

Caregiving Choice and Caregiver-Receiver Relation: Effects on Psychological Well-being of Family Caregivers in Canada

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RÉSUMÉ

Le bien-être psychologique des aidants naturels est influencé par leur relation avec le bénéficiaire des soins et par le fait qu'ils ont pu choisir ou non leur rôle d'aidant. Peu d'études ont exploré les interactions entre les relations aidant-bénéficiaire et le choix fait par l'aidant en lien avec le bien-être psychologique de l'aidant. Cette étude examine si le choix rapporté par l'aidant a une incidence sur l'association entre la relation aidant-bénéficiaire et le bien-être psychologique. Les données populationnelles de la section « Les soins donnés et reçus » de l'Enquête sociale générale du Canada de 2012 ($n = 5\,285$) ont été utilisées dans le cadre d'analyses de régressions et d'ANCOVAs. Les résultats montrent que les aidants naturels prenant soin de leur conjoint ou de leurs enfants déclarent un niveau de bien-être psychologique nettement moindre, alors que le choix libre du rôle d'aidant naturel est associé à un meilleur bien-être psychologique. Le choix de devenir aidant a un effet modérateur sur l'association entre la relation aidant-bénéficiaire et le bien-être psychologique. Les résultats suggèrent que l'offre de services devrait être accrue pour les aidants naturels qui n'ont pas choisi ce rôle, ainsi que ceux qui s'occupent de leurs enfants.

ABSTRACT

The psychological well-being of family caregivers is influenced by their relations with care receivers, and whether they have choice in becoming a caregiver. Limited study has explored the interaction effect of caregiver-receiver relations and caregiving choice on caregivers' psychological well-being. This study examines whether the caregiver's perceived choice moderates the association between caregiver-receiver relation and psychological well-being. Using population-based data from the 2012 Canada General Social Survey – Caregiving and Care Receiving ($n = 5,285$), this study applies regression and ANCOVA analyses. Results show family caregivers for spouses and children report significantly worse psychological well-being, whereas having choice to become a caregiver is associated with better psychological well-being. There was a significant moderation effect of caregiving choice on the association between caregiver-receiver relation and psychological well-being. Findings suggest that more services should be targeted for family caregivers without choice for caregiving as well as those who provide care for their children.

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Background and Objectives

Family caregivers provide help to a wide range of family members or significant others who need care resulting from long-term health conditions or age-

related needs (Family Caregiver Alliance, 2016). In Canada, roughly 46 per cent of individuals aged 15 years and older have provided various types of care and support to their loved ones at home or in the

community (Statistics Canada, 2015). Almost half of family caregivers support their parents and/or parents-in-law; other groups of care receivers include spouses (8%), children (5%), grandparents and other relatives (23%), and non-kin individuals such as friends and neighbors (16%) (Statistics Canada, 2015). For the purposes of this study, caregiving for children differs from parenting, and specifically refers to parents supporting children with disabilities, neurological health issues, or other long-term health conditions.

A substantial number of studies have examined caregiving outcomes based on the different types of relations between caregiver and care receiver, including parent, spouse/partner, siblings, children, grandchildren, or friends (Himes & Reidy, 2000; Namkung, Greenberg, & Mailick, 2017; Petrová Kafková, 2015). Previous studies have confirmed that the association between caregiving and resulting psychological well-being outcomes may be correlated with the nature of caregivers' relationships to their care receivers (Pinquart & Sörensen, 2011). This correlation suggests that caregivers who provide care for spouses and children are more likely to experience decreased psychological well-being than those caring for parents or siblings (Litwin, Stoeckel, & Roll, 2014; Penning & Wu, 2016).

The psychological well-being of family caregivers is best accounted for by taking the interaction between the caregiver-receiver relation and other contextual factors into consideration (NamKung et al., 2017). Some of the factors that influence the association between the relationship of the caregiver to the recipient and the psychological outcome of caregivers include caregiving intensity, living arrangements, quality of relationships between caregiver and care receiver, and the caregiver's age and ethnicity (e.g., Lee & Farran, 2004). However, relatively few studies have examined the effects of caregiving choice on the caregivers' psychological well-being (Quinn, Clare, & Woods, 2009), and no study has addressed the interaction between the perceived choice in caregiving and the caregiver-receiver relation, or the effects of such interaction on caregivers' psychological well-being.

This study investigated the influence of individuals' perceived choice in becoming caregivers, and the effect of interaction between caregiving choice and caregiver-receiver relations on caregivers' psychological well-being. This study explored two research questions: whether having a choice in becoming caregivers is associated with caregivers' psychological well-being; and what effects the interaction of perceived caregiving choice and caregiver-receiver relations have on caregivers' psychological well-being.

Caregiver-Receiver Relations and Psychological Well-being

The negative association between caregiving and psychological well-being has been extensively documented, as have the varying psychological well-being outcomes that depend on caregivers' relationships with their care receivers (Anderson et al., 2013; Mausbach, Chattillion, Roepke, Patterson, & Grant, 2013). In general, caregivers providing support to spouses or children report higher levels of psychological distress and life stress than caregivers for other relatives or non-kin care receivers (Penning & Wu, 2016). Furthermore, evidence has demonstrated the complex relationship between the connection of caregiver to recipient and the caregiver's psychological well-being.

