# Health Status and Transitions in Cohabiting Relationships

Brandon G. Wagner
Office of Population Research, Princeton University

Abstract

While the effect of health on marital entrance or divorce is well documented, less is known about how health influences transitions in cohabiting relationships. In this paper, I explore health effects on the risk of experiencing different cohabitation outcomes. Using longitudinal data from the National Longitudinal Study of Adolescent Health, including a unique subset of complete couples' data, I estimate competing-risk hazard models for the likelihood of a cohabitation transitioning to marriage. For female respondents, poor health is associated with reduced risk of marrying the cohabitation partner, though no such health effect is found for male respondents. Among the dyadic sample, poor health of the female partner is associated with reduced risk of marriage, even after controlling for male partner's health. These results suggest health is an important predictor of cohabitation transitions, but that these transitions may only be sensitive to the health of the female partner.

# Background

## Health Selection and Relationships

Marital status is associated with better lifetime health outcomes for most individuals. But researchers acknowledge that the causal directionality between relationship type and health status is more complicated, as numerous studies have found evidence of health selection into marriage (Fu and Goldman 1996; Goldman 1993; Lillard and Panis 1996; Mastekaasa 1992; Waldron, Hughes and Brooks 1996). Even in historical datasets (Manfredini, Breschi and Mazzoni 2010; Sköld 2003), there is evidence that healthier individuals are more likely to enter into marriage. This focus on marital transitions, however, misses the complexity of the current family context. Cohabitation, in particular, has been relatively understudied with regard to health selection. From its quick increase in the United States during the 1970s and 1980s, the relationship experience of American adults very commonly involves cohabiting relationships. Data from the Current Population Survey (Census Bureau 2011-Table UC1 2011) estimates over 7.6 million currently cohabiting couples. Over half over women (age 15-44) report ever having cohabited with a male partner (NSFG 2006-2010). The widespread engagement in cohabiting behaviors means that understanding how health impact relationships must explore the role of health in shaping cohabitation outcomes as well.

Cohabitation poses particular challenges to understanding the role of health in shaping relationship exposure because of the complexity of the outcomes and variety of meanings. In contrast to marriage, cohabitation can take on a variety of meanings for individuals-from co-residential dating relationships to marriage replacements (Casper and Sayer 2000; Casper and Bianchi 2001). Rather than the divorce/not-divorce dichotomy that can be examined for marital

outcomes, cohabitation can result in dissolution[1], transition to marriage, or maintenance of the cohabiting relationship. As seen by the varieties of meanings for a cohabiting relationship, there is a similarly wide response with regards to these relationship outcomes as well. For those who viewed their cohabitation as a substitute for marriage, five years later the partners are as likely to still live together (39%) as get married (25%) as to separate (39%). Even in even the most tenuous cohabitations, those who view the relationship as merely a co-residential dating relationship, there is a variation in relationship outcome, with 21% still cohabiting, 33% married, and 46% separated (Casper and Sayer 2000; Casper and Bianchi 2001).

**Relevance of Health to Relationship Outcomes**

Though there is no existing literature on the role of health on cohabitation outcomes, either into marriage or dissolving the relationship, there is relevant work from other relationship contexts that provides insight. In general, healthier individuals are more likely to transition to marriage (Fu and Goldman 1996; Goldman 1993; Lillard and Panis 1996; Mastekaasa 1992; Waldron et al. 1996). While it is unclear if the same health effect holds true in the specific context of a cohabitation to marriage transition, on the basis of this work, we might expect that healthier individuals are more likely to experience their cohabitation transitioning to a marriage than are less health individuals. Health status is also associated with an increased risk of marital dissolution (Fu and Goldman 2000; Joung et al. 1998; Wilson and Waddoups 2002). In a prospective study of patients with brain tumors, divorce rates, particularly for female patients, were much higher than in the general population (Glantz et al. 2009). While less healthy

[1] By dissolution, I refer to the end of the co-residential relationship, not necessarily the relationship itself, though the vast majority of these transitions out of a shared residence do coincide with the conclusion of the relationship.

individuals are more likely to experience relationship dissolution, they are also less likely to experience a transition to marriage as well. Thus the existing marriage focused literature may suggest that transitions among cohabiting individuals will similarly favor healthier individuals.

However, there is some indication that transitions involving cohabitation may operate differently than do marital ones. For example, early life health does not appear to be related to selection into cohabitation (Banks, Kelly and Smith 2014). If cohabitation, by creating investment in the relationship, increases the relative likelihood of a given relationship transitioning to marriage, then health selection into marriage may be reduced for relationships with premarital cohabitation. Alternatively, individuals who cohabit are also different from those who do not and this difference could result in greater relevance of health for relationship outcomes. Cohabiters, relative to married individuals, tend to be less religious (Thornton, Axinn and Hill 1992), advocate greater gender equality (Le Bourdais and Lapierre-Adamcyk 2004), desire less structured relationships (Axinn and Thornton 1992), be less family oriented (Clarkberg, Stolzenberg and Waite 1995), desire more autonomy within the relationship (Axinn and Thornton 1992; Clarkberg et al. 1995) and come from less stable family backgrounds (Kamp Dush, Cohan and Amato 2003). Taken together, these features suggest that cohabiting individuals may have a more cynical view towards intimate relationships, making them more accepting of relationship dissolution than those who do not cohabit. In this case, we might imagine that the potential burden of a partner's poor health would be more likely to result in relationship dissolution.

