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Female caregivers for elderly relatives in Russia: social barriers and stereotypes

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Abstract

The article presents the results of a study in which gender issues are shown using the example of variations in home and institutional care for elderly relatives. The objects of the study were women - close relatives of elderly people living in private boarding houses. The authors conclude that social factors such as gender stereotypes, stigmatization, and negative stereotyping of any form of care, except for home care, are the main barriers to turning to institutional forms of care and alleviating the plight of caring women. It is these factors that mainly hinder the development of alternative forms of care for an elderly person, which could provide professional care at a modern level, as well as contribute to an improvement in the quality of life of caring women. Conducting a study during a pandemic with limited opportunities for a personal meeting of an informant and an interviewer became the basis for using, along with traditional, a series of digital interviews, which allowed the authors to draw a number of conclusions about the application of new methods to sensitive gender issues.

Keywords: elderly people; board and care home; female caregiver.

Introduction

For several decades, the demographic situation in Russia has been developing in such a way that the aging of the population can be considered its most characteristic feature. The increase in the relative share and the total number of elderly and very old people sets new special goals and objectives for society. Nowadays, the focus of the desired future in old age is shifting from simple longevity to active longevity. More attention both in socio-economic and scientific discourse is now rightfully paid to representatives of the third age, namely elderly people, who having crossed the calendar retirement threshold, continue to be active actors in various areas of life.

However, the reality is that the third age is almost inevitably followed by the fourth one when health and strength fail and the elderly need more or less care and help from others. Under current conditions, this becomes a real challenge: If in 2006 there were 29.4 million people older than working age for 90.1 million people of working age, then in 2021 this ratio is 38.0 million for 81.4 million[1]. Moreover, an increase in life expectancy leads not only to prolongation of the active period of old age but also to an increase in several chronic age-related diseases in the later period of life, limiting self-care or making it impossible, among which it is necessary to

highlight psychiatric problems, for example, Alzheimer's disease. These factors keep the following questions current: by whom and how the help and support to elderly people in need of care will be provided regularly under modern requirements for ensuring the quality of life. The goal of the research is basing on example of women, which turned to such form of care as a board and care home, to identify and analyze contemporary problems, which they faced while and after the home care, as well as stigmatization and stereotypization of women in the period of care for elderly relatives

Theoretical basis

Historically, there have been several approaches to the implementation of care for the elderly in European countries. In some countries of Southern Europe (Greece, Spain, Italy), elderly people traditionally live together with relatives. The main burden, including the expenses, in this case, are borne by the family. In Germany, Austria, and France, social insurance plays an important role, and care is provided by special services (nurses, assistants, short-term and long-term accommodation in specialized inpatient facilities). In Sweden, Norway, and Finland, the main burden of care for the older generation, both financial and organizational, is put on the state through budget funding (Gilyadova, 2015; Anttonen, 2003).

At the same time, researchers identify such general trends that have formed as a response to the changing socio-economic and demographic conditions of recent decades as professionalization, commercialization, as well as broadening of the window of opportunities and implementation of care associated with them. The *professionalization* trend is due to the increased requirements for ensuring the quality of life of a person at any age, with the advent of new sophisticated medical technologies and means of care for people in need of care. The *commercialization* trend reflects the increased needs of consumers of such services, usually relatives of an elderly person, and is aimed at solving the issue of disburdening home caregivers. Both of these trends form the third one, *the expansion of the repertoire of care practices*, which allows for an elder-centered approach for an elderly person in need of care. It should be noted that under the pressure of the above objective factors, these trends are now observed in the countries of Southern Europe (Da Roit, 2007).

As for Russia, care for close relatives is traditionally entrusted to members of the family, as a rule, the female part of it (Zdravomyslova, 2014). The demographic and socio-economic transformations discussed above have not become a generator of changes in this area either at the institutional level or at the level of everyday representations. For example, the number of beds in inpatient social service facilities for elderly citizens and people with disabilities from 2008 to 2018 slightly increased from 251 to 263 thousand. At the same time, the number of such facilities during this time decreased from 1530 to 1280[2]. A review of domestic scientific sources also indicates insufficient attention of researchers to the problem, although interesting and significant writings of E. Zdravomyslova, O. Krasnova, E. Temkina and O. Tkach allow seeing the depth of the problem. The results of the studies presented in them capture a deep gender asymmetry, as well as a number of acute and insoluble issues faced by women who have assumed the responsibility of caring for an elderly family member (Krasnova, 2000; Tkach, 2015). The general conclusion of the researchers is unanimous: Home care for an elderly relative can be described as a stressful and destructive period in the life of a caring woman, since it negatively affects and is interconnected with many areas of the female caregiver's life.

