


Spousal Caregiving in Community Settings in Canada: Implications for Nursing Professionals

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Abstract

Objective: Spousal caregivers report significantly more health effects and psychological consequences than caregivers of aging parents. Traditional approaches to assist these caregivers often include lifestyle approaches with a lack of health promotion initiatives. Consequently, alternative approaches to facilitate the adaptation to the social context of spousal caregivers' experiences are needed. **Method:** This article systematically reviewed literature on spousal caregiving in Canada using a health promotion approach. Nine peer reviewed articles were identified from the health and social care literature and critically analyzed for relevant themes. **Results:** Gender, social support, health care, and income emerged as themes in the literature published to date. **Discussion:** The article concludes with directions for future research in Canada and suggested solutions for family nursing practice.

Keywords

spousal, caregiving, nursing

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The Canadian health care system has shifted in priorities with a rapidly aging society (Statistics Canada, 2020a), including a focus on health promotion (Sealy & Smith, 2012) and an increased reliance on family caregivers during chronic illnesses trajectories (Turcotte, 2013). While caregiving for aging parents continues to be the most frequent informal caregiving activity, 41% of Canadians aged 75+ are the primary caregivers for their spouses (Turcotte, 2013). Spousal caregivers report significantly higher psychological strain, physical injuries from caregiving tasks, and increased use of health services related to caregiving issues than caregivers of aging parents (Turcotte, 2013). With a continued reliance of informal caregiving, an aging population, and changing demographics of Canadian families (e.g., less children) (Turcotte, 2013), Canadians may see more spousal/partner caregiving occurring in the future. Subsequently, solutions to promote the overall health and well-being for these individuals, family, and costs to the Canadian health care system are imperative.

Traditional solutions for family caregivers include individual lifestyle approaches, such as stress management/respite (Health Canada, 2020) and medication for the caregiver to assist with caregiving activities (Turcotte, 2013). Since spousal caregivers are one main dyad relationship in the family that can be an important source of support during the illness experience (Sealy & Smith, 2012), promoting these family members health

by facilitating adaptation to the social context of their experiences is arguably needed (Sealy & Smith, 2012). The purpose of this article was to summarize the current Canadian literature on spousal caregivers in Canada using a health promotion perspective. The article concludes with directions for future research in Canada and suggested solutions for family nursing practice.

Method

A systematic literature review was conducted to examine Canadian research on spousal caregiving. Articles were obtained through PubMed and CINAHL using Medical Subject Headings (MeSH) terms “spousal “caregiving” AND “Canada.” These MeSH terms were chosen to ensure all articles regarding spousal caregiving were identified. Inclusion criteria included spousal caregiving in community-based settings (i.e., no long-term care or homecare provided), qualitative or quantitative studies, and Canadian-based populations. A total of 13 articles were obtained in initial PubMed search.

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Seven articles were removed based on exclusion criteria; three were review articles, two studied spousal caregiving in long-term care populations, and two were populations based in the United States. The CINAHL results returned three articles; two were duplicates from PubMed search, one was removed for not being a research article. The reference list of identified articles was also examined. A total of nine peer reviewed articles from the health and social care literature were identified and critically analyzed for relevant health promotion themes. The results are presented in Table 1.

Results

Theme 1: The Role of Gender in Spousal Caregiving Relationships

Gender is identified as an important determinant of health (World Health Organization [WHO], 2020b) and emerged as a consistent health promotion theme among the nine articles published to date (Table 1). While the research published varies in study populations, older women in these studies reported significantly more caregiver stress than men (Brazil et al., 2009; Penning & Wu, 2016), while male spouses were likely to recognize their wives distress and make attempts to reduce caregiving stress for their women spouses (Fergus et al., 2002). Further investigations into the research articles identified increased demands of the female spousal caregiver (Brazil et al., 2009; Coombs, 2007; Sabo et al., 2013), illustrating a possible socialization and expectation that women will take on increased responsibilities in the family during illness experiences (Brazil et al., 2009).

To illustrate, Brazil and colleagues (2009) investigated spousal caregivers in community-based palliative settings. These researchers found that older women were providing significantly more tasks of daily living than men (Brazil et al., 2009). Similarly, Coombs (2007) and Sabo and colleagues (2013) research found that older women reported taking on more physically demanding household chores in addition to their caregiving role. In contrast, older male caregivers are significantly more likely to receive assistance from family or friends when caregiving for an older spouse (Brazil et al., 2009). With the lifetime of caregiving expectations (e.g., children, older parents/significant others) and increased demands of the caregiving role (Johnson & Oliffe, 2012), older women may report caregiving for spouses as more difficult (Coombs, 2007) and resent the additional caregiving experiences over time (Sabo et al., 2013). Such attitudes are known to cause guilt in women caregivers leading to increased caregiver stress (Penning & Wu, 2016), or injuries which can result in the inability to perform caregiving roles (Turcotte, 2013).

