

I, THE WIFE'S CARER. MEN FROM THE TRADITIONALISTS/SILENT GENERATION ON THEIR (NEW) IDENTITY

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ABSTRACT

Despite transformations of culture of ageing taking place and pinpointing lesser trivialization of ageing, in many CEE countries and globally, further-reaching approach to ageing experiences and meanings attributed by individuals of either gender have not come of age. Neither has it gained enough attention to cause a significant change towards truly inclusive perspectives or practices. This problem applies to men remaining to a certain extent imperceptible as prime caregivers to their chronically ill wives or partners.. By desk research, own research interpretation and literature review, the paper addressed men caregivers identity. Findings suggest the identity to be shaped by a relationship, and its story, with caregiven wife, identity spoiling as a result of stigma associated with caregiving experience and low social recognition of it. The study recognizes matters to be further assessed and may lay foundations for new directions. It also translates onto gerontological practice by recognizing factors which may assist caregiving professionals and possibly policy makers in better addressing the needs of caregiving individuals.

Keywords: ageing, caregiving, men, identity, social gerontology

INTRODUCTION

Global ageing is no news, projections and estimations are clear: the process shall continue. Twenty years ago in 2000, there were 420 million people aged 65 and older, they were 7% of the world's population. Thirty years from now, in 2050, estimations point to 10% more, that is 17% of the global population and 1,6 billion of older adults. The process is happening almost everywhere, with developing countries opening the league in the most rapid manner [1]. Global perspectives on ageing have an entire array of implications for decision makers in both hemispheres, of different calibres depending on a geographical location, particularly in the financial field. Fortunately, stereotypes pointing at older adults to be more "costly" than children have ever been, are false believes of the past, and are being placed off the modern global narration on ageing. Relatively "young" (using Neugarten's legacy) and active third-agers are perfectly capable of long years of independent, meaningful, productive lives. Fourth-agers, even if double ageing process shall continue at previously expected pace, are not bound

to frailty. Older age dependency/frailty is merely a risk, not a certainty [2]. Therefore, many older adults may have long years of independent lives ahead.

Believes on “silver surfers” limited exclusively to economic burden to society (due to their support needs expenses and dependency ratio) are gradually falling apart. They are being replaced by new perspectives in social gerontology, reorienting towards new paradigms. According to them, over the last decades there has been a steady increase in public health, standards/quality of life and social policies’ awareness as for better addressing older adults’ actual needs. For that reason, some transformations appeared within the culture of ageing. Their exemplifications may be seen in e.g.:

- lesser trivialization of ageing itself, particularly in many of Central-East European countries with old models of basically family only oriented social expectations regarding older frail adults’ care, including end of life care
- greater recognition of consequences behind infantilizing older adults by public services’ administration, including medical encounters as well
- overall better acknowledgement of older adults’ empowerment as beneficial for the society of all ages, and due to it adjoining steadily, inter alia, the goals of The 2030 Agenda for Sustainable Development [3], underlying recognition of older adults as active agents of social development to better accomplish transformation, inclusion and sustainability
- progressive connections between scientists and practitioners in ageing/gerontological fields
- yet most of all, baseline social compliance and incorporation of older adults’ heterogeneity perspective, i.e. appreciation of entire diversity of older adults’ individual experiences of ageing [2].

The scientific disciplines of particularly important contribution to these developments are critical and feministic gerontology. Their search for non stigmatizing discourses, narrations and environments is crucial. From the standpoint of the presented paper, critical and feministic gerontology’s share is of a notable character. The critical gerontology framework is targeted at bridging the gap between the academic perceptions of successful ageing and older adults’ own ones, looking into individual dimensions of ageing, detachment from normative social models of ageing. The feministic gerontology frame, in turn, proves insufficiency of analysis on gender in correlation to ageing, including relations between genders and female experiences of ageing. They both, critical and feministic gerontology, also demonstrate the courses of women and men’s experiences being impacted by structural approaches and shaped by inequalities based on gender throughout cycle of life[2].

Hence I argue gender should be considered as the constitutive human feature in respect to broader ageing comprehension, not scarcely a variable. Primarily, on

the grounds that in all countries in the world women tend to outlive men, so statistically ageing is more often a feminine than masculine reality. Most importantly for the objectives of the presented paper, because relationships between genders are deeply rooted in everyday lives, they tend to stay invisible, while its consequences, on the contrary, especially on the institutional level, are so very visible. Accordingly, analysis undertaking the problem of disclosing gender relations aim at introducing the perspective of the second party, previously omitted. Truly inclusive modern reflections on ageing should follow the rule of inclusiveness, not purely accepting but also applying the perspective of both genders, women and men. It would be a residuum to a more comprehensive, further-reaching approach to ageing cognition and ageing meanings attributed by individuals of either sex. It would then, too, free from gender-oppressive nomenclature of past/traditional gender norms and behavior patterns, disclosing ageing experience in its full human form, like a coin, having both its heads and tails[2].

