

Chapter 2

Who Will Care for the Elder Caregiver? Outlining Theoretical Approaches and Future Research Questions

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Abstract The goal of the current chapter is to explore some of the popular theoretical frameworks used to study the experiences of caregivers. The chapter discusses the relevance of these theoretical frameworks in the context of India, and compare and contrasts them to research in the West. It critically examines household living arrangements and complexities in identifying the primary caregiver in India, especially in the context of elder care in multigenerational households. The chapter concludes by discussing the knowledge gaps and the way forward to study caregiving issues around the elderly in India.

Keywords India • Caregiving • Theories • Family structure • Living arrangement

2.1 Introduction

The world's population is growing and aging. Globally, the population is projected to reach 7 billion by the end of 2011. The percent of the world's population who are aged 65+ has been rising slowly and are about to spike in growth. In the United States, the first wave of "Baby Boomers" is beginning to reach retirement age. Between 2000 and 2010, the percent of the population aged 65+ grew from 12.3 to 13 %; by 2020, this is projected to increase to 16.1 % (see Fig. 2.1). These trends are even more pronounced in less developed settings where, historically, life expectancy and the old age population have been small. For example, in Mexico,

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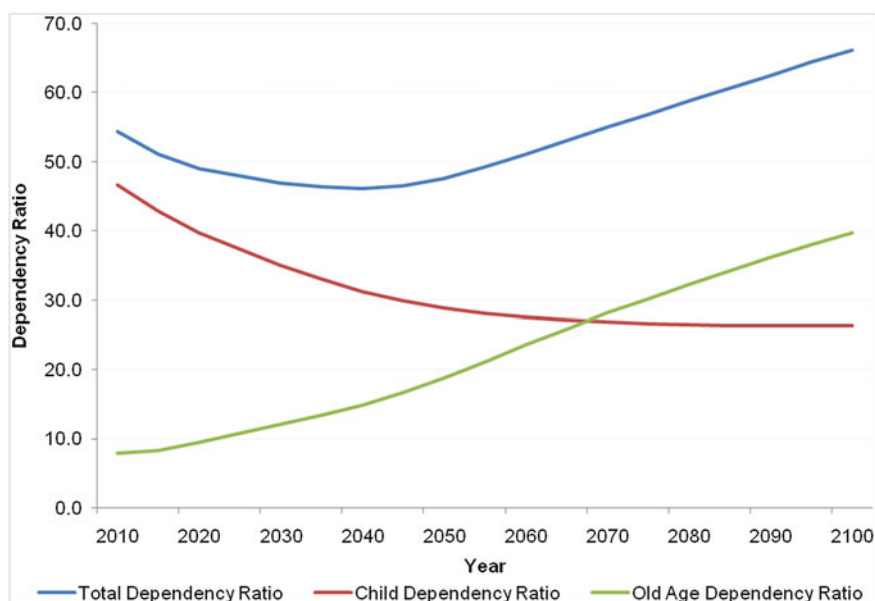


Fig. 2.1 Dependency ratio. *Source* United Nations (2014). Probabilistic population projects based on the world population prospects: the 2012 revision. Population Division, DESA/ST/?/ESA/SER.A/353. <http://esa.unc.edu/unpd/ppp>

the proportion of the population who are aged 65+ is projected to almost quadruple between 2000 and 2050, from only 5.2 to 22.1 %.

Less developed regions will also be home to the vast majority of the world's aged by 2050. Though the distribution of world's aged population was roughly evenly divided between more and less developed regions in 1950, less developed areas represented 62 % of the world's aged as of 2010, which is projected to grow even further to 78 % by 2050.

The implications of population aging for anticipating the informal or at-home care that older adults need for their health are extremely relevant in lower and middle-income countries (LMICs). Disability from factors like depression, accidents, and chronic (particularly, cardiovascular) and communicable (notably, HIV/AIDS) diseases are extremely common among elderly in LMICs (Murray and Lopez 1997a, b). Recent evidence suggests that morbidity is expanding worldwide, including in LMICs, which also translates to more years with care needs (Murray et al. 2012; Salomon et al. 2012; Vos et al. 2012). Moreover, older people in developing settings are socially and economically vulnerable. A significant proportion of the elderly live below the poverty line (Barrientos et al. 2003; Barrientos and Hulme 2008; Deaton and Paxson 1997; Harper 2006) and generally lack access to pension and other benefits that are common support structures in developed settings (Bloom et al. 2010; Harper 2010). Health care access is a further challenge for the elderly in developing

settings, exacerbated because older people tend to live in rural areas where health facilities, in particular, facilities specializing in geriatrics, are scarce (Lloyd-Sherlock 2000, 2002, 2010; Shrestha 2000). Given the symbiotic relationship between care recipient and caregiver, a corollary implication of the aging trends is the increasing numbers of informal caregivers who will face health and financial consequences as they take on the role of caregivers of elderly with health needs.

In this chapter, we question whether contemporary theories of elder caregiving, developed in the United States and Western Europe, apply to LMICs and specifically to the Indian context. A corollary area of inquiry regards *emic* understandings of caregiving and the *etic* and theoretical implications. To do so, we explore the history of family structure and norms of elder care. Since theories are in part a representation of social reality, this discussion will lay the ground to understand differences in normative beliefs around elder care and living arrangements between Euro-Americans and South Asians, and the extent to which the norms may have implicitly or explicitly impacted the theories of caregiving, and their relevance in the current Indian context. The chapter would then describe the different theoretical models of the health and social sciences. We close the chapter by identifying theoretical areas that are problematic when used in the Indian context.

2.2 Western and Indian Family Structures and Norms of Elder Care

Much of the early discussion and research around elder care grew out of concern for the changing family structure: a move from a traditional multigenerational set-up to a nuclear structure, which arguably gave rise to questions about who would care for the elderly, and how and where would care be located.

There is adequate evidence to show that the living arrangements of the elderly have shifted significantly over the decades in almost every Western industrialized country (Alter et al. 1996; Andorka 1995; Ruggles 2007; United Nations 2005). In the USA, intergenerational living by the elderly declined steadily from 70 % in the mid-1800s, to less than 15 % in the 1990s (cited in Ruggles 2011). Living with or adjacent to an adult child's home was replaced by living only with one's spouse, alone or in institutions. The societal changes stemming from economic development help to explain the decline of intergenerational co-residence. These include industrialization, migration to cities, urbanization, reduced ties to the land and the rise of wage labour.

Although daughters and spouses continued to remain the primary caregivers of older adults, the division of labour by gender along with different family and kinship structures brought about by divorce, remarriage and stepfamily formation increased the complexity of who would take on the caregiving role (Silverstein and Giarrusso 2010). As such there is no clear pathway to who is to care for the elderly and whether this is a private or a public responsibility.

