ISCTE IUL
Instituto Universitário de Lisboa

School of Social Sciences

Department of Social and Organizational Psychology

The Role of Caregiver Identity:
Effects on Well-Being and Burden

By:

Joana Raquel Mendes Figueiredo Barros

A Dissertation presented in partial fulfilment of the Requirements for the Degree of *Master* in Social Community Psychology and Child Protection.

Supervisor:

Dr. Sibila Marques, Invited Assistant Professor

ISCTE-IUL

Co-supervisor:

Dr. Kevin McKee, Professor
Dalarna University

October, 2012

"How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and strong. Because someday in your life you will have been all of these."

George Washington Carver

Acknowledgements

My sincerest Thank-You to my supervisor, Professor Sibila Marques, for guiding me through this journey with patience and optimism, for her availability and comprehension throughout this process.

I am also grateful to my co-supervisor, Professor Kevin McKee for all the ideas, tips and suggestions he had to offer, and his general participation in this paper, which was most useful.

A big Thank-You to the institutions that collaborated by mediating the contact with the caregivers, *Santa Casa da Misericórdia de Lisboa*, *Associação Infanta D.ª Mafalda* and *Médicos do Mundo*, for their availability in providing me with the information needed to complete this study.

Thank- You to all the caregivers, those who provide their elder parents such helpful care and whose effort is not always recognized. This study would not have been possible without their patience, availability and openness in sharing their experience with us.

To my family, who have always supported me and, even though the geographical distance, I know will always be there for me.

To my husband, for being my partner and companion, in the true meaning of the words.

Thank-You God, for all the strength and wisdom…

Abstract

Several factors that explore the consequences of caregiving on caregivers' well-being have been studied in these last few years. However, the effects of caregiving on an individual's self-concept and social identity have not been sufficiently explored.The goal of the present study is to address this issue and determine whether the existence of multiple non-conflicting identities, could have an effect on caregiver's well-being and burden.

The identities that were tested in this study were of adult child, caregiver and worker, for the existing literature indicates that these can be important in the caregiving context. Following the proposal of the study conducted by Brook et. al. (2008) our hypotheses was that the importance of these identities should affect well-being and perceived burden, particularly when they have less harmony between them. These effects should be mediated by self-discrepancies emotions.

For this study a total of 40 caregivers of their elder parents were interviewed, and data was collected, using a telephone based procedure. Contact with participants was made through three institutions that provide home help services to the care recipients. Only working, adult-child caregivers were considered for this study, in order to fully test the identities mentioned. A series of instruments were applied in order to test an adapted model (Brook et. al., 2008) which aimed to verify an interaction between the importance of identities, identity harmony and their effect on Well-Being and Caregiving Subjective Burden (CB). Emotions related to self-discrepancies were also included in this model, as a mediator of this interaction.

As expected, results indicated a significant interaction between the caregiver and the worker identities' importance and harmony on caregiver burden. We did not find any effects regarding the relationship between the importance of son/daughter identities. Moreover, no effects were found regarding the mediation effect by self-discrepancy emotions. These results are discussed based on the social psychological and caregiving literatures.

Key-words: caregiving burden, multiple identities, caregiver identities.

PsycINFO Classification Categories and Codes of American Psychological Association:

3100 – Personality Psychology.

Resumo

Vários factores que exploram as consequências da prestação de cuidados no bem-estar de cuidadores informais têm sido estudados nestes últimos anos, embora os efeitos da prestação de cuidados na identidade social e auto-conceito de um indivíduo não tenham sido ainda suficientemente explorados.

O objetivo do presente estudo foi determinar se a existência de múltiplas identidades não conflituosas, poderia ter um efeito sobre o bem-estar e sobrecarga do cuidador.

As identidades que foram testadas neste estudo foram a de cuidador, a de filho(a), e a de trabalhador, pois a literatura existente indica que estes podem ser importantes no contexto da prestação de cuidados. Seguindo a proposta do estudo realizado por Brook et. al. (2008) a nossa hipótese indicava que a importância dessas identidades deveria afectar o bem-estar e a sobrecarga percebida, principalmente quando estas identidades têm menos harmonia entre elas. Pressupõe-se também que estes efeitos sejam mediados pelas emoções auto-discrepantes.

Para este estudo um total de 40 cuidadores (n = 40) dos seus pais idosos foram entrevistados e os dados foram recolhidos utilizando um procedimento baseado no contacto telefónico. O contacto com os participantes foi estabelecido através de três instituições que prestam serviços de apoio domiciliário aos respectivos idosos. Apenas cuidadores que desempenhavam funções profissionais e eram filho(a) do receptor dos cuidados, foram considerados para este estudo, a fim de testar por completo as identidades mencionadas. Uma série de instrumentos foram aplicados a fim de testar um modelo adaptado, que teve como objetivo verificar a interação entre a importância das identidades, harmonia entre as identidade e os seus efeitos no bem-estar e sobrecarga subjetiva dos cuidadores. Emoções relacionadas com auto-discrepâncias foram também incluídas neste modelo, como um mediador desta interacção.

Como esperado, os resultados indicaram uma interacção significativa entre a importância e harmonia das identidades de cuidador/ trabalhador na sobrecarga do cuidador. Não se verificou qualquer efeito na relação entre a importância da identidade de filho(a). Não se constatou também qualquer efeito de mediação das emoções auto-discrepantes. Estes resultados são discutidos com base na literatura relacionada com a psicologia social e cuidadores informais.

Palavras-Chave: sobrecarga do cuidador, múltiplas identidades, identidade de cuidador.

PsycINFO Classification Categories and Codes of American Psychological Association:

3100 – Personality Psychology.

Index

Annexes

Table Index

Figure Index

Glossary

IG - Informal Caregiver

SB – Caregiving Subjective Burden

CS - Caregiving Satisfaction

WB - Well-Being

EM - Self-discrepancy related emotions

Introduction

It is clear that the world population is getting older every year, and scientific predictors affirm that this process will continue and even accelerate in the forward years to come, resulting in an inverted pyramid[1] (Muenz, 2007; INE, 2011). With the rapid aging of world population, another challenge can be pointed out, the physical alterations and consequential health risks and dependency associated with older age (Sequeira, 2010). When it comes to the existence of a support network, the family members are usually the ones to assume the caregiving role, specially the spouse or adult children (Almberg, Grafstrom & Winblad, 1997; Badr et. al., 2007).

The process of transitioning to this new caregiving role can be challenging, involving an adaptation to this situation, which can be difficult to accept. Studies indicate that the caregiver usually steps into the new role automatically, or due to the specific characteristics of circumstances (Sequeira, 2010; Majerovitz, 1997) but if the caregiver is unable to adapt, the consequences can be severely negative, bringing about feelings of stress and anxiety, among others (Endler & Parker, 1990). Evidence indicates that, although the tasks of caring for a loved one can be empowering and rewarding (Koerner, Kenyon & Shirai, 2009), they can also cause distress, burden and depression, for caregivers are known to show a series of risk factors when compared to non-caregivers (Neugaard, Andresen, McKune, & Jamoom, 2008; Perrig-Chiello, 2010; Smith, 2011). Therefore, it is necessary to establish new ways of support in order to prevent the task of caring from turning into a burden for the caregiver (Sequeira, 2010). If the caregiver is unable to adapt to this stressful situation, and in the absence of immediate problem solving mechanisms, the care provider often finds himself in a problematic situation that can lead to psychosocial disorganization (Endler & Parker, 1990). This situation can become more difficult if the caregiver is also a worker and has to perform both roles (Wang et. al., 2011).Therefore, adaptability can have a major effect on the caregiver's well-being, as well as other factors such as job satisfaction, attachment to the care recipient (Cicirelli, 1995) and the caregiving tasks performed (Perkins, 2010), all which will be analysed in the this study.

---

[1] Inverted Pyramid is a term used to describe the fact that there are less young people (with age for active work force) than older people, which is similar to the figure of an inverted pyramid (Muenz, 2007).

In Social Identity Theory, the importance of social group membership to an individual's self-concept and social behaviour is strongly acknowledged (Tajfel, 1982), where the social identity can have a significant impact on self-concept[2] (Luhtanen & Crocker, 1992). It has become an important issue dealing with the multiple roles and tasks of each social group, especially those work-related (Wang et. al., 2010).

Studies also indicate that the importance that individuals give to their social identities, if these same identities are non-conflicting, can have a positive effect on their well-being (Brook et. al., 2008).

Although the literature mostly focuses on the care recipient, recent studies have brought to the attention the importance of the caregivers and their need for support (Sequeira, 2010). The present paper aims to add to this scientific knowledge by presenting a study of multiple identities and their effects on the caregiver's well-being and burden. Therefore, various factors are considered in the analysis performed, in order to provide a clear understanding of the caregiver context. In this sense, we aim to test a series of hypotheses to verify if *the importance and the harmony between the multiple identities of the caregivers have a protective effect on their well-being and perceived burden*, whilst also controlling other demographic factors that the literature considers important.

For this effect, the present dissertation is divided in two parts, where the first, Theoretical Framework, provides a contextual description of the aging and caregiving process, the factors associated to the negative consequences of providing care, as well as the importance of social identities and their impact on the caregiving situation.

The second part refers to the Empirical Study, where a description is made of the instruments, participants and procedures used in this paper.

Finally, the results are presented and discussed, also referring the limitations of this same study and future considerations.

---

[2] Social identity derives from a variety of group memberships, based on an individual's characteristics (Luhtanen & Crocker, 1992), and it's defined as the part of an individual's self-concept that derives from the knowledge of belonging to a social group (Tajfel, 1981).

Part I - Theoretical Framework

Chapter 1 – Facing the need to Provide Care and to Receive Care

1. The Aging Process

The aging process starts at the moment of birth and it's a dynamic process that lasts until the end of life (Sequeira, 2010). It characterizes the various alterations that the organism can suffer during a developmental phase. This phase can be from childhood to teenage hood, and it doesn't necessarily have to be in the later years (Fontaine, 1999).

After 65 years of age, the period from which one is considered to be an older person, several changes take place on a biological, psychological and social level. Although these alterations start very early on, it is mainly after reaching an older age that the characteristics of the aging process become clearer (Sequeira, 2010). On the exterior, the most notorious changes are related to the appearance of white hairs, progressive slowing of movements, balance alterations, decreasing of the muscular strength as well as reaction speed and, internally, emotional and cognitive changes (Sequeira, 2010), changes in memory (Baddeley, 1986), and speed of thought and action (Spar & La Rue, 2005). The physical changes on the older person can have psychological repercussions related to the modification in one's attitudes and behaviours at this stage of life. In this context, it is important to assess the balance between the individual's limitations and potentialities, in order to minimize the losses related to the aging process (Sequeira, 2010).

On a social level, with the decline of several cognitive functions, such as memory, one can feel dislocated from their own social context (Sequeira, 2010). Memory is shown to be essential in the construction of an individual's social identity, for reminiscences are highly valued, both socially and relationally, playing an important role in a healthy aging process. The older person tends to become less participant in his social life, mainly due to the role alterations that can occur in the family, work and occupational context (Sequeira, 2010). The social networks seem to be smaller and the social contacts less frequent in this stage of life, which involve mainly the family and a very restricted group of friends. With the progression of age, a significant part of the individual's social group (family members, friends, colleagues, partners) depart or fade away from one's context, leading to a reorganization of one's informal support networks (Paúl, 2005). It is important to know that the effects of aging are not homogeneous, for older people are very different from each other, meaning that people aren't all equal in the aging process (Fontaine, 1999).

2. Aging in the Portuguese population

The world population is rapidly aging. In Europe, the low fertility and increasing life expectancy predict a reversal in the age pyramid, leading to a growing number of older people. Studies show that, by 2050, the group of individuals over 65 years old will increase by 68%, being the largest growth for people over 80 years of age (Muenz, 2007). Portugal is no exception to these demographic changes, for statistics point to the existence of 19.4% of the total population being over 65 years old (INE, 2011). Similar studies predict that, in 2060, the same group of older people will represent 32% of the Portuguese population, mainly in consequence of the increasing age group of the over 80 years old, which will represent 13% in 50 years (INE, 2009).

Muenz (2007) states a highly important and alarming fact: by the year 2050, Portugal will be one of the three countries in the E.U. with the highest Old Age Dependency Ratio[3] of 58%. Because of the natural implications of old age, mentioned earlier, individuals are more vulnerable in this stage of life, which means that, in the near future, more than half of the older people will be in a somewhat dependent situation (Sequeira, 2010).

3. The Informal Caregivers

Research indicates that around 80% of people over 65 years of age suffer from at least one type of chronic disease, and due to the more vulnerable nature of the aging process, the individual can become more dependent on others to fulfil some basic needs. The increase of longevity also implicates the prevalence of chronic diseases and, consequently, dependence of for the performance of one's daily activities (Sequeira, 2010). With this demographic phenomenon, new challenges arise for families, who play an important role in assisting and maintaining the older individual in his usual environment. Therefore, it is necessary to establish new ways of support in order to prevent the task of caring from turning into a burden for the caregiver (Sequeira, 2010).

