

# **Balancing Paid Work and Caregiving Responsibilities: A Closer Look at Family Caregivers in Canada**

**By**

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## Executive Summary

A caregiver can be defined as:

an individual providing care or assistance to a family member in their home or the care recipient's home who has a physical or mental disability, is chronically ill, frail, or at the end of life.

The research initiative described in this report seeks to increase our understanding of what it means to be an employed caregiver in Canada today. "Employed caregivers" is defined as a caregiver who is employed full time but also provides caregiving to family members. Specifically, this research has two main objectives:

- To increase our understanding of the issues and challenges facing employed caregivers in Canada; and
- To identify the kinds of support key stakeholders in this relationship (i.e. the dependent, the family, organizations and governments) could offer to the employed caregiver to facilitate performance of this role.

To meet these objectives, we conducted two major research studies, one quantitative, the other qualitative. The quantitative study involved original empirical analysis using data collected for the National Work, Family and Lifestyle Study conducted in 2001 by the research team of Dr. Linda Duxbury and Dr. Chris Higgins and funded by Health Canada (n = 32,800). The qualitative study involved in-depth interviews with 30 employed caregivers.

The quantitative study involved a comparison of four groups of Canadian employees:

- No caregiving: Employed Canadians who do not spend any time in childcare or eldercare.
- Parents: Employed Canadians who spend time each week in childcare but do not have eldercare responsibilities.
- Elder caregivers: Employed Canadians who spend time each week in eldercare activities but do not spend any time in childcare.
- Sandwich group: Employed Canadians who spend time each week in both childcare and eldercare activities.

The size of our data set allowed us to further subdivide the eldercare and sandwich groups into three subgroups based on the location of the elderly dependent: elderly dependent living with respondent, elderly dependent living nearby (i.e. a short drive), and elderly dependent living elsewhere.

The qualitative study was done to get a better understanding of the role of employed caregiver (i.e. what employed caregivers do, why they do it, the joys and pressures of assuming the role of employed caregiver, and the kinds of support key stakeholders could offer to the employed caregiver to facilitate performance of this role). This study included 30 semi-structured interviews with a sample of employed caregivers. To be included in the interview study, the caregiver had to have been actively caregiving for at least six months prior to the study, caring for someone in their

own home or the home of the care receiver, and be actively employed for at least 10 hours per week. Caregivers providing care to individuals in hospitals or living in a nursing home, supportive housing/assisted living facility, group home or shelter were not examined in this study.

Key findings from both these studies are provided below. Please note that unless noted, the findings below come from the survey data.

### ***One in four employed Canadians care for an elderly dependent***

The following conclusions with respect to caregiving were supported by the quantitative data:

- The majority of employed Canadians also have caregiving responsibilities.
- Just over one in four (27.8%) employed Canadians have responsibilities for the care of elderly dependents – a percent that, as noted earlier, is likely to grow as the baby boom population ages.
- Almost one in five (16.8%) employed Canadians have responsibility for both childcare and eldercare (i.e. they have dual demands at home and demands at work).
- Only rarely do employed Canadians provide care to an elderly dependent who lives with them (the data would suggest that approximately 1.3% of the workforce is in this situation).
- Just over one in 10 Canadians provide care for an elderly dependent who either lives nearby (12.7%) or in another location altogether (9.7%).
- Twice as many employed Canadians have childcare responsibilities (54.2%) than responsibility for the care of an elderly dependent (27.8%).

### ***Caregiver group membership is associated with life cycle stage***

Our analysis allowed us to create a demographic profile of the various groups considered in this study.

- Employees in the no caregiver group are younger (i.e. under 35), single men and women who live in larger communities. They have higher personal incomes and are more likely to say that for them money is not an issue and that they have money for extras. At work, employees in the no caregiving group are more likely to perceive their manager as being supportive and report higher levels of flexibility with respect to their hours of work.
- Employees in the childcare only group are married men and women (this is the only group in which we had more male respondents than female respondents) between the age of 35 and 45 who, despite the fact that their personal incomes are higher, are more likely to say that money is tight in their family or that they are okay for money but do not have money for extras. They are more likely to live in smaller communities. One in three in this group have children under the age of five at home.
- Employees in the sandwich group are more likely to be older (45 or greater) men and women who live in smaller communities. One in three of the individuals in this group say money is tight in their family, which is consistent with the fact that one in three have lower (i.e. \$39,000 or less) personal incomes.

- Employees in the eldercare only group are more likely to be older, unmarried females without children. That being said, it is interesting to note that one in five in this group are single, childless women under the age of 35. The women in this group tend to have lower personal incomes but, paradoxically, are more likely to say that money is not an issue. This paradox can be explained by the fact that although their incomes are lower, so are their costs (i.e. they do not have children). Individuals in the eldercare group are more likely to live in larger centres.

### *Caregiving is a labour of love*

The following conclusions with respect to caregiving were supported by the qualitative data:

- Consistent with previous research in this area, the majority (75%) of employed caregivers in our sample are middle-aged women who combine paid employment with the care of an elderly parent who has a chronic health problem. The average age of the individual receiving care was 76.7 years.
- Employed caregiving takes many forms. While a majority of the employed caregivers in our sample cared for one family member, a substantive number (14%) had responsibility for the care of both of their parents and one in four were women who had combined paid employment with the care of a spouse/partner in their 50s or 60s who was in poor health.
- Eldercare does not appear to be a transitory condition, as the average caregiver in this sample has been performing this role for almost five years.
- For most people (57% of this sample), caregiving is a “labour of love” (i.e. the individual wants to/chooses to care for their family member because they love them). For a substantive number of employees (40% of this sample), however, this is a role they take on because “there is no one else who can do it.”

### *Employed caregivers have two full-time jobs*

The demands placed on employed caregivers are onerous. The majority of caregivers in the interview study “work” the equivalent of two full-time jobs: they spend an average of 36.5 hours per week in paid employment and 34.4 hours per week in caregiving (30.3 hours per week providing care and 4.1 hours per week commuting because of caregiving commitments).

The distribution of work/caregiving demands faced by employed caregivers is bi-modal. While a substantial portion (37%) of the respondents commit 40 to 60 hours per week to their dual roles, almost one in four spend more than a 100 hours a week fulfilling work and caregiving obligations. Work/caregiving demands are strongly associated with the caregiving arrangement. Those who provide care for an elderly dependent in their own home have more demands on their time (heavy caregiving demands, moderate to heavy work demands) than those whose dependent lives on their own.

This study shows that there is a trade-off in demands that is associated with where the person requiring assistance lives:

- Those who care for a dependent in their own home spend less time in care-related commuting and fewer hours in paid employment but more time in care and have higher work/care commitments overall.
- Those whose dependent lives on their own spend more hours in care-related commuting and more hours in paid employment but fewer hours in care and have fewer work/caregiving commitments overall.

### ***For many, the role of caregiver is emotionally draining***

Employed givers spend the majority of their care time (68%) performing two caregiving roles: providing physical care and offering emotional support. The typical caregiver in the interview sample spends just over 13 hours per week in physical care and eight hours in activities associated with support. In addition, they spend an average of four hours per week in personal care, two hours in nursing, and four hours in activities associated with co-ordination.

A majority of respondents identified emotional support as the most stressful dimension of their caregiving role because they found this role mentally exhausting and upsetting at the same time.

A substantive number of respondents identified the co-ordination role as the most stressful part of employed caregiving – even though the time devoted to this role is much less than that given to physical care. This suggests that the stresses associated with employed caregiving are not simply a function of the amount of time spent in the role but instead are related to the amount of control one has over the role.

### ***Employed caregivers at risk of experiencing high levels of caregiver strain***

Employees who care for elderly dependents can be considered “at risk” of experiencing a particular type of work-life conflict referred to as Caregiver Strain. Caregiver strain is a multi-dimensional construct (physical, financial and emotional strain) which is defined in terms of “burdens” or changes in the caregivers’ day-to-day lives that can be attributed to the need to provide care. This research initiative allowed us to better understand the aetiology of each of these three types of caregiver strain.

### ***What do we know about financial strain?***

The following conclusions are supported by this study:

- Financial strain is not a significant problem for employed Canadians (moderate to high levels reported by only one in 10 of the survey respondents and 7% of those in the interview sample).
- Having children does not increase the risk that those with eldercare responsibilities will experience financial strain (i.e. 12% of those in the eldercare group and 10% of those in the sandwich group report moderate to high levels of financial strain).

- Employees who provide care for dependents who live near (but not with) them experience lower levels of financial strain than their counterparts who provide care for those who live elsewhere suggesting that employees who “care at a distance” incur more costs than those who have their dependents nearby (i.e. travel, phone). Both these costs do, however, pale compared to the costs associated with having your elderly relative live with you (highest levels of financial strain).
- High levels of financial strain are associated with poorer physical and mental health, greater work-life conflict, increased absenteeism, lower job satisfaction, a higher number of visits to the emergency room at the hospital, and reduced fertility. It is also interesting to note that moderate and high levels of financial strain are equally problematic for caregivers.

What causes financial strain? Living in a family with limited financial resources, very heavy and time-consuming caregiving demands (i.e. both respondent and spouse spend a high number of hours per week in eldercare), and lower levels of control (i.e. low perceived flexibility at work, dependent lives farther away from the caregiver or in their home). Examination of these data paint the following picture with respect to financial strain. First, employees who have to spend a lot of time in care have fewer hours to devote to work, which reduces their earning potential and increases the precariousness of their financial situation. Second, caregivers whose dependent lives with them or at a distance have more expenses (i.e. changing their house to accommodate their dependent, commuting, phone costs, out-of-town travel) than those who live a short distance from those they are caring for.

The interview study provided similar findings. It determined that financial strain has two causal factors: a decline in income (their role as an elder caregiver made it virtually impossible for them to work full time) and an increase in expenditures (had to pay for extra help, some living expenses, and medicines).

### ***What do we know about physical strain?***

Physical strain results from the physical effort required to provide care to an elderly dependent (i.e. lifting, cleaning). The following conclusions are supported by this study:

- Approximately one in three of the employed Canadians in both the interview and survey samples reported moderate to high levels of physical caregiver strain.
- Employees who provide caregiving for elderly dependents who live with them experience the highest levels of physical strain.
- Physical strain increases as the physical distance between elderly dependent and employee decreases. The fact that the difference between the “nearby” and “elsewhere” groups is relatively small (3%) does, however, suggest that distance from the dependent does not provide much protection against this kind of strain.
- Higher levels of physical strain are associated with poorer mental health, increased work-life conflict, and increased absenteeism due to eldercare problems. It is also associated with lower levels of family satisfaction.

- Physical strain is more problematic for those in the eldercare group than those in the sandwich group. Aside from the impacts noted earlier, high levels of caregiver strain are associated with poorer physical health, increased visits to the family physician and increased job stress for those in the eldercare group but not their counterparts with both childcare and eldercare.
- Physical strain has a different set of causal factors than financial strain.
- The main predictors of physical strain are distance (employees with their dependent living with them are at higher risk), gender (women have more problems than men), age (older employees have more problems than younger employees) and the families' financial situation (the lower the income, the greater the strain). In other words, these data indicate that older women whose dependent lives with them and cannot afford to purchase support and/or quit their jobs are at the highest risk of physical strain
- Interview respondents indicated that physical strain had two causal factors: the need to do a lot of heavy lifting when caring for the dependent and a lack of sleep.
- Both sets of data indicated that physical strain is largely caused by demands – the more time one spends in the role and the greater the responsibility one has in terms of caregiving, the greater the physical strain. To reduce physical strain, therefore, one needs to try and determine how best to reduce the amount of time that caregivers spend in caregiving activities.

### ***What do we know about emotional strain?***

Emotional strain is defined as feelings of being overwhelmed and worried about how one will cope. The following conclusions with respect to this form of conflict are supported by this study:

- Approximately one-quarter of the employed Canadians sample report moderate to high levels of emotional strain that can be attributed to the stresses associated with caring for an elderly relative.
- Employees who provide caregiving for elderly dependents who live with them experience the highest levels of emotional strain. Emotional strain is not, however, affected by whether or not the elderly dependent lives nearby or elsewhere. It would seem that with one exception (living with), emotional strain is due to the act of caring for an elderly relative, regardless of where this relative lives. People do not experience greater strain when the relative lives far away (i.e. this does not increase worry). Nor does their ability to easily visit/check on them seem to exacerbate or alleviate this strain.
- Employees in the eldercare group are more likely than those in the sandwich group to report high levels of emotional strain.
- Emotional strain is very strongly associated with poorer physical and mental health, increased work-life conflict, higher job stress, increased absenteeism due to eldercare problems and emotional fatigue, lower levels of family well-being and reduced fertility. With a few exceptions, the presence of children in the home made little difference in the strength of these associations.
- Having children at home seems to provide employees with elderly dependents at home some increased ability to cope with eldercare demands as employees in the sandwich group are less likely to report high levels of physical or emotional strain than are those with just eldercare.

While having children seems to help those in the sandwich group cope with strain when the dependent lives with the employee, it has no such salutatory affect when the elderly dependent lives elsewhere.

What causes emotional strain? Living in a family with limited financial resources, physically and emotionally heavy caregiving demands (i.e. respondent spends a high number of hours per week in care and has responsibility for care), lower levels of control at work (i.e. low perceived flexibility at work, the perception that family responsibilities limit advancement opportunities) and gender (women are more predisposed to experiencing this form of strain than men). Hours per week the respondent spends in care is five times more important to the prediction of emotional strain than any of the other predictors.

The perception that family responsibilities make career advancement difficult were unique to the prediction of emotional strain.

The interview study determined that emotional strain had three causal factors: role overload (too much to do, not enough time, exhaustion), uncertainty/worry (what does the future hold? how will they manage? are they safe?) and empathy (their stress becomes my stress).

### ***Challenges associated with caregiving***

The interview study provides a more personal picture of the challenges faced by those who provide eldercare.

At a personal level, virtually all the employed caregivers in this study stated that the need to balance work and eldercare had negatively affected their mental health (they were worried, anxious, stressed and depressed) and their physical health. One in four also said that the demands placed on them by these two roles meant that they had no time for themselves.

Caregivers indicated that they tried to cope with the stress of the role by engaging in a number of healthy coping strategies. The four most common coping strategies (each practiced by 28% of the sample) included looking after their own health by exercising and eating well, cultivating outside interests, joining a support group, and seeking professional help to cope with their stress.

The vast majority (80%) of caregivers also experience challenges that can be attributed to the person they provided care to. Specifically, caregivers have problems when the person they are caring for is difficult to communicate with (they are stubborn, very emotional, rude), depressed, find it difficult to deal with the reversal of the parent/child roles, and have deteriorated mentally/physically (i.e. Alzheimer's, dementia, can no longer walk).

Half of those providing care indicated that the person that they cared for did nothing to help them cope with their role as an employed caregiver. The others assisted by being positive, encouraging the caregiver to engage in other activities, and by being as self-sufficient as they could. What more could this person do to help? Accept care from someone other than the person currently providing care and agree to respite care.

Almost three-quarters of the employed caregivers noted that this role caused them challenges at home. Challenges identified by respondents included the fact that their family and home life suffered from a lack of time and/or energy, that they had to change the physical layout of their home to accommodate the elderly dependent, and that they worry over safety/emergency issues and a lack of home care.

One in three indicated that while their family was aware of the challenges they faced due to caregiving, they did nothing to help them cope with this situation. The rest noted that their family members helped them cope by providing concrete assistance with caregiving tasks (help around house, help provide care) and offering social support (visit, call).

One in three said that there was no more that their family could do “they are doing enough.” The rest requested that their family help by providing more respite care as well as visiting/calling more often.

Two-thirds of the employed caregivers indicated that their caregiving role had presented challenges at work. Specifically, one in three noted their performance at work had suffered because their caregiving role had depleted their time and energy, and that they had to reduce the number of hours they could spend at work/take time off/juggle time to deal with caregiving issues.

One hundred percent of the respondents indicated that their employer was aware of their caregiving situation, 90% said that their employer was providing support, and 60% acknowledged that the support they were receiving from their employer was great.

Respondents identified three things that employers were doing to help: they were sympathetic and understanding of the caregiver’s situation, flexible with start and end times, and gave time off when needed.

One in three of the respondents said that being an employed caregiver had not caused any challenges within their community. The rest noted the following challenges: difficulty finding affordable home or community care services and difficulty accessing community services.

While three-quarters of the respondents indicated that they had made their community aware of the challenges they were facing, almost half felt that the community had not responded. A plurality requested that their community provide more formal support in the way of services to assist those with eldercare and that their community offer some form of respite care

Half of the respondents said that the federal government did nothing to help them cope with the challenges associated with being an employed caregiver, despite their perception that the government was aware that this was an issue. One in four of the employed caregivers in this sample said that while government services to support elder caregivers existed, they had found that trying to find them/access them increased rather than decreased their stress.

What can the federal government do to support employed caregivers? The employed caregivers in this sample had a lot of requests including giving caregivers financial assistance, providing more formal support (i.e. wider variety of services, more respite care), making it easier for caregivers to find and acquire the support services they need, and being more flexible with respect to service qualification and coordination.

The survey data also allows us to look at the challenges faced by employed caregivers in Canada. In this case we are able to extend our analysis to also look at the consequences of caregiving on the key stakeholders in this paradigm: the employee, their family, the employer and Canadian society (operationalized as use of Canada's health care system).

### ***Canadians who combine work and caregiving (child and/or eldercare) pay a price.***

The survey data shows that Canadians who combine work and caregiving (child and/or eldercare) pay a price. Employees with no caregiving have fewer demands on their time than employees with caregiving responsibilities. They spend more time in leisure per week and have a good balance between work and family (i.e. report the lowest levels of role overload (45% high), work interferes with family (20% high) and family interferes with work (3% high) of any group). They are more likely to work for a supportive manager (51%) and enjoy relatively high levels of flexibility with respect to work hours and work location (40% high perceived flexibility). They report higher levels of job satisfaction (47% high), lower job stress (31% high) and are significantly less likely to be absent from work. It is also important to note that employees with no caregiving responsibilities are in better physical and mental health than their counterparts with child and/or eldercare. They make less use of Canada's medical system and are less likely to report high levels of stress (49% high), burnout (30% high), depressed mood (33% high) and more likely to report high levels of life satisfaction (43% high). Finally, employees with no children/elderly dependents report better circumstances at home. In fact, they report the highest levels of family satisfaction (72% high) and family adaptation (well-being) (46% high) in the sample. These findings indicate that Canadians who have children and/or assume the responsibility for the care of an elderly dependent pay a price at home, at work, and personally. They also suggest that employers (higher absenteeism and intent to turnover, lower job satisfaction and stress) and Canadian society (increased use of Canada's health care system) also pay a price when Canadian employees cannot balance work and caregiving demands.

### **Employed parents are relatively better off than their counterparts with eldercare**

While employed parents are relatively better off than their counterparts with eldercare (i.e. those in sandwich and eldercare only groups) – they still have substantive challenges that can be linked to the need to balance work and childcare. This group has a lot of demands on their time: their work demands are the highest in the study (over 45 hours per week), their non-work demands are substantive (33 hours per week) and they have relatively few hours per week to spend in leisure activities (8 hours). On the plus side, approximately half work for a manager who they consider to be supportive. More challenging is the fact that very few employed parents perceive that they have much flexibility with respect to work hours and work location (only 30% high). Not surprisingly, many of the employees in this group experience difficulties with respect to balancing work and family. Two forms of work-life conflict are particularly problematic for the

employed parents: role overload (60% have too much to do and too little time) and family interferes with work (13% say expectations at home make it hard for them to meet expectations at work). These findings are consistent with the lower levels of flexibility given to this group of employees. Furthermore, the data suggest that the need to balance competing family demands is having a negative impact on the families of employed parents as employees in this group are less likely to be satisfied with their families and report lower levels of family well-being (only 31% high).

While the work attitudes and physical and mental health outcomes of the no caregiving and childcare only groups are similar in many ways, areas where they differ are important to note. These include the fact that employees with children at home are more likely than those in the eldercare and no caregiver groups to miss work due to childcare problems and report high levels of stress (54% high). It should be noted, however, that the mental health of employees in the childcare group is better than those in the sandwich and eldercare groups.

### ***Employees in the eldercare group experience problems because of conflicting expectations***

Employees in the eldercare group also experience higher levels of work-life conflict. In this case, the increased conflict manifests itself as higher levels of role overload (60% high) and work interferes with family (39% high). Very few employees in the eldercare (6%) group experience family interferes with work. These findings are striking given the fact that those in the eldercare group spend fewer hours per week in paid employment and caregiving and more time in leisure (only the non-caregiver group have fewer non-work demands and more hours in leisure). It would appear that work-life conflict for those with eldercare is more a function of role requirements than the amount of time spent in work and non-work roles. This interpretation of the data is consistent with the fact that employees in the eldercare groups are in poorer mental and physical health than the employees in the other three groups. They are more likely to report high levels of stress (59% high), burnout (36% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37%). They are also more likely to seek care from other medical professionals (37% did so in a six-month period) and seek care from their family physician (58% did so in a six-month period).

The fact that employees in this group are also less likely to enjoy high levels of flexibility and less likely to perceive that their supervisor is supportive suggests that there is a basic disconnect between what the organization expects of the individuals in this group and what they are able to deliver due to the expectations they place on themselves and the expectations placed on them by Canadian society. The idea that there is a disconnect between work expectations and elder caregiving is consistent with the fact that employees in the eldercare group are more likely to report higher levels of job stress (38% high), lower job satisfaction, (42% high) and increased levels of absenteeism due to ill health (56%), eldercare problems (27% high) and emotional fatigue (39% high). In fact they have the highest level of absenteeism due to emotional fatigue of any group in the sample.

## **Those in the sandwich group experience real challenges “doing it all”**

Employees in the sandwich group face onerous demands at work and at home. They spend the same number of hours in work per week as those in the no caregiving group but also commit 35 hours per week to non-work activities (the highest in the sample). They also had the highest number of hours per week in work and family activities (79.2) and the fewest hours in leisure (7 hours per week). Given the onerous demands faced by the employees in this group, it was not surprising to see that they had the highest levels of work-life conflict in the sample: 67% of the employees in this group report high role overload, 39% report high work interferes with family and 15% report high family interferes with work.

Employees in the sandwich group receive lower levels of support at work and report more negative attitudes towards their employer. Those in the sandwich group are less likely to perceive that their manager is supportive (44% work for a supportive manager) and have the lowest levels of flexibility with respect to work hours and work location of any group in the sample (27% high perceived flexibility). They are less likely to be satisfied with their jobs (42%), more likely to report high levels of job stress (38% high) and more likely than those in the childcare only and no caregiving groups to miss work due to ill health, emotional strain and eldercare problems.

Also consistent with our expectations are the findings supporting the idea that employees in the sandwich group are in poorer health. Compared to those in the non caregiving and childcare groups, they are more likely to report high levels of stress (61% high), burnout (35% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37% high). They are also more likely to seek care from their family physician (57%) and to have medical tests (33%).

Employees in the sandwich group look very much like their counterparts in the childcare only group when it comes to family outcomes. They are more likely than those in the no caregiving and eldercare groups to report high levels of family integration (i.e. greater stability of family unit; ability to participate with family in joint functions and activities) (33% high) and less likely to report high levels of family satisfaction (57% high) and family adaptation (i.e. well-being) (29% high) than those in the no caregiving and eldercare groups.

Contrary to what we had expected, however, multiple family demands did not appear to contribute to a further decline in either physical or mental health for those in the sandwich group above that observed for individuals with just eldercare (i.e. sandwich group reports same levels of stress, burnout, depressed mood and life satisfaction, visits to physician, etc., as the eldercare group). This finding is particularly striking given the fact that employees in this group have very high demands on their time and high levels of work-life conflict. It would appear that having children at home provides employees with elderly dependents some increased ability to cope with the strains associated with eldercare. How does having children at home help? It is hard to say from these data but it is possible that children reduce strain by helping out with eldercare, providing emotional support to their parents, and (strangely enough) providing the employee with another role (that of parent) whose rewards can offset the frustrations and strains associated with the role of elderly caregiver. This third explanation is based on the idea of “role expansion,” which states that people can benefit from multiple roles when the rewards from one set of responsibilities (i.e. raising a child, watching them learn) partially offset the frustrations and stresses of performing a second role (i.e. watching a parent die and lose functioning).

### *How can we reduce caregiver strain?*

The survey data provides the following answers to this question.

What causes caregiver strain? The answer obtained from this analysis is unequivocal – the hours per week the employed individual spends in eldercare activities. In fact, if we know how many hours an individual spends in eldercare per week we can come up with a good estimate of how much physical and emotional strain they will experience. Reducing demands then would appear to be the key to reducing caregiver strain. Suggestions on how best to do this include increasing community supports for employed caregivers and more respite care programs.

We also know that the families' financial situation is an important predictor of financial and emotional strain. In both cases, the tighter the families' finances, the greater the strain. While it is hard to say from these data why this might be the case, it seems plausible to assume that the lower the financial resources, the less ability the respondent has to buy supports from outside the family, the more care that they have to provide themselves (i.e. higher demands) and the more they need the income provided by their job. This second circumstance might be expected to increase conflict between work roles (need to satisfy their employer with respect to meeting work demands by being on time for work, minimizing absenteeism) and eldercare demands (need to spend a lot of time per week in caregiving, need to respond to crisis during work hours). This interpretation of the data is consistent with the fact that increased flexibility at work lowers both financial and emotional strain (i.e. if you can meet both work and caregiving demands, you are healthier emotionally and are not as worried about the financial aspects of caregiving).

These findings suggest that governments need to look at ways to reduce the financial burdens associated with eldercare (i.e. tax write-offs, paid time off work, supported care services in community). They also emphasize the importance of real support at the organizational level. Supportive policies on their own are necessary but not sufficient – these policies must be put into practice and employees must be comfortable using them.

The data also show that financial strain decreases when the dependent lives nearby but not with the employed caregiver. This would suggest that communities who wish to attract and retain labour need to invest in assisted eldercare facilities within their boundaries.

Physical strain arises because of two factors: the physical dimensions of the role (hours per week in care, lifting, lack of sleep) and the emotional aspects of the role (individual feels personally responsible for the dependent). This would suggest that we could reduce physical strain by looking at mechanisms to reduce the amount of time an individual has to spend in care. Things like respite care, eldercare referral services, assisted eldercare facilities, home nursing services, etc., should help in this regard.

The data also show that women are more likely than men to experience one form of caregiver strain – emotional strain. This finding is cause for concern given the very strong association between this form of strain and physical and mental health problems, absenteeism, and reductions in fertility (women who are experiencing emotional caregiver strain cope by having fewer children or no children at all). It would appear from the data that several factors predispose women to this

kind of strain: the fact that they are more likely to feel responsible for the care of the elderly dependent, the fact that they perceive that if they meet responsibilities at home they will not advance at work, and their need for the income stemming from their job (families' financial situation is tight). Again, the fact that perceived flexibility at the organizational end reduces this form of strain gives us one useful approach with respect to reducing it – implement supportive policies within organizations. Many of the suggestions offered earlier with respect to reducing demands at the caregiver end should also help women cope with the emotional demand associated with caregiving.

Finally, it is useful to note that two of the three forms of strain (financial and emotional) meet Karesek's (1979) criteria for a high strain job (i.e. high demand, low control). Thinking of the role of elder caregiver as a high strain job means that we can consult the research literature in this area on how best to address these issues. Karesek's model would suggest that to decrease financial and emotional strain one can either increase the amount of control the employee has over their circumstances (i.e. increase perceived flexibility at the organizational end, community supports for eldercare, financial support for caregivers) and/or reduce the demands they face (i.e. community and government supports for people with eldercare, respite care, eldercare referral services, assisted eldercare facilities, home nursing services).

In the interview we also asked caregivers what kinds of things would help them cope with this role. The respondents provided the following answers to this question.

- Employed caregivers want more tangible support from their families – not just sympathy and understanding.
- Employed caregivers appreciate (and need) flexibility from their employer to deal with the uncertainty arising from the caregiving situation. Specifically they appreciate access to alternative work arrangements and flexibility with respect to time off.
- Elder caregivers offered a number of pieces of advice to others on how best to cope with the role of employed caregiver. Specifically, they advised someone taking on this role to seek practical advice from an expert (don't try and do it all yourself/get government services involved) to look after themselves and their family, to tell their employer straight away (find out what you are entitled to) and to access professional support to help them deal with the stress of the role.
- Employed caregivers want their communities to offer services which make the caregivers job easier. Specifically they asked for respite care and help with travel (i.e. para transportation). They also want community service deliverers to be more flexible in terms of how they determine who is to get care and to do a better job of coordinating care between the different service providers.
- Caregivers feel that the federal government needs to assume a greater level of responsibility with respect to support of employed caregivers. Specifically, care providers asked the government for the following five types of support:
  - Stronger policies to support time off from work for longer time periods (i.e. EI/EA programs);
  - Provide one central place where caregivers can go to arrange for eldercare support services;

- Provide more community programs and services (especially respite care) to support their dependent and them;
- Provide more financial support to caregivers; and
- Listen to employed caregivers and try to be more responsive to their needs.

## Introduction

In the new millennium dependent care is not just a question of care for children. Concern over elder-care responsibilities (defined as providing some type of assistance with the daily living activities for an elderly relative who is chronically ill, frail or disabled) is now increasing due to a number of important demographic shifts underway in Canada.

Canada's population is aging, influenced largely by the baby boom of the 1950s and early 1960s and the baby bust of the late 1960s and early 1970s (Foot, 1996). A continuing low rate of fertility has resulted in an age distribution characterized by an over representation of people in their prime working years and a diminishing pool of young adults aged 15-24.<sup>1</sup> In fact, it has been estimated that by 2021, 17.8% of the Canadian population will be over 65 years of age (Health Canada, 2001).

The aging of the Canadian population has a number of implications for the country, not the least of which is a greater proportion of Canadian employees responsible for the care of elderly dependents. The 1996 census found that 15% of Canadians provided some care to seniors (Scott, 2000) and the Vanier Institute (1997) noted that 66% of seniors over the age of 75 relied on family members for help with housework, cooking and personal care. A relatively recent report by Statistics Canada (1999) dedicated to the topic of eldercare noted that in 1996, about 2.1 million Canadians looked after older family members or friends. Elder caregivers (both male and female) were, on average, in their mid-40s. The majority (over 2/3) were in the paid workforce. Similarly the General Social Survey (2002) reported that in 2002 there were 1.4 million Canadians who combined paid employment and eldercare provision. These employed caregivers provided care to 1.3 seniors. Most had been providing care for over 2 years.

It has also been predicted that work-life conflict will become more problematic over the next several decades as "baby boom" and "baby bust" generations assume responsibility for both dependent children and aging parents (Scott, 2000). Employees with these dual demands have become known as the "sandwich generation" and typically experience extraordinary challenges balancing work and family demands. It has been estimated that one in four Canadians are part of the sandwich generation (Duxbury and Higgins, 2001). Research by the Canadian Council for Social Development (CCSD) suggests that the number of employees who are in the sandwich generation will increase over the next decade as Canadians delay family formation and childbirth (CCSD, 1996).

Declining fertility rates mean that Canadian families are smaller today than they were thirty years ago. The average family size in 1995 was 3.01, down from 3.67 in 1971 (CCSD, 1996). The 2006 census reported that the average number of children per family living at home in 2006 was 1.2.<sup>2</sup> These data, taken to their logical conclusion, suggest that within the next few decades children will be required to provide support for a larger number of elderly family members.

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<sup>1</sup> <http://www12.statcan.ca/english/census06/analysis/agesex/tables.cfm>

<sup>2</sup> <http://www40.statcan.ca/101/cst01/famil50a.htm>

Finally, it is important to note that eldercare is often complicated by distance as elderly parents often live in different communities. Family members who provide “indirect” care such as frequent visits, phone calls and general management of the elder’s affairs from afar have been found to experience tremendous feelings of guilt and increased stress (BNA, 1988). Research suggests that the majority of people who provide eldercare have had to make lifestyle changes since becoming care providers including spending less time with their own family, paying less attention to their own health, and taking fewer vacations (BNA, 1989). Although only about 10% of elder-caregivers had to quit their jobs to care for an elder relative, between 20 and 40% had to rearrange work schedules, reduce their work hours or take unpaid time off.

Demographic projections suggest that society has yet to feel the full effects of eldercare problems. As the baby-boom generation moves towards middle age, and their parents toward old age, employees with such conflicts (often mature employees with substantial work demands) will increase in number. In 2000, Statistics Canada projected that the percent of the workforce involved in eldercare will increase from one in five to one in four in the next decade (Statistics Canada, 2000).

Why should Canadians care about this issue? According to the General Social Survey (2002) almost half of employed caregivers of both genders, experience several work-life balance issues that affect their physical and mental health as well as their productivity at work. Caregivers who are employed experience scheduling conflicts, time pressures, and workplaces compromises, to name a few concerns. According to a National Profile of Family Caregivers in Canada commissioned by Health Canada in 2002, more than one in four family caregivers indicated changes in their employment due to their caregiving responsibilities including quitting/retiring early or having had to make other changes in their work situation (e.g. schedules, role). Not surprisingly, leaving a job entirely has been found to be more widely reported by women and younger caregivers (e.g. under 45 years of age). In addition, disruptions at work have been found to be greater among those who had no choice in taking on the role, and among those caring for someone with a mental disability.

Despite the above trends, we know relatively little about employed caregivers in Canada. The research initiative described in this report seeks to increase our understanding of this important issue by developing a comprehensive profile of what it means to be an employed caregiver in Canada today. Specifically, this research has two main objectives:

- To increase our understanding of the issues and challenges facing employed caregivers in Canada
- To identify the kinds of support key stakeholders in this relationship (i.e. the caregiver, the dependent, the family, the organization and governments) could offer to the employed caregiver to facilitate performance of this role.

To meet these objectives we conducted two major research studies, one quantitative, the other qualitative. The quantitative study involved original empirical analysis using data collected for the National Work, Family and Lifestyle Study conducted in 2001 by the research team of Dr.

Linda Duxbury and Dr. Chris Higgins and funded by Health Canada. The qualitative study involved in-depth interviews with 30 employed caregivers.

The following research questions were used to guide the analysis of the quantitative data:

1. How prevalent is caregiver strain? How prevalent are the three key components of caregiver strain: financial strain, physical strain and emotional strain?
2. What impact do the three forms of caregiver strain have on the employed caregiver? Specifically, what is the relationship between financial, physical and emotional strain and the employed caregiver's physical and mental health? Their experiences at work and at home?
3. What are the key predictors of the three different forms of caregiver strain?
4. In what ways are employed caregivers similar to and different from each other and from those without any caregiving responsibilities?
5. What impact does where the elderly dependent lives (i.e. with employed caregiver, nearby the employed caregiver or elsewhere) have on the above similarities and differences?
6. What kind of strategies can employed caregivers use to cope with caregiver strain?

The qualitative study allowed us to better understand what employed caregivers do, why they do it, the joys and pressures of assuming the role of employed caregiver, how they cope with the demands they face and the kinds of support they currently receive and would like from key stakeholders.

This report is divided into five chapters. Key literature relating to employed caregiving are reviewed in Chapter Two. Chapter Three summarizes the quantitative research study and presents key findings relating to research questions one to six. Chapter Four presents key findings from the interview study. Key conclusions and recommendations are given in the final chapter of the report (Chapter Five).

## Chapter Two

### Literature Review

The purpose of this literature review is to examine caregiving in all its complexities. More specifically this review looks at what is currently known about “employed caregivers” which for the purposes of this review are defined as individuals who are employed in the paid labour force and who also have caregiving responsibilities to ageing and elderly adults. This review seeks to inform ongoing policy debate in this area by seeking answers to the following questions:

- What is the prevalence of this phenomena in Canada at this time?
- What is known about the nature of employed caregiving?
- What are the challenges associated with being an employed caregiver?
- How does the caregiver’s employment status impact the caregiving relationship?
- What are the gaps in our knowledge with respect to employed caregiving?

This literature review was conducted as follows. As a first step an on-line database search was performed of the theoretical and empirical research on employed caregiving published in peer reviewed journals, books, monographs and policy guideline papers. In order to obtain ‘contemporary’ relevance, the research was limited to documents written or published after 1990, written in English and with content relating directly or indirectly to family caregivers of elderly dependents.<sup>3</sup> Key words and phrases used in the search included eldercare, \*caregiving and employment, paid work, informal care, \*caregiver burden, sandwich generation, caring for ageing parents, life course care, family roles and \*care work. Documents reviewed contained data and discussions of issues and debates concerning the challenges of caregiving on the lives of many Canadians. A review of this literature determined that much of this literature dealt with/debated the following issues:

- The extent and nature of employed caregiving (i.e. tasks performed, the burdens of employed caregiving, the coping strategies used by employed caregivers).
- The impact of caregiving on the employed caregiver (i.e. consequences and challenges)
- The impacts of employed caregiving on employers, society and the economy.
- The financial, emotional, health and psycho-social impacts of caregiving on key stakeholders (i.e. the employed caregiver, the care receiver, families, communities, workplaces, governments etc.)
- The context under which employed caregiving is performed (i.e. the role of restructuring in health care, workplaces and communities on employed caregiving).
- Anticipated changes in the number of employed caregivers over time.
- The future of employed caregiving.

Many of these issues are highlighted in the review below. The review itself is divided into eight sections. Section one provides a review of how caregiving is defined in the literature. Included within this section is a discussion of the choice to care and a critique of this body of literature. Section two provides data on the prevalence of caregiving in Canada. Also included in this section is a discussion on how prevalence is expected to change over time. Section three defines

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<sup>3</sup> In some cases the literature we reviewed defined elderly “as aging adults, who are ill and/ or living with chronic or disabling conditions.”

the concept of “sandwich generation” and talks about its prevalence in Canada now and in the future. This is followed in section four by a discussion of the relationship between gender and employed caregiving. The review then turns in section five to an overview of the impacts of caregiving on employed caregivers, employers and society. Information on what contributes to increased caregiver strain is reviewed in section six. This is followed, in section seven, by a summary of what is known about coping with caregiver strain at the level of the individual, the organization, the community and public policy. The paper closes with a critique of the current literature in this area and a summary of the critical gaps in our knowledge at this time.

## **1. Defining ‘Caregiving’**

It is critical to begin a review of this nature with a review of how the term employed caregiver has been defined in the literature. A *caregiver* have been broadly defined in the literature as someone who provides a broad range of financially uncompensated ongoing care to family members, friends or neighbors in need due to physical, cognitive, or mental health conditions (Canadian Caregiver Coalition, 2001). This definition is consistent to that provided by Baines et al. who defines caregiving as “the daily tending, support and monitoring of adults who are incapacitated or have lost autonomy” (1992:23). Eldercare is different from childcare in that it tends to increase in amount and intensity over the course of caregiving (Morris, 2001).

The literature review indicates that many individuals can be considered employed caregivers. For example, caring, as defined in this review may be sporadic or sustained and may involve daily contact or long-distance support (Morris, 2001). Similarly, caregivers, as defined in this review, may include individuals who are the primary caregiver, the sole caregiver, or secondary caregivers who either live with, or live separately from, the person receiving care.

The breadth of the caregiver construct is further illustrated by noting that caregiving, as defined in the literature, goes beyond simply attending to the physical needs of a care recipient. In fact, caregiving has been defined as a continuum of care that takes different forms and displays different levels of intensity at different points in time. Caregiving experiences can range from advocating and decision-making to the provision of complex nursing care. The literature outlines five board categories of caregiving: (Fast and Keating, 2000)

- Personal Care (dressing, bathing, lifting, feeding, toileting, grooming);
- Physical Care (house cleaning, shopping, errands, repairs, transportation, preparing meals);
- Nursing Care (medication administration, changing dressings);
- Support (maintaining social interaction, visiting, supervision, emotional support, reassuring and validating attitudes or perceptions, managing depression anxiety and pain);
- Care Management (linkage between the care recipient and the formal service sector, identifying needed services and locating them in the community, gaining access to services, making appointments, attending information sessions, check-ups, managing financial matters)

Rosenthal and Martin-Matthews (1999) suggest a more simplistic two-part typology of caregiving that distinguishes between ‘care-provider’ (providing direct ‘hands-on’ service) and that of ‘care-manager’ (identifying needed services and managing their provision by others).

## **1.1 Problems with terms and definitions**

There is little consensus in the research literature with respect to how best to define terms such as caregiver and care. The wide variety of definitions in the literature is indicative of the fact that care relationships are diffuse rather than clearly defined. The boundaries for care are usually difficult to draw in terms of what is done, by whom it is done, how long it is done, to what intensities and where it is done. Drawing precise boundaries and procedures around narrow definitions can both inform and limit the range of possibilities for choices about caregiving (Guberman, 1999). Care and care work must, therefore, be understood in all its spheres—formal and informal, paid and unpaid and at micro, macro and policy levels.

The complexity and multitude of care provision manifestations make a single definition of ‘caregiving’ difficult. Definitions are further blurred by the fact that caregiving often involves several types of unpaid work, sometimes seen as unskilled work, similar to that of unpaid household work (Fast, Williamson and Keating, 1999). The wider the definition of what constitutes caregiving, the larger the group of people who will be counted [or potentially conscripted] as caregivers and stakeholders. This literature review suggests that research samples, definitions and statistics may underestimate the full extent and scope of caregiving and its complex nuances. It also points to the need to clarify and qualify what constitutes care in terms of who provides care; when; where; how much; the tasks, meanings, roles and consequences of caregiving.

The definition of family also poses challenges to understanding caregiving. It is an important concept to define since families are where most care ends up (Armstrong and Armstrong, 2004). It is also important for establishing whether obligations for care are explicit or implicit in the definition of family. Finally, the term has important policy implications for recognizing and supporting caregiving and determining responsibility (Keating and Fast 2000). Guberman (2004) notes a number of changes in family structures which may have an impact on employed caregiving including:

- a decrease in family size,
- an increase in the number of single parent families (usually headed by a mother) over the past several decades: such families have fewer extended members to provide support and limited economic and social resources to devote to caregiving
- an increase in the number of reconstructed households over the past several decades: previously married spouses may bring with them multiple caring responsibilities and thus increase the duration of caregiving.

With smaller families and increased care needs, the pool of caregivers is limited as needs are increased; the financial, emotional, physical burdens cannot be readily shared. See Appendix A:1 for an expanded definition of family recently put forward by Service Canada.

Moreover, families often live far from their relatives, creating additional difficulties. While some provide “care-at-a-distance”, especially care management, many move themselves or others in order to give care. In 1996, half a million Canadians moved to give or receive care. The majority of those who moved were married and more than one-third had children under the age of fifteen in addition to their paid work (Cranswick 1997; Rosenthal and Martin-Matthews 1999). While changes to the family context are noted in the literature, little is known about how these changes will affect the ability and willingness of family members to provide care. While some studies note changes to the definition of family may mean broader networks of kin on which to draw on for care support, other studies note increasing ambiguity on moral and legal obligations to care and an overall declining caregiving capacity within families (See Keating and Fast, 2000 for relevant citations). Indeed, the literature on this is mixed.

One consequence of this lack of a sound definition of employed caregiving is that the method for defining care concepts for policy making remains largely an under explored empirical question in itself (Fast and Keating 2000). Future conceptualizations of employed caregiving must include a recognition of these activities are allocated between families, work, market, state and between men and women. Such a definition should also, ideally, facilitate an understating of the associated costs of care for all these groups.

For the remainder of this review, we will use the term employed ‘caregivers’ to refer to employees who work in the paid workforce and who have eldercare responsibilities. Similarly, we use the term sandwich employees to refer to caregivers who have responsibilities for *both* childcare and eldercare in addition to paid work responsibilities. These caregivers, both male and female, are informal and unpaid in the sense that they do not (or may not) have formal training in healthcare but nonetheless administer and tend to the ‘care’ of elderly family members at their own cost.

## **1.2 The ‘Choice’ to Care**

Standard definitions of caregiving do not say anything about the choice involved in giving care. In other words, they do not articulate the degree to which a decision to become a caregiver is voluntary or involuntary, constrained or supported. Caregiving is sometimes referred to as a “labour of love”. This sentiment, while lovely, masks the fact that caregiving is “work” that requires, time, energy, skills and resources that may or may not always be voluntary (Centre of Excellence for Women’s Health). The National Forum on Health (1997: 19) notes that “while most women want to provide various kinds of informal care, they do want to be ‘conscripted’ into this relationship.” It is not surprising then that women report significantly greater perceived obligation to take on caretaking roles than do men (Keating et al. 1999, Stobert and Cranswick 2004; Perkins and DeMeis 1996; Chappel and Blandford, 1991).

The literatures suggests that there are many factors that go into a caregiving decision with multiple and varied consequences. In one study by Health Canada (2002) 35 percent of caregivers indicated that they provide care because there was “no one else available” and 25 percent indicated they provided care because of a “lack of home care services” (Armstrong and Kits 2004). The Canada Profile on Family Caregivers (2002) report cites that only one in two caregivers feel they had a choice in taking on the caregiving responsibility. Lacking alternatives,

and without adequate supports and alternatives, the best and most appropriate care choices cannot be made. Another study based on 20 qualitative interviews, noted several respondents expressed their decisions in terms of doing “what was best for the care recipient” at the time (in immediate terms) despite their recognition of very real potential negative impacts on themselves, their family and their future circumstances. Sacrifices in these situations are made “willingly” but often under constrained circumstances.

Moreover, choices vary and depend on resources. Resources are often unequally distributed; between communities and localities, between women and men and also among women. There is little research available on differences among women caregivers but that which is available does show that income and education profoundly influence caregiving. Morris, Robinson and Simpson (1999) for example, found that poorer women have fewer choices and resources when it comes to providing care. Similarly, Keefe(1997) found that rural communities and many cultural communities made up of new immigrants, have poorer access to care supports and services than do urban ones. This reduced access adversely affects the choices and capacity of rural residents with respect to caregiving.

Though the research needs to be further explored, there is compelling evidence to suggest that the availability of supports, alternatives and resources play a huge role in shaping the choices and outcomes of care experiences, challenges and impacts (Armstrong and Kits 2004). Fewer resources for increasing needs means greater inequality in the coping ability of Canadian families. Thus, given the nature of ‘care choices’ it is not surprising that caregiver experiences are often described as contradictory; rewarding and pleasing while simultaneously frustrating, stressful and costly.

## **2. Prevalence of Caregiving**

Estimates on the prevalence of caregiving vary depending on the sample being studied and how caregiving is defined. According to the 2002 General Social Survey (GSS) Cycle 16 on Social Support and Aging over 1.7 million adults between the ages of 45 and 64 provide unpaid care to almost 2.3 million seniors with a long-term disability or physical limitation.<sup>4</sup> 1.2 million of these caregivers are employed (i.e., individuals with both paid work and unpaid ‘care’ responsibilities). This works out to approximately 70 % of the total number of caregivers between age 45-64. Since the GSS data does not count caregivers younger than 45 or older than 64, these figures likely underestimate the number of employed caregivers as they exclude older women who look after their spouses and younger adults. Estimates of the *total* number of unpaid caregivers (beyond the GSS age criteria) are as high as 2.85 million Canadians (Cranswick, 2003). No estimates were found on the *total* number of employed caregivers (including those below 45 and over 64) but the figure is estimated to be considerably larger than the 1.2 million cited above. Walker (2005), for example, estimates 1.4 million Canadians over the age of 45 combine paid work and caregiving.

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<sup>4</sup> That works out to each caregiver providing help to an average of 1.3 seniors at *one* fixed point in time (Stobert and Cranswick, 2004).

Other research in the area show that the vast majority of eldercare (between 85 and 90 percent) is provided by unpaid caregivers (i.e. family members, friends, neighbors etc.) (Denton 1997; Morris 2004; Zukewich, 2003). This figure may actually understate the total amount of unpaid care since help is given more often and in more ways than is reported in surveys – mainly because people do not consciously think about what they do as providing ‘care’. Research samples, definitions and statistics may, therefore, underestimate the full extent and scope of caregiving and its complex nuances since factors such as the time and skill of care often become invisible in the process of ‘counting care.’

In order to better understand employed caregivers and the multidimensional demands on their time, it is necessary to understand the tasks, intensities and degrees of caregiving as well as the ways in which each are organized and distributed in households.

Most caregivers (73.4 % women and 80.9 % men) have been providing care for two years or more and are providing care for more than one person at a given point in time. Statistics Canada notes that in 2002 each employed caregiver provided care for an average of 1.3 individuals and that many caregivers, women in particular, will have to care for more than one person during the course of their lives (GSS 2002). Since caregiving often spans over a period of several years, 20% of caregivers report caring for more than 10 years (Health Canada, 2002). These data suggest that anyone who studies employed caregivers need to consider a long-term lens when discussing caregiving experiences.

Who gives more care? Studies show that on average, caregivers who live with the care receiver often provide more care of a wider variety and of greater intensity (Boddy, Cameron and Moss 2006; Dee, Jones and Peter 1992).

There are mixed findings in the literature on how employment status affects intensity of caregiving and how caregiving responsibilities in turn impact on employment status and intensity; precisely because it is difficult to separate the two in a linear causal direction. Pavalko and Artis (1997) found that women’s employment status had little influence on whether they assumed the responsibilities of care, but noted that the initiation of care work did increase the likelihood of reducing employment or leaving the labour force altogether. In a similar study, Rosenthal et al. (2004) set out to determine how providing help to elderly parents (-in-law) varied by the employment status of daughters (in-law). Their study found that in general, employment *per se* did not reduce the amount or type of help women provided to parents (-in-law).

## 2.1 Rising Care Demands

There is consensus in the literature that the demands and expectations for care will continue to grow with the number of people over 65 expected to double by 2026. With seniors accounting for 21% of the population, the number of people requiring care in the future will grow significantly (Brink, 2004). According to the Canadian Caregiver Coalition (2001), it is not a matter of “if you become a caregiver, but when.”

Recent reforms to health care and social services throughout Canada have resulted in a series of policies and developments that have severely impacted, limited and constrained the choices available for care. Specifically, policy changes have resulted in “reduced government expenditure on health, income security and social services” (Fast and Keating, 2000). Rising care demands are in direct conflict with pressures to reduce public expenditures to support formal and unpaid care work. The redistribution of costs and the reframing of entitlements have important implications for all stakeholders, particularly those most vulnerable--the elderly, the poor and women-- who are disproportionately affected by the consequences of reduced spending. The impacts have also meant “increased geographic inequity in health and social service delivery” (Rajnovich et al. 2005).

Traditionally, after WWII, eldercare was heavily supported by government and carried out in institutions. This will change with this new policy direction as more and more eldercare is now being redistributed to the community. As the location of long-term eldercare moves into homes and communities, the responsibility and burdens of care shift to families. Janice Keefe (2002) notes that it is not problematic that care is provided *in* the community, *per se* in terms of location (she notes, in fact, that this location might prove to be desirable). Rather, Keefe (2002) feels that it is expectations with respect to who will provide the care (family roles dictate it will be the woman) that is problematic. It is thus crucial to understand how policy changes in the health care system affect community resources, and family capacities to absorb change.

Current trends for early release from hospitals are expected to continue and will further increase demands for care. As medical technologies become more sophisticated, more and more care that were at one time the exclusive responsibilities of formal caregivers in institutional settings are taking place in the home. There has been little empirical work done on the impacts of the transfer of complex technical care to unpaid caregivers, but existing studies note that the transfer is associated with increased feelings of stress, anxiety, powerlessness and inadequacy. Advances in technology will make it more likely that more services will be provided in the home (Armstrong and Kits, 2004).

Furthermore, the demands of contemporary workplaces, including greater demands for labour mobility, increasing competition and intensifying workloads are increasingly at odds with the values required to maintain the short- and long-term health and well being of Canadian families. Given this new economic reality, families with caregiving responsibilities are left in a precarious situation (Vosko, 2006).

The nature and direction of employment change are key to understanding future caregiving challenges. It is contended that perhaps “government retrenchment and greater deregulation of

labour markets may solidify the assumption that the unpaid work of families – and of women in particular—can stretch infinitely to cope with work-family-community demands” (White and Keefe, 2005) Hence, the interconnection of work-family-caregiving-community must be seen as such—interconnections and not disconnected entities.

### 3. The ‘Sandwich Generation’

A growing segment of the caregiving population consists of unpaid caregivers who simultaneously manage responsibility for elderly parents and their own children while participating in the paid labour market—a group that is often referred to as the sandwich generation.

