COMMUNAL COPING IN THE CONTEXT OF FILIAL CAREGIVING

by

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ABSTRACT

KIRBY R. MAGID. Communal Coping in the Context of Filial Caregiving.
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In the U.S., there has been a steady increase in the number of adult children providing care to their aging parents (i.e., filial caregivers). Filial caregiving impacts not only the caregiver and recipient, but also caregivers' spouses. This necessitates an understanding of how filial caregivers and their spouses cope with the stressors of caregiving. Communal coping, which involves both couple members viewing a stressor as a shared problem and responsibility that is managed together (Lyons et al.,1998), provides a promising framework for understanding how couples cope with chronic stressors. However, in the context of filial caregiving, wherein the responsibility of providing care is an extra-dyadic stressor, and the non-caregiving spouse may feel less obligated to be involved in providing care, it is unclear whether communal coping would be beneficial for caregivers' and spouses' personal and relational well-being, and whether there are motivations driving communal coping. This dissertation was designed to examine the antecedents and consequences of communal coping in this unique context. Forty-two filial caregivers and their spouses ($N = 83$ individuals) completed an online survey assessing relational motives (i.e., compassionate goals and communal strength), communal coping, and personal and relational well-being. Results indicated that communal coping was beneficial for caregivers' relational well-being and that compassionate goals may be an important predictor of communal coping for spouses. These findings broaden our understanding of the consequences of communal coping for caregivers' and spouses' personal and relational well-being and offer insight into how relational motives contribute to communal coping in the context of filial caregiving. Further research examining the relationship between relational motives, communal coping, and subsequent effects on well-being in the filial caregiving context is suggested.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: REVIEW OF THE LITERATURE

The number of older adults (≥ 65 years of age) living in the U.S. is projected to reach 95 million by 2060 (Vespa et al., 2020). Aging is accompanied by increased chronic disease and health deterioration. Caregiving for the current aging baby boomer cohort typically falls to their adult children, with 50% of family caregivers in the U.S. caring for a parent or in-law in 2019 (AARP & National Alliance for Caregiving, 2020). More broadly, 48 million family caregivers provided unpaid care to an adult in 2019 (AARP & National Alliance for Caregiving, 2020), and 2021 estimates place the economic value of that care at $600 billion (Reinhard et al., 2023). Despite the availability of institutional-based long-term care (LTC), informal care remains the preferred form of LTC in America. A majority of caregivers of aging parents are a part of the "sandwich generation," which refers to having responsibility as primary caregivers for their children and simultaneously being primary caregivers for their parents or parents-in-laws (Steiner & Fletcher, 2017). These sandwiched caregivers are typically in middle to late adulthood and must navigate their multiple roles as parents, caregivers, and workers, leading to increased responsibility and greater potential for personal and relational distress.

Filial caregivers – adult children caring for aging parents – experience greater stress, burden, and depression, as well as lower well-being and health than same-aged non-caregivers (Pinquart & Sorenson, 2003). The caregiving experience may impact not only the caregiver and care recipient, but also caregivers' spouses. Although there is limited research on the topic, caregivers' spouses must often accommodate their partner's caregiving role and make significant lifestyle adjustments. They must also cope with the stressors of their spouse providing care to aging parents. The aging population and growing importance of filial caregivers necessitates an understanding of how these caregivers and their spouses cope with and navigate the stressors of caregiving without sacrificing their own health and personal and relational well-being.

Communal coping, which involves both couple members viewing a stressor as a shared (i.e., “our”) problem and managing it together (“our responsibility;” Lyons et al.,1998), shows promise in helping relationship scientists understand how couples cope with chronic stress. Across contexts, (e.g., natural disasters, community stressors, and among couples wherein one partner is chronically ill), communal coping has been related to benefits such as lower distress, improved health, and enhanced relationship satisfaction (e.g., Helgeson et al., 2018). However, in the context of filial caregiving, wherein the responsibility of providing care to an aging parent is an extra-dyadic stressor, and where the other partner may feel less obligated to be involved in providing care, it is unclear whether communal coping would be beneficial. This project examines the consequences of communal coping in this unique context.

To date, coping scholars know little about the interpersonal processes involved in communal coping that affect filial caregivers and their spouses. As a result, little is also known about how relational motivations or what a person “wishes to accomplish in that circumstance, at that moment in time, with that partner” (Reis, 2021, p. 256) could promote or hinder communal coping. Because relational motives are an important determinant of relationship behavior, they may shed light on whether and how filial caregivers and their spouses cope with caregiving stressors together. Unlike personality traits and other individual difference variables, people can choose the relational motives that underlie their behavior in a given situation, and as such, motives can shift from day to day and even moment to moment (Crocker & Canevello, 2008). Thus, understanding how relational motives relate to communal coping may broaden our understanding of how individuals and couples engage in the communal coping process and the factors necessary to promote it. It may also provide a potential avenue for therapeutic interventions for individuals and couples to enhance communal coping (Grosse Holtforth et al., 2006). Relational motives take different forms; some focus on supporting others and providing care in relationships and others focus on adhering to norms in relationships (e.g., Canevello & Crocker, 2020; Mills et al., 2004). Therefore, I am also interested in understanding the unique contribution of these different motives to communal coping. An additional aim of this research is to identify what role different types of motives play in communal coping.

Thus, this dissertation addresses the following questions: (1) Is communal coping related to improved personal and relational well-being for filial caregivers?; (2) Is communal coping related to improved personal and relational well-being for the spouses of filial caregivers? In the remainder of this introduction, I will first discuss the extant work on filial caregiving and its relationship with personal and relational well-being. Next, I will discuss communal coping and how it might be applied to the context of filial caregivers and their spouses. I will then propose two potential antecedents to communal coping – compassionate goals and communal strength – in the context of filial caregiving and end with an overview of my hypotheses.

1.1 Caregiving for Aging Parents

Due to the growing aging population in the U.S., a large portion of baby boomers are the primary caregivers for their aging parents (Miyawaki et al., 2020). This generation often balances competing demands of caring for their children and caring for their parents, while simultaneously holding a career and being a spouse (e.g., Lei et al., 2023). Additionally, considerable evidence demonstrates that women more frequently assume the role of primary caregiver for their parents compared to men (Barnes et al., 1992; Kang & Marks, 2016; Pavalko & Artis, 1997; Yee & Schulz, 2000). Indeed, an estimated 11 million caregivers provided unpaid care to an adult while also caring for their children in 2019, and 61% of these caregivers were women (AARP & National Alliance for Caregiving, 2020). Therefore, this dissertation specifically focuses on women who are filial caregivers.

Filial caregivers balancing multiple roles experience additional strain when taking on the caregiving role (e.g., Flynn & Mulcahy, 2013). They are often thrown into the role with little notice and must quickly transition without any prior experience, knowledge, or skills to deliver adequate care to their aging parent (Reinhard et al., 2008). Thus, filial caregiving is related to increased burden, stress, and physical health problems (Luichies et al., 2021; Pinquart & Sorenson, 2011). Additionally, it can lead to increased financial stress due to taking on the financial responsibility of parents and potential loss of income if caregiving interferes with one's ability to work (Kanti & Falconier, 2017). In a number of studies, filial caregivers report social isolation, feelings of being trapped or restricted, and experiencing a lack of control of the situation (Donorfio & Kellett, 2006; Kanti & Falconier, 2017; McDonnell & Ryan, 2014).

Despite substantial literature on how filial caregiving affects caregiver health, limited work examines how filial caregivers' spouses are affected by their partners' caregiving experience. Bookwala (2009) found that long-time caregivers reported lower martial satisfaction and greater marital role inequity than recent caregivers. A study by Suitor and Pillemer (1994) found that wives' transition into the new role of caregiving had a negative effect on marital quality, resulting from a lack of husbands' emotional support and/or husbands' interference with wives' caregiving efforts. In line with these findings, a dyadic study by Bethea et al. (2002) found that having an aging parent reside in the same household as their adult child caregiver was related to decreased communicative satisfaction among filial caregivers and their spouses. Lastly, in a study examining levels of caregiving burden and marital satisfaction in filial caregiving daughters and their spouses, higher levels of caregiver burden were associated with lower marital satisfaction in filial caregivers' spouses (Higginbotham, 1996).

Although there is limited research focused on how filial caregiving affects the non-caregiving spouse's health and well-being, scholars have argued that caregiving is embedded in the context of families that extends beyond the caregiver-care recipient dyad (e.g., Deimling et al., 2001; Matthews & Rosner, 1988). That is, stress experienced by the caregiver can have a "spillover effect" on spouses and other family members (Szinovacz, 2003). In line with this idea, Ghasemi and colleagues (2020) found that, in caregivers of older adult family members with heart failure, a higher burden of care was associated with poorer family functioning (e.g., communication, emotional involvement, behavioral control). Thus, it is likely that filial caregivers and their spouses both experience stressors related to filial caregiving that each must deal with individually as well as within the context of their relationship (Coyne et al., 1981; Pearlin et al., 1981).

1.2 Coping in a Relational Context

Although several theoretical models outline the coping process and strategies people use to cope with stressors (e.g., Lazarus & Folkman, 1984; Roth & Cohen, 1986), they tend to either focus on individuals' coping efforts and ignore the broader social context in which coping occurs or they focus on the outcomes of the dyad and ignore individual contributions to the coping process and outcomes of the coping process. Recently, however, there has been increased recognition that people are nested within larger social contexts when they encounter and cope with stress (Afifi et al., 2020a; Bodenmann, 1997; Berg & Upchurch, 2007; Lyons et al., 1998; Zajdel & Helgeson, 2020). Most of the literature on coping stems from Folkman and Lazarus's (1985) perspective of stress and coping. In short, this perspective conceptualizes the coping process as a dynamic, transactional relationship between an individual and their environment (Folkman & Lazarus, 1980). When an individual encounters a stressor, there is an interaction between the perceived demands of the stressor (e.g., whether the situation is appraised as stressful, intensity of stress experienced) and one's own availability of resources to respond to these demands (Lazarus & Folkman, 1984). If an individual perceives the demands of a stressor to exceed the resources available to deal with such demands, the individual experiences stress (Lazarus & Launier, 1978. This perspective was the first to examine the role of the person-environment interaction and to conceptualize coping as a dynamic process, rather than a trait, wherein people shift their cognitions and behaviors as the demands of a stressor change. Although this approach recognizes that coping is embedded in social context, a main limitation of this model is that stress and coping are still conceptualized as an individual level process (Lazarus & Folkman, 1984).

In contrast, the relationship-focused coping model (Coyne & Smith, 1991; O'Brien & DeLongis, 1996) recognized the shortcomings of prior perspectives on stress and coping (Lazarus & Folkman, 1984). Relationship-focused coping highlights the importance of managing and sustaining relationships during stressful periods. This model also acknowledges the positive and negative outcomes related to coping in an interpersonal context (Coyne & Smith, 1991; O'Brien & DeLongis, 1996). According to Coyne and Smith (1991), relationship-focused coping reflects efforts aimed at "grappling with each other's presence and emotional needs" (p. 405). Thus, successful coping efforts include not only problem solving and managing negative emotions, but also maintaining one's relationships in the face of stressors (Coyne & Smith, 1991). Though this model accounts for the involvement of others in coping with stressors, it focuses on relationship-focused coping strategies in response to stress (e.g., withdrawal and criticism, compromising, empathetic responding, providing support) and relationship outcomes (e.g., marital satisfaction, adjustment) as opposed to individual outcomes, such as how these coping strategies affect each couple member's individual health outcomes and well-being. Thus, it is not possible to determine the individual-level contributions to coping or individual-level outcomes of coping.

Similar to relationship-focused coping, the congruence model emphasizes the role of others in the coping process and refers to the extent to which two people's coping responses are coordinated and mutually supportive, which is expected to maximize positive outcomes (Revenson, 1994). Unlike other models, coping congruence is operationalized at both the individual and relational level. At the relational level, it focuses on the interplay and similarity between couple members' individual strategies to cope with their own stress as opposed to partners' joint strategies to cope with stressors or individuals' coping responses to their partner's stress (e.g., Revenson, 2003). Coping congruence assesses the fit between two individuals' coping responses when couples are facing stressors and suggests that maximizing the fit between couple members' coping responses increases that the likelihood that efforts will be effective (Revenson, 1993; Revenson, 1994). One notable limitation of this model is that empirical support for it has been mixed at best (e.g., Badr, 2004; Pakenham, 1998).

Another prevalent model is the systemic-transactional model of dyadic coping – a dynamic and transactional stress management process, wherein couples cope with and manage stressful events together in the context of their relationship (Bodenmann, 2005). This model postulates that one person's experiences and behavior will impact their partners' experiences in an interdependent and mutual way (Bodenmann, 2005). That is, one partner's stress will affect the other partner, and one partner's resources will increase the coping resources of the other partner. The systemic-transactional model assumes that individuals first express their stress verbally or nonverbally and with subtle or explicit requests for assistance from their partner. These actions and requests are then appraised by their partner, who may respond by engaging in dyadic coping that reflects their reaction to the individual, the relationship, and the stressor and they might engage in individual coping (Bodenmann, 1995, 1997). In contrast to other models, this model emphasizes stress appraisals and highlights the collaborative and individual efforts people use to assist their partners in coping with stress on their own or to cope with stress together. One limitation of this framework is that whether the stressor is viewed as an individual issue or a shared issue is not included as a component of dyadic coping. Rather, the dyadic coping process begins when an individual first expresses their stress to their partner. However, collaborative efforts and providing assistance to manage a stressor may be interpreted differently depending on whether it is appraised as more of an individual problem versus a shared problem and thus, the appraisal of the stressor is important to include in the conceptualization of coping.

1.3 Communal Coping

The theory of communal coping was first introduced by Lyons et al. (1998) to explain how couples might cope with one partner’s stressor. This theory addresses some limitations of the aforementioned models. To engage in communal coping, individuals must view a stressor as shared, communicate about the stressor verbally and non-verbally, and collaborate to manage the stressor’s demands (e.g., Helgeson et al., 2018). Communal coping is characterized by two dimensions – one cognitive and one behavioral, which are shared appraisal and collaboration, respectively. *Shared appraisal* refers to the extent to which an individual perceives the stressor as “our problem,” instead of just “my problem,” and thus, views the stressor as a shared responsibility (Helgeson et al., 2018). Prior work shows that individuals who have shared appraisals in the context of chronic illness are more likely to communicate with their partner about their illness, prompting both couple members to share knowledge, learn about the illness together, and adopt shared expectations for managing the illness (e.g., Lyons et al., 1998). This leads to more frequent and open communication about the illness between couple members, a greater understanding of the chronically ill partner's needs, and thus a greater likelihood of couple members collaborating to manage the illness (Helgeson et al., 2018).

The behavioral dimension of communal coping, referred to as *collaboration*, reflects any observable joint or individual actions that are perceived as working together to manage and reduce the adverse effects of a stressor (Helgeson et al., 2018). Couple members can collaborate in a variety of ways, such as by combining efforts, negotiating responsibilities, discussing issues related to the stressor, and pooling resources (e.g., Berg et al., 2008; Van Vleet et al., 2018). Importantly, individuals do not need to engage in the same stress management behaviors, they just need to be perceived as coordinated efforts to reduce a stressor's effects (Lyons et al., 1998). For example, couple members who cook a meal together are likely to be categorized as collaborative. Instances in which one partner provides support to another, such as when a caregiving partner might cook a meal for their chronically ill spouse, can also be interpreted as collaboration when this support interaction/exchange is viewed as "working together' to address the demands of the illness rather than as one person helping the other with their illness-related responsibilities (Helgeson et al., 2018). Helgeson et al. (2018) suggest that adopting a shared appraisal of a stressor leads to an interpretation that support is collaborative as opposed to one-sided because couple members appraise the stressor as a shared responsibility (Helgeson et al., 2018). For instance, in the context of a shared illness appraisal, an ill spouse is likely to interpret their caregiving spouse making dinner as collaboration – they are working together to manage their diet and eat healthier. In the absence of this shared illness appraisal, when managing the illness is viewed as just the chronically ill spouses' problem, the ill spouse and caregiving spouse are likely to interpret the caregiver spouse's efforts in making dinner as support but not necessarily collaboration.

Past work also shows that shared appraisal and collaboration operate in a particular order, with shared appraisal initiating the process of collaboration (Afifi et al., 2020a; Zajdel & Helgeson, 2020). Although some communal coping researchers do not account for both shared appraisal and collaboration in their conceptualization of communal coping, both dimensions are critical in determining whether coping is communal (Basinger, 2020). Additionally, there is some discrepancy regarding whether both individuals or just one individual in the relationship must appraise a stressor as shared for communal coping to occur (Afifi et al., 2020a). I adopt the perspective endorsed by Helgeson et al. (2018), Afifi et al. (2020a), and Lyons et al. (1998), which suggests a personal orientation to communal coping, wherein only one person needs to appraise the stressor as shared in order for communal coping to be effective. Examining communal coping in this way allows for a better understanding of how each couple member's communal coping is related to their own personal and relational outcomes as well as their partner's personal and relational outcomes (Afifi et al., 2020a). Further, it allows for insight into how each member of the couple is appraising and coping with the stressors of caregiving. Whereas other models (e.g., relationship-focused coping,) have considered the level of analysis to be the dyad, what these models miss is how each individuals' perception affects not only themselves, but also their actions toward partners.

Adopting a personal orientation to communal coping also allows researchers to assess the individual level contributions to communal coping as well as the individual level consequences of communal coping (Afifi et al., 2020a). Theoretically, it is possible for two couple members to experience the same stressor and still engage in individual coping if they both view the same stressor as a personal problem and engage in individual coping strategies to manage it (Afifi et al., 2006). However, holding a shared stress appraisal drives an interpretation that support is collaborative because couple members individually perceive that they are both responsible for managing the stressor. Additionally, adopting a personal orientation privileges people's subjective viewpoints over more objective assessments of whether communal coping is happening. Even if only one couple member in the relationship perceives a stressor as shared and collaborates to manage that stressor, they will arguably experience the benefits of communal coping, regardless of what is happening objectively. Thus, adopting a personal perspective is vital to determine how motivation may drive communal coping and its subsequent benefits for personal and relational well-being.

Although social support has been linked to positive health and relationship outcomes (e.g., Uchino, 2009; Uchino et al., 2012), research shows that support efforts can fail and may not always be perceived as intended (Helgeson et al., 2018). For example, in the context of managing diabetes or other chronic illnesses, social support from spouses and close others can sometimes be misinterpreted as social pressure, such as nagging, criticism, or controlling behavior (Wiebe et al., 2016). However, appraising a stressor, such as diabetes, as shared and construing partner assistance as "working together," (i.e., collaborating) may circumvent the potential negative consequences of how social support is perceived. That is, viewing a stressor as a shared problem instead of one partner's problem (i.e., shared appraisal) can make it more likely that a partner's supportive efforts will be perceived as collaborative and as motivated by positive intentions toward the other (Helgeson et al., 2017). Although couple members' contributions to coping efforts may not be equal depending on the nature of the stressor and its demands, a defining feature of collaboration is that couple members' roles (e.g., the roles as caregiver partner) "are de-emphasized but not eliminated" (Helgeson et al., 2018, p.173). That is, both couple members are equally involved in problem-solving through a variety of joint efforts including combining efforts and negotiating responsibilities (Berg et al., 2008; Helgeson et al., 2018). Studies have shown that perceptions of working together (i.e., collaboration) are related to more positive emotions, better self-care behavior, improved mental health, and greater relationship quality in samples of adults with chronic illness and their spouses (Berg et al., 2008; Zajdel et al., 2018, 2019; Zajdel & Helgeson, 2020).

Although the few studies that have examined the full construct of communal coping (i.e., shared appraisal and joint action) have focused on spousal patient-caregiver and spousal patient-non-caregiver dyads affected by chronic illness, they have collectively shown that communal coping is related to positive outcomes for both couple members. One study of young adults with type 1 diabetes in romantic relationships found that communal coping was associated with greater support received from partners. Partner support, in turn, was related to higher relationship quality (Helgeson, 2017). Another study of type 2 diabetes that included both patients and their caregiver partners found that patient and caregiver communal coping was related to relationship quality as well as reduced depression, perceived stress, and increased life satisfaction in both the patient and caregiver (Helgeson et al., 2017). More recently, Zajdel et al. (2018) found that one's own communal coping was related to better mood in both patients and caregivers with type 2 diabetes. Lastly, Basinger et al. (2021) examined whether shared appraisal and joint action were related to patients' and non-caregiving spouses' resilience and perceived physical health in individuals diagnosed with a severe health issue and their spouses. They found that non-caregiving spouses' collaborative efforts were related to non-caregiving spouse's own resilience. They also found that patients' joint action was related to patients' own physical health, but non-caregiving spouses' joint action was not related to the physical health of non-caregiving spouses (Basinger et al., 2021).

Surprisingly little work has examined communal coping between caregivers and close others who are *not* recipients of care (Afifi et al., 2020a; Kam et al., 2017; Yang, 2023). In the case of filial caregiving, the responsibility of care is an extra-dyadic stressor that is occurring outside the context of the relationship. Because patient and caregiver communal coping has been related to better relationship and psychological outcomes in the context of chronic illness management (i.e., type 2 diabetes; Helgeson et al., 2020b), it is important to determine whether the theory of communal coping can be extended to the context of filial caregivers and their spouses, wherein the stressor is not inherent in the relationship.

