

Center for Demography and Ecology

University of Wisconsin-Madison

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Nadine F. Marks

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Nadine F. Marks

Department of Sociology

University of Wisconsin-Madison

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Midlife Caregiving: Do Effects Differ by Gender?

Abstract

Most studies of caregivers are limited to nonrepresentative samples, samples only of women, or samples of caregivers nominated by care recipients. This makes it difficult to place caregiving in a population context, to analyze differences between caregivers and noncaregivers, and to explore possible gender by caregiving interaction effects. This study used nationally representative data from the National Survey of Families and Household 1987-88 to: 1) describe the prevalence of caregiving among midlife men and women (ages 35-64, N=5,643); 2) examine differences between caregivers and noncaregivers in health, psychological well-being, social participation, and marital quality; and 3) examine evidence for differences between men and women in the effects of caregiving on these outcomes. Almost one in five midlife adults were found to have recently been involved in caregiving either in or out of their residence. The ratio of female to male caregivers in this study was about four to three -- indicating a much higher prevalence of male involvement than most nonrepresentative sample studies indicate. Few health and well-being effects of caregiving were found to differ by gender; there were no differences between men and women in caregiving effects on depression. The biggest differences between caregiving men and women were evident in marital quality -- more disagreement, less sex, less activity, and a higher predicted likelihood of having their marriage end reported by women.

Midlife Caregiving: Do Effects Differ by Gender?

The health and well-being of adults in middle adulthood is important not only for midlife adults themselves, but for all those depending upon them -- young and old, employers and community. Midlife adults are often carrying the load of leadership and responsibility in multiple domains. When they are thriving, others around them are likely to thrive as well. Likewise, when they suffer, others in their social networks are likely to suffer, too.

The well-being of "women in the middle" -- that is, women carrying multiple responsibilities for caregiving, often along with employment, during midlife -- has justly received increased attention during the last decade or so (Brody, 1981, 1985, 1990). Less is known, however, about "men in the middle," and how they differ from women, if they do, in the effects of caregiving on them. It is often presumed that there just aren't enough male caregivers to worry about. However, this presumption is not based on strong evidence from population samples (Horowitz, 1985, 1992; Schulz, Visintainer, and Williamson, 1990). Even in national sample studies, such as those done with the National Survey of Informal Caregivers (e.g., Stone, Cafferata, and Sangl, 1987; Coward, Horne, and Dwyer, 1992), many caregiving men are omitted because the focus is only on caregiving only to the most impaired elderly rather than all persons needing help with personal care. In many other cases the focus is only on primary caregivers; men are often secondary caregivers (Stone et al., 1987) and are thereby not included.

It is important that our study of the caregiving experience expands to more seriously include men and to include caregiving other than the most extreme examples of elder and spouse care that have dominated research attention. Due to demographic changes, including lengthened lives, fewer children, and increased rates of singleness at older ages, it is increasingly likely that for at least some period of

time, perhaps several episodes of time, adults of both sexes will be confronted with a family member and/or friend who will need some extra help with care either living on their own or in residence (Coward et al., 1992; Uhlenberg, Cooney, and Boyd, 1990; Watkins, Mencken, and Bongaarts, 1987). It is vital that this caregiving be well-documented and made a clearer part of public consciousness as social security provisions, health care provisions, employee benefit provisions, and life course plans are made by individuals and social institutions.

To contribute to this effort in understanding, this research cast a wider net than is typical in studying the midlife experience of caregiving. It used recent nationally representative data to look at men and women who give care either in their households or out of their households to children, spouses, parents, and/or other family members or friends. Caregiving was not limited to help with specific tasks. Secondary and other caregivers were included as well as primary caregivers. Caregiving outcomes were not limited to psychological distress, but also included dimensions of positive psychological well-being, health, social participation, and marital quality.

In short, this project took a broader perspective on caregiving to address three main questions:

1) How prevalent is in-household and out-of-household caregiving to disabled or otherwise unusually dependent children, spouses, parents, and other relatives and friends among men as well as women during midlife (ages 35-64)?

2) What health, psychological well-being, social participation, and marital quality effects are associated with caregiving to different relations at these ages?

3) Is midlife caregiving associated with different effects for women and men?

