Family and Household Composition and Health:
Mechanisms and Moderators over the Life Course

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Extended Abstract

Marital status differences in mental health are widely documented in empirical research (Horwitz, White, and Howell-White 1996; Kessler and McRae 1984; Kim and McKenry 2002; Marks and Lambert 1998; Mirowsky and Ross 1989; Ross et al. 1990; Umberson et al. 1996; Waite and Hughes 1999; Gove, Hughes, and Style 1983; Pearlin and Johnson 1977; Thoits 1986; Waite and Gallagher 2000). Married individuals report better mental health using a wide variety of indicators of psychological well-being including happiness (Waite and Luo 2003), alcohol use (Horwitz, White and Howell-White 1996a; Simon 2002; Waite and Luo 2003) anxiety (Barrett, 2000), hostility (Marks and Lambert 1998; Waite and Luo 2003) depression (Beckett and Elliott 2002; Cotton, 1999; Horwitz, White and Howell-White 1996a; 1996b; Menaghan and Lieberman 1986; Marks and Lambert 1998; Simon 2002; Waite and Luo 2003), and other forms of psychological distress (Mastekaasa 1995). Furthermore, the relationship has been demonstrated using both discrete measures of mental illness such as diagnoses or psychiatric treatment, and continuous measures that use symptom counts and other methods to capture more variation in psychological well-being (Barret 2000; Turner and Lloyd 1999).

Stress theory can help us understand the links between marital status and health by directing our attention to differences among the various marital statuses in the availability of resources with which to cope with stress. Individuals can call upon various internal and external resources to cope with or avoid a stressful situation or event. Personal resources can be viewed as the internal assets that can be utilized to avoid or deal with stress (e.g. mastery and self-esteem), and social and financial resources can be viewed as the external assets that can be utilized to avoid or deal with stress (e.g. friends and family, money). Marital status provides access to financial, social and personal resources, which then act as intervening mechanisms in the association between martial status and mental health**.**

The need to focus on the role of age and the life course in the modeling of the stress process has been articulated numerous times in the research literature (Elder, George & Shanahan, 1996; Ensel & Lin, 2000; George, 1989; 1992; 1996), but few have taken up the challenge. Despite the large number of studies that have examined the effect of marital status on depression most only include age as an independent variable, or a control variable. This approach neglects the fact that the effect of marital status on depression may be contingent upon age. Although not everyone experiences career and family stages at the same ages, there are typically normative age ranges associated with them. Experiencing a life stage outside of the normative age range influences societal reaction and even personal meaning typically associated with the stage. As a result, age and life stage interact in shaping the context of the experience. In addition, the demands placed on individuals and the resources available to them to cope with these resources may also vary with age

The purpose of this paper is to critically examine the link between marital status and mental health, with an emphasis on the contributions of the life course perspective, stress process theory to our understanding of this relationship. A number of mechanisms that may account for the persistent relationship between marital status and mental health will be tested and their relative importance at different stages of the life course explored. These potential mediators include household composition, financial resources, social support, social integration, self-esteem, personal mastery and religious participation.

Data for this study will come from two waves (1987-1988, 1992-1994) of the National Survey of Families and Households (NSFH). The initial wave of the survey (1987-1988) involved a national, stratified, multistage area probability sample of the non-institutionalized population aged 19 and older, living in the contiguous United States. Individuals under the age of 19 were included in the sample only if they were married, or lived in a household where no one was age 19 or older (Sweet, Bumpass and Call 1988). One adult per household was randomly selected for interview. Interviews with 13, 007 respondents were conducted, representing a main sample of 9, 637 persons, plus an over-sampling of minorities and households containing single-parent families, step-families, recently married couples, and

cohabiting couples (Sweet and Bumpass 1996). To facilitate the collection of sensitive information, some portions of the interview were collected using self-administered questionnaires.

The interview response rate for the entire wave one sample was 74% (Sweet, Bumpass and Call 1988). The second wave of the NSFH (1992-1994) was conducted five years later, and included interviews with 10, 005 respondents from the original sample. Excluding the 763 members of the original sample who died, the response rate for wave 2 was 82%. Only respondents interviewed at both waves can be included in these longitudinal analyses. To compensate for the unequal representation of the over-sampled populations, the NSFH created sample weights. All analyses in this study will be conducted using sample weights, so the results will reflect the general population.

The dependent variable in this study will be an index of depressive symptoms. Depressive symptoms were measured using 12 items from the Center for Epidemiological Studies Depression (CES-D) Scale. The CES-D is a commonly used measure of depressed mood that has high construct validity and internal consistency (Radloff 1977). In all waves of the NSFH respondents were asked how many days in the past week: (1) "You were bothered by things that usually don't bother you?"; (2) "You felt lonely?"; (3) "You felt that you could not shake off the blues, even with help from your family or friends?"; (4) "Your sleep was restless?"; (5) "You felt depressed?"; (6) "You felt that everything you did was an effort?"; (7) "You felt fearful?"; (8) "You had trouble keeping your mind on what you were doing?"; (9) "You talked less than usual?"; (10) "You did not feel like eating, your appetite was poor?"; (11) "You felt sad?"; (12) "You could not get going?" Responses to these 12 items will be summed to create an index of depressive symptoms with a range 0-84.

The independent variable of interest in this study will be marital status coded as married, cohabiting, separated/divorced, widowed and never married, with married individuals as the reference category. Age, race and gender will be included as control variables, and explored as possible moderating variables. Education will also be controlled for. Potential mediating variables include household composition, home ownership, household income, self-esteem, personal mastery, social support, social integration and religious participation.

Path analysis, which tests the hypothesized direct and indirect causal relationships among independent, intermediary and dependent variables, will be used in this study. It allows the researcher to operationalize the idea of a causal chain and obtain appropriate statistical estimates (Campbell, Mutran, and Parker 1987). One of the advantages of using this type of analysis is that the total effect of one variable on another can be broken down into direct and indirect effects, and hypotheses regarding the pathways through which one variable influences another tested (Alwin and Hauser 1975). This makes path analysis ideal for research questions that are designed to test hypothesized causal chains among variables, or are interested in the relative size and strength of these relationships.

It is anticipated that the magnitude and significance of the relationship between marital status and mental health will vary over the life course, with marriage have a stronger impact during some life stages than others. The relative importance of the various mechanisms through which marital status influences health are expected to differ by age as well. For example, personal resources such as self-esteem and personal mastery may mediate the relationship between marital status and mental health to a greater extent at younger ages, than at older ages, whereas in the older age groups social support may be a more substantial mediator.