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The Pivotal Role of Women in Informal Care

Piet Bracke
Wendy Christiaens
Naomi Wauterickx
University of Ghent, Belgium

Supporting and caring for each other are crucial parts of the social tissue that binds people together. In these networks, men and women hold different positions: Women more often care more for others, listen more to the problems of others, and, as kin keepers, hold families together. Is this true for all life stages? And are social conditions, among other things bound to the organization of work and family, an essential explanation of these differences? Data from the sixth wave (1997) of the Panel Study of Belgian Households allow us to answer these questions. The results show that women are the glue holding social relations together. They play a central role as friends, daughters, sisters, mothers, and grandmothers throughout all stages of the life course. Similar life commitments do not reduce these gender differences but instead emphasize them even further.

Keywords: *social networks; gender; Belgium*

Informal care is still an important requisite in society today despite many far-reaching demographical changes. One of these changes is the rise of alternative family types, such as two-income families and single-person households (Marks, 1996; Vanderleyden, 2005). For society in general, and informal care in particular, these changes have important consequences. For example, there is a rise in female paid employment and an increase in the possibility of divorce. Additionally, the growing number of singles is a heavy burden for the number of available caregivers that cannot be solved by living together with adult children (Audenaert, 2001). Another important demographical evolution is the growing life expectancy of the population. Combined with a decreased fertility rate, the declining number of available siblings, and growing geographical mobility, caring for older relatives will become even less obvious in the future (Merrill, 1997).

Authors' Note: Please address correspondence to Piet Bracke, Korte Meer 5, B-9000 Ghent, Belgium; e-mail: Piet.Bracke@UGent.be. Full versions of Tables 1-6 are available from the author upon request.

Women, the most important source of care, are the ones most influenced by these demographical changes (Aldous, 1994). They are having fewer children and having children at an older age, and the fathers of those children are more often absent than in the past. Women have more work responsibilities, and older women, especially, are in need of informal care. A possible solution for these growing female responsibilities is a redistribution or substitution of masculine for feminine care work (Gerstel & Gallagher, 2001). Indeed, Sullivan (2004) has found an increase in time spent on care work by men, but it is far too small to compensate for the large decrease in care time provided by women. Additionally, the role of friends, which has grown, may provide a substitute for care work by women. Although already important caregivers across the life span, the presence of friends as caregivers can increase in importance when the role of family—especially wives, mothers, and daughters—declines (Himes & Reidy, 2000). Therefore the main questions are (a) Who are considered the primary caregivers across the life span? and (b) Do women still perform the pivotal role in care today?

Although care research is abundant (Abel, 1990; Brubaker, 1990; Gerstel, 1988; Gerstel & Gallagher, 2001; Himes & Reidy, 2000; Keith, 1995), our study contains some important improvements. Most studies of informal care are task oriented. In other words, the focus is on physical care, emotional care, financial care, or social care. This kind of research is, however, inappropriate when specific tasks are gender specific (Abel, 1990). In our research, the received care is undefined; the respondents therefore have the opportunity to report their most often appraised informal carer. Another flaw in other studies is that not all care partners are considered. For the most part, only children, parents, and partners are studied. This study, however, recognizes that informal care encompasses a number of other potential role partners: In addition to parents, partners, and adult children, there are also adult children-in-law, other family members, friends, neighbors, and colleagues (Marks, Lambert, & Choi, 2002). Consequently, it is important to expand the array of kin and nonkin types considered in studies of care (Rossi & Rossi, 1990). Another important advantage of our study is the sample of respondents, which is a national, representative sample of Belgian men and women. This is an improvement on studies that consider only small samples of specific care groups (Umberson, Chen, House, & Hopkins, 1996). Finally, we were able to consider the gender of both the care receiver and care provider when looking into the care relation of partners, parents with children, and siblings. So in addition to exploring gender differences in care behavior, we will try to answer a third core question of the present study, namely, (c) What is the

relevance of the gender mixity of the care relationship for the provision and the receipt of care?

Although important cross-national differences occur, we expect the Belgian case to be very informative for other countries in North America and Europe. As concerns informal care, cross-national comparisons concerning informal care are difficult. Recent figures (Deboosere et al., 2006) show that in Belgium, approximately 7.9% of men and 10.7% of women ages 15 years and older provide informal care to sick or disabled persons at least once a week. These percentages are lower than those of Canadian women and men, at 20.9% and 15.2%, and of British women and men, at 14.0% and 11.0%. The overall high figures underline the importance of studying the distributions and the determinants of informal care.

More statistics are available to illustrate the social changes interfering with the care behavior of adults. With regard to family status and marital status, the Belgian population is known for its high divorce rates—3.1 per 1,000 inhabitants—and low marriage rates—4.2 per 1,000 inhabitants—compared to the EU25 averages of 4.8 and 2.1 in 2004, respectively (Eurostat, 2006). The Belgian divorce rate is the highest in western Europe but is still substantially lower than the U.S. rate of 3.8 per 1,000 inhabitants. In 2005, 66% of Belgian households had no children, and 18% of the households with children were single-parent households, the latter being substantially above the EU25 average. In comparison, in the United Kingdom, 24% of households with children are single-parent households (Eurostat, 2006). Employment rates for both men and women 15 years and older, 60.9% and 42.3%, are below the EU15 average and below the U.S. rates of 69.6% and 57.2% (United Nations Economic Commission for Europe, 2003).

Gender Differences in the Hierarchy of Care

To determine which caregiver is important in what life stage, it is essential to realize that potential care receivers place caregivers in a specific hierarchy of care, also called the "hierarchical compensatory model" (Noelker & Bas, 1994) and the "convoy model" (Hogan & Eggebeen, 1995). This means that every individual has a number of interpersonal relationships that are hierarchically ordered so they can be contacted in times of need. Overall, family members, especially, are responsible for social care work (Abel, 1990). However, when considering the hierarchy of care within families, the results are inconsistent. Some studies conclude that most help is given by the partner, then by the children, especially the eldest daughter

or the daughter-in-law (Abel, 1990; Breda & Jacobs, 1984). Others state that adult children are more important than family members such as spouses (Gerstel & Gallagher, 2001). The difference in these two conclusions, however, can be explained by the gender of the care receiver. Although women and men expect their children to help in times of need, men are still more inclined to name their wives as primary caregivers (Hogan & Eggebeen, 1995). Children, parents, and spouses are also at the top of the care hierarchy, but siblings are not to be discounted either, especially in childhood (White, 2001). The sister–sister relationship is the most important, followed by the sister–brother relationship and the brother–brother relationship (Brubaker, 1990). Notwithstanding the importance of the sister role, it is still weaker than the role of the wife, mother, or daughter (Horwitz, Tessler, Fisher, & Gamache 1992).

