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Trials and Triumphs of Caregiving: Insights across Diverse Family Caregiver Archetypes

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Executive Summary

While caregiving is undeniably challenging, it is important to recognise its benefits for caregivers, which are largely psychological in nature. This brief presents a comprehensive analysis of caregivers' experiences across four distinct caregiver archetypes that vary in the relative extents of the burden and benefits of caregiving: **Satisfied** (Low Burden, Highest Benefits), **Balanced** (Least Burden, Moderately High Benefits), **Intensive** (Highest Burden, High Benefits), and **Dissatisfied** (Moderate Burden, Least Benefits). The findings are from a longitudinal qualitative study, "Qualitative Insights into Caregiving Transitions", or the *Quali-T Study*, completed in March 2024. The *Quali-T Study* involved 39 caregivers (9-10 caregivers from each archetype) who participated in in-depth interviews twice, at a 12-month interval. Caregivers in the Quali-T Study were purposively sampled across the four caregiver archetypes observed from a larger study – the Caregiving Transitions Among Family Caregivers of Elderly Singaporeans (TraCE) study, which tracked caregiver-care recipient dyads to examine how caregiving experiences evolve over time. The interviews conducted in the Quali-T Study captured caregiving-related motivations, outcomes, challenges, and coping strategies of caregivers across the four caregiver archetypes as they navigated their roles.

Key Findings

The *Quali-T Study* provides important insights that describe how caregivers across the four archetypes manage their caregiving roles. Although all caregivers faced significant stressors, their ability to cope varied with available resources, support networks, and personal capacities. Key differences across the archetypes were observed in terms of caregivers' motivations, goals and resources, which in turn, influenced individual caregivers' perceptions and experiences of caregiving's burdens and benefits.

1. **Satisfied** and **Balanced** caregivers were more effective in managing stressors and observed to engage in positive coping strategies, bolstered by supportive and strong family networks, financial stability, and opportunities for personal or spiritual growth.

2. Experiences of financial strain, family conflict, and physical, emotional and mental fatigue were more pronounced among **Intensive** and **Dissatisfied** caregivers. These caregivers struggled with managing higher levels of stress, experienced social isolation and emotional strain due to limited support, information and financial resources, and resorted to maladaptive coping strategies that intensified caregiver burnout.

3. Positive perceptions of caregiving may provide caregivers with a psychological buffer against caregiving burden. The themes generated on the benefits of caregiving focus on caregivers' esteem, self-affirmation and outlook on life. References to feeling fulfilled and achieving personal growth, sense of competence and strengthened relationships were more common amongst **Satisfied** and **Balanced** caregivers. **Intensive** and **Dissatisfied** caregivers expressed feeling accomplished in fulfilling their caregiving responsibilities. The inclination towards spiritual growth as a reward for fulfilling caregiving duties was most prevalent among **Intensive** caregivers. On the other hand, a sense of helplessness and pessimism towards caregiving was more dominant among **Dissatisfied** caregivers, who struggled with finding positive meaning in caregiving.

4. In terms of coping strategies, **Intensive** and **Dissatisfied** caregivers described their situation as past "breaking point" – a point in which perceived caregiving burden outweighs its benefits, making it difficult for them to cope with caregiving. Meanwhile, **Satisfied** and **Balanced** caregivers' coping strategies, support networks and resources cushioned them from reaching breaking point. The need for caregiver respite was echoed across all archetypes.

Key Recommendations

Development of more proactive caregiver support, tailored to diverse caregiving contexts, is key to amplifying the benefits of caregiving and delaying or preventing caregiver burnout.

Dyadic Model of Care Delivery
- Implement care plans that manage the caregiver and care recipient as a dyad.
- Customise care plans based on available resources and establish clear escalation pathways for timely support, especially for complex cases (such as care recipients with dementia).

Empowering Caregivers Through Training and Support Networks
- Case managers and eldercare staff to develop caregivers' resilience by co-creating care plans and providing referrals to social networks (e.g., support groups) and professional networks (including counsellors specialising in caregiver stress and family dynamics, occupational therapists to improve caregiving techniques, and financial advisors to navigate caregiving costs).
- Leverage on existing health coaching programmes and workshops that offer personalised wellness plans and strategies to manage caregiver health and prevent burnout.

Service Models Focused on Caregivers' Needs

- Develop guidelines which prioritise caregiver support, especially during the discharge planning process, when care recipients transition from care facilities to home.
- Assess caregivers' physical, emotional, and financial ability to manage responsibilities and tailor support plans to align with specific needs and limitations.
- Develop centralised, user-friendly resources that consolidate caregiving information, including financial aid, legal advice, and service access.
- Implement systems that automatically connect caregivers with relevant services and proactive follow ups after discharge to ensure ongoing support.

Flexible Work Arrangements (FWA) to Support Working Caregivers

- Encourage companies to utilise the Ministry of Manpower's FWA policy to include accommodations for caregivers' work arrangements, such as telecommuting or flexible work hours.

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1   Introduction

1.1   Importance of understanding both burden and benefits of caregiving

In Singapore, family caregivers play a vital role in eldercare due to the cultural significance of filial piety and the societal expectations and policies that promote caring for older adults at home.[1-2] Not only do family caregivers provide direct care to older adults at home, they also supervise migrant domestic workers (MDWs) in providing eldercare, as well as playing a major decision-making role in the older adult's healthcare and long-term care (LTC) service utilisation.[3] Despite its central importance in eldercare and ageing-in-place policies, family caregiving carries the notion of only being burdensome or stressful for the caregiver, which further reinforces negative perceptions of caregiving.[4] Self-stigma, which refers to the shame and guilt internalised by individuals caring for loved ones with complex illness (e.g., dementia), may result in increased feelings of being burdened, and a lower quality of life for caregivers.[5,6,7]

While caregiving is undeniably challenging, it is also important to recognise the benefits of caregiving for caregivers. Research has demonstrated growing evidence indicating the psychological benefits of caregiving in terms of caregivers' satisfaction, meaning, self-esteem and wellbeing.[8] **Thus, a better understanding of both the burden and benefits of caregiving is needed to present a more nuanced picture of family caregiving that will inform the development of appropriate interventions, while also contributing to public discussions and policies that offer greater support to family caregivers.**

1.2   Importance of longitudinal data on family caregiving

Caregiving is not a static experience; rather, it is highly dynamic. Family caregivers' situations often change significantly over time, including variations in the type and extent of assistance they provide to older care recipients,[9] the kinds of support services they access for themselves,[10] the size and quality of their social support network,[11] and their health, work, and caregiving outcomes.[12-15] In addition, the care recipient's health status can also shift, sometimes rapidly.[16] **These evolving needs highlight the importance of studying family caregiving longitudinally, over time, as opposed to cross-sectionally, at a single time-point. A longitudinal approach offers an in-depth understanding of the ongoing and evolving challenges that caregivers encounter and the various adjustments they must make in order to adapt over time.**

