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ELDERLY WOMEN CARING FOR THE ELDERLY: SOCIOLOGICAL DIMENSIONS OF THE 'I CAN BARELY TAKE CARE OF MYSELF' EXPERIENCE

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Abstract[1]

One of the most significant demographic challenges facing the world today is the steadily aging population. As ageing progresses, physical changes make it increasingly difficult for older individuals to carry out daily activities independently, often leading them to rely on the care and support of others. In Turkey, as a result of the prevailing traditional and patriarchal social structure, the responsibility of caring for dependent elderly individuals is largely assigned to women. However, when caregivers themselves are also of advanced age, i.e. 65 and above, this responsibility becomes a multidimensional issue. In this study, in-depth interviews were conducted with 13 elderly women who provide round-the-clock care for their elderly relatives, within the scope of a qualitative research approach. This research approach was chosen in order to facilitate 'narrative interviews' - whereby the subjects were asked a series of questions that required them to answer with their own, personal experiences, enabling variation and subtlety of responses. The data obtained was analyzed to reveal the challenges faced by elderly female caregivers, their experiences, and the needs that arise in the caregiving process. Main findings confirmed existing literature and studies, revealing that elderly female carers, who are not only dealing with chronic illnesses, mobility limitations and decreased energy that naturally accompany aging, are also facing psychosocial difficulties such as stress, burnout, social isolation, and depression, as a result of burdenous caregiving. Moreover, the invisibility and unpaid nature of care work further push them into a socially and economically

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disadvantaged position. Therefore, elderly care labor emerges as a critical social issue that must be addressed not only on an individual level, but also within sociological, psychological, and policy-making frameworks. This study demonstrates the need to redesign and expand care policies in Turkey. It further emphasizes that care labor not be regarded solely as a responsibility assigned to women, but rather as a collective societal responsibility.

***Keywords**: Elderly Care, Women, Care Burden, Aging.*

YAŞLI KADININ YAŞLIYA BAKIMI: 'KENDİME HAYRIM YOK' DENEYİMİNİN SOSYOLOJİK BOYUTLARI

Öz

Dünyanın karşı karşıya olduğu en önemli demografik sorunlardan biri, nüfusun giderek yaşlanmasıdır. Yaşlanmayla birlikte insan bedeninde meydana gelen fiziksel değişiklikler, yaşlı bireylerin gündelik yaşam aktivitelerini bağımsız bir şekilde yerine getirmelerini zorlaştırmakta ve çoğu zaman başkalarının bakım desteğine ihtiyaç duymalarına yol açmaktadır. Türkiye'de ise hâkim olan geleneksel ve ataerkil toplumsal yapı nedeniyle, bakıma muhtaç yaşlı bireylerin bakım sorumluluğu büyük ölçüde kadınlar tarafından üstlenilmektedir. Ancak bakım verenlerin kendilerinin de 65 yaş ve üzeri olması durumunda, bakım sorumluluğu daha kapsamlı ve çok boyutlu ele alınması gereken bir konu haline gelmektedir. Bakım sorumluluğunu 24 saat kesintisiz olarak üstlenen 13 yaşlı kadınla yürütülen araştırmada, kadınların bakım sürecine ilişkin öznel deneyimlerini daha kapsamlı biçimde irdelemek amacıyla nitel araştırma yöntemi tercih edilmiş; bu doğrultuda, katılımcılarla yapılandırılmış ve ayrıntılandırılmış sorular eşliğinde derinlemesine görüşmeler gerçekleştirilmiştir. Elde edilen veriler, yaşlı kadın bakıcıların karşılaştıkları zorlukları, deneyimlerini ve bakım sürecinde ortaya çıkan ihtiyaçlarını ortaya koymak üzere analiz edilmiştir. Temel bulgular, mevcut literatür ve çalışmaları doğrulamış; yaşlı kadın bakıcıların, yaşlanmayla birlikte doğal olarak ortaya çıkan kronik hastalıklar, hareket kısıtlılıkları ve azalan enerjiyle başa çıkmanın yanı sıra, ağır bakım sorumluluklarının bir sonucu olarak stres, tükenmişlik, sosyal izolasyon ve depresyon gibi psikososyal güçlüklerle de karşı karşıya olduklarını ortaya koymuştur. Bakım emeğinin görünmezliği ve karşılıksız oluşu ise bakım verenleri sosyal ve ekonomik açıdan daha da dezavantajlı bir konuma itmektedir. Dolayısıyla, yaşlı bakım emeği yalnızca bireysel bir olgu olarak değil, aynı zamanda sosyolojik, psikolojik ve politika yapım süreçleri bağlamında ele alınması gereken kritik bir toplumsal mesele olarak ortaya çıkmaktadır. Bu çalışma, Türkiye'de bakım politikalarının yeniden tasarlanması ve kapsamının genişletilmesi gerekliliğine işaret etmektedir. Ayrıca, bakım emeğinin yalnızca kadınlara özgü bir sorumluluk alanı olarak değil, kolektif bir toplumsal sorumluluk alanı olarak değerlendirilmesi gerektiğini de vurgulamaktadır.

***Anahtar Kelimeler:** Yaşlı Bakımı, Kadınlar, Bakım yükü, Yaşlanma*

Introduction

One of the most significant demographic problems affecting the world is the aging of the population. The increase in life expectancy and the decrease in fertility leads the world's elderly population to increase fast, and Turkey is one of the countries with a rapidly aging population (TURKSTAT, 2025b). This rapid rise also brings about the problem of who will take care of elderly individuals who are dependent on the care of others. In Turkey, the responsibility for the care of elderly individuals, just like other individuals in need of care, such as disabled individuals and children, usually falls upon the women of the family, as an extension of their traditional gender roles and responsibilities. However, when the caregivers of the elderly are also aged 65 or above, the burden in this process becomes even more severe for caregiving women.

When caregivers are themselves elderly, they must cope not only with chronic illnesses and health problems associated with aging, but also with a range of psychological, physiological, economic, and social challenges arising from caregiving responsibilities. Elderly women caregivers, despite facing numerous issues related to their own aging, sometimes assume the responsibility of caring for another elderly household member, often as an extension of traditional gender roles and simply because they are women. This situation reflects a position of double burden**,** stemming from the intersection of being both elderly and female (Fengler, 1979; Riedel, 1998; Özateş Gelmez, 2016; Gürer et al., 2019).

In this study, the participants' comments on the caregiving process, such as, *"I can barely take care of myself,"* and *"A woman's care ordeal never ends,"* vividly illustrate the experiences of elderly women who, despite being of advanced age themselves, provide care for other older individuals. These expressions reveal the intersectional effects of both aging and womanhood on the caregiving burden, emphasizing the severe and multifaceted nature of this load across physical, psychological, and social dimensions. Within this framework, the study aims to examine the caregiving burden and care labor of elderly women caregivers during later life, with a particular focus on the influence of gender roles. The research was conducted through in-depth interviews with a total of 13 elderly women, who had continuously undertaken caregiving responsibilities on a 24/7 basis, for periods ranging from 2 to 33 years. The collected data was analyzed to explore the participants' experiences, the challenges they faced and their emerging needs, thereby revealing the multidimensional nature of care labor within the intersecting contexts of gender and aging.

