AGAINST THE ODDS: A GENDERED ANALYSIS OF SONS' INVOLVEMENT IN FILIAL CARE

by

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Abstract

The objective of this thesis is to examine factors that predict son's involvement in filial care. In addition to exploring selected family structure and demographic factors that relate to men's involvement in different types of care, the gender and health status of the care recipient were considered as integral components in the provision of filial care. Data for this research comes from the Work and Eldercare Survey (1995) conducted by the Work and Eldercare Research Group of CARNET: The Canadian Aging Research Network. Data from 108 adult male caregivers were analyzed with regards to their involvement in three gendered types of care-traditionally female (e.g. bathing), traditionally male (e.g. yard work) and gender neutral care (e.g. shopping). This thesis tests a model that was originally devised by Campbell and Martin-Matthews (2003) and is predicated on Finch and Mason's (1989) concept of legitimate excuses, which explores the 'how' and 'why' behind men's limited involvement in filial care. Results show that the men in this sample were more likely to report providing gender neutral care than the other two types of care. Furthermore, the expectation that other family and work obligations would impede men's involvement in caregiving was not supported. However, numerous characteristics of the elderly care recipient did influence the likelihood of men's involvement in numerous types of filial care. Men were more likely to provide gender neutral and traditionally male care to mothers than to fathers. Also, for each of the types of care, the lower the reported health status of the care recipient, the greater the likelihood of son's being involved in care provision.

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The purpose of this thesis is to explore the caregiving experiences of men, namely sons. More specifically, this thesis explores the contributions made by sons in the context of filial care to elderly parents. This area of inquiry is important insofar as the contributions made by men in their roles as brothers or sons in caregiving tend not to be acknowledged, or tend to be seen as less important than that of the contributions made by women in their roles as sisters or daughters. Matthews (1995) suggests that what care men do provide to their aging parents is not as readily accepted as 'genuine care'. Their contributions may be viewed from within the norm of 'female care' and discounted as lesser in value or quality. Furthermore, oftentimes sons' and brothers' own voices are not reflected in the accounts of their contributions. Rather their sisters formulate and express opinions regarding what contributions they think that their brothers are making (Aronson, 1992). According to Matthews (2002) "information about brothers is largely secondhand, provided by sisters who often portray their brothers as unwilling to help" (p. 17). With this is mind, the current study aims to explore the first hand experiences of sons in various filial care tasks.

The gerontological research generally reports that women are the carers, the kinkeepers, the life force behind the aging family. It is estimated that 72% of care providers to the elderly are female, usually wives providing care to a frail spouse (Stone, Caffereta, & Sangl, 1987). Among adult children, approximately 70- 80% of care is provided by daughters (Stephens & Christiansen, 1986). Not surprisingly, men caregivers (and sons in particular) have been much less likely than women to be included in caregiving research. Limited attention has been paid to the important minority of men who play an active role in the provision of care to an aging parent. Rarely are these men studied as an entity in their own right; rather, they are compared to their female counterparts. Sons report providing fewer services, devoting less time, and being in contact with their parents less often than daughters (Crawford, Bond, & Balshaw, 1994; Hamon, 1992; Montgomery, 1992). Furthermore, son caregivers report being less negatively

affected than daughter caregivers by their caregiving experience. These sons report less caregiving strain, less emotional, physical and financial stress, and less interference from caregiving in their personal and social lives than their female counterparts (Horowitz, 1985; Chang & White-Means, 1991; Mui, 1995). Research alludes to the differential ways in which men and women may experience their roles as caregivers, but the male experience of this highly gendered activity is largely overlooked. More importantly, scant attention is given to the circumstances under which these men choose to provide care to an elderly parent or relative.

Comparing the contributions made by male caregivers to those of female caregivers, however informative, does not allow us insight into the circumstances which enable men's caregiving involvement. The literature explains men's limited filial care involvement in terms of gender role socialization. Men generally function within the more expected role of secondary caregiver, as the person who provides assistance to an elder which supplements the care already being provided by a primary caregiver (Campbell & Martin-Matthews, 2000a; 2000b). This, in large part, has been attributed to the gendered nature of caregiving responsibilities, which may serve to define men's caregiving roles as secondary to women's (Harris, 1998). But men's caregiving experience is gendered in more than a one- dimensional manner. Male caregivers are constrained by not only the stereotypes involving their own gender, but also the gender taboos involving the care recipient and the gendered nature of the care tasks. These factors combine to create a complicated situation for male caregivers. Given this, the present research addresses the issues of men's filial care roles, and attempts to advance our understanding of the relationship between the gendered nature of care tasks and the subsequent provision of care.

Background Literature

The gendered nature of care tasks

Historically, gender has been used as an organizing principle within societal expressions of care. Anthropologists and sociologists show that in every society there are care tasks which

are defined as the province of men or women (Coltrane & Galt, 2000). Care work has tended to be divided according to gender lines, which serve to restrict and confine members of each gender to appropriate courses of action. With respect to caregiving, gender and care tasks are strongly related, in that care tasks tend to be heavily weighted towards activities which are traditionally performed by women. Most of the tasks associated with intensive filial caregiving- that is bathing, dressing, laundry, meal preparation- are tasks which are typically associated with women in North American culture (Dwyer & Coward, 1992). It seems that we, as a society, draw upon cultural definitions of gender in developing understandings of the types of care 'appropriate' to different genders. The fact that both son and daughter caregivers provide assistance to aging parents in gender specific ways is evidence of this. For example, daughters are more likely than sons to provide more domestic, or 'hands on' care. Daughter caregivers are three times more likely than son caregivers to provide assistance with activities of daily living (ADLs), which are those personal care tasks which are necessitated by an increased level of need on the part of the elderly parent (Lee, Dwyer, & Coward, 1993). ADLs are oftentimes the tasks to which one refers when instances of intensive caregiving occur. When men do provide care, they tend to perform tasks consistent with traditional gender roles such as home or yard maintenance, and financial assistance (Young & Kahana, 1989; Horowitz, 1985).

Matthews and Heidorn (1998) found that when asked about the services they provide, a sample of son caregivers reported tasks typically deemed appropriate for their gender. They did not report instances of cooking for an aging parent, nor cleaning, nor providing hands on care. What they did report doing was mowing the lawn, changing storm windows, cleaning the gutters and painting the house. Furthermore, when examined over time the tasks that men appear to perform are those consistent with their gender (e.g. financial management) (Montgomery & Kamo, 1989). Interestingly, it has been suggested that part of a man's role as a primary caregiver may be to delegate tasks not traditionally considered to be performed by men (e.g. personal care

tasks) to other care providers within the family (Campbell & Martin-Matthews, 2000a; 2000b). Caution must be used in the interpretation of these findings, as it has been suggested that equating parental care with a specific set of tasks that women are more likely to perform may subsequently diminish the important contributions made by men (Matthews & Heidron, 1998). Ultimately, the male pattern of care provision must be understood as a distinct style that has merit outside of the characteristic female style to which it is compared. Consequently, in this study the focus is not on gender comparisons but rather on contrasting within gender circumstances that may predict patterns of sons' filial care.

Legitimate Excuses

Considering the relative scarcity of data on male caregivers within this area of inquiry, it is important to discuss the circumstances within which men provide care to aging parents. But it is not the circumstances, per se, which are of interest here so much as the conceptual framework which is being used to enable our understanding of the circumstances within which men provide care. For the purposes of the present discussion, the focus here will be exclusively on one specific conceptual framework- that of legitimate excuses. Legitimate excuses is a concept developed by Finch (1989) that encompasses the reasons or circumstances which are considered valid explanations for an individual's limited involvement in filial care. According to this construct, such excuses absolve individuals who are seen to be unable, rather than unwilling, to provide care. Basically, this concept is useful for understanding the complex reasons as to why (and how) some individuals are legitimately 'excused' from caregiving. Finch and Mason (1993) identified five categories of legitimate excuses: employment, family commitments, competence, geographic distance, and lack of resources. In essence, having prior commitments (such as a job or children) serves to distance individuals from their filial obligations. Campbell and Martin-Matthews (2003) suggest that this term is meant to be employed in a non- judgmental way, so as to "reflect a range of accounts, explanations and justifications that get constructed when

individuals negotiate family obligations and care relationships" (p. S351). These legitimate excuses however, are not static entities that are specific to any given individual. Rather they arise through a process of negotiation and extend throughout the matrix of the caregiving family. There must be a degree of consensus and approval for an excuse to be considered legitimate. As an illustration, a person's attempts to use their obsession with video games as a legitimate excuse would likely not be received with much seriousness or significance by their family members. What then constitutes a legitimate excuse? This question is complicated further by the fact that it is not the excuse alone which is perceived of as legitimate, rather it is the relationship between the 'excuse' itself and other factors such as who is making the excuse and how readily these reasons are accepted by others.

The concept of legitimate excuses has been utilized in discussions of obligation (Finch, 1989) and negotiating family responsibilities (Finch & Mason, 1993). Campbell and Martin-Matthews (2003) use this concept in their examination of how men come to be 'excused' from their caregiving responsibilities. Matthews (2002) without explicitly referencing 'legitimate excuses' discusses numerous circumstances that son and daughter caregivers use to explain their own involvement (or lack thereof) in filial care. Montgomery (1992), in an attempt to explain gender differences in patterns of parent child caregiving relationships, refers to the time available and the external resources hypotheses. These hypotheses offer time constraints and work obligations as valid reasons for the removal of one's self from the familial caregiving constellation. These hypotheses fit within the framework suggested by Finch (1989) and are consistent with the conceptual framework of Finch and Mason (1993). It must be noted, however, that these excuses do not function identically across genders. Finch and Mason (1993) found that the ability to get excuses accepted as legitimate varied across gender, in that women's excuses were less readily accepted than men's. It seems that men and women may have a different repertoire of excuses upon which to rely.

Irrespective of potential gender differences, the concept of legitimate excuses is an important concept in the negotiation of care relationships. Campbell and Martin-Matthews (2000b) utilized this conceptual framework in a study of Canadian men who provided care to their aging parents and found that involvement in caregiving could be explained using various socio-demographic factors that reflect different types of legitimate excuses. As an illustration, men who lived closer to their relatives were significantly more involved in care than were men who lived farther away. This emphasizes geographical proximity as a legitimate excuse in relation to the provision of care. Furthermore, those men having older children in the household provided more care to parents than did those men with younger children in the household. Campbell and Martin-Matthews (2000b) found the presence of young children therefore to be a legitimate excuse delimiting men's involvement in filial care. An analogy can be made here, such that the more attention one must direct towards one aspect of life justifies the lack of attention paid to another. It is excusable to not take dad to church if the kids have soccer. Ultimately, men's (and women's) caregiving contributions are shaped by competing obligations and constraints.

Of particular relevance to the proposed research is the issue of competence as a legitimate excuse. A lack of competence or skill has been found to be a legitimate excuse for not helping elderly parents. Finch and Mason (1993) cite a lack of 'natural aptitude' as a reason which distances men from the role of caregiver. This is witnessed continually within the literature, whereby women are seen to be 'natural carers' and somewhat more competent in the provision of care than men (Walker, 1991). In addition there appear to be gender taboos revolving around the giving and receiving of care (Finch & Mason, 1993). For example, cross gender taboos may prevent men from engaging in a care relationship involving particular kinds of personal care with an aging mother. Research shows that older adults in need of care generally prefer that the caregiver's gender be consistent with that of their own (Stoller, 1990; Lee, Dwyer

& Coward, 1993). This same gender preference is witnessed in the fact that mothers very rarely choose sons as their primary caregivers (Lee et al, 1993). This preference is also mirrored in the sentiments of the caregiver. One brother remarked that: "My mother would not feel comfortable with my bathing her" (Matthews, 1995; p. 315). Furthermore, in marital dyads who shared responsibility for filial care, the husbands assumed responsibility for personal care when the care recipient was male (Globerman, 1996). The son caregivers in Globerman's sample did not deem it appropriate for their wives to engage in cross-gendered personal care.