The quality of the relationship between caregiver and receiver helps to explain the differing psychological outcomes of the caregiving process, due to the fundamental differences in relationships such as those between spouses, between parents and children, and between friends and neighbours (Quinn et al., 2009; Williams, Morrison, & Robinson, 2014). For example, the effect of relationship quality on the psychological well-being of caregivers differs between caregiving daughters and caregiving sons: Caregiving daughters who have a lower relationship quality with their parents report better mental health, whereas caregiving sons with lower relationship quality report worse psychological well-being than those with higher relationship quality (Marks, Lambert, Jun, & Song, 2008).

Some other aspects of the connection of caregiver to receiver influence the psychological well-being outcomes through their association with varying levels of caregiving intensity and strain. Spousal caregivers are most likely to become depressed, compared to other types of relationship, such as daughters or daughters-in-law (Lee & Farran, 2004). The intensity and strain of caregiving among spousal caregivers are likely to increase because the caregivers and recipients typically live together, which further affects the caregivers' mental health and quality of life. In addition, disparity in psychological well-being outcomes between different age groups has been observed (Ha, Hong, Seltzer, & Greenberg, 2008; Nijboer et al., 2000). Compared to older spousal caregivers, younger adult children caring for aging parents tend to experience more negative effects due to the stress and strain resulting from multiple roles, including the disruption to their work schedule and social activities (Nijboer et al., 2000). Therefore, the complexity of caregiver-receiver relations and their influence on caregivers' psychological well-being underscores the importance of identifying more factors in the caregiving context to provide a better understanding of family caregivers' psychological well-being.

Caregiving as Choice in Caregiving Context

Not every family caregiver takes on caregiving responsibility by choice. Previous studies have shown that about 54 per cent to 69 per cent of family caregivers indicated they had a choice in taking care of others (Longacre, Ross, & Fang, 2014; Winter, Bouldin, & Andresen, 2010). Family relationship is one important factor related to caregiving choice. For example, individuals are less likely to have a choice in caregiving for parents or spouses than for non-family members or relatives (Schulz et al., 2012). Various other factors also influence the decision to become a caregiver, such as the availability of social services for the care receiver, and the nature of the relationship between caregiver and receiver, which is associated with obligation, affection, and cultural norms (Stajduhar & Davies, 2005). For instance, Arksey and Glendinning (2007) have pointed out that available social service options are closely related to family caregivers' sense of choice in the caregiving situation. In some cases, it is assumed that a certain family member has more time or capability for caregiving responsibilities, and so that family member becomes the caregiver. Another study found that some people choose to become family caregivers because they do not trust their siblings' capability in taking care of aging parents (Tatangelo, McCabe, Macleod, & Konis, 2018). Therefore, an individual's perception of caregiving choice is affected by many relevant factors in the caregiving context.

Some studies have sought to explore the function of caregiving choice, and previous studies have confirmed that lack of choice can be a risk factor in family caregivers' psychological well-being. For example, Winter et al. (2010) have reported that, compared to caregivers who had a choice, those who did not become caregivers by choice were three times more likely to experience caregiving stress. Other studies indicate that having more flexible options in caring for family members is associated with higher life satisfaction, more positive affect, and lower distress, whereas lack of choice in caregiving is correlated with caregivers' emotional stress, physical strain, and other negative health effects (Longacre et al., 2014; Pakenham, Chiu, Bursnall, & Cannon, 2007). A lack of choice in the decision to become a caregiver further affects caregivers' willingness and motivation to take care of family members in need (Burrige, Winch, & Clavarino, 2007); such caregivers also tend to resent their caregiving role, and feel less rewarded and quite dissatisfied with caregiving (Williams et al., 2014). Some studies show that when individuals are forced to become caregivers, they may feel reluctant to perform caregiving tasks or to learn the skills and knowledge to be effective caregivers, which can further affect their psychological and mental well-being (Burrige et al., 2007; Williams et al., 2014).

Theoretical Framework

This study was guided by three streams of thought related to caregiving choice. First, according to Dowding's (1992) model of extending (or increasing) choice, making a choice becomes meaningful when at least two alternative options are available. When individuals are provided with options to support family members in need, such as family caregiving and/or services such as adult day care or long-term care facilities, making a caregiving choice is meaningful. However, choosing to become a family caregiver instead of using public social services could be out of the family's control: Necessary services might be unavailable, or budgets for public services might be limited; information or knowledge about services could be lacking, or the services themselves could be inflexible (Arksey & Glendinning, 2007; Wiles, 2003). In this case, taking care of family members or friends in need at home becomes the only option for many family caregivers. In such cases of limited choice without alternative options, the choice is not meaningful.

In addition, individuals' psychological well-being can be affected by their sense of control (Schulz et al., 2012). Making a choice is a way of practicing that sense of control; consequently, the absence of choice can be a stressor (Leotti, Iyengar, & Ochsner, 2010). When choices are minimal to nonexistent, caregivers are likely to lose control over the decision to become family caregivers and find themselves forced into the role. Having control over becoming a caregiver closely relates to how an individual manages caregiving responsibilities and the associated stress and burden (Szabo & Strang, 1999). In addition, the stress process model of caregiving (Pearlin, Mullan, Semple, & Skaff, 1990) emphasises how family caregivers understand the caregiving context affecting their psychological well-being. In other words, a positive appraisal of the caregiving situation tends to result in a positive caregiving outcome. Thus, psychological well-being is influenced by how caregivers perceive the choice to take on the responsibility of care (Pakenham & Bursnall, 2006).

