Caregiver Identity and Perceived Partner Changes: An Exploratory Path Analysis of Relationships to Subjective Happiness and Health

Nicolas Westrelin[1, 2], Sophie Lelorain[3], Catherine Denève[2], & Emmanuelle Zech[1]

[1] Person Centred Research and Training Lab (PCLab), Psychological Sciences Research Institute, UCLouvain, Louvain-La-Neuve, Belgium

[2] ETHICS EA-7446, Catholic University of Lille, France

[3] PHASE, Université de Lausanne, Lausanne, Switzerland

Accepted for publication October 14, 2025 in *Scandinavian Journal of Caring Sciences*

The authors have no known conflict of interest to report.

Correspondence concerning this article should be addressed to Nicolas Westrelin, nicolas.westrelin@uclouvain.be

Acknowledgements

The authors would like to thank the caregivers who took time to contribute to this research. They also wish to thank Pr P. Hilpert for his precious support with the statistical analysis.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Research ethics and patient consent

Before initiating data collection, a thorough review and approval of this study were conducted by an Hospital-Faculty Ethics Committee (ref: 2023/02MAI/213). As delineated in the Method section, all participants provided written informed consent before engaging in the study.

ABSTRACT

***Objective*:** In the context of a health condition affecting their partner's autonomy, spouses may perceive changes in their partner. Due to the affective bond between partners, the increase in perceived change in the partner may lead to a shift from the identity of spouse to caregiver. However, although the literature hypothesis that the identification to the caregiver role may be a protective factor against the negative outcomes of caregiving negative, it remains unclear how this change in identification affects spouse caregivers' happiness and health.

Methods: In this cross-sectional study, 102 spouse caregivers completed an online survey measuring their perception of their partner's changes, identification with the caregiver role, and the perceived impact of caregiving on their health and happiness.

Results: Path analysis revealed that only the perception of cognitive and relational changes in the spouse predicted identification to the caregiver role (standardized β ranged from -0.31 to 0.44; $p \leq .05$). A higher level of identification with the caregiver role explained less happiness (standardized β = -0.37, $p \leq .01$) but a smaller perceived impact of caregiving on health (standardized β = -0.39, $p \leq .001$).

Conclusion: Due to its influence on happiness and health, caregivers' identity and its personal meaning should be considered a determining factor in the experience of caregiving for a spouse and should be taken into account by the professionals supporting them.

Key words: Informal caregivers, couple, identity, well-being, health

Word count: 4890

Introduction

Informal caregivers provide care to their close relatives or loved ones outside of formal professional settings. They provide assistance to individuals facing health conditions or the effects of typical aging, which may impair their autonomy (1). While experiencing psychological, physical, social, and financial strains associated with caregiving, informal caregivers often neglect their own health and subjective well-being in favor of their care recipients (2–4). They are less likely to use medical services and face poorer cardiovascular health, psychosomatic and immunological problems (5–7). Among informal caregivers, spouse caregivers experience more negative effects of caregiving (e.g., depression, anxiety), compared to other types of caregivers, (e.g., adult children, siblings) and they are more reluctant to self-identify as caregivers (8–10). Additionally, self-identification with the caregiver role plays a pivotal role in the help-seeking process and the health of caregivers (11–13).

Three main factors may influence the identification process as a caregiver: the relationship with the care-receiver, the caregiving tasks and the perception that the care-receiver has changed. The first two factors have been widely explored and confirmed as determinants (see 10,14,15). In sum, the more the relationship with the care recipient is altered by the health condition, the stronger the caregiver identification will be. Additionally, the heavier the caregiving tasks, the stronger an individual will identify with the caregiver role. Nevertheless, the last factor and its impact on caregivers' identification seems less studied.

The perceived changes within care-recipients' identity and their affective relationship with their caregiver result from their health condition (16), particularly in cases of cognitive impairment (17). Perceiving the care partner having changed is reported to cause distress for

caregivers (18,19). Two types of coping strategies stem from perceiving that the care recipient has changed. First, the depersonalization of the care partner (e.g., objectification, negative characterization) is interpreted as a defense mechanism aimed at buffering the emotional distress resulting from the gap between the “former partner” and the “current partner” (19). This mechanism serves to both distance caregivers from their relational role and facilitate a more objective assessment of the caregiving situation. Second, some informal caregivers have other coping strategies such as distinguishing their “partner” from their “health condition” (20,21), which might enable them to empathize with their spouses while putting blame on the disease. These changes are perceived both in the personhood of the care partner and their abilities (i.e., cognitive, relational, physical). As the impairment from the health condition worsens, caregivers find it increasingly difficult to recognize their partner as “they were before”, as they lose attributes that defined their identity (21,22).

Identification with the caregiving role was usually perceived as a protective factor. Self-identification as an informal caregiver might play a pivotal role in caregivers’ health, particularly in terms of the support-seeking process and managing role pressure. For instance, caregivers who do not identify themselves as such may not feel entitled to seek formal support such as financial assistance or professional home help (12,23). In fact, individuals who perceive their caregiving tasks as part of their role as a "relative" rather than explicitly as a "caregiver" often experience greater strain due to the mismatch between their role (relative) and their caregiving tasks. This mismatch can lead to a decline in their physical and mental health (12,24,25). However, there is also some data showing that the identification with the caregiving role might in fact be detrimental to the caregiver’s health or well being. In fact, having a strong couple identity (rather than caregiver identity) have been demonstrated as a protective factor

against negative aspects of caregiving, such as relational deprivation, loss of self, or sense of captivity (26). To that extent, it remains unclear whether caregiver identity acts as a vulnerability or a protective factor for health and subjective well-being.

