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Enthusiasm and Moral Commitment: What Sustains Family Caregivers of Those With Dementia

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Elderly ($n = 22$) and young ($n = 15$) primary family caregivers of persons diagnosed with dementia and nonprimary caregivers ($n = 13$) were interviewed to assess their commitment to caregiving, internalization of the caregiving role (i.e., autonomy and self-determination), well-being, and appraisal of problematic situations. Primary caregivers reported a higher level of moral commitment than nonprimary caregivers. Young primary caregivers experienced more negative affect and less enthusiasm about caregiving and their relationship with the patient than other caregivers. Regression analyses suggest that greater identification with caregiving may generate enthusiasm, which in turn seems to foster well-being in primary caregivers and dampen their appraised threat of problematic situations. Finally, a tendency to appraise difficult situations as challenges when highly morally committed might explain primary caregivers' persistence.

Although Alzheimer's disease and related dementias are not normal consequences of aging, it is estimated that at least 10% of the population age 65 and older is afflicted by some form of dementia (Dorgan, 1995). This statistic increases to 47% in the population age 85 and older. Dementias such as Alzheimer's disease are among the most widespread and debilitating diseases affecting elderly individuals, yet they generally have no known cure or preventable cause (American Psychiatric Association, 1994). Alzheimer's disease, the most prevalent form of dementia, is associated with a gradual deterioration in physical and mental abilities (American Psychiatric Association, 1994; *Magill's Medical Guide*, 1995). As the proportion of North Americans over the age of 65 increases as a result of changing demographics, the total number of persons afflicted with dementia constantly is growing. Because of the devastating effects of this syndrome and the growing number of its victims, impaired elderly individuals increasingly must rely on their spouse, children, and close others for care.

As these elderly persons' physical and mental abilities deteriorate, their increasing needs for care take their toll on family caregivers' well-being. When compared to a community sample, caregivers of individuals with dementia experience poorer mental health and are less able to maintain their desired level of social activities (George & Gwyther, 1986). More specifically, caregivers report greater stress symptoms, poorer affect, and less satisfaction with life than respondents in a community sample. Caregivers also have less contact with family and friends and less time to devote to hobbies and relaxing. The negative effects of patients' illness on caregivers' mental health and social contact are long-lasting, persisting up to 20 months after the patient's death (Bodnar & Kiecolt-Glaser, 1994).

Nonetheless, caregivers vary in how they are affected by their loved one's illness, with some faring better than others. These differences between caregivers are explained by various factors. Living with the patient is associated with poorer mental health and fewer social activities (George & Gwyther, 1986). The use of more emotional coping and fewer instrumental and problem-solving coping strategies generally is found to increase the negative outcomes of caregivers (see Hodgson & Cutler, 1994, for a review). More frequent family visits, greater availability of social support, greater satisfaction with social support, and reporting less need for social support are associated with better caregiver outcomes (George & Gwyther, 1986; Hodgson & Cutler, 1994; Teri, 1997; Vitaliano, Russo, Young, Teri, & Maiuro, 1991; Zanetti, Magni, Sandri, & Frisoni, 1996; Zarit, Reever, & Bach-Peterson, 1980).

It is surprising to note that the use of formal social support programs, such as respite services, does not appear to have an effect on caregiver well-being (Flint, 1995; Lawton, Brody, & Saperstein, 1989). Caregivers' well-being generally is not explained by the severity of patients' cognitive or physical impairments (Farran, Keane-Hagerty, Tatarowicz, & Scorza,

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1993; George & Gwyther, 1986; Mangone et al., 1993; Neundorfer, 1991; Zanetti et al., 1998; Zarit et al., 1980), although inconsistent findings have been noted (e.g., Harper & Lund, 1990). Yet, caregivers' well-being is related to their reports of patients' disruptive behaviors (Farran et al., 1993; Mangone et al., 1993; Schultz, O'Brien, Bookwala, & Fleissner, 1995; Zanetti et al., 1998). Furthermore, comparisons between caregivers with different relationships to the patient have yielded inconsistent findings. Cantor (1983), George and Gwyther (1986), and Zanetti et al. (1998) reported more negative outcomes for spouse caregivers than for nonspouses (generally adult children). Robinson (1983) and Zarit et al. (1980) found no such differences between spouse and adult child caregivers, whereas Harper and Lund (1990) noted that caregiving daughters who lived with the patient experienced a greater burden than spouse caregivers.

The purpose of this study is to further our understanding of the factors associated with the well-being of family caregivers of persons with dementia by examining the contributions of commitment and self-determination theory. Caregivers' commitment and the self-determination of their motives for providing care are both constructs concerned with the reasons for which caregivers provide care. These constructs are expected to be useful in explaining who is most likely to take on the responsibility of primary caregiver and also why certain caregivers may experience poorer well-being than others. By taking a closer look at why people are primary caregivers of people with dementia (i.e., what binds them to this role and what drives their provision of care), we should better understand why some caregivers are less adversely affected than others by this demanding role.

COMMITMENT TO A CLOSE RELATIONSHIP

To our knowledge, the construct of commitment has yet to be examined in the context of caregiving for an elderly loved one. However, commitment in the context of a close relationship has been shown to be an important predictor of relationship duration and has been strongly associated with relationship satisfaction (Bui, Peplau, & Hill, 1996; Lydon, Pierce, & O'Regan, 1997; Rusbult, 1983, 1991) and the willingness to sacrifice (Van Lange et al., 1997). Although commitment might be viewed as a single unidimensional construct, many theorists actually have argued against such a conceptualization and consequently have suggested different types or dimensions of commitment (Brickman, 1987; Johnson, 1991; Lydon, 1996; Meyer & Allen, 1984). In previous work, we proposed two types of commitment that might be most consequential in the context of close relationships: enthusiastic and moral commitment (Lydon, 1996; Lydon et al., 1997). *Enthusiastic commitment* to a relationship is derived from positive attitudes toward the partner and the relationship and feelings of satisfaction with the relationship. This commitment dimension is similar to Brickman's (1987) enthusiasm dimension of commitment, Johnson's (1991) personal commitment, and Meyer and Allen's (1984) "want to" commitment. When individuals are enthusiastically committed to something or someone, they are in the relationship or, in the case of caregivers, they provide care because they want to. Enthusiastically committed caregivers would say they provide care to the patient because they enjoy it and do not see it as a burden to them.

