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Compulsive Sensitivity—A Consequence of Caring: A Qualitative Investigation Into Women Carer's Difficulties in Limiting Their Labours

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Compulsive Sensitivity—A Consequence of Caring: A Qualitative Investigation Into Women Carer's Difficulties in Limiting Their Labours

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Women are expected to care, both in public and private life, for the sick as well as the healthy. Some women have difficulties in limiting their caring, despite being deeply careworn. In this life-course study, based on in-depth interviews with elderly women in Sweden, the concept "compulsive sensitivity" presents a way toward understanding their difficulties. Compulsive sensitivity denotes the compulsion to see and respond to other people's needs, whatever one's own situation.

BACKGROUND

Our article is one aspect of a larger qualitative study, and is concerned with women who have difficulty limiting their caring. In our work as family doctors (AF, GC) we have encountered many women, both young and old, who are exhausted by their heavy load of caring for others, sometimes at work, frequently at home. However tired they are, they find it almost impossible to limiting their commitments. They blame themselves for their situation and often are blamed by others—among them health workers who suggest they have a drive to become victims.

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Gender, Caring, and Health: A Review

Throughout the world, it is the women who carry out most of the caring work, whether unpaid or paid. This holds true whether the caring is for the sick, the otherwise exposed, or the healthy (see, e.g., Arber & Khlal, 2002; Doyal, 1990a, 1990b; Luxton, 1997; Meleis & Lindgren, 2002; Miller & Cafasso, 1992; Walters et al. 1996; Wuest, 2000). The visible and invisible tasks involved in caring—housekeeping, cooking, cleaning, laundering, child-rearing, comforting, active listening, being at hand, and so on—form a great part of many women's work, often throughout their life. Reaching the age of retirement does not limit the demands for such efforts (Lee & Porteous, 2002; Navaie-Waliser, Spriggs, & Feldman, 2002; Sawatzky & Fowler-Kerry, 2003).

Research on gender and carer's workload, and health in relation to family caring, deals mostly with caregiving to family members who are disabled or diseased. Several studies conclude that women caregivers provide more time-consuming and complex care than men (Kramer & Kipnis, 1995; Miller & Cafasso, 1992 [meta-analysis]; Navaie-Waliser et al., 2002; Yee & Schulz, 2000 [review]) and have more problems balancing caregiving with other family and employment responsibilities (Kramer & Kipnis, 1995; Navaie-Waliser et al., 2002). Women also receive less formal (Gustafsson & Szebehely, 2001; Morris, Woods, Davies, & Morris, 1991 [review]; Navaie-Waliser et al., 2002) or informal assistance (Yee & Schulz, 2000). They carry on caring longer, and for recipients in poorer health (Collins & Jones, 1997; Navaie-Waliser et al., 2002; Yee & Schulz, 2000). Altogether, women are found to carry higher caregiving burdens than men (Yee & Schulz, 2000).

Caring women suffer more from anxiety and depression than caring men and achieve less life satisfaction (Lee & Porteous, 2002; Morris et al., 1991; Navaie-Waliser et al., 2002; Yee & Schulz, 2000). Some studies also report higher rates of ailments such as chronic fatigue, sleeplessness, stomach problems, and back pain (Lee & Porteous, 2002; Wilcox & King, 1999). Data has been presented indicating increased risk for coronary heart disease in wives caring (more than 9 hours a day) for an ill or disabled spouse (Lee, Colditz, Berkman, & Kawachi, 2003). Further, women are more likely than men to neglect health-promoting activities (Lee & Porteous, 2002; Navaie-Waliser et al., 2002; Sisk, 2000).

Thus, women assume heavier caregiving tasks in their private life than men, and they continue to care for severely disabled recipients over long periods, even when suffering from bad health themselves due to this work. This fact is sometimes discussed in the literature. In their study, Collins and Jones (1997) found that both the men and women considered women to be better suited to giving care than men, and that women found it easier to give care. Together with Morris and colleagues (1991), they also found that women felt more guilt than men at the thought of relinquishing care. They spoke more often of being "without a choice" when asked why they continued. Yee and Schulz (2000) conclude that women are expected to assume caring

responsibilities, and are therefore more likely to take on such responsibilities than men, whatever their own circumstances.

When we review this literature focusing on caring in private life, we feel a lack of narrative studies, allowing women's own understandings of their caring experiences to appear. Furthermore, most research has focused on caregiving associated with a particular illness, disability, or developmental stage, so the accumulated lifelong health effects of all kinds of paid or unpaid caring demands seldom have been explored (cf. Wuest, 1998, 2001). These gaps in the literature also are noted in some of the references above (Miller & Cafasso, 1992; Navaie-Waliser et al., 2002).

