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**Transitions to Caregiving, Marital Disagreement,
and Psychological Well-Being**

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Transition to caregiving, marital disagreement, and psychological well-being:

A prospective U.S. national study

Key Words: caregiving, parent care, spouse care, marriage, marital quality, marital disagreement, well-being, depression, happiness, mastery

Abstract

Guided by a life course perspective, this study investigated whether the psychological consequences of transitioning into a caregiver role for a biological parent, parent-in-law, spouse, other kin, or nonkin among married adults might be moderated by marital role quality. Using longitudinal data from a national sample of 1842 married adults aged 35 years and older, this study estimated regression models examining whether differences in marital disagreement predicted differences in change in global happiness, depressive symptoms, and personal mastery due to a transition into caregiving. Results indicated that the transition to caregiving compromised mental health outcomes for women biological parent caregivers and men spouse caregivers who reported a higher level of marital disagreement. These findings suggest that the psychological effects of becoming a caregiver for a biological parent or spouse are contingent on marital role quality.

Transition to caregiving, marital disagreement, and psychological well-being

With a longer life expectancy and aging of the population, a potentially widening gap between growing needs for care and limited familial and social resources to meet these needs has become a major social issue (Biegel, Sales, & Schulz, 1991; Dwyer & Coward, 1992).

Considerable research has highlighted the negative psychological consequences of caregiving for individuals, such as an increased risk of depression, anxiety, and caregiver burden (see Pinquart & Sörensen, 2003; Schulz, Visintainer, & Williamson, 1990, for reviews). Nevertheless, great variability has also been demonstrated among caregivers in their ability to adapt to the demands of caregiving (e.g., Townsend, Noelker, Deimling, & Bass, 1989). Research has indicated that some of this heterogeneity may stem from the quality of caregivers' other role engagements in marriage, employment, and parenthood (Moen, Robison, & Dempster-McClain, 1995; Penning, 1998; Reid & Hardy, 1999; Spitze, Logan, Joseph, & Lee, 1994; Stephens & Townsend, 1997; Stoller & Pugliesi, 1989; Voydanoff & Donnelly, 1999).

Guided by a life course perspective, this study examined the moderating effect of marital quality on the psychological well-being of married individuals who made the transition to become a caregiver. Marital quality may be one of the key role contexts to examine in relation to caregiving: Approximately two thirds of caregivers are currently married (N. Marks, 1996; Stone, Cafferata, & Sangl, 1987); the marital relationship has a robust impact on physical and mental health status throughout adulthood (see Burman & Margolin, 1992; Ross, Mirowsky, & Goldsteen, 1990; Waite & Gallagher, 2000, for reviews); and most importantly the stress and rewards from marriage carry over to other life domains (e.g., Barnett, 1994). In addition to caregiver role context, existing literature also suggests that the nature of care and its psychological consequences might differ depending on the type of role relationship between

caregiver and care recipient and the gender of the caregiver (Hoyert & Seltzer, 1992; N. Marks, Lambert, & Choi, 2002). Therefore, the goal of this study was to explore whether the mental health outcomes of transitioning into five role relationship types of caregiving (i.e., caregiver for a biological parent, parent-in-law, spouse, other kin, and nonkin) might be moderated by one important dimension of marital quality—marital disagreement—for married men and women caregivers.

Theoretical Framework

The life course perspective conceptualizes the individual life course as consisting of multiple, interdependent role trajectories in domains such as education, marriage, parenthood, and work (Elder, 1998; George, 1993). According to this theoretical perspective, social norms and expectations largely determine the timing, duration, and sequences of transition into and exit from these roles (Elder; George). Within the constraints of social norms and expectations, individuals exercise a certain amount of control over their lives by coordinating their roles to minimize excessive role demands and maximize resources (Elder; George).

Caregiving poses a unique challenge to individuals in their efforts to coordinate their role involvements. Caregiving is an unexpected career (Pearlin & Aneshensel, 1994). Individuals typically do not have control over the timing of the transition into caregiving or over its duration. The nature of the caregiving and the resources/vulnerabilities of the caregivers largely determine the extent to which this inherent unpredictability may exert potentially negative impacts on psychological well-being (Pearlin & Aneshensel). The life course perspective suggests that the resources and vulnerabilities are embedded in an individual's overall role repertoire to a significant degree.

Two theoretical traditions that underscore the importance of role occupancy (Goode, 1960; S. Marks, 1977; Sieber, 1974) and role quality (Baruch & Barnett, 1986) have provided a basis for examining the effect of multiple role involvements on psychological well-being, as the life course perspective postulates. The role strain hypothesis (Goode, 1960) would predict that other role occupancy, such as being married, may compete with caregiving for caregivers' limited time and energy, thereby causing psychological distress by overburdening the caregivers. A contrasting perspective—the role enhancement hypothesis (S. Marks, 1977; Sieber, 1974)—would posit that being married would counterbalance the demands of caregiving by expanding caregivers' psychosocial resources, e.g., enhancing self-esteem or augmenting social support. Empirical studies overall appear to support the role enhancement hypothesis in the case of combining the marital and caregiving roles: Married caregivers report either better mental health than unmarried caregivers (Reidy & Hardy, 1999) or no difference has been found between the two groups (Penning, 1998; Stoller & Pugliesi, 1989).

