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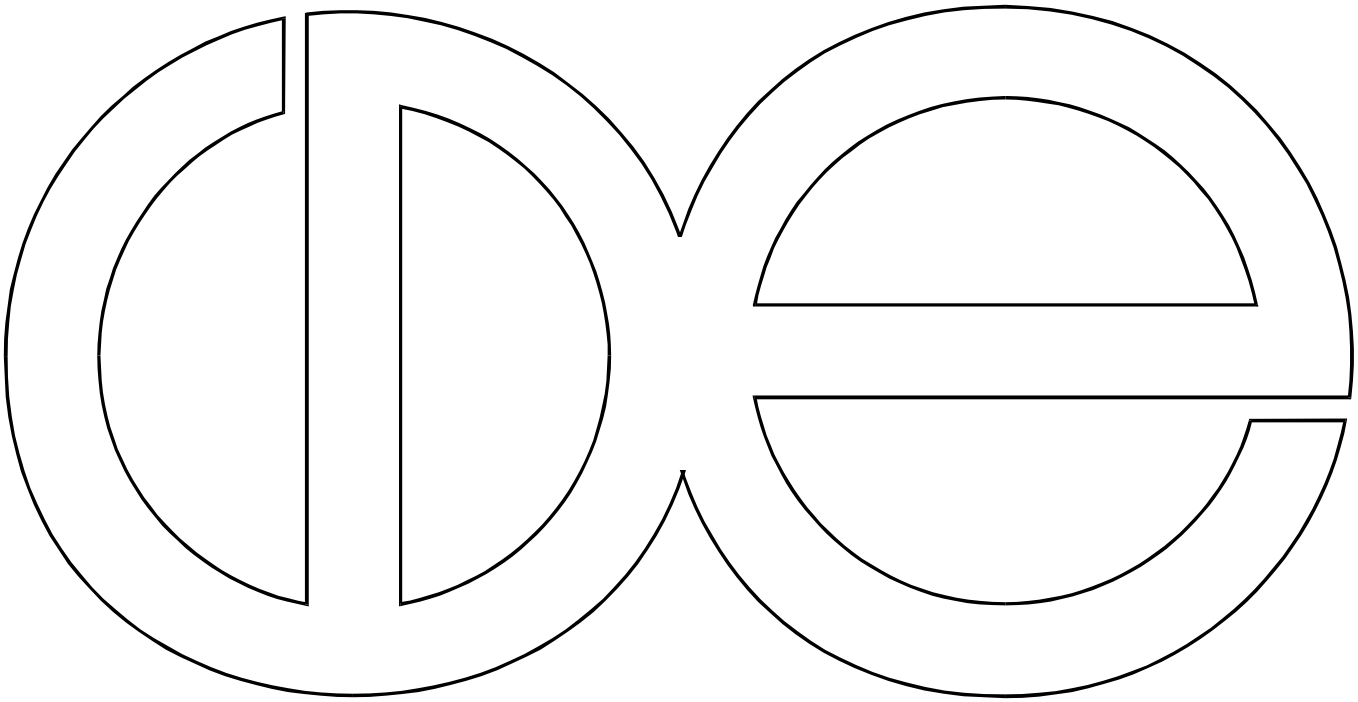

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Abstract

Social relationships are an important factor influencing health, but much existing research linking social relationships with health gives inadequate attention to differential quality of social relationships, potential gender differences in processes linking social relationships and health, and the multiplicity of factors that influence the trajectory of women's social relationships across the lifecourse. This chapter reviews evidence documenting how the structure and quality of women's social relationships with mothers, fathers, siblings, partners, other kin, and friends change from childhood to middle adulthood, and considers how biological, psychological, and social factors uniquely, cumulatively, and interactively influence the quantity and quality of women's social relationships over time. The relative importance of early life course factors for helping to determine later life relationships and relationship quality is discussed. Lifecourse differences between women and men and differences among women of varying socioeconomic status are noted. The chapter concludes with suggestions for future research and implications for policy.

Lifecourse influences on women's social relationships at midlife

The importance of social relationships for health has become increasingly recognized.[1-5] Several prospective studies of mortality from the United States and Europe provide evidence that the existence of social ties predicts lower mortality rates.[6-9] Social support has also been linked to factors implicated in the etiology of physical disease and morbidity, although evidence for these outcomes is less consistent.[1,3,4,5,10-12] The inconsistency in results linking social relationships and morbidity may be due to lack of differentiation of health outcomes as well as lack of sufficient differentiation of social relationship *quality* in much existing research. It has become clear that not all social relations are equally beneficial for mental and physical health. Considering the demands, burden, and strain as well as the beneficial support involved in social relationships is critical to discerning whether and how social ties will influence health,[13] particularly since evidence suggests that negative aspects of people's social networks are more highly associated with well-being than positive aspects.[13,14-16]

The "ties that bind," therefore, have the potential to provide both health-promoting solidarity and health-deterring demands, sometimes at the same time. Social relationships that incur strains as well as gains, or even mainly strains, may be more common among women than men, because women internalize and enact more responsibility for maintaining and providing support in social relationships, especially kin relationships, than men.[17-19] Women may thus be more vulnerable to the costs of caring and maintaining their commitments to social relations.[20,21] These considerations suggest that potential gender differences must be more systematically evaluated when considering linkages between social relationships and health. The mortality advantage of social ties, in fact, has been noted to be somewhat smaller (and sometimes

nonexistent, or even reversed) for women in contrast to men when the genders are considered separately,[4,22] and a qualitatively different meaning of social ties and processes linking social relationships with health for women may play a part in this.[22,23]

Beyond inadequate attention to relationship quality and gender differences in much previous epidemiological research linking social relationships to health, there has been relatively little consideration of how the quality and quantity of social relationships in middle adulthood is cumulatively determined by biological, psychological, and social factors across the lifecourse. The major focus of this chapter is to review evidence documenting how the structure and quality of women's social relationships changes from childhood to middle adulthood. It is guided by a lifecourse perspective on this process, considering how biological, psychological, and social factors uniquely, cumulatively, and interactively influence the quantity and quality of women's social relationships over time, which might, in turn, be expected to influence women's health. Several types of relationships comprising the "convoy" of social ties[24] shaping women's lives are considered--with mothers, with fathers, with siblings, with partners, with children, and with friends. The relative importance of early life course factors for helping to determine later life relationships and relationship quality is examined. Wherever possible, lifecourse differences between women and men, and differences between persons of varying socioeconomic status (SES) are addressed. It concludes with suggestions for future research and implications for policy.

Women's relationships with their mothers

The first significant relationship in a woman's life is most typically with her mother, who is usually her primary caregiver. Attachment theory gives the primary caregiver relationship

significant primacy and suggests that this tie is the prototypical social tie, that it has significant organic underpinnings, and lifelong consequences for the formation and development of other social relationships.[25-27] Not all early ties with mothers are of similar quality. Attachment researchers have differentiated three main styles of early attachment--secure, anxious-avoidant, and anxious-ambivalent.[28] Attachment style results from the degree to which mothers are sensitive, responsive, and accessible to the cues of need provided by infants. Securely attached infants (about 67%) evidence successful use of the caregiver as a secure base when distressed; anxious-avoidant infants (about 21%) evidence avoidance of the caregiver and exhibit signs of detachment when distressed; anxious-ambivalent infants (about 12%) display a mixture of attached behaviors with overt expressions of protest and anger toward the primary caregiver when distressed.[29] A fourth attachment type--disorganized--has been added in recent years to accommodate the incoherent attachment patterns of seriously maltreated children, and is characterized by an anomalous mixture of clinging, avoiding, ambivalent, stilling, freezing, and fear reactions in response to the caregiver.[30,31]

Attachment style is posited to result in internal "working models" both of self and of typical patterns of interaction with significant others.[26,28,32] These internal schemas, in turn, guide social behavior and the development of social relationships. Securely attached persons view themselves as likable and friendly and view significant others as trustworthy and reliable. Persons with an anxious-ambivalent attachment style consider themselves unconfident and misunderstood, and view significant others as being unreliable and either unwilling or unable to commit to permanent relationships. Persons with an anxious-avoidant attachment style view themselves as suspicious and aloof, and view significant others as generally unreliable or overly

eager to commit to unreliable relationships. Persons with a disorganized attachment style consider themselves "bad" and unworthy of care and display hypervigilance to threat of harm in relationships. Some theorists have also emphasized the importance of attachment style for managing negative affect, which is critical for making and maintaining satisfying and harmonious social relationships.[33]

Continuity in attachment style has been observed during preschool ages, particularly among middle-class, relatively stable families.[32,34,35] However, research with economically disadvantaged families who report more life stress and life change has also suggested much less stable early attachment patterns,[36,37] which is consistent with the life course paradigm's emphasis on ongoing person-environment interaction and plasticity. Insecure attachment styles are also more typically reported among children reared in poverty in every culture, families with a history of abuse, and families where the mother has been diagnosed as seriously depressed.[38] Depression among mothers, more typical in lower socioeconomic groups,[39,40] is associated with less ability to respond effectively to infants and children, resulting in poorer attachment style outcomes in infancy, and problematic developmental outcomes.