1.3   Key research gaps in the context of family caregivers of older Singaporeans

An extensive review of research studies on family caregiving in Singapore identifies key research gaps.[17] First, most studies place more emphasis on negative caregiving outcomes,[1,18] such as burden, stress and depression, with less focus on positive outcomes, such as meaning, outlook on life, self-affirmation, and caregiver esteem. As a result, research and practice that considers both positive and negative aspects of caregiving to optimise caregiving interventions has been gaining traction.[19] Second, most studies are cross-sectional, pertaining to a single point in time, thus unable to provide information on the evolving experiences of family caregivers throughout their caregiving journey.[20-22] Third, the studies tend to be disease-focused (e.g., dementia or stroke)[23-25] and may not capture broader contextual experiences of caring for older adults who need care due to physical frailty or

age-related declines in health. Finally, most studies utilise quantitative methods, which are useful in identifying risk or protective factors associated with caregiving outcomes but are limited in providing nuanced explanations of mechanisms that underpin diverse caregiving experiences. This understanding is crucial for developing interventions that may reduce the burden and promote the benefits of caregiving. Nevertheless, this gap can be addressed through qualitative research, which provides a deeper exploration of the lived experiences of caregivers. **The need for systematic, longitudinal data that examines both the burden and benefits of caregiving is critical. Such data, used as part of a mixed methods approach, would provide a more comprehensive view of the caregiving experience in Singapore, especially in informing policy and programme development.**

1.4 The TraCE Study

Between 2019 to 2023, the Centre for Ageing Research and Education conducted a longitudinal study – *Caregiving Transitions Among Family Caregivers of Elderly Singaporeans* (TraCE) (PI: Assoc. Prof. Rahul Malhotra)[26]. The TraCE study surveyed 278 caregiver-care recipient dyads up to four times, at 6- to 12-month intervals, to track changes in their health, work, and caregiving-related outcomes, including the burden and benefits of caregiving. Care recipients in the TraCE study were Singapore citizens or permanent residents aged 75 years and above, who were receiving human assistance for one or more activities of daily living (ADLs) or instrumental ADLs (IADLs) due to their physical or health condition(s). Caregivers in the TraCE study were family members of the care recipient who were most involved in at least two of the following activities for the care recipient: (a) providing direct care, (b) ensuring provision of care, and (c) making health or social care decisions.

Latent class analysis was conducted on data collected on the burden and benefits of caregiving in the baseline interview of the TraCE study of the caregivers (see *Appendix* for the scales used). The analysis identified four distinct caregiver archetypes that varied in the relative extent of their burden and benefits[27]:

Satisfied (Low Burden, Highest Benefits)	Balanced (Least Burden, Moderately High Benefits)
Intensive (Highest Burden, High Benefits)	**Dissatisfied** (Moderate Burden, Least Benefits)

These identified caregiver archetypes formed the basis for further research in a longitudinal qualitative study titled "Qualitative Insights into Caregiving Transitions", or the *Quali-T Study*. The Quali-T study explored caregiver profiles and their lived experiences across the four archetypes in more depth. In doing so, it complements the TraCE study by facilitating a nuanced understanding of the differences and commonalities across the four caregiver archetypes.

1.5 Aims

First, this research brief provides an overview of the profiles of caregivers across the four archetypes – Satisfied, Balanced, Intensive and Dissatisfied. *Second*, it describes the diverse contexts that shape caregiving motivations, goals and approaches across the four caregiver archetypes. *Third*, it outlines various caregiving stressors and discusses the multifaceted nature of caregiving burden. *Fourth,* it elaborates upon how the archetypes manage their caregiving demands and the factors that influence their coping strategies. *Fifth*, it highlights key differences across the archetypes, focusing on the extent of caregiving burdens and benefits, and their implications towards caregiver interventions and support. *Finally*, the brief discusses caregivers' needs, bringing to attention existing gaps in the eldercare sector. Drawing upon the key lessons gleaned from this study, the brief offers key recommendations to support family caregivers in their caregiving journey.

2   The *Quali-T* Study: Methods

The Quali-T study employed a longitudinal, qualitative research design with purposive sampling to recruit 40 caregivers from the TraCE study who (i) had consented to participate in follow-up research, (ii) were able to respond to interviews independently without requiring assistance, (iii) were willing to participate in two interviews, approximately 12 months apart, and (iv) agreed for the interviews to be audio-recorded. Caregivers in the Quali-T study were engaged in direct care, supervising other caregivers (e.g., MDWs), or involved in care-related decisions for their care recipients who required human assistance with at least one ADL. The research team recruited 10 caregivers from each of the four archetypes (i.e., Satisfied, Balanced, Intensive, Dissatisfied) while also ensuring sample diversity in terms of gender, ethnicity, and relation to care recipients (e.g., daughter–father; wife–husband). The Quali-T study was conducted with approval from the Institutional Review Board (IRB) at the National University of Singapore (NUS) (NUS-IRB Reference No: NUS-IRB-2021-566). Written informed consent was obtained from all study participants.

At study completion, 39 of the 40 caregivers had participated in both in-depth interviews – baseline (wave 1) and 12-months post-baseline (wave 2). One caregiver withdrew from the study at wave 2. The findings presented in this research are based on cross-sectional data of 40 caregivers (wave 1) and longitudinal data of 39 caregivers (waves 1 and 2).

The in-depth interviews were conducted in caregivers' preferred language and setting, and were audio-recorded, transcribed and translated (for non-English language interviews) verbatim. The data was uploaded to NVivo 12 software. The research team then manually coded the data to identify preliminary themes and develop an initial codebook that was further refined through reiterative coding of the data set. Main themes were developed through discussions and deliberations of patterns and relationships observed in the coding process, with internal validation ensured through member checking and triangulation with quantitative data where possible.

3   Profiles of Caregivers according to Caregiver Archetypes

In this section, we provide a brief description of profiles of caregivers by the four caregiver archetypes: **Satisfied, Balanced, Intensive and Dissatisfied (Table 1).**

Table 1. Profile of Caregivers according to Caregiver Archetypes

	Satisfied (n=10)	Balanced (n=10)	Intensive (n=10)	Dissatisfied (n=10)
	Number of caregivers			
Age (in years)				
39-60	2	4	3	4
61-80	7	6	5	5
81+	1	-	2	1
Sex				
Female	7	10	8	6
Male	3	-	2	4
Ethnicity				
Chinese	6	8	9	7
Malay	3	1	1	2
Indian	1	-	-	1
Others	-	1	-	-
Employment Status				
Working full-time	3	4	2	3
Working part-time	2	2	2	1
Retired and/or not working	5	4	5	6
Never worked	-	-	1	-
Perceived Income Adequacy				
More than adequate	1	1	-	1
Adequate	5	6	3	8
Occasionally adequate	3	2	4	1
Usually inadequate	1	1	3	-
Relation to Care Recipient				
Child/Child-in-law	9	9	7	8
Spouse	1	-	3	2
Niece	-	1	-	-
Duration of Caregiving				
Less than or equal to 5 years	-	3	-	5
More than 5 to 10 years	4	4	6	2
More than 10 years	6	3	4	3
	Average Hours of Caregiving per Week			
For activities of daily living	16.6	19.2	49.9	18.6
For instrumental activities of daily living	13.5	14.2	46.1	9.85

3.1   Satisfied Caregivers (Low Burden, Highest Benefits)

Satisfied caregivers were predominantly women aged 61 to 80 years, and most were caring for their parent. Slightly more than half of them had been caring for their care recipient for more than 10 years, and half of them were working either full-time or part-time. A majority perceived their income to be adequate. They spent an average of 16.6 hours per week on ADL-related care and 13.5 hours per week on IADL-related care for their care recipient.