We conducted our qualitative interview study in Sweden, with the aim of exploring women's paid and unpaid work, and associated health and ill health, in a lifetime perspective (Carlstedt & Forssén, 1999; Forssén & Carlstedt, 2001). We wanted to give space to women's own perceptions of their work, not least their unpaid caring work, and to their own accounts of health and ill health. We wanted to do this because women's work experience is less known in a medical context than men's, so theories regarding work and health are largely based on men's experiences (Angus, 1994; Carlstedt & Forssén, 1999; Doyal, 1990a, 1990b, 1995; Forssén & Carlstedt, 2001; Meleis & Lindgren, 2002; Walters et al., 1996).

This paper constitutes a deeper analysis of some of our collected data regarding caring and health. We focus particularly on one of our findings, conceptualised as "compulsive sensitivity." We believe that this concept explains, at least in part, the difficulties that some women have in warding off excessive caring demands.

Feminist theory constitutes the frame of reference for our research.

CARING, WORK, AND HEALTH IN FEMINIST THEORY

The lack of a lifelong perspective in research on caring may be linked to the common tenor of the concept. While caregiving, in most cases in the literature, is conceptualised as an activity directed toward the elderly and ill, caring is placed on an equal footing with love and commitment, and not work (Carlstedt & Forssén, 1999; Waerness, 1987; Wuest, 1998, 2001). In their exposition on caring work Benoit and Heiting (1998), however, state, "*caring work, that is, caring for and about others* [italics added], involves physical activity, social organisation, and emotional involvement" and is, "inevitably entangled with gender arrangements (p. 1101)."

Consequently, in our research, caring is seen as work. The concept of caring will be used synonymously with caregiving or caring work (cf. Wuest, 1998, 2001). The skills necessary for all the different kinds of caring are understood to be gained through doing caring work.

Regarding the "emotional involvement" needed for caring, the term "emotional labor" is used by many feminists to emphasise that emotional

involvement requires time, planning, and effort (Angus, 1994; James, 1989). There is also a common assumption that women simply are more emotional than men, implying that the emotional contribution is something that women give naturally and without effort. This attitude is criticised as another way of obscuring the work that women do as part of their caring (Bowlby, Gregory, & McKie, 1997; Fishman, 1978; Luxton, 1997; Shaw, 1995). Oakley (1981), Smith (1987), and Waerness (1987) point out that the everyday physical and emotional labour that women expend in the reproduction of healthy family members is particularly undervalued and not recognised as work.

According to Davies (2001), caring has become established as a necessary quality for women during the last two centuries. Caring skills have become identified with respectability and responsibility, not least through the history of nursing. In this way, caring and the construction of femininity have walked hand in hand, and "a caring self" has been constructed as the normative feminine ideal (Davies, 2001; cf. Wuest, 1998, 2001).

Being a caring-self requires both mental and physical engagement, which, in turn, forms the caring person. This formation is discussed in terms of "mothering and praxis" by Holm (1992, 1993). According to Holm, women are expected to "mother" just because they are women, so many women try to live up to this expectation. The mothering activity influences both their behaviour toward other adults and their character; that is, it helps to form their identity (cf. Wuest, 2001). Holm (1993) also notes that women judge themselves, and are judged, by their performance in carrying out caring responsibilities.

Theories on the relationship between women's caring and health are few (Wuest, 2001). In her research, Wuest (1997, 1998, 2000, 2001) considered the different kinds of caring that women may perform during their lifetime, such as caring for children, elderly relatives, or an ailing husband. Based on this research, Wuest (2001) has termed the process of managing caring demands as "precarious ordering." Strategies acquired and refined during this process are conceptualised as "setting boundaries" (on caring demands), "negotiating" (with helping systems), and "repatterning care." These strategies are needed to manage competing and changing caring demands. Precarious ordering is seen as a continuing and iterative process. Thus, Wuest's theory emphasises that caring women develop and employ strategies to manage diverse caring demands. This often is done throughout their lives. The effectiveness of these strategies has a strong impact on their health.

According to Wuest (1998, 2001), the strategy of "setting boundaries" is executed by "attending to one's own voice" and "determining legitimacy." Awareness of physical, cognitive, financial, and emotional strengths and limitations are important aspects of attending to one's own voice, as are trusting one's own judgement and instinct. Three aspects help to determine legitimacy: the degree of dependency of the demanding person, potential harm to self or others if caring is refused, and the valued expectations of others. From Wuest's study, previous abuse was seen as a legitimate

reason to refuse a caring demand, but nevertheless potential harm might give legitimacy to the same demand. Judgements regarding legitimacy might reduce the caring load, but also create conflicts, dilemmas, and increased demands. Wuest concludes, however, that most women are able to develop strategies for limiting caring demands, despite existing societal and family pressures.

