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Unfair to Me or Unfair to My Spouse: Men's and Women's Perceptions of Domestic Equity and How They Relate to Mental and Physical Health

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Research examining the relationship between household labor and health has not sufficiently considered perceptions of domestic equity, physical health, or potential gender differences in these relationships. Using survey data from 1,234 lawyers, we examine how perceptions of domestic equity are related to mental and physical health and whether these relationships differ by gender. The results indicate that perceiving the division of household labor as unfair to oneself is related to poorer mental health, whereas perceiving the division as unfair to one's spouse is related to poorer physical health, regardless of gender. This article demonstrates the importance of treating perceptions of unfairness to oneself and one's spouse as distinct experiences, while also considering the wider context wherein these relationships exist.

KEYWORDS household labor, mental health, perceptions of domestic equity, physical health, work and family

INTRODUCTION

In the past, men and women often specialized in different roles such that men were the sole breadwinners and women cared for the home and children (Robinson & Spitze, 1992; Tichenor, 2011). This division of labor is less common today; instead, both men and women are often involved in both work and family domains. Women have increased their involvement in paid employment, specifically in professional male-dominated careers such as

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medicine, engineering, and law, and decreased the time they spend completing household tasks, whereas men have increased their household involvement (Bartley, Blanton, & Gilliard, 2005; Duffy & Pupo, 2011; Pavalko, Gong, & Long, 2007; Percheski, 2008; Ravanera, Beaujot, & Liu, 2009). As a result, men's and women's contributions to household labor have moved toward becoming more similar and equitable. Despite these shifts, domestic responsibilities have been slower to change than involvement in paid employment, and women continue to bear primary responsibility for household labor, even when they are involved in full-time professional careers (e.g., Bianchi & Milkie, 2010; Lennon & Rosenfield, 1994; Marshall, 2006; Treas & Lui, 2013).

The division of household labor and, more importantly for this article, how it is perceived, may have serious implications for mental and physical health (e.g., Glass & Fujimoto, 1994; Robinson & Spitze, 1992; Tao, Janzen, & Abonyi, 2010). In addition to the actual division of housework, feelings of inequity are in and of themselves potential sources of psychological distress (Bird, 1999). Regardless of the actual distribution of household chores, perceptions of unfairness or inequity can negatively impact health, which has not been sufficiently examined in the literature. Although much of the research examining housework and health has focused on the actual division of household labor and how it is related to women's mental health, it is critical to consider how perceptions of domestic equity are related to men's and women's mental and physical health, especially given that both genders are increasingly involved in both work and family domains. Furthermore, it is important to consider that perceiving the division of household labor as unfair to oneself may be distinct from perceiving it as unfair to one's spouse (Wheaton & Young, 2009; Young, Wallace, & Polachek, 2013).

We therefore examine the following research questions: (1) Are there differences between men and women with regard to their mental and physical health and their perceptions of domestic equity? (2) How are perceptions of domestic equity related to men's and women's mental and physical health? (3) Do the associations between perceptions of domestic equity and health differ for men and women?

In addressing these questions, we use questionnaire data from a sample of practicing lawyers. The respondents are all employed and married or living in common-law relationships, which makes this sample ideal for examining how perceptions of domestic equity are related to health within the context of balancing work and home demands. Our sample, however, is unique in several important ways. First, the sample represents educationally and financially elite professionals with demanding work schedules. Professionals, such as lawyers, must devote substantial time and energy to their work (Coltrane, 2004; Wallace, 2005), and women who have entered this demanding, high-status, male-dominated field may be exceptionally committed "career women" (Epstein, 1993; Wallace, 2008).

Second, the literature tends to assume that professional women experience more egalitarian marriages (Yogev, 1981) and that this may be particularly true for lawyers because their profession is grounded in principles of justice and fairness (Kay & Gorman, 2008). However, as Yogev (1981) and Coltrane (2004) noted, whereas professionals are more likely to share the breadwinner role, caregiving and household roles still tend to be "limited by nostalgic family ideals and gender stereotypes" (Coltrane, 2004, pp. 214–215). Despite this, professional couples may be more sensitive to domestic inequity compared with working class couples (Perry-Jenkins, Newkirk, & Ghunney, 2013).

In essence, then, we examine a specific social class. The respondents are situated in a unique social context where the division of household labor and perceptions of domestic equity may have different meanings than in other social contexts (see Perry-Jenkins et al., 2013). Few studies have examined elite professionals, despite the fact that social class and context may be important in shaping experiences and consequences (see Perry-Jenkins et al., 2013). This article therefore controls for social context and education levels by examining a single occupational group and enables a more nuanced understanding of how perceptions of domestic equity may be related to mental and physical health for this particular group.

Review of the Literature

To answer our research questions, we draw on equity theory and relational ethics to understand how perceptions of domestic equity may be related to mental and physical health. Equity theory suggests that when individuals perceive relationships to be inequitable, they will experience distress and will try to restore either actual or perceived psychological equity (Walster, Walster, & Berscheid, 1978). Equity theory further specifies that perceiving relationships as inequitable may involve being either over- or under-benefited but that both conditions may be distressing. That is, receiving more or less than deserved may be distressing, although being under-benefited will be relatively more distressing than being over-benefited. In line with this, marital relationships where the division of household labor is perceived to be unfair to either spouse may be worse for one's mental health than marital relationships where the division is perceived as fair to both partners.