Matthews (1995) suggests that family members internalize cultural assumptions about what constitutes gender appropriate behavior, which in turn influences who provides various forms of care. Campbell and Martin-Matthews (2000a) found that when sons provided traditionally male care (e.g. home maintenance) there were no gender differences in who they reported providing such care to (e.g. mother or father). However, when the necessary care was nontraditional for males and personal in nature, sons were more likely to assist their fathers than they were their mothers. Strong 'gender boundaries' dictate the tasks being performed, thereby making it less expected and less acceptable for men to provide intimate forms of care, especially when the care recipient is a mother (Arber & Ginn, 1995; Brewer, 2001). Within the care relationship there appears to be a tendency towards gender consistency. Adult children are more likely to provide care to a parent of the same sex (Lee et al, 1993). When asked who would be called upon in an emergency, one sister said: "In the case of my father, if he would have a problem he would call my brother. If my father thought my mother was having a problem, he would call me" (Matthews, 1995; p. 315).

Health Status as a Determining Factor in Filial Care

A perceived lack of competence in the area of caregiving may very well act as a reason for not taking on the responsibility of filial care in the first place. But it may also come into play when certain types of care are required, or more so when the health status of the care recipient

necessitates a specific type of involvement. In instances such as these, lack of expertise, experience or natural ability (competence) may act to change previous levels of care involvement. Declines in parental health status may reintroduce the notion of competence into the caregiving relationship. Diminished health status may be associated with increased levels of need on the part of the care recipient and an increased level of involvement on the part of the care provider. The type of care required at this point in the caregiving relationship requires skills that men may not have acquired due to lack of experience or practice, or the power of socialization. This perceived lack of competence may limit men's involvement in care as parental health status declines. Ironically, little is known about men's filial involvement as a function of the health status of the care recipient.

Guberman (1999) found that in the face of the deteriorating health of the care recipient, son's strong feelings of filial obligation did not translate directly into active caregiving. In contrast, some researchers have postulated that son's caregiving involvement is dependent upon their parent's reaching a specific level of need (Hamon, 1992). In this sense, the level of need of the aging parent dictates the care provided by the son. Hamon (1992) found that sons provided more care when the parents' condition was unstable. However, there is no clear agreement as to how the health status of the elder influences son's subsequent care involvement. Dwyer and Coward (1992) found that as the level of parental functioning decreased, son's involvement in filial care decreased accordingly. Likewise, Montgomery and Kamo (1989) found that son caregivers were not likely to fulfil their caregiving responsibilities throughout the duration of their parent's dependency period. In contrast, Stoller (1990) reported continuity in sons caregiving over time.

In an in depth qualitative study of 37 son caregivers, Campbell (2002) found a theme that emerged throughout the interview sessions was caregiving as a gradual process. Sons who provided care to their aging parents perceived their role as one which had evolved and

changed over time. This change, not surprisingly, was contingent upon the health status and needs of the elder parent. The sons in this sample reported an increase in care involvement over time. They chronicled a movement from anticipated to unanticipated care, which mirrors a movement from more traditional care to care less traditional to their role as men. A son who provided care to his frail father briefly summarized his own experiences within the role as caregiver:

> *"I guess part of it is that you grow into the care. Initially it was more mechanical things that I was doing, you know, I was helping him with his banking, and I was helping take him here and there and you know fixing things around the house. But in more recent months, the type of care has changed and I'm doing more personal care stuff, like I help him with his toileting skills and I went over and showered him one night"* (Campbell, 2002; p. 19).

In order to examine the relationship between parental health status and men's involvement in filial care tasks, Campbell and Martin-Matthews (2003) used age as a proxy for a more direct measure of parental health status and found that men with older parents were more involved in filial care. But it is not sufficient to say that son's involvement in care changes over time, or as a function of the need level of the elder, without acknowledging the accompanying changes in tasks performed. Campbell and Martin-Matthews (2000b) found that being a primary provider of care intensified men's involvement in care but only in the types of care which were consistent with traditional gender role expectations. This is consistent with more recent work done by Campbell and Martin-Matthews (2003) which found that the relationship between son's care involvement and length of time providing care was mediated by the gendered nature of the tasks. More specifically, those sons who provided care for longer periods of time were less involved in gender neutral care (e.g. transportation, help with shopping) and traditionally female care (e.g. dressing, bathing, feeding) and more involved in traditionally male care. This suggests

that among men care that is less gender specific to men diminishes with time, and care which coincides with traditional male gender roles continues. These results, although implying a longitudinal design, are predicated on cross sectional data and in that sense must be interpreted with caution.

The goal of the present thesis is to build upon extant research by integrating the literature on men's filial involvement and the gendered nature of care tasks. In addition to exploring the factors that relate to men's involvement in different types of care, the gender and health status of the care recipient will be considered as integral components in the provision of filial care. This research builds upon previous analyses of a national dataset which focused on socio-demographic factors which predicted men's overall involvement in caregiving. The current study is an extension of research done by Campbell and Martin-Matthews (2003) which examined the gendered nature of men's filial care. The dataset contains information from later phases of the research, and allows access to information which was unavailable to the previous researchers (see Methods section for more detail). Campbell and Martin-Matthews (2003) acknowledge numerous limitations in the earlier phases utilized in their analyses. "The data available did not allow for differentiation of care recipients by gender or relationship" (p. S357) nor did it "provide an indicator of the older parent's health status or need" (p. 356). The current thesis was not constrained by these limitations, but rather examined these variables in the provision of filial care.

Research Objectives and Hypotheses

Many questions remain unanswered about the experiences of men with regard to their filial care involvement. How do characteristics of the care recipient (e.g. gender) impact men's involvement? What happens to men's involvement in caregiving as the health status of the elderly care recipient declines? Ultimately, the questions explored in the current thesis revolve around numerous socio-demographic factors and the ways in which they are thought to impact

men's involvement in filial care.

The following four hypotheses were tested in the analysis of data:

Hypotheses.

H1: Men with other family, work and distance constraints will be less likely to be involved in each type of care than are men without these competing obligations or constraints (this will be particularly true with regards to traditionally female care).

H2: Men who are providing cross gender care (to a mother, mother in law or grandmother) will be less likely to be involved in each type of care than are those men providing care to an elderly relative of the same gender (This will be especially true of traditionally female care).

H3: Men who report having parents in poorer health will be more likely to be involved in each type of care (This will be especially true of traditionally male and gender neutral care).

H4: The relationship between health status of the elder care recipient and filial care involvement will be moderated by the gender of the care recipient. More specifically, when the reported health status of the elder care recipient is poor, men will be more likely to provide care when the care recipient is a male compared to when the care recipient is a female.

It is important to note here that Hypothesis One is the same hypothesis as that tested in Campbell and Martin-Matthews (2003). However, the current data analysis of the hypothesis will differ in three significant ways: the sample size will be smaller, thereby limiting the number of independent variables used; information regarding the health status and gender of the care recipient will play an integral role in the analyses; and this study will test the model on a sub-sample of the men studied by Campbell & Martin Matthews (2003) with data collected three years after the data in the earlier analyses. This allows for the following question to be addressed- Does the model still account for variance in the gendered provision of care, three years later?

Method

Sample Characteristics

The data for this thesis come from the Work and Eldercare Research Group of CARNET: the Canadian Aging Research Network. Data from CARNET were collected in 2 phases: Phase I utilized the Work and Family Survey, which was conducted between 1991 and 1993. Data were collected from men and women employed in 9 Canadian organizations including government agencies, health services, manufacturing, financial services, and educational institutions in both public and private sectors. In attempts to target those individuals most likely to be involved in providing care to an aging parent, surveys were distributed only to 'older' employees (aged 35 years or above). Of the 9, 693 surveys distributed in the workplaces, 5, 496 surveys were returned (2, 060 from men and 3, 407 from women) for an overall response rate of 53%. The response rate varied by organization, from a high of 73% to a low of 23%. Of this original sample (n= 2, 337) 46% responded 'yes' to the question: "Have you provided care or assistance to a relative 65 years of age or older in the previous six months?" The data analyzed by Campbell and Martin-Matthews (2000a; 2000b; 2003) were based on the responses of the 778 men who answered 'yes' to this question.

In the summer of 1994, a follow up interview was conducted whereby respondents who had indicated in Phase I of the research that they would be willing to participate in another interview were contacted and questioned as to their continued involvement in parental care. In this 'screener survey', contact was made with 676 of the 878 respondents who had self-identified as caregivers for the purposes of continued involvement in the study. The subsequent sample of 497 respondents chosen from the screener survey then constituted the basis for the final sample for the Phase II Work & Eldercare Survey. Of these, 250 respondents were selected from the sample of 497 to participate and were selected on the basis of the following criteria: They had to be currently employed and providing assistance to an aging relative. More importantly however, they were required to be engaged in the provision of assistance with one

personal care task (ADL) such as eating, dressing, bathing, and toileting; or two IADL's which involve basic household management tasks such as shopping, banking, household chores. The data from Phase II come from The Work and Eldercare Questionnaire and were gathered in the spring of 1995 (e.g., as displayed in Appendix B). The Phase II 1995 Work and Eldercare Survey repeated many of the measures from the 1991/ 93 Work and Family Survey concerning work-family balance issues. However, unlike Phase I, the Phase II study did not aggregate the data on care tasks for all elders assisted. Rather, it asked about care tasks specifically for each elderly relative (to a maximum of three relatives). It also measured the health status of each elder receiving care, and focused also on 'secondary helpers' and the use of community services.

Thus, this research is based on a secondary analysis of data on the 108 men from Phase II who indicated that they provided care or assistance to at least one parent or parent in law aged 65 years or older. Thus, for each of the 108 men there are linked data from three points in time: the 1991- 1993 Work & Family Survey (Phase I), the 1994 screener and the 1995 Work and Eldercare Questionnaire (Phase II). Table 1 contains the demographic characteristics of this sample of caregiving men.

Measures

Dependent Variables

The current analysis is based upon the classification of care tasks developed by Campbell and Martin-Matthews (2003). To create this classification system, 18 care tasks were divided into 3 groups: traditionally male care, gender neutral care and traditionally female care. This grouping was determined primarily through analyses of the existing literature (Chang & White-Means, 1991; Coward & Dwyer, 1990; Montgomery & Kamo, 1989; Spitze & Logan, 1990; Stoller, 1990; Young & Kahana, 1989). For each of the 18 tasks, respondents were asked how often they provided that type of assistance, with response options of 0 'Never', 1 'Once a month', 2 'Several times a month', 3 'Once a week', 4 'Several times a week', and 5 'Daily.

Table 1

Sample Characteristics

Characteristic	n	%
Respondent		
Age		
Mean: 43.64 years		
Range: 26- 64; *SD*: 7.39		
Employment Status		
Full- time	87	88.8
Part- time	11	11.2
Marital Status		
Married/ Common Law	90	91.8
Divorced/ Separated	8	8.2
Parental Status		
Have children 18 years or under at home	54	55.1
No kids under 18 at home	44	44.9
Care Recipient		
Age		
Mean: 76.99 years		
Range: 48- 100; *SD*: 9.47		
Marital Status		
Married	29	29.0
Widowed	66	66.0
Separated/ Divorced	5	5.0
Gender		
Male	19	19.2
Female	76	76.7

A score of 0 to 5 was then determined for each task for all respondents, with these scores summed to create the three 'gendered care' scales.

