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Topic Avoidance and Negative Health Perceptions in the Distant Family Caregiving Context

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This study examines topic avoidance motivations and frequency from a multiple goals perspective in relation to self-reported negative health perceptions in the distant family caregiving context. A sample of 130 self-identified distant family caregivers completed an online survey about their communication with their care recipient. Overall topic avoidance and the self-protection and partner unresponsiveness motivations were significant, positive predictors of distant family caregivers' self-reported negative health perceptions. The remaining topic avoidance motivations were not significant predictors. This study is one of the first known to examine communication in the distant family caregiving context, and it offers possibilities for future research on communication barriers and health issues that impact this growing population.

There are over 7 million Americans providing informal care for family members who reside an hour or more away (National Alliance for Caregiving and the Metlife Mature Market Institute [NAC/MMMI], 2004). As the number of these caregivers is expected to double by 2022 (Benfield & Beck, 2007), long-distance caregiving (LDC) is becoming a reality for many Americans. Distant family caregivers must manage travel costs, workplace accommodations, time constraints, and familial/relational difficulties while providing care (NAC/MMMI). Further,

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LDC communication is uniquely constrained by geography (Stafford, 2005, 2010). Even with the advent of new technologies such as video chat and videophones (e.g., Demiris, Parker Oliver, Hensel, Dickey, Rantz, & Skubic, 2008), LDC makes promptly responding to emergencies and assisting with daily needs difficult (Bevan & Sparks, 2011; NAC/MMMI). Indeed, LDC is so noteworthy that the American College of Physicians' ethical caregiver guidelines recommend that providers "recognize that geographically distant caregivers may face unique challenges" (Mitnick, Leffler, & Hood, 2010, p. 257).

Despite the fact that planning for future care needs can reduce worry and depression, many families avoid the topic of caregiving (Pinquart & Sorensen, 2002) or cope with caregiving by avoiding (e.g., Claar et al., 2005; Knussen, Tolson, Brogan, Swan, Stott, & Sullivan, 2008). Long-distance partners also employ topic avoidance to minimize communication differences and protect themselves and their relationships (Stafford, 2010). However, the many stresses brought on by LDC, combined with these communication difficulties, can be linked to compromised distant caregiver health (NAC/MMMI, 2004). Distance, then, has implications for caregivers' communication strategies and concordant health. This study thus employs Caughlin's (2010) multiple goals perspective to explore the link between topic avoidance and self-reported negative health perceptions from the distant family caregivers' perspective.

Family Caregiving and Distance

A long distance relationship is a situation where communication is restricted due to geographic barriers (Stafford, 2005). Though there are multiple definitions of distance (Merolla, 2010), minimal distance could restrict communication in certain circumstances (Zechner, 2008). As such, consistent with Sahlstein (2004, 2006), we consider distant care as being subjectively determined by the family caregiver (Finch & Mason, 1993). This consideration of distance also reflects the belief that "there is no simple equation between geographical distance and level of support" (Baillie, 2007, p. 145). A distant family caregiving relationship thus involves caregivers (i.e., "anybody who provides unpaid help, or arranges for help, to a relative or friend because they have an illness or disability;" Donelan et al., 1998, p. 223) who perceive themselves as being geographically distant from their familial care recipients (Bevan & Sparks, 2011).

Negative caregiver health

Research finds that the stress of caregiving, which can be overwhelming in terms of time and responsibilities, is strongly related to geographically close caregivers' compromised physical and mental health (e.g., Graham, Christian, & Kiecolt-Glaser, 2006). Vitaliano, Zhang, and Scanlan's (2003) meta-analysis determined that caregiver self-reports and physiological illness indicators were higher than for noncaregivers. The association between caregiving stress and health therefore has important implications, as diminished family caregiver health can compromise their ability to provide distant care.

Although there is no known research on LDC health correlates, distant caregivers likely also can be confronted with negative health. Distance adds "unique and complicated challenges to what is already an often emotion-laden and stressful job" and LDC is a complex situation that often positions career versus family and creates guilt and financial strain for the caregiver

(NAC/MMMI, 2004, p. 3). However, because LDC is often compartmentalized, caregivers may not feel that they are “allowed” to be stressed (Baldock, 2000). Thompsell and Lovestone (2002) note that LDCs of relatives with dementia experienced as much stress as proximal caregivers, despite the fact that LDCs tend to provide more indirect care such as coordinating outside services and cleaning (Koerin & Harrigan, 2002). It is no wonder, then, that 18% of family LDCs reported declining health as a result of providing care (NAC/MMMI, 2004). As such, the stress caused by distance and its accompanying communication challenges could be related to negative health perception levels commensurate with those reported by local caregivers, who consistently shoulder more of the daily care burden.