Similarly, relational ethics is concerned with whether benefits and burdens are equitably distributed among individuals in a relationship (Boszormenyi-Nagy & Krasner, 1986). Relational ethics refers to "the balance of give and take that exists within relationships" and suggests that if relationships are imbalanced, mental and physical health problems may arise (Grames, Miller, Robinson, Higgins, & Hinton, 2008, p. 184). That is, in imbalanced relationships, individuals may experience poorer mental health and a variety of physical health problems, including sexual malfunction, anorexia,

diabetes, or heart conditions (Grames et al., 2008). In line with this, marital relationships where there is a perceived imbalance between husbands' and wives' contributions to household labor may be worse for one's mental and physical health than relationships characterized by a balance of give and take or compromise in household labor responsibilities.

Following equity theory and relational ethics, the next sections summarize the existing literature about gender differences in health and perceptions of domestic equity, the relationships between perceptions of domestic equity and men's and women's mental and physical health, potential gender differences in these relationships, and the family and work context where the division of household labor exists.

Gender differences in health

Research frequently shows gender disparities in mental and physical health (Moen & Chermack, 2005). Women tend to experience poorer mental health, higher rates of depression and distress, and longer periods of treatment for depression than men (Bergdahl, Allard, Lundman, & Gustafson, 2007; Bird, 1999; Kessing, 2005). Women also tend to have poorer physical health, more acute and chronic illness or disability, and more frequent interactions with health professionals, whereas men tend to have infrequent but more life-threatening illnesses (Krantz, Berntsson, & Lundberg, 2005; Macintyre, Hunt, & Sweeting, 1996; Ross & Bird, 1994; Verbrugge, 1983). We therefore hypothesize the following:

Hypothesis 1: Women will report worse mental and physical health than men.

Gender differences in perceptions of domestic equity

Perceptions of domestic equity are the extent to which individuals believe the division of household labor between them and their spouse is fair. Research examining gender differences in perceptions of domestic equity shows that women are more likely than men to report the division of household labor is unfair to themselves, whereas men are more likely to report the division is unfair to their spouse (DeMaris & Longmore, 1996; Lennon & Rosenfield, 1994; Robinson & Spitze, 1992; Tao et al., 2010). Put another way, both men and women tend to recognize that wives complete an unfair share of the housework and are under-benefited compared with husbands. Despite this, research also shows that most men and women believe the division of household labor is equitably distributed between spouses (Carriero, 2011; Coltrane, 2000; Lennon & Rosenfield, 1994). We therefore hypothesize the following:

Hypothesis 2a: Women will be more likely than men to report that the division of household labor is unfair to themselves.

Hypothesis 2b: Men will be more likely than women to report that the division of household labor is unfair to their spouse.

Hypothesis 2c: Men and women will be equally likely to report that the division of household labor is fair to both spouses.

Relationship between perceptions of domestic equity and health

As equity theory and relational ethics suggest, perceiving the division of household labor as unfair may have implications for mental and physical health (Bird, 1999; Boszormenyi-Nagy & Krasner, 1986; Robinson & Spitze, 1992; Tao et al., 2010; Walster et al., 1978). Individuals may believe the division of household labor is unfair to either themselves or to their spouse, but it is important to consider that these different experiences of being either under- or over-benefited may have unique associations with mental and physical health.

Some research shows that believing the division of household labor is unfair to oneself is related to distress and depression but that viewing it as unfair to one's spouse is unrelated to mental health (Voydanoff & Donnelly, 1999). Other research, however, suggests that perceiving the division as unfair to *either* spouse may be related to poorer mental health (Glass & Fujimoto, 1994; Lennon & Rosenfield, 1994; Mirowsky & Ross, 2003; Wheaton & Young, 2009). In line with this, equity theory and relational ethics posit that individuals who believe a relationship is inequitable and imbalanced, either because they are over-benefited or under-benefited, will experience poorer mental health (Walster et al., 1978). As such, perceiving the division of household labor as unfair to either spouse may be related to poorer mental health.

Similarly, it is also likely that feelings of inequity are related to poorer physical health. Relational ethics suggests that when relationships are no longer characterized by balance and mutual compromise, individuals may experience physical health problems (Grames et al., 2008). Therefore, if an individual believes the division of household labor is unfair and imbalanced, he or she will likely experience negative physical health effects. Although little research has examined this, Ren (1997) reported that those who believed the division of household labor was unfair were significantly more likely to report poorer overall health compared with those who believed it was fair. Based on these ideas we hypothesize the following:

Hypothesis 3: Perceiving the division of household labor as unfair to either spouse will be associated with worse mental and physical health.