However, the impact on the gender relationship in caregiving and mental health may not be as clear. In a cross-sectional study, Penning and Wu (2016) found that

while caregiving for a spouse was the highest stress rating among women who were working, older women cohorts in this study reported lower levels of caregiver stress when caregiving for an older spouse. While further longitudinal inquiry was needed, this finding may reflect employment or that older cohorts may consider spousal caregiving to be a normal transition in context of marital vows (Penning & Wu, 2016), leading to decreased perceived psychological distress. Younger cohorts who are balancing working and caregiving for spouse may have higher caregiver stress.

Theme 2: The Effect of Social Support and Health Outcomes in Spousal Caregiving

From the identified research in Table 1, older women may experience significantly more caregiver stress during the caregiving spousal relationship (Brazil et al., 2009; Coombs, 2007; Sabo et al., 2013). Social support is an identified determinant of health, and supportive spousal relationships and other social relationships can positively influence health (WHO, 2020a). The research to date has focused on the supportive experiences with spouses (Creese et al., 2008; Fergus et al., 2002) and other friends/family (Coombs, 2007).

Fergus and colleagues (2002) illustrated the influence of social support in spousal caregiving relationships. While these men were in cancer recovery, male care receivers discussed wanting to maintain a connection with spouse and were considerate of spousal female caregivers' feelings to reduce their distress. The study highlighted that the attention to spousal caregiver-receiver relationship which can provide social support to female caregivers may ease perceived stress.

However, when a spouse is seriously ill (e.g., dementia), the loss of social support may lead to role burden (Creese et al., 2008). In this case, the study suggested that social support from neighbors can positively influence health in spousal caregiving relationships. In a sample of eight older males ($n = 3$) and females ($n = 5$) living in rural settings, Coombs (2007) found that women having supportive neighbors to assist with transportation reduced barriers to health services. The women in this study also discussed hope and optimism within the caregiving relationship context. While this study had too small sample size for generalizability, Coombs (2007) illustrated that having social supports outside the spousal relationship positively assisted with the health of the spouse, and indirectly the health of the spousal care receiver.

While the research evidence to date provides insight into the influence of social support on health outcomes with spousal caregiving, there is little evidence on the effects of other identified family members (e.g., children) in the supporting social relationships. Investigations into this form of support are needed to understand the extent of the impact of social support in families. Also, given that female caregivers are less likely to receive

Table 1. Identified Studies on Spousal Caregiving in Community Settings in Canada.

