

Caregiving To Aging Parents

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Abstract

It is a well-established fact that the United States is an aging society. Increasing longevity and life expectancy has increased the number of elderly persons with chronic health conditions who are in need of special social services and caregiving by family members. Due to the fact that the aging population has grown significantly, the need for adult children to care for their parents has increased dramatically (Atchley and Barusch, 2004, p. 221). Currently, many of the large cohort of baby boomers (persons born between 1946 and 1964), who will become a part of the elderly population of the future, are caregivers for their aging parents. The baby boomers of today are likely to spend more years caring for a parent than for children (Federal Trade Commission, 1998). These social changes and population trends have created the need to gain a better understanding of the patterns of caregiving by adult children to their aging parents and how adult children can assist their parents in managing and planning for the consequences of aging.

The purpose of this paper is to examine the patterns of caregiving by adult children to their aging parents. The specific objectives are: (1) to describe the demographic realities that create the need for caregiving; (2) to present two alternative theoretical perspectives on caregiving to the elderly; (3) to enhance understanding of how family relationships influence patterns of caregiving to aging parents; (4) to discuss the importance of planning for caregiving by adult children with their aging parents; and (5) to apply relevant case material to illustrate several major points presented throughout the discussion.

Demographic Realities

In 2005, there were 36 million people age 65 and over in the United States, who represented 13 percent of the total population. By the year 2050, the projection is that one in every five residents or 82 million people will be age 65 and over (U. S. Bureau of the Census, 2000). Life expectancy of the average citizen has increased to almost 80 years. The 85-plus population is the fastest growing age group in America and is expected to triple in size between 1980 and 2020, from 2.3 million to 6.9 million (U. S. Department of Human Services, 1987, p. 15). The National Alliance for Caregiving (1997) reported the following findings:

- Nearly 25% of the U. S. households, or 22 million people, are involved in family caregiving for an older relative or friend;
- Almost three-fourths of caregivers are women;
- The typical caregiver is a 46-year-old employed woman who spends 18 hours a week caring for her mother, who lives within a short drive;

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- A typical care recipient is a 77-year-old woman living alone with a chronic illness that restricts her activities of daily living;
- Nearly one-third of caregivers are caring for two or more elderly relatives or friends;
- Transportation to medical appointments, grocery shopping, and help with household chores are the most common types of assistance provided by caregivers;
- Almost 40% of caregivers are caring for under-age children;
- Approximately 4.1 million caregiving households are involved in “intense” caregiving of 40+ hours per week;
- Nearly 70% of caregivers feel positively about their caregiving role;
- Caregiving costs U. S. employers \$29 million annually in lost productivity, or \$3,142 annually per employee providing care; and
- Caregivers spend over \$2,000 annually on un-reimbursed out-of-pocket expenses associated with caregiving.

These demographic realities have increased the need, scope, and challenge of caregiving in the U. S. population.

Exchange theory and modernization theory are two alternative theoretical frameworks that can enhance our understanding of the factors that influence different patterns of caregiving. Although exchange theory is a micro-level theory and modernization is a macro-level theory, these theories provide alternative perspectives for understanding the phenomenon of caregiving. In the next section, the main tenets and propositions of each of these two theories are briefly discussed.

Exchange Theory and Caregiving

Exchange theory may be useful in explaining the relationships between the caregiver and the care recipient. Exchange theory, which originated with the work of Homans (1961) and further

developed by Blau (1961), attempts to explain how certain factors influence patterns of interaction and relationships between two actors. Based on the tenets of exchange theory, relationships between the caregiver and care recipient depend on the capacity of the actors to mutually reward one another with something of value (Emerson, 1972). For example, in an exchange relationship, resources that may be used to reward others may include assistance with personal grooming, housework, money, information, affection, approval, labor, compliance, or various types of material support. If one actor has a lower capacity to reward the other person in the relationship, then the actor with less exchange resources is assumed to be more dependent in the relationship.