Culture e Studi del Sociale-CuSSoc, 2021, 7(1), pp. 119-132
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This destructive effect, which has been emphasized by both Russian and foreign researchers, especially in prolonged care, has the following *targets*:

1. *Helper (caregiver) health*. The issue of preservation of health is developing in connection with both the objectively greatly increased costs for the home care, which is reflected by the society in Russia first of all as a female duty, and with the subjective perceptions of the burden as unsustainable. Female caregivers experience strong emotional stress associated with constant tiredness and emotional burnout. This is especially true for people caring for relatives with dementia. Current studies confirm the findings of L. Pearlin (Aneshensel, Pearlin & Schuler, 1993) about the multi-factor nature of stress in care for elderly people with dementia. According to these findings, the primary stressors include the time spent by the female caregiver, pressure and physical work; the secondary stressors include those that are caused by nervous exhaustion and a lack of resources, namely conflicts, problems in the family and at work. Further, the "secondary intra-physical stress" is added, leading to a loss of self-respect and loss of self, and thereby physical health deterioration: The emergence of new and exacerbation of chronic diseases. Thus, according to studies by M. Alshanskaya, A. Makushina, N. Aleksandrova, conducted among female helpers caring for elderly relatives, 15% of respondents experience fear and anxiety about the preservation of their health, 18% of respondents state that they look worse, 21% of respondents state constant tiredness and a decrease in overall vitality, 34% of respondents report a deterioration of sleep, appetite and mood, (Alshanskaya, Makushina, Aleksandrova & Lemish, 2019). Conspicuous is the fact that in our opinion, deterioration of sleep and appetite of caregivers are more objective markers, while the rather low percentage of people who are concerned about their health can be explained by social attitudes, according to which the fulfillment of family responsibilities in care cannot and should not be accompanied by negative emotions;

2. *Home environment and family atmosphere.* As a rule, the decision to live together and provide care for an elderly relative is made in families collectively and is usually supported by all family members (Krasnova, 2000). This is due, firstly, to the traditions of intergenerational relations: The prospect of living together with an elderly relative is discussed or, at least, spoken out long before the decision is made, therefore it is often perceived as unambiguous and inevitable. Secondly, such a living, to a variable degree, helps the family to solve or improve their living conditions: either to expand their own apartment or to provide separate housing for the younger generation. However, in general, *relatives are unprepared* for the difficulties and problems that inevitably accompany such a decision. 56% of respondents report a significant change in their lifestyle after they start living with an elderly relative, 40% report a significant decrease in quality of their life due to the need to care for an elderly relative (Alshanskaya *et al.*., 2019).

Studies by O. Tkach indicate that a "caring home", on the one hand, sidelines an elderly person, on the other hand, the home environment is completely remade to suit his/her needs (Tkach, 2015). The daily routine of all family members changes, special pieces of furniture, helping devices, care products, and new smells appear. The house becomes a hospital with single patient and unqualified personnel. Inadequate housing, blurring of personal boundaries and a chronic shortage of free time often lead to a narrowing of social contacts of an elderly person's relatives and further isolation. Therefore, the family atmosphere is often characterized by increased conflict (Stuart-Hamilton, 2002). High physical and psychological stress lead to a lack of attention and support that family members providing constant care for an elderly person give to each other. This is confirmed by the findings of gender-

