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WHY SHOULD I GET MARRIED: IMPLICATIONS OF CLASS AND GENDER DIFFERENCES ON HEALTH OUTCOMES FOR COHABITATING AND MARRIED BLACK COUPLES

by

Korrie Dchonn Johnson

A Thesis

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Abstract

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Health problems that disproportionately affect blacks could be regarded as a result of African American's tendency towards non-normative family patterns. Cohabitation has become a popular non-normative family formation within the United States as well as with blacks. This has led many to study the role of cohabitation on health. Scholars have compiled a long list of negative consequences of such practices, while generating another list of positive outcomes of marriage, but these studies of cohabitation might be capturing the consequences of resources and income disparities rather than cohabitation in itself. Existing studies of cohabitation, as well as marriage, neglect the role of class in differential outcomes as well as an intersectional approach. My results indicate that class improves health more than marriage and the benefits of marriage are not identical across gender with black married men reporting negative health outcomes compared to black married women.

Table of Contents

Introduction

The family institution plays an important role in the production and reproduction of inequalities. The state of a family greatly impacts the life course of children, which then, those children have children and the inequalities or benefits begin to reproduce themselves. This has led many to study the family in order to understand what practices improve the life chances of families. Family scholars have found that marriage is a social good for the well-being of families; longer life expectancy and protective factors against heart disease (Hess and Stanton 2012). Marriage is now seen as a social good for the entire nation because of the benefits that are associated with the institution of marriage (Waite and Gallagher 2000). Many of the studies conclude that the health benefits of marriage do not transfer to other family formations such as cohabitation or single parenting which are more prevalent family formations within the black community, were cohabitation and single parenting makes up 30% (the highest among any race) of the family formation and marriage 40% (US Census 2012). This trend has been interpreted as family formation differences perpetuating health disparities in the United States. Our nation's support of marriage is evident by the Defense of Marriage Act and the validation of the institution of marriage, but this support for marriage fails to account for multiple inequalities that are experienced by blacks.

Feminists have long acknowledged that different women experience different kinds of inequality (McCall 2005; Davis 2008). Differences in women are echoed again by black feminist theorists such as Ida B. Wells and Patricia Hill Collins (2000). Out of this understanding of heterogeneity among women, intersectionality was created to respond to such differences. The study of intersectionality is thus the study of multiple

dimensions of inequality which women face simultaneously. Feminists coined "intersectionality" but it has been used beyond the realm of feminist studies, one example is W. E. B. Du Bois.

While the benefits of marriage have been thoroughly researched, existing research does not, as W.E.B. Du Bois advocated, take race into account holistically. Du Bois advocated for the black population to be studied from a holistic perspective and account for the many aspects—race, class, gender, and historical development—in the black population to fully understand the impact certain institutions have on blacks (Hill 1994). This study incorporates the argument of Du Bois by revealing how the intersections of race, class, and gender more fully demonstrate the impact of marriage and cohabitation on the health of the black population.

Du Bois' holistic perspective follows the structure of intersectionality by considering different intersections of inequality such as race and class. Robert Hill (1994) stated: "Du Bois contended that a proper understanding of blacks in America could not be achieved without systematically assessing the influence of historical, cultural, social, economic, and political forces" (Hill 1994:7). While incorporating an intersectional approach, this study is guided by Dillaway and Broman (2001) who highlight the importance of structural inequalities and urge other family scholars to consider adopting an intersectional approach when studying marital satisfaction (or any other family topic) in the future. Although blacks share a common experience of race-based discrimination, within-group differences caused by differences in social location – gender, class, sexuality and disability for example – yield different outcomes (Pattillo-McCoy 1999). When we look at the results of an analysis of an entire population, such as blacks, we

might be masking subgroup differences within the black population. Therefore, an intersectional approach is best for uncovering these subgroup differences and understanding the multiple dimensions of inequality.

In the case of family formations and health, we might be looking at blacks who have low economic status and not giving those who have high economic status a story. If a majority of the sample is of low income and few are from a middle class income, our results will conclude the status of the majority which are low income families. Are those findings generalizable for the entire population of blacks or just a particular class of blacks? We might be able to learn from the middle class family formations what helps sustain the black community, which is why an intersectional approach to the topic of family formation needs to be undertaken. This study will compare health outcomes of married and cohabitating couples based on the intersection of race, class, and gender.

