

INTIMATE PARTNER CAREGIVING: 65 YEARS AND OLDER

A Thesis by

Lydia D. Ibarra

Bachelor of Arts, Wichita State University, 2015

Submitted to the Department of Sociology
and the faculty of the Graduate School of
Wichita State University
in partial fulfillment of
the requirements for the degree of
Master of Arts

May 2017

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SPOUSAL AND INTIMATE PARTNER CAREGIVING: 65 YEARS AND OLDER

The following faculty members have examined the final copy of this thesis for form and content, and recommend that it be accepted in partial fulfillment of the requirement for the degree of Master of Arts with a major in Sociology.

Twyla Hill, Committee Chair

Jodie Hertzog, Committee Member

Brien Bolin, Committee Member

DEDICATION

To my husband and our children.

To my Isabel who gave up so much of her mommy time.

Thank you for your sacrifice and support

as I pursued my dream.

ACKNOWLEDGEMENTS

I would like to thank Dr. Hill for her patience, guidance, and support through this process. I would like to thank Dr. Jodie Hertzog for mentoring me for the two years that I was in the McNair program and for the support to get me to the next stage in my education. I also would like to thank the McNair program advisors LaWanda Holt-Fields and Ashley Cervantes for the guidance and support to turn a dream into a reality. I would like to thank the sociology professors that instructed me while in my undergrad and graduate program. Each of you showed a passion for teaching that encouraged me to strive to be a better student. I would like to thank LaDawna Hobkirk for her commitment to keep the department up and running. And lastly, I would like to thank Brittany and Ashton for being great peers over the course of these two years and my niece Juliana, for her dedication to see me through to the end.

ABSTRACT

It is not likely that many people dream about entering their golden years with frailties and illnesses. But for many of those that are sixty-five years and older that is how they live their lives. Receiving care is essential at this stage of their adult life and for many older adults, formal care is not an option. One out of every five older adults needing care will get it from their primary caregiver, their spouse. This study utilized the RAND HRS Family Data, a national longitudinal study of retirement and health among the elderly in the United States to explore social and demographic factors and the effects that they have on *spousal and intimate partner caregiving*. Of the 2,126 in the sample, all spouse/partners need help but only thirty-five percent get help with at least one activity of daily living. Of the 2,126 respondents, 1.2% were same-sex couples and 8.5% were cohabitating. The results of the Logistic Regression indicated five of the fifteen factors - the race-ethnicity of the respondents, the age, self-report of health, and education of the respondent's spouse/partner, and the number of children helping - had significant effect on the active receipt of help by the spouse/partner.

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INTRODUCTION

Spousal and Intimate Partner Caregiving: 65 Years and Older

In the year 2011, the first wave of baby boomers began turning 65 years old and by year 2050 the remaining members of this generation will be 85 years old (Colby & Ortman, 2014; Ortman, Velkoff, & Hogan, 2014). It is estimated there are more than 323 million people currently residing in the United States, of which, 47 million are 65 years and older; approximately 65.5% are married 25.7% are widowed, 14.6% are divorced. 1.3% are separated, and 4.8% have never married (U.S. Census Bureau, 2012). Of all same-sex couples, 14.6% are 65 years and older and of all opposite-sex couples, 22.5% are 65 years and older (U.S. Census, 2015). Per the 2000 Census, there were more than 12.5 million people in the aging population (50 years and older) and 1.1 million were living in an intimate cohabiting relationships (Noël-Miller, 2011, 341). In 2010 that number increased to 2.75 million, more than doubling previous U.S. Census reports (Brown, Bulanda, & Lee, 2012). In 2012, there was a 13% increase in the 65+ population, with an additional growth of 7% expected to have occurred by 2030, which will result in a demographic totaling 20% percent of the U.S. population (Ortman, Velkoff, & Hogan; Mann, Raphael, Anthony, & Nevitt, 2016). Furthermore, in the year 2050 it is predicted the population will have reached 83.7 million (Ortman, Velkoff, & Hogan, 2014; Mann, Raphael, Anthony, & Nevitt, 2016). This is partially due to the influx of the baby boomer generation [those born between 1946- 1964].

In the United States the average healthy American that reaches 65 years of age can potentially live up to an additional 18 years (Ortman, Velkoff, & Hogan, 2014). Sociologists agree that this greater life expectancy among the older population has created more need for long-term care (Noël-Miller 2011). The rise in life expectancy has also been recognized as a contributing factor related to why many older adults are entering subsequent romantic relationships after the

end of their first marriage to fulfill basic emotional needs (Koren, 2015; Noël-Miller 2011). As the baby boomers are aging they are also increasing the rising rate of cohabitation among the older population (Brown, Bulanda, & Lee, 2012).

The variations in types of subsequent relationships such as cohabitating, living apart together (LAT) and remarriage which are being formed within the aging population create experiences that are often more complex in regards to role expectations in comparison to the traditional first marriage experienced when they were younger (Coleman, Fine, Ganong, Downs, & Pauk, 2001; Fox & Shriner, 2014; Schramm & Adler-Baeder, 2014). Research suggests non-traditional couples receive less support from their children, are more at risk of not receiving care from an absent spouse, and these relationships may result in “complex partner and family histories, resulting in large and diffuse kinship networks” (De Jong Gierveld, 2015, p. 358).

The goal of the literature review is to focus on caregiving within intimate spousal/partner relationships among the aging population. Whether the union is a marriage, remarriage, or cohabitation, a variety of factors influence and affect the quality care a fragile spouse/partner is experiencing in the relationship. For my study, I use the RAND Health and Retirement Family Data Version C, a random representative dataset, to research intimate spousal/partner caregiving among the older population to answer, “*Do you help your spouse/partner with activities of daily living?*” There are several factors that affect how the couple initiates the care they provide one another. These factors include but are not limited to: gender, age, education, retired, race, ethnicity, self-report of health, and depression. Other factors such as, whether it is a same-sex or opposite union, whether marriage or cohabitation, whether there are children helping with caregiving, and household income, also affect the care in the relationship. These factors will be explored and measured to determine who is giving the care in an intimate relationship. Where past

studies have explored areas in which the respondent is the focus of receiving the care, this study is specifically asking if the respondent is the one providing the care to a spouse or partner, net of all other factors.

The focus of this study explored whether the respondent offered any care to the respondent's spouse or partner in the relationship who needed help with daily tasks such as; walking across a room, help in and out of bed, getting help with bathing or showering, help with eating, help with dressing, and or help with using the toilet. The analysis is that only thirty-five percent of the respondents' spouses or partners received the care with one or more of those daily tasks. That thirty-five percent included older spouses or partners, spouses or partners with a higher education, minority spouses or partners, and those spouses or partners with a low self-report of health. In those relationships with more children helping the spouses or partners were more likely to get help. The dependent variable is just about whether the spouses or partners get help with daily tasks. So, children helping in the relationship indicates more confidence that the results for the other independent variables are more reflective of the help afforded by the respondent in the relationship. The significance in having children does not imply that they are the primary giver but rather children potentially assist in giving care to their parent. Besides, the literature shows that children are often the secondary caregivers when the spouse is the primary caregiver.

LITERATURE REVIEW

Spouse & Intimate Partner Caregiving

Many Americans in the older population were hopeful in their younger years they would age successfully. “*Successful aging*” is a term that is used to define the “enjoyment of health and vigor of the mind, body, and spirit into middle age and beyond...the freedom from impairment and the ability to live independently” (Wagnild, 2003, p. 43). Unfortunately, that does not occur for many who age into their golden years. Often long-term care is required due to a chronic illness (Qualls, 2016). In the United States, 4% of those 65 years and older will enter a long-term care facility; 1% of the aging population are between 65 years to 74 years and 15% of those who are 85 years and older (Hill, 2015). In the United States, many of those aged 65 years and older need help getting ready every single day of their lives and that help often comes from a family member.

Repeatedly, the literature confirms that family members are the ones primarily responsible for the care needed by an elderly spouse/partner and this care is usually carried-out by a single individual known as the primary caregiver (Hill, 2015). This type of care is called *informal care* and it comes at a personal cost to the caregiver. Informal care is the act of caregiving that involves assisting someone that is unable to “perform certain activities on their own” (Brown & Brown, 2014, p. 75). This care is often provided by a family member or a friend compared to *formal care* (medical services) that is “paid care...is almost always a supplement to informal care” (Hill, 2015, p. 4). Caregiving can be burdensome and is related to the tasks that are associated with *caregiving* - “helping behavior that provides, or is intended to provide aid or assistance to individuals in need” (Hill, 2015). This feeling of being burdened can be measured as an *objective burden* - “the actual tasks the caregiver performs and the effects those jobs have on finances, physical health, or social life of the caregiver” or is measured as a *subjective burden*- the emotional and/or psychological strain associated with the caregiving” (Hill, 2015, p. 10).