**Goals of the Paper**

This paper will test how health structures outcomes of cohabiting relationships by

examining the association between health of individuals in cohabiting relationships and the subsequent disposition of these relationships. I will test this association in two ways, examining the association of self-reported health with first the nature of the cohabitation outcome and second the relative risk of experiencing the outcome. In addition to a test of these hypotheses using individual level data, I will use a small sample of matched dyadic responses to test the influence of both partner's health status on the subsequent relationship outcome.

# Methods

### Data

Data for this project is drawn from the National Longitudinal Study of Adolescent Health (Add Health). This study used a school-based stratified cluster design to construct a nationally representative sample of adolescents in grades 7-12 in the 1994-95 school year and interviewed the adolescents and a parent in an in-home Wave I interview (N=20,745). Original respondents have been followed over time with three follow-up in-home interviews: 1996 (Wave II), 2001-02 (Wave III), and most recently in 2008-09 (Wave IV). For more information on the study design and implementation see Harris et al. (2009). This study uses two different samples from the Add Health data, leveraging this longitudinal data collection to assess the association between health and the outcome of a cohabiting relationship.

This study is well-suited to the current investigation. As society wide changes in cohabitation have occurred over time between cohorts (Guzzo 2014), the close age range of this single cohort limits the possible confounding effects of a multi-cohort dataset. This change in the nature of cohabiting relationships is particularly acute given the limited nature of available dyadic data. Many studies rely on data from the Health and Retirement Study (HRS) as this

dataset almost uniquely contains health information about both members of a relationship. However, this dataset corresponds to a decidedly older generation, so Add Health's focus on a more recent cohort enables us to examine cohabitation in the manner that individuals are experiencing it now.

The first sample assesses how an individual's health is related to the outcome of a cohabiting relationship. It includes all respondents in a heterosexual, cohabiting romantic relationship as of Wave III and combines prospective information on respondent health (via Wave III) and the retrospective reconstruction of the relationship history (via Wave IV). There are 3,431 individuals with complete data from Waves III and IV who were in a cohabiting relationship at the time of the Wave III data collection.

However, while this sample combines health while in the relationship with the subsequent outcome of the relationship, it relies on reports from only one member of the relationship. Given the dyadic nature of relationships, it may be possible that an observed relationship is the result of partner characteristics. To address this potential obstacle, the second analytic sample uses a unique feature of the Add Health data to create matched dyadic pairs. As part of the Wave III data collection, 1,500 respondents who were in a current romantic relationship (one-third in each dating, cohabitating, or marital relationships) had the Wave III instrument administered to their current relationship partner. By merging together data from both partners as well as subsequent relationship disposition, I can examine how individual characteristics, net of partner characteristics, may influence relationship outcomes.

For clarity, I will refer to the first sample, constructed using individual level data, as the individual sample. In the same vein, the second sample, constructed with data from both members of the relationship, will be referred to as the couples sample.

**Measures**

There are three possible transitions that currently cohabiting relationships can make: the cohabitation can continue, the cohabitation can end, or the relationship could transition to a marriage. By matching current relationships in Wave III to the relationship timings provided in Wave IV, I am able to determine what, if any, transition (marriage or dissolution) occurred for the respondent's cohabiting relationship. Using the relationship calendar to identify the date of the transition, I also determine in what month of the relationship this transition occurred.

To measure health, I use self-reported health, an indicator that has consistently found it to be a valid measure of current physical health status and predictor of mortality among adults (Benyamini and Idler 1999; Idler and Benyamini 1997), and from one study that found it to be a moderately stable and reliable spontaneous health assessment among adolescents in Add Health (Boardman 2006). Responses ranged from 1 = "excellent" to 5 = "poor" but, because few respondents rated their health as poor, the categories for fair health and poor health were combined prior to the analysis. Additional sensitivity checks, discussed in the conclusion, included other potential health measures.

Controls for the analysis of the individual sample include race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, Asian, and Other Race), educational attainment (less than high school, high school or equivalent, some college, and college or more), age, and sex. For the couples sample, I control for satisfaction with the relationship (of both partners), whether the partners are of the same race, difference in ages in years (male partner’s age minus female partner’s age), and educational attainment of each partner (less than high school, high school, or at least some college). Where possible, I have endeavored to maintain comparable measures

between the two samples. However, this commonality is balanced against differences in available data and the need to preserve degrees of freedom in the smaller couple data set.

### Models

Health may influence cohabitation relationship trajectories in two ways, either through the nature or the timing of the relationship's transition. To answer the first question, I use a multinomial logistic regression to estimate the association between respondent health and the outcome of a cohabitating relationship.