Race, Health, and Family Formation

Although the behaviors of blacks are generally in response to structural conditions, responses to structural conditions are often seen as black cultural deficiencies. These cultural practices have been targeted as the root cause of many inequalities and disadvantages that have disproportionately affected the black population. Daniel Moynihan for example attributed the inequalities faced by the black population to cultural practices. Moynihan published a report titled *The Negro Family: A Case for National Action* (1965) that looked at the state of the black family. This report came at the beginning of the "War on Poverty" to help address what needed to be done to lower poverty rates for blacks in the United States. Daniel Moynihan was the Assistant

Secretary of Labor when he produced this report. His study's basic findings are as follows:

> *The cumulative result of unemployment and low income, and probably also of excessive dependence upon the income of women, has produced an unmistakable crisis in the black family, and raises the serious question of whether or not this crisis is beginning to create conditions which tend to reinforce the cycle that produced it in the first instance. (Furstenberg 2007:439).*

Moynihan questioned if the state of the black family was beginning to reproduce its own inequalities through cultural practices the black family had developed. In particular, Moynihan questioned if high percentages of single parenting, out of wedlock children, high divorce rates, the lack of black fathers, and cohabitation were the root cause of a disproportionate amount of inequalities. This led to the study of black family patterns such as single parenting, cohabitation, and marriage. Moynihan acknowledged that the black middle class was achieving great success within the United States but he failed to see that the middle class was made up of more than just married couples and that class played an important role in the welfare of the black population. By pathologizing alternative family formation and ignoring the role of class in outcomes, research has privileged marriage as central to improving the status of marginalized populations especially blacks.

This perception of "black cultural pathology" has echoed throughout studies of blacks including health outcomes. Scholars agree that health problems disproportionately affect blacks. According to the CDC health disparities and inequalities report (2013), blacks have a higher infant mortality rate than whites. Blacks are also more likely to have a stroke or coronary heart disease than whites. Blacks were also more likely to have preventable hospitalizations than whites. Obesity is higher among blacks than whites.

Blacks were more likely to report fair or poor health than whites. Diabetes is also highest among blacks (CDC 2013). The CDC health disparities and inequalities report findings conclude the state of the black population's health is overall poor relative to whites. These facts are often associated with the behaviors of black family formation within the United States rather than looking at the structural and class impact on these health disparities.

Family Formations and Health Outcomes

Marriage has been identified as a mitigating mechanism for health disparities. In recent years, research has found that marriage might play a crucial role in the improvement of health (Waite and Gallagher 2000; Hughes and Waite 2009) specifically marriage has been linked to better health, both physical and mental (Proulx, Helms, and Buehler 2007).

One of the most commonly discussed returns of marriage is better physical health outcomes. Hess and Stanton (2012) report that married people enjoy a number of health benefits of being married such as better physical health, protective influence against both minor and major health issues such as colds, flu, migraine headaches, cancer, heart disease, and even heart attacks (Newton and Kiecolt-Glaser 1995). Married people are also more likely to live longer (Ali and Ajilore 2011). They are also less likely to need surgery. Hess and Stanton (2012) also report that wives are more likely to discourage drinking, smoking, unnecessary risk-taking, and also improve their family's diet. This could be a result of women's attention to healthier trends and peer pressure from social networks and media.

Not only is physical health improved by marriage but mental health is also improved. Hess and Stanton (2012) reported that married individuals had significantly lower rates of severe depression and were less likely to develop any psychiatric disorder than never-married, cohabitating, and divorced people (Waite and Gallagher 2000; Simon 2002). Hess and Stanton (2012) reported that these marital benefits did not transfer over to cohabitation or any other family formation outside of marriage. Uecker (2012) show that those who are married report higher life satisfaction that those in other romantic relationships and those who were married had lower frequency of alcoholism than those who are not married. Waite (2000) and others (Ali & Ajilore 2011) reports the same; marriage is associated with greater well-being, happiness, health, and family/job satisfaction than those who are not married.

Although the research is mixed, when gender is introduced marriage still improves the health of those who are married. Simon (2002) found that when social roles are accounted for, marriage improves the mental health of both men and women. Horwitz and White (1998) found that cohabitators (both men and women) reported higher levels of depression than married people.

Black cohabitators specifically are not often studied. Most studies assess the state of black cohabitators with cohabitation in general and when race is controlled for in the study, blacks tend to share the same results as cohabitators in general (Mullan, Lee, and DeLeone 2010). Even Census Bureau reports very little on black cohabitators let alone black middle class cohabitators (US Census 2012). What is known is that black cohabitators and single parents make up 30% of the family formations within the black community. The Census Report does not differentiate between single parenting and

cohabitating so exact numbers are not known. This, again, is potentially masking the effect of cohabitation on health in the black population. This study's focus on black cohabitators is the result of this lack of data and the growing trend of cohabitation (Waite 2000). One of the goals of this study is to increase our knowledge on black cohabitators.

The concern with most of these findings is that class and race are rarely mentioned. One of the leading works on the benefits of marriage comes from Linda Waite and Maggie Gallagher's book *The Case For Marriage* which they outline the findings that have been presented here. They themselves ask the question if marriage is the social good or if other factors facilitate better health outcomes. They come to the conclusion that marriage itself offers protective factors but they come to this conclusion prematurely. In the discussion of health benefits, race and class are never discussed as influential factors on health. Musick and Bumpass (2012) actually find that the differences and benefits of marriage are not always advantageous and might actually dissipate over time.