The literature distinguishes two types of caregiving: formal and informal. The first concept defines caring as a professional activity and is usually performed by qualified

---

[3] The ratio of population 65 years and above to the population aged 15-64 years (WHO).

professionals (doctors, nurses, psychologists, social workers, etc.), also known as the formal caregivers (Sequeira, 2010). The other type of care involves assisting the elder in his home environment, a task usually performed by family members, friends or neighbours. Informal caregiving can be defined as ‘activities and experiences involved in providing help and assistance to relatives or friends who are unable to provide for themselves.’ (Badr, Acitelli & Taylor, 2007, p.213). These informal caregivers (IC) perform unpaid, unanticipated tasks that involve providing a total or part of the care for the recipient (Sequeira, 2010) that demonstrates health or functional needs (Weuve, Boult & Morishita, 2000). There are three types of IC described in various investigations: primary, secondary and tertiary (Sequeira, 2010; Almberg, Grafstrom & Winblad, 1997). The primary caregiver is the main carer, who assumes the full responsibility for the caregiving tasks, having to supervise, guide and accompany and care directly for the older person in need of care. This person provides most of the care (Davies, 1992; Carrero, 2002). The secondary caregiver is someone who helps with the caregiving tasks regularly or occasionally, but does not have the responsibility of caring. These are frequently other family members that assist the primary caregiver with economic and leisure tasks or social activities. This carer can replace the primary care provider in his absence or in emergency situations (Penrod, Kane, Kane & Finch, 1995; Neri & Carvalho, 2002). The tertiary caregiver is usually a family member, neighbour or close friend who helps sporadically or only when requested in emergency situations, but is not responsible for caring (Neri & Carvalho, 2002).

In terms of gender, the majority of IC are women (Grelha, 2009), whereas in kinship, the spouse is the one who mainly assumes this role (Sequeira, 2010; Almberg, Grafstrom & Winblad, 1997; Badr et. al., 2007) followed by the son/daughter (Lockenhoff & Friedman, 2011; Da Silva, Marques & Da Silva, 2009). On the other hand, gender also seems to have an impact on the nature of the care, for as women are known to provide more personal and domestic house care, whilst men tend to help with transportation and financial management (Miller & Cafasso, 1992). Co residence is also shown to be an important factor related to caregiving due to the physical and affective proximity between the caregiver and care recipient, as it also may favor the care provider with the caregiving tasks (Penrod et. al., 1995).

4. Effects of caring on the Caregiver

Caring for a loved one can be rewarding and empowering (Koerner, Kenyon & Shirai, 2009). The quality of the attachment between care recipient and the caregiver can be a predictor of the amount of care provided (Cicirelli, 1995), as at the same time, insecurely attached children may be less eager to care for their parents because the psychological rewards for maintaining this relationship are not immediately known (Carpenter, 2001). Besides the positive rewards and effects of caregiving, there are also negative consequences to this role. On average, caregivers exhibit more depression than their non-caregiving peers, for this is shown to be one of the negative effects that arise with the task of caring. Depressed caregivers are more likely to engage in harmful behaviour, consequently relating depression with care lower in quality (Smith, 2011). Similar studies highlight the stressful process that family caregiving can be, due to all the potentially negative physical and psychological outcomes (Perrig-Chiello, 2010). The stress associated to the caregiving process has been shown to have a negative impact on health-related quality of life (Neugaard, Andresen, McKune, & Jamoom, 2008), social and economical outcomes (Scott, 2000) as well as morbidity and mortality (Vitaliano et. al., 2003). The caregiving situation can also have a negative impact on one's work situation (Perrig-Chiello, 2010). Although there are many effects on the caregiver's physical health, it seems that their psychological health is the most affected (Pinquart & Sörensen, 2003; Neugaard et al., 2008).

In terms of characteristics, it seems that younger caregivers (< 50 years old) show to have less decline in health-related quality of life in comparison to older care providers (Neugaard et. al., 2008). Adult child caregivers are also shown to be more burdened than spouses (Thiede-Call, Finch, Huck, & Kane, 1999; Young & Kahana, 1989). Increased social support is positively associated with caregivers' mental and physical heath (Markowitz, Gutterman, Sadik, & Papadopoulos, 2003), as well as a positive view of the caregiving experience (Nijboer, Triemstra, Tempelaar, Sanderman, & van den Bos, 1999).

In recent studies regarding compound caregivers, or caregivers who care for multiple family members, negative outcomes haven't been established between the multiple caregiving tasks, or responsibility for caring for a second person, and well-being. This can be due to the skills and mastery obtained through the experience of caregiving, facilitating the transition to a secondary caregiving role (Perkins, 2010). Although compound caregivers have not been found to experience poorer well-being than their noncompound caregiving counterparts, these often show distress and difficulties in managing their multiple caregiving tasks (Perkins, 2010).

5. Caregiver burden and satisfaction

As stated earlier, providing care to a family member can be exhausting and cause both psychological and emotional distress (Gaugler, Pearlin, Davey & Zarit, 2000). The stress theory describes caregiving as a stressor that derives from an event that threatens an individual's usual activities and produces a need for adjustment to the caregiving conditions (Martin, Paúl & Roncon, 2000).

An interesting approach to the caregiving research is Lawton's (1991) Two-Factor-Model, which suggests that the evaluation of caregiving is processed according to two dimensions: (1) the caregiver's perception and definition of burden, which is the negative element of caregiving and, (2), the caregiver's degree of satisfaction, which is the positive element in the caregiving process. Both of these factors are independent and therefore can be converted into potential predictors of the caregiver's well-being (Martin, Paúl & Roncon, 2000).

According to Braithwaite (1992), caregiver burden is the distress that results from dealing with the physical and mental incapability of the care recipient. This author also distinguishes five crisis situations present in the continuous and almost always irreversible process of caregiving: acknowledgement of the degeneration; unpredictability; time limitations; relationship between the caregiver and care recipient; and lack of choices (Martins, 2003). Consequently, caregiver burden is viewed as an example of external demand or potential threat that has been appraised as a stressor (Lawton et al., 1989).

Considering that all caregiving demands are stressful is a matter of subjective appraisal, since all tasks are not interpreted as burdensome, yet still, the positive aspects of caregiving have received far less attention than the negative. In the process of giving care to a family member, the concept of "uplifts" is highly relevant. This term is used by Lazarus and Folkman (1984) to describe the everyday small events that evoke some response of pleasure, joy or affirmation in the care provider. People may vary in the proportions of uplifts and "hassles", the negative daily experiences, but the presence of both is undeniable. In sum, it is possible to affirm that caregiving appraisal is multifaceted and, as it is a subjective phenomenon, represents the external stressor imperfectly. The main dimensions of caregiving appraisal are caregiving satisfaction, perceived caregiving impact, caregiving mastery, caregiving ideology and subjective caregiving burden, all of these referring to both positive and negative perceptions (Lawton et. al., 1989).

There are some demographic factors that can have a positive or negative effect on caregiver burden and satisfaction. Closeness of the relationship between adult-child caregivers and their parents was found to be related to caregiving burden (Williamson & Schulz, 1990), which is why attachment between caregiver and care recipient can be an important dimension (Cicirelli, 1995). Co residence is also shown to be an important factor related to caregiving due to the physical and affective proximity between the caregiver and care recipient, as it also may favor the care provider with the caregiving tasks (Penrod et. al., 1995). Age seems to be an important variable to analyze, as younger caregivers show to have less decline in health-related quality of life in comparison to older care providers (Neugaard et. al., 2008). Increased social support is positively associated with caregivers' mental and physical heath (Markowitz, Gutterman, Sadik, & Papadopoulos, 2003).

6. Transition into the caregiver role

Throughout time, the caregiving function has been mostly attributed to family members (Lage, 2005) and it is mainly in this context that the assimilation process of the caregiver role[4] takes place. Research indicates that the adoption of the IC role is mainly done by one's own initiative, meaning that the family member or close friend usually steps into this function by assuming the responsibility of caring for the elder, frequently by themselves or with little help from others (Sequeira, 2010). Studies show that perceiving the relationship between caregiver and care recipients as an extension of oneself, or high levels of couple identity, may help to minimize the negative effects of the caregiving experience on caregivers' mental health, maximizing the positive effects. The proof that having a strong couple identity enhances marital and mental health outcomes can also suggest that identity may play a fundamental role in mediating the stress process for these individuals (Badr et al., 2007).

According to Sequeira (2007), the main reasons that lead to the adoption of a caregiving role are by one's own initiative and the family members' decision. Four main factors can be appointed as essentially important when choosing the informal caregiver: the

---

[4] The terms role and identity are used throughout this paper referring to the same concept.

familiar relationship; co residence; gender of the caregiver and care recipient; and conditions regarding the descendents (Martin, 2005). In many cases, the caregiver provides care in a systematic and sometimes lonely way, without any direct and frequent help from others (Sequeira, 2010). Every family has their own rules and norms, derived from the family's interactions and inter-relationships as well as the need for receiving care (Aneshensel and col., 1997). The cultural values and the personal views regarding the aging and the caring process are, therefore, a crucial factor for both choosing and accepting the caregiver role, influencing the means to which one adapts to this new identity (Morcy, 1993). Studies indicate that the descendants who adopt the role of caregiver base their decision on the needs and resources of the elder, as well as their availability for caring for their parent (Wolf, Freedman & Soldo, 1997). Other factors that can potentially influence the choice or adoption of the caregiving role are related to marital status, culture, professional status, the clinical condition of the care recipient as well as their needs, which will consequently determine the frequency and intensity of the care, therefore influencing the adoption of the caregiver role (Sequeira, 2010).

Taking into account that the performance of a caregiver role implicates a transition, involving the caregiver, care recipient and the context on which the care providing relationship is built (Sequeira, 2010), during a transition process, awareness is a key factor. This awareness can be an initial presupposition for the mobilization of resources in order to take action, for the care provider needs to acknowledge their situation and consequently obtain information about it and fulfill other needs. Awareness is a necessary factor that leads to involvement. In order for a person to be involved in the caregiving process, one needs to be aware of their situation and of their need for intervention, in other words, involvement is impossible without a previous sense of awareness. There are also a various number of other factors that can clearly facilitate or complicate the transition process, such as knowledge and ability, beliefs and attitude, economic status, community and social resources (Meleis et. al., 2000).

Schlossberg (1981) refers to the transition process as a need for change, where one becomes aware of a discontinuity in their life and therefore needs new adjustment responses. Therefore, the transition concept is closely related to that of adaptation, in which an initial critical event triggers the need for a transition, and adaptation is the means in which one experiences the transition process. Research notes that caregivers that experience a recent care episode report distress soon after the event but seem to gradually adjust to care responsibilities. The onset into the caregiving role may be variable, as for some family members, the onset of care begins with a crisis, whereas for others the transition into caregiving occurs gradually and imperceptibly (Gaugler, Pearlin & Zarit, 2003).

According to Shyu (2000), the care provider needs to contemplate 4 stages in order to adapt to an effective transition process to perform the caregiver role. Role engaging means that the caregiver needs information regarding the elderly. The second stage, known as role negotiating refers to the need for help with the care provided and the development of a sense of mastery in the care. In the final stage, role settling, there is a strong need for emotional support in order for the caregiver to feel more comfortable with their new role.

In sum, the transition into the caregiver role is a complex process that contemplates different phases throughout the caregiving progression.

7. Caregiver and worker roles

Evidence points to the influence that work demands, such as excessive workload and time pressure, can have on family caregivers. In the past, work demands like workplace inflexibility and more time spent at work, have been significantly associated with work/ family conflict (Lechner 1993, Voydanoff 2005, Yildirim & Aycan 2008).

It is known that working caregivers can experience more negative effects in terms of declining health and physicall illness, than unemployed caregivers (Lechner 1993, Wakabayashi & Donato 2006) and also present significantly higher caregiving burden than unemployed caregivers (Robinson 1983).

It is also important to understand that many caregivers want to both work and care for the care recipient, but the responsibilities and pressure that derive from their caregiving tasks can make it difficult for the reconciliation of the two roles, so many opt to withdraw from the labour market (Laczko & Noden 1993). On the other hand, some caregivers prioritize their jobs, over caring, and are more likely to stop caregiving than to give up work due to the income that help meet the financial costs of care, but also due to the social networks and the opportunities to share concerns with colleagues (Dautzenberg et al., 2000). In this sense, literature indicates that work can be a means of escaping the emotional strain associated with providing care, reducing the likelihood of depression (Wilson et. al., 2007).

Greater work related conflicts have been associated with higher role overload, worry and strain for employed caregivers of older people (Edwards et al. 2002). Previous studies indicate that the decrease in family caregivers working full-time (Boaz, 1996) can also be related to the decreased performance of ADLs by the care recipient and the resulting increase in caregiving burden for the caregiver. However, caregivers being unable to work full-time can also be a consequence of less support (formal or informal) that can provide the needed assistance, resulting in the lack of reconciliation of work and caregiver roles (Stephens et al. 2001).

