

# Growing old together: Compassionate love and health in older adulthood

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## Abstract

The health benefits associated with marriage are disproportionately large in older adulthood, due in part to the powerful role spouses play in promoting each other's well-being. What remains unclear is what motivates this caretaking. To determine whether compassionate love plays a role, the current study used an Actor–Partner Interdependence Model to examine how 64 older couples' compassionate love is linked to their health. Feeling compassionate love was linked to better health for wives. The partner effects, however, painted a more complicated picture, with the receipt of compassionate love appearing to undermine health. Given the unprecedented growth in the number of older adults in the United States, we have a vested interest in determining how compassionate love may help or hinder well-being in later-life marriages.

## Keywords

Compassionate love, health, marriage, older adulthood

Although being unmarried is associated with poorer health throughout the life span (Kiecolt-Glaser & Newton, 2001), the effects of marital status accumulate over time (Dupre & Meadows, 2007), making the disparities between the married and the unmarried disproportionately large in older adulthood. Relative to their married counterparts, unmarried older adults have higher rates of chronic illness (Pienta, Hayward, & Jenkins,

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2000), disability (Goldman, Korenman, & Weinstein, 1995), and mortality (Holt-Lunstad, Smith, & Layton, 2010). Although many explanations have been offered for why marriage confers these benefits, from selection effects to financial resources (Lillard & Panis, 1996; Zissimopoulos, Karney, & Rauer, 2013), the answer may have to do with the unique and powerful role individuals play in promoting the well-being of their spouses. For example, individuals with spousal support are more successful when trying to quit smoking and combat alcoholism compared to those without support (Mermelstein, Cohen, Lichtenstein, Baer, & Kamarck, 1986; Sobell, Sobell, Toneatto, & Leo, 1993). Further, spouses are often the initial caregivers when one partner becomes ill or faces a health problem (Stoller & Cutler, 1992).

Impressive as the literature has been in documenting the benefits of spousal care, what remains unclear is what motivates people to tend to their partner's health. Without knowing why spouses take care of one another before their health circumstances in effect remove their choice in the matter, it is difficult to capitalize on this potentially invaluable resource. We propose that spouses' compassionate love, defined as a desire to selflessly enhance the well-being of another (Underwood, 2002), may be what motivates them to take an active interest in each other's health. Accordingly, the current study examined how spouses' self-reported and spouse-reported compassionate love was linked to health in a sample of high-functioning older married couples. Given the unprecedented growth in the number of older adults in the United States coupled with a surprisingly grim picture that has emerged of their health (King, Matheson, Chirina, Shankar, & Broman-Fulks, 2013), researchers and policymakers alike have a vested interest in understanding how to promote older adults' well-being without exacerbating the already ballooning health care costs in the United States (CDC, 2007). Understanding the role of compassionate love in older marriages may represent a critical and necessary step toward achieving this goal.

## **The importance of marriage for health in older adulthood**

Considering the increases in the incidence of chronic illness, disability, and dependency in older adulthood that have accompanied the increased life expectancy (Hodes & Suzman, 2007; U.S. Census Bureau, 2005), it is not surprising that marriage plays an increasingly important role later in life (Bookwala, 2005). Perhaps the best evidence for the salience of marriage for older adults' health is that this when transitions into spousal caregiving become more common (Burton, Zdaniuk, Schulz, Jackson, & Hirsch, 2003). Unfortunately, these transitions often cause declines in the caregivers' own well-being (Pinquart & Sorensen, 2007; Vitaliano, Zhang, & Scanlan, 2003). Owing in large part to these declines, the federal government created the Family Caregiver Program in 2000 to provide resources to fund local programs that provide help to family members taking care of their loved ones (U.S. DHHS, 2001).

Although this program represents a crucial step toward promoting the well-being of many individuals in later-life intimate relationships, these efforts and the underlying research are often targeted toward those individuals who are caring for loved ones with terminal illnesses or cognitive impairments (Purk & Richardson, 1994). However, the seeds of this caregiving are planted earlier in the marriage. For example, marital status

has been related to compliance to medical treatments, with married patients more likely to keep their doctor's appointments than unmarried patients (Gruzd, Shear, & Rodney, 1986). This may be due to the instrumental support the partner provides (e.g., transportation to appointments) or it may reflect a desire on the part of the ill spouse to improve his or her health as part of a commitment to the marriage (Wood, Goesling, & Avellar, 2009). This begs the question of which older couples are likely to be invested in both their own and their spouses' health before full-blown caregiving is required.

## **Is compassionate love the critical piece for health promotion in older couples?**

Compared to individuals in more casual relationships, individuals in close relationships are especially susceptible to experiencing their partner's emotions, in particular their distress, and thus have great motivation to take care of each other (Schulz et al., 2007). Those individuals most affected by their partner's well-being should be also the ones most active in promoting their partner's health and their own as well. This supposition nicely aligns with Sprecher and Fehr's (2005, p. 630) definition of compassionate love as an enduring attitude that includes "an orientation toward supporting, helping, and understanding the other(s), particularly when the other(s) is (are) perceived to be suffering or in need." The authors found that having this orientation for a close person was linked to providing more support for that person. Given the robust links between spousal support and health (Heffner, Kiecolt-Glaser, Loving, Glaser, & Malarkey, 2004; Slatcher, 2010), more compassionate love should be linked to better health.

