


Usable Flexibility, Caregiving Concerns, and Health-promoting Behaviors: A Study of Employed Caregivers to Elders and Other Adults



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The U.S. workforce now includes many employees with caretaking responsibilities for elders and other adults (e.g., disabled spouses, adult children).

In one recent study, as many as 43% of employees 50 and older had provided elder care in the past year (quoted in Pitt-Catsouphes & Smyer, 2007).

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Previous research has focused on caregiving *per se* which has generally been operationalized in terms of objective indicators (e.g., caregiving hours).

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In general, objective indicators have been less closely linked to health outcomes than such subjective indicators as role quality (Neal & Hammer, 2003).

In this paper, we focus on a subjective measure of employee concerns about their care recipients, as distinguished from objective care burden.




CARE (Concerns about Adult Relatives and Elders)

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Employed caregivers are likely to have worries and concerns while they are at work about their dependents' well-being.

These concerns or CARE may be heightened today because the mobility of the American workforce means that many employed caregivers must provide care indirectly (e.g., through a relative or friend who lives close by or through an intermediary, perhaps a social worker).



Flexible work schedules might reduce employee caregiving concerns

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Flexible work schedules might reduce employee caregiving concerns.

But, Americans now work longer hours than their counterparts in other industrialized countries and typically have limited access to flexibility options.


Moreover, previous research shows that many employees who have access to such policies do not use them for fear of negative career consequences (Bond, Galinsky, & Swanberg, 1998; Williams, 2000).

Caregiving concerns are likely to escalate when work environments have inflexible work schedules, and/or penalize employees for taking advantage of flexible scheduling options.

High caregiving concerns are likely to affect employee caregivers.

Specifically, employees with high caregiving concerns might be more physically exhausted and emotionally drained and therefore less able to maintain their typical health-promoting routines.

For example, they may report a decrease in the amount of sleep they are getting, a decrease in eating healthy meals, and an increase in eating quicker-to-prepare meals (e.g., fast food and snacks), and a decrease in their exercise levels.



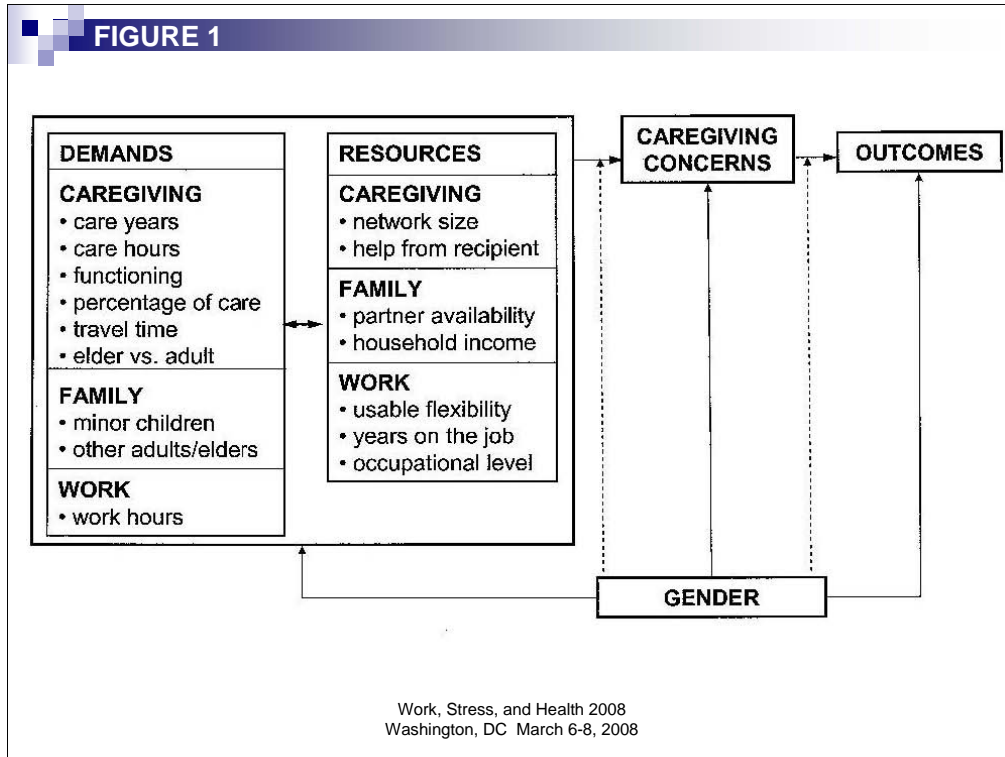
Usable Flexibility is the perception that employees can use flexibility options without incurring career penalties.

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In contrast to flexibility per se, usable flexibility creates an atmosphere at work that should reduce caregiving concerns.

Usable flexibility is the perception that employees can use flexibility options without incurring career penalties.

In this view, usable flexibility is a work resource that affects caregiving concerns, which, in turn, affect health-promoting behaviors.



As you can see, we conceptualize caregiving concerns as arising from the balance between available caregiving, family and work demands and resources.

