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# CANADIAN Social Trends

## FEATURES



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# CANADIAN Social Trends

# Features



# Also in this issue

# Always the bridesmaid: People who don't expect to marry

*by Susan Crompton*

Despite all our worries about "fractured families" and declining family values, most Canadians still want to be husbands, wives and parents. A 2004 study of Canadians' opinions about family life found that the vast majority still hold very traditional views about love, marriage and having children.[1] However, researchers still warn that despite their most honourable intentions, people who delay marrying may never walk down the aisle.

Research consistently shows that delaying marriage tends to increase the likelihood that a person will never marry.[2] After age 30, a single person may not wish to marry; it may seem less feasible or less desirable than it did when they were younger.

This article uses the 2001 General Social Survey to look at "mature singles," that is, men and women older than the average age at which people first marry (28 for women, 30 for men) but not yet past prime working-age (under 55). These men and women numbered over 1.1 million in 2001; they had never legally married and were not living common-law at the time of the survey. More than half a million of them (550,000) did not think they would ever get married. This article examines some of the differences between those mature singles who do not expect to marry and those who do.

## CST What you should know about this study

Data in this article are drawn from the 2001 General Social Survey (GSS) on family and marital history. The survey was conducted by telephone in over 25,000 households in the 10 provinces. All respondents who had never been legally married were asked: "Do you think you will ever marry?" This study uses only those respondents who answered either "Yes" or "No" who were not living common-law at the time of the survey, and who were at least one year older than average age at first marriage, yet still of prime working-age.[1] The resulting study population of *mature singles* comprises just over 1,600 respondents representing about 526,000 women aged 29 to 54 and almost 621,000 men aged 31 to 54.

The sample was restricted in order to create a clearer picture of the study population. Respondents under the average age at first marriage might reasonably expect to marry simply because of their age, which is highly correlated with marriage. However, after age 30, the likelihood of contracting a first marriage begins to fall and by age 55, it is virtually nil. Respondents who answered "Do not know" were excluded as having no opinion, as were persons living common-law since they are neither single nor married and would confound the results.

*Will-marrys, wills*: Mature singles who think they will eventually marry.

*Won't-marrys, won'ts*: Mature singles who do not think they will ever marry.

1. In 2002, average age at first marriage was 28 for women and 30 for men; prime working-age is conventionally defined as ages 25 to 54, because it is the age group with the highest rate of labour force participation.

### Dreaming of Mr. or Ms Right

Madame Sosostris[3] and her psychic sisters all know that women want to marry a man who is tall, handsome and wealthy, while men want to marry a supermodel. Social researchers know this too, and numerous studies of mate selection identify the same basic characteristics. Simply put, women generally want a wealthy,

socially dominant man and men generally want an attractive younger woman able to have children.[4]

A particularly detailed U.S. study of single 19- to 35-year-olds ranked some of the principal criteria people consider when looking for a marriage partner.[5] They differ somewhat for men and women, but in general, they are quite mercenary. Both sexes would prefer to marry someone who earns more money and has more education than themselves, and they would be willing to consider someone who is more than 5 years older (age is highly correlated with income). They would not really want to consider accepting someone who has trouble keeping a steady job, has children or has been married already.[6]

## *Won't-marrys* tend to have fewer socio-economic resources

Mature singles who do not think they will marry have lower incomes than those who do. Their median income is 16% lower than that of *will-marrys* (about $29,700 versus $34,400). In addition, mature singles who don't envisage marriage are less well-educated than those who do, with only 24% versus 34% having a university degree; in contrast, they were almost twice as likely to be high school drop-outs, at 17% versus 9% of *wills*. And while most mature singles in both groups are employed, 13% of *won'ts* (but virtually no *wills*) were not in the labour force because of family responsibilities or illness.[7] *Will-marrys* were also more likely to be men (56% compared with 44% women) but *won't-marrys* were no more often men than women. (For many characteristics, the differences between men and women are not statistically significant; therefore, male-to-female comparisons will be limited only to those that are significant.)

That *will-marrys* have higher incomes, and the educational qualifications to maintain or improve their earning power, certainly makes them better potential mates. Also, they are younger and have more years during which to use those advantages to build wealth and economic security. Just over half of mature singles who expect to marry are 35 years or older, with an average age of about 36. In contrast, 83% of *won't-marrys* are 35 or older, with an average age of 42. Women in both groups tended to be younger than men.

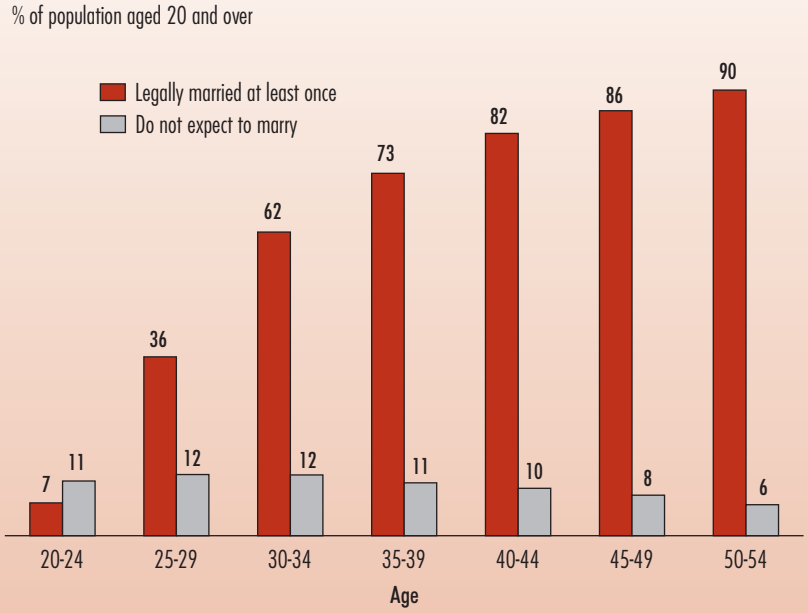
Being older may also influence a person's expectations of marriage in other ways. With friends, work and leisure interests, mature singles satisfied with their lives may feel no need for the companionship of a spouse; alternatively, they may have obligations to an existing family that might make it difficult to accommodate a spouse.

About half of *won't-* and *will-marrys* live alone, and about one-third with their parents or other adults. However, *won't-marrys* were significantly more likely to be living with children—20% versus 12% of *will-marrys*. Furthermore, the responsibility for childcare falls preponderantly on women: fully 38% of female *won'ts* and 23% of *wills* live with their children, compared with few men.

Almost two-thirds of mature single women living with their child (or children) do not think they will find a husband, which may reflect a realistic assessment of their marital potential. On the one hand, single mothers most often want a partner who helps to provide economic support and improves their social standing;[8] on the other hand, having a child without a husband increases the chances of living in poverty, making these single mothers less attractive partners to the type of man they would consider marrying.[9]

As is clear from the fact that many have children, a substantial number of mature singles may never have married, but they have lived in a conjugal relationship. Proportionally more *won'ts* (43%) than *wills* (33%) have lived common-law, and it is

**CST About 1 in 10 people in their 30s and early 40s doubt they will ever marry**




Source: Statistics Canada, General Social Survey, 2001.

## CST *Won't-marrys* are older and less well-educated than *wills*

| | Mature singles: Won't marry | | | Mature singles: Will marry | | |
|---|---|---|---|---|---|---|
| | Total | Men | Women | Total | Men | Women |
| Number ('000s) | 550 | 288 | 261 | 597 | 332 | 265 |
| Average age | 42.1 | 42.2 | 41.9 | 36.5 | 37.3 | 35.6 |
| Median income ('000s) | 30 | 31 | 29 | 34* | 36 | 32 |
| | % (distribution downward) | | | | | |
| **Age group** | | | | | | |
| 29 to 34 | 17 | 13 | 21† | 48* | 43 | 55† |
| 35 to 39 | 23 | 25 | 19 | 28* | 32 | 24 |
| 40 to 44 | 26 | 28 | 25 | 14* | 14 | 13 |
| 45 to 49 | 17 | 18 | 16 | 7* | 7[E] | 7[E] |
| 50 to 54 | 16 | 15 | 18 | 3[E]* | 3[E] | F |
| **Annual personal income** | | | | | | |
| Under $30,000 | 46 | 42 | 50 | 37 | 32 | 44† |
| $30,000 and over | 54 | 58 | 50 | 63 | 68 | 56† |
| **Highest level of schooling completed** | | | | | | |
| University | 24 | 23 | 25 | 34* | 34 | 35 |
| College | 26 | 24 | 28 | 30 | 29 | 30 |
| Some postsecondary | 11 | 9[E] | 12 | 12 | 12[E] | 13 |
| High school | 21 | 25 | 17 | 13* | 14 | 12 |
| Less than high school | 17 | 16 | 17 | 9* | 10[E] | 8[E] |
| **Main activity in previous 12 months** | | | | | | |
| Working | 77 | 79 | 75 | 82 | 83 | 81 |
| Looking for work | 4[E] | 5[E] | F | 4[E] | 4[E] | F |
| Family responsibilities | 6[E] | F | 11[E] | 3[E] | F | 7[E] |
| Long-term illness | 7[E] | 8[E] | 7[E] | F | F | F |
| Other | 5[E] | 5[E] | 5[E] | 7[E] | 7[E] | 7[E] |

| | Mature singles: Won't marry | | | Mature singles: Will marry | | |
|---|---|---|---|---|---|---|
| | Total | Men | Women | Total | Men | Women |
| | % (distribution downward) | | | | | |
| **Living arrangement** | | | | | | |
| Alone | 51 | 62 | 40† | 48 | 51 | 44 |
| Child, children | 20 | 4 | 38† | 12 | 3[E] | 23† |
| Parents with or without siblings and/or others | 14 | 18 | 11[E] | 20 | 21 | 18 |
| With others | 14 | 16 | 11 | 20 | 24 | 15 |
| **Romantic liaisons** | | | | | | |
| Have lived common-law | 43 | 37 | 50† | 33* | 29 | 38 |
| Have never lived common-law | 57 | 63 | 50† | 67* | 71 | 62 |
| Currently in intimate relationship | 20 | 24 | 16 | 39* | 36 | 43 |
| Not in intimate relationship | 77 | 74 | 79 | 58* | 61 | 54 |
| **Region of residence** | | | | | | |
| Atlantic region | 5 | 5[E] | 5[E] | 7 | 7 | 8 |
| Quebec | 43 | 44 | 43 | 17* | 16 | 18 |
| Ontario | 27 | 25 | 29 | 40* | 40 | 39 |
| Prairie region | 12 | 11 | 12 | 17* | 18 | 16 |
| British Columbia | 12 | 14 | 10 | 18* | 18 | 19 |
| **Main language spoken at home** | | | | | | |
| English | 52 | 54 | 50 | 73* | 77 | 68 |
| French | 42 | 42 | 42 | 13* | 11[E] | 15 |
| Other (including multiple languages) | 6[E] | 4[E] | 7[E] | 14* | 12[E] | 16[E] |

Note: Women aged 29 to 54, men aged 31 to 54. Family responsibilities include caring for children and household work.

[E] Use with caution.

F Too small to be reliable.

* Significantly different from *won't-marrys* ($p<0.05$).

† Significantly different from men in same marital expectation group ($p<0.05$).

Source: Statistics Canada, General Social Survey, 2001.

possible that their reluctance to marry may stem in part from an unfavourable experience in such a relationship. Interestingly, women who don't expect to marry are more likely than men to have lived common-law (50% and 37%, respectively).

While the mature singles in this study were not living common-law at the time of the survey, many were dating. However, the *wills* were certainly more active: twice as many were in an intimate relationship with someone living in a separate household, at 39% versus 20% of *won't-marrys*. Since marriage is a potentially viable option for them, their romantic attachment may influence their expectations of marrying; alternatively, the fact that they wish to marry may have led them to look for a partner in pursuit of that goal.

### Hearing the beat of a different drummer

There are socio-economic differences between *wills* and *won't-marrys* that may play into their respective suitability as marriage partners. But it seems the real sticking point is that love (being part of a couple), marriage and family are simply not as important to *won't-marrys* as they are to other mature singles.

