

Ranked motives of long-term care providing family caregivers

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Scand J Caring Sci; 2008; 22; 29–39

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Family caregivers provide long-term care to their chronically ill loved ones and as a consequence they experience physical, relational and financial problems. This study investigates how long-term family caregivers rank 12 motives for caregiving. Motives are derived from the views of four philosophical anthropologists and are related to self-reported stress and joy and to several different background characteristics of respondents. Motives that focus on feelings concerning the relationship between caregiver and care recipient are more popular as a first choice than motives stemming from feelings of obligation or a general

feeling of happiness and are also more popular than more self-directed motives. An analysis of full ranking data shows that two groups can be distinguished, one group of family caregivers with mixed motives and one group of family caregivers with motives that focus on reciprocal mutually equal relationships. The latter are mainly women taking care for a partner or a child, the former report high levels of stress. Implications for intervention programmes and health policy are being discussed.

Keywords: family care, motives, long-term care, philosophical anthropology.

Submitted 13 July 2006, Accepted 2 May 2007

Introduction

Increasingly, family caregivers are expected to provide care to their loved ones when they are chronically ill or handicapped. McNally et al. (1) attribute this to the trend towards reducing healthcare expenditure seen in most Western countries since the 1990s and to the changes of attitudes towards caregiving, implying that providing care more and more is seen as a private matter. Family caregivers thus are allotted an important role in a good functioning of the healthcare system and, as a consequence, the pressure on them is huge. They have physical problems, relational problems and problems with respect to their social life and their personal happiness, and problems with respect to finances and housing (2). Despite this, many people provide care for their loved ones not just temporarily, but often for many years and intensively. But what motivates these long-term family caregivers and how much stress and/or joy do they experience when providing care? In the present study, we asked long-term family

caregivers to rank 12 motives for caregiving as to how important these motives are for them and we related these rankings to several characteristics of the respondents.

Motives of family caregivers

Several studies have been done into the motives of long-term family caregivers (3–6). These studies have three shortcomings which we try to overcome in the study we discuss here. First, almost all of these studies show that family caregivers have more than just one motive for providing care, but none of the studies investigates the relative weight of the different motives for individual caregivers. Second, most of the motives discussed in these studies are singular. That is, they either concern the caregiver as a person or the care recipient in his or her situation or with his or her characteristics. Few items on the motivation scales used in the studies are directed at the family as a system. They do not deal with the complex relationship between caregiver and care recipient as an important and meaningful constituent of the life of both. Third, none of the studies mentioned above study the joy that giving care to a loved one can yield. Let us elaborate on the three points mentioned above.

Cicirelli (3) studied the relation between motive daughters have for providing intensive and long-term care to their

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mothers and the perceived burden or stress of these daughters. He found that filial obligation increases the sense of burden whereas filial attachment decreases it and that both motives are important for daughters' provision of help. Cicirelli argued for considering at least two motives and perhaps multiple motives in further studies on this subject.

Walker et al. (6) studied the relationship between quality and motives for caregiving in daughters who provide care to their mothers. They distinguished discretionary motives, that is, the helping person's own wish to help, vs. obligatory motives: the helping person's feeling of being obliged to help. They found that the vast majority of 174 elderly dependent mothers and their caregiving daughters believed daughters provided care primarily for discretionary reasons. Mothers who reported low discretionary motives of their daughters also reported lower intimacy in their relationships and perceived that they had received care for more years than mothers who reported highly discretionary motives of their daughters. Yet, about 25% of the daughters and 11% of the mothers reported both motives either to be highly valid or to be lowly valid.

Feeney and Collins (4) identified and examined the correlates of specific motivations for caregiving in romantic couples to predict caregiving behaviour and relationship functioning. They found a number of distinct motivations for providing care to their partners. Although their target group was very different from ours, the scale they used to measure motives is relevant. Their scale contained seven motives for caregiving. All of these motives were defined in terms of either the perspective of the helping person (e.g. I enjoy helping people solve their problems, I am pretty good at handling stress) or the perspective of the help receiving person as conceived by the helping person (I want my partner to be happy, My partner really needs my help).

Smith et al. (5) used the motivation-to-help theory of Batson (7) to develop a scale with four types of motives (reward seeking, punishment avoidance, distress reaction motive and altruistic motive). Three of Batson's four types of motives (reward seeking, altruism, and punishment avoidance) were extracted during factor analysis. The scale items representing Batson's fourth type of motive, distress reaction, were not retained because of cross loading. So, Smith et al. found that their scale measures three of four theoretically derived motivations for helping another. Also the motives of Smith et al. were defined either from the perspective of the caregiver (e.g. she wants to gain financial, social or psychological benefits; she wants to avoid social disapproval or feelings of guilt) or from the perspective of the patient as perceived by the caregiver (e.g. the caregiver wants to help such that the needs of the patient are met).