One out of every five primary caregivers are going to be the spouse/partner to one who needs twenty-four hours of care, seven days a week (Population Reference Bureau, 2016). Spousal/partner care is diverse in the ways in which it is implemented. When the spouse/partner becomes the primary caregiver he/she may have a change in their living arrangements (different sleeping accommodation), a change in job or work schedule, missed work, and/or possible termination of their employment to take the new role as primary caregiver (Carpenter & Mak, 2007, p. 48). Along with those changes, changes in their social interactions take place.

Sociologists agree the way in which caregiving is conducted in some subsequent relationships, is directly affected by the issues of children, extended family, and the presence of an ex-spouse in the remarried couple's lives (Noël-Miller 2011). These issues brought on by the extended family is possibly due to boundary ambiguity (Sherman & Boss, 2007). *Boundary ambiguity* "identifies the state when family members do not know or agree on who is 'in' or 'out' of the family system" (Sherman & Boss, 2007, p. 247). Those persons whom couples surround themselves, as well as the outside relationships with family, friends, and society in general, all tend to influence the elderly couple's daily lives and the dynamics of the relationship. For some primary caregivers, they may have to rely on a type of formal caregiving- from home healthcare workers, visiting nurses, therapists etc. and "well-meaning adult children, relatives, or friends" offering suggestion or aid that can be perceived as intrusive and unwanted (Carpenter & Mak, 2007, p. 49).

Relationships are often defined by the characteristics of the couple and the characteristics of relationship. The literature review explores factors associated with the caregiving in a spousal and intimate partner's relationship. These factors are representative of characteristics for the Respondent, Spouse/Partner, and Relationship, and are separated into three individual model segments to help identify how each of these characteristics can affect the caregiving in the

relationship.

RESPONDENT FACTORS

Gender

Gender is one of the strongest contributing factors when it comes to spousal/partner caregiving. It is more expected that the female will care for the male in the relationship than vice versa (Noël-Miller, 2011). This expectation is supported by the traditional gender roles that society has assigned to the biological sex of the person. For example, men are expected to be strong and are to never cry; and women are soft, gentle, and caring. So, naturally it is expected for a woman to be the caregiver (Noël-Miller, 2011).

Gender expectations are not any different for the married or cohabitating couples in the aging population. Much of the literature does support the inequality of caregiving between genders but research discovered that more men in their late mid-life years were acting as primary caregivers and provided more hours of care compared to female primary caregivers at the same stage of life (Hill, 2015). These men at this stage of their lives are an exception to the gender role expectation. Generally, it is women that place more emphasis, value, and meaning to their relationship assigning it as the center of all that they do and it is women that suffer more from the burden of caregiving than men, however (Be, Whisman, & Uebelacker, 2013).

However, placing the romantic relationship at the center of their life and the feeling of being burdened is less true of women in a living apart together [LAT] relationships. De Jong Gierveld (2015) suggests that women are more attracted to the LAT arrangement because they have the commitment and intimacy without losing their sense of independence (Carpenter & Mak, 2007). Marrying during one's golden years presents a greater chance that women in the older population will "take on the burden of caregiving" for a potentially chronically ill spouse/partner

at a time when “men’s traditional familial obligation, namely, economic provision, ends” (Brown, Bulanda, & Lee, 2005, p. S23; Koren, 2015). A ‘LAT’ relationship allows the intimacy without the commitment and “poor health may make one less attractive as a potential spouse” (Brown, Bulanda, & Lee, 2005, p. S23). This type of relationship makes allowances for women to have their own money, own home, and chosen responsibilities without having to be accountable to or having to care for a frail husband/partner (De Jong Gierveld, 2015). It does not mean that the frail spouse/partner is not going to receive needed care, they are just not going to receive it from their significant other.

Age

With the increase of life expectancy, it is not surprising that providing care for a partner may last well into their golden years. In a study conducted by The National Alliance for Caregiving in conjunction with AARP more than 1,200 participants as young as 18 years old were sampled. That study revealed one out of every ten in their sample was married and was providing care for a spouse. Ten percent were caregivers aged 75 years old or older and caring for another adult (National Alliance for Caregiving & AARP, 2015). On average, the primary caregiver was a white female, 79 years of age, typically unemployed, and offering 34 hours of unpaid care weekly, at minimum for the last five and a half years of her life (National Alliance for Caregiving & AARP, 2015, p. 17). This coincides with Hill’s (2015) findings that 85% of caregivers are 65 years and older and of those, nearly 50% are 75 years or older.

Education

Older generations are at a disadvantage compared to younger generations “in that they have less education, lower professional status ... even before retirement” (Pinquart & Söresen, 2000, p. 187). There have been many studies that concur as one attains higher education (bachelor’s

degree or higher) their income increases due to having a higher paying job. The American Council on Education attests that one's continuance in the workforce past the age of retirement is partially due to the level of education a person attains (Lakin, Mullane, & Robinson, 2007). Of the baby boomers those born between 1946 and 1951 have a higher education than the generations before them; 25% of 60 to 69 years old and 18 % of 70 years and older have attained a higher education (Lakin, Mullane, & Robinson, 2007). Also, higher education is associated with better health (American Psychological Association, 2017).

Work Status: Retirement

When one anticipates retirement, there is a feeling of excitement but a forced retirement does not have that same excitement and there is little satisfaction (Matour & Prout, 2007). For many women having to balance work and caregiving is not easily accomplished, but more times than not these women are forced into an early retirement (Carr, Murray, Zaninotto, Cadar, Head, Stansfeld, & Stafford, 2016). With the high cost of formal caregiving, many of those that retire do so by way of terminating their employment to supplement formal caregiving with informal caregiving thus, minimizing the cost of caregiving. Remarkably, in 2013 informal caregivers contributed half a trillion dollars in unpaid care (Mann, et al., 2016).

There are more positive outcomes to retirement when married compared to being single or never married (Tamborini, 2007). However, retirement after a career can alter the relationship between spouses, which in turn affects the "emotional qualities of marital interaction and marital satisfaction" (Bozoglan, 2015, p. 991). Some of the areas that are affected by retirement are: "roles, identities, expectations, attitudes, and relationships with the partner could change in this period" (Bozoglan, p. 922). Bozoglan's research revealed two effects of retirement on the elderly couple, "women become distressed particularly in the domestic domain in the retirement period,

while men may develop depressive symptoms” (Bozoglan, 2015, p. 921). Reasons for the wife’s distress can be contributed to the increase of a husband’s help around the house and a wife that once spent much time outside her home, now she stays home more to share in the activities and responsibilities of the home; in turn causes increased symptoms of depression in women and a lowered marital satisfaction (Bozoglan, 2015, p. 922).

One aspect of retirement is *empty nest syndrome*. What is known as the ‘empty nest syndrome’ can pose a threat to the intimate relationship between both spouses/partners. Some of the challenges experienced during the “post parental stage of life” are changes in the “roles or loss of roles, marital disharmony, career challenge, shifts in care giving, physical challenge and passion for relationship with children,” (Kumar, 2015, p. 78). More times than not, children are the secondary caregiver to a frail parent. If a child is not present, the entire burden of caregiving often falls entirely on the other parent. As stated previously, the “who” the couple surrounds themselves with does affect the caregiving in the relationship.

Caregiver’s Physical Wellbeing

When someone becomes the primary caregiver. For their spouse aspects of their life are forced to change. In the process of making the change, the caregiver tends to step away from social roles and social events that once helped to relieve stress but now possibly result in more stress that “can negatively influence the well-being of spousal caregivers of any ethnicity” (Yarry, Stevens, & McCallum, 2007, p. 27). When caring for the other person in the relationship, one of the hardest things to cope with is the shift in the roles and responsibilities the caregiver once held. When a spouse or partner becomes the primary caregiver often they will forgo their desire for sexual intimacy, neglect friends and aspects of self-care such as diet, sleep, and exercise (Carpenter & Mak, 2007). This behavior is a predictor of future health related issues such as, “depression,

worsening physical health, loss of friends, family disagreements, employment conflict, and economic problems;” which can cause a reoccurrence of previous health issues (Harris, Adams, Zabatsky, & White, 2011, p. 954).