3.2   Balanced Caregivers (Least Burden, Moderately High Benefits)

Balanced caregivers were exclusively women, and most were Chinese, between the ages of 61 to 80 years, and caring for their parent. The duration of years in caregiving in this group was most diverse, compared to other archetypes, with the highest proportion having provided care to their recipient for more than 5 to 10 years. Most were either working full-time or retired and perceived their income as adequate. They spent an average of 19.2 hours per week on ADL-related care and 14.2 hours per week on IADL-related care.

3.3   Intensive Caregivers (Highest Burden, High Benefits)

Intensive caregivers were mostly Chinese, women, diverse in terms of age, and had cared for their parent or spouse for more than 5 to 10 years. While not shown in the table, this archetype had the highest proportion of individuals with more than 15 years of caregiving duration (40%). Slightly more than half of them were retired, not working or had never worked. Compared to caregivers from other archetypes, a higher proportion of caregivers in this archetype perceived their income to be occasionally adequate and usually inadequate. They spent an average of 49.9 hours per week on ADL-related care and 46.1 hours per week on IADL-related care – the highest for ADL- and IADL-related care across all archetypes.

3.4   Dissatisfied Caregivers (Moderate Burden, Least Benefits)

Dissatisfied caregivers were mostly Chinese, between the ages of 61 to 80 years. This archetype included more men, as well as had the highest proportion of caregivers providing care for less than 5 years, as compared to other archetypes. They were mostly Chinese, between the ages of 61 to 80 years. Slightly more than half were retired or not working and perceived their income as adequate. They spent an average of 18.6 hours per week on ADL-related care but 9.9 hours per week on IADL-related care – the lowest among the archetypes.

4   Caregiving Contexts according to Caregiver Archetypes

Table 2 provides a summary of the diverse caregiving contexts that shaped the different approaches to caregiving across the four archetypes. Generally, all caregivers expressed feeling unprepared to take up the role even when they were aware that needing to care for their family member was inevitable. The next sub-sections will elaborate on caregiving motivations, care approach and goals, and accessibility and availability of family support.

Table 2. Summary of Caregiving Contexts across Caregiver Archetypes

Caregiver Archetypes	Caregiving Motivations	Caregiving Goals	Family Support
Satisfied (Low Burden, Highest Benefits)	More pragmatic– best option for caregiving + reciprocate care, role was anticipated	Proactive and intentional about managing care plans; focus on engagement and quality of life	Strong and reliable family support
Balanced (Least Burden, Moderately High Benefits)	Initially unprepared but adapted and found purpose through experience	Initially ambivalent; became more proactive with experience; focus on engagement and quality of life. Prioritize self-care	Strong and reliable family support
Intensive (Highest Burden, High Benefits)	Unexpected entry; compelled into the role due to lack of care options, moral obligation	Acceptance of end-of-life; focus on care recipients' survival and comfort; day-to-day logistics	Limited support; often feel abandoned and isolated; no other option for care
Dissatisfied (Moderate Burden, Least Benefits)	Unexpected entry, pressured by family, religious duty, not by personal choice	Fulfil basic needs for care recipient's survival, day-to-day logistics	Lack of family support, perceive family to be capable but withholding support; feel abandoned

Caregiving Motivations: Self-fulfilment or Family and Social Obligation?

Caregiving motivations – what drives caregivers into a caregiving role, and drives them to continue providing care, varied significantly across the archetypes. **Satisfied** caregivers were driven by more pragmatic objectives – that they were the best option to address their family's care needs and could leverage on family support. **Balanced** caregivers were more motivated by their own personal growth in terms of how they adapted to their caregiving role and the increased competence and confidence in their caregiving abilities over time. During the caregiving journey, **Satisfied** and **Balanced** caregivers continued to be motivated by a sense of life purpose and fulfilment of their personal or cultural values.

In contrast, a lack of viable care options meant that care responsibilities fell disproportionately on **Intensive** and **Dissatisfied** caregivers. **Intensive** caregivers were driven more by social and familial obligation, and usually in the context of distressing circumstances such as an unexpected health crisis or sharp decline in the care recipient's health. **Dissatisfied** caregivers were pressured by other family members to become caregivers and conform to familial or religious expectations, or both, often against their personal wishes. During the caregiving journey, **Intensive** and **Dissatisfied** caregivers continue to be motivated by their sense of responsibility towards their care recipient and the desire to be valued and appreciated for their caregiving efforts.

Care Approach and Goals: Engagement, Comfort and Survival

Caregiving motivations influence participants' care goals, which also differ across the archetypes. **Satisfied** and **Balanced** caregivers tended to be more proactive in managing care and had a positive outlook towards caregiving while being focused on ensuring a high quality of life for their care recipients. **Balanced** caregivers were initially ambivalent about managing care but became more proactive with care plans or care goals through experience. Both these archetypes prioritised keeping their care recipient engaged and happy by deepening their emotional and physical connection with them. To them, caregiving was a form of reciprocal care, to "give back" to their care recipient having nurtured and provided for them in the past.

In contrast, **Intensive** and **Dissatisfied** caregivers had a more reactive approach to care provision, usually in response to a health crisis or emergency, rather than anticipating and preparing for potential crises. Almost half of the **Intensive** caregivers had been providing care for longer than 15 years, compared to caregivers in the other archetypes. Due to prolonged high care demands, they were more likely to express acceptance towards the end-of-life of their care recipients. Their care goals focused on the acceptance of prioritising care recipients' comfort, minimising suffering and maintaining dignity at the end-of-life. They tended to prioritise care recipients' needs over their own self-care, were often stretched to their limits performing daily care and did not have adequate bandwidth to develop care plans or discuss care goals. Similarly, due to limited bandwidth, **Dissatisfied** caregivers focused on fulfilling basic care needs (e.g., physical and functional) for their care recipient's survival. They were less inclined to develop specific care plans to engage with or improve the care recipient's emotional wellbeing. Care goals were primarily about meeting day-to-day logistical needs as they were faced with limited resources, emotional capacity, or support systems with little to no alternative care options.

Family Support

The access to family and social support for caregivers varied across the archetypes. **Satisfied** and **Balanced** caregivers were able to manage the demands of caregiving more effectively as they had a supportive family network and adequate care support. The bulk of caregiving hours was spent supervising and managing the care load with the assistance of other family caregivers or MDWs, rather than providing direct care to the care recipient.