The 2002 GSS indicates 2.6 million people between 45 and 64 had unmarried children under 25 living with them. Of these, 27% (712,000 individuals) also performed eldercare. The vast majority of those with both childcare and eldercare responsibilities, (83 % of this group or 589, 000 individuals) were employed (GSS 2002; Cranswick and Thomas 2005). In other words, more than 8 in 10 of those in the sandwich group fall into our category of employed caregiver.

The research in the area shows that members of the ‘sandwich generation’ who were employed outside the home have maintained or even increased their participation as primary caregivers over time (Cranswick and Thomas 2005). The evidence also shows that women are more likely than men to be sandwiched and face additional strain from all directions as they persistently take on the majority of childcare and eldercare responsibility within two-parent households, even when both parents are in the labour force.<sup>5</sup>

Brody (1990) refers to sandwiched daughter caregivers as “women in the middle”“ since children, parents and husbands alike make demands upon their time and emotions. This is in conflict with perceived expectations of many women that in their middle years their caring responsibilities and ties to the home will be reduced not increased. The unforeseen necessity to provide care for an elderly dependent is often unexpected and unplanned for many women, bringing with it major alterations in their lifestyles and future plans (Dee and Peter 1992; Cranswick 1997).

There is very limited statistical and analytical research on the sandwich generation, but there is a general consensus in the broader caregiving literature that this is a significant and important group to consider, one that is likely to “grow substantially” in the next decade as baby boomers age (Williams, 2005). Keating and Fast (2001) found that more than one quarter (25%) of eldercare providers also have children under age 15. Census reports indicate a recent growth in the sandwich generation--more than 2 million people in 2001, up from 1.7 million in 1996 --- leading some researchers to predict an increasingly younger face of caregivers). It is significant to note however, that despite active attempts to locate estimates on the future size of the sandwich group, none were found; a glaring gap in the research. Given population projections that by 2026 *one in five* Canadians will be 65 or older, up from *one in eight* in 2001, this trend will likely inflate the sandwich generation. It is, however, unclear by the extent to which

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<sup>5</sup> Among the reasons noted why women are more likely to be sandwiched is because of the fact that children tend to live with their mothers after a marital breakdown (Hicks et. al 2003)

membership in the sandwich group will increase overtime given changes in mortality and fertility rates (Williams, 2004).

Other reasons to believe that the sandwich group will grow in size and have more difficulties with respect to coping are noted by Hicks, Rowe and Gribble (2003:13) who argue that “the more recent cohorts will have younger children, older parents, fewer siblings, and will more likely be employed than did earlier cohorts.” The trend toward the later onset of children (along with the later age of marriage, completing education at higher levels than previous cohorts) means a greater percent of the population more will have preschool children and aging parents at older ages (Hicks et.al. 2003). It is also likely that sandwich group will be adversely affected by the competing and compounding demands on their financial resources. For some, there is a real concern that the caregiving expenses will exacerbate the financial and economic demands of families (Doty et.al 1998; Hicks, Rowe and Gribble, 2003).

#### **4. Gender Differences in Employed Caregiving**

Though the term ‘caregiver’ is gender neutral, caregiving is not as women comprise the vast majority of caregivers and perform the bulk of caregiving work (See Appendix A:2). The research in this area (See Appendix A:3) shows that daughters, daughters-in-law and female spouse are the most common unpaid caregivers (Keating et. al. 1999; Morris 2001; Armstrong, 1994). Other research supports the idea that women do the majority of caregiving work. Stobert and Cranswick (2004) for example, found that women dedicate almost twice as much time per month to caregiving tasks as their male counterparts (29.6 hours for women compared with 16.1 hours for men). Senior women in particular were found to devote considerably more time to caregiving activities than their male counterparts – 33 versus 21 hours per month. Similarly, the GSS (2002) reported that employed women spent an average of 26.4 hours a month in caregiving while employed men spent 14.5 hours.<sup>6</sup> Other data shows that men who provide care are more likely than women to be low-intensity caregivers. Statistics Canada (2006) reports, for example, that 27% of men and 44% of women are involved in high intensity caregiving.

Data from the GSS (2002) indicate that higher proportions of male (74.6%) than female (63.5%) caregivers were in the labour force. It is important to recognize, however, that the figures in the GSS do not capture the decisions involved in women ‘choosing’ to withdraw from the labour market in order to care.

While the recent census figures on caregivers indicate a less dramatic gender split in employed caregiving (averaging a 54/46 split between women and men respectively) Health Canada (2002) reports a more dramatic gender division of caregiving when the *total* population of caregivers is considered (i.e. carers younger than 45 and older than 65) and the *total* amount of labour counted. Health Canada’s national study of 417 family caregivers done in 2002, for example found that 77% of family caregivers were female “regardless of the type of family recipient or the type of care provided.” This gender difference is greatest among caregivers under 45 years of

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<sup>6</sup> 77 % of male caregivers aged 45-64 reported that their main activity was working at a job; 93% of whom were working 30 hours or more per week. The majority of female caregivers aged 45-64 were also working (63%), 72 % of those were full time (Stobert and Cranswick, 2004).

age (82% of whom are women) and smaller in the 65 and older cohort (71% of women are women). (Health Canada 2002:6)

The research is clear about the persistence of a gendered division of labour in the allocation of caregiving work, with women, regardless of employment status, income and family structure, being more likely than men to perform the more intensive personal and physical care tasks (Campbell et al.1998; Neal et., al., 1993; MacDonald, Phipps and Lethbridge, 2005; Rajnovich, Keefe and Fast. 2005; Williams, 2004). In other words, compared to women men do different *amounts* as well as different *types* of care work and in different combinations with paid work and formal care help (Guberman 1999; Rajnovich et al., 2005).

Whereas both employed men and women occupy a combination of both types of caregiving roles, women tend to occupy many roles at once while men are likely to occupy one role, that of 'care manager.' Employed male caregivers are also more likely than their female counterparts to make use of formal services (Campbell and Martin-Matthews 2003; Morris 2004)). Men who are employed caregivers are more likely than women to engage in activities which involve the provision of financial support, locating services and taking part in transportation and some household repairs (Rosenthal and Martin-Matthews, 1999; Grunfeld et al., 1997). Women, on the other hand, are more likely than men to take on the bulk of daily, personal care tasks and emotional support (Campbell and Martin-Matthews 2003; Morris 2004). Essentially, this means that women are more likely to provide the types of care tasks that are daily and inflexible while men tend to provide care that can be more readily planned and organized around paid work (Gignac et al. 1996; Armstrong and Kits 2004). While some research suggests that higher income earning women are more likely to become care managers than providers, there is little consensus in the literature on this topic. In fact, the literature on employed caregiving among women is fragmented and inconclusive (Morris et al. 1999). Similarly, while some studies suggest that men's care work is increasing, little is known about how their strategies for combining paid employment and unpaid care work differ from those used by women (Palvko and Henderson, 2006).

While some men provide the full range of care forms, particularly when caring for their spouse it would appear that "fewer men are called on for such care because their wives usually outlive them--a result of women's greater longevity and the pattern of men marrying women significantly younger than themselves" (Armstrong and Kits 2004: 53).

The above data supports the need to employ a gender lens when trying to understand caregiving in its entirety. Many researchers support this view and suggest that any study on the distribution of the burden and consequences of caregiving take gender into account (Armstrong and Armstrong, 2001; Rajnovich et al., 2005; Rosenthal et al., 2004; Ward-Griffin et al., 1995).

## 5. The Challenges of Employed Caregiving

The literature has identified a broad range of costs (both economic and non-economic) associated with the responsibility of caregiving including: making adjustments to social and work life, altering future plans and dealing with the physical and emotional demands of caregiving while managing family/work relations and coping with the illness or potential death of the caregiver (Guberman 1999; Rajnovich et al. 2005; White and Keefe, 2005).

The literature also notes the increasing necessity to recognize costs across multiple dimensions including the social location of caregivers and care recipients (i.e. class, gender, education, occupation, age, ethnicity, regional locality) and the stakeholder(s) (i.e. informal eldercare recipients, informal eldercare providers, families of unpaid eldercare providers, and employers of unpaid eldercare providers). Though caregiving is increasingly recognized and acknowledged as an economically and socially valuable activity, the question remains as to how to recognize it as such. While many of the costs of caregiving include very real out-of-pocket financial and time expenditures (i.e. foregone opportunity, unpaid labour, career interruption, time lost from work, financial loss and, especially for women, job loss) emotional and physical costs to caregivers are often characterized as ‘hidden-costs’ since they are less visible and do not directly factor into the ‘costs’ of the public health care system (Fast et al. 1999; Keating et al., 1999). It is crucial then to document the conditions, costs and distribution of costs of unpaid caregiving across all spheres—home, work, life, gender and families. The review below summarizes what is known about the impact of employed caregiving on individual caregivers, employers and society.

### 5.1 Impact on individual caregivers

The literature talks about the impact of caregiving on employee wellbeing, physical health, work-life balance and economically. Each of these impacts are discussed in turn in the section below.

**Wellbeing:** The literature indicates that caregivers experience a range of social, physical and emotional costs in face of combined demands of care and paid employment. For example, caregivers (especially women) consistently have higher rates of stress, depression and guilt than non-caregivers (Smith and Dumas 1994; Scharlach 1994; Rajnovich et al. 2005, Statistics Canada 2006). The feelings are compounded if the caregiver is the sole confidante and decision-maker and by cultural pressures and family tensions (Jones and Peter 1992). Changes to lifestyle, social activities, holiday plans and disrupted sleep patterns are common costs, with women reporting greater disruptions. Cranswick (2003) reports 40% of female caregivers and 30% of male caregivers changed their social activities because of their caregiving responsibilities; more than one third alter their holiday plans; and 17% alter their vacation plans (Cranswick, 2003).

Several studies have highlighted stress as a prime concern for caregivers (Rajnovich et al. 2005; Rosenthal and Martin-Matthews, 1999; Keating et al. 1999; Armstrong and Armstrong 2004). According to Health Canada (2002) caregivers are most likely to feel stressed in terms of their emotional health and the degree to which they feel they are managing work-life balance; with close to eight in ten reporting that caregiving had resulted in significant (29%) or some (48%) emotional difficulties. Among men, 24.9% said they sometimes feel stressed and 6.5% said they

nearly always feels stressed. In contrast, 35.7% of women said they sometimes felt stressed and 14.2% said they nearly always feel stressed (General Social Survey, 2002). Other major stress-related drawbacks of caregiving identified in the literature include: abuse, financial insecurity, burnout, physical/emotional breakdown, illness, isolation, role overload and losing one's sense of identity (Campbell et al. 1998, Keating et al. 1999). These emotional consequences of stress, in turn, cause employed caregivers to feel overwhelmed, fearful, angry, frustrated, helpless and powerless (Morris 2004).

Several studies note the strains and challenges that caregiving has on families including pressures on time available to spend with family members and, even when time is available, increased stress and worry. Some studies have noted a correlation between caregiving and strained relations, tensions and anxieties among family members as well as increased conflict with siblings over perceived inequities in the distribution of parent-caring activities (Brink 2004, Fast et al. 1999). One study found 21% of caregivers reported problems in getting other family members to cooperate in the patient's care (Rosenthal and Martin-Matthews 1999).

**Physical health:** There is strong evidence that caregiving has a substantial impact on health and well-being. Women in particular, report serious physical consequences of caregiving. Notably, higher proportions of women (20.2%) than men (6.5%) said that caregiving had negatively affected their health (GSS 2002).

Caregiving has also been found to be associated with the development of specific ailments such as ulcers, headaches, stomach aches, hypertension and chronic pain (Campbell et al. 1998, Morris et al. 1999). Some studies have found that caregivers have more disease symptoms, physical limitations, chronic conditions and poorer immune function than non-caregivers (Pavalko and Henderson 2006, Fredriksen and Scharlach, 1999). Similarly, Higgins, Duxbury and Johnson (2004:14) note that employed caregivers -- both men and women-- with high levels of role overload are in poorer physical and mental health and make greater use of Canada's health care system. The authors also note "the link between hours in work and role overload, burnout and physical and mental health problems suggest[s] that these work loads are not sustainable over the long term" (Duxbury and Higgins, 2005:16)

The literature also aptly points out that the health of unpaid caregivers is intricately connected to the amount and intensity of the care provided. As the demands of caregiving increase, so do the associated strains and stresses. In a study done by the Conference Board of Canada (1995) 48 percent of caregivers who provided personal care versus 30 percent of those who provided other forms of support said it was difficult or very difficult to balance their personal and job responsibilities. Almost one third (31%) of caregivers said they experienced a great deal of stress in trying to juggle their various roles. The severity of disability of the care receiver and the level of difficulty in arranging affordable, accessible, dependable care of good quality were found to be strong predictors of the level of strain and work/life balance experienced by caregivers

**Work-life balance:** The challenge of balancing demands of caregiving with other roles is significant (Scharlach, 1994). Murphy et al (1997) describe what they call "conflicted workers" as "those maintaining their work roles in the face of adverse effects due to caregiving." 'Conflicted workers' are those particularly stressed and overloaded. Those who are also

caregivers of dependent children experience high overload and life conflict. According to a national telephone survey research project by Murphy et al. (1997), indicators of conflicting roles for work and caregiving include: having repeated interruptions at work, having less energy for work, working less productively/efficiently, having to reduce hours or take unpaid leave, having to take a less responsible job, or having to quit work entirely. Those who were 'conflicted' (self-defined as such) or who had quit work (indicating work role conflict) reported higher overload than traditional non-workers and un-conflicted workers (Murphy et al., 1997). Work role conflict varied in terms of severity of recipient disability, hours spent caring and living arrangements. The study also found equal proportions of part-time and full-time workers were 'conflicted' (Murphy et al. 1997). Indeed the impact and persistence of 'unmet needs' (real or perceived) of everyone in a caregiving situation, be it children, adults and elderly, is a real and ongoing struggle among competing needs. Sandwiched caregivers are at particular risk for negative consequences resulting from their dual roles (Fredriksen and Scharlach 1999).

**Economic Impacts:** Economic consequences involve money or money equivalents that are employment-related, out-of-pocket, and/or unpaid labour costs. They refer to lost current and future employment income and benefits as well as expenses on services, equipment, supplies and transportation. Many caregivers make changes to their work patterns or reduce hours to provide care. In one study, over half of employed caregivers, 55 percent of whom were women and 45 percent men, noted that caregiving affected their everyday work life, specifically, coming in to work late, leaving early or having to miss work, taking extra calls and loss of concentration and motivation (Keating and Fast 2000)

In addition to affecting seniority, benefits and direct costs, work interruptions may have future indirect costs such as the inability to maintain or improve skills, the slowing or termination of a career, repercussions affecting productivity and work satisfaction (Brinks, 2004). Studies note that foregone employment opportunities result in reduced income and employment-related benefits as well as future income due to inability of caregivers to get additional training, attend conferences, get promotion and do extra jobs that might have led to salary increases. Cranswick (1997) estimates that such career-related opportunities are relinquished by as many as 18% of employed unpaid eldercare providers. Women tend to reduce work hours more than men—14.5% and 10% respectively. A study by Stommel et al (1994) estimated lost wages of caregiver who given up employment to be \$2,299 or 42% of the total costs associated with their family caregiving over a three month period (quoted in Fast, Williamson and Keating 1999). For the most part however, the monetary value of the impact of forgone career-related opportunities has not yet been determined.

In their 1999 study, the Mature Market Institute found almost all employed caregivers had made some sort of adjustment to their work schedule, including reducing their hours of work (33%), changing from full- to part-time work (20%), and taking leaves of absence (22%). Forty percent reported that their caregiving responsibilities had limited their advancement opportunities and two-thirds indicated that there had been a direct impact on their earnings.

Armstrong and Kits (2001) argue that rather than taking time off from work to provide care, as a coping strategy, many women take jobs with shorter hours or that can be done at home in order to balance work and caregiving. They note for instance that in 1999, 41 percent of employed

women aged 15-64 worked in a non-standard employment situation, compared to 35 percent in 1989. Other studies have found that eldercare puts women at greater risk for reducing hours or leaving the labour force, it is not clear whether this trend will continue for more recent cohorts of women (Pavalko and Henderson, 2006). The pattern suggests that women limit their work rather than their caregiving commitments (Murphy et al. 1997).

There are considerable costs associated with the 'choices' around employment, including reduced income, security and benefits. Thus, the literature notes the need for discussion of 'choices' surrounding employment, the choice to give care as well as the demand for and supply of paid and unpaid labour.

"Of all economic costs, incurring extra expenses as a result of caregiving was the most commonly report costs" (Rajnovich, Keefe and Fast 2005). The Canada Profile on Family Caregivers (2002) estimates close to half of all caregivers are paying out-of-pocket expenses to care for their family members. The report notes 40% are spending between \$100 and \$300 per month, one in four (24%) spend in excess of \$300 per and interestingly, 18% could not (or did not) say how much they are paying on their own to provide care.

In addition to the expenses commonly associated with caregiving, such as payment for care services, prescriptions, adaptive equipment, medication and home modifications; *care-related* expenses include such things as buying convenience foods, televisions, adjustable beds, transportation services or paying for the delivery of services in order to make caregiving easier, less stressful or because they cannot leave the care receiver alone (Guberman 1999, See Appendix A: 4 for a breakdown of costs). This cost was experienced by 39.9% of women and 36.7% of men. Financial costs mainly fall on recipients and families. Those without money, capacity and supports simply do with unmet needs. The poor and isolated fare the worst.

**The Sandwich Group:** Several studies on the impacts of caregiving have focused specifically on the sandwich group. These studies show that in maintaining paid employment, the demands confronting these caregivers necessitated life adjustments, including alterations to work arrangements. About one in seven sandwiched workers had reduced their work hours over the previous 12 months, 20% shifted their work hours, and 10% lost income (Williams, 2004). In addition, 4 in 10 sandwiched workers incurred extra out-of-pocket expenses from such things as:

- renting medical equipment
- mobility services
- home modifications for safety and ease of caregiving
- transportation equipment
- medication

One study, drawing on data from 20 qualitative interviews with caregivers, reveal the ways in which people feel the anxieties and stresses associated with the 'cost' of 'sandwiched' caregiving. Respondents expressed it as an 'ongoing struggle' of balancing and adjusting their spending patterns to accommodate additional expenses related to caregiving (Perkins and DeMeis, 1996). For many, caregiving meant "living more frugally," "vacations and recreation are luxuries, in terms of money, time and responsibility". Sandwiched workers in general are more likely to feel stressed and experience work-life interference. About 70% of them reported

stress, compared with about 61% of workers with no child-care or elder-care responsibilities (Williams, 2004)

### **Impact on employers**

There are few studies in the literature that directly investigate the impacts of conflicts between labour force participation and eldercare (Doty, Jackson and Crown 1998; Palvalko and Artis 1997, Ward-Griffin et al 1995). Most studies have been concerned with determining whether conflicts between employment and caregiving responsibilities caused caregivers to withdraw from the labour market, be late or absent, take unpaid leave, or reduce their hours of work on a regular basis and the costs associated with these patterns.

The Conference Board of Canada (1999) has drawn up a list of potential problems specifically related to long-term eldercare responsibilities and the workplace. They include: absenteeism, tardiness, frequent interruptions from work, lack of availability for overtime and business trips, inability of workers to accept projects or added responsibilities, requests for a reduction of work hours, health problems, stress, poor morale and work attitude, stress-related disorders, depression, tension, sleep disorders, redistribution of work hours, higher frequency of unpaid leave, reduced quality and quantity of work, greater number of accidents, staff turnover, increased costs and decreased productivity (Conference Board of Canada 1999, Matusicky 2003).

By definition, care incurs direct labour costs. Unpaid care involves unpaid work similar to that of unpaid household work, which increasingly (though inadequately) has been acknowledged as productive and economically valuable (Keating and Fast, 2000). There have been a variety of attempts to revise national accounting systems to measure and value unpaid work and the costs of caregiving at a macro level to show their contribution to the overall economy. For example, a 1999 Health Canada report estimates that employees juggling work and family demands cost Canadian employers at least \$2.7 billion a year in absenteeism, and the health care system approximately \$425.8 million for physicians visits (Doty, Jackson and Crown 1998, Matusicky 2003). Factors in this cost escalation included the repeated use of sick leave and personal or family leave and subsequent costs of replacement workers. Another way to measure unpaid care work is to assign a value to a caregiver time equivalent to the hourly wage the individual could earn in the labour market. Using this methodology, Zukewick (2005)<sup>7</sup> estimated that unpaid caregiving work would be worth approximately \$50.9 billion in 1998.

The evidence also suggests that responsibilities of caregiving have a direct impact on employee productivity and on the productivity of those who work with them. It is recognized, however, that such impacts are difficult to measure. Brink (2004) study notes that just over half of those balancing work with caregiving modify their work schedules, come in late, leave early, take long lunches, make or receive phones calls at work related to caregiving, miss work to take the care receiver to appointments, or take leave to deal with sudden crises.

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<sup>7</sup> This method is called the “opportunity cost valuation method” It uses time and money measurements to determine the magnitude of unpaid informal caregiving.

The unpaid work done by unpaid caregivers may also generate costs for governments and society in general. In some cases, a person's withdrawal from the workforce to take care of someone with decreasing independence entails a short and long-term decrease in the state's tax revenue. In addition, the fact that a person leaves paid employment to provide care might also mean an increased reliance on social income security programs. Indeed, to the extent that the person will have contributed for a shorter period of time to a public or private pension plan, they will be less well prepared financially for their own retirement (Keefe and Medjuck 1997).

## **Impacts on Society**

There are multiple stakeholder groups in each caregiving relationship. Harlton, Keating and Fast (1998) define stakeholders to include a broad set of constituents including elder adults themselves, their family members, friends and neighbors, those who provide formal and unpaid services and those who develop policy in relation to eldercare services. Each of these stakeholders has different mandates in relation to eldercare, each maintain their own perspectives and each experience change and challenge differently (Harlton et al, 1998) All members of society experience the consequences of unpaid caregiving in one form or another, although societal consequences are experienced at a relatively macro level.

Some of the impacts on stakeholders and society at large that have been identified in the research literature include:

- Short and long term economic and social costs to everyone: We are all likely to require care ourselves over time and many of us are and will be providing care for someone we love in the future.
- Standard of living and quality of life (all members of communities are affected).
- Foregone income tax revenue (as result of foregone employment income to meet their caregiving responsibilities).
- Strain on health resources and services affects everyone.

In addition, when the strains of care work affect caregiver's health, as the research shows it does significantly, they are more likely to require additional health care services themselves incurring costs for public expenditures and for society as a whole (Fast, Williamson and Keating 1999, Duxbury and Higgins 2005). Since caregivers tend to defer their own health care needs, the literature warns that failure to help family members provide care could risk direct and indirect increases in health costs as injuries or illnesses of the elder and/or family caregiver abuse (Armstrong and Kits, 2004). There is also some evidence that shows the deterioration of unpaid caregiver's health and well-being can speed up the institutionalization of the elder[s] for whom they are caring, which also leads to increased public expenditures (Grunfeld et al., 1997).

The economic value provided by family caregivers is enormous. It is estimated that help and care given to seniors saves the public system over 5.3 billion a year, which is equivalent to the work of 276, 500 full-time employees (Gignac, Kelloway and Gottlieb, 1996).

Increased demand for nursing and other health care services by an aging population and increased retirement of workers in nursing and other health care fields, along with a predicted inadequate number of new graduates, are indications of a growing future shortage of registered nurses and health care workers that will put affect everyone (Canadian Nurses Association, *Canadian Nurses Association Report*, 1997). In this way, both components of the care system (formal and informal) will experience shortages in the future.

Some researchers posit a possible “crisis” of care work” due to the fact that the demand for care work is increasing at the same time as traditional sources of paid and unpaid supply are decreasing (MacDonald, Phipps and Lethbridge 2005). More than just a matter of shifting resources from one sector to another, caregiving must be considered in its totality of caregiving relationships. So far most economic and social institutions (including government workplaces and public services) have failed to acknowledge and confront the full *scale* of these [long-term] changes and their implications for future caregivers (Morris 2004). The changes mean that unpaid caregivers are doing more, whether it be more hours of care work, more juggling of multiple responsibilities, more managing of multiple care providers and more complex care provision.

While changes to health and home care policy are adding to the list of responsibilities of families, many employment protections are being removed in a deregulated market. The result has meant increased burden with family members taking on multiple roles and multiple responsibilities coupled with increased vulnerability and insecurity in the workplace. The rise in non-standard work (e.g. irregular shifts, shifting hours and place of work); increasing precariousness (insecurity and uncertainty about employer, employment contract, employment conditions and benefits) and changing employment norms (increased part-time, contract, temporary, self-employed, split-shift, home-working) are adding to the increased precious nature of employment.

In response to many of these changes, more men and women are working longer hours, often at two jobs (Statistics Canada 2000). As a result, fewer families have the time or resources to provide much care just as care demands are increasing (Armstrong and Kits 2001). Giving the increasing numbers of Canadians who face simultaneous paid and unpaid work responsibilities, policies governing the rights and responsibilities of employers and employees may have an impact on caregiving capacity and on the consequences of caregiving.

Canadian demographic trends including the drop in the birth rate, the increase in the divorce rate and the changing family structure along with the geographic dispersion of families are all factors that limit, and will continue to limit, the capacity of families to shoulder greater responsibility for eldercare and of the healthcare system to support. This implies the number of employed Canadians who will be balancing paid work and caregiving will also increase.

There is a relational and shifting distribution of stakeholder costs whereby the costs borne by each are dependent on the costs borne by all. Unpaid care cannot be assumed to a ‘free good’ without consequences to individuals, employers, and families, the economy and society at large. The literature speculates how that distribution of costs is affected by the nature of the policy regime (i.e. current policy reform has redistributed the costs of eldercare among stakeholders—

mostly unpaid caregivers), but more explicit research is needed to determine the extent and nature of this relationship (Fast, Williamson and Keating, 1999). Costs of all varieties will continue to grow, threatening the viability and sustainability of the current health care and income security systems. The net result of these broader and longer-term society consequences is largely unknown.

Though caregiving also bring rewards, caregiver's experiences are contradictory and the literature tends to focus on the negative, more consequential impacts of caregiving on caregivers (Armstrong and Kits 2001, Aronson 1998). Many people see caregiving as a rewarding experience that is often done out of love and a sense of duty. However, 'loving' someone for whom you care does not negate the challenges and costs associated with caregiving; in other words caring *about* a loved one does not make it easy to care *for* them (Armstrong and Armstrong, 2001). In either way, the rewards of caregiving come at other costs to caregivers in the form of personal, social, economic and career (Cranswick, 1997).

The findings of this literature review suggest that there is a wide range of economic and non-economic costs that arise when employed people take on unpaid caregiving responsibilities. Ranging from personal strains to work disruptions, to foregone opportunity, time and financial costs, the negative effects of caregiving do not seem to be diminishing despite recent efforts and policies to mitigate their impacts. Indeed, the diversity and breadth of caregiving situations along with demographic changes in the Canadian context reveal the growing and changing nature of the 'caring face' of our society (Gahagan et al. 2004).

The research in the area also shows that the challenges, burdens and costs are also gendered with women reporting greater strain and tension between their caregiving and paid work, and between their caregiving and other family responsibilities. For both men and women however, the consequences of work interruptions and additional strains can be felt well into the future and may be passed on to subsequent generations.

## **6. Predictors of Caregiving and Caregiving Strain**

While just about everyone is a member of an actual or potential caregiver network (Doty et al., 1998) the diversity of experiences among people combining work and family care responsibilities suggest the importance of identifying specific factors that are predictive of higher levels of caregiver strain and occupation impacts. The section below reviews what is known about this issue.

### **Predictors of Caregiving**

Although findings are mixed, several studies note that while a number of factors play a role in the caregiving relationship, gender, family structure, and geographic proximity were found to play very important roles in determining the division, intensity and scope of caregiving labour (Rosenthal et al., 2004; Boddy, Cameron and Moss (2006). According to the 2002 General Social Survey, most caregivers were married, but the rates of married men and women caregivers varied considerably. Among women providing care 70.6 percent reported that they were married or in a common-law relationship, while 83.1 percent of men indicated they were married

(Rajnovich et al. 2005). Other identified predictors of assuming caregiving responsibility include geographic proximity, health status and to a lesser extent, competing demands on time (e.g. other family responsibilities and employment). These factors may determine selection of someone other than a spouse or an adult daughter even if one of these family members available and willing (Rosenthal et al., 2004).

Though caregivers are found across all income strata, Health Canada (2002) reports that most caregivers have household incomes below the national average--only 35% of households with caregivers report income over \$45 000 (Appendix 1). Caregiving needs, networks, resources and limitations vary in degree, from caregiver to caregiver and from time to place. Studies have found income to be a major determinant of whether and how many services were purchased. The higher one's income the more options and flexibility caregivers have in obtaining services to meet their needs (Morris 2004; Armstrong and Armstrong, 2001; McDonald et al. 2005).

It has also noted that women with less formal education provide more hours of care (Morris 2004). When comparing caregivers with non-caregivers, education was not significantly different but women with lower levels of education tended to provide more hours of care. Keating et al. (1999) estimate that women with higher levels of education may be in a better position to reduce their caregiving hours by purchasing care and other supports.

Age is seen as an important determining characteristic in predicting who becomes a caregiver. For both men and women, approximately 43% of caregivers are between the ages of 45 and 59. Guberman (1999) identifies the aging of caregivers as a new trend that is consistent with the increase in life expectancy and the increase in the age of both those who receive and those who give care. Data from the 2002 GSS indicates that 10% of women and more than 8% of men caregivers are 75 years of age or older (Statistics Canada).

There exists considerable regional variation on indicators of care responsibility such as community supports and employment patterns that affect the likelihood of combining employment with helping elderly parents. Other social indicators include specific attributes of localities including availability and access to employment, the degree of unemployment, the availability of elderly parents, patterns of work, income and education, family structure, settlement, migration and religious values—all of which can vary by region as well as within regions (Keating et al, 1997). Keefe (1999) notes that unique age structures are found in different-sized communities with a general pattern of a higher proportion of elderly persons in rural areas as compared to urban areas. Keefe's (1999) study of rural/urban and community contexts revealed the gap between rural and urban is highest among employed women, noting almost one-quarter of rural women who are employed full time provided help to elder parents, compared to 11% of urban women

### **Predictors of Caregiver strain**

Numerous studies of working parents and caregivers have found that women are more likely than men to experience greater strain between work and family care responsibilities (Armstrong and Armstrong 2001; Aronson and Neysmith, 2006; Fast and Keating 2000; Gahagan et al. 2004). Such gender differences have much to do with the unequal division of family care

responsibilities, sex role expectations and socialization and limited alternative opportunities for the provision of care (Armstrong and Armstrong 2001; Frederick and Scharlach 1999; Ward-Griffin 1995).

A survey of over 1800 employees by Frederick and Scharlach (1999:193) concluded that “more demanding work and family situations, such as caring for persons with higher levels of disability experiencing greater problems with care, and having a more demanding job, each made a significant contribution to deleterious personal and workplace outcomes.”

Younger caregivers have been found to experience greater difficulty with work and family responsibilities and increased work interruptions (Neal et al. 1993) possibly because they have access to fewer psychological, social or financial resources with which to buffer the stress of family care (Frederick and Schlach 1999). While these studies do not address the issue of caregiver strain, the findings with respect to work-life balance suggest that younger employees may also be at higher risk for caregiver strain.

The degree of need and disability of the care recipient are also critical components in determining care and predicting strain. While a study by Health Canada (2002) found caregiving intensity to be a significant indicator of caregiver strain, the connection was not linear or causal. For instance, high levels of caregiving hours resulted in “substantial consequences for more than 50 percent of all women caregivers, regardless of the number of hours of paid work.” Women working longer hours were more likely to feel socio-economic consequences’ (Statistics Canada, 2006). Women who provided relatively few hours of care but who worked longer hours had the highest proportion of feelings of guilt (7 in 10). Hence, the type of strain varied by both intensity of caregiving and intensity of work, the consequences varied from financial and economic strain to social and emotional. Men were more likely to be employed but they are were also more likely to be low-intensity caregivers (Statistics Canada). The vast majority, nearly 80 percent, of employed female caregivers worked 40 hours or less per week, with the rest working longer (more women work in part-time, contingent and non-standard jobs). In contrast, 53 percent of men worked 40 hours or less, and 47 percent worked longer (Statistics Canada, 2006).

## **7. Dealing with Caregiver Strain**

Four types of coping strategies are discussed in the section below: those that can be implemented at the level of the individual caregiver, those that that can be put in place by the employer, those that operate within the community and public policy supports. Details on each are given below.

### **7.1 The Individual:**

The research in the area suggests several ways that individual caregivers can cope with the strains associated balancing looking after an elderly dependent and paid employment. Gahagan et al ( 2004) identifies a number of supports that individual caregivers would find helpful with respect to maintaining a ‘healthy balance’ between caregiving and employment including: information about available supports; support from family, employers and health care providers;

training and skill development; respite and help with day to day chores; emotional support and financial support

When asked what would be most useful in assisting people with their caregiving, ‘occasional relief’ was the most frequent response (Statistics Canada 2006). Almost seven in ten caregivers reported they needed a break from the caregiving responsibilities either frequently (21%) or occasionally (47%) (Statistics Canada 2006; Gahagan et al., 2004). While this response was frequently requested by low-intensity caregivers, the extent to which people mention such support as useful increased within the high intensity caregiving group (i.e. employees who combined longer hours of work with long hours of physically and emotionally taxing caregiving). For example While 6 in 10 high-intensity caregiving women who were not employed mentioned relief as desirable, the number was almost 8 in 10 for those who worked longer hours.” Occasional relief can come from a variety of sources, including family members paid formal help, or government-arranged home care (Statistics Canada 2006).

As noted earlier, society must recognize that at the individual level people have, in theory anyway, the choice to adopt this role or not. Thus the question for individual caregivers that must be asked is: Is caregiving voluntary? It can be voluntary only if there is access to alternatives and if there are the kinds of supports available that allow choice to be made. Families differ in their capacity to provide care and caregivers must feel that they have a right to modify their level of involvement at any time. In other words, caregivers must have a choice in becoming active participants in caregiving and should have the right to choose the degree of their involvement at every point on the continuum of care. For employed caregivers, having choice about establishing the conditions for work and in deciding how, when and where care is provided is also critical in easing the caregiving burden (Armstrong and Armstrong, 2004). Acknowledging, valuing and respecting the contributions of caregivers should be a guiding principle in helping to ease the strain and emotional burdens of caregiving.

## **7.2 The Employer**

Flexible work arrangements were commonly identified as a way of easing the difficulties of caregiving (Statistics Canada 2006; Barr et al., 1992). This could take the form of allowing an employee to adjust regular work hours or allowing time off as needed. A study by Neal et al. (1993) showed flexible schedules and workplace policies which facilitate caregiving were linked to increased productivity due to better morale, reduced stress and a feeling of loyalty to the employer. Similarly, ‘flexible work arrangements’ (flextime, compressed work weeks, flexible schedules to adjust irregular work hours, reduced hours of work, flexible location protected part-time work) were found to be associated with decreased work interference (Scharlach 1994). Flexible scheduling, job sharing, telecommuting, family illness days, family leave and similar policies have consistently been advocated in the literature as helpful in reducing the potential conflict between work and caregiving responsibilities (Guberman 1999; Duxbury and Higgins, 2003).

While research has noted the benefits of workplace programs, it has also noted its limits. (Brody et al., 2006; Lechner and Gupta 1996; Neal et al. 1993). Many workplace programs are available only to a minority of Canadian workers, generally those working for large companies,

and they are often provided in a discretionary manner (Guberman 1999). In addition, while many work places are seeking to better accommodate caregivers; heavy workloads, non-supportive management, unclear policies, continuous change, temporary, part-time and contingent work as well organizational culture were all found to be contributing factors to making the balance of work and caregiving more difficult (Fredriksen and Scharlach 1999; Duxbury et al. 2003). A supportive workplace culture including a cultural acceptance of eldercare responsibilities was also identified as missing in the work place.

While problems and challenges persist, with the appropriate policies and supports in place, employment can play a complementary role in enhancing the caregiver role by providing the space and resources that buffer caregivers from the negative impacts of caregiving such as greater financial and social resources, networks and support for assisting caregivers (Rosenthal et al. 2004).

### **7.3 The Community**

Families and caregivers rely on a host of community supports to meet their caring needs. Caregivers have actively requested various forms of support from the community in order to better assist their caregiving; others are unaware of what supports exist and which ones help. Requests have included the development or expansion of educational, informational and support programs that enable providers to be better caregivers and to better deal with the strains of caregiving (Keefe, 2003). Counseling services to provide coping strategies, advice and support have also been identified as necessary and helpful. Another important support is information and referral services to help caregivers navigate community services and recourse banks. Indeed, caregivers need a continuum of services and supports such as training and education, respite and other care services in conjunction with workplace policies, job security and income compensation programs (Rajnovich et al 2005).

### **7.4 Public Policy**

The challenges that caregivers face when dealing with the social policy are compounded by the “ambiguous status of caregivers” in relation to public policy and programs (Rajnovich et. al 2005). Since caregivers are not official clients of the health and social services systems, they generally are not entitled to services in their own right, but through the care receiver (Guberman 1999). Assessments tend to give little attention to caregivers’ needs, despite research that supports the need to do so. Furthermore, when determining needs and entitlements, the underlying premise of many care programs is that families—often women-- are responsible for providing care. “Services are provided not to support or ease the burden of caregiver, but only as a last option to fill gaps not being met by family”(Guberman, 1999). This premise must be challenged and public policy must look at the social and economic needs of caregivers and ask: what direct and indirect benefits to they need and provide?

Currently, there exists a fragmented array of supports— tax credits, compensation programs and workplace policies—that have been identified as critical to relieving and supporting caregivers. But conditions for access to such programs are often limiting and need reexamination (Eales, Keating and Fast, 2001).

In 2004 the Government of Canada introduced The Compassionate Care Benefits Employment Insurance (CCB)<sup>8</sup> program:

“Compassionate Care is a special benefit of Employment Insurance. It provides temporary income support for eligible workers who take leave to provide care or support for a family member who has a significant risk of death within six months. To be eligible, it will be necessary to submit a medical certificate from the attending physician of the family member who is ill.”

The CCB is considered Canada’s foremost workplace policy support for emergency caregiving situations and is a concrete recognition of the diversity and strain of caregiving on family members who are in the paid workforce. In light of the increasing heterogeneity of families, the CCB recently (June 2006) expanded its definition of ‘family’ to include a broader conceptualization of the term (see Appendix A: 1). While a positive step in the right direction, critics of The Compassionate Care Benefit have noted several ways it could be improved, including: expanding eligibility (to include *all* who provide significant levels of care); increasing the benefit amounts (current benefits are inaccessible to some low income workers); extend eligible caregiving relationships to include in-laws, aunts and uncles, friends and neighbors; expanding the program to provide access to contract, temporary and self-employed workers and part-time workers who are currently not eligible; and to extend the amount of paid leave time (White and Keefe, 2005).

## **8. Gaps in the literature**

The goal of this review was to provide a picture of the context in which employed caregivers provide care and to move forward in finding new ways of supporting caregivers, both to reduce the consequences and costs, and to ensure the sustainability and quality of the caregiving relationships. Analysis of the existing literature reveals the following gaps in research and knowledge.

- Clear figures and estimates on the ‘sandwich generation: How large will this group grow and how fast is it growing? What is the extent and nature of sandwich responsibilities and how do these differ from those with only eldercare responsibilities? What effect might this distinction have on policy and ‘care’ conceptualizations? What will the future impacts and costs be for these increasingly squeezed caregivers?
- Conceptual and theoretical groundwork for calculating the full range of costs and consequences of unpaid caregiving: Given that caregiving is gendered, a gender-based analysis lens is also needed to adequately theorize ‘gender’ in the realm of caregiving in order to ensure thorough, equitable and inclusive policy development.

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<sup>8</sup> For a description of this program see [http://www.hrsdc.gc.ca/en/ei/types/compassionate\\_care.shtml](http://www.hrsdc.gc.ca/en/ei/types/compassionate_care.shtml)

- Expanding the concept of caregiver: Most research has focused on the caregiving burden on relatives-- especially on the wives, and daughters who do the majority of care, to the neglect of understanding the contribution and burden on friends, volunteers and men.
- Methodological gaps in the caregiving research: Problems here include small sample sizes; rigid and faulty measurement categories along with definitional issues in surveys and statistical analyses that need theoretical grounding and better conceptual explanation; a lack of longitudinal studies as well as a lack in comparative regional, national and international studies.
- Urban versus rural contexts: How does out-migration of young people and in-migration of retirees to rural areas affect caregiving networks? How do we address the lack of caregiving services in rural compared to urban areas?
- Cultural Diversity: How do caregiving relationships differ across cultural groups in Canada (current policy tends to assume homogeneity)? How do families from diverse cultures present a different caregiving picture and how do their needs differ? How does race, ethnicity and immigration intersect with caregiving?
- Lack of focus on low-income workers: How does income, education and socio-economic-status affect caregiving patterns?
- Identifying the relationship between caregiving and non-standard work: What is the impact of different patterns of work structure (i.e. the move toward more non-standard, part-time, contract, self-employment) and caregiving.
- Appreciation of the context of care: Currently we do not understand how the benefits and costs are distributed across families, communities, states, markets and employers and how this distribution is affected by policies. Future research needs to be done to increase our understanding of how the interconnected consequences of the caregiving burden (e.g. increased expenditures, reduced incomes, increased strain and stress that unpaid care providers often experience as result of taking on caregiving impact family members) are shared among family members.

In summary, there still exists a major gap between research, public policy and practice when it comes to the issue of employed caregiving. Even though the literature is clear that we need to understand the holistic caregiving picture to include multiple roles, stressors and the varied situations of family caregivers, few services and policies uniformly assess the full context of family caregiver's well being. The research undertaken in this study should help close some of these gaps in the literature.

## **Chapter Three**

### **What Does the Balancing Work, Family and Lifestyle Study Tell Us About Employed Caregiving in Canada?**

#### **1. Introduction**

As noted in the literature review, Canada's population is aging, influenced largely by the baby boom of the 1950s and early 1960s and the baby bust of the late 1960s and early 1970s (Foot, 1996). A continuing low rate of fertility has resulted in an age distribution characterized by an over representation of people in their prime working years and a diminishing pool of young adults aged 15-24. It has been estimated that by 2021, 17.8% of the Canadian population will be over 65 years of age (Health Canada, 2001).

The aging of the Canadian population has a number of implications for the country, not the least of which is a greater proportion of Canadian employees responsible for the care of elderly dependents. The 1996 census found that 15% of Canadians provided some care to seniors (Scott, 2000) and the Vanier Institute (1997) noted that 66% of seniors over the age of 75 relied on family members for help with housework, cooking and personal care. A recent report by Statistics Canada (1999) dedicated to the topic of eldercare noted that in 1996, about 2.1 million Canadians looked after older family members or friends. Elder caregivers (both male and female) were, on average, in their mid-40s. The majority (over 2/3) were in the paid workforce.

This demographic transition has also resulted in the growth of a group which has been labelled the "sandwich generation" – employees in the "baby boom" and "baby bust" generations who have responsibility for both dependent children and aging parents. Employees with these dual demands typically experience extraordinary challenges balancing work and family demands (Vanier, 1997). It has been estimated that one in four Canadians are part of the sandwich generation (Duxbury and Higgins, 2003). Johnson et al (2001) reported that in 1996, 16% of women aged 25-54 and 9% of men in this age group provided unpaid child and senior care. Research by the Canadian Council for Social Development suggests that the number of employees who are in the sandwich generation will increase over the next decade as Canadians delay family formation and childbirth (CCSD, 1996).

Employees who care for elderly dependents can be considered "at risk" of experiencing a particular type of work-life conflict referred to as Caregiver Strain. Caregiver strain is a multi-dimensional construct which is defined in terms of "burdens" or changes in the caregivers' day to day lives which can be attributed to the need to provide care (Robinson, 1983). Analysis using data from the 2001 Balancing Work, Family and Lifestyle National Study (Duxbury and Higgins, 2003) determined that approximately one in four employees (26%) experience what can be considered to be high levels of total caregiver strain: physical, financial or mental stress that comes from looking after an elderly dependent. This study also quantified the impact of caregiver strain on key stakeholders (Duxbury and Higgins, 2003). Compared to their counterparts with low caregiver strain, employees with high caregiver strain were:

- 13 times more likely to miss 3 or more days of work in a six month period due to eldercare problems,

- twice as likely to miss work because they were mentally, emotionally or physically fatigued, to report high levels of depressed mood, to report high levels of perceived stress, to report high levels of burnout, to have sought care from a mental health professional, to say their health is fair/poor, to have made 6 or more visits per year to a physician, to have received care on an outpatient basis, to have made 8 or more visits per year to an other health care professional, to have required inpatient hospital care, to have visited a hospital emergency room, and to have spent \$300 in the last year for prescription medicine for their personal use.

On the other hand, employees with low levels of caregiver strain were twice as likely as those with high levels of this form of conflict to report high levels of life satisfaction.

Of particular concern are findings which show that respondents with high levels of caregiver strain appear to be at the highest risk with respect to perceived stress, depressed mood and impaired physical health. They are also the least likely to be satisfied with their lives.

The financial costs of high levels of caregiver strain are also overwhelming. Duxbury and Higgins (2003) and Higgins et al. (2004) estimate:

- the direct costs of absenteeism due to high levels of caregiver strain to be just over one billion dollars per year (indirect costs are estimated at another one to two billion dollars).
- the direct costs of inpatient hospital stays due to high caregiver strain to be approximately \$4 billion per year, of physician visits due to high caregiver strain to be approximately \$1 billion per year and of visits to the hospital emergency department due to high caregiver strain to be approximately one hundred million dollars per year (i.e., total cost of approximately \$5 billion for these three services)
- that companies could save an approximately \$128 per employee per year in prescription costs alone if they could reduce caregiver strain.

These costs can be expected to increase in the future as the proportion of the workforce with eldercare responsibilities increases (see Higgins and Duxbury, 2002 for a discussion of this issue).

These data provide a compelling argument as to why organizations and governments need to identify and implement strategies to reduce caregiver strain. An extensive review of the literature (see Chapter Two) indicates that very little empirical work has been done on the antecedents, consequences and moderators<sup>9</sup> of caregiver strain for employed individuals with responsibilities for the care of one or more elderly dependents and those in the sandwich generation. Furthermore, very little is known about the prevalence of this type of strain within Canada's workforce.

The research initiative reported on in this section of the report uses quantitative data from Duxbury and Higgin's 2001 National Work-Life Study to address these gaps in the research literature. It does this by undertaking analysis to examine how working caregivers in Canada

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<sup>9</sup>Higgins, Duxbury and Lyons (2007) have just completed a major study on the moderators of caregiver strain.

compare to employees without any caregiving responsibilities. In this analysis working caregiver is operationalized as follows:

- Parents: employed Canadians who spend time each week in childcare but do not have any elder care responsibilities,
- Elder caregivers: employed Canadians who do spend time each week in eldercare activities but do not spend any time in childcare
- Sandwich group: employed Canadians who spend time each week in both childcare and eldercare activities.

The size of our data set allows us to further subdivide the eldercare and sandwich groups into three subgroups based on the location of the elderly dependent:

- Elderly dependent living with respondent,
- Elderly dependent living nearby, and,
- Elderly dependent living elsewhere.

## **1.1 Research Questions**

The following research questions were used to guide the analysis:

1. How prevalent is caregiver strain? How prevalent are the three key components of caregiver strain: financial strain, physical strain and emotional strain?
2. What impact do the three forms of caregiver strain have on the employed caregiver? Specifically, what is the relationship between financial, physical and emotional strain and the employed caregiver's physical and mental health? Their experiences at work and at home?
3. What are the key predictors of the three different forms of caregiver strain?
4. In what ways are employed caregivers similar to and different from each other and from those without any caregiving responsibilities.
5. What impact does where the elderly dependent lives (i.e. with employed caregiver, nearby the employed caregiver or elsewhere) have on the above similarities and differences?
6. What kind of strategies can employed caregivers use to cope with caregiver strain?

## **Outline of the Chapter**

The rest of this chapter is structured as follows. The research methodology is described first in Section 2. Estimates on the number of Canadian employees in each of the caregiver groups is presented in Section 3. This is followed in Section 4 by data on the prevalence of the three key components of caregiver strain: financial strain, physical strain and emotional strain. Section 5 explores the impact each of these forms of caregiver strain have on an employee's physical and mental health and their ability to balance competing work and family demands, the employer, the family and Canadian society. Section 6 identifies the key predictors of the three different forms

of caregiver strain. Section 6 looks at the different caregiving groups with the aim of increasing our understanding the similarities and differences between the groups.

## **2. Methodology**

The methodology section is divided into three parts. Information on the sample is presented first. This is followed by a brief discussion of the procedures used to operationalize the constructs examined in this study. The statistical techniques used to answer the research questions outlined earlier are covered in section three.

### **2.1 Who Responded to the National Work–Life Conflict Study?**

The sample for the “National Work–Life Conflict Study” was drawn from 100 Canadian companies with 500+ employees. Forty of these organizations operated in the private sector, 22 were from the public sector and 38 were from the not-for-profit sector. Private-sector companies from the following sectors were included in the sample: telecommunications, high technology, retail, transportation, pharmaceutical, financial services, entertainment, natural resources and manufacturing. The public-sector sample included 7 municipal governments, 7 provincial government departments, and 8 federal public service departments/agencies. The not-for-profit sector sample consisted of 15 hospitals/district health councils, 10 school boards, 8 universities and colleges, and 5 “other” organizations that could best be classified as not-for-profit/greater public service (e.g. social service, charity, protective services).

A total of 31,571 employees responded to the survey. The sample is distributed as follows:

- Just under half (46%) of the respondents work in the public sector. One in three work in the not-for-profit sector and 20% are employed by a private-sector company.
- Just over half (55%) of the respondents are women.
- Just under half (46%) of the respondents work in managerial and professional positions, 40% work in non-professional positions (e.g., clerical, administrative, retail, production) and 14% work in technical jobs.
- Just over half (56%) of the respondents have dependent care responsibilities (i.e., spend an hour or more a week in either childcare or eldercare).

A full description of the sample can be found in Reports One (demographics, demands), Two (work-life conflict and its impact), Three (impact of work-life conflict on use of health care system), Four (predictors of work-life conflict) and Five (moderators of work-life conflict of this series (see Appendix B for bibliographic details). Key details which may be of interest to the readers of this report are given below.

#### **2.1.1 Demographic Profile of Respondents**

The 2001 survey sample is well distributed with respect to age, geographic area of residence, community size, job type, education, personal income and family income. The mean age of the respondents is 42.8 years. Approximately half of the respondents are highly educated knowledge workers (i.e., managers and professionals). The majority of respondents (75%) are married or living with a partner and are part of a dual-income family (69% of the sample). Eleven percent

are single parents. Twelve percent live in rural areas. One quarter of the respondents indicate that money is tight in their family which is consistent with the fact that 29% of respondents earn less than \$40,000 per year. One in three of the respondents have high school education or less.

Most respondents have responsibilities outside of work. Seventy percent are parents (average number of children for parents in the sample is 2.1); 60% have eldercare responsibilities (average number of elderly dependents is 2.3); 13% have responsibility for the care of a disabled relative; 13% have both childcare and eldercare demands (i.e., are part of the “sandwich generation”). The fact that the demographic characteristics of the sample correspond closely to national data provided by Statistics Canada (see Higgins and Duxbury, 2002) suggests that the findings from this study can be generalized to a larger population.

### **2.2.2 Sample Profile: Levels of Work–Life Conflict**

Four types of work–life conflict are examined in this study: role overload, work interferes with family, family interferes with work, and caregiver strain. Role overload occurs when the total demands on time and energy associated with the prescribed activities of multiple roles are too great to perform the roles adequately or comfortably. The majority of employees in our sample (58%) are currently experiencing high levels of role overload. Another 30% report moderate levels of role overload. Only 12% of the respondents report low levels. Our research suggests that the proportion of the workforce experiencing high levels of role overload increased substantially from 1991 to 2001 (i.e., by approximately 11%).

Work interferes with family occurs when work demands and responsibilities make it more difficult for an employee to fulfil family role responsibilities. One in four Canadians in this sample reports that work responsibilities interfere with their ability to fulfill responsibilities at home. Almost 40% of respondents report moderate levels of interference. The proportion of the Canadian workforce with high levels of work to family interference has not changed appreciably from 1991 to 2001.