Considerable empirical research has now confirmed that different mental models regarding attachment exist in adults as well as children,[41-43] and that they are associated with retrospective accounts of childhood relationships with mothers and fathers.[42] Main et al.[32] have reported strong associations between adults' attachment history and the attachment styles of their own young children; however, some parents do manage to develop a better attachment style with their own children than they experienced as children. This and other evidence of multiple life course pathways evolving from similar infant attachment patterns[44] again suggests potential

plasticity in attachment style over the lifecourse based on differentials in environmental experience and in other relationships.

Secure attachment style has been empirically linked to greater social competence, more friends, and more social support in childhood[45,46] and adolescence.[47] Research is now linking differences in attachment style to differences in the formation and maintenance of romantic partner relationships.[42,48-50] Quality of attachment to mothers at a young age may also influence lifelong patterns of closeness between mothers and daughters[19] and daughters' caregiving motivation and consequences.[51,52]

Temperament (i.e., constitutional differences in reactivity and self-regulation[53]) is another biologically-based characteristic that influences interindividual differences in relationships, including mother-daughter attachment. While there is considerable controversy about the exact dimensions of temperament in infants and the mechanisms whereby temperamental dispositions become translated through culture and life experience into particular dimensions of adult personality,[54] there is some consensus that there are interindividual temperamental differences due to genetic patterning at birth in sociability/inhibition (perhaps related to later extraversion) and negative emotionality (perhaps related to later neuroticism).[55-57] Both of these temperamental characteristics influence the development, quality, and maintenance of social relationships over the lifecourse. Research on adult twins suggesting that genetic factors predict between 28% and 52% of the variance in perceived support and formal affiliative interaction[58] is also consistent with the proposition that aspects of relatively enduring temperament and personality play a role in the development and maintenance of social relationships.

Unanticipated family life transitions can also influence girls' social development.

Children who lose a mother to death typically display more troubled emotional and behavioral expressions,[59-61] more struggles with social competence and self-perception,[62] and more anxiety about forming and maintaining other close relationships[63] than nonbereaved peers. Problems in each of these emotional and behavior areas can influence future social relationships. Depression, whether due to parental loss or other factors to be noted subsequently, can elicit negative reactions from social network members and also result in decreased social support[64-66] and poorer marital quality.[67]

Living with a single mother during childhood can also alter mother-daughter relationships and women's social trajectories. It is increasingly common for children to be born to an unmarried mother[68] and/or to live at least part of their lives in a household with only their mother present due to parental divorce.[68,69] Divorce and living in a mother-headed household are associated with greater risk of poverty, lower school quality, living in a neighborhood of poorer quality, more residential moves, a decline in mother involvement, a decline in supervision and mother-child talks, poorer psychological well-being, greater propensity to drop out of high school (lowering a woman's own SES), a greater propensity to engage in earlier sexual activity, and greater risk of experiencing a teen birth (increasing a woman's own potential to become a young, single parent).[68-73]

Although during the initial period after parental divorce boys appear to display more negative effects than girls, evidence suggests girls experience more delayed effects--e.g., more distress if their mothers remarry and problems in establishing emotional commitments in early adulthood.[74-76]

Adult women whose parents divorced in childhood also have been found to have poorer

psychological well-being,[70,77] to be more likely to be depressed as adults,[67,78] and to experience poorer marital quality.[67,77]

However, not all divorces have the same impact on children, and research suggests a number of moderating effects.[70,72] For example, adults who experience only one divorce during childhood that does not lead to a decline in their relationship with both parents report similar psychological and social well-being to those who grew up in very happily intact families, and they report better psychological and social well-being than adults who report they grew up in unhappily intact families.[77]

Mothers and daughters tend to retain a close (if sometimes also conflictual), relationship over the life course. Chodorow[18] hypothesized that daughters do not need to disconnect from their mothers as much as sons during identity development, which leads to continued strong mother-daughter ties, as well as the ongoing socialization of a schema for identity that emphasizes nurturance and embeddedness in close relationships. Of the four possible family dyad ties--mother-daughter, mother-son, father-daughter, father-son--the mother-daughter tie evokes the highest levels of normative obligation, affectional support, and instrumental support across adulthood.[19]

Overall, mothers continue to provide a range of financial, emotional, and instrumental support to daughters across the adult years.[19,79,80] Beginning in early adulthood, there is also a considerable amount of reciprocity in the relationship--especially in emotional and instrumental support. It is only after mothers become relatively older--typically in their 60s or 70s--that daughters are more likely to provide more support to mothers than they continue to receive.[19] Thus, mothers often remain a critical social resource to women, through early adulthood and into

middle age.

There are, however, demographic differences in patterns of support from mothers. Mothers who have more income provide more financial support to daughters. There is more help provided to daughters by mothers across early and middle adulthood when daughters also report there was greater family cohesion in childhood; when there is current affective closeness and contact; when the mother is married; and when the daughter is single, not employed, younger, and has a lower income.[19,80] Greater help provided to mothers from daughters is likewise predicted by greater early family cohesion, greater current affective closeness, less geographic distance, poorer mother health, and mother being single.[19,81]

Low-income persons and African-Americans in the U.S. receive less money, emotional support, and childcare from parents (mothers and fathers) than higher income persons and non-Hispanic whites,[79] yet African-American women are more likely to coreside with parents than whites.[82,83] While strong kin ties may be culturally emphasized in many race ethnic families, in actuality, tight resources may not always allow for the high levels of compensatory intergenerational exchanges policy-makers often count upon.[79,84,85]

An important part of a woman's adult life is typically spent now in relationship to parents who are living into older ages and often experiencing a considerable period of increasing functional limitation and disability prior to death. Men and women from contemporary midlife birth cohorts are likely to spend more years with one or more parents aged 65 and older than they are to spend with children under age 18.[86] By middle adulthood, many women are beginning to experience some caregiving demands from mothers and/or fathers.[87-90] A little over one in ten U.S. women aged 35-64 report having lived with or cared for a disabled parent during the

previous year.[90]

The hierarchical model of caregiving[91] suggests that if spouse care is not available, care from a child (typically a daughter, if she is available) is sought out next in most Western societies. However, the need for care among aging mothers varies significantly by SES. Due to consistent associations between lower SES and poorer physical and mental health,[39-40,92-95] lower SES mothers are more likely to become more functionally impaired at younger ages than higher SES mothers, and therefore require more care. Lower SES and ethnic minority mothers are more likely to be single due to earlier partner mortality or divorce,[96] and therefore more likely to seek care from a daughter. Additionally, lower SES children tend to live closer to their mothers and are therefore more proximately available for provision of instrumental and emotional support.[19,81]

Providing care to disabled elderly parents (as well as others) has been linked to considerable strain, burden, psychological distress, and sometimes poorer health[87,89,97-101] although caregiving can also be associated with psychological benefits.[101,102] Overall, most studies suggest that women providing parent care experience more burden and distress than men, although the evidence is not entirely consistent.[103,104] Part of the stress of elder care for midlife women often comes from attempting to combine this typically unanticipated care with other role commitments to employment, children, and/or a spouse.[87,89,101,105]

In sum, daughters' temperament and mothers' SES, marital quality, marital history, and mental and physical health trajectory influence the quality of early mother-daughter attachment and quality of the mother-daughter relationship over time. Early mother-daughter attachment has a major impact on the trajectory of women's quality of social relations with others across the lifecourse. At midlife, middle-class white women are more likely to have healthier, married,

more affluent mothers who can continue to provide emotional, financial, and instrumental support to them rather than vice versa. More highly educated women are also more likely to live more distant from kin, including mothers, which makes it less likely for them to become involved in intense hands-on caregiving. Lower SES women and women of color at midlife are more likely to have lost mothers to death, to have mothers who are less able to provide them with financial and other resources due to their own relatively restricted means, or to have mothers who have health needs that require daughters to participate in day-to-day caregiving and support.

Women's relationships with fathers

Fathers, too, have an important influence on women's lives and lifecourse social development through their multifaceted roles as care providers, companions, spouses, protectors, models, moral guides, teachers, and breadwinners in families.[106] While there is controversy whether biology predisposes women to be more optimally equipped for nurturant parenting than men,[107] considerable research has suggested there is nothing about the biological makeup of fathers that prevents them from becoming a critical secondary (or even primary) attachment figure for infants.[108] Most infants do become attached to their fathers, and this attachment is not necessarily the same style (i.e., secure or insecure) as to mother.[108]

Fathers tend to spend proportionately less time with children than mothers across childhood, and their style of interaction tends to emphasize play while mothers' style emphasizes caregiving.[109] Fathers tend to interact less with daughters than sons at all ages, but particularly during adolescence. Since fathers give infants and young children different types of social cues, having an involved father appears to aid a child's early development of interpersonal differentiation, social competence, and social understanding.[108,110-112] Couple interactions

between mother and father are also predictive of both maternal and paternal responsiveness to a child, and, in turn, to socioemotional outcomes for daughters as well as sons.[113] Therefore, fathers positively influence their daughter's social development both through sensitive response to them directly, but also through sensitive responding and support provided to their mothers and other members of the family.