The role of perceived choice in the caregiving context can thereby be explained in terms of the stress process model, the caregivers' sense of control, and meaningful choice. Therefore, when examining family caregivers' experiences and particularly with regard to caregivers' psychological well-being, these three elements underlie the importance of caregiving choice in caregiving situations. However, there has been relatively little research on the effects of caregiver choice on the association between caregiver-receiver relation and caregivers' psychological well-being. Consequently, we undertook this study to examine whether the

caregiver's perceived choice moderates the association between caregiver-receiver relations and psychological well-being.

Research Design and Methods

Data and Sample

The study sample for this project is selected from the Public Use Microdata File (PUMF) of the 2012 Canada General Social Survey (GSS, Cycle 26): Caregiving and Care Receiving. GSS 26 is a national survey focusing on Canadians who provide help or care to others as a result of long-term health issues, disability, or aging-related needs. A total of 23,093 respondents aged 15 years and older and living in private households in Canada completed the survey. We selected participants for this study according to the following criteria: those who had an identified primary care receiver and were still providing care during the survey; and those who completed the survey in a non-proxy interview. This study focused on a group of 5,285 participants who met these two criteria.

Focal Measures

Psychological well-being of caregivers is measured in terms of two main variables: life satisfaction and psychological symptoms.

Life Satisfaction

Life satisfaction, one of the most frequently used indicators of psychological well-being, refers to the evaluation of one's quality of life (Winefield, Gill, Taylor, & Pilkington, 2012). This study measured life satisfaction by asking participants, "How do you feel about your life as a whole right now?" Responses were represented on a scale of 0 to 10, where 0 meant "very dissatisfied" and 10 meant "very satisfied".

Psychological Symptoms

Inviting participants to report whether they experienced any psychological symptom to indicate their psychological wellness is common in studies examining psychological well-being (Gaugler, Eppinger, King, Sandberg, & Regine, 2013), as well as in family caregiving studies (Monin, Schulz, & Kershaw, 2013). One example is the Brief Symptom Inventory scale to assess psychiatric symptoms such as somatic symptoms, anxiety, and depression (Brown et al., 2006). In the current study, psychological symptoms were an aggregated variable computed from 10 different symptoms that participants experienced due to caregiving, including tiredness, worry or anxiety, feeling overwhelmed, loneliness, isolation, short temper or irritability, resentment, depression, appetite loss, or disturbed sleep. This

10-item scale has a high level of internal consistency with the Cronbach's alpha at 0.838. Each reported symptom was counted and this variable rated on a scale from 0 to 10, with 0 indicating no symptoms and 10 indicating a maximum number of symptoms.

Caregiver-Receiver Relation

The nature of the relationship between caregivers and their care receivers was measured according to 25 categories, which were further grouped into five main categories: spouse (spouse/partner of respondent), children (son and daughter), parents (father and mother), relatives (ex-spouse, brother, sister, grandson, granddaughter, and so on), and non-kin others (close friend, neighbor, and co-worker). This five-category classification of caregiver-receiver relations was similar to that used by Penning and Wu (2016), and we only modified their categories by grouping siblings as relatives because there were no significant differences between the two groups in terms of caregiving stress and mental health.

Caregiving Choice

Participants were asked, "Do you feel you had a choice in taking on your caregiving responsibilities in the past 12 months?", and the answers were recorded as "yes" (1) or "no" (0).

Caregivers' Characteristics

The background information of participants included their age, gender, marital status, highest education attainment, employment status, country of birth, and personal annual income. Age was divided into three levels: younger than age 45 years, aged 45 to 64 years, and aged 64 years and older. Gender was classified as male or female. Marital status information was originally collected within eight categories, and further re-grouped into two levels (married/common law and not married). Education level was divided into four levels, from less than high school to university degree received. Employment status was divided into three categories, including employed, retired, and other (such as household work or going to school) based on participants' main activity during the 12 months prior to the survey. The country of birth was classified as Canada or elsewhere. Personal annual income was originally grouped into 13 categories, which were later re-grouped into three levels with cutoffs at \$30,000 and \$60,000.

Care Receivers' Condition

The characteristics of primary care receivers in this study include gender (female or male), age (younger than age 65 or aged 65 and older), and major health conditions. The main health condition information was

originally collected according to more than 20 categories. For the purpose of data analysis, we organised these into four main categories: (a) aging/old age/frailty; (b) chronic disease and disability such as arthritis, cardiovascular disease, developmental disability or disorder; (c) mental illness and neurological issues such as Alzheimer's disease or dementia; and (d) other debilitating conditions such as injury resulting from an accident or surgery.

Caregiving Context

Another five variables related to caregiving context include (a) caregiving demand, (b) living arrangements between caregiver and primary care receiver, (c) primary caregiver status, (d) availability of formal social support, and (e) use of coping strategies. Previous studies have confirmed the relationships of these variables to family caregivers' health and well-being outcomes (e.g., Kim, Carver, Shaffer, Gansler, & Cannady, 2015; Mackay & Pakenham, 2012). Participants were asked whether they provided eight different types of caregiving tasks to other individuals, including transportation, meal preparation, house maintenance or outdoor work, personal care, medical treatment, and so on. The more tasks in which participants were engaged, the higher the level of caregiving demanded of them.