Nevertheless, existing studies have predominantly recruited caregivers who already identify themselves (at least to some extent) with their caregiving role. This recruitment bias is a major limitation, as it excludes the majority of caregivers who do not identify as such (8). As a result, our understanding of the full range of caregiver experiences and identities remains incomplete.

To address these gaps, this study aims to explore the process of identification with the caregiver role and how this identification influences health and happiness across a diverse group of spouse caregivers (e.g., dementia, cancer, chronic illness), including those who may not initially identify with the caregiving role. Specifically, (1) we aim to explore the association between perceived changes in the spouse and caregivers' identification with the caregiver role, and (2) we intend to examine the association between identification with the caregiver role and caregivers' health and subjective well-being. As a complementary objective, we investigate whether the insidious and untreatable nature of dementia (27,28) results in a different caregiving experience for spouse caregivers compared to other contexts. By doing so, we hope to provide a more comprehensive understanding of caregiver identity and its implications for caregiving outcomes.

Method

Procedure

The aim was to engage a diverse array of spouse caregivers (e.g., cancer, dementia, psychiatric disorders) to capture the multifaceted nature of informal caregiving. The study was structured to center on caregiving for a spouse experiencing autonomy loss. Then, three inclusion criteria were defined: participants had to be able to answer the questionnaire in French, and to be currently providing care, described in the study as "*providing free assistance to a loved one, such as managing household and administrative tasks, finances, health and/or personal needs*", (3) to be providing care for their spouse, including same-sex partner as recommended by Fredriksen-Goldsen et al (29). In order to get a representative and less biased representation of caregivers, no age limit was used in our study. As recommended by Oldenkamp et al. (30) and given the emphasis on caregiver identity, the term "caregiver" was intentionally omitted from the survey, consent form, and demographic questions. The expression "assisting a spouse with autonomy loss" was used instead.

An online survey was developed using the Qualtrics® survey platform. Upon clicking the provided link, participants were provided with detailed information about the study's objectives, along with the informed consent procedures. The survey link, accompanied by a brief explanatory text, was disseminated across various online platforms including websites, social media groups, and forums. Furthermore, an email outreach caregiving associations and medical professionals in Belgium and France, inviting them to share the survey link with their respective members and on their organizational websites. In adherence to the guidelines stipulated by the institutional Ethics Committee, informal caregivers in the study were required to provide informed consent digitally, prior to completing the questionnaire. Data collection started after receiving ethical approval from Hospital-Faculty Ethics Committee (ref: 2023/02MAI/213) and participants could take the survey from July 2023 to March 2024.

Measures

Identity change in partner was measured with the rating scale of *Perceived Identity Change* (PIC; 31). It comprises a single item gauging the extent to which caregivers perceive their spouse as different from their previous self (i.e., "To what degree would you say your partner has changed from who she/he was, before his/her difficulties began?"). To capture a more comprehensive assessment of perception change in the caregiving context, we included three additional items with the same format, focusing respectively on cognitive, physical, and relational change. Prior to responding to these questions, participants were asked, "*Do you feel your partner is different from who he/she was in the past, before his/her difficulties began?*". Those responding affirmatively were then presented with the four PIC items. A higher score indicates a greater perception that their spouse was different since the onset of the health condition. Participants rated changes on a Likert scale from 1 "*No change"* to 7 "*Extreme Change*". The internal consistency of this scale, comprising four items, was moderate ($\alpha = .62$). To avoid conceptual overlap, the item assessing 'general change' (i.e., global perception of change in the partner) was not included in the analyses. We therefore relied on the three specific changes (i.e., relational, physical, cognitive) to ensure clearer conceptual distinction and interpretability of results.

Spouse caregivers' identification with their caregiver role was assessed using the Family Caregiver Identity Scale (FCIS; 14, 32). The latest version of this scale includes 18 items divided into five dimensions: (1) Role Engulfment & Loss of Self defined as "*when the role of caregiver and responsibilities of caring begin to consume a person, leaving little time for other activities and behaviors that may have defined the person previously*" (14) (RELS, 4 items, e.g., "Because of providing care to my ill family member, I do not have time to do things that I

