The Effects of Health and Marital Support on Subjective Well-being in Midlife and Old Age

by

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Abstract

Subjective well-being (SWB) is an indicator of life quality. I examined age cohort differences in SWB and the relative effects of health and marital support. Data came from the Health and Retirement Study, a representative study of the US population over age 50 (n = 4228). I hypothesized that; 1) marital support is associated with higher levels of SWB; 2) functional limitations with lower levels of SWB; and 3) marital support moderates the negative impact of functional limitations on SWB. There were significant age differences in SWB even when controlling for covariates. My hypotheses about the effects of marital support and functional limitations were partially supported. High levels of marital support reduced increases in negative affect associated with more functional limitations. This study suggests the importance of investigating different components of SWB (life satisfaction, positive affect, negative affect) to obtain a complete picture of life quality in later life.

The Effects of Health and Marital Support on Subjective Well-being in Midlife and Old Age

Subjective well-being has become an issue of interest for many researchers as an individual, community and national indicator of life quality. Subjective well-being is made up of three main components, positive affect, negative affect, and life satisfaction, in addition to other smaller domain satisfactions, such as work, family, and finances (Diener, Suh, Lucas, & Smith, 1999). Subjective well-being is an important issue to look at because it is highly correlated with many positive life outcomes (Lyubomirsky, King, & Diener, 2005). People with higher levels of subjective well-being report less physical and mental illness. Because it is a self-reported measure it allows researchers to ascertain how well individuals perceive their lives to be going. This perception of well-being need not be closely associated with more objective measures such as income and health (George, 2010).

Age and Subjective Well-being

Subjective well-being increases with age peaking after retirement in the 70s decade (Diener et al., 1999). Middle-aged people tend to have low levels of life satisfaction (Brockman, 2010; Stone, Schwartz, Broderick, & Deaton, 2010). In longitudinal and cross-sectional studies older age is associated with lower levels of negative affect (Charles & Carstensen, 2010). Older age is also associated with stable levels of positive affect or slight decreases in very old age. (Charles & Carstensen, 2010). One explanation for these age differences is proposed by discrepancy theorists (George, 2010). Discrepancy theory states that life satisfaction is maximized when the discrepancy between one's goals and achievements is minimized. This discrepancy is much lower in older adults; however it is unknown if the lower levels of discrepancy are due to having achieved more or more realistic expectations among older adults.

Another explanation of the processes underlying the general increase in subjective well-being among older adults is that social comparison plays a role (George, 2010). According to this approach, we make judgments about our lives by comparing our status with others around us. Because the social stereotype of older adults is that they are likely to have poor health and become widowed, an older adult in relatively good health with a living spouse may judge themselves to have higher levels of subjective well-being when thinking about this social image and the lives of some of their less-healthy peers.

The oldest old are reported to be at risk for decreased subjective well-being most likely due to increasing functional limitations and losing many important members of their personal networks (Mroczek, 2001). However, researchers suggest that the existing, closest members of their personal networks become even more important in very old age and compensate for the negative effects of declining health (Levenson, Carstensen, & Gottman, 1993).

Predictors of Subjective Well-being

Decades of psychological research has shown that many factors contribute to an individual's subjective well-being and that it is important to tease apart what exactly leads to life satisfaction at different ages and in different subgroups in the population (Diener et al., 1999). Some of the key factors for well-being in mid-life and old age are health, financial stability, and love (George, 2010) each of which will be examined in turn below.

Health and subjective well-being. Health plays a large role in determining life satisfaction. There are multiple ways to measure health; however, most objective measures of health, such as a physician's observations and diagnoses, are not as strongly correlated with well-being as more subjective measures, such as a self-report of overall health status (Diener et al., 1999).

This may be because objective measures of health are standardized and do not take the individual or the age of the individual into consideration. Some individuals are more impacted at different ages by certain conditions than others, and different illnesses cause different amounts of discomfort (e.g. pain) and disruption to daily life. Further more, a 95-year-old woman who develops a chronic illness may still feel that she is in good health because she sees herself as in good health relative to others her age. But if a 50-year-old woman developed the same illness she may feel that her health is very poor because most of her peers have few illnesses or physical limitations.

