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**Transitions to Caregiving, Gender, and  
Psychological Well-Being:  
Prospective Evidence from the  
National Survey of Families and Households**

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**Transitions to Caregiving, Gender, and Psychological Well-Being:  
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**ABSTRACT**

Guided by a life course role theoretical framework, this study examined the effects of transitions into the role of caregiver for either a disabled child, spouse, parent, other kin, or other nonkin on eleven dimensions of psychological well-being. Data came from a national probability sample of adults ages 19-95, who were noncaregiver primary respondents to the National Survey of Families and Households in 1987-88, and who were followed up longitudinally in 1992-93 (N=8,305). Results from multivariate regression analyses confirmed that the transition to a caregiver role is often associated with negative effects; e.g., becoming a caregiver for a disabled child, spouse, or parent is associated with increased psychological distress. However, in selected instances we found that taking on a caregiver role was also associated with beneficial effects. Evidence regarding gender differences in the effects of transitioning into a caregiver role was inconsistent, varying across different outcomes and caregiving role relationship types.

## **Transitions to Caregiving, Gender, and Psychological Well-Being:**

### **Prospective Evidence from the National Survey of Families and Households**

Transitioning into a caregiving role for a disabled family member or friend over the adult life course is becoming increasingly likely for both women and men (Brody, 1990; Stone, Cafferata, & Sangl, 1987; Marks, 1996). Several demographic and health care trends are contributing to this: longer life expectancy (coupled with an increased likelihood of chronic disability at older ages), smaller sibships, higher rates of divorce, higher rates of female employment and continuous labor force participation, earlier discharge policies by health care institutions, and increased health policy disincentives to institutionalization (Biegel, Sales, & Schulz, 1991; Dwyer & Coward, 1992). A recent cross-sectional national prevalence study indicated that among American adults age 19 and older, about 16% (14% for men, 18% for women) had given either out-of-household or in-household care to a disabled family member or friend during the last year (Marks, 1996). Rates of caregiving peaked for middle-aged adults (ages 35-64) and young-old adults (ages 65-74); at these ages approximately one in five persons reported giving care—with rates for men trailing those of women, but not by very much (Marks, 1996). Lifetime rates of transitioning into this major social role are undoubtedly significantly higher.

As public awareness has grown about the prevalence and social significance of informal caregiving during the last few decades, research on this topic has mushroomed—particularly research on geriatric caregiving for aging parents and spouses. A major focus of this research has been to document psychological distress and burden associated with the caregiver role (e.g., Anthony-Bergstone, Zarit, & Gatz, 1988; George & Gwyther, 1986; Hoyert & Seltzer, 1992; Schulz & Williamson, 1991), and caregiving researchers have typically focused their efforts on studying the

mediators and moderators of caregiver stress and burden. Gender differences in the effects of caregiving have also been a prominent topic of interest, although the research findings in this area are inconsistent.

Recently, the incorporation of a life course and “career” perspective on caregiving has led to interest in making a more differentiated examination of the well-being effects that occur during different temporal phases of the caregiving career--e.g., the effects of transitioning into the caregiving role, the effects of long-term continuity in the caregiving role, the effects of transformations in the caregiving role that accompany institutionalization, and the effects of transitioning out of the caregiving role due to either recovery of the care recipient or bereavement (Aneshensel, Pearlin, Mullan, Zarit, Whitlach, 1995; Pearlin, 1992; Pearlin & Aneshensel, 1994). Additionally, scholars are beginning to suggest that the stress and crisis model for caregiving has led to relatively little understanding of the potential well-being “gains” as well as “strains” that may occur in the caregiving role (Kramer, 1997; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991).

The transition into caregiving has been the least well studied phase of the caregiving career to date, since, optimally, it requires a prospective population sample research design. The primary aim of this study was to contribute to a population and life course perspective on caregiving by examining the well-being effects of the transition into caregiving of multiple types (i.e., for a spouse, for a parent, for a disabled child, for a disabled relative, for a disabled friend) using longitudinal U.S. national sample data. Its secondary aim was to systematically examine gender differences in these effects.

## **BACKGROUND**

### *A Life Course Theoretical Perspective on Caregiving*

This study was guided by a life course perspective on caregiving. This theoretical orientation suggests that caregiving be viewed as a life course role that one is likely to enter and exit one or more times during adulthood (Moen, Robison, & Fields, 1994; Moen, Robison, & Dempster-McClain,

1995; Suito & Pillemer, 1990). Using this model, the caregiving role is not prejudged a “crisis” or “stressor” as it is in the more dominant caregiving paradigm, the family stress and coping perspective (Hill, 1949; McCubbin & Patterson, 1983; McCubbin & McCubbin, 1993; Pearlin, Mullan, Semple, & Skaff, 1990).

The life course perspective puts a considerable emphasis on studying how family members’ lives are “linked” and on understanding the impact of life transitions into and out of major social roles on human development (Elder, 1992, 1998; George, 1993). One way to conceptualize life transitions into and out of a particular role is to consider how transitions cumulatively form a “career.” In recent years, Leonard Pearlin and his colleagues have applied this insight to innovate theory in life course caregiving, urging a more temporally sensitive and differentiated approach to understanding the entire “caregiving career” (Aneshensel, Pearlin, Mullan, Zarit, Whitlach, 1995; Pearlin, 1992; Pearlin & Aneshensel, 1994). According to the Pearlin model, the archetypical caregiving career consists of several “transitions” and periods in a state--e.g., role acquisition (the start of care after illness onset), role enactment (noninstitutionalized caregiving, and sometimes continued informal care as a complement to institutionalized care), and role disengagement (following care recipient’s death).

