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"Day and night people run after money … where is the time to spend chit-chatting with parents?": Challenges of, and coping strategies for, supporting older relatives in adults of varied socioeconomic backgrounds in Tamil Nadu, India

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ABSTRACT

Fertility has declined significantly across the socioeconomic spectrum in the south Indian state of Tamil Nadu, which has the potential to increase the strains of support provision for family members and to limit support for dependent older people. We used a qualitative approach to explore the challenges that adults (N = 113) from varying socioeconomic backgrounds (urban/rural and socioeconomic status) in Tamil Nadu experience when supporting their older relatives, and to understand how they cope with these challenges. While the broad challenges mirrored those seen elsewhere in India and globally (e.g., role conflict), some were particular to the context of contemporary Tamil Nadu (e.g., difficulties around supporting son/child-less or non-co-resident elders). The challenges experienced were qualitatively similar across socioeconomic groups but affluent families had more coping strategies available to limit the negative outcomes of support provision. We highlight the potential value of universal health coverage for promoting family-based support for older Indians, the urgent need for strategies to ease the challenges for lower socioeconomic status families, and the importance of wider socioeconomic policy to reduce the financial and time pressures that restrict the support that much of the population can provide each other.

1. Introduction

Policy makers across the globe are grappling with how to meet the needs of growing populations of older people. Currently, unpaid social ties such as family or friends are key sources of social support (e.g., material, practical, emotional) worldwide, which saves considerable public funds (Wimo, Gauthier, & Prince, 2018). Support provision (or more typically, exchange) is a standard component of social relationships. However, providing support for a family member in need (for instance due to illness, disability, or other reasons) can be challenging and can result in adverse health and wellbeing outcomes (Del-Pino-Casado, Cardosa, López-Martínez, & Orgeta, 2019; Schulz, Beach, Czaja, Martire, & Monin, 2020). When family members feel burdened by their support role, conceptualised as "caregiver burden", it can lead to relinquishment of the role and increase the risk of elder abuse (Bastawrous, 2013; Johannesen & Logiudice, 2013; Luppa, Luck, Brähler, König, & Riedel-Heller, 2008; van der Lee, Bakker, Duivenvoorden, & Dröes, 2014; Zarit, Reever, & Bach-Peterson, 1980).

The challenges of support provision could significantly impact societies with ageing populations, systems of support that primarily rely on unpaid support providers, and limited social welfare systems. In India, alternatives to family-based support are limited for much of the older population. Formal care and private health insurance and pensions are only available to a minority of wealthier urban individuals, and though public pensions are targeted at people below the poverty line, uptake is low (Brijnath, 2012; UNFPA, 2012). The Indian healthcare system is characterised by high levels of out-of-pocket spending across socioeconomic strata (Bali & Ramesh, 2015; World Health Organization, 2020), meaning supporting an older relative can also involve financing of healthcare costs (Pandey, Ploubidis, Clarke, & Dandona, 2018). However, this may be changing as the central Ayushman Bharat scheme was introduced in 2018 to improve the primary care system and provide

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insurance coverage for secondary and tertiary care for 40% of the Indian population (Chalkidou, Jain, Cluzeau, & Glassman, 2019).

In 2007, the Government of India enacted 'The Maintenance and Welfare of Parents and Senior Citizens Act', hereon referred to as the Maintenance Act (Ministry of Social Justice and Empowerment India, 2007). The Maintenance Act legislates to place the responsibility of supporting "senior citizens" (aged 60-plus) on children, or relatives if deemed potential heirs to property of childless individuals. The support ("maintenance") is defined as food, clothing, residence, and medical attendance and treatment. The act also provides for old-age homes in each district, which are the responsibility of state governments, though institutional care is highly stigmatised (Brijnath, 2012; Dey, 2016; Ministry of Social Justice and Empowerment India, 2007). In sum, support in later life remains largely the responsibility of the older individual and their spouse – a large share of Indians continue to work at older ages out of necessity– or their children (Selvaraj, Karan, & Madheswaran, 2014; UNFPA, 2012). Sons and daughters-in-law are socially expected to support older parents due to the patrilineal and patrilocal structure of much of Indian society. Despite this, evidence from Tamil Nadu (the focus of this study) indicates that sons of low-income families often do not co-reside with or financially support their parents, particularly if they feel they lack the resources to also adequately support their own nuclear family (Vera-Sanso, 2004).

Tamil Nadu has distinct family structures that could impact the support experience. Fertility rates are among the lowest in the country and sonless families are relatively common (Allendorf, 2019; International Institute for Population Sciences (IIPS) and ICF, 2017a). Crucially, fertility has dropped significantly across socioeconomic strata. Fertility is low in rural women (Total Fertility Rate (TFR) = 1.9 versus 1.5 in urban women) and lower socioeconomic status women (TFR = 1.9 versus TFR = 1.7 in least versus most educated women, in comparison to TFR = 3.1 and TFR = 1.7 at the national level) (International Institute for Population Sciences (IIPS) and ICF, 2017b, 2017a). Co-residence with children is also among the lowest in the country (Ministry of Statistics and Programme Implementation, 2016). These family structures could indicate high time strains for support providers and less readily available support for older people without sons or living independently. However, it should be noted that having a son or co-residing with children does not necessarily translate to support needs being met, and vice-versa (Jothikaran, Meershoek, Ashok, & Krumeich, 2020; Vera-Sanso, 2004).

