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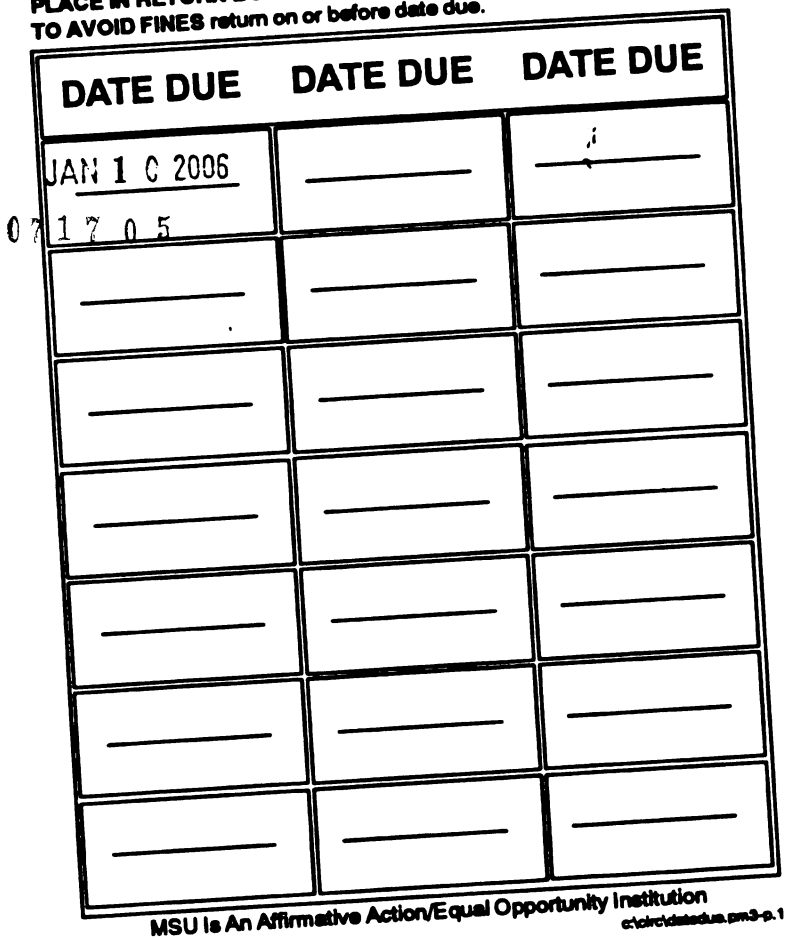

RACIAL AND GENDER DIFFERENCES IN THE IMPACT OF PARENTING ON HEALTH AND WELL-BEING

by

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ABSTRACT

RACIAL AND GENDER DIFFERENCES IN THE IMPACT OF PARENTING ON HEALTH AND WELL-BEING

by

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In this work, it is argued that the conditions which characterize unequal race and gender relations in our society create fundamentally differing experiences of family, thus impacting differently the health and well-being of men, women, blacks, and whites. A series of regression equations were performed to test this assertion using various measures designed to tap respondents perceptions of the quality of their parenting and childcare experiences, both for themselves, as well as for others, and assess how well these predict health and well-being. This was done both for the aggregate group and for the following four sub-groups: black women, white women, black men, and white men. Findings reveal that there are differences in the health and well-being by race-gender groups as mediated by experiences of parenting and childcare. These findings have important implications for future research because of past inattention to the differential impact of parenting by women and men, as well as blacks and whites.

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In creating any work, in addition to the author, there are a number of people who contribute to the finished product. This work is no exception.

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Next, I must acknowledge the immense contributions from all of my colleagues/friends, in particular JL, HW,TK, BH, CW, and IU, for all of their intellectual and emotional support. Thanks to BPK for all his love and support.

Finally, and most importantly, this work acknowledges and is dedicated to all the women in my family tree, who have made me who I am. Through their examples, I have learned how to strive, survive and succeed in a world that is not always accommodating to our dreams. It is to all these women, past and present, that this work is lovingly dedicated.

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INTRODUCTION

Asking the question "Why are we different?" elicits many responses depending upon whom you ask. For the sociologist, an answer can be found in just one phrase--structured inequality. Simply put, this means that we are arranged in a hierarchial manner along lines of difference--generally delineated by race, class and gender--which translates into material rewards or deprivation. Diversity results as different groups adapt to their social location and the allocation of societal resource accordingly. Recently, scholars (Andersen & Collins 1992) have stressed the importance of examining the multiple realities of class, race, and gender. Race, class, and gender exert tremendous pressures on the social landscape, dovetailing in various settings. Like geological plates coming together, fault lines erupt and the workings of these pressures become visible. We are able to glimpse the otherwise imperceptible workings of race, class, and gender constructions, thus gaining more complete and accurate understandings of our society.

One of these many fault lines can erupt within the context of families. It is in the family where the nexus of structural phenomena converge and impact on individual members' life chances. This interfacing of family and society produces many outcomes, the nature of which often depends upon where the individuals that comprise a given family are placed in our social hierarchy. Families mediate the impact of the structural on the personal, but do so differently across racial ethnic, and class groups and even within families by gender.

This emphasis on difference is a key component of the present study. It has

been well-documented that racial and gender oppressions have real consequences for the oppressed in health and well-being. The impact of family life on the health and well-being of individuals is equally well researched, yet while much research has documented gender differences in this area, the impact of race has been largely neglected. In this paper, I am arguing that conditions that characterize unequal race and gender relations in this society create fundamentally different experiences of family, thus, having a different impact on health and well-being for different groups. For example, black women's experiences of family are different from white women's because of the "double bind" of race and gender stratification that black women experience. This then--so far as the family is a mediator--can explain some of the differences in health and well-being between black and white women. In this paper, I focus on one aspect of family life--child care and parent/child relationships--as it impacts health and well-being. Parent/child relationships are especially relevant because of the unique demands that parenting places upon mothers and fathers. Children require tremendous amounts of economic, physical, and emotional support. When such capacities are already strained to maximum --as could occur when mothers and fathers deal with oppressive forces such as racism and sexism--the impact of family life produces different consequences for different groups. In order to gain a full grasp of this, I will begin by reviewing the literature on gender and race differences in health and well-being, and then move on to the impact of parenthood and parent/child relationship quality before proceeding with my analysis.