Loss of a father to death during childhood has been associated with greater anxiety, more somatic symptoms, and more problems in peer relationships.[62] Parental divorce, together with the negative effects noted previously, also usually critically disrupts the father-daughter tie. After a divorce between parents, children typically reside with their mother (about 86% do so in the U.S.), and contact with a father tends to dramatically decline.[72,74,114] Nonresident divorced fathers also typically remarry, at which time contact with nonresident daughters tends to decline even more.[72,74]

The effects of divorce on daughter-father relationships continues into adulthood. Divorced and remarried fathers are less likely to indicate positive attitudes toward parental obligation to adult children and are less likely to have contact with and provide financial, instrumental, and emotional support to adult daughters than are continuously married fathers.[19,79,115,116]

Overall, the father-daughter bond and reciprocity is much more sensitive to environmental and life course changes than the mother-daughter bond. Marital unhappiness among parents tends to realign family bonds even if divorce does not ensue--resulting in daughters typically remaining closer to an unhappily married mother than to the unhappy married father. This also extends to grandparent relationships: marital unhappiness among parents also

tends to reduce children's contact with paternal grandparents.[19]

Due to gender differences in mortality, and the fact that fathers tend to be somewhat older than mothers, fathers tend to die before mothers.[95] Using recent U.S. population data, Marks, Bumpass, and Jun[117] report that young adults (aged 25-39) are more than three times more likely to have a sole surviving mother than a sole surviving father. By midlife ages 40-59, less than one in ten adults reports a father alive; more than one quarter report the loss of both parents. Additionally, lower SES fathers die at younger ages than higher SES fathers,[95] and in the U.S. African-American fathers also die younger than non-Hispanic white fathers.[95,118]

In sum, the quality of mother-father social interaction and the mother-father partnering trajectory (e.g., continuously married, married and later divorced or separated, never married, divorced and remarried to another) have a critical influence on the development of early daughter-father attachment, daughter-father contact, and the quality of daughter-father relationships over the life course. Fathers, in turn, shape the lifecourse of women's other social relationships in multiple ways--through their nurturing and attachment in infancy, through their different styles of interaction and social cues aiding in women's development of social understanding (i.e., the competent differentiation of social cues and the learning of appropriate social response to social cues), through their interactions with women's mothers in modeling adult social interaction, through economic support leading to women's opportunities for educational and occupational attainment, and through ongoing financial, emotional, and instrumental support in adulthood. Women who have disrupted ties with fathers through absence due to desertion, divorce, or death in childhood lose an important social capital and economic resource, which can influence a trajectory of other experiences (e.g., early sexuality, early birth)

that can result in impoverished relationship quality at midlife--with a partner, with children, with friends, and with other family. Lower SES fathers and ethnic minority fathers are more likely to be under social constraints that do not allow them to fulfill all the roles of fatherhood as adequately as higher SES fathers, and they are more likely to become disabled and die at younger ages than high SES fathers--leaving mothers to the care of daughters, and reducing the multifaceted support adult daughters might otherwise experience from fathers.

Women's relationships with siblings

Sibling relationships are typically the longest enduring social relationships of individuals' lives. A large majority of children have at least one sibling, and among current cohorts of midlife and elderly persons most have at least one living sibling.[119] Sibling relationships are relatively unique in that they typically involve sharing a common genetic heritage, cultural milieu, and early life experiences with parents. Quality within sibling relationships (as measured by dimensions of rivalry, conflict, control, and friendliness) varies greatly across sibling dyads and across time.[110] Sibling relationships in childhood are often intense and ambivalent; a high level conflict often concurrently occurs with a high level of friendliness. Birth order, temperament, gender mix, age differences, parental interaction patterns with both siblings, all influence sibling relations.[110] Individual differences in parent-child, marital, and parent-sibling relationships also have important effects on sibling relationships,[110] highlighting how the quality of social relationships are interconnected in the family system.

Sibling relationships offer young children the experience of a relationship that often combines some aspects of complementarity (e.g., an older sibling teaching a younger sibling) as well as reciprocity (e.g., both siblings playing together as equals), and may therefore be

instrumental in a child's development of social understanding.[110,120]

From preschool ages forward, children begin to develop more connections to friends, and sibling ties may begin to diminish in prominence through middle childhood and adolescence. This process tends to continue as young adults leave home and begin to make decisions about individual life paths, education, employment, and partners. Early adulthood is the period during which sibling ties may be the least actively pursued.[119]

In middle adulthood, siblings may become closer again--especially after launching children and life events like a divorce, death of a spouse, or in the event of parent health issues.[121] Siblings are often considered "in reserve" as sources of support if need arises--particularly for never-married childless women.[122] Norms of obligation to siblings are less than for most inner circle family members (i.e., parents, children, and spouse),[19] yet siblings provide emotional support and services when needed, especially if they live close by. Siblings are more likely to maintain active long-distance relationships than are friends. Sibling relationships with sisters tend to be emotionally closer than with brothers.[122-123] Sister-sister dyads tend to be particularly intense in interidentification--often leading to intimacy, volatility, stress, and ambivalence.[124] Making decisions about caregiving sometimes brings siblings into more contact;[87,125] however, negative sibling interaction can also create more stress for women who are primary caregivers.[87,126]

Different cultural and ethnic communities vary in norms for sibling relationships.[122] In the U.S., African-Americans and Mexican-Americans exhibit more instrumental and emotional help exchange than do non-Hispanic whites.[127,128]

As social circles narrow with age, siblings may value each other even more as kin and

confidantes due to their long-shared history.[122] In some cases, especially if a spouse or an adult child is not available, a sibling may become caregiver for another sibling.[129] Sibling caregiving is also likely to occur if a sibling has a lifelong disability and parents are no longer able to provide care.[130]

Having one or more siblings reduces the likelihood of receiving support from mothers and fathers during adulthood.[19] Only children, however, are more likely to need to respond to the needs of aging parents.[131]

In sum, temperament, gender mix, age difference, and birth order, as well as the quality of parent-child, marital, and parent-sibling relationships influence the quality of early sibling relationships. Sibling relationships often provide rich (and challenging) opportunities for social learning and social development at young ages, which, in turn, influences the quality of later social relationships. At midlife, siblings are often part of a secondary layer of social support women may rely upon for companionship, emotional support, and sometimes services. Sister-sister bonds tend to be closer than sister-brother bonds, but both types of sibling relationships can be important resources for women at midlife. Sibling tensions tend to smooth out as women age; however, prior family histories, and ongoing challenges in meeting the needs of aging parents can still influence the quality of midlife sibling relationships.

Women's partner relationships

Beginning in adolescence, partner relationships become prominent social relationships in women's lives. Yet there is great variance in the timing, quantity, and quality of partner relationships experienced by women.

Young women's involvement in dating and sexual relationships in early adolescence is

significantly influenced by a biological factor--pubertal timing. Early maturing girls are at more risk of early sexual relations, earlier partnering, earlier childbearing, delinquency, and diminished educational attainment than later maturing girls.[132-136] This is critical for the life course of women and the evolution of their social relationship quality over time, since earlier childbearing, younger age at marriage, and less education are associated with a greater risk of poorer marital quality, divorce, and single parenting.[132]

While there has been a major upheaval in the stability of marriage, most women continue to develop cohabiting or marital partnerships during their adult years. Due to increases in divorce rates, lowering of remarriage rates, and increases in women's longevity, the proportion of women's adult lives spent married now, compared to fifty years ago, however, is becoming smaller.[137,138] This is even more dramatically the case for African-Americans in the U.S. in comparison to whites.[139] Marriage now, compared to fifty years ago, is typically occurring at older ages for both women and men.[137,138] Ever more commonly, contemporary marriages occur after a period of cohabitation.[140,141]

Historically, being married generally has been associated with lower mortality and less distress than being unmarried,[142-146] yet being in a unhappy marriage also has been associated with more psychological and physical health problems than being single.[143,147] As marriage has become more delayed, cohabitation more common, divorce more common, and a period of single living has become more typical and acceptable for young adults, there has been some speculation and even some evidence that marriage, per se, may have become less important for adult happiness.[148,149] Overall, however, population research continues to suggest that marriage is associated with better mental and physical health for both women and men.[150-152]

The mechanisms related to better health outcomes may differ by gender, however: marriage may be associated with health for men due to its offering men more support for positive health behaviors and more emotional support, while marriage may be associated with better health for women in large part due to the financial advantages of being married for women.[150,152]

Women generally report less satisfaction with their marriages than husbands. Better quality of marital relationships (as perceived by wives) and stability of marriage over time has been associated with higher SES (i.e., more woman's education, more husband's and family income, greater financial assets), fewer environmental stressors (e.g., not having an unemployed husband), positive childhood factors (e.g., having had a happy childhood, not having experienced a parental divorce), lifecourse factors (e.g., no premarital pregnancy, no cohabitation prior to marriage) as well as more positive personality and mental health factors (e.g., less neuroticism, more extraversion, more conscientiousness, more agreeableness, less depression, more self-esteem).[153]

In sum, temperament/personality factors, pubertal timing, socioeconomic factors from childhood and adulthood, race-ethnicity, childhood factors, and lifecourse event trajectories all influence the likelihood, timing, quality of and duration of partner relationships for women. While marriage is associated with better health in most epidemiological work, contemporary cohorts of women spend proportionately less of their adult years married than birth cohorts born in the early decades of the twentieth century. There is considerable variance among women now in the timing of marriage, the stability of marriages, the sequencing of serial periods of cohabitation and marriage across the life course, and the quality of marital and cohabiting partnerships.