There is a wealth of evidence that supporting older relatives can impact people differently. Socioeconomic status for example, is theorised to affect the challenges that people experience as well as the ways they manage these (Pearlin, Mullan, Semple, & Skaff, 1990). Quantitative evidence from India indicates that family income is negatively associated with the feeling of being burdened (Gupta, 2009) but does not elucidate how it is related. The qualitative literature from across India has highlighted the difficulties of funding out-of-pocket healthcare costs, supporting individuals with dementia with limited understanding of the condition, the impact of dual-career households on family conflict and providing in-person support, the high time and emotional strains on daughters-in-law, and the difficulties experienced due to perceived inflexibility of the older individual. However, these studies have largely focused on primary caregivers for people with dementia (Brijnath, 2012; Danivas et al., 2016; Narayan et al., 2015; Patel & Prince, 2001; Shaji, Smitha, Praveen Lal, & Prince, 2003) or explored the effect of sociodemographic trends such as emigration or changing living arrangements (Jothikaran et al., 2020; Jothikaran, Meershoek, Ashok, & Krumeich, 2021; Ugargol & Bailey, 2018). A recent study with support providers in south Indian states (including Tamil Nadu) demonstrated the importance of sharing the support role and adjusting emotionally to manage the difficulties of support (Jothikaran et al., 2021). However, there is a lack of evidence on the experience of supporting elder relatives of people of varied socioeconomic backgrounds in Tamil Nadu. This is important as India's National Policy for Older Persons has been critiqued as being largely designed for the middle-class, with inappropriate strategies for families of lower socioeconomic status (Ministry of Social Justice and Empowerment India, 1999; Rajan & Mishra, 2011; Vera-Sanso, 2016). Identifying challenges that can be targeted, and emic coping strategies that could be promoted, is key for developing appropriate policy and interventions to improve health and wellbeing outcomes of both support providers and recipients and for understanding the potential implications of support provision. As such, this study aimed to explore the challenges that adults from varying socioeconomic groups (rural/urban and socioeconomic status) in the south Indian state of Tamil Nadu experience when supporting their older relatives, and the ways in which they cope.

2. Material and methods

2.1. Study design

We used a qualitative descriptive approach which aims for "a comprehensive summary of an event in the everyday terms of those events" (Sandelowski, 2000). This approach involves minimal inference, treats language as a "vehicle of communication, not itself an interpretive structure that must be read", and aims to stay close to the participant's point of view by describing their experiences in a manner that would appear accurate to them.

We used both focus-groups and in-depth interviews. There is evidence that the interpersonal and interactive nature of focus-groups can lead to different results in comparison to one-on-one interviews. Some studies indicate that the sensitivity and breadth of topics discussed in focus-groups is higher in comparison to interviews, while others indicate the opposite (Guest, Namey, Taylor, Eley, & McKenna, 2017). Supporting elder family members is perceived as a moral obligation in India (Cohen, 1992). As such, we assumed that more difficult or rarer challenges or coping strategies would not be discussed in focus-groups as they may be perceived as countering social expectations of supporting your parents gladly. We nevertheless felt that the group setting may make participants more comfortable talking about commonly experienced challenges. As such we used both methods. We aimed to recruit adults who had provided some form of care (பராமரிப்பு) and support (ஆதரவு) for an older (மூத்தோர்) family member in the past few years. We purposefully allowed participants to define what they considered 'older' and kept the definition of support undefined to understand the challenges of providing different types of support and to avoid restricting our sample to specific genders or relations. பராமரிப்பு corresponds to taking care of someone, while ஆதரவு corresponds to emotional support and comfort. However, the two words are often used interchangeably. We restricted participation to those to aged 20–64 to understand participants' perspectives as providers of support rather than recipients. However, we acknowledge this is a relatively arbitrary concept in a society where intergenerational support is common over the lifecourse. The relatively young upper age cut-off meant that no participants were supporting older spouses with high support needs. As such, our results largely translate to support from younger generations, mostly children.

2.2. Setting and participants

Tamil Nadu has the largest population in south India (Government of India, 2019). It is a relatively socioeconomically developed and gender equitable state and has above average rates of income and women's literacy and employment (Census of India, 2019; Pande, Namy, & Malhotra, 2020). However, Tamil Nadu has higher than average levels of consumption inequality and an estimated 12% of the population live below the poverty line (Suryanarayana, Agrawal, & Prabhu, 2011; World Bank Group, 2017). Participants were recruited in two neighbouring districts of Tamil Nadu, Chennai and Kancheepuram. Chennai is urban and the state capital (Census of India, 2019). Roughly a third of Chennai inhabitants live in slum or slum-resettlement colonies, which are mostly situated on the outskirts of Chennai city (Census of India, 2019). Kancheepuram is a neighbouring district and is composed of peri-urban and

rural areas, including agricultural and fishing villages. Both districts have above state average literacy rates and child-sex ratios, and lower than average early (before age 18) women's marriage rates and fertility, indicating relatively high socioeconomic development and gender equity outcomes in comparison to the rest of the state and country (Census of India, 2011).

We used a purposive sampling strategy, aiming to sample a variety of people according to their gender, urban/rural residence and socioeconomic status. During recruitment, we proxied socioeconomic status by employment sector (agricultural labourers, fishermen, teachers and school staff, housekeeping staff, and staff of a multi-national corporation). In Chennai, we recruited interview participants from non-slum areas through residential WhatsApp groups, and from slum and slum-resettlement colonies through local NGO contacts. We recruited urban focus-group employee participants through their employers, and a focus-group of female homemakers through a residential WhatsApp group.

In Kancheepuram, we recruited participants from one fishing town and nine agricultural villages. Rural recruitment was facilitated by The Banyan, a south Indian NGO that trains local women to provide mental health support to their communities (The Banyan, 2019). The community workers supported recruitment by identifying and contacting local people fitting the recruitment criteria and co-organising and mobilising participants for the interviews and focus groups.

