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Women Caregivers: An Asset of the Family

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Abstract

Family caregivers have changed during the past two decades, reflecting national trends as well as greater option for care. The four most recent national long term care surveys and three national house hold caregiver surveys conducted in collaborations with AARP14 revealed some relatively consistent trends in family life over the past 20 years. Men have taken on more care giving responsibilities although women still make up more than 60% of care givers. Like the general population caregivers families have become more diverse racially and ethnically. Fewer caregivers are married than those 20 years ago, and fewer are caring for a spouse. Care giving is most likely to be done by one person, and caregivers generally have less time for family.

Keywords: Woman; Informal Caregiver; Family; Elderly.

Introduction

Four decades of scholarship and changing public policies of family and informal care giving for older adults have brought us far, but we have far yet to go. Many issues and concerned rose long ago continue to confront us today as a result of their complexities and the l imitations of scholarships and public policy on this important issue.

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Informal caregivers devote much of their lives to caring for someone they love, often at great cost to their own health and well being. Defined as individual who provide the majority of unpaid help for a relative or friend, informal caregivers report relationship and financial difficulties, decrease in social support and leisure time, and carrier and family disruption. Moreover compared to non caregivers, they tend to have poorer physical health impaired immune functioning exacerbation of medical condition and elevated levels of depressions and anxiety. These negative effects have been documented up to three years after the cessation of care giving. Three steps were used to locate studies on religiousness and religious copying among informal caregivers, defined as those who provide the majority of unpaid care e.g.

Physical care, emotional support, household tasks for kin and friends suffering from a variety of illness and disabilities e.g. Alzheimer's patients, terminally ill, disabled children.[2]

This study reports on the topic of why daughters becomes primary care to frail and ageing parents and what factors contributes to the current genders imbalance in care giving in Ireland. using a qualitative approach , in depth interviews were conducted with a simple of (1) current carers, (2)ex- carers, (3) non carers. Results shows that for most of the women in the sample , care giving was not a consciously adopted role but rather was one that was taken on incrementally , generally in the absence of any family discussion. Findings showed that men's involvement in the care role

tended to be peripheral and this lack of men's commitment to care giving was seldom questioned by either daughters or parents.

These study findings raised that about current gender attitudes to caregivings and the future willingness of women to provide round the clock care to their frail ageing parents. Throughout the western world family caregiving remains a gendered issue with women significantly outnumbering men in care roles. Although some studies show that male involvement in care roles is greater than had been previously thought the higher proportion of male carers generally entails older men looking after ageing wives. When husband and wives share the care of an ageing parent at home, men are said to average 8 minutes a day, while women 139 minutes.[3]

The data on which this study is based come from a 1990 study of family care giving of the elderly and a 1996 exploratory study of the role of male caregivers. The data for the 1990 study was collected largely in Shiga Prefecture through a mail survey (n=75) of people who attended a week long international forum on civil participation in social welfare. This non-random survey was supplemented by observations and interviews with 18 public health officials, community service providers, and journalists interested in social welfare issues (Harris and Long 1993; Long and Harris 1997). The 1996 study was based on interviews with 16 husbands and sons in the Kansai region who were caring for a frail and/or demented family member. The interviews were in Japanese and lasted 1-2 hours. The men in the study were referred by home health nurses, private physicians, a senior centre, and a dementia assessment center. The interview guides had been used successfully with an American sample of husbands and son caregivers (Harris and Bichler 1997), and were discussed at length with a Japanese social worker/researcher to assess the guide's cultural relevance (Harris, Longand Fujii 1998). These results were supplemented by discussions with family members of severely ill patients in a 1996 participant-observation study of end-of-life decision making in three hospitals and several home care settings in Japan.' In this paper, we take a broad perspective and contemplate the significance of gender for care giving and its relationship to social change in Japan.[4]

Social Responsibility

In societies around the world, when people become ill and need assistance in daily living, the majority of caregiving is provided informally by family. Most often, this has meant that women have become the unpaid home helpers, nurses, and companions to frail, elderly spouses and parents. In Japan, Confucian ethics point to the responsibility of sons, especially eldest sons, to care for elderly parents, but historically this has been translated from the abstract ethic of filial piety into the concrete day-to-day care giving tasks actually performed by the daughter-in-law (the wife of the eldest son). This represents for some people the 'traditional' ideal, based on the following prerequisites:

1. The existence of a married son
2. Tthe continued co-residence of the son and his wife with his parents after marriage; and
3. The daughter-in-law's labor being centered around household production, as in farm or shop-keeping families, and/or secondary to that of her husband and thus dispensable when caregiving needs arise. The ideal also assumes that
4. These daughters-in-law are willing, or at least have no other option but, to take on this role. However, each of these prerequisites for achieving the Confucian-inspired ideal is being challenged by the realities of demographic, economic, social, and value changes in post-World War II Japan.[5]

