The Health Consequences of "Good Breadwinner" and "Good Parent" Work-Family Strategies for Three Cohorts Of Men And Women

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ABSTRACT

We investigate whether four work-family strategies affect the physical health of adult men and women; and explore the extent to which these patterns vary for three cohorts: Silent Generation (born 1931-1943); Baby Boom (born 1944-1959); and Baby Bust (born 1960-1970). We consider three strategies that are consistent with the "good parent" ideal (stopping work, reducing work hours, or taking a flexible job to have more time with children) and one strategy that is consistent with the "good breadwinner" ideal (working longer hours to provide for children). Analyses are based on data from the 1995 and 2005 waves of the Midlife Development in the United States (MIDUS) survey. Baby Bust men who make sacrifices consistent with the "involved parent" ideal have an elevated risk of high blood pressure. This finding likely reflects their life course stage, where young men are currently grappling with the competing demands of work and family.

Men's and women's work and family roles have undergone considerable transformation over the past four decades. Middle-class white men and women raised in the 1940s and 1950s could look forward to holding clearly demarcated gender roles in adulthood; married men would serve as the primary breadwinner and would leave childrearing responsibilities to their wives, who would typically exit the labor force all together when their children were young (Baruch, Barnett and Rivers 1983; Bernard 1981; Coontz 1992). In contrast, women and men who came of age in the late 1960s and later faced an entirely new set of normative expectations for appropriate work and family roles. While men of the Baby Boom and Baby Bust cohorts are still expected to fulfill the traditional role of breadwinner, they also are expected to be involved fathers who play a larger role in childrearing and homemaking than their own fathers did (Gerson 1993; Hochschild 1989; Kaufman and Uhlenberg 2000; Wilkie 1993). Women, too, are now expected to maintain a household and care for their children as their mothers did, but also to work for pay outside the home. Men's and women's economic contributions to the family have shifted concomitantly: wives' contributions to household income have risen dramatically over the last several decades with an almost 300% increase in the number of wives who provide at least half of the marital income (Raley, Mattingly, and Bianchi 2006).

This shift from the "male breadwinner/female homemaker" marriage to the "dual earner/co-parent" marriage may carry important implications for health and well-being. The psychological consequences of shifting gender roles, and particularly women's work-family struggles, have been widely documented (Carr, 2002; Grzywacz and Bass, 2003). The consequences for men's well-being are less clear, however. Some evidence suggests that sharing financial power in marriage results in emotional and physical distress for men (Rosenfield 1992; Springer 2006a; Staines, Fudge, and Pottick 1986). Yet other studies suggest that the

consequences may be contingent upon whether one's behavior is consistent with *cohort-specific normative expectations*. Carr (2002) found that Baby Bust men (born 1960-1970) who cut back on paid employment in order to meet family demands enjoyed mental health benefits, whereas Silent Generation men (born 1920-1935) who did so suffered psychological decrements. Similarly, Springer (2006a, 2006b) has documented that Silent Generation men (born 1931-1941) who were economically dependent on their wives suffered from poorer self-rated health than did men who were the primary breadwinner. Springer argued that "breadwinner anxiety" may represent an assault to one's sense of masculinity, which in turn takes a toll on physical health. Taken together, these studies would suggest that men of the Silent Generation who had made professional sacrifices in order to fulfill the "good father" role may have poor health compared to their peers who did not make similar sacrifices, and compared men of younger generations who made similar tradeoffs.

However, the distinctive effects of work-family tradeoffs for a given birth cohort also may reflect cohort members' age or *developmental stage*. Baby Bust men, most of whom are now in their late 30s and early 40s, may currently be in the midst of juggling work and family responsibilities. As such, they may show physical health decrements if the competing demands of work and family outstrip their personal resources, such as time, energy, coping skills, or social support (O'Neil & Greenberger, 1994; Voydanoff, 2002).

