

Guided primarily by transitions theory, this study examined changes over two points in time (approximately 5 years apart) in multiple life domains (i.e., household tasks, social life, marital relationship, and well-being) between two groups of husbands aged 60 and older, who indicated that their wives were not in need of care or assistance due to an illness or disability at the initial interview. The two groups included husbands who identified themselves as a provider of care at Time 2 (T2; i.e., they had transitioned into the caregiver role; $n = 26$), and those married to healthy wives at T2 (i.e., noncaregivers; $n = 262$). Data came from a national probability sample of U.S. adults who were primary respondents to the National Survey of Families and Households in 1987-88, and who were followed up longitudinally in 1992-93. Findings suggested that husbands who entered the caregiving role demonstrated significant changes in household responsibilities, social integration, marital relationship, and well-being. Implications for practice and future research on the older husband caregiver are highlighted.

Key Words: Male caregiver, Household tasks, Social life, Well-being

Caregiving as a Life Course Transition Among Older Husbands: A Prospective Study

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Although men "provide care in substantial numbers" (Marks, 1996, p. 34), making up nearly 30% of all caregivers (Cantor, 1983; Chang & White-Means, 1991) and over 36% of spouse caregivers (Stone, Cafferata, & Sangl, 1987), the vast majority of research has centered on the experience of the female caregiver. Attention to the experience of the male caregiver, particularly the husband caregiver, is important for three primary reasons. First, husbands play a major and important role in caring for older women with chronic illness. We know that they are the first persons usually called upon to meet their wives' needs for care, they are the oldest subgroup of caregivers, and they report spending the greatest number of extra hours fulfilling caregiver responsibilities (Chang & White-Means, 1991; Stone et al., 1987). Second, husbands are severely underrepresented in interventions designed for assisting caregivers (Toseland & Rossiter, 1989), which is perhaps a reflection of our failure to craft interventions that respond to the unique needs of the male caregiver. Finally, the current national prevalence of male caregiving and projected future demographic

trends suggest that increases in men's rates of marriage and declines in male mortality will significantly increase the number and proportion of husband caregivers in the future (Himes, 1992; Marks, 1996). Identifying the ways in which the transition into the caregiving role may reorganize the internal and external world of the older man is vital to planning interventions and services for this unique and growing population.

Caregiver Role Acquisition as a Life Course Transition

Over the past three decades, a tremendous amount of attention has been given to the study of transitions across the life span, but only recently has this concept emerged in the caregiving literature (Pearlin & Aneshensel, 1994; Schumacher, 1995; Seltzer & Li, 1996; Skaff, Pearlin, & Mullan, 1996). Pearlin and Aneshensel (1994) have suggested that caregiving may be conceptualized as a "career" that changes through time and involves several major transitions. The essential transition into the caregiving role is referred to as *role acquisition* or *role enactment*. Because prior research has relied on samples of persons already occupying the caregiving role, this is the least studied transition, and yet the one about which most assumptions have been made (i.e., assuming that the effects reported by caregivers currently occupying the caregiver role are the result of role acquisition). Role acquisition is believed to be highly insidious when the conditions requiring care are chronic and progressive, as are the majority of later life illnesses (Pearlin & Aneshensel, 1994; Seltzer & Li, 1996). Seltzer and Li (1996) pointed out that it is very difficult for family caregivers to identify

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the beginning of caregiving because much of what is done in this role is an "extension of an ongoing caring relationship and grows out of prior patterns of support and assistance" (p. 614). This is especially true for spouses because of the personal and legal commitments made in the marital contract (Montgomery, 1996).

Although life course transitions have traditionally been conceptualized as occurring with the onset of certain discrete events (e.g., birth of a baby, first day at school, retirement), theoreticians in this area are urging for a redefinition—one that views transitions as long-term social processes (Elder, 1991; Cowan, 1991). Within this contemporary view, transitions may be defined as life changes and long-term "processes" that influence both external (e.g., changes in behavior, role arrangements, social and interpersonal relationships) and internal (e.g., shifts in perceptions) aspects of one's life (Cowan, 1991). As recommended by George (1993), this study integrates a life course perspective, social stress theory, and role theory to yield a richer understanding of life transitions experienced by husbands in later life. The primary intent of this study is to examine changes over two points in time (approximately 5 years apart) in multiple life domains (i.e., household tasks, social integration, marital relationship, and well-being) between two groups of husbands who all indicated that their wives were not in need of care or assistance due to an illness or disability at the initial interview. The two groups of husbands included those who identified themselves as providers of care at Time 2 (T2; i.e., they had transitioned into the caregiver role) and those married to healthy wives at T2 (i.e., noncaregivers). It is proposed that husbands who have transitioned into the caregiving role will show evidence of changes in household tasks, social integration, marital relationship, and well-being, whereas husbands who have well spouses at both times of measurement will not.