In the context of filial caregivers and their spouses, communal coping should be positively associated with personal well-being (i.e., lower depression and negative affect, and greater positive affect and self-rated health) because it signals that spouses are actively involved in the management of caregiving responsibilities and are adding to the resources that caregivers have available (Helgeson et al., 2020b). Thus, caregivers should appraise caregiving as less stressful because they have more resources (i.e., their spouse) to address the stressor. Because an event is viewed as stressful when an individual's resources do not meet the demands of the environment (Lazarus & Folkman, 1984), communal coping should help decrease the negativity of stressor appraisals associated with caregiving. First, the joint appraisal of the stressor (i.e., caregiving responsibilities) as shared should reduce how threatening the stressor is perceived (primary appraisal), and collaboration should provide caregivers with enough resources to meet the demands of the stressor (secondary appraisal; Helgeson et al., 2018; Lazarus & Folkman, 1984). This should be particularly beneficial for caregivers as they must navigate the struggles of dividing their time and resources among those in their immediate family, their work responsibilities, and providing care to their aging parent, all of which are associated with greater depression, negative mood, and poorer health. Additionally, spouses of filial caregivers should appraise the situation as less stressful by knowing that joint efforts are being exerted to manage the stress and daily hassles associated with caregiving. This should, in turn, increase the likelihood that caregivers experience enhanced personal well-being, which should subsequently increase spouses' personal well-being. Communal coping may also enhance self-regulation by increasing resources and thus, preventing depletion, which is related to better communication, problem-solving, and reduced stress, and depression (Baumeister & Heatherton, 1996; Lyons et al., 1998).

Caregivers higher in communal coping should also experience more positive moods because their spouse's involvement in caregiving provides reassurance that they are not alone and have a teammate they can work with to manage the stressors of caregiving (Zajdel et al., 2018). For spouses, communal coping should be related to better mood because involvement in caregiving may provide them with a better sense of control over the situation, which has been related to better mental health outcomes. In addition, prosocial behavior, such as providing support to a partner and communally coping to manage the stressors of caregiving, should be related to increased mood for spouses (Snippe et al., 2018). Communal coping should also be related to better perceived health for caregivers and their spouses. Specifically, those who engage in communal coping have more resources to deal with the demands of the stressor and perceive themselves as working as part of a team with their partner, which should lead couple members to feel less emotionally and physically depleted (Helgeson et al., 2018). This, in turn, should increase perceptions of their own health. Prior research has shown that communal coping promotes positive mental health and reduces chronic stress (Afifi et al., 2021). Additionally, in the context of patients with type 2 diabetes and their spouses, research has demonstrated that both dimensions of communal coping are related to less psychological distress for both couple members as well as better diabetes self-care behavior for patients (Zajdel & Helgeson, 2020). Thus, I expect that communal coping will be related to greater personal well-being, conceptualized as reduced depression and negative affect and greater positive affect and self-rated health for caregivers and their spouses.

In addition, communal coping should be associated with greater relational well-being because it signals positive messages to couple members, such as mutual care and respect for one another, commitment (Mickelson et al, 2001), and support (Helgeson et al., 2018), all of which should be related to greater relationship quality. Further, when couples view a stressor as a shared problem, caregivers should have fewer barriers from their partner in adapting to their caregiving role and they should also appraise caregiving as less stressful because they will have more pooled resources to meet the demands of the stressor (Helgeson et al., 2018). Because communal coping conveys responsiveness and open communication (Afifi et al., 2020a; Zajdel & Helgeson, 2020), this should also lead to conversations and actions that are beneficial for the relationship and increase each partners’ satisfaction in the relationship. Prior research consistently shows that one’s own communal coping is related to better relationship quality in patients with type 2 diabetes and their partners (Helgeson et al., 2020b; Van Vleet et al., 2018). Moreover, when caregivers and their partners openly communicate, view a stressor as shared, and actively work together to manage the stressor, both couple members should experience less stress, conflict, and burnout in their relationship. This should lead them to feel more satisfied and less strained in their relationship (Afifi et al., 2016; Afifi et al., 2021). Therefore, I expect that one's own communal coping will be positively related to greater relational well-being for caregivers and their spouses conceptualized as greater relationship satisfaction and commitment, and less relational load.

1.4 Antecedents to Communal Coping: Relational Motives

Consistent with the notion that there are other motivations beyond reducing stress (e.g., social motivation such as relational maintenance) that may drive communal coping (Lyons et al., 1998), I suggest that people's relational motives uniquely contribute to communal coping in caregivers and their spouses. Relational motives are important determinants of relationship behavior, which in turn can shape relationship experiences and the sustainability and functionality of the relationship over time (Canevello & Crocker, 2015). These motives can vary in content with some focusing on supporting others and providing care in a relationship whereas others focus on benefiting the self without regard for other's well-being. The current project focuses on two types of relational motives: compassionate goals, defined as intentions to be supportive, constructive, and to not harm others (Crocker & Canevello, 2008) and communal strength – the degree to which an individual is motivated to be responsive to a communal partner's needs (Clark et al., 1987; Mills et al., 2004). Given that these motives activate and guide behavior in relationships, I expect that they will be related to whether couple members' will appraise filial caregiving as a shared stressor and collaborate with their partner to manage the stressors associated with caregiving.

1.5 Compassionate Goals and Communal Coping

Compassionate goals to be supportive, constructive, and to not harm others are energized by the ecosystem – a motivational system wherein people care deeply about others and things beyond themselves and seek to promote the well-being of others (Crocker & Canevello, 2015). People with compassionate goals view their relationships as working in nonzero-sum ways. That is, they believe that when potential relationship issues arise, it is possible to find solutions that are good for both people in the relationship. They do not have a "tit-for-tat mentality" when seeking desired outcomes for themselves; they believe the well-being of one partner does not come at the expense of the other's well-being (Crocker & Canevello, 2008). Accordingly, people with compassionate goals want to make a positive difference for others, regardless of whether others reciprocate, and consistently behave in ways that promote others' well-being and thriving, in both the short and long term (Crocker & Canevello, 2008). They have a collaborative and cooperative mindset that cultivates mutual care and concern, and they are motivated to grow as a person and understand and support what others need.

When problems do occur, people with compassionate goals have greater optimism that these problems can be overcome and feel a sense of shared responsibility for solving the issue, leading to more constructive engagement about the problem with their partners and improved relationship functioning (Crocker et al., 2017; Canevello et al., in preparation). They typically try to listen, understand partners' perspectives, identify the root of the problem, and engage constructively in discussions with partners, which should lead to better outcomes, including greater perceived progress with solving and managing problems associated with caregiving, and increased relationship quality (Canevello et al., in preparation). People who are higher in compassionate goals are more supportive and responsive to their partners and perceive their partners as more responsive to their needs (Canevello & Crocker, 2010). Because they believe that issues in relationships can be resolved in nonzero-sum ways that are good for both people, they also experience less conflict in their relationships than those lower in compassionate goals (Crocker & Canevello, 2008; Canevello et al., in preparation).

Because people with compassionate goals recognize that people are interconnected, that their well-being is related to the well-being of others and the social environment, and that they have a role in supporting people, they should view stressors such as caregiving as a shared problem. Further, people with compassionate goals care deeply about the well-being of others in addition to themselves and assume that what is good for one person in a relationship can be good for both people, which should also lead them to appraise caregiving as a joint stressor. Because appraising a stressor as shared should lead people with compassionate goals to feel a shared sense of responsibility and ownership for managing caregiving responsibilities and issues, they should be more likely to collaborate with their partners to manage these issues and responsibilities together (Canevello et al., in preparation). Thus, I propose that when filial caregivers and spouses have compassionate goals they should view filial caregiving as a shared stressor and engage in behaviors to manage stressors together (i.e., communally cope).

1.6 Communal Strength and Communal Coping

In romantic relationships, people vary in the degree to which they feel responsible for meeting other people’s needs such that the needs of some relationship partners likely take priority over the needs of other relationship partners (Le et al., 2013; Mills et al., 2004). This quantitative difference in the degree of motivation to feel responsible for and respond to a specific partner’s needs is referred to as *communal strength* (Mills et al., 2004). Mills et al. (2004) have described the concept of communal strength in many ways, including, (a) the degree of responsibility a person feels for a specific partner’s welfare, (b) the sacrifices or costs a person is willing to incur to benefit the other when the other is in need, (c) the amount of a distress or guilt a person would feel if they were unable to meet a specific communal partner's needs (Mills et al., 2004), and (d) in terms of a hierarchy of communal relationship (e.g., strong communal relationships, moderately strong communal relationships, and very weak communal relationships), wherein strong communal relationships are typically those with a spouse, children, or parents (Mills et al., 2004).

Importantly, communal strength refers to partner-specific communal orientation and is different from a general communal orientation disposition, which refers to a person's tendency to follow communal norms in relationships (Mills et al., 2004; Stafford, 2020). Communal strength is conceptualized as a person's motivation to provide for the needs of a specific other. People who are more inclined to prioritize being responsive to the needs of their specific communal partner are characterized as having a high communal strength toward their partner, which is related to adherence to communal norms (Clark et al., 1987; Mills et al., 2004). Mills and Clark (2001) suggested that a cultural norm exists for romantic partners to be equal in communal strength such that an increase in an individual's communal strength toward their partner should result in an increase of the partner's communal strength toward that individual. Communal strength is also distinct from compassionate goals to be supportive, constructive, and not harm others. Whereas communal strength is about the costs one is willing to incur to benefit the other and is characterized by an adherence to communal norms and a hierarchy of communal relationships, compassionate goals focus on supporting the well-being of others in one's environment. Those with compassionate goals do not adhere to norms and they do not view their relationships in a hierarchical fashion, wherein one partner's needs take precedence over the other partner's needs (Crocker & Canevello, 2008).

Because people high in communal strength will go great lengths to ensure their communal partner's needs are met and consider the support, presence, and accessibility of their partners when appraising stressors and their coping abilities (Mills et al., 2004), they should be more likely to view caregiving as a shared stressor and thus, collaborate with their partners to manage it together. Further, when individuals perceive their partners to be communally responsive to them (measured by individuals' ratings of the communal strength of their relationships with various partners), they are more likely to express emotions such as happiness, sadness and anxiety to these partners. This should lead both couple members to have a greater awareness of each other's needs and due to their motivation to benefit their partner's welfare, they should be more likely to respond each other's needs and offer (and accept) help noncontingently (Stafford, 2020).

Research suggests that people with higher communal strength engage in relationship maintenance behaviors even in the face of perceived relationship inequity (Stafford, 2020). Consistent with this idea, communal strength is an important predictor of social support and helping processes in romantic relationships (Feeney & Collins, 2001). Those high in communal strength strive to understand, care for, and validate their partner, have a genuine interest in promoting their partner's well-being (Clark & Finkel, 2005) and feel good about providing help to communal partners (Williamson & Clark, 1992). Further, relationships characterized by high communal strength may provide security and a "safe haven" wherein there is an implicit and mutual understanding that support is there and will be there in times of need (Hazan & Shaver, 1994; Clark et al, 2017). This motivation to be responsive to a partner's needs along with the implicit sense of mutual support should increase filial caregivers' and spouses' efforts to jointly manage caregiving issues that negatively impact their welfare and the well-being of the relationship. Thus, I hypothesize that communal strength toward partners will be positively related to communal coping in both filial caregivers and their spouses because partners' will be more attentive to each other's distress and needs and have a greater desire to meet each other's needs. Additionally, because higher communal strength is related to positive well-being outcomes such as greater daily positive emotion, self-esteem, and satisfaction with relationships (Le et al., 2012), I also expect that communal strength will indirectly relate to the personal and relational well-being of caregivers and their spouses.

1.7 Covariates

In addition to testing key predictions, it is also important to rule out other factors that may account for the association between relational motives, communal coping, and well-being. Those with higher relationship quality exhibit greater commitment and satisfaction in their relationships. They are also more likely to exhibit empathy and forgive their partners after hypothetical transgressions (Fincham et al., 2002), and they are more likely to perceive that their partner understands them (Pollmann & Finkenauer, 2009; Reis et al., 2017). Therefore, those with higher relationship well-being characterized as greater general relationship satisfaction and greater general relationship commitment may be more likely to engage in communal coping. Additionally, prior research shows that interdependent construals are related to compassionate goals (Jiang et al., 2017) and communal strength (Mattingly et al., 2011). Construals have been suggested as a predictor of communal coping because those with interdependent construals define themselves in terms of their relationship with others and are more easily able to incorporate others in all aspects of their lives (Afifi et al., 2020a; Helgeson et al., 2018). Thus, those with higher interdependent self-construals may engage in more communal coping when they experience stressors such as caregiving. Lastly, the nature of caregiving and accompanying demands will likely affect the degree to which caregivers and spouses engage in communal coping. For instance, the duration of time caregiving, the amount of caregiving shared with other family members, how much choice the caregiver had in taking on the caregiver role, and perceived burden of caregiving, may all impact the extent to which caregivers perceive caregiving as a joint problem that they manage with their spouses. Thus, the nature of caregiving may account for the link between communal coping and personal and relational well-being for caregivers. Importantly, because caregiving is a gendered role (e.g., Barnes et al., 1992; Kang & Marks, 2016), this study specifically focuses on testing the hypothesized associations in women who are filial caregivers and their male spouses.

CHAPTER 2: RESEARCH OVERVIEW AND HYPOTHESES

In the current research, I propose a number of hypotheses (see Table 1). First, I propose that communal coping will be positively related to personal well-being (H1a) and relational well-being in filial caregivers (H1b). Second, I propose that communal coping will be positively related to personal well-being (H2a) and relational well-being in spouses (H2b). Third, I hypothesize that relational motives will be related to communal coping. Specifically, I expect that caregiver's compassionate goals will positively predict caregiver's communal coping (H3a) and that spouse's compassionate goals will positively predict spouse's communal coping (H3b). Fourth, I hypothesize that caregiver's compassionate goals will be indirectly related to greater caregiver personal well-being (H4a) and relational well-being (H4b) through communal coping. I also expect that spouse compassionate goals will be indirectly related to spouse personal (H5a) and relational well-being (H5b) through communal coping. Specifically, combining my hypothesis that compassionate goals will be related to communal coping (H3) and that communal coping will be related to personal and relational well-being (H1, H2) suggests an indirect effect wherein one's own communal coping should mediate the link between compassionate goals and one's own personal and relational well-being. Fifth, I hypothesize that caregiver communal strength will predict their own greater communal coping (H6a) and that spouse communal strength will predict their own greater communal coping (H6b). As with compassionate goals, I also expect that caregiver communal strength will indirectly relate to caregiver's personal (H6c) and relational well-being (H6d) through communal coping. Similarly, I expect that spouse communal strength will indirectly relate to spouse personal (H6e) and relational well-being (H6f). See Figure 1 for the hypothesized conceptual model. Finally, for exploratory purposes, I will examine how compassionate goals and communal strength uniquely contribute to communal coping and test relational well-being and interdependent construal as covariates in the relationship between relational motives and communal coping. I will also test indicators of nature of caregiving as covariates in the link between communal coping and personal and relational well-being for caregivers only.

Table 1

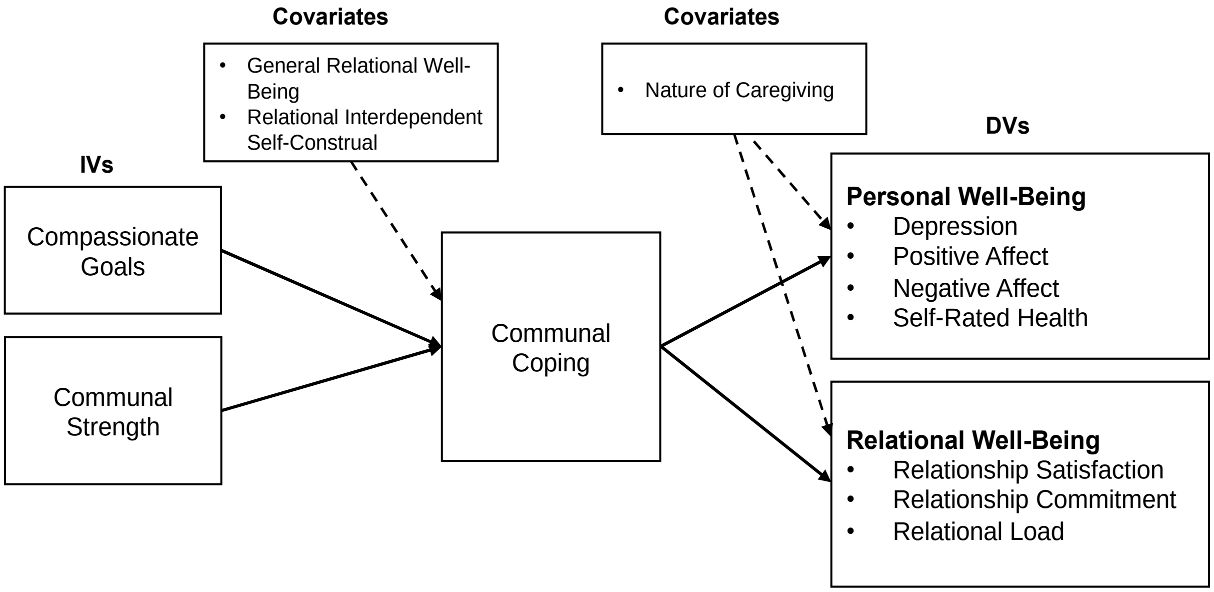
List of Hypotheses

Hypothesis	
H_{1a}	Caregiver communal coping will be positively related to caregiver personal well-being
H_{1b}	Caregiver communal coping will be positively related to caregiver relational well-being
H_{2a}	Spouse communal coping will be positively related to spouse personal well-being
H_{2b}	Spouse communal coping will be positively related to spouse relational well-being
H_{3a}	Caregiver compassionate goals will be positively related caregiver communal coping
H_{3b}	Spouse compassionate goals will be positively related to spouse communal coping
H_{4a}	Caregiver communal coping will mediate link between caregiver compassionate goals and caregiver personal well-being
H_{4b}	Caregiver communal coping will mediate link between caregiver compassionate goals and caregiver relational well-being
H_{5a}	Spouse communal coping will mediate link between spouse compassionate goals and spouse personal well-being
H_{5b}	Spouse communal coping will mediate link between spouse compassionate goals and spouse relational well-being
H_{6a}	Caregiver communal strength will predict caregiver communal coping
H_{6b}	Spouse communal strength will predict spouse communal coping
H_{6c}	Caregiver communal coping will mediate link between caregiver communal strength and caregiver personal well-being
H_{6d}	Caregiver communal coping will mediate link between caregiver communal strength and caregiver relational well-being

H_{6e}	Spouse communal coping will mediate the link between spouse communal strength and spouse personal well-being
H_{6f}	Spouse communal coping will mediate the link between spouse communal strength and spouse relational well-being

Figure 1

Conceptual Model of Proposed Hypothesis



CHAPTER 3: METHODS

3.1 Participants

Forty-two heterosexual romantic dyads wherein the female was currently providing filial care to an aging parent or in-law and the male was not a primary caregiver for an adult relative were recruited for a study on “close relationships and caregiving.” Prior to participating in the study, one member of the couple completed a screening questionnaire to ensure that both couple members met the following inclusion criteria (See Appendix A for the full screener questionnaire). Participating couple members were required to: (a) be at least 18 years old; (b) be married and living with a romantic partner or unmarried and living with a romantic partner for at least one year (Helgeson et al., 2022); (c) reside in the United States; (d) speak English as their primary language; and (e) the female member of the couple must have currently been the primary caregiver for a parent and the male member of the couple must have not been a primary caregiver. Further, to eliminate the influence of additional caregiving-related stressors, couple members could not have a chronic condition in which they are dependent on each other and could not have children with chronic physical, developmental, behavioral, or emotional conditions that require care beyond that required by other children generally. One spouse did not complete the survey, resulting in a finale sample of 42 female caregivers and 41 male spouses. I conducted a sensitivity analysis (Faul et al., 2009), which suggested that the sample of 42 participants provides .80 power to detect a moderate to large effect size (R^2) of .20.

Couples reported that they were married (97.7%) or in an exclusive relationship (2.3%). They reported relationship lengths between four and 51 years, with an average of approximately 24 years (M = 24.57 years, SD = 13.51).

Table 2 provides detailed demographic information for both caregivers and spouses and descriptive information about the nature of care provided by caregivers. Caregivers ranged in age from 31 to 73 years old (M_{age} = 53.56 years, *SD* = 10.86). A majority of caregiver participants reported their racial identity as White/European American (78.6%), and others reported being Latina/Latinx (9.5%), Black/African American (7.1%), or East Asian (4.8%). They indicated their highest level of education as completing a Bachelor’s degree (35.7%) or a Master’s degree (38.1%). Additionally, caregivers reported their employment status. They indicated whether they were employed (42.9%) or not employed (57.1%).

Caregivers were additionally asked questions about the nature of their caregiving situation. Their duration of time caregiving ranged from five months to 25 years, with an average duration of approximately four years (*M* = 3.93 years, *SD* = 4.37). A majority of caregiver participants reported caring for an older parent (86%), while a smaller percentage reported caring for a parent in-law (14%). The majority of caregivers cared for female relatives (71.4%); 26.2% provided care to male relatives. One participant (2.4%) reported caring for both parents. The majority (33.3%) of caregivers reported spending over 40 hours a week caregiving. Nearly half of female caregivers (47.6%) lived with their parent or in-law care recipient, 40.5% lived less than one hour away, and 11.9% lived more than one hour away. Thirty-eight point one percent of caregivers reported having children in their household, whereas 61.9% did not have children in their household. Caregivers were also asked to report the number of siblings they had; 38.1% had one sibling, 38.1% had two siblings, 16.7% had three siblings, and 7.1% did not have any siblings. In terms of birth order, 45.2% of caregiver participants indicated that they were the youngest child, whereas 23.8% were the middle child, 23.8% were the oldest child, and 7.1% were only children. They also reported whether the care recipient received any paid caregiver support (e.g., in the form of respite care, home health aides, or nurse aides); 38.1% received paid support, and 61.9% did not receive any paid support.