To note, given that men have poorer health and that women are more likely to try to manage others' health (Kiecolt-Glaser & Newton, 2001), wives may be more likely to express compassionate love than their husbands. Gender differences in the effects of this love, however, may not be as prominent in older adulthood. For example, Beach, Katz, Kim, and Brody (2003) found no gender differences in the magnitude of the within-spouse or cross-spouse effects linking middle-aged spouses' marital satisfaction to their later depression. As previous studies in this area had found stronger effects for wives when examining younger couples, we may find fewer gender differences in compassionate love and its links to health in older adulthood.

Unfortunately, relatively little is known about compassionate love in older adulthood, as it has been primarily studied in younger populations (Neff & Karney, 2009; Sprecher & Fehr, 2005, 2006). For several reasons, however, the period of older adulthood represents an ideal window into the nature and potential health benefits of compassionate love. First, Marks and Song (2009) suggest that older adults are more concerned with caring for others than are younger adults because the former have more time and energy to devote to others. The authors believe this may be one reason why providing support is more valuable for well-being than receiving it in older adulthood, a finding consistent with the extant literature (Brown, Nesse, Vinokur, & Smith, 2003). Second, most marriages in older adulthood are longer-term and thus compassionate love has had years or even decades to deepen. Couples who have been together a long time should be fairly accurate at identifying each other's needs and responding accordingly (Neff & Karney, 2009). Third, many of the roles and responsibilities that may have precluded spouses

attending to each other are reduced in older adulthood (e.g., work, parenthood), and therefore, spouses may have an easier time putting each other first. Finally, Roberts, Wise, and DuBenske (2009) suggest that the health declines in older adulthood present more opportunities for spouses to demonstrate their compassionate love for each other. To note, although this explanation raises the possibility that it is health that leads to compassionate love, we investigate here the pathway from compassionate love to health, as this is consistent with the literature on support and health (Heffner et al., 2004).

The few studies that have looked at compassionate love in older adulthood have focused on families in which partners are suffering from terminal illnesses and cognitive impairments (Ott, Sanders, & Kelber, 2007; Roberts et al., 2009). The benefits associated with compassionate love, however, should not be limited to the contexts in which it is most tested. Slatcher's (2010) conceptual model linking marriage to physical health would suggest that we would find links between couples' compassionate love and their health even in a more normative population of older adults. This model proposes that positive marital dimensions, collectively referred to as marital strengths, can directly affect physical health. As compassionate love is thought to be a marital strength (Oman, 2011), it should be linked to one's own health and that of one's partner. Therefore, the current study will explore how compassionate love enables individuals to adapt to the physical, emotional, and psychological changes associated with their own and their partner's aging by focusing on health benefits among a population of higher functioning older adults.

## **The challenges of capturing compassionate love: The importance of a dyadic perspective**

Given the nature of compassionate love, it is surprising that researchers have focused almost exclusively on the benefits of compassionate love for the one who reports feeling it, with the assumption being that the recipient of this love should also benefit (Perlman & Aragon, 2009). In fact, Fehr and Sprecher (2009) suggested that although the provision of compassionate love is associated with a number of positive benefits for the self, individuals report even more positive outcomes when they report being the recipient of compassionate love. However, Fisher, Nadler, and Whitcher-Alagna (1982) have suggested that receiving help and care can be a mixed blessing. Help can be supportive as it communicates caring, but it can simultaneously imply an inferiority–superiority relationship between the recipient and the provider. If compassionate love activates feelings of inferiority in the recipient, it may unintentionally undermine that person's health. This may explain why providing support is more beneficial than receiving it (Brown et al., 2003; Marks & Song, 2009), as there is no such ambivalence for the provider.

Very little research, however, has been carried out from the recipient's perspective to test which of these perspectives may be operating with regard to compassionate love. Perhaps part of the reason for this gap in the literature is due to the relative newness of the field (Oman, 2011), with most researchers relying on self-reports to capture compassionate love. Although scales such as Sprecher and Fehr's (2005) Compassionate Love scale have repeatedly been demonstrated to capture compassionate love (Sprecher & Fehr, 2005, 2006), Oman (2011, p. 972) suggested that in order for the study of

compassionate love to have endurance, “a wider and more methodologically varied set of measures” needs to be developed.

What is needed is a way to also capture whether or not people are sensitive to being the beneficiaries of compassionate love and if it is beneficial as expected (Perlman & Aragon, 2009). This would help minimize problems associated with relying solely on self-reports. For example, self-report questionnaires can be susceptible to cognitive limitations as the individual attempts to recall and summarize all of his or her past experiences (Schwarz, Groves, & Schuman, 1998), especially if the meaningful acts or demonstrations happened several years, if not decades, earlier. Further, given the social expectation to be compassionate toward one’s spouse, social desirability may also play a role in reporting positive relationship interactions (see Eisenberg et al., 1989). Therefore, to address current criticisms of the compassionate love field (Oman, 2011; Perlman & Aragon, 2009), the current study uses both self-reported data and observer-coded degree of compassionate love as described by the spouse, referred to here as spouse-reported compassionate love, to capture not only one’s own feelings of compassionate love but the partner’s experience of that compassionate love as well. Utilizing this multi-reporter approach to studying compassionate love thus builds upon and extends the current literature by providing a clearer, more comprehensive picture about the nature of compassionate love in marriage and its benefits for health in older adulthood.