The Existing Evidence

Household Tasks.—From a life course perspective, it is not surprising that research on the division of household labor indicates significant cohort differences in the amount of time spent by husbands in household tasks (Stoller & Cutler, 1992). Despite some change toward somewhat more egalitarian patterns of household work among younger cohorts of married couples, several small- and large-scale investigations have demonstrated the presence of traditional gender differentiation in the division of household responsibilities in later-life families, which persists after taking employment status and retirement into consideration (Ade-Ridder & Brubaker, 1988; Keith, 1980, 1985, 1994; Szinovacz, 1989). Common responsibilities traditionally and consistently reported by older wives include indoor activities and tasks such as cooking, washing dishes and clothes, writing letters, and cleaning; whereas common responsibilities reported by husbands include outdoor activities and tasks such as yard work, car maintenance, and home repairs (Brubaker & Kinsel, 1985; Szinovacz, 1980). Although men after retirement do

more housework than other husbands (Rexroat & Shehan, 1987), their contribution remains small compared to that of their wives (Dorfman & Heckert, 1988; Keith & Schafer, 1986). However, these studies do not take caregiving status into account. Family caregivers commonly report work role disruptions (Kramer & Kipnis, 1995), and spouses become more involved in household tasks that are not traditional for their gender if their partner has serious health problems (e.g., see Kaye & Applegate, 1994; Szinovacz, 1980; Wright, 1993). As suggested by role theory this may result in role incongruence for men as they take on entirely new household roles (Allen, 1994). In one of the few caregiving studies to simultaneously compare time spent in household tasks among noncaregiving and caregiving husbands and wives, Wright (1993) reported that among noncaregiving spouses, the division of labor fell along traditional gender lines; however, the caregiving spouses spent significantly more time engaging in all household tasks and responsibilities than their afflicted spouses.

Social Integration.—Life transitions commonly involve reorganization in relationships between individuals and their social networks (Cowan, 1991). Recent evidence from longitudinal studies suggests that there tends to be stability in time spent in social and recreational activities across the life span, but that more change is evident in the later years (Singleton, Forbes, & Agwani, 1993). Many of the changes that accompany chronic illness and caregiving may lead to significant declines in the social life and contacts of the later-life couple (Biegel, Sales, & Schulz, 1991). Restrictions in social activities are greatest among spousal caregivers when compared with other subgroups of caregivers (Barber & Pasley, 1995). In a study of predominantly male spouses living with wives with chronic illness, Revenson and Majerovitz (1991) reported that nearly one third of husbands interviewed reported declines in social and recreational activities. In a cross-sectional study comparing caregivers to a noncaregiving random community sample, George and Gwyther (1986) reported that caregivers had substantially lower levels of social participation for multiple social activity indicators, with the exception of church attendance.

For many older adults, religious involvement is an important source of social connection and support. National estimates suggest that religious involvement is higher among older adults than among any other age group (Princeton Religion Research Center, 1994). Although some longitudinal studies have suggested that religious involvement is relatively stable over time (Markides, 1983), others have found a decline in religious activity with age but stability in religious attitudes (Blazer & Palmore, 1976). Data from a three-wave longitudinal study revealed that "indicators of religiosity remained fairly stable over time, with the possible exception of religious attendance, which declined slightly among the very old" (Markides, Levin, & Ray, 1987, p. 664). One possible explanation for this finding is that illness may reduce the ability of older adults to attend church. This has not yet been investigated among caregiving samples.

The restrictions in social life that often accompany chronic illness and caregiving may simultaneously limit the availability of emotional support to the older man. Given that older men have been found to rely almost exclusively on their spouses for emotional support (Chappell, 1990), spousal illness and the accompanying symptoms, pain, or preoccupation with illness conditions may further reduce the availability of emotional support from ill wives (Hafstrom & Schram, 1984; Revenson, 1994). Several studies have indicated that husbands with ill spouses were reluctant to add to their wives' concerns by seeking their support (Leiber, Plumb, Gerstenzang, & Holland, 1976; Lichtman & Taylor, 1986; Van der Does & Duyvis, 1989).

Marital Relationship.—A large proportion of the caregiving research that has examined changes in the marital relationship has focused on samples of persons caring for spouses with dementia. These studies reported that significant declines in marital intimacy and quality were associated with the caregiving role (Blieszner & Shiflett, 1990; Morris, Morris, & Britton, 1988; Wright, 1991). Social exchange and equity theories would suggest that persons who transition into caregiving will experience less marital happiness than noncaregivers as the result of the inequities in benefits and costs that are associated with the caregiving role (Buunk & Hoorens, 1992). Role theory suggests that marriages coping with chronic illness and caregiving may "suffer a crisis because of the resulting challenge to the established roles and myths that maintained the system" (Thompson & Pitts, 1991, p. 121). Indeed, caregiver spouses have reported significantly more changes in their marital relationship over time than noncaregivers (Russo & Vitaliano, 1995). Spousal illness may affect marital quality, marital interaction, and marital status (Burman & Margolin, 1992). Using a longitudinal design and a national sample of 1,298 married persons, Booth and Johnson (1994) reported that decrements in health were associated with a decline in marital happiness and an increase in divorce proneness.