As a consequence, some caregivers can miss days of work in order to perform their caregiving duties (Wilson et. al, 2007), quit their jobs (Stone et al. 1987), or sacrifice their leisure times to meet caregiving and work demands (Spillman and Pezzin 2000). Similarly, caring for older parents has been shown to reduce the number of caregivers in the labour supply (Boaz, 1996).

8. Caregiver and adult-child roles

When a parent is physically or mentally incapable and therefore dependant, the adult-child caregiver is confronted with the changes in the relationship, and the difficulties in accepting these modifications (Majerovitz, 1995). Olson (1991b) defines adaptability as ″the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental needs” (Olson, 1991b, p. 717). This means that more adaptable couples or families are more likely to make changes in their routines and methods of problem solving than less adaptable couples, corroborating Olson’s (1991a, 1991b) Circumplex Model of Family Functioning, that states that families with more moderate levels of adaptability are expected to experience better family adjustment and a consequent greater well-being. The construct of family closeness is contemplated as a crucial factor in family adjustment.

In previous studies involving both spouse caregivers and adult-child caregivers (Rankin, Haul, & Keefover, 1992), marital adaptability, communication and cohesion were all related to lower levels of depression and higher levels of family satisfaction for caregivers. Other research indicates that low levels of adaptability, combined with a lack of caregiver identity can be related to higher levels of depression (Majerovitz, 1997). In sum, an individual's adaptation or adjustment to their new role as a caregiver can have a major effect on one's well-being. If the caregiver is unable to adapt to this stressful situation, and in the absence of immediate problem solving mechanisms, the care provider often finds himself in a problematic situation that can lead to psychosocial disorganization, frequently followed by negative emotions like fear, guilt and anxiety. As these feelings cannot be tolerated for long, the caregiver tends to adopt new methods known as coping strategies in order to overcome this crisis situation. This adaptation can be positive or negative, bringing unhealthy emotional repercussions (Endler & Parker, 1990).

Chapter II – Multiple Social Identities and Implications for Caregivers

1. Social identity

In social identity theory, the importance of social group membership to an individual's self-concept and social behaviour is strongly acknowledged (Tajfel, 1982), distinguishing two main aspects of self-concept. The first is personal identity, which includes specific attributes of the individual, such as talent, sociability and competence. On the other hand, social identity derives from a variety of group memberships, that can be based, for instance, on gender and occupation (Luhtanen & Crocker, 1992), and it's defined as the part of an individual's self-concept that derives from the knowledge of belonging to a social group[5] (Tajfel, 1981). Whilst a personal identity refers to how people view themselves as individuals, social identity is how people see the groups to which they belong. According to this theory, individuals strive not only to have a positive personal identity, but also a positive social identity (Luhtanen & Crocker, 1992), enhancing the importance that the social aspects assume on one's self-concept and the need for support within groups (Haslam & Reicher, 2006).

2. Multiple identities

People belong to various social groups and living through these groups can be done with more or less difficulty. It has become an important issue dealing with the multiple roles and tasks of each social group, due to the increasing complexity of modern society where, for example, women build their careers in addition to their traditional family responsibilities and students are involved in sports and volunteering activities as well as maintaining a good academic route (Brook, Garcia & Fleming, 2009). Some research shows that having multiple identities or social roles leads to better mental health, for self-complexity (the number and distinctiveness of self-aspects that make up a person's self-concept) has been associated with better mental health. This can be due to the fact that self-complexity prevents the "spread" of negative events in one dimension of the self to the rest (Linville, 1985, 1987). Different and numerous identities can provide more ways for a person to self-affirm (Niedenthal, Setterlund & Wherry, 1992), and are related with lower depression (Gara et. al., 1993), providing resources that lead to a greater well-being (Marks, 1977; Sieber, 1974), such as lower anxiety (Menaghan, 1989). In contrast, other research affirms that having more identities lowers well-being (Gara et. al., 1993; Woolfolk, Novalany, Gara, Allen, & Polino, 1995). Some identity researchers argue that this negative effect of multiple identities on well-being is due to the fact that these roles may reduce time and energy by expecting incompatible behaviours, or role conflict (Coser, 1974).

---

[5] Social goup is a collection of individuals who see themselves as members of the same social category (Luhtanen & Crocker, 1992).

The role meaning hypothesis (Simon, 1995) explains both contrasting theories on multiple identities and well-being by suggesting that multiple identities lead to greater well-being if they require similar behaviours, leading to lower well-being if they require different behaviours. Some theorists have claimed that identities can vary in importance, to a person (Stryker & Serpe, 1982, 1994) and that a higher identification with groups is associated with greater well-being (Jetten, Branscombe, Schmitt, & Spears, 2001). Thus, evidence has also indicated that the combination of importance and harmony between multiple identities may interact to predict well-being since the existence of role conflict has been proven to induce stress (Settles, 2004).

3. Self-Discrepancy theory and emotions

Evidence has shown that people with conflicting or incompatible beliefs are likely to experience discomfort, something that has been studied throughout several years, in psychology, relating these same self-inconsistencies to emotional problems (Higgins, 1987). The literature reveals the existence of emotional clusters as a consequence of these self-inconsistencies(e.g., Cattell, 1973; DeRivera, 1977; Ewert, 1970; Kemper, 1978; Zuckerman & Lubin, 1965). According to Higgins' (1987) self-discrepancy theory, there are multiple representations of the self. The attributes and traits one actually has are represented by the actual self, the ideal self contemplates the attributes one would like to own, and the ought self reflects the attributes one feels one should have. It is important to consider that a person can think of these representations from a self or significant other perspective. From this point of view, self-discrepancies are the perceived differences between the actual self and the ought and ideal selves. In sum, discrepancies between the actual and ideal self are associated with dejection related emotions, where one is more vulnerable to disappointment and dissatisfaction, and discrepancies between the actual and ought selves are associated with agitation related emotions (shame, embarrassment, downcast).

Caregivers experience a range of emotions related to the tasks performed and relationship with the care recipient, which is why the effect of multiple identities on caregivers' well-being, even with the existence of harmony between them, may vary.

A study conducted by Brook and colleagues (2008) analyzing the effects of multiple identities on well-being concluded that having more identities which are considered highly important, can have a positive effect on psychological well-being, versus having less important identities. This effect is only present if the identities are in harmony with each other, because the roles provide resources and expect similar behaviours from the individual. These authors also proposed that emotions corresponding to self-perceptions of actual/ought self-discrepancies mediated these effects (Figure 1). In order to test their model, the authors applied questionnaires to 372 undergraduate students from a research university.

The results indicated that people whose identities facilitated each other had higher psychological well-being than those whose identities conflicted with each other. Having important, facilitating identities predicted greater well-being than having important, conflicting identities. For low to moderately important identities, results suggested that having low important facilitating identities predicted higher well-being than having low to moderately important conflicting identities.

In terms of the mediator variable, results proved that the three way interaction did not predict the different types of self-discrepancy related emotions, as a whole, as the authors expected. Thus, none of these emotions mediated the effect of the three way interaction on well-being. However, the three way interaction did predict actual/own versus ought/own discrepancy related emotions, the type of emotions considered to be more important in this context. In sum, the actual/own versus ought/own self-discrepancy emotions fully mediated the effect of Number of Identities x Identity Harmony x Importance interaction on well-being (Brook et. al., 2008).

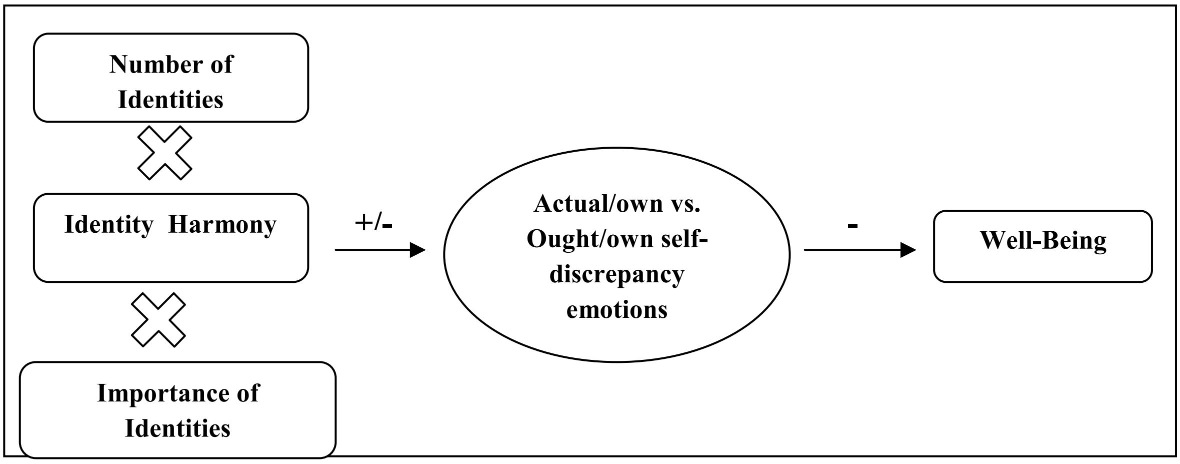

Figure 1 – Three way interaction model used by Brook et. al. (2008).

Chapter III - Our Study

Considering the existing literature that points to the importance of multiple identities on well-being, as well as the lack of studies that focus primarily on caregivers, one of this paper's central purpose is to contribute to the scientific knowledge on this topic. This study focuses on three identities: adult-child, worker and caregiver, which according to the existing literature, are considered important in the caregiving context, especially considering the family-work conflict. The objective is to analyze the role that the importance given to each one and the harmony between them play as key determinants of the caregiver's well-being and perceived burden. Therefore our question is, does harmony between the multiple identities of the caregivers have a protective effect on their well-being? In order to answer this question, the following hypotheses are stated:

H^1*:* If there is harmony between identities that are considered important, there will be higher well-being and lower caregiver burden.

H^2: The effect of the interaction between identity importance and harmony on well-being and caregiving burden will be mediated by self-discrepancy emotions in the sense that important and less harmonical identities are related with an increase in self-dicrepancy emotions which, in turn, will lead to a decrease in well-being and an increase in perceived caregiven burden (see Figure 2).

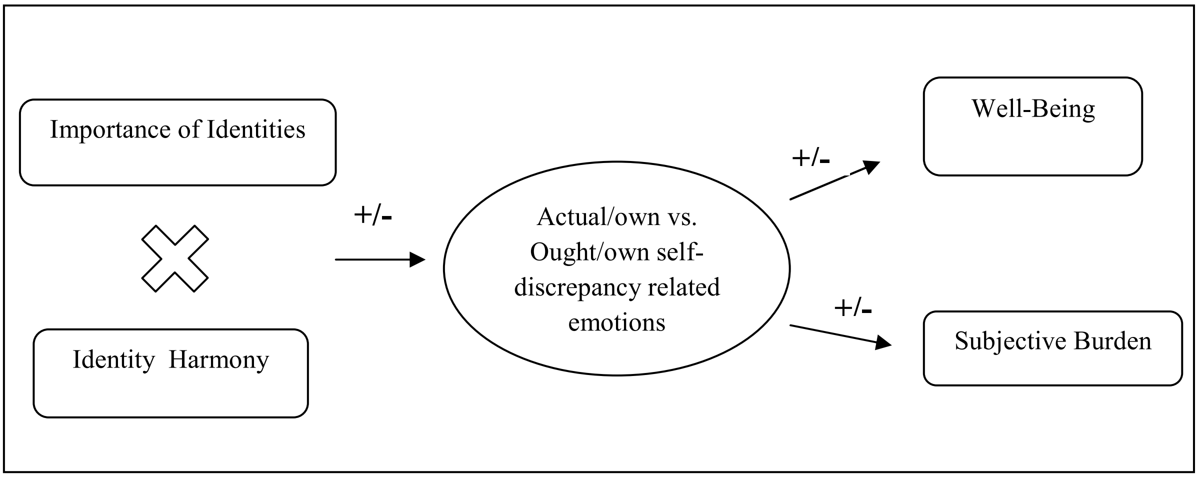

Figure 2 – Importance of Identities x Identity Harmony mediated by discrepancy emotions model.

Part II – Empirical Research

Chapter IV - Method

1. Participants

The sample used in the present study is composed of 40 caregivers, who are sons (45%) and daughters (55%) of the elder, for there is homogeneity in terms of gender, as shown in *Figure 3*.