The transition into the role of caregiver has been hypothesized to be one of the most stressful periods of the caregiving career, because it involves the experience of watching an undesired change in the life of a loved one (the onset of disability), which then results in the need to take on a whole new set of unanticipated behavioral expectations for action associated with the caregiver role identity (Aneshensel et al., 1995). In contemporary American culture, in friendships and family relationships (with the possible exception of the early parent-child relationship), there is a norm for “good” relationships to be characterized by relative independence and equity (Sabatelli & Shehan, 1993). The caregiver role relationship vis a vis a care recipient is often characterized by a less socially desirable “script” for a close relationship--i.e., a relationship including relatively more dependence by one party

and relatively less equity--which might be expected to lead to a decline in well-being for someone taking on the caregiver role. Additionally, behavioral expectations for the caregiving role are often in conflict with the expectations for the caregiver's other social roles (e.g., employee role, marital role, parent role) and this might be expected to cause role strain or role overload leading to a decline in well-being (Marks, 1998).

### *The Multidimensionality of Well-Being*

Considerable research on the structure of psychological well-being indicates that positive well-being and negative well-being are related, but do not form a bipolar continuum (Bradburn, 1969; Bryant & Veroff, 1982; Ryff, 1989; Ryff & Keyes, 1995). Therefore, since positive well-being and negative well-being are somewhat independent dimensions, a person may experience some aspects of negative well-being at the same time he or she experiences additional aspects of positive well-being. For example, while parents may worry and experience distress caring for children, most parents also report that caring for children is meaningful and a frequent source of pleasure (see Umberson & Gove, 1989). Similarly, being a caregiver for a disabled family member may be distressing, but at the same time, caregiving may offer an opportunity to experience increased purpose in life and personal growth (Kramer, 1997).

Ryff and her colleagues (Ryff, 1989; Ryff, 1995; Ryff & Essex, 1991; Ryff & Keyes, 1995) have used adult development theory to guide the creation and validation of new measures of six distinct dimensions of adult psychological well-being and development: autonomy, environmental mastery, purpose in life, personal growth, personal relations with others, and self-acceptance. Our use of these measures in this study provides us with an expanded opportunity to explore the consequences of caregiving on positive psychological wellness as well as psychological distress.

*Caregiving and Well-Being*

There is now a sizable multidisciplinary literature which has examined family caregiving and its association with well-being. (See Biegel, Sales, & Schulz, 1991; Chappell, 1990; Given & Given, 1991; Horowitz, 1995a; Schulz et al., 1990; Schulz et al., 1995, for helpful reviews.) Most studies in this line of research have concluded that the caregiving role is associated with an increased sense of burden and psychological distress (e.g., Anthony-Bergstone, Zarit, & Gatz, 1988; George & Gwyther, 1986; Hoyert & Seltzer, 1992; Schulz & Williamson, 1991; Strawbridge, Wallhagen, Shema, & Kaplan, 1997).

However, large as the caregiving literature now is, there are still a number of significant gaps in the evidence. First, the bulk of caregiving research has been done with nonrepresentative samples of caregivers, making it difficult to generalize findings to the general population of caregivers (Schulz et al., 1990, 1995). Second, caregiving studies seldom include noncaregiver comparison groups to evaluate whether the caregiving experience is actually contributing to significant differences in well-being between caregivers and noncaregivers. Third, the bulk of caregiving research is limited to studies of women caregivers; studies that examine men caregivers are less prevalent, and nonrepresentative samples of men are potentially subject to significant selection issues that lead to questions about the generalizability of results (Horowitz, 1992). Fourth, most caregiving studies of caregiving are limited to an examination of negative dimensions of mental health (e.g., depression) and ignore potential positive dimensions of psychological wellness (e.g., personal growth). Fifth, most caregiving studies are limited to studying the effects of one type of caregiving--e.g., spousal or adult child caregiving, or combine multiple relationship types of caregiving together, making it difficult to evaluate potential differences across different types of caregiving relationships--including nonkin relationships. Additionally, many caregiving studies do not control for other demographic factors that may contribute to the poor well-being observed among caregivers--e.g., lower education, lower income, being single, minority ethnic group

status.

The transition to caregiving--the “role acquisition” phase of caregiving--important as it is, remains the most understudied aspect of the caregiving career. No study we have been able to find has examined the well-being of caregivers prospectively and longitudinally in a nationally representative U.S. population sample--that is, elicited well-being information for a U.S. national sample prior to caregiving role onset as well as subsequent to role acquisition so that an evaluation of well-being change associated with a transition into the caregiving role might be examined.