Psychological Well-Being.—Stress and coping theories commonly propose that stressful life events will be associated with poorer well-being (George, 1993), and many variations of social stress theory have been used to study family caregiving (see Kramer & Vitaliano, 1994, for a review of the literature). Two reviews of the caregiving literature have concluded that although studies are largely limited by their cross-sectional nature, a fairly consistent pattern of elevated rates of depression is found among caregivers when compared to noncaregiving controls or population norms (Kriegsman, Penninx, & van Eljk, 1994). Findings of higher levels of depressive symptoms among caregivers as compared to age-matched controls are documented in both large- and small-scale studies (Kiecolt-Glaser et al., 1987; McNaughton, Patterson, Smith, & Grant, 1995; Reese, Gross, Smalley, & Messer, 1994; Russo, Vitaliano, Brewer, Katon, & Becker, 1995). In the few studies that have contrasted caregiving husbands with noncaregiving husbands in particular, caregiving

husbands have reported significantly higher scores on depression than noncaregiving controls (Fuller-Jonap & Haley, 1995; Marks, 1998). Less attention has been given to examining happiness as a well-being outcome in caregiving, but several longitudinal studies have supported the premise that stressful life transitions resulted in decrements in happiness over time (Chiriboga, 1996).

Research Question and Hypotheses

The primary research question guiding this study is to what extent will husbands who transition into the caregiving role show evidence of changes in the amount of time spent in household tasks, social integration, marital relationship, and psychological well-being? Based on previous research and drawing upon a life course perspective, role theory, stress theory, and transitions theory, four hypotheses were tested.

1. Husbands who have transitioned into the caregiving role will report a greater increase than noncaregiving husbands in time spent doing household tasks that are traditionally performed by older wives.
2. Husbands who have transitioned into the caregiving role will be more likely than noncaregiving husbands to report a decline in their social and recreational activities, church social events, and emotional support.
3. Husbands who have transitioned into the caregiving role will be more likely than noncaregiving husbands to report a decline in marital happiness and to view that their marriage is in trouble.
4. Husbands who have transitioned into the caregiving role will be more likely than noncaregiving husbands to report an increase in depression and a decrease in happiness.

Methods

Data

The data used for this research are from the first and second waves of the National Survey of Families and Households (NSFH). The first wave (T1), collected in 1987 and 1988, included a nationally representative sample of 13,008 noninstitutionalized American adults aged 19 and older. This survey included a main sample of 9,637 respondents, with an additional oversample of African Americans, Mexican Americans, Puerto Ricans, single parents, stepparents, cohabitators, and recently married persons. The second wave (T2) of the NSFH, collected between 1992 and 1994, includes reinterviews with 10,008 of the original primary respondents from the first wave.

A random selection was done in each of the sampled households to choose a primary respondent. Data for both waves were collected during face-to-face interviews and, at various segments of the interviews, respondents were asked to complete a self-administered questionnaire in order to facilitate the collection of sensitive information. The response rate at T1 (1987–88) was about 75%. The response rate at T2 was about

82% of first wave respondents. This yielded national population coverage at a rate of about 61% (.75 × .82) for data from both waves (see Sweet, Bumpass, & Call, 1988, for more design details).

Selecting the Analytic Sample

The analytic sample for this study consisted of NSFH primary respondents who (a) were age 55 or older at T1; (b) were married to the same spouse at both T1 and T2; (c) responded that they had not given care or assistance to a spouse due to illness or disability at T1 (described in more detail below), and who were also respondents again at T2; and (d) were not themselves impaired in activities of daily living (ADLs), and indicated that they did not receive care or assistance due to illness or disability at T1 or T2 (18 non-caregivers and 3 caregivers were eliminated on this criterion). This final criterion was used because it is plausible that being a recipient of care and the conditions that require one to need care may affect one's ability to perform household tasks, and may also effect changes in one's social life, marital relationship, and psychological well-being. These criteria yielded a sample of 322 husbands.

To assess caregiver status at T1, respondents were asked, "Do you (or does anyone living here) require care or assistance because of a disability or chronic illness?" As discussed above, respondents in the analytic sample were included on the basis of responding "no" to this inquiry. At T2, respondents were asked, "During the last 12 months have you, yourself, given anyone living with you at the time any help or assistance because of their long-term physical or mental condition, illness, or disability?" If the respondent answered "yes," he was asked, "Who did you give the most personal care of this kind?" If respondents answered anyone other than their spouse, they were excluded from this study. Respondents who answered "yes" to the inquiry regarding giving help and assistance at T2, but not at T1, and who also indicated "spouse" as the person they gave the assistance to, were classified as *spousal caregivers*. Participants who responded "no" were classified as *noncaregivers*. Thirty-four of the husbands in the noncaregiving group were excluded from the study because they reported that their spouses had serious chronic illnesses that were similar to the illnesses reported by the caregiver group. Among the caregiver group, primary illnesses specified included the following: malignant cancer or tumors ($n = 7$); serious respiratory disease ($n = 2$); heart attack or serious ongoing heart conditions ($n = 4$); stroke ($n = 1$); digestive and/or urinary disorder ($n = 2$); mental illness ($n = 1$); chronic musculoskeletal disease ($n = 3$); and arthritis ($n = 2$). Four of the caregiving husbands did not specify their spouse's illness condition. The following primary conditions were identified by the 34 husbands in the noncaregiving group: malignant cancer ($n = 5$); serious respiratory disease ($n = 4$); heart attack or serious ongoing heart conditions ($n = 14$); stroke ($n = 2$); chronic musculoskeletal disease ($n = 6$); serious neurological disorder ($n = 1$); amputation ($n = 1$); and mental illness ($n = 1$). These