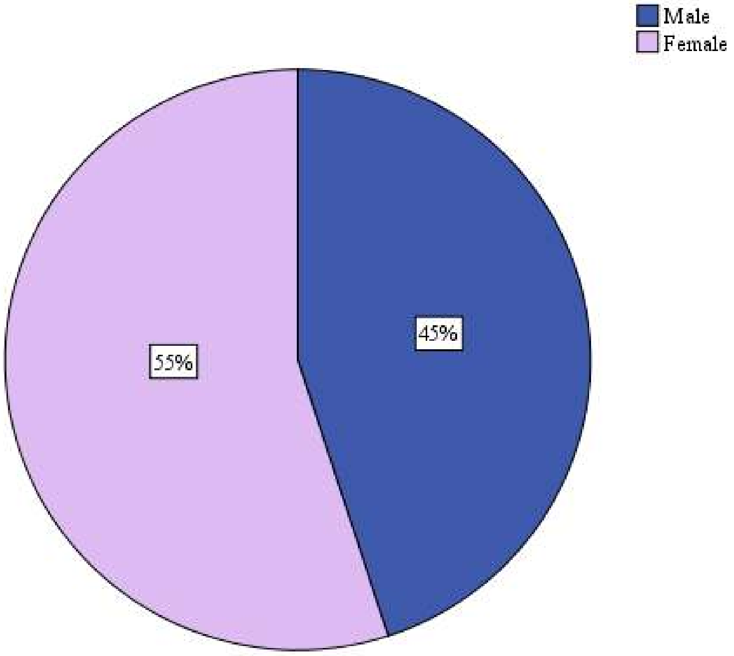

Figure 3 – Gender of the caregivers

When it comes to marital status, the majority are married (55%) although a high percentage is either separated or divorced (30%). The ages range between 39 and 65 years old, with a mean of 51 years and a standard deviation of 7 years. On an educational level, 40% of participants had a high school degree and 30% had a college degree. One quarter of participants had a *middle school* educational level, and 5% a primary school level of education, as indicated by *Figure 4*. Therefore, all of the caregivers could both read and write.

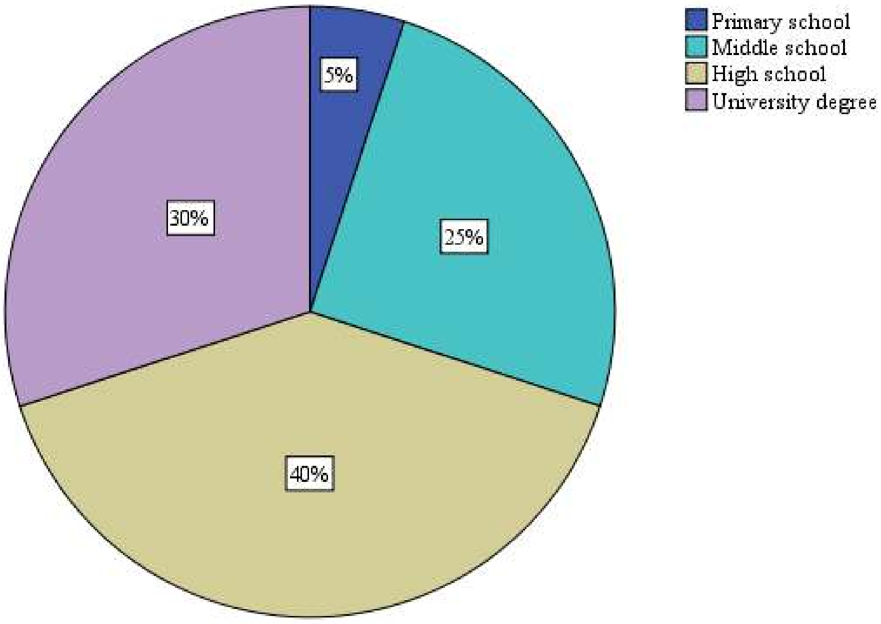

Figure 4 – Caregivers' educational level

All of the participants have a professional role, and almost all worked full-time (92.5%), more than 26 hours weekly and most of them over 41 hours per week (62.5%). In terms of household, most live with their spouse (62.5%) followed by their adult children (40%) and young children (27.5%).

The care recipients are 40 elders, with ages between 70 and 93 years old, with an average of 83 years and a standard deviation of almost 6 years. The majority are women (65%). To measure the level of dependency of the care recipients we used the Katz Index (1983). It assesses the elder's ability in six dimensions: bathing, dressing, toileting, transferring, feeding, and continence. The care recipients are scored from one to three for independence in each of the 6 functions. A total score of 6 indicates independence, 7 to 10 is partially dependent, 11 to 16 is dependant and over 17 is totally dependent. According to the results obtained using this instrument, the participants are characterized as dependent (45%), totally dependent (22.5%), partially dependent (17.5%) and independent (15%).

As *Figure 5* demonstrates, 40% of participants live with the care recipient, followed by 30% who live 30 minutes distance. Only 5% live within over an hour's distance from the care recipient.

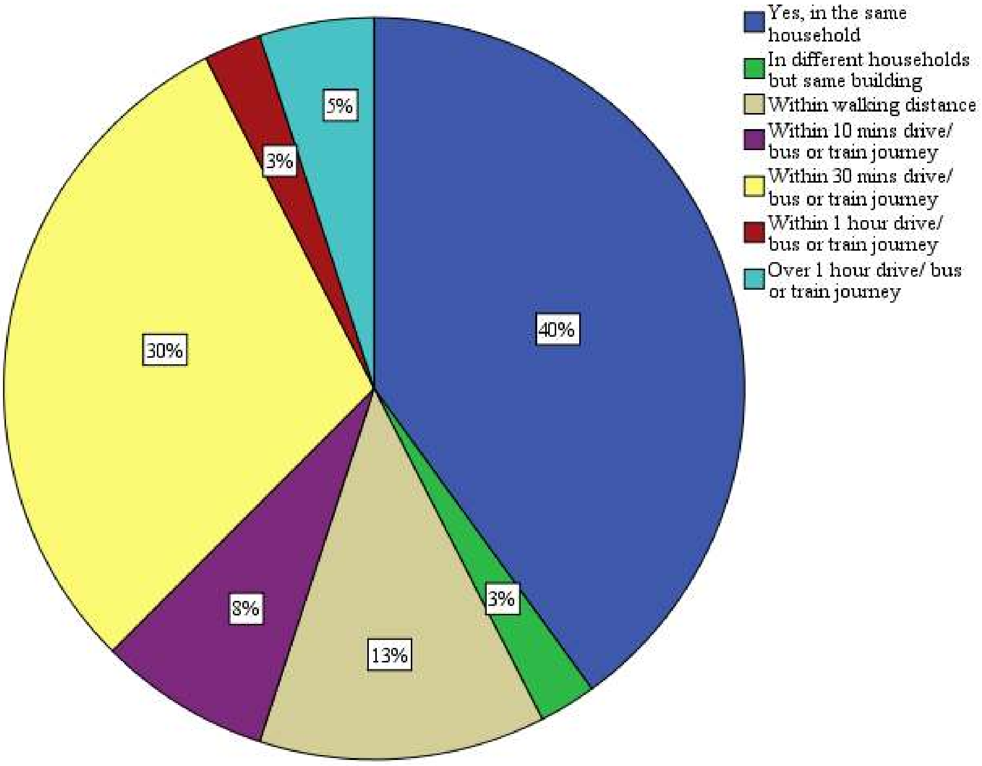

Figure 5 – Caregiver's distance from care recipient

A great number of the caregivers provide care to another person (45%) who is mostly the other parent (30%). The results shown in *Figure 6* indicate that most of the participants care for the elder between 6-20 hours weekly (33%) although 25% care for 21-30 hours, and 30% care for less than 5 hours. Only 3% of caregivers spend from 45 to 60 hours caring for the elder.

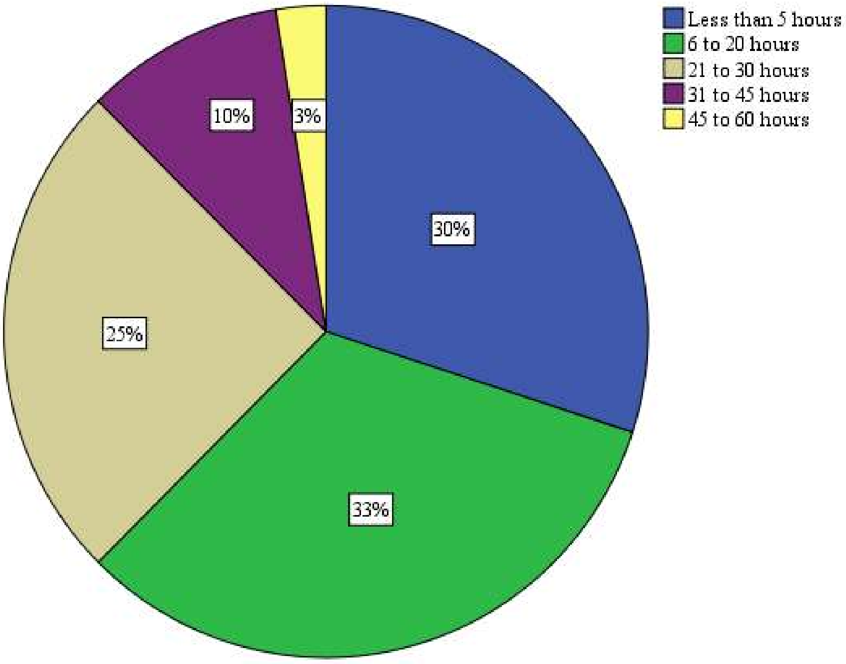

Figure 6 – Hours spent assisting the care recipient

The caregivers have been providing care, on average, for 46 months, with a standard deviation of 54 months, for the extent to which the participants have assumed the caregiving tasks ranges between 3 months to 17 years. More than half of participants (52.5%) assume they have informal help with the tasks they perform, usually from a sibling (30%) or a spouse (15%). The tasks usually performed are mainly short travels (90%) which involve accompanying the elder to a doctor appointment, shopping trips, etc., followed by house chores (70%), help with food and meals (67.5%), personal hygiene tasks (57.5%) and caring for the elder's image (50%) which involves dressing the care recipient, and other tasks that improve the elder's self-esteem.

2. Instruments

A 22 item questionnaire was used to assess a variety of dimensions. The instrument is composed of multiple response answers and aims to measure seven concepts: job satisfaction (Chambel & Marques-Pinto, 2008); well-being (Diener, 1995); attachment between adult child and older parent (Cicirelli, 1995); importance of identities (Luhtanen & Crocker, 1992); identity harmony (Tompson & Werner); self-discrepancy emotions (Brook et. al., 2008) and caregiving appraisal (Martin et. al., 2000). The first group of questions are used to provide a descriptive background of the caregivers' personal characteristics and are pure demographic questions (ex: gender, marital status, educational level). The questions that follow are more directly related to providing care, and have been proven to have an effect on caregiving burden and well-being, such as residence distance from the care recipient (Penrod et. al., 1995), caregiving tasks performed (Aneshensel et. al., 1995).

Other measures are used that empirical studies have shown to be related to harmony between identities, such as work satisfaction and quality of the relationship between caregiver and care recipient (Williamson & Schulz, 1990; Cicirelli, 1995). Well-being and caregiving burden are measured using known instruments that have been applied by different authors.

The order of the questions was thoroughly considered due to the personal content of the questions themselves and in order to maintain a flowing conversation throughout the completion of the instrument.

In order to guarantee good psychometric results, the measures used were all based on previous literature. A pre-test was conducted using a sample of three participants, which led to some preliminary adjustment of the scales in accordance with the sample characteristics.

2.1. Demographic background

The questionnaire created for this study includes 15 items that are intended to characterize the participants on an array of demographic factors that have been consistently referred in the literature as having an effect on caregiving burden or well-being. Hence, we included items measuring demographic characteristics such as age and gender. We also included some items to explore the caregiving connection with the hours of work, co-residence, familiar, demographic and social factors (ex:., age; gender; hours of work; co-residence; age of care recipient; social/ familial support; type of care given; hours spent caring). The questions are mostly of multiple choice, although one item asks the participants to state the kinship of the people that compose their household (Annex 1).

2.2. Work Satisfaction

To assess the individual's satisfaction with their professional life, an abbreviated version of the scale used by Brayfield and Roth (1951) was applied, containing 5 items with a

5-point Likert response scale from 1 (*strongly disagree*) to 5 (*strongly agree*). This scale was translated and validated for the Portuguese population by Chambel and Marques-Pinto (2008), where the internal consistency was of 0.84. In this study the alpha is 0.73, considering this to be a value of a good internal consistency. A composite score of this measure was also created by averaging the five items.

2.3. Well – Being Scale

Diener's (1995) scale was used to measure participant's satisfaction with life and level of happiness, using two Likert-type scales ranging from 1 (*extremely unhappy/extremely unsatisfied*) to 10 (*extremely happy/extremely satisfied*). This measure reported a high internal consistency of 0.838.

2.4. Adult Attachment Scale

Using Cicirelli´s (1995) Adult Attachment Scale, to measure basic aspects of secure attachment between adult-children and their elder parents, we adapted this existing scale by reducing the response scores from a 7-point Likert scale to 5 points, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). This alteration was made after pre-testing the questionnaire, in order to shorten the response options and facilitate the response method for participants. The internal consistency obtained was very good and identical to the original scale (α = 0.95).