Dowd (1975; 1980), who was among the first to use the exchange theory in social gerontology, advanced the argument that aging affects exchange relationships in the sense that people desire to profit from social interaction with others and that profit consists of a perception that the reward coming from the interchange outweighs the costs. The ability to profit from an exchange depends on the exchange resources that the actors bring to the exchange. When resources are reasonably equal, then a mutually satisfying interdependence may emerge. However, if one of the actors has substantially fewer exchange resources, then the actor's ability to profit from the exchange can be sharply restricted. In other words, actors attempt to maximize their rewards and minimize their costs in their interactions with others. Exchange relations that get too far out of balance may lead to unstable relationships that could have negative consequences for both the caregiver and care recipient, such as stress, role strain, feelings of guilt, and feelings of dependency.

One of the most common patterns of exchange relationships occurs within the context of the family, where adult children are the caregiver for aging parents. Exchange relationships among family members develop at different intervals over the life course of the parties involved and may be shaped in different ways by various factors, including resources, social class, gender, ethnicity,

personality, health, residence, and the duration, intensity, and quality of the relationship between the caregiver and care recipient.

Modernization Theory and Caregiving

Unlike exchange theory, which is a micro-level theory, modernization is a macro-level theory, which deals with the influence of societal changes on social roles, relationships, and resources, which may directly or indirectly influence caregiving. Modernization theory proposes that the processes that cause society to change from a traditional social system to a modern industrial social system may change the status that older people occupy in society and the esteem afforded to them individually as members of a social category (Atchley and Barusch, 2004, p. 45). Modernization may give rise to new ways of thinking and doing things that lead to changes in roles and norms of family members, such as the use of modern medical technology, increase in cost of living, changes in the structure and requirements of work (e.g., increased specialization, rationalization, standardization, and formalization), new communication techniques, increased geographical mobility, increase in complex, bureaucratic, impersonal organizations, changing political and governmental interventions, increase in the production and use of scientific knowledge, and universal education.

Societal changes may have positive and negative consequences for individuals and groups in society. For example, some scholars have explained how factors associated with modernization have devalued the status of older people in society: demographic trends produce a higher proportion of older people in the population; increase in use of technology has reduced the demand for workers and heightened the competition for jobs between the old and young; new types of jobs have reduced the demand for the experience and skills of older people; retirement has lowered the social value of

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older people and reduced their income; child-centered education outside the family has made obsolete the knowledge, skills, and roles in parenting and grandparenting; and urbanization has often left many older people behind in rural areas or economically depressed and socially isolated areas (Cowgill, 1972; 1974; 1986).

Leo Simmons (1945), an anthropologist, conducted one of the earliest studies of the effects of modernization, using a cross-cultural group of 71 societies. Simmons concluded that in relatively stable agrarian societies, elders usually occupy positions of honor, favor, and power, mainly due to the norms of seniority rights. However, when the rates of changes increase, older people lose their advantaged status. From a sociological perspective, Cottrell (1960) saw modernization as creating conditions that lead to more complex forms of organization, including the family. In such families, older members lose many of their dominant roles in making family decisions and performing family functions. Accordingly, family roles shift from ascribed to achieved roles and statuses, which influence the distribution of power and resources and pattern of relationships among family members. The lower status of older people in the family tends to limit their roles and choices, reduce their authority, and thus, make them more dependent on other family members. In this way, modernization may influence caregiving exchange relationships between adult children and their aging parents.

Some critiques argue that some theorists and researchers emphasize the negative effects of modernization and place less emphasis on the positive effects of modernization. Notwithstanding the negative effects resulting from technological advancements, modernization has raised the level of education, increased the level of income, vastly improved health and medical technology, and created many scientific discoveries and breakthroughs, which have significantly increased the

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quality and quantity of life. The death rate has decreased sharply over the past century and advanced medical technology has produced effective treatments for many diseases. The life expectancy for the total U. S. population has reached 78 years and the 85-plus population is the fastest growing age group in the nation.