In contrast, *moral commitment*, as described by Johnson (1991), stems from a sense of obligation toward the other person. This obligation is associated with "feeling that one ought to continue a relationship" (p. 121) because it reflects one's own values. Moral commitment involves a sense of self-constraint. That is, it is based on an internal set of constraints rather than social pressures or a fear of negative reactions from others if the relationship is not maintained. When individuals are morally committed to something or someone, they are in the relationship or, in the case of caregivers, they provide care because they feel they ought to. Morally committed caregivers would say they provide care to the patient because it is their duty and they feel personally obligated to do so.

It has been suggested that the effects of commitment on close relationships are most salient under conditions of adversity; that is, in stressful situations where external forces challenge the maintenance of the relationship (Lydon, 1996, 1999). The intense and prolonged demands placed on family caregivers of persons with dementia represent a situation of high adversity in which caregivers' enthusiasm and moral commitment toward the patient are likely to be diagnostic of outcomes such as (a) the decision to take on and persist in the role of primary caregiver, and (b) how well caregivers adjust to this extremely demanding situation (i.e., their well-being).

The caregiving experience is likely to provide a strong stress test (Kelly, 1983) of commitment. To develop hypotheses with respect to the role of these two types of commitment in the context of caregiving for a person with dementia, we drew on findings from a study of students involved in long-distance dating relationships (Lydon et al., 1997). In this previous study, we found that moral commitment to the relationship predicted staying in the relationship for a longer period (i.e., the objective level of involvement in the relationship). We also found that enthusiastic commitment, but not moral commitment, was strongly correlated with satisfaction with the relationship and feeling that it was rewarding (i.e., the subjective experience of the relationship).

As moral commitment was associated with persistence in a relationship, it also should help explain the objective level of involvement in the caregiver role. Moral commitment to caring for a close other diagnosed with dementia should predict greater and persistent involvement in the caregiver role out of a sense of duty. Therefore, caregivers who are primarily responsible for the day-to-day care of patients should report a higher level of moral commitment than those whose involvement in care is much lower (i.e., nonprimary caregivers).

The degree of enthusiasm toward a relationship was related to the person's subjective experience. Enthusiasm[1] regarding the patient and caregiving, but not moral commitment, should therefore be predictive of the subjective experience of caregiving. Thus, caregivers' enthusiasm regarding their relationship with the patient and caregiving should be associated with their subjective well-being.

SELF-DETERMINATION AND CAREGIVING

In addition to commitment to their role, another reason people are primary caregivers of persons with dementia may be that they are motivated to do so because they have internalized certain values or beliefs that drive them to take on this role. Theory and research on the internalization of beliefs (i.e., how people "take on" certain standards as their own) might help distinguish which caregivers are at greater risk than others of experiencing poor well-being. In a series of studies pertaining to the internalization of religious beliefs, Ryan, Rigby, and King (1993) examined the positive consequences on psychological well-being associated with a more autonomous, self-determined internalization of a role. Self-determination theory (Deci & Ryan, 1985, 1991) postulates that the more people experience their behavior as something they freely choose and value (i.e., as self-determined), the more their experience will be a positive one. In contrast, when people feel they are not freely engaging in a behavior (i.e., that their behavior is not self-determined), their experience should be more negative.

An important point along the self-determination continuum is between two types of internalized motives for behavior: identification and introjection. In both cases, a person is internalizing a set of originally external regulations and integrating such regulations into more self-determined regulations. However, identification represents a greater degree of internalization, internal locus of control, and self-determination than introjection. When values or beliefs are internalized in an identified fashion, they are integrated into the self-concept. However, when they are internalized in an introjected style, they remain more external to the self-concept (Deci & Ryan, 1991).

In the context of caregiving, identification represents internalizing a set of values and beliefs such that caregiving is seen as relatively freely chosen. Introjection represents a more limited internalization of values and beliefs such that caregiving is seen as more imposed and less freely chosen.

Ryan et al. (1993) reported that an identified internalization but not an introjected internalization of religious beliefs was associated with greater psychological well-being. In the context of caregiving, we would expect an identified but not an introjected style of internalization of caregiving to predict caregivers' psychological well-being.

Both commitment and motivation may be considered reasons for which caregivers engage in their role. Although research to date has not examined associations between different types of commitment and different motives within the self-determination theory framework, clearly there would appear to be linkages. First, enthusiastic commitment reflects a personal identification with the close relationship and the other person. This "want to" type of commitment surely should be associated with the relatively more self-determined motive of identification and not with introjection.

Less obvious are the possible associations between moral commitment and internalized motives. One might link moral commitment with an introjected motivation because the sense of duty and obligation is characteristic of moral commitment. However, both theory (Johnson, 1991) and research (Lydon et al., 1997) maintain that moral commitment reflects one's personal values more so than the values and standards of others. A strong correlate of moral commitment is the extent to which the close relationship reflects the person's values, identity, and sense of self (Lydon et al., 1997). Given that identification represents a set of motives more fully integrated into the self-concept, moral commitment should be associated with identification.

In sum, moral commitment was expected to be associated with caregiver status (primary vs. nonprimary) and identified motives for caregiving. Enthusiastic commitment was expected to be associated with well-being and identified motives for caregiving. Moreover, identified motives were expected to be associated with well-being. Thus, it was posited that identified motives would lead to well-being to the extent that such motives fostered enthusiastic commitment. That is, enthusiastic commitment would mediate the association between identification and well-being.

APPRAISAL OF POTENTIALLY PROBLEMATIC SITUATIONS

We expected caregivers' well-being to be associated with their motives for caregiving and with the type of commitment binding them to this highly demanding role. However, the process through which motives and commitment affect caregivers' well-being still must be clarified. One possible expla-

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[1] In Lydon et al. (1997), enthusiastic and moral commitment scores were generated using factor scores. Thus, the face valid commitment item contributed to both of these scores. Because this study had a smaller sample, it was inappropriate to use factor scores. Instead, we generated measures of enthusiasm and moral commitment using only the items that had loadings higher than .40 on that particular factor. As the face valid commitment item now only contributed to the moral commitment score, it seemed more appropriate to label the second factor enthusiasm.

nation is that motives and commitment are associated with different ways of appraising difficult situations brought on by the loved one's illness. In their theory of stress and coping, Folkman and Lazarus (1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986) explained that when faced with stressful situations, people engage in a two-step appraisal process that molds their thoughts and behaviors in response to these situations and, ultimately, influences their adjustment to stressful events. *Primary appraisal* refers to the person's evaluation of what effect the event might have. At this stage, one might appraise a potentially problematic situation as threatening; that is, as a situation that might bring harm to oneself or to a relationship. One also could appraise a potentially problematic situation as challenging—that is, as a situation to be overcome. *Secondary appraisal* refers to the cognitive or behavioral efforts that one can muster to deal with the event. At this stage, the person evaluates what coping strategies are available to him or her.