To our knowledge, no previous attempt has been made to develop a measure of such concerns.




Concerns about Adult Relatives and Elder (Care)

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In the present study, we use a new 13-item measure of caregiving concerns, or CARE to assess employee concerns about care recipients.

Sample items

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1. How difficult is it for you to contact the care recipient you have selected while you are at work?
 2. To what extent are you concerned about the overall safety of the care recipient you have selected?
 3. To what extent are you concerned that the care arrangements that have been made for the care recipient you have selected will fall through or break down?
 4. To what extent are you concerned that the care recipient you have selected will face an unexpected need or situation and that no one will be available who is able to handle it?
 5. To what extent are you concerned that there will not be enough financial resources available to meet the needs of the care recipient you have selected?

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Usable flexibility

We asked participants to indicate whether six flexibility options were available to them. The response options were yes, no, and don't know.

1. flexibility to take off part of a workday to deal with family matters, if necessary,
2. flextime, or the ability to change regular starting and quitting times within a certain range of hours,
3. daily flextime, or the ability to change starting and quitting times on a daily basis,
4. compressed work week,
5. ability to work from home, if necessary, and
6. ability to work from home on a regularly scheduled basis.


Respondents also indicated on a scale ranging from 1 (*not at all*) to 5 (*extremely*) to what extent employees in their organization who used these supports would experience career consequences as a result.

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Usable flexibility was computed as the summed availability score divided by the penalty rating.

Thus, if all six forms of flexibility are available, but in one organization there are extreme penalties for using them and in another there are none, the usability flexibility scores would be 1.2 and 6.0, respectively.

The distribution of this variable is positively skewed, so we applied a log transformation to scores.

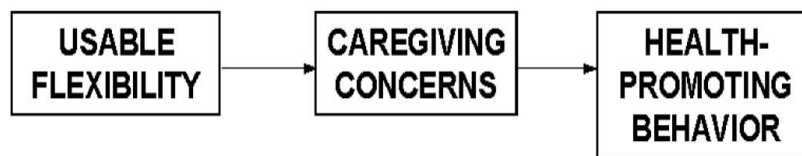


Little attention has been paid to the pathways through which usable flexibility policies might have positive effects.

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It is assumed that usable flexibility will have beneficial effects on employee health, yet little attention has been paid to the pathways through which usable flexibility policies might have positive effects.

Figure 2



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We then estimated a mediational pathway linking usable flexibility to caregiving concerns to health-promoting behavior.



Hypothesis

The relationship between usable flexibility and employee health-promoting behavior is mediated by a reduction in caregiving concerns.

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SAMPLE

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1. This sample was drawn from a larger study conducted at four companies, but employees at two companies were excluded from the present analysis because they were not asked about changes in health-promoting behavior.

2. 400 employed caregivers (79.5% women) who worked at one of two companies and who were providing or overseeing some care for an elder or other adult (18+) who is disabled or chronically ill, even if the employee was not the main caregiver.




Caregiving was defined broadly, as visiting, monitoring, or helping directly, as well as arranging, managing, or coordinating care that others provide.

Care recipients could live locally or at a distance and might be family members, friends, neighbors, or other adults for whom the respondents provided or oversaw care.

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How did we recruit our sample?



Four U.S. companies agreed to invite their employees to participate in a 20-minute Web survey including items assessing :

- demographics
- the caregiving situation
- caregiving concerns
- workplace supports, and
- a range of work-related and well-being outcomes

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We asked respondents to indicate the number of elders/adults for whom they provide/oversee care and the weekly hours of care they provide.

Respondents were instructed to answer the remaining caregiving questions with regard to a specific target care recipient; if they had more than one recipient, they were instructed to choose the one they worry about most as the “target.”



RESULTS

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Care Providers

Employee gender	79.5% women; 20.5% men
Race	80.1% white; 13.6% black; 2.4% Asian; 3.9 % other
Work hours	Mean = 43.9 hours per week (<i>SD</i> = 7.9; <i>range</i> = 20-80)
Age	47.6 years old (<i>SD</i> = 7.9; <i>range</i> = 20-70)
Household income	Median fell into the range \$90,000-\$104,999, considerable variability (e.g., 21.6% of the sample had household incomes under \$60,000).

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Care Providers, contd.

Marital status	65% married or partnered, 35% single
Partner availability	49.5% had a partner working 20+ hours per week; 15.2% had a partner working fewer than 20 hours per week.
Minor children	34.0% of the sample had resident minor children in addition to their elder/adult-care responsibilities.

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Care Recipients

Gender	68.2% women; 32.8% men
Age	Mean = 73.8 (<i>SD</i> = 15.8; <i>range</i> = 18-104)
Relationship	76.1% comprised respondents' or their partners' parents.
Living arrangements	43.5% lived in their own homes; 27.3% lived with the caregiver.

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Care Providers, contd.