The number of older adults with functional limitations is increasing, and they are living longer (Greenfield & Marks, 2007). There are many physiological functions that deteriorate with age. On average as people age they cannot metabolize carbohydrates as well as younger people, they have less bone density, their level of cognitive functionality decreases, and it becomes more difficult for them to perform daily tasks (Rowe & Kahn, 1987). This is what Rowe and Kahn (1987) refer to as usual aging. In contrast, they defined successful aging as being characterized by a below average level of physiological deterioration and above average levels of autonomy and functionality. A person who is aging successfully will be at a low risk for disease, will have a high level of mobility and cognitive function, and will be engaged with life. Also, older adults who have fewer functional limitations and feel more in control of their lives score higher on measures of life satisfaction (Rowe & Kahn, 1987).

Mollaoğlu, Tuncay, and Fertelli (2010) found that self-reported health was a significant predictor of life satisfaction among older adults. Decline in life satisfaction in old age is also attributable to self-reported health (Gwozdz & Sousa-Poza, 2010). Self-reported health is important to look at because the way people perceive their health is more important in

determining their subjective well-being than their actual health. It also allows researchers to account for individual differences in the impact of chronic illnesses and functional limitations.

Socioeconomic factors and subjective well-being. Because education and income are highly correlated (Diener et al., 1999) this study only looks at education as a predictor of subjective well-being. Education is usually a significant predictor of well-being but it only accounts for a small portion of the variation in subjective well-being. Socioeconomic factors do not generally have a large impact on subjective well-being, provided that basic needs are met (Diener et al., 1999).

Social relationships and subjective well-being. Social relationships and social participation can have a positive effect on subjective well-being. For example, Greenfield and Marks (2007) found that men in middle and old age who are active, willing participants in some form of a group with a strong social component are less likely to have increased levels of depression after developing functional limitations; however, this finding does not hold true for women. High levels of social support are also correlated with a lower risk of mortality (Rowe & Kahn, 1987).

One of the most important parts of a personal network for middle-aged and older adults is the spouse (Antonucci, 2001). Because marriage is such a prevalent phenomenon it is important to examine how this affects well-being. Married couples tend have higher levels of objective measures of well-being such as physical and mental health (Hawkins & Booth, 2005). Marriage is also associated with lower levels of depression (Ross, 1995). According to Lucas (2007), marriage does cause a slight rise in subjective well-being initially, but over time subjective well-being eventually returns to the baseline level for the individual. What is interesting about this study is that people who eventually divorce have a lower baseline on average and recover almost

to their previous baseline but not entirely. Widowhood has a similar baseline to marriage, but most people do not regain their baseline level of subjective well-being after losing a spouse.

Being married per se is not the best indicator of well-being; however, initial levels of marital satisfaction seem to play a key role in how satisfied a couple will be throughout their marriage. For most couples, marital satisfaction dips after the first year of marriage and continues to decrease until after the couple's children have moved out of the house. However, this pattern was much less noticeable for couples who initially reported the highest level of marital satisfaction, and it was much more noticeable for couples who initially reported the lowest level of marital satisfaction (Dush, Kamp, & Taylor, 2008).

Marriage provides different benefits to men and women. Women only benefit from satisfying marriages and are more likely to report physical and mental health problems when they are dissatisfied with their marriages than when they are satisfied (Antonnuci, 1994). Men benefit from marriage regardless of the quality (Levenson et al., 1993). However, remaining in an unhappy marriage has been associated in midlife with low levels of life satisfaction, overall happiness, self-esteem, and health (Hawkins & Booth, 2005). People without partners show lower levels of depression than those who are very unhappy with their relationships (Ross, 1995). It is also important to note that divorce results in more economic hardship for women, but lower levels of social support for men (Ross, 1995).

The present study uses data from the Health and Retirement Study (HRS), a representative US sample of adults over fifty years of age. The majority of the sample (65%) is married, reflecting data from the US census. I examine the effects of different levels of marital support and health on three components of subjective well-being, life satisfaction, positive affect, and negative affect. I selected HRS participants who are married and who completed the HRS

Psychosocial Questionnaire in 2008. I expected to find age cohort differences among the components of subjective well-being, the predictors of subjective well-being, and the covariates. I also expected to find that marital support (e.g., feeling supported by one's spouse) contributes to higher subjective well-being, but higher levels of functional limitations are related to lower subjective well-being. In addition, I hypothesized that martial support moderates the negative effect of functional limitations on subjective well-being.

