Baby Boom Caregivers: Care in the Age of Individualization

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Purpose: Many Baby Boomers are faced with the care of aging parents, as well as that of disabled or ill spouses or children. This study examines how Baby Boomers in Quebec, Canada, perceive and play their role as caregivers and how this might differ from their parents’ generation. Design and methods: This was a qualitative and empirical study using an interpretive constructivist design. We interviewed 39 Baby Boomers caring for a family member with a semistructured guide that examined respondents’ identification with their social generation, their relationship to and values regarding caregiving, and the reality of the caregiving they offered. Results: In contrast to our perceptions of previous generations, the majority of interviewees refuse to be confined to the sole identity of caregiver, as they work to juggle caregiving, work, family, and social commitments. To succeed in this juggling act, they have high expectations of support from services. Based on this new approach to caregiving, we advance the idea of a “denaturalization” of care, no longer seen as a “natural” destiny or “normal” family responsibility. Implications: The new conception of caregiving as work that can and should be shared with services is in direct opposition to public policy that is based on the assumption of family care as the cornerstone of long-term care. Can the healthcare system adapt to the new expectations of the Baby Boom generation or will these caregivers be forced to take on elements of caregiving they no longer consider legitimate? Key Words: Conceptions of care, Family responsibility, Generational change

Although numerous studies have examined the phenomenon of family caregiving, not a lot is known about the lives and expectations of the specific category of Baby Boom caregivers. Baby Boomers, in general, have often been characterized in popular and scientific literature as narcissistic, individualistic, demanding, and focused on self-realization (Buckley, 2007; Queenan, 2001; Wilber, 2003). It is suggested that members of this generation may have less of a tendency to identify with their family commitments and the obligation to care. Therefore, the need to take on helping and caring for a sick relative could create a number of problems (Bonvalet & Ogg, 2009; Guberman et al., 2006).
Although still active professionally, Baby Boomers are often caught between the needs of their children and those of their parents who require help and care (Black et al., 2010; Kingsmill & Schlesinger, 1998). Past studies have shown that despite certain rewarding aspects of care (Kramer, 1997; Raschick & Ingersoll-Dayton, 2004), family caregivers of all ages also pay important costs as a part of their commitment to care. Many caregivers describe themselves as being tired or anxious, and the deterioration of their mental and physical health is common (Brink, 2004; Fortinsky, Tennen, Frank, & Affleck, 2007; Salva, Almeida, Davey, & Zarit, 2008). In many cases, they may be obliged to cut back on leisure time or work hours, suffer loss of income, and may find that family conflicts develop or become aggravated (Chung, McLarney, & Gillen, 2008; Wakabayashi & Donato, 2006). This can result in marital problems, professional difficulties, anxiety, depression, and burn out (Frémontier, 2003). Are Baby Boomer caregivers willing to assume these costs?

**Baby Boom Caregivers: Higher and More Exacting Expectations of the Health System**

In Canada, and particularly in Quebec, the Baby Boom generation has grown up with the welfare state, a substantial decline in religious practice, major changes in male–female relationships with high divorce rates, very low fertility rates, and women’s integration into the labor force (Olazabal, 2009). Its members appear to have developed a different relationship with their parents than previous generations and have higher expectations toward public services (Lavoie, Guberman, Bickerstaff, Blein, & Olazabal, 2009). They have a better understanding of their rights, seek precise and complete information, and question norms (Lavoie, 2000; Steinhorn, 2006). Lavoie, Lessard, Barylak, and Côté (2003) have shown that in dealings with professionals, daughters of the Baby Boom generation express their needs clearly, compared with spousal caregivers of the previous generation who expect and ask little. In addition to the obvious problems caused by this new way of entering into a relationship with professionals, we can anticipate that the need for services of this cohort may be very different from that of previous cohorts, particularly because the majority of the women of the Baby Boom are employed (Institut de la Statistique du Québec, 2006). As the Baby Boomers arrive at an age when they are key targets of social policy push-
services. These two forms of caregiving may reflect two divergent models of autonomy (Clément & Lavoie, 2001; Luna et al., 1996). The first involves family autonomy from formal services and tends to be linked more to a familist model of family cohesion and functioning characterized by a strong family identity, compulsory and generalized solidarity, and distrust of the outside world, including reluctance to use services (Luna et al., 1996). The second model is based on individual autonomy, of both the person requiring care and of other family members. Its focus is on personal autonomy and identity, selective solidarity, negotiated forms of interaction, and use of services outside the family. Formal services allow for a certain balance and help ensure personal autonomy with regard to the family (Clément & Lavoie, 2001). This model is seen as reflecting the values of Baby Boomers.