Family interferes with work occurs when family demands and responsibilities make it difficult for an employee to fulfil work-role responsibilities. Only 10% of the Canadians in this sample report high levels of family to work interference. Another third report moderate levels of family to work interference. Our data suggest that the percentage of working Canadians who experience this form of interference has doubled over the past decade.

Approximately one in four respondents experience what can be considered to be high levels of caregiver strain: physical, financial or mental stress that comes from looking after an elderly dependent. While most respondents (74%) rarely experience this form of work–life conflict, 26% report high levels of caregiver strain.

Who has more problems balancing work and family responsibilities? The evidence from this research is quite clear—employed Canadians with dependent care responsibilities. Employees who have child and/or eldercare responsibilities report higher levels of role overload, work interferes with family, family interferes with work, and caregiver strain, than their counterparts without dependent care. The fact that employed parents and elder caregivers have greater

difficulty balancing work and family is consistent with the research in this area and can be attributed to two factors: greater non-work demands and lower levels of control over their time.

Job type is associated with all but one of the measures of work–life conflict explored in this study. Managers and professionals are more likely than those in “other” jobs to experience high levels of overload and work interferes with family. This finding is consistent with the fact that the managers and professionals in this sample spent significantly more time in paid employment and were more likely to perform unpaid overtime than colleagues who worked in clerical, administrative, technical and production jobs. Those in “other” jobs, on the other hand, are more likely to report higher levels of caregiver strain from the financial stresses associated with eldercare.

Women are more likely than men to report high levels of role overload and high caregiver strain. This is consistent with the finding that the women in this sample devote more hours per week than men to non-work activities such as childcare and eldercare and are more likely to have primary responsibility for non-work tasks.

## **2.2 The Research Instrument**

A 12-page survey produced in a mark-sensitive format with a unique bar code given to each organization participating in the study was used to collect the data. This survey was divided into nine sections: your job; your manager; time management; work, family and personal life; work arrangements; work environment; family; physical and mental health; and “information about you.” Virtually all of the scales used in the questionnaire are psychometrically sound measures that have been well validated in other studies. A list of where they measures can be found is provided in Appendix C.

## **2.3 Caregiver Group**

The following procedure was used to classify the individuals who responded into our survey into the eight groups being examined in this analysis. First, individuals with caregiving responsibilities were identified using the following questions from this study:

- Do you have responsibility for the care of an elderly dependent? If yes,
  - How many elderly relatives in each of the following categories do you have responsibility for: Living in your home? Living nearby (i.e. within a short drive)? Living elsewhere?
  - How many hours per week do you spend caring for elderly relatives?
- How many children do you have? Please indicate the age of each of these children.
- How many hours per week do you spend in childcare or in activities with your children?

These questions allowed us to identify the following groups from our sample:

- No caregiving,
- Childcare only (restricted to children in the home and one or more hours of childcare per week),
- Eldercare only, and
- Sandwich generation (both childcare and eldercare).

The size of our data set allowed us to further subdivide the eldercare and sandwich groups into the following three subgroups:

- Elderly dependent living with respondent,
- Elderly dependent living nearby, and,
- Elderly dependent living elsewhere.

To our knowledge this study is the first one that has examined the relationship between where the person requires care is living and caregiver strain.

## 2.4 Caregiver Strain

Caregiver Strain was quantified in this study using a modified three-item version of Robinson's (1983) Caregiver Strain Index (CSI). This index measures objective (rather than subjective) burden in three areas. Respondents were asked to indicate (using a five point Likert scale) how often they had difficulty in caring for an elderly relative or dependent because of physical strains (i.e. effort or concentration), financial strains or because it left them feeling completely overwhelmed (i.e. worry about how I/we will manage). Response options included never, monthly, weekly, several days per week or daily. It should be noted that research on caregiver strain has typically focused on strains associated with the provision of eldercare or care for a disabled dependent rather than those linked to childcare itself. Consistent with past practices, Duxbury and Higgins used caregiver strain to measure strain and burden associated with eldercare only.

*Total Caregiver Strain* was calculated as the summed average of the respondents score on these three questions. Higher scores indicate greater strain. This measure has been used in a number of studies with good results (Robinson reports a Cronbach alpha of 0.91). In this study, the Cronbach alpha was 0.78.

In order to increase our understanding of the caregiver strain construct it was decided to focus our analysis on each of the three types of caregiver strain (financial, physical, emotional) rather than the entire construct<sup>10</sup>. This decision was supported by the fact that initial analysis indicated that antecedents, consequences and prevalence all depend on the form of strain being considered.

To determine who had high, moderate and low scores on each of the three forms of caregiver strain examined in this study we divided the total sample into three groups on the basis of their response to the caregiver strain item of interest. Respondents with high levels of strain reported that they experienced such stresses several times a week or daily. Those with low levels of strain indicated that they experienced such stress never or monthly or less. Employees who reported that they experienced such stress on a weekly basis were considered to have moderate levels of strain.

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<sup>10</sup> The reports Duxbury and Higgin's prepared for Health Canada all focus on Total Caregiver Strain. As such, this analysis supplements rather than duplicates existing analysis.

## 2.5 Antecedents and Outcomes of Caregiver Strain

This study makes use of the following data from the 2001 Balancing Work, Family and Lifestyle National Study:

- *Demographic*: age, gender, income, education, marital status, where live – rural/versus urban, population of town, province, age of spouse, education of spouse, age of children), family's financial status.
- *Employment*: sector of employment, job type, hours per week in employment – paid and unpaid overtime – benefits provided by employer, work arrangement, work status (permanent/temporary), perceived flexibility, culture of organization, supportive management.
- *Work and Non-work Demands*: hours per week in paid employment, childcare, eldercare, home chores, leisure, and volunteer activities; responsibility for childcare, responsibility for eldercare.
- *Employee Outcomes*: stress, depressed mood, life satisfaction, perceived health.
- *Work-life Outcomes*: role overload, work interferes with family, family interferes with work, caregiver strain.
- *Work Outcomes*: absenteeism due to childcare, eldercare, physical and emotional fatigue, and poor health, organizational commitment, job stress, intent to turnover.
- *Family Outcomes*: family integration, family well being, family satisfaction.
- *Societal Outcomes*: use of health care system, decision to have children.

The outcomes examined in this analysis were all quantified using well established instruments from the academic literature. These measures are grouped as follows in this study:

- employee physical and mental health outcomes: perceived stress, depressed mood, life satisfaction, perceived physical health,
- work-life outcomes: role overload, work interferes with family, family interferes with work
- organizational outcomes: organizational commitment, job stress, job satisfaction, intent to turnover, absenteeism
- family outcomes: family adaptation (i.e. well being), family satisfaction, parental satisfaction, family integration and positive parenting
- societal outcomes: use of Canada's health care system, and fertility.

Details on each of these outcomes as well as how they are defined and measured in this analysis can be found in Appendix C. Greater detail on each of these outcomes can be found by looking at Duxbury and Higgins body of work in this area (see Appendix B). Full details on the other questions of interest to this study (i.e. those used to describe the demographics of the sample as well as their work environments and their work and non-work demands) can be found in Duxbury and Higgins (2001) and Higgins and Duxbury (2002).

## 2.6 Statistical Analysis

A number of different statistical techniques were used to answer the different research questions. Details on each are given below. Key statistical terms used in the write up of this report are summarized in Box 1.

## **Box 1**

### **Terms Used in Discussing Statistical Analysis**

**Regression:** a technique where one group of variables (called independent variables) is used to predict a dependent variable. In this report, we look at three dependent variables: financial strain, physical strain, and emotional strain

**Dependent variable:** The outcome variable of the research (i.e. caregiver strain)

**Independent variable:** A variable that is expected to influence the dependent variable (i.e. time in eldercare, management support)

**R<sup>2</sup> (R-squared):** the amount of variance in the dependent variable that is explained by the independent variables. This statistic is used to determine the strength of the association between dependent and independent variables and ranges from 0 to 1. The closer R<sup>2</sup> is to 1, the stronger the association. Researchers often multiply the R<sup>2</sup> value by 100 and talk about the percent of the variation in the dependent variable (in this case caregiver strain) explained by the independent variable (demands, work environment, demographics).

**F-test:** statistic used to evaluate whether the predictive power of the regression model is null. If we reject the null model, we say we have a significant regression (i.e. the independent variables included in the regression are significantly able to predict our dependent variable).

**p-value:** level of statistical significance. Traditionally, p-values of 0.05 or less are considered to be statistically significant. In this study we applied a **Bonferroni adjustment** which is a more conservative approach to hypothesis testing which is done to reduce the chances of making a type 1 error (i.e. the error of rejecting a null hypothesis when it is true) and identified significance as a p-values of 0.000 or less.

**Pratt's Measure/Co-efficient:** Statistic which is calculated to determine the relative importance of each independent variable in the regression equation.

### **2.6.1 Descriptive Statistics**

As a first step in all analysis we calculated the percent of each of the various research samples reporting low, moderate and high levels of each of the attitudes and outcomes being studied. Details on how this was done (which varies depending on what construct is being considered) are provided in Duxbury and Higgins various reports (See Appendix B).

We also calculated the mean and standard deviation for each of the demand items and frequencies for the various demographic variables included in the analysis (i.e. percent married, percent with university education).

## 2.6.2 Chi square analysis

Chi square analysis was used to test for significance between group-differences. In most cases (i.e. caregiver strain by outcomes) the Chi square was a three by three analysis (i.e. high, medium and low caregiver strain versus high, moderate and low perceived stress). With the dichotomous variables (i.e. yes, no) the analysis was a three by two Chi square. Only part of these analyses are shown in the report (i.e. we show the percent of the low, moderate and high caregiver strain samples that have high stress but not the proportion with low or moderate stress levels). Given the large sample sizes, almost all differences were significant. To ensure that differences were substantive (i.e. worthy of note) as well as significant, we focus here on variations that are significant at the  $p < .000$  level and substantive which we define as between group differences of at least 10%.

## 2.6.3 Analysis of Co-variance (ANCOVA)

This technique was used in this study to assess differences in means between caregiver groups when we were working with continuous data (i.e. time in work per week). Gender was included as a covariate in all of these analysis. Again, the focus in this discussion will be on statistically significant results ( $p < .000$ ) that are substantive in nature.

## 2.6.4 Regression

Regression is a technique where one group of variables (called independent variables) is used to predict a dependent variable. For example, one could use knowledge of a person's family situation (e.g. number of children), income and hours per week spent working to predict role overload. In our analyses, we did a series of regressions using financial, physical and emotional caregiver strain as dependent variables. Regression models were run for the four following groups of independent variable models:

- *Demographic situation:* family's financial situation, parental status, gender, age, elderly dependent lives with respondent/nearby/elsewhere
- *Demands:* total hours per week the respondent spends in paid employment, total hours per week the respondent spends in eldercare, total hours per week the respondent's partner spends in eldercare, responsibility for childcare, responsibility for eldercare, gender, elderly dependent lives with respondent/nearby/elsewhere
- *Characteristics of work:* job type, supportive manager, non-supportive manager, availability of following organizational supports: on-site day care, elder-care referral services, child-care referral services, flexible work hours, telework, EAP, supportive relocation policies, family/emergency days off work, unpaid leave of absence, paid personal days off work, time off instead of overtime, short-term personal/family leave, part time work with pro-rated benefits), descriptors of organizational culture (not acceptable to say no to more work, if you do not work long hours you will not get ahead, family responsibilities limit career advancement, co-workers supportive of personal/family responsibilities, managers supportive of personal/family responsibilities, feel comfortable

using supports provided by the organization), perceived flexibility of work (i.e. hours, location, days, ability to take time off when needed), gender and elderly dependent lives with respondent/nearby/elsewhere

- *Total:* significant predictors from models one to three.

To determine the impact of where the elderly dependent lives on caregiver strain it was necessary to control for this factor in the regression equations. Details on the technique and the regression analysis undertaken in this report are provided in Appendix D. Complete regression results are also included in this Appendix in section D:2.

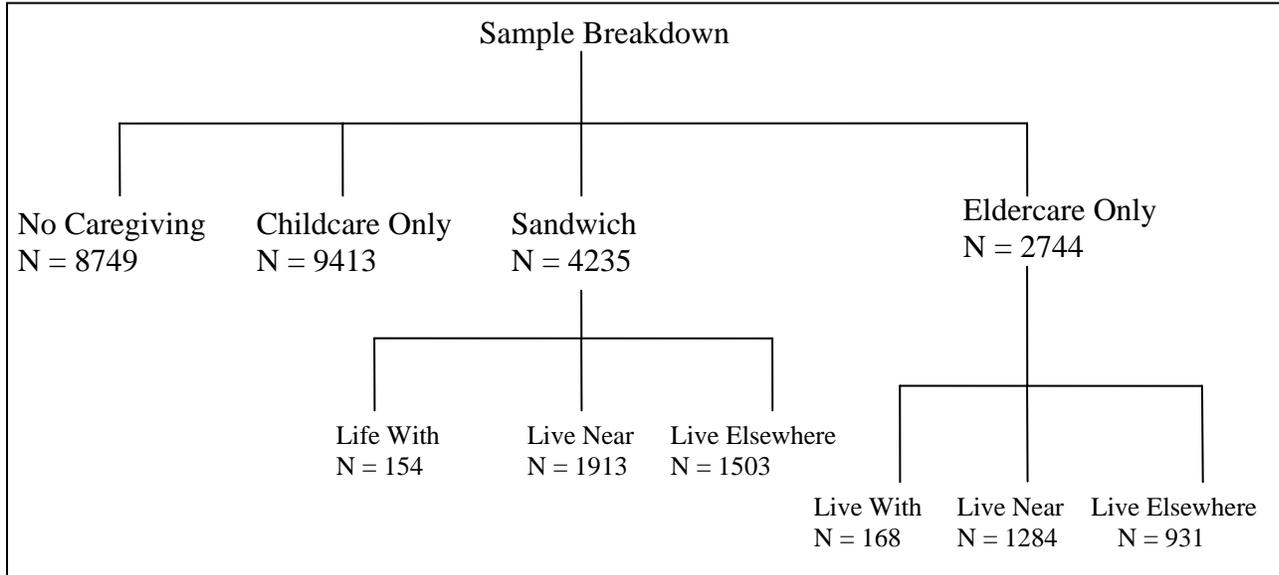
### **3. Prevalence of Employed Caregiving**

The sample frame for this analysis is summarized in Figure One.

Given the fact that Duxbury and Higgin's sample is considered generalizable to the population of Canadians working for the country's larger (i.e. 500+) firms, these data give us the following estimates of the prevalence of the different employed caregiver groups within Canada in 2001:

- No caregiving: 34.8% of workforce
- Childcare only: 37.4% of workforce
- Sandwich generation: 16.8% of workforce
  - Elderly dependent lives with employee
    - 0.6% of workforce
    - 3.6% of sandwich group
  - Elderly dependent lives near employee
    - 7.6% of workforce
    - 45.2% of sandwich group
  - Elderly dependent lives in another location than the employee
    - 6.0% of the workforce
    - 51.2% of the sandwich group
- Eldercare only: 11.0% of workforce
  - Elderly dependent lives with employee
    - 0.7% of workforce
    - 6.1% of eldercare only group
  - Elderly dependent lives near employee
    - 5.1% of workforce
    - 60.0% of eldercare only group
  - Elderly dependent lives in another location than the employee
    - 3.7% of the workforce
    - 33.9% of eldercare only group

**Figure 1: Sample Frame**



### **One in four employed Canadians have eldercare responsibilities**

The following conclusions can be drawn from these data:

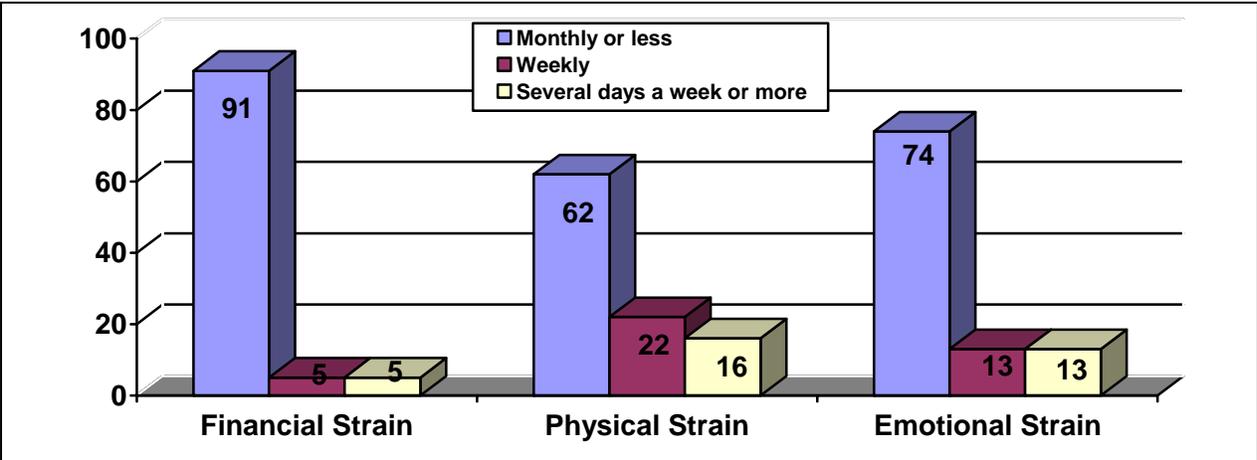
- The majority of employed Canadians also have caregiving responsibilities (66.6%).
- Just over one in four (27.8%) of employed Canadians have responsibilities for the care of elderly dependents – a percent that as noted earlier, is likely to grow as the baby boom population ages.
- Almost one in five employed Canadians (16.8%) have responsibility for both childcare and eldercare (i.e. they have dual demands at home and demands at work).
- Only rarely do employed Canadians provide care to an elderly dependent who lives with them (the data would suggest that approximately 1.3% of the workforce is in this situation)
- Just over one in ten of Canadians provide care for an elderly dependent who either lives nearby (12.7%) or in another location altogether (9.7%)
- Twice as many employed Canadians have childcare responsibilities (54.2%) than responsibility for the care of an elderly dependent (27.8%)

### **4. Prevalence of Caregiver Strain**

The prevalence of the various forms of caregiver strain in the total sample is summarized in Figure 2. The following observations can be drawn from these data:

- Physical strain is the most prevalent form of Caregiver Strain. Approximately one in three (38%) of the employed Canadians in this sample report moderate to high levels of physical caregiver strain.
- Emotional strain is also problematic: Approximately one quarter of the employed Canadians in this sample report moderate to high levels of emotional strain that can be attributed to the stresses associated with caring for an elderly relative.
- Financial strain is relatively rare for employed caregivers. Only one in ten employed Canadians in this sample experience moderate to high levels of financial caregiver strain.
- The percent of the working population that can be considered to be in the high risk group with respect to physical and emotional caregiver strain is very similar.
- Approximately twice as many employed Canadians can be considered to be at moderate risk with respect to physical caregiver strain than emotional strain.

**Figure 2: Distribution of Caregiver Strain (percent)**



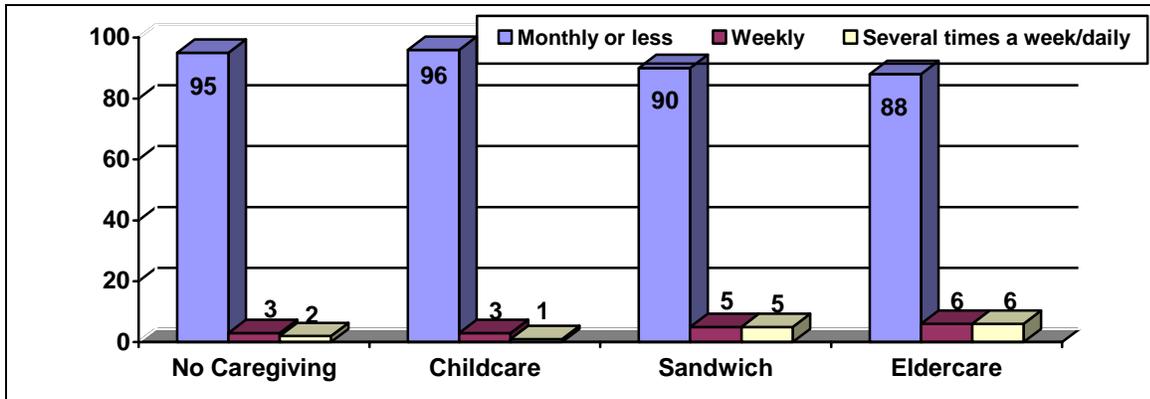
**4.1 Impact of Caregiver Group on Caregiver Strain**

Figure 3 shows the distribution of the three forms of caregiver strain by caregiver group. Key observations from these data are summarized below:

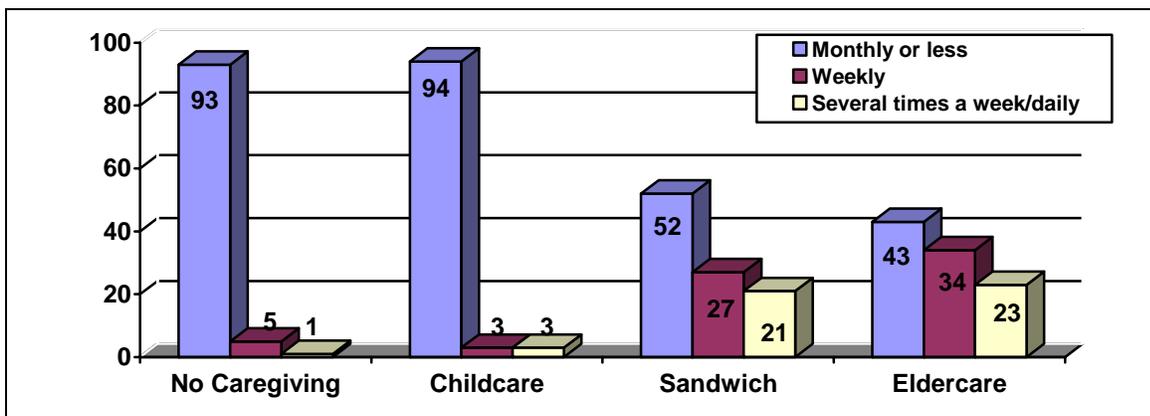
- If you do not have eldercare responsibilities, you are unlikely to experience any form of caregiver strain.
- Financial strain does not appear to be a significant problem for employed Canadians (moderate to high levels reported by only one in ten of the respondents)

**Figure 3: Distribution of Caregiver Strain by Caregiver Group (percent)**

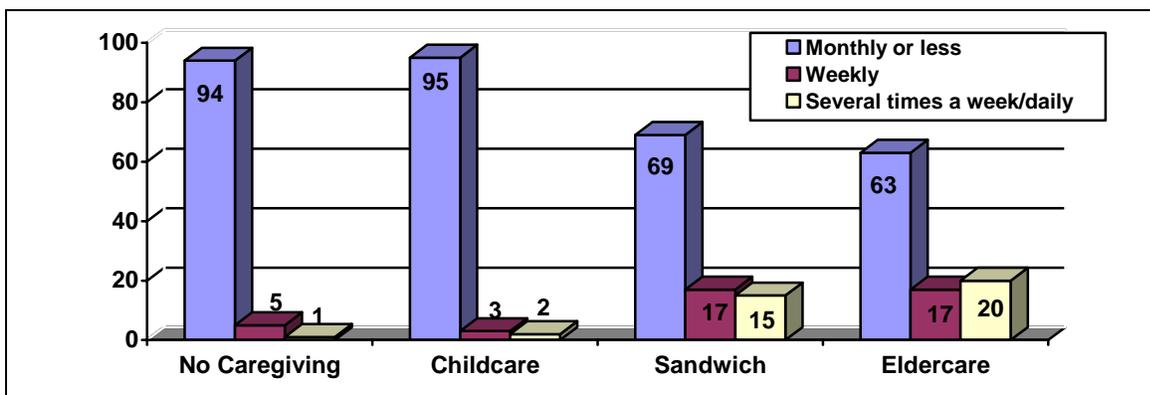
**a. Financial Strain**



**b. Physical Strain**



**c. Emotional Strain**



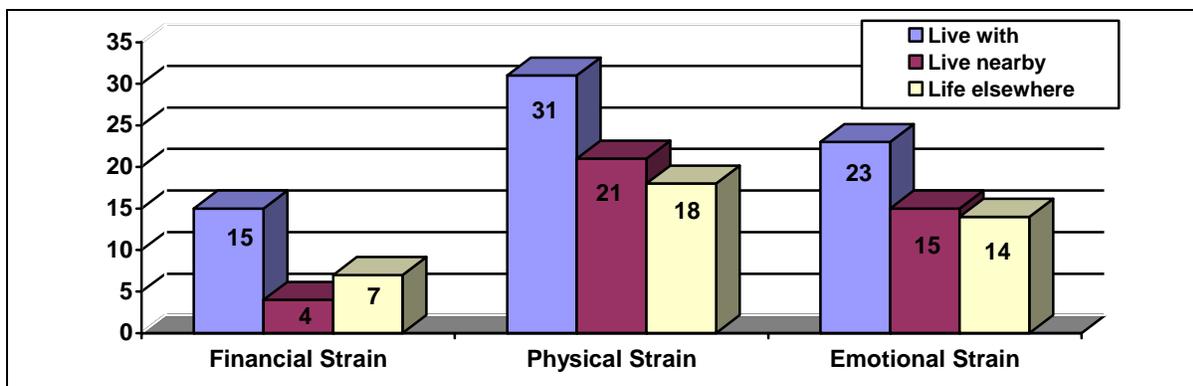
- Having children does not increase the risk that those with eldercare responsibilities will experience financial strain: 12% of those in the eldercare group and 10% of those in the sandwich group report moderate to high levels of financial strain.
- Employees in the sandwich and eldercare groups are equally likely to report high levels of physical strain (just over one in five employees in each of these groups report such strains several times a week/daily).
- Employees in the eldercare group are more likely than their counterparts in the sandwich group to report moderate levels of physical stress.
- Employees in the eldercare group are more likely than those in the sandwich group to report high levels of emotional strain.
- Having children does not increase the risk that those with eldercare responsibilities will experience moderate levels of emotional strain.

#### 4.2 Impact of Where Elderly Dependent Lives on Caregiver Strain

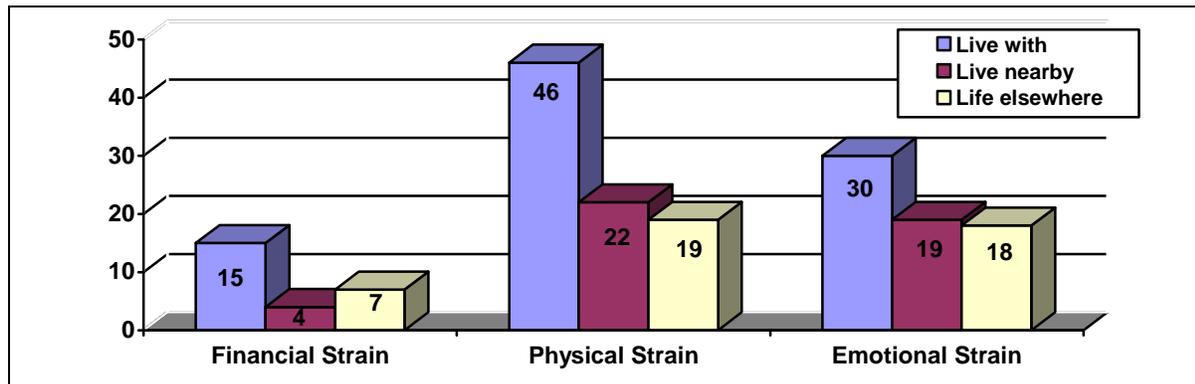
To gain a greater understanding of who is at risk (defined as individuals who experience strain weekly or more) of caregiver strain we did additional analysis using the sandwich and eldercare samples. The relationship between where the elderly dependent lives (with employee, near by or elsewhere) and high levels of the various forms of caregiver strain are given in Figure 4.

**Figure 4: Impact of Where Elderly Dependent Lives on Caregiver Strain:**

**a. Sandwich (% reporting high levels of strain)**



**b. Eldercare (% reporting high levels of strain)**



The following conclusions are supported by these data:

- Employees who provide caregiving for elderly dependents who live with them experience the highest levels of financial strain, physical strain and emotional strain. While the data does not tell us why this may be the case the literature reviewed in Chapter Two suggests that the following factors may contribute to this finding:
  - dependents who live with family members are in poorer health than those who do not and as such require more care,
  - people who have their dependents living with them provide more care and have more competing demands on their time,
  - people who have dependents living with them feel a greater obligation to spend time with/help their elderly dependent,
  - people whose dependent lives with them are more likely to see a decline in the dependents physical and mental health,
  - it is hard for people whose elderly dependent lives with them to put the situation out of their mind.
  - people whose dependent lives with them are different socio-demographically (i.e. older, more financial problems) than those whose dependent does not live with them.
- Employees who provide care for dependents who live near (but not with) them experience lower levels of financial strain than their counterparts who provide care for those who live elsewhere suggesting that employees who “care at a distance” incur more costs than those who have their dependents nearby (i.e. travel, phone). The data shows, however, that both these costs pale compared to the costs associated with having your elderly relative live with you.
- Having children does not increase the risk that those with eldercare responsibilities will experience high levels of financial strain (i.e. no differences in incidence of financial strain between sandwich and eldercare groups)
- Employees in the eldercare only group who have their elderly dependent living with them are at greatest risk with respect to both physical and emotional strain. The extent to which

these two forms of strain are problematic for the individuals in this group can be appreciated by recognizing that approximately half of the employees in this sample report high levels of physical strain while one in three report emotional strain.

- Having children at home seems to provide employees with elderly dependents at home some increased ability to cope as employees in the sandwich group are less likely to report high levels of physical or emotional strain than are those with just eldercare. How does having children at home help? It is hard to say from these data but it is possible that children reduce these strains by helping out with eldercare, providing emotional support to their parents, and (strangely enough) providing the employee with another role (that of parent) whose rewards can offset the frustrations and strains associated with the role of elderly caregiver. This third explanation is based on the idea of “role expansion” which states that people can benefit from multiple roles when the rewards from one set of responsibilities (i.e. raising a child, watching them learn) partially offset the frustrations and stresses of performing a second role (i.e. watching parent die and lose functioning).
- Whether the elderly dependent lives near the employee or elsewhere affects physical but not emotional strain. For both the eldercare and sandwich groups, the less the physical distance between elderly dependent and employee, the greater the physical strain. The fact that the difference between the nearby and elsewhere groups is relatively small (3%) does, however, suggest that distance from the dependent does not provide much protection against this kind of strain.
- Emotional strain is not affected by whether or not the elderly dependent lives nearby or elsewhere. It would seem that with one exception (living with), emotional strain is due to the act of caring for an elderly relative, regardless of where this relative lives. People do not experience greater strain when the relatively lives far away (i.e. this does not increase worry). Nor does their ability to visit/check on them easily seem to exacerbate or alleviate this strain.
- While having children seems to help those in the sandwich group cope with strain when the dependent lives with the employee, it has no such salutatory affect when the elderly dependent lives elsewhere.

## **5. Impact of High Caregiver Strain**

This section is divided into five parts: impact of strain on employees’ physical and mental health, employees’ work-life balance, the organization, the family and Canadian society. Within each of these five sections we will look at the impact of financial strain, physical strain and emotional strain on the outcomes of interest. We will also provide a summary of the relative impact of the various forms of caregiver strain on the various outcomes. It should be noted that due to the small sample size the analysis for financial strain was done using the total eldercare and sandwich sample (n = 6979) rather than by caregiver group. It should also be noted that data are shown only in those cases where a significant relationship was observed between strain and outcome. The figures referred to in this section can be found in Appendix E.

## **5.1 Impact of Caregiver Strain on Employee Physical and Mental Health**

Four dimensions of physical and mental health are examined in this analysis: perceived stress, depressed mood, life satisfaction and perceived health.

### **5.1.1 Impact of Financial Strain on Physical and Mental Health**

The relationship between financial strain and employee mental health and physical health outcomes are shown in Figure E1 (see Appendix E). The following conclusions can be drawn about from these data:

- Financial strain is positively associated with stress ( $\Delta^{11} + 11$ ) and depressed mood ( $\Delta + 24$ ).
- Financial strain is negatively associated with the perception that ones health is very good/excellent ( $\Delta - 17$ ) and life satisfaction ( $\Delta - 20$ ).
- Moderate and high levels of financial strain are equally stressful.

### **5.1.2 Impact of Physical Strain on Physical and Mental Health**

The relationship between physical strain and employee mental health and physical health outcomes are shown in Figure E2 (see Appendix E). The following conclusions can be drawn from these data:

The following conclusions can be drawn from these data:

- Physical strain is positively associated with stress and depressed mood for employed caregivers in both the sandwich and eldercare groups.
- Physical strain is associated with a greater increase in perceived stress levels ( $\Delta + 25$  versus  $\Delta + 16$ ) and depressed mood ( $\Delta + 24$  versus  $\Delta + 10$ ) for those in the eldercare group, than in the sandwich group.
- Moderate and high levels of physical strain are equally stressful for those in the sandwich group. For those in the eldercare group, on the other hand, perceived stress increases concomitant with physical strain.
- Physical strain is not associated with either life satisfaction or perceived health for employed caregivers with children at home (i.e. sandwich group).
- Physical strain is negatively associated with life satisfaction ( $\Delta -18$ ) and perceived health ( $\Delta -15$ ) for employed elder caregivers.

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<sup>11</sup> The symbol  $\Delta$  is used to reflect the change in the outcome seen when one compares those with high strain to those with low strain. + indicates a positive association (i.e. outcomes increases as strain increases), - indicates a negative association (i.e. outcomes declines as strain increases)

Taken together these data support the following conclusion: physical strain has a more deleterious effect on the mental and physical health of those in the eldercare only group than their peers in the sandwich situation. This finding is consistent with the data reported earlier with respect to the incidence of caregiver strain and supports our hypothesis that children may reduce some of the burdens associated with eldercare.

### **5.1.3 Impact of Emotional Strain on Physical and Mental Health**

The relationship between emotional strain and employee mental health and physical health outcomes are shown in Figure E3 (see Appendix E). The following conclusions can be drawn from these data:

- Emotional strain is positively associated with stress and depressed mood for employed caregivers in both the sandwich and eldercare groups.
- Emotional strain is negatively associated with life satisfaction and perceived health for employed caregivers in both the sandwich and eldercare groups.
- Emotional strain is equally problematic in terms of physical and mental health to employees in both the sandwich and eldercare groups.
- The real decline in physical and mental health is experienced when one moves from the no strain to moderate strain (i.e. weekly) situation. While further declines can be seen when one moves from the moderate to high strain condition, the increase tends to be less. For example, the increase in high perceived stress from the no strain to moderate strain is  $\Delta +26$  for those in the eldercare group and  $\Delta + 20$  for those in the sandwich group. While the percent with high perceived stress increases yet again as one moves from moderate to high levels of emotional strain, the rise ( $\Delta + 6$  for those in eldercare group and  $\Delta + 7$  for those in the sandwich group) is considerably smaller.

### **5.2 Impact of Caregiver Strain on Work-Life Balance**

Three aspects of work-life balance are examined in this analysis: role overload, work interferes with family and family interferes with work. Key findings on the relationship between caregiver strain and work-life balance are presented below.

### 5.2.1 Impact of Financial Strain on Work-life Balance

The relationship between financial strain and work-life balance outcomes are shown in Figure E4 (see Appendix E). The following conclusions can be drawn from these data:

- Financial strain is positively associated with increased work-life conflict. Specifically, it is associated with an increase in role overload of  $\Delta + 16$ , an increase in work interferes with family of  $\Delta + 19$  and an increase in family interferes with work of  $\Delta + 33$ .
- Financial strain is more problematic in terms of family interferes with work than with the other two types of work-life conflict. It may be that people with eldercare responsibilities have to reduce the amount of time they spend in work (i.e. high family interferes with work) which, in turn, has a negative impact on their financial situation. Alternatively, it may be that people with lower incomes are less able to purchase the supports they need to help them actively manage their eldercare situation. As such, they need to do more of these kinds of things themselves, perhaps during work hour, which would increase the extent to which their family situation (in this care eldercare) interfered with their ability to perform their work role.
- Moderate and high levels of financial strain are equally problematic in terms of role overload and work-interferes with family (i.e. real increase in both these forms of work-life conflict are observed when one compares the no strain and moderate strain situations).

### 5.2.2 Impact of Physical Strain on Work-life Balance

The relationship between physical strain and work-life balance outcomes are shown in Figure E5 (see Appendix E). The following conclusions can be drawn from these data:

- Physical strain is positively associated with increased role overload, work interferes with family and family interferes with work (i.e. greater work-life conflict)
- The relationship between role interference (i.e. work interferes with family and family interferes with work) and physical strain is identical for those in the sandwich and eldercare groups.
- If one looks at the differences in overload reported at high versus low levels of physical strain one would conclude that this physical strain is associated with a greater increase in overload for those in the eldercare group ( $\Delta + 27$ ) than the sandwich group ( $\Delta + 13$ ). It should, however, be noted that overall, the two groups experience identical levels of overload at high levels of physical strain (just over 75% with high overload). Employees in the eldercare group with low physical strain, on the other hand, report significantly lower base levels of overload (51% high) than their counterpart in the sandwich group with children at home (64% high).

### **5.2.3 Impact of Emotional Strain on Work-life Balance**

The relationship between emotional strain and work-life balance outcomes are shown in Figure E6 (see Appendix E). The following conclusions can be drawn from these data:

- Emotional strain is positively associated with role overload, work interferes with family and family interferes with work (i.e. greater work-life conflict)
- The relationship between work-life conflict and emotional strain is identical for those in the sandwich and eldercare groups.
- Employees in the sandwich group with high levels of emotional strain report very high levels of family interferes with work. In fact, one third of the respondents in this group report high levels of this form of interference as compared to 12% of the total sample.

### **5.3 Impact of Caregiver Strain on Organizational Attitudes and Outcomes**

The relationship between caregiver strain and the following organizational attitudes and outcomes were examined in this analysis: organizational commitment, job stress, job satisfaction, intent to turnover and absenteeism due to a number of causes. Examination of the data on the relationship between caregiver strain and these key organizational indicators give us an indication of the extent to which caregiving strain is negatively impacting the organizations bottom line (and Canada's productivity)

Preliminary analysis of these data indicate that organizational commitment is not associated with caregiver strain, regardless of which sample (i.e. eldercare, sandwich) or type of strain (i.e. financial, physical, emotional) we look at. There are, however, a number of other findings that are worthy of note. These are summarized below.

#### **5.3.1 Impact of Financial Strain on Organizational Attitudes and Outcomes**

The relationship between financial strain and organizational attitudes and outcomes are shown in Figure E7 (see Appendix E). The following conclusions can be drawn from the data about the association between financial strain and organizational attitudes and outcomes:

- Financial strain is not associated with organizational commitment, job stress, or intent to turnover.
- Financial strain is negatively associated with job satisfaction ( $\Delta - 10$ ).
- Financial strain is positively associated with absenteeism due to health problems ( $\Delta + 14$ ), childcare problems ( $\Delta + 14$ ), eldercare issues ( $\Delta + 24$ ), emotional fatigue ( $\Delta + 20$ ), and all causes combined ( $\Delta + 14$ ). The increases in absenteeism due to eldercare problems and emotional fatigue at moderate and high levels of this form of strain are worthy of note for organizations.

- Moderate and high levels of financial strain are equally problematic with respect to increases in absenteeism due to childcare, eldercare, emotional fatigue, and all causes combined.
- Employees with high levels of financial strain are less likely to be absent from work due to ill health than are employees with moderate strain. While these data may reflect improved health in this group, it is more likely that these findings can be attributed to the fact that employees with high financial strain are more likely to go to work when they are sick (i.e. need money and do not want to lose job).

### **5.3.2 Impact of Physical Strain on Organizational Attitudes and Outcomes**

The relationship between physical strain and organizational attitudes and outcomes are shown in Figure E8 (see Appendix E). The following conclusions can be drawn from the data with respect to the link between physical strain and organizational attitudes and outcomes:

- Physical strain is not associated with organizational commitment, job satisfaction, intent to turnover, and absenteeism due to health problems, childcare, and emotional fatigue for employed caregivers, regardless of whether or not they have children in the home.
- Physical strain is not associated with job stress for those in the sandwich group. High physical strain is, however, positively associated with high levels of job stress for those in the eldercare group ( $\Delta + 19$ ).
- Physical strain is positively associated with absenteeism due to eldercare problems for both sandwich ( $\Delta + 31$ ) and eldercare ( $\Delta + 28$ ) groups. Again, having children at home does not appear to affect this relationship. Absenteeism due to all causes is also positively associated with physical strain for those in the sandwich group ( $\Delta + 11$ ).

### **5.3.3 Impact of Emotional Strain on Organizational Attitudes and Outcomes**

Emotional strain is associated with many of the organizational outcomes examined in this report. The relationship between emotional strain and organizational outcomes are shown in Figure E9 (see Appendix E). The following conclusions can be drawn from these data:

- Emotional strain is not associated with organizational commitment.
- Emotional strain is positively associated with job stress for employed caregivers in both the sandwich ( $\Delta + 13$ ) and eldercare ( $\Delta + 17$ ) groups. The relationship between these two stresses does, however, depend on whether or not the caregiver had children at home. For those in the sandwich group, the levels of job stress are the same at moderate and high levels of emotional strain. For those in the eldercare group, job stress increases concomitant with emotional strain.
- Emotional strain is negatively associated with job satisfaction for those in the sandwich group ( $\Delta - 14$ ). No such relationship is observed in the eldercare group.

- Emotional strain is positively associated with intent to turnover for those in the eldercare group ( $\Delta + 13$ ). No such relationship is found in the sandwich group. These differing results may reflect the fact that these two groups are at different life cycle stages (i.e. eldercare group at the end of their career and decide to leave as a way of coping with eldercare stresses; those in the sandwich group cannot quit but end up unhappy in their work).
- In both sandwich and eldercare groups, emotional strain is associated with increased absenteeism due to all causes, emotional fatigue and eldercare problems. Those in the sandwich group are also more likely to be absent due to ill health. With one exception (absenteeism due to eldercare) the relationship between high levels of emotional strain and absenteeism is very similar between the eldercare and sandwich groups. High levels of emotional strain are, however, more likely to be associated with increased absenteeism due to eldercare problems in the sandwich than the eldercare group.
- Absenteeism due to childcare problems is not associated with emotional strain.

#### **5.4 Impact of Caregiver Strain on Family Outcomes**

The impact of caregiver strain on the family was studied by looking at the relationship between caregiver strain and a number of family outcomes including family adaptation (i.e. well being), family satisfaction, parental satisfaction, family integration (i.e. how well the family works together) and positive parenting. Key findings are reported below.

##### **5.4.1 Impact of Financial Strain on the Family**

Financial strain was not significantly associated with any of the family outcomes examined in this study.

##### **5.4.2 Impact of Physical Strain on the Family**

Only one of the five family outcomes included in this study, family satisfaction was significantly associated with physical strain (see E10 in Appendix E). The following conclusions can be drawn about the relationship between physical strain and family outcomes:

- Physical strain does not impact family integration, family adaptation, parental satisfaction or parental performance.
- Physical strain is negatively associated with family satisfaction for employees in both the sandwich ( $\Delta - 10$ ) and eldercare ( $\Delta - 16$ ) groups. The impact is more profound for those in the eldercare group than the sandwich group.

These results would suggest that elderly caregivers try and compartmentalize the stresses associated with eldercare demands.

### **5.4.3 Impact of Emotional Strain on the Family**

The relationship between emotional strain and family outcomes are shown in Figure E11 (see Appendix E). The following conclusions can be drawn from the data with respect to the link between emotional strain and family outcomes.

- Emotional strain does not impact family integration, parental satisfaction or parental performance, regardless of whether or not the employee has children in the home.
- Emotional strain is negatively associated with family adaptation for employees in both the sandwich ( $\Delta - 14$ ) and eldercare ( $\Delta - 24$ ) groups. Emotional strain is also negatively associated with family satisfaction ( $\Delta - 24$ ) for those in the eldercare group.
- The negative impact of emotional strain on families is more apparent in eldercare only group than in the group with childcare and eldercare (i.e. sandwich group).

### **5.5 Impact of Caregiver Strain on Societal Outcomes**

The impact of caregiver strain on the Canadian society was quantified by looking at the relationship between caregiver strain and two groups of variables: those associated with the decision to have children, and those associated with the use of Canada's health care system. There were very few significant relationships of note in this phase of the analysis. Generally, the data support the idea that none of the forms of caregiver strain studied in this analysis were associated with seeking care from other types of medical providers or from mental health professionals, overnight hospital stays, or the need for medical tests. Nor, with one exception (financial strain) was caregiver strain associated with the decision on how many children to have or the need to visit the emergency room at the hospital for care.

The few significant relationships of note are summarized below.

#### **5.5.1 Impact of Financial Strain on Societal Outcomes**

Financial strain is associated with the decision to have children and receiving medical care at the hospital emergency room (see E12 in Appendix E). The following conclusions can be drawn from the data with respect to the relationship between financial strain and societal outcomes:

- Employed caregivers with moderate and high levels of financial strain are more likely to restrict the number of children they have (likely because of financial concerns) ( $\Delta + 15$ ).
- The use of Canada's hospital emergency rooms is positively associated with high levels of financial caregiver strain. It may be that this group uses the emergency system because they do not have a regular family physician.

### **5.5.2 Impact of Physical Strain on Societal Outcomes**

There is only one significant relationship between physical strain and the societal outcomes examined in this study (see Figure E13 in Appendix E). The following conclusion is supported by the data:

- Physical strain is positively associated with visits to the family physician for those in the eldercare group (but not the sandwich group). This finding is consistent with many of the results noted previously (i.e. caregivers more likely to say they are in poor health).

### **5.5.3 Impact of Emotional Strain on Societal Outcomes**

Again, only one of the societal outcomes was significantly associated with emotional strain for both those in the sandwich and eldercare groups. This relationship is shown in Figure E14. The following conclusion are supported by these data:

- Employed Canadians with high levels of emotional caregiver strain are more likely to delay or not have children (perhaps as a way to cope with the strains associated with caregiving). This would suggest that Canada could increase its fertility rate by providing more concrete forms of eldercare support to its citizens.
- A high percent of those in the eldercare only group have used this strategy – and may in fact have delay so long that they are now childless.

The analysis also indicates (see Figure E14) that emotional strain is associated with visits to the physician for those in the eldercare group. These data suggest that elder caregivers try and cope with the physical and emotional strains inherent in eldercare by visiting their doctor. This finding suggests that we could reduce the demands on our health care system and our family doctors by increasing the support for eldercare within the community. Such a strategy makes sense in an environment where many cannot find a family doctor.

## **5.6 Conclusions: The Impact of Caregiver Strain**

The impact of caregiver strain depends on many factors including the type of strain being considered, the population being considered (i.e. sandwich group versus eldercare) and outcome of interest (i.e. mental health, work-life balance). Key findings with respect to the impact of caregiver strain are summarized in Table 1 and discussed in the section below.

**Table 1: Summary of Key Findings**

Outcome	Financial Strain	Physical Strain		Emotional Strain	
		Sandwich	Eldercare	Sandwich	Eldercare
<b>Physical and Mental Health</b>					
Perceived Stress	$\Delta + 11$ *	$\Delta + 14$	$\Delta + 25$	$\Delta + 27$	$\Delta + 32$
Depressed Mood	$\Delta + 24$	$\Delta + 10$ *	$\Delta + 24$	$\Delta + 32$	$\Delta + 32$
Life Satisfaction	$\Delta - 20$	ns	$\Delta - 16$	$\Delta - 20$	$\Delta - 22$
Perceived Health	$\Delta - 17$	ns	$\Delta - 15$	$\Delta - 19$	$\Delta - 18$ *
<b>Work-Life Balance</b>					
Role Overload	$\Delta + 16$ *	$\Delta + 13$	$\Delta + 27$	$\Delta + 22$	$\Delta + 25$
Work Interferes Family	$\Delta + 17$ *	$\Delta + 12$	$\Delta + 10$	$\Delta + 18$	$\Delta + 20$
Family Interferes Work	$\Delta + 34$	$\Delta + 12$	$\Delta + 12$	$\Delta + 22$	$\Delta + 19$
<b>Organizational Outcomes</b>					
Commitment	ns	ns	ns	ns	ns
Job satisfaction	$\Delta - 10$ *	ns	ns	$\Delta - 14$	ns
Job stress	ns	ns	$\Delta + 19$	$\Delta + 13$ *	$\Delta + 17$
Intent to turnover	ns	ns	ns	ns	$\Delta + 13$
Absenteeism: All causes	$\Delta + 14$ *	$\Delta + 11$	ns	$\Delta + 10$	$\Delta + 11$
Absenteeism: Health	$\Delta + 14$	ns	ns	$\Delta + 11$	ns
Absenteeism: Childcare	$\Delta + 14$ *	ns	ns	ns	ns
Absenteeism: Eldercare	$\Delta + 24$ *	$\Delta + 26$	$\Delta + 29$	$\Delta + 37$	$\Delta + 26$
Absenteeism: Emotional	$\Delta + 19$ *	ns	ns	$\Delta + 13$	$\Delta + 10$
<b>Family Outcomes</b>					
Family adaptation	ns	ns	ns	$\Delta - 14$	$\Delta - 20$
Family satisfaction	ns	$\Delta - 10$	$\Delta - 16$	ns	$\Delta - 16$
Parental satisfaction	ns	ns	ns	ns	ns
Family integration	ns	ns	ns	ns	ns
Positive parenting	ns	ns	ns	ns	ns
<b>Societal Outcomes</b>					
Seen Physician	ns	ns	$\Delta + 12$	ns	$\Delta + 11$
Sought other types of care	ns	ns	ns	ns	ns
Seen mental health worker	ns	ns	ns	ns	ns
Spent time in hospital	ns	ns	ns	ns	ns
Visited emergency	$\Delta + 14$	ns	ns	ns	ns
Had medical tests	ns	ns	ns	ns	ns
Delayed/had no children	ns	ns	ns	$\Delta + 11$	$\Delta + 25$
Had fewer children	$\Delta + 14$ *	ns	ns	ns	ns

\* means that there is no difference in this outcome between moderate and high levels of caregiver strain

ns means that this outcome is not significantly associated with caregiver strain for this group

### 5.6.1 Impact of Caregiver Strain: Type of Strain

**Impact of Financial Caregiver Strain:** This type of caregiver strain has little to no impact on the family and societal outcomes examined in this study. It is associated with poorer physical and mental health, greater work-life conflict, increased absenteeism, lower job satisfaction, a higher number of visits to the emergency room at the hospital, and reduced fertility. It is also interesting to note that moderate and high levels of financial strain are equally problematic for caregivers.

**Impact of Physical Caregiver Strain:** This type of strain has little to no impact on the family, societal, and organizational outcomes considered in this study. It is associated with poorer mental health, increased work-life conflict, and increased absenteeism due to eldercare problems. It is also associated with lower levels of family satisfaction. Physical strain is more problematic for those in the eldercare group than those in the sandwich group. Aside from the impacts noted earlier, high levels of caregiver strain are associated with poorer physical health, increased visits to the family physician and increased job stress for those in the eldercare group but not their counterparts with both childcare and eldercare. The idea that physical strain is more problematic for those in the eldercare only group is supported by the fact that the difference in stress, depressed mood and role overload between the no physical strain and high physical strain conditions is much greater for those in the eldercare group than the sandwich group.

**Impact of Emotional Caregiver Strain:** This type of strain has little to no impact on family and societal outcomes. Emotional strain is, however, very strongly associated with poorer physical and mental health, increased work-life conflict, higher job stress, increased absenteeism due to eldercare problems and emotional fatigue, lower levels of family well-being and reduced fertility. With a few exceptions, the presence of children in the home made little difference in the strength of these associations. That being said, the impact of emotional strain varies with caregiver group as follows. For those in the sandwich group, emotional strain is associated with lower levels of job satisfaction, and much higher levels of absenteeism due to eldercare (and hence greater absenteeism overall) than could be seen in the eldercare group. For those in the eldercare group, on the other hand, emotional strain was associated with a greater intent to leave ones job, a higher number of visits to the family doctor, and reduced family satisfaction.

### 5.6.2 Impact of Caregiver Strain: Type of Outcome

**Mental and Physical Health:** Physical strain seems to be less problematic to the mental and physical health of those in the sandwich group than in the eldercare only group. The strong association between increased financial and emotional caregiver strain and poorer physical and mental health does not, however, vary with caregiver group.