## CST Couplehood is still important to over half of mature singles who do not expect to marry

| | Mature singles | | | | | |
|---|---|---|---|---|---|---|
| | Won't marry | | | Will marry | | |
| | Total | Men | Women | Total | Men | Women |
| Number ('000s) | 550 | 288 | 261 | 597 | 332 | 265 |
| | % | | | | | |
| **Being part of a couple is...** | | | | | | |
| Important or very important to my happiness | 54 | 57 | 52 | 92* | 94 | 91 |
| Not very or not at all important | 46 | 43 | 48 | 8* | 6[E] | 9 |
| **Being married is...** | | | | | | |
| Important or very important to my happiness | 13 | 12[E] | 14 | 69* | 72 | 65 |
| Not very or not at all important | 87 | 88 | 86 | 31* | 28 | 35 |
| **Having a child is...** | | | | | | |
| Important or very important to my happiness | 42 | 34 | 52† | 68* | 68 | 68 |
| Not very or not at all important | 58 | 66 | 48† | 32* | 32 | 32 |

Note: Age range for females is 29 to 54 years of age; for males it is 31 to 54 years. Excludes no opinion.

[E] Use with caution.

* Significantly different from *won't-marrys* ($p<0.05$).

† Significantly different from men in same marital expectation group ($p<0.05$).

Source: Statistics Canada, General Social Survey, 2001.

Respondents were asked to rank how important it was to their personal happiness to achieve certain family-related goals.[10] In each instance, *won't-marrys* were significantly less conventional than *wills*. Of course, most *won'ts* (87%) do not think that being married is important to their happiness, while 69% of *wills* believe that it is. They are more open-minded when it comes to being part of a couple: 54% of *won'ts* concede that having a partner would add to their happiness, whereas almost all *wills* (92%) feel that way. For both groups, being a parent is less critical than being in a partnership: having a child is important or very important to 42% of *won'ts* and 68% of other mature singles. And while male and female *wills* are equally agreed on the importance of children to their happiness, male and female *won't-marrys* are sharply split on the issue, at 52% of women but only 34% of men.

Although unique experiences and beliefs have no doubt shaped *won't-marrys*' unconventional attitudes to love, marriage and family, it is worthwhile to have a brief glance at some of the factors that may have helped to mould them. For example, people who attend religious services frequently tend to be more family-oriented, placing more importance on marriage and raising children than other adults.[11] Half of *won'ts* claiming a religious faith had not attended religious services in the past year compared with less than one-third of *wills*.[12]

*Will-marrys* were also substantially were likely to be foreign-born (24% versus 10% of *won'ts*) or to have foreign-born parents (36% compared to 13%). This might be expected since many recent immigrant communities highly value family formation.

When discussing attitudes to marriage, it is crucial to remember that they differ substantially between Quebec and the rest of Canada. Common-law relationships are far more popular in Quebec, where they effectively function not just as a "trial marriage" but as a socially acceptable marriage substitute. Sure enough, a substantial proportion of *won't-marrys* are Quebecers, at 43% versus 17% of *wills*. *Won'ts* are also over three times more likely to be francophone, at 42% compared with 13%.

While people generally absorb the values and mores of the society in which they live, their experiences growing up within their own families will also shape their attitudes toward marriage. The breakdown of their parents' marriage is often viewed as contributing to a negative assessment of matrimony. But there seems little evidence of this.

Almost all mature singles in both groups were born to married parents and 8 in 10 lived with both their parents until they were at least 15; in fact, about two-thirds of them reported that their parents were still together as a couple (or had remained so until death separated them). *Won'ts* were slightly less likely to report being close to their parents when they were children: 17% of *won'ts* and 11% of *wills* felt they had not had a close relationship with their mother growing up; 38% and 22%, respectively, had not been close to their father. But over 80% of both *wills* and *won'ts* did agree that they had had a happy childhood.

### What makes a mature single think they will never marry?

Clearly, *won't-marrys* differ in some measurable ways from other mature singles who do think they will eventually walk down the aisle. But do any of these factors have a greater predictive power than the others in identifying whether a mature single thinks she or he will not get married some time in the future?

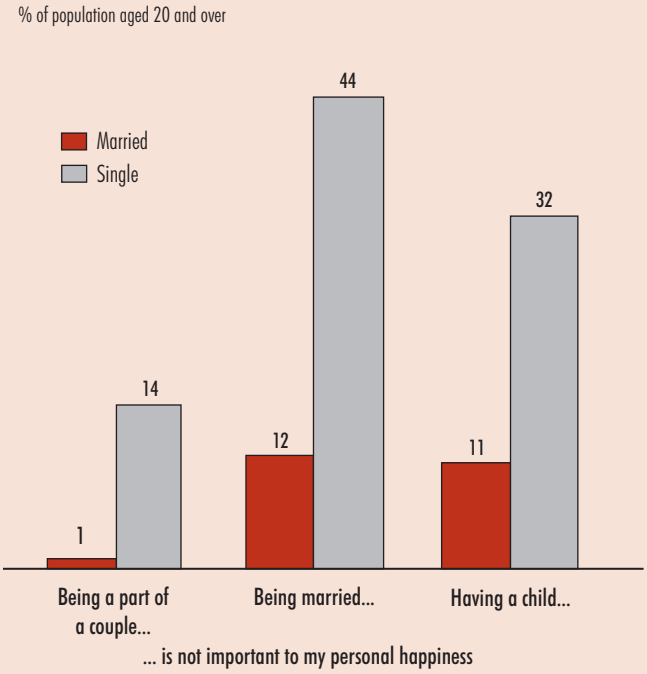
Using a logistic regression model, it is possible to estimate the odds that a person will be a *won't-marry* rather than a *will-marry*, given a particular set of characteristics. The

## CST Singletons and smug marrieds (with apologies to Bridget Jones)

Historically, marriage has marked the transition to adulthood and so people who remain single are often thought to be rejecting their proper role in life. Society has implicitly viewed marriage as "natural and necessary" and has shown a tendency to stigmatize single adults. In 1957, just over half of Americans considered unmarried people to be sick, immoral or neurotic.[1] In the post-war decades, some psychologists and psychotherapists agreed, describing single adults as having schizoid personalities[2] and (as late as the 1970s) being "selfish, irresponsible, impatient, frigid, hedonistic, immature or a combination of these characteristics."[3]

Even today, when so many diverse family forms are generally accepted by society—from lone parents and blended families to unmarried and gay couples—many single people clearly feel the sting of condescension, if not outright prejudice. For example, in recent news articles, singles describe being made to "feel like a second-class citizen" by their married acquaintances, and of being excluded from employment benefits because of society's "fetishizing of coupling."[4]

Many single adults are certainly more indifferent than the average person to love, marriage and family, but their views are not nearly as unconventional as they might think. Some married people express similar views; for example, according to the GSS, over 1 in 8 married Canadians aged 20 and over do not think it is important for them to be married to be happy. This finding is in the same vein as a large 2003 German study which showed that most people were no more satisfied with their lives after marrying than they had been before. The researchers concluded that marriage does not affect everyone the same way, and that people who are very satisfied with life may have less to gain from marriage than those who are dissatisfied.[5]




Source: Statistics Canada, General Social Survey, 2001.

1. Israel, B. 2002. *Bachelor Girl: The Secret History of Single Women in the Twentieth Century*. New York: William Morrow. 233.
2. Johnston, M.W. and S.J. Eklund. December 1984. "Life-adjustment of the never-married: A review with implications for counselling." *Journal of Counseling and Development* 63: 230-236.
3. Edwards, M. 1977. "Coupling and re-coupling vs. the challenge of being single." *Personnel and Guidance Journal* 55. Cited in Johnston and Eklund.
4. Stone, A. February 25, 2004. "The high cost of not marrying." *Business Week Online*; Zernike, K. November 30, 2003. "Just say No to the dating industry." *The New York Times*.
5. American Psychological Association. March 16, 2003. "Are married people happier than unmarried people? Study involving over 24,000 people finds general life satisfaction affects attitude toward marital happiness." APA press release.

model's results show that, of the 20 possible contributing factors discussed, only a handful are significant predictors. Models were run separately for men and women.

The clearest indicators that a mature single of either sex does not expect to marry are his or her attitudes to love and marriage. If they do not believe it is important to be part of a couple, the odds that a man is a *won't-marry* are 4.8 times greater than a man who does, and 3.0 times greater for a woman, all other factors being equal. Similarly, mature singles who place no real importance on being married have very high odds (7.4 for men and 8.8 for women) of being *won't-marrys*.

Age is also a prime predictor of marital expectations, especially for women. The probability of being a *won't* is between 5.0 and 13.1 times higher for mature single women in their 40s or early 50s than for those aged 35 to 39; the odds for a man aged 50 to 54 is 2.6 times higher.

As one might expect, men who do not have good employment prospects more frequently believe they will never marry. Compared with employed mature singles, men with a long-term illness (8.1) have significantly higher odds of being *won't-marrys*. Being unemployed or out of the labour force for other reasons does not seem to affect the probability of being a *won't-marry*, perhaps because these men expect the duration of their non-employment to be short.

While employment status is not a predictor of marital expectation among women, education is, and those mature single women with less than a high school education have odds 5.2 times higher than university graduates of being *won't-marrys*, all other factors being held constant. Having a child or children also increases the odds that a woman is a *won't-marry* (1.7) but has no impact on men.

Some cultural factors affected the probability of being a *won't-marry*. Odds are 4.6 times higher for a male francophone than a male anglophone. A woman living in Quebec has much higher odds (3.7), compared with a woman living elsewhere in Canada, when all other variables were held constant. In contrast, a mature single woman who was in an intimate relationship has significantly lower odds (0.3) of being a *won't-marry*.

## Summary

Single people who do not expect to marry represent a small but distinct group of adults. For the most part, they are quite similar to mature singles who plan to marry, but they differ in some key ways; for instance, many are single parents, their incomes tend to be lower, and they are less likely to be well-educated. In this respect, their profile tends to conform to a growing trend, in the U.S. at least, which shows that marriage rates are slipping among people in lower socio-economic groups even as they rise among the highly-educated.[13]

### CST Age and attitudes are the main predictors of being a *won't-marry*

| Odds ratio that a mature single would not expect to marry | Men (Model 1) | Women (Model 2) |
|---|---|---|
| **Love and marriage** | | |
| Not at all or not very important to be part of a couple | 4.8* | 3.0* |
| *Important or very important to be part of a couple* | *1.0* | *1.0* |
| Not at all or not very important to be married | 7.4* | 8.8* |
| *Important or very important to be married* | *1.0* | *1.0* |
| *Not currently in an intimate relationship with someone* | ... | *1.0* |
| Currently in an intimate relationship | ... | 0.3* |
| **Age group** | | |
| 29 to 34 | 0.5* | 1.0 |
| *35 to 39* | *1.0* | *1.0* |
| 40 to 44 | 1.7 | 5.4* |
| 45 to 49 | 1.3 | 5.0* |
| 50 to 54 | 2.6* | 13.1* |
| **Highest level of schooling completed** | | |
| *University* | ... | *1.0* |
| College or trade/technical diploma | ... | 1.3 |
| Some postsecondary | ... | 1.4 |
| High school | ... | 2.0 |
| Less than high school | ... | 5.2* |
| **Children** | | |
| Have one or more children | ... | 1.7* |
| *Have no children* | ... | *1.0* |
| **Region** | | |
| Quebec | ... | 3.7* |
| *Rest of Canada* | ... | *1.0* |
| **Main activity during the year** | | |
| *Working* | *1.0* | ... |
| Looking for work | 1.8 | ... |
| Family-related (includes childcare, household work, paternity leave) | 1.5 | ... |
| Long-term illness | 8.1* | ... |
| Other (includes going to school and retired) | 0.5 | ... |
| **Main language spoken at home** | | |
| *English* | *1.0* | ... |
| French | 4.6* | ... |
| Other | 0.4 | ... |

Note: This table presents the odds that a respondent would not expect to marry in the future, relative to the odds of a benchmark group when all other variables in the model are held constant. Age range for males is 31 to 54 years of age.

... Not applicable.

* Statistically significant difference from benchmark group ($p<0.05$).

Source: Statistics Canada, General Social Survey, 2001.