studies, according to which all female respondents (family caregivers) state that they pay much less attention both to themselves and to other family members (Alshanskaya *et al.*., 2019). The important fact should be mentioned that care for an elderly ill relative is far from being universal. By presenting an elderly person as an impersonal object of care, we miss a whole layer of problems, and therefore, opportunities for constructive analysis. In fact, the history of the caregiver's relationship with the elderly relative is imposed on the initially difficult life situation of constant, often long-term care, intensifying the pre-existing conflicts between them. Moreover, it is extremely important how successfully the elderly person has overcome his/her, perhaps, last age crisis. D. Levinson states that the positive option in this case is associated with the giving in of the leadership and playing "supporting roles" (Levinson, 1980). According to R. Peck, the successful aging of a person and its final part are associated with "loss of self-concern" and a shift in attention to the well-being of close ones who are left without him/her. If this final crisis is not overcome by an elderly person due to different life circumstances, then another direction of attack on the home environment and family atmosphere of relatives is formed (Peck, 1968);

3. Career. Overload of female caregiver, fatigue, negative emotions, lack of free time and stress affect her professional life. Thus, 15% of women caring for ill elderly relatives leave their jobs due to the inability to combine care and career (Alshanskaya *et al.*., 2019). A decrease in performance efficiency during this period of life may be evidenced by the fact that almost a one fourth of female caregivers report that they have financial difficulties (Alshanskaya *et al.*., 2019). K. Aneshensel and L. Pearlin, based on their studies, found that the consequences of care, which are not directly related to the care settings, have the most direct impact on the career of a family caregiver. The authors describe such secondary stressors as a long-term stable feeling of a state of captivity or imprisonment, critically reducing a person's potential, which harms her career efficiency.

It is worth noting that the overwhelming majority of female caregivers in Russia are 45-60-year-old women, daughters (or wives of sons) of elderly ill relatives who need constant care. Turning to the well-known periodization of the labor subjects' development by E. Klimov, we can see that at this age a specialist is either at the stage of his/her excellence or, with favorable development of events, enters the next stage - the stage of authority (Klimov, 1996). In any way, his/her working activity is stable and maximally effective, has an individual, unique style, which is confirmed by such formal signs as high skill category, academic degree, rank. Consequently, the traditional shifting of the burden of constant care for elderly ill relatives onto family caregivers (or, more precisely, female caregivers) reduces the contribution to the country's economy of the most resourceful part of the population in terms of professional competence. Intensive home care lasts from several months to several years. At the current rate of development, it is very hard for a family caregiver to return to previous positions after such a long break.

Private board and care home as an alternative form of care for the elderly

The traditional model of family care in modern demographic and socio-economic conditions comes into conflict with reality. A total underestimation of the burden of female caregivers, while discussion of the problem at all levels in the categories of responsibilities and customs have not only sad but fatal results for many people:

Culture e Studi del Sociale-CuSSoc, 2021, 7(1), pp. 119-132
ISSN: 2531-3975

1) problems of one social group are solved mainly at the expense and by means of another, the damage of which we have just considered;

2) excessive burden of female caregivers, leading to emotional burnout, cannot but reduce the quality of care;

3) obsolete rules impede the development of social institutions and market mechanisms that could relieve female family members of an elderly relative in whole or in part, and give them a choice that they currently do not have (or have a little alternative as an exception).

We are faced with logical questions: are changes possible, and is society ready for them? Researchers note an increased conservatism and traditionalism that are characteristic of the economically poor, which, together with limited affordability, practically close the possibility of initiating changes from there. Therefore, the "first echelon" in the transition to new (or combined) forms of care for ill elderly people are better-off groups (Da Roit, 2007). Thus, in response to the changed conditions and the social demands that have just begun their formation, private board and care homes for the elderly began to be made in large cities.

Analysis of the market for the services provided and living conditions allows getting a fairly clear idea, since, although the offers vary significantly in terms and prices, it is possible to highlight the features and characteristics inherent in most objects. A modern private board and care home for the elderly is usually a two-story house with a well-equipped backyard area intended mainly for walking. The price includes five or six meals a day, medical care and leisure activities. Twenty-four-hour medical supervision in private board and care homes is achieved in a very simple way: A specialist with secondary medical education and experience of working as a nurse is appointed as the head (senior caregiver). Such work presupposes accommodation and meals in the board home itself, which are attractive working conditions for many people who come to Moscow for work. Private board and care homes accept elderly people, both for permanent residence and for limited periods, for example, during the vacation period of relatives who provide primary care. The residents of such facilities are people not only with serious diseases (dementia, blindness, diabetes) but also relatively independent elderly people, for whom it has become uncomfortable to live separately.

