

Elder Caregiving in South-Asian Families in the United States and India

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1 Introduction

Provision of care to the elderly has been identified as a chronic stressor that places caregivers at risk for physical and emotional problems (Aneshensel, Pearlin, Mullan, Zarit, & Whitlach, 1995). Providing care to an elderly relative often restricts the personal life, social life, and employment of the caregiver. It is also associated with increased psychological distress (Donaldson, Tarrrier, & Burns, 1998; Schulz, O'Brien, Bookwala, & Fleissner, 1995). For example, up to 48% of dementia caregivers have been identified as being at risk for psychiatric symptomatology (Brodarty & Hadzi-Pavlovic, 1990; Draper, Poulos, Cole, Poulos, & Ehrlich, 1992). Caregivers may have less time to spend with friends, fulfill family obligations, or to pursue leisure activities (Gilleard, Gilleard, Gledhill, & Whittick, 1984; Kosberg & Cairl, 1986; Zarit, Reeve, & Bach-Petersen, 1980). Furthermore, caregivers are often faced with difficult care giving tasks while faced with verbal, physical aggression, confusion (Teri, Truax, Logsdon, Uomoto, Zarit, & Vitaliano, 1992) and behavior problems of demented care recipients. Because the progression of the care receivers' illnesses and care needs are difficult to foresee, caregivers feel uncertain about their own abilities to carry out all the tasks for their own well being as the well being of the recipient (Poulshok & Deimling, 1984).

In general, care giving is fraught with uncertainties and disillusionment for most caregivers, though care giving often brings with it rewarding experiences for many caregivers. The positive and negative consequences of care giving may vary widely across caregivers. Since elder care giving is often provided within family settings, changes in number of factors such as care giving attitudes of family members, family structure, and location may influence the level of caregiver burden. In spite of the variations in caregiver burden, there are likely to be commonly shared patterns and feelings with respect to care giving (Gupta, 2009). While research on caregiver burden has focused on isolating key determinants of caregiver burden very few studies have attempted to investigate caregiver burden levels associated with various stages of elder care giving. Given the vast variations in the structure and composition of families within which elder care giving occurs, investigation of caregiver burden determinants will require controls for extraneous factors that may influence caregiver burden. Consequently comparative research methods play a crucial role in the systematic analysis of the phenomenon of elder caregiver burden. In this chapter, we describe the elder caregiver burden among Asian Indian families in two settings, in Dallas, United States and Allahabad, India.

2 Eldercare burden: A brief literature review

Research on well being of elder caregivers remains beset with contradictory and inconsistent findings. The inconsistencies in studies comparing caregivers and non caregivers make it difficult to draw clear conclusions about the prevalence of poor psychological and physical

health of caregivers. For example, whereas Vitaliano, Russo, Scanlan, and Greeno (1996) and Bodnar and Kiecolt-Glaser (1994) reported higher levels of depression in caregivers than in non caregivers while Haley et al. (1995) did not find significant differences. Similar contradictions are found for physical health as well (Rose-Rego, Strauss, & Smyth, 1998, vs. Barnes & Patrick, 2000; Haley, West, Wadley, Ford, White, Barrett, 1995).

There are both methodological and conceptual reasons for these inconsistencies. First, there are sampling issues with caregiver research. Many studies on care giving are based on non representative samples that over represent distressed caregivers (Schulz et al., 1995, 1997). Thus, caregivers might not experience significantly higher levels of distress than the general population, if they were sampled differently. On the other hand, Schulz et al. (1997) have also suggested that more representative studies may underestimate caregiver stress because of how they define caregivers. In some studies a caregiver is defined as a person sharing the household with an impaired family member without clarifying whether the respondent provides care or not. Second, many studies have large random sampling errors due to small sample sizes. If the magnitude of population effect sizes is low to medium, then the effects may not be detectable in these studies (Rosenthal, 1991). Third, caregivers often derive benefits from the care giving experience, such as increased closeness to the family member being cared for, and satisfaction at fulfilling one's duty (Kramer, 1997). Thus, caregivers may not be disproportionately stressed compared to non caregivers, unless the care giving situation is unusually stressful and there are no positive aspects to their care giving experience.