Much of the existing research relies on self-reported health data in which respondents are asked to rate their health on a scale ranging from excellent to poor. Self-reported health has been used in many national health surveys such as the National Health Interview Survey and has become a common question that is found in health surveys. The Centers for Disease Control also uses self-reported health in the analysis of health. Self-reported health is an important measure of health outcomes as earlier studies suggests that self-reported health is linked to health status and morbidity (the rate of having a disease or being sick). Maddox (1999), reports that self-reported health is a good predictor for health and outcomes. Maddox (1999), also reports that self-reported health

is theoretically important for health behavior and outcomes. Idler and Benyamini's (1997) study is widely known for finding that self-report health is a good predictor of mortality, or death. Their study found that self-reported health is predictive of mortality, or death, in almost all countries. Studies since Idler and Benyamini have concluded the same results: self-reported health predicts mortality (Han et al. 2005). Schnittker and Valerio (2014) find that self-reported health is becoming a more reliable measure of predicting mortality. For this study, self-reported health will be used to assess a respondent's health given its relationship to predicting mortality which covers a general account of well-being.

The Chicken or the Egg: Family Formation vs. Class

The concern now is if marriage is in itself socially beneficial or if marriage is masking other factors (such as class) that facilitate better health outcomes or perhaps if both marriage and other factors improve health outcomes. This is to say, do those who marry receive better health benefits compared to other family formations or do those who marry have previous class and health benefits that are correlated with better health?

Historically marriage has been achieved prior to economic stability making it a cornerstone within adulthood (Waite 2000). Marriage allowed for the roles of personal life to be specialized. Men specialized in economic attainment and women specialized in household stability. This approach to economic stability and family life worked and lasted within the general population, but is less visible with a growing number of women entering the labor market (Bureau of Labor Statistics 2000). This approach worked for the time period, which points to the structural adaptation of the United States; because

structurally women were not able to obtain high paying jobs or credentials to compete for such jobs.

This approach did not work for all groups within the United States. Blacks were not as likely to achieve such specialization within the family given the inequality that both men and women faced in the labor market and other social institutions (such as higher education). Black men were not able to achieve similar incomes for similar jobs (Waite 2000). Black men were not able to even achieve similar jobs as their white counterparts. This has led black women to historically be an active role within the workforce (Waite 2000).

With the expansion of economic opportunities for women during the 1960s, increased divorce rates, the civil rights movement, and women's liberation, economic independence became more of a marker of adulthood for women including black women (Waite 2000). The gains of the feminist movements allowed for women to enter colleges and obtain jobs that were once only attainable by men. Both men and women began to see economic stability as an indicator of adulthood more than marriage. The increase in divorce rates also had an impact on the views of marriage. With the increasing likelihood of divorce, independent economic stability prior to marriage allowed for the fear of economic collapse after a divorce to be eased (Waite 2000). Economic independence also allowed for women to redefine themselves through personal achievement rather than a coupling identity with men.

Historically marriage came before economic stability and was the marker of adulthood (Waite 2000), although this approach was not equally attainable, then economic stability became the marker of adulthood in the wake of women's liberation

and other beneficial structural changes. Marriage is now more of a capstone within adulthood, although marriage is not needed for achieving adulthood. This is further supported by Smock and Manning (1997), who demonstrates that male's economic circumstances (employment type, educational attainment, and earnings) have a major impact on the likelihood of transitioning to marriage. This is even repeated again five years later; Manning and Smock (2002) found males' socioeconomic status generally predict the likelihood of marriage. Women were more likely to expect marriage if their partner has achieved high socioeconomic status. Those who are college educated are more likely to get married and stay married out of any other type of educational background across all races (Manning and Smock 2002).

Those who marry are more likely to be college educated; this is referred to as educational assortative mating. Shafer and Qian (2010) found that the college educated were more likely to marry later but overall were more likely to marry than any other educational group. This is again repeated by Marsh et al. (2007) who finds that black college educated men were more likely to be married than non-college educated black men. The importance of socioeconomic status on health has also been documented within the public health discipline (Kawachi 2005; Williams 2005; Sudano and Baker 2006) this research supports the notion that health status cannot be assessed without accounting for socioeconomic status or structural differences.

These studies suggest that marriage is no longer viewed as a means of increasing economic circumstances, although many still do marry in order to join resources to further increase their social and economic well-being. This also shows that marriage itself does not increase health outcomes but that socioeconomic status and class predicts

marriages which improves health alongside of marriage. The impact of class and resources on quality of life is echoed again by Lareau ([2003] 2011), who shows that resources matter for families. Middle-class families tend to have more resources because they have more education, money, time, social, and cultural capital. With similar resources, single mothers and other family formations, e.g., cohabitators, could also have access to the outcomes these resources provide, thus I argue, class clearly matters for health outcomes.

This standpoint supports the notion that structural differences account for a great deal of health disparities. The differences between white and black health outcomes can be attributed to class, race, and gender structures. Many blacks have not been able to achieve a college degree (US Census 2012) compared to whites. The majority of blacks have not been able to achieve the standard middle class income (US Census 2013). These structural constraints on blacks are exacerbated by gender. Black women fare even worse structurally and economically which increases the health disparities of black women. Furthermore, these structural inequalities may impact the advantages and health outcomes of married blacks compared to whites. In other words, blacks might not get the same health returns to marriage because they have lower socioeconomic status and are more likely to experience structural discrimination.