However, in contrast to focusing on role occupancy per se, some researchers emphasize subjective experiences in each role and bidirectional influences between roles (e.g., Baruch & Barnett, 1986; Barnett, 1994). The premise here is that some individuals may occupy the same set of roles as others, but their mental health status can be very different contingent upon the quality of experiences in each role. Literature on the work-family interface has highlighted stress contagion, such as marital stress spilling over to other life domains such as employment (e.g., Barnett). Caregiving literature, on the other hand, has emphasized positive role experiences—mostly perceived social support from role partners such as spouse—for caregiver well-being (Horowitz, 1985). The marital relationship is considered one of the most important sources of

social support (Ross et al., 1990; Waite & Gallagher, 2000) and poor quality marriage tends to be associated with a lower level of supportive emotional exchanges (Cutrona, 1996).

This study examined marital disagreement as a moderator of caregiving impact on well-being. Marital stress such as negative interactions with spouse might spill over to caregiving experiences and compromise the level of social support married caregivers perceive from their partner. Therefore, this study hypothesized that a higher level of marital disagreement might exacerbate the potential for caregiving to have negative impact on the psychological well-being of caregivers.

Literature Review

Understanding the psychological consequences of transitioning into caregiving involves taking into account two fundamental elements in the caregiving process: the nature of the transition and the context in which the process occurs. The present study specifically focuses on marital quality as a key role context. In terms of sharpening the meaning of the transition, existing literature has provided ample evidence that the nature of care differs as a function of who is the care recipient in the kinship system and the gender of the caregiver.

Caregiver-care recipient relationship and psychological well-being

Extending and receiving care are fundamental exchanges of resources that are expected to occur within kinship, preferably between closest kin (Rossi & Rossi, 1990). Individuals feel the strongest obligation to help their closest kin—parent, spouse, and child—especially in times of need (Rossi & Rossi). In addition to entitling kin to rights to receive support and care from its kin network members, kinship norms also prescribe what type of, and how much help and assistance is to be allocated within the kinship system (Rossi & Rossi).

A majority of previous research has focused on the differential nature and effect of spouse care and parent care. Spouses provide the most intensive and extensive care, maintaining the caregiver role longer, and tolerating a greater level of disability in the care recipient than other types of caregivers, including caregivers for older parents (see Biegel et al., 1991; Horowitz, 1985, for reviews). Consequently, spousal caregivers typically report worse mental health outcomes than adult child caregivers (Hoyert & Seltzer, 1992).

A handful of studies have examined care for primary kin as well as for more distant kin or nonkin (Gerstel & Gallagher, 1993; N. Marks, 1998; N. Marks et al., 2002). Primary kin provide the majority of informal caregiving (Stone et al., 1987; N. Marks, 1996) and typically assume more demanding caregiving responsibilities than distant kin or nonkin caregivers (Himes & Reidy, 2000). With regard to the consequences of providing such care, Gerstel and Gallagher reported that less normative other-kin care leads to more stress than normative filial care; N. Marks (1998), however, found that caregivers for more distant kin tend to show better psychological well-being than individuals providing care for their parent, spouse, or child. A few studies that have examined nonkin caregivers suggest that nonkin caregivers may benefit from giving such care (e.g., N. Marks et al.).

Parents-in-law occupy a unique place in the kinship system: Parents-in-law appear to evoke the same level of obligation of care as grandparents, siblings, or grandchildren (Rossi & Rossi, 1990) without the life-long emotional bond that often characterizes other kin relationships. Parent-in-law care also is likely to serve two purposes at the same time—meeting the care needs of the parent-in-law and also the filial needs of the marital partner. With regard to caregiving activities for parents-in-law, children-in-law appear to provide less intensive caregiving than biological children (Merrill, 1993), but results are not conclusive (Ingersoll-Dayton, Starrels, &

Dowler, 1996). Findings are also inconsistent regarding the mental health consequences of parent-in-law caregiving (Ingersoll-Dayton et al.; N. Marks et al.).

Gender of caregiver and psychological well-being

In addition to delineating the scope and level of care that an individual is entitled to in the kinship system, kinship norms typically socialize women to take on a specialized position—kinkeepers (Rosenthal, 1985). Nearly two thirds of care is provided by women (N. Marks, 1996; Stone et al., 1987), and women typically perform more intensive, hands-on, day-to-day care than men (see Horowitz, 1985; Yee & Schulz, 2000, for reviews). Consequently, female caregivers typically report higher levels of psychological distress than their male counterparts, whose caregiving activities more often are limited to intermittent, complementary tasks such as housework/repairs or financial management (Yee & Schulz). Additionally, gender differences sometimes vary across role relationship types (N. Marks et al., 2002). Therefore, we examine men and women separately in this study.