## The current study

In light of previous work underscoring the robust links between marriage and health in older adulthood and recent studies highlighting the importance of compassionate love in intimate relationships, the current study used a multimethod approach to explore whether self-reported and spouse-reported compassionate love were linked to self-reported health in a sample of 64 higher functioning older couples. Using the World Health Organization’s (WHO’s) definition of health as a state of wellness coupled with an absence of disease or infirmity, we drew upon multiple self-reports of health (subjective, comparative, and doctor-diagnosed diseases) known to have excellent validity (Hodes & Suzman, 2007; Idler & Benyamini, 1997). This focus on identifying what might promote health in older couples is critical as the great strides seen in longevity over the past century are no longer being matched with progress in terms of health during the later years (King et al., 2013), an especially troubling fact in light of the growing number and proportion of older adults in the United States (U.S. Census Bureau, 2005).

To account for the linked nature of married couples’ compassionate love and their health, we examined spouses using an Actor–Partner Interdependence Model (APIM; Kashy & Kenny, 2000). Researchers studying the links between marriage and health have been encouraged to use APIMs (Slatcher, 2010), as this technique not only accounts for couples’ interdependence, but it allows for the simultaneous examination of both actor and partner effects. In the current study, the actor effects capture the links between one’s own compassionate love (both self-reported and spouse reported) and one’s health, thus building upon the existing literature documenting the benefits of compassionate love (Sprecher & Fehr, 2006; Underwood, 2009). Addressing a notable gap in the literature (Perlman & Aragon, 2009), we also examined partner effects to capture the links

between having a compassionate partner (again determined through both self-report and spouse report) and an individual's health. Having a spouse be more oriented to one's well-being should translate into not only feeling better about one's health but also reporting fewer health problems. Therefore, the current study seeks to address the following questions: (1) To what extent do self-reports and spouse reports of compassionate love overlap?; (2) Is compassionate love related to health and if so, is it better to be on the offering or receiving end of compassionate ?; and (3) Do these associations differ for husbands and wives?

## Methods

### Participants

Sixty-four married heterosexual couples were recruited as part of The Marriage and Retirement Study, a larger study examining marital relationships and individual and relationship well-being in older adulthood. Couples were recruited from newspaper advertisements, churches, and other community organizations in the Southeast United States. Recruitment materials described the study as an exploration of the links between marriage and health in retirement. To be eligible to participate, spouses had to meet three criteria: (1) be married, (2) be at least partially retired (i.e., working <40 h a week), and (3) be able to drive to the on-campus research center to ensure that participants still had relatively high functional health.

Husbands and wives were, on average, approximately 71 years old ( $SD = 7.4$ ; range = 59–93; 16% under the age of 65) and 70 years old ( $SD = 7.0$ ; range = 56–89; 20% under the age of 65), respectively. Husbands and wives were predominantly white ( $n = 61$  and 60, respectively). With regard to education, 10 husbands had a high school education or less, 11 attended some college, 22 had college degrees, and 21 had post-college education. For wives, 4 wives had a high school education or less, 3 attended some college, 21 had college degrees, and 36 had post-college education. Couples' median annual income was US \$74,000 ( $SD = US \$64,074$ ) and the median total wealth (i.e., property, pensions, individual retirement accounts, and income) was US \$750,000 ( $SD = US \$1,277,611$ ). Of the total couples in the study, 47 were fully retired (73.4%) and in 17 couples, at least one spouse was currently working for pay. In all, 51 couples (79.7%) were in their first marriage, and couples were married for an average of 42 years ( $SD = 15.0$ ). On average, the couples reported having 2.6 children ( $SD = 1.3$ ; range = 0–6). Complete data were available from 63 couples.

### Procedure

Couples participated in a visit lasting around 2–3 hours at an on-site research laboratory. During this visit, couples participated in several marital communication tasks (a relationship narrative task, a baseline picture-viewing task, a problem-solving task, a compassionate love task, and a support task). The compassionate love task is the focus of the current study. Couples received a questionnaire that assessed individual and marital functioning, including the self-reported compassionate love measure, at the conclusion

of the visit to ensure that they were not aware of some of the more specific goals of the study prior to completing the observational tasks (e.g., focus on caregiving). Couples were compensated US \$75 for their participation in the study once they returned their questionnaires via a pre-addressed, pre-stamped envelope.

## Measures

**Compassionate love.** Both self-reported and spouse-reported compassionate love were assessed. To assess participants' reports of their own compassionate love for their spouse, participants completed the 21-item Compassionate Love Scale (Sprecher & Fehr, 2005). The current study used a five-point scale to assess the willingness, desire, and frequency of putting a partner's needs above one's own (e.g., "I spend a lot of time concerned about the well-being of my partner"). This measure has been found to have strong convergent and discriminant validity (Sprecher & Fehr, 2005). Reliability was excellent (husbands:  $\alpha = .93$ ; wives:  $\alpha = .95$ ).