The living arrangements of participants and primary care receivers were classified into two categories: living in the same household or not living together. Primary caregiver status was determined according to whether the care receiver considered the participant to be the primary caregiver. In the data file, the participants were originally asked whether they had occasional relief or respite care; received money from government programs; or received any federal tax credits for eligible caregivers. If the participants answered "yes" to any of these, they were considered to have had available formal support. Coping with family caregiving was measured according to the question, "Have you used any coping methods to help with your caregiving responsibilities in the past 12 months?" with the possible answers "yes" or "no".

Data Analysis Procedure

We first performed a descriptive analysis to explore the characteristics of the study sample. Then, we conducted two sets of bivariate analysis: one on five different types of caregiver-receiver relations between caregivers and care receivers, and the other on participants' perceived caregiving choice. For the numeric variables, an analysis of variance (ANOVA) post hoc test was also performed to classify the multiple group differences. Two sets of hierarchical linear regression were conducted to examine, first, the associations between the

caregiver-receiver relation and psychological well-being (life satisfaction and psychological symptoms), and, second, the moderating effect of the perceived caregiving choice on these associations. In model a, we included all the relevant variables; in model b, we added the interaction between caregiver-receiver relation and perceived caregiving choice. We also performed a two-way analysis of co-variance (ANCOVA) to examine the main effect of the interaction between caregiving choice and caregiver-receiver relations in predicting the life satisfaction and psychological symptoms of the caregivers, and the simple effects of those two potential interacting factors.

We conducted a preliminary analysis to detect the missing values in the data set to determine the nature of missing values. Missing values from most variables are less than 1.6 per cent, and the nature of missing values is completely at random (MCAR) (Little's MCAR test, $p > .05$). Only the personal income variable has about 12.7 per cent missing value. Because of the large proportion of missing data, this study indicated missing data as "not stated". In addition, the multicollinearity test indicated that the variation inflation factor (VIF) is less than 2, and the tolerance is more than 0.5. Both indicators meet the recommendation for further regression data analysis (Braun & Oswald, 2011). Also, for all the data analyses we conducted, the sampling weight was applied for descriptive analysis, and standardised weight was performed for all bivariate and multivariate analyses.

Results

Almost 42.3 per cent of caregivers provided care for parents, followed by 28.5 per cent of caregivers caring for other family members, 9.4 per cent, for spouses, 12.7 per cent, for non-kin others such as friends, and 7.2 per cent, for children (Table 1). Roughly 55.3 per cent of participants reported that they had a choice to be caregivers. Family caregivers showed significantly different levels of perceived life satisfaction and psychological symptoms depending on their relationship to their primary care receivers (Table 2). The results of the post hoc test indicated that family caregivers who were taking care of relatives and non-kin individuals reported the highest level of life satisfaction; those who were supporting their spouses or children reported the lowest level of life satisfaction. A similar pattern was identified for psychological symptoms: family caregivers caring for their spouses and/or children reported the most psychological symptoms, followed by those taking care of parents, other relatives, and non-kin individuals. Roughly 80.4 per cent of family caregivers for non-kin others had the choice to become caregivers, followed by 67.6 per cent for relatives and 49.9 per cent

Table 1: Social and demographic characteristics of participants (n = 5,285; weighted n = 4,565,694)

Variables	Percentage/ Mean (SD)
Gender	
Male	44.74
Female	55.26
Age	
Younger than 45 years old	43.13
45 to 64 years old	45.50
65 years and older	11.37
Marital status	
Unmarried	34.80
Married/Common law	65.20
Highest education attainment	
Below high school	13.23
High school or equivalent	30.32
College diploma/certificate	32.66
University degrees	23.79
Employment status	
Employed	59.76
Retired	15.47
Others	24.78
Personal annual income	
Less than \$30,000	38.42
Between \$30,000 and \$60,000	28.65
More than \$60,000	21.37
Not stated	11.56
Country of birth	
Outside Canada	16.93
Canada	83.07
Life satisfaction	7.69 (1.79)
Psychological symptoms	2.79 (2.65)
Relationship with care receiver	
Spouse	9.37
Children	7.15
Parents	42.29
Other relatives	28.48
Non-kin individuals	12.71
Living arrangement	
Not together	68.03
Living together	31.97
Amount of caregiving tasks performed	6.66 (0.73)
Formal social support	
Not available	76.04
Available	23.96
Coping strategy	
Not used	68.39
Used	31.61
Primary caregiver	
No	52.69
Yes	47.31
Have choice to be caregiver	
No	44.75
Yes	55.25

All the results are based on weighted data.

for parents, as compared to 23.9 per cent of caregivers for spouses and 30.7 per cent for children.

As illustrated in Table 3, the differences between caregivers with and without choice in caregiving showed that a higher proportion of participants who were

female, married/common law, and living with their care receiver tended to have less choice about their caregiving roles. Family caregivers with choice in caregiving reported significantly higher levels of life satisfaction and fewer psychological symptoms when compared to those without choice.

The results of hierarchical regression are presented in Table 4. Model 1a shows that family caregivers who took care of children, parents, other relatives, and non-kin others were more likely to report higher levels of life satisfaction than spousal caregivers. In addition, family caregivers' perception of caregiving choice was significantly associated with higher levels of life satisfaction. In Model 1b, the interaction terms of caregiver-receiver relations and caregiving choice were added, and the results showed the significant moderating effect of caregiving choice on caregiver-receiver relations in predicting the caregivers' level of life satisfaction.

