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Changes to caregiving roles

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Key Findings

- During the COVID-19 pandemic 15% of the population aged 60 and older report that they cared for someone, more than double the proportion (6%) who report caring in 2018.
- A similar proportion of women (19%) and men (16%) are carers, increased from 7% of women and 5% of men in 2018.
- The average age of carers is 69 for women and 71 for men.
- Carers are more likely to be married, and women who are carers are more likely to have a tertiary education.
- Women who live in Dublin are more likely to report they had cared for someone during the pandemic (23%) compared to women (15%), and men (12%) who live in a rural area.
- More than 50 hours of care per week is provided by 27% of women and 25% of men who are carers aged 60-69 years and 36% of women and 41% of men who are carers aged 70 years and older.
- 43% of women and 48% of men carers aged 60-69 years report that the main recipient of care was their spouse.
- Carers aged 60-69 years also provided care for other family members: among, carers 14% of women and 15% of men report that they provide care for parents, 12% of women and 6% of men report they provide care for other relatives, 14% of women and 8% of men report they provide care for children and 10% of women and 12% of men report they provide care for grandchildren 6% of women and 10% of men also provide care for friends and neighbours.

- Among carers aged 70 years and older, the main recipient was their spouse (71% of women and 88% of men)
- Women aged 70 years and older who provided care during the pandemic also provided care to children (10%) and grandchildren (14%).
- 4% aged 60 years and older stopped caring since 2018, 2% have continued caring since 2018 and 13% of adults aged 60 years and older who report caring during the COVID-19 pandemic are new carers.
- Women aged 70 years and older who continued as carers during the pandemic have a higher purpose in life than women who report either no caring or who became a new carer during the COVID-19 pandemic in the same age group.
- Men aged 70 years and older who became a new carer during the COVID-19 pandemic report lower quality of life, higher depressive symptoms and higher perceived stress compared to non-carers.
- Becoming a new carer was associated with worse self-rated mental health than non-carers for men aged 60-69 years and 70 years and older.
- Women aged 70 years and older who became new carers during the pandemic had increased depressive symptoms and higher anxiety compared to those who were not carers in the same age group.
- Many of the older population took on new caring roles during the COVID-19 pandemic. To enable family caring to continue, state-provided home support must also be available to facilitate and support carers.

8.1 Introduction

Previous TILDA reports have documented the use of social and community care services by the older population in Ireland by frailty and disability status. (1, 2) While community-based care can facilitate ageing in place, and has the potential to delay admission to a nursing home and improve quality of life (3), the majority of caring provided to older adults is unpaid, informal care by a family member. (4) Generally, family caring was associated with positive health outcomes for the carer, but this depended on the intensity of caring. Compared to non-carers, women providing comparatively low-intensity caring (up to 49 hours per week) reported better self-rated health and wellbeing (higher quality of life score), lower depressive symptoms and higher functional mobility, while lower depressive symptoms were seen in men reporting any caring. (4) Where an excess of care hours was provided, this was associated with higher depressive symptoms, lower quality of life, more chronic pain, lower functional mobility and increased hypertension. (4)

This supports previous research which showed that carers are healthier and demonstrate better mood than non-carers (5-7), with similar findings associated with grandchild care. (8) There is strong evidence supporting the health benefits of remaining physically and socially active, which caring at lower numbers of hours may facilitate. These benefits were mainly seen for women, as were the detrimental effects of caring at high intensity, for both physical health and wellbeing including lower quality of life and higher depressive symptoms. (4)

The initial public health response to the COVID-19 pandemic in Ireland recommended that older people aged 70 years and older remain at home, and physically isolate from those outside their household as much as possible. There was little consideration given to the impact this would have on the older population who were in receipt of informal care from family members, and who were themselves providers of informal care to their family and friends. This is likely to have had an impact on both the provision and receipt of care by the older population, as maintaining these activities is a challenge in the context of lockdown and physical distancing; there may consequently have been changes in the patterns of care giving during the pandemic. As carrying out such roles fulfils an important need for those receiving care, and potentially provides important physical and mental health benefits for the older person giving care, stopping may have negative consequences for both care recipients and carers. We examine whether there have been changes in family caring by the older population, and associated wellbeing and mental health outcomes.

This chapter is structured in three sections. The first describes caring during the pandemic; the second section describes how this has changed since Wave 5; and the third section examines wellbeing and mental health outcomes by caring status.

8.2 Caring during the COVID-19 pandemic

Participants were asked 'Did you look after anyone during the COVID-19 pandemic (including your partner or other people in your household)? By "look after" we mean the active provision of care?' They were also asked what their relationship to the person was, and for how many hours on average per week.

8.2.1 Sociodemographic characteristics associated with caring

Overall, 15% report they had cared for someone during the pandemic, 14% of men and 16% of women, and this was similar in those aged 60-69 and 70 years and older. The average age of carers is 69 years for women and 71 years for men.

This varies according to education, with men who had a primary education more likely to report caring during the COVID-19 pandemic (18%) than men who had secondary (13%) or third level education (10%) (Figure 8.1). Reported caring did not vary by educational attainment for women, although a higher proportion of women with a third level education reported caring (21%) than both third level and secondary-educated men.

