

Is Spousal Caregiving Associated With Enhanced Well-Being? New Evidence From the Panel Study of Income Dynamics

Vicki A. Freedman,¹ Jennifer C. Cornman,² and Deborah Carr³

¹Institute for Social Research, University of Michigan, Ann Arbor, Michigan.

²Jennifer C. Cornman Consulting, Granville, Ohio.

³Department of Sociology and Institute for Health, Health Care Policy & Aging, Research Rutgers University, New Brunswick, New Jersey.

Objectives. We explore whether spousal caregiving is associated with enhanced well-being for older husbands and wives.

Method. We use time diary data from the 2009 Panel Study of Income Dynamics and Disability and Use of Time supplement. We measure experienced well-being as ratings of happiness and frustration during activities recalled for the previous day. We estimate separately for husbands and wives 3 distinct effects on experienced well-being: having a spouse with a disability; doing household or personal care tasks (“chores”) for someone other than a spouse with a disability; and doing such tasks for a spouse with a disability (“care”).

Results. For husbands, neither care status nor spouse’s disability status are associated with experienced well-being. In contrast, for wives, carrying out chores is associated with *lower* reports of happiness compared with other activities and providing care to one’s husband is associated with *greater* reports of happiness than carrying out chores.

Discussion. For women, chores such as meal preparation, laundry, and cleaning—but not caregiving per se—are associated with worse experienced well-being than other activities. Findings underscore that there are positive aspects of spousal caregiving for older wives that offset the innately unpleasant nature of household tasks.

Key Words: Caregiving—Experienced well-being—Disability.

UNPAID caregivers, most often family members, provide the bulk of assistance with daily activities to older Americans (Federal Interagency Forum on Aging-Related Statistics, 2012; Spillman & Pezzin, 2000). Among older couples, spouses are first in line to provide care despite the fact that many spouses may be experiencing declines in health themselves (Cantor, 1979). An unresolved issue in the caregiving literature is whether the provision of support to a spouse is beneficial or harmful to the care provider’s well-being. Most studies document the diminished well-being of caregivers, particularly women (Lin, Holly, & Wu, 2012; Pinqart & Sörensen, 2003, 2006), although some recent studies have found that older caregivers have better physical, emotional, and cognitive health outcomes and reduced mortality relative to noncaregivers (Bertrand et al., 2012; Brown et al., 2009; Fredman et al., 2010a; Fredman, Doros, Cauley, Hillier, & Hochberg, 2010b). The latter work suggests that positive aspects of caregiving may provide a sense of meaning, emotional closeness, and purpose for the caregiver (e.g., Boerner, Schulz, & Horowitz, 2004) and is consistent with a largely separate body of research that suggests beneficial effects on well-being of altruistic behaviors, including helping family members (Brown, Nesse, Vinokur, & Smith, 2004; Post, 2007).

A number of methodological and measurement issues may account for these equivocal findings. First, defining and operationalizing “spousal care” is challenging; inconsistent or imprecise measures across studies may yield conflicting or misleading findings. Studies that ask individuals to enumerate hours of care over some recent time period (e.g., last week or month) may provide an incomplete assessment of hours if spouses do not perceive their activities to be “care,” per se (Bittman, Fast, Fisher, & Thomson, 2004). For instance, wives who have always cooked dinner may continue doing this chore after their husbands develop debilitating conditions and may not view time spent preparing meals to be “care” work. Traditional diary-based measures, which obtain data on the specific activities performed over a 24-hr period, also are problematic because they do not typically identify *why* or *for whom* household activities are carried out. For instance, a husband may do the laundry for himself, or for his (fully able) wife (i.e., chore), or for his wife with a disability who is incapable of doing the task herself (i.e., care).

Second, unlike studies of altruism and helping behavior, the caregiving literature has often focused on samples of active and/or intense caregivers only, thereby restricting comparisons with those not providing care. Such studies

confound *for whom* the activity is done with *what* is done, typically a combination of household chores and personal care tasks. Studies examining experienced well-being for older adults suggest that household chores in particular are less enjoyable than many other activities (Smith, Ryan, Becker, & Gonzalez, 2011). These empirical findings are consistent with feminist writings on housework, which point out that the least satisfying tasks are those that need to be done continually and daily (e.g., cooking, house cleaning) as opposed to sporadic task-based projects that may evince a sense of completion and success (e.g., household repairs). The former tasks are typically performed by wives, whereas the more occasional home maintenance tasks are typically performed by husbands (Hook, 2010). Consequently, it remains unclear whether the act of caring for a spouse with a disability erodes (or enhances) well-being or whether the nature of the tasks and activities that commonly constitute caregiving does so.