Fourth, caregivers to older adults with dementia may be considerably more distressed than caregivers to other older adults. However, these groups are rarely differentiated in studies of care giving (Cattanach & Tebes, 1991; Pinquart & Sorenson, 2003; Teel & Press, 1999; Wallsten, 2000), thus influencing observed differences between caregivers and non caregivers. Finally, research on the protection of psychological well-being and positive self-concept in adulthood has found the presence of considerable resilience of the self (Brandtstadter & Greve, 1994). Thus, many caregivers may cope well with their role without showing negative effects on psychological or physical health (Garity, 1997). A comparative research approach is useful also in assessing and explaining differential findings with respect to eldercare giving. Very few studies have examined the differences in the determinants of caregiver burden among members of the same communities in two different cultural settings. Such studies offer opportunities to control for cultural factors in natural settings.

3 Demographics of older Adults in India and the U.S.

India has one of the highest growth rates of older adult population in the world. In India, the population aged 60 and over constitutes about 7.4% of the population of over a billion (Census of India, 2001). The number of older persons (defined as those who are sixty years of age or older) in India was 71 million in 2001 and is projected to rise to 173 million by 2026 (Census of India, 2001). This phenomenal growth will make the Indian elderly the largest older population group in the world. A unique characteristic of the Indian population is that the sex ratio among the elderly, 60 years and above, favors males. At ages 70 years and above, the number of elderly persons is likely to increase more sharply than those 60 years and above during the next four decades. It is estimated that during 2010 to 2050, at ages 70 years and above, the sex ratio will favor females (Swain, 2011). The 2010 Asian Indian population in Texas was 245,981 with about 100,000 of them living in the Dallas-Fort Worth –Arlington Metropolitan Area. The total population of Asian Indians in the US is 1.7 million (Census Bureau, 2010).

4 Methodology

The U S. Sample: Dallas, Texas

A critique of the caregiver burden literature suggests a lack of criteria for defining concepts such as “elder” and the “caregiver” (Barer & Johnson, 1990). In multigenerational households, several family members often share care giving tasks. The care giving literature suggests that there is at least one person in the family who perceives himself or herself as a primary caregiver and provides more caregiver services than the rest of the family (Soldo & Myllyluoma, 1983). In this study, a primary caregiver is one who self-identifies or is identified by a family member as the person who provides at least 4 hours of care per week and assists the care recipient in at least one activity of daily living (ADL) or two instrumental activities of daily living (IADL). In addition, in this study, the caregiver is a first generation Asian Indian/Pakistani male/female immigrant taking care of a parent or parent-in-law who is at least 60 years-of-age or older and has lived in a multigenerational Asian Indian/Pakistani household for at least one year.

Caregivers and elderly who congregate at places of worship in the Dallas-Fort Worth area were approached, and their participation in the study was solicited. In order to gather the elderly at a pre-specified venue, the principal investigator conducted several educational sessions at places of worship. This was also a cost-effective way to contact the elderly and the caregivers. The caregivers and care recipients who participated were encouraged to provide names and addresses of caregivers who were known to them and who resided in the Dallas-Fort Worth area. In addition, community leaders were approached to identify potential respondents -- senior citizens and their caregivers.

The first phase of the study involved compiling a list of households in the Dallas-Fort Worth area with elderly persons receiving care from family members. In order to develop this list, Asian religious and nonprofit organizations in the Dallas-Fort Worth area were approached. Six religious organizations, including two Hindu temples, a Gurdwara, (a place for worship for Sikhs) a Jamat khana, (a place of worship for the Aghakhani Muslims) and two churches, agreed to participate. Out of the 48 nonprofit organizations, 15 organizations in the Dallas Fort Worth area agreed to participate in the study. The remaining 33 organizations did not participate because they did not have information on caregivers of the elderly in the Dallas-Fort Worth area.

The final list contained approximately 500 multigenerational Asian Indian/Pakistani caregivers that are first-generation immigrants to the United States. Two hundred households were selected randomly for a preliminary interview. The final sample constituted hundred and eighteen cases without missing data. Participants were read a script for the telephone interview, and a verbal informed consent form was read over the telephone. Appointments for weekend evening telephone interviews that would last approximately 1 to 2 hours were obtained.

