

# Partners' health and silver splits in Europe: A gendered pattern?

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## Funding information

Next Generation EU-National Recovery and Resilience Plan, Investment Partenariato Esteso PE8 "Conseguenze e sfide dell'invecchiamento", Research Program Age-It (Ageing Well in an Ageing Society), Grant/Award Number: PE8-B83C22004800006

Edited by: Spencer Olmstead

## Abstract

**Objective:** Building on the Theory of Dyadic Illness Management, this paper addresses the correlates of silver splits—voluntary union dissolutions after age 50—among mixed-gender couples in Europe focusing on the role of partners' health status.

**Background:** Family diversity at older ages is growing in wealthy countries, with late union dissolutions increasingly occurring through separation and divorce rather than widowhood. Nonetheless, the correlates of silver splits in Europe, particularly regarding health within couples, remain underexplored.

**Method:** We utilized data from the European Survey of Health, Ageing, and Retirement (SHARE), spanning Waves 1 (2004–2005) to 9 (2021–2022), and employed discrete-time event-history analysis to model the risk of silver splits, separately among couples aged 50–64 and 65+ ( $N = 31,915$  and  $48,361$  couple-years, respectively). We inspected three health dimensions: self-rated health, Global Activity Limitations Index, depression.

**Results:** We found a non-negligible and gendered association between health and union dissolution among couples aged 50–64. Couples in which the woman reported poor self-rated health or faced severe activity limitations, whereas the man maintained good health, exhibited a higher risk of silver splits compared to couples in good health. Conversely, the risk of silver splits did not change significantly when the man experienced poor self-rated health or activity limitations compared to couples in good health. Results among older couples suggested that the health/silver split link weakens with age.

**Conclusion:** Gendered health-related selection effects appear among older European couples, as men struggle

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more than women with a partner's declining health, potentially jeopardizing the couple's stability.

#### KEYWORDS

divorce, gender, health, older adults, relationship dissolution

## INTRODUCTION

Population aging is a major, and unprecedented, 21st century phenomenon. This demographic shift is having profound impacts on many different aspects of society, including family life (Furstenberg et al., 2020). With longer life expectancies, the odds of unions ending through death are lower, but the duration of exposure to the risk of union dissolution is longer. Family diversity at older ages is thus growing, with late union dissolutions increasingly occurring through separation rather than widowhood (Uhlenberg & Myers, 1981). As older adults experience union dissolutions, or witness them among their friends and family members, they are likely to be more accepting of union disruption as a viable option for ending a marriage or a cohabitation. Additionally, a growing share of older adults are in higher order unions, reflecting divorce experienced at earlier stages of the life course. Previous research has shown that second or higher-order unions are more likely to end in divorce than first unions (Brown & Lin, 2012).

In the US, approximately 5 in 1000 married persons aged 50 and older experienced a divorce in 1989. By 2010, the number doubled to 10 per 1000 (Brown & Lin, 2012), even if a more recent study showed a decline to 9.64 per 1000 in 2019 (Brown & Lin, 2022). A similar pattern has been found in England and Wales from the 1990s to 2019 (ONS, 2023). Silver splits are on the rise in Europe as well. In France, for example, the divorce rate among people aged 50–54 has increased from approximately 5% in 1990 to 12% in the early 2010s; in the same period, among those aged 55–59 the divorce rate has increased from approximately 3% to 8% (Solaz, 2021). In Belgium, the percentage of divorced couples in which at least one former partner was over the age of 50 at the time of divorce rose from 21% in 2002 to 40% in 2018 (Zilincikova & Schnor, 2021). Union dissolution is increasingly occurring not only in marriages, but also among cohabitations (Alderotti et al., 2022). As a result, silver splits—that is, voluntary union dissolutions after the age of 50—are now commonplace among older adults in Europe and constitute a sizeable share of all union dissolutions.

Research on the correlates of silver splits in Europe is in its initial stages (Alderotti et al., 2022). This paper extends prior studies by recognizing that as populations age, family dynamics are inherently intertwined with partners' health issues (Boddi et al., 2015; Rastrelli et al., 2012; Sparano et al., 2024). Poor health can adversely impact marital quality and undermine relationship stability (Yorgason et al., 2008). Moreover, when one partner serves as the primary caregiver, the stress associated with caregiving responsibilities may further diminish relationship quality (Booth & Johnson, 1994). In this study, we adopted a dyadic, couple approach to the study of silver splits in Europe and focused on the relationship between partners' health status and the risk of union dissolution after age 50.

Although the significance of each partner in the adult patient–care partner dyad is well acknowledged, much of the existing research on illness management has overlooked the health dynamics of the couple (Lyons et al., 2002; Northouse, 2012; Revenson et al., 2016). Theoretical perspectives in family research highlight the need to capture the complexity of family systems by considering the involvement of both partners and their interactions (e.g., Kelly, 1983; Van Lange & Balliet, 2015; West & Zimmerman, 1987). This paper drew on the Theory of Dyadic Illness Management proposed by Lyons and Lee (2018), which frames health issues as a dyadic phenomenon. This perspective emphasizes the importance of examining both individual and couple-level patterns of health discordance and their implications, particularly during

middle and later life (Polenick et al., 2021). Qualitative studies strongly support the notion that in older, different-gender married couples, the health of both partners is closely tied to marital quality (Latham-Mintus et al., 2022; Thomeer & Ostergren Clark, 2021). Nonetheless, quantitative research on silver splits frequently includes both members of a dyad but examines them separately (e.g., Alderotti et al., 2022), which limits our understanding of how illness impacts the dyad as an interconnected unit. Here, we investigated the association between dyadic health status and silver splits across Europe, identifying dyads where both partners were simultaneously experiencing positive health outcomes, albeit not necessarily to the same degree, in contrast to those where only one or neither partner was faring well.

Traditional gender-role attitudes, which emphasize the husband as the breadwinner and the wife as the homemaker, reinforce unequal power dynamics within families (Rogers & Amato, 2000). Health events can serve as pivotal moments or transitions (Thomeer et al., 2019), potentially leading to changes in social roles. Women generally provide more frequent health-related support to their spouses compared to men (Thomeer et al., 2015). Accordingly, in older couples where the female partner acquires a health issue, there may be an elevated risk of union dissolution because men strive more to adapt to a changing health status of their female partner and, eventually, adapt to a new caregiving role.

We used data from the European Survey of Health, Ageing and Retirement (SHARE), and employed discrete-time event-history analysis to model the probability of union dissolution (i.e., divorce or separation) among heterosexual couples between two waves. We examined three different health dimensions: self-rated health (SRH), the Global Activity Limitations Index (GALI), and depression (EURO-D). To better examine the partners' health/silver splits nexus, we differentiated younger senior couples (aged 50–64) from their older counterparts (at least one member aged 65+). This distinction was driven by at least three key reasons. First, gender differences between partners may lose prominence at the micro level with age, as suggested by the 'degendering' hypothesis, which posits that individuals may place less emphasis on gender as a central component of their identity as they grow older (Lemaster et al., 2017). Second, age and health are inextricably linked, with the aging process often bringing a higher prevalence of health issues and unique pathologies (Robert et al., 2009). As individuals grow older, the likelihood of developing chronic illnesses, such as cardiovascular disease, arthritis, and dementia, increases significantly. Hence, couples in the 50–64 age range may face different health-related challenges compared to those aged 65 and above, where illnesses might be more severe and multifaceted. Finally, couples in different age groups may have varying expectations of relationships and differing capacities to navigate a potential separation (Leopold, 2018). Understanding this distinction allowed for a more nuanced analysis of how health influences gender relationships, caregiving responsibilities, and union stability.

## BACKGROUND

### Health status and silver splits

Studies for the US have suggested that factors traditionally associated with union dissolution among younger adults were also salient for older adults (Berardo, 1982; Hammond & Muller, 1992; Uhlenberg & Myers, 1981). Birth cohort, educational level, presence of children, and previous divorce experience have been identified as the key correlates of silver splits (e.g., Lin et al., 2018). Recent evidence has illustrated that the European antecedents of silver splits are similar to those found for the US (Alderotti et al., 2022). Surprisingly, the role of health status in shaping silver splits has been partly neglected in family demography. Only few

studies have explored the link between poor health and union dissolution, and the results have been inconclusive (Charles & Stephens Jr, 2004; Joung et al., 1998; Teachman, 2010; Wilson & Waddoups, 2002). These studies have typically focused on relatively young populations, however, despite the effects of poor health on divorce may become more significant as individuals age (Uhlenberg & Myers, 1981). During late middle age and early older ages, people often experience the start of severe health issues. As divorce is more accepted and occurs more frequently, an illness could be an increasingly significant risk factor for divorce among new generations of older Europeans.

There are several channels through which health may affect silver splits. First, physical limitations can increase the likelihood of union dissolution by causing stress and reducing the quality of the marital relationship (Amato, 2010; Daniel et al., 2009; Yorgason et al., 2008). As people age, they are more likely to experience chronic health problems (Crimmins & Beltrán-Sánchez, 2011), and advances in medical treatment have prolonged the lives of people with serious illnesses, despite their poor health (Crimmins, 2004). This means that some individuals may live with chronic conditions for longer periods, which could raise their risk of silver splits by contributing to relationship strain (Karraker & Latham, 2015a). Some studies have observed an increased likelihood of divorce following such events (Blekesaune & Barrett, 2005; Karraker & Latham, 2015a; Singleton, 2012). However, other research has not found significant links between poor health and divorce in older age groups (Lin et al., 2018). Galinsky and Waite (2014) have highlighted the significance of sexual activity and psychological well-being as possible mechanisms in the association between declining physical health and diminishing marital quality. Research into health as a determinant of divorce in old age has confirmed that worsening health deteriorates marital quality and increases the likelihood of divorce (Booth & Johnson, 1994), as do differences in spouses' health status (Butterworth & Rodgers, 2008; Wilson & Waddoups, 2002).

Second, when one spouse becomes ill, roles within a relationship can change. The unhealthy individual may require assistance with daily personal care tasks, and the partner is usually the primary caregiver (Wolff & Kasper, 2006). The healthy partner can witness an increase in their caregiving responsibilities, which can strain the dynamics of the relationship. Although caregiving can be a rewarding and fulfilling experience, it can also be emotionally and mentally taxing because spousal caregiving is often provided with continuous high intensity. Caregivers may experience a range of negative emotions, such as stress, anxiety, depression, and frustration, as they navigate the challenges of providing their partner with care (Schulz & Beach, 1999). The psychological strain of caregiving can be attributed to several factors. One is the physical demands of caregiving, such as helping with daily-living activities, managing medications, and providing transportation. Another factor is the emotional burden of caregiving, which can involve coping with partners' illness or disability, dealing with changes in their behavior or personality, and managing their emotions. Additionally, caregivers may experience social isolation as they spend more time caring for their loved one and less time engaging in activities with friends and family (Glaser et al., 2006). Choi and Marks (2006) found that caregiving may alter marital dynamics, causing distress, particularly if the initial marital quality was low.

