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Understanding Female Full-Time Social Workers' Experience Providing Informal Care for Older Loved Ones

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This is to certify that the doctoral study by

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Walden University
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Abstract

Understanding Female Full-Time Social Workers' Experiences Providing Informal Care for Aging Loved Ones

by

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Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Abstract

Limited research existed regarding the experience of informal caregiving that female social workers provide to older loved ones while managing a full-time social work position. The purpose of this qualitative action research study was to understand how Female Master's level Social Workers (FMSWs) who are also informal caregivers manage these roles and whether the roles impact current and future well-being. Role spillover theory and cumulative disadvantage theory were the theoretical frameworks. Data were collected from nine participants through interviews completed on Zoom. The participants responded interview questions about significant changes in their levels of stress, resiliency, or burnout at work or other areas of their lives in the short term and long term; skills, resources, or supports they have as social workers in their caregiving role; and any increase in feelings of burden, disadvantages, or fear of future financial or health-related consequences due to performing both roles simultaneously. Themes identified through narrative analysis included feelings of stress caused by role spillover. The most critical nonmaterial resource was the connections participants established as social workers. The financial burden experienced by participants of color was an issue most thought would affect their aging process. Positive social change implications for the profession include acknowledging the struggles social workers face while providing informal care and identifying relevant tools and supports that can be used to ease the burdens.

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Dedication

To all social workers who strive to make a difference in this world yet find time to help their friends, families, and loved ones. This dedication is to all of you, as I hope you will be able to give yourselves the same love, energy, and support that you graciously give to others.

Acknowledgments

This capstone project was a long time in the making and would not have occurred without several people's support. Although I cannot mention everyone who supported this long endeavor, I am so grateful to have had so many people who believed in me, even when I sometimes doubted this would happen. This project began when I worked as the clinical director for an agency that works with lesbian, gay, bisexual, and transgender (LGBTQ+) aging persons in New York City. I was so thrilled to help my community and to primarily provide support, nurturance, and love to so many older LGBTQ+ people who, by living their lives, made my life easier and honor them as the heroes they genuinely are. Simultaneously, I became an informal caregiver for my mother and realized just how challenging these two roles can be and how many other female social workers I knew silently suffered while working and tending to their aging loved ones.

I appreciated all of the guidance and support I received from my committee; I am thankful to have completed my DSW at Walden as it allowed me to contact dedicated and excellent social workers all over the United States as well in many other countries. They inspire me and remind me to keep the faith and keep moving forward as we are all over the world, focusing on social justice, equality, and humanity's betterment.

I also have to thank one of my teaching mentors and a real inspiration to obtain this degree, Dr. Lisa Rose. She hired me, guided me, and inspired me to achieve greatness. I love her very much and dedicate this capstone project to her.

I owe an outstanding debt of gratitude to all of the participants who shared their most intimate stories and feelings regarding their roles as social workers and informal caregivers. You have inspired me to continue this work and make sure that your stories are documented and heard throughout the social work community. You are all truly amazing women. Not even a world pandemic could keep you down.

Finally, I must acknowledge my wife, Maureen, who for years has missed so many play dates and time together while I obtained my DSW. She stood with me, encouraged me, loved me, and gave me the time to complete this multiyear project. I was supported, nourished, loved, and helped to continue, even when life and COVID-19 got in the way. I am the luckiest doctoral student in the world to have someone like Maureen at my side. I would finally like to thank my furry kitties, who provided me with kisses and never caused too much harm to my computer when typing time spilled over into play and petting time. While they are not all still around, I want to thank Paddy, KT, Loui, and Lady Pippa for their love and supportive meows.

Table of Contents

List of Tables......iv

List of Figures......v

Section 1: Foundation of the Study and Literature Review......1

 Informal Caregiving and Socioeconomic Status......4

 Social Work Profession and Socioeconomic Status......6

 Justification of the Study......7

 Problem Statement......8

 Purpose Statement and Research Questions......9

 Nature of an Action Research Project......9

 Significance of the Study......11

 Theoretical and Conceptual Framework......11

  Role Spillover Theory......15

  Cumulative (Dis)advantage Theory......17

 Review of Professional and Academic Literature Review......20

  Aging Population in the United States......20

  Informal Elder Caregiving......23

  Value of Caregiving......25

  Caregiver Burden (Stress) and Caregiver Satisfaction (Resilience)......26

  Reviewing the Role of Informal Elder Caregiving......30

  Caregiver Role: Demographics and Tasks......30

The Value of Women's Worth and Social Work 37

Social Workers: Uncovering Common Themes Relating to Work-Related Stress 38

Uncovering Themes: Dual Roles as Social Worker and Informal Caregiver 41

Summary 43

Section 2: Research Design and Data Collection 44

Research Method 44

Research Design 44

Participant Selection 46

Recruitment Process 46

Sample 46

Procedure 47

Researcher Role 48

Analysis 49

Summary 49

Section 3: Presentation of the Findings 50

Data Analysis Techniques 51

Findings 55

Demographic Characteristics 56

RQ1: Changes in Feelings of Stress, Resiliency, and Burnout 59

RQ2: Skills, Resources, and Supports Utilized Across the Roles 69

RQ3: Burden, Disadvantages, and Fear of Future Financial and Health-Related Consequences 77
Unexpected Findings....87
Summary 87
Section 4: Application to Professional Practice and Implications for Social Change....90
Application to Professional Ethics in Social Work Practice 98
Recommendations for Social Work Practice 100
Implications for Social Change 102
Summary 103
References....105
Appendix A: Codebook 129
Appendix B: Interview Questions 135
Appendix C: Demographic Questions....136

List of Tables

Table 1. Demographics of Aging – Male/Female 20

Table 2. Research Questions and Themes 56

Table 3. Demographics 57

Table 4. Feelings of Stress 60

Table 5. Self-Care 67

Table 6. Support for Informal Caregivers 73

Table 7. Identity Disadvantages or Advantages 79

List of Figures

Figure 1. Percentage of Adults in the U.S. Aged 60+ Who Are Concerned About Health Issues........22

Figure 2. Number of Informal Care Hours Worked by a Caregiver’s Age Each Week....24

Figure 3. Care Receivers........58

Section 1: Foundation of the Study and Literature Review

Social workers experience high levels of stress and exposure to multiple traumas due to the profession's demands, given that they are frontline workers in direct practice with vulnerable communities who experience and share their trauma with their social worker (Singer et al., 2019). The ongoing and frequent dealings with clients' trauma narratives include violence, fear, abuse, and other painful emotions, causing social workers to be susceptible to increased burnout, psychological distress, and vicarious trauma (Singer et al., 2019). The addition of other roles for informal caregivers doubles their stress levels, trauma, and psychological distress when caring for an older loved one (Hausler et al., 2017). Tement and Korunka (2015) stated that 65% of the U.S. workforce has reported being a caregiver for an older adult while working outside the home. Although social workers are in the business of caring for others, the extra responsibility of caring for an aging adult adds short-term and long-term costs.

Women are the most significant subpopulation within the social work profession who carry the primary responsibilities for caregiving in the United States (Boehmer et al., 2018). Women experience higher adverse outcomes, stressors, and burdens due to discrimination, poverty, or other socioeconomic factors throughout their lifetimes (Boehmer et al., 2018; Lee et al., 2015). Although all women experience higher levels of oppression and long-term burdens, women of color and lesbians often experience higher rates of adverse outcomes and accumulated debt, greater financial insecurity, and lower access to affordable health care over their lifetime (Boehmer et al., 2018; Lee et al., 2015). The current project study addressed the experiences of FMSWs regarding how these two roles (social worker and informal caregiver) affect their current and future ability to plan for their aging process. Three million older adults need care and still reside at home (Clancy et al., 2019). About 25% of them are unable to afford professional caregivers and rely on family and informal care (Freedman & Spillman, 2014).

Over the past 30 years, federal and state lawmakers reduced services and entitlements and increased the costs of care at a time when an increasing number of older adults needed expanded services (Clancy et al., 2019). These additional political stressors included increasing nursing home closures, reducing staff-to-client ratios, and requiring more charitable options and family members to assume caregiving and financial responsibilities (Clancy et al., 2019). With higher longevity rates of older adults come increases in diseases, illnesses, and conditions that are considered age related and often impact an aging person’s ability to independently complete their daily living skills or instrumental daily living skills (Karel et al., 2012). The costs of health care and caregiving needs continue to increase, along with a substantial increase in life expectancy rates due to advancements in medical care, technology, nutrition, and other factors (Murray et al., 2015; Stewart et al., 2013; Weisman de Mamani et al., 2017). With costs rising and the numbers and ages of older Americans continuing to increase, it is not clear how are these older adults’ needs are going to be met and the toll it will take on their family members who provide the care while working full-time.

Aging adults (ages 50+) are the largest and most rapidly growing segment of the world’s population (AARP, 2018). According to the U.S. Census Bureau, APS PUMS (2017), aging adults live longer due to health and medical breakthroughs. Currently, there are 93.27 million Americans who are 55 years or older; 50 million are women, which is the largest cohort (Statista, 2019). Although these numbers are noteworthy, they reflect a smaller proportion of the actual numbers because many uncommunicative or weakened aging adults and undocumented aging persons cannot participate in surveys (AARP, 2018).

As more significant numbers of people age, they often become more susceptible to Parkinson’s disease, dementia, Alzheimer’s disease, debilitating arthritis, diabetes, high blood pressure, and other aging-related illnesses (Bauer & Sousa-Poza, 2015; Clancy et al., 2019). These illnesses often impede a person’s ability to complete their daily living skills or instrumental daily living skills, leaving them unable to care for themselves without significant assistance. The National Alliance for Caregiving (2019), and Reinhard, et al., (2019) indicated that due to the high cost of professional care, families have to provide home care, financial support, and other care of their older loved ones, resulting in increasing numbers of informal care providers and causing additional burdens and pressures on the informal caregivers’ health, well-being, family–work–life balance, and current and future financial security.

The high cost of professional home care is becoming more out of reach for most middle-class Americans’ financial abilities to pay for professional home care, while 10 million older adults are dependent on the support of informal caregivers (AARP, 2018). The unsustainable costs of informal care and the lack of government support are borne by those who have to provide care for their loved one because they cannot afford to pay for professional care. Schulz and Eden (2016) noted that informal caregivers do not only provide care for an older loved one but must also incorporate that role within other roles and obligations in their lives.

Informal Caregiving and Socioeconomic Status

Informal caregivers can experience several adverse outcomes in their lives (Schulz & Eden, 2016). Informal caregivers often miss more work and are less able to hold a full-time job or assume more leadership positions (Schulz & Eden, 2016). Informal caregivers often leave the workforce or seek more accommodating jobs that have flexibility but pay less (Hausler et al., 2017). Women provide over 80% of caregiving responsibilities in the United States yet make up less than 50% of the workforce (Talley & Crews, 2007; Versey, 2017). In addition, 33% of employed women do not receive promotions in executive or management positions, and many end up remaining in the labor force on a part-time basis, primarily due to their caregiving demands (Damaske & Frech, 2016).

Over their lifetimes, employed women who provide informal elder care will experience a substantial lifetime income loss, as well as a $50,000 decrease in pension benefits (MetLife Mature Institute, 2011). Most women often become caregivers multiple times over their life span, resulting in more significant deterioration of financial status due to the loss of economic stability, lack of health care once they leave their jobs, and increased negative feelings from financial insecurity and job withdrawal (Denton & Boos, 2007). Women historically have experienced a higher frequency of adverse outcomes, stressors, and burdens due to discrimination, poverty, and other socioeconomic factors (Boehmer et al., 2018). Women are more likely to accumulate debt, experience financial insecurity, and cope with lack of health insurance over their lifetime when they take on the role of informal caregiving while working outside the home (Boehmer et al., 2018; Lee et al., 2015).

Wakabayashi and Donato (2006) and Lee et al. (2015) concluded that women who have been caregivers early in their lives will make less money than men. Women have fewer opportunities to move up in their occupation and are at a higher risk for long-term economic and health disadvantages later in their lives. Women experiencing these stressors throughout their life span are cumulatively disadvantaged (Wakabayashi & Donato, 2006). In the current project study, I addressed how an accumulation of disadvantages across a woman's life span impacts the following domains: education, health care, nutrition, finances, housing, and obstacles to secure a livable wage that decrease their ability to sustain their current or future aging needs. Informal caregiving also contributes to health disparities among informal caregivers. They are often remiss in taking care of their ongoing medical care due to the additional time constraints involved in providing informal care to an older loved one while working full-time (Greenfield et al., 2018).

Social Work Profession and Socioeconomic Status

As of 2015, 83% of all social workers in the United States were women over the age of 40, and 85% of those who obtained an MSW degree were female (Council of Social Work Education, 2018). Sixty-four percent of these women inhabit dual roles as workers and informal caregivers for older loved ones (Tement & Korunka, 2015). Many older adults need care but are unable to afford formal caregivers; as result, social workers, like many other working people, and are becoming informal caregivers for aging family members (Gautun et al., 2012; Healy, 2018; Kupper, 2010).

The social work profession is unpredictable and financially dependent on government and charity. Social work agencies are fraught with operational stress, poor access to resources, limited professional supervision, and a bureaucratic maze of requirements and paperwork (Singer et al., 2019). The stressors within the social work profession include organizational obstacles, client stressors, and personal issues that cause social workers to be at high risk for developing burnout, compassion fatigue, and other negative symptoms (Gonzalez, 2019; Singer et al., 2019). The Council of Social Work Education (2018) identified direct care practitioners such as social workers as having the most significant compassion fatigue potential. With the pressures and lack of adequate resources and supervision that exist, many social workers experience adverse health outcomes including high blood pressure, depression, sleeplessness, anxiety, post-traumatic stress disorder, and suicidality (Figley, 2002; Singer et al., 2019).

The current project study focused on FMSWs who provide informal caregiving for an older adult. Because informal caregiving and the social work profession are highly stressful roles, this project focused on understanding female social workers' experiences of holding multiple roles, including being an informal caregiver of an older adult and a social worker. In this project study, I explored participants' understanding of these roles and how they intersect across the participants' lives and planning for their future aging.

Justification of the Study

As an FMSW who provides informal caregiving for several older family members, I experienced many of the same challenges that other FMSWs and other working professionals experience in juggling multiple roles. In reviewing the literature and engaging with my peers in supervision groups, I discovered that many other FMSWs experienced similar emotions, time management issues, work–life balance, and burnout while juggling informal caregiver responsibilities (see Funk et al., 2010). Given the increasing numbers of older adults who need additional care by another person, more working people will be caregiving, and many will be negatively impacted later in their lives (see Funk et al., 2010). Working parents or guardians who take care of their children, their older loved ones, or both at the same time spend many hours a day on caregiving. This care is essential for the survival and well-being of the care recipients because many cannot afford to pay for professional care. This is an issue that the social work profession needs to address in helping aging clients find care and resources and making sure that social workers have the resources and support they need to be healthy and productive.

Although my experience and professional role qualified me as a participant in this exploratory qualitative study, I, as the researcher, understood that being in both roles could have created a potential for researcher bias or caused intended or unintended influence (see McNiff & Whitehead, 2011). An action researcher's role is to be self-critical and reflective to address the potential for bias. Both researchers and participants should be aware of how the researcher's participation may cause intended or unintended consequences on the project, outcome, or other participants (McNiff & Whitehead, 2011). Because the researcher can exert influence over the participants, project, or outcomes, I continually assessed whether my participation contributed to the project and how it was tolerated by the participants (see McNiff & Whitehead, 2011; Stephens et al., 1997).

Problem Statement

At the time of this study, limited research existed regarding the experience of informal caregiving that FMSWs provide to older loved ones while managing a full-time social work position. I explored the experiences of employed FMSWs who are also informal caregivers for older adults. I also explored the cumulative advantages or disadvantages that FMSWs experience while working and providing care for an older adult, as well as any potential effects these roles may have on their long-term financial and health outcomes (see Dahl et al., 2015; Lee et al., 2015; Sanchez-Moreno et al., 2015; Wagaman et al., 2015).

Purpose Statement and Research Questions

This project study addressed how the participants managed the additional stressors that arose when they became an informal caregiver for an older family member. The goal was to understand how the participants described the affective domains (feelings, strategies, and concerns) when integrating two challenging roles: social worker and informal caregiver. The second purpose was to understand whether there are short-term and long-term negative consequences for female social workers who are also informal caregivers for older adults. The research questions (RQs) this study addressed were the following:

RQ1: How do FMSWs describe significant changes in their levels of stress, resiliency, or burnout at work or other areas of their lives in the short term and long term?