Traditionally male care was measured on a scale that included the following types of help: managing money, completing forms and documents, regular financial assistance, and home maintenance and yard work. The scale for gender neutral care included such tasks as: household chores, transportation, help with shopping, assistance in getting around, arranging assistance from agencies, dealing with serious memory problems, and dealing with mood swings or extreme behaviors. These tasks are consistent with Katz's (1962) formulation of Instrumental Activities of Daily Living (IADLs). The final scale, traditionally female care, involved tasks which were generally considered non-normative for men such as: dressing and undressing, laundry, bathing, washing, grooming, toileting, feeding/eating, taking medications, and preparing meals. In general, these tasks are considered, by Katz's formulation, to be Activities of Daily Living (ADLs).

The above mentioned scales were developed by Campbell and Martin-Matthews (2003) through analyses of the tasks outlined in Phase I of the CARNET study. Unfortunately, the questionnaire utilized in Phase II did not measure involvement in each specific task in the same manner as did Phase I. Rather than asking about each task independently, the tasks are condensed into 5 overarching questions. As an illustration, one question asks: "How often have you helped your older relative with bathing, feeding, dressing, toileting, or taking medication?" As can be seen, the tasks remain consistent with the suggested classification (traditionally female care) but each task is not asked about separately. Of the 5 overarching questions, one asks exclusively about tasks associated with traditionally female care; one asks about tasks consistent with the classification of gender neutral care and one asks about tasks which are considered normative for men (traditionally male care). The two remaining questions, however, do not as easily fit into the 'gendered care' scales. One question inquires about emotional and moral

easily fit into the 'gendered care' scales. One question inquires about emotional and moral support, which was not included in Phase I of the study and is based upon the work of MacRae (1984) on emotion work in caregiving. An analysis of the preexisting literature does not provide much guidance in the subsequent classification of these tasks on the basis of gender. However, Horowitz (1985) found that emotional support was a caregiving task common to both son and daughter caregivers in her sample. Furthermore, she suggested that emotional support as a caregiving task was beyond the influence of stereotypical sex-role expectations and behaviors. Consistent with Horowitz's (1985) rationale, the question regarding moral and emotional support will be classified as gender neutral care.

The remaining question appears to combine tasks from different 'gendered care' scales. For example, it inquires about both laundry (gender neutral care) and yard work (traditionally male care). The present author acknowledges this as a shortcoming in the current thesis but does not see it as insurmountable. For the purposes of the present thesis, this question will be characterized as gender neutral care. This classification is based on a preliminary factor analysis done by Campbell (1997) which found that the tasks of helping with laundry and yard maintenance clustered with the factor for gender neutral care. In subsequent analyses, Campbell (1997) decided to depart from the factor analysis in her classification of these tasks (namely helping with meals and laundry, and home maintenance) and to follow more closely the literature in the area. However, Campbell's 1997 factor analysis will guide the current categorization of these particular care tasks in this thesis.

For each of the 5 questions, respondents were asked how often they provided each type of help, with response options of 1 'Daily', 2 'Several times a week', 3 'Once a week', 4 '2-3 times a month', 5 'Every 1 or 2 months', 6 '1- 2 times in 6 months' and 7 'Never'. As it stands, a high score on any of these questions denotes limited involvement in filial care. This proves to be counterintuitive and makes interpretation of the results cumbersome. Therefore for a matter of

simplicity, the value labels were reverse coded to ensure that a higher number would denote a higher degree of caregiving involvement. For the purposes of the final statistical analyses, the response options were as follows: 1 'Never', 2 '1-2 times in 6 months', 3 'Every 1 or 2 months'. 4 '2-3 times a month', 5 'Once a week; 6 'Several times a week' and 7 'Daily'. In the end, each respondent had a score (1- 7) for each of the questions which make up the dependent variable.

Considering that the categories of traditionally female care and traditionally male care utilize only ONE item in their construction, the score that each respondent received on each individual item was retained and labeled accordingly (e.g. traditionally female care, and traditionally male care). However, since the category of gender neutral care utilized 3 items in its construction, a gender neutral care score was created by summing the relevant questions and dividing by the number of questions used. Furthermore, an overall care score was obtained by summing all 5 items related to filial care involvement. In the end, each respondent had 4 caregiving scores; 3 pertaining to each of the gendered care tasks- traditionally female care, traditionally male care and gender neutral care; and an overall care score. The sample size for traditionally female care was 99 men, 21 of who report providing some form of this type of care. Scores for traditionally female care range from 1 to 7 with a mean of 1.48 and a *SD* of 1.17. The sample size for traditionally male care was 98 men, 63 of whom report having provided some form of this type of care in the last 6 months. Scores for this measure ranged from 1- 7 with a mean of 2.30 and a *SD* of 1.49. Furthermore, the sample size for gender neutral care was 97 men, 88 of whom had provided some form of this type of care in the last 6 months. The mean for this caregiving scale was 3.01 with a *SD* of 1.54.

Independent Variables

The literature, and more specifically the work of Campbell and Martin- Matthews (2000a; 2000b; 2003), suggest a number of independent variables to be included in the analyses. However, in contrast to Campbell and Martin- Matthews' sample size of 778 male caregivers,

the Phase II data are based on a much smaller sub- sample of 108 men. As a result, data analyses were constrained by sample size and did not permit the analysis of all of the independent variables optimal in the model.

Family Structure: The measures which address the concept of legitimate excuses include numerous family structure variables such as: parent status, gender of care recipient, sibling network composition and respondent's marital status. These are the variables which the literature indicates should be included in the subsequent analyses of legitimate excuses. Parent status is represented by a dummy coded variable: Have any children 18 years of age or younger in the home (which is the reference category, and represents 55 % of the sample), and No children/ no children under 18 in the home (44.9%).

The gender of the care recipient is represented by a dummy coded variable: female (e.g. mother or mother in law) which is the reference category, and male (e.g. father or father in law). This variable also comes directly from Phase II. It should be noted that in the Work and Eldercare Questionnaire, the men provide information about their caregiving responsibilities for a maximum of 3 relatives. For the purposes of the present thesis, the number of relatives utilized in subsequent analyses were restricted to one. The choice of relative to be the focus of analysis of helping behavior by sons was based on reported assistance levels, in that the relative to whom the respondent reports providing the most assistance was the one included for analysis. These individuals were broken down into gender categories of female (which was the reference category and represented 76.7% of the sample), male and gender unknown. Unfortunately, within the sample of 108, there were 4 respondents who stated that the person they provide the most care to is a friend. Obviously a gender could not be determined for these individuals; likewise, the care provided between friends is not of central importance in the current research, in that it is not filial in nature. Therefore these individuals were excluded. Furthermore, 7 respondents did not specify the gender of the care recipient. Not wanting to lose further cases

from the sample, these 7 care recipients for whom gender was unspecified were coded as female. The logic behind this course of action is as follows: 1) The majority of men in the sample report providing care to a female care recipient and 2) Demographically speaking the elderly care recipient is more likely to be female due to women's increased life expectancy.

Thus for each variable, the referent relative is chosen from the 3 possible relatives and is used in all subsequent analyses.

Sibling network is a continuous variable which asks the respondent- How many living sisters do you have? Responses range from 0 (31.5% of the sample reported having no living sisters) to 7 (1.9 % of the sample report having 7 living sisters). The mean for this variable was 1. 28 with a *SD* of 1.39. This information was not inquired about in Phase II; therefore the data are extracted from the data provided in the Phase I Work and Family Survey (Appendix A). It must be noted here that the current methodology departed from Campbell and Martin-Matthews' at this juncture. These authors utilized information pertaining to both brothers and sisters; and constructed a sibling network constellation measure which included such categories as sisters only, brothers only, brothers and sisters and no siblings. However to be included in the regression analyses each of these categories must be dummy coded. It was not logical to utilize that many dummy coded variables in these analyses due to the constraints which are in place due to issues of a limited sample size. Furthermore, sibling networks are not a key element in these analyses; therefore this variable was reduced into one continuous variable- number of living sisters. The logic behind this decision was also based on the research regarding the role of siblings in filial care involvement. It is generally found that the presence of sisters is one of the prime predictors of son's involvement in filial care (Horowitz, 1985). The presence (or absence) of brothers does not seem to impact filial care involvement to the same extent as does the presence (or absence) of sisters. In that regards, the exclusion of brothers from the analysis seemed a valid methodological decision.

Distance Constraints: This variable addresses issues of geographic proximity and was determined using the reported travel time to the home of the referent elder. The mean reported travel time to the care recipients' home was 145.04 minutes with a *SD* of 261.43 minutes. Within this variable, 12 respondents reported a 0 minute travel time which was subsequently recoded as co-residence.

Employment Constraints: The employment variable includes the number of hours worked in a given week. This variable was taken from Phase II of the study, and includes two response categories: 35 hours or more, or less than 35 hours. This variable was represented by a dummy coded variable: Full time status, that is working 35 hours or more a week (which was the reference category and represents 88% of the sample) and part time status (12%). Due to the limited sample size, those respondents who reported being unemployed (n =7) were included in the category of part time status for in theory 0 hours of work constitutes less than 35 hours of work per week.

Personal Resources: This variable included a measure of the respondent's education and personal income. Approximately 67% of the sample had at least some university education. Likewise, the mean personal income reported by the respondents was $50,000- $59,999. These variables came directly from questions posed in Phase I of the study. Due to the restrictions placed upon the number of variables which could be used in my model, these two variables were collapsed into one overall socioeconomic status (s-e-s) variable. The collapsing of these variables was achieved using factor analysis, and these 2 variables loaded together on the same factor. The results of the factor analysis were saved as a variable, thereby permitting the use of a standardized measure of the respondent's socioeconomic status.

Other variables: Another variable included in the analysis was the health status of the elder care recipient. 2 questions were taken from Phase II of the study and were utilized in the creation of a health status variable. These items asked about the overall physical health status

and overall mental/ emotional health status of the care recipient as perceived by the respondent. For each of the questions, the respondents were asked how they would rate the care recipients' overall health (both physical and mental/ emotional), with response options of: 1 'Excellent', 2 'Good', 3 'Fair', and 4 'Poor'. The mean overall physical health score was 2.69 (with a *SD* of 0.82) whereas the mean overall mental/ emotional health score was 2.29 (with a *SD* of 0.86). Overall, the care recipients were in relatively good health, with the mean health score falling somewhere between good and fair. Once again, using the logic outlined in the section labeled 'Personal resources', a factor analysis was performed on these two questions and a factor score was obtained combining overall physical and mental/ emotional health.

Data Analysis

An univariate analysis was performed on all relevant variables (both dependent and independent). These analyses were simple functions within SPSS and encompassed running the frequencies for all variables. Next, bivariate analyses were performed between all of the dependent variables and each of the independent variables. This involved utilizing the explore function for nominal variables and the correlate and scatter plot function for ordinal/ scale variables. To rule out the possibility of multicollinearity, cross tabulations were run and a correlation matrix was computed.

Once these preliminary analyses were conducted, a hierarchical multiple regression was employed. Step one of the regression analysis tested Campbell and Martin-Matthews' (2003) model to determine the significant predictors of men's involvement in filial care (hypothesis one). Step two of the analysis added the two variables which were previously unexplored in the original model, that is the health status and gender of the care recipient (hypotheses 2 and 3). Furthermore, an interaction term was constructed using the health status and the gender of the care recipient and was analyzed using the ordinary least squares multiple regression (hypothesis 4). Each of these analyses were run separately for each of the types of care provided

(traditionally female care, traditionally male care, gender neutral care and overall care).

Results

Sample Characteristics

The present study

Table 1 outlines the demographic characteristics of the total sample of caregiving men. Participants were typically middle aged, with a mean age of 43.64 years. These men reported providing care to a care recipient with a mean age of 77 years (*SD*= 9.47) who was typically a mother or a mother in law (61% of the sample). These men were highly educated and remunerated; they reported relatively high education levels (mean = some university) and similarly high income levels (mean= $ 50, 000- 59, 999). The jobs that these men held were typically professional and/or managerial in nature. As an illustration, 18% of the sample held jobs as insurance brokers, 15% were employed in financial management, while 9% were employed as computer programmers. Furthermore, 89% of the sample reported working full time hours. With respect to family responsibilities, 92% of the sample was married or living common law with their partner; while 55% of the sample had children less than 18 years of age living in the home. Furthermore, these men were generally part of a sibling network which included one or more sisters. In actuality, only 32% of the sample reported having no sisters.