Economic factors may serve as an additional mechanism through which health status influences the likelihood of silver splits. Dew's (2021) review highlights a strong connection between financial issues and relationship quality, underscoring the importance of considering economic characteristics within the dynamics of relationships in old age (Kridahl & Duvander, 2023). Illness often reduces household income, as one or both spouses may become unable to work (Teachman, 2010), thereby introducing financial strain that can exacerbate relationship tensions (Brown & Lin, 2012). Furthermore, one spouse's illness might impact the other's ability to remain employed, compounding the economic burden. Evidence suggests that financial instability is closely tied to marital dissolution. Job loss and earnings shocks, for instance, have been linked to an increased risk of divorce (Charles & Stephens Jr, 2004; Weiss & Willis, 1997).

Additionally, perceived financial strain is gaining recognition as a significant factor in late-life divorce (e.g., Canham et al., 2014). Recent findings by Alderotti et al. (2022) corroborated this, showing that individuals experiencing severe financial distress are at an elevated risk of silver splits. In our study, we tested this economic mechanism by considering two key factors—couples' employment status and their level of financial distress—potentially intervening in the relationship between partners' health and silver splits.

## Health dimensions

Diverse health dimensions may be differently correlated to silver splits. In this paper, we concentrated on three interrelated but distinct health dimensions: self-rated health (SRH), activity limitations (through the GALI, the Global Activities Limitation Indicator), and depression (through the EURO-D index).

SRH is a subjective measure of an individual's perception of their own health status. It is typically assessed by asking individuals to rate their overall health on a scale from excellent to poor. SRH has been widely used as a reliable and valid measure of health status and has been found to be a strong predictor of mortality, morbidity, and healthcare use (Mossey & Shapiro, 1982). Despite being subject to drawbacks, such as gender differences in health-rating styles (Grol-Prokopczyk et al., 2011), an individual's SRH can provide insights into their actual health status and their likelihood of developing health problems in the future. As SRH is a broad assessment of overall health, its impact may stem from various factors, including health-related limitations in daily activities, heightened healthcare needs, and financial strain. Older adults who perceive their health as poor may be more likely to experience marital or non-marital dissolution compared to those who rate their health more positively. Wilson and Waddoups (2002) illustrated that, for the US, marriages in which only one spouse experienced lower levels of SRH had a higher risk of divorce compared to marriages where both spouses were healthy. However, this was only the case among marriages where both spouses reported high levels of marital satisfaction. Percheski and Meyer (2018) found that, among married couples with young children, mothers' poor SRH is positively associated to divorce.

A person's health status can be operationalized also through disability indicators. Measures of disability are designed to evaluate the extent to which individuals are limited in their ability to perform daily activities, such as self-care, mobility, communication, and participation in social roles. These measures can include tools such as GALI, which is a single-item survey instrument that belongs to the family of disability indicators. It targets scenarios where health issues have affected individuals' regular activities and has been found to show good agreement with other objective and subjective measures of limitations, including the activity of daily living (ADL) score, and the instrumental activities of daily living (IADL) score (Jagger et al., 2010). In contrast, subjective measures of health may not provide a comprehensive assessment of the specific demands placed on caregivers of individuals with disabilities. For example, a person with a disability may rate their SRH as 'good' despite inducing significant stress to their caregiver. Therefore, disability measures may provide a more accurate indication of the caregiver's stress levels because they consider the specific needs of the person with a disability and the demands placed on the caregiver (Penning & Wu, 2019). An elevated risk of divorce among midlife men following work-related disability emerged in prior research (Han et al., 2021; Singleton, 2012; Teachman, 2010). However, Charles and Stephens Jr (2004) did not find evidence supporting an increased risk of divorce following work disability.

Finally, mental health—or a person's overall psychological and emotional well-being—is another health dimension potentially associated with silver splits. Mental health problems can significantly impact marital or partnership quality, especially at older ages. These conditions can impact communication, emotional regulation, and decision-making abilities, making it

challenging for partners to navigate difficulties and sustain healthy relationships. For example, depression can lead to negative thinking patterns, low self-esteem, and social withdrawal, which may hinder maintaining intimacy or emotional connection with a partner. Studies on the risk of divorce among young adults have found that individuals with higher levels of psychological well-being are less likely to divorce (e.g., Mastekaasa, 1994). However, other studies have found no such association (Charles & Stephens Jr, 2004). Regarding older adults, Alderotti et al. (2022) found a positive association between depression—operationalized as a continuous variable on the EURO-D depression scale—and silver splits in Europe. Investigating the link between health and union dissolution among parenting couples, Percheski and Meyer (2018) found that fathers' depression (either at the baseline or developed between the baseline and the subsequent interviews) predicts union dissolution. Furthermore, Bulloch et al. (2009), relying on longitudinal data for Canada, found the link between depression and marital disruption to be bidirectional, as they noted both an increased probability of marital disruption among depressed individuals and a higher risk of depression among the divorced or separated.

## Dyadic health

The majority of studies on illness management have primarily focused on the patient alone, with less attention on the role of informal care partners, such as spouses. Similarly, most theories related to illness and symptom management remain predominantly patient-centric, emphasizing self-management (Dodd et al., 2001; Riegel et al., 2012). Nonetheless, health management and caregiving are inherently dyadic processes (Lyons et al., 2002; Northouse, 2012; Revenson et al., 2016).

Lyons and Lee (2018) introduced the Theory of Dyadic Illness Management, which frames illness management as a fundamentally dyadic process. This theory shifts the focus from the individual responses of the patient and care partner, emphasizing instead the dyad as an interdependent team. This theory advocates for research that examines dyadic management across various behaviors, with a particular emphasis on how dyads collaborate and balance the needs of both partners. In particular, this framework places a strong attention on dyadic health—both physical and mental—arguing that the well-being of both individuals within the dyad must be equally prioritized.

Research has shown that spouses influence each other's physical activity levels (e.g., Li et al., 2013; Monin et al., 2016) and exert mutual, lasting effects on various health indicators such as chronic conditions, pain levels, functional limitations, and depressive symptoms (e.g., Hoppmann et al., 2011; Polenick et al., 2017, 2018; Thomeer, 2016). Therefore, it is crucial to examine the presence of discordant health issues at the couple level (between partners) and to explore their relationship with the couple's wellbeing over time.

The Theory of Dyadic Illness Management aligns with other research perspectives that emphasize the importance of examining the “black box” of the household to understand the social dynamics between partners (e.g., Bisdee et al., 2013; Pahl, 1990; Zelizer, 1989). Central to this approach is the principle of linked lives, a foundational concept in life course theory (Elder, 2003), which highlights how individuals' lives are interconnected, with each partner's health experiences shaping those of the other (Thomeer et al., 2017). Family psychology has also emphasized the importance of viewing stress and coping as interconnected processes within couples. Bodenmann (1995) suggested that stress-coping dynamics in couples should be viewed as a dyadic exchange, where one partner's stress prompts coping responses from the other, often resulting in shared strategies. This perspective highlights the need to see couples not just as two independent individuals, but as a unified entity characterized by mutual interactions and relationships. In this framework, stress is considered a concern for both partners, rather than a personal issue faced by one. Bodenmann (1995: 36) identifies “conditions or situations that affect

one or both partners (e.g., job stress) and which inevitably impact the other partner” as significant sources of stress. We argue that health-related challenges are a critical stressor within couples, deeply influencing both partners and their interaction.

## Gender differences

Middle-aged and older couples may be at a higher risk of union dissolution when the female partner, rather than the male partner, is in poor health (Karraker & Latham, 2015a). This may be due to several reasons, both demographic and sociocultural in nature. The share of women at older ages outnumbers those of men due to the former's greater longevity (UN, 2022). Additionally, men tend to marry women who are younger than they are (Esteve et al., 2009; Presser, 1975). Consequently, older men have a larger pool of potential partners in the remarriage market than older women. The union market is further skewed by the stronger normative value placed on youthful beauty for women, resulting in women being more devalued than men as potential partners as they age (England & McClintock, 2009). Not only are men much more likely to remarry than women (Shafer & James, 2013), but they also tend to have a larger age gap with their wives at the time of remarriage (England & McClintock, 2009).

In addition, gender norms regarding role changes that often accompany illness may contribute to gender differences in the relationship between health status and silver splits. Previous research suggests that responses to physical health challenges in different-gender marriages—such as the decision to provide support or the impact of health issues on relationship quality—may be influenced by gendered expectations of being a husband or wife (Schulz, 2020; Thomeer et al., 2015). Gender differences in support roles may be attributed to the perception that women are inherently more skilled at nurturing and emotional caregiving (Hays, 1998; Jack & Ali, 2010). Particularly midlife and older women are more strongly socialized into caregiver roles compared to their male partners (Floridi et al., 2022). Research on older adults indicates that while men do provide support during their spouses' health challenges, this support is often less intensive and sustained compared to that provided by women, and may rely more on external assistance (Pinquart & Sörensen, 2006). Due to these established patterns, older women are more likely to become caregivers for a frail spouse (Noël-Miller, 2011). This dynamic might lead to greater challenges for male partners as they adapt to the caregiving role. Wives receiving care are indeed more likely to report experiencing gaps in necessary caregiving from their spouses compared to husbands (Allen, 1994).

Qualitative studies that involved both male and female primary caregivers of frail older couples revealed varied dynamics within these relationships (Racher, 2002; Thomeer & Ostergren Clark, 2021). While some couples successfully established reciprocal roles and mutual interdependence, others experienced significant friction, tension, and frustration. Quantitative, clinical studies have reported a higher risk of divorce when wives, rather than husbands, are diagnosed with cancer (Glantz et al., 2009; Kirchoff et al., 2012), or when women are affected by cancers specific to them, such as cervical cancer (Carlsen et al., 2007). However, these findings are limited to relatively young or small samples—they have yet to be replicated in large-scale social surveys or across a range of illnesses. In their retraction, Karraker and Latham (2015b) concluded that no differences emerged in the relationship between gender, pooled illness onset, and divorce. Their study was based on a specific group of couples who were initially healthy, meaning that their results cannot be generalized to all older married individuals in the US who face the possibility of divorce in later life (Lin et al., 2018). Our research drew on these qualitative and quantitative insights by examining gender dynamics in support through a longitudinal, dyadic health perspective utilizing representative micro-level data for Europe.

## Confounders

A series of sociodemographic factors—or confounders—may simultaneously affect health status and the risk of silver splits. Marital biographies, including marriage order, duration, and age gaps, significantly influence divorce risk (Wu & Penning, 2018). Second or subsequent marriages are more prone to divorce, as those who have divorced may be more willing to do so again (Sweeney, 2010). Additionally, the risk of divorce decreases with longer marital duration, as dissatisfied couples are more likely to separate over time, leaving more stable unions intact.

Limited evidence exists regarding the association between having children and grandchildren with late-life union dissolutions. Weingarten (1988) emphasized the role of children as sources of support for older parents, contributing to marital quality and stability after the age of 60. However, as parents and children age, strained relationships and conflicts may arise, potentially undermining union stability (Wu & Penning, 2018). Recent studies for the U.S. (Brown et al., 2021) and Europe (Alderotti et al., 2022) suggested that experiencing grandparenthood may lower the likelihood of late-life divorce.