We accordingly attempt to expand the growing knowledge base about communication and caregiver health by exploring the links between topic avoidance and self-reported health perceptions in LDC via Caughlin’s (2010) multiple goal perspective. Topic avoidance is relevant to LDC for two reasons: (1) long-distant partners have “fewer opportunities to enact certain behaviors” and also sidestep potentially negative interactions to maximize their time when together (Stafford, 2005, p. 107), creating an appealing environment for LDC topic avoidance; and (2) current research has only begun to explore the link between this communication strategy and health outcomes, and doing so will bridge the gap between research on approach and avoid interpersonal processes and health communication noted by Parrott (2004). Self-reported health perceptions are of specific interest here because “they influence one’s sense of well-being as well as behaviors such as usage of medical care” (Segerstrom & Roach, 2008, p. 38).

Topic Avoidance

Topic avoidance is “purposely refraining from discussing certain topics” (Caughlin & Affi, 2004, p. 487) and is an important, but understudied, aspect of health communication (Parrott, 2004). Because topic avoidance is a negative form of relational maintenance (Dainton & Gross, 2008), which has recently been proposed by Merolla (2010) as a central aspect of long-distance relationships, it should be relevant to LDC. Further, long-distance communication can be less frequent, more difficult, and yet focused on more positive topics than geographically close interactions (Stafford, 2005, 2010).

Specifically, LDC is a unique family communication situation that can be challenged by shifting familial roles, the decline of care recipients’ physical and/or mental abilities, and difficulties in obtaining sufficient, accurate health information, which can all be compounded by physical distance (Bevan & Sparks, 2011). To fulfill their caregiving duties while coping with this vast array of LDC challenges and highlighting positive aspects of the situation, distant family caregivers may employ topic avoidance with their care recipients. Indeed, compared to proximal caregivers, LDCs accessed less information about their relatives’ dementia and felt more dissatisfied with that information (Thompsell & Lovestone, 2002), possibly due to topic avoidance.

Multiple goals perspective

We consider LDC topic avoidance through the lens of the multiple goals perspective (Caughlin, 2010), which views interpersonal communication as a purposeful act. Multiple interaction goals are also believed to be simultaneously pursued, and thus can clash with one another.

Goals, which are what one desires to either gain or avoid (Monahan, Miller, & Rothspan, 1997), are used to create messages, assess message sophistication, and guide message interpretation (Caughlin). The complex nature of LDC suggests that family distant caregiver topic avoidance will be driven by multiple, conflicting motivations. For example, family members are not only dealing with the ongoing illness or health condition across the miles, but also with coordinating their schedules and other responsibilities as well as renegotiating long-held family roles.

This theoretical perspective is also applicable to topic avoidance for three reasons. First, topic avoidance logically fits into the multiple goals perspective. Caughlin, Hardesty, and Middleton (2010) note that conflict avoidance – which is conceptually similar to topic avoidance, as well as one of the specific topic avoidance motivations explored here – is inherently goal-focused, as it involves an individual striving to not have an overt discussion about an issue. As such, Donovan-Kicken and Caughlin (2010) successfully applied the multiple goals perspective to topic avoidance in couples with breast cancer. Indeed, topic avoidance itself can be both relationally helpful (e.g., Baxter & Wilmot, 1985) and harmful (e.g., Paul & Berger, 2007), meaning that its enactment can be conflicting for LDCs.

Second, the perspective's fundamental premise is that individuals pursue multiple goals in a single interaction. Our consideration of five distinct topic avoidance motivations in LDC thus reflects the diverse nature of this communication strategy. It also applies these commonly salient motivations to LDC, which is a specific communication instance that can shape how these motivations are related to distant family caregiver negative health perceptions (Caughlin, Bute, Donovan-Kicken, Kosenko, Ramey, & Brashers, 2009). Finally, our focus on negative health perceptions illustrates the multiple goals perspective's interest in the interpretation and outcomes of strategic messages (Caughlin, 2010). In so doing, we extend the multiple goals perspective to the understanding of individual outcomes, in addition to the relationship impact variables that tend to be the theory's focus (e.g., Donovan-Kicken & Caughlin, 2010).