**Work-Life Balance:** The impact of caregiver strain on work life conflict depends on both the form of strain and the aspect of work-life conflict being considered. For example:

- Physical and emotional strain are more likely to be associated with high levels of role overload, especially for those in the eldercare group.
- Emotional and financial strain are more likely to be associated with high levels of work interferes with family.

- Financial strain is most problematic when it comes to family interferes with work.

**Organizational Outcomes:** The impact of caregiver strain on the organization depends very much on group membership and strain type. The following key conclusions are supported by this analysis:

- None of the forms of caregiver strain influenced commitment.
- Financial strain is associated with lower job satisfaction for employees in both the eldercare and sandwich groups.
- Emotional strain is associated with lower job satisfaction for employees in the sandwich group. Emotional strain and job stress appear to go hand in hand (strong positive association for all caregivers)
- Physical strain can also be linked to higher job stress for those in the eldercare group. Absenteeism seems to be very strongly linked to financial strain and emotional strain.
- The relationship between caregiver strain and absenteeism due to eldercare problems is very strong for all caregiver groups.
- Emotional strain increases the likelihood that those in the eldercare group will quit their jobs.

## 6. Predicting Caregiver Strain

As noted in the methodology section, we did a series of regressions to better understand that key determinants of financial, physical and emotional caregiver strain. Four regression models were run for each type of strain:

- *Demographic situation:*
- *Demands:*
- *Characteristics of work*
- *Total:* significant predictors from models one to three.

Complete regression results are included in Appendix D and summarized in Tables 2 and 3.

**Table 2: Summary of Regression Results**

<b>Regression</b>	<b>Financial Strain</b>	<b>Physical Strain</b>	<b>Emotional Strain</b>
Demographics	$R^2 = 6.8\%$	$R^2 = 6.4\%$	$R^2 = 4.9\%$
Demands	$R^2 = 8.7\%$	$R^2 = 11.2\%$	$R^2 = 9.2\%$
Work Environment	$R^2 = 5.2\%$	$R^2 = 3.0\%$	$R^2 = 4.1\%$
Total	$R^2 = 14.3\%$	$R^2 = 13.5\%$	$R^2 = 15.5\%$

**Table 3: Key Predictors in Regression Models**

<b>Regression</b>	<b>Financial Strain</b>	<b>B</b>	<b>Physical Strain</b>	<b>B</b>	<b>Emotional Strain</b>	<b>B</b>
Demographics	Family Financial situation	0.64	Distance 2	0.36	Family Financial situation (-)	0.39
	Distance 1 (-)	0.17	Gender	0.23	Gender	0.37
	Distance 2	0.12	Age	0.16	Distance 2	0.12
	Parental status	0.08	Family Financial situation (-)	0.15	Parental status (-)	0.09
Demands	Hrs/wk eldercare	0.51	Hrs/wk eldercare	0.56	Hrs/wk eldercare	0.64
	Hrs/wk partner eldercare	0.19	Responsibility eldercare	0.21	Responsibility eldercare	0.21
	Distance 1 (-)	0.14	Hrs/wk partner eldercare	0.15		
	Distance 2	0.09				
	Responsibility eldercare	0.08				
Work Environment	Perceived flexibility (-)	0.27	Distance 2	0.42	Perceived flexibility (-)	0.30
	Distance 1 (-)	0.19	Perceived flexibility (-)	0.15	Family resp. make advancement difficult	0.20
	Distance 2	0.16	Family resp. make advancement difficult	0.13	Feel comfortable using organizational supports (-)	0.11
	Non-supportive manager	0.14	Non-supportive manager	0.11	Non-supportive manager	0.82
	Feel comfortable using supports (-)	0.07	Supportive manager (-)	0.10	Co-workers supportive (-)	0.81
	Family resp. make advancement difficult	0.07	Feel comfortable using organizational supports (-)	0.08	Not acceptable to say no to more work	
Total	Family Financial situation	0.26	Hrs/wk eldercare	0.53	Hrs/wk eldercare	0.50
	Hrs/wk eldercare	0.26	Responsibility eldercare	0.16	Responsibility eldercare	0.15
	Hrs/wk partner eldercare	0.11	Hrs/wk partner eldercare	0.13	Family Financial situation (-)	0.09
	Perceived flexibility (-)	0.08			Gender	0.09
	Distance 1 (-)	0.08			Family resp. make advancement difficult	0.06
				Perceived flexibility (-)	0.06	

All B are positive unless otherwise marked  
 - means no children

## **6.1 Prediction of Financial Strain**

### **6.1.1 Demographic Predictors**

Four of the seven demographic variables included in the regression equation explain almost 7% of the variation in financial strain. Not surprisingly, the families' financial situation was the most important predictor. In fact, the Pratt's coefficient indicates that this one factor accounts for 60% of the variance explained in financial strain. The regression results also indicate that the physical distance between caregiver and elderly dependent is also a key predictor of financial strain. These results are quite interesting in that they indicate that financial strain is highest for two groups of employees: those whose dependent lives in their home with them, and those whose dependent lives "elsewhere". Employees whose dependent lives near by experience less financial strain. Finally, the regression results indicate that it is employed caregivers with children (i.e. those in the sandwich group) who are at greatest risk of financial strain.

To summarize, men and women in lower income families, who care for an elderly dependent who either lives with them or who lives at a distance and who also have children in the home are more likely to experience financial strain. Gender and age have little role to play in this prediction.

### **6.1.2 Demands as predictors**

Five of the nine demand elements included in the regression equation explain almost 9% of the variation in financial strain. The largest predictor (explained half the variance in financial strain) was the hours per week in eldercare activities. The second most important predictor was the number of hours the employees' partner spent in dependent care. Also important to financial strain was where the dependent lived. As was the case with the demographic predictors, employed caregivers were at greater risk when their elderly dependent lived with them or far away. The last predictor worthy of note is responsibility for eldercare – the greater the responsibility, the higher the financial strain. What these data suggest is that employees who have to devote a lot of time and energy (and whose partners also have to spend a lot of time and energy) caring for a dependent who lives either in their home or at a distance will experience financial strain. It may be that the hours in care takes away from their earning potential which increases the precariousness of their financial situation. Alternatively, it may be that they are spending a lot of time away from work caring for their dependent who lives in a different location. Alternatively it may be that caregivers whose dependent lives with them or at a distance have more expenses (i.e. changing their house to accommodate their dependent, commuting and phone costs) than those who live a short distance from those they are caring for.

What does not predict financial strain?: the total hours per week the respondent spends in paid employment, responsibility for childcare and gender

### **6.1.3 Work Environment as Predictors**

Only six of the 27 measures included in the work environment regression were found to be significant predictors of financial strain. These six variables (four measured aspects of the work

environment, two were control variables which represented where the dependent (requiring care lived) explain 5% of the variation in financial strain. Examination of the equation yields the following conclusions:

- Perceived flexibility reduces financial strain
- Living near the person(s) that one is providing care for reduces financial strain
- Caring for an elderly dependent who lives with you or elsewhere increases financial strain
- Working for a non-supportive manager increases financial strain
- Working for an organization where the culture penalizes people who have family responsibilities by making it more difficult to advance increases financial strain
- Working for an organization whose culture discourages employees from using the family friendly supports that are available increases financial strain.
- Supportive policies and benefits, on their own, have no impact on financial strain
- Neither job type nor gender influence financial strain when work environment variables are included in the regression model

Taken together, these results suggest that financial strain is exacerbated when the caregiver is employed by an organization where workers have little control over when and where they work (i.e. low perceived flexibility and a non-supportive manager) and are financially penalized (i.e. not given promotions) when they put family first (i.e. if they use supportive policies and meet family responsibilities). In such an environment supportive work-life policies have little to no impact on caregiver strain as they are seldom put into practice (Higgins, Duxbury and Lyons, 2007).

#### **6.1.4 Key Predictors of Financial Strain**

In the final analysis five variables were found to explain 14% of the variation in financial strain: two demographic (families financial situation, where the dependent lives), two demands (hours per week in eldercare, hours per week partner spends in eldercare) and one work environment (perceived flexibility) variable. Two of these variables, the families' financial situation and the hours per week the respondent spends in care were twice as important to the prediction of financial strain as the other three predictors.

This analysis provides the following answer to the question "What causes financial strain?" Living in a family with limited financial resources, very heavy and time consuming caregiving demands (i.e. both respondent and spouse spend a high number of hours per week in care), and lower levels of control (i.e. low perceived flexibility at work, dependent lives in a different community from caregiver).

## **6.2 Prediction of Physical Strain**

### **6.2.1 Demographic Predictors**

Four of the seven demographic variables included in the regression equation explain just over 6% of the variation in physical strain. The analysis indicates that physical strain has a somewhat different aetiology from financial strain. The main predictors of physical strain are distance (employees with their dependent living with them are at higher risk), gender (women have more problems than men), age (older employees have more problems than younger employees) and the families financial situation (the lower the income, the greater the strain). In other words, these data indicate that older women whose dependent lives with them and cannot afford to purchase support and/or quit their jobs are at the highest risk of physical strain

### **6.2.2 Demands as predictors**

Three of the nine demands included in this regression equation explain 11% of the variation in physical strain. The regression results indicate that physical strain is, not surprisingly, largely the result of the hours per week in eldercare activities – the more hours, the greater the chance of physical strain. The number of hours the employees' partner spends in dependent care as well as the amount of responsibility one has for the elderly dependent are also important predictors of physical strain, which seems to be a function of how much you do.

Again, it is interesting to note what is not a predictor of physical strain which in this case includes the total hours per week the respondent spends in paid employment, responsibility for childcare, gender, and in this case, where the elderly dependent lives.

### **6.2.3 Work Environment as Predictors**

Work environment variables explain very little of the variation in physical strain ( $R^2 = 3\%$ ). Only six of the 27 measures included in the work environment regression were significant predictors of physical strain. Five of these variables are identical to those predicting financial strain. Examination of the equation yields the following conclusions:

- Caring for an elderly dependent who lives with you increases physical strain
- Perceived flexibility reduces physical strain
- Working for an organization where the culture penalizes people who have family responsibilities by making it more difficult to advance increases physical strain
- Working for a non-supportive manager increases physical strain
- Working for a supportive manager decreases physical strain

- Working for an organization whose culture discourages employees from using the family friendly supports that are available increases physical strain.
- Supportive policies and benefits, on their own, have no impact on physical strain
- Neither job type nor gender influence physical strain when work environment variables are included in the regression model

Taken together, these results suggest that physical strain is exacerbated when the caregiver is employed by an organization where workers have little control over when and where they work (i.e. low perceived flexibility and a non-supportive manager) and are financially penalized (i.e. not given promotions) when they put family first (i.e. if they use supportive policies and meet family responsibilities). In such an environment supportive work-life policies have no impact on caregiver strain. Employed caregivers who work for a supportive manager and have high perceived flexibility do, however, seem to be more able to cope with the physical strains associated with eldercare. These findings imply that supportive policies, on their own, are not enough to help employed caregivers cope: they must be put into practice to have an impact (Higgins, Duxbury and Lyons, 2007).

#### **6.2.4 Key Predictors of Physical Strain**

In the final analysis three variables were found to explain 13.5% of the variation in physical strain. The fact that all three of these variables tapped into the demand element suggests that this form of strain is largely one of demand – the more time one spends in the role and the greater the responsibility one has in terms of caregiving, the greater the physical strain. The fact that just over half of the variation in physical strain is explained by one variable, hours per week in eldercare activities, emphasizes the nature of the relationship. This would suggest that to reduce physical strain one needs to try and determine how to reduce the amount of time caregivers spend in caregiving activities.

### **6.3 Prediction of Emotional Strain**

#### **6.3.1 Demographic Predictors**

Four of the seven demographic variables included in the regression equation explain 5% of the variation in emotional strain. The analysis indicates that emotional strain has a similar aetiology to physical strain. Again, we see that the financial situation of the family is an important predictor of strain as is gender, with women being at higher risk of emotional strain than men. Again, we can see that having a dependent who lives with you also increases your risk with respect to emotional strain. What makes this form of strain different, however, is the fact that the analysis indicates that caregivers without children are more likely to experience emotional strain associated with eldercare than are those in the sandwich group. In summary then, these results would indicate that it is women without children in families where money is tight and who care for an elderly dependent who lives with them who are at greatest risk of this form of strain.

### **6.3.2 Demands as predictors**

Two of the nine demands included in this regression equation explain 9% of the variation in emotional strain: hours per week in eldercare activities (explains almost two-thirds of the variation) and the amount of responsibility one has for the elderly dependent. The high link between demands and strain is consistent with the work of Karasek (1979) who developed the demand/control/support model. According to Karasek, the most strain is experienced by individuals with high demands but low control. It would appear from these data that the need to care for an elderly dependent can be considered a high demand (lots of hours, lots of responsibility), low control job.

The data also show that total hours per week the respondent spends in paid employment, the total hours per week the respondent's partner spends in eldercare, responsibility for childcare, gender and where the elderly dependent lives are not significant predictors of emotional strain in this equation – this form of strain is primarily a function of the demands associated with eldercare.

### **6.3.3 Work Environment as Predictors**

Again, the data indicate that work environment variables have little to do with the prediction of emotional caregiver strain (i.e.  $R^2$  is only 4%). Once more, we see the following dimensions of the work environment making a difference (either positively or negatively) with respect to the manifestation of strain:

- Perceived flexibility (high levels of flexibility associated with reduced strain).
- The culture of the organization (working for an organization where family responsibilities limit advancement, employees do not feel comfortable using the family friendly supports that are available are all associated with increased strain).
- Non-supportive management (associated with increased strain).

Emotional strain is also uniquely predicted by the attitudes of ones co-workers to family responsibilities (having supportive co-workers is associated with reduced strain) and working in an organization where it is not acceptable to say no to more work (i.e. culture of hours exacerbates emotional strain).

Finally, it is important to note that while the findings with respect to the link between gender, job type, policies and emotional strain are identical to those found with financial and physical strain, the fact that where the elderly dependent lives makes little difference in emotional strain when work environment variables are taken into account is different. This suggests this form of strain is more about the organizational culture and support for caregiving than distance. Distance is, however, a key predictor of physical and financial strain, regardless of what variables are being included in the regression.

### **6.3.4 Key Predictors of Emotional Strain**

In the final analysis six variables were found to explain 15.5% of the variation in emotional strain: two demographic (families' financial situation, gender), two demands (hours per week in eldercare, responsibility for eldercare) and two work environment (perceived flexibility, family responsibilities made advancement difficult) variables. Two of these variables, gender and the perception that family responsibilities make advancement difficult, were unique to the prediction of this form of strain. Again, it should be noted that the hours per week the respondent spends in care is five times more important to the prediction of emotional strain than the other four predictors.

This analysis provides the following answer to the question "*What causes emotional strain?*" Living in a family with limited financial resources, physically and emotionally heavy caregiving demands (i.e. respondent spends a high number of hours per week in care and has responsibility for care), and lower levels of control at work (i.e. low perceived flexibility at work, the perception that family responsibilities limit advancement opportunities). Finally, the data would suggest that women are more predisposed to experiencing this form of strain than men.

### **6.4 Conclusions: Prediction of Caregiver Strain**

What causes caregiver strain? The answer obtained from this analysis is unequivocal – the hours per week the employed individual spends in eldercare activities. The importance of this predictor can be seen by noting that: (1) it was the only variable that appeared in all three regression equations, and (2) Pratt's coefficient indicated that it was the most important (or tied for the most important) predictor of all three forms of strain. In fact, if we know how many hours an individual spends in eldercare per week we can come up with a good estimate of how much physical and emotional strain they will experience.

What else does this data tell us about the prediction of the various forms of caregiver strain?

First, and perhaps most importantly, the families' financial situation is an important predictor of financial and emotional strain. In both cases, the tighter the families' finances the greater the strain. While it is hard to say from these data why this might be the case it seems plausible to assume that the lower the financial resources the less ability the respondent has to buy supports from outside the family, the more care that they have to provide themselves (i.e. higher demands) and the more they need the income provided by their job. This second circumstance might be expected to increase conflict between work roles (need to satisfy their employer with respect to meeting work demands by being on time for work, minimizing absenteeism) and eldercare demands (need to spend a lot of time per week in caregiving, need to respond to crisis during work hours). This interpretation of the data is consistent with the fact that increased flexibility at work lowers both financial and emotional strain (i.e. if you can meet both work and caregiving demands, you are healthier emotionally and are not as worried about the financial aspects of caregiving). These findings suggest that governments need to look at ways to reduce the financial burdens associated with eldercare (i.e. tax write-offs, paid time off work, supported care services in community). They also emphasize the importance of real support at the

organizational level. Supportive policies on their own are necessary but not sufficient – these policies must be put into practice and employees must be comfortable using them.

Second, financial strain decreases when the dependent lives nearby but not with the employed caregiver. This would suggest that communities who wish to help their citizens and attract and retain labour need to invest in assisted eldercare facilities within their boundaries.

Third, physical strain is really about the physical (hours per week in care) and emotional (individual feels personally responsible for the dependent) aspects of the role. This would suggest that we could reduce physical strain by looking at mechanisms to reduce the amount of time an individual has to spend in care. Things like respite care, eldercare referral services, assisted eldercare facilities, home nursing services etc. should help in this regard.

Fourth, the data show that women are more likely to experience one form of caregiver strain – emotional strain. This finding is cause for concern given the very strong association between this form of strain and physical and mental health problems, absenteeism, and reductions in fertility. It would appear from the data that several factors predispose women to this kind of strain: the fact that they are more likely to feel responsible for the care of the elderly dependent, the fact that they perceive that if they meet responsibilities at home they will not advance at work, and their need for the income stemming from their job (families' financial situation is tight). Again, the fact that perceived flexibility at the organizational end reduces this form of strain gives us one useful approach with respect to reducing it – implement supportive policies within organizations. Many of the suggestions offered earlier with respect to reducing demands at the caregiver end should also help women cope with the emotional demand associated with caregiving.

Finally, it is useful to note that the aetiology of two of the three forms of strain (financial and emotional) meet Karasek's criteria for a high strain job (i.e. high demand, low control). It would appear then, that the unpaid job of elder caregiver can be considered a high strain job. Karasek's model would then suggest that to decrease these forms of strain one needs to determine how to either increase control (i.e. increase perceived flexibility at the organizational end, community supports for eldercare) or reduce demands (i.e. community and government supports for people with eldercare) or both.

## **7. What Do We Know About Caregivers?**

The size of the Balancing Work, Family and Lifestyle data set allows us to look in detail at the composition of the various caregiver groups in our study (see Figure 1) with the goal of identifying similarities and differences between the various groups. Such information should help policy makers identify the key at risk groups in terms of caregiver strain. It also gives us another mechanism to identify key antecedents and consequences of the different forms of strain.

This section is divided into two main parts. Part one deals with the predictors of caregiver strain (i.e. demographics, demands, work environment). Part two, on the other hand, pertains to the outcomes of caregiver strain (i.e. physical and mental health, organizational attitudes and outcomes, societal outcomes). The demographic characteristics of the different caregiver groups

will be examined first. This will be followed by an examination of how work environment and demands differ by caregiver group. After we compare the various predictors of caregiver strain we will turn our attention to possible outcomes and look at the relationship between caregiver group membership and physical and mental health outcomes, work-life balance, organizational outcomes, family outcomes and societal outcomes. In all cases three comparisons will be done:

- a four way comparison (i.e. no caregiving, childcare only, sandwich group and eldercare group),
- a three way comparison of those within the sandwich group (live with, live nearby, live elsewhere) and
- a three way comparison of those within the eldercare group (live with, live nearby, live elsewhere).

## 7.1 Demographic Characteristics of Caregivers

Data on the demographic characteristics of the four main caregiver groups are given in Table 3.

The following observations can be made from these data:

- Caregiver group is not associated with educational status or where the respondent lives (i.e. urban/rural).
- Employees in the no caregiver group are younger (i.e. under 35), single men and women who live in larger communities. They have higher personal incomes and are more likely to say that for them money is not an issue and that they have money for extras.
- Employees in the childcare only group are married men and women (this is the only group in which we had more male respondents than female respondents) between the age of 35 and 45 who, despite the fact that their personal incomes are higher, are more likely to say that money is tight in their family or that they are okay for money but do not have money for extras. They are more likely to live in smaller communities. One in three in this group have children under the age of five at home.
- Employees in the sandwich group are more likely to be older (45 or greater) men and women who live in smaller communities. One in three of the individuals in this group say money is tight in their family, which is consistent with the fact that one in three have lower (i.e. \$39,000 or less) personal incomes.
- Employees in the eldercare group are more likely to be older, unmarried females without children. That being said, it is interesting to note that one in five in this group are single, childless women under the age of 35. The women in this group tend to have lower personal incomes but, paradoxically, are more likely to say that money is not an issue. This paradox can be explained by the fact that although their incomes are lower, so are their costs (i.e. they do not have children). Individuals in the eldercare group are also more likely to live in larger centres.

**Table 3: Demographics for Total Sample By Caregiver Group**

	<b>No Caregiving</b>	<b>Parents</b>	<b>Sandwich</b>	<b>Eldercare</b>	<b>Total Sample</b>
Gender (% female)	63	49	60	70	58
Age					
• under 35	39	16	9	21	24
• 35 to 45	21	48	43	25	35
• over 45	40	36	48	54	42
Marital status (% married)	62	88	86	66	76
Education					
• High school or less	35	38	39	36	31
• College diploma	22	25	26	23	38
• University	43	47	45	41	31
Personal Income:					
• \$39,999 or less	26	26	32	36	31
• \$40,000 to \$59,999	39	37	38	40	38
• \$60,000 or more	35	37	30	24	31
Family Financial Status					
• Money tight	18	27	30	22	24
• Okay: no money for extras	42	48	45	40	44
• Money not an issue	40	25	25	38	32
Population of community					
• 24,999 or less	25	32	30	24	28
• 25,000 to 99,999	20	21	21	20	20
• 100,000 to 499,999	30	29	30	30	30
• 500,000 or more	25	18	19	26	22
% live in Urban area	89	87	88	90	88
Parental Status (can be > 100%)	71	0	0	63	33
• No children	0	31	18	0	20
• Children ≤ 5 years of age	0	35	29	0	26
• Children 6 to 12	0	51	55	0	41
• Children 13 to 18					

To get a better appreciation of who is in the sandwich group we compared the demographic characteristics of those in the three different groups within the sandwich sample. These data are given in Table 4.

**Table 4: Demographics For Sandwich Sample**

	<b>Lives With</b>	<b>Lives Nearby</b>	<b>Lives Elsewhere</b>
Gender (% female)	62	66	53
Age			
• under 35	12	8	9
• 35 to 45	40	46	41
• over 45	49	46	50
Marital status (% married)	78	86	90
Education			
• High school or less	37	40	36
• College diploma	23	27	25
• University	40	33	39
Personal Income:			
• \$39,999 or less	37	34	28
• \$40,000 to \$59,999	29	40	36
• \$60,000 or more	24	26	36
Family Financial Status			
• Money tight	32	25	29
• Okay but no money for extras	48	47	46
• Money not an issue	20	28	25
Population of community			
• 24,999 or less	27	28	29
• 25,000 to 99,999	25	30	22
• 100,000 to 499,999	32	32	30
• 500,000 or more	16	20	19
% live in Urban area	92	87	86
Parental Status (can be > 100%)			
• Children 5 years of age or less	25	16	20
• Children 6 to 12	25	28	37
• Children 13 to 18	57	57	57
• Children > 18	62	57	57

The following observations can be made from these data:

- There were no differences within the sandwich group with respect to the following demographic variables: age, education, population of community and where the respondent lives (i.e. urban/rural).
- Employees in the sandwich group who have their dependents living with them are more likely to be unmarried women with young children (there is a higher percent of single mothers in this group) who have lower personal incomes and say that money is tight in their families. It may be that they care for their dependent in their home because they cannot afford other options. Alternatively, it may be that their incomes are lower because their family situation limits their advancement at work.

- Employees in the sandwich group who have their dependents living nearby are similar to those with elderly dependents in the home in that both groups have a higher percent of females with lower personal incomes. In this case, however, money does not seem to be as much of an issue (75% say they are okay for money or money is not an issue), probably because respondents in this sample are more likely to be married and live in a family with two incomes.
- Employees in the sandwich group who have their dependents living elsewhere are more likely to be male (only group with equal number of men and women) who make higher personal incomes. They are also more likely to have children between the age of 6 to 12 at home.

To get a better appreciation of who is in the eldercare group we compared the demographic characteristics of the three different groups within the sandwich sample. These data are given in Table 5.

**Table 5: Demographics for Eldercare Sample**

	<b>Lives With</b>	<b>Lives Nearby</b>	<b>Lives Elsewhere</b>
Gender (% female)	67	74	67
Age			
• under 35	22	19	21
• 35 to 45	27	28	27
• over 45	51	53	52
Marital status (% married)	27	67	72
Education			
• High school or less	34	39	32
• College diploma	25	22	24
• University	41	39	44
Personal Income:			
• \$39,999 or less	38	37	30
• \$40,000 to \$59,999	40	41	40
• \$60,000 or more	22	22	30
Family Financial Status			
• Money tight	23	22	21
• Okay but no money for extras	41	39	43
• Money not an issue	36	40	36
Population of community			
• 24,999 or less	23	24	24
• 25,000 to 99,999	15	20	23
• 100,000 to 499,999	34	30	29
• 500,000 or more	27	27	25
% live in Urban area	90	89	88
Parental Status (can be > 100%)			
• Children 18 +	20	60	66

This analysis shows that the three groups who have eldercare only are, with two significant exceptions, very similar demographically. In fact, there were no substantive demographic differences between the eldercare group whose dependents live near by and those whose dependents live elsewhere. Employed caregivers who provide dependent care to someone who lives with them do, however, differ in two very important ways from the rest of the caregiver samples in that they are more likely to be unmarried women without any children.

**Table 6: Characteristics of Work Total Sample By Caregiver Group**

	<b>No Caregiving</b>	<b>Parents</b>	<b>Sandwich</b>	<b>Eldercare</b>	<b>Total Sample</b>
Sector					
• Public	45	47	51	49	47
• Not for profit	22	19	17	18	20
• Private	34	34	32	32	33
Job Type					
• Manager/professional	49	52	51	49	51
• Administrative/clerical	26	23	27	30	24
• Technical	14	15	15	12	25
• Other	11	10	7	9	10
Employment status					
• % Full Time	92	92	89	91	90
• % Permanent	88	92	91	90	90
% member of a union	48	48	56	56	50
Work arrangement					
• Regular	49	50	48	50	50
• Flextime	20	20	20	18	20
• CWW	12	10	13	13	12
% with a supportive manager	51	48	44	44	47
Perceived flexibility					
• High	40	30	28	33	33
• Low	24	29	32	29	28

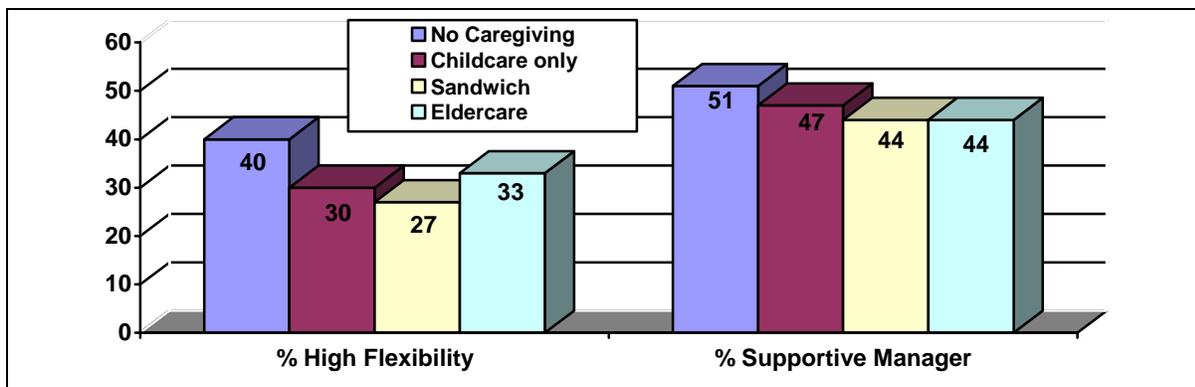
Note: the availability of the various family friendly benefits and supports was not associated with caregiver status (See Higgins, Duxbury and Lyons, 2007). Nor was the employees view of the organization as a place to work or (with one exception) their view of the organizations culture. Members of the sandwich group had a very different view of the organizational culture at their place of employment. Key differences are outlined in the text.

## 7.2 Employed Caregiver's Situation at Work

To answer the question of whether or not the employment situation was different for individuals in the different caregiver group we looked for differences between the various caregiver groups with respect to the following variables: sector, job type, employment status (i.e. full versus part time; permanent versus temporary), union membership, work arrangement, supportive management, perceived flexibility, perceptions of organizational culture, and the availability of 13 different family friendly benefits and supports. The results of this comparison for the four main caregiver groups are given in Table 6. A further breakdown of work environment data by sandwich and eldercare sub-groups are given in Tables 7 and 8 respectively. Key observations on the work environments of these groups are provided below. As before, the majority of the figures discussed in this section of the report can be found in Appendix E.

The comparison by caregiver group shows that there are very few differences with respect to conditions of work between the various groups (i.e. no difference by sector or job type). This is an important finding in that it reinforces the need for organizations to put policies and practices in place to address the needs of this sizable group of employees. There are, however, several between-group differences that are worthy of note. These include the fact that employees with no caregiving responsibilities are more likely to feel that they work for a supportive manager and report higher levels of perceived flexibility (See Figure 5). These data imply that organizations have enough flexibility for employees with fewer demands outside of work (who likely do not ask for a lot of flexibility) but not enough for employees who are responsible for child and/or eldercare who need higher levels of flexibility and support to deal with non-work demands, both predictable and unpredictable. The data on the sandwich and eldercare groups presented below supports this conclusion.

**Figure 5: Perceived Flexibility and Supportive Management by Caregiver Group**



**Table 7: Characteristics of Work for Sandwich Sample**

	<b>Lives With</b>	<b>Lives Nearby</b>	<b>Lives Elsewhere</b>
Sector			
• Public	55	52	53
• Not for profit	15	18	15
• Private	30	30	33
Job Type			
• Manager/professional	48	49	55
• Administrative/clerical	28	30	22
• Technical	16	14	14
• Other	10	7	9
Employment status			
• % Full Time (versus part time)	89	89	90
• % Permanent (versus temporary)	87	91	91
% member of a union	53	60	52
Work arrangement			
• Regular	57	49	45
• Flextime	19	20	21
• CWW	12	13	13
% with a supportive manager	48	43	43
Perceived flexibility			
• High	36	28	28
• Low	33	32	33
Organization has emergency days off <sup>12</sup>	56	61	66
<b>View of the culture depends on family situation: % who agree that:</b>			
Manager is supportive of family responsibilities	65	56	56
Manager gives flexibility to arrange work schedule to meet family needs	60	48	47
Family responsibilities make it difficult for people to advance	21	33	35
If one does not work long hours it will limit their career advancement	35	40	47
It is not acceptable in their organization to say no to more work	35	47	47
Feel comfortable using the supports offered by the organization	40	25	25
Organization discourages the use of their supportive policies	38	48	43

<sup>12</sup> Note: availability of other 12 family-friendly benefits not associated with caregiver status

**Table 8: Characteristics of Work for Eldercare Sample**

	<b>Lives With</b>	<b>Lives Nearby</b>	<b>Lives Elsewhere</b>
Sector			
• Public	54	48	51
• Not for profit	17	19	17
• Private	29	33	32
Job Type			
• Manager/professional	38	48	52
• Administrative/clerical	34	32	25
• Technical	18	15	12
• Other	10	5	11
Employment status			
• % Full Time (versus part time)	94	90	92
• % Permanent (versus temporary)	89	90	90
			54
% member of a union	61	59	54
Work arrangement			
• Regular	57	53	46
• Flextime	21	16	19
• CWW	10	13	16
% with a supportive manager	40	45	41
Perceived flexibility			
• High	34	33	31
• Low	28	30	28
Time off in lieu of pay available	54	62	62
Pro rated part-time work available	39	46	44
Flextime hours available	40	43	47
EAP available	58	67	68
Manager gives flexibility to meet personal needs	39	46	47

Note: the availability of the other 8 family friendly benefits and supports not associated with caregiver status.

Note: Only one of the dimensions of culture measured in this study associated with caregiver status.

The comparison of the three groups within the sandwich sample indicates that employees who care for an elderly dependent who lives with them report a very different situation at work than those whose elderly dependent lives nearby or elsewhere. Compared to the sandwich employees in the other two caregiver groups, employees who have an elderly dependent living in their homes are more likely to work a regular work day, perceive that they have high flexibility, and have a more positive view of the culture in their organization when it comes to support of family issues. Specifically, they are more likely to say that their manager is supportive of family responsibilities and gives them flexibility to arrange their work schedule to meet family needs and that they feel comfortable using the supports offered by the organization. They are also less likely to perceive that their organization has either a culture of hours (i.e they are less likely to agree that if one does not work long hours they will not advance and that it is not acceptable in their organization to say no to more work) or a culture of work or family (i.e they are less likely to agree that family responsibilities make it difficult for an employee to advance). They are also less likely than the employees in the other two groups to feel that their organization discourages the use of their supportive policies. These results are interesting as they would suggest that organizations do offer flexibility to valued employees (half the people in the sandwich group with dependents in their home are managers and professionals) who are obviously experiencing high work-life conflict (i.e. caring for an elderly dependent in their home and children). Those in the sandwich group whose caregiving responsibilities are not as visible (dependent does not live with them) are not as positive about the supports offered within their workplace.

Similarly, a comparison of the three groups within the eldercare sample shows that those in the eldercare in the home group are very different from those who care for a dependent lives elsewhere. In this case, however, the employee with the dependent living with them perceived that they receive less support from their employer than those in the other two eldercare groups. They are more likely to work a regular work day (this seems to be the work arrangement of choice for an employee with heavy caregiving demand) and less likely to have access to a number of benefits which could make the balance between work and caregiving easier including time off in lieu of pay, pro-rated part time work, flextime arrangements, EAP and a manager who gives them flexibility to meet personal needs. It is also important to note that in this case, the differential access to these benefits may be due to the fact that those in the eldercare in home group are less likely to be managers and professionals.

### **7.3 Caregivers Demands**

To answer the question of whether or not employees in the different caregiver groups had different demands on their time we looked for between group differences in the following variables: hours in work per week, hours in unpaid overtime per month, hours per week in home chores and errands, childcare, eldercare, leisure, educational activities and volunteer work, responsibility for childcare and responsibility for eldercare.

The results of this comparison for the four main caregiver groups are given in Table 9. A further breakdown of demands placed on individuals in the different sandwich and eldercare sub-groups are given in Tables 10 and 11 respectively. Key observations on the demands faced by employees in the different groups are provided below.

**Table 9: Work and Non-work Demands Total Sample By Caregiver Group**

	<b>No Caregiving</b>	<b>Parents</b>	<b>Sandwich</b>	<b>Eldercare</b>	<b>Total Sample</b>
Hours in work per week	39	40	39	39	39
Hours in unpaid overtime per week	4.5	5.1	4.2	3.5	4.3
Hrs in employment/wk	43.5	45.1	43.2	42.5	43.3
Hours per week in:					
• Home chores/errands	10	12	14	11	11
• Childcare	-	11	11	-	8
• Eldercare	-	-	5	5	3
• Leisure activities	14	8	7	11	10
• Educational activities	5	5	3	5	4
• Volunteer work	4	4	3	4	4
Time in non-work/week	19	33	36	25	29
Responsibility for childcare					
• I have it	-	33	41	-	36
• It is shared	-	38	39	-	38
• Partner has it	-	29	20	-	26
Responsibility for eldercare					
• I have it	-	-	46	51	48
• It is shared	-	-	40	42	41
• Partner has it	-	-	14	7	12

The following conclusions can be drawn about the work and family demands of the employees in the full sample:

- Employees in the no caregiving group spend more time in leisure per week and fewer hours in non-work activities than the employees in the other groups. They also have fewer responsibilities outside of work.
- Employees in the parents group spend more time in unpaid work per week and work longer hours than those in the other groups. They also have the second highest non-work demands and spend fewer hours per week in leisure activities. They also have a very high number of hours committed to work and family activities per week (78).
- Employees in the sandwich group spend the same number of hours in work per week as those in the non-caregiver group but also commit another 35 hours per week to non-work activities. In fact this group has the highest non-work demands in the sample. They have the highest number of committed hours per week (79.2 in work and non-work) and the fewest hours in leisure.

- Employees in the eldercare group spend fewer hours in paid employment per week, fewer hours in non-work and more time in leisure (only the non-caregiver group have fewer non-work demands and more hours in leisure). This is not surprising given that most of those in the eldercare group have responsibility for people who do not live in their homes.

Finally it is interesting to note that in about 40% of the families in the sample the partners share childcare and eldercare responsibilities. It would appear that for a growing number of Canadians, neither childcare nor eldercare are “women’s” work anymore.

**Table 10: Work and Non-work Demands for Sandwich Sample**

	<b>Lives With</b>	<b>Lives Nearby</b>	<b>Lives Elsewhere</b>
Hours in work per week	38	38	41
Hours in unpaid work per week	3.8	3.8	4.5
Hours in employment per week	41.8	41.8	45.5
Hours per week in:			
• Home chores and errands	13	13	13
• Childcare	11	10	10
• Eldercare	8	5	5
• Leisure activities	7	8	8
• Educational activities	6	4	4
• Volunteer work	4	3	4
Hours in non-work activities per week	42	35	36
Responsibility for childcare			
• I have it	33	45	36
• It is shared	52	38	41
• Partner has it	15	17	24
Responsibility for eldercare			
• I have it	51	48	42
• It is shared	34	40	42
• Partner has it	15	13	16

Examination of the data in Table 10 on the demands of those in the sandwich group leads to the following observations:

- Employees who care for an elderly dependent who lives elsewhere spend the most time in paid employment per week. They also have a very high number of hours per week committed to work and non-work activities (81.5).
- Employees who care for an elderly dependent in their home spend the most hours in non-work hours per week and the most time committed to work and non-work activities (83.8). The increase in time spent in eldercare accounts for this large difference (8 hours per week versus 5 for those in the other two groups).

- The employees who care for an elderly dependent who live nearby spend a relatively modest 76.8 hours per week in work and non-work activities.
- Employees who have an elderly dependent living with them are more likely to share the responsibility of childcare and give responsibility for eldercare to the female partner (data not shown).

**Table 11: Work and Non-work Demands for Eldercare Sample**

	Lives With	Lives Nearby	Lives Elsewhere
Hours in work per week	37	38	41
Hours in unpaid overtime per week	2	4	4
Hours in employment per week	39	42	45
Hours per week in:			
• Home chores and errands	11	11	11
• Childcare	--	--	--
• Eldercare	10	5	5
• Leisure activities	10	12	12
• Educational activities	6	5	5
• Volunteer work	4	4	4
Hours in non-work activities per week	31	25	25
Responsibility for eldercare			
• I have it	63	54	44
• It is shared	31	39	47
• Partner has it	6	7	9

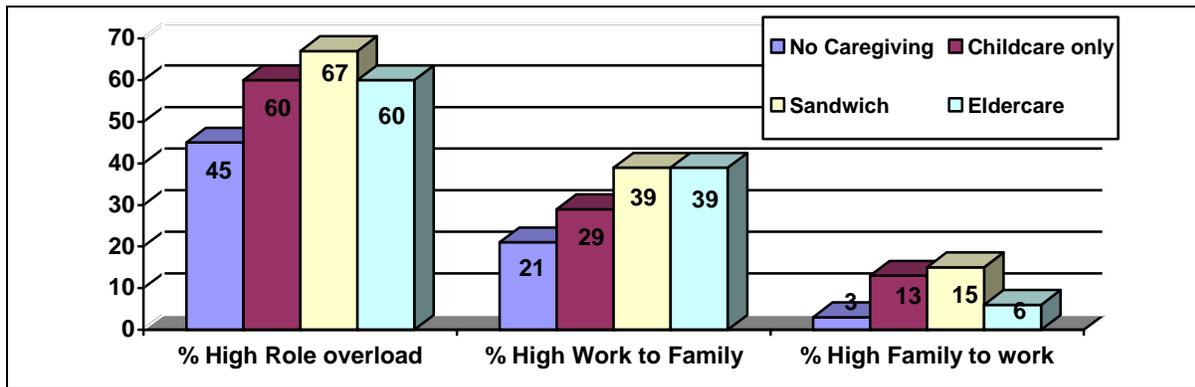
The data in Table 11 indicate that work and non-work demands are strongly associated with where the dependent lives for those in the eldercare group. This variation is mainly due to the large variation in time spent per week in eldercare. Consider the following:

- Employees in the eldercare group whose dependent lives with them spend twice as much time in eldercare (ten hours per week) as any other group in the sample. Two thirds of these individuals (who are mostly women) have primary responsibility for the care of this elderly dependent. Not surprisingly, given the number of hours in dependent care, employees in this group spend fewer hours per week in paid employment and are less likely to engage in activities associated with career advancement such as unpaid overtime. They commit 70 hours to work and non-work activities per week, which is more than can be observed in the lives nearby (67 hours per week) group.
- Employees in the eldercare group whose dependent lives elsewhere also spend 70 hours per week in work and non-work activities. In this case, however, their demands are due to higher amount of time in work than non-work. This group is also more likely to be in a family where eldercare responsibilities are shared.

## 7.4 Work-Life Issues for Caregivers

As noted earlier, work-life balance was quantified in this study by looking at three constructs: role overload, work interferes with family, and family interferes with work. Data on these three constructs are given for the total sample in Figure 6 and for the sandwich and eldercare groups in E14, Appendix E. In the discussion below, the no caregiver situation will be used as a benchmark to help us identify changes in work-life balance associated with childcare, eldercare and sandwich care.

**Figure 6 Impact of Caregiver Group On Work-Life Balance (% high)**



The following conclusions can be drawn from these data with respect to role overload:

- The more demands one has outside of work, the more overloaded one becomes.
- Childcare and eldercare responsibilities are equally likely to contribute to role overload.
- Employees in the sandwich group (both childcare and eldercare) are the most likely to experience high levels of role overload (67% with high overload) – a finding which is consistent with the data on demands presented earlier. Employees in the sandwich group whose elderly dependents live with them are most likely to report high levels of role overload (almost three quarters of the individuals in this group are overloaded).
- The majority of the employees in the childcare and eldercare groups report high levels of overload. Employees with no caregiving responsibilities, on the other hand, are significantly less likely to report that they are overloaded (45% high).
- Within the eldercare group, employees whose dependent lives nearby (i.e. a short driving distance away) are less likely to report high levels of role overload than their counterparts who care for a dependent who either lives with them or lives elsewhere – a finding that is consistent with the data on time in work and non-work activities presented earlier. The lower levels of overload for the “lives nearby” group may be due to the fact that the elderly dependent who lives nearby is more self sufficient and requires less care and/or the fact the

employee can visit with relatively little effort if something is wrong or they need to check up on things.

The findings are somewhat different if one looks at role interference. In this case:

- Approximately one in three of employed Canadians meet their work demands at the expense of their life outside of work (i.e. report high work interferes with family as opposed to high family interferes with work). Very few of the employed Canadians in this sample put family ahead of work.
- Employees in the sandwich and eldercare groups are more likely to report high levels of work interferes with family (39% high).
- Where the elderly dependent lives impacts work interferes with family for employees in both the sandwich and eldercare groups.
- Employees in the sandwich and eldercare group whose elderly dependents lives with them are less likely to experience high work interferes with the family. The increased ability of employees with elderly dependents in the home to cope with work interferes with family is consistent with the fact that they seem to receive significantly more support from their employer/colleagues in terms of work-life issues.
- Employees in both the sandwich and eldercare groups who care for a dependent who lives elsewhere are more likely to report high work interferes with family. This may reflect the fact that it is harder for these employee to get the amount of time off work that they need for eldercare activities when their dependent is not in town.
- Just under one in three (29%) of the employees with childcare but not eldercare responsibilities report high work interferes with family.
- One in five of the employees with no caregiving responsibilities report high work interferes with family.
- There is very little variation in family interferes with work within the sample.
- Employees with childcare (13%) or sandwich (15%) responsibilities are more likely to report high family interferes with work. Where the elderly dependent lives does not have a substantive impact on family interferes with work for those in the sandwich group. It does, however, influence the incidence of this form of work-life conflict for those in the eldercare group.
- Employees in the eldercare group whose dependent lives with them are more likely to report that their family interferes with their work than are employees in either of the other two eldercare groups. This finding may be attributed to any of the following factors from the literature in this area: employees who care for someone in their home often have little to no caregiver support and have to take time off work to deal with pressing eldercare issues,

caregivers who look after their dependent in their home often reduce to part-time work status to deal with the demands at home, and/or dependents who live with a family member often are in poorer physical or mental health.

- Very few employees in the no care (3%) or eldercare (6%) groups experience family interferes with work.

If the no caregiving situation can be considered the baseline condition, it would appear then that:

- Eldercare is more likely than childcare to contribute to work-interferes with family,
- Childcare is more likely than eldercare to contribute to family interferes with work, and
- Eldercare (even when the dependent lives in the home) is not as likely to lead to high family interferes with work as is childcare (see Figure 6).
- Multiple demands at home (i.e. both child and eldercare) do not increase work interferes with family or family interferes with work (i.e. sandwich group reports same levels of work interferes with family as eldercare group and same level of family interferes with work as the childcare group). They do, however, contribute to increased levels of role overload.
- Where the elderly dependent lives has a substantive impact on all three forms of work-life conflict for those in the eldercare group.

## **7.5 Caregiver's Mental Health**

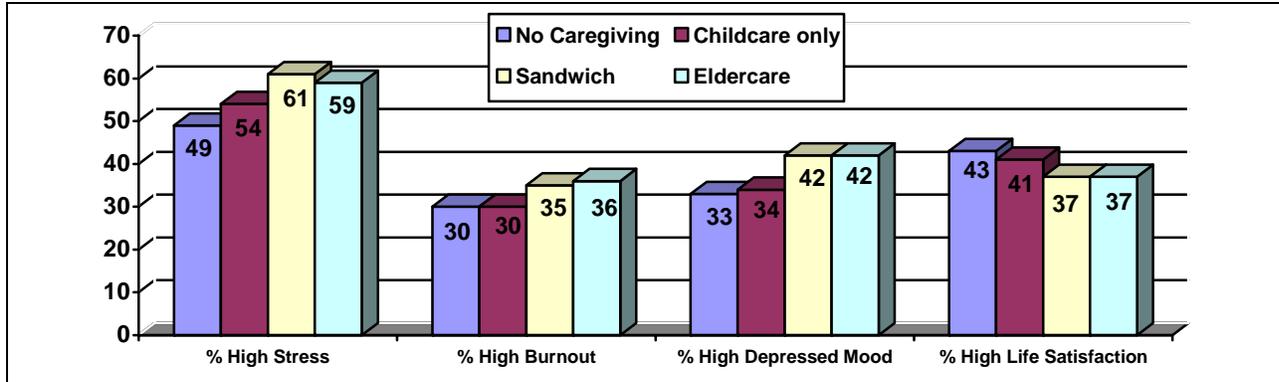
The impact of caregiving responsibilities on employee's mental health was examined by looking at between group differences in four areas: perceived stress, burnout, depressed mood, and life satisfaction. Data on these four constructs are given for the total sample in Figure 7 and for the sandwich and eldercare groups in E14, Appendix E. Again, the no caregiver situation will be used as a benchmark to help us identify changes in organizational attitudes and outcomes associated with childcare, eldercare and sandwich care.

The following conclusions can be drawn from these data:

- Employees with no caregiving responsibilities are in the best mental health. They are less likely to report high levels of stress (49%), burnout (30%), depressed mood (33%) and more likely to report high levels of life satisfaction (43%).
- Employees in the sandwich and eldercare groups have the poorest mental health. They are more likely to report high levels of stress, burnout and depressed mood and less likely to report high levels of life satisfaction.
- The mental health of those in the sandwich group does not depend on where the elderly dependent lives.

- Levels of burnout and depressed mood of those in the eldercare only group do not depend on where the elderly dependent lives.
- Employees in the eldercare group who have their elderly dependent living with them are more likely to report high levels of stress and less likely to report high levels of life satisfaction than are their counterparts whose elderly dependents live nearby or elsewhere.
- Employees in the eldercare group with their elderly dependent nearby report higher levels of stress than those whose dependent lives elsewhere.
- The mental health of employees in the childcare group is slightly poorer than their counterparts in the no caregiver group but better than those in the sandwich and eldercare groups.
- Multiple family demands do not appear to contribute to a further decline in mental health above those observed for individuals with just eldercare (i.e. sandwich group reports same levels of stress, burnout, depressed mood and life satisfaction as the eldercare group).
- Eldercare demands are more problematic in terms of the mental health of employees than are childcare demands.

**Figure 7: Impact of Caregiver Group On Employee Mental Health (% High)**

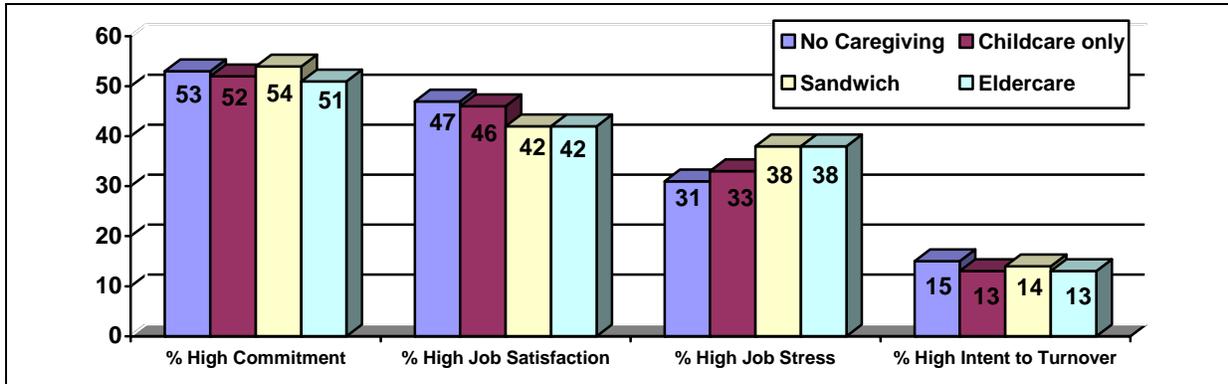


## 7.5 Link between Caregiving and Organizational Outcomes

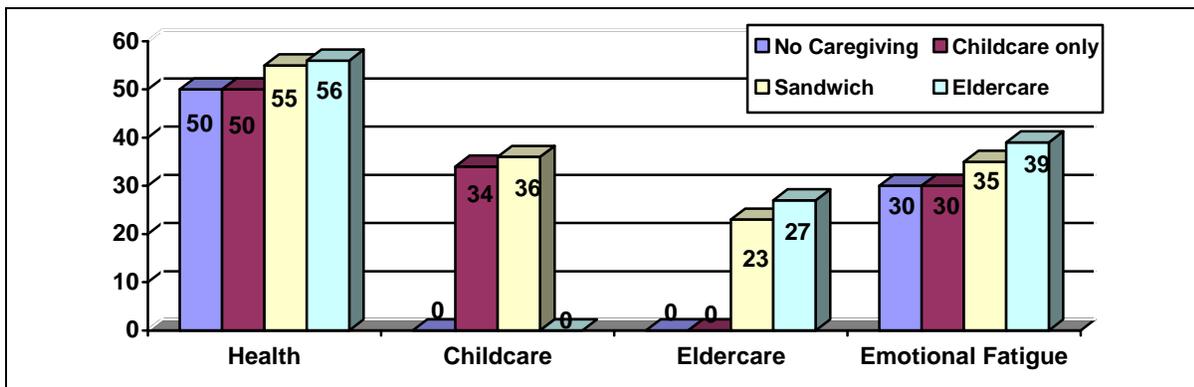
The impact of caregiving on a number of key employee attitudes and outcomes was examined by looking at between group differences in the following key areas: Organizational commitment, job satisfaction, job stress, intent to turnover and absenteeism due to childcare, eldercare, health problems, emotional fatigue and in total. Data on these organizational attitudes and outcomes are given for the total sample in Figure 8 and for the sandwich and eldercare groups in E15, Appendix E. Again, the no caregiver situation will be used as a benchmark to help us identify changes in organizational attitudes and associated with childcare, eldercare and sandwich care.