RQ2: What types of skills, resources, or supports have FMSWs developed that can be used across their roles?

RQ3: In what ways did FMSWs increase their current feelings of burden or disadvantages or fear of future financial or health-related consequences due to their caregiving responsibilities while working full-time?

Nature of an Action Research Project

By implementing this action research (AR) project, I made a case for improving the social workforce's health and long-term well-being. I also obtained knowledge about the impact of role spillover that FMSWs experience, which may elicit new conversations between social workers, employers, and policymakers in understanding the growing concerns for social workers who provide informal care for older adults. This AR project was grounded in exploring the immediate and long-term experiences and obstacles faced by FMSWs when working full-time and providing informal care to an elder loved one. AR is a systemic practice that is predicated on capturing participants' shared experiences and participation and provides a mechanism to study the issues and allow the participants to share their story and help them find solutions they can utilize on their own after the research project is completed (Stringer, 2013). This project began when I became an informal caregiver for my mother while I was a full-time social worker.

AR was appropriate for this project because AR provided a mechanism for the participants to share their experiences and stories. Participants described their feelings, fears, time management skills, work–life balance, level of psychological distress, or resiliency related to managing two stressful roles among the other roles in their lives (see Abdollahpour et al., 2018; McNiff & Whitehead, 2011; Stephens et al., 1997). In this AR study, I focused on pertinent practice and well-being issues meant to uncover and improve practice issues that can improve the profession's well-being and improve clients' current and future well-being (see Stringer, 2013). Although I initially intended to use in-person focus groups, that process changed to individual online interviews due to the onset of the COVID-19 pandemic. The interviews were based on a narrative analysis dialogue with the participants to identify the events and experiences that shaped the participants' meaning (see Riessman, 2008). The benefit of using this type of format allowed for a textured understanding of the participants' experiences and perceptions within their specific conditions and situations (see Stephan et al., 2018).

Significance of the Study

This study's significance was to understand if there were immediate and long-term effects on FMSW's work–life–health balance and the potential impact on their accumulation of resources for their future aging needs. This study may result in opportunities for the social work profession to understand informal caregiving's impact on the most significantly marginalized percentage of its workforce. The findings showed that these participants feel invisible to the social work profession even though they feel that they provide the most significant social work and informal care for older adults. However, the social work profession and researchers have not addressed how juggling these roles increases caregiver burden, employee burnout, or other long-term issues FMSWs experience while in their aging process. Participants were asked if they are better equipped to deal with the additional informal caregiving responsibilities and whether having those coping skills helps them to mitigate their rates of stress, burnout, and other consequences while they manage both roles and later as they age.

Theoretical and Conceptual Framework

I used Sieber's (1974) role spillover theory (RST) and Carmichael and Ercolani's (2016) cumulative (dis)advantage (CDAT) theory as the investigative framework in studying how FMSWs working full-time and providing informal care to an older loved one manage their dual roles and deal with any negative spillover that may occur between the roles. The intent of choosing RST and CDAT as the framework was to ascertain the types and intensity of role spillover when inhabiting these roles simultaneously and the long-term effects on participants' aging planning and process.

Previous researchers addressed only the relationship between these two roles. Together these two roles cause more significant stress, financial loss, health issues, loss of work opportunities, and family distress (Bakker & Demerouti, 2013). At the same time, for some FMSWs the combination of roles and spillover between roles can create a greater sense of caregiver satisfaction and resiliency (Bakker & Demerouti, 2013; Carton & Ungureanu, 2018; Geurts & Demerouti, 2002), but there was no indication if these feelings of resiliency offset the negative experiences particularly around long-term health and financial outcomes. The third research question in the current project study addressed the literature gap regarding the long-term consequences of FMSWs over their lifetime when simultaneously providing informal care for an older adult.

The literature on role theory included studies on the costs of role integration and role segmentation regarding issues of stress, work satisfaction, and health and well-being (Carton & Ungureanu, 2018; Edwards & Rothbard, 1999; Greenhaus & Powell; 2003, Kossek et al., 2006; Kreiner et al., 2006). Theorists who studied multiple role management literature highlighted the transition strategies, including role segmentation, where people try to keep their role boundaries distinct and develop strategies to create a space between the roles so that when they enter one role, there is no connection to other roles (Ramarajan, 2014; Reyt & Wiesenfeld, 2015).

Theorists did not provide any information about the processes that people with multiple roles use to create a place for themselves. Theorists did not address the struggle of FMSWs to maintain, enlarge, or negotiate all of their roles and responsibilities at a given period. There was also insufficient understanding of how knowledge and other elements are transferred from one role to other roles. Other role theorists focused on micro role transitions with a role boundary framework and addressed role boundary creation, maintenance, and role crossing (Ashforth, Kreiner, & Fugate, 2000; Kreiner et al., 2000; Nippert-Eng, 1996). Ashforth et al. (2000) provided two critical concepts to their role boundary theory and determined that the process of micro role transitions is flexible and permeable. Other studies focused on theories that address work–life role management (Cohen et al., 2009; Greenhaus & Powell, 2003; Rothbard et al., 2005). Several role theorists such as Bakker and Demerouti (2013) and Carton and Ungureanu (2018) addressed role boundary and role identity, but they did not focus on the long-term impact of carrying these two roles when the potential for role spillover is high and the participants perceive that their role boundaries are permeable but not necessarily flexible.

The focus of role theory literature regarding caregiving for older people is on how people incorporate the informal caregiving role at different stages in their lives and for what reasons (Bakker & Demerouti, 2013; Carton & Ungureanu, 2018; Geurts & Demerouti, 2002; Greenhaus & Powell, 2003). However, most researchers focused on the conflicts and choices that emerge when caregiving responsibilities and work obligations coincide (Moen et al., 2008). Although role theory researchers provided the groundwork for understanding how people with multiple roles manage their roles and the domains within knowledge flows between the roles, there was little qualitative research addressing the dynamic relationship that occurs when aspects of the roles infiltrate each other, specifically between the role as an FMSW and the caregiving role (Bakker & Demerouti, 2013; Carmichael & Ercolani, 2016; Carton & Ungureanu, 2018; Greenhaus & Powell, 2003; Moen et al., 2008). There was little evidence of how professionals who provide informal caregiving simultaneously move between these roles and the strategies they use to manage multiple roles. In this project study, I explored positive and negative knowledge, feelings, well-being, and outcomes when role spillover occurs (see Bakker & Demerouti, 2013; Carton & Ungureanu, 2018, p. 438; Greenhaus & Powell; 2003, Sieber, 1974).

Similarly, although social science researchers provided a limited number of informal caregiver narratives about caregiving, employment, and family dynamics at a specific moment in time, they did not capture the impact caregiving has on the caregivers who work full-time. Also, role theorists did not provide a longitudinal picture of the ways that informal caregiving and employment histories grow, merge, impact, and intertwine throughout a lifetime, and can impact the future well-being of caregivers, even after the caregiving is over or after the caregiver retires (Carmichael & Ercolani, 2016).

Role Spillover Theory

I used RST to understand the immediate and long-term impact of informal caregiving for FMSWs (see Bakker & Demerouti, 2013; Carton & Ungureanu, 2018; Geurts & Demerouti, 2002; Greenhaus & Powell, 2003; Peng et al., 2019; Sieber, 1974). RST is a model that addresses how these two roles intersect. Informal caregiving and working as an FMSW can impact current and long-term well-being, and researchers have not examined these scenarios. A gap existed in the literature regarding whether informal caregiving impacts social workers' trajectory in their professional career and retirement planning.

The theorists who developed the personality enrichment model focused on how work impacts family life and how family life affects work. Zedeck (1992) found that there are positive correlates between life satisfaction and work satisfaction. Pleck (1977) focused on role theory and how men experience more spillover from their work roles into their family role while women (who provide more informal caregiving than men) experience more spillover from their family role into their work roles.

Within role theory literature, role spillover can be positive, negative, or both (Linville, 1987; Repetti, 1987). Positive spillover results in feelings of satisfaction, resiliency, and knowledge, which spreads to the other role and creates an overall sense of satisfaction across all roles (Stephens et al., 1997). Negative spillover often results in stress, burnout, psychological distress, and depression, which can spread across all roles causing an overall sense of failure, distress, or anxiety (Stephens et al., 1997). Negative role spillover results from the transfer of stress, anxiety, and other emotions from one role domain (e.g., work) to another role domain (e.g., informal caregiving), while positive role spillover results in a transfer of resiliency, satisfaction, and competency (Peng et al., 2019).

RST emerged from the social role theory that emerged during the 1980s to study the differences between genders and social behaviors (Eagly et al., 2000). Edwards and Rothbard (2000) studied the RST as it related to caregiving and found a strong relationship between work and family life and that if adverse reactions and feelings such as exhaustion travel from one role to another, it would be labeled a work-family conflict signaling incompatibility. For example, if the tiredness generates similarities between these two roles, it would then be considered a negative work-to-family spillover (Rantanen, 2008). Greenhaus and Powell (2006) identified two types of spillover based on these categories, including affective and instrumental work–family spillover. Affective work–family spillover occurs when the participants indicate that they bring work-related moods or attitudes to the other roles in their family lives, such as being a caregiver for an older loved one (Greenhaus & Powell, 2006).

Researchers used RST to focus on the current plight of older informal caregivers and their impact on the other roles that they inhabit (Iwata & Horiguchi, 2016). For example, role theorists described how caregivers who also work full-time are at greater risk for role strain (Iwata & Horiguchi, 2016). Role strain occurs when juggling family roles and nonfamily roles on an ongoing basis (Iwata & Horiguchi, 2016; Lee et al., 2015; Rozario et al., 2004). Although role theories focus on the impact between roles, the current study focused on why female informal caregivers who also work outside the home accumulate more negative consequences across their life span and future aging process (Lee et al., 2015).

RST was one of the frameworks I used to discuss the impact of managing these two roles simultaneously. RST theorists described how the roles often infiltrate or intersect each other positively but do not mitigate most of the negative aspects also encountered (Stephens et al., 1997). Linville (1987) concluded that the role spillover stress and satisfaction from within one role is not always compartmentalized and often crosses over into other role domains. Given the close relationship of the types of work done as a social worker and an informal caregiver, the boundaries between these roles are often poorly defined. It often happens that "experiences, thoughts, and feelings in one role to spill over and color the experiences, thoughts, and feelings in another role" (Stephens et al., 1997, p. 37). Therefore, role spillover is bidirectional, and any experiences that a person has in their roles potentially influence the capabilities, moods, feelings, and emotions in other roles (Bolger et al., 1989; Linville, 1987; Repetti, 1987).

Cumulative (Dis)advantage Theory

CDAT (Carmichael & Ercolani, 2016) was the other theoretical framework used for this project. I used the CADT to identify financial stability or other nonpsychological or social issues that impact a person's current and future financial security, health, and aging success. CDAT was an additional lens to understand how FMSWs who have accumulated disadvantages due to misogyny, racism, heterosexism, classism, disability, unequal pay, and fewer promotional opportunities accumulate further disadvantages later in their life as a result of additional informal caregiver responsibilities throughout their professional and personal lives (see Dahl et al., 2015; Sanchez-Moreno et al., 2015)

CDAT (Carmichael & Ercolani, 2016) captures the interconnected histories between how employment and informal caregiving experiences over time impact people as they age while considering the intersection of gender and social constructs. CDAT is a life-course model that addresses the impact of early life influences and may lead to disparate tracks later in life. CDAT theorists also provide the framework for understanding why some informal caregivers, often women, people of Color, and LGBTQ+ people, face more significant poverty levels throughout their adult lives (Carmichael & Ercolani, 2016; Lee et al., 2015). As a life-course model, CDAT means that reduced access to resources in early life can create poorer outcomes in later life due to a lack of decent health care, access to education, safe housing, and proper nutrition (Lee et al., 2015). Cumulative inequality or disadvantage theory links the lack of access throughout a person's life to unequal outcomes (Quesnel-Vallee et al., 2016). CDAT shows that a person's socioeconomic status is related to lifelong accumulations of disadvantages. CDAT theorists also show how inequalities in access to health, wealth, and other types of resources throughout a person's lifetime result in inequality in old age (Quesnel-Vallee et al., 2016).

The CDAT framework (Carmichael & Ercolani, 2016) helped me understand whether adding the role of informal caregiver placed the participants at a higher risk for poverty or other catastrophic problems throughout their lifetimes (see Lee et al., 2015; Wakabayashi & Donato, 2006). Women's financial and health status deteriorates when they take on elder caregiver roles due to increased withdrawal from the workforce, less opportunity to be upwardly mobile, increased out-of-pocket expenses for caregiving costs, and a decline in their health and well-being (Lee et al., 2015, Lilly et al., 2007; Wakabayashi & Donato, 2006). Social workers who are primarily middle income to low wage earners are more likely to experience cumulative disadvantages as their lower wages often result in the higher likelihood that they will leave the workforce and become full-time caregivers (Lee et al., 2015; Wakabayashi & Donato, 2006).

I conducted this project study to identify how the participants described positive and negative results, feelings, and experiences that transfer from one role to another while investigating if they feel that previous cumulative disadvantages they experienced as women throughout their earlier life spans. These disadvantages, including access to education, medical care, and financial security, impact the successful integration of work and caregiving roles. I explored FMSWs' experiences as employed social workers and informal caregivers, among the other roles they undertake. I also explored if these FMSWs experience role spillover and cumulative disadvantage due to their gender, race, or gender orientation and how it impacts their future retirement plans.

Review of Professional and Academic Literature Review

The following is a literature review regarding the need for care of older people, the status of informal care of older people in the United States, and the significant responsibilities that social workers undertake.

Aging Population in the United States

The aging population's increasing needs for additional informal care have highlighted the importance of meeting those needs and the stressors it creates with the caregiver (Dahl et al., 2015; Sanchez-Moreno et al., 2015; Wagaman et al., 2015). The number of older adults over 55 years old has increased by more than 274% from 1960 through 1994. Currently, people in the United States, who are fifty-five years and older, are subdivided in age cohorts (Statista, 2019), as shown in Table 1.

Table 1

Demographics of Aging – Male/Female

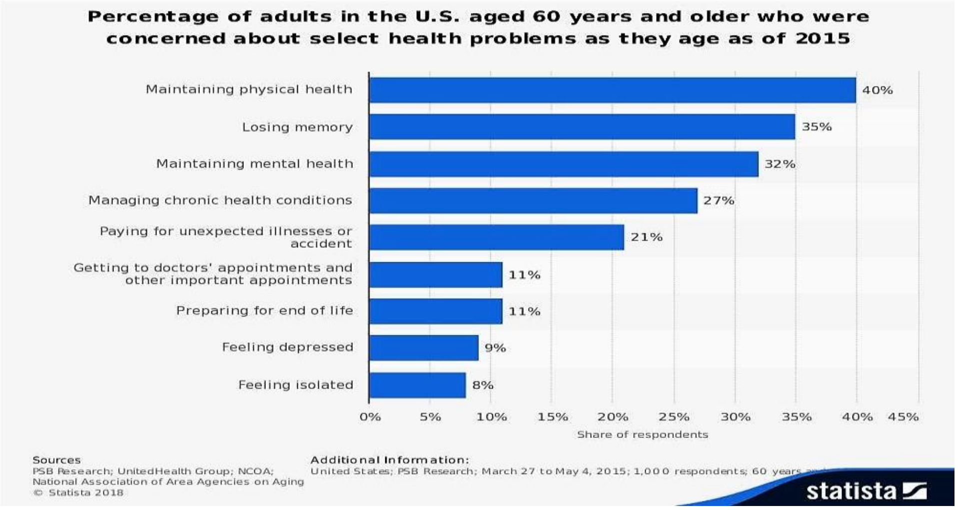
Age	Female	Male
55–59 years	11.31 million	10.70 million
60–64 years	10.43 million	9.56 million
65–69 years	8.91 million	7.93 million
70–74 years	6.9 million	5.95 million
75–79 years	4.89 million	3.9 million
80–84 years	3.86 million	2.51 million
85 years +	4.19 million	2.28 million

Although the older populations (65 years and older) grew by 100%, the entire U.S. population grew by only 45% (U.S. Census Bureau, APS PUMS, 2018). The oldest (85+) cohort will number 19 million in 2050, making them 24% of older Americans and 5% of all Americans (U.S. Census Bureau, APS PUMS, 2018). Currently, 1 out of 10 older adults is non-White and, by 2050, this rate will change to at least 2 in 10, while the proportion of Hispanic/Latino older people will grow from 4% to 16% in the same period (U.S. Census Bureau, APS PUMS, 2018).

