

Research article

Emotions in spouse caregiving: a study based on written stories

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Abstract

Research on caregiving has traditionally focused on coping with negative life changes. This article aims to widen the scope from the challenges caregivers encounter in their lives to the emotions they experience in caring, and the situations associated with them. The article's approach is predominantly social pedagogical. We discuss social pedagogy as a pedagogical theoretical orientation and a way of thinking that emphasise the social basis of human growth and education. Social pedagogy provides a useful lens for examining caregivers' personal growth, especially how inclusion, well-being and social functional capacity can be promoted, thus preventing and alleviating social exclusion. In this article, the focus is on emotions in everyday encounters and relations that have an important coping function for caregivers. The data came from the written stories of spouse caregivers, and the method of analysis was joint abductive and inductive content analysis. A modified version of the Basic Emotion Scale was used to identify and classify the emotions in the written stories. These emotions were grouped according to the following themes: happiness, sadness, fear, anger and guilt. The encounters associated with the emotions were also analysed and classified. As a result, the role of emotions

as key markers of well-being and important life changes was discovered. Emotions are important indicators that show us what needs special attention in everyday caregiving encounters. This information can be used by social and health-care professionals seeking ways to support and empower caregivers.

Keywords caregiving; emotions; social pedagogy; spouse caregivers; personal growth; well-being

Introduction

Family caregiving is an important public-health issue. In many countries, the social and health-care authorities aim to help people live at home as long as possible. To achieve this aim, the physical, emotional, cognitive and social needs of caregivers and care recipients must be considered, and multiprofessional support from social workers, home-care workers, therapists, doctors or nurses may be needed. As people get older, they experience many health problems and might need end-of-life support. They manage loss and bereavement and try to maintain social networks. Social workers offer the necessary help to cope with these types of situations (Ray et al., 2015). The needs of care recipients and caregivers' ability to cope with such needs have been studied extensively (Glendinning et al., 2009). This article seeks to understand the roles of emotions and the encounters linked to them in the personal growth of caregivers from a social pedagogical perspective (Hämäläinen, 2003).

Social pedagogy can be understood as a tradition and discipline of pedagogical thinking and action, which examines the social conditions of human growth and the educational conditions of social development. But social pedagogy has also been defined institutionally and based on professional practices (Hämäläinen, 2003; Nivala, 2019; Shure, 2024).

In terms of professionalism, a key factor differentiating country-specific usage of the concept of social pedagogy is the existence or absence of a social educator or social pedagogue profession in the country. It is common for countries with professional training for social pedagogues to talk about social pedagogy as a professional discipline of that professional group, while in countries without a social pedagogy profession, social pedagogy has been developed as a pedagogical way of thinking that can be applied in many professions in the field of education and welfare (Hämäläinen, 2015). For example, in the country where the material for this study was collected, there is no specific profession of social pedagogy, but social pedagogy has been developed as an academic field of learning, training and research. In this study the concept of social pedagogy is applied as a pedagogical way of thinking. Social pedagogy offers a wide range of application possibilities in the professions of education and social and health-care work (Cameron et al., 2021; Cedersund et al., 2021; Nivala, 2019).

In this article, we discuss social pedagogy as a pedagogical theoretical orientation and a way of thinking that emphasises the social basis of human growth and education. Interpreted in this way, social pedagogy offers a relevant conceptual research framework for producing information in accordance with the realisation of the personal human growth of caregivers through informal learning and related informal and professional social support (Hämäläinen, 2015; Úcar, 2024).

Recently, there have been increasing efforts to apply the social pedagogical perspective to education seniors (Kornbeck and Rosendal Jensen, 2011; Pohjola et al., 2020). The literature on social pedagogical support for the elderly emphasises educational forms of work that promote the inclusion, self-determination, well-being and social functioning of older people (Hunter, 2020; Kurki, 2007; Nivala, 2019). The starting point is often the idea that life offers opportunities for personal growth until its end (Crăciun, 2023, pp. 129–49). This is why social pedagogy is useful for examining caregivers' growth, especially in terms of how inclusion, well-being and social functional capacity can be promoted, thus preventing and alleviating social exclusion (Hämäläinen, 2012). The idea that social pedagogy happens in everyday encounters and relations (Monteux and Monteux, 2020) is also relevant because emotions accompany these encounters and relations. This kind of understanding can strengthen professionals' work in supporting caregivers' personal growth and well-being (Cameron, 2020).

