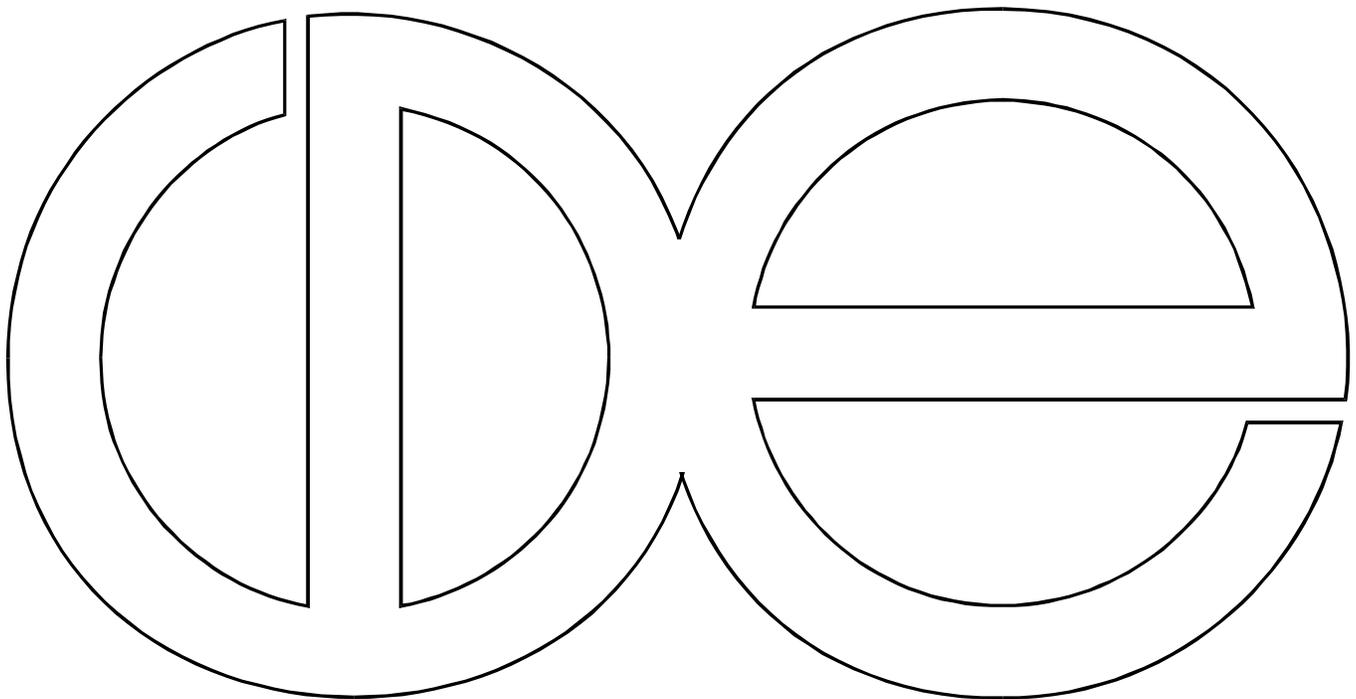


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**Does it Hurt to Care?  
Caregiving, Work and Family Conflict, and Midlife Well-Being**

**Nadine F. Marks**

**CDE Working Paper No. 95-02**



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**ABSTRACT**

This study examined the effects of caregiving for disabled children, spouses, parents, and other kin and nonkin on multiple dimensions of negative and positive psychological well-being and development using data from a population sample of N=5,782 employed Wisconsin Longitudinal Study middle-aged women and men respondents in 1992-93. A life-course role-identity theoretical framework was employed to hypothesize that the contemporary social ecology of caregiving leads to conflicting demands across the roles of employee and caregiver, and that this conflict is an important factor in accounting for the negative well-being effects of caregiving. Multivariate regression analyses confirmed this hypothesis, and further revealed that if work and family conflict differences between caregivers and noncaregivers were eliminated, the caregiving role would also in more instances lead to positive well-being benefits.

Key words: caregiving, midlife, psychological well-being, work and family conflict

## **Does it Hurt to Care? Caregiving, Work and Family Conflict, and Midlife Well-Being**

Understanding the well-being consequences of assuming the role of caregiver to a disabled family member or friend is becoming an increasingly important private and public issue. Population estimates of caregiving now make it clear that the caregiving role is not a rare life course event (Marks, 1996; Stone, Cafferata, & Sangl, 1987). The prevalence of caregiving for the frail and disabled peaks for midlife adults when about one in five women and men are providing some degree of care (Marks, 1996; Stone et al., 1987), bringing about particular concern for middle-aged women and men “in the middle” of considerable role responsibilities to multiple generations of family members, employment, and community (Brody, 1981, 1985, 1990). The prevalence of midlife caregiving responsibility for elders is only expected to increase, too, as we become ever more an “aging” and “aged” society (Coward, Horne, & Dwyer, 1992). Demographic trends that have resulted in longer lives, smaller families, higher rates of divorce, lower rates of marriage and remarriage, and higher rates of women’s employment than previously mean that we can expect caregiving for frail elders will fall on relatively fewer shoulders in the years ahead, and that the risk of becoming a caregiver at some time or multiple times over the life course is likely to increase (Coward et al., 1992; Marks, 1996; Moen, Robison, & Fields, 1994).

Research on the consequences of caregiving has focused predominantly on documenting negative well-being outcomes and has been limited to nonrepresentative samples, often including only women caregivers and no noncaregiver comparison group. The results of this research suggest that caregiving for the frail and disabled is associated with increased distress and burden (Schulz, Visintainer, & Williamson, 1990). There is some evidence that caregiving for disabled family members is also associated with poorer personal health (Schulz et al., 1990; Marks, 1996).

However, the potential gains as well as strains related to the caregiving role are yet to be well investigated (Kramer, 1997).

Another shortcoming of most caregiving research is that it usually does not consider the total social ecology within which the caregiving role is embedded in contemporary Western society (Cantor, 1991; Kahana, Kahana, Johnson, Hammond, & Kercher, 1994). A sizable proportion of caregivers today are faced with blending the often contradictory normative expectations that accompany the employee role and the caregiver role. Previous studies of caregivers have indeed noted considerable reports of work and family conflict concerns among caregivers (Stone et al, 1987; Scharlach & Boyd, 1989). However, no previous study has systematically examined the question of how much of the negative well-being consequences of caregiving are a result of taking on the caregiving role itself and how much can be accounted for by the additional work and family conflict experienced by employed caregivers.

The goal of this research study was to address exactly this issue. Drawing on a life course role-identity theoretical perspective, this investigation first examined associations between several contrasting types of caregiving for disabled persons (i.e., disabled child care, spouse care, parent care, and other care) and multiple dimensions of negative psychological well-being (depression, hostility) and positive psychological well-being (e.g., personal growth, purpose in life, autonomy) as well as self-reported health using data from a large population sample of employed midlife men and women. Then it considered evidence related to how much work and family role conflict accounts for negative effects of caregiving on midlife well-being. Gender differences in the effects of caregiving on well-being and in the effects of caregiving on reported work and family conflict were also evaluated.

## THEORETICAL FOUNDATION

### *Adaptation Models for the Consequences of Caregiving*

Early research on the well-being consequences of caregiving was relatively atheoretical and typically focused on measuring the *burden* experienced by family caregivers (Montgomery, 1989). This tradition did, in fact, document considerable burden expressed by caregivers, particularly women caregivers (Miller & Cafasso, 1992), as measured by indicators of frustration, guilt, resentment, fatigue, and time strains.

