Interpersonal Conflict and Health Perceptions in Long-Distance Caregiving Relationships

Jennifer L. Bevan a, Sean K. Vreeburg b, Sherri Verdugo b & Lisa Sparks c d

a Department of Communication Studies, Chapman University, Orange, California, USA
b Schmid College of Science, Chapman University, Orange, California, USA
c Schmid College of Science, Chapman University, Orange, California
d Chao Family Comprehensive Cancer Center, University of California, Irvine, Irvine, California, USA

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Interpersonal Conflict and Health Perceptions in Long-Distance Caregiving Relationships

JENNIFER L. BEVAN
Department of Communication Studies, Chapman University, Orange, California, USA

SEAN K. VREEBURG AND SHERRI VERDUGO
Schmid College of Science, Chapman University, Orange, California, USA

LISA SPARKS
Schmid College of Science, Chapman University, Orange, California, and Chao Family Comprehensive Cancer Center, University of California, Irvine, Irvine, California, USA

With job markets expanding globally and life expectancy continually increasing, more demands are being placed on distant relatives to provide care for their aging family members, creating a health care situation known as long-distance caregiving. An online survey explored the relations between negative health perceptions by long-distance caregivers and conflict frequency and conflict strategy usage. The authors observed positive significant relations between distant caregiver negative health perceptions and conflict frequency and usage of the distributive and avoidance conflict strategies. However, they observed no significant associations between distant caregiver negative health perceptions and usage of the two integrative strategies. Implications for long-distance caregiving communication are discussed.

Current rapid technological and medical improvements are remarkably boosting life expectancy and continually creating novel and distinct research issues regarding eldercare. As the elderly population continues to grow, elongated comprehensive care often becomes the responsibility of the aging adult’s family (Miller, Shoemaker, Willyard, & Addison, 2008). Indeed, 29% of U.S. adults, or roughly 65.7 million Americans, engage in informal care (National Alliance for Caregiving/American Association for Retired Persons, 2009). Of these, 5–7 million provide care from a distance, a figure that is expected to double within 15 years (Benefield & Beck, 2007).
As family residential distance increases (e.g., Zechner, 2008), stress is often placed on individuals who provide distant care to an aging adult. Caregiving is a potential public health issue that will challenge society with caregivers who themselves suffer from various medical conditions (Talley & Crews, 2007). Further, long-distance caregiving (LDC) is a significant enough health issue that The American College of Physicians recently recommended that doctors “recognize that geographically distant caregivers may face unique challenges” in their ethical guidelines for caregivers (Mitnick, Leffler, & Hood, 2010, p. 257). As such, LDC communication is identified as a health care topic that should be more thoroughly investigated to better understand the repercussions it has on care providers, care recipients, and the overall health care system (Bevan & Sparks, 2011).

Of particular interest here is examining how specific LDC communication barriers between care recipients and caregivers are related to negative health perceptions. A significant communication barrier that is ubiquitous across close relationships is interpersonal conflict (Canary, Cupach, & Messman, 1995). Interpersonal conflict occurs in caregiving (e.g., Pecchioni & Nussbaum, 2001) and long-distance relationships (e.g., Stafford, 2010). Professional geriatric care managers, who can assist long-distance caregivers, note that family conflict is their greatest occupational challenge (Kelsey & Laditka, 2009). Accordingly, our study extends and combines the research consensus that interpersonal conflict (e.g., Graham, Christian, & Kiecolt-Glaser, 2006) and caregiving (e.g., Miller et al., 2008) are related to compromised health by examining the associations between negative distant caregiver health perceptions and LDC conflict frequency and strategy usage.