By looking at encounters related to emotions, we can see which issues are challenging in caregiving and which increase caregivers' well-being and promote inclusion. Many studies have been conducted

on emotions in caregiving families, and negative emotions have been especially emphasised (AboJabel et al., 2021; Behrouian et al., 2020; Meshkinyazd et al., 2020; Noyes et al., 2010; Wakefield, 2020). This is probably because scholars have traditionally focused on caregivers' burdens and their ways of coping with life challenges. Positive emotions have received considerably less attention (Autio and Rissanen, 2017, 2020; McLennon et al., 2011; Quinn et al., 2010). However, in recent years, several researchers have begun to explore positive emotions alongside ambivalent and mixed ones (AboJabel et al., 2021; Francis et al., 2020; Liu and Zhang, 2020; Turner and Finch-Guthrie, 2020).

In this article, we seek to answer the following question: What emotions are associated with spouse caring and in what encounters do they arise? Answering this is important for social and health-care professionals seeking ways to support and empower caregivers. Our research data consist of 58 stories written by spouse caregivers. These stories were not originally written for research purposes; they were submitted to a writing competition organised by a caregivers' association in Finland. The entry criteria asked the participants to write about their daily lives and emotions as caregivers. The publication of a book containing the stories was also mentioned. Eventually, the association did publish some of the stories as a book, as well as in other forms. For our study, we analysed all the submitted spouse caregiver stories in their original forms. This enabled us to capture the authentic voices of the storytellers. The board of the association approved the use of the data for research.

Basic emotions in caregiving research

Emotions are an important source of information when studying people's ways of coping with life challenges (Lazarus, 1991). The emotions attached to caring can be examined using the concept of basic emotion. This concept focuses on the functional characteristics of emotions, and it emphasises their adaptive value in coping with fundamental life tasks (Ekman, 1992; Finucane et al., 2012; Lazarus, 1993). In many studies, emotions such as happiness, sadness, anger, fear and disgust are defined as basic emotions (Finucane et al., 2012; Dalgleish and Power, 2004).

Positive emotions can be viewed through the dimension of happiness. Happiness 'reflects the appraisal that progress towards a valued goal is being made' (Finucane et al., 2012, p. 15). In caregiving research, positive emotions are associated with a sense of meaningfulness and success as a caregiver, with expressions of gratitude, with the pleasure and satisfaction of the care recipient, and with coping at home (Andrén and Elmståhl, 2005; Liu and Zhang, 2020; Quinn et al., 2010; Turner and Finch-Guthrie, 2020; Wilkins et al., 2020). The end of caregiving may also involve positive feelings (Salmon et al., 2005; Supiano et al., 2020). Furthermore, the notions of resilience and personal growth prove useful when studying positive emotions. Resilience is associated with a positive impact on quality of life and emotional distress. A positive coping style and resilience have been shown to play an intermediary role between social support and post-traumatic growth (Luo et al., 2020; Palacio et al., 2020). Li et al. (2020) discovered that positive coping strategies promoted post-traumatic growth and acted as important mediators between family functioning and growth.

Sadness occurs when one experiences loss or failure regarding an event of personal significance (Li et al., 2020). The literature provides good evidence that caregiving involves many types of loss (for example, McKeown et al., 2003; Noyes et al., 2010). These might involve personal sacrifices as well as feelings of isolation, sadness, longing and worry (Chan et al., 2020). The sorrow felt while caring might be interpreted as a response to loss – for example, the loss of a relationship, the mental capacity of the care recipient, future plans, social connections, work and freedom (Champlin, 2020; Dempsey et al., 2020; Farran et al., 1991; Holley and Mast, 2009; Marwit and Meuser, 2002).

Sorrow has been described in the literature as a universal response to the heavy losses that a caregiver experiences over the course of a worsening memory disorder (Meuser and Marwit, 2001). McEvoy et al. (2019) have stated that individuals who care for partners with dementia work through feelings of loss, grief and burden as their spouses' abilities and personalities change, altering their relationships. The caregivers of cancer patients can also experience tremendous sadness as the cancer progresses (Lim et al., 2020). The sorrow associated with a progressive disease has been described as ongoing (Meuser and Marwit, 2001) and chronic (Rabins, 1984). Marwit and Meuser (2005) have spoken of 'minor deaths' (p. 192) in reference to the decline of the cognitive abilities of patients with memory disorders and their social death before the final deterioration of their physical capabilities. This

phenomenon has also been called dual dying (Sanders et al., 2008) to highlight the experience of sorrow due to the gradual loss of a loved one and the sorrow that follows their death (Ott et al., 2007).

People who encounter many threatening situations in life may come to view the world as dangerous and full of hazards (Öhman, 2010). Many caregivers deal with traumatic situations and losses, which can make the world seem unpredictable and frightening. Concerns about one's future health or disease recurrence can lead to anxiety (Cervantes et al., 2020; Prado et al., 2020). The expected loss of relationships, hobbies and friends may also evoke fear (Bachmann, 2020; Bannon et al., 2020; Chua et al., 2020). Those who care for people with memory disorders have been shown to experience clinically meaningful anxiety and depression (Cooper et al., 2008; Mahoney et al., 2005).