Method

Participants

The participants were selected from the 2008 HRS data set using a filter that determined if they had completed the psychosocial leave-behind self-administered questionnaire that contained most of the variables of interest to the present study. The sample was subsequently restricted to only those participants who were married. The sample, $n = 4228$, consisted of 49.3% males and 50.7% females. The age of the participants ranged from 50 to 95 ($M = 67.92$, $SD = 8.95$). Of the participants, 82.2% were White-Caucasian and 14.4% were Black or African American. Most of the participants had at least completed high school ($M = 12.92$, $SD = 4.05$).

Measures

Life satisfaction. Life satisfaction was measured using the Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985). This scale is widely used and a well established, reliable measure of life satisfaction ($\alpha = .88$). The participants are asked to rate five different statements (*In most ways my life is close to ideal; The conditions of my life are excellent; I am satisfied with my life; So far I have gotten the important things I want in life; If I could live my life again, I would change almost nothing.*) using a seven point scale (*1 = Strongly disagree, 2 = Somewhat disagree, 3 = Slightly disagree, 4 = Neither agree nor disagree, 5 =*

Slightly agree, 6 = Somewhat agree, 7 = Strongly agree). I recoded so that higher scores indicate satisfaction. The HRS study included this scale in a take home self-administered questionnaire.

Negative affect. Negative affect was measured using the Positive and Negative Affect Schedule – Expanded Form (PANAS-X) (Watson & Clark, 1994). This is a highly reliable measure of negative affect ($\alpha = .89$). The participants were asked to what degree they endorsed each of twelve different items (*During the last 30 days, to what degree did you feel…? , afraid, upset, guilty, scared, frustrated, bored, hostile, jittery, ashamed, nervous, sad, distressed*) using a five point scale (*1 = Very much, 2 = Quite a bit, 3 = Moderately, 4 = A little, 5 = Not at all*). I recoded so that higher scores indicate higher negative affect.

Positive affect. Positive affect was also measured using the Positive and Negative Affect Schedule – Expanded Form (PANAS-X) (Watson & Clark, 1994). This is a highly reliable measure of positve affect ($\alpha = .92$). The participants were asked to what degree they endorsed each of thirteen different items (*During the last 30 days, to what degree did you feel…? , determined, enthusiastic, active, proud, interested, happy, attentive, content, inspired, hopeful, alert, calm, excited*) using a five point scale (*1 = Very much, 2 = Quite a bit, 3 = Moderately, 4 = A little, 5 = Not at all*). I recoded so that higher score indicate higher positive effect.

Subjective health. Subjective health was measured using self-reported health status. Participants were asked to rate their health on a five point scale: *Would you say your health is excellent (5), very good (4), good (3), fair (2), or poor (1)?*

Functional limitations. Functional limitations was measured by taking the sum of 23 questions measuring activities of daily living (ADLs), instrumental activities of daily living (IADLs), and questions measuring mobility, strength, and motor skills. These items and measures are adapted for HRS (Fonda & Herzog, 2004) and derived from widely used measures

(Nagi, 1969, 1976; Rosow & Breslau, 1966). ADLs are basic activities necessary for caring for oneself such as walking, bathing, and eating. IADLs are activities necessary for a person to live alone such as preparing a hot meal, managing money, and shopping for groceries. Questions measuring mobility strength and motor skills include questions about a person's ability to do things such as walk several blocks, get up from a chair after sitting for long periods of time, lift weights over ten pounds, and climbing stairs without resting.

Marital support. I used three sets of items to create this score. First, there was a measure of marital closeness (*How close is your relationship with your spouse or partner?*) using a four point scale (*1 = Very close, 2 = Quite close, 3 = Not very close, 4 = Not at all close*) that was reverse scored. There were also three positive (*How much do they really understand the way you feel about things? , How much can you rely on them if you have a serious problem? , How much can you open up to them if you need to talk about your worries?*) and four negative (*How often do they make too many demands on you? , How much do they criticize you? , How much do they let you down when you are counting on them? , How much do they get on your nerves?*) measures of social support from one's spouse ($\alpha = .83$). Participants responded to the support items on a four-point scale (*A lot, Some, A little, Not at all)* which was recoded. Marital closeness and social support from a spouse were highly correlated ($\alpha = .76$) and were combined to make an eight item scale that will be referred to as the marital support scale. The eight items in the marital support scale, showed a high reliability ($\alpha = .85$).

