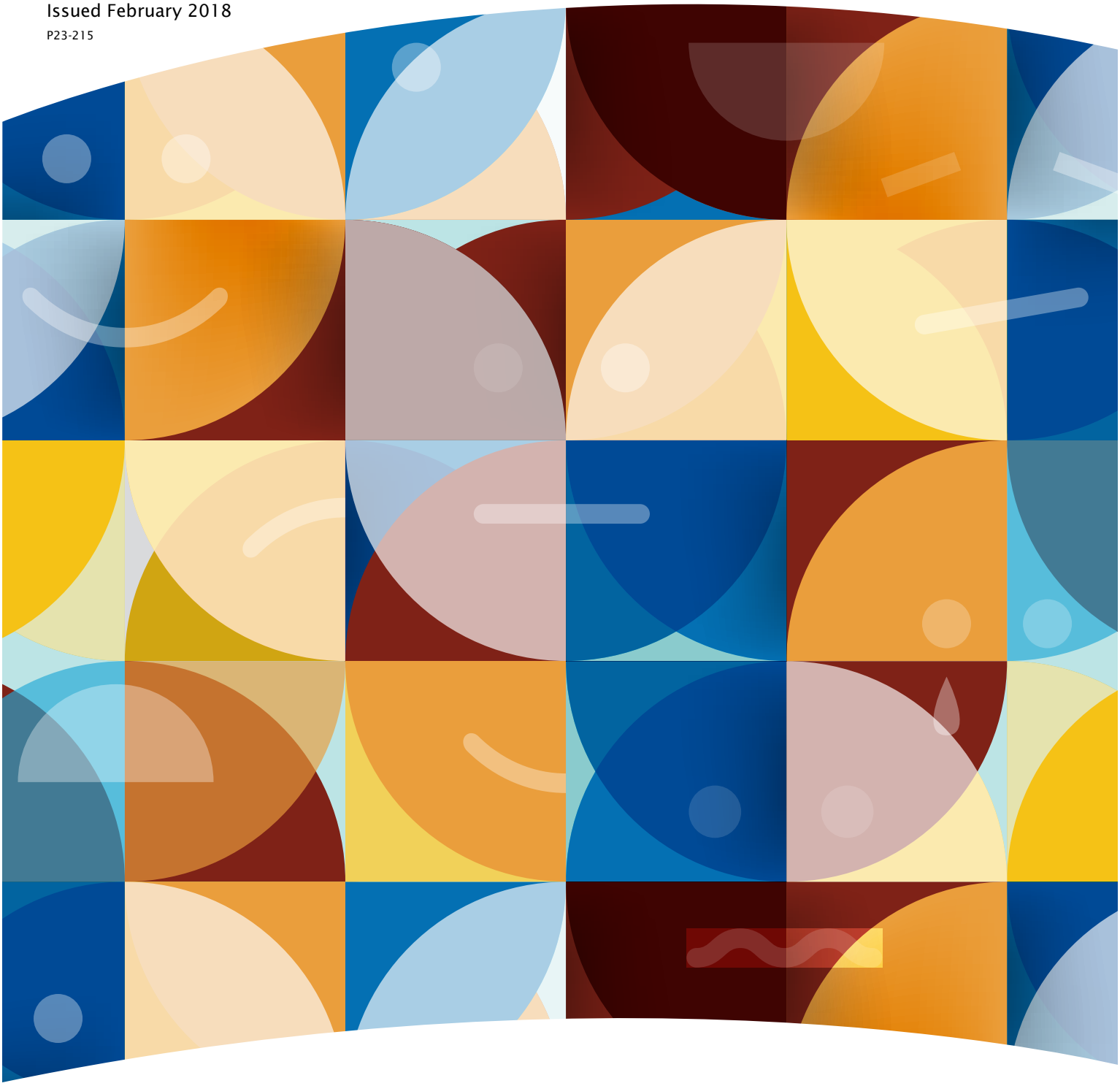
Subjective Well-Being of Eldercare Providers: 2012–2013

Current Population Reports

Wan He, Rose M. Weingartner, and Liana C. Sayer

Issued February 2018

P23-215



United States™ Census Bureau

U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov

U.S. Department of Health and Human Services
National Institutes of Health
NATIONAL INSTITUTE ON AGING

Acknowledgments

This report was prepared by **Wan He**, U.S. Census Bureau, and **Rose Malinowski Weingartner** and **Liana C. Sayer**, University of Maryland Time Use Lab and Sociology Department, under the direction of **Loraine A. West**, Chief, Demographic and Economic Studies Branch, Population Division. **Glenn Ferri**, former Assistant Division Chief, International Programs, and **Karen Battle**, Chief, Population Division, provided overall direction.

Research for and production of this report were supported under an interagency agreement with the Division of Behavioral and Social Research (DBSR), National Institute on Aging (NIA), **John G. Haaga**, Director.

The authors are grateful to **Andrea Miles** and **Iris Poe,** Population Division, for providing literature and data search, table and graph production, verification, and other general report preparation. Statistical testing review was conducted by **James Farber**, Demographic Statistical Methods Division.

The authors give special thanks to **Mitali Sen** and especially **Marc Perry**, Population Division, for their thorough review. Under the direction of **Dana Plude**, NIA DBSR, anonymous reviewers from NIA provided valuable comments and constructive suggestions.

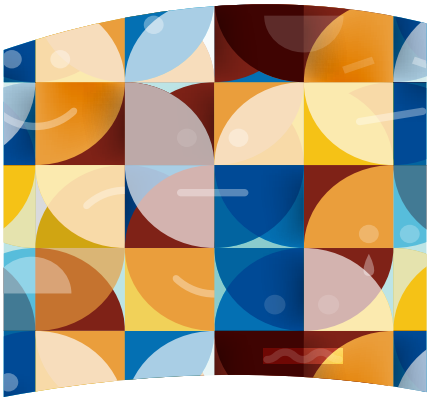
Janet Sweeney, **Amanda Perry**, and **Corey Beasley** of the Census Bureau's Public information Office provided publication management, graphics design and composition, and editorial review for print and electronic media. **George E. Williams** of the Census Bureau's Administrative and Customer Services Division provided printing management.

Subjective Well-Being of Eldercare Providers: 2012–2013

Current Population Survey Reports

Issued February 2018

P23-215



U.S. Department of Commerce
Wilbur Ross,
Secretary

Ellen Herbst,
Acting Deputy Secretary

Economics and Statistics Administration
Karen Dunn Kelley,
Under Secretary for Economic Affairs

U.S. CENSUS BUREAU
Ron Jarmin,
Performing the Nonexclusive Functions and
Duties of the Director

SUGGESTED CITATION
He, Wan, Rose M. Weingartner,
and Liana C. Sayer,
U.S. Census Bureau,
Subjective Well-Being of Eldercare Providers: 2012–2013,
P23-215,
U.S. Government Printing Office,
Washington, DC, 2018.

Economics and Statistics Administration

Karen Dunn Kelley,
Under Secretary for Economic Affairs

U.S. CENSUS BUREAU
Ron Jarmin,
Performing the Nonexclusive Functions and
Duties of the Director

Enrique Lamas,
Performing the Nonexclusive Functions and
Duties of the Deputy Director and Chief Operating Officer

Eloise Parker,
Acting Associate Director for Demographic Programs

Karen Battle,
Chief, Population Division

Contents

INTRODUCTION

It is well known that the pace of U.S. population aging has been accelerating since the first Baby Boomers turned age 65 in 2011.[1] The large birth cohort of the Baby Boom generation will continue to have a major impact on the nation's age distribution and make it top-heavy. According to the U.S. Census Bureau 2014 National Population Projections, the Baby Boomers will add more than 26 million people to the older ranks from 2015 to 2030, when the youngest Baby Boomers turn age 65 (U.S. Census Bureau, 2014a). This translates into an average of 1.8 million new older people every year.[2] Meanwhile, the oldest-old population, those aged 85 and over, is projected to increase by 2.8 million in this 15-year span, or an average of 350,000 per year. By 2030, the population aged 65 and older is projected to represent 21 percent of the total population in the United States—and at that time will be similar in size to the population under age 18 (U.S. Census Bureau, 2014b).

Increasing life expectancies contribute to the rapid growth of the older population. According to the National Center for Health Statistics, in 2014, an average American woman at age 65 was expected to live another 20.5 years and an older man of the same age, another 18.0 years (National Center for Health Statistics, 2016). Their older counterparts, women and men at age 75, were expected to live another 13.0 and 11.2 years, respectively.

Modern medicine and technology along with healthier lifestyles have prolonged life at older ages, but have also resulted in a large number of older people with functional limitations or ill health who are likely to eventually need help or care in their daily life. Decennial censuses show that the vast majority of older Americans live at home; in fact, the share of older people living in nursing homes declined starting in the 1990s, perhaps partly due to older people's preference to live at home (West et al., 2014). American Community Survey data show that less than 10 percent of older Americans with a disability live in nursing homes (He and Larsen, 2014).

