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Gendered emotion work around physical health problems in mid- and later-life marriages ☆

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ABSTRACT

The provision and receipt of emotion work—defined as intentional activities done to promote another's emotional well-being—are central dimensions of marriage. However, emotion work in response to physical health problems is a largely unexplored, yet likely important, aspect of the marital experience. We analyze dyadic in-depth interviews with husbands and wives in 21 mid- to later-life couples to examine the ways that health-impaired people and their spouses provide, interpret, and explain emotion work. Because physical health problems, emotion work, and marital dynamics are gendered, we consider how these processes differ for women and men. We find that wives provide emotion work regardless of their own health status. Husbands provide emotion work less consistently, typically only when the husbands see themselves as their wife's primary source of stability or when the husbands view their marriage as balanced. Notions of traditional masculinity preclude some husbands from providing emotion work even when their wife is health-impaired. This study articulates emotion work around physical health problems as one factor that sustains and exacerbates gender inequalities in marriage with implications for emotional and physical well-being.

Emotion work—activities done with the intention of promoting another's positive emotional state—is conceptualized as part of the division of unpaid household work commonly done within marriage (Eichler & Albanese, 2007; Erickson, 2005; Hochschild, 1979, 2003; Pfeffer, 2010). Much like other forms of unpaid work, the division of emotion work is highly gendered wherein women do a disproportionate share of emotion work relative to men (Erickson, 2005; Hochschild, 2003; Umberson, Thomeer, & Lodge, 2015). Previous research suggests that emotion work is especially present within marriage during times of high stress (Erickson, 2005; Pfeffer, 2010), and one of the most pervasive stressor in mid- and later-life occurs when one or both spouses have physical health problems (Taylor & Aspinwall, 1996). Emotion work done in the context of physical health problems is an especially important consideration in mid- to later-life as physical health problems often emerge or worsen at this life stage (Hung, Ross, Boockvar, & Siu, 2011; Ward, 2013), likely eliciting heightened expectations for emotion work from spouses. We expect emotion work dynamics in the context of physical health problems to be gendered as physical health problems have been shown to alter gender divisions in other types of unpaid work (e.g., caregiving, housework; Allen & Webster, 2001; Pinquart & Sorensen, 2006).

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Most studies that examine emotion work or physical health problems in marriage focus on either the health-impaired person[1] or her or his spouse (Allen & Webster, 2001; Gove, 1984; Russell, 2001). However, individual-level approaches provide only one spouse's perceptions of emotion work and physical health problems, overlooking the inherent dyadic dimensions of physical health problems in marriage (Hepburn et al., 2002; Kirsi, Hervonen, & Jylhä, 2000). For example, studies of health-impaired people identify how physical health problems challenge the gender identity of the health-impaired person (Pudrovska, 2010; Wall & Kristjanson, 2005), while studies of people with a health-impaired spouse identify how gender inequalities are often produced and reproduced through care work (Calasanti & Bowen, 2006; Russell, 2001). Because gender and marital practices are co-constructed, negotiated, and enacted relationally by both husbands and wives (Chappell & Kuehne, 1998; Seymour-Smith & Wetherell, 2006), we argue that it is critical to use dyadic methods to examine the gendered ways that spouses provide and explain their emotion work, as well as the degree to which husbands and wives agree on these accounts. In this study, we use dyadic qualitative methods to examine how mid- to later-life husbands and wives in long-term heterosexual marriage conceptualize their own—or their spouse's—emotion work during periods of their own—or their spouse's—physical health problems. Specifically, we ask:

(1) Who is described as doing or not doing emotion work in response to physical health problems?
(2) How do spouses explain the provision or lack of provision of emotion work?
(3) How are these explanations different for husbands compared to wives?

In addressing these questions, this study provides new insight into the ways in which emotion work, physical health processes, and marriage are interactive or contested as individuals age.

Theoretical background

Spouses are at the front line when physical health problems strike. However, how heterosexual married adults respond to their own or their spouse's physical health problems (e.g., whether or not they provide caregiving, how distressed they become) may be related to gendered constructions of being a husband or wife. To understand these dynamics, we draw on a gender relations framework which suggests that masculinities and femininities must be understood in relation to each other (Connell, 2005; Schippers, 2007). In this perspective, hegemonic masculinity, the culturally defined ideal of how men should behave, is defined in opposition to emphasized femininity, the expectation that women should accommodate to men's interests and desires (Connell & Messerschmidt, 2005). In heterosexual marriage, masculinities and femininities are typically seen as exclusive and oppositional, borne out of a strict gender binary imbued with essentializing personality attributes specific to each gender (Ferree, 2010).

[1] For ease of reading, respondents currently experiencing physical health problems are generally referred to as "health-impaired people"; spouses are referred to as "health-impaired people's spouses."

Socially constructed gender differences within marriage contribute to disparities in emotion work (Erickson, 2005; Pfeffer, 2010; Umberson et al., 2015). Emotion work was first conceptualized by Arlie Hochschild (2003) as a component of both paid work outside the home (i.e., emotional labor) and unpaid work in the home (i.e., emotion work). Emotion work involves efforts to promote the emotional well-being of others, often through the suppression and regulation of one's own emotions (Hochschild, 1979). Alongside other forms of unpaid work, including childcare and housework, emotion work is more often done by women compared to men and is often unacknowledged and invisible (Eichler & Albanese, 2007; Erickson, 2005). Emotion work can be a source of stress, particularly when it is unreciprocated and unappreciated and when it involves suppressing one's own emotions (Umberson et al., 2015). For example, a person may act upbeat and happy while hiding his/her true feelings of anxiety and worry over a spouse's depression in an effort to improve the spouse's psychological state; this process may create stress and anxiety by increasing a sense of responsibility for the emotion worker (Thomeer, Umberson, & Pudrovska, 2013).

Spouses attribute gender differences in emotion work to the social understanding that women are more "naturally" adept at reading and tending to emotions contrasted with men as rational problem-solvers with high agency (Thomeer et al., 2013; Ussher & Sandoval, 2008). Inequality in emotion work is also linked to the expectation of emotion work as a natural component of wifehood, drawing on constructions of "intensive mothering" and "self-silencing" which dictate that women should nurture and support others by obscuring their own emotional distress (Hays, 1996; Jack, 1993). These gendered notions produce a false dichotomy between the emotional and the rational while devaluing the emotional and contribute to a dualistic structure of gender within marriage (Calasanti, 2004; Cheng, 2008).

We argue that gender inequality around emotion work is especially important to consider during periods of physical health problems. Gender scholars suggest that the meanings of being a husband include the belief that men are not naturally disposed to understanding emotions or being emotional but rather are able to maintain emotional control and rationality; aging scholars also find this to generally be the expectation for older men (Bennett, 2007; Thompson, 2002). This expectation may shift during physical health problems, especially when men are involved in caregiving; studies find that men do provide care for health-impaired spouses, perhaps as much as women do (Allen & Webster, 2001; Hepburn et al., 2002; Pinquart & Sorensen, 2006). Past research reports that caregiving men are rarely understood (or understand themselves) as emotionally nurturing, yet these studies do not examine men's provision of emotion work in the context of their or their spouse's physical health problems (Calasanti, 2004; Calasanti & Bowen, 2006). Previous research has not considered whether or how emotion work is linked to physical health problems in marriage.

Gendered emotion work dynamics in the context of marriage and physical health problems are especially important to consider among aging adults. It may be that mid- to later-life adults, compared to younger adults, have more traditional and dichotomized ideas about gender differences (Brewster & Padavic, 2000; Davis & Greenstein, 2009). Therefore, mid- to later-life adults may have particularly