Anger occurs when a goal that is personally meaningful is blocked or frustrated (Finucane et al., 2012). According to a review by Queluz et al. (2020), dementia patients' caregivers express feelings of frustration and anger towards family members who refuse to support them. Further, the care recipient's abnormal behaviour, communication difficulties or constant need for help may cause irritation and anger (Croteau et al., 2020). In their scoping review, Ramazanu et al. (2019) identified the emotional challenges of stroke patients' caregivers, which included overwhelm, irritability and intolerance. They also described spouse caregivers' feelings of aggression as they struggled to comprehend their partners' post-stroke behavioural changes and other symptoms.

Finally, guilt follows from a sense of personal failure. Compared to shame, where the focus is on the self, with guilt, the focus is on one's activities and behaviours towards others (Lewis, 2010). Caregivers find it difficult to manage their needs and those of the care recipient. Emotions of guilt arise especially in situations where one's actions are deemed to be unsuccessful. They tend to increase markedly when the care recipient moves into a care institution (Gaugler et al., 2008; Nolan and Dellasega, 2002). Bris (1993) noted that guilt is also common when the caregiver feels that they are not doing enough or well enough, when they reject the care recipient due to their own need for rest, or when they use hostile language due to anger (Lim et al., 2020). Feelings of guilt can also be imposed on the caregiver by other people (Bachmann, 2020; Gallego-Alberto et al., 2020). In the results, we will look at which emotions are found in our data and in which kinds of encounter they are expressed. By doing so, it is possible to explain how social pedagogical practices could help caregivers with their personal growth and their challenges in everyday encounters and relations.

In our earlier literature review, we indicated that personal growth is a comprehensive concept and is manifested in the form of experiences such as valuing human contact and life, finding new skills, and feeling one's strength and confidence in coping with life's adversities (Autio and Rissanen, 2020). Moreover, post-traumatic growth refers to a positive self-change experienced by individuals when coping with major life crises (Tedeschi and Calhoun, 2004). Tedeschi and Calhoun (2004) define post-traumatic growth as the result of struggling in a stressful situation. Growth does not mean returning to the basic state but rather reaching a better permanent state. Life crises can act as catalysts for the improvement of people's personal or social resources, improved coping skills or spiritual insights. The concept of personal growth (for example, Findler et al., 2014) is used in parallel with post-traumatic growth. In the research literature (Joseph and Linley, 2006; Tedeschi and Calhoun, 2004), three broader dimensions of growth have been highlighted. First, growth leads people to value their relationships more, value their friends and family more, and feel more compassion and selflessness towards other people. Second, growth changes people's view of themselves in some way. They experience an increased sense of personal resilience and gain wisdom and strength, which bring a greater acceptance of their own vulnerability and limitations. Third, growth changes people's outlook on life. They learn to appreciate each new day and the things that really matter. This change in outlook may also involve changes in spiritual beliefs. Paradoxically, trauma survivors report that their losses brought valuable growth experiences (Tedeschi and Calhoun, 2004).

The emotions that arise in challenging situations, such as sadness, fear, anger and guilt, can require the caregiver to reflect and try to find ways to make their own situation and everyday coping easier. Our earlier analysis showed that several positive emotions in caregiving are connected to experiences of growth, as positive emotions can be a manifestation of growth, while they can also contribute to the experience of growth (Autio and Rissanen, 2017; Fredrickson and Cohn, 2010).

Data and method of analysis

The data consist of 58 stories written by spouse caregivers. The entry criteria of the competition for which the stories were written asked the caregivers to write about their daily lives and feelings and emotions as caregivers. Nine stories were written by men, 49 by women. The experiences of working or recently retired caregivers were described in 13 stories, while 40 stories were about retired elderly caregivers. In five stories, the age of the caregiver was unclear. The main health problems were memory disorders (17 stories) and stroke (16 stories). The data amounted to 34,415 words, which were examined with joint abductive and inductive content analysis. The process of analysis is summarised in Table 1. Previous research has indicated that spouse–caregiver and care–recipient couples react in an emotionally unified manner and that their relationships can be examined as single units (Karademias and Thomadakis, 2020). In our analysis, we consider the mutual interactions of the care partnership, as well as the encounters related to various emotions.

Table 1. Main phases of the research process

Phase 1	The texts were anonymised (all names and place names were changed) and numbered
Phase 2	The stories were studied by inductive content analysis to identify descriptions of emotions. The analysis was limited to emotions expressed during interactions between the spouses
Phase 3	A modified version of the Basic Emotion Scale was used to identify and classify emotions
Phase 4	Inductive content analysis was employed to examine the encounters related to the emotions
Phase 5	The encounters were classified, and the literature was used to deepen and strengthen the interpretation

The Basic Emotion Scale (BES) organises 20 expressions of emotions into five items (Finucane et al., 2012). In our study, we made a minor modification to the last item of the scale (Table 2) and used this version to identify and classify the emotions documented in the stories. In our modified version of the BES, the last item focuses on guilt. This change made the scale more suitable to our case.