The U.S. Census Bureau, APS PUMS (2018) also identified older adults' primary concerns as they age. Figure 2 indicates the top nine concerns that adults over 60 years of age have: deteriorating physical health, memory loss, increasing mental health issues, increasing chronic health conditions, financial insecurity, inability to keep up with medical care appointments, and other out of the home appointments, preparing for the end of life, increased feelings of depression; and, finally feeling isolated. Figure 1 shows the percentages of older adults as of 2015 (Statista, 2019).

Figure 1

Percentage of Adults in the U.S. aged 60+ Who Are Concerned about Health Issues



According to the U.S. Census Bureau, APS PUMS (2018), the poverty rate for people under 65 is 15%. This rate decreases to 11% for the 65–74 year olds U.S. Census Bureau, APS PUMS (2018),. As this cohort ages and their financial resources run low, the poverty rate increases from 11% to 16% for those over 75 years old (U.S. Census Bureau, APS PUMS, 2018). Aging women at every age level have higher poverty rates than men (AARP, 2018). It is important to note that 34% of all caregivers in the United States are over 65 years old (AARP, 2018; National Alliance for Caregiving, 2019), meaning that older women provide over 30% of all caregiving, potentially impacting their aging process.

Informal Elder Caregiving

A family or informal caregiver is an unpaid person, usually a family member or friend, who assists aging neighbors, friends, or loved ones with their daily living activities or medical/financial care (Schulz & Eden, 2016). The role of caregiving and the trajectory of care vary for each person (Gitlin & Wolff, 2011; Schulz & Eden, 2016). Informal caregiving becomes more complex, time-consuming, and intense because people live longer with more significant comorbidities (Schulz & Eden, 2016).

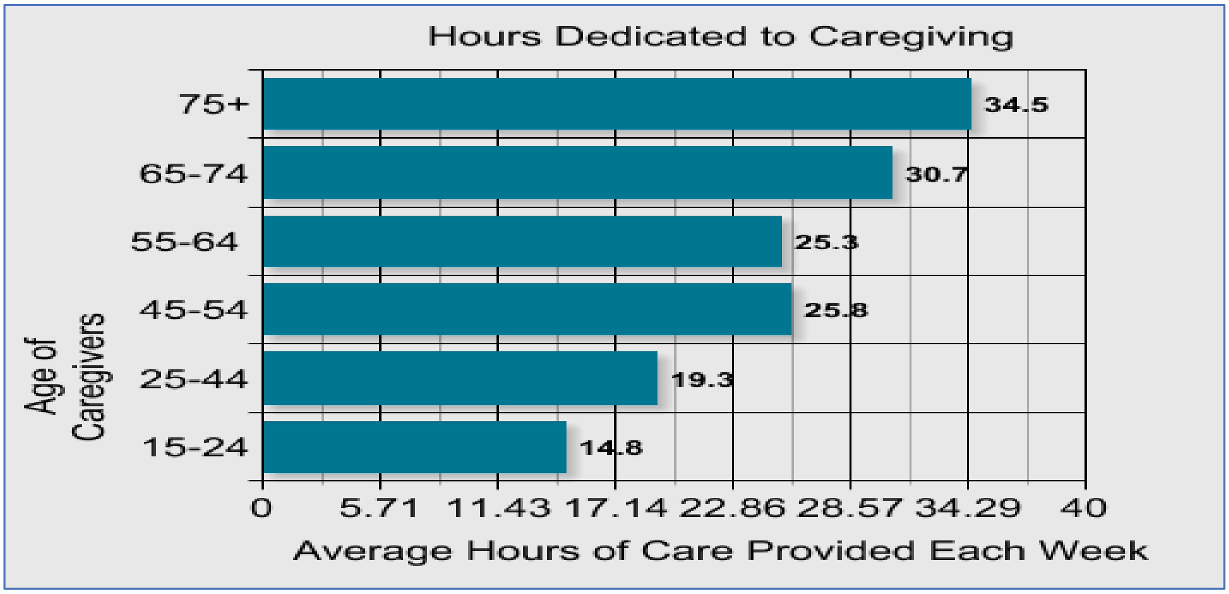
Other factors impact a caregiver's resilience or stress levels, such as their socioeconomic status, societal stereotypes and bias, length of being a caregiver, and other roles they maintain (Gitlin & Wolff, 2011; Schulz & Eden, 2016). Schulz and Eden (2016) focused on an aging population with cancer and their caregivers in which the care recipients usually experienced short and episodic but intense periods of disability; Schulz and Eden (2016) found the caregiver role may ebb and flow over time.

An informal caregiver works across multiple settings, depending on their loved one's location, and usually supports long and ongoing medical visits, lab visits, hospital stays, and rehabilitation admissions/discharges. Schulz and Eden (2016) noted that informal caregivers provide a range of assistance from helping to make and attending medical appointments (60.5%); medication management and assistance with medical procedures such as injections (48.6%); chores (44%); activities of daily living including bathing, dressing, toileting, ambulating, and eating (38.4%); insurance requirements (33.6%); special dietary needs (27.4%); and transportation needs (23%). Informal caregivers work across many settings outside of the home, such as providing care to older loved ones in nursing homes or hospice settings for end-of-life care and support (Schulz & Eden, 2016).

These types of caregiving ups and downs, which include the informal caregiver's support and the declining health and death of the older loved one, affect all aspects of an informal caregiver, including their health, well-being, and work–life–family balance (Peacock et al., 2014). Figure 2 shows the number of caregivers providing these services with little to no professional training.

Figure 2

Number of Informal Care Hours Worked by a Caregiver's Age Each Week



The number of weekly caregiving hours by age of caregiver shows the amount of informal caregiving is equivalent to a job somewhere between what is considered part-time and full-time in the paid workforce.

Value of Caregiving

The value of informal caregiving services is staggering. According to AARP (2018), in 2017 over 41 million informal family caregivers provided over 34 billion hours of care at a cost of 72 billion dollars in unfunded wages. Since 2013 the value of unpaid caregiving eclipsed the value of professional care plus the entire amount spent by Medicaid in that same year (AARP, 2018). AARP (2018) reported that in 2013 the value of informal caregiving was almost identical to Walmart's sales that year, which were 477 billion dollars.

There are 34.2 million Americans who provide informal and accessible care to an adult age 50 or older (National Alliance for Caregiving, 2019; AARP, 2018), and the numbers are increasing. About 75% of all caregivers are women who often spend as much as 50% more time providing care than their male counterparts (National Institute on Aging, 2016). Most caregivers are middle-age women juggling marriages, raising children, and working full-time (AARP, 2018). Hausler et al. (2017) researched health care workers and informal caregiving by breaking up caregivers into two categories relevant to the current study. The first category included workers who also provide informal care to aging family members and are called double-duty caregivers because they work professionally and provide informal care for an aging loved one (Hausler et al., 2017). The second cohort was those who work full-time and are sandwiched between providing informal care for two generations that usually include their children and their aging parents or siblings and are called triple-duty caregivers (Hausler et al., 2017).

Additional studies indicated that most caregivers of aging people spend at least 10% of their annual incomes on their caregiving role, with more than 34% needing to dip into their savings to cover these additional caregiving costs (AARP, 2018; Hausler et al., 2017; National Alliance for Caregiving, 2019; Schulz & Eden, 2016). Often the caregivers who end up losing their jobs, reducing their hours, or taking full leave lose 48% of their current earnings and an untold amount of potential earnings (Aumann et al., 2010; Damaske & Frech, 2016). On top of the extreme disparity in caregiving provision by women compared to men, women experience additional disadvantages. Women's poverty rate hovers around 16%, while it remains steady for men at 9%, and women do not have income equity with men (National Alliance for Caregiving, 2019).

Caregiver Burden (Stress) and Caregiver Satisfaction (Resilience)

Although the literature is replete with qualitative studies indicating that caregivers often feel a sense of satisfaction from helping their loved ones, there is insufficient evidence that caregiver satisfaction mitigates the stressors that caregivers face when providing support for an older family member (Bohlmann & Zacher, 2019; DePasquale et al., 2017). Researchers showed that caregivers more often than not experience high rates of psychological distress and caregiver burden that negatively impact their health and well-being (Boscarino et al., 2004; Brouwer et al., 2005; Cohen et al., 2009; Hansen & Slagsvold, 2015; Miyashita et al., 2009). My review of the literature indicated substantial evidence that social workers and informal caregivers experience high rates of distress, burden, and poor health outcomes. There was also extensive evidence that both roles are largely performed by women, yet there was little information regarding the deleterious effects that adding the role of informal caregiving has on female social workers when they simultaneously provide informal care for older loved ones (Camacho, 2016; Giebel et al., 2021, Green, 2009; Hempling, 2009).

Although there was a great deal of research documenting that social workers and family caregivers are at high risk for burnout, psychological distress, and compassion fatigue, there was less research on how social workers cope when adding a family caregiver's role to their formal employment responsiblities. Stack (2012) defined *coping* (related to people with multiple roles) as the ongoing adaptation of a person's actions, thoughts, and moods necessary to manage multiple demands in each role when thee person's needs are often greater than the resources available. *Burnout* is a syndrome of emotional fatigue and a changed worldview (i.e., cynicism) that frequently occurs within the human services profession and caregiving (Maslach & Jackson, 1985). *Psychological distress* includes feelings and symptoms of anxiety, powerlessness, depression, and anger resulting from an unresolved or ongoing stressor (Stack, 2012).

More recent literature indicated that U.S. caregivers provided an average of 92 hours per month of informal caregiving and increased financial burdens, which have resulted in job losses for about 15% of these caregivers who were previously working (Abdollahpour et al., 2018; Brodaty & Donkin, 2009; Langa et al., 2001). Over the past century, life expectancy rates have substantially increased due to advancements in medical care, technology, nutrition, and other factors (Murray et al., 2015; Stewart et al., 2013; Weisman de Mamani et al., 2017). With higher life expectancy rates come increases in diseases, illnesses, and conditions that are considered age related and often impact an older person’s ability to independently complete their daily living skills or their instrumental daily living skills (Karel et al., 2012; Alzheimer’s Association, Thies, & Bleiler, 2013). Although there is ample literature on caregiving for aging people as a general factor in millions of caregivers’ lives, researchers have not addressed informal caregiving’s impact within the social work community.

Hilbrecht et al. (2017) implemented a work–life model that focused on a community of caregivers residing in three large urban areas in Canada. Hilbrecht et al. explored the connection between the number of hours spent on caregiving and feelings of well-being associated with the work–life fit. Hilbrecht et al. (2017) found that the more hours an employed caregiver provided to their loved one, the overall health and well-being is more likely to decrease, principally if the informal caregivers do not have time for other relationships and obligations in the other areas of their lives, and they perceive that their finances are inadequate. According to the National Alliance for Caregiving (2019), over 60% of informal caregivers also are employed full-time. According to Duxbury et al. (2011) and Sinha (2013), having multiple roles puts caregiver employees at higher risk for work, personal family, and social conflicts and distress when the caregiver role spreads into their work life or affects their family’s well-being.

One research gap was the experiences, attributes, and emotions experienced in a role spread into other roles that informal caregivers perform. For example, given the complex and challenging roles that social workers perform along with additional stressors as a family caregiver, it is not clear what elements of the social worker role or caregiver role might “mediate or moderate more positive cross-role relationships” (Greenhaus & Powell, 2006, p. 79). Similarly, there are less than a handful of articles that describe the issues that social workers face when caring for an aging adult while working as a full-time social worker (Camacho, 2016; Green, 2009; Hempling, 2009). Social work researchers provide that both social workers and informal (unpaid family) caregivers are at high risk of burnout, psychological distress, exposure to compassion fatigue, and other multiple stressors (Harker et al., 2016; Hilbrecht et al., 2017).

Harker et al. (2016) conclude that human service workers experience frequent exposure to the trauma stories of the most vulnerable, abused, and disenfranchised communities. As a result, those social workers regularly exposed to vicarious trauma from their client’s stories are at a higher risk of experiencing “psychological distress, burnout, and secondary traumatic stress” (Mor Barak et al., 2001). In a meta-analysis of 25 articles, Mor Barak et al. (2001) focused on the higher rates of job turnover related to the relationship between social worker demographics, personal insights, and the conditions and environment they experience at work. Their review found burnout, job dissatisfaction, availability of employment alternatives, inadequate organizational or supervisory support, and little social support rate as the highest predictors of job turnover (Mor Barak et al., 2001). It is noticeable that their literature review only addressed work-related stressors and did not focus on work/life balance or any personal issues that impact workers outside the scope of their job (Mor Barak et al., 2001). This literature review reinforces how stressful the profession is when working with traumatized and vulnerable clients.

Reviewing the Role of Informal Elder Caregiving

Researchers who focus on elder caregiving literature indicates that being an informal caregiver to a disabled family member often creates caregiver burdens, including high levels of psychological stress resulting in poor psychosocial outcomes, including depression and distress (Schulz et al., 1990; Wright et al., 1993; Zarit, 1989). Researchers also show that some informal caregivers, even those who have full-time jobs, can develop a sense of resiliency and satisfaction (Kinney et al., 1995; Lawton et al., 1989; Stephens et al., 1997). Yet no data exists indicating this resiliency mitigates any obstacles or eliminates long-term negative emotions and outcomes.

Caregiver Role: Demographics and Tasks

A central theme throughout this study is that as people live longer and need additional care, the majority of that care is given by informal caregivers who often experience a range of issues when they incorporate the role of informal caregiver amongst the other multiple roles they wear, such as employee, spouse, child, or parent. Feinberg (2019) studied informal caregivers who also work while caregiving in 2014. She found that 60% of the informal caregivers for aging adults also worked for pay along with their caregiver role (Feinberg, 2019). On average more than 25% of all full-time workers provide at least 21 hours of unpaid informal elder care. The rates of fully employed caregivers rise, and the Millennial generation is currently providing more informal elder care than any previous generation (Feinberg, 2019; National Alliance of Caregiving (2019) & AARP, (2018).

Caregiver Role: Age

Per Flinn (2018), around 40 million American people currently support an informal or family caregiver. The most recent caregiver study completed by the National Association of Caregiving (2019) and AARP (2018) shows that the average informal caregiver a White female around the age of 49 years old who is taking care of her 69-year-old White mother. As the Baby Boomer generation (people born between 1946-1964) continue to age and need care, the Millennial generation (people born between 1981-1996) has become the fastest-growing informal caregiver segment for their aging family members.

As of 2018, one in four Millennials provides informal care for a family member (Flinn, 2018). 18 to 24-year-olds make up 35% of the Millennial caregivers, and those between the ages of 25-29 years old provide 31% of informal care, while those between 30-34 years old provide 34% of their older loved ones’ needs (Flinn, 2018). It is also important to note that caregivers’ millennial generation is the most diverse informal caregiver cohort (Flinn, 2018; National Alliance of Caregiving, 2019 & AARP, 2018).

Caregiver Role: Gender

Women, to date, provide 85% of the caregiving in the United States, including informal care for an elder loved one, and spent over 50% more time than men providing informal eldercare (AARP, 2018; Family Caregiver Alliance, 2019). Higher hour informal caregivers who spend more than 21 hours per week are four times likely to be caring for a male spouse or partner (Family Caregiver Alliance, 2019). After the age of 75 years or higher, spouses equally do the caregiving responsibilities. Finally, women are primarily responsible for managing the most challenging and complex tasks such as helping with their activities of daily living, including bathing, dressing, toileting, and eating (36%), while men help more with financial issues, arranging care needs, and other less burdensome chores (24%) (AARP, 2018; Family Caregiver Alliance, 2019, para. 5; National Alliance of Caregiving, 2019). Globally, women experience a greater impact from the COVID-19 pandemic (Gausman & Langer, 2020). As the COVID-19 pandemic enters a second year, it is vital that researchers develop a “gender lens” (Gausman & Langer, 2020, pg. 466) to understand how the policies, distribution of resources and actions that are being implemented to deal with the pandemic do not create more harm to disadvantaged and “resource-poor” communities such as women, people of color and the LGBT communities (Gausman & Langer, 2020, pg. 466).