Figure 8.1. Proportion caring by educational attainment and sex

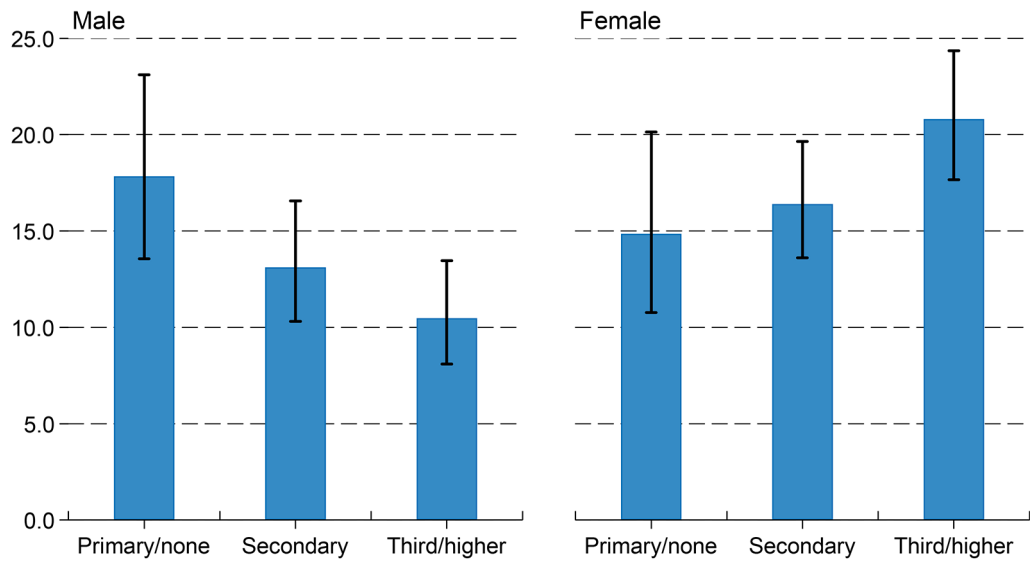
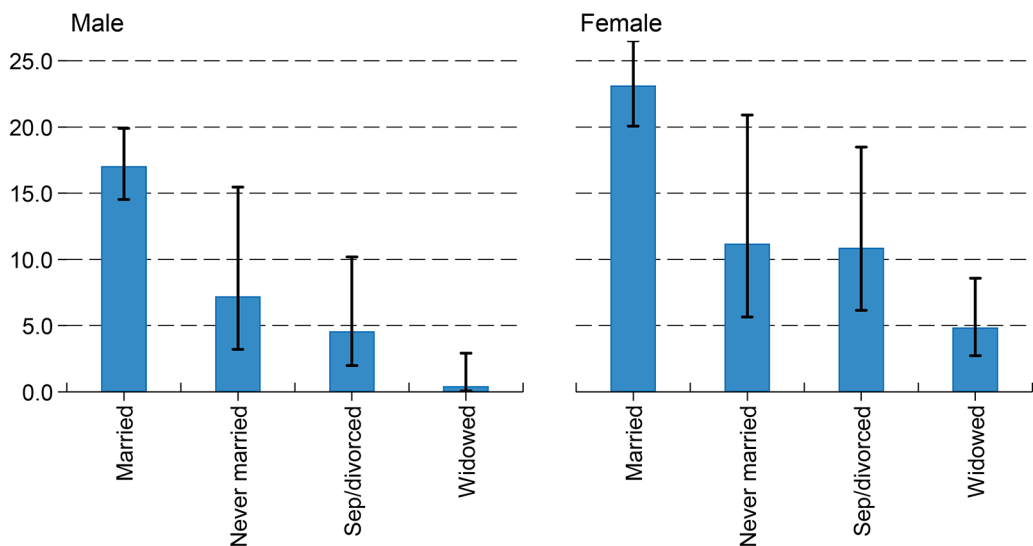


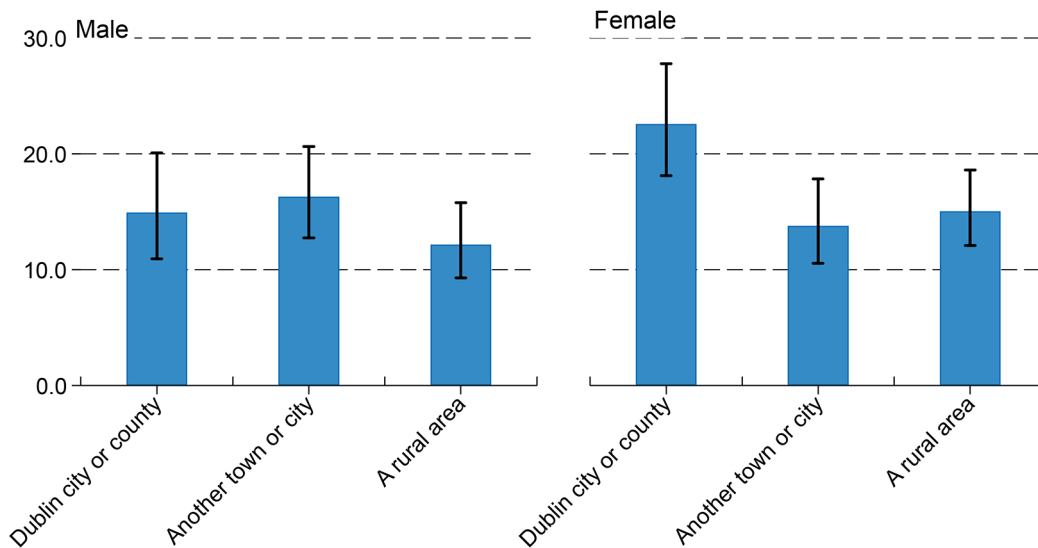
Figure 8.2 shows that married men (17%) and women (23%) were more likely to report caring during the COVID-19 pandemic than those who were single, separated or divorced, or widowed.