To capture the spousal perspective on compassionate love, participants completed the compassionate love task. Both spouses were asked to share "a time when you felt your spouse put your needs ahead of their own," an operationalization of compassionate love stemming from Underwood's (2002) conceptualization of compassionate love. Spouses were asked to describe to the experimenter when this happened, what their spouse did, how it made them feel, and if they had told their spouse how they felt. No other directions were given or questions asked. Spouses completed this task in a room together and the average duration of the task was 4 min ( $SD = 2.6$  min). The task was video recorded and later coded for compassionate love. Two coders were trained on a subsample of video recordings until the interobserver agreement was above 80%.

Based on the content of the individual's memory of his/her spouse, a score of 1 to 4 was given for how compassionate the participant *sounded* according to the memory shared by the spouse. Compassionate love was defined by the kindness, sensitivity, and love that an individual showed toward his/her spouse, especially in placing the spouse's needs above one's own. Both the frequency and meaningfulness of the compassionate love described in the experience were included in the scoring of this code. A score of "1" indicated that the individual sounded not at all to minimally compassionate, suggesting that the individual never to rarely shows meaningful compassionate love (e.g., "I don't know the answer to that one"). A score of "2" indicated the individual sounded modestly compassionate, occasionally demonstrating compassionate love toward the spouse and/or showing it in a less meaningful way (e.g., "She does some of the yard work"). A score of "3" indicated that the individual sounded as though they regularly show compassionate love toward their spouse and/or compassionate love is demonstrated in a meaningful way (e.g., "He really helped take care of the kids while they were growing up and it was really special"). A score of "4" indicated that the individual always shows compassionate love toward the spouse and/or it is demonstrated in an extremely meaningful way (e.g., "She gave up so much to move around the country for my job. She never complained and did so much for our family. It meant everything to me and I am so thankful for her"). Interrater reliability was good ( $r = .72, p < .001$  for husbands;  $r = .86, p < .001$  for wives).

**Health.** Participants' health was assessed with three different self-reported indices. The first item asked participants to evaluate their current health on a four-point scale by asking, "Overall, would you describe your health as poor, fair, good, or excellent?" The second item assessed participants' comparative health on a three-point scale by asking, "Do you consider your health to be better, about the same, or worse than other people your age?" Questions regarding general subjective health and comparative health have been found to yield different results, as they are thought to tap into different facets of overall well-being (Baron-Epel & Kaplan, 2001). Finally, we assessed whether participants had ever been diagnosed by their doctor with any of the following diseases/conditions common in older adulthood: heart trouble, diabetes, cancer, arthritis, asthma, stroke, lung disease, stomach problems/ulcers, leg problems, back problems, and depression. Participants responded either yes or no to each condition and affirmative responses were summed to create a total doctor-diagnosed disease score that ranged from 0 to 11. Higher scores indicated a greater number of doctor-diagnosed diseases and thus poorer health. This summative approach to assessing chronic conditions and diseases has been well validated in the literature as an indicator of health in older adulthood (Hodes & Suzman, 2007).

**Controls.** For a conservative examination of the compassionate love–health link, we attempted to reduce potential confounds by controlling for variables that may influence compassionate love and/or health: wealth (Rauer, Zissimopoulos, & Karney, 2008), marital duration (Dupre & Meadows, 2007), and husbands' and wives' marital satisfaction (Kiecolt-Glaser & Newton, 2001). Spouses' marital satisfaction was assessed using the 24-item Marital Satisfaction Questionnaire for Older Persons (Haynes et al., 1992). Possible scores ranged from 24 to 139, with higher scores indicating greater satisfaction (husbands:  $\alpha = .92$ ; wives:  $\alpha = .93$ ).

### Data analysis plan

Descriptive statistics and correlations were conducted to examine the nature of and relations among study variables. We created two latent health variables (one for husbands and one for wives) using subjective health, comparative health, and doctor-diagnosed diseases and conducted confirmatory factor analyses to determine model fit. To examine the contributions of older adults' self-reported and spouse-reported compassionate love to both their own and their partner's reports of health, we conducted an APIM model (Kashy & Kenny, 2000) in MPlus Version 5.0, which allows for the inclusion of participants with missing data using full information maximum likelihood estimation (Muthén & Muthén, 2007). The model controlled for couples' wealth, marital duration, and both spouses' reports of marital satisfaction. Goodness of model fit was evaluated using the  $\chi^2$  statistic, the comparative fit index (*CFI*), the root mean square error of approximation (*RMSEA*), and the standardized root mean square residual (*SRMR*). To explore gender differences in the strength of these associations, we conducted a series of  $\Delta\chi^2$  tests to examine whether the actor or partner effects were stronger for husbands or for wives.