Other critiques argue that modernization is a continuing and uneven process, thus, making it difficult to determine the degree or direct source of the societal influences. Moreover, changes in values, attitudes, beliefs, knowledge, and practices comprise a complex process that may precede modernization at the initial point, which raises the age-old question of “did the chicken come before the egg?” However, we do know that at some point, advanced technology does change the ways in which we live and make decisions that influence family life and functioning, including caregiving relationships between adult children and their elderly parents. Accordingly, modernization theory can be useful in explaining how aging and treatment of older persons as a social category have changed within a given period of time. This theory may also be useful in explaining why and how certain societal changes influence the structure and dynamics of caregiving to the elderly population.

The Family Context of Caregiving

The family is the major source of caregiving. Coward (1992) reported that 85% of the older people sampled received assistance from their family, 10% received assistance from friends, 15% received assistance from paid household workers, and 13% received assistance from social service agencies. Family members tend to provide personal care, while friends tend to provide emotional support. Older people tend to feel that family members are obligated to provide personal care and do not expect much personal care from friends (Antonucci, et al., 1996). As one might expect, caregiving from family members and friends can reduce the need for institutional care for older

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people.

Although most elderly persons are able to live independently, taking care of an elderly family member is a concern of approximately five million people each year (Blieszner and Alley, 1990). Approximately 7.3 million adults provide unpaid caregiving to an ill, frail, or disabled relative and an estimated 38% of these are adult children (American Society on Aging, 2002). The spouse is the primary caregiver for a large percentage of married older persons who need care, while adult children are the next most common source of caregiving for older parents (Atchley, 2004, p. 212). Spouses make up 42% of the caregivers (23% are wives and 19% are husbands). Children are the secondary caregivers when the spouse is present and the primary caregiver when the spouse is not present or unable to assume the caregiver role.

The typical caregiver is a 46-year-old employed woman who spends eight hours a week caring for her mother, who lives only a short distance away. The majority of caregivers are employed and have children of their own. This means that many adult children who have the responsibility of caring for their own children, have the added responsibility of caring for their aging parents. Often this requires the caregiver to juggle the competing demands of family caregiving with employment and parenting their own children. These multiple roles may necessitate making changes in their daily work schedule and arrangements for their children. Sometimes this leads to role conflict and role strain within the family or between the family and the job. About one-fourth of employed caregivers reported having family conflict arising from caregiving (National Alliance for Caregiving, 1997). In one-fifth of all caregiving homes, children under the age of 18 are present and approximately 44% of caregiving daughters and 55% of caregiving sons are employed in the labor force (Cantor, 1983; Stone et al., 1987). Employed adult children provide a similar number of hours

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of assistance to their aging parents compared to non-employed adult children, although the tasks may vary (Brody and Schoonover, 1986; Cantor, 1983).

Most aging parents prefer receiving caregiving in their own residence or home. Parents who live with their children may make caregiving more convenient. However, the disadvantages of such an arrangement could be loss of privacy, parental interference, role conflicts, and added stress. About 20% of elderly people live with their children or in multi-generational household, usually shared with one or more of their children. Some older parents are cared for by their daughters, some by their sons, some in their own household by unmarried children, and some in multi-generational households by their married children. Some older parents are cared for almost exclusively by one adult child, while others are cared for by a network of adult children who share responsibilities. About 29% of caregivers are adult daughters and nine percent are sons (American Society on Aging, 2002). However, a study by Raymond Coward (1992) reported that 41% of mothers included in his study received care from adult daughters, compared to 20% from adult sons; also, 20% of fathers received care from daughters, compared to 15% from sons. The type of caregiving tasks performed by adult daughters for older parents include shopping, household work, bathing, dressing, and eating (69%); handling finances (59%); administering medication (57%); and assistance with ambulation (44%). Adult sons are more likely to perform caregiving tasks such as providing transportation and helping with physical mobility. Adult children on average provide about four hours of care per day (National Alliance for Caregiving, 1997). A number of factors influence decisions concerning how much care adult children provide for parents, including parent's sex, age, marital status, and level of functional disability (Checkovich and Stern, 2002, p. 444).

