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Research Article

Male and Female Partner-Caregivers' Burden: Does It Get Worse Over Time?

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Abstract

Background and Objectives: The general view is that partner-caregiver burden increases over time but findings are inconsistent. Moreover, the pathways underlying caregiver burden may differ between men and women. This study examines to what degree and why partner-caregiver burden changes over time. It adopts Pearlin's Caregiver Stress Process Model, as it is expected that higher primary and secondary stressors will increase burden and larger amounts of resources will lower burden. Yet, the impact of stressors and resources may change over time. The wear-and-tear model predicts an increase of burden due to a stronger impact of stressors and lower impact of resources over time. Alternatively, the adaptation model predicts a decrease of burden due to a lower impact of stressors and higher impact of resources over time.

Research Design and Methods: We used 2 observations with a 1-year interval of 279 male and 443 female partner-caregivers, derived from the Netherlands Older Persons and Informal Caregivers Survey Minimum Data Set. We applied multilevel regression analysis, stratified by gender.

Results: Adjusted for all predictors, caregiver burden increased over time for both men and women. For female caregivers, the impact of poor spousal health on burden increased and the impact of fulfillment decreased over time. Among male caregivers, the impact of predictors did not change over time.

Discussion and Implications: The increase of burden over time supports the wear-and-tear model, in particular for women. This study highlights the need for gender-specific interventions that are focused on enabling older partners to be better prepared for long-term partner-care.

Keywords: Informal caregiving, Caregiver stress, Healthcare policy, Spousal care, Gender differences

With increased life expectancy, the risk for long-lasting impairments and multi-morbidity increases. More people are getting old together with their partner and will act as caregivers when the partner experiences health problems. Partner-caregivers run a higher risk of overburdening compared to other types of informal caregivers (Pearlin, Mullan, Semple, & Skaff, 1990; Pinquart & Sörensen, 2003; Wolff & Kasper, 2006); they are often older, co-reside with the care recipient, provide intensive hours of different types of

care, and have a stronger emotional relationship with the care recipient (Pinquart & Sörensen, 2011). Because of the development of long-term care policies prioritizing “aging in place,” many older couples face long-term care situations at home and increased risk for caregiver burden. More insight is needed into how partner-caregiver burden develops over time, and which factors may alleviate burden.

Some longitudinal studies on caregivers report an increase in burden over time, and they attribute this to the

accumulation of the need for care and the resulting erosion of the caregiver's resources and well-being (Gaugler, Kane, Kane, Clay, & Newcomer, 2003; Oldenkamp et al., 2016). Other longitudinal studies, however, report no change or even a lower level of caregiver's burden over time, which is explained as caregivers adapting to the situation and managing the care and care-related problems in other domains more effectively over time (O'Rourke & Tuokko, 2004; Wong & Wallhagen, 2012). These mixed results make it unclear under what conditions an increase or a decrease of burden will appear among partners. We add to current knowledge by using Pearlin's Caregiver Stress Process Model (Pearlin et al., 1990) to identify which factors increase or alleviate caregiver burden over time.

The Caregiver Stress Process Model

We define burden as the caregiver's emotional evaluation of the caregiving situation, which is expressed as the extent to which the caregiver finds it difficult to care for the partner (Montgomery & Borgatta, 1989). The Caregiver Stress Process Model states that stressors in patient's health trigger behavioral and emotional evaluations of the caregiver and specifies how social and psychological resources (e.g., help from others) may impact burden. There are primary and secondary stressors (Pearlin et al., 1990). Both are positively associated with burden. Primary stressors indicate the demands of care, the need factors of the patient. Various kinds of impairments indicate the need for care, such as problems experienced with activities of daily living, lack of psychological well-being, and dementia. The behavioral response to the need for care is the time spent on providing care. Both the need for care and the care provision may contribute to secondary stressors, which are emotional responses, reflecting perceived conflicts with roles and activities outside the caregiving situation (Chappell & Reid, 2002; Savundranayagam & Montgomery, 2010). Caregivers may, for example, feel they have less time and energy for work and their social life as a result of caring for the partner (Zarit, Todd, & Zarit, 1986).

