Double Jeopardy:
The Costs of Caring at Work and at Home

Nancy L. Marshall, Rosalind C. Barnett, Grace K. Baruch, Joseph H. Pleck

Wellesley College
Center for Research on Women

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Women have traditionally had primary responsibility for caring for others. Although many women find this responsibility gratifying, it can also be a source of stress and thus have negative consequences for women's mental and physical health. Women are also vulnerable to the stresses of caring in the labor market. Many of the women now in the labor force are employed in the expanding service sector of the economy as direct service providers in the fields of health and social service. This chapter examines whether women responsible for caring both at home and at work face a double jeopardy.

Numerous researchers document women's greater involvement in caring for significant others, including members of their immediate family, extended family members, and friends. In studies of marriages, husbands are more likely to rely on their wives as confidants than wives are on their husbands (Veroff, Douvan & Kulka, 1981; Lowenthal & Haven, 1968). Historically, women have been the primary caregivers of young children, the elderly and the ill. Studies of social networks show that women are more likely than men to be named as counselors, companions and providers of emotional support (c.f., Fischer, 1983). Women often do the day-to-day work needed to maintain extended family networks (Bott, 1971; Stack, 1974; Young & Willmott, 1962) and are responsible for establishing and maintaining larger social networks from which they can draw resources for themselves and their families (Gilligan, 1982; Kibria, 1985).

Not only are women more likely to be engaged in these "network caregiving" activities than men, but they appear to be more vulnerable to psychological distress because of their involvement in the lives of others.[1] Kessler and McLeod (1984) compared women's and men's reports of major life events. Men and women responded in similar ways to marital disruption and income loss, but women reported more events occurring to others in their networks, and they were more vulnerable to these events. Kessler and McLeod demonstrated that much of women's greater vulnerability to depression and anxiety can be explained by their greater exposure to others' stress and their greater emotional responsiveness to other's difficulties.

Many women also have caregiving responsibilities at work. Almost half (43%) of employed women hold jobs in the services industries, the majority as nurses, teachers, social workers, housekeepers, and members of other caregiving occupations. Although women represented just 44 percent of the labor force in 1985, they constituted fully 61% of the employees in the services industries (professional, personal, business and repair, and entertainment and recreation services). The services industries' share of the labor force almost doubled between 1950 and 1980, growing from 13.7 percent to 24.1 percent. As our economy continues to shift from a concentration of jobs in goods-producing industries to jobs in service-producing industries, we can expect the employment of women as caregivers to increase.

Research on mental and physical illness related to "stressors" on the job has identified the importance of job demands such as work load, deadlines, or conflicting tasks (Theorell, 1976; Caplan et al, 1975; Quinn et al, 1971). Although much of the existing occupational stress research has focused on men (Baruch et al, 1987), employed women also experience occupational stress.

However, caregiving occupations can be expected to differ from other occupations in the nature of the demands. The demands of such jobs may include the following:

1. Working with clients or patients in crisis;
2. Dealing with issues, such as abuse or death and dying, over which the care provider may have little control;
3. Being asked to give more than the provider is capable of emotionally;
4. Seeing little change as a result of the caregiver's actions;
5. Being responsible for a large number of people in need of care.

To some extent, these demands are inherent in the nature of caregiving; "caring" means responding to the needs of others. However, the demands of caregiving occupations can also arise from, or be increased by, the conditions of the job. Women in caregiving occupations who are also responsible for network caregiving may experience a double burden, with adverse consequences for their mental and physical health.

THE STUDY

The research reported in this chapter is part of a larger study of occupational stress and health among 404 women employed as social workers or licensed practical nurses (LPNs). The sample was randomly drawn from women who were between the ages of 25 and 55, living in eastern Massachusetts, and listed in the registries of these two occupations. Black women were oversampled; 15% of the respondents were Black. The sample also was designed to include a variety of household types. As a result, 30 percent of the women were parents and married or living with a partner, 27 percent were single

parents, 18 percent were married or living with a partner and did not have children, and 25 percent were single (never married, separated, or divorced) women who did not have children.

This chapter describes the experiences of the 326 respondents who reported that their jobs always or almost always involved responsibility for clients or patients. The interviews lasted an average of two hours and included both close-ended and open-ended questions about each woman's job, her family and friends, and her mental and physical health.

THE BURDEN OF SOCIAL NETWORK CARING

Jane Wilson is married to a man who had a massive heart attack last year and is still very sick. In addition, her own parents are in their late seventies; her father is ill and Jane has been involved in his care. Jane worries about having to take care of her mother when her father is gone.