In comparison, **Intensive** caregivers had limited to no family and social support and felt isolated in their role, which was further emphasised by a prolonged caregiving tenure. The lack of other viable care options in this archetype makes caregiving more challenging. Similarly, **Dissatisfied** caregivers frequently mentioned being abandoned by their families, whom they perceived as capable and yet withholding support.

5   Challenges in Caregiving and Coping Strategies

5.1   Common Caregiving Stressors

We take the definition of caregiving stressors as the state of mental and emotional strain or tension resulting from the demands of the caregiving role.[28] In this section, we elaborate upon the five main stressors faced by the caregivers in the study.

Adapting to the Caregiving Role

Caregiving was especially challenging for caregivers who had a limited understanding of their care recipients' health conditions and care trajectories, including what to do during a health crisis or emergency. While this difficulty was common across all archetypes, poor health literacy and informational support among **Intensive** and **Dissatisfied** caregivers further amplified their sense of helplessness.

The physical and emotional demands of caregiving, intensified with the lack of respite, may encroach upon caregivers' personal space and time, requiring sacrifice or compromising of one's own needs. Caregivers across all archetypes juggled multiple additional responsibilities such as managing work responsibilities and caring for younger children or grandchildren, while tending to their care recipient. For **Dissatisfied** caregivers, the constant balancing act became overwhelming and left them with little room to breathe or recharge.

In addition to these pressures, some caregivers (in the **Intensive** and **Dissatisfied** archetypes) often felt invisible – the emotional labour they invested into providing care (i.e., comforting, worrying about and supporting their care recipient) was rarely acknowledged. Meanwhile, **Satisfied** and **Balanced** caregivers struggled with anticipatory grief – a fear of the loss of their care recipient, with whom they shared a strong bond.

Hiring and Managing MDWs

A significant number of caregivers across archetypes relied on migrant domestic workers (MDWs) to assist with caregiving. However, the process of hiring and retaining a reliable MDW was a major stressor. Caregivers often felt they were gambling time, energy and finances to find the right person, all while managing the day-to-day demands of caregiving themselves. Building rapport between the MDW and the care recipient took time, especially with cultural differences and language barriers. Caregivers also expressed difficulties trusting that a 'stranger' would be able to understand and respect their care recipients' needs. Among **Intensive** caregivers, anxiety over the MDW being verbally abused or mistreated by care recipients was more palpable.

Communication and Relationships with the Care Recipient and Family Members

Many caregivers struggled with communication, especially when the care recipients' health deteriorated. Interactions become more difficult, due to fatigue, cognitive decline, or limited verbal abilities. Being unappreciated and unvalued by their care recipient and family members were also common stressors among all caregivers. **Intensive** caregivers were more likely to describe pre-existing tensions that made communication with their care recipient difficult, while **Dissatisfied** caregivers tended to describe care recipients' favouritism towards other siblings as a source of conflict.

Family dynamics around care decision-making processes added to caregivers' emotional burden. **Dissatisfied** caregivers often felt unsupported with siblings who were critical but withheld help. **Balanced** and **Dissatisfied** caregivers acknowledged that their family members were sometimes ill-equipped to provide care, leaving the bulk of the caregiving responsibility to them. Finally, **Intensive** and **Dissatisfied** caregivers struggled with coordinating care decisions with other family members and often felt isolated in the caregiving process.

Managing Care Recipients' Behavioural Issues

Managing care recipients' behavioural issues was a huge stressor, particularly for caregivers caring for persons with dementia. Care recipients with higher care needs required constant attention and monitoring, leaving their caregivers feeling exhausted and isolated.

Caregivers described having to deal with emotional blackmail from care recipients who would make comments to elicit guilt (e.g., wanting care recipient to die) or engage in manipulative behaviours (e.g., turning siblings against each other) to garner attention.

Ensuring that the care recipients adhered to their care plans was a huge stressor for caregivers. When care recipients refused to cooperate (e.g., in public places, or medication adherence), caregivers had to come up with new, creative ways to maintain their safety and wellbeing lest they be accused of or judged for not competently caring for their care recipients.

Increasing Caregiving Needs

As the care recipients' health deteriorated, and their care needs increased, the physical and emotional toll of being the sole caregiver became overwhelming – owing also to the anxiety of not having an alternative caregiver in the event of an emergency. **Intensive** caregivers described feeling trapped and helpless as their responsibilities escalated, while receiving little to no support from their family members.

As care needs increased, some caregivers neglected their own wellbeing by prioritising the care recipient's needs above their own. The idea of taking time for themselves felt selfish or became an impossible task. Over time, the self-neglect left such caregivers (i.e., mostly **Intensive** caregivers) physically and emotionally depleted.

5.2   Positive Coping Strategies: Satisfied and Balanced Caregivers

Caregiver burden is a multifaceted concept which refers to "the extent to which caregivers perceive that caregiving has had an adverse effect on their emotional, social, financial, physical and spiritual functioning"[29]. Caregiving burden is highly subjective, as caregivers may respond differently to adverse situations and have different stress coping strategies even if experiencing similar stressors (as explained in **5.1**).

In overcoming caregiving challenges, caregivers in the **Satisfied** and **Balanced** archetypes were more adept at engaging in positive coping strategies. Their first response to stress was to actively seek support and assistance to preserve their wellbeing, rather than internalise responsibility and compromise self-care. In addition, they had access to financial resources, as well as emotional and informational support, which enhanced their capacity to cope with an increasing care load over time, including procuring necessary care services or outsourcing caregiving tasks when needed. Their financial stability reduced the stress associated with caregiving.

A 49-year-old male **Satisfied** caregiver shared how he ensures adequate financial resources by allocating incoming funds according to his 86-year-old mother's caregiving needs:

"There's financial contribution from two other siblings. You know, Pioneer Generation, sometimes give $200 once a year, maybe they give like quarterly. So, it will be kept in this joint account, add up like got a few thousands. I use this money to pay for the care, the caregiver, the part time caregiving service, so got the funds."

In terms of social support, these caregivers were also bolstered by strong and reliable familial and social networks. Proactive support from family and friends not only alleviated the physical aspects of caregiving, but also provided emotional strength and validation, amplifying the caregiver's sense of purpose and fulfilment.

A 58-year-old female **Balanced** caregiver, caring for her 93-year-old father, highlighted how having social connections reinforced her positive outlook on life:

"It's a good thing that I have friends. You know, so now that father is out [at day care] for 6 hours, I try to go out with friends at least on a weekly basis. That will get rid of a lot of stress because we talk about pleasant things and do a lot of good things."

Additionally, these caregivers were also resourceful and competent at gathering information, communicating with healthcare professionals, and working on a care plan with and for their care recipients. Overall, they were able to reframe caregiving as a meaningful and fulfilling experience, where they were able to utilise their problem-solving skills, proactively seek social support when needed, all of which allowed them to thrive in their caregiving roles.