2.3. Conceptual framework

Study conceptualisation (i.e., focus on stressors, coping strategies), methods (sampling people of varying socioeconomic backgrounds) and the corresponding analysis were informed by Pearlin's theory of caregiving and the stress process (Pearlin et al., 1990). Pearlin's framework proposes that outcomes for the support providers (for example yielding of the role, anxiety) result from the interaction of potential stressors (defined as 'conditions, experiences, and activities that are problematic for people') and mediators that people use to manage these stressors, namely coping strategies and social support (Pearlin et al., 1990). Both stressors and mediators are influenced by the person's background (e.g., socioeconomic status) and context (e.g., rural and urban Tamil Nadu). When designing the topic guides, we included questions on aspects of the experience that are 'difficult' (கஷ்டம்), which corresponds to stressors, and questions on how participants 'dealt' with these difficulties, which corresponds to mediators (i.e., coping strategies and social support). While the analysis was primarily inductive, more detail provided below, the topic guides shaped the analytical framework.

2.4. Data collection

We conducted 25 in-depth interviews and 12 focus-group discussions (average length of both methods of 52 min, range of 30–94 min). Each participant also completed a short sociodemographic questionnaire. The size of most focus-groups was between 6 and 8 participants, while one group had 13 participants. Focus-groups were conducted in pre-existing groups and homogenous groups, e.g., male agricultural labourers from the same village or female homemakers residing in the same housing complex. As such, focus-group participants often knew one another. Most the interviews and focus-groups were conducted in Tamil with same-gender interviewers with backgrounds in social work, though a handful were conducted by the primary UK-based researcher with participants who spoke fluent English. Interviews and focus-groups were conducted concurrently. Separate topic-guides were developed for each method, the interview guide focused more on attitudes towards varying support arrangements while the focus-group guide focused more on dynamics of support provision. However, both explored the challenges of support provision. Both topic guides were adapted as data collection was ongoing to incorporate issues that participants felt were important (e.g., emotional support). With permission of the participants, all but one of the interviews and focus-groups were audio-recorded.

2.5. Ethical considerations

Sharing experiences that are sensitive and deemed private could have led to distress or negative repercussions with family members. To avoid this, we undertook all interviews and focus-group discussions in private locations, selected either by the participant or the person assisting with recruitment. In focus-groups, we stated that we could not ensure anonymity. We prepared contact details of toll-free mental health helplines for any participants that expressed distress. In the rural communities, the Banyan's community workers were also potential sources of support. The study information sheet and consent forms were explained and provided to the participant in Tamil or English, following this, participants signed (if literate) or thumb-printed (if not literate and in the presence of a literate observer) the consent form to provide their written consent to participate. The study was approved by the Institutional Ethics Committee of the Indian Institute of Technology Madras and of The London School of Hygiene and Tropical Medicine.

2.6. Data analysis

We used thematic analysis methods to analyse our dataset, taking a critical realist position and inductive/deductive orientation, and coding semantically (Braun & Clarke, 2021; Byrne, 2022; Fletcher, 2016; Fryer, 2020). Our critical realist position means that while we assume an objective truth that could hypothetically be observed (e.g., the 'stressor'), we propose that this truth can be perceived differently by individuals and in turn influence how they are impacted. The audio-recordings were transcribed (and translated if conducted in Tamil) in English and the data-set consisted of the transcripts (N = 36) and fieldnotes (N = 37). JL and DP (a member of the research team) each initially selected eight varied transcripts (by gender, socioeconomic characteristics, method) and independently developed descriptive frameworks, which were collaboratively combined into a final framework (Ritchie, Spencer, & O'Connor, 2003). JL then undertook line-by-line coding, searching for variation within the framework with IPN intermittently supervising (e.g., talking over coding decisions). Though the coding framework largely reflected the topic guides used, itself shaped by the conceptual framework, it was flexible as coding was ongoing. As such, the final analysis was both inductive and deductive. The interview and focus-group transcripts were analysed together as we did not observe any discernible difference in the way people responded during fieldwork or when reading the transcripts. For instance, some of the more personal and sensitive issues were shared during focus-groups, which we attributed to the group setting of the focus-group (with similar participants who often knew each other) removing some of the awkwardness of one-on-one interviews. Once the data was coded, JL searched for patterns with background characteristics (gender and socioeconomic status, as proxied by completed education) from the sociodemographic questionnaire. Quotes have been included to support our points ("M" – moderator (i.e. interviewer), "R" – respondent).[1] Data management and analysis were conducted using NVivo 12 (QSR International Pty Ltd. Version 12, 2018).

2.7. Reflexivity

The following comments refer primarily to the lead author (JL) who coordinated the study in the field and conducted much of the coding. JL

[1] In the year following data collection, we re-interviewed a subsample of the participants (N = 3 of varied socioeconomic backgrounds). We summarised and presented our conclusions to the participants to assess whether they corresponded with participants' own views of their experiences (in line with the qualitative descriptive approach). Participants agreed with the conclusions, though they had not experienced all the issues described because of the socioeconomic variability. We did not incorporate these transcripts into the dataset and this step largely did not affect the results and conclusions.

is white English. In England, older people are less likely to live with their children than in India, and more likely to use residential or in-home formal care. These differences are well known in India and formal care is perceived as a negative Western influence (Lamb, 2006, 2013). Given this, participants may have felt that the study team were there to 'push' a formal care agenda and felt unwilling to share negative experiences. While most the interviews and focus-groups were conducted by field-workers from Tamil Nadu, the field team were also relatively educated in comparison to the rural and lower socioeconomic status participants, which may have elicited a similar response.

While we have not taken an explicit feminist approach, JL is of the view that gender roles (including those related to support provision) are a result of socialisation rather than inherit sex specific traits. Given this, we may have particularly focused on gender related aspects of the results, particularly the role of daughters, as stigma around daughter-based support is not common in the UK. Further, JL has a public health background and is from a high-income Western country, where dependence is relatively stigmatised and where ageing is medicalised (Brosius & Mandoki, 2020; Lamb, 2006, 2013), which may have led us to focus more on health or 'independence' related issues or solutions. Different members of the co-author team (of different nationalities and with varied research interests) were involved in developing the framework, making coding decisions, and interpreting the results. Their reflections are available in the appendix.