But it seems that the key distinction between mature singles who do not expect to marry and those who do are attitudinal: they have decidedly less conventional views about the importance of love, marriage and family. These characteristics have undoubtedly presented *won't-marrys* with different life options than other mature singles. But it is impossible to say whether their opinions have shaped

their behaviour and thus their life choices; or whether their views have grown out of their life experience.

**Susan Crompton** is Editor-in-Chief of *Canadian Social Trends*.

1. The Vanier Institute of the Family. December 2004. *The Future Families Project: A Survey of Canadian Hopes and Dreams*. www.vifamily.ca/library/publications/futured. html (accessed December 9, 2004).
2. Surra, C.A. November 1990 "Research and theory on mate selection and premarital relationships in the 1980s." *Journal of Marriage and the Family* 52, 4: 844-865.
3. "Madame Sosostris, famous clairvoyante,/.../Is known to be the wisest woman in Europe,/With a wicked pack of cards." T.S. Eliot. "The Wasteland." Part I, lines 43-46. *The Complete Plays and Poems, 1909-1950*. Harcourt, Brace and World, Inc.: New York. 1971.
4. Cramer, R.E. and J.T. Schaeffer. Summer 1996. "Identifying the ideal mate: More evidence for male-female convergence." *Current Psychology* 15, 2: 157-166; England, P. 2004. "More mercenary mate selection? Comment on Sweeny and Cancian (2004) and Press (2004)." *Journal of Marriage and the Family* 66, 4: 1034-1037.
5. South, S.J. November 1991. "Sociodemographic differentials in mate selection preferences." *Journal of Marriage and the Family* 53, 4: 928-940.
6. Other factors—such as being of a different religion, much younger, not good looking or having less education—fall somewhere in-between, and probably assume more or less importance depending on the attractiveness of the candidate's other qualities.
7. Family responsibilities include caring for children and household work.
8. Huston, T.L. and H. Melz. November 2004. "The case for (promoting) marriage: The devil is in the details." *Journal of Marriage and the Family* 66, 4: 943.
9. Hollander, D. September-October 1995. "Having a premarital birth reduces the likelihood a woman will marry." *Family Planning Perspectives* 27, 5: 221-222.
10. Respondents were asked to rank their answers using a four-point scale, but these have been collapsed into two categories for the sake of brevity: *Not important* includes the original responses "Not at all important" and "Not very important"; *Important* includes the original responses "Important" and "Very important." Percentages presented exclude no opinion and non-response.
11. Clark, W. Autumn 1998. "Religious observance, marriage and family." *Canadian Social Trends*. p. 2-7.
12. Percentage of those reporting a religious affiliation who attended religious services or meetings in the 12 months preceding the survey, excluding special occasions such as wedding, funerals or baptisms.
13. Huston and Melz. 2004; Goldstein, J.R. and C.T. Kenney. August 2001. "Marriage delayed or marriage forgone? New cohort forecasts of first marriage for U.S. women." *American Sociological Review* 66, 4: 506-519.

# What do Canadians eat?

Are you a nutritionist, food industry analyst, market researcher or a consumer who needs to know what Canadians are eating? If the answer is yes, then the publication ***Food Consumption in Canada*** will meet your needs.

**This two-part publication offers:**

- comprehensive coverage on consumption patterns of numerous foods and beverages;
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# Elder care and the complexities of social networks

*by Kelly Cranswick and Derrick Thomas*

We live in an aging society. And much has been written about how care will be provided to an aging population. Will the health care system through institutions, hospitals and home care provide the bulk of care? Or will family and friends chip in and assist their loved ones with everything from meals to personal care?

Social networks represent an important area of study because, unlike aging or health status, for many, they can be developed with relative ease by individuals and other stakeholders. We can't stop aging, and our capacity to affect our health as we age is limited, but we may be able to build social networks, adjust our living arrangements or otherwise change our behaviour to get the care we may need.

The size, quality and proximity of people's social networks are arguably among the things that determine whether seniors receive formal care delivered by professionals, rely on informal care provided by family and friends or, indeed, receive no care at all. The likelihood of receiving care of each type will perhaps depend partially on how many family members and friends a person has, whether they live close by, and the quality of the relationship with them.

In this article, we look at the relationship between the social networks of non-institutionalized seniors and whether they receive formal, informal or no care. Data are drawn mainly from the 2002 General Social Survey (GSS), supplemented by data from the 1996 GSS and the 2001 Census of Population.

## More seniors in private households receive care

For the past two decades, the proportion of seniors who have been receiving care through institutions has been declining. Fewer than 10% of senior women and only about 5% of senior men—about 287,000 persons—resided in health care institutions in 2001.

There are a number of possible reasons for this shift. For example, seniors often prefer to age in the familiar surroundings of their own homes and neighbourhoods; most are living longer, often without serious health problems; and governments may find it less expensive to provide some form of support to seniors in their homes, rather than to assume broader responsibility for them in an institution.[1]

As a result, the proportion of seniors who have been receiving care while residing in a private home has been increasing. According to the 2002 GSS, about one-quarter of seniors—1.0 million—living in private households were receiving care due to a long-term health problem. About another 2% of seniors outside institutions were experiencing unmet caregiving needs; that is, they reported that they needed care but received none. This group was younger and healthier on average than those who said they were receiving the assistance they

## CST What you should know about this study

Most of the data in this article come from the 2002 General Social Survey (GSS) on aging and social support. The GSS telephone survey covered the non-institutionalized population in the 10 provinces. Respondents were randomly selected from a list of individuals aged 45 and over who had responded to another Statistics Canada survey. Data were collected from about 25,000 respondents over an 11-month period from February to December 2002. Data was also used from the 1996 General Social Survey on aging and social support, as well as the 2001 Census of Population.

In order to help us explain how the type of care that a senior receives depends on their individual characteristics, we employed a series of multinomial logistic regression models. Among the characteristics examined for each senior were gender, age, level of education, whether or not they professed a religious affiliation, and whether or not they (or a household member) owned the home in which they lived. We also looked at some fairly direct measures of the proximity, size and quality of their social network, including: who lived with them; how many other family members they considered close; how many other friends they considered close; and their level of satisfaction with these relationships.

Multivariate models allow us to isolate the effect of each characteristic on the probability that a senior will receive formal care delivered by paid professionals, informal care provided by family or friends, or no care at all. When the effect of a particular characteristic is measured independently of the influence of the other characteristics in the model, it helps to ensure that the results observed are not due to the correlation between different characteristics. To examine the impact of one characteristic, all the others are held constant at their typical, most common or average value. Thus, the probability of receiving care is always calculated for a person who, with the exception of the characteristic being tested, is a *typical* or *average senior*.

**Typical, average senior:** A senior who represents all seniors, created by using the relevant characteristics at their typical, most common or average value. This senior is of average age (74.2 years) and average health (Health Utility Index of 0.78). He or she lives with their spouse, professes a religious affiliation, has a secondary school education, and lives in a home owned by themselves or a household member. The senior is satisfied with the quality of the relationship with their family and their friends. They have an average number of close family members (5.8) and an average number of close male (3.6) and female (4.5) friends. These characteristics remain constant, except for the characteristic being tested; for example, the probability of a senior receiving care based on age is estimated for a senior possessing all the standardized characteristics above, except that his or her age is not 74.2 but varies from 65 to 90 years.

**Care receiver:** Canadians aged 65 and over who reported receiving assistance with at least one task in the 12 months prior to the survey because they had a long-term health problem.

**Care:** Help with inside-the-house activities, outside-the-house activities, transportation or personal care.

**Informal care:** Help with care activities provided by family and friends.

**Formal care:** Help with care activities provided through government organizations or non-government organizations or directly by an employee paid by the senior or someone acting on behalf of the senior.

**Health status:** This was categorized using the *Health Utility Index*, which is a composite index based on quantitative measures of the senior's level of vision, hearing, speech, mobility, dexterity, and cognition; as well as qualitative aspects of health such as emotion, pain and discomfort. Individuals are assigned an index number from 0 to 1, with 1 being perfect health.

required; at the same time, they were older and less healthy than those who did not need care. They appear, in short, to be a group in transition to care.

Of those 1.0 million non-institutionalized seniors receiving care, just under one-half (45%) received help exclusively from family and friends, while just over one-half (55%) received at least some formal assistance. About half of those getting formal care also reported having informal assistance from family and friends.

Women are more likely to receive care because of a long-term health problem: over 30% compared with fewer than 20% of men. Even after taking account of age, health and other factors, senior women are more likely than men to receive help, particularly through the formal care system. The differing life spans and life cycles of men and women is no doubt one of the factors at play. Women, for example, tend to outlive their partners. Because the conditions under which they receive care often differ, men and women will generally be discussed separately in this article.

## Poor health is the main reason seniors receive care

As one might expect, the most important determinant of receipt of care for men and women living outside an institution was health status. While the probability of receiving care was about 20% for seniors in average health, the probability of receiving care increased dramatically with declining health.

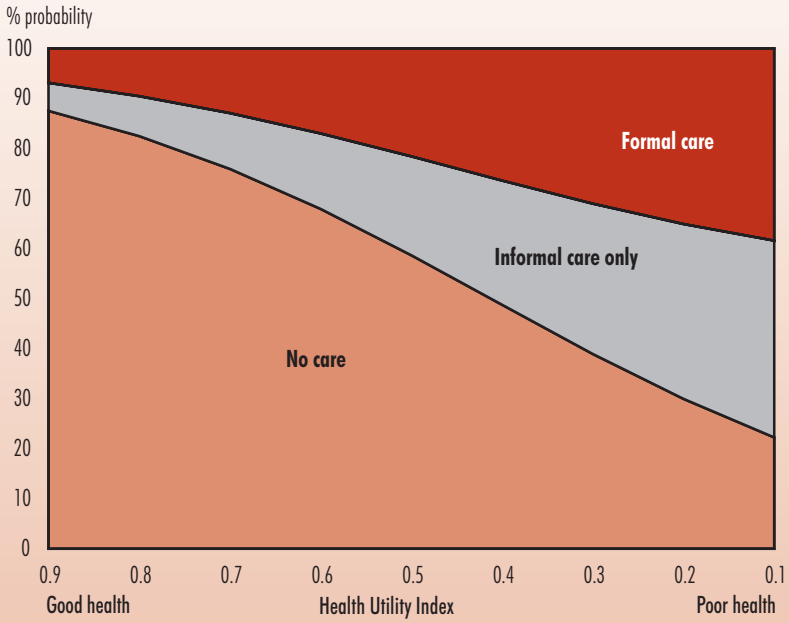
For the otherwise typical senior, the probability of receiving care rose from about 12% for those in very good health to almost 80% for the very ill. Although the actual probabilities were different for senior men than for women, the relationship between health and receipt of care remained the same. However, it is important to note that, while health status may help us to predict who will receive care, it is not a very good predictor of whether that care will be formal or informal.

## Older seniors also receive more care

Of course, increasing age also has a strong impact on the care received by seniors. For the otherwise typical senior, the probability of receiving care increased with age.

The relationship is very reminiscent of the one between health and receipt of care, with the exception that people who were in stable health were more likely to receive formal as

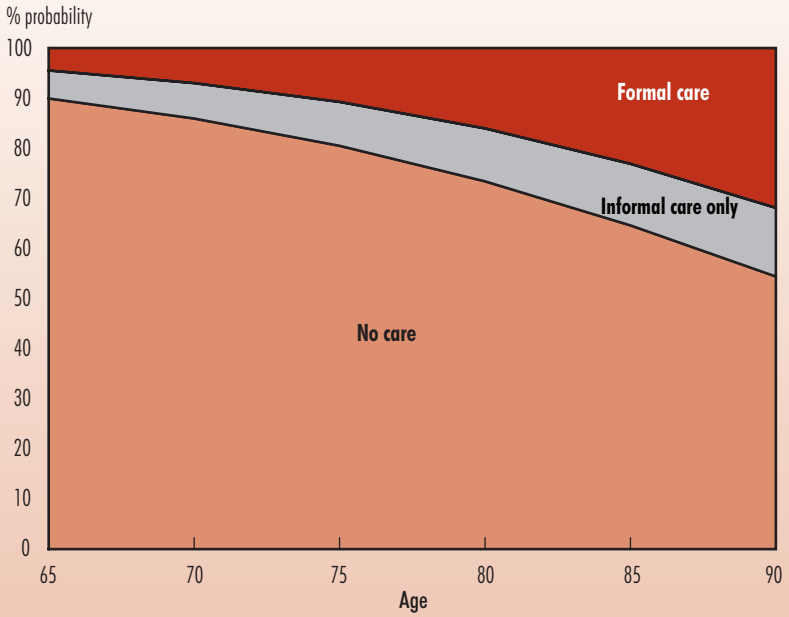
### CST Seniors with poorer health receive more care of both types regardless of their age




Note: Probabilities are calculated for the typical senior, where health status varies but all other variables in the model are held constant. For the definition of the typical senior, see "What you should know about this study."