Older people living in a household who have a limitation in physical, mental, or cognitive functioning are often cared for by unpaid, informal caregivers (National Academies of Sciences, 2016). During 2013–2014, 16.1 percent of the U.S. civilian noninstitutionalized population aged 15 and over provided unpaid care to someone aged 65 or older; on days they provided eldercare, persons spent an average of 3.2 hours in caregiving activities (Bureau of Labor Statistics, 2015). Providing care, especially to those with chronic diseases or functional limitations, can be stressful (Barbosa et al., 2011; Bevans and Sternberg, 2012; Lin, Fee, and Wu, 2012; Adelman, et al., 2014). The burden for the family of caregiving to older people is likely to increase with the growth of the older population and lower fertility which has reduced the number of family members available to provide care (Seltzer and Bianchi, 2013). Hence, it is important to investigate the health and well-being of the caregivers, especially those who shoulder the double responsibility of taking care of their parents while caring for young.

Most research on caregiver burden relies on eldercare providers' general assessment of their health or stress level, and relatively little is known about their feelings when performing specific activities. What is the state of subjective well-being for eldercare providers? Do they report relatively more positive affects than negative feelings? Are there age or sex differences? How do providers compare with those who do not provide eldercare in terms of well-being indicators and overall life satisfaction?

This report addresses these questions by examining the subjective well-being of eldercare providers using data from the American Time Use Survey. Subjective well-being refers to how people evaluate their lives in general and the negative and positive feelings experienced during daily activities. It covers a wider range of concepts beyond just happiness and includes three distinct aspects—evaluative well-being, experienced (or hedonic) well-being, and eudemonic well-being (Dolan, Layard, and Metcalfe, 2011; Stone, 2012; OECD, 2013; Steptoe, Deaton, and Stone, 2014). Evaluative well-being, measured by life satisfaction, refers to people's thoughts about the overall quality of their lives. Experienced well-being refers to feelings or moods during everyday activities, such as experienced happiness, sadness, stress, tiredness, or feelings about pain. Eudemonic well-being focuses on judgments about the meaning and purpose of one's life.

Levels and determinants of subjective well-being have gained increasing attention from researchers and policy makers. Subjective well-being broadens concepts and measures of well-being by going

[1] Baby Boomers include people born from mid-1946 to 1964 (Hogan, Perez, and Bell, 2008).

[2] In this report, "older population" or "older people" refer to those aged 65 and over.

beyond material standards of living and market-based economic models (U.S. National Institute on Aging, U.K. Economic and Social Research Council, and U.S. National Academy of Sciences, 2011; Stone and Mackie, eds., 2013). Increasingly, happiness is regarded as the meaning and purpose of life and considered a fundamental human goal and a proper measure of social progress. Advancing understanding of subjective well-being is a public policy goal of the United Nations and many governments, and subjective well-being research informs social and economic policies aimed at improving people's lives (United Nations, 2011; Brooks, 2013; Helliwell, Layard, and Sachs, eds., 2017).[3]

DATA AND MEASUREMENT OF SUBJECTIVE WELL-BEING

This study uses data from the American Time Use Survey (ATUS). The ATUS, started in 2003, is a nationally representative survey drawn from the Current Population Survey and is composed of the civilian, noninstitutionalized population residing in occupied households in the United States (see Box 1 "What Is the American Time Use Survey"). ATUS collects data via telephone interviews and asks the respondents to report all activities undertaken in the last 24 hours. The detailed diary records provide estimates of how, where, and with whom Americans spend their time on all activities of daily life, including the full range of nonmarket activities, from childcare to volunteering.

Starting in 2011, eldercare questions were added to ATUS.

Box 1.

What Is the American Time Use Survey

The American Time Use Survey (ATUS) is the first federally administered, continuous survey on time use in the United States (Bureau of Labor Statistics, 2016a). The ATUS sample is drawn from the Current Population Survey and is composed of the civilian, noninstitutionalized population residing in occupied households in the United States.

The ATUS measures the amount of time people spend doing the full range of daily activities, including paid work, childcare, volunteering, and socializing. Data collection began in January 2003, and the first estimates were published in September 2004.

ATUS data are collected via telephone interviews, with over 170,000 interviews conducted from 2003 to 2015 (Bureau of Labor Statistics, 2016b). The main part of the ATUS interview is the 24-hour time diary. This part of the interview is used to collect a detailed account of the respondent's activities, starting at 4 a.m. the previous day and ending at 4 a.m. on the interview day. For each activity reported, the interviewer asks how long the activity lasted, where they were during the activity, and if they were with anyone during the activity. After the interview is complete, coders assign a code to each activity. The ATUS classification system contains 17 major time-use categories, with each category containing two additional levels of detail.

Source: Bureau of Labor Statistics, American Time Use Survey, <www.bls.gov/tus/>.

Eldercare in ATUS is defined as providing unpaid care or assistance to someone aged 65 and older who needed help because of a condition related to aging, which includes an ongoing ailment or physical or emotional limitation that typically affects older people (see Box 2 "Eldercare Questions in ATUS").

A Well-Being module was included in the 2010, 2012, and 2013 ATUS (Bureau of Labor Statistics, 2014). The ATUS Well-Being module is the only federal government data source in the United States that links self-reported well-being information to individuals' activities and time-use patterns on the national level (National Research Council, 2012). The Well-Being module asks each respondent of ATUS to rate, for each of three randomly selected activities, six feelings experienced during those activities: happy, meaningful, sad, stressed, tired, and pain.[4] Activities such as sleeping, grooming, and private activities are not included in the range of selected activities. The Well-Being module also includes a question for the respondents to assess their overall life satisfaction.[5] It does not ask judgments about the meaning or purpose of one's life and thus does not contain indicators of eudemonic well-being.

The ATUS Well-Being module was developed to determine how affective states, or emotions, vary across different activities and contexts (National Research Council,

[3] Bhutan, for example, added in their 2005 Census a question on subjective happiness levels to measure Gross National Happiness (Brooks, 2013).

[4] Respondents were asked to rate the feelings on a scale from 0 to 6, with 0 indicating that the feeling was not present, and 6 if the feeling was very strong.

[5] Respondents were asked to rate where their personal life is on an imaginary ladder where 0 equals the bottom of the ladder and represents the worst possible life and 10 equals the top of the ladder and represents the best possible life.

Box 2.

Eldercare Questions in ATUS

Recognizing the need for quality eldercare data, the Bureau of Labor Statistics introduced questions on eldercare to the American Time Use Survey (ATUS) in 2011. Based on an expert panel's recommendations, the eldercare questions went through questionnaire development, questionnaire review, and cognitive pretesting before being added to the ATUS (Denton, 2012). The ATUS eldercare questions were designed specifically to identify eldercare providers and to measure the time they spent providing eldercare. Additional information, such as the relationship between the care provider and care recipient, the age of the care recipient, and the types of care activities performed by care providers, is also collected.

Eldercare in ATUS is defined as providing unpaid care or assistance to someone aged 65 or older who needs help because of a condition related to aging (Bureau of Labor Statistics, 2015). ATUS defines a condition related to aging as an ongoing ailment or physical or emotional limitation that typically affects older people, such as becoming more frail; having difficulty seeing, hearing, or physically moving; becoming more forgetful; tiring more quickly; or specific medical ailments that are more common among older adults. It also refers to existing conditions that become progressively worse as one ages.

Eldercare can involve a range of care activities, such as assisting with grooming and feeding, preparing meals, arranging medical care, and providing transportation. Eldercare can also involve providing companionship or being available to assist when help is needed, and thus can be associated with nearly any activity.

In the ATUS survey, an eldercare provider is someone who provided eldercare more than one time in the 3 to 4 months prior to the interview day. This time frame varies slightly by respondent because the question asks about care provided between the first day of a given reference month and the interview day.

Source: Bureau of Labor Statistics, American Time Use Survey, <www.bld.gov/tus/>.

2012). Four measures of positive affective states and two measures of negative affective states were collected to ascertain salient dimensions of hedonic, or experienced, well-being anchored to a specific activity, time, and place (Lee et al., 2015). Recall of affective states in recent specific activities reduces recall and social desirability bias from the ephemeral nature of episodic experiences (Schwarz, Kahneman, and Xu, 2009). The hedonic measures used in the ATUS are associated with evaluative well-being and health outcomes, such that individuals who report higher life satisfaction and self-reported health also report higher levels of positive well-being and lower levels of negative well-being (Lee et al., 2015).

This report uses pooled data from ATUS 2012 and 2013, when both the eldercare questions and the Well-Being module were included. This study examines well-being reported on the randomly selected activities asked in the Well-Being module by eldercare providers defined by ATUS. The six experienced feelings are presented with their mean scores, derived by averaging the scores (0 to 6) reported by the respondent for each of the three randomly selected activities on the diary day. A mean score of 0 indicates the worst well-being and 6 indicates the best well-being. In order to have consistent interpretations of the mean scores of well-being, the four negative affect indicators (sad, stressed, tired, and pain) are presented as inverted variables (sad*i*, stressed*i*, tired*i*, and pain*i*), where the mean score of 0 represents the highest negative feeling and worst well-being, while the mean score of 6 represents the lowest negative feeling and best well-being. Two composite variables were created and included in the study—the composite variable of "positive affect" is the combined average of the two positive feeling indicators (happy and meaningful), and the composite variable of "negative affect" is the combined average of the four negative feeling indicators (sad, stressed, tired, and pain). As with the four individual inverted negative feeling indicators, the composite variable "negative affect" is also presented as an inverted "negative affect*i*" in this study. Throughout the report, a higher score always represents better well-being, and vice versa.