Covariates. Sociodemographic factors including age, gender (0 = men; 1 = women), years of education, and race (0 = White; 1 = Black) were included in the analysis as covariates.

Analysis

The data were analyzed using three multiple regression models, one for each of the three components of subjective well-being (life-satisfaction, positive affect, and negative affect). The covariates entered into the three models are identical except for the outcome variable. The first step in each model included the sociodemographic covariates (gender, age, race, and education). The second step included the health covariates, subjective health and sum of limitations. The third step added marital support. A final step included an interaction term for marital support and sum of limitations. This term was created by centering sum of limitations around its mean and multiplying it by a dummy variable for marital support. The dummy variable for marital support was created by setting all observations below the mean equal to zero and all observations above the mean equal to one.

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Results

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The results are presented in two parts. I first report descriptive information and age cohort differences for the sample on the three components of subjective well-being and covariates and follow this with a report of the finding from the multiple linear regression models.

Descriptive Analyses and Age Cohort Effects

Table 1 provides descriptive age cohort data for the three components of subjective well-being, the central study variables: marital support, subjective health, number of functional limitations, and participant characteristics.

Figure 1 is a plot of the means of life satisfaction, positive affect, negative affect, and marital support by decade. Life satisfaction and positive affect appear to have a slightly inverted U shape, negative affect appears to have a U shape, and marital support continues to increase with age, although not all these group trends were significant.

The mean composite score for the Diener et al. (1985) SWLS was 5.14 ($SD = 1.46$). There were significant differences among the age cohorts (F (3, 4114) = 8.71; $p < .001$). Post-hoc comparisons revealed that those people in their 50's scored lower on this scale than those in their 60's and 70's. There were no other significant between-group differences.

Positive affect had a mean score of 3.52 ($SD = 0.70$), and negative affect had a mean score of 1.72 ($SD = 0.60$). Positive affect showed significant age cohort differences (F (3, 4068) = 21.77; $p < .001$), and post hoc comparisons showed that those people in their 80's were significantly lower on this measure than the other age cohorts. There were no other significant between group differences for positive affect. Negative affect also showed significant age cohort differences (F (3, 4072) = 11.90; $p < .001$). Post hoc comparisons showed that those people in their 50's were significantly higher on this measure than any other age cohort. There were no other significant between group differences for negative affect.

The mean composite score for the marital support scale was 3.23 ($SD = .59$). This supported the findings by Dush et al. (2008) that the majority of people report being satisfied with their marriage. Marital Support also showed significant age cohort differences (F (3, 4056) = 6.64; $p < .001$). Post hoc comparisons revealed that people in their 50's were significantly lower on this measure than those in their 70's and 80's. The participants in their 60's were also significantly lower on this measure than those in their 70's and 80's. There were no significant differences between people in their 50's and 60's or between those in their 70's and 80's.

The sum score of functional limitation ranged from 0.00 to 23.00 with a mean score of 3.20. There were significant age cohort differences (F (3, 4118) = 41.00; $p < .001$), and post-hoc comparisons showed that each decade was significantly different from every other decade.

Regression Analyses

Table 2 includes the zero-order correlations between all variables entered into the three regressions, one for each component of subjective well-being. The correlations are all moderately significant as expected, and are not very highly correlated with the components of subjective well-being.

Table 3 contains results from the hierarchical ordinary least squares regression analyses that assess the relationship among life satisfaction, the covariates (age, gender, race, education), health related measures (subjective health and sum of limitations), marital support, and the interaction term (marital support x sum of limitations). I examined four models. First I regressed the covariates gender, age, race, and education on life satisfaction. Model 2 added the effects for subjective health and sum of functional limitations, and model 3 evaluated the effect of marital support. The final model included an interaction term for marital support and sum of functional limitations.

The findings from the first step in this regression analysis (Model 1) indicated that people with a higher level of education show higher levels of life satisfaction. Gender, age, and race were not uniquely significant in this model. This model only explained 1% of the variance in life satisfaction.