Source: Statistics Canada, General Social Survey, 2002.

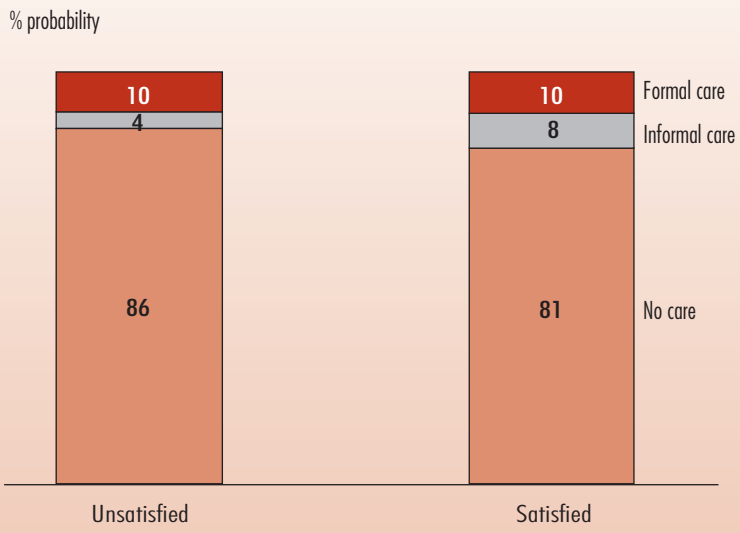
### CST Seniors receive more formal care as they age because they are losing their social networks




Note: Probabilities are calculated for the typical senior, where age varies but all other variables in the model are held constant. For a definition of the typical senior, see "What you should know about this study."

Source: Statistics Canada, General Social Survey, 2002.

## CST Seniors satisfied with their family network receive more informal care




Note: Probabilities are calculated for the typical senior, where relationship satisfaction varies but all other variables in the model are held constant. For a definition of the typical senior, see "What you should know about this study."

Source: Statistics Canada, General Social Survey, 2002.

opposed to informal care as they got older. This is at least partly due to the fact that advanced age is correlated with the decay of the support network that might have provided informal support and that older seniors are more likely to be without surviving close family or friends.

### Living arrangements were associated with care received by women

The person with whom one lives represents a key aspect of one's social network, and senior men and women differ significantly in respect of their living arrangements. According to the 2002 GSS, two-thirds of non-institutionalized senior men lived in a two-person household with a spouse, while only a little over one-third of women did. Women most often lived alone (43%) while it was the least common arrangement among men (16%). About 19% of women and 17% of men opted for living with family and friends (this could include living with a spouse as well as other family members or friends).

For a typical man, the probability of receiving either formal or informal care was not significantly affected by his living arrangements.

For a typical woman, however, the probability of receiving formal care increased from about 9% for those who lived with children and others to almost 12% for those who lived with a spouse. Women who lived alone had the highest probability of receiving formal care at about 15%, while women living with children and others were more likely to rely on informal care. Somewhat surprisingly, however, women living with a spouse were the least likely to depend on informal care.

It is a little puzzling that more informal care was not received in two-person households. As we have seen, a substantial minority of senior women and the majority of men live with a spouse. The apparent lack of care in these arrangements might be traced to a divergence in each partner's understanding of what constitutes care. It may be that some categories of assistance such as meal preparation, laundry, transportation and home maintenance, are perceived as part of the traditional division of labour between spouses and are only identified as caregiving when one partner can no longer perform them. If the contributions of their spouses were apparent to them, it might well be that more informal care would be reported by both sexes and that living arrangements would be identified as a significant factor in the care received by men.

### The size of the social network is important to receiving formal and informal care

For the average woman 65 years of age and older, the more relatives she feels close to, the more care she tended to receive; not surprisingly, this extra assistance is principally in the area of informal care. On the other hand, women with a large network of close female friends had a higher probability of receiving formal care. This suggests that while an extended family tends to take direct responsibility for the care of senior women, friends help them to seek out formal care. Alternately, it may be that people who maintain relationships with a relatively large number of friends also have a greater familiarity with the larger world which helps them to arrange formal care. On the other hand, extensive social networks seem to make little difference to the care men receive; in fact, having a large number of male friends was associated with less formal care.

Seniors who were satisfied with the kind and frequency of contact with family members were, all else being equal, more likely than other seniors to have received informal care. Meanwhile, satisfaction with the quality of their friendships was associated with the probability of receiving formal care, especially for men. Among women, the effect of

friends is described by the extent of the network.

### Better educated seniors receive more formal care

The level of education they have attained has an impact on whether seniors get formal care or rely solely on informal care. The probability of receiving formal help increased from about 7% for the typical senior without high school to over 13% for the typical senior with a university degree or college diploma. All else held constant, educated people less often had to rely exclusively on informal care and were less likely to receive no care at all. The effect of education on receipt of care is a little stronger for men than for women.

This link may exist because educated persons are better able to negotiate the institutional channels that could prove a barrier to accessing formal care for less literate seniors. Education is also correlated with lifetime earnings and wealth, which may mean that people with more education have the means to pay for formal assistance.

### Home ownership is associated with care for women

Another key measure of wealth—home ownership—has predictive power only for women. All other things being equal, typical senior women who lived in a home owned by themselves or a household member were more likely than renters to receive care (both formal and informal). The difference between owners and renters was somewhat greater for informal care.

Education captures the effect of household wealth for senior men, who earned that wealth over a long period of paid employment. Since women in this age group are not likely to have a similar work history, home ownership is a better predictor of financial resources available to wives, since it represents the assets built up by the couple. That there is a relationship between home ownership and care receipt for women may also lie in a greater propensity for women to adjust their living arrangements (that is, sell their home) when their spouse dies. Getting rid of the house can lessen the need for help with yard work or home maintenance, reducing a woman's dependence on the systems that provide this type of care.

### Women who profess a religion receive more care

Senior women who reported having a religious affiliation were more likely to receive care than women who did not. They were more apt to receive informal care but were also more likely to get formal care. Acknowledging a religious affiliation may be indicative of membership in a community and suggests a social network on which one may be able to depend. Religion may also reflect traditional values or links with traditional networks (in the same way as a large family) that may allow one to receive care informally. This may be contrasted with the ostensibly weaker ties of friendship, which are associated with reliance on the formal system.

Frequency of attendance at religious services seemed, however, to be correlated positively with health status and was associated with less rather than more care (both formal and informal). This can likely be explained by people needing to be in fairly good health in order to attend a service.

For men, religion apparently played no role in the likelihood they would receive care.

### Summary

As the proportion of seniors receiving care through institutions has been declining, the proportion receiving care outside them has been increasing. Seniors receive this care

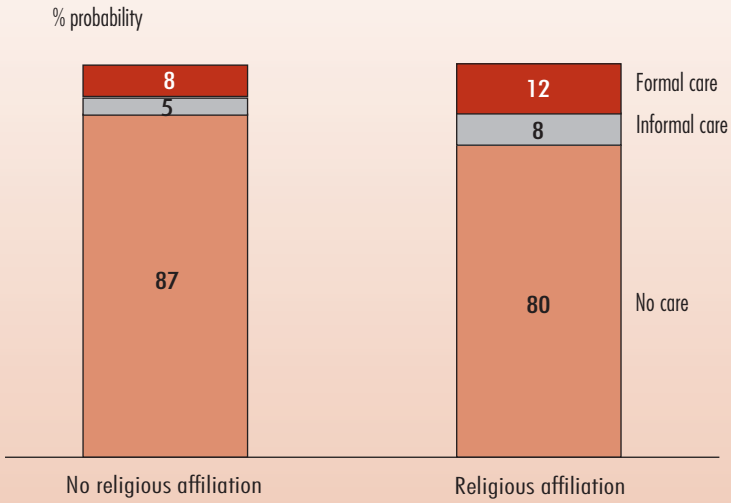
**CST Women who live in their own home receive more formal and informal care**


Note: Probabilities are calculated for the typical senior, where housing tenure varies but all other variables in the model are held constant. For a definition of the typical senior, seee "What you should know about this study."

* Owned by themselves or another household member.

Source: Statistics Canada, General Social Survey, 2002.

## Women who profess a religious affiliation receive more care of both types




Note: Probabilities are calculated for the typical senior, where religious affiliation varies but all other variables in the model are held constant. For a definition of the typical senior, see "What you should know about this study."

Source: Statistics Canada, General Social Survey, 2002.

because of their declining health; however, the distribution of non-institutionalized seniors between the formal and informal systems seems to be conditioned by factors other than health. Perhaps due to shrinking informal networks, older seniors were more likely to receive formal care. Those with higher levels of education, many friends and satisfying relationships with friends were more likely to receive formal care; in contrast, those with large families or who professed a religion tended to rely on informal care. Women who lived alone acquired more formal care than those who lived with a spouse, who in turn received more than those who lived with their children or others.

It would be a mistake to view social networks as constraining or determining the receipt of care in the same way as health and age, or even education and income. Social networks and living arrangements are related to the type of care received in potentially more complex ways. It is possible for care receivers and providers to adjust their networks or living arrangements to obtain or provide care. While seniors cannot change their age or health status, they may contact friends, move in with family, move into an institution or even move to a different community, in order to get the help they require. Information about the value of social networks is important as seniors age and make choices affecting their overall well-being.

**Kelly Cranswick** is a senior analyst at the Statistics Canada Manitoba Research Data Centre and **Derrick Thomas** is a senior analyst with Social and Aboriginal Statistics Division, Statistics Canada.

1. In many ways, institutionalization extends or substitutes for formal care, thereby affecting the demand for, and receipt of, care in the community. Although there are important differences in the rate of institutionalization across jurisdictions, regional disparities do not substantially change the findings of this study.

# The sandwich generation

*by Cara Williams*

This article is an adaptation of "The sandwich generation," *Perspectives on Labour and Income* (Statistics Canada Catalogue no. 75-001-XIE, vol. 5, no. 9), available at www.statcan.ca:8096/bsolc/english/bsolc?catno=75-001-X20041097033.

Balancing home and work, particularly when young children and a full-time job are in the picture, can be challenging for the best of us. It is easy to see why: eight hours at the office, plus commuting, arranging children's activities, helping with homework, preparing meals, doing household chores and planning for family time makes balance seem more like an elusive goal than a firm reality. For some, the task becomes even more difficult when they must provide care to aging parents or other relatives. These people make up the sandwich generation, whose members are caught between the often conflicting demands of caring for children and caring for seniors.

While today's sandwich generation is relatively small, it is likely to grow substantially as baby boomers age. Because of their sheer numbers, when boomers become seniors, they will account for a much larger proportion of the population than do the elderly today. In fact, population projections indicate that by 2026, one in five Canadians will be 65 or older, up from one in eight in 2001.

Another factor associated with a growing sandwich generation involves lower fertility rates, which may translate into fewer adults available to care for the elderly. Finally, because today's young adults frequently delay marriage and parenthood, it is not unusual for older family members to require care at a time when young children and teens are still part of the household. Indeed, delayed marriage, postponement of children, and decreased fertility rates, coupled with increased life expectancy, mean that the average married couple may have more living parents than children.[1]

The personal and financial sacrifices made by members of the sandwich generation have been highlighted in the media.[2] At the same time, however, some analysts have argued that because the sandwich generation is small, the negative consequences of belonging to this group are overstated.[3] Yet others think that most care of seniors by family members is better defined as "helping" and that intensive caregiving is very limited.[4] To date, however, little empirical data exist for Canada. This article uses the 2002 General Social Survey (GSS) to examine care of the elderly by persons aged 45 to 64 with children still at home. The analysis focuses on the types of care given, the time spent on these activities, the effects on the individual from both a work and a personal perspective, and the resources that could benefit caregivers.