Table 2. Basic emotions and the specific feelings related to them

Basic emotions	Specific feelings
Happiness (OS, MS)	Happiness, joy, love and cheerfulness
Sadness (OS, MS)	Despair, misery, gloominess and mournfulness
Fear (OS, MS)	Anxiety, nervousness, tension and worry
Anger (OS, MS)	Anger, frustration, irritation and aggression
Disgust (OS)	Shame, guilt, humiliation and blame
Guilt (MS)	Shame, guilt and the feeling of being blamed

Notes: OS = original scale; MS = modified scale.

Results

The results are described in the following sections according to the modified BES. Some information pertaining to everyday-life encounters is also presented.

Happiness

The stories show that happiness arose in many different daily encounters (Table 3).

Table 3. Variation and classification of the encounters related to happiness in the spouses' interactions

Encounter	Sub-classification	Main classification
Care recipient with memory disorder was still able to remember important things (M29) Care recipient with stroke was able to leave the wheelchair and learnt to walk again (S38, S39) Care recipient ate well or felt less pain (O53) Care recipient was able to do things or watch TV; care recipient was livelier for a while (M1, O53) A small improvement in the care recipient's condition (O27)	A momentary or stable improvement in the care recipient's condition or functioning	The good moments in the care recipient's daily life
Care recipient responded positively to the caregiver's caring (M24) Caregiver received a smile or thanks for caring (M52, O57)	Care recipient's good mood due to the care	Care recipient's satisfaction with the care
Care recipient returned home after a short-term period of care elsewhere (M18, M51) Caregiver had the possibility to cook again for the care recipient after a short-term period of care elsewhere (M29)	Return home after a short-term period of care elsewhere	Spouses' time together or with the family
Reminiscing together (S46) Being together at home (O22, O27) Being together in the care unit (M3)	Shared moments with the care recipient	
Visits by children; happiness related to having a family (O23, O27, M30, S40, S43) Family celebrations (M51)	Being together with the family	
Understanding that things could be even worse (S43) Gratitude for the presence of the care recipient (S21, M26, M35)	Valuing the existence of the care recipient	Appreciating the care
Start of caregiving (S46) Being able to provide care until the end (M1, O15, M25, M51) Gratitude for the care recipient's peaceful end of life (O23)	Being a caregiver – positive conclusion to the caring	

Notes: S = stroke; M = memory disorder; O = other health problem.

Some caregivers of spouses with memory disorders described how joy followed moments when their care recipients remembered key things about their life together. In the excerpt below, the wife is both overjoyed and saddened when her husband recalls that he has spent the best years of his life with her, although he is no longer able to recognise her. This encounter shows how happiness can be hidden, and its detection requires sensitivity:

He looked at me for a moment, lifted himself up a little, and said in a clear voice, 'You are not my first, Lisa [name changed]; please don't be angry. With her, I lived my best years and raised my children – I do miss her.' Tears were running down his face, and I also let my tears go afterwards. For me, though, the tears were both of sorrow and joy. After all, he said that he had spent his best years with me. Even though we were living through this phase of diapers, and the situation was what it was, we still had the memories of our past, and they bound us together. (M29)

Positive emotions also came to the fore when a spouse who had had a stroke learnt to walk again and was able to live without a wheelchair. Joy and pleasure were described regarding shared moments at home or in an institution as well as when the care recipient returned home after a short-term period of care elsewhere. Caregivers also derived happiness from family relationships, especially from grandchildren whose visits brought joy to both spouses. Some caregivers described feelings of satisfaction following a period of caregiving that had come to an end – 'I'm happy to have been able to love and care for [him or her] throughout the hard years' (M1) – which can be interpreted as positive recollections of past caregiving. As this evidence shows, the spouses' happiness can be interpreted as existential life experiences, which included sharing joyful moments in daily life, recognising the meaning of being together and discovering positive meaning through caring.

Sadness

Descriptions of despair and melancholy were abundant in the stories. Experiences of sorrow were associated with the decline in the care recipient's functional capability, the changed relationship between the spouses and expectations of the future (Table 4).

The stories told about the caregivers' sadness for the gradual loss of their spouses' skills or their living in a world made up entirely of memories. Sorrow was also caused by changes in the intimate relationship between the spouses and the need to adopt new roles. Periods of short-term care elsewhere were sad moments, particularly if the care recipient was unwilling. The caregivers also described the stage of institutional care as the sad, final loss of their partners: 'When I took him to the healthcare centre, I thought that I'd feel relieved, but I felt something totally different. I felt the pain of giving up. It was so final. I knew that he wouldn't come home again' (M25).