A 38-year-old female **Balanced** caregiver shared how she was initially clueless about caring for her 89-year-old aunt with dementia until she sought out professional advice and started to educate herself and other family members on her aunt's condition:

"Because we don't know how to handle [dementia], we have no knowledge, we don't know why she behaves this way. I went to a counsellor, and the counsellor actually talked to me, they said that this is what will happen, and you have to prepare yourself, and so on. Then from there I started to go online to check, and started to realise that oh, there's a lot of things that will be happening. So, I actually printed out and showed my siblings. From there, we read up and understood what happened. Then we started to accept it."

5.3 Prolonged Burnout and Maladaptive Coping Strategies: Intensive and Dissatisfied Caregivers

Caregivers in the **Intensive** and **Dissatisfied** archetypes, on the other hand, often struggled with prolonged burnout. They adopted maladaptive coping strategies as a response to limited resources and support throughout their long-term caregiving journey. These caregivers experienced financial strain, had to rely heavily on subsidies, and were forced to make difficult care decisions, such as cutting back on treatment, to save costs. This financial strain exacerbated their caregiving stress and affected their wellbeing.

A 55-year-old female **Dissatisfied** caregiver lamented how costly it was to follow through with her 83-year-old father's treatment plan:

"I asked them [the community-based service], they said that I have to pay for the transport to transport him there. Not cheap you know. If AIC [Agency for Integrated Care] can allow like unlimited therapist help, then I don't need to have trouble visiting this community service. I can't get help in the area. Community [services] is not [at] community rate."

In terms of social support, these caregivers felt isolated from friends and family members and received minimal to no assistance with caregiving tasks or emotional support. Without a reliable and supportive network, they struggled to cope with increasing caregiving demands.

At the same time, they were hesitant to seek help, feeling overwhelmed by the healthcare system and the various sources of information they had to navigate. Spirituality, for these caregivers, was often invoked to justify the hardships they had to endure and to signal their virtue in the process of providing care.

One such example was of a 77-year-old female **Intensive** caregiver, who described her hardship as a spiritual 'test' whenever she experienced stress in caring for her 84-year-old husband:

"There is nothing to be stressed about – I just don't think about it. If I happen to think about it, then I do. Otherwise, I don't. It is a test, and my fate. I just accept it. Who knows, one day I would be in a better position? That's all part of God's plan. But today, it is my test, so I accept it."

Further, escape-avoidance behaviours such as denial or distancing themselves from their caregiving responsibilities were common for these archetypes, alongside a general hesitance to seek help, further perpetuating their burnout and dissatisfaction. **Intensive** caregivers hesitated to seek help due to a strong sense of self-responsibility, though they eventually deferred to family members when the situation became necessary.

This strong sense of self-responsibility is underlined by a mistrust that, while there are family members they can speak to, these individuals will also not be able to assist with caregiving decisions. An 85-year-old female **Intensive** caregiver who cared for her 91-year-old husband shared:

"I lack someone whom I can discuss things with. I have to make a decision on my own. Be it right or wrong, I will have to make the decision myself. If I make a wrong decision, I will be scolded for it. I told my sister that I am feeling really lonely. No one I can discuss with."

Burnout was evident in a 64-year-old female **Intensive** caregiver who would rather be uninformed about her 92-year-old mother's condition than submit her to 'unnecessary' interventions and treatments that may prolong her mother's life:

"I don't know whether she needs to go for her medical check-ups or not, at that age. It's safer to live at home as it is, have an unknowing if you have any condition, you know? Because once you go to the doctor, they find something, they will want to prick you, take blood, of course, the treatment. And is that necessary at this kind of age?"

Dissatisfied caregivers tended to avoid seeking help altogether, feeling reluctant to turn to either family members or formal care agencies. This further intensified their feelings of being burdened and isolation in their caregiving role.

There were also instances where the caregiver limited the mobility of their care recipients to prevent additional caregiving duties which would require constant attention. A 55-year-old female **Dissatisfied** caregiver embodied this practice with her 83-year-old father:

"I made that decision at that time to put him in bed forever, in the sense that he doesn't get up to even shower, just sponge. Because every time he comes down [from the bed], he faints. Then I got to send him to the hospital. What is the point? I go through all this trouble for that, just to let him come out of the bed. I also got things to do right, even if I don't work. So, I mean some decisions are for my selfish intention."

5.4   Changes in Caregiving Experiences over Time and Adapting to New Stressors

Over the year between waves 1 and 2 of the Quali-T study, caregivers who perceived an improvement in their caregiving experience attributed it to:

- More initiative and support from family members and better family communication including conflict resolution
- Stability in care recipients' health conditions and increased competence or experience in handling care recipients' complex care
- Reliability and competence of outsourced help (e.g., MDWs) and access to respite care (e.g., formal services or alternative family caregivers)

On the other hand, factors such as unresolved family conflicts, rapid deterioration of care recipients' health leading to increased care dependence, caregivers' poor health, or work-related stress contributed to no change or a worsened caregiving experience.

We found that, in a span of a year, caregivers from the **Balanced** and **Satisfied** archetypes were better equipped to cope and adapt to new stressors (e.g., change in health conditions, work demands) by leveraging on their existing resources (e.g., financial, family support and informational resources) or seeking support to cope with newfound challenges (e.g., flexible work arrangements, home care, putting family members to task).

In contrast, the majority of caregivers from the **Intensive** and **Dissatisfied** archetypes struggled to cope with additional caregiving demands or new stressors unless there was a drastic change in the physical aspects of caregiving (e.g., admission of care recipient into a nursing home, presence of a reliable MDW, family members stepping in readily to assist), increased financial support through subsidies or family allowance and/or reconciliation, and increased emotional support and validation from other family members (e.g., mediation of family conflicts, conflict repair).

5.5 Experiencing Caregiving Benefits Despite Burden

We focused on caregivers' coping strategies because the capacity for coping with caregiving challenges amplifies the perceived benefits of caregiving, which then offers a buffer or protective mechanism against the caregiving burden. Caregiving benefits were described mainly in terms of caregivers' outlook on life, self-affirmation and caregiver esteem, which correspond to the constructs in scales used for assessing the benefits of caregiving in the TraCE study (i.e., short-Positive Aspects of Caregiving Scale[30] and esteem domain of the modified Caregiver Reaction Assessment[31]; see *Appendix*).

In terms of perceived benefits, **Satisfied** caregivers derived satisfaction from their involvement in caregiving, feeling fulfilled by the ability to help a loved one, the strengthening of familial bonds and their personal growth throughout their journey. **Balanced** caregivers benefited from the problem-solving skills they developed over time, whereupon caregiving became an opportunity to practice self-care and demonstrate generativity, passing on their knowledge and experiences to younger family members.

Intensive caregivers drew personal validation through a reliance on spiritual or moral frameworks that affirmed and provided meaning for stressful experiences, which enhanced their self-esteem and helped them cope with burden. Compared to the other archetypes, **Dissatisfied** caregivers struggled with low self-esteem and feeling underappreciated or unrecognised for their efforts. They expressed helplessness and pessimism even while they felt accomplished in fulfilling their care responsibilities.