Studies have found that caregiving has an intense impact on the caregiver's lifestyle,

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including increased stress due to confinement, relinquishing job to take care of an elderly family member (9%), changing work schedule (29%), reducing hours of work (21%), and taking time off from work without pay (19%) (Blieszner and Alley, 1990). Other sources of stress include conflicting work and caregiving responsibilities, work absenteeism, work interruptions, job turnover, and missed opportunities (Scharlach and Boyd, 1989). An elevated level of stress of caregiving usually result from the demands of caring for severely impaired elderly persons, disruptive lifestyle, lack of sources of relief, and high levels of perceived burden (Blieszner and Alley, 1990).

Patterns of Caregiving for Aging Parents

Silverstein and Litwak (1993) developed a topology of caring that included two different categories of support tasks performed by the primary caregiver to elderly parents: household tasks and social-emotional support tasks. These tasks were further sub-divided into four patterns, including isolation, obligatory, modified-extended, and traditional. Their study revealed that most elders fit the modified-extended pattern (40%), in which they receive only social-emotional support, or the traditional pattern (45%), in which they receive both social-emotional and household support, 12.2% were isolated, 1.1% received neither social-emotional nor household support, and 1.7% fit the obligatory pattern, in which they received household support only and no social-emotional support. Older persons who were not married and who were disabled were significantly more likely to follow the traditional pattern than the modified-extended pattern of care. Other factors which correlated with having a traditional family support structure included ethnicity (being Hispanic), having a large number of adult children, living in close proximity to adult children, and having unmarried adult children.

Using content analysis of the responses of a total of 70 caregivers who were rendering care to

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impaired parents, Albert (1990, pp. 323-324) found that attitudes about dependency and obligation reflected shared knowledge in a culture of caregiving. Four attitudinal patterns of caregiving were derived from the responses of the caregivers, including: (1) caregiving as a return to one's parents; that is, children return care for a parent in need, who once provided care for them, from which a feeling of gratification is derived; (2) caregiving as caring for a part of oneself; that is, caregiving is seen as an extension of one's own bodily connection to the parent; (3) the impaired parent is viewed as an ill person and the caregiver stresses the need to help an ill person, without trying to assume the role of parent; and (4) the impaired parent is viewed as a child, due to dependency resulting from illness of the parent.

Effectiveness of Caregiving to Aging Parents

How effective do adult children feel they are in meeting their older parent's caregiving needs? Noelker and Townsend (1987) reported that about two-thirds of their sample of adult child caregivers felt that they were doing an effective job of caring for their older parents. Factors associated with a positive perception of caregiving effectiveness included having less impaired older parents, using community support services, having other family support and formal support workers who cooperate in providing care, and maintaining a positive view of the caregiving situation. However, as the amount and intensity of care increases, and as difficulty in finding people or community support services to help increases, so does the level of stress involved in caregiving.

Negative perceptions of caregiving were more likely to occur when the caregiver felt distressed and overwhelmed and when the older parent was more impaired. The more impaired the older care recipient, the greater the reluctance of the older person to accept community support service workers as caregivers. Caregivers were more likely to view caregiving negatively when the

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parent was perceived to be too dependent, too demanding, critical, or unappreciative of the child's efforts, and when the child felt that she or he could never do enough no matter how much was done (Mui, 1995). Under such negative conditions, caregivers were more likely to feel a high level of strain in their role as caregiver (Mui, 1995). Sometimes caregivers struggle with guilt because they feel that they have failed in some aspect of their caregiving or did not meet their own expectations, which may be unrealistic and detrimental to their mental health. Accordingly, as our older population ages, the proportion of adult children to older parent caregiving situations that encounter difficulties can also be expected to increase.

