

Exploring the Daily Capabilities and Challenges of Male Caregivers

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Background

The number of caregivers without formal medical training is anticipated to continue growing across the United States (US), largely driven by the amount of baby boomers who require more assistance as they age.¹ As the friends and family of older individuals respond to this growing need for these “informal” caregivers, they often find themselves taking on a new role with new responsibilities and stressors.

Informal caregivers (referred to as caregivers here on) often volunteer to help support a friend or family member with physical or mental disabilities.² Caregivers may hold their caregiving role for years and may have to assist multiple friends or family members simultaneously³ while maintaining their own personal and familial responsibilities. The demands of caregiving responsibilities may be overwhelming for caregivers and may have negative effects on both the caregiver’s emotional well-being and physical capabilities.

Traditionally, the role of caregiving has been predominantly occupied by women, and research on caregiving has shown that female caregivers report worse mental and physical health outcomes relative to male caregivers.⁴ For these reasons, a majority of the existing support services for caregivers have been specifically tailored for women.^{5,6} Secinti and colleagues (2021) found that while female caregivers still reported worse general health, mental health, and physical health compared to male caregivers,⁸ male caregivers were actually significantly more

likely to report experiencing health-related interferences with daily tasks.⁸ Health-related interferences with daily tasks were defined as experiencing 14 or more days in the past month in which “poor physical or mental health” prevented the respondent from fulfilling their usual activities, including “self-care, work, or recreation.”⁸ Their finding is counterintuitive and suggests a larger need for professional support services among male caregivers. It has been estimated that 40% of caregivers in the US are men, which translates into approximately 16 million male caregivers.⁷

Older and racially/ethnically diverse individuals more often require financial support and personal care from their caregivers, compared to older White individuals.⁹⁻¹² Minority caregivers often encounter a higher number of obstacles that may equate to higher likelihood of stress and burnout. Such obstacles include potential language barriers, low awareness of or lack of access to culturally appropriate professional support services, and a higher number of potentially stressful responsibilities. Minority caregivers often take on more caregiving tasks, take care of multiple individuals simultaneously, and provide higher intensity services, yet less often use supplemental care supports such as nursing homes.^{13,14}

Overall, minority caregivers tend to experience increased financial burden due to being younger, less educated, and more likely to have full-time work, yet lower income, compared to White caregivers.¹⁵⁻¹⁷ Minority caregivers often also experience poorer general health compared to

White caregivers, which may worsen while providing longer-term care.¹⁸ Despite these heightened risk factors from both gender and race, minority male caregivers are barely addressed in current research.^{19,20}

In this study, we assess differences in the risk of self-reported health-related interferences with daily tasks among a sample of adults from 40 US states across four Poisson logistic regression models. First, in Model 1, we assess whether male caregivers are still at higher risk compared to female caregivers.⁸ Then, in Model 2, we assess whether male caregivers are at significantly higher risk compared to non-caregiving male adults. In Model 3, we assess if the race/ethnicity of caregivers overall is associated with differences in the risk of reporting health-related interferences with daily tasks. Lastly, in Model 4, we explore differences by race/ethnicity in health-related interferences among only male caregivers.

Methods

We used the 2021 Behavioral Risk Factor Surveillance System (BRFSS)²¹ anonymized public-use datasets to conduct these analyses. This study received IRB exemption from the KDH Research & Communication (KDHRC) internal IRB, FWA00011177, IRB 00005850. In the 2021 BRFSS dataset, 40 US states/territories administered the optional caregiving module that we used for analyses. We used the provided BRFSS weights to achieve representativeness of each state's respective population. We treated answer selections of "Not sure" and "Refused" as missing and excluded these observations from analyses. Significance was set at $p \leq 0.05$.

Sample and study population

In the 2021 BRFSS study, 232,368 respondents answered yes or no to the question: "During the past 30 days, did you provide regular care or assistance to a friend or family member who has a health problem or disability?" There were 18,711 respondents who reported being caregivers that were included in Models 1 and 3; 36,158 respondents were male and included in Model 2; and 6,495 were male caregivers that were included in Model 4. The BRFSS weighting makes each model representative of 13,013,530; 26,649,192; 13,013,530; and 4,840,901 adults, respectively.