Caregiver: The African American Experience

African American caregivers develop significantly higher caregiver burden levels from their informal elder caregiving roles and spend more time than their White or Asian-American peers (AARP, 2018; Family Caregiver Alliance, 2019). African Americans spend about 30 hours per week on informal caregiving, 57% more than their White and Asian counterparts (AARP, 2018). Over 50% of African American caregivers provide care for more than one older family member or friend and care for their children and grandchildren (Epps et al., 2019). Since women make up the largest cohort of caregivers, it should be noted that at least 66% of all African American female caregivers work on a full or part-time basis. This study included participants who increased this researcher's understanding of women of color's unique plight who wear multiple roles in their work and home lives and caregiving roles. It is interesting to note that African American caregivers often report greater caregiver satisfaction than White or Asian caregivers, and they indicated that caregiving also provides them with a more appreciative and positive outlook on life (Epps et al., 2019; Roth et al., 2015). African American caregivers are more resourceful, have more "positive cognitions," and experience greater psychological well-being than their White counterparts (Bekhet, 2015; Epps et al., 2019, p. 20).

Conversely, although African American caregivers perceive their caregiver role through a positive lens, they are at high risk for negative employment consequences for multiple reasons. Due to multiple factors, including racism and unequal access to appropriate education, housing, nutrition, and employment throughout their life span, African American caregivers account for only about 12.3% of all persons employed in the United States (over the age of 16 years old) with only 9.6% in "management or professional positions while 16.6% are in production, service and transportation occupations (Hastert et al., 2020, p. 6). With fewer African Americans in leadership, executive, and professional positions, they are often less likely to receive more significant benefits under employer-provided benefits such as various long-term insurance options, vacation time, salary, and sick time (IWPR, 2016).

Caregiver: The Experiences in LatinX and Hispanic Communities

LatinX (formally called Latino and Latina) and Hispanic communities are most likely to age at home and less apt to utilize formal caregiving services as a result of multiple positive and negative factors that include their keen sense of family, distrust of others, and fear of professional caregivers, and a lack of resources to pay for professional support (Marques et al., 2017). The LatinX and Hispanic cultures stress close family relations and interdependence through family values taught throughout their lifetimes (Sabogal et al., 1987). According to the Family Caregiver Alliance's (2016) national survey, one-quarter of all caregivers are LatinX and Hispanic, and one-third of all LatinX and Hispanic households include at least one family member providing informal care for an aging adult. These caregivers provide about 32 hours of care for their aging loved one per week, while White caregivers provide 24 hours of weekly care (AARP, 2018).

This discrepancy is due to differing cultural values regarding taking care of aging family members and lesser resources to work with, meaning lower-income families need to provide the care themselves (National Hispanic Council on Aging, 2017). The literature does not clearly show whether LatinX and Hispanic caregivers find their caregiving role more satisfying or experiencing higher levels of depression and other psychological and health disorders. Similar to African American caregivers, the answer may be that both occur. Many studies have shown that LatinX and Hispanic caregivers, specifically Mexican informal spousal caregivers, have higher adverse outcomes than Caucasian, Japanese, and African caregivers (Boscarino et al., 2004). Due to a more significant accumulation of disadvantages across their life span, LatinX and Hispanic caregivers often receive lower education levels, lower incomes, and often predominate lower-wage occupations (Coon et al., 2004). While they do experience a great sense of caregiver satisfaction regarding the actual caregiving activities, they are more prone to adverse outcomes relating to their lower income levels, less available work supports and benefits as well as experiencing both historical and current accumulation of disadvantages due to racism and other forms of oppression (Champine et al., 2019).

Caregiver: The Lesbian, Gay, Bisexual, and Transgender Experience

Until the beginning of this century, while there has been a great deal of literature on informal caregivers' experiences, very little research focused on the caregiving issues experienced by the LGBTQ+ communities (Jablonski et al., 2013; McGovern, 2014). Before changes were made under the Obama administration in 2015, none of the national research centers studied issues relating to LGBTQ+ caregiving communities (National Alliance of Caregiving, 2019). To date, the census still has not yet included any questions regarding one's sexual orientation or gender identity. Due to historic and life-long heterosexism, LGBTQ+ caregivers, are less trusting of outside help, so they are more likely to provide more complex medical tasks usually performed by nurses such as giving medications or injections, food preparation for feeding tubes or specific diets, open wound care, and other complex tasks (Anderson & Flatt, 2018).

Current LGBTQ+ aging adults grew up at a time when their identity or preference were considered criminal or mentally ill. As a result, LGBTQ+ communities did not have equal civil rights, which included accessing one’s partner’s health care, along with the other legal rights that exist for heterosexual individuals and couples such as getting married, as well as laws to protect them against discrimination or violence (Anderson & Flatt, 2018). Since marriage among LGBTQ+ communities only became the law within the last decade, many older adults do not have family members, children, or others that typically provide informal care. As a result of historical and current heterosexism, LGBTQ+ people, in general, report high levels of financial insecurity and poor health outcomes, which already impacts their well-being and future planning, so that LGBTQ+ elder caregivers are already at an extreme disadvantage before any caregiving or adverse caregiving outcomes start (Shiu, Chengshi, Fredriksen-Goldsen, 2016)

Per the National Alliance and AARP (2015) survey, 10% of the caregiving population identify as Lesbian, Gay, Bisexual, or Transgender (non-binary). There are 3 million people over the age of 55 who identify as LGBTQ+. Within the LGBTQ+ community, gay men spend more time than lesbians, bisexuals, or transgender in providing elder caregiving (41 hours per week for gay men versus 29 hours for lesbians. LGBTQ+ caregivers are more concerned about earning a livable wage, experiencing loneliness as they age, fearing deteriorating physical health concerns, and worrying about their inability to care for themselves, or having anybody take care of them as they age (Shiu, Chengshi, Fredriksen-Goldsen, 2016). LGBTQ+ aging adults who are also largely informal caregivers for other aging adults are twice as likely to be unmarried, reside alone, and three to four times less likely to have children. (MetLife, 2010). LGBTQ+ caregivers, like the LatinX and African American communities, experience multiple barriers to services and supports, lower rates of higher education, high salaried employment, ongoing and sufficient health care while dealing with systemic, historical, societal oppression, and violence. These factors contribute to a greater accumulation of disadvantages for the LGBTQ+ communities

The Value of Women’s Worth and Social Work

Although there have been substantial changes in women’s employment options, it remains unequal to men, unevenly dispersed, stalled, and even lower for non-White women (Boushey, 2008; England, 2010; Lee et al., 2015). Damaske and Frech (2016) identified significant inequality in women’s employment experiences throughout their adult life. They found that women have only two clear pathways to consistent full-time work, three routes to find part-time employment, and only one pathway to unfunded labor (Damaske & Frech, 2016). Although most women need full-time work for their sustainability, about 10 percent could not find paid work (Damaske & Frech, 2016). The study concluded that women face the long-term influence of work-family conflict and early socioeconomic advantages and disadvantages, notably women of Color, transwomen, and lesbians (Damaske & Frech, 2016). Women’s careers and work outside the home are impacted by “race, poverty, educational attainment, and early life and family characteristics” (p. 366). Women’s employment trajectories are impacted by available resources, personal drive, and systemic or changing social environments (Damaske & Frech, 2016; Milgrom & Petersen, 2006). By understanding their life course trajectory and the cumulative advantages/disadvantages experienced over time, women are tracked at an early age into work pathways based on historical and systemic sexism, classism, racism, heterosexism, and work-family constraints (Damaske, 2011).

Social Workers: Uncovering Common Themes Relating to Work-Related Stress

Since women are the largest cohort of social workers and caregivers, their work and financial worth is consistently undervalued while maintaining the highest adverse health and financial outcomes. The social work profession and the policymakers must work harder to eliminate gender discrimination, unequal pay, and the lack of access to opportunities. If women are to gain full pay and employment equity with men while decreasing their current increased risk for adverse health outcomes, distress, and burnout, there must be some form of consensus amongst labor and professional policymakers on how to address these growing disparities. (Lyons et al., 2015; Versey, 2017). While the numbers of women entering the job market are increasing, at the same time, many women are being left out or not climbing the ladder of success as the need for elder caregiving has grown at its fastest rate (Versey, 2017).

Since the caregiving role is fluid, often unanticipated, and usually happens more than once and for multiple recipients creates even more significant psychological distress, financial insecurity, and poorer health outcomes even after the caregiving is no longer required (Musil et al., 2013). Over one-half of all Americans are women between the ages of 40-50 years old and already manage multiple caregiving roles (Musil et al., 2013). Similarly, about 85% of all professional (paid) caregivers are also female, meaning that most adult working females in the United States also work and wear multiple informal caregiver roles (Versey, 2017). It is critically necessary for social work research to understand the obstacles that over 51% of the population face at home and in the workplace (Parker & Patten, 2013; Versey, 2017).

The current literature is replete with quantitative studies that focus on social work burnout, social work distress, caseload size, type and frequency of supervision, vicarious trauma, and other personal factors related to specific types of social work (Dekel & Baum, 2009). Dekel and Baum (2009) studied the impact of “shared traumatic reality” (p. 1927), where social workers provide support to clients in cases when both the client and the social worker have experienced the same traumatic event and reside within the same community. Dekel and Baum (2009) demonstrate that when the same event impacts a social worker and their client, the phenomenon of shared trauma occurs from events such as terrorism, wars, natural disasters, and pandemics. Often, in this disaster situation, social workers experience initial trauma from their personal experience along with the secondary trauma they may experience from their client’s experiences (Dekel & Baum, 2009). Unfortunately, before Dekel and Baum’s (2009) study, there was scant research on this phenomenon in the United States until 2011. Hopefully, due to the COVID-19 pandemic, researchers will be able to expand on their research over the next year.

Similarly, there is a literature gap regarding shared traumatic events such as caregiving for a dying spouse or relative. Although Dekel & Baum (2009) only addressed social workers' well-being around terrorism and natural disasters, their work is relevant to this capstone project. The participants in this project experienced direct trauma in their informal caregiver role while facing a high risk of repeated exposure to vicarious trauma and collective trauma from the current COVID-19 pandemic. (Abdollahpour et al., 2018; Brodaty & Donkin, 2009; Langa et al., 2001).

The literature indicates that when healthcare professionals are experiencing a shared traumatic reality, they usually are primarily focused on their safety, family, personal obligations and cannot effectively assist clients until they put their affairs in order (Granot, 1992; Shamai & Ron, 2009). When there is collective trauma, a social worker who is also a primary, informal caregiver faces extreme stress and challenges, making it often impossible to completely resolve their caregiving responsibilities (Harker et al., 2016; Hilbrecht et al., 2017). Dekel and Baum (2009) conclude that informal caregiving can create a traumatic reality between the caregiver and their aging care receiver. They explore how the traumatic reality as a caregiving can and often will impact their social work role and relationship with their clients while reducing the social worker's ability to maintain proper self-care techniques and experience greater exposure to vicarious trauma, psychological distress, and burnout (Dekel & Baum, 2009).

Uncovering Themes: Dual Roles as Social Worker and Informal Caregiver

There are a handful of articles that address the issues of informal caregivers who are social work professionals. Green (2009), an African American, non-geriatric care social worker, published her personal experience of caring for her dying father. She describes both the attributes of being a social worker and how that helped advocate for her father and speak with the hospital/hospice staff. She also described herself as a “double-duty caregiver” who is a health-related professional and informal caregiver (Green, 2009; Ward-Griffin et al., 2005). Green also describes the negative feelings and experiences she encountered that impacted her professional work and caregiving abilities for her father and her children.

She describes how the lines between her role as a social worker and daughter began to merge (Green, 2009). She also described the mental and physical exhaustion she felt as a quadruple caregiver in that she provided care for her father, mother, children, and clients. Green indicated that while she was grateful to have the additional skill set of a social worker, she often found her emotional state of anxiety, anticipatory grief, and grueling daily schedule impacted her ability to remember and use her work skills with her father’s care (Green, 2009). This narrative is essential in identifying how informal caregiving impacted an African American social worker and represented the importance of using qualitative research designs to understand how social workers, even with appropriate skill sets, are positively and negatively impacted by informal caregiving.

Beckett's book, Lifting Our Voices is a qualitative study designed as a discovery-oriented, detailed investigation (see Hempling, 2009).

Per Hempling (2009), Beckett indicated that a narrative and qualitative design could get information about family caregiving and the relationship to one's personal and professional life that is not easily identified through quantitative methods. Beckett's study relies on her own experience, along with the experience of nine other social workers who are also informal caregivers (see Hempling, 2009). She used an interactive process that allowed for storytelling and narratives from the participants (see Hempling, 2009).

The final article that addressed the experience of a social worker, researcher, and informal caregiver by Camacho (2016) shares his personal caregiving story. Camacho (2016) concludes that these qualitative studies help eliminate the literature gap related to the emotional reactions perpetuated when one is an informal caregiver and a social worker. Camacho (2016) states that his caregiver research shows that informal caregiving took a toll on his psychological and physical well-being. Similarly, social workers also repeatedly listen to clients with trauma narratives, putting the social workers at risk for vicarious trauma reactions such as adverse emotional reactions, burnout, and other negative coping skills (Camacho, 2016).

This literature review provides relevant insights into understanding the multitude of factors that exist when informal caregivers also work outside their caregiving responsibilities. The literature review also highlighted how women have a much harder time negotiating both roles. This feminization of both of these roles means less money and respect for these women, which accumulate additional disadvantages over their life span, potentially causing more significant short and long-term adverse outcomes such as financial insecurity and poorer health outcomes. Studies have shown that in addressing these factors, it is imperative to understand how FMSW are already experiencing unequal access and have accumulated multiple disadvantages while juggling these multiple roles (Damaske & Frech, 2016; Milgrom & Petersen, 2006).

Summary

This capstone project was an action research (AR) design, meaning that the participants provided their knowledge about how they as FMSWs maintain these dual roles; and whether they have developed skills from their practice that helps reduce caregiver burden or stress or create an opportunity to reduce financial insecurity later in their lives. The goal was to uncover whether these women, an already marginalized population, are at a higher risk of immediate or future adverse outcomes, even within the social work profession. Conversely, the stakeholders also described that they also feel a sense of resiliency and skills development that is valuable and needs to be understood by professionals and other social workers who are also increasingly providing informal care for their older loved ones as well (Dahl et al., 2015; Sanchez-Moreno et al., 2015).

Section 2: Research Design and Data Collection

In this capstone research project, I focused on understanding how experienced FMSWs address their well-being and work–life balance when simultaneously providing informal care for an older loved one. This section includes data sources, participants, sampling strategy and instrumentation, data collection and analysis, and ethical procedures.

Research Method

Research Design

Although the initial research design included the use of two in-person focus groups, this approach became untenable when the COVID-19 pandemic began. As a result, I changed the research design to individual online interviews that included nine participants. Individual interviews with open-ended questions are acceptable qualitative research methods in which a researcher can obtain rich and descriptive experiences from the participants (Esterberg, 2002; Rabionet, 2011; Stephan et al., 2018). I used individual interviews with a narrative analysis to help the participants focus on the events and experiences that shaped their understanding of how they managed the roles of social worker and informal caregiver while also acknowledging that they feel invisible within the social work profession as well as within the world of work (see Aysola et al., 2018; Riessman, 2008). Researchers used narrative analysis to focus on reducing inequities in health care while helping health care systems retain a diverse workforce (Aysola et al., 2018). The use of narrative analysis enabled health care workers to describe which factors contributed to “inclusive work and learning environments and what can be done to improve inclusion within health care organizations” (Aysola et al., 2018, p. 1). The benefit of using online interviews includes eliciting a textured understanding of the participants’ individual experiences and perceptions within their specific conditions and situations (Stephan et al., 2018). A narrative inquiry highlights the everyday stories that participants experience as they live their lives (Aysola et al., 2018; Tytarenko, 2020).

Narrative analysis includes a greater focus on language form, social context, and audience than other approaches (Aysola et al., 2018; Tytarenko, 2020). Narrative analysis is continually evolving, and researchers need to understand the “benefits and institutional barriers of such a qualitative approach” (Tytarenko, 2020, p. 3). Qualitative researchers’ goals in using narrative research are to put forth thematic analysis that highlights individual agency, characteristics, and circumstances (Aysola et al., 2018; Tytarenko, 2020).

Allport (1942) confirmed that narratives help researchers understand complex topics in which little is known. Narrative approaches focus on the lived human experience as retold by each participant (Creswell & Poth, 2018). Narrative approaches are grounded in a social justice framework that often questions or challenges the dominant group’s viewpoint and practice standards (Fraser, 2004). Narrative approaches aim to concentrate the participant’s attention and story, but narrative analysis can be impacted by unintended and contradictory harms brought forth by the researcher’s power dynamic (Fraser, 2004; Riessman, 2008). The current study was approved by the Walden

University Institutional Review Board in 2019. The approval number for this study was 08- 04-20-0568854.