FINDINGS

Well-being for eldercare providers by demographic characteristics

Data show that among the 51.0 million eldercare providers aged 15 and older, most were female (56.4 percent). Those aged 45 to 64 accounted for 43.8 percent. See Table A-1 for additional details on percentage distribution by age, sex, race, and Hispanic origin. This study also compares the well-being of eldercare providers with that of noneldercare providers.

Eldercare providers aged 15 and over reported relatively high levels of positive well-being on the six experienced well-being indicators measured in the ATUS. Their experienced feelings of happiness and meaningfulness were similar; both registered a mean score of about 4.3 on a scale of 0 to 6 (Table 1 and Figure 1; see Table A-2 for standard errors for the mean score estimates). Eldercare providers also reported relatively high well-being scores regarding sadness or pain (5.32 for sad*i* and 4.96 for pain*i*, where 6.00 was the highest score possible).[6] Tiredness was the negative feeling that was related to the poorest well-being, with a mean score of 3.62. About one in five eldercare providers report feeling fatigued and overwhelmed (Schulz et al., 2016). Caregivers who report feelings of time pressure or stress related to second and third shift caregiving are more likely to have poor health (Pinquart and Sörensen, 2007).

Age: The association between eldercare providers' age and well-being was better illustrated by reports of negative feelings during daily activities. Older eldercare providers reported better well-being when asked about negative indicators (sadness, stress, tiredness, or pain) compared with younger eldercare providers. For example, those aged 65 to 74 recorded less stress and tiredness and thus better well-being than all younger age groups (Figure 2, Table 1). However, the youngest providers, those aged 15–24 and 25–34, experienced less pain, reflecting better well-being than all older age groups.

[6] Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being, and 6=lowest negative feeling/best well-being.

Table 1.
Mean Score of Subjective Well-Being Indicators for Eldercare Providers Aged 15 and Over by Age, Sex, Race, and Hispanic Origin: 2012–2013

Characteristics	Happy	Meaningful	Sad*i*	Stressed*i*	Tired*i*	In Pain*i*		Positive Affect	Negative Affect*i*
Total	**4.33**	**4.30**	**5.32**	**4.54**	**3.62**	**4.96**		**4.32**	**4.61**
Age									
15–24	4.32	3.85	5.51	4.52	3.24	5.45		4.08	4.68
25–34	4.20	4.17	5.42	4.38	3.36	5.20		4.18	4.59
35–44	4.30	4.27	5.36	4.42	3.44	4.97		4.28	4.55
45–54	4.34	4.43	5.25	4.44	3.60	4.79		4.38	4.52
55–64	4.36	4.44	5.22	4.54	3.74	4.75		4.40	4.56
65–74	4.46	4.45	5.23	4.89	4.27	4.84		4.46	4.81
75–84	4.29	4.64	5.38	4.96	4.02	4.84		4.46	4.80
85 and older	4.48	4.65	5.01	4.80	4.04	4.80		4.57	4.66
Sex									
Male	4.25	4.22	5.38	4.67	3.75	5.01		4.24	4.70
Female	4.39	4.37	5.27	4.44	3.51	4.93		4.38	4.54
Race and Hispanic Origin									
White alone	4.26	4.21	5.34	4.54	3.63	4.95		4.23	4.61
Black alone	4.61	4.71	5.34	4.70	3.81	5.00		4.66	4.71
Other races	4.32	4.28	5.14	4.35	3.48	4.91		4.30	4.47
Hispanic	4.52	4.53	5.27	4.45	3.39	5.01		4.52	4.53
Not Hispanic	4.31	4.27	5.33	4.55	3.64	4.96		4.29	4.62

Notes: The mean score is derived by averaging the scores reported during three different activities on the diary day.

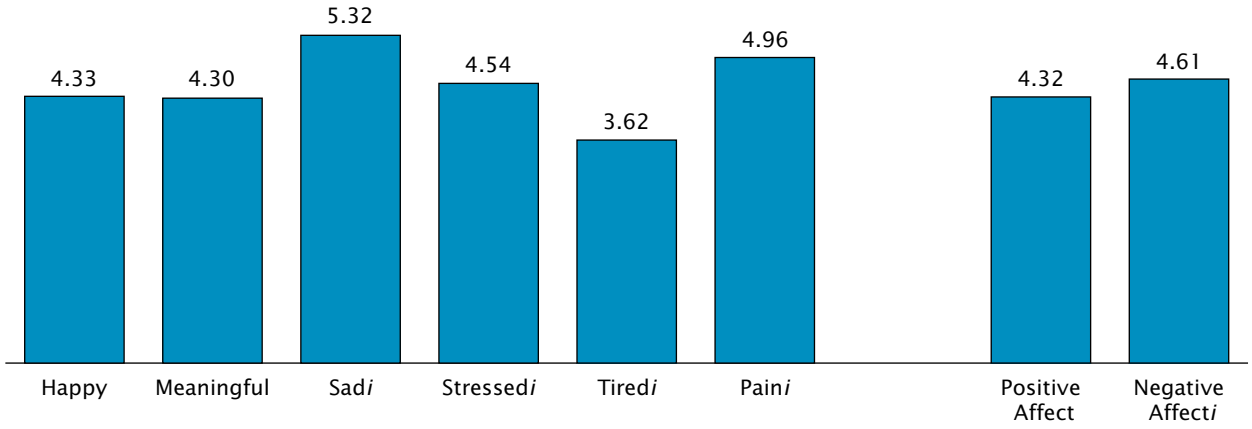
Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.

The composite variable "Positive Affect" is the combined average of the two positive well-being indicators of "Happy" and "Meaningful." The composite variable "Negative Affect*i*" is the combined average of the four negative well-being indicators of "Sad*i*," "Stressed*i*," "Tired*i*," and "Pain*i*."

"Other races" includes any respondent who did not identify as White or Black and did not identify as Hispanic/Latino to the detailed CPS race question. Other races includes American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, and respondents who identified multiple races.

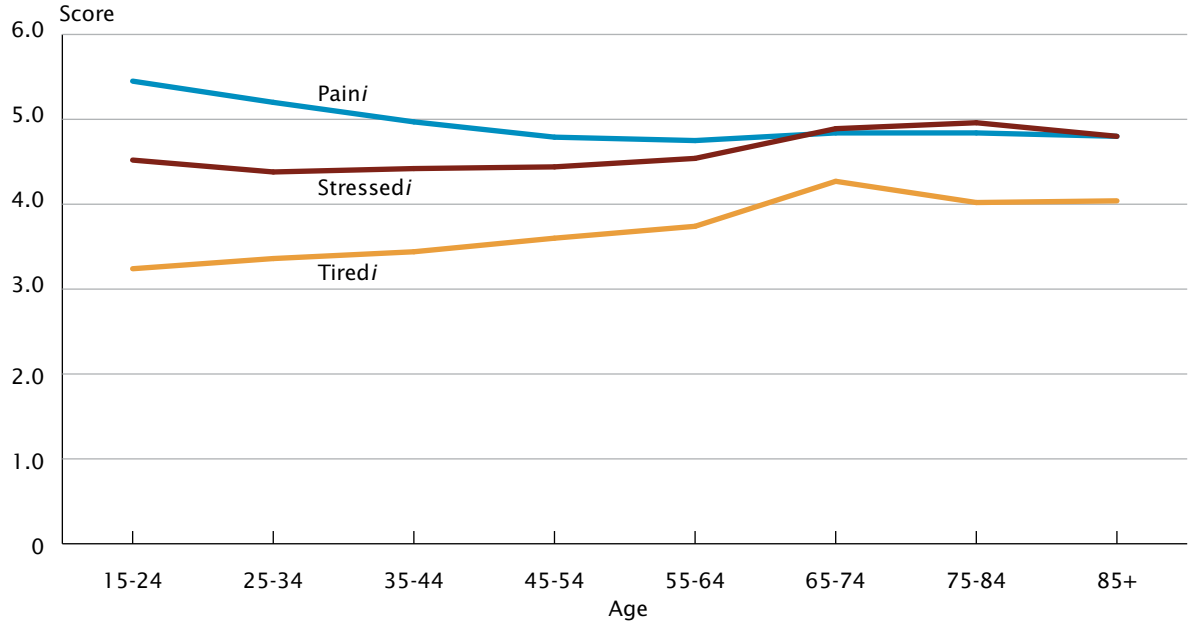
Source: American Time Use Survey, 2012–2013.

Figure 1.
Mean Score of Well-Being Indicators for Eldercare Providers Aged 15 and Over: 2012–2013



Notes: Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.
The composite variable "Positive Affect" is the combined average of the two positive well-being indicators of "Happy" and "Meaningful."
The composite variable "Negative Affect*i*" is the combined average of the four negative well-being indicators of "Sad*i*," "Stressed*i*," "Tired*i*," and "Pain*i*."
Source: American Time Use Survey, 2012–2013.

