Abstract

The protective effects of marriage on health are widely documented, yet recent research shows that these advantages are limited to high quality marriages. We describe the ways that marital quality affects a range of physical and mental health outcomes, with attention to gender, race, and life course differences therein. We also document how the effects of widowhood and divorce on health are moderated by the quality of the lost marriage. We highlight avenues for future research, including investigations of the linkages between relationship quality and health in cohabiting unions, same-sex partnerships, and remarriages.

The protective effects of marriage on health and well-being are widely documented. Studies dating back to Emile Durkheim’s classic Suicide (1897) show that married persons enjoy better physical and mental health, including a lower risk of suicide, relative to their unmarried counterparts. Yet in recent decades, research has shown persuasively that all marriages are not equally beneficial, and that high quality marriages are particularly protective for health, well-being, and longevity – although the strength of this effect may vary by gender, race, and life course stage. In this article, we begin by defining ‘marital quality’ and ‘health,’ and show how these concepts are measured in empirical studies. Next, we describe how overall patterns of marital quality vary based on gender, race, and life course stage. We then describe key theoretical and methodological explanations for the protective effects of marital quality on health and well-being, and review recent empirical studies documenting statistical associations, with a focus on subgroup differences in the strengths of these patterns. Importantly, scholars have argued that one reason why marriage may be more beneficial to the health of men versus women, and whites versus blacks, is that men and whites typically report higher quality marital relations than their counterparts, and thus reap larger rewards. We also describe why and how the health-depleting effects of marital dissolution (i.e., divorce and widowhood) vary based on the quality of the dissolved marriage. Finally, we identify avenues for future research, and highlight the ways that research on marital quality and health can inform policies and practices to enhance well-being over the life course.

Marital Quality and Health: Concepts, Measures, and Methods

Marital Quality

Marital quality is a broad construct that encompasses a range of positive and negative marital interactions and perceptions. Its components may include interactions such as activities shared by the spouses, disagreements, and marital problems, as well as one’s feelings toward their partner and level of satisfaction with the relationship. Some scholars go so far as to argue that divorce is the ultimate indicator of a poor quality marriage. Most empirical studies of marital quality focus on the specific dimensions of marital happiness or satisfaction, which are typically measured by asking an individual either a single question or a series of questions assessing how happy or satisfied one is with the marriage. Although satisfaction and happiness are conceptually similar, researchers draw the distinction that happiness taps one’s feelings or emotions about the marriage, whereas satisfaction reflects a cognitive appraisal of one’s relationship relative to some standard (e.g., what one hoped for in marriage, what others’ marriages are like) (Campbell et al., 1976).

Most research on marital quality has focused on positively worded items such as “How happy are you in your marriage?” yet in recent years scholars have also assessed negatively worded items such as “my partner can get on my nerves,” as well as the frequency of arguments and one’s perceived likelihood that their marriage will dissolve. Researchers also may ask respondents to indicate how often they experience or how strongly they agree that a particular marital attribute characterizes their relationship. Items encompassing positive attributes typically refer to the amount of love, affection, support, and understanding one receives from one’s spouse, whereas negative attributes include conflicts or excessive demands imposed by one’s spouse. Scholars increasingly understand that positive and negative aspects of marriage are not opposite ends of a single pole; rather, positive and negative sentiments and interactions can coexist in a single relationship. For example, researchers have developed the measure of marital ambivalence, which encompasses high levels of positive and negative perceptions of one’s spouse. This stands in stark contrast with marital indifference, which is marked by very low levels of both positive and negative sentiments (Fincham and Linfield, 1997).

Based on citations alone, the most widely used measure of marital quality is the Dyadic Adjustment Scale (Spanier, 1976), which comprises the subdimensions of troublesome dyadic differences, interpersonal tensions and personal anxiety, dyadic satisfaction, dyadic cohesion, and consensus on matters of importance to dyadic functioning (Spanier, 1976: p. 17). Other widely used measures include the Short Marital Adjustment Test (Locke and Wallace, 1959), and single-item global
measures such as “Taking things all together, how would you describe your marriage?”