PREVIOUS RESEARCH

Gender and Health and Well-being

Sex differentials in health and well-being are well-documented (Kessler & McRae 1981; Bird & Fremont 1989; Gove 1984; Verbrugge 1985,1989; Verbrugge & Madans 1985; Waldron 1976). Biological or constitutional arguments attribute these sex differential to certain biological factors such as chromosomal and hormonal differences, and woman's reproductive physiology (Verbrugge 1985, 1989; Waldron 1976). For example, woman have two large X chromosomes, while men have only one X and one smaller Y chromosome. It is believed that the larger X chromosomes contain more genetic information, and that this is responsible for the higher survival rates of female infants. Furthermore, hormonal differences in men and women are also attributed to women's lower rates of premenopausal coronary heart disease (Nathanson 1989).

Another argument posits that sex differentials in health and well being are attributable to differential socialization and role occupation. For example, men's higher levels of mortality are generally attributable to the socially ordained patterns of riskier male behavior, like cigarette smoking and alcohol consumption (Waldron 1988). Waldron (1976) estimates that male mortality exceeds female by roughly 100%, but that one-third of this difference is attributable to men's higher levels of smoking, and one-sixth is explained by a greater prevalence of aggressive, competitive, risky behavior. Despite this, the seven year advantage in mortality favoring women is diminished due to women's greater levels of illness. Women experience more chronic

conditions and adopt the sick role more frequently than men (Verbrugge 1985). For acute conditions, a 20-30% difference between men and women has been documented. Even when reproductive related morbidity is controlled, a sizable sex difference remains (Verbrugge 1985; Verbrugge & Wingard 1987). The sex disadvantage is well-documented for psychological well-being as well (Gove 1984, 1972; Gove & Tudor 1973).

Explanations for these differences usually focus upon the nature of subordination for women and the unique roles that men and women occupy in our society. Women have traditionally been expected to take the nurturant, affective roles, while men have been ascribed to instrumental, rational ones. While women's and men's roles are transmuting, substantial pressure is still exerted on men to be "men" and women to be "women". It is hypothesized by various researchers (Gove & Tudor 1973; Gove & Hughes 1979; Verbrugge 1989, Bird & Fremont 1989) that these roles differentially expose the genders to risks associated with differing levels of health and well-being. The notion of acquired risks and social exposure has been shown to be powerful predictors of women's poorer health and well-being. Verbrugge's (1989) suggestive findings unveiled a male health disadvantage when social factors like lesser levels of employment, stress and unhappiness levels, were controlled. Bird & Fremont (1989) uncovered similar results when gender specific time constraints, like housework, childcare, paid employment, leisure, and sleep, were controlled.

Race, Health and Well-being

The best knowledge of racial differences in health comes from the Secretary's Task Force on Black and Minority Health conducted by the United States Department of Health and Human Services. Released in 1985, the Task Force's report found that Blacks suffer 59,000 excess deaths annually. The term "excess deaths" is used to refer to "the difference between the number of deaths experienced by minority groups and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the white population (Secretary's Task Force 1985). Estimates for 1988 put the total number of excess deaths for blacks at as many as 80,000 annually (Hale 1992). Specific causes for this mortality include cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accident deaths, and infant mortality (Secretary's Task Force 1985). African-American death rates from diabetes, cirrhosis, infant mortality, homicides, and acquired immune deficiency syndrome (AIDS) were found to be two or more times greater than that for whites (Hale 1992). Black males have the greatest chance for age-adjusted mortality--1.6 times greater than white male, and 1.8 times greater than black females. African-American females have a 1.5 times greater age-adjusted mortality risk than white females. The disadvantage experienced by blacks in physical health is also mirrored in mental health. Although only 12.3 percent of the total population, African-Americans comprised almost 20 percent of all hospital admissions in 1980, which included state and county mental hospitals, private psychiatric hospitals (Manderscheid & Barrett 1987). Furthermore, non-whites are consistently diagnosed with more

serious mental illnesses than whites (Bell et al 1983), tend to have higher rates of phobic disorders (Brown et al 1990), and are over-represented in the homeless and drug addicted populations, which have clear links to mental illness (Taylor 1992).

Many of the explanations for these disparities focus upon the structural disadvantages face by blacks in our racially stratified society. Poussaint (1983:234) contends that "there appear to be no safety-nets that protect the health or the psyche of the Afro-American from institutional racism, poverty, high unemployment, and a stagnant economy.". African-Americans are over-represented in groups of the homeless, and the chemically dependent. They are younger, poorer, and less likely to be fully employed than their white counterparts (Hale 1992). Such factors contribute to the African-American health and well-being disadvantage.

Parenthood and Psychological Well-being

Parenthood today is marked by a conflict of ideals and reality. Many hold the belief that parenthood is an avenue to fulfillment. To be a parent is to be imbued-at least ideally--with a particular status not accorded to the childless. In general, becoming a parent delivers almost instant perceptions of stability, trustworthiness, and normalcy. Despite such clearly pronatalistic ideals, much social science research suggests that parenthood negatively impacts a parent's health and well-being (see McLanahan & Adams 1987, Ross, Mirowsky & Goldstein 1990 for reviews). When one considers the ambivalent nature of parenthood--it is fulfilling and at the same time detrimental--questions arise as to the nature of the relationship between parents and children. How can something that most believe to be important and enriching

simultaneously detract from our health and well-being?

Umberson & Gove (1989) examined this question in light of the costs and benefits associated with parenting. Hypothesizing that the obligations of parenting negatively impact parents' well-being while the value placed upon children by parents provided meaningfulness and positive impact, they found modest relationships between parenthood and psychological well-being. Married respondents with adult children living away from home were found to have the most positive states of affect and satisfaction. Their findings lend support to the conclusions of Ross, et. al. (1990), and Reskin & Coverman (1985) that children in the home decrease psychological well-being and that positive effects of children do not appear until the children leave home. This indicates that the obligations of child-rearing--the financial, physical and emotional costs-- mediate the positive regard that parents have for children overall. Umberson (1989) found that quality of the parent-child relationships, as well as parent's characteristics such as age, marital status, employment status and gender had a significant effect on psychological well-being but that living arrangements, along with number and ages of children had only minimal effects.

Gender differences in well-being are especially relevant considering that the bulk of child-care responsibilities today still falls to the mother. Most of the literature that examines gender differences looks at the impact of parental status as it is mediated by other factors--parental satisfaction, or other measures of relationship quality, and the interplay of work-family roles.

Results in the area of relationship quality have been mixed. Veroff et al (1981)

found that mother's were less positive in their appraisals of their children and reported more parental problems than fathers, yet Hoffman & Manis (1978) found that mother's reported more parental satisfaction. Campbell et al (1976) found no gender differences in parental satisfaction. Mothers and fathers do not differ in perceptions of the quality of the parent-child relationship, yet mother's report that they feel their children place too many demands on them (Umberson 1989).

