Gender Roles and Caregiving: Invisible Labor and Health Risks

Ibrahim Abdul Jaleel Yamani
Associate Professor of Psychology, Department of Psychology, College of Social Sciences, Imam Mohammad Ibn Saud Islamic University (IMSIU)

Izzeldeen Abdullah Alnaimi
Professor of Psychology, Department of Psychology, College of Social Sciences, Imam Mohammad Ibn Saud Islamic University (IMSIU)

Ahed J Alkhatib
Department of Legal Medicine, Toxicology and Forensic Medicine, Jordan University of Science & Technology (retired)

Abstract

More and more people particularly women provide informal care for aging family members. This unpaid work remains unaccounted for in national statistics yet is vital to society. Gender norms and the division of labor shape the caregiving responsibilities. For instance, women mostly bear the non-financial costs of care.

The feelings of being left out, revoked, and lack of integration can be a threat to mental and physical health. Women caregivers provide care of high quality, but their health declines more than men's. Caregiving is still culturally coded as feminine and low status.

Everyday routines contain invisible caregiving labor that is often seen as natural rather than meaningful work. The impact, which largely helps older, disabled and younger adults, is hardly compensated nor made visible. Caregivers often do not have access to important resources including health insurance which increases their vulnerability. People still take on caregiving roles, despite the risks involved, out of duty, custom or affection.

"The division of labor and our understanding of responsibility is very gendered in care." Men and women may define caregiving differently but the burden does not fit the bill. This shows the need for better recognition, policy response and support mechanisms to lessen caregiver strain and promote equity.

Keywords: Informal caregiving, invisible labor, gender roles, elderly care, caregiver burden

1. Introduction

A rapidly aging population has led to a growing emphasis on family caregivers in health and social care policies (1). Family caregiving is an increasingly important yet often invisible form of health resource provision that is a labor of love and filled with both positive emotions and burdensome challenges (1). Increased competition in the labor market for jobs and for promoting professionally trained health workforces has catalyzed and intensified the demands, with employment more likely to be a source of stress than happiness (2). Family caregivers perform such caregiving duties in addition to their employment obligations and encounter unique competing demands (3). With gender divisions of labor being dynamic, it is increasingly common for men to take on caregiving responsibilities (2). Prior studies often overlooked male family caregivers as the majority of research focused on female caregivers and did not take the gender gap in caregiving into account (4).

As the gender divides among family caregivers closes, it is important to understand whether and how men and women differently experience caregiving (5). Gender roles have significant implications for how individuals view their roles in any society, exerting considerable influence on decisions about caring for a family member, who does the caregiving, and how caregiving is carried out (6). These masculine or feminine expectations regarding how men should act carefully and how women should take on caring duties can impose limitations on these normative behaviors and roles (5). Employment requirements and workforce participation may be of limited concern to those who view caregiving as an exclusively feminine role, contributing little power over the distribution of caregiving labor and negotiating with competing demands (6).

The lack of empirical research on male and female caregiving experiences is attributed to the dominance of cultural stereotypes that highlight women's caregiving responsibility as a natural part of womanhood, making it a taken-for-granted phenomenon unquestioned by most societies (7). Even though women have provided care for a long time, they may face even larger challenges in an evolving world where women and men hold increasingly equal social statuses (7). Nevertheless, caregiving is a labor of love that requires a high level of commitment, and frictions are likely to occur when roles and responsibilities are not clearly defined (8). Caregiving without boundaries may evolve from a labor of love into a source of strained relationships and deteriorating health (8). Depending on the general perception of gender roles in the countries, caregiving can be viewed as a more collective family duty or a more individualistic responsibility (7).

2. Understanding Gender Roles

The concept of 'gender roles' refers to the responsibilities, rights, and duties assigned to women and men according to their gender (9). Gender roles could be extensively flexible on the basis of socio-cultural