**Figure 8: Impact of Caregiver Group on Organizational Outcomes**

**a Commitment, job satisfaction, job stress and intent to turnover (% high)**



**b. Absenteeism (% Who Missed Work in Past Six Months Due To)**



The following conclusions can be drawn from the data shown in Figure 8 and E16.

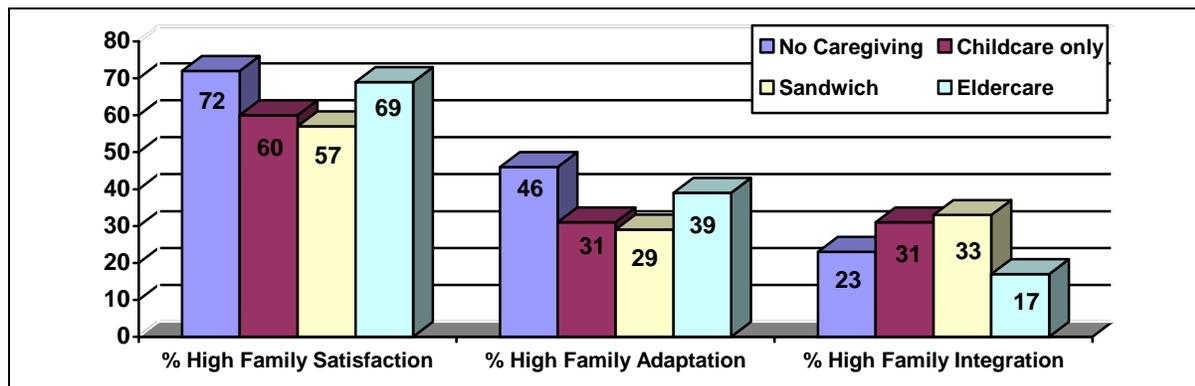
- Organizational commitment is not associated with caregiving.
- Employees in the sandwich and eldercare group are less likely to be satisfied with their jobs than their counterparts in the childcare only and no caregiving groups. These differences in job satisfaction can be attributed to the low levels of job satisfaction for those in the sandwich group with elderly dependent elsewhere and for those in the eldercare group whose dependents live with them.
- Employees in the sandwich and eldercare groups are more likely to report high levels of job stress than their counterparts in the childcare only and no caregiving groups. These differences in job stress can be attributed to the fact that employed caregivers whose elderly dependent lives elsewhere are more likely to report high stress, regardless of whether or not they have children at home.

- Caregiving does not appear to be linked to intent to turnover when one considers the analysis done with the total sample. Examination of the subgroup data, however, indicates that this is not the case. Instead it would appear that employees whose elderly dependent lives with them are significantly more likely to be thinking of leaving their job than other groups of employees, regardless of whether or not they are in the sandwich and eldercare groups.
- Employees in the sandwich and eldercare groups are more likely to miss work due to ill-health. This form of absenteeism is not, however associated with where the elderly dependent lives when one looks specifically at absenteeism in the sandwich and eldercare samples.
- Employees in the childcare and sandwich groups are more likely to miss work due to childcare problems. This form of absenteeism is not, however associated with where the elderly dependent lives when one looks specifically at absenteeism in the childcare and sandwich samples.
- Employees in the sandwich and eldercare groups are more likely to miss work due to eldercare problems. This form of absenteeism is strongly associated with where the elderly dependent lives in both the sandwich and eldercare samples. In both cases the closer the employee lives to the elderly dependent, the more likely they are to be absent due to eldercare problems. In fact, approximately 40% of employees whose dependent lives with them missed work due to eldercare issues in the 6 months prior to this study being undertaken.
- Employees in the sandwich and eldercare groups are more likely to miss work due to emotional fatigue than are employees in the other two caregiving groups. This form of absenteeism is not, however associated with where the elderly dependent lives when one looks specifically at absenteeism in the sandwich and eldercare samples. It is, however, important to note that individuals in the eldercare only group are more likely to miss work due to emotional fatigue than are those with both eldercare and childcare. This supports the idea, expressed earlier, that employees in the sandwich group are more able to cope with the stresses associated with eldercare than are their counterparts with eldercare only.

## **7.6 Link between Caregiving and Family Outcomes**

The impact of caregiving on a number of key family outcomes was examined by looking at between group differences in the following key areas: family satisfaction, family adaptation, family integration, parental satisfaction and perceived parental performance. The results from this analysis are shown in Figure 9 (total sample), and Figure E17. Again, the no caregiver situation will be used as a benchmark to help us identify changes in family outcomes associated with childcare, eldercare and sandwich care.

**Figure 9: Impact of Caregiver on Family Outcomes (% High )**



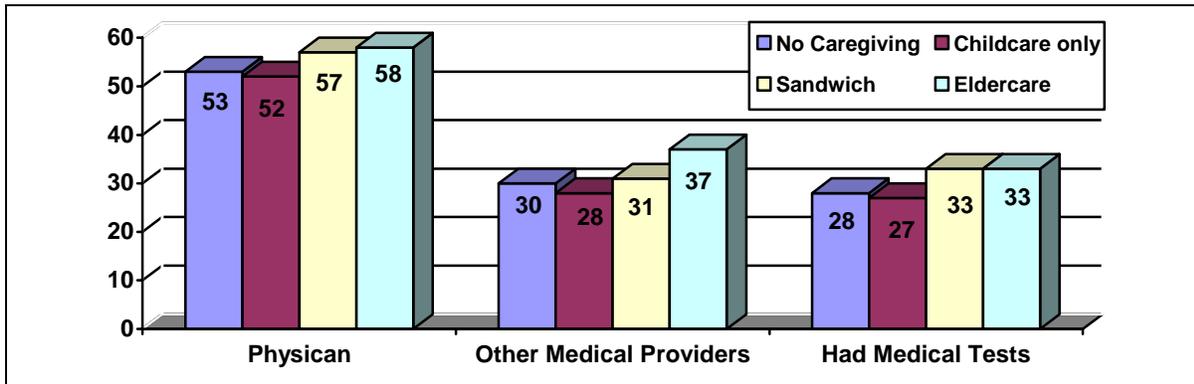
The following conclusions are supported by this analysis:

- Parental satisfaction and parental performance are not associated with caregiving group (i.e. no difference in these two outcomes between the childcare only and sandwich groups).
- Employees in the no caregiving and eldercare groups were more likely to be satisfied with their families and report high levels of family adaptation (i.e. family well being).
- Employees in the childcare and sandwich groups were more likely to report high levels of family integration (i.e. greater stability of family unit; ability to participate with family in joint functions and activities).
- Within the sandwich group, employees who care for elderly dependents in their home report higher levels of family satisfaction, family well being and family integration than their counterparts who care for dependents who live nearby or elsewhere.
- Within the eldercare group, on the other hand, employees who care for elderly dependents in their home are less likely to report high levels of family satisfaction and family well being than their counterparts who care for dependents who live nearby or elsewhere. They are, however, more likely to report high levels of family integration than are employees in these other groups.

## **7.7 Link between Caregiving and Societal Outcomes**

The impact of caregiving on Canadian society was quantified by looking at the relationship between caregiver group and the use of Canada's health care system (i.e. visited family doctor, other health care providers, mental health provider and the emergency department, had medical tests and stayed overnight in the hospital. Caregiving was not significantly associated with visits to the emergency room, use of mental health services and overnight hospital stays. The results from the rest of this analysis are shown in Figures 10 (total sample) and E18.

**Figure 10: Impact of Caregiver Group on Use of Canada’s Medical System:  
( % Indicating Personal Use of Following Services in Last Six Months)**



The following conclusions can be drawn from these data:

- Employees with eldercare responsibilities are more likely to seek care from their family physician and to have medical tests. Since there was no difference between the sandwich and eldercare groups with respect to both of these uses of the health care system it would appear that it is eldercare rather than childcare which is contributing to the increased use of the health care system.
- Employees in the eldercare group are more likely than those in the other three groups to seek care from other medical professionals.
- Where the elderly dependent lives has no impact on how frequently those in the sandwich group seek medical care.
- Where the elderly dependent lives has no impact on how frequently those in the eldercare group seek the following forms of medical care: visits to physician, hospital stays, visits to emergency department.
- Employees in the eldercare group whose elderly dependent lives with them have fewer medical tests and make fewer visits to mental health providers and other care providers than their counterparts who care for dependents who live nearby or elsewhere.

## **7.8 Conclusions: Characteristics of the Various Caregiver Groups**

A number of key conclusions can be drawn from this part of the analysis.

First, Canadians who combine work and caregiving (child and/or eldercare) pay a price. Employees with no caregiving have fewer demands on their time than employees with caregiving responsibilities. They spend more time in leisure per week and have a good balance between work and family. (i.e. report the lowest levels of role overload (45% high), work interferes with family (20% high) and family interferes with work (3% high) of any group).

They are more likely to work for a supportive manager (51%) and enjoy relatively high levels of flexibility with respect to work hours and work location (40% high perceived flexibility). They report higher levels of job satisfaction (47% high), lower job stress (31% high) and are significantly less likely to be absent from work. It is also important to note that employees with no caregiving responsibilities are in better physical and mental health than their counterparts with child and/or eldercare. They make less use of Canada's medical system and are less likely to report high levels of stress (49% high), burnout (30% high), depressed mood (33% high) and more likely to report high levels of life satisfaction (43% high). Finally, employees with no children/elderly dependents report better circumstances at home. In fact, they report the highest levels of family satisfaction (72% high) and family adaptation (well being) (46% high) in the sample. These findings indicate that Canadians who have children and/or assume the responsibility for the care of an elderly dependent pay a price at home, at work, and personally. They also suggest that employers (higher absenteeism and intent to turnover, lower job satisfaction and stress) and Canadian society (increased use of Canada's health care system) also pay a price when Canadian employees cannot balance work and caregiving demands.

Second, while employed parents are relatively better off than their counterparts with eldercare (i.e. those in sandwich and eldercare only groups) – they still have substantive challenges that can be linked to the need to balance work and childcare. This group has a lot of demands on their time: their work demands are the highest in the study (over 45 hours per week), their non-work demands are substantive (33 hours per week) and they have relatively few hours per week to spend in leisure activities (8 hours). On the plus side, approximately half work for a manager who they consider to be a support. More challenging is the fact that very few employed parents perceive that they have much flexibility with respect to work hours and work location (only 30% high). Not surprisingly, many of the employees in this group experience difficulties with respect to balance work and family. Two forms of work-life conflict are particularly problematic for the employed parents: role overload (60% have too much to do and too little time) and family interferes with work (13% say expectations at home make it hard for them to meet expectations at work). These findings are consistent with the lower levels of flexibility given to this group of employees.

Third, while the work attitudes and physical and mental health outcomes of the no caregiving and childcare only groups are similar in many ways, areas where they differ are important to note. These include the fact that employees with children at home are more likely than those in the eldercare and no caregiver groups to miss work due to childcare problems and more likely to report high levels of stress (54% high) than employees without childcare/eldercare. It should be noted, however, that the mental health of employees in the childcare group is better than those in the sandwich and eldercare groups.

Fourth, it would appear that the need to balance competing family demands is having a negative impact on the families of employed parents as employees in this group are less likely to be satisfied with their families and report lower levels of family well being (only 31% high).

The fifth conclusion pertains to the eldercare group. The data show that although employees in the eldercare group also experience higher levels work-life conflict, in this case it manifests itself as higher levels of role overload (60% high) and work interferes with family (39% high). Very

few employees in the eldercare (6%) group experience family interferes with work. These findings are striking given the fact that those in the eldercare group spend fewer hours per week than the employees in the other three groups in paid employment and caregiving and more time in leisure (only the non-caregiver group have fewer non-work demands and more hours in leisure). These data support the following conclusion: work life conflict for those with eldercare is more a function of role requirements than the amount of time spent in work and non-work roles. This interpretation of the data is consistent with the fact that employees in the eldercare groups are in poorer mental and physical health than the employees in the other three groups. They are more likely to report high levels of stress (59% high), burnout (36% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37%). They are also more likely to seek care from other medical professionals (37% did so in six month period) and seek care from their family physician (58% did so in six month period).

The fact that employees in this group are also less likely to enjoy high levels of flexibility and less likely to perceive their supervisor is supportive suggests that there is a basic disconnect between what the organization expects of the individuals in this group and what they are able to deliver due to expectations they place on themselves and the expectations placed on them by Canadian society. The idea that there is a disconnect between work expectations and elder caregiving is consistent with the fact that employees in the eldercare group are more likely to report higher levels of job stress (38% high), lower job satisfaction, (42% high) and increased levels of absenteeism due to ill- health (56%), eldercare problems (27% high) and emotional fatigue (39% high). In fact they have the highest level of absenteeism due to emotional fatigue of any group in the sample.

We expected the final caregiving cluster examined in this analysis, the so called sandwich group with responsibilities for both childcare and eldercare, to fare worse than any of the other caregiver groups (i.e. higher demands, more work-life conflict, greater absenteeism, poorer health). In some cases our expectations were borne out by the data: in some cases they were not

In terms of demands, for example, employees in the sandwich group spent the same number of hours in work per week as those in the no caregiving group but also committed 35 hours per week to non-work activities (the highest in the sample). They also had the highest number of committed hours per week (79.2 in work and family) and the fewest hours in leisure (7 hours per week). Given the onerous demands faced by the employees in this group it was also not surprising to see that they had the highest levels of work-life conflict in the sample: 67% of the employees in this group report high role overload, 39% report high work interferes with family and 15% report high family interferes with work.

Also consistent with our expectations is the fact that employees in the sandwich group receive lower levels of support at work and report more negative attitudes towards their employer. Those in the sandwich group are less likely to perceive that their manager is supportive (44% work for a supportive manager) and have the lowest levels of flexibility with respect to work hours and work location of any group in the sample (27% high perceived flexibility). They are less likely to be satisfied with their jobs (42%), more likely to report high levels of job stress (38% high) and more likely than those in the childcare only and no caregiving groups to miss work due to ill-health, emotional strain and eldercare problems.

Also consistent with our expectations are the findings supporting the idea that employees in the sandwich group are in poorer health. Compared to those in the non caregiving and childcare groups they are more likely to report high levels of stress (61% high), burnout (35% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37% high). They are also more likely to seek care from their family physician (57%) and to have medical tests (33%).

Employees in the sandwich group look very much like their counterparts in the childcare only group when it comes to family outcomes. They are more likely than those in the no caregiving and eldercare groups to report high levels of family integration (i.e. greater stability of family unit; ability to participate with family in joint functions and activities) (33% high) and less likely to report high levels of family satisfaction (57% high) and family adaptation (i.e. well being) (29% high) than those in the no caregiving and eldercare groups.

Contrary to what we had expected, however, multiple family demands did not appear to contribute to a further decline in either physical or mental health above that observed for individuals with just eldercare (i.e. sandwich group reports same levels of stress, burnout, depressed mood and life satisfaction, visits to physician etc. as the eldercare group). This finding is particularly striking given the fact that, as expected, employees in this group have very high demands on their time and high levels of work-life conflict. It would appear that having children at home provide employees with elderly dependents some increased ability to cope with the strains associated with eldercare. How does having children at home help? It is hard to say from these data but it is possible that children reduce strain by helping out with eldercare, providing emotional support to their parents, and (strangely enough) providing the employee with another role (that of parent) whose rewards can offset the frustrations and strains associated with the role of elderly caregiver. This third explanation is based on the idea of “role expansion” which states that people can benefit from multiple roles when the rewards from one set of responsibilities (i.e. raising a child, watching them learn) partially offset the frustrations and stresses of performing a second role (i.e. watching parent die and lose functioning).

Finally, a number of key conclusions can be derived by using the no caregiver group as the baseline and comparing the findings obtained with the childcare, eldercare and sandwich groups. Specifically, the data supports the following conclusions with respect to the relationship between care group and key outcomes:

- The more demands one has outside of work, the more overloaded one becomes.
- Childcare and eldercare responsibilities are equally likely to contribute to role overload.
- Eldercare increases the likelihood that an employee will experience work interferes with family, regardless of whether or not the employee also has childcare.
- Childcare increases the likelihood that an employee will experience family interferes with work, regardless of whether or not the employee also has eldercare.

- Multiple demands at home (i.e. both child and eldercare) do not increase work interferes with family or family interferes with work (i.e. sandwich group reports same levels of work interferes with family as eldercare group and same level of family interferes with work as the childcare group). They do, however, contribute to increased levels of role overload.
- Eldercare demands are more problematic in terms of the mental health of employees than are childcare demands: Employees who provide eldercare are more likely than those in the childcare and no care groups to report high levels of stress (61% high), burnout (35% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37% high). The fact that there are no differences in any of these mental health indicators between those in the sandwich and eldercare groups suggests that eldercare has a more deleterious impact on employee mental health than childcare.
- Multiple family demands do not appear to contribute to a further decline in mental health above those observed for individuals with just eldercare (i.e. sandwich group reports same levels of stress, burnout, depressed mood and life satisfaction as the eldercare group).
- Employees with eldercare demands are significantly less likely than those with no caregiving or with just childcare to receive support from their employer (i.e. less likely to work for a supportive manager and have very low levels of work time and work location flexibility). The fact that there are no differences in management support and perceived flexibility between the sandwich and eldercare groups suggests that challenges in this area are linked to eldercare rather than childcare.
- Employees with eldercare demands are significantly less likely than those with no caregiving or with just childcare to be satisfied with their jobs (42%) and more likely to report high levels of job stress (38% high). They are also more likely to miss work due to ill-health, emotional strain and eldercare problems. The fact that there are no differences in job satisfaction, job stress and absenteeism between the sandwich and eldercare groups suggests that it is the need to provide eldercare (rather than childcare) that is contributing to these negative work outcomes.
- Employees with eldercare responsibilities are more likely those in the childcare and no care groups to seek care from their family physician and to have medical tests. Since there was no difference between the sandwich and eldercare groups with respect to both of these uses of the health care system it would appear that it is eldercare rather than childcare which is contributing to the increased use of the health care system.
- Employees with responsibilities for childcare are less likely than those in the no caregiving and eldercare groups to report high levels of family satisfaction and family adaptation/ well being. Since there was no difference between the sandwich and childcare groups with respect to these outcomes, it would appear that it is childcare rather than eldercare that is contributing to problems with the family unit.

## **Chapter Four**

### **Balancing Work and Eldercare: A View From the Trenches**

#### **1. Introduction**

To get a better understanding of the role of employed caregiver (i.e., types of tasks being done, hours of care, financial issues) Duxbury and Higgins worked with VON to identify a sample of employees with eldercare/disabled care responsibilities. We then worked with HRSDC to create a semi-structured interview (see Appendix F) that looked at the caregiver experience in detail. Specifically we asked questions that allowed us to better understand what employed caregivers do, why they do it, the joys and pressures of assuming the role of employed caregiver, and the kinds of support key stakeholders could offer to the employed caregiver to facilitate performance of this role.

For this purposes of this study caregiver was operationally defined as:

“an individual providing care or assistance to a family member in their home or the care recipient’s home who has a physical or mental disability, is chronically ill, frail, or at the end of life.”

To be included in this study the caregiver had to have been actively caregiving for at least 6 months prior to the study, caring for someone in their own home or the home of the care receiver, and be actively employed for at least 10 hours per week. Caregivers providing care to individuals in hospitals or living in a nursing home, supportive housing/assisted living facility, group home or shelter were not examined in this study.

This chapter is divided into seven sections. The research methodology is described first. This is followed by a description of the interview sample. Two sets of descriptors are relevant here: those relating to the employed caregiver (often referred to in this chapter as the caregiver) and those pertaining to the person being cared for (often referred to in this chapter as the dependent). Part Three seeks to further our understanding of the demands associated with the role of employed caregiver. Part Four examines the employed caregiver role in more detail while Part Five looks at the association between employed caregiving and caregiver strain. Section six looks at the challenges faced by employed caregivers. The final section of this chapter summarizes the recommendations on how key stakeholders can best address the challenges faced by employed caregivers offered by the caregivers who participated in this study.

#### **2. Methodology**

The sample was obtained as follows. The Research Project Manager at the VON worked with existing partners and VON Branches to recruit employed caregivers to be part of this study. VON sent over 100 individual letters (see Appendix F) to key contacts within VON network including VON branches, caregiver associations/groups, social work groups, eldercare consultants and several listservs of professionals who work with caregivers in their practice. The letter was sent out to the network on 3 separate occasions between January 7 and March 21, 2008. Caregivers who wished to participate in the study were asked to contact the VON National Office to schedule an interview. The sample selection process ensured that we had

people in different locations in Canada with different forms of caregiving responsibility (i.e. dependents in the home and dependent lives in own home).

Just over 70 individuals responded to this request for participation. Of this group, 43 were employed caregivers who felt they met the criteria for inclusion in the research. All interviews were conducted by a trained Research Assistant who contacted interested caregivers and scheduled an interview. The Research Assistant contacted all 43 of the employed caregivers who thought that they met the research criteria. After talking to this group, 30 interviews were scheduled. Ten individuals were eliminated from the sample as they did not meet the inclusion criteria (i.e. not working at time of caregiving, caregiving experience more than 2 years ago, caring for a young child rather than an elderly dependent). Three others were eliminated from the sample after 3 unsuccessful attempts to schedule an interview were made.

All interviews were done by phone and averaged 45 minutes in length. Strict ethical procedures with respect to data collection and reporting were followed during this process (i.e. we promised anonymity to those involved).

In total, 30 people participated in the interview process. Duxbury and Higgins analyzed the taped telephone interview data using well established qualitative data analysis techniques (i.e. grounded theory, case analysis, content analysis). Key themes were documented and form the foundation for this section of the report. In the discussion below we look at findings with respect to the total sample. To increase our understanding of the quantitative data presented in the previous chapter of this report we also examine the impact of caregiver arrangement on the results. Two caregiving arrangements are considered in this part of the study: the dependent lives with the caregiver, and the dependent lives on their own (also referred to in this report as elsewhere).

### **3.0 Description of the Sample**

The following pieces of demographic data were collected from the interview respondents (i.e. the caregiver): postal code, age, gender, marital status, parental status (if they had children living at home), and hours a week in childcare. Analysis of these data support the following observations:

- All but 8 of the respondents lived in Ontario. Those who did not live in Ontario lived in BC (6) and the Maritimes (2). The Ontario sample came from all over the province.
- All but one of the respondents was female
- The mean age of the caregiver in this sample was 53. The age distribution of the sample was skewed as more than half (57%) of the caregivers were in their 50s and approximately one in five (17%) were either in their 60s or their 40s (20%). Only 6% of the respondents were less than 40 (one in their 20s and one in their 30s).
- Two thirds of the respondents were married.

- The majority of the sample (83%) were empty nesters in that their children were grown and no longer lived at home. This is consistent with the age data presented earlier. The rest of the respondents (17%) can be considered to be in the sandwich group as they care for an elderly dependent and also have children living at home. It should be noted, however, that in all but one of these cases, the children at home were in their teens and time spent in childcare a week by the respondent was relatively low (approximately 5 hours per week).

We collected, from the caregiver, a number of pieces of information to allow us to create a picture of the individual being cared for. We began by asking the caregiver how many people over the age of 50 they were currently caring for. We then asked them to tell us (for each person they cared for) the person's gender, age, relationship to the caregiver, how long they had been caring for him/her and whether or not this individual lived with him/her. For those individuals who cared for a dependent who lived elsewhere we asked the caregiver how far they needed to travel to provide care and how often they made the journey. Finally we asked why they had assumed the role of caregiver and how much choice they had in terms of their taking on this role?

Half of the sample (56%) were caring for a female dependent while the other half (44%) were caring for a male dependent.

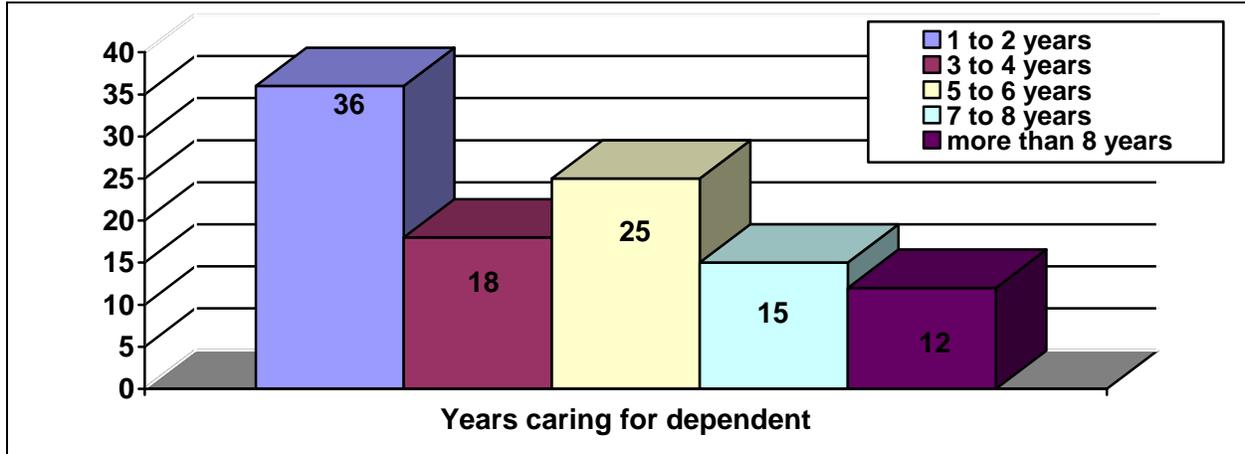
The majority (83%) of respondents were caring for one elderly dependent. The rest (17%) were caring for two. With one exception, the individuals who were caring for two individuals were responsible for the care of a couple (one male, one female dependent) – either their parents or their in-laws. In the other case, the employed caregiver had assumed care for their own partner as well as their mother.

The majority (63%) of the caregivers in this sample provided care for either their mother or their father. A substantive number (30%) provided care for their spouse or partner while 7% had assumed responsibility for the care of their partner's mother/father.

Most of the employed caregivers in this sample cared for an elderly dependent (average age of dependent was 76.7). A plurality of the respondents cared for a dependent in their 70's (24%), 80's (38%) or 90's (15%). That being said, one in four cared for a relatively young individual (12% cared for an individual in their 50s and 12% cared for someone in their 60's). In all these cases, the dependent was the spouse of the caregiver.

Eldercare does not appear to be a transitory condition. On average the caregivers in this sample have been performing this role for 4.9 (SD 4.4) years. That being said, it is important to note that the sample was well distributed with respect to the amount of time the respondent had been caring for their elderly dependent (see Figure 11 below).

**Figure 11: Distribution of Years Spent Caring for Dependent Data**



The sample was skewed with respect to the living arrangements of the elderly dependent as the majority of caregivers (57%) looked after a dependent who lived with them. This finding is likely due to how the sample was selected (we excluded people who looked after a dependent who was in hospital, in a nursing home etc.).

Twelve people cared for a dependent who lived in their own home. The majority of these women (75%) indicated that the person that they cared for lived more than 30K from where they themselves resided (equivalent to the “elsewhere” category in the quantitative study). One in four cared for a dependent who lived between 6 and 25K from their home (equivalent to the “near by” category in the quantitative study).

We asked those who cared for an individual who did not live with them “*How often do you need to travel to care for this person?*” The typical caregiver in this sample who cared for a dependent who lived elsewhere checked in on their dependent several times a week (42%) or on a weekly basis (25%). While one in four (typically individuals who lived a great distance from those they were caring for) made the journey to care for their dependent only once a month, one woman who lived more than 30K from the person she was caring for made the journey daily!

Why did the people in the sample assume the role of caregiver? The majority (57%) indicated that they had chosen to take on this role because “It’s what you do for your loved ones”. That being said, 40% indicated that they had little choice in the matter and that they had assumed the role because either there was no one else who could do it or they were the only one in their family who had “stepped up” when the need arose. One individual assumed the role because “financially it makes sense.” None of the employees who cared for a dependent in their own home said that they had assumed this role because there was no one else.

Along these lines we also asked respondents “*What kinds of rewards (if any) do you get from caring for others?*” Just over 10% of the respondents (14%) could not think of any rewards associated with this role. The rest identified the following rewards:

- Knowing I’m helping someone I care about: 59%

- Knowing they are in a home environment: 28%
- Enjoy spending time with them/strengthened our relationship: 14%
- Avoids guilt/helps me sleep at night and face myself in mirror in morning: 10%
- Thanks and appreciation: 7%

These findings suggest that caregiving is a “labour of love” – undertaken by those who are also engaged in paid labour because they love the person they are caring for. Those who chose to care for someone in their own home do so because they do not feel comfortable with care facilities and want their family member in their own home where they perceive they will be more comfortable. The above responses also imply that individuals who chose to care for a dependent while still employed receive altruistic rewards rather than actually thanks.

“My mom treats my children so well. She knows how much that means to me”

“My husband and I have learned a different way to live together and it is amazing”

“Knowing I haven’t failed the people I love”

We also asked respondents how they would characterize the health status of the person they provided care to? We gave them the following options:

- Acute
- Chronic (includes dementias and neurological conditions)
- Episodic/generally ok with medications
- Palliative

The majority of respondents (77%) indicated that the person they cared for had a chronic condition. One in five (18%) stated that the condition was episodic and 3% said palliative (cared for in respondent’s home). Where the dependent lived was not associated with their health status.

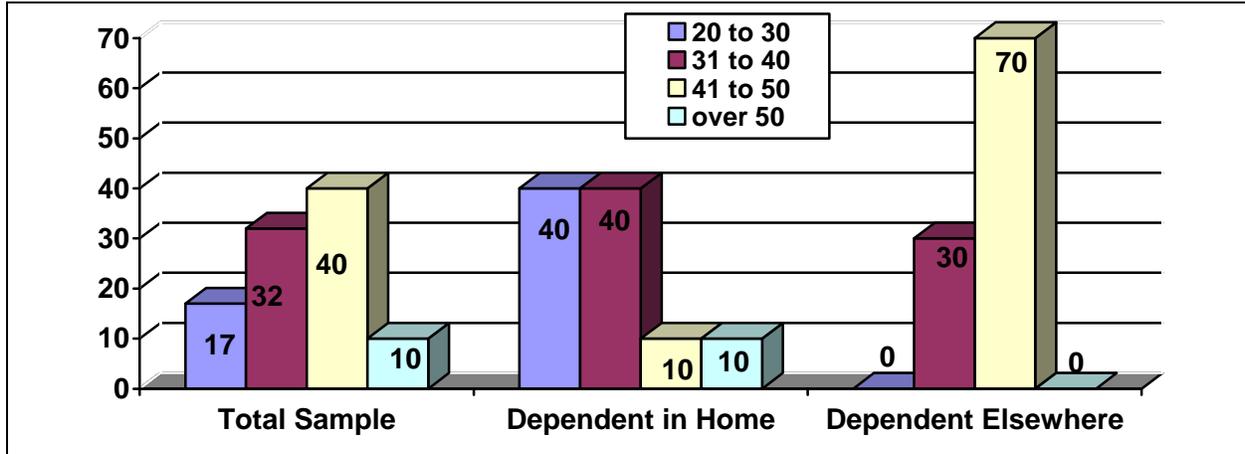
## **4. The Demands Associated With the Employed Caregiver Role**

We examined two sets of demands in this analysis: those associated with paid employment and those associated with caregiving. While we also asked respondents about their childcare demands, this data is not reported below as the majority of respondents no longer had children in the home (i.e. spent little to no time each week on childcare).

### **4.1 Demands associated with paid employment**

Data on the number of hours per week the respondents to this study spent in paid employment are shown in Figure 12.

**Figure 12: Hours in Paid Employment Per Week**



The majority (83%) of respondents work full time as well as performing caregiving. The rest (almost one in five) work part time. On average, the respondents spend 36.5 (sd 8.8) hours per week in paid employment.

The number of hours spent in paid employment is dependent on whether or not the care recipient lived with the caregiver or in their own home (i.e. the caregiving arrangement). Respondents who provided care to a dependent who lived with them were more likely to work part time than were their counterparts whose dependent lived on their own, none of whom worked part time. Employees whose dependent lived in their own home, on the other hand, were significantly more likely to work 41 or more hours per week than their counterparts with care in the home (70% versus 20%). Put another way, caregivers whose dependent lived with them spent an average of 35.1 hours per week in paid employment – which is significantly fewer hours in employment than observed in the sample of caregivers whose dependent did not live with them (i.e. an average of 40.6 hours per week).

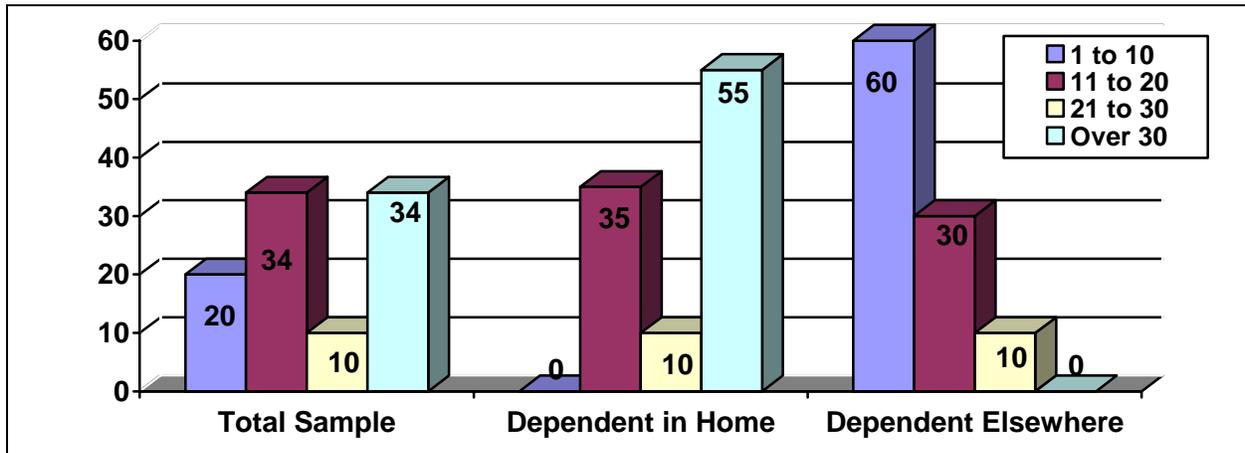
#### **4.2 Demands associated with caregiving**

Two sets of caregiving demands were examined in this analysis: time spent in care and time spent commuting each week because of caregiving commitments. Analysis of the data showed that, on average, the caregivers in this sample spent 30.28 hours per week (sd 23.2) providing dependent care and 4.1 (sd 5.0) hours per week commuting because of caregiving commitments. Data discussed in this section are shown in Figures 13 (hours per week in caregiving) and 14 (hours per week commuting due to caregiving commitments).

Hours spent in caregiving is strongly associated with the caregiving arrangement as demands increase dramatically for those who provide care in their own home as compared to caring for a dependent who lives elsewhere. Consider the following:

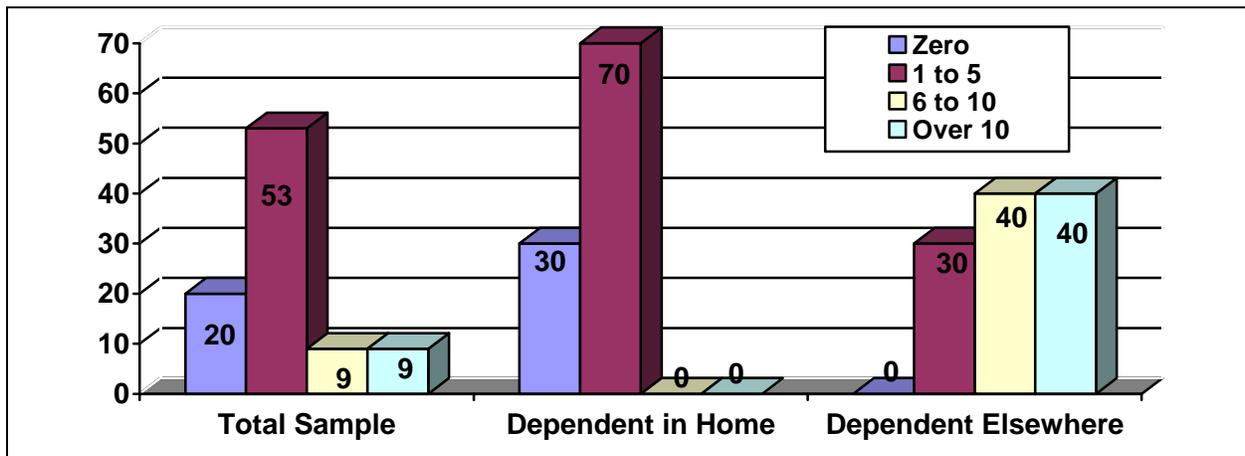
- Caregivers who care for a dependent in their home spend an average of 35.1 hours per week in caregiving and 1.3 hours per week in care related commuting.
- Caregivers who care for a dependent who lives elsewhere spend an average of 10.0 hours per week in caregiving and 15.2 hours per week in care related commuting.

**Figure 13: Hours in Caregiving Per Week**



The onerous caregiving demands of those providing care within their home can be appreciated by noting that 4 individuals in this group spend 50 to 70 hours a week in caregiving while another 4 spend 71 hours per week or more in caregiving. Sixty percent of those who provide care to a dependent who lives elsewhere, on the other hand, spent less than 10 hours per week in caregiving activities. Furthermore, no one in this group spent more than 30 hours per week in care whereas 55% of those whose elderly dependent lived with them devoted this much time or more to caregiving activities.

**Figure 14: Hours Commuting Per Week Because of Caregiving Commitments**



It is hard to tell the direction of causality from these data – do employees who are required to spend a tremendous amount of time each week in caregiving encourage their dependent to move in with them as a way to cope, or does having a dependent living with you create greater demands with respect to care? In either case, the data is unequivocal – those who provide care for an elderly dependent in their own home have more demands on their time (heavy family demands, moderate to heavy work demands) than those who do not have their dependent living with them in their home

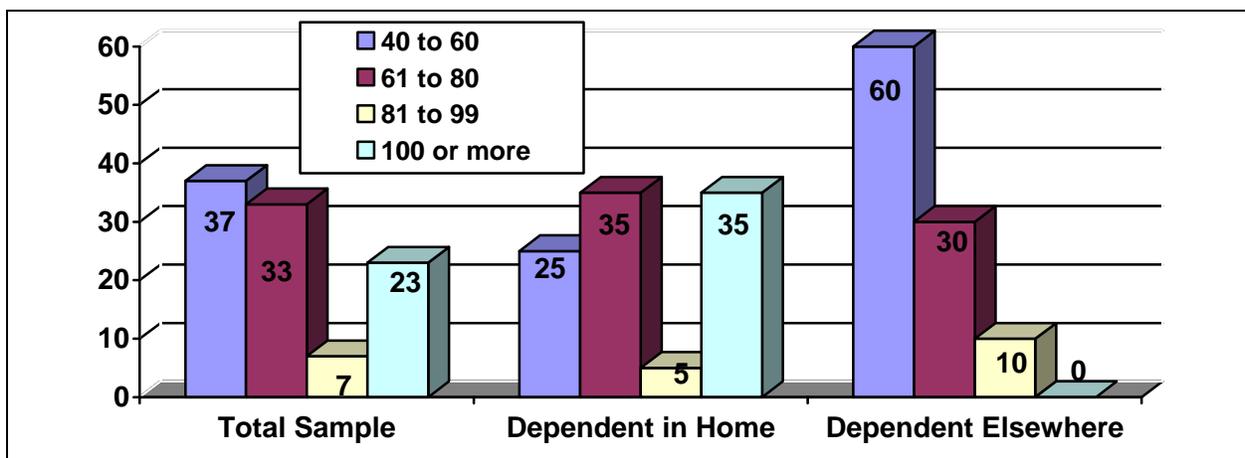
The majority (53%) of the respondents spend 1 to 5 hours per week commuting due to caregiving commitment. Not surprisingly, while employees who provide care to family members who live with them spend more time providing care, employees whose dependent lives elsewhere spend more time commuting due to caregiving commitments. Examination of the data in Figure 13 show that almost one in three of the employees in the first group spend no time commuting while the rest in this group spend one to five hours per week. By comparison, 40% of those employees who care for a dependent who lives elsewhere spend more than 10 hours a week commuting. These data indicate that there is a trade off in demands that is associated with where the person requiring assistance lives: those who have the dependent living with them spend less time commuting but more time in care overall while those whose dependent lives elsewhere spend more hours commuting but fewer hours in care overall.

### 4.3. Total Demands

To get an idea of the total demands faced by employed caregivers in their dual roles (i.e. work and caregiving) we summed time spent in paid employment, time in caregiving and time commuting a week due to caregiving commitments. These data are shown in the Figure 15.

It would appear from this analysis that the demands faced by employed caregivers are bi-modal in distribution. While a substantial portion (37%) of the respondents commit 40 to 60 hours per week to their dual roles and one in three commit 61 to 80 hours per week, almost one in four spend more than a 100 hours a week fulfilling work and caregiving obligations! Furthermore, the data shows that this bi-modal pattern in the data can be partially explained by looking at the caregiving arrangement. All of the respondents with very heavy work and caregiving demands cared for a dependent in their homes while those who cared for a dependent who lives elsewhere are 2.5 times more likely to spend fewer hours (40 to 60 per week) in work and care.

**Figure 15: Total Hours Committed Per Week to Work and Caregiving**



## 5. The Caregiving Role

As noted earlier, the research literature in this area outlines five broad categories of caregiving: (Fast and Keating, 2000) that individuals can assume when providing care to someone else:

- Personal Care (dressing, bathing, lifting, feeding, toileting, grooming)
- Physical Care (house cleaning, shopping, errands, repairs, transportation, preparing meals)
- Nursing Care (medication administration, changing dressings)
- Support (maintaining social interaction, visiting, supervision [related to forgetfulness or frailty], emotional support, reassuring and validating attitudes or perceptions, managing depression, anxiety and pain)
- Coordination of Care (linkage between the care recipient and the formal service sector, identifying needed services and locating them in the community, gaining access to services, making appointments, attending information sessions, check- ups, managing financial matters)

In the interview we asked respondents how much time per week they spend engaged in each of these kinds of activities. We also asked about which of these roles they find most difficult or troubling and why. Results to these questions are given in Table 12. .

As noted earlier, the typical employed caregiver spends approximately 31 hours a week in caregiving activities. This study suggests that the majority of this time (68%) is devoted to two roles: physical care and emotional support (the typical caregiver in this sample spends just over 13 hours per week in physical care and 8 hours in activities associated with support). In addition they spend an average of 4 hours per week in personal care, 2 hours in nursing, and 4 hours in activities associated with co-ordination.

**Table 12: Hours Per Week in the Different Caregiving Roles**

<b>Role</b>	<b>Total Sample</b>	<b>Dependent in Home</b>	<b>Dependent Elsewhere</b>
Personal Care	4.1	6.3	1.7
Physical Care	13.4	16.8	5.8
Nursing	2.3	4.3	0.5
Support	8.4	8.0	5.0
C-ordination	3.9	4.6	3.1
Most Difficult Role:			
• Physical	6.7%	10.0%	0%
• Nursing	6.7%	10.0%	0%
• Support	57.2%	55.0%	60%
• Co-ordination	31.1%	25.0%	40%

Caregivers who have their dependent living in their home spend significantly more hours than their counterparts who care for dependents who live elsewhere in three of the five roles considered in this study: personal care, physical care, and nursing. The amount of time spent offering support and co-ordination is similar for the two groups.

Which roles do the respondents find most stressful? The answer is unequivocal – the support role. The fact that this aspect of caregiving is equally stressful for both groups examined in this study suggests it is the role rather than the location of the dependent that makes this aspect of caregiving stressful. It is also interesting to note that a substantive number of individuals find the co-ordination role to be most stressful – even though the time devoted to this role is much less than that given to physical care. It would appear that in this case stress is not associated with time in the role but rather the difficulty of coordinating different schedules over which one has little control (i.e. work, medical appointments, family events).

The respondents were also asked to tell us why they found the role they identified as most stressful problematic. Almost half of the respondents indicated that they had identified the support role as most stressful because they found this role mentally exhausting and upsetting. Those with care in the home also noted that in their case a lot of emotional support was needed by the dependent.

Respondents who mentioned the co-ordination role as the most frustrating talked about the fact that the role was extremely time consuming and involved a lot of phone calls. It should be noted that twice as many respondents whose dependents lived elsewhere than those who cared for someone in their home identified this role as the most frustrating (57% versus 22%). They indicated that they experienced frequent interruptions and phone calls at work – and felt frustrated by their inability to respond immediately. Other reasons for identifying a particular role as stressful included:

- It is frustrating, it is embarrassing and uncomfortable, it is physically exhausting, and my emotional needs are put last (these responses were only given by those whose dependent lived with them)
- They were worried about the future (this response was only given by those whose dependent lived elsewhere)

The following comments help illustrate the day to day frustrations associated with the caregiving role:

“I find it very frustrating when my parents won’t follow the doctor’s instructions”

“The bank makes it very difficult to have a bank card for both my parents and myself”

“I am constantly fighting these battles (with governments) which is extremely frustrating.”

## **6. Caregiver strain**

As noted earlier in the report, employees who care for elderly dependents can be considered “at risk” of experiencing a particular type of work-life conflict referred to as Caregiver Strain. Caregiver strain is a multi-dimensional construct which is defined in terms of “burdens” or

changes in the caregivers' day to day lives which can be attributed to the need to provide care (Robinson, 1983).

Several questions were included in the interview to give us an indication of the association between the role of employed caregiver and three types of caregiver strain. Respondents were asked the following:

*I am going to list a few things other caregivers have found to be difficult in their role as a caregiver. How often do any of these apply to you (Never, monthly, weekly, several times a week, daily)?*

- *Caregiving is a physical strain?*
- *Caregiving is a financial strain?*
- *Caregiving leaves me feeling overwhelmed (i.e. I worry about how I/we will manage)?*

Individuals who indicated that they experienced a particular strain several times a week or daily (i.e. reported high levels of strain) were asked

- *In what ways is it a physical strain?*
- *In what ways is it a financial strain?*
- *In what ways is it overwhelming?*

The questions were designed so that we could compare the interview findings with those obtained in the survey. The interview questions also allowed us to clarify the relationship between caregiving and the various types of caregiver strain. Key results from this phase of the interview are summarized below. It should be noted that sample size does not allow us to examine the impact of where the dependent lives on the responses to the follow up questions.

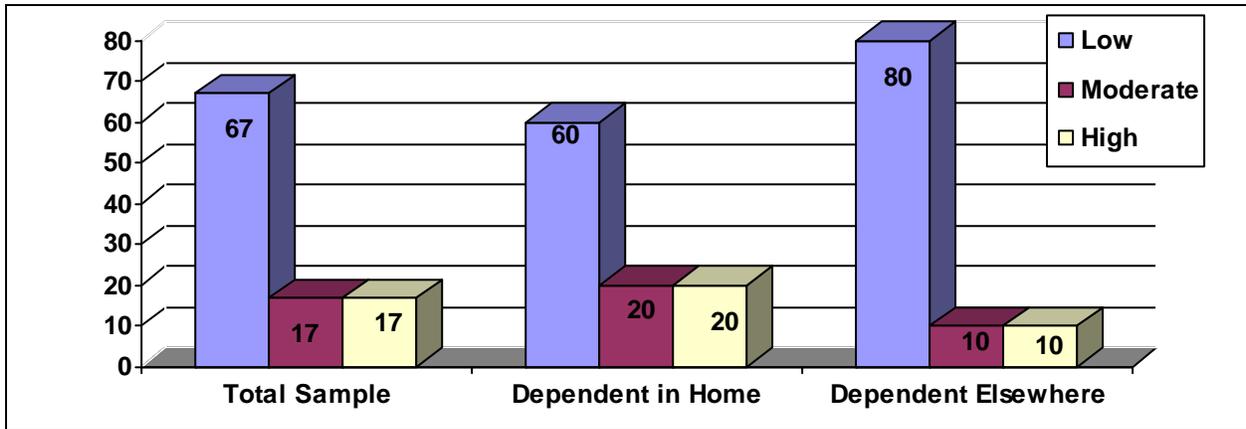
## **6.1 The Incidence of the three forms of strain**

The following conclusions can be drawn from these data shown in Figure 16:

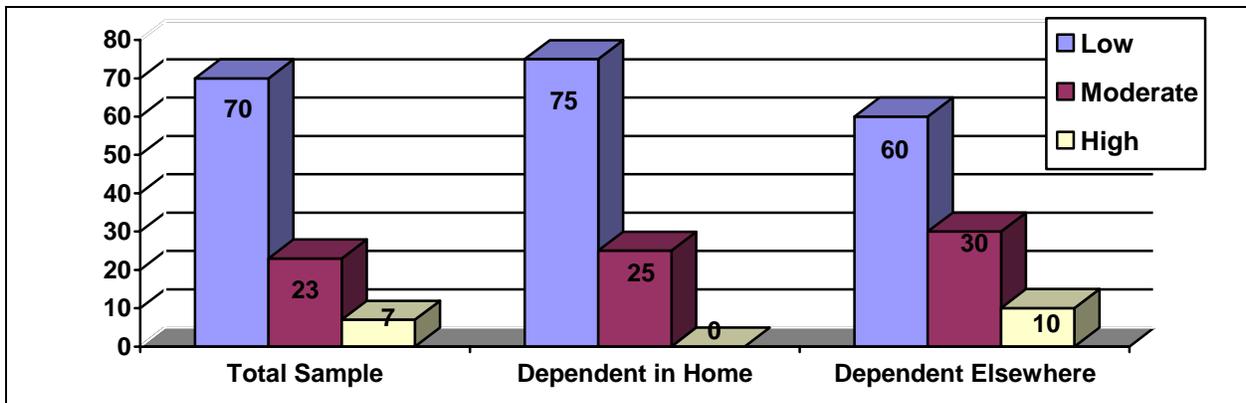
- The most problematic aspect of being an employed caregiver is emotional strain. While a substantive number of employed caregivers experience physical strain, high levels of financial strain are rare.
- Half of all employed caregivers experience high levels of emotional strain (i.e. feel overwhelmed). The likelihood of experiencing emotional strain is not associated with where the dependent lives. What it is, however, associated with, is heavy demands either at work, at home or in both locations.
- Approximately one in three (34%) individuals experience moderate (17%) to high (17%) levels of physical strain. Employees whose dependent lives with them are more likely to experience moderate to high physical strain (40%) than are those whose dependent lives elsewhere (20%).
- While high levels of financial strain appear to be rare (7%), approximately one in three (30%) individuals experience moderate to high levels of this form of caregiver strain. Employees whose dependent lives on their own are more likely to experience moderate to high financial strain (40%) than are those whose dependent lives with them (25%).

Figure 16: Caregiver Strain:

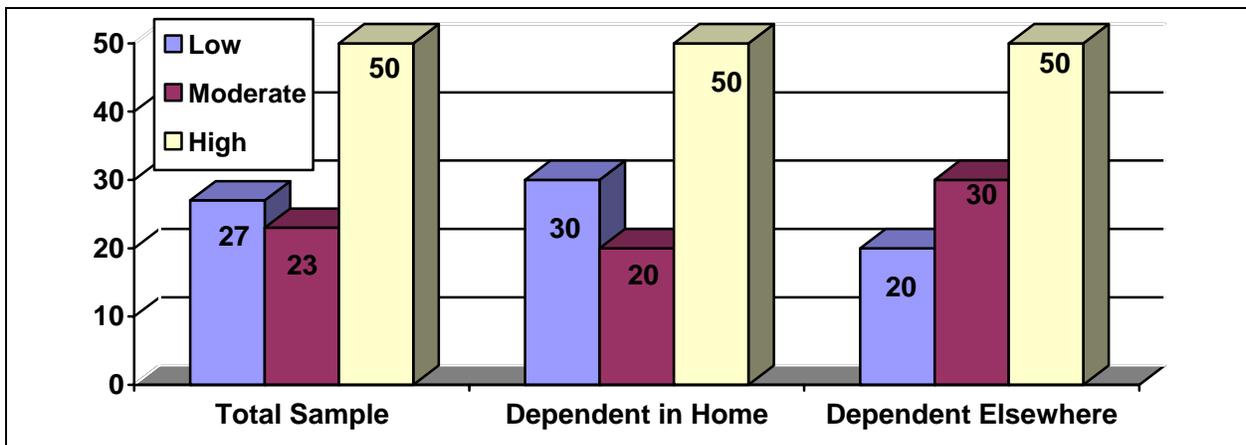
a. Physical Strain



b. Financial Strain



c. Emotional Strain



The fact that the percent of the interview sample with high levels of each of these three forms of caregiver strain is slightly greater than was observed in the survey study is consistent with the fact that a greater proportion of the interview than the survey sample cared for a dependent in their own home (as noted earlier, this is a key predictor of caregiver strain). It should be noted, however, that both studies found that emotional strain was the most common form of caregiver strain and financial strain the less prevalent.

