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Expanding the Second Shift: Exploring Women's Work in Elder Care

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Expanding the Second Shift:

Exploring Women’s Work in Elder Care

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Expanding the Second Shift:
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Abstract

Informal caregivers provide the backbone of elder care-work. Current estimates suggest that between 30 and 38 million Americans (age 18 and older) provide care to an aging adult with limited functioning. Although they often go unrecognized in public policy discussions, these family members, friends, and neighbors provide the majority of long-term services and support to the aged and disabled. However, researchers have become increasingly aware of the need for informal caregivers as public concern grows over the sustainability of Social Security, as well as the potential lack of adequate formal care, in the near future. Although more attention is being given to concerns about physical availability, the concern over whether or not informal caregivers are mentally and emotionally prepared to handle elder care-work is noticeably lagging. To better understand the caregiver experience, this study evaluates contributing factors for caregiver stress among individuals caring for someone aged 65 or older.

Using the 2004 National Survey of Informal Caregivers I argue: (1) greater involvement in caregiving increases caregiver stress; (2) access to social and emotional support alleviates caregiver stress; and (3) living with the care recipient increases caregiver stress. I also argue that
the way elder care-work is experienced reflects a new dimension of Hochschild’s (1989) work on the “second shift.” For this reason, I expect to find that women disproportionately experience caregiver stress compared to men because the act of “caregiving” is closely tied to gendered notions of mothering and femininity. Thus, I expect women to be more emotionally invested in and critical of their care-work than men. When care-work is done “in the home” it is subject to even greater scrutiny because the “home” represents a “woman’s domain.” Using OLS regression technique and a sample of 519 informal caregivers, this study finds that extent of care, social support, and gender significantly influence the level of stress experienced by caregivers. Having access to an available social network alleviates stress while the number of care-related tasks and ‘being female’ increases caregiver stress. Using the ‘Second Shift’ as a framework, this analysis suggests that interpreting elder care-work as a dimension of the larger gendered identity of “caregiver” will help expose gendered inequities in emotional labor among elder caregivers.
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I. Introduction

Informal caregivers provide unpaid care to persons with disabilities at any age. Current estimates suggest that between 30 and 38 million Americans (age 18 and older) provide care to adults with a limitation in any activity of daily living (ADL) or instrumental activity of daily living (IADL) (Gibson and Houser 2007). While they often go unrecognized in public policy discussions, these family members, friends, and neighbors provide by far the majority of long-term services and support to the aged and disabled (Gibson and Houser 2007). However, as public concern about the growth of America’s aging population increases, researchers have become increasingly aware of the need for informal caregivers. Additional concerns over the stability and longevity of Social Security, as well as the potential lack of adequate formal care, has prompted debate over whether or not informal caregivers will be able to shoulder the primary responsibility of providing care to so many aging Americans (Dwyer and Coward 1991; Moen, Robison and Fields 1994; Wolf, Freedman and Soldo 1997).

What we know about informal caregivers for the elderly is that they are primarily women. Recent research suggests that of the total number of primary caregivers assisting impaired persons (aged 65 and older), 38 percent are spouses and 41 percent are adult children and women represent 73 percent of these two categories (Wolff and Kasper 2006). However, various social and demographic factors threaten the caregiver availability. These factors include: (1) increase in 65 and older population; (2) growing number of elderly living with chronic pain and illness; (3) changes in family composition; (4) increase in women’s labor force participation; and (5) growing uncertainty in the sustainability of Social Security. Each of these factors complicates the issue regarding whether or not informal caregivers have the time, resources, knowledge, and skills to adequately provide care.
Although more public attention is being given to concerns about physical availability, the concern over whether or not informal caregivers are mentally and emotionally prepared to handle the demands of caregiving to an aged person is noticeably lagging. To better understand the mental demands of this experience, I evaluate the contributing factors of caregiver stress. I am particularly interested in whether or not the number of care-related tasks, access to social and emotional support, and living with the care recipient influences caregiver stress. Moreover, I expect to find that women disproportionately experience caregiver stress compared to men because the act of “caregiving” is closely tied in with gendered notions of mothering and femininity. Thus, I expect women to be more emotionally invested in and critical of their care-work particularly when it is accomplished in the home or “her domain.” The fact that the “typical” caregiver in the U.S. is a 46 year old woman who works outside the home gives reason for me to contend that “women’s work” in elder caregiving is a new dimension of Hochschild’s (1989) work on the “second shift.” Using data from the 2004 National Survey of Informal Caregivers, I argue: (1) greater involvement in caregiving increases caregiver stress; (2) access to social support and emotional support alleviates caregiver stress; and (3) living with the care recipient increases caregiver stress. Further, because women are more invested than men in the emotional labor required of the “caregiver” role, I also expect to find a significant gender effect across all models in this analysis.
II. Literature Review

Growth in Caregiving: Social and Demographic Trends

Informal caregivers have always been a vital source of support for older people in America (Gibson and Houser 2007). Recent estimates indicate that between 65 and 80 percent of all long-term care services are exclusively provided by family members and friends (Wolff and Kasper 2006; Neal and Wagner n.d.). However, researchers are becoming increasingly concerned about whether or not informal caregivers will be able to meet the demands of this growing population. Five major social and demographic factors will likely affect the availability of informal caregivers in the near future:

The Growth of America’s Aging Population

The population of persons aged 65 or older is growing dramatically, from 31.2 million in 1990 to 35 million in 2000 (U.S. Census Bureau 2001; Gist and Hetzel 2004). Current estimates show that now 37 million people living in the U.S. are aged 65 or older (U.S. Census Bureau 2005-2007). However, with the first wave of the more than 75 million Baby Boomers expected to reach age 65 in 2011, this number is projected to exceed 80 million by the year 2030 (U.S. Census Bureau 2005-2007). Much of this growth has to do with the fact that human beings are living longer. Life expectancy in the U.S. has risen steadily over the 20th century such that a child born in 1900 could expect to live 47 years while a child born in 2000 could expect to live 74 years (Marks and Lambert 1997; U.S. Census Bureau 2000). More telling is that the highest growing portion of the older population is among the “oldest-old” (persons aged 85 and older). This segment of the population experienced a 38% increase between 1990 and 2000 alone.
What this suggests is that a major portion of the population is at increased risk for developing age-related disabilities and illnesses that require daily assistance (Bronfenbrenner, Urie, Mcclelland, Ceci, Moen and Wethington 1996; Gist and Hetzel 2004).