**Long-Distance Caregiving**

Caregiving involves providing help for another, the time spent assisting, and the amount of tasks performed for the betterment of an individual in need (Ellis, Miller, & Given, 1989). There is no defined time limit for caregiving, which is typically unpaid (Ellis et al., 1989). Caregiving further involves daily activities that directly and indirectly benefit the care recipient. Direct activities of daily living (e.g., Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963), include providing medication, and help with bathing, dressing, and feeding. Indirect instrumental activities of daily living (e.g., Lawton & Brody, 1969) involve cleaning, laundry, food preparation, errands, financial management, and arranging or supervising outside services. Distant caregivers typically participate in more instrumental activities of daily living than do proximal caregivers (Koerin & Harrigan, 2002).

Although distance presents an additional caregiving burden (e.g., Kelsey & Laditka, 2009; Mitnick et al., 2010), how much distance constitutes an LDC relationship is variable and subjective (Finch & Mason, 1993). Further, Stafford (2005) defined a long-distance relationship as one in which communication is restricted by geographic barriers. Therefore, LDC involves the elements of Ellis and colleagues’ (1989) definition enacted by individuals who perceive themselves as being geographically distant (Bevan & Sparks, 2011).

Individuals providing LDC typically encounter different issues that may cause increased stress compared with those at a more proximal, convenient distance. For example, time off work, proximal family responsibilities, and distance traveled to provide care can result in emotional stress, fatigue, and financial difficulty (Ilardo & Rothman, 1999), each of which can initiate LDC conflict. In addition, many distant
caregivers feel as if they are not doing enough and that they were not initially given “license to leave” by their families (Baldock, 2000, p. 209), which may produce guilt, regret, and frustration that could give rise to conflict. Baldock (2000) also suggested that conflict could occur if distant caregivers’ request that their care recipients move closer is resisted. As such, the LDC situation could be prone to conflict.

Perhaps more notable is that caregiving itself (regardless of whether conflict is present) is correlated with negative caregiver health. For example, 17% of U.S. caregivers report fair or poor health, compared with 13% of the general adult population (National Alliance for Caregiving/American Association for Retired Persons, 2009). Further, caregivers experience more depression and stress as well as poorer subjective and objective physical health than do noncaregivers (Pinquart & Sorensen, 2003b). Pinquart and Sorensen (2003a, 2007) also determined that poorer caregiver health was correlated with greater levels of care recipient behavioral problems, caregiver psychological distress, more caregiving hours a week, and longer caregiving duration. A next important research step, then, is to ascertain what specific communicative caregiving aspects are linked to these health assessments to ultimately improve caregiver health. We now turn to two LDC conflict elements that may be linked to negative distance caregiver health perceptions: frequency and strategy usage.

**Interpersonal Conflict Elements**

Interpersonal conflict involves relational partners’ pursuit of incompatible goals (Canary & Spitzberg, 2006). Distance adds to conflict’s inherent incompatibility. Stafford (2010) recently noted that those in long-distance romantic relationships may compensate for fewer opportunities for physical intimacy by engaging in less conflict.

Although rising life expectancy means that intergenerational communication in adulthood (which frequently characterizes LDC) will be increasingly important, researchers have not sufficiently examined conflict in this domain (Bengtson, 2001). Further, intergenerational barriers such as stereotyping, memory, and language issues often present multiple communication problems for older adults, which can create conflict and hinder effective health care (Sparks & Nussbaum, 2008). In addition, Sahlstein (2006) noted that there is minimal information regarding long-distance conflict management, even though conflict is linked to relational satisfaction and stability. Each of Sahlstein’s (2006) negative qualities in long-distance family relationships could spark LDC conflict, including the following: (a) relational maintenance difficulties (e.g., expense or inconvenience); (b) tension and stress; (c) minimal interaction quantity/frequency; (d) difficulty maintaining current information; (e) difficulty reassuring, comforting, and supporting one other; and (6) difficulty managing individual and family challenges.

