Marriage and similar partnered relationships—such as heterosexual or same-sex intimate relationships with or without cohabitation—are among the most significant interpersonal relationships in which individuals engage during the adulthood years. Views held by young adults about marriage are largely positive, and demographers project that most young adults will eventually marry; however, more accepting social attitudes that prevail today regarding single lifestyles and unions outside of marriage have resulted in increasing numbers of individuals opting for intimate relationships other than traditional marriage (Amato, Booth, Johnson, & Rogers, 2007). This chapter reviews empirical developments published after 1995 (when the first edition of this handbook was published) on (a) the nature and quality of marriage and similar partnered unions during the middle and late adulthood years, (b) factors that play a role in shaping these relationships, and (c) the role of such relationships in health during this life stage. Contemporary theoretical explanations for trends in findings also are discussed. Although the vast majority of the research on midlife and late life partnered relationships has focused specifically on marriage between heterosexual adults, evidence on other marriage-like intimate relationships is reviewed where available.

With its social and legal recognition as a distinctive relationship characterized by specific benefits, protections, rights, and obligations, marriage between heterosexual individuals remains the most common intimate relationship of its kind during the middle and later adulthood years, especially for men. According to the 2000 U.S. Census (U.S. Census Bureau, 2003), upward of 75% of men between the ages of 55 and 74 were married and more than 70% of those aged 45 to 54 years and 75 to 84 years were married. In contrast, a much smaller percentage of men 85 years and older was married.
(56.3%). The proportions of married women by age group were substantially lower relative to the statistics for men. Approximately two-thirds of women aged 45 to 64, slightly more than one-half of those aged 65 to 74, and about one-third of women 75 to 84 years of age were married. Of women who were more than 85 years of age, only 19.4% were married; moreover, more than half of these women's husbands did not reside with them in the same home, presumably due to serious health conditions requiring institutionalization. (In comparison, only one-fifth of men's wives in the same age category did not reside with them.)

Despite the widespread prevalence of marriage as a social institution, other forms of partnered relationships are gaining in popularity and societal acceptance (Amato et al., 2007). Legal recognition of civil unions between same-sex partners is widespread (Kennedy, 2005), and gay and lesbian families reside in 99.3% of all counties in the United States (Human Rights Campaign Foundation, 2001). Cohabiting relationships, those wherein couples elect to live together sans marriage, also are becoming common among middle-aged and older adults in the United States and other Western societies. Based on 2000 U.S. census data, Brown, Lee, and Bulanda (2006) found that 4% of the nonmarried older adult population cohabited with a partner and the vast majority of these cohabiting elders had been previously married. Beckman, Waern, Gustafson, and Skoog (2008) found that among Swedish 70-year-olds, 6% of men and 5% of women were involved in cohabitational relationships in 2000 compared with 1% and 3%, respectively, in 1992. Likewise, Moustgaard and Martikainen (2009) reported that cohabiting relationships among Finnish older men and women nearly doubled between 1990 and 2003 (to 3.4% and 2.1%, respectively).

An emerging form of noncohabiting intimate relationships in Western societies includes living apart together or LAT relationships (Levin, 2004). An LAT relationship is one in which a couple does not share the same household but the two individuals define themselves and are defined by their social network as a couple (Levin & Trost, 1999). Levin and Trost reported that more than 4% of the Swedish population aged 18 to 74 participated in LAT relationships, with even larger proportions reported in other Western European countries such as France and Germany. Using national data from the 1996 and 1998 General Social Surveys, Strohm, Seltzer, Cochran, and Mays (2009) reported that 6% of men and 7% of women aged 23 to 70 were in LAT relationships. Using data from California in 2004–2005, they reported that the prevalence rates of LAT relationships were even higher for those in both heterosexual relationships (13% of men, 12% of women) and same-sex relationships (17% of gay men, 15% of lesbians) in that state. Although a focus on LAT relationships specifically among middle-aged and older adults in the United States is lacking (Casalanti & Kiecolt, 2007), researchers in Western Europe have recognized them as a growing phenomenon in these age groups. For example, De Jong Gierveld and Peeters (2003) reported...
that 32% of Dutch elders who started a new partnered relationship after ex­periencing the dissolution of a marriage later embarked on a LAT rela­tionship.

Ghazanfareeon Karlsson, Johansson, Gerdner, and Borell (2007) described LAT relationships as primarily serving as a vehicle for giving and receiving emotional support without the duties and obligations associated with marriage. As such, LAT relationships offer the opportunity to combine intimacy with autonomy. Some common reasons uncovered by Levin and Trost (1999) for establishing an LAT relationship included one or both individu­als having minor children living with them in the home, providing care to another person (especially a parent), being employed or pursuing education in different places, and personal reasons such as not wanting to repeat a mis­take and wanting to maintain their own household after retirement. Gender differences appear to underlie motives for involvement in LAT relationships. Ghazanfareeon Karlsson and Borell (2002) found that women offered less ambiguous reasons than men for being in LAT relationships and were often the driving force behind the establishment of such a union. Women were especially likely to endorse reasons such as the desire for and privilege of maintaining one’s own household and of being freed from household and partner-related duties that occur in marriage.

**RELATIONSHIP QUALITY AND SATISFACTION**

Research on relationship quality across the adult life span, especially within marriage, has seen considerable growth in the past decade or so. Cross­sectional studies comparing positive dimensions of marital quality (e.g., mar­ital satisfaction, marital happiness) across young, middle-aged, and older adults have found support for a U-shaped trend with marital satisfaction and hap­piness lower among middle-aged adults compared to those who are younger or older (e.g., Henry, Berg, Smith, & Florsheim, 2007; Van Laningham, Johnson, & Amato, 2001). However, longitudinal studies spanning extended periods of time have found that marital satisfaction and happiness typically decline after the newlywed years and into middle adulthood and then either stabilize or continue to decline after midlife (Umberson, Williams, Powers, Liu, & Needham, 2006; Van Laningham et al., 2001). Methodological arti­facts are likely to be responsible for the U-shaped marital quality curve over the adult lifespan that is evident in cross-sectional research. Marriages of es­pecially poor quality are most likely to be terminated prior to entry into the late adulthood years resulting in the uptick observed in marital quality in older samples. Cohort effects also may operate whereby different age groups have different expectations for their marriage that, in turn, influence their ratings of marital quality.

In contrast to marital research, longitudinal research on changes in re­lationship quality within cohabiting relationships or stable gay and lesbian
relationships is scarce. One exception is a study conducted by Willetts (2006) who compared the relationship quality of long-term cohabiting relationships and marriages. Using a probability-based sample with an average age in the early to mid-40s, Willetts found that long-term cohabiting relationships are likely to share similar characteristics as marital unions in terms of relationship quality with only small differences between these two groups of couples on relationship satisfaction, frequency of interaction with the partner, or frequency of conflict. In a study comparing relationship quality across heterosexual marriages and stable same-sex relationships, Kurdek (2008b) found that relative to the declining trend evident in marital quality, stable gay and lesbian relationships showed no significant change in relationship quality over a 10-year period following relationship initiation. In addition, he reported that overall relationship quality was fairly high in these stable gay and lesbian relationships. It should be noted, however, that Kurdek’s study only speaks to temporal trends in relationship quality among gay and lesbian couples until they are in their mid-40s, and thus, we cannot draw conclusions about changes in the quality of these relationships in late adulthood. Moreover, the gay and lesbian respondents were considerably older (in their mid-30s) at the start of Kurdek’s study than were the heterosexual respondents (late-20s), thereby confounding age with group membership.