Figure 2.
Mean Score of Stressed*i*, Tired*i*, and Pain*i* for Eldercare Providers Aged 15 and Over by Age: 2012–2013



Note: Stressed*i*, Tired*i*, and Pain*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.
Source: American Time Use Survey, 2012–2013.

Age was also differentially associated with eldercare providers' view on whether their daily activities were meaningful. The youngest age groups of 15–24 and 25–34 reported the lowest levels of meaningfulness, while the older age groups above age 65 recorded higher levels with mean scores exceeding those of the youngest age groups (Table 1).

Sex: Self-reported emotional well-being by men and women revealed differences between positive and negative indicators. Women reported a slightly better state of well-being than men on the two positive affect indicators, feeling happy (4.39 compared to 4.25) and meaningful (4.37 compared to 4.22) (Table 1). In contrast, men fared better than women on negative affect indicators, with higher well-being scores regarding feelings of sadness (5.38 vs. 5.27), stress (4.67 vs. 4.44), and tiredness (3.75 vs. 3.51). These differences are likely associated with the intensity of caregiving and the type of care provided. Women are more likely than men to be providing care to individuals with more severe mental and physical health needs and more of their care is spent in activities like housework and physical care (National Academies of Sciences, 2016).

Race and Hispanic origin: Race and ethnicity are not associated with many statistical differences in well-being. Black eldercare providers were happier and more likely to find their daily activities meaningful than their White counterparts or a combined group of other races (4.61 vs. 4.26) (Table 1).[7] Hispanic providers reported higher levels of feeling happy and meaningful than non-Hispanic providers (4.52 vs 4.31; and 4.53 vs. 4.27, respectively). Higher well-being reports from Black and Hispanic eldercare providers is consistent with the higher levels of evaluative well-being among racial-ethnic minority caregivers reported in the literature (Pinquart and Sörensen, 2005).

[7] "Other races" includes American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, and respondents who identified multiple races.

Eldercare providers' well-being by marital status and living arrangement

Beyond the basic demographic characteristics, this report also examined how eldercare providers' marital status, presence of spouse/partner, living with other relatives, or presence of own children under age 18 are related to their experienced well-being (Table 2).

Marital status: The marriage advantage was demonstrated by better well-being scores of both positive and negative emotional indicators. Eldercare providers who were married reported being

Table 2.
Mean Score of Subjective Well-Being Indicators for Eldercare Providers Aged 15 and Over, by Marital Status and Living Arrangement: 2012–2013

Characteristics	Happy	Meaningful	Sad*i*	Stressed*i*	Tired*i*	Pain*i*		Positive Affect	Negative Affect*i*
Marital Status									
Married	4.41	4.43	5.35	4.59	3.69	4.95		4.42	4.65
Widowed	4.43	4.47	5.17	4.79	3.85	4.65		4.44	4.61
Divorced/separated	4.20	4.38	5.09	4.34	3.61	4.57		4.29	4.40
Never married	4.22	4.00	5.38	4.47	3.43	5.20		4.11	4.62
Spouse or Partner Present									
Spouse present	4.42	4.43	5.37	4.62	3.70	4.96		4.43	4.66
Unmarried partner present	4.06	3.96	5.32	4.18	3.39	4.97		4.01	4.46
No spouse present	4.24	4.17	5.26	4.47	3.53	4.97		4.20	4.56
Living With Other Relative									
Living with other relative	4.35	4.19	5.34	4.53	3.39	5.09		4.27	4.59
Not living with other relative	4.32	4.36	5.31	4.54	3.73	4.90		4.34	4.62
Living With Children Under 18									
Living with children	4.37	4.26	5.43	4.46	3.37	5.13		4.32	4.60
Not living with children	4.31	4.33	5.26	4.58	3.75	4.87		4.32	4.62

Notes: The mean score is derived by averaging the scores reported during three different activities on the diary day.
Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.
The composite variable "Positive Affect" is the combined average of the two positive well-being indicators of "Happy" and "Meaningful." The composite variable "Negative Affect*i*" is the combined average of the four negative well-being indicators of "Sad*i*," "Stressed*i*," "Tired*i*," and "Pain*i*."
Source: American Time Use Survey, 2012–2013.

happier or more likely to find their activities meaningful than those divorced or never married (Table 2). Interestingly, those widowed recorded similar levels of happiness or meaningfulness as their married counterparts.

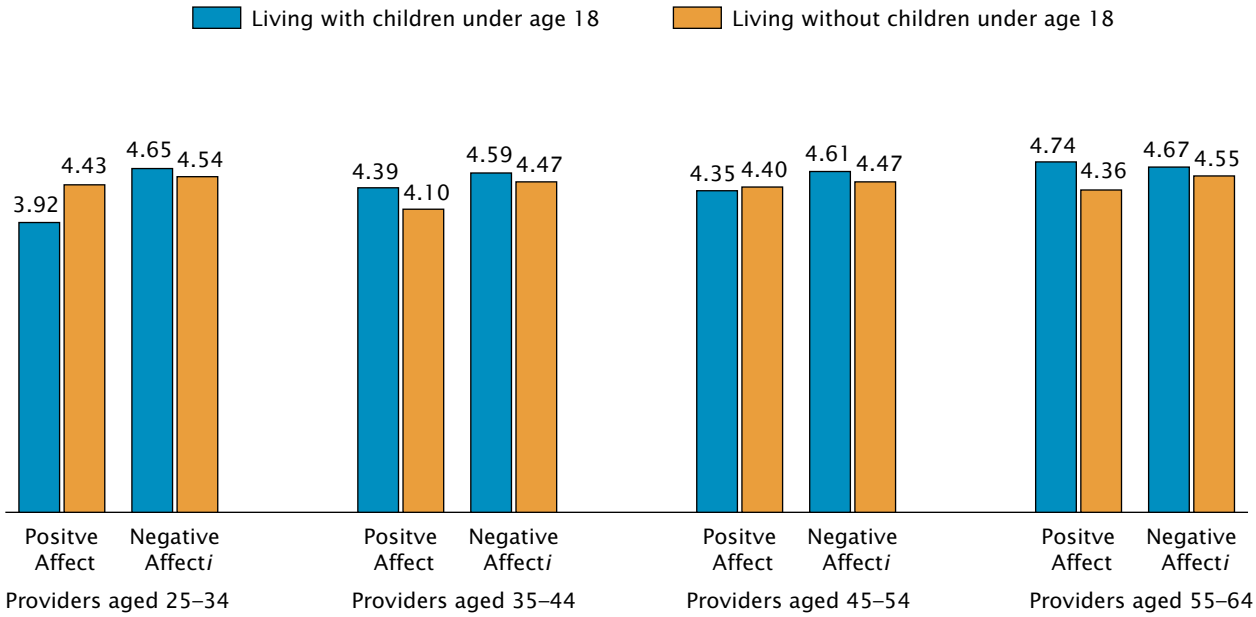
It is also noted that eldercare providers who were never married scored worse than those who were married, widowed, or divorced in composite positive affect (4.11 for never married compared to 4.42 for married, 4.44 for widowed, and 4.29 for divorced).

Spouse or partner present: Eldercare providers who had a spouse present, compared with those with an unmarried partner present or no spouse present, reported higher well-being levels regarding happiness and meaningfulness. The presence of a spouse is also associated with fewer reports of negative emotions of sadness, stress, and fatigue, compared with those whose spouse was not present. Whether eldercare providers were living with other relatives did not seem to be associated with their positive well-being.

Living with children under 18: Living with nonadult children may provide emotional satisfaction but childcare could also add stress or other negative feelings (Wang, 2013; Musick, Meier, and Flood, 2016). ATUS data showed that having nonadult children (under age 18) living in the same household has mixed associations with eldercare well-being. While living with children did not result in significant differences for eldercare providers' feelings toward happiness or meaningfulness of their activities, they reported better well-being regarding sadness and pain but worse well-being regarding stress and fatigue than those without children living in the household (Table 2).

A further analysis of eldercare providers by age groups showed that having nonadult children living in the same household was correlated with better composite positive emotions for those aged 35–44 and 55–64, but interestingly lower composite positive emotions for providers aged 25–34 (Figure 3). On the other hand, those aged 45–54 living with children under age 18 reported lower scores for composite negative affect than their counterparts without.

Figure 3.
Mean Score of Well-Being Indicators for Eldercare Providers, by Presence of Children Under Age 18 and Provider Age: 2012–2013



Notes: The composite variable "Positive Affect" is the combined average of the two positive well-being indicators of "happy" and "meaningful."
The composite variable "Negative Affect*i*" is the combined average of the four negative well-being indicators of "Sad*i*," "Stressed*i*," "Tired*i*," and "Pain*i*." Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.
Source: American Time Use Survey, 2012–2013.

Health of eldercare providers: Eldercare providers' self-reported own health has a positive association with their well-being—the better their health, the higher the level of well-being they experienced during their activities.[8] This is consistent with studies that examine associations of hedonic well-being with self-reported health among all adults (Lee et al., 2015). While providers with excellent health reported a higher level of happiness (data not shown), it is the four negative feeling indicators that demonstrated clearly the progression of well-being (Figure 4).[9] Strikingly, but perhaps not surprisingly, providers with poor health experienced worse well-being related to fatigue and pain (2.59 for tired*i* and 2.83 for pain*i*), scores lower than the middle point on the scale of 0-6 and the lowest seen in this study. Additionally, reports of excellent health were associated with the highest well-being scores in this report (5.61) for lack of both sadness and pain.