Campbell and Martin-Matthews' study

The current sub sample of men differs from Campbell and Martin-Matthews (2003) sample in that they are slightly younger in age, with the mean age of Campbell and Martin-Matthews' male participants being 45 years. Furthermore, the care recipients in the current study are slightly older in years than those in Campbell and Martin-Matthews' investigation (77 years vs. 75 years respectively). Generally, Campbell and Martin-Matthews' sample was very similar to the current sub sample of men in that the men were typically married with children in the home, working full time in a professional/ managerial job while occupying a relatively high

socioeconomic status.

Filial Care Involvement

Overall, the gendered nature of the care tasks emerged as significant in the provision of care to an aging relative. For example, the reported frequency of care involvement was highest with gender neutral care tasks. Respondents were more likely to report providing gender neutral care than the other two types of care. That is to say that the vast majority of care being provided was care not typically associated with either gender. This would include such things as helping the care recipient with transportation, errands and household chores. Furthermore, respondents were more likely to report providing traditionally male care than traditionally female care. Thus the care recipients were more likely to receive help with financial management than they were to receive help with personal care tasks.

The vast majority of respondents (72%) reported never providing any traditionally female care to the care recipient. This form of care, however, would be necessitated only if the care recipient was in poor health, such that they could not perform such tasks as dressing, bathing, feeding and toileting by themselves. For those respondents who did provide this type of care, the amount of care they reported providing was minimal. The mean score for traditionally female care was 1.48, which represented a midpoint between non-participation and providing care 1- 2 times in 6 months. Overall, the respondents demonstrated low participation levels in this type of care. In contrast, 92% of respondents reported providing some form of gender neutral care. The average caregiving involvement for gender neutral care falls between being involved every 1- 2 months and being involved 2- 3 times per month (mean score = 3.01). A low percentage of the overall sample participated in gender neutral care tasks weekly (5%) but a large percentage participated on a monthly basis (77%). Furthermore, 66% of respondents report providing some traditionally male care in the preceding 6 months. The average score on the provision of traditionally male care was 2.30, which represented care involvement somewhere between 1- 2

times in 6 months and every 1- 2 months. Overall, 90% of respondents report providing 1 hour of care or more per week (irrespective of type of care).

Multivariate Analysis Results

It was postulated that care provision would vary as a function of the gendered nature of the care task. Hypothesis one states that men with other family, work and distance constraints would be less likely to be involved in each type of care than men without these competing obligations or constraints. However, this was thought to be particularly true with respect to traditionally female care. With this logic in mind, the analysis was run separately for 4 types of care- traditionally female, gender neutral, traditionally male and overall care. However, within each of these types of care, two models were tested using a hierarchical multiple regression analysis. The first model in the analysis tested the model which was employed by Campbell and Martin-Matthews (2003) to determine the relevance of legitimate excuses in men's care provision. This model looks at the sociodemographic variables which were suggested by Campbell and Martin-Matthews to be important predictors in men's filial care involvement. However, it must be noted that the model could not replicated in its entirety as the sample size in the current study precluded the use of all the variables in Campbell and Martin-Matthews model. Model two tests the current revised version of Campbell and Martin-Matthews' model, with the addition of two variables which were previously unavailable for exploration- that is, gender and health of the care recipient.

Overall Care

Results for the hierarchical regression analysis for overall care are reported in Table 2. Model one explains approximately 13% of the variance in men's involvement in overall care; whereas model two explains approximately 21% of the variance in these tasks. Again, this change in the variance (R^2 change= 0.080) from model one to model two is significant and demonstrates the importance of these variables within the model ($F = 4.206$, $p = 0.018$).

Table 2

Summary of Hierarchical Regression Analysis for Variables Predicting Men's Involvement in Overall Care

	Model 1		Model 2	
Variable	b	β	b	β
Geographic proximity	- 0.006**	(- 0.262)	- 0.006**	(-0.265)
Parental status				
Have children under 18 years in home	--------	--------	--------	--------
No children/ under 18 in home	- 1.642	(- 0.137)	-1.090	(-0.091)
Employment status				
Full time	--------	--------	--------	--------
Part time	-2 . 202	(- 0.116)	-1.496	(-0.079)
Sibling Network- Sisters	- 0.654	(- 0.141)	- 0.544	(-0.118)
Education/ Income	0.441	(0.072)	0.792	(0.129)
Health status			1.446**	(0.246)
Gender of care recipient			2.707*	(0.185)

Note. R^2= 0.129 for Model 1; ΔR^2 = 0.080 for Model 2 (ps < 0.05)

*p < 0.05; **p < 0.01.

Geographic proximity is significant (in both model one and two), and demonstrates a negative relationship with overall care involvement. This relationship indicates that men who live closer to the care recipient are more likely than those who live father away to provide care to an elderly relative. As well, the health status of the care recipient is significant, with care recipients in poorer health receiving more care from the respondents than care recipients in good health.

The gender of the care recipient is also significantly related to men's involvement in overall care. Men who provide care to a female care recipient show more involvement in this overall amount of care than those who provide care to a male care recipient.

Traditionally Female Care

Results for the hierarchical regression analysis for traditionally female care are reported in Table 3.

Table 3

Summary of Hierarchical Regression Analysis for Variables Predicting Men's Involvement in Traditionally Female Care

	Model 1		Model 2	
Variable	b	β	b	β
Geographic proximity	- 0.001	(-0.126)	- 0.001	(- 0.138)
Parental status				
Have children under 18 years in home	--------	--------	--------	--------
No children/ under 18 in home	- 0.444	(- 0.182)	- 0.358	(- 0.147)
Employment status				
Full time	--------	--------	--------	--------
Part time	0. 208	(0.054)	0. 300	(0.078)
Sibling Network- Sisters	- 0.077	(- 0.082)	- 0.054	(- 0.057)
Education/ Income	- 0.069	(- 0.055)	- 0.023	(- 0.019)
Health status			0.313*	(0.162)
Gender of care recipient			0.005	(0.002)

Note. R^2= 0.049 for Model 1; ΔR^2 = 0.065 for Model 2 (ps > 0.05)

*p < 0.05.

Model one explains approximately 4% of the variance in men's involvement in traditionally female tasks; whereas model two explains approximately 11% of the variance in these tasks. This change represents a 6% increase in the variance from model one to model two (R^2 change= 0.065) however, this change in the variance from one model to the next does not reach statistical significance ($F = 3.029$, $p = 0.054$).

The health status of the care recipient is a significant predictor of care involvement in traditionally female care. In this particular case, traditionally female care involvement and the health status of the elder demonstrate a positive relationship, in that the poorer the reported health status of the care recipient the greater the likelihood of the men's involvement in traditionally female care. Men who have parents in poorer health are more likely to provide traditionally female care than those men who have parents in good health.

Geographic proximity, respondent's parental status, employment status, sibling composition, socioeconomic status and gender of the care recipient are not significant variables in the prediction of men's traditionally female care involvement. However, with respect to distance constraints, the direction of the relationship is consistent with what was hypothesized but does not reach statistical significance. As the number of minutes required to travel to a care recipients house increases, participation in traditionally female care decreases, but not significantly so.

Gender Neutral Care

Results for the hierarchical regression analysis for gender neutral care are reported in Table 4. Model one explains approximately 18% of the variance in men's involvement in gender neutral care tasks; whereas model two explains approximately 26% of the variance in these tasks. This difference in the variance (R2 change) from model one to model two demonstrates the importance of the two variables (health status and gender of care recipient) which were added in the second step of the analysis. These two variables add significantly to the initial model ($F = 4.863$, $p = 0.010$) and represent a 8% increase in variance from model one to model two.

Geographic proximity is a significant predictor of care involvement in both model one and model two of the analysis. In both models, this variable (distance constraints) and gender neutral care are represented by a negative relationship, in that the greater the distance between the respondents home and that of the care recipient the lesser the likelihood of there being

Table 4

Summary of Hierarchical Regression Analysis for Variables Predicting Men's Involvement in Gender Neutral Care

	Model 1		Model 2	
Variable	b	β	b	β
Geographic proximity	- 0.002**	(- 0.281)	-0.002**	(-0.284)
Parental status				
Have children under 18 years in home	--------	--------	--------	--------
No children/ under 18 in home	- 0.472	(- 0.153)	- 0.326	(- 0.106)
Employment status				
Full time	--------	--------	--------	--------
Part time	- 0. 816	(- 0.166)	-0.626	(- 0.128)
Sibling Network- Sisters	- 0.218	(- 0.183)	- 0.190	(- 0.160)
Education/ Income	0.118	(0.176)	0.211	(0.134)
Health status			0.370**	(0.245)
Gender of care recipient			0.778**	(0.206)

Note. $R^2 = 0.176$ for Model 1; $\Delta R^2 = 0.086$ for Model 2 ($ps < 0.01$)

*$p < 0.05$; **$p < 0.01$.

involvement in gender neutral care. More specifically, men who live closer to their aging relatives are more likely to provide care than those who live at greater distances. As well, the health status of the care recipient is significant, with poorer health necessitating greater involvement in this type of care. Ultimately, men who have parents in poorer health are more likely to provide gender neutral care than those men with parents in good health.

Gender of the care recipient also emerges as significant for this type of care. The relationship between gender neutral care and the gender of the care recipient proved to be a strong positive relationship with men being more likely to provide care to a female parent. Parental, socioeconomic and employment status, along with sibling composition are not

significant for involvement in gender neutral care tasks.

Traditionally Male Care

Approximately 3% and 10% of the variance in men's traditionally male care involvement can be explained by model one and model two of the analysis, respectively. Results for the hierarchical regression analysis for traditionally male care are reported in Table 5.

Table 5

Summary of Hierarchical Regression Analysis for Variables Predicting Men's Involvement in Traditionally Male Care

	Model 1		Model 2	
Variable	b	β	b	β
Geographic proximity	- 0.001	(- 0.150)	-0.001	(-0.155)
Parental status				
Have children under 18 years in home	--------	--------	--------	--------
No children/ under 18 in home	- 0.039	(- 0.013)	0.068	(0.024)
Employment status				
Full time	--------	--------	--------	--------
Part time	0. 280	(0.061)	0.452	(0.099)
Sibling Network- Sisters	- 0.050	(- 0.045)	- 0.036	(- 0.032)
Education/ Income	0.091	(0.025)	0.167	(0.113)
Health status			0.294*	(0.204)
Gender of care recipient			0.692*	(0.196)

Note. R^2= 0.033 for Model 1; ΔR^2 = 0.067 for Model 2 (ps > 0.05)

*p < 0.05.

This change in variance represents a 6% increase from one model to the next but is not statistically significant (F = 4.863, p= 0.010). Furthermore, none of the structural variables associated with the legitimate excuses literature emerge as significant in explaining involvement

in this type of care. However, the geographic proximity variable behaves in the predicted fashion (as distance between households increases, involvement in this type of care decreases) but does not reach statistical significance.