The experience of love within partnered relationships is theorized by some researchers to undergo a transformation over time, in which a predominance of passionate love during the young adulthood years is replaced by the experience of higher levels of companionate love during the midlife and later years (Bierhoff & Schmohr, 2004). Passionate love is characterized by intense emotional, psychological, and physiological longing for the partner, whereas companionate love comprises affection, intimacy, and commitment (Hatfield & Rapson, 1993). Using existing theories of love (e.g., Hatfield, 1985; Hatfield & Rapson, 1993; Lee, 1973) and the lifespan theory of control (Heckhausen & Schulz, 1995), Bierhoff and Schmohr posited that, in general, the opportunities for forming and sustaining passionate love relationships decline starting in middle adulthood because the formation of partnered relationships is characterized by age-graded opportunity structures and age-graded goals in partnered relationships. Starting at midlife, unpartnered individuals may find fewer age-peers with whom they can initiate new intimate relationships because by this life stage most of them are already involved in long-term relationships. According to Bierhoff and Schmohr, the gain in importance of companionate love over passionate love within long-term relationships as people age represents a type of compensatory secondary control strategy in the face of diminished availability of romantic experiences.

Bierhoff and Schmohr’s model is consistent with other models that describe life course changes in the experience of love within long-term rela-
tionships. For example, Hatfield and Rapson (1993) also pointed out that, in general, passionate love relationships between older individuals are less likely to develop because such relationships more closely coincide with the developmental tasks of young adulthood that include forming a sexual union, entering marriage, and starting a family. Bierhoff and Schmohr also blamed prevailing negative age stereotypes for the lower likelihood of forming a new relationship marked by passionate love during or after middle adulthood. Resulting from these negative age stereotypes, older individuals are more likely to engage in the deactivation of passionate love goals as a compensatory mechanism to avoid the negative consequences associated with failure to attain such goals. Drawing further on the lifespan theory of control, Bierhoff and Schmohr proposed that older individuals are motivated to substitute goals more in line with companionate love in forming and sustaining partnered relationships. It is plausible that this strategy serves as a means to protect elders' emotional and motivational resources and may be more successful because later life offers a more favorable opportunity structure for companionate love relationships with age-peers. Factors associated with the formation and maintenance of partnered relationships in late life and how these may be moderated by contextual factors such as gender, ethnicity, and sexual orientation are important areas for future research.

When evaluating the fit of their lifespan model of love using findings obtained by their team and others, Bierhoff and Schmohr (2004) found some support for their hypotheses. Romantic love (a component of passionate love) was lower in respondents who were middle-aged, whereas the pragmatic form of love (a component of companionate love) was more common among middle-aged and older individuals. However, other components of passionate love (e.g., love styles marked by possessiveness and manipulation) did not show the expected negative trend over increasing age, nor did some elements of companionate love (e.g., altruistic love and friendship-based love) show the expected positive linear relationship with age. Bierhoff and Schmohr's results indicate that, despite theoretical explanations for hypothesized differences in the experience of love with aging, the data do not necessarily conform to such expectations. Moreover, it is important to note that these theoretical models for the development and experience of love over the life course appear to be most relevant to partnered relationships with age-peers or life stage-peers. They do not account for individual differences that may prompt older individuals to engage in passionate love relationships with considerably younger partners. Moreover, Bierhoff and Schmohr's (2004) model primarily addresses lifespan-related changes in the experience of love within heterosexual relationships. They speculated, however, that the age-related change in opportunity structures associated with intimate relationships and the use of compensatory control strategies to deal with such change are, in general, likely to characterize same-sex relationships as well. Kurdek's
work (2008a) supports this view, showing that processes that regulate relationships are similar across both heterosexual and cohabiting same-sex intimate partnerships.

**MARITAL DISAGREEMENT AND CONFLICT**

Marital and other partnered relationships are not characterized exclusively by positive dimensions during the middle and late adulthood years. Indeed, marital relationships can be marked by ambivalence, with criticism and other hurtful emotional behaviors co-occurring with positive feelings and behaviors (Akiyama, Antonucci, Takahashi, & Langfahl, 2003; Birditt, Fingerman, & Almeida, 2005; Fingerman, Hay, & Birditt, 2004). Marital conflict also occurs in midlife and late-life marriages. For example, in a qualitative study with 105 late-life married couples, Henry, Miller, and Giarrusso (2005) found that the most common conflict issue was related to leisure activities (in 23% of the responses) followed by issues related to emotional and physical intimacy, finances, personality, relationships with children and grandchildren, household concerns, personal habits, health issues, and work or retirement.

Several early studies found inequities in marital role allocation or division of household labor to be significant areas of disagreement and conflict, especially during the child-rearing middle-adulthood years, and that such marital role inequities typically favor husbands over wives (e.g., Feeney, Peterson, & Noller, 1994; Peterson, 1990). In addition, Bookwala (2009) found that middle-aged married women caregivers were more likely to report inequities in the allocation of marital roles than their married male counterparts. Studies with individuals in late life (rather than midlife), however, tend to report more role equity in marriage. Kulik (2002a, 2002b), for example, found no differences between husbands and wives among Israeli late-life couples in the performance of domestic tasks, maintenance tasks, and outdoor tasks. Hagedoorn, van Yperen, Coyne, van Jaarsveld, Ranchor, van Sonderen, and Sanderman (2006) likewise found that marital inequity was more the exception than the rule in the later years. In their longitudinal population-based study of Dutch older adults, 84% of married persons described their marriage to be equitable compared to less than 10% each reporting that they were underbenefited in their marriage or overbenefited.

In a probability-based sample of long-term heterosexual cohabiters and married adults with an average age of early to mid-40s, Willetts (2006) found no differences between the groups on perceived relationship equity at baseline or follow-up five to seven years later. In fact, Willetts found age to play a role in perceptions of relationship equity such that as the age of the couple increased, perceptions of equity increased; however, older cohabiters showed
Marriage and Other Partnered Relationships in Middle and Late Adulthood

Disagreement and conflict are not unique to heterosexual couples. They occur in same-sex couples as well, with some relationships showing a spiraling cycle of escalating abuse (Peplau & Fingerhut, 2007). Research on same-sex intimate relationships indicates, however, that role equity is more typical of gay and lesbian relationships (see Kurdek, 2006; Peplau & Fingerhut, 2007) with greater equity in same-sex couples with no children (and heterosexual couples with no children) compared to heterosexual couples with children (Kurdek, 2006), and greater equity in lesbian relationships than in gay partnerships (Kurdek, 2007). It is important to note, however, that these studies have typically focused on lesbian and gay partnerships between young rather than older persons and little is known about equity in same-sex relationships during the middle and late adulthood years.