Previous Research

The bulk of caregiver studies have been done on small, nonrepresentative samples. Often these

studies have only studied women caregivers or they have studied only one or two relational categories of caregivers, e.g., spouses and/or adult children. Perhaps the best-known national profile of caregivers comes from the 1982 National Long Term Care Survey (NLTCS). Robyn Stone and her colleagues (Stone et al., 1987) used data from the 1982 National Survey of Informal Caregivers (NSIC), a component of the 1982 NLTCS to produce an extremely useful description of caregivers of the frail elderly. Raymond Coward and his colleagues also used the 1982 National Long Term Care Survey to describe differences in the prevalence of caregiving by gender (Coward et al., 1992). These analyses took a large step forward in developing understanding about the size and characteristics of the caregiver population for the nation's functionally impaired aged. However, even these very valuable analyses have limitations as comprehensive national studies of caregivers. First, by design, the National Survey of Informal Caregivers included a sample of caregivers for persons age 65 and older only -- not caregivers of *all* care-needy persons. Second, it relied upon the nomination process of care recipients, a process that may entail some biases -- especially when it is tied (as it was in the National Survey of Informal Caregivers) to including the nominee in a new survey (Horowitz, 1985, 1992; Raveis, Siegel and Sudit, 1990). Horowitz (1992), for example, has conjectured (based on her own research experience), that elderly persons are more likely to nominate daughters rather than sons because they are afraid to take part in having their sons "bothered" by survey researchers and afraid of having sons perturbed with them for having given out their names and phone numbers. Third, caregiving is definitionally in the NSIC is limited to providing care with at least one activity of daily living (ADL) -- specifically, bathing, dressing, eating, toileting, or getting around inside or outside the house -- a relatively restrictive definition of caregiving. Fourth, the database itself does not include a comparison group of noncaregivers. And finally, few measures of well-being outcomes are included.

Caregiving in its various forms has usually been associated with increased distress and burden (see,

for example, Schulz et al., 1990, for a recent review). There is also some evidence that caregiving is associated with poorer personal health, but many studies of caregivers do not control for income and other demographics that may be the actual cause of the association (Schulz et al., 1990). Evidence that caregiving restricts social participation among caregivers has been noted (Cantor, 1983). In the research on caregiving to spouses, there is also evidence that wives suffer greater deterioration in relationships than men (see Stoller, 1992, for a recent review). There has been less research regarding the influence of caregiving for persons other than spouses on marital quality.

Gender differences in the effects of caregiving on more limited samples have provided mixed results. Overall, the research suggests that women caregivers suffer more distress than men (Barusch and Spaid, 1989; Cantor, 1983; Fitting, Rabins, Lucas, and Eastham, 1986; Gallagher et al., 1989; Horowitz, 1985; Young and Kahana, 1989; Zarit and Zarit, 1982; Zarit, Todd, and Zarit, 1986). However, in some studies, men appear to suffer at least as much distress as women (e.g., Gallagher et al., 1989). Inconsistent results may well be the result, in part, of problems of recruitment of men into caregiver studies (Horowitz, 1992). Focussing on burden and depression may also be misleading, or at best, incomplete, if, for example, men are less likely to acknowledge burden, lack of competence, or symptoms of distress (Horowitz, 1992).

It can be hypothesized that caregiving should have more negative effects for women than men because women are more vulnerable to the stresses of others in their networks, as they experience their identities to be more relationally contingent (Abel, 1990; Gilligan, 1982; Gilligan et al., 1988; Jordan et al., 1991; Kessler and McLeod, 1984). However, it can be argued in a contrary fashion that precisely because women are socialized to be caregivers and have more experience with caregiving (cf. Chodorow, 1978), when men assume this role it should be more problematic for them. This analysis examined evidence for both hypotheses.

Data and Measures

The Sample

The data used for this study are from the first wave of the National Survey of Families and Households, which interviewed a nationally representative sample of 13,017 noninstitutionalized American adults age 19 and older living in the continental U.S. in 1987 and 1988 (see Sweet, Bumpass, and Call, 1988 for design and interview details). The main cross-section sample includes 9,643 households, with an additional oversample of 3,374 blacks, Mexican-Americans, Puerto Ricans, single parents, stepparents, cohabitators, and recently married persons. The response rate was approximately 74 percent. Sampling weights correcting for selection probabilities and nonresponse allow this sample to match the composition of the U.S. population on age, sex and race.