3. Results

In total we recruited 113 individuals (characteristics described in Table 1). Participants had varied socioeconomic backgrounds for instance ranging from having no education (13%) to higher education (36%). Participants often spoke about supporting several family members, as such we have not provided a corresponding description of the characteristics of support recipients.

Table 1
Sample characteristics, by method (N = 113).

	N (%)		
Characteristic	Focus group	Interview	Total
Method			
Women	55 (63)	15 (60)	70 (62)
Men	33 (38)	10 (40)	43 (38)
Age-group			
20–29	9 (10)	7 (28)	16 (14)
30–39	36 (41)	4 (16)	40 (35)
40–49	30 (34)	7 (28)	37 (33)
50–59	10 (11)	5 (20)	15 (13)
60–64	2 (2)	2 (8)	4 (4)
No data	1 (1)	0 (0)	1 (1)
Settlement type			
Urban (Chennai)	42 (48)	16 (64)	58 (51)
Rural (Kancheepuram)	46 (52)	9 (36)	55 (49)
Education			
None	13 (15)	2 (8)	15 (13)
Primary	10 (11)	2 (8)	12 (11)
Middle	22 (25)	6 (24)	28 (25)
Secondary	12 (14)	1 (4)	13 (12)
Higher	28 (32)	13 (52)	41 (36)
No data	3 (3)	1 (4)	4 (4)
Employment type			
Household-based	9 (10)	7 (28)	16 (14)
Casual labour	30 (34)	5 (20)	35 (31)
Salary labour	40 (46)	7 (28)	47 (42)
Self-employed	6 (7)	1 (4)	7 (6)
Retired	0 (0)	3 (12)	3 (3)
Student	0 (0)	1 (4)	1 (1)
No data	2 (2)	2 (8)	4 (4)
Total	**88 (100)**	**25 (100)**	**113 (100)**

3.1. Overview: challenges and coping strategies

We inferred several challenges from the data that we outline in Table 2 and in detail below. These were role conflict (related to how participants managed support provision alongside other roles such as childcare or employment), financial difficulties, difficult behaviours (behaviours of the recipient that the participant struggled with), normative roles (the social expectations of daughters and daughters-in-law), and personal care (related to tasks such as toileting and dressing). Each challenge was underscored by compounding factors that made the challenge particularly difficult and led to specific coping strategies and the use of varying types of social support. We inferred that participants also used wider coping strategies (e.g., accepting their limitations, focusing on motivations to support) to manage the emotional impact of support provision.

3.2. Financial difficulties

Participants across socioeconomic groups experienced difficulties in covering their elders' expenses alongside other household costs, particularly children's schooling, and other indirect costs, for instance travel costs when living separately. Men in particular stated that financially supporting both parents and in-laws was challenging. This may reflect the larger role that men play as financial providers, or the fact that men financially supporting their parents-in-law diverges from the social norm. The impact of financial difficulties appeared to be greater in lower socioeconomic status groups, where financial support was repeatedly stated as the hardest task. A rural focus-group of women who worked for daily-wages described the impact on their families:

> If they are unwell and bedridden … we cannot stay home … If they have money in their hand they can support themselves but it's not possible since we are poor, so I have to spend my money for them that time, then I'll be having no money so I have to work for extra expenses also. R: Money is a huge concern, causes a lot of tension … R: That time if we don't have money then we will be stressed, will become more anger and sometimes we also think whether to save their lives or not.

The focus-group also lamented their lack of options, for instance when asked how they coped, the group responded:

> R: Only people who have money can do whatever they want, but people like us have only 100 rupees in our hand so if that 100 rupees is spent for the hospital expenses then what we can do, nothing can be done. R: If we have money, all problems solved, if money has finished, we have to go to government hospital and treat them, no food at home then.

Healthcare expenses (for instance hospital and medicine costs, transport) were unequivocally perceived as the highest and most difficult expense across socioeconomic groups. This was underscored by a consistently strong dislike and avoidance of government hospitals, with participants citing long waits, poor quality, and the need for bribes or contacts ("my friend's friend's friend") to receive timely care. Participants who did not struggle with financial support had parents in good health or who had private pensions and health insurance. However, some urban higher-educated participants whose parents had health insurance still struggled with indirect costs like transport, high age-related premiums, inflated hospital expenses and rejected claims. A highly educated male retiree in Chennai protested:

> Healthcare is very expensive. Very very very expensive. Terribly expensive. I can't tell you how much. These guys swindle us … you go tell the hospital, "I have healthcare insurance" they simply blindly charge them, and these guys will say "No I will not accept this, I will not accept that".

Table 2
Description of challenges and coping strategies.

Challenge	Compounding factors	Social support	Coping strategies	
Financial difficulties - Healthcare - Children - In-laws & parents - Travel - Lost wages	Cost & perceived quality of healthcare Difficulties saving Public pensions Distance (non-co-resident households)	Informal financial support (close family)	Public healthcare Closer/Co-residence	
Role-conflict - Employment - Childcare - Domestic work - Other elders	Necessary and inflexible employment Distance (non-co-resident households) Children prioritised	Formal and informal practical support	Job change Closer/Co-residence	
Difficult behaviours - "Child-like" - Physically abusive - Refusing support - Controlling	Elder's physical & psychological health Relationship dynamics Private nature of support	Informal emotional support	Separate residence Institutionalization	Focus on motivations and downplay difficulties. Acceptance.
Normative roles - Daughter-in-law - Daughter	Limited women's autonomy Limited household resources		Secret financial support to parents	
Personal care - Toileting - Bathing - Dressing	Time intensive Physicality Embarrassment	Formal support and informal support (close family)	Western-style toilets and grab rails	

Though participants rarely independently raised the topic of public pensions, or lack of, the lack of public provisions was evident. Though the government provides pensions for certain groups, only a minority of lower socioeconomic status participants' elders received a pension. The public pension was largely perceived as impossible to live on, unreliable - sometimes stopping for months - and difficult to obtain due to the documents required, strict eligibility rules, and time and effort needed to apply. A woman from a Chennai slum who worked at a labour union felt strongly:

> They are giving just one thousand rupees as pension, which is insufficient for two or three days … Despite the provision of the law, they reject it pointing out some lame excuses like your name doesn't match in both documents, there is a spelling mistake in yours.