Gender, perceptions of domestic equity, and health

In addition to gender differences in health and perceptions of domestic equity, it is also possible that the *relationship* between perceptions of

domestic equity and health may differ for men and women. As Bianchi, Casper, and King (2005) explain, work and family may impact men's and women's health in different ways, even when they experience similar roles or contexts, as a result of gendered expectations, behaviors, and responses to stress (Froberg, Gjerdingen, & Preston, 1986; Moen & Chermack, 2005).

More specifically, some research shows that perceptions of domestic equity are related to mental health, but only for men (e.g., Tao et al., 2010). Most research, however, suggests the opposite: that perceptions of domestic equity are related to women's mental health but not men's (e.g., Glass & Fujimoto, 1994; Robinson & Spitze, 1992; Voydanoff & Donnelly, 1999). It is also likely that there may be gender differences in the relationship between perceptions of domestic equity and physical health. For example, Krantz et al. (2005) suggest differences in how men's and women's physical health is impacted by work and family. Their research shows that women's physical health is related to both work conditions and household responsibilities but that men's physical health is only related to work conditions. It is possible, then, that perceptions of domestic equity will be related to women's physical health but not men's if men's health is only affected by paid employment.

Given the contradictory findings and lack of research, we consider these relationships in an exploratory way. Specific hypotheses are not presented; instead, we take a more general approach to explore how perceptions of domestic equity are related to men's and women's mental and physical health. We therefore hypothesize the following:

Hypothesis 4: Men's and women's mental and physical health will be differentially related to perceptions of domestic equity.

Family and work context

To effectively analyze the association between perceptions of domestic equity and health among men and women, we must consider the broader context in which perceptions of domestic equity exist, because work and family do not occur in isolation (Perry-Jenkins et al., 2013). For this reason, we include a series of secondary variables that tap other family demands, family resources, work demands, and work resources (Voydanoff, 2004, 2005).

Family demands such as *time spent in housework on work days* and on *nonwork days*, the *presence of children*, and *spouse's work hours* may be related to greater household involvement and to poorer mental and physical health (e.g., Aguilera, 2005; Bird & Fremont, 1991; Glass & Fujimoto, 1994; Lee, 2007; Perry-Jenkins et al., 2013; Robinson & Spitze, 1992). On the other hand, family resources such as *income* and the use of *paid help* may be related to less household involvement and to improved mental and physical health (e.g., Marshall, 2006; Treas & Tai, 2011; Ross & Bird, 1994).

Work demands such as *work hours* and *work overload* may limit one's involvement in housework and may be related to poorer mental and physical health (e.g., Aguilera, 2005; Kleiner & Pavalko, 2010; Voydanoff, 2005; Wallace, 2005). Finally, work resources such as *schedule control* and working in an environment with a supportive *work–family culture* may be related to greater involvement in housework as well as better mental and physical health (e.g., Kelly, Moen, & Tranby, 2011; Moen & Yu, 2000; Voydanoff, 2005; Wallace, 2005). Finally, *age* is included as a control variable because household labor and health, as well as work and family demands, vary throughout the life course (Bianchi, Milkie, Sayer, & Robinson, 2000; Bird, 1999; Treas & Tai, 2011; Verbrugge, 1983).

METHODS

Data Source and Participants

This study uses questionnaire data from a survey of lawyers in Alberta, Canada. In total, 5,921 active members of the Law Society of Alberta were eligible for inclusion in the study. Of the 5,921 lawyers who were eligible, 1,799 returned completed questionnaires, yielding a response rate of 30%. The data obtained from this sample were compared with population data from the Law Society, and the sample data had similar proportions in terms of gender, workplace, and city of practice (available from authors). For this article we restricted the sample to those respondents who were married or living in a common-law relationship, who worked at least 10 hours per week in the practice of law, and who did not have missing data for any of the variables included in this analysis. In total, the data include 809 men (66%) and 425 women (34%). Descriptive statistics are shown in Table 1.

Measures

Unless otherwise indicated, responses are coded so that higher values reflect greater amounts of that variable. Several ordinal scales are used, and these were generated by summing the values for each item and then dividing this sum by the number of items to obtain a mean score. For scales containing missing values, respondents are included if they completed the majority of the items for each scale.

Mental and physical health

Mental health is the extent to which an individual experiences emotional and psychological well-being. Mental health is frequently examined using measures of depression where mental health and depression are considered

TABLE 1 Descriptive Statistics ($n = 1{,}234$)