## **6.2 What contributes to high levels of caregiver strain?**

Five individuals reported high levels of physical strain. The majority (80%) attributed this strain to the fact that their role as caregiver meant that they had to do a lot of heavy lifting. The other individual (one who put in more than 70 hours of care per week) said that she was physically exhausted because of constant interruptions to her sleep.

Three individuals reported high levels of financial strain. These individuals attributed their financial strain to the fact that their income had declined since they began providing care (their role as elder caregiver made it virtually impossible for them to work full time) while their expenditures had increased (had to pay for extra help, some living expenses, and medicines).

Fifteen respondents reported high levels of emotional strain. The reasons they gave for feeling overwhelmed included:

- There is just not enough time in the day – I worry about how I will do everything (50%)
- I don't have time for myself (50%)
- It is emotionally hard/their stress becomes my stress (40%)
- Constant worries about what the future holds financially, medically, finding care etc (40%)
- I just do not have enough time to care for elderly dependent (33%)
- No respite/ no life (33%)
- Constant worries about how they are when I'm not there – are they safe (33%)

Scanning this list it would appear that emotional strain has three causal factors: role overload (too much to do, not enough time, exhaustion), uncertainty/worry (what does the future hold? how will they manage? are they safe) and empathy (their stress becomes my stress).

## 7. The Challenges Faced by Employed Caregivers

As noted in the literature review Harlton, Keating and Fast (1998) identify stakeholders in the eldercare paradigm to embrace a broad set of constituents including elder adults themselves, their family members, friends and neighbors, those who provide formal and unpaid services and those who develop policy in relation to eldercare services. Each of these stakeholders has different mandates in relation to eldercare, each maintain their own perspectives and each experience change and challenge differently (Harlton et al, 1998)

To get a comprehensive idea of the challenges faced by employed caregivers we asked them to answer a series of questions for each of the five key groups of stakeholders noted above: the caregiver (i.e. themselves), the person they care for, their family, their employer, and the government. Responses are presented below.

### 7.1 The Employed Caregiver

We began by asking respondents to identify the personal challenges they currently face with respect to providing care. All 30 respondents were able to identify personal challenges they had faced due to their role as an employed caregiver. The vast majority (77%) stated that their mental health was suffering (they were worried, anxious, stressed, depressed). Half also noted that their physical health was suffering. One in four said that they felt that they had no life (no time for myself, no time to meet other demands or commitments). One in ten stated that they were always frustrated. Respondents who cared for someone in their home were more likely to state that eldercare had negatively impacted their physical health. Those who cared for someone who lived elsewhere, on the other hand, were more likely to feel that they had no life!

The following comments typify the kinds of things that we heard in the interview:

“I feel very guilty about being a long distance caregiver”

“I worry constantly that if something happens to me he will have no one to care for him”

“ I have stress when we have too many errands to do”

We then asked respondents to tell us how they coped with the personal challenges they had just identified. While one in ten said that they did nothing, the rest of the sample identified the following six coping strategies:

- Physical (I try and exercise; I eat healthily; I look after my health) :28%
- Active coping (cultivate spiritual/physical interests outside my role as a “carer”): 28%
- Social support (part of informal or formal support group): 28%

- Seek help (I am in therapy; I receive counseling; I take medication: I took stress leave): 18%
- Escapism: (drinking and/or eat excessively): 18%
- Have a positive attitude: (I take strength from the relationship; “things aren’t going to be perfect, you have to make peace with that”) 14%

It is reassuring to note that most respondents were employing healthy coping strategies to deal with their situation. It is also interesting to note that the use of personal coping strategies was not associated with the caregiving arrangement.

## 7.2 The Dependent

We began by asking respondents to identify the challenges that they faced that could be attributed to the person they provided care to. Almost one in five of the respondents said that they had not experienced any caregiving challenges that they could attribute to the person they were caring for. The other 80% identified four main challenges, each of which were mentioned by approximately 20% of the sample. These challenges include the following:

- The person they are caring for is difficult to communicate with (they are stubborn, very emotional, rude).
- The person they are caring for is depressed/have mental health issues,
- Either they, or the person they are caring for, finds it difficult to deal with the fact that the parent/child roles have changed/reversed, and
- The mental and/or physical changes that the person they are caring for have undergone are overwhelming (i.e. Alzheimer’s, dementia, can no longer walk).

Respondents whose dependent lived on their own were more likely than those who cared for a dependent in their home to say that they had no challenges in this area. Those who cared for the dependent in their home were more likely to note that they had experienced challenges because the person that they cared for could not accept the fact that their roles were reversed, had deteriorated mentally, and/or were depressed.

The following comments help illustrate the above challenges:

*“It has been hard to reverse the roles, particularly because of the traditional father daughter relationship*

*“I am back in the role I was in when I was a young mom. I can’t just decide to go places without consideration”*

We then asked the caregiver if the person(s) that they cared for were aware of the challenges they faced providing care. Two thirds of the respondents (virtually all of those who cared for a dependent who did not live with them and half of those who cared for their dependent in their home) indicated that yes, the person that they cared for was aware of the challenges they faced. We then asked if the dependent did anything to help the respondent cope with their role as an employed caregiver. Half of the sample indicated that the dependent did nothing to help them cope. One in three said that the person that they cared for (who in most cases lived with them) helped by trying to be positive and cheering them up when they were down, and by encouraging them to get out of the house and do something. One in five said that the person who they cared for (who in this case was more likely to live elsewhere) helped by trying to do as much as they could for themselves.

Finally, we asked respondents if they could think of anything that the dependent could do to help them cope with their role as employed caregiver. While one in three could not think of anything that the dependent could do to help, one in three said that the person could try and be more cheerful. An equal number wanted the person that they cared for to accept help from someone other than themselves/agree to respite care. These responses were not associated with caregiver arrangement.

### **7.3 The Family**

We began by asking respondents to identify the challenges they faced at home because they worked and cared for an elderly dependent. Almost one in five of the respondents said that being an employed caregiver had not caused any challenges at home. The rest of the sample noted the following challenges at home:

- Lack of home care causes me work/worry (35%),
- My family and my home life are suffering – I just do not have enough time or energy for them (25%),
- Physical layout changes needed to make the place safe for the dependent (18%), and
- Safety/emergency issues are a concern (10%)

Respondents who cared for a dependent who lived elsewhere were more likely to say that eldercare had not caused them any problems at home and that they worried about a lack of home care. Those whose dependents lived with them, on the other hand, were more likely to talk about the physical layout of their home or safety issues (in fact, only this group mentioned these challenges. The last concern, lack of time and/or energy for ones family, was mentioned by one in four of the caregivers in both groups. As one respondent put it:

*“It is hard to find time to care for my mother as a young caregiver”*

We then asked respondents whether or not they thought that their family was aware of the challenges they faced with respect to working and providing dependent care and if they did

anything to help them cope. While all but one respondent indicated yes – their family was aware – a substantive number (one in three) indicated that their family did nothing really to help them cope with this situation. In virtually all cases this situation was reported by those who cared for a dependent who lived in their own home. Employees who cared for dependents who lived with them offered the following examples of how their family had helped them cope:

- They help me provide care: 35%,
- They are very understanding: 20%,
- They help me around the house: 10%,
- They visit and call: 10%, and
- They take me out: 7%

In other words, families assist by providing concrete assistance with caregiving tasks and offering social support. As one respondent noted:

“I can’t say enough about how much support I get from my family”

Finally, we asked respondents what else they would like their family to do. One in three said “nothing – they are doing enough.” The rest asked their family for the following types of support:

- Be more understanding and sympathetic (26%),
- Provide respite for me sometimes (26%), and
- Visit or call more often (20%)

The likelihood of a respondent asking for these forms of support was not associated with caregiving arrangement.

#### **7.4 The Employer**

While one in three of the respondents said that being an employed caregiver had not caused any challenges at work, an equal number said that their performance at work had suffered because their caregiving role had been depleting their time and energy. It is interesting to note that employees who have their dependent living with them (especially a dependent spouse) were significantly more likely to say that they had not experienced any challenges at work. This may be due to the fact that the employer is more understanding when the presence of the dependent is more visible. It may also be due to the fact that those with dependent care in the home are more likely to have reduced their work hours as a way to cope. Other challenges respondents noted that they faced at work because of their situation include the fact that the employee has had to reduce hours/take time off/juggle time to deal with caregiving issues (cited by 29%) and the fact

that work-life balance has become much more difficult/demanding (cited by 11%). Those who cared for a dependent who lived with them were more likely to give the first response while those who cared for a dependent who lived with them were more likely to give the second.

Again, the following quotes are offered as an illustration of how people responded to this question.

“My employer has been very flexible and supportive”

“My work is very supportive, I am blessed and it makes being a caregiver much easier”

“I have a very stressful job, and when I get off work it is sometimes difficult to go into another stressful situation”

“If they call too often during the day and my boss comes out and stands by my desk, that’s a signal to stop the personal phone calls”

“My employer has been very flexible and supportive”

“I struggle – I am dedicated and loyal to my organization and want to do a good job – but at the same time I feel I need to be at home”

We then asked respondents whether or not their employer was aware of the challenges they faced with respect to working and providing dependent care and did their employer do anything to help them cope with these challenges. The answers here were extremely positive. One hundred percent of the respondents indicated that their employer was aware of their situation and only 10% said that their employer was doing nothing to help. Furthermore, almost two thirds (60%) of the respondents indicated that there was nothing more that their employer could do to help them – “they are already doing all they can – they’re great.” What are employers doing that helps? The respondents identified three things: they are sympathetic and understanding of my situation (40%), they are flexible with my start and end times (36%) and they give me time off when I need it (36%).

As noted earlier, when asked what else their employer could do to help, the majority said “nothing.” The rest (20%) asked for more time off (i.e. “more care days”) and the ability to work flexi-hours/ telework.

## **7.5 Government Support**

This research looked at two levels of government support for employed caregivers: that offered by the community and that provided by the federal government.

We began by asking respondents to identify the eldercare challenges they faced within their community. Again, one in three of the respondents said that being an employed caregiver had not

caused any challenges with the community. The rest of the respondents identified the following challenges associated with the community in which they lived:

- Difficulty/cost of finding home or community care services: 33%,
- Access to community services is difficult: 20%, and
- My community work is suffering: 12%

Those who cared for a dependent who did not live with them were more likely to face challenges with respect to community care services while those with a dependent in their home were more likely to give the other two responses.

The findings with respect to community support for employed caregiving was significantly less positive than that observed with respect to employers. While three-quarters of the respondents indicated that they had made their community aware of the challenges they were facing, 45% said there was nothing available within the community to help them cope. Furthermore, very few respondents reported access to any type of community support. Three individuals noted that their community offered them social support, three said their community provided specific on-call health care services (i.e. nurse, physio) and one mentioned respite care. Furthermore, respondents seemed fatalistic when it came to their communities' ability to help them cope with the challenges of paid employment and caregiving. One in three said that they could not think of any form of help that their community could provide/that they already did enough. For example:

“I’m just thankful for what community and government help we’ve got”

“VON is a godsend to me”

Others (20%) gave very general responses such as “help my family when I am busy” that would be difficult to implement. The most common concrete request was to provide more formal support within the community in the way of services to assist those with eldercare (20%) and to offer some form of respite care (20%).

To get a more complete idea of what governments at all levels (not just municipal governments) do to support employed caregivers we began by asking respondents if they felt that the government was aware of the plight of employed caregivers. Sixty percent said yes, 30% said no, and 10% said they had no idea. In response to the question, “what does the government do to help you cope with the challenges associated with employed caregiving, almost half of those interviewed said “nothing.” One in four stated that the government provided care assistance or equipment and 12% said that the government gave them financial help. One in four felt that services to help them existed but said that trying to find them/access them increased rather than decreased their stress. The following quotes speak to this issue:

“Government support is unreliable. Our time seems to be less important than their time. I’ve turned to private agencies”

“Some case managers are very good. Others are not so good and it makes a big difference. It should not depend on who you get to see – but it does.”

“The new rules prevent public servants from using their professional discretion. It makes it all so much harder.”

“I’ve seen a lot of waste in the way that the government handles home care”

Only 20% of the sample indicated that in their opinion there was nothing more that the government could do to support them as “they are doing all they can.” What can the government do? The employed caregivers in this sample had a lot of requests including:

- Give me financial assistance as a carer (20%),
- Provide additional/respite care directly (20%),
- Make it easier to find/get services (20%),
- Offer more formal support or services/ respite care (20%), and
- Be more flexible with service qualification and coordination (20%).

Again these suggestions did not depend on dependent care arrangement.

## **8. Respondent’s Recommendations**

At the end of the interview we asked a number of questions designed both to wrap up the interview and to provide directions on the way forward. Specifically we asked respondents:

- *What one thing could each of the following groups do to help you cope with the challenges associated with being an employed caregiver?*
  - *Your family*
  - *Your employer*
  - *The community*
  - *The government*
- *What one piece of advice would you offer to a friend who has all of a sudden assumed care of someone else due to a physical, mental or cognitive condition?*
- *What one piece of advice would you offer to the government in terms of supporting employed caregivers in Canada?*

Responses are given below.

What one thing could family members do? They could:

- Visit or call more often (40%),

- Help me with caring sometimes (20%),
- Provide respite care for me (20%), and
- Do more around the house/ other household chores (15%).

These responses show that employed caregivers want more tangible support from their families – not just sympathy and understanding.

What one thing could employers do? They could:

- Continue doing what they already do (they are doing all they can; they're great) (40%),
- Let me work flexi-hours/telework (30%), and
- Give me time off (i.e. care days) to deal with eldercare issues (24%)

Employees appreciate (and need) flexibility from their employer to deal with the uncertainty arising from the caregiving situation.

What one thing could communities do? They could:

- Offer more formal support or services (i.e. help with travel) (36%),
- Offer respite care (26%), and
- Be more flexible with service qualification and coordination (10%),

Again, we see employed caregivers asking for tangible help from their community – help with travel, help with care. They also want community services to be more flexible in terms of how they determine who is to get care and coordination between the different groups.

What one thing could provincial/federal government do? They could:

- Provide more care services/facilities where they are needed (28%),
- Give me money/provide money to help keep elderly/sick at home, provide respite care (28%),
- Provide one place for finding services and information, be more accessible (20%),
- Do better job of assessing needs/ listening to caregivers (12%), and
- Increase staffing to deal/help employed caregivers (12%).

Caregivers believe that the federal and provincial governments need to assume a greater level of responsibility with respect to support of employed caregivers. Specifically care providers want the government to “step up to the plate” and offer more services, a wider variety of services more facilities and more staff. They also want the government to provide the caregiver with direct financial support and streamline how they offer services and provide caregiving to those in need.

The following comments typify what we heard during the interviews:

“The government needs to allocate funding based on the distance caregivers must travel.”

“Para Transpo is too unreliable to use”

“Don’t send a 24 year old person who can’t do a good job assessing. You need all of your knowledge and skill to make a good decision on the needs of a person”

“It would be very helpful to have subsidized in home respite care”

“The government needs to be aware of the demographics and the need to support the caregivers.”

“The government needs to educate the public about the role of caregivers in our society”

“Take into account what the caregiver has to go through. Shouldn’t be adding to our stress”

What one piece of advice would respondents offer to a friend who found themselves in a situation where they had to provide eldercare? Respondents advised their friend to:

- Seek practical advice from an expert/ don’t try and do it all yourself/get government services involved (30%),
- Don’t forget to look after yourself and your family/get out and make time for own interests (30%),
- Tell your employer straight away – find out what you are entitled to (10%),
- Find a support group and if necessary seek professional therapy for yourself (10%),
- Have empathy, put yourself in their shoes (10%), and
- Look to long term, make sure you can do it now and in future (10%).

Again, we provide a few quotes to help the reader better understand the advice offered:

“Make sure you look after yourself, because if you crash, your loved one who you are caring for will crash too.”

“Go get help. If you have to advocate, advocate, advocate.”

“Look after yourself – you can’t look after someone if you are not well.”

“Its a very difficult balance to achieve (work and caregiving). Make sure you know what you are getting in for.”

What one piece of advice would respondents offer to the government in terms of supporting employed caregivers in Canada? Respondents asked the government for five types of support. Each type of support was requested by approximately 20% of the respondents, suggesting that they are all equally important. Details on each are given below.

First, caregivers asked for stronger policies to support time off from work for longer time periods (i.e. EI/EA programs). In line with this, they wanted some form of assurance that they would be guaranteed employment if they took on this role.

Second, caregivers noted that no one seems to know what services are available right now (many silos, lots of competition between services). These individuals asked government to provide one central service and do a better job of communicating with caregivers. The following quotes illustrate this point.

“There has to be better communication to the primary caregiver about the health of patients when they are transferred between care facilities”

“I have a sense that there are other programs out there that could be beneficial but I don’t know who to ask or what questions to ask”

“People under estimate what caregivers do. We need more education in this area.”

“It took a fair amount of time and work to even find out about “self managed care” -’ what does that mean”

Third, caregivers pleaded for more community programs and services to support their dependent and them. Respite care services in particular, were mentioned by many. Respondents said:

“They (the government) have a role to play and they’re not playing it.”

“Caregivers are stretched to the limit in their role. They need more support and services”

“If we don’t care for our family nobody else is going to be able to do it.”

“We need help – especially those of us who are not retired – otherwise we will need care ourselves.”

“Caregiving takes a lot of time. The government should be leaders in providing care – not just leave it up to the family.”

“Government subsidized homes are sub standard and I would never put mother in one – this is not acceptable.”

Fourth, respondents felt that the government should provide more financial support to caregivers. This group felt that they were performing a service for free that the government should either deliver or support. Many were incensed by this fact as is indicated by the following comments:

“The government needs to acknowledge that home caregivers are saving our society valuable resources by taking care of their elders. They should be compensated fairly”

“My pension will suffer if I move to part time, which I would prefer. So I am forced to make a choice between caring fully for my husband and having financial security. The government needs to help us help our family”

“We should get some pension benefits for the time lost to provide home care”

For pete’s sake recognize we’re out there providing free labour- nobody looks after us”

“I had to go overseas to afford care assistance.”

“It is costing us personally to provide care for my mother.”

Finally, respondents asked governments at all level to listen to caregivers and try and be responsive to their needs. They noted the following.

“Right now you are made to feel bad asking for support”

“Government agencies should provide services that I need, not services that they want to provide”

## **Chapter Five**

### **Conclusions and Suggestions on Ways Forward**

This study investigated the stresses associated with employed caregiving. We determined that:

- The majority of employed Canadians also have caregiving responsibilities
- Just over one in four (27.8%) of employed Canadians have responsibilities for the care of elderly dependents – a percent that is likely to grow as the baby boom population ages.
- Almost one in five employed Canadians (16.8%) have responsibility for both childcare and eldercare (i.e. they have dual demands at home and demands at work).
- Only rarely do employed Canadians provide care to an elderly dependent who lives with them (the data would suggest that approximately 1.3% of the workforce is in this situation)
- Just over one in ten of Canadians provide care for an elderly dependent who either lives nearby (12.7%) or in another location altogether (9.7%)
- Twice as many employed Canadians have childcare responsibilities (54.2%) than have responsibility for the care of an elderly dependent (27.8%)

The following questions were addressed in this study:

1. What do employed caregivers do and why they do it?
2. How prevalent is caregiver strain? How prevalent are the three key components of caregiver strain: financial strain, physical strain and emotional strain?
3. What impact do the three forms of caregiver strain have on the employed caregiver? Specifically, what is the relationship between financial, physical and emotional strain and the employed caregiver's physical and mental health? Their experiences at work and at home?
4. What are the key predictors of the three different forms of caregiver strain?
5. In what ways are employed caregivers similar to and different from each other and from those without any caregiving responsibilities?
6. What impact does where the elderly dependent lives (i.e. with employed caregiver, nearby the employed caregiver or elsewhere) have on the above similarities and differences?
7. What kind of strategies can employed caregivers use to cope with caregiver strain?
8. What can be done to reduce caregiver strain?

The answers to these questions are provided below.

## **5.1 What do employed caregivers do and why to they do it?**

Employed caregiving takes many forms. While a majority of the employed caregivers in our sample cared for one family member, a substantive number (14%) had responsibility for the care of both of their parents and one in four were women who had combined paid employment with the care of a spouse/partner in their 50s or 60s who was in poor health.

Eldercare does not appear to be a transitory condition as the average caregiver in this sample has been performing this role for almost 5 years.

For most people (57% of those in the interview sample) caregiving is a “labour of love” (i.e. the individual wants to/chooses to care for their family member because they love them). For a substantive number of employees (40% of the interview sample), however, this is a role they take on because “there is no one else who can do it.”

Employed givers spend the majority of their care time (68%) performing two caregiving roles: providing physical care and offering emotional support. The typical caregiver in the interview sample spends just over 13 hours per week in physical care and 8 hours in activities associated with support. In addition they spend an average of 4 hours per week in personal care, 2 hours in nursing, and 4 hours in activities associated with co-ordination.

A majority of respondents identified emotional support as the most stressful dimension of their caregiving role because they found this role mentally exhausting and upsetting at the same time.

A substantive number of respondents identified the co-ordination role as the most stressful part of employed caregiving – even though the time devoted to this role is much less than that given to physical care. This suggests that the stresses associated with employed caregiving are not simply a function of the amount of time spent in the role but instead are related to the amount of control one has over the role.

## **5.2 How prevalent is caregiver strain?**

Employees who care for elderly dependents can be considered “at risk” of experiencing a particular type of work-life conflict referred to as caregiver strain. Caregiver strain is a multi-dimensional construct (physical, financial and emotional strain) which is defined in terms of “burdens” or changes in the caregivers’ day to day lives which can be attributed to the need to provide care. This research initiative allowed us to better understand the aetiology of each of these three types of Caregiver Strain.

- Financial strain is not a significant problem for employed Canadians (moderate to high levels reported by only one in ten of the survey respondents and 7% of those in the interview sample).

- Approximately one in three of the employed Canadians in both the interview and survey samples reported moderate to high levels of physical caregiver strain.
- Approximately one quarter of the employed Canadians sample report moderate to high levels of emotional strain that can be attributed to the stresses associated with caring for an elderly relative.

### **5.3 What impact do the three forms of caregiver strain have on the employed caregiver?**

The impact of caregiver strain depends on many factors including the type of strain being considered, the population being considered (i.e. sandwich group versus eldercare) and the outcome of interest (i.e. mental health, work-life balance). The following conclusions with respect to the impact of the various forms of caregiver strain are summarized below.

#### **5.3.1 Impact of Financial Caregiver Strain:**

This type of caregiver strain is associated with poorer physical and mental health, greater work-life conflict, increased absenteeism, lower job satisfaction, a higher number of visits to the emergency room at the hospital, and reduced fertility. It is also interesting to note that moderate and high levels of financial strain are equally problematic for caregivers.

#### **5.3.2 Impact of Physical Caregiver Strain:**

This type of strain is associated with poorer mental health, increased work-life conflict, and increased absenteeism due to eldercare problems. It is also associated with lower levels of family satisfaction. Physical strain is more problematic for those in the eldercare group than those in the sandwich group. Aside from the impacts noted earlier, high levels of caregiver strain are associated with poorer physical health, increased visits to the family physician and increased job stress for those in the eldercare.

#### **5.3.3. Impact of Emotional Caregiver Strain:**

Emotional strain is strongly associated with poorer physical and mental health, increased work-life conflict, higher job stress, increased absenteeism due to eldercare problems and emotional fatigue, lower levels of family well-being and reduced fertility. With a few exceptions, the presence of children in the home made little difference in the strength of these associations. That being said, the impact of emotional strain varies with caregiver group as follows. For those in the sandwich group, emotional strain is associated with lower levels of job satisfaction, and much higher levels of absenteeism due to eldercare (and hence greater absenteeism overall) than could be seen in the eldercare group. For those in the eldercare group, on the other hand, emotional strain was associated with a greater intent to leave ones job, a higher number of visits to the family doctor, and reduced family satisfaction.

## **5.4 What are the key predictors of the three forms of caregiver strain?**

### **5.4.1 What causes financial strain?**

This study identified the following key predictors of financial strain: living in a family with limited financial resources, very heavy and time consuming caregiving demands (i.e. both respondent and spouse spend a high number of hours per week in eldercare), and lower levels of control (i.e. low perceived flexibility at work, dependent lives farther away from the caregiver or in their home). Examination of these data paint the following picture with respect to financial strain. First, employees who have to spend a lot of time in care have fewer hours to devote to work which reduces their earning potential and increases the precariousness of their financial situation. Second, caregivers whose dependent lives with them or at a distance have more expenses (i.e. changing their house to accommodate their dependent, commuting, phone costs, out of town travel) than those who live a short distance from those they are caring for.

The interview study provided similar findings. It determined that financial strain has two causal factors: a decline in income (their role as an elder caregiver made it virtually impossible for them to work full time) and an increase in expenditures (had to pay for extra help, some living expenses, and medicines).

### **5.4.2 What causes physical strain?**

Physical strain has a different set of causal factors than financial strain. The survey study determined that the main predictors of physical strain are distance (employees with their dependent living with them are at higher risk), gender (women have more problems than men), age (older employees have more problems than younger employees) and the families' financial situation (the lower the income, the greater the strain). In other words, these data indicate that older women whose dependent lives with them and cannot afford to purchase support and/or quit their jobs are at the highest risk of physical strain

Interview respondents indicated that physical strain had two causal factors: the need to do a lot of heavy lifting when caring for the dependent, and a lack of sleep.

Both sets of data indicated that physical strain is largely caused by demands – the more time one spends in the role and the greater the responsibility one has in terms of caregiving, the greater the physical strain. To reduce physical strain, therefore, one needs to try and determine how best to reduce the amount of time caregivers spend in caregiving activities.

### **5.4.3 What causes emotional strain?**

The survey study determined that the main predictors of emotional strain include living in a family with limited financial resources, physically and emotionally heavy caregiving demands (i.e. respondent spends a high number of hours per week in care and has responsibility for care), lower levels of control at work (i.e. low perceived flexibility at work, the perception that family responsibilities limit advancement opportunities) and gender (women are more predisposed to

experiencing this form of strain than men). Hours per week the respondent spends in care is five times more important to the prediction of emotional strain than any of the other predictors.

The perception that family responsibilities make career advancement difficult, were unique to the prediction of emotional strain.

The interview study determined that emotional strain had three causal factors: role overload (too much to do, not enough time, exhaustion), uncertainty/worry (what does the future hold? how will they manage? are they safe) and empathy (their stress becomes my stress).

## **5.5 In what ways are employed caregivers similar to and different from each?**

Our analysis allowed us to create the following profiles of the various groups considered in this study.

### **5.5.1 Employees in the no caregiving group**

Employees in the no caregiver group are younger (i.e. under 35), single men and women who live in larger communities. They have higher personal incomes and are more likely to say that for them money is not an issue and that they have money for extras. At work employees in the no caregiving group are more likely to perceive that their manager is supportive and report higher levels of flexibility with respect to their hours of work.

Employees with no caregiving have fewer demands on their time than employees with caregiving responsibilities. They spend more time in leisure per week and have a good balance between work and family. (i.e. report the lowest levels of role overload (45% high), work interferes with family (20% high) and family interferes with work (3% high) of any group). They are more likely to work for a supportive manager (51%) and enjoy relatively high levels of flexibility with respect to work hours and work location (40% high perceived flexibility). They report higher levels of job satisfaction (47% high), lower job stress (31% high) and are significantly less likely to be absent from work. It is also important to note that employees with no caregiving responsibilities are in better physical and mental health than their counterparts with child and/or eldercare. They make less use of Canada's medical system and are less likely to report high levels of stress (49% high), burnout (30% high), depressed mood (33% high) and more likely to report high levels of life satisfaction (43% high). Finally, employees with no children/elderly dependents report better circumstances at home. In fact, they report the highest levels of family satisfaction (72% high) and family adaptation (well being) (46% high) in the sample. These findings indicate that Canadians who have children and/or assume the responsibility for the care of an elderly dependent pay a price at home, at work, and personally. They also suggest that employers (higher absenteeism and intent to turnover, lower job satisfaction and stress) and Canadian society (increased use of Canada's health care system) also pay a price when Canadian employees cannot balance work and caregiving demands.

### **5.5.2 Employees in the childcare only group**

Employees in the childcare only group are married men and women (this is the only group in which we had more male respondents than female respondents) between the age of 35 and 45 who, despite the fact that their personal incomes are higher, are more likely to say that money is tight in their family or that they are okay for money but do not have money for extras. They are more likely to live in smaller communities. One in three in this group have children under the age of five at home.

While employed parents are relatively better off than their counterparts with eldercare (i.e. those in sandwich and eldercare only groups) – they still have substantive challenges that can be linked to the need to balance work and childcare. This group has a lot of demands on their time: their work demands are the highest in the study (over 45 hours per week), their non-work demands are substantive (33 hours per week) and they have relatively few hours per week to spend in leisure activities (8 hours). On the plus side, approximately half work for a manager who they consider to be supportive. More challenging is the fact that very few employed parents perceive that they have much flexibility with respect to work hours and work location (only 30% high). Not surprisingly, many of the employees in this group experience difficulties with respect to balancing work and family. Two forms of work-life conflict are particularly problematic for the employed parents: role overload (60% have too much to do and too little time) and family interferes with work (13% say expectations at home make it hard for them to meet expectations at work). These findings are consistent with the lower levels of flexibility given to this group of employees. Furthermore, the data suggest that the need to balance competing family demands is having a negative impact on the families of employed parents as employees in this group are less likely to be satisfied with their families and report lower levels of family well being (only 31% high).

While the work attitudes and physical and mental health outcomes of the no caregiving and childcare only groups are similar in many ways, areas where they differ are important to note. These include the fact that employees with children at home are more likely than those in the eldercare and no caregiver groups to miss work due to childcare problems and report high levels of stress (54% high). It should be noted, however, that the mental health of employees in the childcare group is better than those in the sandwich and eldercare groups.

### **5.5.3 Employees in the eldercare only group**

Employees in the eldercare only group are more likely to be older, unmarried females without children. That being said, it is interesting to note that one in five in this group are single, childless women under the age of 35. The women in this group tend to have lower personal incomes but, paradoxically, are more likely to say that money is not an issue. This paradox can be explained by the fact that although their incomes are lower, so are their costs (i.e. they do not have children). Individuals in the eldercare group are more likely to live in larger centers.

Employees in the eldercare group experience higher levels of work-life conflict. In this group the increased conflict manifests itself as higher levels of role overload (60% high) and work interferes with family (39% high). Very few employees in the eldercare (6%) group experience

family interferes with work. These findings are striking given the fact that those in the eldercare group spend fewer hours per week in paid employment and caregiving and more time in leisure (only the non-caregiver group have fewer non-work demands and more hours in leisure). It would appear that work life conflict for those with eldercare is more a function of role requirements than the amount of time spent in work and non-work roles. This interpretation of the data is consistent with the fact that employees in the eldercare groups are in poorer mental and physical health than the employees in the other three groups. They are more likely to report high levels of stress (59% high), burnout (36% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37%). They are also more likely to seek care from other medical professionals (37% did so in six month period) and seek care from their family physician (58% did so in six month period).

The fact that employees in this group are also less likely to enjoy high levels of flexibility and less likely to perceive their supervisor is supportive suggests that there is a basic disconnect between what the organization expects of the individuals in this group and what they are able to deliver due to the expectations they place on themselves and the expectations placed on them by Canadian society. The idea that there is a disconnect between work expectations and elder caregiving is consistent with the fact that employees in the eldercare group are more likely to report higher levels of job stress (38% high), lower job satisfaction, (42% high) and increased levels of absenteeism due to ill- health (56%), eldercare problems (27% high) and emotional fatigue (39% high). In fact they have the highest level of absenteeism due to emotional fatigue of any group in the sample.

#### **5.5.4 Employees in the sandwich group**

Employees in the sandwich group are more likely to be older (45 or greater) men and women who live in smaller communities. One in three of the individuals in this group say money is tight in their family, which is consistent with the fact that one in three have lower (i.e. \$39,000 or less) personal incomes.

Employees in the sandwich group face onerous demands at work and at home. They spend the same number of hours in work per week as those in the no caregiving group but also commit 35 hours per week to non-work activities (the highest in the sample). They also had the highest number of hours per week in work and family activities (79.2) and the fewest hours in leisure (7 hours per week). Given the onerous demands faced by the employees in this group it was not surprising to see that they had the highest levels of work-life conflict in the sample: 67% of the employees in this group report high role overload, 39% report high work interferes with family and 15% report high family interferes with work.

Employees in the sandwich group receive lower levels of support at work and report more negative attitudes towards their employer. Those in the sandwich group are less likely to perceive that their manager is supportive (44% work for a supportive manager) and have the lowest levels of flexibility with respect to work hours and work location of any group in the sample (27% high perceived flexibility). They are less likely to be satisfied with their jobs (42%), more likely to report high levels of job stress (38% high) and more likely than those in

the childcare only and no caregiving groups to miss work due to ill-health, emotional strain and eldercare problems.

Also consistent with our expectations are the findings supporting the idea that employees in the sandwich group are in poorer health. Compared to those in the non caregiving and childcare groups they are more likely to report high levels of stress (61% high), burnout (35% high) and depressed mood (42% high) and less likely to report high levels of life satisfaction (37% high). They are also more likely to seek care from their family physician (57%) and to have medical tests (33%).

Employees in the sandwich group look very much like their counterparts in the childcare only group when it comes to family outcomes. They are more likely than those in the no caregiving and eldercare groups to report high levels of family integration (i.e. greater stability of family unit; ability to participate with family in joint functions and activities) (33% high) and less likely to report high levels of family satisfaction (57% high) and family adaptation (i.e. well being) (29% high) than those in the no caregiving and eldercare groups.

Contrary to what we had expected, however, multiple family demands did not appear to contribute to a further decline in either physical or mental health for those in the sandwich group above that observed for individuals with just eldercare (i.e. sandwich group reports same levels of stress, burnout, depressed mood and life satisfaction, visits to physician etc. as the eldercare group). This finding is particularly striking given the fact that employees in this group have very high demands on their time and high levels of work-life conflict. It would appear that having children at home provide employees with elderly dependents some increased ability to cope with the strains associated with eldercare. How does having children at home help? It is hard to say from these data but it is possible that children reduce strain by helping out with eldercare, providing emotional support to their parents, and (strangely enough) providing the employee with another role (that of parent) whose rewards can offset the frustrations and strains associated with the role of elderly caregiver. This third explanation is based on the idea of “role expansion” which states that people can benefit from multiple roles when the rewards from one set of responsibilities (i.e. raising a child, watching them learn) partially offset the frustrations and stresses of performing a second role (i.e. watching parent die and lose functioning).

## **5.6 What impact does where the elderly dependent lives have on caregiver strain?**

In this analysis we looked at the impact of caregiver arrangement on caregiver strain. In the survey study we looked at three types of caregiving arrangements: dependent lives with caregiver, dependent lives nearby (i.e. within a short drive), and the dependent lives elsewhere (a significant commute away). A summary of the key significant differences associated with caregiver arrangement identified from this analysis are provided in Table 13 and summarized below.

**Table 13: Impact of Caregiving Living Arrangement: Quantitative Data**

<b>Factor</b>	<b>Eldercare Only Group</b>	<b>Sandwich Group</b>
Personal demographics	<u>Dependent lives with them:</u> more likely to be unmarried women with no children	<u>Dependent lives with them:</u> more likely to be unmarried women with young children (especially single mothers) who have lower personal incomes and say that money is tight in their families. <u>Dependent lives elsewhere:</u> more likely to be male (only group with equal number of men and women) who make higher personal incomes. They are also more likely to have adolescent children at home.
Work situation	<u>Dependent lives with them:</u> more likely to work a regular work day and less likely to have access to a number of benefits which could make the balance between work and caregiving easier including time off in lieu of pay, pro-rated part time work, flextime arrangements, EAP and a manager who gives them flexibility to meet personal needs	<u>Dependent lives with them:</u> more likely to work a regular work day, perceive that they have high flexibility and a supportive manager and have a more positive view of the culture in their organization when it comes to support of family issues
<b>Demands</b>		
Work Demands	Closer the dependent lives to the employee the fewer hours they spend per week in paid employment (live with = 39; live elsewhere 45)	<u>Dependent lives elsewhere:</u> spends more time in paid employment per week (45.5 hrs)
Non-work Demands	<u>Dependent lives with them:</u> spends more time in non-work activities per week (31 hrs) Spend more time in eldercare per week (10 hrs)	<u>Dependent lives with them:</u> spends more time in non-work activities per week (42 hrs) Spend more time in eldercare per week (8 hrs)
Total Demands	<u>Dependent lives nearby:</u> spends the least time per week in work and non-work (67 hrs) than the employees in either of the other two groups (70 hrs)	<u>Dependent lives with them:</u> spends the most time per week in work and non-work (84 hrs) <u>Dependent lives nearby:</u> spends the least time per week in work and non-work (77 hrs)

<b>Factor</b>	<b>Eldercare Only Group</b>	<b>Sandwich Group</b>
<b>Work-Life Conflict</b>		
Role overload	<u>Dependent lives nearby:</u> Lowest levels of role overload (58% high)	<u>Dependent lives with them:</u> Highest levels of levels of role overload (72% high)
Work interferes with family	<u>Dependent lives with them:</u> Lowest levels of work interferes with family (22% high) <u>Dependent lives elsewhere:</u> Highest levels of family interferes with work (30% high)	<u>Dependent lives with them:</u> Lowest levels of work interferes with family (26% high) <u>Dependent lives elsewhere:</u> Highest levels of family interferes with work (39% high)
Family interferes with work	Family interferes with work not associated with caregiving arrangement	Family interferes with work not associated with caregiving arrangement
<b>Organizational Attitudes and Outcomes</b>		
Job satisfaction, job stress	<u>Dependent lives with them:</u> Lowest levels of job satisfaction (39% high) <u>Dependent lives elsewhere:</u> Highest levels of job stress (40% high)	Job satisfaction not associated with caregiving arrangement <u>Dependent lives elsewhere:</u> Highest levels of job stress (43% high)
Intent to turnover	<u>Dependent lives with them:</u> More likely to be thinking of quitting their job (19% high)	<u>Dependent lives with them:</u> More likely to be thinking of quitting their job (22% high)
Absenteeism	Absenteeism due to ill health not associated with where dependent lives Closer the dependent lives to the employee the more likely they are to be absent due to eldercare issues	Absenteeism due to ill health not associated with where dependent lives Closer the dependent lives to the employee the more likely they are to be absent due to eldercare issues
<b>Mental Health</b>		
Stress	Closer the dependent lives to the employee the more likely they are to report high levels of stress	Stress not associated with caregiving arrangement
Depressed Mood	Depressed mood not associated with caregiving arrangement	Depressed mood not associated with caregiving arrangement
Burnout	Burnout not associated with caregiving arrangement	Burnout not associated with caregiving arrangement
Life Satisfaction	<u>Dependent lives with them:</u> Reports the lowest levels of life satisfaction (26% high)	Life Satisfaction not associated with caregiving arrangement

<b>Factor</b>	<b>Eldercare Only Group</b>	<b>Sandwich Group</b>
<b>Family Outcomes</b>		
Family Satisfaction	<u>Dependent lives with them:</u> lowest levels of family satisfaction (54%)	<u>Dependent lives with them:</u> highest levels of family satisfaction (65%)
Family Integration	<u>Dependent lives with them:</u> highest levels of family integration (27%) Other two groups are very low	<u>Dependent lives with them:</u> highest levels of family integration (34%)
Family Adaptation	<u>Dependent lives with them:</u> lowest levels of family adaptation (32%)	<u>Dependent lives with them:</u> highest levels of family adaptation (35%) Other two groups are very low
<b>Societal Outcomes</b>		
Use of health care system	<u>Dependent lives with them:</u> Have fewer medical tests and make fewer visits to mental health professionals In all other cases the use of the health care system not associated with caregiving arrangement.	Use of health care system not associated with caregiving arrangement

The conclusions one draws about the impact caregiving arrangement has on caregiver strain from this data depends on the criteria being examined as well as the group one is looking at. The following conclusions are supported by the survey data examined in this analysis.

- Employees whose dependent lives with them are more likely to work a regular work day. It may be that this arrangement gives them more ability to predict their hours of work and leave at a particular time.
- Generally speaking, the closer the dependent lives to the employee who is providing care:
  - the more hours the caregiver spends in caregiving,
  - the fewer hours the caregiver spends in paid employment,
  - the higher the role overload reported by the caregiver,
  - the lower the work interferes with family reported by the caregiver,
  - the more likely the employee is to be absent from work due to eldercare issues
  - the more likely the employee is to be thinking of quitting their job, and
  - the higher levels of family integration.
- Employees in the eldercare group who care for their dependent in their home report lower levels of job satisfaction, family satisfaction, life satisfaction and family adaptation and higher levels of stress. The fact that no such relationships were observed in the sandwich group supports our contention that having children in the home mitigates many of the negative impacts of eldercare on the care provider. This conclusion is supported by the fact that respondents in the sandwich group report higher (not lower) levels of family satisfaction

and family adaptation than do caregivers in this group whose dependents live nearby or elsewhere.

- Employees whose dependent lives elsewhere report very high levels of work interferes with family and higher job stress.
- Employees who care for a dependent who lives nearby spend fewer hours in caregiving per week and report lower levels of role overload.

In the interview study we looked at two types of caregiving arrangements: dependent lives with caregiver, dependent lives on their own (60% live elsewhere and 40% live near by). A summary of the key differences associated with caregiver living arrangement identified from this analysis are provided in Table 14 and discussed in the section below.

**Table 14: Impact of Caregiving Living Arrangement: Interview Study**

<b>Factor</b>	<b>Dependent lives with caregiver</b>	<b>Dependent lives in own home</b>
Why assumed this role	100% said it was their choice – “It’s what you do for your loved ones”	60% said they had no choice in the matter – there was no one else to do it
Work demands	Employee more likely to work part-time Spend an average of 35.1 hours per week in paid employment	Employee more likely to work more than 41 hours per week Spend an average of 40.6 hours per week in paid employment
Caregiving demands	Spend an average of: X 35.1 hours per week in caregiving, and X 1.3 hours per week in care related commuting. 55% spend more than 30 hours per week in caregiving activities 0% spend more than 10 hours per week in care related commuting	Spend an average of: X 10.0 hours per week in caregiving, and X 15.2 hours per week in care related commuting. 0% spend more than 30 hours per week in caregiving activities 40% spend more than 10 hours per week in care related commuting
Total Demands	25% spend between 40 and 60 hours per week in work/care activities 55% spend more than 100 hours per week in work/care activities	60% spend between 40 and 60 hours per week in work/care activities 0% spend more than 100 hours per week in work/care activities
Caregiving Role	Spend <u>more</u> hours per week in: X Personal care (6.3) X Physical care (16.8) X Nursing (4.3) 55% say emotional support role most stressful More likely to find physical and personal care roles most stressful	Spend <u>fewer</u> hours per week in: X Personal care (1.7) X Physical care (5.8) X Nursing (0.5) 60% say emotional support role most stressful More likely to find the co-ordination role most stressful

<b>Factor</b>	<b>Dependent lives with caregiver</b>	<b>Dependent lives in own home</b>
Caregiver Strain	40% experience moderate to high levels of physical strain 25% experience moderate to high levels of financial strain	20% experience moderate to high levels of physical strain 40% experience moderate to high levels of financial strain
Personal Challenges	More likely to say caregiving had negatively impacted their physical health	More likely to say that caregiving had negatively impacted the amount of time they had for themselves
Challenges with dependent	More likely to experience the following challenges: deterioration of physical/mental state overwhelming, they are depressed and they cannot accept parent/child role reversal	More likely to say no challenges
Dependent helps by	More likely to say the person they care for helps by trying to be positive and encouraging them to get out of the house	More likely to say the person they care for helps by trying to do as much as they can for themselves
Challenges at home	More likely to mention fact that they had to change the physical layout of their home and worry over safety	More likely to say no challenges and to worry about a lack of homecare
Family helps by	More likely to say family helped by offering social support and providing assistance with caregiving tasks	More likely to say family does nothing to help
Challenges at work	Less likely to experience challenges at work More likely to feel that performance at work had suffered	More likely to experience challenges at work More likely to say that caregiving had caused them to miss work and juggle work commitments
Challenges within community	More likely to experience challenges accessing community services	More likely to experience challenges finding home or community care services

Before we talk about the links between caregiver arrangement and strain, it is also important to recognize those areas where caregiver arrangement makes no difference. In this study caregiver arrangement was not associated with the amount of time spent in emotional support and coordination, the likelihood that a caregiver will find the role emotionally stressful (in fact, in this study both groups found the emotional support role to be the most stressful of the five caregiver roles considered in this study), the incidence of emotional caregiver strain, how people cope with caregiver strain and the types of support needed from the government.

The interview data support the idea that the caregiving experience is fundamentally different depending on whether or not the dependent you care for live with you. Consider the following.

Employees who care for a dependent in their home are more likely to have chosen this role. They have accommodated the very high number of hours that they spend in caregiving (55% spend more than 100 hours per week in work/care activities) by reducing to a part time work schedule. Most of their care is provided in their own home with relatively little time spent in care related commuting. These caregivers are more likely to experience physical strain and say that caregiving has negatively impacted their physical health. They experiencing a number of unique challenges because the person they are caring for lives with them. Specifically, they are challenged by the fact that the person they are caring for has experienced an overwhelming deterioration of their physical/mental state and cannot accept parent/child role reversal. Many have also had to change the physical layout of their home to accommodate their dependent and worry about their safety. These individuals are, however, more likely to perceive that family members and those they care for do whatever they can to help make the situation easier. Specifically they note that the person they care for helps by trying to be positive and encouraging them to get out of the house, and that their family has helped by offering social support and providing assistance with caregiving tasks. Employees in this group are less likely to experience challenges at work – probably because they have reduced to part-time status. They do, however, recognize that their performance at work has suffered because of their caregiving situation. Finally, caregivers in this group are more like to say that they have experienced challenges accessing community services such as respite care.

Employees who care for a dependent who lives elsewhere are more likely to say that they did not choose the caregiver role – that they had assumed this role because no one else could/would do it. This group spends more hours a week in paid employment and care related commuting and fewer hours each week in caregiving than their counterparts with a dependent in their home. All things considered, this group of caregivers have fewer demands on their time overall (0% spend more than 100 hours per week in work/care activities). This group is more likely to experience financial strain and say that caregiving has negatively impacted the amount of time they have for themselves. They note that the person they care for helps by trying to do as much as they can for themselves but are frustrated by a lack of homecare and support from their family who they say does nothing to help. This group is more likely to experience challenges at work and note that caregiving has caused them to miss work and juggle work commitments. Finally employees in this group are more likely to experience challenges finding home or community care services.

## **5.7 What kind of strategies can employed caregivers use to cope with caregiver strain?**

In the interview study caregivers indicated that they tried to cope with the stress of the role by engaging in a number of healthy coping strategies. The four most common coping strategies (each practiced by 28% of the sample) included:

- looking after their own health by exercising and eating well,
- cultivating outside interests,
- joining a support group, and
- seeking professional help to cope with their stress.

The eldercare providers who participated in the interview study also offered a number of pieces of advice to others on how best to cope with the role of employed caregiver. Specifically, they advised someone taking on this role to:

- seek practical advice from an expert (don't try and do it all yourself/get government services involved)
- look after themselves and their family,
- tell their employer straight away (find out what you are entitled to) and
- access professional support to help them deal with the stress of the role.

## **5.8 Suggestions on Ways Forward**

The final research question addressed the issue of how key stakeholders could work together to reduce caregiver strain. To address this question we first looked at what causes caregiver strain. The answer obtained from this analysis is unequivocal – the hours per week the employed individual spends in eldercare activities. In fact, if we know how many hours an individual spends in eldercare per week we can come up with a good estimate of how much physical and emotional strain they will experience. Reducing demands then would appear to be the key to reducing caregiver strain. Suggestions on how best to do this include increasing community supports for employed caregivers and more respite care programs.

We also know that the families' financial situation is an important predictor of financial and emotional strain. In both cases, the tighter the families' finances the greater the strain. While it is hard to say from these data why this might be the case it seems plausible to assume that the lower the financial resources the less ability the respondent has to buy supports from outside the family, the more care that they have to provide themselves (i.e. higher demands) and the more they need the income provided by their job. This second circumstances might be expected to increase conflict between work roles (need to satisfy their employer with respect to meeting work demands by being on time for work, minimizing absenteeism) and eldercare demands (need to spend a lot of time per week in caregiving, need to respond to crisis during work hours). This interpretation of the data is consistent with the fact that increased flexibility at work lowers both financial and emotional strain (i.e. if you can meet both work and caregiving demands, you are healthier emotionally and are not as worried about the financial aspects of caregiving).

These findings suggest that governments need to look at ways to reduce the financial burdens associated with eldercare (i.e. tax write-offs, paid time off work, supported care services in community). They also emphasize the importance of real support at the organizational level. Supportive policies on their own are necessary but not sufficient – these policies must be put into practice and employees must be comfortable using them.

The data indicate that financial strain decreases when the dependent lives nearby but not with the employed caregiver. This would suggest that communities who wish to attract and retain labour need to invest in assisted eldercare facilities within their boundaries.

Physical strain arises because of two factors: the physical dimensions of the role (hours per week in care, lifting, lack of sleep) and the emotional aspects of the role (individual feels personally responsible for the dependent). This would suggest that we could reduce physical strain by looking at mechanisms to reduce the amount of time an individual has to spend in care. Things like respite care, eldercare referral services, assisted eldercare facilities, home nursing services etc. should help in this regard.

The data also show that women are more likely than men to experience one form of caregiver strain – emotional strain. This finding is cause for concern given the very strong association between this form of strain and physical and mental health problems, absenteeism, and reductions in fertility (women who are experiencing emotional caregiver strain cope by having fewer children or no children at all). It would appear from the data that several factors predispose women to this kind of strain: the fact that they are more likely to feel responsible for the care of the elderly dependent, the fact that they perceive that if they meet responsibilities at home they will not advance at work, and their need for the income stemming from their job (families' financial situation is tight). Again, the fact that perceived flexibility at the organizational end reduces this form of strain gives us one useful approach with respect to reducing it – implement supportive policies within organizations. Many of the suggestions offered earlier with respect to reducing demands at the caregiver end should also help women cope with the emotional demand associated with caregiving.

Finally, it is useful to note that two of the three forms of strain (financial and emotional) meet Karesek's (1979) criteria for a high strain job (i.e. high demand, low control). Thinking of the role of elder caregiver as a high strain job means that we can consult the research literature in this area on how best to address these issues. Karesek's model would suggest that to decrease financial and emotional strain one can either increase the amount of control the employee has over their circumstances (i.e. increase perceived flexibility at the organizational end, community supports for eldercare, financial support for caregivers) and/or reduce the demands they face (i.e. community and government supports for people with eldercare, respite care, eldercare referral services, assisted eldercare facilities, home nursing services).

In the interview we also asked caregivers what kinds of things would help them cope with this role. The respondents provided the following answers to this question.

- Employed caregivers want more tangible support from their families – not just sympathy and understanding.
- Employed caregivers appreciate (and need) flexibility from their employer to deal with the uncertainty arising from the caregiving situation. Specifically they appreciate access to alternative work arrangements and flexibility with respect to time off.
- Employed caregivers want their communities to offer services which make the caregivers job easier. Specifically they asked for respite care and help with travel (i.e. para transp). They also want community service deliverers to be more flexible in terms of how they determine who is to get care and to do a better job of coordinating care between the different service providers.

- Caregivers feel that the federal government needs to assume a greater level of responsibility with respect to support of employed caregivers. Specifically care providers asked the government for the following five types of support:
  - Stronger policies to support time off from work for longer time periods (i.e. EI/EA programs)
  - Provide one central place where caregivers can go to arrange for eldercare support services
  - Provide more community programs and services (especially respite care) to support their dependent and them
  - Provide more financial support to caregivers.
  - Listen to employed caregivers and try to be more responsive to their needs.