To answer the second question, how health may structure the risk of experiencing a transition over time, I estimate competing risk hazard models for each cohabiting relationship, predicting the likelihood of the cohabitation eventuating in marriage, compared to the competing event of relationship dissolution. Cohabitation remaining unchanged is a censored response. As cohabitations that ended prior to Wave III would not be included in the dataset, this model accounts for the delayed entry into observation (time between cohabitation initiation and observation at Wave III).

The relevance of health for relationship outcome may differ between men and women. To account for this potential difference between the sexes, sex stratified models are estimated on the individual level (i.e. not couple's sample) data.

# Results

### Individual Sample

A description of the individual sample, overall and by respondent sex, is shown in Table 1. About 60% of cohabitations in Wave III eventuated in marriage, while only 9% stayed as

purely cohabiting relationships. While this is a higher estimate than previous work, the nature of the sampled relationships will tend to capture the more long-term and serious cohabitations, as indicated by the fact that the cohabitations sampled were, on average, about a year and a half long when included in the sample. In terms of most controls, we see little difference between men and women in these samples. There is however, a slight difference in the likelihood of women reporting worse status, which is in keeping with existing literature on self-reported health status by sex.

Table 2 presents the results of sex-stratified multinomial logistic regression models predicting the relative risk ratios of a cohabitation eventuating in marriage rather than dissolving. Results for the likelihood of the cohabitation continuing without entering marriage are not shown due to low case count, though there are no significant associations with self-reported health for this outcome. For female respondents (shown in the leftmost set of columns), there is a significant association between self-reported general health and the likelihood of the cohabitation resulting in marriage rather than dissolving. Women who report fair, poor, or good health are significantly less likely than their healthier counterparts to experience a marriage with their cohabitating partner rather than cohabitation dissolution. There is no analogous health finding with regard to male respondents though; self-reported health status does not appear to significantly predict the relative risk of experiencing a marriage rather than breakup. In both models, I find that the odds of experiencing a marriage with the current cohabiting partner rather than a breakup is lower for younger rather than older and black rather than white respondents.

To further investigate the relative timing of these potential cohabitation outcomes, the estimates of competing risk hazard models for marrying the cohabiting partner are shown in Table 3. Again, among women (leftmost columns), I find that women who report poorer health

(good, fair, or poor health) are at lower risk of their cohabitation transitioning to marriage than women who report being in excellent health. To aid in the interpretation of this finding, a graphical representation of these findings is available in Figure 1. For men (rightmost columns), I find no significant association between self-reported health status and the risk of marrying the current cohabitation partner.

**Couples Sample**

A description of the couple sample of the Wave III Add Health data collection is provided in Table 4. As would be expected, these data find educational and racial homogamy between cohabiting partners (Blackwell and Lichter 2000; Mare 1991; Schwartz and Mare 2005). Almost three-quarters of respondents reported very high satisfaction with the current relationship. As in the previous sample, the distribution of health status reported by men is slightly more favorable than that reported by women. There is (not shown) evidence of health status homogamy (chi-square p value <0.01), with healthier men in relationships with healthier women as expected from previous work (Di Castelnuovo et al. 2009; Monden 2007). While there is a correlation, it does not appear to be so great as to threaten multi-collinearity, therefore I include health statuses of both partners as independent predictors of relationship outcome.

The multinomial logistic regression model output for the outcome of cohabitations in the couples sample is shown in Figure 5. As with the previous analysis, the table shows relative risk ratios for the likelihood of marrying the cohabiting partner rather than dissolving the cohabitation. Results for the cohabitation remaining unchanged are not shown, though again, I find no evidence of an association between health and the likelihood of remaining in rather than dissolving the cohabitation. Unsurprisingly, the results of this model suggest that satisfaction of

either partner is associated with an increased likelihood of the relationship transitioning to marriage rather than breaking up. Education, at least of the female partner, is similarly associated with increased odds of marrying rather than dissolving the relationship. With regards to health, this model suggests that the health of the female partner, even after controlling for her male partner's self-reported health, is associated with a significant increase in the odds of marrying rather than breaking up with the cohabiting partner. Women who reported good or very good health rather than fair or poor health were three times as likely to marry their cohabiting partner as to end the cohabitation.

The results of the competing risks hazard model predicting marriage of the cohabiting partner are shown in Table 6. Again, satisfaction of either partner with the relationship increases the risk of the relationship transitioning to marriage. Relative to cohabitations where the woman reports being in fair or poor health, those in which the women is in better health are significantly (marginally significantly in the case of excellent health) more likely to transition to marriage. A graphical depiction of the risk of marriage in these cohabitations is shown in Figure 2 by women's self-reported health status.

## Discussion

Taken together, these results suggest that health is an important predictor of the outcome of a cohabiting relationship. However, this does not appear to be the case for both men and women, as it is solely the health of the female partner that is significantly associated with the outcome of the cohabitation. In cohabitations where the woman has worse health status, there is an increased likelihood of the cohabitation dissolving rather than resulting in a marriage.