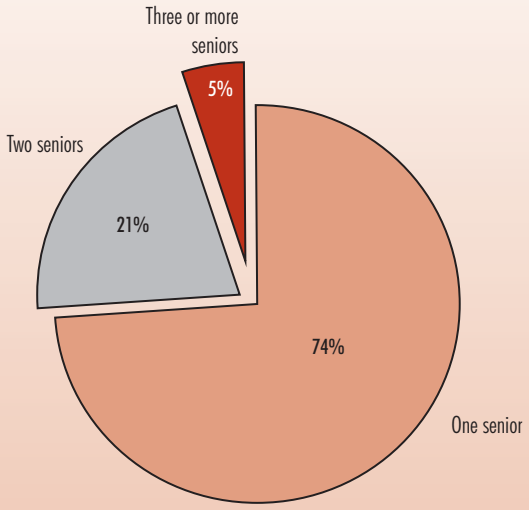
## Balancing care of children and seniors is not a new phenomenon

Providing care to elderly relatives is not new and, until quite recently, families played a pivotal role in this regard.[5] In the past, it was not unusual to find three generations in one household, with the primary caregiving done by the middle-aged woman in the home. While some striking similarities exist between past and present caregiving, one crucial difference is evident: Today, the majority of working-age, non-senior women engage in paid work and are not full-time homemakers. However, while parents have seen childcare services evolve, little formal support has been established for the growing number of middle-aged men and women caring for seniors.

So how are families coping? Research has shown that women do more child care and housework, while men spend longer hours at paid work. But what happens when elder care enters the mix? Are women more likely to be on call or is the responsibility shared?

According to the 2002 GSS, about 2.6 million people between 45 and 64 had children under 25 living with them. Approximately 27%—or 712,000—also performed some type of elder care. These individuals make up the sandwich generation. While

## CST One-quarter of sandwiched Canadians care for more than one senior




Source: Statistics Canada, General Social Survey, 2002.

the vast majority provided elder care for their parents or parents-in-law, about 25% cared for other relatives, friends, neighbours or co-workers.

### Some sandwiches are thinly spread

Caring for both children and elderly relatives can be stressful, particularly for those with young or multiple children.[6] If, in addition, more than one elderly person needs to be looked after, the situation may become even more complicated. Indeed, about 21% of sandwiched workers cared for two seniors and another 5% for at least three.

The vast majority (more than 8 in 10) of those who provided care for their children as well as a senior stated that their main activity in the last 12 months had been paid work. In comparison, only 65% of individuals who cared for an elderly person but who had no children were employed. Balancing work and family can be tough. Interestingly, however, according to the 2002 GSS, most people (82%) who worked while providing both child care and elder care were generally satisfied with the balance they had struck.

Nonetheless, caring for both children and seniors does sometimes necessitate life adjustments, such as a change in work hours, refusal of a job offer, or a reduction in income. About one in seven sandwiched workers had reduced their work hours over the previous 12 months, 20% shifted their work hours, and 10% lost income.

Sandwiched workers have been portrayed as unable to meet their other responsibilities because of caring for a senior.[7] However, results of the GSS show that only slightly more than 1 in 10 workers aged 45 to 64 who were caring for an elderly person, either with or without children at home, had difficulty meeting their other responsibilities.

### Sandwiched workers spend less time on elder care than those without children at home

The 2002 GSS looked at the number of hours respondents spent on elder-care activities such as housework and meal preparation; yardwork and outside home maintenance; driving to appointments; and helping with bathing or dressing. Although results indicate that the incidence of providing care was similar, sandwiched workers spent fewer hours on these activities than those with no children at home: an average of 20 hours per month versus 26 hours, respectively. The two groups spent a similar amount of time on their paid job—sandwiched workers 42 hours per week and workers with no children at home, 41 hours.

The number of hours spent caring for someone provides an indicator of intensity. Sandwiched workers who spend eight hours or less per month on elder care can be considered low-intensity caregivers, while those spending more are their high-intensity counterparts. Effects on the caregiver differ significantly based on these groupings. However, it is not only the amount of care that matters. While two caregivers may spend similar amounts of time helping a senior, the tasks they need to perform may differ substantially. For example, one care receiver may need help only with outside chores such as mowing the lawn, while another may require assistance with daily living, such as bathing, dressing or feeding.

Not surprisingly, caregivers in the high-intensity group were more likely to experience negative health effects. Indeed, 76% of these individuals felt stressed compared with 67% of their low-intensity counterparts. While 22% of high-intensity caregivers reported changes in their sleep patterns, only 9% of those in the low-intensity group stated similar occurrences. In addition, 23% of high-intensity individuals found their general health affected by elder care versus 7% of

## CST Over half of high intensity sandwiched workers incurred extra expenses as a result of elder care

| | Intensity of elder care | |
|---|---|---|
| | Low (8 hours or less per month) | High (more than 8 hours per month) |
| | % | |
| **Proportion feeling stressed** | | |
| Very/somewhat | 67 | 76* |
| Not very | 23 | 19 |
| Not at all | 9E | 5E |
| Don't know/no opinion | F | F |
| **Care giving has resulted in** | | |
| Health repercussions | 7E | 23* |
| Changed sleep patterns | 9E | 22* |
| Extra expenses | 32 | 55* |
| Change in social activities | 28 | 50* |
| Change in holidays | 17 | 43* |
| Care receiver moving closer | 7E | 10E |
| Caregiver moving in with care receiver | F | 6E |
| **Effects on work** | | |
| Work hours shifted | 11 | 35* |
| Work hours reduced | 10 | 26* |
| Income reduced | 6E | 17* |
| **Overall burden** | | |
| None | 60 | 37* |
| Little/moderate | 34 | 56* |
| Quite a bit/extreme | 3E | 6E |

Note: Percentages may not add to 100 due to some non-response.

* Indicates statistically significant difference from the low-intensity sandwiched group.

E Use with caution

F Too unreliable to publish

Source: Statistics Canada, General Social Survey, 2002.

low-intensity caregivers. And, about one-half of those in the high-intensity group had to change their social activities and 43%, their holiday plans. These individuals were also much more likely than their low-intensity counterparts to feel constantly stressed: 20% versus 9%.

Caregivers in the high-intensity group were also considerably more likely to experience work-related problems. They were three times as likely to shift their work hours, and more than twice as likely to reduce them or to experience a drop in income.

### Women more involved in caregiving

Women continue to shoulder much of the childcare responsibility within two-parent households, even when both parents are in the labour force.[8] This also holds true for elder care, both in terms of the likelihood of providing care and in performing the most intensive tasks such as bathing, dressing and cooking.[9] About 25% of 45- to 64-year-old men with children at home provided elder care compared with 32% of women in similar circumstances.

The amount of time devoted to elder care also varied between men and women. Working women with children at home spent more than twice as many hours per month caring for an older person as their male counterparts (29 hours versus 13). This may be due in part to the type of care performed. For example, 69% of outside home maintenance and 65% of transportation assistance was done by men. Conversely, women were more likely to provide personal care (79% versus 22% of men), and in-home care such as food preparation and clean-up (65%). This pattern also held true for those who provided elder care only.

### Although satisfied with life, sandwiched workers are more stressed than others

Two schools of thought have emerged with respect to the personal consequences of caring simultaneously for seniors and children. According to one, such people feel no more rushed or stressed than anyone else, since the negative aspects of caregiving are balanced by increased self-esteem.[10] According to the second, the two roles may lead to overload, poor health, increased stress, and an inability to find balance in life.[11] In addition, many adult children have considerable emotional difficulty caring for their aging parents. As a result, the situation can be stressful for both caregiver and care receiver, especially as failing health necessitates more care.[12]

The 2002 GSS supports both schools of thought. For example, 95% of sandwiched workers reported feeling satisfied or very satisfied with life in general—virtually the same proportion as those with fewer responsibilities. However, although generally satisfied, sandwiched workers were significantly more likely to feel stressed (70%) than either those who provided elder care only (64%) or those with no childcare or eldercare responsibilities (61%).

This is not surprising, given that working full time, raising children and caring for seniors often leaves little time for social activities or holidays

## CST Seven in 10 sandwiched workers reported feeling very or somewhat stressed

| | Employed persons aged 45 to 64 | | |
|---|---|---|---|
| | Sandwiched | Elder care only | Neither |
| | % | | |
| **Overall health** | | | |
| Excellent/very good | 74 | 74 | 73 |
| Good | 22 | 21 | 21 |
| Fair/poor | 4 | 5 | 5 |
| **Stress level** | | | |
| Very/somewhat | 70 | 64* | 61* |
| Not very | 21 | 25 | 26 |
| Not at all | 7 | 10 | 10 |
| Don't know/no opinion | F | F | F |
| **Job, family balance** | | | |
| Very satisfied | 21 | 28* | 29* |
| Satisfied | 61 | 57 | 57 |
| Neither/no opinion | 5 | 5 | 4 |
| Dissatisfied | 11 | 8 | 8 |
| Very dissatisfied | F | F | F |
| **Satisfaction with life** | | | |
| Very satisfied | 34 | 32 | 29* |
| Satisfied | 61 | 62 | 65 |
| No opinion | F | F | F |
| Not very satisfied | 3[E] | 4 | 3 |
| Not at all satisfied | F | F | F |

[E] Use with caution

F Too unreliable to publish

* Indicates statistically significant differences from sandwiched workers.

Source: Statistics Canada, General Social Survey, 2002.

and may, in addition, contribute to health problems. Indeed, more than one-third of these caregivers found it necessary to curtail social activities, and a quarter had to change holiday plans. Often a call for help can come in the night and the caregiver must leave the house to provide assistance. Some 13% experienced a change in sleep patterns, and the same percentage felt their health affected in some way. While 1 in 10 sandwiched workers lost income, 4 in 10 incurred extra expenses such as renting medical equipment or purchasing cell phones.

Nonetheless, for many, caregiving has positive aspects. More than 60% of caregivers felt they were giving back some of what life had given them, and 70% reported that their relationship with the elderly person was strengthened. While caregiving can be difficult to fit in with other obligations and responsibilities, only about 5% of respondents felt it to be an extreme burden.

### The caregiver's wish list

Those busy balancing children, work and elder care reported needing support in the form of workplace programs or appropriate government policy. Workplace support includes flexible hours, telework, and information about community resources in particular, and health and aging in general.[13] However, despite concerns that potential work absences by sandwiched caregivers would lead to higher associated costs and productivity losses, eldercare programs are less likely to be available than childcare programs—and even if offered, they are not often used.[14] The 1999 Workplace and Employee Survey (which excludes public administration) found that 802,700 individuals or 7% of employees had access to childcare services but only 78,800 (just under 10%) made use of them. While fewer employees had access to elder care (394,300), the take-up rate was slightly higher at about 13%.

Researchers put forward several reasons to explain the low utilization rate of workplace eldercare services. For example, it appears that programs often do not adequately meet the needs of either the care recipients or caregivers. As well, according to some focus group research, caregivers may try to hide their caregiving responsibilities, fearing that they are career-limiting. And finally, workplace culture may not support the use of such programs even when offered.[15]

The caregiver's wish list was very similar for all individuals providing elder care, whether they had children at home or not. For example, both groups were equally likely to want compensation or tax breaks, information on long-term illnesses or disabilities, or counseling. However, some differences were evident. Of those working, sandwiched individuals were more likely than those caring for an elderly person only to feel they could do a better job if respite care was available (52% versus 46%). Sandwiched workers were also more likely to want flexible work or study arrangements (46% versus 36%).

## CST Caregiver's wish list

| | Employed | |
|---|---|---|
| | Sandwiched | Elder care only |
| | % | |
| Respite care | 52 | 46* |
| Flexible work or study arrangements | 46 | 36* |
| Information on long-term disabilities | 43 | 39 |
| Information on caregiving | 42 | 37 |
| Financial compensation or tax breaks | 36 | 35 |
| Counselling | 28 | 24 |
| Other | 12 | 10 |

* Indicates statistically significant difference from sandwiched group.