Method and methodology

The goal of the study and research questions.

Our study aimed to identify the grounds, causes, and social barriers that arise and are formed among women caring for elderly sick relatives while turning to such a form of institutional care as private boarding houses for the elderly. Research questions are:

- Why do female caregivers turn to the institutional form of care of elderly relatives?
- What kind of barriers and stereotypes have been they faced while seeking of assistance from private board and care homes for the elderly?
- How can female caregivers evaluate the results of turning to the institutional form of care of the elderly relatives?

Method.

The study was planned by in-depth interviews in Moscow and the Moscow Region for the spring of 2020. The empirical base should have been 64 in-depth unstructured interviews with women in Moscow and the Moscow region aged 40 to 65 years. The informants were close female relatives of elderly people living in elven private board and care homes (N=64). The board and care homes that are located in different districts of Moscow and the Moscow Region and offer care services in the price range from 750 to 2000 rubles per day were selected for the study, which was due to the need to minimize the possible economic determinism. The socio-demographic structure of the sample corresponds to the socio-demographic specificity of the group (repeatedly articulated by Russian and foreign researchers) that traditionally provides home-based care, and thus includes the majority of 45-60-year-old women with an average income[3] (from 40 to 70 thousand rubles).

The interview guide had three conceptual blocks. The first block dealt with the reasons why informants turned to the institutional form of care. Within the framework of the second block, the main attention was paid to the barriers faced by the informants in deciding whether to seek assistance from the private board and care homes for the elderly. The final part considered the informants' evaluation of the "final results" of this decision.

Pandemic-related limitations and methodological solution.

Began in spring 2020 the COVID-19 pandemic changed our habitual way of life. In the context of sociological research conducted by the qualitative interview method, this was expressed in the following methodological limitations:

- Low motivation of informants to take part in face-to-face interviews due to health risks;
- Due to the anti-COVID measures, the possibilities of free movement around the city were limited, therefore it was difficult to hold a personal meeting between the researcher and the informant;
- Due to the anti-COVID measures, almost all public spaces were closed, so finding a place to conduct interviews was a challenge.

These limitations put us before a choice: to stop the study; to limit the number of interviews with the number of already provided face-to-face interviews; or to adapt the qualitative research methodology to new conditions.

During the pandemic, the role of digital technologies has grown significantly: They turned from a highly specialized sphere into one of the most important means of labor and "means of production". This transformation has affected the methods of sociological research as well. Accordingly, it was decided to replace the face-to-face interview with an online/digital interview in the form of in-depth interviews in Skype or Zoom, when the informant was at home and at a convenient time. The guide of the interview remained the same. Since pandemic-related restrictions have become more stringent since fieldwork began, 25 interviews were traditional, and 39 were conducted using digital technologies.

As we decided to continue our study in new conditions and with an updated methodology, the methodological goal of the study was added to the sociological one: to analyze and compare the features, as well as the level of openness of

Culture e Studi del Sociale-CuSSoc, 2021, 7(1), pp. 119-132
ISSN: 2531-3975

informants during traditional and digital interviews on a sensitive topic within the framework of gender research.

Results

Decisions made and the reasons for their making.

In the first part of the interview, most of our informants state that much work prevents them from providing quality home care as a reason for turning to private board and care homes for the elderly: *"I work a lot. My mother can no longer stay alone in the apartment. She needs constant supervision. Therefore, we made such a decision. The whole family, together. Here she is under medical supervision, and that gives us peace of mind"* (Valentina, 56 y.o.).

However, references on other grounds for such a decision were appearing during the interview. Thus, it turned out that in most cases, applying to a private board and care home was preceded by many months and years of family care. According to our informants, their own *health* was becoming materially worse during that time. Here are some excerpts from the interview: *"To be honest, I was physically unable to take care of my mother. My health simply deteriorated. When I started caring for her, I was a perfectly healthy woman. Over a year, I turned into a wreck. Before that, I was doing fitness, I could run several kilometers. And that all gone in a year. I am not talking about running, it became difficult for me to get to the metro station without stopping because of my heart condition"* (Zhanna, 49 y.o.); *"I am not in good health now. By the way, I even have records that evidence this. I undergo a preventive medical examination every year. So, after a year of such a life, my cholesterol is 9 (normal is 4), and my hemoglobin is greatly increased. Do you know who has such results? Soldiers during military operations. I read that the Americans conducted such studies. That is, my body decided that I am at war. My blood really got oily and thick. Probably so that I don't lose a lot of blood in case of injury. That's what I have"* (Oksana, 50 y.o.).