The interview questionnaire was translated into Hindi and back translated into English by two bilingual, bicultural (Hindi/English) professors. A large proportion of the Indian/Pakistani population understands both the Hindi and English languages. Pakistanis speak Urdu and understand Hindi because both languages are very similar except for slight lexical differences. Some Indians and Pakistanis speak Hindi as a second language. About seventeen percent of the sample preferred the interview to be conducted in Hindi. After the translation, the

questionnaires were pilot-tested by administering the questionnaires to ten middle-aged adults who provide care to an elderly relative in the United States.

The Indian Sample: Allahabad

This study utilizes a cross sectional survey design method. A survey was conducted in the city of Allahabad in India. Allahabad city has of a population of 1,042,229 people (Census of India, 2001). The multistage probability sampling technique is used to generate a sample of primary caregivers. In this study, the term caregiver refers to persons 18 years of age or older who satisfy a number of eligibility criteria for selection. In order to be eligible for inclusion in this study, the caregiver should be a male/female taking care of a parent or parent in law, grandparent, or hired help, neighbor or distant relative who is at least 60 years of age or older and has lived in a joint household with the older adult care recipient for over a year. In joint households, several members of the family share care giving tasks and reside in the same household (Soldo & Myllyluoma, 1983). A caregiver is one who self-identifies himself or herself as the person who provides at least 4 hours of care per day and assists the care recipient on at least one activity of daily living (ADL) or two instrumental activities of daily living (IADL). Among caregivers, the primary caregiver is someone who provides more care to the elderly (in the number of ADL or IADL tasks performed) compared to other caregivers in the family.

A questionnaire was created to gather data required for this study. The interview questionnaire was translated into Hindi, the Indian national language. Hindi is the main language spoken in Allahabad. Even though Muslims speak Urdu, they understand Hindi because the two languages are very similar. After the translation, the questionnaire was pilot-tested by administering the questionnaires to twelve middle-aged adults who provided care for their elderly. Information from the pilot survey was used to accomplish a few modifications in the wording of the questions and the organization of the questionnaire in order to enhance clarity. The interviewers made contact with household members from each of the selected households in this study. In a structured face-to-face interview with the primary caregiver, the interviewers first described the study. Informed verbal consent was taken for each interview. Each interview lasted approximately 1 to 2 hours. Of the 575 households contacted, 354 households had primary caregivers. From these 354 households, 263 agreed to participate in the study and were interviewed. As a result, the response rate for the study was 73 percent.

Description of the American and Indian Samples

Dallas: Out of the final sample of 150 caregivers, 118 were included in the final study after listwise deletion of cases (with incomplete information) resulted in a smaller sample. Of the 118 caregivers, 60.2 percent were females. Among females 20.3 percent were daughters and 38.1 percent were daughter-in-laws while the remaining were other female caregivers. Almost 40% (39.8) percent of the sample was male caregivers, of which 34 percent were sons and 3.4 percent were son-in-laws. Nearly 90 percent (89.8%) of the caregivers interviewed were married, 5.9 percent were never married and 4.2 percent were divorced. The average age of the caregiver was 41.7 years, and the average age of the elder (care-recipient) was 70.7 years.

Eighty three percent of elders lived with their adult child in a multigenerational household. Almost 52 percent (51.7%) of elderly care-recipients were female elders, while 48.3 percent were male. Over half, approximately 54 percent, of the elder care-recipients were widowed

A small proportion (2.5 percent) of caregivers, had annual family income below \$10,000, and only 12.7 percent of caregiver's had annual family income over \$100,000. The annual family income is the income derived from several members in the family working and pooling into the family income. In terms of educational attainment of the primary caregiver, a large percent had some college education forty five percent (44.9%), and 35.6 percent had 16-18 years of college. However, it is not clear whether the college education of the participants was from India/Pakistan or obtained in United States. The respondents who classified themselves as professionals are likely to have obtained some of the education, and licenses to practice in the United States.

The sample represents four major religious groups of Indian / Pakistani immigrants in the Dallas-Fort Worth metroplex. Hindus comprised of 64.4% of the sample, Muslims 19.5 %, Christians 9.3% and Sikhs 6.8%. Overall, 17.8% of caregivers were from Pakistan while the remaining were from India.

Allahabad: A total of 259 respondents (25 percent were males and 75 percent were females) caregivers of the elderly participated in the research study.