The stories also contained descriptions of the expected death of the care recipient, the final 'giving up' and being left alone. The loss described by the caregivers was associated with the basic things of life, which, once lost, could throw their entire existences into uncertainty.

Fear

Fear, concern and anxiety were described in the stories at the early stages of the health problem and when it worsened (Table 5).

The writers described how their spouses' diagnoses evoked fear, and the future became unpredictable. Similarly, a spouse's severe condition at the beginning of a stroke could become imprinted on the caregiver's mind, and the fear attached to it, due to a sense of having minimal resources, could be reactivated later in life:

I remember how life stopped after the doctor contacted me – 'Your husband is unconscious. He is paralysed, and it is impossible to give a prognosis ...' How many nights of despair and bouts of depression did I go through while he was unconscious? The struggle to cope with very few resources left a permanent feeling in me, which returns again and again. (S39)

Some caregivers were also afraid of their spouses' changing behaviours and personalities. Many aspects concerned the writers, such as the worsening of their spouses' health problems and daily life becoming more complicated. The care situations also involved vaguer emotions than fear, such as anxiety, especially regarding the future. The evidence shows that emotions of fear and concern were mostly associated with the diminishing abilities of the care recipients to cope by themselves and the resulting unpredictability of what lay ahead.

Table 4. Variation and classification of the encounters related to sadness in the spouses' interactions

Encounter	Sub-classification	Main classification
Despair at the beginning of the health problem (S39) Sorrow when the health problem began (S37, S36)	Beginning of the health problem	Losing the healthy spouse
Appearance of new health problems (S43)	New health problems begin	
Care recipient is no longer able to eat (M35) Care recipient's former handicraft skills are lost (M29) Care recipient is no longer able to speak (M32) Care recipient's functional capacity is weakened (M25, O53)	Weakening of the care recipient's functioning	
Care recipient no longer recognises the caregiver (M29) Care recipient lives in the past (M18)	Existing memory disorders	
Care recipient's condition makes the caregiver feel sad or hopeless (O49, M51, S37)	Care recipient's poor condition	
Sorrow for the lost partnership (O49) Longing for intimacy (M25, M52)	Partnership ends	Losing partnership
Care recipient starts short-term period of care elsewhere (M29, S41) Care recipient moves to a care institution (M1, M25, M31)	Care recipient moves permanently or temporarily into care outside the home	Losing shared family life
Sorrow regarding the care recipient's impending death (O5, M25) Grief after the care recipient's death (O15, O23)	Care recipient's death	Final loss of the spouse

Notes: S = stroke; M = memory disorder; O = other health problem.

Anger

Hate, irritation and aggression were also present in the stories. These emotions were mainly related to experiences of injustice when beginning caregiving, disruptive behaviour associated with the health problem and the spouse's constant need for help (Table 6).

The caregivers described how the care recipients' jealousy and unconventional behaviours caused irritation. Knowing that the cause of these issues was the health problem did not always prevent this feeling: 'One thing that really tests my strength is answering my husband's constant questions. I know that the endless asking is caused by his condition, but I can't always bear it. Sometimes, it feels like nagging. But what can you do? Once a man, twice a child' (M16).

Some caregivers described their irritation at their care recipients' dependency and incessant need for help. The speech impediments of the stroke patients were sometimes depicted as wearing. The level of exasperation was heightened if daily life felt rushed. Some of the caregivers felt that they no longer had any rights and that their lives were dictated by their spouses' conditions. The writers also described frustration at not being able to stand up for themselves and at the fact that care work dominated their lives. The caregiving relationship and the situation of the family raised feelings of bitterness as both seemed unjust. As S39, the caregiver of a stroke patient, wrote, 'Sometimes, I'm just overwhelmed by a sense of anger. Why our family? Why our father? Will this ever end?' Difficulties in recognising exhaustion and the limits of one's resources were also causes of anger, and the caregivers were often late in identifying their need for rest

Table 5. Variation and classification of the encounters related to fear in the spouses' interactions

Encounter	Sub-classification	Main classification
Onset of care recipient's health problem (M2, M25, M29, M51, S36) Concern for care recipient's survival (S39) Managing at home after discharge from hospital (O6)	Beginning of the health problem	Downturn in care recipient's condition
Managing at home after a period in hospital due to a decline in the condition (O4) Care recipient's health crises (O19) Onset of new symptoms (S39) Concern about future decline in the care recipient's condition (S11)	Worsening of the care recipient's health problem or situation	
Care recipient's disruptive behaviour/changes in care recipient's behaviour (M1, O50, M51, O16)	Onset of disruptive behaviour	Changes in care recipient's behaviour
Concern about care recipient's ability to manage alone at home (O9, O10, M25, O16, O46)	Care recipient unable to manage alone	Decrease in care recipient's ability to cope independently

Notes: S = stroke; M = memory disorder; O = other health problem.