**Increase in Long-Term Chronic Ailments**

While improvements in sanitation and medicine have significantly increased life expectancy, the likelihood that a person will experience some form of age-related chronic pain, illness, or disability has also increased (Bronfenbrenner et al. 1996; Gist and Hetzel 2004). Recent Census data suggests 80 percent of persons aged 65 and older have at least one chronic health condition and 50 percent have at least two (He, Sengupta, Velkoff, and DeBarros 2005). Some of the most common health conditions today include diabetes, heart disease, arthritis, musculoskeletal diseases, lower respiratory diseases, Alzheimer’s, hearing and vision impairments, and various cancers (Marks and Lambert 1997; Heron 2007). What all of these ailments and diseases have in common is that they usually involve an extended period of disability that requires help from others (Marks and Lambert 1997; He et al. 2005; Heron 2007; Neal and Wagner n.d.). Current estimates suggest about 14 million non-institutionalized older persons aged 65 and older are living with some type of disability (He et al. 2005). Taken together, increases in life expectancy and chronic health conditions indicate a growing need for assistance. However, if government-sponsored programs (i.e. Medicare, Social Security) or formal institutions (i.e. nursing homes, hospice, and in-home nurse aids) are unable to meet the needs of our nation’s growing older population, the work will likely fall to informal caregivers.
Changes in Family Composition

Another potential factor to consider is that younger generations of Americans are not keeping pace with the expanding older population. Family size is markedly smaller now that women are having fewer and later births (or choosing to remain childless altogether) than previous generations of women (May 1995; Marks and Lambert 1997; Neal and Wagner n.d.). If these trends continue, we can expect that many informal caregivers will have fewer relatives (i.e. siblings, aunts, uncles) to call upon for help (Treas 1995; Neal and Wagner n.d.). Another potential issue is the fact that more and more adults are now reaching midlife without a spouse or partner to help them provide care to an aging parent (Marks and Lambert 1997). The rise in divorce rates and single-parent households suggest that some informal caregivers not only lack help from others but have fewer resources to draw upon. A similar trend has emerged among the older population as well. Approximately 1 in 3 women born during the 1950s is unmarried at age 50; 1 in 2 is unmarried at age 65 (Uhlenberg, Cooney, and Boyd 1990). Considering that spouses are usually the first to assume responsibility, what this trend implies is that the responsibility will either increasingly fall to adult children or the criteria for caregivers will broaden to include other relatives (Marks and Lambert 1997; Wolff and Kasper 2006).

Rise in Women’s Labor Force Participation

Although women perform more care-work than men, the rise in female labor force participation suggests that many of these women also work outside the home. Recent estimates indicate that 50 percent of adult children who perform care for an elder parent also work (Wolff and Kasper 2006). If we combine this trend with the overall trend of longer workdays (Hochschild 2001), we can see the potential for more informal caregivers having to struggle to
balance work and family demands. Already at least half of all working caregivers report at least some level of work-family conflict (Wolff and Kasper 2006). Additionally, we have seen how the proportion of primary caregivers without any form of support from others has grown (Wolff and Kasper 2006). The number of primary informal caregivers that reported receiving no help from others rose from 35 percent in 1989 to over 52 percent in 1999 (Wolff and Kasper 2006). This finding may indicate that social support among relatives, friends, and neighbors is waning or that social networks are becoming less accessible for informal primary elder-caregivers.

The Decline of Social Security

Social Security is currently the largest income provider for eligible retirees, but with public concern growing over whether it has long-term sustainability, many people worry about the government having enough resources to absorb the increasing costs of the expanding older population. Although 90 percent of people (aged 65 and over) receive Social Security today, the 2003 federal Old-Age, Survivors, and Disability Insurance (OASDI) Trustees Report projects that the annual cost for Social Security will exceed tax income as early as 2018 (He et al. 2005). The OASDI Trustees Report also projects that Social Security will become exhausted by 2042\(^1\) (He et al. 2005). Three main reasons can account for this trend. First, the number of beneficiaries is increasing faster than the number of covered workers. For instance, the worker-beneficiary ratio has decreased from 41.9 in 1945 to just 3.3 in 2002 (He et al. 2005). Second, longer life expectancies indicate that support needs to cover beneficiaries over longer periods of time (He et al. 2005). Third, future pensions are not expected to make up for the projected loss in Social Security income. Only 52 percent of retirees received pension income in 2002 (He et al. 2005). Millions more are currently expected to be “at risk” of having an inadequate income during their
retirement years (He et al. 2005). Taken together, each of these contributing factors pose a significant threat to how well elder care can be managed and performed by informal caregivers.

**Models of Caregiving**

Although women are overwhelmingly more likely than men to provide care to elder persons, previous research reminds us to not assume that their work is experienced uniformly and therefore should not be theoretically treated as if it were (Barusch and Spaid 1989; Dwyer and Coward 1991; Doress-Worters 1994). Two models of caregiving provide the basic framework with which to develop my “second shift” approach. The first, role theory, assumes that whoever is expected to perform the role of “caregiver” is more likely to be doing the care-work and, subsequently, also more likely to have greater levels of care-related stress. In the context of elder care, this approach suggests that because care-work reflects a larger societal expectation for women to assume the role of caregiver in all capacities (such as wife or mother) we can expect that women experience the same elder care-work differently than men (Parsons and Bales 1955 in Doress-Worters 1994).