Third, with few exceptions, studies of well-being do not distinguish between the psychological consequences of having a relative who *needs care* versus *providing care* to that particular relative. Thus, the purported effects of caregiving may capture both the strains of providing direct care, as well as the distress “caused by the decline and impending death of someone they love” (Schulz, O’Brien, Bookwala, & Fleissner, 1995, p. 788). One study that distinguishes these two effects found that having a relative who needs care is more important than actually providing care in determining a potential caregiver’s well-being (Amirkhanyan & Wolf, 2003).

Fourth, studies that have explored well-being often have examined evaluative measures of life satisfaction or decontextualized affect measures (how happy are you?) and how they vary with caregiving intensity, typically measured as care given over the last week or month. Studies comparing such evaluative measures with diary-based measures conclude that individuals may rely on general beliefs about experiences rather than true moment-to-moment experiences in such assessments (Schwarz, Kahneman, & Xu, 2009). Yet with few exceptions, experienced well-being of older caregivers has not been explored (Bittman et al., 2004; Poulin et al., 2010).

Finally, most caregiving literature has focused on negative outcomes, such as depressive symptoms, poor self-rated health, anxiety, perceived burden, and mortality risk. Far less emphasis is placed on positive outcomes such as self-worth, increased closeness in relationships, or feeling useful (Kramer, 1997; Marks, Lambert, & Choi, 2002; Raschick & Ingersoll-Dayton, 2004). Studies that have examined positive aspects find that caregiving is associated with feeling purposeful (Marks et al., 2002), feeling good about oneself and appreciating life more (Lin et al., 2012), and feeling a sense of fulfilling obligations or a sense of duty (Cohen, Colantino, & Vernich, 2002). The inclusion of positive outcomes also may reconcile some of the previously noted

differences that are reported in the caregiving and helping/altruism literatures.

In this study, we use nationally representative time diary data for older couples to explore the circumstances under which caring for one’s spouse is associated with positive and negative experienced well-being. Unlike prior studies, the diary-based data that we use allow distinctions among having a spouse with a disability, providing spousal care (doing a household or personal care activity *for a spouse with a disability*), and doing “chores” (household activities not related to a spouse’s health or functioning). The diaries also offer an opportunity to understand experienced (as opposed to evaluative) well-being. Because data are from couples we are able to explore differential patterns for husbands and wives. Results from this study may offer new insights into the aspects of spousal caregiving that influence experienced emotion and, in turn, potentially contribute to formulation of new approaches to enhancing well-being in later life.

Conceptual Framework and Hypotheses

Figure 1 summarizes our conceptualization of the effects of caregiving on experienced well-being. We adopt the approach suggested by Amirkhanyan and Wolf (2003) and differentiate the effects of having a spouse with a disability from the effects of providing care to a spouse with a disability. A close relative’s poor health status can produce stress or negative psychological outcomes for an individual even if that individual is not the primary caregiver of the sick relative. For example, one may feel guilty for not providing care, sadness over the relative’s condition, or frustrated with how the family is responding (Amirkhanyan & Wolf, 2003). We therefore hypothesize that having a spouse with a disability, whether care is provided, will have a negative effect on experienced well-being (e.g., inversely associated with happiness but positively correlated with frustration).

Consistent with the literature on time use, we expect that household chores will be less enjoyable than other activities (Smith et al., 2011). We therefore expect lower happiness and higher frustration when carrying out chores including meal preparation, cleaning, and laundry, irrespective of the caregiving context (Hook, 2010).