Caregiver’s Mental Wellbeing

Not only do these married couples share many of the same daily living experiences, they share psychosocial experiences, also known as *emotional contagion* - the transfer of emotions from one person to another (Ryan, Wan & Smith, 2014; Be, Whisman, & Uebelacker, 2013). For example, research that sampled married couples where the wife had been diagnosed with stage I-III breast cancer, found that the husband’s anxiety “predicted wife’s own anxiety as well as depression, fatigue, and symptom management” (Ryan, Wan, & Smith, 2014, p. 1110). This is evident that the emotional and mental wellbeing of the caregiver is associated with the marital relationship. Much of the literature states that women who care for their ailing spouse/partner endure more physical and mental health issues than that of their male counterparts (Boeije & Van Doorne-Huiskes, 2003) and caregiving is the second most contributing factor for increased depressive symptoms (Taylor, Kuchibhatla, Ostbye, Plassman & Clipp, 2008). Due to the long lengths of time that women care for their spouse/partner with dementia and, or any other chronic illness, eventually they will suffer from “negative physical, psychological, social, and financial effects” and can lose their sense of self (Brown & Alligood, 2004, p. 105).

Another area that can cause a mental strain on the caregiver is the need for help. Literature states that little is known about why caregivers may wait to seek help for their loved one after the symptoms of a degenerative disease have been made manifest (Brown & Alligood, 2004, p. 106). The *Theory of Help-Seeking Choices* has been utilized in research studies to help further understand the association between the illness of a loved one and the “help-seeking patterns” of

the wife (Brown & Alligood, 2004, p. 109). Some of those emerging patterns were among “persons who share similar medical diagnoses or life experiences; and interactive patterns of interpersonal relationships, such as patterns of help-seeking, arising from tensions created by the husband’s dementing illness” (Brown & Alligood, 2004, p. 109). What the study revealed was, as symptoms of dementia became obvious the wife responded in one of three ways; *shouldering* which involved drawing on internal resources and assuming the burden rather than reaching out; *facing* which involved acknowledging the need for help and reaching out to obtain it; and *consciousness* which is defined as the “informational capacity of the system [caregivers] to interact with the environment” (Brown & Alligood, 2004, p. 109). It is possible that these behaviors allowed for women to continue caring for their husband even if they did not recognize there was anything wrong with him, other than old age. It is also possible women felt it was their responsibility to be the sole caregiver because of the commitment to the vows made to their spouse in marriage [*for better or for worse, in sickness and in health*].

SPOUSE/PARTNER FACTORS: Recipient of Caregiving

Gender

Although, women have higher rates of morbidity (Pinquart & Sörensen, 2001) research indicates that men have higher rates of functional impairments and a higher number of restrictions in their daily activities (Allen, Goldscheider, & Ciabrone, 1999). For most frail elderly men needing care, it is their spouse/partner that is caring for them and elderly frail women are more likely being cared for by their adult daughter or adult son and his wife (Brown & Alligood, 2014) because their spouse/partner has passed away. Other studies have indicated that men who fight an aggressive cancer in their late life are more likely to receive formal medical services compared to women that fight breast cancer at earlier stages of their lives (Allen, Goldscheider, & Ciabrone,

1999). It is not that one gender needs help more than another, it is just that the type and amount of help needed is differentiated by the need and when needed.

Age

The average age of a care recipient is 69 years old (National Alliance for Caregiving & AARP). In the United States, those aged 65 years and older, approximately 20% reported they need help with “routine daily activities, such as shopping, transportation, bathing, walking, meals, or managing medication” and 29% reported they get the help with such activities (Population Reference Bureau, 2016, p. 3). In 2015, the study conducted by the National Alliance for Caregiving and AARP reported that the average recipient of care was a married 77 years old male suffering from Alzheimer's, heart disease, or some other issues resulting from old age. Those 70 years and older diagnosed with probable dementia are recipients of more than 171 hours of monthly care compared to those without dementia who receive 66 hours of care on average (Population Reference Bureau, 2016; Skira, 2012). Aging is a natural process, but for many the aging process is related to worsening of health.

Education

Literature states it is likely that those who do not invest in their education are more likely not to invest in their health and will more than likely suffer “higher mortality from almost all causes, including diabetes, hypertension, and heart disease, and to show higher levels of disability, functional loss, and cognitive impairment” (Waite, 2004, p. 7). As the 65 and older population continues to grow, so does the number of those with a lower education compared to those older adults that have a higher education (Szanton, Seplaki, Thorpe, Allen, & Fried, 2010). Research has linked greater risks for depression, dementia, and Alzheimer's disease to later life for those older persons with less than a high school education. (American Psychological Association, 2017).

Physical Wellbeing

When it comes to the wellbeing of the aging population, lower SES is associated with lowered quality of life (American Psychological Association, 2017). It is estimated an average of 144 hours of care per month are provided to help an older adult with activities of daily living; 31% provided by the spouse (Population Reference Bureau, 2016). The number of hours and the quality of care that is received is determined by the spouse's/partner's physical and mental state. For example, unexpected-aggressive chronic illness such as cancer requires more care, for a shorter amount of time due to being terminal "whereas caregiving for patients with dementia, diabetes, or physical frailty involves several years, if not more, of constant help" (Youngmee & Schulz, 2008, p. 486). One study that sampled older Latin Americans revealed "the need for long-term care among older Latinos was greater than elderly people in general" (Aranda & Knight, 1997, p. 345). The reason for this is due to the disadvantages in "basic self-care activities... and in instrumental activities of daily living (Aranda & Knight, 1997, p. 345). Physical disabilities are not the only problems in the lives of aging adults, having mental health deficiencies can take a toll on their lives (Deimling & Bass, 1986.).

Mental Wellbeing

Much of caregiving research is focused on those with dementia or some form of mental disability. The American Psychological Association [APA] has estimated that twenty to twenty-five percent of the aging population meet the criteria for having some form of a mental health issue as they age. It has been predicted in the year 2030, fifteen million older adults will be dealing with a mental issue (American Psychological Association, 2017). Cognitive symptoms are one of the first signs that someone is undergoing a negative mental change and these changes can spur behavioral problems in the care recipient (Deimling & Bass, 1986).

RELATIONSHIP FACTORS

Seventy-five percent of men and 41% of women 65 and older are married and do live together (Waite, 2004). For these couples, marriage is associated with feelings and thoughts about the relationship and how the couple behaves, interacts, and responds to one another are grounded in those feelings and thoughts (Sabey, Rauer, & Jensen, 2014). But a shift towards cohabitating is taking place in this age demographic, more specifically within the baby boomer generation and few scholars are yet to utilize their research skills into studying this living arrangement among the 65 years and older population (Brown, Bulanda, & Lee, 2005 & 2012).

From the start of the intimate relationship it is not uncommon for spouses/partners to care for each other and offer practical and emotional support (Carpenter & Mak, 2007). For example, a positive attitude, being understanding to the other's needs and concerns, and showing care and assurance [being there for one another] are ways in which couples guard their union (Sabey, Rauer, & Jensen, 2014). Sociologists believe the labor of love “expresses the duality between the affection that is supposed to underlie the act of informal caregiving and its labor-intensive nature” (Boeije & Van Doorne-Huiskes, 2003, p. 224).

Research suggests that “the intimacy inherent in the caregiving role renders an emotionally close marriage as an important criterion in the selection of spouse as caregiver” (Harris, Adams, Zubatsky, & White, 2011, p. 951). Often, the care one is providing for their spouse is out of obligation. An obligation that is associated with love and affection, a desire to return the care the caregiver once received from the spouse/partner, or due to the “cultural norms of obligation associated with filial or spousal responsibility” (Hill, 2015, p. 10). However, compassionate love and the labour of love influence the satisfaction in older adulthood. The labour of love “expresses the duality between the affection that is supposed to underlie the act of informal caregiving and its

labour-intensive nature” and is associated with their loyalty to their spouse and relationship (Boeije & Van Doorne-Huiskes, 2003, p. 224). For example, being attentive to the needs, offering emotional support, and offering affirmation to their spouse/partner are protective factors for the relationship (Sabey, Rauer, & Jensen, 2014, p. 595).