Participant Selection

Qualitative research relies on participants to provide accurate information (Lodico Spaulding & Volgtie, 2010). A sample size of nine FMSWs was selected. Data collection had to meet the saturation point when there was no new information or themes presented in the data (see Walker, 2011). Purposive sampling was the technique used to recruit nine participants. Selection criteria included employed FMSWs who provide informal care to an older loved one.

Recruitment Process

The recruitment process included posting invitation ads on several group pages on Facebook and LinkedIn. This process included posting ads on individual group sites that focused on caregivers and social workers. A convenience sampling method was used as a recruitment process that included finding members of the identified study population who were available to participate. Convenience sampling included the use of snowball sampling to provide access in an efficient and timely manner to members who did not use social media (see Naderifar et al., 2017).

Sample

The inclusion criteria required every participant to be a master’s-level female social worker in New York City and informal caregiver to an aging loved one. Nine participants were selected. Participant demographic questions were used because there was a diverse group of FMSWs involved in the study.

Procedure

The data collection process allowed the participants to present their experiences and knowledge while encouraging learning and developing knowledge to help create solutions or attention to the problem. The format of individual online interviews allowed for a greater variety of participants because they did not need to travel, and this data collectio method provided them with a safe alternative during the pandemic lockdown to provide “their opinions without being judged” (Krueger & Casey, 2014, p. 4). Qualitative interviews are used to collect and categorize the data into knowledge by creating categories and themes (Krueger & Casey, 2014). The interviews in the current study provided an awareness of the participants’ behaviors and potentially promoted change. Participants had the opportunity to share their perceptions, opinions, feelings, and experiences regarding their well-being, work–life balance, and roles as social workers and informal caregivers (see Krueger & Casey, 2014). The data obtained from the interviews included responses to open-ended questions while discussing topics that arose during the online interview sessions (see Njoku, 2015). The findings from this project study provided information about the participants’ experiences and behaviors and their insight and concerns, which may be useful for employers, policymakers, and schools of social work in addressing the practical issues and considerations that impact its diverse workforce.

Researcher Role

As the researcher, I tracked and reduced researcher bias, developed competency as a researcher, collected and analyzed the data, and presented the findings. Camacho (2016) found that social workers will often use their experiences to create knowledge or normalize a client's situation. Unlike other research methods focusing on objective and scientific approaches, as a qualitative action researcher I addressed participants' emotional reactions, which are intrinsically valuable and necessary (see Camacho, 2016). Action research also provides room for researchers' emotions and reactions to the participants' stories of pain, emotional trauma, previous violence issues, and other emotionally charged topics (Camacho, 2016).

People are assumed to have inherent bias and points of view, and researchers must be as transparent about bias throughout the research process (Stringer, 2013). When researchers do not acknowledge and address their bias or point of view, they can impact the participants, process, outcome, and goals (Stringer, 2013). As recommended by Lietz and Zayas (2010), I conducted an ongoing evaluation of bias to assess its potential impact on this project study.

All data were collected in a confidential manner. I did this by assigning numbers, letters, or pseudonyms to protect the participants (see Kaiser, 2009). All data forms, emails, texts, hard copies, and recordings were solely in my possession and locked in a file cabinet in my home office. All electronic files were password protected and were only available after completing a two-step password authentication process. All digital recordings were destroyed after completed and reviewed transcriptions were produced. All data, written records, transcription notes, and hard copies of the signed informed consent were placed in a secure cabinet and will be preserved for the length required by the United States Department of Health and Human Services, Office of Research Integrity (2006). The rule states that these materials cannot be discarded until 3 years after completing the study.

Analysis

My use of narrative analysis focused on how participants shared their stories. I transcribed and analyzed based on codes, categories, themes, and answers to the research questions as they related to the process, procedures, knowledge, and obstacles that were shared by the participants (see Stringer, 2013).

Summary

In this chapter, I described the research design and the changes that were necessitated by the COVID-19 pandemic, resulting in the use of online virtual interviews. Additionally, I described why narrative analysis helped me understand complex topics in which little was known or documented in the social science literature. In the next section, I discuss why I focused on this topic, present the research questions, describe how this project study created knowledge, and summarize the data that I collected, analyzed, and validated.

Section 3: Presentation of the Findings

This action research study began with my experiences as a full-time female social worker who provided informal caregiving to my mother. While supplying informal care for 5 years, I came across many colleagues in the same position. These colleagues stated that they felt invisible to their employers and the social work profession because no one offered any acknowledgment or recognition of their experience within the schools of social work, the profession, or the social work literature. Consequently, I decided to examine these issues by designing and completing this project study.

In trying to understand these women's experiences, I used two theoretical approaches. First, I chose RST (see Kanter, 1977; Pleck, 1977; Sieber, 1974) to determine whether there are positive and negative aspects of these roles that spill over into each other or different aspects of their lives, and also how that spillover affects their day-to-day lives and their well-being. I also selected CDAT (see Carmichael & Ercolani, 2016) to address whether there are differences in how these women accumulated advantages or disadvantages due to societal oppression based upon their socioeconomic status, gender identity, race, or color. Findings may initiate new conversations and understanding within the social work profession, among mental health employers, and among social welfare policymakers.

In this chapter, I address the three research questions and describe how the data were collected, analyzed, and validated.

RQ1: How do female, masters' level social workers (FMSWs) describe significant changes in their levels of stress, resiliency, or burnout at work or in their lives in the short-term and long-term due to juggling both roles?

RQ2: What types of skills, resources, or supports have FMSWs developed that can be used across their roles?

RQ3: In what ways do FMSWs increase their current feelings of burden or disadvantages or fear of future financial or health-related consequences due to their caregiving responsibilities while working full time?

Data Analysis Techniques

Individual interviews were conducted with nine participants. Participants had the opportunity to share their beliefs, opinions, feelings, and experiences regarding their well-being, work–life balance, and roles as social workers and informal caregivers in a 60–90-minute interview on a secure virtual platform at a time identified by each participant (see Krueger & Casey, 2014). The COVID-19 pandemic also affected the sample size. Potential participants were harder to reach because many people faced added responsibilities in their full-time social work position and informal caregiving role during the pandemic. In October 2020, I sent out social media invitations on my Facebook and LinkedIn pages; I also sent the same invitations to several social work and informal caregiving Facebook groups. Within 5 days, I had 28 responses, but 16 respondents did not meet the criteria because they were not female, they did not reside or work in New York City, they were not social workers, or they were not currently working or caring for an older loved one. However, by inviting participants to an online interview, I found a diverse range of candidates from all five boroughs of New York City. If this investigation process had required face-to-face focus groups, the likelihood of meeting with participants from New York City's outer boroughs, including Queens and Staten Island, would not have been as high due to the distance those participants would have had to travel (over 1.5 hours each way) to attend.

My communication strategy with each participant included a short introductory email that included the participant's invitation, and the consent form. I then reached out by phone to continue the discussion and to answer any additional questions the participant had. Once I secured a group of eligible candidates, I scheduled individual phone sessions with the first nine participants who had reached out to me and confirmed their interest in participating in the study. By the end of September 2020, I had spoken to each candidate and had set up an interview date and time. All of the interviews occurred over the weekend because participants preferred to meet on Saturday or Sunday. Each interview lasted 60–90 minutes, and I completed two to four interviews each weekend for three consecutive weeks.

While transcribing the data at the end of October through mid-November 2020, I became more familiar with each participant's data. To protect their privacy, I changed their names to pseudonyms. I transcribed the recorded interview data into Microsoft Word files. As promised in the welcome email, I sent each participant a copy of their interview transcript via email with a request for a 2-day response turnaround to validate the data. None of the participants requested any changes to the transcripts. After the transcript review, I skimmed the data to prepare for the qualitative analysis process. The final email I sent to the participants included a thank-you message and a link to a $25 Amazon gift card to compensate them for participating in the interview. Although I estimated the period for collecting data at 30 days, I completed all interviews in 21 days.

After collecting and transcribing the data, I transferred the Microsoft Word files to NVivo Version 12 software, and I started the coding process. I used the NVivo thematic framework with auto-coding. Each interview was uploaded into individual NVivo files. Then each of those interview files were opened and I created two new files one for the interview questions and, one file where I placed all of the participants responses. Once that was completed, I started the coding process by creating two NVivo theme node files (categories), where I collected the references from the participants' interviews. One category was named "disadvantages or negative" and the other category was named "advantages or positive". I then used the auto-code tab in paragraph and style format. When the auto coding was complete, I went through all of the data that from the participants' interviews and put them in to the appropriate category (disadvantages/negatives or advantages/positives). The next step involved sorting through the data in each category to create the themes that I used in this analysis. The themes were created based on the number of times the coded words were used by the participants in each category. For example, the participants used the words such as distress, and overwhelmed. These words were put under the category of disadvantages/negatives and were combined under the theme of feelings of stress. I did the same for other highly identified words such as financial and mental health. After performing this multi-step process, I removed several unnecessary codes and ended up with a total of 100 codes.

The three levels of coding are presented in the codebook (see Appendix A). The file column refers to the number of research participants who expressed a specific code. The references column shows how many times the codes appeared in the interviews. For example, the code “overwhelmed” was expressed six times by four research participants while the theme “feelings of stress” was expressed 56 times by nine participants. I ensured reliability by allowing readers to track my qualitative research process through the codebook so that future researchers might replicate this study.

To address internal validity, trustworthiness, and credibility, I used software (NVIVO) and human approaches (see McNiff & Whitehead, 2011). These approaches included consultations with my chair after I sent her all of the transcripts, we reviewed them during two separate meetings. Also, with my advisor, I used a debriefing process that provided me with the ability to help uncover any bias or assumptions as further validation of my findings (see Lincoln & Guba, 1994). This validation process enabled me to understand the lens that I used to focus on the participants’ responses. This process also made me aware of how I felt about the data and analysis method. Finally, discussions with a disinterested, objective editor and advisor helped me examine and confirm the viability and plausibility of emerging themes.

There were several limitations in this study. The first limitation was the small sample size with limited demographics. The second was geographical as the participants represented only New York City. A similar research approach in other states and countries may show different results, especially if there are differences in remuneration or caregiver policies. Another limitation was the data collection method, as the aim of collecting data through qualitative interviews was to understand the phenomenon through unbiased questioning and not to determine the existence and frequency of certain factors. The findings were limited to the participants' information. Some elements of the participants' experience were excluded, such as perceived trauma by the caregivers. This study was limited in scope and generalizability; however, it allows for further research on similar topics.

Findings

This project study was conducted to explore and describe the short-term and long-term experiences and obstacles that FMSWs encounter when working full-time while providing informal care to an aging loved one. This section addresses sample characteristics and background information on research participants' roles. The section also provides thematic answers to each of the research questions as shown in Table 2.

Table 2

Research Questions and Themes

RQ topic	Theme 1	Theme 2	Theme 3
1. Significant change in feelings of stress, resiliency, or burnout	Feelings of stress	Resiliency vs. burnout	Self-care
2. Skills, resources, and supports utilized across the roles	Nonmaterial resources and strategies	Support for informal caregivers	SW gives useful skills
3. Burden, disadvantages, and fear of future financial and health-related consequences	Identity disadvantages or advantages	Burden	Fear of health-related consequences

Demographic Characteristics

Nine master’s-level FMSWs who work in the five boroughs of New York City were interviewed for this AR project. During the data analysis process, I changed their names to pseudonyms to protect their identities. The pseudonyms I used were Emily, Heather, Barbara, Michelle, Patricia, Fay, Christina, Eva, and Wendy. Their demographics are presented in Table 3.

Table 3

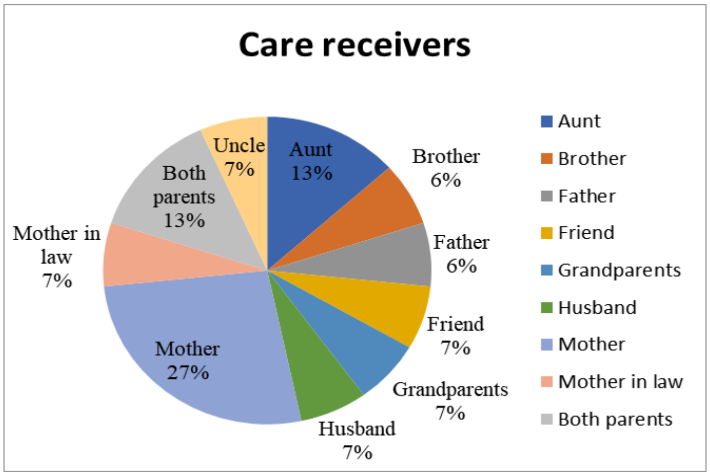
Demographics

Characteristics	Number of participants
Age	
30–39	4
40–49	1
50–59	2
60–69	2
Sexual orientation	
Lesbian	3
Heterosexual	6
Disability	
Yes	2
No	7
Race	
Black	4
White	3
LatinX	2

The most surprising information related to research participants’ professional backgrounds was that 66% of them have two or more jobs. These jobs include associate director, child welfare, church ministry, clinical social work, consulting practice, geriatric social work, macro social work, private practice, regional director, supervisor, and professor at a college. All research participants had obtained a master’s degree and were female. Besides their full-time jobs, all research participants are informal caregivers to older adults. Figure 3 indicates the relationships that the participants had with their care receivers.

Figure 3

Care receivers



Participants reported that they fulfill the roles of informal caregivers through various caregiving activities. These activities include managing finances and medical documentation, giving medications, shopping, preparing food, toileting, doing housework, and checking in and ensuring that everything is in place.

RQ1: Changes in Feelings of Stress, Resiliency, and Burnout

RQ1: How do FMSWs, who provide informal caregiving for an older adult, describe any significant change in their feelings of stress, resiliency, or burnout at work or in other areas of their lives, both in the short-term and long-term?

To a greater or lesser extent, each participant had experienced stressful situations caused by spillover between social worker and informal caregiver roles. Participants revealed different levels of stress and resiliency. They referred to resiliency by considering boundaries, balance, separation of private and personal life, and self-care. COVID-19 affected the short-term changes in feelings toward personal and professional life and motivated participants to think more about self-care.

In the first research question, I intended to explore if FMSWs who provide informal caregiving for aging adults describe any significant change in their feelings of stress, resiliency, or burnout at work or other areas of their lives, both in the short term and long term.. The participants made references to different feelings of stress. They also explained how they tend to mitigate burnout by building resiliency and emphasizing the importance of self-care.

Feelings of Stress

Participants used an array of expressions (included in Table 4) to describe changes in their feelings of stress at work and other areas of their lives in the short term and long term.

Table 4

Feelings of Stress

Feelings of stress (codes)	Number of participants	References in interviews
Struggling	6	10
Frustrating	4	7
Interruptions	4	7
Overwhelmed	4	6
Fear	3	4
Stressful	4	4
Trauma	3	4
Anxiety	3	3
Insomnia	2	3
It depends on the day	2	2
Not having time to breathe	2	2
Depressed	1	1
Edge of the nervous breakdown	1	1
Emotionally drained	1	1
Own emotional needs	1	1

To some extent, all research participants had experienced stressful situations caused by the spillover between their roles as social workers and informal caregivers. Short-term changes in stressful feelings usually occurred when a particular situation, such as a call from their care receiver, interrupted them at work. At these moments, FMSWs immediately switched from social worker role to informal caregiver role. Their social worker roles were also interrupted by their informal caregiver roles. Four research participants explained how these interruptions, usually in phone calls, made them feel stressed out at work. For example, Michelle shared how she does not like to be interrupted during her private practice sessions:

> The only time I get stressed out is that if I am getting a phone call, and when you are in session, you cannot make any phone calls or do any of them. So that is where I get stressed out. Like when I must call up my mother's doctor or make an appointment for my brother or get calls from their aides while I am on a session. When the phone rings, I am thinking, like, oh, my God, is it an emergency? I cannot answer the phone when I am with clients, but I start thinking about what is going on. So that is the only time it leaks in.

Six out of nine participants said they struggle to manage their roles and other aspects of their lives. These struggles may affect their well-being, both in the short-term and long term. Emily stated, "I must think about how you say this, thinking about what I am experiencing now and what is to come in the long-term. It is the thing that is killing me inside, and I am struggling." Three participants said that sometimes they feel fear.