The original scale has a score between 16 and 112, with the higher score indicating a higher level of attachment. The final score is obtained from the sum of the answers. Since the scale used for this study was adapted, the score varies from 16 to 80. For this measure, a composite score was created by averaging the 16 items.

2.5. Importance of Identities Subscale

This measure aims to evaluate the importance given to the caregiver, worker and son/daghuters identities. We adapted the Importance to Identity subscale of the Collective Self-Esteem Scale, developed by Luhtanen and Crocker (1992). For each one of the three identities, participants were asked to answer three items on a 5-point Likert response scale from 1 (*strongly disagree*) to 5 (*strongly agree*). The three items read: *"Being a* *(son/caregiver/worker) is an important reflection of who I am"*, *"Being a (son/caregiver/worker) is unimportant to my sense of what kind of a person I am"* and *"In general, being a (son/caregiver/worker) is an important part of my self image"*. The second item was reversed for each of the identities. The internal consistency for the importance of being a son/daughter was moderate ($\alpha = 0.66$), as was the importance of being a caregiver ($\alpha = 0.56$). The alpha for the importance of the worker identity was significantly higher ($\alpha = 0.77$) and the overall consistency for the nine items was even higher ($\alpha = 0.84$). The final score of this subscale is measured using the average results of the nine items, in order to obtain a global score of importance of the three identities. To calculate the importance of each identity individually, the average score obtained for the three items related to that identity, is used.

2.6. Identity Harmony

In order to verify the existence of harmony between the three identities previously mentioned, a measure developed by Tompson and Werner (1997) was used. The scale crosses all of the identities using a table with the roles written on the left-hand side and the repeated roles on the top of the table. The participants had to compare each role to each other role, indicating to which extent the participation in one role facilitated, did not affect or conflicted with the comparison role. The 5-point Likert scale reflected the following responses: -2 (*participation in one role had a harmful or conflictual effect on the other*), -1 (*a somewhat harmful/conflictual effect*), 0 (*no effect*), +1 (*a somewhat facilitative or helpful effect*), +2 (*a very facilitative or helpful effect*). A total score is obtained for each participant, with a negative sum indicating high conflict between the roles and a positive score indicating greater overall facilitation. To verify the existence of harmony between one pair of identities, the average score is calculated using only the two identities. This measure reported an acceptable alpha ($\alpha = 0.70$).

2.7. Self-discrepancy related emotions measure

To measure self-discrepancy emotions, we adapted the Actual/Own versus Ought/Own self-discrepancies subscale used by Brook et. al. (2008). The items contain affirmations such as "*I feel guilty*" and "*I feel angry with myself*". The subscale has a total of 7 items measured with a 5-point Likert scale, ranging from 1 (*does not apply at all*) to 5(*applies very much*).

The scores are assessed by averaging the results obtained, with a good internal consistency (α = 0.76). [6]

2.8. Caregiving Appraisal

To measure the caregiving appraisal we used the Portuguese version (Martin et al., 2000) of the Lawton's Caregiving Appraisal Scale (1989). The scale has a total of 13 items grouped into three dimensions: Subjective Caregiving Burden (SCB), Impact of Caregiving (I) and Caregiving Satisfaction (CS), assessed using a 5-point Likert scale (1= *Strongly disagree* until 5=*Strongly agree*). Factorial analyses in the present study revealed these three factors explaining 64.37% of total variance, although some adjustments had to be made regarding the original version of the scale. Factor 1 called Impact of Caregiving explained 11.66% of the total variance and revealed good consistency (Cronbach α = 0.75), contemplating questions such as *"Taking care of your mother/father makes you feel trapped"*, *"You feel isolated and alone as a result of caring for your mother/father"*, *"Your mother/father frequently affects in a negative way, your relationship with other family members".*The Subjective Caregiving Burden (α= 0.68) was measured using two items: *"Your health has suffered because of the care you must give to your mother/father"* and *"It's difficult to plan ahead when the needs of your mother/father are so unpredictable",* explaining 22.06% of the total variance obtained. Caregiving Satisfaction (α= 0.85) was assessed with four items, the same used in the original scale to asses this dimension: *"You really like being with your mother/father"*, *"You feel that your mother/father shows real appreciation for what you are doing for him/her"*, *"Your mother/father's pleasure in little things gives you pleasure"*,explaining 30.64% of total variance . One item, that was part of the original scale, was removed from this factor in order to increase the alpha score: *"Caring for my mother/father has improved my self-esteem".*

3. Procedure

---

[6] This measure is used to measure self-discrepancy of the actual/own versus ought/own type as a whole, and not for each of the identities.

Forty adult caregivers of their elder parents participated in this study. The care recipients also receive formal care at home from an institution that provides home help services in Lisbon, a factor which facilitated the access and contact with the sample.
The participants had to be professionally active, and assume themselves as primary caregivers performing at least one Activity of Daily Living (ADL).
Initial contact was made with three institutions that provide home help services in Lisbon, Portugal, mainly Santa Casa da Misericódia de Lisboa, Associação Infanta D.ª Mafalda and Médicos do Mundo, who provide care with most of the ADL to elderly and dependant people. After this initial contact, a formal email was sent in order to obtain permission to collect data for the study (*Annex A*). Upon contact, the institutions were asked to inform caregivers of the present study and obtain consent for participation. The institutions elaborated a list that included seventy-one caregivers, although 31 could not be included because they had a different kinship with the care recipient (e.g. spouse; neighbour) or were currently unemployed or retired. The final sample included 40 caregivers of 40 elders.

After obtaining permission and the telephone numbers of the participants, they were contacted by phone and were asked to answer the questionnaire. They were informed that the instrument took between 20 to 30 minutes to be completed and, in some cases, a different time was scheduled to fill in the questionnaire. It was explained to the participants that the questionnaire was anonymous and that they would be asked a series of questions about their caregiving activities as well as their work activities. Data was collected during a three-month period. The results were analyzed using the Statistical Package for the Social Sciences (SPSS) version 19.

Chapter V – Results

In order to meet the objectives initially created and answer the primary question - *does the importance and the harmony between the multiple identities of the caregivers have a protective effect on their well-being and perceived burden,* a series of tests and analysis were conducted, that are described in this chapter.

Descriptive results

On average, participants show a medium job satisfaction, for the average score was of *M*= 3.68 (*SD*= 0.63) on the 5-point Likert scale. According to the results obtained in terms of Subjective Well Being, the average score was 6.

In terms of the Adult Attachment Scale, participants show significantly slightly higher level of attachment to their parent (*M*= 3.53; *SD* = 0.88) than the mean, *t*(39)= 3.79; *p*= 0.001.

For the importance of identities subscales, in general the participants consider these identities to be important (*M*= 4.22; *SD*= 0.624), as was verified with a One-Samples T test, which pointed to the existence of a significant difference from the scale midpoint (3), reporting the following results [*t* (39)= 12.41; *p*= 0.00] with the caregiver identity assuming a higher importance than the average result (*M*= 4.28; *SD*= 0.511; *t* (39)= 15.77; *p*= 0.00), followed by the worker identity (*M*= 4.22; *SD*= 0.624; *t* (39)= 12.41; *p*= 0.00) and the son/daughter identity (*M*= 4.16; *SD*= 0.622; *t* (39)= 11.77; *p*= 0.00).

The results for the harmony between identities subscale show that the roles do not facilitate or conflict with each other (*M*= 0.13; *SD*= 0.64) in the sense that this did not significantly differ from the midpoint of the scale, (*t* (33)= 1.22; *p*= 0.23, ns). The results obtained in the Caregiving Appraisal Scale show an average mean in terms of *subjective caregiving burden* (*M*= 3.29; *SD*= 1.21) not significantly different from the mean of the scale (*t* (39)= 1.63; *p*= 0.11, ns), *impact of caregiving* indicates a slightly lower mean (*M*= 2.18; *SD*= 1.09, *t* (37) =-4.58; *p*= 0.00) and *caregiving satisfaction* has the highest mean of the three dimensions (*M*= 4.20; *SD*= 0.82, *t* (39)= 9.25; *p*= 0.00).

In terms of the self-discrepancies regarding the actual/own versus ought/own selves, results indicate a mean of *M* = 1.83 (*SD* = 0.65). By conducting a One-Sample T test, it was possible to find that participants showed a significantly low level of self-discrepancy than the mean of the scale (*t* (39)= -11.49; *p*= 0.00).

Correlations between demographic and predictive factors

Firstly we tried to understand the impact of the demographic factors (age, gender, marital status, etc.), *job satisfaction, attachment* between adult child and elder parent, and *self-discrepancy related emotions, importance of identities* and *identity harmony* on well-being and the caregiving appraisal dimensions. For these findings correlation analysis was conducted, using the *Pearson Correlation Coefficient*, which indicating the existence of a significant correlation between the *gender of the care recipient* and *caregiving burden (CB)*, (r = -.449; p = < 0.05). The *attachment* between adult child an elder parent had a medium effect on *CB* (r = 0.324; p = < 0.05), and *CB* revealed a medium negative effect on *well-being* (r = -.465; p = < 0.01).

The *age of the care recipient* was found to be correlated with *caregiver satisfaction* (CS), (r = -.96; p = < 0.01). There was also a medium effect between *CS* and three other variables such as: *importance of identities* (r = 0.328; p = < 0.05), *self-discrepancy related emotions* (EM) (r = -.460; p = < 0.01), and a higher effect for *attachment* (r = 0,564; p = < 0.01).

The actual/own versus ought/own *EM* indicated a significant correlation with both *importance of identities* (r = - .373; p = < 0.05) and *CS* (r = - .460; p = < 0.05).

Another correlation was found between *attachment* and *CS*, revealing a positive effect (r = 0.564; p = < 0.01) between the two variables. The results are reported on *Table 3* (*Annex C).*

Whenever significant results between demographic and care-related factors were found those were controlled for in later tests.

Testing the Hypotheses

We attempted to test our hypothesis taken into consideration our main dependent variables: *well being* and the dimensions used to measure caregiving appraisal (*burden, impact, satisfaction*). In order to do this we performed several multiple regression analysis by introducing first the Importance of identities, then the Harmony between identities and then the Interaction term between these two variables.

First and following the proposal of Brook and colleagues (2008) firstly, we analyzed the model considering the three identities together. Multiple regression analysis was conducted in order to verify the effects of the two-way interaction (importance of identities and identity harmony) on well-being and the three dimensions of caregiving burden. All of these variables were centered and we regressed once at a time each dependent variable on both importance of identities and identity harmony, considering all three identities and then the two-way interaction. *Table 1* reports the descriptive results.

Table 1 – Descriptives of predictors and outcome variables

Variables	N	M	SD	Min.	Max.
Importance of Identities	40	4.22	0.624	3	5
Identity Harmony	34	0.13	0.635	-1	2
Well-Being	40	6.33	1.781	2	10
Caregiving Burden	40	3.30	1.165	1	5
Actual/own vs. ought/own emotions	40	1.83	0.645	1	3

We did not find any significant results so we decided to analyze the model considering the pairs of identities separately (caregiver/worker and caregiver/adult child). Once again we tested for both these pairs of identities our model and taking in consideration well-being and each one of the three dimensions of caregiving appraisal. Whenever necessary we controlled for the effect of the demographic and care-related factors.

The only result we found to be significant was related with the pair caregiver/worker identities. Table 2 summarizes the analysis results.

Table 2 – Results of the multiple regression model

Variables	Caregiving Burden		
	B	SE B	β
Constant	3.790	0.224	
Gender or Care Recipient	-1.220	0.363	-0.499
Importance CG /Worker Identities	-0.666	0.359	-0.279
Harmony CG/Worker Identities	-0.436	0.236	-0.315
Importance CG/Worker x Harmony CG/Worker	1.118	0.480	0.400

Note: All variables were centered at their mean

The results indicated a significant interaction between the *importance of caregiver and worker* identities and *harmony* between these same identities, $\beta = 0.40$, $t\ (30) = 2.33$, $p < 0.05$. These results were significant even when the gender of the care recipient was controlled for, $R^2 = 0.377$; $F\ (4, 29) = 33$; $p < 0.01$. Simple slope analysis revealed that in the existence of harmony between caregiver/worker identities, importance of these same identities has no effect on CB, $B = 0.40$, $t\ (30) = 0.62$, $p = 0.5$. However, when there is low harmony, it is possible to see the effect of importance of identities on CB in the sense that in this condition those who give less importance to the caregiver and worker identities have higher caregiver burden, $B = -2.14$, $t\ (30) = - 3.30$, $p < 0.01$ (Figure 7).