Differences in well-being by eldercare provider status

Whether one was an eldercare provider is reflected in differences, albeit small, in self-reported well-being (Figure 5). A similar composite positive affect notwithstanding, in general eldercare providers fared less well than those who did not provide care to older people.

Interestingly, the only indicator on which eldercare providers reported better well-being than their nonprovider counterparts was to feel what they were doing was meaningful.[10] This pattern can be observed across the demographic characteristics of sex, race, Hispanic origin, and age groups of under 25, 45–54, and 75–84 (see Table A-2 for data).[11] Eldercare providers with poor health also reported higher scores (4.57) than nonproviders with poor health (3.94) on meaningfulness.

Life satisfaction for eldercare providers and nonproviders

The ATUS includes an evaluative well-being question where the respondents were asked how they viewed their life on an imaginary ladder of 0 to 10, where 0 represents the worst possible life and 10 represents the best possible life. Eldercare providers aged 15 and over were in general satisfied with their overall life, with an average mean score of 7.03 out of 10 (Figure 6). The older providers,

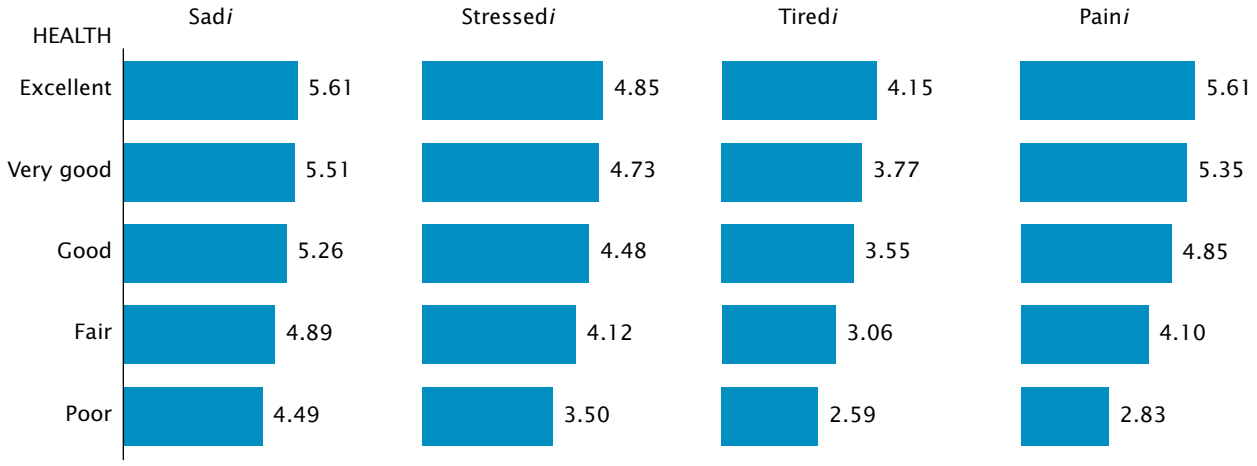
[8] Respondents were asked, "Would you say your health in general is excellent, very good, good, fair, or poor?"

[9] The mean scores for stressed*i* between excellent health and very good health are not statistically different.

[10] The three randomly selected activities asked in the Well-Being module may or may not be eldercare-specific.

[11] The differences by eldercare provider status for females, other races, and Hispanics are not statistically significant.

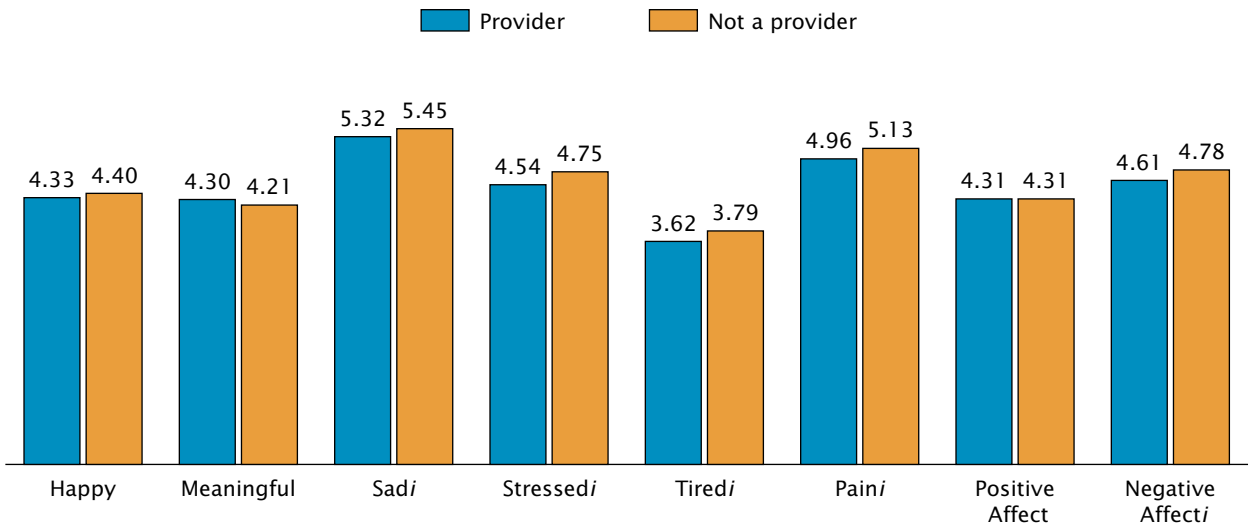
Figure 4.
Mean Score of Negative Emotional Well-Being Indicators by Health Assessment of Eldercare Providers Aged 15 and Over: 2012–2013



Notes: Sad*i*, Stressed*i*, Tired*i*, and Pain*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.
Source: American Time Use Survey, 2012–2013.

Figure 5.

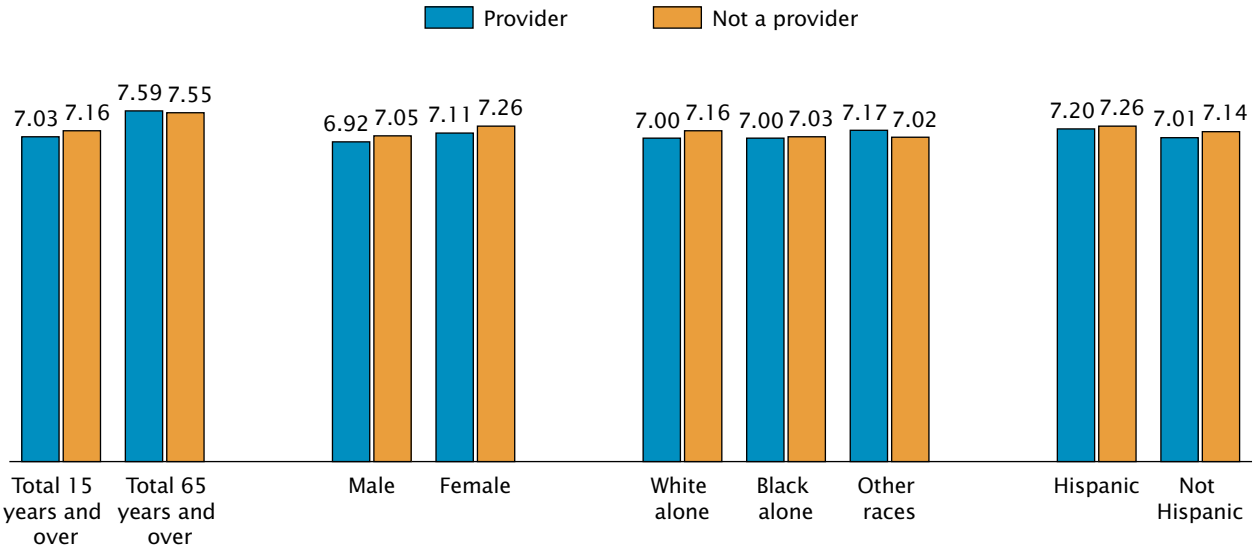
Mean Score of Well-Being Indicators for Population Aged 15 and Over by Eldercare Provider Status: 2012–2013



Notes: Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.
The composite variable "Positive Affect" is the combined average of the two positive well-being indicators of "Happy" and "Meaningful."
The composite variable "Negative Affect*i*" is the combined average of the four negative well-being indicators of "Sad*i*," "Stressed*i*," "Tired*i*," and "Pain*i*."
Source: American Time Use Survey, 2012–2013.

Figure 6.

Mean Score of Life Satisfaction for Population Aged 15 and Over by Eldercare Provider Status: 2012–2013



Note: "Other races" includes American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, and respondents who identified multiple races.
Source: American Time Use Survey, 2012–2013.

those aged 65 and over, reported a higher level of life satisfaction, at 7.59.

Female providers assessed their life with a higher degree of satisfaction than male providers (7.11 vs. 6.92). This is consistent with the pattern observed in reports on feeling happy and finding meaning about the activities they were doing. Race and Hispanic origin did not yield statistically significant comparisons.