Over time, caregiving research has more frequently employed a family systems perspective. Under this conceptual framework, caregiving is viewed as a family “crisis” with which a family must cope. Models such as the ABCX family crisis model (Hill, 1949), the double ABCX model of family adaptation (McCubbin & Patterson, 1983), and the family systems resilience, adjustment and adaptation model (McCubbin & McCubbin, 1993) have been used in this research. Additionally, Pearlin, Mullan, Semple, and Skaff (1990) have suggested a related model of the stress process that has been applied to caregiving. In all of these theoretical frameworks, caregiving is considered an undesirable *stressor* that is expected to have implications (usually negative) for the caregiver’s well-being. Over time, empirical work utilizing stress and coping models has evolved from a sole emphasis on the more caregiver role-specific outcome of burden to more general well-being considerations, including positive psychological well-being (e.g., life satisfaction), negative psychological well-being (e.g., depression, anxiety), and physical health (George & Gwyther, 1986; Biegel, Sales, & Schulz, 1991). A two-factor model that examines both the gains as well as the strains of the caregiver role and relates these to both positive and negative psychological well-being

dimensions is now becoming more prominent in the literature (Lawton, Moss, Kleban, Glicksman, & Rovine, 1991; Kramer, 1997).

### *A Life Course Role-Identity Approach to Caregiving*

Another theoretical approach to understanding caregiving and its consequences incorporates a life course perspective. 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). Following life course perspective principles (Elder, 1992), in order to understand the likely well-being consequences of the caregiving role, it becomes useful to consider the developmental timing of transitions into and out of the caregiver role, the intersection of other roles in relation to the caregiving role, the changing historical context for enactment of the caregiving role, and the cumulative patterns of caregiving across the life courses of varying birth cohorts (Moen, Robison, & Fields, 1994).

For this research project I employed a life course perspective on caregiving--considering caregiving activities to be helping behaviors associated with taking on the role of caregiver for a frail or disabled family member or friend. Viewed in this way, caregiving is not necessarily prejudged a "stressor." I also suggest that it is useful here to incorporate insights from structural symbolic interaction's role-identity theory (Stryker, 1980). This theory suggests that when a person assumes any social role he or she internalizes the socially constructed behavioral expectations associated with that status (at that historical time) as part of her or his role identity. Each role a person assumes--e.g., mother, wife, employee, caregiver--has its accompanying socially based behavioral expectations and identity. The combination of these identities is the basis for the person's "self." Role-identity theory predicts that the more competently and easily a person is able to fulfill all the internalized

normative behavioral expectations related to all her or his social roles the more likely the person will be to exhibit high self-esteem and well-being (Stryker, 1980).

While some role combinations can lead to beneficial effects on well-being (e.g., Moen, Dempster-McClain, & Williams, 1989, 1992; Marks, 1977), the assumption of multiple roles also has the potential for introducing conflicting behavioral expectations leading to “role conflict.” For example, if a person’s caregiver role expectation is that she or he be available to take a frail mother to the hospital on a weekday morning for a required critical test at the same time her or his employee role expectation is to be available for a required office staff meeting, work and family (caregiver) role conflict are likely to result. Additionally, as a result of such work and family role conflict (resulting in problematic role enactment), role-identity theory would predict a decline in self-related well-being.

#### *The multidimensionality of well-being*

One of the serious limitations with the research done thus far on the caregiver role is that typically, a full range of positive well-being outcomes have not been investigated along with negative outcomes (Kramer, 1997). 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). In other words, because positive well-being and negative well-being are somewhat independent dimensions, a person may experience aspects of negative well-being at the same time he or she experiences aspects of positive well-being. For example, a parent may well worry and experience distress at times caring for a child, but most parents also find caring for a child meaningful and a frequent source of pleasure (cf. Umberson & Gove, 1989). Similarly, caring for a frail elderly parent may likewise be distressing, but at the same time, it might offer a gratifying opportunity to make a difference to a loved one, and

therefore experience added purpose in life and personal growth as a result (Kramer, 1997).

Ryff and her colleagues' (Ryff, 1989; Ryff; 1995; Ryff & Essex, 1991; Ryff & Keyes, 1995) theoretically grounded efforts to develop 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--allow for an expanded opportunity to explore the consequences of caregiving on positive psychological wellness as well as the more typically considered outcome of psychological distress. An examination of these more positive outcomes together with the one more typical outcome examined in caregiving research--psychological distress--is an important component and contribution of this study.

## **PREVIOUS RESEARCH**

### *The well-being consequences of caregiving*

A voluminous multidisciplinary literature has accrued studying family caregiving and its consequences for caregivers during the last few decades (see Horowitz, 1985; Given & Given, 1991; Chappell, 1990; Biegel, Sales, & Schulz, 1991, for useful reviews). Overall, a sizeable body of research now suggests that caregiving is associated with considerable burden, depression, and, in some cases, poor health (Schulz, Visintainer, & Williamson, 1990; Anthony-Bergstone, Zarit, & Gatz, 1988; George & Gwyther, 1986; Lawton, Brody, & Saperstein, 1989; Strawbridge, Wallhagen, Shema, & Kaplan, 1997). The vast majority of this literature, however, is based on nonrepresentative samples that most typically do not include a noncaregiver reference group.

Gender differences in the effects of caregiving have also been a prominent topic of interest, although the research findings in this area are inconsistent. Overall, most studies suggest women experience more burden and distress than men as caregivers, although some studies find men

experience more burden and distress, while others find no gender differences (see Miller & Cafasso 1992; Stoller 1992; Montgomery 1992 for reviews). It is hypothesized that women suffer more consequences of caregiving due to their typical engagement in more personal care and hands-on care activities than men in the caregiver role (Horowitz, 1985), as well as their generally greater role-identity investment in interpersonal relationships, which makes them more vulnerable to experiencing a more empathetic sharing of suffering with others than men (Chodorow, 1978; Gilligan, 1982; Kessler & McLeod, 1984).

The role-relationship of caregiver to care recipient has also emerged as a potentially important moderator of the relationship between engaging in the activities of the caregiving role and well-being. Overall, the *well-being* of spousal caregivers appears to be more strongly impacted than that of filial caregivers (Biegel, Sales, & Schulz, 1991; George & Gwyther, 1986); however, coresidence, and its association with additional burden may be a confounding influence in these relationships. Parental caregiving for a mentally ill child has also been associated with more negative impact on well being than other categories of kin relationship to a mentally ill relative (Biegel, Sales, & Schulz, 1991).

#### *Blending the caregiving role and the employment role*

Although in some caregiver research there has been an attempt to look at mediators of caregiver stress, such as respite services and social supports to the caregiver, a more expansive approach to the social ecology within which caregiving takes place is only beginning to be fully investigated (Cantor, 1991; Kahana et al., 1994). For example, one social structural factor that may be making caregiving particularly difficult is the increasing need to combine caregiving with employment (Seccombe, 1992). Both women and men are working more and more hours in an economy that is downsizing and where the real income of most Americans has been declining. The

pressures of an employment structure that has *not* been historically organized to facilitate employees' fulfillment of family care responsibilities leads to the prediction here that assuming the caregiving role for an employee will be associated with an exacerbation of work and family conflict among employed caregivers.

If this turns out to be the case, and work and family conflict is also associated with poorer well-being, it can be hypothesized that one mediator of the negative effects of caregiving might be the degree to which work and family conflict is experienced by caregivers. In the gerontological caregiving literature, for example, it is becoming more apparent that so-called "women in the middle" are actually more likely to be in the middle of elder care and employment responsibilities than in the middle of elder care and young child care responsibilities (Brody, 1990; Seccombe, 1992). And for men, who may be increasingly called upon into the caregiving role from both egalitarian relationship pressures and demographic pressures (e.g., no sisters or no wives), employment responsibilities are also a good candidate for being a problematic factor in being responsible for family care.