Same-Sex Union

According to literature, “couple-hood in midlife and old age is a prevalent social context” (Ryan, Wan, & Smith, 2014, p. 1109). That is easily supported by the demographics of the aging population. As stated previously there are more than 47 million 65 years and older people in the aging population. In 2015, the American Community Survey reported of all the coupled household 15 years and older 28% were opposite-sex married and unmarried couples and 6% were unmarried same-sex couples 65 years and older (U.S. Census, 2015).

Marriage is not just a social institution but it has become “a well socialized order” that is beneficial to all parties involved, including the community (de Vries, 2007, p. 19). What history has conveyed is that society has and will continue to afford married couples a publicly affirmed marital relationship, social support, and beneficiary benefits [medical and financial] which contribute to better mental and physical health than for those couples who are only cohabitate (de Vries, 2007, p. 19). Unfortunately, same-sex couples have not and are not afforded the same support.

In 2007, it was approximated that 3 million people of this aging population were a member of the lesbian, gay, bi-sexual, and transgender (LGBT) community and it is projected that by the year 2030 the LGBT population will grow to more than 4 million persons (de Vries, 2007). Though the size of the LGBT population will continue to grow, these men and women have not been afforded the same social support in their late-life years as is expected for heterosexual men

and women (de Vries, 2007). For example, marital status is associated with opposite-sex couples and this status will continue into their late-life years. But it is likely 40% to 60% of gay men in and 20% to 55% of lesbian women who are in a relationship will take on a status of “non-partnered” in their late-life years (de Vries, 2007). The recent overturn of DOMA on June 26, 2015 was a victory for the LGBT community. Still, many states are enacting their legislative power and contesting same-sex marriages. Because these relationships are not being recognized, research on same-sex marriage and same-sex late-life partner care within the aging population is outdated and there is very little of it.

Marriage/Cohabitation

In the United States, it is estimated that nearly half of all marriages taking place annually are remarriages (Coleman, Fine, Ganong, Downs, & Pauk, 2001). Many of these new relationships are formed by older individuals that enter a subsequent intimate relationship after a divorce or after the death of their previous partner (Harris, Adams, Zubatsky, & White, 2011). Marriage is no longer the only option available for instituting romantic relationships for those 65 years and older. The baby boomer generation has made a shift from marriage to cohabitating resulting in higher rate of cohabitation than the rate of remarriage (Noël-Miller 2011). Still, no matter what type of relationship an older couple forms, the relationship will have problems.

In comparison to first marriage caregiving, older-remarried couples receive less support from stepchildren; and compared to husband caregivers, the wife receives less support from their children, step or otherwise (Sherman & Boss, 2007, p. 249). What is more disturbing is, compared to the older married couples, LAT spouses or partners in need of care are at a greater risk for not being provided the needed care due to the absent spouse/partner (De Jong Gierveld, 2015). Also, older disabled individuals in a cohabitation are at a higher risk for not receiving the needed care

from their live-in partner than older married couples (Population Reference Bureau, 2016). What is common for both married and cohabitating couples, however, is the feeling of obligation to be a caregiver (National Alliance for Caregiving & AARP, 2015).

Relationship differences have been noted between couples who have chosen to marry and those who have chosen to cohabitate. Marriage produces “higher levels of mental and physical health” compared to cohabitation (Brown, Bulanda, & Lee, 2005, p. S22). Literature concurs that poorer health can increase stress in the intimate relationship and is associated with depression for the caregiver no matter the relationship’s arrangement (Brown, Bulanda, & Lee, 2005).

Children Helping

The way in which individuals care for one another is dependent on the influences [family, friends, and society] that a couple allows into their lives (Yarry, Stevens, & McCallum, 2007). All of these influences do impact their culture, and “guides the behavior of individuals and influences the roles individuals play within their communities” (Yarry, Stevens, & McCallum, 2007, p. 24). Culture has been associated with how caregiving is perceived. When it comes to relationship dynamics and family dynamics, culture affects how elderly couples relate to one another and how their family members relate to them (Yarry, Stevens, & McCallum, 2007). For example, divorce has an influence on whether adult children will help care for their aging parents (Population Reference Bureau, 2016). With the rise in divorce rates among the baby boomer generation it is highly possible that many of them will enter their golden years single with no spouse to act as caregiver. Per the report given by the Population Reference Bureau (2016) it is projected the number of 75-year-olds within the baby boomer generation without a spouse in the year 2030 is estimated to be more than 1.8 million. With so many without a spouse and many children not wanting to care for their parents, many older adults will turn to formal caregiving (Population

Reference Bureau, 2016).

When children do care for their parents, usually it is the daughter that offers much of the care. Research shows that 29% of daughters contribute approximately 31 hours of care monthly compared to 18% of sons who contribute 16 hours of care (Population Reference Bureau, 2016). It is not that males do not wish to take care of their aging parents but because of repetitious, stereotypical statements such as “it is not part of their gender role,” they just don’t (Finley, 1989, p. 79).

Within the African American and Latino American cultures there is little spousal caregiving that takes place because many of the elderly are no longer married and live in “single-parent families and multigenerational homes” and a considerable amount of the dependency on family members is impart to a sense of *familism* that can easily be defined as ‘family first’ (Yarry, Stevens, & McCallum, 2007, p. 24 & 26). The study *Caregiving in the U.S. 2015*, reported that 23% of Blacks compared to 13% of all other races combined, care for someone other than their parent. This care is informal and is not limited to only biological family members but it extends to those persons that have been embraced into the family. In the black culture, the adult child and the adult child’s spouse take on much of the caregiving responsibility. Unfortunately, in Latino/Hispanic families there is a dynamic that is taking place that possibly can leave a parent without a caregiver. Latinos/Hispanics that report having three or more children, were less likely to receive caregiving from their children than the White and African Americans (Aranda & Knight, 1997). This misfortune for the aging parent is very important to understanding what is taking place in the Hispanic culture which does not line up with the sense of *familism* and how it is associated with caregiving.

Household Income

In the United States, the overall median household income is \$56,516 compared to the median income of 65 years and older population, \$38,515 (Proctor, Semega, & Kollar, 2016). Per the U.S. Census Bureau (2014), 15.1% of the older population make less than \$35,000 annually; 31.2% make between \$35,000 thru \$75,000 annually; and 53.7% make \$75,000 or greater annually. Despite the median household income for the older population, it is estimated that 8.8% are living in poverty (Proctor, Semega, & Kollar, 2016).

When a man or woman arrive at that point in their life where they can put away work clothes and retire, they can expect to lose about one-third of their income (Pinquart & Söresen, 2000) and for those transitioning into retirement, the average amount saved is \$14,500; unfortunately, many older Americans do not have any income saved (Mann, et al., 2016). Much of the income the 65 years and older population depend on are governmental programs such as Social Security and Medicare and for some it is their only source of income (Waite, 2004). If fortunate to have worked in their lifetime, an older person can expect to receive an average of \$16,000 in Social Security payments throughout the year (Mann, et al., 2016). For many older women that did not work or did not work long enough to qualify for a pension, retirement benefits, or any federal subsidy their marriage is a source of financial stability (Waite, 2004).

There are differences between the single and married couple as well as differences between married and cohabitating households. Some of the difference are; “the poor and near poor are more likely to be cohabiting than their non-poor counterparts;” in a cohabitating relationship women have higher incomes than married women; and “cohabiting men are less likely to be working and have smaller incomes than either married or single men” (Brown, Bulanda, & Lee, 2005, p. S22).

Literature states that the need for long-term care is associated with lower incomes (Kaye,

Harrington, & LaPlante, 2010) and it is these households that are producing many older primary caregivers. In 1996, the Census Bureau reported that 11% of those 65 to 74 years of age and 20% of those aged 85 and older were poor (Waite, 2004). With the increasing rates of late-life remarriage [with the potential of stepfamily formation], cohabitation, and LAT relationships, which are becoming more prevalent for couples 65 years and over there is little research on this population that is creating this social dynamic (Sherman & Boss, 2007). Much of the research surrounding the 65 and older population is reflective of a first marriage. As previously stated, changes in living arrangements among the aging population are taking place and unfortunately, research is not keeping up.