Education may play a noteworthy role in influencing the likelihood of silver splits, acting both as a proxy for socioeconomic status and reflecting earning potential and labour market engagement. Previous studies on silver splits have noted a positive correlation between education and late divorce among both genders (e.g., Wu & Penning, 1997, for Canada). Conversely, more recent studies conducted in the US (e.g., Brown & Lin, 2012; Lin et al., 2018) and Europe (Alderotti et al., 2022) have suggested that educational attainment has only a modest impact on the likelihood of a late union dissolution.

Finally, the geographical context can shape gender, health and family dynamics. Schmitz and Lazarevič (2020) found that Southern Europe exhibits larger disparities in disadvantages faced by women regarding poor SRH, activity limitations, and depression, whereas Northern Europe shows relatively smaller gender differences in multimorbidity, depression, and SRH compared to other European regions. Additionally, the prevalence of union dissolution at later ages varies across Europe: Northern and Western European countries tend to have a slightly higher risk of silver split compared to Southern and Eastern European countries (Alderotti et al., 2022).

All the confounding factors discussed thus far were operationalized and included in the model equation analyzing the relationship between partners' health and silver splits in Europe.

## RESEARCH QUESTIONS

Based on the background outlined so far, three research questions were central to our empirical investigation. First, what role does health play as a correlate of union dissolution in later life? Second, do the different dimensions of health (SRH, activity limitations, and mental health) have similar associations with the probability of experiencing a union dissolution in later life? Third, are these health correlates of union dissolution shaped by gender?

## METHOD

### The SHARE data

Our study drew upon data obtained from the European Survey of Health, Ageing, and Retirement (SHARE), a comprehensive longitudinal investigation covering various domains. This survey collects detailed information on individuals aged 50 and older, along with their current cohabiting partner, irrespective of their age. We used Waves 1 (2004–2005) through 9



(2021–2022), but excluded Wave 3 because it primarily collects retrospective information and lacks most current sociodemographic and health variables. To capture late union dissolutions, we excluded countries that contributed data for only one wave. Thus, the analytical sample included respondents from the following European countries: Austria, Belgium, Bulgaria, the Czech Republic, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and Switzerland. The SHARE survey uses a probability-based sampling design to ensure representativeness of the population aged 50 and older across participating countries; however, the methodology varies depending on the characteristics of sampling frames in each country. For more details, see Bergmann et al. (2017).

We considered union dissolution rather than divorce in the strict sense of the term. Therefore, our sample was limited to individuals aged 50 or over who either (1) were married or in a registered cohabitation, or (2) were engaged in an informal cohabiting arrangement. We included individuals classified as 'living with a partner' but not in a formal relationship (such as marriage or registered cohabitation) only if they were assigned a 'couple ID'. In the SHARE dataset, individuals were given a couple ID if they share a residence with a partner. Therefore, all individuals in a cohabiting relationship were assigned a couple ID (including the respondent's partner regardless of age; for more details on the surveying characteristics of SHARE, please refer to Alcsér et al., 2005). However, the proportion of couples in either registered or informal cohabitations within our dataset was minimal, accounting for less than 5% compared to the predominance of married couples, which made up approximately 95% of the sample. Consequently, in the empirical analysis, we opted not to differentiate between marriages and cohabitations. Starting with 148,085 individuals, we excluded those not within a union, thus reducing the size to 111,864. We also had to eliminate individuals who were in couple but whose partner's interview was not available, leading to a sample of 97,664 individuals (i.e., 48,832 couples).

To observe late union dissolutions across waves using a dyadic approach, we only retained individuals who participated in at least two waves alongside their partners (thus losing an additional 23,290 couples). This approach ensured that we would capture potential union dissolutions by observing individuals who were in a union in one wave and potentially divorced in a subsequent wave. In cases of union dissolution, only one member of the couple was surveyed in subsequent waves, resulting in asymmetrical observations within the couple. Subsequently, we obtained a dataset in which each record corresponds to a couple-year—that is, each couple appears in the dataset as many times as the partners are interviewed before the (potential) union dissolution occurs. Couples entered the observation in the first wave they both participate in the survey, and were observed until union dissolution or until they leave the sample for attrition (e.g., death).

Our final sample consisted of 25,542 heterosexual couples—5331 entering in Wave 1; 2170 in Wave 2; 7567 in Wave 4; 4536 in Wave 5; 2532 in Wave 6; 3406 in Wave 7; and 176 in Wave 8.

Potential implications of the sample selection process are discussed in Section 6.3.

## Dependent variable

The dependent variable examined was the occurrence of divorce or union dissolution among couples who were either married or in a relationship ( $n = 275$ ). Specifically, we defined a couple as having experienced a divorce or separation if one partner reported being single or divorced at Wave  $t$ , but they both reported being married or cohabiting at Wave  $t - 1$ . In instances where the couple was not observed at Wave  $t - 1$ , we considered data from Wave  $t - 2$  (or the earliest available wave).

## Key independent variables

For each health dimension, we constructed variables that captured various combinations of both partners' health conditions per wave, measured at wave  $t - 1$  to ensure that health is considered prior to the divorce. For SRH, individuals were categorized into two groups: those reporting excellent, very good, or good SRH (labeled as 'good SRH'), and those reporting fair or poor SRH (labeled as 'poor SRH'). To capture mental health, we used the EURO-D depression scale, which assesses the presence or absence of 12 depressive symptoms. The scale was calculated by summing these responses, resulting in a score ranging from 0 (not depressed) to 12 (very depressed) (see Prince et al., 1999). Following previous studies (e.g., Uccheddu et al., 2019), we considered individuals with a score of 4 or higher as depressed. Finally, to address the role of functional limitations, we used the GALI, which assessed the extent to which individuals have been restricted due to health issues in activities typically performed by people over the past 6 months (see Berger et al., 2015). Responses included: not limited, moderately limited, or severely limited. We categorized individuals who reported being not limited or limited, but not severely so, as 'not limited'. This operationalization arises from the fact that individuals with severe disabilities are more likely to require care, potentially inducing caregiver stress in their partners.

Subsequently, we created couple-level variables for each health dimension. The first category comprised couples in which both partners were in good health across all indicators. This means that both members reported good SRH, were not depressed, and neither reported severe limitations. The second and third categories represented couples in which one partner had a health issue for that particular dimension (regardless the other two dimensions) while the other was in good health with respect to all three indicators. For example, in the case of SRH, the second category included couples where one partner reported poor SRH (regardless their health status in terms of limitations and depressions), while the other was in good health across all dimensions; similarly, in the depression variable, it included cases where one partner was depressed (regardless their health status in terms of SRH and limitations), while the other was in good health across all dimensions. The fourth category included couples in which both partners had a health issue for the specific dimension being considered—that is, both partners reported poor SRH, both were depressed, or both had severe functional limitations. A final residual category encompassed couples with mixed health combinations that did not fit into the previous categories. For example, this might include couples where one partner reported poor SRH while the other reported good SRH but had severe functional limitations and was depressed. Another example could be a couple where one partner was depressed while the other was not depressed but had severe functional limitations and had poor SRH. This category captured these mixed cases where the health conditions of the partners did not align neatly into any single health dimension category.

Accordingly, the three variables appear as the following. For SRH: (1) 'both partners are in good health'; (2) 'the man has poor SRH, the woman is in good health'; (3) 'the man is in good health, the woman has poor SRH'; (4) 'both partners have poor SRH'; and (5) 'residual category'. For EURO-D: (1) 'both partners are in good health'; (2) 'the man is depressed, the woman is in good health'; (3) 'the man is in good health, the woman is depressed'; (4) 'both partners are depressed'; and (5) 'residual category'. For GALI: (1) 'both partners are in good health'; (2) 'the man has severe limitations, the woman is in good health'; (3) 'the man is in good health, the woman has severe limitations'; (4) 'both partners have severe limitations'; and (5) 'residual category'.

As shown in Table 1, which provides descriptive statistics for all variables, the residual categories of the variables concerning couples' health account for non-negligible proportions of observations (however, only 2.5% of the total couple-years fell into the residual category across all three health variables). To investigate whether this may have introduced bias into our

**TABLE 1** Descriptive statistics ( $N = 80,276$  couple-years).

	% or mean	
	Ages 50–64	Ages 65+
Silver split	0.61	0.16
SRH		
Both partners are in good health	48.62	36.49
Only man has poor SRH	12.64	14.49
Only woman has poor SRH	13.80	15.68
Both have poor SRH	12.90	23.11
Residual category	12.05	10.22
GALI		
Both partners are in good health	48.62	36.49
Only man has severe limitations	4.83	5.22
Only woman has severe limitations	4.97	5.76
Both have severe limitations	2.02	3.75
Residual category	39.56	48.78
Depression		
Both partners are in good health	48.62	36.49
Only man is depressed	2.66	2.41
Only woman is depressed	7.67	6.22
Both are depressed	2.79	3.56
Residual category	38.26	51.32
Mean age (man)	58.81	72.42
Mean age (woman)	56.83	69.13
Union duration		
Less than 20 years	8.56	4.19
20–39 years	68.11	16.05
40+ years	11.41	72.02
Missing information	11.93	7.74
Education		
Both tertiary	13.69	10.46
Only woman tertiary	9.97	6.90
Only man tertiary	10.47	11.39
Both secondary or lower	65.87	71.25
Children/grandchildren		
The couple has no children	20.14	19.14
The couple has children but no grandchildren	32.40	10.15
The couple has children and grandchildren	47.46	70.71
Have previous divorce experiences	3.64	2.48
Country group		
Southern EU	21.96	25.30
Western EU	36.29	33.49

(Continues)

TABLE 1 (Continued)

	% or mean	
	Ages 50–64	Ages 65+
Northern EU	11.17	12.12
Eastern EU	30.57	29.09
Wave of entrance		
Wave 1	16.47	24.20
Wave 2	9.92	10.25
Wave 4	29.12	28.60
Wave 5	17.08	16.06
Wave 6	12.81	8.54
Wave 7	11.53	9.27
Wave 8	3.08	3.07
Employment		
Both employed	36.65	1.54
Only man employed	19.71	3.35
Only woman employed	14.81	6.68
Both non-employed/retired	26.05	86.97
One of the two missing	2.78	1.46
Financial distress		
Couple makes ends meet easily	62.77	65.65
Couple makes ends meet with difficulties	37.22	34.35
Couple-years	31,915	48,361

Source: Authors' elaboration on SHARE data.

results, we conducted a robustness check by altering the formulation of the variable pertaining to couples' health. For each health dimension, the revised categorization scheme maintained the distinction between couples based on their health status, but without generating residual categories. Specifically, the first category included couples in which both partners are in good health according to that specific indicator (e.g., both reported good SRH). The second and third categories encompassed couples in which one partner had poor health whereas the other did not, with reference to that specific indicator (e.g., one partner had poor SRH whereas the other had good SRH, regardless of the other health indicators). The fourth category comprised couples in which both partners experienced health issues across the dimension under consideration. This modified categorization ensured that all couples were assigned to one of the four categories, eliminating residual categories. Importantly, although the main findings of our analyses remained valid under this alternative formulation, the results were generally less clear cut: we surmise that this might be due to the fact that the alternative formulation did not examine the situation in which one partner had poor health whereas the other was in good health (across all health indicators), thus hindering proper interpretation. For instance, under the alternative categorization, couples classified in the second and third categories might consist of scenarios in which the male partner experienced severe limitations whereas the female partner did not; however, the female partner may still be experiencing depression, thus rendering the health contrast between the partners somewhat ambiguous. Accordingly, we chose to retain the original categorization due to our belief that it more accurately identifies couples with divergent health statuses (the results of the alternative categorization are available upon request).