Primary appraisals of threat or challenge are anticipatory; that is, they are made before a potentially problematic situation is experienced. Yet, theory and research on cognitive appraisal suggest that these appraisals are associated with the use of different coping strategies as a situation unfolds, and with later adjustment to the stressful situation (Folkman & Lazarus, 1985; Pierce, Baldwin, & Lydon, 1997). Thus, caregivers' appraisal of potentially difficult situations brought on by the patient's illness should be indicative of their caregiving experience. Consistent with this theory of appraisal, in a study of caregivers of a spouse with dementia, Neundorfer (1991) reported that caregivers' appraisal of the stressfulness of patients' memory and behavior problems explained 43% of the variance in caregivers' depression and anxiety. If caregivers are predisposed to appraise potentially stressful situations as threats or challenges as a result of their internalization style or commitment to caregiving, over time this should influence their general well-being.

Although stress appraisal by caregivers has been linked to caregivers' well-being, the distinction between threat and challenge appraisals in the context of caregiving has not been made. More important, possible associations between relationship factors (e.g., commitment) and caregivers' stress appraisals have not been examined. Commitment has been found to prompt benign appraisals that enhance subjective well-being and increase behavioral persistence (Lydon, 1999; Lydon et al., 1997). Thus, greater commitment should predict lower appraisals of threat and increased appraisals of challenge. Appraising potentially problematic situations as less threatening should be associated with one's psychological well-being, because it would make events seem less stressful. Therefore, enthusiastic commitment, which is hypothesized to predict psychological well-being, is a likely predictor of benign threat appraisals. Appraising potentially problematic situations as challenging should facilitate persistence in caregiving in the face of adversity, as such situations are seen as problems to be overcome. Given that moral commitment has been associated with persistence in the face of adversity (Lydon et al., 1997), we correspondingly should find moral commitment to be associated with appraising potentially problematic situations as challenges to be overcome.

HYPOTHESES TESTED IN THIS STUDY

H1: Primary caregivers have a higher level of moral commitment than nonprimary caregivers do.

H2: Whereas moral commitment is not associated with primary caregivers' psychological well-being, greater enthusiasm toward the patient and the provision of care is associated with greater well-being in primary caregivers.

H3: An identified but not introjected motivation for caregiving is associated with primary caregivers' well-being.

H4: Enthusiasm and moral commitment both are correlated with an identified internalization of the caregiving role.

H5: Identified motives for caregiving give rise to enthusiastic commitment such that the association between identified internalization and well-being is mediated by enthusiasm toward the patient and the provision of care.

H6a: Identified motives for caregiving and enthusiasm are associated with the appraised threat of potentially problematic situations, with enthusiasm mediating the association between identification and threat appraisals.

H6b: Decreased threat appraisal is the process by which enthusiasm enhances well-being.

H7: Moral commitment increases the appraised challenge of potentially problematic situations, which is unrelated to primary caregivers' well-being.

METHOD

Participants

Interviews were conducted with 37 primary caregivers (25 women and 12 men) who were caring at home for a person with dementia. Twenty-two of these caregivers were the wife ($n = 9$), husband ($n = 8$), sister ($n = 4$), or brother ($n = 1$) of a person with dementia, hereafter referred to as the elderly caregivers. The remaining 15 primary caregivers were a daughter ($n = 11$), son ($n = 2$), daughter-in-law ($n = 1$), or son-in-law ($n = 1$) of the patient, hereafter referred to as the young caregivers. To serve as a comparison group, 13 other close relatives who were not living with the patients with dementia also were interviewed. This other group was composed mainly of daughters of the patients ($n = 8$) but also contained 3 sons, 1 niece, and 1 granddaughter. These constituted the group of young nonprimary caregivers.

The elderly caregivers were older ($M = 67.4$ years, $SD = 7.66$) than the young primary and nonprimary caregivers (Ms = 47.6 and 41.3 years, SDs = 6.45 and 9.89, respectively),

$t(49) = 6.27$, $p < .001$, $d = 1.62$. The young primary caregivers were also older than the young nonprimary caregivers were, $t(49) = 2.09$, $p < .05$, $d = 0.45$. However, when the one granddaughter (age 32) was excluded from the sample of nonprimary caregivers, this difference no longer attained significance, $t(48) = 1.81$, $p < .10$, $d = 0.40$.

Procedure

The names of primary caregivers of people recently diagnosed with dementia were obtained from case files at the Memory Clinic of the Douglas Hospital of Montreal. A letter describing the study was sent to the person identified in the file as the primary caregiver. A research assistant telephoned primary caregivers to confirm that the patient was not placed in an institution, that they were caring for the person with dementia in their home or lived near him or her, and that they were the primary person caring for the patient on a daily basis. Caregivers who met these criteria were asked to take part in the study. All primary caregivers were interviewed in their home by a trained interviewer. The interview contained measures of commitment, internalization, affective state, appraisal of threat and challenge, amount of support provided to the patient, and caregivers' satisfaction with providing care. On completion of the interview, caregivers were given a packet of questions to be completed on their own and mailed back the following week. The packet contained measures of well-being (i.e., quality of life, caregiver strain, and depression), dispositional optimism, and the patient's level of physical disability. This procedure was adopted because of concerns regarding the length of the interview and the demand characteristics associated with the administration of certain questionnaires within the interview (e.g., optimism and depression). Forty-two of the 50 participants mailed back this supplementary packet, including 30 primary caregivers and 12 nonprimary caregivers (84% return rate). During the interview, primary caregivers were asked to give the name of a person close to them and to the patient, but who was not responsible for the daily care of the patient and who would be interested in taking part in the study. These nonprimary caregivers were contacted and interviewed in a similar manner.