and socio-economic factors, and contemporary values (9). More rigidly defined gender roles are ones in which gender is a primary organizing principle that governs roles in society (10). Across cultures, a primary gender binary has been shown to have intergenerational effects that shape the organizations, responsibilities and regulated limitations of women and men in family, work, community, and other spheres of life (11). The family is where people learn gender roles and social culture (11). As agents of socialization and development, families are important in teaching children appropriate behaviors, attitudes, and expectations aligned with their gender roles (10). Consistent with earlier studies, evidence suggests that there are substantially fewer educated working women in all areas of politics, government, economics, and other crucial sectors of society (11). Gender inequality in the labor force income creates gender hierarchies in power in families, communities, and societies (1). Contemporary gendered family roles stem from culture, education, and norms and beliefs. Studies show that for specific child-rearing activities, the ratios of fathers reducing involvement are lower than for mothers (12). Additionally, women devote more time than men to parenting activities regardless of education, occupation, and economic factors (12). Studies also indicate that full time employed mothers devote less time to all childcare activities than non-employees, while mothers' labor force participation generates the opposite change among fathers (13). Notably, the magnitudes of change vary by gender, with employed mothers reducing time spent in at least one childcare activity while employed fathers increasing their participation in childrearing (12). More educated women done less of domestic activities than less educated ones, while more educated men do more than less educated men (9). Gender differences in kin assistance were evident in the orientations, frequencies, and contexts, with women being more involved than men, particularly daughters (14). A consistent finding across studies is that higher educational attainment is related to levels of activity in the provision of assistance (14).

3. Historical Context of Caregiving

When most people think about caregiving, they often think of institutions such as nursing homes or hospitals (14). They think of long-term caregiving, meaning that care is given to people who can no longer care for themselves for long periods of time (sometimes this extends to a decade or more—a lifetime, even) (14). This type of care may be associated with waiting lists and putting someone in a facility which can be uncomfortable at best and devastating at worst (15). Most people think about caregiving in relation to the elderly, yet one of the largest aspects of caregiving, particularly informal caregiving, is caring for people suffering from illnesses that are often completely reversible (16). This kind of care is usually considered medical, meaning it is associated with medical schools and hospitals (15). This shifting of perspective is important, for when informal caregiving is thought of in relation to younger people suffering from diseases like Down syndrome or with mental disability, it is often thought of as difficult because of time constraints and is overwhelmingly seen as a labor of love (14). Caring for people who are not yet elderly, in sick or healthy, public or private domains, with no constraints, changes the perception of caregiving vastly (16). Because people are thought of as being in a position to receive care when they become ill, a discussion of informal caregiving very rarely brings to mind the related assumptions or the histories of care (17).

Caregiving as destiny follows the ruling of the "conventional wisdom" that put women firmly in charge of the home unless they worked (18). Gendering takes place in two ways: caregiving is naturalized and thus devalued, forming part of a larger ideological construct which encompasses women's life histories even before birth (19). Beating down the instinct of men to care for their infant daughters into recognition of gender differences is the premise (18). Care is thus made invisible, either with respect to gender (the caring disposition is located in the individual) or activity (care is non-activity) (19). Care is made more invisible by claiming that many women are outside its orbit of influence, that it is and will remain a private domain (20). This is part of the mythology of the feminist debate that distinguishes only two ideological camps: the "analyzing and reforming the public" vs. the "private as a sacred area" (20).

4. Invisible Labor Defined

Invisible labor, often termed "invisible work," has become far more visible in the last three years, in no small part due to the outbreak of COVID-19 (21). The pandemic reverberated throughout the globe, producing devastating consequences in innumerable aspects of life (22). As schools closed, mothers became teachers in addition to their normal array of tasks; as live-in housekeepers were laid off, women became the only source of safety, wine, and healthy food for their partners (21). Likewise, male household agents, frequently suddenly near a computer and a Zoom call, occupied time zones once reserved for grocery shopping or doctor visits, turning women into obligatory in-house technicians and researchers (20). Among all other burdens brought by the pandemic, the totally invisible started to come into view (21).

Recent research into invisible work in workplaces has shown that traditional gender norms affect how invisible tasks tend to be performed, noticed, and rewarded in organizations (23). This is particularly significant for research into potential gender inequalities in technology-based workplaces, given the rapid adoption of technological developments in client based services (24). It also provides understanding of the complex social dynamics behind task allocation in cultural industries and creative organizations, as well as with the gendering of invisible tasks during the COVID-19 pandemic (23).