Another category of caregivers consists of relationships that form by marriage, such as children-in-law and parents-in-law (Johnson, 2000). Although sons-in-law are not very much involved in care, daughters-in-law perform a considerable amount of care work, especially in providing assistance to their husbands (Merrill, 1997). Fictive relatives, such as friends, foster children, colleagues, and neighbors, are the last plausible informal caregivers (Johnson, 2000). Compared to siblings, friends are adversaries when it comes to received care (Eriksen & Gerstel, 2002). Their help is also much more concentrated on routine assistance (Hogan & Eggebeen, 1995) involving free-time activities and confidential tasks (Gerstel, 1988). Colleagues can be seen as social capital, but when comparing the intensity and multicomplexity of ties and social relationships, work-related relations are weak (Flap & Völker, 2001).

Overall, when family relations are not available, friends and neighbors are the second choice, followed by formal care options. This last care possibility could become more important in the future if the demographical changes keep undermining the availability of informal care.

Women Are Gatekeepers in Caregiving

When considering the hierarchy of care, it is clear that women control care work (Arber & Gilbert, 1989). The most common explanation for the greater involvement of women in care work is the socialization theory (Coltrane, 1988; Finley, 1989) or the internalization of personality differences that men and women form during primary socialization (Gerstel & Gallagher, 2001; Lawrence, Goodnow, Woods, & Karantzas, 2002). Women are socialized not only to take more care responsibilities but also to expect

less involvement from male family members in care work (Montgomery & Datwyler, 1990). This gender-ideology theory differs from the evolutionary explanation, which states that women have a biological advantage in parenthood and caretaking (Spitze & Ward, 1998).

Women are also known as "gatekeepers," which means that women are ambivalent vis-à-vis the active involvement of men with important others, such as children, because it threatens their sense of control over central life domains (Doherty, Kouneski, & Erickson, 1998). It is the women in the life of men who define the amount and type of care men provide (Gerstel & Gallagher, 2001). Wives complement and sisters substitute the care tasks of men. Daughters involve their fathers more in relationships where care is required. This is why we speak of "women in the middle and men on the periphery" (Brubaker, 1990). Not only men receive and expect care from wives, daughters, and sisters; women also direct their attention to other women, such as mothers, sisters, and daughters, for care (Aldous, 1994). Mothers, especially, are normative gatekeepers for their own mothers, sisters, and same-sex relatives (Rossi & Rossi, 1990).

From these insights, we have developed our first three research questions. First of all, we ask ourselves, Who is the person others call upon in times of need, considering a possible hierarchy of care? In other words, do people prefer family members to friends and neighbors for giving or receiving care? As previously stated, research about the hierarchy of care is not new (Allen, Blieszner, & Roberto, 2000; Breda & Jacobs, 1984; Gerstel & Gallagher, 2001; Hogan & Eggebeen, 1995; Noelker & Bas, 1994). Nevertheless, by taking into account several additional categories of relatives and nonrelatives from a national sample of men and women in Belgium, our study contributes to a more complete understanding.

Another important question is, Do women perform most of the informal care? Again, research on gender and care is not new. However, we will take research one step further when looking into the care relation of partners, parents with children, and siblings by giving special attention not only to the gender of the care receiver but also to the gender of the care provider. The analyses will be done separately for men and women. For a subset of care relations, we will be able to answer the third research question: What is the relevance of the gender mixity of the care relationship for the provision and the receipt of care?

Equally important for the study of the determinants of informal care is the main alternative explanation to the pivotal role of women hypothesis: the life commitments (or structural) theory. According to the structural perspective, differences in the social–structural locations of men and women,

not gender, are responsible for gender differences in informal care (Marks, 1996; Moore, 1990). Although the influence of family status, marital status, and socioeconomic status, also known as life commitments, seems important, research has shown that they only lessen the gender differences in care; they do not eliminate them (Sarkisian & Gerstel, 2004). Nevertheless, because of the ongoing, profound changes in the social positions of women and men, it is possible that women today, with their own families, jobs, and careers, have less time for caring activities (Horwitz et al., 1992). That is why it is important to consider life commitments as possible interfering factors in primary relationships between men, women, and significant others.

Life Commitments as Structural Constraints

Family status. Children can have both a positive and a negative effect on the caregiving activities of their parents (Gallagher & Gerstel, 2001). On the negative side of the equation, children isolate parents, especially mothers, from the wider community. On the other, more positive side, they are the core of family life and strengthen the ties of both parents with kin and nonkin. The age and the gender of the child(ren) involved are important (Lieber & Sandefur, 2002). Women with small children remain primary caregivers and provide even more care than women without offspring (Marks, 1996). Younger children are inclined to derange the formation of ties with family and friends. This influences the composition and size of social networks. Overall, mothers and fathers report smaller social networks when they have small children (Moore, 1990). The presence of older daughters provides the most positive influence in caregiving to others; younger sons, however, influence care in a negative way (Gallagher & Gerstel, 2001). It should be noted that the kind of care that is involved is, however, not influenced by the number of children in a family (Komter & Vollebergh, 1998). One of the most important functions of children is to provide, at a later life stage, a reversal from parents to adult children of the care role. However, because of the current trend toward postponing childbirth and a decrease in fertility in general, it is possible this positive child effect has weakened. In our analyses, the age and gender of the children will be taken into account.

Marital status. Married adults have close ties with parents, relatives, and in-laws (Rossi & Rossi, 1990). In contrast, nonmarried cohabitants are not as committed to networks of relatives, resulting in less care reciprocity than that found in men and women in a more traditional living state (Cherlin, 1978; Marks & McLanahan, 1993). Married adults cannot be completely

identified with nonmarried cohabitants, however, because that living state is not yet completely, formally accepted.

Marital dissolution also has consequences for care received and given by women and men. Although both men and women lose a lot of confidence after a divorce, relatives are more present for men in the first stages of the process, but this availability declines over time (Gerstel, 1988). Maternal bonds remain much stronger because of the greater likelihood of women having legal guardianship of their children after a divorce (Spitze & Ward, 1998). When comparing divorced, never-married, and widowed respondents, widowed men and women receive the most support, and never-married people the least (Lieber & Sandefur, 2002). This is because unmarried people have more ties with nonrelatives (especially friends) and married individuals have more ties with relatives.

Socioeconomic status. According to the relative resources theory, relative means, which are externally acquired, such as education and income, determine the power dynamics in the family and, as such, the division of care work (Aldous, Mulligan, & Biarnason, 1998).

Nevertheless, despite the fact that women have taken up more paid labor, and despite the fact that men perform more household tasks, which means men, too, can distribute more care to others (Spitze & Ward, 1998), research (Dentiger & Clarkberg, 2002; Merrill, 1997) shows that the most common care providers are still women, especially unemployed women. So contrary to what relative resource theory suggests, the care men provide is influenced to only a small extent by the work status or income of their partners, even if the partners also work full-time (Marks, 1996).

