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Review article

Union and Family Formation During Young Adulthood: Insights From the Add Health

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A B S T R A C T

Family formation patterns among US young adults are shifting, reflecting an accelerating retreat from marriage coupled with significant increases in cohabitation and nonmarital childbearing. Drawing on a selection of published longitudinal studies, this article reviews key contributions to the literature on these trends in union and family formation that have stemmed from research conducted using the National Longitudinal Study of Adolescent to Adult Health, or Add Health. Add Health is integral to deciphering the adolescent precursors to young adult union formation and childbearing, allowing researchers to gauge the roles of multiple social contexts such as family, schools, peers, and adolescent romance, with attention to variation across racial-ethnic groups and by socioeconomic status. In turn, researchers use Add Health to assess how young adult family formation behaviors are related to numerous indicators of health and well-being, ranging from mental and physical health to relationship quality and stability, interpersonal violence, and crime. With its sibling and couples samples, genetic data, and detailed partnership histories for both different- and same-sex relationships, Add Health is an invaluable data source for tracking the familial experiences (formation and dissolution) of a large cohort from adolescence into middle age.

IMPLICATIONS AND CONTRIBUTION

Add Health data are uniquely suited for examining the adolescent precursors to cohabitation, marriage, and childbearing and the ramifications of these family formation behaviors for subsequent health and well-being, whether during young adulthood or as the cohort ages into midlife.

Young adulthood is a demographically dense period of the life course that is often marked by the initiation of family formation behaviors, such as cohabitation, marriage, and childbearing [1]. Family formation occurs alongside other markers of adult status that characterize young adulthood, including the completion of schooling and the assumption of employment, which are intertwined with family building [2]. The timing and sequencing of family behaviors are shifting in the United States as cohabitation has supplanted marriage as the dominant first union type and first births increasingly occur outside of marriage, often to cohabiting parents. Meanwhile, young adults are waiting longer to wed as the median age at first marriage hovers around 30 in the United States [1].

These changing family formation patterns are the subject of a burgeoning literature that encompasses research on the trends, antecedents, and consequences of union formation and childbearing. Much of this research relies on the National Longitudinal Study of Adolescent to Adult Health (Add Health) because its study design has several unique features that make it especially well-suited for investigations of union and family formation [3,4]. Respondents were first interviewed in 1994–1995 (Wave I)

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when they were in grades 7–12 with follow-up interviews of respondents still in secondary school (grades 8–12) conducted roughly 1 year later (Wave II, 1996), providing a critical lens on early developmental processes and life course events. In turn, researchers can link these adolescent experiences with young adult behaviors and outcomes, which were measured initially in Wave III (2001–2002) when respondents were ages18–26 and again in Waves IV (2008, ages 24–32) and V (2016–2018, ages 33–43). Importantly, the Add Health design ensured a racially and ethnically diverse sample, permitting researchers to examine both group differences and within-group variation in family behaviors [3], an invaluable feature given both long-standing racial-ethnic differences in cohabitation, marriage, and childbearing and the accelerating growth in non-White and multiracial populations, which partially reflects increasing levels of interracial unions, including intermarriage, and childbearing. Also, Add Health captures sexual identity along with same-sex partnerships, measures that are core to the rapidly expanding knowledge base on the dynamics of same-sex partnerships during young adulthood [5].

Additional study components augment the developmentally rich longitudinal data collected from the Add Health cohort. Information about the neighborhoods, counties, and states in which respondents reside, including economic, demographic, and policy indicators, enable researchers to move beyond individual-level factors to assess the role of the larger socioeconomic-political context on family formation behaviors [6,7]. Another innovative feature of Add Health is its collection of biospecimens that began in earnest in Wave III, which scholars use to investigate the intersections between social and biological factors in family building [8,9]. Add Health also incorporates genetic samples, including sibling pairs, permitting methodologically rigorous examinations of within-family variation in young adult union formation and childbearing patterns [10,11]. Finally, two study components that may be of particular interest to union and family formation scholars are couple-level datasets [12,13]. In Wave I, respondents could nominate their romantic or sexual partners and those who were in the sample (typically from saturated schools) were combined into a romantic pair dataset. In Wave III, a random sample of respondents was asked to recruit their romantic partners to complete the entire Wave III survey and provide biospecimens, producing a quota sample of 500 dating, 500 cohabiting, and 500 married couples.