Topic avoidance motivations

We examined five of Caughlin and Afifi's (2004) six reasons for topic avoidance in relation to distant family caregiver health perceptions: self-protection, relationship protection, conflict avoidance, partner unresponsiveness, and lack of closeness. Based on the definition of privacy, which involves the desire to not share information about oneself, or optimizing individuality (Caughlin & Afifi), it was not a logical or likely LDC motivation. Though these reasons are not explicit goals, they do parallel fundamental goal concepts and have been examined via the multiple goals perspective (Donovan-Kicken & Caughlin, 2010). Further, determining how topic avoidance motivations are related to negative self-reported health perceptions is a useful interpretive frame for strategically enacted avoidance (Donovan-Kicken & Caughlin).

The self-protection reason involves "wanting to avoid criticism and/or avoid the vulnerability that comes with openness" (Afifi & Guerrero, 1998, p. 236). Self-protection is a way to cope with or reduce anxiety (Donovan-Kicken & Caughlin, 2010) and is the most significant (or primary, from the multiple goals perspective) family topic avoidance reason (Guerrero & Afifi, 1995). This motivation is also central in health contexts. For example, self-protection emerged as a motivation for both cancer patients and their family members for avoiding illness discussions (Zhang & Siminoff, 2003). Further, Donovan-Kicken and Caughlin's breast cancer participants believed that self-protection was a moderately influential reason for their romantic partners to

avoid cancer-related topics. When patients themselves were motivated by self-protection, and perceived that their partners were similarly motivated, they experienced greater physical debilitation. Based on these findings, LDCs' reluctance to discuss medical or care concerns for fear that these topics may cause them anxiety or personal discomfort could be linked to their own negative health perceptions. As such, hypothesis one predicts:

H1: Topic avoidance motivated by self-protection will be positively related to self-reported negative health perceptions for the distant family caregiver.

Relationship protection is an individual's desire "to maintain the strength of their current relationship and prevent relationship deterioration" (Caughlin & Afifi, 2004, p. 483). Children avoided topics with their parents for this reason (Guerrero & Afifi, 1995), which was also a primary motivation for family caregivers avoiding discussing patients' late-stage Huntington's disease (Lowit & van Teijlingen, 2005). Lowit and van Teijlingen cautioned that such avoidance could reduce social support, anxiety, and stress. The more breast cancer patients perceived that their partners engaged in topic avoidance to protect the relationship, the greater the patients' physical debilitation (Donovan-Kicken & Caughlin, 2010). Consistent with these findings, hypothesis two predicts a similar relationship in the LDC context:

H2: Topic avoidance motivated by relationship protection will be positively related to self-reported negative health perceptions for the distant family caregiver.

The conflict avoidance reason involves preventing disagreements with the relational partner. When individuals avoid topics because they expect their partners will be unable or unwilling to respond, the partner unresponsiveness reason occurs. A perceived lack of relationship closeness can also motivate topic avoidance. Limited research has linked these motivations with self-reported health outcomes. However, Bevan's (2009) research observed positive significant correlations between multiple negative health outcomes reported by individuals with irritable bowel syndrome (IBS) and the partner unresponsiveness and lack of closeness topic avoidance motivations. The distance caregiving context could certainly exacerbate these topic avoidance motivations. For example, partner unresponsiveness may be related to poor health perceptions among caregivers, as many illnesses (e.g., Alzheimer's, dementia, or stroke) may physically prevent care recipients from replying to their distant caregivers. H3 and H4 thus propose:

H3: Topic avoidance motivated by partner unresponsiveness will be positively related to self-reported negative health perceptions for the distant family caregiver.

H4: Topic avoidance motivated by lack of closeness will be positively related to self-reported negative health perceptions for the distant family caregiver.

Avoiding conflict can have negative health implications (e.g., Graham et al., 2006; Harburg, Kaciroti, Gleiberman, Julius, & Schork, 2008). Conflict occurs in family caregiving (e.g., Davis, 1997; Pecchioni & Nussbaum, 2001) and is suggested as a potentially important aspect of LDC (Bevan & Sparks, 2011). Further, Zhang and Siminoff (2003) found that 77% of family members avoided cancer discussions to reduce tension. Taken together, these findings tentatively suggest that the conflict avoidance topic avoidance motivation may be related to distant caregiver self-reported negative health perceptions. This potential relationship is explored via our sole research question:

RQ1: Will topic avoidance motivated by conflict avoidance be related to self-reported negative health perceptions for the distant family caregiver?

