CHAPTER - II
THEORETICAL BACKGROUND

INTRODUCTION
There are different models, approaches and theories related to caregivers of elders and they were given by different proponents in different periods. These models, approaches and theories conceived by researchers from a range of disciplines incorporate the personal, social, and temporal contexts. They focus on caregivers’ perception, strain, burden, coping, well-being and outcome of caring.

MODELS
Double ABC- X Model was drawn by Hill (1981) and elaborated by McCubbin (1989). The model focuses on formal and informal caregivers of the family (McCubbin and Patterson, 1982). The model proposes that an event such as an illness (A) invokes a family’s resources (B); the family interprets the event (C) and a crisis or non-crisis produced (X). The model emphasizes:
(a) caregivers of elder life stress and strains which shape the adaptation of filial caregivers’ family situation, (b) critically assess the interfamilial, social resources, social relationship and managing crisis situations of caregivers, c) appropriate assistance may act to protect the informal caregiver strain, stress and potential crisis, (d) act as caregivers’ coping strategies (e) the range of outcome of caregivers of elder and e) social relationships which include: attachment, positive family bonds, effective communication, social isolation and perceptions. The range in cognitions and attitudes between hope and personal effectiveness vs. despair and helplessness of informal caregiver and their family members (Patterson, 1983) which ultimately produces a maladaptive or adaptive outcome of elderly caregivers (Boss, 2002).

Family Spiritual Interdependence Model (FSIM) describes the level of interdependence, related to spirituality and well-being in informal care giver’s family. This model is applicable
only to short and long term care situations within the family environment. Every family member provides proper care and support for their filial elder. Elder well-being is similar to caregivers’ well-being and elder’s spirituality is similar to caregivers’ spirituality. The spirituality and well-being both of them are correlated between elders and their informal caregivers (Kim, 2007).

Hierarchical Compensatory Model (HCM) was widely developed by Cantor (1991). The model posits that the source of assistance follows a pattern based on the primacy or closeness of social relationships, social care system and explaining the interface between informal and formal caregivers. The key element of the model is societal norms about the primacy of relationships govern the elders preferences for frail care help. This conceptual framework asserts that the frail elder prefer spouse is the first choice as caregiver, followed by children and other kin. Therefore, the filial elder expected to be performed by the closest family member for their care. The family members are not available for help the care receiver select friends and neighbors are the next choices for assistance and followed by formal service providers. In this model, each group successively provides assistance when a more preferred source is unavailable, either because one does not exist or it is unable to meet needs. That means the informal sector is the prime sources of assistance for frail elder care (Noelker and Bass, 1994).

Kin Independence Model (KIM) describes that within the family; every member is responsible for taking care of the filial elders’ needs. The kin caregiver is a part of family. Such caregivers independently meet the impaired person’s needs, assistance and all kind of support without the involvement of formal and other service providers. The cultural values are highly influenced the kin care service (Noelker and Bass, 1989).

Quality Health Outcomes Model (QHOM) highlights death, disability, dissatisfaction, disease and discomfort (Five Ds) of caring situation. The model emphasizes that the quality of care has
shifted from structures (having the right things) to processes (doing things right) to outcomes (having the right things happen) of health care. It includes the health-related quality of caregiver and care receiver’s perceived dimensions of physical, social, mental health perceptions. It is categorized as: achievement of appropriate self-care, demonstration of health-promoting behaviors, health-related quality of life and perception of well-being. The model assesses the outcome of satisfaction, care process, and structure with care quality, reciprocal and dynamic relationships of caregiver and care receiver end-of-life care situation (Donabedian, 1966).

**Social Control Model (SCM)** asserts that social support has positive effects on health. When an individual is embedded in a social network, it can place pressure on people to follow healthy behaviors by giving individuals meaningful roles that enhance an obligation to life (Lewis and Rook, 1999).

**Stress Process Model (SPM)** is presented as the appropriate paradigm for considering the chronic illness experience of caregivers of elder. Chronic illnesses can lead to change the caregiver roles and impact role performance, which directly and indirectly influenced the caregivers’ physiological, psychological and social well-being. The model focuses on stress and strain of the caregiver it may classified into three part as primary stressors (care recipient’s mental impairment), secondary stressors (family distress), and contextual demographic characteristics (caregiver gender, education, income, relationship to the care recipient, and living arrangement) which influenced the caregiver level of strain, burden and quality of life of the caregiver of elder (Pearlin, Mullan, Semple and Skaff, 1990)

**Supplementation (Complementary) Model** developed by Edelman (1986) proposes the task sharing of informal care giving, the most assistance needed by chronically ill, disabled elder as personal care, daily activities, technical and specialized care. The supplementation by informal
caregiver alleviates the time consuming and potentially exhausting demands on informal service. The model asserts that the primary caregivers are the major helpers and use service providers to augment their efforts or for respite (Edelman and Hughes, 1990).