men were excluded from the analyses because these illness conditions may negatively effect changes over time in the domains under investigation, and it is possible that these men are providing care to their wives even though they do not identify themselves as caregivers. In addition, because illness conditions for spouses were not ascertained at T1 for respondents who did not report caregiving, it can not be concluded with any certainty that these men experienced a "transition" concerning the onset of spousal illness. In sum, the final sample included 288 husbands aged 60 or older who were married to the same wife at T1 and T2, who did not initially report providing care to a spouse, who responded to both survey points, and who were not receiving care themselves. Approximately 10% ($n = 26$) made the transition into caregiving during the 5-year study period, and the remaining 262 husbands served as noncaregiving controls.

Measures

Functional Impairment of Spouse.—At T2 only, spouses were asked if their partner needed assistance with five primary ADLs. These were bathing, dressing, eating, transferring, and toileting. A scale was computed for ADLs summing these five conditions ($\alpha = .70$).

Household Tasks.—Respondents were asked to indicate the number of hours typically spent per week on the following tasks: meal preparation, washing dishes, cleaning house, shopping, laundry, auto maintenance, driving, outdoor tasks, and paying bills. This is the customary measurement approach used in research studies examining time spent in household tasks and it has good face validity (Rexroat & Shehan, 1987; Szinovacz & Harpster, 1994). The first five of these items (i.e., those traditionally associated with the female role) scaled well together (i.e., $\alpha = .90$) and were of primary interest to this study. A decision was made to drop the auto maintenance and outdoor tasks variables as they are traditionally performed by men and there is little reason to believe that they may be changed as a result of caregiver role acquisition. Driving and paying bills are two household tasks variables that are not as clearly differentiated by gender. Although they were not of central interest to this study, these are variables that may be influenced by caregiving (e.g., driving spouse to medical appointments or taking over the bill-paying chores as spouse becomes ill). These two items are examined separately. Descriptives for all T1 and T2 household task measures and all other outcome measures are provided in Table 1.

Social Integration.—Three primary indicators of social integration were identified. The respondents' involvement in *social recreational activities* was assessed by asking how often they "participate in a group recreational activity, such as bowling, golf, square dancing, etc." Responses were reported on a 5-point scale that included 1 = never, 2 = once a year or less, 3 = about once a month, 4 = about once a week, and 5 = several times a week. Participation in *church social events* was assessed by inquiring how often

Table 1. Descriptive Statistics for Analysis Variables

	Well Spouse Group (n = 262)		Caregiver Group (n = 26)	
	Time 1 Mean (SD)	Time2 Mean (SD)	Time 1 Mean (SD)	Time 2 Mean (SD)
Household Tasks ^a				
Traditional tasks of older wives ^b	7.42 (9.49)	9.90 (9.08)	6.24 (6.49)	17.16 (15.81)
Driving	.91 (2.13)	.76 (1.99)	1.08 (1.60)	1.24 (2.04)
Paying bills	1.41 (1.99)	1.47 (1.77)	2.08 (2.05)	1.44 (1.80)
Social Integration				
Social recreational activities	.76 (1.22)	.90 (1.31)	.87 (1.26)	.60 (1.12)
Religious social events	1.27 (1.27)	1.26 (1.09)	1.72 (1.31)	1.80 (1.08)
Emotional support	.72 (.45)	.61 (.49)	.87 (.34)	.44 (.51)
Marital Relationship				
Marital happiness	6.25 (1.23)	6.27 (1.35)	6.04 (1.17)	5.83 (1.75)
Perception that marriage in trouble	.07 (.26)	.05 (.23)	.08 (.28)	.16 (.37)
Psychological Well-Being				
Depression	2.49 (1.69)	2.46 (1.47)	2.61 (1.48)	3.61 (1.27)
Happiness	5.92 (1.38)	5.92 (1.32)	5.71 (1.27)	5.35 (1.36)

Notes: Descriptive statistics calculated using unweighted data. Dichotomous variable means are proportions.

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

^aMean number of hours spent per week on these tasks.