Planning for Caregiving

Planning for aging is a completely logical and rational need, considering the fact that most persons will reach old age. After all, we plan for our education, career, marriage, vacations, and retirement. However, many people have the perception that caregiving is a natural and emotional response by a family member to take care of another family member who has a chronic health problem. While helping to care for an aging family member certainly plays an important role, it should begin with planning for aging at an earlier stage of life and continue during the latter stage when critical needs arise due to chronic health conditions (Aging Parents, 2003). In this regard, planning for caregiving ideally involves anticipation of future needs and preparing for how these needs will be met in a later stage of life. This concept has been referred to as anticipatory socialization, which means the process of learning how to take care of a need before the need actually arises (Atchley and Barusch, 2004, p. 165). We know that if we continue to live, we will inevitably grow old and face some type of health conditions that will create the need for short-term or long-term care. Aging is less difficult to deal with if we think about it and plan for it before

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critical needs occur. However, many people reach old age without having made adequate plans for chronic health conditions that they may experience. They pretend that aging is not happening to them. Sometimes they deny or avoid the issue altogether until a crisis occurs (Aging Parents, 2003) They fail to follow the wisdom found in the adage that it is better to prevent a crisis than to resolve a problem in the midst of a crisis.

Why do many people fail to plan for getting old? One of the main reasons for failure to plan for old age is denial of aging. Denial may be defined as an unwillingness to accept reality or avoiding a problem, situation, or responsibility. It may even be an unconscious defense mechanism characterized by refusal to acknowledge painful realities, thoughts, and feelings. Denial can be a major emotional barrier to planning for aging. Many aging parents deny the fact that they are aging for several reasons. They fear their own mortality and believe that by talking about sickness or death will actually bring it on. They do not want to alarm their children about issues they think will make them feel uncomfortable. They lack sufficient information to approach the subject of aging confidently, so they may avoid the issue altogether. They do not realize the consequences and dangers that denial can have on them, as well as the entire family. Likewise, many adult children deny the fact that their parents are aging. Often times they fear losing the parent, do not have enough information to make a decision confidently, or do not want to make their parents feel uncomfortable, or remain at a distance from their parents to avoid having to deal with a problem or situation (Aging Parents, 2003). Consequently, they are unprepared to deal with a crisis when it occurs.

Many life situations and personal conditions may require aging persons to involve their adult children in planning for old age. However, many older aging parents find it difficult to plan for their

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aging with their adult children. They may be hesitant to ask their children to assist them in planning. They may fear losing their privacy and independence. They may see their needs as their private business and are reluctant to involve family members. They may see their adult children as dependents or not having the capability to help them with financial or health matters. They sometimes do not want to bother their children with their personal problems or needs. Adult children should be aware of how their parents feel about their aging experiences.

Adult children, however, must know how to assess their parent's needs in a non-threatening way in order to facilitate caregiving to their parents. Some simple but thoughtful ways to assess the parent's needs, while performing the role of caregiver for aging parents are: offer to assist them with financial matters, help around the house, shop for groceries, take the car in for an oil change, manage the bills, and make decisions with parents rather than for parents. Adult children who are caregivers should not deprive their parents of their dignity and independence. And most important, adult children should remain an active part of their parent's life.

Another part of the problem for many families is that adult children do not know how to help their aging parents. They may see themselves as children who should not interfere in their parent's business unless they are asked to do so. As odd as it sounds, many adult children simply find it difficult to communicate with their parents about sensitive, personal matters or business of their parents. Often they are not well-versed on how to shift roles, where they assume the lead role as a decision maker or take on the responsibility of caregiver. Some adult children may feel uncomfortable in discussing personal matters with their parents or think they may make their parents feel uncomfortable. For example, adult children may suspect that their mother may be developing Alzheimer's Disease, but never discuss their mother's needs or plans with her. When a crisis occurs,

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it may be too late to adequately plan or resolve the problem.