The second model, the life course approach, stresses interdependency suggesting that an individual’s life experiences are both enhanced and limited by the lives of their significant others. However, women’s actions and decision-making are thought to be more affected by the experiences and expectations of their spouses, children, and aging parents than men’s (Moen, Robison, and Dempster-McClain 1995). For this reason, I posit that the more social and emotional support a caregiver receives, the less their care-related stress. I also expect to find that because they experience elder care-work differently than men, having equal access to outlets of support does not diminish the effect of gender on caregiver stress.
Hochschild’s (1989) “second shift” provides additional insight into how we can conceptualize elder caregiving because it integrates elements from role theory and the life course approach and incorporates a discussion about identity and emotional labor within the home. Thus, in the context of elder care, the “second shift” approach asks us to consider how women perceive their “caregiver” status and manage care-related emotional labor when it is performed in the home context of “her domain.” I provide a brief overview of these models in the following section.

Role theory

Role theory research suggests that social behavior reflects larger societal expectations that govern how individual actors engage with and conform to prescribed social roles. A major focus in the literature looks at how gender roles create a division of labor in which men and women perform different kinds of tasks (Doress-Worters 1994). Men are expected to specialize in instrumental tasks (i.e. providing economic needs) while women are expected to specialize in expressive tasks (i.e. domestic responsibilities) (Parsons and Bales 1955 in Doress-Worters 1994; Pavalko and Woodbury 2000). Much of the research that examines women’s work has focused on the roles of young adult women, typically defined within the employment, marriage, and child-rearing literature (Doress-Worters 1994).

There is, however, a growing body of research that attempts to unearth the previously marginalized roles of women in midlife and beyond. Because women are having children later, many midlife women are still caring for children while also caring for an impaired spouse, parent or parent-in-law (Doress-Worters 1994; Moen, Robison, and Fields 1994; Norton, Stephens, Martire, Townsend, and Gupta 2002). However, the nature of the relationship between caregiver
and care recipient dictates how the care-work is performed and how it is interpreted by the caregiver. This is because the role of “elder caregiver” is less defined than “child caregiver” and thus more often confusing and difficult to navigate.

Another major aspect of role theory approach suggests that although caregiving is an essential part of family organization, it has been arbitrarily assigned to women, bringing both costs and benefits to their well-being (Miller 1976; Doress-Worters 1994). The traditional view of care-work suggests that, through caring for others, women receive a valid identity (Doress-Worters 1994). Despite these claims, such roles exact substantial costs from women. These include keeping women isolated in the home, reducing their opportunities for employment, and impeding their ability to adopt and maintain other meaningful roles (Doress-Worters 1994). Consequently, because women are socialized to feel responsible for dependents, many may feel guilty or inadequate if they don’t have the “natural” inclination to perform care-work. In the context of elder care, women may even feel resentful of the care recipient because s/he is no longer able to function independently (Doress-Worters 1994). Therefore, while I expect that doing more care-work results in greater caregiver stress, I also expect that because women are expected to assume the role of “caregiver,” they experience the physical labor of care-work differently than men and, subsequently, have higher levels of care-related stress.

Life course approach

The life course approach looks at the most distinctive stages of life—infancy, childhood, adolescence, young adulthood, and so on—and inquires about the most prominent roles and events an individual experiences. What is important to consider here is that each stage of life influences the next. In other words, the dynamics of an earlier stage affects how
subsequent events are interpreted and roles are performed. Further, the life course approach identifies social interdependencies as major determinants of life experience (Moen et al. 1995). However, because men and women are socialized differently at each stage of life, women’s life trajectories tend to be more embedded in and structured by the experiences and expectations of their spouses, children, and aging parents (Moen et al. 1995). For this reason, women tend to view caregiving as a life-long experience. However, a direct result of viewing care-work in this way is that it places a disproportionate amount of strain on women to manage various family crises (Elder and Caspi 1990 in Moen et al. 1994).

To expand on this point, we can look at how certain roles develop into careers with multiple events operating in ways that mark different stages of life over time (Moen et al. 1995). Because roles are gendered, only women are expected to see how caring for an aging or ailing relative represents the larger “career role” of “caregiver” (Moen et al. 1995). Although this approach suggests that early life roles and events prepare one for later roles and events, assuming that women’s early work in sibling and child care adequately prepares them for elder care-work later in life is misleading. That is because caring for an aging spouse or parent tends to be more ambiguous than caring for a dependent child or younger sibling. Therefore, although gender influences every stage of life, we cannot presume to expect women in midlife to have already been socialized to fully anticipate the stress of elder care-work. As such, I expect that the presence of social and emotional support play an important role in how informal caregivers manage care-related stress. Treating care-work as “women’s work” not only leaves women to shoulder the primary responsibility of elder care alone but it can potentially put the caregiver’s physical and mental health in jeopardy. For example, informal caregivers report having one or more chronic conditions at nearly twice the rate of non-caregivers (45 percent vs. 24 percent)
(Gibson and Houser 2007). Therefore, I expect that having social and emotional support alleviates care-related stress although it may not diminish the expected “second shift” gap between men and women.

*The Second Shift*

Nearly 70 percent of married women in the U.S. with at least one child under the age of 18 living in the home are also employed in the labor force (U.S. Census Bureau 2007). In *The Second Shift* (1989), Arlie Hochschild exposes the “hidden labor” (i.e. child care, housework) these working women face in the home. She uncovers a noticeable “leisure gap” between men and women, one that is largely reminiscent of the “wage gap” in the workforce, and suggests it exists because women are performing a “second shift” of unpaid work in the home. Unequal societal expectations about the division of labor in the home are the primary driving force behind women’s double duty. The argument here is that although women are now fully integrated into the labor force, women’s status as “employees” does not overshadow their primary role which is to perform the work of the “nurturing” sex.