## Sociodemographic variables

We accounted for several sociodemographic variables that could potentially confound the relationship between health and the risk of union dissolution. These included both partners' age as continuous variables. Age was also employed as a stratification variable, as the analyses were conducted separately for couples in which both partners were aged between 50 and 64, and for couples in which at least one of the partners was aged 65 or older. We controlled for union duration, categorized as: (1) 'less than 20 years'; (2) '20–39 years'; (3) '40 or more years'; and (4) 'missing information'. Additionally, we considered the experience of previous divorce(s) by adding a dummy variable, categorized as either (0) 'has never divorced', or (1) 'has already divorced at least once.' We included a time-varying variable denoting the presence of children and/or grandchildren within the couple, categorized as: (1) 'the couple has no children'; (2) 'at least one member of the couple has children, but no grandchildren'; and (3) 'at least one member of the couple has children and grandchildren.' We also controlled for educational level, with categories indicating: (1) 'both partners have tertiary education'; (2) 'only the woman has tertiary education'; (3) 'only the man has tertiary education'; and (4) 'both partners have secondary education or lower.' To account for geographical differences in the prevalence of both health problems and silver splits, and given that the sample size and the number of events did not allow for country-specific analyses, we controlled for country group, distinguishing between: (1) 'Southern Europe', (2) 'Western Europe', (3) 'Northern Europe', and (4) 'Eastern Europe'. Finally, since we pooled together individuals who were first surveyed in the initial wave (2004) and those in the last wave (2022), we controlled for the couple's wave of entry to account for potential period effects (with possible values ranging from 1 to 8, excluding wave 3, as it is not included in the analysis).

## Economic-related variables

We considered two more variables that may operate as channels in the relationship between couples' health and the risk of union dissolution. These included the couple's employment status (time-varying), categorized as (1) 'both partners are employed'; (2) 'only the man is employed'; (3) 'only the woman is employed'; and (4) 'both partners are non-employed or retired'; and financial distress, accounted for with a time-varying variable distinguishing between two categories: (1) 'the household is able to make ends meet easily' and (2) 'the household is able to make ends meet with difficulty'.

Descriptive statistics for all the variables are reported in Table 1.

## ANALYSES

We employed discrete-time event-history models to analyze the relationship between the probability of experiencing union dissolution and both partners' health status, separately among couples where both partners are aged 50–64 and for couples in which at least one partner was aged 65 or older. Each couple was classified into the appropriate age group at each wave based on the age of its members. If a union dissolution occurred, it was attributed to the age group 50–64 if both members of the couple were younger than 65, and to the 65+ age group otherwise, while health was measured at the preceding wave. Finally, to address potential correlations in the error terms, we clustered the standard errors at the country level.

We employed a multistep modeling approach: first, we ran a univariate model, which included only the dependent variable (late union dissolution) and the specific health dimension under consideration. Subsequently, to account for potential sociodemographic confounding

factors, we implemented a multivariable model. This model incorporated control variables such as age, education level, presence of children and/or grandchildren, experiencing previous divorce(s), union duration, wave of entrance, and country group. Finally, we extended our analysis by introducing additional variables possibly serving as potential mediators. Specifically, we included time-varying employment status and financial distress in addition to the aforementioned control variables. For each health dimension, we showed results from the univariate model (M0), results from the model with confounding factors (M1), and finally results from the full model—that is, including employment and financial distress (M2).

Predicted probabilities of late union dissolution were calculated for each combination of partners' health conditions and for each of the three models, facilitating the interpretation of the results. Furthermore, we computed the average marginal effects (AMEs) related to each health dimension based on the full models only. We visually represented the predicted probabilities and the AMEs along with confidence intervals to facilitate pairwise comparisons (5% significance level), estimated at 83.4% (e.g., Goldstein & Healy, 1995).

## RESULTS

This section presents the results separately for the two groups of couples in which both partners were aged between 50 and 64, and couples in which at least one partner was 65 or older. While detailed results are provided for the former group, we offer only a brief description for the latter, as most findings lack statistical significance. The complete models are reported in Appendix S1 (Tables S2–S4).

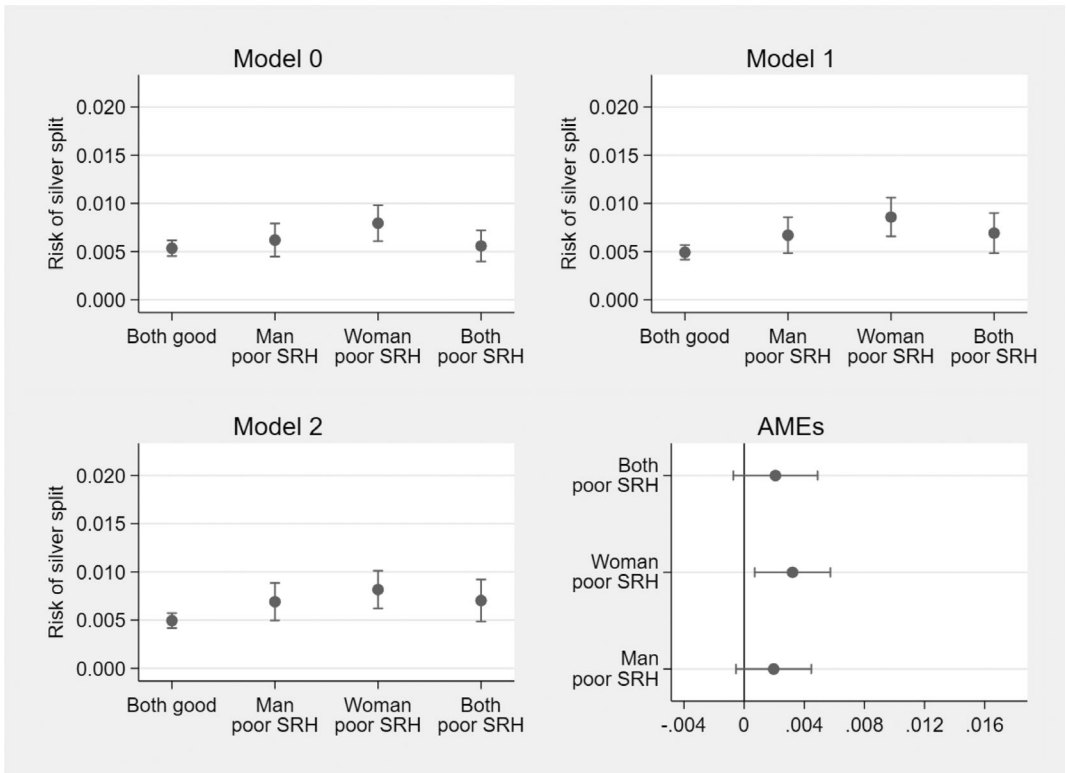
### Ages 50–64

#### Self-rated health

Figure 1 presents the predicted probabilities of silver splits by couples' health status in terms of SRH, derived from the three models, as well as the AMEs from the full model. Model 0, which included no control variables, indicated that couples in which only the woman reported poor SRH, while the man was in good health, had the highest risk of silver split (0.8% compared to 0.5% for couples where both partners were in good health), although this difference was not statistically significant. When control variables were added, it became evident that couples where either partner or both partners reported poor SRH faced a higher risk of silver split. However, this difference was significant only for couples in which the woman had poor SRH while the man was in good health. Notably, adding variables related to employment and financial stress (i.e., two factors that may explain the link between health and union dissolution) in Model 2 resulted in only minor changes. The last panel of Figure 1, displaying the AMEs from Model 2, confirmed that the risk of silver split significantly increased—by about 0.3 percentage points (pp)—for couples aged 50–64 in which only the woman reported poor SRH while the man was in good health.

#### Activity limitations

Figure 2 presents the results concerning the role of activity limitations on the risk of silver splits among couples aged 50–64. The univariate model indicated that couples in which the man had severe activity limitations while the woman was in good health had a lower risk of union dissolution. In contrast, the risk was higher when either only the woman or both partners had severe

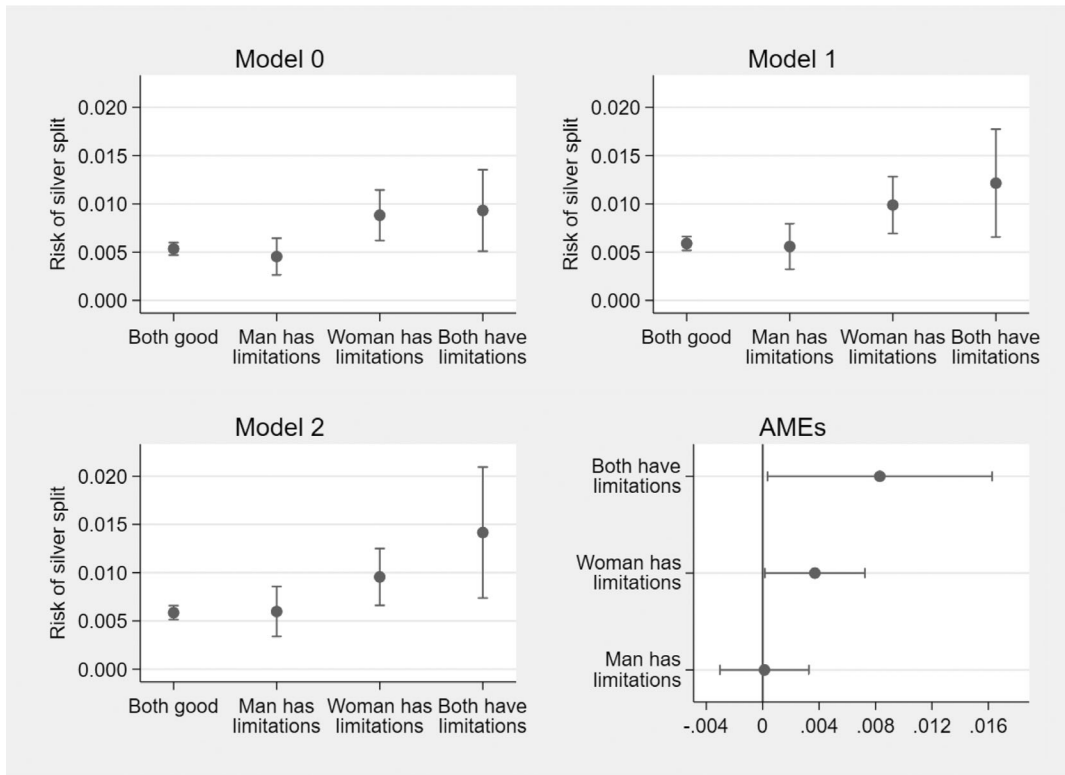


**FIGURE 1** Predicted risk of silver split by partners' health status in terms of SRH, and average marginal effects (AMEs). Ages: 50–64. Model 0 has no control variables. Model 1 controls for age, education level, presence of children and/or grandchildren, union duration, experience of previous divorce(s), country group, and wave of entrance. Model 2 also controls for employment status and financial distress. Confidence intervals for predicted probabilities are at 83.4%, whereas those for the AMEs are at 90%. *Source:* Authors' elaboration on SHARE data.

limitations, with these differences being significant. After adding control variables (Model 1), the risk of union dissolution became nearly identical for couples where both partners were in good health and for those where only the man had severe limitations. However, the risk remained notably higher for couples in which either only the woman or both partners had severe limitations. Once again, adding variables related to employment and financial stress (Model 2) resulted in only minor changes to the predicted probabilities of silver split. Ultimately, the AMEs revealed that couples where either only the woman or both partners experienced severe limitations had a significantly higher risk of union dissolution compared to those where both partners were in good health (by 0.4 and 0.8 pp., respectively).