The literature also suggests a complex relationship between gender and well-being (George, 2010) and between caregiving and well-being (Pinquart & Sörensen, 2003, 2004). Many studies find that the costs of caregiving are greater for women than for men (Pinquart & Sörensen, 2006; Yee & Schulz, 2000) and that women are more likely to report stress or negative experiences in relation to caregiving, whereas men are more likely to report positive experiences, although some of these findings depend on who the caregiver is in relation to the care recipient (Lin et al., 2012). Some literature suggests that the role of caregiver is more salient to the identities of women relative to men and that women have higher expectations for the quality of the

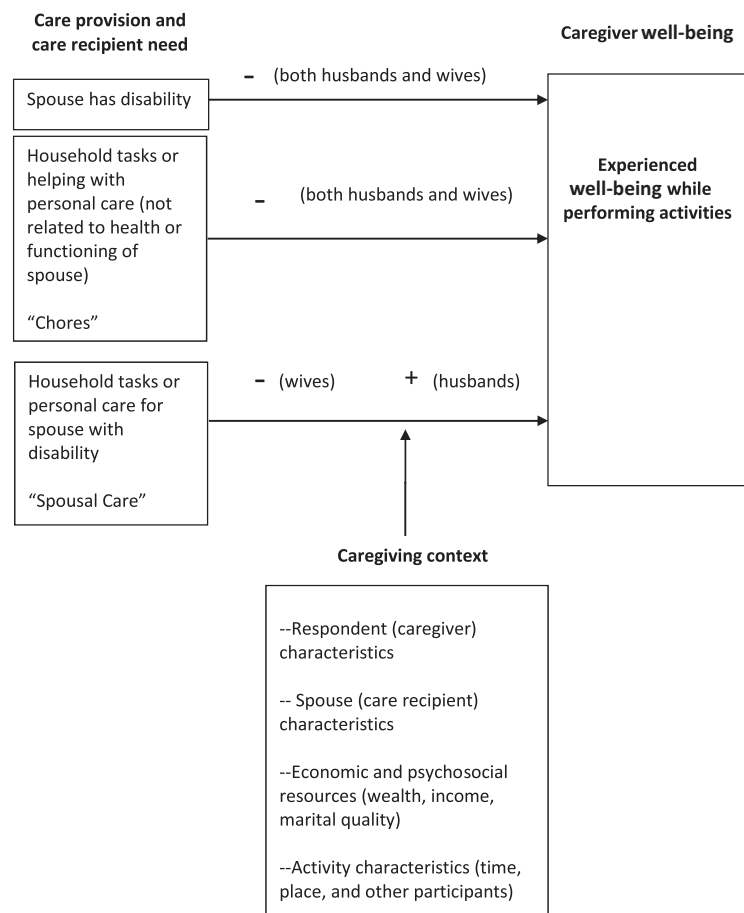


Figure 1. Components of caregiving and hypothesized effects on well-being.

care they deliver (e.g., Miller & Cafasso, 1992); as such, caregiving may be more distressing for women. We therefore expect spousal caregiving to have a negative effect on well-being for women (e.g., caregiving will be negatively associated with happiness and positively associated with frustration) but a positive effect for men (e.g., caregiving will be positively associated with happiness but negatively associated with frustration).

Men and women also differ in emotional reactivity, with women typically evidencing stronger reactions than men. For example, in a study of gender differences in emotional responses to interpersonal tensions within one's social network, Birditt and Fingerman (2003) find that women experience distress and express emotions more intensely than men. Likewise, Chentsova-Dutton and Tsai (2007) show that, when reliving emotional events, women report feeling love and anger more strongly than men. In relation to caregiving more specifically, Calasanti and King (2007) find that when coping with the stress of caregiving and the sorrow of a spouse's health decline, men tend to adopt strategies whereby they block or repress their emotions and focus on the caregiving tasks that need to be done. By contrast, women tend not to separate emotions and tasks. In light

of these findings, we also hypothesize that the effect of caregiving on experienced well-being will be stronger for women than for men.

Finally, our framework acknowledges that caregiving occurs in a context that is shaped by social and health characteristics of the caregiver and care recipient, social psychological and economic resources, and the context (time, place, and other participants) of the particular caregiving activities. Although we do not have specific hypotheses about the effects of these potential confounds on the caregiving–well-being relationship, previous research has shown that such factors are related to caregiver well-being and, in some cases, account for the association between the provision of care and well-being. (see, e.g., reviews and analyses by Kramer, 1997; Lin et al., 2012; Pinquart & Sörenson, 2003, 2006).