A Brief Overview of Studies on Female Care Labor at Old Age

According to data from the World Health Organization, one in every six people in the world will be 60 years old or older in 2030, and the population over the age of 80 will triple, to reach 426 million in the period of 2020-2050 (WHO,

2022a). This fast demographic change experienced in the elderly population, as one of the primary aging-related problems worldwide, raises the question of who will take care of the elderly. The aging of the population of Turkey, as in other countries, continues without losing any momentum. According to the TURKSTAT Active Aging Index 2024 data, the proportion of the elderly (aged 65 and above) within the general population in Turkey was 10.6%. Based on this information, one in every ten people is now considered elderly. The increasing population of the elderly highlights the need for focusing more on multiple aspects of life, especially social security, health, and education (TURKSTAT, 2025a).

There are numerous factors at play in the question of who will provide care to individuals in the family, taking into context: the modern societal structure; the transition from collectivist living to individualized living; the evolution from the extended family to the nuclear family; the constant decrease in the amount of free time in the lives of individuals in the labor force; the necessities of urban life; and the replacement of social relationships based on protection, support, solidarity, and charity among biologically-related individuals in small groups, with individualized relationships, as opposed to collectivist relationships (Altunay & Özkul, 2022).

The World Health Organization (2022) defined elderly care as: *"Services that are provided at home by family, friends, or neighbors, or at institutions by healthcare professionals, to elderly individuals who need assistance and care, for the purpose of meeting their vital needs and offering them the best quality of life based on the principle of living with dignity,"* (WHO, 2022b).

Although care services can be provided to the elderly by professional caregivers at public or private care centers, in cases of inadequate institutional care service opportunities, or the wish of the person to be given care at home, elderly care is usually given in informal settings at the home of the person in need, or that of their caregiver. Individuals aged 65 or above may be given assistance in the context of getting dressed, eating, going to the toilet, or bathing. This assistance becomes more difficult and burdensome for those over the age of 75 (Morgan et al., 2020).

While care is a process that is often regarded as professional in nature, within households it may be considered a part of a traditionally sexist division of labor, and it is mostly taken on by the women of the family (Özateş Gelmez, 2016). Women constitute 81% of all caregivers providing care to the elderly worldwide. As the world's population continues to age, caregiving will remain a significant burden for women (Commonwealth Fund, 2024). This considerably active involvement of women in the care process not only means that these women stay dependent on the working members of their families, but also is an indicator of the patriarchal role patterns at home. In patriarchal societies, the "caregiving" roles of women are associated mainly with motherhood and other roles attributed to motherhood, due to their biological fertility and maternal potential. These roles lead

women, regardless of whether or not they have children, to be prepared for the care roles expected from them by society and become the subject of all care-related responsibilities, particularly for children, the elderly, and the disabled (Samav Cantürk, 2017: 166).

Similarly, in her work discussing the care process from a gender perspective, entitled "*Fortunes of feminism: From state-managed capitalism to neoliberal crisis"*, Fraser (2013) argued that the care process is often associated with women's compassion. Within this process, Fraser continues, while women struggle with housework and long, exhausting working hours, they also try to organize their care responsibilities, ultimately finding themselves in the middle of a tiring, long, and burdensome journey. Simone de Beauvoir (1993: 142-143), who approached the problem of care from a feminist point of view in her work "*The Second Sex"*, stated that women become the indispensable and constant actors of the care burden because they are forced to live their own lives according to the roles and expectations imposed upon them by society.

According to Walby, the active involvement of women in the care process is an extension of gender norms. Based on this view, in traditional and patriarchal societies, care needs are often associated with the nature or psychic needs of the individual and identified with "compassion", which results in the attribution of care roles to women (Walby, 2016). The definition of care labor as the duty of women, by psychologically associating it with women's feelings such as sympathy and compassion, makes the already disadvantaged and secondary position of women in society even more disadvantaged, and reinforces the social roles and responsibilities of women in the household to their detriment (Özateş Gelmez, 2016).

Chappell and Reid (2002), who studied the experiences of women as caregivers, reported that caregiver women experienced much difficulty in this process. These women sometimes lost their self-confidence and self-esteem, were impacted more negatively by this process when they had chronic diseases, and were more disadvantaged compared to men, in terms of taking on care-related duties by taking more responsibilities. Calasanti and Bowen (2006) also asserted that female caregivers were strongly influenced by gender role expectations while adopting these roles, and society deemed care labor 'a job for women'.

In cases where the care process is prolonged, women are strained even more and can develop various mental disorders, particularly depression. In a study on care burden, Zarit et al. (2006) found that long-term caregivers were 40% to 70% more predisposed to depression, while a quarter to half of these caregivers displayed the diagnostic criteria for major depression. Therefore, all caregiving individuals should be given information about the burden of this process and the situations that it can lead to, and necessary precautions should be taken.

Kinney et al. (1995) stated that caregivers of stroke patients, especially those patients who lacked self-sufficiency, were more exposed to the risk of depression, and they had more negative relationships with their environment. Watsons (1998) reported the extent to which caregivers found it difficult to create time to even meet their own needs, demonstrating that they did not have time to spare for themselves. Other notable studies focusing on this issue include the study conducted by Haley (2003) on the care burden of family members providing care to elderly individuals with chronic diseases; the study carried out by Borman et al. (2016) on the burden of providing care to elderly patients receiving rehabilitation; the study performed by Predebon et al. (2021) on elderly people requiring rehabilitation and their caregivers; and the study by Kazemi (2021) on strategies for coping with the care process. Academic studies in this field have revealed that caregivers struggle with substantial degrees of burnout syndrome, depression, and various other psychological issues. Feelings of burnout rise even further as their care burden increases. It is seen that caregivers can face several physical, emotional, and psychological challenges including stress, intense depression, anxiety, anger, helplessness, and hopelessness.

Studies note the aging process is accompanied by increased physical limitations, chronic illnesses, and a decline in energy levels, all of which make the performance of caregiving tasks more challenging (Schulz & Sherwood, 2008). Particularly for older women, the internalization of caregiving responsibilities as a result of socially prescribed gender roles illustrates that, although such burdens may be assumed voluntarily, they nonetheless have detrimental effects (Calasanti & King, 2007). In the context of elderly caregivers, this situation necessitates the simultaneous management of the needs of both the caregiver and the care recipient, creating a complex and demanding dynamic.

From a sociological perspective, it has been reported that older women experience higher levels of burnout, anxiety, and depression in the process of providing care for the elderly compared to younger caregivers (Pinquart & Sörensen, 2003). This is primarily due to the fact that older caregivers may have a more limited capacity to cope with stress as a result of physical health problems and restricted social support prolonged caregiving responsibilities can exacerbate social isolation, thereby negatively impacting life satisfaction (Brodaty & Donkin, 2009). This situation adversely affects both the quality of care provided and the caregiver's own health, thus constituting a significant area of concern from a social policy standpoint.