## Depression

Figure 3 illustrates the relationship between depression and the risk of silver split. The univariate model shows that, compared to couples where both partners were in good health, those where either the man or the woman was depressed had a higher risk of union dissolution, with predicted probabilities of 1.5% and 0.8%, respectively, compared to 0.5% for healthy couples. Including control variables initially, and then adding employment and financial distress factors, had almost no impact on the results. The full model produced results very similar to Model



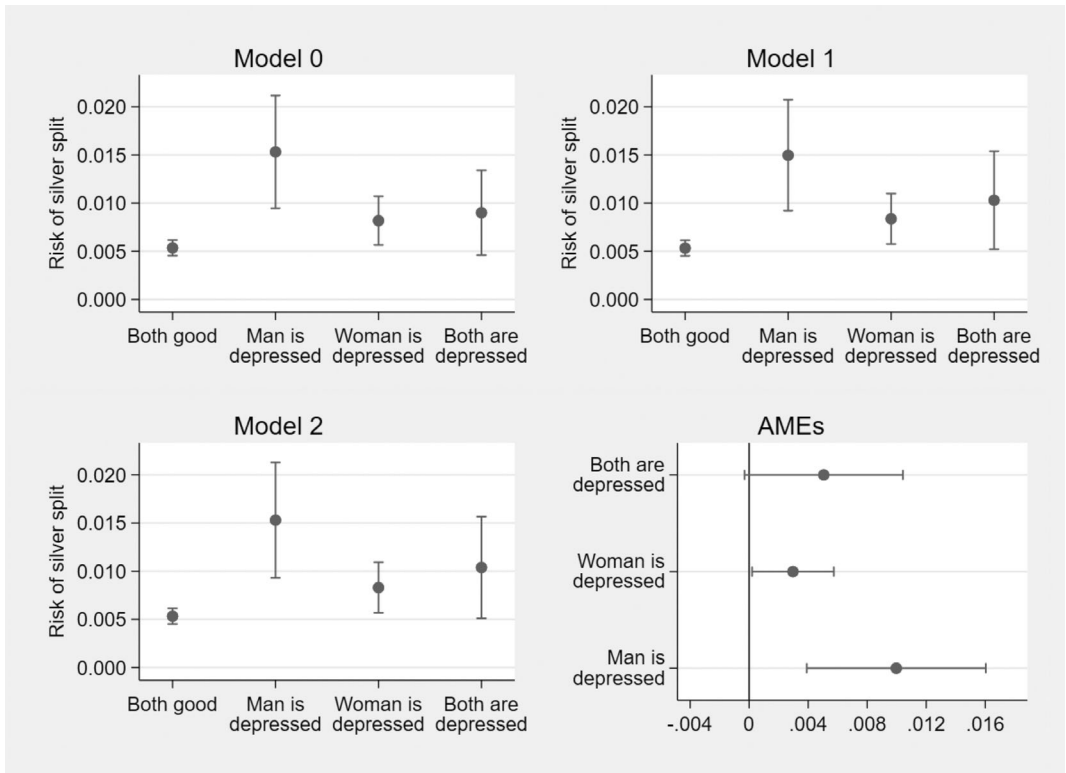
**FIGURE 2** Predicted risk of silver split by partners' health status in terms of activity limitations, and average marginal effects (AMEs). Ages: 50–64. Model 0 has no control variables. Model 1 controls for age, education level, presence of children and/or grandchildren, union duration, experience of previous divorce(s), country group, and wave of entrance. Model 2 also controls for employment status and financial distress. Confidence intervals for predicted probabilities are at 83.4%, whereas those for the AMEs are at 90%. *Source:* Authors' elaboration on SHARE data.

0, with the exception of a slightly higher probability of silver split among couples where both partners were depressed in Model 2. The AMEs confirmed that the presence of depression in just one partner significantly raised the risk of a silver split; however, the increase in risk was not significant (though slightly elevated) when both partners were depressed.

## Ages 65 and over

The same set of analyses discussed in the previous paragraphs were repeated on couples in which at least one member was aged 65 or older. However, most of the estimates were not statistically significant. First, the risks of silver split were generally much lower compared to younger couples. When considering SRH, the results showed a relatively flat trend, with predicted risks of silver split not changing substantially across the various types of couples. Larger variations were found when activity limitations were considered. We found a higher risk of silver splits when either the male or female partner had severe limitations, while the other was in good health (0.36% and 0.20%, respectively), and when both reported severe limitations (0.35%) compared to couples in which both partners were in good health (0.13%). However, none of these differences were found to be statistically significant. Finally, we also observed depression to increase the risk of silver splits. Couples in which the man was depressed while the woman was





**FIGURE 3** Predicted risk of silver split by partners' health status in terms of depression, and average marginal effects (AMEs). Ages: 50–64. Model 0 has no control variables. Model 1 controls for age, education level, presence of children and/or grandchildren, union duration, experience of previous divorce(s), country group, and wave of entrance. Model 2 also controls for employment status and financial distress. Confidence intervals for predicted probabilities are at 83.4%, whereas those for the AMEs are at 90%. *Source:* Authors' elaboration on SHARE data.

not, and couples in which both partners were depressed were not at a greater risk of a silver split compared to couples in which both partners were in good health. Conversely, couples in which the woman was depressed while the man was not depressed showed a significantly higher risks of a silver split compared to the reference group (0.37%). Results are summarized in Figure S4 in Appendix S1. The figure shows the predicted probabilities of silver splits for different combinations of partners' health status across each health dimension, as well as the AMEs, both obtained from the full model (i.e., controlling for all factors).

## Further analyses and robustness checks

The results presented thus far illustrate the link between each health domain and silver splits separately. However, the three health domains considered are not independent of one another. To address this concern, we first provide an overlap matrix in Table S5 (see Appendix S1) that shows the distribution of couples across all possible combinations of health issues (single or multiple, e.g., the man had only poor SRH while the woman had poor SRH and severe limitations). While some combinations may be of particular interest—for example, because the combination of different health issues may create situations of heightened stress, potentially affecting union stability—the small number of cases limited the power of our analysis. Second,

we conducted further analyses by replicating the above models, but without distinguishing the nature of the health concern. Specifically, we categorized couples based on whether only the man, only the woman, or both partners had at least one health problem (i.e., either poor SRH, severe limitations, or depression). The results remained consistent and confirm that, in general, the risk of silver splits increased in response to poor health conditions by one or both partners; however, the risk of silver splits was significantly higher—compared to couples with two healthy partners—only among couples in which the woman had a health problem whereas the man was in good health, confirming the existence of a gendered link between health and union dissolution risk. Interestingly, with this alternative specification of the key independent variable, a gendered pattern seems to emerge also among older couples (i.e., aged 65 or more), as the only significant AME is the one signaling an increased risk of silver splits for couples in which only the woman had a health problem. Results are showed in Appendix S1 (see Figure S5). Similar results (albeit significant only among couples aged 50–64) are obtained when we categorized couples based on whether only the man, only the woman, or both partners had at least two health problem (i.e., poor SRH and severe limitations, or severe limitations and depression). Results are showed in Appendix S1 (see Figure S6) and proved that a significant increase in the risk of silver splits emerged only when it is the woman who reported two or more health problems while the man was in good health (compared to couples in which both partners were in good health). While these analyses do not aim to represent an exhaustive investigation on the health/silver split link in case of multimorbidity on one partner's side, they provided further evidence taking into account people reporting multiple health issues.

We also tested the robustness of our findings by replicating the analyses using different age thresholds to divide our sample into younger and older couples (i.e., ages 64 and 66 instead of 65). The results remained virtually unchanged and are available upon request. Similarly, we repeated our analysis of mental health by changing the EURO-D indicator threshold to distinguish between depressed and non-depressed individuals. The results remained unchanged when defining individuals with a score of 3 (instead of 4) or higher, but the estimates notably lost statistical significance if we defined individuals with a score of 5 (instead of 4) or higher as depressed.

Finally, to address the potential bias introduced by the sample selection process, we provided descriptive statistics comparing the analytical sample with individuals who were excluded. The descriptive statistics are reported in Table S6 and show that individuals excluded from the sample exhibited poorer health across all three indicators, higher probabilities of financial distress, and a larger share of missing information. The fact that our sample is positively selected on health may suggest that we are underestimating the total effect of health on the risk of silver split, as individuals with health problems were less likely to be included in the sample, likely due to dropout.

## DISCUSSION

Despite extensive research on the causes and consequences of population aging, our understanding of family diversity in aging societies, and in particularly the reasons behind increasing union dissolution rates in old age, remains limited. By recognizing that the lives of coupled individuals (married or cohabiting) are typically interconnected, particularly among older couples experiencing health problems (Robb et al., 2008), this paper extends previous research on silver splits in Europe by focusing on the role of health status from a gender perspective. The findings of this study reveal that health status is a significant and substantial determinant of union dissolution in later life, particularly before age 65. Nevertheless, the association varies across health dimensions and operates in distinctly gendered ways.

We found that couples aged 50–64 in which the woman reported poor SRH or faced severe activity limitations, whereas the man maintained good health, exhibited a higher risk of silver splits compared to couples in good health, aligning with our expectation of a gendered effect of health on silver split probability. Conversely, we observed that the probability of silver splits does not change significantly when the man experienced activity limitations compared to couples in good health. This gendered health/silver split nexus remains after controlling for partners' employment status and household financial distress, indicating that mechanisms beyond economic factors are at play. The degree and duration of activity limitations can lead to various implications for the burden of caregiving, work limitations, and reduction in other areas of life. Disability measures may offer a precise depiction of the caregiver's stress levels, as they consider the distinct requirements of the person with activity limitations and the caregiving demands imposed on the caregiver. Interestingly, such gender inequality did not emerge among couples aged 50–64 when depression is taken into consideration: issues with depression in either partner elevate the risk of union dissolution.