CURRENT STUDY

With the rising rates of remarriage, LAT relationships, and cohabitating in this population, it is important for there to be a greater understanding of the factors that are associated with the intimate spousal/partner caregiving for this 65 years and older population. In general, “caregiving fosters the development and survival of members” (Qualls, 2016, p. 286). The knowledge from this study is a starting point for formation of future policies that will assist older informal caregivers with their efforts to care for their ailing spouse/partner. There are several hypotheses that will help answer the question, “*Do you help your spouse/partner with activities of daily living?*”

Hypotheses

- More females than males will offer care to their spouses/ partners.
- Individuals in couples who make less money will offer more care to their spouse/partner than those couples that make more money in the intimate relationship.
- Minorities are more likely to offer caregiving in an intimate relationship.

- It is more likely that caregiving is afforded to a spouse in a marriage than to a partner in a cohabitating relationship.

METHOD

Sample

This study is based on the RAND HRS Family Data Version C that is a national longitudinal study of retirement and health among the elderly in the United States. It is taken from the original *Health and Retirement Study* (HRS) dataset that is sponsored by the National Institute of Aging (NIA) with additional support from the Social Security Administration. The HRS is a survey administered by the University of Michigan's Institute for Social Research (ISR). The HRS contains a full sample size, that is approximately 37,000 participants 50 years and older born between the years of 1931 to 1959. In addition to the respondents, the survey also interviewed the respondents' partners and spouses regardless of their age. The main purposes of this national study are to provide panel data that facilitate research and analysis to back and support the policies on retirement, health, and well-being of the aging population. The survey has compiled data containing demographics, income, assets, health, cognition, family, health care utilization and costs, housing, job status and history, and insurance information about the population being researched. The RAND dataset is a cleaned version of The Health & Retirement Study (HRS) and it contains variables pertaining to respondents' and their families. As of 2014, the RAND dataset contains 12 waves, including the years 1992, 1993, 1994, 1995, 1996, 1998, 2000, 2002, 2004, 2006, 2008, and 2010. The focus of this research study is on the 2010 wave. The current study uses public-use data from the RAND HRS and has been approved for research by the Wichita State University Institutional Review Board (IRB) for the Protection of the Human Subjects.

Measures

Data Selection

The sample selection was made based on the criteria such as: if respondent's marital status was married or partnered and if the respondent's spouse/partner needs help with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Then, a new relative weight was created to correct for a possible inflated sample size. To create the relative weight, the standard weight was divided by the mean value of the standard weight. Once the relative weight was created, cases were selected that carried a relative weight that was greater than zero. This was done so that sampling error is not underestimated that can result in biasing estimates. Once these selections were made and a new relative weight was created it did decrease the sample size from 37,000 to 2,126.

Spouse/Partner Needs Help

The primary question in the research study is *“Do you help your spouse/partner with activities of daily living?”* In order, for that question to be answered it needed to be first determined if the spouse/partner needed help. To calculate the variable, Spouse Needs Help from the RAND HRS dataset, multiple steps were taken to recode two variables into one variable. Each variable was composed of five task associated with daily living. The dataset included one question that asked the spouse/partner if they had difficulties performing any tasks related to activities of daily living (ADL). The question was coded as follows: 0 = no difficulty, 1 = some difficulty with 1 activity of daily living up to 5 = some difficulties with 5 activities of daily living. Also, included in the dataset was one question that asked the spouse/partner if they had difficulties performing any tasks related to instrumental activities of daily living (IADL). The question was coded as follows: 0 = no difficulty, 1 = some difficulty with 1 instrumental activity of daily living up to 5 =

some difficulty with 5 instrumental activities of daily living. To create the variable, Spouse Needs Help, the two original variables were added together and only those cases greater than zero were selected. By doing so, this gave a sample size of 2,126 cases.

Dependent Variable: Spouse Gets Help

To calculate the dependent variable, Spouse Gets Help from the RAND HRS dataset multiple steps were taken to recode several variables into one dependent variable. The dataset asked questions of the spouse/partner if they get help with walking across the room, if they get help in and out of bed, if they get help with bathing or showering, if they get help with eating, if they get help, if they get help getting dressed, and if they get help using the toilet. A frequencies analysis was conducted to check for any missing cases on these variables. The frequencies statistics indicated that gets help with walking across the room had 1576 missing cases, if they get help in and out of bed had 1531 missing cases, if they get help with bathing or showering had 1608 missing cases, if they get help with eating had 1,875 missing cases, they get help getting dressed had 1,159 missing cases, and they get help using the toilet had 1,752 missing cases. Each of these variables were coded 0 = No and 1 = Yes and each was recoded so that the missing cases received a value equal to 0. Since people who didn't need help with that activity were not asked about getting help. A second frequency statistics revealed there were no longer any missing cases. Next the dependent variable was created by adding all the previous variables together; creating an index to measure whether the spouse/partner gets help with activities of daily living. The dependent variable was recoded so that 'getting help' with any of the activities of daily living received a value of 1 and 'no help' received the value 0. Thus, creating a binary variable for Spouse Gets Help.

Independent Variables

Model Segment: Respondent

The first model segment included seven questions that inquired of the respondent characteristics; gender, age, race/ethnicity, education level, if they considered themselves to be retired, their self-report of health, and their Center of Epidemiological Studies Depression Scale (CESD) score. A frequencies analysis was conducted to check for any missing cases for the seven variables. The frequency statistics indicated that gender, age, and self-report of health had no missing cases but race had 3 missing cases, education had 1 missing case, considers self-retired had 79 missing cases, and the CESD score had 117 missing cases. The missing cases for the variables education, considers self-retired, and the CESD score were recoded so that the missing cases received a value of 0 so not to alter the sample size. A second frequency statistics revealed there were no longer any missing cases. The dataset included one question about the gender of the respondent. The question was coded so that male = 1 and female = 2. To create a binary variable, gender was recoded so that male received a value of 0 and female received the value of 1.

Race-Ethnicity

The Race-Ethnicity variable was not included in the dataset and had to be created. The dataset included one question about the race of the respondent and was coded so that 1 = White/Caucasian, 2 = Black/African, and 3 = Other. The dataset asked one question about the ethnicity of the respondent. Ethnicity was coded so that 0 = Not Hispanic and 1 = Hispanic. To create the new variable, Race-Ethnicity a crosstabulation was conducted between the race and ethnicity variables and then recoded. If the respondent's race was White and ethnicity was not Hispanic then race-ethnicity was given a value of 1, White. If the respondent's race was Black and ethnicity was not Hispanic then race-ethnicity was given a value of 2, Black. If the

respondent's race was Other and ethnicity was not Hispanic then race-ethnicity was given a value of 3, Other. If the respondent's race was White and ethnicity was Hispanic then race-ethnicity was given a value of 4, Hispanic. If the respondent's race was Black and ethnicity was Hispanic then race-ethnicity was given a value of 4, Hispanic. If the respondent's race was Other and ethnicity was Hispanic then race-ethnicity was given a value of 4, Hispanic.

Model Segment: Spouse/Partner

The second model segment included five questions that inquired of the spouse/partner characteristics; gender, age, education level, self-report of health, and CESD score. A frequencies analysis was conducted to check for any missing cases for the five variables. The frequency statistics indicated gender, age, and education had no missing cases but self-report of health had 1 missing case and the CESD score had 190 missing cases. The missing cases for the variables self-report of health and the CESD score were recoded so that the missing cases received a value of 0 so not to alter the sample size. A second frequency statistics revealed there were no longer any missing cases. The dataset included one question about the gender of the spouse/partner. The question was coded so that male = 1 and female = 2. To create a binary variable, gender was recoded so that male received a value of 0 and female received the value of 1.

Model Segment: Relationship

The third model segment included four questions about the characteristics of the relationship; whether a same-sex or opposite-sex relationship, whether a marriage or cohabitation, number of children helping, and the total household income. A frequencies analysis was conducted to check for any missing cases for the five variables. The frequency statistics indicated the number of kids helping had no missing cases. The dataset did not inquire of the sexuality of the relationship [Same-Sex or Opposite-Sex]. The dataset did inquire about the respondent's

marital status [Married or Partnered] but, it did not specifically ask if the respondent was a married or cohabitating. These variables were created to answer the research question, “*Do you help your spouse/partner with activities of daily living?*”

Computed Variables

Relationship

To ask the question whether the respondent was in a same-sex or opposite-sex relationship a new relationship variable was created by way of a crosstabulation between the gender variable for the respondent and gender variable for the spouse/partner. If the respondent’s response was female and spouse/partner was male than the relationship was given the value of 1, Opposite-Sex. If the respondent’s response was male and spouse/partner was female than the relationship was given the value of 1, opposite-sex. If the respondent’s response was female and spouse/partner was female than the respondent was given the value of 0, Same-Sex. If the respondent’s response was male and spouse/partner was male than the respondent was given the value of 0, Same-Sex. Thus, creating a binary variable for the relationship’s sexuality.