METHOD

Data

Data for this study are from the Disability and Use of Time (DUST) supplement to the 2009 Panel Study of Income Dynamics (PSID). Begun in 1968, the PSID is a

longitudinal study of a representative sample of families in the United States, including an oversample of low-income families. From 1968 to 1997, families were interviewed annually, and since 1997, interviews have been conducted biennially. Reinterview rates have been consistently 98% per year (96% over 2 years) and the sample of families now exceeds 8,000. Because adult children who have left their parents' households have been followed, with sampling weights, the design produced a nationally representative cross-section of families each year.

The DUST supplement was administered separately to husbands and wives in eligible married couples (both spouses at least aged 50 and at least one spouse aged 60 or older) by telephone within a few months following the 2009 core PSID interview. In order to enhance opportunities for studying disability, couples in which one or both spouses had a chronic condition that limited their daily activities (who were identified in the core PSID interview) were oversampled and strata further divided by the husband's age (<70, 70+).

The DUST telephone interview was designed as a 24-hr diary, which was paired during the first of two interviews with a supplemental questionnaire on health and functioning. In order to obtain a balanced sample of days, couples were systematically assigned interview days that would yield one weekday diary and one weekend diary. Hence, up to four diaries could be completed per couple. The diary portion of the interview asked about all the activities occurring on the previous day, beginning at 4:00 a.m. and continuing until 4:00 a.m. the morning of the interview. At the end of the diary, respondents were asked more detailed questions about how they felt while doing up to three randomly selected activities, a validated approach to measuring experienced well-being known as the Day Reconstruction Method (Kahneman, Krueger, Schkade, Schwarz, & Stone, 2004; Krueger, 2007).

Of the 543 eligible couples who were sampled for DUST, at least one diary was completed for 394 couples, yielding a response rate of 73%. In addition, 33 respondents (4%) had a spouse who could not participate because of a permanent health condition (e.g., memory loss, hearing loss). For these couples, diaries were collected from the one spouse who was able to participate. The sample for analyses of well-being yesterday included 4,392 randomly selected diary activities (2,140 from 371 men and 2,252 from 384 women).

Measures

Diary-based approach to care status yesterday.—During the diary interview, activities were reported in open text fields, which were later coded by trained staff using an extensive three-digit lexicon. The first digit refers to a broad “supercategory,” for instance, household activities. The second digit further classifies the activity into a more specific

category (e.g., food and drink preparation), and the third digit further refines the classification into detailed subcategories (e.g., kitchen and food cleanup). Only 1 of the 4,392 activities could not be coded (and was assumed consistent with the modal response to be neither care nor chore). For details on coding and editing rules, see Freedman and Cornman (2012).

We included 18 household and care activities (subcategories) when developing the care status measure: grocery shopping; food and drink preparation; kitchen and food cleanup; laundry and repairing clothing; other laundry-related activities; indoor cleaning (except laundry); indoor maintenance and repair; outdoor cleaning; outdoor maintenance and repair; other household chores; vehicle repair and maintenance; appliance setup, repair, and maintenance; financial management; banking; physical care for someone else; looking after someone else; other caring-related activities; and providing medical care to someone else.

For each household and care-related activity, respondents were asked for whom the activity was carried out. Based on these reports, the activity was categorized as being done only for self/someone other than spouse with disability (“chore”) or done (also or only) for spouse with a disability (“care”). Out of 788 household and care activities, 58 (7%) were missing information on for whom the activity was carried out. In these cases, we assumed (consistent with the modal response) that the activity was carried out for only the respondent (a chore).

Experienced well-being.—For up to three randomly selected diary activities, respondents were asked to report experienced well-being, including how happy and how frustrated they felt while completing the activity (Kahneman et al., 2004; Krueger, 2007). Respondents were asked to use a scale from 0 to 6, where 0 meant *the feeling was not present at all* and 6 meant *the feeling was very strong*. Don't know or refused was reported for happiness in six cases and for frustration in two cases; modal responses were assigned accordingly (6 and 0, respectively).

Activities were selected based on three random times assigned to couples. Each random time was drawn from a 4-hr window (8:00 a.m.–11:59 a.m.; 12:00 p.m.–3:59 p.m., and 4:00 p.m.–8:00 p.m.), ensuring distribution throughout the waking day. The activity that included the randomly assigned time was selected for detailed, experienced well-being questions. If respondents were sleeping during that window, a randomly assigned backup time was used instead. Further details are available in Freedman and Cornman (2012).