A few longitudinal regional studies have moved in this direction. Strawbridge and his colleagues (1997) used population sample data from 1,885 respondents in the Alameda County Study to examine well-being differences between grandparent, spouse, and adult-child caregivers and their noncaregiving peers. They did find that in 1994 all caregiver groups had poorer mental health than noncaregivers, and that grandparent caregivers also had poorer physical health than noncaregivers. Although they did not include a measure of 1974 well-being in their multivariate analysis predicting 1994 well-being, they did show in a supplementary analysis that spouse and adult-child caregivers in 1994 were not significantly different in 1974 well-being scores in comparison with noncaregivers. Grandparent caregivers, on the other hand, were already doing more poorly in terms of both physical and mental health in 1974 than respondents who were noncaregivers in 1994. Although longitudinal, this study was not truly prospective. There was no assessment of caregiving in 1974, and while the study assumed that caregiving was not taking place for any of the respondents in 1974, this may be a tenuous inference given the prevalence of caregiving across the adult life course (Marks, 1996).

Moen and her colleagues (1995), taking a life course role approach, used data from a random sample of 293 wives and mothers from upstate New York who were interviewed in 1956 and 1986 to examine caregiving and its association with well-being. While they found no simple direct relationship between occupancy in the caregiver role and well-being among their women in 1986, they did find

several instances in which caregiving was associated with poorer well-being. For example, caregiving was found to be more problematic for women in their late 60s to 70s in contrast to their 50s and early 60s, for women whose early life well-being (in 1956) was poor, for women less involved in religious activities, and for women heavily involved in other social roles prior to taking on a caregiving role. Although these authors did not control for 1956 well-being in all their analyses, they do report that overall early well-being (in 1956) did not predict selection into caregiving. College-educated women were the exception; for these women, early reports of higher life satisfaction were associated with a greater likelihood of acquiring a caregiving role.

When men have been included in caregiving studies, gender differences in the association of caregiving with well-being have often been an important focus of interest. Although there is not total consistency in results across studies, the preponderance of evidence suggests that women experience more burden and psychological distress in the caregiving role than men (see Miller & Cafasso, 1992; Montgomery, 1992; Stoller, 1992, for reviews). The caregiving role is a gendered role; women who assume a caregiving role typically feel expected to engage in a higher level of involvement in intense personal care tasks than men, and women caregivers tend to be provided with less supplemental support from other network persons than men caregivers (Horowitz, 1995b). Greater socialization of women than men to take responsibility for family relationships and others' well-being might also be expected to lead to greater vulnerability for women to experience heightened distress due to a caregiving role (Chodorow, 1978; Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Kessler & McLeod, 1984; Miller, 1990).

Another moderator of the association between caregiving and well-being is role relationship to the care recipient. Overall, spousal caregivers have been found to experience more negative effects from caregiving than adult children who are caregivers (Biegel et al., 1991; George & Gwyther, 1986; Young & Kahana, 1989). Therefore, role relationship is an important aspect of caregiving that needs

to be taken into account in evaluating the impact of a caregiving role on well-being (Schulz et al., 1990).

## **OBJECTIVES AND HYPOTHESES**

In sum, in an effort to help fill in some of the gaps in understanding caregiving and its effects among men and women, the objectives of this research project were: 1) to study caregiving among a large nationally representative sample of American adults, 2) to examine caregiving effects using a prospective longitudinal design, 3) to examine several different relationship types of caregiving in contrast to noncaregiving in well-being effects, 4) to systematically examine gender differences across multiple relationship types of caregiving and controlling for many potentially confounding demographic factors, and 5) to examine the impact of transitioning into a caregiving role on positive dimensions of psychological wellness as well as negative dimensions of psychological dysfunction.

Given prior literature we formulated the following hypotheses:

Hypothesis 1: Transitioning into the caregiver role will be associated with a decline in psychological well-being as measured by indicators of psychological dysfunction (e.g., psychological distress) and psychological wellness (e.g., self-esteem).

Hypothesis 2: Transitioning into the caregiver role will be associated with greater distress for women than for men.

## **METHODS**

### *Data*

The data for these analyses came from the first and second waves of the National Survey of Families and Households (NSFH), which includes information from personal interviews conducted in

1987-88 (Time 1) and in 1992-93 (Time 2; five years later) with a nationally representative sample of 13,007 noninstitutionalized American adults, 19 years old and older. This survey included a main sample of 9,637 respondents, with an additional oversample of African-Americans, Mexican-Americans, Puerto Ricans, single parents, stepparents, cohabitators, and recently married persons. The response rate at Time 1 (1987-88) was 75%. The response rate at Time 2 was 82% of first wave respondents. This yielded national population coverage at a rate of 61% for data from both waves. 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 (see Sweet, Bumpass, & Call 1988, for more design details). The analytic sample for this study consisted of NSFH primary respondents who indicated they were *not* caregivers at Time 1 (i.e., they responded “no” to questions regarding giving care or assistance either in-household or out-of-household due to illness or disability at Time 1), and who were also respondents again at Time 2 (N=8,305; n=4,957 women, n=3,348 men).

### *Measures*

*Caregiver status.* At Time 2, respondents were asked, “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?” If respondents answered “yes,” to this question, they were further queried: “Who did you provide with the most help?” On the basis of these answers, respondents were coded into mutually exclusive categories of out-of-household caregiving including (a) disabled child care (care for a disabled child of any age), (b) spouse care, (c) parent care (including parents-in-law and stepparents), (d) other care-kin (including grandparents, siblings, aunts, uncles, and other relatives), (e) other care-nonkin (including friends, ex-spouses, and neighbors), and (f) no caregiving (time 1 or time 2).