We know of no studies that have evaluated empirically the ways that work-family strategies affect the physical health of men across cohorts, and over the life course. Carr (2002) investigated only the psychological (rather than physical) consequences of the work-family strategies adopted by three generations of women and men. By contrast, Springer (2006a; 2006b) investigated physical health outcomes, yet conceptualized men's gender roles in terms of their

economic contributions to the household; she did not consider the specific strategies that men enact in order to fulfill the roles of breadwinner and/or involved parent.

In this study, we build upon the work of Carr (2002) and Springer (2006a, 2006b), and examine: (a) whether four specific work-family strategies affect men's and women's physical health (self-rated health, and high blood pressure); and (b) the extent to which these health consequences differ across birth cohorts and/or life course stages. Specifically, we consider three work-family strategies that are consistent with the *involved parent* ideal (stopping work to care for children; cutting back on hours of work to care for children; and taking a less demanding or more flexible job to care for children) and one strategy that is consistent with *good breadwinner* role expectations (working longer hours to support family). We use two waves of data from the Midlife Development in the United States (MIDUS) study, a survey of approximately 3,000 men and women born between 1920 and 1970, and who participated in interviews in 1995 and 2005.

Data and Methods

Sample

The MIDUS is a national multistage probability sample of noninstitutionalized, English-speaking adults born between 1920 and 1970, selected from working telephone banks in the coterminous United States. Telephone interview and self-administered questionnaire data were obtained in 1995-96 and 2004-05. In the first stage of the 1995 data collection, households were selected via random-digit dialing. Disproportionate stratified sampling was used at the second stage to select respondents. The response rate for the self-administered questionnaire was 87 percent; the response rate for the telephone interview is 70 percent.

In 1995, 7,108 respondents completed the telephone interview and, of these, 6,329 people completed both the telephone and mail surveys. In 2005, 4,963 of the 7,108 possible respondents

from 1995 were successfully contacted to participate in the 2005 MIDUS telephone interview. In total, 4,032 persons completed the 2005 telephone and mail surveys. The analytic sample used here comprises 3,054 adults (1,408 men and 1,646) women. We limit our analysis to those who completed the self-administered questionnaire at baseline because work-family strategies were assessed with that instrument. We further limit our sample to include people who have children and complete data on all variables of interest. Because of the moderate rate of nonresponse, caution is needed in extrapolating the study results to the total population in the same age range.

Measures

Dependent Variables

We use two indicators of health, assessed in the 2005 self-administered questionnaire: self-rated health, and high blood pressure. We focus on these two conditions only because our sample is still relatively young and healthy, and thus has low rates of more serious health concerns such as cardiovascular disease. Additionally, we selected those physical health outcomes that may be at least partially susceptible to the potential strains associated with the violation of gender-typed social roles (Springer 2006a, 2006b). *Self-rated health* is assessed with the question: "In general, would you rate your health as excellent, very good, good, fair or poor." Higher scores reveal better health. *High blood pressure* is assessed with the question: "In the past 12 months, have you experienced or been treated for high blood pressure/hypertension?"

Independent Variables

Work-Family Strategies. Our key independent variables are four *specific work-family strategies* that represent compliance with (or departure from) the good breadwinner and involved parent ideals. Respondents are asked: "We are interested in how having children may have changed your work situation. Which of the following changes did you make because you were

living with children? Did you: (1) Stop working at a job to stay home and care for the children; (2) Cut back on the number of hours worked at a job to care for the children; (3) Switch to a different job that was less demanding or more flexible to be available to the children; or (4) work longer hours to meet the added expenses of having children." The first three items represent compliance with the involved parent model, whereas the latter is consistent with the good breadwinner role. We also created a single "tradeoff" variable which was coded as "1" if the respondent engaged in any of the work reduction strategies consistent with the "good parent" model. We use the indicator assessed in 1995, to address the possibility of endogeneity between health in 2005 and contemporaneous work life adjustments.

Birth Cohort/Life Stage. A core objective of our study is to investigate whether the consequences of work-family tradeoffs vary by birth cohort. We consider three cohorts: *Silent Generation*, born between 1931 and 1944 (ages 61 to 74 in 2005); *Baby Boom*, born between 1944 and 1959 (ages 46 to 60 in 2005); and *Baby Bust*, born between 1960 and 1970 (ages 35 to 45 in 2005).