**Conflict Frequency**

Although interpersonal conflict research tends to focus on communicative styles or strategies, conflict frequency is also integral to relational quality. Specifically, conflict frequency contributes to marital disruption above and beyond the effects of conflict style or resolution (McGonagle, Kessler, & Gotlib, 1993). Further, as older wives’ marital quality (which included a measure of conflict frequency) decreased over a 2-year period, their depressive symptoms increased (Kim & Moen, 2002). These findings suggest that LDC conflict frequency may be similarly linked to distant caregiver negative health perceptions.
In the caregiving context, conflict is a frequent event (Usita, Davis, & Hall, 2006). Specifically, sibling conflict about care provision for an elderly parent, which was frequent, ongoing, and sometimes involved the parent (Merrill, 1996), could hamper collaboration (Fowler & Fisher, 2009). In addition, the presence of caregiver–care recipient conflict was strongly related to caregiver strain and negative affect (Sheehan & Nuttall, 1988).

Frequency of distant caregiver–care recipient conflict could be linked with distant caregivers’ negative health perceptions, which involve a general sense of physical well-being (Pinquart, 2001). For example, Koerner, Shirai, and Kenyon (2010) determined that the more frequent family conflict about care provision, the greater caregivers’ experience of physical health symptoms. Further, lower family relationship quality (which included conflict) was linked to increased caregiver health difficulties (Francis, Worthington, Kypriotakis, & Rose, 2010). Family conflict regarding care was also positively related to caregiver mental impairment and strain (Sharlach, Li, & Dalvi, 2006). Last, that caregivers had greater depression and anxiety than noncaregivers was explained by greater conflict frequency (Butterworth, Pymont, Rodgers, Windsor, & Anstey, 2010). We thus offer the first hypothesis for the LDC context:

The more frequently distant caregivers engage in conflict with their care recipients, the greater the distant caregivers’ negative health perceptions.

Conflict Strategies

Putnam and Wilson’s (1982) distributive, avoidance, and integrative conflict strategies have each been observed in caregiving conflicts (Pecchioni & Nussbaum, 2001). Distributive communication involves being intimidating and adamant about getting one’s own way. Avoidance involves evading the conflict or downplaying differences between the two parties. The integrative strategy focuses on collaborating or compromising in order to arrive at a satisfying resolution and was later dissected into distinct compromise and collaborative conflict strategies (Wilson & Waltman, 1988).

Preliminary research suggests that avoidance may be a recurrent, frequent method for managing conflict about caregiving (e.g., Kam, 2008). Caregivers may not want to challenge care recipients and so avoid conflict to preserve established familial roles (Plowfield, Raymond, & Blevins, 2000). As for negative health perceptions, avoidance has been associated with caregiver distress (Knussen et al., 2008), increased anxiety (Claar et al., 2005; Dew, Myaskovsky, DiMartini, Switzer, Schulberg, & Kormos, 2004), and greater depression (Stephens, Norris, Kinney, Ritchie, & Grotz, 1988). Further, Kiecolt-Glaser and colleagues (1996) found that wives’ stress-response hormones increased when their husbands withdrew from conflict and Stafford (2010) recently determined that long-distance romantic relationships used conflict avoidance more than geographically close partners. Family caregivers also responded to other family members’ conflict avoidance with anger and depression (Davis, 1997).

Hostile, negative spousal conflict behaviors (which are similar to the distributive strategy) are consistently related to increased immune function dysregulation, changes in stress hormones, and cardiovascular activity (e.g., Robles & Kiecolt-Glaser, 2003; Whitson & El-Sheikh, 2003). Further, Graham, Robles, and colleagues (2006) found
that caregiver hostility was related to increased C-reactive protein levels (as an indicator of systemic inflammation), pain, and depression. Distant caregivers in conflict may be particularly prone to negative health perceptions. At least five positive acts are needed to counteract a single negative behavior (Gottman, 1994), and distance and fewer opportunities and channels for interaction may make achieving this ratio difficult for distant caregivers. Taken together, these research findings suggest that distant caregivers' use of distributive communication and avoidance in conflict with their care recipients will be positively associated with their negative health perceptions. Hypothesis 2 thus states the following:

The more distance caregivers use the (a) distributive and (b) avoidance conflict strategy with their care recipients, the greater the distant caregivers' negative health perceptions.