Wuest's work on "setting boundaries" is most relevant to the subject of this article, difficulties in limiting caring work. But all three of Wuest's strategies—setting boundaries, negotiating, and repatterning care—are interwoven with one another. In this article we show how prolonged and extensive caring, combined with limited control over caring conditions, may subvert women and undermine their ability to employ such strategies.

MATERIALS AND METHODS

Participants

Two of us (AF, GC) carried out a sequence of in-depth, unstructured interviews with 10 women each (Kvale, 1996). We chose elderly women, 63 years or older, because we wanted to look at women's work and health in a life perspective, but also because we explicitly wanted to know more about elderly women's work and health. All the women had lived in Sweden for most of their lives, although two grew up in other European countries. (In these generations, immigrants to Sweden were few, coming mostly from Finland and Eastern Europe.) The women were selected stepwise to represent a variety of life and work experiences, based on a preliminary analysis of each interview (purposeful sampling). In addition to criteria such as occupation and civil status, differences between having and not having children, and in unpaid work, also were considered (see Table 1). Hence we did not choose participants on the basis of illness or diagnosis. Also they were not our own patients, but found through other health care workers, benevolent organisations, or distant acquaintances.

The women were informed about, and agreed to, research and publishing procedures. They were allowed to withdraw from the study if and whenever they wanted to (no one did). Ethical approval for the study was obtained from the Umeå Clinical Research Ethics Committee.

Interviews

Interviews lasting $1\frac{1}{2}$ to 3 hours were audiotaped in the women's homes and later transcribed into a slightly modified verbatim mode (Kvale, 1996). Since the aim was to explore an entire working life and attendant daily health, we met each woman 2–4 times. This gave them time to reflect on

TABLE 1. Information about the 20 interviewees

N	Age	Civil status	Children	Occupation	Husband's occupation ^a
1	79	W	4B	Farmer	Farmer
2	83	DMW	1B	Kitchen maid/home help	Attendant
3	63	S	0	Telegraph forwarding agent	
4	78	W	2B	Shop assistant	Shop manager
5	70	M	2B	Cleaner/preschool teacher	Industrial worker
6	79	D	3B/3F	Hairdresser/industrial worker	Military officer
7	83	W	5B	Industrial cleaner	Unskilled labourer
8	68	M	0	Nurse	Official
9	68	M	2B	Nurse/nursing teacher	Official
10	66	M/A	4B/6F	Nurse/midwife	Clergyman
11	70	M	3B	Housewife	Engineer
12	80	W	2B	Dental nurse/housewife	Headmaster
13	79	W	0	Industrial worker	Industrial worker
14	66	D	4B	Medical doctor/psychiatrist	Medical doctor
15	83	W	3B	Chief secretary	Clerk
16	83	S/A	3F	Lower secondary school teacher/ painter	
17	72	M	2B	Upper secondary school teacher	Upper secondary school teacher
18	72	W	10B	Housewife	Sawmill worker
19	80	M	3B	Nurse's assistant/farmer/cleaner	Farmer/taxi driver
20	68	S	0	Engineer	

M = married

W = widow

D = divorced

S = single

A = "apartners," that is, living in a relationship without sharing a household.

B = biological child

F = foster child

^aHusband's occupation was important for the family status and economy as well as the amount of unpaid work that the women had to do.

their memories. Although they were elderly, their memories were clear and detailed (cf. Thompson, 1978). The way they thought about their experiences may have changed over the years, however, in accordance with changes in the surrounding society. Also, their memories may have been modified, simply to make life more bearable (Haug, 1992).

The interviews provided the best information when we allowed them to become conversations, where the women had a great influence on the content. We assumed that women interviewers would encourage a degree of openness. We were concerned however, with avoiding the assumption of further common ground, an assumption not necessarily justified, or with the women adjusting to us as doctors (Haug, 1992). We therefore encouraged the women to express themselves as clearly as possible in their own language. As a whole, our interview design was chosen considering our power position (as researchers and doctors) vis-à-vis the women.

The two of us who performed the interviews listened to each other's interviews while reading the corresponding transcriptions. This cross-checking was important, because the women declined to check the transcriptions themselves. Coding was checked through comparative coding of each other's interviews, and, partly, through discussion with the third author.