Family caregiving provided to frail older adults is continuously a women's domain, however over the last years, more men take up this activity/role/work, The reasons behind such a change are broadly known: altering sex norms and raising share of women on the job market. In case of older adults aged 75 and beyond, it has been estimated that spousal caregiving performed by men is more probable than vice versa, as it is men who are more statistically likely to be living with a spouse/partner at this age and hence their co-residing stretches to caregiving [4].

Generally, male caregiving has been receiving certain scientific attention [5]. Yet, the 60+ old men remain imperceptible as prime caregivers to their wives and partners, more insight is being directed to younger men and their parental roles transformations [2]. Over a decade ago, it was stated that “the invisibility of women's care work was and is not an accident. It was a strategic choice made through a series of United Nations rules (...) which described all women's unpaid work as “of little or no importance” [6]. My point here is that by invisibility of women in care work, the care work itself becomes invisible. Adjoining men into analysis, since their participation continues to grow, is freeing from dichotomous discourses appointing to care as a category of gender difference but it also allows attempts to “capture” and acknowledge care as a concept, reality and practice for increasing numbers of people [6]. Moreover, I believe it shifts certain paradigms. From a normative model of care which could be referred to as “the Vitruvian care” (reduced to care delivered by women) within intellectual humanistic traditions [7], transgressing towards post humanistic approaches, towards “the post humanistic care, where every caring person is the right one, not portrayed as a carer of a different category due to their (male) gender. After all, it is in nobody's interest to favor dialectics of the gender difference in caregiving, placing “the other”, i.e. men, off the caregiving mainstream as it enforces structural ignorance. The term “structural ignorance” actually aims at managing and resolving [7] masculinism, racism, white supremacy, the dogma of scientific discovery, though

it is a very fruitful perspective when it comes to managing caregiving towards all human experience, and therefore towards its emancipation.

MALE CAREGIVER IDENTITY - THEORETICAL UNDERPINNINGS

10-25% of the total European population are informal caregivers, varying between particular countries. In Poland they make 20% of the population, in Bulgaria 10% but in Belgium, the percentage is 30, and in Greece reaches 34 [8]. However, the absolute number of informal caregivers may be of a higher volume considering many caregivers who do not identify themselves as such [6]. The majority of caregiving is provided for older adults. Their caregivers number estimations vary, too. For example, already in the end of the 1980s English research pointed at a third of frail older adults caregivers as men, while 2015 survey [9] reveals 40% of family caregivers of adults people are men. Regardless of the proportions, caregivers in general compose a diverse group, so do male caregivers, and their identity has many facets.

Yet, what is caregiver's identity? It has been presented within a Montgomery, Rowe and Kosloski theory [10] which describes this identity as a result of a relationship with the person cared for. The caregiver's identity outcome is shaped by a variety of factors. Among most relevant are: social norms and rules, individual's ethnic and cultural norms, a family one-of-a-kind ethos regulating which family member(s) take(s) up the role. Therefore from the very beginning, the identity here is the caregiver-recipient relationship's hereditary. With time, increased care demand follows as well as caregiver behaviour adaptations to new tasks and possible health deterioration of the care recipient. On identity development path may then appear contradictions between the spousal/husband previous identity and new, caregiver one. In order to achieve inner harmony with the new, more and more time/task demanding identity, a series of adjustments is required from the caregiving husband. The process of caregiving identity development includes five phases [10]:

1. taking up new activities which did not compose previous chores portfolio in spousal division of duties
2. comprehending excessive tasks as caregiving and self perception as a caregiver, proportion between previous spouse-only and present caregiver role: ca.75% to 25% (of time, tasks, efforts, etc.)
3. in addition to previous tasks, personal care pursues, possible discomfort for both parties, proportion between previous spouse-only and present caregiver role: ca. 50% to 50%

4. caregiving dominates over previous spousal role, proportion between previous spouse-only and present caregiver role: ca. 80% to 20%
5. this phase is reached when informal caregiving comes to a halt and formal one commences in a form of a nursing home, proportion between previous spouse-only and present caregiver role: ca.75% to 25%, as in phase 2.