The present paper, focusing on couple-level analyses rather than individual perspectives, highlights the gendered nature of caregiving and support, with women typically providing more assistance. Our findings align with the understanding that health dynamics within unions reflect an interdependent process (Bennett, 2013), not merely the health needs of one partner or the other's propensity for support. Situations where female partners are dependent on male partners for care are often more stressful than the reverse, leading to elevated risks of silver splits. This dynamic is rooted in the gendered nature of caregiving and is consistent with qualitative studies based on a 'linked lives' approach and a gender relations framework (Thomeer et al., 2020). These gendered patterns of support are not only developed and maintained throughout marriage (Thomeer & Ostergen Clark, 2021), but they also intersect with power relations, where women often experience unique challenges related to financial dependence, inequality, and economic vulnerability (Pahl, 1990; Vogler & Pahl, 1994; Zelizer, 1989). Our analysis, using representative micro-level data for Europe, supports the idea that these gendered support patterns persist, despite evolving gender norms and labor divisions that may become more equitable (Shu & Meagher, 2018). In particular, the health issues and caregiving needs of women affect relationship stability, reflecting persistent gender inequality.

On the other hand, the analysis revealed no significant disparity in the likelihood of experiencing silver splits among couples where at least one partner is aged 65 or older. This finding provides some support for the 'degendering' hypothesis, which suggests that as individuals age, gender may become a less significant component of their identity (Lemaster et al., 2017). However, gender inequalities in marital relationships do not entirely disappear with age, as they likely remain deeply embedded in structural inequalities within the social order, shaped by and reinforcing gender-based divisions. Indeed, our findings still reflect traces of gender inequality among couples aged 65 or older—specifically, an increased risk of silver splits when the woman is depressed, while the man remains healthy.

## Study limitations

It is important to acknowledge that our study has limitations. First, in order to adopt a couple approach, we had to apply restrictive criteria to our sample selection, as we had to drop all individuals with non-responding partners or whose partners were not interviewed. Second, due to the small number of cases, it was not possible to conduct a country-specific analysis. Therefore, our findings represent average effects across countries, and any potential country-specific patterns (see, e.g., Schmitz & Lazarevič, 2020) may have been obscured. This opens the possibility for future investigations into the relationships proposed in this paper using more extensive longitudinal (country-specific) datasets. Third, the relatively small sample size limited our ability

to conduct more detailed analyses aimed at exploring silver splits when one partner has two (or three) health problems while the other has none. Such investigations would be particularly valuable for examining possible interactions among health measures. Forth, we could not explore specific mechanisms in the possible causal chain from health issues to silver splits as the data used did not collect related information (i.e., partners' sexual activity) or because they contain too many missing values to be reliable (partners' caring activity). Fifth, attrition is a known issue in panel analyses. Various solutions have been proposed to effectively control for attrition, depending on the mechanisms that generate loss at follow-up stages (Enders, 2010; Little & Rubin, 2002). Despite our efforts to include a wide range of control variables to address attrition bias, this approach can only reduce the consequences of attrition to the extent that it depends on observable characteristics. Previous analyses have found little evidence of selective attrition bias in SHARE (Bergmann et al., 2017; Kneip et al., 2015). Sixth, SHARE data do not permit researchers to isolate or account for Living Apart Together (LAT) relationships in empirical investigations. However, family literature indicates that being 'single' in terms of residence does not equate to being 'without a partner' in relational terms. Dyadic health management and caregiving responsibilities may manifest differently in LAT contexts. To enhance the characterization of silver splits, we encourage future qualitative and quantitative research to include LAT relationships in the discussion. Finally, we also acknowledge that our analysis has limited power to inform about causal relationships. We cannot rule out the possibility that individuals with certain health issues may also systematically vary in their propensity to dissolve a union. Nonetheless, our goal was to document any (gendered) relationship between the partners' health conditions and the risk of observing a silver split, not to make inferences about causation.

## CONCLUSION AND IMPLICATIONS

With increasing union dissolution rates, family dynamics are becoming more diverse and complex, especially among middle- and older-aged adults. Previous studies have mostly focused on the socioeconomic and health-related consequences of late union dissolutions, but the correlates of silver splits remain overlooked, especially in Europe. In this article, we found a significant association between health status and the likelihood of separation among European couples aged 50–64. This association emerges when a dyadic approach is considered, and persists after controlling for economic factors that may filter the link between poor health and increased risk of silver split such as employment and financial distress. Moreover, this relationship is gendered in the case of SRH and disability indicators: if the female partner reports poor SRH or has severe limitations while the male is in good health, the risk of separation increases. Conversely, if it is the man who reports poor SRH or has limitations while the woman is in good health, the risk of separation does not change significantly compared to couples in good health. This gender effect was not evident when mental health was considered. Overall, examining health outcomes and their family-related consequences through a dyadic lens reveals insights that would remain obscured in individual-centered approaches. By treating the individual and partner as distinct entities, we fail to gain insights into how health is managed within the dyad. This evidence points to the need for longitudinal surveys to capture both partners' perspectives in each wave, as well as to document reasons for attrition (e.g., death or divorce) when one partner is missing from a subsequent wave. By doing so, research can provide a more encompassing view on partners' health trajectories and family dynamics.

This study's findings support the idea that partners' health impacts union stability, with persistent patterns of gender inequality in caregiving among the older European generations represented in this study. This highlights the importance of considering health as a stressor on union stability and urges caution when interpreting cross-sectional studies as evidence of benefits of

unions, as selection effects related to health and gender dynamics are likely at play among couples in early old age. Future research should investigate marital quality as a potential moderating factor in these patterns. Latham-Mintus et al. (2022) offer compelling evidence that marital quality—particularly the enjoyment of shared time—strongly predicts the risk of marital dissolution among older couples, suggesting a nuanced role for relationship satisfaction in these dynamics. Hence, future studies should explore the role of marital quality as a potential mediator/moderator in the patterns observed in our findings.

By emphasizing the nexus between health status and silver splits during middle and older ages, we enhance our understanding of the factors that increase the likelihood of late-life union dissolution. This demographic group now represents a larger proportion of all dissolutions. Gendered health-related selection effects are clearly at play among older couples in Europe, with men struggling more than women with a partner's deteriorating health, thus jeopardizing the couple's stability.

## ACKNOWLEDGMENTS

The authors thank the members of the Population and Society Unit (UPS) of the University of Florence and of the Laboratory on Longevity and Ageing (LoLA) for their useful comments. This article was produced with cofunding from the European Union–Next Generation EU, in the context of the National Recovery and Resilience Plan, Investment Partenariato Esteso PE8 “Conseguenze e sfide dell'invecchiamento,” Project Age-It (Aging Well in an Aging Society, PE8-B83C22004800006). Open access publishing facilitated by Università degli Studi di Firenze, as part of the Wiley - CRUI-CARE agreement.

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## REFERENCES

- Alcser, K. H., Benson, G., Börsch-Supan, A., Brugiavini, A., Christelis, D., Croda, E., & Weerman, B. (2005). *The survey of health, aging, and retirement in Europe – Methodology*. Mannheim Mannheim Research Institute for the Economics of Aging.
- Alderotti, G., Tomassini, C., & Vignoli, D. (2022). ‘Silver splits’ in Europe. The role of grandchildren and other correlates. *Demographic Research*, 46, 619–652. <https://doi.org/10.4054/DemRes.2022.46.21>
- Allen, S. M. (1994). Gender differences in spousal caregiving and unmet need for care. *Journal of Gerontology*, 49(4), S187–S195. <https://doi.org/10.1093/geronj/49.4.S187>
- Amato, P. R. (2010). Research on divorce: Continuing trends and new developments. *Journal of Marriage and Family*, 72(3), 650–666. <https://doi.org/10.1111/j.1741-3737.2010.00723.x>
- Bennett, F. (2013). Researching within-household distribution: Overview, developments, debates, and methodological challenges. *Journal of Marriage and Family*, 75(3), 582–597. <https://doi.org/10.1111/jomf.12020>
- Berardo, D. H. (1982). Divorce and remarriage at middle age and beyond. *The Annals of the American Academy of Political and Social Science*, 464(1), 132–139.
- Berger, N., Van Oyen, H., Cambois, E., Fouweather, T., Jagger, C., Nusselder, W., & Robine, J. M. (2015). Assessing the validity of the global activity limitation indicator in fourteen European countries. *BMC Medical Research Methodology*, 15, 1–8.
- Bergmann, M., Kneip, T., De Luca, G., & Scherpenzeel, A. (2017). *Survey participation in the survey of health, ageing and retirement in Europe (SHARE), wave 1–6*. Munich Center for the Economics of Aging.
- Bisdee, D., Daly, T., & Price, D. (2013). Behind closed doors: Older couples and the gendered management of household money. *Social Policy and Society*, 12(1), 163–174.
- Blekesaune, M., & Barrett, A. E. (2005). Marital dissolution and work disability: A longitudinal study of administrative data. *European Sociological Review*, 21(3), 259–271. <https://doi.org/10.1093/esr/jci017>
- Boddi, V., Fanni, E., Castellini, G., Fisher, A. D., Corona, G., & Maggi, M. (2015). Conflicts within the family and within the couple as contextual factors in the determinism of male sexual dysfunction. *The Journal of Sexual Medicine*, 12(12), 2425–2435. <https://doi.org/10.1111/jsm.13042>