## Results

### *Capturing compassionate love in older couples*

Descriptive statistics and intercorrelations among study variables are presented in Table 1. Paired *t* tests revealed no significant differences between spouses on any of the variables. We found that spouses reported feeling high levels of compassionate love for their partner (4.47 and 4.44 out of 5 for husbands and wives, respectively), which is consistent with previous work using this measure (Sprecher & Fehr, 2011). Corroborating these reports of one's own compassionate love were our ratings based on how spouses' described each other, as these were also high (3.11 and 3.17 out of 4 for husbands and wives, respectively). Underscoring the interdependence of couples, we found that both self-reported and spouse-reported indicators of compassionate love were significantly correlated between spouses, indicating that couples were similarly compassionate. Despite these significant cross-spouse correlations, however, significant within-spouse correlations only emerged for wives, whereby how compassionately she reported herself to be corresponded with how compassionately she was described as by her husband. For husbands, on the other hand, self-reported and spouse-reported compassionate love appeared to tap into different facets of the construct, as how compassionately he reported being did not significantly overlap with how compassionately he was perceived as by his wife.

### *A dyadic path model linking couples' compassionate love and their well-being*

A confirmatory factor analysis indicated good fit for the measurement model for husbands' and wives' health,  $\chi^2(8) = 10.42$ , *ns*; *CFI* = .96; *RMSEA* = .07; *SRMR* = .07, which was created from the observed variables of subjective health, comparative health, and doctor-diagnosed diseases. All factor loadings were significant for both husbands ( $p < .05$ ) and wives ( $p < .01$ ). For husbands, the  $R^2$  was as follows: 66.7% for subjective health, 47.5% for comparative health, and 14.7% for doctor-diagnosed diseases. For wives, the  $R^2$  was: 32.9% for subjective health, 53.7% for comparative health, and 51.4% for doctor-diagnosed diseases.

We next fit an APIM model to examine the links between the observed variables of self-reported and spouse-reported compassionate love and the latent factor of health controlling for wealth, marital duration, and both spouses' marital satisfaction<sup>1</sup> (see Figure 1). We found that the model demonstrated an excellent fit,  $\chi^2(40) = 38.61$ , *ns*; *CFI* = 1.00; *RMSEA* = .00; *SRMR* = .07. Looking first at the actor effects, we only found evidence for one actor effect, whereby the more wives reported feeling compassionate love for their husbands, the better the wives' reported health,  $\beta = .42$ ,  $p < .05$ . Looking at the partner effects, two partner effects emerged. First, wives had marginally poorer health when their husbands reported feeling more compassionate love for them,  $\beta = -.26$ ,  $p = .07$ . Second, husbands had significantly poorer health when they described their wives as more compassionate,  $\beta = -.41$ ,  $p < .01$ . The model accounted for 34% of the variance in husbands' health and 39% of the variance in wives' health.

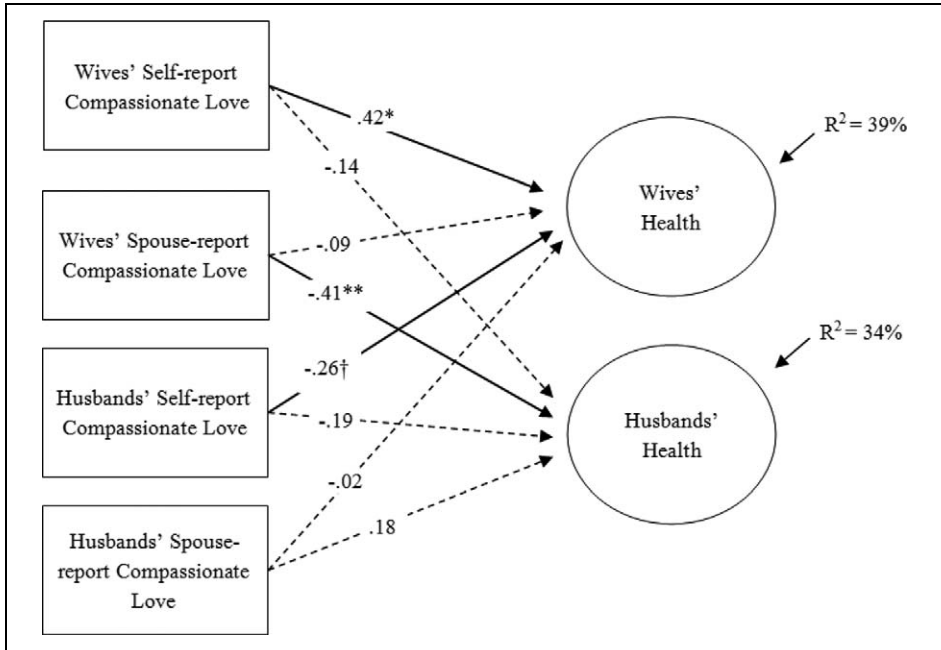
**Table 1.** Descriptive statistics and intercorrelations for study variables of husbands and wives (N = 64).