Figure 8.2. Proportion caring by marital status and sex



Caring during the COVID-19 pandemic differed by area of residence. Women who lived in Dublin were more likely to report they had cared for someone during the pandemic (23%) compared to women (15%) and men (12%) who lived in a rural area (Figure 8.3). The proportion of men caring was similar for men in Dublin (16%) and in another town or city (18%).

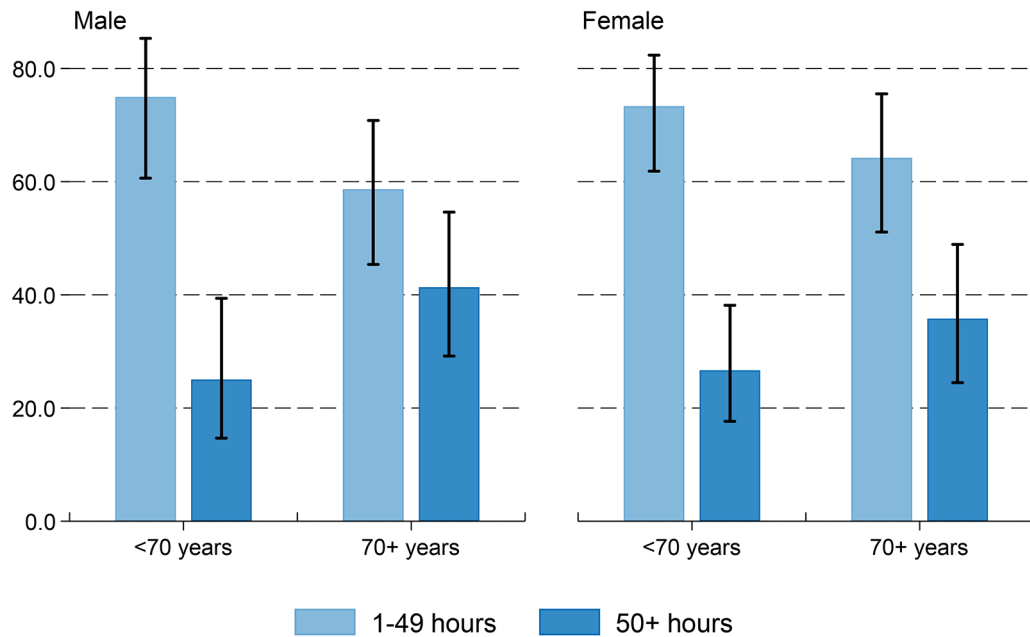
Figure 8.3. Proportion caring by area of residence and sex



8.2.2 Sociodemographic characteristics associated with hours of caring

The average number of hours of care given in the last week was 53 hours. Figure 8.4 shows that most people providing care did so for between 1 and 49 hours in the past week. More than 50 hours of caring was also common however, particularly in the older age group. 26% of adults aged 60-69 years who provided care during the pandemic (25% of men and 27% of women) provided 50 or more hours in the last week. This proportion increased among adults aged 70 years and older who provided care during the pandemic, with 38% (41% of men and 36% of women) providing 50 or more hours in the last week (Figure 8.4).

Figure 8.4. Distribution of hours of caring for those who report caring by age group and sex



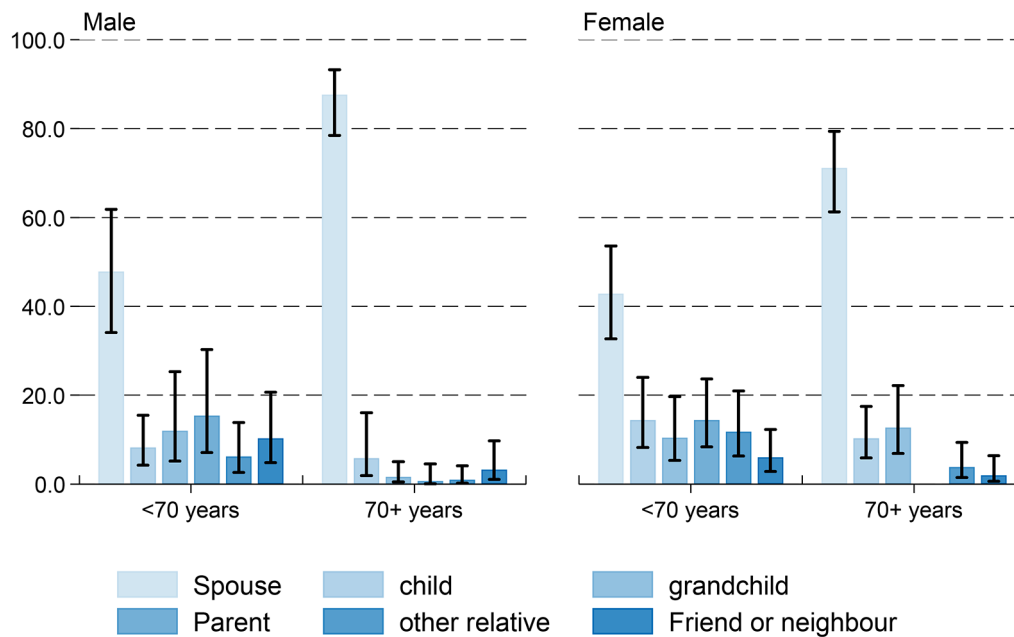
8.2.3 Relationship of carer to care recipient

We asked carers whom they provided care for, and Figure 8.5 shows that, for most carers, care was given to their spouse. The proportion of carers who provided care for their spouse increased from 48% of men and 43% of women aged 60 to 69 years to 88% of men and 71% of women aged 70 years and older.