A large proportion of caregivers for disabled and frail family and friends are, in fact, employed (Marks, 1996; Stone et al., 1987). Caregivers report a number of ways in which caregiving and work roles interfere with each other (Stone et al., 1987; Scharlach & Boyd, 1989; Gottlieb, Kelloway, & Fraboni, 1994). However, no study has systematically assessed whether caregivers truly have *more* negative work to family spillover and more negative family to work spillover than noncaregivers, and whether this helps account for negative effects of caregiving on well-being.

Spitze, Logan, Joseph, and Lee's (1994) study using data from a representative sample of N=763 midlife (aged 40 to 65) men and women respondents to their 1988 survey of upstate New York residents comes closest to considering the issues also under consideration here with population

data. Their goal was to examine different roles (spouse, parent of minor coresident child, parent of adult coresident child, helper to parents, helper to adult children) and their combinations for midlife adults and to consider how different roles and their interactions with each other affected psychological well-being (burden, distress, life satisfaction). The results of their analyses suggested that hours of help provided to parents was not associated with a difference in well-being among women; among men, help to parents was associated with more distress. Combining employment with help to parents somewhat buffered the association of help to parents with distress for men-- suggesting that the caregiver role and the work role do *not* tend to conflict for men, leading to poorer well-being. No significant interaction effect for this combination of roles for women also suggested that combining employment with helping a parent was not a major problem for women's well-being. However, while this study represents an important contribution to the literature, caution must be used in generalizing its results to all caregivers, since the measure of caregiving used was based on hours of help provided and no constraint was made on the parent's condition that led to such help (that is, there is not a specification that disability led to the help; it might have well been a reciprocal exchange of help between two healthy generations of adults). Also only help to parents and adult children (also likely to be healthy) was considered; this study did not consider caregiving for a disabled child, spouse, or other kin and nonkin.

To summarize, while a large literature exists regarding caregiving and well-being, a number of serious limitations exist in this literature as well. The vast majority of studies utilize small, purposive samples of caregivers. These studies are well-suited to examining intragroup differences *among* caregivers, but they do not give us an understanding of how different caregivers are from otherwise similar noncaregiving members of the population. Many studies do not include men, making gender

comparisons impossible. Most studies only examine one kinship relationship type of caregiving (e.g., spousal caregiving or adult child caregiving) or and do not allow for comparisons of well-being effects across kinship relationship types. In-household and out-of-household caregiving is not often differentiated. Well-being outcomes are often limited to depression and sometimes life satisfaction, but a full range of potential positive outcomes is not usually examined. Work to family spillover and family to work spillover has never yet been systematically contrasted between caregivers and noncaregivers, and although there is much discussion in the literature on the potential for this to be a problem for caregivers, no careful examination of whether work and family negative spillover helps account for negative outcomes for caregivers in contrast to noncaregivers has ever been undertaken.

This study addresses these gaps in the caregiving literature in the following ways: 1) it utilizes a large population sample that includes both caregiving and noncaregiving women and men, 2) it provides contrasts between caregivers to disabled children, caregivers to spouses, caregivers to parents in-household, caregivers to parents out-of-household, caregivers to other kin and nonkin, and noncaregivers; 3) it examines an expansive array of positive and negative well-being indicators, including self-reported health; 4) it evaluates differences in work to family negative spillover and family to work negative spillover between caregivers and noncaregivers; and 5) it systematically examines whether work and family conflict help account for negative effects of caregiving on well-being.

Based on the current literature on caregiving and life course role-identity theory, this study investigated the following hypotheses:

Hypothesis 1: Persons who have a caregiver role will evidence poorer well being (all

dimensions) than noncaregivers.

Hypothesis 2: Gender will moderate the effect of caregiving such that the well-being effects of caregiving will be more deleterious for women in contrast to men.

Hypothesis 3: Persons who have a caregiving role will report more work stress spillover to family and family stress spillover to work (i.e., work and family conflict) than noncaregivers.

Hypothesis 4: Gender will moderate the effect of caregiving on work and family conflict such that women (who are typically more personal-care intensive caregivers) will report more work and family conflict associated with the caregiver role than men.

Hypothesis 5: Work and family conflict differences between caregivers and noncaregivers will help account for the negative effects of caregiving on midlife well-being.

## **METHODS**

### *Data*

Data from the Wisconsin Longitudinal Study (WLS) were used for these analyses. The WLS is a long-term study of a random sample of 10,317 men and women who graduated from Wisconsin high schools in 1957. Survey data were collected from the original respondents or their parents in 1957, 1964, and 1975. In 1992-93, when most respondents were 53 or 54 years old, 10,031 (97.2%) of the original 1957 sample of men and women were located. Computer-assisted telephone interviews (averaging about 1 hour) conducted by trained interviewers employed by the Letters and Science Survey Laboratory at the University of Wisconsin-Madison were completed with 89.8% of still-living respondents (N = 8,493). Twenty-page mail-back surveys were received from 80.9% of telephone respondents (N = 6,875). Mail-back questionnaire data in 1992-1993 included extensive information about health, psychological distress, positive psychological well-being, and work and

family stress spillover. Although this is a longitudinal study, the data for these analyses were all obtained from the respondents who mailed back the 1992-1993 surveys. The response rate for the mailback data used for this analysis is about 73% of living original sample (1957) respondents. (For additional survey design details see Hauser et al., 1994.) The analytic sample used for this study is the subsample of mailback questionnaire respondents who were employed full or part-time--about 80% of the women (n=2926) and 94% of the men (n=2856).

Only a few WLS respondents are not non-Hispanic White due to the population composition of Wisconsin in 1957 and the fact that minority residents during that era were much less likely to complete high school. (The overall high school completion rate in Wisconsin in 1957 was approximately 75%.) Because WLS respondents are all high school graduates they represent a somewhat advantaged population group. However, they are still relatively representative of the approximately 66% of the U.S. population now in their mid-50s who are non-Hispanic White and high school graduates (Kominski & Adams, 1992).

### *Measures*

Outcomes. *Psychological distress* was measured with a slightly adapted version of the 20-item Center for Epidemiological Studies Depression (CES-D) index (Radloff, 1977). Respondents were asked to rate how many days in the last week (0-7) they experienced each of 20 symptoms (e.g., feel sad, feel depressed, feel bothered by things that usually don't bother you). Cronbach's alpha for this scale is .88. (See Table 1 provides descriptives for analysis variables; see the Appendix for a full listing of index items.)

[Table 1 about here]

*Hostility* was measured with a three-item index that asked respondents to indicate how many

days in the last week they felt irritable, or likely to fight or argue; felt like telling someone off; and felt angry or hostile for several hours at a time. Cronbach's alpha for this index is .77.

Positive psychological wellness was measured using six self-administered scales developed and validated by Ryff (1989; Ryff & Keyes, 1995). Each scale included seven items where respondents were asked to "decide the extent to which each statement describes you." Respondents were given a six-point response scale, ranging from *disagree strongly* to *agree strongly* (e.g., for self-acceptance--"The past has had its ups and downs, but in general, I wouldn't want to change it"; for environmental mastery--"I am quite good at managing the many responsibilities of my daily life"; for positive relations with others--"I know I can trust my friends, and they know they can trust me"; for purpose in life--"I enjoy making plans for the future and working to make them a reality"; for autonomy--"My decisions are not usually influenced by what everyone else is doing"; for personal growth--"I think it is important to have new experiences that challenge how I think about myself and the world"). Internal consistency (Cronbach's alpha) for each scale is acceptable: self-acceptance (.79), environmental mastery (.72), positive relations with others (.78), purpose in life (.78), autonomy (.69), and personal growth (.76).