Measures

Commitment to the relationship and to providing care. Caregivers' commitment was assessed in the interview with a 16-item measure of enthusiasm and moral commitment. Eight items addressed commitment to the relationship. These were drawn from a previous study of commitment to a long-distance dating relationship (Lydon et al., 1997). To ascertain enthusiasm toward the relationship, caregivers were asked to indicate the extent to which they felt enthusiastic about the relationship, enjoyment about the relationship, relief if not in the relationship, and to what degree they perceived the relationship as a burden. The last two items were reverse scored. Moral commitment items included the extent to which caregivers felt committed to their relationship, felt attached to the patient, felt obligated, and felt a duty toward him or her. In addition, these eight items were reworded to assess enthusiasm and moral commitment toward the provision of care. Participants rated each statement on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). The mean of items pertaining to enthusiasm and moral commitment to the relationship was highly correlated with the corresponding mean score for the provision of care, $rs(48) = .79$ and $.84$, respectively, $ps < .001$. Items pertaining to the relationship and to the provision of care therefore were combined to create two eight-item measures of enthusiasm and moral commitment ($\alpha = .88$ and $.81$, respectively). Scores were obtained by averaging responses to the corresponding eight items. The resulting measures of enthusiasm and moral commitment to the relationship and the provision of care were not significantly correlated, $r(48) = -.22$, $p = .12$.

Internalization of caregiving. Ryan et al.'s (1993) measure of religious internalization was modified to address how caregivers have integrated the duties and responsibilities resulting from their loved one's illness. The internalization of caregiving was assessed in the interview with a 10-item measure designed to assess caregivers' autonomy or self-determination in tending to the patient's needs. Five items address more autonomous and self-determined reasons for providing care, reflecting the identified style of internalization of caregiving (hereafter referred to as identification; e.g., "I provide care for [patient] because he or she is important to me"). The remaining 5 items assess more controlled, approval-based reasons for providing care, whereby caregiving is motivated by social pressures or a desire to avoid guilt or shame (Ryan et al., 1993). These items reflect the introjected style of internalization of caregiving (hereafter referred to as introjection; e.g., "I provide care for [patient] because others would disapprove if I didn't"). Participants rated each item on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). The alpha coefficients for the identified and introjected subscales were $\alpha = .86$ and $.75$, respectively. Means of each of the two sets of 5 items were calculated to produce identified and introjected scores. The two scores were not significantly correlated, $r(48) = -.05$, $p = .74$. These values are similar to those reported by Ryan et al.

Caregivers' well-being. Four different measures were used to assess caregivers' well-being: affective state, quality of life, caregiver strain, and depression. All of these measures were assessed in the packet, which caregivers returned in the mail, except the measure of affective state, which was assessed in the interview. Affective state was ascertained using a subset of 20 items from the Derogatis (1975) Affect Balance

Scale. Ten items reflected positive affect, and 10 reflected negative affect. Participants rated the extent to which they experienced each affect during the past week on a 5-point scale ranging from 0 (*not at all*) to 4 (*almost always*). The overall affect score was obtained by subtracting the average score on negative affect items from the average score on positive affect items ($\alpha = .86$). Affect balance scores could range from –4 to 4, with higher scores reflecting more positive and less negative affect. The quality of life (Andrews & Withey, 1976) questionnaire comprises 13 questions about how satisfied participants felt about different aspects of their lives ($\alpha = .89$). Scores could range from 1 (*terrible*) to 7 (*delighted*). Caregiver strain was measured with the Caregiver Strain Index developed by Robinson (1983). Respondents indicated, by a yes or no answer, whether they experienced each of 13 possible inconveniences or disturbances because they lived with a person with dementia (e.g., disturbed sleep, physical strain, financial strain, and work adjustments). For each positive response, 1 point is added to the overall strain score, such that higher scores reflect greater strain ($\alpha = .83$). Finally, depression was assessed with the 13-item short form of the Beck Depression Inventory (Beck, Steer, & Garbin, 1988). Depression scores could range from 0 to 39, with higher scores indicating greater depression ($\alpha = .89$).

Appraisal of threat and challenge. Three scenarios describing difficult and potentially problematic situations that could arise due to the significant other's illness were developed for this study. These scenarios were read to primary caregivers during the interview. They described incidents in which (a) the patient repeatedly asks a visiting close friend who they are, (b) the caregiver has to make decisions regarding the patient's financial investments, and (c) the caregiver is unable to calm the patient who becomes extremely angry about something. In response to hearing each scenario, caregivers responded to two questions, using a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). The first question addressed the extent to which they would feel ashamed, uneasy, or upset about the incident and perceive dementia as a threat to their relationships and daily lives. The second question addressed the extent to which caregivers would accept the incident as a natural consequence of dementia and see it as a challenge they must take on and overcome. Responses to the three scenarios were averaged to yield scores of appraised threat and appraised challenge ($\alpha = .49$ and $.65$, respectively). These scores were not significantly correlated, $r(35) = .05$, $p = .79$.

Amount of support provided and satisfaction. During the interview, caregivers were asked to rate, on a scale ranging from 0 (*not at all*) to 4 (*extremely*) how satisfied they had been with providing care to the patient. Caregivers also were asked to rate, on a scale ranging from 0 (*not at all*) to 4 (*almost always*), how often they provided care for the patient, told him or her how to do things, physically did things for the patient, and gave the patient emotional support. The sum of responses to these four questions was used as an indicator of the amount of support the caregiver provided to the patient ($\alpha = .60$).

Dispositional and status measures. Variables that potentially could explain the effects of commitment and internalization on criterion variables also were assessed in the mailed packet. Dispositional optimism was measured with the Life Orientation Test (Scheier & Carver, 1985; $\alpha = .78$). The patient's level of physical disability was reported by caregivers using the Rapid Disability Rating Scale (Linn & Linn, 1982; $\alpha = .87$). Finally, a clinical psychologist determined the patient's level of mental disability, using the Hierarchic Dementia Scale (Cole & Dastoor, 1983). This score was obtained from patients' hospital records.

RESULTS

Comparing the Different Groups of Caregivers

A series of three one-way analyses of variance (ANOVAs) were performed to compare the three caregiver groups. Planned contrasts were conducted to compare elderly primary caregivers, young primary caregivers, and young nonprimary caregivers. The contrast coefficients used were (1, 1, –2), (1, –1, 0), and (0, 1, –1). First, analyses of the amount of care provided and satisfaction with care were performed to validate the classification of participants into groups of primary and nonprimary caregivers. This was followed by the primary analyses of commitment, internalization, and well-being.