This combination of features is unique to Add Health and provides distinct advantages over other large national datasets for scholars examining union and family formation. For example, the National Survey of Family Growth is a repeated cross-sectional study with detailed information on cohabitation, marriage, and fertility spanning decades for women (and more recently men) of childbearing age, but it lacks a developmental component that allows researchers to examine potential mechanisms underlying family demographic behaviors in a longitudinal perspective [14]. It also lacks the extensive measures of health and well-being that characterize Add Health. The 1997 National Longitudinal Study of Youth (NLSY) biennially tracks a cohort from adolescence into young adulthood, but its measures of cohabitation are less detailed, the data do not capture sexual identity, and only very recently did NLSY begin to measure the gender of respondents' partners [15]. The sample sizes of the National Survey of Family Growth and the NLSY are roughly half that of the Add Health and their samples are also less racially and ethnically diverse. In short, the Add Health enjoys several notable methodological advantages that set it apart from other data sources.

The goal of this review article is to describe the unique contributions to the field that have emerged from research on union and family formation using Add Health data. Studies were selected for potential inclusion in the review using the search engine on the Add Health web page to identify published longitudinal research on the basis of several key terms, namely "marriage," "cohabit[ation]," "union formation," "childbearing," and "fertility." This search resulted in a lengthy list of articles and books, from which the articles cited in this review were selected according to the guidelines provided by the coeditors of this special supplement showcasing a quarter century of Add Health research on the implications of adolescence for adult health and well-being. Specifically, the guidelines stipulated prioritizing research that takes advantage of the longitudinal design of the Add Health to link adolescent experiences (captured in Waves I and II) with young adult outcomes (measured in Waves III and IV). This thematic review centers on research on union and family formation that addresses disparities across demographic factors (e.g., age, sex/gender, race ethnicity, immigrant status, sexual minority status), takes account of social context (e.g., parents, peers, romantic partners, neighborhoods, schools, policy), or considers the roles of biological or genetic factors.

Research using Add Health data has been central to painting a portrait of early family formation, including patterns of same-sex partnerships. By drawing on the first two waves of data, family scholars have deciphered the developmental precursors of young adult family formation, elucidating how parental, peer, and romantic relationships as well as the family and the larger educational and social environments of adolescence are linked to entry into cohabitation, marriage, and parenting in young adulthood [13,16–19]. Add Health is also a premier data source for assessing how family formation influences the health of young adults, and identifying the roles played by earlier life experiences that often exert enduring effects [8,12,20,21]. Throughout the article, I attend to variation in family behaviors by race ethnicity and socioeconomic status. I conclude with a discussion of future directions for research on family formation as the Add Health cohorts ages into midlife.

Union and Family Formation Patterns

During the transition to adulthood, women experience varied family formation pathways. Drawing on the detailed union and fertility histories obtained in Wave III, Schoen et al. [22] estimated a series of multistate life tables to track women's early adult family formation behaviors up to age 24. They found that the most common family behavior during this stage of the life course was cohabitation with nearly three-quarters (72%) of women having formed a nonmarital coresidential union. These cohabiting unions were more than twice as likely to end through separation than to culminate in marriage. Indeed, marriage was unusual among young women; just 33% married by age 24. Childbearing was experienced by a larger share of women as nearly two in five (38%) had a first child by age 24. Only one-quarter of these births were marital. Nearly half (46%) were to single mothers and another 28% were to cohabiting mothers. Schoen et al. [22] concluded that the routes to family formation during young adulthood can be classified into four categories: marriage among nonparents (24%), single parenthood (28%), cohabitation only (25%), and no family transitions (23%).

Family formation behaviors differ by racial-ethnic group. Young women identifying as Black exhibited relatively low levels of cohabitation and marriage and a high level of childbearing. One-half were in the single parenthood category and another one-quarter were in the no transitions category, meaning the remaining one-quarter were split between the marriage before parenthood and cohabitation-only categories. For Mexican American women, the modal category was single parenthood (35%) with marriage before parenthood a close second (30%). Mexican American women more often experienced no transitions (22%) than only cohabitation (13%). For White women, union formation was relatively common with 28% experiencing cohabitation only and another 28% in the marriage before parenthood category. Single parenthood and no transitions each constituted the experiences of about 21% of White women [22].

Socioeconomic status is closely linked with young women's early family formation behaviors [23]. Maternal education was negatively associated with cohabitation and childbearing during early adulthood and positively related to making no family transitions during this life course stage. The linkage with marriage was generally negative although the role of maternal education was rather modest. Maternal education tended to have larger effects on the family building behaviors of young women who identified as White than as Black, underscoring the distinct associations evident between socioeconomic status and family formation for young women by race-ethnicity. Moreover, these unique effects illustrate the importance of gauging both racial-ethnic and socioeconomic variation in early family building behaviors [23].