In order to provide effective caregiving, adult caregivers and their older parents must have the necessary information to permit them to make the best decision for a given matter. Sometimes adult children tend to provide caregiving based on their perceived need of care for their parents. Factors such as residential proximity, functional health status of the parent and the caregiver, practicality, and the needs of the family of the caregiver, may influence the quality and quantity of caregiving to aging parents. In order to provide adequate care for parents, it is necessary for adult children to gather essential information from reliable sources, such as doctors, nurses, social workers, and the parents. Lack of information may lead to hasty decisions and impulsive actions that seriously impair the ability of adult children to make good and rational decisions about caregiving (Atchley and Barusch, 2004, 213).

Effective communication is an important element of caregiving. Whenever possible, decisions to provide care should be a joint decision between the adult child and the older parent. Cicirelli (1992) found that adult daughters who grew up in traditional paternalistic households were more likely to take over decision making from their parents (Cicirelli, 1992). Paternalistic decisions were more likely to be made with regard to health and financial decisions than decisions about daily routine living. Some have referred to this form of interaction between parent and child as role reversal, where the child assumes the role of “parenting” and the older parent assumes the role of dependent. However, paternalistic decision making by adult daughters is not so much a reversal of roles, but rather involves borrowing ideas from their mother about how to provide caregiving in different situations (McGrew, 1991). It should also be noted that communication between adult children and their aging parents is a two-way process that usually involves reciprocity between the

parties.

The following two cases, involving caregiving to aging parents by adult children, illustrate many of the points mentioned in the preceding sections.

Case Study #1

Mrs. Hamilton is a married black female, approximately seventy years of age and a retired university professor of American Literature. Mrs. Hamilton is the primary caretaker of her ninety-two year-old mother who lives with her. The caregiver is ambulatory, verbal, and energetic. She does have some health problems such as hypertension and arthritis which are controlled by medication.

Mrs. Hamilton is highly responsive to the needs of her mother. She assumes total responsibility for medical appointments, transportation to appointments, meal preparation and housekeeping duties. The caregiver's mother suffers from dementia, which is a syndrome, a constellation of symptoms and characteristics that requires multidimensional assessment and treatment (Blanche, 2005). Mrs. Hamilton is well aware of the many problems associated with caring for her mother. She provides her mother with a very safe and secure environment. She attends local seminars given by social service agencies in order to receive training, understanding and awareness about her mother's illness. Mrs. Hamilton realizes that caretaking responsibilities are enormous but despite the difficulties of caring for her ninety-two year-old mother, she does not feel the usual caregiver grief issues such as anger, negativism, or denial. She does however complain of

being tired but not “burned-out.” Mrs. Hamilton continues to perform the duties of a loving and compassionate daughter.

The caregiver, Mrs. Hamilton, does receive some social and emotional support from her husband, who continues to work full-time as a college professor. He also helps to provide financial assistance to his wife’s mother. He is understanding and supportive but leaves the responsibility for care giving to his wife. Their children are grown and are living outside the state of Louisiana.

Mrs. Hamilton involves herself and mother in church related activities. Meditation, prayer, church music and scriptural reading are a daily part of her life. Church music is played extensively in their home. Mrs. Hamilton has learned from various educational seminars that the power of music has proven to be very stimulating for elderly patients. Moreover, music, when used appropriately with elderly patients, can help to manage stress-induced agitation, stimulate positive interactions, facilitate cognitive functions, and coordinate motor movements (Clair, 2005).

Social interactions for Mrs. Hamilton comes primarily from her spouse, extended family members, minister, and church family. Mrs. Hamilton looks forward to the opportunity for social interaction with other family members and friends. Due to the nature of her mother’s illness, Mrs. Hamilton has limited opportunity for social interaction and leisure activities.