Study	Purpose	Study design/participants	Data collection/ methods	Analyses	Results	Plausibility/limitations	Identified social determinants of health influencing health
Fergus et al. (2002)	Spousal receiver's perceptions	QUALITATIVE Phenomenology N = 34 (males = 34) Age = 65.8 years Prostate Cancer	Audiotapes and Interviews (before surgery, 8–10 weeks post surgery, 1 year post surgery)	Interviews transcribed for themes	Themes: Easing spousal burden Keeping up Maintaining connection Considering spouse	STRONG Member checking (participants reviewed data for accuracy) All men were relatively healthy, had prostate removed	Gender Social support
Coombs (2007)	Experiences of spousal caregivers for stroke survivors	QUALITATIVE Phenomenology N = 8 (males = 3) Age = 65.5 years Stroke	Audiotapes and semistructured interviews	Interviews transcribed for themes	Themes: Experiencing sense of loss Adjusting to new relationship Taking on new responsibilities Feeling demands of caregiving Having to depend on support of others Maintaining hope and optimism	STRONG Member checking Member checking (participants reviewed data for accuracy) All participants were English speaking, did not ask about other family caregivers, limited to persons with home telephones	Gender Social support Income/social status
Lohfeld et al. (2007)	Continuity of care experiences from spousal caregivers of advanced cancer patients	QUALITATIVE Phenomenology N = 12 (males = 3) Age = 70.3 years Palliative	Audiotapes and interviews	Interviews transcribed for themes	Themes: Management continuity Relational continuity Communication continuity Identified problems with interdisciplinary teams.	STRONG member checking Member checking (participants reviewed data for accuracy) triangulation, audit trail maintained All participants were English speaking, did not ask about other family caregivers, limited to persons with home phones	Gender Social support Income/social status Physical environment
Creese et al. (2008)	Sleep disruption, health outcomes in spousal caregivers of persons with Alzheimer's disease	QUANTITATIVE Cross-sectional N = 60 (males = 19) Age = 73.6 years Alzheimer's Disease	Telephone interviews	Descriptive data (means, SD frequency) Pearson correlations ($p > .05$)	Spouses reported good sleep quality in last month, but worse quality than year ago 47% awoken during the night Sleep quality, change in sleep quality, and frequency of nocturnal disruptions correlated with role burden and depressive symptoms ($p > .05$) No significant differences with those who didn't share bed	WEAK Cross-sectional study; correlation does not equal causality All participants lived in urban areas, prior psychiatric diagnosis, did not investigate type and amount of other family caregivers, care recipients had other serious medical illnesses, and severe decline in last 10 years, greater independence in ADLs than IADLs	Social support Physical environment
Brazil et al. (2009)	Gender differences in spousal caregiving at end of life	QUANTITATIVE Cross-sectional N = 283 (male = 85), Age (men) = 65.8 years; age (women) = 68.7 years Palliative	Telephone interviews	t test, logistic regression ($p > .05$)	Females significantly more caregiver strain than males ($p = .035$) Female caregivers provided toileting more ($p = .044$) males mobility tasks ($p = .011$) Care recipients who had female caregiver had lower odds of receiving support from family and friends in tasks associated with personal care ($p = .002$)	WEAK Cross-sectional study All participants were English speaking, did not investigate type and amount of other family caregivers, care recipients	Gender Social support

(continued)

Table 1. (continued)

Study	Purpose	Study design/participants	Data collection/ methods	Analyses	Results	Plausibility/limitations	Identified social determinants of health influencing health
Sabo et al. (2013)	Effect of spousal caregiving on psychosocial health in stem cell transplant receivers; Identification of at risk spouses to caregiver burden and secondary trauma	MIXED METHODS Phenomenology; Cross-sectional N = 11 (males = 4) Aged 30–60 years Cancer (hematopoietic stem cell transplantation)	One-on-one interviews and questionnaires administered at 4 points in time (before transplant, 6 weeks after, 6 months after, 1 year after)	Interviews transcribed for themes Descriptive statistics (means and SD), Pearson correlations ($p > .05$), logistic regression	Themes: Need for reassurance and hope Uncertainty Waiting Need for give and take in relationship Self-rated quality of life low at all points in time; greater caregiver dissatisfaction after 1 year. Overall, spousal caregivers experience greatest risk of distress, burden, and secondary trauma stress in acute phases Spouses may be vulnerable to adverse psychosocial effects (depression, stress) at 1 year if quality of life remains low	STRONG Member checking (Member checking (participants reviewed data for accuracy), audit trail All participants were White and middle class and English speaking, small sample size, specific population of stem cell transplantation	Gender Social support
Turcotte (2013)	To investigate the intensity and type of care provided based on relationship to care recipient	QUANTITATIVE Cross-sectional N = 8,000,000 Men = 2,080,000 Ages 15+ Any help or care to relative or friend in last 12 months	Telephone interviews	Descriptive statistics (means and SD)	Highest (41%) of spousal caregivers were 75+; 31% of spousal caregivers provided care for 30+ hours; 95% lived together Reasons for spousal caregiving include cancer (17%), cardiovascular disease (11%), neuro disease (9%), mental health problems (7%) Spousal caregivers provided more activities of daily living and instrumental activities of daily living and psychosocial support than caregivers of mother/father 69% felt no option to be caregiver Spousal caregivers reported more psychological distress, health consequences, and financial strain than caregivers of mother/father	MODERATE Large population based study, response rate 57.7% Definition of “caregiver” does not capture extent of relationship—at least once in last year, did not include remote caregivers, participants limited to those with home telephones	Income/social status Employment and working conditions

(continued)

Table 1. (continued)