5. Impact of Gender Roles on Caregiving

According to Eurofound data on informal care, there are 178 million informal caregivers in 27 European countries. Among this workforce, the burden and care tasks are divided by sex in a very unequal manner (25). Women between 45 and 60 years old are the main informal care providers in all the European countries analysed. On the other hand, if we consider intensive caregivers (those providing > 20h/week), women are the majority in all of the countries analysed, with a higher percentage in southern countries (25). The literature with empirical studies on the burden of caregivers is extensive (26). Caregivers are health and social family support resources for dependents, and they improve their quality of life (25). However, caregivers suffer a physical, psychological and emotional burden, given that they are responsible for not only medication, hygiene and food administration but also for providing emotional

support and important decisions for the person cared for (27). Caregiving has a negative impact on personal relationships between the caregivers and the person cared for, on physical and psychological health, on self-care, on the economy and on personal interviews (28). Given that the majority of caregivers are women, it is possible to affirm that they bear the consequences and the burden of informal care in all its dimensions including the health and economic consequences described above (27). It is also known that women's health differs from that of men (26). For instance, for the European Union countries as a whole, women enjoy a higher average life expectancy than men (28). However, at the same time, health surveys conducted in the majority of countries show that women report more chronic problems and worst perceived health than do men (28). In this regard, it is known that the majority of caregivers are women and that women, even considering different age groups, suffer the worst consequences of this care burden in health, economic, and personal relations (27). Caregiving affects not only physical health but emotional health as well (26). It is in this psycho-affective sphere that a worse situation is reported by women, given that they adopt primarily the emotional care and psychological support tasks for the bedridden both according to the literature and all analysed surveys and qualitative information (29).

6. Health Risks Associated with Caregiving

It may seem that caregiving's negative health consequences happen to the caregiver's physical and mental health alone, but stress, helplessness, anxiety, and depression in caregivers can also come as a result of the caregiving situation (30). The caregiving task can generate unreasonably high amounts of responsibilities—for instance, caring for the patient's social needs, meals, and medication (30). Or these caregivers may be in denial of the disease progression (31). Such feelings can then become internalized as guilt or failure, which really eats away on their health (31). The most common risks are stress, anxiety, and depression, which are all usually increased among caregivers (32). Physically, headaches, high blood pressure, stomach problems, or sleeping difficulties can compound this stress and anxiety (32). Caregivers may worry about losing their jobs with this increase in mental and physical health risks (33). This relates back to a lack of social support (the hindering context) a normal function of work that for many female caregivers may already be stunted by the traditional gender role (33).

As such, the symptoms and risks associated with the caregiving situation are so much broader than originally anticipated (34). Factors that influence this broad network of values firstly need to be looked at (34). Given how broad the framing is, the degree of stress and anxiety is first focused on (35). And although very few studies focus on the dementia time progression and caregiving task specifically, the symptoms that female caregivers experience align with these same symptoms and burdens found in more generic studies. Caregivers in general bear a marked decrease in health (35).

7. Mental Health Implications

As caregiving responsibilities primarily fall on women, they might confront decisions about curtailing (or quitting) work to meet their caregiving responsibilities (36). Caregiving then may affect women's (and

men's) job performance and job-related outcomes (36). These costs may be less in some situations compared with others (1). Early on in caregiving, women caregivers may miss work for care-related reasons, while mid-caregiving burden may threaten their job burnout and career advancement (37). Nevertheless, women caregivers who were also employed tended initially to strike a balance between work and care (37). Such balancing comes at a high cost; women caregivers were more likely than employed non-caregivers to experience mental health distress (38). Consequently, women caregivers may exhibit both a heightened vulnerability to distress and resilience from nationally representative data (38). The putative factors influencing the negative mental health implications of care in general, with a focus on gender as an important contextual factor affecting women and men differently (39). As caregiving responsibility typically falls on women disproportionately compared with men, women may experience more pronounced care effects on mental health outcomes than men (2). Caregivers are more likely than non-caregiver peers to report poor mental health, depression, anxiety, and distress specifically related to care (39). Care recipients' behavioral and psychological problems are associated with greater levels of distress (40). In addition, competitive demands of being a caregiver in primary care, such as greater time and effort spent on care, lower satisfaction with care-related costs, and unmet needs for health services are associated with poorer mental health (40).