^bScale included meal preparation, dishes, cleaning, shopping, and laundry.

respondents “attend a social event at your church or synagogue.” Again, responses ranged from 1 = never to 5 = several times a week. *Emotional support* was elicited by asking respondents the following question: “During the past month, from whom have you received advice, encouragement, moral, or emotional support?” Responses were coded 0 for none received and 1 for some received.

Marital Relationship.—*Marital happiness* was assessed using the question, “Taking things all together, how would you describe your marriage?” Responses ranged from very unhappy (1) to very happy (7). *Marital trouble* was indicated by responses to the following inquiry: “During the past year, have you ever thought that your marriage might be in trouble?” Responses were coded 0 = no and 1 = yes.

Psychological Well-Being.—*Depression* was operationalized using a modified (12-item) version of the Center for Epidemiological Studies–Depression (CES-D) scale (Radloff, 1977). This measure is a brief self-report scale designed to identify depressive symptomology and has been used extensively in caregiver research. The CES-D has satisfactorily high internal consistency and test–retest reliability (Radloff, 1977) and is predictive of clinical depression (Roberts & Vernon, 1983). Respondents were asked, “On how many days during the last week did you: feel bothered by things that usually don’t bother you, not feel like eating, feel you could not shake off the blues, have trouble keeping your mind on what you were doing, feel depressed, feel that everything you did was an effort, feel fearful, sleep restlessly, talk less than usual, feel lonely, feel sad, feel you could not get going?” Each of the 12 symptoms was scored from 0 days of the symptom to 7 days of the symptom. The log transformation of the

depression score was used as the continuous outcome measure to help correct the positively skewed distribution. In the current study, the Cronbach’s alphas for this index for T1 and T2 were .92 and .89, respectively. *Global happiness* was measured with a standard one-item indicator: “Taking things all together, how would you say things are these days?” Respondents answered this question in a self-administered booklet that provided a 7-point scale anchored at one end by “very unhappy” and at the other end by “very happy.”

Demographic Controls.—Several additional demographic variables were also controlled in all analyses to control for T1 differences in the sample. As will be discussed in the section on demographic comparisons, three social demographic variables differentiated the two samples at T1. These included age, household income (continuous measure totaled across all types of earned and unearned income for all household members at T1), and employment status (dichotomously coded 1 = employed vs 0 = not employed). National studies document that with increasing age caregiving is more likely, that older spousal caregivers are less likely to be employed, and that they have lower incomes (Soldo & Myllyluoma, 1983; Stone et al., 1987); all of these variables have known associations with the outcomes investigated. Another covariate entered in all analyses was race/ethnicity (dichotomously coded 1 = non-White vs 0 = non-Hispanic White). Relative to the total aged population, persons of color are more likely to suffer from functional and health limitations (Macken, 1986), to experience poorer well-being resulting from marginalized economic and social opportunities (Markides, Liang, & Jackson, 1990), and to show a differential pattern of change in health, well-being, and social integration in later life (Beckett & Dungee-Anderson, 1992).

Analytic Plan

Prior to analysis, all variables were examined for missing values, and fit between their distributions and the analytic assumptions. As recommended by Tabachnick and Fidell (1989), procedures were followed to determine whether the data were missing randomly. A variable was constructed that included missing and nonmissing cases. Then tests for differences were examined on demographic and other study variables, and no systematic pattern was identified. Inspection of *z* scores and graphical methods were used to identify several outliers on household tasks within each group, and procedures were followed to reduce their influence. For example, as recommended by Tabachnick and Fidell, 1989 extreme outliers (i.e., cases for which the standardized *z* scores were in excess of + or -3.00) were truncated (i.e., high scores exceeding the allowed high value were recoded to the highest allowable value) so that they remained deviant, but not so deviant that they would unduly skew the results. Variables transformed to improve the distributions of moderately skewed variables were analyzed, resulting in a similar pattern of findings as with those not transformed. For ease of interpretation, results using untransformed data will be presented (with the exception of depression, which was more seriously skewed).

The research question involves examining changes over time and the differences between the means of two groups of husbands, while holding constant their T1 scores and covariates. Analysis of covariance (ANCOVA) was used to test the mean differences while controlling for covariates (Cohen & Cohen, 1983). All of the covariates have known association with the dependent variables and as such, the ANCOVA approach helps to minimize error variance (Stevens, 1986; Tabachnick & Fidell, 1989). Although the ANCOVA approach is best suited to continuous variables, it has been found to be highly robust against nonnormality for type 1 error (Stevens, 1986), and as such the two dichotomous variables (i.e., emotional support and perception of marital trouble) were retained for these analyses.

Results

Sample Description

Demographic Comparisons.—A description of the analytic sample (*N* = 288) is presented in Table 2 by caregiver status. The two groups differed significantly in age, income, and employment status. Members of the caregiver group were approximately 3 years older, had lower incomes, and were less likely to be employed than the well spouse group. There were no significant differences between the two samples in education, race, duration of marriage, and marital history. There was also no significant difference between the caregivers (*M* = 3.73) and noncaregivers (*M* = 3.95) in their T1 health status, which was measured on a 5-point scale from 1 = very poor to 5 = excellent, *t*(268) = 1.18, *p* = .24.