Caregivers rated how much caregiving responsibility was shared with other family members (i.e., “How much caregiving responsibility is shared with other family members such as your siblings?”) on scale ranging from 1 (*I take little to no responsibility)* to 9 (*I take all responsibility)*. Overall, they reported having relatively high levels of personal responsibility for providing care (*M* =7.72, *SD* = 1.52). Additionally, they answered one question about how much choice they had in taking on the responsibility for caring for their parent or in-law (i.e., “How much choice did you have in taking on the responsibility of caring for your parent or in-law?”) on a scale ranging from 1 (*I fully chose to do this*) to 5 (*It was completely forced upon me*). The mean score was 2.21 (*SD* = 1.32), suggesting that on average, caregivers chose to take on the responsibility of providing care to their aging parents or in-laws. Lastly, to assess the subjective burden of caregiving, caregivers completed a modified version of the Zarit Burden Interview (ZBI; Zarit et al., 1980). They indicated the extent to which they agreed with each of seven items on a scale ranging from 1 (*never)* to 5 (*nearly always)*, with higher scores reflecting greater perceived burden of caregiving. Sample items included, “Do you feel strained when you are around your parent/in-law?” and “Do you feel stressed between caring for your parent/in-law and trying to meet other responsibilities for your family or work?” Overall, caregivers reported levels of burden that were slightly higher than the midpoint of the scale (*M* = 3.47, *SD* = .66). The scale demonstrated good reliability in the current study (α = .81).

Spouses ranged in age from 35 to 78 years old (M_{age} = 55.46 years, *SD* = 11.50). A majority of spouses reported their racial identity as White/European American (82.9%), and others reported being Latino/Latinx (4.9%), Black/African American (4.9%), Multiracial (4.9%), or South Asian (2.4%). A majority of spouses also indicated their highest level of education as completing a Master's degree (41.5%), Bachelor's degree (22%), or some college (19.5%). Lastly, 78% of spouses reported being employed; 22% reported being unemployed.

Table 2

Demographics by Role

Variable	Caregivers (*n* = 42)	Spouses (*n* = 41)
Age in years, *M* (*SD*)	53.56 (10.86)	55.46 (11.50)
Race, *n (%)*		
Black/African American	3 (7.1%)	2 (4.9%)
East Asian	2 (4.8%)	0 (0%)
Latino/Latina/Latinx	4 (9.5%)	2 (4.9%)
South Asian	0 (0%)	1 (2.4%)
White/European American	33 (78.6%)	34 (82.9%)
Multiracial	0 (0%)	2 (4.9%)
Education, *n (%)*		
High school graduate or G.E.D.	4 (9.5%)	5 (12.2%)
Some college	4 (9.5%)	8 (19.5%)
Bachelor's degree	15 (35.7%)	9 (22%)
Master's degree	16 (38.1%)	17 (41.5%)
Doctoral degree	3 (7.1%)	2 (4.9%)
Employment status, *n (%)*		
Employed	18 (42.9%)	32 (78%)
Not employed	24 (57.1%)	9 (22%)
Caregiver Characteristics of Caregiving		
Length of time caregiving in years, *M (SD)*	3.93 years (4.37)	
Care recipient gender, *n (%)*		
Man	11 (26.2%)	
Woman	30 (71.4%)	
Both parents	1 (2.4%)	
Hours per week caregiving, *n (%)*		
2-9 hours per week	9 (21.4%)	
10-20 hours per week	11 (26.2%)	
21-40 hours per week	8 (19%)	
> 40 hours per week	14 (33.3%)	
Proximity from care recipient, *n (%)*		
Lives with care recipient	20 (47.6%)	
1 hour away or less	17 (40.5%)	
> 1 hour away	5 (11.9%)	
Children in household, *n (%)*		

Yes	16 (38.1%)
No	26 (61.9%)
Children ≤ 18 years old, *n (%)*	14 (33.3%)
Number of siblings, *n (%)*	
None	3 (7.1%)
One	16 (38.1%)
Two	16 (38.1%)
Three	7 (16.7%)
Birth order, *n (%)*	
Oldest	10 (23.8%)
Middle	10 (23.8%)
Youngest	19 (45.2%)
Only child	3 (7.1%)
Shared Caregiving Responsibility with Other Family, *M* (*SD*)	7.72 (1.52)
Paid Support, *n* (*%*)	
Yes	16 (38.1%)
No	26 (61.9%)
Choice in Taking on Caregiving Role, *M (SD)*	2.21 (1.32)
Caregiver Burden, *M* (*SD*)	3.47 (.66)

Note. Length of time caregiving is reported in years. Shared caregiving responsibility with other family measure ranged from 1 (*I take little to no responsibility*) to 9 (*I take all responsibility*). Choice in taking on caregiver role measure ranged from 1 (*I fully chose to do this*) to 5 (*It was completely forced upon me*). Caregiver Burden measure ranged from 1 (*Never)* to 5 (*Nearly Always)*.

3.2 Procedure

Couples were recruited from caregiving Facebook groups and websites, as well as through flyers distributed nationally at caregiver meet-ups, senior centers, community centers and adult cares and healthcare centers. Interested participants contacted the P.I. who screened them for eligibility. If eligible, each couple member was emailed the link to an online survey. After indicating their consent, both caregivers and spouses first completed self-report questions assessing their role (e.g., caregiver or spouses) in the relationship and the length of time of caregiving. Caregivers were asked additional questions in their online survey about the nature of the caregiving situation (e.g., duration of caregiving, proximity from care recipient, perceived burden of caregiving). Next, both couple members completed measures of caregiver burden and communal coping. Following this, couple members were asked questions about their general relationship satisfaction and general relationship commitment, which were used as covariates in the study. They then completed a section of measures assessing qualities of their relationship with their romantic partner since caregiving began, which were used as the main independent variables and relational well-being outcomes in the study. These measures included: compassionate goals, communal strength, relationship satisfaction since caregiving began, commitment since caregiving began, and relational load. Next, couple members completed a section of personal well-being outcomes, which included measures of depression, positive and negative affect, and self-rated health since caregiving began. Lastly, they completed a measure assessing relationship interdependent self-construal, which was used as a covariate, followed by several demographic questions. Participants were also asked if there was anything else they would like to add about the survey and were provided with space to add their own comments. Couples received a $25 gift card in exchange for completing the survey.

3.3 Measures

Compassionate Goals. I assessed compassionate goals for participants' relationships with their spouses using a modified version of Crocker and Canevello's (2008) compassionate goals scale. Items begin with the stem: "In my relationship with my partner, I want/try to…" and was rated on a scale ranging from 1 (*not at all*) to 5 (*extremely*). Compassionate goals were measured on an eight-item subscale with items such as: "be supportive of my partner" and "avoid being selfish or self-centered (see Appendix B)." A composite measure of compassionate goals was created by averaging the items, with higher scores representing higher compassionate goals. This scale demonstrated good internal consistency (Caregivers $\alpha = .81$; Spouses $\alpha = .89$).

Communal Strength. Communal strength was assessed using a 10-item scale (Mills et al., 2004), wherein participants were instructed to fill in the initials of their romantic partner in blank spaces in each of the items and rate the extent to which they were willing to sacrifice or meet the needs of their specific romantic partner on an 11-point scale (0 = *not at all*; 10 = *extremely*). Items were averaged into a single total score, with higher scores reflecting greater communal strength. Sample items include “How far would you be willing to go to visit ___?” and “How high a priority for you is meeting the needs of ___? (see Appendix C).” This scale demonstrated adequate reliability in the current study (Caregivers α = .77; Spouses α =.76).

Communal Coping. Participants reported their communal coping using an adapted version of Basinger’s (2018, 2020) communal coping scale which included two subscales. Items and instructions were adapted to focus on the caregiver’s stressors and responsibilities of caregiving for both caregivers and spouses. The shared appraisal subscale measured participants’ cognitions about the stressors and responsibilities of caregiving. Instructions for caregivers read: “As you answer the following questions, focus on what you have THOUGHT about your caregiving responsibilities since you began caregiving for your loved one.” Instructions for spouses asked respondents to focus on their thoughts about their partners’ caregiving responsibilities since caregiving began. Participants rated their agreement with seven items on a five-point Likert-type scale (1 = *strongly disagree;* 5 = *strongly agree*), with higher scores indicating a greater shared appraisal. A sample item for caregivers included “I feel like I share ownership of my caregiving responsibilities with my partner.” Items for spouses paralleled those for caregivers but shifted the referent to caregivers’ responsibilities (e.g., “I feel like my partner shares ownership of their caregiving responsibilities with me”; see Appendix D for the full measure).

The six-item joint action subscale assessed individual or joint behaviors that participants engaged in to manage caregiving. Instructions for caregivers read, "Now, think about how you and your romantic partner have managed your caregiving responsibilities since you began caregiving. As your answer the following questions, focus on what you and your partner have DONE to manage your caregiving responsibilities**.**" Parallel instructions that referred to their partners' caregiving responsibilities were provided to spouses. Participants rated their agreement with each item on a five-point Likert-type scale (1= *strongly disagree*; 5 = *strongly agree*; see Appendix D for full measure). Sample items for caregivers include "My partner and I have joined together to deal with my caregiving demands" and "I depend on my partner to help me handle caregiving demands." Spouses responded to a parallel set of items that focused on their support of caregivers in providing care (e.g., "My partner depends on me to help them handle their caregiving demands.")

In previous research, the items assessing each dimension of communal coping have lacked stability (e.g., Basinger, 2020; Basinger et al., 2021). Therefore, I conducted a CFA using AMOS (v.28.0) with two latent variables to assess dimensionality prior to creating two composite scores for each subscale. The following values were used as model fit criteria recommended by Browne and Cudeck (1992) and Kline (2005): χ^2/df = < 3.0, confirmatory fit index (CFI) ≥ .9, and root mean square error of approximation (RMSEA) < .10. Additionally, item factor loadings of 0.3 or higher on any scale were considered acceptable (e.g., Hair et al., 2010). The initial CFA was structured so that seven items loaded on the shared appraisal latent variable and six items loaded on the joint action latent variable. The two latent variables were allowed to correlate. Factor loadings from the initial CFA are reported in Table 3. Three of the seven items assessing shared appraisal had factor loadings above |.3| and all items assessing joint action had factor loadings above |.3|; while the ratio of χ^2 to degrees of freedom and RMSEA suggested that the model demonstrated adequate fit, CFI for this model was below .9, χ^2/df = 1.87, *p* < .001; CFI = .84; RMSEA = .10.

I conducted a second CFA in which I dropped the four items from the shared appraisal subscale for which factor loadings were less than |.30|. Results for this model showed that factor loading for all items were greater than |.3| and model fit was adequate (χ^2/df = 1.72; CFI = .94; RMSEA = .09; see Table 3). The fit of the second model was improved over the first, $\Delta\chi^2$= 75.31, *df* = 38, *p* < .001. Both subscales demonstrated adequate reliability (shared appraisal: caregivers α = .62; spouses α =.71; joint action: caregivers α = .86; spouses α =.88). This model was used to guide scoring for the current study.

Table 3

CFA Factor Loadings on Communal Coping Subscales

	Original Model	**Revised Model**
Subscale/Item	Factor Loading	Factor Loading
Shared Appraisal		
I feel like I share ownership of my caregiving responsibilities with my partner.	.74	.73
Caregiving is my and my partner's problem together.	.63	.66
Caregiving is only my problem.	-.47	-.49
I feel like I am the only one with ownership of caregiving for my loved one.*	-.27	---
My caregiving responsibilities influence my partner.*	-.21	---
My partner is affected by my caregiving responsibilities.*	-.12	---
Only I am affected by caregiving for my loved one.*	-.09	---
Joint Action		
I deal with caregiving alone.	-.86	-.86
I depend only on myself to manage the demands of caregiving.	-.79	-.79
I depend on my partner to help me handle caregiving demands.	.76	.77

I make plans for dealing with caregiving by myself.	-.68	-.68
My partner and I have joined together to deal with my caregiving demands.	.66	.67
I do not rely on my partner to cope with caregiving stress.	-.63	-.63
Fit Indices		
χ^2/df	1.87	1.72
CFI	.840	.939
RMSEA	.103	.094

Note. *Item was removed due to poor factor loading during CFA. The items displayed reflect the wording for caregivers. See Appendix D to see how items were worded for spouses.

Personal Well-Being. I used measures of depression, positive and negative affect, and self-rated health since caregiving began to assess participants' personal well-being. The instructions for this set of measures read "The next set of questions asks about your own thoughts and feelings *since you/your partner began caregiving*. Please try to answer these next questions as honestly as possible."

Depression. Participants completed the seven-item depression subscale of the Depression, Anxiety, and Stress Scale (Henry & Crawford, 2005). Participants rated the extent to which they agreed with each item since caregiving began on a 4-point Likert-type scale ranging from 0 = *did not apply to me at all* to 3 = *applied to me most of the time*. Items began with the stem "Since I/my partner began caregiving." Sample items include "I can't seem to experience any positive feeling at all" and "I feel that I have nothing to look forward to (see Appendix E for the full scale)." Items were averaged into a single score whereby higher values reflect greater depressive symptoms. This subscale demonstrated excellent reliability (Caregivers: α = .93; *M* = .64, *SD* = .66; Spouses: α = .90; *M* =.25, *SD* = .42).

Positive and Negative Affect. Participants completed a modified 10-item version of the Positive and Negative Affect Schedule (Watson et al., 1988), consisting of five adjectives assessing positive affect (e.g., enthusiastic, inspired, excited, strong, attentive) and five adjectives assessing negative affect (e.g., distressed, upset, scared, irritable, hostile; see Appendix F for the full scale). Participants indicated their emotions since caregiving began on a five-point scale (1= *very slightly or not at all;* 5 = *extremely*). Items from each subscale were averaged into separate composite scores for positive and negative affect, wherein higher scores reflect greater positive affect and greater negative affect. Both positive affect (Caregivers: α = .89; *M* = 2.73, *SD* = .71; Spouses: α =.95, *M* = 3.40, *SD* =.98) and negative affect (Caregivers: α =.86*; M* = 2.39, *SD* = .79; Spouses: α = .87, *M* = 1.64, *SD* = .62) subscales demonstrated good reliability.

Self-Rated Health. To assess perceptions of health, participants rated a single item from the Short Form 36 Health Survey (Ware & Sherbourne, 1992; see Appendix G). They were asked to rate their health, in general, with a five-point Likert scale ranging from 1 = *excellent*; 5 = *poor*. This item was reverse coded whereby higher scores reflect better self-rated health (Caregivers: *M* = 3.41, *SD* = .91; Spouses: *M* = 3.64, *SD* =.90).

I conducted a CFA to determine whether each of the four indicators of personal well-being (i.e., depression, positive and negative affect, and self-rated health) loaded onto a higher-order latent variable. The CFA was structured so that the composite scores for each of the four indicators loaded onto a single latent variable. All factor loadings were above 0.30 (see Table 4) and model fit was adequate χ^2/df = 6.32; CFI =.92; RMSEA = .25, thus the final composite for personal well-being included all four measures. Prior to creating the personal well-being composite score, measures of depression and negative affect were reverse scored, and all four measures were subsequently standardized and averaged to create a composite measure in which higher scores indicated greater personal well-being. This composite had good reliability (Caregivers α = .69; Spouses α =.78).

Table 4

CFA Factor Loadings for Personal Well-Being

Measure	**Factor Loading**
Negative Affect	.96
Depression	.88
Positive Affect	.57
Self-rated health	.33
Fit Indices	
χ^2/df	6.32
CFI	.92
RMSEA	.25

Relational Well-Being. I used measures of relationship satisfaction, relationship commitment, and relational load to assess participants' relational well-being. Participants reported their relationship satisfaction and commitment since caregiving began and in their relationship in general; they also reported their relationship load since caregiving began. The instructions for this set of measures read "The next set of questions asks about your relationship with your romantic partner since you/your partner began caregiving unless otherwise stated. Please try to answer these next questions as honestly as possible." The instructions for the set of general relational well-being measures read "The next set of questions ask about your relationship with your romantic partner, in general. Please try to answer these questions as honestly as possible."

Relationship Satisfaction. To measure relationship satisfaction since caregiving began and in general, participants completed two modified versions of the relationship satisfaction subscale of the Perceived Relationship Quality Components Inventory (Fletcher et al., 2000), wherein they indicated their agreement with three items on a seven-point scale (1 = *not at all*; 7 = *extremely*). Items assessing relationship satisfaction since caregiving began included the stem "Since you/your partner began caregiving." Items included: "How satisfied are you with your relationship?" "How content are you with your relationship?" and "How happy are you with your relationship (see Appendix H for the full measures)?" Items assessing general relationship satisfaction began with the stem, "In general" and included the same three items.

Within each version of the scale, items were averaged into a single score, with higher scores indicating greater satisfaction since caregiving began (Caregivers: α = .94, *M* = 5.54, *SD* = 1.20; Spouses: α = .96, *M* = 5.88, *SD* = 1.07) and in general (Caregivers: α = .96, *M* = 5.82, *SD* = 1.12; Spouses: α = .95, *M* = 5.94 , *SD* = 1.07).

Commitment. To assess participants' commitment to their relationships since caregiving began and in general, they completed two 5-item measures from the Investment Model Scale (Rusbult et al., 1998), wherein they rated their agreement with statements regarding their relationship commitment since caregiving began and in general, on a nine-point Likert-type scale (0 = *do not agree at all*; 8 = *agree completely*). Instructions for measures assessing relationship commitment since caregiving began instructed participants to respond to items with that time frame in mind (i.e., since caregiving began). Sample items include "I am committed to maintaining my relationship with my partner," and "I want our relationship to last forever" (see Appendix I for the full measures). Instructions for the measures assessing relationship commitment in general instructed participants to respond to items in reference to their relationships, more generally. Items began with the stem "In general," and included the same items as the relationship commitment since caregiving began measure.

When scoring the relationship commitment measures as intended, the reliabilities were acceptable for caregivers (relationship commitment since caregiving began α = .65; general relationship commitment α = .72), but low for spouses (relationship commitment since caregiving began α = .45; general relationship commitment α = .55). When I looked at the impact of individual items on each scale's reliability, there was one reverse scored item ("I would not feel very upset if our relationship were to end in the near future."), that consistently brought down the scales' reliability. When this item was removed from both versions of the scale, the reliability improved for caregivers (relationship commitment since caregiving began α = .89; general relationship commitment α = .95) and spouses (relationship commitment since caregiving began α = .76; general relationship commitment α = .87). Therefore, this item was subsequently dropped from both measures for caregivers and spouses in order to maintain consistency. Each of the final scales contained four items and were averaged into two scores with higher scores indicating greater relationship commitment since caregiving began (Caregivers: *M* = 7.64, *SD* = .83; Spouses: *M* = 7.79, *SD* = .48) and greater general relationship commitment (Caregivers: *M* = 7.68, *SD* = .80; Spouses: *M* = 7.82, *SD* = .56).

Relational Load. To assess relational load, defined as feelings of burnout in their romantic relationship, participants completed the eight-item measure from Afifi and colleagues (2020b). Participants rated the extent to which they agreed with each item using a 5-point scale (1 = *strongly disagree;* 5 = *strongly agree*). Sample items include "I feel burned out from my romantic relationship," "I worry that my romantic relationship is hardening me emotionally," and "I have become insensitive or uncaring toward my romantic partner," (see Appendix J). Items were averaged into a single score with higher scores reflecting greater relational load. The scale demonstrated high internal consistency in the current study (Caregivers: α = .87; *M* = 2.23, *SD* = .86; Spouses: α = .85; *M* = 2.09, *SD* = .68).

It was not possible to a conduct a one-factor CFA with the measures of relationship satisfaction since caregiving began, relationship commitment since caregiving began, and relational load prior to creating the dependent variable relational well-being composite score. A one-factor CFA with three indicators is just-identified (*df* = 0) when no errors correlate, and thus, testing this model provided no opportunity for the data to falsify the model (Brown, 2015). Because there was no valid justification for correlating the error terms, it was not possible to conduct a CFA with the three measures loading onto a latent variable. The three measures were moderately to strongly correlated ($r_{caregivers}$ = .34 to .64; $r_{spouses}$ = .48 to .78). Because correlation coefficients indicate the degree to which measures "tap the same construct" (Stansfield & Ross, 1988, p. 16), the relational load measure was reverse scored and the three measures were subsequently standardized and averaged to create a composite score, in which higher scores represent greater relational well-being. This measure demonstrated adequate reliability (Caregivers α = .70; Spouses α =.80).

Relationship-Interdependent Self-Construal. To measure participants' tendency to include their romantic relationship in their self-definition, they completed the 11-item Relational-Interdependent Self-Construal Scale (Cross et al., 2000). Participants rated the extent to which they agree with statements such as "My close relationships are an important reflection of who I am," and "In general, my close relationships are an important part of my self-image" on a seven-point scale (1= *strongly disagree*; 7= *strongly agree*; see Appendix K). Items were averaged into a single total score, with higher scores reflecting higher relationship-interdependent self-construal. The scale demonstrated good internal reliability in the current study (Caregivers: α = .90; *M* = 5.06, *SD* = 1.13; Spouses: α = .89; *M* = 5.19, *SD* = 1.10).

Demographic Questionnaire. Participants provided demographic information pertaining to their racial and ethnic background they identify with, their education level, employment status, socioeconomic status, and the year they were born (see Appendix L).