When considering the social class of men, it seems that men in lower socioeconomic classes deliver more care (Grünell, 2003). A possible reason for this is that working-class families live much closer to their extended families and are more actively involved in familial activities (Johnson, 2000). In working-class families, care work happens more on a local basis (Breda & Jacobs, 1984), where sons- and daughters-in-law share the care responsibilities on a larger scale (Merrill, 1997). In middle-class families, especially two-earner families, there are fewer opportunities to support others; buying care services can compensate for this (Lee & Duxbury, 1998). Overall, paid employment does not eliminate care; it constrains it (Gerstel & Gallagher, 2001).

Finally, persons with a higher educational degree give (and receive) more support to friends, whereas those with a lesser degree give more support to family members (Komter & Vollebergh, 1998; Lieber & Sandefur, 2002). Men and women alike with a lesser educational degree or with more

limited financial means maintain more relationships with relatives because they are more dependent on these relatives (Rossi & Rossi, 1990). This, too, will not be ignored in the following analyses.

In summary, in addition to the above-mentioned research questions, we ask ourselves, Does care work respond to constraints and opportunities derived from life commitments, in particular, the influence of family status, marital status, and socioeconomic status? and, finally, To what degree do these social conditions mediate gender differences in care work?

Method

Sample

The data used for this study are from the sixth wave (1997) of the Panel Study of Belgian Households (PSBH). The PSBH is a random sample of Belgian private households. All household members older than 16 years of age are included in the sample. The present analysis is based on answers from all respondents. Information about possible siblings was not available in this wave but could be retrieved from the third questionnaire of the PSBH (1994). Not all respondents participated in both waves, which restricted the number of respondents to 5,791, or more specifically, 2,699 (46.6%) men and 3,092 (53.4%) women (see Table 1). Because the PSBH is a panel survey of households, individual probabilities to be selected in the sample differ. Therefore, analyses were performed on weighted samples. Sample weights were calculated from the weight-sharing method used by Eurostat (Verma, 1995). Weighted samples are representative of the Belgian population at a given point in time and are suited for cross-sectional analyses (Dewilde, Bauwens, Marynissen, & Lauwers, 2000). Table 1 contains descriptive statistics on both unweighted and weighted samples. Test statistics are calculated on the unweighted samples because the statistics are the most conservative.

The women in this sample are on average a bit older and work less, preferably half-time. Men are definitely more labor minded, which confirms the typical gender division in labor once more. More men than women live together with a partner (married and nonmarried), whereas women are more often divorced or widowed. Interesting to note is the fact that in this sample, more women have adult daughters than do men. This can create an overestimation of the help given to women by adult daughters.

Table 1
Sociodemographic Characteristics of the Respondents According to Gender
(*n*, means, weighted means, percentages, and weighted percentages)

	Women			Men			
Variable	*M* (*SD*) or %	*n*	Weighted *M* or %	*M* (*SD*) or %	*n*	Weighted *M* (*SD*) or %	Significance (on unweighted sample)
Education							
<7 years	17.8%	523	20.8%	15.5%	394	18.9%	χ^2 =69.83, *df* =3, $p < .001$
7-12 years	51.3%	1,508	52.5%	53.8%	1,369	54.1%	
13-15 years	19.5%	573	17.3%	13.4%	341	12.0%	
>15 years	11.5%	337	9.4%	17.4%	442	15.0%	
Paid labor							
0-9 hr/week	57.4%	1,775	60.8%	38.7%	1,044	41.6%	$\chi^2 = 667.4$, *df* = 2, $p < .001$
10-32 hr/week	17.8%	550	16.5%	5.0%	134	4.2%	
More than 32 hr/week	24.8%	767	22.7%	56.4%	1,521	54.2%	
Marital status							
Married	57.0%	1,753	58.2%	63.8%	1,711	65.0%	$\chi^2 = 157.2$, *df* = 4, $p < .001$
Partner (not married)	7.7%	236	5.6%	8.8%	235	6.4%	
Divorced	7.5%	230	6.8%	4.9%	132	4.3%	
Widowed	11.1%	342	12.3%	3.1%	84	3.8%	
Never married	16.7%	514	17.1%	19.4%	520	20.6%	

(continued)

Table 1 (continued)

Variable	Women					Men					Significance (on unweighted sample)
	M (*SD*) or %		*n*	Weighted *M* (*SD*) or %		*M* (*SD*) or %		*n*	Weighted *M* (*SD*) or %		
Age	46.1	(18.2)	3,092	47.9	(19.0)	45.1	(17.2)	2,699	46.7	(18.0)	$t = 4.660$, sig. $t = .031$
Physical complaints	1.40	(0.97)	3,043	1.47	(1.04)	1.35	(0.86)	2,650	1.39	(0.90)	$t = 4.274$, sig. $t = .039$
Number of children <13 years old	0.42	(0.83)	3,092	0.40	(0.82)	0.44	(0.85)	2,699	0.41	(0.85)	$t = 0.586$, *ns*
Number of daughters >18 years old	0.47	(0.85)	3,092	0.52	(0.48)	0.39	(0.76)	2,699	0.44	(0.42)	$t = 14.72$, sig. $t < .001$
Number of sons >18 years old	0.51	(0.93)	3,092	0.57	(0.48)	0.45	(0.88)	2,699	0.49	(0.42)	$t = 7.40$, sig. $t = .005$
Number of sisters	0.97	(1.35)	3,092	1.04	(0.48)	0.93	(1.29)	2,699	1.00	(0.42)	$t = 1.2$, *ns*
Number of brothers	0.94	(1.30)	3,092	1.03	(0.48)	0.94	(1.29)	2,699	1.00	(0.42)	$t = 0.00$, *ns*

Variables

Dependent variables. The caring networks and hierarchy of care men and women prefer were researched according to the following questions. First, the respondents were asked to name those persons whom they can turn to in times of sickness. More specifically, the question was Who can you turn to when you need help as a result of sickness or when you are not able to perform your normal activities for a few days? Possible responses include seven caregiver categories: partner or husband or wife, parents, children, sibling, other family, friends, neighbors, and colleague or study mate.

This question, concerning the care one receives, was then complemented with information about the care one gives to others. The respondents were asked whether they take care of someone who needs special care because of old age or illness and this without any form of payment. Again, different categories could be considered: partner or husband or wife, parents, parents-in-law, children, another relative, and no relative. This information was then combined with information from a second question concerning care behavior, more specifically, whether one gives help regularly to one or more people outside the household. Giving help is identified as caring, supportive activities that are less radical in one's life or less time-consuming than being the actual primary caregiver of one person. Again, respondents could respond according to different categories of care receivers: parents, parents-in-law, children, another relative, neighbors, and friends. Where possible, answers from both questions were combined in specific care indicators. When, for example, a person responded negatively on the first and second questions concerning care to a parent, they received a 0 score on the combined indicator. A score of 1 indicates the existence of at least one positive answer to both care questions. The same principle was applied to care of parents-in-law and children. The information concerning care for a partner or spouse was based solely on the answers to the first question, and information about neighbors and friends was based on the answers to the second question. It is important to remember that the information on both received and provided care is self-reported. Hence, it is more accurate to talk of *perceived* care.