A standard one-item measure of self-rated health was examined. Respondents were asked, "How would you rate your health?" Five response categories were provided ranging from and given ranging from very poor (1) to excellent (5).

Predictors. Caregiving for disabled family members and friends was measured with responses to the telephone question: "Sometimes because of a physical or mental condition, illness, or disability, people have trouble taking care of themselves and require the assistance of friends or relatives. During the last 12 months have you, yourself, given personal care for a period of one month or more

to a family member or friend because of a physical or mental condition, illness, or disability?” If respondents answered yes, they were asked: “To whom did you give the most personal care?” A series of additional follow-up questions were also asked regarding where the care took place and the extent of care given.

Table 2 details the distribution of caregiving across men and women and the results of t-tests of bivariate level gender differences. In the caregiver (total) row we find that about 9% of employed men and about 15% of employed women reported giving care for one month or more during the last 12 months. In analyses (not shown) I compared the caregiving rates for the employed only sample and full sample in the WLS and found they were almost identical. In the full sample about 12.7% of persons reported giving care in the last year. The additional fraction resulted from slightly more care for parents and other persons reported by the full sample.

[Table 2 about here]

One in eight persons is hardly an insignificant proportion of the population to report this degree of personal care. However, to further put this cross-sectional estimate in life course context, an additional estimate of lifetime prevalence of caregiving of this type was computed for this sample based on a pooling of the respondents who answered “yes” to the one year incidence question and those who answered yes to a follow-up question asked only of those who said “no” to the one-year question: “Have you *ever* given care for a period of one month or more to a family member or friend who, because of along-term physical or mental condition, illness or disability was not able to take care of him- or herself?” The resulting estimates indicated that the lifetime incidence of such intense caregiving at about age 53 among these employed adults was about one in three overall (31.5%); about 1 in 4 (23.8%) for men, and about 2 in 5 (39.4%) for women. Caregiving rates were

significantly higher for women than men in every case besides disabled child care and other care in the home.

Breakdowns of caregiving by care recipient type in Table 2 indicate that caregiving for parents is most prevalent--and that this care takes place both in the home and out of the home. Caregiving for other persons--this can include grandparents, siblings, aunts, uncles, friends, etc.--is next in prevalence (and yet this is usually not included in caregiver studies). Care for others usually takes place outside the home. Caregiving for spouses was always done in the home. Caregiving for children was almost always also done in the home. Therefore, I constructed the following mutually exclusive caregiving type categories to be contrasted with noncaregivers: disabled child care, spouse care, parent care (in household), parent care (out-of-household), and other care.

Mediators. Two work and family conflict scales were evaluated as potential mediator variables for caregiving and well-being relationships. Four items assessed family stress spillover to work (e.g., “Family worries or problems distract me from my work”, Cronbach’s alpha=.72) and three items assessed work stress spillover to family (e.g., “My job reduces the amount of time I can spend with the family, Cronbach’s alpha=.59). Items for both indexes were self-rated from 1=strongly disagree to 5=strongly agree.

Demographic controls. A number of additional demographic factors known to be associated with well-being (Ross, Mirowsky, & Goldsteen, 1990) were also controlled in these analyses. Marital status was ascertained during the telephone interview. Respondents were coded 1 if presently married, 0 otherwise. The presence of a child (biological, adopted, or step) under age 19 in the household was determined from a listing of household members and their ages that was also elicited from all telephone respondents.

Years of completed education were included as a continuous measure. Household income, which included estimates of earnings and other income across all members of the household was computed. To avoid excluding cases where there was some missing data on household income, a dichotomous variable for missing on income was also included in multivariate analyses.

Analytic sequence. Ordinary least squares multiple regression analyses were employed to examine the relationships between caregiving and well-being as well as caregiving and work and family stress spillover. Gender interaction variables for each caregiving type (e.g., Gender X Disabled Child Care) were created and included in initial analyses to examine differences between men and women in the effects of caregiving and also work and family stress spillover on well-being. Since a number of gender interactions were found in combined gender analyses, additional analyses of women and men separately were undertaken, and the results from these latter analyses are reported here (with significant gender interactions from combined-gender models also noted).

## **RESULTS**

### *Caregiving and Work and Family Conflict*

To evaluate Hypothesis 3 regarding the association of caregiving with work and family conflict and Hypothesis 4 regarding gender differences in the degree to which the caregiving role would lead to work and family conflict, I began by examining models that regressed the two work and family spillover measures on caregiving role types along with the additional demographic controls. The results of these models are reported in Table 3.

[Table 3 about here]

The predictors of work stress spillover for women suggest that being a caregiver for a disabled parent in residence in the last year is associated with reporting more work stress spillover

into family life than being a noncaregiver. Additionally, trend effects suggest that disabled child care, spouse care, and parent care out of the household are also related to more work stress spillover for women. Among men, spouse care was significantly related to work stress spillover, and a trend effect also emerged for parent care out-of-household. No significant gender interaction effects were found in combined gender analyses; therefore, Hypothesis 4, that women caregivers would experience exacerbated work stress spillover to family due to caregiving was not supported for this outcome. However, for women, other than for other care, and for men giving care to spouses and parents out of household, Hypothesis 3, predicting that the caregiver role would be related to work stress spillover was confirmed.

In the case of family stress spillover to work, there is even clearer evidence of support for Hypothesis 3. For women, in every case again except other care there is a robust association between being a caregiver and reporting more family stress spillover; for men, this strong relationship extends to all types of caregiving. Again, however, only one significant gender interaction effect was observed in combined-gender models, suggesting that family stress spillover to work is even more accentuated for men than for women who undertake the role of spouse caregiver. This result is clearly contrary to Hypothesis 4 regarding gender differences in the impact of gender on work and family conflict. Overall, the hypothesis that caregiving is positively associated with work and family conflict is supported here (Hypothesis 3), by the hypothesis that women caregivers experience more work and family conflict than men caregivers is clearly refuted.

#### *Caregiving, Work and Family Conflict, and Midlife Well-Being*

To examine the associations between caregiving and well-being, preliminary models regressing all of the well-being outcomes on gender, the caregiving role types, Gender X Caregiving

Role Type interactions, and demographic controls were estimated. The results of these analyses provided evidence of a number of gender interaction effects. Therefore, it was deemed advisable to proceed by examining models for women and men separately. The results of these analyses are reported as Model 1 in Tables 4-5, with superscript notation indicating significant gender interactions found in the combined gender models.

For each outcome a second model was then estimated, adding the measures for family stress spillover and work stress spillover into the equation. The results of these estimations are reported as Model 2 in Tables 4-5.

[Table 4 about here]

In the first model predicting psychological distress, being a caregiver for a disabled child, spouse, or parent in or out of the home was associated with more distress for working women (supporting Hypothesis 1). In the second model when work and family stress spillover is controlled, though, the negative effects of parent care in or out of the home are reduced to nonsignificance, and the effects for spouse care and child care are each considerably reduced (supporting Hypothesis 5). For men, the only distinctive negative effect of the caregiving role on depression was found in the case of being a caregiver to a spouse. Contrary to Hypothesis 1, providing care to persons outside one's immediate family (other care) was actually associated with *less* depression. Further, when family and work stress spillover was held constant across men caregivers and noncaregivers, the negative effect of spouse care was reduced by half and the beneficial effects associated with other care even increased (supporting Hypothesis 5). It is also useful to note (as evidence of mediation) that both family stress spillover and work stress spillover show evidence of being independently robustly associated with psychological distress, as they prove to be with every subsequent well-being

outcome examined here.