Hochschild (1989) contends that deeply embedded feelings of guilt are a major motivation for women’s willingness to take on more family demands, whereas working men are largely exempt from these feelings. This is because women’s guilt stems from more than just a sense of role obligation. Rather, it is rooted in their gendered identity. Thus, how women evaluate their work in domestic labor is a major part of how they define themselves as “good” women. Hochschild (1989) maintains that this phenomenon has led to a stalled gender revolution. Specifically, although most women work outside the home (which constitutes a revolution), the jobs they secure and the men they come home to are not adapting as rapidly.
(representing the stall in the revolution). Elder care-work provides another dimension of
domestic labor that overlaps with Hochschild’s (1989) theoretical perspective, because being a
“good” caregiver, in any capacity, is a direct reflection of her being a “good” woman. Elder care-
work that is performed in the home is subject to even harsher scrutiny because the home setting
represents the traditional notion of the “woman’s domain.” This overlap will become more
obvious as the elder caregiver population continues to grow.

Hochschild’s (1989) work also provides a conceptual framework that looks at how
women emotionally manage the “second shift” experience. Although Hochschild (1989) exposes
the inequities of physical labor (i.e. housework, child care) between men and women, she also
redefines domestic work to include notions of emotional labor. In other words, not only should
women balance the competing demands of work and family life but they must do so in a
nurturing environment of their own creation. Hochschild (1989) traces links between the
gendered division of labor and the underlying “economies of gratitude” between partners by
asking “who is grateful to whom and for what?” She discovers that even though some couples do
share a similar load of physical work, the emotional demands required of women are still greater.
This finding suggests that the emotional labor women invest in the “running of the home” is
more intense than men. In the context of elder care, I argue that emotional inequities exist
because emotional labor and, subsequently the stress associated with emotional labor, are linked
with gendered notions of mothering and femininity.

Expanding the “Second Shift”

Hochschild (1989) provides a template for how we can conceptualize elder care. Previous
studies about women’s domestic work examine how competing roles affect care-related stress
(Remennick 1999; Pavalko and Woodbury 2000; Norton et al. 2002). Only recently has there been any real interest in assessing the cumulative impact multiple roles have on care-related stress (Doress-Worters 1994). Expanding the “second shift” approach incorporates aspects of role theory (extent of care) and the life course approach (social and emotional support) while giving particular emphasis to the importance of location (living with care recipient) and emotional labor. Role theory supports the notion that while women tend to perform more elder care-work than men, they may also perceive the role of “caregiver” differently than men. As a result, I expect to find that women experience greater caregiver stress than men even if they are doing similar amounts of care-related tasks. The life course approach expects women’s experiences (relative to men’s) are more structured by the expectations of their spouses, children, and aging parents. Therefore, I suggest that caregiver stress decreases if the caregiver has (1) access to others who can provide assistance (i.e. relatives and friends) and (2) access to outlets of emotional support. However, I also suggest that having equal access to outlets of support will not diminish the expected gender gap in caregiver stress among caregivers.

My “second shift” approach utilizes these variables and speaks to how the location of the elder-care recipient (of being “in the home”) can complicate how care-related stress is interpreted and internalized. While this approach suggests that living with the care recipient increases caregiver stress it also implies an inherent gender gap due to the nature of the home setting. In other words, I expect women to disproportionately experience care-related stress when they live with the care recipient because women’s identities are still closely tied to “the home.” Therefore, I expect that because women invest more emotional labor in the “running of the home” than men they experience greater levels of caregiver stress.
III. Data and Methods

Data
The data for this study comes from the 2004 National Survey of Informal Caregivers, a supplemental extension of the 2004 National Long Term Care Survey. The National Long Term Care Survey (NLTCS) is a nationally representative, longitudinal survey. It is designed to study changes in the health and functional status of those aged 65 or older (i.e. eligible Medicare beneficiaries). The NLTCS provides an ancillary survey, the 2004 National Survey of Informal Caregivers (NSIC), which measures other characteristics of the 65 and older sample from the perspectives of their informal caregivers. Informal caregivers can include spouses or spousal equivalents, children, children-in-law, siblings, legal guardians or other relatives living in or outside the home. The NSIC survey includes various topical sections about caregiver stress, extent of care, access to social and emotional support, and whether or not the caregiver lives with the care recipient.

Method
I used ordinary least squares (OLS) regression to test the different models in this analysis. The purpose of using ordinary least squares (OLS) is to estimate the unknown parameters in a linear regression model. The OLS method has good statistical properties for a broad set of situations which is why it is one of the primary multivariate estimation techniques used by social science researchers. The advantage of using the ordinary least squares (OLS) regression technique in this analysis is that it can determine whether or not the independent variables enhance or diminish the effect of the “Female” variable across each of the models.
The NSIC surveyors sampled different sub-sets of informal caregivers. To reduce potential sampling error, I utilized a list-wise deletion method to exclude respondents that had a missing value on any one variable. This method produced a sample of 519 respondents. Because of limitations with the data, it was necessary for me to limit my sample to only caregivers who are caring for someone other than a spouse. Table 1 presents findings for each of the models examined. Table 2 (Appendix A) provides a full description of the means and standard deviations for each of the variables. Table 3 (Appendix A) presents all the bi-variate relationships. Model 1 is the baseline model that includes only demographic variables and the “female” variable to explain caregiver stress. I then introduced role theory variables and life course variables in Models 2 and 3 and combined them in Model 4. Finally, I ran the full model (Model 5) which included the “second shift” variable to see how the variables would affect each other and how they would affect the “female” variable.

Measures

Dependent Variable

Overall Stress-Level: The dependent variable in this study measures the caregiver’s overall amount of care-related stress. The NSIC uses a single question to measure the stress level of respondents: “How much stress does it cause you to do all of the things you do to help [CARE RECIPIENT]?” Respondents are asked to identify their stress level on a scale of 1 to 10 with “1” indicating “not much stress at all” and “10” indicating “a great deal of stress.”
Independent Variables

Five independent variables are used in this analysis as factors that influence and/or can account for caregiver stress which include: (1) extent of care; (2) social support; (3) emotional support; (4) work status; and (5) living with the care recipient. Each factor is presented below.