Despite its perceived burdens, many caregivers were able to find fulfilment in their caregiving role, which was often strengthened by various factors. For example, caregivers who experienced a sense of accomplishment and competence felt more fulfilled in their roles. Support and affirmation from family members, care recipients, and healthcare professionals provided emotional reinforcement, which made the caregiving journey feel less isolated. In addition, the ability to navigate and manage complex caregiving situations, such as medical crises, behavioural issues, or family conflicts, expanded a caregiver's locus of control and personal mastery. Caregivers found meaning in a caring role that transcended the basic duty of care, which extended to personal or even spiritual growth, especially when experiencing tangible outcomes such as improved family relationships or the maintenance of the care recipient's health.

5.6 "Breaking Point": When Burden Outweighs Benefit

One of the common threads across all caregiver archetypes was the notion of a "breaking point," which is when the burden of caregiving outweighs its benefits, making it difficult for caregivers to cope with caregiving. Caregivers may reach this point when they lose reliable support or experience a decline in their capacity to provide care, such as through deteriorating physical health, or having exhausted their emotional and physical capacities due to an absence of respite. Other factors contributing to the breaking point include financial strain, an inability to manage the care recipient's behavioural issues, and a reluctance to seek help.

Caregivers in the **Intensive** and **Dissatisfied** archetypes were more likely to report being at or beyond their breaking point, as the limits on their resources and support systems exacerbated their caregiving challenges.

5.7 Implications for Policy and Practice: Holistic, Timely and Tailored Interventions

Our findings underscore the need for holistic and targeted interventions that cater to diverse caregiver dispositions, family dynamics and lived caregiving experiences. Addressing relational and resource-based gaps is essential to reduce the stress associated with caregiving and improving the overall wellbeing of caregivers across all archetypes. Interventions cannot focus solely on one component such as improving mental health, without considering how stress in other areas, like inadequate family support or rigid workplace policies, also affects caregivers. Effective intervention strategies must acknowledge how different types of stressors intertwine, so that more comprehensive and sustainable solutions can be developed to mitigate caregiver burnout.

For caregiving to be rewarding, positive aspects of caregiving must be amplified to compensate for the inevitable stressors it brings. One of the ways to do so is to identify potential "breaking points" for caregivers (i.e., burden > benefits) and provide proactive support to caregivers before they reach their breaking point, rather than when they reach it.

Caregivers in the **Intensive** and **Dissatisfied** archetypes were more prone to engaging in maladaptive coping strategies, which exacerbated their challenges. Thus, the timely identification of potential breaking points and delivery of earlier and appropriate interventions are crucial. Interventions must focus on providing appropriate support, resources, and relief to help caregivers manage responsibilities more effectively while mitigating the risk of burnout. By understanding the nuanced experiences of caregivers across the archetypes, tailored support systems can be developed to improve the overall wellbeing of both caregivers and care recipients.

6   Empowering and Supporting Caregivers: Key Gaps in Eldercare

Access to respite care, reliable alternative care and therapeutic support were major concerns for caregivers across the four archetypes. In this section, we elaborate on the importance of providing caregivers with reliable and competent alternate or complementary carers and service personnel to support their wellbeing.

6.1   Respite Care

Respite is crucial to provide temporary relief to caregivers from day-to-day caregiving responsibilities, so they can return to their roles well-rested and rejuvenated. Caregivers raised concerns with regards to existing options for respite care in Singapore, pertaining to limited availability and options, a limited ability to accommodate emergency and urgent requests, and affordability.

This section lists the different types of respite care along with limitations as highlighted by the caregivers.

- **Day Care Services**
  - Day care services, such as dementia care centres, provide temporary relief for caregivers during the day, allowing care recipients to engage in structured activities while caregivers attend to their own personal needs.
  - These services are valuable for caregivers seeking short-term breaks, but they are often unavailable during weekends and public holidays, limiting their overall utility for caregivers who need more consistent support.

- **Nursing Home Respite**
  - For caregivers needing a longer break, nursing homes offer respite care that typically lasts between seven and thirty days. This option is particularly useful for caregivers who need an extended period away from caregiving duties, such as for vacations or personal health recovery.
  - However, this solution depends on the care recipient's willingness to transition into a temporary setting, which may pose challenges if the care recipient is resistant to such changes.

- **Night Respite Services**
  - Night respite services are designed to assist caregivers dealing with challenging behaviours, such as sundowning, which is common in individuals with dementia. These services provide temporary relief during the night, allowing caregivers to rest.
  - At the time our study concluded, night respite was available at only three locations (i.e., Vanguard Woodlands, Peacehaven Nursing Home @ Upper Changi, St Joseph's Home @ Jurong West), making accessibility a concern for many caregivers. Additionally, transport to and from these locations had to be arranged, adding another layer of complexity to an already limited service.
  - During caregiver interviews, night respite was not mentioned, even though some expressed challenges with managing care needs during the night. This suggests a possible lack of awareness or accessibility of night respite services at the time.
  - As of 1 December 2024, the Agency for Integrated Care (AIC) and associated service providers have ceased accepting new applications for night respite services. This recommendation should remain in place if and when the service is reinstated in Singapore.
  - Private providers such as Homage continue to offer night respite services, which can be requested through their mobile app, offering an alternative for caregivers seeking overnight support.

- **Home-based Respite Care**
  - Home-based respite care is the option which most caregivers prefer as it allows for their care recipients to remain in the comfort and familiarity of their own home, especially when an emergency arises.
  - However, this service is currently limited to palliative patients, with restrictions on the use of services. Each home palliative care patient may use up to 30 single shifts of home-based respite care or up to 14 consecutive days of shifts in the patients' lifetime.
  - Due to the need for advance booking in addition to restrictions on service, home-based respite care is often not a viable option for caregivers in urgent or non-palliative situations.

Each of these respite care options may offer temporary relief to caregivers, but the logistical challenges necessitate careful planning. However, sudden changes in caregiving contexts make planning challenging. Improving respite care options to accommodate urgent respite due to emergency or sudden changes in caregiving arrangements will likely provide relief to caregivers with limited alternative care support.

6.2 Alternative Caregivers

Our findings suggest that caregivers who can provide care without compromising their personal needs and time were more likely to describe their caregiving journey as rewarding. For caregivers to attain a good balance between their care recipients' needs and their own self-care, they need to rely on 'alternative caregivers', such as family members, MDWs, or service providers. Having 'alternative caregivers' allows primary caregivers to take time away from their caregiving responsibilities, to attend to their personal needs, and maintain or enhance their wellbeing. However, merely having someone to fill in temporarily is not sufficient. Caregivers in our study highlighted key competencies that such 'alternative caregivers' must possess to provide adequate care:

- **Sourcing and Understanding Caregiving-related Information**
  - The ability to find and understand caregiving-related information is essential for any 'alternative caregiver'. They must be resourceful in navigating medical and care related instructions, especially when it comes to complex conditions like dementia. Confidence in administering medications is equally important, as caregivers need to understand dosage requirements, potential side effects, and any contraindications that may arise from a patient's health issues.