Social and psychological resources may alleviate caregiver burden. Support reduces informal caregiver burden (Roth, Fredman, & Haley, 2015). The support can be instrumental (assistance in caregiving) or emotional (understanding, comforting). Professional assistance may also alleviate caregiver burden by substituting care hours and offering emotional support, although empirical evidence is not convincing in this respect (Verbakel, Metzelthin, & Kempen, 2016). Moreover, caregiving can be evaluated as positive and fulfilling (Broese van Groenou, de Boer, & Iedema, 2013), which serves as a psychological resource that makes the caregiving less burdensome (Beach, Schulz, Yee, & Jackson, 2000; Roth, Fredman, & Haley, 2015).

Hypotheses

Given the mixed evidence on changes in caregiver burden over time, it is likely that for some caregivers the burden

increases whereas for others it decreases. Thus, we first count the number of people for whom the level of burden increases, decreases, and remains stable. On the basis of the Caregiver Stress Process Model, we hypothesize (Hypothesis 1) that a higher level of burden is associated with a higher level of need, more hours of caregiving and larger secondary stressors, and with less care provided by others, lower perceived support, and lower feelings of fulfillment. Thus, a lower level of burden is associated with fewer stressors and more resources.

Yet, there may be two exceptions to this straightforward hypothesis. First, it is possible that caregiver burden increases while there are no significant changes in the level of its predictors. For example, a partner providing the same hours of caregiving over a year may feel more burdened after a while than at the start of the care process. Moreover, help from others may provide less relief over time as it may involve more complexity in coordinating and discussing the care with others. Thus, an increase of burden over time is due to either a larger positive effect of stressors on burden or a smaller positive effect of resources on burden (Hypothesis 2a). This is known as the wear-and-tear model: a long-term or chronic exposure to stressors is more debilitating than a limited or short-term exposure (Townsend, Noelker, Deimling, & Bass, 1989). The second option is that burden decreases over time in an unchanged situation. The caregiver gets used to the situation, gets more grip on the situation, and feels less overwhelmed by it, or help from others may be perceived as more effective and relieving (Gaugler, Davey, Pearlin, & Zarit, 2000). This is known as the adaptation model (Faison, Faria, & Frank, 1999), in which a decrease of burden over time is due to either a smaller positive effect of stressors or a large negative effect of resources on burden (Hypothesis 2b). Both Hypotheses 2a and 2b imply that there is an interaction of time and multiple independent variables in our model of caregiver burden.

Gender Differences

Gender differences in partner-caregiver outcomes are omnipresent: female caregivers feel more burdened than male caregivers (Penning & Wu, 2016; Pinquart & Sörensen, 2006; Polenick & DePasquale, 2018; Yee & Schulz, 2000). Explanations are twofold. First, because of socialization and role expectations, women are expected to provide care for more hours with more severe care tasks than men (Miller & Montgomery, 1990), yet ask for help from others less often (Bédard et al., 2001; Brank & Wylie, 2016). Second, men and women cope differently with the caregiving situation (Calasanti & Bowen, 2006; Chappell, Dujela, & Smith, 2015). Women are more concerned with the enhancement of others' emotional well-being and with the provision of emotional support and are more emotionally involved in caregiving (Beeber & Zimmerman, 2012). Men have a more task-oriented approach to the caregiving situation. They accept their caregiving role as a challenge

and focus on necessary tasks (McDonnell & Ryan, 2013; Robinson, Bottorff, Pesut, Oliffe, & Tomlinson, 2014). This suggests that the level as well as the impact of the predictors on burden develop differently over time for men and women. We, therefore, test the hypotheses separately for men and women.

Methods

Data

The data are derived from the Older Persons and Informal Caregivers Survey Minimum Data Set (TOPICS-MDS), which is a public-access data repository designed to capture essential information on the physical and mental well-being of older persons and their informal caregivers in the Netherlands (Lutonski et al., 2013). Thirty-one Dutch projects collected data among older care recipients from 2008 to 2015; 24 collected data on their primary informal caregiver. Thirty-eight projects included longitudinal data. The 12-month measurement was most complete and will, therefore, be used at follow-up in this study. Projects varied in kind of impairments, study design, sampling frame, and inclusion criteria. All used uniform instruments to measure the physical, psychological, and social health and well-being of older persons and their informal caregivers. More detailed information about TOPICS-MDS and the individual projects can be found elsewhere (www.topics-mds.eu).