Union-Type

The dataset did not ask if the respondent was in a cohabitating relationship. The marital status of the respondent was coded so that married = 1 and partnered = 3. The marital status of the spouse/partner was coded so that married = 1 and partnered = 3. A new variable, union type was created by way of crosstabulation between the marital status variable of the respondent and marital status of the spouse/partner. If the respondent is married and the spouse/partner is married than the union type was given the value of 0, Married. If the respondent is married and the spouse/partner is partnered than the union type was given a value of 1, Cohabitating. If the respondent is partnered and the spouse/ partner is married and then the union type was given a

value of 0, Cohabiting. If the respondent is partnered and the spouse/partner is partnered then the union type was given a value of 1, Cohabiting.

Income

The dataset included one question about the total household income for the respondent and the spouse/partner. The total household income range was from \$.00 thru \$955,998.47. To better manage the vast range of the total household income it was divided into twenty-five percentile groups.

RESULTS

Univariate Analysis

Dependent Variable

This analysis examined univariate statistics. One-hundred percent of the 2,126 spouses/partners said they need help with one or more activity of daily living, however. Only 35.0% of the sample said they get help with one or more activities of daily living (Table 1.2). The dependent variable (Spouse Gets Help) was comprised of six dichotomous variables. Each measured whether the Spouse/Partner gets help with a single activity of daily living. Twelve percent said they get help to walk across a room, 13.0% said they get help in and out of bed, 14.20% said they get help bathing, 6.0% said they get help eating, 24.20% said they get help dressing, and 5.10% said they get help using the toilet (Table 1.2). Less than two percent (1.30%) said they get help with all six activities and 17.0% said they get help with one activity of daily living (Table 1.1).

Independent Variables

This analysis examined the univariate statistics. The predominant racial group was the White non-Hispanic which composed 76% of the sample (Table 2). Of the sample 52.0% of the respondents were female (Table 2). Approximately 36.50% of the sample acquired a high school diploma or GED and 20.2% graduated college with a minimum of a four-year degree (Table 2). Of the respondents 46.0% considered themselves as completely retired (Table 2). Approximately 59% reported they were in good to excellent health (Table 2). Fifty-eight percent showed a minimum of one sign of depression on the Center of Epidemiological Studies Depression Scale (Table 2.1). The age of the respondent ranged between 50 to 98 years old with a mean age of 65.7 years, SD = 10.45 years (Table 2.3). The total household income ranged from \$0.00 to

\$955,998.47; the mean income was \$59,488.44 (13th percentile), SD = \$67,325.43 (\$7,214.00) (Table 2.3).

Of the spouse/partner respondents, the proportion of the genders was almost even. Male (52.30%) was slightly above that of female (Table 3). Twenty-four percent of the sample did not complete high school, 36.20% acquired a high school diploma or GED, and 16.50% graduated college with a minimum of a four-year degree (Table 3). Approximately 40.0% reported they were in good to excellent health (Table 3). Seventy percent showed a minimum of one sign of depression on the Center of Epidemiological Studies Depression Scale (Table 3.1). The age of the spouse/partner ranged between 30 to 98 years old with a mean age of 65.62 years, SD = 11.837 years (Table 2.3).

Of the 2,126 respondents, 1.20% were in a same-sex relationship (Table 2.2). Approximately 8.60% were cohabitating (Table 2.2). Eighty-five percent of the sample reported that there were not any children that helped them with any activity of daily living (Table 2.2). The most common answer was one child (11.30%) of children helped a parent with ADLs (Table 2.2).

Bivariate Analysis

A series of bivariate statistical analyses were conducted to test for any associations between the dependent variable – Spouse Gets Help and independent variables - gender, race-ethnicity, relationship status, and income.

Chi-Square

A chi-square test was conducted to test the relationship between respondent gender and spouse gets help as shown in table 4.1. More males said the spouse get help (51.30%) than females (49%) that said spouse get help. There is a statistical relationship between respondent gender and spouse gets help ($X^2 = 5.208^a$, $df = 1$, $p < .05$).

A second chi-square test was conducted to test the relationship between respondent race-ethnicity and spouse gets help as shown in table 4.3. In comparison to 69.40% of Whites that say spouse get help, 11.40% of Blacks said spouse get help, 3.90% of Other said spouse get help, and 15.40% of Hispanics said spouse get help. There is a strong statistical relationship between race-ethnicity and spouse gets help ($X^2 = 32.068^a$, $df = 1$, $p < .001$).

A third chi-square test was conducted to test the relationship between the relationship union type and spouse gets help as shown in table 4.2. There was no statistical difference.

Independent Samples T-Test

An independent samples t-test was conducted to compare difference in means in spouses get help and the income of the relationship (Table 4). There was a significant difference in income ($M = 1.607$, $t(1593) = 4.990$).

Multivariate Analysis

Logistic Regression Model Segment

Table 5.1 presents how odds ratios can increase or decrease after the introduction of various model segments. Models 1, 2, and 3 all had Hosmer and Lemeshow tests that were not significant, indicating that these models did fit well. The model that accounts for the least variance in the Nagelkerke R^2 is model 1; with a value of .032, it accounts for almost 3% of the change in predictions (Table. 5.1).

Logistic Regression Full Model

A Logistic Regression (Table 5) analysis was conducted to evaluate how well three models of independent variables - gender, age, race-ethnicity, education level, considers self to be retired, self-report of health, CESD score, sexuality of the relationship, union type, the number of children

helping a parent, and the household income- can predict how much effect on the dependent variable -Spouse Gets Help. Where there was statistical significance in the chi-sq. between respondent gender & spouse gets help (Table 4.1), net of all other factors in the Logistic Regression there was no statistical significance. A test for outliers was conducted and the results indicate there are no outliers in the samples data. The Nagelkerke R^2 has a value 0.182, which suggests that the independent variables account for 18% of the predicted variation effect on the dependent variable spouse gets help.

The Logistic Regression (Table 5) analysis further indicates a significance that Blacks are 45% more likely to give help to their spouse/partner compared to Whites ($p < .05$). Hispanics are 69% more likely to give help to their spouse/partner compared to Whites ($p < .001$). For one additional unit increase in age, the spouse/partner is 3% more likely to receive help ($p = .001$). For one additional unit increase in self-report of health, the spouse/partner is 70% more likely to receive help ($p < .001$). For one additional unit increase in the level of education, the spouse/partner is 10% more likely to get help ($p < .05$). For every increase in the number of children that help, the spouse/partner is 55.6% more likely to get help ($p < .001$).

DISCUSSION

The goal of this study was to explore certain predictors that influence the care instituted in intimate spousal/partner caregiving in the sixty-five and older population. For example, how does gender, age, race-ethnicity, education, working or retired, physical and mental well-being of older couples affect the caregiving in their relationship. Also, whether the couples are married or cohabitating, in a same-sex or opposite-sex relationship, and how much income the couples make. The number of children helping was used to help control for the effects on the care in the relationship.

Much of the literature on caregiving is focused on the traditional nuclear family and the social roles that have been assigned according to the biological sex of the spouses. The problem with some studies is that a high proportion of samples are White - non Hispanics and this limits available data. In this study the White – non Hispanic was used as the control group and it was hypothesized that *minorities are more likely to offer care in an intimate relationship* and the analysis did support my hypothesis. The literature provided in this area imply that Black and Hispanic families have a higher sense of family and this sense of family influences the caregiving aspect of the relationship (Yarry, Stevens, & McCallum, 2007). Furthermore, it was hypothesized that *more females than males will offer care to their spouses/ partners*. The analysis showed that the gender of the respondent did not influence the care in the relationship. Females did not offer more caregiving to their spouse/partner than males. This finding is contrary to what other research studies and literature has reported that older women offer the most care in the relationship than males (Noël-Miller, 2011). Other factors such as the age, gender, self-report of health, and education level of the spouse/partner and the number of children in the relationship were significant factors for spouse getting help.

Many of the older persons in need of care are faced with having to receive formal care from medical professionals or informal care that is received from family members or close friends. Four percent of older adults will enter a nursing care facility (Hill, 2015) but most older adults that need informal care are receiving this informal care from their spouse/partner (Hill, 2015). Many of the older adult population's only source of income comes from Social Security (Waite, 2004). This income alone is not enough to bring an older couple above the poverty line. In this study it was hypothesized that *individuals in couples who make less money will offer more care to their spouse/partner than those couples that make more money in the intimate relationship* and the analysis did not support my hypothesis.