Heather said that she struggles with her fear, especially when her mom, whom she cares about, feels sad:

> You know, for me, the weakness is when my mom is sad. I struggle with that because I am used to her being strong and outspoken. Moreover, when she is in pain, like when she starts to moan, it hurts me and distracts me when I am at work.

Three research participants felt anxiety from time to time, while two participants were having trouble sleeping. Through analyzing the overall interview narratives, I concluded that two out of nine participants expressed an alarming level of stress-related issues. Eva said that she realizes that she needs therapy, "because sometimes I feel like the hamster running and chasing the wheel. How do I make time and carve out time for myself when I am starting to feel like, sometimes, I cannot breathe?" Heather, who expressed an alarming level of stress, said:

> When I noticed that something was not okay with Mom, it's been tough to deal with, and I'm quite overwhelmed by the role and even as a social worker. Like yesterday, I felt like I was going to have a nervous breakdown just because I was so overwhelmed by everything. I am trying to figure out how I am going to take care of stuff for myself. I have a baby, I take care of her dad, and I must make sure everything is okay with my mom…Then on top of that, there is another thing that we are going to move. I am going to (be) moving back home with my mom by the end of the month so save money and share expenses.

Six of nine participants expressed that managing these roles and dealing with the spill-over of time and energy between them caused them to experience many struggles and challenges. Fay acknowledged:

> I must think about...what I am experiencing now and what is to come in the long term. It is the thing that is killing me inside, and I am struggling. So, it is very challenging. I am struggling. I could be 100% honest I am struggling immensely.

Barbara expressed her challenge relating to the financial cost of managing her mom's care. She said: "Yeah, I am struggling too much as now I am paying for two sets of groceries, two sets of electricity bills, and it is becoming very overwhelming and very costly."

Michelle shared her struggle in taking care of her mother and how that caregiving infiltrates and spills over into her work and personal life:

> [My] weakness and struggle increase when my mom is sad. I struggle with that because I am used to her being strong and outspoken. And when she is in pain, like when she starts to moan, it hurts me and is so distracting when it happens when I am at work. I say [mom], did you take the Tylenol? And I am not trying to be harsh, but I want that pain to go away, quick, so we could get back to just like that daily living….And I feel like it is a weakness in me because I feel like that, and then I am less compassionate at work because I want her to get healthy again.

By analyzing these narratives, I observed that the research participants experience various feelings of stress. They often feel that they are struggling while also experiencing frustration, interruptions, fear, and anxiety. These feelings affect their everyday lives, both in the short-term and long term.

Resiliency Versus Burnout

People can manage burnout caused by high levels of stress by building resiliency. Research participants referred to resiliency by considering boundaries, balance, separation of private and personal life, and self-care. Interviewed FMSWs attached such great importance to self-care that it will be explored as a unique theme. Some research participants became more resilient than others, but they all recognized the importance of dealing in healthy ways with various stressors and challenges.

Wendy illustrated how it might be hard to separate private and professional life, especially if the type of performed social work is connected to a particular aspect of identity or sexual orientation:

> It has been straightforward over the years not to shut work off, especially as an LGBT person myself and thinking about LGBT elders. It is all very personal. It is hard to shut off being a social worker and leave it at the front door and not bring it in the home. I think that has been a real challenge over the years and something that can verge on burnout, especially if you are not paying attention to how it impacts your life. However, you know, also on the positive side, that it provides us with skills, knowledge, and expertise in navigating social service systems. You know the aging network and things that hopefully prepare us for aging and our aging family members. So, I see the negatives and positives to it.

By pointing both to challenging and positive sides of intertwined private and professional life, she expressed her awareness and resiliency. Heather also thinks that intertwined private and professional life is a positive thing, and she believes in a fight for social justice both at work and outside of work:

> Being a social worker is my life and not in a bad way. It structures how I see the world, how I see people, my need to be more vocal as an advocate, and crosses over into my personal life. At times like this, we need social workers to stand for social justice even outside their work time, as I do.

For Fay, the inability to separate work from personal life was problematic, primarily due to the COVID-19 pandemic: “I suffered a little sense of depression during the first couple of months of the pandemic: I was home. I had no separation of work from caregiving or personal life. Everything was here at home.”

Four out of nine research participants discussed the challenges of setting boundaries. These boundaries were about separating private and personal life and handling the relationships with their care receivers. Living with the care receiver may pose an additional challenge, as Christina shared, while she was describing the relationship with her aunt: “Now doing this caregiving and I live with her, she sometimes thinks she can call me anytime she wants, even in the middle of the night. She has no boundaries. It is just really exhausting to do all of this.” She later added that in some situations, she had to say “no” to set the boundaries:

> My family does not help me set boundaries and always tries to get me to do things for them. One of them asked me to help them with their medication, but once I start, I will always be responsible, and I do not want that, so I said I cannot help them. That was all about self-care and boundaries.

Eva admitted multiple times during our conversation that she does not know how to set boundaries: “And it sounds like a burden, and I must work on putting in boundaries so that I do not become burnt out.” She also said that she “never really learned about self-care or setting boundaries in social work school.”

Three participants, who expressed higher resiliency levels and positivity throughout the interviews, shared that caregiving is not an obstacle for them. Another important aspect of resiliency is finding a balance. Three research participants said that they are still trying to find the balance, while one participant shared that she is currently very close to finding the right balance between the roles. Michelle thinks it is hard to give general advice because everyone struggles with different issues: “the whole how to balance everything and self-care like where we always hear the word self-care. However, what does that look like in action? And that is so individual. Each person must find what works for them.” In this quote, she showed that one-size-fits-all solutions are unsustainable. It was interesting to me as a researcher to see how participants are aware of the possible burnout and how they express their resiliency by discussing boundaries.

Self-Care

The theme of self-care conceptually fits into resiliency, but I have singled it out here because the research participants attached great importance to it. Self-care is closely related to the presented feelings of resiliency. Throughout the self-care theme, I tried to examine the activities that research participants interpret as self-care. In Table 5, identified activities of self-care are presented.

Table 5

Self-care

Self-care activities	Number of participants	References in interviews
Outdoor and nature	5	5
Workout	4	4
Wine	3	3
Hobbies	2	2
SPA	2	2
Gardening	1	1
Spending time with friends	1	1

Spending time outdoors and in nature was the most pleasant activity for most of the research participants. Fay said how a simple walking routine with a friend became an even more valuable experience during the COVID-19 lockdown: “We decided we are going to start walking every day. That is the only thing you can do, everything is closed, but you can still walk around. Thus, we started walking. I had lost 20 pounds within three months.” Wendy enjoys spending time in nature with her partner: “Thankfully, we have an RV, and we have been able to take advantage of doing things in nature. We love to hike, love to sleep outside, love to fish, and it is also kayak[ing] that’s been our self-care.”

The second self-care activity on the list was exercising and working out. Having a drink or having SPA moments also helps research participants to relax. Barbara shared: “My self-care [includes] baths, wine, cooking, and walking.” Also, hobbies, such as singing in a church choir, and spending time with friends, were listed as self-care activities.

The need for self-care increased during the ongoing COVID-19 pandemic. In one way or another, seven out of nine research participants emphasized that the pandemic caused additional burdens regarding balancing between roles. Time and further research will show if COVID-19 related changes influence stress levels in the short-term or long term.

RQ2: Skills, Resources, and Supports Utilized Across the Roles

RQ2: What type of additional skills, resources, or supports can FMSW’s utilize across their roles?

This question explores how FMSWs utilize nonmaterial resources and strategies across the two roles, how their family members and friends supported them in their efforts, and how they use social work skills in their informal caregiving roles. The most crucial nonmaterial resource that helps FMSWs “juggle” across the roles more efficiently has been knowledge and connections. Since elder caregiving often requires activities, such as taking care of finances and medical documentation, giving medications, and referring to various services, research participants emphasized that they feel well equipped and educated as social workers to manage these activities. FMSWs think that because of the skills they learned as social workers (e.g., filling out the insurance forms), they can help their friends, family members, and care receivers. The unexpected finding was that faith and spirituality might help FMSWs connect their social workers’ and informal caregivers’ roles more positively.

In this following subsection, I will present three themes: how FMSWs utilize nonmaterial resources and strategies across the roles, how their friends and families support them in their efforts, and how they use social work skills in informal caregiving.

Nonmaterial Resources and Strategies

An essential nonmaterial resource helps FMSWs juggle roles more efficiently, having connections to their systems in both roles. Wendy summarized what having connections means in elder caregiving:

> I think it is also helpful that I have many connections within the social work field, so I also know whom to call, what to do, whether we need more than an informal caregiving situation or need to look at a geriatric care manager or home care company, so I can help make those types of calls as well.

Three participants shared stories where their social work connections helped them supply adequate care for aging family members. Patricia expressed that she is satisfied with the care that she managed to provide for her mother-in-law:

> Again, I think that having had a social work background and having had those connections made it so much easier for us to put into place what we needed for my mother-in-law. She is 104, and she is living at home, and I mean, she has had a couple of falls. We are cautious about her advanced directives; everything is in place.

Christina shared how being a good listener and having patience, both qualities that come naturally for social workers, help her deal with her aunt. She thinks that her aunt's outbursts "could lead somebody else to be burned out by," but that she possesses knowledge and experience that is valuable in these situations:

> Instead of making it worse, I can de-escalate it and bring it back down and have a talk and listen to her about it. So, all of that has come very naturally to me. But I have learned to see that. For others, it is not, so I am just lucky, maybe because I am a social worker.

Eva also stressed the importance of being a good listener and being motivated to help people. She uses these nonmaterial resources gained through her profession:

> It means just being able to make a difference and use what I already have innately like a good listener. I care about people. I want to help people. I want people to see and to know what is inside of them. And I have always been good.

Not only do social workers' nonmaterial resources help in informal caregiving for aging people, but it also goes the other way around. Fay explained that she is always surrounded by aging people, which is why she decided to specialize in gerontology, "by utilizing what I have, which is being empathetic and understanding, a voice of reason." She shared:

> Ever since I was a child, I kind of always gravitate towards older adults. You know, hanging out after school was going to my grandmother's neighbor's house and playing the piano with her or sitting down and having a cup of hot chocolate with the neighbors down the street or checking and shoveling snow because you know they were getting older.

The second most unexpected finding in the research was that faith and spirituality could also be understood as nonmaterial resources or strengths that help FMSWs connect their social work and informal caregivers' roles. As a result, these women indicated that they developed spiritual and religious practices that helped sustain them through both roles' good times and hardships. When the research participants talked about faith and spirituality in dealing with stress, they interpreted faith and spirituality as helpful strategies in managing the stress from both roles. Four out of nine participants maintained a Christian practice, two identified as Jewish, and the remaining three described themselves as unaffiliated with no significant Eastern or Western religious practices.

Emily shared her view and emphasized the importance of her religious upbringing and family values:

> I think it is important to touch on how important faith is to my mom. She instilled that in me as well. How do I deal with my frustration are just so many things I cannot even really put into words and that spiritual peace like, I have to do this? I have spiritually broken myself. How do I get that back? And how do I become whole and keep myself complete while going through this challenging time, you know, so I just kick-ass and cannot stop going back to the fact that I feel like many of our institutions just miss it.

Heather shared a similar experience: "I will just share a little thing; we went to Catholic school. We were religious and, I would say I was more religious than spiritual, but now, I'm spiritual more than religious." Faith and spirituality are often focused on social work and helping people so that these concepts may be used as bridges across the roles and nonmaterial resources.

Support to Informal Caregivers

FMSWs interviewed for this project support older adults who expressed their need for more help juggling across the roles. Different types of support are mapped in FMSWs' narratives (Table 6). Support networks are built both in professional and personal settings.

Table 6

Support for Informal Caregivers

Support	Number of participants	References in interviews
Other family members are not involved	5	8
Support from close people	5	7
Organizational support	4	6
Paying for additional caregiving	4	5
Schools of social work	3	5
Supportive boss	3	3
Support groups for caregivers	2	2
Policymakers	1	1

Some research participants indicated that other family members assisted them, but most of the participants lacked any other relatives' assistance. Five out of the nine research participants said that other family members are not involved in caregiving. The reasons for this lack of support vary. The compositions of families are different. Some family members live far away, so they are not able to help. However, some family members are physically close, but they are not helping enough. *"*I have sisters, but they do nothing more than call me to tell me that our dad is in trouble,*"* Eva said.

However, the support from family members may change over time. For example, Fay shared that her younger sister, who lives in the same neighborhood, has not taken part in caregiving for their grandparents in the past, but lately, she "started to step in slowly." She felt relief when her family started to help. Heather shared a positive experience with her brother's support:

> I would be remiss if I did not mention my brother because my brother does equally, if not more, than what I do. We divide it up, so I take care of her wants, whatever she wants. She wants to get her nails done, get a manicure and pedicure. We just went to get her manicure yesterday. My brother takes care of her needs. He makes sure all the bills are paid. He makes sure that she has money in her debit card for whatever she wants to spend it on, but he makes sure that all the bills that need to be paid, the taxes on the house, and things like that.

Organizational support and a supportive employer are also crucial for research participants. Only four out of nine participants said that they feel that they have a positive experience with their bosses, supervisors, and teams in general—they can leave work earlier if they have a doctor's appointment or some other activity related to informal caregiving. A slim majority of the participants did not feel that their employers were supportive or flexible.

However, all the research participants shared their concerns about the lack of focus on informal caregiving in social work schools. According to them, schools of social work are not doing enough to educate future social workers about the informal caregiving of elders and the potential for role spillover. Similarly, every participant indicated that they also felt invisible to the entire profession. All of the FMSWs stated that the National Association of Social Workers and the research community remain primarily silent and out of touch with this large cohort of social workers (Jacobs, Van et al., 2019).

Wendy shared her criticism:

> Do you know how many social workers do not even recognize what informal caregiving is? The profession and schools do not help clarify what informal caregiving is and how social workers can manage both roles. They need to know what happens across the lifespan. Some workers are sandwich caregiving at bookends, meaning they care for their children or grandchildren and their aging parents or aging friends. And so how many of us are, you know, informal caregivers, and we are just not calling it that.

Michelle thinks that geriatric courses should be mandatory in schools of social work, “just like the social policy is compulsory in social work schools, where you learn more about how someone manages an aging family member? Like, how do you deal with it all? I had to learn this all by myself,” she said. Emily thinks that “the policymakers are missing the mark" because they are not creating, financing, and implementing the programs which target the issue of elder care.

Social Work Gives Useful Skills

All research participants agree that being a social worker provided them with the skills useful for informal caregiving and other aspects of life. "It gives you the skills that you use in your personal life and that you use in your professional life. It gives you a particular slant on the world. And it is giving back in a very profound kind of way," said Patricia.

Most importantly, FMSWs feel that they can help their friends, family members, and care receivers because of their skills, which they obtained through social work. For example, Christina said: "My social work experience helps me with any family members who need assistance, like filling out paperwork or entitlements. It also helps me with my caregiving responsibilities." They are also equipped to supply insurance information to people who need it, including the care receivers: "So being a case manager, I already knew many things like Medicaid applications, homecare, life-alert, and many things that she [her aunt] needed," she explained. While many participants feel that their social work skills often make it easier for them to access resources and support for their loved ones, they are painfully aware that they continue to face an uphill battle if they and their growing needs remain invisible to the social work profession.

Eva shared how she feels obliged to use her social work skills while she spends time with family and friends: "So, by having the title of the social worker or therapist, everyone in my family and friends feels like I have the answer. You know, like at family gatherings and holidays," and later added, "it feels like I never leave work." By using social work skills across the roles, research participants always question boundaries and balance. In that manner, Barbara said:

> When I said it is in my being's fabric, it permeates everything you know; it is like a clock is never off. For example, you talk about COVID-19; during COVID-19, when I too was in the house, totally in the house, and on my phone, every week, I was giving somebody a referral for therapy. You know, to friends, friends of friends of friends, in addition to my students.

Heather explained: "I think it structures how I see the world, how I see people, my need to be more vocal as an advocate, and crosses over into my personal life."

Therefore, social work is a particular lens through which research participants see the world and which they use to provide informal caregiving.

RQ3: Burden, Disadvantages, and Fear of Future Financial and Health-Related Consequences

RQ3: In what ways do FMSWs increase their current feelings of burden or disadvantages or fear of future financial or health-related consequences due to their caregiving responsibilities while working full time?