Spouse's disability status.—We captured spouse's disability status with three measures. First, we created a single dichotomous indicator of whether the husband or wife had a disability based on six items developed for the American Community Survey: whether they had serious difficulties in hearing; seeing even when wearing glasses; concentrating, remembering, or making decisions because of a physical,

mental, or emotional condition; walking or climbing stairs; difficulty dressing or bathing; and difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition (Weathers, 2005). We also created an indicator of severity of underlying impairments (Freedman, Stafford, Schwarz, Conrad, & Cornman, 2012) from questions about common problems in the last 7 days (breathing problems; heart or circulation problems; stomach problems; back or neck problems; limited strength or movement in one's shoulders, arms, or hands; limited strength or movement in one's hips, legs, knees, or feet; low energy or easily exhausted; difficulty remembering everyday things). Husbands and wives who reported an impairment were asked on how many of the last 7 days the impairment limited their activities (none, 1–2 days, 3–4 days, 5 or more days). These items formed a one-factor severity scale (ranging from 0 to 30) with all but one factor loading exceeding .40 (stomach problems, which was retained for completeness). We categorized the severity scale into low, medium, and high tertiles. Finally, in order to capture an approximation of how long care needs may have existed, we drew information from the PSID interviews over the previous 10 years to create a count of the number of years that the spouse has had a limiting chronic condition (with a top code of 10 or more). The 33 cases with no diary interview because of their health or functioning were assumed to have a disability with high severity (duration was available for these cases).

Caregiving context.—As suggested by the conceptual model, we controlled for potential confounders likely to be related to both care status and well-being. Variables included: own and spouse's age group (in three 10-year categories designed to capture the nonlinear association with well-being and the different distributions by gender; see [Supplementary Table 1](#)); own disability and severity of limitations (as previously described); own education (years); race (black vs other); indicators of social engagement outside the home (whether, in the last 7 days, respondents volunteered, socialized with family and friends, or worked); household income quartile; household wealth quartile; marital duration; marital quality (average rating [0–4] for six items reflecting both marital strain and support, with higher scores representing higher quality; Whalen & Lachman, 2000); and characteristics of the activity (e.g., whether the activity was done at home, whether the spouse was actively involved, and whether the activity took place on the weekend [vs weekday]).

Sample characteristics are presented in [Supplementary Table 1](#) and show that compared with wives, husbands are slightly older (69 vs 66 years), are less likely to have a spouse with a disability, socialize less often and work more often, report higher marital quality, and are less likely to carry out activities at home.

Analytic Strategy

We first examined care status, stratifying by gender, by activity type, and overall. Next, we calculated mean happiness and frustration scores by care status for husbands and wives. We then estimated a series of ordinary least square regression models. We first ran an unadjusted model with a contrast between mutually exclusive categories of carrying out “chores” versus other activities and between providing “care” and carrying out “chores.” We then controlled for whether the spouse has a disability. This additional parameter allows us to distinguish *having* a spouse with a disability from *providing care* to a spouse with a disability. Finally, we introduced controls for respondent, spouse, and couple characteristics and characteristics of the day/activity. For each pair of models (husbands, wives), we used seemingly unrelated regression models to test whether there are statistically significant gender differences in the effect of chore/care variables. We also estimated predicted mean well-being by whether an activity was considered to be care, a chore, or neither and by spouse's disability status for the subset of models with significant coefficients at the .05 level.

All analyses were weighted using sampling weights that take into account differential sampling probabilities of DUST respondents. Standard errors in all models have been adjusted for the complex survey design of the PSID and DUST and to account for multiple observations (activities) per person.

RESULTS

Bivariate Analyses

Wives' activities were more likely than their husbands' activities to involve either care or chores. As shown in [Table 1](#), for women, one in four activities could be classified as either care or chores. In contrast, half as many—only 12%—of husbands' activities could be considered care or chores. Care activities were reported nearly 3 times more often among wives than husbands: Only 3.3% of men's activities were care activities compared with 8.6% of women's activities. Chores were reported more often than care and twice as often for wives than for husbands: About 9% of activities for men and 17% for women were chores.