The Benefits of an Intersectional Approach

Marriage has been established as a beneficial social good through the positive health outcomes that are associated with it such as better physical and mental health. The United States has promoted marriage because of the benefits associated with it (both health and economic) believing that everyone (including blacks) can benefit from cultural

practices such as marriage, possibly even helping negate some of the inequalities that are faced by the black population. In this section I suggest that taking a closer look at the intersection of race, class and gender demonstrates that this is not the case. Marriage is not created or experienced equally because of structural inequalities that are faced by different groups.

According to Davis (2008), intersectionality is the study of multiple identities and experiences of exclusion and subordination. Blacks are among one of many groups that experience many types of exclusion or inequalities. Black lower class men, while they have the title of being a male, experience class exclusion as well as race exclusion. Black women experience both racial exclusion as well as gender exclusion. When groups, such as blacks, experience multiple exclusions, it creates a situation where multiple exclusion/inequalities have to be accounted for in order to accurately assess the cause of a social ill. When studying blacks, health, and family formation, accounting for race, class, and gender inequalities allows for a more accurate understanding of health and family outcomes while accounting for multiple inequalities that might skew results. This study incorporates that holistic perspective by examining race, family formations, gender, and class forces together in an effort to better understand the impact of marriage on health by controlling for within race differences, family formation differences, gender differences, and class differences.

This intersectional approach is further supported by the works of Andrew Billingsley (1988) and his concept of ethnic sub-society. Ethnic sub-society is a concept that reflects some of the dimensions of variation within the ethnic group. His definition originates from Milton Gordon's definition of an ethnic group: a relatively large

configuration of people with a "shared feeling of peoplehood" (Gordon 1964). Gordon has stressed three social dimensions that help to capture some of the variation within ethnic groups:

> *Social class, rural or urban residence, and region of the country lived in… Thus a person is not simply a white Protestant, he is simultaneously a lower-middle class white Protestant, living in a small town in the South, or he is an upper-middle class white Catholic living in a metropolitan area of the Northeast or a lower-class Negro living in the rural south and so on … (Gordon 1964:47).*

Billingsley (1988) emphasizes here that black families should not only be compared and contrasted with other races, such as whites, but between classes, urban and rural, and southern or northern residence. Most importantly he argued that blacks should be compared and contrasted with each other across these different social locations.

Few studies to date have attempted to capture the variation within the black population. Most studies rely on comparison analysis of blacks and whites which doesn't allow for a discussion of just one race. We have learned much from the comparison of blacks and whites, as suggested above in the literature review, but those studies have only acknowledged that many structural inequalities shape the health outcomes of blacks compared to whites. As scholars, we should begin to identify ways in which we can improve the structural inequalities that previous research has brought to light. In order to begin identifying ways to improve the black population, a comparison of different blacks needs to be undertaken. In this comparison we will begin to understand the differences that shape the outcomes of working class blacks and middle class blacks.

This lack of data within the black community has hindered our understanding of differences within the black community which has been echoed by Mary Pattillo-McCoy (1999), as she argues that even though the black middle class has achieved middle class

status, they still face inequalities within the middle class therefore the black middle class should be studied as well as low income blacks. Furthermore, she argues that the success of the black middle class changes from decade to decade with the changes in the mode of production and the economic structure of the United States. Patillo-McCoy also points out the resources that the black middle class have been able to acquire, such as better schools, safer neighborhoods and better social networks relative to poor black neighborhoods, which are important to understanding how upward mobility can improve the lives of low income blacks. Capturing the differences of subsystems in the black family within the black population should introduce a new understanding and concept of the impact of such subsystems.

The lack of attention of class on social ills, such as health outcomes, while studying blacks is the focus of this study. Although previous research suggests marriage being beneficial to better mental and physical health outcomes, this study explores the relationship between blacks, class, gender, marriage and cohabitation, and health outcomes. This study is concerned with the impact of family formation on health outcomes in the black population across class, race, and gender. Does family formation affect general (perceived) health? Are there social class differences in this relationship? That is, are the health advantages of being married explained away by accounting for the mediating impact of social class? Are there health differences between black men and black women? How do middle class women differ in health outcomes from non-middle class women? How do middle class men differ in health outcomes from non-middle class men? Do black men and women health outcomes respond to marriage and cohabitation differently?

Methods

Data. The data used in this study comes from the 2012 National Health Interview Survey (NHIS). The Interview was administered by the United States Census Bureau and the data is maintained by the Center for Disease Control. The data sets include 16,771 black respondents. To participate in the Interview the individual had to be 17 years old or older. Respondents were interviewed within the household of the respondents. The National Health Interview Survey is a cross-sectional household interview survey. The sampling plan follows a multistage area probability design that permits the representative sampling of households and non-institutionalized group quarters. The National Health Interview Survey purposely oversamples both black persons and Hispanic persons. For a full description of this data set, visit the Center for Disease Control's National Health Interview Survey website (US Census 2012).