The one-way ANOVA of the amount of support provided was significant, $F(2, 47) = 7.51$, $p < .001$, $\eta^2 = .26$. Contrasts revealed that elderly and young primary caregivers provided significantly more support to the patient than young nonprimary caregivers, $t(47) = 3.74$, $p < .001$. Elderly and young primary caregivers did not significantly differ on this measure, $t(47) = 0.63$, $p = .53$. Regardless of these differences in the amount of support provided, primary and nonprimary caregivers were similarly satisfied with the care they had been providing to the patient, $F(2, 46) = 1.89$, $p =.16$, $\eta^2 = .07$. According to J. Cohen (1988, 1992), the power to detect a small ($f = .10$), medium ($f = .25$), or large ($f = .40$) effect size at $\alpha = .05$ in this analysis was .08, .31, and .67, respectively. (See Table 1 for group means and standard deviations.)

As hypothesized, the three groups of caregivers differed in their level of moral commitment, $F(2, 47) = 14.91$, $p < .001$, $\eta^2 = .42$. In addition, they differed in their level of enthusiasm toward their relationship with the patient and the provision of care, $F(2, 47) = 3.20$, $p < .05$, $\eta^2 = .13$. The

TABLE 1
Mean Scores and Standard Deviations for the Three Groups of Caregivers

	Caregivers					
	Elderly Primary		*Young Primary*		*Young Nonprimary*	
	M	SD	M	SD	M	SD
Support provided						
Amount (0–16)	11.09_a	2.99	10.53_a	2.26	7.62_b	2.36
Satisfaction (0–4)	3.09	.53	2.71	1.07	2.54	1.05
Commitment						
Enthusiasm (0–4)	2.19_a	.81	1.61_b	.94	2.37_a	.86
Moral commitment (0–4)	3.16_a	.62	3.11_a	.50	2.14_b	.54
Internalization						
Identified (0–4)	2.43	.99	2.12	.88	2.72	.75
Introjected (0–4)	1.39	1.03	1.01	.72	1.18	.79
Well-being						
Affect balance score (–4–4)	1.48_{ab}	.83	$.95_a$	1.08	1.78_b	.67
Beck Depression Inventory (0–39)	4.02	2.72	5.75	7.27	2.86	3.03
Caregiver strain (0–13)	5.38_a	3.07	6.57_a	3.46	2.42_b	2.68
Quality of life (1–7)	4.77	.69	4.52	1.26	4.92	.65

Note. Different subscripts across a row indicate significant differences at $p < .05$.

groups did not significantly differ in identification, $F(2, 47) = 1.56$, $p = .22$, $\eta^2 = .07$, or introjection, $F(2, 47) = 0.82$, $p = .44$, $\eta^2 = .03$, of the caregiver role. In these last two analyses, the power to detect small, medium, or large effect sizes at $\alpha = .05$ was .09, .33, and .70 (J. Cohen, 1988, 1992).

Planned contrasts, using the contrast coefficients described previously, revealed results consistent with H1. Elderly and young primary caregivers did not differ in moral commitment to the patient, $t(47) = 0.22$, $p = .83$, whereas both groups were higher in moral commitment than were young nonprimary caregivers, $t(47) = 5.41$, $p < .001$. Thus, primary caregivers are distinguished from nonprimary caregivers by their higher level of moral commitment. Contrasts also revealed that elderly primary caregivers were more enthusiastic than young primary caregivers were about the provision of care and their relationship with the person with dementia, $t(47) = 2.04$, $p < .05$. Young nonprimary caregivers were also more enthusiastic than young primary caregivers, $t(47) = 2.35$, $p < .05$, exhibiting a level of enthusiasm similar to that of elderly primary caregivers, $t(47) = 0.60$, $p = .55$ (post hoc analysis). Thus, elderly primary caregivers reported high levels of both enthusiasm and moral commitment to the patient. In contrast, young primary caregivers reported similarly high moral commitment but lower enthusiasm, and young nonprimary caregivers reported lower moral commitment but high enthusiasm (see Table 1).

A final series of one-way ANOVAs was performed to compare groups along the four well-being measures. The overall F test attained significance for measures of affect, $F(2, 47) = 3.36$, $p < .05$, $\eta^2 = .14$, and caregiver strain, $F(2, 37) = 5.27$, $p < .01$, $\eta^2 = .26$, but revealed no significant differences between groups on measures of depression, $F(2, 37) = 1.21$, $p = 31$, $\eta^2 = .08$, or quality of life, $F(2, 37) = 0.55$, $p = 58$, $\eta^2 = .04$. In these last two analyses, the power to detect small, medium, or large effect sizes at $\alpha = .05$ was .08, .25, and .57 (J. Cohen, 1988, 1992).

Planned contrasts revealed that primary caregivers in general tended to report poorer affect than nonprimary caregivers, $t(47) = 1.94$, $p = .06$, but this was due to the young primary caregivers experiencing significantly poorer affect than young nonprimary caregivers, $t(47) = 2.50$, $p <.05$. Young primary caregivers also tended to experience poorer affect than elderly primary caregivers, $t(47) = 1.90$, $p < .07$. The elderly primary caregivers' affect scores more closely resembled those of young nonprimary caregivers, $t(47) = 0.89$, $p = .38$ (post hoc analysis). With respect to caregiver strain, contrasts indicate that elderly and young primary caregivers reported greater strain in comparison to young nonprimary caregivers, $t(37) = 3.25$, $p < .01$. Furthermore, elderly and young primary caregivers did not significantly differ on this measure, $t(37) = 0.90$, $p = .37$. No other contrast attained statistical significance (i.e., $\alpha \leq .05$), yet there was a consistent trend across all measures for young primary caregivers to report a poorer level of well-being than both elderly primary caregivers and young nonprimary caregivers (see Table 1).

In summary, comparisons between groups revealed that both groups of primary caregivers can be distinguished from young nonprimary caregivers by the greater amount of support they provided to the patient, their greater level of moral commitment, and their greater experience of caregiver strain. Furthermore, young caregivers differed from both elderly caregivers and young nonprimary caregivers on two measures. Young primary caregivers were less enthusiastic about the provision of care and their relationship with the person with dementia. They also experienced poorer affect than did other respondents.