Measures

Our main independent variable was the act of caregiving, defined as having provided informal care to a friend or family in the past 30-days. We also explored associations of sex and race/ethnicity among only caregivers. Our dependent variable was health-related interferences with daily tasks, defined as 14 or more days in the past month in which "poor physical or mental health" prevented the

respondent from fulfilling their usual activities including "self-care, work, or recreation."⁸

Covariates

Across all models, we controlled for variables related to the wellbeing of caregivers as used in previous research,^{8,22-28} including: age, race/ethnicity, education level, employment status, income, marital status past 30-day physical activity, ever having been diagnosed with depression, body mass index (BMI), cigarette smoking status, and heavy drinking status. We further controlled for the following continuous variables: number of days in the past 30-days of "not good" mental health, number of days in the past 30-days of "not good" physical health, the number of chronic conditions the caregiver was diagnosed with, and self-ratings of overall general health. In Models 1, 3 and 4, we controlled for the following variables only asked to caregivers: weekly hours of caregiving, length of time as a caregiver, the main health problem experienced of the person being cared for, the relation of the caregiver to the person being cared for, whether the caregiver provided personal care, and whether the caregiver provided help with household tasks.

Analyses

We used STATA 16.1 for all statistical analyses. We conducted four Poisson regression models²⁹ using health-related interferences with daily tasks as the dependent variable for each model. In Models 1 and 3, we used only respondents who reported being a caregiver as the sample ($n=18,711$) to assess gender differences and race/ethnicity differences among caregivers overall. In Model 2, we used only male respondents in analysis to assess whether caregiving males differed from non-caregiving males ($n=36,158$). In Model 4, we used only respondents who were male caregivers in the analysis to explore differences by race/ethnicity among male caregivers ($n=6,495$).

Findings

In Model 1, male caregivers had significantly higher risk of reporting health-related interferences with daily tasks relative to female caregivers (14+ days of interferences: $RR = 1.19$ 95% $CI = [1.0-1.4]$). In Model 2, male caregivers had significantly higher risk of health-related interferences relative to non-caregiving males (14+ days of interferences: $RR = 1.17$ 95% $CI = [1.0-1.3]$). In Model 3, Latino caregivers had significantly higher risk of health-related interferences relative to White caregivers (14+ days of interferences: $RR = 1.27$ 95% $CI = [1.0-1.6]$). Model 4 showed higher risk of health-related interferences among Asian male caregivers ($RR = 1.90$ 95% $CI = [1.12-3.2]$) and non-Latino male caregivers who

reported their race as other (RR = 0.58 95% CI = [0.38-0.88]).

Discussion

We were able to confirm that male caregivers are at higher risk of experiencing health-related interferences relative to female caregivers using data spanning 40 states in 2021. We were also able to confirm that male caregivers had higher risk of experiencing health-related interferences relative to non-caregiving males. While we did not find significantly higher risk among Black caregivers, we found that Latino and Asian caregivers overall had higher risk of experiencing health-related interferences relative to White caregivers. Among male caregivers, we found that Asian men and non-Latino men who reported their race as other were at higher risk relative to White male caregivers.

Our findings provide evidence that male caregivers, Asian and Latino caregivers overall, and Asian and Other race male caregivers are groups of caregivers that need uniquely tailored professional support services. Although we are limited in our ability to make causal inferences due to cross-sectional data, our findings show that the act of caregiving may particularly affect the capabilities of male caregivers to accomplish daily tasks. Previous literature has found these caregivers have fewer relevant professional support services tailored to their experiences, as most existing supports have been developed for other caregiver groups, particularly White, female caregivers.³⁰ The observed risk disparities regarding health-related interferences are addressable through informed and targeted health equity interventions.

