

**MARITAL STATUS STABILITY, MARITAL TRANSITIONS, AND HEALTH: A
LIFE COURSE PERSPECTIVE***

KRISTI WILLIAMS**

University of Chicago

and

DEBRA UMBERSON

University of Texas at Austin

WORD COUNT: 6,218

TABLES: 2

FIGURES: 5

RUNNING HEAD: Marriage and Health Across the Life Course

KEYWORDS: Marital status, Life course, Health, Morbidity, Age, Sex Differences

*We thank Christopher Ellison, Ross Stolzenberg, and Linda Waite for insightful comments on earlier drafts.

**Address correspondence to Kristi Williams, Center on Aging and NORC, University of Chicago, 1155 E. 60th Street, Chicago, IL 60637 (kwilliam@uchicago.edu)

Abstract

We work from a life course perspective to test competing explanations for the link between marital status and health. Using longitudinal data, we assess the impact of stability and change in marital status on subsequent change in self-assessed health and morbidity. We find that continuity *and* change in marital status are strongly linked to physical health. However, the extent to which marital status stability and change affects health is highly dependent on gender and the age at which particular marital statuses are occupied or during which a marital status transition occurs. Our results also raise questions about the tacit assumption that marriage is good for all people at all times and that transitions out of marriage always result in net declines in health and well-being.

MARITAL STATUS STABILITY, MARITAL STATUS TRANSITIONS AND HEALTH: A LIFE COURSE PERSPECTIVE

Research consistently demonstrates that the married enjoy a health advantage over the unmarried. Previous research on marriage and health, however, focuses almost exclusively on assessing the effects of marital status at one point in time on current or later well-being. The failure to distinguish between stability in particular marital statuses and transitions into or out of marriage obscures our understanding of the link between marriage and health. In fact, we know very little about the short-term and long-term processes through which marriage and marital status transitions affect health. Moreover, focusing exclusively on marital status at one point in time ignores the possibility that becoming married may produce strains that temporarily undermine health and or that exiting marriage may provide benefits that enhance health.

In the present study, we work from a life course perspective and suggest that the life course timing of transitions and continuities in family roles should strongly influence the effect of these roles on individual well-being (Elder, 1992). Moreover, because men and women face different structural constraints across the life course, the effect of marital status continuity and marital status change at various stages of the life course should differ for men and women (Moen, 1992). We explore the possibility of life course and gender variation in the effects of marital status stability and continuity on health with analysis of national, longitudinal data.

Distinguishing between marital status stability and transitions into and out of marriage contributes to our understanding of marital status differences in health in a number of ways. First, this approach contributes to theoretical work on marriage and well-being by helping to sort out different theoretical explanations for the link between marital status and health (e.g., the marital resource model, the dissolution/crisis model). Second, distinguishing between marital status continuity and change allows for the examination of a previously ignored topic: the short-term effects of transitions into and out of marriage on physical health status. Third, this approach provides a unique opportunity to examine for the first time how the health effects of marital status transitions and marital status stability varies across the adult life course of men and women.

THEORETICAL AND EMPIRICAL BACKGROUND

Marital Status Stability, Marital Transitions and Health

A preponderance of evidence indicates that marriage provides substantial benefits for the physical health of individuals. For example, married men and women report better self-assessed health, have lower rates of long-term illness, and live longer than their unmarried counterparts (Anson 1989; Goldman 1993; Hemstrom 1996; Hu and Goldman 1990; Lillard and Waite 1995; Murphy, Glaser, and Grundy 1997; Rogers 1995; Zick and Smith 1994; Waldron, Weiss, and Hughes 1997; also see Umberson and Williams 1999 and Waite and Gallagher 2000 for a review). The link of marital status with health and mortality has been demonstrated for men and women, African Americans and whites, and across continents (Hu and Goldman 1990; Murphy et al. 1997; Rogers 1995; Waldron et

al. 1997). Moreover, the health benefits of marriage persist even with statistical controls for sociodemographic variables known to affect both marriage and health (e.g., economic well-being, age, education).

Although marital status is undoubtedly linked to physical health, little agreement exists on the specific processes that account for the better health of the married compared to the unmarried. Theoretical explanations for observed associations between marital status and physical health or psychological well-being typically take one of two forms. The *marital resource model* suggests that the salutary effects of marriage on health are largely due to the greater economic resources and social support that the married enjoy, as well as to the social control that spouses exercise over the health of one another (Ross, Mirowsky, and Goldstein 1990; Umberson 1992). In contrast, the *crisis or stress model* suggests that the strains of marital dissolution undermine health and well-being more than the resources of marriage protect it (Booth and Amato 1991; Williams et al. 1992). Thus, according to the crisis/stress model, the better health of the married compared to the divorced or the widowed is more reflective of the negative health consequences of marital loss than of the benefits of being married (see Umberson and Williams 1999 for a review of these arguments).

It is likely that both the marital resource model and the crisis model contribute to the observed association between marital status and physical health. Yet selection may also play a part. Two methodological conventions---reliance on cross-sectional data and the failure to distinguish between marital status stability and marital status change---make it difficult, if not impossible, to sort out the relative contributions of each explanation.

Until very recently, most research on the association of marital status with health relied on cross-sectional data. The cross-sectional association between marital status and health cannot reveal whether marital status primarily influences health or if health primarily influences marital status.

In more recent work, some sociologists rely on longitudinal data to assess the impact of marital status at one point in time on a subsequent change in health, thereby reducing the probability that observed associations between marital status and health reflect selection processes. Despite the obvious contributions of this approach, it is of little utility in determining how the two additional paradigms---the marital resource model or the crisis model---contribute to observed marital status differences in health. To do so requires distinguishing between continuity in particular marital statuses and transitions into and out of marriage. For example, the marital resource model implies that, lacking the resources provided by marriage, those who are consistently unmarried across a particular period of time should continue to experience declines in physical health status. In contrast, the crisis or stress model suggests that those who experience a recent transition out of marriage will experience declines in physical health for a period of time, but will eventually adjust to the transition and their health will stabilize or return to pre-transitions levels. Thus, the crisis model implies that those who are consistently unmarried after this period of adjustment has passed will not continue to experience declines in health.