Other family caring by those aged 60-69 years was provided for parents (15% of men, 14% of women) and other relatives (6% of men and 12% of women). Perhaps as expected, care was also provided by those aged 60-69 years for children (8% of men, 14% of women) and grandchildren (12% of men, 10% of women). Further, care was also provided for friends and neighbours and represented 10% of care provided from men and 6% of care from women aged 60-69 years.

A substantial proportion of care provided by women aged 70 years and older during the pandemic was also provided to children (10%) and grandchildren (14%).

Figure 8.5. Relationship of care recipient to carer by age group and sex



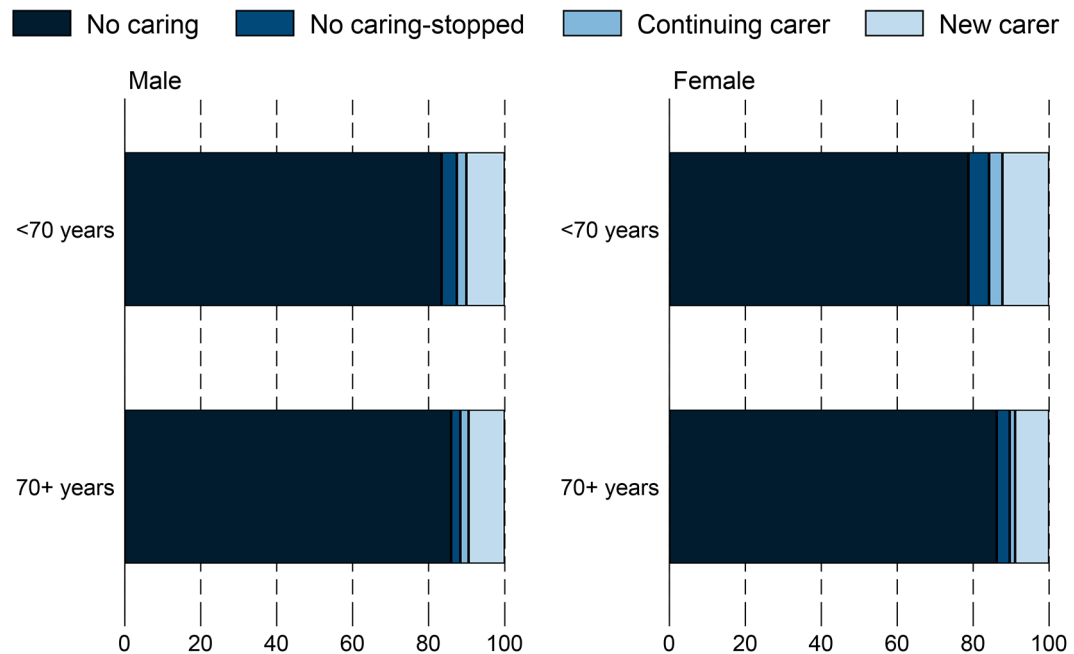
8.3 Change in caring status since Wave 5

Change in hours of caring was estimated by comparing reported caring hours during the COVID-19 pandemic with caring hours reported in the last TILDA wave in 2018 (Wave 5). Change in caring hours was grouped into four categories; No caring; No caring - Stopped since Wave 5; Continued to care; and New carer, defined as someone who reports caring during the COVID-19 pandemic who had previously not reported providing care in Wave 5.

8.3.1 Change in caring during the COVID-19 pandemic for carers from Wave 5

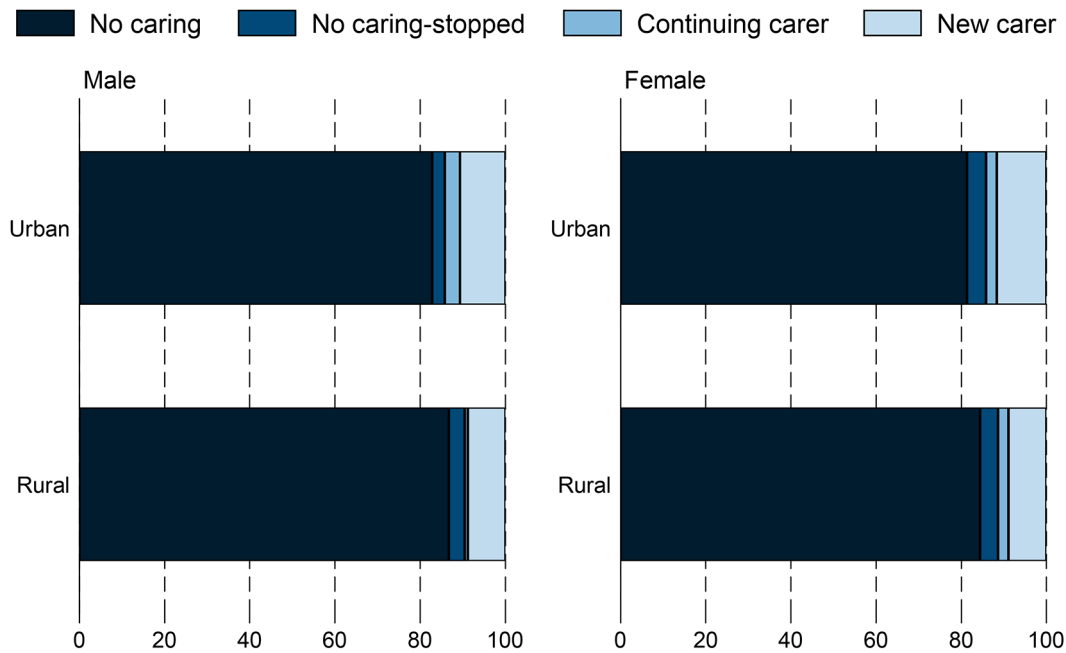
The proportion of the older population aged 60 years and over who report caring during the COVID-19 pandemic increased from 5% of men in Wave 5 to 14% during the pandemic and from 7% of women in Wave 5 to 17% during the pandemic. Overall, 84% of adults aged 60 years and older report no caring during the pandemic (4% were carers in Wave 5 but stopped being a carer), 2% continue to be a carer and 13% are new carers (Figure 8.4). The proportion of new carers is similar for men (12%) and women (14%) (Figure 8.6).