**Wheel of Wellness Care Model (WWCM)** model proposes five life event tasks there are; spirituality, work and leisure, friendship, love, and self-direction. These five tasks are subdivided into 12 subtasks such as: sense of worth, sense of control, realistic beliefs, emotional responsiveness and management, intellectual stimulation, problem solving, and creativity, sense of humor, exercise, nutrition, self-care, gender identity, cultural identity, and stress management. It interact the caregivers of elder stress, strain, burden and physical and mental health outcomes. The model focuses on strengths as well as prevention measures of caregiver problems and to promote caregiver wellness (Waters, 1995).

**APPROACHES**

**Bowen’s Family System Approach** underlines the potential for interpersonal crises in family subunits for individuals who give inordinate amounts of time to the care of elder and also possibilities for interpersonal conflicts, role strain, family abuse, and family disruptions. The result both generations can face the tasks of caring the elder (Tobin and Kuly, 1980).

**Family Centered Intervention Approach** may have particular utility for alleviating the stress, strain, burden and well-being level of caregivers of elder, who have providing the care within the family members. The approach generally attempt to do one or more of the following: a) improve collaboration and coordination among family members, b) facilitate reorganization of family roles and adjustment of expectations and norms, c) enhance family closeness and mutually supportive interactions, d) minimize interpersonal hostility and conflict, or e) mobilize the family’s natural support systems. Such approaches contrast with most existing caregiver and
focused on the needs of individual caregivers rather than the family system. Family centered informal caregiver service beneficial for elder families, where family well-being may take as a motivator for care giving activities (Weihs et al., 2002).

Family Resilience Approach (Walsh, 1996) combine ecological and developmental perspectives to view the family, which influenced the large societal context and evolves in a multigenerational life cycle, each family member to take responsibility and lead the family and family members’ care and support and well-being (Carter and McGoldrick, 1998).

General Care Giving Approach refers to care giving and the caregiver’s ability to handle the day to day tasks required to take care of an elders. The approach includes: family member’s strengths, limitations, current needs, basic requirement and fulfilling quality of life. The caregiver focused on person centered care, manage their own emotions and manage family and community resources, it provided by the family normative behavioral expectations related to caregivers caring role, which exhibit the well-being of caregiver and their family (Stryker, 1980).

Multi-dimensional Approach (Baltes and Smith, 1999) focuses on the physical and psychological demands on caregivers. The caregivers, due to caring, may gain caring experience on one side; and on the other side, they may lose or sacrifice their life. The gains and losses are associated with informal caregiver life events. That means some caregivers of elder have the capacity to successfully adapt to their changing family roles while in other cases, care giving may lead to failure or difficulty to adapt their new care giving role (Piercy and Chapman, 2001).

THEORIES

Activity / Developmental Tasks Theory (Cavan, Havighurst, 1961) elaborates caregiver self-concept like social interactions and caring tasks. The caring tasks arise at certain periods of
achievement in their life, which leads to caregiver happiness and success. It is mainly focused on biological (physical maturation) psychological (aspirations or values) and cultural (expectation of society) bases. To maintain morale of the informal caregiver in caring the elder, substitutions must be made for loss roles, work burden, loss of employment and financial problems. Care giving contributes to self-concept, satisfaction and establishes new roles (Friedman and Havighurst 1954; Havighurst and Albrecht 1953).

**Anomie Theory** is focused on the social institutionalized norms of caring the elder. When these social norms or social system weaken the family, the anomie will set in and affect the family’s values and success. There were a number of adaptations possible in response to secure the social systems. The individual adapts to the strains and innovation, ritualism, pursued, retreatism and rebellion through that the goals and means are rejected, accepted and pursued along with the legitimate means and new structure is advocated in the family (Merton, 1938).