Although marriages are not free from conflict in midlife and late life, cross-sectional data show a downward age-related trend for negative marital processes, with marital disagreement and conflict being reported less often by older respondents than younger respondents. Bookwala, Sobin, and Zdaniuk (2005) found an age-graded decline in the frequency of heated arguments and aggressive acts within marriage (namely, hitting or throwing things at each other) in a national probability-based sample of adults. Henry et al. (2005) found age differences in the types of difficulties and disagreements that were reported in married older adults. Older respondents (65+ years) were more likely to mention difficulties or disagreements related to leisure activities, intergenerational relationships, and household concerns, whereas younger respondents (<65 years) were more likely to face challenges in the realms of emotional and physical intimacy and personality. Henry et al. also reported that respondents who were 65+ years were more likely to report no problems in their relationship relative to those who were younger than 65.

Findings about the lower likelihood of marital disagreement or conflict in late-life marriage relative to earlier life stages should be treated with caution because alternative explanations may exist for the age-related trend. Possible explanations include the operation of cohort effects in cross-sectional samples or selection effects wherein the most seriously conflicntual and abusive marriages do not endure into middle and late adulthood. Moreover, some longitudinal evidence supporting the reverse age-trend has been reported recently. Using multiwave data from a national sample, Umberson and Williams (2005) found that marital strain in the form of feeling upset about the marriage or feeling upset about disagreements in the marriage tends to increase linearly over time after age 40. They found, however, that this upward trend was more characteristic of women than men; men were more likely to experience an increase in marital strain until age 60, after which
their marital strain showed a plateauing trend. In addition, Umberson and Williams found that women after age 40 report higher levels of baseline marital strain relative to men, and this gender difference widens further at older ages.

Regardless of the frequency of marital disagreement in midlife and late life, how spouses behave during disagreement can undermine marital satisfaction. Henry et al. (2007) examined the relationship between marital satisfaction and couples' positive and negative spouse behaviors during an observation task in which they discussed a topic of disagreement. Henry et al. found that positive spouse behaviors were associated with higher marital satisfaction and negative behaviors with lower marital satisfaction in middle-aged and late-life couples, with no distinction in the strength of these associations between the two age groups. Smith et al. (2009) instructed couples to discuss a topic representing an unresolved issue for them. They found that although older couples reported less anger and rated their spouses as less hostile than did middle-aged couples, these age differences disappeared when couples' marital satisfaction was controlled.

Inequity in role allocations within intimate relationships also has consequences for relationship quality and well-being. Role inequities in long-term marriages are associated with lower marital quality (Kulik, 2002b) and greater psychological distress (Hagedoorn et al., 2006). Likewise, Kurdek (2007) found that satisfaction with the division of labor within gay and lesbian couples was related to higher relationship satisfaction and relationship stability. Moreover, he found that the association between satisfaction with the division of labor and relationship satisfaction was fully mediated via perceived equality in the relationship. These findings linking role allocation inequities and relationship satisfaction are consistent in general with equity theory (Walster, Walster, & Berscheid, 1978), which posits that individuals seek fairness in their intimate relationships, and unfairness is likely to be associated with relationship and more general distress.

**SEXUAL ACTIVITY AND SEXUAL SATISFACTION**

Despite pervasive negative stereotypes and conventional wisdom regarding the sexuality of older individuals, sexual intimacy and satisfaction are prevalent in marriage and similar relationships during the later years and are important to older adults. For example, on examining the attitudes regarding the role and value of sex in later life in a small sample, Gott and Hinchcliff found that partnered elders rated sex as at least somewhat important and several respondents rated it to be very or extremely important; only unpartnered elders rated sex to be of no importance at all. In a large national study of premenopausal and early perimenopausal women conducted at multiple sites in the United States, Cain et al. (2003) also found that 76% of the
sample reported that sex was of moderate or greater importance. Upward of 86% of those who had engaged in sexual activity in the preceding six-month period, regardless of menopause status, reported feeling moderate or greater emotional satisfaction. An even greater proportion of women reported feeling similarly high levels of physical satisfaction. Indeed, sexual intimacy and satisfaction play an important role in positive relationship evaluations in the later years. DeLamater and Moorman (2007) found that more frequent sexual activity was associated with more positive evaluations of the relationship in a large representative sample of elders 45 to 94 years of age. In a longitudinal study using five waves of data from 283 middle-aged married couples, Yeh, Lorenz, Wickrama, Conger, and Elder (2006) found that higher sexual satisfaction was related to greater marital satisfaction that, in turn, was related to lower marital instability among both husbands and wives.

The importance of sexual behavior and satisfaction in middle and late life notwithstanding, large-scale studies with heterosexual elders typically have found that age is negatively related with sexual activity. For example, in a probability-based sample of men and women between the ages of 57 and 85 years Lindau et al. (2007) found that sexual activity declined from a fairly high level of 73% of respondents aged 57 to 64 years to 53% of those aged 65 to 74 years to 26% among those aged 75+ years. From her review of research findings related to sexual behavior among middle-aged and older adults, Burgess (2004) also concluded that the frequency of sexual activity was lower in older than younger age groups; however, she noted that there was considerable variability in their sexual activity. This variability was strongly linked to relationship status; partnered elders were more likely to report sexual engagement than their single counterparts.

Some recent evidence suggests, however, that rates of sexual activity in older samples appear to be rising overall. A recent time-series cohort analysis of trends in self-reported sexual activity among 70-year-old Swedes revealed increases over time (Beckman et al., 2008). This study used data on sexual activity and satisfaction from four cohorts (N = 249–500) during the time period spanning 1971–2001. Findings indicated that the proportion of respondents who reported engaging in sexual intercourse increased over time among both married and unmarried cohorts with a much greater proportional increase among unmarried elders. More recent cohorts also reported higher satisfaction with their sexual activity, fewer sexual dysfunctions, and more positive attitudes toward sexuality in later life than earlier-born cohorts. Although a similar analysis has not been undertaken in the United States and similar cultures, it is likely that Beckman et al.’s findings would be replicated given the changing social and sexual norms in most Western societies.

As with heterosexual relationships, age is negatively related to sexual activity in same-sex relationships (Peplau, Fingerhut, & Beals, 2004). In their review of research on gay and lesbian sexuality, Peplau and her colleagues
noted that being older was significantly associated with lower frequency of sexual activity in a number of studies; however, this association was weaker than the one between length of relationship and frequency of sexual activity. Consistent with findings on heterosexual relationships, Peplau et al. also noted that higher sexual frequency was associated with higher sexual satisfaction and with higher levels of relationship satisfaction in same-sex relationships. Note, however, that Peplau et al. did not focus their review specifically on research done with gay and lesbian older adults. The studies they reviewed often included samples with a wide age range (e.g., 20 to 77 years); however, these studies typically controlled for age and relationship length in their statistical analyses rather than focusing on the effects of these variables.

Although increasing age is widely viewed as a broad-based explanation for decline in sexual interest and activity during the late life years, this link may be far more complex. For example, DeLamater and Moorman (2007) proposed that declines in sexual activity over the life span can be better understood by applying the broad biopsychosocial model that has been used effectively to understand declining health over the life span. They studied sexuality in late life using secondary data from nearly 1,400 individuals aged 45+ years (mean age approximately 60 years). As hypothesized, DeLamater and Moorman found that age was negatively associated with frequency of partnered and unpartnered sexual behavior but that this relationship was significantly attenuated when biological and psychosocial factors were controlled. Thus, age may serve as a proxy for poorer health and declines in psychosocial resources as underlying factors responsible for the decrease observed in sexual behavior as people age.

