Invited Commentary

Invited Commentary: Toward a More Comprehensive Social Epidemiology of Marital Trajectories and Mortality

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Marriage is a central social institution in the United States that confers legally recognized rights and responsibilities, is a central pillar of the organization of family life, implies joint economic decision making and forces of social support, and has implications for physical and mental health and well-being (1). Given the centrality of marriage in the life of many adults, it is unsurprising that marital status has clear associations with health and mortality in the United States (2, 3), and at least some research suggests that the relation is causal (4, 5). As Dupre et al. (6) point out, however, much (though not all) of that prior research focuses on the relation between measures of current marital status or on single transitions into or out of marriage, without fully considering how marital status unfolds over the life course in ways that impact mortality.

Dupre et al. (6) make 3 important contributions to the literature. First, they examine multiple dimensions of marital status (i.e., current marital status, timing of first marriage, number and kinds of transition out of marriage, and the duration of time spent in marital statuses over the life course) in a large, nationally representative cohort of US adults. Seldom have researchers had access to such detail on marital status trajectories. Dupre et al. necessarily simplify the many possible dimensions of marital status; their findings deserve replication, and further research should explore theoretically important interactions among various aspects of marital status trajectories.

Second, the authors (6) consider several sets of factors that might mediate the relation between marital trajectories and mortality: socioeconomic status, health behaviors, and health status. Because marriage joins the economic, legal, and psychosocial well-being of couples through legal and normative expectations (1), it seems intuitive that the potential mediators included by the authors would at least partially account for the relation between marital trajectories and mortality. However, it is also interesting that adjusting for these potential mediators does not entirely account for the impact of marital status trajectories on mortality either because, as the authors note, measures from later life underestimate variation in these factors that occurred earlier in life or because other unmeasured factors might also be important mediators.

Finally, the authors (6) use the Health and Retirement Study to address their aims. Although the study is more often used by sociologists, demographers, and economists than by epidemiologists, Dupre et al. illustrate the value of these data for examining health in a cohort of aging adults. That said, one important limitation of their research results from the design of the Health and Retirement Study data. Not all individuals born between 1931 and 1941 survived to be eligible for inclusion in the first wave of the Health and Retirement Study in 1992, and those who died may have had different marital trajectories than those who survived to...
1992. I am aware of no other data that could address this problem while providing such rich detail on marital status trajectories and other covariates. Although it is preferable to have imperfect estimates than no estimates at all, readers should be aware of the potential biases introduced by selective survival.

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As with many good papers, the research by Dupre et al. (6) raises more questions than it answers. Their paper finds broad and interesting patterns that deserve additional research, especially toward a more substantial articulation of the mechanisms that link marital trajectories to mortality and other health outcomes. However, as Link (7) points out, few data sources exist that can provide a systematic accounting of the various social, economic, and psychological factors that shape important health outcomes. Additional data collection and research in several areas could improve our understanding of the mechanisms that link marital trajectories with health and mortality outcomes throughout the life course.

Mechanisms

First, various psychosocial resources and risk factors might account for the cumulative impact of marital trajectories on mortality. Marriages that are emotionally nurturing and socially supportive may reduce stress and lower the risk of death, although marriages marked by strain can accelerate age-related declines in health (8, 9). Some individuals may also be better able than others to cope with marital loss. Dupre et al. (6) find that the risk of death associated with divorce weakens with time spent in a divorced state, and it would be useful to know whether those persons with greater coping resources recover from marital dissolution more quickly than their peers. Furthermore, the impact of a person’s marital status on mortality may depend on his or her family structure over the life course. Marital status trajectories are intertwined with the availability of social support, as well as the presence of children, grandchildren, or elderly and frail parents who may require care (10, 11). It would also be useful to know whether all marital dissolutions lead to increased mortality. It seems likely that the person who initiates the divorce may expect life to improve after the divorce (12), which suggests that his or her health should suffer less than the spouse’s.

Second, little research has empirically examined, in detail, when or how spouses promote healthy behaviors. Prior research has revealed correlations in personal and spousal health behaviors (13, 14), although the reasons for those correlations warrant further study. Spouses might provide clear behavioral models that could promote healthy (e.g., exercise) or unhealthy (e.g., smoking) behaviors, depending on their own behavioral profiles. However, spouses could also encourage behavior in others that they themselves are unable to maintain, such as smoking cessation or undertaking regular physical activity, and wives typically expend more effort than husbands on controlling their spouses’ health behaviors (15). Furthermore, having young children is associated with fewer risky behaviors among married couples (16), which suggests, again, that the impact of marriage on shaping health behaviors depends on stage of the life course and broader family circumstances.

Third, marriage is of central importance for shaping the educational, work, and savings decisions of both spouses, given that their well-being is closely linked (17). However, some research has found that personal and spousal income and time at work may have different impacts on health and mortality among husbands and wives (18, 19), although the reasons for gender differences are unclear. Economic trajectories often unfold over the life course in different ways for men and women (20–22), and those trajectories might be particularly useful for understanding gender differences in the impact of early or late marriage on later-life mortality documented by Dupre et al. (6).

Fourth, future studies could consider the importance of marriage markets for understanding the relation between marital trajectories and mortality. Marriage markets that offer few high-quality partners to choose from are associated with lower odds of getting married and lower marital quality (23). Research on marriage markets has often focused on younger adults who are searching for a first marriage and looking forward to having children. Future research could examine whether marriage markets for those of older ages, when males are in short supply because of their younger average age at death, impact marital quality or the likelihood of divorce or remarriage in later life. Over the past several decades, changes in average age at first marriage, the prevalence of divorce, and age at first childbirth (1) suggest the importance of examining cohort differences in the impact of marital status trajectories on mortality.

Changes in marital status

Two major shifts in the organization of marriage in the United States may have implications for health and mortality. First, cohabitation has been increasingly common in the United States in recent decades, even among older adults (24). When examining the relation between cohabitation and mortality or between marriage and mortality for those relationships that began with cohabitation, we must be mindful that couples are not randomly assigned to marriage or cohabitation, and people may choose one over the other for reasons that may be correlated with health and mortality outcomes (25, 26). Furthermore, cohabitation varies substantially. Some individuals rapidly cycle through cohabiting relationships, others cohabit indefinitely and effectively become common-law married, and others use cohabitation as a short stop on the way toward marriage (1). Each style of cohabitation may entail different commitments from each partner and have different implications for subsequent marital trajectories and mortality risks.

Second, at the time of this writing, several US states have recently begun allowing same-sex marriage, and other states are poised to follow suit in the future. However, the contours of economic decision making, gender roles, and social support and psychosocial resources within same-sex marriages are largely unknown. Thus, the implications of
marriage for gays and lesbians deserve focused study to examine whether the mechanisms that impact health and mortality in opposite-sex marriages play a similar role in same-sex marriages.

CONCLUSION

The article by Dupre et al. (6) offers greater insight into how marital trajectories unfold over the life course in ways that have important implications for mortality. Social epidemiologists can extend their findings by focusing on the social, economic, and psychosocial mechanisms that link marital trajectories to mortality and other health outcomes in the United States. Doing so would prove especially useful for understanding how marriage and broader family relationships shape the health of our population now and in the future.

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