Researchers who examine the link between marriage and psychological well-being have begun to focus on continuity and change in marital statuses in an effort to sort out

these processes (see Marks 1998, Booth and Amato 1991, and Aseltine and Kessler 1993). Although the approaches taken differ and the evidence is too limited to draw any firm conclusions, some research suggests that, at least in terms of divorce, the crisis model is more relevant in accounting for the better psychological well-being of the married compared to the divorced or separated (Booth and Amato 1991; Williams et al. 1992). Moreover, the impact of continuity and change in marital status on psychological well-being differs depending upon the sociodemographic characteristics of the individual (Marks 1998). No research to date, however, has examined the impact of marital status stability and marital status transitions on physical health.

Distinguishing between marital status continuity and change is important for an additional reason. It allows for the examination of a previously ignored question: the short-term effects of transitions into marriage on physical health status. Although there is little doubt that the married enjoy a health advantage over the unmarried in the long-run, virtually nothing is known about the short-term processes through which entry into marriage and the lifestyle adjustments that it entails affect health and well-being. Some evidence suggests that individuals who remarry following divorce or widowhood face considerable strains and role adjustments, particularly when both one or both spouses have children from previous relationships (Whitsett and Land 1992). Because most previous research focuses on marital status at one point in time, the impact of transitions into marriage on health and well-being and the sociodemographic characteristics that might moderate this relationship remain largely unexamined.

Marital Status Stability, Marital Transitions and Health Across the Life Course

The life course perspective emphasizes that the timing of both childhood and adult role transitions forms an important social context that influences: (1) the ease with which new roles are incorporated into one's identity, (2) the normative status and social acceptance of new roles, (3) the resources that are available to the individual to adjust to, cope with, and thrive in the new role, and consequently, (4) the effect of these transitions on individual well-being (Bengtson and Allen 1993; Elder 1992; Baltes 1987, Elder and O'Rand 1995). Not only is life course stage an important context in which transitions are experienced, but it is also important to an understanding of continuity in particular statuses and roles.

The life course perspective suggests several reasons that the impact of marital status and marital status transitions would vary over the adult life course (see Marks 1998). First, the normative status of marriage and marital status transitions differs at various stages of the life course. For example, being never-married at age 18 likely has very different consequences for individual well-being than being never-married at age 50, in part because social norms and institutions support the former but not the latter situation. Similarly, some evidence suggests that becoming widowed at relatively young ages has more negative mental health consequences than becoming widowed later in life when this transition is more common. The age-graded impact of similar transitions on physical health status remain completely unexamined.

The normative status of being married or unmarried is not the only factor influenced by timing and life course stage. Age and other life course markers (e.g., age

and living arrangements of children) influence a range of other psychosocial and structural attributes---all of which may impinge on the process through which marriage and marital status transitions affect health. For example, many older adults experience a pile-up of stressors associated with the death of significant others (i.e., loss of alternative sources of social support), increased health problems, and declines in economic well-being (Mirowsky and Ross 1992). Therefore, the social support provided by marriage may become more important with age as it becomes necessary to cope with an increasing number of age-linked chronic strains and stressful life events.

Other evidence suggests that the psychosocial resources that individuals acquire throughout the life course may help them to more effectively cope with stressful marital status transitions at older compared to younger ages. For example, research indicates that older individuals have higher levels of personal control than their younger counterparts (Mirowsky and Ross 1986). Personal control is defined as “the belief that one’s own intentions and behaviors can impose control over one’s environment (Williams and Umberson 1999: 554),” and is beneficial to health and psychological well-being because it helps individuals cope with stress (Mirowsky and Ross 1986). Therefore, stressful marital status transitions may have fewer negative effects on the physical health of older compared to younger adults because of the personal control and other coping resources that tend to accompany age. In sum, there are clear theoretical reasons to expect that the impact of marital status continuity and change on health will vary across the adult life course.

Gender, Marital Status, and Health Across the Life Course

Early studies indicated that the physical health advantage of marriage was greater for men than for women (Berkman and Breslow 1983; Gove 1973). More recent research also suggests that differences in rates of mortality between unmarried and married men is greater than the difference between unmarried and married women (Hemstrom 1996; Lillard and Waite 1995). The effect of marriage on health behaviors also appears to vary by gender. Differences between the unmarried and the married on protective health behaviors are significantly greater for men than for women, largely because wives are more likely to regulate the health of their spouses than are husbands (Umberson 1992).

The finding that marriage is more beneficial to the physical health status of men than women is based largely on research that examines the impact of marital status at one point in time on present or later health. Therefore, we know very little about whether the health effects of transitions into or out of marriage or continued occupancy of an unmarried status differ for men and women. There are a number of reasons to expect that they may. Marriage provides different benefits to men and women and, despite a convergence of gender roles, men's and women's roles within marriage still differ considerably. It is therefore likely that exits from marriage and entrances into marriage entail a different balance of rewards and costs for women and men. It is this balance of rewards and costs---of support and strain---that determines how these marital status configurations affect health and well-being.

Gender differences in the impact of marital status continuity and change on health may be even more pronounced when the moderating impact of life course stage is

considered. As Phyllis Moen's research indicates, "the intersection of age and gender produces distinctive life patterns for men and women at all stages of the life course. (Moen 1996; 171)." Because men and women face different structural constraints across the adult life course, the impact of marital status and marital status transitions at various stages of the life course may differ by gender.

THE PRESENT STUDY

We consider how marital status stability and transitions affect the health of men and women over the life course by addressing the following questions:

1. What are the effects of exits out of marriage on subsequent physical health status, controlling for health prior to divorce/separation or widowhood?
2. What are the effects of entrances into marriage on subsequent physical health status, controlling for health prior to marriage or remarriage?
3. How does the physical health status of the continually never-married, continually divorced or separated, and continually widowed change over a five-year period relative to the health status of their continually married counterparts?
4. Does the magnitude and/or direction of the effects on physical health of transitions into and out of marriage and of continuity in an unmarried status (outlined in 1-3 above) depend upon the age at which these transitions occur or during which these statuses are occupied?
5. Do the effects of marital status continuity and change on physical health status (outlined in 1-3 above) differ for men and women?

DATA and MEASURES

Data

The data used in the present study are from the second and third waves (1989 and 1994) of the Americans' Changing Lives surveys (House 1986). Face to face interviews lasting approximately 90 minutes were conducted with a nationally representative sample of 3,617 persons ages 24 and older in 1986 residing in the contiguous United States. Follow-up interviews were conducted with 2,876 of these respondents in 1989 and with 2,516 respondents in 1994. 2,313 respondents were interviewed in both 1989 and 1994.