Philosophy and motives for caregiving

Thus, as we have indicated above, the motives for caregiving in all of these studies are directed at the needs and

wants of the individual caregiver or the individual care recipient. In our study, more than half of the motives focus primarily on the relationship between caregiver and care recipient. Motives are derived from three philosophical anthropologists, namely, Buber, Levinas and Ricoeur, and from a family therapist who works in the tradition of Buber, namely, Boszormenyi-Nagy. We chose for these four for two reasons. First, because they explicitly or more implicitly discuss why people care for each other starting from the relationship between humans as the major constituent of human happiness. Second, because they view caring not only as a possible source of stress and burden but, rather, as a source of joy and personal fulfillment. We will very briefly describe their views (see also 8).

The view of the philosopher Buber (9, 10) implies that people care for each other out of an inborn desire to live in relationships with other people, and that people care for each other to be really human and live a meaningful life. In mutual and reciprocal relations with other persons, individuals find a way to live a meaningful life and be really human. Boszormenyi-Nagy (11, 12), a family therapist with philosophical views derived from Buber, thinks we care for each other in families because of the loyalty that developed from the irrevocable blood tie and/or from what people in a family relationship have done for each other in a mutual past. In Levinas' view we care for each other because the existence of the other calls us to responsibility and thus also to caring, and we care for each other because this makes it possible for us to become detached from ourselves and live in the world with others. Levinas (13, 14) sees the relationship between human beings as rather detached and altruistic. The philosopher Ricoeur (15, 16) thinks that we care for each other because there has been given to us and caring is a way to do something in return. And he thinks we care for each other because this enables us to develop a balance between being like others and being unlike others, based on respect for myself and respect for others. The caring relationship is a direct consequence of the given life, the will to lead a good life, and the understanding that the caregiver, in other circumstances, could have been the care needing patient.

These four philosophers, different as they are, all place the incentive of people to care for their loved ones in a relational perspective of reciprocity and mutuality or in a perspective of living a meaningful life. From their views we developed 12 motives for caregiving (see the Methods section). Table 1 contains for each of the four philosophers the core of motivation for caregiving as they view it.

Thus, we investigated how long-term family caregivers rank motives for providing care. We looked at the relative importance of the different motivational orientations to caregiving by asking participants to rank the 12 items. We then tried to identify subgroups among the respondents and their rankings, using latent class analysis. Finally, we looked at the relation between motivations for caregiving

Table 1 Core of motivation for caregiving viewed by the four philosophers

Views of:	Motives for caregiving:
Boszormenyi-Nagy	Obligation, loyalty
Buber	Desire to live in relationships, meaningful life
Levinas	Responsibility, altruism
Ricoeur	Reciprocity, morality

and perceived joy and stress and several background characteristics.

Methods

Participants and procedure

To find participants for this study, we used the file of an organization for family caregivers of the largest province in the Netherlands. This organization gives information and practical as well as emotional support to a large number of family caregivers in cooperation with the local government and with welfare and health organizations. Our study was approved by the ethical review board of this organization. All members of our file provided family care in the sense that they were giving intensive and long-term care; that this care springs from the social link between the patient and the family caregiver; and that this care is not coming from an organized setting and is not provided within the framework of professional social care (17).

The file of the organization contained addresses of 1236 family caregivers. All of them received a questionnaire by mail which they could fill in anonymously. We received 240 filled-in questionnaires, 236 of which were usable. This is a response of nearly 20%. Baruch (18) replicated earlier findings that response rates of mailed questionnaires are lower than those of questionnaires distributed by the researcher or others, response rates being around 20%. He also referred to research which found the main reason for not responding to be 'too busy'. Given the fact that our respondents are giving intensive care, often next to multiple other tasks, the response is appropriate. Table 2 gives some background information about the respondents.

We did two pilot studies before the definitive questionnaire was developed. Two different groups of 15 family caregivers filled in preliminary versions of the questionnaire and afterwards the first author discussed it with them. The questionnaire was thereupon adjusted. The main alterations implied abbreviating the formulations of the motives and making them less abstract. During the pilots, we also explicitly asked the respondents whether they had any difficulties ordering the 12 motives. None of them reported any difficulties.

After the two pilot studies, the questionnaire was adjusted and sent to our respondents. They could fill in the

Table 2 Descriptive statistics of respondents

Variable	Percentage
Gender (ref. = men)	77
Age	
15–34	3
35–44	6
44–54	21
55–64	28
65–74	27
≥75	15
Care recipient	
Partner	47
Parent	22
Child	18
Other family member	8
Nonfamilial relation	5
Duration of caring	
0–12 months	1
1–3 years	11
3–5 years	21
5–10 years	24
> 10 years	43
Income (monthly)	
0–1000 Euro	19
1000–2000 Euro	60
>2000 Euro	21
Total	100 (n = 236)

questionnaire anonymously, at home, and send it back to us in a stamped envelope they had received from us. They were not paid for filling in the questionnaire.