Figure 8.6. Change in caring hours for carers since Wave 5 by age group and sex



The proportion of carers who stopped caring during the COVID-19 pandemic was largest for men living in a rural area. Figure 8.7 shows that, overall, 4% of men living in a rural area stopped caring since Wave 5, while the proportion of men who stopped caring who lived in an urban area was 3%; 1% in a rural area report continuing caring, compared to 3% living in an urban area. A similar proportion report new caring however in both rural (11%) and urban (12%) areas. No differences in change of caring status by region of residence were seen in women. Four percent resident in rural areas and 5% of carers resident in urban stopped caring; 2% of women in rural and 3% in urban areas continued caring, while 13% of rural and 15% of urban women residents were new carers during the COVID-19 pandemic.

Figure 8.7. Change in caring hours since Wave 5 by area of residence and sex



8.4 Wellbeing and mental health by caring status

A number of measures of wellbeing and mental health were collected in the COVID-19 SCQ. These measures are described in this section and examined by caring status. We present wellbeing and mental health measures for those who report no caring (combining those who didn't report caring previously and those who stopped caring since Wave 5), for continued caring and for new carers.

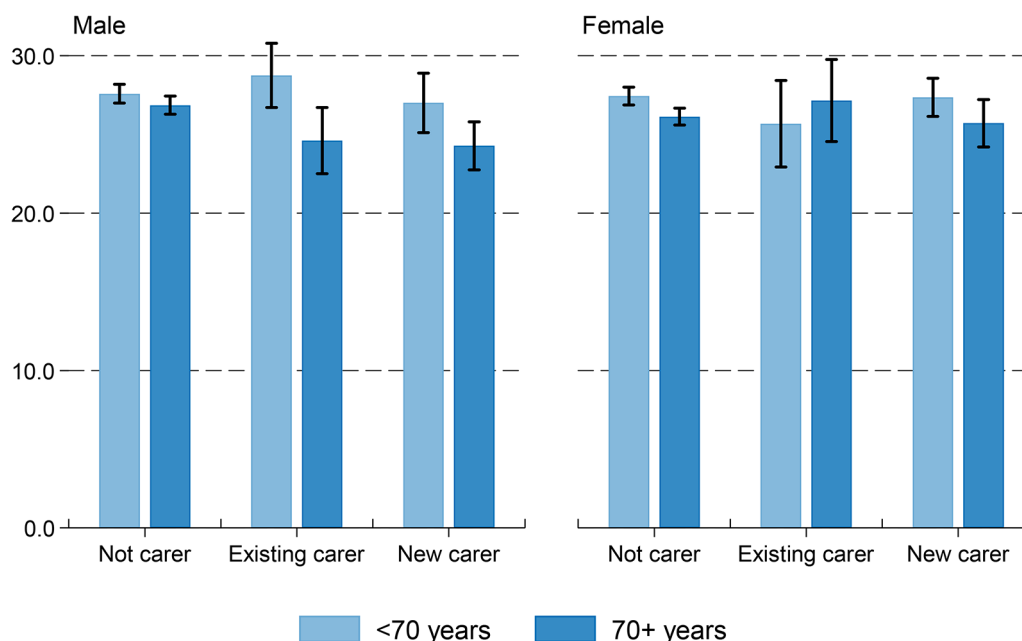
8.4.1 Quality of life by caring status

Quality of life is measured in TILDA using the 12-item self-report measurement, CASP-12. The scale covers the four domains (Control, Autonomy, Self-realisation, Pleasure) considered to encompass quality of life. Each item is summed to give an overall score (range 0 to 36), with higher scores indicating better quality of life.

Both men and women aged 70 years and older report a lower quality of life than those aged 60-69 years (26.2 CASP-12 score for 70 years and older compared to 27.4 for those aged 60-69 years). When new carers were compared with those who report no caring, men aged 70 years and older who reported being a new carer during the COVID-19 pandemic had a small but significantly lower quality of life score (24.7) than men who

did not report caring (26.9) (Figure 8.8). Men who continued to be a carer also had lower quality of life scores than those who reported no caring in this age group (24.6). These differences were not seen in women aged 70 years and older, with similar quality of life scores seen in each group: women who became a new carer (25.6), existing carers (27.7), and women who did not report caring (26.1).