Given the relatively few studies on the specific experience of Baby Boomer caregivers and our theoretical framework, our research objectives were (a) to better understand the diverse realities of Baby Boomer caregivers (their values concerning family solidarity, their various forms of organizing help, and the impacts on the different aspects of their lives) and (b) to identify their specific needs and expectations with regard to support and services. To meet these objectives, we chose an interpretive constructivist design (Schwandt, 1994) taking inspiration from grounded theory (Glaser & Strauss, 1967) or what Charmaz (2005) calls constructivist grounded theory. While referring to the main methods of grounded theory: “making comparisons, developing categories, engaging in theoretical sampling, and integrating an analysis” (p. 510), this approach does not adhere to the objectivist premises and the “hard” inductive perspective proposed by Glaser and Strauss. This design is pertinent in helping understand behaviors, perceptions, and motives. Our principal tool for the production of material was the semidirected interview based on a thematic interview guide. Early sampling was non-probabilistic aimed at gaining the broadest range of perspectives on the experience of Baby Boomer caregivers. Afterward, we moved to the theoretical sampling to build on or refute the developing analyses and “emerging hypotheses.” We stopped recruitment after having interviewed 39 self-selected caregivers, having attained theoretical saturation. Caregivers were recruited in 2006 and 2007 through community groups or support groups for caregivers, posting in different work places, sports and leisure centers, laundromats, and corner stores, as well as through ads in community newspapers and presentations to community organizations. Posters and pamphlets asked: Are you between 45 and 60? Were you born in Canada or have you lived here since 1955? And do you take care of a relative with physical or cognitive disabilities (due to aging, illness, accident or other)? (We chose to recruit immigrants who had spent the better part of their youth in Canada so that all interviewees would have participated in the social and historical events of the Baby Boomer cohort.)

Differently from the United States, the demographic Baby Boom in Quebec began at the end of World War II and continued to the mid-60s (Hamel, 2009; Olazabal, 2009), but in terms of a social generation, authors speak of two or three distinct groups (Gillon, 2004; Olazabal, 2009). As we were attempting to study a social rather than a demographic group, we limited our sample to people born between 1945 and 1959. This group would have experienced the historical and social changes of the 60s and the early 70s and arrived on a labor market still in expansion, just before the recession of the early 80s, making their cohort experiences more similar than those born after 1959. As well, it is in this group of 50- and 60-year-olds that we find the majority of caregivers.

In our sample of 31 women and 8 men, 19 were born between 1946 and 1952 and 20 born between 1953 and 1959 (resembling the two groups defined by Gillon, 2004 and Olazabal, 2009). Twenty attended university, 6 college, 10 completed high school, and 2 did not respond to this question. Family incomes vary considerably: 12 had a family income less than Can $20,000, 6 between Can $20,000 and $39,999, 4 between Can $40,000 and 59,999, and 14 more than Can $60,000; the figures were not available in 3 cases. Twenty-nine of the caregivers we interviewed (6 men and 23 women) cared for an older parent with a physical disability or loss of autonomy, while the others cared for a disabled spouse (one man and seven women) or adult child (one man and three women) or sibling with physical and intellectual disabilities or mental health problems (three women; total is more than 39 as five women were caring for a parent and a spouse or a child). We were unable to recruit many caregivers of ethnocultural minorities who fit our inclusion criteria. In all, we interviewed 29 persons of French-Canadian origin, 3 of English-Canadian origin, and 7 of Italian descent (of whom 4 were interviewed in English and 3 in French).
Members of the research team (two senior researchers, three masters students, and one doctoral student trained by the researchers) conducted qualitative interviews of 60–90 min with each participant in their home or a public place of their choice (research office, restaurant). Students first assisted at an interview conducted by a senior researcher for modeling and then were accompanied to their first interview to ensure that they had mastered the interview guide and interview style. The interview guide used by all covered the following themes: respondents’ perceptions of Baby Boomers and their identification with this group, the division of tasks related to the caregiving and the trajectory which led to their involvement in care, their use or not of public, private, or community services and the rational for this, the consequences of this organization for the participants, and their expectations about their own care and needs as caregivers. The interviews were recorded and transcribed in their entirety. We also administered and discussed a questionnaire on norms and values with regard to caregiving that we had developed for a previous study (Guberman et al., 2006). The study received ethical approval from the research ethics committee of the university to which the principal author is affiliated.