Model 2a shows that family caregivers who cared for parents, other relatives, and non-kin individuals were more likely to report fewer psychological symptoms than spousal caregivers. No significant differences were identified between caregivers for children and for spouses. Perception of the choice to be a caregiver was significantly associated with fewer psychological symptoms. With the interaction terms added (Model 2b), the results showed the significant moderating effect between caregiving choice and caregiver-receiver relations, particularly for caregivers for children, parents, and other relatives when compared to caregivers for spouses.

Figures 1 and 2 show the significant interaction effect between caregiving choice and caregiver-receiver relations in predicting life satisfaction ($F = 5.287, p < .001$) and psychological symptoms ($F = 41.557, p < .001$). As indicated in Figure 1, when family caregivers have no choice, the lowest level of life satisfaction ($M = 6.569$) was reported by spousal caregivers, followed by caregivers for children ($M = 7.023$) and caregivers for parents ($M = 7.370$). Caregivers for relatives and non-kin others reported the highest levels of life satisfaction, and there was no difference between these two groups of caregivers. In addition, when caregivers had the choice to become caregivers to family members, no significant difference was observed between spousal caregivers and caregivers for children or parents, whereas caregivers for relatives and non-kin others reported higher levels of life satisfaction than spousal caregivers ($p = .005$ and $p = .039$ respectively). When caregiving was a choice, family caregivers for children reported significantly lower levels of satisfaction than caregivers for parents ($p = .001$), relatives ($p < .001$), and non-kin others ($p = .001$). This was also the case for family caregivers for parents when compared to relatives ($p = .012$).

Table 2: Comparison among caregivers with different types of relation ($n = 5,285$; weighted $n = 4,565,694$)

	(a)	(b)	(c)	(d)	(e)	
	Spouse	Children	Parents	Relatives	Non-kin	χ^2 (df) / F
Gender (Female) (%)	49.84	64.63	53.77	53.24	63.72	42.88 (4) ***
Age (%)						805.38 (8) ***
Younger than 45 years old	15.16	34.70	39.61	59.36	42.83	
45 to 64 years old	45.45	52.33	56.02	32.05	37.60	
65 years and older	39.40	12.97	4.37	8.59	19.57	
Marital status (Married/Common law) (%)	98.36	74.54	64.05	57.57	56.21	316.95 (4) ***
Highest education attainment (%)						54.52 (12) ***
Below high school	15.15	11.30	11.10	15.80	14.64	
High school or equivalent	35.12	28.02	28.57	32.88	28.51	
College diploma/certificate	30.22	37.27	33.74	31.02	31.56	
University degrees	19.52	23.41	26.58	20.30	25.30	
Employment status (%)						390.49 (8) ***
Employed	46.10	59.37	67.03	58.00	49.76	
Retired	41.30	13.50	10.84	11.25	22.77	
Others	12.60	27.13	22.13	30.75	27.47	
Personal annual income						126.26 (12) ***
Less than \$30,000	35.29	39.82	32.22	46.39	43.31	
Between \$30,000 and \$60,000	31.95	26.48	30.11	26.89	26.70	
More than \$60,000	18.13	23.91	24.83	19.26	15.31	
Not stated	14.63	9.78	12.84	7.46	14.69	
Country of birth (Canada) (%)	79.73	80.33	84.42	83.52	81.32	10.34 (4) *
Life satisfaction (mean/SD)	7.13(2.04)	7.12(1.82)	7.62(1.73)	8.01(1.70)	7.92 (1.77)	38.08***, a < c,d,e; b < c,d,e; c < d,e
Psychological symptoms (mean/SD)	4.11(2.64)	4.62(2.70)	2.99(2.67)	2.03(2.27)	1.86 (2.34)	143.83***, a < b; a > c,d,e; b > c,d,e; c > d,e
Living arrangement (Living together) (%)	96.41	72.94	28.30	17.96	5.55	1593.63 (4) ***
Amount of caregiving tasks performed (mean/SD)	6.85(0.48)	6.67(0.75)	6.70(0.67)	6.58(0.78)	6.51 (0.88)	22.34 ***, a > b,c,d,e; b > e; c > d,e;
Formal social support (Available) (%)	34.80	52.10	21.19	22.44	13.56	245.41 (4) ***
Coping strategy (Used) (%)	43.10	48.48	32.09	25.33	26.50	114.71 (4) ***
Primary caregiver (Yes) (%)	96.40	76.44	50.40	26.79	30.44	937.88 (4) ***
Have choice to be caregiver (Yes) (%)	30.69	23.90	49.92	67.61	80.40	555.85 (4) ***

All the results are based on weighted data.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Furthermore, family caregivers for spouses, parents, other relatives, and non-kin others reported higher levels of life satisfaction when they had a choice in caregiving, as compared to when they did not, but no difference was identified between caregivers for children who had a choice to do so and those who did not.