Extent of Care: Extent of care is measured by counting the number of caregiving tasks respondents perform. This measure is meant to capture a range of activities that a caregiver may perform while involved in elder care-work. The following NSIC items identify these care-tasks:

- help with walking
- help with eating
- help with getting in/out of bed
- help with dressing
- help giving shots
- help administering medication
- help with bathing
- help assisting on the toilet
- help with bed pan
- help with a catheter

- clean up bowel accidents
- prepare meals for care recipient
- manage money for care recipient
- make phone calls
- help with dishes
- help cleaning up
- help with grocery shopping
- help with running errands
- help the recipient get around outside
- help with transportation

Respondents are asked if they assist the care recipient for each activity. A response of “Yes” is coded “1” and “No” coded “0.” I created the variable “extent of care” by counting how many of the tasks were performed by the participant. The values on the scale ranges from zero to twenty. The Cronbach’s Alpha for this measure is 0.874.

Social Support: Respondents were asked to assess whether or not they had access to others who could physically assist them in caregiving. The NSIC item used for this variable asks respondents: “If you were unable to help [SAMPNAME], is there someone else who could?” Responses were coded with “Yes” as “1” and “No” as “0.”

Emotional Support: Respondents were asked to evaluate how much emotional support they received from others. Using eight NSIC items, respondents reported how well they felt they
were being supported by their available social network during this time when they are also caring for the care recipient. These NSIC items include:

1. “There is really no one who understands what you are going through,”
2. “The people close to you let you know that they care about you,”
3. “You have a friend or relative in whose opinion you have confidence,”
4. “You have someone whom you feel you can trust,”
5. “You have people around you who help to keep your spirits up,”
6. “There are people in your life who make you feel good about yourself,”
7. “You have at least one friend or relative you can really confide in,” and
8. “You have at least one friend or relative you want to be with when you are feeling down or discouraged.”

Likert-type responses for each question range from 1 to 4 with “1” equal to “Strongly Disagree,” “2” equal to “Disagree,” “3” equal to “Agree,” and “4” equal to “Strongly Agree.” Responses to the questions are then combined and averaged across the items. The Cronbach’s Alpha for this measure is 0.905.

Work Status: Respondent’s work status stems from the question “How many hours per week do you usually work?” The responses are coded from 1 to 160 hours per week.” I recoded the responses so that “1” is equal to “Full-time” (35 or more hours per week) and “0” is equal to “Less than Full-time” (less than 35 hours per week).

Living with Care Recipient: Respondents identify whether or not they currently live with the care recipient. Responses to the question are coded “Yes/No.” I recoded “Yes” to equal “1” and “No” to equal “0.”

Demographic Variables

Race of Respondent: Respondents self-identified their racial group. “White, non-Hispanic” is coded as “1” and “Other, non-White” is coded as “0.” Previous research suggests that because of historical discrimination many racial minorities in the U.S. have relied more heavily on
extended kinship networks for intergenerational care than whites. Thus, being “non-white” may increase the amount or intensity of caregiving. However, due to the unusually large and complex categorical values given to race (40+ categories), I recoded the categories to only distinguish between “non-Hispanic White” and “Other, non-White.”

**Household Income:** Household income has been shown to affect caregiver availability in terms of how much a caregiver can afford to provide care. Those with greater financial resources may be able to outsource caregiving while those with fewer resources are left without formal assistance which may influence level of stress. I recoded household income and divided it into twenty income categories ranging from $1,500 to $150,000 annually where “1” is equal to $1,500 and “20” is equal to $150,000. See Table 2 (Appendix A) for a full description.

**Education Level:** Highest level of education is coded into five categories so that “1” is equal to “less than High School” and “5” is equal to “Graduate/Professional School and Beyond.” Previous research suggests a strong correlation between education and income which may have an effect on caregiver stress jointly. However, after checking the correlation between income and education (0.216) I determined that there is not an issue of multi-collinearity in this analysis (Table 3: Appendix A). Therefore, both variables are included in the models.²

**Marital Status:** Respondents self-report current marital status. Previous research suggests that marital status can influence how care-work and care-related stress is managed; having a spouse or partner in the home can enhance or alleviate stress (Cantor 1983; Barusch and Spaid 1989). I recoded marital status with “1” equal to “married or partnered” and “0” equal to “not married or partnered.”

**Sex of Respondent:** Sex of the respondent is a central component in this analysis. I expect that women experience greater levels of care-related stress than men across all models.
Further, I do not expect that the other variables will greatly diminish this effect. I recoded sex of respondent so “1” is equal to “Female” and “0” is equal to “Male.” Thus, my interpretations are framed so that they evaluate the effect of “being female” on caregiver stress.
IV. Results

Findings

Model 1: Demographic Variables

Table 1 presents findings from OLS regression of caregiver stress on the demographic variables and the “female” variable. This model represents the baseline model for this analysis. None of the demographic variables were significant except for the positive effect of “education” ($b = 0.102, p<.05$). This finding suggests that caregiver stress increases as education level increases. Although this could indicate that with greater knowledge comes greater awareness of care responsibilities, we cannot rule out a possible interaction effect between age and the “education” variable. For instance, it may be that mid-life adult children feel a greater sense of duty than young adult children to care for an aging parent which may influence their stress level. The “female” variable proved to be highly significant in this model ($b = 0.416, p<.001$). The finding provides support for my original argument that “being female” increases the propensity that a caregiver will experience care-related stress.

Model 2: Extent of Care on Caregiver Stress

Model 2 introduces the “extent of care” variable into the analysis. None of the demographic variables were significant in this model. Once I included the “extent of care” measure, the “education” variable was no longer significant ($b = 0.070$). This finding suggests that when number of care-related tasks is controlled for, the relationship between education and stress level disappears. In other words, education no longer matters when respondents are performing a comparable amount of care-work. Importantly, Model 2 shows that the “extent of
Table 1: Coefficients and Standard Errors from OLS Regression of Caregiver Stress on Demographic Variables, Extent of Care, Social Support, Emotional Support, and Living with the Care Recipient