Although several studies have tracked the family formation behaviors of young women, few have explicitly modeled same-sex union formation. A notable exception is work by Prince et al. [6] which investigated union formation among sexual minorities. They found that the median age at first same-sex union formation was about 1 year older than first different-sex union formation. For men, the median age at first same-sex union formation was 23.8 versus 22.4 years for first different-sex union formation. The analogous figures for women were 22.1 and 20.9 years. Add Health first measured sexual orientation identity in Wave III. In an analysis predicting first union formation by Wave IV among sexual minorities who had never formed a union at Wave III, Prince et al. determined that nearly 60% of sexual minorities identified as bisexual (vs. mostly or 100% homosexual). Nearly half of sexual minorities formed a first union between Waves III and IV, with 25% forming a different-sex union and 21% forming a same-sex union. The odds of forming a same-sex union were lower among sexual minority women than men but did not appreciably differ by race-ethnicity or familial socioeconomic status. In comparison, nearly two-thirds of young adults identifying as heterosexual formed a first union [6].

A Life Course Perspective on Union and Family Formation

The patterns of union and family formation that mark young adulthood reflect circumstances and events experienced earlier in the life course. Encompassing detailed information on the family environment, including family structure and stability, parent-child relationships, and economic resources, as well as measurement of adolescent romantic relationships, sexual behaviors, and pubertal timing, the Add Health data are uniquely suited for uncovering the adolescent precursors of cohabitation, marriage, and childbearing during young adulthood. In line with a life course perspective, which points to the role of developmental processes linking life stages, numerous Add Health studies have tied adolescent experiences to young adult outcomes [13,17–19].

The family environment is key to child and adolescent development and it has enduring consequences for the transition to adulthood, including union and family formation behaviors [13,24,25]. For decades, family scholars have known that children who grow up outside of married two biological parent families tend to experience earlier family formation, whether through marriage or childbearing [26]. Add Health has contributed to significant advances in this line of inquiry. For instance, the inclusion of cohabitation histories in Wave III was a notable innovation that allowed researchers for the first time to examine the precursors of not just marriage entry but also the formation of cohabiting unions, capturing the ongoing rapid acceleration in cohabitation among young adults [13].

Family structure and stability

Parental union status and family processes (gauged by parental marital distress) are linked to young women's union and family formation behaviors at Wave III [27]. Young women whose parents were either divorced or remarried faced higher odds of cohabitation and nonmarital childbearing in contrast to those who grew up with continuously married parents. The insulative effects of parental marriage on cohabitation and nonmarital childbearing persisted even in the face of poor parental marital quality. However, being in a distressed remarried stepfamily heightened young women's early family formation transitions, whether through cohabitation, marriage, or nonmarital childbearing, illustrating the importance of stepfamily status as well as family functioning for young adult family behaviors [27].

Moreover, the Add Health's rich family structure and stability data have allowed researchers to pinpoint which features of family structure histories matter for early family formation [24]. Childhood family instability is related to early family formation, but only recently have researchers begun to decipher whether the *number*, *types*, or *timing* of family transitions along with the *duration* of childhood time spent in a particular family living arrangement are consequential. The number of family transitions experienced was positively related to forming an early (Wave III) cohabiting union. However, family stability as indicated by having always lived in a single parent family (vs. always lived with married or cohabiting parents) and having had no family transitions also was associated with increased odds of forming a cohabitation, revealing heterogeneity in the effects of various types of family stability, too. Other evidence of the signal role of transition type is the intergenerational transmission of family structure. Young adults who had spent some of their childhood in a stepfamily or whose mothers formed a new marriage were more likely to wed themselves. Specifically, the amount of time spent in a single mother family while growing up was positively related to forming an early cohabiting union whereas the duration of time spent in a stepfamily was positively associated with early marriage. Only the timing of family transitions was unrelated to union formation during early adulthood [24].

Other Add Health research on the transition to adulthood as observed through Wave IV has yielded similar findings, showing that family instability largely operated through Wave I family structure with those in single-mother families especially likely to

become cohabiting parents and those residing in mother-stepfather families particularly likely to have married by age 24 (Wave IV) [2,27]. These adolescent precursors to early family formation hold for women and men alike, but less is known about whether they persist across racial and ethnic groups [2]. An examination of union formation among Asian Americans compared with Whites revealed that the former group was less likely than the latter group to form a cohabiting or marital union in early adulthood and this difference was attributable to distinct family socialization patterns (e.g., higher religiosity in Asian American families) as well as adolescent romantic relationship experience (which was lower among Asian Americans than Whites) [18].

Parent-child relationships

Parent-child relationship dynamics are a primary mechanism through which family structure and instability operate on offspring outcomes, including union formation, and Add Health includes numerous measures of the adolescent's relationship with their parents. Family belonging, which taps into how much adolescents feel their family pays attention to and understands them, they have fun with their family, and they do not want to leave home, was negatively associated with cohabitation but unrelated to marriage [22]. This finding aligns with that of other work showing that adolescent reports of closeness to parents were negatively related to forming a cohabiting union as a young adult [2]. Closer parent-child relationships during adolescence were associated with an increased likelihood of forming an intra-racial (vs. inter-racial) cohabiting union but had no appreciable association with the racial identity of spouses who married directly [28]. Parental attitudes and values are also linked to early union formation. Higher parental aspirations for the offspring to go to college as well as parental religiosity and disapproval of offspring sexual activity were negatively related to forming either a marital or cohabiting union among Asian American and White young adults (other racial-ethnic groups were excluded) [18].