Marsha Smith's father died this year, after a long illness. She too is concerned about her mother's health and her own responsibility to care for her mother. In addition, a close friend of hers is sick with bone cancer, and Marsha visits her regularly and accompanies her to the doctor's.

Susan Brown lives with her mother and her younger brother and sister. Her older sister and her sister's child came to live with them recently after their home burned down. Susan's older sister is not employed. Susan is concerned that her mother, a diabetic, will have to stop working and that Susan then will be the only wage earner in the household.

Pat Murphy says "love is hard work". She and her husband raised three children, one of whom had a serious illness a few years ago. Two children are still living at home. Her father-in-law has Parkinson's disease and recently had a stroke. She has been visiting him daily in the hospital; her in-laws will be coming to live with her when he is released from the hospital.

Each of these women is experiencing a high level of burden from her caring responsibilities for people in her network of significant others, including immediate family, parents and parents-in-law, and friends. We measured this burden using a "Burden of Caring Scale", which asked respondents to evaluate how true each of the following items was for them, when thinking about the people who are important to them:

1. "People ask more of me than I can give."
2. "I feel that I don't really get all the help I need."
3. "The people I care about make too many demands on me."

This scale is internally consistent, with a Cronbach's alpha of 0.81. (The Cronbach's alpha test is a measure of the extent to which a given respondent responds in similar ways to all items in a scale.)

CONTAGION STRESS

Women's greater involvement with others can negatively affect their mental and physical health when they experience a sense of burden from the demands of caring; it can also expose women to others' stresses. Exposure to others can lead to "contagion stress" in various ways, including worrying about other

people's problems, feeling unable to help important others, or blaming oneself for others' difficulties. We measured the respondents' exposure to people in difficulty using the "Contagion Stress Scale", which included the following two items:

1. "Some of the people I care about have problems I can't solve."
2. "Some of the people I know are having difficult times right now."

This scale is internally consistent with a Cronbach's alpha of 0.60.

The Contagion Stress Scale is different from the Burden of Caring Scale. Women may have high scores on both scales -- Marsha Smith is one example. However, other women who experience high burden because of their involvement in caretaking may feel that they actually can help with the problems of others and so have lower Contagion Stress scores; this is true for Jane Wilson.

A low score on the Burden Scale does not necessarily ensure a low score on the Contagion Scale. Some women who are not involved in regular caretaking for friends and family still have family and friends with difficult problems and therefore may have high Contagion Stress scores. Rachel Jones, for example, has three children in their twenties. Only the middle one is doing well. The youngest was in reform school during adolescence and continues to have "serious problems". Her oldest is currently serving a jail term. Because the children live far away, they do not burden Rachel with requests for assistance. Nevertheless, her children are of serious concern for her.

THE COSTS OF CAREGIVING AT WORK

Karen Barnes is the leader of a team of clinicians who provide assessment and treatment for victims of child sexual abuse, their families and offenders.

Her clinical work requires her to deal with emotionally difficult situations and to respond to families in crisis. She must also interact with a complex structure of agencies involved in the identification and treatment of child sexual abuse. As the supervisor of the team, she must also help other clinicians respond to difficult situations and crises.

Mary Connors is an LPN on a medical-surgical floor with 34 patients. She is personally responsible for 11 to 17 patients each evening, and only occasionally has a nurse's aide to help out. Mary is responsible for complete care for these patients, including treatments, teaching, medications, intravenous medications, feeding, physical therapy and chest physiotherapy, as well as for documenting the care for each patient on a daily basis. Because the hospital is short-staffed and has recently hired many new inexperienced nurses, she often has more responsibilities than she can manage and must provide on-the-job training for new nurses. Supervisors and administrators recognize problem of overload, but tell Mary to do the best she can and to just keep the patients breathing during her eight-hour shift.

Joan Matthews is an elementary school guidance counselor. She provides individual counseling to students with social and emotional needs, and group counseling for students about self-awareness, drugs and alcohol abuse, sexuality, and death and dying. Joan is responsible for identifying special needs children and serves as a case manager for these children, advocating for programs to meet their needs. She also provides support to teachers with classroom problems and counsels the parents of the students.

Chris Price is a social worker in a community health center. Her caseload consists primarily of clients with serious psychiatric diagnoses. She says about her job: "Emotionally it's draining. The cases I see are so difficult, and handling all the paperwork is impossible."