Sample Selection. Because this study is focused on social class and gender differences in the relationship between health and marital status within the black population, a group for which we are still building an understanding of class (and other subsystem) differences, I will only be using data from black respondents. NHIS oversampled for the purpose of having additional underrepresented respondents. Data collected for this study comes from the year 2012, the most recent year data were collected. From here I stratified the sample by the best available data confining this study to a sample of 4,152 black married respondents and 896 black cohabitating respondents with incomes available for the previous year, resulting in an analytic sample size of 5,048. Single blacks were not included in the sample given the focus on married and cohabitating family formations. Cohabitation is used in the study because there is a lack

of data on black cohabitators, a growing trend in cohabitation amongst all races, and an interest in understanding the role of cohabitation within the black population.

Measures. The dependent variable consists of self-assessed health status, e.g. self-reported health. Self-reported health is labeled as PHSTAT in the NHIS and is asked in the following way; "Would you say your health in general is excellent, very good, good, fair, or poor?" For this study, self-reported health was recoded making "fair" and "poor" one category (poor) and "excellent", "very good", and "good" into another category (excellent) making our dependent variable dichotomous.

The primary independent variables consist of family formation/marital status (single, divorce or widowed, married, and cohabitation), and a black middle class index (BMCi). In the NHIS 2012 Person File codebook, the name for marital status is R_MARITL (marital status). R_MARITL is based on the question "Are you now married, widowed, divorced, separated, never married, or living with a partner?" R-_MARITL has several possible answers for married (spouse in household, spouse not in household, spouse in household unknown) so these answers were recoded into one category, married. The response "living with partner" is considered to be the cohabitating respondents in this sample. The response "single" stayed the same (although it is not used) and "divorced, widowed, and separated" is recoded to the category "others". The response "unknown marital status" was dropped.

The black middle class index was created from household income, home ownership and education based on a study by Marsh et al. (2007) study. Marsh et al. (2007) created this index to explain the changing family patterns of the black middle class and to have a more robust account of middle class status than previous researchers.

Middle class is such a loosely defined category that using the most robust account of middle class is the best way to account for the validity of middle classness. Such a robust account for middle class status also has racial implications. The black middle class sample is drastically reduced given that the black middle class is smaller than the white middle class. In the NHIS 2012 Family File codebook, the variable name for education is FM_EDUC1 and home ownership is HOUSEOWN. FM_EDUC1 is based on the question "Education of adult with highest education in family" and HOUSEOWN is based on the question "Is this house/apartment owned or being bought, rented, or occupied by some other arrangement by [you/or someone in your family]?" For the index, a person received a point on the index if they owned a house. A person received another point on the index if they also had at least a bachelor's degree. The other component of the index is household income, as described below.

To accurately assess household income Marsh et al. (2007) used a formula to account for the number of children in the household and the number of adults. This formula would better assess if the household was truly middle class or not. In this study, household income is calculated using three variables: number of adults, number of children and household income. In the NHIS 2012 Family File codebook, the name for number of adults is FM_SIZE, number of children is FM_KIDS and household income is INCGRP2. FM_SIZE is based on the question "Size of Family," FM_KIDS is based on the question "number# of family members under 18 years of age" and INCGRP2 is based on the question "Total combined family income (grouped)." INCGRP2 was recoded by the median of each group so that the variable would be a scale instead of a category (Income_Recode_HH).

The family and children file must be grouped together to account for number of children in the household, and this was done by merging the datasets based on a unique identifier (HHXFMX). This allowed for families with children to be grouped together. The actual measure of per person household income was calculated using the following formula:

$$\frac{(\text{Income\_Recode\_HH})}{(\text{FM\_SIZE} \div \text{FM\_KIDS})}$$

Or Income_Recode_HH divided by the quotient of FM_SIZE and FM_KIDS. According to the 2013 Census poverty line, an individual with no children had to earn $12,000 dollars a year or less to be considered in poverty. This poverty threshold is used in this study. A person received a point on the index if their individual income (accounting for other family members) was over $12,000 a year.

The black middle class index is based on a 3 point scale. In order to be considered as middle class for this study a respondent has to have a 3 on the index. To get a 3 on the index, a person must have a college degree, own a home, and have earnings above the poverty line. The total number of middle class respondents is approximately 400 (5.6%). The resulting middle class sample size is also a product of missing data. 47% of the respondent's income information is missing within this sample because income information was not given. Respondents who did not know their income were allowed to leave the answer blank. The Centers for Disease Control created a separate data set that predicted the income of respondents who did not give an actual income amount. This additional data set was not added to this study because of the time constraints and complexity of merging three data sets.