Caregiving, marriage and psychological well-being

When marriage is considered in the context of caregiving, earlier research has been mainly concerned about examining whether caregiving might result in a decline in marital quality. Overall, research findings suggest that this is not the case (Suitor & Pillemer, 1994). Two research studies have examined the interactive effects of caregiving and marriage on psychological well-being for adult men and women who provided care for their parents (Stephens & Townsend, 1997; Voydanoff & Donnelly, 1999).

Stephens and Townsend (1997) recruited a convenience, cross-sectional sample of 296 women caregivers for a parent or parent-in-law to test whether the amount of stress and rewards that they experience in marital relationships would moderate the impact of caregiving stress on

caregivers' mental health. The findings showed no moderating effects of either marital stress or marital rewards on depressive symptoms and life satisfaction. Voydanoff and Donnelly (1999) tested the same interaction model for depressive symptoms between caregiving and marital quality. Unlike the Stephens and Townsend study, this study employed cross-sectional data from a U.S. national probability sample of 2,414 men and women. Findings showed that the number of hours spent on providing care for parent(s) was associated with more depressive symptoms for adult daughter caregivers who reported a higher level of marital disagreement. Likewise, hours spent on providing filial care was associated with less depressive symptoms for adult daughter caregivers who indicated a higher level of marital happiness. No interaction between parent care and marital quality was found for son caregivers.

Like the Voydanoff and Donnelly (1999) study, this study uses the National Survey of Families and Households (NSFH). However, this study extends the Voydanoff and Donnelly study by employing a prospective, longitudinal design; by examining a range of caregiving role relationship types; and by including an examination of three distinct dimensions of psychological well-being.

In sum, guided by a life course perspective and previous research on caregiving, this study used longitudinal U.S. national data to examine the hypothesis that a higher level of marital disagreement will exacerbate the potential for a transition to caregiving to have a negative impact on the mental health of married men and women across diverse role relationship types of caregiving.

Method

Sample

The data used for this study came from the first and second waves of the National Survey of Families and Households (NSFH). At Time 1 (1987-1988), a nationally representative sample of 13,007 noninstitutionalized American adults aged 19 and older were recruited, including a main sample of 9,643 respondents and additional over-samples of African-Americans, Mexican-Americans, Puerto Ricans, single parents, step-parents, cohabitators, and recently married persons. At Time 2 (1992-1993), 10,005 of the original respondents were reinterviewed. The response rate at Time 1 was 75% and 82% at Time 2, yielding an overall response rate of about 61.5% ($.75 \times .82$) for data from both waves. Weights allow this sample to represent the U.S. population on age, sex, and race. (See <ftp://elaine.ssc.wisc.edu/pub/nsfh/c1intro.002> and <ftp://elaine.ssc.wisc.edu/pub/nsfh/README>, for a brief overview of the NSFH.)

The analytic sample for this study included: (1) respondents who were aged 35 and older at Time 1 (T1) and who participated in both waves of the study; (2) respondents who indicated that they were not caregivers at T1; (3) respondents who were not care recipients at Time 2 (T2); (4) respondents who were married to the same spouse between T1 and T2. These sample selection criteria yielded a total of 1,842 continuously married respondents (918 women and 924 men) for analyses.

Measures

Caregiving. For respondents who did not provide any type of caregiving at T1, the following inquiries were made at T2. “Sometimes because of a physical or mental condition, illness, or disability, people require the assistance of friends or relatives. During the last 12 months, have you, yourself, given anyone *not living with you* at the time any help or assistance because of their health problem or disability?” (i.e., out-of-household care) and “During the last 12 months, have you, yourself, given anyone who was *living with you* at the time any help with

personal care because of their long-term physical or mental condition, illness, or disability?" (i.e., in-household care). If respondents answered yes to either of these questions at T2, they were further asked, "Who did you give the most personal care of this kind?" Separately for in-household and out-of-household care, mutually exclusive categories of caregiver-care recipient role relationship types were created with the responses. A closer examination of the distribution of in-household and out-of-household caregiving occurrences across caregiver-care recipient role relationship types revealed that, among this sample of married men and women, the vast majority of caregiving was provided out of household except for spouse care, where all caregivers shared residence with their care recipients. To maintain homogeneity of the nature of caregiving within each type of caregiving, 9 cases of nonspousal in-household care (i.e., 2 biological parent care, 5 parent-in-law care, 1 other kin care, 1 nonkin care) were excluded from analyses. Individuals who did not provide care for anyone at either wave were included as a noncaregiver comparison group. Individuals who indicated that they started providing both in- and out-of-household care for different role relationship types also were excluded from the analyses to maintain the clear distinction by caregiver-care recipient role relationship.