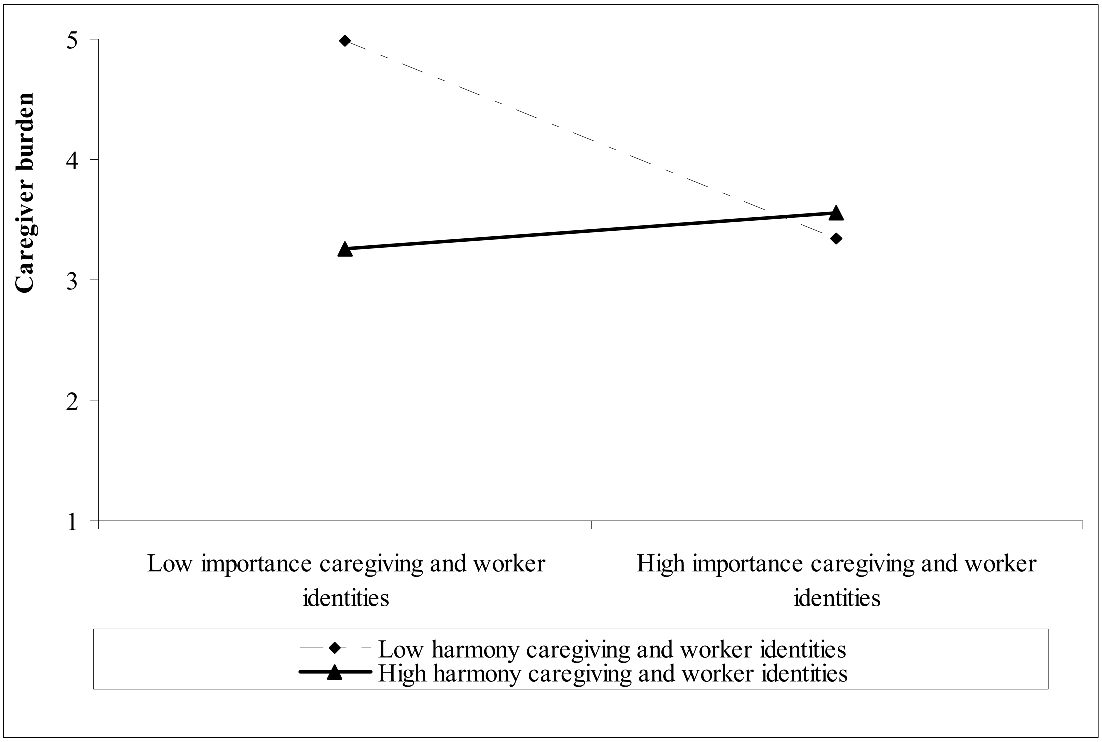

Figure 7 – Effect of the importance of caregiver and worker identities, harmony between caregiver and worker identities on caregiver burden.

Only when both harmony and importance of these two identities is low, it is possible to verify a significant increase of the perception of CB thus partially confirming H^1. Although we did find an interactive effect of importance and harmony on CB, the effects seem to occur in the opposite direction as it was hypothesized.

We also explored the possible mediator role of the self-discrepancy related emotions. However, since we found no significant correlations with caregiver burden this result goes against the idea that these emotions mediate the effect of importance of identities and harmony on well-being and caregiving burden, thus rejecting H^2.

Discussion

The hypotheses of the present study focused on the decrease of caregiving burden and the increase of well-being when the identities are considered important and there is harmony between them. It was initially proposed that self-discrepancy related emotions of the actual/own versus ought/own type would have a mediating effect on this interaction.

Even though these hypotheses were not confirmed in terms of the interaction of the three identities, an interesting result was obtained, pointing to the importance given to the identities of worker and caregiver. The results indicated that when participants perceive their identities of caregiver and worker as being in harmony with each other, the importance given to these identities do not influence caregiving burden. However, when perceived harmony is low, those that also perceive these identities to be less important have more caregiving burden.

The significant results relating to the identities of caregiver and worker support the studies performed by Wang (1997) and other authors (Laczko & Noden 1993; Edwards et al. 2002), confirming the existing conflict between the two roles because of the importance that both identities assume on an individual's life.

Many caregivers see their worker role as an important part of their self-concept because work can be a means of escaping the emotional strain associated with providing care (Wilson et. al., 2007). Besides the emotional effects, worker identities assumes an additional importance due to the financial income it provides, helping attenuate the economic aspects of the caregiving tasks, as well as the social networks it provides (Dautzenberg et al., 2000). In this sense, many caregivers prioritize their jobs over their caregiving tasks, which can be an indicator of the importance of this identity.

The effect of the tested model of interaction between identity importance and harmony on caregiver burden was only present when comparing the identities of caregiver and worker. When both the importance given to these identities, as well as harmony, were low, caregiver burden results increased, results which are similar to those reported in studies involving role conflict between these two identities, that relate work-to-family conflict to a negative perception of health, lower well-being and more strain and burden (Lechner 1993, Voydanoff 2005, Yildirim & Aycan 2008; Robinson, 1983). The study performed by Yildirim and Aycan (2008), for instance, concluded that work overload and irregular work schedules have a significant impact on work-to-family conflict, and that this conflict is associated to lower job and life satisfaction.

By analyzing the results obtained from the demographic and predictive factors, an interesting interaction was observed. Job satisfaction was positively correlated to identity harmony, which, once again, confirms the importance that the worker identity assumes on the caregiver.

This work has the merit to show for the first time that both the importance and perceived harmony of the carer and worker identities play an important role on caregiving burden. These results show that those carers who do not find these identities important and do not perceive them to be in harmony are the ones in greater strain and risk. In fact, this is in accordance with Social Identity Theory (Tajfel & Turner, 1982) perspective that emphasizes the protective role that perceiving oneself as part of a group and sharing a social identity may have on an individual's self-esteem and adjustment. Weak social identification has been related with a higher level of burnout, stress, and a lower well-being (Amiot & Sansfaçon, 2011). It is also relevant to mention the importance of positive identification, for people seek group identifications that contribute to enhancing their positive self-esteem (Brewer & Crano, 1994).

Nevertheless, in spite of its merits, this work also presents some unexpected findings. For instance, the fact that the adult-child role did not assume an important part in this interaction was surprising. However, we think that this could be explained in terms of the interconnectedness between these two identities. In fact, it is relatively easy to assume that caregiving is a part of the adult-child's responsibilities. Caregiving is intrinsic to close relationships (Badr et. al., 2007), and some adult sons/daughters may perceive caregiving as an extension of their adult-child identity, therefore not distinguishing between the identities of caregiver and son/daughter. Another possible option may be that the caregivers attribute more importance to the caregiver identity due to the demands and responsibilities associated to this role.

In the same vein, contrary to what we predicted, there were no significant effects of the interaction on well-being. This goes against the original social psychological study in this domain (Brook et al. 2008). However, we think that this can be explained by the fact that well-being is a very general construct, and that a series of overall life events can influence this factor. On the other hand, caregiving burden contemplates a more specific measure for the caregiving context and, therefore, is likely to be more sensitive to the effects of the variables being assessed in comparison to a broader and non-specific construct.

We also tested the model on the other dimensions of the Caregiving Appraisal (impact of caregiving and caregiving satisfaction) but no significant effects were found. Impact of caregiving, for instance, measures a construct which is highly similar to caregiving burden and can be easily presumed as such, being closely related to one another. As Lawton et. al. (1989) indicates, a plausible explanation is that there is a causal relationship between caregiving burden and caregiving impact.

Finally, even though the *actual/own versus ought/own* self-discrepancy related emotions did not mediate the interaction, as was initially predicted, this variable was shown to have a negative effect on both importance of identities and caregiver satisfaction. This gives some emphasis to the importance of this variable on these types of processes.

The current findings have considerable practical and theoretical importance. Research indicates that an increasing number of people may be adopting multiple identities (Brook et. al., 2008) and on the other hand, the world population is getting older. In the light of this issue, the caregivers are strongly assuming a more important role in taking care of their dependent family member, for demand in terms of family caregivers is gradually increasing. Women’s increasing participation in the workforce has led to changes in the roles of men and women in society, therefore gender roles are expanding with women being more active in professional work life whereas men are more active in family life. As a consequence of these alterations, it has become a challenge for working people to maintain a balance between work and family responsibilities (Yildirim & Aycan 2008). Considering that the general population is gradually assuming multiple roles, women, especially, are no longer confined to traditional family roles, thus at risk for family-work and other inter-role conflicts. In this sense, it is necessary to continue studying this factor. The results obtained could also be used and applied by professionals working directly with caregivers, by defining strategies and activities that can result in the promotion of multiple facilitative identities. Another strategy can be in the sense of finding ways to decrease the existing work-to-family conflict, in order to support the caregivers by promoting the harmony between these roles.

In terms of limitations considered in this study, it is relevant to mention the sample that participated in the study. The initial aim was to interview a higher number of caregivers, but due to the criteria used, excluding non-working caregivers, this was not possible, therefore it is hard to say if this study can be generalized to other populations. Increasing the number of participants in the future may help us test more complex models. Due to the fact that many caregivers may assume their adult child responsibilities as their caregiving responsibilities and tasks, as it happens with marital identity (Badr et al., 2007) , it was not possible to fully explore the nature of this identity interaction.

Future studies should focus on distinguishing more clearly the adult-child identity from the caregiver identity in order to explore this first role, as well as the role interaction, in greater depth.

It is important to consider, in later studies, the testing of a similar model on a larger sample of caregivers, as well as the use of a different procedure when applying the instrument, instead of a telephone interview. Another interesting approach would be to study the effect of other identities that could be considered important to the caregivers.

In sum, it is extremely important to understand the effect of, not only work demands, but also the demands of other identities on caregivers so that effective interventions and relevant policies can be identified.

References

Almberg, B., Grafstrom, M., & Winblad, B. (1997). Caring for a Demented Elderly Person – Burden and Burnout among Caregiving Relatives. *Journal of Advanced Nursing, 25*, 109-116.

Amiot, C., & Sansfaçon, S. (2011). Motivations to Identify With Social Groups: A Look at Their Positive and Negative Consequences. *Group Dynamics: Theory, Research and Practice, 15*(2), 105-127.

Aneshensel, C. S., Pearlin, L. I., Mullan, J. T., Zarit, S. H., & Whitlatch, C. J. (1995). *Profiles in caregiving: the unexpected career*. San Diego: Academic Press.

America Psychological Association (2010). *Publication Manual of the American Psychological Association, Sixth Edition*. USA: Washington DC.

Baddeley, A. D. (1986). *Working Memory*. Oxford: Clarendon Press/Oxford University Press.

Badr, H., Acitelli, L. K., Carmack Taylor, C. L. (2007). Does couple identity mediate the stress experienced by caregiving spouses? *Psychology & Health, 22*(2), 211-229.

Boaz R.F. (1996) Full-time employment and informal caregiving in the 1980s. *Medical Care, 34*(6), 524–536.

Braithwaite, V. (1992). Caregiving burden, making the concept scientifically useful and policy relevant. *Research on Aging*, *14*(1), 3-27.

Brayfield, A. H. & Rothe, H. F. (1951). An index of job satisfaction. *Journal of Applied Psychology*, *35*(5), 307-311.

Brewer, M. & Crano, W. (1994). *Social Psychology*. USA: West Publishing Company.

Brook, A. T., Garcia, J., & Fleming, M. (2008). The Effects of Multiple Identities on Psychological Well-Being. *Personality and Social Psychology Bulletin, 34*, 1588.

Carpenter, B. D. (2001). Attachment bonds between adult daughters and their older mothers associations with contemporary caregiving. *The Journals of Gerontology*, *56*, 257-266.

Carrero, M. (2002). Ante la enfermedad de Alzheimer: pistas para cuidadores y familiares. Bilbao: Ed. Desclée de Brouwer.

Cattell, R. B. (1973). *Personality and mood by questionnaire. San Fran*cisco: Jossey-Bass.

Chambel, M.J., & Marques-Pinto, A. (2008). *Consequences of work and family facilitation in employees' satisfaction and engagement*. Faculdade de Psicologia e de Ciências da Educação, Universidade de Lisboa. Working Paper.

Cicirelli, V. G. (1995). A Measure of Caregiving Daughters' Attachment to Elderly Mothers. *Journal of Family Psychology, 9*(1), 89-94.

Coser, L. (1974). *Greedy institutions*. New York: Free Press.

Da Silva, M. J., Marques, M. B., & Da Silva, B. C. T. (2009). Avaliação da Presença da Síndrome de Burnout em Cuidadores de Idosos. *Enfermería Global, 16*, 1-10.

Dautzenberg M.G.H., Diederiks J.P.M., Philipsen H., Stevens F.C.J., Tan F.E.S. & Vernooij- Dassen M.J.F.J. (2000). The competing demands of paid work and parent care: middle-aged daughters providing assistance to elderly parents. *Research on Aging 22*(2), 165–187.

Davies, L. (1992). Building a science of caring for caregivers. *Family Community Health, 15*(2), 1-9.

Edwards A.B., Zarit S.H., Stephens M.P. & Townsend A. (2002). Employed family caregivers of cognitively impaired elderly: an examination of role strain and depressive symptoms. *Aging & Mental Health, 6*, 55–61.