Table 6. Variation and classification of the encounters related to anger in the spouses' interactions

Encounter	Sub-classification	Main classification
Care recipient's jealousy (M28) Care recipient's unconventional behaviour (M2) Care recipient's excessive thriftiness (M16) Care recipient's threatening behaviour (M51)	Care recipient's behavioural changes associated with the memory disorder	Effects of the health problem on the care recipient's behaviour
Care recipient's constant questions (M16) Care recipient living in the past (M2)	Problems related to the care recipient's memory disorder	
Dependency and helplessness of the care recipient (S8, O9, O15) Constant assisting with dressing (S11)	Care recipient's continuous need for assistance	
Life ruled by the health problem (S42) Sense of hurry in caring (S12)	The health problem determines every aspect of life	The care recipient's problem consumes all the resources of the caregiver
Caregiving exceeds one's resources (O9) Inability to defend oneself (O50)	Exceeding one's resources	
The start of the problem brings a sense of unfairness (M51) Feelings of bitterness in daily life (M2) Hating the family's and care recipient's circumstances (S39, O49)	The unfairness of the situation of the care recipient and the family	Sense of unfairness in life

Notes: S = stroke; M = memory disorder; O = other health problem.

Guilt

In the stories, the caregivers described emotions of guilt. For example, this feeling was generated by situations where their resources and the needs of their spouses were in conflict or imbalanced (Table 7). As one caregiver put it, 'Whether you do this or that, you always have a bad conscience' (O26).

Table 7. Variation and classification of the encounters related to guilt in the spouses' interactions

Encounter	Sub-classification	Main classification
Tiredness and exhaustion of the caregiver (O9, M26, M31)	Caregiver tiredness	Caregiver's diminishing resources and efforts to maintain them
Putting the care recipient into short-term institutional care or hospital (M3, M29, S41, S42)	Managing one's resources	
Conflicting decisions that must be taken in care work (O9)		

Notes: S = stroke, M = memory disorder, O = other health problem.

The caregiver's infirmity could also cause feelings of guilt. Some of the writers felt guilty for decisions they had to make to safeguard their own physical and psychological well-being, and they were troubled by these decisions for a long time, which was very draining: 'Even today, I still feel guilty for the choices I had to make to stay alive physically and psychologically. I have done my best, and no one can ask more than that' (O9).

When the caregiver needed time to rest but the care recipient did not want to leave home, their wishes could come into conflict. The caregivers sometimes felt that they had not done enough and that by doing more, they could have avoided putting their spouses into short-term institutional care and creating dissatisfaction. Some of the writers also felt guilty for admitting their tiredness when they compared their relatively good health to that of their care recipients.

Strengths and limitations

The strength of this study lies mainly in the careful analysis of the data. The criteria for entering the stories in the competition placed significant emphasis on providing real-life accounts. Based on our examination, the writers crafted very genuine depictions of their lives, which made it possible to identify the whole spectrum of emotions involved in caring.

The emotions, as well as the encounters that they were associated with, were identified from the stories. Then, they were numbered according to the numbers assigned to the caregivers, and the numbers were entered into Tables 1–7. This allowed us to check the interpretations made during the analysis.

After the first inductive phase of the analysis, the results were still unclear. A modified version of the BES (Finucane et al., 2012) was used to identify and interpret the expressions of emotions. This made it possible to study and classify the encounters to which the emotions were connected. The data were also compared to the literature, which allowed us to further develop our interpretation. Previous studies conducted in a variety of countries strongly confirm our results. Peer debriefing was used to check the research process and the interpretations (McLeod, 2024). Prolonged engagement was realised thanks to our long experience of conducting research and working on caregiver issues (QDAcity, n.d.). In addition, one of the authors of this article had personal experience as a spouse caregiver, which brought a realistic viewpoint to our understanding.

One limitation of the analysis was that it was not possible to identify more complex emotions. The data could have been strengthened with interviews, but this was not possible given the design of this study. In addition, the main limitation of the study was that the stories were collected in 1996. Since then, certain aspects referred to in the stories, such as social services support, have changed. However, we focused on emotions and the daily encounters associated with them, which represent individual caregiving experiences that are independent of time. The literature supports this interpretation. The stories are full of details about the encounters between caregivers and care recipients, and this kind of information is lacking in other studies. Further, our analysis increases scholars' understanding of the impacts of caregiving on the well-being of caregivers, and it will help to find new ways of supporting caregivers. Finally, it was ethically reasonable to use secondary data, and this was done in compliance with ethical principles (Finnish National Board on Research Integrity, 2019).