The final categories for the type of relationship between caregiver and care recipient were biological parent care, parent-in-law care, spouse care, other kin care (i.e., grandparents, siblings, and other relatives), and nonkin care (i.e., friends and neighbors). Child care was one of the caregiving categories originally created, but was excluded from the analyses due to insufficient sample size. Table 1 provides the percentage distribution and frequency of NSFH respondents who transitioned into caregiving between T1 and T2 and who met the sample selection criteria of this study.

[Table 1 about here]

Psychological well-being. The outcome variables for the present study included three distinct dimensions of psychological well-being (Bryant & Veroff, 1982): global happiness (a measure of positive affect), depressive symptoms (a measure of negative affect), and personal mastery (a measure of self-evaluation). At T1 and T2, *global happiness* was assessed with a standard, single-item indicator, “Taking things all together, how would you say things are these days?” (1=very unhappy to 7=very happy). (See Table 2 for descriptive statistics for all analytic variables.)

[Table 2 about here]

At both waves, *depressive symptoms* were measured with a modified 12-item version of the Center for Epidemiological Depression (CES-D) index (Radloff, 1977). Sample survey questions include, “On how many days during the past week did you feel bothered by things that usually don't bother you?” (0=never to 7=everyday during the week; alpha = .93 at T1, alpha=.92 at T2; mean across items used).

Respondents were also asked at T1 to report how much they agree or disagree with the following single statement assessing personal mastery: “I have always felt pretty sure my life would work out the way I wanted it to.” At T2, four items from the Pearlin Mastery Scale (Pearlin, Lieberman, Menaghan, & Mullan., 1981) were included to measure *personal mastery* along with a repeat of the single personal mastery item assessed at T1. The Pearlin scale items were, “I can do just about anything I really set my mind to,” “Sometimes I feel that I'm being pushed around in life,” “There is really no way I can solve some of the problems I have,” “I have little control over things that happen to me” (1= strongly agree to 5=strongly disagree; 5-item scale alpha = .68; mean across items used). Negatively worded items were recoded so that higher scores represented a greater sense of personal mastery.

Marital disagreement. At both T1 and T2, respondents were asked to rate frequency of their marital disagreement with six questions: “How often, if at all, in the past year have you had open disagreements about each of the following: a) household tasks, b) money, c) spending time together, d) sex, e) in-laws, f) the children?” (1=never, 2=less than once a month, 3=several times a month, 4=about once a week, 5=several times a week, 6=almost everyday; T1 alpha = .73; T2 alpha=.60; mean across items used). Marital disagreement at T1, prior to the transition into caregiving, was used as the moderating variable of interest. To control for potential change in marital disagreement between T1 and T2 possibly due to caregiving, a measure of marital disagreement change between T1 and T2 was created by computing the difference in marital disagreement scores (T2 –T1) and added to all models.

Control variables. Key sociodemographic variables associated with caregiving and psychological well-being were controlled in all analyses (Horowitz, 1985). These included age at T1 (in years), education at T1 (in years), income at T2 (total household income in dollars), missing on household income at T2 (dichotomously coded 1=missing on income, 0=income reported), race/ethnicity (1=nonwhite, 0=white), employment status at T2 (1=employed, 0=unemployed), and parental status at T2 (1=has at least one child under age 19 at home, 0=no child under age 19 at home).

Analytic Sequence

Separately for men and women, three Ordinary Least Squares regression models were estimated to examine whether marital disagreement moderated the impact of transitioning into various types of caregiving on the psychological well-being of caregivers. To predict global happiness, depressive symptoms, and personal mastery, the regression models included variables for types of caregiving, marital disagreement at T1, change in marital disagreement between T1

and T2, and Marital Disagreement at T1 \times Caregiving Type interactions, in addition to demographic controls. The same set of analyses was conducted using weighted data as well as unweighted data. Because weighted analyses revealed a similar pattern of estimates, this study reports results based on the unweighted analyses (Winship & Radbill, 1994).

Time 2 global happiness and depressive symptoms were regressed on global happiness and depressive symptoms at T1 respectively, allowing for estimation of change in the mental health outcomes following the acquisition of a caregiver role. For personal mastery, no exact correspondence of measurements existed between T1 and T2. Yet, because one item administered at T1 was included in the T2 personal mastery scale, rough estimates of change between the two waves were obtained by controlling for personal mastery at T1. Correlation between the single item repeated at T2 and the entire T2 scale was .57.

When significant interactions between caregiving and marital disagreement emerged in regression analyses, the simple slope test (Aiken & West, 1991) was conducted subsequently to probe the nature of the interactions. A significant interaction indicates that different regression slopes (i.e., the simple slopes) of psychological well-being on caregiving existed at different levels of marital disagreement. The simple slope test examines specifically at which levels of marital disagreement the association between caregiving and psychological well-being is statistically significant. The present study conducted the simple slope test at three levels of marital disagreement—high marital disagreement (one standard deviation above the mean marital disagreement score), mean level marital disagreement, and low marital disagreement (one standard deviation below the mean).