Care Receiver Level of Impairment.—At T2, all spouses were asked whether their partner needed assistance

Table 2. T1 Comparisons of Social Demographic Characteristics by Caregiver Status

Demographic Characteristics	Well Spouse Group (<i>n</i> = 262) Mean (<i>SD</i>)	Caregiver Group (<i>n</i> = 26) Mean (<i>SD</i>)	Test Statistic
Age	64.66 (7.26)	68.09 (7.23)	<i>t</i> = -2.40*
Education	11.63 (3.97)	11.08 (4.60)	<i>t</i> = .65
Non-Caucasian	.17	.23	χ^2 = .65
Income (\$ in thousands)	39.78 (42.04)	29.74 (21.72)	<i>t</i> = 2.04*
Employed	.50	.23	χ^2 = 6.87**
Duration of Marriage	33.88 (13.77)	38.64 (12.10)	<i>t</i> = -1.85
Married More Than Once	.25	.15	χ^2 = 1.24

Notes: Descriptive statistics calculated using unweighted data. Dichotomous variable means are proportions.

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

p* < .05; *p* < .01.

with bathing, dressing, eating, transferring, and toileting. Five (19%) of the 26 husbands in the caregiver group indicated that their wives had one or more ADL impairments at T2. All five of these men reported that their spouses required assistance with bathing, three reported ADL impairments in dressing, and one additionally reported ADL spousal impairments in mobility and toileting. Interestingly, 21 (81%) of the caregiving husbands reported that their wives did not require assistance with ADLs. None of the noncaregiving husbands reported spousal ADL impairment.

Changes Associated With Caregiver Role Acquisition

Household Tasks.—As shown in Table 3, there was a significant difference between the two groups of husbands in the performance of household tasks traditionally performed by older wives. As hypothesized, husbands who entered the caregiving role reported more time spent doing these household tasks than noncaregiving husbands. Indeed, after controlling for the T1 measure and the covariates, caregivers were spending approximately 7 more hours per week on average than husbands with well spouses performing the tasks of meal preparation, dishes, cleaning, shopping, and laundry. As reported in Table 1, prior to taking on the caregiving role, husbands in the caregiving group did an average of 6 hours per week of household tasks, which increased to approximately 17 hours after taking on the caregiving role. In contrast, in the well spouse group, there was only a 2-hour increase in the amount of time spent on household tasks. There was no difference between the two groups of husbands in the amount of time spent driving or paying bills.

Social Integration.—Table 3 reveals that there were changes over time in two social integration variables

Table 3. Adjusted Means and Analysis of Covariance of T2 Household Tasks, Social Life, Marital Relationship, and Well-Being by Caregiver Status (*N* = 288)

	Well Spouse Group (<i>n</i> = 262)	Caregiver Group (<i>n</i> = 26)	<i>F</i> ^a Covariates	<i>F</i> ^b Caregiver Status (df)
Household Tasks ^c				
Traditional tasks of older wives ^d	9.95	17.11	9.65***	13.29*** (1, 255)
Driving	.81	1.19	14.55***	.84 (1, 255)
Paying bills	1.55	1.36	8.82***	.17 (1, 255)
Social Integration				
Social recreational activities	.89	.64	35.48***	1.29 (1, 241)
Religious social events	1.35	1.80	16.96***	4.68* (1, 239)
Emotional support	.61	.39	2.01	3.98* (1, 241)
Marital Relationship				
Marital happiness	6.36	5.80	5.19***	3.77* (1, 237)
Perception that marriage in trouble	.07	.17	20.24***	4.51* (1, 226)
Psychological Well-Being				
Depression	2.42	3.38	10.15***	10.70*** (1, 236)
Happiness	5.94	5.26	6.46***	6.80*** (1, 219)

Notes: Analyses included controls for age, non-White ethnicity, income, employment status, and T1 measures for each variable, and were calculated using unweighted data.

Source: National Survey of Families and Households, 1987–1988; 1992–1994.

^aThe overall *F* ratio for the covariates age, race, income, employment status, and T1 measure is presented.

^bAll comparisons adjusted for covariates.

^cMean number of hours spent per week on these tasks.

^dScale included meal preparation, dishes, cleaning, shopping, and laundry.

p* < .05, *p* < .01, ****p* < .001.

that differentiated the groups of husbands, though one was not in the expected direction. As hypothesized, husbands who transitioned into the caregiving role were more likely than noncaregiving husbands to report a decline in their perception of emotional support from T1 to T2. As shown in Table 1, prior to taking on the caregiving role, approximately 87% of husbands in the caregiver group reported receiving emotional support at T1, which declined to 44% at T2. Alternatively, there was only a 10% difference in the perception of emotional support received between T1 and T2 among the well spouse group (i.e., from 72% to 61%). The adjusted means reported in Table 3 indicate that after controlling for the T1 score and covariates, only 39% of the caregivers at T2 reported receiving some form of emotional support as compared to 61% of the noncaregivers. Although it was anticipated that the caregiver group would report a decrease in religious social events as compared to the noncaregiving group, the results suggested that they actually reported an increase in time spent in religious social events.