Husbands and wives also engaged in different types of chores and care activities. With respect to chores, husbands most often did household repairs (42.7% of chores by husbands), whereas for women, meal preparation was most common (42.6% of chores by wives). For care activities, men most often made meals (35.1%) or carried out household repairs (26.4%), whereas women most often made meals (58.6%), did laundry (14.8%), or cleaned (13.4%).

Overall, husbands and wives report similar levels of positive and negative experienced well-being (5.1 and 5.0 for happiness, respectively, and 0.8 and 0.9 for frustration; see [Table 2](#)). For men, care status is not related to either happiness

Table 1. Weighted Percentage of “Chore” and “Care” Activities by Gender

	Husbands (<i>n</i> = 2,140)		Wives (<i>n</i> = 2,242)		Total (<i>n</i> = 4,382)	
	Chore	Care	Chore	Care	Chore	Care
Percent of all activities	8.8	3.3	17.2	8.6	13.3	6.1
Percent of chore/care activities						
Laundry	1.8	2.0	15.1	14.8	10.9	11.6
Cleaning	18.6	9.7	14.6	13.4	15.8	12.5
Meal preparation	15.9	35.1	42.6	58.6	34.3	52.6
Shopping/errands	14.0	8.7	3.6	7.5	6.8	7.8
Household repairs	42.7	26.4	12.3	1.6	21.8	7.9
Finance	4.8	8.9	3.2	1.7	3.7	3.5
Physical/medical care	2.1	9.2	8.6	2.3	6.6	4.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
<i>n</i>	205	81	296	204	501	285

Table 2. Experienced Well-Being by Care Status and Gender

	Overall	Care status (any care activity)		
		Neither	Chore	Care
Mean reported happiness (0–6)				
Husbands	5.1 (1.2)	5.1 (1.2)	5.1 (1.3)	4.8 (1.2)
Wives	5.0 (1.2)	5.0 (1.1)	4.6** (1.3)	4.9 (1.4)
Mean reported frustration (0–6)				
Husbands	0.8 (1.5)	0.8 (1.5)	1.1 (2.0)	1.0 (1.6)
Wives	0.9 (1.6)	0.9 (1.6)	1.0 (1.5)	0.7 (1.5)

Notes. *N* = 2,140 for husbands; *N* = 2,242 for wives; standard deviations in parentheses.

***p* < .01 for difference from neither.

or frustration, and for women, care status and frustration are not significantly associated at the .05 level. But for women, doing chores is associated with lower happiness relative to doing other kinds of (noncare) activities (*p* = .005).

Multivariate Analyses

In multivariate models, a similar pattern is observed (top panel, Table 3). For husbands, none of the care effects in the happiness models are statistically significant at the .05 level, before or after introducing controls. For wives, however, doing chores is associated with significantly lower happiness relative to other activities ($\beta = -.48$, *p* = .002). Controlling for the effect of having a spouse with a disability reveals a significant positive effect of providing care relative to chores ($\beta = .42$, *p* = .032, Model W2) on happiness and the negative effect of chores remains unchanged ($\beta = -.49$, *p* = .001, Model W2). Effects remain after introducing additional control variables, with only slight attenuation of the effect size for care versus chores ($\beta = .35$, *p* = .035, Model W3; see Supplementary Table 2 for full models). However, explained variance remains quite low, even in the fully adjusted models (as indicated by an adjusted *R*² of .11), suggesting other factors contribute to experienced happiness. Across all three models predicting happiness, gender differences in the coefficients for care are statistically significant at the .05 level (*p* values range between .015–.046; not shown)

Turning to multivariate analyses of frustration (bottom panel, Table 3), again none of the effects are statistically significant at the .05 level for husbands. For wives, levels of frustration do not differ for chores versus other activities in the unadjusted models. The effect becomes larger ($\beta = -.44$, *p* = .036) when spouses' disability is controlled but is attenuated and no longer significant at the .05 level when other controls are introduced ($\beta = -.36$, *p* = .056). None of the effects of the caregiving components on levels of frustration differ significantly at the .05 level by gender.