Source: Statistics Canada, General Social Survey, 2002.


### Summary

In 2002, about 712,000 Canadians aged 45 to 64 were caught between the responsibilities of raising children and caring for seniors. For more than 8 in 10 of these individuals, paid work was added to the loads. These sandwiched workers found that in caring for a senior, 15% had to reduce their work hours, 20% had to change their schedules, and 10% experienced a reduction in income. Not surprisingly, these individuals also felt the burden in terms of their health and social life.

However, not all consequences of caregiving are negative. More than 60% of those working and caring for an older person while still having children at home felt that caring for


## CST What you should know about this study

Data in this article come from the 2002 General Social Survey (GSS) on social support and aging. The target population comprises all persons aged 45 and over as of December 31, 2001 in private households in the 10 provinces. Data were collected between February and December 2002. The sample was selected from respondents to the 2001 Canadian Community Health Survey.

For this article, the population of interest was 45- to 64-year-olds caring for children and seniors simultaneously. Individuals were considered *sandwiched* if they provided elder care to someone over 65 and had single children less than 25 living at home. *Sandwiched workers* had a paid job or business as their main activity in the previous 12 months.

This article focuses on types of care given to seniors, hours spent on care, and effects on the caregiver. Caregiving in the form of emotional support is not included. Caregiving activities comprise *personal care* (assistance with bathing, toileting, care of toenails/fingernails, brushing teeth, hair care, and dressing); *care inside the home* (meal preparation and clean-up, housecleaning, laundry and sewing); *care outside the home* (house maintenance and outdoor work); and *transportation care* (shopping for groceries or other necessities, providing transportation, or doing a senior's banking or bill-paying).

### Data limitations

While there are undoubtedly individuals under 45 who are sandwiched, they were not as likely as those aged 45 to 64 to be in this group.[1] According to some, younger caregivers may find elder care more burdensome because their children are younger. To determine if age of children had an effect on responses, sandwiched workers with children under 15 were examined. Results indicated that there was no difference between those with younger children and the population of interest.

Additionally, just over 10% (81,000) of sandwiched workers were not asked 'impact of caregiving' questions if the person for whom they provided care had died during the previous 12 months. Consequently, there may be some bias in the 'impact of care' responses. Finally, since only those providing elder care were asked 'impact of care' questions, it is not possible to compare them with the general 45- to 64-year-old population. Thus, the major comparison group comprised 45- to 64-year-olds who provided elder care but had no children at home. When possible, comparisons have been made with individuals not providing elder care and having no children at home.

1. Wisensale, S.K. October 1992. "Toward the 21st century: Family change and public policy." *Family Relations* 41, 4: 417-422.

a senior was simply giving back what they had received, and 70% stated that the relationship was strengthened. While these individuals were just as likely as other workers to be satisfied with their work–home balance, they were much more likely to feel generally stressed. They were also significantly more likely to wish for flexible work arrangements or respite care to enable them to be better caregivers.

Those who spent more than eight hours a month on elder care were more likely than those spending less than this amount to feel the effects. Of the high-intensity caregivers, half had to change their social activities, and about 35% had to alter their work schedule.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14. ibid.

15. ibid.

# Social anxiety disorder: Much more than shyness

*by Margot Shields*

This article is an adaptation of "Social anxiety disorder—beyond shyness" in *How Healthy Are Canadians?*, an annual supplement to *Health Reports* (Statistics Canada Catalogue no. 82-003), published in October 2004. For a complete list of references, please consult the original work, available free at www.statcan.ca/english/freepub/82-003-SIE/82-003-SIE2004000.htm.

Most people have felt awkward or embarrassed in a social or performance situation at some point in their lives. However, people with social anxiety disorder (also known as social phobia) experience much more discomfort than this. They go through life feeling extremely uncomfortable or paralyzed in social situations because they intensely fear being scrutinized or embarrassed. So they either totally avoid social encounters, or face them with dread and endure them with intense distress.[1] Although social anxiety disorder is often dismissed as shyness, studies have shown it to have a chronic and unremitting course that is characterized by severe anxiety and impairment.[2] The disorder has been aptly described as "crippling shyness."[3]

It is difficult to estimate how many individuals actually have social anxiety disorder, as most people with the condition do not seek professional treatment for their fears. Social anxiety disorder was thought to be a rare and usually mild condition until the 1980s, when it was recognized as a separate disorder in the Diagnostic and Statistical Manual of Mental Disorders. Then in the 1990s, several epidemiological studies suggested that social anxiety disorder was associated with significant impairment and was far more prevalent than initially thought.[4] In fact, by this time, it was considered one of the most common mental disorders. Because few people are formally treated, however, epidemiological population-based studies are really the only way to estimate the prevalence of social anxiety disorder and the burden it can impose.

Using data from the 2002 Canadian Community Health Survey (CCHS): Mental Health and Well-being, this article presents current and lifetime prevalence rates of social anxiety disorder for Canadians aged 15 years or older. It also discusses the age of onset, duration of symptoms, relationship with other mental disorders, the burden of the condition as well as the number of people with the disorder who sought professional help.

## Performing or public speaking most scary for those with social anxiety

According to the 2002 CCHS, just over 2 million Canadians aged 15 or older (8% of the total population) reported they had a "lifetime history" of social anxiety disorder; in other words, they had symptoms at some point in their lives. Approximately 750,000 people (3%) currently had the disorder, meaning they had symptoms in the 12 months before the survey interview.

The most commonly feared situation for people with social anxiety disorder was performing or giving a talk, but many reported facing several other situations with anxiety; for example, meeting new people, talking to authority figures, or entering a roomful of people. The majority with social anxiety disorder reported fearing 10 or more of the 14 social situations covered by the CCHS, and close to 95% feared 5 or more. For half of the situations, women were slightly more likely than men to report a fear.

## What you should know about this study

The Canadian Community Health Survey (CCHS) cycle 1.2: Mental Health and Well-being was conducted in the 10 provinces in 2002. The survey used the World Mental Health version of the Composite International Diagnostic Interview (WMH-CIDI) to estimate the prevalence of various mental disorders in the Canadian household population aged 15 or older. The CIDI was designed to be administered by lay interviewers and is generally based on diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Based on the advice of experts in the field of mental health, the WMH-CIDI and the algorithms used to identify mental disorders were revised over a period of time. The questionnaire used for the CCHS is available at www.statcan.ca/English/concepts/health/cycle1.2/index.htm.

For some disorders, a set of screening questions was asked to determine if it would be appropriate to ask the respondent the more detailed questions designed to assess a particular disorder. This was done to reduce the number of questions posed to respondents without mental disorders. In some cases these screening questions were also used to categorize respondents as having a disorder.

## Social anxiety disorder is less prevalent among those aged 55 and older

| | Lifetime | Current (past 12 months) |
|---|---|---|
| | % | |
| **Total** | **8.1** | **3.0** |
| **Sex** | | |
| Men | 7.5* | 2.6* |
| Women | 8.7 | 3.4 |
| **Age group** | | |
| 15-24 | 9.4 | 4.7* |
| 25-34 | 9.6 | 3.8 |
| *35-54* | *9.1* | *3.1* |
| 55 or older | 4.9* | 1.3* |
| **Marital status‡** | | |
| *Married/common-law* | *8.0* | *2.5* |
| Widowed | 7.0[E] | 2.4[E] |
| Divorced/separated | 12.7* | 5.0* |
| Never married | 12.0* | 5.0* |
| **Education‡** | | |
| Less than secondary graduation | 9.1 | 3.9* |
| Secondary graduation | 8.8 | 3.3 |
| Some postsecondary | 10.3 | 3.9* |
| *Postsecondary graduation* | *8.9* | *2.7* |
| **Household income** | | |
| Low/lower-middle | 9.8* | 4.6* |
| Middle | 7.8 | 3.0 |
| *Upper-middle/high* | *8.2* | *2.8* |

Note: Reference categories are marked in italics.
Household population aged 15 or older, Canada excluding the territories.

[E] Use with caution.

‡ For people aged 25 to 64.

* Significantly different from estimate for reference category ($p<0.05$).

Source: Statistics Canada, Canadian Community Health Survey: Mental Health and Well-being, 2002.

### Social anxiety disorder begins early in life

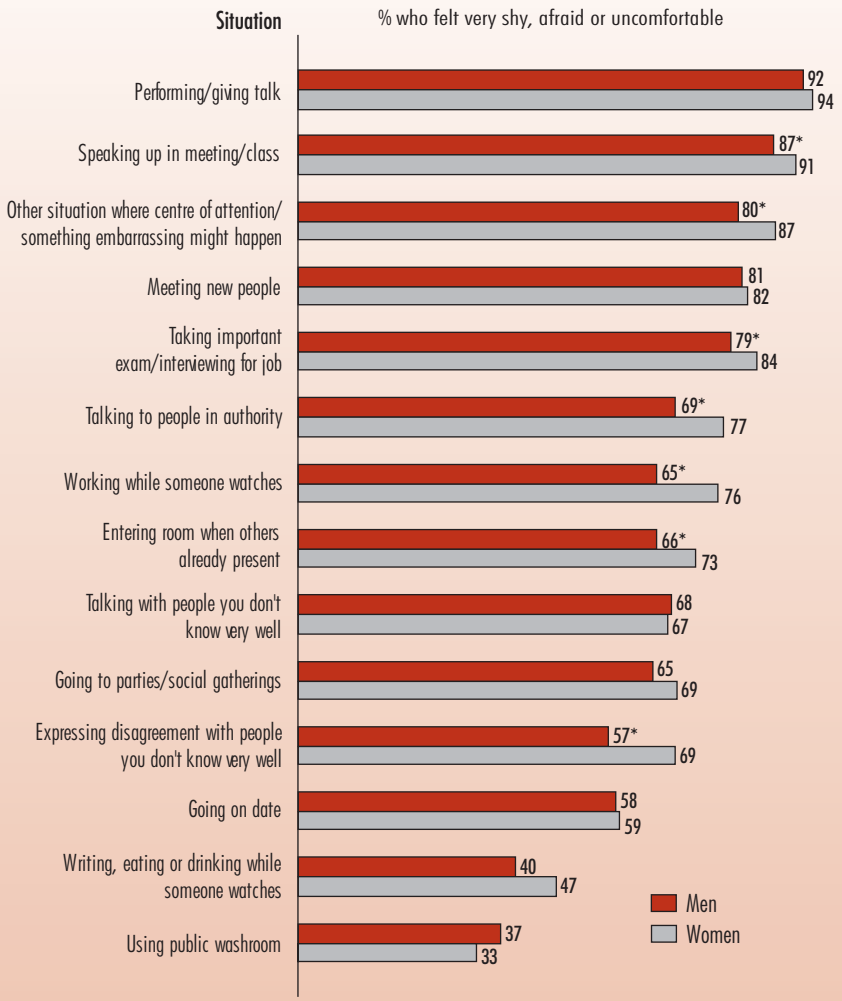
A striking feature of social anxiety disorder is its early age of onset: symptoms typically begin appearing in childhood or early adolescence. CCHS respondents were asked to report the age at which they first strongly feared or avoided social or performance situations. Among those with a lifetime history of social anxiety disorder, the average age of onset was 13; only 15% reported that symptoms first began after age 18. By contrast, the first symptoms of two other common disorders—panic disorder and depression—were evident much later, at ages 25 and 28, respectively.

Along with its early onset, social anxiety disorder can be a long-standing problem. Many studies have found that symptoms persist for years, often for two decades or longer.[5] Among CCHS respondents with a lifetime history of the disorder, the average duration of symptoms was 20 years. This underestimates the true burden of the disorder, because many were still suffering from it at the time of the survey.

### Social anxiety disorder more common among women

In 2002, women were more likely than men to have social anxiety disorder—both lifetime and current. The ratio

## CST Major triggers of shyness, fear and discomfort for people with social anxiety disorder




Note: Estimate for each situation excludes respondents who indicated situation did not apply. Household population aged 15 or older, Canada excluding territories.

* Significantly lower than estimate for women ($p<0.05$).