The integrally transcribed interviews were first submitted to an intra-case or monographic and thematic analysis, using the support of QRS N’Vivo 7 (Sorensen, 2008). Coding took place in two stages. First, we employed an intermediate approach, situated between inductive (emerging from the text, Glaser & Strauss, 1967) and deductive (provided by our theoretical framework) logics. The early interviews were coded for each unit of meaning, and then, comparing the codes to the various units, the codes were refined to become denser and more analytic. The interviews were then recoded with the new codes. Two or more researchers separately coded each interview, and inter-judge comparisons were done in the process of discussing and developing the new codes. Next, more global categories were developed and efforts were made to ensure they were exhaustive, unique, homogeneous, and relevant (Mayer, Ouellet, Saint-Jacques, & Turcotte, 2000). We then did an inter-case analysis of each category to deepen the analysis and develop analytic subcategories in line with our research questions. The research team constantly revised the analysis until we felt we had a complete understanding of our material in line with our objectives.

In qualitative research, rather than reliability and validity, one looks for credibility, dependability, and confirmability (Mason, 1996; Zyzanski, McWhinney, Blake, Crabtree, & Miller, 1992). To that extent, credibility and dependability were conferred by the thick description developed, the use of inter-judge accords for coding and category development, and theoretical saturation for our major theoretical categories. As well, the coherence between our qualitative analyses and the analysis of the questionnaire data reinforce dependability. The external confirmation of our interpretations by presentations to groups of Baby Boomer caregivers for validation give the findings confirmability without allowing us to make generalizations outside the Quebec context.

Results

Being a Baby Boomer (or Not . . .)

The caregivers we interviewed were chosen on the basis of their objectively belonging to the demographic Baby Boom. Half of them recognized themselves in the social category of Baby Boomer and referred to many of the dominant images portraying Baby Boomers:

We were more spoiled than the previous generations from the point of view of education, health . . . we are better at getting services. Plus there is the fact that we have gotten an education, so we know how to formulate our demands.

However, the other half had greater difficulty in recognizing themselves as being a part of the social and cultural universe of the Baby Boomers. For certain, this term was not meaningful. As one caregiver remarked: “It’s funny because when you said on the phone that I was a Baby Boomer, I just then realized I was a Baby Boomer . . . I hadn’t put myself in that category before.”

Others recognized themselves as Baby Boomers by common historical markers. These include growing up during a period of economic prosperity, in a context of dynamic social changes—the sexual revolution, the break with religion, the rise of feminism—having benefited from a greater access to education and the development of the welfare state and free, universal health and social services, (Olazabal, 2009; Sirinelli, 2003). They nevertheless did not consider themselves to be truly part of this generation:

For me, it is quite simply a timeline that usually signifies a very pleasant period in the sixties where, from an economic point of view, there were no big problems. . . . It is just that, for me, it is not there at the psychological level because I can’t see myself in it.
Others, not necessarily corresponding to what they consider to be the typical portrait of a Baby Boomer, categorically refused to identify themselves with that label: “I am demographically part of the Baby Boom, but . . . the three houses, plus the two cars, I can’t afford all that. I will never be at ease financially; I don’t have a secure retirement.”

But even for those participants who felt they were Baby Boomers, many made a distinction between themselves and the majority of Baby Boomers, that is, those not providing care. Being a caregiver seems to distinguish these participants from other members of this age cohort. Our participants consider themselves to have more humane values, particularly focused on sharing as compared with the perceived egotism of the Baby Boomers around them. One caregiver put it this way: “We are four girls at our place. I can’t see any of my sisters doing what I do. It would take away their freedom.”

The participants were all certainly a part of the demographic Baby Boom, but the particular context of caregiving distanced them from the popularly ascribed characteristics of Baby Boomers. Taking care of a family member made the participants more conscious of altruistic values and of the importance of responsibilities toward others. They did not consider that they had experienced the same trajectory as those whom they described as the real Baby Boomers (corresponding to the stereotyped image in circulation):

“You have to be fulfilled, you have to have an interesting job; the family comes afterwards. So, you have to establish these things before thinking of others. You have to be fulfilled before thinking of others. I would say that this is what most characterizes the values of the Baby-Boomers.