Independent variables. The central independent variable is without doubt gender, but most analyses will be done separately for men and women. Other important indicators are linked to the family structure. To find any differences between married and nonmarried individuals, a variable was constructed with *married* as reference category and *cohabitant*, *divorced*, *widowed*, and *never married* as counterparts. This method allows us to compare respondents according to their specific *marital status*. Also important for the family structure

is the number of (adult) daughters, sons, brothers, and sisters available if care is needed. The number of children 11 years of age and younger in the household is considered an indicator for the amount of parental burden.

Another important issue is the degree of paid labor respondents have taken up: working full-time (more than 32 hr a week), half-time (between 10 and 32 hr per week), or for a rather small part of the week (0 to 9 hr per week). The educational degree is measured according to years of schooling: <7 years, 7 to 12 years, 13 to 15 years, and >15 years of schooling.

The last variable, physical complaints, is an important control measure. Respondents were asked to give a personal assessment of their health, choosing between five categories ranging from *very good* to *very bad* health. A higher score on this variable indicates more health problems.

Analytic Strategy

The analyses were done in several phases. First of all, possible life cycle effects were explored by looking at the different care hierarchies according to men and women during their life course. Chi-square tests were performed to estimate gender differences. The results are presented in Table 2.

In the second step, the effects of the life commitment variables were estimated, showing the impact of social constraints and opportunities on the care work of both women and men. When analyzing the specific care possibilities, we accounted for the absence of certain categories of potential care providers or care receivers. For example, when considering the help given to or received from parents, the analyses were performed only for those respondents who still had living parents. The same principle was applied for the presence of a partner, parents-in-law, children, siblings, and colleagues. Because the dependent variables are dichotomous, the analyses were done with logistic regression. Tables 3 through 6 contain the results for women and men. The tables contain parameter estimates. To preserve space, odds ratios (ORs) were calculated for significant effects only. They are mentioned in the text. Moreover, the rows containing the parameter estimates (PE) of age, education, work status, marital status, work status, and physical complaints were omitted from the tables to preserve space. Significant effects are mentioned in the text. (Full tables are available from the author upon request.)

Third, gender interaction effects were estimated. These interaction effects signal gender differences in the effects the gender and the number of siblings and children have on the outcomes. All gender interaction effects were entered simultaneously in the equation. Interaction effects significant at the .05 level are indicated in Tables 3 through 6.

(text continues on page 1365)

Table 2
Men and Women Who Reported Giving Care to or Receiving Help From Others According to Age and Gender (in percentages, weighted sample)

	16-34		35-49		50-64		65-74		75+	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Giving care to										
Partner	0.0	0.0	0.2	0.9	0.8	0.9	2.6	3.2	2.3	6.5
Parent(s)	3.2	3.5	8.6	9.4	*15.8*	*32.6*	*11.1*	*47.3*		
Parent(s)-in-law	1.9	4.2	3.9	4.0	3.9	4.2	2.2	.0	.0	.0
Child(ren)	1.3	3.3	1.8	3.1	*3.4*	*8.5*	3.7	3.7	3.2	4.6
Other relatives	2.3	3.6	*2.6*	*4.5*	*2.7*	*5.4*	3.3	4.0	2.3	2.6
Neighbor(s)	1.3	1.2	1.9	2.9	2.6	3.5	1.2	2.2	.8	2.0
Friend(s)	2.5	2.4	3.0	4.0	*2.8*	*5.9*	2.0	3.1	1.0	2.1
Receiving help from										
Partner	*98.0*	*94.4*	96.6	93.7	94.2	93.2	89.4	85.6	94.4	90.3
Parent(s)	88.8	88.7	59.3	63.6	24.0	21.9	0.0	3.2		
Child(ren)	7.1	11.6	*42.4*	*54.5*	*71.5*	*80.0*	84.4	83.3	83.4	84.1
Brother(s) and/or sister(s)	65.3	65.5	47.9	54.0	35.1	39.5	28.3	28.8	11.3	18.9
Other relatives	45.8	43.6	25.5	24.8	20.3	19.0	18.9	15.5	19.1	23.5
Friend(s)	63.3	68.0	55.1	56.2	39.9	44.0	37.5	40.1	30.8	32.4
Neighbor(s)	36.2	36.1	38.0	42.1	39.1	38.0	*41.4*	*46.2*	40.0	42.0
Colleague(s)	37.7	39.4	22.9	17.7	15.8	9.8	3.4	3.5	2.2	.6

Note: When $n < 5$, cell is left empty. Significant gender differences (within age categories) are italicized.

Table 3
From Men: Providing Care and Help to Parents, Partner, Parents-in-Law, Children, Other Relatives, Friends, and Neighbors (logistic regression parameter estimates, weighted sample)

Men	Parents	Partner	Parents-in-Law	Children	Other Relatives	Friends	Neighbors
Number of children <13 years old	0.095	–13.43	–0.144	–0.225	–0.412*	0.065[a]	–0.184
Number of daughters >18 years old	–0.358*	0.271	–0.574**	–0.041[a]	–0.197	–0.075	–0.237
Number of sons >18 years old	–0.100	0.200	0.152	0.646***[a]	0.039	0.088	–0.001
Number of sisters	–0.206*	–0.318	–0.038	–0.145	0.184[a]	0.102	0.233[a]
Number of brothers	0.284***[a]	–0.126	0.183	0.030	0.153	0.255*	0.312**
Constant	–5.714***	–15.09	–4.631**	–3.622***	–7.353	–3.912***	–7.111
2 log likelihood	1193.9	224.3	746.16	567.88	932.7	876.19	641.61
Model χ^2	150.0***	45.78***	34.78**	51.47***	38.33***	46.60***	52.47***
df	16	13	13	16	16	16	16

Note: Results are controlled for age, education, marital status, work status, and the presence of physical complaints.
a. The parameter estimate differs significantly ($p < .05$) from the corresponding parameter estimate in Table 4 (women).
*$p < .05$. **$p < .01$. ***$p < .001$.