Outcome Variables

To evaluate *health* I used a one-item global self-report measure. Respondents were all asked "Compared with other people your age, how would you describe your health?" (1=very poor to 5=excellent).

Three dimensions of psychological well-being determined to be factorially distinct (Bryant and Veroff, 1982) were evaluated as outcomes: positive affect (*happiness*), distress (*depression*), and self-adequacy (*self-esteem*). *Happiness* is evaluated with a standard one-item measure: "Taking things all together, how would you say things are these days?" Respondents answered this question in a self-administered booklet questionnaire that provided a 7-point scale anchored at one end by "very unhappy" and at the other end by "very happy."

For *depression* I used responses to a modified (12-item) version of the Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977). Respondents were asked, "On how many days during the last week did you: feel bothered by things that usually don't bother you, not feel like eating,

feel you could not shake off the blues, have trouble keeping your mind on what you were doing, feel depressed, feel that everything you did was an effort, feel fearful, sleep restlessly, talk less than usual, feel lonely, feel sad, feel you could not get going?" Each of the 12 symptoms was scored from 0 days of the symptom to 7 days of the symptom. The log of the summed scores plus one was used as the continuous outcome measure for depression to help correct the distribution for the typical skew toward zero. Cronbach's alpha coefficient evaluating internal consistency for this index is .93.

Self-esteem was assessed using an index created by summing the responses by degree of agreement to three Rosenberg (1965) self-esteem items: "On the whole I am satisfied with myself"; "I feel that I'm a person of worth, at least on an equal plane with others"; "I am able to do things as well as other people." Internal consistency of this three-item index is .66. (Cronbach's alpha).

Social participation was measured with three outcome variables. *Work hours* is a measure of the number of hours of employed work a respondent reported they usually do in a week. Unemployed persons were given a value of zero on this variable.

Socializing with kin was measured with a single indicator asking about how often the respondent spends a social evening with relatives (0=never, 1=several times a year, 2=about once a month, 3=about once a week, and 4=several times a week).

Socializing with friends was measured with a 17-item index which included questions about the frequency of spending a social evening with friends outside the neighborhood; frequency of going to a bar or tavern; frequency of participating in a group recreational activity like bowling or golf; and frequency of participation in 14 types of organizations: fraternal, service, veterans', political, labor, sports, youth, school-related, hobby or garden, school fraternity or sorority, nationality, farm, literary/art/study, professional, or academic. The indicators for informal socializing with friends rather than just formal organizational participation (as is typical in many sociological analyses of social

participation) were included to provide a less class-biased measure. For each of these indicators the responses ranged from 0=never to 4=several times a week and all 17 items were added to create the index. Cronbach's alpha for this index is .70.

Marital quality is evaluated with five measures. Frequency of *marital activity* is assessed by the question, "During the past month, about how often did you and your husband/wife spend time alone with each other, talking, or sharing an activity?" (1=never to 6=almost every day). *Marital sex* was measure by asking the question, "About how often did you and your husband/wife have sex during the past month?" The index of *marital disagreement* (Cronbach's alpha=.77) reflects answers to five queries regarding how often in the last year respondents had open disagreements about household tasks, money, spending time together, sex, and children (each item: 1=never to 6=almost every day). *Marital happiness* was assessed with the global question, "Taking things all together, how would you describe your marriage?" (rated on a seven-point scale anchored by very unhappy at the low end and very happy at the highest end). *Probability of a marital split* is based on responses to the question, "It is always difficult to predict what will happen in a marriage, but realistically, what do you think the chances are that you and your husband/wife will eventually separate or divorce?" Answers to this question ranged from very low to very high on a five-point scale.

Predictor Variables

In-household caregiving is assessed using answers to the question, "Do you (or does anyone living here) require care or assistance because of a disability or chronic illness?" If respondents answered "yes" they were asked for the names, ages, and relationship to them of up to four disabled persons in their households. Separate classifications were created for *child care*, *spouse care*, *parent care* (including in-laws and stepparents), and a residual category for *other care* for all other relatives (e.g.,

grandparents, siblings) and friends.