The second step (Model 2) explained an additional 15% of the variance in life satisfaction with the addition of self-reported health and the sum of functional limitations. Self-reported health, sum of limitations, gender, and age were significant in this model in the presence of the other variables. Older participants showed higher levels of life satisfaction, as did participants with higher levels of self-rated health and male participants. Participants with more functional limitations showed lower levels of life satisfaction.

The third step (Model 3) added marital support. This model explained a total of 28% of the variance in life satisfaction, an addition of 13% above Model 2. Gender, age, subjective health, sum of limitations, and marital support all remained significant in this model. Again, older participants showed higher levels of life satisfaction, as did participants with higher levels of self-rated health. Men and individuals with high marital support scores also showed higher levels of life satisfaction. Participants with more functional limitations showed lower levels of life satisfaction in this model as well.

The fourth and final step (Model 4) included an interaction term for marital support with sum of functional limitations. This model explained a total of 28% of the variance in life satisfaction, less than a one percent increase from the previous model. Gender, age, subjective health, sum of limitations, and marital support were significant in this model. The interaction term was not significant.

Table 4 contains results from the hierarchical ordinary least squares regression analyses that assess the relationship among positive affect, the covariates (age, gender, race, education), health related measures (subjective health and sum of limitations), marital support, and the interaction term (marital support x sum of limitations). This analysis examined the same four models as applied previously for life satisfaction.

Age, and education were significant in the first step (Model 1) in the presence of the other variables. Individuals with more education and younger individuals had higher levels of positive affect. This model explained 5% of the variation in positive affect.

In the second step (Model 2) education, subjective health, and sum of limitations were all significant. This model explained a total of 11% of the variance in positive affect. Participants with more education and higher levels of self rated health showed higher levels of positive affect.

Participants with a greater number of functional limitations showed lower levels of positive affect.

Gender, age, education, subjective health, sum of limitations, and marital support were all significant in the third step (Model 3). Older participants, men, and participants with more education all had higher levels of positive affect. Participants with higher levels of self-rated health and those with higher levels of marital support also had higher levels of positive affect. Again, participants with a greater number of functional limitations showed lower levels of positive affect. This model explained a total of 21% of the variance in positive affect, a 10% increase from the previous model.

The fourth and final step (Model 4) showed the same findings as the third step (Model 3), but added the interaction term for marital support with sum of limitations. This model explained less than an additional .01% of the variance than the previous model did, and the interaction term was not significant.

Table 5 contains results from the hierarchical ordinary least squares regression analyses that assess the relationship among negative affect, the covariates (age, gender, race, education), health related measures (subjective health and sum of limitations), marital support, and the interaction term (marital support x sum of limitations). This analysis was conducted in the same four steps as the two previous models.

Age, gender and education were significant in the first step (Model 1) in the presence of the other variables. Individuals with more education, males, and older individuals had lower levels of negative affect. This model explained only 2% of the variation in positive affect.

In the second step (Model 2) gender, age, subjective health, and sum of limitations were all significant. This model explained a total of 13% of the variance in positive affect an 11%

increase from the previous model. Male participants and older participants showed lower levels of negative affect. Participants with higher levels of self-rated health also showed lower levels of negative affect. Participants with a greater number of limitations showed high levels of negative affect.

Gender, age, subjective health, sum of limitations, and marital support were all significant in the third step (Model 3). Older participants and men had lower levels of negative affect. Participants with higher levels of self-rated health and those with higher levels of marital support also had lower levels of negative affect. Again, participants with a greater number of functional limitations showed higher levels of negative affect. This model explained a total of 23% of the variance in positive affect, a 10% increase from the previous model.

The fourth and final step (Model 4) showed the same findings as the third step (Model 3), but added the interaction term for marital support with sum of limitations. This model explained a total of 24% of the variance in negative affect. The interaction term was significant in this model, meaning that as marital support increases the effect of the sum of limitations on negative affect decreases. For participants with high marital satisfaction, the effect that more limitations increases the experience of negative affect is reduced.

Discussion

In this study I examined the effects of marital support and health on three components of subjective well-being, life satisfaction, positive affect, and negative affect. I expected to find age cohort differences among the components of subjective well-being, the predictors of subjective well-being, and the covariates. I also expected to find that marital support (e.g. feeling supported by one's spouse) contributes to higher subjective well-being, but higher levels of functional

limitations are related to lower subjective well-being. I hypothesized that martial support moderates the negative effect of functional limitations on subjective well-being.