	Mean	Range
Depression	1.92	1.14–4
Physical health	3.75	1–5
Perceptions of domestic equity		
Division of housework is unfair to me	.15	0–1
Division of housework is unfair to my spouse	.25	0–1
Division of housework is fair to both of us	.60	0–1
Gender (1 = Male)	.66	0–1
Family demands		
Time spent in housework on work days	1.64	0–9
Time spent in housework on nonwork days	3.83	0–12
Children under 6 (1 = yes)	.28	0–1
Children aged 6–12 (1 = yes)	.32	0–1
Children aged 13–18 (1 = yes)	.26	0–1
Children over 18 (1 = yes)	.12	0–1
No children (1 = yes)	.35	0–1
Spouse's work hours	33.66	0–100
Family resources		
Income (in thousands)	123.60	2–750
Paid help (1 = yes)	.27	0–1
Work demands		
Work hours	50.87	10–100
Work overload	3.49	1–5
Work resources		
Schedule control	3.45	1–5
Work-family culture	3.03	1–5
Age	42.20	26–81

as opposite ends of a single continuum (Luhmann, Hofmann, Eid, & Lucas, 2012; Payton, 2009). Therefore, we assess mental health using Ross and Mirowsky's (1984) shortened version of the Centre for Epidemiology Studies' Depression scale. Respondents were asked how often in the last week they experienced each of seven symptoms (e.g., trouble getting to sleep or staying asleep, felt everything was an effort, felt sad, felt lonely) ($\alpha = .84$). Responses range from "never" (coded 1) to "most of the time" (coded 4), where higher scores indicate more symptoms of depression and thus poorer mental health.

Physical health reflects the extent to which an individual experiences physical well-being and was assessed following the National Survey of Families and Households (see Sweet, Bumpass, & Call, 1988). Respondents were asked to rate their health compared with other people their age. Responses range from "poor" (coded 1) to "excellent" (coded 5). This self-report measure of overall physical health was shown to be reliable, reproducible, highly correlated with more objective assessments made by physicians, and predictive of mortality and functional ability (Bird & Fremont, 1991; Idler & Benyamini, 1997; Idler & Kasl, 1995; Mossey & Shapiro, 1982).

Perceptions of domestic equity

The *perception of domestic equity* is the extent to which an individual believes the division of housework between them and their spouse is fair. This is assessed following Glass and Fujimoto (1994) by asking respondents how fair they believe the division of housework is between them and their spouse. Responses include "very unfair to me," "somewhat unfair to me," "pretty fair to both of us," "somewhat unfair to my spouse," and "very unfair to my spouse." Past research treats this as a linear variable, with scores ranging from 1 (very unfair to me) to 5 (very unfair to my spouse) and a value of 3 indicating the division is fair to both spouses (e.g., Glass & Fujimoto, 1994; for similar linear coding see also Lennon & Rosenfield, 1994). Most researchers recode perceptions of fairness into a dummy-coded variable where believing the division is unfair to oneself and one's spouse are coded together as "perceptions of unfairness" and compared with the other category "fair to both" (e.g., Tao et al., 2010; Voydanoff & Donnelly, 1999). More recently, it has been suggested that perceiving the division as unfair to oneself or to one's spouse may have different meanings and consequences and therefore should not be treated along the same continuum nor as equivalents (Wheaton & Young, 2009; Young et al., 2013). In line with this, perceptions of domestic equity were recoded as two dummy variables where "the division is unfair (or very unfair) to me" (coded 1) and "the division is unfair (or very unfair) to my spouse" (coded 1) are compared with "the division is fair to both of us" (coded 0).

Gender

Gender is assessed by asking respondents to report their sex and responses include male (coded 1) and female (coded 0).

Family and work context

In addition to the focal variables that are central to our hypotheses, a number of additional variables also need to be taken into account. These variables reflect the family and work context and, more specifically, represent family and work demands and resources (Voydanoff, 2004, 2005).

Family demands are measured by *time spent in housework on work days* and *on nonwork days, presence of children*, and *spouse's work hours*. *Time spent in housework on work days* and *nonwork days* are the number of hours an individual spends doing housework (e.g., cooking, cleaning, repairs, shopping, yard work, and banking) in a typical day when they also work in paid employment and when they do not work in paid employment, respectively. *Presence of children* is assessed by asking respondents how many children they have under the age of 6, between 6 and 12, between

13 and 18, and over 18. This is recoded as a series of dummy variables and compared with having no children. *Spouse's work hours* are the number of hours an individual's spouse works per week in paid employment, including evenings and weekends.

Family resources are measured using *income* and *paid help*. *Income* is assessed by asking respondents to report their pretax income for 1999 from the practice of law (Canadian dollars). Missing cases were estimated based on the income of other respondents with similar values for several significant predictors of income (e.g., years of experience, firm size, position within the firm, number of hours worked per week, and gender). The natural log was then taken to normalize the distribution. *Paid help* refers to whether an individual received paid help with house cleaning at least once a week (coded 1) or not (coded 0).

Work demands are measured by *work hours* and *work overload*. *Work hours* are the average number of hours an individual spends in their paid employment as a lawyer in a typical week including evenings and weekends. *Work overload* is assessed using Caplan, Cobb, and French's (1975) four Likert items. Respondents were asked about their workload being heavy, having to work very quickly to get everything done, not having enough time to get everything done, and often feeling rushed ($\alpha = .79$). Responses range from "strongly disagree" (coded 1) to "strongly agree" (coded 5).