During the interviews, we constructed so-called life-lines in cooperation with the women (Nilsen, 1994). A life-line is a graphic time illustration of important events during life, such as births and deaths in the family, marriage and separation, moving, starting new jobs, periods of illness, and so on. Making life-lines helped the women to retrieve memories from the past and to locate different events in time. For us, the life-lines opened up new areas for questioning and helped us structure the life histories.

After selecting the 20 women, and meeting them several times, we judged the analysis as having reached satisfactory saturation. Another important reason for stopping at this point was the risk of an unwieldy amount of material (Kvale, 1996).

Analysis

We conducted a cross-sectional analysis, followed by or overlapping a life-course analysis.

The *cross-sectional analysis* was conducted according to Tesch's (1990) method of decontextualizing and recontextualizing, together with Giorgi's (1985) phenomenological method (Malterud, 1993). Main steps included the following:

- (i) We identified themes relevant to the research aims through readings of the entire material.
- (ii) We chose quotations from the interviews as meaning units and placed them under one or several themes (coding).
- (iii) We organised the meaning units in subcodes and abstracted them.
- (iv) We described the content of each subcode and gave it a summarising heading. For some codes, we created new concepts that expressed the findings as headings (see findings below).
- (v) We referenced the findings (descriptions and headings/concepts) back to the initial citations, as well as to the individual life histories.

In the *life-course analysis* (Bjerén & Elgqvist-Saltzman, 1994; Plummer, 2001; Thompson, 1978) we carefully summarised the women's narratives and wrote them down as life histories (different from the verbatim interview transcriptions). Typical headings follow: growth, education, marriage, giving birth to children, caring work, employment, social life outside family, health questions. We adjusted headings and chronological order to the individual life histories.

FINDINGS

"Compulsive sensitivity" is one of our findings regarding the relationship between caring and health. We begin by summarising some results necessary to properly understand this finding.

Responsibility for Care

Regardless of position in the labour market, all married interviewees ended up assuming the main responsibility for housework and family care. This was in accordance with the prevailing norms. Responsibility for family care meant feeding, rearing, and caring for children. But it also implied responsibility for physical and emotional contact in the family as a whole—keeping the family together, mediating, and creating a sense of sharing and belonging—as well as maintaining good relations with people surrounding the family. These responsibilities made it necessary for the women to learn to identify and satisfy needs, particularly the needs of those not able to care for themselves.

Despite the distribution of housework and caring work being similar for all the women in the study, their feelings about this distribution differed greatly. Those who viewed care of children and husband as their most important task, and who received due recognition from their men, were fairly content with their situation. Those who wanted, but failed to achieve, a more equal distribution of the work found themselves in a constant state of disappointment and conflict. The relationship between the spouses exerted a great influence on the women's working life and well-being.

Most paid employment for women was within the caring sector, and 9 of the interviewees had worked for many years in such jobs. Some of those working in other fields told about caring responsibilities that they were expected to take on, such as arranging a nice social environment at the workplace, or listening when someone was having a hard time. Seven of the women performed caring work for sick relatives, while holding down their paid jobs, during long periods of their lives.

By the time we met the women, half of them had been, or still were, caring for sick and ailing husbands. They assumed this task "as a matter of course" and because they "wanted to," while acknowledging some pressure to shoulder this responsibility in order to remain "good wives."

Responsibility Giving Meaning, but Also Causing Suffering

We found that the women we interviewed had assumed responsibility for the well-being of others for a mixture of reasons: partly because they were expected to do so, partly because they wanted this responsibility, but also because exposed people—children and the sick—depended on them. At the same time, the healthy men and other relatives around them made themselves more and more dependent on the women, for example, for cooking, laundry,

and social relations. Thus some women's load of responsibility grew with time, as did their feelings of obligation to take on the load.

Through caring for others, the women became needed, which brought a deep meaning to their lives, strengthened them, and gave them acknowledgement. Close relationships with those they cared for made many of them speak of "feeling rich." But responsibility for others also meant effort, and, sometimes, suffering. Some women exerted themselves beyond their real capacity. They became extremely tired, and often ignored their own diseases and illnesses.

Compulsive Sensitivity to the Needs of Others

For 5 of the interviewees (numbers [N] 6, 10, 14, 18, 19), it was particularly true that they pushed themselves too far. They described a strong sensitivity to other people's needs, not least to those of ill or otherwise exposed people. This resulted in an inner demand to take responsibility and to put the needs of these people before their own. We call this "compulsive sensitivity." When the women felt that this readiness to perceive and help was exploited by other people, and when it tied them to people who once, or still, dominated them, their situation became particularly stressful.