Measures

We randomized the 12 motives with the computer program SPSS 11.5 (SPSS Inc., Chicago, IL, USA) and put them in the questionnaire (see Appendix 1). We indicated them not with numbers but with letters (motive A, motive B, etc.). Respondents were asked to order the 12 motives, putting the one that applied most to them at the first place and putting the one that applied least to them at the last place.

We also asked family caregivers to indicate the amount of stress they perceived when providing care. Cicirelli (3), mentioned above, measured perceived burden in terms of the extent to which caregiving interfered with other parts of the caregivers life (e.g. job, relationship with spouse) and with her physical and mental health. Dwyer et al. (19) measured perceived stress by asking respondents to give stress points for all of the things together, done by the caregiver for the care recipient, starting from the assumption that 'bathing the care recipient' counted for 100 stress points. They measured perceived burden by presenting nine problems a caregiver could experience as a result of caregiving (e.g. the care recipient embarrasses the

caregiver, or is uncooperative) and asked caregivers whether or not they experienced each of these problems. They then counted the amount of positive responses. We developed an instrument for measuring stress that more than Cicirelli's was directly related to the providing of care. Moreover, in contrast to Dwyer et al. we focused on care tasks in general without *a priori* labelling them as problems and we gave respondents a brief overview of the different care tasks to help them better assess their amount of perceived stress. We used the same instrument to measure perceived joy. Perceived joy in caregiving seldom has been studied, probably because joy is not a problem. Here, we followed our philosophers, who point to the positive feelings caring can yield.

As the pilot studies showed that family caregivers – almost by definition an overextended group – were reluctant to fill in questionnaires, we looked for a brief instrument to measure perceived stress. Marcera et al. (20) developed a brief instrument for measuring perceived burden of family caregivers. They used 15 items referring to the different care tasks caregivers perform. To make the instrument still more comprehensible for the respondents, we ordered Marcera's items into four groups (i.e. practical matters, domestic help, personal care and personal support) and asked respondents to indicate how much stress they perceived when performing each group of care tasks and how much joy they perceived when performing each group of care tasks. We used three-point rating scales (i.e. much stress, little stress, no stress and much joy, little joy, no joy respectively). We labelled our measures of stress and joy as 'self-reported stress of caring' and 'self-reported joy of caring'. When we refer to stress or joy in the following paragraphs, we refer to the measures labelled as such.

First, we submitted these items to exploratory principal component analysis. A Varimax rotated solution clearly indicated two dimensions, with one dimension indicating the degree of experienced stress and one dimension indicating the degree of experienced joy. Subsequently, we checked the statistical reliability of the resulting scales by calculating Cronbach's alpha coefficients. This analysis showed that alpha for both scales would be maximized if we omitted one item in each dimension. For the three items used to measure experienced stress, internal consistency was 0.56 and for the three items used to measure experienced joy, internal consistency was 0.70. We note, of course, that because of the limited reliability of our measure of experienced stress, correlations with other variables maybe attenuated. Both scales are indexes based on the mean score of item ratings. For convenience of interpretation we recoded item scores so that higher scores on both scales indicated higher levels of stress and joy (mean of scale for self-reported stress = 1.629, SD = 0.574; mean of scale for self-reported joy = 2.087, SD = 0.584). Thus, the respondents reported both stress and joy, but they reported somewhat more joy than stress.

Statistical models for ranking data

This study investigated how long-term family caregivers ranked 12 motives of providing care. We looked at their first choice and at their full ranking, and we identified subgroups among the respondents and their rankings. In other words: do our respondents belong to one cluster of individuals with the same pattern of preferences of motives or can we identify different clusters with different patterns of preferences of motives? A cluster or a class is a group of persons who share similar interests, values, characteristics or behaviour (21). Both terms are used in the following paragraphs.

To answer this question we used statistical approaches for ranking data because the respondents ranked all 12 motives. This means that respondents' choices were not made independently of each other; each choice respondents made was limited by their earlier choices and limited their further choices. Most statistical methods, however, are based on the assumption of independent observations. We used statistical approaches that incorporate the dependencies just mentioned. We used two approaches to construct models for describing the response patterns of motives for caregiving, namely, the latent class conditional logit approach and the latent class sequential logit approach (21). The first approach provides model-based estimates of the probability that a particular first choice will be made from a range of alternatives. In the second type of approach we used the full ranking information, that is, we looked at all 12 choices respondents made simultaneously. Both approaches lead to the construction of different models, each model identifying one or more latent classes (i.e. clusters) within the population of family caregivers. The models which we estimated are special types of logistic regression models. Thereupon, a combination of statistical and theoretical consideration leads to one preferred model for the first choices, and one preferred model for all 12 choices.