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Wealth	—													
2. Marital duration	.15	—												
3. H: marital satisfaction	.16	-.06	—											
4. W: marital satisfaction	.34**	-.14	.54***	—										
5. H: self-reported CL	.19	.12	.44***	.34**	—									
6. W: self-reported CL	.42**	.20	.37**	.62***	.45**	—								
7. H: spouse-reported CL	.15	-.24†	.36**	.26*	.20	.07	—							
8. W: spouse-reported CL	.17	-.29*	.36**	.46***	.15	.35***	.43**	—						
9. H: subjective health	.04	.21†	.27*	.26*	.06	.14	.02	-.09	—					
10. W: subjective health	.36**	-.13	.11	.18	-.02	.18	-.00	.05	.05	—				
11. H: comparative health	-.07	.22†	.06	.15	-.03	.00	.07	-.22†	.57**	-.01	—			
12. W: comparative health	.25†	.02	.11	.20	-.09	.37**	.10	.14	.23†	.39**	.07	—		
13. H: doctor-diagnosed diseases	-.18	-.17	-.07	-.11	-.06	-.23†	.01	.01	-.31*	.00	-.28*	-.13	—	
14. W: doctor-diagnosed diseases	-.31*	.12	-.13	-.21†	.06	-.18	.02	-.04	.04	-.43**	.17	-.51**	.14	—
M	13.41	42.40	118.02	117.55	4.47	4.44	3.11	3.17	3.22	3.18	2.73	2.69	2.33	2.41
SD	1.13	14.97	12.38	14.57	.38	.54	.92	.77	.63	.56	.48	.53	1.59	1.70

W: wife; H: husband; CL: compassionate love.

Note. Wealth is natural log transformed.

†p &lt; .10; \*p &lt; .05; \*\*p &lt; .01; \*\*\*p &lt; .001.



**Figure 1.** Links between couples' compassionate love and their health. Note. Path coefficients are standardized. Significant pathways are indicated in boldface, nonsignificant pathways are indicated as dashes, and cross-sectional correlations, factor loadings, and controls are not shown to improve the clarity of presentation. † $p \leq .10$ ; \* $p \leq .05$ ; \*\* $p \leq .01$ .

### Gender differences in the links between couples' compassionate love and well-being

We next used a series of  $\Delta\chi^2$  tests using nested models to determine whether the pathways between one's own and one's spouse's compassionate love and health were stronger for husbands or for wives. For each pathway between compassionate love and health, we compared two models, one with free parameters and one in which a path was constrained to be equal between spouses. Significant  $\chi^2$  difference tests between these models indicated that husbands and wives could not be considered as a single population. Using this approach, we only found evidence of gender differences for one of the two actor effects and one of the two partner effects. First, we found that the association between wives' self-reported compassionate love and her health did significantly differ from husbands' self-reported compassionate love and his health,  $\Delta\chi^2(1) = 5.37, p < .05$ , with the former having a significantly stronger actor effect. Second, the association between spouse reports of wives' compassionate love and husbands' health was significantly stronger than the link between spouse reports of husbands' compassionate love and wives' health,  $\Delta\chi^2(1) = 4.20, p < .05$ . This suggests that of the gender differences that did emerge, they served to underscore the importance of wives' compassionate love for both their own well-being and that of their husbands.

## Discussion

At the beginning of most marriages, couples vow to spend the rest of their lives together in sickness and in health. At the heart of these vows is a promise to take care of each other, should the need arise. For couples who successfully navigate the early years of marriage, the later years may prove to be a time when their earlier vows are called upon, as their health starts to noticeably and permanently decline (Hodes & Suzman, 2007). We explored here whether compassionate love might be the critical piece to understanding who abides by their vows by taking an active role in promoting their partner's health before caregiving is required. We found compelling evidence linking compassionate love to health, with particularly strong evidence emerging for the role of wives' compassionate love in both spouses' health. Underscoring the importance of taking a dyadic approach, the cross-spouse pathways between compassionate love and health painted a more complex picture than the within-spouse pathways, suggesting that the role of compassionate love in marriage may be more complicated than previously thought.

### *Compassionate love in older adult marriages: It is better to give than to receive?*

These findings shed light on the effects of giving and receiving compassionate love and begin to illuminate, which might be more beneficial within the context of later-life marriage. Fehr and Sprecher (2009) suggest that the recipient should benefit more than the provider does, but our findings are more in line with Fisher et al.'s (1982) view of help as potentially harmful. Although Fehr and Sprecher (2009) anticipated compassion burnout for those engaging in extraordinarily high levels of prosocial acts, the only positive pathway to emerge in our dyadic model was between the provision of self-reported compassionate love and wives' health. Further, we found that receiving compassionate love was associated with worse health for both spouses. The question is why would the receipt of compassionate love be linked to poorer health in our sample of older couples, in light of previous assumptions that the recipient, not the provider, should be the one to reap the most benefits (Fehr & Sprecher, 2009; Underwood, 2009)?

The answer may lie in the unique challenges associated with aging, particularly within the couple context. One of the biggest fears older adults report is that of being dependent (Knight & Ricciardelli, 2003), as older adults do not wish to be a burden, especially to those they love. Perhaps due to this fear, the links between support receipt and well-being are less positive than at earlier points in the life span. Across most studies, receiving support is uniformly beneficial for health, especially from a loved one (Heffner et al., 2004). In older adulthood, however, it appears to be more complicated (Uchino, 2009). Even the most well-intentioned support can exacerbate older adults' fears of dependence by eroding their feelings of competence (Silverstein, Chen, & Heller, 1996). Considering that Fisher et al. (1982) found that help elicited more negative reactions when it was seen as a threat to autonomy or implied the loss of important freedoms, receiving compassionate love later in life may be perceived as an early manifestation of caregiving. As the transition to caregiving is well-known to be laden with stress and problems (Burton et al., 2003; Pinquart & Sorensen, 2007), older adults may have an understandably negative response to any spousal overtures that are perceived as prematurely ushering in this new stage of the marriage.