Figure 8.8. Quality of life (CASP-12) by caring status, age group and sex

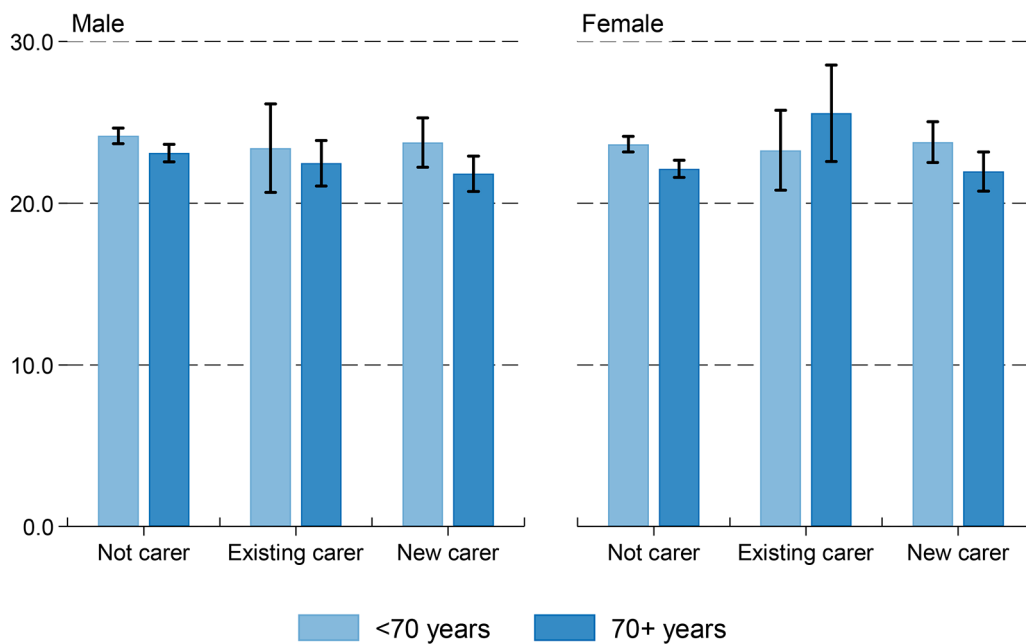


8.4.2 Purpose in life by caring status

Purpose in life was measured using Rhyff's scale. It is a 7-item scale scoring from 0-35. Higher scores indicate a person has a higher sense of purpose in life: has goals; has a sense of directedness; feels a meaning to past and present life and that life has purpose; and has aims and objectives for living.

Purpose in life score was lower in those aged 70 years and older, and this difference was seen in men, regardless of caring status. Figure 8.9 shows that this varied for women; women aged 70 years and older who continued to be a carer had a higher purpose in life than women in the same age group who did not report caring (25.6 PIL score compared to 22.1 for women who reported no caring and 22.3 for new carers). These differences were not seen for men or those aged less than 70 years.

Figure 8.9. Purpose in Life by caring status, age group and sex

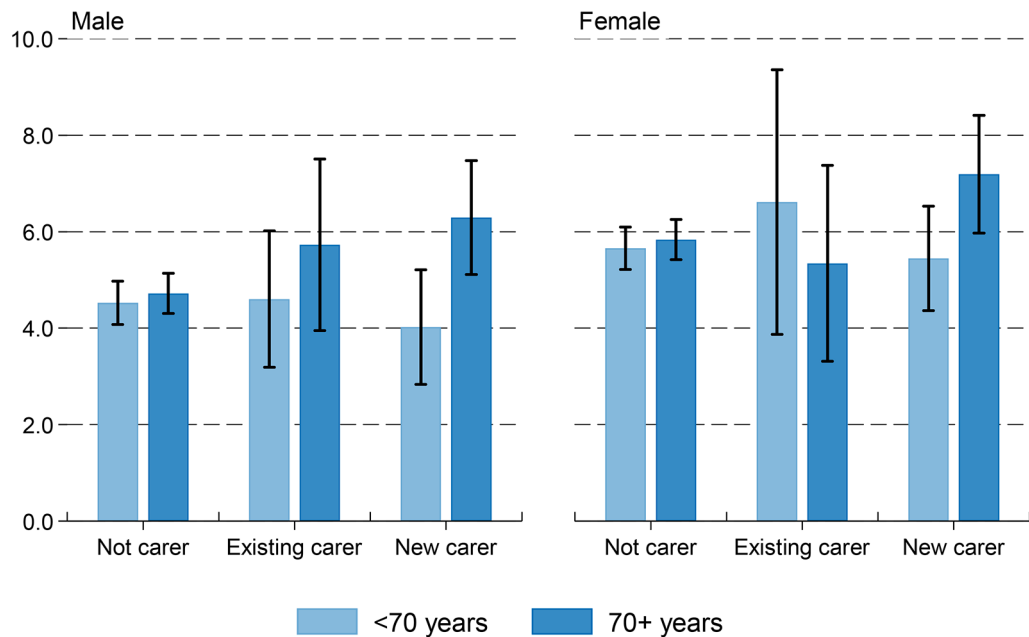


8.4.3 Depressive symptoms by caring status

Depressive symptoms were measured using the Centre for Epidemiological Studies Scale for Depression (CES-D8), an 8-item scale. This scale measures the frequency that participants have experienced a variety of depressive symptoms in the past week. The responses are summed to give a total score ranging 0-24, with higher scores indicating more depressive symptoms.

Men aged 70 years and older who report new caring during the COVID-19 pandemic have higher depressive symptoms (6.4 CES-D score) than men who do not report caring (4.7) or existing carers (5.7) (Figure 8.10). A similar increase in depressive symptoms was seen in women aged 70 years and older, with new carers having higher depressive symptoms (6.6) than women who were existing carers (5.3) or non-carers (5.8). There was no difference in depressive symptoms in men or women aged under 70 years by caring status.