Marital Relationship.—As shown in Table 3, both of the marital relationship indicators significantly distinguished the two groups. As hypothesized, husbands who transitioned into the caregiving role were more likely than noncaregiving husbands with well spouses to report a decline in marital happiness and to view that their marriages were in trouble. As reflected in Table 1, the T1 and the T2 means among the well spouse group for marital happiness (i.e., 6.25 and 6.27) and for the perception that the marriage is in trouble (.07 and .05) demonstrated little change over time. Alternatively, the mean marital happiness rating among

the caregiver group declined from 6.04 to 5.83, and the perception that the marriage was in trouble approximately doubled from .08 to .16.

Psychological Well-Being.—Table 3 indicates significant differences between the two groups of husbands in the adjusted means for both indicators of psychological well being. As hypothesized, the caregiving husbands were more likely than the noncaregiving husbands who had well spouses to report an increase in depression and a decrease in happiness from T1 to T2. As reflected in Table 1, there is little evidence of change among the noncaregiving group in mean levels of T1 and T2 depression (i.e., 2.49 to 2.46) or happiness (i.e., 5.92 to 5.92). In contrast, mean levels of T1 and T2 scores among the caregiver group for depression increased from 2.61 to 3.61, and decreased from 5.71 to 5.35 for happiness.

Examination of Other Possible Transitions

One might hypothesize that the transition to another living environment or to retirement could influence changes in several of the dependent variables under investigation (Rexroat & Shehan, 1987). The caregiving and noncaregiving husbands were additionally compared to determine possible differences in these two transitions that are often associated with aging and that may offer competing explanations to the patterns of findings. There were no significant differences between the two groups in relocation status or retirement status (i.e., they were comparable in the likelihood of these events).

Discussion

This longitudinal study is the first to examine the transition into the caregiving role among older husbands. The incidence of caregiving role acquisition was approximately 10% among the relatively healthy, continuously married men aged 60 and older, who responded at both time points. The primary conclusion drawn from this study is that husbands who have transitioned into the caregiving role experience significant changes in their household tasks, social integration, marital relationship, and well-being, albeit not always in the expected directions. This conclusion will be highlighted in the next section, followed by a discussion of limitations and possible implications for research and practice.

Evidence of Change.—Compared with noncaregiving husbands, men who transitioned into the caregiving role demonstrated significant changes in multiple life domains. Even after controlling for T1 differences between the samples, caregiving husbands were spending significantly more time engaged in household responsibilities that are traditionally performed by older wives. This finding supports the premise that spousal illness may require significant changes in role behavior. According to transitions theory, transitional life events are typified by changes in patterns of behavior and roles that may be added, redefined, or involve shifts in the salience of currently occupied roles (Cowan, 1991).

Husbands who entered the caregiving role showed significant changes in two aspects of social integration. They reported a greater increase in participation in religious social events, and a greater decline in their emotional support than husbands with well spouses. Although one prior cross-sectional study noted no difference in church attendance between caregivers relative to a random community sample (George & Gwyther, 1986), it is interesting to note that caregiving husbands in this study actually reported an increase in participation in religious social events. This finding was surprising as it was expected that illness and disability of the spouse might reduce the ability of older adults to attend religious events. An interesting question that remains to be examined is the extent to which the increase in church attendance might be a function of the decreased availability of emotional support. For many older adults, religious involvement is an important source of social connection and support. Does attendance at religious social events provide needed social contact that those who are typically isolated experience? Idler and Kasl (1997) noted that disabled older adults who were actively involved in religious activities "received particular benefits in terms of additional contacts and closeness with friends, more numerous holiday celebrations, more optimism, and more positive affects" (p. S303). Suitor and Pillemer (1990) proposed that family caregiving may be viewed as social status acquisition that is typically accompanied by reduced contact with social network members who have become less similar and a desire to intensify or develop relationships with others who are perceived

to be more similar. It is possible that caregiving husbands are looking for ways to be connected with others who possess similar values through religious social events. Alternatively, the church or synagogue may be perceived as a place where husbands may provide opportunities for socialization for wives who are not as functional as they have been in the past.

Contrary to the expectation, there was no significant difference found for time spent in social and recreational activities among caregiving husbands, although several cross-sectional studies have noted differences between caregivers and noncaregivers in social activities. Some evidence suggests that social activity restrictions are more frequently reported among spouses with cognitive impairments (Bass, McClendon, Deimling, & Mukherjee, 1994), and most of the illnesses reported by our analytic sample would preclude such conditions. It is also possible that we have captured a sample that has not yet experienced such restrictions. Alternatively, it may be that the relatively small size of the caregiver group limits our power to detect the differences that do exist. For example, the mean for T2 is lower for the caregiving group and higher for the noncaregiving group than the T1 scores; however, the sample size may not allow for detection of these differences or the differences may not yet be great enough to detect. Another explanation might be that although women are often found to cut back on their social activities to care for their husbands, men might not cut back to care for their wives, possibly because they do not have an extensive and active social life to begin with.