Family and neighborhood socioeconomic status

The association between family instability and early family formation partially reflects selection effects. Family instability is a more common experience among children born to young, unmarried mothers with lower levels of education [2]. Socioeconomic disadvantage during adolescence, as captured by family income, was linked to higher levels of early cohabitation (by age 20) and early marriage (by age 26) [29]. Neighborhood context shapes mate selection as young adults who grew up in neighborhoods with more racial and ethnic diversity more often formed inter-racial unions during early adulthood (Wave III) [28,30].

Romantic relationships and sexual behaviors

Consistent with a key tenet of the life course perspective that experiences during an earlier life stage have enduring influences on the experiences characterizing subsequent stages of life, research using longitudinal Add Health data has provided strong evidence of continuity in romantic relationship behaviors between adolescence and early adulthood [31]. Women and men who had romantic relationships in 11th or 12th grade were more likely to form a union (either marriage or cohabitation) in early adulthood. Nonromantic sexual relationships during adolescence were predictive of forming a cohabiting union, but not marriage during early adulthood. These linkages, which were robust to a range of control variables, illustrate the continuity of romantic relationships across the life course [31]. Meier and Allen [32] described romantic relationships during adolescence as "social scaffolding on which young adult romantic relationships rest."

The well-documented racial-ethnic variation in union formation is presaged by distinct patterns of adolescent romantic relationship experience [32]. Adolescents who identified as Black were less likely than their White counterparts to have had romantic relationships during adolescence, which contributed to their lower likelihood of forming a cohabiting union during early adulthood. However, Blacks with steady adolescent dating experience were actually less likely to marry, indicating that adolescent and young adult relationship experiences are not uniformly continuous [32].

Puberty and precocious maturity

Pubertal timing among girls is not solely a biological phenomenon but also has sociological significance as a marker of the transition into adolescence, shaping both how girls perceive themselves and how others respond to them [17]. Early union formation, whether through cohabitation or marriage, was most common among women who experienced puberty at a relatively young age. This association held net of a range of individual and family characteristics and was more pronounced for women from more advantaged socioeconomic backgrounds. The link between early puberty and marriage in young adulthood was largely accounted for by adolescent romantic relationship experiences, underscoring the role of life course continuity. Early pubertal timing was related to accelerated adolescent romantic involvement which in turn contributed to early marriage. But, adolescent romantic relationships did not appreciably reduce the association between pubertal timing and the formation of a cohabiting union in early adulthood, signaling that early cohabitation and marriage are distinctive pathways undergirded by unique processes [17].

Precocious maturity describes the premature assumption of adult roles. For instance, adolescent employment can curtail teens academically and socially, and contribute to problem behaviors. Time-intensive (at least 21 hours per week) paid work during adolescence gauged at Wave I was positively associated with a range of early family behaviors captured at Wave II, including sexual intercourse, pregnancy, and union formation, and these associations were robust to the inclusion of numerous factors such as family socioeconomic status, relationships with parents, school performance, delinquency and peer relationships, and dating behaviors [33].

Union and Family Formation: Consequences for Health and Well-Being

Union formation and childbearing shape individual health and well-being with these family behaviors having ripple effects across the adult life course. The longitudinal design of Add Health allows researchers to assess how family formation is related to health outcomes accounting for well-being prior to family formation, making the data ideally suited for studies that address whether and how (early) marriage contributes to adult well-being, a subject that continues to generate considerable

scholarly attention. The Add Health encompasses a wide array of well-being indicators, ranging from physical and mental health to violence, spurring research from multiple disciplines on the links among family behaviors, health, and well-being.

Mental and physical health

Married individuals exhibit better mental health, on average, than their unmarried counterparts, but average differences may obscure variation across contexts or subgroups [34]. For instance, early marriage may offer fewer psychological benefits because it is an off-time event that is less socially normative. An examination of Wave III relationship status and multiple indicators of mental health uncovered only modest benefits associated with early marriage relative to either singlehood, dating, or cohabitation, accounting for engagement to be married status among those in a romantic relationship, net of Wave I psychological well-being. Married persons reported fewer depressive symptoms than did singles, but more symptoms than engaged daters. The mental health benefits experienced by engaged daters did not extend to engaged cohabitors. Alcohol consumption behavior, an indicator of externalizing psychological distress, was comparable among married persons, engaged daters, and engaged cohabitors. The one domain in which married individuals exhibited a clear advantage was life satisfaction, and this effect was robust to numerous controls, leading the author to conclude that the sense of accomplishment that accompanies the successful transition to adulthood exemplified by marriage could account for this finding. Notably, young adults who married relatively early were generally comparable to those who married at a more typical age, with the latter group only exhibiting an advantage in terms of higher life satisfaction. Teen marriage was selective of individuals with higher psychological distress. Economic factors did not alter the associations between relationship status and mental health. Rather, relationship stability, operationalized as not having multiple sex partners in the past year, explained part of the mental health advantage for married versus single young adults. Some of the apparent benefits of marriage observed among young adults may be short-lived, reflecting the honeymoon phase of new marriages [34].