The age of respondents ranged from 18 years to 88 years of age, with a mean age of 42 years. The majority of the respondents were married, with children, and living within the house owned by the elderly person they were providing care. The mean household monthly income was Rs.7000, (\$146) with an average of 1.9 people contributing to the household income. Of the head of the household who were employed, a quarter held professional jobs. Caregivers reported that the elderly received an average income of Rs.800 per month.

In North India a male member who provides the most income per month is considered the head of the household, as they are the primary bread-winners. About 25% of the head of the household were holding professional jobs and about 47% were working as cleaning/unskilled workers earning very little income. In joint family system several members of the family participate in care giving of the elderly. The task of earning money is rarely the responsibility of the primary caregiver. More than twenty three percent of the head of the household had completed college and more than a quarter had attained a post graduate degree.

The majority (61%) of the respondents identified as being Hindus followed by Muslims, Christians and Sikhs, which is consistent with the religious composition of the population of Allahabad. There was an average of 7 persons living in one joint household. More than seventy five percent of the caregivers in the sample had an elderly person suffering from health problems for which they had to take more than one prescribed medicine a day. (In India a large proportion of the elderly population uses home-made herbal, Ayurvedic, and homeopathic medicine, as the prescription of Western medications are expensive). Forty eight percent of the elderly person were mentally confused (e.g. lack of awareness of current year, names of people) or suffering from behavioral problems (such as verbally abusive, paranoid thinking, crying or yelling without any reason).

Over sixty percent of the caregivers were married. Thirty percent of the primary caregivers were daughters-in-law followed by twenty percent of daughters, sons and grandchildren. The caregivers reported providing care to about an equal number of married and widowed elderly. About forty eight percent of the caregivers perceived their physical health as being good.

5 Analysis

Table 1 presents a list of variables and their definitions. The dependent variable as mentioned earlier is care giver burden.

Dallas

Allahabad

| Label | Definition | Label | Definition |
|----------|----------------------|----------|----------------------|
| Cgburden | Caregiver burden | Cgburden | Caregiver burden |
| Rconflic | Role conflict | Rconflic | Role conflict |
| RQ | Relationship Quality | RQ | Relationship Quality |
| Eldertsk | Elder support tasks | Eldertsk | Elder support tasks |

Table 1. Variables

The data were analyzed using Multivariate techniques such as multiple regression and path analysis. The following section provides an overview of the findings on the determinants of caregiver burden among South-Asian families in Allahabad and Dallas.

Findings – United States

Dallas

Asian Indian population has continued to grow in the U.S., reaching about 1.7 million today (Navsaria & Petersen, 2007). Our findings indicate that a few (about 15%) of the older adults receive some form of support such as Social Security Income and Medicaid. A large proportion of them are only partially dependent on the caregivers for financial support. The mean age of care recipient is approximately 71 years and about 85% of them had lived in the U. S. less than five years. The annual income of caregivers ranged from 41 and 70 thousand dollars. Caregivers were on the average 30 years younger than the care receivers. Slightly more than 80 percent of the caregivers had some amount of college or higher education. Ninety percent of them were married and approximately 75 percent of them had lived in the U S for nine or more years. Nearly 59 percent of the caregivers were women - either daughters or daughters-in-law of the elderly care recipients.

The older adults contributed to their families by providing tangible support (such as child care and assistance with household chores) and also emotional support to their caregivers. Care providers are more likely to have children under 12 years of age, when they have the older adult living with them. Older adults living with the caregiver are more likely to be mentally healthy and alert than the rest. A high proportion of the older adults were single men and women who had moved to their adult child's home after losing their spouse. Most adults in the multigenerational caregiver households were employed outside the home.

The caregivers were primarily in the higher socio economic group of immigrants. Majority of caregivers adhered to Asian cultural norms of dharma. Given the dharmic duty to take care of elder parent, most of the current caregivers had not only invited the older adult but also aided in their process of securing visa by providing financial sponsorship to comply with

immigration regulations. The caregivers in US who are highly educated (over 16 years of education) are less likely to place the older adult in a nursing home and are more likely to find in home support services, should caregiving tasks become too much. Overall females provide more care compared to male caregivers.