Other control variables were health coverage, region, race, and age. Sex is controlled for because women and men experience inequalities differently and therefore sex is an important indicator. Health coverage is controlled for because the differences in self-reported health could be a product of health coverage. Regional difference in obesity might skew our findings especially since most blacks live in the south, so region is controlled for. Finally, age matters for class because those under the age of 25 are less likely to own a house but typically report better health. In the 2012 Person File codebook, sex is labeled as SEX, health coverage is labeled as NOTCOV, region is labeled as REGION, race is labeled as RACREI3, and age is labeled as AGE_P. SEX is based on the question "[Are/Is] [you/person] male or female?". This study splits respondents by sex in order to capture gender differences. NOTCOV is based on the question "Cov stat as used in Health United States," and this question identifies if the person has health coverage or not. REGION is based on the question "region" which is based on whether the respondent lived in the South, Northeast, Midwest, or West. REGION is recoded into a dichotomous variable making "South" one category and combining all other regions into one category (not the south). RACREI3 is based on the question "What race or races do you consider yourself to be? Please select 1 or more of these categories." RACRECI3 is recoded by NHIS based on the respondent's answer to race (respondents who chose multiple races were recoded as such unless a primary race was selected). For this study, those who chose only black as a race were selected since interracial marriage and dating only accounts for a small proportion of family formations. AGE_P is based on the question "Age." Age is recoded; 1-24 were made one category, 25-54 were made one category and 55 and older were made into one category. This study only includes the age

category 25-54 which is based on Marsh et al. (2007). The weight used in this study is WTFA.

Analytic Plan. This study uses SPSS statistical analysis software version 21. This study also uses a Logistic Regression to indicate if marriage vs. cohabitation affects self-reported health and whether class mediates this relationship. An intersectional approach here includes looking at race, class, and gender together.

Model 1A:

Model 1A tests the relationship between family formation (Marriage and Cohabitation) and self-reported health for males. Hypothesis 1: Previous research suggest that a significantly positive relationship between marriage and self-reported health for males.

Model 1B:

Model 1B tests to see if the relationship's strength stays consistent after the introduction of class (BMCi) for males. Hypothesis 2: I expect to see class as a significantly positive indicator of self-reported health, thereby mediating the relationship between marriage and health for males.

Model 1C:

Model 1C tests to see if the relationship's strength stays consistent after the introduction of class (BMCi) while controlling for other variables (e.g. region and health coverage). Hypothesis 3: I expect that the relationship between social class and health will remain robust after the introduction of pertinent controls for males.

Model 2A:

Model 2A tests the relationship between family formation (Marriage and Cohabitation) and self-reported health for females. Hypothesis 4: Previous research suggests that a

significantly positive relationship between family formation and self-reported health for females.

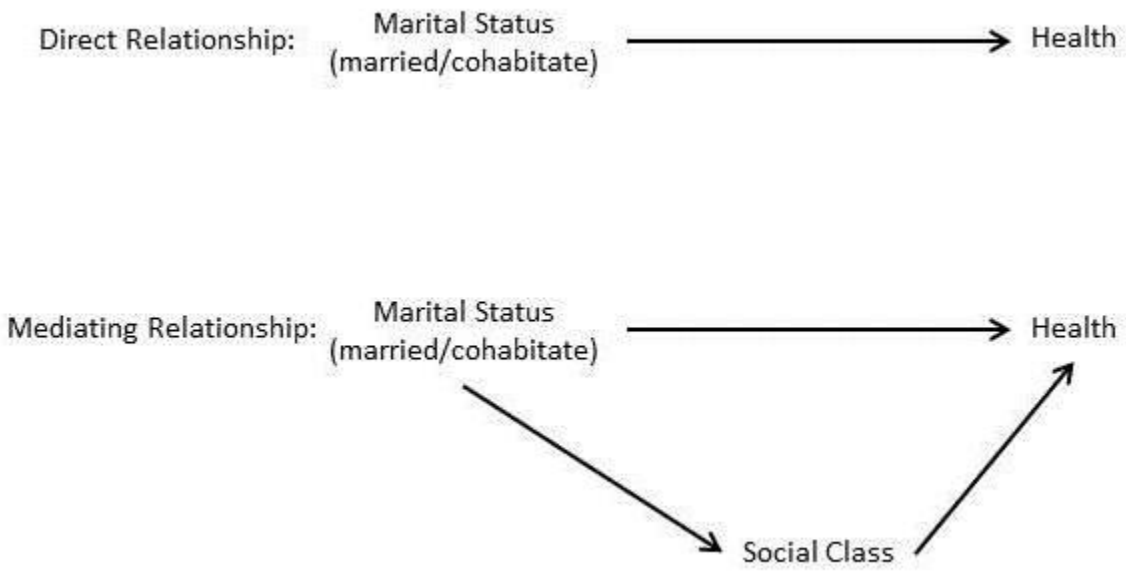
Model 2B:

Model 2B tests to see if the relationship's strength stays consistent after the introduction of class (BMCi) for females. Hypothesis 5: I expect to see class as a significantly positive indicator of self-reported health, thereby mediating the relationship between marital status and health for females.