Our analysis was mainly exploratory. This means that we *a priori* calculated three latent class conditional models for estimating the probability that a particular first choice will be made out of the 12 motives and the three latent class sequential models for estimating the probability for a certain choice pattern of all 12 motives. Within these models we distinguished one, two, and three clusters of respondents with different choice patterns. All models were estimated with the Choice-Module of the software program Latent Gold 4.0 (21). Thereupon, we chose the model which showed the least deviations from our empirical data based on Aikake's Information Criterion (AIC) and the Bayesian Information Criterion (BIC). The latter are well-known measures for model selection from different statistical models. Rule of thumb is that the model with the lowest AIC or BIC should be chosen (22). Finally, we analysed whether belonging to a particular cluster with

Table 3 Model fit statistics of latent class conditional logit approaches (about first choices, models 1–3) and of latent class sequential logit approaches (about all 12 choices, models 4–7)

		BIC (LL)	AIC (LL)
Model 1	1-class choice	899	889
Model 2	2-class choice	920	897
Model 3	3-class choice	941	905
Model 4	1-class ranking	7655	7645
Model 5	2-class ranking	7661	7638
Model 6	3-class ranking	7682	7646
Model 7	2-class ranking with covariates	6837	6765

AIC, Akaike’s Information Criterion; BIC, Bayesian Information Criterion; ‘LL’, Log-Likelihood.

respect to motives for caregiving was related to particular characteristics of family caregivers.

Table 3 shows the results of the model estimations. Models 1, 2 and 3 give the results of the analysis of the first choices whereas models 4, 5 and 6 relate to the results of the analysis of the full ranking data. Model 7 shows a new analysis of model 5, namely, with respect to the relation between belonging to a particular cluster and stress and joy indications, gender, age and household income of the caregiver, nature of relationship of caregiver to care recipient, and duration of care provided. Model 7 is a two-class model, which means that within the total group of family caregivers two subgroups (clusters or classes) could be distinguished, each with their own preference pattern of motives. Such a two-class model pictured better the heterogeneity within our group of respondents than a one-class model, like model 4.

According to the BIC and the AIC, model 1 had the best fit for the analysis of the first choices, as these values were lowest for model 1. For the analysis of the full ranking data we found two models with the best fit: model 4 (according to the BIC) and model 5 (according to the AIC). Therefore, we will discuss the results in terms of both models. Our discussion of the results proceeds in three steps. We start with the results of the analysis for the first choice of respondents based on model 1 (step 1); subsequently, we will discuss the results of model 4 and model 5, for the full ranking data (step 2). We finish with the relation between choice patterns on the one hand and stress and joy indications and background characteristics of respondents on the other hand, based on model 7 (step 3).

Results

Step 1: analysis of first choices of motives for caregiving

Figure 1a shows the predicted probabilities for each of the 12 motives to be chosen as the first choice. Based on model 1, we may assume that this pattern of choice preference

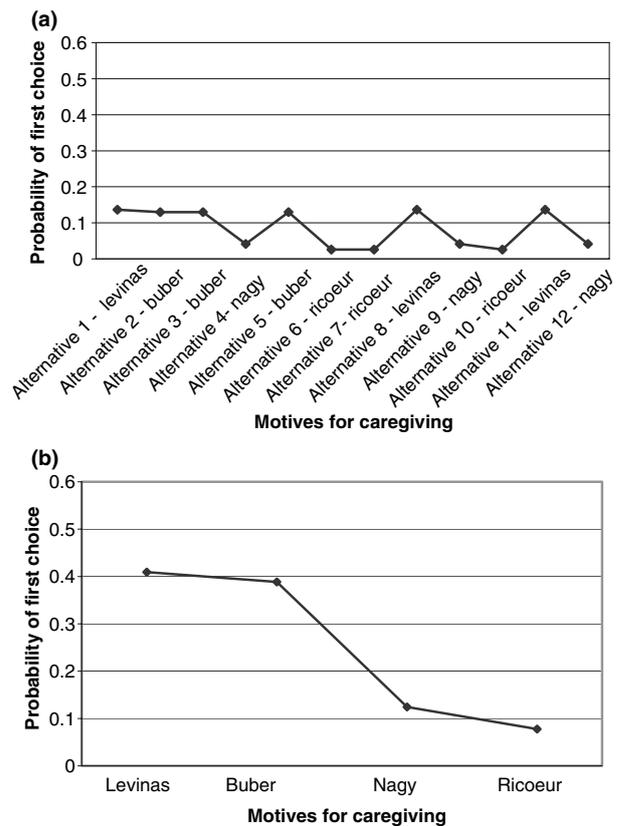


Figure 1 (a) Probability of first choice of caregiving alternatives – results from one-cluster conditional logit model (model 1). (b) Probability of first choice of motives for caregiving alternatives grouped according to philosophical ideas – results from one-cluster conditional logit model (model 1).

holds for the entire population under study. Although the predicted probability of a particular alternative to be chosen as the first choice is low for all 12 alternatives, it is also clear that not all alternatives have the same probability of being chosen as the first choice. In particular, alternatives 1, 2, 3, 5, 8 and 11 have a higher probability of being chosen as the first choice than the other alternatives. These six alternatives belong to the views of Levinas (alternative 1, 8 and 11) and Buber (alternative 2, 3 and 5).