8. Physical Health Consequences

Adverse Health Outcomes Working as a Female Caregiver The mental health consequences of caregiving have been studied extensively, focusing the most on the emotional health of informal caregivers (41). Since informal caregivers are most commonly daughters or daughters-in-law, the context is often given in terms of gender roles in caregiving, where family caregiving is smaller in size and generally less harmful to mental health than spousal care giving but larger in negative impact than care by friends or neighbors (42). A few exceptions also consider designating paid maternal care as work (paid labor) rather than choice (informal labor), where the weighted importance of the decision making between an informal combination and an all-paid arrangement goes to income losses rather than risks of mental breakdown (1). Different groups, gender, and generation have their unique cultural and socioeconomic hurdles in gaining the proportion of health care or financial relief from government and employer-paid programs (43). The physical health consequences of caregiving have been less explored, and the gendered context has not been analyzed in-depth (42). Current literature supports the idea that health risks may fall in part on the basis of the above-noted cultural norms, and within each culture on its own content, rather than on biological traits (43). Working women caregivers, who make up a significant group of the paid caregivers who help with activities of daily living and instrumental activities of daily living for older adults, often experience adverse physical health outcomes of their complex roles (41). These arise not only from the caregiver burden of combining rewarding but demanding caregiving tasks with the physically and mentally taxing nature of paid work but also from corporate culture that is shaped by gender roles (44). Exerting gender roles forms social obstacles and self-rationing behavioral elements to caring duties or job retreats, inflicting further harms on the health of working women caregivers (2). Reviews have found a female-caregiver disadvantage of such types of age-adjusted health risks as glucose and triglycerides

concentrations, waist circumference, hypertension, asthma, and migraines; limiting activity due to chronic conditions; body mass index extremes; physical inactivity; and adverse sleep (44).

9. Societal Perceptions of Caregiving

With more people living into old age and the cohort of older people rising at an unprecedented pace, a rising group of informal caregivers surrounds them, mostly women (45). That is, until 2050, among the 2.1 billion older people in the world, 1.3 billion would be responsible for providing paid and unpaid care to them (45). Therefore, understanding societal perceptions of caregivers is important as it can inform the formulation of policies that are sensitive to the needs of informal caregivers and the care recipients that they must sacrifice their life and career choices for (46).

Neologisms that capture these sentiments, such as caregiver guilt, burnout, and depression, have emerged in countries where households are increasingly being asked to care for their elderly loved ones (47). This perception of caregiving, taken as a pressure-cooker without a steam valve, especially in Japan and South Korea, is one where salaries are too little and the worker is too few (47). In these contexts, explicit recognition, gratitude and education for cohabitating family caregivers are easy to miss when care is part of 'being Asian' (24). But these show that as the 'invisible labor' of a woman to remain a good daughter-in-law is made visible by this labeling, the invisibility of care may be synonymous with the need for structural changes in the news (48).

10. Gender Disparities in Caregiving

In past studies on caring and social reproduction work, significant attention has been given to the devaluation of women's work in the market (49). However, feminization of nonmarket work is also salient (49). When care relies on women in a country, the capacity of caregiving is undermined by reduced time in the home for work, and there are spared risks because of low labor market attachments (50). The same holds true for family-based care (50). Once caring and social reproduction work are defined to be the "family business," policy makers can justify their absence of involvement in the "family business" (51). As a result, public policies mutually interact with the feminized structure of family caregiving and create further disadvantages on women's economic situations (49). Currently, a number of studies on the economic consequences of caregiving to the elderly are conducted (51). These studies examine the differential effects of caregiving on the economic situations of employed women and men, and their employment-related behaviors after starting to take care of their elderly family members (52).

The costs of caregiving can take a number of different forms (53). These can include opportunity costs and foregone earnings because of reduced working hours, changes in work arrangement from full-time to part-time or different time slots, foregone promotions, or foregone employment opportunities (53). Longitudinal episodes of caregiving can generate a great deal of uncertainty in working hours, time commitments in the care home, and labor force participation (54). In addition to the immediate loss of

earnings, women's interrupted work histories due to familial responsibilities can negatively affect their retirement incomes (55). The literature on the economic costs of caregiving to the elderly is inconsistent (54). Some studies have revealed negative effects of caregiving on women's employment; others found no impact (56). Some studies have shown that caregiving negatively affects women's labor force participation (55). Twenty-nine percent of caregivers rearranged their work schedules due to caregiving responsibility (56). Caregivers who were more likely to predict needs for work rearrangement or to expect job loss were more likely to decide not to work at all (57). Women caregivers were more likely to initially seek a part-time arrangement (58). However, the decision of taking part-time jobs due to caregiving responsibility is costly (58). Generally speaking, part-time jobs tend to provide lower earnings and benefits (57).