Figure 8.10. Depressive symptoms (CES-D) by caring status, age group and sex

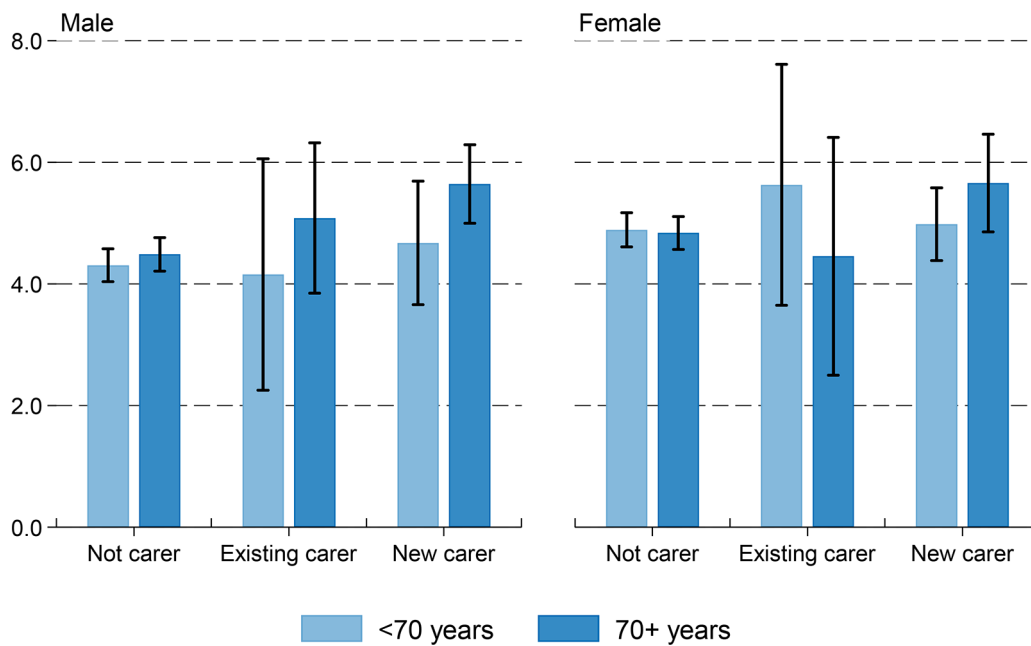


8.4.4 Perceived stress by caring status

The Perceived Stress Scale (PSS) is used for measuring the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. The questions in the PSS ask about feelings and thoughts during the last month. In each case, participants are asked how often they felt a certain way. The scale scores from 0-16, a higher score indicating more perceived stress.

Overall, perceived stress was relatively low, with an average score of 4.5 for men and 4.9 for women. Men aged 70 years and older who reported becoming a new carer had a higher perceived stress score (5.4) than men in the same age group who did not report caring (4.5) or existing carers (5.1). These differences were not seen for men aged 60-69 years or in women of either age group (Figure 8.11).

Figure 8.11. Perceived Stress by caring status, age group and sex

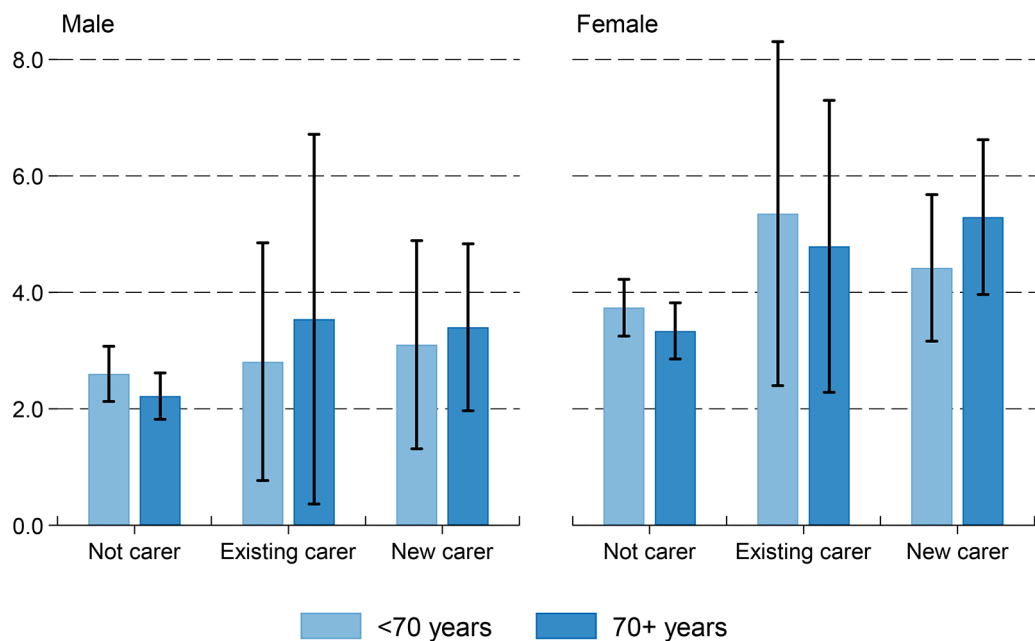


8.4.5 Generalised anxiety by caring status

Anxiety was measured using the Generalised Anxiety Disorder (GAD7) screening questionnaire. This is a 7-item measure that scores from 0-21, with higher scores indicating higher anxiety, and a score above 5 indicating mild to moderate anxiety.

Overall, anxiety was relatively low in the population aged 60 years and older, with an average score of 3.2 (sd 4.5). Figure 8.12 shows that women aged 70 years and older reporting new caring during the COVID-19 pandemic had higher anxiety scores than those who reported no caring: 4.4 GAD7 score compared to 3.3 in women who didn't care, and 4.8 in women who were existing carers, while there was no difference in anxiety scores in those aged 60-69 by caring status, or in men of either age group.