Table 4
From Women: Providing Care and Help to Parents, Partner, Parents-in-Law, Children, Other Relatives, Friends, and Neighbors (logistic regression parameter estimates, weighted sample)

Women	Parents	Partner	Parents-in-law	Children	Other relatives	Friends	Neighbors
Number of children <13 years old	–0.064	0.319	–0.174	–0.053	–0.159	–0.405**[a]	–0.065
Number of daughters >18 years old	–0.303**	0.210	–0.071	0.486***[a]	–0.267*	0.237*	–0.154
Number of sons >18 years old	–0.040	0.174	0.225	0.189*[a]	0.066	0.116	0.169
Number of sisters	–0.187**	–0.031	–0.020	–0.050	–0.044[a]	0.080	–0.180[a]
Number of brothers	–0.080[a]	0.180	0.264**	0.010	0.171*	0.234**	0.261**
Constant	–5.706***	–8.344***	–2.644***	–3.67***	–4.070***	–3.251***	–4.478***
2 log likelihood	1564.8	355.41	840.9	1163.3	1506.9	1334.6	985.7
Model χ^2	289.0***	58.12***	40.49***	63.41***	46.64***	101.9***	42.19***
df	16	13	13	16	16	16	16

Note: Results are controlled for age, education, marital status, work status, and the presence of physical complaints.
a. The parameter estimate differs significantly ($p < .05$) from the corresponding parameter estimate in Table 3 (men).
*$p < .05$. **$p < .01$. ***$p < .001$.

Table 5
To Men: Perceived Care and Help From Parents, Partner, Siblings, Children, Other Relatives, Friends, Neighbors, and Colleagues (logistic regression parameter estimates, weighted sample)

Men	Parents	Partner	Siblings	Children	Other Relatives	Friends	Neighbors	Coworkers
Number of children <13 years old	–0.051	–0.095	–0.123*	–0.738***	–0.081	0.011[a]	0.081	–0.221**
Number of daughters >18 years old	0.047	0.003[a]	–0.122*	0.487***	–0.104	–0.006	–0.091	0.063
Number of sons >18 years old	–0.387***[a]	–0.061	–0.055	0.205**	–0.213***	–0.037	–0.062	–0.007
Number of sisters	–0.016[a]	0.142	0.137***	0.069	–0.011	–0.058	–0.018	0.074[a]
Number of brothers	–0.189***[a]	–0.214**	0.092*	0.045	0.047	0.059	–0.007	–0.024
Constant	0.588	4.386***	1.254***	–2.987***	0.036	1.297***	–0.663***	–3.495
2 log likelihood	2490.0	1153.4	3387.4	2631.3	4587.9	5308.2	5306.4	2686.8
Model χ^2	762.4***	44.92***	329.2***	1081.0***	228.5***	233.6***	43.7***	85.9***
df	16	13	16	16	16	16	16	15

Note: Results are controlled for age, education, marital status, work status, and the presence of physical complaints.
a. The parameter estimate differs significantly ($p < .05$) from the corresponding parameter estimate in Table 6 (women).
*$p < .05$. **$p < .01$. ***$p < .001$.

Table 6
To Women: Perceived Care and Help From Parents, Partner, Siblings, Children, Other Relatives, Friends, Neighbors, and Colleagues (logistic regression parameter estimates, weighted sample)

Women	Parents	Partner	Siblings	Children	Other Relatives	Friends	Neighbors	Coworkers
Number of children <13 years old	–0.009	–0.320***	–0.237***	–0.829***	–0.197***	–0.128**[a]	0.020	–0.287***
Number of daughters >18 years old	0.060	–0.287***[a]	–0.202***	0.541***	–0.165**	–0.027	–0.010	–0.017
Number of sons >18 years old	–0.067[a]	–0.258***	–0.139**	0.162**	–0.225***	–0.093*	–0.118**	–0.121
Number of sisters	–0.152**[a]	0.127	0.203***	0.100*	–0.035	–0.019	0.036	–0.168**[a]
Number of brothers	–0.046[a]	–0.086	0.078*	0.093*	0.068	0.055	0.043	0.032
Constant	5.754***	3.913***	1.476***	–2.217***	0.362	1.617***	–0.762***	–0.569
2 log likelihood	2513.44	1471.5	3871.4	3135.0	5092.0	5920.0	6104.2	2118.2
Model χ^2	952.9***	78.1***	454.8***	1315.7***	337.0***	414.7***	95.6***	125.6***
df	16	13	16	16	16	16	16	15

Note: Results are controlled for age, education, marital status, work status, and the presence of physical complaints.
a. The parameter estimate differs significantly ($p < .05$) from the corresponding parameter estimate in Table 5 (men).
*$p < .05$. **$p < .01$. ***$p < .001$.

Finally, analyses were performed on the total sample to model gender differences in care work, controlling for the life commitment variables, the control variable, and the number and the gender of children and siblings (no table). These analyses test whether "gender" can be reduced to "structure."

Results

Gender Differences in the Prevalence of Caregiving and Receiving Across the Life Span

Table 2 helps us define the way in which social care relationships change through the years and how social relationships are rearranged so that men and women can maximize their care possibilities. Likewise, the specific care hierarchies according to specific age categories can be untangled according to male and female care responsibilities.

To whom does one provide care? Both women and men perform care activities (see Table 2, upper half). Nevertheless, it is clear that women perform most of the caring tasks. The difference between men and women is most pronounced in the midlife group (50 to 64 years old). In this group, women care significantly more than men for their parents, children, other relatives, and friends.

When considering the youngest age group (16 to 34 years old), it is clear that because of fewer family responsibilities at this life stage, care is given primarily to parents and other relatives but is also given to nonrelatives (friends and neighbors). At later age stages, family—that is, the partner, the parents, and the children—gains importance. It is also interesting to note the modest role friends play both as care receivers and as care providers. Relatives represent the preferred social relationships people devote care tasks to.

From whom does one receive care? The lower half of Table 2 provides information about receiving care and help. Women clearly receive more care than men from children and neighbors. Men mention their partner more often as a caregiver than women do. Surprisingly, gender differences do not play a role in the perception of friends or colleagues as care providers.

Those in the youngest age category are, in times of illness, in most cases assisted by their partner and by their parents. Again, relatives provide more care than friends. However, it is clear that compared to the older respondents, for 16- to 34-year-olds, nonrelatives have a more pronounced place in the care hierarchy. An example is the role of friends, who give a degree of assistance comparable to that of siblings. In the middle age group, children

replace parents as caregivers, although the partner is still the primary caregiver. Nevertheless, along the life course, certain emphases change. We see the caring role of siblings and other relatives diminish across the different age categories. The role of friends follows a similar, but less steep, decline. The role of neighbors is constant. This means that despite the differing living arrangements of the respondents (the parental home, the new home of young families, service flats, etc.), people living nearby, such as good neighbors, are very important in the social network at all ages. Colleagues are important only for people during the years of paid labor; afterward, the bond diminishes rapidly.

In summary, relatives are still very important when it comes to daily assistance. The role of friends is modest, except in the younger age categories. For care, the proximity of the caregiver is important, hence the constant role of neighbors in caregiving across the life span. Within the family, children and parents reverse the caring responsibilities through the years, whereas overall, the partner, especially the wife, remains the first choice of caregiver. Finally, although women provide care more than men do and receive more help from others, gender differences are rather small. They are seldom statistically significant. Substantive gender differences occur only with regard to the provision of care for parents by women and men ages 50 to 75 years old.