Initial age cohort (50s, 60s, 70s, and 80+) analysis for the central study variables education, life satisfaction, subjective health, sum of limitations, marital support, and the three component of subjective well-being revealed significant group effects. As expected, 50 year olds were significantly lower in life satisfaction and higher in the experience of negative affect. Although 80 year olds did not differ in life satisfaction, their reported lower levels of positive affect contradict the existing literature (Brockman, 2010; Charles & Carstensen, 2010; Stone, Schwartz, Broderick, & Deaton, 2010). It is possible that positive affect is not consistent with the literature because many previous studies have not had a large, representative sample of older adults in their 80's and above. Because HRS data is a representative sample, these data may be more accurate than previous samples of older adults. It is unclear if these effects are due to age or to cohort differences. A longitudinal analysis of education, life satisfaction, positive and negative affect, subjective health, functional limitations, and marital support would help to disentangle if the mean level differences in these factors among age cohorts are due to aging. However, longitudinal studies comparing different cohorts (i.e., cross-sequential studies) over different time periods are required to separate age and cohort effects.

The regression analysis supported my hypothesis that marital support would be a significant predictor of life satisfaction, positive affect, and negative affect, even when controlling for other factors. Over and above age and gender, feeling that one's spouse understands you and doesn't get on your nerves is associated with higher life satisfaction, higher positive affect, and lower negative affect. My analysis used a composite marital support scale that combined measures of marital closeness and social support from one's spouse. This

composite scale supported similar findings such as findings that marital satisfaction and psychological well-being are correlated (Dush et al., 2008). Marital support is an important variable to consider, because the spouse plays such an important role in many individual's social support network (Antonucci, 2001).

Sum of limitations was also found to be a significant predictor of life satisfaction, positive affect, and negative affect. A greater number of functional limitations was associated with lower life satisfaction, lower positive affect, and higher negative affect. This was expected because a greater number of functional limitations would impede an individual's ability to perform everyday activities necessary for autonomy. Rowe and Kahn (1987) reported that older adults with fewer functional limitations had higher levels of life satisfaction, although they did not report effects on positive or negative affect.

The regression analysis showed that self-reported health was a significant predictor of the three components of well-being as well. This supported Mollaoğlu et al.'s (2010) findings the self-reported health and life satisfaction are correlated in older adults and Gwozdz and Sousa-Poza's (2010) findings that the decline in life satisfaction among the oldest old can be largely attributed to changes in self-reported health.

The regression analyses partially supported my hypothesis that marital support would a moderate the effects of functional limitations on the three components of subjective well-being. The interaction term between marital support and functional limitations was not significant for life satisfaction or positive affect. However, it was significant for negative affect. Specifically when considered with Ross's (1995) finding that marriage decreases levels of depression, it may be possible that marital support is beneficial in keeping a spouse from becoming as sad, distressed, and frustrated with their functional limitations. A person with a high number of

functional limitations may not be as adversely affected if their spouse can step in and help them prepare meals, take medications, bathe, and perform other necessary functions.

A limitation of this study is the lack of an established measure of marital satisfaction in the HRS dataset. My composite measure of marital support was face valid and highly correlated with the measure of marital closeness; however, an established measure of marital satisfaction would have been useful in differentiating among marital support, quality, and satisfaction. According to Kahn and Antonucci (1980), social support is comprised of three components, affect, affirmation, and aid. Affect is emotional support; aid is financial, physical, or some other form of tangible support; and affirmation is support in the form of having one's views or values acknowledged and validated. Future studies may be interested in looking at the composite measure used in this study and why it was the strongest predictor for all three components of subjective well-being even after controlling for covariates and other predictors.

George (2010) reported that health, financial stability, and love are some of the key factors for well-being in mid-life and old age. This study found that love (marital support) was the strongest predictor of subjective well-being. People need support from their social network, and a supportive spouse can contribute positively to subjective well-being. Working as an interviewer in an ongoing related study, I've met many research participants who are in good health for their age and comfortable financially, but they are very dissatisfied with their lives because they do not have support from their social network. Their children no longer visit them; and they are divorced, or their spouse has passed away. By further looking at this new measure of marital support and its components, researchers may be further able to unravel the complexities of subjective well-being and the best ways to measure it. My study adds to the literature examining the importance of looking at the different components of subjective well-

being and their predictors in later life.