would normally do"); (2) Loss of Shared Identity described as "*changes to a person's dyadic identity because the dyad is diminishing or lost*" (14) (LSI, 4 items, e.g., "I feel less like a daughter/wife/husband/son/other because of providing care to my ill family member"). Unlike perceived relational change, which assesses transformations in the partner, this dimension captures the caregiver's own sense of diminished role identity within the dyad (i.e., as spouse); (3) Family obligation & Gender Norms represent "*a system of assumptions, beliefs, and values created by a society that frame how family should respond to a caregiving situation and who is expected to be the caregiver*" (14) (FOGN, 3 items, e.g., "Providing care to others is part of a woman's role"); (4) Extension of Former Role defined as "*Caregiving is seen as a normal and natural part of being a spouse*" (14) (EFR, 3 items, e.g., "Being a daughter/wife/husband/son/other means providing care to my family member if he/she becomes ill"), and (5) Master Identity described as "w*hen the caregiver role becomes the dominate identity, replacing or overtaking any other important identity*" (14), (MI, 4 items, e.g., "Being a caregiver is a significant part of who I am"). Participants rated the extent to which each statement represented their thoughts on a four-point Likert scale, ranging from 0 "*Completely disagree"* to *3 "Completely agree*". A higher score indicates a stronger identification with their caregiver role. As there was no validated French version of this scale, we translated it with the assistance of native English-speaking colleagues. For the purpose of the study, we replaced the mentions "daughter/wife/husband/son/other" or "ill family member" with the term "partner" to align with our study population. We also modified the rating scale of each item to range from 1 *"Strongly disagree"* to 5 "*Strongly agree*", allowing participants to provide a neutral option if needed. Internal consistency was moderate for RELS, LSI, and EFR (Cronbach's $\alpha = .79$,

.65, .67 respectively), and poor for FOGN and MI (Cronbach's α = .37, .42 respectively) so that these two subdimensions had to be discarded for the analysis.

Caregivers' perceived impact on health was assessed using the 4-item health problems subscale of the validated French scale (33) of the *Caregiver Reaction Assessment* (CRA-h), such as: "My health has got worse since I started caring for …" (34). Participants rated the extent to which each statement represented their experience in the last two weeks on a five-point Likert scale, ranging from 1 "*Strongly disagree"* to 5 "*Strongly agree"*. This subscale generated a total score ranging from 4 to 20, with higher scores indicating a greater impact on health. Internal consistency in our study was acceptable (Cronbach's α = .74), consistent with the Cronbach's α reported in the validated French scale (α = .78; (33)).

Although much of the existing literature we draw upon refers to the broader construct of subjective well-being, happiness is often considered a central component of this broader construct (36). For the present study, we adopted Lyubomirsky and Lepper's narrower conceptualization of happiness as a global, subjective evaluation of one's overall life happiness. To align with this definition, we selected the Subjective Happiness Scale (36), which directly captures this dimension while providing a brief yet psychometrically robust measure of global subjective happiness (35, 36), making it particularly well-suited for populations at risk of questionnaire burden, such as informal caregivers. Subjective happiness was assessed using the validated French scale (35) of the *Subjective Happiness Scale* (SHS; 36). This scale includes two items measuring participants' self-perception of their happiness (e.g., "In general, I consider myself [happy]") and two items assessing their happiness in comparison with others (e.g., "Compared to most of my peers, I consider myself [happy]"). Participants rated each item

on a seven-point Likert scale, ranging from 1 "*less happy*" to 7 "*more happy*". A higher score indicates a higher level of subjective happiness. Internal consistency in our study was acceptable (Cronbach's α = .76), consistent with the Cronbach's α reported in the validated French scale (α = .83; (35)).

Data analysis

To gain a deeper understanding of the association between our variables, multiple analyses were used. Initially, Pearson correlations were used to examine the relationships between variables, utilizing IBM SPSS Statistics version 29. Subsequently, path analysis were conducted with R version 4.3.1 (lavaan package), employing the maximum likelihood method. Regression between standardized parameter estimates was considered significant at a .05 level, and the predictive power was interpreted using three levels: small ($r < .10$), medium ($r < .30$), and large ($r < .50$) (37). Covariances among explanatory variables and among mediators were estimated to account for their conceptual interdependence, as they derived from the same instrument to account for shared method variance. In addition, residual covariances derived from items within the same instrument were allowed to account for shared method variance, in line with established SEM recommendations (38). No other residual covariances were specified.

Multiple types of fit indexes were utilized, including sample-adjusted indices and parsimony-adjusted indices, such as $\chi 2$, CFI, TLI, RMSEA, and SRMR. Acceptable fit indexes are expected to meet the criteria of ≥ 0.90 for CFI and TLI, and RMSEA ≤ 0.06 (38). To better identify differences between spouse caregivers' experiences across different health conditions, we performed independent t-tests on each variable differentiating spouse caregivers in the context of dementia from those in other contexts, using IBM SPSS Statistics version 29.

Given the modest final sample size (N = 102), we conducted a parsimonious path analysis using observed variables rather than latent constructs. This decision reduced the number of estimated parameters and is consistent with methodological recommendations for small to moderate samples (38). The model was therefore designed to balance theoretical relevance with statistical appropriateness given the sample size.

Results

Description of sample and bivariate analysis of investigated variables

A total of 152 participants completed our questionnaire; however, 50 individuals were excluded as they did not meet the inclusion criteria (i.e., caregiving for a parent, for a child). As detailed in **Table 1**, the final sample included 102 spouses' caregivers, and was mainly constituted of women (70.6%), their age ranged from 22 to 88 years old, with a mean age of 67.31 years old (SD = 11.02). They were mainly taking care of a male spouse (70.6%), their age ranged from 22 to 89 years old with a mean age of 70.21 years old (SD = 11.55). Out of the 102 included spouses' caregivers, two were in same-sex relationship. The health conditions of the care-recipients varied, predominantly encompassing dementia (65.7%), physical disabilities and chronic illness (e.g., HIV, diabetes). Furthermore, 27.7% of our participants were providing care for a spouse with multiple health conditions, ranging from two to four health conditions.