Figure 1b shows this pattern more clearly. Here, the alternatives are grouped with respect to the philosophers they are derived from. Then, for each grouping the predicted probability that a particular motive for caregiving – based on a particular philosopher – is chosen first is estimated. We now see more clearly that, on average, respondents are most likely to choose Levinas motives as a first choice, followed by Buber motives as a first choice. Nagy motives and Ricoeur motives are relatively less popular in the population of family caregivers. We performed a Wald test (21), which tests the null hypothesis that first choice preferences between the four groupings of caregiving motives are equal. The results indicated that this

hypothesis should be rejected ($p < 0.001$). Thus, caregivers clearly differ with respect to the first choice of motives for caregiving.

Step 2: analysis of the full ranking of motives for caregiving

Next, we investigated which alternatives are ranked highest when prior choices of alternatives are excluded during the full sequence of ordering the alternatives. Thus, a second choice is considered to be a first choice from the set of alternatives that excludes the first choice, and so on for the third, fourth and additional choices. Figure 2 presents the results of the analysis of these full rankings of motives by respondents, both in the one-class model (based on the results of model 4) and in a two-class model (based on the results of model 5). We first present the full ranking analysis of the separate alternatives (left-hand side figures) and the full ranking analysis with groupings according to philosophical ideas (right-hand side figures).

From the one-class model (model 4) for the analysis of the separate alternatives in the upper left side of Fig. 2, we infer that alternatives 2, 3 and 5 (which are the Buber motives) have a somewhat higher predicted probability of

being ranked highest. In the one-class model where we grouped the alternatives according to philosophical ideas, the Buber motives also have a somewhat higher probability of being ranked highest. A Wald-test (*ibidem*) shows this difference between groups of motives to be significant ($p < 0.001$).

These results indicate that there may be a separate group within the population with a preference for Buber motives. The results of model 5, which assumes that the population of family caregivers consists of two clusters, confirm this. We present the results of this model in the lower half of Fig. 2. In the left lower part of Fig. 2 we distinguish between a class which more strongly prefers Buber motives and a class which has no particular preference (a 'mixed' cluster, note that this class has a somewhat elevated probability of ranking Levinas alternatives highest). In particular, we see that Buber motives by individuals from class 2 are relatively more often ranked highest than the other alternatives. In the right lower part of Fig. 2 we see that class 2 has a somewhat lower predicted probability to rank Levinas motives highest, a clearly higher predicted probability to rank Buber motives highest (i.e. a probability of 0.53), about the same probability as individuals