In contrast, intergeneration family continues to be the site for elder care in India. However, it needs to be cautioned that intergenerational family in the context of eighteenth century US/Western Europe was no way comparable to an intergenerational family in the Indian context. According to Le Play (cited in Ruggles 2010), the most dominant family structure of peasant households in mid-eighteenth century Europe was the “stem family” structure. The arrangement involved one child usually selected by the father to live near parental homestead and work on the farm while the other’s left home on reaching adulthood to form their nuclear families. This is in contrast to family structures seen historically in several Asian countries, including India and China, where three or more generations live under the same roof, referred to as the joint family. Therefore historically, the joint family structure was never part of the Western European family structure.

In India, the family has long been viewed as the primary site of age (Rajan and Kumar 2003; Jamuna 2003). The ideal Indian joint family (may also be referred to as extended family) includes three or more generations living together, with the patriarch being the head of the household. A joint family household could have grandparents, aunts, uncles, nephews and nieces, all living under the same roof. This family structure has historically served as a safety net for the elderly (Jamuna et al. 2003) irrespective of their health status. Although the original form of joint family structure has changed, an intergenerational household arrangement that is living with only adult children, preferably the son, continues to be the dominant living arrangement for majority elderly Indians above the age of 60. In a study of 9852 elderly above the age of 60 in 2011, 70.03 % reported living in intergenerational households (UNFPA 2011).

Historically, the norms of eldercare revolve around the concept of filial piety, which underpins elderly caregiving in India. Caregiving, also termed as “*seva*” (incorporates components of respect, care, love, moral and spiritual indebtedness and obligation), is a family responsibility, passed on from one generation to the other, with usually the elder son (although there are regional variations) taking upon the primary responsibility of aging parents. In the context of India, sons represent old age security (Jamuna 2003). However, it needs to be cautioned that while sons take upon the caring role, a significant amount of the assistance with daily living activities for the elderly are provided by the spouse, followed by daughters-in-law who usually move in with their parent-in-law upon marriage. Therefore, *emic* understandings of intergenerational caregiving consider it natural, obligatory, guided by a sense of filial piety, and simultaneously sustaining and challenging.

From an *etic* perspective, the ideal arrangement of elder care is possible if families continue to live jointly. However, research from Asian countries, such as China, Korea, Taiwan, Japan, which traditionally had joint family structures (see Ruggles 2010 for review), show patterns of declining intergenerational co-residential structures (Martin 1990; Hiroshima 1997; Hermalin et al. 1992; De Vos and Lee 1993; Chattopadhyay and Marsh 1999; United Nations 2005). Forces of development have been cited as potential determinants of the change. Although there is no empirical evidence to support the same, there is a consensus that similar patterns are emerging in India too. Under such circumstances, much is left to understand how the change in

family structure, would eventually impact care and location of care of the elderly. Second, the *etic* perspective, focusing on “the family” as the site of care rather on the specifics of who is performing the care, fails to highlight the pivotal role of daughters-in-law, daughters, and spouses who provide the majority of the care. Unlike the West, where daughters tend to be the primary providers of care to an aging parent, in the Indian context daughters usually relinquish their family of origin after marriage and are not dependent for care (Lamb 2005). Instead, spouse and daughters-in-law are expected to take on the role of caregiving (Jamuna 1997).

Given that social theories are a replication of social reality, it is but natural to ask whether the social science theories widely applied in the Western literature on caregiving can be validly applied in the context of India. To do so, we first review the theories of care from the health and social sciences to be able to ground our analysis of whether the theories apply to the Indian context and signal areas of fruitful theoretical development in the future.

2.3 Theories of Caregiving

It needs to be cautioned that there are no specific theories of caregiving per se. Instead, the field of caregiving research has borrowed theories and models extensively from disciplines such as sociology and psychology to explore the experiences of caregivers and their elderly care recipients.

Some of the core sociological theories discussed are the role theory and the cumulative advantage/disadvantage theory. In addition to the theories, are models and perspectives, such as the life course perspective, Pearlin’s stress and coping model and the convoy models, used extensively to understand caregiver experience and the impact of caregiving on caregiver’s physical, social and psychological wellbeing. It also needs to be emphasized that life course perspective, the stress process model and the role theories, are not stand-alone models and theories, but share substantial overlap among themselves. Recent work by Pearlin (2010) has attempted to find a “conceptual overlap and cross-fertilization” between the models of stress and coping and the life course perspective. These models are continually under integration and development and frame the way for future theories of caregiving. As such there is much scope for its use to understand better caregiving experiences both in the developed north as well as in the global south.

2.3.1 *Pearlin’s Stress and Coping Model*

The most widely used model in caregiving research, including in gerontological caregiving, is Pearlin’s stress and coping model, developed by Pearlin et al. (1990). This model that comes from the health sciences postulates that stressors have the ability to affect wellbeing, but the extent of their impact on wellbeing is determined

by the availability of resources to counter the negative effects or burden as these are technically known. Included in the caregiving and stress process model is moderating factors, such as coping strategies and social support. Although developed in the context Alzheimer's care, this framework is extensively used across different ethnic groups in the U.S. because it provides a path towards caregiver interventions that seek to reduce caregiver burden. The model is used in the context of health-related caregiving. The model has been critiqued for its emphasis on burden which may overlook positive aspects of caregiving. However, the model can be adapted for use in the Indian context. Outstanding questions to adapt the model to India are the discovery of specific strategies of coping, the detailing of social support, factors that constitute burden and whether the pathways or processes of burden and wellbeing hold true in the Indian context. All three areas may benefit from culturally appropriate measures that can capture coping, social support and burden. For example, greater attention needs to be paid to the constructs of filial piety as a potential moderating factor and its intersection with gender and kinship relationship. A study by Gupta et al. (2009) found a distinct gender difference in determinants of burden among caregivers to the elderly. For the men, greater role overload predicted significantly higher burden, but the impact of role overload was higher for women who had higher adherence to Asian cultural norms, compared to women who had lower adherence to Asian cultural norms, specifically filial piety [measured using a 22-item scale by Ho and Lee (1974)]. Much work is needed to deconstruct the components of filial piety in the Indian context and theorizes how it relates to care in later life.

Because the model is used in the context of health-related caregiving, it remains to be seen how it can be adapted to the study of elder caregiving in the absence of a disabling condition in India, where the definition of a "dependent" elder is even more ambiguous than it already is in the West. Elderly recipients of care may not necessarily consider themselves as dependents, but "receivers", who hold legitimate right over the received care because of their prior contribution towards the child and the family (Lamb 2005). On the flip side, caregivers may not consider themselves "caregivers", but simply as fulfilling a kinship role of reciprocity by providing material, financial, physical and emotional support (Lamb 2005), to an extent that it is less common in the Western context. In summary, one additional gap in the application of the model and fact in general when thinking about elder caregiving for the Indian context is who is a caregiver and who considers themselves to be caregivers. An understanding of when it is that "receivers" cross the threshold, if at all, to being dependents and who is a caregiver rather than simply a spouse or a daughter-in-law will be key in defining sampling populations who may have unmet needs.