Table 1.

Description of the sample (N=102)

	Mean (SD)	N (%)
Caregiver		
Age	67.31 (11.02)	
Women		72 (70.6%)
Nationality		
Belgian		12 (11.8%)
French		90 (88.2%)
Education		
Primary		18 (17.6%)
Secondary		31 (30.4%
Superior		39 (38.2%)
Third cycle		7 (6.9%)
Other		7 (6.9%)
Occupation status		
Student		1 (1%)
Jobless		11 (10.8%)
Employee		14 (13.7%)
Freelance		4 (3.9%)
Retired		72 (70.6%)
Care-receiver		

Age	70.21 (11.55)	
Women		30 (29.4%)
Health status [a]		
Dementia		67 (65.7%)
Physical disability		31 (30.4%)
Chronic illness		17 (16.7%)
Cancer		7 (6.9%)
Autonomy loss attributed to typical aging.		5 (4.9%)
Substance abuse		1 (1%)
Mental disorder		10 (9.8%)
Multiple health conditions		28 (27.5%)

[a] Due to comorbidities, the amount health issues exceed the number of care-recipients

Descriptive statistics of the investigated variables and Pearson's correlations are displayed in **Table 2**. The three types of perceived change investigated are linked to different aspects of caregiving: cognitive change is positively associated with identification to the caregiver role, physical change is related to negative outcomes of caregiving (i.e., greater impact of caregiving on health, less happiness), and relational change is associated with all of the above. All dimensions of caregiver identity were associated with the impact of caregiving on health, and two dimensions were associated with happiness: role engulfment & loss of self, and loss of shared identity. Finally, there was a very significant negative relationship between happiness and the impact of caregiving on health.

Table 2

Pearson correlation matrix of investigated variables

	PCC	PPC	PRC	CRA-h	SHS	RELS	LSI	EFR
PCC	1							
PPC	.03	1						
PRC	.35**	.16	1					
CRA-h	.04	.27*	.28**	1				
SHS	-.02	-.33**	-.20	-.32**	1			
RELS	.31**	.09	.29**	.30**	-.33**	1		
LSI	.03	.11	.41**	.32**	-.51**	.63**	1	
EFR	.22	-.07	-.22	-.30**	-.08	.13	.10	1
Mean	5.57	4.53	5.16	12.28	14.85	8.96	9.30	7.00
SD	1.33	1.62	1 .51	3,23	5.15	2.01	1.76	1.25

Note. $N = 102$

Abbreviations: PCC, Perceived Cognitive Change; PPC, Perceived Physical Change; PRC, Perceived Relational Change; CRA-h, Caregiver reaction Assessment-health; SHS, Subjective Happiness Scale; RELS, Role engulfment & Loss of Self; LSI, Loss of Shared Identity; EFR, Extension of Former Role.

*$p < 0.05$.; **$p < 0.001$.

Effects of Perceived change in partner on Identification to the Caregiver Role

The first model displayed on **Figure 1** provided a reasonable fit of the sample data ($\chi 2$=11.08, df=7; p = .31; CFI=.953; TLI=.835; RMSEA=.089; SRMR=.056). In this model, the three types of perceived change accounted for 10%, 21%, and 20% of the variance for Role Engulfment & Loss of Self, Loss of Shared Identity, and Extension of Former Role, respectively. Overall, perceived changes in the partner and caregiver's identity accounted for 14% of caregivers' level of happiness and 30% of the impact of caregiving on their health.

In the context of caregiving, parameter estimates indicated that Perceived Cognitive Change (PCC) significantly predicted Extension of Former Role (β = .32; p < .01). Perceived Physical Change (PPC) did not predict any of the three dimensions of the caregiver's identity. Perceived Change in the Relationship (PCR) positively predicted Loss of Shared Identity (β = .44; p < .001) and negatively predicted Extension of Former Role (β = -.31; p < .01). In sum, perception of cognitive change within the partner predicted a stronger identification with the caregiver role, while perceiving change in the relationship predicted both greater and weaker identification with the caregiving role, depending on the dimension.