Women's relationships with children

Although great advances in birth control across the last few decades have increasingly made it possible to separate sex from parenthood, and to allow for more options and timing of parenthood, about 90% of currently midlife women are biological, adoptive, or stepparents.[154] Children become social ties of lifelong significance and potential gratification, yet the demands in this relationship are very heavy for women.[89,155,156] Overall, evidence suggests that being a parent is associated with greater psychological distress than being childfree,[157,158] and that parenting is associated with more strains for women than men,[159,160] likely due to the greater normative and behavioral responsibility for children women maintain.[19,109]

However, many factors moderate the degree to which motherhood is distressing. Single parenting has been found to be more distressing than parenting with another parent.[157,158,161-163] Stepparenting has also generally been associated with elevated distress.[164,165] Worries about child care exacerbate the stress of working mothers.[155] Poverty and residence in poor quality neighborhood environments adds to the challenges of parenting.[89,96,156,166,167] Greater father involvement and better marital quality also reduce the distress of parenting for women.[155] Having older children, especially "launched" nonresidential adult children, has been associated with greater life satisfaction, meaning, and psychological wellness.[117,157,162,168]

Adolescent childbearing can create a sequelae of challenges for women, including poorer psychological functioning, lower rates of school completion, lower levels of marital stability, less stable employment, higher rates of poverty, more likelihood of subsequent nonmarital births, and somewhat greater rates of health problems for mothers as well as children in contrast to women who postpone childbearing.[132] Yet, consistent with a life course perspective emphasizing

ongoing developmental plasticity and moderating environmental factors, longitudinal studies have demonstrated that successful trajectories can result for some women who bear children as teens if family and social program support, opportunities to continue in school, solid employment, a good marriage, or some combination of these factors are available.[169,170]

Young children at home tend to reduce the social networks of mothers (especially in terms of friends and associates), reducing their reliable social support, and creating more localized networks than is the case for similar women without children.[171] Women's social networks as well as well-being also continue to be influenced by the life course development of adult children. A significant proportion of contemporary adult children continue to coreside with parents for some period of time to get their adult lives established or "boomerang back" to the parental home after some period on their own. About 30 percent of all U.S. parent householders with a child or stepchildren aged 19 and older report a coresident adult child.[172] Most parents are not dissatisfied with this arrangement (selection plays a part in this), however, greater dissatisfaction with coresidence is evident when the parent is of higher SES and when the adult child is more economically dependent, returns home after a divorce, or returns home with a child.[173] Mothering a child with a lifelong disability such as mental retardation also typically entails extended parent-child coresidence and creates unique challenges as well as rewards for midlife mothers.[174]

In sum, most women become mothers at some point during the lifecourse. Mothering can be both distressing and meaningful for women. The distress and rewards of mothering across young adulthood and into midlife is moderated by a number of lifecourse factors--timing of and number of births, ages of children, family SES and resources available to meet the demands and

challenges of parenting, neighborhood quality, marital status and marital history of the woman, marital quality, mother's employment, father's participation and support, and children's needs and developmental trajectories. Mothers of young children typically have more limited social networks than women who are not mothers. There is considerable variance in the "launching" of children to independence. Continued coresidence or a return to the parental home by contemporary young adult children for some period of time is not uncommon.

Women's relationships with other kin

In childhood, girls' relationships to kin outside the immediate family are dependent upon parents' contact and quality of relationships with their kin. Mothers tend to maintain more contact with their families of origin than fathers do, so most children have more contact with maternal extended kin than paternal extended kin.[19] Grandparents are most likely to be an important part of children's lives, and sometimes aunts, uncles, and cousins. Paternal kin ties may be diminished further if divorce occurs, and daughters continue to reside with their mothers. Overall, relationships with kin beyond the immediate family do not appear to be a major part of the daily social contact of most children's lives in industrialized societies.[175]

In adulthood, women name more kin (beyond parents and children), more kin types, and a greater proportion of their overall social network as kin than men.[171,176,177] Women (as well as men) with less education and less income tend to have an even higher proportion of kin (in contrast to nonkin) in their social networks than their peers with more education and more income.[171,177] Contrary to popular stereotype, there is also some evidence that African-Americans and Mexican-Americans in the U.S. have smaller, less supportive, and more culturally confined kin networks than comparable non-Hispanic whites.[171] Urbanicity also influences kin networks;

urbanites in Fischer's social network study[171] reported 40 percent fewer relatives and almost 50 percent more nonrelatives in their networks than respondents from less urban areas.

Grandchildren typically become new important kin ties for women in midlife,[154] and often bring new rewarding relationships into women's lives.[178] The experience of grandmothering can vary significantly, though, depending upon the marital status, proximity, and economic need of the adult child parent.[19,178] Additionally, grandmothers sometimes become extensive caregivers, even custodial caregivers for grandchildren when their own adult children are unable to handle their parenting responsibilities. Over one in ten American grandparents report raising a grandchild at some point for at least 6 months, and usually for three or more years.[179] Undertaking custodial grandparent caregiving is associated with a greater risk for poor health.[180]

Overall, women report higher levels of normative obligation to "kinkeeping" and kin work than men,[19] and they continue to predominate in the provision of emotional and instrumental support, including personal caregiving, to other kin.[19,88,90,176] While providing support to other kin (in contrast to primary kin) may be somewhat more voluntary and therefore less likely to lead to a decline in well-being,[101] providing support to a larger number of other kin (beyond parents and children) has also been associated with more psychological distress.[176]

In sum, ties to other kin in childhood are largely dependent on parents' ties to kin and parents' marital histories. In midlife, SES, race-ethnicity, urbanicity, and adult child marital and fertility trajectories influence the number of other kin ties reported by women. Women tend to have more other kin in their social networks than men. Some of these relationships offer important solidarity and support. Some kin relationships demand a fair amount of care and help. Overall, providing support for other kin may not be overly problematic for women. But at times,

extended kin relationships may become emotionally draining and labor-intensive (e.g., custodial grandparenting) and problematic for women's mental and physical health, as well as women's pursuit of more equitable and rewarding social relationships with friends.

Women's relationships with friends

Friendships constitute a critical part of women's social networks across the lifecourse. As noted previously, temperament, attachment style, and social understanding influence the quality of early peer relations. Beginning in the preschool years, and increasingly into school ages and adolescence, both boys and girls have been found to prefer same-sex friendships.[175,181] Therefore, girls tend to emphasize friendships with other girls beginning at young ages. While many studies do not find gender differences in the extensiveness of friendship networks during childhood and adolescence, some studies find boys have more nonkin interaction due to boys' greater likelihood of participating in large groups, such as teams.[175,182,183] Girls, by contrast, show a preference for dyadic interaction and for private settings, emphasizing more self-disclosure, intimacy, nurturance, and exclusivity in their friendships.[182,184]

In childhood and adolescence girls tend to seek more emotional help from friends and give more emotional help to friends than boys do. Girls' emphasis on self-disclosure and dyadic relationships may bring the emotional benefits of confidante relationships, but this same style of interaction may also make them more vulnerable to their peers when relationships do not go well. For example, girls' greater concerns about the faithfulness of friends and rejection by friends may, in part, reflect greater vulnerability due to greater self-disclosure in their friendships.[182] Boys also seek out friends when stressed, but more typically to engage in distracting activity.[182]

In adulthood, many of the same gendered patterns of friendship continue. Quantitatively,

overall, women tend to name fewer nonkin in their social networks than men,[23,171,177] but this varies somewhat by life stage. For example, Fischer[171] found that younger women, especially young mothers, had smaller social networks and fewer "just friends" than younger men had; however, at midlife, women tended to rebuild their social ties to friends, and older women had more friends than older men. Unemployed women tended to know more neighbors; however, residential mobility (often occurring due to poverty or divorce) was likely to fracture social networks in the neighborhood.