**Health**

Most studies of marital quality and health rely on large random-sample surveys that obtain self-reported measures of physical and mental health, as well as the marital quality items described above. Researchers can then explore statistical associations between one’s marital quality appraisals and self-reported health measures in order to understand linkages between the two. Health can be defined as the “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2006). Consistent with this definition, studies of marital quality and health cast a wide net, linking marital characteristics to physical health outcomes including mortality risk and risk of particular diseases (e.g., heart disease, diabetes, and cancer) and health symptoms (e.g., high blood pressure, sleep problems); mental health outcomes such as depressive symptoms, anxiety, and substance use; and measures of social well-being like life satisfaction, psychological well-being, and self-esteem (Proulx et al., 2007).

One of the most important advances in the past two decades has been linking marital quality to physiological markers of health called ‘biomarkers.’ A growing number of population-based surveys now obtain biological indicators that provide information on one’s cardiovascular functioning (e.g., blood pressure readings), endocrine systems (e.g., cortisol levels), and immune function (e.g., natural killer cell lysis); each of these biomarkers is associated with the development of particular diseases (Robles and Kiecolt-Glaser, 2003). Major surveys in the United States such as the Midlife in the United States (MIDUS), National Social Life, Health, and Aging (NSHAP), and Wisconsin Longitudinal Study (WLS) obtain detailed self-reports of one’s marriage, physical health, and mental health, as well as biological measures such as heart rate and levels of stress hormones associated with the development of chronic diseases.

Mounting research also explores marital quality and health in laboratory settings. In such studies, researchers might induce a marital spat, and then explore whether the induced threat to marital quality affects physiological markers associated with illness, such as blood pressure, cortisol levels, or the speed with which a laboratory-induced injury will heal. For example, a team of researchers at Ohio State University brought into their laboratory 42 healthy married couples, whose ages ranged from 20 to 80. When the study started, the researchers gave each spouse a small (though relatively painless) cut on their forearm. Some study participants were then told to discuss a potentially contentious topic with their spouse, such as in-law woes or financial worries. The researchers found that the couples with the most heated arguments had significantly slower wound-healing, evidenced by how quickly the small forearm cut healed. Most subjects healed within 5 days, but those who had a heated discussion with their spouse took 1 full day more to heal. The researchers also obtained information on how the couple interacted during the argument. They videotaped the arguments and rated how ‘hostile’ the exchanges were; those couples rated as being hostile toward one another took fully 7 days to heal (Kiecolt-Glaser et al., 2005). Taken together, these studies reveal the broad range of measures and methods used to identify linkages between marital quality and health.

**Subgroup Differences in Marital Quality**

Before further delving into linkages between marital quality and health, it is important to first review social factors that affect marital quality. Patterns vary slightly based on the samples and methods used, yet most studies conclude that men, whites, and newlyweds report higher levels of marital quality than women, blacks, and longer-married persons, respectively. The former two differences, in particular, may partly explain why marriage is generally more protective for the health of men and whites, relative to blacks and women; those who experience the most rewarding marriages will reap the most profound health benefits. We briefly describe subgroup differences in marital quality, and potential explanations for these differentials.

**Gender**

One of the most widely documented findings in marital quality research is that women report lower levels of marital quality and satisfaction than men, although the magnitude of these differences is modest (Jackson et al., 2014). The main explanations given for women’s slightly lower marital quality ratings relative to men’s are: women’s lower levels of power in marital relations; their elevated risk of experiencing domestic violence or mistreatment; the disproportionate burden that women bear regarding child care, housework, and other tasks essential to maintaining a household; their greater emotional investment in sustaining a successful marriage; and their greater willingness to acknowledge and address problems in the marriage (Jackson et al., 2014).

**Race and Ethnicity**

Surprisingly few studies have explored race and ethnic differences in marital quality, with most of this work focusing on black–white differences. Most studies conclude that blacks report higher levels of marital conflict and strain, higher rates of divorce, and lower levels of marital satisfaction than their white counterparts (Broman, 2005). The main explanations for these gaps focus on behaviors within the marriage, where blacks report more frequent fighting, substance use, and infidelity than their white counterparts (Broman, 2005). Blacks’ elevated risk of socioeconomic adversities also may take a toll on one’s marriage: stressors like unemployment, discrimination, and financial strain may contribute to marital tensions (Corra et al., 2009). Few studies focus on marital quality among Latinos, yet there is mounting evidence that Mexican-Americans report significantly higher levels of marital quality than blacks, although both subgroups experience elevated risk of socio-economic adversities. Mexican-Americans’ relatively high quality marriages are attributed to a familistic pro-marriage culture that supports and sustains marriage in many Latino communities (Bulanda and Brown, 2006). The high quality marriages documented among Mexican-Americans also may
contribute to the well-known ‘Latino paradox’ in health; Mexicans report relatively good health, despite their poor economic status compared to whites – perhaps due to the health-enhancing benefits received by their strong marriages.