In both sex stratified analyses of full Add Health sample and the matched couple sample,

the female partner's health appears to be more relevant to the success of the cohabitation than does her male partner's. Men may be more selective of women's health status with regards to marriage than vice versa. Gender differences, either in attractive features of relationship partners or willingness to undertake health care burden, may be responsible for this difference. Many of the features on which men evaluate potential romantic partners are physical features that, at their most basic, are underwritten by health itself. Consequently, men may be more selective of health status than are women in their romantic relationships. But previous work in a variety of contexts suggests that women are more likely to be engaged in care work for sick family members than are men. Given the relative ubiquity of this finding, perhaps we would anticipate that women would be more willing to shoulder the burden associated with a partner in poor health than are men.

Direct comparison of self-reported health status of men and women does raise the concern of sex differentiated norms in self-reported health status. While men in the United States experience higher mortality, women report consistently higher morbidity and worse health status. Part of this difference may exist in culturally defined understandings of health or the acceptability of acknowledging health problems. As seen in the delayed or foregone use of medical care by men, men are generally resistant to the idea of being in poor health. Stoicism bound into conceptions of masculinity could lead to decreased likelihood of reporting poor health status in men, something that the descriptions of these samples suggest is the case. While this systematic sex bias in reporting could threaten the reported finding, two features of the current study suggest that it is not solely responsible for the reported results. First, in the model using all male respondents in cohabiting relationships during Wave III, there is no association between self-reported health and disposition of the cohabitation in the model limited to male

respondents. While we might assume that men overstate their health, were men's health predictive of the outcome of cohabitation, we would still expect that those in poor health would be less likely to transition to marriage than their healthier counterparts. Second, even when men's health status is included as a control in the couple's sample data, I still find a significant association between women's health status and the outcome of a cohabiting relationship.

Another related concern is the singular use of self-reported health to measure health. As a general prediction of health it performs well, but there are concerns about what it seems to be measuring. To address some of this concern, I ran additional sensitivity analyses that controlled for the respondent's depression status (CES-D subscale) to test whether it was physical or psychological health that was responsible for these results. I found that including controls for depressive symptoms or using a different measure of physical health (number of physical limitations) found similar results, suggesting that the results are due, in fact, to differences in physical health.

While work on this project has generally coalesced around the results presented here, by PAA, a few additions will have been added. In addition to the 365 cohabiting couple, I will find a way to include 73 other cohabitations that I currently can determine ended but am still unsure as to when this happened. These cases correspond to cohabitations that in the Wave IV relationship calendar were not included by the respondent as having happened. Using the calendar provided, I will construct an estimate of the likely conclusion of the cohabitation. Second, I plan to include additional measures into the general Add Health analysis. While the current analysis relies on respondent specific measures, the respondent does provide reports of general information about their relationship partner (race/ethnicity, age, etc.) that I plan to include in these models.

Table 1: Description of Analytic Sample of Cohabiting Respondents in Wave III, National Longitudinal Study of Adolescent Health

| | All Respondents | | Women | | Men | |
|---|---|---|---|---|---|---|
| | Mean/Proportion | se | Mean/Proportion | se | Mean/Proportion | se |
| Self-Reported Health | | | | | | |
| Excellent | 0.30 | | 0.27 | | 0.35 | |
| Very Good | 0.39 | | 0.38 | | 0.39 | |
| Good | 0.26 | | 0.28 | | 0.22 | |
| Fair or Poor | 0.05 | | 0.67 | | 0.03 | |
| Race/Ethnicity | | | | | | |
| Non-Hispanic White | 0.58 | | 0.58 | | 0.56 | |
| Non-Hispanic Black | 0.19 | | 0.19 | | 0.19 | |
| Hispanic | 0.14 | | 0.14 | | 0.16 | |
| Asian | 0.05 | | 0.05 | | 0.06 | |
| Other Race | 0.03 | | 0.03 | | 0.04 | |
| Education | | | | | | |
| Less than High School | 0.13 | | 0.12 | | 0.16 | |
| High School | 0.48 | | 0.47 | | 0.48 | |
| Some College | 0.32 | | 0.32 | | 0.30 | |
| College or More | 0.07 | | 0.09 | | 0.06 | |
| Cohabitation Outcome | | | | | | |
| Still Cohabiting | 0.09 | | 0.09 | | 0.09 | |
| Relationship Ended | 0.33 | | 0.32 | | 0.34 | |
| Married | 0.58 | | 0.59 | | 0.57 | |
| Age | 22.31 | 0.03 | 22.16 | 0.04 | 22.54 | 0.05 |
| Cohabitation Duration (Months) | 81.26 | 0.65 | 83.37 | 0.84 | 77.96 | 1.03 |
| Cohabitation Observed at: | 27.12 | 0.36 | 28.78 | 0.48 | 24.52 | 0.53 |
| | | | | | | |
| N | 3431 | | 2093 | | 1338 | |