A large proportion of caregivers of the elderly experiences high degree of role overload and role conflict. Similar findings were reported by earlier research studies (Hooyman, & Kiyak 2008) among the Anglo population of caregivers providing care for their elderly persons. Because of high levels of role conflict and role overload a large proportion of Asian Indian caregivers are at risk for stress related health problems due to overwork and burnout. Thus, the greater the role overload the Asian Indian caregivers experienced, the greater the perception of burden.

The study suggests that relationship quality is negatively related to perceived caregiver burden. That is, poor quality of the relationship between the caregiver and the elderly increases the perception of burden among Asian Indian caregivers. Earlier studies have revealed that relationships between the child and parent in Asian Indian families are nurtured over a life-time. Mutual interdependency among generations is a cultural norm. Children are cared for and socialized to the obligations of taking care of parents in their old age (Kurian, 1986). These findings reinforce findings by Mercier, Shelley, and Paulson, (1988) who studied eighty-seven mother daughter pairs and seventy father daughter pairs and reported that the greater the relationship quality, the greater the feelings of filial obligation the daughters felt toward providing care for their elderly parent. Another study by Scharlach (1987) found that providing cognitive-behavioral treatment to daughters reduced caregiver strain the daughters felt due to competing role demands and increased the relationship quality between mothers and daughters.

A large proportion (76%) of Asian Indian females are employed outside the home. This produces conflict among the roles, as caregivers are sandwiched between providing care for their young children and their elderly parents (Rangaswamy, 1995). Such conflicts sometimes increase the perception of caregiver burden, as was found in the present study. Role overload, both directly and indirectly (via role conflict), influenced burden. Both role conflict and support tasks by the elder were mediated by relationship quality.

Elder health problems influenced the perception of burden among Asian Indian caregivers. This is consistent with earlier research that indicates that caregivers perceive greater burden when the elder has health problems (Mindel & Wright, 1982). This is especially true for Asian Indian caregivers as 75% of the elderly persons do not have any form of health insurance and very few sources of income. With the increase in federal budget cuts, several caregivers with the elderly parents were very worried about the future care of their elderly persons. When questioned about the health care planning for their elderly parent many stated, "We do not know, what we will do if our parent/in-law becomes too ill to require medical attention, but rush them to the nearest emergency room."

Earlier studies have consistently pointed out that female caregivers perceive more burden than male caregivers. Earlier caregiving research work has shown that women are more likely to experience great amount of role conflict as they attempt to juggle occupational demands and the demands of caregiving (Hooyman, & Kiyak, 2008). This study also points out that Asian Indian female (child/in-law) caregivers experience more burden in providing care for the

elderly than the males. However, the effects of gender on burden are mediated by relationship quality.

Two significant sources of reduction in role demands are size of the network and the extent of identification with Asian filial piety norms. These two background cultural factors are positively related. South-Asian caregivers who have a large social support network of extended family and friends tend to have fewer role demands placed on them. This study found several indirect correlates of perceived caregiver burden mediated by relationship quality. The elderly in Asian Indian families perform several support tasks which improves the quality of relationship between the caregiver (adult children) and the care-recipient (elderly).

Contrary to the expectations with respect to caregiver burden, the support tasks by the elder do not directly reduce the level of perceived burden. The effect of support task on caregiver burden is indirect through role conflict and relationship quality. One reason for the non support of the hypothesis could be that the support tasks performed by the elderly do not lower the perception of caregiver burden directly as the support tasks are limited. For example, a great majority of the immigrant Asian Indian elderly was not able to drive or speak English and thus the tasks they were able to perform were limited to light household chores. It was also found that when Asian Indian caregivers were overloaded with an increasing number of roles, the support tasks by the elderly influenced relationship quality reducing the perception of burden. Thus, the caregiver to a certain extent feels rewarded by the support tasks provided by the elderly.

It was found that male caregivers had better relationship quality with the elderly as compared to female caregivers who could be due to the stress women feel providing care. Caregivers who had greater number of conflicting roles had poorer relationship quality with the elderly than caregivers who did not have conflicting roles. Caregivers who have conflicting roles may have very little time to spend with the elderly (Gupta, 2000). Caregivers with several role demands also had conflicting tasks (for example, taking their young children for soccer or piano lessons on Sunday afternoon and having to drive the parent/in-laws to the temple, church or mosque).