It is necessary to highlight the influence of the *experience* of friends who have been providing family care for many years on the decision to use the services of a private board and care home. Informants state that there are women in their environment lifestyle of which has become a warning for them: despite the social approval of home care, the female caregivers themselves are deprived of private life, their health is undermined, and communication with other family members is broken: *"My friend has been caring for her paralyzed mother for 7 years. During this time, she developed cancer. She turned into an old woman. The children were just at a transition age, it turned out that they grew up practically without their mother because she could not be everywhere at once, she started using drugs as a result. Such a tragedy ... My friend said that she would probably die before her mother. And I listened to her and thought to myself – so would I* (Marina, 56 y.o.); *"There was also an example before my eyes: a neighbor was taking care of her mother. Her mother has been wrong in the head for a long time, for many years. The neighbor has now health issues, she looks older than her mother, she quit her job. Honestly, when I look at her, I understand that my life will become like that very soon"* (Irina, 55 y.o.).

Many informants reported the deterioration in the psychological climate in the family, an increase in conflict during the period of home care, affirming the point of the crisis nature of long-term care for an elderly seriously ill patient for the whole family. Moreover, the frequency of conflicts increased between the female

caregivers themself and both the elderly persons and other family members. Our informants attribute this mainly to two factors, namely physical and psychological overload and character traits of the elderly person: *"I was so tired that I began to take out on everyone, the family, of course, was the first one. But, at the same time, it was hard to provide care, I felt exhausted"* (Nadezhda, 60 y.o.). The results of the interviews confirm the findings of the researchers (Levinson, Peck), given above, and make it possible to separate the issue of caring for elderly parents who have stable personality traits throughout their life that make it difficult to communicate with them. Under home care, this circumstance greatly increased the crisis of the situation for the caring women: *"My dad has been hard to get on with all his life. We took him to live with us to take care of him, he became medically fragile. But it turned out that only physically. The character traits remained as in his youth. He was bringing me to white heat and I used to think: it would be better if he had dementia..."* (Elena, 52 y.o.).

A fundamentally different opinion about the reasons for using the services of a private board and care home was given in only one interview. The informant resides permanently in the United States, and for several years her elderly mother is a resident of a private board and care home in Moscow. She stated that the appropriate choice was made due to the impending departure, the transfer of such experience to her own approaching old age: *"This is a very good board and care home. Mom feels good here. I am constantly in touch with her and with the personnel ... When I retire, I will return to Moscow. I have a son with his family in Moscow. And I told him a long time ago that I wanted to live in the same board and care home. Many people in America do this, and I think it's right"* (Natalia, 55 y.o.).

However, in most cases, the decisions on the need for using the services of private board and care homes by our informants were made only after tangible damage to health and other personal losses against the background of the conviction that it was impossible to provide full care for an elderly person and their acute experience of this fact. Here is an interesting statement about the period of home care made by Anna, the daughter of an elderly woman suffering from dementia, who has been living in a board home for more than a year: "*While this does not affect you personally, you have no idea about this problem, about the fact that many families live like this for many years, just like in captivity. But when this affects you, it is as if you are in an extra dimension. Suddenly it opens up to you how many families and women live like this! And before that, I did not even notice them, as if they were invisible to me"* (Anna, 54 y.o.).

Barriers or why is it so difficult to make a decision?

One of the main questions of the study was the question of the factors that impeded the choice of a private board and care home as an alternative form of care. The analysis of the previous block (on situations and reasons for such a choice) made it even more current. Indeed, despite the heaviest, traumatic conditions for everyone that is involved in the home care, the unbearable burden on the caregivers when they realize that it is impossible to provide care that meets modern requirements for quality of life, nevertheless, the decision on an alternative form of care is postponed by our informants to the utmost. It seems clear that this is possible only in the presence of very specific, extremely high barriers, to overcome which extraordinary events or conditions are required. The results of the gender-study made it possible to reveal the social nature of the studied barriers and to highlight several specific features.