Analytical Sample

We used the dataset available in November 2016. We included data with one follow-up measurement ($N = 7,031$). We excluded caregiving pairs with caregivers other than the partner (e.g., a child or friend; $n = 4,032$ at T1 and $n = 147$ at T2). We excluded 335 cases with missing data on the caregiver at T1, and 1,519 couples with no follow-up data on the caregiver. From the remaining couples ($n = 998$), we excluded 21 couples with less than 9-month or more than 15-month interval between T1 and T2, 75 couples with inconsistencies in the data (i.e., age or gender of the respondent did not correspond between T1 and T2), and 34 caregivers whose partner lived in a nursing home. We also excluded 146 couples for whom data on burden at baseline or follow-up was missing. Data of 722 couples (279 male and 443 female partner-caregivers) are analyzed. Mean interval is 384 days; $SD = 46$. For 83 couples, the gender of the caregiver was missing, but there were no missing data on gender of the care recipient. Given the low number of registered same sex couples (1%; Statistics Netherlands, 2016), we assumed all the couples are heterosexual. Additional analyses (data not shown) using the sample without the replacements showed comparable findings. Care recipients were on average 78 years old ($SD = 6.4$; range 54–99) and caregivers were on average 74 years old ($SD = 7.9$; range 38–92).

Measurements of the Caregiver

Caregiver burden

We used the overall, one-item “self-rated burden scale” (Van Exel et al., 2004): “On the scale below, 0 means you now feel that caring for or accompanying your loved one is not hard at all and 100 means you now feel that caring for or accompanying your partner is much too hard. Please indicate with an x on the scale how much of a burden you feel caregiving is at the moment.”

Hours of care given

For the total hours of care given, the caregivers were asked whether in the past week they have had to help with the following, due to their partner’s health problems: (a) activities such as preparing food and drinks, cleaning the house, washing, ironing and dusting, shopping, maintenance work, odd jobs, and gardening; (b) activities such as help with personal care and going to the toilet; and (c) mobility outside the home, taking trips, or organizing help. For each activity, we asked the respondent: “If you engaged in any of these activities, how many hours a week did you spend on them?” We summed the three reports on hours as total hours of care given in the previous week before interview. Because of the skewed distribution, we created five ordinal categories: 0 h (0; 29%); 1–10 h (1; 19%); 11–20 h (2; 19%); 21–40 h (3; 18%); and more than 40 h per week (4; 14%).

Care provided by other informal caregivers or volunteers

A one-item question asked whether, besides the partner, other informal caregivers or volunteers provided help with the three activities in the week before the interview: no (0) or yes (1).

Perceived social support

A one-item question asked whether the caregiver perceived no (0), some (1), or a lot of (2) support from others.

Secondary stressors are derived from the CarerQoL-7D instrument (Lutonski et al., 2015). Caregivers reported whether they had experienced problems for different dimensions of the caregiving situation. The caregivers responded to three statements: I have no (0), some (1), or many (2) relational problems with the care recipient; I have ... financial problems; I have ... problems combining my care tasks with my daily activities because of the caregiving situation.

Fulfillment

A one-item question asked whether the caregiver gained no (0), some (1), or a lot of (2) fulfillment from performing the care tasks.

Gender

We created a dummy for gender, female caregiver (0) and male caregiver (1).

Measurements of the Care Recipient

Primary stressors

Functional disability was measured using a modified version of the Katz Index of Independence in Activities of

Daily Living and Instrumental Activities of Daily Living. Respondents were asked if assistance is required for six basic functions (bathing, dressing, eating, toileting, use of incontinence products, and getting up from a chair) and eight instrumental functions (grooming, use of telephone, traveling, grocery shopping, meal preparation, household tasks, taking medications, and financial management; 0 = no, 1 = yes). The mean item score is computed (reliability KR-20 = 0.86).