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>s.e.</td>
<td>b</td>
<td>s.e.</td>
<td>b</td>
</tr>
<tr>
<td>White</td>
<td>-0.202</td>
<td>0.134</td>
<td>-0.042</td>
<td>0.127</td>
<td>-0.163</td>
</tr>
<tr>
<td>Household Income</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Education</td>
<td>0.102*</td>
<td>0.048</td>
<td>0.070</td>
<td>0.045</td>
<td>0.098*</td>
</tr>
<tr>
<td>Marital Status</td>
<td>-0.149</td>
<td>0.114</td>
<td>-0.135</td>
<td>0.106</td>
<td>-0.129</td>
</tr>
<tr>
<td>Female</td>
<td>0.416***</td>
<td>0.115</td>
<td>0.251*</td>
<td>0.109</td>
<td>0.418***</td>
</tr>
<tr>
<td>Extent of Care</td>
<td>---</td>
<td>---</td>
<td>0.107***</td>
<td>0.012</td>
<td>---</td>
</tr>
<tr>
<td>Social Support</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>-0.796***</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>-0.002</td>
</tr>
<tr>
<td>Work Status</td>
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<td>---</td>
<td>---</td>
<td>0.002</td>
</tr>
<tr>
<td>Lives with Care Recipient</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

R²: 0.040 0.166 0.123 0.221 0.221
N: 519

***p<.001; **p<.01; *p<.05
care” variable \((b = 0.107, p<.001)\) is a highly significant predictor of caregiver stress. This result supports my claim that the more involved a person is in care-related tasks the greater their stress.

Finally, a major finding in this model is that the “female” variable \((b = 0.251, p<.05)\) remains significant. While it is important to note that the “extent of care” measure reduced the size and significance of the “female” coefficient, the fact that this variable remains significant suggests further investigation is warranted. From this finding we can conclude that “being female” increases caregiver stress after controlling for number of care-related tasks. In other words, women still have greater care-related stress than men even when the physical labor is comparable. This latter finding may be an indication that looking at inequities in emotional labor or gendered identities is a reasonable approach to consider.

\[\textit{Model 3: Social and Emotional Support on Caregiver Stress}\]

Model 3 removes the “extent of care” measure and includes the “work status,” “social support,” and “emotional support” variables, which are associated with the life course model.\(^4\) There are four key findings in this model. First, the “education” effect \((b = 0.098, p<.05)\) is significant again. This result suggests that having access to sources of social and emotional support does not diminish the effect education level has on caregiver stress. In other words, an increase in education increases care-related stress even when controlling for sources of support.

The two other major findings come from the “life course” variables. First, the analysis shows that the “social support” variable is highly significant \((b = -0.796, p<.001)\). Having access to a social network that could assist in caregiving dramatically reduces caregiver stress. Second, neither “emotional support” \((b = -0.002)\) nor “work status” \((b = 0.002)\) are significant. This suggests that having access to outlets of emotional support or having to balance the demands of
paid work does not affect caregiver stress. Taken together, these findings only partially support the “life course” claim that having access to both kinds of support reduces caregiver stress. In other words, the findings suggest that knowing there are others you can call upon for assistance matters with regard to the stress experienced, but having access to others who can provide emotional support or having to work outside the home does not; they neither enhance nor diminish caregiver stress.

Finally, Model 3 shows that the “female” variable is highly significant ($b = 0.418$, $p < .001$). This finding suggests that controlling for work status, social support, and emotional support does not eliminate the effect of “being female” on caregiver stress. Therefore, we can conclude that “life course” variables such as social support tend to reduce stress but emotional support does not have a similar ameliorating effect. Further, work does not appear to increase stress. As such, we cannot explain why working women experience greater care-related stress than working men even when they have comparable access to outlets of support.

**Model 4: Extent of Care, Social Support, and Emotional Support on Caregiver Stress**

Model 4 combines the variables from Models 2 and 3. Consistent with findings from Model 2, the addition of the “extent of care” measure makes the “education” variable ($b = 0.069$) no longer significant. Also, no other demographic variables are significant. However, both the “extent of care” ($b = 0.097$, $p < .001$) and the “social support” ($b = -0.653$, $p < .001$) variables remain highly significant. This indicates that both factors are important in explaining caregiver stress and that neither can diminish the effect of the other. Consistent with model 3, the “emotional support” ($b = -0.024$) and “work status” ($b = 0.003$) variables are not significant. Finally, being “female” ($b = 0.279$, $p < .01$) remained moderately significant in the model. The
finding indicates that the combination of “role theory” and “life course” variables does not eliminate the effect of “being female” on caregiver stress. It would appear then that some other variable (or variables) are causing women to have a disproportionately greater amount of care-related stress than men.

Model 5: Extent of Care, Social Support, Emotional Support, and Living with the Care Recipient on Caregiver Stress

Model 5 is the final model in my analysis. This model represents my “second shift” approach because it includes both “role theory” and “life course” variables and contains the additional element of whether or not the caregiver lives with the care recipient. Living with the elder care recipient is an important variable to consider because closer proximity to the care recipient means that care-work will fall to the “first person available.” I argue that if the location of care-work is done “in the home” it puts greater pressure on women to perform well, because it is being done in what has traditionally been thought of as “her domain.” The end result of this hypothesis would be greater stress for women than for men when all these other variables are included in the model.

The findings from Model 5 show a number of factors that are consistent with earlier models. First, none of the demographic variables are significant. Second, the “extent of care” \( (b = 0.097, p<.001) \) and “social support” \( (b = -0.653, p<.001) \) measures were highly significant while the “emotional support” \( (b = -0.024) \) and the “work status” \( (b = 0.003) \) variables were not significant. Similarly, the “female” variable was also significant \( (b = 0.278, p<.01) \). Surprisingly, living with the care recipient \( (b = -0.008) \) was not significant. This result indicates that my “second shift” variable does not exacerbate care-related stress for women. At the same time, this
finding does reinforce the idea that, despite other potential explanations, simply “being female” significantly increases the likelihood that a caregiver will experience care-related stress.