Table 5

Correlations Between Primary Study Variables

Measure	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Compassionate Goals	--	.52***	.33*	.18	.17	.39*	.32*	.23	.19
2. Communal Strength	.34*	--	.19	.23	.19	.54***	.10	.36*	.47**
3. Shared Appraisal	.10	.17	--	.60***	-.20	.14	.13	.07	-.04
4. Joint Action	-.00	.23	.59***	--	-.03	.12	.25	.16	.08
5. Personal Well-Being	.05	.24	.23	.03	--	.56***	.29	.62***	.06
6. Relational Well-Being	.18	.57***	.32*	.43**	.50**	--	.27	.84***	.56***
7. Relationship Interdependent Self-Construal	-.24	.12	-.15	-.18	-.18	-.13	--	.31*	.15
8. General Relationship Satisfaction	.21	.30*	.21	.30*	.34*	.77***	-.10	--	.45**
9. General Relationship Commitment	.13	.55***	.28	.35*	.34*	.77***	.02	.43**	--
Female Caregiver									
Mean	4.11	8.73	3.23	3.11	-.05	.00	5.06	5.82	7.68
Standard Deviation	.44	.94	.95	.99	.73	.80	1.13	1.12	.80
Range of Scores (Min-Max)	3.31–4.92	6.30–10	1–5	1–5	-1.78–1.43	-2.32–.93	1.36–6.91	3–7	4–8
Cronbach’s α	.81	.77	.62	.86	.69	.70	.90	.96	.95
Male Spouse									
Mean	4.15	8.67	3.89	3.40	.01	.00	5.19	5.94	7.82
Standard Deviation	.58	1.12	.72	.90	.83	.87	1.10	1.07	.56
Range of Scores (Min-Max)	3–5	5.5–10	2.33–5	1.83–5	-3.21–1.19	-2.41–.85	1.55–7	3–7	4.75–8
Cronbach’s α	.89	.76	.71	.88	.78	.80	.89	.95	.87

Note. $n_{female\ caregivers}$ = 42; $n_{\text{male spouses}}$ = 41. **p* < .05. ***p* < .01. ****p* < .001. Values below the diagonal represent caregiver correlations; values above the diagonal represent spouse correlations. Scores for Personal and Relational Well-Being are standardized. Scales ranged from 1-5 for Compassionate Goals, Shared Appraisal, and Joint Action. Scales ranged from 1-7 on Relationship Interdependent Self-Construal and General Relationship Satisfaction. The General Relationship Commitment scale ranged from 0-8. The Communal Strength scale ranged from 0-10.

CHAPTER 4: OVERVIEW OF ANALYSIS AND ANALYTIC PLAN

I conducted analyses in six phases using SPSS version 28.0.1. Following the work of Basinger and Hartsell (2021) and Basinger et al. (2021), each dimension of communal coping (shared appraisal and joint action) was tested in separate analyses to avoid issues of multicollinearity (r [40] = .59, p <.001 for caregivers; r[39] = .60, p < .001 for spouses) in all six phases of analyses. All tests of mediation were conducted using Model 4 in PROCESS (Hayes, 2013), with 10,000 bias-corrected bootstrapped samples.

In Phase 1, I first tested whether caregiver communal coping was positively related to caregiver personal well-being (H1a) using bivariate correlations. Next, for exploratory purposes, I tested whether each of the four indicators of nature of caregiving (i.e., duration of caregiving, shared responsibility of caregiving with other family members, choice in taking on the caregiver role, and caregiver burden) explained the association between communal coping and personal well-being for caregivers in a total of eight separate regression analyses, each controlling for a separate indicator of nature of caregiving (RQ1). Third, I tested whether caregiver communal coping was positively related to caregiver relational well-being (H1b) using bivariate correlations. For exploratory purposes, I then tested whether the same four indicators of nature of caregiving explained the association between communal coping and relational well-being for caregivers in a total of eight separate regression analyses, each controlling for a separate indicator of nature of caregiving (RQ2). Fifth, I tested whether spouse communal coping was positively related to spouse personal (H2a) and relational well-being (H2b) using bivariate correlations.

In Phase 2, I tested whether caregiver compassionate goals were associated with caregiver communal coping (H3a) and whether spouse compassionate goals were associated with spouse communal coping (H3b) using bivariate correlations. I then tested whether interdependent self-construal and general relational well-being (general relationship satisfaction and general commitment) explained the association between compassionate goals and communal coping in separate analyses for caregivers and spouses (RQ3 and RQ4). To test this, I regressed communal coping on compassionate goals in four separate analyses (two for caregivers and two for spouses), each controlling for a separate covariate (interdependent self-construal and the two indicators of general relational well-being).

In Phase 3, I tested whether caregiver communal coping mediates the associations between caregiver compassionate goals and caregiver personal well-being (H4a) and between caregiver compassionate goals and caregiver relational well-being (H4b). I also tested whether spouse communal coping mediates the links between spouse compassionate goals and spouse personal well-being (H5a) and between spouse compassionate goals and spouse relational well-being (H5b). Because the appraisal and action dimensions of communal coping were tested as separate independent variables, a total of eight analyses were conducted.

In Phase 4, I tested whether caregiver communal strength is associated with caregiver communal coping (H6a) and whether spouse communal strength is associated with spouse communal coping (H6b) using bivariate correlations. In Phase 5, I tested whether caregiver communal coping mediates the associations between caregiver communal strength and caregiver personal well-being (H6c) and between caregiver communal strength and caregiver relational well-being (H6d). I also tested whether spouse communal coping mediates the relationships between spouse communal strength and spouse personal well-being (H6e) and between spouse communal strength and spouse relational well-being (H6f).

Finally, in Phase 6, for exploratory purposes, I examined whether compassionate goals and communal strength each explain unique variance in communal coping in caregivers and spouses separately (RQ5). To test this, I regressed communal coping on compassionate goals and communal strength in separate analyses for caregivers and spouses, for a total of four multiple regression analyses.

CHAPTER 5: RESULTS

5.1 Phase 1: Associations Between Communal Coping and Personal and Relational Well-Being

Caregiver Communal Coping and Caregiver Personal Well-Being

To test my hypothesis that caregiver communal coping would be positively related to their personal well-being (H1a), I tested the bivariate correlations between the shared appraisal and joint action dimensions of caregiver communal coping and their personal well-being. The shared appraisal and joint action dimensions of caregiver communal coping were unrelated to caregiver personal well-being (shared appraisal: r [37] = .23, p = .152; joint action: r [37] =.03, p = .863). Thus, Hypothesis 1a was not supported.

Does the Nature of the Caregiving Situation Account for the Associations Between Communal Coping and Personal Well-Being? I conducted exploratory analyses to test whether indicators of nature of caregiving (i.e., duration of caregiving, shared responsibility of caregiving with other family members, choice in taking on caregiving role, and caregiver burden) explained the relationship between caregiver communal coping and caregiver personal well-being. To test this, I conducted two sets of four multiple regressions. In one set, I regressed caregiver personal well-being on caregiver shared appraisal in four models, each controlling for a separate covariate of nature of caregiving. I conducted a second set of parallel analyses in which joint action replaced shared appraisal as the primary predictor. Table 6 reports the correlations between caregiver communal coping, caregiver personal and caregiver relational well-being and the four indicators of nature of caregiving.

Table 6

Correlations between Communal Coping, Personal and Relational Well-Being, and Nature of Caregiving Covariates (Caregivers only)

Measure	1.	2.	3.	4.	5.	6.	7.	8.
1. Shared Appraisal	--							
2. Joint Action	.59***	--						
3. Personal Well-being	.23	.43**	--					
4. Relational Well-being	.32*	-.29	.50***	--				
5. Duration of Caregiving	-.07	-.02	-.05	-.18	--			
6. Shared Responsibility of Caregiving with Other Family	.14	.11	.06	.04	.13	--		
7. Choice in Taking on Caregiving Role	.08	.13	-.36*	.08	.29	-.12	--	
8. Caregiver Burden	.04	.13	-.63***	-.17	.05	.13	.34*	--

Note. *n* = 42. **p* < .05. ***p* < .01. ****p* < .001.

Testing Covariates when Shared Appraisal is the Predictor. The association between caregiver shared appraisal and caregiver personal well-being was nonsignificant when I controlled for duration of caregiving, $\beta = .23$, $p = .164$, 95% CI = [-.07, .42], shared responsibility of caregiving with other family members, $\beta = .30$, $p = .081$, 95% CI = [-.03, .47], or choice in taking on the caregiver role, $\beta = .26$, $p = .092$, 95% CI = [-.03, .42]. These findings were consistent with those from analyses that did not include covariates. When controlling for caregiver burden, caregiver shared appraisal and caregiver personal well-being were positively associated, $\beta = .28$, $p = .027$, 95% CI = [.02, .39]. Thus, the positive association between caregiver shared appraisal and caregiver personal well-being when controlling for caregiver burden suggests that caregiver burden strengthens the association between caregiver shared appraisal and caregiver personal well-being.

Table 7

Linear Multiple Regression Models for Shared Appraisal Predicting Personal Well-Being Controlling for Nature of Caregiving Indicators

DV: Personal Well-Being						
Variable	*b*	*SE*	*β*	*(adj.)* R^2	*p*	95% CI [LL, UL]
Model 1: Controlling for Duration of Caregiving						
Shared Appraisal	.17	.12	.23	.00	.164	[-.07, .42]
Duration of Caregiving	-.00	.00	-.04		.819	[-.00, .00]
Model 2: Controlling for Shared Responsibility of Caregiving with Other Family Members						
Shared Appraisal	.22	.12	.30	.04	.081	[-.03, .47]
Shared Responsibility of Caregiving with other Family Members	.00	.08	.00		.978	[-.16, .16]
Model 3: Controlling for Choice in Taking on Caregiving Role						
Shared Appraisal	.19	.11	.26	.15	.092	[-.02, .42]
Choice in Taking on Caregiving Role	-.20	.08	-.38		.017	[-.37, -.04]
Model 4: Controlling for Caregiver Burden						
Shared Appraisal	.21	.09	.28	.44	.027	[.02, .39]
Caregiver Burden	-.74	.14	-.65		<.001	[-1.03, -.46]

Note. *n* = 39. Regression analysis included caregivers only.

Testing Covariates when Joint Action is the Predictor. The association between caregiver joint action and caregiver personal well-being was nonsignificant when controlling for duration of caregiving, β = .01, p = .939, 95% CI = [-.24, .26], shared responsibility of caregiving with other family members, β = .07, p = .703, 95% CI = [-.21, .30], choice in taking on the caregiver role, β = .07, p = .664, 95% CI = [-.18, .28], or caregiver burden, β = .09, p = .504, 95% CI = [-.13, .25]. These findings did not change from earlier analysis that did not include covariates, which found that caregiver joint action was unrelated to caregiver personal well-being.

Table 8

Linear Multiple Regression Models for Joint Action Predicting Personal Well-Being Controlling for Nature of Caregiving Indicators

		DV: Personal Well-Being				
Variable	b	SE	β	(adj.) R^2	p	95% CI [LL, UL]
Model 1: Controlling for Duration of Caregiving						
Joint Action	.01	.13	.01	-.05	.939	[-.24, .26]
Duration of Caregiving	-.00	.00	-.05		.775	[-.00, .00]
Model 2: Controlling for Shared Responsibility of Caregiving with Other Family Members						
Joint Action	.05	.12	.07	-.05	.703	[-.21, .30]
Shared Responsibility of Caregiving with other Family Members	.03	.08	.06		.732	[-.14, .19]
Model 3: Controlling for Choice in Taking on Caregiving Role						
Joint Action	.05	.11	.07	.08	.664	[-.18, .28]
Choice in Taking on Caregiving Role	-.20	.08	-.37		.025	[-.37, -.03]
Model 4: Controlling for Caregiver Burden						
Joint Action	.06	.09	.09	.37	.504	[-.13, .25]
Caregiver Burden	-.73	.15	-.63		<.001	[-.1.03, -.43]

Note. $n = 39$. Regression analysis included caregivers only.

Caregiver Communal Coping and Caregiver Relational Well-Being

Next, to test my hypothesis that caregiver communal coping would be positively related their relational well-being (H1b), I tested the bivariate correlations between the shared appraisal and joint action dimensions of caregiver communal coping and their relational well-being. The shared appraisal and joint action dimensions of caregiver communal coping were positively related to caregiver relational well-being (shared appraisal: r [40] = .32, p = .041; joint action: r[40] = .43, p = .004). Thus, Hypothesis 1b was supported.

Does the Nature of the Caregiving Situation Explain the Associations Between Communal Coping and Relational Well-Being? For exploratory purposes, I tested whether the same four indicators of nature of caregiving (i.e., duration of caregiving, shared responsibility of caregiving with other family members, choice in taking on caregiving role, and caregiver burden) explained the association between caregiver communal coping and caregiver relational well-being. To test this, I conducted two sets of four regression analyses. In one set, I regressed caregiver relational well-being on caregiver shared appraisal, with each of the four models controlling for one covariate that captured the nature of caregiving. The second set of parallel analyses replaced shared appraisal with joint action as the primary predictor.

Models for Shared Appraisal Predicting Caregiver Relational Well-Being. The association between caregiver shared appraisal and caregiver relational well-being remained significant and positively associated when controlling for duration of caregiving, β =.31, p = .048, 95% CI = [.00, .51], choice in taking on the caregiver role, β = .31, p = .046, 95% CI = [.00, .52], or caregiver burden, β = .32, p = .036, 95% CI = [.02, .53]. When controlling for shared responsibility of caregiving with other family members, caregiver shared appraisal and caregiver relational well-being were unrelated, β =.31, p = .061, 95% CI = [-.01, .54]. These exploratory findings were mostly consistent with the original analysis that did not include any covariates, with the exception that controlling for shared responsibility of caregiving with other family members led the association between caregiver shared appraisal and relational well-being to become nonsignificant.

Table 9

Linear Multiple Regression Models for Shared Appraisal Predicting Relational Well-Being Controlling for Nature of Caregiving Indicators

DV: Relational Well-Being						
Variable	*b*	*SE*	β	*(adj.)* R^2	*p*	95% CI [LL, UL]
Model 1: Controlling for Duration of Caregiving						
Shared Appraisal	.26	.13	.31	.08	.048	[.00, .51]

Duration of Caregiving	-.00	.00	-.16		.279	[-.01, .00]
Model 2: Controlling for Shared Responsibility of Caregiving with Other Family Members						
Shared Appraisal	.26	.13	.31	.05	.061	[-.01, .54]
Shared Responsibility of Caregiving with other Family Members	.00	.09	.00		.999	[-.18, .18]
Model 3: Controlling for Choice in Taking on Caregiving Role						
Shared Appraisal	.26	.13	.31	.06	.046	[.00, .52]
Choice in Taking on Caregiving Role	.04	.09	.06		.687	[-.15,.23]
Model 4: Controlling for Caregiver Burden						
Shared Appraisal	.27	.13	.32	.09	.036	[.02, .53]
Caregiver Burden	-.22	.18	-.18		.227	[-.59, .14]

Note. n = 42. Regression analysis included caregivers only .

Models for Joint Action Predicting Caregiver Relational Well-Being. Caregiver joint action remained positively related to caregiver relational well-being when I controlled for duration of caregiving, β = .41, p = .009, 95% CI = [.09, .59], shared responsibility of caregiving with other family members, β = .44, p = .006, 95% CI = [.11, .62], choice in taking on the caregiver role, β = .43, p = .005, 95% CI = [.11, .59], or caregiver burden, β = .46, p = .002, 95% CI = [.15, .61]. This general pattern of findings did not differ from the original analyses conducted that did not include these covariates.

Table 10

Linear Multiple Regression Models for Joint Action Predicting Relational Well-Being Controlling for Nature of Caregiving Indicators

	DV: Relational Well-Being					
Variable	*b*	*SE*	β	*(adj.)* R^2	*p*	95% CI [LL, UL]
Model 1: Controlling for duration of caregiving						
Joint Action	.34	.12	.41	.15	.009	[.09, .59]
Duration of Caregiving	-.00	.00	-.06		.667	[-.01, .00]
Model 2: Controlling for shared responsibility of caregiving with other family members						

Joint Action	.37	.13	.44	.15	.006	[.11,.62]
Shared Responsibility of Caregiving with other Family Members	.03	.08	.05		.726	[-.14, .19]
Model 3: Controlling for choice in taking on caregiving role						
Joint Action	.35	.12	.43	.15	.005	[.11, .59]
Choice in Taking on Caregiving Role	.02	.09	.04		.804	[-.16, .20]
Model 4: Controlling for Caregiver Burden						
Joint Action	.38	.11	.46	.20	.002	[.15, .61]
Caregiver Burden	-.28	.17	-.23		.107	[-.63, .06]

Note. *n* = 42. Regression analysis included caregivers only.

Spouse Communal Coping and Spouse Personal and Relational Well-Being

I tested the parallel hypotheses that spouse communal coping would be positively related to their personal and relational well-being (H2a and H2b) using bivariate correlations. Results indicated that both dimensions of communal coping were unrelated to spouse personal well-being (shared appraisal: *r* [34] = -.20, *p* = .235; joint action: *r* [34] = -.03, *p* = .839). The shared appraisal and joint action dimensions of spouse communal coping were also unrelated to spouse relational well-being (shared appraisal: *r*[39] = .14, *p* = .377; joint action: *r* [39] = .12, *p* = .438). Thus, Hypothesis 2a and 2b were not supported.

5.2 Phase 2: Associations Between Compassionate Goals and Communal Coping

Caregiver Compassionate Goals and Caregiver Communal Coping

In Phase 2 analyses, I first tested my prediction that caregiver compassionate goals would be positively associated with their communal coping (H3a). Bivariate correlations revealed that caregiver compassionate goals were unrelated to both dimensions of caregiver communal coping (shared appraisal: *r*[40] = .10, *p* = .544; joint action: *r*[40] = -.00, *p* = .977). Thus, Hypothesis 3a was not supported.

Spouse Compassionate Goals and Spouse Communal Coping

Next, I tested the parallel prediction that spouse compassionate goals would be positively related to their communal coping (H3b). Bivariate correlations revealed that spouse compassionate goals were positively associated with the shared appraisal dimension of spouse communal coping, *r*(39) = .33, *p* = .034, but spouse compassionate goals were unrelated to the joint action dimension of spouse communal coping, *r*(39) = .18, *p* = .267. Thus, Hypothesis 3b was partially supported.

In sum, contrary to what I predicted, H1a-H3b were largely unsupported, with a few exceptions. As hypothesized, caregiver communal coping was moderately positively correlated with caregiver relational well-being (H1b). Spouse compassionate goals were also positively related to the shared appraisal dimension of spouse communal coping, providing partial support for Hypothesis 3b.

Table 11

Correlations Between Caregiver Communal Coping, Compassionate Goals, Communal Strength, and Personal Well-Being and Relational Well-Being

Variable	1	2	3	4	5	6
1. Shared Appraisal	—					
2. Joint Action	.59***	—				
3. Compassionate Goals	.10	-.00	—			
4. Communal Strength	.17	.23	.34*	—		
5. Personal Well-Being	.23	.03	.05	.24	—	
6. Relational Well-Being	.32*	.43**	.18	.57***	.50**	—

Note. n = 42. **p* < .05. ***p* < .01. ****p* < .001. Higher scores on personal and relational well-being indicate greater well-being.

Table 12

Correlations Between Spouse Communal Coping, Compassionate Goals, Communal Strength, and Personal Well-Being and Relational Well-Being

Variable	1	2	3	4	5	6
1. Shared Appraisal	—					
2. Joint Action	.60***	—				
3. Compassionate Goals	.33*	.18	—			
4. Communal Strength	.19	.23	.52**	—		
5. Personal Well-Being	-.20	-.03	.17	.19	—	
6. Relational Well-Being	.14	.12	.39*	.54***	.56***	—

Note. *n* = 41. **p* < .05. ***p* < .01. ****p* < .001. Higher scores on personal and relational well-being indicate greater well-being.

Does Relationship Interdependent Self-Construal Account for the Association Between Compassionate Goals and Communal Coping?

For exploratory purposes, I tested whether relationship interdependent self-construal explained the association between compassionate goals and communal coping. I conducted linear multiple regressions for caregivers and spouses separately. For caregivers, I first regressed caregiver shared appraisal on caregiver compassionate goals controlling for caregiver relationship interdependent self-construal. In a second model, I regressed caregiver joint action on caregiver compassionate goals controlling for caregiver relationship interdependent self-construal. Parallel analyses were conducted for spouses.

Models Predicting Caregiver Communal Coping. Results revealed that when relationship interdependent self-construal was included as a covariate, caregiver compassionate goals were unrelated to caregiver shared appraisal, β = .06, *p* = .695, and joint action, β = -.05, *p* = .755.

Models Predicting Spouse Communal Coping. When relationship interdependent self-construal was included as a covariate, spouse compassionate goals were unrelated to spouse shared appraisal, β = .32, p = .052, and spouse joint action, β = .11, p = .512. See Tables 13 and 14 for the full results of each model. In sum, the positive association between spouse compassionate goals and spouse shared appraisal became nonsignificant when controlling for interdependent self-construal. Thus, although spouse compassionate goals may be associated with spouse shared appraisal, that effect slightly changes when relationship interdependent self-construal is accounted for in the model.

Table 13

Linear Multiple Regression Model for Compassionate Goals Predicting Shared Appraisal Controlling for Relationship Interdependent Self-Construal

			DV: Shared Appraisal			
Variable	*b*	*SE*	*β*	*(adj.)* R^2	*p*	95% CI [LL, UL]
Caregiver Model						
Relationship Interdependent Self-Construal	-.11	.14	-.13	-.02	.417	[-.39, .16]
Compassionate Goals	.14	.34	.06		.695	[-.57, .84]
Spouse Model						
Relationship Interdependent Self-Construal	.02	.11	.03	.07	.859	[-.20, .23]
Compassionate Goals	.40	.20	.32		.052	[-.00, .81]

Note. $n_{caregiver}$ = 42; n_{spouse} = 41. Regressions for caregivers and spouses were conducted separately in two separate models.

Table 14

Linear Multiple Regression Model for Compassionate Goals Predicting Joint Action Controlling for Relationship Interdependent Self-Construal

			DV: Joint Action			
Variable	*b*	*SE*	*β*	*(adj.)* R^2	*p*	95% CI [LL, UL]
Caregiver Model						
Relationship Interdependent Self-Construal	-.17	.14	-.19	-.01	.241	[-.45, .12]
Compassionate Goals	-.11	.36	-.05		.755	[-.84, .61]
Spouse Model						
Relationship Interdependent Self-Construal	.17	.13	.21	.02	.201	[-.10, .45]
Compassionate Goals	.17	.25	.11		.512	[-.34, .68]

Note. $n_{caregiver}$ = 42; n_{spouse} = 41.