- **Communicating with Care Recipients**
  - Good communication skills are important to engage with care recipients and soothe them, especially when managing challenging behaviours related to dementia.
  - Good communication skills are also important during medical consults. Caregivers are usually tasked to be spokespersons advocating for the care needs of their care recipients. 'Alternative caregivers' should be able to raise concerns and discuss care goals or strategies and ensure the care recipient's medical needs are adequately addressed.

- **Physical Strength and Capacity to Provide Care**
  - Care recipients with mobility, personal hygiene, and toileting needs require 'alternative caregivers' who are physically able to assist them (e.g., lift and transfer).
  - 'Alternative caregivers' must be able to monitor vital signs and know when to detect issues and escalate care. Without these skills, the primary caregiver cannot fully entrust their responsibilities to them, making it difficult to obtain respite.

Our findings reiterate the importance of recognising support for caregivers in terms of an ecosystem – a combination of individuals and services, rather than a single individual or service. Based on the competences described by the study participants, it would be difficult to match the traits mentioned above to a single service or individual. Yet, there are still circumstances in which family caregivers are made to manage the different components of care on their own, with limited support. When caregiving competences are broken down into specific traits, it is clear how and why caregiver burnout becomes inevitable for such individuals (e.g., **Intensive** and **Dissatisfied** caregivers).

6.3   Reliable and Strong Family and Social Support Systems

Across waves 1 and 2, our findings demonstrated the importance of strong family and social support to amplify positive caregiving experiences.

- **Support and Encouragement to Seek Help**
    - o Caregivers may face difficulties reaching out to family members or confiding in them. This can stem from strained family dynamics or a lack of confidence in initiating conversations about their caregiving struggles.
    - o Empowering caregivers through confidence-building sessions with counsellors could provide a solution, helping them engage more effectively with their families.
    - o The success of this approach depends heavily on the willingness of family members to listen, value, and respect the caregiver's experiences. Without mutual understanding within the family, caregivers may continue to feel unsupported despite these efforts.

- **Conflict Resolution and Family Mediation**
    - o In cases where family members refuse to cooperate or provide support, mediation services may offer a way to resolve conflicts and encourage cooperation.
    - o Mediation can provide a structured environment where caregivers can raise concerns and set boundaries, facilitating a more equitable distribution of caregiving responsibilities.
    - o This approach requires both caregivers and family members to agree to participate, which can be a hurdle if there is resistance or denial of the need for shared responsibility.

- **Caregiver "SOS" Helpline**
    - o Currently, there are four dedicated helplines for caregivers (i.e., Agency for Integrated Care, Caregivers Alliance, ComCare, and Touch) which operate only during office hours. However, caregivers would greatly benefit from a helpline that is available beyond these hours, especially during urgent situations. This extended support could be offered through multiple platforms, such as telephone or online chat. In addition, to reduce stress and improve responsiveness, these helplines should be staffed by human operators who are trained to provide immediate assistance upon connection, rather than having caregivers transferred between multiple call points.
    - o Helplines can equip caregivers with information resources, coping strategies and emotional support, helping them maintain their wellbeing.
    - o There needs to be dedicated efforts to raise awareness for the helplines, as caregivers may be too overwhelmed with their caregiving tasks to even know that such helplines are available.

- **Caregiver Peer Support Groups and Platforms**
  - o The ability to find and understand caregiving-related information is essential for any 'alternative caregiver'. They must be resourceful in navigating medical and care related instructions, especially when it comes to complex conditions like dementia. Confidence in administering medications is equally important, as caregivers need to understand dosage requirements, potential side effects, and any contraindications that may arise
  - o Some caregivers mentioned needing a safe space to express difficult emotions and various caregiving dilemmas with other individuals or service providers, who can immediately identify with their challenges, provide useful advice and not judge their struggles.
  - o Caregivers acknowledged that their caregiving responsibilities made it challenging for them to have a social life. This, over time, may lead to social isolation. Becoming a member of peer support groups will provide caregivers with a break to socialise, while also being able to share with and learn from other caregivers.
  - o The effectiveness of these support groups depends largely on caregivers' willingness to come forward and share their stories with others, as support groups may be perceived as an additional burden or an intrusion of privacy (e.g., airing dirty laundry in public).
  - o Raising awareness about the benefits of group therapeutic support and encouraging families to participate in these initiatives can eliminate stigma and enhance emotional support for caregivers.

6.4 Accessible and Reliable Information

The need for informational support was consistent across both waves 1 and 2. Participants expressed their lack of confidence in making uninformed care decisions and were unsure about how and where to obtain relevant information. While there was awareness that information may be readily available online, caregivers cited fatigue and feeling overwhelmed to navigate various online resources to get the support needed. Some participants, especially those who were not literate in English, mentioned difficulty in searching for and understanding information available only in English.

Services such as home medical care, therapy, and nursing support may alleviate some caregiving burden, but difficulties encountered during the application process – especially involving online systems that may be complex or require digital skills – may pose additional burden for caregivers who are experiencing burnout. Moreover, the cost of such services, even with subsidies, can be prohibitive for some, adding to the strain. Social workers or case managers can play a vital role by guiding caregivers through available financial resources, such as subsidies and grants, and assisting with paperwork. At the same time, it is important to streamline paperwork processes to not impose the additional burden of preparing, submitting and renewing documents which can add to caregivers' stress.

7   Lessons Learnt and Key Recommendations

Caregiving stressors are the product of a complex interplay of individual, interpersonal and structural factors. For caregiving interventions to be effective, they need to be holistic and timely, tailored to the diversity of caregivers. Our findings have highlighted key intervention areas to amplify positive experiences and minimise the burden of caregiving. Interventions focused on family mediation, home care and respite, flexi-work arrangements, caregiver training support, counselling services, as well as health coaching for caregivers, are key to supporting family caregivers in the community.

We found that caregivers who were well-resourced and supported by the family and community services were better able to cope, adapt to new stressors and handle the risk of burnout more effectively. In contrast, new stressors intensified the caregiving burden of caregivers who were resource-deprived and lacked family and social support. Without active and timely intervention, caregivers in the **Intensive** and **Dissatisfied** archetypes continued to experience further burnout.

To alleviate caregiver burnout, our study reiterates the need for caregivers to be supported in terms of:

- Provision of reliable and competent carers and service personnel to complement or fill-in as alternate caregivers
- Assistance in family conflict mediation, relationship trauma, therapeutic or counselling services to manage stress
- Proactive service referrals
- Consolidation of appropriate and relevant information
- Health-coaching
- Options for flexible work arrangements

By drawing on diverse caregiving contexts and experiences across the different caregiver archetypes, we further posit that caregiving interventions need to consider family dynamics not just at the point of care but also in terms of the relationships between caregiver, family and care recipient prior to the start of caregiving.

Strategies to Improve Caregiver Wellbeing: Key Recommendations for the Eldercare Sector

Dyadic Model of Care Delivery

A key recommendation for enhancing caregivers' wellbeing is to implement care plans that manage the caregiver and their care recipient as a dyad. This approach ensures that the needs of both parties are addressed, particularly in complex cases such as care recipients with dementia. Care plans should be customised based on available resources and priorities, taking inspiration from models used in education and disability services. Establishing clear escalation pathways will help ensure that timely and effective support is provided for both the caregiver and care recipient.