References

- ¹Spillman, B. C., Allen, E. H., & Favreault, M. (2021). *Informal caregiver supply and demographic changes: Review of the literature. Office of the Assistant Secretary for Planning and Evaluation Report*. Retrieved from <https://aspe.hhs.gov/reports/informal-caregiver-supply-demographic-changes-review-literature-0>
- ²Centers for Disease Control and Prevention. (2019). Caregiving for Family and Friends — A Public Health Issue. Retrieved from <https://www.cdc.gov/aging/caregiving/caregiver-brief.html>
- ³American Psychological Association. (2011). What do family caregivers do? Retrieved from <https://www.apa.org/pi/about/publications/caregivers/faq/family>
- ⁴Pinquart, M., Sörensen, S. (2006). Gender Differences in Caregiver Stressors, Social Resources, and Health: An Updated Meta-Analysis. *The Journals of Gerontology: Series B*, 61(1), P33-P45. doi:<https://doi.org/10.1093/geronb/61.1.P33>
- ⁵Jacobs, B. J. (2014). When Genders Collide While Caregiving. How to resolve resentment that siblings' differing roles and reactions can create. Retrieved from <https://www.aarp.org/home-family/caregiving/info-01-2014/caregiving-family-gender-siblings-jacobs.html>
- ⁶Fee, A., McIlfatrick, S., Ryan, A. (2020). Examining the support needs of older male spousal caregivers of people with a long-term condition: A systematic review of the literature. *Int J Older People Nurs*, 15(e12318). doi:<https://doi.org/10.1111/opn.12318>
- ⁷Accius, J. (2017). Breaking Stereotypes: Spotlight on Male Family Caregivers. Retrieved from <https://www.aarp.org/content/dam/aarp/ppi/2017-01/Breaking-Stereotypes-Spotlight-on-Male-Family-Caregivers.pdf>
- ⁸Secinti, E., Lewson, A.B., Wu, W., Kent, E.E., Mosher, C.E. . (2021). Health-Related Quality of Life: A Comparative Analysis of Caregivers of People With Dementia, Cancer, COPD/Emphysema, and Diabetes and Non-caregivers, 2015–2018 BRFS. *Annals of Behavioral Medicine*, 55(11), 1130-1143. doi:<https://doi.org/10.1093/abm/kaab007>
- ⁹Min, J. W. B., C. J. (2004). Differences in Amount of Informal Care Received by Non-Hispanic Whites and Latinos in a Nationally Representative Sample of Older Americans. *Journal of Cross-Cultural Gerontology*, 53(1). doi:10.1111/j.1532-5415.2005.53027.x
- ¹⁰U.S. Department of Health and Human Services [HHS] Office of Disease Prevention and Health Promotion [ODPHP]. (2010). Healthy People 2020.
- ¹¹Bullock, K., Crawford, S.L., Tennstedt, S.L. (2003). Employment and Caregiving: Exploration of African American Caregivers. *Social Work*, 48(2), 150-162. doi:<https://doi.org/10.1093/sw/48.2.150>
- ¹²Han, H. R., Choi, Y. J., Kim, M. T., Lee, J. E., & Kim, K. B. (2008). Experiences and challenges of informal caregiving for Korean immigrant. *Journal of Advanced Nursing*, 63(5), 517-526. doi:10.1111/j.1365-2648.2008.04746.x
- ¹³McCarthy, C. (2020). Keeping teens home and away from friends during COVID-19. . Retrieved from <https://www.health.harvard.edu/blog/keeping-teens-home-and-away-from-friends-during-covid-19-2020041419533>
- ¹⁴Fabius, C. D., Wolff, J. L., & Kasper, J. D. . (2020). Race Differences in Characteristics and Experiences of Black and White Caregivers of Older Americans. *The Gerontologist*, 60(7), 1244-1253.
- ¹⁵AARP, & National Alliance for Caregiving. (2020). The "Typical" African American Caregiver.