Thus, what we may have seen is that compassionate love from one's partner, although designed to enhance health, may have undermined the older adult's sense of well-being. For example, if one's wife is selflessly providing large amounts of support and care, a husband may feel as if he needs more help than the average person to justify his wife going to such lengths. As requiring greater assistance is seen as a sign of poor health, the underlying motivation on the part of the spouse to enhance the well-being of his or her partner may in fact have the opposite effect. Perhaps offering insight into this complex process are findings from Clipp and George (1992) that spousal caregivers viewed cancer patients' functioning far more negatively than did the patients themselves. Conceivably, individuals may become pessimistic about their health over time as they repeatedly receive messages about their growing health needs, even if those messages are couched within the context of the spouse wanting to help take care of those needs.

An equally plausible and perhaps more sanguine explanation of why compassionate love receipt would be linked to poor health could be that a spouse's ill health may generate greater compassionate love in his or her partner. This line of thought is consistent with Carstensen's (1992) socioemotional selectivity theory, which suggests that as individuals age, they perceive time to be less open-ended. The result of this perspective change is that couples set aside past grievances and focus on enhancing marital intimacy. Health declines likely speed up this process, making it seem more imperative to focus on a partner's needs to maximize the time they have together. It is most likely that both causal pathways exist, a conclusion consistent with the larger literature on marriage and health (Kiecolt-Glaser & Newton, 2001).

If receiving compassionate love in older adulthood may at times inadvertently undermine one's health, what serves to bolster it? It appears compassionate love can benefit health, but it does so primarily for the wives who are giving it. Although this is counter to how compassionate love has been conceptualized to date (Fehr & Sprecher, 2009; Underwood, 2009), it is consistent with the literature on the benefits of support provision. For example, Jensen, Rauer, and Volling (2013) found that support provision was more consistently linked to positive outcomes within the marital relationship than support receipt. Supporting a spouse is thought to increase the support provider's perception of being needed and valuable, which in turn enhances his or her well-being (Knoll, Kienle, Bauer, Pfuller, & Luszczynska, 2007). This has been found to be true even when the support provision is purely altruistic (Bateson, 1998), as compassionate love is thought to be.

Even more compelling evidence for why providing compassionate love would be beneficial comes from the work looking at support provision and health. Brown et al. (2003) found that mortality was significantly reduced for older adults who provided emotional support to their spouse, with no additional effects for support receipt. This may tie back to how older adults conceptualize successful aging (Knight & Ricciardelli, 2003)—those with more independence feel healthier. Perhaps in the context of the marital relationship, what makes older adults feel independent is the sense that they are able to take care of their partner.

### *The critical role of wives' compassionate love*

The question, however, is why the benefits of provision of care would be seen for wives and not for husbands. This differential importance of compassionate love is especially

surprising as we did not see any differences in how much compassionate love spouses either reported themselves or were described by their partners as demonstrating. The lack of gender differences in the amount of compassionate love compared to studies with younger participants may be due to the greater similarity that couples demonstrate over time. Scholars suggest that in Western cultures, the discrepancies between men's and women's sex roles decline with age, meaning that older husbands and wives likely have similar levels of investment in their marriage (Beach et al., 2003). Although spouses may be similarly devoted to each other and thus equally likely to put each other's needs first, they appear to not be equally affected by this devotion. Our analyses revealed that the links between compassionate love and health were stronger for wives than for husbands. This finding was unexpected in light of Beach et al.'s (2003) conclusion that over time, gender differences in the magnitude of links between marriage and health diminish.

The difference in findings may be due to our focus on compassionate love. Research suggests that differences in socialization make women particularly sensitive to support dynamics within close relationships (Kuenzler, Hodgkinson, Zindel, Bargetzi, & Znoj, 2011; Väänänen, Buunk, Kivimäki, Pentti, & Vahtera, 2005). Women derive more benefit when they are the ones benefiting others and they do not feel that they are themselves overbenefiting. For example, Väänänen et al. (2005) found that women who gave more support had fewer sickness absences at work over a 9-year period, whereas men had fewer sickness absences when they received more support. Further, Kuenzler et al. (2011) suggest that wives derive more of the intrinsic rewards of caregiving than do husbands, which aligns nicely with our finding that wives' compassionate love was linked to their better health. However, although women may feel more responsible for the emotional climate of their marriages (Schoenfeld, Bredow, & Huston, 2012), it appears that in our study, they are the only ones to benefit from this extra care and concern.

Together, these findings shed light on Underwood's (2002) definition of compassionate love and begin to offer an answer to the question of whether it is better to give or to receive. Most couples express the desire to enhance each other's well-being regardless of the costs to the self, but the challenges of aging may reduce the ability of older adults to pay any price. Although this does not appear to reduce the feelings of compassionate love, it may alter its benefits. Further, this appears to depend largely on which spouse is being examined, suggesting gender may be a powerful filter through which the compassionate love–health link is experienced.