Relationship quality emerged as a central factor in explaining burden, underscoring the mutual nature of interdependence among South-Asian caregivers and elder care recipients bound by culturally driven expectations of filial responsibility (Sung, 1990).

Findings - India

Allahabad

Our findings indicate, older males receive more care, and elder persons who live in the caregiver's home receive less care. Elder persons who provide informational support receive more care. The elderly who have savings in the bank or who have assets are more likely to receive help with Instrumental activities of daily living (ADL support) like shopping, housekeeping, recreational support from the caregivers. Living with the son's and daughter's families is associated with receiving less emotional care than other forms of living arrangements. The results indicate that there is a gender difference in the availability and provision of care to the older persons. Reciprocity and exchange play out in a way in which older persons contributing informational support receive more care. Age of the caregiver is

positively associated with IADL tasks. Male caregivers provide significantly less IADL and emotional support compared to female caregivers.

Older persons who live with their primary caregivers get taken care of if they contribute to the household either with their savings or with their experience and wisdom. A similar result was found by Kochar (1999) for medical expenditures on the elderly in Pakistan. Male elderly in our sample require more care than female elderly. Increases in quality of relationship with the caregiver appear to bode well for the older person in terms of the care they receive. Those who live with the caregiver get less care than the rest as the caregiver possibly feels less obligated to provide care in the form of tangible tasks for the elder.

In an earlier research study Gupta, Rowe, & Pillai (2009) found that Indian female caregivers provide a number of care giving tasks for the elderly relatives as they are socialized to provide care from early childhood. Daughters-in-law are expected to fulfill the role of the caregiver for their husband's parents. Thus females in India may not think immediately of care giving for the elderly is burdensome. They are more likely to ascribe overload of roles as creating burden when caring for the elderly.

In the Asian Indian family system, several family members contribute resources to a common resource pool. Family members are likely to contribute to the family income which is likely to reduce the burden experienced by the primary caregiver. This was especially true for those who had several family members working so that the total family income alleviates some of the burden on the caregiver. Prior studies on multigenerational families have found that members contribute and assist each other primarily by pooling their finances (Jamuna & Ramurthi, 2000; Chakraborti, 2004).

The behavioral problems of the elder were another major factor in caregivers' perceptions of burden. The caregivers had difficulty in addressing the behavioral problems of their elders for two reasons. First, many caregivers were unaware that behavioral problems could be due to an underlying physical ailment or mental health issue that the elder may be suffering. Second, the taboo against openly acknowledging that an elderly parent could be mentally ill, often leads to a lack of willingness to seek assistive health and mental health services (Gupta, Punetha & Diwan, 2006; Gupta & Pillai, 2002; Bertrand, 2006) even though such services may be available in the community. Instead, the caregivers often use Asian religious beliefs to cope with the consequences of elder's behavioral problems as "hassles of daily living" or as "part of aging process" without attempting to find other forms of relief from this problem. Elder's behavioral problems are seldom diagnosed, and, therefore, remain untreated.

We found that a large number of Asian Indian caregivers adhered to the Asian cultural norm of *dharma* to provide care for the elderly and this belief thus lessened the perception of burden. This result is consistent with earlier studies that show in many parts of the world, family members continue to provide all the care for their elderly parents, especially when they feel it is their duty to do so (Chan, 2005; Milne, & Chryssanthopoulou, 2005).

Although family members in a multigenerational family system may contribute financially, they might not be assisting the primary caregiver with the care giving tasks that are required for the elderly, such as bathing, feeding, and toileting. These and other instrumental activities of daily living, such as recreational and emotional care of the elderly, are left to the primary caregiver. Our results show that the greater the number of care giving tasks provided by the caregiver, the greater the level of perceived burden. Previous studies have shown that

caregivers who provided most of the care giving tasks were likely to burn out or feel depressed.

The higher the age of the caregiver, the greater the care giver burden. Consistent with other studies, we also found that women caregivers experienced greater burden in comparison to men in India (Gupta, Rowe & Pillai, 2009; Gupta, 2007). This may be a result of women feeling more of a burden as they try to maintain a traditional Indian multigenerational household while also engaged in employment outside the home. The Indian female caregivers may feel that they have no choice but to provide care for their in-laws.