- Bodenmann, G. (1995). A systemic-transactional conceptualization of stress and coping in couples. *Swiss Journal of Psychology/Schweizerische Zeitschrift für Psychologie/Revue Suisse de Psychologie*, 54, 34–49.
- Booth, A., & Johnson, D. R. (1994). Declining health and marital quality. *Journal of Marriage and the Family*, 56, 218–223.
- Brown, S. L., & Lin, I. F. (2012). The gray divorce revolution: Rising divorce among middle-aged and older adults, 1990–2010. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 67(6), 731–741. <https://doi.org/10.1093/geronb/gbs089>
- Brown, S. L., & Lin, I. F. (2022). The graying of divorce: A half century of change. *The Journals of Gerontology: Series B*, 77(9), 1710–1720. <https://doi.org/10.1093/geronb/gbac057>
- Brown, S. L., Lin, I. F., & Melencamp, K. A. (2021). Does the transition to grandparenthood deter gray divorce? A test of the braking hypothesis. *Social Forces*, 99(3), 1209–1232. <https://doi.org/10.1093/sf/soaa030>
- Bulloch, A. G., Williams, J. V., Lavorato, D. H., & Patten, S. B. (2009). The relationship between major depression and marital disruption is bidirectional. *Depression and Anxiety*, 26(12), 1172–1177. <https://doi.org/10.1002/da.20618>
- Butterworth, P., & Rodgers, B. (2008). Mental health problems and marital disruption: Is it the combination of husbands and wives' mental health problems that predicts later divorce? *Social Psychiatry and Psychiatric Epidemiology*, 43(9), 758–763. <https://doi.org/10.1007/s00127-008-0366-5>
- Canham, S. L., Mahmood, A., Stott, S., Sixsmith, J., & O'Rourke, N. (2014). Til divorce do us part: Marriage dissolution in later life. *Journal of Divorce and Remarriage*, 55(8), 591–612. <https://doi.org/10.1080/10502556.2014.959097>
- Carlsen, K., Dalton, S. O., Frederiksen, K., Diderichsen, F., & Johansen, C. (2007). Are cancer survivors at an increased risk for divorce? A Danish cohort study. *European Journal of Cancer*, 43(14), 2093–2099. <https://doi.org/10.1016/j.ejca.2007.05.024>
- Charles, K. K., & Stephens, M., Jr. (2004). Job displacement, disability, and divorce. *Journal of Labor Economics*, 22(2), 489–522. <https://doi.org/10.1086/381258>
- Choi, H., & Marks, N. F. (2006). Transition to caregiving, marital disagreement, and psychological well-being: A prospective US national study. *Journal of Family Issues*, 27(12), 1701–1722. <https://doi.org/10.1177/0192513X06291523>
- Crimmins, E. M. (2004). Trends in the health of the elderly. *Annual Review of Public Health*, 25, 79–98.
- Crimmins, E. M., & Beltrán-Sánchez, H. (2011). Mortality and morbidity trends: Is there compression of morbidity? *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 66(1), 75–86. <https://doi.org/10.1093/geronb/gbq088>
- Daniel, K., Wolfe, C. D., Busch, M. A., & McKeivitt, C. (2009). What are the social consequences of stroke for working-aged adults? *A Systematic Review. Stroke*, 40(6), e431–e440. <https://doi.org/10.1161/STROKEAHA.108.534487>
- Dew, J. (2021). Ten years of marriage and cohabitation research in the journal of family and economic issues. *Journal of Family and Economic Issues*, 42, 52–61. <https://doi.org/10.1007/s10834-020-09723-7>
- Dodd, M., Janson, S., Facione, N., Faucett, J., Froelicher, E. S., Humphreys, J., Lee, K., Miaskowski, C., Puntillo, K., Rankin, S., & Taylor, D. (2001). Advancing the science of symptom management. *Journal of Advanced Nursing*, 33, 668–676. <https://doi.org/10.1046/j.1365-2648.2001.01697.x>
- Elder, G. H. (2003). *The emergence and development of life course theory. Handbook of the life course*. Springer.
- Enders, C. K. (2010). *Applied missing data analysis*. Guilford Press.
- England, P., & McClintock, E. A. (2009). The gendered double standard of aging in US marriage markets. *Population and Development Review*, 35(4), 797–816. <https://doi.org/10.1111/j.1728-4457.2009.00309.x>
- Esteve, A., Cortina, C., & Cabré, A. (2009). Long term trends in marital age homogamy patterns: Spain, 1922–2006. *Population*, 64(1), 173–202.
- Floridi, G., Quashie, N. T., Glaser, K., & Brandt, M. (2022). Partner care arrangements and well-being in mid- and later life: The role of gender across care contexts. *The Journals of Gerontology: Series B*, 77(2), 435–445. <https://doi.org/10.1093/geronb/gbab209>
- Furstenberg, F., Harris, L. E., Pesando, L. M., & Reed, M. N. (2020). Kinship practices among alternative family forms in Western industrialized societies. *Journal of Marriage and Family*, 82(5), 1403–1430. <https://doi.org/10.1111/jomf.12712>
- Galinsky, A. M., & Waite, L. J. (2014). Sexual activity and psychological health as mediators of the relationship between physical health and marital quality. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 69(3), 482–492. <https://doi.org/10.1093/geronb/gbt165>
- Glantz, M. J., Chamberlain, M. C., Liu, Q., Hsieh, C. C., Edwards, K. R., Van Horn, A., & Recht, L. (2009). Gender disparity in the rate of partner abandonment in patients with serious medical illness. *Cancer*, 115(22), 5237–5242. <https://doi.org/10.1002/cncr.24577>
- Glaser, K., Evandrou, M., & Tomassini, C. (2006). Multiple role occupancy and social participation among midlife wives and husbands in the United Kingdom. *International Journal of Aging and Human Development*, 63(1), 27–47. <https://doi.org/10.2190/7LGV-01W9-KQBL-4121>
- Goldstein, H., & Healy, M. J. (1995). The graphical presentation of a collection of means. *Journal of the Royal Statistical Society: Series A (Statistics in Society)*, 158(1), 175–177. <https://doi.org/10.2307/2983411>

- Grol-Prokopczyk, H., Freese, J., & Hauser, R. M. (2011). Using anchoring vignettes to assess group differences in general self-rated health. *Journal of Health and Social Behavior*, 52(2), 246–261. <https://doi.org/10.1177/0022146510396713>
- Hammond, R. J., & Muller, G. O. (1992). The late-life divorced: Another look. *Journal of Divorce & Remarriage*, 17(3–4), 135–150. [https://doi.org/10.1300/J087v17n03\\_09](https://doi.org/10.1300/J087v17n03_09)
- Han, S. H., Kim, K., & Burr, J. A. (2021). Activity limitations and depressive symptoms among older couples: The moderating role of spousal care. *The Journals of Gerontology: Series B*, 76(2), 360–369. <https://doi.org/10.1093/geronb/gbz161>
- Hays, S. (1998). *The cultural contradictions of motherhood*. Yale University Press.
- Hoppmann, C., Gerstorf, D., & Hibbert, A. (2011). Spousal associations between functional limitations and depressive symptom trajectories: Longitudinal findings from the study of asset and health dynamics among the oldest old (AHEAD). *Health Psychology*, 30, 153–162. <https://doi.org/10.1037/a0022094>
- Jack, D. C., & Ali, A. (2010). *Silencing the self across cultures: Depression and gender in the social world*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195398090.001.0001>
- Jagger, C., Gillies, C., Cambois, E., Van Oyen, H., Nusselder, W., Robine, J. M., & EHLEIS team. (2010). The global activity limitation index measured function and disability similarly across European countries. *Journal of Clinical Epidemiology*, 63(8), 892–899. <https://doi.org/10.1016/j.jclinepi.2009.11.002>
- Joung, I. M., Van De Mheen, H. D., Stronks, K., Van Poppel, F. W., & Mackenbach, J. P. (1998). A longitudinal study of health selection in marital transitions. *Social Science & Medicine*, 46(3), 425–435. [https://doi.org/10.1016/s0277-9536\(97\)00186-x](https://doi.org/10.1016/s0277-9536(97)00186-x)
- Karraker, A., & Latham, K. (2015a). In sickness and in health? Physical illness as a risk factor for marital dissolution in later life. *Journal of Health and Social Behavior*, 56(3), 420–435. <https://doi.org/10.1177/0022146515596354>
- Karraker, A., & Latham, K. (2015b). Authors' explanation of the retraction. *Journal of Health and Social Behavior*, 56(3), 417–419. <https://doi.org/10.1177/0022146515595817>
- Kelly, J. (1983). The doubled vision of feminist theory. In J. L. Newton, M. P. Ryan, & J. R. Walkowitz (Eds.), *Sex and class in women's history* (pp. 259–270). Routledge and Kegan Paul.
- Kirchhoff, A. C., Yi, J., Wright, J., Warner, E. L., & Smith, K. R. (2012). Marriage and divorce among young adult cancer survivors. *Journal of Cancer Survivorship*, 6, 441–450. <https://doi.org/10.1007/s11764-012-0238-6>
- Kneip, T., Malter, F., & Sand, G. (2015). Fieldwork monitoring and survey participation in fifth wave of SHARE. *SHARE Wave*, 5, 102–159.
- Kridahl, L., & Duvander, A. Z. (2023). Financial disagreements and money management among older married and cohabiting couples in Sweden. *Journal of Family and Economic Issues*, 44(2), 394–411. <https://doi.org/10.1007/s10834-022-09846-z>
- Latham-Mintus, K., Holcomb, J., & Zervos, A. P. (2022). Linked lives: Does disability and marital quality influence risk of marital dissolution among older couples? *Social Sciences*, 11(1), 27. <https://doi.org/10.3390/socsci11010027>
- Lemaster, P., Delaney, R., & Strough, J. (2017). Crossover, degendering, or ...? A multidimensional approach to life-span gender development. *Sex Roles*, 76, 669–681. <https://doi.org/10.1007/s11199-015-0563-0>
- Leopold, T. (2018). Gender differences in the consequences of divorce: A study of multiple outcomes. *Demography*, 55(3), 769–797. <https://doi.org/10.1007/s13524-018-0667-6>
- Li, K. K., Cardinal, B. J., & Acock, A. C. (2013). Concordance of physical activity trajectories among middle-aged and older married couples: Impact of diseases and functional difficulties. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 68, 794–806. <https://doi.org/10.1093/geronb/gbt068>
- Lin, I. F., Brown, S. L., Wright, M. R., & Hammersmith, A. M. (2018). Antecedents of gray divorce: A life course perspective. *The Journals of Gerontology: Series B*, 73(6), 1022–1031. <https://doi.org/10.1093/geronb/gbw164>
- Little, R. J., & Rubin, D. B. (2002). Bayes and multiple imputation. In *Statistical analysis with missing data* (pp. 200–220). John Wiley and Sons, Inc.
- Lyons, K. S., & Lee, C. S. (2018). The theory of dyadic illness management. *Journal of Family Nursing*, 24(1), 8–28. <https://doi.org/10.1177/1074840717745669>
- Lyons, K. S., Zarit, S. H., Sayer, A. G., & Whitlatch, C. J. (2002). Caregiving as a dyadic process: Perspectives from caregiver and receiver. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 57(3), P195–P204. <https://doi.org/10.1093/geronb/57.3.p195>
- Mastekaasa, A. (1994). Marital status, distress, and well-being: An international comparison. *Journal of Comparative Family Studies*, 25(2), 183–205.
- Monin, J. K., Chen, B., & Stahl, S. T. (2016). Dyadic associations between physical activity and depressive symptoms in older adults with musculoskeletal conditions and their spouses. *Stress and Health*, 32, 244–252. <https://doi.org/10.1002/smi.2603>
- Mossey, J. M., & Shapiro, E. (1982). Self-rated health: A predictor of mortality among the elderly. *American Journal of Public Health*, 72(8), 800–808. <https://doi.org/10.2105/ajph.72.8.800>
- Noël-Miller, C. M. (2011). Partner caregiving in older cohabiting couples. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 66(3), 341–353. <https://doi.org/10.1093/geronb/gbr027>
- Northouse, L. L. (2012, September). Helping patients and their family caregivers cope with cancer. *Oncology Nursing Forum*, 39(5), 500–506. <https://doi.org/10.1188/12.ONF.500-506>