Figure 2 indicates the interaction effect of one's perceived caregiving choice and the caregiver-receiver relation in predicting the number of psychological symptoms. When family caregivers had no choice, caregivers for spouses ($M = 4.179$) and children ($M = 4.058$) reported more psychological symptoms than caregivers for parents ($M = 3.606$), for other relatives ($M = 3.130$), and for non-kin others ($M = 3.390$), and no significant difference was identified between caregivers for spouses and children, or between those for relatives and non-kin others. When family caregivers had choice in their caregiving roles and responsibilities, caregivers for children reported more psychological symptoms ($M = 3.372$) than

all the other types of caregiver-receiver relationships. Spousal caregivers showed no significant difference when compared to caregivers for parents, and showed more symptoms than caregivers for relatives ($M = 1.958$, $p = .039$) and for non-kin others ($M = 1.651$, $p = .001$). In addition, family caregivers for parents ($M = 2.319$) reported significantly more psychological symptoms than caregivers for relatives ($p < .001$) and for non-kin others ($p < .001$). Also, caregivers for relatives reported more symptoms than those for non-kin others ($p = .012$).

In addition, family caregivers among all relations with care receivers showed significant differences in psychological symptoms between those with and without choice, and caregivers reported fewer psychological symptoms if they had the choice to be caregivers.

Discussion and Implications

This study suggests that family caregivers' psychological well-being is influenced by their relationships

Table 3: Comparison between caregivers with and without choice (n = 5,285; weighted n = 4,565,694)

	Have no choice	Have choice	X ² (df) / F
Gender (Female) (%)	58.97	52.30	23.37 (1) ***
Age (%)			145.39 (2) ***
Younger than 45 years old	33.98	50.55	
45 to 64 years old	53.01	39.48	
65 years and older	13.00	9.97	
Marital status (Married/Common law) (%)	73.29	58.67	122.31 (1) ***
Highest education attainment (%)			20.83 (3) ***
Below high school	11.40	14.56	
High school or equivalent	29.08	31.46	
College diploma/certificate	33.70	31.75	
University degrees	25.83	22.23	
Employment status (%)			44.51 (2) ***
Employed	61.05	58.79	
Retired	18.03	13.36	
Others	20.92	27.85	
Personal annual income			39.36 (3) ***
Less than \$30,000	33.83	42.03	
Between \$30,000 and \$60,000	30.19	27.36	
More than \$60,000	23.98	19.47	
Not stated	12.01	11.15	
Country of birth (Canada) (%)	81.98	83.95	3.50 (1)
Life satisfaction (mean/SD)	7.32 (1.87)	7.98 (1.67)	-13.28 ***
Psychological symptoms (mean/SD)	3.93 (2.76)	1.87 (2.17)	29.45 ***
Caregiver-receiver relation			555.85 (4) ***
Spouse	14.50	5.22	
Children	12.11	3.09	
Parents	47.25	38.26	
Relatives	20.58	34.90	
Non-kin others	5.56	18.53	
Living arrangement (Living together) (%)	38.35	26.64	82.11 (1) ***
Amount of caregiving tasks performed (mean/SD)	6.68 (0.74)	6.64 (0.72)	1.83
Formal social support (Available) (%)	25.43	22.72	5.31 (1) *
Coping strategy (Used) (%)	39.52	25.26	122.01 (1) ***
Primary caregiver (Yes) (%)	62.19	34.98	379.40 (1) ***

All the results are based on weighted data.

* $p < .05$. ** $p < .01$. *** $p < .001$.

with care receivers, consistent with previous findings (Pinquart & Sörensen, 2011). The results also support theoretical assumptions on the basis of caregiving stress process models, sense of control, and meaningful choice (Dowding, 1992; Leotti et al., 2010; Pearlin et al., 1990), as well as previous studies (Longacre et al., 2014; Tatangelo et al., 2018) showing that family caregivers with perceived choices in caregiving reported better psychological well-being than those without choice.

The findings of this study also show that family caregivers for spouses and children report significantly lower levels of life satisfaction and more perceived psychological symptoms, consistent with the previous studies (Young & Kahana, 1989). The reason for this may be that family caregivers for children and/or spouses tend to take more caregiving responsibilities and perform more caregiving tasks than caregivers for other relatives or non-kin care recipients (Pakenham, 2012). Caregivers for spouses and children are more likely to live with the care recipients, and thus spend more time

performing caregiving tasks, leaving less time for taking care of themselves (Bertrand, Fredman, & Saczynski, 2006), which would further influence their psychological well-being. In addition, Pashos and Mcburney (2008) tried to explain the caregiving situation based on the concept of *biased kin investment*, suggesting a caregiver's investment in the care receiver, and the emotional closeness between caregiver and receiver varies due to different kinship (e.g., maternal relative vs. paternal relative). Therefore, it is also highly possible that family caregivers experience more toll when helping core family members, such as children and spouse, resulting in worse psychological well-being.

This study also supports previous conclusions which found that family caregivers who had no choice in caregiving tend to report worse psychological well-being than those who had a choice (Longacre et al., 2014). When family caregivers realise that they have no alternative or other support in providing care, they tend to compromise their own lives over their role as caregiver,

Table 4: Hierarchical linear regression analysis for variables predicting life satisfaction and psychological symptoms ($n = 5,285$)