Only one gender interaction was found in the combined gender analyses predicting psychological distress. Women caring for a disabled child were significantly more distressed by this role than men caring for a disabled child. This finding provides only limited support for Hypothesis 2, which predicted that women would experience more negative effects from the caregiver role than men.

Examining hostility among women, interestingly, only women providing care to other kin and nonkin reported more hostility than noncaregiving women. There was also a suggestion by a trend effect that women providing care for a disabled child might experience more hostility. When work and family conflict was adjusted for in Model 2 for women, the other care effect was considerably reduced and the trend effect for disabled child care no longer remained.

Men providing spouse care reported more hostility than noncaregiving men; men providing out-of-home care to parents also evidenced a trend toward more hostility (Model 1). Controlling for work and family conflict (Model 2) reduced by about a quarter the negative effect for spouse care and eliminated the negative trend effect for nonresidential parent care (more support for Hypothesis 5).

Only one significant gender interaction was observed in predicting hostility; spouse care was associated with more hostility for men than for women. This result is contrary to what Hypothesis 2 predicted.

In the case of health, for working women, disabled child care and spouse care was associated with poorer reported health (Model 1; support for Hypothesis 1). But when family and work stress spillover were controlled, the negative effect of disabled child care was considerably reduced and the

negative effect of spouse care was eliminated. Among employed men, health among caregivers was not different than that of noncaregivers. Controlling for work and family conflict revealed that there may be a suppressed tendency for spouse caregiver men to report somewhat better health than noncaregiving men.

Only one significant gender interaction was observed in the case of health; the effect for men's spousal caregiving was significantly less deleterious for self-reported health than the effect of women's spousal caregiving (supporting Hypothesis 3).

Table 5 reports the results of analyses of the effects of caregiving on the six Ryff measures of positive psychological wellness and development. Interestingly, contrary to what Hypothesis 1 predicted, there were no differences between caregivers and noncaregivers in reports of autonomy. Neither were there gender differences in the effects of caregiving on autonomy (contrary to Hypothesis 2). When work and family conflict were added to Model 2, trend effects emerged suggesting possibly suppressed positive associations between autonomy and caregiving for a parent out of the household and other care among women, and spouse care among men (supporting Hypothesis 5).

[Table 5 about here]

Considering positive relations with others, we find women who provide care to persons other than their nuclear family actually providing higher ratings than noncaregiving women. Again, when family and work conflict is added to Model 2, a suppressed tendency for parent care, both in and out of the household, to be associated with positive effects is revealed.

Men giving other care reported more positive relations with others, although a trend effect also suggested men providing spouse care might assess the quality of their relations with others less

positively than noncaregiving men (Model 1). Again, when work and family conflict are controlled (Model 2), suppressed positive effects of disabled child care and residential parent care emerge, and the positive association between other care and positive relations increases (more support for Hypothesis 5).

For women, disabled child care is associated with less purpose in life (Model 1; limited support for Hypothesis 1). However, when work and family stress spillover is controlled for (Model 2), this negative effect is eliminated and suppressed positive associations between residential parent care and (at a trend level) other care are evident (support for Hypothesis 5).

Men giving care to others report more purpose in life (contrary to Hypothesis 1); however, men providing spouse care reported less purpose in life than noncaregiving men (supporting Hypothesis 1). Yet again when work and family conflict is held constant across all men, the negative effect of spouse care is eliminated, the positive effect of other care increases, and a trend effect indicating a suppressed beneficial effect of parent care in the household emerges (support for Hypothesis 5).

Disabled child care is associated with less self-acceptance than noncaregiving among women (limited support for Hypothesis 1). This negative effect is observed only for women and not men (limited support for Hypothesis 2). When work and family conflict are controlled in Model 2, the negative effect of disabled child care is no longer significant, and trend effects suggesting suppressed positive effects of residential parent care and other care among men again become evident (support for Hypothesis 5).

In the case of environmental mastery, disabled child care and parent care roles for women are associated with poorer reports than being a noncaregiver (supporting Hypothesis 1). Consistent with

the pattern observed for other outcomes, when work and family conflict is controlled, again, all of the significant negative effects disappear for women. The negative effect associated with spouse care for men also shows a similar pattern of mediation.

Finally, disabled child care among women is associated with a trend toward lower reports of personal growth, but controlling for work and family conflict eliminates this negative trend effect and allows positive suppressed effects for nonresidential parent care and other care to become evident.

The role of caregiver to persons other than immediate family was positively associated with reports of personal growth for men (contrary to Hypothesis 1). When Model 2 also controlled for work and family conflict, this positive effect increased and an additional positive association of spouse care with personal growth was also revealed.

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

The results of this complex analysis of midlife caregiving and well-being suggest a number of intriguing conclusions. First, it is notable that about one in eight employed midlife adults indicated that they had given personal care for one month or more to a disabled or frail relative or friend, and that overall, one in three by age 53-54 had provided this type of care at least *sometime* in the past. Such rates of caregiving suggest that the caregiver role, indeed, is an important life course role to consider along with several more typically considered roles (e.g., marital partner, employee, parent) when considering adult roles and their influence on adult well-being and development for men as well as women.

Second, a global assessment of the caregiving role as being necessarily deleterious for well-being was not substantiated here. The first hypothesis that caregiving would be uniformly associated with negative effects on well-being was far from completely supported across outcomes assessing

psychological distress, psychological wellness, and health. The results of the first model (Model 1) estimated across all nine outcomes, which included forty-five caregiver role by outcome associations, all of which would have been expected to be significant and negative given the “stressor” view of caregiving, yielded only eleven cases where women caregivers evidenced clearly worse well-being in contrast to women noncaregivers. Consistent with previous literature that has emphasized psychological distress associated with caregiving, caregiving was associated with more psychological distress for women caring for a child, spouse, or parent in or out of the household. Other care was also associated with more hostility for women, and child care and spouse care was associated with poorer health for women.

In the case of positive psychological outcomes there were fewer negative effects. Women caregivers for a disabled child evidenced less purpose in life, less self-acceptance, and less environmental mastery. Caring for a parent out of the household was also associated with poorer ratings of environmental mastery for women. In all other cases, caregiving women were found to be no different in dimensions of positive psychological well-being and health than noncaregiving women.

For men, only spouse care was associated with negative effects on well-being. Men spouse caregivers reported more psychological distress, more hostility, less purpose in life, and less environmental mastery than men not providing care. In the majority of cases, the caregiving role was not associated with different well-being in contrast to being a noncaregiver for men. In fact, quite contrary to the first hypothesis of negative effects due to the caregiving role, a few *positive* effects of the caregiving role for men emerged in the initial evaluation of associations between caregiving and well-being (Model 1). Assuming the caregiver role for someone other than an immediate family member was associated with *less* psychological distress, more positive relations with others, more

purpose in life, and more personal growth for men. It is likely that providing other care is more voluntary and less intense than providing care to a disabled child, spouse, or parent, and that this may account for some of these more positive associations. It is also possible that some reverse causality may be taking place here--i.e., men with better well-being are more likely to take on the role of caregiver for kinsperson or friend than men with poorer well-being. The effects of this role-relationship type of caregiving have seldom been studied, yet as the pool of immediate family members available for care is expected to dwindle, and as caregiving in the future may need to be shared more frequently among a network (Cantor, 1979; Penrod, Kane, Kane, & Finch, 1995), such caregiving may be expected to increase. Therefore, it is promising to consider that assuming the caregiver role in such cases may not be associated with a decline in well-being--it may actually offer a buffer from distress and an opportunity to feel even better about one's relations with others, purpose and growth than not being a caregiver.