This research question addresses the disadvantages and advantages of FMSW's identities, burden, and fear of health-related consequences due to their caregiving responsibilities while working full time. Six out of nine research participants believed that people of Color’s financial opportunities are different from White people’s financial opportunities. They shared that White people are provided with better information about managing finances and are more secure because they often accumulate more significant advantages over their lifetime or inherit greater material assets. The financial burden is a massive issue for FMSWs and was the reason that many indicated they had a second part-time job along with their full-time position and caregiving role. Gender is another significant aspect of identity that influences their caregiving responsibilities and their social work position. Four out of nine research participants share an opinion that there is an implicit expectation that women should “naturally perform” the role of caregivers. They are aware that they may experience long-term health-related consequences of stress and self-neglect more than men who supply only about 20% of the informal care in this country.

The spillover of their roles reinforces the disadvantages and advantages of FMSWs’ identities and backgrounds and makes sense of consequences. In the first theme, I defined what these identity disadvantages or advantages are. In the second theme, I emphasize the burden caused by financial insecurity, which manifests the need to work at least two or more jobs. In the third theme, I address their fear of health-related consequences.

Identity Disadvantages or Advantages

FMSWs who participated in this AR project face different types of accumulated disadvantages related to their demographic factors (race, ethnicity, gender, gender preference, sexual identity, class, etc.) Each participant's demographics seemed to be a factor related to how each woman experiences added disadvantages or advantages in juggling across the roles and considering their financial future. The identity disadvantages or advantages that impact FMSWs' caregiving responsibilities and social work career are presented in Table 7.

Table 7

Identity Disadvantages or Advantages

Identity disadvantages or advantages	Number of participants	References in interviews
Financial opportunities for people of Color	6	7
Being a mother	5	12
The expectation of being a caregiver as a woman	4	5
Discrimination towards people of Color	2	5
Informal caregiving as cultural practice	2	3
Caregivers and SWs are women and people of Color	2	2
Salaries and the gender gap	2	2
LGBT identity	1	3
Immigrant background	1	2
Being Jewish	1	1
First-generation college-educated	1	1
Person with disability	1	1

The participants indicated how their perceived role identities connected to the accumulation of advantages or disadvantages in the table above. For example, six out of nine research participants believed that non-White people's financial opportunities are less than those of White people, with Eva stating it twice during the interview. They also believed that White people are provided with better information about managing finances. As identified in table 7, this feeling of accumulated disadvantages is connected to general discrimination that people of Color experience in all areas of their lives. Christina showed substantial differences in the ability to access resources and support for White people versus people of Color. Eva stated:

> My boyfriend and I were talking about this podcast that spoke about race. They were trying to show that White people are often wealthier than people of Color because our parents did not have the resources or knowledge to teach us about future planning and how to deal with a racist society. My parents lived day-to-day and paycheck-to-paycheck, so they did not plan for themselves or teach [my] brother and me how. That was like a setback. So, regardless of gender and race, if everyone could have the same type of knowledge and resources when they are young, it would go a long way to make it better for brown and Black people. It is harder for me as a brown woman to save up to buy a house or something. I speak with my Caucasian friends, and they all have more information, financial security, and a comfortable place to live.

Eva also described her experiences of not finding the resources she needed for her Hispanic father, who resides in a socio-economically impoverished community. She explained:

> I think just being Hispanic, and in a lower-income neighborhood, it is harder to find resources. I have White friends that are not Hispanic or Black, and when I go into their neighborhood, and I am spending time with them. It seems, so I am like, Oh, how did you get that resource so fast but then when you come back to my neighborhood and where my parents live. They live in the projects in Brooklyn. So, it is even more challenging when I go into their community than in my neighborhood, which is more residential and has even fewer medical places that do not often have what I need. So, I would say that being Hispanic in a neighborhood with inadequate resources puts me at a disadvantage.

Emily thinks that people of Color are not taught to manage finances: “We do not have those same opportunities, especially when it comes to financial literacy. We are not taught in the same way as White people or men, so when you grow up, you think you know, but you find out that you do not have any idea.” She also said that it is hard for her to maintain savings for the future: “We just kind of live, paycheck to paycheck. How do you put it aside? If you are always like crabs in a barrel trying to climb your way out, you cannot put to the side.” She would like to teach her daughter finances “so that she does not go through what I am going through now.” Such comments indicate that Black and

Latina participants felt that classism and racism influence their access to quality choices and the number and types of resources available to them or their loved ones.

Heather is very concerned about future financial and health-related security: “We are managing, but my concern would be if my mom becomes very ill and needs more home care because she does not qualify for Medicaid.” She also thinks that White people possess knowledge that helps them to navigate the system better:

> I have listened to how other people, not people of Color, have been able to get Medicaid, and they figured out what the loophole is and still do not have to give up anything and even get [services] like 24-hour care. I do not know why White elders or family members know the loopholes, and I, as a person of Color, do not know about those same loopholes.

Barbara feels the burden because she is not sure if she will be able to provide her children with financial stability:

> I also wanted to say that certainly, in my experience, and I am the first-generation college-educated in my family, I do not have major resources. So, the best I can do is help my family to access what is available to them. I have nothing to give them. I mean, I can give them a meal, and I can give them a bed. However, I have nothing financial to give to them. So, yeah, you know, and that is that weighs heavily too.

Non-White research participants addressed the fact that skin color influences financial and other opportunities. Their narratives illustrate how structural, hidden, and institutionalized discrimination towards people of Color affects their everyday lives.

The second significant aspect of identity, which influences caregiving responsibilities and social work career, is gender. Four out of nine research participants share an opinion that there is an implicit expectation that women should perform the role of caregivers without any compensation. "As for being a woman, I think it is almost expected that women will fulfill this role in some ways," said Wendy. "With females in our society, it is an expectation that we are the family caregivers, or it is our role to take care of other people," Michelle shared. Patricia thinks that women are raised to perform multiple roles at once: "You learn as a woman that you must multitask." She also shared the impression that caregivers and social workers are primarily women and people of Color.

Heather tries to raise awareness among her students about identity advantages and disadvantages regarding race and gender:

> And we should look at women and as social workers. In my class, we do talk about it, but it is not mainstream. We have debates around labor and the labor market, especially [about] the unfairness between salaries between men and women. It is not even about their qualification, because a woman could still have more qualification for a particular position, but they will give it to a male, and then it goes into the whole racial scheme of stuff.

Four out of nine research participants are also mothers, which means that they have additional responsibilities besides working and informal caregiving. Wendy thinks that people who have children are sometimes spared from caregiving:

> I know it sounds kind of cliche, but you know, being in a lesbian relationship and not having children has given me freedom in some ways to take the time to be a caregiver to others because I did not have the same responsibilities that my sister had.

Christina said a similar thing: “I see young mothers with kids getting more advantages and flexibility. At my job, mothers are given better treatment, like leaving early or something like that, because they have kids.” However, by analyzing the narratives of interviewed FMSWs whose mothers are not always spared from adding the informal caregiving role.

Three research participants shared how the cultures to which they belong made them more empathetic and caregiving oriented. Emily stated:

> In terms of being Caribbean, the number one rule you always learn that you take care of your parents, regardless of what is going on in your life; that is a priority. They raised you. You must help them,”

Patricia indicated:

> I think being Jewish, I look at the world through a lens of how I can make things better. Being Jewish and a woman includes caring about family and connections and having important values.

Therefore, the cultural identity poses an advantage for them in juggling across the roles. Similarly, demographic factors and identities (race, ethnicity, gender, gender preference, sexual identity, class, etc.) are essential in shaping the experiences of FMSWs who provide informal care to the elder. These factors influence their further actions and feelings. In many regards, non-White female social workers experience structural disadvantages which may impact their future aging process.

Burden

Besides the psychological burden discussed throughout the first research question, FMSWs interviewed for this project feel a heavy financial burden. Another surprising finding was that six out of nine research participants have two jobs, while some have even three or four jobs. Four of them teach at universities and colleges besides regular jobs. Three of them additionally have private practices. Two research participants said that they notice how social workers must have at least two jobs to be financially stable, implying that social workers’ salaries are inadequate and unsatisfactory.

Fear of Health-Related Consequences

Five out of nine research participants are afraid of the potential health-related consequences of juggling across the roles. They shared that they usually do not have time to go to their doctor because they have too many other responsibilities. They also shared the concerns about their mental health and well-being while juggling across the roles. They are aware that they may experience long-term consequences of stress and self-neglect.

"I need to do my mammogram, and it's been on my calendar since September, and I have not done it yet because every week something else is always coming up," said Emily. She added, "I have not been 100% focused on myself because I am always doing for somebody else." Michelle also said that she has been neglecting doctor's appointments:

> I feel like I put my own doctor's appointments aside, and it is more on them first because they are urging me like they didn't care if I was healthy or not. I have not been to the doctor for three years.

Fay is very concerned about her health because she has chronic health conditions. Eva said that she is regularly at her doctor's appointments due to her physical disabilities: she had learned the importance of medical self-care a long time ago.

Christina urged for greater emphasis on mental health within the social work profession and informal caregiving:

> We need more emphasis on our own mental health needs, and we could use more resources even for those who are planning not to get sick or have issues as they age because they got so burnt out at work and from caregiving. When that happens, the whole planning goes out the window.

Therefore, this capstone project's findings suggest that FMSWs who supply informal caregiving while working full-time, or even over-time social work jobs, are at significant health risk.

Unexpected Findings

There were two unexpected findings in this project. The first one was related to research participants' use of faith and spirituality as nonmaterial resources to balance their roles. The use of faith and spirituality was one way that the participants found support and comfort since so many indicated that they felt invisible and not supported by their profession, employer, or society. The second one was the necessity to do more than one job to ensure financial stability, which supports the literature and the participants' belief that women are undervalued, and the feminization of social work and informal caregiving puts women at a disadvantage work and as they age.

Summary

In this capstone project, I explored and described short-term and long-term experiences and consequences that FMSWs face working full time while providing elders with informal care. Nine significant themes emerged from their narratives: feelings of stress, resiliency vs. burnout, self-care, nonmaterial resources and strategies, support to informal caregivers, valuable skills gained from social work, identity disadvantages or advantages, burden, and fear of health-related consequences.

All research participants have experienced varying stressful situations caused by the spillover between social workers' and informal caregivers' roles. Research participants referred to resiliency by considering boundaries, balance, separation of private and personal life, and self-care. The COVID-19 pandemic motivated them to think more than usual about self-care. While it may seem that the different pandemic-related experiences of FMSWs' stress may be lessened when COVID-19 is no longer such a threat, it is still not known if or how long the pandemic will last and what will be the consequences of a changed work routine. Those who live with care receivers and work from home as social workers feel an additional burden. The financial burden is a massive issue for FMSWs, which is why they are forced to have two or more jobs while simultaneously performing family and informal caregiving roles.

The most critical nonmaterial resource that helped FMSWs juggle across the roles was the connections they developed with providers and entitlement services as a social worker. Since elder caregiving often requires activities, such as taking care of finances and medical documentation, giving medications, and referring to various services, research participants emphasized that, as social workers, they were well equipped and educated to manage these activities. FMSW participants felt that they could help their friends, family members, and care receivers more effectively because of their skills, which they obtained through social work.

Racial and gender identities shape FMSWs' experiences and influence their financial opportunities. They feel that society demands that they perform the roles of informal caregivers. A few research participants support other family members in providing informal caregiving, while others lack family members' support. They also shared the concerns about how juggling across the roles and spillover between roles impacts their mental health and well-being. They are aware that they may experience long-term consequences of stress and self-neglect, meaning FMSWs who provide informal caregiving while working full-time are under severe health and financial risk.

The conducted interviews and AR qualitative research format allowed FMSWs to express their experiences and concerns about role spillover. At the end of the interviews, several research participants said that the interviews were like therapy, confirming the AR approach’s added value. At this point, it is crucial to create more opportunities, supports, and resources for FMSWs who work full time while supplying informal care to elders. Informal caregiving needs to be addressed as labor in both social work education and practice.

Section 4: Application to Professional Practice and Implications for Social Change

In the literature review section, I indicated that limited research existed regarding the experience of informal caregiving that FMSWs provide to aging loved ones while also managing a full-time social work job. The purpose of this project study was to understand how FMSWs manage the additional stressors that arise when they, as full-time social workers, also become informal caregivers for an aging family member. Furthermore, the aim was to understand how FMSWs describe the affective domains of feelings, strategies, and concerns when integrating two challenging roles: social worker and informal caregiver. Last, the purpose was to understand whether there were short-term and long-term negative consequences for FMSWs who provide informal care for aging adults while working as full-time social workers. The following research questions guided the inquiry:

RQ1: How do FMSWs, who provide informal caregiving for an older adult, describe any significant change in their feelings of stress, resiliency, or burnout at work or in other areas of their lives, both in the short-term and long-term?

RQ2: What type of additional skills, resources, or supports can FMSW’s utilize across their roles?

RQ3: In what ways do FMSWs increase their current feelings of burden or disadvantages or fear of future financial or health-related consequences due to their caregiving responsibilities while working full time?

My experiences as a full-time female social worker who simultaneously provided informal caregiving to my mother and her best friend inspired this AR study. Like the participants, I and several of my colleagues found ourselves in similar positions. This anecdotal evidence reflected similar feelings and experiences compared to those reported by participants in the study.

Findings from this AR project may be used to improve social workers’ health and long-term well-being, specifically female social workers who are simultaneously providing informal care to an aging loved one. Findings may also provide knowledge regarding the scope of the impact of role spillover experienced by FMSWs and may inspire new conversations within the social work profession, among employers, and among policymakers to understand the growing concerns that may affect social workers who are also providing informal family care.

After several qualitative inquiry methods were explored, I found that the AR approach would be the most effective and appropriate to answer the study’s research questions. This project was appropriate for AR because it provided a mechanism for the participants to share their experiences and stories. AR is a systematic practice that provides a mechanism to study the issues and allow participants to share their stories and find solutions they can use after completing the research (Stringer, 2013). The participants in the current study were able to describe their feelings, fears, time management skills, work–life balance, level of psychological distress, or resiliency related to managing two stressful roles among the other roles they perform at any given time (see McNiff & Whitehead, 2011; Stephens et al., 1997).

As a result of the COVID-19 pandemic, the initial plan for focus groups had to be reevaluated and discarded. I considered different approaches and determined the best course of action was to conduct individual online interviews to minimize the exposure of the participants. Despite the pandemic-related obstacles, the transcription and coding of the nine interviews provided rich data. The interviews also included narrative analysis to help the participants focus on the events and experiences that shaped their self-understanding (see Riessman, 2008). The interview format elicited a textured understanding of the participants’ experiences and perceptions within their specific conditions and situations (see Stephan et al., 2018).

This AR study focused on pertinent practice and well-being issues meant to uncover substantial practice issues that can improve the profession’s well-being and improve clients’ current and future well-being (see Stringer, 2013). I used two theoretical approaches to understand the experiences of the participants. RST was used to determine whether there were positive and negative aspects of the FMSWs’ roles that spilled over into each other or different aspects of their lives and how that spillover affected their day-to-day lives and well-being. The second theoretical framework was the CDAT. I selected this theoretical framework to address whether there were differences in how the participants were affected due to their socioeconomic status, gender identity, race, or color. Combining these two theoretical frameworks provided the needed foundation to answer the research questions.

My findings provided insight regarding the experiences of FMSWs who were providing informal care to an aging family member in addition to their existing responsibilities as social workers. Before analyzing the data, I explored the participants' demographics to determine whether their demographics could contribute to an increasingly negative or positive experience as a social worker. The demographic analysis revealed that this study was age inclusive and diverse.

My findings also provided new knowledge based on the participants' demographics. In the literature review, I determined that the average informal caregiver was a White woman around 49 years old who takes care of her 69-year-old White mother (AARP, 2018). Another study showed that 18- to 24-year-olds make up 35% of the Millennial caregivers, those between the ages of 25 and 29 years provide 31% of informal care, and the older cohort (those between 30 and 34 years old) provide 34% of informal care (Flinn, 2018). Comparing the findings of these studies and the participants' demographics in the current study, I concluded that female social workers across all ages are the largest cohort to provide informal care to a family member or friend. Women provide the largest share of caregiving in the United States, including informal care for an older loved one, and spend over 50% more time than men providing that care (AARP, 2018; Family Caregiver Alliance, 2019).

Four of the current participants were African/Caribbean women. The remaining participants included three White women and two LatinX women. Sexual orientation, disability, and race were also included in the demographics. Although the participants indicated several challenges regarding race, few participants indicated their sexual orientation was a factor of added stress or burden.