However, if the “true” Baby Boomers are seen as people who will not sacrifice their comforts in order to care, they are not alone in questioning the notion of sacrifice. The caregivers interviewed also distanced themselves from this concept. They stated that they do not wish to sacrifice their lives in order to care the way their parents did, even if, in reality, they do sacrifice many things.

A Caregiver . . . but Not Like My Mother

Unlike their mothers’ cohort for whom caregiving would have represented their principal occupation (taking care of their husband, children, grandchildren, or parents), Baby Boomers who care for a relative have many more central occupations in their lives than just caring (Bonvalet & Ogg, 2009; Guberman et al., 2006). This is due to the fact that a large majority of Baby Boom women work outside the home as well as having other commitments. In fact, several authors note the development of a whole series of new preoccupations among members of this generation (such as concern for their bodies, having active social and cultural lives, or the search for freedom after retirement) and note how these preoccupations translate into the desire to maintain significant autonomy with respect to the generations that follow (Le Breton, 1990; Vigarello, 1993). This appears to be equally the case for generations that preceded them (Guberman et al., 2006).

According to our participants, another important factor that permits the current generation to differentiate itself from previous generations is the existence of services that can come to their aid: [One of the things established by] my generation, once they came to power, was to develop public resources for these people, for our elderly. We couldn’t take them into our homes, so we developed this; we valued it.

Indeed, in Quebec, the Baby Boomers have fully participated in the redefinition of the parental and grandparental structure by involving the (welfare) state as a “partner” in the distribution of services to the family (Dandurand & Kempeneers, 2002). Thus, Quebec caregivers like our participants differ from previous generations through the way they assume their caregiver identity as one among many social identities and refuse to define themselves only through their role as a caregiver. They say that they can do so thanks to their integration into the labor market coupled with the existence of public services.

The Caregivers of the Baby Boom: How Different Is Their Reality?

Nevertheless, like much previous research, our research reveals that caring for a family member can have negative consequences on all aspects of life, despite the resistance of the participants to submit totally to the identity of caregiver. Many participants repeated the same terms as their predecessors to describe their physical and mental health: tired, worn out, back pain, headaches, psychologically burnt out, insomniac, and anxious. In terms of their family life, some spoke of lack of availability for other family members: spouses, children, or grandchildren. The majority of the participants who were or had been employed described the consequences caregiving has had on their professional life.
The problem of balancing work and family caregiving is not new, even if women born between 1945 and 1955 have substantially higher levels of labor market participation than their predecessors (Lavoie, Guberman, & Olazabal, 2008). Yet, according to the participants, the Baby Boomers live out the struggles of life–work balance differently from previous generations by refusing to compromise their work and career for the demands of caregiving: “The Baby Boomers will want to keep their jobs, and their advancement. They won’t leave a job to take care of a family member, only very, very rarely.”

Nonetheless, the majority of the participants have made adjustments to their work in order to make their jobs easier to balance with the demands of caregiving. These changes greatly resemble those developed by caregivers of previous generations interviewed in the 1980s and 1990s (Guberman, Maheu, & Maille, 1993; Scharlach, Sobel, & Roberts, 1991): “I could have gone higher up [in my career . . .] I was so upset by what was going on at home that I couldn’t do both because it would be me that would crack with all this.”

Those who put aside their professional activities to provide care for a relative, do so with a certain amount of bitterness because work remains one of the important identity markers for Baby Boomers: “We define ourselves by our work. So when you work at home taking care of someone, that means you are not doing much of anything. Socially speaking, that was hard to take.”

Unlike previous generations, besides balancing work and caregiving, Baby Boom caregivers must also balance the other multiple identities they wish to maintain, such as parent, grandparent, volunteer, activist, friend, or spouse. Life–work balance is therefore not limited to the poles of work and care. This issue is made more complex for Baby Boomers because they refuse to be limited to one or two identities. As well, they are under pressure from new normative prescriptions requiring them to take care of themselves, to stay in shape and not become ill, creating even more stress.

The question of the financial impact of caregiving also comes up quite explicitly in participants’ interviews. If this problem is not a new one, it seems to be reported more frequently and with greater insistence by our informants. As many cut back on their work hours, took unpaid sabbatical years, quit their job, took early retirement, or withdrew from the labor market due to the care they were providing, they suffered the economic repercussions of these changes. In a social context that calls for careful financial planning for retirement, the majority of the caregivers interviewed who had not been able to do so seemed particularly preoccupied by their financial future.

In the end, we note that the repercussions of caregiving for Baby Boomers are not that different from those experienced by previous cohorts, despite values and a discourse that present caregiving as a relation which should not entail major sacrifices to one’s family life, personal life, and career.