Out-of-household caregiving is evaluated by a more direct question: "Sometimes people help take care of relatives who are seriously ill or disabled, and who do not live with them. Have you provided such care at any time during the last 12 months?" Again, the age and relationship of up to four persons was reported.

Demographic characteristics measured and used as controls in the models include age, marital status (married vs. not married), race/ethnicity (non-Hispanic white vs. minority race/ethnicity), presence of a child or children under 19 (including biological, adopted, and stepchildren) in the household, years of education, and household income (earned and unearned income added across all household members). Descriptive statistics for all the variables used in the analysis are provided in the Appendix.

Results

Prevalence of Caregiving

Table 1 reveals that about 8% of respondents age 35-64 noted persons other than themselves who needed care in their households. Less than 2% of the total sample of midlifers indicated caring for more than one person in their home (not shown). It should be noted that some inference of caregiving must be made here because of the way the question about in-household caregiving was asked. It must be assumed that persons living with a person needing care are providing help with care in some fashion for that coresident person. In most cases this would seem a plausible assumption (e.g., spouse care), but in some cases it may well be, for example, that a husband respondent answering affirmatively that a disabled parent is in the home may not be as involved in taking care of a person in residence as his wife is. No distinction is available in this data between primary caregivers and other caregivers. However, as will be seen in looking at differentiations of caregiving by relationship category, the

majority of in-home caregiving at midlife ages is for spouses and children, and in these cases we might expect that men as well as women will have a significant involvement in care.

About 12% of all midlife respondents reported giving care out of their household during the last 12 months; about one in ten men, and about one in seven women. Again, only about 2% of the total sample of midlifers named more than one person whom they cared for out of their households (data not shown). Very few men and women (1.5%) reported giving care to at least one person in their household and at least one person out of their household.

When the prevalence of *in-household or out-of-household caregiving* is combined, just under one in five midlife adults is observed to give some type of care for a disabled or otherwise needy family member or friend. One in five women is a caregiver, even in this basically cross-sectional snapshot. For men, the rate is just under one in six.

It is interesting to further look at a breakdown of these figures by the categories of persons named by respondents as care recipients. Care for a child was the least prevalent type of caregiving; about 2.6% of midlife respondents overall reported this type of caregiving. The vast majority of such caregiving was done in the respondent's household.

Spouse care is next in prevalence -- about 3.4% of respondents overall. Again, almost all of this care takes place in the respondent's household.

Parent care is reported by about one in ten midlife respondents. The majority of this care takes place out of the home, but a small group of midlifers also report parents with disabilities living with them.

Actually the second largest category of caregiving (4% overall) is to other relatives and friends (mainly other relatives). Again, most of this care takes place out of the household. This caregiving is usually left unmeasured in most studies.

While in the majority of cases the proportion of women doing caregiving of each type is significantly larger than the proportion of men doing caregiving of that type, it is still apparent from this analysis that men are major participants in caregiving during midlife. While only about a third as many men as women were found to be caregivers in the National Survey of Informal Caregivers (Stone et al. 1987), about three-quarters as many men as women are found to be caregivers in this sample from the National Survey of Families and Households.

Health and Psychological Well-Being

Table 2 reports the results of OLS regression models that regressed health and the psychological well-being outcomes on gender, five types of caregiving -- child care (almost all in-household), spouse care (almost all in-household), parent care in household, parent care out of household, and care to other relatives or friends -- and caregiving by gender interactions for each type of caregiving, and includes controls for age, marital status, presence of child(ren) under 19 in the household, race/ethnicity, education, and income.

Net of other factors, women were more likely to report better health, more self-esteem, and more depression. Spouse care and parent care in the household were associated with lower evaluations of personal health. There was marginally significant evidence that women caring for a parent outside of the household tended to report their health to be a little better than men providing such care. However, when models were run separately for men and women (full models not shown), neither men nor women providing parent care out of the home were found to differ significantly from noncaregivers on self-reported health (for men $B = -.09$, $p > .05$; for women $B = .05$, $p > .05$). Running separate models also brought to light though that women providing care to a child reported less good health ($B = -.22$, $p \leq .01$) than women who didn't provide such care. The effect for men providing care for a child remained insignificant ($B = -.04$, $p > .05$). Women providing care to a parent in their home also didn't differ from

noncaregivers in health ($B = -.14, p > .05$), while men providing such care did ($B = -.35, p \leq .01$). Since significant gender interactions in the full model are not apparent, however, these indications of different effects for women and men (and similar others noted subsequently) should be interpreted cautiously.