Does General Relational Well-Being Account for the Association Between Compassionate Goals and Communal Coping?

For exploratory purposes, I also tested whether general relational well-being accounted for the association between compassionate goals and communal coping. I conducted a set of linear multiple regressions for caregivers and spouses separately. Because the two indicators of relational well-being – general relationship commitment and general relationship satisfaction – were only moderately correlated (*r*[40] = .43, *p* =.005 for caregivers; *r*[38] = .45, *p* = .003 for spouses), they were not aggregated into a single general relational well-being score, and instead, entered together as covariates in each model. For the linear multiple regression analyses for caregivers, I first regressed caregiver shared appraisal on caregiver compassionate goals controlling for caregiver general relationship commitment and caregiver general relationship satisfaction. In a second model, I regressed caregiver joint action on caregiver compassionate goals controlling for caregiver general relationship commitment and caregiver general relationship satisfaction. A parallel set of analyses were conducted for spouses.

Models Predicting Caregiver Communal Coping. When controlling for caregiver general relationship commitment and general relationship satisfaction as covariates, the association between caregiver compassionate goals and caregiver shared appraisal was nonsignificant, β = .04, *p* = .780, as was the association between caregiver compassionate goals and their joint action, β = -.08, *p* = .591. See Table 15 for detailed model results.

Models Predicting Spouse Communal Coping. When controlling for spouse general relationship commitment and spouse general relationship satisfaction, spouse compassionate goals were unrelated to spouse shared appraisal, β = .29, *p* = .086 and spouse joint action, β = .11, *p* = .520. See Table 16 for full model results.

Overall, analyses conducted earlier in Phase 2 with no covariates included indicated that spouse compassionate goals were positively related to spouse shared appraisal. Thus, controlling for spouse general relationship commitment and spouse general relationship satisfaction slightly changed the magnitude of the association between spouse compassionate goals and spouse shared appraisal from β = .33 to β = .29. However, I hesitate to over interpret this finding given that there were not strong associations between compassionate goals, communal coping, and either of the covariates. The second finding that spouse compassionate goals were unrelated to spouse joint action is consistent with earlier analyses conducted in Phase 2 that did not include covariates.

Table 15

Linear Multiple Regression Model for Compassionate Goals Predicting Shared Appraisal Controlling for General Relational Well-Being

		DV: Shared Appraisal				
Variable	*b*	*SE*	β	*(adj.)* R^2	*p*	95% CI [LL, UL]
Caregiver Model						
Compassionate Goals	.10	.34	.04	.02	.780	[.78, 10]
General Relationship Commitment	.28	.20	.23		.177	[.69,.28]
General Relationship Satisfaction	.09	.15	.10		.549	[-.21, .39]
Spouse Model						
Compassionate Goals	.26	.20	.29	.01	.086	[-.05, .77]
General Relationship Commitment	.16	.22	-.13		.485	[-.61, .30]
General Relationship Satisfaction	.04	.12	.06		.729	[-.20, .28]

Note. $n_{caregiver}$ = 42; n_{spouse} = 40. Regressions for caregivers and spouses were conducted in two separate analyses.

Table 16

Linear Multiple Regression Model for Compassionate Goals Predicting Joint Action Controlling for General Relational Well-Being

		DV: Joint Action				
Variable	b	SE	β	(adj.) R^2	p	95% CI [LL, UL]
Caregiver Model						
Compassionate Goals	-.18	.34	-.08	.09	.591	[-.87,.50]
General Relationship Commitment	.33	.20	.27		.106	[-.07,.74]
General Relationship Satisfaction	.18	.15	.21		.225	[-.12, .48]
Spouse Model						
Compassionate Goals	.17	.27	.11	-.04	.520	[-.37, .71]
General Relationship Commitment	-.00	.29	-.00		.994	[-.60, .59]
General Relationship Satisfaction	.11	.16	.13		.472	[-.20, .43]

Note. $n_{caregiver} = 42$; $n_{spouse} = 40$. Regressions for caregivers and spouses were conducted in two separate analyses.

5.3 Phase 3: Testing Whether Communal Coping Mediates the Associations Between Compassionate Goals and Personal and Relational Well-Being

Models Predicting Caregiver Personal Well-Being

In Phase 3 analyses, I first tested my hypothesis that caregiver communal coping would mediate the link between caregiver compassionate goals and caregiver personal well-being (H4a). I conducted two mediation analyses with caregiver compassionate goals as the predictor, caregiver personal well-being as the outcome, and the two dimensions of caregiver communal coping (shared appraisal and joint action) as mediators in separate models.

For the model with caregiver shared appraisal as the mediator, the indirect and direct effects were nonsignificant (indirect effect = .02, 95% bootstrapped CI = [-.06, .10]; direct effect: .02, p = .877). Full model results are reported in Table 17. For the model with caregiver joint action as the mediator, the indirect and direct effects were also nonsignificant (indirect effect = -

.00, 95% bootstrapped CI = [-.06, .06]; direct effect = .04, *p* = .748). Thus, Hypothesis 4a was not supported.

Models Predicting Caregiver Relational Well-Being

To test my hypothesis that caregiver communal coping would mediate the link between caregiver compassionate goals and caregiver relational well-being (H4b), I conducted a second set of parallel mediation analyses in which caregiver relational well-being replaced caregiver personal well-being as the outcome variable.

For the model with caregiver shared appraisal as the mediator, the indirect and direct effects were nonsignificant (indirect effect = .02, 95% bootstrapped CI = [-.09, .08]; direct effect = .12, *p* = .337). Similarly, for the model with caregiver joint action as the mediator, the indirect and direct effects were nonsignificant (indirect effect = -.00, 95% bootstrapped CI = [-.20, .13]; direct effect = .14, *p* = .217). Thus, Hypothesis 4b was not supported.

Models Predicting Spouse Personal Well-Being

To test my prediction that spouse communal coping would mediate the link between spouse compassionate goals and spouse personal well-being (H5a), I conducted parallel mediation analyses to those described for caregiver personal well-being. For the model with spouse shared appraisal as the mediator, the indirect and direct effects were nonsignificant (indirect effect = -.08, 95% bootstrapped CI = [-.19, .00]; direct effect β = .22, *p* = .136). For the model with spouse joint action as the mediator, the indirect and direct effects were also nonsignificant (indirect effect = -.01, 95% bootstrapped CI = [-.14, .09]; direct effect = .15, *p* = .305). Thus, Hypothesis 5a was not supported.

Models Predicting Spouse Relational Well-Being

To test my hypothesis that spouse communal coping would mediate the link between spouse compassionate goals and spouse relational well-being (H5b), I conducted parallel mediation analyses to those described for caregiver relational well-being. For the model with spouse shared appraisal as the mediator, the indirect effect was nonsignificant (indirect effect = .00, 95% bootstrapped CI = [-.11, .09]). The direct effect of spouse compassionate goals on spouse relational well-being was positive (direct effect =.33, *p* = .019). For the model with spouse joint action as the mediator, the indirect effect was nonsignificant (indirect effect = .01, 95% bootstrapped CI = [-.08, .08]). The direct effect of spouse compassionate goals on spouse relational well-being was significant (β = .33, *p* = .016). Thus, Hypothesis 5b was not supported.

Overall, contrary to predictions, neither dimension of communal coping mediated the relationship between compassionate goals and personal well-being for caregivers or spouses and thus, Hypotheses 4a, 4b,5a, and 5b were unsupported.

Table 17

Communal Coping as a Mediator Between Compassionate Goals and Personal and Relational Well-Being

	Effect of IV on mediator (*a*)		Unique effect of mediator (*b*)		Indirect effect (*ab*)	BS 95% CI for Indirect Effect		Direct effect (c')		Total Effect (c)	
						LL	UL				
	Standardized *β*	*p*		*p*					*p*		*p*
H4a: Caregiver Compassionate Goals → Caregiver Communal Coping → Caregiver Personal Well-Being											
Mediator: Shared Appraisal	.12	.479	.16	.166	.02	-.06	.10	.02	.877	.04	.751
Mediator: Joint Action	-.05	.770	.02	.852	-.00	-.06	.06	.04	.748	.04	.751
H4b: Caregiver Compassionate Goals → Caregiver Communal Coping → Caregiver Relational Well-Being											
Mediator: Shared Appraisal	.10	.544	.24	.051	.02	-.09	.08	.12	.337	.14	.265
Mediator: Joint Action	-.00	.977	.35	.004	-.00	-.20	.13	.14	.217	.14	.265
H5a: Spouse Compassionate Goals → Spouse Communal Coping → Spouse Personal Well-Being											
Mediator: Shared Appraisal	.32	.048	-.24	.104	-.08	-.19	.00	.22	.136	.14	.321
Mediator: Joint Action	.16	.344	-.05	.713	-.01	-.14	.09	.15	.305	.14	.321
H5b: Spouse Compassionate Goals → Spouse Communal Coping → Spouse Relational Well-Being											
Mediator: Shared Appraisal	.33	.034	.01	.936	.00	-.11	.09	.33	.019	.34	.011
Mediator: Joint Action	.18	.267	.05	.710	.01	-.08	.08	.33	.016	.34	.011

Note. All coefficients reported are standardized. *p* = p-value. CIs of each indirect effect are based on 10,000 resamples.

5.4 Phase 4: Associations Between Communal Strength and Communal Coping

In Phase 4, I first tested my hypotheses that caregiver communal strength would be positively related to caregiver communal coping (H6a) and that spouse communal strength would be positively related to spouse communal coping (H6b). Bivariate correlations revealed that caregiver communal strength was unrelated to caregiver shared appraisal (*r*[40] = .17, *p* = .278) and caregiver joint action (*r*[40] = .23, *p* = .145). Similarly, spouse communal strength was unrelated to spouse shared appraisal (*r*[39] = .19, *p* = .226) and spouse joint action (*r* [39] = .23, *p* =.146). Thus, Hypotheses H6a and H6b were not supported.

5.5 Phase 5: Testing Whether Communal Coping Mediates the Association Between Communal Strength and Personal and Relational Well-Being

Models Predicting Caregiver Personal Well-Being

In Phase 5, I tested my prediction that caregiver communal coping would mediate the link between caregiver communal strength and caregiver personal well-being (H6c). I conducted a mediation analysis with caregiver communal strength as a predictor, caregiver personal well-being as an outcome variable, and the two dimensions of caregiver communal coping (shared appraisal and joint action) as separate mediators in two models.

For the model with caregiver shared appraisal as the mediator, both indirect and direct effects were nonsignificant (indirect effect = .03, 95% bootstrapped CI = [-.02, .14]; direct effect = .15, *p* = .215). Similarly, for the model with caregiver joint action as the mediator, both indirect and direct effects were nonsignificant (indirect effect = - .00, 95% bootstrapped CI = [-.09, .07]; direct effect = .18, *p* = .145). Thus, Hypothesis 6c was not supported.

Models Predicting Caregiver Relational Well-Being

Next, I tested my hypothesis that caregiver communal coping would mediate the link between caregiver communal strength and caregiver relational well-being (H6d). To test this, I conducted a mediation analysis in the same way as Hypothesis 6c, with caregiver relational well-being as the outcome variable.

For the model with caregiver shared appraisal as the mediator, the indirect effect was nonsignificant (indirect effect =.03, 95% bootstrapped CI = [-.02, .14]). The direct effect of caregiver communal strength on caregiver relational well-being was positive (direct effect = .43, *p* = .000). For the model with caregiver joint action as the mediator, the indirect effect was also nonsignificant (indirect effect = .07, 95% bootstrapped CI = [-.03,.18]). The direct effect of caregiver communal strength on caregiver relational well-being was positive (β = .40, *p* = .000). Thus, Hypothesis 6d was not supported.

Models Predicting Spouse Personal Well-Being

Fourth, I tested my prediction that spouse communal coping would mediate the link between spouse communal strength and spouse personal well-being (H6e). To test this, I conducted parallel mediation analyses to those described above for caregiver personal well-being. For the model with spouse shared appraisal as the mediator, the indirect and direct effects were nonsignificant (indirect effect = -.03, 95% bootstrapped CI = [-.12, .04]; direct effect = .19, *p* = .179). For the model with spouse joint action as the mediator, the indirect and direct effects were also nonsignificant (indirect effect = -.02, 95% bootstrapped CI = [-.18, .09]; direct effect = .17, *p* = .239). Thus, Hypothesis 6e was not supported.

Models Predicting Spouse Relational Well-Being

Lastly, I tested my hypothesis that spouse communal coping would mediate the association between spouse communal strength and spouse relational well-being (H6f). To test this, I conducted parallel mediation analyses to those described for caregiver relational well-being. For the model with spouse shared appraisal as the mediator, the indirect effect was nonsignificant (indirect effect =.01, 95% bootstrapped CI = [-.03, .07]). The direct effect of spouse communal strength on spouse relational well-being was positive (direct effect =.46, *p* = .000). Similarly, in the model with spouse joint action as the mediator, the indirect effect was nonsignificant (indirect effect = .00, 95% bootstrapped CI = [-.08, .07]). The direct effect of spouse communal strength on spouse relational well-being was positive (direct effect = .46, *p* = .000). Thus, Hypothesis 6f was not supported.

Overall, H6a – H6f were unsupported. First, communal strength was not associated with either dimension of communal coping for caregivers and spouses and thus, support for H6a and H6b was not found. Accordingly, communal coping did not mediate the link between communal strength and personal well-being or the link between communal strength and relational well-being for both caregivers and spouses.

Table 18

Communal Coping as a Mediator Between Communal Strength and Personal and Relational Well-Being

	Effect of IV on mediator (*a*)		Unique effect of mediator (*b*)		Indirect effect (*ab*)	BC 95% CI for Indirect Effect		Direct effect (c')		Total effect (c)	
	Standardized *β*	*p*		*p*		LL	UL		*p*		*p*
H6c: Caregiver Communal Strength → Caregiver Communal Coping → Caregiver Personal Well-Being											
Mediator: Shared Appraisal	.20	.239	.14	.237	.03	-.02	.14	.15	.215	.18	.139
Mediator: Joint Action	.22	.196	-.02	.887	-.00	-.09	.07	.18	.145	.18	.139
H6d: Caregiver Communal Strength → Caregiver Communal Coping → Caregiver Relational Well-Being											
Mediator: Shared Appraisal	.17	.278	.18	.086	.03	-.02	.14	.43	.000	.46	.000
Mediator: Joint Action	.23	.145	.26	.015	.07	-.03	.18	.40	.000	.46	.000
H6e: Spouse Communal Strength → Spouse Communal Coping → Spouse Personal Well-Being											
Mediator: Shared Appraisal	.16	.338	-.20	.161	-.03	-.12	.04	.19	.179	.16	.264
Mediator: Joint Action	.22	.188	-.07	.642	-.02	-.18	.09	.17	.239	.16	.264
H6f: Spouse Communal Strength → Spouse Communal Coping → Spouse Relational Well-Being											
Mediator: Shared Appraisal	.19	.226	.03	.778	.01	-.03	.07	.46	.000	.46	.000
Mediator: Joint Action	.23	.146	.00	.997	.00	-.08	.07	.46	.000	.46	.000

Note. All coefficients reported are standardized. CIs of each indirect effect are based on 10,000 resamples.

5.6 Phase 6: Do Compassionate Goals and Communal Strength Explain Unique Variance in Communal Coping?

After examining the associations between compassionate goals and communal coping and communal strength and communal coping separately, I conducted exploratory analyses that examined whether compassionate goals and communal strength each explained unique variance in communal coping. To test this, I tested two linear multiple regressions with caregiver compassionate goals and caregiver communal strength as simultaneous predictors and each dimension of caregiver communal coping (shared appraisal and joint action) as the dependent variables. Parallel analyses were conducted for spouses.

Models Predicting Caregiver Communal Coping

Caregiver compassionate goals ($\beta = .04$, $p = .796$) and communal strength ($\beta =.16$, $p = .355$) were unrelated to their shared appraisal. Caregiver compassionate goals and communal strength were also unrelated to their joint action ($\beta = -.09$, $p = .580$ and $\beta = .26$, $p = .123$, respectively).

Models Predicting Spouse Communal Coping

Spouse compassionate goals were unrelated to their shared appraisal ($\beta = .32$, $p = .084$) and spouse communal strength was unrelated to spouse their appraisal ($\beta = .03$, $p = .888$). Additionally, spouse compassionate goals and spouse communal strength were both unrelated to spouse joint action ($\beta = .08$, $p = .678$ and $\beta = .19$, $p = .309$, respectively). See Tables 19 and 20 for full results of each model.

Table 19

Multiple Linear Regression Model for Compassionate Goals and Communal Strength Predicting Shared Appraisal

DV: Shared Appraisal						
	b	*SE*	*β*	*(adj.)* R^2	*p*	95% CI [LL, UL]
Caregiver Model						
Compassionate Goals	.09	.36	.04	-.02	.796	[-.63, .82]
Communal Strength	.16	.17	.16		.355	[-.18, .50]
Spouse Model						
Compassionate Goals	.40	.22	.32	.11	.084	[-.05, .85]
Communal Strength	.02	.12	.03		.888	[-.22, .25]

Note. $n_{caregiver}$ = 42; n_{spouse} = 41. Regressions were conducted separately for Caregivers and Spouses.

Table 20

Linear Regression Model for Compassionate Goals and Communal Strength Predicting Joint Action

DV: Joint Action						
	b	*SE*	*β*	*(adj.)* R^2	*p*	95% CI [LL, UL]
Caregiver Model						
Compassionate Goals	-.20	.37	-.09	.01	.580	[-.95, .54]
Communal Strength	.27	.17	.26		.123	[-.08, .62]
Spouse Model						
Compassionate Goals	.12	.28	.08	.01	.678	[-.46, .69]
Communal Strength	.15	.15	.19		.309	[-.15, .45]

Note. $n_{caregiver}$ = 42; n_{spouse} = 41.

Table 21

Summary of Hypotheses that were Supported/Not Supported

Hypotheses		
H_{1a}	Caregiver communal coping will be positively related to caregiver personal well-being	*Not supported*
H_{1b}	Caregiver communal coping will be positively related to caregiver relational well-being	*Supported*

H_{2a}	Spouse communal coping will be positively related to spouse personal well-being	*Not supported*
H_{2b}	Spouse communal coping will be positively related to spouse relational well-being	*Not supported*
H_{3a}	Caregiver compassionate goals will be positively related caregiver communal coping	*Not supported*
H_{3b}	Spouse compassionate goals will be positively related to spouse communal coping	*Partially supported*
H_{4a}	Caregiver communal coping will mediate link between caregiver compassionate goals and caregiver personal well-being	*Not supported*
H_{4b}	Caregiver communal coping will mediate link between caregiver compassionate goals and caregiver relational well-being	*Not supported*
H_{5a}	Spouse communal coping will mediate link between spouse compassionate goals and spouse personal well-being	*Not supported*
H_{5b}	Spouse communal coping will mediate link between spouse compassionate goals and spouse relational well-being	*Not supported*
H_{6a}	Caregiver communal strength will predict caregiver communal coping	*Not supported*
H_{6b}	Spouse communal strength will predict spouse communal coping	*Not supported*
H_{6c}	Caregiver communal coping will mediate link between caregiver communal strength and caregiver personal well-being	*Not supported*
H_{6d}	Caregiver communal coping will mediate link between caregiver communal strength and caregiver relational well-being	*Not supported*
H_{6e}	Spouse communal coping will mediate the link between spouse communal strength and spouse personal well-being	*Not supported*
H_{6f}	Spouse communal coping will mediate the link between spouse communal strength and spouse relational well-being	*Not supported*

CHAPTER 6: DISCUSSION

Communal coping, which involves both couple members viewing a stressor as a shared problem and managing it together, shows promise in helping relationship scientists understand how couples cope with chronic stress (Zajdel & Helgeson, 2020). To date, the communal coping literature has predominately focused on intra-dyadic stressors. That is, stressors that occur within the relationship, such as in couples wherein one partner faces a chronic condition (e.g., Helgeson et al., 2018). However, it is unclear whether communal coping would be beneficial in the context of filial caregiving, wherein the responsibility of providing care to an aging parent is an extra-dyadic stressor, and the other partner may feel less obligated to be involved in providing care. The goal of this dissertation was to examine communal caregiving in the context of female filial caregivers and their male spouses. Specifically, this project examined: (a) whether communal coping is related to personal and relational well-being; (b) the association between relational motives (i.e., compassionate goals and communal strength) and communal coping; and (c) whether relational motives were indirectly associated with personal and relational well-being through communal coping.

Overall, findings did not support a majority of my hypotheses. Communal coping was unrelated to personal well-being in both caregivers and spouses (H1a and H2a). However, as hypothesized, both dimensions of caregiver communal coping were positively associated with caregiver relational well-being (H1b). In contrast, spouse communal coping was unrelated to spouse relational well-being (H2b). Additionally, caregiver compassionate goals were unrelated to both dimensions of caregiver communal coping (H3a). Spouse compassionate goals were positively associated with their shared appraisal, but unrelated to their joint action, providing partial support for Hypothesis 3b.

Contrary to predictions, but consistent with the results of tests of H1-H3, neither dimension of communal coping mediated the relationship between compassionate goals and personal and relational well-being for either caregivers or spouses (H4a, H4b, H5a, and H5b). Communal strength was also unrelated to communal coping for caregivers and spouses (H6a and H6b). Similarly, neither dimension of communal coping mediated the association between communal strength and personal and relational well-being for caregivers and spouses (H6c, H6d, H6e, and H6f).

In the following paragraphs, I summarize key findings and discuss how these findings support and relate to the existing communal coping literature.