The sample was obtained using multistage area probability sampling with an oversample of African-Americans, individuals over the age of 59, and married women whose husband was over the age of 64. All analyses in the present study are weighted to adjust for the complex sampling design, the oversample of special populations, and the attrition that occurred between waves.

Measures

Marital Status Continuity and Change

Dummy variables represent continuity and change between 1989 and 1994 in the following marital statuses: (1) continually married, (2) continually never married, (3) continually divorced/separated, (4) continually widowed, (5) married to divorced or separated, (6) married to widowed, (7) never married to married, (8) divorced or widowed to remarried, (9) multiple transitions (unmarried to married to unmarried and married to unmarried to married). The continually married are the reference group in all analyses.

Physical Health

Physical health is assessed with indicators of self-assessed health and chronic and serious illness morbidity. Self-assessed health is measured with responses to the following question: “How would you rate your health at the present time?” Response categories range from 1 (poor) to 5 (excellent). Self-assessed health is widely recognized as a valid indicator of overall health status and mortality. Research indicates that it is a stronger predictor of subsequent mortality than are physician assessments of health (Idler and Angel 1990). Following Ferraro and Farmer (1999), self-assessed health is treated as an interval-level variable in all analyses.

Morbidity refers to the number of illnesses reported by the respondent. Research indicates that self-reported morbidity is a better predictor of self-assessed health than physician evaluated morbidity (Ferraro and Farmer 1999). Further, subsequent mortality is more accurately predicted from self-reports of serious illnesses than from physician assessments of health (Ferraro and Farmer 1999). In the present study, respondents were asked if they experienced a range of health problems in the past year. These include lung disease, hypertension, heart attack, diabetes, cancer, stroke, arthritis, foot problems, broken bones, and incontinence. The number of conditions reported by the respondent in 1989 and in 1994 are summed to create a morbidity index for each year. Prior research suggests that the results produced by this additive approach and by measuring each illness with a separate dummy variable are virtually identical (Liang et al. 1990). Because we are interested in overall physical health status rather than specific disease morbidity, we employ the additive approach.

Age and Sociodemographic Control Variables

Life course stage is measured with a continuous variable that indicates that age of the respondent in years in 1989. The 1989 values of the following variables are controlled in all analyses: race (African-American=1; all others=0), education in years, gender (female=1; male=0), presence of a preschool aged child (5 years old or younger) in the home (1=presence of child; 0=no child), presence of a minor child in the home (1=child present; 0=no child present), annual household income in thousands of dollars, and employment status (1=employed; 0=not employed). Unweighted means and standard deviations of all variables of the analysis are presented separately for women and men in Table 1.

(Table 1 about here)

RESULTS

Effects of Marital Status Stability and Marital Status Transitions on Changes in Health

In the first part of the analysis, we estimate the effects of continuity and change in marital status on 1994 physical health, while controlling for 1989 physical health status. Coefficients in lagged dependent variable models essentially reflect the degree and direction of change in the dependent variable across the period of time under consideration (Kessler and Greenberg 1981) Thus, in the present study, a positive coefficient represents an increase in health while a negative coefficient reflects a decrease in health between 1989 and 1994. It is important to note, however, that the present study is not designed to test whether or not selection of the healthiest individuals into marriage occurs. Rather, the lagged dependent variable models reduce the probability that observed associations between marital status transitions and health are not the result of

these selection effects. Because of the small number of individuals experiencing some marital status configurations at some ages, significance levels are presented at the $p \leq .10$, $p \leq .05$, and $p \leq .01$ levels.

The estimated effects of marital status continuity and change on subsequent change in self-assessed health and morbidity are presented in the columns labeled Model 1 (M1) of Table 2. The results of the base models indicate that continuity in the never-married status, the transition to divorce or separation and the transition to first marriage are associated with changes in self assessed health or morbidity. Specifically, continually never-married individuals experience greater declines in self-assessed health and greater increases in morbidity across this five-year period compared to their continually married counterparts.

With respect to marital status transitions, the results indicate that the transition into divorce or separation is associated with an increase in self-assessed health. This likely reflects recovery from the negative effects on health of being in a troubled marriage. The transition into first marriage is associated with increases in both self-assessed health and the number of illnesses reported. Although the observed increases in both self-assessed health and morbidity may at first appear contradictory, they are likely the result of the influence of marriage on health behaviors. Prior research indicates that a primary mechanism through which marriage benefits health is that married individuals, and especially wives, tend to regulate the health of their spouses (Umberson 1992). This likely includes encouraging a spouse to obtain regular medical office visits. Receiving more frequent medical checkups may lead to the diagnosis and treatment of minor

chronic conditions of which these men were previously unaware, but at the same time lead to an improvement in their self-assessed health.

(Table 2 about here)

Moderators of the Impact of Marital Status Stability and Marital Status Transitions on Health

The remainder of our analysis assesses whether the effects of marital status stability and marital status transitions on health are moderated by gender and age. The final models presented here are the result of testing a series of intermediate models. We first estimated separate equations to test the interaction between gender and each marital status configuration, and between age and each marital status configuration, in predicting change in self-assessed health and morbidity. This involved regressing the 1994 value of the dependent variable on the marital status variables, a modifying variable (i.e., age or gender), an interaction term between a marital status variable and a modifying variable, the sociodemographic control variables, and the 1989 value of the dependent variable. Next, models were estimated that included only those two-way interactions that were significant in previous models. These models then became the base models for testing possible three-way interactions. The same estimation procedures described above were then used to test three-way interactions between marital status, gender, and age. The most parsimonious final models are presented and are derived by re-estimating an equation for each dependent variable that includes only those two-way interaction terms that were significant in the intermediate models. None of the three-way interactions between gender, marital status, and age were significant.

Figures are presented to facilitate interpretation of significant interactions between marital status and age. Figures are constructed by calculating the predicted change in self-assessed health or morbidity for those in each relevant marital status configuration at the mean age of individuals experiencing that transition and at one standard deviation above and below the mean age. For comparison, the figures also show the predicted change in health for continuously married men and women at corresponding ages.