Being compulsively sensitive was not only mentally, but also physically, strenuous as it entailed heavy work. It also led to difficulty in resting and relaxing. Weariness in body and soul, as well as worry, burnout, physical ailments and injuries, were judged by the women to be consequences of their excessive caring.

Here are some quotations from the cross-sectional analysis that led to our inference of "compulsive sensitivity" when they were linked to individual life histories:

I couldn't let be taking care of her. I felt used and impatient but I knew that she was ill so what else could I do? Elna (see life-history below)

I could see what they were going through. They needed to talk, but there was so little time. I had to see them after work was finished. Greta (see life-history below)

As a girl you're raised to show consideration for everybody else... I have always felt obliged to attend to the needs of others. Linnea (psychiatrist, four children, one of them handicapped)

I can't stand to see children being badly treated. My sensitivity to their situation has become worse over the years. I can say and do nothing, but I see the problems, and then I can't sleep. Signe (housewife, 10 children)

But this is what has always been my worst enemy—that I enter into other people's feelings. Valborg (see life history below)

The above women had lived very different lives in terms of class, education, and economic circumstances. What they had in common was many years of caring work, paid or unpaid. Summary life histories of 3 of the 5 women will provide a background to our interpretation and illustrate how cross-sectional and life-history analyses were brought together. The chosen life histories illustrate similarities and differences in the women's life courses.

Elna

The woman we call Elna (N6), had four brothers and a younger sister. From her childhood she remembered being under an obligation to tend to her brothers and sister: "A girl is supposed to take care of the others. That's tough." Elna married and bore three children. Her husband divorced her while the children were still small. She became very short of money, so she decided to move back to her parent's home to cut down expenses and receive help with the children. To earn money, she took a full-time job in a spinning mill.

Moving back to her parent's house facilitated her daily life but made her responsible for running a bigger household than before. Further, she added one of her brother's children to the family as she saw that he was badly looked after. When her parents became old and sick she nursed them at home, and also sometimes joined them for long periods in hospital. She did all this without receiving any significant support from her brothers who lived in the same village.

Subsequently, Elna took on the care of her younger sister's children, as well as that of the sister herself who was mentally ill. It is in this connection that she was quoted: "I couldn't let be taking care of her. I felt used and impatient but I knew she was ill so what else could I do?" She continued: "When she and her children lived with me and I worked at the spinning mill I was really exhausted. I don't want to have that time back again." She talked about having been "constantly worried" during these years, particularly about her sister's children, because, as she said, "I never knew how they were getting along while I was at work."

When Elna was asked why she had assumed all these caring duties, she explained: "I was the only one, because there were so many brothers." Looking back, she admitted that she "perhaps was used by quite a few people." But she emphasized that caring for others had brought meaning to her life: "It's good to have somebody to take care of! You feel useful and that makes you strong." She was happy that children in the family still turned to her when they needed to talk. But she continued to have difficulty limiting the demands made on her. For example, she once fainted after forgetting to eat during a day of intensive listening to neighbours in trouble. Elna was severely handicapped by rheumatoid arthritis and suffered from angina pectoris.

Greta

Greta (N10) described early adjustment to looking after other people. As the only girl in the family she had learned this during her upbringing. After leaving home she qualified as a midwife, but abandoned this career a few years later to marry a clergyman. The new situation turned out to be a further step in her serving career. As the vicar's wife, she was expected to offer generous hospitality and to be available for everyone in the parish with their different problems and needs.

Greta had four children of her own, but was also expected to take care of parish children who were badly treated, "since you're not working, they said." She tried to limit the demands made on her without success: "When they came with the last child I said, 'I can't manage anymore!' He stayed for one year. That was my hardest time."

A further frustration in Greta's life was that her husband refused her the money needed to run the household, even though he had enough. Hence Greta was forced to return to work as a midwife sooner than planned. Back at work she met women who needed help, not only with medical questions but also with abuse from their partners: "I could see what they were going through. They needed to talk, but there was so little time. I had to see them after work was finished." She thought her responsiveness to patients was sharpened by her own situation at home, and confessed: "I must say that I was mentally abused by my husband. He wanted to dominate." Finally, in her sixties, Greta had enough of this situation and moved to a flat of her own, without divorcing. Sheltered from her husband's controlling behaviour, her general condition became much better. As her husband was now pensioned, she was also relieved from duties at the vicarage.