Cohabitation is the dominant union type in early adulthood, outpacing marriage [22]. Nonetheless, cohabiting unions tend to be transitory, either culminating in marriage or more often ending through breakup [1]. The longstanding evidence that marriage is selective of those in good health raises the question of whether the health status of cohabitors is predictive of marriage. Using data from Waves III and IV, Wagner [12] found that cohabiting women's self-rated health was positively related to marriage, but men's health was unrelated. This pattern also was obtained using a couples subsample that included data on both partners. Net of the male partner's health status, the female partner's health status was tied to marriage. However, it is possible that impending marriage bolsters cohabiting women's health, illustrating the difficulty inherent in trying to disentangle the causal order between union formation and health [12]. In fact, a study using the twins and sibling samples of the Add Health found that any union formation gains to physical health were due to selection effects, although some benefits accrued for internalizing and externalizing behaviors net of genetic and shared environmental factors, pointing to possible causal influences of marriage (and to a lesser extent cohabitation) on young adult well-being [11].

The associations between early union formation and health differ across various health indicators and unique patterns emerge by gender and race. However, much of the variation in young adult health reflected its sizeable relationship with health during adolescence [7]. Accounting for early marriage or cohabitation had few effects on health outcomes for young adults. According to one study, early marriage provided no appreciable health benefits to Blacks [7], although another using propensity score matching to account for selection concluded that early marriage offered Blacks some protective health effects, namely in the form of significant decreases in alcohol consumption and drug use [35]. For Whites, the sole health benefit from early marriage was a diminution of binge drinking [7]. Early marriage was linked to a range of negative health outcomes for various subgroups, such as an increased BMI (Black women and men, White women), less exercise (White women), increased depressive symptoms (Black men), and increased smoking (White men). Cohabitation experience between Waves I and III was associated with poorer health outcomes for Blacks and Whites regardless of gender compared with remaining single. These patterns persisted even with rich measures of multilevel (e.g., peer, school, and neighborhood) socioeconomic status [7]. Other research on stability and change in depressive symptoms between adolescence and young adulthood uncovered no appreciable effects of cohabitation, marriage, or childbearing on mental health, except that unstable cohabiting unions were linked to increases in depressive symptoms [20]. Similarly, an examination of cardiovascular health found few linkages with cohabitation, marriage, or parenthood except for women in same-sex cohabiting relationships who exhibited better cardiovascular health [36].

Violence and crime

The lengthening road to adulthood reflects more years spent in school as young adults gain the education and experience needed for professional careers. This pathway typically involves college completion and delaying union formation and childbearing beyond early adulthood [2]. But a study using Waves I and III revealed that even as educational attainment was negatively associated with engaging in nonviolent delinquency, alcohol, and marijuana use during early adulthood, young adults who experienced greater socioeconomic advantage during adolescence were more likely to engage in these behaviors [37]. The link between adolescent advantage and early adult delinquency and substance use was partially explained by family formation behaviors, with those who had formed a union or had a child being at reduced risk of experiencing these outcomes. This research underscores how socioeconomic advantage effectively extends adolescence into early adulthood by diminishing the likelihood of family formation and thus contributing to increased risks of delinquency and substance use, even net of educational attainment [37]. Related research shows that early union formation is more common among individuals who experienced "street violence" during adolescence, particularly among youth who experienced victimization during late adolescence [38].

Studies that take advantage of Add Health's genetic measures also point to the role of marriage in desistance from delinquency and crime, an illustration of life course discontinuity. Marriage may alter genetic effects on antisocial behavior, providing evidence of a gene $\times$ marriage interaction. It appears that genetic effects on crime and violence are modified by the environment,

namely marriage, although the specific features of marriage that encourage desistance remain uncertain empirically and merit attention in future research [8]. Conceptually, marriage is a long-term social (and legal) contract that binds spouses to each other and their families, strengthening social bonds and ties to the community that favor conformity [9].