**Gender and Sexuality**

In studies that compared the sexual activity of older women and men, significantly more men than women reported engaging in sexual activity (DeLamater & Moorman, 2007; Lindau et al., 2007). For example, DeLamater and Moorman found that 71% of men aged 60 to 69 years and 64% of men aged 70 to 79 years reported sexual activity at least once in the preceding month; for women, the corresponding percentages were considerably lower at 47% and 26%, respectively. It is important to note that these studies typically defined sexual behavior broadly to include behaviors ranging from masturbation to coital sexual intercourse. The higher levels of sexual activity reported in studies of more recent cohorts of middle-aged and older men also may be partially explained by the male sexual performance-enhancing drugs that have become available to this age group and the availability of more options for them to partner with younger women than available for
older women to partner with young men. These studies, however, did not qualify their results based on these factors. Moreover, individuals vary in their levels of sexual responsiveness over the life span and studies show that gender-based differences exist in sexual response (e.g., see Bancroft, Graham, Janssen, & Sanders, 2009). With age, sexual excitation decreases for both women and men while sexual inhibition is largely unrelated to age among women but can increase among men and may be related to the occurrence of erectile problems. These studies have generally found that women score lower on sexual excitation and higher on sexual inhibition than men.

Women's sexuality during the middle adulthood years, when menopause and its accompanying hormonal changes typically occur, has received considerable research attention. Based on their review of studies on menopause and sexuality that used population-based samples, Dennerstein, Alexander, and Kotz (2003) concluded that the postmenopausal phase is characterized by declines in sexual arousal and interest and that the proportion of women experiencing sexual dysfunction during this phase increases. Mansfield, Koch, and Voda (1998) found that 40% of their sample experienced a change; these changes were more often in terms of a decline in some aspect of sexual responsiveness (that is, decline in desire, arousal, ease of orgasm, enjoyment, and frequency), although a proportion of this group reported an increase in these aspects of sexual responsiveness. Several investigators have examined the links between both age and postmenopausal status and found that postmenopausal status remains significantly linked with declines in sexual function and sexual interest (e.g., see Dennerstein et al., 2003). Other researchers, however, have found that the changes in sexual activity and interest that are seen in middle-aged postmenopausal women may be influenced by other changes such as those related to sexual intimacy in the relationship (Birnbaum, Cohen, & Wertheimer, 2007) and women's desire for change in their own and their partner's sexual qualities (Mansfield et al., 1998).

Early menopausal status (relative to postmenopausal) appears to be less influential in women's sexual interest and activity. Using data from a large national survey of premenopausal and early perimenopausal women, Cain et al. (2003) found that 79% of middle-aged women (who were neither hysterectomized nor using hormone replacement therapy) reported high levels of sexual engagement with a partner during the preceding six-month period. In addition, they found that early menopausal status was not associated with either the importance of or engagement in sex for women. Instead, the most common reason the women provided for not engaging in sex during the preceding six months was the unavailability of a partner (cited by 67%). Lack of interest and the women or their partners being too tired or too busy for sex also were mentioned but less frequently. The most common reasons offered by the women for engaging in sex were the expression of love or the
experience of pleasure and enjoyment (cited by 90% of women who had engaged in sex) and because their partner wanted them to engage in sex (cited by 75%).

MARRIAGE AND LIFE TRANSITIONS

Life transitions can play a powerful role in defining the nature and quality of marriage in midlife and late life (Van Laningham et al., 2001). Some common life transitions include children leaving the home (i.e., the emptying of the nest), retirement, and taking on the caregiver role for an ill parent, parent-in-law, or spouse. Contrary to popular belief regarding the negative marital impact of the empty-nest syndrome, early and more recent studies have shown that the empty nest is associated with significant increases in marital happiness. Gorchoff, John, and Helson (2008), using data from an 18-year study of middle-aged women (spanning the ages of 43 to 61 years), found that marital satisfaction increased in middle adulthood and that this increase was associated with the empty-nest transition. This trend was further explained by an increase in the women’s enjoyment of time with their partners (but not an increase in the quantity of time spent with the partner).

Mackey and O’Brien (1999) conducted retrospective semistructured interviews with a small sample of Caucasian, African American, and Mexican American older couples regarding marital adjustment at different life stages including the empty-nest years. They found that couples in all three groups reported less marital conflict and the use of more face-to-face discussions to resolve marital conflict during the empty-nest years relative to the early marriage years and the child-rearing years. The quality of sexual relations declined during the empty-nest years for all three groups of elders, but more than 75% of the sample indicated that sexual relations were important to marital quality. Psychological intimacy, however, remained high during the empty-nest years, with 77% of the husbands and 70% of the wives describing their relationships as psychologically intimate. Marital satisfaction also was high, with 87% and 85% for husbands and wives, respectively. No differences were recorded on psychological intimacy or marital satisfaction across the three ethnic groups.

Rather than the departure of children from the home compromising parental satisfaction with the marriage during the empty-nest years, Mitchell and Gee (1996) found that the return of adult children to their parents’ home can compromise their parents’ marital satisfaction. They examined the impact on parents’ marital satisfaction of boomerang kids (adult children who had returned home for at least six months). Mitchell and Gee found that having a boomerang kid return home three or more times and having
an adult child who returned home after leaving to pursue work or school (as opposed to leaving home to experience independence) significantly increased the odds of low parental marital satisfaction. Qualitative responses indicated that boomerang effects may be due to the loss of intimacy and privacy for the parental couple on the child’s return, an increase in incurred expenses in providing a home and care for the adult child, and the loss of freedom to pursue their own interests that the parental couple may have enjoyed after launching the children.

Despite support for an increase in marital satisfaction during the empty-nest years, the empty-nest transition can in some cases play a role in marital disruption. Using longitudinal data from a sample of middle-aged women who were in their first marriages at baseline, Hiedemann, Suhomlinova, and O’Rand (1998) found that the empty nest is associated with an increased risk of marital disruption and that this risk is qualified by the duration of the marriage. The transition to the empty nest dramatically increased the odds of divorce or separation for respondents who reached the empty-nest experience relatively early in their marriages but decreased the odds of marital disruption for those who arrived at this life stage relatively late in their marriages. Heidemann et al. also found that women who were employed during the empty-nest transition were at greater risk for marital disruption presumably because employed women were favored with economic independence that permitted them to end poor marriages after the children had been launched. Other reasons for midlife divorce after long-term marriages that were mentioned in a large-scale survey commissioned by the American Association of Retired Persons (AARP; 2004) include some form of abuse (verbal, emotional, or physical), differences between spouses in terms of values or lifestyles, and infidelity. The AARP survey also found that midlife divorce is often initiated by women, with more men being caught by surprise by their divorce.