Finally, in Figure 2, we show predicted marginal mean happiness scores for women by care activity and spouse's disability status. For wives, experienced happiness is lowest for activities classified as chores, regardless of spouse's disability status (4.7 vs 5.1 for those whose husbands do not have a disability and 4.4 vs 5.0 for those whose husbands do). Among wives whose husbands have a disability, happiness levels are similar when providing care to a spouse and when performing noncare activities (4.8 vs 5.0).

DISCUSSION

A vast literature has explored the emotional well-being of caregivers. We move this literature forward in several ways. We examined whether spousal care is associated with experienced well-being—or momentary reports of happiness and frustration experienced while carrying out specific activities. Unlike prior studies, we used time diary data that allowed us to separate the distinctive

Table 3. Coefficients (Standard Errors) From Ordinary Least Square Regression Models^a: Experienced Well-Being by Gender

	Husbands			Wives		
	H1	H2	H3 ^b	W1	W2	W3 ^b
Happiness (0–6) (chore omitted)						
Chore vs other	.04 (.16)	.03 (.15)	-.04 (.14)	-.48** (.15)	-.49** (.15)	-.48** (.13)
Care vs chore	-.29 (.24)	-.26 (.24)	-.21 (.21)	.34 (.20)	.42* (.20)	.35* (.17)
Spouse disability		-.04 (.12)	-.11 (.15)		-.12 (.12)	-.21 (.13)
Adjusted <i>R</i> ²	.00	.00	.14	.02	.02	.11
Frustration (0–6) (chore omitted)						
Chore vs other	.29 (.24)	.29 (.24)	.29 (.24)	.13 (.17)	.14 (.17)	.18 (.15)
Care vs chore	-.09 (.35)	-.06 (.35)	-.16 (.32)	-.35 (.20)	-.44* (.21)	-.36 (.19)
Spouse disability		-.05 (.12)	-.12 (.15)		.13 (.15)	.22 (.19)
Adjusted <i>R</i> ²	.00	.00	.07	.00	.00	.08
<i>N</i>		2,140			2,252	

Notes. DUST = Disability and Use of Time; PSID = Panel Study of Income Dynamics.

^aModels are weighted using sampling weights that take into account differential sampling probabilities of DUST respondents. Standard errors have been adjusted for the complex survey design of the PSID and DUST and to account for multiple observations per person.

^bModel controls for respondent, spouse, and activity characteristics and social psychological/economic resources.

p* < .05. *p* < .01.

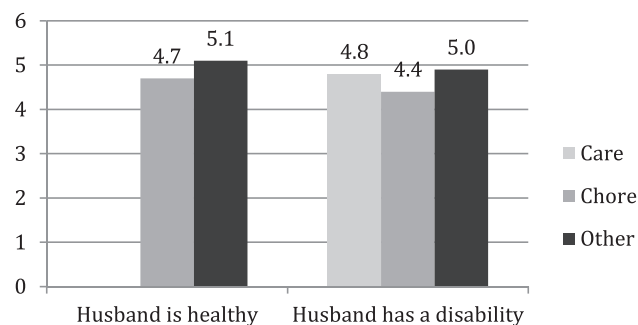


Figure 2. Wife's happiness (0 to 6) while caring for husband, doing chores, and carrying out other activities. Note. Estimates control for respondent, spouse, and activity characteristics and social psychological/economic resources.

effects of having a spouse with a disability, doing chores, and providing care to a spouse with a disability. Consistent with much prior literature, we hypothesized that caregiving tasks would have a negative effect on well-being for women, but a positive effect for men. We further hypothesized that effects would be stronger for women than for men. We find, however, that for husbands, caring for a spouse with a disability is not associated with experienced well-being, whereas happiness is higher when wives provide care to a spouse with a disability compared with carrying out chores.

We found a negative association between chores (vs other activities) and experienced well-being for women but not men. Prior studies of experienced well-being among older adults that have identified the unpleasant nature of chores have not focused on such gender differences (Smith et al., 2011). Our findings are also consistent with analyses of housework (Hook, 2010), which point out women more typically perform continual and daily (e.g., cooking, house cleaning) tasks, whereas husbands are more likely to carry out sporadic task-based projects; the former may be distressing in that the continual

demands imposed may undermine one's sense of control and well-being.