Noneldercare providers reported better life satisfaction than eldercare providers across many characteristics—the total aged 15 and over, men, women, and Whites. Eldercare provider status did not differentiate life satisfaction for Blacks and individuals in other racial categories.

SUMMARY

Using the ATUS Well-Being module, this study examined eldercare providers' positive and negative feelings experienced during their daily activities based on the three randomly selected activities asked in the Well-Being module. We found that the eldercare providers reported better states of well-being when asked about negative feelings than positive feelings (average mean scores of 5 or above on a scale of 0–6 for most negative feeling indicators compared to average mean scores of low 4 for positive feeling indicators). Feelings of sadness or pain seemed to be less directly related to well-being. These results are comparable with well-being indicators reported for all adults in subjective well-being research.[12] Elder caregiving can enhance feelings of closeness to care recipient and reduce worry over the care recipient receiving less than optimal care. Caregiving can also improve the provider's interpersonal communication and problem solving and build confidence (Beach et al., 2000).

Analyses by various characteristics revealed that younger providers (aged 25 to 44) reported worse well-being levels regarding stress and fatigue than older providers and were less likely to report they found daily activities meaningful. Although women providers reported higher levels of happiness and meaningfulness, men fared better emotionally related to sadness, stress, and fatigue. A marriage advantage is observed, as married women and men reported higher well-being compared with those who had never married. Because the ATUS data are cross-sectional, this difference may reflect the influence of widowhood or divorce on momentary affective states. Caregiving is a complex phenomenon with positive and negative consequences on well-being. Living with a spouse may provide benefits through companionship and emotional support via a spouse, but may also be linked with negative benefits if the caregiver is providing eldercare directly to the spouse (Beach et al., 2000). Presence of children (under age 18) showed mixed associations with well-being, evidenced by reporting of better scores for sadness or pain but worse scores for stress and tiredness.

This report also included comparative analysis of well-being between eldercare providers and nonproviders. In general, providers fared less well except that they reported higher scores for meaningfulness than nonproviders.

The ATUS Well-Being module also included an evaluative question on overall life. On average, eldercare providers were satisfied with their overall life (a mean score of 7 out of 10), with older or female providers reporting higher levels of satisfaction than younger and male counterparts. Similar to responses about experienced well-being, eldercare providers reported lower levels of overall life satisfaction than nonproviders.

DISCUSSION

The U.S. older population entered a rapid growth period when the first Baby Boomers turned age 65 in 2011, and this large birth cohort is also experiencing increasing life expectancies at older ages. Families and society are facing a growing urgent demand for caregiving to the older population, especially those aged 85 and over. Much research has been devoted to the health and well-being of the care recipients. Given that the vast majority of care is provided by unpaid, informal caregivers who usually are family members of the recipient, it is equally important to understand the health and well-being of the caregivers.

This report is one of the first studies to report the *experienced well-being* of eldercare providers during daily activities, a contribution to the subjective well-being field that addresses gaps in knowledge about momentary affect. The time diary enabled the eldercare providers to reflect upon their specific feelings when they performed various activities in the immediate past (last 24 hours). By and large, their experienced well-being was

[12] For more information, particularly on the lack of negative affect, see Lee et al., 2016.

consistent with their overall life satisfaction, but the time diary was able to capture the gradation of feelings beyond the overall life assessment. This report showed that a high level of well-being from positive feelings does not equate to a low level of well-being from negative feelings, and the well-being level varies by activity and the respondent's demographic and other characteristics.

Caution is needed when interpreting the report's results—eldercare provider's status in ATUS is defined by a single question: "Not including financial assistance or help you provided as part of your paid job, since the 1st of [reference month], have you provided any care or assistance for an adult who needed help because of a condition related to aging?"[13] The eldercare question is not followed by questions about specific types of eldercare tasks (for example, whether helping with self-care, or driving to doctor's office, or other activities).[14] Note also that the eldercare question is not a diary based measure. The respondents who indicate that they have provided eldercare at some point in the past 3–4 months may or may not do any eldercare related activities on the diary day when the Subjective Well-Being module was also fielded.

In addition, the self-reported well-being by eldercare providers referred to any three randomly selected activities on the diary day. While these caregivers had provided eldercare, the randomly selected three activities based on which they reported their feelings on the diary day may or may not be eldercare-specific activities.[15] Therefore, this study was not able to provide data on the feelings the eldercare providers experienced while performing a specific eldercare task. More specific data are needed in the future to better understand the well-being of the eldercare providers when they provide specific caregiving tasks. Data appropriate for examining eldercare provision as individuals transition into and out of family and employment roles are also needed to advance knowledge on enduring associations of well-being of eldercare providers.

SOURCES AND ACCURACY

The ATUS universe consists of the civilian noninstitutionalized population aged 15 and older and residing in occupied housing units in the United States. ATUS sample members are drawn from the population of households that participated in the Current Population Survey (CPS), a separate survey carried out for the Bureau of Labor Statistics by the U.S. Census Bureau. Because the ATUS uses the CPS as its sample frame, some information—such as age, sex, race, ethnicity, educational attainment, employment status, and household composition—has already been collected before the ATUS interview is conducted. Some of this information is updated in the ATUS interview. Respondents are asked to confirm that each member of the household still lives there; if a former household member has moved or passed away—or, alternatively, if someone new has been born or moved into the household—the information on household members is updated accordingly. Respondents also are asked to provide updates on any changes in employment for themselves and for their spouses or unmarried partners. ATUS respondents aged 15 to 49 are asked about school enrollment. Information on educational attainment, race, and ethnicity is not asked again in the ATUS, but their CPS values are used to generate estimates, and this information is included in the ATUS microdata files. For more information about the ATUS data sources, see <www.bls.gov/opub/hom/atus/data.htm>.

The estimates in this report (which may be shown in text, figures, and tables) are based on responses from a sample of the population. Sampling error is the uncertainty between an estimate based on a sample and the corresponding

[13] The reference month refers to 3–4 months before the interview.

[14] After the eldercare question is answered by yes/no, the eldercare provider answers follow-up questions regarding care provision frequency and duration, number of and age of the recipient(s), and respondent's relations with the recipient(s).

[15] Only about 1 percent of activities included in the Subjective Well-Being module are flagged as eldercare, so while it was possible to identify the eldercare activity among the three randomly selected activities, the analysis would not produce meaningful or statistically significant findings.

value that would be obtained if the estimate were based on the entire population (as from a census). All comparative statements in this report have undergone statistical testing, and comparisons are significant at the 90 percent level unless otherwise noted. In addition to sampling error, nonsampling error may be introduced during any of the operations used to collect and process survey data, such as editing, reviewing, or keying data from questionnaires. For more information on CPS's sampling and estimation methods, confidentiality protection, and sampling and nonsampling errors, see <www.census.gov/programs-surveys/cps/technical-documentation/methodology.html>.

REFERENCES

Adelman, Ronald D., Lyubov L. Tmanova, Diana Delgado, Sarah Dion, and Mark S. Lachs, 2014, "Caregiver Burden: A Clinical Review," *JAMA,* 311(10): 1052–1060.

Beach, Scott R., Richard Schulz, Gail M. Williamson, L. Stephen Miller, Myron F. Weiner, and Charles E. Lance, 2005, "Risk Factors for Potentially Harmful Informal Caregiver Behavior," *Journal of the American Geriatrics Society,* 53(2): 183–366.

Bevans, Margaret and Esther M. Sternberg, 2012, "Caregiving Burden, Stress, and Health Effects Among Family Caregivers of Adult Cancer Patients," *JAMA,* 307(4): 398–403.

Brooks, Jeremy S., 2013, "Avoiding the Limits to Growth: Gross National Happiness in Bhutan as a Model for Sustainable Development," *Sustainability,* 5: 3640–3664.

Bureau of Labor Statistics, 2014, *American Time Use Survey (ATUS) Data Dictionary: 2010, 2012, and 2013 Well-Being Module Data Variables collected in the ATUS Well-Being Module*, <www.bls.gov/tus/wbmintcodebk.pdf>.

_____, 2015, "Unpaid Eldercare in the United States – 2013-2014 Data from the American Time Use Survey," <www.bls.gov/tus>.

_____, 2016a, *American Time Use Survey User's Guide: Understanding ATUS 2003 to 2015*, <www.bls.gov/tus/atususersguide.pdf>.

_____, 2016b, *American Time Use Survey Fact Sheet*, <www.bls.gov/tus/atussummary.pdf>.

_____, 2017, American Time Use Survey, <www.bls.gov/tus/>.

Colby, Sandra L. and Jennifer M. Ortman, 2015, *Projections of the Size and Composition of the U.S. Population: 2014 to 2060*, U.S. Census Bureau, Current Population Reports, P25-1143.

Denton, Stephanie L., 2012, "Adding Eldercare Questions to the American Time Use Survey," *Monthly Labor Review,* November 2012.

Dolan, Paul, Richard Layard, and Robert Metcalfe, 2011, *Measuring Subjective Wellbeing for Public Policy: Recommendations on Measures*, Report to the United Kingdom Office for National Statistics.