6 Conclusion

To conclude, our study finds a number of similarities with respect to the factors that influence care giver burden among South-Asians in Dallas and Ahmadabad. In general, the factors that have considerable effect on caregiver burden are role overload, role conflict, and relationship quality with the older adult. Contrary to the popular belief that sons carry a large share of the burden in providing elder care, women care givers in Dallas and Allahabad report higher levels of burden than male caregivers. Much of the burden experienced in both contexts is due to role overload and role conflict. However, caregivers who strongly believed in elder care giving as a moral duty experienced lower levels of burden than the rest. Filial piety norms have survived and remained strong through the immigration experiences of care givers. A few elder care recipient characteristics also were found to be correlated with care giver burden in both settings. In Dallas, elder health problems affected the level of care giver burden negatively. In the Indian context, behavior problems of the elderly often associated with poor mental health status increased the level of care giver burden. One crucial difference between the two care giver settings was with respect to the contributions of the elderly. In the Allahabad setting informational support in addition to elderly's wealth status reduced caregiver's perceived burden. Among Dallas caregivers, perceived burden was found to have significant negative association with tangible support provided by the elderly. Relationship quality between the caregiver and the elderly played a stronger role in reducing caregiver burden in the Dallas than in Allahabad. The family system remains the most important source of support for elderly people requiring care in both contexts.

A large proportion of caregivers provide care while co-residing with the older adult (parent, in law, spouse or relative) as long as caregivers have a sense of "dharmic duty" along with financial and physical resources to provide care. It is safe to state that the level and magnitude of the effects of factors associated with care giving in first generation Asian Indian families may not remain the same across subsequent cohort of Asian Indian immigrant families. The first generation caregivers are primarily people who immigrated as professionals in the 1960's and brought the culture of care giving with them. In essence they are "frozen in time" as a large proportion of these immigrants adhere to the Asian Indian cultural values and beliefs of care giving which they brought with them at the time they were young immigrants to the US. These immigrant caregivers are also members of the baby boom generation in the US who will soon be requiring elder care in the United States. Since they have lived in the US most of their lives they have become familiar with the American culture. They are more likely to age in place and require some kind of formal support such as in home support services or visiting nurses till they are totally incapacitated. India has become westernized and so the care giving of older adults is becoming difficult for family caregivers. Those who have resources are able to receive some assistance from hired help, and in some cases older adults face a great deal of neglect and abuse.

7 Policy Implications

The U.S.

A large proportion of first generation immigrant Asian Indian (AI) care givers experience role conflict. It is likely that the process of accommodation and adjustment to local host culture brings about the need to perform a number of conflicting roles.

In the case of the AI elderly, belief in filial piety norms plays a significant role in lowering perceived levels of care giver burden. Service providers need to make assessments and interventions based on AI care giver's level of adherence to cultural norms of care giving. Service providers need to assess the level of adherence to Asian cultural values of care giving using in depth interviews before implementing any interventions. Provision of care for the elderly at home is a cost effective way of providing care, and efforts should be made to prevent care giver burnout. Social service workers may help AI care givers by enabling them to preserve their normative context of care giving. Social service provider's understanding of the AI culture particularly with respect to care giving is crucial in this regard. Social service agencies may employ either AI workers or social workers who have competencies for dealing with diverse cultures. This would enable social service agencies to identify cultural resources that are essential and useful in designing intervention programs which reduce perceived care giver burden. Agency services should be accessible and culturally relevant. To accomplish this, cooperative teamwork arrangements with formal and informal support systems such as AI religious and nonprofit organizations should be maintained. In addition, trained interpreters, translators, and cross cultural mediators need to be employed as staff.

Provision of culturally competent support services to AI care givers call for sound knowledge of AI culture as well as professional skills necessary for dispensing culturally relevant support. It is necessary for social service providers to have knowledge of help seeking behaviors among AI communities. In addition, service providers should also recognize how professional values may clash with South-Asian client's values and needs. At the skill level, social service providers should be able to relate accurate information on behalf of AI clients seeking social services. Furthermore, service providers should possess skills necessary for interviewing AI clients. Above all service providers should project genuine interest and empathy with AI clients and should be flexible to accommodate a number of possible solutions facing AI care givers.