We also found that for women caring for a spouse (vs carrying out chores) was associated with better experienced well-being, which signals that women may derive a greater sense of meaning and accomplishment from providing care than do men (Yee & Schulz, 2000), even though it involves activities that are inherently less pleasant. Our findings of no relationship between care status and experienced well-being for men are also consistent with Calasanti and King's (2007) observation that men tend to suppress emotions when coping with the provision of care to a sick spouse. Finally, we examined the effects of having a spouse with a disability separately from the effects of providing care to a spouse with a disability. Unlike Amirkhanyan and Wolf (2003), who found an association between the care recipient's disability and the care provider's well-being, we find that having a spouse with a disability in and of itself is not related to experienced well-being. This may reflect the fact that Amirkhanyan and Wolf (2003) focused on parental caregiving only; recent work suggests that parental caregiving may be more distressing than spousal caregiving (e.g., Lin et al., 2012). Further research is needed to uncover whether the different findings are because of different approaches to measuring well-being, the caregiver's relation to the care recipient, or other differences between the study populations.

Limitations and Future Directions

This study has several limitations. We explored only one broad measure of care that included both household chores and personal care. We could not further parse this measure into the effects of household activities versus hands-on personal care because the number of instances of personal care in our sample was low (<1%). We also did not explore measures of being "on call" or providing "standby" care,

which may be more relevant for high-intensity, dementia caregivers, or whether the volume of care over the day or over time influences moment-to-moment emotions. Moreover, our analysis is cross-sectional and does not allow us to explore the process through which the onset of a spouse's disability or the transition to becoming a caregiver influences both the division of labor in the household and well-being. Longitudinal data are needed to better understand if older adults with greater psychological well-being are more likely to take on caregiving responsibilities. The collection of a second wave of DUST by the PSID in 2013 may provide opportunities in the future for exploring the dynamics of well-being in response to care.

In addition, we cannot generalize beyond the experiences of older adults, so we cannot discuss how caregiving might affect the experienced well-being of younger individuals. Previous research has found that older adults tend to have fewer extreme emotions and that subjective well-being tends to be stable in later life (Kunzmann, Little, & Smith, 2000; Rocke, Li, & Smith, 2009), suggesting that emotional reactions to the provision of care could show greater variation among younger adults. Finally, we could not control for a number of factors that have been shown to be important predictors of caregiver well-being. For instance, whether the care recipient exhibits difficult behaviors (Ingersoll-Dayton & Raschick, 2004), the availability of social support (Lin et al., 2012), and reciprocity with the care recipient (Ingersoll-Dayton & Raschick, 2004) can all influence the caregiving experience.

Nevertheless, our study offers new insights into caregiving's link to well-being and how it varies by gender. Our analysis may be the first to show that—controlling for the specific activities that comprise caregiving—older women actually enjoy providing care to their husbands. Happiness levels were higher when performing a household task—like preparing meals, laundry, or cleaning—for a spouse with a disability than when performing these tasks for other reasons. This finding suggests that for current cohorts of older women, the meaning of an activity—and value to an individual in terms of hedonic payoff—may change when that activity *cannot* be carried out by one's spouse (in contrast to when it simply *is not* carried out by one's spouse). An outstanding question for future research is whether, as gender roles continue to shift in the home and new cohorts enter late life having spent a life time sharing household chores, we will see a waning of the negative “chore” effect for wives—or whether one will emerge for husbands.

Finally, our findings point to practical implications for the lives of older women. We find that caregiving is not uniformly associated with compromised well-being for either women or men, yet household chores are a source of dissatisfaction for older women. These results suggest that interventions for older adults, especially those with impaired spouses, should move beyond emotional support around the caregiving experience. The household chores that women

performed (perhaps begrudgingly) in young or mid adulthood may be particularly daunting as they experience their own health declines, and the health declines and accompanying caregiving demands of their spouse. It may be useful to investigate whether support with housework—although not a panacea for happiness—conveys psychic benefits to older women as it frees up their time and energy to devote to other more meaningful tasks.

SUPPLEMENTARY MATERIAL

Supplementary material can be found at: <http://psychogerontology.oxfordjournals.org/>

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CORRESPONDENCE

Correspondence should be addressed to Jennifer C. Cornman, PhD, 113 Chapin Place, Granville, OH 43023. E-mail: jencornman@gmail.com.

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