Modifying Effects and Self-assessed Health

The final model predicting self-assessed health is presented in the second column of Table 2. There is only one significant gender difference in the impact of marital status stability or marital status transitions on self-assessed health. The significant interaction between gender and the never-married to married transition indicates that the transition into first marriage is associated with an improvement in men's self-assessed health but a decline in the self-assessed health of women (.480-.579). Although, substantively, this decline for women is rather small, it is statistically significant at the .10 level ($t = -1.868$).

The magnitude of the effect of some marital status transitions on self-assessed health depends, in part, on the age at which the transition is experienced. First, the impact of remarriage following divorce or widowhood becomes weaker with age. The nature of this interaction effect is graphically presented in Figure 1. At younger ages (i.e. approximately age 32), those who remarry following divorce or widowhood experience smaller declines in self-assessed health across this five-year period than their continually married counterparts. However, this beneficial effect of remarriage diminishes with age

and reverses direction at approximately age 40 (-1.001/-.025). Thus, older individuals (i.e. approximately age 52) who remarry experience greater declines in self-assessed health than continually married individuals of the same age. In sum, remarriage following divorce or widowhood is beneficial to the self-assessed health status of younger individuals but to undermines the health of individuals in later mid-life.

(Figure 1 about here)

(Figure 2 about here)

The impact of multiple marital status transitions also depends on the respondent's age. This interaction is shown in Figure 2. At the youngest ages (i.e. approximately age 28), those who experience multiple marital status transitions between 1989 and 1994 report greater declines in self-assessed health than their continually married counterparts. The negative effect of multiple marital status transitions on self-assessed health is only observed for the youngest individuals as this association weakens and reverses direction at approximately age 33. Among individuals in the older end of the age range that we were able to examine (i.e. age=48 years), those who experienced multiple marital status transitions across this five-year period exhibited smaller declines in self-assessed health than their continually married counterparts.

The indicator of marital status continuity that predicts change in self-assessed health in the restricted model (Model 1) remains significant after including all significant interactions in Model 2. This indicates that, regardless of gender or age, those who have been never-married for a period of five years or more continue to experience greater declines in self-assessed health than their continually married counterparts.

Modifying Effects and Morbidity

The impact of a number of marital status configurations on change in morbidity depend on age and gender. Several two-way interactions between gender and marital status and between age and marital status are observed. First, being continually divorced or separated across this five-year period has different effects on the morbidity of men and women. As shown in Table 2, continually divorced or separated men experience smaller increases in morbidity than their continually married counterparts. For women, being continually divorced or separated is not significantly associated with change in morbidity. The effect of the transition into first marriage on morbidity also differs for men and women. Although the association is not significant for women, men who experience the transition into first marriage report greater increases in morbidity than their continually married counterparts.

(Figure 3 about here)

Age is a significant moderator of the estimated effect of three marital status configurations on morbidity. The nature of the significant interaction between age and continually occupying the never-married status is depicted graphically in Figure 3. This indicates that among younger adults (e.g., age=28 years), being continually never-married is associated with small but nonsignificant declines in morbidity. However, this association weakens and reverses direction at approximately age 31. Continually never-married mid-life adults (e.g., age=54 years) report significantly greater increases in morbidity than their continually married counterparts.

The estimated effect of the transition to divorce or separation on the morbidity of

men and women differs depending upon the age at which this transition occurs. The nature of this significant interaction is shown in Figure 4. Figure 4 indicates that young men and women who have divorced or separated in the past five years report greater declines in morbidity than their married counterparts. This association weakens with age so that for individuals in later mid-life, the continually married and those experiencing the transition to divorce or separation report similar increases in morbidity.

(Figure 4 about here)

(Figure 5 about here)

The impact of remarriage on morbidity also depends on the age at which these transitions occur. The nature of this interaction is depicted in Figure 5. Figure 5 indicates that remarriage benefits the health of young adults but undermines the health of older adults. Young adults who remarry following divorce or widowhood report smaller increases in the number of illnesses experienced in the last year compared to their continually never-married counterparts. These beneficial effects diminish with age and the association reverses direction at approximately age 46 (1.093/.024). Thus, older mid-life adults (e.g., approximately 52 years) who remarry report greater increases in morbidity between 1989 and 1994 than continually married individuals of the same age.

DISCUSSION

This study provides the first evidence that the effects of stability in particular unmarried statuses and of transitions into and out of marriage on health are strongly dependent upon the stage in the life course in which these statuses are occupied and during which these transitions occur. Sociologists have long recognized that the effects of

marital status on health differ for men and women. Although the present results provide support for this conclusion, they further indicate that age is an equally, if not more, important modifier of the link between marital status and physical health. The health effects of being continually never-married, of remarrying following divorce or widowhood, of exiting marriage through divorce or separation, and of experiencing multiple marital status transitions depend on the age at which these role transitions or continuities are experienced.

The results of this study raise questions about the tacit assumption that marriage is good for all people at all times. Certainly, in the long run and on average, the married are healthier, wealthier, and happier than the unmarried (Waite and Gallagher 2000). However, these findings indicate that, for some individuals (i.e., previously divorced or widowed individuals in mid-life), marriage may produce strains that undermine health, at least in the short-run. Very little research has examined the effects of remarriage on health and well-being. Our findings provide the first evidence that remarriage may undermine the health of mid-life and older adults.

That the effect of remarriage on health differs for young and mid-life adults also suggests that becoming remarried may be associated with a different balance of costs and benefits depending upon one's life course stage. Younger men and women who are unmarried have fewer financial resources than their mid-life counterparts, and financial resources are strongly linked to both mental and physical health (Marmot et al. 1997). Therefore, even if remarriage is associated with strains for younger individuals, the financial benefits of remarriage may outweigh the costs. Additional analyses (not shown)

indicate that for individuals under the age of 45 in 1989, the transition into remarriage is associated with a greater decline in financial strain than for those who are 45 and older. In sum, these preliminary findings suggest that, compared to their younger counterparts, mid-life adults may have less to gain by remarrying. Another possible explanation is that older individuals are more vulnerable to any negative health effects of remarriage since health problems are more likely to occur in middle and later adulthood. Overall, however, we know very little about the contextual and structural factors that influence the ease with which men and women transition into the remarried status. Given the high divorce rate and the increasing prevalence of remarriage, much more research should be devoted to understanding this process and its effects on the health and well-being of men and women of all ages.