As stated previously, twenty percent of primary caregivers are a spouse. However, literature states that there is a shift towards cohabitating taking place in the older population due to the rise of baby boomers turning sixty-five (Brown, Bulanda, & Lee, 2005). In the study, it was hypothesized *married couples compared to cohabitating couples are more likely to get help*. Reasons for cohabitating were associated with freedom from being dependent from a spouse and the quality of the relationship is not much different than that of married couples (Carpenter & Mak, 2007). The finding in this study, partners in a cohabitation were more likely to get the needed help compared to spouses in a marriage. This finding is in contrary to literature.

With the improvement in health among the elderly there has also been a rise in life expectancy (Ortman, Velkoff, & Hogan, 2014). As the sixty-five and older person's age increases, so will the need be for long-term care (Noël-Miller, 2011). The age of the respondent and the age of the spouse/partner were considered as influences for whether the spouse/partner gets help. Though age was not posed as a research question or in a hypothesis, it is important to understand how the age of an older adult can be associated with why a spouse or partner may wait to seek out

help in caregiving (Brown & Alligood, 2004). The literature states that feelings of obligation to their spouse and marriage, pride and stubbornness, and just not being aware of symptoms that are early signs of something more detrimental to the health of their significant other, can be reasons why they do not ask for help for caregiving. Results did not indicate an association between an increase in the respondent's age and giving needed care to their spouse/partner. But older partners were more likely to get help.

Per the results, if this help was not coming from their spouse/partner, then it is assumed it is coming from their children and the results did indicate that the number of children helping was significant in the spouse getting help. But it must be pointed out that one-hundred percent of the sample said they needed help and only thirty-five percent said they get help. This study revealed that some factors thought to be of significance in intimate spousal/partner caregiving are not supported by the results of the analysis. Fifteen factors were tested and only six had any significance in a spouse getting help (Table 5).

Limitations

Initially in the thought process of choosing a topic of study, the thought was to research the remarriage and stepfamilies created among the sixty-five and older population. Unfortunately, the literature to conduct such research is limited. Much of the literature on remarriage or subsequent relationships is founded on traditional first marriages. When searching for literature specific to subsequent relationships there is a gap in the literature on remarriage and cohabitation for the sixty-five and older population. Also, the dataset limited information on caregiving in the intimate relationship.

The HRS dataset was designed to study aspects of retirement and not caregiving. The dataset focused on the retirement and the health of the respondent, on the health of the respondent's

spouse/partner and on aspects of the respondent's children helping a parent with daily activities. The dataset did not have a question that asked of the respondent or the spouse/partner, "Do you take care of your spouse/partner?" Also, there was not a question in the dataset that asked the respondent and the spouse/partner about the sexuality of the relationship. The dataset didn't allow for a closer look at couples in other types of relationships, such as cohabitation and living apart together. And lastly, there wasn't an easy way to separate out people in first marriages from those in remarriages in the dataset. This limited me in the type of data that was available to conduct my research study.

Conclusion

Andrew Cherlin (2004) wrote the article, *The Deinstitutionalization of American Marriage*. His stance on marriage was that it was no longer what it used to be, traditional and institutionalized. Traditional in the sense that the family was composed of a father, a mother, and children, and social norms that are supportive to marriage. He stated, the deinstitutionalization of marriage in the U.S. was due to "a weakening of the social norms that define partners' behavior" (Cherlin, 2004, p. 848). There was a shift away from marriage as more people were choosing cohabitation, single parenting, and same-sex relationships. The literature states that many older adults are forming subsequent intimate relationships to satisfy basic emotional needs (Harris, Adams, Zubatsky, & White, 2011). The baby boomer generation has been partially responsible for the shift from marriage to cohabitation (Noël-Miller 2011).

No matter the relationship for those sixty-five and older, caregiving in the relationship is inevitable. Literature states that twenty percent of spouses are the primary caregiver in the relationship (Population Reference Bureau, 2016). The other eighty percent will be children, a relative, family friend, or they will get the needed assistance from a formal caregiver. In the

literature review topics such as but not limited to: retirement, finances, and education were explored. The literature stated that factors of health and finances are both associated with one's education (American Psychological Association, 2017). It is safe to say that as a person learns more about their own health and what it is to have a healthy lifestyle, they are less apt to be afflicted with illness in their older adult years, and upon reaching age sixty-five they potentially can live up to an additional 18 years (Ortman, Velkoff, & Hogan, 2014).

So, who are the ones getting the help with ADLs? My findings showed that...

...older spouse/partners are more likely to get help.

...those spouse/partners with more education are more likely to get help.

...minority respondents are more likely to give help.

...older spouse/partners with a low self-report of health are more likely to get help.

...older spouse/partners with higher education are more likely to get help.

So, in conclusion, it must be noted that the number of children helping was included in the study to help control for the effects of the dependent variable since the dependent variable is just about getting help. The inclusion of the independent variable, children helping, leads to more confidence that the results for the other 14 independent variables do reflect the respondent giving help. Besides, the literature shows that children are often the secondary caregivers when the spouse is the primary caregiver.

Future Direction

With the limitations that were presented in the dataset, it would be good to conduct a study that can be generalized back to the 65 years and older population that have formed subsequent relationships following the death or divorce of a spouse. The sample could consist of those persons living in Senior Living Communities, Independent Living Communities, Assisted Living

Facilities, Residential Care Facilities, etc. This would allow for more accurate data on caregiving that is initiated between spouses or partners. It would also give us information on care that is received from other informal and formal caregivers.

There is a gap in literature for those persons that are forming stepfamilies and the gap is even greater when it comes to the 65 years and older population who are remarrying (that can potentially form a stepfamily) and for those that are in a cohabitating relationship. Also, the legal changes such as the Defense of Marriage Act being deemed unconstitutional and same-sex marriage being legalized in the United States, would make a difference in how respondents will answer marital status in future studies. There needs to be more studies conducted on the different intimate relationships in the aging population if literature is going to keep up with the changes that are taking place in this 65 years and older population.

Implications

The implications of the study are that 100% of the sample needed help but only 35% were getting the needed help. Possibly a greater number of spouses and partners were getting the needed help from their significant other, because it was not being viewed as help. Rather, the respondent's spouse or partner viewed the help as a commitment to the vows made in marriage – in sickness and in health and 'til death do us part. Findings also showed, that 1,807 cases reported there was not a child that helped in caregiving. Just as the respondent's help is not seen as help, the parent may view a child helping as out of obligation, and in both cases, that is just what you do, you provide care and needed help to your loved ones. Therefore, the help received it is not being reported as such.

There is also indication that there needs to be more support provided through our society for the aging population and their informal care providers. Providing programs that offer home

health care services for the frail older person and training programs that teach the informal caregiver how to care for their loved one would be an ideal. Making programs such as these affordable or even free, would be a step in the right direction by our society.

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APPENDIX

APPENDIX
TABLES

TABLE A

FREQUENCY		
Spouse Needs Help _{w10} , N= 2,126		
	Frequency	Percent
YES	2126	100

Note: w10 refers to the wave of study from which the variable was constructed.

TABLE A.1

FREQUENCY		
Spouse Needs Help _{w10} , N= 2,126		
Number of Daily Activities	Frequency	Percent
1	961	45.2
2	409	19.3
3	240	11.3
4	191	9
5	124	5.8
6	58	2.7
7	50	2.7
8	33	2.7
9	34	2.7
10	27	2.7

Note: w10 refers to the wave of study from which the variable was constructed.