Families (particularly rural and of lower socioeconomic status) attempted to manage these expenses by taking on more work, reducing expenditure elsewhere in household budgets (for instance choosing less expensive schools), moving their elders to a closer or the same household, using government hospitals, delaying/refusing to finance health procedures (for instance operations), and selling jewellery or taking loans (both formal and informal) to fund expensive and unanticipated medical emergencies. It was common for families to share healthcare expenses between children (mostly sons) and sometimes non-co-resident children provided a larger share. Nevertheless, some participants (of varied backgrounds) were sceptical of the financial support available from non-co-resident family, with the view that "there are financial difficulties in the family all the time." Though neighbours and friends occasionally lent money in the short-term (e.g., for transport during medical emergencies), financial support was strictly limited to family members.

3.3. Role-conflict

The most commonly stated challenge across socioeconomic groups (particularly by women) was the difficulty in finding the time and energy to provide practical support for older relations alongside employment, caring for children, and doing domestic tasks. While men occasionally mentioned difficulties with their conflicting roles, their primary support role was to provide financially (in line with employment) or help with more occasional tasks like attending healthcare visits. This led to less role conflict in comparison to women, who were expected to undertake more frequent tasks (e.g., providing food) often alongside employment. A low educated rural woman who worked for daily wages relayed a long list of her day-to-day responsibilities, finally declaring:

> We have to finish all these and only then eat at last, after that we only clean up and by the time we are ready to sleep, it's like a machine how women are working (*other focus-group members clap*).

A handful of urban middle-higher educated participants were struggling to look after both spouses' parents, and sometimes other relations such as aunts and uncles. These non-normative support relationships were typically a result of older relations not having a son or child available due to migration or death.

Role conflict was compounded by the non-negotiable need for adults to work, which paradoxically limited in-person support for both elders and children. When asked how sons could support their parents' well-being, an urban woman with low education responded "Day and night people run after money for their livelihood so where is the time to spend for chit-chatting with the parents?". Participants commonly perceived the cost of living to be high and rising, particularly in the city, and thus for dual-career households to be necessary. When asked whether she was able to work alongside supporting her in-laws, a low-educated rural woman queried:

> I have to go, there is no other option? My husband asks me when I go to work, leaving alone my parents-in-law, 'What will happen to them?' But the field work provides for us. I can go in the morning and come back in the afternoon, provide food for them and return again. I have to do this work.

Professionals in the formal sector also found it difficult to combine work and in-person practical support due to inflexible hours and limited leave. Though family members were typically prioritised by their short-term needs, children's care (particularly schooling) tended to be prioritised above older relatives' needs.

Attempting to fulfil different roles resulted in stress and exhaustion for the primary caregiver. Two women described direct effects on their health and delays in attending healthcare facilities for themselves.

Participants consistently stated that they were not doing "enough" for their elders, which was sometimes worsened by comments from extended family who "add fuel to the fire". Role conflict also resulted in arguments within the family, for instance as a result of the elder (or other family members) scolding the primary caregiver for not providing adequate support, or due to the primary caregiver's high stress levels.

Participants of varied backgrounds mainly coped with their conflicting responsibilities by engaging help from other family members, particularly those that were co-resident or local, or neighbours/friends for short tasks. A handful of highly-educated urban women spoke of quitting (or considering quitting) their own jobs. It should be noted that having an older relative or child in the household was not straightforwardly linked to role conflict. In some families (of varying backgrounds), children and elders (particularly older women in good health) helped considerably with practical support and domestic work, which allowed some women to be employed. Urban higher-educated participants often employed domestic and formal care services to relieve the time strain though this often came with high financial costs. One higher educated retiree who was caring for her mother highlighted the link between India's socioeconomic inequality and the availability of formal care, stating:

> In India we have this luxury of getting maids that is not there in either your country *(UK)* or my children's country *(USA)*. For the love of money you can't get anybody … here you pay a little they're prepared to die for you. You know the poverty rate which is in India.

A few higher educated participants that struggled to provide practical support to non-co-resident elders hoped to move them into their household or nearby which was preferred over moving into the older person's household as participants perceived they could not shift their responsibilities, for example jobs or children's schools.

3.4. Elder's behaviours

Outside of the financial and time strains of support provision, many participants of varied backgrounds spoke of the emotional impact of their elder's behaviours which they found challenging. Older people were commonly described as acting "like children" and being "past reasoning", with a handful of participants described their relatives soiling the bed, repeating questions, and losing their inhibitions (e.g., walking around unclothed). While these sound like dementia related behaviours, only a minority of participants offered a medical diagnosis for the cause (Patel & Prince, 2001; Shaji et al., 2003). Most attributed these behaviours to natural age-related changes. A highly educated homemaker in Chennai described emotionally supporting an older neighbour whose children lived abroad;

> The father has Alzheimer's and the mother, she was a professor in a college but post-retirement she is taking care of uncle. She is also growing old, I can see that frustration, she has a driver she has a full-time attendance to take care of them. But still that emotional support is not there … she keeps talking, there are times she breaks down. So, I generally just go sit and talk to her, I know he's not well, he becomes violent sometimes. But there's nothing that she can do.

In contrast to what lower socioeconomic status participants often proposed, this quote demonstrates that financial resources and formal care do not necessarily translate to a stress-free experience.