Due to gender roles, care work is predominantly undertaken by women, which leads to older women bearing caregiving responsibilities even in the later stages of their own life. The aim of this study is to reveal the physical, psychological, and social challenges faced by older women in the process of caring for elderly individuals, plus the psychological impacts, such as burnout, anxiety,

depression, and the negative consequences of social isolation on life satisfaction; and to examine the reflections of these experiences through the lens of gender roles.

Meaning of Being an Elderly Woman Providing Care to an Elderly Individual at a Physiotherapy and Rehabilitation Center from the Perspective of Female Care Labor

METHODOLOGY

The sample study comprised 13 female patient relatives who had accompanied patients over the age of 65 who had received inpatient treatment at a physiotherapy and rehabilitation center in Istanbul, Turkey and were discharged. Population distributions across the country were taken as a basis in the study. Istanbul was selected because, during the study period, it had an elderly population of almost 1 million, (940,318) constituting 6.35% of its entire population. Also, 14.4% of the total number of elderly individuals in Turkey were living in Istanbul at the time, making it the province hosting the largest elderly population in the country (TURKSTAT, 2025b). The study was carried out between 27 July 2023 and 15 September 2023 after obtaining the approval of the Non-Invasive Clinical Studies Ethics Committee of Burdur Mehmet Akif Ersoy University, with the decision dated 5 July 2023 and numbered GO 2023/416.

This study utilizes the qualitative research method, which is a very powerful technique for revealing the points of view, experiences, thoughts, feelings and perceptions of people. Qualitative studies allow researchers to investigate the experiences of individuals in natural environments. The general themes of the data were created by reviewing the relevant literature and using a question form. All interviews were coded separately by the researcher, and the statements in the interviews were categorized under the themes (Creswell, 2014).

Based on the review of the literature and in line with the purpose of the study, a semi-structured interview form was created by the researcher. During field work, patients who had received inpatient treatment at a physiotherapy center in Istanbul were reached using the snowball sampling method. Also, in-depth interviews were carried out with 13 female interviewees over the age of 65 who had provided care to elderly patients over the age of 65, both at the center and at home.[2]

[2] Information about the care institution and the subjectivity of the participants is not provided to protect the anonymity of the participants.

The interviews were held face-to-face in their homes of the interviewees and at the physiotherapy rehabilitation center for the disabled. Each interview lasted between 60 to 180 minutes, during which time the researcher took notes. The data and interview notes used in the study were collected with the permission of the participants.

The data was then analyzed into themes and the resulting codes were categorized and organized. The personal information of the participants was kept confidential, and the participants were given code names such as CG1, CG2, CG3 and so on. The in-depth interviews were carried out to analyze the caregiving experiences of the participants at home and at the center.[3]

Table 1. Demographic characteristics of the participants

Caregiver	**Caregiver Age**	**Patient Age**	**Relation of Caregiver to Patient**	**Education Level**	**Disability/Health Status of Caregiver**	**Marital Status**	**If Married, Number of Children**	**Duration of Caregiving (years)**
CG1	67	70	Sibling	High school	-	Married	2	24
CG2	65	67	Spouse	Illiterate	Herniated disk, cervical kyphosis	Married	3	33
CG3	73	75	Spouse	High school	Diabetes	Married	2	27
CG4	65	78	Sibling	Middle school	-	-	-	2

[3] The author of this study also had the opportunity to observe both her own experiences and the caregiving processes of elderly women looking after the elderly in the same institution, while she was taking care of her 79-year-old father for four months between June and October 2020 in the hospital where she had interviews with individuals following her father's sudden stroke. Therefore, this study also carries the characteristics of a phenomenological study. Phenomenology is the examination of our own experiences and how objects and events appear to us.

CG5	75	77	Sister-in-law	Primary school	Chronic diseases	-	4	5
CG6	78	82	Spouse	Middle school	Diabetes, heart disease	Married	3	25
CG7	72	82	Spouse	Primary school	Hypertension, herniated disk	Married	2	9
CG8	67	72	Spouse	Middle school	Kidney failure	Married	3	19
CG9	69	75	Spouse	Middle school	Diabetes, heart disease	Married	2	11
CG10	65	66	Sibling	High school	Orthopedic disability	Single	-	7
CG11	73	78	Spouse	Middle school	Herniated disk	Married	4	32
CG12	82	85	Spouse	High school	Diabetes, hypertension	Married	3	20
CG13	65	77	Sibling	High school	Heart disease	Single	3	17

Participants and Data Collection

The data from the study comprised the experiences of 13 women who provided care to patients, all of them over the age of 65, while at a physiotherapy and rehabilitation center for the disabled in Istanbul in 2023, and also at home. The center in question is an inpatient institution. The participants took part in the study voluntarily and the in-depth interview method was used to collect data.[4]

Although the treatment processes at physiotherapy and rehabilitation institutions are performed in the company of experts, there is a need for patient companions/attendants to support patients and fulfill their self-care needs during

[4] In his work 'Asylums' (2015), Erving Goffman describes total institutions as places removed from social life, where many individuals live under strict and formal rules. In the introduction of the book, he explains his objective as follows: "It was to gain knowledge about the social world of a person confined to a hospital, as subjectively experienced by that person." He states that total institutions include facilities such as schools and hospitals aimed at protection/shelter or rehabilitation, housing both harmless and in-need individuals as well as harmful and dangerous ones.

their time of hospitalization. In this process, because women are seen as the main actors of care labor, and care is considered in the context of emotional labor, inpatients are often accompanied by female relatives such as wives, daughters, sisters, and sisters-in-law. This study analyzes the caregiving experiences of elderly female caregivers who traveled to the center in Istanbul from various provinces of Turkey, such as Ordu, Sinop, Sivas and Van, due to the limited physiotherapy resources in their own provinces.

The care labor examined in the context of this study is discussed under two sections, as the care labor of the elderly woman and care labor at the institution, and examined within the following subheadings:

CATEGORICAL MODEL: Categorical Content Perspective[5]

MAIN HEADINGS (CONTEXT)
Construction of subtexts by considering each interview an independent text
Definitions of content categories: Content of sentences, sets of sentences, words, relative clauses, proverbs, idioms, similes, slogans, and life stories
Categories: **Category 1. Care labor of the elderly woman** • Care labor as the dedication of women • Care labor as the extension of compassion • Being an elderly caregiver in elderly care • Social support lost in care burden **Category 2. Care labor of the elderly woman as a companion at the Appearance of elderly care in institutional settings** • Socializing in institutional care • Alleviation of daily life responsibilities in institutional care

[5] This modeling process can be examined further in the doctoral thesis of Cevdet Yılmaz published in 2004 at the Department of Sociology at Ege University titled 'Examination of risk concept in different sociological structures-İzmir case'.