Source: Statistics Canada, Canadian Community Health Survey: Mental Health and Well-being, 2002.

of the rates of women to men was 1.2 for lifetime social anxiety disorder and 1.3 for current (past 12 months). This is consistent with other community and clinical studies, which have generally found rates for women to be higher.[6]

Young people aged 15 to 24 were more likely to have current social anxiety disorder (4.7%) than the middle-aged (3.1%), while individuals aged 55 or older were less likely (1.3%), a pattern also evident in other countries.[7] The CCHS lifetime rates were similar among those aged 15 to 54, after which they dropped off noticeably. It has been suggested that this may result from a cohort effect; that is, people born in the more distant past were less likely to develop social anxiety disorder than more recent cohorts. It is difficult to substantiate this theory, though, because prevalence information for previous decades is lacking. It is also possible that people with social anxiety disorder die at younger ages, or that the elderly may not recall symptoms of the disorder.

### Married people less likely to suffer from social anxiety disorder

In 2002, the prevalence of social anxiety disorder was higher among people who had never married or who were divorced or separated (both 5.0%) than among married individuals (2.5%). Such relationships with marital status have been found in other studies,[8] and it is believed that the early onset of social anxiety disorder hinders the development of social skills, making marriage, or a successful marriage, less likely.

It is also thought that failure to acquire social skills early in life hampers educational success,[9] a finding supported by the CCHS. Individuals who had not completed their secondary or postsecondary education were more likely to have social anxiety disorder than were postsecondary graduates. In the case of postsecondary students, dropping out of school may relate to fears or discomfort surrounding a new social environment, such as starting another school and/or living in a city away from home.

### Social anxiety disorder more prevalent in lower income households

According to the 2002 CCHS, social anxiety disorder was more prevalent among individuals living in lower income households. Furthermore, people who reported symptoms of social anxiety disorder in the past 12 months were less likely to have jobs, and those who did have jobs had lower personal incomes. This may partly result from the lower educational levels for people with social anxiety disorder, as well as difficulties remaining in a job that demands a fair amount of social interaction.[10] People with social anxiety disorder were also more likely

to be financially dependent. In 2002, 10% of those who had current symptoms lived in households reporting income from social assistance or welfare in the past 12 months, compared with 4% for people with no history of the disorder. These CCHS findings regarding financial dependence are consistent with those of other studies.[11]

## Social anxiety disorder associated with other conditions

Substantial evidence indicates that social anxiety disorder is associated with increased risk of other anxiety, mood, and substance abuse disorders as well as the severity and persistence of these other mental conditions.[12]

People with current social anxiety disorder were over six times as likely as the general population to have a major depressive disorder, and they were three times as likely to suffer from substance dependency. Even individuals who no longer had symptoms remained at increased risk of having these other disorders. The relationship between social anxiety disorder and these other mental conditions persisted when examined in multivariate models that controlled for socio-economic factors.

It is thought that social anxiety disorder is more likely to be related to depression for women and to substance abuse for men.[13] When the CCHS multivariate models tested for an interaction between sex and history of social anxiety disorder, the only significant interaction was for depression. Among those currently reporting social anxiety disorder, men had a higher risk than women of also suffering from depression. In contrast, among those with a past history or no history of the disorder, depression was more prevalent among women.

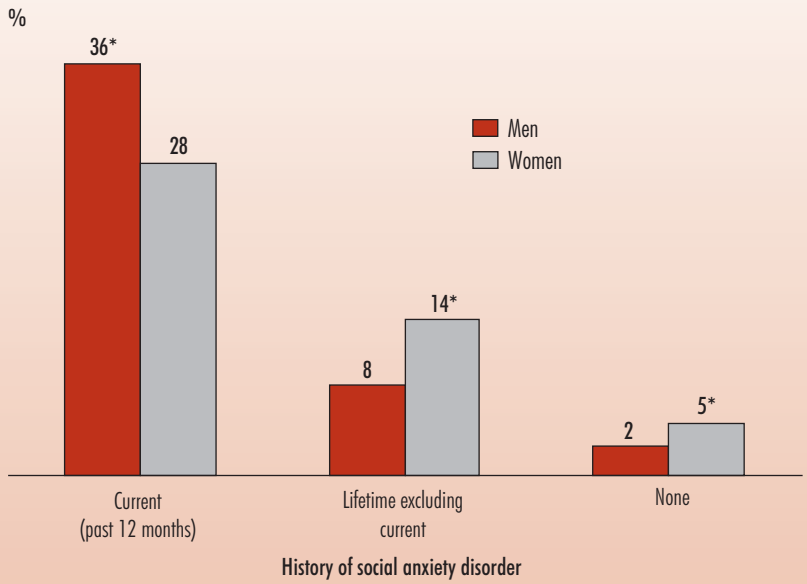
## Other mental disorders often follow social anxiety disorder

According to CCHS data, social anxiety disorder often precedes other mental disorders. In 2002, respondents with a lifetime history of social anxiety disorder and major depressive disorder reported that the symptoms of social anxiety occurred first in about 7 of 10 cases (69%). The age of onset for both disorders was the same in 13% of cases.

When individuals had lifetime histories of social anxiety disorder and panic disorder, social anxiety was evident at a younger age for 59%, and the age of onset was the same for both panic and social anxiety approximately one-quarter of the time.

Although it has not been studied extensively, an association between social anxiety disorder and physical illness has been found.[14] CCHS respondents with current social anxiety disorder reported an average of 1.5 physical chronic conditions, significantly higher than the average number reported for those with a past history (1.2) or no history (1.1).

**CST Among those with current social anxiety disorder, men were more likely than women to have had a major depression**



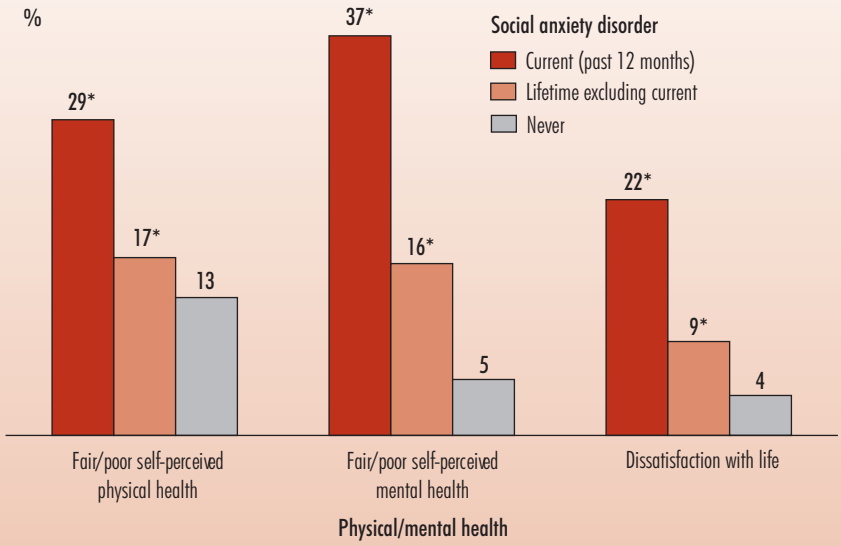

Note: Household population aged 15 or older, Canada excluding the territories.
* Significantly higher than estimate for opposite sex ($p<0.05$).
Source: Statistics Canada, Canadian Community Health Survey: Mental Health and Well-being, 2002.

## People with social anxiety disorder lack social support

Previous studies have found that social anxiety disorder is associated with social isolation, disability, and reduced quality of life. CCHS data provide further evidence of these associations.

Four types of social support were measured in the CCHS: tangible support, affection, positive social interaction, and emotional or informational support. Tangible support is the most concrete type, and involves having someone to provide help when you need it— for example, if you are confined to bed or need someone to take you to the doctor, prepare meals, or help with daily chores. Affection is having someone who shows you love and affection, gives you hugs, or loves you and makes you feel wanted. Having someone to relax or have a good time with, or who helps get your mind off things, provides positive

**CST** **Those with current social anxiety disorder are seven times more likely to report fair/poor mental health than those who have never experienced the disorder**




Note: Household population aged 15 or older, Canada excluding the territories.

* Significantly higher than estimate for "never" ($p < 0.05$).

Source: Statistics Canada, Canadian Community Health Survey: Mental Health and Well-being, 2002.

social interaction. Emotional or informational support comes from people who understand you and your problems, who can give you advice, and share your worries and fears.

Based on CCHS data, people with social anxiety disorder lack adequate social support. Compared with individuals with no history of the disorder, those who currently had it were over twice as likely to have low levels of each type of support. Although the situation was somewhat better for people who no longer had symptoms, they were still more likely to have low social support, compared with those who had no history of the disorder. Clinical studies have found that people with social anxiety disorder actually want social contact, but their fear of interacting prevents this from happening and leads to social isolation.[15] The early age of onset makes it particularly difficult to establish and maintain meaningful relationships.

## Activity limitations more common

Compared with people with no history of the disorder, those with current social anxiety disorder were over twice as likely to report a long-term activity limitation. This means that they were limited in what they could do at home, school, or work or in leisure time because of a long-term physical or mental condition or health problem. They were also over two times as likely to report at least one disability day over the past two weeks; that is, they had spent at least one day in bed, or had cut down on their usual activities because of illness or injury.

Differences in disability days due to mental or emotional health problems or use of alcohol or drugs were even more pronounced. People with current social anxiety disorder were over 10 times more likely to report at least one disability day in the past two weeks due to mental health, compared with those with no history of the disorder. Individuals who previously had social anxiety disorder were more likely to report long-term activity limitations and disability days in the past two weeks compared with those with no history of the disorder, although their impairment rates were substantially below those of people who currently had the disorder.

## Dissatisfaction with life and health

People with social anxiety disorder tended to have a lower quality of life, as indicated by their rather negative perceptions of their own health and their dissatisfaction with life. Close to 30% of people who currently had social anxiety disorder rated their physical health as fair or poor, compared with 17% of those who previously had the disorder, and 13% of those with no history of it. More than a third of people (37%) with current social anxiety disorder rated their mental health as fair or poor, compared with 16% who previously had the disorder and 5% with no history of the condition.

Dissatisfaction with life in general was also related to social anxiety disorder. More than 20% of people with current symptoms indicated that they felt dissatisfied, compared with 9% of people with a past history and 4% of those with no history.

## Measuring the burden

The relationship between social anxiety disorder and social support, disability, perceptions of physical and mental health, and satisfaction with life persisted even after the effects of socio-economic characteristics (sex, age, marital status, education and income) were taken into account. When measures of major depressive disorder, panic disorder, substance dependency and other physical chronic conditions were introduced, the strength of the relationships did diminish, but in most cases, the associations remained statistically significant.

The appropriateness of controlling for other conditions and disorders when attempting to measure the burden of social anxiety disorder has been debated. In most cases, social anxiety disorder develops before other mental disorders, although a cause-and-effect relationship has not been established.[16,17] Nonetheless, some researchers have hypothesized that causal pathways may exist. For example, many people with social anxiety disorder use alcohol or drugs to help them cope, and this may lead to abuse or dependency.[18] In addition, the social isolation associated with social anxiety disorder and failure to achieve education and employment goals may increase the risk of depression.

The findings based on CCHS data are particularly relevant because, even when other mental and physical health problems are taken into account, the odds for all 10 outcome variables were elevated among people with current social anxiety disorder.

## Majority do not seek treatment

People with a lifetime history of social anxiety disorder were asked if they had ever seen or talked on the telephone to a doctor, psychologist, psychiatrist, social worker or other professional about their fear or avoidance of social situations. The majority had not. Only 37% reported that they had sought professional treatment, far below the rates for major depressive disorder (71%) or panic disorder (72%). Just 27% of individuals with current social anxiety disorder (those who reported having symptoms in the past 12 months) had received professional help in the past year. Those who did seek treatment often waited years before doing so. Among CCHS respondents with a lifetime history of social anxiety disorder, help was sought, on average, 14 years after the age of onset. These low treatment rates for social anxiety disorder are consistent with findings from other studies.[19]

Failure to seek treatment may be directly related to the nature of social anxiety disorder. Because of their extreme social fears, people may be reluctant or embarrassed to discuss their symptoms with a health care professional; in fact, the effort of contacting and meeting such a professional face-to-face may be extremely difficult for someone with social anxiety disorder. As well, individuals with the disorder often attribute their intense fears to shyness. Because they are not aware that they have a recognized mental disorder, they do not consider professional help.