But new missions called for Greta: She founded a nonprofit organisation to help abused women in the region. This sometimes meant hiding women in her own home. She also hid refugees to protect them from expulsion from Sweden. She continued with these engagements long after she became a pensioner herself.

Greta often felt she was expected to do more than she could manage, but had difficulty saying no. "They knew they could always ask me," she said. She remembered having been "extremely tired" during much of her life: "Of course I can say that I have lived a rich life, but sometimes it seems to me that it was too much." She drew strength from close relations with her children and foster children, however, as well as from appreciation by patients and others.

Greta suffered from heart problems since the age of 50, and had had several cardiac infarctions.

Valborg

Valborg (N19) was given caring responsibilities before she grew up, in particular looking after her younger siblings. As a young woman she had

several different employments, for example, as a dairymaid, as a nurse's assistant in a hospital and in an old-people's home. She then took a job as a cleaner and continued with this for the rest of her employed life. Throughout her life she had made herself aware of people in exposed positions, and took responsibility: "This is what has always been my worst enemy—that I enter into other people's feelings. . . . You're guilty of all misfortune yourself!"

Valborg married and bore two children, who she was mainly left to look after by herself. The marriage became even more difficult when her husband became an alcoholic. His drinking made her feel very insecure, not knowing what was going to happen from day to day, particularly with money needed by the family. "Not being able to trust him was about the worst thing related to his alcoholism," she said.

When we began the interviews, Valborg was 80 years old. Her husband was sick and she was looking after him at home. This required constant vigilance, and she needed to perform tasks around the clock. She had to get up several times a night to help him and to change urine bags. Every morning she had to do the laundry, since both sheets and bedclothes became wet. She was exhausted and in despair: "I'm worn out, my legs, and my whole body are finished," she said. While carrying out her tasks, she had several accidents, causing a fractured knee and several bruises. Further, she suffered from chronic pain in her neck, shoulders, and back. She also had angina pectoris.

Valborg rarely left her apartment. She knew she would worry too much if she left her husband alone, if only for a few hours. When she was referred to a physiotherapist she refused, because she was "too tired to go."

Valborg's husband refused to move to a home for elderly sick people. And Valborg refused to move him without his consent. She explained, "I can't watch them come and take him by force. In that case, I prefer my own suffering." On the other hand, she was well aware that her husband knew this. "He uses me, you see," she said. This made her believe that she would have experienced the situation differently if her husband had shown respect for her and given her some recognition: "It would be no burden if only he was grateful and not always angry."

While opposing a removal against her husband's will, Valborg nevertheless expressed a strong wish that someone outside the family should arrange it. She knew she would not manage much longer. About a year after our first interview, Valborg's husband was moved, thanks to a district nurse. Valborg admitted great relief, but also guilt because he had not left home voluntarily. She felt it was as if she had "closed the door on him." As a result, she was unable to let go of feeling responsible for him. She visited him every day, which made her very tired. She said,

The children are angry with me. They want me to have a good time now, relax and enjoy life, and not go visiting him all the time. But I can't lose the habit of entering into his feelings and how he is getting along.

DISCUSSION

Compulsive Sensitivity—and Expectations Laid on Women

The women quoted above held themselves responsible for a great part of their excessive caretaking, and regarded their compulsive sensitivity as a personal trait. In this way their exhaustion became their own fault. People around them seem to have taken the same view, while still counting on their help.

But the women also described a social pressure on them, since they were children, to take on all kinds of caring work. Caring was a normative ideal for women. They were expected to do the caring jobs; otherwise, they were not “good women” (Davies, 2001; Hirdman, 1998; Wuest, 2001; Yee & Schulz, 2002). As part of the society, the women embraced this norm themselves (cf. Wuest, 1997). Consequently, they would have been blamed by others, and blamed themselves, if they had not assumed “their” responsibilities. In this way, it became important to their self-respect to meet these expectations (cf. Angus, 1994; Collins & Jones 1997; Holm, 1993). Close day-to-day contact with those for whom they cared accentuated the feeling of compulsion.

The Collins and Jones (1997) report, that women are seen as more suited to giving care than men and find the task easier (even when the contrary is the case), illustrates the close link that is made between caring skills and a “feminine nature” (cf. Benoit & Heitlinger, 1998; Bowlby et al., 1997; Davies, 2001; Forssén, 1995; Shaw, 1995). When a society prevailed by gender division of labour ascribes to women an essential femininity, with inherent skills for caring, this contributes to hiding the work that caring involves. Consequently, it may become difficult, even for the women themselves, to realise how much effort, and knowledge, is part of caring.