Discussion

Emotions offer a good way to look at caregivers' well-being in everyday life. As already mentioned, their emotions give us important information for understanding the coping challenges involved in caring. Social and health-care professionals should be aware of the meanings of these emotions, as well as of the encounters in which they arise. This makes it possible for them to help caregivers going through difficult moments and promote their inclusion and well-being, thereby preventing their social exclusion. The emotions in question offer professionals important information about the challenges that arise in the everyday encounters between caregivers and care recipients (Monteux and Monteux, 2020). Professionals play a key role in finding means to address these challenges in cooperation with caregivers. Caregivers also need this information for self-directed learning.

Table 8 summarises the findings of this study. The positive emotions were associated with encounters such as good moments in the care recipients' daily lives, the care recipients' satisfaction with the care they received, the time spent with their partners and families, and the appreciation of caregiving.

Table 8. Main classification of the encounters related to the emotions stemming from the spouses' interactions

Happiness	Sadness	Fear	Anger	Guilt
The good moments in the care recipient's daily life	Losing the healthy spouse	A downturn in the care recipient's condition	The effects of the health problem on the care recipient's behaviour	The caregiver's diminishing resources and the efforts to maintain them
The care recipient's satisfaction with caregiving	Losing the partnership	Changes in the care recipient's behaviour	The care recipient's health problem consumes all the resources of the caregiver	
Time spent with spouses and together as a family	Losing shared family life	The decrease in the care recipient's ability to cope independently	The sense of unfairness in life	
Appreciating caregiving	The final loss of the spouse			

Our findings are strengthened by studies in which caregivers have been described as experiencing the meaningfulness of caring as well as emotions of gratitude, pleasure and satisfaction (Quinn et al., 2010; Turner and Finch-Guthrie, 2020; Wilkins et al., 2020). The identified positive emotions included experiences of personal growth, such as valuing close relationships and appreciating caregiving. Research has shown that positive emotions affect many cognitive, social and biological processes, and they help people to develop personal strengths as well as cope with stressful situations (Fredrickson, 2001; Fredrickson and Cohn, 2010).

According to our results, experiences of sorrow were associated with the many losses that occurred in the caregiver's daily life, including when the spouse's functional abilities declined or when the relationship or expectations for the future changed. The literature supports the connection between the caregiver's sorrow and the gradually changing relationship with the care recipient, loss of future plans, altered work patterns and changing social relations (Champlin, 2020; Dempsey et al., 2020; Holley and Mast, 2009; Marwit and Meuser, 2002; Noyes et al., 2010). In the present study, the losses described by the caregivers were related to crucial, even existential, aspects of personal life. The loss of a healthy partner, intimate relationship or shared family life throws one's existence into doubt. However, the sorrow

and mourning associated with these changes can open up experiences of growth for caregivers, such as a new appreciation of human relationships and the meaningfulness of shared moments (Tedeschi and Calhoun, 2004). Too many caregivers are forced to bear the burden of sorrow without sufficient social support. According to McGinley and Waldrop (2020), families are more likely to feel emotionally prepared for loss and grief when health-care and social care professionals can meet their needs, communicate compassionately and give consistent information.

Fear reminds caregivers of potential threats; in this sense, it is protective (Öhman, 2010). In our study, the caregivers spoke about their fears, concerns and anxieties. These were described as occurring both at the early stages of the health problem and as the condition progressed. Fear could also be a consequence of the spouse's behavioural changes, as well as their diminished ability to cope.

Anxiety and irritation have also been reported in the relevant literature (Cooper et al., 2008; Croteau et al., 2020; Glendinning et al., 2009; Queluz et al., 2020; Ramazan et al., 2019; Robinson et al., 2005; Sennfalt and Ullberg, 2020). The future health of the care recipient or the risk of recurrence of the health problem (Cervantes et al., 2020; Prado et al., 2020), as well as the possibility of losing relationships, hobbies and friends, can all cause fear (Bachmann, 2020; Bannon et al., 2020; Chua et al., 2020). As a result, caregivers may begin to view life as dangerous and frightening (Robinson et al., 2005; Öhman, 2010). Therefore, professionals should strive to find ways to support the mental well-being of caregivers. For example, understanding the symptoms and stages of the care recipient's health problem can reduce the irritation experienced by the caregiver.

Anger occurs when one's goals are frustrated (Finucane et al., 2012). In this sense, then, this emotion reveals the caregiver's needs (Lemerise and Dodge, 2010). Our findings show that hate and irritation were associated with a sense of injustice felt at the beginning of the caregiving, at the spouse's disruptive behaviour or at their constant need for help. The literature supports this evidence (Ramazan et al., 2019; Sennfalt and Ullberg, 2020; Tooth et al., 2005). The caregiver's irritation at the spouse's inappropriate or unpredictable behaviour can serve as a defence for the caregiver against the spouse's unjust accusations. Furthermore, frustration and irritation can help caregivers pay attention to and seek support for their needs and tiredness (Day and Anderson, 2011). These emotions reveal the caregiver's need for rest, and they can guide professionals in finding workable solutions for this problem.

