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Full-Time Employed and a Family Caregiver: A Profile of Women's Workload, Effort, and Health

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A B S T R A C T

Background: Women provide care for elderly family members while managing their other responsibilities, including full-time employment.
Methods: This descriptive study used an inductively derived workload–effort–health theoretical model to examine workload, effort, and health among 46 full-time employed family caregivers [CG] of community-dwelling older adults from a larger, nonprobability, cross-sectional sample of 110 CGs.
Findings: The women's caregiving workload (time, difficulty, care recipient's [CR] function), effort (perceived exertion of energy experienced in doing a workload), self-assessed health [SAH], depressive symptoms, and sources of help were richly described, and several associations were found, including higher physical and mental effort, were significantly correlated with higher workload time and difficulty and lower CR function, but not SAH. Higher mental effort and workload, and poorer SAH were significantly correlated with high depressive symptoms. Worse effort, workload, and health experiences were reported by daughters and by women who lived with their CR; those who did not have family or formal caregiving help had higher mental effort and were more depressed, suggesting an area for further study.
Conclusions: Suggestions are offered for richer measurement of employment status, caregiving workload, and effort. Findings provide a unique profile of full-time employed women CGs' workload, effort (that is, how they do the work), and health, toward a stronger understanding of how women manage multiple workloads. Workplace policies are needed to address workload, effort and health in this informal caregiving workforce.

The informal workforce of family caregivers (CG) who are employed in addition to their caregiving responsibilities is expected to care for another while managing their other formal relationships and responsibilities. Of the 66 million family CGs in the United States (American Association of Retired Persons [AARP]/National Alliance for Caregiving [NAC], 2011), over half are in the paid labor workforce as well as in the informal caregiving workforce; and as many as 74% are employed within a given year (NAC/AARP, 2009) while also performing highly skilled and complex caregiving tasks (AARP, 2013). Most of the family-provided care is provided by women, according to national estimates suggesting that two thirds of CGs are women (AARP, 2011), and it is not unusual for women to leave the workforce for family care reasons. Many women balance multiple social roles including care provider and employee (Stephens & Townsend, 1997), with related stressors and rewards.

The aging of the U.S. population (Administration on Aging, 2013) suggests a continued and growing need for family-provided care. Valued at over $450 billion, family-provided care reflects a cost savings in the United States of well over double the cost of formal home-based and institution-based long term-care services for older adults (AARP/NAC, 2011). Yet, these cost savings to society may overshadow costs to the CGs' economic stability and health. This research, based on concern for the health and role functioning of this family caregiving workforce, addresses national initiatives to support family-provided elder care (National Institute of Nursing Research, 2011; National Institute on Aging, 2007) through an examination of workload, effort, and health in a sample of women CGs. If the caregiving workload is "what" these women do, then effort is "how" they do it.

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Background

Concerns Related to Managing Both Caregiving and Employment

For this analysis, we examined "full-time" employed women CGs: These women who manage family care and employment can be viewed as managing both paid and unpaid workloads. In the literature addressing CGs' employment circumstances (particularly in the context of U.S. economic circumstances), the term "full-time" is presumed to mean working a particular number of paid hours (generally 40 hours weekly). Yet several categories of employment status are not mutually exclusive, and without consistent terms to describe CGs' employment status, the meaning and magnitude of "employment" is not easy to reconcile in published study findings. What is suggested in literature, however, is that CGs have competing demands of their paid job and their unpaid caregiving commitments and may experience transitions in their paid employment (Metlife, 2010). With concerns about earning potential, missed opportunities for career advancement, and lost employment-related benefits when they need to decrease their amount of paid work or leave the paid workforce (Metlife, 2010) these CGs' unpaid care is not reimbursed, adding strained household income to their care-related stressors. Competing demands manifest as tension between job-related productivity and caregiving responsibilities (Covinsky et al., 2001; Juratovac, 2009; Trukeschitz, Schneider, Mülmann, & Ponocny, 2013) in that caregiving may interfere with work, such as attendance and productivity (Fisher, Bulger, & Smith, 2009; Giovanetti, Wolff, Frick, & Boult, 2009) and work may interfere with caregiving (Reid, Stajduhar, & Chappell, 2010).