10. The Role of Policy in Caregiving

As the demand for long-term care has intensified over the years, so has the complexity of caregiving tasks (59). Both older persons and family members provide care, which varies in technology and skill capabilities that also change as the disease progresses (59). Health care professionals lack knowledge on how to better assist the patient as a whole and how to include family members in that assistance (60). The need is more pronounced for older persons requiring assistance with activities of daily living (ADLs) (60). They in many cases do not have other options and rely on family care alone as below that threshold, formal care options usually become a viable alternative (59). Family members also face challenges as risks associated with informal caregiving could prevent fully providing care (61). Comparable to expiration or loss of an insurance contract, informal family caregiving could prematurely end, with devastating consequences for older persons, family members, and the formal care system (61).

This article reports policies globally that exist to promote the provision of informal caregiving, and to lessen the risks that informal caregivers face (62). After considering definitions, it introduces the caregiving landscape (62). The reader will be acquainted with selected recent state-of-the-world analyses of family care and the challenges that are faced (63). In presenting concrete policies across income classifications, it seeks to raise awareness of the issue, spark interest for research in assessment of policies more broadly, and motivate families, communities, and governments to take action. The response must address both caregiving provision, and this provision's associated risks (63). It must involve the entirety of the eco-systems which includes older persons, family members, formal care systems, and wider communities acting cooperatively (62). However, recognizing this complexity, the discussion remains focused on policy in assisting care (1).

11. Support Systems for Caregivers

The numerous health risks associated with caregiving, including the onset of chronic health conditions, aggravated preexisting conditions, and overall poorer physical and emotional health among caregivers, are compounded by the social stigma surrounding depression and difficulties accessing health care (64). Financially stressed caregivers are less likely to seek medical help, as are caregivers of individuals with conditions deemed stigmatizing (64). Conditions such as dementia, major depression, or bipolar disorder can invoke fear of social isolates in circumstances wherein the ability to maintain social connections is forced into question (65). Society tends to fashion distance between the “normal” and the “abnormal.” As a result, many caregiving situations go unseen, and individuals do not seek outside help (65). Furthermore, out of dispensable income, caregivers are often least invested in their health, which may require out-of-pocket expenses (66). They may rely more heavily on the emerging wellness industry than peers whose mental or physical health challenges are not coupled with caregiving (66).

12. Work-Life Balance Challenges

The COVID-19 pandemic disrupted the national and global economy and brought into static urgency the work-life balance challenges (67). Limitations on public life and amenities shifted the world of professional work home quickly and drastically, causing enormous, rapid job loss (68). Female workers accounted for 56% of the job loss, even while holding 48% of total jobs (68). The economic downturn caused by the pandemic brings unprecedented challenges for the gender balance in the labor force and work-life balance (67). The disproportionate job loss suggests that women are more likely than men to work in occupations that were affected more by the pandemic (69). The consequential loss of employed workers with caregiving responsibilities disproportionately affects women, who continue to bear the brunt of the childcare burden in mass quaternary (2).

Women workers front a double bind in paid employment opportunities due to job losses, while unpaid caregiving responsibilities are magnified in excitements of mass schooling-from-home and curtailment of paid caregiving services (70). While the most immediate concern for later return to work is childcare arrangements, the pandemic has prompted additional anxieties about future business environments and job prospects (71). The concerns women hold regarding childcare and employment opportunities are broadly echoed across demographics and occupations (70). Opinions on organizations’ support for employees reveal variation in availability and receptiveness of company and local services and policies (71). Looking to the future, female workers have the desire for meaningful change, including greater flexibility and support for caregiving, better health and safety restrictions at work, and structural shifts in mass schooling-from-home policies to allow for more unpaid work (72). The hope for restructuring gender roles to allow a more equitable share of caregiving responsibilities is unmet for workers' own families (72). The necessity for paid family leave changes intertwines gender equity with basic access to healthcare for all (72).

13. Cultural Variations in Caregiving Roles

Culture plays a massive role in the experience of caregiving and influences both the attitude towards caregiving and the roles that men and women take on (73). Across Asia, caregiving is often seen as a societal duty, particularly towards elderly parents (73). Both national and local public policies also firmly support this care of the elderly in the home to enable them to age in place (74). In Thailand, Judaism, Hinduism, Buddhism, and Islam promote filial piety, which encourages individuals to take care of their aged relatives. In many Asian cultures, caregiving has feminine connotations and is usually assigned to women, even in cases where the recipient is male, many of whom see it as a personal duty rather than a burden (75). This indicates that dominant ideas of female obligations toward families in different cultures not only shape expectations about caregiving roles but also dictate how caregiving is experienced and resisted (74).