Overall topic avoidance

Family member and cancer patient avoidance of the topic of cancer is widespread (Zhang & Siminoff, 2003). Further, individuals were often inaccurate in their predictions about their elderly spouses' cardiac arrest resuscitation preferences, possibly because of lack of discussion (Uhlmann, Pearlman, & Cain, 1988). The topic avoidance strategy is enacted for multiple reasons and can be interpreted in a variety of ways and the multiple goals perspective provides a useful method of explaining these possible interpretations (Caughlin et al., 2010; Donovan-Kicken & Caughlin, 2010). Further, as few studies have explored the impact of how such strategies are interpreted (Caughlin, 2010), linking topic avoidance to distant caregiver negative health perceptions extends the multiple goals perspective to the understanding of individual outcomes.

Bachner and Carmel (2009) found that open communication between primary family caregivers and individuals with terminal cancer was negatively related to caregiver self-reported depression and emotional exhaustion. Further, Donovan-Kicken and Caughlin (2010) observed a positive relationship between patients' physical debilitation due to breast cancer and patients' and partners' perceived overall topic avoidance about cancer-related issues. Distant family caregivers are likely to see similar changes in their self-reported health outcomes the more they engage in topic avoidance with their care recipients. Therefore, H5 states:

H5: There is a positive relationship between topic avoidance frequency and self-reported negative health perceptions for the distant family caregiver.

METHOD

Participants and Procedures

This study was conducted by researchers from a small, private university in the western United States via an online questionnaire posted on SurveyMonkey.com. Inclusion criteria for participants was that they were at least 18 years old and considered themselves to be an unpaid distant caregiver of an individual who is 55 years or older within the past year. Three participants who reported a trivial distance and easy accessibility to the care recipient (i.e., used an automobile to travel five or less miles) and two respondents whose care recipients were younger than 55 were removed (final $N = 130$).

Most participants were female ($n = 92$, male $n = 10$, did not respond $n = 28$) and white/Caucasian ($n = 91$, African American $n = 4$, Hispanic $n = 3$, Asian $n = 1$, Native American $n = 1$).¹ Participant age averaged 49.4 years ($SD = 10.45$, $range = 26-70$) and care recipients averaged 79.5 years ($SD = 10.44$, $range = 55-98$). Distance between caregiver and care recipient averaged 836 miles ($SD = 1244.82$, $range = 8-10,000$). Participants served as distant caregivers for an average of 54 months ($SD = 47.16$, $range = 3-240$ months), and most currently provide

¹A substantial number of participants did not complete the demographic/relationship items, which were at the end of the survey.

distant care ($n = 100$, no longer providing distant care $n = 28$, don't know $n = 2$). Levels of caregiving involvement included only ($n = 7$) or main ($n = 31$) caregiver, equally shared with another ($n = 34$), or assisted main caregiver ($n = 57$).

Distant family caregivers cared for biological parents ($n = 100$), grandparents ($n = 7$), parents-in-law ($n = 7$), aunts ($n = 5$), other relatives ($n = 4$), or multiple care recipients ($n = 7$). Participants reported contacting care recipients either multiple times a day ($n = 20$), once a day ($n = 21$), a few times weekly ($n = 46$), weekly ($n = 24$), a few times monthly ($n = 9$), monthly ($n = 3$), once every few months ($n = 3$), or once a year or less ($n = 3$). Participants visited care recipients once a day ($n = 5$), a few times a week ($n = 11$), weekly ($n = 8$), a few times a month ($n = 12$), monthly ($n = 29$), once every few months ($n = 49$), or once a year or less ($n = 16$).

Our convenience sample was recruited using research team members' extended social and professional networks via e-mail, Facebook, and Twitter. Respondents were mostly from the United States ($n = 100$), but also reported living in England ($n = 1$), Canada ($n = 1$), Romania ($n = 1$), and Belgium ($n = 1$). Participants were also recruited using public online message boards (e.g., Caring from a Distance Group Discussion and Message Board (n.d.), AARP Online Community Caregiving Group), listservs (e.g., Caregiving Discussion Group – Family Caregiver Alliance, National Alliance for Caregiving), and relevant websites (e.g., www.SilverPlanet.com). When necessary, moderator or website/listserv administrator permission was gained prior to posting. The Internet was primarily used for recruitment due to the unique, specific nature of our population of interest.

Upon clicking on the survey link, participants read the consent form and the purpose of the study. Participants consented by clicking through to begin the survey. After completing the approximately 15–20-minute survey, those who provided their email address were compensated with a \$10 Amazon.com gift card. The study was confidential; after compensation was emailed to participants, all identifying information was removed from the data.