	Life satisfaction		Psycho symptoms	
	Model 1a	Model 1b	Model 2a	Model 2b
Gender (Male)				
Female	-0.032 *	-0.031 *	0.136 ***	0.135 ***
Age of participants (Younger than 45 years old)				
45 to 64 years old	-0.052 **	-0.049 **	0.036 **	0.036 *
65 years and older	0.035	0.039	-0.032	-0.033
Marital status (Unmarried)				
Married/Common law	0.137 ***	0.135 ***	0.021	0.023
Highest education attainment (Below high school)				
High school or equivalent	-0.097 ***	-0.096 ***	0.022	0.023
College diploma/certificate	-0.101 ***	-0.101 ***	0.032	0.034
University degrees	-0.065 **	-0.064 **	0.015	0.017
Employment status (Employed)				
Retired	0.038 *	0.035	-0.027	-0.026
Others	-0.016	-0.015	-0.001	-0.0004
Personal annual income (Less than \$30,000)				
Between \$30,000 and \$60,000	-0.002	-0.002	0.016	0.017
More than \$60,000	0.031	0.031	0.0002	0.001
Not stated	-0.0004	0.0001	0.009	0.009
Country of birth (Outside Canada)				
Canada	0.040 **	0.039 **	-0.040 ***	-0.040 **
Age of care receiver (Younger than 65 years)				
65 years and older	0.010	0.013	-0.007	-0.008
Gender of PCR (Male)				
Female	-0.014	-0.015	-0.006	-0.005
Health condition of receiver (Aging and frailty)				
Chronic issues and/or disability	-0.060 **	-0.060 **	0.104 ***	0.106 ***
Mental and neurological issues	-0.079 ***	-0.080 ***	0.151 ***	0.151 ***
Others	0.001	0.0002	0.071 ***	0.071 ***
Primary caregiver (No)				
Yes	0.015	0.013	0.138 ***	0.138 ***
Living arrangement (Not together)				
Living together	-0.008	-0.009	-0.018	-0.016
Caregiving tasks performed	-0.036 **	-0.035 *	-0.029 *	-0.028 *
Formal social support (Not available)				
Available	0.055 ***	0.057 ***	0.030 *	0.028 *
Coping strategies (Not used)				
Used	-0.063 ***	-0.063 ***	0.299 ***	0.299 ***
Relation with care receiver (Spouse)				
Children	0.037 *	0.073**	0.013	-0.014
Parents	0.177 ***	0.222 ***	-0.067 **	-0.094 **
Other relatives	0.232 ***	0.291 ***	-0.128 ***	-0.172 ***
Non-kin individuals	0.147 ***	0.211 ***	-0.115 ***	-0.092 **
Have choice to be caregiver (No)				
Yes	0.148 ***	0.313 ***	-0.244 ***	-0.341 ***
Relation x Have choice (Spousal x Have choice)				
Children x Have choice		-0.063 **		0.051 **
Parents x Have choice		-0.131 **		0.079 *
Relatives x Have choice		-0.151 ***		0.102 **
Non-kin x Have choice		-0.136 **		0.012
Adjusted R ²	0.094	0.096	0.381	0.382

All the results are based on weighted data. Reference is indicated in the (--).

* $p < .05$. ** $p < .01$. *** $p < .001$.

and to have fewer positive experiences as a family caregiver than those who chose to become caregivers (Pakenham et al., 2007). In general, family caregivers for spouses or children are more likely to have limited choice in becoming caregivers, and to be seen as primary

caregiver, compared to the other three types of caregivers. Likewise, family caregivers who live with their care receiver and support them as primary caregivers are more likely to have no choice in becoming family caregivers at the beginning than those who do not. Therefore,

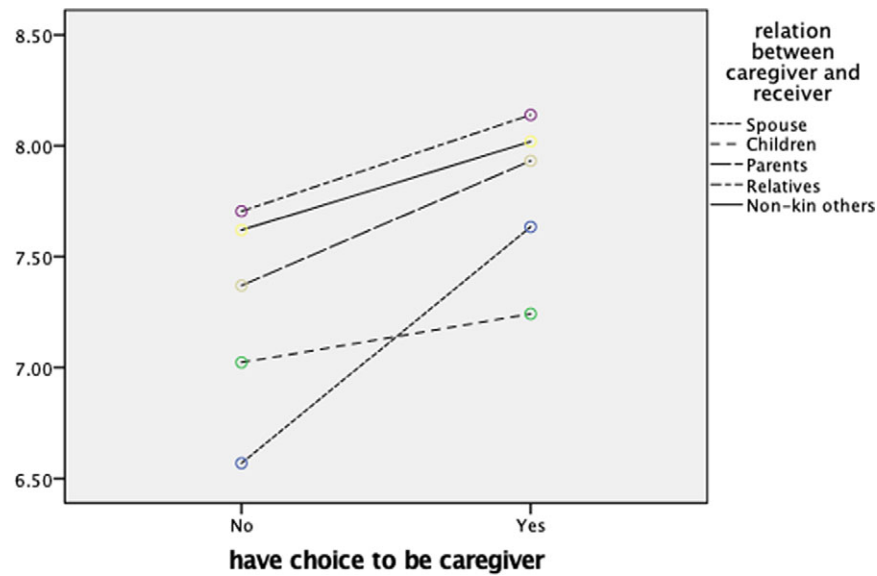


Figure 1: Effect of interaction between relations and choice to be caregiver on life satisfaction