Moore[177] found that while at a bivariate level, U.S. women in 1985 reported fewer types of nonkin (friends, coworkers, and advisors, although not neighbors) in their social networks than men, structural factors related to work (employment status and occupational status), marital status, and SES (education) accounted for this association. Moore, like Fischer,[171] interpreted her findings to suggest that men's quantitative advantage in terms on nonkin ties is structurally determined more than it is a result of dispositional or socialized gender preference.

Overall, SES is the factor most significantly linked to broader, deeper, and richer friendship networks.[171,177] More education is associated with larger networks, more companionship, more intimate relations and wider geographic range of ties. Even adjusting for education and other factors, more income is associated with more nonkin ties, and more secure and companionable support. Poorer people report fewer friends as well as relatives for support.[171] Among the affluent in contrast to the poor, friendship networks are less constrained by children, spatial separation from associates, and community characteristics.[171]

Qualitatively, adult women continue to report more emphasis on intimate ties, more confiding relationships, and more self-disclosure in friendships than men.[184,185] Although,

overall, women report more satisfaction with friendships than family relationships,[23] not all friendships are of equal quality and support. Among lower-SES women, in particular, stress contagion[186] (i.e., the experience of greater stress after having contact with another person experiencing stress) among neighbors, relatives, and friends is likely to occur,[166,187] thus making even shared "support" in efforts like child care potentially burdensome.[188]

In sum, temperament, attachment style, and social understanding influence friendships in early childhood. Girls and women tend to invest intensely in close, intimate friendships, and in adulthood women tend to rate more satisfaction with their friends than with family relationships. However, due to their greater kin responsibilities (e.g., in parenting), and their often-disadvantaged economic and labor market status, women are sometimes less likely to report as wide a range of the types of friendships and associational ties associated with advantage in occupational success, recreation, exercise, and leisure as men do. Under circumstances of economic disadvantage and neighborhood privation where stress contagion is a common risk, even friends may become as much a burden as an asset for women's well-being.

Summary and implications for future research and policy

This chapter reviewed biological, psychological, and social factors across the lifecourse that influence the quality and quantity of women's social relationships at midlife, which, in turn, would be expected to influence women's health. It explored how biologically-based factors--e.g., attachment, temperament, and pubertal timing--in interaction with psychosocial factors--e.g., mental health, personality, family structure, life events, childhood SES, adult SES, life course timing of partnering and parenting, family social support, and neighborhood quality--influence women's social development and the quality of social ties.

While there are a number of factors that can tilt a woman in the direction of cumulative disadvantage in social relationships at midlife--e.g., inhibited or difficult childhood temperament, lower SES parents, childhood with a single parent, childhood in a stepfamily, an insecure attachment style, loss of a parent (or parents) to death, divorce of parents, early pubertal maturation, early sexual relations, teen birth, marriage at a very young age, depression, lower adult SES--none of these risk factors for diminished social relationship quality is definitive in determining the course of a woman's social relationships and social network. The plasticity of ongoing lifecourse development is evident in that for each of these risk factors, there is also evidence that moderating factors (e.g., socially competent mother, father, or partner; school resources; neighborhood resources; family and friend social support; rewarding employment; social service programs; mental and physical health services; income support) can mitigate the direction of trajectories and life course effects. Future social policy might usefully target interventions that provide support to girls and women at multiple junctures of lifecourse risk to social developmental problems: e.g., infancy (especially for "difficult" babies and mothers in poverty to facilitate secure attachment and the development of social competence), childhood (especially for girls suffering parent absence and economic deprivation to facilitate their mental health, social competence, and academic success), adolescence (especially for early-maturing girls, girls suffering parent absence, and girls in high-risk economic and neighborhood circumstances to facilitate their mental health, social competence in developing partner relationships, and planful life course choices in education, occupation, and parenthood), and adulthood (especially for low SES women, single women, mothers of young children, caregivers, and women in poor quality marriages to provide resources to facilitate the maintenance of their

mental and physical health and planful decisions about taking care of self as well as others).

Future research needs to pay particular attention to relationship quality--e.g., strains as well as gains, equity, and reciprocity--in each social relationship in social network analysis. It also would be beneficial for scholars to consider cumulative patterns of social relationships (e.g., marital histories, child in household histories, caregiving histories) as well as one point in time assessments of social networks in order to better gauge how social relationships influence women's health.

This review of some of the variance in the quantity and quality of women's social relationships over the lifecourse suggests that policy-makers should not assume that because women tend to emphasize more intimacy and support in relationships than men, therefore, women's social relationships are necessarily more protective of their health than men's and women's social ties can compensate for women's often-disadvantaged status in families, labor markets, and society. This is particularly true for women of color who may be triply disadvantaged by gender, race/ethnicity, and class.

In sum, women's social relationships at midlife reflect a complex evolution of ties with family, friends, and neighbors that are multiply determined by a range of biological, psychological, and social factors emerging from infancy through middle adulthood. Continued attention to these multiple factors and the cumulative relationship histories of women is important for a better understanding of the ways in which social relationships influence women's health.

References

1 Berkman LF. The relationship of social networks and social support to morbidity and mortality. In: Cohen S, Syme SL, eds, *Social support and health*. Orlando (Florida): Academic Press, 1985:241-59.

2 Ryff, CD, Singer, BH, eds. *Emotion, social relationships, and health*. New York: Oxford University Press, 2001.

3 Cohen SC. Psychosocial models of the role of social support in the etiology of physical disease. *Health Psychology* 1988;**7**:269-97.

4 House JS, Landis KR, Umberson DL. Social relationships and health. *Science* 1988;**241**:540-45.

5 Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: a review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin* 1996;**119**:488-531.

6 Berkman LF, Syme SL. Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *American J of Epidemiology* 1979;**109**:186-204.

7 House JS, Robbins C, Metzner HL. The association of social relationships and activities with mortality: prospective evidence from the Tecumseh community health study. *American J of Epidemiology* 1982;**116**:123-40.

8 Schoenbach VJ, Kaplan BH, Fredman L, Kleinbaum DG. Social ties and mortality in Evans County, Georgia. *American J of Epidemiology* 1986;**123**:577-91.

9 Orth-Gomer K, Johson JV. Social network interaction and mortality: a six year follow-up

study of a random sample of the Swedish populations. *J of Chronic Disease* 1987;**40**:949-57.

10 Cohen S, Herbert TB. Health psychology: psychological factors and physical disease from the perspective of human psychoneuroimmunology. *Annual Review of Psychology* 1996;**47**:113-42.

11 Seeman TE, Berkman LF, Blazer D, Rowe J. Social ties and support and neuroendocrine function: the MacArthur studies of successful aging. *Annals of Behavioral Medicine* 1994;**16(2)**:95-106.

12 Seeman T, McEwen B. Impact of social environment characteristics on neuroendocrine regulation. *Psychosomatic Medicine* 1996;**58**:459-71.

13 Rook KS. The negative side of social interaction: impact on psychological well-being. *J of Personality and Social Psychology* 1984;**46**:1097-1108.

14 Fiore J, Becker J, Coppel DB. Social network interactions: a buffer or a stress? *American J of Community Psychology* 1983;**11**:423-39.

15 Pagel MD, Erdly WW, Becker J. Social networks: we get by with (and in spite of) a little help from our friends. *J of Personality and Social Psychology* 1987;**53**:793-804.

16 Schuster TL, Kessler RC, Aseltine RH. Supportive interactions, negative interactions, and depressed mood. *American J of Community Psychology* 1990;**18**:423-38.

17 Gilligan C. *In a different voice*. Cambridge (Massachusetts): Harvard University Press, 1982.

18 Chodorow N. *The reproduction of mothering: psychoanalysis and the sociology of gender*. Berkeley (California): University of California Press, 1978.

19 Rossi AS, Rossi PH. *Of human bonding: parent-child relations across the life course*. New York: Aldine de Gruyter, 1990.

20 Kessler RC, McLeod JD. Sex differences in vulnerability to undesirable life events. *American Sociological Review* 1984;**49**:620-31.

21 Kessler RC, McLeod JD, Wethington E. The costs of caring: a perspective on the relationship between sex and psychological distress. In: Sarason IG, Sarason BR, eds, *Social support: theory, research, and applications.* Dordrecht: Martinus Nijhoff Publishers, 1985.

22 Shumaker SA, Hill DR. Gender differences in social support and physical health. *Health Psychology* 1991;**10(2)**:102-11.

23 Antonucci T. A life-span view of women's social relations. In: Turner BF, Troll LI, eds, *Women growing older: psychological perspectives*. Thousand Oaks (California): Sage, 1994:239-69.

24 Kahn RL, Antonucci TC. Convoys over the life course: attachment, roles, and social support. In: Baltes, PB, Brim OG, eds, *Life-span development and behavior*. New York: Academic Press, 1990:253-86.