## 5.9 Last Thoughts

*“By not recognizing and valuing caring labour, we are in danger of running out”  
(McDonald et. al. 2005).*

This study makes it clear that eldercare is beginning to take its toll on workers and their employers in various forms and along various dimensions. Unpaid eldercare lies at an intersection of family, work, state and health policy, and cannot be studied in isolation of this wider context. Costs of unpaid caregiving include a range of costs associated with lost hours of paid employment, pension benefits, missed education opportunities and other costs in addition to the immediate financial costs of supporting a care recipient.

Demographic and social trends are diminishing the capability of families to provide care to the elderly. The continuing redefinition and blurring of family roles and the fact that Canadian families are getting smaller will mean more and more demands on traditional providers of care (unpaid, informal) at a time when they have less capacity to do so. The increased heterogeneity of caregivers and caregiver situations, including more complex care arrangements, multiple caregiving to several family members and increased duration of care continue to increase demand and pressure on caregiving (Guberman, 1999; Keating, Fast, Frederick, Cranswick, Perrier 1999).

Compounding these trends has been the shift of caregiving responsibilities from institutions to the family (Ward-Griffin and Marshall, 2003). These factors suggest that caregiving demands on the family have increased, leaving more and more Canadians in flux in the struggle to balance their caregiving and work responsibilities. The National Forum on Health (1997) warned of the potential for health systems and policy reform to impose burdens on women, arguing that “community-based care” should not “become a euphemism for the conscription of women to provided unpaid health care services.” Thus the question policy makers need to ask is how do we create choice so that women who do not have the time, resources, and skills or desire to care are not conscripted into it? (Centre of Excellence for Women’s Health, 2002)

“Caring involves complex relationships that take a variety of forms. These relationships are shaped not simply by individuals, their culture and their personal histories, but also by the services, supports and alternative available to them” (Armstrong and Kits 2004). In order to sustain caregiving relations in the long term, we must understand the complex relationship between the distribution of responsibilities for meeting need, as influenced by public policy and distribution of costs. In this way questions to future research and policy need to address: how is care changing? Who will end up doing care work? Under what conditions and constraints? What are the costs? And who will pay?

The complexity and multitude of care provision manifestations make it difficult to offer simple policy responses to fit such diversity of experience. It is well noted in the literature that a “one size fits all” approach fails to adequately support caregivers. Given the diverse nature of family care responsibilities among employees, policy must develop a lens that considers the full range of family care situations that provide employees with the flexibility to manage (Fredriksen, 1999). Caregivers must have real choices when assuming care for loved ones and the choice must be supported as a social responsibility in partnership of all concerned stakeholders.

It is hoped that this study offers both data and suggestions that help all those involved in this vital issue deal with this vital issue.

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## Appendix A

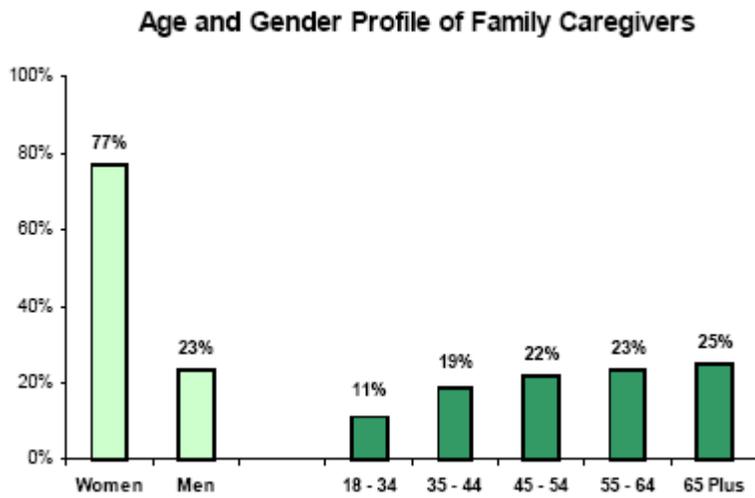
### A:1

<b>Expanded definition of "family member"</b>	
You can receive compassionate care benefits to care for your:	Or to care for the following family members of your spouse or common-law partner
Brothers or sisters and stepbrothers and stepsisters	Brothers or sisters and stepbrothers and stepsisters
Grandparents and step grandparents	Grandparents
Grandchildren and their spouse or common-law partner	Grandchildren
Son-in-law and daughter-in-law, either married or common-law	Son-in-law and daughter-in-law, either married or common-law
Father-in-law and mother-in-law, either married or common-law	
Brother-in-law and sister-in-law, either married or common-law	
Uncle and aunt and their spouse or common-law partner	Uncle and aunt
Nephew and niece and their spouse or common-law partner	Nephew and niece
Current or former foster parents	Current or former foster parents
Current or former foster children and their spouse or common-law partner	
Current or former wards	Current or former wards
Current or former guardians or tutors and their spouse or common-law partner	

*Service Canada*

[http://www.hrsdc.gc.ca/asp/gateway.asp?hr=/en/ei/types/compassionate\\_care.shtml&hs=tyt](http://www.hrsdc.gc.ca/asp/gateway.asp?hr=/en/ei/types/compassionate_care.shtml&hs=tyt)

## A:2



*Source: 2002 National Profile of Family Caregivers in Canada – Final Report. Health Canada, [http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-caregiv-interven/det-anal\\_e.html#1](http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-caregiv-interven/det-anal_e.html#1)*

## A:3

**TABLE 1**  
**Characteristics of Informal Caregivers**

	IN PAID WORK	NOT IN PAID WORK
<b>All caregivers aged 45-64</b>	('000)	('000)
	1,213	507
	Percent*	Percent*
<b>Age</b>		
45-54 years	70.5	36.7
55-64 years	29.5	63.3
Total	100	100
<b>Gender</b>		
Men	54.3	38.0
Women	45.7	62.1
Total	100	100
<b>Marital status</b>		
Married	78.4	77.0
Single	21.3	23.1
Total	100	100
<b>Education</b>		
University degree	26.3	21.5
Some post-secondary	45.4	39.8
High school or less	28.2	38.1
Total	100	100
<b>Region</b>		
Urban	75.4	74.5
Rural	24.6	25.5
Total	100	100
<b>Presence of children</b>		
With youngest child under 18	25.2	13.8
Without children under 18	74.8	86.4
Total	100	100
<b>Employment</b>		
Full time	90.7	n.a.
Part time	9.3	n.a.
Total	100	n.a.
<b>Household income</b>		
Less than \$40,000	14.1	36.6
\$40,000 to \$60,000	19.6	20.9
\$60,000 to \$80,000	17.3	9.5
\$80,000 and over	36.7	14.2
Not available	12.4	18.8
Total	100	100

Notes: \* Does not always add up to 100 due to some non-responses.  
n.a.: Not applicable.

Source: Statistics Canada, 2002 General Social Survey.

**A: 4**

<b>Expense</b>	<b>%<sup>1</sup></b>
Transportation (gas, taxis, public transit, parking)	81
Non-prescription medications	71
Medical supplies	54
Prescription medications	43
Equipment	41
Homemaking supplies (cleaning, food)	39
Home alterations/renovations	29
Professional services (eg: physiotherapy)	20
Someone to provide respite	19
Personal care washer	17
Ambulance services	16
Nursing services	12
Bills/utilities	2
Clothing	2
Other	5

<sup>1</sup> Based on the percent of caregivers who report out-of-pocket expenses (44% of total population).

Health Canada. (2002). *National Profile of Family Caregivers in Canada – Final Report*  
Prepared by Decima Research Inc.

## **Appendix B:**

### **Reports Coming from the 2001 National Work, Family and Lifestyle Study**

Higgins, C., Duxbury, L., and Lyons, S. (2007). Reducing Work-Life Conflict: What Works? What Doesn't?,

[http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/balancing-equilibre/index\\_e.html](http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/balancing-equilibre/index_e.html)

Duxbury, L. and Higgins, C. (2005). Who is at Risk? Predictors of Work-Life Conflict (Report Four). Health Canada, Ottawa

<http://www.phac-aspc.gc.ca/publicat/work-travail/report4/index.html>

Higgins, C., Duxbury, L., and Johnson, K. (2004). Exploring the Link Between Work-Life Conflict and Demands on Canada's Health Care System (Report Three), Health Canada, Ottawa.

<http://www.phac-aspc.gc.ca/publicat/work-travail/report3/index.html>

Duxbury, L. and Higgins, C. (2003). Where to Work in Canada? An Examination of Regional Differences in Work-life Practices, B.C. Council of the Families: Vancouver: B.C.

<http://www.worklifeforum.com>

Duxbury, L. and Higgins, C. (2003). Work-Life Conflict in Canada in the New Millennium: A Status Report (Report Two), Health Canada, Ottawa.

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/work-travail/report2/index.html>

Duxbury, L., Higgins, C., and Coghill, D. (2003). Voices of Canadians: Seeking Work-Life Balance, Human Resources Canada, Cat. No. RH54-12/2003, ISBN: 0-662-67059-0

<http://labour-travail.hrdc-drhc.gc.ca/worklife>

Higgins, C. and Duxbury, L. (2002). The 2001 National Work-Life Conflict Study: Report One, Health Canada, Ottawa.

<http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/work-travail/index.html>

Duxbury, L. and Higgins, C. (2001). Work-Life Balance in the New Millennium: Where are we? Where do we need to go?, CPRN Discussion Paper No. W/12, CPRN: Ottawa.

<http://www.cprn.org/cprn.html>

## Appendix C

### How Outcomes Used in this Study Measured

#### Employee Outcomes

**Perceived Stress** was measured by means of the Perceived Stress Scale (PSS; Cohen, Kamarck and Mermelstein, 1983). The PSS was designed to assess appraisals of the extent to which one's current life situation is unpredictable, uncontrollable and burdensome. Higher scores on this measure indicate greater levels of perceived stress. Population norms are used to interpret the scores. Cronbach's alpha for the entire scale was 0.88.

**Depressed Mood** was measured using a scale developed by Moos et al. (1988). These authors defined depressed mood (DM) as a state characterized by low affect and energy, and persistent feelings of helplessness and hopelessness. Higher scores indicate higher levels of depressive symptomatology. Population norms are used to interpret the scores. In this study, the Cronbach's alpha for the entire scale was 0.85.

**Life Satisfaction** was operationalized using the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen and Griffin, 1985). The SWLS was designed to measure the respondent's global life satisfaction or personal sense of well-being. Higher scores indicate greater levels of life satisfaction. In our study, the Cronbach alpha was .89.

**Perceived Physical Health** was quantified using the following question from the Health and Daily Living Form (HDL; Moos, Cronkite, Billings and Finney, 1988): "Compared to other people your age, how would you describe your usual state of physical health?" A five-point Likert scale was used to collect responses. Response choices included Poor (1), Fair (2), Good (3), Very Good (4) and Excellent (5). Higher scores indicate that the respondent perceives themselves to be in better physical health.

## Work-Life Conflict Outcomes

Three forms of work-life conflict are examined in this study: role overload, work interferes with family and family interferes with work. Information on the working definition and measurement of each of these constructs is given below.

**Role Overload** is having too much to do in a given amount of time. This form of work-life conflict occurs when the total demands on time and energy associated with the prescribed activities of multiple roles are too great to perform the roles adequately or comfortably. Overload was assessed in this study using five items from a scale developed by Bohlen and Viveros-Long (1981). Role overload was calculated as the summed average of these five items. High scores indicate greater role overload. In this study, Cronbach's alpha for this scale was 0.88.

**Role Interference** occurs when incompatible demands make it difficult, if not impossible, for an employee to perform all their roles well. Role interference is conceptualized as having two distinct facets:

- **Work Interferes with Family:** This type of role interference occurs when work demands and responsibilities make it more difficult to fulfil family role responsibilities
- **Family Interferes with Work:** This type of role interference occurs when family demands and responsibilities make it more difficult to fulfil work role responsibilities.

Work interferes with family\_ was measured by means of a 5-item Likert scale developed by Gutek, Searle and Kelpa (1991). Work interferes with family was calculated as the summed average of these five items. High scores indicate higher levels of perceived interference. In this study. Cronbach's alpha for this scale was 0.92.

Family interferes with work was assessed by means of a 5-item Likert scale developed by Gutek, Searle and Kelpa (1991). Family to work interference was calculated as the summed average of these five items. High scores indicate higher levels of perceived interference. In this study, Cronbach's alpha for this scale was 0.87.

## **Organizational Attitudes and Outcomes**

Organizational Commitment refers to loyalty to the employing organization. The nine-item short form of the Job Commitment Scale developed by Mowday et al. (1979) was used in both the 1991 and 2001 studies to measure commitment. High scores indicate greater commitment to the department. In our study, the Cronbach's alpha was 0.90.

Job Stress is viewed in terms of the incompatibility of work demands. It was assessed in both 1991 and 2001 using the Job Tension subscale of Rizzo et al.'s (1970) Work Stress Scale. Responses are on a five-point scale and a summed average score is calculated such that a high score indicates high job stress. In our study the Cronbach's alpha was 0.87.

Job Satisfaction is the degree to which employees have a positive affective orientation toward employment. The five item "facet-specific" measure of satisfaction developed by Quinn and Staines (1979) was used to measure job satisfaction (i.e. satisfaction with job in general, their pay, their work hours, their work schedule and their work tasks). High scores on this scale represent greater job satisfaction. In our study, the Cronbach's alpha was 0.81 for the 5 item measure.

Intent to turnover is defined as an individual's desire to leave an organization. This survey used a measure developed by Duxbury and Higgins for use in this study to examine both intent to turnover and motivations to leave. Intent to turnover was measured by asking respondents to indicate how often in the last six months they had thought about leaving their current organization to work elsewhere. Options given included never, monthly, weekly, several days per week or daily.

Absenteeism was measured by asking respondents: "In the past six months how many days have you:" (1) been unable to work or carry out your usual activities because of health problems? (this item was drawn from the Health and Daily Living Form (HDL; Moos, Cronkite, Billings and Finney, 1988), (2) been unable to work or carry out your usual activities because of children-related problems? (3) been unable to work or carry out your usual activities because of problems concerning elderly relatives?, and (4) taken a day off because you were emotionally, physically or mentally fatigued? Responses were collected on a scale that ranged from 0 days to 10 or more days. Three levels of absenteeism were calculated: those with zero absenteeism, those with low absenteeism (less than 3 days in a six month period) and those with high absenteeism (3 or more days in a six month period).

## **Family Outcomes**

Family Adaptation is defined as occurring when family members use their strengths and capabilities to reduce the demands of the situation, promote individual development of members, and achieve a sense of congruency in family functioning. Families high in family adaptation have a general sense of physical and psychological family health that is referred to as family well-being. The four-item Family Adaptation Scale (FAS) developed by Sourani and Antonovsky (1988) was used in this study to measure family adaptation. A five point Likert scale was used for responses (1 = not satisfied, 3 = moderately satisfied and 5 = completely satisfied). Higher scores reflect higher family adaptation. In this study, the Cronbach's alpha for this scale was 0.86.

Family Life Satisfaction is defined as overall satisfaction with family relationships. The Kansas Family Life Satisfaction scale developed by Schumm, Jurich and Bollman (1986) was used to measure family life satisfaction in this study. The original three-item measure (satisfaction with family life, relationship with children and relationship with spouse) was augmented with two additional items (satisfaction with relationship with your parents and your relationship with your in-laws). A five point Likert scale was used for responses (1 = not satisfied, 3 = moderately satisfied and 5 = completely satisfied). Family Life Satisfaction was calculated as the summed average of the 5 items with higher scores reflecting higher family satisfaction. The Cronbach's alpha of this measure in our study was 0.75.

Parental Life Satisfaction is defined to be perceived satisfaction with the parenting role and one's ability as a parent. The three-item Kansas Parental Satisfaction Scale developed by Schumm (see James et al., 1985) was used in this study to quantify Parental Life Satisfaction. Respondents were asked to indicate, using a five-point Likert scale (1 = not satisfied, 3 = moderately satisfied and 5 = completely satisfied), how satisfied they were with their relationship with their children, the behaviour of their children, and themselves as a parent. We included one additional item in this measure (satisfaction with partner's relationship with their children). Parental Life Satisfaction was calculated as the summed average of the four items. Higher scores reflect higher parental satisfaction. The Cronbach's alpha for this scale in our study was 0.83.

Family Integration is defined in terms of the stability of the family unit and the amount of security family members get by being part of the family and participating with the family in joint activities and functions. An abbreviated 5-item version of the Family Integration Scale (FIS) developed by Sebald and Andrews (1962) was used in this study to measure family integration. A five-point Likert scale (1 = never, 2 = monthly, 3 = weekly, 4 = several days per week, 5 = daily) was used to collect responses. Family integration was calculated as the summed average of the 5 items. High scores reflect higher family integration. The Cronbach's alpha for this scale was 0.77.

Positive Parenting The National Longitudinal Study of Children and Youth has identified a number of behaviours which appear to be associated with positive parenting. Five of these behaviours were included in this study. A five-point Likert scale was used to collect the responses (1 = never, 2 = monthly, 3 = weekly, 4 = several days per week, and 5 = daily). Positive parenting was calculated as the summed average of the 5 items. Higher scores indicate that the respondent perceives that they engage in behaviours associated with positive parenting more frequently. In our study, Cronbach's alpha for this scale was 0.87.

## Societal Outcomes

**Use of Canada's Health Care System** by Canadian employees was estimated by asking respondents to indicate (yes or no) whether or not in the past six months they had:

- seen a physician other than for a regular checkup or maternity related visit?
- sought care from other types of medical/health professional (i.e. physiotherapist, chiropractor)?
- sought care from a mental health professional (e.g. psychologist, psychiatrist, counselor)?
- spent any time (measured in days) in the hospital (respondents were asked to exclude visits to the emergency department or outpatient visits)?
- personally needed to seek medical care at a hospital's emergency department (respondents were asked to exclude visits to the emergency department on behalf of other members of their family)?
- visited a hospital or medical clinic on an outpatient (or day use) basis for medical tests or procedures (e.g. ultrasound, EKG, day surgery)?

Respondents who indicated that they had used any of the above services were then asked to record either the number of visits they had made (or, in the case of hospital use, the number of days they had spent in hospital) in the six month period. These measures are used two ways in this study: (1) as an indicator or demands on various facets of the health care system, and (2) as indicators (albeit crude) of an employee's physical and mental health.

The first question in this series (visits to the physician) was developed by Moos, Cronkite, Billings and Finney (1988) for use in the Health and Daily Living Form. Previous studies have determined that this measure is a good proxy for actual health status and accurately reflects actual physician visits. According, the other measures of use were designed using the same format.

**Fertility:** At Health Canada's request we included to questions in the survey so that we could assess the relationship between work-life conflict and the decision to have children. Respondents were asked to what extent they agreed or disagreed with the following statements:

- I have had fewer children because of the demands of my work
- I have not yet started a family/decided not to have a family, because of the demands of work

## References for Measures

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## **Appendix D: Regression Analysis**

There are three steps in a regression analysis. The first step involves an assessment of the overall regression model. In our example, the researcher would want to know to what extent number of children, income and hours per week working (the independent variables) predicted physical caregiver strain (the dependent variable). To determine this, one looks at the F-test which essentially tests whether the predictive power of the model is null. If we reject this null (i.e. p-value less than 0.05), then we say we have a significant regression. To determine the strength of a regression we look at a statistic called  $R^2$  (R-squared).  $R^2$ , which ranges from 0 to 1, is the percent of variance in the dependent that is explained by the independent variables. The closer  $R^2$  is to 1, the stronger the regression. Determining a threshold value for  $R^2$  depends on what previous researchers have been able to explain. For example, if previous researchers have been able to explain 15% of the variance of overload, then 15% is a minimum standard for researchers to achieve with their regression model. When the regression is significant and we are happy with the level of  $R^2$ , we say we have a substantive regression.

Step one only tells us if the overall model is significant. In step two, we can look at each independent variable separately and determine if it is contributing to the regression. To do this, we look at t-tests associated with each variable. If the significance of the t-test is less than 0.05, we say the variable is a significant contributor to the regression equation. Normally, when a variable is not significant we drop it from the analysis and re-run the regression.

In step three, we determine the importance of each independent variable. To do this, we use a technique described by Thomas et al. (1998). This technique involves multiplying each standardized regression coefficient by its correlation with the dependent variable. Mathematically, if you multiply each standardized coefficient by its correlation with the dependent variable and sum these products, the sum is equal to the  $R^2$  of the regression. Subsequently, if you divide each product by the overall  $R^2$ , your products will now sum to 1 (these products are called Pratt's measure or Pratt's coefficient). To determine importance, you simply rank order Pratt's measure for each variable: the higher the rank, the more important the variable. As a baseline for importance, Pratt's measure should be greater than 1 divided by the number of variables. Thus, if you have five variables, Pratt's measure must exceed 0.2 before being considered important.

One final point needs to be made about regression equations. In a regression, each coefficient measures the contribution of that variable controlling for all other variables in the model. Thus, if the researcher wants to include controls in a regression, he or she simply adds them as independent variables.

To determine the impact of where the elderly dependent lives on caregiver strain it was necessary to control for this factor in the regression equations. In regression analysis, the analyst will often want to examine the effect of a qualitative variable such as gender. To do this, the analyst will create a variable called gender and assign a value of 0 when the response is from a male and a value of 1 when the response is from a female. The numbers 0 and 1 are really quite meaningless as one could have coded males as 1 and females as 0. Qualitative variables such as

gender are known as dummy variables. By looking at the regression coefficient associated with gender, the analyst can determine if gender has an impact on the variable you are trying to predict.

Dummy variables can be extended from two groups (i.e. male, female) to three groups (elderly dependent lives with respondent, nearby and elsewhere) as follows. For a qualitative variable with three levels, we need two dummy variables to uniquely identify each group.<sup>13</sup> We could call these Distance 1 and Distance 2 and code them as shown below.

Elderly dependent lives:	<b>Distance 1</b>	<b>Distance 2</b>
With employee	0	1
Near employee	1	0
Not near employee	0	0

By coding the variable this way, we can measure the impact of where the elderly dependent lives on the dependent variable of interest (e.g. caregiver strain). If Distance 1 (nearby) and/or Distance 2 (with) are significant, then where the elderly dependent lives is a predictor of caregiver strain

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<sup>13</sup> Since assigning the numbers 1, 2, 3 would imply that the numbers have meaning (in reality any group could be coded as 1), we have to code where the elderly dependent lives using a dummy variable.

## D:2: Results of Regression

### FEELING OVERWHELMED

Demographic R <sup>2</sup> 4.9%					
	B	r		Pratts	
distance1	0.021	0.003	0.000063	<b>0.001286</b>	
distance2	0.076	0.075	0.0057	<b>0.116319</b>	*
gender	0.127	0.142	0.018034	<b>0.368018</b>	*
age	0.064	0.026	0.001664	<b>0.033957</b>	
parental status	-0.073	-0.06	0.00438	<b>0.089382</b>	*
family finances	-0.143	-0.134	0.019162	<b>0.391037</b>	*
			0.049003		1
Demands R <sup>2</sup> 9.2%					
distance1	0.02	0.003	0.00006	<b>0.000613</b>	
distance2	0.047	0.075	0.003525	<b>0.036021</b>	
hrs/wk elderly care	0.223	0.283	0.063109	<b>0.644897</b>	*
responsibility – children	-0.061	-0.091	0.005551	<b>0.056724</b>	*
responsibility – elder	-0.129	-0.163	0.021027	<b>0.21487</b>	
elder activities – partner	0.076	0.053	0.004028	<b>0.041161</b>	
hrs/wk	-0.013	-0.043	0.000559	<b>0.005712</b>	
			0.097859		0.999387
Work environment R <sup>2</sup> 4.1%					
distance1	0.041	0.003	0.000123	<b>0.003086</b>	
distance2	0.079	0.075	0.005925	<b>0.148634</b>	*
job type	0.042	0.051	0.002142	<b>0.053734</b>	
work flex	-0.091	-0.133	0.012103	<b>0.303615</b>	*
avail – unpaid leave	-0.031	-0.063	0.001953	<b>0.048993</b>	
avail personal days/pay	0.032	-0.018	-0.00058	<b>-0.01445</b>	
mgr supportive p/f	0.06	-0.08	-0.0048	<b>-0.12041</b>	*
co-workers supportive p/f	-0.042	-0.075	0.00315	<b>0.079021</b>	
family resp make it difficult	0.069	0.117	0.008073	<b>0.202519</b>	*
no acceptable say no feel comfortable using supp	0.041	0.07	0.00287	<b>0.071997</b>	
non-supportive	-0.044	-0.104	0.004576	<b>0.114793</b>	*
	0.046	0.094	0.004324	<b>0.108472</b>	*
			0.039863		1

**PHYSICAL STRAIN**

Demographic R <sup>2</sup> 6.4%					
	B	r		Pratts	
distance1	0.067	0.033	0.002211	<b>0.053717</b>	
distance2	0.135	0.111	0.014985	<b>0.364067</b>	*
gender	0.089	0.105	0.009345	<b>0.227041</b>	*
age	0.098	0.069	0.006762	<b>0.164286</b>	*
parental status	-0.039	-0.039	0.001521	<b>0.036953</b>	*
family finances	-0.088	-0.072	0.006336	<b>0.153936</b>	*
			0.04116		1

Demands R <sup>2</sup> 11.2%					
distance1	0.046	0.033	0.001518	<b>0.012373</b>	
distance2	0.076	0.111	0.008436	<b>0.06876</b>	
hrs/wk elderly care	0.229	0.299	0.068471	<b>0.558095</b>	*
responsibility – children	-0.007	-0.044	0.000308	<b>0.00251</b>	*
responsibility – elder	-0.174	-0.145	0.02523	<b>0.205645</b>	*
elder activities – partner	0.151	0.124	0.018724	<b>0.152616</b>	*
			0.122687	<b>0.987627</b>	

Work environment R <sup>2</sup> 3.0%					
distance1	0.076	0.033	0.002508	<b>0.082181</b>	
distance2	0.114	0.111	0.012654	<b>0.414641</b>	*
job type	0.035	0.034	0.00119	<b>0.038993</b>	
work flex	-0.062	-0.075	0.00465	<b>0.152369</b>	*
avail – unpaid leave	-0.03	-0.057	0.00171	<b>0.056033</b>	
avail personal days/pay	0.021	-0.023	-0.00048	<b>-0.01583</b>	
mgr supportive p/f	0.069	-0.042	-0.0029	<b>-0.09496</b>	*
co-workers supportive p/f	-0.024	-0.042	0.001008	<b>0.03303</b>	
family resp make it difficult	0.056	0.071	0.003976	<b>0.130284</b>	*
no acceptable say no feel comfortable using supp	0.011	0.038	0.000418	<b>0.013697</b>	
non-supportive	-0.035	-0.071	0.002485	<b>0.081427</b>	*
	0.055	0.06	0.0033	<b>0.108133</b>	*
			0.030518		1

## FINANCIAL STRAIN

	Demographic R <sup>2</sup> 6.8%			Pratts	
	B	r			
distance1	-0.09	-0.119	0.01071	<b>0.165296</b>	*
distance2	0.076662	0.102	0.007819	<b>0.12069</b>	
gender	-0.01279	-0.004	0	<b>0</b>	
age	0.016968	-0.017	-0.00029	<b>-0.00445</b>	
parental status	-0.08316	-0.06	0.00499	<b>0.077014</b>	
family finances	-0.2078	-0.2	0.04156	<b>0.641453</b>	*
			0.06479	<b>1</b>	

	Demands R <sup>2</sup> 8.7%			Pratts	
distance1	-0.09666	-0.119	0.011502	<b>0.135048</b>	*
distance2	0.078427	0.102	0.008	<b>0.093922</b>	
hrs/wk elderly care	0.180006	0.241	0.043382	<b>0.509343</b>	*
responsibility – children	-0.01462	-0.019	0.000278	<b>0.003262</b>	
responsibility – elder	-0.09984	-0.061	0.00609	<b>0.071502</b>	
elder activities – partner	0.128392	0.124	0.015921	<b>0.186923</b>	*
			0.085172	<b>1</b>	

	Work environment R <sup>2</sup> 5.2%			Pratts	
distance1	-0.08226	-0.119	0.009788	<b>0.193584</b>	*
distance2	0.079639	0.102	0.008123	<b>0.160651</b>	*
job type	0.045371	0.044	0.001996	<b>0.039481</b>	
work flex	-0.1023	-0.134	0.013709	<b>0.271116</b>	*
avail – unpaid leave	-0.03052	-0.061	0.001862	<b>0.036824</b>	
avail personal days/pay	0.027412	-0.016	-0.00044	<b>-0.00867</b>	
mgr supportive p/f	0.029252	-0.103	-0.00301	<b>-0.05959</b>	
co-workers supportive p/f	-0.03318	-0.081	0.002688	<b>0.053151</b>	
family resp make it difficult	0.03456	0.098	0.003387	<b>0.066981</b>	
no acceptable say no feel comfortable using supp	-0.03846	-0.095	0.003653	<b>0.072252</b>	
non-supportive	0.062123	0.117	0.007268	<b>0.143746</b>	*
			0.050564	<b>1</b>	

<b>COMBINED – PHYSICAL</b>		R <sup>2</sup> 13.5%			
	B	r		Pratts	
distance1	0.037	0.033	0.001221	<b>0.00833</b>	
distance2	0.041	0.111	0.004551	<b>0.03105</b>	
gender	0.037	0.105	0.003885	<b>0.026506</b>	
age	0.07	0.069	0.00483	<b>0.032953</b>	
financial situation	-0.043	-0.072	0.003096	<b>0.021123</b>	
hrs/wk elderly care	0.259	0.299	0.077441	<b>0.528351</b>	*
responsibility – elder	-0.158	-0.145	0.02291	<b>0.156306</b>	*
elder activities – partner	0.151	0.124	0.018724	<b>0.127747</b>	*
hrs/week	-0.038	-0.042	0.001596	<b>0.010889</b>	
work flex	-0.026	-0.075	0.00195	<b>0.013304</b>	
unpaid leave	-0.027	-0.057	0.001539	<b>0.0105</b>	
family resp make difficult	0.048	0.071	0.003408	<b>0.023252</b>	
feel comfortable using supp	-0.02	-0.071	0.00142	<b>0.009688</b>	
			0.146571		1

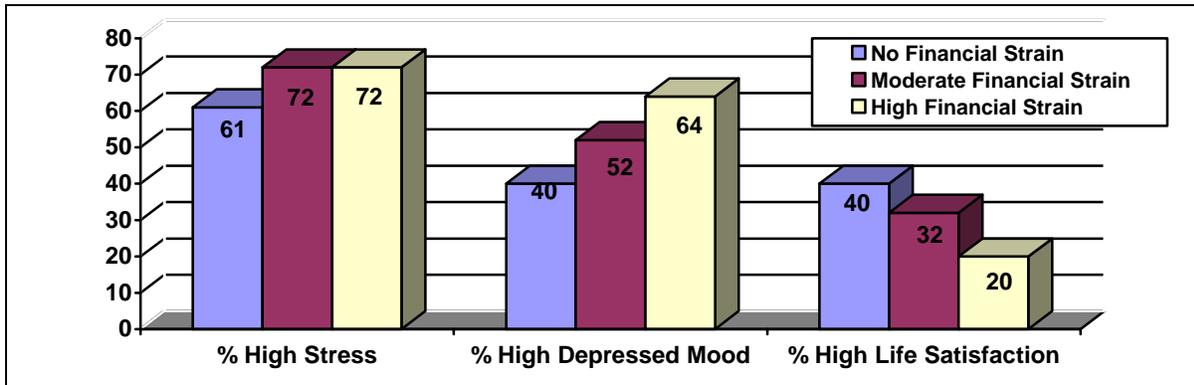
<b>COMBINED – OVERWHELMED</b>		R <sup>2</sup> 15.5%			
distance1	0.011	0.003	0.000033	<b>0.000241</b>	
distance2	0.01	0.075	0.00075	<b>0.005488</b>	
gender	0.075	0.142	0.01065	<b>0.077925</b>	*
age	0.01	0.026	0.00026	<b>0.001902</b>	
financial situation	-0.088	-0.134	0.011792	<b>0.086281</b>	*
hrs/wk elderly care	0.241	0.283	0.068203	<b>0.499038</b>	*
responsibility – elder	-0.127	-0.163	0.020701	<b>0.151468</b>	*
elder activities – partner	0.077	0.053	0.004081	<b>0.02986</b>	
hrs/week	-0.032	-0.043	0.001376	<b>0.010068</b>	
work flex	-0.048	-0.133	0.006384	<b>0.046711</b>	
unpaid leave	-0.014	-0.063	0.000882	<b>0.006454</b>	
family resp make difficult	0.065	0.117	0.007605	<b>0.055645</b>	
feel comfortable using supp	-0.038	-0.104	0.003952	<b>0.028917</b>	
			0.136669		1

<b>COMBINED – FINANCIAL</b>		R <sup>2</sup> 14.3%			
distance1	-0.084	-0.119	0.009996	<b>0.068199</b>	
distance2	0.06	0.102	0.00612	<b>0.041755</b>	
gender	-0.023	-0.004	0.000092	<b>0.000628</b>	
age	-0.028	-0.017	0.000476	<b>0.003248</b>	
financial situation	-0.191	-0.2	0.0382	<b>0.260625</b>	*
hrs/wk elderly care	0.158	0.241	0.038078	<b>0.259792</b>	*
responsibility – elder	-0.103	-0.061	0.006283	<b>0.042867</b>	
elder activities – partner	0.129	0.124	0.015996	<b>0.109135</b>	*
hrs/week	0.007	-0.008	-5.6E-05	<b>-0.00038</b>	
work flex	-0.082	-0.134	0.010988	<b>0.074967</b>	
unpaid leave	-0.035	-0.061	0.002135	<b>0.014566</b>	
family resp make difficult	0.045	0.098	0.00441	<b>0.030088</b>	
feel comfortable using supp	-0.017	-0.095	0.001615	<b>0.011019</b>	
			0.134333	<b>0.916505</b>	

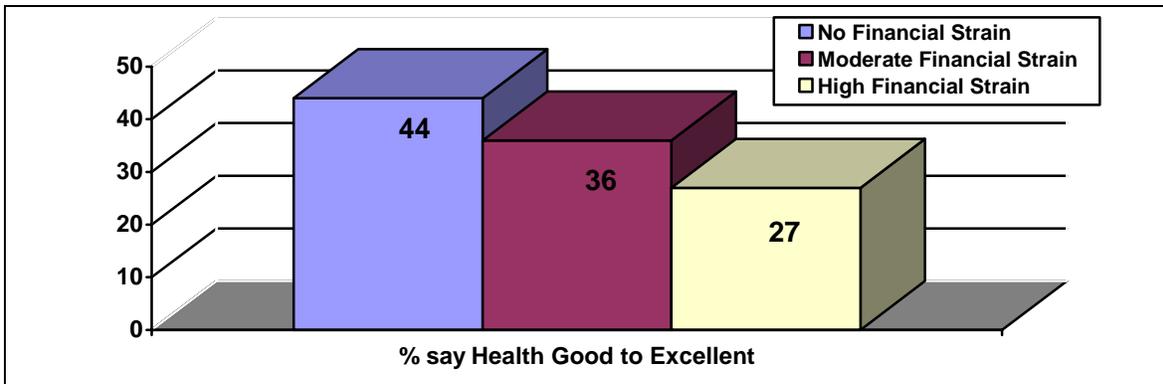
## Appendix E Figures for Chapter Three

**Figure E1: Relationship between Financial Strain and Physical/Mental Health**

a. **Mental Health Outcomes (percent of sample with high stress, depressed mood and life satisfaction)**

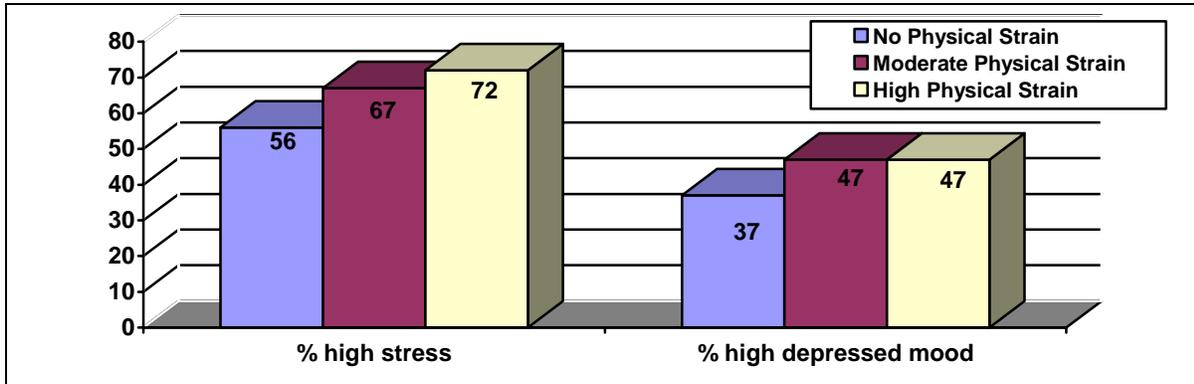


b. **Physical Health Outcomes (percent of sample perceive health is very good to excellent)**

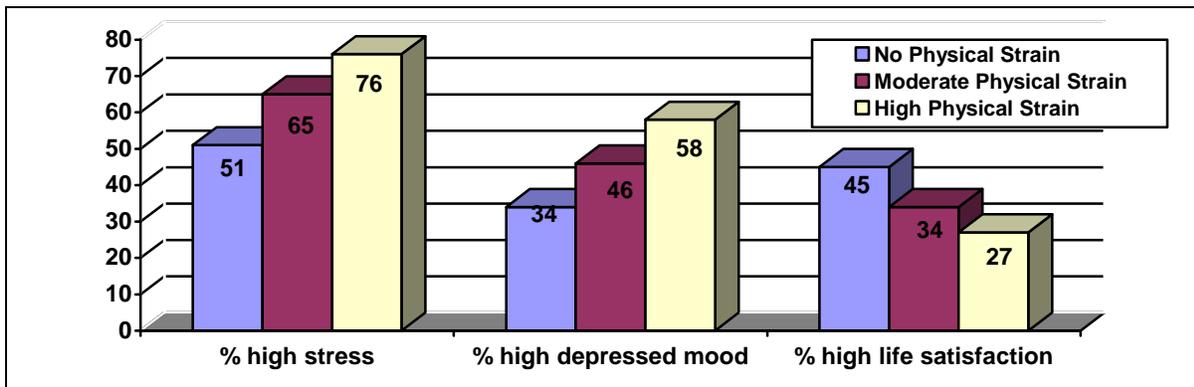


**Figure E2: Relationship Between Physical Strain and Physical/Mental Health**

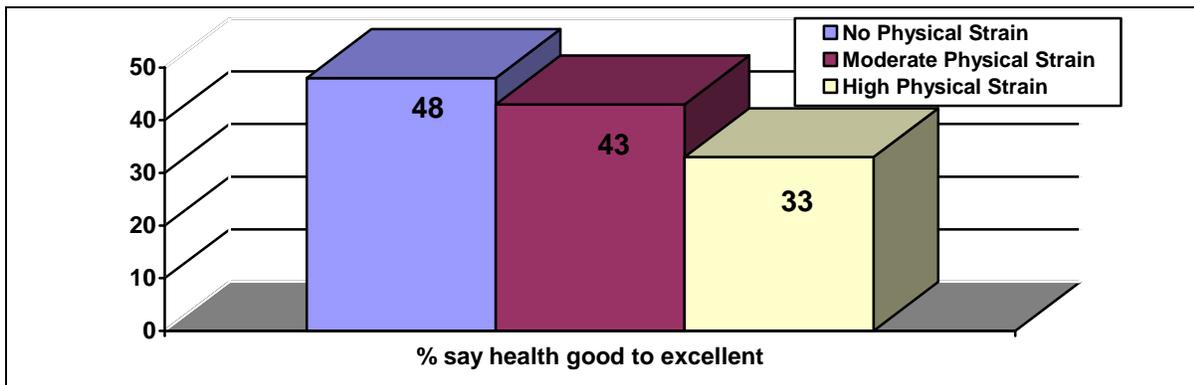
**a. Sandwich Group (percent of sample with high stress and depressed mood)**



**b. Eldercare Group (percent of sample with high stress and depressed mood)**

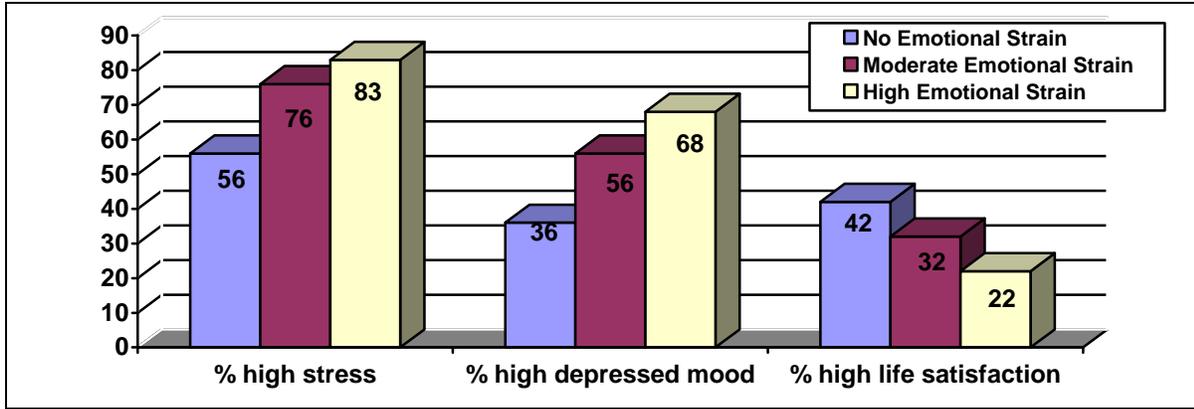


**c. Eldercare Group (percent of sample perceive health is very good to excellent)**

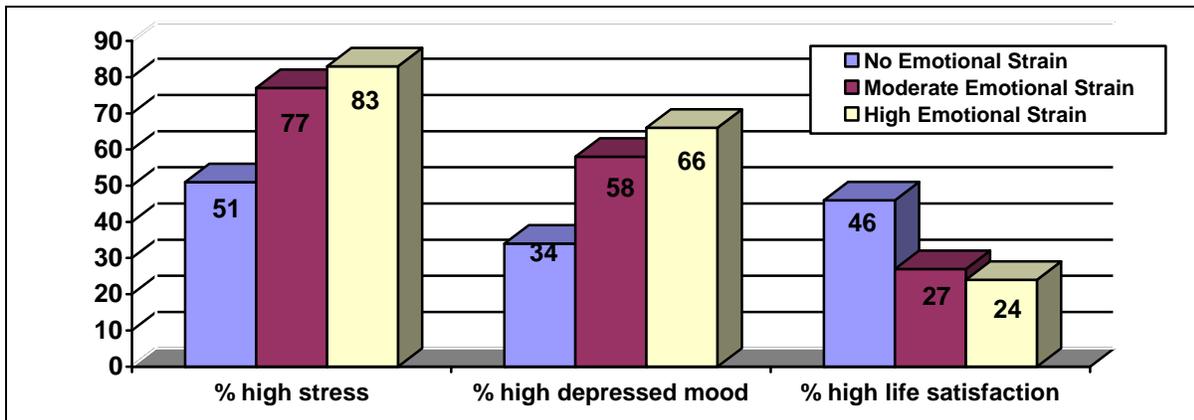


**Figure E3: Relationship Between Emotional Strain and Physical/Mental Health**

**a. Sandwich Group (percent of sample with high stress, depressed mood and life satisfaction)**



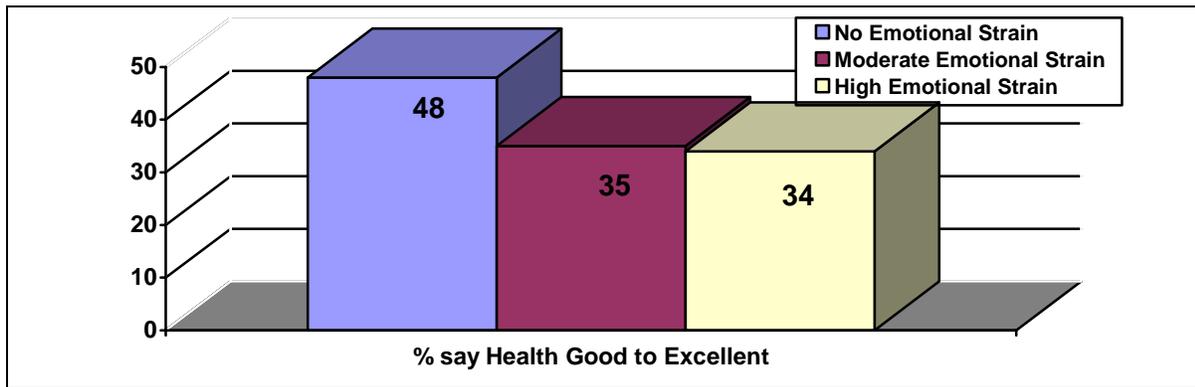
**b. Eldercare Group (percent of sample with high stress, depressed mood and life satisfaction)**



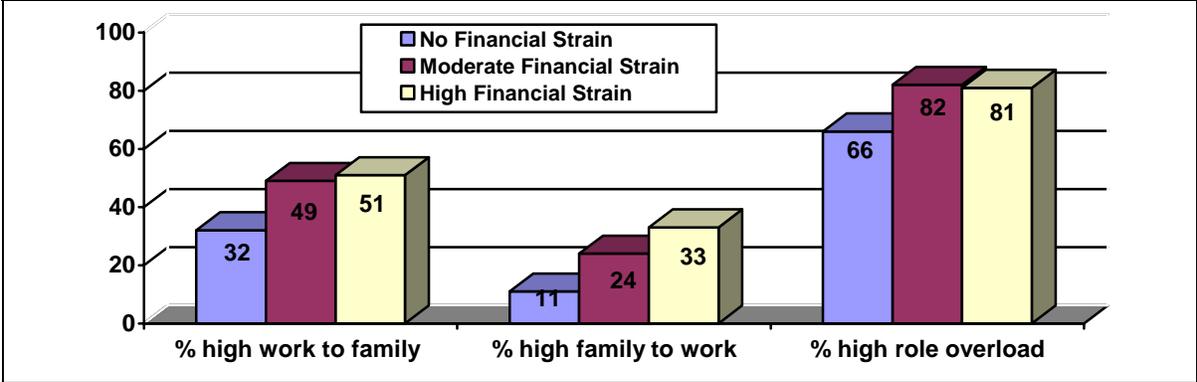
**c. Sandwich Group (percent of sample perceive health is very good to excellent)**



d. Eldercare Group (percent of sample perceive health is very good to excellent)

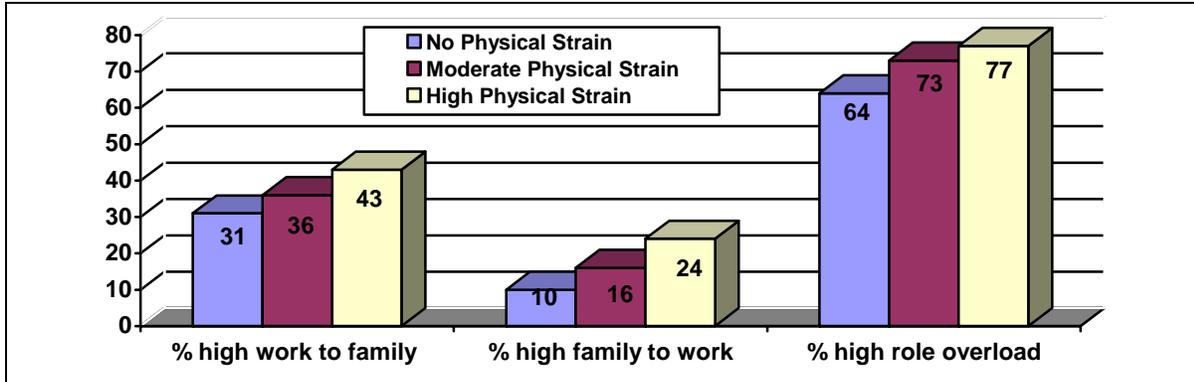


**Figure E4: Relationship Between Financial Strain and Work-life Balance**  
(percent of sample with high overload, work interferes with family and family interferes with work).