Relationship quality and stability

A range of factors contribute to relationship quality and stability. A sibling comparison analysis showed that later timing of first sex was associated with less relationship dissatisfaction, an association that was robust to controls for the genetic and shared family environment of adolescence and adolescent dating involvement [10]. Economic hardship contributes to family stress which can undermine relationship quality for cohabiting and married young adults [39]. For the Add Health cohort, economic factors shape the amounts of affection and violent conflict similarly for cohabitors and married people. Human capital indicators, namely having attended college, were associated with more affection among couples. Economic hardship was positively related to conflict among cohabitors and married people [39].

Among young adults in an unmarried romantic relationship (coresidential or not), relationship commitment, satisfaction, and emotional intimacy levels were comparable across different-sex and same-sex couples [5]. This pattern belies a deficit perspective for same-sex couples, underscoring their resilience in the face of ongoing societal stigma and marginalization due to their sexual identity. Nonetheless, married young adults were excluded from these analyses because at the time of the Wave IV survey, same-sex marriage was only legal in Massachusetts. For this reason, the sample of same-sex couples may have overrepresented the most stable, committed relationships that in a different legal environment would have been formalized through marriage. However, the study also revealed how same-sex couples can do relationships in distinctive ways without diminishing relationship quality. For example, same-sex male couples were more often nonexclusive sexually but this dynamic did not translate into lower relationship quality compared with either same-sex female or different gender couples [5].

Relationship violence peaks during young adulthood and the Add Health data have advanced our knowledge about intimate partner violence, particularly for individuals in nonmarital relationships. Among young women (Wave III), cohabitors reported the highest levels of violent victimization and perpetration, followed by married women, and lastly daters [21]. Among young men (Wave III), levels were comparable for those in cohabiting and marital unions, with those who were in dating relationships at lower risk. High relationship quality was negatively associated with relationship violence but did not explain the associations between relationship type and violence [21]. The apparent asymmetry between women and men by relationship type points to the value of couple-level data. A research team used the Add Health couples sample to develop four latent classes of dating, cohabiting, and married couples according to couple-level drinking patterns, termed drinking partnerships [13]. Drinking partnerships in which only one partner drank heavily were linked to greater relationship violence among married couples, including more severe forms of violence. The roles of drinking partnerships differed by relationship type and often had unique effects on violence perpetration versus victimization [12], illustrating the complexities surrounding the contours of romantic relationship dynamics and intimate partner violence.

Early adult unions tend to be unstable. By Wave IV, one in five respondents who had married had already divorced [40]. And half of all respondents who had cohabited but not married had experienced the dissolution of a cohabiting union. Parental union dissolution (whether cohabiting or marital unions that ended through break up, divorce, or death) was positively associated with young adult union disruption net of a wide range of confounding factors. Moreover, for those young adults coming from stable families, parental discord was positively associated with union disruption. The magnitude of the effect appeared to be comparable to having experienced one parental union dissolution [40]. The Add Health data have allowed researchers to greatly expand our understanding of the intergenerational transmission of divorce by showing that the transmission operates more broadly on cohabiting unions, too, a finding of particular interest given the rapid growth in cohabitation and the high levels of instability characterizing this union type. This line of inquiry is important to pursue as Add Health respondents continue to age and more enter marriage (or cohabitation), placing them at risk of disruption. Likewise, such analyses would require collecting additional information to track parental union disruption beyond the respondent's adolescence.

Contributions and Future Directions

Research on union and family formation is flourishing, reflecting the shifting demographic landscape of young adulthood, which increasingly begins with either cohabitation or nonmarital childbearing as marriage is more often delayed until later ages [1]. Add Health is integral to our understanding of contemporary family formation dynamics and as a cohort study begun during adolescence it provides a richly layered developmental perspective for deciphering the determinants and consequences of both union formation and childbearing during young adulthood [3]. Adolescent experiences across multiple social contexts, including family, neighborhood, schools, and peers, offer a blueprint of sorts for young adult family formation, which is consonant with the life course perspective. Add Health research documents the continuity between adolescent romance and young adult union formation [31,32]. It also expands our understanding of how family of origin experiences shape family building behaviors [24], including by uncovering that the well-established intergenerational transmission of marital stability applies more broadly to union stability [40]. And, it encompasses both different- and same-sex partnerships, permitting researchers to knit together a rich tapestry of family formation experiences that is more representative and inclusive of the lived experiences of a racially and ethnically diverse cohort that has come of age during an era marked by the legalization of same-sex marriage.

For scholars studying family formation, a key innovation of Add Health is the collection of cohabitation history data, which not only reveals the growing centrality of cohabitation in young adulthood, but also has led to several studies elucidating the distinct life course pathways to cohabitation versus marriage [13,19] as well as the myriad consequences of various family formation trajectories for subsequent health and well-being [12,20]. For example, studies using Add Health data inform the large literature on marriage and well-being by showing that early marriage appears to offer few health benefits, at least in the short

term [7,20]. Cohabitation does not seem to confer appreciable benefits, either [20]. As the cohort ages, it will be important to assess the longer term consequences of early union formation and to compare the outcomes with those experienced by cohort members who form unions at later ages. Likewise, many cohort members had not had children by Wave IV, and thus the incidence and timing of first birth and its intersection with union type is another topic that merits future study. To date, most research on family formation using Add Health data has been confined to union formation with comparatively few studies on childbearing.