6.1 Associations Between Communal Coping and Personal and Relational Well-Being

I hypothesized that communal coping would be positively associated with personal well-being for caregivers (H1a). Contrary to predictions, both dimensions of communal coping were unrelated to personal well-being for caregivers (H1a). Though the lack of association between caregiver communal coping and caregiver personal well-being was unexpected, it may be that communal coping is more beneficial in the context of patients with a chronic illness and their spouses, compared to in the context of caregivers providing care to aging parent and their non-caregiving spouses. In the context of filial caregiving, couple members are communally coping with a stressor that is extradyadic (i.e., caregiving is provided outside of the dyad). Engaging in communal coping to deal with an extradyadic stressor may not be beneficial for caregivers' personal well-being in that same way as it is for dealing with a stressor within one's relationship, such as a spouses' chronic illness. Further, there may be other personally stressful factors from caregiving that communal coping does not affect. For instance, caregivers in this sample reported low levels of shared caregiving responsibility with other family members (*M* = 7.72 on a 1-9 scale for which high scores indicate respondents taking full responsibility for caregiving). Caregivers' high levels of personal responsibility for caregiving suggests that despite reporting moderate levels of communal coping, they still felt like the onus of caregiving was on them. This may be one reason why communal coping did not provide benefits to caregivers' personal well-being.

Alternatively, the lack of association between caregiver communal coping and caregiver personal well-being may be attributed to differences in the measurement of communal coping and personal well-being between previous studies and the current study. First, Helgeson et al. (2020a), Van Vleet et al. (2018), and Zajdel and Helgeson (2020) measured observed communal coping by coding videotaped discussions of couples for linguistic indicators of shared appraisal and joint action as opposed to using self-report measures. In addition to measuring observed communal coping, Zajdel and Helgeson (2018) also included self-report measures of shared appraisal and joint action focused on the illness as a shared stressor and daily diary assessments that participants completed over a two-week period. Second, psychological distress in all three studies was assessed using an average score of three general measures of depressive symptoms, satisfaction with life, and perceived stress. In contrast to previous studies, the current study used a different self-report measure of communal coping developed by Basinger (2018, 2020) that has primarily been used in the context of one spouse's chronic illness. Thus, it is possible that this measure does not translate to the context of filial caregivers and their spouses, wherein the stressor is extradyadic. Additionally, the current study assessed personal well-being with different measures (i.e., depression, positive and negative affect, and self-rated health) during a specific timeframe (i.e., since caregiving began). These discrepancies in measurement may be one reason for the differential findings. Notably, the relationship between caregiver shared appraisal and their personal well-being became positive when controlling for caregiver burden in exploratory analyses. However, because the shift in the magnitude of the effect was minimal (β = .23 to β = .28), I hesitate to overinterpret this finding. More research is needed to replicate this result before generalizing these findings.

The two dimensions of communal coping were also unrelated to personal well-being for spouses (H2a). While this finding was unexpected and a majority of prior work has found a positive association between communal coping and personal well-being for spouses (Zajdel et al., 2018; Zajdel & Helgeson, 2020; Helgeson et al., 2017), there have been a few exceptions. Helgeson et al. (2020b) and Van Vleet et al. (2018) found that in a sample of patients with type 2 diabetes and their spouses, spouse communal coping was unrelated to their own psychological distress. Similarly, Basinger et al. (2021) found that in individuals diagnosed with a severe health issue and their spouses, spouse shared appraisal was unrelated to their perceived physical health and spouse joint action was negatively related to their perceived physical health. In the current study, communal coping involved caregivers and spouses working together to manage a stressor that, for most couples, was objectively linked only to the caregiver. Because spouses are theoretically not experiencing the stressor of caregiving in the same way as caregivers, it is perhaps not surprising that spouses would not derive personal well-being benefits from their own communal coping. Importantly, however, the results show that there is no evidence of negative links of communal coping for spouses. Engaging in communal coping to manage a stressor that spouses are not directly tied to could come with costs to one’s personal well-being, such as experiencing greater personal distress (Basinger et al., 2021). Thus, although spouse communal coping did not enhance their personal well-being, it also did not lead to more distress or adverse health outcomes, which has been found in other studies of couples coping communally with one partner’s chronic illness (e.g., Basinger et al., 2021; Lee et al., 2020).

In support of H1b, both dimensions of caregiver communal coping (i.e., shared appraisal and joint action) had a moderate, positive association with caregiver relational well-being. That is, the more caregivers thought of their caregiving stressor as shared with their spouses and the more they collaborated to manage this stressor together, the better their relational well-being. This finding is in line with theory (Helgeson et al., 2018) and previous research suggesting that communal coping conveys responsiveness, open communication, and demonstrates investment in one’s relationship, which should lead to improved relationship outcomes (Afifi et al., 2020a; Helgeson et al., 2020a,b; Van Vleet et al., 2018). Indeed, previous studies of patients with type 2 diabetes and their spouses have found that patient communal coping is associated with greater relationship quality (e.g., Helgeson et al., 2020b; Zajdel & Helgeson, 2020; Van Vleet et al., 2018). Caregivers in the current study reported coping communally with their spouse. Thus, they perceived that they openly communicated their needs, and in turn, felt that their needs were met by their spouses and that they were responsive to their spouse’s needs. As a result, caregivers experienced less stress in their relationships and were more satisfied and committed to their spouse, which translated to greater relational well-being. Additionally, appraising caregiving as a shared responsibility that one jointly manages together with their spouse as a team can create a sense of coherence (Sim et al., 2019) and a mentality that “we are in this together.” Thus, engaging in communal coping likely led caregivers to feel closer to their spouse and more satisfied, committed, and less strained in their relationship, which benefitted their relational well-being.

Of note, the association between caregiver communal coping and their relational well-being remained significant when each indicator of nature of caregiving was included as a covariate, with the exception of shared responsibility of caregiving with other family members. When holding shared responsibility of caregiving with other family members constant, the association between caregiver shared appraisal and caregiver relational well-being became nonsignificant. However, given the small magnitude of change in the effect ($\beta = .32$ to $\beta = .31$), I am hesitant to interpret this finding. More research replicating this association is needed.

Contrary to Hypothesis 2b, there was no association between communal coping and relational well-being for spouses. Prior work suggests that women are more affected by the quality of their relationships than men (Acitelli & Badr, 2005; Seider et al., 2009, Yang et al., 2013; Helgeson et al., 2017), and thus, it may be that women experience greater benefits to their relational well-being from communal coping than men. In support of this notion, Hilpert et al. (2016) found that in a sample of married couples from 35 countries, dyadic coping, which focuses on collaboration between partners in the face of a stressor, was more strongly related to relationship satisfaction in women compared to men. Other research has also found that factors such as spousal support and relationship talk (i.e., talking about the nature of one's relationship, talking in relational terms, and talking about the relationship implications of a shared stressor) are more strongly related to martial satisfaction and marital distress in women compared to men (Acitelli & Badr, 2005; Seider et al., 2009). In the current study, communal coping was linked to relational well-being for female caregivers, but not their male spouses. This finding suggests that appraising caregiving as a shared stressor that caregivers jointly manage with their spouse may have greater implications for caregivers' relational well-being than for spouses. Notably, however, gender and caregiving role were conflated in this study, which restricts the interpretation of this gender difference. It could be the case that caregivers needed to cope communally with the stressors of caregiving because they needed more support than their spouses did, which had a greater effect on their relational well-being. Thus, more research is needed to parse out the effects of gender and caregiving role on communal coping and relational well-being.

Additionally, as noted previously, the context of communal coping in the current study involved caregivers and spouses working together to manage a stressor that is, in general, more strongly linked to the caregiver than their spouse. Spouses were not directly responsible for caregiving and did not experience as much burden from caregiving as their caregiving partners. Indeed, caregivers reported a greater perceived burden of caregiving (M = 3.47) than their spouses (M = 2.34), $t(81) = 7.18$, $p <.001$ (GraphPad Software, 2023 available from https://graphpad.com/quickcalcs/ttest1/). Thus, because spouses were less burdened from caregiving, appraising this stressor as a shared problem that they manage together with caregivers likely did not implicate their relational well-being in the same way as it did for caregivers' relational well-being.

6.2 Associations Between Compassionate Goals and Communal Coping, and the Mediating Effects of Communal Coping on Personal and Relational Well-Being

Contrary to Hypothesis H3a, caregiver compassionate goals were unrelated to their communal coping. This association did not change when controlling for relationship interdependent self-construal, general relationship commitment or general relationship satisfaction. In partial support of Hypothesis H3b, spouse compassionate goals were positively related to spouse shared appraisal, but unrelated to spouse joint action. However, when including relationship interdependent self-construal or general relationship commitment and general relationship satisfaction as covariates, the association between spouse compassionate goals and spouse shared appraisal became nonsignificant. Because the change in the magnitude of the coefficient was small when controlling for relationship interdependent self-construal (β = .33 to β = .32) or general relationship commitment and general relationship satisfaction (β = .33 to β = .29), I hesitate to interpret this finding. Future research is recommended to replicate these results.

There is no previous literature exploring the links between compassionate goals and communal coping or coping more broadly. For caregivers, it may be that the caregiving context is so strong that, regardless of their compassionate goals to be supportive, constructive, and to not harm others, they believe that their caregiving is a shared responsibility that they will jointly manage with their spouse. As previously mentioned, caregivers in this sample reported low levels of shared caregiving responsibility with other family members (*M* = 7.72 on a 1-9 scale for which high scores indicate respondents taking full responsibility for caregiving). They also reported choosing to take on the caregiving role (*M* = 2.21 on a 1-5 scale for which low scores indicate respondents fully choosing to provide care to parents or in-laws). Despite taking on a high degree of personal responsibility for caregiving and not sharing this responsibility with other family members, caregivers still reported moderate levels of shared appraisal (*M* = 3.23) and joint action (*M* = 3.11; both dimensions measured on 1-5 scales). Therefore, it may be that the context of caregiving is providing the impetus for communal coping. Because caregivers are arguably the ones who need support in this context, they may be more inclined to view their spouses as potential sources of support and more likely to engage in communal coping to garner that support without holding compassionate goals to support their spouse. In other words, having the mindset that caregiving is a shared, co-owned responsibility that is managed together with one’s spouse may be beneficial for caregivers to garner support to deal with their caregiving demands, lessening the relevance of compassionate goals.

For spouses, compassionate goals were related to shared appraisal, suggesting that spouses with compassionate goals to support their partners also held a stronger view of caregiving as a stressor and responsibility that they shared with their caregiving partner. In contrast to caregivers, spouses were not directly responsible for the stressors of caregiving. Thus, having a greater orientation to support their caregiving partner’s well-being (i.e., having compassionate goals) motivated non-caregiving spouses to feel a shared sense of ownership and responsibility for managing caregiving responsibilities with their partner.

There was a lack of associations between compassionate goals, communal coping, and personal and relational well-being (with the exception that caregiver communal coping was positively related to their relational well-being). Given this, it is not surprising that communal coping did not mediate the links between compassionate goals and personal well-being and relational well-being for caregivers or spouses (H4a, H5a, H4b, and H5b). However, the direct effect of spouse compassionate goals predicting spouse relational well-being was positive. This direct effect suggests that when spouses have compassionate goals – a desire to be supportive of their partner and do things that are helpful for both them and their partner – they experience greater relational well-being in the context of caregiving.

6.3 Associations Between Communal Strength and Communal Coping, and the Mediating Effects of Communal Coping on Personal and Relational Well-Being

Contrary to Hypotheses 6a and 6b, communal strength was unrelated to communal coping for both caregivers and spouses. These findings were surprising given that prior work has shown that communal strength is an important predictor of social support and helping processes in romantic relationships (Feeney & Collins, 2001) and that those higher in communal strength engage in relationship maintenance behaviors even in the face of perceived relationship inequity (Stafford, 2020). One plausible explanation for the differential finding in the current study is that communal strength reflects self-sacrifice and a sense of responsibility for a partner's well-being, "either out of concern, feelings of obligation," or wanting to please one's partner, with the expectation that one's partner will reciprocate (Canevello & Crocker, 2020, p. 3). Further, communal strength is more about the costs one is willing to incur to benefit their partner based on motivation to adhere to communal norms (Mills et al., 2004). In contrast, communal coping reflects a mentality that "we are in this together" as a team and is motivated by a willingness to care for and support the well-being of one's partner. Thus, having the motivation to provide for the needs of one's partner based on expectations of what one *should* do (i.e., communal strength) may not lead caregivers and spouses to engage in communal coping. Alternatively, for caregivers, they need support to meet their caregiving demands and may derive support by appraising caregiving as a shared stressor that they deal with together with their spouse, regardless of their communal strength. Thus, communal strength may not be a necessary motive for caregivers to engage in communal coping in the filial caregiving context.

Given the lack of associations between communal strength, communal coping, and personal and relational well-being, it is also not surprising that my hypotheses that communal coping would mediate the link between communal strength and personal and relational well-being were not supported (H6c-H6f). Notably, however, several direct effects were significant. In the model for which caregiver shared appraisal was the mediator, the relationship between caregiver communal strength and caregiver relational well-being was positive. Additionally, in the two models for which spouse shared appraisal and spouse joint action were the mediators, the relationship between spouse communal strength and spouse relational well-being was positive. This is largely consistent with prior research showing that when partners are higher in communal strength, they experience higher relationship satisfaction (Champagne & Muise, 2022), greater relationship well-being (Le et al., 2018), and engage in more relationship maintenance behaviors (Stafford, 2020).

6.4 Did Compassionate Goals and Communal Strength Explain Unique Variance in Communal Coping?

For exploratory purposes, I also examined whether compassionate goals and communal strength each explained unique variance in communal coping. Findings indicated that compassionate goals and communal strength did not explain unique variance in either dimension of communal coping for both caregivers and spouses. This finding was not surprising given that both compassionate goals and communal strength were unrelated to communal coping as independent predictors in earlier analyses (with the exception of spouse compassionate goals being related to their shared appraisal).

Overall, to my knowledge, this is the first empirical study to examine the associations between communal coping, personal and relational well-being, and relational motives in the context of filial caregiving. In general, findings from primary analyses indicated that caregiver communal coping was associated with their relational well-being, but not their personal well-being. Thus, communal coping appears to be beneficial for caregivers’ relational well-being, but does not have any implications for spouses’ personal or relational well-being in the context of filial caregiving. Additionally, findings suggest that relational motives (i.e., compassionate goal and communal strength) are generally not important antecedents to communal coping. One exception to this is spouses' compassionate goals, which may increase the extent to which spouses appraise caregiving as a shared responsibility.

6.5 Limitations and Future Directions

The study findings are constrained by several limitations. First, the final sample in this study was a smaller sample than anticipated, resulting in reduced power. This sample provided .80 power to detect moderate to large effects ($R^2 = .20$ or $r = .45$). Recruiting a larger sample was a challenge given that: (a) both female caregivers and their spouses were required to meet strict eligibility criteria, and (b) most caregivers of aging parents are overburdened with juggling work responsibilities, household responsibilities, children and caring for their aging parent, and have limited time for other activities, such as participating in a survey. The magnitude of several associations in the current study were moderate ($\beta = .30$ to .45) and trended in the hypothesized direction, despite not reaching statistical significance. Future work should aim to replicate the current study's findings in larger samples.

Second, participants reported their communal coping, personal and relational well-being, and relational motives within a specific time frame (i.e., since caregiving began). Asking participants to reflect on constructs within specific timeframes has been associated with recall bias and other inaccuracies in responding (Althubaiti, 2016; Rosenman et al., 2011). Thus, in addition to self-report measures, future studies should include daily diary assessments wherein researchers can measure shared appraisal and joint action in individuals as it naturally occurs in real time, over a period of time.

Third, this study adopted a cross-sectional design, which does not allow for tests of the temporal sequence of associations among primary study variables. Longitudinal research that assesses communal coping, relational motives, and personal and relational well-being outcomes could help shed light on directionality. That is, it could help better establish the order in which associations occur between variables, such as whether relational well-being leads to communal coping or vice versa. Ecological momentary assessment (EMA) studies could also allow for a more in-depth investigation into communal coping and personal and relational well-being in the context of filial caregiving stress in real time.

Fourth, because the goals of the study centered on gendered roles in male-female relationships, participants in the current study were required to be in heterosexual relationships wherein the female was the primary caregiver, and the male spouse was not a caregiver. This restricts the generalizability of the study's findings to other groups, such as same-sex couples or for couples in which the male might be the primary caregiver. Thus, examining how communal coping works in same-sex couples and non-binary couples, and in couples wherein the male is the primary caregiver can contribute to our understanding of couples' communal coping.

Fifth, couple members in the study were primarily White, college-educated, and married. Other studies have found that communal coping and its relationship to well-being outcomes may vary by race/ethnicity (e.g., Basinger & Hartsell, 2021). For instance, Helgeson et al. (2020b) found that White couple members were more likely to engage in communal coping and experienced greater benefits to their personal well-being from communal coping compared to Black couple members. Additionally, Basinger & Hartsell (2021) found that communal coping was more strongly related to self-care behavior in Black individuals with type 2 diabetes than White individuals. A large body of work also shows that White individuals are, on average, higher in socioeconomic status and have greater access to social and economic resources compared to Black individuals (e.g., Assari, 2018; Boen, 2016). Because participants in the current study were primarily White and college-educated, they may have had more resources available to meet the demands of the caregiving stressor, and likely experienced less stress as a result. Therefore, couple members may not have had to rely on their spouses as much to manage their caregiving stress. Researchers interested in examining these associations in the future should recruit a more diverse sample in terms of race/ethnicity and socioeconomic status.

Participants in the current study reported unexpectedly low levels of distress (i.e., depression: $M_{caregiver}$ = .64; M_{spouse} = .25 on a 0-3 scale; negative affect: $M_{caregiver}$ = 2.39; M_{spouse} = 1.64 on a 1-5 scale wherein higher scores indicate greater depression and negative affect) and caregiver burden ($M_{caregiver}$ = 3.47; M_{spouse} = 2.34 on a 1-5 scale in which higher scores reflect greater burden). Because couple members were not highly distressed or burdened by caregiving, the current study sample may not be representative of people in filial caregiving situations who could benefit the most from communal coping. Future research in this area should aim to replicate current study findings in couples who might be experiencing greater levels of distress.

Finally, in a similar vein, participants in the current study were in generally happy, long-lasting relationships ($M_{relationshiplength}$ = 24 years). Indeed, participants reported high levels of relationship satisfaction and commitment since caregiving began and in general, and reported low levels of relational load (i.e., relational well-being in general and since caregiving began; see Measures section on page 36). These indicators of relational well-being were related to joint action and marginally related to shared appraisal for caregivers. This alludes to the possibility that relational well-being has important implications for people coping with major life stressors. Further, given relatively high levels of relational well-being in the current study, it is possible that these associations with communal coping would be stronger in unhappy couples or those facing additional, prolonged stressors (e.g., poverty or a chronic health condition). Interestingly, relational well-being since caregiving began and in general was highly correlated with personal well-being for both caregivers and spouses (see Table 5). Couple members with lower relational well-being who suffer from poorer mental and physical health and other stressful circumstances have depleted personal resources (Thoits, 1995), which can affect their ability to cope with stressors alone. As a result, they may be more likely to engage in communal coping because they need pooled resources to effectively manage the stressor and bolster their personal and relational well-being (Afifi et al., 2020a). Thus, future studies examining communal coping in the context of filial caregiving should attempt to recruit couples who might be struggling with their relationships or couples wherein one partner is experiencing greater personal distress.

6.6 Conclusions

Given that informal caregivers are currently the cornerstone of America's long-term care system and receive little to no federal recognition or support, it is important to identify how caregivers cope communally with their spouses to alleviate some of the adverse personal and relational health effects associated with caregiving. Thus, the current study tested whether and to what extent caregivers and their spouses cope communally to manage the stressors of caregiving, as well as several antecedents and personal and relational outcomes of communal coping. Importantly, this study is the first to examine communal coping in the context of filial caregiving and one of the first to test communal coping in the context of an extra-dyadic stressor (Yang, 2023) – a stressor wherein the non-caregiving spouse may feel less obligated to be involved. Overall, this study broadened our understanding of the benefits of communal coping in these contexts. Results indicated that communal coping is beneficial for caregiver relational well-being and suggests that compassionate goals may be an important predictor of communal coping, though more research testing this association is needed. These findings could therefore be used to inform future research and replication studies. Additionally, they could provide an avenue for interventions to enhance communal coping in adult children caregivers and their partners.