The present results also show that although the transition into first marriage is associated with improvements in men's self-assessed health status, it is also linked to an increase in morbidity. Given the positive effect of the transition into marriage on men's self-reported health, the observed increase in morbidity may reflect the health benefits of marriage more than any strains associated with entry into a new marriage. Prior research indicates that married men are more likely than their unmarried counterparts to engage in positive health behaviors (e.g., exercise, medical check-ups, and proper nutrition) and less likely to engage in negative health behaviors (e.g., alcohol abuse, smoking, and risk taking) than their never-married counterparts, largely because wives tend to regulate the health of their husbands (Umberson 1987, 1992). Thus, the increase in chronic conditions experienced by recently first-married men may be due to the fact that these men,

encouraged by their wives, receive more frequent medical check-ups and, therefore, are more likely to be diagnosed with health conditions of which they were previously unaware. Additional analyses (not shown) indicate that the observed increase in morbidity among newly married men is largely due to increases in minor conditions that are not life-threatening and for which treatment is easily offered. This is consistent with the observation that the transition into first marriage is associated with improvements in men's self-assessed health status despite increases in morbidity.

The present findings also call into question the assumption that all transitions out of marriage undermine physical health status. Whether the transition to divorce or separation is associated with a decline in health depends upon the dimension of health examined, the stage in the life course during which the divorce or separation occurs and, likely, the quality of the marriage from which one is exiting. The transition to divorce or separation is associated with improvement in self-assessed health among men and women of all ages (within the range of the data) and with a decline in morbidity among younger men and women. This pattern likely reflects recovery from the negative health effects of occupying a strained marriage. Wheaton's (1990) research on psychological well-being indicates that certain life transitions that might otherwise be assumed to be stressful may be "nonproblematic, or even beneficial to mental health, when preceded by chronic role problems---a case where more 'stress' is actually relief from existing stress (Wheaton 1990: 209)."

Our findings are, for the most part, consistent with this argument, and provide the first evidence that stressful events and transitions may actually improve physical health

when they bring an end to other chronic strains. That the transition to divorce is associated with a decline in morbidity among young and mid-life adults but not their older counterparts may reflect age differences in the amount of marital stress that precedes divorce. Additional analyses (not shown) indicate that, among men and women who divorce between 1989 and 1994, those between the ages of 27 and 45 in 1989 report significantly higher levels of marital conflict prior to the divorce compared to their older counterparts. Divorce may provide more of a relief to younger adults because of their higher levels of pre-divorce conflict. In addition, younger adults may find it easier to resume life as a single person, including greater ease in dating. It may also be that older men and women are more vulnerable to chronic health problems that are triggered or exacerbated by stress.

The results of the present study also inform theoretical work that attempts to account for the better health of the married compared to the unmarried. We elaborate on these theories by specifying two sociodemographic variables that shape the process through which marriage affects health---age and gender. Support for the marital resource model is provided by the following evidence: (1) being continually never-married more greatly undermines the health of older compared to younger individuals, at least in terms of morbidity, and (2) the transition into first marriage is associated with improvements in men's self-assessed health.

The former observation suggests that the resources that marriage provides may be most important to health at mid-life and older ages than at younger ages. The social support provided by marriage may become more important with age as it becomes

necessary to cope with an increasing number of age-linked chronic strains and stressful life events. These findings are also consistent with the life course perspective in that never having married at mid-life or older is a non-normative status and should, therefore, have more negative effects on the individual (Bengtson and Allen 1993).

Additional support for the marital resource model is observed among men who enter their first marriage. Although this transition is associated with an increase in morbidity among men that is probably due to better health behaviors and more frequent medical check-ups, it is also associated with an improvement in men's self-assessed health. That this pattern is observed among men and not among women is consistent with previous research suggesting that marriage provides a greater health benefit to men than to women (Hemstrom 1996; Lillard and Waite 1995). However, we find no evidence of gender differences in the health effect of being continually divorced or separated or continually widowed.

The observation that the transition to divorce or separation is associated with improvements in the health of young and mid-life adults, but not their older counterparts provides some support for the crisis model among older men and women. As noted above, this may reflect the fact that, compared to the experience of their younger counterparts, divorce for older adults is typically preceded by less marital conflict. Therefore, for older individuals, divorce may provide less of a relief from the stressors associated with being in a strained marriage. However, it may also indicate that any positive effects of exiting marriage are outweighed for older adults by the strains associated with making the transition to divorce or separation. Researchers who study

marriage and health should begin to examine in more detail both the positive and negative aspects of marital status transitions, specify how these experiences are shaped by structural and personal characteristics, and determine how these benefits and costs combine to affect the physical health status of individuals.

CONCLUSION

Taken together, these observations question the tacit assumption that marriage is good for all people at all times and that transitions out of marriage always result in net declines in health and well-being. The patterns are much more complex than has been previously recognized. The impact of marital status continuity and change on health is shaped by both structural and personal characteristics, including life course stage and gender. Further, becoming divorced or separated, becoming married, and continually occupying an unmarried or a married status simultaneously confer both benefits and costs. It is the delicate balance of rewards and challenges that determine how these marital status patterns impact health and well-being. Future research that considers the timing in which marital unions and marital losses occur as well as the context in which particular marital statuses are occupied will help to identify the factors that determine who benefits from marriage and who does not. It can also enhance our understanding of the processes through which the benefits and costs of marital status continuity and change are conferred.

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Table 1: Unweighted Means and Standard Deviations for All Variables in the Analysis: U.S.