Measures

Motivations for topic avoidance

The five topic avoidance motivations were measured using Caughlin and Afifi's (2004) 22-item, Likert-type scale (1 = Strongly disagree, 7 = Strongly agree). The motivation subscales have previously demonstrated reliability and validity in a health context (Bevan, 2009): self-protection (5 items; e.g., The care recipient might look down on me; $M = 2.79$, $SD = 1.52$, $\alpha = .81$), relationship protection (4 items; e.g., I want to protect my relationship with the care recipient; $M = 4.42$, $SD = 1.65$, $\alpha = .81$), lack of closeness (2 items; e.g., I am not emotionally close to the care recipient; $M = 2.88$, $SD = 1.66$, $\alpha = .53$), conflict avoidance (2 items; e.g., I want to avoid conflict; $M = 4.37$, $SD = 1.87$, $\alpha = .64$), and partner unresponsiveness (5 items; e.g., It is not worth my time to talk about it with the care recipient; $M = 3.21$, $SD = 1.43$, $\alpha = .71$). Higher values indicate greater motivation to avoid topics.²

²The five topic avoidance motivations were examined as two potential second-order factors: one a self-focused reason comprised of the self-protection, lack of closeness, and conflict avoidance motivations, and the second a partner-focused reason including the relationship-protection and partner unresponsiveness reasons. According to Brown (2006), first-order

Topic avoidance

Topic avoidance was measured using five 7-point Likert type items (1 = strongly disagree, 7 = strongly agree) adapted from Caughlin and Afifi's (2004) scale (e.g., I avoid having in-depth conversations about the care recipient's feelings and beliefs) and 4 items developed by the researchers to address specific caregiving topics (e.g., I avoid discussing the care recipient's health with the care recipient). To determine the items' unidimensionality, an exploratory factor analysis with varimax rotation was conducted. This analysis revealed that the nine items formed a single factor (eigenvalue = 4.59, 50.96% of variance explained, $M = 2.84$, $SD = 1.26$, $\alpha = .87$). Higher values indicate more overall topic avoidance.

Self-reported negative health perceptions

Cohen and Hoberman's (1983) Physical Symptoms Checklist was chosen to measure self-reported negative health perceptions because it was developed to assess perceived physical correlates of life stressors. The 36-item scale described physical symptoms the LDCs may have experienced while providing distant care, such as back pain, headache, and poor appetite (0 = not at all bothered, 4 = extremely bothered). Higher scores indicate more negative health perceptions ($M = 1.97$, $SD = .954$, $\alpha = .98$).

RESULTS

Preliminary Analyses

Merolla (2010) suggested that distance in miles between caregiver and care recipient, frequency of contact, and frequency of visits could impact LDR communication and relational quality perceptions. These three variables were thus each first correlated with the topic avoidance and self-reported health perception variables to ensure they did not exert additional influence upon the variables of interest. None of the correlations were significant at $p < .05$.

Next, as topic avoidance motivations have been found to vary by relationship type (Bevan, 2009; Caughlin & Afifi, 2004) and age (Guerrero & Afifi, 1995) and caregiver health is also associated with age (Vitaliano et al., 2003), each were investigated as potential additional influences on the main variables.³ A series of univariate ANOVAs determined there were no significant relationship type differences for the topic avoidance variables. Bivariate correlation tests detected significant relationships between distant caregiver age and topic avoidance frequency ($r = -.20$,

correlations between factors should initially be examined for logical and theoretical patterns. Specifically, correlations among the three potential self-focused motivations should be higher than between them and the partner-focused reasons, and vice versa for the partner-focused reasons. However, we found that these correlations did not meet Brown's first benchmark in that the expected patterns were not generally observed. For example, the correlation between the two partner-focused variables was relatively low ($r = .38$) and the lack of closeness reason correlated more strongly with relationship protection ($r = .58$) than with conflict avoidance ($r = .30$). Thus, second-order factor analyses were not conducted.

³Vitaliano et al. (2003) also determined that female dementia caregivers experienced poorer self-reported health than male caregivers; however, the small number of males who participated in this study ($n = 10$) prevented us from confidently testing gender as an additional covariate.

$p < .05$), self-protection ($r = -.27, p < .01$), and self-reported negative health perceptions ($r = -.23, p < .05$). Caregiver age was thus a covariate in the primary analyses (see Table 1 for correlations between all study variables).

Primary Analyses

The hypotheses and research question were tested via a series of hierarchical regression analyses, with the distant caregiver age covariate entered in the first block, the relevant topic avoidance predictor variable in the second block, and self-reported negative health perceptions as the dependent variable. For H1, the model was significant, $F = 7.37, p < .01$, adjusted $R^2 = .12$. The self-protection motivation is a significant, positive predictor of distant caregiver self-reported negative health perceptions, $\beta = .29, t = 2.87, p < .01$. Distant caregiver age was not a significant predictor. H1 was supported.