• Meaning of institutional care in the vulnerable phase of old age • Companion role of the caregiver in institutional care
Ordering and blending of texts categorized based on content
Presentation of results, comparisons and comments

In this study, the thematic analysis method was employed to analyze the data. Thematic analysis is a flexible and powerful approach that enables the systematic examination of participants' experiences, perceptions, and attitudes in qualitative research (Braun & Clarke, 2006). This method allows for the identification of meaningful patterns within the data, the organization of these patterns through coding, and their integration under broader themes. Furthermore, it provides the opportunity to analyze data at both descriptive and interpretive levels, thereby revealing different dimensions of the research topic (Nowell, Norris, White, & Moules, 2017).

During the data analysis process, the interview transcripts were repeatedly read in line with the research questions to ensure familiarity with the data. Subsequently, meaningful statements were coded, and similar codes were grouped together to form subthemes. These subthemes were then integrated into broader categories to generate overarching themes. The analysis followed Braun and Clarke's (2006) six-phase framework familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report which provided a systematic structure for the process.

Accordingly, the data obtained in the context of elderly care was treated as independent texts for each interview, and then classified into subthemes and overarching themes. The common experiences derived from the participants' life stories were presented within the established thematic framework, and supported with comparisons and interpretations in the findings section.

Demographic Characteristics of the Participants

The finding obtained during the interviews that the participants who took on the responsibility of elderly care were female household members, such as sisters, spouses, mothers, and sisters-in-law, showed that the care process was an extension of other gender roles. While two of the participants did not have children and two were single, the remaining participants were married and had children, and they

were living with other members of their households for whose care they were also responsible. The participants had a broad age range, from 65 to 82 years old. All the participants had various chronic diseases themselves, apart from CG1 (67 years old) and CG4 (65 years old). One of the participants was illiterate, 2 had primary school degrees, 5 had middle school degrees, and 5 had high school degrees. The duration for which the participants had provided care to their patients varied from 2 years to 33 years.

1. Care Labor of the Elderly Woman

1.1. Care labor as the dedication of women

CG1, a 67-year-old from Ordu, who took on the care responsibility of her older sister living in Istanbul, expressed her caregiving process as follows:
"*My parents passed away 30 years ago. I am taking care of my sister. My daughter sometimes brings the grandchildren for me to look after, and my husband also needs separate care.* ***A woman's care ordeal never ends****. I have been at home for 24 years, but I don't have 5 minutes for myself at home… I dropped out of high school and what I regret most is not being able to study and earn money while looking after my sister. We get a home care allowance, but it's not enough, I can't move any part of my body any more. If my brother helped a bit, at least I would be relieved, but when you are a woman, caregiving becomes your job…*"
CG5, a 75-year-old mother of four taking care of her 77-year-old sister-in-law, described her caregiving experience as follows:
"*Being a woman is probably the same everywhere… I have been looking after my sister-in-law for 5 years. Before that, I raised four children—my husband never helped with that either, and he's not helping now with his own sister. The children grew up, and just when we thought we'd be comfortable, now we have my sister-in-law to look after. I haven't seen the light of day my whole life from looking after children… It's not my sister-in-law's fault, what can she do? But honestly, I can't even go out to do my own shopping. We've come in to this world to dedicate ourselves [to others].*"

1.2. Care labor as the extension of compassion

CG6, a 78-year-old woman providing care to her 82-year-old husband, stated her experience with the caregiving process as follows: "*Who can I leave my husband with and go? You're a woman, you have to look after him… Sometimes I pray, 'Oh Allah, just for one day, save me from this caregiving.' I gave birth to 3 children, I looked after them, raised them, and just when we were about to relax, my husband got sick and he's been like my child for 25 years… He's like a child, you can't throw him away, you can't sell him, you feel sorry for him, so you look after him,*

it's our duty… Aren't all women… slaves to care [for others] in this life?… Since my husband became helpless, everyone [we know] has cut ties [with us]. If we had some support from relatives, neighbors, friends, we would be less tired, but no one understands our situation. I can't leave his side for five minutes, I've literally dedicated myself [to him]…"

Similarly, CG2, a 65-year-old woman taking care of her 67-year-old husband, shared the following statement:

"*…My husband has been helpless for 33 years. Since he became helpless, I've become helpless too. I developed a herniated disk, cervical kyphosis from stress, how I lifted and lowered that grown man for years. Sometimes I wonder, if it were me lying there, would I be looked after?… I haven't even gone out for years, I only see and talk to two people in this environment. I raised three children too, and now I am looking after my husband like a baby who won't grow up. Sometimes, even if [I] get angry, as a woman, [I] can't bring [my]self to abandon him, [I] have to look after him. I just sometimes feel very tired…*"

In the context of gender roles, care labor is seen as a part of 'emotional labor' and 'compassion' in a way, and the women of the household try to expend this labor for others. In this process, while they take on the care responsibilities of their elderly relatives, they also continue to take care of other members of the household. This results in a failure to spare any time for themselves, while completely dedicating their lives to this process (Atagün et al., 2011; Atasü-Topçuoğlu, 2022).

1.3. Being an elderly woman as a caregiver of an elderly person—'I Can Barely Take Care of Myself'

Seventy-five-year-old CG5 from Van, on taking care of her 77-year-old sister-in-law for 5 years:

"*I'm praying for either me or her to go [die] soon. My whole body has been aching for days, we come here for my sister-in-law's physical therapy. I'm over it myself now, I'm so tired, I'm sick myself, I can't even help myself, every part of me is stiff. I'm already in need of care myself, [but] as soon as my husband passed away, the family immediately gave me his sister, who'd had a traffic accident, to look after. You can't please this family—I've been looking after the whole family since I became a bride… For how many years I suffered abuse from my [now]deceased husband. I said, 'Let me still look after her, it's a shame, it's a sin,' but there's no thank you, no support, no one calling or asking [how I am]. I swear I'm like a slave—'Cook the food, carry it, give the medicines regularly'. Just when I'm about to relax, another [thing comes] and settles on my head.* ***I feel a little relieved when I bring her here [to the institution]***."

