Marital Status and Health Beliefs: Different Relations for Men and Women

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Although relations between marital status and health have been substantiated, the results of relatively few studies suggest how or why marriage is associated with health. To understand how marriage and health are associated, this study was designed to examine the role of health beliefs. Two thousand two hundred and six (2,206) adults who participated in the New Jersey Family Health Survey provided information about their marital status, proactive health beliefs, and proactive health behaviors. Results indicated that being married (vs. single) was positively associated with men’s proactive health beliefs, whereas marriage did not appear to influence women’s proactive health beliefs positively. Significant relations between participants’ reports of proactive health beliefs and proactive health behaviors were found. Findings are discussed in terms of the importance of understanding the complex nature of associations between social relationships and health.

KEY WORDS: marriage; health beliefs; health behaviors; gender differences; protective effects of marriage.

Even the earliest “health psychologists” (e.g., Hippocrates) understood that individuals’ lives are inevitably interconnected and social interactions contribute to health and well-being. Modern psychological research continues to provide evidence for this notion, such as the finding that social relationships with meaningful others can have health-enhancing effects (House, Landis, & Umberson, 1988). Of course, the impact of some relationships may be more critical than the impact of others, with more intimate and central relationships of potentially greater importance in determining individuals’ health (House et al., 1988; Kiecolt-Glaser & Newton, 2001). For the majority of adults, relationships with their spouses are their most intimate and central relationships, and research has accumulated across the past few decades to provide a fairly clear picture of the potentially positive associations between marriage and health (Horwitz, White, & Howell-White, 1996; Markey, Markey, & Birch, 2001).

Studies of marital interactions suggest that marital functioning generally impacts physiological functioning, including cardiovascular, endocrine, and immune functions (Kiecolt-Glaser & Newton, 2001). More specifically, associations have been found between marriage and health outcomes, such that married individuals have better health experiences than nonmarried individuals in terms of pain and pain-related disability, substance abuse, periodontal disease, rheumatoid arthritis, cardiovascular functioning, neurological disorders, ulcers, depression, self-reports of overall health status, and longevity (Carels, Sherwood, & Blumenthal, 1998; Coughlin, 1990; Kiecolt-Glaser & Newton, 2001; Levenstein, Kaplan, & Smith, 1995; Marcenes & Sheiham, 1996; Medalie, Stange, Zyzanski, & Goldbourt, 1992; O’Farrell, Hooley, Fals-Stewart, & Cutter, 1998;
Tucker, Friedman, Wingard, & Schwartz, 1996; Turk, Kerns, & Rosenberg, 1992; Vitaliano, Young, Russo, Romano, & Magana-Amato, 1993; Zautra et al., 1998). Despite the accumulating evidence that supports consequential links between marriage and health, in their classic review of the literature through 1990, Burman and Margolin (1992) suggested that minimal information is available to explicate how or why marriage is associated with health.

It has been posited that marriage may serve as a source of health-promotion by somehow encouraging positive health behaviors, which over time culminate and facilitate desirable health outcomes and even longevity (Kiecolt-Glaser & Newton, 2001; Lewis, Rook, & Schwarzer, 1994). The social support and enhanced psychological well-being associated with being in a satisfying marital relationship may also contribute to health (Gove, Hughes, & Style, 1983; Markey et al., 2001). However, the inevitable complexity of these relations and the correlational nature of the majority of past studies make it difficult to discern the most substantial paths of influence from marriage to health. Further, these explanations have not been able to explain fully the reported gender differences in the positive effects of marriage.

Significant gender differences in the protective effect of marriage have been reported: nonmarried men have 250% greater mortality than married men, and nonmarried women have 50% greater mortality than married women (Ross, Mirowsky, & Goldsteens, 1990). Different health behaviors, women’s roles as caretakers (i.e., encouraging other family members—including their husbands—healthy habits), differences in physiological reactivity to stress, and women’s tendencies toward greater social integration then men (regardless of marital status) are reasons that have been suggested to explain this gender difference (Courtenay, 2000; Ewart, Taylor, Kraemer, & Agras, 1991; Kiecolt-Glaser & Newton, 2001; Phillipson, 1997). However, explanations regarding gender differences in relations between marriage and health are far from unequivocal; it remains unclear how marital status is differentially associated with health for men and women.

One possible route linking marriage and health outcomes may be health beliefs. Evidence indicates that changes in health status appear to emerge as a result of marital status. In other words, relations between marital status and mortality risk cannot be accounted for by health status prior to marriage, and even subtle changes in marital experience have been associated with subsequent changes in health and well-being (House, Robbins, & Metzner, 1982; Seeman, Kaplan, Knudsen, Cohen, & Guralnik, 1987; Wickrama, Lorenz, Conger, & Elder, 1997). Thus, it is important to examine how the act of getting married leads to improvements in health. Do married individuals begin to think differently about their health and to develop more proactive health beliefs? For example, are married individuals more likely than their unmarried counterparts to believe it is important to find the time to go to the doctor?

The Health Belief Model (Hochbaum, 1958; Rosenstock, 1990) provides a framework for conceptualizing the potential importance of health beliefs. According to this model, four beliefs are important in determining individuals’ health behaviors: the perceived susceptibility to disease or disability, the perceived severity of a disease or disability, the perceived benefits of health-enhancing behaviors, and the perceived barriers to health-enhancing behaviors. A number of studies (see Janz & Becker, 1984, for a review) suggest that these health beliefs are important contributors to health, including participation in preventative health behaviors (i.e., proactive health behaviors or procedures that have the potential to prevent illness, such as receiving a flu shot). Further, researchers have been able to use this model to understand why some individuals do not participate in programs and procedures that are designed to prevent or detect health problems (Rosenstock, 2004).

The Health Belief Model is not the only model that suggests the critical role of beliefs in health-related behaviors. Growing evidence that indicates the important function of self-efficacy (e.g., Bandura, 1986) and optimistic beliefs about health (e.g., Reed, Kemeny, Taylor, Wang, & Visscher, 1994) in determining positive health outcomes further highlights the importance of examining health beliefs as predictors of health outcomes. Thus, although there is little agreement among health psychologists regarding the model or theory that best represents the role of health beliefs in determining individuals’ health and well-being (Ogden, 2003; Weinstein, Rothman, & Sutton, 2003), it seems clear that understanding individuals’ health beliefs is an important step toward predicting whether or not they will participate in behaviors conducive to health maintenance. Given the potential importance of health beliefs, in this study we examined relations between marital status and health beliefs.