2.3.2 *Life Course Perspective—Aging with Disability, Life Course Perspective*

The life course perspective is a framework extensively used to understand various facets of caregiving. It is not a theory of caregiving per se, but its concepts have

been used extensively to understand caregiving experience. Although primarily used in the context of health-related care research, the perspective offers much scope to understand the non-health-related care, and thus is useful in the Indian context, in conjunction with the stress and coping framework. The framework is inherently dynamic (Dannefer and Sell 1988) and multidisciplinary, and has borrowed heavily from disciplines such as sociology, psychology, history, anthropology (Bengtson and Allen 1993) and demography, to explain individual phenomena via a life course lens. Using the life course perspective caregiving is conceptualized as a “career” or trajectory, which involves entering or exiting the role several times over the life span, for instance becoming a parent or a grandparent, suddenly having a spouse with a spinal cord injury requiring much care. Unlike Pearlin’s stress and caregiving model, the life course perspective by incorporating historical and demographic processes, does not necessarily presuppose caregiving as stressful and having negative impact on caregiver adaptation, but a normative part of life course (Elder et al. 1996) shaped by a range of macro- and micro-level socio-economic-historical, familial and individual structures. These micro- and macro-level factors render advantage or disadvantage accumulated over the life course, which leads to systematic divergence or heterogeneity in experience (Dannefer 2003; Dannefer and Sell 1988). Several concepts, such as (1) linked lives (2) social pathways, trajectories and transitions, and (3) timing of an event, off-timedness and duration, concepts core to the life course perspective has been extensively used to understand the heterogeneity in experiences of both aging care recipients as well as their caregivers. According to the authors, these concepts are universal and could be applied to any caregiving situation in any cultural context.

The life course perspective lays significant importance to historical time and space. This allows an understanding of how the various demographic factors interact with sociocultural and developmental changes over time, and the effect of these on family size, patterns, generational relationships, all of which have consequences for old age (Elder 1994). The life course perspective helps us understand the experiences of the different cohorts of aging adults, and how their early life or historical experiences have shaped their understanding and expectations of kin support in old age and their interaction with formal systems of care, welfare agencies and institutions (Hareven 1994). The concept of historical time and space is significantly important in understanding the intergenerational differences in filial piety, morality, and values attached to elder care; which may significantly impact both caregiver and care recipient wellbeing.

One of the significant contributions of the life course perspective is that it could be applied in any caregiving context to understand an individual’s social pathway. Social pathways are composed of multiple interdependent pathways, which includes both family and non-family roles (Macmillan and Eliason 2003). It is the timing, quality and structure of these roles that determines wellbeing (Settersten 2003). The life course perspective thereby underscores the importance of multiple role trajectories in shaping an individual’s experience.

Another important concept widely used and could be applicable in the Indian context are transitions, perhaps, a construct that has received more interest than any other, in the caregiving literature. According to the construct, caregiving is a role that likely involves several transitions marked by “entry” or “exit” one or more times during adulthood (Aneshensel et al. 1995; Moen et al. 1994, 1995). Transitions, especially entry and exit out of the caregiving role could be stressful. For example, research shows that transitioning into a caregiving role is associated with higher levels of depression, poorer physical health, greater financial burden and lower psychological wellbeing among caregivers (Burton et al. 2003; Ghosh et al. 2012; Kramer and Lambert 1999; Marks et al. 2002; Seltzer and Li 2000), and often gives rise to “competing commitments” (Brody 1981). It is important to explore transitions in the context of India and for countries where caregiving is bound by ties of filial piety. It is not known if the transition to a caregiving role is natural and expected and, therefore, could be less stressful, or could be equally stressful for caregivers as their Western counterparts, and whether there are gender and kinship differences. Given the popular discussion on the erosion of filial piety among the younger cohorts of adults, or the potential caregivers to adults currently in their sixties and seventies, it is also important to investigate whether the impact of transitioning to elder caregiving role is subject to cohort effects. Finally, it is also important to investigate whether the transition to taking on the responsibility of an aging parent who is physically fit, is different from caring for an aging parent who needs active assistance within the Indian context.

Two other concepts, timing and off-timedness, and duration are integral to describing the impact of transitions on an individual’s life course. Timing refers to both the chronological age and life stage when transitions occur. Duration refers to the length of time an individual spends in the state, for example caregiving. Therefore, similar events could evoke different experiences for different people, depending on when they occur in the life course (George 1993). A related concept off-timedness refers to life events that are not age appropriate or life stage appropriate, as these events do not conform to age-appropriate norms, thereby exposing individuals to a range of vulnerabilities (Neugarten et al. 1965). For instance, a daughter-in-law who has young children and relatively young father-in-law in need of care due to ALS, or for an elderly mother or mother-in-law to provide care to an adult son or a daughter-in-law. In the context of India, where sons and daughters-in-law are expected to care for an older adult, the role reversal could significantly violate the age-appropriate norms, and could be a significant source of stress for the caregiver. Therefore, the timing of an event is shown to play an important role in determining caregivers’ unique source of burden, their coping strategies, and the resources available to buffer the effects of stress. The concept of transitions probably plays out in different ways in the Indian context according to the life course of a caregiver. A significant amount of work is needed to understand how the concept of off-timedness plays in the context of India, and investigate some of the mediating and moderating factors that could mitigate the effect of off-timedness on caregiver’s wellbeing. A gap in theory and research is the role of transitions with regard to elder caregiving in India.

2.3.3 *Role Theory*

The role theory has been extensively used in the gerontological research to understand the experiences of middle-aged women, engaged in a parental caregiving role, while at the same time, having to manage additional roles of that of spouse, mother, working woman, friend and so on. Two major perspectives within the role theory that have guided research studies on how women's multiple roles affect their psychological wellbeing are role occupancy theory and role quality theory. Role occupancy theory focuses on the number of roles an individual occupies. Within this theory, there are two competing hypotheses, known as (1) the scarcity/depletion hypothesis and (2) the expansion hypothesis. The scarcity/depletion hypothesis, as referred to by Marks (1977), contends that multiple roles have negative consequences resulting in psychological distress (Gersen 1976; Goode 1960), such that the demands from one role can often result in role strain in another role (Repetti et al. 1989). The hypothesis also asserts that "individuals have a fixed amount of energy and personal resources to allocate across roles" (Bainbridge et al. 2006, p. 490). Therefore, when demands exceed resources, an individual is likely to experience maladaptation, and the onset of a new role could lead to "competing commitments" (Brody 1981).

In contrast, the expansion hypothesis, otherwise known as the role-enrichment hypothesis (Marks 1977; Sieber 1974), contends that multiple roles need not be stressful. Indeed, multiple roles may provide opportunities for personal growth and satisfaction. "The enrichment argument assumes that the benefits of multiple roles outweigh the costs, leading to net gratification" (Rothbard 2001, p. 656). Thus, the loss of resources that might contribute to stress (Hobfoll 1988, 1989), is offset by benefits through participation in other meaningful roles, such as that of a wife, an employee, a parent and a neighbour (Parker 1993; Hong and Seltzer 1995). Further, researchers contend that it is not the number of roles but the quality of the roles that have important impact wellbeing (Aneshensel and Pearlin 1987; Barnett and Baruch 1985).