Given the diversification of women's roles in society, interest in the impact that these multiple roles have on both health and well-being has produced a bulk of research most of which has focused on the interaction of worker and mother roles. Concern over the interaction of these roles arises as women enter the paid labor market in greater and greater numbers, while still retaining the bulk of childrearing responsibilities which leads to issues of role strain and role conflict. Role strain arises as the resources (financial, physical, emotional, temporal) required of parents become stretched to their limits or are nonexistent. Role conflict arises as the occupation of two or more roles place conflicting demands upon the occupant. For working mothers, there are two competing hypotheses in regards to the nature of well-being and health: (1) multiple roles contribute to greater health and well-being as the occupation of these roles enhances self-perceptions, self-esteem, and personal efficacy; (2) multiple roles increase the demands placed upon the occupant and lead to role strain and conflict which detracts from well-being and health. Support has been found for both hypotheses. Working mothers were found to have higher levels of psychological well-being if their husbands shared childcare responsibilities (Kessler &

McRae 1982, Ross et al 1983). Furthermore, Ross et al (1983) found that the benefits of working for mothers was negated if there was a conflict between role ideals and role occupation. For example, in couples who believed in "traditional" work-family roles, there was no positive effect on well-being for working mothers. Barnett & Marshall (1992) found that quality of relationships between working mothers and their children was the best predictor of psychological distress, but that employed mothers were at no greater risk of distress than non-employed mothers.

Parenthood and Physical Health

In general, the literature dealing with physical health and parenthood habitually weave gender into their analysis. This probably stems from the fact that women are, more often than not, the physical caretakers of children, and therefore are more vulnerable to the effects of children on health. It is women who--despite growing numbers of full-time and career oriented participation in the labor market--labor an extra month per year doing "the second shift" (see Hochschild 1990). It is women who tend to the sniffles and sneezes of childhood, and do much of the physically intensive childcare labor. Such is the physical reality of caretaking in contemporary families.

Overall, the effects of parenthood on physical health reveal findings similar to those which studied psychological well-being. Children have been found to have mixed results on the physical health of their parents, but one thing is clear in the literature, physical health is not improved by the presence of children in the home (for a review see, Ross et al 1990), but tendencies toward health damaging behaviors are

reduced by the presence of children in the home (Umberson 1987). Gove (1984) and Arber (1991) found that the presence of and number of children were associated with worse health for women, while Bird and Fremont (1989) found that time spent in child-care had an insignificant impact on self-reported health. Although, childcare was found to be insignificant in the Bird & Fremont study, their study does provide some evidence that when time spent in gender-specific social roles, i.e. child-rearing and housework--is controlled, the gender differences in morbidity are reversed. This supports the non-significant findings of Verbrugge (1989).

Race, Parenthood and Health and Well-being

Although parenthood and its' connections to health and well-being is a well-researched subject among whites, relatively few studies have specifically dealt with the experiences of black parents, or compared blacks and whites. Overall, the research that has been done reveals different patterns than those found in the white population. Broman (1988) found that parenthood was unrelated to satisfaction with life or family. Coleman et al (1987) found similar findings in a sample of middle-aged and older black women--parental status was unrelated to self-esteem, self-efficacy, and physical health. Reskin & Coverman (1985) found that the presence of any children in the home was a significant predictor of psycho-physical distress for white, but not black women. While Reskin & Coverman found the interaction between being black and having children in the home to be significantly related to levels of distress, Waldron and Jacobs (1989) found having children in the home beneficial to the health of employed black, but not employed white women. In fact, Waldron & Jacobs' findings

indicate that for white, but not black women, many of the social roles which produce benefits to health and well-being may be interchangeable. This lends support to Coleman et al's (1987) assertion that the interconnectedness of the social roles of spouse, mother, and worker in the black community may account for the lack of effect found in research when the roles are studied individually.

Intergenerational Emotional Support

Another important component of research on parenthood examines the impact that intergenerational support has upon the health and well-being of family members, particularly aging parents. Within this area there are two major substantive issues: (1) the relationships between the aging parents and their adult children, and (2) the kinds of support, instrumental and affective, that is exchanged between family members. The present study examines parent's perceptions of the emotional support received from their children aged 16 and over. Such support is not bound by age or financial resources. Feeling loved and cared for is essential regardless of stage in the life course. This can be especially true for parents, who may invest a lot in the parental role, and who may judge their successes or failures by their perceptions of the emotional support received from their children.

Emotional support is recognized as an important measure of the quality of parent-child relationships, and is equally important to the health and well-being of parents (Mancini & Blieszner 1989). For example, Houser & Berkman (1984) found only a minimal association between income and filial relationships, suggesting that the financial aspects of parent-child relationships are secondary to the emotional ones.

Evidence exists that close parent-child relations can intervene in aging parents mortality rates and buffer older parents from many of the difficulties associated with aging like declining health and social losses (Silverstein & Bengston 1991). Furthermore, parental self-esteem is increased if they perceive close relationships, by way of communication and support, with their children (Demo et al 1987). The use of the adult child as a confidant by the parent increases the likelihood of both giving and receiving aid which then impacts the well-being of the parents (Mutran & Reitzes 1984).

Intergenerational relations are of particular interest within black families due to the well-documented nature of the extended kin system (for a review see Taylor et al 1990). Because blacks are more likely to reside in extended family households (Angel & Tienda 1982), there are ideally more opportunities for support of all kinds to be exchanged between parents and children. Emotional support is of special interest in black family research. As Silverstein & Bengston's (1991) research demonstrate, affectionate relationships can intervene in declining health and mortality. The question which then arises is whether or not affectionate parent-child relationships can alleviate at least some of the impact that racial oppression has on health and well-being of black parents. There are few studies which examine this topic.

One study examines the impact that family ties have upon the well-being of blacks (Ellison 1990), but it does not separate out the effects of children from other family members. Overall, the study revealed a strong link between close family relations and personal happiness that was consistent across all age groups. For older

blacks, close family relations were related to life satisfaction.