Additionally, respondents were asked, “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?” Again, if the respondent answered, “yes,” they were asked “Who did you give the most personal care of this kind?” On the basis of these responses, respondents were also categorized as in-household caregivers in a fashion similar to out-of-household caregiving. Examining the out-of-household and in-household caregiving variables, we were able to determine that new disabled child care was split about evenly across the in-household and out-of-household context, all of new spouse care took place in the household, parent care was split between in- and out-of-household, other care for kin predominantly took place out-of-household, and nonkin care also took place generally out-of-household (see Table 1). In 143 cases we found that respondents indicated that they gave care both in-household and out-of-household. For analytic purposes (to create mutually exclusive category contrasts) we created a new variable that categorized these persons as providing in- and out-of-household care. We also combined cases of in-household or out-of-household care to create disabled child care, other care-kin, and other care-nonkin categories. We retained a distinction between parent care in-household and parent care out-of-household, since we had a sizeable proportion of parent care providers, and prior literature has suggested that in-household care may be the most taxing type of care (Schulz et al., 1990). Overall, about 26.6% of the NSFH adult sample who were not caregiving in 1987-88 indicated they had acquired a new caregiving role either in-household or out-of-household in 1992-93.

[Table 1 about here]

*Psychological well-being.* Outcome measures included a 12-item modified version of the Center for Epidemiological Studies *depression* (CES-D) index (Radloff, 1977) ( $\alpha=.93$ ), a 3-item measure of *hostility/irritability* (new to NSFH2) ( $\alpha=.85$ ), a standard one-item measure of global *happiness*, a 3-item version of Rosenberg’s (1965) *self-esteem* index ( $\alpha=.62$ ), a 5-item *personal mastery* index consisting of 4 items from the Pearlin Mastery Scale (Pearlin, Lieberman, Menaghan,

Mullan, 1981) along with a single item of control/mastery also used at Time 1 of the NSFH (alpha=.64), and 3-item versions of Ryff's (1989, Ryff & Keyes, 1995) six psychological well-being scales: *autonomy* (alpha=.43), *personal growth* (alpha=.50), *positive relations with others* (alpha=.54), *purpose in life* (alpha=.37), *self-acceptance* (alpha=.53), and *environmental mastery* (alpha=.57) (see Table 2 for descriptives; see Appendix for a list of scale items). The relatively lower internal consistency assessments for the Ryff scales reflects an a priori decision by Ryff to create short versions of her scales that represent the multifactorial structure of the original scales (which consisted of 20 items each) rather than to maximize internal consistency for each scale. These abbreviated scales have been found to correlate from .70 to .89 with the original scales with high demonstrated reliability (Ryff & Keyes, 1995).

[Table 2 about here]

For three measures--depression, global happiness, and self-esteem--Time 1 assessment of the measures were available and were controlled in the respective analyses. For the personal mastery scale, responses to one item measuring personal mastery that was included at Time 1 of the NSFH was included as a Time 1 control (the correlation of this one item at Time 2 with the other 5-item scale at Time 2 is .56). The hostility index and the six Ryff measures were not included at Time 1, so the depression assessment from Time 1 was entered as a control for selection into caregiving based on psychological well-being and to strengthen inferences that non-caregiver vs. caregiver group differences in well-being at Time 2 are likely to be the result of differential longitudinal *change* in well-being over time due to transition (or not) into the caregiving role.

Several additional demographic statuses previously demonstrated to be associated with psychological well-being (Ross et al., 1990) were also controlled in all analyses to reduce the amount of confounding influence they might exert on the caregiving effects. These included marital status (dichotomously coded 1=married, 0=not married), race/ethnicity (dichotomously coded 1=nonwhite vs.

0=non-Hispanic white), education (in years), household income (continuous measure totaled across all types of earned and unearned income for all household members at Time 1), missing on household income at Time 1 (a dichotomous indicator variable used to facilitate inclusion of all respondents missing on income in the regression analyses), having a child age 18 or younger in the household at Time 2 (dichotomous, 1=has child, 0=no child), and employment status at Time 2 (dichotomous, 1=employed, 0=not employed). Ordinary least squares regression models were estimated using SPSS.

## RESULTS

Multivariate logistic regression models were first estimated across the entire sample of both men and women using unweighted data. We also estimated models with weighted data and found a similar pattern of estimates. Since we control for the major factors used in the weights, we report unweighted results (Winship & Radbill, 1994). Our preliminary models included variables for gender, all caregiving types, Gender X Caregiving Type interaction variables, along with the additional demographic controls. These analyses provided evidence of at least one significant gender interaction effect in the case of ten out of eleven outcomes. Therefore, it was deemed appropriate to rerun the models for men and women separately. The results of these analyses are reported in Table 3. Superscripts on this table also denote where significant gender interaction effects were in evidence in the models that combined men and women.

### *The Transition into Disabled Child Care and Well-Being*

[Table 3 about here]

Women who reported becoming a new caregiver for a disabled child did report a significant increase in psychological distress in comparison to women who did not begin such care. A trend effect also suggested that women transitioning into this caregiver role might be experiencing more hostility. Yet at the same time, and contrary to hypothesis, women providing new care to a disabled child during this period reported more autonomy than women not providing this type of care. On other dimensions

of well-being, contrary to expectation, women providing disabled child care were not significantly different when contrasted with noncaregiving women with otherwise similar demographic characteristics.