Mrs. Hamilton is adamant about not placing her mother in a nursing home, and on several occasions she expressed that she would never place her mother in a nursing home. Staples (1976) maintains that the black elderly kinship network and bond is very cohesive and extensive. Moreover, Staples further indicates that census data supports this hypothesis through statistics which show that

a larger proportion of black families take relatives into their households and care for them. Although caregiving is not an easy responsibility for Mrs. Hamilton, she receives joy knowing that her mother's quality of life is good and that she is active and well.

Since Mrs. Hamilton is the primary caregiver at age seventy, she is extremely vulnerable to caregiver mental and emotional strain. The combination of prolonged stress, physical demands of care giving, and biological vulnerabilities that come with age, places the caregiver at risk for significant health problems as well as an earlier death (Family Caregiver Alliance, 2005).

Mrs. Hamilton does not take good care of herself. She does not place emphasizes on herself as a caregiver. When the needs of the caregiver are taken care of, then the recipient of care giving will benefit as well. Thus, Mrs. Hamilton was encouraged to follow through on her own medical appointments and to follow a nutritious diet, and to conduct at home exercises to help relieve caregiver stress emanating from assuming multiple roles that compete for her time, energy and thought.

The caregiver is in need of physical, social and household assistance. Without assistance, it is doubtful if Mrs. Hamilton will be able to continue her role as the major caregiver, particularly in light of her own advancing age. Both medical and social-psychological intervention will be needed in the near future.

Case Study #2

Mrs. Thibodeaux is a seventy-three-year-old married black female. Mrs. Thibodeaux and her husband are both retired, well-educated college professors of chemistry and biology. Mrs. Thibodeaux's mother has Alzheimer's disease. She is ninety-five years of age. Both daughter and son-in-law are extremely attentive to Mrs. Thibodeaux's mother. Their only child lives away from home and in another state. She is unable to come home as frequently as she would like to for family visits.

Mrs. Thibodeaux provides excellent care to her mother. During the day, she makes arrangement for her mother to attend the local adult day care center for Alzheimer's patients. Mr. Thibodeaux, who at age seventy-six, is responsible for transporting his mother-in-law to the center each day. Mr. Thibodeaux is also responsible for transporting the family to all medical appointments, doing most of the grocery shopping, and assisting with meal preparation and housekeeping duties. Mr. Thibodeaux is highly supportive of his family and truly enjoys being the "man of the house".

Mrs. Thibodeaux spends considerable time with her mother in the evening and has indicated that the evening hours are the most difficult. Mrs. Thibodeaux was informed about the Sundown Syndrome in which some Alzheimer's patients experience. Mrs. Thibodeaux discovered that music can be very meaningful for patients with Alzheimer's. Mrs. Thibodeaux stated that, when she plays classical music for her mother, she experienced very "few behavioral problems" with her mother. Some of the behavioral problems that Mrs. Thibodeaux's mother demonstrated were stubbornness, wandering throughout the house repeatedly, insomnia, and aggression. Occasionally, she would

pack her suitcase and sit beside the door. Music has proven to be a form of intervention for her mother's behavioral problems.

Mrs. Thibodeaux's health is not too good and she was recently diagnosed with Parkinson's disease. Consequently, Mr. Thibodeaux has had to assume more responsibility for the household. His increasing challenges include assisting his wife with monitoring her medication intake and helping to take care of his mother-in-law's basic medical needs. Although, Mrs. Thibodeaux continues to provide as much care to her mother as possible, she is limited in this role due to her recent diagnosis of Parkinson's disease.

Mr. Thibodeaux and Mrs. Thibodeaux have very little time for each other after 3:00 p.m. Much of the time the spouses have together is spent planning on how to care for Mrs. Thibodeaux's mother. In view of the ages of the caregivers, Mr. Thibodeaux has discussed placing his mother-in-law in a nursing home; however, Mrs. Thibodeaux has been opposed to the idea of placing her aged mother in a nursing home. The Thibodeaux's receive very little extended family assistance. Mr. Thibodeaux is a native of Brazil and Mrs. Thibodeaux is a native of Nebraska. They do not have close family members in the community or state. The little assistance that the Thibodeaux's do receive in their home comes from a few close friends. Their close friends are also elderly. Church members visit occasionally but not too often. Thus, social interaction is not extensive for this family and social isolation is a growing concern.