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Author Note

Table 1

Age Cohort Differences in Demographic Characteristics, Marital Support and Well-Being (HRS 2008 wave, N=4228)

	Age Cohort				
Covariates	50's	60's	70's	80+	*p*
	(*n* = 882)	(*n* = 1470)	(*n* = 1327)	(*n* = 443)	
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	
Positive Affect (Max = 5)	3.52 (.69)	3.59 (.68)	3.52 (.71)	3.28 (.73)	.00
Negative Affect (Max = 5)	1.81 (.63)	1.70 (.61)	1.66 (.56)	1.67 (.56)	.00
Life Satisfaction (Max = 7)	4.96 (1.52)	5.18 (1.44)	5.27 (1.44)	5.08 (1.46)	.00
Marital Support (Max = 4)	3.21 (.60)	3.23 (.58)	3.29 (.54)	3.33 (.53)	.00
Functional Limitations (Max = 23)	2.43 (3.05)	3.06 (3.36)	3.56 (3.49)	4.48 (4.10)	.00
Subjective Health (Max = 5)	3.39 (1.07)	3.26 (1.05)	3.15 (1.07)	3.01 (1.08)	.00
Education (years)	13.43 (5.08)	12.95 (3.68)	12.74 (3.84)	12.92 (4.08)	.00
%	%	%	%	%	*p (X²)*
White/Caucasian	80.8%	82.1%	84.0%	74.3%	.00 (26.11)
% Male	40.2%	46.6%	55.5%	63.0%	.00 (86.46)

Table 2

Zero-Order Correlations between Predictors of Subjective Well-Being and All Other Variables

(HRS 2008 wave, N=4228)

	1	2	3	4	5	6	7	8	9	10
1. Life Satisfaction										
2. Negative Affect	-.42**									
3. Positive Affect	.42**	-.37**								
4. Marital Support * Sum of Limitations	-.21**	.15**	-.21**							
5. Marital Support	.39**	-.39**	.28**	-.06**						
6. Sum of Limitations	-.29**	.28**	-.28**	.70**	-.12**					
7. Subjective Health	.34**	-.29**	.36**	-.40**	.14**	-.53**				
8. Gender	-.02	-.11**	-.04**	-.06**	.14**	-.07**	-.06**			
9. Education	.06**	-.07**	.19**	-.10**	.08**	-.15**	.22**	.00		
10. Age	.05**	-.08**	-.08**	.15**	.07**	.18**	-.12**	.16**	-.08**	
11. Race	-.01	.01	-.02	.01	-.01	-.01	.02	.00	.02	.01

*p < .05. ** p < .01.

Table 3

Predictors of Life Satisfaction (HRS 2008 wave, N=4228)

Variable	Model 1 β	*Model 2 β*	Model 3 β	Model 4 β
Constant	4.30**	3.25**	.92**	.87**
Women	-.03	-.04*	-.09**	-.09**
Age	.04	.08**	.05**	.06**
Black	-.02	-.02	-.02	-.02
Education	.09**	.01	-.02	-.02
Subjective Health		.27**	.22**	.22**
Sum of Limitations		-.19**	-.17**	-.15**
Marital Support			.36**	.36**
Marital Support x Sum of Limitations				-.03
R^2	.01	.16	.28	.28
ΔR^2		.15	.13	<.01
F	7.10**	92.99**	165.62**	145.25**

*p < .05. ** p < .01.