Study	Purpose	Study design/participants	Data collection/ methods	Analyses	Results	Plausibility/limitations	Identified social determinants of health influencing health
Lee and Zurlò (2014)	Spousal caregiving and financial strain	QUANTITATIVE Cross-sectional N = 5,067 (male = 2,482) Age 45–54 = 46.5% 55–64 = 32.8% 65–74 = 14.4% 75+ = 6.3%	Canadian Community Health Survey: Healthy Aging	Descriptive statistics (means and SD)	35% of spousal caregiver's experience difficulty with financial strain interfering with basic needs Social support was protective, in that affectionate and positive social interactions lessened financial strain perception	WEAK Cross-sectional	Income/social status Social support
Penning and Wu (2016)	Comparison of mental health status of caregivers by gender	QUANTITATIVE Cross-sectional N = 6,140 (men = 982) Age = 58.1 years Subsample of caregivers aged 45+	Secondary data analyses from 2012 General Social Survey on Caregiving and Care Receiving	Descriptive Statistics (frequency, means and standard deviations) Regression analyses ($p > .05$)	10.3% were spousal caregivers, 26.3% of primary caregivers were women Self-rated stress higher among female than males across all caregiving relationships ($p > .05$). Highest stress scores among women caring for a spouse (daily contact), or who were employed or other work-related activities. Older females reported better mental health in spousal caregiving ($p > .05$) Lower income household reported more caregiver stress Higher levels of mental health evident for caregivers with higher education, employed or retired, moderate to high income, caregivers with no illness/activity limitations, and not caregiving with physical and mental health needs.	WEAK Cross-sectional Definition of "caregiver" does not capture extent of relationship—at least once in last year, did not include remote caregivers, participants limited to those with home telephones	Gender Income/social status Employment (younger ages)

social support from family and friends (Brazil et al., 2009), further research into the benefits of community connections is necessary to understand the health impacts of social supports in spousal caregiving (Lohfeld et al., 2007).

Theme 3: The Effects of Health Care on Spousal Caregiving

Lohfeld and colleagues' (2007) research highlighted the importance of perceived support from health care system. These researchers interviewed spousal caregivers and recipients and found that spouses who perceived positive and supportive therapeutic relationships from acute to community settings had increased understanding of treatment regimens and confidence to discuss their caregiving concerns (Lohfeld et al., 2007). While caution is necessary because of the small sample size, these findings highlight the importance of facilitating relationships within the acute and community health care system for spousal caregivers and families.

Theme 4: The Effects of Income on Spousal Caregiving

Income is known to be one of the primary determinants of health (WHO, 2020a), and four research studies have discussed the effect of income on health in the spousal caregiving relationship (Lee & Zurlo, 2014; Lohfeld et al., 2007; Penning & Wu, 2016; Turcotte, 2013).

Many Canadian spouses are finding it difficult to perform caregiving tasks because of reduced incomes in retirement. Despite some older persons retiring with more savings (Martin, 2012), Turcotte (2013) found that 20% of spouses had reported financial hardships, and 42% of women spousal caregivers were finding it difficult to meet their basic needs. This finding may be because of a lifetime of disrupted work/income due to caregiving tasks and that women are less likely to ask or receive support during caregiving tasks (Brazil et al., 2009).

When Canadian spousal caregivers are financially secure, they self-report feelings of better mental health. Penning and Wu (2016) found that persons with moderate to high income were likely to have reported better self-rated mental health and less caregiver stress than persons with lower incomes. This research suggests that receiving financial support to assist with caregiving tasks may reduce the burden associated with caregiving in later ages (Penning & Wu, 2016).

However, it is important to note that the psychological impact of higher incomes may not be as direct. In a sample of 5,067 spousal caregivers, Lee and Zurlo (2014) found that social support, including positive social interactions had lessened perceived financial strain. Although the spousal women in the study were still struggling with finances, having social support

eased the perceived burden of lower incomes. While financial support can assist with providing basic needs, Lee and Zurlo (2014) study implied that social support from family, neighbors, friends, or health care professionals may additionally ease the burden of caregiving in later ages.

Directions for Future Research

Both the physical built environment (WHO, 2020a) and culture (Canadian Public Health, 2020) are identified as important determinants of health. The research published to date has mainly focused on urban settings in Canada (Brazil et al., 2009; Creese et al., 2008; Lohfeld et al., 2007) or has avoided investigating Canadians in remote areas (Turcotte, 2013). One research study presented previously (Coombs, 2007) had highlighted that women in rural areas with transportation issues may seek social support for assistance with health appointments (Coombs, 2007), illustrating a possible interactional effect with built environment, social support, and potential health outcomes in older spousal caregivers.