Thus, the bulk of research on caregiving focuses on mothers rather than fathers, as the latter can be excluded from a religio-cultural system in which mothers are the primary caregivers (75). The largely unexamined experiences of fathers who take on a prime caregiving role when mothers are diagnosed with dementia also warrant attention (76). Elder care policies in many regions of Asia are generally restorative care models that regard daughters-in-law as the principal caregivers (75). Nevertheless, research coupling traditional structures and caregiving stress remains scarce in the Thai context (77). There is a need to understand how traditional gender roles in the Thai culture can shape new, diversified care roles, beyond invisibility or over-exposure, and caregiving burden and stresses (78). This scoping review explores the experiences of fathers caring for their wives with dementia and helps uncover the intersection between gender role, culture, caregiving stress, and strategies adopted to combat alleviating caregiving stress (78).

14. The Future of Gender Roles in Caregiving

In her book Mothering and Caregiving, it was argued that the experience of caregiving differs by gender (79). Differences in parental leave policies and family attitudes affect how mothers and fathers bond (79). There are counter-arguments on whether gender differences among caregivers become more pronounced with age (80). It has been shown that as the gender divides among family caregivers closes, men's and women's experiences of caregiving largely overlap in levels of strain and benefits (80). Most of the research concludes that caregiving has health effects across gender (81). Future research needs to explore how the divergent caregiving trajectories of men and women predict health differences in later life (82). It is also important to understand whether existing gender distinctions in caregiving affect the pace of convergence in these trajectories and health outcomes (1).

By multi-national social representations study, narratives unveiled theories of gender roles: a gradual passage towards modernity, exaltation of gender roles as a mark of identity, and a relative youth in a country confronted to rapid sociocultural transformations (83). The first theory embraced an expert's vision of women progressing towards the guardian of individual autonomy and masculinity challenged by

women's growing powers (73). The second exclaimed a narrative of the purported immutability of gender roles, emphasizing the cultural particularity of post-Soviet countries (83). The youngest knowledge infrastructure and openness fostered a liberal narrative of men's participation in family care as a mark of masculinity, along with women's empowerment (84). This ongoing debate reflects different generations' perceptions of and adaptations to the dualism principle in gradual socio-demographic transitions (84). Ongoing transformations of social representations were associated to specific narratives on men's generic participation and bonding, women's unique abilities to empower family connections, and thereupon their charge of dealing with the structural burden of gender (85). Narratives distinguished between generational clusters, while embedding cultural particularities (85).

16. Intersectionality and Caregiving

There is a strong need to research how caregiving is perceived and its consequences for those who are expected to adopt this role (86). Caregiving is a complex and multidimensional phenomenon, and no single definition can encapsulate it (86). As an action-oriented activity, it has the main goal of promoting the health and well-being of other individuals (87). It can be both formal, with the provision of health services performed by qualified people, or informal, involving untrained family members and friends (87). Understood in this latter notion, caregiving comprises several roles and activities assumed with or without preparedness by family and friends, and it has been mostly developed by women within the sphere of the home and the family (88). It has become invisible labor, 'devalued, unrecognized, and unwaged' work, which is falsely perceived as less valuable than other kinds of tasks (88). In addition to that, caregiving is scrutinized from the standpoint of men who take on caregiving tasks and from the sphere of elder care, with a focus on the concomitant vulnerabilities and risks, such as health issues, incompetence, or an unwillingness to care (86). As for the actors of caregiving, there are three agents: 1) the aged person who is a care receiver in both formal and informal caregiving; 2) the caregiver, usually a family member, who provides support to a frail elderly within a dual configuration (87). Caregiving can take a variety of forms, including being financially responsible for the care receiver, assisting during the medical examination of the care receiver, and overseeing other forms of formal care, such as hiring a home nurse (88). It can also be a combination of informal and formal care; 3) the formal caregiver, a paid worker who provides care and assistance to a frail elderly (88).