Do women caregivers suffer more serious well-being consequences than men caregivers (as predicted by Hypothesis 2)? The results of this analysis suggest that in the majority of caregiving cases, the answer to this question is no. Only four significant ( $p < .05$ ) gender interactions were noted here. Women caregivers for a disabled child reported more psychological distress and self-acceptance than men caregivers for a disabled child. Women also did not get the well-being benefit of other care evidenced by men in the case of psychological distress. Clearly contrary to the hypothesis of more negative effects for women in contrast to men, men providing spouse care reported significantly more hostility than women providing spouse care.

Is the caregiving role associated with more work and family conflict than being a noncaregiver (as predicted by Hypothesis 3)? These results suggest the answer to this question is

clearly yes, especially for family stress spillover to work, but also perceived work stress spillover to family.

Is the caregiving role associated with even more work and family conflict for women caregivers in contrast to men caregivers (as suggested by Hypothesis 4)? No, in the vast majority of cases the caregiver role does not appear to be associated with more work and family conflict for women than men. In fact, the only clear gender difference found here was contrary to hypothesis: men spouse caregivers reported more work and family conflict than women spouse caregivers.

Do work and family conflict differences between caregivers and noncaregivers help account for the negative effects of caregiving that are observed (as predicted by Hypothesis 5)? Yes, clearly, when work and family conflict is held constant across caregivers and noncaregivers, in only five cases do negative effects remain present--more distress for women and men caregiving for a spouse, more hostility for men spouse caregivers, more distress and poorer health for women caring for a disabled child. In all of these cases the negative effects of caregiving are considerably attenuated by controlling for work and family conflict.

In every other case, negative effects of caregiving are eliminated once work and family conflict differences are accounted for. And, remarkably, if differences in the amount of work and family conflict associated with caregiving in contrast to noncaregiving for employed adults are eliminated, a number of unexpected *positive* suppressed effects of caregiving on well-being become evident. Specifically, among women, more positive relations and purpose in life is associated with caregivers of parents in the home in contrast to noncaregivers; more positive relations and personal growth is associated with the caregiver role for parents out of the home in contrast to noncaregivers; more personal growth is associated with the caregiver role for those providing other care than for

noncaregivers. Among men, adjusting for work and family conflict providing care for a disabled child is associated with more positive relations with others than being a noncaregiver, providing spouse care is associated with more personal growth than being a noncaregiver, being a caregiver for a parent in the household is associated with more positive relations than being a noncaregiver, and the beneficial effects of providing other care on less psychological distress, more positive relations with others, more purpose in life, and more personal growth substantially increase.

This study, like all cross-sectional analyses, cannot be definitive about its inferences of causality. In some cases it is plausible that higher well-being has led to taking on the caregiving role rather than caregiving leading to well-being. This is less likely in the case of disabled child care and spouse care, where there is no choice in assuming the caregiver role. Also, in many cases of elder care there is likely to be only a limited amount of choice about assuming this role. Reverse causality may be more likely in some cases of other care.

Further, while this study did delineate that personal care be provided to a disabled family member or friend for one month or more in the last year (a relatively stringent definition of caregiving), it did not further delineate differences in the intensity of the caregiver role that have been shown to contribute to differences in work and family conflict (Gottlieb et al., 1994). Neither was an indicator of primary caregiver vs. secondary caregiver available to factor into this analysis. Additionally, since this was an all Caucasian sample, it would be useful to replicate these findings for other ethnic groups before generalizing too broadly from these results.

Nonetheless, these results clearly suggest that it does not always hurt to care. Certainly, caregiving for immediate family members is associated with more psychological distress for employed women in contrast to noncaregiving; additionally, disabled child care is associated with less physical

and psychological wellness for women. However, if steps were taken to make work and family conflict less problematic for employed caregiving women, women caregivers would evidence considerably less distress than they currently do; and some additional psychological benefits of the caregiving role would emerge more clearly.

Similarly, employed midlife men who are providing care for a disabled spouse are at clear risk for poorer psychological well-being. However, if the increased work and family conflict currently associated with caregiving for these men was eliminated, the negative effects of spouse care would be considerably attenuated, and the positive effect providing spouse care has on the experience of personal growth would become more evident.

Addressing ways to ameliorate work and family conflict among caregiving men and women is critical for reducing the well-being drawbacks of caregiving and increasing the well-being benefits of caregiving. Undoubtedly, we need more research to determine exactly what types of social policies might contribute to the amelioration of this work and family conflict associated with caregiving. Some obvious examples are more flexible time schedules, more availability of quality part time work, “sick” leave and family leave time allowable for family care purposes, informational resources, additional day programs and services for disabled elders and other family members that might relieve the worries of working kin and nonkin caregivers (Neal, Chapman, Ingersoll-Dayton, Ellen, 1993; Seccombe, 1992). Restructuring social institutions, particularly workplaces and caregiver support, so as to socially reconstruct and “remake” (Stryker, 1980) the behavioral expectations of the employee role-identity to become more congruent with the behavioral expectations incumbent upon individuals who must also enact caregiving roles of various types across the life course is critical to ensuring and enhancing adult well-being and development.

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**TABLE 1. DESCRIPTIVES FOR ANALYTIC VARIABLES**

<b>Variable</b>	<b>Total</b>	<b>Men</b>	<b>Women</b>	<b>Cronbach's alpha</b>
	<b>Mean (SD)</b>	<b>Mean (SD)</b>	<b>Mean (SD)</b>	<b>(# of items)</b>
<b><u>OUTCOMES</u></b>				
<b><u>Psychological Distress and Health</u></b>				
Depression (CES-D)	19.2 (14.1)	18.0 (12.9)	20.3 * (15.2)	.88 (20)
Hostility	1.7 ( 2.6)	1.7 ( 2.5)	1.8 ( 2.7)	.77 ( 3)
Global Health	4.2 ( .6)	4.17 ( .6)	4.21 * ( .6)	NA ( 1)
<b><u>Psychological Well-Being and Development</u></b>				
Autonomy	31.6 (5.3)	32.1 * (4.9)	31.2 (5.7)	.69 ( 7)
Personal Relations with Others	34.1 (5.4)	33.0 (5.4)	35.3 * (5.2)	.78 ( 7)
Purpose in Life	34.3 (5.5)	34.1 (5.2)	34.4 * (5.7)	.78 ( 7)
Self-Acceptance	33.4 (5.9)	33.3 (5.6)	33.5 (6.2)	.79 ( 7)
Environmental Mastery	33.9 (5.0)	33.8 (4.8)	34.0 * (5.1)	.72 ( 7)
Personal Growth	33.4 (5. )	32.8 (5.4)	34.0 * (5.5)	.76 ( 7)
<b><u>MEDIATORS</u></b>				
<b><u>Work and Family Conflict</u></b>				
Family Stress Spillover to Work	8.9 (2.8)	8.8 (2.7)	9.0 * (2.9)	.72 ( 4)
Work Stress Spillover to Family	7.9 (2.5)	8.1 * (2.4)	7.6 (2.5)	.59 ( 3)
<b><u>DEMOGRAPHIC CONTROLS</u></b>				
Married	82.7%	87.1% *	78.3%	
Child < 19 yrs in household	15.7%	20.5% *	10.8%	
Education	13.8 (2.4)	14.1 * (2.5)	13.5 (2.1)	
Household Income	85502 (203918)	99592 (264758)	61011 (59830)	
Missing on household income	.29	.21	.38 *	

Source: Wisconsin Longitudinal Study, 1992-93, employed mailback respondents.