These women all hold jobs with heavy caregiving demands and all experience high costs of caregiving at work. We took a slightly different approach in measuring the costs of caregiving at work; we asked the respondents not only whether certain statements about their job conditions were true, but how concerned they were about these job conditions. Respondents' concerns about their jobs included concerns about the demands of the job, poor supervision, discrimination and lack of respect, low wages, and hazardous working conditions. The Costs of Caregiving Scale measures the respondent's concerns about the demands of caregiving on her job, and asks how concerned she is about the following items:

1. "Having to deal with emotionally difficult situations."
2. "The job's taking too much out of you."
3. "Having too much to do."
4. "Having to juggle conflicting tasks or duties."
5. "Other people being dependent on you."

It was impossible to separate concerns about workload from concerns about people and their problems. This is an important feature of caregiving jobs; the workload is a direct reflection of caregiving responsibilities. The extent to which each of these items is related to others is reflected in the internal consistency of the scale, which had a Cronbach's alpha of 0.76.

THE IMPACT OF CARING ON WOMEN'S HEALTH

We measured mental and physical health in four ways, including the depression and anxiety subscales of the Symptom Check List (SCL-90), as a measure of the level of psychological distress (Derogatis et al, 1974); a 14-item subjective wellbeing scale developed by the Rand Corporation (1981); a measure of the frequency and discomfort of 29 physical symptoms; and a single item, asking respondents to compare their health to that of other women their age.

The social workers and nurses who reported greater costs from caregiving at work, greater burden from their social networks, or greater contagion stress had poorer mental and physical health than did other women (see Table 1).[2] The relationships of each of the costs of caring scales to each of the measures of mental and physical health is statistically significant. In other words, these findings are not the result of chance. If we were to examine other women who are employed as social workers or LPNs, we would find that those women who experience greater costs of caregiving also would have poorer mental and physical health. Because health can vary with age, race and income, the analyses reported in Table 1 control for these factors. That means that we can say that, holding the impact of age, race and household income constant for all the women in the sample, greater costs of caring at work or at home are related to poorer health.

The R square values reported in Table 1 are statistics derived from the regression analyses. Each R square represents the proportion of the variation in mental or physical health that is explained by the given measure of the

costs of caring, plus age, race and income. For example, the costs of caregiving at work, along with age, race and income, explains 21% of the variation among women in psychological distress, while the burden of social network caring, along with age, race and income, explains only 12% of the variation in psychological distress.

Table 1: R Squares of Regressions of the Costs of Caring on Mental and Physical Health, Controlling for Age, Race and Household Income

	Psychological Distress	Subjective Wellbeing	Physical Symptoms	Health
Burden of Network Caring	0.12 ****	0.15 ****	0.12 ****	0.05 *
Contagion Stress	0.07 ***	0.04 *	0.05 *	0.05 *
Costs of Caregiving at Work	0.21 ****	0.11 ****	0.05 *	0.05 *
N	307	306	303	306

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ **** = $p < 0.0001$

The next question we asked was: given a certain level of cost from social network caring, does cost from caregiving at work have an additional impact? Our analyses show that, holding constant the level of costs from network caring, women with greater costs from caregiving at work experience greater psychological distress and poorer mental and physical health. (see Table 2). Conversely, holding constant the level of costs from caregiving at work, women with greater burden from network caring experience greater psychological distress and poorer health and wellbeing, and women with greater contagion stress experience greater psychological distress and poorer health.

Table 2 shows the unstandardized regression coefficients, which are the weights assigned to each of the costs of caring measures; unstandardized

coefficients are not adjusted for differences in scale metrics and cannot be compared to each other. The coefficients that are asterisked are statistically significant, at the level of probability indicated. For example, the coefficient for the Costs of Caregiving at Work in the regression on psychological distress is significant at the $p < 0.0001$ level. That means that there is less than 1 chance in 10,000 that the Costs of Caregiving at Work is not significantly related to psychological distress, after holding constant the other costs of caring, as well as age, race and income.

Table 2: Unstandardized Regression Coefficients for Regression Equations with all Three Costs Included, Controlling for Age, Race and Household Income

	Psychological Distress	Subjective Wellbeing	Physical Symptoms	Health
Burden of Network Caring	1.13 ***	-1.55 ****	1.62 ****	-0.07
Contagion Stress	1.05 *	-0.28	1.28 *	-0.02
Costs of Caregiving at Work	1.58 ****	-0.89 ****	0.52 *	-0.02
N	307	306	303	306

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ **** = $p < 0.0001$

Note: High scores on Psychological Distress and Physical Symptoms indicate poor psychological or physical health. High scores on Wellbeing and Health indicate good psychological or physical health.