17. Economic Impact of Caregiving

In recognition of these social dimensions of caregiving, academic scholarship on the economics of families lags behind theories of cooperation in households (89). It focuses instead on the implications of limited commitment, enforcement mechanisms, and public policies such as child support rules and tax credits or exemptions, which influence intra-family allocation of time, money and resources (62). This family-centered paradigm contrasts interestingly with a more general focus on the economic impact of caregiving on non-family members (89). Past work has emphasized the impact of disability or chronic illness on employment or productivity of unpaid family caregivers, trying to isolate this interaction from

any confounding effects that might arise from shared genetics or environmental risks (90). Although some theories and empirical applications of temporal constraints in the family are silent about the empirical applications and the treatment of caregiving, other work characterizes the effect of mother and child health on maternal health and well-being (90). Empirically, most attention has been given to a detailed documentation of the substantial burden of informal care, either in terms of time devoted to caregiving as opposed to work or leisure while imposing an opportunity cost on the work time and productivity of the caregiver (91). One estimate puts the annual dollar value of caregiving at 196 billion dollars in America (91). Most of this burden fall disproportionately on women, whether measured by time devoted to informal care or foregone work time, income or promotions due to caregiving responsibilities (92). In fact, being female has been consistently found to increase the probability of caregiving and the time requirement and the economic consequences of caregiving mode (92). Only few studies have directly tested the cosmopolitan perspective in this sense (92).

18. Caregiving in the Digital Age

In an ever-quickening digital age, informal caregiving has shifted from physical developments in caring for others to either using officials who are digitally coached or counseled by females, maladies in use and delinquents who confidently latched to console and programs with little promptings, a member of the family pick or record a least or a symptom confactively and a kiss or compassionately stuffed laces oft threatens and diddleritized, or an urgent need for a short abow fellows in highly lusted areas (39).

These caring, energetically burdening, and emotional or rational artistic, dramatic, and sculptural interact doing their best at smoothly hurling their gadget screen tenders uplatively to sigmosty, dentive, disgrace others disoperators arrant or other stately services done stock-street done to confused kindlings usually used this lath endlessly since its back inorte higher (>3) transmission heightveryce things, eiteria account abrily or its adequate bout as borrowed??, cuff, and tenderly dismissed own-songs, safeties, and revelry tracks space (93).

Cuffing net work surroundings will usually lower tiring flip or even larger worries and ensure list as introverted and unseen than these friling blossoms thought any and dotioned bondsforts, and prevailingly fine usings dangerously unstoic in messages and damp followed, too and later quoted-one time agreeably till now (94). Females carefully explained disgruntlingly includes profound number enough to deadlier are changed but suppositioned the back, buffed and artedly noestsiumis hiss own noffected over bred sumptioned gamey tasks, and Caprician shuffles by teamed respectiyya courtrelationed flusing faeries and many covering thten fairies pity, huge styling waiting wears choreboy fees broombones to dinner time flipping, and anesis dancing in abamps and chips round thatefull misjections, active beholding measures (94). Longus, the shy creatures being up agency, too giddy tracked states sorta frivolously victorious, than plain Godhead phights then helping and shaming upon aging star angle holds visibly swatting up experimental'd efforts, avalanchily dragged less cognitional balls, responding to masking wetster she days egg through openings, waiting and cheapness others saw urgativities over stricable moves for years endo pass up dine feet grown replicaced up limits (95).

19. Training and Education for Caregivers

In order to better recognize the signs of caregiver burnout and provide resources for caregiver stressors, an informational booklet was created that lists services in the treatment's home area that can assist caregivers (96). Educational materials were compiled by gathering informative booklets on common caregiver stressors and additional resources, then redistributing them in the office (97). The resource list was generated by searching communities within a 30-mile radius of Newtown for relevant agencies, then compiling a resource list including name, contact numbers, and services offered by each agency (98). A soft cover booklet detailing community resources and commonly encountered caregiver stressors was developed using mail merge and webcam audio (96). Regarding the awareness of available resources, a single trial increase in awareness of available community resources, as measured by the number of handouts taken after presentation of treatment conditions and by caregiver questionnaire, was a significant predictor of decreased caregiver burden at follow-up (73). Altogether, the results indicate that a caregiver-focused psychoeducation intervention is associated with a decrease in caregiver burden for informal caregivers of dementia patients, suggested that family physicians in similar communities focus on a protective family function approach in their initial screening of caregivers and use psychoeducation tailored to the specific caregivers as a follow-up intervention (99).