Recently, Mr. Thibodeaux became critically ill, suffering a major heart attack, and had to be rushed to the emergency care unit of a local hospital. It is apparent that Mr. Thibodeaux's effort to

assume primary caregiving responsibility for himself, his wife, and his mother was too overwhelming for him. Consequently, Mrs. Thibodeaux was faced with the reality of a very critical family situation; she was devastated when learning of her husband's heart attack and unfortunately, experienced the negative effects of caregiving on the health and well-being of her husband. Prior to his heart attack, Mr. Thibodeaux seldom took time for self-care; however, following his health crisis, Mrs. Thibodeaux's family arrived to assist with daily tasks and to make arrangements for their mother to be placed in a nearby nursing home. At that time, Mrs. Thibodeaux had finally realized that there were no other options. Her siblings were opposed to continuing with in-home care. Moreover, Mrs. Thibodeaux's siblings helped to understand that caring for an Alzheimer's patient required twenty-four-hour care; something that family members could not provide. All siblings are now elderly.

Mr. Thibodeaux is recuperating from his heart attack and hired a nurse to monitor his blood pressure. Their daughter is spending more time with her parents. Mrs. Thibodeaux's sister has agreed to live with her until Mr. Thibodeaux is better.

Mrs. Thibodeaux's mother is adjusting well in her new environment. Her daughter visits her each week and they enjoy playing classical music and reading her favorite poems by Emily Dickenson.

Mrs. Thibodeaux's mental health is better. She is adjusting to her mother's placement in the nursing home. She regrets not having done so earlier. She no longer feels alienated, isolated, or powerless. She is coping extremely well. The exchange of energy between the spouses appears to be in good balance. Mrs. Thibodeaux is beginning to engage in more extended social interaction with

friends and members of her local Catholic church.

Caregivers who provide care to a family member who suffers from Alzheimer's disease face immense challenges (Mace and Rabins, 2001). These challenges may sometimes adversely affect the caregiver, as in the case of Mr. Thibodeaux and require re-alignment of family roles and responsibilities.

Conclusion

One of the major challenges for families in the United States is providing caregiving to an increasing number of older Americans. By 2020, when the baby boomers become the elderly population, the scope and challenge of caregiving will increase even more dramatically. In light of this reality, there is need to enhance our understanding of the structural and dynamic family as well as societal factors that influence patterns of caregiving to aging parents.

The increasing scope and magnitude of the caregiving need has a profound impact on family life. Although the family has experienced many changes over the past 50 years or so, the family is still the main source of caregiving to aging parents. Spouses and adult children are the main informal sources of caregiving for aging parents. Many caregivers are adult children who are employed full-time and still need to care for their own children. Notwithstanding the constraints that caregiving may have on the family of the caregiver and care recipient, many adult children and their aging parents fail to effectively plan for caregiving during old age.

Effective caregiving should begin with planning for aging. However, before planning can begin, adult children and their parents must avoid or overcome denial of the fact that aging and its effects will happen. Acquiring accurate, relevant, and adequate information and open

communication are two important tools needed for effective caregiving. Both adult children and their aging parents should be aware that caregiving is a two-way process and can not be effective without the consent and cooperation of both parties.

The most stressful situation involving caregiving occurs when adult children and their parents are unprepared, when there is lack of cooperation, when a crisis occurs, or when children make decisions for severely incapacitated or helpless parents without knowing the wishes of their parents. To avoid these problems, adult children and their parents, as much as possible, should begin planning for aging long before a crisis or difficult decision has to be made.

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