CG Health in Work–Effort–Health Context

CGs' health, both physical and mental, is adversely affected by factors in the caregiving experience, especially when CGs are compared with their non-caregiving counterparts (Amirkhanyan &Wolf, 2003; NAC & Evercare, 2006; Pinquart & Sörensen, 2003; Vitaliano, Zhang, & Scanlan, 2003). Several factors and interactions may be influential, such as age, health, and employment. Employed CGs have the potential to be managing their own chronic, comorbid health conditions while caring for another, so their health should be of concern. And, many CGs are elderly themselves (Johnson & Schaner, 2005) while providing care for other elderly family members (AARP, 2011). Thus, family CGs can be viewed as an aging workforce who may leave the paid workforce for reasons that are health related or caregiving related rather than for "retirement."

The purpose of this study was to profile the "working woman" through the lens of the workload, effort, and health experience of women who are employed full time and providing care for elderly family members. The analysis was informed by an inductively derived workload–effort–health theoretical explanation for caregiving (Juratovac, 2009; Juratovac, Morris, Zauszniewski, & Wykle, 2012), the "stress–process" framework (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995; Pearlin, Mullan, Semple, & Skaff, 1990), and the "demand–control" (Hockey, 1993, 1997; Molloy et al., 2005) framework. Two types of effort (i.e., perceived exertion of energy in response to a caregiving workload) that families experience and physical and mental effort, have been described in previous research with family CGs of older adults (Juratovac et al., 2012), and those findings are the first description of effort and workload outside of industrial workplaces. A premise from a workload–effort–health perspective that is foundational to this research that is people may not be able to decrease their workload demands, but they can manage their effort: Managing one's energy exertion while managing a workload may be protective against adverse compensatory health effects that are thought to be associated with workloads involving high demand and high, sustained effort (Hockey, 1993, 1997; Juratovac et al., 2012). Thus, it is vital to examine the workload, effort, and health of full-time employed women CGs who are managing multiple roles, relationships, and responsibilities as they balance employment and caregiving.

To explicate a profile of full time employed women CGs of elders in terms of their caregiving workload, physical and mental effort, and health outcomes, the following research questions were addressed: 1) Are characteristics of the women CGs (age, ethnicity/race, marital status, education, and income), their care recipients (CR; age, number of health conditions, and functional status), and the caregiving situation (relationship to CR, living situation, and availability of help) associated with their: a) caregiving workload (time and difficulty)? b) effort (physical and mental)? and c) health outcomes (self-assessed health [SAH] and depressive symptoms)? And 2) What are the relationships among caregiving workload, effort, and health outcomes in full-time employed women CGs of elderly CRs?

Methods

Design

This descriptive, correlational, secondary analysis used existing, cross-sectional data from a multimethod study of family CGs of older adults.

Sample

The sample for this analysis was 46 women CGs who were employed full time outside the home, from a parent study of 110 family CGs. After approval from our institutional review board, parent study CGs were recruited from public businesses and institutions; and from a multi-agency site that served older adults and family CGs, through January 2009. Eligible CGs were responsible for care or supervision of an older adult ($\geq$60 years) living in the community, who needed help because of a physical or behavioral condition. The sample size ($n = 46$) was sufficient for examining descriptive statistics and associations (Student's t test for differences and Pearson's product moment "r" for correlations, based on the workload, effort and health variables) with an estimated effect size of 0.40, at an alpha set at 0.05 and power of 0.80 (Cohen, 1992).

Human Subjects and Consent

The research packet mailed to participants contained a research questionnaire and a written consent form explaining the study, and potential participants were screened by telephone, with an opportunity to verbally clarify information. Because a waiver of signed consent was granted by the institutional review board, only de-identified questionnaires were returned and contact information was not retained. Thus, the packet also included a handout with information on mental health resources for CGs who might recognize feelings of stress or distress. The response rate for the mailed survey was 85%.