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Cohort differences in the marriage–health relationship for midlife women

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ABSTRACT

The present study aimed to identify potential cohort differences in midlife women's self-reported functional limitations and chronic diseases. Additionally, we examined the relationship between marital status and health, comparing the health of divorced, widowed, and never married women with married women, and how this relationship differs by cohort.

Using data from the Health and Retirement Study (HRS), we examined potential differences in the level of functional limitations and six chronic diseases in two age-matched cohorts of midlife women in the United States: Pre-Baby Boomers, born 1933–1942, $N = 4574$; and Early Baby Boomers, born 1947–1956, $N = 2098$. Linear and logistic regressions tested the marital status/health relationship, as well as cohort differences in this relationship, controlling for age, education, race, number of marriages, length of time in marital status, physical activity, and smoking status.

We found that Early Baby Boom women had fewer functional limitations but higher risk of chronic disease diagnosis compared to Pre-Baby Boom women. In both cohorts, marriage was associated with lower disease risk and fewer functional limitations; however, never-married Early Baby Boom women had more functional limitations, as well as greater likelihood of lung disease than their Pre-Baby Boom counterparts (OR = 0.28).

Results are discussed in terms of the stress model of marriage, and the association between historical context and cohort health (e.g., the influence of economic hardship vs. economic prosperity). Additionally, we discuss cohort differences in selection into marital status, particularly as they pertain to never-married women, and the relative impact of marital dissolution on physical health for the two cohorts of women.

Much of the research on women in midlife has examined the developmental course of specific cohorts that were affected by unique historical events (e.g., Stewart and Healy, 1989), and patterns of health over the life course (e.g., Yasui et al., 2011). Further, marital trajectories have changed in recent cohorts (Ryan et al., 2012), with marital status related to a multitude of health outcomes in middle-aged women (Pienta et al., 2000). However, relatively few studies have examined the association between all three: cohort, marital status, and health in midlife women.

Historical and/or social events have contributed to significant contextual changes in the lives of women who were middle-aged in 1992 (Pre-Baby Boom) and 2006 (Early Baby Boomers). Social roles and expectations for women have changed relatively dramatically since the 1960s; women who came of age in the years following the Women's Movement were exposed to greater freedoms and opportunities (Stewart and Healy, 1989). Comparatively, women in the Pre- and Early Baby Boom cohorts experienced different life histories and differential access to medical advances prior to reaching age 50. For example, Baby Boom women were particularly exposed to ideas promoting healthy lifestyles (e.g., exercising; healthy eating) as young adults, as well as ideas concerning age-related health concerns and illness prevention (Jackson, 2006).

Midlife is a time when many women notice an increase in health issues; middle-aged women have a higher prevalence of physical

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limitations (Pope et al., 2001), often due to osteoporosis or angina, and often related to menopause. According to the National Institute on Aging (NIA), the average age for onset of menopause is 51. Eighty-five percent of women who experience natural menopause do so by age 55 (Harlow and Signorello, 2000), but earlier onset of menopause is associated with greater risk of osteoporosis and heart disease (Gold et al., 2001). In sum, women in midlife may face myriad potential health concerns.

We use data concerning diagnosed chronic illnesses and functional limitations collected in the Health and Retirement Study (HRS) to compare the health status of these two cohorts of women in their 50s. While there is a substantial body of theory and research concerning the health of older women (e.g., Canetto, 2001; Gatz et al., 1995), most of the available empirical research has focused on the health of a single cohort, and neglected notions of inter-individual and inter-cohort differences. Moreover, because mean marital age is different across cohorts, and marital status is known to moderate the age–health relationship (Bennett, 1997; Pienta et al., 2000), we ask if different patterns are evident for married and single (divorced, widowed, and never-married) women in the two cohorts.

1. Theoretical framework: cohorts situated in contexts

We draw on a number of sources for our theoretical framework. Broadly, Bronfenbrenner's Bioecological model (1992) posits that individuals develop within a complex system of relationships affected by multiple levels of social context. Similarly, the biopsychosocial model (Seeman and Crimmins, 2001) describes how individuals' social relationships influence their physical (and mental) health through biological and psychological pathways. Because we are interested in cohorts situated in context, we also draw on the work of Riley, who commented: "Changing lives (aging and the succession of cohorts) are in continuing interplay with changes in society and its structures" (1998, p. 29). Finally, the influence of historical and social events on specific cohorts, particularly for women (Stewart and Healy, 1989) provides a more fine-grained foundation for this study. A recent review by Alwin (2012) suggests the need for greater understanding of the distinctive experiences of aging in different historical times. These ideas have been developed by various researchers who have focused on specific cohorts in the 20th century (e.g., Elder and Hareven, 1994; Stewart and Healy, 1989) whose development was shaped by experiencing historical and social events such as the Great Depression, World War II, and the Women's Movement.