Health status of the elder is significant, in that the higher the level of impairment of the care recipient, the higher the degree of caregiver involvement. Men with parents in poorer health report providing more of traditionally male care. Furthermore, gender of the care recipient also emerges as significant. Again, gender of the care recipient and traditionally male care involvement demonstrate a strong positive relationship; in that men are more likely to provide more of this type of care when the care recipient is female

Interactions

Interaction terms were calculated combining the health status and gender of the care recipient variables, for each of the 4 types of care. These interaction terms were created, and used, to determine whether the gender of the care recipient moderated the relationship between the health status of the care recipient and the filial care involvement. The rationale for the exploration of this interaction relies upon the notion of gender appropriate behaviors. As the health status of the elderly family member declines, the activities required to take care of this individual typically become more intimate and time consuming. Frequently, the tasks which arise gender taboo revolving around the provision of traditionally female care by a male. Results of in the later stages of the decline in health are those activities (bathing, feeling, toileting, and dressing) generally performed by women, and are defined here as traditionally female care. More importantly, these tasks that are now required of the male care giver may not be tasks which men are comfortable providing to a care recipient of the opposite gender. In essence, there may be a the multiple regression analysis for the interaction terms are presented in Table 6. The traditionally female care model explains approximately 7% of the variance in men's involvement in this type of care. Approximately 6% and 3% of the variance can be explained by the gender

Table 6

Multiple Regression (OLS): The Moderating Effect of Gender upon the Health Status of the Care Recipient

	Traditionally Female Care		Gender Neutral Care		Traditionally Male Care		Overall Care	
Variable	b	β	b	β	b	β	b	β
Health status	0.333	0.283	0.265	0.176	0.033	0.023	1.192	0.204
Health X Gender	-0.014	- 0.010	0.151	0.087	0.275	0165	0.338	0.050

neutral care model and traditionally male care model, respectively. Furthermore, the overall care model explains approximately 6% of the variance in men's involvement in overall care. The calculated health and gender interaction terms are not significant for any of these types of care.

Discussion

Legitimate Excuses

The expectation that other family and work obligations would impede men's involvement in caregiving overall was not supported. More specifically, men with other family and work constraints were no less likely to be involved in filial care than men without these competing obligations. This finding is surprising insofar that men's caregiving involvement has been found to be influenced not only by the characteristics of the care recipient, but also by their own characteristics (e.g. employment, marital and parental status). Numerous researchers have found that competing work obligations (e.g. full time employment) decrease the amount of caregiving activities performed by men (Montgomery & Kamo, 1989; Matthews, 2003). As an illustration, Dwyer and Coward (1992) found that employed son caregivers were less likely to provide ADL assistance to an elderly parent than their unemployed counterparts. Furthermore, generally in the literature education/income emerges as a salient characteristic in predicting men's caregiving

involvement. Chang and White-Means (1991), who were interested in the reasons behind men's decision to provide care to an aging relative, found that education arose as significant, in that as the levels of education of the caregivers rose, the contributions being made to the elderly care recipient declined.

However, most of the research investigating the impact of structural variables on men's caregiving involvement uses an overall composite score to measure caregiving involvement and does not distinguish between the gendered nature of certain care tasks and the disparate likelihood of men engaging in each of these types of tasks. Campbell and Martin-Matthews (2003), however, went beyond the composite, overall measurement of caregiving involvement and organized the care tasks according to gender appropriateness. In so doing, Campbell and Martin-Matthews (2003) created a more complex picture regarding men's caregiving involvement and the subsequent role of numerous structural variables. These authors found that men with a lower income were more involved with traditionally female care tasks than were men with a higher income. Furthermore, they found that a lower educational level predicts higher involvement in traditionally male care but not the other two types of care (traditionally female and gender neutral care).

It was the purpose of the present thesis to investigate further the impact of competing family and work commitments on men's involvement in numerous gendered care tasks. Yet of all of the structural variables included in the current analysis (geographic proximity, parental status, employment status, sibling network and income/education), geographic proximity was the only variable to reach statistical significance. But it did not reach significance for all of the 4 types of care; rather, it only did so for gender neutral and overall care. In essence, the closer a man lives to the elderly care recipient, the more gender neutral care and overall care he will provide. How can this finding be explained? Geographic proximity does not impact men's involvement in traditionally female care insofar that men do not generally engage in this type of

care (as was confirmed with these data). Distance does not affect their non participation. Regardless of the distance they live from the care recipient, traditionally female care is not the type of care generally performed by men. No matter the distance these men live from the care recipient, they are equally unlikely to be providing this form of care. With respect to traditionally male care, it could be a function of the measure used in the study. The item pertaining to traditionally male care asks about activities which do not require physical closeness in order to be enacted (managing money and providing money). Men can perform these caregiving responsibilities without being in close physical proximity to the care recipient. In that way, greater distances need not exclude them from helping.

Matthews (2003) conducted a qualitative analysis of son's caregiving involvement and found that proximity, employment status and other family commitments emerged as important variables to consider in son's decision to provide care to an aging parent. Likewise, Cicirelli (1987) interviewed divorced adult children and found that these children assumed that any possible help they would provide for their parents in the future would be limited by the competing demands of their jobs and their children. Obviously, these variables are perceived, both within the gerontological literature and by possible caregivers themselves, as important in the decision to caregive yet they do not show up as significant in the current study. The men in this sample appear to be providing care regardless of the presence of numerous perceived constraints, or competing obligations.

Overall, the current results contradict the work upon which this thesis is predicated. Contrary to the current findings, Campbell and Martin-Matthews (2000a; 2000b; 2003) found that numerous socio- demographic variables (geographic proximity, parental status, employment status, sibling network and income/education) predict men's filial care involvement. These authors found that men with older children in the home provide more care than those men with younger children in the home. They also found that men in no sibling and brothers only sibling

groups are more likely to be involved in caring for an aging parent. Furthermore, the caregiving involvement varied as a function of the gendered nature of the care task. For example, Campbell and Martin-Matthews (2003) found that parental status, income, education, and length of time caregiving all impacted each of the gendered care tasks in separate, distinct ways. The current results, however, go against these findings and others like it.

However, this could partly be due to the size and characteristics of the current sample. First of all, the current sample is comprised of 100 men, which is approximately $1/7^{th}$ the size of Campbell and Martin-Matthews' (2003) sample. Second, the group of men who comprise the 100 men in this sample are unique in numerous ways: they are a group of men who have been providing care to an elderly relative for a prolonged period of time (5 years). Also, these men self identified themselves as caregivers to an elderly relative and agreed to continued involvement in a study pertaining to eldercare. In combination, these factors create a picture of a man who is special in some way, a man who differs significantly from the minority of men in the general population who provide care to an aging relative.

These socio-demographic variables were suggested by Finch and Mason (1993) as representing viable circumstances which would serve to justifiably distance men from the responsibility of filial care. Yet for each of the gendered types of care in the current analysis, the amount of variance explained by the legitimate excuses variables, which include geographic proximity, parental status, employment status, sibling network and income/education, were comparatively low (traditionally female= 4%; gender neutral = 17%; traditionally male= 3% and overall= 13%). This is consistent with previous work done by Campbell and Martin-Matthews (2003). Although the legitimate excuses variables utilized by these authors were significant, the amount of variance these variables explained was still quite low (traditionally female= 11%; gender neutral= 19%; traditionally male= 9%). Although the abovementioned socio-demographic and family structure variables play a part in predicting men's caregiving

involvement, there remains a large portion of the variance which is left unexplained.

Health Status of the Care Recipient

As expected, the health status of the care recipient impacts the likelihood of filial care being provided by men. It was postulated that men with parents in poorer health would be more likely to be involved in filial care than those whose parents were in good health. This hypothesis may, at first glance, appear to be rather intuitive but closer scrutiny allows us to see the complexities of the situation. In actual fact, there exists a body of literature which contradicts this hypothesis. Montgomery and Kamo (1989) found that as parental need for assistance increased (that is their health status decreased), son's involvement in filial care decreased accordingly. These authors suggest that son's abdicate the role of caregiver once their parent's health status declines to a point where assistance is required with routine, personal chores. However, their sample differed significantly from the current sample in that their participants were in very poor health, with approximately 50% of the care recipients being too impaired to complete the interview. Likewise, Dwyer and Coward (1991) found that as an elderly care recipients' health status declines, and their needs change from IADL to ADL assistance, the son's involvement in care tasks declines. However, these findings do not necessarily contradict the present study as the health status of the present care recipients did not reach a level of decline equaling that of the participants in both the Dwyer and Coward (1991) or Montgomery and Kamo (1989) studies. In contrast, the care recipients in the present study were in very good overall health, as only 18 of 100 of them were reported by their sons as being in poor physical health and 9 of the 100 care recipients were reported as being in poor emotional/ mental health. If there is indeed a threshold of parental need and dependency after which son caregivers abdicate their role, it is safe to say that this level of need was not reached in the present sample.

The current results correspond more closely with work done by Hamon (1992) who

studied a sample of fairly healthy elderly individuals living independently in the general population and found that son's caregiving involvement increased as their parent's level of need increased (which is associated with a decrease in health status). This finding is also consistent with findings reported by Campbell and Martin-Matthews (2003) who used age as a proxy for a more direct measure of health status and found that men with older parents were more involved in filial care.

What is intriguing about the present results is the fact that poorer reported health status of the elder predicted an increased likelihood of filial care involvement, regardless of the type of care. That is to say that as health status declined, men increased their involvement in tasks which were gender neutral, traditionally male and traditionally female. There was no distinction made regarding type of task; rather, care involvement increased irrespective of the gendered nature of the care task. This finding seems counterintuitive considering that poor health status is associated with the provision of care tasks which are generally performed by women in our culture. There is a prolific literature revolving around gender socialization and culturally appropriate behaviors (Brewer, 2001; Gerstel & Gallagher, 2001) and the cultural taboo involving the provision of intimate forms of care to a cross gender care recipient (Aronson, 1990). Yet men's likelihood of care involvement was greater when the elderly relative's need for assistance was greater, regardless of the gendered nature of the tasks.

Gender of the Care Recipient

Contrary to prediction, men in this sample were significantly more likely to provide care when the care recipient was of the opposite gender to themselves. The notion that there is a preference for gender consistency within the choosing of caregivers and the enacting of caregiving was not supported. Perhaps this gender consistency is only relevant to daughter caregivers as mothers tend to be the parent most likely in need of care, and daughters the ones most likely to provide this care. Yet Stoller (1990) found that fathers are more likely to report

receiving help from sons than from daughters. Whatever the case may be, it remains that in this sample men provided more gender neutral, traditionally male and overall care to female care recipients than to male care recipients. This result is, in all probability, a function of the characteristics of the sample, in that almost 90% of the sample provided care to a mother.

Furthermore, the female care recipients in this sample were more likely to be widowed and therefore did not have their spouse as a source of support, which their male counterparts did. It was further hypothesized that men would be less likely to provide intimate, personal care (that is traditionally female care) to care recipients of the opposite gender (e.g. mothers, or mothers in law). This hypothesis was not supported. Men in this sample were equally likely to provide traditionally female care to a male as to a female care recipient. This finding is consistent with work done by Lee, Dwyer and Coward (1993) who found that sons were equally likely to provide ADL assistance to mothers as to fathers. Likewise with this sample, it can be said that the male participants were equally unlikely to provide intimate, personal forms of care, regardless of the gender of the care recipient. For out of a sample of 100 men, approximately 72% reported never providing this form of care. This could be attributed to the fact that the care recipients in this study were generally in good health and therefore most did not require the types of assistance associated with traditionally female care.

Consistent with previous research which suggested that men are no more likely to help fathers than mothers with tasks non- normative for men (e.g. traditionally female care tasks) (Campbell & Martin-Matthews, 2000a) this study also suggests that male caregivers provide intimate care to care recipients regardless of gender. These results may be moderately misleading as an important factor was not included in the analysis- that is the relationship of the caregiver to the care recipient (be it biological or otherwise). Campbell and Martin-Matthews (2000a) found that there was no difference in the provision of personal care to a male compared to a female care recipient. However, this finding is predicated on gender categories which are not sensitive to the

type of parent relationship. For example, mother and mother in laws were combined to create an overall female category. Campbell and Martin-Matthews (2000a), in an attempt to more clearly examine the relationship between gender and relationship, removed non biological care recipients from their analyses and created gender categories which included only biological relations (e.g. mothers and fathers). These authors found that the men in their sample were more likely to help fathers with dressing, toileting, bathing and taking their medication than they were to assist mothers. When the caregiver's relationship to the care recipient was controlled for, the expectation regarding same sex care was supported.