CG12, an 82-year-old taking care of her 85-year-old husband:

"*I am a guest in this life myself. My husband's lower body has been paralyzed for years, and his bones break easily, [so] the stress I'm living with is immeasurable… And he's dependent on a wheelchair. In the past two years he's become so irritable, constantly wanting to go to the toilet, eat bread, get up, and he keeps wanting to move as if he's not disabled. I can barely walk myself. If it were a child,*

you'd say they'll grow up, but what can I say to myself? I cry quietly to myself… He only torments me, he doesn't have the heart to torment the children, but I get so tired…"

1.4. *Social support lost in care burden—Inadequacy of social support—Every man for himself*

CG3, a 73-year-old woman looking after her 75-year-old husband, expressed her need for support during the caregiving process as follows:

"*When my husband became disabled, my mother-in-law came to me and said, 'You're half a person, too, now, you won't be able to do much work from now on.' I cried for days because of her words, and I developed diabetes at an earlier age from my sadness! Thank Allah, I have two children. They don't like their father much, my daughter still visits, but my son and daughter-in-law don't bother much. If your own child doesn't support you, will a stranger, friends, or relatives do so? Everyone is in their own world… I'm getting old, too. I can't move any part of my body any more, I've been looking after him since I was 48. If only I knew he would get better, but sometimes when I think about it, I get depressed thinking, 'Your life is over now…'*"

CG8, who was 67 years old and taking care of a 72-year-old patient, similarly expressed her inability to receive support from her close circle during the caregiving process as follows:

"*You'd think they'd come visit their father, take him to the park for five minutes, right? There are 3 grown children, none of them are any good. May Allah give you a good child. There are 5 nephews and nieces, none of them are any good either. Believe me, the only place he sees is this hospital cafeteria. When no one helps, I'm at a loss whether to keep up with the house or my husband… If there weren't trees in the hospital, we'd forget the color green… Just give us some support, we don't ask for much, just knock on our door, that's enough…*"

The participants stated they were unable to receive support from anyone around them during the caregiving process. They experienced a heavier care burden without support. Because they also had to struggle with many conditions brought about by aging themselves and were exhausted by prolonged care processes, they felt like they had become slaves to their caregiving roles. Pruchno et al. (1995) reported that in cases of insufficient social support in female caregivers, caregivers experienced more emotional and physical fatigue, and those who experienced less caregiving satisfaction struggled with more depression.

Care Labor of the Elderly Woman as a Companion at the Institution

2.Appearance of elderly care labor in institutional settings

2.1. Hospital as a setting to socialize

Seventy-seven-year-old CG5 from Van, taking care of her 77-year-old sister-in-law, described her experiences at the institution as follows:

"*When I come here, at least I make a couple of friends and chat. No one visits us in the village, [but here] we can go out to the hospital yard and I take my sister to the cafeteria in her wheelchair. The roads in Turkey are already bad, so we can't go out. It's hard to look after my sister—we gave our house in Van to a contractor after the earthquake and they said they'd install an elevator, [but] we're still waiting. When you have a disabled person, there's no one to look after them, and you become disabled with them, too. We can't leave the house, but here, at least you can talk to people who have similar troubles to your own…*"

CG6, a 78-year-old woman from Istanbul taking care of her 82-year-old husband, described the socialization process at the institution using the following words:

"*The hospital environment is a way of socializing for us—we look at each other and relieve our sorrows. How can I take my husband out of the house? Since he became helpless, he doesn't want to go out… I only see two people like this in the hospital and they ask how I am. It's therapy for me, too. There's a market nearby, we take an hour-long walk with the others during lunch breaks and even that feels good, it's a breath of fresh air…*"

2.2. Alleviation of daily responsibilities in institutional care

CG2, a 65-year-old woman from Istanbul who had taken care of her 67-year-old husband for 33 years, expressed her experiences at the institution as follows:

"*Here, we are free from the troubles of daily life—no laundry, no dishes, no worries about your disabled loved one falling or getting sick. My husband is also very happy and doesn't even want to leave, he's in good spirits. The doctor asks how he's doing every day, 'Are you well, uncle?' … I'm tired, caring for a patient is very difficult and exhausting. Imagine, 33 years, it's easier said than done. Here, at least my mind is at ease, even the worry of what to cook is enough for a woman…*"

CG12, an 82-year-old woman providing care to her 85-year-old husband, described her stay at the hospital to accompany her husband as follows:

"*The daily worry of what to cook, looking after grandchildren, comforting children, cooking, ironing, sending children to school... When I come here, it's therapy for me, too. I put my husband in his wheelchair and take him for a stroll among the trees in the hospital yard, even that is therapy for me.*"

CG8, a 67-year-old woman from Muş who had been caring for her 72-year-old husband for 19 years, described her hospital stay as follows:

"*Here, there's no worry about food or anything, everyone is like you too. Back home, a woman's work never ends. I used to be confused whether to deal with guests coming and going, or with my husband. Here, there's no worry about cooking and carrying things, my mind is very much at ease in this regard…*"

Likewise, CG3, who was looking after her 75-year-old husband, expressed her experience at the hospital as follows:

"*When you see people like yourself, you become happy. Looking after my husband at home is very tiring. It's 24/7 care at home, a woman's work at home never ends. At least here, those chores are gone, I can take a breath or two*."

The participants, who were 24/7 caregivers of their elderly patients, reported that while they were providing care to their patients at home, they were also caring for other members of the household, so they were unable to socialize. They revealed that during the time they stayed at the hospital, they were free from their daily responsibilities, such as housework, to some extent, and they were able to socialize by spending time with other carers like themselves. Thus, they were satisfied with the process at the institution.

2.3. Meaning of institutional care in the vulnerable phase of institutional care

According to the participants, the caregiving process was more difficult when they provided care to patients with comorbidities and those who were older.

CG6, 78 years old, taking care of her 82-year-old husband, said, "*The man is very old and he has illnesses too. Medication tracking is done here. He also has osteoporosis and since he doesn't move, his body has completely given up and I'm afraid to move him, thinking he might break something… This is why it feels easier to look after him here, at least…*"

CG7, 72 years old, providing care to her 82-year-old husband, expressed her experience of looking after a vulnerable elderly person as follows:

"*My husband has developed dementia. The care of others is one way, our care is another way. Even if it [dementia] is not advanced, it's more difficult and exhausting. At least the hospital process feels safer. Even if he can't walk, sometimes he wants to get up and go like in the old days. I'm afraid something will happen. I can't even go to the toilet sometimes—because of the Alzheimer's, he's afraid if I leave him, he'll think I've abandoned him. I don't know what to do*."

2.4. Companion role of the caregiver in institutional care

CG6, a 78-year-old woman taking care of her 82-year-old husband, described the process of using physiotherapy equipment as follows:

"*The hardest part for me at the hospital is the physical therapy equipment. When you first come to physical therapy, there's a system—you have to stabilize your patient first so they don't fall, then you start the machine and set the timer, and you have to stabilize the paralyzed hand with a separate bandage. I can never do these*

[things]. I can't understand technology at this age, I ask for help from other, younger companions at the hospital…"

CG4, a 65-year-old participant taking care of her 78-year-old brother, stated the following:

"*I find it very difficult to make my brother move, my weight is not suitable for making him move, I get tired very quickly. The physiotherapists help, but it's still difficult. I try to come here to help with his treatment, but whether it's due to ignorance or something, I really struggle with these machines. I definitely need help from others, I get stressed."*

CG7, a 72-year-old participant providing care to her 82-year-old husband, expressed the following:

"*As for the equipment, the physiotherapist helps, but most of the work is on me, [so] this part tires me and stresses me. I try to make him do the movements on the equipment as the instructor showed, as much as my mind allows, but when I try to lift and lower my husband's leg [it's difficult]. I have a herniated disk myself and recently I got stuck trying to lift my husband. I ended up in the hospital myself.*"

Although the treatment of elderly family members receiving inpatient care at public institutions, such as physiotherapy and rehabilitation centers, are provided in the company of experts, depending on the status of inpatients, there is still a need for companions who will stay with them throughout their hospitalization process to support and take care of them.