Feelings of guilt can be heightened when caregivers who are striving to fully attend to their spouses feel that their efforts are unsuccessful (Lewis, 2010). In the stories we examined, guilt was described in encounters in which the caregiver's resources and their spouse's needs were in conflict or imbalanced. The caregiver's fatigue, as well as putting the spouse into short-term institutional care or hospital, caused guilt. Many scholars have found feelings of guilt to be common among family caregivers (Bris, 1993; Glendinning et al., 2009; Losada et al., 2018). Guilt especially increases when the care recipient moves into institutional care (Gaugler et al., 2008; Nolan and Dellasega, 2002). The literature also indicates that guilt is frequent in encounters where the needs of the caregiver and those of the care recipient are in conflict (Bris, 1993; Gallego-Alberto et al., 2020). These are difficult moments for caregivers, and empathic professionals can suggest ways of dealing with them. It is important to encourage caregivers to take care of themselves and value the care they provide or have previously provided.

The stress-coping paradigm has a long history in family care (McLennon et al., 2011; Pearlin et al., 1990). However, our study underscores the need to widen its scope. An existential paradigm that highlights personal growth and resources should be adopted. This emphasises values, moral decisions and the personal ability to find meaning in challenging life situations. By combining the existential (Farran, 1997; Farran et al., 1991), growth (Joseph and Linley, 2006; Manne et al., 2004) and personal-strength paradigms (Antonovsky, 1985, 1993; DiBartolo and Soeken, 2003; Jones et al., 2011) with the stress-coping paradigm, we can achieve a wider interpretive framework.

Fredrickson and Cohn (2010) have compared the meaning of positive emotions to that of negative ones, arguing that the former pertains to building a 'good life'. The meaning of these emotions can be explained by using Fredrickson's (2001) broaden-and-build theory, according to which positive emotions increase personal resources (for example, social support, skills and knowledge), thereby improving one's ability to cope with life challenges. At the same time, Fredrickson and Cohn (2010) have highlighted that it is not necessary for people to experience positive feelings all the time and that such feelings should not be considered a panacea. They say that it is useful to frequently experience positive emotions in life; however, depending on the context, one should react positively or negatively to emotionally meaningful situations.

More research is needed into ways of supporting caregivers through the inevitable challenging emotions and losses that they will face with regard to meaningfulness and success in caring. This could be achieved by encouraging dialogues between professionals and caregivers in individual and group sessions (Mündel and Schugurensky, 2008).

In this article, the social pedagogical perspective primarily refers to the conceptual foundation and structuring of research. By supporting positive emotions and experiences of growth, one can come close to a social pedagogical approach where the goal is to support personal and social growth in everyday life (Hämäläinen, 2012; Eriksson, 2014; Nivala, 2019). The social pedagogical perspective offers an opportunity to consider the needs of caregivers, promote inclusion and achieve personal growth. Emotions serve as key markers of well-being and important life changes. They are also important indicators of what needs special attention in caregiving. Social pedagogy could create tools to discuss and support personal growth based on these key markers in everyday encounters. These tools could include, for example, instructions for engaging in a reflective dialogue with the caregiver starting from emotions and developing new, more positive perspectives on difficult encounters in caregiving as well as group-based activities intended to increase well-being and experiences of growth. With the tools it would be possible to support caregivers' personal growth and well-being in terms of self-directed learning as well as educational support from professionals. For example, social workers, home care workers, therapists, doctors and nurses can take advantage of the social pedagogical way of thinking when they support caregivers in their own work.

The focus of this article concerns the personal growth of caregivers, especially through informal learning. However, the information presented can also be applied to the statutory formal support and semi-formal support provided by caregiving associations. The cross-cutting factor is the social pedagogical way of thinking that emphasises the social basis of human growth and upbringing, which covers formal, semi-formal and informal support for caregivers (Hunter, 2020; Hämäläinen, 2015; Nivala et al., 2022).

The article brings a special perspective to the development of the theory and practices of social pedagogy, emphasising the importance of emotions in personal growth and education. The opportunity for personal growth offered by family caregiving is a suitable area of human life in which to study social support in terms of emotions. Social pedagogy, as a way of thinking that emphasises the social nature of education, provides an appropriate conceptual framework for research.

Declarations and conflicts of interest

Research ethics statement

The authors conducted the research reported in this article in accordance with the ethical criteria defined by the Finnish National Board on Research Integrity.

Consent for publication statement

The authors declare that the writers' informed consent to publish their stories was secured prior to publication. All the stories were anonymised, and any identifiable information was changed.

Conflicts of interest statement

Juha Hämäläinen is an editorial board member of this journal. All efforts to anonymise the authors of this article for peer review were made. The authors declare no further conflicts with this article.

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