Most of our informants reported that they initially (in the first months of home care) did not get by with alternative care. As a justification for this position, first of all, we can identify the great influence of the cultural model of kindred care for the older generation. The informants sincerely wanted to provide home care, as was customary to their families and the families of their acquaintances: *"You see, at first this* (private board and care home) *did not even occur to me. I knew that it was my turn to wear ball and chain. And that was that. Every woman does it"* (Oksana, 50 y.o.).

An excerpt of an interview with Anna, in which she talks about the first consultation with a psychiatrist that came on a house call to her mother, who was then still suffering from the initial stage of dementia, also indicates the gradual nature of the problem awareness. In an interview, the informant fixates on the change in her views on the issue of care: *"My mom started to behave in a queer way. I was completely at a loss and didn't know what to do. An emergency doctor (psychiatric service) arrived. He was an elderly man. He talked to my mom. And then he came to me and said: "Do you know how many deaths I have seen?" I was so shocked and asked again: "…of such patients?" And he says: "No. Their relatives." Can you imagine that? And then he said straight to my face: "She won't feel better. But you will lose your health. In a year or two, you will be fired, because you will not be able to work normally. Take your mom to a board and care home. There she will be provided with professional care, and you will save your life." My indignation knew no bounds. What a board and care home?... Then I understood everything. You know, I thought back the words of this doctor every day afterwards. He was right about everything"* (Anna, 54 y.o.). The given excerpt of the interview records the change in the informant's attitude to the problem under the influence of expert knowledge.

An analysis of the interviews allows assuming that the traditions of self-sacrifice, family stories of female home care (often colored and reconstructed in the memory of descendants with the help of time and the older generation), which form the views of the caregivers themselves, act as the primary barrier, the basis of the lack of alternative to home care. Moreover, our study has shown that this state of things is maintained and controlled by the social environment of caring relatives, making barriers of the next (second) level. For five years, our informant Oksana was independently caring for her mother, who had several strokes: *"Then I came to realize that it couldn't go on this way; I felt absolutely done mentally and physically. And most importantly, I couldn't help her much. But there was also a fear of social judgment. And I knew such cases"* (Oksana, 47 y.o.).

The following fact gives the understanding of the "height" of this ("secondary") barrier: almost all of our informants hide from others that they have moved away from the traditional model of care, entrusting the care of a relative to the personnel of a private board and care home. *"I don't tell anyone that my father lives in a board and care home, especially at work. Everyone will condemn me. All five years, while I was caring for my father myself, I was torn between two houses (my father lived separately, and I had a small apartment), all my colleagues were closely following the process. I was regularly asked with deprecatingly when would I take my father to my place? Moreover, none of those who controlled the execution of my mission as a daughter took care of their parents themselves"* (Polina, 49 y.o.). Our informant Zhanna told us about her condition and the first conversation with the senior from the board home, where her mother lives now: *"I often reminisce about Nadezhda. This is the main person in our board and care home. I remember how she calmed me down when we brought my mother there. She said that she saw how relatives are stressed, so many tears... After all, it is clear that it is no longer possible to live like*

this, and there is a feeling of shame at the same time... Nadezhda helped me a lot to psych up" (Zhanna, 49 y.o.).

Starting our study, we assumed that one of the main obstacles to turning to alternative forms of care, perhaps the main one, would be the financial issue. The most common cost of living in a private board and care home on the market is about 30-35 thousand rubles per month (medicines and hygiene products are not included in this amount). However, our study did not accept this hypothesis. *"As for the money ... Yes, it is probably expensive. Our family is limited. But how can all this be measured with money?"* (Olga, 50 y.o.). *"Of course, this is a serious part of the family budget ... Is this an obstacle? No. But now I know how much my life cost - 32 thousand rubles a month"* (Evgenia, 53 y.o.). The traditionally important money issue in line of our problem is clearly on the periphery. The fact that the financial component is almost lost among the influence of cultural practices, socio-psychological contradictions and dramas allows seeing the extraordinary power of this influence.