**Attachment Theory** (Bowlby, 1982) proposes a frame for experience of caregiver. It was found that interaction, quality of care giving relationships, in-depth profile of attachment, care giving dynamics intense need and caregiver caring situation. It poses that caregiver and care receiver internal and emotional attachment and affectionate bond that caregiver as a parent role and protect them care receiver in filial situation. Thus a sense of elder care or filial responsibility is the result of friendship, mutuality, and positive feelings for one’s parents rather than a sense of debt or obligation. In Indian cultures, religious moral principles provide a strong ideological basis for filial piety and status of elders as well as elder caring, it demands that caregiver should love, respect, and serve their elder (Cicirelli, 1989 and 1993).

**Behaviour Change Theory** (Meillier, Lund and Kok, 1997) posits that there is a kind of social utility and social contracts of caregiver and care receiver. The care receiver and caregiver expect
the emotional support, personal care, financial aid and instrumental activities in inside and outside of the home. The caregivers do the multi-factorial role of caring and provide care and support to their elderly parents which are leads to physical and psychological problems of the care giver. The caregivers change their behavior due to traditional norms and operate from a norm of generalized reciprocity rather than specific or balanced reciprocity of both caregiver and care receiver (Ingersoll-Dayton and Antonucci, 1988).

**Bradburn's Two-factor Theory** is focused on positive and negative effects of caregivers’ well-being; these two aspects of well-being are discussed in relation to life events, personal causation, neuroticism and introversion-extra-version. The negative effect was strongly related to inner aspects of the caregiver while positive effect was strongly related to external, interactive aspects of psychological well-being of caring outcome. The caregivers’ life is a strained one. The social supports, coping and satisfactions lead to positive effects and burden and strain are negative effects of psychological well-beings of caregiver (Bradburn, N.M., 1969).

**Caregiver Identity Theory** (Rhonda Montgomery and Jung Kwak, 2007) proposes that the care giving has a number of tasks. It undertakes the length of time, the costs incur and benefits perceive in their care giving role of care giver. The theory recognizes that the experience of care giving is determined by the care recipient's disease, grounded in family roles and culture. The theory describes elder caring is a systematic process of identity change. The caregivers’ needs are multi-dimension and require individualized plans to maintain their own health and quality of life.

**Continuity Theory** (Atchley, 1971) focuses on caregivers of elder maintaining consistency in internal (personality, beliefs) and external (relationships) structures involved throughout the caring years. The caregivers are able to continue and maintain elder caring life because of their
established interests, cultural, moral and legal values. The caregivers face lack of ability to pursue interests, disrupted interaction with family, friends and neighbors, financial instability; care receiver's conditions create the greatest burden to care givers’ life (Atchley, 1989).

**Cumulative advantage / Disadvantage Theory** (Price and Merton, 1960) elaborates on elder caregiver’s quality of care giving. The social, economic and psychological adjustments are playing important role in elder caring. Inequalities have a tendency to become more pronounced throughout the elder caring process. The theory can be expressed in the adage the rich get richer care and the poor get poorer care. The life stages of caregivers’ life span have direct influences on economic and health statuses of informal caregivers’ quality of care (Dannefer, 1998).

**Disengagement Theory** suggests that withdrawing from society and social relationships is a natural part of growing old. There is a natural tendency to withdraw from individuals and society (everyone expects to die one day). There is less reinforcement to conform to social norms (elderly caregiver withdraw) and withdrawal allows a greater freedom from the pressure to conform (social withdrawal is different by men and women because men focus on work and women focus on family). When they withdraw they will be unhappy and directionless until they adopt a role to replace their accustomed role that is compatible with the disengaged state. The theory explains why society is less welcoming to elder caregiver participation in social activities but may have to because their planning does not accommodate the needs of elder informal caregiver. Gradual withdrawal from society and relationships preserves social equilibrium and promotes self-reflection for caregivers (William Henry and Elaine Cumming, 1961).

**Erikson’s Psycho-social Developmental Theory** (Erikson, 1963) is based on stages of psycho-social development. Individuals may experience a sense of satisfaction while supporting and consider supporting as successful developmental tasks. It accepts one’s own life cycle and
provides the foundation for successfully achieving ego integrity which linked to chronological and physical development stages and experience of intimacy vs. isolation of individuals. The care giving of elder may lead to intimacy between the caregiver and care receivers’ relationship. The caregiver must have a strong sense of self and an ability to trust themselves and their elder. Family members express that caring for their elder made them feel good about themselves and that they are giving the caring role to next generation (Blieszner, Mancini and Marek, 1996).

**Exchange Theory** (Dowd 1961) suggests that elder care relationship is mutually exchanging family relationship. It focuses on a large inheritance or participating in social exchange systems via elder care and material and non-material elder caring assumptions are exchange the caregiver and care receiver. Caregiver age, experience and caring involvement are playing important role for elder care. Role loss, negative external labels, breakdown the social framework and social reconstruction are expectable problems of caregivers of elder. Social activities and networks are considered positive experience of caregiver (Kuypers and Bergston, 2000).