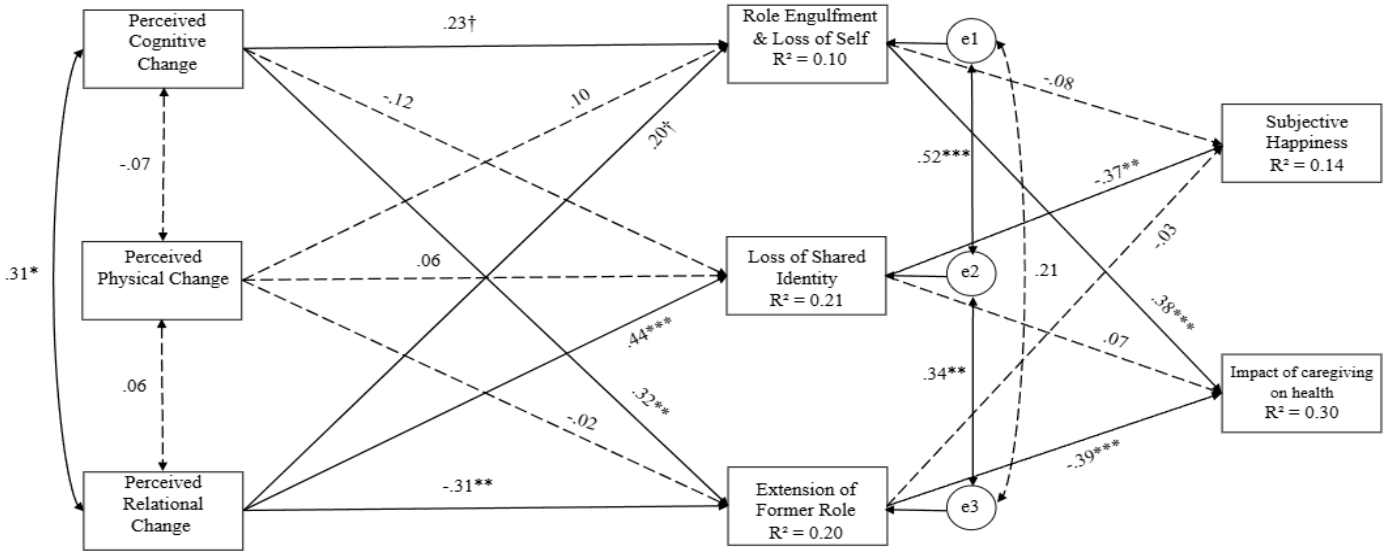
Effects of Identification to the Caregiver role on Caregivers' Health & Happiness

Regarding caregiving outcomes, all three dimensions of caregiver's identity predicted caregiving outcomes. Role Engulfment significantly predicted a greater perceived impact of caregiving on caregiver's health (β = .38; p <.001), while higher Extension of Former Role predicted less perceived impact of caregiving on their health (β = -.39; p <.001). Then, Loss of Shared Identity significantly predicted less happiness in caregivers (β = -.37; p <.01). Furthermore, perceiving changes in the partner indirectly affected caregiving outcomes. Specifically, perceiving relational changes (PRC) had a negative indirect effect on happiness

through the Loss of Shared Identity (β = -0.16; $p < 0.05$) and a positive indirect effect on the impact of caregiving on health through the Extension of Former Role (β = 0.12; $p < 0.05$). Additionally, cognitive change within the partner (PCC) had a negative indirect effect on the impact of caregiving on health through the Extension of Former Role (β = -0.12; $p < 0.05$).

Figure 1

Path analysis Model of the effects of Perceived change in partner on Caregiver Identity, Health and Happiness.



Note. All coefficients are standardized. †$p < 0.10$.; *$p < 0.05$.; **$p < 0.01$.; ***$p < 0.001$. Indirect effects are presented in **Appendix Table A1** and **Appendix Figure A1**.

Effects of Perceived change in partner on Caregiver Identity and its effects on Caregivers' Health and Happiness, depending on the partner's health condition

We compared participants based on the health conditions of their spouses (**Table 3)**. In comparison to those caring for spouses with a different condition, caregivers of a spouse with dementia perceived significantly more cognitive changes, $t(89) = 2.83$, $p < .01$, and significantly fewer physical changes in their partner, $t(89) = -3.11$; $p < .001$. There was no difference observed in the perception of relationship change based on the health condition. Additionally, the dimension of Loss of Shared Identity was significantly higher for caregivers in the context of dementia compared to others, $t(82) = 2.19$; $p < .05$. There were no differences in caregiving outcomes depending on the spouse's health condition.

Table 3

Results of independence t-tests and effect size of the type of health condition on all measured variables

	Dementia Caregiving (N = 65)		Caregiving in other contexts (N = 37)		*t* test	Cohen's *d*
	Mean	*Standard deviation*	*Mean*	*Standard deviation*		
Perceived Cognitive Change (PCC)	5.83	1.07	5.00	1.68	2.83**	0.64
Perceived Physical Change (PPC)	4.19	1.58	5.29	1.46	-3.11**	-0.71
Perceived Relational Change (PRC)	5.30	1.47	4.86	1.56	1.30	0.29

Role Engulfment & Loss of Self	9.12	1.71	8.64	2.50	0.92	0.24
Loss of Shared Identity	9.60	1.46	8.73	2.14	2.19*	0.50
Extension of Former Role	7.11	1.30	6.79	1.14	1.15	0.26
Subjective Happiness	14.89	4.90	14.76	5.70	0.11	0.25
Impact of Caregiving on Health	12.05	3.36	12.76	2.92	-1.00	-0.22

Note. *$p < 0.05$.; **$p < 0.01$.

For exploratory purposes, the same path analyses were conducted on both sub-samples (see **Appendix Figure B1**). The model with caregivers in the context of dementia provided the following fit: χ^2=12.91; df=7; p = .07; CFI=.933; TLI=.733; RMSEA=.133; SRMR=.067. In this model, the three types of perceived change accounted for 16%, 24%, and 31% of the variance for Role Engulfment & Loss of Self, Loss of Shared Identity, and Extension of Former Role, respectively, which is better than in the original model. Overall, perceived changes in the partner, and caregiver's identity accounted for 28% of caregivers' level of happiness and 24% of the perceived impact of caregiving on their health.