2.5. Solidarity in the hospital environment

CG2, a 65-year-old woman taking care of her 67-year-old husband, shared the following statement regarding the solidarity relationships offered by institutional care:

"*We women are born to care—look after your husband, look after your child, and on top of that, look after the disabled person at home. I always give from myself. I don't have 5 minutes to go to the market, I don't even remember the last time I went out. I'm about to go mad. At least at the hospital, sometimes I say, 'Can someone keep an eye on him for two minutes so I can walk around the town's market?' I [can] look around as I please and feel happy. I don't have this opportunity at home for him to get better or for me to breathe. Just not having the worry of [making] food here makes me happy…*"

CG13, who had been looking after her 77-year-old older brother for 17 years, described the environment of solidarity at the hospital as follows:

"*In the hospital, we all become like brothers and sisters to each other—only someone who has fallen off a donkey understands the situation of someone else who has fallen off a donkey. No one knows your caregiving troubles, but we know it here in the hospital. We exchange phone numbers, too. We give each other morale, we confide in each other, we motivate each other. My brother has no one,*

he's a difficult person, caring for him is very tiring, at least I can take a breath here, too… And it makes you happy to see people who are going through the same things as you…"

CG10, a 65-year-old participant taking care of her 66-year-old brother, described the process at the hospital as follows:

"*Outside [the hospital], if you have a disabled person, people stare blankly, 'Why is uncle like this?' Is there a 'why' or a 'how'? You don't help when you see a wheelchair, you just say, 'Oh dear, too bad.' …But here in the hospital, when you see an elderly person, both the companions and the other staff show respect. You experience in the hospital what your own relatives don't do…*"

DISCUSSION

This study examines the caregiving process through the experiences of elderly women who provide care both within the household and in institutional settings, revealing that the caregiving burden is experienced differently by each individual. The study also addresses the condition of "double burden" arising from being both a woman and an elderly caregiver. In traditional and patriarchal societies, caregiving labor is often associated with emotions such as "compassion" and "self-sacrifice," with women positioned as the primary agents of care. This societal perception leads women, regardless of their stage in life, to assume caregiving responsibilities, thereby reinforcing and perpetuating existing gender inequalities between men and women (Riedel, 1998; Walby, 2016).

Under the subheadings "Care Labor as the Dedication of Women" and "Care Labor as the Extension of Compassion," the study addresses the ways in which women, as the invisible actors of unpaid and unrecognized labor, become the primary agents of care throughout much of their lives, and the sacrifices they make from their own lives in this process. In this context, elderly women caregivers are not only occupied with the heavy responsibilities imposed by the caregiving burden, but also face various health problems, such as the deterioration of their physical and mental well-being. The continuous nature of caregiving prevents elderly caregivers from finding time to participate in a social life, compelling them to forgo many aspects of their own lives and live in social isolation, leading to an existence almost entirely dedicated to the caregiving process (Adak, 2003; Lindt et al., 2020).

As elderly women caregivers advance in age, related declines in physiological capacity, an increase in chronic illnesses, and the emergence of various morbidities further intensify the caregiving burden. As noted in the subtitle of this study, *"Being an Elderly Caregiver in Elderly Care—'I Can Barely Take Care of Myself'"*, the caregiver's age emerges as a critical variable in the

caregiving process; as age increases, the process generates greater disadvantages for caregivers (Adelman, et al., 2014). The literature similarly indicates that elderly caregivers experience higher levels of burnout, stress, and depression compared to younger caregivers. They also having more limited capacity to cope with stress, and face health problems that negatively impact the caregiving process (Pinquart & Sörensen, 2003; Schulz & Sherwood, 2008).

Furthermore, the decline in physical capacity among elderly caregivers not only prolongs the time required to perform caregiving tasks, but may also impact the quality of care provided (Gaugler, et al., 2005). This situation creates challenges in meeting the care recipient's needs and often leads caregivers to compromise their own health. Within the framework of gender roles, the social attribution of caregiving responsibilities primarily to women places elderly women caregivers in a position of intersectional disadvantage, stemming from both their age and their gender (Calasanti & King, 2007; Özateş Gelmez, 2016). Therefore, age should be regarded as a critical factor in determining the intensity of the caregiving burden, and policies addressing the needs of elderly caregivers should take this variable into account.

Acar Savran (2002) states that the belief that the caregiving role stems from women's "natural" emotionality leads to the perception of this process as a form of sacrifice that women make for their loved ones. As a result, caregiving continues to remain "invisible" and "unpaid" labor. Current care policies reflect a gradual withdrawal of the state from its responsibilities toward individuals in need of care, with only a limited portion of such services being provided through private sector institutions, while the remaining caregiving responsibilities are encouraged to be borne within the family, usually by women. This situation contributes to the marketization of care, rendering paid care services accessible primarily to high-income families. For middle- and low-income households, care becomes a compulsory domestic task, and women who take on this responsibility often make significant personal sacrifices in their own lives. Therefore, supporting the care of dependent groups, such as the elderly, children, and persons with disabilities, through institutional care services is of critical importance for increasing women's visibility in society and for challenging the perception of caregiving as an inherently female responsibility (Özateş Gelmez, 2016; Erdoğdu Toksöz, 2013).

Fraser (2013) argues that although different strategies are pursued in care services within welfare societies, in all models the understanding of care remains centered on motherhood and grounded in women's emotional labor. The caregiving role and responsibilities traditionally assigned to women continually perpetuate, distancing women from the paid labor market and reinforcing their disadvantaged position in society. This dynamic deepens gender inequality and power imbalances between the sexes, further exacerbating structural disparities between men and women. In line with the findings of the present study, Milligan's (2016) research

on caregivers of older adults revealed that, while providing care, caregivers simultaneously seek meaning in their own lives; yet, during this process, they face multifaceted challenges, such as emotional stress, physical health problems, concerns about the future, work and economic difficulties, restrictions in social activities, and deterioration in family relationships. These findings underscore that caregiving labor is a critical issue not only for the care recipient, but also for the caregiver's quality of life and social position.

In the study, participants frequently emphasized that the caregiving burden increased markedly in situations where social support was insufficient. In the subsection titled *"Social Support Lost in Care Burden"*, it was observed that caregivers, particularly those who lacked the time to make plans for themselves, reported feeling "hopeless". Older participants, who had been carrying both domestic responsibilities and caregiving duties for many years, described themselves as "devoted to care" and "exhausted," often due to their own chronic health conditions. The findings reveal that a significant proportion of women caregivers have abandoned personal needs to such an extent that they no longer prioritize their own lives.