The Effect of Family Structure and the Gender Mixity of Care Relationships

We proceed by exploring the influence of family structure and the gendered nature of family structure on the care behavior of our respondents. The results of these analyses are summarized in Tables 3 through 6.

The presence of *older sons and daughters* is of great importance. Significant gender effects occur, and some interesting patterns are apparent. First, there seems to be a same-sex preference among parents and children with regard to the provision of care, especially among men. Men provide more care to their children when they have more adult sons (Table 3; parameter estimate [PE] = .646, $p < .001$, OR = 1.91 [1.45 to 2.51]); the same is true for women when they have more adult daughters (Table 4; PE = .486, $p < .001$, OR = 1.63 [1.35 to 1.97]). But for women, the effect is less pronounced: Having more adult sons also increases their care taking (Table 4; PE = .189, $p < .05$, OR = 1.21 [1.00 to 1.46]). Furthermore, a higher number of adult sons augments the perceived support from children among both women and men (see Table 5; PE = .205, $p < .01$, OR = 1.23 [1.08 to 1.40]; vs. Table 6; PE = .162, $p < .01$, OR = 1.17 [1.04 to 1.32]), whereas the presence of adult daughters has stronger effects on the support

perceived by women (see Table 6; PE = .541, $p < .001$, OR = 1.72 [1.50 to 1.96]; vs. Table 6; PE = .487, $p < .001$, OR = 1.62 [1.40 to 1.89]). The differences are small and not significant but are consistent. These findings complement the above-mentioned results on providing support to children. Overall, parents perceive the most amount of support from children when adult daughters are present.

A second important finding is that adult daughters can act as a substitute for the care given by their parents to other family members, whereas the presence of adult sons is irrelevant. For instance, both men (Table 3; PE = –.358, $p < .05$, OR = .70 [.53 to .93]) and women (Table 4; PE = –.303, $p < .01$, OR = .74 [.60 to .92]) provide less care to their parents when adult daughters are present. Adult daughters also substitute for the care men give to parents-in-law (Table 3; PE = –.574, $p < .01$, OR = .56 [.38 to .83]). Finally, they relieve their mothers of providing care to other family members (Table 4; PE = –.267, $p < .05$, OR = .77 [.61 to .97]).

Third, the analyses show that with regard to receiving support from others, the presence of both adult sons and adult daughters reduces the dependence of parents on other kin as well. The availability of adult sons diminishes the dependence of men on support from parents (see Table 5; PE = –.387, $p < .001$, OR = .68 [.55 to .84]) and third-grade relatives (see Table 5; PE = –.213, $p < .001$, OR = .81 [.72 to .91]). The presence of brothers decreases the dependence on parents (PE = –.189, $p < .001$, OR = .83 [.75 to .91]) and the partner (PE = –.217, $p < .01$, OR = .81 [.69 to .94]). The presence of adult daughters also decreases the dependence of men on siblings (see Table 5; PE = –.122, $p < .05$, OR = .89 [.78 to 1.0]). The presence of adult daughters or sons diminishes women's dependence on their partner (see Table 6; PE = –.287, OR = .75 [.64 to .89]; and PE = –.258, OR = .77 [.66 to .91]; both $p < .001$), on their siblings (see Table 6; PE = –.202, $p < .001$, OR = .82 [.74 to .91]; and PE = –.139, $p < .01$, OR = .88 [.79 to .96]), and on their third-grade relatives (see Table 6; PE = –.165, $p < .01$, OR = .85 [.76 to .94]; and PE = –.225, $p < .001$, OR = .80 [.72 to .89]). Women with adult sons also report less support from friends and neighbors. These results suggest that for women, daughters and sons provide different kinds of support and hence complement different kinds of support providers: Sons provide a sort of support that more distant relatives and neighbors can also provide.

Finally, similar patterns exist in the influence of siblings on the care behavior of men and women. Overall, the presence of brothers enlarges the amount of time and energy men put into providing care to parents, friends, and neighbors and the amount of time and energy women contribute to

providing care to parents-in-law, third-grade relatives, friends, and neighbors. In contrast, the presence of sisters to a certain degree relieves both women (Table 4; PE = –.187, $p < .01$, OR = .83 [.72 to .95]) and men (Table 3; PE = –.206, $p < .01$, OR = .81 [.69 to .96]) from providing care to parents. The high level of consistency in these findings is striking.

Concerning support received from others (see Tables 5 and 6), same-sex preferences are apparent in the sense that men who have more brothers receive less help from their parents; the same holds for women who have more sisters (both gender interaction effects are significant). Having adult sisters is more important, however. When women have sisters, they depend less on colleagues and turn more to their siblings for support. Men, too, perceive more support from their siblings when sisters are present.

Overall, the most striking gender differences concern the gendered impact of the presence of adult children and siblings on the perception of support received from others. Moreover, the analyses show that the presence of adult siblings and children has a more profound impact on the support perceived by women. For men, of the 32 PEs in the last four rows in Table 5, 9 are significant, whereas for women, 16 are significant (see Table 6). Furthermore, both the gender of the sibling or adult child and the gender of the respondent are important. Same-sex combinations exert different effects than cross-sex combinations. Finally, the effects depend on the type of support provider considered.

To complete the analyses of the impact of family structure, we want to point to the impact of the presence of young, needy children. Being responsible for small children reduces women's provision of care to friends and men's provision of care to third-grade relatives. Among men, the presence of young children comes with less perceived support from children, colleagues, and siblings. The social network of women is more heavily influenced by the presence of their minors. Not only are the nuclear (partner) and the extended (siblings and other relatives) family less available for assistance, but friends, neighbors, and colleagues are also perceived as less willing to give help in times of need.

Age, Work Status, and Marital Status Differences in Informal Care

Age effects. As they get older, both women and men care more for their parents (no table): With each year added, the odds of having to provide care and help to parents increases by 1.09 [1.06 to 1.11] for men (PE = –.083, $p < .001$) and by 1.10 [1.09 to 1.12] for women (PE = .098, $p < .001$).

It is interesting to note that the care women provide to parents-in-law diminishes over time (PE = –.041, $p < .001$, OR = .96 [.94 to .98]), whereas for men, it stays about the same. It seems that women are caregivers for their own family in particular.

Results show that among both women and men, when receiving care from others, important differences with regard to age are present (no table). Older respondents report less assistance from their parents, their siblings, and their third-grade relatives. Friends and coworkers, too, are less available for care and support. On the other hand, when growing older, both men and women can count more on the help of their children and their neighbors. This means that for aging respondents, the nuclear family, especially children, and proximate contacts become most important for help and support.