Notably, the main differences from the general model are that, in the context of dementia caregiving, Perception of Physical Change (PPC) significantly explained Role Engulfment (β = .29; $p < 0.05$), and Role Engulfment no longer significantly explained the perceived impact of caregiving on health (β = .25; $p < 0.10$). Moreover, Perceived Cognitive Change (PCC) and Perceived Change in the Relationship (PCR) no longer covaried (r = .27; p = .14) but Role Engulfment and Extension of Former Role did (r = .33; p = .02). Due to the very small sample size (N = 37), the model with caregivers in other contexts could not be identified.

Discussion

Our results highlight a crucial insight: the way caregivers perceive changes in their partner significantly influences their own identification with the caregiver role. This finding underscores the dynamic nature of caregiver identity, suggesting that it is not static but responsive to the evolving perceptions of the care recipient. The data reveal a nuanced relationship between caregiver identity and the impact on health.

Specifically, our study shows that perceptions of change can lead to varying degrees of identification with the caregiver role. Notably, cognitive changes in the partner led to a stronger identification with the caregiver role. As cognitive changes are highly associated with the partner's symptoms and autonomy, it makes sense that the higher the symptoms, the more spouse endorses caregiving tasks, with in turn increases their identification with the caregiver role (15,39,40). In contrast, perceptions of relational changes had a more complex impact on the identification with this role. A closer examination of the dimensions of caregiver identification reveals that perceiving changes in the relationship with the ill spouse increases the feeling of losing their identity as a couple, thereby strengthening their identification as a caregiver. This is consistent with the literature showing how caregiving affects the couple relationship: such as the loss of reciprocity and diminished emotional expression between partners (11,22,41). However, these relational changes diminish the sense that caregiving is part of their spousal identity leading to a weaker identification with the caregiver role. This apparent paradox reflects the complexity of spousal caregiving: caregiving arises from the relationship with the spouse (10,12), yet the spouse receiving care is perceived as different from before the onset of the health condition (19,21). This change may lead spouse caregivers to feel as though they are caring for a partner who is no longer truly present.

Identification with the caregiver role, in turn, has a dual impact on happiness and perceived impact of caregiving on health, both enhancing and diminishing these outcomes, depending on how the caregiving identity arises. First, when caregivers experience a loss of shared identity, it is linked to decreased happiness among spouse caregivers. This means that when spouse caregivers feel that their dyadic relationship with their partner is lost or diminished, they experience less happiness. This finding is consistent with previous studies showing that spouse caregivers perceive their new relationship with their partner as less fulfilling and of lower quality (42,43). However, the relationship between caregiver identity and perceived impact of caregiving on health is more nuanced. Caregiver identity both diminishes or enhances the perceived impact of caregiving on health depending on how caregiver identity is experienced. Specifically, when caregiving is perceived as an engulfment or a loss of self, the perceived negative impact on health is greater. Conversely, when the Extension of Former Role dimension is high, the negative impact of caregiving on health is smaller. This suggests that if spouse caregivers feel that caregiving has consumed their sense of self, they may experience greater negative health consequences compared to those who perceive caregiving as a natural extension of their role as a spouse. Therefore, how the identity as a caregiver is experienced by the caregiver is a predictor of the perceived impact of caregiving on health. This complex interplay suggests that caregiver identity cannot be conceived merely as a protective or vulnerability factor, but rather as an integral part of the caregiving experience and a key mediator between perceived partner changes and caregiver subjective well-being.

Interestingly, our findings diverge when focusing on dementia caregivers. In this context, the perception of changes in partner explained better caregiver identification and caregivers' subjective happiness. In the context of dementia, different types of perceived changes do not covary. To that extent, it is conceivable that spouse caregivers may perceive

symptoms related to dementia (e.g., cognitive change, physical change) separately from their ill spouse, particularly in relation to changes in their relationship. This phenomenon echoes findings from qualitative studies reporting that dementia caregivers see the disease separately from their spouse (20,21).

Additionally, when the spouse afflicted with dementia is perceived as physically changed (e.g., appearance, facial features), spouse caregivers experience more role engulfment. To our knowledge, the effect of perceived physical change in dementia has not been investigated yet. Thus, we can only hypothesize that, in dementia, caregivers do not expect physical transformations in their spouse, as is common in other conditions (e.g., hair and/or muscle loss in cancer). When compared to other caregivers, spouse caregivers with dementia perceive fewer physical changes in their partner. Therefore, when such changes do occur, caregivers may feel a heavier responsibility to care for their spouse, leading to role engulfment. This indicates that the type of illness plays a significant role in shaping the caregiver's experience. These results are consistent with the literature suggesting that dementia caregiving is uniquely challenging due to the insidious and untreatable nature of dementia (27). Nevertheless, due to the mixed fit indices of this model and the small sample size (N = 65), these findings should be interpreted with caution. While the χ^2, SRMR, and CFI indicate an acceptable model fit of the data, the low TLI and high RMSEA raise concerns about the generalizability of this model.