This aligns with findings in literature. Chappell and Reid (2002) emphasize the importance of social support and solidarity in the caregiving process, noting that the provision of social support substantially reduces the caregiving burden. Similarly, Schulz et al. (2020) found that as satisfaction with social support decreases, the caregiving burden increases significantly. Therefore, strengthening social support mechanisms is considered a critical area of intervention for reducing the risk of burnout among caregivers and preserving their quality of life.

In this study, elderly women caregivers, aged between 65 and 82, reported that, in addition to having multiple chronic health conditions, they also felt psychologically as if they had withdrawn from life. Participants who had experienced institutional care in physical therapy centers stated that in their daily lives, providing 24/7 caregiving often resulted in a sense of "enforced confinement". However, during the institutional care process, while accompanying their patients in the physical therapy center, they were able to interact socially with other caregivers undergoing similar experiences. This interaction fostered solidarity, providing both emotional support and partially alleviating social isolation. Participants emphasized that such mutual support and shared experiences among caregivers temporarily eased their caregiving burden and positively affected their overall well-being.

Gaugler et al. (2005) note that institutional care environments offer caregivers opportunities for social interaction and can temporarily reduce perceived caregiving stress. Likewise, Gonyea et al. (2008) found that solidarity among caregivers not only provides social support, but also mitigates feelings of burnout experienced during the caregiving process. In this regard, institutional care services

can serve as an important "interim respite" for elderly women caregivers, offering benefits both physically and psychosocially.

The findings of the study indicate a strong and positive correlation between the duration of caregiving and the perceived caregiving burden. Interviews were conducted with women caregivers who had undertaken caregiving responsibilities for periods ranging from 2 to 33 years. Participants who had provided care for longer durations reported experiencing greater caregiving burden, more pronounced symptoms of depression, and heightened physical fatigue. They emphasized that, as the caregiving period lengthened, the process became increasingly exhausting, both physically and psychologically.

These results are consistent with previous studies in the literature. Research by Zarit (1980, 2006), Oeki et al. (2012), and Rajabi et al. (2015) has similarly shown that in cases where caregiving is prolonged and unsupported, caregivers experience higher levels of emotional distress, fatigue, sleep disturbances, and depression. Moreover, such caregivers face greater difficulties in maintaining the energy required to provide care, compared to those who have been caregiving for shorter periods.

The second part of the study examines the caregiving process of elderly women who act as companions in institutional care settings. In the section entitled *"Appearance of Elderly Care in Institutional Settings"*, it is emphasized that elderly individuals, in addition to receiving informal care at home, may require professional institutional care services in certain circumstances, such as when they have multiple chronic illnesses, functional impairments, or acute health conditions necessitating medical treatment. Particularly, hospital-based physiotherapy and rehabilitation processes not only facilitate access to medical treatment for elderly care recipients, but also situate the caregiving role of elderly women within a different context.

As highlighted in the literature, institutional care services address the medical and rehabilitative needs of care recipients, while also providing temporary relief from the physical fatigue and psychological stress experienced by caregivers (Gaugler et al., 2005; Gonyea et al., 2008). However, the institutional care process does not entirely remove the caregiver's responsibilities; rather, the time spent as a companion in hospitals or care facilities becomes an experience that can both strengthen and, at times, constrain the caregiver's social and emotional bonds (Colombo et al., 2011). Therefore, institutional care can be understood as producing multidimensional effects for both the care recipient and the caregiver.

In the section *"Socializing in Institutional Care"*, participants reported that being surrounded by others who were experiencing similar circumstances made them feel more socially engaged within the hospital environment. Elderly women caregivers in institutional settings described the act of meeting and interacting with

other caregivers who shared comparable life experiences as socially empowering. According to participants' narratives, the "solidarity" that develops among family members of patients in such environments serves as an important social support mechanism in coping with the challenges of caregiving. Mutual assistance and opportunities for socialization were perceived as providing a degree of relief in their daily lives, even if only temporarily.

These findings align with existing literature, which underscores the role of social support networks in enhancing caregivers' psychological resilience and reducing perceived caregiving stress (Cohen & Wills, 1985; Zauszniewski et al., 2009). Research has demonstrated that structured opportunities for interaction and mutual support within caregiving contexts can buffer the adverse effects of prolonged care responsibilities, thereby improving caregivers' emotional well-being (Chappell & Reid, 2002; Schulz et al., 2020).

In the section *"Alleviation of Daily Life Responsibilities in Institutional Care"*, it was highlighted that elderly women providing care to their elderly relatives in institutional settings were temporarily relieved from domestic responsibilities such as cooking, cleaning, and shopping—tasks they typically managed at home alongside caregiving duties. Participants emphasized that this reprieve offered them an opportunity for physical rest, even if only to a limited extent. Such relief was perceived as temporarily reducing the substantial burden of simultaneously providing 24/7 care for an elderly relative and managing all household tasks.

Consistent with these findings, previous research has shown that respite care interventions can significantly reduce caregivers' risk of burnout and enhance their overall well-being (Gaugler et al., 2005; Zarit et al., 2014). In this regard, institutional care functions not only as a means of supporting the elderly care recipient but also as an important mechanism for sustaining the social and physical well-being of the caregiver.

The process of "solidarity" that develops among relatives of patients in institutional care settings serves as an important social support mechanism during the caregiving process. This mutual assistance and social interaction among caregivers facilitate emotional coping and also provides a degree of relief from the demands of everyday life.

In the section *"Alleviation of Daily Life Responsibilities in Institutional Care"*, it was noted that elderly women caring for elderly relatives in institutional settings were, for the duration of their stay, temporarily freed from household responsibilities such as cooking, cleaning, and shopping—tasks they would otherwise undertake in addition to continuous caregiving at home. Participants reported that this period allowed them some opportunity for rest, alleviating, even

if temporarily, the heavy burden typically associated with providing round-the-clock care for both their elderly relatives and other household members.

In the caregiving process for elderly individuals of advanced age, age-related physiological changes and heightened sensitivities can significantly complicate care provision. In the section, *"Meaning of Institutional Care in the Vulnerable Phase of Old Age"*, it is emphasized that caregiving becomes particularly challenging when elderly frailty accompanies advanced age.

Elderly frailty, clinically defined as a geriatric syndrome, refers to the state in which the ability of older adults to cope with daily or acute stressors is compromised, due to diminished physiological reserve and age-related decline in the functions of multiple organ systems (WHO, 2017; Beğer, 2006). This condition is characterized by gradual deterioration of bodily systems and functions, reduced organ reserve capacity, loss of muscle mass (sarcopenia), decreased bone mineral density (osteopenia), increased susceptibility to inflammation, and aging-related changes in immune and neuroendocrine functions.

Findings from the present study indicate that for elderly caregivers providing care to frail older adults, the process is considerably more demanding due to the greater care needs of these individuals. Consequently, such caregivers are more likely to experience higher levels of emotional strain, including depression and a sense of weariness, and report greater difficulty in coping with these challenges during the caregiving process. These results align with prior research highlighting the heightened burden and psychosocial strain experienced by those providing care to highly dependent or medically complex elderly individuals (Gaugler et al., 2005; Adelman et al., 2014).