Results

Table 3 presents the results of regression analyses of the effects of caregiving and marital disagreement on the psychological well-being of caregivers. Overall, the exacerbating effect of higher levels of marital disagreement on mental health outcomes was most in evidence among adult caregivers who provided care for their biological parent or spouse. For adult daughter caregivers, significant moderating effects emerged for global happiness and depressive symptoms. The graph in Figure 1 describes the pattern of the interaction for global happiness. The three slopes in the graph represent the association between transitioning into biological parent care and global happiness at three levels—low, mean, and high—of marital disagreement. Consistent with the research hypothesis, simple slope tests revealed that the transition to biological parent care was associated with a significant decline in global happiness only when daughter caregivers experienced a higher level of marital disagreement. Conversely, the transition was not associated with a significant change in global happiness for adult daughter caregivers who indicated that their frequency of marital disagreement was at the mean or lower on marital disagreement. Figure 2 illustrates a similar pattern of association between transitioning into caregiving and depressive symptoms. Here, both higher and mean levels of marital disagreement were related to a larger increase in depressive symptoms for new adult daughter caregivers compared to women noncaregivers. No difference in depressive symptoms was observed between daughter caregivers with a lower level of marital disagreement and their noncaregiver counterparts.

[Table 3 about here]

A significant moderating effect of marital disagreement also was found among men spouse caregivers for global happiness. As further illustrated by Figure 3, men spouse caregivers reported a significant decline in global happiness compared to men noncaregivers when they had

a mean level or higher ratings of marital disagreement. In contrast, no significant difference in global happiness was reported between men spouse caregivers with a lower level of marital disagreement and their noncaregiver counterparts.

Two significant interaction effects were found among men who provided care for other kin (e.g., sibling, grandparent) (Table 3). However, a further exploration of the nature of these interactions using simple slope tests showed that significant differences occurred neither at the mean nor at one standard deviation above or below the mean marital disagreement scores. Accordingly, no further attention was given to these findings. Lastly, no significant interactions were found for parent-in-law care and nonkin care.

Discussion

Guided by a life course perspective, this study investigated whether the unexpected life transition of becoming a caregiver might have varying mental health consequences for married men and women as a function of marital quality. The life course perspective posits that the psychological well-being of an individual is significantly influenced by the totality of his or her life experiences in key role involvements and how these role involvements interact with each other (Bengtson & Allen, 1993; Elder, 1998; George, 1993). Building on recent work on caregiving (Moen, Robison, & Dempster-McClain, 1995; Penning, 1998; Reid & Hardy, 1999; Spitze, Logan, Joseph, & Lee, 1994; Stephens & Townsend, 1997; Stoller & Pugliesi, 1989; Voydanoff & Donnelly, 1999), this study focused on explaining interindividual differences in mental health status among caregivers by examining one of their key typically concurrent role engagements—the marital relationship. This study hypothesized that a higher level of marital disagreement might exacerbate the potential for caregiving to have deleterious mental health

outcomes for men and women caregivers across all caregiver-care recipient role relationship types.

Partly consistent with the hypothesis, a higher level of marital disagreement was found to be harmful to the psychological well-being of primary kin caregivers (i.e., caregivers for biological parent and spouse) but not for secondary kin (i.e., parent-in-law, other kin) or nonkin (i.e., friends or neighbors) caregivers. Results also indicated that a different role relationship type of caregiving was influenced by marital disagreement for women in contrast to men. A mean level or higher marital disagreement led to a greater decrease in global happiness and a larger increase in depressive symptoms for women who provided care for their biological parents. On the other hand, the mean or higher ratings of marital disagreement were associated with a greater increase in depressive symptoms for men caregivers who provided care for their wives.

The findings on biological parent care are congruent with the Voydanoff and Donnelly cross-sectional study (1999), which found that a higher level of marital disagreement was associated with a higher level of depression for adult daughter caregivers. This study extended the Voydanoff and Donnelly study, using a prospective longitudinal design to assess mental health change over time due to caregiving. Also, this study examined a broader range of caregiving relationship types and mental health outcomes. Specifically, our results provide evidence that marital disagreement also moderates the impact of transitioning into biological parent care on positive affect (global happiness) among women. Also, few previous studies appear to have investigated the conditional effect of marital quality on the mental health of men spouse caregivers.

Caregiving role relationship types and gender were two major differentiating factors in our results. First, the moderating influences of marital disagreement were present only among

caregivers for primary kin (i.e., parent and spouse). No significant interaction effects emerged among caregivers for parent-in-law, other kin, or nonkin. Focusing only on continuously married respondents between T1 and T2 resulted in too few respondents who provided in-household, “personal” care for their relatives and non-relatives to be analyzed except for spouse caregivers (see N. Marks, 1996, for the distribution of in- and out-of-household care for the entire NSFH sample aged 35 and older who transitioned to caregiving between T1 and T2). This is consistent with existing research findings, documenting that secondary kin care may typically be more limited to sporadic help or voluntary assistance that does not require a substantial investment of time and effort (Himes & Reidy, 2000). As caregiving might not be provided at a level where social support is essential, marital disagreement, or lack thereof, might not be a key factor in determining the mental health consequences of caregiving.