Work resources were measured using *schedule control* and *work–family culture*. *Schedule control* was measured by a single statement asking respondents if they believe they have considerable control over the number of hours they work, and responses ranged from "strongly disagree" (coded 1) to "strongly agree" (coded 5). *Work–family culture* was based on Thompson, Beauvais, and Lyness's (1999) Work-Family Culture Supportiveness Scale where respondents were asked whether they believe they are expected to work more than 50 hours per week, to take work home at night and/or on weekends, and to put their jobs before their families ($\alpha = .79$). Responses ranged from "strongly agree" (coded 1) to "strongly disagree" (coded 5). Scatterplots indicated a potentially curvilinear relationship between work–family culture and both mental and physical health, so a squared term was created and tested. This squared term was significantly related to mental health only and therefore is included in the final regression models for mental, but not physical, health. *Age* was assessed by asking respondents what year they were born and subtracting it from the year of the survey.

Statistical Analyses

We used three types of statistical analyses to address the hypotheses: mean difference tests, ordinary least squares regression, and tests for gender interactions. Mean difference tests were conducted to determine whether significant differences existed between men's and women's perceptions of

domestic equity as outlined in Hypothesis 2. Following this, ordinary least squares regression was used to examine the relationships between gender and mental and physical health (Hypothesis 1) as well as the relationships between perceptions of domestic equity and mental and physical health (Hypothesis 3).

Finally, exploratory tests for gender interactions were conducted to determine whether perceptions of domestic equity were related to health differently for men and women (Hypothesis 4). Two interaction terms were created (e.g., *division is unfair to me* × *gender* and *division is unfair to my spouse* × *gender*) and tested separately in a series of regression equations for mental and then physical health. None of the gender interaction terms were significantly related to either outcome, and therefore only the main effects models for the pooled sample of men and women are presented.

RESULTS

Mean Differences in Domestic Equity for Men and Women

There are significant gender differences in perceptions of domestic equity, as hypothesized (Hypotheses 2a, 2b, and 2c). Women (31%) are significantly more likely than men (7%) to report the division of household labor is unfair to themselves ($t = 12.01$; $p < .001$), whereas men (33%) are significantly more likely than women (11%) to report the division is unfair to their spouse ($t = -8.49$; $p < .001$). Men (61%) and women (58%) are equally likely to report the division of household labor is fair to both spouses ($t = -.96$; $p > .05$).

Ordinary Least Squares Regression Results

The results from the main effects models for mental and physical health are presented in Tables 2 and 3, respectively. In both tables Model 1 examines the relationship between perceptions of fairness and health, independent of gender. Model 2 examines the relationship between perceptions of fairness and health, independent of gender, other family demands, family resources, work demands, and work resources.

Gender and health

The results show partial support for Hypothesis 1, which predicts that women have poorer mental and physical health than men. Table 2 shows that gender is a significant predictor of mental health in Model 1 ($\beta = -.13$, $p < .001$) such that men report less depressive symptoms than women. This relationship is no longer significant in Model 2, however, once the secondary and control variables are added. This suggests that gender differences in mental health may be explained by differences in other family demands,

TABLE 2 Regression of Depression on Perceptions of Domestic Equity, Gender, and Secondary Variables ($n = 1{,}234$)

	Model 1			Model 2		
	b	*SE*	*β*	*b*	*SE*	*β*
Perceptions of domestic equity[a]						
Division of housework is unfair to me (1 = yes)	.17	.05	0.11**	.13	.04	.09**
Division of housework is unfair to my spouse (1 = yes)	.13	.04	0.11***	.07	.04	.06
Gender (1 = male)	−.14	.03	−.13***	−.03	.04	−.03
Family demands						
Time spent in housework on work days				.01	.02	.01
Time spent in housework on nonwork days				.01	.01	.04
Children under 6 (1 = yes)[b]				−.05	.04	−.04
Children aged 6 to 12 (1 = yes)[b]				.01	.03	.01
Children aged 13 to 18 (1 = yes)[b]				.00	.04	.00
Children over 18 (1 = yes)[b]				−.03	.05	−.02
Spouse's work hours				.00	.00	.02
Family resources						
Income (natural log)				−.11	.02	−.15***
Paid help (1 = yes)				.02	.04	.02
Work demands						
Work hours				.00	.00	.01
Work overload				.13	.02	.19***
Work resources						
Schedule control				−.03	.01	−.07*
Work family culture				−.10	.02	−.19***
Work family culture squared				.03	.01	.06*
Age				−.00	.00	−.01
Constant	1.95	.03		2.75	.28	
R^2		.04			.18	

[a]Compared with the reference category "division of housework is fair to both of us."

[b]Compared with the reference category "no children."

*$p < .05$, **$p < .01$, ***$p < .001$ (two-tailed test).

family resources, work demands, and work resources. In addition, the results in Table 3 show that gender is not significantly related to physical health in either Model 1 or 2.