In essence, there is an obvious gender component in the stress associated with elder care-work. The consistency in this finding provides us with additional evidence that the experience of providing care to an elder recipient does reflect traditional gender expectations about care-work. It may be that what can account for these gender differences speaks to how women emotionally invest in care-work and define and internalize the “caregiver” role as part of their “feminine” identity. However, additional analyses are needed to explain why gender differences persist in care-work.
V. Discussion and Conclusions

Discussion

This main goal of this study is to assess whether or not gender structures the experience of elder care-related stress for informal caregivers, even when controlling for a number of other variables believed to influence this relationship. I argue that (1) greater extent of caregiving increases caregiver stress; (2) access to social support and emotional support alleviates caregiver stress; and (3) living with the care recipient increases caregiver stress. However, I also suggest that because women are more emotionally invested in the “caregiver” role, they will experience greater care-related stress than men across all models in this analysis. In other words, women feel more compelled to prove their mental competency in caregiving because their emotional labor is tied to how they evaluate their mothering skills and femininity. Thus, women are more prone to feelings of guilt or shame because they are harsher critics of their caregiving abilities, whereas men are largely exempt from these concerns or worries. For this reason, I contend that elder care-work provides another dimension of women’s domestic labor because being a “good” caregiver, in any capacity, is a direct reflection of what it means to be a “good” woman. Further, when care-work is done “in the home” it is subject to even greater scrutiny because the “home” represents the “woman’s domain.”

Three main findings emerge from this study. First, the “extent of care” measure had a consistent, significant effect on the stress experienced by the caregiver. This finding confirms my initial argument that the more work a caregiver does, the more s/he will experience care-related stress. Second, while social support was found to have a significant effect on caregiver stress, emotional support was not. This finding only partially supports my hypothesis. In other words, having access to an available social network alleviates caregiver stress but having others around
for emotional support does not. While this finding does not make that much intuitive sense, it may be the case that caregivers can manage their emotions much more easily if others can provide assistance and alleviate the burden of care-work. Venting frustrations to others could alleviate stress but this effect is likely to be masked by the need for help from others.

Finally, I confirm that simply “being female,” irrespective of the other variables used in this analysis, significantly increases the amount of stress a caregiver experiences. While previous research about gender and caregiving have been somewhat mixed (Gerstel and Gallagher 2001; Miller 1992), this finding is consistent across multiple models of analysis. This last finding partially supports my “second shift” argument. Although location (being “in the home”) did not have a significant effect on caregiver stress or on the “female” variable, it also did not eliminate the effect “being female” has on caregiver stress. This may indicate that caregiving is tied to my original argument about inequities in emotional labor and/or the “feminine” identity.

This study expands upon the previous literature because it suggests that considering multiple theoretical avenues for exploration can help expose the inequalities in mental health between women and men. Both Role Theory and the Life Course approach suggest that women will experience greater levels of stress. However, I still maintain that to better understand how care-related stress is experienced, we need to focus on how care-work, in any capacity, is related to how women form their identities and evaluate their emotional labor. This approach expands Hochschild’s (1989) work on the “second shift” because it speaks to the larger demands women face as primary care providers. Elder care is a reflection of, rather than an exception to, this rule.

My findings are important in a broader context. An estimated 25 percent of the labor force has been involved in elder care-work at some point in the past 12 months; 13 percent of the labor force are currently providing assistance to an older family member (Wagner 1999 and
caregivers provide long-distance care (a commute of at least one hour) and nearly 40 percent are
part of the “sandwich generation” juggling multiple caregiving responsibilities (Fernandez 1990
in Neil and Wagner n.d.). These numbers should be a signal for employers to address the
growing needs of employees. Although elder care programs began in the 1980s, they continue to
lag behind other work-family programs. For instance, only 1 in 4 businesses in the U.S. (with
over 100 employees) offer elder care programs (Bond et al. 1998 and Neal 1999 in Neil and
Wagner n.d.). The numbers get smaller for the majority of workers who are employed by small
businesses because they tend to offer fewer programs than larger companies (Bond et al. 1998
and Neal 1999 in Neil and Wagner n.d.). Of the few that exist, the most common employer
responses emphasize flexible work schedules, telecommuting, avoidance of mandated overtime,
and family leave policies. However, few programs offer paid or partially paid options for
workers. Likewise, few employers offer means to arrange for substitute or additional caregiver
support. I recommend paid family leave and access to elder-care assistance so workers can afford
and manage their basic living expenses and adequate care. One reason employers give for why
elder-care support programs are not implemented is that few employees bring up elder care
issues (Goodstein 1995). If the population continues to age at this rate, employees may be more
willing to talk about their concerns. Greater focus on elder care within business workshops may
create a more conducive environment for opening up the lines of communication (Goodstein
1995) and create links with agencies that can provide physical assistance in elder caregiving.
Limitations

The findings from this study must be viewed in light of several survey limitations. First, the NSIC survey was vulnerable to non-response bias, non-sampling errors, and question-order effects. In particular, the questions from the NSIC survey contain “Skip To” responses that eliminated a number of respondents who had missing values on any one of the variables. Second, although the data had many in-depth questions, a number of key variables are missing. For example, to protect the anonymity of the respondents, age is not included as a demographic variable. Unfortunately, for this reason I am unable to rule out possible interaction effects between age and the other variables which may be influencing my results. Direct measures of children being present in the household or their corresponding ages are other variables that were left out of the survey. Previous research suggests that having children present in the household can affect an individual’s ability to assume other “caregiving” roles (Doress-Worters 1994; Reminnick 1999). The age of the children might also be important to consider since children under the age of 6 require more intensive caregiving, which could detract from elder care-work.

A third limitation of this study is that the caregiver eligibility criteria are quite broad. Thus, the results may not be generalizable to certain populations of caregivers (e.g., caregivers who provide only direct hands-on care rather than coordinate the care needs of relatives). Another limitation of this study is that my sample was limited to only those who were caring for someone other than a spouse. There are potentially important differences in the process of caring for a spouse versus caring for some other relative so future research should address the importance of the nature of caregiver-care recipient relationship. Finally, a selection effect may exist in this sample because there is a disproportionate ratio of women relative to men who serve as caregivers. As such, caution is warranted for the interpretations of the findings.
Future Research

The results from this analysis point toward new lines of research that focus on how elder caregiving, gender, and mental health issues intersect. For instance, although household income is not a significant factor in this analysis, it may play a key role in other caregiving situations. If a disabled elder is struggling to maintain an independent household or experiencing a high level of disability they will probably require a substantial amount of paid care. This, in turn, might make financial stress a more pressing issue for caregivers.