Constructive (i.e., integrative) conflict strategies are used more by aging mothers and their adult daughters than destructive and avoidant strategies (Fingerman, 1995). Further, solution-oriented conflict strategies were most frequently observed between mothers and daughters when discussing future care provision (Pecchioni & Nussbaum, 2001) and by caregivers in conflict (Usita et al., 2006). It is unsurprising that caregivers' ability to use solution-oriented conflict strategies could enhance care quality (Shaffer, Dooley, & Williamson, 2007). Caregivers who adopt solution-oriented communication styles may also experience more positive caregiving outcomes and be less likely to abuse the care recipient (Plowfield et al., 2000).

Findings regarding the integrative strategy's relationship to health are mixed. Although Kiecolt-Glaser and colleagues (1996) observed a positive relation between positive conflict behaviors and lower stress-response hormone levels for wives but not husbands, another study (Kiecolt-Glaser et al., 1993) found no significant relationship between usage of problem-solving and positive conflict strategies and spouses' blood pressure and immunological changes. Further, physiological correlates of positive marital interactions are in need of more empirical attention (Robles & Kiecolt-Glaser, 2003). As such, we explored whether integrative LDC conflict strategy usage is linked to distant caregiver negative health perceptions by asking the following research question:

Are (a) collaborative and (b) compromise conflict strategies used by distance caregivers with their care recipients related to distant caregiver health perceptions?

Method

Participants and General Procedures

This study was conducted at a small, private university in the Western United States using an online survey on SurveyMonkey.com, a secure web-based survey portal. The criteria for inclusion as a distant caregiver included the following: (a) caring for a person who is 55 years or older, (b) being at least 18 years old, and (c) perceiving a geographical barrier when traveling to provide care (consistent with Sahlstein [2004, 2006] and Finch & Mason [1993]). Three participants reporting minimal distance and easy accessibility to their care recipients and two respondents whose care recipients were younger than 55 were removed (final n=137).
Respondents were mostly female \((n=95, \text{male } n=10)\) and White/Caucasian \((n=94, \text{African American } n=4, \text{Hispanic } n=3, \text{Asian } n=1, \text{Native American } n=1)\) and averaged 49.4 years \((SD=10.58, \text{range}=26–70)\). Their care recipients were also primarily female \((n=65, \text{male } n=35)\) and averaged 79.2 years \((SD=10.56, \text{range}=55–98)\). Participant household income ranged from $11,000–$20,000 \((n=5)\), $21,000–$30,000 \((n=4)\), $31,000–$50,000 \((n=14)\), $51,000–$75,000 \((n=13)\), $76,000–$100,000 \((n=20)\), $101,000–$150,000 \((n=23)\), and more than $150,000 \((n=16)\). Most participants’ highest degree was a bachelor’s \((n=40)\) or master’s \((n=34)\), high school/GED \(n=6\), associate’s \(n=8\), PhD/EdD \(n=15\), MD \(n=3\). Participants were mostly American \((n=100)\), but also were English \((n=1)\), Canadian \((n=1)\), Romanian \((n=1)\), and Belgian \((n=1)\).

The average distance between caregiver and care recipient was 811 miles \((SD=1,234.80, \text{range}=8–10,000)\). Participants provided distant care for 54 months average \((SD=46.39, \text{range}=3–240 \text{ months})\), and most served as distant caregivers when they completed the survey \((n=104, \text{no longer providing distance care } n=29, \text{don’t know } n=2)\). Distant caregiving involvement included being the only \((n=9)\) or main caregiver \((n=32)\), equally sharing care with another \((n=35)\), or assisting a main caregiver \((n=59)\). Distant caregivers engaged in activities of daily living such as giving medicines/injections \((23\%)\), getting the care recipient in and out of chairs/beds \((22\%)\) and to and from the toilet \((15\%)\), dressing \((19\%)\), feeding \((12\%)\) and bathing \((20\%)\) the care recipient, and with diapers or continence \((14\%)\), and in instrumental activities of daily living such as transportation \((49\%)\), managing finances \((63\%)\), housework \((43\%)\), grocery shopping \((47\%)\), meal preparation \((35\%)\), and service arrangement and supervision \((70\%; \text{Katz et al., 1963; Lawton \\& Brody, 1969})\).