This is consistent with the ideology revolving around men's involvement in personal care; insofar that a son is rarely considered as the person who should provide intimate care to an elderly woman (be it a relative or otherwise). Finch and Mason (1990) asked 978 individuals what constitutes the 'proper thing to do' for relatives in specified circumstances. 663 of the 978 respondents said that the daughter should be the one to provide personal care to an elderly mother in need of help. This compares to 43 of Finch and Mason's 978 respondents who said that it should be the son. As can be seen, there are strong ideas revolving around gender appropriate behaviors. However, these ideas differ not only as a function of the gender of the care recipient but also by the caregivers' relationship to the elderly individual.

Conclusion

Ultimately, three of the four hypotheses which were established as the premise for this research were not supported. More specifically, it was hypothesized that numerous competing obligations would impede the likelihood of men providing care to an aging relative. This hypothesis was not supported; men in this sample were equally likely to provide care regardless of the presence or absence of various sociodemographic variables (with distance constraints being the exception). Furthermore, it was hypothesized that the male care providers would be more likely to provide care to a care recipient of the same gender, especially when it comes to

tasks which are personal and intimate in nature (traditionally female care). But this hypothesis was also not supported. Men in this sample provide more care to female care recipients, but when it comes to personal care tasks they are no more likely to provide care to a male compared to a female care recipient. This finding runs counter to expectation and introduces the possibility that gender of the care recipient does not matter when the care tasks are personal in nature, and that the cross gender taboo has more to do with the enactment of personal care tasks than the gender of the care recipient in need of assistance.

Furthermore, it was hypothesized that men with parents in poor health would be more likely to provide care than those men with parents in good health. This hypothesis was supported, in that as the reported health status of the care recipients declined, the likelihood of the men's involvement in care increased. Finally, an interaction between the health status of the care recipient and the gender of the care recipient was hypothesized but was not supported by the findings.

However, stating the hypotheses in the above manner oversimplifies the results as each hypothesis was tested not on one dependent measure of overall care, but on three separate gendered care scales and an overall, composite score. As it turns out, the hypotheses behave in distinct ways when the gendered care scales are considered. As an illustration, the gender of the care recipient exerts a minor influence on men's involvement in traditionally female tasks, but plays a more prominent role in men's involvement in each of the other three types of care (traditionally male, gender neutral and overall care). Overall, the findings from the current study highlight the fact that using an overall care score as the sole measurement tool does not always allow us the greatest insight into the complexity of men's caregiving involvement. Rather, the gendered care scales used in the current study allow tasks to be separated into gender specific categories which provide a clearer picture of what these men are doing, and why. The factors which are thought to influence men's caregiving involvement (numerous competing obligations)

do not behave independently of the gendered nature of the care tasks. As an illustration, geographic proximity emerges as an important factor in explaining men's involvement in filial care, but only for gender neutral and overall care tasks. These research findings help to demonstrate the complexity of men's involvement in filial care. They also help us to understand that men's involvement in caregiving is contingent upon not only their own gender, and the gendered context of filial care, but also by the gendered nature of care tasks themselves. Therefore, examining the gendered nature of care tasks in conjunction with other socio-demographic factors helps us to understand more fully the motivating factors which influence men's involvement in different types of care.

However, it is imperative that attention not be confined to the attributes or characteristics of the caregiver alone when investigating men's involvement in filial caregiving. Numerous characteristics of the elderly care recipient serve to influence the likelihood of men's involvement in numerous types of filial care. In terms of the main variables explored in the present thesis, the two which were statistically significant were variables which pertained to characteristics of the care recipients themselves (that is gender and health status of the care recipient). The inclusion of these variables in the analysis allowed us a deeper understanding of men's filial care roles. These variables allowed us to understand more fully when it is that men participate in the role of caregiving, that is when the health status of the care recipient necessitates it and generally when the care recipient is female.

Limitations

There are numerous limitations one must consider in the interpretation of the present study. First, the participants in this study are a unique group of men. They are not a random subset of the population, rather are a select group of individuals. What makes them unique is the fact that, having initially been contacted in the Phase I study through age- stratified sample selection through their place of employment, they subsequently self- identified as participants in

the provision of care to an aging relative and had indicated their willingness to participate in future research on this topic. This serves to do is to separate these men from the population at large, from the broader population of men who provide filial care to an aging relative. It is difficult to make generalizations from a distinct group of men who may be unique in some way, to men who exist within the general population doing exactly the tasks which were asked about in this study.

Second, the reported care provision scores were quite low. This is especially true for traditionally female care. The vast majority of these men were not intimately involved in caregiving; rather, their roles fit with Matthews's (2003) notion of men as 'helpers' in caregiving. This relates back to the idea that men do not generally perform routine, consistent tasks for elderly family members; rather, they typically provide care sporadically, and when necessary. Reflecting this, the distribution of scores for the dependent variables (traditionally female, gender neutral, traditionally male and overall care) were skewed towards nonparticipation. Furthermore, the survey questions which formed the basis of the dependent variables may not have been sufficient to delve into the issue of the gendered nature of caregiving tasks. As it stands, several care tasks were combined into one question, which did not allow for clarification of which task was most commonly performed, least commonly performed, or avoided. Ultimately, the respondent could not respond to each task separately but only to the composite of tasks which were presented in the survey. A great depth and breath of detail was lost in structuring the questionnaire in this way. This structuring of the survey also posed difficulty in designing the three gendered care scales, as some questions combined tasks which had been associated with different categories in the original Campbell (1997) analyses (e.g. traditionally female and traditionally male care).

Finally, the sample size served to be a major limitation of the present study. Adhering to the rules of statistical analyses allowed for the use of only a limited number of variables in the

model. Deciding which variables to include, and exclude, from the model proved to be a difficult venture, one which would be unnecessary in samples of a larger size. Furthermore, there is always the very real possibility that the small sample size precluded the results which other researchers had previously established.

Future Research

In sum, the findings from the current study do not support the importance which previous researchers have attributed to socio- demographic variables in men's involvement in filial care. The current research suggests that there are other factors, with more explanatory power than structural ones, which serve to dictate the trajectory of men's caregiving involvement. It may be that men's participation in the highly gendered practice of caregiving is influenced by the reality of their competing obligations, but these obligations are not sufficient predictors of men's involvement in caregiving. This research does, however, suggest the importance of numerous characteristics of the care recipient in explaining men's filial care. For example, the health status of the care recipient predicts men's involvement in filial care, regardless of the type of care. In sum, socio- demographic variables should not be viewed as entities unto themselves, but should be conceptualized from within a framework involving other factors which impact men's filial care involvement (e.g. other social, familial, and affective factors). It is the interplay of these factors which would give us a rich, textured picture of the reasons, or circumstances behind men's decision to provide care to an elderly family member.

The notion of legitimate excuses involves the negotiation of family responsibilities, and involves an interplay of family members and their life circumstances. The current research departs from this negotiating process and explores legitimate excuses from a more singular vantage point. It looks to explore the 'excuses' which could be, and have been, considered legitimate reasons for men's limited participation in caregiving. Future research would do well to relocate the notion of legitimate excuses within the men's familial situation. These 'excuses', be

they employment or distance or competence, should be explored in the context of the experiences of these men, from within a setting of numerous other family members. Focus should be given to men's subjective feelings about their decision to become caregivers and the factors which they believe impact and shape their choices. Furthermore, research is needed that explores the barriers which exist for men in their decision to become caregivers, within the family, the community and society at large. Ultimately, insight is needed into how men come to be involved within a female dominated landscape of family responsibility, and the support they may or may not receive once there.

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Appendix A- Pertinent Questions from the Work and Family Questionnaire

1. What kind of work do you do? (Please give you full job title; e.g., accounts clerk, primary school teacher, welder, salesperson). _____

46. a. How many living brothers do you have? _____
b. How many of your living brothers are older than you? _____
c. How many living sisters do you have? _____
d. How many of your living sisters are older than you? _____

47. What is the highest level of education that you have completed? Please CHECK only one category.

(1) Some elementary or public school ..... □
(2) Completed elementary or public school ..... □
(3) Some high school ..... □
(4) Completed high school ..... □
(5) Some vocational, CEGEP, or technical college ..... □
(6) Completed vocational, CEGEP, or technical college ..... □
(7) Some training in a special diploma program
e.g., nursing, teaching ..... □
(8) Completed special diploma program ..... □
(9) Some university ..... □
(10) Undergraduate university degree completed..... □
(11) Some university post- graduate level ..... □
(12) Post- graduate university degree completed ..... □

51. What was your total personal income from wages and salaries during the past 12 months? Please CHECK the appropriate category.

(1) Less than $5, 000 ..... □
(2) $5, 000- $9, 999 ..... □
(3) $10, 000- $14, 999..... □
(4) $15, 000- $19, 999..... □
(5) $20, 000- $29, 999..... □
(6) $30, 000- $39, 999..... □
(7) $40, 000- $49, 999..... □
(8) $50, 000- $59, 999..... □
(9) $60, 000- $69, 999..... □
(10) $70, 000- $79, 999..... □
(11) $80, 000- $89, 999..... □
(12) $90, 000 or over ..... □

Appendix B- Work and Eldercare Questionnaire

This questionnaire is part of a national study of how Canadians combine work and their responsibilities for assisting older relatives. You participation will help make it successful. All the information you provide will be held in strictest confidence.

SECTION 1: ASISTANCE TO OLDER RELATIVES

When we last spoke with you, you indicated that you were providing assistance to:

Rel. 1 _____
Rel. 2 _____
Rel. 3 _____

1. Since we last spoke to you, <u>have you continued to provide assistance to these relatives or assisted other elderly relatives?</u>

☐ YES
☐ NO **[Go to Q.2]**

Please tell us who they are (e.g., mother, father, aunt, etc.,) even if it means repeating relatives from the first part of the question.

Rel. 1 _____ Go to Section II
Rel. 2 _____ Go to Section II
Rel. 3 _____ Go to Section II

2. If you no longer provide assistance to ANY relative and have not done so during the last 6 months, could we call you sometime in the future to respond to a questionnaire geared to assistance that you have provided in the past three years?

☐ Yes, you may contact me in the future
☐ No, I would be unwilling to participate further

Thank you for your interest in helping us. If you are able to assist with a questionnaire that is more applicable to your experiences, we look forward to talking with you in the future.

If you are now providing and/or have provided assistance to older relatives in the last 6 months, please continue with SECTION II: YOUR JOB.

SECTION II: YOUR JOB

We would like to ask a few questions about your work.

3. When we last spoke with you, you indicated that you were working for _____ as a _____.

Is this still the case?

☐ YES
☐ NO. What has changed?

_____
_____
_____

4. On average per week, do you work for pay:

☐ 35 hours or more
☐ less than 35 hours

5. How long does it usually take you to travel (one way) from your home to your work place?

_____ minutes

☐ Not applicable (work at home)

6. In the last three years have you participated in continuing education courses or retraining programs?

☐ Yes
☐ No. **[Go to Q. 8]**

7. What sort of courses or retraining programs did you take?

☐ academic
☐ related to work (improve existing or learn new skills)
☐ computer
☐ leisure/ interest
☐ Other. Please explain:

_____
_____
_____ **[Go to Q. 9]**

8. If you have not taken continuing education course or retraining in the last 3 years, what factors may have prevented you from doing so? (Please check as many reasons as are applicable)

☐ eldercare responsibilities
☐ other family responsibilities
☐ work schedule
☐ lack of money
☐ lack of education
☐ lack of interest
☐ Other. Please explain_____
_____
_____

9. Which if any of the following factors might encourage you to take continuing education courses or retraining in the future? (Please check as many reasons as are applicable).