**Marital Duration**

Marital quality changes with the duration of marriage, where satisfaction waxes and wanes over time, as expectations and social roles change (Brown et al., 2013). The family life cycle explanation suggests that marital satisfaction is high in the very early stages of a marriage (e.g., ‘the honeymoon stage’), and then declines as the spouses face increasing demands with work, childrearing, and home-making. As these stressors diminish over time, marital quality tends to increase in the later years of marriage, once children have left the family home. This is also described as a U-shaped curve (Orbuch et al., 1996). By contrast, a second conceptual model called the disillusionment model presumes that newlyweds hold onto idealized views of their partners, yet after the honeymoon stage passes, spouses may become disappointed, disillusioned, or upset with one another. Whereas the life cycle model posits a U-shaped curve, the disillusionment model presumes that marital quality will either continue to decline, or the marriage will be terminated. Finally, the enduring dynamics model or maintenance hypothesis counters that while unrealistic expectations may be dashed in the early stages of marriage and marital quality may dip after the initial heady years, quality remains relatively steady thereafter, as the partners adjust their expectations to the realities of their lives (Brown et al., 2013).

**Marital Quality and Health: Theoretical and Methodological Explanations**

Why and how does marital quality affect health? Three main classes of explanations are offered: (1) social explanations emphasize the emotional support and health-enhancing assistance exchanged in high quality marriages (e.g., Umberson et al., 2006); (2) biological explanations focus on physiological responses to close and nurturing relationships (e.g., Robles and Kiecolt-Glaser, 2003); and (3) methodological explanations emphasize the concept of ‘social selection,’ where those with better health are predisposed to experiencing more satisfying and enduring marriages (e.g., Butterworth and Rodgers, 2006).

**Social Support and Integration**

High quality social relationships, in general, and marital relations, in particular, are a well-documented source of positive health (Robles et al., 2014). A high quality marriage can provide the sense of security and emotional support that helps to bolster mental health. Happily married persons also enjoy more satisfying and frequent sexual relations, which provide physical and emotional health benefits (Galinsky and Waite, 2014).

Marriage, especially high quality marriage, is also considered a source of ‘social control’ (Umberson et al., 2006). Spouses who love and care about one another will encourage the adoption of healthy behaviors and the loss of unhealthy ones. Husbands and wives may encourage each other to eat nutritious meals, to take their daily medications, to eschew or limit their smoking and alcohol consumption, and to engage in health-enhancing physical activities together. By contrast, persons in poor quality marriages are more likely to engage in risky health behaviors. Persons in unhappy marriages exhibit poor eating habits, erratic sleep patterns, and higher rates of smoking, alcohol use, and nonmedical use of prescription medications (Miller et al., 2013).

A high quality marriage also can protect against or ‘buffer’ the potentially health-depleting effects of stressors like unemployment, work strains, and illness (Cohen and Wills, 1985). For example, several studies of older married couples found that persons with high levels of physical disability, functional impairment, and impaired vision were far less likely to be depressed if they enjoyed high quality marriages, yet were more likely to be depressed if they were in marriages marked by frequent arguments and disagreements (Bookwala, 2011). Thus, marital quality can be a powerful resource that protects against mental health declines, especially as couples face the physical challenges of aging.

**Biological Pathways**

One of the most important scholarly advances of the past two decades has been the exploration of the physiological pathways through which marital interactions ‘get under our skin’ and affect physical health (Ryff and Singer, 1998: p. 214). The pathways most often considered are those that progress through multiple physiological systems, including cardiovascular, endocrine, immune, metabolic, and sympathetic nervous systems (Robles et al., 2014).