Table 4

Predictors of Positive Affect (HRS 2008 wave, N=4228)

Variable	Model 1 β	Model 2 β	Model 3 β	Model 4 β
Constant	3.52**	3.01**	2.25**	2.28**
Women	-.04	-.04	-.09**	-.09**
Age	-.07**	-.03	.05**	.05**
Black	-.02	-.02	-.02	-.02
Education	.20**	.13**	.11**	.11**
Subjective Health		.26**	.24**	.23**
Sum of Limitations		-.13**	-.11**	-.09**
Marital Support			.24**	.24**
Marital Support x Sum of Limitations				-.03
R^2	.05	.16	.21	.21
ΔR^2		.11	.10	<.01
F	38.26**	95.13**	116.95**	102.63**

$*p < .05.$ $** p < .01.$

Table 5

Predictors of Negative Affect (HRS 2008 wave, N=4228)

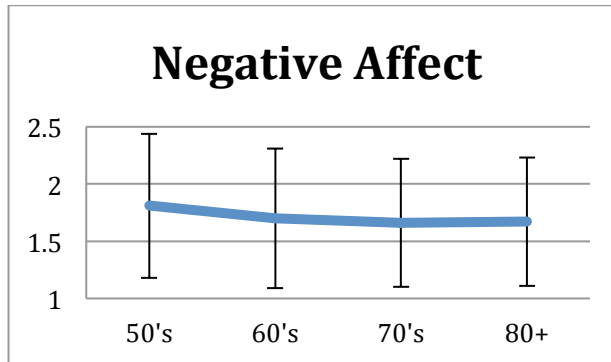| Variable	Model 1 β	*Model 2 β*	Model 3 β	Model 4 β
Constant	2.14**	2.45**	3.35**	3.31**
Women	-.10**	-.08**	-.04*	-.04*
Age	-.04*	-.08**	-.05**	-.05**
Black	.01	.02	.01	.01
Education	-.09**	-.02	-.01	-.01
Subjective Health		-.20**	-.16**	-.16**
Sum of Limitations		.19**	.17**	.22**
Marital Support			-.34**	-.34**
Marital Support x Sum of Limitations				-.07**
R^2	.02	.13	.23	.24
ΔR^2		.11	.10	.01
F	14.77**	72.37**	131.29**	116.50**

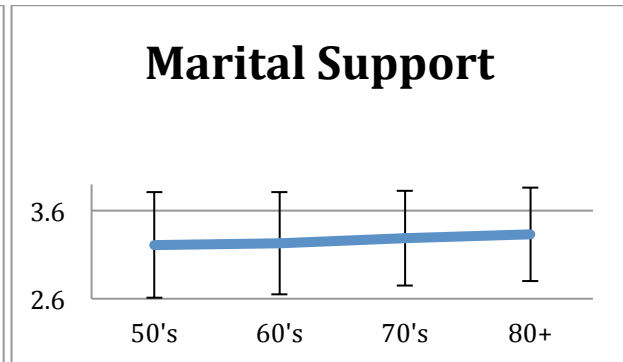*p < .05. ** p < .01.

A.
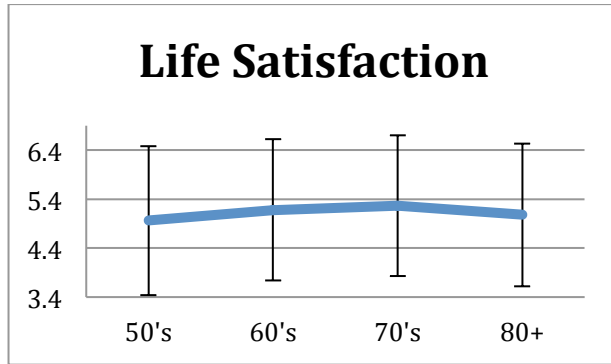
B.
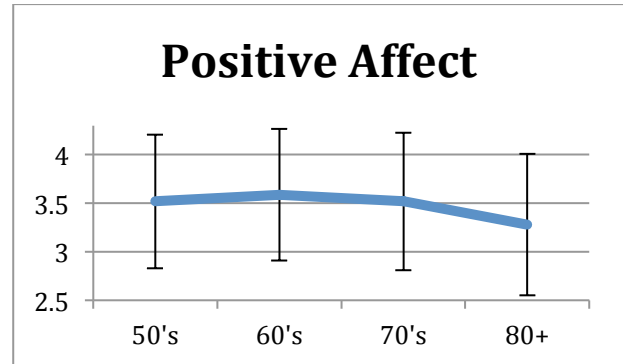
C.

D.

Figure 1. Mean Levels of Life Satisfaction, Positive Affect, Negative Affect, and Marital

Satisfaction by Decade (HRS 2008 wave, N=4228). Error bars represent ± 1 standard deviation.