Freedman, Vick A., Jennifer C. Cornman, and Deborah Carr, 2014, "Is Spousal Caregiving Associated With Enhanced Well-Being? New Evidence From the Panel Study of Income Dynamics," *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences,* 69(6), 861–869.

He, Wan and Luke J. Larsen, 2014, *Older Americans With a Disability: 2008-2012*, U.S. Census Bureau, American Community Survey Report, ACS-29, U.S. Government Printing Office, Washington, DC.

Helliwell, John, Richard Layard, and Jeffrey Sachs, eds. 2017, *World Happiness Report 2017*, New York: Sustainable Development Solutions Network.

Hogan, Howard, Debbie Perez, and William R. Bell, 2008, *Who (Really) Are the First Baby Boomers?*, in Joint Statistical Meetings Proceedings, Social Statistics Section, Alexandria, VA: American Statistical Association, 1009–1016.

Kim, Heejung, Mido Chang, Karen Rose, and Sunha Kim, 2011, "Predictors of Caregiver Burden in Caregivers of Individuals With Dementia," *Journal of Advanced Nursing,* 69(4): 846–855.

Lee, Yoonjoo, Sandra L. Hofferth, Sarah M. Flood, and Kimberly Fisher, 2016, "Reliability, Validity, and Variability of the Subjective Well-being Questions in the 2010 American Time Use Survey," *Social Indicators Research* (126): 1355–1373.

Lin, I-Fen, Holly R. Fee, and Hsueh-Sheng Wu, 2012, "Negative and Positive Caregiving Experiences: A Closer Look at the Intersection of Gender and Relationship," *Family Relations,* 61(2): 343–358.

Musick, Kelly, Ann Meier, and Sarah Flood, 2016, "How Parents Fare: Mothers' and Fathers' Subjective Well-Being in Time with Children," *American Sociological Review,* 81(5): 1069–1095.

National Academies of Sciences, Engineering, and Medicine, 2016, *Families Caring for an Aging America*, Washington, DC: The National Academies Press.

National Center for Health Statistics, 2016, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, Hyattsville, MD.

National Research Council, 2012, *The Subjective Well-Being Module of the American Time Use Survey: Assessment for Its Continuation*, Panel on Measuring Subjective Well-Being in a Policy-Relevant Framework, Committee on National Statistics, Division of Behavioral and Social Sciences and Education, Washington, DC: The National Academies Press.

OECD, 2013, *OECD Guidelines on Measuring Subjective Well-being*, OECD Publishing.

Pinquart, Martin and Silvia Sörensen, 2005, "Ethnic Differences in Stressors, Resources, and Psychological Outcomes of Family Caregiving: A Neta-Analysis," *The Gerontologist,* 45(1): 90–106.

_____, 2007, "Correlates of Physical Health of Informal Caregivers: A Meta-Analysis," *Journal of Gerontology B*, 62(2): 126–37.

Schwarz, Norbert, Daniel Kahneman, and Jing Zu, 2009, "Global and Episodic Reports of hedonic Experience," in *Calendar and Time Diary Methods in Life Course Research*, edited by Robert F. Belli, Frank P. Stafford and Duane F. Alwin, Sage Thousand Oaks, CA.

Seltzer, Judith A. and Suzanne M. Bianchi, 2013, "Demographic Change and Parent-Child Relationships in Adulthood," *Annual Review of Sociology,* 39(1): 275–290.

Steptoe, Andrew, Angus Deaton, and Arthur A. Stone, 2014, "Subjective Wellbeing, Health, and Ageing," *The Lancet,* (385): 640–48, published online November 2014.

Stone, Arthur A., 2012, *Subjective Wellbeing Assessment for Survey Research*, Department of Psychiatry and Behavioral Science Stony Brook University, WHO Technical Meeting, December 2012.

Stone, Arthur A. and Christopher Mackie, eds, 2013, *Subjective Well-Being: Measuring Happiness, Suffering, and Other Dimensions of Experience*, Panel on Measuring Subjective Well-Being in a Policy-Relevant Framework, A.A. Stone and C. Mackie, Editors, Committee on National Statistics, Division of Behavioral and Social Sciences and Education, Washington, DC: The National Academies Press.

United Nations, 2011, Resolution 65/309, *Happiness: Toward a Holistic Approach to Development*.

U.S. Census Bureau, 2014a, 2014 National Population Projections: Summary Tables, Table 3, <www.census.gov/topics/population/population-projections.html>.

_____, 2014b, 2014 National Population Projections: Summary Tables, Table 6, <www.census.gov/topics/population/population-projections.html>.

U.S. National Institute on Aging, U.K. Economic and Social Research Council, and U.S. National Academy of Sciences, 2011, *Workshop on the Role of Well-Being Measures in Public Policy: Workshop Summary*.

Wang, Wendy, 2016, *Parents' Time with Kids More Rewarding than Paid Work – and More Exhausting*, Washington, DC: Pew Research Center.

West, Loraine A., Samantha Cole, Daniel Goodkind, and Wan He, 2014, *65+ in the United States: 2010*, U.S. Census Bureau, Current Population Reports, P23-212, U.S. Government Printing Office, Washington, DC.

Table A-1.

Percentage Distribution of Eldercare Providers Aged 15 and Over Who Reported Subjective Well-Being, by Age, Sex, Race, and Hispanic Origin: 2012–2013

Characteristics	Eldercare providers			Percent eldercare provider of total population		
	Number	Percent	Margin of error	Total	Percentage eldercare provider	Margin of error
Total	**50,985,595**	**100.0**		**100.0**	**20.5**	**0.7**
Age						
15–24	8,216,670	16.1	1.6	100.0	19.2	2.2
25–34	5,743,938	11.3	1.1	100.0	13.9	1.5
35–44	6,598,973	12.9	1.1	100.0	16.7	1.4
45–54	11,780,303	23.1	1.3	100.0	27.1	1.6
55–64	10,573,414	20.7	1.4	100.0	27.4	2.0
65–74	4,890,169	9.6	0.9	100.0	20.2	2.0
75–84	2,684,915	5.3	0.7	100.0	18.4	2.6
85 and older	497,213	1.0	0.3	100.0	13.2	3.9
65 and older	8,072,297	15.8	1.1	100.0	19.0	1.5
Sex						
Male	22,207,545	43.6	1.8	100.0	18.5	1.1
Female	28,778,050	56.4	1.8	100.0	22.4	0.9
Race and Hispanic Origin						
White alone	42,662,528	83.7	1.3	100.0	21.0	0.8
Black alone	6,053,520	11.9	1.1	100.0	20.3	2.1
Other races	2,269,547	4.5	0.9	100.0	14.5	2.7
Hispanic	5,609,279	11.0	1.2	100.0	14.8	1.8
Not Hispanic	45,376,316	89.0	1.2	100.0	21.6	0.8

Note: "Other races" includes any respondent who did not identify as White or Black and did not identify as Hispanic/Latino to the detailed CPS race question. Other races includes American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, and respondents who identified multiple races.

Source: American Time Use Survey, 2012–2013.

Table A-2.

Mean Score and Standard Error of Subjective Well-Being Indicators for Population Aged 15 and Over, by Eldercare Provider Status and Selected Characteristics: 2012–2013