Women who provided care to other relatives and friends were found to report marginally less self-esteem than men providing such care. Analyses run separately for women and men confirmed this finding; women providing other care reported significantly lower self-esteem ($B = -.37, p \leq .05$) than women noncaregivers. For men providing other care there was no difference ($B = .02, p > .05$) in self-esteem. Analyses run separately for women and men also revealed negative effects that reached significance for women caring for a spouse ($B = -.51, p \leq .01$) and women caring for parents out of their home ($B = -.25, p \leq .05$).

Happiness appeared to be reduced somewhat less for women caring for a child than for men caring for a child. Separate analyses run for women and men confirmed that this was true, although for both men and women, caring for a child still significantly reduced happiness in comparison to noncaregivers (for men $B = -.93, p \leq .01$; for women $B = -.43, p \leq .01$).

Interestingly, there were no significant gender interaction effects for depression. Separate sex analyses confirmed this finding. For both men and women, child care, spouse care, and parent care either in or out of the household is associated with increased symptoms of depression.

Social Participation

Table 3 reports the results of similar models run for social participation outcomes. While women overall tend to work fewer hours each week than men, in the case of spouse caregivers there is evidence that men reduce their hours of employment more than women do. This gender interaction was confirmed by analyses run separately for women and men that showed that men caring for a spouse

worked significantly fewer hours per week than noncaregiving men ($B = -9.57, p \leq .001$). For women caring for a spouse the amount of reduction did not reach significance ($B = -2.09, p > .05$).

Women overall reported less participation in social activities and organizations involving friends than men. This reduction is accentuated in the case of care givers of parents in the home. Analyses run separately for women and men confirmed that men who have a disabled parent living with them are actually more likely to be involved in outside social activities with friends than noncaregiving men ($B = 1.92, p \leq .01$). Women, however, with such a parent at home report similar levels of outside involvements with friends as noncaregiving women ($B = .35, p > .05$).

The marginally significant gender interaction for spouse care in the case of socializing with kin was not confirmed when separate analyses for women and men were evaluated. Neither men or women caring for a spouse were found to significantly differ in their visiting with relatives from noncaregivers (for men $B = .21, p > .05$; for women $B = -.09, p > .05$).

Marital Quality

Finally, Table 4 displays the results of running similar models, this time looking at marital quality differences among the married respondents in the sample (75% of the total sample). Providing spouse care was associated with more reduction in marital activity for women than for men. Separate analyses for women and men confirmed this; women providing spouse care were not significantly different from noncaregivers ($B = .11, p > .05$), but men providing such care reported significantly more marital activity than noncaregivers ($B = .51, p \leq .01$).

Intriguingly, giving care out of the household to a parent was associated with a reduction in marital sex for women, but an increase in marital sex for men. This gender interaction was confirmed in separate analyses by gender that revealed significant differences from noncaregivers in each case, but in opposite directions (for men $B = 1.11, p \leq .05$; for women $B = -1.18, p \leq .01$).

No significant gender interactions were found in the combined sex model in the case of marital

happiness. Separate analyses for women and men, however, again revealed some additional patterns. Women caring for a child were found to report significantly less happiness than noncaregivers ($B = -.41, p \leq .05$), while the effect for men remained nonsignificant ($B = .21, p < .05$). The same lowering of marital happiness for women was found in the case of spouse care (for men $B = -.07, p > .05$; for women $B = -.34, p \leq .05$) and care to a parent outside the home (for men $B = .01, p > .05$; for women $B = -.20, p \leq .05$). The reverse was found for parent care in the home (for men $B = -.49, p \leq .05$; for women $B = -.29, p > .05$) and also other care (for men $B = -.34, p \leq .05$; for women $B = -.21, p > .05$).