How the life changed

All our informants highly rated the living conditions in private board and care homes. The interviews stated the friendliness of the personnel, good food, high quality medical care: *"I can only say good things about our board and care home. It is so clean there. There is absolutely no bad smell, it's so surprising. The food is good there, bathing is twice a week. And the important thing is that my mom can communicate with patients of the same age"* (Anna, 54 y.o.); *"The conditions are excellent, of course. The garden plot is large. There is a lawn, cedar trees, a summerhouse. Each room has a TV. The main thing is that the personnel is always in touch with us. We can call at any time, they will tell how are things going, what we need to bring there"* (Alla, 59 y.o.). Most of the informants stated that as a result of the move of an elderly relative to a board and care home, the quality of care for him/her did not deteriorate in comparison with home care, and in some cases, it improved, which informants associate with medical supervision and the constant presence of nurses.

Positive changes are recorded in the lives of our informants after turning to alternative forms of care. It took some time (from several months to a year) for many of them to recover the lost physical and psychological resources, especially in situations of previous long-term home care. *"How has my life changed? A lot. I was recovering for about six months or even more. But now, of course, my health is much better, and, most importantly, I can work normally now, I have the energy"* (Nadezhda, 47 y.o.); *"Honestly speaking, I still wonder how I was not fired then, and how I survived in general..."* (Tamara, 55 y.o.); *"The depression has passed, I pay attention to my grandchildren, this is what I live now"* (Polina, 58 y.o.). The results of the interviews reflect the improvement in the life of both an elderly relative (through the strengthening of the professional component of care, medical supervision, the emergence of new social contacts) and the informants themselves, who have received the right to privacy and free time.

Is everyone happy now?

A separate block of interview questions is about the study of the emotional component of the problem. Thus, the feelings and emotional sufferings of informants about the stay of a relative in a private board and care home at the time of the survey,

Culture e Studi del Sociale-CuSSoc, 2021, 7(1), pp. 119-132
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as well as how, in general, the informants express the situation of using this form of institutional care are of interest now.

Although the majority of our informants clearly recorded an improvement in the quality of their lives in almost all the aspects, as well as a high level of professional care for a relative provided in a board and care home, the study revealed *the overwhelmingly negative emotional coloring in the perception*. For example, some informants admitted that they felt like traitors and guilty all the time for not caring for a relative on their own. Almost all of our informants told us about oppressive feelings and emotions, to one degree or another accompanying them throughout the entire period of a relative's stay in a board and care home, so this can be identified as a tendency. *"It's hard for me to think that strangers are taking care of my mother... I seemed to have broken with something important, tradition or something else... Yes, I understand that this is better for everyone. But there is still a guilt feeling"* (Valentina, 56 y.o.); *"Deep down inside I consider myself a traitor. Is it irrational? Yes. But I feel it"* (Lyudmila, 60 y.o.); *"Is it bad when your parents are in a care home? Of course, it really depresses me. I constantly think if it is possible to somehow solve the issue differently, I go through some options. But I can't find a way out..."* (Oksana, 50 y.o.).

The pathologization by informants of the preference for institutional care for close relatives revealed in the course of the study, their acute experience of non-fulfillment of social practices by them, provoking guilt, are reflected in the frequency and emotional coloring of visiting of relatives in the board and care homes. Some informants state that they visit an elderly relative less often than they could due to feelings of guilt. Such visits are distressing for many informants. *"We visit dad regularly. Once or twice a month... But, of course, it's hard for us. I don't understand why. I try to transfer more money and the personnel can buy him more fruit and sweets. But still, after visiting him, I don't feel very well the next day. Although everything is fine, and heartful people work there"* (Polina, 58 y.o.). Interestingly, the informants themselves record the discrepancy between the objective conditions and the quality of life and their emotional perception.