In sum, the preceding discussion has produced several generalizations with regard to the health and well-being of different groups in our society. Women experience poorer health, yet live longer than men. Blacks, as compared to whites, suffer from poorer health, and have 1.5 or more times greater age-adjusted mortality rate than whites (Hale 1992). Parents experience a variety of differences in health and well-being, indicating that parenthood has mixed effects upon a person's health. Overall, however, the presence of children in the home does not effect health positively (see McLanahan & Adams 1987, and Ross, et al, 1990 for reviews) but, as parents and children age, relationships can have a positive impact for the well-being and health of parents, especially for those who perceive a close and loving relationship with their children. Racial differences in the impact that parenthood has upon health and well-being has also documented mixed results which sometimes contradict those findings for the white population. Yet, as Taylor, et al (1990) points out, there is a dearth of research addressing issues such as this, and as such many empirical investigations leave us with distorted and unclear images of black family life in general, and of the impact of parenthood on black health and well-being in particular. All of these substantive issues fuel the present study. However, it is fundamentally different from previous research in two ways. First, I examine not only women health as it is impacted by experiences of childcare and parenting, but men's as well. This is important because in an era when gender roles must become more fluid to adapt to changing societal forces, and men take more active roles in their families, researchers

must address these changes in their work as well. Second, I compare black and white parents' experiences of childcare and parenting as it impacts health which is important because as noted above, there is a dearth of literature concerned with black and white comparisons. Again this is a major omission if the goal of social research is to create complete, and accurate understandings of the society in which we live.

METHODS

The present study is designed to test the following hypotheses: (1) The level of parent-child relationship quality and experiences of childcare will affect subjective health and well-being positively--higher quality relationships will improve subjective health and well-being; (2) Measures of parent-child relationship quality and childcare will help us to interpret the impact of race and gender on the subjective health measures; (3) These measures of childcare and parent-child relationship quality will help us to interpret subjective health and well-being differently for different race-gender groups: white women, white men, black women, and black men.

Data

The data for this study was taken from the American's Changing Lives (ACL) collected by the Survey Research Center at the University of Michigan. The ACL is a multistage, stratified area probability sample of noninstitutionalized adults 25 and over. The overall response rate was 76%. Blacks and those over 60 years of age were oversampled. The oversampling of blacks makes the ACL appropriate to examine racial differences, however because of the relatively small sample of other minority

groups (N=120, 3.3% of the sample), only black-white differences will be examined. Please see House, 1986 for more details.

Variables

Independent variables for this analysis include race and gender, which were dichotomized so that 1=black and 1=female. Blacks comprised 32.5% of the sample, while women comprised 62.5%. Forty-two percent of the sample were parents, with the same percentage reporting their children living with them.

Measures of the quality of parenting and childcare experiences include three measures of subjective perceptions of childcare, a measure of parental satisfaction, and a measure of older child emotional support. As suggested by House, et al (1988), frequency of contact or other more quantitative measures of parent-child relationships may not necessarily tap relationship quality issues. For instance, contacts may be initiated by both parents and children because of an underlying sense of obligation or societal expectations toward the parent or child. However, as common sense tells us, spending time with someone because we <u>have</u> to and spending time with someone because we <u>want</u> to are distinct motivations for pursuing a relationship. The impact that the relationship has on the people involved, therefore, would also be qualitatively different, with different consequences for perceived health and well-being. It is for this reason that subjective qualitative measures of the parent-child relationship were chosen.

The measures of childcare experiences are designed to tap whether the respondent feels that they are personally better off because of the childcare that they

perform ("self is better"), whether or not they believe that others are better off because of the childcare that they perform ("others are better"), and to what extent the respondent enjoys performing childcare. Parental satisfaction is measured by a three item scale comprised of two positive measures ("At this point in your life, how satisfied are you with being a parent?" and "How happy are you with the way your child has turned out?") and one negative measure ("How often do you feel bothered or upset as a parent?"). Responses were summed, and averaged so that higher average scores represent higher levels of parental satisfaction. This scale is highly reliable with an alpha reliability coefficient of .942. Perceived older child emotional support is similarly measured by a four item scale with two positive measures ("How much does your son/daughter/children make you feel loved and cared for?" and "How much is he/she willing to listen when you need to talk about your worries and problems?") and two negative measures ("How much is he/she critical of you?" and "How much do you feel he/she makes too many demands on you?"). Alpha reliability for older child emotional support is .972.

Age, income, education, employment status, marital status, and number of children are controlled for in all equations. On average, the sample was older (due to over sampling of older adults)--mean age was 53. Most respondents had at least a 12th grade education. Mean income was between $15,000-$19,999. Twenty-one percent of respondents children were under 18, and most parents had at least one child living at home. The categories of marital status is dummy coded with "never married" as the excluded category. Fifty-four percent of respondents were married, 11.3% were

divorced, 4.8% were separated, and 18.1% were widowed. Slightly over 50% of the sample was employed. Employment status was dichotomized where 1=employment.

The dependent measures are self-rated, or subjective health and CESD-11 mean score, a measure of self-rated psychological well-being. Subjective health is measured by a single item which asks the respondent "How would you rate your health at the present time, would you say it is excellent, very good, good, fair or poor?" Responses were coded so that better health corresponds with high scores. Self-rated psychological well-being is constructed from 11 items which asks the respondent about various symptoms of depression, happiness, and the ability to which the respondent felt understood, and liked by others. Responses for the 11 items were summed and averaged. A high score indicates a high level of depressive symptoms. This scale is very reliable with an alpha level of .83 (Umberson et al 1992).

Because of the nature of the questions posed here, subjective measures of health and well-being were chosen. Subjective or self-rated measures have the benefit of avoiding the gender and racial bias that can occur in more objective measures, such as physician diagnosis (Ross & Bird 1994; Taylor 1992). Given the argument of this paper that racial and gender oppression prevail and differentially impact experiences of family and consequently, health and well-being, measures that can avoid such biases are extremely preferable. Furthermore, self-rated health has been found to be a very powerful predictor of mortality--better even than physician-based diagnosis (Mossey & Shapiro 1982; Maddox & Douglas 1973).

Analysis

A series of ordinary least squares regressions were performed to test the hypotheses. Stage one regressed the two health measures on the control variables. Stage two regressed the health measures on the predictors of parent-child relationship quality. This stage of analysis tests hypotheses one and two. Stage three repeated stage two for each of the four race-gender groups, black women, white women, black men, and white men. Stage three was designed to test hypothesis three--that the impact of the parent-child relationship on health and well-being would differ according to the different social locations accorded to each of these groups.

FINDINGS

Preliminary analysis (not shown) revealed that none of the variables were highly inter-correlated. Where higher correlations did occur, it was an expected relationship. For example, many of the independent variables were moderately correlated, the highest score being between parental satisfaction and older child emotional support ($r=.606$, $p<.01$). As noted above, this is an expected relationship because these are two different subjective measures that tap similar experience. If a person believes that he or she is loved and cared for by their children, it makes sense to assume that they would be more likely to be satisfied with being a parent. Similarly moderate inter-correlations were found for some of the socio-demographics which again is expected. The highest correlation was found between income and education ($r=.527$, $p < .01$). All coefficients reported below are unstandardized with

the standard errors reported in parentheses next to the coefficients.