By using the NVivo thematic framework analysis, I identified three themes for each research question. The themes were as follows:

RQ1: feelings of stress, resiliency vs. burnout, and self-care.

RQ2: nonmaterial resources and strategies, support for informal caregivers, and SW gives valuable skills.

RQ3: identity disadvantages or advantages, burden, and fear of health-related consequences.

The findings of the first RQ, regarding the feelings of stress, resiliency, or burnout at work or in other areas of the participants' lives in the short term and long term, indicated that all participants had experienced stressful situations caused by the spillover between social worker and informal caregiver roles. Participants had different levels of stress and resiliency, and all participants did not experience stressful situations with the same intensity. Research participants referred to resiliency by considering boundaries, balance, separation of private and personal life, and self-care. Furthermore, the COVID-19 pandemic affected their short-term changes in feelings toward personal and professional life and motivated them to think more about self-care.

In the literature, informal caregiving was seen as a contributing factor to health disparities among informal caregivers, as this role was an additional stressor to caregivers who had experienced cumulative prior experiences of stressors or adversities (Greenfield et al., 2018). The stressors related to the social work profession include organizational obstacles, client stressors, and personal issues that cause members of the social work profession to be at high risk for developing burnout, compassion fatigue, and other negative symptoms (Gonzalez, 2019; Singer et al., 2019). High numbers of social workers experienced adverse health outcomes, including high blood pressure, depression, sleeplessness, anxiety, post-traumatic stress disorder, and suicidality (Figley, 2002; Singer et al., 2019). Because the caregiving role is subject to change, it has been shown to create significant psychological distress, financial insecurity, and poor health outcomes long after the caregiving is no longer required (Musil et al., 2013). Even though current participants did not disclose information regarding possible stress-related illnesses, my findings were consistent with the literature as the participants relayed their distress regarding stressful situations.

In addressing the second research question, I explored how FMSWs utilized nonmaterial resources and strategies across the two roles, how FMSWs supported their efforts, and how FMSWs used the skills they obtained through social work in their informal caregiving roles. The findings indicated that the most crucial nonmaterial resource that helped FMSWs manage their involvement and care quality across their roles more efficiently was connections within the social work sector. Knowing how, where, and when to complete specific tasks alleviated the burdens of their informal care role. Caregiving of older people often requires activities, such as taking care of finances and medical documentation, giving medications, and referring to various services. Current participants emphasized that they feel well equipped and educated as social workers to manage these activities. Participants reported that the skills they learned as social workers (e.g., filling out insurance forms) helped their friends, family members, and other care receivers.

The unexpected finding was that faith and spirituality might help FMSWs connect their social worker and informal caregiver roles, as mentioned by four of the nine participants. The second RQ findings added value to the literature because the existing research had not focused on the positive implications of social work related to informal care or that faith and spirituality may assist in navigating the complicated lifestyle of FMSWs providing informal care. One of the studies related to this theme indicated that being a social worker and a minister was helpful in advocating for the informal care patient and speaking with the hospital/hospice staff (Green, 2009; Ward-Griffin et al., 2005).

The third research question addressed the disadvantages and advantages of FMSWs' identities, burden, and fear of health-related consequences due to their caregiving responsibilities while working full-time. Six of the nine participants reported that people of Color's financial opportunities differed from White people's financial opportunities. Participants shared that White people were provided with better information about managing finances and were more secure because they often accumulate more significant advantages over their lifetime or inherit more material assets. The financial burden is a prominent issue for FMSWs and was the reason that many indicated they had a second part-time job along with their full-time position and caregiving role. Gender was another aspect of identity that influenced the FMSWs' caregiving responsibilities and social work positions. Four of the nine participants shared that there was an implicit expectation that women should naturally perform the role of caregiver. These participants are aware that they are more likely to experience long-term health-related consequences of stress and self-neglect than men who supply only 20% of the informal care in this United States.

Another surprising finding was that six of the nine participants had two jobs, and some had three or four jobs. Four of them taught at universities and colleges besides performing their regular jobs. Three of them had private practices. Two participants said they noticed how social workers must have at least two jobs to be financially stable, implying that social workers' salaries are inadequate.

In the literature, the caregiving role was considered subject to change, was often unanticipated, and usually happened more than once and for multiple recipients (Musil et al., 2013). The caregiving role has been shown to create financial insecurity and other adverse effects (Musil et al., 2013). Even though the existing research did not focus on the differences in financial burden across demographic factors, it was clear that female social workers have lower incomes than their male counterparts, forcing them to generate additional income by maintaining several jobs (Damaske & Frech, 2016). Furthermore, women have only two clear pathways to consistent full-time work, three routes to find part-time employment, and only one path to unfunded labor (Damaske & Frech, 2016). Although most women need full-time work for their sustainability, about 10% cannot find paid work (Damaske & Frech, 2016). In the current study, I concluded that women face the long-term influence of work–family conflict and early socioeconomic advantages and disadvantages (see Damaske & Frech, 2016).

The most adverse effect of multiple jobs is that FMSWs' divided responsibilities may lead to them being overlooked for promotions and better offers. According to Damaske and Frech (2016), 33% of employed women do not receive promotions in executive or management positions, and many end up remaining in the labor force on a part-time basis, primarily due to their caregiving demands. People who provide informal caregiving can experience several adverse outcomes in their lives (Schulz & Eden, 2016). They often miss more work and are less able to hold a full-time job or assume more leadership positions. Informal caregivers may have to leave the workforce for more accommodating jobs that have flexibility but lower pay (Hausler et al., 2017).

Application to Professional Ethics in Social Work Practice

In this study, the participants and I produced opportunities for the social work profession to understand informal caregiving's impact on the most significant percentage of its workforce. The knowledge created may uncover whether the social work profession assists these large and growing social work cohorts with more tools to manage both roles healthily while helping these women combat caregiver burden, burnout, or other psychological distress. We also provided insight into the FMSWs' informal caregiving experience as they navigate the NASW professional code of ethics (2017) and how it may impact their current and future successful aging outcomes. The NASW's Code of Ethics is based on the principles underlying the social work's core values of service, social justice, dignity, the importance of human relationships, integrity, and competence.

While these principles guide how social workers treat their clients, it was important for the participants to understand that these principles do not spillover from their professional role to their informal caregiving role, meaning that the participants are not obligated to help family members or to put others above their self-care or well-being. It is worth noting as to whether the profession itself is remiss in following its code of ethics when hearing a majority of the participants indicate that they feel invisible to the profession and feel that there are issues around service, social justice, dignity, the importance of human relationships, integrity, and competence that are not being offered to FMSW's. While social workers consider these ethical principles in their practice, many of the participants tried to manage their social work and informal care with the added burden of several jobs to produce a stable income. Many of the participants felt that they experience inequity, social injustice, a lack of dignity by the National Association of Social Workers, and the lack of research on their needs.

Recommendations for Social Work Practice

My recommendations include encouraging NASW to focus on developing further research studies to assess greater methods to increase FMSW's visibility within the profession as well as policy discussions as to how FMSW's can be provided with the necessary resources to prevent unnecessary short- and long-term adverse effects resulting from having to manage too many, responsibilities, particularly since they are the largest subpopulation within the field as well as being members of multiple marginalized communities. The findings of such studies could provide more clarity as to whether the adversities faced by such participants positively or negatively influence their experiences as social workers.

A second recommendation includes conducting further comparison studies regarding the differences in income amongst male and female social workers, and if significant income discrepancies are uncovered, action should be taken to rectify gender-based discrepancies. Financial burden leads to several other stressful circumstances that adversely affect the health of social workers. In this study, the participants also indicated that the interviews were like therapy, confirming that the AR approach added value. It is important to the participants that this knowledge gained from their narratives informs a better understanding of academic curricula, mandatory continuing education classes, and more robust policy directives on family leave options for FMSWs who work full time while supplying informal care elders.

An additional recommendation is that federal policymakers consider compensating informal caregiving expenses, so it does not continue to be an unfunded expense for people who are already marginalized in the workforce and society. In that light and, for the first time in American history, the Biden administration, on May 3, 2021, released 460 million dollars for home and community-based services (HCBS) through the Older Americans Act. This funding provides payments to older adults for many of the services and supports they need for their care, whose family caregivers often bore costs. There are an additional 145 million dollars provided directly to informal caregivers to cover their costs and time in providing their loved one(s) with in-home supports, including respite care, counseling and caregiver training, and other previously unfunded expenses (White House, 2021)

The third recommendation is that social work researchers create knowledge that will close the literature gap around shared traumatic events such as caregiving for a dying spouse or relative or working under a pandemic. As the current research starts to highlight the impact of COVID-19 on the social work profession, the participants in this study want visibility and acknowledgment as they continue to meet their loved one's needs at an unprecedented time when there is no end in sight regarding the recent pandemic (Redondo-Sama et al., 2020). This is particularly true for the FMSW's who are experiencing the same collective trauma and tending to family members but with no assistance from the profession. Overall, the participants did not spend much time discussing the added trauma resulting from the COVID-19 pandemic. My final recommendation is that further qualitative research is conducted to determine if other social workers who provide informal care are struggling and to what extent women in this position cannot secure greater employment opportunities due to the impact that the COVID-19 pandemic collective trauma has had on already marginalized populations.

Finally, in this study, I explored whether FMSWs were better equipped to deal with the additional informal caregiving responsibilities due to their professional tools and activities or express higher rates of stress, burnout, and more negative reactions to negative spillover. My findings indicated that existing social work experience helped the FMSWs fulfill their informal caregivers' role. There may be further exploration of the factors that can ease the role of the informal caregiver, including male social workers, more experienced social workers, and social workers of all cultural backgrounds.

Implications for Social Change

My findings emphasized that discrimination against females, Black, Latinas, and members of the LGBTQ+ community exist in the areas of income, access to services/resources, and remuneration. Although these findings have been reiterated throughout the literature, it is still a challenge that has not been addressed entirely. It is of utmost importance to relieve female social workers' financial burden across all cultural backgrounds regarding social change. Even though White female social workers were believed to have better financial guidance, all women receive lower incomes than their male counterparts. Furthermore, many women are being left out or not climbing the ladder of success as the need for elder caregiving has grown at its fastest rate (Versey, 2017). If women are to gain full pay and employment equity with men while decreasing their current increased risk for adverse health outcomes, distress, and burnout, there must be some form of consensus amongst labor and professional policymakers regarding how to address these growing disparities. (Lyons et al., 2015; Versey, 2017). All forms of discrimination should be taken seriously, and policymakers should focus their attention on actions to fix the current discrepancies and reduce the possibility of discrepancies as a result of discrimination in the future.

Summary

I grounded this action research project in exploring and describing the short-term and long-term experiences and obstacles; FMSWs encounter working full time and providing informal care to an aging loved one. The purpose of my capstone project was to understand how FMSWs carry the additional stressors that arise when they, as social workers, simultaneously become informal caregivers for aging family members. Furthermore, I aimed to understand how these participants described the affective domains, feelings, strategies, and concerns when integrating two challenging roles: a social worker and an informal caregiver. Lastly, my purpose was to understand whether there were both short-term and long-term negative consequences for these FMSWs who informal caregivers for aging adults were.

I identified three themes for each research question. The nine related themes were developed by linking the research participants' experiences to the research questions. The themes were as follows: RQ1 - Feelings of stress, resiliency vs. burnout, and self-care;

RQ2 - Nonmaterial resources and strategies, support for informal caregivers, and SW gives valuable skills; and RQ3 - Identity disadvantages or advantages, burden, and fear of health-related consequences. Amongst these themes, the participants differentiated in relaying their stories and experiences based on race, background, and the nature of their recent life experiences.

My findings provided rich data that added value to the existing literature. My findings added new knowledge to the current literature by showing the positive implications of social work experience on the informal care responsibilities of FMSWs and the positive impact of practicing self-care, faith, and spirituality that assist FMSWs in managing their responsibilities. Several recommendations w made for future research, social work practice, and social change.

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Appendix A: Codebook

Name	Files	References
Background information	9	95
Care receivers	9	24
Aunt	2	4
Brother	1	1
Father	1	1
Friend	1	2
Grandfather and grandmother	1	2
Husband	1	1
Mother	4	8
Mother-in-law	1	1
Parents	2	3
Uncle	1	1
Caregiving activities	9	47
Access in the neighborhood	2	3
Checking that everything is in place	4	7
Food	2	2
Housework	1	2
Medications	4	7
Nursing home	3	4

Shopping	5	9
Taking care of finances and medical documentation	6	11
Toileting	2	2
Type of social work job	9	24
Associate director position	1	1
Child welfare	2	2
Church ministry	1	1
Clinical social work	1	1
Consulting practice	1	2
Geriatric social worker	1	1
Macro social worker	2	2
Private practice	3	4
Regional director	1	1
Supervisor	2	2
Teaching at the university or college	4	7
RQ1	9	154
Feelings of stress	9	56
Anxiety	3	3
It depends on a day	2	2
Depressed	1	1

Edge of the nervous breakdown	1	1
Emotionally drained	1	1
Fear	3	4
Frustrating	4	7
Insomnia	2	3
Interruptions	4	7
Not having time to breathe	2	2
Overwhelmed	4	6
Own emotional needs	1	1
Stressful	4	4
Struggling	6	10
Trauma	3	4
Resiliency vs. burnout	9	41
Balance	4	8
Caregiving is not an obstacle	3	4
Living the care receiver	3	5
Separate private and professional life	5	7
Setting boundaries	4	12
Social life	3	5
Self-care	8	40
Gardening	1	1

Hobbies	2	2
Outdoor and nature	5	5
SPA	2	2
Spending time with friends	1	1
Wine	3	3
Workout	4	4
The influence of the COVID-19 pandemic	7	17
RQ2	9	105
Nonmaterial resources and strategies	9	39
Being around older people	1	2
Being open-minded	1	2
Faith and spirituality	4	7
Free time	2	3
Good listener	3	3
Having connections	4	5
Having conversations	2	2
Having experience	1	1
Helping people	3	3
Identifying with other caregivers	1	2
Juggling	3	4
More aware of peoples’ feelings	1	1

Professional creativity	1	1
The value of upbringing	1	1
Voice of reason	1	2
Support for informal caregivers	9	37
Organizational support	4	6
Other family members are not involved	5	8
Paying for additional caregiving	4	5
Policymakers	1	1
Schools of social work	3	5
Support from close people	5	7
Support groups for caregivers	2	2
Supportive boss	3	3
SW gives useful skills	9	29
Insurance information	2	2
The job of SW is an essential part of life	4	5
Mandatory geriatric courses	3	4
See-through SW lens	2	3
SW as a 24-hour job	2	5
RQ3	9	69
Burden	7	13
Two jobs	6	10

Fear of health-related consequences	5	12
Identity disadvantages or advantages	9	44
Being a mother	5	12
Being Jewish	1	1
Caregivers and SWs are predominantly women and People of Color	2	2
Discrimination towards People of Color	2	5
An expectation of being a caregiver as a woman	4	5
Financial opportunities for People of Color	6	7
First-generation college-educated	1	1
Immigrant background	1	2
Informal caregiving as cultural practice	2	3
LGBT identity	1	3
Person with disability	1	1
Salaries and the gender gap	2	2

Appendix B: Interview Questions

SOCIAL WORK ROLE

1. What type(s) of social work do you provide?

2. What does being a social worker mean to you?

3. Does being a social worker impact your life in any way? Can you describe how?

INFORMAL CAREGIVING ROLE

1. Tell me how you define your role as an informal caregiver for an elder loved one(s)?

2. Can you tell me about your informal caregiving experiences and if it impacts your life or work? Can you share with me some examples of how?

UNDERSTANDING IF AND HOW THESE ROLES CROSS OVER INTO EACH OTHER AND IN OTHER AREAS OF YOUR LIFE

1. Can you share with me examples of how you manage to maintain a full-time role as a social worker while providing informal eldercare to a loved one(s)?

2. Is there any aspect related to your race, gender, gender preference, or sexual identity that you feel is important when understanding how you juggle both roles as a social worker and as an informal caregiver?

3. Do you think providing informal caregiving while working full time could impact your aging and retirement planning? Can you explain how?

4. Can you tell me why your experiences as a female social worker providing informal eldercare should be an essential focus at the schools of social work or for the National Association of Social Work?

Appendix C: Demographic Questions

1. If you are comfortable, can you tell me how you identify:
   a) your sexual orientation/identity?
   b) your race/culture?
   c) your current age?
   d) your religion?