In addition to facilitating the systematic study of the importance of multiple roles on caregiver wellbeing, the role theory substantively addresses the effects of various role combinations on caregiver adaptation. More specifically, role theory contends that different roles have different effects (Barnett and Baruch 1985; Menaghan 1989). Further, according to Menaghan (1989), the effects of roles and role combinations on psychological wellbeing are dependent on the normative appropriateness of the roles. An important determinant of roles on caregiver wellbeing is the volition of the roles. Take for instance, the experience reported from a qualitative study of caregivers in India. A primary female caregiver was hospitalized for back problems after being assaulted by the care recipient who was her father-in-law. "[The father] moved to live with another son who accepted the responsibility of care, though reluctantly. However, he insisted on the father returning, as soon as his sister-in-law returned from the hospital. This led to dispute, ending in a fight between the two sons requiring intervention by the police. Finally, the person with

dementia was brought back to the original caregiver and was looked after by her without support from any other relatives” (Shaji et al. 2003). Here, care is unquestioningly provided by women, though the decisions about care are made by men. This theme of care roles and choice suggests that the extent of women’s provision of care may be in fact out of their control. Significant work is needed to understand the effect that choice or volition has on the wellbeing of caregivers and whether the relationship is moderated by filial piety. Other determinants might include caste, class, educational level and economic independence of the caregiver, which need to be empirically validated.

2.3.4 Convoy Model

The convoy model was first introduced by Kahn and Antonucci (1980). This model is primarily used to understand the social relationships of caregivers and care recipients, because of their far-reaching effects on their health and wellbeing. According to Kahn and Antonucci (1980), individuals move through the life course, surrounded by a network of individuals arranged in a concentric circle, also referred to as convoys. At the centre of the circle is the target individual, and those immediate in the concentric circles are individuals who are closest to the central figure. Although convoys change over the life course, members closest to the centre of the circle are considered to be relatively stable and provide several forms of social, emotional, psychological and instrumental assistance, and also, help mobilize resources to meet the needs. The convoy provides a protective base to the central individual, and has both objective and subjective components and is shaped by personal (gender, education, personality, race) and situational factors (norms, social roles, normative expectations and demands). In general, older adults tend to have a restricted network, where close family members take on a pivotal role, and the structure and the quality of the convoy network are determined by a family’s history, gains and losses due to widowhood, historical contexts, within network dynamics, its structure, function and quality (Kahn and Antonucci 1980). Thus, the convoy model normalizes intergenerational caregiving (Walker and Pratt 1991), as a continuum of aid provided to the elderly.

The convoy model has been used extensively in gerontological literature in a variety of contexts. According to several studies conducted (Antonucci and Akiyama 1987; Depner and Ingersoll-Dayton 1988; Walker and Pratt 1991), adult children have been shown to be the ones who are the closest to the inner social circle for middle-aged and older adults, and provide them with significant social, emotional, psychological, and instrumental and health support. The daughters are important supportive convoys of care for the aging mother, which was evident from a study by Walker and Pratt (1991), who found daughter caregivers to provide aid to mothers, irrespective of whether the aging mothers were “self-sufficient” or

“dependent”, reaffirming intergenerational functional solidarity (Antonucci and Akiyama 1991). Is this theory applicable in the Indian context, where daughters-in-law are usually considered the primary caregivers yet their entry into the family cycle is usually fairly late? Do these findings also explain the popular perception of significant family strife between parents-in-law and daughters-in-law? Could there be some universal truth to the fact that adult children are the ones to remain a continuous source of emotional support through life, and while other individuals get added on, they never come close to the inner circle regardless of the amount of material or instrumental support they provide? Findings from a study by Datta et al. (2003) provide evidence for the same. In the study, the authors compared Indian and Belgian daughters and daughters-in-law caring for their aging mothers and mothers-in-law. The results of the study showed that Indian daughters-in-law were less close to their mothers-in-law compared to their Belgian counterparts, yet provided more care. The authors concluded that actual behaviours associated with care by daughters-in-law are more likely to follow cultural norms, at least in the Indian setting, but are less likely to influence care provided by daughters to their mothers.

2.3.5 *Feminist Economic Theories of Care*

Currently, there is no consensus on a theoretical framework for the study of care in developing contexts. The recent focus on care defines the care work as any activity that supports direct (feeding, bathing) or indirect (preparing food, collecting water) the reproduction of people economy (Esplen 2009). Care work can be performed within the paid economy or outside of it. Debates in the field hinge on whether caregiving should incorporate all forms of unpaid labour (subsistence agriculture, domestic work and direct care of persons) or not. Some have argued that a narrow definition of unpaid caregiving based upon the dependence of individuals allows researchers to distinguish between the developmental stages of various care recipients (baby, child, adolescent, adult, elderly) and their conditions (healthy, ill, chronically ill, disabled) (Friedemann-Sanchez and Griffin 2011). The authors argue that this definition offers the possibility of isolating the benefits to care recipients in developing economies, where home-based work and subsistence work are prevalent, allowing for the measurement of both direct and indirect forms of support for dependents and non-dependents. In this sense, they understand unpaid caregiving of dependents to be a subset of the larger concept of “care work”, which includes both dependents and non-dependents, and of “unpaid labour”, which in turn incorporates unpaid labour force work, unpaid housework and care work. Other scholars may find this definition too narrow arguing that such distinctions are not possible in developing contexts such as India where an individual may be simultaneously performing paid and unpaid activities that support the care of persons who may or may not be dependents.

Despite the absence of consensus on the definition and operationalization of the caregiving, there is much consensus that most caregiving work is done by women who face financial penalties. Unpaid care has negative effects on the participation of women in the paid labour force (Lilly et al. 2007). In fact, studies have shown that income decreases as caregiving time increases, and increases in caring responsibilities have a larger and more immediate effect on the earnings of women than men on the financial penalties faced by caregivers (Bittman et al. 2007). Little research has explored the economic effects of elder caregiving in developing countries. One of the few studies on financial penalties in the developing countries explored the ability of working parents in Vietnam to care for their children and found that 63 % of parents, most of whom were women, lost income or promotions or had difficulty retaining jobs due to caregiving (Vo et al. 2007).

2.4 Gaps in Knowledge

2.4.1 *The Definition of the Caregiver*

Given the discussion on some of the most widely applicable theories used in the study of caregiving in the West, one of the most prominent gaps arises from the fact that the theories are used exclusively to study caregiver stress and burden in the context of adult disability or health-related condition. The core issue that centres on the applicability of Western models of caregiving on non-Western population lies in the definition of caregiver and care recipient. When does a functional adult cross the threshold to become a dependent? Should researchers apply *emic* parameters or *etic* parameters when bounding the concepts? Should the study of caregiving limit itself with the physical and mental wellbeing of care recipient? Should it include instrumental support assuring social and financial wellbeing? Should caregiving research consider only the health effects of caregiving on caregivers or incorporate financial and social outcomes?