Participants cared for a biological parent \((n=100)\), grandparent \((n=7)\), parent-in-law \((n=7)\), aunt \((n=5)\), other relative \((n=4)\), nonrelative/friend \((n=4)\), or multiple care recipients \((n=7)\) and typically provided 1–3 hours of care per week \((n=52, \text{less than 1 hour } n=28, \text{between 4 and 8 hours } n=34, 9 \text{ or more hours } n=22)\). Participants contacted their care recipients multiple times daily \((n=21)\), once daily \((n=23)\), a few times weekly \((n=48)\), once weekly \((n=24)\), a few times monthly \((n=9)\), monthly \((n=4)\), once every few months \((n=3)\), or once yearly or less \((n=3)\) and visited their care recipients either once daily \((n=5)\), a few times weekly \((n=13)\), weekly \((n=10)\), a few times monthly \((n=13)\), monthly \((n=29)\), once every few months \((n=49)\), or once yearly or less \((n=17)\).

Participants were recruited through online via short e-mails or announcements and the survey link. Study information was also placed on Facebook, LinkedIn, and Twitter. Relevant public Internet message boards (e.g., American Association for Retired Persons Online Community Caregiving Group, Caring from a Distance Group Discussion and Message Board), listservs (e.g., National Alliance for Caregiving, National Center on Caregiving), and websites (e.g., www.SilverPlanet.com) were also used to recruit. Permission to post was obtained for all sites requiring moderator approval. The data were anonymous. Participants could provide an optional e-mail address to receive a $10 gift card as compensation.

\(^1\)Totals do not add up to 100\% because some respondents did not complete the demographic items, which were located at the end of the survey.
**Measures**

**Conflict Frequency**

One item, reported on a 7-point scale ranging from 1 (*none at all*) to 7 (*a great deal*), assessed distant caregiver–care recipient conflict frequency (“What is the extent to which you have conflict with the care recipient over caregiving?”; \( M = 2.96, SD = 1.64 \)).

**Conflict Strategies**

Putnam and Wilson’s (1982) Communicative Strategies in Organizational Conflicts Scale measured distant caregiver strategies in disagreements with their care recipients about their care and health on a 7-point scale ranging from 1 (*none at all*) to 7 (*a great deal*). Five items each evaluated collaboration (e.g., “I suggest we work together to create solutions to disagreements”; \( M = 4.71, SD = 1.04, \alpha = .80 \)) and compromise (e.g., “I will go 50–50 to reach a settlement with the care recipient”; \( M = 4.20, SD = 1.05, \alpha = .82 \)). We assessed avoidance with 12 items (e.g., “I shy away from topics that are sources of disputes”; \( M = 3.44, SD = 1.09, \alpha = .89 \)). We measured distributive communication using seven items (e.g., “I assert my opinion forcefully”; \( M = 3.17, SD = 1.12, \alpha = .84 \)).

**Negative Health Perceptions**

Cohen and Hoberman’s (1983) 36-item semantic differential Physical Symptoms Checklist measured distant caregiver negative health perceptions on a 5-point scale ranging from 0 (*not at all bothered*) to 4 (*extremely bothered*) regarding, for example, muscle tension or soreness, headache, sleep problems, cold or cough (\( M = 1.97, SD = .97, \alpha = .98 \)).

**Results**

**Preliminary Analyses**

As communication between long-distance relational partners may be influenced by distance in miles and visit and contact frequency of visits (Merolla, 2010), these variables were correlated with the conflict and health variables. No correlations were significant at \( p < .05 \). Because age, hours providing care, income, and education are related to caregiver health (Pinquart & Sorensen, 2007), these variables were correlated to negative health perception.\(^2\) As the relation between distant caregiver age and negative health perceptions was significant (\( r = -.26, p < .05 \)), age was controlled for in the main analyses.