Not only do the costs of social network caring and of caregiving at work have significant, independent effects on mental and physical health, but women with high costs of caring at work and at home were at greater risk than women with high costs in only one domain. To examine this issue statistically, we added the interaction of the Burden of Social Network Caring with the Costs of

Caregiving at Work to our equation. As Table 3 shows, this interaction term is significant for the regressions on psychological distress, subjective wellbeing and the single item measure of health. (Because the interaction term did not significantly increase the R square for physical symptoms, these data are not included in Table 3. Similarly, the interaction of the Costs of Caregiving at Work and Contagion Stress is omitted from the table because it did not significantly increase the R squares.)

Table 3: Unstandardized Regression Coefficients for Equations with Significant Interaction Terms

	Psychological Distress	Subjective Wellbeing	Health
Burden of Network Caring	3.50 ***	-3.78 ****	-0.20 *
Contagion Stress	1.08 *	-0.31	-0.07
Costs of Caregiving at Work	2.96 ****	-2.18 ****	-0.13 ***
Interaction of Network Burden with Caregiving at Work	-0.20 ****	0.19 *	0.02 *
N	307	306	306

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ **** = $p < 0.0001$

Figures 1 and 2 demonstrate graphically what happens to women's mental and physical health when they experience high costs from both caregiving at work and network caregiving. Women with both low costs of caregiving and low network burden have the lowest levels of psychological distress. As Figure 1 shows, at moderate or low levels of the Costs of Caregiving at Work, an increase in the Burden of Social Network Caring raises the level of distress.

Figure 1

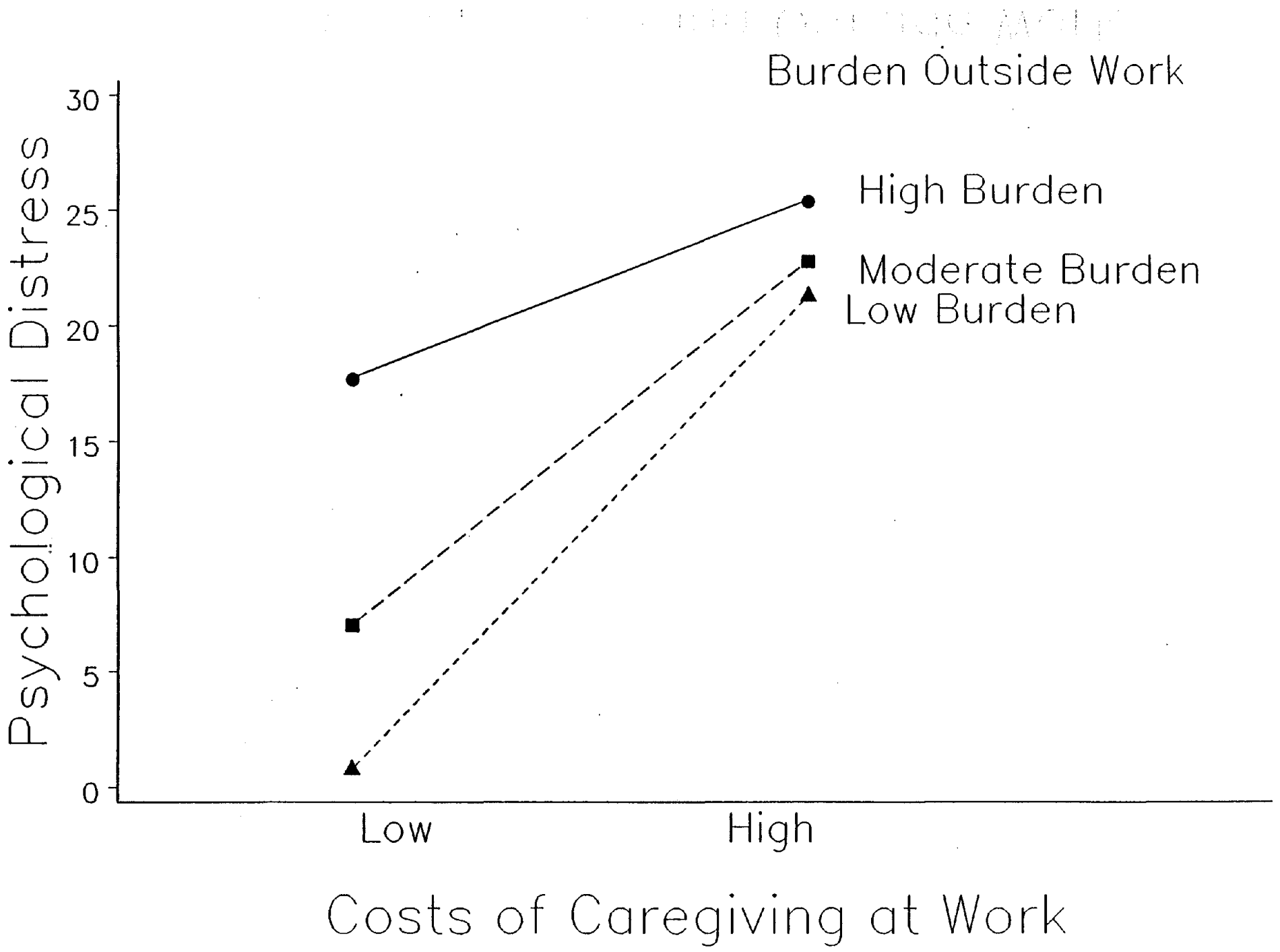
Burden Outside Work
High Burden
Moderate Burden
Low Burden
Psychological Distress
30
25
20
15
10
5
0
Low
High
Costs of Caregiving at Work