Some urban middle socioeconomic status elders would refuse to use formal carers, preferring their children to look after them or balking at the perceived financial burden on their children, and assistive devices (e.g., walking sticks) due to embarrassment. Members of a focus-group of female housekeeping staff in Chennai had previously worked as formal carers and described being hit, having items thrown at them, and spat at by their care recipients. Rural participants also spoke of their relations refusing medicines or healthcare visits, which we suggest may be related to the perceived poor quality of services in rural areas or potential impact on household expenses. Participants also spoke of their elders refusing food following arguments or to avoid needing the toilet, or advice regarding food, which they felt made their support role more difficult by impacting the elder's health and thus leading to higher support needs. An urban man who worked in housekeeping explained:

> Even a day's leave would affect my salary and under that situation my parents might fall sick especially my mother. For instance, I would have told my mother not to eat something specifically but she would eat that and finally she would have loose stools.

Some participants (mostly urban higher educated women) perceived their parents' behaviours to be demanding, attention seeking and overly controlling, which led to arguments and feelings of resentment and guilt. Participants largely attributed this to their parents feeling insecure due to their loss of status and role in the family (for instance following retirement or moving into their child's household) and discomfort with becoming dependent. Changing relationship dynamics appeared to result in more conflict when relationships were previously authoritative. Financial dependency was particularly noted to strain relationships and result in conflict.

Participants consistently expressed the personal and private nature of support and the perceived betrayal that would result from complaining about their parents' behaviours ("washing your dirty linen in public".) Nevertheless, some participants occasionally used emotional support from family or close friends to cope. Alternatively, one participant (an urban professional) relayed a story of another family, whose nieces and nephews placed their (childless) uncle into a private old-age home, as he was "very difficult to live with", for instance stealing money. This was the only example we heard of institutionalization as a coping strategy, likely because it is rare (this is a fairly unusual family dynamic and situation) but perhaps also because of the stigma around institutional care, particularly for those with family in government or NGO funded institutions.

3.5. Normative roles

Women experienced difficulties with the social expectations of the support that women should, or should not, provide to aging in-laws and parents. Gendered support norms dictate that daughters-in-law undertake practical and personal care and domestic work. As a result, some rural less educated women reported their husbands refused to help them with these tasks, regardless of whether women were also employed. Women also stated that their in-laws would expect help with tasks that they were capable of completing themselves, or that their in-laws were never satisfied, easily angered, and complained if support did not fulfil their expectations, resulting in increased time strains and stress on the daughter-in-law, and conflict within the family.

Inversely, while some women (urban and mostly higher educated) were supporting their parents despite sometimes having brothers, a few rural less educated women were prevented by their affinal families (husband and in-laws) from helping their parents, though they wished to. Women were expected to prioritise, respect, and serve their in-laws above their parents, which caused conflict during visits and prevented co-residence. In particular, rural and less educated women were prevented from giving money to their parents, as the household income was perceived to be their in-laws' right. This stood for women whose parents had no sons, resulting in guilt, distress, and resentment towards their affinal families, as women watched their parents struggle to support themselves. Some attempted to manoeuvre this by secretly saving and giving money to their parents. A focus-group of rural low-educated women became emotional when describing their parents' circumstances:

> R: If I give 100 rupees to my parents, then I cannot do that with the knowledge of my in-laws or husband. They are my parents, they depend on me yet I cannot give them the money. R: Since marriage, it's been 13 years and yet I cannot help my parents … R: They have

suffered so much, when they didn't even have money. Now when they are old and want even 30 rupees I cannot give it to them (*crying*).

Their inability to financially support their parents was likely underscored by a lack of household resources, meaning families were less willing/able to share, and low female autonomy. Thus outside of secretly saving money, strategies for coping were limited.

3.6. Personal care

Personal care (for instance dressing, bathing, toileting, washing soiled clothes) was consistently stated as difficult, partly due to feelings of disgust and embarrassment resulting from the nature of the tasks. Recipients needed this assistance when they were in very poor health, for instance following a stroke. As a result, providing personal care alongside other forms of support was time-consuming, particularly as tasks such as toileting were sporadic and affected carers' sleep patterns. Urban middle-higher educated participants' families purchased products to help with this, for example Western style toilets, grab rails, and adult diapers. Poorer families did not have this option, as demonstrated by a rural man's description of caring for his father:

> He was unable to work and so if he had to pass urine or motion I may have to carry him on my shoulders and take him there. Especially during the night, and I used to sleep with him.

Participants used support from family or formal sources (e.g., carers or assistive devices if urban and of middle-higher socioeconomic status) to help with personal care, particularly as they often required lifting and teamwork. This was especially difficult for wives and daughters-in-law when men were at work during the day. The personal nature of the tasks meant older people preferred care from family members of the same gender. As such, a lack of available men resulted in women helping older men with personal care, leading to discomfort for both parties. However, women continuingly stated that they adjusted with time and the embarrassment subsided. Though urban middle-class families often employed carers, some elders (particularly men) were uncomfortable with receiving personal care from non-family, meaning certain tasks (e.g., bathing) would be completed by children once they returned from work.

3.7. Broader coping strategies

In addition to the challenge specific-coping strategies, we have inferred two broader strategies which were used to limit the emotional impact of support provision: focusing on motivations to support and downplaying the difficulties, and accepting the situation. Participants focused on their motivations for supporting their relatives, particularly how their parents had raised them and cared for their grandparents, or the need to set an example to their own children. Women often spoke of envisioning their in-laws as their own parents, particularly when speaking of the discomfort of helping with personal tasks. Participants often downplayed the difficulties they faced and consistently stated that providing support for one's parents should not be viewed negatively as it was a child's duty. A low-educated woman from an agricultural village appeared unwilling to dwell on issues that she was unable to change:

> R: To me, I didn't have anything (*difficulties*) like that. M: Everything was easier for you. R: Yes. I would have difficulties but whom could I tell them.