REFERENCES

AARP and National Alliance for Caregiving. (2020). *Caregiving in the United States 2020*. Washington, DC: AARP. https://doi.org/10.26419/ppi.00103.001

Acitelli, L. K., & Badr, H. J. (2005). My illness or our illness? Attending to the relationship when one partner is ill. In T. A. Revenson, K. Kayser, & G. Bodenmann (Eds.), *Couples coping with stress: Emerging perspectives on dyadic coping* (pp. 121–136). American Psychological Association. https://doi.org/10.1037/11031-006

Afifi, T. D., Hutchinson, S., & Krouse, S. (2006). Toward a theoretical model of communal coping in postdivorce families and other naturally occurring groups. *Communication Theory*, *16*(3), 378-409. https://doi.org/10.1111/j.1468-2885.2006.00275.x

Afifi, T. D., Basinger, E. D., & Kam, J. A. (2020a). The extended theoretical model of communal coping: Understanding the properties and functionality of communal coping. *Journal of Communication*, *70*(3), 424–446. https://doi.org/10.1093/joc/jqaa006

Afifi, T. D., Haughton, C., & Parrish, C. (2021). Relational load: Implications for executive functioning, mental health, and feelings of unity in romantic relationships. *Communication Monographs, 88*(4), 506-529. https://doi.org/10.1080/03637751.2021.1896015

Afifi, T. D., Merrill, A. F., & Davis, S. (2016). The theory of resilience and relational load. *Personal Relationships, 23*(4), 663–683. https://doi.org/10.1111/pere.12159

Afifi, T. D., Zamanzadeh, N., Harrison, K., & Torrez, D. P. (2020b). Explaining the impact of differences in voting patterns on resilience and relational load in romantic relationships during the transition to the Trump presidency. *Journal of Social and Personal Relationships, 37*(1), 3–26. https://doi.org/10.1177/0265407519846566

Althubaiti A. (2016). Information bias in health research: Definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare, 9*, 211–217. https://doi.org/10.2147/JMDH.S104807

Assari S. (2018). Unequal gain of equal resources across racial groups. *International Journal of Health Policy and Management*, *7*(1), 1–9. https://doi.org/10.15171/ijhpm.2017.90

Badr, H. (2004). Coping in marital dyads: A contextual perspective on the role of gender and health. *Personal Relationships, 11*(2), 197–211. https://doi.org/10.1111/j.1475-6811.2004.00078.x

Barnes, C. L., Given, B. A., & Given, C. W. (1992). Caregivers of elderly relatives: Spouses and adult children. *Health & Social Work*, *17*(4), 282–289. https://doi.org/10.1093/hsw/17.4.282

Basinger E. D. (2018). Explicating the appraisal dimension of the communal coping model. *Health Communication*, *33*(6), 690–699. https://doi.org/10.1080/10410236.2017.1300208

Basinger E. D. (2020). Testing a dimensional versus a typological approach to the communal coping model in the context of type 2 diabetes. *Health Communication*, *35*(5), 585–596. https://doi.org/10.1080/10410236.2019.1573297

Basinger, E. D., & Hartsell, H. (2021). Communal coping and self-care in black and white individuals living with type 2 diabetes. *Health Communication*, *36*(14), 1961–1969. https://doi.org/10.1080/10410236.2020.1808408

Basinger, E. D., Wehrman, E. C., Delaney, A. L., & McAninch, K. G. (2021). Couples managing chronic illness: A test of the extended theoretical model of communal coping. *Journal of*

Social and Personal Relationships, *38*(5), 1611-1632. https://doi.org/10.1177/0265407521999461

Baumeister, R. F., & Heatherton, T. F. (1996). Self-regulation failure: An overview. *Psychological inquiry*, *7*(1), 1-15. https://doi.org/10.1207/s15327965pli0701_1

Berg, C. A., & Upchurch, R. (2007). A developmental-contextual model of couples coping with chronic illness across the adult life span. *Psychological Bulletin, 133*(6), 920–954. https://doi.org/10.1037/0033-2909.133.6.920

Berg, C. A., Wiebe, D. J., Butner, J., Bloor, L., Bradstreet, C., Upchurch, R., ... & Patton, G. (2008). Collaborative coping and daily mood in couples dealing with prostate cancer. *Psychology and Aging*, *23*(3), 505-516. https://doi.org/10.1037/a0012687

Bethea, L. S. (2002). The impact of older adult parents on communicative satisfaction and dyadic adjustment in the long-term marital relationship: Adult-children and spouses' retrospective accounts. *Journal of Applied Communication Research*, *30*(2), 107–125. https://doi.org/10.1080/00909880216582

Bodenmann, G. (1995). A systemic-transactional conceptualization of stress and coping in couples. *Swiss Journal of Psychology*, *54*(1), 34-49.

Bodenmann, G. (1997). Dyadic coping: A systemic-transactional view of stress and coping among couples: Theory and empirical findings. *European Review of Applied Psychology, 47*(2), 137-141.

Bodenmann, G. (2005). Dyadic coping and its significance for marital functioning. In T. A. Revenson, K. Kayser & G. Bodenmann (Eds.), *Couples coping with stress: Emerging perspectives on dyadic coping. Decade of behavior* (pp. 33-49). Washington, DC: American Psychological Association. https://doi.org/10.1037/11031-002

Bodenmann, G., Randall, A. K., & Falconier, M. K. (2016). Coping in couples: The Systemic Transactional Model (STM). In M. K. Falconier, A. K. Randall, & G. Bodenmann (Eds.), *Couples coping with stress: A cross-cultural perspective* (pp. 5-22). New York, NY: Taylor & Francis.

Boen C. (2016). The role of socioeconomic factors in Black-White health inequities across the life course: Point-in-time measures, long-term exposures, and differential health returns. *Social Science & Medicine (1982)*, *170*, 63–76. https://doi.org/10.1016/j.socscimed.2016.10.008

Bookwala J. (2009). The impact of parent care on marital quality and well-being in adult daughters and sons. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *64*(3), 339–347. https://doi.org/10.1093/geronb/gbp018

Brodaty, H., & Hadzi-Pavlovic, D. (1990). Psychosocial effects on carers of living with persons with dementia. *Australian and New Zealand Journal of Psychiatry*, *24*(3), 351–361. https://doi.org/10.3109/00048679009077702

Brown, T. A. (2015). *Confirmatory factor analysis for applied research* (2nd ed.). New York, NY: Guilford Press.

Browne, M. W., & Cudeck, R. (1992). Alternative ways of assessing model fit. *Sociological Methods & Research*, *21*(2), 230–258. https://doi.org/10.1177/0049124192021002005

Canevello, A., & Crocker, J. (2010). Creating good relationships: Responsiveness, relationship quality, and interpersonal goals. *Journal of Personality and Social Psychology*, *99*(1), 78-106. https://doi.org/10.1037/a0018186

Canevello, A., & Crocker, J. (2020). Prosocial orientations: Distinguishing compassionate goals from other constructs. *Frontiers in Psychology, 11*, 538165. https://doi.org/10.3389/fpsyg.2020.538165

Canevello, A., Jiang, T., & Crocker, J. (in prep). Relationships in the ecosystem: Constructive approaches to interpersonal problems and their consequences for relationships.

Carlson, R. W., Adkins, C., Crockett, M. J., & Clark, M. S. (2022). Psychological selfishness. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science*, *17*(5), 1359–1380. https://doi.org/10.1177/17456916211045692

Champagne, E. R., & Muise, A. (2022). Responsiveness and relationship satisfaction in couples coping with parkinson's disease: A pilot study. *Psychological Reports, 125*(2), 804–821. https://doi.org/10.1177/0033294121998032

Clark, M. S., Armentano, L. A., Boothby, E. J., & Hirsch, J. L. (2017). Communal relational context (or lack thereof) shapes emotional lives. *Current Opinion in Psychology*, *17,* 176–183. https://doi.org/10.1016/j.copsyc.2017.07.023

Clark, M. S., & Finkel, E. J. (2005). Willingness to express emotion: The impact of relationship type, communal orientation, and their interaction. *Personal Relationships*, *12*(2), 169-180. https://doi.org/10.1111/j.1350-4126.2005.00109.x

Clark, M. S., & Jordan, S. D. (2002). Adherence to communal norms: What it means, when it occurs, and some thoughts on how it develops. *New Directions for Child and Adolescent Development*, (95), 3-25. https://doi.org/10.1002/cd.34.

Clark, M. S., Oullette, R., Powell, M. C., & Milberg, S. (1987). Recipient's mood, relationship type, and helping. *Journal of Personality and Social Psychology*, *53*(1), 94-103. https://doi.org/10.1037/0022-3514.53.1.94

Coyne, J. C., Aldwin, C., & Lazarus, R. S. (1981). Depression and coping in stressful episodes. *Journal of Abnormal Psychology, 90*(5), 439-447. https://doi.org/10.1037//0021-843x.90.5.439

Coyne, J. C., & Smith, D. A. F. (1991). Couples coping with a myocardial infarction: A contextual perspective on wives' distress. *Journal of Personality and Social Psychology, 61,* 404-412. https://doi.org/10.1037//0022-3514.61.3.404

Crocker, J., & Canevello, A. (2008). Creating and undermining social support in communal relationships: The role of compassionate and self-image goals. *Journal of Personality and Social Psychology*, *95*(3), 555-575. https://doi.org/10.1037/0022-3514.95.3.555

Crocker, J., & Canevello, A. (2015). *Relationships and the self: Egosystem and ecosystem*. In M. Mikulincer, P. R. Shaver, J. A. Simpson, & J. F. Dovidio (Eds.), *APA handbooks in psychology®. APA handbook of personality and social psychology, Vol. 3. Interpersonal relations* (p. 93–116). American Psychological Association. https://doi.org/10.1037/14344-004

Crocker, J., Canevello, A., & Brown, A. A. (2017). Social motivation: Costs and benefits of selfishness and otherishness. *Annual Review of Psychology, 68*(1), 299-325. https://doi.org/10.1146/annurev-psych-010416-044145

Crocker, J., Canevello, A., & Lewis, K. A. (2017). Romantic relationships in the ecosystem: Compassionate goals, nonzero-sum beliefs, and change in relationship quality. *Journal of Personality and Social Psychology*, *112*(1), 58–75. https://doi.org/10.1037/pspi0000076

Cross, S. E., Bacon, P. L., & Morris, M. L. (2000). The relational-interdependent self-construal and relationships. *Journal of Personality and Social Psychology, 78*(4), 791–808. https://doi.org/10.1037/0022-3514.78.4.791

Deimling, G. T., Smerglia, V. L., & Schaefer, M. L. (2001). The impact of family environment and decision-making satisfaction on caregiver depression: A path analytic model. *Journal of Aging and Health, 13*(1), 47-71. https://doi.org/10.1177/089826430101300103

Donorfio, L. K. M., & Kellett, K. (2006). Filial responsibility and transitions involved: A qualitative exploration of caregiving daughters and frail mothers. *Journal of Adult Development, 13*, 158-167. https://doi.org/10.1007/s10804-007-9025-4

Falconier, M. K., & Kuhn, R. (2019). Dyadic coping in couples: A conceptual integration and a review of the empirical literature. *Frontiers in Psychology*, *10*, 571. https://doi.org/10.3389/fpsyg.2019.00571

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*(4), 1149-1160. https://doi.org/10.3758/BRM.41.4.1149

Feeney, B. C., & Collins, N. L. (2001). Predictors of caregiving in adult intimate relationships: An attachment theoretical perspective. *Journal of Personality and Social Psychology*, *80*(6), 972-994. https://doi.org/10.1037/0022-3514.80.6.972

Fincham, F. D., Paleari, F. G., & Regalia, C. (2002). Forgiveness in marriage: The role of relationship quality, attributions, and empathy. *Personal Relationships*, 9(1), 27–37. https://doi.org/10.1111/1475-6811.00002

Fletcher, G. J., Simpson, J. A., & Thomas, G. (2000). The measurement of perceived relationship quality components: A confirmatory factor analytic approach. *Personality and Social Psychology Bulletin*, *26*(3), 340-354. https://doi.org/10.1177/0146167200265007

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, *21*(3), 219‒239. https://doi.org/10.2307/2136617

Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48*(1), 150-170. https://doi.org/10.1037/0022-3514.48.1.150

Flynn, R., & Mulcahy, H. (2013). Early-onset dementia: The impact on family caregivers. *British Journal of Community Nursing*, *18*(12), 598-606. https://doi.org/10.12968/bjcn.2013.18.12.598

Ghasemi, M., Arab, M., & Shahrbabaki, P. M. (2020). Relationship between caregiver burden and family functioning in family caregivers of older adults with heart failure. *Journal of Gerontological Nursing*, *46*(6), 25-33. https://doi.org/10.3928/00989134-20200511-04

GraphPad Software. (2023). *T test calculator [online software]*. GraphPad QuickCalcs [online software]. Retrieved August 3, 2023, from https://www.graphpad.com/quickcalcs/ttest1/

Grosse Holtforth, M., Grawe, K., & Castonguay, L. G. (2006). Predicting a reduction of avoidance motivation in psychotherapy: Toward the delineation of differential processes of change operating at different phases of treatment. *Psychotherapy Research, 16*(5), 626–630. https://doi.org/10.1080/10503300600608215

Hair, J.F., Black, W.C., Babin, B.J. and Anderson, R.E. (2010). *Multivariate Data Analysis* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

Hayes, A. F. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach*. New York, NY, US: Guilford Press

Hazan, C., & Shaver, P. R. (1994). Attachment as an organizational framework for research on close relationships. *Psychological Inquiry*, *5*(1), 1-22. https://doi.org/10.1207/s15327965pli0501_1

Hebert, R. S., & Schulz, R. (2006). Caregiving at the end of life. *Journal of Palliative Medicine*, *9*(5), 1174-1187. https://doi.org/10.1089/jpm.2006.9.1174

Helgeson V. S. (2017). Young adults with type 1 diabetes: Romantic relationships and implications for well-being. *Diabetes Spectrum: a publication of the American Diabetes Association*, *30*(2), 108–116. https://doi.org/10.2337/ds16-0020

Helgeson, V. S., Jakubiak, B., Seltman, H., Hausmann, L., & Korytkowski, M. (2017). Implicit and explicit communal coping in couples with recently diagnosed type 2 diabetes. *Journal of Social and Personal Relationships*, *34*(7), 1099–1121. https://doi.org/10.1177/0265407516669604

Helgeson, V. S., Jakubiak, B. K., Van Vleet, M., & Zajdel, M. (2018). Communal coping and adjustment to chronic illness: Theory update and evidence. *Personality and Social Psychology Review*, *22*(2), 170–195. https://doi.org/10.1177/1088868317735767

Helgeson, V. S., Seltman, H., Korytkowski, M. T., & Hausmann, L. R. (2020a). Partner unmitigated communion moderates communal coping benefits in type 2 diabetes. *Journal of Health Psychology*, *25*(5), 674–683. https://doi.org/10.1177/1359105317729561

Helgeson, V. S., Naqvi, J. B., Seltman, H., Vaughn, A. K., Korytkowski, M., Hausmann, L., & Gary-Webb, T. L. (2020b). Links of communal coping to relationship and psychological health in type 2 diabetes: Actor-partner interdependence models involving role, sex, and race. *Annals of Behavioral Medicine*, *54*(5), 346–359. https://doi.org/10.1093/abm/kaz052

Helgeson, V. S., Naqvi, J. B., Zajdel, M., & Horner, F. (2022). Communal coping manifested in daily Life: A focus on gender. *Journal of Social and Personal Relationships*, *39*(4), 1023-1042. https://doi.org/10.1177/02654075211052633

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): construct validity and normative data in a large non-clinical sample. *The British Journal of Clinical Psychology*, *44*(2), 227–239. https://doi.org/10.1348/014466505X29657

Higginbotham, L.L. (1996). *The effects of caregiving on the noncaregiving spouse* (Publication No. 1382999) [Master's thesis, California State University, Fullerton]. ProQuest Dissertations & Theses Global.

Hilpert, P., Randall, A. K., Sorokowski, P., Atkins, D. C., Sorokowska, A., Ahmadi, K., Aghraibeh, A. M., Aryeetey, R., Bertoni, A., Bettache, K., Błażejewska, M., Bodenmann, G., Borders, J., Bortolini, T. S., Butovskaya, M., Castro, F. N., Cetinkaya, H., Cunha, D., David, O. A., DeLongis, A., … Yoo, G. (2016). The associations of dyadic coping and relationship satisfaction vary between and within nations: A 35-nation study. *Frontiers in Psychology, 7*, 1106. https://doi.org/10.3389/fpsyg.2016.01106

Jiang,T., Canevello, A., Gore, J.S., Hahn J.H., & Crocker, J. (2017). The association between compassionate goals and relational-interdependent self-construal. *Self and Identity, 16*(2), 143-170. https://doi.org/10.1080/15298868.2016.1238406

Kam, J. A., Basinger, E. D., & Guntzviller, L. M. (2017). Communal coping among spanish-speaking mother–child dyads engaging in language brokering: A latent class analysis. *Communication Research*, *44*(5), 743–769. https://doi.org/10.1177/0093650216684927

Kang, S., & Marks, N. F. (2016). Marital strain exacerbates health risks of filial caregiving: Evidence from the 2005 National Survey of Midlife in the U.S. *Journal of Family Issues, 37*(8), 1123–1150. https://doi.org/10.1177/0192513X14526392

Kanti, M.K. & Falconier, M.K. (2017). Asian Americans caring for elderly parents in the U.S. *Journal of Cultural Diversity, 24*(3), 73-83.

Kline, R. B. (2005). *Principles and practice of structural equation modeling* (4th ed.). New York, NY: Guildford Press

Lazarus, R. S., & Folkman, S. (1984). Coping and adaptation. In W. D. Gentry (Ed.), *The Handbook of Behavioral Medicine* (pp. 282-325). New York, NY: Guilford Press

Lazarus, R. S., & Launier, R. (1978). Stress-related transactions between person and environment. In L. A. Pervin & M. Lewis (Eds.), *Perspectives in Interactional Psychology* (pp. 278-327). New York, NY: Plenum Press.

Lee, J., Helgeson, V. S., Van Vleet, M., Tracy, E. L., de Grey, R. G. K., Zajdel, M., & Berg, C. A. (2020). Implications of we-talk for relationships and health among patients with type 1 diabetes and their spouses. *Journal of Social and Personal Relationships, 37*(1), 345–354. https://doi.org/10.1177/0265407519865613

Le, B. M., Impett, E. A., Kogan, A., Webster, G. D., & Cheng, C. (2013). The personal and interpersonal rewards of communal orientation. *Journal of Social and Personal Relationships, 30*(6), 694-710. https://doi.org/10.1177/0265407512466227

Le, B. M., Impett, E. A., Lemay, E. P., Jr., Muise, A., & Tskhay, K. O. (2018). Communal motivation and well-being in interpersonal relationships: An integrative review and meta-analysis. *Psychological Bulletin, 144*(1), 1–25. https://doi.org/10.1037/bul0000133

Lei, L., Leggett, A. N., & Maust, D. T. (2023). A national profile of sandwich generation caregivers providing care to both older adults and children. *Journal of the American Geriatrics Society (JAGS)*, *71*(3), 799–809. https://doi.org/10.1111/jgs.18138

Luichies, I., Goossensen, A., & der Meide, H. V. (2021). Caregiving for ageing parents: A literature review on the experience of adult children. *Nursing Ethics*, *28*(6), 844–863. https://doi.org/10.1177/0969733019881713

Lyons, R. F., Mickelson, K. D., Sullivan, M. J. L., & Coyne, J. C. (1998). Coping as a communal process. *Journal of Social and Personal Relationships, 15,* 579-605. https://doi.org/10.1177/0265407598155001

Matthews, S. H., & Rosner, T. T. (1988). Shared filial responsibility: The family as primary caregiver. J*ournal of Marriage and the Family*, *50*(1), 185 – 195. https://doi.org/10.2307/352438

Mattingly, B. A., Oswald, D. L., & Clark, E. M. (2011). An examination of relational-interdependent self-construal, communal strength, and pro-relationship behaviors in friendships. *Personality and Individual Differences*, *50*(8), 1243-1248. https://doi.org/10.1016/j.paid.2011.02.018

McDonnell, E., & Ryan, A. A. (2014). The experience of sons caring for a parent with dementia. *Dementia*, *13*(6), 788–802. https://doi.org/10.1177/1471301213485374

Mickelson, K. D., Lyons, R. F., Sullivan, M. J. L., Coyne, J. C., & Sarason, B. R. (2001). Yours, mine, ours: The relational context of communal coping. In S. Duck (Ed.), *Personal relationships: Implications for clinical and community psychology* (pp. 181-200). New York, NY: John Wiley.