**Primary Analyses**

We examined the research question and hypotheses using hierarchical regression analyses, with distant caregiver age entered in the first block, the conflict variable in the second block, and negative health perceptions as the dependent variable.

\(^2\)Although female caregivers tend to experience more negative health than do male caregivers, the small number of male distant caregivers who participated in this study (\( n = 10 \)) meant that we could not confidently test gender as an additional covariate.
The regression model for Hypothesis 1 was significant, $F=7.44$, $p < .01$, adjusted $R^2=.12$. Conflict frequency was a significant, positive predictor of distant caregiver negative health perceptions, $\beta=.25$, $t=2.64$, $p < .01$, and age was a significant, negative covariate, $\beta=-.24$, $t=-2.47$, $p < .05$. Thus, Hypothesis 1 was supported.

The regression model of Hypothesis 2a was significant ($F=7.18$, $p < .01$, adjusted $R^2=.13$) and distributive communication was a significant, positive predictor of distant caregiver negative health perceptions ($\beta=.25$, $t=2.61$, $p < .01$). The regression model of Hypothesis 2b was also significant ($F=10.11$, $p < .001$, adjusted $R^2=.16$), and avoidance was a significant, positive predictor of negative health perceptions ($\beta=.33$, $t=3.50$, $p < .001$). Age was a significant, negative predictor for both models: distributive ($\beta=-.21$, $t=-2.16$, $p < .05$) and avoidance ($\beta=-.25$, $t=-2.63$, $p < .05$). Thus, Hypothesis 2 was supported.

For the research question, although the collaboration ($F=3.72$, $p < .05$, adjusted $R^2=.05$) and compromise ($F=3.83$, $p < .05$, adjusted $R^2=.06$) regression models were significant, neither collaboration ($\beta=-.06$, $t=-.62$, $p=.54$) nor compromise ($\beta=.08$, $t=.76$, $p=.45$) significantly predicted negative health perceptions. Age was a significant predictor in the collaboration ($\beta=-.25$, $t=-2.50$, $p < .05$) and compromise ($\beta=-.26$, $t=-2.67$, $p < .01$) models. Neither collaboration nor compromise is related to distant caregiver negative health perceptions.

Correlations between study variables are shown in Table 1.

Discussion

Understanding how health is related to conflict in informal illness management can contribute to a productive and positive environment for care recipients and caregivers. Thus, we investigated conflict frequency and strategy usage in relation to negative health perceptions in LDC. As predicted, conflict frequency (Hypothesis 1) and usage of distributive and avoidant (Hypothesis 2) conflict strategies positively predicted distant caregivers’ negative health perceptions. However, collaboration and compromise (research question) were not associated with negative health perceptions in LDC. These findings and their implications are discussed below.

Conflict Frequency

Consistent with Hypothesis 1, frequency of care provision conflict between distant caregiver and care recipient positively predicted negative distant caregiver health, which aligns with recent findings that link family conflict and caregiver health (e.g.,

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<td>1. Conflict frequency</td>
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<td>2. Collaboration</td>
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<td>3. Compromise</td>
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<td>6. Negative health perceptions</td>
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**Significant at $p<.01$; ***significant at $p<.001$.**
Francis et al., 2010). Our study further expands these findings to include conflict with the care recipients themselves, who are clearly crucial actors in the caregiving situation. In addition, the moderate amount of LDC conflict (2.96 on a 7-point scale) that we observed is generally consistent with caregiving conflict frequency research (e.g., Usita et al., 2006) and suggests that distance may not be inhibiting how much conflict occurs in LDC.

Further, conflict frequency was significantly, positively related to distributive communication and avoidance, but unrelated to compromise or collaboration. Adding distance to this negative conflict pattern could exacerbate the likely deleterious effects, as there may be fewer opportunities to engage in the positive interactions that will counteract negative behaviors (e.g., Gottman, 1994). Overall, our preliminary findings tentatively extend conflict frequency’s association with relational quality (McGonagle et al., 1993) to individual health perceptions in LDC. One logical future question arising from the findings of Hypothesis 1 and from Butterworth and colleagues (2010) research is the extent to which conflict explains why distant caregivers have greater negative health perceptions than noncaregivers and proximal caregivers.