For example, laboratory studies show that maintaining physical contact and closeness with one’s spouse when placed under a stressful experimental condition leads to decreases in blood pressure and heart rate, and an increase in the hormone oxytocin. Oxytocin weakens the potentially harmful impact of stress on cardiovascular and endocrine systems (Light et al., 2005). Similarly, in another laboratory study, women who held their husband’s hand while experiencing painful electric shocks reported less pain, and showed decreased activity in the brain region responsible for directing the body’s stress response. By contrast, women who held either a stranger’s hand or no one’s hand (control group) did not evidence such positive physiological responses, underscoring the distinctive effects of the marital relationship (Coan et al., 2006).

Negative interactions, such as marital strain and hostility, also compromise immune system responses (Robles and Kiecolt-Glaser, 2003). The immune system protects the body from bacteria and viruses by releasing antibodies and white blood cells into the circulatory system. In one experimental study, happily married couples were prompted to argue about a ‘real problem’ that they disagreed about. Spouses who showed supportive and constructive behaviors during the argument evidenced reduced stress hormone levels, with steeper effects among wives than husbands. Similarly, a prospective study of older persons in long-term marriages marked by higher levels of conflict and frequent negative behaviors evidenced significantly worse immune system
responses, compared to persons in marriages marked by low conflict and negative behaviors. Taken together, these studies reveal that couples who show the least negativity and most positivity in their marital relations enjoy the healthiest immune, cardiovascular, and endocrine system responses.

**Social Selection**

Thus far, the theories and data we have reviewed suggest that marital happiness can protect health, whereas marital conflict can hurt. Yet a mounting body of research suggests that marital quality and health may be mutually influential, and that poor physical and mental health may impede both one’s own and one’s spouse’s assessment of marital quality. Physical health problems may put a damper on a married couple’s sexual relationship, and may also place difficult caregiving demands on the healthier partner, thus compromising marital quality (Pinquart and Sorensen, 2011). Health problems may also affect one’s ability to maintain steady work, which in turn may place financial strains on the couple. Mental health problems also may compromise a marriage. An emotionally volatile or depressed spouse may not be able to provide their partner the love, attention, and support they desire. Likewise, a spouse with a substance use disorder in particular may be likely to abuse their partner emotionally or physically, and may not contribute effectively to the daily household chores and activities that are at the centerpiece of a good marriage. Consistent with the notion that health problems may suppress marital quality, several studies have documented an elevated risk of divorce in couples where one or both spouses have a series physical or mental health condition (e.g., Butterworth and Rodgers, 2006).

**Marital Quality and Health: Subgroup Differences**

**Gender**

Does marital quality have more powerful effects on the health and well-being of women or men? Research is equivocal, with clinical and laboratory-based studies generally finding greater female vulnerability to marital strain, and population-based studies detecting few if any gender differences (Umberson and Williams, 2005). For example, some studies show that women experience greater physiological arousal in response to laboratory-induced arguments than do men, and this greater arousal, in turn, may have deleterious consequences for their physical health (Robles and Kiecolt-Glaser, 2003). Similarly, prospective studies of congestive heart failure patients show that marital quality is a stronger predictor of survival among women than men (Coyne et al., 2001). By contrast, survey-based studies and a recent meta-analysis (Robles et al., 2014) find relatively weak evidence of gender differences.

To the extent that gender differences exist, scholars have posited several explanations for the stronger linkages among women. First, interpersonal relationships, especially marriage, are considered more highly salient to the self-concept of women – whereas work-related accomplishments are considered more salient to the identities of men. As such, women may be more aware of and responsive to a relationship’s ups and downs, and may evidence greater physiological responses to stressors related to their marriage (Robles et al., 2014). Second, some argue that women have lower social status than men in society, and this power imbalance follows men and women into marriage. Low status, in turn, is associated with greater levels of stress reactivity; thus, women may react more strongly to marital strains and suffer the health consequences thereof (Wanic and Kulik, 2011).

**Race**

Surprisingly little research has explored whether the ties between marital quality and health vary by race and ethnicity. This is an important omission. Some scholars have proposed that the well-documented black–white gap in nearly every health outcome ranging from mortality to cardiovascular disease to diabetes is partially due to the fact that blacks are less likely than whites both to be married, and to maintain high quality marriages. However, little is known about whether a high quality marriage provides richer health benefits to blacks versus whites.