Table 2: Sex-Stratified Multinomial Logistic Models Predicting Cohabitation Outcomes Comparing Risk of Marriage to Risk of Cohabitation Dissolution (Outcome of Continuing Cohabitation Not Shown), National Longitudinal Study of Adolescent Health

| | Women | | | Men | | |
|---|---|---|---|---|---|---|
| Self-Reported Health (ref=Excellence) | RRR | SE | p | RRR | SE | p |
| Very Good | 0.84 | 0.13 | | 0.94 | 0.14 | |
| Good | 0.71 | 0.13 | ** | 1.03 | 0.16 | |
| Fair or Poor | 0.53 | 0.21 | ** | 0.74 | 0.32 | |
| | | | | | | |
| Age (Wave III) | 1.31 | 0.03 | *** | 1.26 | 0.04 | *** |
| | | | | | | |
| Education (ref=Less than HS) | | | | | | |
| High School or Equivalent | 1.09 | 0.16 | | 1.05 | 0.17 | |
| Some College | 1.06 | 0.16 | | 1.02 | 0.19 | |
| College or More | 1.04 | 0.23 | | 1.09 | 0.30 | |
| | | | | | | |
| Race/Ethnicity (ref=Non-Hispanic White) | | | | | | |
| Non-Hispanic Black | 0.35 | 0.13 | *** | 0.46 | 0.16 | *** |
| Hispanic | 0.91 | 0.15 | | 0.92 | 0.17 | |
| Asian | 0.67 | 0.21 | + | 1.06 | 0.27 | |
| Other Race | 0.67 | 0.27 | | 0.73 | 0.30 | |
| | | | | | | |
| Constant | 0.01 | 0.66 | *** | 0.01 | 0.82 | *** |
| Log Likelihood | -1228.86 | | | -1841.05 | | |
| N | 2093 | | | 1338 | | |

+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Table 3: Sex-Stratified Competing Risk Hazard Model for Cohabitations Ending in Marriage, Couple's Sample of National Longitudinal Study of Adolescent Health

| | Female Respondents | | | Male Respondents | | |
|---|---|---|---|---|---|---|
| | SHR | SE | p | SHR | SE | p |
| Self-Reported Health | | | | | | |
| Very Good | 0.92 | 0.06 | | 0.98 | 0.08 | |
| Good | 0.81 | 0.06 | ** | 1.02 | 0.10 | |
| Fair or Poor | 0.70 | 0.10 | ** | 0.82 | 0.17 | |
| | | | | | | |
| Age | 1.11 | 0.02 | *** | 1.09 | 0.02 | *** |
| | | | | | | |
| Educational Attainment | | | | | | |
| High School | 1.18 | 0.11 | + | 1.15 | 0.12 | |
| Some College | 1.25 | 0.13 | * | 1.18 | 0.13 | |
| College or More | 1.43 | 0.19 | ** | 1.34 | 0.23 | + |
| | | | | | | |
| Race/Ethnicity | | | | | | |
| Non-Hispanic Black | 0.53 | 0.05 | *** | 0.57 | 0.06 | *** |
| Hispanic | 0.90 | 0.07 | | 0.95 | 0.09 | |
| Asian | 0.80 | 0.10 | + | 0.93 | 0.12 | |
| Other Race | 0.85 | 0.15 | | 0.83 | 0.17 | |
| | | | | | | |
| N | 2093 | | | 1338 | | |
| Log Pseudolikelihood | -876.27 | | | -5051.59 | | |

+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Table 4: Description of Cohabiting Couples in Wave III, National Longitudinal Study of Adolescent Health

| | Mean/Proportion | SE |
|---|---|---|
| Female Partner's Self-Reported Health | | |
| Excellent | 0.25 | |
| Very Good | 0.40 | |
| Good | 0.27 | |
| Fair or Poor | 0.08 | |
| Male Partner's Self-Reported Health | | |
| Excellent | 0.30 | |
| Very Good | 0.44 | |
| Good | 0.22 | |
| Fair or Poor | 0.05 | |
| Partners are the Same Race | 0.78 | |
| Female Partner's Educational Attainment | | |
| Less than High School | 0.16 | |
| High School Degree or Equivalence | 0.70 | |
| Education Beyond High School | 0.14 | |
| Male Partner's Educational Attainment | | |
| Less than High School | 0.17 | |
| High School Degree or Equivalence | 0.71 | |
| Education Beyond High School | 0.12 | |
| | | |
| Difference in Partner Ages (Years) | 1.73 | 0.18 |
| Male Partner is Very Satisfied | 0.69 | |
| Female Partner is Very Satisfied | 0.74 | |
| Duration of Cohabitation (month) | 76.27 | 1.9 |
| Cohabitation Observed at Time | 18.89 | 0.89 |

Table 5: Multinomial Logistic Models Predicting Cohabitation Outcomes Comparing Risk of Marriage to Risk of Cohabitation Dissolution (Outcome of Continuing Cohabitation Not Shown), Cohabiting Couples Sample of National Longitudinal Study of Adolescent Health

| | RRR | SE | p |
|---|---|---|---|
| Female Partner's Self-Reported Health (ref=Fair or Poor) | | | |
| Excellent | 1.96 | 0.53 | |
| Very Good | 2.80 | 0.51 | * |
| Good | 3.30 | 0.53 | * |
| | | | |
| Male Partner's Self-Reported Health (ref=Fair or Poor) | 1.00 | | |
| Excellent | 1.24 | 0.64 | |
| Very Good | 0.85 | 0.62 | |
| Good | 0.89 | 0.65 | |
| Female Partner is Very Satisfied | 3.30 | 0.30 | *** |
| Male Partner is Very Satisfied | 2.39 | 0.28 | ** |
| Partners are Same Race | 1.00 | 0.29 | |
| | | | |
| Female Partner's Education (ref= Less than HS) | 1.00 | | |
| High School | 2.97 | 0.38 | ** |
| At Least Some College | 3.70 | 0.52 | * |
| | | | |
| Male Partner's Education (ref=Less than HS) | 1.00 | | |
| High School | 1.38 | 0.37 | |
| At Least Some College | 1.50 | 0.53 | |
| Difference in Ages | 0.98 | 0.04 | |
| Constant | 0.03 | 0.96 | *** |
| | | | |
| N | 365.00 | | |