The regression model for H2 was significant, $F = 3.88, p < .05$, adjusted $R^2 = .06$; however, the relationship protection topic avoidance reason did not significantly predict LDC negative health perceptions, $\beta = .13, t = 1.29, p = .20$. Distant caregiver age was a significant, negative predictor, $\beta = -.24, t = -2.43, p < .05$. H2 was not consistent with the data.

For H3, the partner unresponsiveness regression model was significant, $F = 7.41, p < .01$, adjusted $R^2 = .12$, and this topic avoidance motivation was a significant predictor of self-reported negative health perceptions for distant caregivers, $\beta = .28, t = 2.93, p < .01$. The lack of closeness motivation (H4) regression model was significant, $F = 3.91, p < .05$, adjusted $R^2 = .06$, but this motivation did not predict distant caregiver self-reported negative health perceptions, $\beta = .13, t = 1.31, p = .20$. The regression model for conflict avoidance (RQ) was significant, $F = 3.84, p < .05$, adjusted $R^2 = .06$; however, this motivation did not predict self-reported negative health perceptions, $\beta = .13, t = 1.26, p = .20$. Distant caregiver age was a significant negative predictor in the partner unresponsiveness, $\beta = -.25, t = -2.63, p < .05$, lack of closeness, $\beta = -.25, t = -2.47, p < .05$, and conflict avoidance, $\beta = -.24, t = -2.35, p < .05$, models. Therefore, H3 was supported, whereas H4 was not. For the RQ, conflict avoidance did not predict LDC self-reported negative health perceptions.

For H5, the regression model was significant, $F = 7.79, p < .01$, adjusted $R^2 = .12$, and topic avoidance was a significant, positive predictor of self-reported negative health perceptions for the

TABLE 1
Correlations between Study Variables

	2	3	4	5	6	7
1. Self-Protection	.40***	.61***	.65***	.53***	.46***	.33***
2. Relationship Protection		.38***	.26**	.58***	.23**	.11
3. Partner Unresponsiveness			.49***	.40***	.53***	.27**
4. Lack of Closeness				.30***	.35***	.22**
5. Conflict Avoidance					.44***	.15
6. Topic Avoidance Frequency						.35***
7. Self-Reported Negative Health Perceptions						1

Note. ** $p < .01$, *** $p < .001$.

distant caregiver, $\beta = .30$, $t = 3.11$, $p < .01$. Distant caregiver age was not a significant predictor, $\beta = -.17$, $t = -1.75$, $p = .08$. H5 was therefore supported.⁴

DISCUSSION

The present research determined that when distant caregivers engage in topic avoidance with their care recipients (H5) and do so for self protection (H1) and partner unresponsiveness (H3) reasons, they experience greater self-reported negative health outcomes. These significant relationships emerged even when distant caregiver age, which should logically be a negative predictor of negative health outcomes, was a significant covariate. However, when distant caregiver topic avoidance is motivated by relationship protection (H2), lack of closeness (H4), and conflict avoidance (RQ), distant caregiver self-reported negative health outcomes are not impacted. These findings, discussed here, offer an initial glimpse into how distant family caregivers' topic avoidance with their care recipients can be related to their self-reported health.

Our results determined that when distant family caregivers avoid topics for self-protective reasons (H1), but not to protect their relationships (H2), they report an increase in negative perceptions of their health. Similar to the relationship variables of satisfaction (Caughlin & Afifi, 2004; Donovan-Kicken & Caughlin, 2010) and closeness (Dillow, Neary Dunleavy, & Weber, 2009), health perceptions are more likely to be negative when distant family caregivers avoid topics to defend and protect themselves, but unaffected when topics are avoided for more altruistic purposes, such as protecting the relationship. This pattern of findings extends into the LDC context and supports the multiple goals perspective, which states that different motivations are associated with varying outcomes (e.g., Caughlin et al., 2010).