During their many years of caring, our women inevitably, and irrespective of their natural disposition, were trained to observe and respond to the needs of others. Using Holm’s (1993) theory of mothering and praxis, we consider this as making a strong impact on the women’s subsequent behaviour, as well as on their character: They were formed by their experience of caring.

In our opinion, these circumstances, combined with the positive feelings that caring also brings (cf. Angus, 1994; Wuest, 1997), strongly influenced the women’s perception of how much they could be asked to do—and made it very difficult for them to do less.

Life Conditions, Caring, and Health

The 5 women listed were not the only ones in our study who felt sensitive to the needs of others. Other participants described similar feelings. But they were able to limit both the demands placed on them and their efforts, in a way that these quoted women were not. Although strong caring norms were conveyed to all women in these generations, and, thus, to all interviewees, the listed women were particularly affected by these norms. This was due to the

extra caring duties laid on them in childhood, probably as a result of having had many brothers. Thus, they became involved in caring work early, and continued with this almost for the rest of their lives. We will point out some further conditions that, in our opinion, contributed to their inability to ward off caring demands.

The 20 interviewees had experienced very different life situations, as children, young adults, and mature adults. This divergence of experience included economy. Four of the 5 women (the exception being Linnea) whom we have termed compulsively sensitive were quite poor or had little control over their means. Economy is judged to be an important factor regarding health outcome in family caregivers (Lee & Porteous, 2002; Navaie-Waliser et al., 2002). Robinson (1990) found that better-off women were better equipped than poorer women to cope with, and ward off, the responsibilities of caring for their spouses. This suggests that poorer women, or women with little financial control, run a bigger risk that their caring responsibilities will lead to ill health. Wuest (1998) came to a similar conclusion.

A general finding in our study was that the marital relationship had a strong impact on the women's self-assessed general health (cf. Kiecolt-Glaser & Newton, 2001). Four of the five women (the exception being Signe) experiencing what we have called compulsive sensitivity described relationships where their husbands showed controlling or abusive behaviour (for definitions and comparisons see Lundgren, Heimer, Westerstrand, & Kalliokoski, 2001; Moss, 2002). One of those (Elna) divorced early. The remaining 3 described making constant adjustments to their men. They also described a lack of consideration: They were expected to care for their husbands but received very little concern in return. We consider that the tension implied by continuous adjustment, and the feelings of loneliness and lack of respect, all contributed to their inability to care for themselves and place limits on caring demands. Their sensitivity to the needs of others also may have been augmented; Greta, who felt mentally abused by her husband, took this experience to her job. There, it heightened her awareness of what patients could be going through and led to her taking on extra work (cf. Wuest, 1997).

Our findings regarding the importance of the marital relationship for women's health is supported by other research. There is increasing evidence that marital problems contribute to women's emotional distress and poor health, for example, coronary disease, pain, and depression, more than they affect men (Balogh et al., 2003; Kiecolt-Glaser & Newton, 2001; Orth-Gomér et al., 2000). The marital relationship is also shown to impact on the rehabilitation process and prognosis for women suffering from musculoskeletal pain (Hamberg, Johansson, Lindgren, & Westman, 1997) and coronary heart disease (Orth-Gomér et al., 2000) among others. There is also increasing evidence concerning the extensive damage to women's health caused by men's physical and mental abuse (Plichta, 2004).

When caring for a spouse, the perceived level of burden is found to be related to the earlier or ongoing marriage relationship, but more so in women than in men. According to Husband (1987, in Morris et al., 1991) such a correlation is found only in female spouse carers. Robinson (1990) found past marital adjustment to be the best predictor of subjective burden among wife caregivers. Those with an unhappy marriage history experienced their caregiving as more oppressive than the others.

Our findings therefore support earlier research. Financial security and marital quality both influence the ability of caring women to acknowledge their own needs and limit their labours (cf. Helgeson, 1994; Kiecolt-Glaser & Newton, 2001). We understand the marriage as a crucial working environment for women in relation to caring in the family.

Why Does She Never Stop Sacrificing Herself?

When we first met her, Valborg desperately needed outside help to free herself from an impossible burden of care. This is similar to the need for intervention expressed by abused women of whom it is often asked, "Why doesn't she leave her partner?" For women who give more caring than they can manage, the question might be, "Why does she never stop sacrificing herself?"

Lundgren's (1995) theory, "the process of normalisation of violence," helps us to understand why abused women have difficulty leaving their abusers. Over a long period, the women become mentally and physically subverted by living day and night in an abnormal reality, that is, a reality characterised by violence but also including love and warmth from the abuser. Their perspective becomes displaced and they start to blame themselves for being abused. They need the help of others to break away.