Psychological well-being

The RAND-36 mental health subscale (Lutomski et al., 2017) asks how much of the time during the past month the care recipient was very nervous, downhearted and blue, felt down, happy, and peaceful. Answering categories were all of the time (0) to none of the time (6). Item scores on happy and peaceful were reversed, as they were opposite feelings to the other three, and summed (Cronbach's $\alpha = 0.80$), so that a higher score means better psychological well-being. The total score was rescaled to range from 0 to 10.

Dementia

One question asked whether the care recipient was diagnosed with dementia (0 = no, 1 = yes).

Time

We created a dummy for time at T1 (0) and T2 (1).

Projects

As the sample is derived from different projects, we used dummy variables for the *sampling frame* (general population 49%, primary care 26%, hospital 25%) and *study design* (prospective 71%, randomized controlled trial 13%, intervention 9%, or quasi-experimental 7%).

Procedure

Analyses were stratified for male and female caregivers. For psychological well-being of the care recipient at T2 a substantial amount of data were missing (14% for male caregivers and 16% for female caregivers). For all other variables, less than 5% data were missing. The imputation model contained all variables that were used in the analyses, including the outcome variable (Von Hippel, 2007), with 15 iterations to create the dataset. First, we explored for how many respondents caregiver burden decreased (by more than half a standard deviation), changed less than half a standard deviation or increased. Second, differences between means at T1 and T2 were calculated, using *t* tests for continuous variables and chi-square tests for categorical data. Third, multilevel regression analyses of burden, with two observations nested in respondents, were conducted. We checked for multicollinearity and observed no problems (tolerance was 0.70 or higher). Model 1 included time. We controlled for study design and sampling frame. Testing Hypothesis 1, Model 2 also included need factors, hours

of caregiving, secondary stressors, care provided by others, perceived support, and fulfillment. Independent variables are entered as fixed effects. A random effect at the respondent level is included to control for the dependency between observations of the same individuals. To test Hypotheses 2a and 2b, interactions of all variables with time were examined one by one (with all other factors included) to test whether the impact of the predictor changed over time. Table 3 reports main and interaction effects; effects of other factors are not presented. To illustrate effects, we calculate the estimated marginal means of burden. To test whether regression coefficients differed between male and female caregivers, *z* values were calculated: $(B_{\text{female}} - B_{\text{male}}) / \sqrt{(SE_{\text{female}}^2 + SE_{\text{male}}^2)}$; Paternoster, Brame, Mazerolle, & Piquero, 1998).

Results

Descriptives of Male and Female Caregivers

For 17% of the male caregivers burden decreased (mean burden 59–22), for 57% burden remained the same (mean 38), and for 26% burden increased (mean 26–57). There were no differences between the means at T1 and T2 for all measurements of male caregivers (Table 1). They provided an average of about 20 h of care per week, and one quarter of the partners received care from others. The highest secondary stressor for male caregivers was combining the care with other activities. They experienced a high level of fulfillment with the caregiving tasks.

For 16% female caregivers burden decreased (mean 42–32), for 51% burden remained the same (mean 43), and for 32% burden increased (mean 29–64). For women, the mean level of burden increased between T1 and T2 ($t = -4.0$; Table 1), the mean number of physical limitations of their partner increased ($t = -2.4$), and the caregiving intensity per week decreased ($t = 3.9$). The percentage of care recipients receiving care from people other than the partner decreased ($\chi^2 = 5.3$).

Multilevel Regression of Burden on Predictors of Burden

Male caregivers

For male caregivers, average burden did not change over time (Model 1; Table 2). However, when we take into account the need factors, hours of caregiving, secondary stressors, care provided by others, perceived support, and fulfillment (Model 2), burden increased (4.0 points). Additional analyses showed that the increase in burden became apparent when the variable hours of caregiving were added to the model: the intensity of caregiving decreased (although not significantly), whereas burden increased (Table 1). Model 2 also shows the direct effects of the independent variables. A higher level of burden is associated with poor physical functioning of the care recipient, providing more total hours of care, experiencing more problems combining the care, and more financial problems,

Table 1. Descriptives for Male Caregivers and Female Partner-Caregivers at T1 and T2