Second, a higher level of marital disagreement had most deleterious effects only for women biological parent caregivers and for men spouse caregivers. Despite the same residential arrangement (i.e., out-of-household care) as secondary kin caregivers, biological parent care might still have involved substantially more demanding caregiving activities than non-primary kin care (e.g., Rossi & Rossi, 1990), particularly for women in this study compared to men. The centrality of a caregiver role for women (e.g., Rosenthal, 1985) might also have led them to be more susceptible to potentially negative consequences of biological parent care (Thoits, 1992). Besides being indicative of a lack of emotional support by husband, a higher level of marital disagreement prior to transitioning to biological parent care might have acted as a vulnerability factor, predisposing women to feel that caregiving compromised her role performance as a wife. Women might experience the largest decline in psychological well-being when they feel they have difficulty balancing the two most important roles—i.e., daughter (caregiver) and wife.

Men new caregivers, on the other hand, reported a greater increase in depressive symptoms when they had a higher level of marital disagreement prior to the transition. Providing “personal care” for their wife is a major departure from their typical pattern of social support exchanges with their spouse. When intensive care needs to be provided in a marital relationship already burdened with frequent marital disagreements, men’s psychological well-being might be compromised to the greatest extent. A higher level of marital disagreement for men might also indicate that they lack the most important source of social support—social support from their wife. Women, on the other hand, might see caregiving activities for their husbands as a natural extension of their role as wives, at least initially. Women typically also have a broader network of kin support (Moore, 1990) that could be counted on in times of need compared to men.

No differences in change in mental health outcomes were observed among women biological parent caregivers and men spouse caregivers compared to their respective noncaregiver counterparts, when they reported lower ratings of marital disagreement prior to the transition to caregiving. This finding warrants further consideration because biological parent care and spouse care are the two most demanding of all caregiving types. High quality marriages might protect new primary kin caregivers to the point of not only reducing but actually negating the potentially detrimental effects of primary kin care on their psychological well-being.

Despite its strengths as a longitudinal study based on a representative sample of the U.S. population, this investigation has several limitations. First, the level of impairment of the care recipient and intensity of caregiving activities could not be taken into account. The NSFH does not include information for all caregivers on these issues. Second, although this study attempted to explore the transition phase of caregiving across various types of caregiving, the exact time past since the transition could not be identified except for the fact that all new caregivers since

NSFH T1 gave some care within the last year. Third, quality of other concurrent roles, e.g., employment role, was not evaluated in conjunction with marital role quality.

Nevertheless, this study suggests that the mental health of caregivers for a biological parent or spouse needs to be understood in the context of marital quality and gender of the caregiver. Additional research on how other contextual factors might moderate the effects of caregiving will be critical to more fully understanding caregiving and its effects on psychological well-being.

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Table 1

Unweighted percentage distribution (unweighted N) of caregiving status among married persons from Time 1 to Time 2

	Women	Men
	% (N)	% (N)
No caregiving at T1 or T2 ^a	69.5 (638)	77.1 (712)
New biological parent care at T2	9.5 (87)	7.0 (65)
New parent-in-law care at T2	5.0 (46)	4.3 (40)
New spouse care ^b at T2	3.9 (36)	3.7 (34)
New other kin care at T2	5.6 (51)	3.6 (33)
New nonkin care at T2	6.5 (60)	4.3 (40)
Total	100.0 (918)	100.0 (924)

Notes. Data source is the National Survey of Families and Households, 1987-1993, respondents aged 35 and older who were not caregivers at Time 1, who were not care recipients at Time 2, and who were continuously married between Time 1 and Time 2 (N=1842; Women=918; Men=924).

^aT1=Time 1, T2=Time 2.

^bAll spouse caregivers shared residence with their care recipients. All the other types of caregiving are provided out of household.

Table 2

Descriptive Statistics for Analysis Variables

Variable	Women Mean (s.d.)	Men Mean (s.d.)	Range
<u>Mental health (T2)</u>			
Global happiness	5.59 (1.27)	5.61 (1.29)	1-7
Depressive symptoms (CES-D)	.98 (1.19)	.68 (.90)	0-7
Personal mastery ^a	3.56 (.66)	3.75 (.67)	1-5
<u>Mental health (T1)</u>			
Global happiness	5.69 (1.33)	5.70 (1.26)	1-7
Depressive symptoms (CES-D)	.96 (1.20)	.73 (1.09)	0-7
Personal mastery ^b	3.69 (.92)	3.75 (.90)	1-5
<u>Marital disagreement (T1)</u>	1.65 (.65)	1.69 (.67)	1-6
<u>Difference in marital disagreement (T2 –T1)</u>	.08 (.67)	.07 (.68)	-3 – 3.83
<u>Sociodemographic characteristics</u>			
Age (in years) (T1)	48.10 (10.81)	49.42 (11.90)	35-89
Ethnicity (nonwhite=1, white=0)	.15 (.36)	.18 (.38)	0-1
Education (in years) (T1)	12.80 (3.01)	13.29 (3.54)	0-20
Household income (T2)	49321.44	53004.39	0-135000