Model 2C:

Model 2C tests to see if the relationship's strength stays consistent after the introduction of class (BMCi) while controlling for other variables (e.g. region and health coverage). Hypothesis 6: I expect that the relationship between social class and health will remain robust after the introduction of pertinent controls for females.

A graphical illustration of the conceptual model is included below:



Results

The results provide some support for my assumptions. Hypothesis 1 predicted a significantly positive relationship between marriage and self-reported health for black males. The results of this study support this hypothesis. As shown in Table 1, black married males were 1.076 more likely to report better self-reported health compared to cohabitating black males.

Hypothesis 2 predicted a significantly positive relationship between class and self-reported health, thereby mediating the relationship between marriage and self-reported health for black males. The results support this hypothesis. After the introduction of class (BMCi) marriage no longer predicted better health, furthermore, marriage worsened health outcomes. As shown in Table 1, middle class black males are 2.4 times more likely to report better self-reported health compared to those who are not middle class, this is for married men and cohabitators alike. Also, married men were 10% less likely to report better health compared to cohabitators.

Hypothesis 3 predicted that class would stay a significant positive indicator of self-reported health after the introduction of important control variables. After the introduction of health coverage and region, class still remained a significant positive indicator of self-reported health. As shown in Table 1, black males with health coverage were 1.2 times more likely to report better self-reported health. Black males outside of the South were .9 times more likely to report poorer self-reported health.

Table 1: Men

Variables	Model 1a		Model 1b		Model 1c	
	OR	95% C.I.	OR	95% C.I.	OR	95% C.I.
Marriage vs. Cohabitation	1.076***	1.065-1.088	.948***	.938-.959	.907***	.897-.917
BMCi (not middle class vs. middle class)			2.414***	2.374-2.455	2.364***	2.324-2.404
Health Coverage (not covered vs. covered)					1.184***	1.171-1.197
Region (not living in the south vs. living in the south)					.885***	.877-.893

*.05 level, **.01 level, ***.001 level

Table 1: Males

Hypothesis 4 predicted a significantly positive relationship between marriage and self-reported health for black females. The results find this hypothesis to be true. As shown in Table 2, married black females were 1.2 times more likely to report better self-reported health than cohabitating black females.

Hypothesis 5 predicted a significantly positive relationship between class and self-reported health, thereby mediating the relationship between marriage and self-reported health for black females. As shown in Table 2, the results indicate that class has a significantly positive relationship with self-reported health, although there was not a mediating factor for marriage. Black middle class women are 3.4 times more likely to report better self-reported health than those who are not middle class across family formations.

Hypothesis 6 predicted that class would stay a significant positive indicator of self-reported health. Table 2 provides the results of introducing control variables which support this hypothesis. After introducing health coverage and region, class remained a significant positive indicator of self-reported health, marriage remained significantly

positive as well. Black women with health coverage were 1.3 times more likely to report better self-reported health. Black women outside of the South were 1.2 times more likely to report better self-reported health.

Table 2: Women

Variables	Model 1a		Model 1b		Model 1c	
	OR	95% C.I.	OR	95% C.I.	OR	95% C.I.
Marriage vs. Cohabitation	1.485***	1.470-1.500	1.261***	1.248-1.274	1.239***	1.226-1.252
BMCi (not middle class vs. middle class)			3.516***	3.463-3.569	3.416***	3.365-3.467
Health Coverage (not covered vs. covered)					1.275***	1.261-1.288
Region (not living in the south vs. living in the south)					1.184***	1.175-1.194

*.05 level, **.01 level, ***.001 level

Table 2: Females

Discussion and Conclusion

The disproportionate negative health outcomes are a result of mostly class differences not cultural practices and family formations as previous studies have reported. The choice of family type, whether it is marriage or cohabitation is a result of preference and structural inequalities to which blacks have responded. Family scholars that reported health benefits of marriage seem to have neglected to account for class and multiple dimensions of inequality and its effect on health for blacks. Furthermore, the "black culture pathology" (Moynihan 1965) appears to stem from class and multiple dimensions of inequality as well. While marriage does have some benefits, at least for black women, these results are not as robust for blacks as previous studies have suggested for the general population. The impact of marriage on blacks is only marginal while class greatly

impacts and improves the health of blacks, both men and women. Although the answer is complex, for blacks, class matters more than marriage for health outcomes, concluding that class improves health. Finally we see that an intersectional approach has greatly improved our understanding of black family formation, class, gender and health.

As far as black cohabitators, being middle class improves their health as well more than them transitioning to marriage. Also, the fact that black cohabitators can be middle class allows for us to begin understanding cohabitation's role within the black population. It is unclear whether cohabitation is an alternative family formation or a transition to marriage (Osborne, Manning, and Smock 2007) for blacks but they do exist within the middle class population. Cohabitation on average doesn't last longer than two years and ends in either marriage or dissolution (Smock 2000). The actual proportion of black middle class cohabitators has not been calculated but within this study, cohabitators accounted for 16.7% of the sample and black middle class cohabitators accounted for 2.5% of the sample. Other studies that look at black family formations (Marsh et al. 2007) do not accurately assess cohabitators in their study and their results indicate that there is a growing single and living alone population within the black middle class but fail to interpret the status of cohabitators (although it is difficult to interpret everything in the results of an intersectional approach). Future research on the black middle class should account for the growing diversity of family formations within the black population, including cohabitation.