Women and Men Ages 27-98 in 1989				
	Women (n=1,460)		Men (n=815)	
	Mean	S.D.	Mean	S.D.
<i>Marital status 1989-1994</i>				
Continually married	.423	.494	.639	.481
Continually never-married	.060	.238	.094	.293
Continually divorced/separated	.135	.342	.108	.310
Continually widowed	.231	.422	.045	.208
Married to divorced/separated	.024	.153	.035	.183
Married to widowed	.060	.237	.014	.119
Never-married to married	.009	.093	.018	.133
Divorced or widowed to married	.029	.167	.023	.149
Multiple transitions	.030	.171	.026	.160
<i>Physical health status</i>				
Self-assessed health 1989	3.369	1.023	3.599	1.028
Self-assessed health 1994	3.334	1.081	3.498	1.072
# of chronic conditions 1989	1.454	1.352	.983	1.248
# of chronic conditions 1994	1.693	1.436	1.272	1.426
Age	55.836	16.739	50.758	15.675
Minor child in home	.326	.469	.357	.480
Race (African-American=1)	.301	.459	.235	.425
Education in years	11.801	3.129	12.387	3.458
Employed	.444	.497	.683	.465
Income (in 10,000s)	2.670	3.024	3.824	4.002

Table 2: Unstandardized OLS Regression Coefficients for the Regression of 1994 Self Assessed Health and 1994 Morbidity on Marital Status Stability and Transitions 1989-1994, Gender, Age, and Selected Independent Variables: U.S. Adults Ages 27-98 in 1989

	Self-Assessed Health		Morbidity	
	M1	M2	M1	M2
<i>Marital status 1989-1994</i>				
Continually never-married	-.212**	-.212**	.188*	-.343
Continually divorced/separated	.001	.002	.001	-.178
Continually widowed	-.060	-.052	-.057	-.016
Never-married to married	.261 [†]	.480*	.607**	1.114***
Divorced or widowed to married	.009	1.001*	-.071	-1.103*
Married to divorced/separated	.169 [†]	.168 [†]	-.134	-1.115***
Married to widowed	-.052	-.049	.059	.097
Multiple transitions	.109	-.719 [†]	.008	-.010
<i>1989 value of dependent variable</i>	.558***	.555***	.596***	.597***
<i>1989 sociodemographic variables</i>				
Female	.020	.025	.039	.029
Age 1989	-.002	-.002	.014***	.012***
Race (African-American=1)	-.177**	-.179**	.157**	.158**
Minor child in home	.036	.031	-.063	-.080
Education	.023***	.023***	-.022**	-.022**
Employed	.086 [†]	.098*	-.125*	-.128*
Income	.008	.009 [†]	-.004	-.005

Table 2 continued from previous page

	Self-assessed Health		Morbidity	
	M1	M2	M1	M2
<i>Marital status X gender</i>				
Continually divorced/separated X female	---	---	---	.251 [†]
Never-married to married X female	---	-.579 [†]	---	-1.102**
<i>Marital status X age</i>				
Continually never-married X age	---	---	---	.011*
Divorced or widowed to married X age	---	-.025*	---	.024*
Multiple transitions X age	---	.022*	---	---
Married to divorced/separated X age	---	---	---	.024*
Constant	1.228***	1.234***	.328 [†]	.462**
R ²	.338***	.342***	.482***	.487***

^a Compared to the continually married 1989-1994

[†] p ≤ .10 * p ≤ .05 **p ≤ .01 ***p ≤ .001 (two-tailed tests)

Figure 1: Estimated Effect of Transition from Divorce or Widowhood to Remarriage on Change in Self-Assessed Health by Age

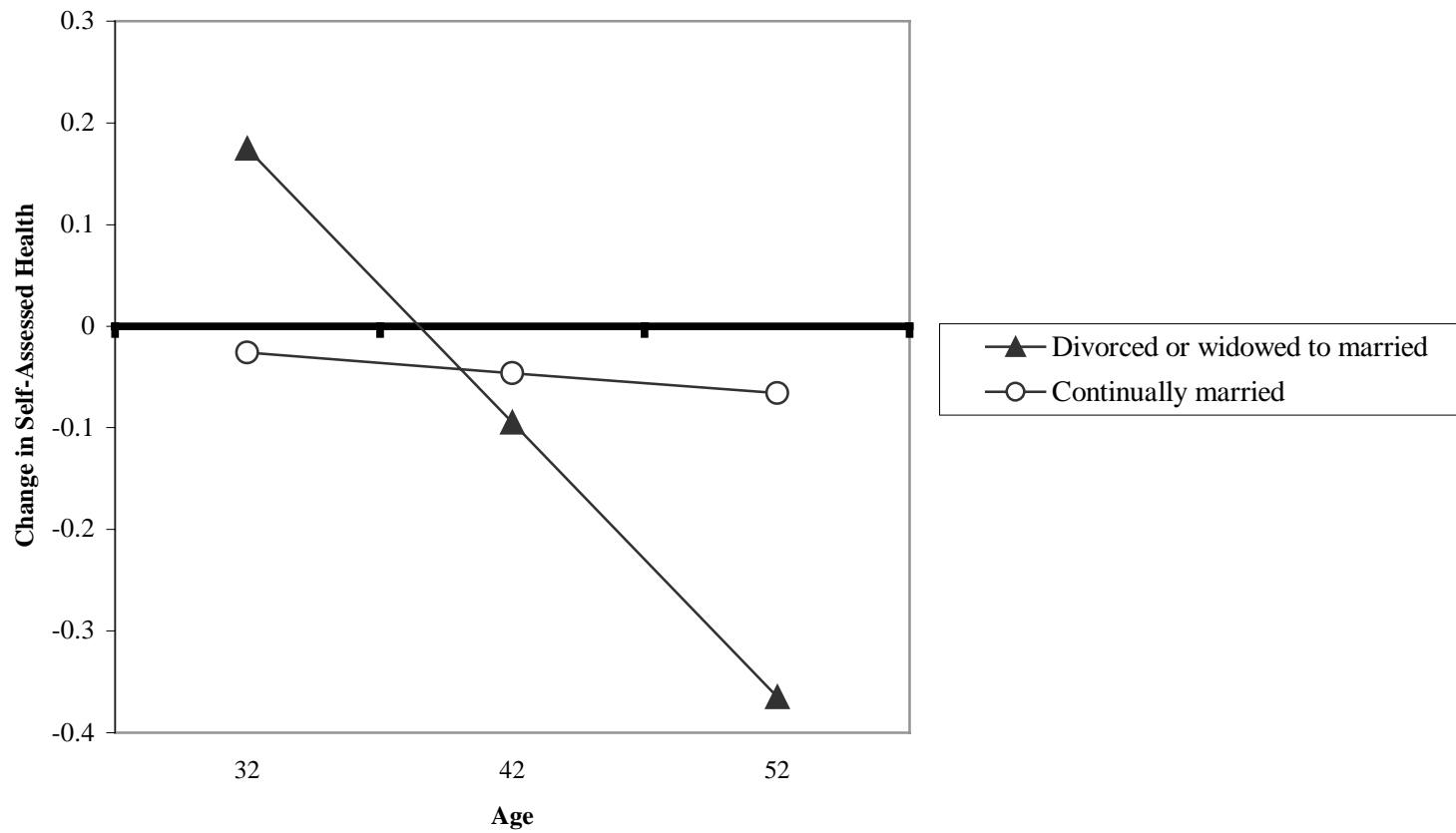


Figure 2: Estimated Effect of Multiple Marital Status Transitions 1989-1994 on Change in Self-Assessed Health by Age