Empowering Caregivers through Training and Support Networks

In addition, caregiver empowerment goes beyond basic caregiver training. It requires a concerted effort from eldercare staff and case managers to address the unique challenges each caregiver faces. A key part of this support includes developing caregivers' resilience by co-creating care plans and connecting them with essential social and professional networks. Peer support groups allow caregivers to share experiences, gain encouragement, and learn from others in similar situations. Professional networks (e.g., counsellors, occupational therapists, financial advisors) tailored to caregivers' specific needs are also important. Counsellors can help caregivers manage stress and navigate complex family dynamics, occupational therapists provide practical advice to improve caregiving techniques, and financial advisors can offer guidance on managing caregiving expenses. These networks allow caregivers to have a comprehensive support system while allowing them to feel less isolated and more empowered in their roles.

Existing health coaching programmes and workshops are another vital component of caregiver empowerment, offering personalised wellness plans and practical strategies to help caregivers maintain their health and prevent burnout. For instance, Nanyang Technological University's (NTU) "Health Coaching for Older Adults" programme[32] focuses on equipping caregivers with skills to promote healthy ageing and manage chronic conditions, while the "Health Coaching Techniques" course[33] teaches practical methods to address mental health challenges and enhance caregiving capacity. Similarly, NTUC Health's Community of Care Team[34] provides personalised health coaching sessions and links caregivers with support groups and community resources. At Tan Tock Seng Hospital, the "Carer Matters" initiative[35] includes workshops to help caregivers build resilience and how to effectively navigate the caregiving journey.

By leveraging on existing health coaching initiatives alongside tailored referrals to social and professional networks, caregivers can gain access to a robust support system. This integrated approach to caregiver support prioritises their wellbeing and equips them to manage caregiving responsibilities with confidence and resilience, with ample support at every step.

Service Models Focused on Caregiver Needs

Eldercare agencies should develop explicit guidelines that prioritise caregiver support as part of their service model. This would ensure that caregiver needs are factored into the discharge planning process when care recipients leave care facilities. Eldercare staff can address this by assessing caregivers' physical, emotional, and financial capacities to manage their responsibilities. Through one-on-one consultations or standardised assessments, eldercare staff can identify the caregiver's unique challenges and tailor support plans to align with their needs and limitations. By placing caregiver capacity at the forefront of these discussions, agencies can better prepare caregivers for the responsibilities they will face and provide the necessary resources to ensure successful outcomes for both the caregiver and care recipient upon discharge. Including caregivers in the development of these care plans ensures that their voices are heard and that their specific needs are addressed.

An important part of supporting caregivers lies in simplifying access to the information they need. Many caregivers feel overwhelmed by the abundance of resources, instructions, and options they must navigate, often on top of their already demanding responsibilities. By creating a centralised, easy-to-use resource (e.g., a handbook or online platform), caregivers can more easily find essential details about available services, financial aid applications, and practical caregiving tips. This streamlined approach can significantly reduce stress, giving caregivers a clearer path forward. It is equally important that these resources are regularly updated to ensure caregivers have the most accurate and current information and are available in all the four official languages. Additionally, offering training on how to navigate these tools can further empower caregivers and help them make confident and informed decisions.

Support for caregivers should not stop at the point of discharge or when care shifts to the home. Eldercare agencies can play an active role in easing the burden by making proactive service referrals. Instead of leaving caregivers to seek help on their own, agencies should connect them with relevant services, such as home-based care, counselling, respite care, or community programmes tailored to their loved one's needs. Regular follow-ups by case managers can be helpful, ensuring caregivers are not left to manage challenges in isolation. These check-ins can provide caregivers with timely advice, address emerging issues, and refine care plans as situations evolve. By taking these proactive steps, agencies can help close gaps in care, prevent burnout, and create a more supportive environment for caregivers and their care recipients.

Ultimately, these strategies – whether through proactive integration, tailored engagement, or collaborative care models – are critical in ensuring that caregivers do not face the caregiving journey alone. By providing comprehensive support, timely interventions, and recognising the nuanced needs of different caregiver archetypes, we can not only minimise burnout but also improve the overall wellbeing of both caregivers and care recipients, creating a more sustainable caregiving ecosystem.

Flexible Work Arrangements (FWA) to Support Working Caregivers

FWAs support employees in balancing caregiving and professional responsibilities, offering the flexibility needed to manage both effectively while maintaining wellbeing and productivity. As caregiving becomes more prevalent in our ageing society, FWAs enable caregivers to handle essential tasks, such as medical appointments, without jeopardising their jobs or income. According to the Tripartite Guidelines on Flexible Work Arrangement Requests by the Ministry of Manpower[36], FWAs also allow employees to adjust their schedules to meet personal and family needs while achieving workplace goals, thereby benefiting employers through improved employee satisfaction, retention, and resilience.

FWAs offer a win-win solution. They allow caregivers to balance their dual responsibilities while staying active in the workforce, and help employers build a more adaptable, motivated team, an important step forward in an ageing society.

Supplementary Materials

Scales used for assessing burden and benefits of caregiving

Category	Domain	Scale	Items*
Burden	Disrupted schedule and health problems	mCRA[37]	• My activities are centered around care for the care recipient • I have to stop in the middle of my work or activities to provide care • I have eliminated things from my schedule since caring for the care recipient • The constant interruptions make it difficult to find time for relaxation • I visit family/friends less since I have been caring for the care recipient • It takes all my physical strength to care for the care recipient • My health has gotten worse since I've been caring for the care recipient • Since caring for the care recipient, it seems like I'm tired all of the time
	Lack of family support	mCRA	• My family works together at caring for the care recipient • Since caring for the care recipient, I feel my family has abandoned me • It is very difficult to get help from family in taking care of the care recipient • Others have dumped caring for the care recipient onto me • My family (brothers, sisters, children) left me alone to care for the care recipient
	Financial problems	mCRA	• It is difficult to pay for the care recipient • Caring for the care recipient puts a financial strain on me
Benefits	Caregiver esteem	mCRA	• Caring for the care recipient is important to me • I enjoy caring for the care recipient • Caring for the care recipient makes me feel good • I feel privileged to care for the care recipient • I really want to care for the care recipient • I will never be able to do enough caregiving to repay the care recipient

Category	Domain	Scale	Items*
	Self-affirmation	S-PAC[38]	Providing help/care to or ensuring provision of care to the care recipient has… • Made me feel more useful • Made me feel needed • Made me feel appreciated • Made me feel important • Made me feel strong & confident
	Outlook on life	S-PAC	Providing help/care to or ensuring provision of care to the care recipient has… • Enabled me to appreciate life more • Strengthened my relationships with others

* Response options for items from the mCRA are "strongly disagree," "disagree," "neither agree nor disagree," "agree," and "strongly agree," and for the items from the S-PAC are "disagree a lot," "disagree a little," "neither agree nor disagree," "agree a little," and "agree a lot".

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