Using an intersectional perspective produces a more nuanced look at the benefits of marriage. When we examine the benefits of marriage through class we see that the relationship favors class. Class produces the benefits of marriage that were previously

examined, rather than marriage itself being the social good. The results of this study are complex but reveal a different story about the black middle class and marriage. Blacks' poorer health outcomes are not solely related to family formation but to differences in class.

For black men, marriage negatively impacts self-reported health but this impact, although statistically significant, is minor. Since black families are more likely to be egalitarian (Vespa 2009) and black men are less likely to be satisfied in egalitarianism relationships (Dillaway and Broman 2001), this could be a product of gender roles within the black family. Further research is needed to assess black married men's negative self-reported health. The other side is that class is a strong indicator of self-reported health. Black middle class men are 2.4 times more likely to report better health compared to black men who are not middle class. This is a dramatic difference in health outcomes that possibly point to structural differences in class. Patillo-McCoy highlighted that resources are clustered in middle class neighborhoods and are not easily accessible to other neighborhoods such as low income neighborhoods and this clustering of resources may account for class differences in health outcomes. These resources include better food options and even health care options which impact health. As we see in Table 1, marriage does not increase self-reported health for men.

For black women, marriage has some benefits. As we see in Table 2, marriage improves the health of black women. This could be accounted for by the social ties and the social meaning of having a significant other and the stigma that comes with not being married. Studies have shown that social ties do improve health outcomes and this could be the case for black women who experience the double minority status of being black

and being a woman (Hill 2013). While there is a positive relationship between marriage and self-reported health, this relationship does not contend with the benefits of class. Black middle class women were 3.4 times more likely to report better health than black women who were not middle class. This finding compared to family formations (married black women were 1.3 times more likely to report better health) shows that the benefits of class outweigh that of family formation. In other words, you are likely to receive a bigger benefit from middle class status than from marriage although both do benefit black women.

Although the control variable REGION did not influence or change the impact of class, the control variable does add to this study. In particular black women's and black men's reported health varied differently by region. For black men, living in the south contributed to better health, although marginally but still significant, where for black women living outside the south was associated with better health. This could be the result of multiple inequalities such as the gender roles in the south, the lack of healthy resources in the south, the educational differences between regions or the overall obesity differences between regions. Further research is needed to assess these differences between region.

Future directions for researchers could look to expand our knowledge on the role of cohabitation within the black population. In general, cohabitation only lasts approx two years (Smock 2000). This has led many scholars to conclude that cohabitation is a short lived transitional period to marriage or dissolution. Since we see a growing trend in cohabitation, it would be ideal to reexamine the time span of cohabitation within the black population. Since there is a black middle class cohabitating population, their

average length might exceed the general population. Also, black middle class cohabitators might differ in other ways such as happiness and relationship satisfaction. Happiness and positive relationship satisfaction has been found to be a product of marriage (Waite 2000), but since we know that class impacts health, the differences between marriage and cohabitation, in regards to happiness and relationship satisfaction, might also be a result of class differences. Future research should look into the role of class on other perceived benefits of marriage such as happiness and relationship satisfaction. The comparison of blacks within the black population has been undertaken and a future approach should compare whites within the white population as well as other racial groups. This type of comparison could theoretically show the differences (or likeness) between many groups and classes. Furstenberg (2007) has shown that previous studies compared races by classes and this approach has shown that races have more in common when compared across class. If future studies begin to reincorporate this approach, we might begin to understand the impact of class on all races.

In conclusion, marriage matters for health outcomes, although it does so differently for black men and black women. However, class is a more powerful predictor of good health for both black men and black women. We should begin incorporating an intersectionality approach in all studies of the black population given the different inequalities that shape the black population experience. We now see that there is no simple way of examining the black population, possibly any population in general, and when we do attempt to generalize the findings of an entire population who is negatively affected by inequalities, we will miss the full story.

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Appendix

Descriptive Statistics

Variable	Description	Metric	Mean	S.D.
Dependent Variable				
Self-Reported Health	Would you say your health in general is excellent, very good, good, fair, or poor?	0 = Poor 1 = Excellent	.8490	.00277
Demographic Variables				
Race	Race is black	0 = no 1 = yes	1.000	.000
Region	Region	0 = South 1 = Not South	.4472	.00008
Sex	[Are/Is] [you/person] male or female?	0 = male 1 = female	.5336	.00008
Health Coverage	Cov stat as used in Health United States	0 = not covered 1 = covered	.8390	.00006
Marital Status	Are you now married, widowed, divorced, separated, never married, or living with a partner?	0 = Cohabitation 1 = Married	.8208	.00011
Black Middle Class Index	Index to determine black middle class status	0 = not middle class 1 = middle class	.0622	.00006