Care is often conceived more broadly in LMICs countries than just assistance with IADL/ADL limitations alone or other health-specific tasks. Qualitative evidence suggests that many consider keeping elder family members company and “watching out” for them as part of the range of duties of care (Abdulraheem 2005; Mendez-Luck et al. 2008). Thus, prevalence estimates based solely on physical and health-related care may underestimate what is considered to be the full scope of a caregiver’s duties. By the same token, it is possible that people’s report of time spent caring may reflect these other activities that are not otherwise captured by a structured, closed-ended quantitative survey of the types of health care provided. To have a full discussion of what it means to care for an elder family member, we consider some of the data available on care recipients, which imply different definitions of care.

2.4.2 *Time-Use Data*

Since there is no standard definition of what a caregiver is or who is a care recipient, research to date has used a variety of proxy measures to determine the prevalence of caregiving. One of these comes from time-use studies. One cross-national study investigated the prevalence of care work in six countries. They used existing time-use surveys from Argentina, Nicaragua, South Africa, Tanzania, India and Korea to analyse the extent of time spent on caring for other persons. Although this study's use of time-use data was limited in its ability to differentiate old age care from childcare, it is notable that in India, 44 % of women and 17 % of men participated in person care (Budlender 2008). Clearly, any child under the age of seven is a dependent, at least in as far as physical safety and security are concerned. A limitation of time-use surveys is that it is not able to discern if the care performed is on behalf of a dependent or not (Friedemann-Sanchez and Griffin 2011). For instance, caring for individuals with chronic or acute health conditions is different than doing domestic labour on behalf of an adult in good health. Time-use surveys replicate the problematic lack of distinction with regard to unpaid labour in the dominant economic development literature ((Friedemann-Sanchez and Griffin 2011). Furthermore, time-use surveys probably underestimate the time demands on caregivers when the care recipients' health status critically depends on the availability of caregivers such that the caregiving activities themselves do not take long, but may conjoin caregiver and care recipient on an intermittent yet hourly basis limiting caregivers from engaging in paid labour or other activities (Folbre 2014).

2.4.3 *Dependency Ratios*

The second proxy measure to assess the prevalence of care recipients is dependency ratio. The old age dependency ratio is the proportion of older persons (aged 65+) to those who are economically productive (15–64). Neither the ages in the numerator nor the denominator of this ratio are fixed; the ratio could be of the population aged 65+ or 70+ about the number of the population aged 20–64 (or 20–69, in the case of the 70+ dependency ratio). The old age dependency ratio is sometimes combined with child dependency ratios (# aged 0–5 per 100 persons aged 15–64) for a “total” dependency.

Many critique the usefulness of the dependency ratio. Of the total dependency ratio, others note that the kind of care required by a child under 5 is very different than the care required by an older adult (Folbre and Nelson 2000). Moreover, the total ratio does not offer insight into the distribution of the “dependents”. Since one driver of total population aging is declining fertility, we would expect old age care to increase.

However, the total dependency ratio would not reflect this change in the distribution of the numerator (i.e. dependents) explicitly; instead, if the number of

Table 2.1 Old age dependency ratio (# aged 65+ per 100 aged 15–64): 2000–2050

Column 1	2000	2010	2020	2030	2040	2050
World	11	12	14	18	22	25
Less developed regions	8	9	11	15	19	23
More developed regions	21	24	29	36	41	45
U.S.	19	19	25	32	34	35
China	10	11	17	24	35	38
Ghana	6	6	7	8	10	12
India	7	8	9	12	15	20
Mexico	9	10	13	18	28	36
Russia	18	18	23	30	32	39
South Africa	6	7	10	12	13	15

Source Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: the 2008 revision, <http://esa.un.org/wpp/>, Medium Variant Projections

United Nations (2008)

dependents stayed the same, we would not know from the total dependency ratio alone the extent to which the burden was from older adults or from children. For instance, although the total dependency ratio in India is projected to decline until 2040, this decline masks a steady increase in the old age dependents (Fig. 2.1). Nonetheless, dependency ratios, either old age or total, are commonly used as a broad measure of the burden of population aging.

Outside of India, the old age dependency ratio is projected almost to triple for less developed regions between 2000 and 2050 and double in more developed regions. The old age dependency ratio is projected to spike between 2010 and 2020 during which time the burden of caring for the elderly will begin to grow a great deal, and it will maintain or continue to grow through 2050 (Table 2.1).

2.4.4 Intergenerational Co-residence

Family demographers also commonly focus on how families and households are arranged and composed. With whom older adults live offers a useful impression of the extent to which an older adult has care available to her. Information on intergenerational co-residence is perhaps the proxy indicator that has had the most influence in caregiving studies.

In lower and middle-income countries, the care needs of older persons nearly always fall to family members alone (Apt and Gracco 1994; Cattell 1990; Wachter 1997). In many areas of the world, there is a cultural expectation that older people will live with and receive their care from relatives than in developed settings (Bongaarts and Zimmer 2002; De Vos 2003; Ruggles and Heggeness 2008). Among households with older people in China, the 2000 Census found that about

11 % were older person living alone or an older couple living alone, respectively (Kincannon et al. 2005). Others cite that institutionalized care in China is primarily held only for the “three-no” elders: no living children/relatives, little or no income, and no physical ability to work (Gu et al. 2007). Data from the Chinese Longitudinal Healthy Longevity Survey and elsewhere suggest that nearly 60 % of the institutionalized elders do not have children to care for them (Zhan et al. 2005; Zhan 2002, 2005).

In India, over 70 % of the older population lives with family members (Bloom et al. 2010). One study used Demographic and Health Survey and census data from over 60 countries, including India. They found that Indian women aged 60 had an almost 2.5-fold greater odds of living alone than men ($p < 0.001$) (United Nations 2005). Intergenerational co-residency is an important indicator of availability of care, as much of the informal care comes from family members, typically daughters and/or daughters-in-law. Though economic development has changed the family structure, traditional patterns still persist like the “joint family system” in India (Gupta 2009). Patrilineal family patterns where a woman would live with her husband’s family even after his death. (Lloyd-Sherlock 2010) Older women, particularly widows (Patel and Prince 2001; Shaji et al. 2002, 2003) are often disenfranchised, yet we know little about the care demands placed on them.

Because informal care from family members is culturally normative in many lower and middle-income settings, there is typically a weak formal care infrastructure, such as long-term or residential care facilities (Lloyd-Sherlock 2010), to support older adults if they have more substantial needs than what the family can provide.

2.5 Caring for the Caregiver: Implications

Research in the developed West shows the significant burden of care borne by caregivers of older adults with disabilities, in the form of poor physical and psychological wellbeing, lower social support and financial constraints. In contrast, literature of caregivers is scant and much of the literature on aging in India (Jamuna 1995) have risen out of concern for the elderly, focusing on their poor wellbeing and unmet needs, yet the unmet needs of caregivers or the effects of caregiving has little to no attention.