**Conflict Strategy Usage**

**Distributive Communication**

Reviews of conflict and health studies (e.g., Graham, Christian, et al., 2006) conclude that negative communication elicits pronounced physiological arousal. Further, Robles and Kiecolt-Glaser (2003) implicated marital strain (including negative conflict interactions) as a psychosocial risk factor that can negatively affect one’s health as much as smoking or physical inactivity. Support for Hypothesis 2a, which found that distant caregiver distributive conflict strategy usage was positively related to negative health perceptions, thus adds to the considerable research examining these two variables. More important, because caregivers were found to have marginally more hostility than noncaregivers (Graham, Robles, et al., 2006), this preliminary set of findings is particularly relevant to caregiving scholars. Health care professionals should advise caregivers to minimize distributive conflict with their care recipients. This recommendation may be especially important in LDC, where fewer chances for interaction may mean that using distributive conflict strategies will potentially be more pronounced and deleterious to caregivers’ health.

**Avoidance**

Hypothesis 3 revealed a significant, positive relationship between conflict avoidance and increased distant caregiver negative health perceptions. This finding is consistent with Davis (1997), who determined that conflict avoidance was related to caregiver anger and depression, and with the body of research linking caregivers’ use of the avoidance coping strategy with individual well-being (e.g., Knussen et al., 2008). Stafford (2010) noted that conflict avoidance may be less illicit for long-distance romantic relationships than for those in proximal relationships, and instead could be relationally comforting and optimistic. As such, distant caregivers may avoid conflict to protect their relationships (e.g., Roloff & Wright, 2009), but doing so may exacerbate their negative individual health perceptions. Using this reasoning, LDC conflict avoidance could possess benefits and drawbacks.
Distant caregiving may provide an optimal backdrop for a link between conflict
avoidance and negative health perceptions. Although avoidance may seem to be an
appealing short-term option in circumstances where distant caregivers do visit or
contact their care recipient as often as they could if they were geographically close,
it can become damaging over time (e.g., Stephens et al., 1988). As with research that
recommends assisting caregivers in more adaptive coping (e.g., Claar et al., 2005;
Knussen et al., 2008), we suggest that distant caregivers be advised of the potential
peril to individual well-being that can accompany conflict avoidance.

**Integrative Communication**

The integrative conflict strategies, collaboration and compromise, were unrelated
to distant caregiver negative health perceptions (research question). Perhaps distant
caregivers select integrative conflict strategies as a way to preserve their relationships
with care recipients. Integrative communication is typically best for a satisfying
relationship (e.g., Pecchioni & Nussbaum, 2001) and caregivers in conflict with their
aging parents chose constructive communication to prevent relational harm (Usita
et al., 2006). Stafford (2010) noted that long-distance romantic relationships may
compensate for distance by being more positive in their interactions, which then
creates positive relational affect and fulfills critical relational needs. The distance itself
may thus be an additional relationship-centered (rather than individual-centered)
consideration when distant caregivers select collaboration or compromise in conflict.

Despite their lack of significant association with negative health perceptions,
the moderate-to-high usage of these two conflict strategies that we observed is
still promising, as solution-oriented strategies can improve caregiving quality and
outcomes (Plowfield et al., 2000; Shaffer et al., 2007). However, the minimal attention
(e.g., Robles & Kiecolt-Glaser, 2003) and inconsistent research findings (e.g., Kiecolt-
Glaser, 1996) regarding positive communication and health mean that further
scholarly investigation is warranted.