	Male caregiver (N = 279)			Female caregiver (N = 443)			Male-female	
	T1	T2	T1-T2	T1	T2	T1-T2	T1 _{m-f}	T2 _{m-f}
	Mean	Mean		Mean	Mean			
Burden CG (0-100)	38.11	40.27		41.16	47.64	***		***
Physical functioning CR	5.22	4.96		4.94	5.57	***		**
Dementia CT (0-1)	0.08			0.31			***	***
Psychological well-being CR (0-10)	6.97	7.15		7.28	7.17		**	
Care intensity CG (0-4)	2.1	2.0		1.68	1.31	***	**	***
Relational problems CG (1-3)	1.35	1.35		1.61	1.62		***	***
Problems combining care CG (1-3)	1.41	1.36		1.56	1.55		***	***
Financial problems CG (1-3)	1.13	1.12		1.12	1.13			
Care by others CG (0-1)	0.30	0.23		0.17	0.12	***	*	***
Support from others CG (1-3)	1.55	1.57		1.69	1.71		***	*
Fulfillment CG (1-3)	2.49	2.56		2.44	2.35			***
Sampling frame (0-1):								
Primary care	0.42			0.26				
General population	0.22			0.49				
Hospital	0.36			0.25				
Study design (0-1):								
Prospective	0.55			0.71				
RCT	0.23			0.14				
Intervention	0.13			0.09				
Quasi-experimental	0.09			0.07				

Notes: Chi-square and *t* tests. CR = care recipient and CG = caregiver.

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

when others also provided care, and less fulfillment was experienced.

Female caregivers

For female caregivers, burden increased 6.5 points when unadjusted for the other variables (Model 1; Table 2). Adjusted, burden increased 7.3 points (Model 2). Having a partner with lower physical functioning, giving more hours of care, experiencing more relational problems, and more problems with combining the care with other activities are associated with higher burden. Similar to male caregivers and in contrast to Hypothesis 1, more care provided by others increased burden.

Differences between men and women

Differences between the models for men and women are found for the association of three predictors on burden (Table 2). The impact of physical functioning on burden is higher for male caregivers compared with female caregivers (*B* = 1.4 vs 0.6; *z* = -2.5). The impact of relational problems on burden is small for male caregivers compared with female caregivers (*B* = 1.9 vs 6.1; *z* = 2.0). Fulfillment lowered burden for male caregivers but not for female caregivers (*B* = -5.3 vs 0.1; *z* = 2.8).

Changes in Impact of Predictors

Among male caregivers, all predictors have a similar impact over time (Table 3 presents interactions with time).

For female caregivers, the impact of having a partner with dementia, problems with combining caregiving activities with other activities, and feelings of fulfillment on burden differed between the observations over 1 year. For example, the estimated marginal means of burden of female caregivers with a partner with dementia increased from 44 at T1 to 61 at T2, and among females with partners without dementia from 47 to 50. The impact of having problems combining care with other activities decreased over time. Females experiencing problems with combining the care with other activities (at T1 and T2) had higher burden at T1 and this burden remained high at T2 (60 points on the burden scale), whereas those who did not experience problems combining the care with other activities (at T1 and T2) had lower burden at T1 then showed an increase in burden at T2 (from 32 to 50 points). The protective effect of feeling fulfillment with the caregiving tasks decreased. Those who felt fulfillment (at T1 and T2) had lower burden at T1 but increased burden at T2 (from 39 to 48 points), whereas those who did not feel fulfillment (at T1 and T2) started with higher burden at T1 and their level of burden remained the same at T2 (47 points).

Discussion and Implications

We studied changes in burden in a 1-year interval among caregiving older partners, separately for men and women. We examined to what extent these changes in burden were

Table 2. Multilevel Regression Analysis of Burden of Male Caregivers (558 Observations from 279 Respondents) and Female Caregivers (886 Observations from 443 Respondents)