- ¹⁶Douglas Flynn. (2018). CAREGIVING CHRONICLES: African-American family caregivers face higher burdens in caring for their loved ones. Retrieved from <https://www.caregivingmetrowest.org/Caregiver-Toolkit/Blog-Caregiving-Chronicles/african-american-family-caregivers-face-higher-burdens-in-caring-for-their-lovedones#:~:text=African%2DAmerican%20caregivers%20devote%20more,the%20assistance%20of%20paid%20help>
- ¹⁷Goins, R. T., Spencer, S. M., McGuire, L. C., Goldberg, J., Wen, Y., & Henderson, J. A. (2011). Adult caregiving among American Indians: The role of cultural factors. *The Gerontologist*, 51(3), 310-320.
- ¹⁸Harvard Health Publishing. (2020, April). Keeping teens home and away from friends during COVID-19. Retrieved from <https://www.health.harvard.edu/blog/keeping-teens-home-and-away-from-friends-during-covid-19-2020041419533>
- ¹⁹Deskins, B. P., Letvak, S., Kennedy-Malone, L., Rowsey, P. J., Bedini, L., & Rhew, D. (2022). The Experiences of African American Male Caregivers. *Healthcare (Basel)*, 10(2). doi:10.3390/healthcare10020252
- ²⁰Mott J., S. B. M., MacWilliams B. (2019). Male caregivers: Shifting roles among family caregivers. *CJON*, 23, 17-24. doi:10.1188/19.CJON.E17-E24.
- ²¹Centers for Disease Control and Prevention. (2022). 2021 Behavioral Risk Factor Surveillance System Data. Retrieved from: https://www.cdc.gov/brfss/annual_data/annual_2021.html
- ²²Chen, H. Y., Baumgardner, D. J., & Rice, J. P. (2011). Health-related quality of life among adults with multiple chronic conditions in the United States, Behavioral Risk Factor Surveillance System, 2007. *Preventing chronic disease*, 8(1), A09.
- ²³Jiang, Y., & Hesser, J. E. (2011). A comparison of depression and mental distress indicators, Rhode Island Behavioral Risk Factor Surveillance System, 2006. *Preventing chronic disease*, 8(2), A37.
- ²⁴Abell, J. E., Hootman, J. M., Zack, M. M., Moriarty, D., & Helmick, C. G. (2005). Physical activity and health related quality of life among people with arthritis. *Journal of Epidemiology and Community Health*, 59(5), 380-385. doi:<https://doi.org/10.1136/jech.2004.028068>
- ²⁵Centers for Disease Control and Prevention. (1998). Self-reported frequent mental distress among adults--United States, 1993-1996. *MMWR. Morbidity and mortality weekly report*, 47(16), 326-331.
- ²⁶Centers for Disease Control and Prevention. (2020). CDC measuring healthy days: Population assessment of health-related quality of life. Retrieved from <https://www.cdc.gov/hrqol/pdfs/mhd.pdf>.
- ²⁷Strine, T. W., Chapman, D. P., Kobau, R., Balluz, L., & Mokdad, A. H. (2004). Depression, anxiety, and physical impairments and quality of life in the U.S. noninstitutionalized population. *Psychiatric services* 55(12), 1408-1413. doi:<https://doi.org/10.1176/appi.ps.55.12.1408>
- ²⁸Brown, D. W., Balluz, L. S., Heath, G. W., Moriarty, D. G., Ford, E. S., Giles, W. H., & Mokdad, A. H. (2003). Associations between recommended levels of physical activity and health-related quality of life. Findings from the 2001 Behavioral Risk Factor Surveillance System (BRFSS) survey. *Preventive Medicine*, 37(5), 520-528. doi:[https://doi.org/10.1016/s0091-7435\(03\)00179-8](https://doi.org/10.1016/s0091-7435(03)00179-8)
- ²⁹Zou, G. (2004). A Modified Poisson Regression Approach to Prospective Studies with Binary Data. *Am. J. Epidemiol.*, 159(7), 702-706. doi: doi: 10.1093/aje/kwh090
- ³⁰Singleton, A. (2020). The Future of Family Caregiver Support Is Diverse and Inclusive. Research, training and outreach is needed to better equip these communities. Retrieved from <https://www.aarp.org/caregiving/basics/info-2020/inclusive-support-for-diverse-caregivers.html>



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