Characteristics	Happy	Meaningful	Sad*i*	Stressed*i*	Tired*i*	In Pain*i*		Positive Affect	Negative Affect*i*
Eldercare Provider									
Total	4.33	4.30	5.32	4.54	3.62	4.96		4.32	4.61
(Standard error)	0.02	0.03	0.02	0.03	0.03	0.03		0.02	0.02
Sex									
Male	4.25	4.22	5.38	4.67	3.75	5.01		4.24	4.70
(Standard error)	0.04	0.04	0.04	0.05	0.05	0.04		0.04	0.03
Female	4.39	4.37	5.27	4.44	3.51	4.93		4.38	4.54
(Standard error)	0.03	0.03	0.03	0.04	0.04	0.04		0.03	0.03
Age									
Under 25	4.32	3.85	5.51	4.52	3.24	5.45		4.08	4.68
(Standard error)	0.07	0.09	0.04	0.09	0.09	0.06		0.07	0.05
25–34	4.20	4.17	5.42	4.38	3.36	5.20		4.18	4.59
(Standard error)	0.07	0.09	0.05	0.08	0.09	0.08		0.07	0.06
35–44	4.30	4.27	5.36	4.42	3.44	4.97		4.28	4.55
(Standard error)	0.06	0.07	0.06	0.08	0.08	0.07		0.05	0.05
45–54	4.34	4.43	5.25	4.44	3.60	4.79		4.38	4.52
(Standard error)	0.05	0.05	0.05	0.06	0.06	0.07		0.04	0.04
55–64	4.36	4.44	5.22	4.54	3.74	4.75		4.40	4.56
(Standard error)	0.05	0.06	0.05	0.06	0.07	0.07		0.05	0.05
65–74	4.46	4.45	5.23	4.89	4.27	4.84		4.46	4.81
(Standard error)	0.07	0.08	0.07	0.08	0.08	0.10		0.06	0.06
75–84	4.29	4.64	5.38	4.96	4.02	4.84		4.46	4.80
(Standard error)	0.10	0.10	0.08	0.09	0.13	0.13		0.08	0.09
85 and older	4.48	4.65	5.01	4.80	4.04	4.80		4.57	4.66
(Standard error)	0.30	0.27	0.31	0.29	0.30	0.27		0.24	0.23
Race and Hispanic Origin									
White alone	4.26	4.21	5.34	4.54	3.63	4.95		4.23	4.61
(Standard error)	0.03	0.03	0.02	0.04	0.03	0.03		0.03	0.02
Black alone	4.61	4.71	5.34	4.70	3.81	5.00		4.66	4.71
(Standard error)	0.07	0.09	0.07	0.10	0.09	0.08		0.07	0.06
Other races	4.32	4.28	5.14	4.35	3.48	4.91		4.30	4.47
(Standard error)	0.13	0.13	0.15	0.16	0.15	0.17		0.11	0.12
Hispanic	4.52	4.53	5.27	4.45	3.39	5.01		4.52	4.53
(Standard error)	0.07	0.09	0.07	0.10	0.09	0.10		0.07	0.06
Not Hispanic	4.31	4.27	5.33	4.55	3.64	4.96		4.29	4.62
(Standard error)	0.03	0.03	0.02	0.03	0.03	0.03		0.03	0.02
Health									
Excellent	4.63	4.30	5.61	4.85	4.15	5.61		4.46	5.06
(Standard error)	0.05	0.08	0.14	0.07	0.07	0.04		0.06	0.04
Very good	4.39	4.19	5.51	4.73	3.77	5.35		4.29	4.84
(Standard error)	0.05	0.05	0.03	0.05	0.05	0.04		0.04	0.03
Good	4.29	4.40	5.26	4.48	3.55	4.85		4.35	4.53
(Standard error)	0.04	0.04	0.04	0.05	0.06	0.05		0.04	0.04
Fair	4.03	4.31	4.89	4.12	3.06	4.10		4.17	4.04
(Standard error)	0.06	0.08	0.07	0.09	0.09	0.10		0.06	0.07
Poor	3.95	4.57	4.49	3.50	2.59	2.83		4.25	3.35
(Standard error)	0.13	0.14	0.15	0.22	0.18	0.21		0.12	0.15

See notes at end of table.

Table A-2.

Mean Score and Standard Error of Subjective Well-Being Indicators for Population Aged 15 and Over, by Eldercare Provider Status and Selected Characteristics: 2012–2013—Con.

Characteristics	Happy	Meaningful	Sad*i*	Stressed*i*	Tired*i*	In Pain*i*		Positive Affect	Negative Affect*i*
Marital Status									
Married	4.41	4.43	5.35	4.59	3.69	4.95		4.42	4.65
(Standard error)	0.03	0.03	0.03	0.04	0.04	0.04		0.03	0.03
Widowed	4.43	4.47	5.17	4.79	3.85	4.65		4.44	4.61
(Standard error)	0.10	0.10	0.03	0.10	0.12	0.13		0.09	0.09
Divorced/separated	4.20	4.38	5.09	4.34	3.61	4.57		4.29	4.40
(Standard error)	0.06	0.07	0.09	0.08	0.07	0.08		0.06	0.05
Never married	4.22	4.00	5.38	4.47	3.43	5.20		4.11	4.62
(Standard error)	0.05	0.06	0.02	0.06	0.06	0.05		0.05	0.04
Not Eldercare Provider									
Total	4.40	4.21	5.45	4.75	3.79	5.13		4.31	4.78
(Standard error)	0.01	0.02	0.01	0.01	0.02	0.01		0.01	0.01
Sex									
Male	4.32	4.10	5.47	4.82	3.92	5.21		4.21	4.85
(Standard error)	0.02	0.02	0.01	0.02	0.02	0.02		0.02	0.01
Female	4.48	4.31	5.42	4.68	3.67	5.05		4.40	4.70
(Standard error)	0.02	0.02	0.01	0.02	0.02	0.02		0.02	0.01
Age									
Under 25	4.33	3.67	5.61	4.84	3.59	5.54		4.00	4.89
(Standard error)	0.04	0.05	0.02	0.04	0.04	0.03		0.04	0.02
25–34	4.38	4.13	5.57	4.62	3.57	5.40		4.25	4.79
(Standard error)	0.03	0.04	0.02	0.03	0.03	0.03		0.03	0.02
35–44	4.40	4.34	5.45	4.55	3.62	5.21		4.37	4.71
(Standard error)	0.03	0.03	0.02	0.03	0.04	0.03		0.03	0.02
45–54	4.33	4.32	5.33	4.63	3.78	4.92		4.33	4.67
(Standard error)	0.03	0.04	0.03	0.04	0.04	0.04		0.03	0.03
55–64	4.36	4.41	5.26	4.72	3.86	4.74		4.38	4.65
(Standard error)	0.04	0.03	0.03	0.04	0.04	0.04		0.03	0.03
65–74	4.63	4.49	5.45	5.15	4.37	4.90		4.56	4.97
(Standard error)	0.04	0.04	0.03	0.04	0.04	0.04		0.03	0.03
75–84	4.55	4.37	5.33	5.06	4.33	4.85		4.46	4.89
(Standard error)	0.06	0.06	0.04	0.05	0.06	0.05		0.06	0.04
85 and older	4.59	4.36	5.35	5.02	4.19	4.58		4.47	4.79
(Standard error)	0.07	0.09	0.07	0.09	0.11	0.11		0.06	0.08
Race and Hispanic Origin									
White alone	4.35	4.10	5.49	4.76	3.80	5.13		4.22	4.79
(Standard error)	0.02	0.02	0.01	0.02	0.02	0.02		0.01	0.01
Black alone	4.52	4.45	5.34	4.84	3.90	5.10		4.49	4.79
(Standard error)	0.03	0.05	0.03	0.04	0.05	0.04		0.03	0.03
Other races	4.26	4.19	5.43	4.72	3.80	5.23		4.22	4.79
(Standard error)	0.05	0.06	0.04	0.06	0.07	0.05		0.05	0.04
Hispanic	4.61	4.47	5.34	4.67	3.68	5.12		4.54	4.70
(Standard error)	0.04	0.04	0.03	0.04	0.04	0.03		0.03	0.03
Not Hispanic	4.36	4.15	5.47	4.76	3.81	5.13		4.26	4.79
(Standard error)	0.01	0.02	0.01	0.02	0.02	0.01		0.01	0.01
Health									
Excellent	4.71	4.29	5.71	5.09	4.14	5.68		4.50	5.15
(Standard error)	0.03	0.04	0.02	0.03	0.03	0.02		0.03	0.02
Very good	4.51	4.19	5.63	4.93	3.98	5.49		4.35	5.00
(Standard error)	0.02	0.03	0.01	0.02	0.02	0.02		0.02	0.01
Good	4.34	4.21	5.42	4.70	3.77	5.11		4.27	4.75
(Standard error)	0.02	0.03	0.02	0.02	0.02	0.02		0.02	0.01
Fair	4.11	4.21	5.03	4.31	3.28	4.21		4.16	4.21
(Standard error)	0.03	0.04	0.04	0.04	0.04	0.05		0.03	0.03
Poor	3.52	3.94	4.11	3.41	2.36	2.60		3.72	3.12
(Standard error)	0.08	0.09	0.09	0.09	0.08	0.09		0.07	0.07

See notes at end of table.

Table A-2.

Mean Score and Standard Error of Subjective Well-Being Indicators for Population Aged 15 and Over, by Eldercare Provider Status and Selected Characteristics: 2012–2013—Con.

Characteristics	Happy	Meaningful	Sad*i*	Stressed*i*	Tired*i*	In Pain*i*		Positive Affect	Negative Affect*i*
Marital Status									
Married	4.50	4.38	5.49	4.79	3.87	5.13		4.44	4.82
(Standard error)	0.02	0.02	0.01	0.02	0.02	0.02		0.02	0.01
Widowed	4.52	4.41	5.21	4.95	4.12	4.65		4.47	4.73
(Standard error)	0.04	0.04	0.04	0.04	0.05	0.06		0.03	0.04
Divorced/separated	4.31	4.34	5.24	4.57	3.74	4.73		4.32	4.57
(Standard error)	0.03	0.04	0.03	0.04	0.04	0.04		0.03	0.03
Never married	4.26	3.84	5.49	4.72	3.62	5.35		4.05	4.80
(Standard error)	0.02	0.04	0.02	0.03	0.03	0.02		0.03	0.02

Notes: The mean score is derived by averaging the scores reported during three different activities on the diary day.

Sad*i*, Stressed*i*, Tired*i*, Pain*i*, and Negative Affect*i* are inverted scores where 0=highest negative feeling/worst well-being and 6=lowest negative feeling/best well-being.

The composite variable "Positive Affect" is the combined average of the two positive well-being indicators of "Happy" and "Meaningful." The composite variable "Negative Affect*i*" is the combined average of the four negative well-being indicators of "Sad*i*," "Stressed*i*," "Tired*i*," and "Pain*i*."

"Other races" includes any respondent who did not identify as White or Black and did not identify as Hispanic/Latino to the detailed CPS race question. Other races includes American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, and respondents who identified multiple races.

Source: American Time Use Survey, 2012–2013.