Perceptions of Domestic Equity and Health

The results also show partial support for Hypothesis 3, which predicts that perceiving the division as unfair to either spouse is associated with poorer mental and physical health. Starting first with mental health (Table 2), the results show that perceiving the division of household labor as unfair to oneself is significantly related to poorer mental health, even after the secondary and control variables are included in Model 2 ($\beta = .09$, $p < .01$). Perceiving the division of household labor as unfair to one's spouse is also significantly related to poorer mental health in Model 1 ($\beta = .11$, $p < .001$), although this

TABLE 3 Regression of Physical Health on Perceptions of Domestic Equity, Gender, and Secondary Variables ($n = 1{,}234$)

	Model 1			Model 2		
	b	*SE*	*β*	*b*	*SE*	*β*
Perceptions of domestic equity[a]						
Division of housework is unfair to me (1 = yes)	−.15	.08	−.05	−.12	.08	−.04
Division of housework is unfair to my spouse (1 = yes)	−.40	.07	−.18***	−.34	.07	−.15***
Gender (1 = male)	.08	.06	.04	.01	.07	.00
Family demands						
Time spent in housework on work days				.02	.03	.02
Time spent in housework on nonwork days				−.02	.02	−.04
Children under 6 (1 = yes)[b]				−.09	.07	−.04
Children aged 6–12 (1 = yes)[b]				−.06	.07	−.03
Children aged 13–18 (1 = yes)[b]				.08	.07	.04
Children over 18 (1 = yes)[b]				−.02	.10	−.01
Spouse's work hours				−.00	.00	−.00
Family resources						
Income (natural log)				.17	.05	.13**
Paid help (1 = yes)				−.06	.07	−.03
Work demands						
Work hours				−.01	.00	−.08*
Work overload				−.10	.04	−.08*
Work resources						
Schedule control				−.02	.03	−.03
Work family culture				.10	.03	.11**
Age				.00	.00	.00
Constant	3.82	.05		2.39	.59	
R^2		.03			.08	

[a]Compared with the reference category "division of housework is fair to both of us."

[b]Compared with the reference category "no children."

*$p < .05$, **$p < .01$, ***$p < .001$ (two-tailed test).

relationship is no longer significant once we consider secondary and control variables in Model 2. With regard to physical health, the results in Table 3 indicate that perceiving the division as unfair to oneself is unrelated to physical health in both models. Perceiving the division of household labor as unfair to one's spouse, however, is significantly related to poorer physical health in Model 1 and in Model 2 after the secondary and control variables are added ($\beta = -.15$, $p < .001$).

Family and Work Context

Although other family and work demands and resources are not the focus of this study, several interesting findings in Tables 2 and 3 are worth briefly noting. Time spent in housework on work days and on nonwork days was not related to mental or physical health. Having children in the home and spouse's work hours were also unrelated to mental or physical health.

Income was related to better mental and physical health, but having paid help was not. Work overload was related to poorer mental health, whereas both work hours and work overload were significantly related to poorer physical health. Finally, schedule control and work–family culture were related to better mental health, whereas only work–family culture was related to better physical health. Interestingly, the mental health benefit of working in an environment with a positive work–family culture appeared to taper off at high levels as indicated by the positive coefficient for work–family culture squared. Age was not related to mental or physical health.

DISCUSSION

We examined how perceptions of domestic equity are related to men's and women's mental and physical health within the broader context where household labor exists. As such, we addressed three research questions, which are further discussed here.

Are There Gender Differences in Health and Perceptions of Domestic Equity?

Consistent with the literature, this study found that women report significantly poorer mental health than men. The results for physical health, however, are somewhat unexpected. Women in this study did not have significantly poorer physical health than men. This may be because, as Macintyre et al. (1996) suggest, the relationship between gender and physical health may vary only for specific health conditions. Women may report poorer physical health than men for certain conditions such as more frequent migraines, rheumatism, hypertension, coronary heart disease, and cancer, for example, but it appears that women may not have poorer *overall* physical health than men (see Krantz et al., 2005; Walters, McDonough, & Strohschein, 2002), which was assessed in this study. As well, this association may be a consequence of our sample, which comprises individuals from a relatively high socioeconomic status. It is likely that both men and women in elite professions will report good physical health. The respondents were employed and had university degrees, high incomes (mean = $123,600 CDN), and professional careers with significant occupational prestige, all of which offer health benefits (see Babones, 2010; Froberg et al., 1986; Fujishiro, Xu, & Gong, 2010). This study therefore compares the health of men and women in a select, advantaged social position rather than in the general population.

It is also possible that the women in this sample were less likely than other women to report poorer physical health, regardless of actual levels. Lawyers must maintain an image of competence, and reporting poor physical

health may be detrimental to upholding this image. Women, in particular, may be reluctant to admit poor health because they are often required to portray an exaggerated ideal of success (Kay & Hagen, 1998). As a result of this, the women in this sample of elite professionals may report more similar health status to their male counterparts than would be observed in the general population.