☐ help with eldercare
☐ help with family responsibilities
☐ changes in work schedule
☐ having someone else pay for the course
☐ knowing the course would be useful
☐ Other. Please explain

_____
_____
_____

SECTION III: FAMILY CHARACTERISTICS

10. What is your present marital status?

☐ Married ☐ Divorced
☐ Common Law ☐ Widowed
☐ Separated ☐ Single/ Never Married

11. If you are married or in a common law relationship, does your spouse/ partner work for pay?

☐ Yes, Full-time
☐ Yes, Part-time
☐ No [Go to Q. 13]

12. How long does it usually take your spouse/ partner to travel (one way) from your home to his/ her place of work?

_____ minutes

☐ Not applicable (work at home)

13. How many children do you have age 18 or younger living at home?

_____ child (ren)

b. What are their ages?

i. _____ ii) _____ iii) _____ iv) _____

14. Would you say that over the last three years your level of household income has:

☐ increased
☐ stayed the same
☐ decreased

SECTION IV: CHARACTERISTICS OF OLDER RELATIVES

	Relative 1 is my _____	**Relative 2 is my** _____	**Relative 3 is my** _____
15. How old is your relative?	_____ **years**	_____ **years**	_____ **years**
16. What is your older relative's current marital status?	☐ Married or Common-Law ☐ Widowed ☐ Separated ☐ Divorced ☐ Never Married	☐ Married or Common-Law ☐ Widowed ☐ Separated ☐ Divorced ☐ Never Married	☐ Married or Common-Law ☐ Widowed ☐ Separated ☐ Divorced ☐ Never Married
17. How would you describe your older relative's financial situation?	☐ Very Good ☐ Good ☐ Fair ☐ Difficult ☐ Do not know	☐ Very Good ☐ Good ☐ Fair ☐ Difficult ☐ Do not know	☐ Very Good ☐ Good ☐ Fair ☐ Difficult ☐ Do not know
18. What are your older relative's living arrangements?	☐ Lives with me ☐ Lives in their own home or apt. ☐ Lives in retirement home or nursing home ☐ Other. Please specify: _____ _____	☐ Lives with me ☐ Lives in their own Home or apt. ☐ Lives in retirement home or nursing home ☐ Other. Please specify: _____ _____	☐ Lives with me ☐ Lives in their own home or apt. ☐ Lives in retirement home or nursing home ☐ Other. Please specify: _____ _____
19. For those relatives who do <u>not</u> live with you or in a retirement / nursing home, do they live alone?	☐ Yes ☐ No. With whom do they live? ☐ their spouse ☐ my brother or sister ☐ another relative ☐ other	☐ Yes ☐ No. With whom do they live? ☐ their spouse ☐ my brother or sister ☐ another relative ☐ other	☐ Yes ☐ No. With whom do they live? ☐ their spouse ☐ my brother or sister ☐ another relative ☐ other

	Relative 1	**Relative 2**	**Relative 3**
20. Does your older relative have the same living arrangements year round?	☐ Yes ☐ No. Please explain: _____ _____ _____	☐ Yes ☐ No. Please explain: _____ _____ _____	☐ Yes ☐ No. Please explain: _____ _____ _____
21. Where does your older relative live?	Name of community and province (or country if international) _____ _____	Name of community and province (or country if international) _____ _____	Name of community and province (or country if international) _____ _____
22. How long has your older relative lived there?	Length of Residence: _____ years	Length of Residence: _____ years	Length of Residence: _____ years
23. How do you usually get to your older relative's home?	☐ Walk ☐ Bus ☐ Taxi ☐ Car ☐ Train ☐ Plane ☐ Not applicable (older relative lives with me)	☐ Walk ☐ Bus ☐ Taxi ☐ Car ☐ Train ☐ Plane ☐ Not applicable (older relative lives with me)	☐ Walk ☐ Bus ☐ Taxi ☐ Car ☐ Train ☐ Plane ☐ Not applicable (older relative lives with me)
24. How long does it usually take to travel (one way) from your home to your older relative's home?	For a one way trip: _____ hours _____ minutes ☐ Not applicable (older relative lives with me)	For a one way trip: _____ hours _____ minutes ☐ Not applicable (older relative lives with me)	For a one way trip: _____ hours _____ minutes ☐ Not applicable (older relative lives with me)

	Relative 1	Relative 2	Relative 3
25. How many times has your older relative moved in the last 3 years?	☐ None [Got to Q. 28] Older relative moved ___________ times	☐ None [Got to Q. 28] Older relative moved ___________ times	☐ None [Got to Q. 28] Older relative moved ___________ times
26. Thinking in terms of the <u>most recent</u> move, did your older relative move for any of the following reasons? **Please check as many as are applicable.**	☐ To be closer to you (but not into your home) ☐ To live with you ☐ To live in a retirement home or nursing home ☐ To live in a home or apt. of their own that was 'easier' for them ☐ To be closer to services they need ☐ To be closer to, or live with, another relative ☐ Other ________________	☐ To be closer to you (but not into your home) ☐ To live with you ☐ To live in a retirement home or nursing home ☐ To live in a home or apt. of their own that was 'easier' for them ☐ To be closer to services they need ☐ To be closer to, or live with, another relative ☐ Other ________________	☐ To be closer to you (but not into your home) ☐ To live with you ☐ To live in a retirement home or nursing home ☐ To live in a home or apt. of their own that was 'easier' for them ☐ To be closer to services they need ☐ To be closer to, or live with, another relative ☐ Other ________________
27. Did these moves affect the assistance you provide to your relative?	☐ No ☐ Yes. Please explain ________________ ________________ ________________ ________________	☐ No ☐ Yes. Please explain ________________ ________________ ________________ ________________	☐ No ☐ Yes. Please explain ________________ ________________ ________________ ________________

	Relative 1	Relative 2	Relative 3
28. In the last <u>6 months,</u> have you done any f the following to meet or prepare for any of your older relatives need for care? **Please check as many as are applicable to your situation**	☐ urged an older relative to move closer to where I live ☐ Made arrangements for an older relative to move closer to me ☐ urged an older relative to move into my home ☐ Made arrangements for an older relative to move into my home ☐ Looked into moving closer to an older relative ☐ Made arrangements to move closer to an older relative	☐ urged an older relative to move closer to where I live ☐ Made arrangements for an older relative to move closer to me ☐ urged an older relative to move into my home ☐ Made arrangements for an older relative to move into my home ☐ Looked into moving closer to an older relative ☐ Made arrangements to move closer to an older relative	☐ urged an older relative to move closer to where I live ☐ Made arrangements for an older relative to move closer to me ☐ urged an older relative to move into my home ☐ Made arrangements for an older relative to move into my home ☐ Looked into moving closer to an older relative ☐ Made arrangements to move closer to an older relative
29. Does your older relative drive?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
30. Was your older relative born in Canada or in another country?	☐ Born in Canada ☐ Born in another country	☐ Born in Canada ☐ Born in another country	☐ Born in Canada ☐ Born in another country
31. Does you older relative have difficulty communicating in either of the official languages (English or French)?	English ☐ Yes ☐ No French ☐ Yes ☐ No	English ☐ Yes ☐ No French ☐ Yes ☐ No	English ☐ Yes ☐ No French ☐ Yes ☐ No

SECTION V: HEALTH STATUS OF OLDER RELATIVES

	Relative 1	Relative 2	Relative 3
32. How would you rate your older relative's general physical health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor
33. How would you rate your older relative's emotional or mental health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor
34. Has your older relative been hospitalized in the past year?	☐ No ☐ Yes Number of time in Hospital: _____ Total number of days: _____	☐ No ☐ Yes Number of time in Hospital: _____ Total number of days: _____	☐ No ☐ Yes Number of time in Hospital: _____ Total number of days: _____

35. How well do you think your older relative can manage to do the following?

	Relative 1 **My older relative can do this task:**	**Relative 2** **My older relative can do this task:**	**Relative 3** **My older relative can do this task:**
i. Get up and down stairs and steps	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all
ii. Get around the house (except for stairs)	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all

iii. Get in and out of bed	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all
iv. Cut their toenails	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all
v. Bath, shower, or wash all over	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all
vi. Go out and walk down the road	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all	☐ on their own ☐ on their own, but with difficulty ☐ only with help, or not at all

Now we will ask you about some types of help which you may have provided to your older relatives in <u>the past 6 months</u>.

	Relative 1	**Relative 2**	**Relative 3**
36. How often have you helped your older relative with bathing, dressing, feeding, toileting, or taking medication?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these**	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these**	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these**

	types of assistance? ☐ Yes ☐ No	**types of assistance?** ☐ Yes ☐ No	**types of assistance?** ☐ Yes ☐ No
37. How often have you helped your older relative by providing transportation, doing shopping and/or errands?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No
38. In the last 6 months, how often have you helped your older relative with laundry, household chores, meal preparation, home maintenance or yard work?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No
39. How often have you helped your older relative by providing them with moral or emotional support?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in

	the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No
40. <u>In the last 6 months,</u> how often have you help your older relative with money management or provided them with money, or negotiated on their behalf (e.g., with other family members or health service providers)?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never. **Do they need any of these types of assistance?** ☐ Yes ☐ No
41. Overall, please estimate the number of hours of help you have provided to your older relative in an average week <u>or</u> month?	Number of hours/ week ____________ <u>OR</u> Number of hours/ month ____________	Number of hours/ week ____________ <u>OR</u> Number of hours/ month ____________	Number of hours/ week ____________ <u>OR</u> Number of hours/ month ____________
42. In the last 6 months has anyone assisted you in helping your elderly relatives in any of the following ways? ☐ **No [Go to Q. 44]** ☐ **Yes** **Please check as many as are applicable to your situation.**	☐ Household chores ☐ Childcare ☐ Financial assistance ☐ Home/ yard maintenance or repair ☐ Moral/ emotional support ☐ Other. Please specify: ____________ ____________ ____________ ____________	☐ Household chores ☐ Childcare ☐ Financial assistance ☐ Home/ yard maintenance or repair ☐ Moral/ emotional support ☐ Other. Please specify: ____________ ____________ ____________ ____________	☐ Household chores ☐ Childcare ☐ Financial assistance ☐ Home/ yard maintenance or repair ☐ Moral/ emotional support ☐ Other. Please specify: ____________ ____________ ____________ ____________

43. Who helps you? **Please check as many as are applicable to your situation for each relative.**	☐ your spouse ☐ your daughter (s) ☐ your son (s) ☐ your sister (s) ☐ your brother (s) ☐ Other family members ☐ friends ☐ caregiver support group ☐ respite care ☐ Other. Please specify: __________ __________	☐ your spouse ☐ your daughter (s) ☐ your son (s) ☐ your sister (s) ☐ your brother (s) ☐ Other family members ☐ friends ☐ caregiver support group ☐ respite care ☐ Other. Please specify: __________ __________	☐ your spouse ☐ your daughter (s) ☐ your son (s) ☐ your sister (s) ☐ your brother (s) ☐ Other family members ☐ friends ☐ caregiver support group ☐ respite care ☐ Other. Please specify: __________ __________

SECTION VI: CRISIS SITUATIONS

We would now like to ask you about crisis situations that your older relatives have experienced such as illness, accident, personal tragedy, or family crisis.