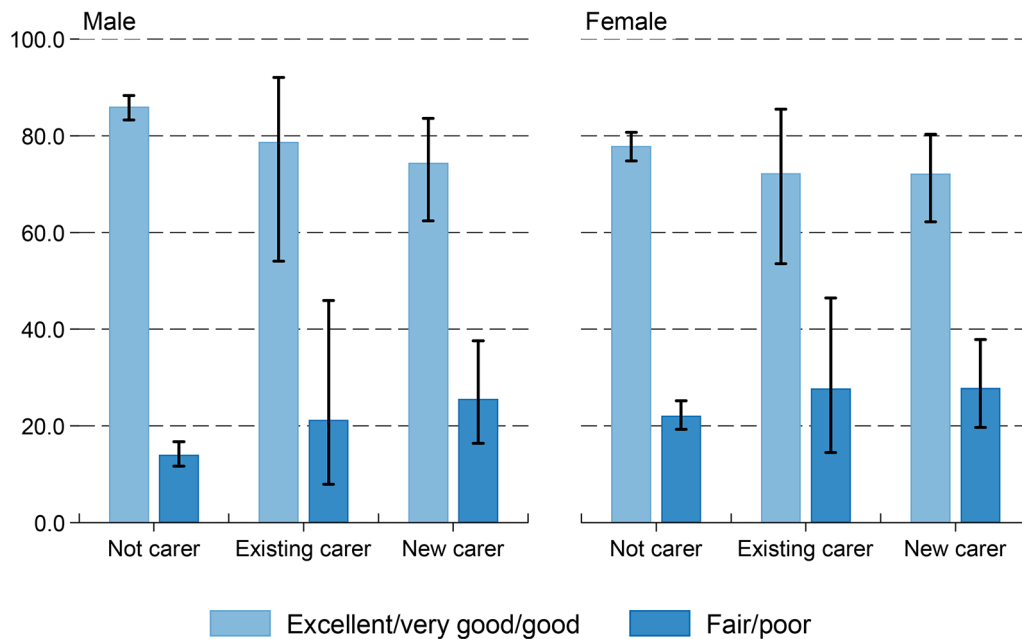
Figure 8.12. Generalised anxiety (GAD7) by caring status, age group and sex



8.4.6 Self-rated mental health in carers

TILDA also asks participants to rate their mental health; options were: Excellent, very good, good, fair or poor. Most participants rate their mental health as Excellent/very good or good (81%) with 19% rating their health as fair or poor. This varied by sex and caring status. Figure 8.13 shows that a higher proportion of women (23%) reported their mental health as fair or poor than men (15%), and this was similar by caring status. Men who reporting becoming a new carer during the pandemic were however more likely to report their mental health as fair or poor (23%) compared to men who reported no caring (14%). These differences were not seen in women.

Figure 8.13. Self-rated mental health by caring status and sex



8.5 Discussion

We found that 15% of the older population report caring for someone during the COVID-19 pandemic. Overall, there have been important changes in the proportion of care that older people are providing, and, while one in four carers at Wave 5 (2018) report that they have stopped caring since the pandemic, a large proportion of those providing care are new carers (68% of men and 66% of women who report caring). As before the pandemic, a large proportion of care is provided for the family, although the proportion provided to children and grandchildren has decreased by 11% compared to prior to the pandemic (4). While most carers are caring for their spouse or another relative, 5% also report caring for someone outside of their family, either a friend or neighbour. Sociodemographic characteristics (marital status, educational attainment and area of residence) were related to prevalence of, and changes to, caring during the pandemic.

We find that continuing to be a carer is associated with higher purpose in life in women aged 70 years and older. This agrees with existing research that has also found that low-intensity caring is associated with better mental and physical health; research also shows there are a variety of positive gains from providing care and support for loved ones. (8, 9) We also however find some evidence that becoming a new carer was associated with poorer wellbeing and mental health outcomes in those aged 70 years and over, particularly

for men. A large proportion of older adults who report caring during the pandemic have taken on new duties for which they may be ill-equipped and unsupported. It is likely that the withdrawal of home supports provided by state or private firms, in addition to other family members (children or other relatives) no longer being able to travel and support their older family members due to travel and visiting restrictions during the pandemic, has contributed to increased caring within the home by the older population and to the expanded need for support.

A substantial proportion of those aged 70 years and older who are providing care are doing so at levels of high intensity, and this proportion has increased from previous years. Both our previous research and international research has found that higher levels of caring hours have been associated with poorer mental health and wellbeing outcomes. (4, 7, 10, 11)

Continued support is needed for family carers. The pandemic was unprecedented and could not have been adequately planned for; however, removing the availability of both formal and informal family care for older people through restricted movements and reducing contacts, and thus transferring that responsibility onto their older family household members, may have impacted badly on older people's wellbeing and mental health; and these negative effects were seen particularly in men. This may have added to the already increased burdens on wellbeing and mental health associated with loneliness and worry within this population in Ireland during the COVID-19 pandemic.

In conclusion, this chapter provides further evidence of the continued contribution of the older population to family caring. While becoming a new carer during the pandemic was associated with poor wellbeing and mental health outcomes in those aged 70 years and older, our previous findings suggest interventions to increase social inclusion of family carers and enhance home support through formal care mechanisms should reduce these negative effects on the wellbeing and health of carers. Investigating the impact of the pandemic and the role of changes in care provision, with the corresponding reduction in more rewarding grandchild care and other volunteering and social participation, on broader health and well-being outcomes for older people, is an important further investigation. It will provide an evidence base for policymakers to inform what areas should be prioritised to enable the older population to resume their positive and essential roles in our society.

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