TABLE 1

FREQUENCY		
Dependent Variable Spouse Gets Help _{w10}		
	Frequency	Percent
YES	753	35.40%
NO	1373	64.60%

TABLE 1.1

FREQUENCY		
Dependent Variable Spouse Gets Help _{w10}		
<u>Activities of Daily Living</u>	<u>Frequency</u>	<u>Percent</u>
0	1373	64.6%
1	362	17%
2	160	7.5%
3	112	5.3%
4	54	2.6%
5	37	1.8%
6	27	1.3%

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 1.2

FREQUENCY		
Dependent Variable Spouse Gets Help _{w10} ; N=2126		
<u>Activity of Daily Living</u>	<u>Frequency</u>	<u>Percent</u>
Spouse gets help	753	35.40
Spouse gets no help	1373	64.60
Spouse gets help walking across the room	255	12.00
Spouse gets no help	1871	88.00
Spouse gets help in and out of bed,	277	13.00
Spouse gets no help	1849	87.00
Spouse gets help bathing/showering	302	14.20
Spouse gets no help	1824	85.80
Spouse gets help eating	129	6.00
Spouse gets no help	1998	94.00
Spouse gets help dressing	514	24.20
Spouse gets no help	1612	75.80
Spouse get help using the toilet.	109	5.1
Spouse gets no help	2017	94.90

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 2

FREQUENCY			
Respondent Characteristics; $N = 2126$			
		Frequency	Percent
GENDER			
	Male	1019	47.90
	Female	1107	52.10
RACE/ETHNICITY _{w10}			
	White non-Hispanic	1616	76.00
	Black non-Hispanic	194	9.10
	Other	79	3.70
	Hispanic	237	11.20
EDUCATION			
	Less than High-school	429	20.20
	GED	128	6.00
	High-school graduate	651	30.60
	Some college	488	22.90
	College and above	429	20.20
CONSIDERS SELF-RETIRED			
	Not retired	791	33.50
	Completely retired	979	46
	Partly retired	252	11.90
	Question irrelevant	104	4.90
SELF-REPORT OF HEALTH			
	Excellent	150	7.10
	Very good	577	27.10
	Good	679	31.90
	Fair	526	24.70
	Poor	194	9.10

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 2.1

FREQUENCY
Respondent CESD Scale

Number of Symptoms	Frequency	Percent
0	890	41.8
1	502	23.6
2	256	12
3	131	6.1
4	101	4.8
5	71	3.3
6	65	3.1
7	68	3.2
8	42	2

TABLE 2.2

FREQUENCY			
Relationship Characteristics			
		Frequency	Percent
Relationship _{w10}			
	Same-Sex	26	1.2
	Opposite-Sex	2101	98.8
Union Type _{w10}			
	Married	1943	91.4
	Cohabiting	183	8.6
Number of Kids Helping			
	0	1807	85
	1	241	11.3
	2	60	2.8
	3	15	0.7
	4	3	0.1
	5	1	0

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 2.3

		<u>Minimum</u>	<u>Maximum</u>	<u>Mean</u>	<u>Std. Deviation</u>
RESPONDENT					
	Age	50	98	65.71	10.457
	CESD Score	0	8	1.58	2.071
SPOUSE/PARTNER					
	Age	30	98	65.62	11.837
	CESD Score	0	8	2.37	2.398
RELATIONSHIP					
	Income	1	25	13	7.214

TABLE 3

		FREQUENCY	
		Spouse/Partner Characteristics; <i>N</i> = 2126	
		Frequency	Percent
GENDER			
	Male	1113	52.30
	Female	1013	47.70
EDUCATION			
	Lt High-school	519	24.40
	GED	186	8.80
	High-school graduate	583	27.40
	Some college	485	22.80
	College and above	352	16.50
SELF-REPORT OF HEALTH			
	Excellent	57	2.70
	Very good	242	11.40
	Good	548	25.80
	Fair	759	35.70
	Poor	521	24.50

TABLE 3.1

FREQUENCY		
Spouse/Partner CESD Scale; N = 2126		
Number of Symptoms	Frequency	Percent
0	639	30.1
1	362	17
2	312	14.7
3	238	11.2
4	134	6.3
5	126	5.9
6	117	5.5
7	120	5.6
8	78	3.7

TABLE 4

Group Statistics					
Spouse Gets Help by Respondent's Characteristics					
<u>CHARACTERISTICS</u>	<u>SPOUSE GETS HELP</u>	<u>N</u>	<u>Mean</u>	<u>S.D.</u>	<u>T-TEST</u>
Income	NO	1373	13.57	7.261	4.990***
	YES	753	11.96	7.015	

*Note: Standardized coefficients reported, *p < .05, **p < .01, ***p < .001.
w10 refers to the wave of study from which the variable was constructed*

TABLE 4.1

		CHI-SQUARE	
		Respondent Gender by Spouse Gets Help	
		Spouse Gets Help	
		NO	YES
	Respondent Gender	1373.435	752.667
Male	N= 1019.249	62.10%	37.90%
Female	N= 1106.853	66.90%	33,10%
	TOTAL	100.00%	100.00%

Pearson Chi-Square 5.208a; p < .05

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 4.2

		CHI-SQUARE	
		Relationship Union Type by Spouse Gets Help	
		Spouse Gets Help	
		NO	YES
	Relationship Union Type _{w10}	1373.435	752.667
Married	N= 1943.381	64.60%	35.40%
Cohabiting	N= 182.721	64.70%	35.30%
	TOTAL	100.00%	100.00%

Pearson Chi-Square .967a, p < .05

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 4.3

		CHI-SQUARE	
		Respondent Race-Ethnicity by Spouse Gets Help	
		Spouse Gets Help	
		NO	YES
	Respondent Race-Ethnicity _{w10}	1373.435	752.667
White	N= 1616.406	67.70%	32.30%
Black	N= 193.500	55.80%	44.20%
Other	N= 79.066	62.80%	37.20%
Hispanic	N= 237.130	51.20%	48.80%
	TOTAL	100.00%	100.00%

Pearson Chi-Square= 32.068a; p < .001

Note: w10 refers to the wave of study from which the variable was constructed

TABLE 5

LOGISTIC REGRESSION FULL MODEL			
Predicting changes in odds of Spouse Gets Help _{w10}			
	<u>B</u>	<u>S.E.</u>	<u>Odds Ratio</u>
RESPONDENT CHARACTERISTICS			
Black	0.379*	0.173	1.461
Other	0.177	0.257	1.193
Hispanic	0.525**	0.164	1.691
Female	-0.124	0.502	0.883
Age	-0.018	0.01	0.982
Education	-0.001	0.043	0.999
Considers self-retired	-0.004	0.066	0.996
Self-report of health	-0.073	0.052	0.930
CESD score	0.016	0.026	1.016
SPOUSE/PARTNER CHARACTERISTICS			
Female2	0.106	0.503	1.112
Age	0.031***	0.009	1.032
Self-report of health	0.537***	0.053	1.711
Education	0.096*	0.042	1.101
CESD score	0.026	0.022	1.026
RELATIONSHIP CHARACTERISTICS			
Same-Sex _{w10}	0.456	0.506	1.577
Cohabiting _{w10}	0.029	0.185	1.030
Number of kids helping	0.937***	.105	2.552
Household Income	-0.015	0.008	0.986
Constant	-4.214***	0.851	0.015
Nagelkerke R ² = 0.182			
N = 2,126			

*Note: Standardized coefficients reported, *p < .05, **p < .01, ***p < .001.
w10 refers to the wave of study from which the variable was constructed
Comparison Group White; Spouse does not get help = 0; Spouse gets help = 1.*

TABLE 5.1

LOGISTIC REGRESSION MODEL SEGMENTS				
Predicting changes in odds of Spouse Gets Help _{w10}				
		<u>Odds Ratio</u>	<u>Odds Ratio</u>	<u>Odds Ratio</u>
RESPONDENT				
	Black	1.627**	1.748***	1.461*
	Other	1.231	1.303	1.193
	Hispanic	1.864***	1.822***	1.691***
	Female	.826*	0.938	0.883
	Age	1.012**	0.986	0.982
	Education	.949	0.961	0.999
	Considers self-retired	.982	0.992	0.996
	Self-report of health	1.023	0.974	0.930
	CESD score	1.046	1.018	1.016
SPOUSE/PARTNER				
	Female2	-	1.286	1.112
	Age	-	1.033***	1.032***
	Self-report of health	-	1.746***	1.711***
	Education	-	1.077	1.101*
	CESD score	-	1.036	1.026
RELATIONSHIP				
	Same-Sex _{w10}	-	-	1.577
	Cohabiting _{w10}	-	-	1.030
	Number of kids helping	-	-	2.552***
	Household Income	-	-	0.986
<hr/>				
	Constant	.247***	.000***	0.015***
<hr/>				
	Nagelkerke R ²	0.032	0.124	0.180

*Note: Standardized coefficients reported, *p < .05, **p < .01, ***p < .001.*

w10 refers to the wave of study from which the variable was constructed

Comparison Group White; Spouse does not get help = 0; Spouse gets help = 1.