A second area of research has to do with race and elder caregiving. Although race is not a significant factor in the present research, this may be a function of the need to collapse a diverse set of race/ethnic minorities into one group for the purposes of analysis. Yet, we should not forget that racial minorities may be experiencing care-work differently than whites. Future research should look at the relationship between race and “extent of care” including a number of contextual factors like frequency and duration of care and how it relates to mental health issues (Cantor 1983; Barusch and Spaid 1989; Thompson, Futterman, and Gallagher-Thompson, Rose and Lovett 1993). Researchers might also focus on how extended kinship networks influence mental health issues in racial minorities involved in care-work (Collins 1990; Yeo and Gallagher-Thompson 2006). For example, racial minority caregivers are shown to experience symptoms of depression at a rate nearly twice that of the general population which is believed to increase with duration of care or if the care recipient is suffering from dementia (Zarit, Reever, and Bach-Peterson 1980; Anthony-Bergstone, Zarit, and Gatz 1988; Bethell et al. 2001). Oversampling racial minorities on these issues might allow researchers to explore these relationships in more detail. Looking at different types of care in addition to the extent of care may offer a fuller scope of analysis.
References


Miller, Baila and Lynda Cafasso. 1992. “Gender Differences in Caregiving: Fact or Artifact?”


*Journal of Gerontology: Social Sciences* 44: S3-S11.
U.S. Census Bureau. 2000. “Keeping up with Older Adults: Older Adults, 2000.”

*Population Profile of the United States: 2000.*


U.S. Census Bureau. 2007. “Employment Status of Women by Marital Status and Presence and


John Wiley & Sons, Ltd.
Table 2: Means and Standard Deviations for Caregiver Stress, Independent Variables, and Demographic Variables.

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Stress (1 =No Stress; 10=Great Stress)</td>
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<td>2.59</td>
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</table>

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Mean</th>
<th>Std. Dev.</th>
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<tr>
<td>Extent of Care (1-20 tasks)</td>
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<td>4.29</td>
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<tr>
<td>Social Support (%)</td>
<td>0.73</td>
<td>0.44</td>
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<td>Emotional Support(1=SD; 2=D; 3=A; 4=SA)</td>
<td>3.08</td>
<td>0.62</td>
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<td>Work Status (hours per week)</td>
<td>35.81</td>
<td>14.53</td>
</tr>
<tr>
<td>Living with Care Recipient (%)</td>
<td>0.44</td>
<td>0.50</td>
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</table>

<table>
<thead>
<tr>
<th>Demographic Variables</th>
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<th>Std. Dev.</th>
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<tbody>
<tr>
<td>White (%)</td>
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<tr>
<td>Household Income (in thousands)</td>
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<td>40136.67</td>
</tr>
<tr>
<td>Education (1 = &lt;HS; 5 = Grad +)</td>
<td>2.99</td>
<td>1.14</td>
</tr>
<tr>
<td>Marital Status (%)</td>
<td>0.60</td>
<td>0.49</td>
</tr>
<tr>
<td>Female (%)</td>
<td>0.68</td>
<td>0.47</td>
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</table>
### Table 3: Correlation Matrix for Dependent Variable, Independent Variables, and Demographic Variables

<table>
<thead>
<tr>
<th></th>
<th>Total Stress</th>
<th>Extent of Care</th>
<th>Social Support</th>
<th>Emotional Support</th>
<th>Lives w/Care Recipient</th>
<th>White</th>
<th>Education Level</th>
<th>Household Income</th>
<th>Marital Status</th>
<th>Work Status</th>
<th>Female</th>
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<tbody>
<tr>
<td>Total Stress</td>
<td>1.000</td>
<td>0.426</td>
<td>-0.223</td>
<td>0.033</td>
<td>0.139</td>
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<td>-0.001</td>
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<td>0.003</td>
<td>0.106</td>
</tr>
<tr>
<td>Extent of Care</td>
<td>1.000</td>
<td>0.057</td>
<td>0.367</td>
<td>0.057</td>
<td>0.003</td>
<td>-0.146</td>
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<td>Social Support</td>
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<td>0.026</td>
<td>0.019</td>
<td>0.088</td>
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<td></td>
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</tr>
<tr>
<td>Lives w/Care Recipient</td>
<td>1.000</td>
<td>-0.064</td>
<td>-0.076</td>
<td>-0.464</td>
<td>-0.313</td>
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<tr>
<td>White</td>
<td>1.000</td>
<td>0.100</td>
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<td>0.148</td>
<td>0.029</td>
<td>0.157</td>
<td>0.172</td>
<td></td>
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<td>Education Level</td>
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<td>0.100</td>
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<td>0.119</td>
<td>0.000</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Household Income</td>
<td>1.000</td>
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<td>Marital Status</td>
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<tr>
<td>Work Status</td>
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<td>0.000</td>
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<td></td>
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</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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The Old-Age, Survivors & Disability (OASDI) Trustees Report is published by the Social Security Administration. It contains a substantial amount of information on the past and estimated future financial operations of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

Previous research also suggests that collapsing these categories will not significantly affect variation. Therefore, we can expect similarities among the responses of those who have less than a high school diploma as well as for those who have achieved an advanced degree (Marks and Lambert 1997; Bethell, Lansky, and Fiorillo 2001).

The NLTCS surveyors removed information about respondent’s age for anonymity purposes so I cannot rule out possible effects from age-related spuriousness in this analysis.

The “Work Status” variable is included in the life course model because this approach emphasizes the cumulative impact of multiple roles within each stage of life. Having to perform paid work simultaneously with domestic work and care work is thought to cause additional stress for the individual.

I tested for an interaction effect between marital status and living with the care recipient but it did not prove to be significant in my analysis.