	Male caregiver						Female caregiver						Z_{m-f}
	Model 1			Model 2			Model 1			Model 2			
	<i>B</i>	<i>SE</i>		<i>B</i>	<i>SE</i>		<i>B</i>	<i>SE</i>		<i>B</i>	<i>SE</i>		
Intercept	42.0	3.3	***	4.1	7.0		37.3	2.1	***	1.7	5.6		
Time	2.4	1.7		4.0	1.4	**	6.5	1.2	***	7.3	1.2	***	
Physical functioning				1.4	0.3	***				0.6	0.2	**	***
Dementia				4.5	4.3					3.8	2.6		
Psychological well-being				0.2	0.5					−0.9	0.4	*	
Care intensity				4.1	0.9	***				3.5	0.5	***	
Relational problems				1.9	1.8					6.1	1.1	***	***
Problems combining care				13.5	1.7	***				12.0	1.2	***	
Financial problems				6.7	2.9	*				2.8	2.0		
Care by others				2.6	1.3	*				2.1	1.0	*	
Support from others				−0.8	2.4					1.0	1.9		
Fulfillment				−5.3	1.4	***				0.1	1.1		***
Sampling frame													
Primary care (reference)													
General population	2.6	5.4		−0.1	4.3		14.2	2.6	***	6.4	2.7	*	
Hospital	−3.1	3.9		−1.7	2.8		−6.3	2.7	**	−4.0	2.1		
Study design													
Prospective (reference)													
RCT	−2.0	3.9		−2.1	3.0		8.1	3.2	**	1.7	2.5		
Intervention	−10.0	4.9	*	−4.6	3.6		−0.1	3.1		−1.4	2.9		
Quasi-experimental	−15.9	5.1	**	−13.7	3.8	***	1.1	4.1		−4.0	3.1		

Note: Results of the pooled sample after multiple imputation.

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

Table 3. Multilevel Regression Analysis of Burden of Male Caregivers (558 Observations From 279 Respondents) and Female Caregivers (886 Observations From 443 Respondents): Main and Interactions Effects of Predictors and Time From 10 Models

	Male caregiver				Female caregiver			
	Main effects	Time	Interaction	$p_{\text{interaction}}$	Main effects	Time	Interaction	$p_{\text{interaction}}$
Physical functioning	1.18	2.05	0.38		0.59	7.96	−0.09	
Dementia	0.58	3.40	9.20		−2.54	3.12	14.03	***
Psychological well-being	0.18	4.37	−0.05		−1.65	−1.65	1.54	*
Care intensity	3.91	3.22	0.38		3.99	8.99	−1.15	
Relational problems	2.39	5.40	−1.02		6.76	9.36	−1.31	
Problems combining care	13.69	4.55	−0.48		14.03	13.75	−4.20	*
Financial problems	7.37	5.52	−1.35		3.81	9.56	−2.03	
Care by others	−1.70	4.36	1.91		−0.36	6.75	3.29	
Support from others	1.38	0.52	2.24		0.62	2.26	3.01	
Fulfillment	−5.11	3.54	−0.53	0.83	−2.07	−2.05	3.88	*

Note: Main effects adjusted for the other predictors (Table 2).

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

explained by either the level of predictors or the impact of predictors. On average, older partner-caregivers' burden increases over time, in particular when adjusted for all predictors of burden. The average increase was estimated to be 4.0 points for male caregivers and 7.3 points for female caregivers, on a scale from 1 to 100. This average change is

rather low, reflecting the fact that about half of the sample remained stable in their level of burden. As a larger proportion of women than men report an increase in burden, and their increase is larger in points, our findings corroborate that spousal care is more burdensome for women than it is for men.

Hypothesis 1 was supported by our observation, we observed that greater need for care, a higher intensity of caregiving, and more secondary stressors were associated with higher burden. Moreover, the model showed a direct and independent effect of time on caregiver burden, which supports the wear-and-tear model. In other words, burden increases, next to how the caregiver process evolves. Further support for the wear-and-tear model was that the impact of care recipients' health (poor well-being and having dementia) on burden was stronger at T2 than at T1, whereas the impact of fulfillment was weaker at T2 than at T1 (Hypothesis 2a), yet only for female caregivers. For female caregivers having a partner with dementia had a greater impact over time. This corresponds with results from research showing dementia care is the most burdensome (Schulz & Martire, 2004; Van der Lee, Bakker, Duivenvoorden, & Dröes, 2014). Only one finding supported the adaptation model (Hypothesis 2b): the impact of combining care with other activities (a secondary stressor) on burden decreased for female caregivers. We can conclude that there is more support for the wear-and-tear model than for the adaptation model.