**Family Systems Theory** (Bertalanffy, 1968) views family as an interdependent system in which each family member has psychological influence over another. The intra and intergenerational family dynamics relationships, the caregiver and care receiver outcomes are seen to prosper (positive) or decline (negative). These diverse patterns of dyadic mental health outcomes exhibit better understanding process of caring. The elder family member illness leads to physical and financial strain and stress of care giver, which influences the caregiver quality of life, the caregiver applied different kinds of coping pattern and sense of mastery have strengthen the caregiver well-being (Ingolds., 2004).

**Feminist Theory** gives priority to gender as an organizing principle for social life across the life course, the gender should be examined the context of social meanings, every-day experiences
and reflecting the influence of social constructionism. The feminist perspective, family care giving can be understood as an experience of obligation, structured by the gender-based division and the devaluing of unpaid work like caring the dependent family members (Stroller, 1993).

**General Systems Theory** (GST), which was in part a response to positivist thinking about applying the natural science to human science. It can look at outside observers to establish own sense of social reality. A greater majority of household and caring work are done by the women in the family system. The caring is a universal element of women’s identity. As per the general system women are responsible for caring the aged, children, sick, disabled and destitute family members.

**Hierarchical Compensatory Theory** focuses on the importance of recipients’ preferences. The caregivers of elder seeking help have an ordered preference based on the primacy of the relationship between the caregiver and elderly recipient (Messeri et al., 1993). Caregiver prefer the assistance of elder, they turn first to children, second to other relatives, third to friends or neighbors and last to formal groups (Cantor, 1991).

**Human Science and Human Caring Theory** (Watson, 1988) particularly helps to understand interdependent influence between caregivers and care receiver in situations. It formulates the congruence of spirituality between caregivers and elders. The spirituality emphasized higher level of consciousness for transcendence. It engages personal, social, moral and spiritual dimensions in a transpersonal caring relationship between caregiver and care receiver. The transpersonal caring relationship was described as inter subjective human to human relationship. The caregiver affects the care receiver and also affects the caring moments. Thus, both the elder and the caregiver have an opportunity to learn from each other (Falk Rafael, 2000).
Illness Trajectory Theory (Everett Hughes, 1971) focuses that the illness career to portray the continuum of health care, which comprise caregivers health care, safety, comfort, sentimental information and caregiver work done over the course of the disease. The effect on the caregiver health and their work considered as reciprocal consequences of interaction, social context and social relationships.

Karma Theory states that the fate or destiny according to an individuals’ actions in previous life. Good actions of the past life ensure better fate in next life and make people in charge of their life. Karma contains the idea of endless circle of birth and death in which individual soul progresses or regresses through the levels of existence. It also impels balancing right and wrong actions of dharma and adharma (Prakash, 1997).

Life Course Theory (Bengston and Allen, 1993) assumes that human development is structured by the order and timing of life events that occur throughout the life, the informal caregiver interact within societal and cultural contexts that shape their life decisions as well as health outcomes. The concepts of life course include: a) caregiver roles occupy family and non-family roles, b) role configurations focus age-specific social roles like amount of time the caregiver able to provide care to the elder and maintain relationship all roles are change in time to time, c) trajectories and transitions that culminate into reality of the life, caregivers of elder roles have diverse associations with caregiver outcomes, caregivers are expected to differ in their ability to manage transitioning into and out of multiple roles and the responsibilities. This is the pathways roles associated with the caregivers psychological and physical health (Marks et al, 2008).

Lifestyle-Exposure Theory suggests that, lifestyle differences are the product of care givers’ adaptation, structural constraints and role expectations. These are directly influenced the caregivers’ demographic characteristics such as age, sex, income, marital status, occupation, and
education level. Caregivers spend significant time to care elder and their family members or shifts in role expectations can result in changes in structural constraints reciprocal role of elder caring (Hindelang, Gottfredson and Garofalo, 1978).