India, a society steeped in filial piety, family is still considered to be the ideal setting for elder care (see Lamb 2013). However, traditional structures, such as the joint family that had been responsible for elder care have changed or are fast changing. Further, laws and policies often get framed to support the elderly and not much to protect their caregivers, who are primarily women. These raise questions and speak to the extent to which cultural and moral visions around elder care dominate public and academic discourse, and raises pertinent questions on where the future of elder care is to be located, and who would be responsible for their care: the family or the state. For example, the Maintenance and Welfare of Parents and

Senior Citizens Act in India, implemented by the Ministry of Social Justice and Empowerment, India, in 2007 made it legally obligatory for children and heirs to provide maintenance to senior citizens and parents, by providing them with monthly allowance. The primary goal of this Act was to protect the lives and ensure financial security of the elderly in India by making it legally binding for families to care for them. Arguments provided by activists, bureaucrats, academics and demographers for the creation of the Act, centre on the breakdown of family, brought about by forces of development, such as modernization, migration, urbanization and the like. Thus, there was an implicit belief that the breakdown of the intergenerational family was the root of the old age depravity and a need for state intervention. Similar arguments were also provided by the early framers of the US Social Security Act in 1936 stated: “in the old days, the old-age assistance problem was not so great so long as most people lived on farms, had big families, and at least some of the children stayed on the farm”. (Eliot 1961). However, although similar arguments were provided, the solutions sought in the two different contexts reflect a fundamental difference in the approach in how, where and who is responsible for the long-term care of the elderly. Unlike the U.S. Social Security Act, which meant “state” and only recognizes as beneficiaries those employed in the paid labour force and who have contributed financially to the system, the Maintenance and Welfare of Parents and Senior Citizens Act in India through state intervention made it legally obligatory for elderly to be cared for by their children/caregivers. The solutions sought were therefore to an extent a reflection of culture and what it values as the place and person to be involved in the care for an elderly.

2.6 The Way Forward

Given the status of caregivers of the elderly and their invisibility from popular discourse as well as policy formulation how can we move forward the agenda that makes caregivers of the elderly visible and that responds to the needs of caregivers? Who will care for the caregiver? How can we care for caregivers? In order to advance this research agenda, we have identified some theoretical and empirical questions, which can be summarized as follows:

- Identify what is meant by caregiving in the context of India.
- Identify factors associated with becoming a caregiver.
- Identify the unique sources of burden and stress among caregivers and also the various factors that might mitigate the relationship between caregiver stress and wellbeing.
- Empirically assess whether the existing theoretical frameworks could be applied in the study of caregiving.

- Study how changes in household composition are affecting caregivers. Such changes are not reflected in current theoretical approaches to the study of elder care.
- Time frames used in studies of elder care in Western contexts make invisible intermittent long-distance care. *Emic* definitions of caregiving can incorporate such type of care to better reflect caregiving realities.

A next step will be to integrate current theories and gaps in order to develop a comprehensive framework for the study of elder caregiving in India.

References

- Abdulraheem, I. S. (2005). An opinion survey of caregivers concerning caring for the elderly in Ilorin metropolis, Nigeria. *Public Health*, 119(12), 1138–1144.
- Alter, G., Cliggett, L., & Urbiel, A. (1996). *Household patterns of the elderly and the proximity of children in a nineteenth century city: Verviers, Belgium, 1831–1846* (pp. 30–42). Berlin: de Gruyter.
- Aneshensel, C. S., Pearlin, L. I., Mullan, J. T., Zarit, S. H., & Whitlatch, C. J. (1995). *Profiles in caregiving: The unexpected career*. San Diego, CA: Academic Press.
- Aneshensel, C. S., & Pearlin, R. F. (1987). Structural contexts of sex differences in stress. In R. C. Barnett, L. Biener, & G. K. Baruch (Eds.), *Gender and stress* (pp. 75–95). New York, NY: Free Press.
- Andorka, R. (1995). Household systems and the lives of the old in eighteenth-and nineteenth-century Hungary. In *Aging in the past: Demography, society and old age* (pp. 129–155).
- Antonucci, T. C., & Akiyama, H. (1987). An examination of sex differences in social support among older men and women. *Sex Roles*, 17(11–12), 737–749.
- Antonucci, T. C., & Akiyama, H. (1991). Convoys of social support: Generational issues. *Marriage & Family Review*, 16(1–2), 103–124.
- Apt, N. A., & Gricco, M. (1994). Urbanization, caring for elderly people and the changing African family: The challenge to social policy. *International Social Security Review*, 47(3–4), 111–122.
- Bainbridge, H., Cregan, C., & Kulik, C. (2006). The effect of multiple roles on caregiver stress outcomes. *Journal of Applied Psychology*, 91(2), 490–497.
- Barnett, G. K., & Baruch, R. C. (1985). Role quality, multiple role involvement, and psychological wellbeing in midlife women. *Journal of Personality and Social Psychology*, 51(3), 578–585.
- Barrientos, A., Gorman, M., & Heslop, A. (2003). Old age poverty in developing countries: Contributions and dependence in later life. *World Development*, 31(3), 555–570.
- Barrientos, A., Hulme, D., University of Manchester Brooks World, P. I., & Chronic Poverty, R. C. (2008). *Social protection for the poor and poorest: Concepts, policies and politics*. Basingstoke England; New York: Palgrave Macmillan.
- Bengtson, V. L., & Allen, K. R. (1993). The life course perspective applied to families over time. In *Sourcebook of family theories and methods* (pp. 469–504). New York, USA: Springer US.
- Bittman, M., Hill, T., & Thomson, C. (2007). The impact of caring on informal careers' employment, income and earnings: A longitudinal approach. *Austrian Journal of Social Issues*, 42(2), 255–273.
- Bloom, D. E., Mahal, A., Rosenberg, L., & Sevilla, J. (2010). Economic security arrangements in the context of population ageing in India. *International Social Security Review*, 63(3–4), 59–89.