Mills, J., & Clark, M. S. (2001). Viewing close romantic relationships as communal relationships: Implications for maintenance and enhancement. In J. Harvey & A. Wenzel (Eds.), *Close romantic relationships: Maintenance and enhancement* (pp. 13–25). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Mills, J., Clark, M. S., Ford, T. E., & Johnson, M. (2004). Measurement of communal strength. *Personal Relationships*, *11*(2), 213-230. https://doi.org/10.1111/j.1475-6811.2004.00079.x

Miyawaki, CE, Bouldin, ED, Taylor, CA, & McGuire, LC (2020). Baby boomers as caregivers: Results from the behavioral risk factor surveillance system in 44 states, the District of Columbia, and Puerto Rico, 2015–2017. *Preventing Chronic Disease*, *17*(17), E80. https://doi.org/10.5888/pcd17.200010

O'Brien, T. B., & DeLongis, A. (1996). The interactional context of problem-, emotion-, and relationship-focused coping: The role of the big five personality factors. *Journal of Personality, 64,* 775-813. https://doi.org/10.1111/j.1467-6494.1996.tb00944.x

Pakenham, K. I. (1998). Couple coping and adjustment to multiple sclerosis in care receiver–carer dyads. *Family Relations*, *47*(3), 269–277. https://doi.org/10.2307/584977

Pavalko, E. K., & Artis, J. E. (1997). Women's caregiving and paid work: Causal relationships in late midlife. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *52*(4), S170-S179. https://doi.org/10.1093/geronb/52b.4.s170

Pearlin, L. I., Lieberman, M. A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social Behavior*, *22*(4), 337–356. https://doi.org/10.2307/2136676

Pinquart, M., & Sörensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. *Psychology and Aging*, *18*(2), 250–267. https://doi.org/10.1037/0882-7974.18.2.250

Pinquart, M., & Sörensen, S. (2011). Spouses, adult children, and children-in-law as caregivers of older adults: A meta-analytic comparison. *Psychology and Aging*, *26*(1), 1–14. https://doi.org/10.1037/a0021863

Pollmann, M. M., & Finkenauer, C. (2009). Investigating the role of two types of understanding in relationship well-being: Understanding is more important than knowledge. *Personality and Social Psychology Bulletin*, *35*(11), 1512-1527. https://doi.org/10.1177/0146167209342754

Reinhard, S.C., Caldera,S., Houser, A., & Choula, R.B. (2023). *Valuing the Invaluable 2023 Update: Strengthening Supports for Family Caregivers*. Washington, DC: AARP Public Policy Institute. https://doi.org/10.26419/ppi.00082.006

Reinhard S.C., Given B., Petlick N.H. & Bemis A. (2008) Supporting family caregivers in providing care. In: R.G. Hughes (Ed.) *Patient safety and quality: An evidence-based handbook for nurses* (pp. 341–404). Rockville, MD: AHRQ Publication

Reis, H. T. (2021). Relational motives. In P. A. M. Van Lange, E. T. Higgins, & A. W. Kruglanski (Eds.), *Social psychology: Handbook of basic principles* (pp. 240–262). New York, NY: Guilford Press

Reis, H. T., Lemay Jr, E. P., & Finkenauer, C. (2017). Toward understanding understanding: The importance of feeling understood in relationships. *Social and Personality Psychology Compass*, *11*(3), e12308. https://doi.org/10.1111/spc3.12308

Revenson, T. A. (1994). Social support and marital coping with chronic illness. *Annals of Behavioral Medicine, 16,* 122-130. https://doi.org/10.1093/abm/16.2.122

Revenson, T. A. (2003). Scenes from a marriage: Examining support, coping, and gender within the context of chronic illness. In J. Suls & K. A. Wallston (Eds.), *Social Psychological Foundations of Health and Illness* (pp. 530-559). Malden, MA: Blackwell

Rosenman, R., Tennekoon, V., & Hill, L. G. (2011). Measuring bias in self-reported data. *International Journal of Behavioural and Healthcare Research*, *2*(4), 320–332. https://doi.org/10.1504/IJBHR.2011.043414

Roth, S., & Cohen, L. J. (1986). Approach, avoidance, and coping with stress. *American Psychologist*, *41*, 813-819. https://doi.org/10.1037//0003-066x.41.7.813

Rusbult, C. E., Martz, J. M., & Agnew, C. R. (1998). The investment model scale: Measuring commitment level, satisfaction level, quality of alternatives, and investment size. *Personal Relationships*, *5*(4), 357-387. https://doi.org/10.1111/j.1475-6811.1998.tb00177.x

Seider, B. H., Hirschberger, G., Nelson, K. L., & Levenson, R. W. (2009). We can work it out: Age differences in relational pronouns, physiology, and behavior in marital conflict. *Psychology and Aging*, *24*(3), 604–613. https://doi.org/10.1037/a0016950

Sim, A., Cordier, R., Vaz, S., & Falkmer, T. (2019). “We are in this together”: Experiences of relationship satisfaction in couples raising a child with autism spectrum disorder. *Research in Autism Spectrum Disorders*, *58*, 39-51. https://doi.org/10.1016/j.rasd.2018.11.011

Snippe, E., Jeronimus, B. F., aan het Rot, M., Bos, E. H., de Jonge, P., & Wichers, M. (2018). The reciprocity of prosocial behavior and positive affect in daily life. *Journal of Personality*, *86*(2), 139-146. https://doi.org/10.1111/jopy.12299

Stafford, L. (2020). Communal strength, exchange orientation, equity, and relational maintenance. *Journal of Social and Personal Relationships*, *37*(8-9), 2345-2365. https://doi.org/10.1177/0265407520923741

Stansfield, C. W., & Ross, J. (1988). A long-term research agenda for the Test of Written English. *Language Testing*, *5*(2), 160–186. https://doi.org/10.1177/026553228800500204

Steiner, A.M., Fletcher, P.C. (2017). Sandwich generation caregiving: A complex and dynamic role. *Journal of Adult Development*, *24*(2), 133–143. https://doi.org/10.1007/s10804-016-9252-7

Suitor, J. J., & Pillemer, K. (1994). Family caregiving and marital satisfaction: Findings from a 1-Year panel study of women caring for parents with dementia. *Journal of Marriage and Family*, *56*(3), 681–690. https://doi.org/10.2307/352878

Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior, 35*, 53–79. https://doi.org/10.2307/2626957

Uchino, B. N. (2009). Understanding the links between social support and physical health: A life-span perspective with emphasis on the separability of perceived and received support. *Perspectives on Psychological Science*, *4*(3), 236-255. https://doi.org/10.1111/j.1745-6924.2009.01122.x

Uchino, B. N., Bowen, K., Carlisle, M., & Birmingham, W. (2012). Psychological pathways linking social support to health outcomes: A visit with the “ghosts” of research past, present, and future. *Social Science & Medicine, 74*(7), 949-957. https://doi.org/10.1016/j.socscimed.2011.11.023

Szinovacz, M. E. (2003). Caring for a demented relative at home: Effects on parent – adolescent relationships and family dynamics. *Journal of Aging Studies, 17*(4), 445–472. https://doi.org/10.1016/S0890-4065(03)00063-X

Van Vleet, M., Helgeson, V. S., Seltman, H. J., Korytkowski, M. T., & Hausmann, L. (2018). Communally coping with diabetes: An observational investigation using the actor-partner interdependence model. *Journal of Family Psychology*, *32*(5), 654–663. https://doi.org/10.1037/fam0000414

Vespa, J., Medina, L. & Armstrong, D. M. (2020) Demographic turning points for the United States: Population projections for 2020 to 2060. U.S. Census Bureau, Available from: https://www. census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf. [Accessed 7 December 2022]

Zajdel, M., & Helgeson, V. S. (2020). Communal coping: A multi-method approach with links to relationships and health. *Journal of Social and Personal Relationships*, *37*(5), 1700–1721. https://doi.org/10.1177/0265407520903811

Zajdel, M., Helgeson, V. S., Seltman, H. J., Korytkowski, M. T., & Hausmann, L. R. M. (2018). Daily communal coping in couples with type 2 diabetes: Links to mood and self-care. *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine*, *52*(3), 228–238. https://doi.org/10.1093/abm/kax047

Zarit, S. H., Reever, K. E., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *The Gerontologist*, *20*(6), 649-655. https://doi.org/10.1093/geront/20.6.649

Ware, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical Care, 30*(6), 473–483. https://doi.org/10.1097/00005650-199206000-00002

Warttig, S. L., Forshaw, M. J., South, J., & White, A. K. (2013). New, normative, English-sample data for the short form perceived stress scale (PSS-4). *Journal of Health Psychology*, *18*(12), 1617-1628. https://doi.org/10.1177/1359105313508346

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: the PANAS scales. *Journal of Personality and Social Psychology*, *54*(6), 1063–1070. https://doi.org/10.1037//0022-3514.54.6.1063

Weber-Raley, R. (2019). *Burning the Candle at Both Ends: Sandwich Generation Caregiving in the U.S.* The National Alliance for Caregiving. https://caringacross.org/wp-content/uploads/2019/11/NAC_SandwichCaregiving_Report_digital112019.pdf

Wiebe, D. J., Helgeson, V., & Berg, C. A. (2016). The social context of managing diabetes across the life span. *The American Psychologist*, *71*(7), 526–538. https://doi.org/10.1037/a0040355

Williamson, G. M., & Clark, M. S. (1992). Impact of desired relationship type on affective reactions to choosing and being required to help. *Personality and Social Psychology Bulletin*, *18*(1), 10-18. https://doi.org/10.1177/0146167292181002

Wooldridge, J. S., Gray, C., Pukhraj, A., Geller, J., & Trivedi, R. B. (2019). Understanding communal coping among patients and informal caregivers with heart failure: A mixed methods secondary analysis of patient-caregiver dyads. *Heart & Lung*, *48*(6), 486–495. https://doi.org/10.1016/j.hrtlng.2019.05.008

Yang, Y. C., McClintock, M. K., Kozloski, M., & Li, T. (2013). Social isolation and adult mortality: The role of chronic inflammation and sex differences. *Journal of Health and Social Behavior*, *54*(2), 183–203. https://doi.org/10.1177/0022146513485244

Yang, Y (2023). *Understanding the role of open communication on couples' relationship and psychological well-being during menopause: An examination of the mediating effects of communal coping with an Actor-Partner Interdependence Model* (Master's thesis). http://dx.doi.org/10.26153/tsw/45989

Yee, J. L., & Schulz, R. (2000). Gender differences in psychiatric morbidity among family caregivers: A review and analysis. *The Gerontologist*, *40*(2), 147–164. https://doi.org/10.1093/geront/40.2.147

Appendix A

Screener Questionnaire

What is your age? _____ years

What is your relationship status?
Single (i.e., no current sexual or romantic partners) [BUMP]
I am in a sexual, but non-romantic relationship [BUMP]
Casually dating (i.e., I am in a non-monogamous romantic relationship)
Exclusively dating (i.e., I am in a monogamous romantic relationship)
Engaged to be married
Married/Civil Union/Domestic Partnership
Other (*Please Specify*)

How long have you been in your current relationship?
__Years
___Month

Do you and your romantic partner live together?
Yes
No

Does you have a chronic condition that requires assistance from your partner with daily activities?
Yes [BUMP]
No

Does your romantic partner have a chronic condition that requires you to provide care or assistance with daily activities?
Yes [BUMP]
No

Do you provide unpaid care to an older adult relative?
Yes
No [BUMP]

What is your relation to the older adult care recipient?
Daughter
Daughter-in-law
Son
Son-in-law
Brother [BUMP]
Sister [BUMP]
Granddaughter/Grandson [BUMP]
Niece/Nephew [BUMP]
Friend/neighbor [BUMP]

Husband [BUMP]
Wife [BUMP]
Other (please specify): ______

Do your romantic partner provide unpaid care to another older adult relative?
Yes [BUMP]
No

Do you have any children with chronic physical, developmental, behavioral or emotional conditions that require care beyond that required by other children generally?
Yes [BUMP]
No

Appendix B

Compassionate Goals (Crocker & Canevello, 2008)

Please indicate how much you want/try to do each of the following in your relationship with your partner **In my relationship with partner, I want/try to…**		**Not at all**	**A little**	**Somewhat**	**A lot**	**Extremely**
1.	Have compassion for my partner's mistakes and weaknesses.	1	2	3	4	5
2.	Be supportive of my partner.	1	2	3	4	5
3.	Be constructive in my comments to my partner.	1	2	3	4	5
4.	Avoid being selfish or self-centered.	1	2	3	4	5
5.	Avoid doing things that aren't helpful to me or my partner.	1	2	3	4	5
6.	Avoid neglecting my relationship with my partner.	1	2	3	4	5
7.	Avoid doing anything that would be harmful to my partner.	1	2	3	4	5
8.	Be aware of the impact my behavior might have on my partner's feelings.	1	2	3	4	5
9.	Make a positive difference in my partner's life.	1	2	3	4	5
10.	Avoid closing myself off emotionally from my partner.	1	2	3	4	5
11.	Avoid saying things to my partner that I don't mean.	1	2	3	4	5
12.	Create for him/her what I want to experience myself.	1	2	3	4	5
13.	Do things that are helpful for both me and my partner.	1	2	3	4	5

Appendix C

Communal Strength (Mills et al., 2004)

Please answer each item below while thinking about your partner.		**Not at all**									**Extremely**
1.	How far would you be willing to go to visit ___?	1	2	3	4	5	6	7	8	9	10
2.	How happy do you feel when doing something that helps _____?	1	2	3	4	5	6	7	8	9	10
3.	How large a benefit would you be likely to give _____?	1	2	3	4	5	6	7	8	9	10
4.	How large a cost would you incur to meet a need of _____?	1	2	3	4	5	6	7	8	9	10
5.	How readily can you put the needs of ____ out of your thoughts?*	1	2	3	4	5	6	7	8	9	10
6.	How high a priority for you is meeting the needs of _____?	1	2	3	4	5	6	7	8	9	10
7.	How reluctant would you be to sacrifice for _____?*	1	2	3	4	5	6	7	8	9	10
8.	How much would you be willing to give up to benefit _____?	1	2	3	4	5	6	7	8	9	10
9.	How far would you go out of your way to do something for _____?	1	2	3	4	5	6	7	8	9	10
10.	How easily could you accept not helping _____?*	1	2	3	4	5	6	7	8	9	10

Appendix D

Communal Coping (modified from Basinger, 2020)

As you answer the following questions, focus on what you have THOUGHT about your caregiving responsibilities since you began caregiving for your loved one.		**Strongly disagree**				**Strongly agree**
1.	I feel like I am the only one with ownership of caregiving for my loved one.*(R)	1	2	3	4	5
2.	My partner is affected by my caregiving responsibilities.*	1	2	3	4	5
3.	Only I am affected by caregiving for my loved one.*(R)	1	2	3	4	5
4.	Caregiving is my and my partner's problem together.	1	2	3	4	5
5.	Caregiving is only my problem.(R)	1	2	3	4	5
6.	My caregiving responsibilities influence my partner. *	1	2	3	4	5
7.	I feel like I share ownership of my caregiving responsibilities with my partner.	1	2	3	4	5
Now, think about how you and your romantic partner have managed your caregiving responsibilities since you began caregiving. As your answer the following questions, focus on what you and your partner have DONE to manage your caregiving responsibilities.		**Strongly disagree**				**Strongly agree**
1.	My partner and I have joined together to deal with my caregiving demands.	1	2	3	4	5
2.	I make plans for dealing with caregiving by myself. (R)	1	2	3	4	5
3.	I depend only on myself to manage the demands of caregiving. (R)	1	2	3	4	5
4.	I do not rely on my partner to cope with caregiving stress. (R)	1	2	3	4	5
5.	I deal with caregiving alone. (R)	1	2	3	4	5
6.	I depend on my partner to help me handle caregiving demands.	1	2	3	4	5

(R) indicated the item is reverse scored.
*Item was dropped following confirmatory factor analysis

Appendix E

Depression Subscale (Modified from Henry & Crawford, 2005)

Please indicate the extent to which each statement applies to you since you began caregiving. **Since I began caregiving,**		**Does not apply to me at all**	Applies to me to some degree, or some of the time	Applies to me to a considerable degree, or part of the time	**Applies to me most of the time**
1.	I can't seem to experience any positive feeling at all	0	1	2	3
2.	I find it difficult to work up the initiative to do things	0	1	2	3
3.	I feel that I have nothing to look forward to	0	1	2	3
4.	I am unable to become enthusiastic about anything	0	1	2	3
5.	I feel down-hearted and blue	0	1	2	3
6.	I feel I'm not worth much as a person	0	1	2	3
7.	I feel that life was meaningless	0	1	2	3

Appendix F

Positive and Negative Affect Schedule (Modified, Watson et al., 1988)

This scale consists of a number of words that describe different feelings and emotions. Please read each item and then indicate to what extent you have been feeling this way since you began caregiving using the scale below.		**Very slightly or not at all**	**A little**	**Moderately**	**Quite a bit**	**Extremely**
1.	Distressed	1	2	3	4	5
2.	Excited	1	2	3	4	5
3.	Upset	1	2	3	4	5
4.	Scared	1	2	3	4	5
5.	Irritable	1	2	3	4	5
6.	Strong	1	2	3	4	5
7.	Hostile	1	2	3	4	5
8.	Inspired	1	2	3	4	5
9.	Enthusiastic	1	2	3	4	5
10.	Attentive	1	2	3	4	5

Appendix G

Self-Rated Health (Ware & Sherbourne, 1992)

In general, would you say your health is…				
Excellent	Very good	Good	Fair	Poor

Appendix H

Relationship Satisfaction Scales (modified from Fletcher et al., 2000)

Relationship Satisfaction Since Caregiving Began

Think about your relationship since you began caregiving. Using the scale below, please indicate the extent to which you agree with the following items. **Since you began caregiving,**		**Not at all**						**Extremely**
1.	How satisfied are you with your relationship?	1	2	3	4	5	6	7
2.	How content are you with your relationship?	1	2	3	4	5	6	7
3.	How happy are you with your relationship?	1	2	3	4	5	6	7

General Relationship Satisfaction

Think about your relationship, in general. Using the scale below, please indicate the extent to which you agree with the following items. **In general,**		**Not at all**						**Extremely**
1.	How satisfied are you with your relationship ?	1	2	3	4	5	6	7
2.	How content are you with your relationship?	1	2	3	4	5	6	7
3.	How happy are you with your relationship?	1	2	3	4	5	6	7

Appendix I

Relationship Commitment Scales (modified from Rusbult et al., 1998)

Commitment Since Caregiving Began

Please indicate the degree to which you agree with each of the following statements regarding your current relationship since you began caregiving using the scale below.		Do not agree at all				Agree somewhat				Agree completely
1.	I want my and my partner's relationship to last for a very long time.	0	1	2	3	4	5	6	7	8
2.	I am committed to maintaining my relationship with my partner.	0	1	2	3	4	5	6	7	8
3.	I would not feel very upset if our relationship were to end in the near future.*(R)	0	1	2	3	4	5	6	7	8
4.	I feel very attached to our relationship –very strongly linked to my partner.	0	1	2	3	4	5	6	7	8
5.	I want our relationship to last forever.	0	1	2	3	4	5	6	7	8

General Relationship Commitment (modified from Rusbult et al., 1998)

Please indicate the degree to which you agree with each of the following statements regarding your current relationship in general using the scale below. In general,		Do not agree at all				Agree somewhat				Agree completely
1.	I want my and my partner's relationship to last for a very long time.	0	1	2	3	4	5	6	7	8

2.	I am committed to maintaining my relationship with my partner.	0	1	2	3	4	5	6	7	8
3.	I would not feel very upset if our relationship were to end in the near future.*(R)	0	1	2	3	4	5	6	7	8
4.	I feel very attached to our relationship –very strongly linked to my partner.	0	1	2	3	4	5	6	7	8
5.	I want our relationship to last forever.	0	1	2	3	4	5	6	7	8

(R) indicates the item is reverse-scored.
*Item was dropped following confirmatory factory analysis.

Appendix J

Relational Load (Afifi et al., 2020b)

Using the scale below, please indicate how you feel about your romantic partner.		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1.	I feel emotionally drained from my romantic relationship.	1	2	3	4	5
2.	Being in my romantic relationship is a real strain for me.	1	2	3	4	5
3.	I feel burned out from my romantic relationship.	1	2	3	4	5
4.	I worry that my romantic relationship is hardening me emotionally.	1	2	3	4	5
5.	I feel very energetic in my romantic relationship.	1	2	3	4	5
6.	I feel frustrated by my romantic partner.	1	2	3	4	5
7.	I feel used up in my romantic relationship.	1	2	3	4	5
8.	I have become insensitive or uncaring toward my romantic partner.	1	2	3	4	5

Appendix K

Relationship Interdependent Self-Construal (Cross et al., 2000)

Please indicate the extent to which you agree or disagree with each of the following statements.		Strongly disagree			Neither agree nor disagree			Strongly Agree
1.	My close relationships are an important reflection of who I am.	1	*2*	3	4	5	6	7
2.	When I feel very close to someone, it often feels to me like that person is an important part of who I am.	1	*2*	3	4	5	6	7
3.	I usually feel a strong sense of pride when someone close to me has an important accomplishment.	1	*2*	3	4	5	6	7
4.	I think one of the most important parts of who I am can be captured by looking at my close friends and u understanding who they are.	1	*2*	3	4	5	6	7
5.	When I think of myself, I often think of my close friends or family also.	1	*2*	3	4	5	6	7
6.	If a person hurts someone close to me, I feel personally hurt as well.	1	*2*	3	4	5	6	7
7.	In general, my close relationships are an important part of my self-image.	1	*2*	3	4	5	6	7
8.	Overall, my close relationships have very little to do with how I feel about myself. (R)	1	*2*	3	4	5	6	7
9.	My close relationships are unimportant to my sense	1	*2*	3	4	5	6	7

	of what kind of person I am. (R)							
10.	My sense of pride comes from knowing who I have as close friends.	1	*2*	3	4	5	6	7
11.	When I establish a close friendship with someone, I usually develop a strong sense of identification with that person.	1	*2*	3	4	5	6	7

(R) indicates the item is reverse-scored.

Appendix L

Demographic Information

What is your gender?
Man
Woman
Another identity (please specify) _______________

What is your race?
Black or African-American
East Asian
Latino/Latina/Latinx
Middle Eastern
Native American or First Nation
Native Hawaiian or Pacific Islander
South Asian
White or European American
Multiracial
Other (please describe) _________________

Do you identify as Hispanic, Latino, or Latina?
Yes
No

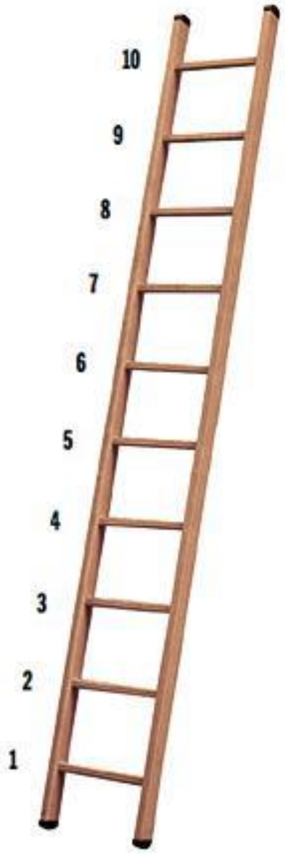
What is the highest level of education you have completed?
11th grade or less (not high school graduate)
High school graduate or G.E.D.
Vocational or technical school after high school
Some college, including 2 year degrees
Bachelor's Degree
Master's Degree
Doctoral Degree (Ph.D., M.D., J.D., etc)
I would rather not report this.

Are you currently employed?
Yes [skip to below question]
No, I was not employed before I started caregiving for my loved one
No, I am not currently employed because I am a caregiver

If yes,
How many hours per week do you work? ____________

Think of this ladder as representing where people stand in the United States. At the TOP of the ladder are the people who are the best off - those who have the most money, the most education, and the most respected jobs. At the BOTTOM are the people who are the worst off - who have the least money, least education, and the least respected

jobs or no job. The higher up you are on this ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.



Where would you place yourself on this ladder?

Please indicate the rung where you think you stand at this time in your life, relative to other people in the United States:

1	2	3	4	5	6	7	8	9	10

What year were you born? ___________

Did you experience any confusion at any time during the study, or have any difficulty with any part of the study? If yes, how so?

Do you have any other comments you would like to share with the researchers?