25 Bowlby J. *Attachment and loss. Volume I: Attachment.* New York: Basic Books, 1969.

26 Bowlby J. *Attachment and loss. Volume II: Separation: anxiety and anger*. New York: Basic Books, 1973.

27 Bowlby J. *Attachment and loss. Volume III: Loss.* New York: Basic Books, 1980.

28 Ainsworth MDS, Blehar MC, Waters E, Wall S. *Patterns of attachment: a psychological study of the strange situation*. Hillsdale (New Jersey): Erlbaum, 1978.

29 Van Ijzendoorn MH, Sagi A. Cross-cultural patterns of attachment: universal and contextual dimensions. In: Cassidy J, Shaver PR, eds, *Handbook of attachment: theory, research, and applications*. New York: Guilford, 1999:713-34.

30 Main M, Solomon J. Discovery of a disorganized/disoriented attachment pattern. In: Brazelton TB, Yogman MW, eds, *Affective development in infancy*. Norwood (New Jersey): Ablex, 1986:95-124.

31 Cicchetti D, Toth SL. Child maltreatment and attachment organization: implications of intervention. In: Goldberg S, Muir R, Kerr J, eds, *Attachment theory: social, developmental and clinical perspectives*. Hillsdale (New Jersey): Analytic Press, 1995:279-308.

32 Main M, Kaplan N, Cassidy J. Security in infancy, childhood, and adulthood: a move to the level of representation. In: Bretherton I, Waters E, eds, *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development*, 1985;**50(1-2, Serial No. 3209)**:66-104.

33 Sroufe LA, Schork E, Frosso M, Lawroski N, LaFreniere P. The role of affect in social competence. In: Izard C, Kagan J, Zajonc R, eds, *Emotions, cognitions and behavior*. New York: Cambridge University Press, 1984:289-319.

34 Main M, Cassidy J. Categories of response to reunion with the parent at age 6: predictable from infant attachment classifications and stable over a 1-month period. *Developmental Psychology* 1988;**24**:415-26.

35 Waters, E. The reliability and stability of individual differences in infant-mother attachment. *Child Development* 1978;**49**:520-616.

36 Egeland B, Sroufe LA. Attachment and early maltreatment. *Child Development* 1981;**52**:44-52.

37 Vaughn B, Egeland B, Sroufe LA, Waters E. Individual differences in infant-mother attachment at twelve and eighteen months: stability and change in families under stress. *Child Development* 1979;**50**:971-75.

38 Spieker SJ, Booth CL. Maternal antecedents of attachment quality. In: Belsky J, Nezworski T, eds, *Clinical implications of attachment*. Hillsdale (New Jersey): Erlbaum, 1988:95-135.

39 Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry* 1994;**51**:8-19.

40 Mirowsky J, Ross CE. *The social causes of psychological distress*. New York: Aldine de Gruyter, 1989.

41 Feeney JA, Noller P. Attachment style as a predictor of adult romantic relationships. *J of Personality and Social Psychology* 1990;**58**:281-91.

42 Hazan C, Shaver P. Romantic love conceptualized as an attachment process. *J of Personality and Social Psychology* 1987;**52**:511-24.

43 Simpson JA. Influence of attachment styles on romantic relationships. *J of Personality and Social Psychology* 1990;**59**:971-80.

44 Skolnick A. Early attachment and personal relationships across the life course. In: Baltes PB, Featherman DL, Lerner RM, eds, *Life-span development and behavior*. Vol. 7. Hillsdale (New Jersey): Erlbaum, 1986:173-206.

45 Waters E, Wippman J, Sroufe LA. Attachment, positive affect, and competence in the peer group: two studies of construct validation. *Child Development* 1979;**50**:821-9.

46 Sroufe LA. Infant-caregiver attachment and patterns of adaptation in preschool: the roots of maladaptation and competence. In: Perlmutter M, ed. *Minnesota symposium on child psychology*. Vol. 16. Hillsdale (New Jersey): Erlbaum, 1983:41-81.

47 Kobak RR, Sceery A. Attachment in late adolescence: working models, affect regulation, and representations of self and others. *Child Development* 1988;**59**:135-46.

48 Shaver PR, Hazan C. Adult romantic attachment: theory and evidence. In: Jones WH, Perlman D, eds, *Advances in personal relationships*. Vol. 4. London: Jessica Kingsley, 1993:29-70.

49 Kobak RR, Hazan C. Attachment in marriage: effects of security and accuracty of working models. *J of Personality and Social Psychology* 1991;**60**:861-9.

50 Reis HT, Patrick BC. Attachment and intimacy: component processes. In: Tory Higgins E, Kruglanski AW, eds, *Social psychology: handbook of basic principles*. New York: Guilford Press, 1996:523-563.

51 Cicirelli V. Adult children's attachment and helping behavior to elderly parents: a path model. *J of Marriage and the Family* 1983;**45**:815-24.

52 Cicirelli VG. Attachment and obligation as daughters' motives for caregiving behavior and subsequent effect on subjective burden. *Psychology and Aging* 1993;**8**:144-55.

53 Rothbart MK, Derryberry D. Development of individual differences in temperament. In: Lamb ME, Brown AL, eds, *Advances in developmental psychology*. Vol. 1. Hillsdale (New Jersey):1981:37-86.

54 Halverson CF Jr., Kohnstamm GA, Martin RP, eds. *The developing structure of temperament and personality from infancy to adulthood.* Hillsdale (New Jersey): Erlbaum, 1994.

55 Robins RW, John OP, Caspi A. Major dimensions of personality in early adolescence: the Big Five and beyond. In: Haverson CF Jr., Kohnstamm GA, Martin RP, eds, *The developing structure of temperament and personality from infancy to adulthood*. Hillsdale (New Jersey): Erlbaum, 1994:267-91.

56 Ahadi SA, Rothbart MK. Temperament, development, and the Big Five. In: Haverson CF Jr, Kohnstamm GA, Martin RP, eds, *The developing structure of temperament and personality from infancy to adulthood*. Hillsdale (New Jersey): Erlbaum, 1994:189-207.

57 Kagan J. Temperamental contributions to social behavior. *American Psychologist* 1989;**44(4)**:668-74.

58 Kessler RC, Kendler KS, Heath A, Neale MC, Eaves LJ. Social support, depressed mood, and adjustment to stress: a genetic epidemiologic investigation. *J of Personality and Social Psychology* 1992;**62**:257-272.

59 Bowlby J. The nature of the child's tie to his mother. *International J of Psychoanalysis* 1958;**39**:350-373.

60 Kranzler EM, Shaffer D, Wasserman G, Davies M. Early childhood bereavement. *J of the American Academy of Child and Adolescent Psychiatry* 1999;**29**:513-20.

61 Gray RE. Adolescent response to the death of a parent. *J of Youth and Adolescence* 1987;**16**:511-25.

62 Worden JW. *Children and grief*. New York: Guilford, 1996.

63 Harris M. *The loss that is forever*. New York: Plume, 1995.

64 Coyne JC. Toward an interactional theory of depression. *Psychiatry* 1976;**39**:28-40.

65 Kowalik DL, Gotlib IH. Depression and marital interaction: concordance between intent and perception of communication. *J of Abnormal Psychology* 1987;**96**:127-34.

66 Turner RJ. Social support as a contingency in psychological well-being. *J of Health and Social Behavior* 1981;**22**:357-67.

67 McLeod JD. Childhood parental loss and adult depression. *J of Health and Social Behavior* 1991;**32**:205-20.

68 Seltzer JA. Families formed outside of marriage. *J of Marriage and the Family* 2000;**62**:1247-68.

69 McLanahan S, Sandefur G. *Growing up with a single parent: what hurts, what helps*. Cambridge (Massachusetts): Harvard University Press, 1994.

70 Amato PR. The consequences of divorce for adults and children. *J of Marriage and the Family* 2000;**62**:1269-87.

71 Cherlin AJ, Furstenberg FF Jr., Chase-Lansdale PL, Kiernan KE, Robins PK, Morrison DR, Teitler JO. Longitudinal studies of effects of divorce on children in Great Britain and the United States. *Science* 1991;**252**:1386-9.

72 Hetherington EM, Stanley-Hagan MM. The effects of divorce on fathers and their children. In: Lamb ME, ed, *The role of the father in child development.* 3rd edition. New York: Wiley and Sons, 1997:191-226.

73 Wadsworth MEJ, Maclean M, Kuh D, Rodgers B. Children of divorced parents: a summary and review of findings from a national long-term follow-up study. *Family*

Practice 1990;**7**:104-9.

74 Furstenberg FF Jr. Divorce and the American family. *Annual Review of Sociology* 1990;**16**:379-403.

75 Chase-Lansdale PL, Hetherington EM. The impact of divorce on life-span development: short and long term effects. In: Baltes PB, Featherman DL, Lerner RM, eds, *Life-span development and behavior.* Volume 10. Hillsdale (New Jersey): Erlbaum, 1990:105-150.

76 Wallerstein JS, Blakeslee S. *Second chances: men, women, and children a decade after divorce.* New York: Ticknor and Fields, 1989.