- Bongaarts, J., & Zimmer, Z. (2002). Living arrangements of older adults in the developing world: An analysis of demographic and health survey household surveys. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 57(3), S145–S157.
- Brody, E. M. (1981). Women in the middle and family help to older people. *The Gerontologist*, 21, 471–480.
- Buddender, D. (2008). *The statistical evidence on care and non-care work across six countries* (Vol. 4, pp. 1–61). Geneva: United National Research Institute for Social Development.
- Burton, L. C., Zdaniuk, B., Schulz, R., Jackson, S., & Hirsch, C. (2003). Transitions in spousal caregiving. *The Gerontologist*, 43(2), 230–241.
- Cattell, M. G. (1990). *Models of old age among the Samia of Kenya: Family support of the elderly*. Dordrecht: Springer Netherlands.
- Chattopadhyay, A., & Marsh, R. (1999). Changes in living arrangement and familial support for the elderly in Taiwan: 1963–1991. *Journal of Comparative Family Studies*, 30, 523–537.
- Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 58(6), S327–S337.
- Dannefer, D., & Sell, R. R. (1988). Age structure, the life course and “aged heterogeneity”: Prospects for research and theory. *Comprehensive gerontology. Section B, Behavioural, Social, and Applied Sciences*, 2(1), 1–10.
- Datta, P., Poortinga, Y. H., & Marcoen, A. (2003). Parent care by Indian and Belgian caregivers in their roles of daughter/daughter-in-law. *Journal of Cross-Cultural Psychology*, 34(6), 736–749.
- De Vos, S. (2003). *Research note: Revisiting the classification of household composition among elderly people*. Dordrecht: Springer Netherlands.
- De Vos, S., & Lee, Y. J. (1993). Change in extended family living among elderly people in South Korea, 1970–1980. *Economic Development and Cultural Change*, 41, 377–393.
- Deaton, A., & Paxson, C. (1997). *Poverty among children and the elderly in developing countries* (Vol. 179). Princeton, NJ: Princeton University, Woodrow Wilson School of Public and International Affairs, Research Program in Development Studies.
- Depner, C. E., & Ingersoll-Dayton, B. (1988). Supportive relationships in later life. *Psychology and Aging*, 3(4), 348.
- Elder, Jr, G. H. (1994). Time, human agency, and social change: Perspectives on the life course. *Social Psychology Quarterly*, 4–15.
- Elder, Jr, G. H., George, L. K., & Shanahan, M. J. (1996). *Psychosocial stress over the life course*.
- Eliot, T. A. (1961). Social Security Administration Headquarters; Baltimore. The legal background of the Social Security Act, Speech delivered. Retrieved from <http://www.ssa.gov/history/officials.html>
- Esplen, E. (2009). *Gender and care*. Overview report: Institute of Development Studies.
- Folbre, N. (2014). The care economy in Africa: Subsistence production and unpaid care. *Journal of African Economies*, 23(suppl 1), i128–i156.
- Folbre, N., & Nelson, J. A. (2000). For love or money—Or Both? *The Journal of Economic Perspectives*, 14(4), 123–140.
- Friedemann-Sanchez, G., & Griffin, J. M. (2011). Defining the boundaries between unpaid labor and unpaid caregiving. Review of the health and social sciences. *Human Development and Capabilities*, 12(4), 511–534.
- George, L. K. (1993). Sociological perspectives on life transitions. *Annual Review of Sociology*, 19, 353–373.
- Gersen, E. M. (1976). On quality of life. *American Sociological Review*, 41, 793–806.
- Goode, W. J. (1960). A theory of role strain. *American Sociological Review*, 25, 483–496.
- Ghosh, S., Greenberg, J. S., & Seltzer, M. M. (2012). Adaptation to a spouse’s disability by parents of adult children with mental illness or developmental disability. *Psychiatric Services*, 63(11), 1118–1124.
- Gu, D., Dupre, M. E., & Liu, G. (2007). Characteristics of the institutionalized and community-residing oldest-old in China. *Social Science and Medicine*, 64(4), 871–883.

- Gupta, R. (2009). Systems perspective: Understanding care giving of the elderly in India. *Health Care for Women International*, 30(12), 1040–1054.
- Gupta, R., Rowe, N., & Pillai, V. K. (2009). Perceived caregiver burden in India implications for social services. *Affilia*, 24(1), 69–79.
- Hareven, T. K. (1994). Aging and generational relations: A historical and life course perspective. *Annual Review of Sociology*, 20, 437–461.
- Harper, S. (2006). *Addressing the implications of global ageing*. Dordrecht: Springer Netherlands.
- Harper, S. (2010). The capacity of social security and health care institutions to adapt to an ageing world. *International Social Security Review*, 63(3–4), 177–196.
- Hermalin, A. I., Ofstedal, M. B., Chang, M-C. (1992). Types of supports for the aged and their providers in Taiwan. In: K. Hareven Tamara (Ed.), *Aging and Generational Relations: Life-Course and Cross-Cultural Perspectives*. pp. 179–215. New York: Aldine DeGruyter.
- Hirosima, K. (1997). Projection of living arrangements of the elderly in Japan: 1990–2010. *Genus*, 53, 79–111.
- Ho, D. Y. F., & Lee, L. Y. (1974). Authoritarianism and attitude toward filial piety in Chinese teachers. *The Journal of Social Psychology*, 92(2), 305–306.
- Hobfoll, S. E. (1988). *The ecology of stress*. Washington DC: Hemisphere Publication Services.
- Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist*, 44, 513–524.
- Hong, J., & Seltzer, M. M. (1995). The psychological consequences of multiple roles: The non-normative case. *Journal of Health and Social Behavior*, 36, 386–398.
- Jamuna, D. (1995). Elder care: The developing Indian scenario. In *Challenges before the elderly: An Indian scenario* (pp. 257–272).
- Jamuna, D. (1997). Stress dimensions among caregivers of the elderly. *The Indian Journal of Medical Research*, 106, 381–388.
- Jamuna, D. (2003). Issues of elder care and elder abuse in the Indian context. *Journal of Aging & Social Policy*, 15(2–3), 125–142.
- Jamuna, D., Lalitha, K., & Ramamurti, P. V. (2003). Future of elder care in India: Hope or despair some alternative core models. *Indian Journal of Gerontology*, 17, 147–156.
- Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: Attachment, roles, and social support. *Life-Span Development and Behavior*.
- Kincannon, C., He, W., & West, L. (2005). Demography of aging in China and the United States and the economic well-being of their older populations. *Journal of Cross-Cultural Gerontology*, 20(3), 243–255.
- Kramer, B. J., & Lambert, J. D. (1999). Caregiving as a life course transition among older husbands: A prospective study. *The Gerontologist*, 39(6), 658–667.
- Lamb, S. (2005). Cultural and moral values surrounding care and (in) dependence in late life: Reflections from India in an era of global modernity. *Care Management Journals*, 6(2), 80–89.
- Lamb, S. (2013). In/dependence, intergenerational uncertainty, and the ambivalent state: Perceptions of old age security in India. *South Asia: Journal of South Asian Studies*, 36(1), 65–78.
- Lilly, M., Laporte, A., & Coyte, P. (2007). Labor market work and home care's unpaid caregivers: A systematic review of labor force participation rates, predictors of labor market withdrawal, and hours of work. *The Milbank Quarterly*, 85(4), 641–691.
- Lloyd-Sherlock, P. (2000). Old age and poverty in developing countries: New policy challenges. *World Development*, 28(12), 2157–2168.
- Lloyd-Sherlock, P. (2002). Formal social protection for older people in developing countries: Three different approaches. *Journal of Social Policy*, 31(04), 695.
- Lloyd-Sherlock, P. (2010). *Population ageing and international development: From generalisation to evidence*. Bristol, UK; Portland, OR: Policy.
- Macmillan, R., & Eliason, S. R. (2003). *Characterizing the life course as role configurations and pathways* (pp. 529–554). US: Springer.
- Marks, R. K. (1977). Multiple roles and role strain: Some notes on human energy, time and commitment. *American Sociological Review*, 42, 921–936.