+ p<0.1; * p<0.05; ** p<0.01; *** p<0.001

Table 6: Competing Risk Hazard Model for Cohabitations Ending in Marriage, Cohabiting Couple's Sample of National Longitudinal Study of Adolescent Health

| | B | se | p |
|---|---|---|---|
| Female Partner's Self-Reported Health | | | |
| Excellent | 0.63 | 0.39 | + |
| Very Good | 0.79 | 0.37 | * |
| Good | 0.79 | 0.37 | * |
| | | | |
| Male Partner's Self-Reported Health | | | |
| Excellent | 0.11 | 0.40 | |
| Very Good | -0.04 | 0.39 | |
| Good | -0.02 | 0.40 | |
| | | | |
| Female Partner is Very Satisfied | 0.72 | 0.22 | ** |
| Male Partner is Very Satisfied | 0.56 | 0.20 | ** |
| Partners are Same Race | -0.05 | 0.18 | |
| Female Partner's Education | | | |
| High School | 0.87 | 0.29 | ** |
| At Least Some College | 1.15 | 0.36 | ** |
| Male Partner's Education | | | |
| High School | 0.42 | 0.25 | + |
| At Least Some College | 0.50 | 0.33 | |
| Age Difference of Partners | -0.02 | 0.02 | |

+ $p<0.1$; * $p<0.05$; ** $p<0.01$; *** $p<0.001$

Figure 1: Risk for a Woman's Cohabitation to End in Marriage by Women's Self-Reported Health Status, National Longitudinal Study of Adolescent Health