A New Conception of Care

However, Baby Boomers in our study appear to have a new conception of care whereby the known consequences of caregiving are no longer considered legitimate. This conception seems to have arisen in parallel with changing notions of family solidarity that are dictated by norms that are becoming less prescriptive. This leaves room for an interpretation of family obligations, which increasingly depend on the types of interpersonal relationships one has with the person requiring care, one’s availability to care, one’s family’s situation, and so on. As has been noted by Finch (1989) or Lavoie (2000), many reasons can be found to reinforce or restrain this sense of responsibility. When one accepts to provide care, that care is more and more conditional, limited, and circumscribed.

I told her: “no, that I can’t do.” Or: “that, I can.” Or if she told me: “I need to go to the hospital.” Well, I tell her: “Look . . .” I give her my schedule, and I slot her into it, if you will. Sometimes I have changed my schedule; often, even. But when I felt that it was going to be a “No,” then . . .

But if my mother asks me to do her housework, to wash her fridge every week, to change her bedclothes, etc., I don’t want to deal with that, because . . . I just don’t want to do it! There are limits that I have to set and it is those limits that I need to negotiate with my mother because I am not ready to drop all my activities. That’s it. In that, I am a real Baby Boomer!

Respondents are willing to provide support for a family member but not to the point where they sacrifice everything or become lost in the identity of a caregiver. Given this understanding of caregiving, they consider public services to be very important in supporting their disabled relative and want to delegate some of the care to home-care workers, especially the more instrumental tasks (Clément & Lavoie 2001). But their expectations with regard to services go beyond the simple completing of tasks they want to delegate.
Baby Boom caregivers we interviewed do not want services to be limited to, maintaining the person with disabilities at home; they must also offer some type of stimulation and rehabilitation. They expect to see cultural activities and physical therapy for their relatives, at the same time as they question the type of activities currently being offered which tend to infantilize the person with disabilities:

Monday she has a singing class. Otherwise, during the week, there are the activities provided by the residence, but the activities . . . it’s cards, bingo, things like that . . . We would like activities that will help them fight boredom, stimulate them, interest them. A service that provides leisure activities, travel, entertainment, that seems to me to be essential, and a service providing social integration.

In this way, our respondents increasingly see their role as guaranteeing quality of life for the disabled person and as managing services, with the latter expected to offer the instrumental support and personal and nursing care.

But participants also have expectations of services specifically for themselves such as psycho-social support and financial compensation. The demand for financial compensation including the possibility of a salary for the work of the caregiver is a relatively new proposition by Baby Boom caregivers. This demand comes up in our study in a way that is more marked than studies of previous cohorts of caregivers. In fact, more than half of the participants mentioned demands or proposals of this type. While those who are taking care of an adult child or spouse—for whom the question of financial compensation seems less important, as the care for a spouse or child is perceived as somehow more natural (even if that is not always the case)—the great majority of caregivers of older persons wish to receive some form of financial recognition:

Someone who does not work, and then goes to help their parents, their expenses should be accounted for. Someone who is working and is obliged to leave their job then finds that they are having a hard time getting social assistance because they are caring for a parent, well they should probably get paid a salary.

Other respondents do not necessarily seek a salary but would welcome having their expenses paid or an allowance for the days spent caregiving.

Discussion

Although all the caregivers interviewed do not self-identify as Baby Boomers, we can see that they all have been shaped by their common cohort history (Elder, 1975). This helps us to understand why they all claim they are experiencing care in a completely different way from their mothers and that they have a different perception of what caring for a relative means. They are increasingly reluctant to take on the daily, even hourly, demands of instrumental and personal care. The care they feel they can legitimately be asked to and that they are willing to provide is more related to “being there” for their relative and organizing and supervising the quality of care provided by others. This concept of care emerges in part as a strategy aimed at reconciling the different imperatives to which this generation of caregivers are subjected. Women, particularly, are now faced with somewhat conflicting expectations for social success and self-actualization, intermingled with certain lingering traditional expectations of women’s role in the family that have not altogether disappeared from society. It is all these demands that must now be balanced along with the demands of caregiving.