Men and women caregivers clearly differed in their levels of marital disagreement when they were caring for children or spouses. Analyses run for women and men separately confirmed that women reported significantly more marital disagreement than noncaregiving women when they were caring for either a child ($B = 1.50, p \leq .001$) or a spouse ($B = 1.41, p \leq .001$). Men caregivers of children did not differ from noncaregivers in marital disagreement ($B = .07, p > .05$), and men caregivers of a spouse actually reported *less* marital disagreement than noncaregivers ($B = -.88, p \leq .05$). Parent care in the household, although not out of the household, increased marital disagreement for both men and women (for men $B = 2.04, p \leq .001$; for women $B = 2.04, p \leq .001$).

Women giving care to a parent in the home also reported a higher expectation that their marriage might split in the future than men caregiving a parent at home. Separate analyses for women and men confirmed this gender difference, revealing that women doing such caregiving were significantly different than noncaregiving women ($B = .56, p \leq .001$), while men in-household caregivers of parents were no different than noncaregiver men in their predictions of long-term marital survival ($B = -.11, p > .05$).

Summary and Conclusions

Women are indeed more likely overall to be caregivers during midlife, but the differential in caregiving reduces significantly when the total population is examined and when caregiving is not definitionally limited to the most extreme care. Almost one in five midlife adults in this cross-sectional study reported providing care, and the ratio of female to male caregivers found here was closer to four to three in contrast to the more usual finding of about three to one. About one in ten midlife adults reported giving care to a parent.

Spouse care and parent care in the home was associated with poorer health. Spouse care and child care were associated with less happiness. Few gender differences in health and well-being effects of caregiving were found, however. The most frequently studied outcome of caregiving -- depression -- revealed no gender differences. Women overall reported more depressive symptoms, but both men and women caregivers were likely to report similar levels of additional distress if giving care to children, spouses, or parents. This finding goes counter to much of the previous literature on gender differences in caregiving distress and may implicate sample selection bias and inadequate demographic controls in previous analyses. It is also contrary to *either* of the hypotheses of difference.

While we should remain concerned about gender inequality in the workplace and at home that contributes to reducing rates and hours of employment for women who would prefer to work more, this study indicated that men, even more than women during midlife, were likely to have evidence curtailed employment hours in comparison to noncaregiving peers when a spouse needed care. This finding should help highlight the fact that employment benefits taking caregiving responsibilities into consideration are not just a women's issue, but an issue of importance to men as well.

Contrary to what some previous research might have led us to expect, socializing with friends and other family members did not appear to be significantly reduced for caregivers in this study. In fact, men with disabled parents in their homes actually reported *more* outside activities with friends than

noncaregiving men. This may be indirect evidence that men are more likely and perhaps more able to seek respite from caregiving in their homes than women. Perhaps some of the most interesting gender interactions occur in the case of the impact of caregiving on marital quality. On these outcomes women caregivers were found to be disadvantaged in comparison to men caregivers -- reporting less enjoyable marital activity in the case of spouse care, less sex in the case of out-of-home parent care, more marital disagreement in the case of child care and spouse care, and more concern about a marriage ending in the case of in-home parent care. This may provide some evidence that husbands are less supportive of wives giving care to children and parents than wives are of husbands giving care. It also aligns with some previous research indicating that in the case of spouse care, women perceive more deterioration in their relationship than men do (e.g., Fitting et al., 1986). Men may actually feel that caregiving for their wife is a way of reciprocating for previous caregiving (cf. Spitze and Logan, 1989). Or perhaps wives are easier to care for than husbands. In most cases evaluated here, caregiving is associated with similar effects for both women and men. But the effects of caregiving are found to vary more depending upon relationship to the caregiver, whether the caregiving takes place in the household or not, and the outcome studied.

The results of this study should argue for more studies of representative sample populations with appropriate demographic variables controlled and differentiations made by gender, relational category to caregiver, and location of caregiving (in-home vs. out-of-home) along with a multidimensional approach to outcomes. However, by no means is this study a complete specification of important factors that might be expected to be associated with effects of caregiving. This research did not, for example, go so far as to delineate different intensities of care recipient need. It did not control for different types of care activities that might or might not be related to differential outcomes. There is no doubt that smaller-scale and more in-depth studies continue to be needed, too, to complement the

large-scale approach. Current and long-term quality of relationships with the care recipient might be usefully explored, the duration of the caregiving relationship, formal support, informal support from others for the care recipient and caregiver -- all these important factors in caregiving deserve attention. Likewise, another possibly important gender difference may obscure the meaning of gender effect differences until it is more completely understood -- that is, differential selection of men and women into the role of caregiver. Hopefully large-scale and small-scale studies can continue to interactively inform one another in the important project of developing adequate information and understanding to guide public policy development and other social institutional support to aid the considerable population of women and men who care.