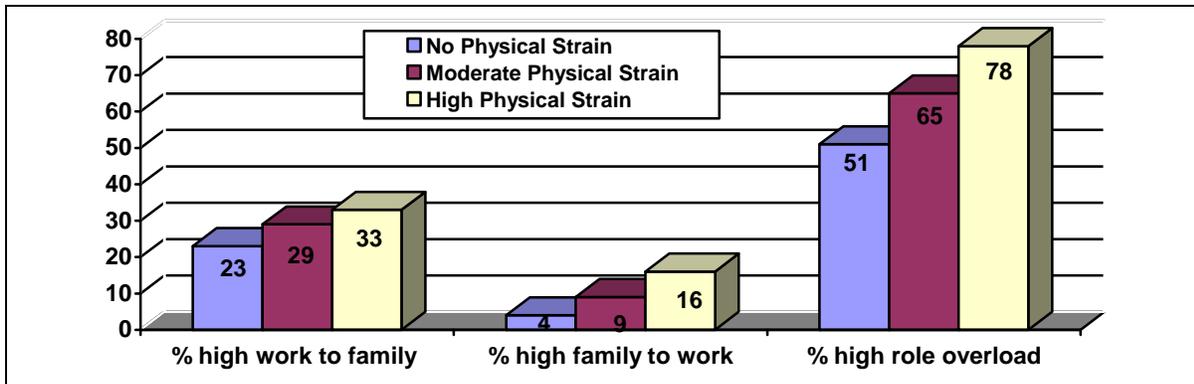


**Figure E5: Relationship Between Physical Strain and Work-life Balance**

**a. Sandwich group (percent of sample with high overload, work interferes with family and family interferes with work).**

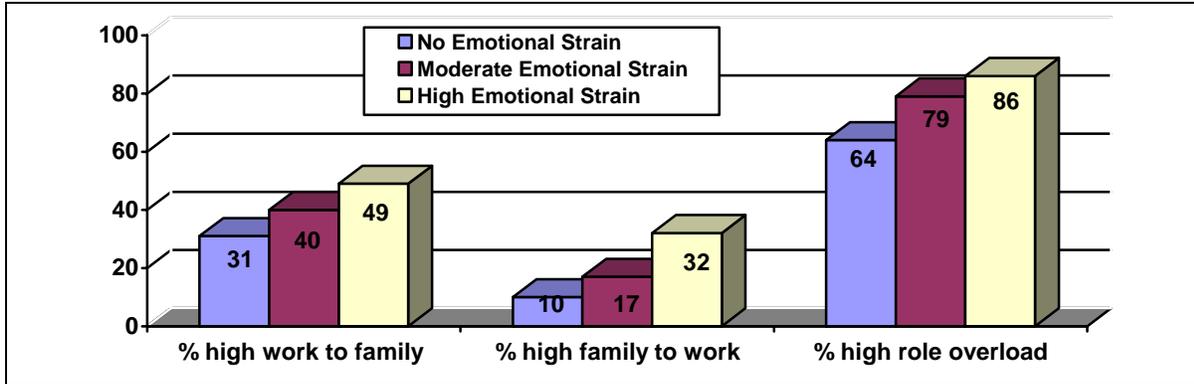


**b. Eldercare group (percent of sample with high overload, work interferes with family and family interferes with work).**

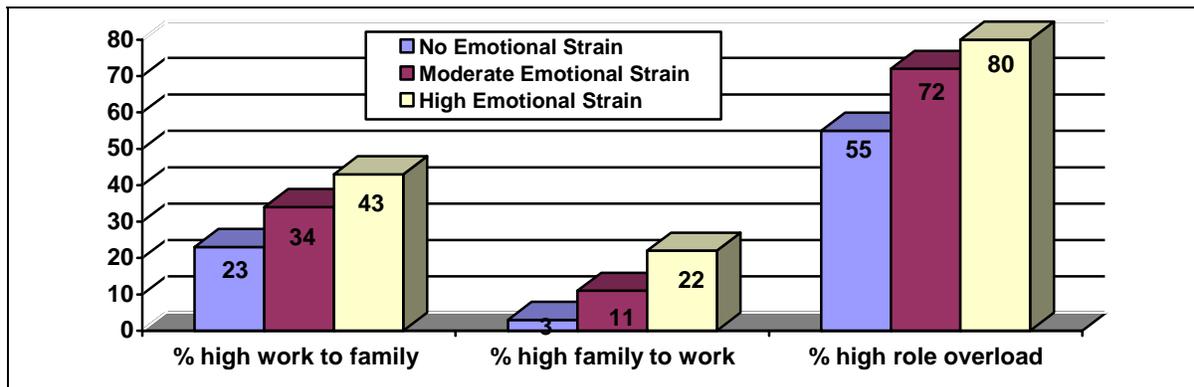


**E6: Relationship Between Emotional Strain and Work-life Balance**

**a. Sandwich group (percent of sample with high overload, work interferes with family and family interferes with work).**

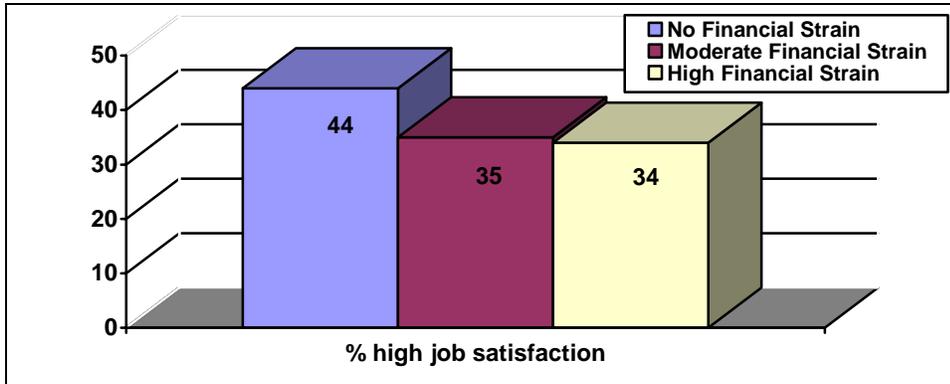


**b. Eldercare group (percent of sample with high overload, work interferes with family and family interferes with work).**

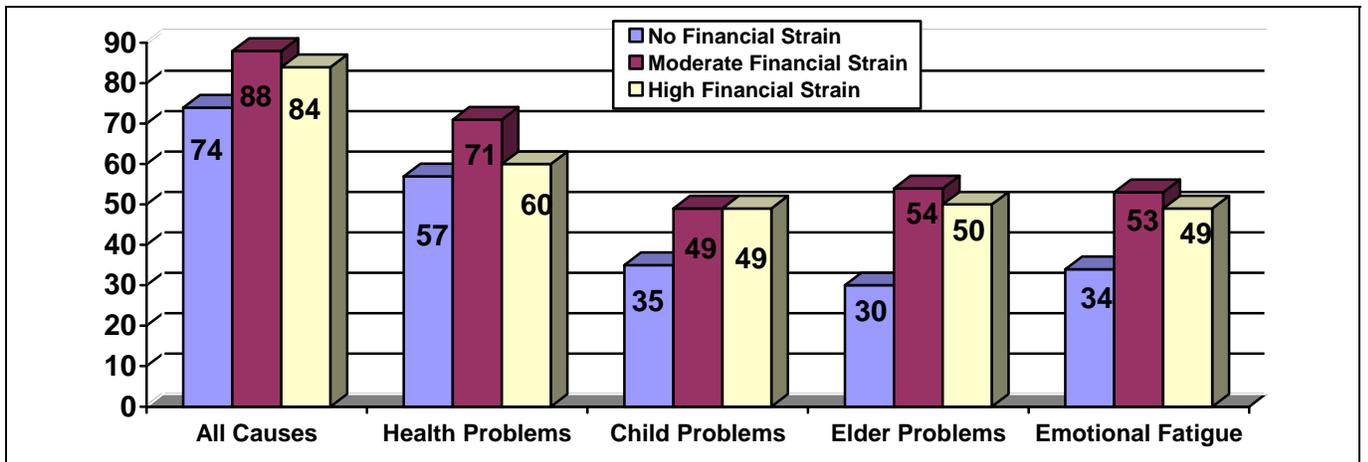


**E7: Relationship Between Financial Strain and Organizational Outcomes**

**a. Job Satisfaction (percent of sample with high job satisfaction)**

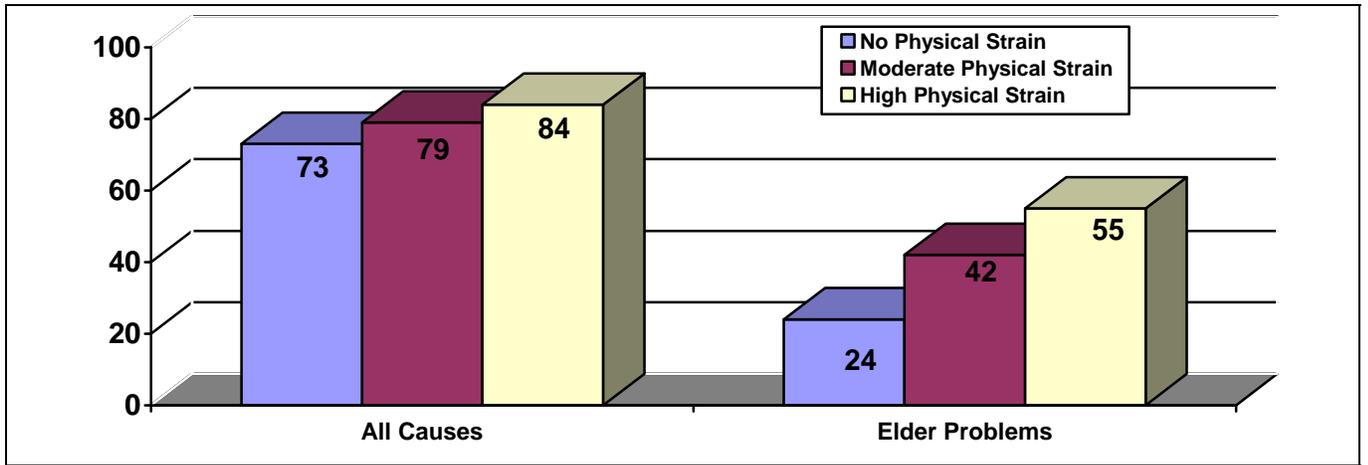


**b. Absenteeism (percent of sample missed work in past six months due to)**

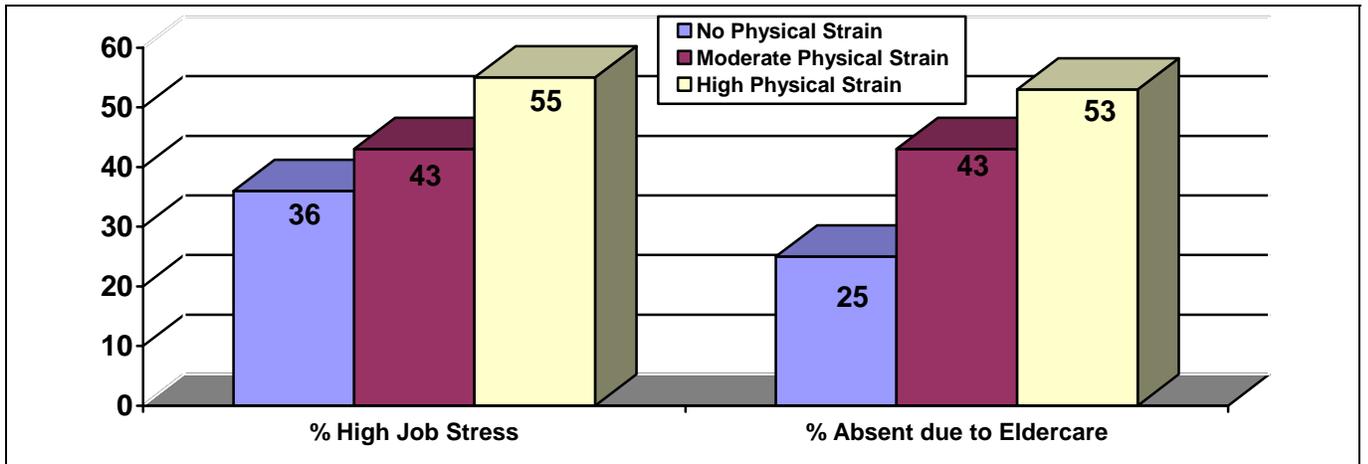


**E8: Relationship Between Physical Strain and Organizational Outcomes**

**a. Sandwich Group (percent of sample missed work in past six months due to)**

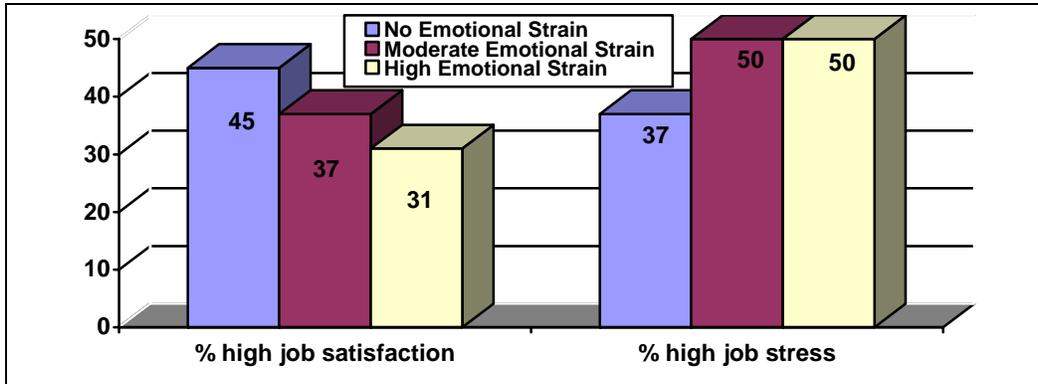


**b. Eldercare Group: (percent of sample with high job stress and percent of sample missed work in past six months due to)**

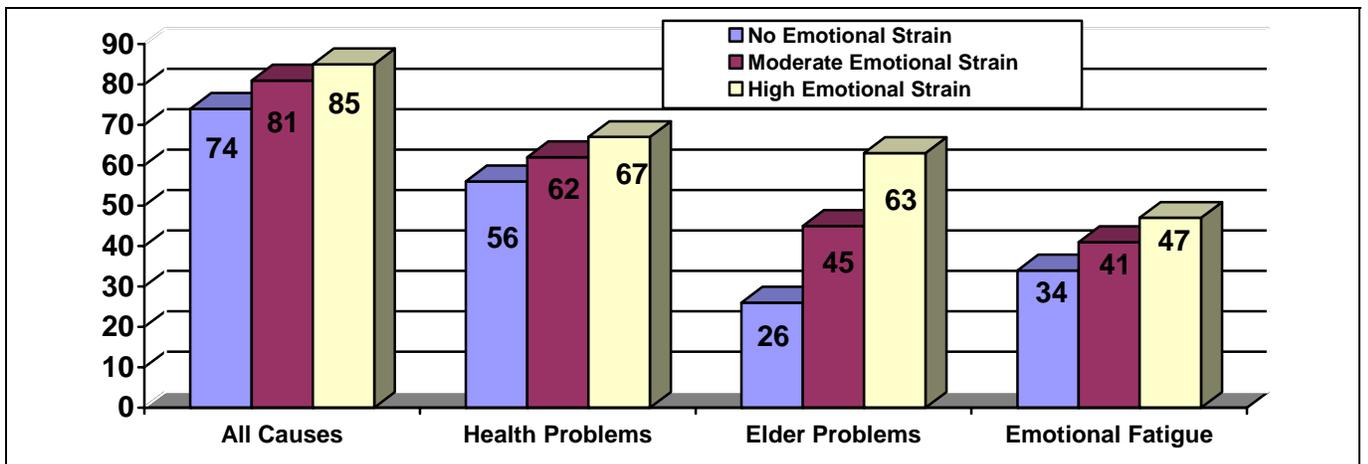


**E9: Relationship Between Emotional Strain and Organizational Outcomes**

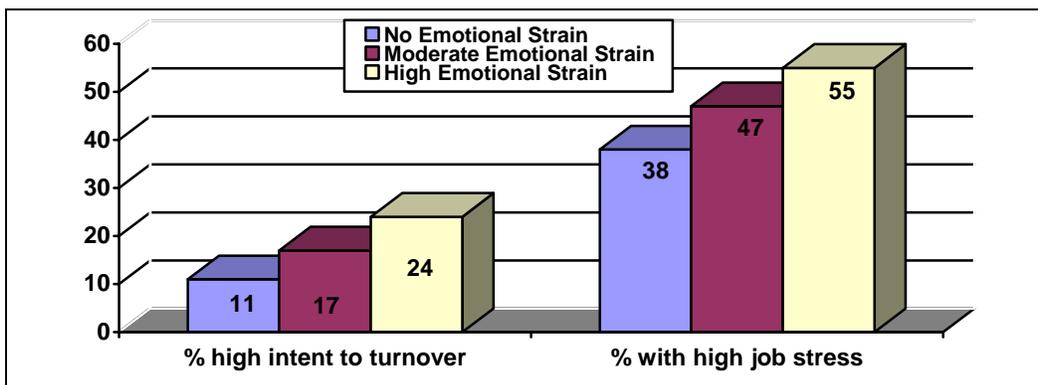
**a. Sandwich Group (percent of sample with high job stress and high job satisfaction)**



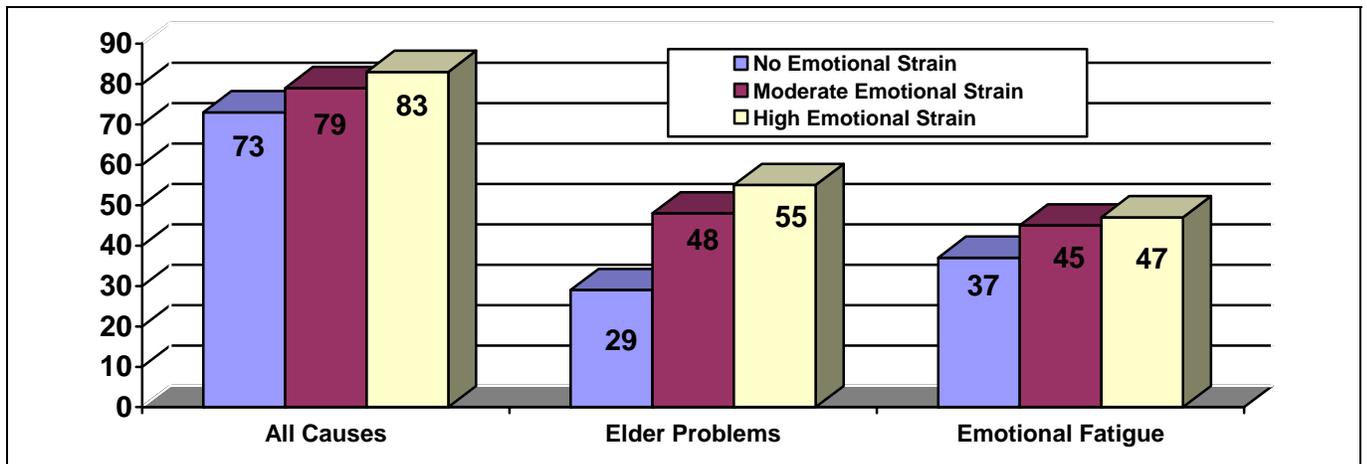
**b. Sandwich Group (percent of sample missed work in past six months due to)**



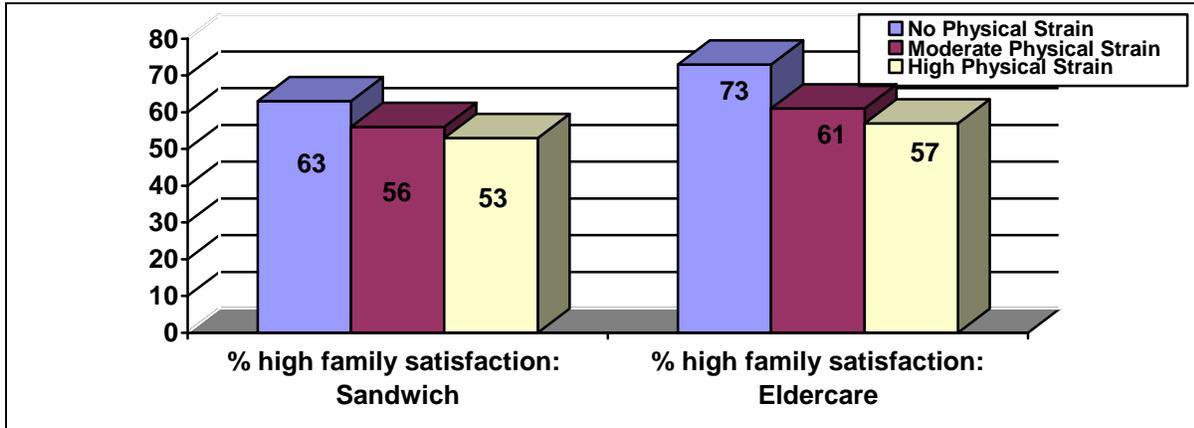
**c. Eldercare Group (percent of sample with high intent to turnover and high job stress)**



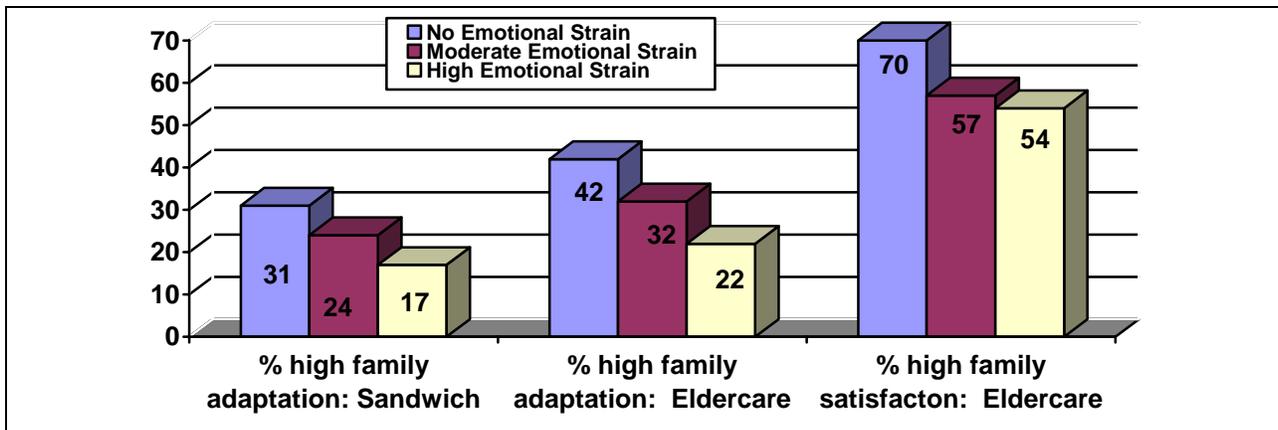
d. Eldercare Group (percent of sample missed work in past six months due to)



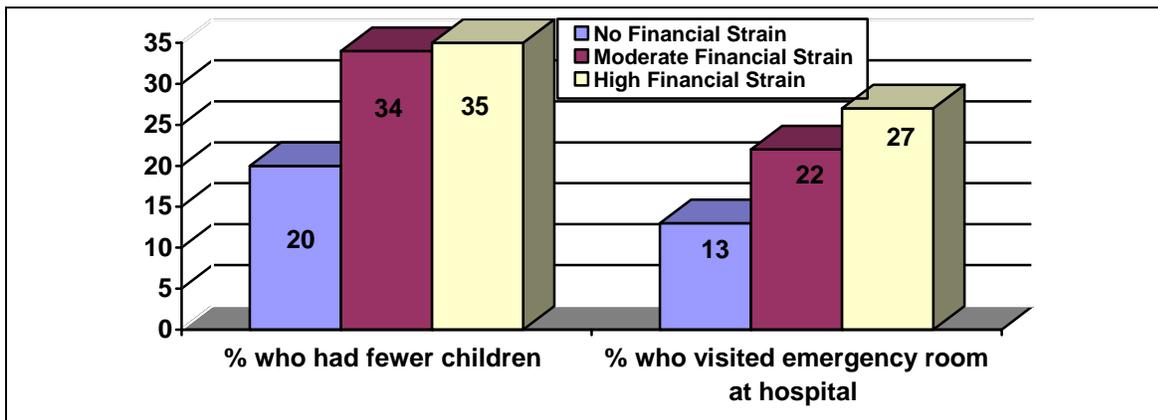
**E10: Relationship Between Physical Strain and Family Outcomes**  
(percent of sample with high family satisfaction)



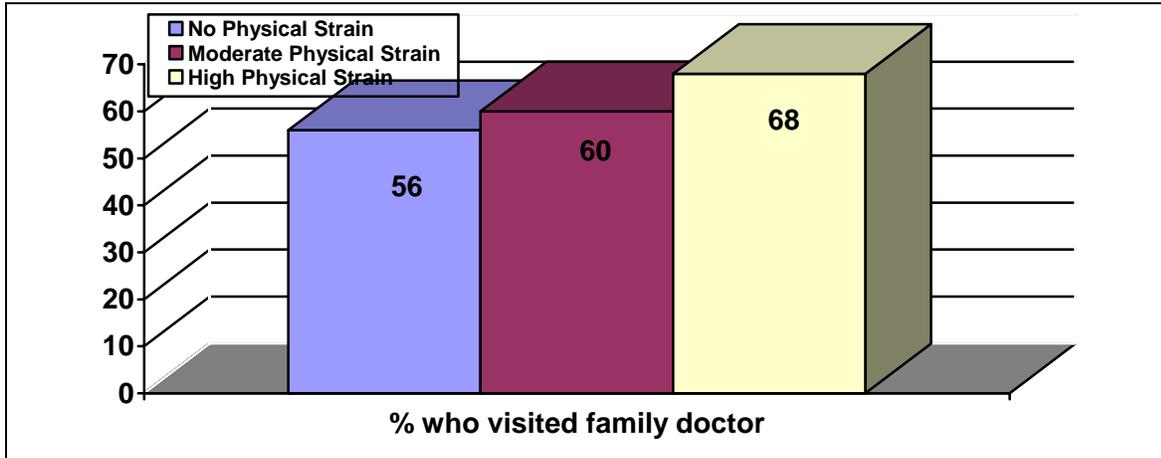
**E11: Relationship Between Emotional Strain and Family Outcomes**  
(percent of sample with high family adaptation and family satisfaction)



**Figure E12: Relationship Between Financial Strain and Social Outcomes**  
(% of sample who had fewer children and % who visited emergency room at the hospital)

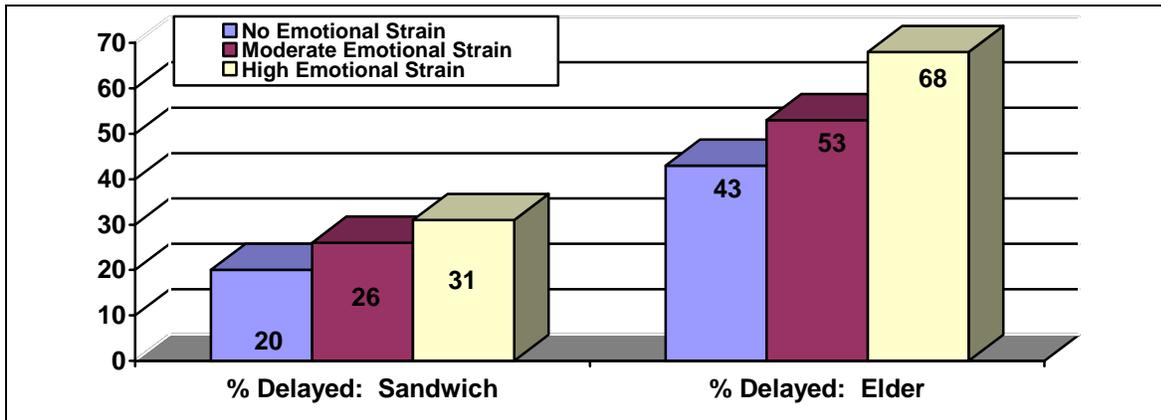


**Figure E13: Relationship Between Physical Strain and Social Outcomes**  
 (% of eldercare only sample who visited family doctor)

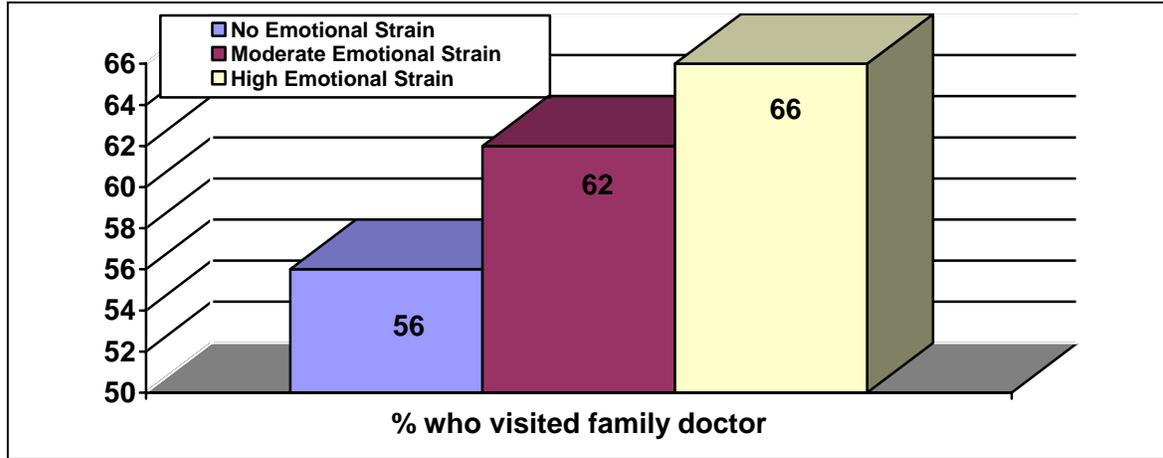


**Figure E14: Relationship Between Emotional Strain and Social Outcomes**

a. Sandwich and Eldercare Groups (% Who Delayed/Did Not Have Children)

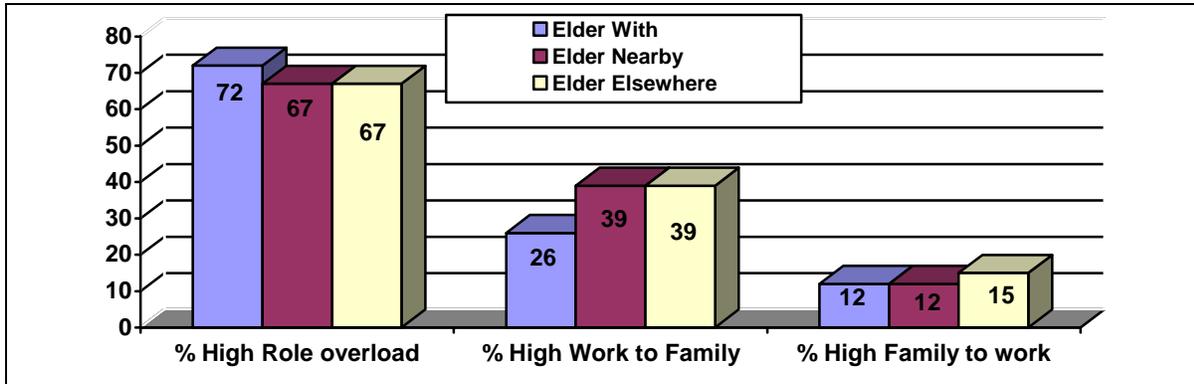


**b. Eldercare Group (% who have visited family physician)**

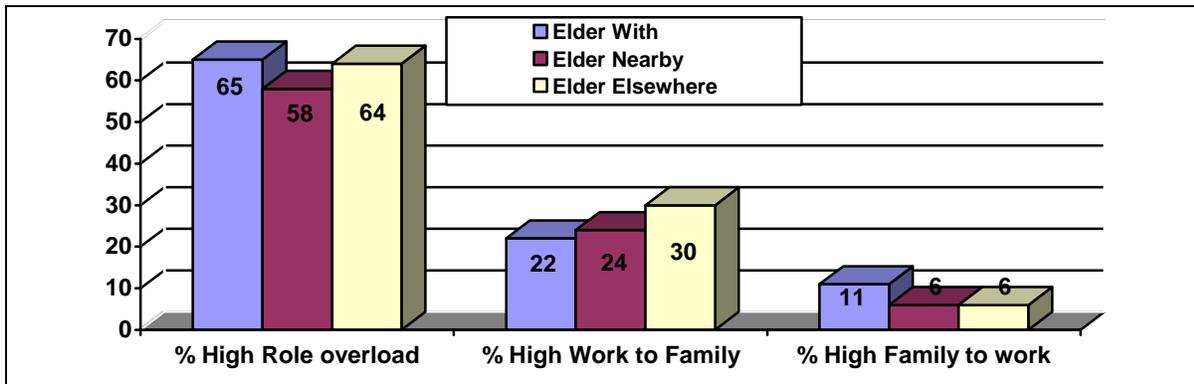


**Figure E14: Relationship Between Where the Dependent Lives and Work-Life Conflict**

**a. The Sandwich Group (% of sample with high work-life conflict)**

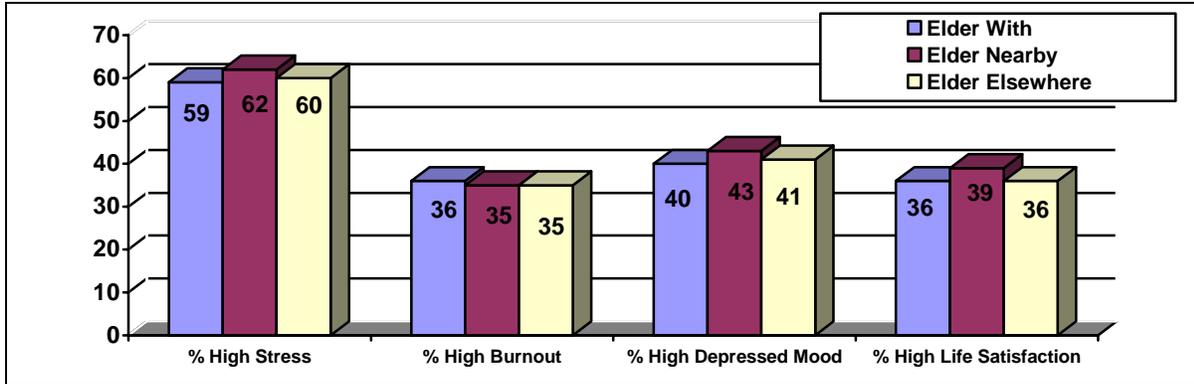


**b. The Eldercare Group (% of sample with high work-life conflict)**

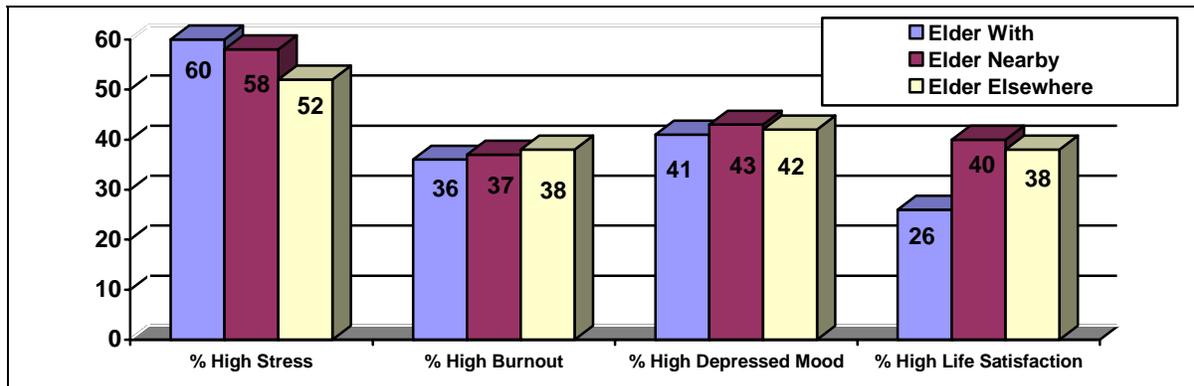


**Figure E15: Relationship Between Where the Dependent Lives and Mental Health:**

**a. The Sandwich Group (% of the sample with high stress, burnout, depressed mood and life satisfaction)**

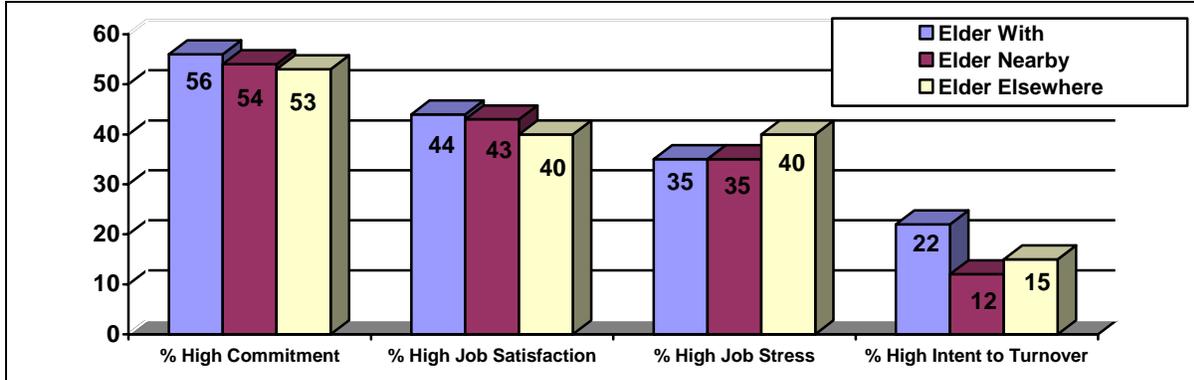


**b. The Eldercare Group (% of the sample with high stress, burnout, depressed mood and life satisfaction)**

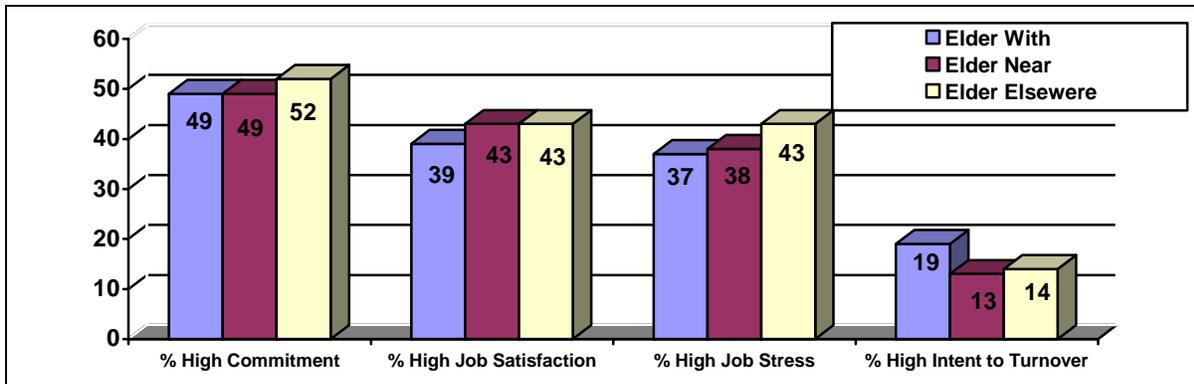


**Figure E16: Relationship Between Where the Dependent Lives and Key Organizational Attitudes and Outcomes**

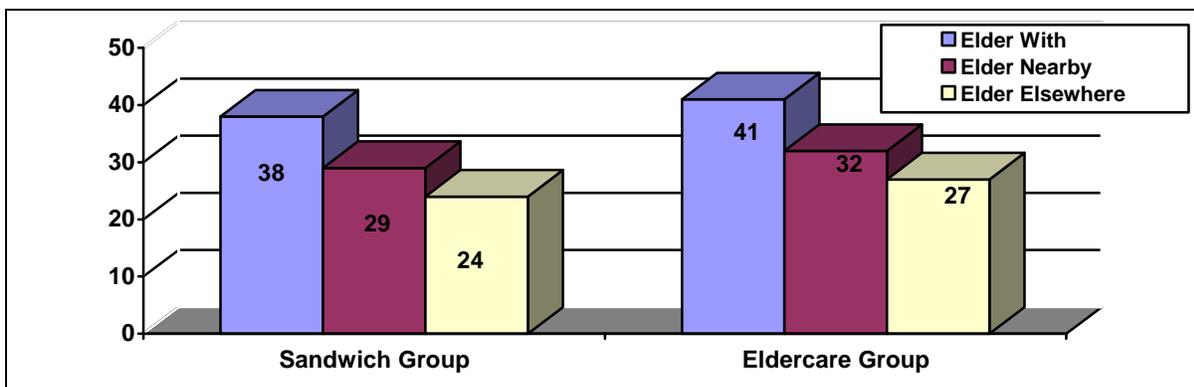
**a. The Sandwich Group (% of the sample with high commitment, job satisfaction, job stress and intent to turnover)**



**b. The Eldercare Group (% of the sample with high commitment, job satisfaction, job stress and intent to turnover)**



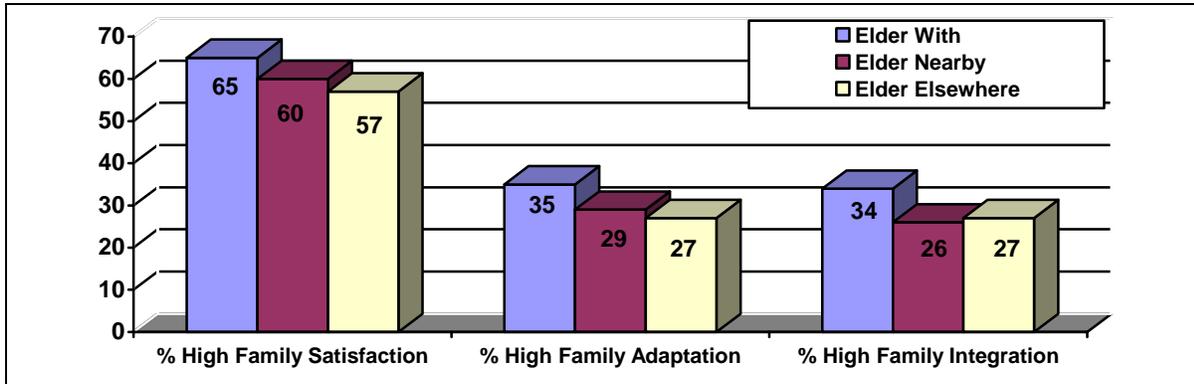
**c. Impact of Caregiver Group on Absenteeism (% Who Missed Work in Past Six Months Due To Eldercare Issues)**



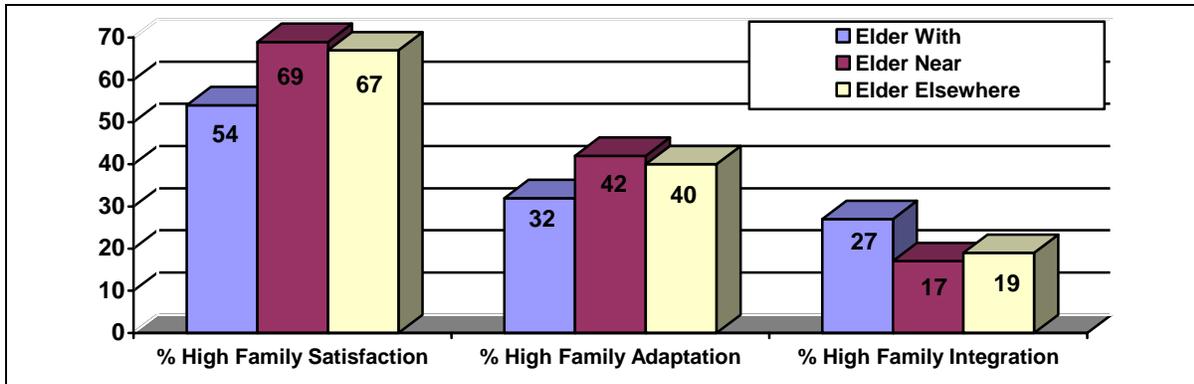
No differences in absenteeism due to health, children, or emotional figure in either the sandwich or eldercare sub-samples.

**Figure E17: Relationship Between Where the Dependent Lives and Family Outcomes**

**a. Sandwich Group (% high family satisfaction, family adaptation, family integration)**

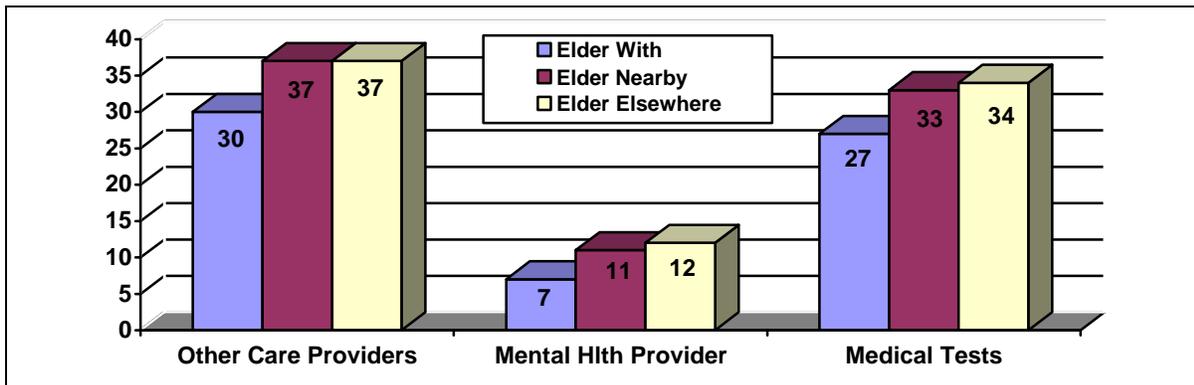


**b. Eldercare Group (% high family satisfaction, family adaptation, family integration)**



**Figure E18: Relationship Between Where the Dependent Lives and Societal Outcomes**

**a. Eldercare Group (% Indicating Personal Use of Following Services in Last Six Months)**



## Appendix F

### Interview Guide for Employed Caregivers Study and Cover Letter to Participants

Hello, my name is [insert name] and I am calling on behalf of VON Canada.

I am returning the call of [Name]?

If unavailable, leave a message to call back.

From your message, you have expressed an interest in participating in the interview to discuss your experience as an employed caregiver? Are you still interested?

yes  no → If **no**: Thank them. End call.

First, I need to confirm a few questions to ensure that you can are able to participate.

Have you been a caregiver to a person over the age of 50 for at least 6 months?

yes  no → If **no**: Thank them. End call.

Are you employed more than 10 hours a week?  yes  no → If **no**: Thank them. End call.

Do you care for someone who either lives with you or in their own home (not a hospital, long-term care facility, residence, etc.\*\*)?  yes  no → If **no**: Thank them. End call.

(\*\*NOTE to Interviewer: They may be currently in the hospital, but expected to be released to their own home within the month.)

→ If **yes** to all 4 above questions:

Thank you for your answers. You are eligible to participate in the study. First, let me review the purpose of the research and list the risks and benefits.

- It is a 10-month project and funded by Human Resources and Skills Development Canada to look at paid work and caregiving responsibilities.

The purpose of this interview is to explore how caregivers strive to balance their work responsibilities with their caregiving role? What is it that helps them balance these roles or not? What are the circumstances that facilitate and/or prevent this ‘balancing’?

- The interview will be audio taped to support the analysis of the data. The tapes will be stored in a locked cabinet until they are destroyed. Names and other identifying information will not be shared with the funder, Human Resources and Skills Development Canada, or included in the material produced by the project to ensure confidentiality.
- Are you ok with this interview being audio taped? Yes No
  - If yes, proceed with recording the call by pressing play.

- No, ask what are the concerns? Address concerns if possible, otherwise thank them and end interview.
- So just to confirm, you consent to this interview and are aware it is being taped?
- Thanks! Just a bit more background information. While the issues raised will be personal in nature, I hope to create a safe environment during the interview so that you can share your thoughts. If you experience some difficulties with the process or uncomfortable answering the question, you can ask to skip a question or you may end the call at any time.
- Therefore, your participation is voluntary.
- Your participation will not affect the level of service you currently receive from VON or your employment status.
- There are no direct benefits to you personally for the participating in the study. Study results will help policy makers to understand the experiences of employed caregivers. The results may help direct research and policy development thereby benefiting caregivers in the future.
- If you are not sure what the questions is, please feel free to ask for clarification at any time.
- This is a brief overview. Do you have any questions about the project and/or interview?
  - yes       no
  - ➔ If **yes**: Answer any questions they may have.
  - ➔ If they have no further questions and express interest in participating, ask:

Are you available now for the 45 minute interview or should we schedule another time to call back?

- yes   proceed to interview.
- no    Thank them and schedule a date and time to call back.

Date: \_\_\_\_\_ time: \_\_\_\_\_

## Interview Questions

**The first couple of questions are related to your caregiving situation, to help us understand who provides care and who you are caring for.** I will be asking progressively more personal questions. Some may seem obvious (like your gender), but I would like the answer recorded on the tape to support data analysis.

What are the first three digits of your postal code?

Your age?

Your gender?

Are you married/living with a significant other?

Do you have any children currently living at home?

If yes:

- How many children?
- How old are they?
- How many hours per week do you spend caring for the child/children?
- If you have partner: How many hours per week does your partner spend in childcare?

How many persons over the age of 50 are you currently caring for?

For each person ask:

- Gender of person you care for
- Age of person
- Relationship of person to you
- How long have you been caring for him/her?
- Do you live with him/her?
- If not, how far do you need to travel to provide care? How often?

Why have you assumed the role of caregiver?

(prompt: How much choice do you have in terms of your taking this role?)

**The next couple of questions deal with the demands associated with being an employed caregiver.**

Approximately how many hours per week do you spend:

In paid employment?

Caring for the person(s)?

Commuting because of caregiving commitments?

I am going to list a few things other caregivers have found to be difficult in their role as a caregiver.

How often do any of these apply to you?

(Never, monthly, weekly, several times a week, daily)

- Caregiving is a physical strain?

- Caregiving is a financial strain?
- Caregiving leaves me feeling overwhelmed (i.e. I worry about how I/we will manage)?

If they answered several times a week or daily ... ask them:

In what ways is it a physical strain?  
 In what ways is it a financial strain?  
 In what ways is it overwhelming?

Research in this area has identified five different roles that individuals can assume when providing care to someone else. I am going to describe each of these roles and then ask you a couple of questions about them.

First Role: Personal Care (dressing, bathing, lifting, feeding, toileting, grooming)

- How much time per week do you spend engaged in these kinds of activities?

Second Role: Physical (house cleaning, shopping, errands, repairs, transportation, preparing meals)

- How much time per week do you spend engaged in these kinds of activities?

Third Role: Nursing Care (medication administration, changing dressings)

- How much time per week do you spend engaged in these kinds of activities?

Fourth Role: Support (maintaining social interaction, visiting, supervision [related to forgetfulness or frailty], emotional support, reassuring and validating attitudes or perceptions, managing depression, anxiety and pain)

- How much time per week do you spend engaged in these kinds of activities?

Fifth Role: Coordination of Care (linkage between the care recipient and the formal service sector, identifying needed services and locating them in the community, gaining access to services, making appointments, attending information sessions, check- ups, managing financial matters)

- How much time per week do you spend engaged in these kinds of activities?

Which of these roles do you find most difficult or troubling? Why?

How would you characterize the health status of the person you provide care to?  
 Prompts: Acute (less than six months)? Chronic (over 6 months)? Episodic?  
 Palliative/end of life?

What kinds of rewards do you get from caring for others? If any?

What are the challenges you currently face with respect to providing care?

- Personal challenges (i.e. health)?
- With the person you provide care to? (i.e. behaviour, mental health, quality of the relationship)
- At home?
- At work?
- Within your community?

How do you cope with these challenges?

- What do you personally do?
- What does your person(s) you care for do? Are they aware? What else could they do?
- What does your family do? Are they aware? What else could they do?
- What does your employer currently do? Are they aware? What else could they do?
- What does your community currently do? Are they aware? What else could they do?
- How about the government? Are they aware? Is there anything more they could do?

What one thing could each of the following groups do to help you care for your person?

- Your family
- Your employer?
- Your community?
- The government?

What one piece of advice would you offer to a friend who has all of a sudden assumed care of someone else due to a physical, mental or cognitive condition?

What one piece of advice would you offer to the government in terms of supporting employed caregivers in Canada?

Is there anything else you wish to share at this time?

Thank you for your time and sharing your experiences, this concludes the interview.

NOTE to Interviewer: Turn off tape now.

Are you interested in receiving a copy of the final report?

If yes, collect contact information.

Thank you!

If you have questions about this project following this call, you can call Bonnie Schroeder, Project Manager at 888-VON-CARE.



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February 27, 2009

**Project Title:**

A Closer Look at Family Caregivers: Paid Work and Caregiving Responsibilities

**Primary Investigators:**

Linda Duxbury and Chris Higgins, Higgins, Duxbury and Associates Bonnie Schroeder, Project Manager, Public Affairs and Community Engagement, VON Canada

**Funder:** Human Resources and Social Development Canada

**Invitation to Participate:**

**You are being invited to participate in a research study as a caregiver who is employed in the paid labour market.**

In order to understand if you want to be part of this study, the letter will outline the involvement, potential risks and benefits, and other details of the study. Once you understand the study, you are asked to call the Research Assistant to participate in the study. Please take you time to make your decision.

Bonnie Schroeder, Linda Duxbury, and Chris Higgins are conducting this study as part of a larger study on paid work and caregiving responsibilities. Other parts of the study include a literature review and analysis of an existing data set of employed caregivers owned by Higgins, Duxbury, and Associates.

**Who should participate?**

Are you a caregiver or have been a caregiver to an adult?

Are you employed more than 10 hours a week or employed for more then 10 hours during your caregiving?

Do you care from some one who lives either with you or in their own home (not a hospital, LTC facility, or care residence)?

(Note: If you expect them to be released from hospital within a month, you are still eligible.)

If you answered yes to these questions, please read on before making you decision to participate in the study.

**Why are we doing this study?**

The purpose of this study is to profile caregivers who are in the paid labour force and to examine factors that affect their ability to balance work and caregiving responsibilities. Which caregivers feel they are able to balance their work responsibilities with their caregiving role? What is it that helps them balance these roles? What are the circumstances that facilitate the 'balancing'?

**What will happen during the study?**

You will be asked a series of questions related to your experiences as a caregiver who combines paid work and caregiving responsibilities. We are expecting to interview 50 caregivers in similar situations balancing paid work and caregiving responsibilities. The interview will be audio taped to support

the analysis of the data. The tapes will be stored in a locked cabinet until they are destroyed. Names and other identifying information will not be shared with the funder or included in the report to ensure confidentiality.

**Will there be potential harm during the study?**

While the issues raised will be personal in nature, we hope to create a safe environment so that you can share. If you have trouble with the process or uncomfortable answering the question, you can ask to skip a question and we will move to the next one.

**What are the benefits if I participate in the study?**

There are no direct benefits to you personally for participating in this study. Study results will help policy makers to understand the experiences of employed caregivers. The results may help direct future research and policy development.

**Who will know what I said or did in the study?**

Elaine Owens, a Research Assistant with VON Canada, will conduct interviews. The Principal Investigators, Linda Duxbury and Chris Higgins will analyse the interview results; however, your name will not be attached to the interviews being analysed. The findings will be included in a report to Human Resources Social Development Canada as part of the deliverables for the project. Again, personal information or other identifying information will not be included in the report to the funder. Your personal information collected in this form is for this research project only. This information will be kept in confidence. This information will not be used for any other purpose or disclosed without your consent.

**What if I change my mind about participating in the study?**

Your participation is voluntary. You may decide to withdraw from the study at any time with no further consequence to you. Your participation will not affect the level of service you currently receive from VON or your employment status.

**Will I have access to the final report?**

The written report of the study will be available to you if you wish.

**Who do I contact to participate or for more information?**

If you want to participate in an interview or have questions about this project, please call Elaine Owens at [Elaine.owens@von.ca](mailto:Elaine.owens@von.ca) or 1-888-VON-CARE or Bonnie Schroeder, Project Manager at [bonnie.schroeder@von.ca](mailto:bonnie.schroeder@von.ca) or 1-888-VON-CARE.