By regressing self-rated health and psychological well-being on the socio-demographic variables, we find most of the expected relationships. As Table 1

TABLE 1: REGRESSION OF SELF-RATED HEALTH AND PSYCHOLOGICAL WELL-BEING ON SOCIO-DEMOGRAPHICS

	Self-rated Health	Psychological Well-being
race	-.103*(.041)	.112**(.041)
sex	.007(.039)	.123**(.038)
number of children	-.005(.019)	.014(.018)
age	-.009**(.002)	-.011**(.006)
income	.065**(.010)	-.045**(.009)
education	.044**(.007)	-.043**(.006)
employment status	.413**(.046)	-.202**(.045)
married	-.026(.067)	-.386**(.065)
divorced	-.066(.077)	-.079(.075)
separated	-.008(.099)	.077(.096)
widowed	.105(.080)	-.204**(.078)
constant	3.026**	1.605**
R-squared	.182**	.127**
N	3175	3175

Note: ** = p < .01 * = p < .05 Standard errors are in parentheses next to the coefficients.

illustrates, the socio-demographic variables explain a moderate to good amount of the variance in the dependent variables, self-rated health and psychological well-being. Blacks reported poorer self-rated health and more depressive symptoms than whites. While women also reported more depressive symptoms than did men, gender was not found to be a statistically significant predictor of self-rated health. This finding is perplexing given the strength of the evidence that demonstrates that gender is a strong predictor of health measures. For both health measures, employment status, income,

and education had positive impact. Younger respondents reported better health than did older ones, but this was reversed on psychological well-being--older respondents averaged fewer depressive symptoms. Married and widowed respondents reported fewer depressive symptoms than their never married counterparts.

Stage two of the analysis delves deeper by adding the measures of childcare and parent-child relationship quality into the equations (see Table 2). Both models are improved by the addition of the independent variables. The explained variance increases slightly for self-rated health, but is notably improved for psychological well-being. The predictor, "self is better", significantly affects both of the dependent measures. Table 2 also reveals that the relationship between race and both dependent measures is explained away. This is an interesting finding given the well-documented relationship between race and health measures. It seems that by holding the level at which the respondents believe either themselves or others to be better off by the childcare they provide, we see that the expected differences between black and white health cease to be significantly different. The relationship of sex remains the same as in stage one of the analysis: women report more depressive symptoms than men, while sex was not found significant for self rated health. Older child emotional support had a negative impact on self-rated health, which runs counter to my expectations. Parental satisfaction was related to better self-rated health and fewer depressive symptoms. Because of the way in which the instrument was constructed, a substantial decrease in the sample size occurred as only those who reported performing any childcare were included in some questions. Because of this sample attrition, I

TABLE 2: REGRESSION OF SELF RATED HEALTH AND PSYCHOLOGICAL WELL-BEING ON ALL PREDICTORS

	Self-rated Health	Psychological Well-being
race	-.103(.070)	.069(.072)
sex	.013(.072)	.162*(.074)
number of children	.008(.029)	.035(.030)
age	-.007(.004)	-.011**(.004)
income	.072**(.017)	-.057**(.017)
education	.019(.013)	-.033**(.013)
employment status	.324**(.080)	-.062(.082)
married	-.059(.136)	-.358**(.138)
divorced	-.106(.141)	-.165(.144)
separated	.082(.155)	.046(.158)
widowed	-.209(.186)	.009(.189)
older child support	-.054*(.022)	.012(.022)
parental satisfaction	.141**(.042)	-.328**(.042)
enjoyment of childcare	.037(.054)	.013(.055)
self is better	.124**(.047)	-.099*(.048)
others are better	.008(.031)	-.059(.032)
constant	2.175**	2.755**
R square	.201**	.204**
N	1062	1062

Note: ** = $p < .01$ * = $p < .05$
Standard errors are in parentheses next to the coefficient.

next entered each of the predictors singly, removing "enjoyment of childrcare" from the analysis because it failed to produce any effects in premlinary analysis (see Tables 3 and 4). All four models in Table 3 explain a good amount of the variance in self-rated health. As Table 4 indicates, the four models predicting psychological well-being explain slightly less variance than those for self-rated health, but they still explain a good amount of it. Across both measures, race predicts better health and well-being for only parental satisfaction and older child emotional support. The impact of race on health and well-being is explained away for both "self is better" and "others are better". This repeats the pattern noted in Table 2 above. Sex is a significant predictor of psychological well-being only. For psychological well-being, all of the independent variables were found to be significant and predicted fewer depressive symptoms. Better self-rated health was predicted by "self is better" and parental satisfaction.

These findings provide support for my first and second hypotheses, with one exception: the negative impact that older child emotional support was found to have on both health measures in Table 2. Overall, however, higher quality relationship with children do seem to produce better experiences of health and well-being. In the case of the independent variables, "self is better" and "others are better", it seems that they have a powerful impact upon the dependent variables for blacks. These measures of childcare experiences explained away statistically significant health differences between blacks and whites. The third stage of the analysis tested my third hypothesis that these effects would differ by the four race-sex groups in this study: black women,

TABLE 3: REGRESSION OF SELF-RATED HEALTH ON PREDICTORS AND CONTROLS

	1	2	3	4
race	-.112 (.069)	-.123 (.070)	-.019**(.041)	-.099* (.042)
sex	-.023 (.071)	-.004 (.071)	-.014 (.039)	.007 (.039)
number of children	-.002 (.029)	-.012 (.029)	-.029 (.019)	-.007 (.019)
age	-.015**(.003)	-.016**(.003)	-.010**(.002)	-.009**(.002)
income	.072**(.017)	.068**(.017)	.066**(.010)	.067**(.009)
education	.023 (.013)	.023 (.012)	.045**(.045)	.043**(.007)
employed	.291**(.079)	.298**(.080)	.407**(.046)	.417**(.047)
married	.009 (.134)	.030 (.134)	-.165**(.073)	-.012 (.069)
divorced	-.069 (.140)	-.063 (.141)	-.181* (.081)	-.063 (.079)
separated	-.109 (.154)	.007 (.155)	-.089 (.101)	.114 (.100)
widowed	-.136 (.185)	-.121 (.186)	-.007 (.083)	.102 (.081)
1. self is better	.173**(.043)	----	----	----
2. others are better	----	.029 (.030)	----	----
3. parental satisfaction	----	----	.067**(.013)	----
4. older child support	----	----	----	-.002 (.011)
constant	2.294**	3.479**	3.010**	3.028**
R-square	.177**	.165**	.206**	.201**
N	1079	1079	3176	3146

Note: ** = $p < .01$ * = $p < .05$
"----" indicates that predictor was not entered for that model.
Standard errors are noted in parentheses next to coefficients.