**Mid-range Descriptive Theory or Ambiguous Loss Theory** focuses the symbolic perspective of caregiver. The elder have serious or chronic illnesses, they lose their physical strength and intellectual power that effect ambiguous loss of elder. The caregiver providing care with lack of clarity and ambiguous loss, will develop caregivers’ stress, anxiety, depression, somatic illness, family dysfunction, appetite or sleep disruption, low energy, low self-esteem, hopelessness, sadness and caregiver strain. The boundary ambiguity, spirituality and marital relationships are playing important role in caregiver strain. The caregiver alternates their familial roles and responsibility, involving social, spiritual activities and the handling of finances. Elder caregivers find it difficult to cope with their family relationship and ambiguous boundaries, spirituality is the sources to cope with their strain (Boss, 1999).

**Modernization Theory** states that with the impact of modernization, the joint family system weakened and formed the nuclear family system, which is in transition to individualistic family. The influence of modernization, caring norms were changed and caregivers lost their manual powers, status and responsibility to care. At present situation the caring is a kind of social exclusion and caring of elder relative is a voluntary obligation without fear of social censure. The theory suggests that the care receiver is abandoned, facing economic and social problems and loses much of familial support since that person becomes a nonproductive economic burden (Cowgill and Holmes 1972).

**Relative Deprivation Theory** refers to caregivers’ perceptions of their well-being and strain. The well-being may be estimated based on a number of dimensions, including wealth, income,
power and prestige. The elderly caregiver strain may occur at all levels, and may help to explain the weak effect of strain measures on caring the elders. It is considered to predict caregiver behavior, compared with more objective measures of deprivation such as poverty or inequality (Agnew et al., 1996).

**Role Strain Theory** (Goode, 1960) commonly deals with a combination of demands and assistance. The demands concern with the work, obligations, financial problems, take time away from other roles, time devoted to care giving and lack of time spent working as well as the assistance concern with daily living, behavioral problems, and overload and role captivity. Too many demands and assistance the caregiver cannot meet their requirements and their duties which are leads to feelings of caregiver role strain and burden (Aneshensel, Pearlin and Schuler, 1993).

**Self-Concept Discrepancy Theory** states that the caregivers can be expected to internalize the cultural expectations and legal regulations in their socialization. The informal caregivers have their own expectations to caring their elderly parents, which may be achieved or not. If not, the caregiver emotionally suffers stress and strain. The self-concept discrepancy refers to the gap of self-state representations. It is used to measure and explore the individuals’ perceptions and their personal attributes, these attributes are explore the caregivers’ evaluation and accomplishments, it exists the care giving context, performance and sibling support of caring the elder (Higgins, 1980).

**Self-Efficacy Theory** (Alberta Bendura, 1977) believes that one has the power to produce that effect by completing a given task or activity related to that competency. It is the expectation that one can master a situation, and produce a positive outcome. Behaviors, environment, and personal/cognitive are the factors of self-efficacy. It is the extent or strength of one's belief in
one's own ability to complete tasks and reach goals. The informal caregivers of elder equipped with adequate knowledge about chronic disease and disability management, caregivers could become psychological activities proactively shaping their lives. Informal caregiver self-efficacy as outcomes of caregiver effectiveness, encounters with primary care physicians and other health care professionals (Aneshensel, 1995).

**Social Competence and Breakdown Theory** states that the caregivers gain a sense of self through interpretation of others’ responses (e.g., approval, criticism and self-concept) to their own behavior. The caregivers’ self-concept may be vulnerable because of role loss, negative and stereotypes of work, it leads to labeling of the caregiver as dependent by a health professional, family or others in the social environment. The sudden and unexpected dependency of an aged family member can bring forth the problem of caring. The understanding of the nature of individual familial environmental interactions affecting competence can facilitate the identification of interventions that may improve family functioning and reduce the sense of helplessness for many caregivers. These kinds of negative consequences of elder caring (e.g., illness, loss) can lead to a breakdown in the social competence of the elder caregiver (Bengtson and Kuypers, 1999).

**Stress Process Theory** conceptualizes that the stress and strain as an experienced process by informal caregivers. The theory assumed that caregivers provided specific amounts or types of care that occurred in the context of other roles such as marital, parenting. It is including: a) background characteristics and contexts (gender, race/ethnicity, age as well as attained roles) It represent a social stratification of “rewards, privileges, opportunities, and responsibilities” that are directly and indirectly related to every component of the stress process experienced by caregivers, b) Primary stressors (care recipients’ problematic behaviors, dependencies, and
cognitive disturbances), c) Secondary role and intra-psychic strains (perceptions of family conflict, occupational conflict, and financial restraints), d) Mediators (coping strategies and social support prevent or reduce stressors and negative outcomes), and e) outcomes (depression, anxiety, physical health, cognitive disturbance, and the decision to stop providing care) are associated with care giving. The theory focused direct relationship between caregiver characteristics and caregiver outcomes such as social roles as statistical controls, consequently failing to give adequate attention to the relative impact of changing family and non-family roles on caregiver outcomes (Pearlin and colleagues, 1990).