The movement of the Add Health cohort from young adulthood to middle age presents a host of new research opportunities. In addition to assessing union formation during early midlife, which is increasingly common as young adults delay marriage entry, deciphering predictors of union instability and divorce as well as subsequent repartnering will take on greater salience. The relationship biographies of adults become more complex with age as they form and dissolve unions. Teasing apart the features of these biographies (e.g., the roles of union transition timing, type, and duration) that have implications for health and well-being will be an important task for future research. The detailed information on both cohabiting unions and same-sex partnerships will contribute to new knowledge about these union types spanning from early adulthood to midlife. The data are also ideally suited to provide portraits of family building behaviors through midlife across racial and ethnic groups to identify how structural inequalities and individual factors shape the life course trajectories of this cohort.

Of course, family formation is less common among today's young adults than prior generations. Young people are increasingly eschewing the traditional pathway of marriage and childbearing, preferring instead to either go solo or form more flexible partnerships such as living apart together relationships that combine both commitment and autonomy [41]. Meanwhile, record shares of young people are residing with their parents [42]. Many single young adults are raising children in coparenting relationships. In short, singlehood is gaining ground and singles are a heterogeneous group. There are numerous paths to "doing family" outside the confines of a coresidential union. These shifts point to new avenues for exploration in subsequent waves of data collection. Add Health should gauge romantic relationships, including novel forms such as living apart together relationships, but also attend to other relationship ties, such as friends and family members (especially parents and siblings), in providing social and other forms of support as the cohort ages because these ties are prominent in the lives of unpartnered adults [43,44]. The ongoing retreat from marriage and childbearing foregrounds the need to investigate the developmental precursors of singlehood (or nonparent status) and their roles on health and well-being as the cohort confronts middle age. Since its inception, Add Health has been pivotal in the generation of new knowledge about the landscape of union and family formation and even as the terrain continues to shift, and it is poised to remain at the forefront.

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References

[1] Smock PJ, Schwartz CR. The demography of families: A review of patterns and change. J Marriage Fam 2020;82:9–34.
[2] Fomby P, Bosick SJ. Family instability and the transition to adulthood. J Marriage Fam 2013;75:1266–87.
[3] Harris KM, Halpern CT, Whitsel EA, et al. Cohort profile: The national longitudinal study of adolescent to adult health (Add Health). Int J Epidemiol 2019;48:1–12.
[4] Harris KM. The national longitudinal study of adolescent to adult health (Add health), waves I & II, 1994–1996; wave III, 2001–2002; wave IV, 2007-2009; wave V, 2016-2018 [machine-readable data file and documentation]. Chapel Hill: NC: Carolina Population Center, University of North Carolina at Chapel Hill; 2018. dataset.
[5] Joyner K, Manning WD, Prince BF. The qualities of same-sex and different-sex couples in young adulthood. J Marriage Fam 2019;81:487–505.
[6] Prince BF, Joyner K, Manning WD. Sexual minorities, social context, and union formation. Pop Res Policy Rev 2020;39:23–45.
[7] Harris KM, Lee H, DeLeone FY. Marriage and health in the transition to adulthood: Evidence for African Americans in the Add health study. J Fam Issues 2010;31:1106–43.
[8] Li Y, Liu H, Guo G. Does marriage moderate genetic effects on delinquency and violence? J Marriage Fam 2015;77:1217–33.
[9] Barnes JC, Beaver KM. Marriage and desistance from crime: A consideration of gene–environment correlation. J Marriage Fam 2012;74:19–33.
[10] Harden KP. True love waits? A sibling-comparison study of age at first sexual intercourse and romantic relationships in young adulthood. Psychol Sci 2012;23:1324–36.
[11] Horn EE, Xu Y, Beam CR, et al. Accounting for the physical and mental health benefits of entry into marriage: A genetically informed study of selection and causation. J Fam Psychol 2013;27:30–41.
[12] Wagner B. Health status and transitions in cohabiting relationships of American young adults. J Marriage Fam 2019;81:847–62.
[13] Wiersma JD, Cleveland HH, Herrera V, Fischer JL. Intimate partner violence in young adult dating, cohabitating, and married drinking partnerships. J Marriage Fam 2010;72:360–74.
[14] National Center for Health Statistics (U.S.). National Survey of Family Growth (NSFG), United States, 2011-2019. Hyattsville, MD: Inter-university Consortium for Political and Social Research [distributor]; 2021.
[15] Bureau of Labor Statistics, U.S. Department of Labor. National longitudinal survey of youth 1997 cohort, 1997-2017 (rounds 1-18). Produced and distributed by the center for Human resource research (CHRR). Columbus, OH: The Ohio State University; 2019.
[16] Amato PR, Landale NS, Havasevich-Brooks TC, et al. Precursors of young women's family formation pathways. J Marriage Fam 2008;70:1271–86.
[17] Cavanagh SE. Early pubertal timing and the union formation behaviors of young women. Soc Forces 2011;89:1217–38.
[18] Cheng YHA, Landale NS. Adolescent precursors of early union formation among Asian American and white young adults. J Fam Issues 2011;32:209–36.
[19] Landale NS, Schoen R, Daniels K. Early family formation among White, Black, and Mexican American women. J Fam Issues 2010;31:445–74.
[20] Booth A, Rustenbach E, McHale S. Early family transitions and depressive symptom changes from adolescence to early adulthood. J Marriage Fam 2008;70:3–14.
[21] Brown SL, Bulanda JR. Relationship violence in young adulthood: A comparison of daters, cohabitors, and marrieds. Soc Sci Res 2008;37:73–87.
[22] Schoen R, Landale NS, Daniels K. Family transitions in young adulthood. Demography 2007;44:807–20.
[23] Schoen R, Landale NS, Daniels K, Cheng YHA. Social background differences in early family behavior. J Marriage Fam 2009;71:384–95.
[24] Ryan S, Franzetta K, Schelar E, Manlove J. Family structure history: Links to relationship formation behaviors in young adulthood. J Marriage Fam 2009;71:935–53.
[25] Thorsen ML. The adolescent family environment and cohabitation across the transition to adulthood. Soc Sci Res 2017;64:249–62.