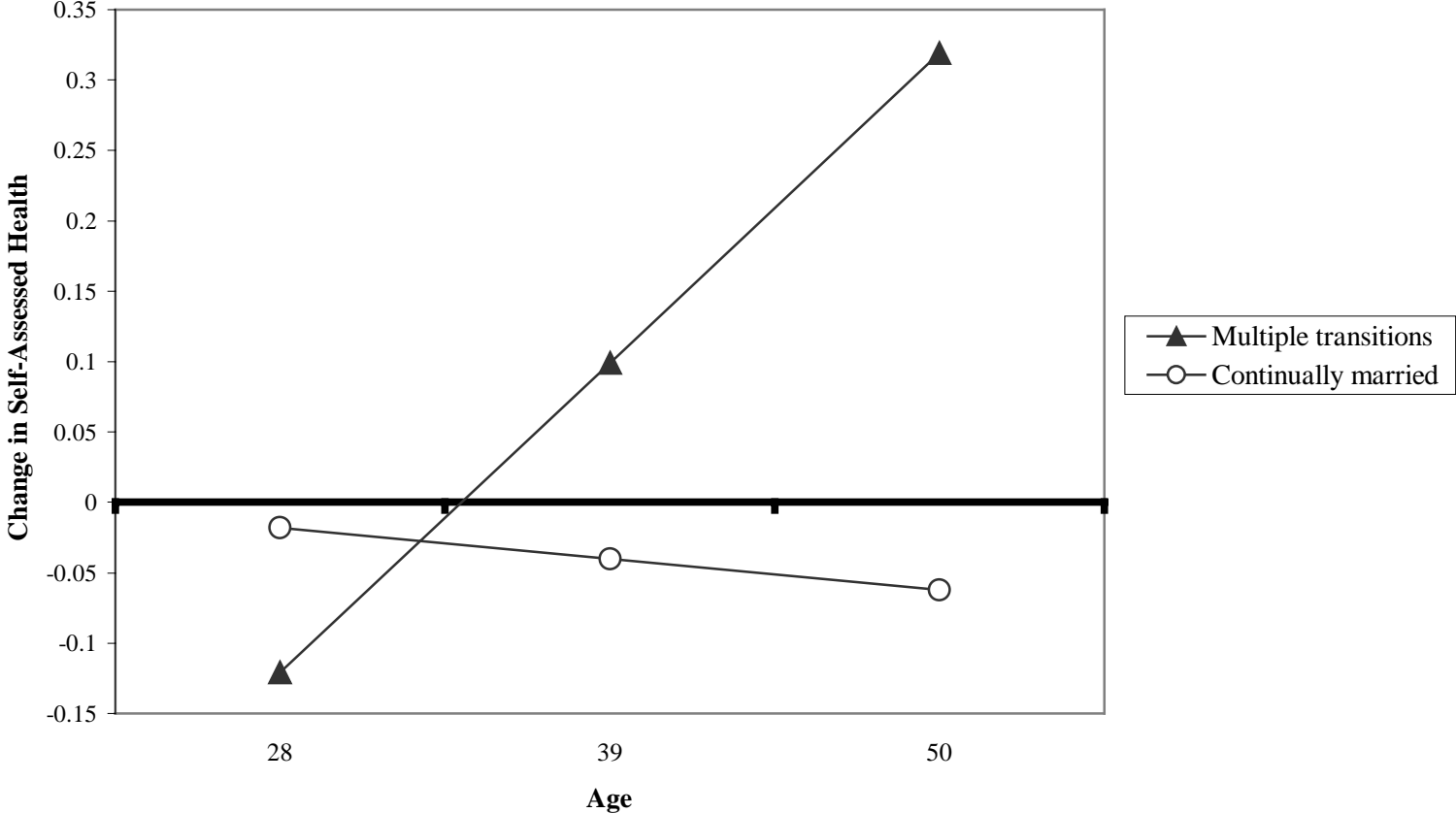


Figure 3: Estimated Effect of Being Continually Never-Married on Change in Morbidity by Age