What Factors Foster Well-Being in Primary Caregivers?

To better understand the factors that contribute to caregiver well-being, the correlations between well-being and the different commitment and internalization measures were examined. Nonprimary caregivers were included in earlier analyses to compare the experience of primary caregivers to that of patients' close relatives who are not responsible for their daily care. However, the distinctively different nature of their caregiving made these nonprimary caregivers inadequate participants for the following analyses. Correlational analyses focus exclusively on primary caregivers, those who assumed the demanding responsibility of caring for the daily needs of a person diagnosed with dementia.

To reduce the number of analyses and acknowledge the conceptual overlap among these different measures, affect, depression, caregiver strain, and quality of life were combined into a general index of well-being. Depression and strain scores were reversed to produce measures in which higher scores consistently reflect greater well-being. The combination of standardized scores on these four measures was justified by their relatively high level of intercorrelation ($M\ r = .63$, $Mdn\ r = .70$, range = .24–.87).

Consistent with H2, the resulting index of well-being was significantly correlated with enthusiasm, but not with moral commitment. Furthermore, the correlation between well-being and introjection did not attain significance, whereas the correlation between well-being and identification approached significance (H3; see Table 2 for the full correlation matrix). These correlations did not differ when statistically controlling for the patient's level of mental or physical disability, as assessed by the Hierarchic Dementia Scale and the Rapid Disability Rating Scale; neither were they altered when statistically controlling for caregiver's level of optimism or their satisfaction with the care they had been providing.

As hypothesized (H4), identification was significantly correlated with both enthusiasm and moral commitment. In addition, introjection was not significantly correlated with enthusiasm or moral commitment, although the latter correlation approached significance (see Table 2).

Because of the significant correlation of enthusiasm and identification, a regression analysis was performed to test the hypothesis that caregivers who more strongly identify with the provision of care are more likely to be enthusiastic about the provision of care and, in turn, experience greater well-being (i.e., analysis tested for a mediation model; H5). In the first step of the regression, identification partially explained well-being ($f^2 = .08$). However, entering enthusiasm in the second step of the regression improved the fit of the model ($f^2 = .28$). Enthusiasm was a significant predictor of well-being. Including enthusiasm in the model decreased the association between identification and well-being (see the first section of Table 3 for results of this regression analysis). These results support the notion that enthusiasm and identification with caregiving can help explain caregivers' well-being. They also suggest that enthusiasm mediates the association between identification with caregiving and well-being.

TABLE 2
Intercorrelations of Commitment, Internalization, Well-Being, and Appraisals

Variable	*1*	*2*	*3*	*4*	*5*	*6*
1. Enthusiasm	—					
2. Moral commitment	–.13	—				
3. Identified internalization	.40**	.33**	—			
4. Introjected internalization	–.02	.27	.11	—		
5. Well-being	.50***	–.17	.30*	–.14	—	
6. Appraisal of threat	–.50***	–.02	–.39**	.28*	–.30*	—
7. Appraisal of challenge	–.22	.39**	.06	.10	–.03	.04

Note. $N = 37$. The sample comprised only primary caregivers.
*$p < .10$. **$p < .05$. ***$p < .01$.

Elderly primary caregivers, who were more enthusiastic than young primary caregivers, generally were married to the patient (17 of 22; 77%). In contrast to young primary caregivers, elderly primary caregivers then had a longer standing and possibly more intimate relationship with the person. Greater identification with caregiving could result from this relationship with the patient. However, caregiving spouses did not differ from other primary caregivers[2] in their reported identification with caregiving, $t(35) = 1.43$, $p = .16$, $d = 0.46$, power (at $\alpha = .05$) = .27. These two groups also did not differ in their overall well-being, $t(35) = 0.71$, $p = .48$, $d = 0.24$, power (at $\alpha = .05$) = .11. (See Table 1 for group means and standard deviations.)

Alternatively, it could be that the relationship with the patient (spousal vs. nonspousal) simply was associated with greater enthusiasm toward the patient and caregiving, irrespective of the level of identification. To test for this possibility, a regression analysis was performed, entering both identification and a categorical variable for relationship status (spouse vs. nonspouse) as possible predictors of enthusiasm. Although there was a trend for relationship status to be associated with enthusiasm, this did not account for the association between identification and enthusiasm (see the second section of Table 3). On the basis of these results, we conclude that, re-

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[2] These other primary caregivers refer to a post hoc grouping of caregiving siblings and young primary caregivers.

TABLE 3
Results of Regression Analyses

		Step 1				*Step 2*			
Criterion and Predictors	*r*	β	*sr*	*t*	*Adj.* R^2	β	*sr*	*t*	*Adj.* R^2
Well-being									
Identification	.30*	.30	.30	1.87*	.07	.12	.11	0.77	.22
Enthusiasm	.50***					.45	.41	2.79***	
Enthusiasm									
Identification	.40***	.33	.32	2.14**	.18				
Relationship status	.35**	.28	.27	1.77*					
Appraised threat									
Identification	–.39**	–.39	–.39	–2.54**	.13	–.23	–.21	–1.48	.26
Enthusiasm	–.50***					–.41	–.38	–2.62**	

Note. *r* = zero-order correlation; β = standardized beta; *sr* = semipartial correlation; Adj. R^2 = adjusted R^2.
*$p \le .10$. **$p \le .05$. ***$p \le .01$.

gardless of the type of relationship they had with the patient, caregivers who more strongly identified with their role were also more likely to feel enthusiastic toward their relationship and the provision of care. This enthusiasm, in turn, fostered greater well-being in primary caregivers.

Commitment, Self-Determinations, and the Appraisal of Difficult Situations

We hypothesized that primary caregivers' appraisal of potentially problematic situations as threatening or challenging was related to commitment and caregiving motives. Identification and enthusiasm were expected to be negatively associated with appraised threat (H6a). Moral commitment was expected to be positively associated with appraised challenge (H7). We also expected threat appraisals to be related to caregivers' well-being, such that enthusiasm could be said to influence well-being by its predisposing effect on threat appraisals (H6b).

Our hypotheses generally were supported. Measures of appraisal were significantly associated with commitment and internalization measures. Appraised threat was negatively correlated with enthusiasm and identification, whereas appraised challenge was positively correlated with the moral commitment of these primary caregivers. However, the correlation between the appraised threat of the scenarios and well-being only approached significance. The appraised challenge of these same scenarios was not significantly correlated with well-being (see Table 2).

