a person with
dementia. The FMTCS is a reliable and valid method of assessing caregivers' feelings of
loss and powerlessness and their perceptions of how they find provisional and ultimate
meaning. A particular strength of this measure is its concurrent and discriminant validity
with three existentially oriented criterion measures not commonly used in caregiver
research. Concurrent and discriminant validity was further supported by stress/adaptation
criterion measures more commonly used in caregiver research. This measure should be
useful for future caregiver research that focuses on understanding why or how caregivers
do so well in spite of the many difficulties they experience. Likewise, the measure may be
used in clinical settings to identify caregivers' strengths and potential areas for interven-
tion (Farran, Horton-Deutsch, Choi, & Fogg, 1997; Farran & Kuhn, 1998).

Of note is that there was some conceptual overlap between LP and PM, as noted with
the confirmation factor analysis, and PM and UM subscales, as noted with bivariate
correlations. Frankl's (1963, 1978) seminal work suggested that these constructs simul-
taneously exist and that through the experience of suffering and loss/powerlessness, per-
sons may make intentional choices as to how to respond to difficult life events, and that
they have the potential of moving toward finding provisional and ultimate meaning.
These data suggest that the PM subscale reflects the positive aspects of caregiving, whereas
the LP subscale reflects areas of difficulty experienced in caregiving, and the UM sub-
scale reflects other internal coping mechanisms associated with higher philosophical/

spiritual/religious concerns. Some additional issues underlying each of these subscales will be discussed in turn.

Loss/Powerlessness

With respect to the Loss/Powerlessness subscale and its close association with two caregiver distress measures (depression and global role strain), further attention needs to be given to understanding how it is that these stressful feelings may coexist with more positive aspects of caregiving. We currently do not know at what point these feelings express the normal feelings of loss and grief associated with caregiving; under what circumstances these feelings of loss/powerlessness may lead to despair (Frankl, 1978), changes in physical health, and the inability to continue caring for another; or whether positive aspects might mitigate these more difficult feelings and potentially alter negative caregiver outcomes. Longitudinal studies that track the positive and the more difficult aspects of caregiving are needed to answer these questions.

Provisional Meaning

The PM subscale increases our understanding of how caregivers find day-to-day meaning in their experiences. The direct negative relationship with depression and global role strain in the multivariate analyses of these data in a related study suggested that higher levels of provisional meaning moderate levels of depression and role strain (Farran, Miller, Kaufman, & Davis, 1997). These findings support the usefulness of this subscale for both clinical assessment and potential interventions (Farran & Kuhn, 1998).

The PM subscale is also most similar to other positive caregiver measures currently being used. Kinney and Stephens' (1989) Uplifts are similar to PM items that focus on the caregiver's relationship with the impaired person (8, 20) and with other friends and family (26). Lawton et al.'s (1989) measure of Caregiver Satisfaction and Pearlin et al.'s (1990) measure of Personal Gain, also provided strongest support for validity of the PM subscale. Lawton et al.'s Caregiver Satisfaction measure is most similar to PM items that focus on the caregiver/care-receiver relationship (8, 16, 20, 22, 33), whereas items from Pearlin et al.'s measure of Personal Gain are most similar to caregivers' feelings concerning their own strengths and abilities (15, 21, 28, 40, 43).

Remaining PM items, not reflected in any of these existing measures, focus on caregiver values as expressed in the memories they share with their family member (14), personal choices as reflected in attitudes they develop toward the future (27), positive attitudes and feelings of being blessed (9, 32, 38, 42), and the ability to find purpose and meaning (10). The responsibilities caregivers assume are reflected in their sense of rightness about their situation and the need to make the best of it (39).

Further research concerning PM is needed, however. An examination of these subscale items suggests some similarities to cognitive appraisal/reappraisal coping strategies (Lazarus & Folkman, 1984), and we currently do not understand whether they are similar or different constructs.

Ultimate Meaning

The UM subscale was consistent in both studies in that it functioned as a stronger measure of nonorganized and private religiosity, as opposed to organized or public religiosity. These findings assist us to understand the overlap between UM and PM, as prior work

supports the notion that a close association may exist between persons' religious perspectives (UM) and their expression of these beliefs in their daily lives (PM; Batson & Ventis, 1982). A limitation of the UM subscale is that it was grounded in qualitative comments made by caregivers who reflected primarily a Judeo-Christian perspective. Hence, terms such as *Lord* and *God* may not be appropriate for all caregivers. Researchers in the future may wish to include a broader range of measures that reflect potential philosophical/spiritual/religious perspectives.

Although causality cannot be determined from these cross-sectional data, existing research suggests how UM and PM might function in a larger caregiver model, particularly because PM functioned as a significant variable in mediating relationships between caregiver stressors, depression, and role strain, and ultimate meaning did not (Farran et al., 1997). A combination of an existential and stress/adaptation caregiver model facilitates our understanding of how positive caregiving appraisals might affect caregiver outcomes. Briefly summarized, a combination of these two models suggests caregiver stressors might be affected by religiosity as a resource variable (Picot et al., 1997); religiosity as one resource variable might affect caregivers' positive appraisals of such things as rewards and the process of finding provisional meaning (Farran et al., 1997; Picot et al., 1997); and caregiving appraisals, both positive and negative, might differentially affect caregiver outcomes (Lawton et al., 1991).