TABLE 4: REGRESSION OF PSYCHOLOGICAL WELL-BEING ON PREDICTORS AND CONTROLS

	1	2	3	4
race	.083(.072)	.098(.072)	.116**(.040)	.115**(.041)
sex	.086*(.074)	.174*(.074)	.144**(.034)	.139**(.038)
number of children	.026(.029)	.037(.029)	.049*(.018)	.023(.018)
age	-.010**(.003)	-.009*(.003)	-.009**(.001)	-.007**(.002)
income	-.059**(.017)	-.055**(.017)	-.045**(.009)	-.042**(.009)
education	-.031*(.013)	-.032*(.013)	-.045**(.006)	-.044**(.006)
employed	-.030(.082)	-.032(.082)	-.201**(.045)	-.193**(.045)
married	-.500**(.138)	-.516**(.139)	-.196**(.040)	-.342**(.067)
divorced	-.241(.145)	-.247(.146)	.079(.079)	-.303(.077)
separated	-.023(.160)	-.029(.160)	.216*(.099)	.118(.098)
widowed	-.103(.191)	-.114(.192)	-.050**(.081)	-.177(.079)
1. self is better	-.173**(.044)	----	----	----
2. others are better	----	-.071*(.031)	----	----
3. parental satisfaction	----	----	-.086**(.012)	----
4. older child support	----	----	----	-.040**(.011)
constant	2.066**	1.612**	1.636	1.475**
R-square	.159**	.151**	.138**	.129**
N	1079	1079	3176	3149

Note: ** = $p < .01$ * = $p < .05$
"----" indicates that predictor was not entered into the model. Standard errors are indicated in parentheses next to the coefficient.

white women, black men and white men. R-squared statistics indicate that all of the subgroup models explain a moderate to good amount of the variance in the dependent health measures (see Tables 5a-6b). For self-rated health (see Table 5a and 5b), "self is better" and parental satisfaction remain significant for whites only. This is important in light of the findings that both were significant when the entire sample was analyzed together. Another important race and sex difference appears when we look at psychological well-being (Table 6a and 6b). "Others are better" significantly predicts fewer depressive symptoms for black women only, while "self is better" remains statistically significant predictor for whites. For black women and whites, the patterns reflected by these findings are mirror images of one another, pointing to important differences between blacks and whites. Consistent with my previous analyses, parental satisfaction improves respondents psychological well-being, but older child emotional support was found to improve well-being significantly for all groups but white men.

It is important to briefly note the impact of some of the independent variables on the relationship to the health measures. When we look at the marital categories, we find that being married remains a significant predictor of psychological well-being for black women only. For black men, marriage improves psychological well-being only when older child emotional support was held constant. This finding was not found in the white subgroups. That marriage is a significant predictor for blacks, but not whites is an important finding, especially for black women, since they are most likely of any of these sub-groups to be the sole heads of households.

TABLE 5A: REGRESSION OF SELF-RATED HEALTH ON PREDICTORS BY RACE-SEX GROUPS

	BLACK WOMEN				BLACK MEN			
	1	2	3	4	1	2	3	4
number of children	.028(.052)	.017(.053)	-.026(.039)	-.040(.039)	-.089(.091)	-.063(.089)	-.049(.059)	-.028(.058)
age	-.020**(.007)	-.020**(.007)	-.012**(.003)	-.009*(.004)	.005(.010)	.006(.010)	-.011*(.005)	-.009(.005)
income	.040(.039)	.032(.039)	.038(.026)	.028(.026)	.006(.056)	.016(.057)	.033(.031)	.032(.031)
education	.039(.028)	.039(.028)	.035(.014)	.034*(.014)	.038(.040)	.028(.040)	.017(.020)	.019(.020)
employed	.303*(.144)	.325*(.145)	.402**(.100)	.416**(.101)	1.045**(.362)	1.058**(.361)	.617**(.160)	.646**(.163)
married	.055(.218)	.082(.219)	-.033(.147)	.095(.148)	.424(.438)	.345(.440)	.065(.204)	.169(.197)
divorced	-.221(.213)	-.211(.214)	-.025(.158)	-.169(.159)	-.477(.598)	-.497(.595)	-.430(.229)	-.336(.228)
separated	.197(.203)	.202(.204)	.057(.160)	.108(.161)	a	a	-.238(.283)	-.103(..279)
widowed	.057(.285)	.062(.286)	-.035(.157)	.029(.157)	-.497(.771)	-.597(.766)	.051(.273)	.124(.268)
1. self is bettter	-.160(.082)	—	—	—	-.120(.138)	—	—	—
2. others are better	—	.029(.057)	—	—	—	-.138(.120)	—	—
3. parental satisfaction	—	—	.043(028)	—	—	—	.053(.039)	—
4.older child support	—	—	—	-.039(.023)	—	—	—	-.005(.036)
constant	2.831**	3.349**	3.144**	3.199**	2.525*	2.601**	3.235**	3.189**
R-squared	.159**	.149**	.155**	.152**	.212**	.217**	.194	.194**
N	331	331	721	714	106	106	357	355

Note ** = $p < .01$ * = $p < .05$. "a" = not able to be computed. "—" indicates predicator not entered into the model. Standard errors noted in "( )".