	Relative 1	**Relative 2**	**Relative 3**
44. Has there been an episode in the past 6 months when your older relative (s) experienced a crisis?	☐ Yes ☐ No **[Go to Q. 53]**	☐ Yes ☐ No **[Go to Q. 53]**	☐ Yes ☐ No **[Go to Q. 53]**
45. How many separate crises have there been in the past 6 months?	________ Crises	________ Crises	________ Crises

Please answer Questions 46- 52 thinking about the crisis in which you were <u>most involved.</u>

46. What kind of crisis was it?

____
____
____
____

47. How long did it last?

_____
_____
_____

48. How were you involved?

_____
_____
_____
_____
_____

49. If you help more than one older relative, which one did this crisis involve?

_____
_____

50. Did this crisis I any way interfere with your work or home life?

☐ No
☐ Yes. Did this require:

☐ travel
☐ lengthy or frequent telephone conversations
☐ time off work
☐ altered work schedules
☐ Other. Please explain: _____
_____
_____
_____

51. Were there factors at work that helped you to deal with this crisis?

☐ No
☐ Yes. Please check as many as are applicable:

☐ Supportive Supervisor
☐ Supportive Coworker
☐ Could take leave from work
☐ Could rearrange work schedule
☐ Could renegotiate work responsibilities
☐ Could take paid leave
☐ Other. Please explain: _____
_____
_____
_____

52. Were there any factors at work that made it difficult for you to deal with this crisis?

☐ No
☐ Yes. Please check as many as are applicable:

☐ Unsupportive Supervisor
☐ Unsupportive Coworker
☐ Could not take leave
☐ Could not rearrange work schedule
☐ Could not renegotiate work responsibilities
☐ Could not take paid leave
☐ Other. Please explain: _____

_____

_____

_____

We would now like to ask you how you feel about combining work responsibilities with the responsibilities you have to your older relatives.

53. Please CHECK how much you agree or disagree with the following statements

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
a. My job prevents me from spending as much time as I would like with my older relatives.	☐	☐	☐	☐
b. After work, I am too tired to do some of the things I'd like to do with my older relatives.	☐	☐	☐	☐
c. When I am at home I am distracted by thoughts about job responsibilities.	☐	☐	☐	☐
d. My job prevents me from giving the kind of attention I would like to give to my older relatives.	☐	☐	☐	☐
e. My responsibilities to my older relatives take up time that I'd like to spend working on my job.	☐	☐	☐	☐
f. I'm often too tired at work because of the things I have to do for my older relative.	☐	☐	☐	☐
g. When I am at work I am distracted by thoughts about my responsibilities to older relatives.	☐	☐	☐	☐
h. The quality of my work suffers because of demands of my older relative.	☐	☐	☐	☐

54. Now, considering life in general, how often in the last month have you:

	Never	Rarely	Sometimes	Often	Very Often
a. Been upset because of something that happened unexpectedly?	☐	☐	☐	☐	☐
b. Felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
c. Felt nervous and "stressed"?	☐	☐	☐	☐	☐
d. Felt confident about your ability to handle your personal life?	☐	☐	☐	☐	☐
e. Felt that things were going your way?	☐	☐	☐	☐	☐
f. Found that you could not cope with all of the things that you had to do?	☐	☐	☐	☐	☐
g. Been able to control irritations in your life?	☐	☐	☐	☐	☐
h. Felt that you were on top of things?	☐	☐	☐	☐	☐
i. Been angered because of things that happened that were outside of your control?	☐	☐	☐	☐	☐
j. Found yourself thinking about things that you have to accomplish?	☐	☐	☐	☐	☐

55. Have any of the following job related situations happened to you in the past 6 months because of your responsibilities to your older relatives?

a. I had to take sick days when I was not sick.

☐ Yes
☐ No

If "yes", please estimate how many days this happened in the past 6 months _____ Days

b. I had to stay away from work for a period of time.

☐ Yes
☐ No

If "yes", how many days were involved _____ Days

What were these days? ☐ Paid days ☐ Unpaid days ☐ Combination of paid and unpaid days

c. I had to lose time from work because of arriving late, leaving early, or extending lunch hours or breaks by 20 minutes or more.

☐ Yes
☐ No

d. I had to use vacation days to take care of responsibilities to my elderly relatives.

☐ Yes
☐ No

If "yes", on how many days did this happen in the past 6 months? _____ Days

e. I was unable to go on business trips.

☐ Yes
☐ No
☐ Not applicable

f. I was unable to attend meetings or training sessions.

☐ Yes
☐ No
☐ Not applicable

g. I was unable to take on extra projects or responsibilities at work.

☐ Yes
☐ No
☐ Not applicable

h. I was unable to seek or accept a promotion or job transfer.

☐ Yes
☐ No
☐ Not applicable

i. I was unable to attend social events related to my job that took place outside regular work hours.

☐ Yes
☐ No
☐ Not applicable

j. Thinking only about the last month, did your responsibilities to older relatives interrupt your work day for at least 20 minutes?

☐ Not during this month
☐ One day this month

☐ 2 to 4 days this month
☐ More than 4 days this month

56. Have your responsibilities to your older relatives caused you to reduce the amount of time you give to:

	No	Yes (In the Last 6 months)	Yes (More than 6 months ago)
a. Volunteer Work	☐	☐	☐
b. Leisure Activities	☐	☐	☐
c. Socializing with friends	☐	☐	☐
d. Sleeping/ Resting	☐	☐	☐
e. Other	☐	☐	☐

SECTION VII: OTHER HELPERS AVAILABLE TO OLDER RELATIVES

Now we would like to ask you a number of questions concerning the involvement of others in the family in providing assistance to your older relatives.

We would like you to focus on the relative to whom you provide the most assistance.

57. Who is that relative? _____

58. Are you the only person who helps this older relative?

☐ Yes **[Go to Q.65]**
☐ No

	Helper 1	**Helper 2**	**Helper 3**
59. Who else has helped this relative? **Please indicate whether this is your spouse or your relative's spouse, your sister, or your relative's sister, your friend, or your relative's friend, etc.**	Helper 1 is _____	Helper 2 is _____	Helper 3 is _____

	Helper 1	**Helper 2**	**Helper 3**
60. Within the past 6 months, how often has this person helped your older relative with bathing, dressing, feeding, toileting, or taking medication?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never
61. How often has this person helped your older relative by providing transportations, shopping and/or errands?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never
62. How often has this person helped your older relative with laundry, household chores, meal preparation, home maintenance or yard work?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never
63. How often has this person helped your older relative with emotional support?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never

64. How often has this person helped your older relative (s) with money management or providing money, or negotiating on their behalf (e.g., with other family members or health service providers)?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ Every 1 or 2 months ☐ Once or twice in the last 6 months ☐ Never

SECTION VIII: COMMUNITY SERVICES

We would now like to ask you a series of questions about services your older relative (s) receive, either within or outside of their own home, which assist or support them in some way. This help could be provided by a government program (for example, Homecare), by a voluntary group in the community (for example, a church or social club), or by paid help.

65. Please tell us if <u>any</u> of your older relatives have used (in the last 6 months) or are currently using community services?

☐ Not now, or in the last 6 months
☐ In the last 6 months, but <u>not</u> now **[Go to Q.67]**
☐ Yes, services are being used currently **[Go to Q.68]**

66. Why didn't any of your older relatives use community services? (Please check as many responses as applicable).

☐ My older relatives' needs were/are not sufficiently serious
☐ I, or other relatives, provide any needed assistance
☐ Suitable services were/are not available **[Go to Q.80]**
☐ Services were/are too expensive
☐ Other (Please specify)

_____

_____

67. Why did your older relatives stop using community services? (Please check as many responses as applicable).

☐ My older relative (s) no longer required the services
☐ My older relative (s) was (were) no longer eligible for the service
☐ I, or other relatives, took on the responsibility for providing needed assistance
☐ My older relative (s) no longer wanted the service
☐ The cost of services became a problem **[Go to Q.80]**
☐ Other (Please specify)

_____

_____

_____

Thinking in terms of <u>the relative to whom you provide the most assistance</u>, please tell us as much as you can about each community service he or he receives now or in the last 6 months. If your older relative receives more than 3 services, please tell us about the 3 services that are most important to their well-being.

68. Before you begin, please remind us which relative you are thinking about:
☐ Relative 1, ☐ Relative 2, ☐ Relative 3

	Service 1 is _____	**Service 2 is** _____	**Service 3 is** _____
69. What type of assistance does the service provide?			
70. Did you arrange for the service?	☐ Yes ☐ No. Who did? _____	☐ Yes ☐ No. Who did? _____	☐ Yes ☐ No. Who did? _____
71. How frequently is the service used?	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ About once a month ☐ Less than once a month	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ About once a month ☐ Less than once a month	☐ Daily ☐ Several times a week ☐ Once a week ☐ 2-3 times a month ☐ About once a month ☐ Less than once a month
72. Has your relative received services on a weekend?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
73. Is a fee paid for any of the services?	☐ No ☐ Yes. Who pays? _____	☐ No ☐ Yes. Who pays? _____	☐ No ☐ Yes. Who pays? _____

	Service 1	Service 2	Service 3
74. Still thinking in terms of the relative to whom you provide the most assistance, did you or your older relative experience problems obtaining community services?	☐ Yes ☐ No **[Go to Q.76]**	☐ Yes ☐ No **[Go to Q.76]**	☐ Yes ☐ No **[Go to Q.76]**
75. What sort of problems were experienced in obtaining services? **Please check as many responses as are applicable.**	☐ Suitable service not available ☐ Service not available at suitable times ☐ Older relative was not eligible for the service ☐ Appropriate person not available ☐ Other. Please specify: _____	☐ Suitable service not available ☐ Service not available at suitable times ☐ Older relative was not eligible for the service ☐ Appropriate person not available ☐ Other. Please specify: _____	☐ Suitable service not available ☐ Service not available at suitable times ☐ Older relative was not eligible for the service ☐ Appropriate person not available ☐ Other. Please specify: _____
76. Have you or your older relative experienced problems while using community services?	☐ Yes ☐ No **[Go to Q.78]**	☐ Yes ☐ No **[Go to Q.78]**	☐ Yes ☐ No **[Go to Q.78]**
77. What sorts of problems were experienced in using services? **Please check as many responses as are applicable.**	☐ Service was not of high quality ☐ Service was not reliable ☐ Times and schedules were no suitable ☐ Service was expensive ☐ Transportation ☐ Older relative did	☐ Service was not of high quality ☐ Service was not reliable ☐ Times and schedules were no suitable ☐ Service was expensive ☐ Transportation ☐ Older relative did	☐ Service was not of high quality ☐ Service was not reliable ☐ Times and schedules were no suitable ☐ Service was expensive ☐ Transportation ☐ Older relative did

	not like service provider ☐ Other. Please specify: _____ _____	not like service provider ☐ Other. Please specify: _____ _____	not like service provider ☐ Other. Please specify: _____ _____

78. To what extent has the use of community services by any of your older relatives helped you balance your work and your responsibilities to them?

☐ Not at all **[Go to Q.80]**
☐ Somewhat
☐ Quite a bit
☐ Very much

79. Please tell us how community services helped you to balance your work and family responsibilities.

_____
_____
_____
_____
_____

80. How might existing community services be improved to help you meet your need as an employed caregiver?

_____
_____
_____
_____
_____

81. What sorts of new community services or programs might be started to help you meet your needs as an employed caregiver?

_____
_____
_____
_____
_____

82. Overall, how satisfied are you with the assistance that your older relative receives from family members (including yourself), friends, community services and/or paid help?

☐ Satisfied
☐ Somewhat satisfied

☐ Neither satisfied nor dissatisfied **[Go to Q.83]**
☐ Somewhat dissatisfied
☐ Dissatisfied

83. What would make a difference?

_____
_____
_____
_____
_____

Thank you for assisting us with this survey. Upon receipt of your questionnaire, we will be pleased to forward to you a cheque for $10 in acknowledgement of your time and effort. You support of this project is most appreciated.

Thank you very much for taking the time to complete this questionnaire.

We are very interested in any further comments you may wish to make about combining work and family responsibilities. Please feel free to use the space below for your comments.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____