Endler, N.S., & Parker, J.D. (1990). Multidimensional assessment of coping: A critical evaluation. *Journal of Personality and Social Psychology*, *58*(5), 844-854.

Field, A. (2009). *Discovering statistics using SPSS* (3rd Edition). SAGE Publications.

Fontaine, R. (1999). *Psicologia do Envelhecimento*. Lisboa: Climepsi Editores.

Gara, M. A., Woolfolk, R. L., Cohen, B. D., Goldston, R. B., Allen, L. A., & Novalany, J. (1993). Perception of self and other in major depression. *Journal of Abnormal Psychology*, *102*, 93-100.

Gaugler, J. E., Pearlin, L. I., Davey, A. & Zarit, S. H. (2000). Modeling Caregiver Adaptation Over Time: The Longitudinal Impact of Behavior Problems. *Psychology and Aging, 15*(3), 437-450.

Gaugler, J. E., Pearlin, L. I., & Zarit, S. H. (2003). The Onset of Dementia Caregiving and Its Longitudinal Implications. *Psychology and Aging, 18*(2), 171–180.

Grelha, P. (2009). *Qualidade de Vida dos Cuidadores Informais de Idosos Dependentes em Contexto Domiciliário: Estudo sobre a influência da educação para a saúde na qualidade de vida*. Tese de Mestrado em Cuidados Paliativos. Faculdade de Medicina de Lisboa.

Haslam, S. A., & Reicher, S. (2006). Stressing the Group: Social Identity and the Unfolding Dynamics of Responses to Stress. *Journal of Applied Psychology, 91*(5), 1037–1052.

Hertzog, A. (1989). Influences of cognitive slowing on age differences in intelligence. *Developmental Psychology, 25*(4), 636-651.

Higgins, E. T. (1987). Self- Discrepancy: A Theory Relating Self and Affect. *Psychological Review, 94*(3), 319-340.

Instituto Nacional de Estatística (2009). *Projecções da População Residente 2008-2060.* Portugal: INE.

Instituto Nacional de Estatística (2011). Censos 2011 – *Resultados Provisórios*. Portugal: INE.

Jetten, J., Branscombe, N. R., Schmitt, M. T., & Spears, R. (2001). Rebels with a cause: Group identification as a response to perceived discrimination from the mainstream. *Personality and Social Psychology Bulletin*, *27*, 1204-1213.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, 31(12), 721-726.

Katz Index, available online:

http://www.trabalhosdeenfermagem.com/2011/02/indice-de-katz.html a 10.12.2012.

Koerner, S. S., Kenyon, D. B., & Shirai, Y. (2009). Caregiving for elder relatives: Which caregivers experience personal benefits/gains? *Archives of Gerontology and Geriatrics, 48,* 238 –245.

Laczko F. & Noden S. (1993) Combining paid work with eldercare: the implications for social policy. *Health and Social Care in the Community 1*(2), 81–89.

Lage, I. (2005). Cuidados familiars a idosos. In: C. Paúl, & A. M. Fonseca (Eds.), *Envelhecer em Portugal*. Lisboa: Climepsi Editores.

Lawton, M. P., Kleban, M. H., Moss, M., Rovine, M., Glicksman, A. (1989). Measuring Caregiving Appraisal. *Journal of Gerontology: Psychological Sciences, 44*(3), 61-71.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lechner V.M. (1993) Support systems and stress reduction among workers caring for dependent parents. *Social Work 38*, 461–469.

Linville, P. W. (1985). Self-complexity and affective extremity: Don't put all your eggs in one cognitive basket. *Social Cognition*, *3*, 94-120.

Lockenhoff, C. E., Duberstein, P. E., & Friedman, B. (2011). Five-Factor Personality Traits and Subjective Health Among Caregivers: The Role of Caregiver Strain and Self-Efficacy. *Psychology and Aging*, *26 (3),* 592–604.

Luhtanen, R., & Crocker, J. (1992). A Collective Self-Esteem Scale: Self-Evaluation of One's Social Identity. *Personality and Social Psychology Bulletin, 18*(3), 302-318.

Majerovitz, D. S. (1995). Role of Family Adaptability in the Psychological Adjustment of Spouse Caregivers to Patients with Dementia. *Psychology and Aging, 10*(3), 447-457.

Markowitz, J. S., Gutterman, E. M., Sadik, K., & Papadopoulos, G. (2003). Health related quality of life for caregivers of patients with Alzheimer disease. *Alzheimer Disease and Associated Disorders, 17*, 209–214.

Marks, S. R. (1977). Multiple roles and role strain: Some notes on human energy, time and commitment. *American Sociological Review*, *42*, 921-936.

Martin, I. (2005). O cuidado informal no âmbito social. In: C. Paúl, & A. M. Fonseca (Eds.), *Envelhecer em Portugal*. Lisboa: Climepsi Editores.

Martin, I., Paúl, C., & Roncon, J. (2000). Estudo de Adaptação e Validação da Escala de Avaliação de Cuidado Informal. *Psicologia, Saúde & Doenças, 1*(1), 3-9.

Martins, T., Ribeiro, J. P., & Garrett, C. (2003). Estudo de Validação do Questionário de Avaliação da Sobrecarga para Cuidadores Informais. *Psicologia, Saúde & Doenças, 4*(1), 131-148.

McArdle, W.D., Katch, F. I., & Katch, V.L. (1998). Fisiologia do exercício, energia, nutrição e desempenho humano. Rio de Janeiro: Guanabara Koogan.

Meleis, A. I., & col. (2000). Experiencing Transitions: An Emerging Middle-Range Theory. *Advanced Nursing Science, 23*, 12-28.

Menaghan, E. G. (1989). Role changes and psychological well-being: Variations in effects by gender and role repertoire. *Social Forces*, *67*, 693-714.

Miller, B., & Cafasso, L. (1992). Gender differences in caregiving: fact or artefact? *The Gerontologist, 32*, 498-507.

Morcy, R. (1993). Caregiving families and cross-cultural perspectives. In: S. H. Zarit, L. I. Pearlin, & K. W. Schaie (Orgs.), *Caregiving systems: informal and formal helpers*. Hillsdale: Erlbaum.

Muenz, R. (2007). Aging and Demographic Change in European Societies: Main Trends and Alternative Policy Options. *SP Discussion Paper*, no. 0703. Social Protection: the world bank.

Neri, A. L., & Carvalho, V. A. M. L. (2002). O bem-estar do cuidador: aspectos psicossociais. In: E. V. Freitas et. al. (Eds.), Tratado de Geriatria e Gerontologia. Rio de Janeiro: Guanabara Koogan.

Neugaard B., Andresen E. A., McKune, S. L., & Jamoom, M.S. (2008). Health-related quality of life in a national sample of caregivers: Findings from the Behavioral Risk Factor Surveillance System. *Journal of Happiness Studies, 9*, 559–575.

Niedenthal, P. M., Setterlund, M. B., & Wherry, M. B. (1992). Possible self-complexity and affective reactions to goal-relevant evaluation. *Journal of Personality and Social Psychology*, *63*, 5-16.

Nijboer, C., Triemstra, M., Tempelaar, R., Sanderman, R., & van den Bos, G. (1999). Determinants of caregiving experiences and mental health of partners of cancer patients. *Cancer, 86*, 577–588.

Olson, D. H. (1991a). Commentary: Three-dimensional (3-D) Circumplex Model and revised scoring of FACES III. *Family Process, 30,* 74-79.

Olson, D. H. (1991b). Family types and response to stress. *Journal of Marriage and the Family, 53,* 786-798.

Paúl, C. (2005). *A construção de um modelo de envelhecimento humano.* In: C. Paúl & A. M. Fonseca (Eds.), *Envelhecer em Portugal*. Lisboa: Climepsi Editores.

Penrod, J. D., Kane, R. A., Kane R. L., & Finch, M. D. (1995). Who care? The size scope and composition of the caregiver support system. *The Gerontologist, 35*(4), 489-497.

Perkins, E. A., & Haley, W. E. (2010). Compound Caregiving: When Lifelong Caregivers Undertake Additional Caregiving Roles. *Rehabilitation Psychology, 55*(4), 409–417.

Perrig-Chiello, P., & Hutchison, S. (2010). Family Caregivers of Elderly Persons: A Differential Perspective on Stressors, Resources, and Well-Being. *GeroPsych, 23*(4)*,* 195–206.

Pinquart, M., & Sörensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. *Psychology and Aging, 18*, 250–267.

Rankin, E. D., Haul, M. W., & Keefover, R. W. (1992). Clinical assessment of family caregivers in dementia. *The Gerontologist, 32,* 813-821.

Robinson B.C. (1983) Validation of a caregiver strain index. *The Gerontologist, 23*(5), 344–348.

Scott, L. D. (2000). Caregiving and care receiving among a technologically dependent heart failure population. *Advance in Nursing Science, 23*(2), 82–97.

Sequeira, C. (2007). O aparecimento de uma perturbação demencial e suas repercussões na família. Tese de Doutoramento, Instituto de Ciências Biomédicas de Abel Salazar da Universidade do Porto, Porto.

Sequeira, C. (2010). *Cuidar de idosos com dependência física e mental*. Porto: Lidel.

Settles, I. H. (2004). When multiple identities interfere: The role of identity centrality. *Personality and Social Psychology Bulletin*, *30*, 487-500.

Shyu, Y. (2000). The needs of family caregivers of frail elders during the transition from hospital to home: a Taiwanese sample. *Journal of Advanced Nursing, 32*(3), 619-625.

Sieber, S. D. (1974). Toward a theory of role accumulation. *American Sociological Review*, *39*, 567-578.

Simon, R. W. (1995). Gender, multiple roles, role meaning, and mental health. *Journal of Health and Social Behavior*, *36*, 182-194.

Smith, G.R., Williamson, G. M., Miller, L. S., & Schulz, R. (2011). Depression and Quality of Informal Care: A Longitudinal Investigation of Caregiving Stressors. *Psychology and Aging, 26* (3), 584–591.

Spar, J. E., & La Rue, A. (2005). Guia Prático Climepsi de Psiquiatria Geriátrica. Lisboa: Climepsi Editores.

Spillman, B. C. & Pezzin, L. E. (2000). Potential and active family caregivers: Changing networks and the ‘‘sandwich generation’’. *Milbank Quarterly, 78*(3), 339–347.

Stephens M.A., Townsend A.L., Martire L.M. & Druley J.A. (2001). Balancing parent care with other roles: interrole conflict of adult daughter caregivers. *Journal of Gerontology Series B-Psychological Sciences & Social Sciences, 56*, 24–34.

Stone R. & Short P.F. (1990). The competing demands of employment and informal caregiving to disabled elders. *Medical Care, 28*(6), 513–526.

Stryker, S., & Serpe, R. T. (1982). Commitment, identity salience, and role behavior. In W. I. E. Knowles (Ed.), *Personality, roles, and social behavior,* 199-218. New York/Berlin: Springer-Verlag.

Tajfel, H. (1981). *Human groups and social categories: studies in social psychology*. Cambridge: Cambridge University Press.

Tajfel, H. (1982). Social psychology of intergroup relations. *Annual Review of Psychology, 33*, 1-39.

Thiede-Call, C., Finch,M. A., Huck, S. M., & Kane, R. A. (1999). Caregiver burden from social exchange perspective: Caring for older people after hospital discharge. *Journal of Marriage and the Family, 61*, 688–699.

Vitaliano, P., Zhang, J., & Scanlan, J. (2003). Is caregiving hazardous to one’s physical health? A meta-analysis. *Psychological Bulletin, 129*, 946–972.

Voydanoff P. (2005) Work demands and work-family and family-work conflict: direct and indirect relationships. *Journal of Family Issues, 26*, 707–726.

Wakabayashi C. & Donato K.M. (2006). Does caregiving increase poverty among women in later life? Evidence from the health and retirement survey. *Journal of Health & Social Behavior, 47*, 258–274.

Wang, Y.-N., Shyu, Y.-I.L., Chen, M.-C. & Yang P.-S. (2011). Reconciling work and family caregiving among adult-child family caregivers of older people with dementia: effects on role strain and depressive symptoms. *Journal of Advanced Nursing, 67*(4), 829–840.

Weuve, J. L., Boult, C., & Morishita, L. (2000). The Effects of Outpatient Geriatric Evaluation and Management on Caregiver Burden. *The Gerontologist*, *40 (4),* 429–436.

Williamson, G. M., & Schulz, R. (1990). Relationship orientation, quality of prior relationship and distress among caregivers of Alzheimer's patients. *Psychology and Aging, 5,* 502-509.

Wilson, M. R., Van Houtven, C. H., Stearns, S. C. & Clipp, S. C. (2007). Depression and Missed Work among Informal Caregivers of Older Individuals with Dementia. *Journal of Family Economics, 28*, 684–698.