It has to be underlined that the trajectory has its limitations. The phases vary in their realization or pace and may have a different conduct depending on a pre-care spousal relationships. Secondly, phase 5 has a limited administration in many countries, where caregiving has been imprinted in social expectations and norms as a private, family issue and family, not state/community obligation, which is the case in multitude of family care trajectories in Central East Europe. Regardless, caregiving hardship may lead to dissonance within caregiver's identity as for what is being actually done and what is perceived as what should be done within the caregiving role [10]. Moreover, I find it of great importance that caregiving identity may be attached to a person without their readiness or acceptance. This new identity attachment may take place due to a sudden life event or quite opposite - due to a progressive yet steady decrease in partner's health condition however without consent for the situation and its consequences for the caregiver. Spousal caregivers experiences may also embrace feeling obliged to perform caregiving tasks what induce inability to undertake non-care activities constructing self perception with own wellbeing being subordinate to the care recipient's one [11].

Person's identity is socially constructed, it is also a product of social interactions. The above recalled spousal experiences reflect it, too. In case of gaining caregiver's identity/being labelled as a caregiver, one can observe processes of certain absorption of an original, personal, non spousal ID. It is shadowed by feelings of insignificance or subordination to the caregiving role, as indicated earlier. Irrespective of a caregiver's identity phase, I believe this contributes substantially to possible harm or impairment of one's identity both in respect to caregiving and without it, simply as a deterioration of own wellbeing.

Therefore I find it relevant to include a perspective on **identity which is spoiled**. Erving Goffman coined the term spoiled identity in his famous book "Stigma: Notes on the Management of a Spoiled Identity" [12]. The stigma represents there an experience of living with a disfavoured attribute such as race, sexual orientation, gender, religion, size of a body or disability. In the Goffman's original inventory caregiving is not mentioned. Nonetheless, it seemed a productive attempt to investigate how caregiving identity reveals itself through features acclaimed as Goffman's spoiled identity in own research carried out among husbands caregiving for chronically ill wives, men in their seventies and beyond, members of so called Silent Generation.

METHOD

The study was carried out in 2017-2018 with men who were husbands and prime caregivers of chronically ill wives. Addendum study involved social assistance workers or care coordinators and NGO workers who supported obtaining the prime caregivers. Efforts were made to carry out spot observation, too. The study purpose was to examine male caregiving based on a conceptual framework of counter-storytelling as described by Hulco et al. [6, p.198] as “the process of creating and sharing stories that challenge dominant or normative understandings of the social worlds in which we live and work”. The research has a qualitative character. Data were from semi-structured interviews, collected in many sites in Poland. A total of 60 male caregiving participants took part, aged 60-94, composing a varied group in terms of urban-rural settings, socioeconomic status and caregiving time. Addendum study covered 10 semi-structured interviews with professionals engaged in provision of caregiving services.

For the paper, I decided to limit analyses to men who were 75+ (N=19), whose wives were predominantly suffering from neurodegenerative diseases while the caregivers themselves experienced severe health deteriorations, such as various stages of cancerous conditions, cardiovascular problems, arthritis, hearing and vision difficulties, and/or advanced Parkinson Disease. All men were caregiving at their homes, that is where interviews were conducted, too, in accordance with the participants' demand.

The results presented in the paper therefore refer to the study subgroup of 19 men, 75 to 94 years of age. They represent a demographic cohort described as The Silent Generation or Traditionalists, whose early years of lives were scarred by world war I and II. The results are of a preliminary character, as the entire study analysis is in progress. Additionally, conclusions were drawn from introductory reasoning based on addendum study.

RESULTS – PRELIMINARY FINDINGS

Own research participants in most cases were somewhere within the phase 4 of Montgomery et al caregiving identity. Only three out of 19 men were in an earlier phase 3, what was a result of support received from adult children and/or a combination of substantial (i.e. couple of hours Monday-Friday) participation of social assistance with additional hours of assistance from the private sector. All men pointed at earlier phases as better, easier to bare, allowing some kind of a balance between caregiving and spousal role but also between caregiving and personal identity. The earlier phases were characterised as times of more advantageous communication patterns with wives and greater degree of closeness.

According to data from men caregivers, their identity was indeed hereditary to the relationship and its history. The better the relationship history the better transmission made to caregiving experience and identity:

“If you make a promise to love someone and they loved you back for half a century, my job now is obvious, I don’t think of it as a nuisance, we are fine where we are. I take care of her, that’s OK, that’s no big deal.” [M (men) 40 (participant number)_82 (participant age)]

The caregiving identity is not recognized as such in majority of cases, instead original spousal obligation of mutual care resonates very often:

“I did say for better or for worse, now it’s time to realize the vows, it could have been expected –that’s life plus it could have been me and she would have given best care then so I try and do the same for her.” [M14_86]

“Am I a caregiver? Hard to say, I am a husband, that’s all. [M27_76]

The men caregivers’ portray obtained from professionals engaged in provision of caregiving services (N=10, all females themselves in this study sample; yet another gender issue) exposes normative perception pattern as dominant and transcribes into perceiving men caregiving as lesser to women’s, not accurate enough, not thorough enough, possibly inattentive and generally different to images attributed with caregiving provided by women. The men caregiving seemed necessary given the circumstances in particular study cases, yet not equal to normative, female model. It had a stigmatizing outcome but was irreflexive, perhaps due to internalization processes. For that reason I decided to analyse caregiving identity using the lens of its spoiled connotation [12]. It was quite striking how thoroughly the spoiled identity features [13] resonated with experiences of the participants.