### ***Strengths and limitations***

Our confidence in these results is enhanced by a number of strengths in our study design. First, addressing what some have considered to be a critical gap in the compassionate love literature (Perlman & Aragon, 2009), we utilized a dyadic approach to understand the potential benefits of both giving and receiving compassionate love. By including both spouses, we were able to find complex associations not only between the provision and receipt of compassionate love and health but also the extent to which these links differed based on who was reporting on the compassionate love and whose health was in question. For example, analyses revealed that wives' health was linked to how each

spouse saw himself or herself, whereas husbands' health was linked to how he saw his spouse, underscoring an interesting gender difference. Second, our confidence is bolstered by the fact that our findings regarding the importance of compassionate love for health remain even after controlling for husbands' and wives' marital satisfaction. This suggests that it is compassionate love that is responsible for these associations with health, rather than the overall quality of the couples' relationship. Finally, in line with the WHO's current definition of health, using multiple well-validated measures of self-reported health enabled us to begin to paint a more comprehensive picture of how compassionate love may affect health.

Despite these strengths, these findings should be interpreted within the study's context. Although our focus on high-functioning older adults represents an important advance, factors enabling our sample to be high functioning may also preclude generalizing to other populations. For example, our sample was primarily composed of highly educated, financially well-off, White couples, characteristics that have all been linked to better health (Blane, 1995; Hodes & Suzman, 2007; Ross & Wu, 1996). As the field progresses, it will be important to examine whether the benefits of giving and receiving compassionate love will be seen in populations in which health is a more pressing concern, as research has found that the benefits of compassion can diminish when the individuals become overwhelmed by providing help (Post, 2005).

Second, the cross-sectional nature of our study prevents us from determining whether compassionate love is affecting health or whether ill health inspires more compassionate love. It is likely that both pathways are operating, which is consistent with the larger literature on marriage and health (Kiecolt-Glaser & Newton, 2001). The magnitude of each effect, however, may change over the life span in response to normative changes in health. Only following these couples over time as they experience health declines would enable us to examine the extent to which each pathway was operating and for whom.

Third, although our multi-reporter approach to capturing compassionate is novel and addresses an important gap within the current literature (Oman, 2011), our disparate methods of assessing compassionate love must be acknowledged as a possible limitation as the measures are not directly comparable. The self-reported compassionate love tapped into general feelings of compassionate love for the spouse, whereas the spouse-reports asked individuals to remember and describe a specific event that demonstrated compassionate love. As research has shown that wives have more vivid memories of their relationship events than do husbands (Ross & Holmberg, 1992), this may have amplified the gender differences we found here. Additionally, the high scores on the self-reported compassionate love measure may have been due to this construct being primed during the observational task, though this is somewhat mitigated by most couples completing their questionnaires 2–3 weeks after the visit.

Finally, current models linking marriage and health suggest a more complex picture is operating than the one we began to explore here. For example, Slatcher's (2010) model linking marital functioning and physical health suggests that these pathways operate through psychological and biological mechanisms and that the strengths of these associations depend greatly on the external context in which they are occurring (e.g., financial stress). Therefore, understanding how compassionate love is linked to health

and under what circumstances represents an important next step for those who might wish to capitalize on its benefits.

## **Conclusion**

As the need for spousal caregiving grows, so too has the literature documenting the high costs associated with caring for a loved one (Pinquart & Sorensen, 2007; Vitaliano et al., 2003). Thus, although spousal caregiving may represent an expedient fix for a health care system overwhelmed with the needs of an aging society (Talley & Crews, 2007), it may increase the long-term costs as the burdens traditionally associated with this caregiving begin to take a toll. Without knowing why spouses take care of one another before major health problems make caregiving compulsory, policymakers are left to rely on the more costly tertiary interventions that target only those couples already most affected by health problems (Pope & Tarlov, 1991). Providing this type of assistance through programs such as the Family Caregiver Program only offers temporary respite for couples, which fails to address the larger needs of an aging society. What is needed are primary preventions that can enhance wellness through targeted behavioral changes, as these are more cost-effective and have wider spread, longer term benefits.

Recent work suggests that focusing on promoting social relationships in particular presents a major opportunity to improve individuals' quality of life and even their survival (Holt-Lunstad et al., 2010). The challenge, however, is that the complexity of social relations can make it difficult to identify what aspect of individuals' relationships should be targeted. The findings of the current study coupled with recent work by Oman, Thoresen, and Hedberg (2010) demonstrating that compassionate love is malleable to intervention suggest that enhancing spouses' compassionate love earlier in the life span, particularly their provision of it, may have promise as a specific target for primary preventions. Our findings also suggest, however, that any intervention in which couples are encouraged to support each other may also need to address the challenges associated with receiving that care later in life. Not only would this more nuanced approach benefit the couples as they deal with the challenges associated with aging, but it would likely spill over to benefit society as well.

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## Note

1. Per recent recommendations (Simmons, Nelson, & Simonsohn, 2011), we also fit the model without any controls. The model fit was comparable,  $\chi^2(24) = 19.78$ , *ns*; *CFI* = 1.00; *RMSEA* = .00; *SRMR* = .06. In contrast to the model that included the controls, the pathway between husbands' self-reported compassionate love and their wives' health was not significant in the uncontrolled model,  $\beta = -.17$ ,  $p = .12$ . The pattern of results for the remaining pathways was similar between the two models.

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