TABLE 5B: REGRESSION OF SELF-RATED HEALTH ON PREDICTORS BY RACE-SEX GROUPS

	WHITE WOMEN				WHITE MEN			
	1	2	3	4	1	2	3	4
number of children	-.096(.056)	-.101(.056)	-.043(.034)	-.016(.034)	.029(.057)	.023(.053)	-.028(.036)	-.011(.035)
age	-.014*(.006)	-.016**(.027)	-.011**(.003)	-.011**(.003)	-.007(.006)	-.008(.006)	-.007**(.003)	-.007* (.003)
income	.119**(.026)	.116**(.027)	.098**(.015)	.096**(.015)	.038(.031)	.032(.031)	.046**(.016)	.049**(.016)
education	.009(.020)	.006(.020)	.059**(.011)	.058**(..011)	.027(.021)	.032(.021)	.056**(.012)	.051**(.012)
employed	.110(.115)	.121(.116)	.255**(.069)	.264**(.070)	.842**(.241)	.777**(.245)	. 601**(.096)	.627**(.097)
married	-.073(.332)	-.098(.339)	-.237(.146)	.006(.137)	.496(.646)	.459(.656)	-.269(.139)	-.105(.121)
divorced	.017(.336)	-.005(.342)	.026(.156)	.220(.150)	.707(.664)	.654(.647)	-.244(.156)	-.108(.145)
separated	-.101(.371)	-.147(.377)	-.153(.219)	.038(.216)	.336(.838)	.284(.851)	-.334(..254)	-.291(.242)
widowed	-.174(.412)	-.153(.418)	.060(.156)	.259(.149)	.316(.754)	.180(.763)	-.071(.185)	.079(.175)
1. self is better	.265**(.082)	—	—	—	.203**(.069)	—	—	—
2. others are better	—	.047 (.051)	—	—	—	.040(.053)	—	—
3. parental satisfaction	—	—	.090**(.022)	—	—	—	.054* (.026)	—
4. older child support	—	—	—	.019 (.018)	—	—	—	.002(.023)
constant	2.849**	3.823**	2.703**	2.765**	1.559*	2.285**	2.791**	2.763**
R-square	.162**	.141**	.209**	.201**	.195**	.171**	.245**	.247**
N	361	361	1252	1240	278	278	843	837

Note: ** = p < .01 * = p < .05. "—" indicates that predictor was not included in the model. Standard errors included in "( )".

TABLE 6A: REGRESSION OF PSYCHOLOGICAL WELL-BEING ON PREDICTORS BY RACE-SEX GROUPS

	BLACK WOMEN				BLACK MEN			
	1	2	3	4	1	2	3	4
number of children	.046(.053)	.061(.053)	.045(.027)	.026(.038)	.048(.086)	.061(.083)	.102(.054)	.077(.054)
age	-.012(.007)	-.009(.006)	-.011**(.014)	-.008*(.004)	-.021*(.038)	-.021*(.009)	-.018**(.005)	-.014*(.005)
income	-.067(..040)	-.060(.040)	-.044(.026)	-.041(.025)	-.039(.052)	-.049(.054)	-.039(.028)	-.036(.028)
education	-.025(.028)	-.025(.028)	-.053**(.014)	-.051**(.015)	-.056(.038)	-.054(.039)	-.049**(.019)	-.050**(.018)
employed	.028(.147)	.022(.146)	-.141(.096)	-.126(.098)	-.511(.338)	-.519 (.339)	-.433**(.148)	-.440**(.150)
married	-.547**(.223)	-.563* (.221)	-.414**(.142)	-.491**(.144)	-.359(.409)	-.351(.413)	-.297(.189)	-.362* (.182)
divorced	-.239(.217)	-.252(.216)	-.225(.152)	-.303(.155)	-.634(.558)	-.520(.559)	.142(.213)	.112(.210)
separated	-.069(.207)	-.090(.206)	.007(.155)	-.043(.156)	a	a	-.023(.262)	-.079(.258)
widowed	-.096(.291)	-.109(.289)	-.294(.151)	-.381*(.152)	.078(.719)	.032(.719)	.076(.253)	-.015(.248)
1. self is better	-.088(.084)	—	—	—	-.107(.129)	—	—	—
2. others are better	—	-.138*(.058)	—	—	—	.045(.113)	—	—
3. parental satisfaction	—	—	-.118**(.027)	—	—	—	-.091*(.036)	—
4. older child support	—	—	—	-.045*(.023)	—	—	—	-.082*(.033)
constant	2.000**	1.995**	2.361**	1.978**	2.949**	2.439**	2.408**	2.174**
R-square	.111**	.125**	.122**	.104**	.184*	.179*	.158**	.166**
N.	331	331	721	714	106	106	357	355

Note: ** = p < .01 * = p < .05 "a" =not able to be computed "—" indicates that predictor was left out of the model. Standard errors are indicated in parentheses.

TABLE 6B: REGRESSION OF PSYCHOLOGICAL WELL-BEING ON PREDICTORS BY RACE-SEX GROUPS

	WHITE WOMEN				WHITE MEN			
	1	2	3	4	1	2	3	4
number of children	-.018(.066)	-.015(.060)	.029(.035)	-.005(.035)	-.015(.063)	-.005(.048)	.025(.034)	-.013(.033)
age	-.007(.007)	-.005(.007)	-.010**(.002)	-.008**(.003)	-.006(.005)	-.006(.006)	-.005*(.002)	-.005(.003)
income	-.065(.031)	-.062(.031)	-.049**(.015)	-.042**(.015)	-.023(.028)	-.017(.029)	-.042**(.015)	-.041**(.016)
education	-.022(.024)	-.019(.024)	-.050*(.011)	-.053**(.011)	-.045*(.019)	-.053**(.019)	-.037**(.019)	-.032**(.001)
employed	-.009(.136)	-.015(.138)	-.156*(.070)	-.131(.070)	-.086(.229)	-.028(.225)	-.198*(.090)	-.213*(.091)
married	-.568(.394)	-.515(.399)	-.021(.147)	-.231(.138)	.412(.590)	.460(.603)	.118(.131)	-.137(.114)
divorced	-.129(.398)	-.083(.404)	.304(.157)	.140(.151)	.309(.606)	.387(.619)	.317* (.147)	.120(.137)
separated	.119(.439)	.188(.444)	.521(.222)	.359(.218)	.523(.765)	.557(.785)	.482* (.240)	.364(.229)
widowed	-.037(.488)	-.039(.493)	.118(.158)	-.066(.151)	1.104(.688)	1.262(.702)	.392* (.175)	.161(.165)
1. self is better	-.270**(.098)	—	—	—	-.219**(.064)	—	—	—
2. others are better	—	-.010(.060)	—	—	—	-.001(.049)	—	—
3. parental satisfaction	—	—	-.094**(.022)	—	—	—	-.099**(.025)	—
4. older child support	—	—	—	-.043**(.018)	—	—	—	-.033(.022)
constant	2.576**	1.657**	1.765**	1.635**	1.286	1.394	1.103**	1.045**
R-square	.132**	.118**	.105**	.096**	.111**	.072*	.101**	.087**
N	361	361	1252	1240	278	278	843	837

Note: **= $p < .01$ and * = $p < .05$. "—" indicates predictor not entered for that equation.

Marriage provides beneficial effects across all of the independent variables of parenting and childcare experiences for black women. The addition of another parent to the household may alleviate many of the drains on health and well-being that can occur for single parents. For black women, this may be dually beneficial alleviating some (but certainly not all) of the strains not only of single parenting, but single parenting as a black woman in a sexist and racist society.