77 Amato PR, Booth A. Consequences of parental divorce and marital unhappiness for adult well-being. *Social Forces* 1991;**69(3)**:895-914.

78 Brown GW. Early loss and depression. In: Parkes CM, Stevenson-Hinde J, eds, *The place of attachment in human behavior.* New York: Basic Books, 1982:232-68.

79 Eggebeen DJ, Hogan DP. Giving between generations in American families. *Human Nature* 1990;**11**:211-32.

80 Cooney TM, Uhlenberg P. Support from parents over the life course: the adult child's perspective. *Social Forces* 1992;**71**:63-84.

81 Wadsworth MEJ. Social and historical influences on parent-child relations in midlife. In: Ryff CR, Seltzer MM, eds, *The parental experience in midlife*. Chicago: University of Chicago Press, 1996.

82 Beck RW, Beck SH. The incidence of extended households among middle-aged black and white women. *J of Family Issues* 1989;**10**:147-68.

83 Hogan DP, Hao LX, Parish WL. Race, kin networks, and assistance to mother-headed

families. *Social Forces* 1990;**68(3)**:797-812.

84 Hofferth SL. Kin networks, race and family structure. *J of Marriage and the Family* 1984;**46**:791-806.

85 Roschelle AR. *No more kin: exploring race, class, and gender in family networks*. Thousand Oaks (California): Sage, 1997.

86 Watkins SC, Mencken JA, Bongaarts J. Demographic foundations of family change. *American Sociological Review* 1987;**50**:689-98.

87 Brody EM. *Women in the middle: their parent-care years*. New York: Springer, 1990.

88 Stone R, Cafferata GL, Sangl J. Caregivers of the frail elderly: a national profile. *The Gerontologist* 1987;**27**:616-26.

89 Graham H. *Women, health and the family*. Harvester Press: Brighton, Sussex, 1984.

90 Marks NF. Caregiving across the lifespan: national prevalence and predictors. *Family Relations* 1996;**45**:27-36.

91 Cantor MH. Neighbors and friends: an overlooked resource in the informal support system. *Research on Aging* 1979;**1**:434-63.

92 Wilkinson, RG, ed. *Class and health: research and longitudinal data*. London: Tavistock. 1986.

93 Adler NE, Boyce WT, Chesney MA, Folkman S, Syme SL. Socioeconomic inequalities in health: no easy solution. *Journal of the American Medical Association* 1993;**269**:3140-5.

94 Marmot MG, Kogevinas M, Elston MA. Social/economic status and disease. *Annual Review of Public Health* 1987;**8**:111-35.

95 Geronimus AT, Bound J, Waidmann TA, Colen CG, Steffick D. Inequality in life

expectancy, functional status, and active life expectancy across selected black and white populations in the United States. *Demography* 2001;**38**:227-51.

96 Seccombe K. Families in poverty in the 1990s: trends, causes, consequences and lessons learned. *J of Marriage and the Family* 2000;**62**:1094-1113.

97 Schulz R, Visintainer P, Williamson GM. Psychiatric and physical morbidity effects of caregiving. *Journals of Gerontology: Psychological Sciences* 1990;**45**:P181-91.

98 Kiecolt-Glaser, JK. Stress, personal relationships, and immune function: health implications. *Brain, Behavior, and Immunity* 1999;**13**:61-72.

99 Schulz R, O'Brien AT, Bookwala J, Fleissner K. Psychiatric and physical morbidity effects of Alzheimer's disease caregiving: prevalence, correlates, and causes. *The Gerontologist* 1995;**35**:771-91.

100 Schulz R, Newsom J, Mittelmark M, Burton L, Hirsch C, Jackson S. Health effects of caregiving: the caregiver health effects study: an ancillary study of the cardiovascular health study. *Annals of Behavioral Medicine* 1997;**19(2)**:110-16.

101 Marks NF. Does it hurt to care? Caregiving, work-family conflict, and midlife well-being. *J of Marriage and the Family* 1998;**60**:951-66.

102 Kramer BJ. Gain in the caregiving experience: where are we? what next? *The Gerontologist* 1997;**37**:218-32.

103 Montgomery RJV. Gender differences in patterns of child-parent caregiving relationships. In: Dwyer JW, Coward RT, eds, *Gender, families, and elder care.* Newbury Park (California): Sage, 1992:65-83.

104 Yee JL, Schulz R. Gender differences in psychiatric morbidity among family caregivers: a

review and analysis. *Gerontologist* 2000;**40**:147-64.

105 Neal MB, Chapman NJ, Ingersoll-Dayton B, Emlen AC. *Balancing work and caregiving for children, adults, and elders*. Newbury Park (California): Sage, 1993.

106 Lamb ME. Fathers and child development: an introductory overview and guide. In: Lamb ME, ed. *The role of the father in child development.* 3rd edition. New York: Wiley and Sons, 1997:1-18.

107 Rossi A. Gender and parenthood. *American Sociological Review* 1984;**49(1)**:1-18.

108 Lamb ME. The development of father-infant relationships. In: Lamb ME, ed. *The role of the father in child development.* 3rd edition. New York: Wiley and Sons, 1997:104-20.

109 Pleck JH. Paternal involvement: levels, sources, and consequences. In: Lamb ME, *The role of the father in child development*. 3rd edition. New York: Wiley and Sons, 1997:66-103.

110 Dunn J. *Young children's close relationships: beyond attachment*. Newbury Park (California): Sage, 1993.

111 Lewis C. Fathers and preschoolers. In: Lamb ME, ed. *The role of the father in child development.* 3rd edition. New York: Wiley and Sons, 1997:121-42.

112 MacDonald K, Parke R. Bridging the gap: parent-child play interaction and peer interactive competence. *Child Development* 1984;**55**:1265-77.

113 Cummings EM, O'Reilly AW. Fathers in family context: effects of marital quality on child adjustment. In: Lamb ME, ed, *The role of the father in child development.* 3rd edition. New York: Wiley and Sons, 1997:49-65.

114 Seltzer JA. Relationships between fathers and children who live apart. *J of Marriage and*

the Family 1991;**53**:79-101.

115 Marks NF. Midlife marital status differences in social support relationships with adult children and psychological well-being. *J of Family Issues* 1995;**16**:5-28.

116 Cooney TM, Uhlenberg P. The role of divorce in men's relations with their adult children after mid-life. *J of Marriage and the Family* 1990;**52**:677-88.

117 Marks NF, Bumpass LL, Jun H. Family roles and well-being during the middle life course. In: Ryff C, Kessler R, Brim B, eds, *Midlife development in the United States.* Chicago: University of Chicago Press, *forthcoming*.

118 Sorlie PD, Backlund E, Keller JB. US mortality by economic, demographic, and social characteristics: the national longitudinal mortality study, *Am J of Public Health* 1995;**85**:949-956.

119 Cicirelli VG. Sibling influence throughout the lifespan. In: Lamb ME, Sutton-Smith B, eds, *Sibling relationships: their nature and significance across the lifespan*. Hillsdale (New Jersey): Erlbaum, 1982:267-84.

120 Bryant BK. Sibling relationships in middle childhood. In: Lamb ME, Sutton-Smith B, eds, *Sibling relationships: their nature and significance across the lifespan.* Hillsdale (New Jersey): Erlbaum, 1982.

121 Connidis IA. Life transitions and the adult sibling tie: a qualitative study. *J of Marriage and the Family* 1992;**54**:972-82.

122 Bedford VH. Sibling relationships in middle and old age. In: Blieszner RB, Bedford VH, eds, *Aging and the family: theory and research*. Westport (Connecticut): Praeger, 1996.

123 Gold D. Sibling relations in old age: a typology. *International J of Aging and Human*

Development 1989;**28**:37-51.

124 Downing C. *Psyche's sisters: reimaging the meaning of sisterhood*. San Francisco (California): Harper and Row, 1988.

125 Matthews SH, Rosner TT. Shared filial responsibility: the family as the primary caregiver. *J of Marriage and the Family* 1988;**50**:185-95.

126 Suitor JJ, Pillemer K. Support and interpersonal stress in the social networks of married daughters caring for parents with dementia. *J of Gerontology: Social Sciences* 1993;**48**:S1-8.

127 Myers DR, Dickerson BE. Intergenerational interdependence among older, low-income African American, Mexican American, and Anglo siblings. *Family Perspective* 1990;**24**:217-43.

128 Taylor RJ, Chatters LM, Mays VM. Parents, children, siblings, in-laws, and non-kin as sources of emergency assistance to black Americans. *Family Relations* 1988;**37**:298-304.

129 Cicirelli VG. Siblings as caregivers in middle and old age. In: Dwyer JW, Coward RT, eds, *Gender, families, and elder care*. Newbury Park (California): Sage, 1992:84-101.

130 Seltzer GB, Begun A, Seltzer MM, Krauss MW. Adults with mental retardation and their aging mothers: impact of siblings. *Family Relations* 1991;**40**:310-7.