This quote also demonstrates the lack of options available to this woman.

Participants also described accepting that they were unable to fulfil all expectations and needing to mentally adjust to the situation, particularly because older people were deemed to be "like children" and thus unable to adapt themselves. No participants openly proposed retracting support or using old-age homes as a strategy for the difficulties they faced, thus outside of the challenge-specific strategies, accepting shortfalls in support appeared to be the final line in their emotional defence. However, participants held high expectations for themselves and accepting their constraints was often countered by guilt of not doing more. The following quote of a professional woman in Chennai exemplifies this emotional balancing act:

> But since they have taken care of their parents and in-laws, we will feel guilty if we don't because they have given us the best of education. … So at least this is time to repay … I feel I do, but I am not giving my 100%. … I have to play the role of a mother, office goer, a daughter. Sometimes it takes its toll on me and I hit the roof. I shout at them but then the next day I will feel guilty, but then I continue to do whatever best I can.

4. Discussion

Our study highlights the challenges that adults of varying socioeconomic backgrounds experience in supporting older relatives in contemporary Tamil Nadu, and the varied ways in which they cope with these challenges. In comparison to other Indian states, some of these challenges may be particularly prevalent due to Tamil Nadu's distinct family structures. Urban and higher educated participants spoke of the additional time and financial strains that resulted from supporting parents who lived separately (noted in other recent studies in Tamil Nadu (Jothikaran et al., 2021)), and from supporting both a husband and wife's parents when there were no other children available to help (which has also been noted in Kerala, a similarly low fertility state (Ahlin & Sen, 2020)). Conversely, rural lower socioeconomic status women were distressed when they were prevented by their affinal families to help their sonless parents. This emotional impact has been noted previously in middle-class women in Maharashtra, though in contrast to our results, these women wished to support their parents because they felt their brothers' support was inadequate and the requests were primarily rejected by their own parents because of the perceived stigma (Dhar, 2012).

This divergence between the experience of daughters of sonless parents was the only clear distinction in the stressors experienced between socioeconomic groups. Other stressors tended to be qualitatively similar, though the means of coping, and thus the apparent impact (in line with Pearlin's framework (Pearlin et al., 1990)) varied. Lower socioeconomic status families relied heavily on informal support from family and neighbours, though this was greatly restricted by financial pressures and the need for dual-career households. The coping strategies available were relatively limited, for example working more hours, using unpreferred (public) healthcare or forgoing healthcare completely. Pearlin's framework focuses on the primary caregiver and was based on research with caregivers to people with Alzheimer's in the US (Pearlin et al., 1990). However, in the context of lower socioeconomic status families in Tamil Nadu, a setting with a predominantly informal system of support and relatively little social welfare, our results indicate that supporting an older dependent relative could impact those outside the primary caregiver role (e.g., children and elders, in-laws and parents). For instance, forgoing expensive healthcare treatments could negatively impact the older person's health while working more hours could increase physiological and psychological stress for the worker. Similar to the literature on "detrimental coping strategies" for healthcare expenditure (Murphy, McGowan, McKee, Suhrcke, & Hanson, 2019), this demonstrates the potential wider and long-term impact of support provision in families with limited resources.

In contrast, the financial resources of urban wealthier groups meant they had more coping strategies available to them, for example by employing domestic or formal staff to relieve time strains, using assistive devices or Western toilets to ensure elder's safety, or maintaining

separate (but nearby) households to avoid conflict (as has been noted elsewhere in India (Patel & Prince, 2001)). However, while having more financial resources limited more severe outcomes of support provision (e.g., healthcare costs impacting household food budgets), it also increased the options (and thus expectations) for support. Private healthcare, domestic staff, and formal care services mean the financial cost of providing support is essentially limitless. Catastrophic healthcare expenditure is actually higher in wealthier households in India (Pandey et al., 2018). Thus, the morally charged nature of parental support in India may mean the goalposts of support adjust as potential options expand.

It has been theorised that groups with fewer practical coping strategies available to them (lower socioeconomic status families in this instance) are more likely to attempt to manage the emotional impact of stressors (Lazarus & Folkman, 1984). However, emotion-focused strategies (e.g., accepting the situation) were used by participants across socioeconomic groups. We suggest two reasons behind this. First, though relinquishment of the support provider role (e.g., using institutional care) is a suggested outcome of support related stress in Pearlin's theory and concerns about the 'next step' are integral to the concept of "caregiver burden" in the literature in high-income Western populations (Bastawrous, 2013; Zarit et al., 1980), this was not raised by the study participants. Available coping strategies could often not negate all stressors, so support providers of all socioeconomic groups were left with limiting the emotional impact of challenges. Second, social expectations of caring for parents in India are high – the debt that children owe to their parents is perceived to be so large that it will never be repaid (Brijnath, 2012; Lamb, 2000; Vatuk, 1990) – which may lead to feelings of inadequacy across the socioeconomic spectrum.

We aimed to identify stressors that can be targeted to improve the wellbeing of support providers and recipients. As people are more likely to undergo a behaviour (e.g., supporting an older relative) if they feel able and are confident it will not have negative consequences (Cane, O'Connor, & Michie, 2012), we also propose that reducing the difficulties of support provision could promote family-based support for the growing older population (the preferred system for most the older population (UNFPA, 2012)).

While varied challenges were highlighted by participants, financial strains were stated as the biggest issue in lower socioeconomic groups and were often stated as difficult in other groups. Evidence from the current study (and others) indicates that financial dependence is viewed most negatively in comparison to other types of support (Vatuk, 1990; Vera-Sanso, 2004). We suggest that reducing out-of-pocket healthcare costs through universal health coverage, tackling poor quality and perception of public healthcare services, and regulating private healthcare and health insurance would greatly benefit older individuals and families, particularly those of lower socioeconomic status (Datta & Chaudhuri, 2020; Dodd, King, Humphries, Little, & Dewey, 2016; Zuurmond et al., 2019). Improved access to high-quality healthcare could also reduce the feedback loop between lack of healthcare access and poor health (and high support needs) in poorer sections of society (Srivastava & Gill, 2020).