\* Mean for this gender group is significantly larger than the mean for the other ( $p < .05$ ).

**TABLE 2. PERCENTAGE DISTRIBUTION (SAMPLE *n*):  
MIDLIFE CAREGIVING TYPE BY GENDER**

	<b>Men</b> ( <i>n</i> =2856)	<b>Women</b> ( <i>n</i> =2926)	<b>Total</b> ( <i>n</i> =5782)
<b>CAREGIVING TYPE</b>			
Caregiver in home	4.0	6.0	5.0 *
Caregiver out of home	4.2	8.5	6.3 *
Caregiver (total)	8.8	15.1	11.9 *
<hr/>			
Disabled Child Care in home	.7	1.2	1.0
Disabled Child Care out of home	.1	.4	.3
<b>Disabled Child Care (total)</b>	<b>.9</b>	<b>1.4</b>	<b>1.1</b>
<hr/>			
Spouse Care in home	1.4	2.5	2.0 *
Spouse Care out of home	.0	.0	.0
<b>Spouse Care (total)</b>	<b>1.4</b>	<b>2.5</b>	<b>2.0 *</b>
<hr/>			
Parent <sup>1</sup> Care in home	.9	2.0	1.4 *
Parent <sup>1</sup> Care out of home	2.3	4.8	3.5 *
<b>Parent<sup>1</sup> Care (total)</b>	<b>3.3</b>	<b>6.9</b>	<b>5.1 *</b>
<hr/>			
Other <sup>2</sup> Care in home	1.3	.8	1.1
Other <sup>2</sup> Care out of home	1.9	3.9	2.8 *
<b>Other<sup>2</sup> Care (total)</b>	<b>3.1</b>	<b>4.3</b>	<b>3.7 *</b>

Source: Wisconsin Longitudinal Study, 1992-93, employed mailback respondents.

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

Note: Some totals do not add up due to rounding error.

<sup>1</sup> Parent care includes care for stepparents and parents-in-law.

<sup>2</sup> Other care includes care for other relatives and other nonkin.

**TABLE 3. UNSTANDARDIZED OLS REGRESSION ESTIMATES OF  
THE EFFECTS OF CAREGIVING TYPES ON WORK AND FAMILY CONFLICT**

<u>Predictors</u>	<u>Work Stress Spillover to Family</u>		<u>Family Stress Spillover to Work</u>		
	<u>Women</u>	<u>Men</u>	<u>Women</u>	<u>Men</u>	
No care for disabled	--	--	--	--	
Disabled child care	.62+	.34	1.84***	2.44***	
Spouse care	.47+ <sup>b</sup>	1.06*** <sup>b</sup>	.89*** <sup>a</sup>	1.93*** <sup>a</sup>	
Parent care (home)	.69*	.59	1.89***	1.71***	
Parent care (out of home)	.32+	.43+	.87***	.57 *	
Other care		.10	.16	.33	.53 *
Constant	6.88**	6.73**	7.98***	7.90***	
R <sup>2</sup>	.01	.02	.04	.03	

Source: Wisconsin Longitudinal Study 1992-93, employed mailback respondents.

Note: Models also controlled for marital status, parental status, education, and household income.

<sup>a</sup> A significant gender difference ( $p < .05$ ) was noted in a combined-gender model.

<sup>b</sup> A significant gender difference ( $p < .10$ ) was noted in a combined-gender model.

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

**TABLE 4. UNSTANDARDIZED OLS REGRESSION ESTIMATES OF THE EFFECTS OF CAREGIVING TYPES AND WORK AND FAMILY CONFLICT ON PSYCHOLOGICAL DISTRESS AND SELF-REPORTED HEALTH**

<u>Predictors</u>	<u>Psychological Distress</u>		<u>Hostility</u>		<u>Health</u>	
	<u>Model 1</u>	<u>Model 2</u>	<u>Model 1</u>	<u>Model 2</u>	<u>Model 1</u>	<u>Model 2</u>
<b><u>Women</u></b>						
No care for disabled	--	--	--	--	--	--
Disabled child care	10.33*** <sup>a</sup>	7.22**	.78+	.43	-.23* <sup>b</sup>	-.18*
Spouse care	5.41**	3.89*	.17 <sup>a</sup>	-.04	-.13* <sup>b</sup>	-.09
Parent care (in home)	4.16*	1.07	.14	-.22	-.07	-.01
Parent care (out of home)	2.80*	1.24	.13	-.05	-.03	-.01
Other care	1.63 <sup>a</sup>	.81	.57* <sup>b</sup>	.49*	-.05	-.04
Family stress spillover		1.12***		.11***		-.02***
Work stress spillover		1.21***		.22***		-.03***
Constant	34.51***	17.25***	2.85***	.43	3.63***	4.01***
R <sup>2</sup>	.03	.16	.01	.09	.03	.06
<b><u>Men</u></b>						
No care for disabled	--	--	--	--	--	--
Disabled child care	2.47 <sup>a</sup>	-.34	.15	-.15	-.01 <sup>b</sup>	.03
Spouse care	6.42**	3.33*	1.76*** <sup>a</sup>	1.33***	.07 <sup>b</sup>	.14+
Parent care (in home)	1.84	-.43	.15	-.23	-.02	.02
Parent care (out of home)	.75	-.24	.48+	.35	.04	.06
Other care	-3.05* <sup>a</sup>	-3.77**	.03 <sup>b</sup>	-.06	.04	.06
Family stress spillover		.92***		.10***		-.01***
Work stress spillover		1.12***		.23***		-.04***
Constant	24.03***	9.05***	2.04***	.25	3.49***	3.84
R <sup>2</sup>	.03	.14	.01	.09	.04	.07

Source: Wisconsin Longitudinal Study 1992-93, employed mailback respondents.

Note: Models also controlled for education and household income.

<sup>a</sup> A significant gender difference ( $p \leq .05$ ) was noted in a combined-gender model.

<sup>b</sup> A significant gender difference ( $p \leq .10$ ) was noted in a combined-gender model.

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

**TABLE 5. UNSTANDARDIZED OLS REGRESSION ESTIMATES OF THE EFFECTS OF CAREGIVING TYPES AND WORK AND FAMILY CONFLICT ON PSYCHOLOGICAL WELL-BEING AND DEVELOPMENT**

<u>Predictors</u>	<u>Autonomy</u>		<u>Positive Relations</u>		<u>Purpose in Life</u>	
	<u>Model 1</u>	<u>Model 2</u>	<u>Model 1</u>	<u>Model 2</u>	<u>Model 1</u>	<u>Model 2</u>
<b><u>Women</u></b>						
No care for disabled	--	--	--	--	--	--
Disabled child care	-.03	.64	-1.04 <sup>b</sup>	-.33	-1.75*	-.83
Spouse care	.02	.41	.06	.52	-.64	-.06
Parent care (home)	-.24	.48	.49	1.32*	.09	1.19*
Parent care (out of home)	.30	.64+	.38	.78*	-.32	.20
Other care	.66	.77+	1.01*	1.17**	.44	.69+
Family stress spillover		-.26***		-.22***		-.41***
Work stress spillover		-.29***		-.49***		-.39***
Constant	27.08***	31.21***	31.90***	37.07***	26.56***	32.54***
R <sup>2</sup>	.03	.08	.02	.11	.05	.15
<b><u>Men</u></b>						
No care for disabled	--	--	--	--	--	--
Disabled child care	-.06	.81	1.01 <sup>b</sup>	2.03*	-.02	1.04
Spouse care	.92	1.12+	-1.12+	.03	-1.36*	-.27
Parent care (home)	.19	.85	.72	1.62*	.36	1.24+
Parent care (out)	-.24	.00	.28	.64	-.26	.07
Other care	.31	.51	2.07***	2.31***	1.44**	1.69***
Family stress spillover		-.33***		-.35***		-.39**
Work stress spillover		-.25***		-.51***		-.36***
Constant	30.41***	34.65***	32.21***	38.67***	28.62**	34.06***
R <sup>2</sup>	.01	.07	.01	.12	.04	.13

Source: Wisconsin Longitudinal Study 1992-93, employed mailback respondents.