The partner unresponsiveness topic avoidance motivation was a significant, positive predictor of self-reported negative distant family caregiver health perceptions (H3), a finding that is consistent with other studies that have linked this motivation to decreased relational quality (Caughlin & Afifi, 2004; Dillow et al., 2009). It is likely that distance itself may represent a barrier to partner responsiveness. Further, distant family caregivers may be contributing significant amounts of time, attention, support, and other resources that cannot be reciprocated by care recipients due to the nature of their medical conditions or life stage. For example, Gallagher et al. (2011) found that Alzheimer's patients' cognitive decline and dependence were positively associated with caregiver burden. With Alzheimer's disease accounting for 60 to 80% of all dementia cases and one in eight older Americans having the disease (Alzheimer's Association, 2011), the burdens

⁴As a moderating relationship has been observed in previous topic avoidance research (e.g., Caughlin & Afifi, 2004; Donovan-Kicken & Caughlin, 2010), the possibility that the topic avoidance reasons would each moderate the relationship between LDC topic avoidance and self-reported negative health perceptions was considered here via supplementary analyses. Per Aiken and West's (1991) recommendation, the predictor variables were mean-centered before the interaction terms were computed. A series of hierarchical regressions were conducted, each of which had the predictor variables (topic avoidance and one of the five reasons for avoidance for each regression test) in the first block, and the interaction term for these variables in the second block. None of the interaction terms significantly predicted distant caregiver self-reported negative health perceptions. Thus, topic avoidance motivations did not moderate the association between topic avoidance frequency and self-reported negative health perceptions. Whereas our outcome variable was individual in nature, a relationship variable (relationship satisfaction) was the outcome variable in Donovan-Kicken and Caughlin's (2010) and Caughlin et al.'s (2004) research. This discrepancy may explain the inconsistent findings.

of cognitive decline are important for understanding the complexities of caregiving for later-life adults. In fact, almost 15 million Americans are unpaid caregivers for a person with Alzheimer's disease (Alzheimer's Association, 2011). Later-life diseases, which render care recipients cognitively incapable of responding to caregivers, add another layer of difficulty onto the already challenging LDC communication environment.

The lack of closeness motivation for topic avoidance did not significantly predict self-reported negative health perceptions (H4). Perhaps by virtue of the distance between them, LDCs may not expect to be close with their care recipients and thus do not experience negative health perceptions when motivated to avoid topics for this reason. Dillow et al.'s (2009) recent research determined that some, but not all, topic avoidance motivations were related to closeness, suggesting that closeness is a variable that is relevant to both topic avoidance and distance and should thus continue to be investigated in these contexts.

Our RQ's finding contrasts the substantial body of research that finds that conflict avoidance is negatively related to individual well-being (e.g., Graham et al., 2006; Harburg et al., 2008). Distant family caregivers reported that conflict avoidance (along with relationship protection, which was also unrelated to negative health perceptions) was a particularly strong (i.e., with a mean of 4.42 on a 7-point scale) topic avoidance motivation. From the multiple goals perspective, these appear to be the two most primary topic avoidance motivations for distant caregivers.

Kam (2008) similarly found that caregivers frequently avoided conflict with family members, and did so because engaging in conflict would not likely be productive. Perhaps, based on this reason and the challenge of long-held family relationship roles (e.g., Plowfield, Raymond, & Blevins, 2000), distant family caregivers feel that this is a useful, successful topic avoidance motivation and employing it is thus not linked to their health perceptions. This explanation is consistent with the multiple goals perspective assertion that understanding which goals are most relevant to a particular situation can be a central determinant of the outcomes of family interactions (Caughlin et al., 2010). Alternately, research (e.g., Davis, 1997) suggests that conflict avoidance with other members of the LDC's family may be related to their health. Future research should explore this possibility.

The lack of significant relationships between distant family caregiver self-reported negative health perceptions and the lack of closeness and conflict avoidance motivations could also be at least partially explained by low scale reliability (α s of .53 and .64), which may have contributed to Type II error. Remaining true to the scale structure, as we did here, is generally useful, as differences in study findings that use the same scale may be due to the employment of different factor structures rather than to the concepts themselves. However, how this measure adapts to additional health contexts may require future consideration.

Results for H5 expand upon previous research that has consistently observed positive relationships between avoidance as a caregiving coping strategy and compromised health (e.g., Claar et al., 2005; Knussen et al., 2008). Stafford (2010) recently also found that distant romantic partners avoided taboo topics more than geographically close partners. Distance may also uniquely contribute to this association, as infrequent visits and face-to-face interactions may encourage topic avoidance, even if it is linked to unhealthy LDC health perceptions. From the multiple goals perspective (Caughlin et al., 2010), perhaps the meaning attributed to the goal of topic avoidance is negative in the context of LDC, which then explains why it shares a positive relationship with distant caregivers' negative health perceptions. Although not hypothesized, the moderate level of

overall topic avoidance (i.e., 2.85 on a 7-point scale) observed here also indicates that LDCs are indeed employing this communication strategy with their care recipients.