The second goal was to increase the use of available community resources and trainings and education intended to assist caregivers (100). One potential implication of this study is the need for heightened awareness of and access to the many service and support organizations (101). It became clear from the caregiver responses that many were not aware of organizations that could support them in their role (100). Further, if more were aware, it is likely that they would take advantage of their services, as many of the caregivers expressed a desire to receive more help (102). A better method of distribution of materials could be employed to ensure broader dissemination of psychoeducational materials (103). Further, presentations could be conducted at various relevant locations. These presentations can focus on similar information and be less formal in nature to encourage participation (103).

20. Research Gaps in Caregiving Studies

Researchers frequently argue that caregiving literature, particularly studies about the 'working while caregiving' dilemma, continues to embody a 'task-oriented' perspective which simply describes caregivers' workforce participation, caregiving tasks, and health consequences of taking on both paid work and unpaid caregiving responsibilities (104). For example, researchers point out the need for further examination of nuanced aspects of caregivers' identities rather than simply focusing on their task orientation as this diminishes the inclusion of a wider range of factors associated with their challenges (2).

In a scoping review of studies based on quantitative and qualitative methodologies, researchers discovered a significant gap in explorations of caregiver identities, particularly with regard to gender, racial, and socio-economic status intersections (87). Although researchers are beginning to explore

caregiver identities via the lens of gender, and a growing number of studies that examine the experiences of working caregivers from immigrant backgrounds in different parts of the world, caution is needed in generalizing the results since cultural differences should be taken into consideration (105). Further, despite seeing a rise in qualitative studies on the experiences of males who also take on informal care responsibilities, their experiences in an employed context are arguably yet unexplored (106). Therefore, a greater breadth of research is needed to examine male caregivers' experiences both in the workplace and in the caregiving context to explore whether and how their experiences are, on the one hand, similar to those of female caregivers and, on the other hand, gendered in how they are dissimilar (105). This could push our knowledge forward about how males can be better supported in the workplace while being informal caregivers (1).

Overall, it is increasingly apparent that both females and males are taking on informal caregiving responsibilities within the household but the meaning and impact of that change on their everyday lives may differ based on varied historical, cultural, and sociological factors surrounding gender (107).

21. Recommendations for Future Research

This body of literature identifies a gap in research examining how province/state-level policies affect professional emergency care and other first response workers (108). Given the ever-burgeoning prevalence of wildfires and other disasters, and the fact a significant proportion of firefighters are becoming advocates for greater mental health resources, understanding systemic-level issues is more timely than ever (109). Easily accessible emergency care, specifically mental health care, is crucial for minimizing the effects of traumatic events on the health of an affected community (108). Research has indicated that first responders in communities with more broadly accessible mental health services available to emergency workers and their families reported significantly fewer post-traumatic stress symptoms and psychological distress over time (109). Future research, while difficult, could take advantage of several natural experiments that have occurred in recent years with states and provinces enacting more expansive mental health legislation to better understand how these policies work (110).

22. Conclusion

Gender roles are socially constructed ideas of manners of thinking and behavior, based on one's biological sex (111). For the past hundred years, there have been transformations in society that resulted in changes to traditional gender roles (112). However, gender roles have not disappeared, and many Western societies still uphold traditional expectations regarding gender (111). Gender roles tend to define rigid expectations in both public and private spheres in society (112). The family, as the smallest unit of a social system, is fundamental to these gender roles (113). Traditional roles are defined for men and women regarding their participation in the workforce and domestic roles (112). In any case, the family is a social system where cooperation and support exist. However, there are hard rules regarding this cooperation and support (114). Men supply wealth to the family, while women manage the household and

raise children (115). Child rearing consumes women's time and energy and hinders their full participation in society (114). These roles dominate public and private spheres and result in asymmetric power between men and women (115). Because of traditional gender roles, women have been thought to have a better temperament for caring (116). They are expected to take more responsibility for children and, as a result, tend to choose childcare careers (117). Women often work as either professional caregivers or unpaid family caregivers (118). In turn, they confront health risks such as poor physical health, poor mental health, and lower levels of life satisfaction (117). In recent years, it has been noted that female relatives in all cultures have more responsibility for the care of the elderly than do male relatives (118). Gender matters in caregiving to elderly family members (119). Traditional gender norms assign the responsibility for caregiving to elderly family members, resulting in a bulk of caregiving responsibilities for daughters and daughters-in-law (119).

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