Stewart and Healy (1989) studied the lives of different birth cohorts of women ranging from World War I to the Baby Boom. They posit that the importance of events in defining a sense of identity is mediated by the age at which they are experienced. Women of the Baby Boom (born approximately 1946–1964) who were young adults during the late 1960s/early 1970s, were more likely to find the Women's Movement a meaningful foundation on which to base their identities, particularly their expectations for marriage, education, and career opportunities. For more mature women, such as those born prior to the Baby Boom, the Women's Movement offered the same opportunities for behavioral change, but their identities would remain linked to more traditional roles such as wife and mother.

2. Cohort differences in midlife health

Some evidence suggests that people are living longer and in better health (Manton et al., 2008). Often, however, it is difficult to parse cohort from period effects, as Reither et al. (2009) found in their study of birth cohorts and obesity. This mix of cohort and period trend is also evident in life expectancy predictions. At age 55 in the early 1990s, Pre-Baby Boom women could be expected to live another 27.29 years, whereas by 2007, Early Baby Boomers had gained almost a full further year in life expectancy (28.2 years; U.S. Department of Health and Human Services, 2011). There are also cohort differences in certain types of diseases (Reynolds et al., 1998): although Baby Boomers may exhibit lower levels of cardiovascular disease, arthritis, and emphysema, they may also show faster increases in frailty, and higher levels of musculoskeletal disorders and orthopedic problems than earlier cohorts at the same age.

Much of the research regarding disability focuses on older individuals (e.g., Seeman et al., 2010). However, midlife individuals are not immune to disability; Verbrugge and Yang (2002) comment that "The greatest diversity of disability experience is at the middle ages" (p. 253). Women, in particular, are more likely to suffer from chronic, debilitating diseases (Verbrugge, 1990), such as arthritis, high blood pressure, and chronic back conditions (Verbrugge and Jette, 1994). Reynolds et al. (1998) also provide evidence of cohort differences in rates of disability, with women born between 1916 and the early 1950s showing successive decreases in disability, although disability rates increased for those born after these dates. Furthermore – and contrary to previously-mentioned improvements in health and fitness – shifts in patterns of eating and exercise have led to a 'fattening' of the overall population (Kelley-Moore, 2010, p. 102), with a related increase in prevalence of obesity-related disability. However, we might expect that women of the early Baby Boom (i.e., those in the current study born between 1947 and 1956) would exhibit predominantly lower levels of disability.

Regular exercise contributes to physical health and gains in life expectancy, even in midlife (e.g., Moore et al., 2012). Although intuitively we might expect Baby Boomers to be more physically active than previous cohorts, there is some evidence that this is not the case (Swan et al., 2008), although they possibly show a lesser decline in physical activity after age 50. Moreover, participation in exercise, whether vigorous or mild, can depend on myriad factors. For example, single people and those with a high level of spouse and family support tend to participate more in vigorous exercise (Grzywacz and Marks, 2001), and women engage in vigorous exercise less often than men (Moen, 2001).

3. Cohort and marital status

The rates of women who marry (or not), get divorced, or are widowed have changed over the past few decades. Rates of marriage have declined, post-WWII, a situation often attributed to – amongst other demographic shifts – women's increasing labor force participation (Becker, 1981; Oppenheimer, 1994). Waite (1995) also observed that the benefits to marriage for women are reduced, and that employed wives are less dependent on marriage as a source of financial and emotional security. Work by Waldron et al. (1996) supports this theory; they found health benefits of marriage only in those women who were not employed. Historically, long-term single women were more economically advantaged than their counterparts; this has changed as more married women become less dependent on their spouses, which in turn has ramifications for less economic disadvantage with marital dissolution.

For women born between 1931 and 1941, 36% of marriages ended in divorce, whereas for women born between 1946 and 1950, 41% of marriages ended in divorce (Schoen et al., 1985). In the 1970s, the majority of divorces for women were granted to those in the 35-to-44 age group. One in four divorces in 2010 involved adults aged 50 and over (Brown and Lin, 2012), and the rate for divorce in this age group doubled between 1990 and 2010. Rates of