Tamil Nadu has had a state-sponsored health insurance scheme since 2009 which covered secondary and tertiary care for over half the population defined as poor, near-poor, and vulnerable. Nevertheless, out-of-pocket payments have remained high and our results (and others from Tamil Nadu (Dodd et al., 2016; RamPrakash & Lingam, 2021)) demonstrate a strong distrust and dislike of public healthcare. Further, though Tamil Nadu's healthcare system has been put forward as a model of success, some health system indicators are worsening with time (Gaitonde, Muraleedharan, San Sebastian, & Hurtig, 2019). Suggested weaknesses include a narrow target oriented approach focusing on a few indicators, understaffing, loss of services at the village level, and a focus on maternal and child health to the detriment of services for adult health (Das Gupta et al., 2010; Gaitonde et al., 2019). Since 2018 the state-scheme has been transitioning into the centrally-sponsored Ayushman Bharat scheme, however we were unable to explore its impact on the support provision experience as this was introduced the same year of the study (Bali & Ramesh, 2021; Chalkidou et al., 2019; Chhabra et al., 2019).

Financial and emotional strains that result from financial dependency would also be eased by increased access to, and amount of, public pensions for older people of varied backgrounds, which grassroots groups such as Pension Parishad are campaigning for (Vera-Sanso, 2016). While these schemes already exist, barriers to uptake should be targeted to improve implementation and the resulting benefit, e.g., clear campaigns around eligibility, benefits, and ways to access pensions, and reduced administrative barriers.

While there is a clear market for formal care and assistive devices, these are currently only affordable and accessible to middle-class families. Screening for disabilities and distributing assistive devices for lower socioeconomic status populations could reduce physical and potentially healthcare needs for these groups. However, though formal care may provide a solution for a sector of Indian society, its rise also prompts the question of who supports the formal carers' relatives. It is unlikely that formal care will become affordable to much of the population in the near future, though several volunteer-based home care models have been implemented on scale in other Indian states or Low and Middle-Income Countries which could provide a solution for practical support needs (Lloyd-Sherlock, Pot, Sasat, & Morales-Martinez, 2017; Singh & Harding, 2015). Our suggestions could potentially benefit older Indians and their families in the short-term. However, without a widescale move away from informal support, a sustainable and effective system of support for much of the older Indian population will not be possible without socioeconomic change to reduce the financial pressures that limit the support family members are able to provide each other (Vera-Sanso, 2017).

4.1. Limitations

This is a sensitive subject matter and the study focus was explained during participant recruitment. As such, some people may have not participated or participants may have not shared particularly difficult experiences or stigmatising views such as wishing to use old-age homes. Thus, we appreciate that there may be challenges and coping strategies that were not raised.

We focused on the negatives of support provision with the potential public health consequences in mind. However, we hope to not contribute to the perception of ageing and ageing populations as a unanimously negative experience and cause for concern. There is a growing literature that highlights the importance of ambivalence in intergenerational relationships at older ages in India, rejecting the perception of later life as a period of burden, conflict, and distress, as well as the idea of the harmonious joint family (Gangopadhyay & Samanta, 2017; Jothikaran et al., 2021; Samanta, 2019). Keeping with this, participants often also reported positive experiences, which we plan to explore separately.

We focused on Tamil Nadu due to its distinct family structures. However, in comparison to other states, levels of poverty are relatively low and Tamil Nadu has a higher quality health system (Gaitonde, 2015; International Institute for Population Sciences (IIPS) and ICF, 2017a; World Bank, 2017). Though much of the existing literature and available data has similarly focused on states with more aged populations (UNFPA, 2012), our (and existing) results highlight the importance of financial pressures for support strains. As such, we recommend further research on the support, health, and wellbeing of lower socioeconomic status older individuals, particularly in less developed states where older people may be at more of a vulnerable position on the whole.

4.2. Conclusion

Participants of varied socioeconomic backgrounds experienced significant challenges supporting their elder relatives, including some that are linked to Tamil Nadu's demographic transition and thus may become

increasingly prevalent across India. Given these changes, caution should be taken to not assume an endless and easy supply of support from families without a corresponding impact on them. We suggest that interventions to make the support experience easier would be an effective strategy for not only improving the wellbeing of those providing support and the wider family, but also sustaining family-based support for the older population.

While India's National Policy for Older Persons outlines strategies for alleviating strains on families, these are more appropriate for the middle-classes (e.g., tax rebates) and are unknown to much of older population (Ministry of Social Justice and Empowerment India, 1999; Rajan & Mishra, 2011; UNFPA, 2012; Vera-Sanso, 2016). As such, the current policy focuses the responsibility of support on the family with little public assistance, at least for poorer families who have fewer coping strategies to buffer support related strains. The Government of India appear to be strengthening this position by introducing legislation to increase the potential punishment for not providing 'maintenance' to parents (Ministry of Social Justice and Empowerment India, 2019). Our findings suggest this strategy may be unsustainable as evidence already demonstrates that support is lacking for poorer older individuals (Vera-Sanso, 2004). As such, we hope to highlight the potential value of universal health coverage for support of older people of varied socioeconomic backgrounds, the need for targeted strategies to support lower socio-economic status families and elders, and the importance of broader socioeconomic policy for reducing the financial and time pressures that restrict the support that much of the population can provide each other.

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Ethical statement

This study received ethical approval from the Institutional Ethics Committees of the Indian Institute of Technology Madras (IITM, reference: IEC/2018/01/BT/15) and the London School of Hygiene and Tropical Medicine (LSHTM, reference: 14583).

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2023.100262.

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