As well, participants tend to object to being confined to the sole identity of caregiver at the expense of the other aspects of their lives. Being a caregiver no longer seems to be something normal, to be taken for granted in one’s trajectory. What appears normal to our respondents is having a professional life, an active social life, and regular activities that allow them to take care of themselves, and this, even if they are caregivers. In a social context where identity is profoundly marked by the values and social imperatives of productivity, personal growth, and self-realization, Baby Boom family caregivers are continually admonished to fulfill themselves in all spheres of life: as a worker, a lover, a parent, a grandparent, a friend, or a volunteer. This leads to the development of many identities that must be maintained in order to confer a feeling of success.

This new relation to caregiving appears to emerge as a product of the social historical postwar era with its values of autonomy and self-actualization supported by a strong welfare state. Hands-on caregiving as no longer being seen as “natural” destiny; a phenomenon we call the “denaturalization” of care (Lavoie, Guberman, Olazabal, & Grenier, 2009). This concept is developed in opposition to the historical notion of caregiving as a “normative” family stage (Brody, 1985) and in line with the notion of naturalization of Dannefer and Settersten (2010) as “(t)he social practice of mistakenly attributing social arrangements to human nature or other natural forces,” (p. 4).
A good example of this phenomenon is that more and more people are taking on the label of caregiver, which was not the case even a decade ago (Lavoie, 2000). That is, they consider that what they are doing goes beyond the normal expectations one should have of a daughter, a son, or a spouse and thus requires a specific label to denote this. As our respondents state: “I am no longer just her daughter, I have become a caregiver.” This change corresponds with the process of individualization under way (Beck, 1992; Fine, 2005) by which people are expecting to be treated as individuals and not as members belonging to a group or social category, individuals who want to develop “relational autonomy” (Fine, 2005; Mackenzie & Stoljar, 2000). For Beck, individualization constitutes emancipation from the traditional constraints permitting the development of new forms of sociability within which autonomy is achieved and recognized through social relations. The relationship of care can thus develop on the basis of mutual recognition, intimacy, and reciprocity, the care becoming perceived as the result of a rapport between the different parties inside of which prevail mutual respect, the stimulation of capabilities, and the autonomy of the beneficiary (Fine, 2005, p. 257). It is this type of care relationship, a relationship not stemming from a norm imposed by the family bond, which is sought by study participants, even if in reality, this type of relationship is rarely fully achieved.

Also, as care is no longer something innate to the status of daughter, mother, or spouse, it can more easily be conceived as something that can be shared with other actors. Our data thus support the idea that Baby Boom caregivers adhere to a model of individual autonomy, selective solidarities, and the use of formal services (Clément & Lavoie, 2001).

Implications

The expectations of Baby Boomer caregivers have direct implications for service organization. To meet these expectations, services, as well as the other actors in the public health sector, will need to make changes in the way caregivers are understood and treated. Clearly, the caregivers we interviewed no longer wish to be perceived as a resource but as partners in the organization of care (Guberman & Maheu, 2002; Lavoie & Guberman, 2010). They want to negotiate and set limits to the amount and kind of care they wish to undertake. This will require the existence of alternative resources to family care and policy and practice that no longer takes family caregiving for granted (Kane & Penrod, 1995). Will services be able to meet these expectations? Given the current situation in Quebec where public home care is seriously under-funded, Baby Boomer caregivers are likely to be disappointed and many may be forced to take on elements of caregiving they no longer consider legitimate.

Evidently, there are limits to the extrapolations we can make from a Quebec sample to the larger Canadian and North American contexts. Quebec “modernization” took place with an important time lag after that of the rest of North America. It was not until the 1960s that the Catholic Church lost its hold over society and the government, leading to major social transformations. Today, for example, Quebec has the highest rates of divorce and of non-married couples with children in North America, and the rates of women with minor children in the workforce are similar to those of Scandinavian countries. Familist values are less present, and Quebec has developed innovative and to a certain extent “model” social measures with regard to child care (1 year paid maternity and/or paternity leave, publically subsidized daycares costing $7/day, and modest legislation aimed at work–family balance). Its answer to the changing values and situations of caregivers may lead to original measures for the care of disabled older people. However, their transferability to a larger North American context is not self-evident, given the very different social and cultural environments.

Based on the Quebec example, future research could be undertaken to study the realities of Baby Boomer caregivers in the rest of Canada and in the United States to determine if our study has revealed a Quebec reality or a generational one. Both qualitative studies which look at areas similar to those we examined or quantitative designs using, among other things, our questionnaire on norms and values of responsibility for elder care (Guberman et al., 2006), which corroborated our interview data, would develop comparative knowledge to enhance our understanding of Baby Boomers confronted with family caregiving.

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References