Furthermore, research has mostly investigated Caucasian (Sabo et al., 2013) and/or persons with English proficiency (Brazil et al., 2009; Coombs, 2007; Lohfeld et al., 2007; Sabo et al., 2013). Given the effects of culture on health (Canadian Public Health, 2020), investigating the influences of the various Canadian cultures in spousal and family caregiving relationships and health outcomes is warranted.

Finally, with the reduced gender gap in life expectancy and changing families (Statistics Canada, 2020b), there may be an increase in older men caregiving for spouses/partners and other significant others. Future research needs to address the male caregiver and include evidence-based gender sensitive solutions to spousal caregiving in later life (WHO, 2020b).

Implications for Nursing Practice

Four themes of gender, social support, health care, and income have emerged as important determinants of health in the research in Canada on spousal caregiving. Brazil and colleagues (2009) warned that if Canadians continue to equate spousal caregiving as a natural part of family relations without investigation of spousal experiences, this family issue may not translate to policy actions or concerns for community and family health nursing (Brazil et al., 2009). Based on literature found, there is a strong need to move beyond current treatments for spousal caregiving, and one that is sensitive to the needs of the spousal caregiving community (Brazil et al., 2009).

While the effect of gender on caregiving health outcomes is nonmodifiable, nurses on the family health team need to be aware of the older women spousal caregiver needs. Initial and ongoing assessments of the

spouse are necessary to identify the strengths of the spouse, family, and communities which would be conducive for spousal health, including available social supports, health care utilization, and income. Assessments should also regularly include best practice questions on caregiver strain (Registered Nurses' Association of Ontario, 2020). Nurses need to uphold the standard of therapeutic relationships (Community Health Nurses Association of Canada, 2020) and ensure the family or spouse is not at risk for harm. Therefore, in these assessments, nurses need to inquire about feelings of violence and abuse in the relationship, as elder abuse can occur under stress (Ontario Network for the Prevention of Elder Abuse, 2020). The spouse must understand that resentful caregiving feelings can be normal, but the nurse must make appropriate referral to an interdisciplinary team to protect care receiver within financial means of the family (Ontario Network for the Prevention of Elder Abuse, 2020).

Although caution is necessary in interpreting results, Friedemann and Buckwalter (2014) study suggested that nurses need to pay attention to older women spouses who are resistant to family and community resources. While having the right to refuse resources, these women may view caregiving as a spousal duty and be resistant to seeking assistance (Brazil et al., 2009), or alternatively, these women may not have the necessary finances for treatment (Lee & Zurlo, 2014). Community health nurses and other nurses must continue to build relationships with spouses and families through relational practices (Community Health Nurses Association of Canada, 2020) during any point of contact to ensure that spouses can discuss and feel supported during the illness while understand their specific perspectives and expectations (Community Health Nurses Association of Canada, 2020). For these spouses, nurses may also want to consider the development of personal skills in community forums. Affordable community-based education targeted to remain safe from injury, including basic nursing skills for safe personal care (Penning & Wu, 2016) and awareness of elder abuse and stress could be taught to reduce injuries in the older spousal caregiver relationships. This meets the standard of building community capacity and facilitating access and equity (Community Health Nurses Association of Canada, 2020).

Furthermore, nurses must recognize the spouse's needs in the transitioned relationship. Based on the evidence on the strength of social support, nurses can consider the development of activities in communities that will empower spouses to participate in health promoting activities. Having opportunities for community support networks such as supporting friendly visitor programs (Victorian Order of Nurses, 2020) and relationship building in the community for health (e.g., neighborhood driving program) will benefit the family and spousal caregivers.

Finally, nurses need to be aware of the intersectoral financial options and facilitate this information for

families. These options can include discussion with banks for specific financial management, knowledge with online applications to the federal government's compassionate care benefit program, and the Family Caregiver amount on income tax forms. Nurses can continue to advocate for affordable and tax breaks for assistive devices (St. Elizabeth, 2020).

However, Turcotte (2013) reported that only 3–28% of the 3.1 million Canadians who engaged in caregiving roles were eligible for tax credits (Turcotte, 2013). Based on the known disruptions for women in their caregiving roles (Sealy & Smith, 2012), there is a need for nurses to be aware and involved in the development of healthy public policy for women and across the lifespan.

Conclusion

This article investigated the current Canadian literature on older spousal caregivers in Canada. Social support and income were the identified facilitators that spousal caregivers have identified to health. Building relationships (Community Health Nurses Association of Canada, 2020), facilitating access to information (St. Elizabeth, 2020), and public policy/advocacy (Turcotte, 2013) were identified within the nursing profession and Canadian society to alleviate the adverse effects of spousal caregiving. Future research should address evidence-based gender solutions (WHO, 2020b) and additional determinants of health on the spousal caregiving family.