The findings revealed here support my third hypothesis--that blacks' and whites' experiences of childcare and parenting do seem to impact health and well-being differently for the different groups. These differences which have been uncovered may be a reflection of fundamental race and gender differences in childcare experiences, a topic which I will discuss in the next section.

DISCUSSION

The major findings of this study reveal that there are indeed differences in health and well-being by race-gender group as it is mediated by the aspects of parenthood measured here. The major findings are: (1) The respondent believing that he/she is better off because of the childcare that they perform predicts better health and well-being for whites only, and believing that others are better off because of the childcare that he/she perform predicts better psychological well-being only for black women. (2) Parental satisfaction was found to predict better self-rated health for whites, but not blacks. (3) Older child emotional support predicts less depressive symptoms for all groups except white men. (4) Being married significantly predicts

better psychological well-being for blacks, but not whites. This is especially true for black women for whom being married predicted better well-being across all measures of parenting and childcare experiences. (5) The two variables "self is better" and "others are better" explain away some of the relationships of the socio-demographics and self-rated health and psychological well-being, and more importantly they explain away the effect of race on health and well-being.

The two findings that "self is better" predicts better health and well-being for whites, and that "others are better" predicts better psychological well-being for black women may indicate different perspectives of childcare within white and black communities. For example, Collins (1990) discusses the importance of "other mothering" in the black community, and community oriented child-rearing. Similarly, Stack (1974) reports similar findings in The Flats, the black community which she studied. "Child-keeping" was a familiar strategy for childcare where various kin would care for a woman's child for periods of time. This strategy grew out of the economic deprivation experienced within the community which required such pooling of resources for survival's sake. It was also community recognition of the problems faced by very young women with children--"child keeping" allowed other kin to care for a child when there were doubts about the emotional ability of the mother to care for the child herself. These kin networks that both Stack and Collins describe are controlled and maintained by black female kin. Black women may be more affected by caring for children, and having such care being connected to the community, may produce a more external focus for the work that they do. Thus, the impact of

believing that others are better off because of the childcare performed may be a significant predictor of health for black women. This is also consistent with the findings that, for whites, believing that they are personally better off because of the childcare that they perform significantly impacts better health and well-being. As Collins (1990) discusses, Euro-centric, as compared to Afro-centric child rearing, focuses more upon the individual relationship between parent and child. For whites, the child becomes the private responsibility of the parents, whereas within black communities, as in Stack's (1974) study, children are seen as responsibilities of the community delineated by the child's kin network. In white communities, individual responsibility for childcare is highly valued. Therefore, believing that they are personally better off because of the childcare performed may be significant predictors of health for whites because of the more individual, and private context within which childcare occurs. These conclusions must be approached with some caution. In Stack's study, the community is a poor, urban community of blacks, and adaptations, like "child keeping" are adaptations to the specific circumstances of poverty. Likewise, Collins' analysis does not distinguish class differences in this communal orientation. Because of this, generalizations must be approached with the proper caution. It may be the differences that are attributed to race, may primarily stem from economic disparities and the disproportionate representation of blacks in the under classes.

The next major finding was that parental satisfaction was found to predict better self-rated health for white, but not for black respondents. This may be further

evidence for the structural constraints placed upon family life and health by racial oppression. Given that blacks disproportionately make up the poorer segments of our society, and given that whites, and white women in particular, are more likely to have a partner in the household than their black counterparts, it could be that parental satisfaction may be a function of these demographic patterns. When a family is poor, little comfort and satisfaction may be found in the parent-child relationship when a child represents potential drain on already scarce resources. For whites, the simple presence of another person, and the resources that they bring to the relationship may enable whites to enjoy the parental relationship more, thereby affecting their health positively. This finding points to potential race and sex differences in parenting experiences as well. For all groups, except white men, older child emotional support predicts better well-being. That white men are not affected by older child emotional support may point to the privileged social location that they generally occupy. It may be that for white and black women, and black men, older child emotional support alleviates some of the negative effect on well-being that subordinate positions create. Finally, for blacks, in general, and black women, in particular, being married predicts better health. Again this points to a major racial difference in the present study for the reasons noted above. What all of these finding point to, is that for individuals in different race-gender groups, experiences of family life are indeed shaped by structural constraints, producing differences which then impact health and well-being differently.

One final note on my findings is necessary. The explanatory power of the variables "self is better" and "others are better" seems an important finding, especially

where race is concerned. When I held "self is better" and "others are better" constant, the significant racial differences in health and well-being disappeared. This is highly suggestive, but must be interpreted somewhat cautiously because of the sample attrition which occurred on these two measures (although the standard errors do not indicate extreme sampling variability). It would be ideal to replicate this analysis with a larger sample within subgroups. It must also be noted that because the data used here is cross-sectional, causal relations between the variables are questionable. The analysis here assumes causal links between the variables, when it could be the case that social selection is occurring where only the healthier segments of the population are becoming parents which could then bias the findings. Future research must deal with these issues by utilizing longitudinal designs to test for selection.

CONCLUSION

Now that all of the numbers have been "crunched", we are left to discern what this research means--coefficients and explained variances tell us only so much of the story. I believe that the most important thing that this research leaves us with is the impression that childcare and parenting as it affects health and well-being are richly complex aspects of our social lives. They are shaped by the intersections of race and gender, producing different outcomes for different groups. This research gives us insight into the under-studied experiences of men--in general, we see by this research that they are affected by childcare and parenting. This general observation is important in itself, because of the dearth of research on men's experiences in this arena

of family life. Furthermore, for black men, it creates a more accurate portrait of their social lives. Black men are the least understood and most under-studied of these groups. When black men are included in social analyses, too often they are seen only as a collective for social problems. This has led to a distorted image of black men's lives. By placing black men in an analysis as parents, a valued social role, I hope that a small, but important, piece has been added to the extremely limited understandings that social science has of this group of individuals.

This research also indicates that racial differences are extremely prevalent in the realm of parenting as it impact health and well-being. This research lends support to the assertions of other scholars concerning different perspectives on childcare in white and black communities, and suggests that these perspectives have important impact on health and well-being. This has important implications for further research because of past inattention to these differences in this field of scholarship.

Overall, this research points to the necessity of examining race and gender as fundamental to the experiences of family life and its' subsequent impact on health and well-being. Important differences exist which were only illuminated by sub-group analysis. These differences must be accounted for if social science is to create an accurate and complete portrait of the lives of those individuals who comprise our society.

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