- Marks, N. F., Lambert, J. D., & Choi, H. (2002). Transitions to caregiving, gender, and psychological well-being: A prospective US National Study. *Journal of Marriage and Family*, 64(3), 657–667.
- Martin, L. G. (1990). Changing intergenerational family relations in East Asia. *Annals of the American Academy of Political and Social Science*, 510, 102–114.
- Menaghan, E. G. (1989). Role changes and psychological well-being: Variations in effects by gender and role repertoire. *Social Forces*, 67(3), 693–714.
- Mendez-Luck, C., Kennedy, D., & Wallace, S. (2008). Concepts of burden in giving care to older relatives: A study of female caregivers in a Mexico City neighborhood. *Journal of Cross-Cultural Gerontology*, 23(3), 265–282.
- Moen, P., Robison, J., & Dempster-McClain, D. (1995). Caregiving and women's wellbeing: A life course approach. *Journal of Health and Social Behavior*, 36, 59–273.
- Moen, P., Robison, J., & Fields, V. (1994). Women's work and caregiving roles: A life-course approach. *Journal of Gerontology, Social Sciences*, 49, S176–S186.
- Murray, C. J. L., & Lopez, A. D. (1997a). Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. *The Lancet*, 349(9063), 1436–1442.
- Murray, C. J. L., & Lopez, A. D. (1997b). Regional patterns of disability-free life expectancy and disability-adjusted life expectancy: Global Burden of Disease Study. *The Lancet*, 349(9062), 1347–1352.
- Murray, C. J., Vos, T., Lozano, R., Naghavi, M., Flaxman, A. D., Michaud, C., et al. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: A systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, 380(9859), 2197–2223.
- Neugarten, B. L., Moore, J. W., & Lowe, J. C. (1965). Age norms, age constraints, and adult socialization. *The American Journal of Sociology*, 70(6), 710–717.
- Parker, G. (1993). *With this body: Caring and disability in marriage*. Buckingham, England: Open University Press.
- Patel, V., & Prince, M. (2001). Ageing and mental health in a developing country: Who cares? Qualitative studies from Goa, India. [10.1017/S0033291799003098]. *Psychological Medicine*, 31, 29–38.
- Pearlin, L. I. (2010). The life course and the stress process: Some conceptual comparisons. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 65(2), 207–215.
- Pearlin, L. I., Mullan, J. T., Semple, S. J., & Skaff, M. M. (1990). Caregiving and the stress process: An overview of concepts and their measures. *The Gerontologist*, 30, 583–594.
- Repetti, R. L., Matthews, K. A., & Waldron, I. (1989). Effects of paid employment on women's mental and physical health. *American Psychologist*, 44, 1394–1401.
- Rothbard, N. P. (2001). Enriching or depleting? The dynamics of engagement in work and family roles. *Administrative Science Quarterly*, 46, 655–684.
- Rajan, S. I., & Kumar, S. (2003). Living arrangements among Indian elderly: New evidence from national family health survey. *Economic and Political Weekly*, 75–80.
- Ruggles, S. (2007). The decline of intergenerational co-residence in the United States, 1850 to 2000. *American Sociological Review*, 72(6), 964–989.
- Ruggles, S. (2010). Stem families and joint families in comparative historical perspective. *Population Development Review*, 36(3), 563–577.
- Ruggles, S. (2011). Intergenerational coresidence and Family Transitions in the United States, 1850–1880. *Journal of Marriage and Family*, 73(1), 138–148.
- Ruggles, S., & Heggeness, M. (2008). *Intergenerational coresidence in developing countries*. Amsterdam: Blackwell Publishing Ltd.
- Salomon, J. A., Wang, H., Freeman, M. K., Vos, T., Flaxman, A. D., Lopez, A. D., et al. (2012). Healthy life expectancy for 187 countries, 1990–2010: A systematic analysis for the Global Burden Disease Study 2010. [Research Support, Non-U.S. Gov't]. *Lancet*, 380(9859), 2144–2162.

- Seltzer, M. M., & Li, L. W. (2000). The dynamics of caregiving transitions during a three-year prospective study. *The Gerontologist*, 40(2), 165–178.
- Settersten, R. A. (2003). *Invitation to the life course: Toward new understandings of later life*. Amityville, N.Y.: Baywood Pub. Co.
- Shaji, K. S., Arun Kishore, N. R., Lal, K. P., & Prince, M. (2002). Revealing a hidden problem. An evaluation of a community dementia case-finding program from the Indian 10/66 Dementia Research Network. (10.1002/gps.553). *International Journal of Geriatric Psychiatry*, 17, 222–225.
- Shaji, K. S., Smitha, K., Lal, K. P., & Prince, M. J. (2003). Caregivers of people with Alzheimer's disease: a qualitative study from the Indian 10/66 Dementia Research Network. *International Journal of Geriatric Psychiatry*, 18(1), 1–6.
- Shrestha, L. B. (2000). Population aging in developing countries. *Health Affairs*, 19(3), 204–212.
- Sieber, S. D. (1974). Toward a theory of role accumulation. *American Sociological Review*, 39, 567–578.
- Silverstein, M., & Giarrusso, R. (2010). Aging and family life: A decade review. *Journal of Marriage and Family*, 72(5), 1039–1058.
- United Nations. (2005). Living arrangement of older persons around the world (Vol. ST/ESA/SER.A/240). New York, NY: United Nations.
- United Nations. (2008). World population prospects: The 2008 revision population database, from <http://esa.un.org/unpp/>
- United Nations Population Fund. (2011). Report on the status of elderly in selected states of India. Retrieved from http://www.isec.ac.in/AgeingReport_28Nov2012_LowRes-1.pdf
- Vo, P. H., Penrose, K., & Heymann, J. (2007). Working to exit poverty while caring for children's health and development in Vietnam. *Community, Work and Family*, 10(2), 179–199.
- Vos, T., Flaxman, A. D., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M., et al. (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: A systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, 380(9859), 2163–2196.
- Wachter, K. W. (1997). Kinship resources for the elderly. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences*, 352(1363), 1811–1817.
- Walker, A. J., & Pratt, C. C. (1991). Daughters' help to mothers: Intergenerational aid versus caregiving. *Journal of Marriage and the Family*, 53(1), 3–12.
- Zhan, H., Liu, G., & Bai, H.-G. (2005). Recent development in Chinese elder homes: A reconciliation of traditional culture. *Ageing International*, 30(2), 167-187-187-167-187-187.
- Zhan, H. J. (2002). Chinese caregiving burden and the future burden of elder care in life-course perspective. *The International Journal of Aging and Human Development*, 54(4), 267–290.
- Zhan, H. J. (2005). Social-economic context of parent care—Explaining Chinese caregivers' psychological and emotional well-being. *Journal of Gerontological Social Work*, 45(4), 83–100.

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