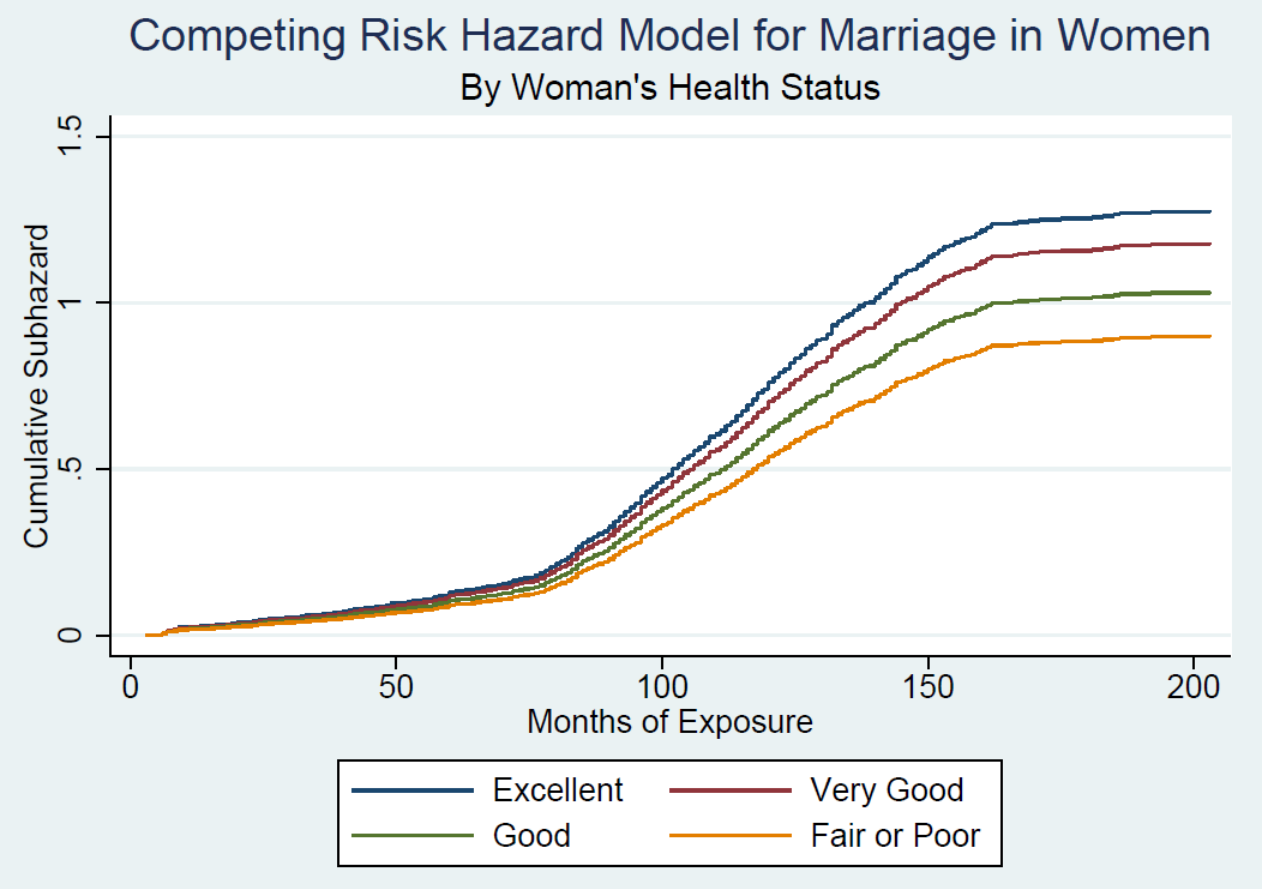
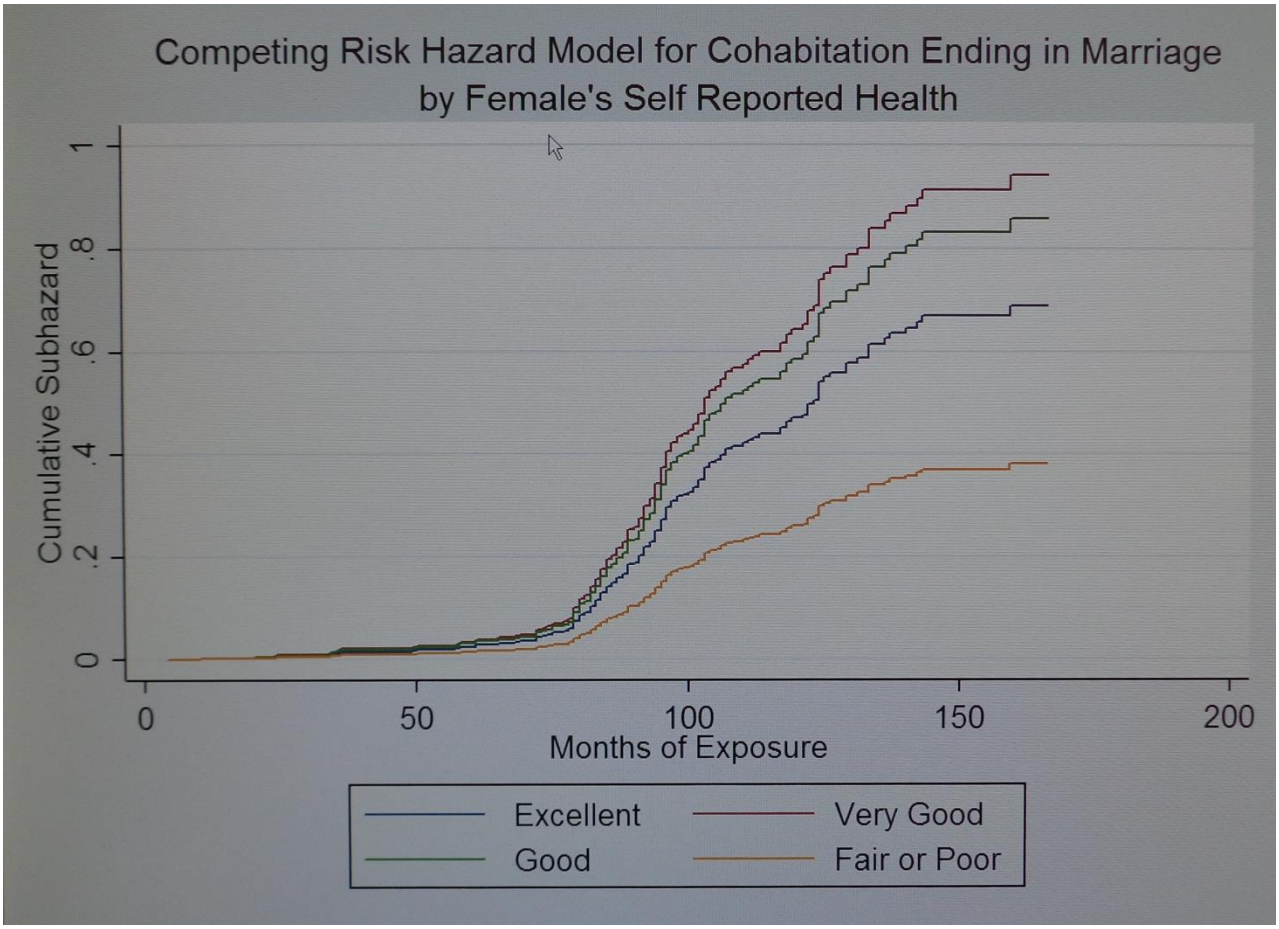


Figure 2: Risk for Cohabitation to End in Marriage by Female Partner's Self-Reported Health Status, Cohabiting Couple's Sample-National Longitudinal Study of Adolescent Health



References

Axinn, W.and A. Thornton. 1992. "The relationship between cohabitation and divorce: Selectivity or causal influence?" *Demography* 29(3):357-374.

Banks, J., E. Kelly, and J.P. Smith. 2014. "Spousal Health Effects: The Role of Selection." in *Discoveries in the Economics of Aging*, edited by D.A. Wise. Chicago, IL: University of Chicago Press.