Note: Models also controlled for education and household income.

significant gender difference ( $p \leq .10$ ) was noted in a combined-gender model.

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

<sup>b</sup> A

**TABLE 5. UNSTANDARDIZED OLS REGRESSION ESTIMATES OF THE EFFECTS OF CAREGIVING TYPES AND WORK AND FAMILY CONFLICT ON PSYCHOLOGICAL WELL-BEING AND DEVELOPMENT (continued)**

<u>Predictors</u>	<u>Self Acceptance</u>		<u>Environmental Mastery</u>		<u>Personal Growth</u>	
	<u>Model 1</u>	<u>Model 2</u>	<u>Model 1</u>	<u>Model 2</u>	<u>Model 1</u>	<u>Model 2</u>
<b><u>Women</u></b>						
No disabled care	--	--	--	--	--	--
Disabled child care	-2.60*** <sup>a</sup>	-1.52	-1.86*	-.84	-1.30+	-.67
Spouse care	-.47	.15	-.77 <sup>b</sup>	-.07	-.06	.30
Parent care (home)	-1.04	.26	-.99+	.24	-.36	.39
Parent care (out of home)	-.41	.12	-.99*	-.42	.50	.85*
Other care	.33	.57	-.42	-.17	.67+	.81*
Family stress spillover		-.42***		-.40***		-.30***
Work stress spillover		-.49***		-.62***		-.23***
Constant	26.46***	33.23***	30.69***	38.15***	24.59***	28.53***
R <sup>2</sup>	.04	.16	.02	.22	.08	.13
<b><u>Men</u></b>						
No disabled care	--	--	--	--	--	--
Disabled child care	-.05 <sup>a</sup>	1.17	-.41	.71	-.37	.22
Spouse care	-.88	.44	-2.20*** <sup>b</sup>	-.92+	1.01	1.74*
Parent care (home)	.44	1.43+	-1.21	-.26	.50	1.03
Parent care (out of home)	-.24	.18	-.57	-.13	.44	.67
Other care	.55	.85+	.05	.34	1.52**	1.67**
Family stress spillover		-.44***		-.39***		-.19***
Work stress spillover		-.44***		-.54***		-.37***
Constant	28.86***	35.32***	31.45***	38.13***	26.54***	30.54***
R <sup>2</sup>	.03	.14	.02	.18	.04	.09

Source: Wisconsin Longitudinal Study, 1992-93, employed mailback respondents.

Note: Models also controlled for education and household income.

<sup>a</sup> A significant gender difference ( $p \leq .05$ ) was noted in a combined-gender model.

<sup>b</sup> A significant gender difference ( $p \leq .10$ ) was noted in a combined-gender model.

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

## APPENDIX

### I. PSYCHOLOGICAL WELL-BEING SCALES (Ryff, 1989)

Rating scale: Strongly agree--Strongly disagree (6 point scale)

#### Autonomy

My decisions are not usually influenced by what everyone else is doing.

I have confidence in my opinions even if they are contrary to the general consensus.

I tend to worry about what other people think of me.\*

I often change my mind about decisions if my friends or family disagree.\*

I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.

Being happy with myself is more important to me than having others approve of me.

It's difficult for me to voice my opinions on controversial matters.\*

#### Positive Relations with Others

I don't have many people who want to listen when I need to talk.\*

I enjoy personal and mutual conversations with family members and friends.

I often feel lonely because I have few close friends with whom to share my concerns.\*

It seems to me that most other people have more friends than I do.\*

People would describe me as a giving person, willing to share my time with others.

Most people see me as loving and affectionate.

I know I can trust my friends, and they know they can trust me.

#### Purpose in Life

I enjoy making plans for the future and working to make them a reality.

My daily activities often seem trivial and unimportant to me.\*

I am an active person in carrying out the plans I set for myself.

I tend to focus on the present, because the future nearly always brings me problems.\*

I don't have a good sense of what it is I am trying to accomplish in life.\*

I sometimes feel as if I've done all there is to do in life.\*

I used to set goals for myself, but that now seems like a waste of time.\*

#### Self-Acceptance

I feel like many of the people I know have gotten more out of life than I have.\*

In general, I feel confident and positive about myself.

When I compare myself to friends and acquaintances, it makes me feel good about who I am.

My attitude about myself is probably not as positive as most people feel about themselves.\*

I made some mistakes in the past, but I feel that all in all everything has worked out for the best.

The past had its ups and downs, but in general, I wouldn't want to change it.

In many ways, I feel disappointed about my achievements in life.\*

#### Environmental Mastery

I am good at juggling my time so that I can fit everything in that needs to get done.

I often feel overwhelmed by my responsibilities.\*

I am quite good at managing the many responsibilities of my daily life.  
I do not fit very well with the people and community around me.\*  
I have difficulty arranging my life in a way that is satisfying to me.\*  
I have been able to create a lifestyle for myself that is much to my liking.  
I generally do a good job of taking care of my personal finances and affairs.

### **Personal Growth**

I am not interested in activities that will expand my horizons.\*  
I have the sense that I have developed a lot as a person over time.  
When I think about it, I haven't really improved much as a person over the years.\*  
I think it is important to have new experiences that challenge how I think about myself and the world.  
I don't want to try new ways of doing things--my life is fine the way it is.\*  
I do not enjoy being in new situations that require me to change my old familiar way of doing things.\*  
There is truth to the saying you can't teach an old dog new tricks.\*

## **II. CENTER FOR EPIDEMIOLOGICAL STUDIES DEPRESSION SCALE (CES-D)** **(modified from Radloff, 1977)**

**Rating scale: 0-7**

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?
- Think your life had been a failure?
- Feel happy?\*
- Feel that people were unfriendly?
- Feel lonely?
- Enjoy life?\*
- Have crying spells?
- Feel that people disliked you?
- Feel sad?
- Feel depressed?
- Have trouble keeping your mind on what you were doing?
- Not feel like eating, your appetite was poor?
- Feel you were just as good as other people?\*
- Feel everything you did was an effort?
- Feel hopeful about the future?
- Feel fearful?
- Sleep restlessly?
- Talk less than usual?
- Feel you could not "get going"?

## **III. HOSTILITY INDEX**

**Rating scale: 0-7**

On how many days in the last 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?

#### **IV. WORK/FAMILY CONFLICT INDICES**

Rating scale: Strongly agree--Strongly disagree (5 point scale)

##### **FAMILY STRESS SPILLOVER TO WORK INDEX**

Family matters reduce the time I can devote to my job.

Family activities stop me from getting the amount of sleep I need to do my job well.

Family worries or problems distract me from my work.

Family obligations reduce the time I need to relax or be by myself.

##### **WORK STRESS SPILLOVER TO FAMILY INDEX**

My job reduces the amount of time I can spend with the family.

Problems at work make me irritable at home.

My job takes so much energy I don't feel up to doing things that need attention at home.

\* Item reverse-coded.

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