The transition to retirement from one’s primary employment also can bring the marital relationship into central focus (Trudel, Turgeon, & Piche, 2000). Decisions to transition into retirement among older married couples are typically influenced by both spouses (Pienta & Hayward, 2002; Smith & Moen, 1998), and studies show a link between retirement and marital quality at the couple level. For example, Moen, Kim, and Hofmeister (2001) longitudinally studied the link between marital quality and various phases of retirement using a random sample of individuals residing in upstate New York. They found that for older adults who retired between the two study waves marital quality was lower and marital conflict higher relative to those who remained employed over the course of the study or who were already retired at baseline. These findings were characteristic of both women and men in the sample. Interestingly, Moen et al. also found that the level of marital conflict was contingent on the retirement status of both members of the couple.
Marital conflict was greater for women and men who transitioned into retirement but whose spouse remained employed versus for those who transitioned into retirement and whose spouse was not employed. In addition, older women who had not yet retired reported greater marital conflict if their husbands were no longer employed.

Research conducted by Szinovacz and her team (Szinovacz, 1996; Szinovacz & Schaffer, 2000) shows that the retirement status of both husbands and wives influences marital satisfaction and marital conflict. Using data from married couples participating in a national probability-based sample, Szinovacz (1996) found that when couples were characterized by traditional gender roles, marital quality was lower if the husband was retired but the wife worked. Marital quality also was lower in cases where both spouses were retired and the wife had recently entered retirement compared to those where both spouses were still employed. Using the same national sample of older couples, Szinovacz and Schaffer (2000) found that husbands reported a decline in heated arguments upon their wives’ retirement but wives did not; moreover, if either spouse reported strong attachment to the marriage, husbands reported greater engagement in calm discussions upon their own retirement. Although research on retirement in same-sex couples is scarce, a recent study on a small convenience sample indicates that relationship satisfaction is typically high among retirees in same-sex relationships and that those who reported engagement in financial planning and life planning were likely to report higher relationship satisfaction (Mock, Taylor, & Savin-Williams, 2006).

Transitioning into the role of caregiver to a family member or friend is a widely prevalent experience during the middle or late adulthood years (e.g., Bookwala, 2009; Marks, Lambert, & Choi, 2002). According to recent national estimates, 19% of all adults occupy the role of informal caregiver to an individual aged 50+ years (National Alliance for Caregiving, 2009). Although little research has examined caregiving issues in couple relationships other than marriage in the midlife and later years, preliminary evidence suggests that care expectations and experiences are common in other types of partnered relationships as well. Ghaanfareeoon Karlsson et al. (2007) examined care-related attitudes and experiences in a sample of older Swedish adults engaged in LAT relationships. They found that both women and men rated their LAT partner as providing more support than any other network member and expected more care from their partner than from other relatives. Men in LAT relationships reported more willingness to provide future care to their LAT partner relative to women in such relationships, and they were less likely to consider ending the LAT relationship in the event that their partner became seriously ill.

Studies show that occupation of the informal caregiver role is related to lower marital quality among adult-child caregivers and spouse caregivers
alike. For example, Bookwala (2009) conducted a prospective study using data from a national probability sample to examine differences in marital quality as a function of transitions into and out of the parent care role. She found that sustained occupation of the parent care role is related to poorer marital quality. Adult sons and daughters who transitioned into the parent care role and occupied this role across two subsequent waves of data collection over a 15-year period reported less marital happiness and more marital role inequity than those who were more recent occupants of the parent care role (i.e., the transition occurred later in the study period).

A study with a community-based sample of individuals providing care to a spouse or coresiding partner also examined the relationship between caregiving and relationship quality (Svetlik, Dooley, Weiner, Williamson, & Walters, 2005). Svetlik et al. found that greater care provision emerged as the only significant predictor of decline in caregivers' satisfaction with physical intimacy in the relationship, which, in turn, was related to a greater sense of relationship loss experienced by the caregiving spouse or partner. When examining discrepancies between spouses' evaluations of marital quality in a sample of elderly couples, Carr and Boerner (2009) found that spouse caregivers provided more negative appraisals of their marriage than did their partners. Spouse caregivers were only half as likely as noncaregivers to rate their marriage more positively than did their spouse.

**MARRIAGE, MARITAL QUALITY, AND HEALTH**

**Marital Status and Health**

Numerous studies point to the health protective role of married status in middle and late adulthood. Pienta, Hayward, and Jenkins (2000) found that being married during the retirement years has a wide array of health benefits including lower prevalence of fatal and nonfatal chronic diseases, higher functional levels, and lower disability. In a large study of long-term illness rates in Great Britain, Murphy, Glaser, and Grundy (1997) found that until about the age of 70 years, long-term illness rates are lowest among individuals in first marriages compared with all other marital status categories (widowed, remarried, divorced, and never married). Likewise, Prigerson, Maciejewski, and Rosenheck (2000) found that married individuals aged 50 years and older reported fewer chronic illnesses, better functional health, fewer nursing home days, and fewer physician visits than widowed individuals in the same age group.

Zhang and Hayward (2006) used longitudinal data from a national probability-based sample to show that the prevalence of cardiovascular disease is higher among middle-aged and older women and men who have experienced some form of marital loss (in the form of widowhood or divorce).
relative to continuously married individuals. Gender differences in the incidence of cardiovascular disease, however, were observed by Zhang and Hayward. They found that women who experienced marital loss were at higher risk of developing cardiovascular disease over the course of the eight-year study whereas the onset of cardiovascular disease in male participants during this same period was largely unrelated to marital loss. Cohabiting elders do not necessarily enjoy the same health privileges as their married counterparts. Brown and colleagues (2006) compared cohabiting elders with other marital status groups on functional disability and alcohol use using national-level data. They found that although cohabiters did not vary from married or remarried individuals on functional disability, they reported greater alcohol use than both married groups.

**Remarriage and Health**

Even remarriage may not offer the same health protections as stable marriages; studies have shown that marital disruptions in the form of divorce and widowhood are linked to greater morbidity. Zhang and Hayward (2006) found that the prevalence of cardiovascular disease was higher among remarried women and men relative to their continuously married peers. Using data from a national longitudinal study of middle-aged adults, Hughes and Waite (2009) found that marital disruptions in the form of divorce and widowhood had adverse health consequences in the form of more chronic conditions, greater mobility limitations, poorer self-rated health, and more depressive symptoms. Furthermore, even among individuals who had remarried after marital disruption, health was worse than among those who were continuously married. The negative impact of early marital disruptions also was greater for slower-to-develop and more chronic health conditions.

Gender differences exist, however, in the link between marital transitions and health. In their study with middle-aged and older adults, Zhang and Hayward (2006) found that remarried men had a lower incidence of cardiovascular disease than continuously married men whereas remarried women had a higher incidence of the disease than continuously married women. Although they did not examine explanatory factors for this gender difference, a comparison of remarried men and women in the sample indicated that remarried women had lower incomes, more depressive symptoms and emotional problems, and higher cholesterol than remarried men, which, in turn, may make them more vulnerable to cardiovascular disease.

Dupre and Meadows (2007) found that failure to remarry following divorce or widowhood for both women and men is associated with higher risk of disease (diabetes, cancer, heart attack, or stroke). They further found that the negative effects of divorce transitions are greater for women and those of widowhood are greater for men and that having more (re)married years
attenuated the negative health effects of divorce for women but not of widowhood for men. Although they did not test possible explanations for these gender differences, Dupre and Meadows suggested that women may more effectively adjust to divorce over time, especially because marital dissolution tends to occur earlier in the life course relative to widowhood; widowhood tends to occur at a later age for men, making it more difficult for them to recover from its negative health effects.