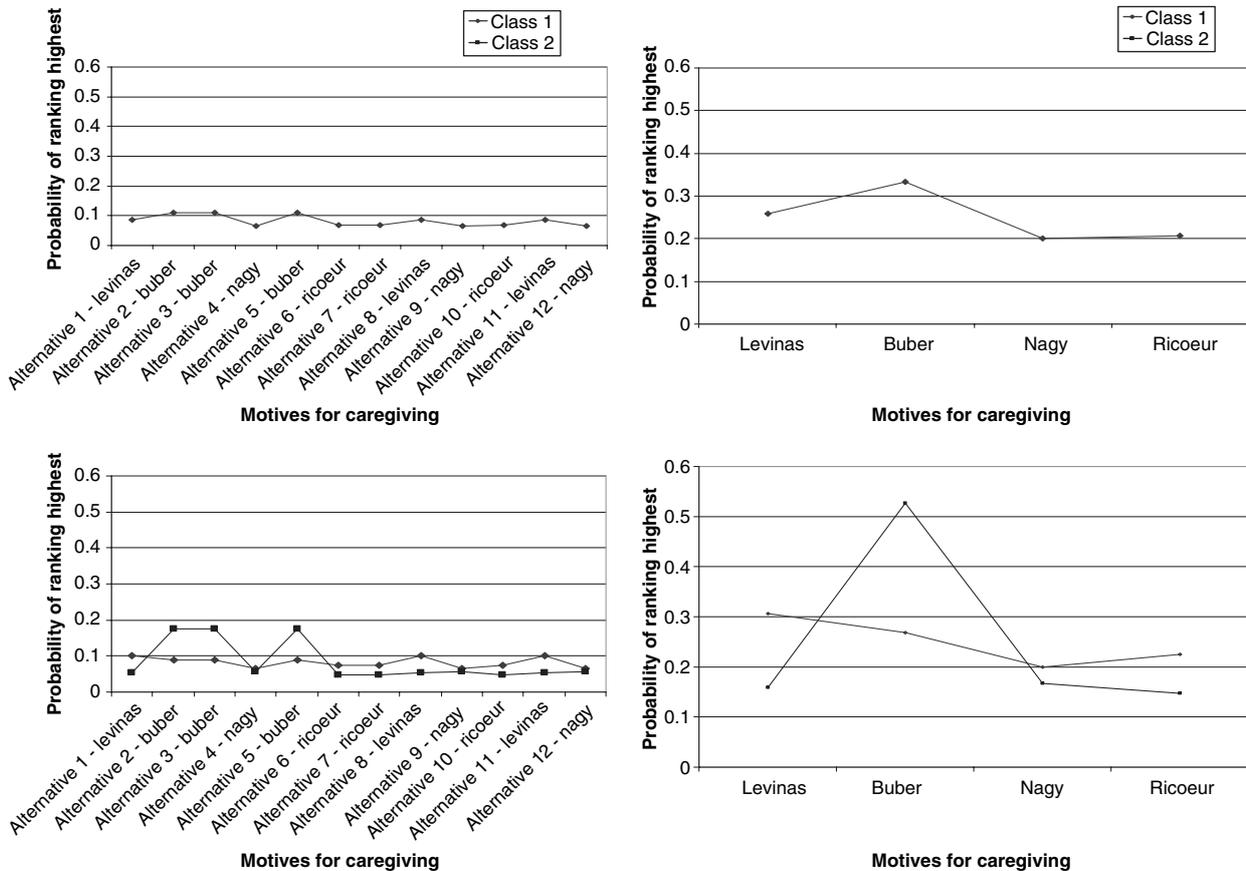


Figure 2 Probability of ranking motives for caregiving highest – results of one-class sequential logit models (model 4) and two-class sequential logit models (model 5).

belonging to class 1 to rank Nagy motives highest, and, finally, a somewhat lower probability than individuals belonging to class 1 to order Ricoeur motives highest. Again, the differences are significant ($p < 0.001$). Finally, the results indicate that the size of the two classes is considerable. According to this model 67% belongs to class 1 and 33% to class 2.

Step 3: analysis of the full ranking of motives for caregiving with covariates

Finally, for exploratory purposes, we investigated whether stress and joy indications and selected background characteristics of caregivers are related to class membership. Covariates are variables that may be used to describe or predict (rather than to define or measure) the latent classes. For example, they are often used to profile the latent classes in terms of demographic or other exogenous variables. Because of the limited sample size, we were by necessity restricted in the number of characteristics that could be included in the analysis. Here, we choose to examine the effects of the following characteristics of caregivers: self-reported stress and joy of caring by the caregiver, sex, age (recoded into six age categories), the duration of caring (recoded into two categories), the nature of the relationship between the caregiver and the care recipient, and the household income of the caregiver. The results of this exploratory analysis are reported in Table 4.

The results indicate that the two classes can indeed, to some extent, be described in terms of the included covariates: the p-values associated with the Wald statistic suggest that, overall, some of the effects are significant using the conventional level of significance $\alpha = 0.05$. In particular, the logit-parameters associated with sex (-4078 and 4078) suggest that females are, on average, less likely than males belong to the mixed class and more likely than men to belong to the Buber class. Furthermore, those who care for a partner or for a child are less likely than others to belong to the mixed class and more likely than others to belong to the Buber class. Finally, we see that respondents who report high levels of stress are more likely than respondents who report low levels of stress to belong to the mixed class and less likely to belong to the Buber class.

Discussion

The present study investigated how long-term family caregivers rank 12 motives for caregiving. We related the results to self-reported stress and joy of caring by the caregiver, sex, age, the duration of caring, nature of relationship of caregiver to care recipient and the household income of the caregiver.

Family caregivers and their first choice of motives

An analysis of caregivers' first choice, Fig. 1a, shows that the probability that one particular motive will be the first

Table 4 Logit-parameters for two-class ranking model with covariates (model 7)

Covariates	Class 1 (mixed)	Class 2 (Buber)	Wald	p-value
Sex (ref. = male)	-4.078	4.078	4.839	0.028
Age groups				
15-34 years old	-2.595	2.595	3.260	0.660
35-44 years old	0.684	-0.684		
45-54 years old	-0.151	0.151		
55-64 years old	1.797	-1.797		
65-74 years old	0.570	-0.570		
75-84 years old	-0.305	0.305		
Duration of caring (ref. = <3 years)	-3.316	3.316	0.127	0.720
Caring for partner	-7.248	7.248	9.008	0.003
Caring for parent	0.727	-0.727	0.251	0.620
Caring for child	-8.266	8.266	6.725	0.010
Caring for other family member	0.757	-0.757	0.229	0.630
Caring for nonfamilial relation	-1.423	1.423	0.000	1.000
Self-reported stress of caring	3.982	-3.982	5.818	0.016
Self-reported joy of caring	0.271	-0.271	0.134	0.710
Household income				
Monthly household income: 0-1000 Euro	-2.019	2.019	3.898	0.140
Monthly household income: 1000-2000 Euro	-0.205	0.205		
Monthly household income: >2000 Euro	2.224	-2.224		

The Wald statistic can be used to assess the statistical significance of effects associated with a given covariate (21). 1 Euro = 1.31 US dollar = 0.67 Pounds.

choice of caregivers are not very high for each of the 12 motives. However, Levinas motives and Buber motives have a higher chance to be the first choice than Nagy motives and Ricoeur motives; and Nagy motives have a slightly higher chance to be the first choice than Ricoeur motives. This is even more distinct when the motives are grouped according to the philosopher they stem from, in Fig. 1b. Levinas motives as a group have a chance of slightly more than 4 in 10 to be the first choice, closely followed by the Buber motives which as a group have a chance of slightly <4 in 10 to be the first choice. Nagy motives stay behind considerably with a chance of between 1 and 1.5 in 10 and Ricoeur motives have a chance of <1 in 10 of being first choice. Now, we first must point to the fact that the respondents more or less seem to group the different motives, which we have offered them in random order, according to how they were grouped originally, that is, stemming from four different philosophers.