When a woman becomes a caregiver of an elderly relative, she is in many ways carrying on other roles she has performed over her life course. Numerous women in our studies have cared for multiple elderly relatives (Harris and Long 1993, 1999; Harris, Long and Fujii 1998; Long and Harris 1997). One in her late 30s, for example, told us that she had cared for her father-in-law for 41 days before he died from a heart attack. Ten years previously, she had cared for her 94-year-old grandmother-in-law, who had broken her hip and become demented. Despite more flexibility in gender roles in recent years, most women continue to perform the majority of household tasks and are the primary caretaker of children. They are more likely than their husbands to have cared for ill children or other relatives, and are more likely to have a job that involves these skills, for example, domestic service, nursing, or food service. Furthermore, society expects women to have such skills because of their female genes or their life experiences.

As they are growing up, girls are explicitly taught the skills and attitudes needed to be nurturers and caregivers to family. In contrast, for men, caregiving most often means moving into uncharted territory. In particular, the husband caregivers in our 1996 study were challenged to learn new skills in their later years, a source of both stress and pride. Japanese husbands emphasized that they had to learn how to do tasks their wives had performed previously, such as housekeeping, cooking, shopping and laundry. In some cases, nearby daughters or daughters-in-law assisted them. Despite the physical hardship of getting the impaired elderly person in and out of deep Japanese bathtubs, the Japanese men surveyed seemed more comfortable with bathing their wife or parent than with some of the other tasks, perhaps because bathing together had been more a part of their pre-caregiving experience than cooking and cleaning. Most of the men took seriously the need to acquire skills to make their wives physically comfortable, including sponge bathing, turning, feeding and toileting.

They learned these skills informally, through trial-and-error, practice, and advice from health professionals, female relatives and home helpers. A few local governments in Japan have begun to offer adult education classes on homemaking for men (Jenike 1997: 334), but none of the men in our sample had participated in these programs. Several had

joined support groups for families of demented elderly, which offered a forum to discuss problems with sympathetic others.[6]

Geographical Trends

It is necessary to stress that the increasing need for family caregiving in the United States is not only the consequence of inexorable demographic trends. The view of the federal government today is that the United States cannot afford the high cost of institutional care for the growing elderly population. Public policies thus seek to shift more of the burden of long- term care on family members. Since 1983, hospitals have been encouraged to discharge elderly patients earlier and a variety of measures have limited the use of nursing homes. These policies are based on the assumption that relatives of the frail elderly can easily provide any care that is necessary. But several developments may weaken the caregiving network. As the age of the frail elderly population rises, caregivers also are growing older. One recent study found that a third of all caregivers of the disabled elderly have health problems which restrict their own lives. Another factor which has additional consequences is delayed childbearing. For example, an increasing proportion of American women are waiting until their thirties and even forties to have their first child. Some observers worry about the problems of middle aged women who have to care for small children and elderly parents at the same time. The steep rise in the divorce rate in the U.S. also may weaken the informal support system. A decreasing proportion of elderly people have partners to whom they can turn for assistance. Single women raising children while working full-time may have little time to take care of their aging parents' needs.[7]

Caring for someone with advanced illness is fraught with hazards and opportunities. The impact of caregiving on health and well-being varies widely. Most who do so are motivated by love and concern. Giving to others can be very rewarding. It can also be very stressful. Many factors determine the extent to which caregiving is a burden and a blessing. Among these are the length and intensity of caregiving, the nature of the relationship with the person needing care, the amount of psychological, social, and physical support provided to the caregiver, the presence of professional caregivers, and the self-perception and emotional health of person.

The optimal period of caregiving appears to be months rather than years. Most of us can muster the inner resources to devote ourselves to the needs of some- one we care about for a distinct period of time. But when caregiving responsibilities are considerable and no end is in sight, we feel more strain. This stress is both physical and financial. Over one-third of terminally ill patients have substantial care needs.3 Long-term, open-ended caregiving is often characteristic of the needs of the chronically ill with advanced skills.

How much support is needed to take care of a person in the final phase of illness? Those leaving the hospital have had the advantage of pharmacy services, transport aides, all the special supplies from a hospital bed right down to special cleansers, "24/7" surveillance and monitoring by a variety of nursing staff, dietary services, maintenance, housekeeping, and so on. We send people home who are very sick and do not make the correlation that an untrained person or family will have to do the work of an entire hospital staff. If they are fortunate, they will get hospice care or a limited "prescription" for home health care, which may come after they have already been providing care for a long time.[8]

Caregiving to family members comprises a major part of familial obligations in the United States. Informal caregiving is unevenly distributed in society, with women performing most of the work and bearing the burden of its costs. This paper addresses the cost dimension of informal caregiving to family members by examining whether and how it penalizes women's employment. Drawing data from the 1987 and 1992 National Survey of Families and Households, we examine whether and how caregiving transitions affect changes in women's labor force participation and the implications of this caregiving transitions for their earnings. We calculate how these effects vary for demographically different groups of women: those older and younger, with and without high levels of education, and married and not married. Our findings reveal that for most women, the initiation of caregiving led to a substantial reduction in their weekly hours worked and annual earnings. However, the effects were different for various subgroups of women: those older, with fewer skills, and more competing roles paid substantial costs if they began caregiving between 1987 and 1992.