**Marriage and Mortality**

The link between married status and survival across the adult life span is similar to that seen with other health indicators. The risk of mortality is lower for married elders relative to their nonmarried counterparts (see Kaplan & Kronick, 2006). Cohabitation with a partner once again does not appear to have the same protective benefits for survival as seen with married persons. Moustgaard and Martikainen (2009) found that cohabiting elders had a somewhat higher mortality risk compared to their married counterparts: 27% of cohabiting men and 15% of cohabiting women had died over a five-year period compared with 22% and 11% of married men and women, respectively. That cohabitation is not as protective for survival as being married may be due to the higher risk of separation and resulting loss of partner support and care that can be associated with cohabitation.

To gain a better understanding of the relative risk of mortality by marital status among older adults, Manzoli, Villari, Pirone, and Boccia (2007) performed a meta-analysis in which they pooled the findings of 53 studies conducted on European or American samples. Pooling comparisons that drew data from more than 250,000 elders, their meta-analysis confirmed that the relative odds for survival was significantly greater for married than widowed, divorced, and never married elders. This risk differential remained significant after controlling for gender and study quality characteristics. As with the link between marital history and health, the occurrence of marital disruptions also is linked to higher risk of mortality. Tucker, Friedman, Wingard, and Schwartz (1996) used longitudinal data from a sample of highly educated and intelligent women and men to examine the relationship between marital history at midlife and mortality. They found that continuously married individuals survived longer than those who had experienced a marital disruption even if the latter had remarried.

Unlike Kaplan and Kronick's (2006) findings that never-married individuals have a higher mortality risk relative to their ever-married peers, Tucker et al. (1996) reported that in their privileged sample, those who had never married were at no higher mortality risk relative to those who were continuously married. Recent research shows that adults who remain single after age 40 are not at higher risk for poor emotional well-being relative to their
married counterparts if they are high in personal mastery and self-sufficiency (Bookwala & Fekete, 2009). Tucker et al.’s privileged sample may comprise a group with such personal resources that, in turn, may partially explain why never-married participants’ survival in their study matched that of the continuously married. Another explanation for the resilience of older never-married individuals may be that they have less stressful life experiences than elders who are single for other reasons such as widowhood, separation or divorce, or institutionalization of the spouse. Some support for this explanation comes from research showing that the strains associated with being single in later life are higher among widowed and divorced individuals than among never-married elders (Pudrovská, Schieman, & Carr, 2006). These findings also may explain why never-married middle-aged and older adults were comparable to their continuously married peers on the prevalence and incidence of cardiovascular disease (Zhang & Hayward, 2006).

**Marital Quality and Health**

Among married elders, the quality of the marital relationship plays a significant role in health and well-being. Numerous empirical studies have documented that marriages of better relationship quality are associated with higher psychological and physical well-being among older adults. For example, Bookwala and Jacobs (2004) found that greater marital happiness and less marital disagreement was associated with lower depressive symptomatology among older adults participating in a national study and that negative aspects of marriage are less salient and positive aspects of marriage are more salient to depressed affect with increasing age maturity. These findings are consistent with socioemotional selectivity theory (Carstensen, Isaacowitz, & Charles, 1999), which predicts that as individuals become older and view their time as becoming more limited, they are more likely to regulate their emotions to maximize the experience of positive emotions. Thus, married older adults are more likely to focus on positive emotional experiences within their spousal relationship relative to their younger counterparts and, in turn, why positive marital processes rather than negative ones are more salient to their well-being. Mancini and Bonanno (2006) found that greater marital closeness in late life was associated with lower levels of depressive symptoms, less anxiety, and greater self-esteem in a national probability sample of married older adults.

In a probability-based sample of older adults in the Netherlands, Hagedoorn et al. (2006) observed a curvilinear relationship between marital inequity and psychological distress such that psychological distress was higher among respondents who reported feeling either underbenefited or overbenefited in their marriage relative to those who perceived their marriages as equitable. Miller, Townsend, and Ishler (2004) found that greater marital dissatisfac-
tion at baseline and increments in marital dissatisfaction over time predicted more negative mood symptoms at follow-up among wives (but not husbands) using data from a probability sample of older couples. A recent literature review on the relationship between characteristics of the marital relationship and health in studies that focused on both members of late-life couples confirmed a link between marital quality and psychological well-being. Walker and Luszcz (2009) found that, in general, psychological well-being in one or both partners in the marriage was higher when the marital relationship was marked by support and closeness, whereas psychological well-being was lower when the marital relationship was marked by dissatisfaction or conflict.

In terms of physical health, Bookwala (2005) found that from among a range of marital quality indicators, negative exchanges with the spouse singly and consistently were related to multiple physical health indicators in a probability-based sample of middle-aged and older adults. More negative spouse exchanges were associated with more physical disability, higher physical symptomatology, more chronic health conditions, and poorer self-rated health. Using panel data obtained from a national sample of older adults, Umberson and colleagues (2006) also found that marital strain was associated with poorer physical health over time and that this association was strengthened with increasing age for both older women and older men. However, Umberson and Williams (2005) found that older women reported greater marital strain in midlife and later relative to older men and that this gender difference only increases with age. They attributed this gender difference to the trend for women typically to marry older men combined with the likelihood for men to experience serious illnesses that could be chronic or terminal earlier than do women.

For these reasons, in late life married women may be more likely to be involved in providing care to an ill spouse than their male counterparts, which, in turn, may contribute to the higher levels of marital strain they experience. Umberson and Williams concluded that this gender difference in marital strain in old age may provide men with a clear advantage over women during the very life stage when marital strain is most strongly related to poor physical health.

Clearly, sufficient evidence exists to document the importance of a good quality marriage to better health and well-being. These findings are further strengthened by studies that have examined the interplay of marital status and marital quality in contributing to well-being. These studies show that poor quality marriages in late life are associated with compromised health and well-being and may be at levels that are lower than those associated with nonmarried elders. For example, Hagedoorn et al. (2006) found that older adults who were in an inequitable marital relationship were more distressed than their counterparts who had always been single. Gallo, Troxel,
Matthews, and Kuller (2003) examined the interplay of marital status and marital quality in cardiovascular health using longitudinal data from middle-aged women who were in the perimenopausal or postmenopausal phase. They found that women in less satisfying marriages showed levels of cardiovascular risk factors over time that were parallel to those found among non-married women; both groups had cardiovascular profiles over time that were less healthy relative to women in more satisfying marriages.

In addition to the direct benefits associated with a good quality marriage, such a marriage can act as a buffer in the face of stress during the middle-aged and subsequent years. These buffering effects are especially clear in the link between functional disability and psychological well-being. Bookwala and Franks (2005) found that older adults who were more functionally disabled and in better quality marriages (i.e., they reported fewer disagreements) had lower levels of depressive symptoms than those with similar levels of functional disability and high levels of marital disagreement. Likewise, Mancini and Bonanno (2006) found that older adults who were more functionally disabled and reported high marital closeness had lower levels of depressive and anxiety symptoms and higher self-esteem than their functionally disabled counterparts who were in marriages marked by low levels of closeness. More recently, Bookwala (2011) found that higher marital satisfaction mitigates the adverse effects of poor vision on depressive symptoms and functional loss in a national sample of older adults.