CCHS results, like those of other studies, indicated that seeking treatment for social anxiety disorder was far more likely if the person had another mental disorder. Among individuals with a lifetime history of both social anxiety and another mental disorder, 51% had sought professional treatment for their social fears—more than twice the rate for those with social anxiety alone (25%). The gap was even broader among those who had sought treatment in the past year: 43% of people with social anxiety in addition to another disorder reported receiving professional treatment versus 16% of individuals with social anxiety disorder alone.

The low treatment rates for social anxiety disorder and the number of years people wait before seeking treatment are troublesome given that, in many cases, the disorder can be treated successfully. In fact, among CCHS respondents who did have professional help, the majority (69%) felt that their treatment was helpful and effective.

## Summary

Social anxiety disorder has been described as an "illness of lost opportunities." Results from the 2002 Canadian Community Health Survey: Mental Health and Well-being provide further evidence supporting this description. The disorder often begins in childhood or early adolescence: the self-reported average age of onset established using the CCHS data is 13. And symptoms persist—an average of two decades among CCHS respondents with a lifetime history of the condition.

This study of national data found that social anxiety disorder is related to lower educational attainment, reduced employment opportunities, low income and dependence on welfare or social assistance, decreased likelihood of marriage or of having a successful marriage, and social isolation. It is also associated with higher rates of disability, rather negative perceptions of physical and mental health, and dissatisfaction with life.

Although effective treatment is available, most people with social anxiety disorder do not seek professional help to deal with their fears. The effort and commitment required to start and maintain a formal treatment program can be extremely challenging for patients with social anxiety disorder, and if that initial hurdle can be overcome, finding a trained professional may be difficult. However, other studies suggest that early intervention and treatment may not only allow people with this disorder to realize their full potential, but it may also prevent subsequent mental disorders.

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# KEEPING TRACK

## Postsecondary education: Who leaves and why

About one out of every seven young people aged 20 to 22 who had attended a postsecondary institution at some point in their life had left for one reason or another by December 2001.

Almost one in three reported that they left because they didn't like their program or felt that the program was not for them. A further 9% reported that their main reason for leaving was to change programs or institutions.

Leavers were also less likely to have higher grades during their first year of university or college. For example, only 18% of leavers reported an overall postsecondary grade average of 80% or more, less than half the proportion (37%) of those who did not leave.

When asked at the age of 18 to 20 what barriers they might see preventing them from pursuing further education, about one-third of both leavers and non-leavers responded that it was financial barriers that would get in their way.

**Who Pursues Postsecondary Education, Who Leaves and Why: Results from the Youth in Transition Survey**

*Catalogue no.* 81-595-MIE2004026

## Smoking: one step forward, one step back

According to the National Population Health Survey, the proportion of daily smokers who quit has risen steadily over four successive two-year periods since the mid-1990s. The study showed that between 1995 and 1997, about 10% of daily smokers quit. By the two-year period between 2001 and 2003, this proportion had increased to almost 17%.

Smoke-free environments were strongly related to cigarette consumption levels. Men who smoked daily but lived in a smoke-free home averaged 14 cigarettes a day, compared with 20 a day for those who did not live in smoke-free homes. For women, the corresponding numbers were 10 and 16.

Men and women who had their first cigarette within 30 minutes of waking were less likely to quit than those who waited for more than an hour. For men, the odds of quitting were 40% lower for those who had their first cigarette within 30 minutes, and for women there was a 30% reduction in the odds of quitting.

**Healthy Today, Healthy Tomorrow? Findings from the National Population Health Survey**

*Catalogue no.* 82-618-MWE

## Alcohol and illicit drug dependence

In 2002, an estimated 641,000 people, or about 2.6% of the population aged 15 or older, reported symptoms suggesting that they were dependent on alcohol. In addition, 194,000 people, or just under 1% of the adult population, had symptoms that suggested dependence on illicit drugs.

The two most common symptoms of alcohol dependence reported by heavy monthly drinkers were being drunk or hung over at work or school or while taking care of children, and drinking much more than they had intended. The symptom of dependence reported by monthly illicit drug users was taking drugs in larger amounts than intended, followed by increased tolerance, and withdrawal.

More than a quarter (26%) of people who were dependent on illicit drugs had had a major depressive episode in the past year, a significantly high rate compared with those who had not used such drugs. Even those who reported using illicit drugs less than once a month had elevated levels of depression. As well, 15% of people who were dependent on alcohol had had a major depressive episode in the past year, a significantly high rate compared with those who had not done any heavy drinking in that time.

**How Healthy Are Canadians? — Annual Report 2004**

*Catalogue no.* 82-003

## Victim services

Victim service agencies across Canada helped almost 360,000 people affected by crime in 2003, according to Victim Services Survey. A one-day survey snapshot, taken on October 22, 2003, showed that more than three-quarters of the people who sought assistance were victims, either directly or indirectly, of violent crime, and the majority were women or girls.

Not counting those affected by homicide and victims of criminal harassment, one-half of the people served that day were victims of a violent crime committed by a family member, spouse, ex-spouse or intimate partner.

About 33% had been victimized by a spouse, ex-spouse or intimate partner, while an additional 18% were victimized by a family member other than a spouse.

**Victim Services in Canada**

Vol. 24, no. 11

*Catalogue no.* 85-002

# SOCIAL INDICATORS

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|
| **LABOUR FORCE** | | | | | | | | |
| Labour force ('000) | 15,059 | 15,297 | 15,575 | 15,842 | 16,111 | 16,580 | 16,954 | 17,183 |
| Total employed ('000) | 13,677 | 14,019 | 14,390 | 14,759 | 14,947 | 15,308 | 15,665 | 15,950 |
| Men | 7,458 | 7,606 | 7,794 | 7,970 | 8,035 | 8,182 | 8,344 | 8,480 |
| Women | 6,219 | 6,414 | 6,596 | 6,789 | 6,912 | 7,126 | 7,321 | 7,470 |
| Workers employed part-time (%) | 19.1 | 18.8 | 18.4 | 18.1 | 18.1 | 18.8 | 18.9 | 18.5 |
| Men | 10.6 | 10.5 | 10.3 | 10.3 | 10.5 | 11.0 | 11.1 | 10.9 |
| Women | 29.4 | 28.7 | 27.9 | 27.2 | 27.0 | 27.7 | 27.9 | 27.1 |
| Involuntary part-time | 31.2 | 29.2 | 26.8 | 25.3 | 25.8 | 26.9 | 27.6 | 26.7 |
| Looked for full-time work | 10.6 | 10.1 | 9.1 | 7.5 | 7.5 | 8.1 | 8.8 | 8.3 |
| % of women employed whose youngest child is under 6 | 15.7 | 15.1 | 14.8 | 14.4 | 13.8 | 13.4 | 13.0 | 12.9 |
| % of workers who were self-employed | 17.2 | 17.3 | 17.0 | 16.2 | 15.2 | 15.1 | 15.3 | 15.4 |
| % of employed working over 40 hours per week | 17.5 | 17.5 | 16.9 | 16.4 | 15.9 | 15.2 | 15.1 | 15.7 |
| % of workers employed in temporary/contract positions | 9.3 | 9.7 | 10.0 | 10.5 | 10.8 | 11.0 | 10.5 | 10.8 |
| % of full-time students employed in summer | 45.4 | 46.9 | 48.4 | 50.5 | 50.8 | 52.3 | 53.1 | 52.5 |
| Unemployment rate (%) | 9.2 | 8.4 | 7.6 | 6.8 | 7.2 | 7.7 | 7.6 | 7.2 |
| Men aged 15-24 | 17.2 | 16.6 | 15.2 | 13.8 | 14.5 | 15.3 | 15.3 | 14.9 |
| 25-54 | 8.0 | 7.3 | 6.5 | 5.8 | 6.3 | 6.9 | 6.6 | 6.1 |
| Women aged 15-24 | 15.2 | 13.6 | 12.7 | 11.4 | 11.1 | 11.7 | 11.8 | 11.8 |
| 25-54 | 7.8 | 7.0 | 6.4 | 5.8 | 6.0 | 6.2 | 6.3 | 5.9 |
| Population with high school or less | 12.2 | 11.3 | 10.3 | 9.4 | 9.7 | 10.3 | 10.2 | 9.7 |
| Population with postsecondary certificate or diploma | 7.5 | 6.6 | 5.9 | 5.2 | 5.8 | 5.9 | 5.8 | 5.6 |
| Population with university degree | 4.8 | 4.4 | 4.3 | 3.9 | 4.6 | 5.1 | 5.4 | 4.9 |
| **EDUCATION** | | | | | | | | |
| Total enrolment in elementary/secondary schools ('000) | 5,386 | 5,370 | 5,442 | .. | .. | .. | .. | .. |
| Secondary school graduation rate (%) | 76.3 | 76.0 | 76.3 | 77.1 | 76.9 | .. | .. | .. |
| Postsecondary enrolment ('000) | | | | | | | | |
| Community college, full-time | 398.6 | 403.5 | 408.8 | .. | .. | .. | .. | .. |
| Community college, part-time | 91.6 | 91.4 | 85.4 | .. | .. | .. | .. | .. |
| University, full-time | 573.1 | 580.4 | 593.6 | 607.3 | 635.6 | .. | .. | .. |
| University, part-time | 249.7 | 246.0 | 254.9 | 243.2 | 251.1 | .. | .. | .. |
| Community college diplomas granted ('000) | 91.4 | 88.4 | .. | .. | .. | .. | .. | .. |
| Educational attainment of 25- to 54-year-olds (%) | | | | | | | | |
| Less than high school graduation | 18.7 | 17.9 | 17.2 | 16.1 | 14.9 | 14.3 | 13.4 | 12.9 |
| High school graduation | 20.7 | 20.7 | 20.9 | 21.2 | 20.7 | 20.9 | 20.1 | 20.1 |
| Some postsecondary | 8.1 | 8.1 | 7.9 | 8.2 | 7.8 | 7.7 | 8.1 | 8.0 |
| Postsecondary certificate or diploma | 33.5 | 33.9 | 33.9 | 33.6 | 34.9 | 34.9 | 35.3 | 35.8 |
| University degree | 18.9 | 19.4 | 20.1 | 21.0 | 21.7 | 22.2 | 23.1 | 23.3 |

.. not available for a specific reference period

Sources: Statistics Canada, Labour Force Survey and Centre for Education Statistics.

# LESSON PLAN

**Suggestions for using *Canadian Social Trends* in the classroom**

## "Always the bridesmaid: People who don't expect to marry"

### Objectives

- To explore the importance of marriage to the next generation of potential husbands and wives.

**Curriculum areas**: Family studies, social studies.

### Classroom instructions

1. Survey the class to determine what percentage of the class expects to marry. Discuss the reasons why some expect to marry while others do not.
2. People marry for many reasons in addition to love; among other things, they want financial security, social status, a partner with whom to have children, and someone with whom to share decision-making and household labour. Make a list of the criteria that you think are important in choosing a compatible husband or wife. What factors are most important?
3. Mature singles who don't expect to marry do not believe that settling down is important to their personal happiness. But a cross-sectional (snapshot) survey like the General Social Survey on which this study is based cannot tell if people have always felt this way, or if their views have changed over time. For instance, someone who has always been very content having close friends, satisfying work or fulfilling hobbies may never have felt that being married would make them more happy; on the other hand, someone who has had a rough time finding a spouse may have decided to withdraw from the "marriage market" in order to avoid further disappointment. What factors would contribute to unmarried people changing their marital intentions as they grow older? Explain the reasons for your answer.
4. Divorce has made many people hesitant to marry. Nevertheless, they still want the love and companionship that comes from being part of a couple; in fact, many people who refuse to marry are perfectly happy to live common-law with someone. Discuss whether being together and being married are different or the same thing.

### Using other resources

See the Family Studies kit at www.statcan.ca/english/kits/Family/intro.htm

To find lesson plans, articles and data for elementary and secondary schools, check the Statistics Canada Web site at www.statcan.ca/english/kits/teach/htm. There are more than 150 lesson plans for high school classes, many articles, E-STAT access and other data.

### Educators

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