A regression analysis, with appraised threat as the criterion, revealed a path model similar to the one supported for well-being. In the first step of the regression, identification significantly explained appraised threat, $f^2 = .15$. Including enthusiasm in the second step of the regression improved the fit of the model, $f^2 = .35$. Enthusiasm was a significant predictor of appraised threat. Adding enthusiasm decreased the association between identification and well-being (see the third section of Table 3). These results suggest that, as was the case for well-being, a more identified internalization of their role leads caregivers to appraise difficult situations as less threatening. This effect is mediated by caregivers' enthusiasm, which attenuates the appraised threat of problematic situations. The nearly significant correlation between appraised threat and well-being suggests that the reduced likelihood of appraising such situations as threats may be one of the processes through which identification and enthusiasm enhance caregivers' well-being. Finally, although moral commitment was significantly correlated with identification, no mediational analysis was attempted because of the lack of a significant correlation between identification and appraised challenge (Baron & Kenny, 1986; see Table 2).

DISCUSSION

The findings of this study suggest that primary caregivers can be distinguished from nonprimary caregivers by their higher levels of moral commitment and caregiver strain. Young primary caregivers reported less enthusiasm than elderly primary caregivers. They also reported significantly poorer affect than young nonprimary caregivers and tended to report poorer affect than did elderly primary caregivers (nonsignificant trend). Analyses conducted with primary caregivers were supportive of the hypothesized association between identifying with caregiving and well-being. This association was mediated by enthusiasm toward caregiving.

Further analyses revealed that greater identified internalization also was associated with appraising potentially difficult situations as less threatening. This association also was mediated by enthusiasm toward caregiving. Thus, internalizing the roles and responsibilities of caregiving and identifying with them might elicit greater enthusiasm about the caregiver role that helps reduce threat appraisals and, in turn, enhances caregivers' well-being.

Of course, cross-sectional correlational data such as these are open to alternative explanations. For example, well-being may dampen threat appraisals and enhance enthusiasm, which prompts one to conceptualize one's caregiving in a more identified fashion. To put it in the negative, those who are unhappy and depressed may distance themselves motivationally to reduce dissonance. Longitudinal research, particularly with a sample in the early stages of the caregiver role, would be advantageous.

Greater moral commitment was correlated with appraising the same incidents as challenges to be overcome. This finding, paired with the greater level of moral commitment of primary caregivers in contrast to nonprimary caregivers, could suggest that family caregivers who are not highly morally committed to the relationship and the provision of care do not take on or persist in the role of primary caregiver. That is, the high level of adversity arising from the sacrifices and efforts required by the provision of care to a person with dementia might prompt spouses or children with low moral commitment to disengage from their role as a primary caregiver and turn over this responsibility to another family member or an institution at an earlier stage of the patient's illness. This conclusion might be warranted by our previous work (Lydon, Dunkel-Schetter, Cohan, & Pierce, 1996; Lydon et al., 1997), but it must remain speculative because this study did not include primary caregivers who had placed the patient with another family member or in an institution. Yet, the young nonprimary caregivers, who had not themselves taken on the role of being primarily responsible for the patient's well-being, did report significantly lower moral commitment than did primary caregivers. This hypothesis would be best tested with a longitudinal study of primary caregivers in which the duration of at-home caregiving is compared across different groups of caregivers, initially high or low in moral commitment.

Explanations for the Differences Among Primary Caregivers

In comparison to other primary and nonprimary caregivers, young primary caregivers reported less enthusiasm with respect to their relationship with the patient and to the provision of care. This lower level of enthusiasm was accompanied by poorer affect. The reduced enthusiasm of young primary caregivers could be explained by several factors, including, but not limited to, motives for caregiving, interpersonal expectations, social norms, and developmental life stages.

Motives for caregiving. One hypothesis for the difference in enthusiasm between young and elderly primary caregivers can be addressed with the data available in this study. Namely, adult children's lower level of enthusiasm, in contrast to that of elderly primary caregivers, might result from an absence of feelings of self-determination. The extent to which caregivers see the provision of care as self-determined was assessed by the measure of identified internalization. The absence of a significant difference between elderly and young primary caregivers does not support this hypothesis (see Table 1). However, the power available to detect even a medium-sized effect in these analyses was only .33. Had larger samples of elderly and young primary caregivers been available, this difference might have attained significance.

When all primary caregivers were grouped together, regression analyses yielded results that support our hypothesized association between identification and enthusiasm toward caregiving. The path model tested with regression analyses supports the theoretical assumption that enthusiasm stems from a more self-determined internalization of caregiving. This enthusiasm was then a significant predictor of caregivers' general well-being. Yet, because the data were collected at a single time point, we can only interpret this effect as a causal one on the basis of previous research (Lydon et al., 1997). It is also possible that caregivers' well-being fueled their enthusiasm toward caregiving. Again, a longitudinal study of primary caregivers would be needed to elucidate the direction of this effect.

Interpersonal expectations. Another explanation for the lower enthusiasm of young primary caregivers might reside in their interpersonal expectations in relation to the patient (generally their parent). Adult children might have different expectations regarding the provision of care to their parents than spouses or siblings of those with dementia. Throughout their lives, children have looked to their parents for support, and they have not expected their parents to rely on them. Unlike within peer relationships, parent–child relationships might not entail expectations of mutual care. Elderly caregivers might be more enthusiastic about the provision of care, because it is more consistent with the relationship they have developed with the patient. This hypothesis is consistent with theory and research on communal orientation. Individuals who are more communally oriented focus more on the other than on the self within a close relationship (Helgeson, 1994). With respect to caregiving, this would entail a more selfless, altruistic view of the relationship, where enjoyment and satisfaction are derived from helping the other (Clark & Mills, 1979). In a study of primary caregivers of Alzheimer's patients, Williamson and Schulz (1990) found that being more communally oriented was associated with experiencing less depression. Thus, although not assessed in this study, we would expect communal orientation to be associated with enthusiasm in caregiving and young primary caregivers to be less communally oriented than elderly caregivers.