Men transitioning into caregiving for a disabled child reported a significant increase in depression and declines in happiness, personal mastery, environmental mastery (trend), and personal growth (trend). Gender differences noted in the combined gender models indicated that contrary to hypothesis, men becoming new caregivers for a disabled child experienced greater declines in well-being than women in terms of depression (trend), personal mastery (trend), environmental mastery, personal growth (trend), and positive relations with others (trend).

#### *The Transition into Spouse Care and Well-Being*

Making the transition into caring for a spouse was associated a somewhat different pattern of effects. Both men and women providing spouse care experienced a greater increase in depression and decline in happiness than their noncaregiving peers. Both men and women also showed evidence of possibly experiencing less autonomy (trend effect) after transitioning to a spouse care role.

In contrast to disabled child care, consistent with our second hypothesis, for this type of caregiving role there was some evidence that women caregivers experienced a greater decline in well-being across multiple dimensions in contrast to men caregivers. Specifically, women caregivers for a spouse reported significantly greater hostility, greater decline in personal mastery, and lower levels of environmental mastery, personal growth, positive relations purpose in life, and self-acceptance than did men caregivers for a spouse.

#### *The Transition into Care for a Parent and Well-Being*

Becoming a new caregiver for a parent in the household was associated with more hostility, less happiness, less personal mastery, less autonomy, less personal growth, and less self-acceptance (trend) for caregiving women in contrast to noncaregiving women. Men providing parent care in their

households also reported a trend toward a greater increase in psychological distress as well as less personal mastery, less positive relations with others (trend), and less self-acceptance. In five of eleven outcomes, the effects of parent caregiving for women were significantly different than the effects for men. For three outcomes, the effects for women were significantly worse--more hostility, less happiness, and less autonomy (trend). However, for two other outcomes, men fared more poorly than women; men caregivers for parents in-household reported less personal mastery (trend) and less purpose in life than women caregivers for parents in-household.

The transition to parent care out-of-household was associated with a significant increase in depression for both men and women. Men caregivers of parents out-of-household also reported more hostility, less happiness, less personal mastery and less environmental mastery than men not providing care. Women caregivers of parents out-of-household reported less happiness (trend). But contrary to hypothesis, and contrary to the assumptions made in most caregiving research, women who transitioned to parent care out-of-household also reported significantly more purpose in life, and evidenced trends toward experiencing more personal growth and positive relations with others than their noncaregiving women peers.

The combined gender analyses also indicated that the effects for men and women of transitioning to caregiving for a parent out-of-household were different in the case of psychological distress, hostility, environmental mastery (trend), personal growth (trend), and positive relations with others (trend). For each of these dimensions of psychological well-being, contrary to expectation, becoming a caregiver for parents out-of-household had a more negative impact on the psychological well-being of men in contrast to women.

### *The Transition into Other Kin Care and Well-Being*

There has been little previous research on the well-being effects of becoming a caregiver for other types of disabled kin. We found that women who had recently transitioned into this caregiver role

reported a higher level of hostility, and less happiness (trend); but simultaneously these women reported more autonomy, and more positive relations with others (trend).

Men who began giving care to other kin were not dissimilar in well-being than noncaregiving men, except for noting more psychological distress and reporting less personal growth. In the case of both psychological distress and also personal growth, contrary to expectation, the combined gender analysis indicated that transitioning into care for other kin types was more detrimental to mental health for men than women.

#### *The Transition into Care for Nonkin and Well-Being*

The literature on nonkin care is virtually nonexistent. Yet the transition to caring for a friend was more prevalent in our national sample than any other type of caregiving except parent care (see Table 1). We found that entering into nonkin care was associated with a decline in happiness for men (a trend level gender difference). However, no other negative effects for this type of care were noted. On the contrary, nonkin care was associated with a number of positive effects on well-being: more autonomy, more personal growth, more positive relations (trend), more purpose in life, and more self-acceptance for women; as well as more personal growth and more positive relations with others (trend) for men.

A number of gender interaction effects in the combined gender analysis were contrary to our expectation. Specifically, in terms of autonomy (trend), purpose in life, and self-acceptance, providing care to a friend or neighbor was associated with more well-being benefit for women in contrast to men.

#### *The Transition into In- and Out-of-Household Care and Well-Being*

The group of caregivers in this category represents a combination of relationship types of care, so it is difficult to clearly interpret the meaning of the parameters for this group. However, using it as a contrast may provide some clues regarding the effects of caregiving to multiple persons across households. (Note: For both in-household and out-of-household care at Time 2, there is only

information about who was cared for *most*. Time 2 data does not allow us to know how many persons in total are cared for in-household and out-of-household. At Time 1, 2.6% of all adults age 19 and older in the NSFH reported providing care to more than one person in and/or out of their household (Marks, 1996)).

Men and women who became caregivers in both residential and nonresidential contexts reported more psychological distress and hostility (trend levels for men). Women providing care in both contexts reported a decline in happiness, a decline in personal mastery, less environmental mastery, less personal growth (trend), less positive relations with others (trend), and less self-acceptance. A trend level gender difference in effect was observed in the case of happiness--women dual context caregivers reported significantly less happiness than men dual context caregivers.