Benyamini, Y.and E.L. Idler. 1999. "Community Studies Reporting Association between Self-Rated Health and Mortality: Additional Studies, 1995 to 1998." *Research on Aging* 21(3):392-401.

Blackwell, D.L.and D.T. Lichter. 2000. "Mate Selection Among Married and Cohabiting Couples." *Journal of Family Issues* 21(3):275-302.

Boardman, J.D. 2006. "Self-rated health among U.S. adolescents." *J Adolesc Health* 38(4):401-408.

Casper, L.and L. Sayer. 2000. "Cohabitation transitions: Different Attitudes and Purposes, Different Paths." in *Population Association of America*. Los Angeles, CA.

Casper, L.M.and S.M. Bianchi. 2001. *Continuity and change in the American family*: Sage Publications, Inc.

Clarkberg, M., R.M. Stolzenberg, and L.J. Waite. 1995. "Attitudes, Values, and Entrance into Cohabitational versus Marital Unions." *Social Forces* 74(2):609-632.

Di Castelnuovo, A., G. Quacquaruccio, M.B. Donati, G. de Gaetano, and L. Iacoviello. 2009. "Spousal Concordance for Major Coronary Risk Factors: A Systematic Review and Meta-Analysis." *American Journal of Epidemiology* 169(1):1-8.

Fu, H.and N. Goldman. 1996. "Incorporating Health into Models of Marriage Choice: Demographic and Sociological Perspectives." *Journal of Marriage and Family* 58(3):740-758.
—. 2000. "The Association Between Health-Related Behaviours and the Risk of Divorce in the USA." *Journal of Biosocial Science* 32(01):63-88.

Glantz, M.J., M.C. Chamberlain, Q. Liu, C.-C. Hsieh, K.R. Edwards, A. Van Horn, and L. Recht. 2009. "Gender disparity in the rate of partner abandonment in patients with serious medical illness." *Cancer* 115(22):5237-5242.

Goldman, N. 1993. "Marriage selection and mortality patterns: Inferences and fallacies." *Demography* 30(2):189-208.

Guzzo, K.B. 2014. "Trends in Cohabitation Outcomes: Compositional Changes and Engagement Among Never-Married Young Adults." *Journal of Marriage and Family* 76(4):826-842.

Harris, K.M., C.T. Halpern, E. Whitsel, J. Hussey, J. Tabor, P. Entzel, and J.R. Udry. 2009. "The National Longitudinal Study of Adolescent Health: Research Design."

Idler, E.L.and Y. Benyamini. 1997. "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies." *Journal of Health and Social Behavior* 38(1):21-37.

Joung, I.M.A., H.D. van de Mheen, K. Stronks, F.W.A. van Poppel, and J.P. Mackenbach. 1998. "A longitudinal study of health selection in marital transitions." *Social Science & Medicine* 46(3):425-435.

Kamp Dush, C.M., C.L. Cohan, and P.R. Amato. 2003. "The Relationship Between Cohabitation and Marital Quality and Stability: Change Across Cohorts?" *Journal of Marriage and Family* 65(3):539-549.

Le Bourdais, C.and É. Lapierre-Adamcyk. 2004. "Changes in conjugal life in Canada: Is cohabitation progressively replacing marriage?" *Journal of Marriage and Family* 66(4):929-942.

Lillard, L.A.and C.W. Panis. 1996. "Marital status and mortality: the role of health." *Demography* 33(3):313-327.

Manfredini, M., M. Breschi, and S. Mazzoni. 2010. "Spouse selection by health status and physical traits. Sardinia, 1856–1925." *American Journal of Physical Anthropology* 141(2):290-296.

Mare, R.D. 1991. "Five Decades of Educational Assortative Mating." *American Sociological Review* 56(1):15-32.

Mastekaasa, A. 1992. "Marriage and psychological well-being: Some evidence on selection into marriage." *Journal of Marriage and the Family*:901-911.

Monden, C. 2007. "Partners in health? Exploring resemblance in health between partners in married and cohabiting couples." *Sociology of Health & Illness* 29(3):391-411.

Schwartz, C.and R. Mare. 2005. "Trends in educational assortative marriage from 1940 to 2003." *Demography* 42(4):621-646.

Sköld, P. 2003. "The Beauty and the Beast — Smallpox and Marriage in Eighteenth- and Nineteenth-Century Sweden." *Historical Social Research / Historische Sozialforschung* 28(3 (105)):141-161.

Thornton, A., W.G. Axinn, and D.H. Hill. 1992. "Reciprocal effects of religiosity, cohabitation, and marriage." *American Journal of Sociology* 98(3):628-651.

Waldron, I., M.E. Hughes, and T.L. Brooks. 1996. "Marriage protection and marriage selection--prospective evidence for reciprocal effects of marital status and health." *Soc Sci Med* 43(1):113-123.

Wilson, S.E.and S.L. Waddoups. 2002. "Good marriages gone bad: Health mismatches as a cause of later-life marital dissolution." *Population Research and Policy Review* 21(6):505-533.