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Table 1. Weighted Percentages (Unweighted N): Midlife Caregiving Type by Gender

	MEN (2286)		WOMEN (3357)		TOTAL (5643)
CAREGIVING TYPE					
Caregiver in home	6.9		8.9		7.9*
Caregiver out of home	9.6		13.9		11.9*
Caregiver BOTH in and out of home	1.1		2.0		1.5*
Caregiver to more than one person	2.4		4.1		3.3*
Caregiver (total)	15.5 (320)		20.9 (671)		18.3* (991)
<hr/>					
Child Care in home	1.6		2.7		2.2* ChildCare
out of home	.3	.6	.4		
Child Care (total)	1.9 (39)		3.3 (112)		2.6* (151)
<hr/>					
Spouse Care in home	2.7		4.0		3.4*
Spouse Care out of home	.0		.1		.0
Spouse Care (total)	2.7 (57)		4.1 (107)		3.4* (164)
<hr/>					
Parent ¹ Care in home	2.2		1.7		1.9
Parent ¹ Care out of home	6.8		10.0		8.5*
Parent¹ Care (total)	8.9 (177)		11.0 (360)		10.2* (537)
<hr/>					
Other ² Care in home	.7		.8		.7
Other ² Care out of home	2.8		3.8		3.3* Other ²
Care (total)	3.4 (76)		4.6 (158)		4.0* (234)

Source: National Survey of Families and Households 1987-88, primary respondents age 35-64. Unweighted N=5,643.

* Significant difference ($p < .05$) in proportions by gender.

¹ Parent care includes care for stepparents and parents-in-law.

² Other care includes care for other relatives and other nonkin.

**Table 2. Unstandardized OLS Regression Estimates:
Health and Psychological Well-Being on
Gender, Caregiving, and Gender/Caregiving Interactions**

	Health	Esteem	Happiness	Depression
PREDICTORS				
FEMALE	.06**	.18***	.02	.28***
CHILD CARE	-.04	-.20	-.93***	.46**
SPOUSE CARE	-.27**	-.27	-.46**	.42**
PARENT CARE--IN HOME	-.36**	-.04	-.08	.45**
PARENT CARE-OUT OF HOME	-.10	-.22	.06	.32***
OTHER CARE	.03	.05	.03	.15
FEM*CHILD CARE	-.17	.02	.48 ⁺	-.11
FEM*SPOUSE CARE	-.13	-.25	-.18	.25
FEM*PARENT CARE-IN HOME	.23	.21	-.20	-.10
FEM*PARENT CARE-OUT OF HOME	.16 ⁺	-.04	-.09	-.13
FEM*OTHER CARE	-.10	-.42 ⁺	.05	-.06
CONSTANT	3.26***	11.09***	4.61***	3.22**
R ²	.12	.03	.05	.07

Source: National Survey of Families and Households, 1987-88. Primary respondents age 35-64.
(Unweighted N=5,643)

Note: Models controlled also for age, marital status, child(ren) under age 19 at home, race/ethnicity, education, and household income. (Data used weighted to scale.)

⁺ p ≤ .10 * p ≤ .05 ** p ≤ .01 *** p ≤ .001 (two-tailed test)

**Table 3. Unstandardized OLS Regression Estimates:
Social Participation on
Gender, Caregiving, and Gender/Caregiving Interactions**