Education and work status. At first glance, these structural variables have little influence on the care behavior of men and women (no table). A few gender differences are apparent, however. First, there is a tendency among women with more higher education to put nonrelatives, that is, friends and neighbors, more toward the center of their caring network; whereas third-grade relatives receive less care and help, although the effects are far from linear, and the gender interaction effect is significant only as it concerns neighbors. Men with more higher education provide more care to their children and friends. Again, the effects are largely confined to differences between men with less than 6 years of education and the rest. Finally, men working half-time are more inclined to help friends and neighbors (see Table 3). Men working full-time are more inclined to provide care to their parents. For women, the amount of time they spend in the labor market seems irrelevant to their caring behavior. Hence, we are inclined to conclude that whereas men's care behavior is influenced more by actual working conditions, women's care behavior is influenced more by time spent in school instead of in the labor market.

Education and work status have important effects on the perceived support of men and women (no table). Initially, it seems that overall, the less educated have smaller support networks. Less educated women perceive parents, friends, and neighbors as less inclined to help, whereas less educated men report less support from parents, siblings, friends, third-grade relatives, and coworkers. There is one revealing exception to this general rule: Women with more higher education see their children less as support providers and rely more on their partner. Hence, these women have more diverse support networks and seem to rely less on the parent–child bond as an exclusive source of support. As concerns working status, the data suggest

that full-time working men depend more on kin for support, whereas nonkin are perceived as less supportive. Women in paid labor depend more on kin, too. Compared to women working full-time, women working part-time perceive their first- and second-grade relatives as more supportive.

Marital status. When considering the marital status, the cohabitant, divorced, and widowed are compared to the married (no table). In general, effects are more pronounced for women. Overall, the findings suggest that marriage pulls women into family care networks. For men, few differences are significant. The most relevant finding is that divorced men provide more care to their parents (PE = 1.277, $p < .001$, OR = 3.38 [1.99 to 5.74]).

Marital status also has gender-specific consequences for the perceived support from others. First of all, it seems that cohabitant men, especially, depend more on their partner, and they depend less on their parents, children, neighbors, and other relatives. Cohabitating women depend less on their parents, siblings, and children. The impact of divorce is substantial, too. Among the divorced, children and third-grade relatives are perceived as less supportive. Moreover, in contrast to women, divorced men report more support from parents and siblings, whereas divorced women perceive more support from friends. Divorce seems to change the composition of the support network of men more profoundly: To a certain extent, among men, the parental relation substitutes for the partner relation after divorce. Finally, men who have lost their wives through death do not report any influence on their care networks, except that they report depending on third-grade relatives more (PE = .473, $p < .05$, OR = 1.60 [1.05 to 2.44]). Because of the small number of cases in this social category ($n = 84$ in the unweighted sample), most differences fail to reach significance. Widowed women report more support from third-grade relatives, too (PE = .454, $p < .001$, OR = 1.58 [1.21 to 2.05]). Furthermore, they perceive more support from friends and less support from children.

Additional Analyses

Some finalizing analyses were conducted to estimate the contributions of life commitments and the number and the gender of children and siblings toward the gender differences in support provided and support received. These analyses (no table) made clear that after statistically controlling for the above-mentioned conditions, gender differences in support from kin and support to kin generally remain at the same level or tend to increase rather than to decrease. For instance, after controlling for the effects of the other variables in the model, the odds of women's perceiving support from their children

are 1.40 [1.23 to 159] times the odds of men, whereas in the uncontrolled model, the odds ratio equals 1.30 [1.19 to 147]. Similar increases in the gender ratio are observed for perceived support from parents and from siblings. Adding variables to the equation does not alter perceived support from the partner (no table). Gender differences in support from nonkin and support to nonkin tend to decrease and disappear while controlling for the other variables in the model. For instance, the gender ratio for perceiving help and care from coworkers is OR = 1.19 [1.03 to 1.36] in the uncontrolled model and OR = 1.01 [.86 to 1.17] in the controlled model. Findings for neighbors are similar, and the gender ratio for help from friends remains unchanged by controlling for life commitment indicators (no table). In summary, the differing social conditions of women and men do not explain gender differences in the support networks with kin but totally account for the gender differences in the support networks with nonkin.

Discussion

Using information on providing and receiving care, we tried to map the *ego-centered* care networks of a representative sample of the Belgian population (2,699 men and 3,092 women). We focused on gender differences in two ways. First, we compared the care work of women and men. Second, we used information on the gender of the children and the siblings of the respondents to estimate the effects of the gender mixity of the care relations on the provision and reception of care. Also, we tested the explanatory power of the main alternative explanation of the pivotal-role-of-women hypothesis, the structural or life commitment hypothesis. Results showed some very consistent gender differences in providing and receiving care, although these dissimilarities are dwarfed by the similarities in the care work of both sexes. Nevertheless, very consistent patterns arose from the data, confirming the importance of women as kin keepers.

The present study is important because, contrary to most studies on gender and care work, (a) a national, representative sample of women and men is used; (b) most of the potential care partners are considered; (c) the care is undefined, giving an opportunity to the respondents to report their most-often appraised informal carer; and finally, (d) when looking into the care relation of partners, parents with children, and siblings, the gender of both the care receiver and the care provider is considered.

Nevertheless, the present investigation has some shortcomings that should be kept in mind when interpreting the results. First of all, the dependent variables

are dichotomous. Separately, they contain only limited information. Mistakes are easily made when people have to make choices between only two response categories. Consequently, the reliability of the individual responses should not be overestimated. To compensate for this shortcoming, a variety of potential care receivers and care providers are considered together, and attention is focused on patterns that rise from a broad range of care relationships. The consistency of the findings is an indication of the overall reliability and validity of the indicators used. A second shortcoming is that the information is self-reported and based on the perception of the respondents. The indicators of care provided and care received are more accurately described as perceived care provided and perceived care received. The question is to what extent the care work mentioned is in the eye of the beholder. For instance, it is possible that adult children report more support given to parents than parents report having received. The reason for this discrepancy is that older parents want to acknowledge their independence, whereas at the same time, adult children want to show their willingness to give support (Ikkink, van Tilburg, & Knipscheer, 1990). This can lead to an overestimation of the help adult daughters and sons give to their parents. The present research design does not allow us to estimate the magnitude nor the direction of this perception bias.

Finally, this information is gathered at one moment in time. The cross-sectional design does not allow us to describe certain dynamics in the care relations. In addition, because we could not work with longitudinal data, trends are not discovered, nor do the results separate age effects from cohort effects and period effects. This is important because the rationale behind the life commitment hypothesis for gender differences in care behavior is largely based on the expectation that contemporary changes in these social conditions will force men to take on more care work. Like most studies in this field, the present design does not allow us to test this hypothesis.