Family Characteristics. In order to assess the health effect of work-family conflicts it is essential to account for current family characteristics including number and age of children. Past research had demonstrated that larger number of children, having children in the home, having younger children, and having fewer social supports exacerbate both the likelihood and consequences of work-family conflict (e.g. Voydanoff, 2002). Therefore, we include *current marital status* (current, former, or never married), *number of children, children in the home,* and *age of children* in our multivariate models.

Socioeconomic Status and Background Factors. We recognize that the relationship between work-family strategies and current physical health may be spurious, reflecting early life

endowments or persistent health conditions. Similarly, socioeconomic resources also are associated with both work-family strategies and health. Moreover, the physical health consequences of work-family tradeoffs may operate via the economic rewards (or costs) of such decisions. Thus, our multivariate analyses will control for *income* (one's own earnings from wages, salary and self-employment income in the year prior to salary); *educational attainment*; *total number of years work experience, full-time or part-time status* in current job; *marital status*; *parental status*; race; and one's self-reported *physical health at age 16*.

Gender Role Attitudes. We will also control for one's *attitudes towards men's family roles* with the two-item scale assessing one's level of agreement or disagreement with two items: "Men should share equally with their wives in the work around the house;" and "Men should share equally with their wives in taking care of young children." In our analyses, we will consider this measure as both a potential mediator and moderator the relationship between work-family strategies and physical health.

Analytic Plan

We will use OLS regression analyses to predict self-rated health, and logistic regression models to predict a self-reported diagnosis of high blood pressure. Our baseline models will separately evaluate the effects of each of the four work-family strategies on each of the two health outcomes; we will also evaluate the effects of a single dichotomous measure indicating that one made any of the three strategies consistent with the "good parent" model. Our second set of models will evaluate two-way interaction terms between each cohort/age group indicator, and each of the work-family strategy indicators. A statistically significant two-way interaction term would suggest that the physical health consequences of a given strategy differ significantly by birth cohort or across life course stage. We will also evaluate the extent to which these

relationships are attributable to the control variables and potential pathway variables described above.

Preliminary Findings

Bivariate Analysis

We first evaluated whether each of the three cohorts of men and women reveal different patterns of work-family tradeoffs. Table 1 reveals the proportion of who made any work-reduction family tradeoff, as well as those who stopped working, cut back on hours, took a less demanding job, or worked longer hours to meet the financial needs of their children. Among men, we found a monotonic increase across cohorts in the proportion who made sacrifices that are consistent with the "involved father" model. The proportion who reduced hours or took a more flexible job so that they could care for their children increased from just 3-4 percent among the Silent Generation, to 17 and 11 percent respectively for Baby Bust men. The proportion who stopped working all together increased substantially across the cohorts, yet this remained the least common strategy enacted by any of the cohorts of men – with just 9 percent of Baby Bust men doing so. We also found that the proportion who increased their work hours to support their family – the one strategy consistent with the "good breadwinner" ideal – increased across the three cohorts, although the magnitude of the decline was slight (45 percent among Silent Generation, 41 percent among Baby Boomers, and 38 percent among Baby Bust men).

[Table 1 about here]

For women, we found a clear contrast between the Silent Generation women and the younger two cohorts, although we did not see a stark difference between the practices adopted by Baby Boom and Baby Bust women. This may reflect the fact that women's gender roles have been evolving since the late 1960s, yet changes in men's gender roles occurred much more

slowly, with the "stalled [gender] revolution" only recently starting to occur for men (Hochschild, 1989). The proportion of women who stopped work all together when they had children declined steadily across the cohorts from 59 percent among Silent Generation women to 52 percent among Baby Bust women. Silent Generation women also were less likely than their younger counterparts to increase their work hours in order to better support their families financially. Thus, we find that strategies for juggling the competing roles of worker and parent have undergone considerable change for recent birth cohorts.