Availability of flex policies	On average, 3.2 (<i>SD</i> = 1.9) of the six flex-time/flex-place policies were available at their workplaces
Likelihood of negative career consequences	29.2% of the sample reported quite a bit or extreme negative career consequences for using those policies
Care hours	Mean = 24.1 hr/wk providing or overseeing care over the past three months (<i>SD</i> = 33.5; <i>range</i> = 0.5-168.0).
Main care provider	81.9% were the main caregiver

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RESULTS

To test the mediation hypothesis, we estimated two regression models.

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Covariates

- Usable Flexibility
- Caregiving Concerns
- Caregiver Age
- Caregiver Gender
- Care Years
- Care Hours
- Recipient Functioning
- Care Percentage
- Travel Time
- Elder or Adult
- Number of Adults/Elders
- Work Hours
- Network Size
- Recipient Help
- Partner Availability
- Household Income
- Job Tenure
- Occupational Level
- Number of Minor Children
- Negative Affectivity



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Table 1						
<i>Model without Covariates: Mediating Effect of Caregiving Concerns on the Relationship Between Usable Flexibility and Health-Promoting Behavior.</i>						
Variable	Step 1: Usable Flexibility to Caregiving Concerns			Step 2: Caregiving Concerns to Health-Promoting Behavior		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Usable Flexibility	-.438	.146	-.149*	.042	.236	.009
Caregiving Concerns	---	---	---	-.416	.080	-.270*
<i>R</i> ²	.02			.07		
Adjusted <i>R</i> ²	.02			.07		

Note. *N* = 400 (20.5% men and 79.5% women).
* *p* < .05. † *p* < .10.

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In Step 1, usable flexibility was significantly linked to caregiving concerns.

In Step 2, caregiving concerns were significantly linked to health-promoting behavior with usable flexibility included in the model.

Following Baron and Kenny (1986), we used the Goodman (I) version of the Sobel test to assess the statistical significance of the mediation effect.

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Caregiving concerns were a significant mediator ($z = 2.56, p = .010$).

That is, employed caregivers who lacked usable flexibility on the job reported significantly higher levels of caregiving concerns (Cohen's $d' = -0.30$, a small effect; Cohen, 1988), which were associated, in turn, with changes for the worse in the way respondents took care of their own physical health (Cohen's $d' = -0.55$, a moderate effect).

We then entered all the covariates from Figure 1 in the models.

Again, usable flexibility was significantly linked to caregiving concerns, which were in turn significantly linked to health-promoting behavior.

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* <i>p</i> < .05. † <i>p</i> < .10. ❖						
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However, once all covariates had been entered in the model, mediation was no longer significant ($z = 1.59$, $p = .112$; Cohen's $d' = -0.33$ for Step 1 and -0.38 for Step 2).

Thus, the mediating effect was suppressed when the covariates were included.

Of particular note, our analysis controls for the effect of negative affectivity, which can be seen both as a control of the tendency to view life events negatively and as an adjustment for the common methods of self-report using Likert-type scales (Brennan & Barnett, 1998).


While we use negative affectivity as a control here, it has not been widely adopted in analysis of self-reported well-being.

The removal of negative affectivity alone while the other 17 covariates remain in the analytic models restores a clearly significant effect of the mediator ($z = 2.37$, $p = .018$).



CONCLUSIONS

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This is the first study to suggest a plausible pathway between usable flexibility and health-promoting behavior.


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Our findings suggest that employers and employees will benefit if employees are assured that they can take advantage of available flexibility options without career penalties.

Employed caregivers will then experience lower levels of caregiving concerns and employers will have workers who engage in health-promoting behaviors, resulting in fewer absences or costly health insurance claims.

Research suggests that even when flexibility programs are available, they are often not implemented or communicated effectively to employees (Bagilhole, 2006; Sabattini & Crosby, in press).


Therefore, another implication of our findings is that employers would be well advised to ensure that all employees are made aware of the usable flexibility options that are available.



Caregiving concerns may be a more powerful predictor of health-related outcomes than objective aspects of care burden.

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Moreover, given the paucity of results of previous studies relating elder caregiving *per se* to health, these findings suggest that caregiving concerns should also be assessed in future studies because more and more employed caregivers live at a distance and cannot provide direct care; therefore, defining caregiving solely in terms of direct-care provision excludes an unknown but probably large group of caregivers from caregiving research.




In cross-sectional studies,
health-promoting behaviors
may be more reactive to
caregivers' concerns than are
objective health outcomes

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These findings also suggest that in cross-sectional studies, health-promoting behaviors may be more reactive to caregivers' concerns than are objective health outcomes.


In future longitudinal studies, it would be helpful to include both change in health outcomes and change in health-promoting behaviors.



Future research linking caregiving concerns to health-promoting behaviors should look separately at employed and nonemployed caregivers.

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Finally, these results suggest that future research linking caregiving concerns to health-promoting behaviors should look separately at employed and nonemployed caregivers, as the relationships and pathways may differ.



In sum, our measures of usable flexibility and caregiving concerns (i.e., CARE) warrant further study.

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