As hypothesized, significant gender differences exist in perceptions of domestic equity. Women are more likely than men to perceive the division of household labor as unfair to themselves, whereas men are more likely than women to perceive the division as unfair to their spouse. Both men and women appear to recognize wives' greater contributions to household labor. Despite this, over half of all respondents report that the division is equitably distributed between spouses, consistent with previous research (e.g., Coltrane, 2000; Lennon & Rosenfield, 1994). It is likely that this pattern, although paradoxical, may be due in part to gender norms, expectations, and ideologies. Housework has traditionally been women's work, and it appears that gender continues to play a pivotal role in determining household labor and perceptions of domestic equity, even in this sample of elite professionals. Despite the assumption that professionals have more egalitarian marital relationships (e.g., Kay & Gorman, 2008; Yogev, 1981), the results indicate that perceptions of domestic equity mirror those reported in research on the general population. Measures of gender ideology are not available in the data used for this study, but previous research demonstrates that traditional gender attitudes are related to greater perceptions of domestic equity (Braun, Lewin-Epstein, Stier, & Baumgärtner, 2008; Coltrane, 2000; DeMaris & Longmore, 1996).

How Are Perceptions of Domestic Equity Related to Health?

This study demonstrated partial support for the hypotheses regarding domestic equity and health posed here. Looking first at mental health, we found that compared with perceiving the division of household labor as fair to both spouses, perceiving the division as unfair to oneself or to one's spouse was related to poorer mental health, as suggested by equity theory and relational ethics. Feeling either under-benefited or over-benefited by the division of household labor was detrimental to mental health. It is important to note, however, that perceiving the division as unfair to one's spouse was no longer significantly related to poorer mental health after the secondary and control variables were included. This means the relationship between perceiving the division as unfair to one's spouse and mental health may be due to other factors, namely work overload. Therefore, only perceiving the division of household labor as unfair to oneself was significantly related to poorer mental health, independent of other family demands, family resources, work demands, and work resources.

Looking next at physical health, we found that compared with perceiving the division of household labor as fair to both spouses, perceiving the division as unfair to one's spouse was significantly related to poorer physical health. Perceiving the division as unfair to oneself was not significantly worse for physical health than perceiving it as fair to both spouses. Although this finding is somewhat unexpected based on relational ethics, it may be due in part to issues of forgiveness and guilt. Research shows that forgiveness is related to better immune function, lower blood pressure, and fewer physical health problems (see Wilson, Milosevic, Carroll, Hart, & Hibbard, 2008). Therefore, if an individual forgives his or her spouse for an inequitable division of household labor, this may serve as a buffer against the potentially negative effects of perceived unfairness to oneself. Individuals may feel under-benefited, but this may not be related to worse physical health if they forgive their spouse rather than blame them for the imbalanced situation. If individuals believe the division is unfair to their spouse, however, they may feel guilty and be unable to forgive themselves. Research shows that self-forgiveness is related to improved ratings of physical health (Wilson et al., 2008), and, by extension, it is possible that being unable to forgive oneself for disadvantaging their spouse is related to poorer physical health. As Mirowsky (1985) further points out, believing the division is unfair to one's spouse may lead to lower self-worth, disapproval from others, fear of retaliation or punishment, and physical health problems such as cold sweats, trembling hands, headaches, and stomach acidity.

It is also possible that part of this relationship between perceiving the division of household labor as unfair to one's spouse and worse physical health is due to crossover effects. That is, an individual's stress or strain may come to impact their spouse's health (Bakker, 2009; Wallace, 2005). Stress and strain are often obvious, and because spouses typically talk about their experiences and empathize with one another, it is possible the other spouse may indirectly experience poorer physical health, particularly if the couple has a close relationship (Bakker, 2009; Wallace, 2005). For example, if an individual is feeling overburdened and under-benefited with their share of the housework, it is possible that he or she may put extra pressure on his or her spouse to complete more of the housework, and in this way, stress may cross over and impact the other spouse's physical health.

Furthermore, with regard to both mental and physical health, it is possible that having poor health actually leads to perceptions of domestic inequity, although this causal ordering is less likely given our sample of elite professionals. The data we used in this study are cross-sectional, and therefore we cannot determine the causal ordering of the relationship between perceptions of domestic equity and health. When individuals have poor mental health—that is, when they are already depressed or distressed—it is possible they will be pessimistic about the division of household labor and come to feel under-benefited by it. Similarly, when individuals have poor physical

health, it is possible their spouse will complete a larger share of the household labor, and as a result, the spouse with poor health may come to feel over-benefited by the division of household labor.

Are Men's and Women's Health Differentially Related to Perceptions of Domestic Equity?

Exploratory interaction tests were conducted to determine whether perceptions of domestic equity are related to men's and women's health in different ways. These tests indicated that the relationship was not significantly different for men and women. Rather, mental and physical health were related to perceptions of domestic equity in similar ways, regardless of gender. This finding is unexpected, but it is possible that the men and women in this sample are more similar to one another than in the general population. Most research examining housework does not focus on individuals in highly demanding, male-dominated, professional careers such as law. In populations of this sort, it is likely that women may become more similar to their male counterparts as a result of their professional socialization, male role models, and masculine work cultures (see Guinier, Fine, & Balin, 1997; Macerollo, 2008; Ranson, 2005). Female lawyers may also face subtle discrimination, particularly in terms of career advancement, and as such may adapt themselves to fit the masculine culture, norms, and expectations of the organization to be successful (Kay & Hagan, 1998; Ranson, 2005).