Some scholars have argued that high quality marriage may be less protective (and strained marriages less deleterious) to the health of blacks versus whites because marriage may be less salient to blacks than whites. For example, blacks’ social networks include a higher proportion of persons from their religious community and extended family, relative to whites. These networks may provide many of the supports that might otherwise be provided by spouses (Levin et al., 1994). However, one recent review of the literature concluded that marital quality figures equally into the health of blacks and whites (Blackman et al., 2005).

**Life Course Stage**

Mounting research shows that the protective effects of marital quality on health vary over the life course. In particular, the deleterious effects of marital strain on health intensify with age (Umberson et al., 2006). These findings are consistent with the core themes of socioemotional selectivity theory: this perspective holds that as adults grow older and their time horizons constrict, their closest relationships (such as marriage) become more salient to them than their other more distant social ties (Carstensen, 1991). Moreover, age-related biological vulnerabilities also explain these patterns; immunological impairment increases with age, and the stress associated with marital strain may further accelerate aging of the immune system (Kiecolt-Glaser and Glaser, 2001). Finally, cumulative advantage perspectives argue that the harmful consequences of exposure to stress may accumulate over time, rendering unhappily married older adults more vulnerable from the ‘wear and tear’ that they have experienced over the life course (Dannefer, 2003).

**Marital Dissolution and Health: Does Marital Quality Matter?**

Research consistently shows that widowed and divorced persons have poorer physical and mental health than their married counterparts, with effects documented for
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Conclusions and Future Directions

Marital quality is protective for adult well-being because high quality marriages provide emotional and instrumental support as well as physiological rewards that enhance physical and mental health. Yet researchers continue to grapple with unanswered questions regarding marital quality and health. First, research on marriage and health generally shows that first marriages are more protective than are higher-order marriages (i.e., remarriages), cohabiting unions, and long-term same-sex relationships. One explanation offered for these patterns is that different types of unions provide different socioemotional benefits that, in turn, protect one’s health and well-being. However, few studies recognize that relationship quality may vary widely even within particular types of unions; we urge researchers to identify the specific aspects of marital interactions in remarriages, same-sex unions, cohabiting unions, and dating relationships that are protective for health.

A second limitation of extant research is that most studies focus on the associations between one individual’s marital quality assessments and his or her health, with little attention paid to the partner’s views of the marriage. Husbands’ and wives’ reports of marital quality vary widely, typically yielding correlations of just 0.50 to 0.60 (Carr and Boerner, 2009). As such, researchers are increasingly interested in ‘crossover’ or ‘partner’ effects; this research explores whether one partner’s reports of marital satisfaction affect the other spouse’s health and well-being. For example, an unhappily married spouse may be less motivated to provide his or her partner with the emotional support and caregiving that enhances the partner’s health. The development of statistical techniques like actor-partner independence models (Kenny et al., 2006), as well as the collection of couple-level data in large-scale sample surveys like the NSHAP, WLS, and Disability and Use of Time (DUIST) daily diary supplement to the Panel Study of Income Dynamics, now enable researchers to explore how one’s own health is linked to one’s spouse’s level of satisfaction and happiness in the marriage (Carr et al., 2014).

Understanding the complex ways that marital interactions affect health (and vice versa) is important from a public policy perspective. In the early 2000s, policy makers believed that being married was protective to the well-being of spouses and their children, thus President George H.W. Bush’s administration supported social programs to encourage marriage. Yet in recent years, scholars have documented that not all marriage is good marriage, and that high quality marriages are protective for health. This research has triggered investment in programs aimed at enhancing communication, closeness, and cooperation in marriages (Staton, 2009). Interventions to facilitate communication, minimize conflict, and uphold high quality marriage may be an essential step to protecting the health of adults in the United States.

See also: Aging and Health in Old Age; Heterosexuality; Marriage; Motivation: Life Course and Sociological Perspectives; Personality and Marriage; Sexuality Over the Life Course; Social Relationships in Adulthood.

Bibliography


Relevant Websites

The following data resources include rich measures on physical health, mental health, and marital quality:

http://www.isr.umich.edu/ACLI/ – Americans Changing Lives (ACL)

http://psidonline.isr.umich.edu/DUST/dust09_USERGuide.pdf – Disability and Use of Time Supplement to the PSD

http://midius.wisc.edu/ – Midlife Development in the United States (MIDUS)


http://www.ssc.wisc.edu/intervresearch/ – Wisconsin Longitudinal Study (WLS)