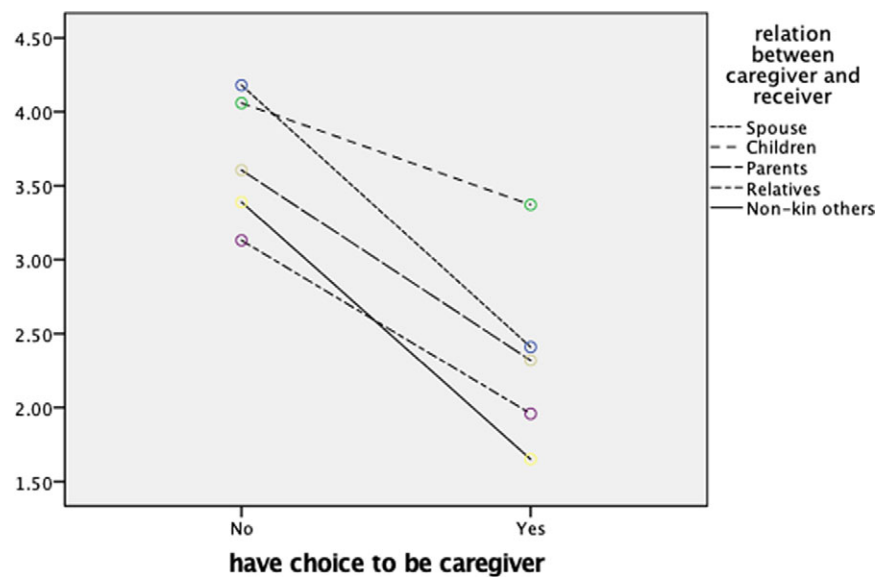


Figure 2: Effect of interaction between relations and choice to be caregiver on psychological symptoms

caregiving choice plays an essential role in predicting family caregivers’ psychological well-being.

Furthermore, this study also points out the significant interaction effect between caregiving choice and caregiver-receiver relationship on family caregivers’ psychological well-being. It is notable that the moderating effect of caregiving choice is limited for caregivers for children, since caregivers for children are the only group to report the same level of life satisfaction regardless of caregiving choice. Also, when they have a choice in becoming a caregiver, caregivers for children experience the greatest toll on their psychological well-being among

all relations. This is because caregivers for children usually deal with long-term health conditions including intellectual and developmental disabilities and other neurological health issues (Miodrag & Hodapp, 2010), and they are likely to report significantly greater distress, chronicity of distress, and more emotional and cognitive problems (Brehaut et al., 2004), regardless of whether or not they had the choice to become caregivers.

Another potential reason for these results is that caregivers for children tend to feel a lack of control over their own lives. As reported by Murphy, Christian, Caplin, and Young (2007), caregivers for children with

disabilities tend to receive unexpected calls from school as a result of their children's health conditions, or they need to spend extra time dealing with teachers, doctors, or other agents to advocate for their children's welfare. In addition, caregivers for children tend to worry about their children's future (Knock, Kline, Schiffman, Maynard, & Reeves, 2011). Caregivers might experience concern or even suffer from long-term anxiety when they plan for their children's future, including life arrangements for the children when they live independently, medical expenditures, and available services (Murphy et al., 2007). One additional reason could be related to employment and income loss. About 60 per cent of the caregivers for children in this study were employed. Earle and Heymann (2012) have pointed out that caregiving for children with special health needs increases the possibility of lost income by 48 per cent, which is significantly higher than that of caregivers for adults with health issues (29%). Therefore, family caregivers for children may need to worry more about negative consequences for employment and income in their daily lives.

Another notable result is that when there is no caregiving choice, family caregivers to non-kin others share similar psychological well-being traits with those individuals caring for parents or relatives. As a result of demographic trends in the population, people increasingly provide support for unrelated care receivers (Nocon & Pearson, 2000). This type of care receiver is likely to be single, without children, and/or without active social networks. Therefore, they would heavily rely on their caregivers' support (Barker, 2002), even though caregiving tasks might be simply instrumental and practical tasks such as grocery shopping or transportation (Himes & Reidy, 2000). However, this would still increase the family caregiver's emotional burden and the intensity of caregiving, resulting in a feeling of strain (Nocon & Pearson, 2000).

The findings of this study have implications for public policy and community service organisations to provide more tailored service and support to family caregivers for children who have intellectual and developmental disabilities. Family caregiving for children can be a life-long commitment that takes a great toll on health and well-being, whether the children live with their parents or somewhere else (Seltzer, Floyd, Song, Greenberg, & Hong, 2011). More respite services and intervention programs would help parents better handle the caregiving situation and balance their family responsibilities and other social roles. It is expected that more support and care would be provided by non-kin individuals, such as friends and neighbors, because increasingly fewer family members can provide care and support for individuals who require care (Pleschberger & Wosko, 2017; Redfoot, Feinberg, & Houser, 2013). Our findings suggest that

caregivers who provide help for non-kin others experience similar psychological symptoms regardless of their choice in becoming caregivers. Therefore, community services can provide support to individuals without family members or caregivers who are supporting their friends, neighbors, and co-workers.

There are limitations in this study. Participants in the GSS 26 were asked to identify one primary care receiver if they provided care to more than one person in the past 12 months. Thus, only the information relating to the primary care receiver was collected, and we were unable to account for the effects of other care receivers on the participants' psychological well-being. In addition, the question about caregiver choice is limited to the caregivers' feelings over the past 12 months. However, there is a possibility that family caregivers might have initiated care earlier than 12 months, and the feeling of caregiving choice might have changed over time, which is not indicated in the data set. Future studies should explore the role of perceived choice in caregiving, and how it would affect caregivers' health and well-being from different perspectives.

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