These findings demonstrate that the negative impact of stressors can be buffered by a good quality marriage. As such, these findings are consistent with the stress-buffering hypothesis of social support delineated in social support theory (see Cohen & Wills, 1985), which posits that the availability of supportive social relationships can serve as an effective buffer against stressors that individuals encounter. In addition, Mancini and Bonanno used socio-emotional selectivity theory (Carstensen et al., 1999) to explain the stress-buffering nature of a good marriage in late life. According to them, functional disability in late life serves as a proxy for the perception that one's time is constrained and, as a result, older adults derive especially significant benefits from the positive emotional characteristics of their marital relationships.

**Couples Coping with Illness**

The health benefits of a good marriage notwithstanding, it is important to note that marital relationships themselves may be vulnerable to the stress associated with health problems that may occur in late life. For example, Roberto, Gold, and Yorgason (2004) examined the impact of pain associated with osteoporosis on the marital relationship among elderly couples. They found that discrepancies within dyads about the pain experienced by
the wife were related to marital adjustment. Specifically, wives who reported experiencing greater pain than they were perceived to experience by their husband reported lower marital adjustment than their counterparts whose husbands perceived the wife to be experiencing greater pain than she herself reported experiencing.

Pruchno, Wilson-Genderson, and Cartwright (2009) found varying patterns of change in marital satisfaction in a community-based sample of older couples where one spouse was diagnosed with end-stage renal disease. Marital satisfaction for the patient remained relatively stable over time but declined significantly for the spouse. Pruchno et al. interpreted the downward linear trend in marital satisfaction for the undiagnosed spouse as a self-preservation strategy of emotional withdrawal employed in the face of a terminally ill spouse who may have limited time to live.

Research also has shown domain-specific concordance between spouses on indicators of well-being. Using data from a probability-based sample of older couples, Bookwala and Schulz (1996) found that more depressive symptoms and poorer self-rated health in one spouse predicted more depressive symptoms and poorer self-rated health, respectively, in the other. Siegel, Bradley, Gallo, and Kasl (2004), who used longitudinal data from a national sample of older couples, also found evidence for spousal concordance in depressive symptomatology. In their study, participants who had a spouse with more depressive symptoms at baseline and whose spouse experienced an increase in depressive symptomatology across time reported more depressive symptoms at follow-up. More recently, Pruchno et al. (2009) found that depressive symptoms of both the person with end-stage renal disease and the spouse increased over time. Both patients and spouses had similar initial levels of depressive symptoms and similar growth patterns over time in these symptoms.

The findings on spousal similarity or concordance of well-being are consistent with Berg and Upchurch's (2007) developmental-contextual model of couples coping with chronic illness. Berg and Upchurch posited that illness experienced by one spouse makes coping and adjustment demands on both the patient and the spouse. As a result, how patient and spouse react to and cope with the illness is of import to their own and each other's adjustment. Further, Berg and Upchurch noted that how couples cope with chronic illness varies as a function of individuals' life stages, the day-to-day demands associated with the illness, and the unfolding stages of the chronic illness. The broader (sociocultural factors, gender) and more proximal (the quality of the couple relationship, the type of illness) contexts within which the couple operates also play a role in shaping the dyad's responses and adjustment to the illness condition. The concordance of emotion between spouses in the context of illness also is consistent with Larson and Almeida's (1999)
model of emotional transmission. According to this model, emotions are transmitted from one spouse to another on a day-to-day basis and these, in turn, can influence the health and well-being of both members of the dyad.

SUPPORT FUNCTIONS IN PARTNERED RELATIONSHIPS

Throughout adulthood, intimate relationships serve as a significant source of support (Antonucci, Lansford, & Akiyama, 2001), especially in times of stress. Cutrona (1996) explained that in the context of marriage and similar relationships, support is conceptualized as responsiveness to a loved one's needs and involves acts that communicate caring and facilitate adaptive coping with stressors. Franks, Wendorf, Gonzalez, and Ketterer (2004), for example, examined the frequency of health-promoting support exchanges in older couples. They found that 100% of wives and husbands reported initiating some form of health-promoting spousal support at least once or twice in the previous month and upward of 93% of wives and a full 100% of husbands reported receiving as much support from their spouse. Hong and colleagues (2005) also examined the support of exercise behavior in older married couples wherein one member was a cardiac rehabilitation patient. They found that among couples in which both spouses engaged in similar exercise behavior, dyadic exchanges of exercise support were likely to be reported independently, demonstrating that intended exercise support given by one spouse was perceived as such by the other.

When older adults are coping with chronic illness, the types of support offered by the spouse can play a significant role in psychological well-being. Fekete, Stephens, Mickelson, and Druley (2007) studied the role of emotional (positive) and problematic (negative) support from the husband in the psychological well-being of older women experiencing a lupus flare-up. They found that more lupus-related emotional support from the husband was interpreted as greater emotional responsiveness from him, which, in turn, was associated with higher well-being in the wife. In contrast, more problematic support from the husband that was related specifically to the wife's lupus was perceived by the wife as him being less emotionally responsive and this, in turn, was associated with lower well-being in the wife. In a subsequent study with the same sample, Khan, Masumi, Stephens, Fekete, Druley, and Greene (2009) found that patients' self-efficacy rather than perceived emotional responsiveness mediated the link between spousal support and patients' psychological and physical well-being. These studies demonstrate that support by the spouse plays an integral role in coping with illness in the later years but that the specific mechanisms through which support may shape patient adjustment to illness require further clarification.

Social control theory has been used to explain the mechanisms and strategies through which spouses can play a positive or negative role in managing
their partners’ health-related behaviors during times of illness. Social control refers to tactics used by an individual to effect change in another person’s behavior. Typically, such tactics are intended to promote health-protective and health-maintenance behaviors but can do so with the accompanying costs of frustrating the recipient of social control especially when more coercive strategies are employed (Lewis & Rook, 1999; Tucker, Orlando, Elliott, & Klein, 2006).

Within marriage and similar partnered relationships, the spouse often serves as a powerful source of control, notably so later in life when health-related problems become more common. Stephens, Fekete, Franks, Rook, Druley, and Greene (2009) examined the role of the spouse as an agent of control in promoting medical adherence pursuant to orthopedic knee surgery among older adults diagnosed with osteoarthritis. Comparing two forms of social control strategies, they found that both persuasive and pressure strategies were associated with greater medical adherence even though they were differentially associated with positive and negative emotional reactions in the patient with osteoarthritis. Positive emotional responses in the patient were associated with the use of persuasion strategies by the spouse whereas negative emotional responses in the patient were associated with the use of pressure tactics by the spouse. Moreover, Stephens et al. found that the association between the spouse’s involvement early in the recovery period and health benefits experienced by the patient in the long-term following the surgery was indirectly explained by the experience of positive reactions in the patient to the control strategies used by the spouse. These findings suggest that persuasion strategies (which result in positive emotional reactions in the recovering spouse) may be the most beneficial form of social control in the context of couples coping with illness.