Longitudinal studies that include a broader variety of these potential resource, appraisal, and outcome variables are needed to verify such a model. As well, researchers in the future should work toward an increased understanding of whether persons are endowed with these abilities, or whether they are developed or learned over the process of caring for their family member. Prospective and longitudinal studies are needed to examine these issues. On the basis of data presented, the FMTCS appears to offer a unique method to further assess positive caregiving appraisal and begin addressing some of these questions.

Appendix 1

Attitudes Toward Caregiving
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This questionnaire contains a number of statements related to opinions and feelings about yourself, your impaired relative, and your caregiving experience. Read each statement carefully, then indicate the extent to which you agree or disagree with the statement. Circle one of the alternative categories.

	SA STRONGLY AGREE	A AGREE	U UNDECIDED	D DISAGREE	SD STRONGLY DISAGREE
Loss/Powerless Subscale (LP)					
1. I miss the communication and companionship that my family member and I had in the past.	SA	A	U	D	SD
2. I miss my family member's ability to love me as he/she did in the past.	SA	A	U	D	SD
3. I am sad about the mental and physical changes I see in my relative.	SA	A	U	D	SD
4. I miss the little things my relative and I did together in the past.	SA	A	U	D	SD

Appendix 1 continued.

	SA STRONGLY AGREE	A AGREE	U UNDECIDED	D DISAGREE	SD STRONGLY DISAGREE
5. I am sad about losing the person I once knew.	SA	A	U	D	SD
6. I miss not being able to be spontaneous in my life because of caring for my relative.	SA	A	U	D	SD
12. I miss not having more time for other family members and/or friends.	SA	A	U	D	SD
13. I have no hope; I am clutching at straws.	SA	A	U	D	SD
18. I miss our previous social life.	SA	A	U	D	SD
19. I have no sense of joy.	SA	A	U	D	SD
24. I miss not being able to travel.	SA	A	U	D	SD
25. I wish I were free to lead a life of my own.	SA	A	U	D	SD
30. I miss having given up my job or other personal interests to take care of my family member.	SA	A	U	D	SD
31. I feel trapped by my relative's illness.	SA	A	U	D	SD
34. We had goals for the future but they just folded up because of my relative's dementia.	SA	A	U	D	SD
36. I miss my relative's sense of humor.	SA	A	U	D	SD
37. I wish I could run away.	SA	A	U	D	SD
41. I feel that the quality of my life has decreased.	SA	A	U	D	SD
7. My situation feels endless.	SA	A	U	D	SD

Provisional Meaning (PM)

8. I enjoy having my relative with me; I would miss it if he/she were gone.	SA	A	U	D	SD
9. I count my blessings.	SA	A	U	D	SD
10. Caring for my relative gives my life a purpose and a sense of meaning.	SA	A	U	D	SD
14. I cherish the past memories and experiences that my relative and I have had.	SA	A	U	D	SD
15. I am a strong person.	SA	A	U	D	SD
16. Caregiving makes me feel good that I am helping.	SA	A	U	D	SD
20. The hugs and "I love you" from my relative make it worth it all.	SA	A	U	D	SD
21. I'm a fighter.	SA	A	U	D	SD
22. I am glad I am here to care for my relative.	SA	A	U	D	SD
26. Talking with others who are close to me restores my faith in my own abilities.	SA	A	U	D	SD
27. Even though there are difficult things in my life, I look forward to the future.	SA	A	U	D	SD
28. Caregiving has helped me learn new things about myself.	SA	A	U	D	SD
32. Each year, regardless of the quality, is a blessing.	SA	A	U	D	SD
33. I would not have chosen the situation I'm in, but I get satisfaction out of providing care.	SA	A	U	D	SD

(continued)

Appendix 1 continued.

	SA STRONGLY AGREE	A AGREE	U UNDECIDED	D DISAGREE	SD STRONGLY DISAGREE
38. Every day is a blessing.	SA	A	U	D	SD
39. This is my place; I have to make the best out of it.	SA	A	U	D	SD
40. I am much stronger than I think.					
42. I start each day knowing we will have a beautiful day together.	SA	A	U	D	SD
43. Caregiving has made me a stronger and better person.	SA	A	U	D	SD
Ultimate Meaning (UM)					
11. The Lord won't give you more than you can handle.	SA	A	U	D	SD
17. I believe in the power of prayer; without it I couldn't do this.	SA	A	U	D	SD
23. I belive that the Lord will provide.	SA	A	U	D	SD
29. I have faith that the good Lord has reasons for this.	SA	A	U	D	SD
35. God is good.	SA	A	U	D	SD

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