### **SUMMARY, DISCUSSION, AND CONCLUSIONS**

The results of our analysis of the effects of transitioning into caregiving on psychological well-being yield a complex story. First, it is notable that we found that among a large population sample of adults who were not providing care to a disabled relative or friend in 1987-88, five years later, more than one in four reported having taken on a caregiver role within the last year. Almost one in ten adults reported beginning care for a disabled parent. This relatively high rate of caregiver role acquisition highlights the growing importance of this role in the life course of contemporary adults.

Next, our results do allow us to confirm with longitudinal, U.S. population sample evidence that transitioning into a caregiver role for a disabled child, a disabled spouse, or a parent is associated with increased depressive symptoms. This is a significant finding, with considerable implications for mental health in the adult population. With a growing prevalence of caregiving for disabled family members among adults, it is critical for social institutions and policies governing workplace environments, health care, and social services to become ever more responsive to the emotional and instrumental needs of family caregivers.

While depressive symptoms and other negative effects were often found to be associated with taking on a caregiver role, there were notable exceptions where acquisition of the caregiver role was associated with no differences in well-being when contrasted to not having acquired a caregiver role (e.g., self-esteem across all caregiving types, nonkin care across all dimensions of well-being for women and across all dimensions except happiness for men). In fact, contrary to hypothesis, in a few cases becoming a caregiver was associated with more beneficial well-being than remaining without such a role. Specifically, women providing disabled child care and care to a kinsperson outside the nuclear family reported more autonomy than women who did not provide such care. Transitioning into a role of providing parent care out-of-household, nonkin care, and care both in- and out-of-household were associated with more personal growth than not providing care. There was suggestive trend effect evidence that becoming a new caregiver for a parent out-of-household, another type of kinsperson, or a nonkin person might be associated with a perception of more positive relations with others for women. Nonkin care was also associated with more purpose in life and more self-acceptance for women in contrast to occupying no caregiver role. Nonkin care was also associated with more personal growth and a trend toward more positive relations with others for men.

All of these beneficial effects of caregiving are outside what the general stress model of caregiving might have guided us to discover. These results suggesting potential well-being gains in the caregiving role (Kramer, 1997) highlight the importance of continuing to examine evidence across multiple dimensions of well-being when we consider a complex adult life role like caregiving. In sum, for the first time we now have suggestive longitudinal, national population evidence indicating that a caregiving role can be associated with some positive psychological well-being effects as well as negative well-being effects.

The overall pattern of gender differences in our results was not clear. Gender differences in caregiving effects (at a  $p \leq .05$  level of significance) were observed in only eleven out of seventy-seven

tested instances. In six of these cases the hypothesis that women experience greater decline in well-being in taking on the caregiver role than men was supported. While there was not an altogether clear and consistent pattern of gender differences in any of the role relationship types, overall across outcomes it appeared that the transition to disabled child care was more difficult for men than for women; the transition into spouse care was more difficult for women than for men, the transition into care for a disabled parent was more difficult for men than for women, the transition to caring for another type of kin person was somewhat more difficult for men than for women, the transition to nonkin care was more rewarding for women than for men.

Based on this inconsistent evidence we conclude that the global hypothesis that women suffer more from taking on a caregiving role than men is not supported in our study. But neither do we feel we have developed compelling evidence that the reverse is true, or that there are no gender differences in the effects of caregiving. The somewhat different patterns we found for different role relationship types of caregiving leads us to suggest that gender differences in caregiving may vary across relationship type and dimension of well-being under consideration. Additional contextual factors that we were not able to explore here (e.g., whether primary or secondary caregiver, role configuration, role demands) may also influence under what conditions gender differences in caregiving consequences may occur.

Although we believe this analysis takes some important steps in filling gaps in the caregiving literature, we forthrightly acknowledge its limitations. We are well aware that our definition for caregiving in this national survey will include persons who are providing many different intensities of care for many different types of disability that we have not differentiated here. We also do not control for the exact duration of caregiving (we do not have this information at Time 2) and additional resources caregivers may or may not have in meeting the needs of their care recipients. We view this research as a population-level study designed to complement the important, rich, in-depth studies of caregiving that already exist and that continue to be done. In future research we plan additional more focused analyses

of the different caregiving role relationship types--e.g., spouse care and parent care--using additional information from the NSFH that may further help us understand these caregivers and the moderating and mediating effects of other factors on caregiving outcomes.

Notwithstanding these limitations, we believe this longitudinal analysis yields the following conclusions: Transitioning into a caregiving role is a common event for contemporary American men and women. The caregiving role for close family members is, indeed, associated with increased symptoms of psychological distress. However, an investigation of multiple dimensions of psychological well-being does not indicate that acquiring a caregiver role is always associated with negative effects on well-being. An expanded examination of several dimensions of psychological wellness suggests that acquiring a caregiving role may actually be related to some well-being benefits, especially among women. Gender differences in the effects of caregiving are not consistent across caregiving role relationship types. Future life course research should take the caregiver role into account whenever possible, and should examine more closely the moderators and mediators of the impact of acquiring a caregiving role on multiple dimensions of adult well-being and development.