Practical Applications

The results from this exploratory study paired with prior research suggest that topic avoidance is negatively associated with both relational and individual well-being. Although avoiding topics may be a logical response for individuals who find themselves in a challenging and likely frustrating LDC environment, this reaction could potentially be linked with distant caregivers' perceived physical and psychological stress. Perhaps then, more targeted, strategic disclosures may to some extent alleviate negative health perceptions of LDCs. Since caregivers reportedly experience greater stress, higher anxiety, and greater health risks than do noncaregivers (e.g., Roscoe et al., 2009; Vitaliano et al., 2003), strategies that may help to minimize these potentially harmful health perceptions would be beneficial.

However, managing care from a distance also requires a certain degree of privacy. A helpful way to understand this apparent tension between disclosure and privacy is offered by Stafford's (2010) research, which found that long-distance romantic partners narrow their communication to more positive topics, possibly to recast their relationships in a more positive light. Distant family caregivers may be pursuing similar goals; however, doing so may in some instances be related to negative health, both for distant family caregivers and care recipients, whose health and care could be compromised because they are not being discussed.

This research thus has applications for health communicators and distant caregivers. Popular resources for distant family caregivers (e.g., *Caring from a Distance*, n.d.; National Institutes of Health, 2007) and healthcare professionals (e.g., Davidhizar, 1999) advocate active information-seeking as an important way to evaluate caregiving options and make decisions. As such, a first practical application is that messages should encourage LDCs to consider *why* they may be avoiding communicating with their care recipients instead of simply encouraging open communication in all instances and about all topics. Only when LDCs determine that they are avoiding topics for self-protective and unresponsive partner motivations should communication then be encouraged. This may be especially challenging for caregivers of later-life adults with diseases that create instrumental barriers to effective communication, such as Alzheimer's. However, doing so may also improve distant family caregivers' health perceptions and, indirectly, their ability to provide optimal care (e.g., Navaie-Waliser et al., 2002; Schulz & Sherwood, 2008).

Because care recipients who are already vulnerable could respond to distant caregiver disclosures with greater anxiety and stress, family caregivers may also be advised to reach out to others to cope with LDC. For example, other geographically close caregivers or members of a local caregiver support group could serve as integral support and informational resources (Davidhizar, 1999). Doing so may even ease distant caregivers' negative health perceptions. Proximal caregivers or other LDCs who encounter similar difficulties may be individuals to whom the distant caregivers feel more comfortable communicating with. Further, by utilizing what is already known in terms of topic avoidance frequency and motivations and LDC health perceptions, support groups, written materials, and related health campaigns can be developed to meet specific LDC communication needs and ultimately improve the overall caregiving environment.

Limitations and Conclusions

Despite the potential usefulness of our findings, limitations do exist. Our participants were a relatively small convenience sample comprised primarily of female, white, upper income individuals. However, according to recent national statistics (National Alliance for Caregiving and the American Association for Retired Persons [NAC/AARP], 2009), our sample is similar to the typical family caregiver population. Nevertheless, future studies should examine a broader sample that includes a wider range of cultural and economic groups, especially since the family caregiving environment can vary by ethnicity (NAC/AARP). Further, the online survey design is convenient for collecting data from this difficult to access population, but has the potential for participants to provide false responses. Future researchers should verify respondent validity before analyzing results.

In conclusion, this study extends topic avoidance research to the context of distant family caregiving. Further, it supports the utility of the multiple goals perspective (Caughlin, 2010) in two ways. First, by identifying the varying associations between the topic avoidance strategy and its motivations and the individual outcome of self-reported negative health perceptions, our findings support the notion that multiple, conflicting motivations are at play when LDCs are determining whether they should avoid the topic of caregiving with their care recipients. Second, our study offers additional support for topic avoidance as a situation to which the multiple goals perspective is applicable (Donovan-Kicken & Caughlin, 2010), as well as extending it to the specific LDC context. Future researchers should both employ the multiple goals perspective and expand upon Roscoe et al.'s (2009) research to understand which communication techniques have the potential to contribute positively to family caregiver health.

As the United States population continues to age, LDC is increasingly becoming a reality for many family members. Distant family caregivers report high levels of stress and often put their health at risk to provide care to their loved ones. The strategic decision to avoid health and care topics in LDC is especially disconcerting when considering that distance alone is already likely providing a significant communication barrier. Family and health communication research that seeks to understand correlates of these health perceptions can thus shed light on ways to minimize the difficulties of LDC. A reduction in poor health among this growing population will benefit their care recipients, as well as the population at large.

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