	(32671.87)	(33978.19)	
Missing income (T2)	.01 (.09)	.00 (.06)	0-1
Employment status (T2) ^c	.56 (.50)	.69 (.46)	0-1
(1=employed 0=unemployed)			
Parenthood status (T2) ^d	.34 (.47)	.40 (.49)	0-1

Notes. Data source is the National Survey of Families and Households 1987-1993 (N=1842; Women=918; Men=924). Means for dichotomous variables are proportions. Descriptive statistics are based on unweighted data. T1=Time 1. T2=Time 2.

^aFive-item measure was used at T2.

^bOne-item measure was used at T1.

^cEmployment status was defined as having either part-time or full-time job at T2.

^dParental status was defined as having at least one child aged 19 or under in the household at T2.

Table 3

Unstandardized Regression Coefficients for the Transition to Caregiving and the Moderating Effects of Marital Disagreement on Global Happiness, Depressive Symptoms, and Personal Mastery

	Global happiness		Depressive symptoms		Personal mastery	
	Women	Men	Women	Men	Women	Men
Depressive symptoms (T1)			0.34***	0.22***		
Global happiness (T1)	0.19***	0.22***				
Personal mastery (T1)					0.14***	0.16***
Age (T1)	-0.00	-0.00	-0.00	-0.00	-0.01*	-0.00
Race/ethnicity	0.00	0.13	0.18	0.10	0.15**	-0.11*
Education (T1)	-0.01	-0.01	-0.01	-0.02*	0.03***	0.03***
Household income (T2)	-0.00	0.00	-0.00	-0.00	0.00	0.00**
Missing on household income (T2)	0.04	-1.87**	-0.06	1.20**	-0.12	0.01
Employment (T2)	-0.14	0.15	0.04	-0.24**	-0.01	0.01
Presence of minor child (T2)	0.21	-0.27**	-0.13	-0.00	0.04	0.07

Marital disagreement (MD) (T1)	-0.54***	-0.52***	0.37***	0.31***	-0.20***	-0.21***
Difference in marital disagreement (T2-T1)	-0.54***	-0.41***	0.38***	0.31***	-0.22***	-0.24***
Biological parent care (T2)	0.68	0.28	-0.47	-0.27	0.14	0.19
Parent-in-law care (T2)	-0.13	-0.28	-0.43	-0.60	0.22	-0.24
Spouse care (T2)	-0.61	0.63	-0.57	-0.25	0.58	-0.01
Other kin care (T2)	-0.49	0.19	0.44	-0.74*	-0.04	0.60*
Nonkin care (T2)	0.28	0.67	0.17	0.15	0.43	-0.13
MD*Biological parent care	-0.51*	-0.20	0.44**	0.27	-0.13	-0.15
MD*Parent-in-law care	-0.07	0.22	0.24	0.32	-0.05	0.12
MD*Spouse care	0.06	-0.92**	0.74	0.31	-0.45	-0.07
MD*Other kin care	0.27	0.02	-0.09	0.44*	0.01	-0.30*
MD*Nonkin care	-0.22	-0.31	-0.08	-0.02	-0.19	0.09

Constant	5.73***	5.50***	0.16	0.40	3.20***	3.25***
R ²	0.15	0.21	0.27	0.22	0.14	0.17

Notes. Data source is the National Survey of Families and Households 1987-1993 (N=1842; Women=918; Men=924). T1=Time 1.

T2=Time 2. Significant coefficients of zero have real values smaller than .005. The F statistic for all models was significant at p<.001.

* p≤ .05, ** p≤ .01, *** p≤ .001 (one-tailed test).