In the US, provision of social services to reduce role conflict involves enabling care givers to plan their occupational and social activities. Developing the abilities to plan is crucial for successful adaptation to the local cultural milieu. In addition, successful planning also involves identification and utilization of available services from local agencies such as area agencies on aging. Thus there is a need for social service providers to provide inputs to AI care givers in the form of accessing several channels of support from within the community and also from outside. In this regard, social service worker may provide educational seminars in such areas as resource planning, role adjustments, role management, assessing and prioritizing current roles and activities, and time management. Given the hierarchical nature of power relations and decision making in AI households, it may be inappropriate to involve adult children, care givers and elder parents in an open discussion. Educational programs for AI care givers should be designed with the assistance of South-Asian community leaders and professionals (Segal 1991). Earlier researchers have made policy and practice recommendations for providing care giver support to Asian Indian female caregivers. Gupta (2000) recommended a strong partnership between formal governmental services and family

networks to meet the needs of the elderly population. These partnerships would require an integration of male and female efforts as well as public and private resources. Another implication is that service providers need to tailor programs for females as they would need emotional and physical support from the larger Asian Indian community. In this study we find that social exchange plays an important motivator for caregivers to provide informal care giving. The population most vulnerable to abuse and neglect are the Indian elderly females who may not have any exchange rewards, such as providing informational support tasks or may not be able to contribute monetarily to their care givers. Therefore to prevent abuse and neglect of the elderly the Indian government needs to have a watchdog agency such as the Adult Protective Services to deal with reports of neglect and abuse.

An important policy implication that emerges from these results is that older persons might be guaranteed care by their relatives if they have something to give in exchange. Perhaps policy can be targeted in empowering the low-income elders with either pension support or provide families with tax relief for looking after their elderly relatives.

India

As long as adult children feel obligated to support their elderly parents and relatives, their sense of *dharma* or duty to their parents must be admired and given public recognition. The female caregivers who experience the burden of care should be assessed and their ability to provide care be gauged realistically. In-home support and cash award incentives by the government should be tailored to their needs. The optimal solution would be to integrate filial care provided by the family with the community care approach that rallies the support of the public for elderly people living in the community. In order to build communities, new ways need to be adopted that mix informal and formal support services aimed at enhancing the caring functions of the family within the community.

Institutional care should not be regarded as a last resort, as it is the most appropriate form of care for those requiring intensive support, especially when the behavioral problems of the elderly have been determined to have a biological origin. The admission of an elderly person into institutional care should in no way be taken as an act of disregard for the elder.

The proposed recommendations to support the elderly are not meant to be exhaustive. Policy makers in India should devise an aged care policy for elderly Indian citizens. Each region or state government in India must, therefore, devise its aged care policy in support of its frail elderly people, taking into account the existing formal and informal systems with the unique needs of each family.

There is clearly a need for social workers to provide information to caregivers in the form of improving their skill levels to access several channels of support from within the community and also from outside. Social worker should provide educational seminars and link the female caregivers to prevention services for health and mental health assessment of the care recipient. The social worker should form a coalition of caregivers who advocate for the rights and services for the elderly.

Limitation: There are a few limitations to this study because it did not take into account variations in the adjustments caregivers make to care giving over time. Future studies would benefit from in-depth qualitative analysis of interviews of both recipients of care as well as caregiver dyads across two or more points in time, facilitating investigation of changes in care giving once the elderly person becomes sick or approaches the end of life.

The small sample size and cross-sectional nature of the study do not provide a comprehensive view of the determinants of caregiver burden among Asian Indian caregivers. Additionally, the self report nature of measures used in this study for the assessment of burden must be considered a limitation. Future research on this population should include both quantitative and qualitative research with a focus on health problems of the elderly and the caregiver.

Based on the baseline empirical data provided in this study, further applied social work research for this population is needed. Ethnic sensitive, cognitive-behavioral therapy, time management, and caregiver skills training can be provided for the Indian / Pakistani caregivers so that they have realistic expectations about things they can do to reduce the feelings of caregiver stress. Ideally through the collaborative involvement with Asian Indian communities, a successful research agenda, and an education program for the caregivers and the care-recipients should be defined and developed.

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