This study is not without limitations. The cross-sectional design provides a snapshot of spouse caregivers' experiences at a given time. Nevertheless, since identification with the caregiver role is a process rather than a fixed state, future studies should investigate how perception, identification, and caregiving outcomes fluctuate over time. Methodologically, the scale used to assess caregiving identity (i.e., Family caregiver Identification Scale; 21) was not validated in French. Consequently, it is possible that some items may have different meanings

in English and French. This discrepancy could also explain why two out of the five dimensions of this scale did not provide satisfactory Cronbach's alpha. The relatively small sample size may limit the stability and generalizability of our SEM results. These findings should therefore be interpreted with caution and ideally replicated with larger samples. Nevertheless, recruiting from this specific population posed significant challenges, and the current study provides valuable preliminary insights.

In conclusion, our study bridges important gaps in the literature by demonstrating that caregiver identity is a key mediator between perceived partner changes, caregiver subjective well-being and the perceived impact of caregiving on their own health. Given the significant impact of caregiver identity on health and happiness, it is essential for professionals to consider these dynamics when supporting caregivers. This role is critical and should be the focus of future interventions aimed at supporting caregivers. Interventions should be tailored to address the specific perceptions and identity shifts experienced by caregivers, particularly in the context of dementia. For example, professionals should focus on preserving dyadic identity, emphasizing that caregiving is part of their role as a partner, and preventing role engulfment for spouse caregivers. Future research should continue to explore the link between caregiver identity and the willingness to seek professional help, as well as the effect of such help on caregiving outcomes.

References

1. Schulz R, Beach SR, Czaja SJ, Martire LM, Monin JK. Family Caregiving for Older Adults. Annu Rev Psychol. 2020;71(1):635–59.

2. Gérain P, Zech E. A Harmful Care: The Association of Informal Caregiver Burnout With Depression, Subjective Health, and Violence. J Interpers Violence. 2021 Jan 5;0886260520983259.

3. Pinquart M, Sörensen S. Correlates of Physical Health of Informal Caregivers: A Meta-Analysis. J Gerontol B Psychol Sci Soc Sci. 2007 Mar 1;62(2):P126–37.

4. Schulz R, Tompkins CA. Informal Caregivers in the United States: Prevalence, Caregiver Characteristics, and Ability to Provide Care. In: The Role of Human Factors in Home Health Care: Workshop Summary. National Academic Press. 2010. p. 117–30.

5. Carretero S, Garcés J, Ródenas F, Sanjosé V. The informal caregiver's burden of dependent people: Theory and empirical review. Arch Gerontol Geriatr. 2009 Jul 1;49(1):74–9.

6. Grunfeld E, Coyle D, Whelan T, Clinch J, Reyno L, Earle CC, et al. Family caregiver burden: results of a longitudinal study of breast cancer patients and their principal caregivers. CMAJ. 2004 Jun 8;170(12):1795–801.

7. McPherson KM, Pentland B, McNaughton HK. Brain injury - the perceived health of carers. Disabil Rehabil. 2000 Jan 1;22(15):683–9.

8. Broese van Groenou MI, de Boer A, Iedema J. Positive and negative evaluation of caregiving among three different types of informal care relationships. Eur J Ageing. 2013;10(4):301–11.

9. Cheung DSK, Ho KHM, Cheung TF, Lam SC, Tse MMY. Anticipatory grief of spousal and adult children caregivers of people with dementia. BMC Palliat Care. 2018 Dec;17(1):124.

10. Hughes N, Locock L, Ziebland S. Personal identity and the role of 'carer' among relatives and friends of people with multiple sclerosis. Soc Sci Med. 2013 Nov 1;96:78–85.

11. Hayes J, Boylstein C, Zimmerman MK. Living and loving with dementia: Negotiating spousal and caregiver identity through narrative. J Aging Stud. 2009 Jan;23(1):48–59.

12. Montgomery RJV, Kosloski K. Caregiving as a Process of Changing Identity: Implications for Caregiver Support. Generations. 2009 Spring;33(1):47–52.

13. O'Connor DL. Self-identifying as a caregiver: Exploring the positioning process. J Aging Stud. 2007 Apr 1;21(2):165–74.

14. Eifert EK, Adams R, Dudley W, Perko M. Family Caregiver Identity: A Literature Review. Am J Health Educ. 2015 Nov 2;46(6):357–67.

15. Skaff MM, Pearlin LI. Caregiving: Role Engulfment and the Loss of Self. The Gerontologist. 1992 Oct 1;32(5):656–64.

16. Betts Adams K, McClendon MJ, Smyth KA. Personal losses and relationship quality in dementia caregiving. Dementia. 2008 Aug 1;7(3):301–19.

17. Cohen-Mansfield J, Parpura-Gill A, Golander H. Salience of self-identity roles in persons with dementia: Differences in perceptions among elderly persons, family members and caregivers. Soc Sci Med. 2006 Feb 1;62(3):745–57.

18. McCormack L, Tillock K, Walmsley BD. Holding on while letting go: trauma and growth on the pathway of dementia care in families†. Aging Ment Health. 2017 Jun 3;21(6):658–67.