The Buber and Levinas motives are significantly more often preferred as a first choice. As can be seen in Appendix 1, the Levinas motives and the Buber motives all focus very much at feelings that have to do with the relationship between caregiver and care recipient: feeling responsible for the dependent other, highly valuing the relationship and the care for the other. Motives stemming from feelings of obligation (Nagy), from a general feeling of happiness (Ricoeur, alternative 10) and more self-directed motives (Ricoeurs other two motives: feeling to be a good human being, expecting to become the dependent party in the future) are less popular as a first choice. These results indicate that support programmes and interventions should be directed at relational themes between the family caregiver and the patient. We return to this point at the end of the discussion.

Family caregivers and their full ranking of 12 motives

Next to the first choices, we analysed the respondents' ranking of all 12 motives. Analyses show that both a one-class model and a two-class model fit the full ranking data. When we view all the motives taken separately, in the one-class model (the left-hand upper side of Fig. 2), the Buber motives have the highest chance of being ordered highly, followed at some distance by the Levinas motives and then the Nagy and Ricoeur motives. When we order the motives in four groups according to their origin (the right-hand upper side of Fig. 2), we see the same picture: first Buber, followed by Levinas and then by Nagy and Ricoeur. In both analyses, Nagy and Ricoeur end up about even, as last and the Levinas motives are in-between Nagy and Ricoeur on the one hand and Buber on the other hand. However, Levinas ends up closer to Nagy and Ricoeur than to Buber. In a two-class model (the left-hand and the right-hand lower part of Fig. 2) we

see a group with a very clear preference for Buber motives over and above all other motives next to a group in which Buber motives and Levinas motives still – though to a lower degree – are preferred over Nagy motives and Ricoeur motives. As we have mentioned, statistics allow both a one-class and a two-class model. However, the analyses with covariates give some support for a two-class model.

The relation between background characteristics of family caregivers and their full ranking of 12 motives

Women and caregivers who care for a partner or a child are more likely to belong to the Buber group than men and caregivers who care for another family member. The Buber motives focus at close relationships so it is plausible that these motives are preferred by people who provide care to those with whom they have an intimate relationship. Apparently, even providing long and intensive care to a partner who is ill does not, for caregivers, decrease the importance of and the orientation towards the relationship with the patient. Buber is more oriented to a reciprocal, mutually-equal relationship than Levinas and this apparently is also something which does not fade away when one partner provides long-term and intensive care to the other partner in the relationship: the caregiver experiences the relationship as reciprocal and equal, despite the fact that the other is very dependent of the caregiver.

That women more than men choose for Buber motives perhaps reflects an orientation to relations that traditionally has been and perhaps still is attributed to women. The possible interaction effects could not be measured with the available statistical techniques but descriptives show that men relatively more often provide care to their partner whereas women more often provide care to a parent or a child. Men and women provide care to other family members or other social relations only rarely (about 7% to other family members and about 5% to other social relations). Thus, the majority of our respondents, both men and women, provide care to a close relative.

Stress and joy of family caregivers

More interesting is the fact that those who report high levels of stress are more likely to belong to the mixed group and less likely to belong to the Buber group. This again points to the need that supportive interventions should focus at the relationship between caregiver and patient. Furthermore, programmes and interventions should be directed at the balance between what the family caregiver, who wishes to provide care because she feels responsible, can sustain and what she should sustain: her burden of care tasks and the physical and mental costs they bring along.

Comparison with other studies

In our introduction we discussed several studies with respect to motives of long-term family caregivers. New in our study was, first, the combination between relational and individual motives for caregiving; second, the fact that we asked respondents to rank the motives and, third, the source we derived the motives from: philosophical anthropologists instead of sociological and psychological concepts. Still, there are common grounds. Our results seem to support those of Cicirelli (3). Cicirelli found that filial obligation increased the sense of burden. We found a higher level of stress in the mixed group than in the Buber group. The mixed group contains respondents who prefer motives for caregiving based on obligation. Further comparisons with the studies discussed in the Introduction must be made prudently, as the motives they measured are so different from ours. However, we think our study shows that motives directed at the relationship between caregiver and care recipient are an important addition to the motives measured in the other studies.