Wolf, D. A., Freedman, V., & Soldo, B. J. (1997). The division of family labour: care for elderly parents. *Journal of Gerontology: Social Sciences*, *52*, 102-109.

Woolfolk, R. L., Novalany, J., Gara, M. A., Allen, L. A., & Polino, M. (1995). Self-complexity, self-evaluation, and depression: An examination of form and content within the self-schema. *Journal of Personality and Social Psychology*, *68*, 1108-1120.

World Health Organizaton (WHO). Health Situation in the South-East Asia Region 1998-2000. Available online: http://www.searo.who.int/en/Section1243/Section1382/Section1386/Section1898_9352.htm

Yildirim D. & Aycan Z. (2008). Nurses' work demands and work-family conflict: a questionnaire survey. *International Journal of Nursing Studies, 45*(9), 1366–1378.

Annexes

Annex A

Email requesting the collaboration of the home-care service institutions

---

"Boa tarde,

chamo-me Joana Figueiredo e encontro-me neste momento a frequentar o 2º ano do mestrado em Psicologia Comunitária e Protecção de Menores, no Instituto Superior das Ciências do Trabalho e da Empresa, a realizar a tese final. Pretende-se realizar um estudo com cuidadores informais de idosos dependentes, no sentido de estudar os vários papéis que estes assumem. Desta forma, solicita-se o vosso apoio no sentido de ter acesso a uma amostra de cerca de 100 cuidadores de idosos, beneficiários do vosso SAD. Pretende-se, ainda, que estes cuidadores sejam simultaneamente filhos dos idosos aos quais prestam apoio e que se encontrem a exercer algum tipo de profissão. Caso estejam disponíveis a participar neste estudo, precisamos que nos possam eventualmente fornecer alguns dados dos próprios beneficiários e respectivos cuidadores (avaliação psicológica, grau de dependência, etc.). Caso não haja essa possibilidade, pedimos que seja a vossa instituição a identificar e escolher uma amostra mais homogénea dentro dos critérios existentes.

Para o estudo será utilizado um pequeno questionário, anónimo e confidencial, obtendo também o consentimento informado dos participantes. Pretende-se ainda que o questionário seja respondido através de uma conversa telefónica.

Esperemos que haja disponibilidade da vossa parte em participar neste estudo inovador e essencial neste domínio. Precisamos de uma resposta com a maior brevidade possível, pois gostaríamos de proceder à aplicação dos questionários já na próxima semana (19 de Março).

Esta situação já tinha sido discutida com uma técnica da vossa instituição, pelo que lhe tida enviado um email com estas mesmas informações, contudo a técnica ficou de baixa e não tivemos qualquer resposta entretanto.

Caso seja necessário qualquer outra informação, por favor contacte-me.

Com os melhores cumprimentos,

Joana Figueiredo."

Annex B

Caregiver Identity Inventory

---

1. Age: _____ **2. Gender**: ☐ M ☐ F

3. Status: ☐ Married ☐ Single ☐ Widowed ☐ Living together

4. Education

☐ Can't read/write ☐ Can read/write ☐ Primary School ☐ Middle School
☐ High School ☐ University Degree

5. Work status

☐ Unemployed but informally working ☐ Employed Part-time ☐ Employed Full-time

6. On average, how many hours do you work per week?

☐ Less than 5 hours ☐ 6-10 hours ☐ 11-15 hours ☐ 16-20 hours ☐ 21-25 hours
☐ 26-30 hours ☐ 31-40 hours ☐ More than 41 hours

7. Work Satisfaction Scale (Chambel & Marques-Pinto, 2008).

We would like to know your level of satisfaction with your work life. In general, think of how you feel about your job and answer to which level you agree with the following statements, from **1-** Strongly Disagree to **5**- Strongly Agree.

	SD	**D**	**+/-**	**A**	**SA**
1. I feel very satisfied with my professional life.	1	2	3	4	5
2. I find true satisfaction in my job.	1	2	3	4	5
3. I consider my job to be better than most jobs.	1	2	3	4	5
4. Most days I feel enthusiastic about my professional life.	1	2	3	4	5
5. I rarely feel upset about my job.	1	2	3	4	5

8. **Do you live with the care recipient?**

☐ Yes, in the same household
☐ In different households but same building
☐ Within walking distance
☐ Within 10 mins drive/ bus or train journey
☐ Within 30 mins drive/ bus or train journey
☐ Within 1 hours drive/ bus or train journey
☐ Over 1 hours drive/ bus or train journey

9. **Gender of the care recipient:** ☐ M ☐ F

10. **Age of the care recipient:** _______ years old.

11. **Composition of your household.**

Kinship	Age

12. **Do you care for any other family members?** ☐ Yes ☐ No If yes, who?__________

13. **In which activities do you assist the care recipient?**

☐ Personal higiene (shower, …) ☐ Tasks related to sel-image (dressing, hair, shaving, etc.)

☐ Food/meals ☐ Household chores ☐ Travelling (shopping, medical appointments,etc.)
☐ Others - Ex: ______________________________

14. **How many hours on average, per week, do you assist the care recipient?**

☐ Less than 5 hours ☐ 6-20 hours ☐ 21-30 hours ☐ 31-45 hours ☐ 45-60 hours ☐ Over 61 hours

15. **For how long have you been assisting the care recipient?** _____ months

16. **Do you have informal support from a family member/friend with assisting the care recipient?** ☐ Yes ☐ No If yes, who? ______________________________

17. Subjective Well-Being Scale (Diener, 1995)

We would now like to know how you feel in the present moment.

Considering all aspects of your life, which level of happiness do you feel? Please answer using a scale of 0 to 10.

Extremely unhappy										Extremely happy
00	01	02	03	04	05	06	07	08	09	10

Overall, which is your level of satisfaction with life? You are…

Extremely unsatisfied										Extremely satisfied
00	01	02	03	04	05	06	07	08	09	10

18. Adult Attachment Scale (Cicirelli, 1995).

We would like to know more about your relationship with your mother/father, whom you care for. Please tell us to which level you agree with the following statements: **1**- Strongly disagree, **2**- disagree, **3**- don't agree or disagree, **4**- agree, **5**- strongly agree.

	SD	D	+/-	A	SA
1. Being with my father/mother makes me feel very happy.	1	2	3	4	5
2. At times when I have some trouble or difficulty, my father/ mother's image seems to come to my mind.	1	2	3	4	5
3. If I am unable to see my mother/father for a while, it bothers me a lot.	1	2	3	4	5
4. When I have not seen my father/mother for a while, it makes me happy when I see him/her again.	1	2	3	4	5
5. When I feel alone and anxious, my father//mother is the first person I think of.	1	2	3	4	5
6. When I am with my father/mother, I feel very close to him/her.	1	2	3	4	5
7. I feel a sense of joy to be with my father/mother again after we have been separated for a while.	1	2	3	4	5

8. I feel lonely when I don't see my father/mother often.	1	2	3	4	5
9. When I am with my father/mother, I feel I am with someone I can depend on.	1	2	3	4	5
10. If I am in trouble, the first person I want to talk to is my father/mother.	1	2	3	4	5
11. The thought of losing my father/mother is deeply disturbing to me.	1	2	3	4	5
12. When I have been away from my father/mother for a long time, I feel a sense of security to be with her again.	1	2	3	4	5
13. If I feel depressed, my father/mother is always a source of strength for me.	1	2	3	4	5
14. When I am with my father/mother I feel that I am with someone I can trust completely.	1	2	3	4	5
15. After we have been apart for a time, I feel a sense of relief when I see my father/mother again.	1	2	3	4	5
16. It would be very difficult for me to kove far away from my father/mother.	1	2	3	4	5

19. Importance of Identities (Luhtanen & Crocker, 1992)

In your life you incorporate several roles/identities. For exemple, you're someone's "son/daughter", you're a "worker" and you're also your father/mother's "caregiver". We would like you to focus on these specific roles/identities. Answer to which level you agree with the following statements.

Son/Daughter	**SD**	**D**	**+/-**	**A**	**SA**
1. Being a son/daughter is an important reflection of who I am.	1	2	3	4	5
2. Being a son/daughter is unimportant to my sense of what kind of a person I am.	1	2	3	4	5
3. In general, being a son/daughter is an important part of my self image.	1	2	3	4	5

Caregiver	**AD**	**D**	**+/-**	**A**	**SA**
1. Being a caregiver is an important reflection of who I am.	1	2	3	4	5
2. Being a caregiver is unimportant to my sense of what kind of a person I am.	1	2	3	4	5
3. In general, being a caregiver is an important part of my self image.	1	2	3	4	5

Worker	SD	D	+/-	A	SA
1. Being a worker is an important reflection of who I am.	1	2	3	4	5
2. Being a worker is unimportant to my sense of what kind of a person I am.	1	2	3	4	5
3. In general, being a worker is an important part of my self image.	1	2	3	4	5

20.Identity Harmony (Tompson & Werner, 1997)

Now we would like you to think to which point the tasks of one role/identity (ex: “caregiver”) affect the tasks of another role/identity (ex: “son/daughter” or “worker”) by rating each pair of identities. **1** –one role has a *very harmful* and conflictual effect on the other; **2** –one role has a *somewhat harmful* and conflictual effect on the other; **3** –one role has *no effect* on the other; **4** –one role has a *somewhat facilitative* or helpful effect on the other; **5**-one role has a *very facilitative* or helpful effect on the other.

	Worker	**Son/Daughter**	**Caregiver**
Worker	-------------------		
Son/Daughter		------------	
Caregiver			--------------

21. Self-Discrepancy Related Emotions (Higgins, 1987; Brook et. al., 2008)

There are certain emotions (ex: happiness, joy, fear, sadness) that you may experience as a son/daughter, caregiver and worker. For each of the following statements, we would like you to tell us to which level they describe your current feelings. **1 –** Strongly Disagree**; 5 –** Strongly Agree.

	SD	D	+/-	A	SA
1. I feel guilty.	1	2	3	4	5
2. I feel disgusted with myself.	1	2	3	4	5
3. I feel angry at myself.	1	2	3	4	5
4. I feel annoyed at myself.	1	2	3	4	5
5. I feel self critical.	1	2	3	4	5
6. I feel uneasy with myself.	1	2	3	4	5
7. I feel uncomfortable with myself.	1	2	3	4	5

22. Caregiving Appraisal (Lawton et. al., 1989; Martin, Paúl & Roncon, 2000)

We ask you to tell us to which level you agree with the following sentences related to the tasks, feelings/emotions and attitudes that you may experience as a caregiver: **1 –** Strongly Disagree; **5 –** Strongly Agree.

	SD	**D**	**+/-**	**A**	**SA**
1. Your health has suffered because of the care you must give to your mother/father.	1	2	3	4	5
2. You really like being with your mother/father.	1	2	3	4	5
3. Taking care of your mother/father makes you feel trapped.	1	2	3	4	5
4. You feel that your mother/father shows real appreciation for what you are doing for him/her.	1	2	3	4	5
5. It's difficult to plan ahead when the needs of your mother/father are so unpredictable.	1	2	3	4	5
6. Your mother/father's pleasure in little things gives you pleasure.	1	2	3	4	5
7. Caring for your mother/father makes you feel closer to her/him.	1	2	3	4	5
8. You feel isolated and alone as a result of caring for your mother/father.	1	2	3	4	5
9. Your mother/father frequently affects in a negative way, your relationship with other family members.	1	2	3	4	5
10. Caring for your mother/father does not allow you as much privacy as you would like.	1	2	3	4	5
11. It's uncomfortable to have friends in your home because of your mother/father.	1	2	3	4	5
12. Caring for your mother/father has interfered with the use of space at home.	1	2	3	4	5
13. Taking care of your mother/father has improved your self-esteem.	1	2	3	4	5

Annex C

Table 2 - Correlations between demographic and variables in the study

	1	2	3	4	5	6	7	8	9	10
1.Caregiving Burden	-	-.086	-.115	-.004	.227	.309	.324*	-.465**	.175	-.076
2.Importance of Identities	-.086	-	.127	.328*	.038	-.373*	.160	.254	.280	.032
3.Identity Harmony	-.115	.127	-	.095	-.197	-.142	.089	.062	.393*	-.103
4.Caregiving Satisfaction	-.004	.328*	.095	-	-.113	-.460**	.564**	-.070	.015	-.201
5.Impact of Caregiving	.227	.038	-.197	-.113	-	-.007	-.272	-.182	.064	.339*
6.Emotions	.309	-.373*	-.142	-.460**	-.007	-	-.116	.096	.063	.159
7.Attachment	.324*	.160	.089	.564**	-.272	-.116	-	-.306	.268	-.182
8.Well-Being	-.465**	.254	.062	-.070	-.182	.096	-.306	-	-.107	.137
9.Job Satisfaction	.175	.280	.393*	.015	.064	.063	.268	-.107	-	-.032
10.Age of Care Recipient	-.076	.032	-.103	-.201	.339*	.159	-.182	.137	-.032	-

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

a. Cannot be computed because at least one of the variables is constant.