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Table 1

Weighted Percentage Distribution (Unweighted n) of Transitions to Caregiving

Caregiving Status (Time 2) Weighted	In Household		Out of Household		Combined In and Out		Total Sample	
	Unweighted	Weighted	Unweighted	Weighted	Unweighted	Weighted	Unweighted	
	N	Percent	N	Percent	N	Percent	N	Percent
No Caregiving (Time 1 or Time 2)	----	----	----	----	----	----	5981	73.4
Disabled Child Care (biological or adopted)	73	.8	72	.7	----	----	145	1.5
Spouse Care	163	2.2	----	----	----	----	163	2.2
Parent Care (biological or in-law)	37	.5	806	9.3	----	----	843	9.8
Other Care-Kin	13	.1	446	5.2	----	----	459	5.3
Other Care-Nonkin	7	.1	564	6.0	----	----	571	6.1
In <u>and</u> Out of Household Care	----	----	----	----	143	1.7	143	1.7
Total	293	3.7	1888	21.2	143	1.7	8305	100.00

Source: National Survey of Families and Households, 1987-1993, primary respondents who were not providing care in 1987.

Table 2

Descriptive Statistics for Analysis Variables

	Total Sample Mean (s.d.) n=8,305
<u>Psychological Well-Being</u>	
Depression (Time 1)	2.07 (1.18)
Depression (Time 2)	2.05 (1.14)
Hostility (Time 2)	.98 (1.34)
Global Happiness (Time 1)	5.47 (1.34)
Global Happiness (Time 2)	5.41 (1.33)
Self-Esteem (Time 1)	4.14 (.58)
Self-Esteem (Time 2)	4.09 (.63)
Personal Mastery (1-item; Time 1)	3.63 (.96)
Personal Mastery (5 items; Time 2)	18.19 (3.37)
Positive Relations with Others (Time 2)	13.74 (3.13)
Purpose in Life (Time 2)	13.53 (2.96)
Self-Acceptance (Time 2)	13.93 (2.73)
Environmental Mastery (Time 2)	13.90 (2.76)
Autonomy (Time 2)	14.54 (2.49)
Personal Growth (Time 2)	14.94 (2.52)
<u>Demographic Characteristics</u>	
Female	.51
Age (Time 1)	41.39 (16.49)
Nonwhite	.20
Married (Time 2)	.64
Child # 18 in Household (Time 2)	.39
Employed (Time 2)	.64
Years of Education (Time 1)	12.85 (3.03)
Household Income (in thousands) (Time 2)	49.65 (45.05)
Missing on Income Data (Time 2)	.07

Source: National Survey of Families and Households, 1987-1993.

Note. Descriptive statistics calculated using weighted data. Dichotomous variable means are proportions.

Table 3  
 Unstandardized Regression Coefficients for the Effects of Transitions into Caregiving on Psychological Well-Being by Gender

PREDICTORS	Depression		Hostility		Global Happiness		Self-Esteem		Personal Mastery	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
No Caregiving T1 or T2 (omitted)	----	----	----	----	----	----	----	----	----	----
Disabled Child Care	.19* <sup>b</sup>	.49** <sup>b</sup>	.20+	.26	-.11	-.40*	.004	-.04	-.11 <sup>b</sup>	-1.08* <sup>b</sup>
Spouse Care	.31**	.23*	.44*** <sup>a</sup>	-.01 <sup>a</sup>	-.42**	-.40**	.02	.01	-1.08*** <sup>b</sup>	-.32 <sup>b</sup>
Parent Care-In Household	.28	.40+	.82*** <sup>a</sup>	.13 <sup>a</sup>	-.76*** <sup>a</sup>	.35 <sup>a</sup>	-.06	.04	-.20 <sup>b</sup>	-1.81* <sup>b</sup>
Parent Care-Out of Household	.11*** <sup>a</sup>	.27*** <sup>a</sup>	.02 <sup>a</sup>	.19*** <sup>a</sup>	-.11+	-.18*	-.02	-.04	-.14	-.11
Other Care-Kin	.05 <sup>b</sup>	.20** <sup>b</sup>	.15*	.04	-.18*	-.03	-.02	.04	-.21	-.09
Other Care-NonKin	.01	.04	-.004	.09	.02 <sup>b</sup>	-.18* <sup>b</sup>	.01	-.02	.12	-.21
In <u>and</u> Out of Household Care	.19*	.21+	.38**	.23+	-.47*** <sup>b</sup>	.08 <sup>b</sup>	-.01	-.01	-.58*	-.57
<b>Time 1 Variables</b>										
Depression	.37***	.33***	.30***	.24***						
Global Happiness					.24***	.22***				
Self-Esteem							.34***	.33***		
Personal Mastery (1-item)									.69***	.76***
Constant	2.08***	1.99***	1.48***	1.31***	3.80***	3.77***	2.27***	2.44***	12.98***	13.69***
R <sup>2</sup>	.19	.17	.12	.09	.09	.10	.14	.16	.11	.11

  