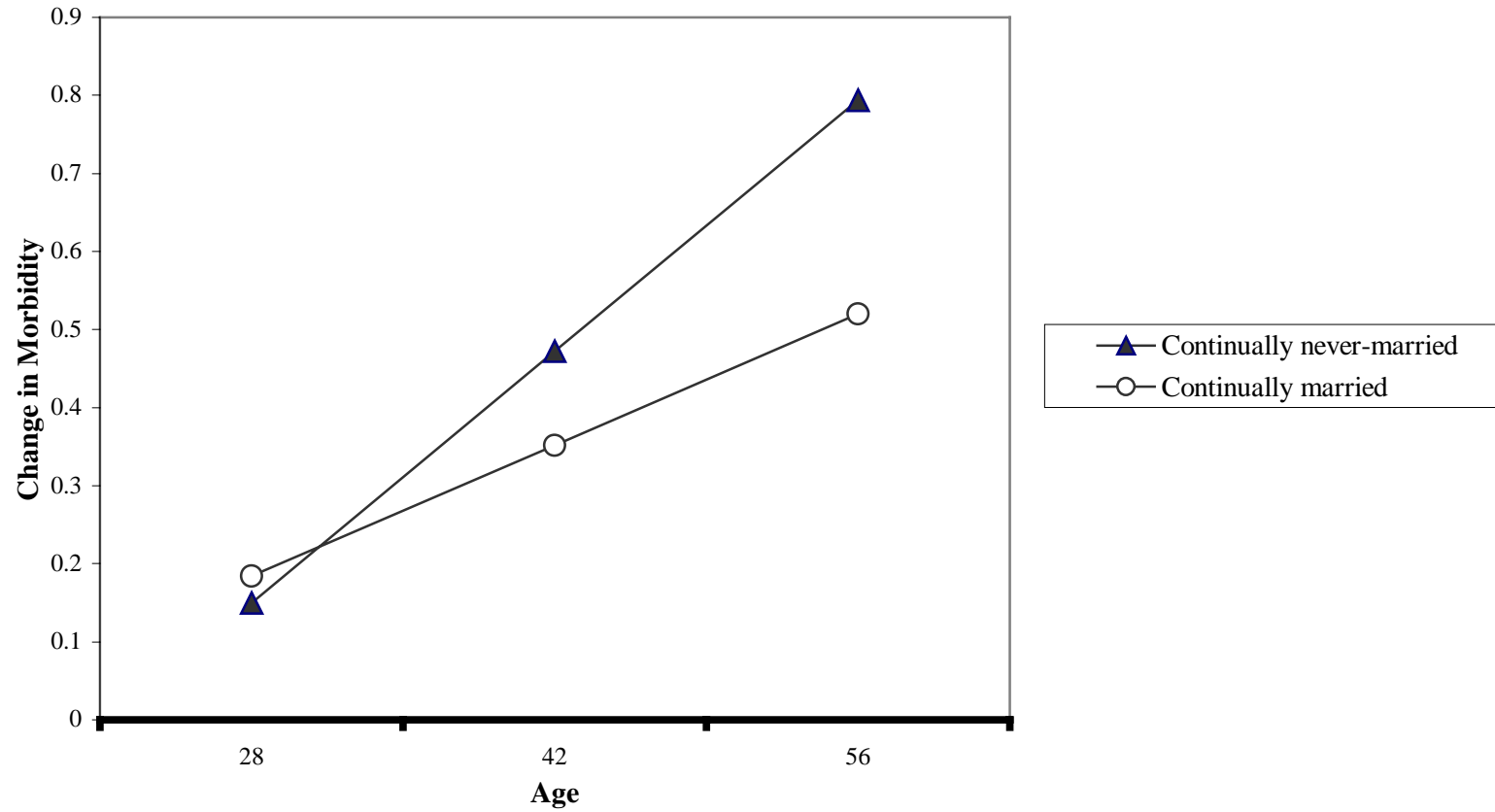


Figure 4: Estimated Effect of Transition to Divorce or Separation on Morbidity by Age

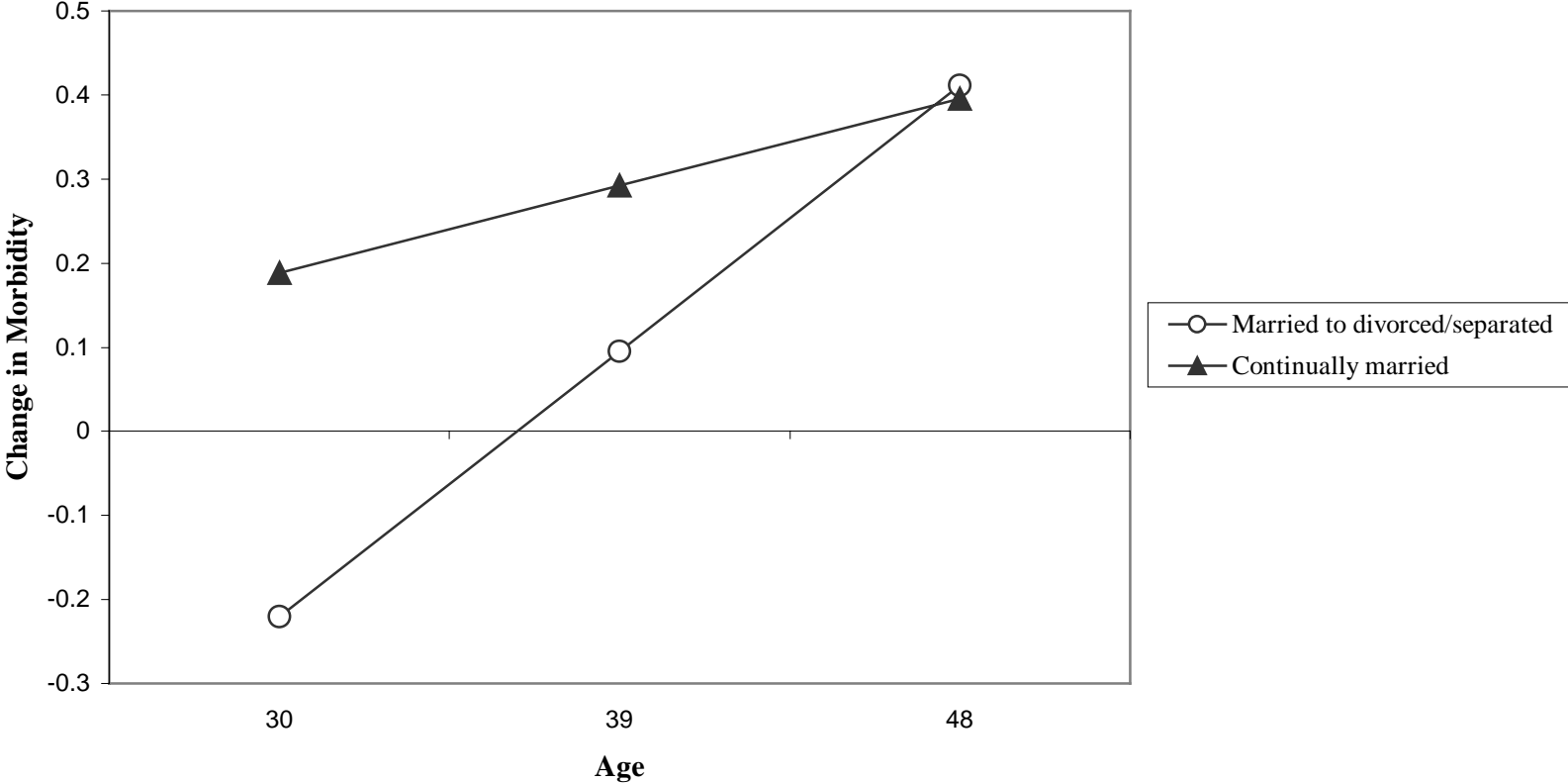


Figure 5: Estimated Effect of Transition from Divorce or Widowhood To Remarriage on Change in Morbidity by Age