	Work Hrs/Wk	Socialize w/Nonkin	Socialize w/Kin
PREDICTORS			
FEMALE	-13.96***	-.77***	.18***
CHILD CARE	- .96	.25	-.19
SPOUSE CARE	- 9.48***	-.30	.22
PARENT CARE-IN HOME	- .76	1.93**	.31*
PARENT CARE-OUT OF HOME	.69	.46	.05
OTHER CARE	- 1.88	.24	.21 ⁺
FEM*CHILD CARE	- .47	-.46	.29
FEM*SPOUSE CARE	6.89*	.33	-.33 ⁺
FEM*PARENT CARE-IN HOME	.74	-1.57 ⁺	-.12
FEM*PARENT CARE-OUT OF HOME	- 1.49	.35	.13
FEM*OTHER CARE	- .04	.05	-.20
CONSTANT	53.76***	3.50***	1.79***
R ²	.22	.14	.02

Source: National Survey of Families and Households, 1987-88. Primary respondents age 35-64 . (Unweighted N=5,643)

Note: Models controlled also for age, marital status, child(ren) under age 19 at home, race/ethnicity , education, and household income. (Data used weighted to scale.)

⁺ p ≤ .10 * p ≤ .05 ** p ≤ .01 *** p ≤ .001 (two-tailed test)

**Table 4. Unstandardized OLS Regression Estimates:
Marital Quality on
Gender, Caregiving, and Gender/Caregiving Interactions
(MARRIED RESPONDENTS ONLY)**

	Marital Activity	Marital Sex	Marital Happiness	Marital Disagree	Prob of Split
PREDICTORS					
FEMALE	.12**	.14	-.04	-.20	-.05*
CHILD CARE	-.34 ⁺	-.51	-.22	.48	.06
SPOUSE CARE	.57***	-1.65*	-.04	-1.36**	-.01
PAR CARE-HOME	-.28	.00	-.45*	2.74***	-.12
PAR CARE--OUT	-.16	1.16*	-.01	.53	.01
OTHER CARE	-.16	.25	-.33 ⁺	.50	-.14
F*CHILD CARE	.11	-.51	-.19	1.24 ⁺	.15
F*SPOUSE CARE	-.48*	-.04	-.31	3.17***	.00
F*PAR CARE-HM	-.17	-.91	.14	-.49	.69***
F*PAR CARE-OUT	.13	-2.31***	-.19	-.38	.04
F*OTHER CARE	.04	-1.22	.11	-.11	.05
CONSTANT	3.54***	12.87***	5.69***	12.63***	2.06**
R ²	.10	.07	.02	.11	.04

Source: National Survey of Families and Households, 1987-88,
MARRIED primary respondents age 35-64. (N=3,451)

Note: Models controlled also for age, child(ren) under age 19 at home, race/ethnicity,
education, and household income. (Data used weighted to scale.)

⁺ p ≤ .10 * p ≤ .05 ** p ≤ .01 *** p ≤ .001 (two-tailed test)

Appendix: Descriptives for Analysis Variables

VARIABLE	Mean¹	Standard Deviation	Range
<u>OUTCOMES</u>			
HEALTH	3.99	.89	1-5
SELF-ESTEEM	12.40	1.79	3-15
HAPPINESS	5.42	1.40	1-7
DEPRESSION	1.98	1.21	0-4.44
WORK HOURS	29.37	21.21	0-95
SOCIALIZE WITH FRIENDS	5.87	5.26	0-63
SOCIALIZE WITH RELATIVES	1.80	1.12	0-4
MARITAL ACTIVITY	4.99	1.37	1-6
MARITAL SEX	5.83	5.78	0-90
MARITAL HAPPINESS	5.92	1.37	1-7
MARITAL DISAGREEMENT	9.04	3.83	5-30
MARITAL PROBABILITY OF SPLITTING	1.32	.68	1-5
<u>DEMOGRAPHIC CONTROLS</u>			
FEMALE	.53		0-1
AGE	47.70	8.86	35-64
MARRIED	.75		0-1
WHITE	.81		0-1
YRS OF EDUCATION	12.78	3.26	0-20
HOUSEHOLD INCOME	45060	48968	0-989450
CHILD UNDER AGE 19 IN HOME	.45		0-1

Source: National Survey of Families and Households 1987-88, primary respondents age 35-64 .
Unweighted N=5,643.

Note: Descriptives are weighted estimates.

¹ Means for dichotomous variables are proportions.

Center for Demography & Ecology
University of Wisconsin
1180 Observatory Drive, Rm. 4412
Madison WI 53706-1393
U.S.A.

FAX (608) 262-8400