New in our study was also that we asked how much joy family caregivers experience from different care tasks. Respondents report both stress and joy, but they report somewhat more joy than stress. This is noticeable, given that we are dealing here with people who are giving long-term and intensive care. More research is needed here, especially qualitative research into what contributes to the joy of caring and what diminishes this joy. However, it is clear that professionals who support family caregivers should follow up on this perceived joy. They should help family caregivers to live on that joy in those moments when the burden of care is weighing heavily.

Recommendations for professionals and healthcare policy

To professionals involved in supporting family caregivers, our study shows the importance of the relationship between the caregiver and the care recipient as a motivating force which helps family caregivers to carry on. Interventions should fit in with this. For example, a counsellor should talk not only with family caregivers individually but also with patients, and with family caregiver and patient together, discussing relational themes. In some situations a counsellor who talks with the family as a whole will be necessary, for instance when problems occur concerning role reversal, loyalty and/or recognition. Both family caregivers – youngsters and adults – and patients should have room for communicating expectations and disappointments with respect to how their relationship develops with the ongoing illness. Let us give an example to illustrate the above. In a family, mother is partly paralyzed by a stroke. Father and daughters, each in his or her own way, feel responsible for her and have taken up many domestic tasks, while the mother feels guilty about her illness. Each

of them runs into problems. At a certain point, the caregiving daughter is supervised by a family care consultant, the other daughter by regional child care service, the father by a psychologist and the mother has her own nurse. Instead of four different care workers who approach this family as a set of individuals, it could be more helpful to have one care worker guiding this family as a system. In this way, family care support takes the shape of family guidance in which each family member learns to deal with the situation and there is extra attention for the endangered reciprocity between the caregivers and the patient.

Not only the reciprocal relationship but also the sense of responsibility of the family caregiver in this study has been shown to be important. Professionals should respect and acknowledge this sense of responsibility by, on the one hand, leaving those tasks to the family caregiver which she wants to perform herself and, on the other hand, explore the limits of that responsibility together with the family caregiver, so that she does not become physically, psychologically or socially overburdened.

Thus, the healthcare policy with respect to family caregivers should be directed more at the family system. Moreover, a systemic policy could help to prevent the growth of a new group of patients: family caregivers. In addition, the results of our study provide a tool for defining the limits of family care. If we agree with our philosophers Buber and Levinas that having a relationship, a reciprocal relationship, is essential for human flourishing – at least our family caregivers seem to agree with that – family care has reached its limits when it threatens the quality of that relationship because the family caregiver gets overburdened. In a society where the responsibility for providing care more and more is put in the hands of individual citizens, it is of major importance to watch the limits of family care and to safeguard the strength of family caregivers. Therefore, intervention programmes and the policy they stem from should help preserving systemic relations where they are in good order, improving them where they are disturbed, and stimulating them where growth is still possible. Providing care to each other thus can remain in balance.

Acknowledgements

We would like to thank the persons who participated in the study; the family caregivers who filled in the questionnaire and the family caregivers who participated in the pilot study. We would also like to thank the Organization for Family Caregivers Midden-Brabant for their cooperation.

Author contributions

Deirdre Beneken genaamd Kolmer wrote this paper, was responsible for study conception and design, data

collection and analysis and obtaining funding. Agnes Tellings was responsible for study design, data analysis, writing, critical revisions and important intellectual content. John Gelissen was responsible for data analysis, statistical expertise and writing the manuscript. Henk Garretsen and Inge Bongers were responsible for study design, intellectual content, critical revisions and supervision.

Funding

Grants from the Tilburg University, Radboud University and the Organization for Family Caregivers Midden-Brabant made this study possible.

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Appendix 1

Motives for caregiving based on Boszormenyi-Nagy, Buber, Levinas and Ricoeur (in the questionnaire the motives were given letters, so A instead of 1, B instead of 2, etc., and, of course, the names of the philosophers were removed)

1. I care for my family member because I feel responsible for her (Levinas).
2. I care for my family member because this gives me the feeling that we have a relationship: she is there for me and I am there for her (Buber).
3. I care for my family member because the relationship I have with her is very important in my life (Buber).
4. I care for my family member because we have a bond and thus I feel obliged to care for her (Nagy).
5. I care for my family member because caring for others makes one's life meaningful (Buber).
6. I care for my family member because I feel that because of that I am a good human being (Ricoeur).
7. I care for my family member because perhaps I will become ill later as well and then I will be glad when somebody cares for me (Ricoeur).
8. I care for my family member because her dependence touches me (Levinas).
9. I care for my family member because in the past she has done much for me (Nagy).
10. I care for my family member because I am glad to be alive and therefore I wish to do things for others (Ricoeur).

11. I care for my family member because I can do much for her and it is not important that she cannot do much for me in return (Levinas).

12. I care for my family member because I feel obliged to care for her.

Because she put me into the world (when you care for your mother or father).

Because I put her into the world (when you care for a daughter or son).

Because we are family (when you care for another family member than a parent or a child) (Nagy).