Methodological results

The second significant part of the study was a transformation of the chosen methodological approach, which was caused by new conditions and restrictions related to COVID-pandemic. The research method was the in-depth interview, but at the moment of the beginning of the empirical part, COVID measures became stronger, so we planned to provide interviews in proportion 1:1 – 1 "traditional" per 1 "digital"-interview. But the restrictions became even more harder and that became impossible to conduct face-to-face interviews, so we provided 25 traditional and 39 digital interviews. In interviews, several informants were allowed, as an exception, to turn off the camera while discussing the most sensitive topics and talking about the most emotionally difficult experience.

Discussing methodological results, traditional and digital interviews should be compared according to the following criteria: (1) duration; (2) emotionality of informants; (3) subjective comfort of informants; (4) willingness of informants to discuss sensitive topics.

Duration. The duration of the digital interview lasted 20% longer (ca. 60 min. for traditional interview and ca. 80 min. for digital interview) due to two main reasons: (1) the block with instruction was expanded; (2) being in a comfortable environment,

informants either mentioned more details or, conversely, digressed and changed the subject.

Emotionality of informants. Due to the high sensuality of the research topic, the level of emotionality of informants was very high during traditional as well as digital interview.

Subjective comfort of informants. The level of subjective comfort was higher when conducting digital interview since the informants were at their homes and at convenient time. During the COVID-pandemic that was a very important condition for the informants, that there was no need to leave their own houses (due to the health risk). At the same time, digital interviews were conjugated with the risk of technical malfunctions and defects 'caused by dependence from the Internet connection and the individual technical skill and experience of each informant.

Willingness of informants to discuss sensitive topics and openness.

We did not notice any significant differences between the levels of openness during traditional and digital interview, but during digital interviews, respondents were less likely to avoid the most acute and sensitive topics. That should be also emphasized, that respondents were very thankful as they were allowed "to hide a face" (turn off the camera) while talking out the most stressful themes and topics.

Generalized, several main advantages, as well as disadvantages of digital interview as a research method, could be named. The advantages are (1) digital interview became a full-fledged alternative for traditional face-to-face interview in conditions when personal meeting is impossible or related to personal risk for participants; (2) this makes it easier for informants to talk about the most sensitive topics. The disadvantages are (1) dependence from Internet connection and technical skill of each respondent; (2) since there is no direct face-to-face contact, the researcher should save attention, concentration and interest of the informants for the talking.

Conclusions

Thus, the results of our study allow drawing the following conclusions.

1. Private boarding house and nursing home - the "last choice" option for relatives of elderly people who need constant care. It applies when all adaptation options have been exploited and one or more primary goals (health, home environment, caregiver career) have suffered significant damage;
2. Barriers preventing the use of this form of institutional care are social factors - social stereotypes and traditions of gender and intergenerational relations, normalization and the cult of self-sacrifice, fear of social stigma;
3. There are also feelings of guilt and betrayal that accompany relatives throughout the entire stay of an elderly person in a boarding house and nursing home, as well as public disapproval of this practice;
4. Informants recognize that feelings are ambiguous and rather negative, and their feelings are irrational, and their assessments are contradictory.

Culture e Studi del Sociale-CuSSoc, 2021, 7(1), pp. 119-132
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The analysis carried out does not contradict the data of other authors and confirms that constant home care for elderly sick relatives carries a pronounced strong gender component and is a critical life situation for caring women. The main barriers to the formation of new, multivariate forms of care are in the field of social, including gender stereotypes and ideas that reproduce outdated norms of intergenerational care that are often unsuitable for modern life. As the main constraint, these social perceptions limit the development of a whole range of modern forms of care (which has been shown in the example of private boarding houses), which provide the elderly with decent care, and their children the opportunity for private life and professional fulfillment.

Discusses results of the "methodological experiment" one can say for sure that the methodology of digital research showed its effectiveness: through digital methods under condition of contemporary "COVID-Society" sociological researches (even in such sensitive fields as gender-studies) staid possible and staid theoretical relevant. The study made showed there are some advantages of using of the method of digital in-depth interview: 1) there is no need for direct face-to-face interaction (it is especially relevant for today); 2) this makes it easier for informants to talk about the most sensitive topics. The most important disadvantage of this method is dependence from the software and speed of Internet-Connection: both researcher and informants should have necessary skills in personal "video-communication". The second one is that because informants stay at home or in other "comfortable" places the researcher should save attention, concentration and interest of the informants for the talking.

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