In the last 15 years, many studies have examined effects of informal care to aging family members on women's employment (see, for example, Dautzenberg et al. 2000; Doty et al. 1998; Ettner 1995a, b; McLanahan & Monson 1990; Moen et al. 1994; Pavalko & Artis 1997; Wolf & Soldo 1994). Findings from these prior studies are mixed. Some have shown that caregiving reduces women's labor force participation. For example, using the 1989 Informal Caregivers Survey, Doty et al. (1998) reported 54% of employed female primary caregivers rearranged work to manage conflicts between caregiving to the elderly and their own employment.

Using the 1987 National Survey of Families and Households (NSFH), McLanahan and Monson (1990) found that caregiving lowered married women's chances of being employed and hours worked for pay, but did not affect male caregivers' employment. Furthermore, Boaz and Muller (1992) reported that women caregivers were more likely than men caregivers to initially seek part-time arrangements. Women's working part-time often means lower earnings and no fringe benefits, although once part time work was arranged, caregiving did not affect women's hours worked (Boaz & Muller 1992). Relying on data from the 1984 and 1987 National Longitudinal Surveys of Mature Women, Pavalko and Artis (1997) examined the causal relationships between women's caregiving and paid work, and found that women's employment status did not affect their decisions about whether they became caregivers.

Studies Recommendations

However, once women started care giving, they were more likely to reduce their hours worked for pay or to leave the labour force. In addition, terminating caregiving did not increase their hours worked, suggesting difficulty with recovering the employment losses experienced by women in midlife (Pavalko & Artis 1997). Other studies have reported no effect of caregiving on women's employment. Wolf and Soldo (1994) found no significant effect of caregiving to parents on married daughters' hours worked for pay. Moen et al. (1994) found that caregiving did not interrupt women's labor force participation. When women were both workers and caregivers, they were more likely to stop caregiving than to leave the labor force (Moen et al. 1994). Using a probability sample in the Netherlands, Dautzenberg et al. (2000) also found that parent care did not affect daughters' employment, but employment did reduce the chances of becoming a caregiver to their parents. Although initiation of caregiving led to significantly greater declines in women's employment and earnings, stopping caregiving did not permit women to recover from these losses.

Although this finding may be related to peculiarities of the small number of women who stopped caregiving (approximately four percent of the 2638 women in our sample), it may also signify obstacles to women's employment. This idea is consistent with Pavalko and Atis (1997), who found that middle-aged women's employment prospects are particularlyvulnerable after informal caregiving ends.

Middle-aged women maybe unable to re-enter the labor force or increase their working hours because they begin to experience their own health problems or because they experience age discrimination in the workplace, or both. Despite women's substantial losses due to assuming the role of caregiver, informal caregiving is still not recognized as a public concern. In part, this reflects the fact that many assume women's unpaid full-time labor is still available in U.S. households (Harrington 2000) and that U.S. welfare policies often assume women provide caregiving services to family members (Folbre 1994). Despite these assumptions, approximately three-quarters of women aged 35- 54 years were employed (U.S. Bureau of Labor Statistics 2003a) and less than 15% of all families fit the traditional model of husband as breadwinner and wife as homemaker in 2000 (U.S. Bureau of Labor Statistics 2003b). These patterns suggest a declining pool of women available to provide free caregiving labor.

Aim of The Study

The aim of the present paper is focusing on the woman caregivers who are taking care to their aged family members and thinks that taking care of them is their moral obligation and responsibility.

Conclusion

Given the rapid aging of the population, it appears the demand for family caregiving is on the rise precisely when the supply of free labor is shrinking. Solutions to this problem are not straightforward. Evaluating caregiving costs paid by women caregivers is certainly a first step, but what is really needed is a system of family supports that assists caregivers and their recipients, and treats family caregiving as a public concern (Folbre 1994; Harrington 2000; Mellor 2000; Tronto 1993). The Family and Medical Leave Act enacted in 1993 was a first step, but the family leaves that it permits are not paid (Harrington 2000). Offering tax credits to individuals who have purchased long-term care insurance may be another form of governmental support (Mellor 2000). Because the impact of caregiving appears more severe for older women and those with less education, welfare options in some form may be considered for these low-income caregivers (Harrington 2000; Mellor 2000)[9]

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