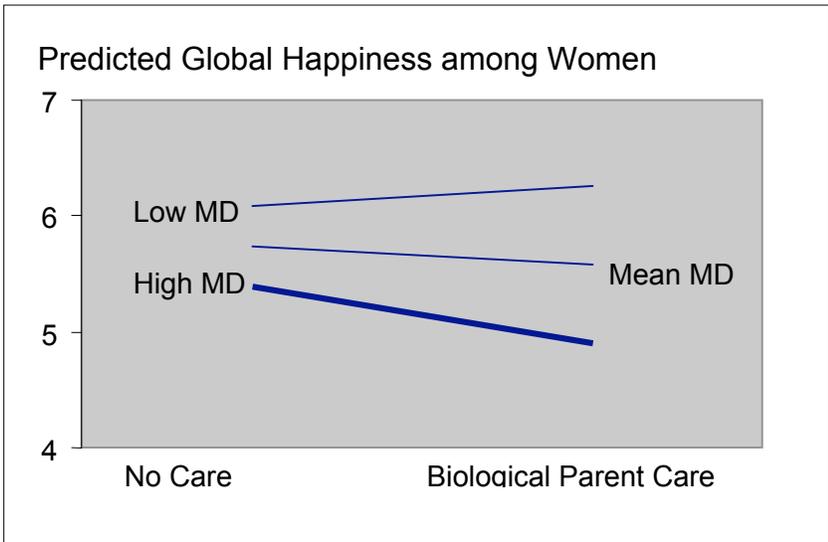


Figure 1

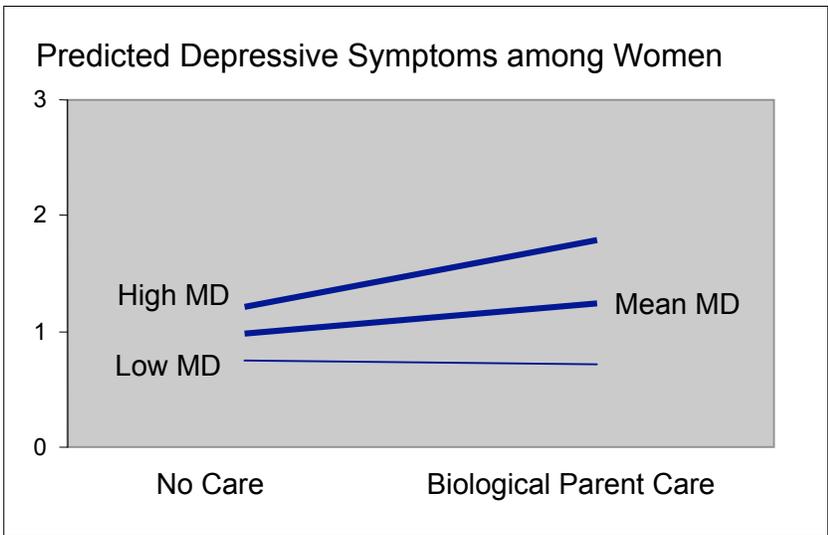


Figure 2

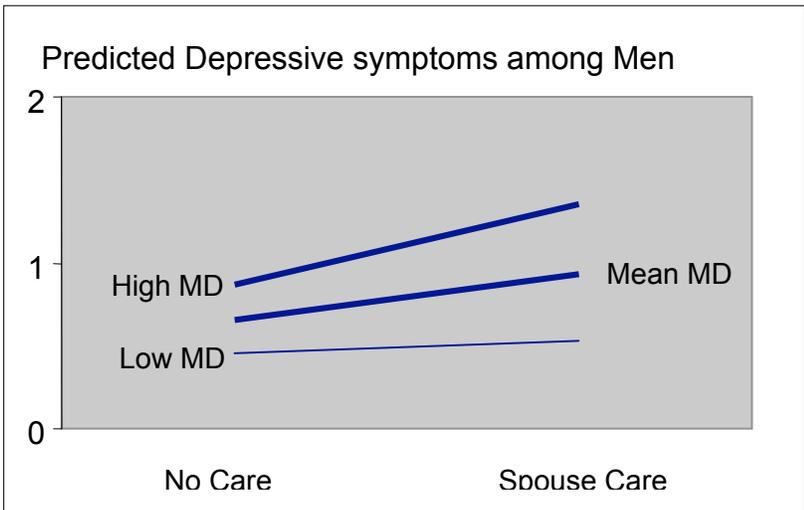


Figure 3

Figure 1. Effects of transitioning into biological parent care on women caregivers' global happiness by women caregivers' level of marital disagreement (MD). High MD is defined as one standard deviation above the mean for marital disagreement scores, low MD as one standard deviation below the mean. Bolded line represents a significant ($p < .05$) difference between caregivers and non caregivers at this level of marital disagreement. The global happiness scale ranges from 1 (very unhappy) to 7 (very happy).

Figure 2. Effects of transitioning into biological parent care on female caregivers' depressive symptoms by female caregivers' level of marital disagreement (MD). High MD is defined as one standard deviation above the mean for marital disagreement scores, low MD as one standard deviation below the mean. Bolded line represents a significant ($p < .05$) difference between caregivers and non caregivers at this level of marital disagreement. The depressive symptoms scale ranges from 0 (never) to 7 (every day during the week).

Figure 3. Effects of transitioning into spouse care on male caregivers' depressive symptoms by male caregivers' level of marital disagreement (MD). High MD is defined as one standard deviation above the mean for marital disagreement scores, low MD as one standard deviation below the mean. Bolded line represents a significant ($p < .05$) difference between caregivers and non caregivers at this level of marital disagreement. The depressive symptoms scale ranges from 0 (never) to 7 (every day during the week).

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