Overall, an interesting aspect of our findings that may be unique to LDC emerged.
Our sample of distant caregivers diverges from the typical caregiver (according to the
National Alliance for Caregiving/American Association for Retired Persons, 2009),
in that they spend less time providing care, visit the care recipient less, and are less
likely to assist with activities of daily living or be the primary caregiver. Further,
the National Alliance for Caregiving/American Association for Retired Persons’s
participants reported poorer health if their caregiving was high burden, they lived
with their care recipients, and they provided more than 20 hours of care per week.
In contrast, although our participants typically shouldered relatively less caregiving
burden and responsibility, they also reported moderate conflict frequency, usage of
distributive and avoidant conflict strategies, and negative health perceptions (i.e., 1.97
on a 5-point scale). As such, even caregiving that involves comparatively less time,
burden, and responsibility appears to be characterized by destructive communication
and compromised health. The extent to which this is evident in LDC should be
considered in future research.

**Practical Applications**

Our preliminary findings suggest a number of practical suggestions for improving
LDC conflict. We propose that formal health services not only recognize that conflict
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exists in family caregiving (per Sheehan & Nuttall’s [1988] recommendation), but
also understand that this conflict is communicatively handled in different ways
that may or may not be related to caregivers’ perceptions of their health. Further,
the growth of distant caregiving makes the formal acknowledgment of and
assistance with conflict management even more pressing, as the limited interaction
opportunities in LDC may be spent in conflict about caregiving rather than on
care provision. As successful past caregiver interventions have been conducted via
telephone (e.g., Grant, Elliott, Weaver, Bartolucci, & Giger, 2002), distance should
not be a significant obstacle in the design and implementation of conflict-based
caregiver interventions.

Rivera, Elliott, Berry, Grant, and Oswald (2008) concluded that the absence of
negative problem solving was more important than the presence of positive problem
solving in predicting depression risk for caregivers. This same logic can certainly
extend to the four conflict strategies examined here and their associations with distant
caregiver negative health perceptions. Our second practical suggestion, then, is that
rather than encouraging the use of positive conflict strategies in LDC, health care
professionals may instead consider focusing on curbing usage of distributive and
avoidant conflict strategies to better safeguard the LDC relationship.

Last, communication competence has been offered as a potential solution for
allaying caregiving conflict (Kam, 2008; Lobchuk, 2006) and this suggestion can
extend to LDC as well. Competence is a major component of interpersonal conflict
research (e.g., Canary, Cupach, & Serpe, 2001; Canary & Spitzberg, 2006), and the
balancing of effectiveness and appropriateness is a concept that distant caregivers can
likely understand and easily implement in their interactions with their care recipients.
In addition, future research could consider the extent to which communication
competence in interactions between distant caregivers and care recipients could buffer
against distant caregiver negative health perceptions.

Limitations and Conclusions

Although our study produces some interesting insights, it also possesses limitations.
First, our few male distant caregiver participants prevented gender comparisons,
which are particularly important because female caregivers report greater depression
and poorer subjective and physical health than do male caregivers (Pinquart &
Sorensen, 2003). In addition, it is possible that our participants may represent a
segment of the population that is comfortable with disclosing information regarding
the occurrence of conflict and use of conflict strategies. Differences that exist between
those who comfortably disclose personal information and those who do not were not
accounted for in this study. Last, this study examined retrospective recall data, which
was necessary to the extent that distance would likely preclude bringing caregivers
and their care recipients together to participate. A longitudinal, dyadic examination
of actual conflicts that occur between care recipients and their distant caregivers (as
well as other caregivers, if they are present) would be a useful area of future research.

In conclusion, this study provides introductory steps toward understanding
the relationships between conflict frequency and strategy usage and corresponding
negative health perceptions in the long-distance caregiving context. Our findings
suggest that conflict between distant caregiver and care recipient is not only present
but is associated with distant caregivers’ negative perceptions of their health. As such,
the care recipient and the distant caregiver could experience compromised health
when engaging in conflict with one another about caregiving. Bevan and Sparks (2011) underscore the value of focusing on LDC communication and our conflict findings offer initial understanding of this important, and growing, long-distance health relational context.

References