- Office for National Statistics. (2023). Divorce in the UK, 2021 and 2022. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/divorce/datasets/divorcesinenglandandwales>
- Pahl, J. (1990). Household spending, personal spending and the control of money in marriage. *Sociology*, 24(1), 119–138. <https://doi.org/10.1177/0038038590024001009>
- Penning, M. J., & Wu, Z. (2019). Caregiving and union instability in middle and later life. *Journal of Marriage and Family*, 81(1), 79–98. <https://doi.org/10.1111/jomf.12534>
- Percheski, C., & Meyer, J. M. (2018). Health and union dissolution among parenting couples: Differences by gender and marital status. *Journal of Health and Social Behavior*, 59(4), 569–584. <https://doi.org/10.1177/0022146518808707>
- Pinquart, M., & Sörensen, S. (2006). Gender differences in caregiver stressors, social resources, and health: An updated meta-analysis. *The Journals of Gerontology Series B*, 61(1), P33–P45. <https://doi.org/10.1093/geronb/61.1.p33>
- Polenick, C. A., Brooks, J. M., & Birditt, K. S. (2017). Own and partner pain intensity in older couples: Longitudinal effects on depressive symptoms. *Pain*, 158, 1546–1553. <https://doi.org/10.1097/j.pain.0000000000000949>
- Polenick, C. A., Renn, B. N., & Birditt, K. S. (2018). Dyadic effects of depressive symptoms on medical morbidity in middle-aged and older couples. *Health Psychology*, 37, 28–36. <https://doi.org/10.1037/hea0000573>
- Polenick, C. A., Birditt, K. S., Turkelson, A., Bugajski, B. C., & Kales, H. C. (2021). Discordant chronic conditions and depressive symptoms: Longitudinal associations among middle-aged and older couples. *The Journals of Gerontology: Series B*, 76(3), 451–460. <https://doi.org/10.1093/geronb/gbz137>
- Presser, H. B. (1975). Age differences between spouses: Trends, patterns, and social implications. *American Behavioral Scientist*, 19(2), 190–205. <https://doi.org/10.1177/000276427501900205>
- Prince, M. J., Beekman, A. T., Deeg, D. J., Fuhrer, R., Kivela, S. L., Lawlor, B. A., & Reischies, F. (1999). Depression symptoms in late life assessed using the EURO-D scale. *The British Journal of Psychiatry*, 174(4), 339–345. <https://doi.org/10.1192/bjp.174.4.339>
- Racher, F. E. (2002). Synergism of frail rural elderly couples: Influencing interdependent independence. *Journal of Gerontological Nursing*, 28(6), 32–39. <https://doi.org/10.3928/0098-9134-20020601-09>
- Rastrelli, G., Corona, G., Fisher, A. D., Silverii, A., Mannucci, E., & Maggi, M. (2012). Two unconventional risk factors for major adverse cardiovascular events in subjects with sexual dysfunction: Low education and reported partner's hypoactive sexual desire in comparison with conventional risk factors. *The Journal of Sexual Medicine*, 9(12), 3227–3238. <https://doi.org/10.1111/j.1743-6109.2012.02947.x>
- Revenson, T., Griva, K., Luszczynska, A., Morrison, V., Panagopoulou, E., Vilchinsky, N., & Hagedoorn, M. (2016). *Caregiving in the illness context*. Palgrave Macmillan UK. <https://doi.org/10.1057/9781137558978>
- Riegel, B., Jaarsma, T., & Strömberg, A. (2012). A middle-range theory of self-care of chronic illness. *Advances in Nursing Science*, 35(3), 194–204. <https://doi.org/10.1097/ANS.0b013e318261b1ba>
- Robb, C., Small, B., & Haley, W. E. (2008). Gender differences in coping with functional disability in older married couples: The role of personality and social resources. *Aging and Mental Health*, 12, 423–433. <https://doi.org/10.1080/13607860802224326>
- Robert, S. A., Cherepanov, D., Palta, M., Cross Dunham, N., Feeny, D., & Fryback, D. G. (2009). Socioeconomic status and age variations in health-related quality of life: Results from the National Health Measurement Study. *The Journals of Gerontology: Series B*, 64B(3), 378–389. <https://doi.org/10.1093/geronb/gbp012>
- Rogers, S. J., & Amato, P. R. (2000). Have changes in gender relations affected marital quality? *Social Forces*, 79(2), 731–753. <https://doi.org/10.2307/2675515>
- Schmitz, A., & Lazarevič, P. (2020). The gender health gap in Europe's ageing societies: Universal findings across countries and age groups? *European Journal of Ageing*, 17, 509–520. <https://doi.org/10.1007/s10433-020-00559-6>
- Schulz, R. (2020). The intersection of family caregiving and work: Labor force participation, productivity, and caregiver well-being. In S. J. Czaja, J. Sharit, & J. B. James (Eds.), *Current and emerging trends in aging and work* (pp. 399–413). Springer. [https://doi.org/10.1007/978-3-030-24135-3\\_20](https://doi.org/10.1007/978-3-030-24135-3_20)
- Schulz, R., & Beach, S. R. (1999). Caregiving as a risk factor for mortality: The caregiver health effects study. *Jama*, 282(23), 2215–2219. <https://doi.org/10.1001/jama.282.23.2215>
- Shafer, K., & James, S. L. (2013). Gender and socioeconomic status differences in first and second marriage formation. *Journal of Marriage and Family*, 75(3), 544–564. <https://doi.org/10.1111/jomf.12024>
- Shu, X., & Meagher, K. D. (2018). Beyond the stalled gender revolution: Historical and cohort dynamics in gender attitudes from 1977 to 2016. *Social Forces*, 96(3), 1243–1274. <https://doi.org/10.1093/sf/sox090>
- Singleton, P. (2012). Insult to injury: Disability, earnings, and divorce. *Journal of Human Resources*, 47(4), 972–990. <https://doi.org/10.1353/jhr.2012.0035>
- Solaz, A. (2021). La hausse des ruptures et des remises en couple chez les cinquante ans et plus. *Population & Sociétés*, 586, 1–4. <https://doi.org/10.3917/popsoc.586.0001>
- Sparano, C., Rastrelli, G., Corona, G., Vignozzi, L., Vignoli, D., & Maggi, M. (2024). Age disparity in couples and the sexual and general health of the male partner. *Andrology*, andr.13738. <https://doi.org/10.1111/andr.13738>
- Sweeney, M. M. (2010). Remarriage and stepfamilies: Strategic sites for family scholarship in the 21st century. *Journal of Marriage and Family*, 72(3), 667–684. <https://doi.org/10.1111/j.1741-3737.2010.00724.x>
- Teachman, J. (2010). Wives' economic resources and risk of divorce. *Journal of Family Issues*, 31(10), 1305–1323. <https://doi.org/10.1177/0192513X10370108>



- Thomeer, M. B. (2016). Multiple chronic conditions, spouse's depressive symptoms, and gender within marriage. *Journal of Health and Social Behavior*, 57, 59–76. <https://doi.org/10.1177/0022146516628179>
- Thomeer, M. B., & Ostergren Clark, K. (2021). The development of gendered health-related support dynamics over the course of a marriage. *Journal of Women & Aging*, 33(2), 153–169. <https://doi.org/10.1080/08952841.2020.1826624>
- Thomeer, M. B., Reczek, C., & Umberson, D. (2015). Gendered emotion work around physical health problems in mid- and later-life marriages. *Journal of Aging Studies*, 32, 12–22. <https://doi.org/10.1016/j.jaging.2014.12.001>
- Thomeer, M. B., Donnelly, R., Reczek, C., & Umberson, D. (2017). Planning for future care and the end of life: A qualitative analysis of gay, lesbian, and heterosexual couples. *Journal of Health and Social Behavior*, 58(4), 473–487. <https://doi.org/10.1177/0022146517735524>
- Thomeer, M. B., Hernandez, E., Umberson, D., & Thomas, P. A. (2019). Influence of social connections on smoking behavior across the life course. *Advances in Life Course Research*, 42, 100294. <https://doi.org/10.1016/j.alcr.2019.100294>
- Thomeer, M. B., Umberson, D., & Reczek, C. (2020). The gender-as-relational approach for theorizing about romantic relationships of sexual and gender minority mid-to later-life adults. *Journal of Family Theory & Review*, 12(2), 220–237. <https://doi.org/10.1111/jftr.12368>
- Uccheddu, D., Gauthier, A. H., Steverink, N., & Emery, T. (2019). The pains and reliefs of the transitions into and out of spousal caregiving. A cross-national comparison of the health consequences of caregiving by gender. *Social Science & Medicine*, 240, 112517. <https://doi.org/10.1016/j.socscimed.2019.112517>
- Uhlenberg, P., & Myers, M. A. P. (1981). Divorce and the elderly. *The Gerontologist*, 21(3), 276–282. <https://doi.org/10.1093/geront/21.3.276>
- United Nations Department of Economic and Social Affairs, Population Division. (2022). World Population Prospects 2022: Summary of Results. UN DESA/POP/2022/TR/NO. 3.
- Van Lange, P. A. M., & Balliet, D. (2015). Interdependence theory. In *APA handbook of personality and social psychology, Volume 3: Interpersonal relations* (pp. 65–92). American Psychological Association. <https://doi.org/10.1037/14344-003>
- Vogler, C., & Pahl, J. (1994). Money, power and inequality within marriage. *The Sociological Review*, 42(2), 263–288. <https://doi.org/10.1111/j.1467-954X.1994.tb00090.x>
- Weingarten, H. R. (1988). Late life divorce and the life review. *Journal of Gerontological Social Work*, 12(3–4), 83–97. [https://doi.org/10.1300/J083v12n03\\_06](https://doi.org/10.1300/J083v12n03_06)
- Weiss, Y., & Willis, R. J. (1997). Match quality, new information, and marital dissolution. *Journal of Labor Economics*, 15(1, Part 2), S293–S329. <https://doi.org/10.1086/209864>
- West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & Society*, 1(2), 125–151. <https://doi.org/10.1177/0891243287001002002>
- Wilson, S. E., & Waddoups, S. L. (2002). Good marriages gone bad: Health mismatches as a cause of later-life marital dissolution. *Population Research and Policy Review*, 21, 505–533. <https://doi.org/10.1023/A:1022990517611>
- Wolff, J. L., & Kasper, J. D. (2006). Caregivers of frail elders: Updating a national profile. *The Gerontologist*, 46(3), 344–356. <https://doi.org/10.1093/geront/46.3.344>
- Wu, Z., & Penning, M. J. (1997). Marital instability after midlife. *Journal of Family Issues*, 18(5), 459–478. <https://doi.org/10.1177/019251397018005001>
- Wu, Z., & Penning, M. J. (2018). Marital and cohabiting union dissolution in middle and later life. *Research on Aging*, 40(4), 340–364. <https://doi.org/10.1177/0164027517698024>
- Yorgason, J. B., Booth, A., & Johnson, D. (2008). Health, disability, and marital quality: Is the association different for younger versus older cohorts? *Research on Aging*, 30(6), 623–648. <https://doi.org/10.1177/0164027508322570>
- Zelizer, V. A. (1989). The social meaning of money: “special monies”. *American Journal of Sociology*, 95(2), 342–377.
- Zilincikova, Z., & Schnor, C. (2021). Who moves out and who keeps the home? Short-term and medium-term mobility consequences of grey divorce in Belgium. *Demographic Research*, 45, 291–328. <https://doi.org/10.4054/DemRes.2021.45.9>

## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

**How to cite this article:** Vignoli, D., Alderotti, G., & Tomassini, C. (2025). Partners' health and silver splits in Europe: A gendered pattern? *Journal of Marriage and Family*, 1–25. <https://doi.org/10.1111/jomf.13077>