Of the three types of resources, only fulfillment showed the expected negative association with caregiver burden, albeit only for men. For women, the association between fulfillment and burden weakened over time, suggesting that fulfillment does not help female caregivers cope with the burden of caregiving. Other studies showed that positive evaluations of caregiving (as fulfillment) are strongly related to individual motivations and attitudes regarding caregiving, which, in turn, are not strongly related to caregiver burden (Broese van Groenou et al., 2013). This suggests that it is more an outcome of caregiving than a resource (Kramer, 1997). More insight is needed into how positive evaluations affect caregiver burden and to what degree this differs by gender.

Being supported by others was not associated with lower burden, whereas care provided by others was associated with increased burden. The latter suggests that care by people other than the partner is called on in severe care conditions when burden is already high (Verbakel et al., 2016). This may also indicate that, despite the fact that professionals are supposed to address the needs of informal caregivers, they are still more focused on the patient and less on the support needs and well-being of the spousal caregiver (Wittenberg, Kwekkeboom, Staaks, Verhoeff, & de Boer, 2018). It is not the mere presence of other helpers that serves as a resource in the caregiver process; it is more who is present, how they meet the needs of the spousal caregiver, and how the spousal caregiver stays in control of the caregiving process. The findings of this article thus stress the impact of national policies on family caregiving patterns and practices. One of the possible consequences of the "aging in place" policy is that the caregiving process becomes more complex as more helpers are involved. A recent study showed that an unclear division

of responsibilities between formal and informal caregivers may lead to higher stress levels (Wittenberg et al., 2018). This calls for more information regarding which structural and functional features of the care network (Carpentier & Ducharme, 2003) may reduce the burden of (spousal) caregivers.

This study has some limitations. First, we assumed that the two measurement points are representative for various phases in the process of caregiving. However, the process may not develop linearly; burden can also develop exponential or irregularly. Second, no information is present about the duration of caregiving. For some couples the care process may have just begun, whereas others may have been providing care for many years. Third, the period of 1 year is perhaps too short to notice changes. This may have underestimated the effect of time in the analyses, in particular the interaction analyses. Both wear-and-tear and adaptation processes in caregiving may take more time to affect caregiver burden. Fourth, this study assumed all couples to be heterosexual. It is not said that the same gender differences would be found in LHBT couples. For these reasons, future research should include more observations over a longer time period (to observe whether the development is linear), preferably following the care process from the onset of caregiving (to disentangle different stages of caregiving) and distinguish between LHBT couples. Finally, findings in our study do not show an impact of financial stress on caregiver burden, which is in contrast with a study in the United States (Bouldin, Shaull, Andresen, Edwards, & McGuire, 2018). This suggests that financial stressors may be context based as there are several possibilities to lower financial costs in the Netherlands (e.g., tax reduction when costs are made for transportation) that may not be present in the United States. Also, a European study showed that financial help did not reduce caregivers strain (Calvo-Perxas et al., 2018), but this may differ in the United States as well. More insight in how stressors and support in the financial domain may impact caregiver burden in various national contexts remains a topic for further study.

We included partners with 0 h of caregiving because the care recipient identified them as being the primary informal caregiver. It could be that they provided care for less than a half an hour, or did not perform those tasks in the past week, or conducted other types of tasks not reported in this study. People with an ill partner may feel burdened even if they are not providing care; this is referred to as "noncaregiver stress" (Amirkhanyan & Wolf, 2006). A focus merely on active partner-caregivers leads to an underestimation of burden among spouses of care recipients.

Because partner-caregiver burden increases over time, it is necessary to develop interventions for partner-caregivers that take into account the particularities of the care situation (Roth, Fredman, & Haley, 2015). Etters, Goodall, and Harrison (2008) reported that multi-component interventions, including a diversity of services to facilitate the

caregiving (e.g., education, support and respite care), help to reduce the burden of caregivers. Our findings suggest that women in particular may benefit from interventions that help them deal emotionally with the consequences of caregiving, whereas men may benefit from reducing the burden of care related to severe physical impairment. Furthermore, feelings of fulfillment may reduce the negative impact of caregiving. Positive appreciation of partner-caregiving improves this feeling of fulfillment, sustaining the well-being of partner-caregivers.

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Conflict of Interest

None reported.

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