In addition to being a resource during times of illness, particularly during the middle and late adulthood years when illness becomes more normative (Siegler, Bosworth, & Poon, 2003), spouses also can be supportive as collaborators in the domain of cognitive function, serving to enhance cognitive performance in the later years. Partnered relationships in late life may offer older individuals the opportunity to optimize their cognitive performance and compensate for losses they may experience in the cognitive domain (Meegan & Berg, 2002; Strough & Margrett, 2002). In general, working with a social partner on cognitive tasks in experimental conditions, commonly referred to as collaborative cognition, increases performance outcomes among older adults (Cheng & Strough, 2004; Dixon & Gould, 1998).

These gains can be especially marked when working collaboratively with one’s spouse (Dixon & Gould, 1998). For example, Kimbler and Margrett (2009) conducted a study in which older adults were required to perform both individually and collaboratively on an everyday problem-solving task. They manipulated the familiarity of the collaborative partner across older
adults such that participants worked either with a stranger or their spouse. Performance was superior in the collaborative engagement condition than when the participant worked alone. Moreover, the familiarity of the partner influenced cognitive performance with older adults who worked with their spouse showing better outcomes than those who worked with a stranger.

The benefits of collaboration are not limited to the domain of cognition, however. In a daily diary study, Berg and her colleagues (2008) showed that among older couples dealing with the husband's prostate cancer, perceiving the spouse to be a collaborative partner in day-to-day decision-making was related to more same-day positive mood in both the men dealing with prostate cancer and their wives and less same-day negative mood in the men. In addition, these associations were mediated by greater perceived effectiveness of dealing with the stressor such that both husbands and wives reported more coping effectiveness on days in which they perceived their spouses to be more collaborative partners in coping efforts. Results from both studies are generally consistent with social support theory (Cohen & Wills, 1985) that explains the direct benefit of interpersonal support on well being. In addition, these findings are consistent with the developmental-contextual model of couples coping with illness (Berg & Upchurch, 2007) that views individual members of couples as interdependent in their appraisal of stressors and the way they cope with these stressors.

CONCLUSIONS AND IMPLICATIONS

The literature reviewed in this chapter indicates that partnered relationships are diverse in nature, and while research on marriage remains the most widely prevalent, other types of intimate relationships, such as same-sex relationships, LAT relationships, and cohabiting relationships, also are emerging as important foci of research. In general, partnered relationships in late life are marked by higher levels of companionate love and longitudinal research shows that relationship satisfaction at least within marriage may decline over the life span. It also is common for partnered relationships to be marked by role inequities, disagreement, and conflict but such negative relationship processes typically are less salient to well-being as individuals age. Sexual intimacy remains significant to relationship satisfaction in middle and late adulthood although sexual interest and activity decline during this period. Relationship satisfaction in the later years also is responsive to the experience of life transitions, such as transitions into the empty-nest years, retirement, and the caregiving role.

A major theoretical and empirical focus has been on the effects of marital or partnered relationship status and quality on health. Research continues to document the health-protective role of married status in the middle and later years and the importance of a good quality relationship in enhancing health and well-being and protecting partners from the adverse consequences
of health-related stressors. It also is clear that couples cope collectively with such stressors and partners offer support in health-protective behaviors and serve as valuable allies in enhancing cognitive function as individuals age.

The findings reviewed in this chapter have important clinical implications for gerontological practitioners. Sexual concerns of middle-aged and older individuals are important elements of partnered relationships and it is important to assess the extent to which declines in sexual interest or activity are caused by health or psychosocial factors that may be amenable to clinical intervention. Likewise, clinicians working with middle-aged women should consider seeking broader explanations than menopausal status alone for changes in their clients’ sexuality. Such alternatives may better enable them to assist with women’s sexuality concerns during the later years.

The quality of marital and similar relationships clearly plays a role in health and well-being and thus, a comprehensive assessment of the latter should include obtaining information about the quality of older adults’ partnered relationships. By doing so, practitioners will be better able to determine the extent to which difficulties in such relationships underlie their clients’ psychological and physical well-being. To the extent that these relationship difficulties are amenable to modification, effective intervention efforts may result in a substantial gain in health and well-being for elderly clients. Moreover, given that better relationship quality buffers the health impact of age-related stressors, couple-focused workshops via the use of role-playing and a focus on improving communication strategies could augment the resources available in midlife and late life for effectively dealing with stressors. When a client has an ill partner or spouse, gerontological practitioners also must assess the impact of the illness on both members of the dyad and offer strategies that can enhance the couple’s efficacy in coping with the illness.

Finally, it is important that clinicians address the importance of stressful life transitions in the lives of their clients. These transitions often can have an impact on the quality of the partnered relationship of the individual, which, in turn, can negatively affect the spouse’s well-being. Creating an awareness in older adults of the impact of life transitions on their relationship and offering strategies to maintain relationship quality may be valuable in maintaining health and well-being in the midlife and late life years.

Despite the considerable gains in current knowledge about marriage and similar partnerships in middle and late adulthood, significant gaps exist in the literature. First, research must expand its focus to incorporate the diversity of intimate relationships that exist in this life stage, directing attention to the processes, correlates, and consequences of nonmarital cohabiting and noncohabiting intimate relationships among heterosexual and same-sex couples. For example, studies on the impact of life transitions such as retirement and caregiving have focused almost exclusively on married individuals; the study of these same variables within the context of same-sex, cohabiting, and LAT couples is an important need in the field. Second,
cross-sectional studies remain the norm in much of relationship research; more longitudinal studies are required that examine the nature, causes, and consequences of relationship quality change during the later years in marriage and other partnered relationships. Third, more studies are necessary that use the couple as the unit of analysis. Using data gathered from both members of the dyad will provide a more comprehensive understanding about the nature of partnered relationships at the couple level, the process by which relevant factors influence relationship quality for both members, and the interplay of health and relationship quality for each of them. Fourth, further clarity is necessary on the links between menopause and sexuality for older women. Existing studies have typically included women in their 50s or early 60s and are quite diverse in terms of the phases of menopausal transition they examine, the outcomes they assess (e.g., sexual interest, desire, responsiveness, or activity), and the sampling strategy they use (ranging from convenience sampling to the use of probability-based samples). These factors underscore the need for both more methodologically consistent studies on the effects of age versus menopause on women’s sexuality and studies that use prospective longitudinal designs spanning several years. Research also is needed on the extent to which menopausal status may serve as a proxy for other health-related and psychosocial changes that also occur during menopause in explaining changes in women’s sexuality. Finally, a focus on diversity in terms of cultural and ethnic differences in the nature and structure of intimate relationships also is largely missing in the field.

Studies are needed on couple relationships in the later years that specifically focus on cultural and ethnic similarities and differences in relationship quality, including causes and consequences of differences. Future studies must be grounded in existing life course and life span theoretical frameworks related to social support, control strategies, socioemotional selectivity, collaborative coping and cognition, and developmental-contextual models of relationships and health and use their findings to further inform and refine these models. Such a generation of new studies will result in significant advancement of relationship research over the life span, building knowledge about establishing and maintaining these intimate partnerships and enhancing their effects on well-being in the middle and late adulthood years.

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