Figure 2

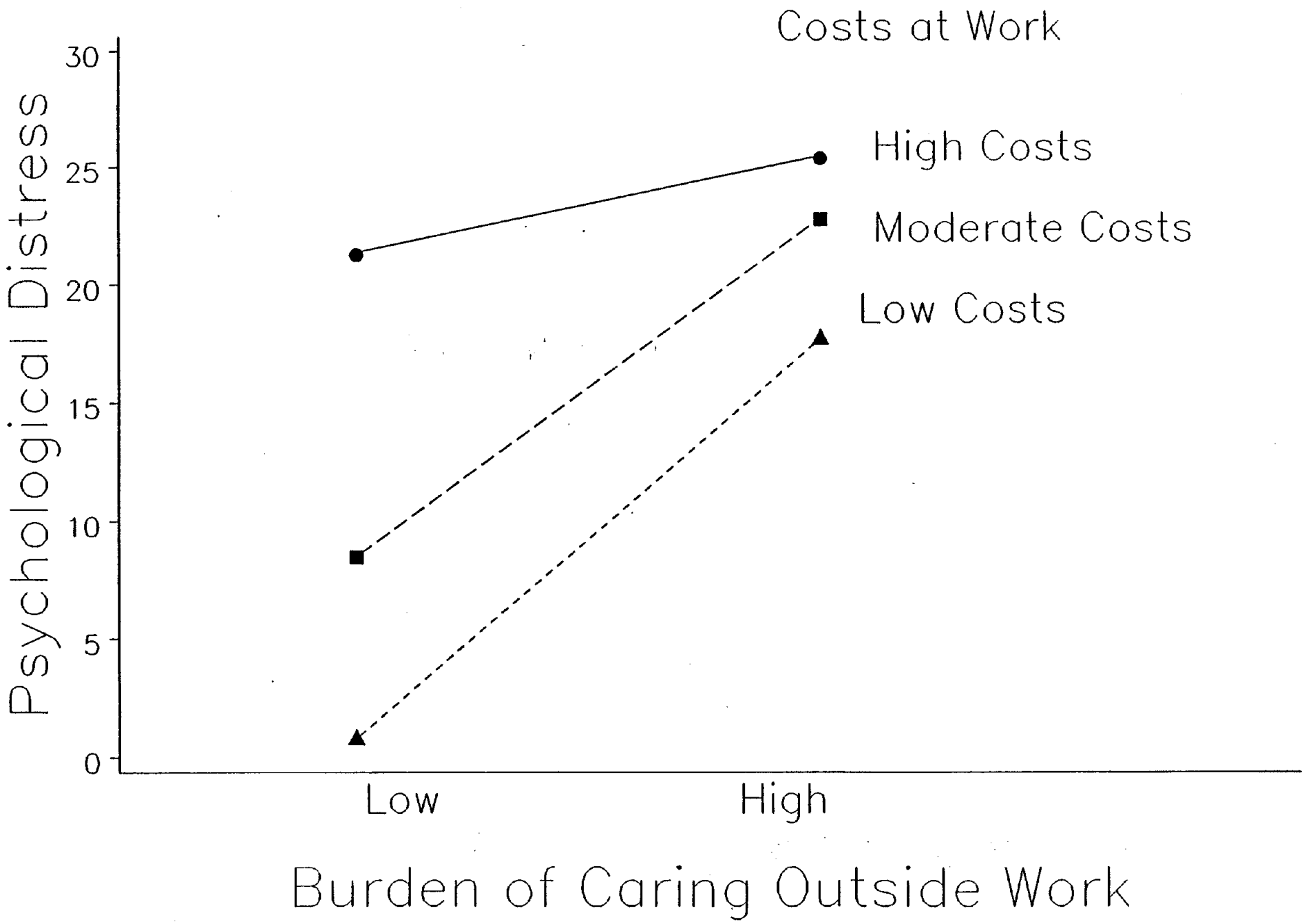
Costs at Work
High Costs
Moderate Costs
Low Costs
Psychological Distress
30
25
20
15
10
5
0
Low
High
Burden of Caring Outside Work