PREDICTORS	Autonomy		Environmental Mastery		Personal Growth		Positive Relations		Purpose in Life		Self-Acceptance	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
No Caregiving T1 or T2 (omitted)	----	----	----	----	----	----	----	----	----	----	----	----
Disabled Child Care	.47*	.02	.21 <sup>a</sup>	-.69+ <sup>a</sup>	.06 <sup>b</sup>	-.59+ <sup>b</sup>	.22 <sup>b</sup>	-.59 <sup>b</sup>	-.25	.40	-.13	.05
Spouse Care	-.38+ <sup>a</sup>	.38+ <sup>a</sup>	-.58* <sup>a</sup>	.08 <sup>a</sup>	-.48*	-.15	-.98*** <sup>b</sup>	-.22 <sup>b</sup>	-.80*** <sup>a</sup>	.04 <sup>a</sup>	-.62*	-.001
Parent Care-in household	-1.09* <sup>b</sup>	-.04 <sup>b</sup>	-1.04*	-.16	-.98*	-.05	-.13	-1.01+	.72 <sup>b</sup>	-.36 <sup>b</sup>	-.89+	-1.10*
Parent Care-out household	.13	-.14	-.06 <sup>b</sup>	-.37*** <sup>b</sup>	.16+ <sup>b</sup>	-.01 <sup>b</sup>	.23+ <sup>b</sup>	.03 <sup>b</sup>	.29**	.11	-.15	-.13
Other Care-Kin	.27*	.04	.16	-.11	.08 <sup>a</sup>	-.35* <sup>a</sup>	.27+	.18	.13	-.02	-.02	-.22
Other Care-NonKin	.27* <sup>b</sup>	-.05 <sup>b</sup>	.004	-.04	.28*	.31*	.22+	.37+	.31* <sup>a</sup>	-.08 <sup>a</sup>	.25* <sup>a</sup>	-.22 <sup>a</sup>
In <u>and</u> Out of Household Care	-.06	-.23	-.65*	-.33	.33+	.11	-.43+	-.34	.01	.11	-.58*	-.35
<b>Time 1 Variables</b>												
Depression	-.27***	-.19***	-.51***	-.49***	-.24***	-.21***	-.43***	-.42***	-.21***	-.26***	-.49***	-.50***
Constant	13.88***	14.50***	12.99***	13.77***	13.73***	14.72***	11.58***	12.89***	12.05***	12.67***	12.41***	13.35***
R <sup>2</sup>	.04	.01	.08	.08	.14	.11	.10	.05	.18	.17	.11	.10

Source: National Survey of Families and Households, primary respondents (N=8,305).

+ p # .10 \* p # .05 \*\* p # .01 \*\*\* p # .001 (one-tailed test).

<sup>a</sup> = p # .05 <sup>b</sup> = p # .10 (one-tailed test). Significant gender differences found in combined gender analysis.

Note: All models also controlled for age, race/ethnicity, employment status, years of education, household income, marital status, and presence of a child # age 18 in household.

Appendix  
Index Items

*I. Ryff Psychological Well-Being Scales*

*(rated on a 6-point scale: strongly disagree to strongly agree)*

*Autonomy*

I tend to be influenced by people with strong opinions.\*  
I have confidence in my opinions, even if they are different from the way most other people think.  
I judge myself by what I think is important, not by the values of what others think is important.

*Positive Relations with Others*

Maintaining close relationships has been difficult and frustrating for me.\*  
I have not experienced many warm and trusting relationships with others.\*  
People would describe me as a giving person, willing to share my time with others.

*Purpose in Life*

I live life one day at a time and don't really think about the future.\*  
Some people wander aimlessly through life, but I am not one of them.  
I sometimes feel as if I've done all there is to do in life.\*

*Self-Acceptance*

I like most parts of my personality.  
When I look at the story of my life, I am pleased how things have turned out.  
In many ways, I feel disappointed about my achievements in life.\*

*Environmental Mastery*

The demands of everyday life often get me down.\*  
In general, I feel I am in charge of the situation in which I live.  
I am quite good at managing the many responsibilities of my daily life.

*Personal Growth*

I gave up trying to make big improvements or changes in my life a long time ago.\*  
I think it is important to have new experiences that challenge how you think about yourself and the world.  
For me, life has been a continuous process of learning, changing, and growth.

Appendix  
Index items (continued)

*II. Rosenberg Self-Esteem Scale*

Please indicate how much you agree or disagree with the following statements:

- On the whole I am satisfied with myself.
- I am able to do things as well as other people.
- I feel that I'm a person of worth, at least on an equal plane with others.

*III. Pearlin Personal Mastery Scale (abbreviated)*

Please indicate how much you agree or disagree with the following statements:

- 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.\*
- I have always felt pretty sure my life would work out the way I wanted it to.

*IV. Center for Epidemiological Studies Depression Index (CES-D) (modified)*

On how many days during the past week did you....

- Feel you could not shake of the blues even with help from your family and friends?
- Feel bothered by things that usually don't bother you?
- Feel lonely?
- Feel sad?
- Feel depressed?
- Have trouble keeping your mind on what you were doing?
- Not feel like eating, your appetite was poor?
- Feel everything you did was an effort?
- Feel fearful?
- Sleep restlessly?
- Talk less than usual?
- Feel you could not "get going"?

*V. Hostility Scale*

On how many days during the past week did you....

- Feel irritable, or likely to fight or argue?
- Feel like telling someone off?
- Feel angry or hostile for several hours at a time?

---

\* Item reverse-coded.

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