Social norms. A difference in enthusiasm, interpersonal expectations, or communal orientation between the two generations of primary caregivers also could be explained by a difference in social norms. Such a difference might be culture specific or mainly a cohort effect. The sample was composed of urban North Americans. Research has shown that inhabitants of rural areas and those in less individualistic cultures are more communally oriented than urban North Americans (Stockard & Dougherty, 1983). In contrast to this urban sample, adult children and peer caregivers in either rural communities or more collectivist societies might not differ in their enthusiasm toward caregiving, as they would generally be more communally oriented. As Lee and Sung (1997) reported, in Korean families, filial responsibility of children toward their parents is a highly valued social norm. In contrast to North American children, as Korean children grow older, they expect to be responsible for their aging parents and value caregiving as a means of expressing their respect and gratitude to their parents. In such a setting, we might not find a difference in enthusiasm toward caregiving in elderly and young primary caregivers.

The difference between the two groups of primary caregivers in this study also might be explained by a cohort effect, whereby elderly caregivers, in comparison to young primary caregivers, might have more communal values and different attitudes toward others in general and toward caring for an ill family member in particular. In support of this hypothesis, Yamamoto and Wallhagen (1997) reported that in a sample of caregiving Japanese daughters and daughters-in-law, the older caregivers had internalized the traditional social norm of filial responsibility and valued the caregiving role more than younger caregivers, who were more influenced by individualistic Western values. In our sample, younger caregivers might have internalized more individualistic social norms than elderly caregivers who were raised with more communal social norms.

Life stages. An alternative explanation for this group difference may be found in the life stages of psychosocial development postulated by Erikson (1997). The young caregivers are middle-aged and, accordingly, should be at Erikson's stage of generativity versus stagnation. This stage is one in which the individual progressively becomes more attentive to the needs of others than to his or her own needs. This stage is resolved ideally by an increased caring for others, yet the young caregivers may be less likely than elderly caregivers to have reached this level of resolution and caring for others. Hassan and Bar-Yam (1994) linked this life stage with the development of mutually supportive relationships and interconnectedness, which may be tied to a more communal orientation.

Commitment and Appraisals of Potentially Problematic Situations

A final objective of this study was to consider possible processes by which enthusiasm helps maintain well-being and moral commitment helps sustain caregiving efforts. For this purpose, the appraisal of potentially problematic situations was examined as a function of caregivers' enthusiasm and moral commitment. Regression analyses revealed that a higher level of enthusiasm was conducive to appraising potentially problematic situations as less threatening. This tendency to appraise such situations as less threatening may enhance caregivers' well-being over time. As difficult situations repeatedly occur, appraising them as less threatening might serve to reduce the anxiety and stress brought on by caregiving, maintaining greater well-being in the more enthusiastic caregivers (Pierce et al., 1997).

Furthermore, the same potentially problematic situations were more likely to be appraised as challenges to be overcome when primary caregivers were more morally committed. As the patient's illness progresses, such situations are likely to occur more frequently. Thus, caregivers who do not appraise those situations as challenges to be overcome may be more likely to disengage themselves from their caregiving role by placing the patient with another family member or in an institution. As moral commitment was associated with persistence in long-distance dating relationships (Lydon et al., 1997), it was here a feature distinguishing primary from nonprimary caregivers. More morally committed primary caregivers appear more likely to appraise potentially problematic situations as challenges, which may lead them to persist longer in their role as a primary caregiver, delaying the time at which they relinquish this responsibility.

In sum, moral commitment and enthusiasm have different functions in sustaining caregivers. Moral commitment motivates appraisals that help maintain the caregiving role, whereas enthusiasm motivates appraisals that help maintain the caregiver's well-being.

Practical Implications of These Findings

This research might be helpful to health professionals who wish to detect caregivers at elevated risk of experiencing poorer well-being. It suggests that a lower level or a decline in caregivers' enthusiasm toward their role might be a marker for a decline in well-being. This decline might operate through an increased likelihood of appraising potentially stressful situations as threatening. Thus, less enthusiastic primary caregivers or those with declining enthusiasm might be among those with a greater need for support services or counseling.

To improve or sustain these caregivers' well-being, this research suggests that interventions by health professionals might be aimed at increasing the self-determination of caregivers, which in turn would increase their enthusiasm toward caregiving. Providing caregivers with opportunities for autonomy in their role, helping them see the different options available to them, and allowing them greater freedom of choice with respect to caregiving tasks should increase their level of self-determination (Deci & Ryan, 1985; O'Connor & Vallerand, 1994; Spicker, 1990). This can be done in a variety of ways, such as giving them information on the different ways in which they can provide care or resolve problems (i.e., giving them choices) or encouraging them to relinquish less self-determined caregiving tasks to other family members or to home care services.

Directions for Future Research

The correlational nature of this study and the absence of longitudinal data prevent us from drawing conclusive causal inferences with respect to the associations between identification, enthusiasm, and caregivers' well-being. Thus, longitudinal research would be needed to support these hypothesized causal effects. Future research also should explore possible factors other than an identified internalization of caregiving beliefs and values, which influence and promote caregivers' enthusiasm. These factors could include the quality of the caregiver's relationship with the patient prior to the onset of illness, the process of deciding who will become the primary caregiver, the circumstances surrounding the adoption of the caregiver role, or other family members' support and appreciation of the primary caregiver.

This study was conducted mainly with female caregivers. This is generally characteristic of research in this field (e.g., C. A. Cohen, Gold, Shulman, & Zucchero, 1994; Lee & Sung, 1997; Miller & Kaufman, 1996) and is consistent with a considerably higher proportion of women among primary caregivers (see Mathew, Mattocks, & Slatt, 1990). Nonetheless, it should not be assumed that the processes examined in this study are equally representative of the experience of male primary caregivers. Future research could examine possible differences in the level of self-determination, moral commitment, and enthusiasm in male versus female caregivers and how this might account for sex differences in their well-being (Draper, Poulos, Poulos, & Ehrlich, 1996; Grafstroem, Fratiglioni, & Winblad, 1994; Lutzky & Knight, 1994).

In conclusion, although this study was conducted with only a small sample of caregivers, it serves to demonstrate how considering the enthusiasm and moral commitment of primary caregivers of those with dementia may help us understand the caregiving experience. Enthusiasm and moral commitment may clarify why caregivers who experience apparently similar situations, caring for loved ones with similar levels of cognitive and physical impairment, differ in well-being and in their desire to persist in caring for their loved one at home.

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