131 Spitze G, Logan JR. Sibling structure and intergenerational relations. *J of Marriage and the Family* 1991:**53**;871-84.

132 Coley RL, Chase-Lansdale PL. Adolescent pregnancy and parenthood: recent evidence and future directions. *American Psychologist* 1998;**53(2)**:152-66.

133 Magnusson D, Stattin H, Allen VL. Differential maturation among girls and its relations

to social adjustment: a longitudinal perspective. In: Baltes PB, Featherman, DL, Lerner, RM, eds, *Life-span development and behavior*. Vol. 7. Hillsdale (New Jersey): Erlbaum, 1986:135-72.

134 Simmons RG, Blyth D. *Moving into adolescence: the impact of pubertal change and school context*. New York: Aldine de Gruyter, 1987.

135 Caspi A, Moffit TE. Individual differences are accentuated during periods of social change: the sample case of girls at puberty. *Journal of Personality and Social Psychology* 1991;**58**:250-58.

136 Caspi A, Lynam D, Moffitt TE, Silva PA. Unraveling girls' delinquency: biological, dispositional, and contextual contributions to adolescent misbehavior. *Developmental Psychology* 1991;**29**:19-30.

137 Schoen R, Urton WL, Woodrow K, Baj J. Marriage and divorce in 20th century American cohorts. *Demography* 1985;**22**:101-14.

138 Schoen R, Weinick RM. The slowing metabolism of marriage: figures from 1988 US marital status life tables. *Demography* 1993;**30**:737-46.

139 Castro-Martin T, Bumpass LL. Recent trends and differentials in marital disruption. *Demography* 1989;**26**:37-51.

140 Bumpass L, Sweet JA. National estimates of cohabitation: cohort levels and union stability. *Demography* 1989;**26**:615-25.

141 Bumpass L, Lu H-H. Trends in cohabitation and implications for children's family contexts in the US. *Population Studies* 2000;**54**:29-41.

142 Booth A, Amato P. Divorce and psychological stress. *J of Health and Social*

*Behavior*1991;**32**:396-407.

143 Gove WR, Hughes M, Style CB. Does marriage have positive effects on the well-being of the individual? *J of Health and Social Behavior* 1983;**24**:122-31.

144 Pearlin LI, Johnson JS. Marital status, life-strains and depression. *American Sociological Review* 1977;**42**:704-15.

145 Gove WR. Sex, marital status and mortality. *American J of Sociology* 1973;**79**:45-67.

146 Litwak E, Messeri P. Social supports and mortality rates: a disease specific formulation. In: Steinmetz SK, ed. *Family and support systems across the life span.* New York: Plenum, 1988:257-81.

147 Renne K. Health and marital experience in an urban population. *J of Marriage and the Family* 1971;**33**:338-48.

148 Glenn ND, Weaver CN. The changing relationship of marital status to reported happiness. *J of Marriage and the Family* 1988;**50**:317-24.

149 Lee G, Seccombe K, Shehan C. Marital status and marital happiness: an analysis of trend data. *J of Marriage and the Family* 1991;**53**:839-44.

150 Hahn, BA. Marital status and women's health: the effect of economic marital acquisitions. *J of Marriage and the Family* 1993;**55**:495-504.

151 Marks NF, Lambert JD. Marital status continuity and change among young and midlife adults: longitudinal effects on psychological well-being. *J of Family Issues* 1998;**19**:652-86.

152 Waite L. Trends in men's and women's well-being in marriage. In: Waite LJ, ed. *The ties that bind: perspectives on marriage and cohabitation*. Hawthorne (New York): Aldine de

Gruyter, 2000:368-92.

153 Karney BR, Bradbury TN. The longitudinal course of marital quality and stability: a review of theory, method, and research. *Psychological Bulletin* 1995;**118(1)**:3-34.

154 Marks NF. Social demographic diversity among American midlife parents. In: Ryff CD, Seltzer MM, eds, *When children grow up: development and diversity in midlife parenting*. Chicago: University of Chicago Press, 1996:29-75.

155 Arendell T. Conceiving and investigating motherhood: the decade's scholarship. *J of Marriage and the Family* 2000;**62**:1192-1207.

156 Graham H. *Hardship and health in women's lives.* Hertfordshire: Harvester Wheatsheaf, 1993.

157 McLanahan SS, Adams J. Parenthood and psychological well-being. *Annual Review of Sociology* 1987;**13**:237-57.

158 McLanahan SS, Adams J. The effects of children on adults' psychological well-being: 1957-1976. *Social Forces* 1989;**68(1)**:124-46.

159 Simon RW. Parental role strains, salience of parental identity, and gender differences in psychological distress. *J of Health and Social Behavior* 1992;**33**:25-35.

160 Scott J, Alwin DF. Gender differences in parental strain: parental role or gender role. *J of Family Issues* 1989;**10**:482-503.

161 Aneshensel CS, Frerichs RR, Clark VA. Family roles and sex differences in depression. *J of Health and Social Behavior* 1981;**22**:379-393.

162 Umberson D, Gove WR. Parenthood and psychological well-being. *J of Family Issues* 1989;**10**:440-62.

163 Hope S, Power C, Rodgers B. Does financial hardship account for elevated psychological distress in lone mothers? *Social Science and Medicine* 1999;**29**:381-89.

164 Coleman M, Ganong L, Fine M. Reinvestigating remarriage: another decade of progress. *J of Marriage and the Family* 2000;**62**:1288-1307.

165 White LK, Booth A. The quality and stability of remarriages: the role of stepchildren. *American Sociological Review* 1985;**59**:689-98.

166 Belle D. The stress of caring: women as providers of social support. In: Goldberger L, Breznitz S, eds, *Handbook of stress: theoretical and clinical aspects*. New York: Free Press, 1982:296-505.

167 Burton LM, Jarrett RL. In the mix, yet on the margins: the place of families in urban neighborhoods and child development research. *J of Marriage and the Family* 2000;**62**:1114-35.

168 White L, Edward JN. Emptying the nest and parental well-being: an analysis of national panel data. *American Sociological Review* 1990;**55**:235-42.

169 Furstenberg FF Jr., Brooks-Gunn J, Morgan SP. *Adolescent mothers in later life*. New York: Cambridge University Press, 1987.

170 Horwitz SM, Klerman LV, Ko HS, Jekel JF. School-age mothers: predictors of long-term education and economic outcomes. *Pediatrics* 1991;**87**:862-67.

171 Fischer CS. *To dwell among friends*. Chicago: University of Chicago Press, 1982.

172 Aquilino WA. The likelihood of parent-adult child coresidence: effects of family structure and parental characteristics. *J of Marriage and the Family* 1999;**52**:405-19.

173 Aquilino WA. Predicting parents' experiences with coresident adult children. *J of Family*

Issues 1991;**12**:323-42.

174 Seltzer MM, Krauss MW, Choi SC, Hong J. Midlife and later-life parenting of adult children with mental retardation. In: Ryff CD, Seltzer MM, eds, *The parental experience in midlife*. Chicago: University of Chicago Press, 1996:459-89.

175 Feiring C, Lewis M. The child's social network: sex differences from three to six years. *Sex Roles* 1987;**17**:621-36.

176 Gerstel N, Gallagher SK. Kinkeeping and distress: gender, recipients of care, and work-family conflict. *J of Marriage and the Family* 1993;**55:**598-607.

177 Moore G. Structural determinants of men's and women's personal networks. *American Sociological Review* 1990;**55**:726-35.

178 Cherlin A, Furstenberg FF Jr. *The new American grandparent*. New York: Basic Books, 1986.

179 Fuller-Thomson E, Minkler M, Driver D. A profile of grandparents raising grandchildren in the United States. *Gerontologist* 1997:**37**:406-11.

180 Minkler M, Fuller-Thomson E. The health of grandparents raising grandchildren: results of a national study. *American J of Public Health* 1999;**89**:1384-89.

181 Douvan E, Adelson J. *The adolescent experience*. New York: Wiley, 1966.

182 Belle D. Gender differences in children's social networks and supports. In: Belle D, ed, *Children's social networks and social supports*. New York: Wiley, 1989:173-88.

183 Berndt TJ, Perry TB. Children's perceptions of friendship as supportive relationships. *Developmental Psychology* 1986;**22**:640-48.

184 Maccoby EE. Gender and relationships: a developmental account. *American Psychologist*

1990;**45(4)**:513-20

185 Blieszner R, Adams RG. *Adult friendship*. Newbury Park (California): Sage, 1992.

186 Wilkins W. Social stress and illness in industrial society. In: Gunderson E, Rahe R, eds, *Life stress and illness*. Springfield (Illinois): Charles C. Thomas, 1974:242-54.

187 Stack C. *All our kin: Strategies for survival in a black community*. New York: Harper and Row, 1974.

188 Goldsteen K, Ross CE. The perceived burden of children. *J of Family Issues* 1989;**10**:504-26.

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