[26] Kiernan KE. The impact of family disruption in childhood on transitions made in young adult life. Popul Stud 1992;46:213–34.
[27] Amato PR, Kane JB. Parents' marital distress, divorce, and remarriage: Links with daughters' early family formation transitions. J Fam Issues 2011;32:1073–103.
[28] Yahirun JJ, Kroeger RA. Parent-child relationships and interracial first union formation in the United States. Adv Life Course Res 2019. https://doi.org/10.1016/j.alcr.2019.100307.
[29] Meier A, Allen G. Intimate relationship development during the transition to adulthood: Differences by social class. New Dir Child Adolesc Dev 2008;119:25–39.
[30] Zhang X, Sassler S. The Age of Independence, revisited: Parents and interracial union formation across the life course. Sociol Forum 2019;34:361–85.
[31] Raley RK, Crissey S, Muller C. Of sex and romance: Late adolescent relationships and young adult union formation. J Marriage Fam 2007;69:1210–26.
[32] Meier A, Allen G. Romantic relationships from adolescence to young adulthood: Evidence from the national longitudinal study of adolescent health. Sociological Q 2009;50:308–35.
[33] Staff J, VanEseltine M, Woolnough A, et al. Adolescent work experiences and family formation behavior. J Resadolesc 2012;22:150–64.
[34] Uecker JE. Marriage and mental health among young adults. J Health Soc Behav 2012;53:67–83.
[35] Ali MM, Ajilore O. Can marriage reduce risky health behavior for African-Americans? J Fam Econ Issues 2011;32:191–203.
[36] Frech A, Lynch J, Barr P. Health consequences of same and opposite-sex unions: Partnership, parenthood, and cardiovascular risk among young adults. J Behav Med 2016;39:13–27.
[37] Kuhl DC, Chavez JM, Swisher RR, Wilczak A. Social class, family formation, and delinquency in early adulthood. Sociol Perspect 2016;59:345–67.
[38] Kuhl DC, Warner DF, Wilczak A. Adolescent violent victimization and precocious union formation. Criminology 2012;50:1089–127.
[39] Halliday HJ, Lucas A. Economic factors and relationship quality among young couples: Comparing cohabitation and marriage. J Marriage Fam 2010;72:1141–54.
[40] Amato PR, Patterson SE. The intergenerational transmission of union instability in early adulthood. J Marriage Fam 2017;79:723–38.
[41] Strohm CQ, Seltzer JA, Cochran SD, et al. "Living apart together" relationships in the United States. Demogr Res 2009;21:177–214.
[42] Mazurik K, Knudson S, Tanaka Y. Stuck in the nest? A review of the literature on coresidence in Canada and the United States. Marriage Fam Rev 2020;56:491–512.
[43] Gilligan M, Stocker CM, Jewsbury Conger K. Sibling relationships in adulthood: Research findings and new frontiers. J Fam Theor Rev 2020;12:305–20.
[44] Mair CA. Alternatives to aging alone?:"Kinlessness" and the importance of friends across European contexts. J Gerontol B Psychol Sci Soc Sci 2019;74:1416–28.