Multivariate Analyses

Our preliminary multivariate analyses reveal that men's work-family tradeoffs are associated with a lower risk of high blood pressure in the overall sample, yet are associated with a significantly elevated risk of hypertension among Baby Bust men only. By contrast, the "involved father" types of work family tradeoffs do not have significantly distinct effects on the high blood pressure risk for the other two cohorts of men, nor do tradeoffs have a significant impact on men's self-rated health. This finding suggest that the strain of juggling work and family may be harmful for men's health when they are at the life course stage where such pressures are most acute. Consistent with the stress hypothesis, we also found that the "good breadwinner" strategy of increasing work hours to support one's family was associated with poorer self-rated health among men, although this effect did not vary significantly by birth cohort.

For women, we found no evidence that work-family strategies were associated with risk of hypertension. However, we also found that women who had stopped working to care for their children reported significantly better health, whereas those who increased their hours to provide for their families evidenced poorer health. Thus, for women, those behaviors that violate

traditional gender-role expectations are associated with compromised physical well-being. In our final analyses, we will explore the extent to which these findings persist when all other control, and potential confounding and mediation variables are entered into the final model.

Discussion

Prior studies have found that both men and women reap psychological rewards when they engage in work-family strategies that are consistent with the sociocultural norms that prevailed during their formative years, and that are endorsed by their peers (Carr, 2002). However, we found little evidence that a similar pattern emerges for physical health outcomes. Rather, we found that Baby Bust men who cut back on their paid employment in order to spend time with their children report a significantly elevated risk of high blood pressure. This finding remained statistically significant and did not decline in magnitude when we included numerous control variables, alleviating our concern about spurious relationships. In our subsequent analyses, that we hope to present at the 2008 Population Association of America annual meeting, we will consider whether gendered attitudes account for, or exacerbate, this association. Theoretically, the finding that work sacrifices by Baby Bust men harms health, could reflect the fact that men in their 30s and 40s are currently in the throes of juggling work and family demands. By contrast, Baby Boom and Silent Generation men presumably made such sacrifices years earlier, when their now-adult children were young. As such, young men may be evidencing the same types of physical and emotional distress that have been documented among young women coping with role overload (e.g., O'Neil & Greenberger, 1994).

Among women, we did find limited support that those behaviors that are consistent with the "good mother" role – cutting back on one's employment to care for children – was associated with better self-rated health, whereas increasing one's work hours to be a "good provider" was

associated with poorer self-rated health. Before concluding definitively that compliance with gender-typed norms enhances women's health, we will further explore whether the physical costs associated with increased work hours reflect other risk factors, such as single parenthood, having a disabled and/or unemployed spouse, and working at a low-wage job that requires long hours if one is to earn a living wage.

The results of our project provide further evidence of the complexity with which work-family strategies influence well-being. Specifically, the findings demonstrate that making work and family tradeoffs influences different aspects of physical health, based on one's gender and cohort. Furthermore, our findings provide suggestive evidence that younger men who are involved fathers suffer the adverse consequences of role-overload that have long been documented in women. Unfortunately, this could indicate that involved fathering does not serve to improve the well-being of both parents – at least in the short term, but rather shifts the burden to men. The results underscore the importance of public policy initiatives, such as paid parental leave, which support combining paid and unpaid work for both men and women.

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Table 1. Work-Family Trade-Offs by Gender and Cohort, MIDUS 1995

	Men				Women		
	b. 1931-1943	b. 1944-1959	b. 1960-1970		b. 1931-1943	b. 1944-1959	b. 1960-1970
Any work-reduction family tradeoff	.08	.20	.27		.69	.72	.69
Stopped working to care for children	.02	.04	.09		.59	.58	.52
Cut back on hours of work to care for children	.03	.12	.17		.36	.46	.44
Took less demanding or more flexible work to care for children	.04	.11	.11		.23	.32	.24
Worked longer hours to meet children's needs	.45	.41	.38		.18	.20	.20
Valid N	446	771	191		522	816	308

Note: Limited to persons with children who have complete data on all variables of interest. The "any work-reduction family tradeoff" variable is an indicator of whether the respondent reported stopping work for children, cutting back on hours, or taking a less demanding/more flexible job to care for children.