Nevertheless, there are several noteworthy findings. First, when considering the hierarchy of care, the analyses revealed a definite preference for some categories of care providers or care receivers, which changes according to the different life stages. The partner is the number one caregiver in all age categories. Women, especially, fulfill care activities when their partner is ill. When couples get older, we could expect children to take over this leading role. However, it is not the partner whom children replace but the parents. This is in accordance with the existing social norms about care preferences (Abel, 1990; Breda & Jacobs, 1984; Noelker & Bas, 1994). Apart from the roles of the partner, parents, and children, the importance of nonrelatives in the care hierarchy is a lot smaller. Friends, presumed to be

a growing caregiver group, are mainly important among the youngest adults in our sample. Neighbors are more important in old age, presumably because of their geographic proximity.

Second, it is important to notice the pivotal role of women in this hierarchy of care. Not only do women give more help and assistance through the years, but they receive it more often as well. The partner relation is an exception to this general rule. Of course, many men perform more care work than the majority of women, and a huge variation in caring for others among women and among men is present. Hence, we cannot ignore men as carers (Arber & Gilbert 1989). Nevertheless, the findings are so consistent that the gender difference still begs for an explanation.

We turned to the social–structural or life commitment hypothesis as the most important alternative to the more common socialization theory or the more controversial evolutionary explanation for the preponderance of females in care work. We hypothesized that gender-differential social conditions could largely explain the pivotal role of women. We came to the very important conclusion that the social–structural hypothesis has limited value in explaining the dominance of women in care for kin but to a large extent accounts for gender differences in the support networks with nonkin. To our knowledge, the present study is one of the first to show that the validity of the life commitments explanation depends on the differences between kin and nonkin support networks. This finding renders some credibility to both the evolutionary explanation, which strongly stresses the link between female care behavior and female reproductive strategies, and the social–structural or life commitment explanation, which points to the primary role of social conditions. The findings further suggest that education- and work-related changes in the social positions of women and men influence only kin-related care networks when they interfere with the social organization of kinship, for example, through relationship formation and dissolution, fertility, and/or life expectancy. Care networks with nonkin are functions of these family relationships and are more vulnerable to changes in work- and education-related conditions.

Taking into account previous research (Lawrence et al., 2002; Moore, 1990; Sarkisian & Gerstel, 2004), the inclusion of different categories of caregivers and care receivers provides new insight into the influence of these life commitments. When considering the results of parental status, it is obvious that small children have a negative effect on the social networks of their parents. They do not extensively influence the care men and women give to others, but they do derange the care adults receive from relatives and nonrelatives. Women, especially, experience more negative side effects because

of their young offspring, which supports the idea that children isolate their mothers from broader community ties (Gallagher & Gerstel, 2001) as well as from relatives and nonrelatives.

Concerning marital status, we conclude that Cherlin's (1978) observation that cohabitation is an "incomplete institution" still holds. Indeed, results showed that cohabitant women, in comparison to married women, get less help from parents, siblings, and children, and cohabitant men get less help from children and other relatives.

According to our results, divorce is particularly detrimental to the consistency of care where men are concerned. Not only do they give less support (to parents), but divorced men also get less help from their children and other relatives. Consequentially, older divorced men have the greatest chance of becoming isolated from supportive networks as a result of lost contact with offspring (Aldous, 1994). Fortunately, these men can count more on the help and aid of friends. Although friends are still a minority in social networks of care (Himes & Reidy, 2000), they will become increasingly important as this demographic development continues its course. Not only divorced men but widowed and never-married men (except widowers) and women get less help from their children. The difference for divorced men, however, is that they can count on the help and assistance of relatives in times of need. This can be an indication that the hierarchy of care as we know it, with the dominating family relationships, changes only when a voluntary and violent disruption of social ties, such as a divorce, takes place.

When considering the amount of schooling, we found that men and women with a lesser degree get less support from relatives. Moreover, women and men with more higher education give more help to nonrelatives, especially friends and colleagues. This confirms earlier results (Komter & Vollebergh, 1998; Lieber & Sandefur, 2002; Marks, 1996). Furthermore, highly educated women get less help from children and from colleagues.

The working status (defined as the amount of working hours per week) does not seem to have an effect on the care behavior of women. Others have already noted that taking up paid labor has little to no impact on the caring roles of both women and men (Brubaker, 1990; Gerstel & Gallagher 2001; Marks 1996). In two-earner families, men have more opportunities in care work and care relations. When they work half-time instead of full-time—when, in other words, they are not the primary money providers of the family—they give more help and support to friends and neighbors. This confirms the finding that the relationship between men and women is not a zero-sum relationship (Gerstel & Gallagher, 2001). Overall, working more hours is also positive for the amount of care received by family members.

A very important finding concerning the intertwinement of gender and family in the realm of care has to do with the influence of the gender mixity of the care relations. Our results confirm the "women in the middle and men on the periphery" hypothesis (Brubaker, 1990). We found that adult daughters, especially, take up the caregiving role to substitute care provided by their parents. When adult daughters are present, fathers provide less help to their own parents and their parents-in-law and receive less care from their siblings; mothers with adult daughters provide less help to their parents and their third-grade relatives but more to their friends. This can be explained by the fact that women, more than men, expect their children, especially their daughters, to help in times of need (Hogan & Eggebeen, 1995). Adult daughters are obviously willing to respond to this need.

Another interesting result was the same-sex preference in care where parents and adult children were concerned. More specifically, women give more help to their daughters and men give more help to their sons. This confirms the earlier results of Doherty et al. (1998) that found fathers to be more involved with their sons than with their daughters, especially at an older age. Overall, children are more inclined to care for a same-sex parent, and parents are more inclined to receive care from a same-sex child (Lee, Dwyer, & Coward, 1992).

The presence of siblings gives an even clearer example of the gender differences in care. We expected sisters to provide more care than brothers (Eriksen & Gerstel, 2002). The results show that the presence of sisters indeed relieves care but also that the presence of brothers enlarges care. Generally, adult daughters and sisters are the most specialized in giving personal support, although it should not be forgotten that sons and brothers take up care tasks as well, although to a much lesser extent.

Overall, this study confirms that female family members, such as wives, daughters, and sisters, are the most prevalent caregiving members of society. Not only are they more specialized, but they also define the amount and type of care men provide. Men, according to the hierarchy of care, are first and foremost dependent on their wives or partners. Daughters and sisters can substitute for the care men provide to others, as such, relieving men from any form of care burden. As a result, men not only receive but also expect feminine care from a wife, a daughter, or a sister. Wives and daughters continue to take up pivotal roles as effective and normative gatekeepers for their own mothers, sisters, partners, other relatives, and nonrelatives, despite the numerous recent demographic developments. It seems to us that the gender-versus-structure debate with regard to care provided to and received from kin needs to shift to a new level: Instead of trying to

explain gender differences in care behavior based on the different social conditions affecting women and men, a more fruitful endeavor could be the exploration of the positions both sexes hold in the social organization of reproduction or kinship networks and exploration of social changes in these family relations. Relationships between women as mothers, grandmothers, sisters, and (adult) daughters form the axes around which these kin care networks revolve. These axes determine not only the care behavior of all male kin involved but also, obviously, the care relationships with nonkin.

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