Feature 1: isolation tendency, possible low mood/depression, anxiety and overall confusion

“There is nobody left form my old bunch, you would get away from it all at times, but there is nowhere to go, you become left alone with all that.” [M (male) 21 (participant number)_78 (participant age)]

“It is sad, there is no one to love, the old her is gone, the person inside this sick body is a stranger.” [M22_94]

“She became distant due to the condition, doesn’t want to eat when I am near, so I must leave the room, it’s hers. I eat alone then, watching TV. And that’s how we live now, together but apart, it’s none of my choice. You can’t even visit anyone, it would be too awkward.” [M38_80]

Feature 2: insecurity based on a prediction/fear of no respect from others

“I don’t visit doctors who talk to me, not to her. Once I told a doctor, listen mister, she isn’t translucent, there is a person in front of you, talk to the person. He mumbled something but didn’t say sorry.”[M40_82]

“Only once I heard >>you are a hero<<, but people don’t get it what it means to take care of her, it is invisible to neighbours and own kids. No respect, no understanding, there’s no point even talking about it, I must do my job, end of the story, to the very end of my life or hers.” [M39_80]

Feature 3: feeling visible and judged

“An alcohol drop once in a while? Never! Imagine what could happen if anyone saw or smelled it? People would call the police, TV and portray me as a rascal who didn’t care for his wife. No, it’s impossible, everyone’s got eyes and ears open here. I’m not the alcohol type anyhow.” [M40_82]

“Even when I manage to make her want to go to a park, she must have her hair done well, and in the summer she has a perfect colourful pedicure. She’s always liked that plus you know, what would people say –a former teacher and now what, she cannot look like a homeless, she’s not one.” [M18_84]

Feature 4: over anticipation of the supposed negatively judged feature

“There’s nothing to say, every normal person will tell you the same – caregiving in such a case is a fate’s punishment, destiny, whatever. You have to come to terms with it till you turn to dust, then it will be over and that would be the end of the story.” [M19_82]

“Everyone around talk about her dignity, and what about my dignity? My sleep, my work? I am devoid of any rights, as a citizen too in this case. But that is of nobody’s interest and I don’t think the situation would change soon.” [M21_78]

The inconsistency between “managing somehow” men caregivers’ prevailing picture drawn by professionals engaged in provision of caregiving services and men caregivers identity uncertainty may be the cause of its spoiling. Given that identity is a product of social interactions, it was claimed in relevant theories, the inconsistency is alerting, especially that caregiving men opinions on the professionals balances between perceiving them as Goffman’s *normals* and *wise* and dice loading in neither favour [11].

The caregiving performed by men seems to be stigmatised as different from typical expectations [14] towards caregiving, i.e. performed by women. The negative after-effect stretches onto a multitude of directions. Goffman’s stigma [11], here analysed through caregiving lens, has a potential to shape and maintain social hierarchy. Should there be no progress as for changes in the caregiving

discourse and gender, social development and inclusive transformations will be on hold or, come to a halt. Men would then fade from caregiving not just when it comes to ageing but throughout other life stages, women would keep dominance in the caregiving field, perhaps even achieve a position now available to mother gatekeepers, as women depriving fathers from parenting experiences are commonly named. It's not win-win situation, to nobody.

Further analyses are needed and planned to achieve a more thorough insight into data and its possible implications. The preliminary view presented in the text is an obvious limitation and shall be substantially expanded in forthcoming works.

CONCLUSION

The caregiver's identity is marked by the relationships, it is fluid, shaped by many factors of an individual and social character. The identity is a consequence of the story between people in a family and may have been constituted by ambivalence, as many family relationships have. Inadequately recognized caregiving identity among men performing the role for their chronically ill wives can result in insufficient support received from informal and formal sources. When caregiving loads proceeded and caregiving role was taking over the spousal one, some men experienced malfunctions destroying own wellbeing.

Therefore narration and attention should be given to the subject because the consequences of oppressively self-perceived identity, status and situation are a threat to positively performed and experienced caregiving. Unattended, marginalised caregiving as experienced by men can result in a feeling of a hostile takeover or own life inhibitor, self negligence – all endangering caregiving as informally provided by spouse and accelerating adult children caregiving, formal-only one or institutional placement, causing distress for all parties involved.

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