Figure 2 shows that the reverse is also true. At moderate or low levels of the Burden of Social Network Caring, an increase in the Costs of Caregiving at Work raises the level of distress. As both figures show, when either cost is high, the other cost adds relatively little to an already high level of distress. However, women with high levels of costs of caring at work and at home have the highest levels of psychological distress. Similar patterns hold for subjective wellbeing and health.

DISCUSSION

Like many other women, the nurses and social workers we interviewed care for children, parents, other relatives, and friends. When this caring taxes their personal and material resources, or when they experience contagion stress from exposure to others' problems, they suffer greater psychological distress, reduced wellbeing and poorer health.

In addition, these women are employed as caregivers, helping others through counseling, advocacy and direct physical care. Other parts of our research have demonstrated that paid employment is not only good for women, but also "good medicine" because it buffers them from the strains they experience in other arenas (Barnett et al, 1987). But when women face overwhelming demands for caregiving at work, their mental and physical health suffers.[3]

It therefore is imperative that we find ways to reduce the costs of caring. Some of these costs are inherent in the tasks. The nature of caregiving means responding to others, and as such is not so easily structured or limited as other forms of work. But much of the costs of caregiving jobs are a result of heavy workloads and limited resources. In addition, direct service jobs often are poorly paid, and may offer limited autonomy and challenge. The same is

true for network caring. Much of the burden of network caring and of contagion stress is a consequence of women's uneven responsibility for network caregiving, limited societal resources for network caregiving, and inadequate emotional and material support.

In general, there are two approaches that will reduce the costs of caring; we can reduce the demands associated with caregiving, and we can increase the resources and rewards available to caregivers. We can reduce the costs of caregiving at work by reducing caseloads and providing adequate material resources and supportive supervision. In addition, jobs that offer other rewards, such as decent pay, autonomy, challenging work, opportunities for advancement, and the opportunity to actually make a difference in someone else's life, may strengthen a woman's resilience and allow her to cope with the demands of caregiving jobs (Marshall et al, 1988).

We can reduce the costs of network caring in several ways. We can involve men more thoroughly in the day-to-day caring for network members. Men's employers need to recognize that, from time to time, an individual man will need to cut back or take time off to care for an ailing parent or a sick child. In addition, as a society we need to stop relying on women's unpaid, and often unacknowledged, labor of network caring and provide paid caregivers during times of great burden. We can also reduce the costs of network caring by ensuring that care providers receive adequate emotional support and the resources they need to help others.

Without "good jobs" and personal and societal support to meet network caregiving needs, women like Pat Murphy and Karen Barnes will face a double jeopardy: women caregivers who are burdened by network caring and who are burdened by their caregiving responsibilities at work will be at risk for high

levels of psychological distress, poor health and reduced subjective wellbeing.

ENDNOTES

1. It has been argued that women are not more vulnerable to depression and anxiety, but simply more willing to report it. However, Kessler and McLeod's findings that women and men respond in similar ways to marital disruption and income loss, but not to network events, suggests that this is, at best, only a partial explanation of the high levels of depression and anxiety found among women.

2. Our theoretical model posits that greater costs from caregiving at work, and the other independent variables, cause poorer mental and physical health. However, it is possible that women in poorer health are more easily overwhelmed by difficulties at work and in their networks. Longitudinal analyses are necessary to untangle the direction of effect.

3. It may be that the combination of any job and network caregiving is stressful. However, jobs that involve caregiving have been identified as among the most stressful. The resolution of this question awaits investigation of the costs of caring among women and men in different occupations.

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