The study findings indicate that caregivers providing care to non-mobile or semi-mobile individuals within the "frail elderly group" are exposed to significantly higher levels of stress. Similarly, Kinney (1995) reported that the caregiving burden increases substantially when care recipients are semi-mobile or non-mobile. Kramer and Kipnis (1995) likewise found that caring for elderly patients with multiple comorbidities is associated with greater caregiving responsibilities, thereby intensifying the overall burden. In alignment with these findings, Ding et al. (2022) observed that family members providing care to frail older adults and individuals with multiple chronic conditions bear a substantial caregiving load. The study further revealed that female caregivers of older adults with multiple illnesses and limited social support constitute the highest-risk group for caregiving burden.

Katz et al. (1970) developed the Activities of Daily Living (ADL) Index to assess the care needs of older individuals, categorizing six fundamental functions: bathing, dressing, toileting, transferring, personal hygiene, and feeding. The ADL scale is widely used in both home-based and institutional care settings to evaluate

the degree of care required and to provide a standardized measure for care planning (Graf, 2008; Lawton & Brody, 1969).

In this study, under the section *"Companion Role of the Caregiver in Institutional Care,"* it was observed that elderly women providing care to patients in physical therapy and rehabilitation centers also undertook additional responsibilities during the institutional care process, in addition to the informal care they provided to elderly family members at home. These responsibilities included monitoring the administration of prescribed medications in the hospital, carrying out small-scale daily shopping tasks, supporting basic daily living activities, and assisting patients during physical therapy sessions by helping them perform exercises and accompanying them throughout the process.

Thus, elderly women who provide care both at home and in institutional settings face increased physical, psychological, and emotional burdens due to their dual caregiving responsibilities. Similarly, the literature indicates that such dual caregiving roles heighten the risk of burnout, reduce quality of life, and make the sustainability of caregiving more challenging (Schulz & Eden, 2016; Adelman et al., 2014).

In the caregiving process, elderly women caregivers, who are themselves in advanced age, simultaneously strive to manage tasks such as medication management for the care recipient, shopping, and meeting basic activities of daily living, while also coping with the psychosocial, physical, stress-related, anxiety, and depressive effects of caregiving (Özgen & Babekoğlu, 2001; Chadda, 2014). Particularly, situations in which the care recipient expresses a strong desire for independent behavior, frequently moves around or wanders, has a high frequency of toileting needs that disrupt the caregiver's sleep, or exhibits abusive or exploitative attitudes toward the caregiver, have been observed to significantly intensify the caregiving burden, sometimes reaching the level of overburden (Folstein & McHugh, 1975; Adelman et al., 2014). Similarly, the literature indicates that the presence of behavioral and psychiatric symptoms during the caregiving process substantially increases caregiver burnout, psychological distress, and physical exhaustion (Schulz & Sherwood, 2008; Brodaty & Donkin, 2009).

CONCLUSION

This study examines the caregiving process through the experiences of elderly women, aged 65 and above, who provide care both within the household and in institutional settings, revealing that the caregiving burden is experienced differently by each individual. The study also addresses the condition of the "double burden" arising from being both a woman and an elderly caregiver. In traditional and patriarchal societies, caregiving labor is often associated with

compassion and self-sacrifice, leading women to assume caregiving responsibilities at every stage of their lives. Within this framework, current social policy practices, rather than publicizing and collectivizing care labor, continue to place the burden of care within the family, predominantly on the shoulders of women (Riedel, 1998; Walby, 2016).

As emphasized in Walby's (2016) analysis of patriarchy, the perception of women as the primary subjects of care perpetuates gender hierarchies to the disadvantage of women. Accordingly, the caregiving labor of elderly women should not be understood merely as an individual responsibility but rather as a political issue that reflects broader power relations and the institutionalized practices of patriarchal structures. In Turkey, the fact that elder care is largely relegated to the family and that public care services remain insufficient, further intensifies the caregiving burden on women, thereby deepening existing gender inequalities.

Making care labor visible at both academic and political levels holds critical importance for the development of future social policies in this field. Future research should comparatively examine the experiences of elderly female caregivers across diverse cultural contexts, socio-economic groups, and care settings, including those involving various health conditions. Additionally, studies that explore the psychosocial effects and long-term consequences of caregiving, as well as the effectiveness of intervention strategies, would generate valuable insights into the multifaceted challenges of elder care. Linking such findings to policy implications is essential for developing evidence-based measures that directly address the needs of elderly caregivers. In particular, future research could inform policies aimed at strengthening support mechanisms for caregivers, improving the accessibility and quality of institutional care services, and mitigating the intersectional disadvantages women face due to age and gender. Integrating such policy-oriented recommendations would not only enrich academic literature, but also provide practical pathways for advancing gender-sensitive social policies and constructing more equitable and sustainable care systems.

Alleviating the caregiving burden of elderly women requires the implementation of multi-layered strategies. First, the accessibility and quality of institutional care services provided by the state must be improved. Home-based care services should be professionalized, and caregivers should be granted social security, pension rights, financial support, and access to psychosocial counseling. Second, social policies grounded in gender equality should be developed in order to reinforce the understanding that caregiving is not solely the responsibility of women, but a shared obligation of society as a whole. Third, support mechanisms, solidarity networks, and community-based services should be expanded through the active involvement of civil society organizations and local governments.

In conclusion, the caregiving burden of elderly women is not merely an individual issue but a multidimensional social problem directly linked to gender inequalities, welfare policies, and the broader power relations within society. Therefore, making care labor visible and developing comprehensive social policies that prioritize gender equality is imperative. Only in this way can the quality of life of elderly women be improved and a more equitable and sustainable care system be established.

Limitations and Strengths of the Study

The findings of this study should be interpreted in light of certain limitations related to the research design and participant characteristics. Firstly, there was a wide variation in the duration of caregiving among participants, ranging from 2 to 33 years. While this diversity contributed to the richness of reflections on caregiving experiences and coping strategies, it may also have made direct comparisons more difficult and weakened the consistency of certain themes.

The age range of the caregivers, from 65 to 82 years, may also have influenced how the challenges of caregiving were perceived and experienced. Older participants are likely to face different difficulties compared to younger elderly individuals, in terms of physical endurance, energy levels, and overall health. Furthermore, participants' various chronic health conditions, such as herniated discs, diabetes, and hypertension, added diversity to the physical and psychological demands of caregiving. These health differences may individually alter the difficulty level of caregiving and limit the generalizability of the findings.

Nevertheless, the strengths of this study are also noteworthy. By providing in-depth and qualitative data on the caregiving experiences of elderly women who care for older individuals, the research makes visible the intersectional dimensions of care labor within the context of gender and aging. The originality and vividness of the participants' narratives offer significant contributions to understanding the multidimensional nature of the caregiving burden. Furthermore, the study serves as a valuable foundation for discussions in the fields of social policy, gender roles, and aging research, thereby offering an important reference point for future scholarly inquiries.

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