This is supported by a brief examination of work hours. Approximately 24% of Canadian women worked 30 or fewer hours per week in 2001 (Ferrao, 2010), compared with only 8% of women in this sample. Furthermore, although approximately 7% of women in the general population worked 50 or more hours per week in 2000 (Canadian Policy Research Networks, n.d.), 39% of women in this sample worked these long hours. The women in this sample worked longer hours than women in the general population (mean = 48 vs. 34 hr/wk), and the difference between men's and women's work hours was smaller in this sample than in the general population (difference = 4 vs. 8 hr/wk) (Statistics Canada, n.d.). Female lawyers appear to display more masculine work practices in terms of work hours than other women, and it is possible that their perceptions of domestic equity may also be similar to their male counterparts as they balance work and home. Gender differences may therefore be masked in this sample of elite professionals.

Conclusions

This article examined how perceptions of domestic equity are related to men's and women's mental and physical health using a sample of elite professionals, namely lawyers. Overall, this study shows that independent of the family and work context where perceptions of domestic equity exist, feeling

under-benefited by the division of household labor is detrimental for mental health, whereas feeling over-benefited by the division of household labor is detrimental for physical health. For high status professionals, being either advantaged or disadvantaged by the division of household labor is detrimental to health, but in different ways: being advantaged is detrimental to one's physical health, whereas being disadvantaged is detrimental to one's mental health. Interestingly, these relationships are the same regardless of gender, and men's and women's mental and physical health are related to perceptions of domestic equity in similar ways. Therefore, if professional men and women held similar perceptions of domestic equity, their health may be impacted in similar ways.

These findings suggest a number of important implications. Both men and women perceive wives to under-benefit from the division of household labor, which suggests the division remains gendered. Even among elite professionals, a traditional division of household labor exists, supporting the notion of a lag between women's entrance into professional occupations and men's greater involvement in the home. Moreover, divisions of household labor perceived to be inequitable may have significant consequences for both mental and physical health. Feeling under-benefited may harm one's mental health, whereas feeling over-benefited may harm one's physical health. Although perceptions of domestic equity have the same effects on professional men's and women's health, gendered health disparities may arise as a result of how men and women perceive the division. Because women tend to feel more disadvantaged by the division of household labor than men, it is likely that women's mental health may suffer more than men's, which may partially explain women's poorer mental health. On the other hand, because men tend to feel more advantaged by this division than women, it is likely that men's physical health may suffer more than women's. Taken together, these findings also imply that divisions of household labor that are perceived as equitable may be healthier for both men and women. More broadly, if we treat the division of household labor as an insight into power dynamics in intimate relationships (see Davis & Greenstein, 2013), this means that, in line with equity theory and relational ethics, intimate relationships that are perceived as more equitable and are characterized by compromise are likely healthier for both spouses, not just women.

Past research focuses primarily on how the division of household labor is related to women's mental health, and therefore this article addresses several important gaps. First, it examined how perceptions of domestic equity are related to mental and physical health for both men and women. It also examined these relationships in the wider context in which household labor exists, and important differences were noted once the family and work context was considered. Specifically, it appears that gender differences in mental health may be due to factors such as work overload. Finally, this study took a unique approach to the measurement of perceptions of domestic equity. Few

studies consider perceiving the division of household labor as unfair to oneself separately from perceiving the division of household labor as unfair to one's spouse. However, we clearly demonstrate that these are distinct experiences that have different relationships with health, and treating them as a continuum may mask important differences in how these experiences are related to health. For example, as Mirowsky (1985) explains, perceptions of inequity to oneself and one's spouse may be related to two different types of poor mental health. Being under-benefited may be related to anger and a lack of control, whereas being over-benefited may be related to guilt, poorer self-worth, and fear of retaliation.

Although this study extends previous research and provides a more nuanced understanding of how perceptions of domestic equity are related to health for professionals, we also highlight the need for further exploration of the relationships between domestic equity and health. Future research should examine the relationship between perceptions of domestic equity and health for both men and women in various samples to determine whether these findings are unique to lawyers or other elite professionals. In particular, research should further explore potential gender differences in this relationship, because our findings may be unique to individuals in relatively high social statuses. Although we are confident there are minimal differences between how elite professionals and the general population divide and perceive household labor, we are less certain of whether our findings from this sample of elite professionals would generalize to the wider population, particularly with regard to potential gender differences in the relationship between perceptions of domestic equity and health. Ideally, future research using samples comprising both professionals and working class individuals should be conducted to compare whether perceptions of domestic equity are related to health in similar ways for various occupational groups. Future research should also include measures of other family demands, family resources, work demands, work resources, gender ideology, guilt, and forgiveness and should test the potential mediating effects of these variables. Because the data we used in this study are cross-sectional, future research should also examine these relationships using longitudinal data to determine whether perceiving the division as inequitable results in poorer health or whether poorer health leads to perceiving the division as inequitable. Most importantly, future research should consider perceptions of unfairness to oneself and to one's spouse as distinct experiences because they have unique relationships with mental and physical health.

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