Declaration of Conflicting Interests

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Ethical Consideration

The article is in compliance with ethical standards.

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References

- Brazil, K., Thabane, L., Foster, G., & Bedard, M. (2009). Gender differences among Canadian spousal caregivers at the end of life. *Health & Social Care in the Community*, 17(2), 159–166.
- Canadian Public Health. (2020). *Social determinants of health and health inequalities*. <http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php>
- Community Health Nurses Association of Canada. (2020). *Canadian community health nursing standards of practice*. <http://neltoolkit.nrao.ca/sites/default/files/Canadian%20>

- Community%20Health%20Nursing%20Standards%20of%20Practice%20mar08_english.pdf
- Coombs, U. (2007). Spousal caregiving for stroke survivors. *Journal of Neuroscience Nursing, 39*(2), 112–119.
- Creese, J., Bedard, M., Brazil, K., & Chambers, L. (2008). Sleep disturbances in spousal caregivers of individuals with Alzheimer's disease. *International Psychogeriatrics, 20*, 149–161.
- Fergus, K., Gray, R., Fitch, M., Labrecque, M., & Phillips, C. (2002). Active consideration: Conceptualizing patient-provided support for spouse caregivers in the context of prostate cancer. *Qualitative Health Research, 12*, 492–514.
- Friedemann, M., & Buckwalter, K. (2014). Family caregiver role and burden related to gender and family relationships. *Journal of Family Nursing, 20*, 313–336.
- Health Canada. (2020). *Respite for family caregivers—An environmental scan of publicly-funded programs in Canada*. <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/home-continuing-care/respice-family-caregivers-environmental-scan-publicly-funded-programs-canada.html>
- Johnson, J. L., & Oliffe, J. L. (2012). Gender and community health. In L. L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (3rd ed., pp. 300–310). Pearson Canada.
- Lee, Y., & Zurlo, K. (2014). Spousal caregiving and financial strain among middle-aged and older adults. *International Journal of Aging and Human Development, 79*(4), 302–321.
- Lohfeld, L., Brazil, K., & Willison, K. (2007). Continuity of care for advanced cancer patients: Comparing the views of spousal caregivers in Ontario, Canada, to Dumont et al.'s theoretical model. *Journal of Palliative Care, 23*, 117–126.
- Martin, L. S. (2012). Older adult health. In L. L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (3rd ed., pp. 311–325). Pearson Canada.
- Ontario Network for the Prevention of Elder Abuse. (2020). *Elder abuse: The hidden crime*. https://www.sdglegal.com/uploads/yDwuya4u/elder_abuse.pdf
- Penning, M., & Wu, Z. (2016). Caregiver stress and mental health: Impact of caregiving relationship and gender. *The Gerontologist, 56*, 1102–1113.
- Registered Nurses' Association of Ontario. (2020). *Caregiver Strain Index*. <https://bpgmobile.rnao.ca/sites/default/files/Caregiver%20Strain%20Index%20%28CSI%29.pdf>
- Sabo, B., McLeod, D., & Couban, S. (2013). The experience of caring for a spouse undergoing hematopoietic stem cell transplantation. *Cancer Nursing, 36*(1), 29–40.
- Sealy, P., & Smith, J. (2012). Family health. In L. L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (3rd ed., pp. 267–282). Pearson Canada.
- Statistics Canada. (2020a). *An aging population*. <https://www150.statcan.gc.ca/n1/pub/11-402-x/2010000/chap/pop/pop02-eng.htm>
- Statistics Canada. (2020b). *Life expectancy in Canada*. <http://www.statcan.gc.ca/eng/help/bb/info/life>
- St. Elizabeth. (2020). *The caregiver compass*. <https://www.saintelizabeth.com/getmedia/930d239f-33c7-4146-a85e-db85d1435b20/caregiver-compass.pdf.aspx>
- Turcotte, M. (2013). *Family caregiving: What are the consequences?* <http://www.statcan.gc.ca/pub/75-006-x/2013001/article/11858-eng.htm>
- Victorian Order of Nurses. (2020). *Friendly visitor program*. <https://www.von.ca/en/services>
- World Health Organization. (2020a). *The determinants of health*. <http://www.who.int/hia/evidence/doh/en/>
- World Health Organization. (2020b). *Gender and genetics*. <https://www.who.int/genomics/gender/en/>