We suggest that a similar shift in perspective can affect a person worn down by many years of excessive caring. Adjustment to the needs of the recipient increasingly shut out the person's own needs. Together with fatigue and isolation, which in themselves cause feelings of powerlessness, this adjustment gradually distorts their sense of normality. Any move toward changing the situation causes feelings of guilt.

In her article on setting boundaries Wuest (1998) states that if caring leads to personal growth, then this personal growth helps the person to set limits. As we understand the experiences described in Findings section above, the process of caring does not necessarily lead to personal growth. The result may be quite the opposite; the caring person's self is diminished. In consequence, possibilities of setting boundaries to the demands and employing strategies such as "negotiating with helping systems" or "repatterning care" diminish.

For Whom and in What Context Can These Results Be Used?

The transferability of our results must be judged by potential users. However, we will give some of our own thoughts on this point.

This article is based on interviews with 20 elderly women living in Sweden. In addition to gaining a deeper knowledge of elderly women's life situation, choosing elderly participants made it possible to understand the women's current self-rated health in relation to their entire life experiences. As many elderly women in Sweden as well as other (Western) societies are still taking on prolonged caring responsibilities (Lee & Porteous, 2002; Navaie-Waliser et al., 2002; Sawatzky & Fowler-Kerry, 2003), we believe that our finding regarding compulsive sensitivity also will apply to some of those.

Regarding transferability to younger women, elderly informants might be considered an obstacle, as societies change continuously. We suggest that our findings apply also to younger women, however, at least in Western societies. This belief is based on the fact that three-quarters of all family caregivers in the Western world are women (Lee & Porteous, 2002, Sawatzky & Fowler-Kerry, 2003). Looking into the future, Lee and colleagues (2003) predict that "more than half of American women will care for a sick or disabled family member at some point during their adult lives" (p. 113). Health care reforms will increase the demands on women to undertake caring responsibilities (Wuest, 2000). Even in "equal" countries such as Sweden, women contribute much more to household chores and child care than men, and women usually carry the main *responsibility* for family care, even when not performing all the tasks (Statistics Sweden, 2003). Moreover, household economics force more women to take on full-time jobs in addition to family management than in the past. Most employees in the caring sector are women (Evans & Steptoe, 2002; Moss, 2002). Thus, the life courses of many younger women may turn out to be similar to the life courses of our interviewees. The experience of these older women can teach us about the accumulated health damage caused by life-long caring demands in difficult living conditions.

Situated Knowledges

Our research is performed within a feminist frame of reference (Harding, 1986) and based on the theory of situated knowledges (Haraway, 1991). Both the researchers' and interviewees' actions and understandings of their lives and work are situated—that is, they form part of and are related to the surrounding society. Consequently, our feminist perspective, and our experiences as Swedish women and doctors, are involved in the research process and outcome. Haraway argues that there are no neutral research viewpoints, but, rather, the researcher's position, experience, and conception of the world make part of, and inform, the knowledge that is created.

Conclusions and Implications

This research is based on the experiences of a selected sample of elderly women having difficulty limiting their caring load, in spite of exhaustion and illness. The concept of compulsive sensitivity is presented as a way of

understanding their difficulties. If correct, it will apply to other women in similar situations.

Compulsive sensitivity denotes the feeling of being “caught in caring,” of being compelled to notice other people’s needs and respond to them wherever possible, even at the expense of one’s own. It entails mental as well as physically strenuous work, exacerbated by difficulty in relaxing and resting. We suggest that it may be connected to ill health such as fatigue, worry, and burnout, as well as coronary disease, muscular pain, and injuries.

Compulsive sensitivity is understood to be the result of extensive and long-lasting caring demands, in unpaid or combined caring work, with little control over the workload and other aspects of the caring conditions. We consider compulsive sensitivity to be a consequence of the gendered division of labour prevailing in most societies, and the societal creation of “femininity,” that is, social norms regarding how “a good woman” should be and how she should act. Further, we see it as linked to class and gender differences in financial resources and control, as well as to men’s greater access to power, even in married life.

For the health care sector, compulsive sensitivity should help caregivers to identify and understand women who are worn out by extensive caring. Instead of placing the guilt on the patients themselves when they are unable to “stop sacrificing themselves,” they can understand that the patient’s attitude stems from a destructive process in prolonged caring work. Relieving them from the burden of blame and self-blame, and making them aware of the work they have performed, will help them in the healing process and create a basis for empowerment. Further, of course, they should be offered help with their daily workload.

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