19. Walters AH, Oyebode JR, Riley GA. The dynamics of continuity and discontinuity for women caring for a spouse with dementia. Dementia. 2010 May 1;9(2):169–89.

20. McIntyre AE, Reynolds F. There's no apprenticeship for Alzheimer's: the caring relationship when an older person experiencing dementia falls. 2012;

21. Westrelin N, Denève C, Gérain P, Zech E. "He is changing, but I'm changing too": An Interpretative Phenomenological Analysis of Spouse Caregivers' Identity in the Context of Dementia. Scand J Caring Sci. 2024;1–10.

22. Quinn C, Clare L, Woods B. The impact of the quality of relationship on the experiences and wellbeing of caregivers of people with dementia: A systematic review. Aging Ment Health. 2009 Mar 1;13(2):143–54.

23. Eifert EK, Dudley W, Eddy J, Perko M, Adams R. Preliminary Evidence for the Validity of the Family Caregiver Identity Scale. J Appl Gerontol. 2021 Jul 1;40(7):742–51.

24. Carroll L, Chippior J, Karmali S, Sriram D, Ysseldyk R. We Are Caregivers: Social Identity Is Associated with Lower Perceived Stress among Rural Informal Caregivers. Can J Aging Rev Can Vieil. 2019 Mar;38(1):59–75.

25. Pinquart M, Sorensen S. Correlates of Physical Health of Informal Caregivers: A Meta-Analysis. J Gerontol B Psychol Sci Soc Sci. 2007 Mar 1;62(2):P126–37.

26. Badr H, Acitelli LK, Carmack Taylor CL. Does couple identity mediate the stress experienced by caregiving spouses? Psychol Health. 2007 Feb 1;22(2):211–29.

27. Richardson TJ, Lee SJ, Berg-Weger M, Grossberg GT. Caregiver Health: Health of Caregivers of Alzheimer's and Other Dementia Patients. Curr Psychiatry Rep. 2013 May 28;15(7):367.

28. World Health Organization. Dementia [Internet]. 2022 [cited 2022 Oct 12]. Available from: https://www.who.int/news-room/fact-sheets/detail/dementia

29. Fredriksen-Goldsen KI, Kim HJ, Muraco A, Mincer S. Chronically ill midlife and older lesbians, gay men, and bisexuals and their informal caregivers: The impact of the social context. Sex Res Soc Policy J NSRC. 2009 Dec 1;6(4):52–64.

30. Oldenkamp M, Hagedoorn M, Stolk RP, Wittek RPM, Smidt N. The Lifelines Cohort Study: a data source available for studying informal caregivers' experiences and the outcomes of informal caregiving. J Compassionate Health Care. 2017 Dec;4(1):6.

31. Enright J. Identity and caregiver burden in dementia: An evaluation of telehealth reminiscence for informal caregivers [Thesis]. University of Saskatchewan; 2016

32. Eifert EK. Measuring caregiver identity: Scale development and validation. Vol. 76. ProQuest Information & Learning (US); 2014

33. Antoine P, Quandalle S, Christophe V. Vivre avec un proche malade : évaluation des dimensions positive et négative de l'expérience des aidants naturels. Ann Méd-Psychol Rev Psychiatr. 2010 May 1;168(4):273–82.

34. Given CW, Given B, Stommel M, Collins C, King S, Franklin S. The caregiver reaction assessment (CRA) for caregivers to persons with chronic physical and mental impairments. Res Nurs Health. 1992;15(4):271–83.

35. Kotsou I, Leys C. "Subjective Happiness Scale (SHS): Psychometric properties of the French version of the scale (SHS-F) and its relationship to psychological well-being, affect and depression". Can J Behav Sci Rev Can Sci Comport. 2017;49:1–6.

36. Lyubomirsky S, Lepper HS. A Measure of Subjective Happiness: Preliminary Reliability and Construct Validation. Soc Indic Res. 1999 Feb 1;46(2):137–55.

37. Kline RB. Principles and practice of structural equation modeling. 4th ed. New York (N.Y.): Guilford press; 2016

38. Kline RB. Principles and practice of structural equation modeling [Internet]. Guilford publications; 2023

39. Heward K, Gough B, Molineux M. Change of identity: the psychological and emotional impact of caring for someone with multiple sclerosis. Soc Care Neurodisability. 2011 Jan 1;2(1):21–32.

40. Saria MG, Courchesne N, Evangelista L, Carter J, MacManus DA, Gorman MK, et al. Cognitive dysfunction in patients with brain metastases: influences on caregiver resilience and coping. Support Care Cancer. 2017 Apr 1;25(4):1247–56.

41. Cross AJ, Garip G, Sheffield D. The psychosocial impact of caregiving in dementia and quality of life: a systematic review and meta-synthesis of qualitative research. Psychol Health. 2018 Nov;33(11):1321–42.

42. Ablitt A, Jones GV, Muers J. Living with dementia: A systematic review of the influence of relationship factors. Aging Ment Health. 2009 Jul 1;13(4):497–511.

43. Sedlar N, Lainscak M, Farkas J. Living with Chronic Heart Failure: Exploring Patient, Informal Caregiver, and Healthcare Professional Perceptions. Int J Environ Res Public Health. 2020 Jan;17(8):2666.