**Task-specific Theory** categorizes social network groups as primary, informal, and formal groups (Litwak, 1985). Each social network has different social networks; each network group can optimally manage different tasks (Litwak, 1985; Messeri, Silverstein, and Litwak, 1993). This theory also emphasizes that most people have various needs and their necessary for both formal and informal groups to cooperate in most areas of life (Messeri et al. 1993). In addition, the provision of aid varies across different relationships even within the primary groups such as relatives and non-relatives. Therefore they continuously have face-to-face contact and can provide social support over a long period of time. On the other hand, neighbors living close have a face-to-face primary contact, but unlike caregiver they typically do not provide long term commitments (Messeri et al. 1993).

**Theory of Ashramas** is fourfold stage in the life of an individual. According to Dharamshastras and Smritis, during one’s life an individual passes through four stages, namely, Brahmacharya (student life), Grastha (married life), Vanaparatha (life of retirement) and Sanyasa (the life of renunciation). The movement from one stage to another was gradual with prescribed specific duties and observances associated with each stages. Vanaprastha corresponded to the stage of
life when an individual withdraws himself out of the status of the householder and gradually hand over the resigns of the family to his eldest son. Hence, the responsibility of welfare of the family passes down to the next generation. Each stage of life along with corresponding rights and duties were generally followed by the members of the family. The needs of the elderly has been often taken care by the immediate family members. Personal care, economic and emotional support are provided by the near kith and kin the task of providing care has traditionally been fulfilled by women in different capacities as spouse, daughter or daughter in law.

**Transactional Stress Theory** (Lazarus and Folkman, 1984) focuses on stress, burden and outcomes associated with care provision. The theory maintains the influence of socio-demographic characteristics of caregivers and care-recipients in adaptation to the stress processes of care. The theory suggests that the role of subjective and objective primary stress factors that can spawn secondary stress factors that may further produce negative objective outcomes (e.g. lose of free time, disruption of employment) that may lead to negative subjective assessments (e.g. decreased self-esteem, etc.), which maintains that caregivers experience positive and negative reactions though reflecting different aspects of the caring experience (Iecovich, 2011).

**Unrealistic Optimism Theory** focuses on optimism bias (also known as unrealistic or comparative optimism). It is a bias that causes a person to believe that they are less at risk of experiencing a negative event compared to others. There are four factors that cause a person to be optimistically biased: their desired end state, their cognitive mechanisms, the information they have about themselves versus others, and overall mood. The optimistic bias is seen in an elder care giving of situations (Weinstein’s, 1980).
ANALYSIS OF THEORETICAL BACKGROUND

The researcher referred the relevant models, approaches and theories related to the study. The details are given below:

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Theoretical Background of the Study

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See Annexure – III

The table reveals the theoretical background of the selected study. The researcher referred 9 models, 5 approaches and 32 theories relevant to the topic. Perception, strain, burden, coping, well-being and outcome related models, approach, theories were sighted.

The models, approaches and theories focus on family system and its issues. Each and every member of the family is responsible to care their sick elder. The informal caregivers are the major helpers. Family members extend service to elders. The frail elder prefers spouse is the first choice, followed by children, kin, friends, neighbors and formal service for their order of expect the help. The caregivers face psychological, physical and family problems such as lack of professional skills, experience and clarity of elder caring and loss of their personal roles and employment leads to financial problems.

Caregiver’s helping tendency, active involvement, self-satisfaction and caregiver and care receiver relationship characteristics and boundary ambiguity, spirituality, marital relationships, combination of demands and assistance, requirements and duties play an important role in
positive perception of elder caring. The caregiver’s physical, social, mental, and health related perceptions influence the caregiver quality of life.

The informal caregivers have their own expectations to caring their filial elder, which may be achieved or not. If not, the caregiver will suffer strain and burden. The care giver’ character and quality of life is directly associated with caregivers’ strain and burden. The caregivers adopt different kinds of coping strategies to prevent or reduce their strain and burden. Their positive coping patter leads to dyadic mental health outcomes and strengthens their well-being.

CONCLUSION
In India the informal caregivers of elder face different kinds of familial and care giving problems. The models, approaches and theories help the researcher to understand the reality of informal caregivers and their issues related to elder.