Husbands who entered the caregiving role showed evidence of potentially detrimental changes in the marital relationship. Caregiving husbands reported a significantly greater decline in marital happiness and were more likely to perceive that their marriage was in trouble than husbands in the well spouse group. This is consistent with findings reported by Russo and Vitaliano (1995) in which greater decrements in marital relationship were reported among caregivers as compared to noncaregiving spouses. We do not know how many later-life marriages end in divorce as a result of illness. But given that declines in marital happiness are strongly linked to divorce (Johnson & Booth, 1998), these findings suggest that more attention should be given to the potential implications of these findings for later-life families.

Finally, this study found evidence of reduced psychological well-being among husbands who have transitioned into the caregiving role. Not surprisingly, these husbands are becoming less happy and more depressed than husbands with well spouses, even after controlling for age, employment status, income, and race. Although these findings are not surprising, they do suggest that older men who acquire the spousal caregiving role are worse off in terms of psychological well-being than noncaregiving husbands, and that further attention should be paid to understanding how the experience of caregiving is unique for the older man. A sizable body of research has emerged to explore the contributors to well-being among caregivers, yet minimal attention has been given to the male caregiver in

this regard. What is it about this later-life transition that affects these changes in well-being? Is it the mere presence of spousal illness and concern about their health? Is it the strain associated with providing care? Answers to these questions could be central to gender-sensitive intervention development.

Although we believe this analysis fills an important gap in the caregiving literature, we readily acknowledge several of its limitations. First, we are well aware that our inclusion criteria restrain the extent to which these results may be generalizable beyond the relatively healthy husbands aged 60 or over who make up this sample. The changes experienced over time in household tasks, social life, marital relationship, and well-being may indeed be very different for older men who themselves have serious chronic conditions and need care. Similarly, we recognize that many of the wives receiving care in this sample were not restricted in ADLs. Results may vary among husbands caring for wives with more intense caregiving needs. Second, the caregiver group has a relatively small *n*, and this fact limits the power to detect group differences and also raises the question of stability of findings if a replication study were done. It is noteworthy that, even with such a small sample, several significant findings emerged. Third, although secondary analysis of national probability data holds many advantages, there are also measurement and design limitations. For example, though less than ideal, there are several single-item indicators that were used in order to obtain a breadth of data in multiple domains, and the duration of time between T1 and T2 is 5 years. Finally, we do not have data on duration of caregiving, duration of illness, or additional resources that husbands may or may not have in meeting the needs of their wives, so we do not control for these variables. Our hope is that this population-level study will suggest areas for further inquiry into the older male caregiver and complement the richer and more in-depth studies of caregiving that are underway.

Conclusions and Implications.—These limitations notwithstanding, the results from this study demonstrate that there are several changes in multiple life domains over time among husbands who transition into the caregiving role. The particular changes that occur suggest several potential implications for practitioners who work with older caregiving men. First, their increased participation in religious social events might suggest alternative settings in which supportive or educational interventions might be offered to later-life couples. Greater emphasis could be placed on providing interventions in religious settings that could help to prepare the growing population of male caregivers for the transitions associated with spousal illness. Programs could be developed to help noncaregiving members of religious institutions to become better educated about the best ways to support those in caregiving roles and those who become ill. Second, we would advocate that interventions be designed with couples in mind, as opposed to targeting programs to individual caregivers. Spousal illness and spousal caregiving are highly interpersonal endeavors, and this study suggests that they may potentially have a detrimental impact on the

marital relationship. As one partner experiences loss associated with illness and the other responds, and both partners experience the changing roles that accompany transitions in later life, it seems preferable to consider ways to intervene therapeutically with both the husband and his ill wife. Third, as mentioned previously, further investigation is required to understand better what the changes in household tasks mean to the older husband caregiver and the role that these changes play in the husband's well-being. Such understanding could reveal potential implications for intervention (e.g., educational programs for skill development in household tasks).

In conclusion, the image portrayed by these findings concerning husbands' shifting household roles and the decline in emotional support, accompanied by a heightened sense of marital instability and depressive symptoms, does not suggest the benign experience of male caregiving that is so frequently conveyed in gender comparative studies. The results also suggest the importance of carefully examining the characteristics of persons included in noncaregiving comparison groups. For example, many caregiving studies use spousal illness condition as an indicator of caregiving. We found that 11% of older husbands in this sample had wives with serious chronic illness conditions that are similar to those reported by caregiving husbands, yet they did not identify with the caregiving role. This study has revealed several important findings, but it has also raised many more questions that require investigation so that a fuller understanding of the unique experience of the older male caregiver may be revealed.

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