

Early Family Transitions and Depressive Symptom Changes

From Adolescence to Early Adulthood

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Abstract

Some research and theory suggest that early cohabitation, parenthood, and marriage have negative long term implications. Nevertheless, in the context of their resources and opportunities, early transitions may represent positive choices for some individuals. We studied the family and personal characteristics of young adults (N = 8,172) who did, versus those who did not, make early family transitions. We assessed changes in their depressive symptoms from adolescence to young adulthood. Individuals who made early family transitions were disadvantaged in many respects, but differed little from those who did not with respect to changes in depressive symptoms. That they stay “even” with those who do not make transitions suggests that some young adults make positive choices from among limited options.

Key words: Youth/emergent adulthood, Life events and/or transitions, Depression, Cohabitation, Marital Status, Transition to Parenthood

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From Adolescence to Early Adulthood

From a developmental perspective, emerging adulthood, the period from 18 to 25 years of age, has been described as a time for identity exploration in the domains of world views, love and work among youth in modern industrialized societies (Arnett, 2000). From this perspective, identity exploration is made possible by delaying the assumption of adult roles such as marriage and parenthood. An extended period of identity formation, in turn, serves as a foundation for making positive choices and creating a stable, satisfying life structure (Arnett). By implication, individuals who fail to postpone family role transitions miss out on opportunities (e.g., for education and work experience), make poor choices (e.g., about romantic partners), and consequently may experience adjustment problems.

Some demographic research is consistent with this perspective. For instance, parenting during the years of emerging adulthood has been linked to socioeconomic disadvantage and marital instability over the long term (e.g., Astone & Upchurch, 1994). Early marriage is linked to increases in fertility which may foreclose socioeconomic opportunities (e.g., Teachman, Polonko, & Leigh, 1987), and decrease educational (e.g., Marini, 1985) and occupational achievement (e.g., Otto, 1979). Little is known about the implications of cohabitation during emerging adulthood; this can be viewed as an alternative to marriage (Brown & Booth, 1996), a step toward marriage, or as an alternative to singlehood (Rindfuss & Vanden Heuvel, 1990).

In the face of the aforementioned theory and research, we explore an alternative scenario. We begin with the idea that opportunities to treat young adulthood as a time of exploration are not open to all individuals given their personal, social, and economic resources. In these cases, early family transitions may not have the same negative implications as they do in the case of

more privileged individuals. In this scenario, some young adults make early family transitions because they expect to benefit from them. Indeed, research shows that marrying, cohabiting, and becoming a parent, at least at older ages, provides a range of benefits (Coleman, 1988). These include increasing social capital that buffers individuals from stressful life circumstances, fostering a sense of belonging and social connection, and providing more positive, living arrangements. Increases in economic capital, such as income from a partner are also possible (e.g., Pears, Pierce, Kim, Capaldi, & Owen, 2005). Although some theory and research support the proposition that early family formation has long term negative consequences, these findings suggest that some young adults may benefit from family transitions. To date, researchers have not examined the short term outcomes of transitions, particularly in the domain of psychological adjustment wherein positive implications of family transitions may be most apparent.

To test our alternative scenario, this study addressed two questions. Using data from the National Longitudinal Study of Adolescent Health, we first asked whether individuals who made family transitions in early adulthood, compared to those who did not, came from less advantaged family backgrounds and/or had attributes and experiences in adolescence that put them at risk for poorer psychological well-being. Second, we tested whether those who made early family transitions, as compared to those who did not, exhibited different patterns of change in depression symptoms from adolescence to young adulthood. The family background characteristics we studied were family income, parental education, and family structure (i.e., whether youth did or did not live with two biological parents). We also examined mother-child relationship quality, verbal ability, school attachment, and delinquent behavior in adolescence as potential risk/protective factors for psychological well-being. Given the different meanings of family transitions for women and men, we studied the role of gender in these processes.

We expected that those making transitions would come from less advantaged families and be more at risk for adjustment difficulties than those who do not. Also, we suggested three possibilities regarding the link between family transitions and patterns of change in depressive symptoms from adolescence to young adulthood. First, stresses associated with family formation, above and beyond the presence of background and risk factors, may mean that those who make early transitions are more likely to show increases or remain at higher levels of depressive symptoms from adolescence to young adulthood relative to those who do not make transitions. Second, the benefits of family transitions could ameliorate the background and risk factors such that those who make early transitions are more likely to show decreases in depressive symptoms relative to those who do not marry, cohabitate, or become parents. Third, the benefits associated with family transitions and the debilitating aspects of background and risk factors may balance each other such that there are no differences between those who do and do not make transitions.

Family Background and Risk/Protective Factors and Their Link to Family Transitions

The family background and risk/protective factors included in this study have been investigated in relation to a wide range of adolescent orientations toward risky sexual behaviors as well as problem behaviors, more generally (e.g., Kurdek & Fine, 1994; Steinberg, Lamborn, Darling, Mounts, & Dornbusch, 1994). To date these factors have not been examined vis a vis family transitions during early adulthood. We review possible mechanisms by which these factors may influence the decision to make an early transition.

Low family income is known to lead to parental conflict which, in turn, is linked to poorer parent-child relationship quality (Conger, Ge, Elder, Lorenz, & Simons, 1994). Other work shows that poorly educated adults tend to be less skilled parents (Amato & Booth, 1997). Growing up in families comprised of one or no biological parents is associated with problematic

parent-child relationships, specifically less affection, less consensus, and less perceived support (Amato & Booth, 1997). A divisive home environment and poorer parenting skills may encourage offspring to seek social support in early marriage or cohabitation.

Low levels of parental warmth and affection and a lack of clear expectations and limits are linked to poorer self regulation and social competence in youth, and in turn, higher levels of problem behavior (Parke & Buriel, 1998). Early family transitions may provide individuals with an opportunity to escape from an unloving home environment as well as the possibility of creating a more positive and supportive family context. Verbal intelligence is an individual characteristic that has been linked to educational and occupational achievement (Woodward, Fergusson, & Horwood, 2001) and also has implications for the development of coping strategies for dealing with adversity, including soliciting assistance and support from others (Masten, Best, & Garnezy, 1990). Relatedly, high levels of school attachment indicate a sense of belonging with peers and teachers and may enhance school achievement. In contrast, individuals who are unable to garner social support or succeed in school may decide to have a child who will love them unconditionally (Edin & Kefalas, 2005). A final personal characteristic of interest is delinquency, which may be reflective of both a lack of support and limit setting in the family as well as poor self regulation and impulse control in the individual (Parke & Buriel). Delinquent activities marginalize youth from their families and social institutions. For these individuals, early family formation may be a way to make up for their lack of connectedness and achievement.

Of course the same qualities that lead to early family formation may also lead to stress in new family relationships. If underdeveloped social skills and poor impulse control challenge the quality of interaction with a new partner or baby, an increase in depressive symptoms may ensue.

In addition to these family and personal characteristics we also expected that gender would be a factor in early family transitions and their link with depressive symptoms. Women tend to be more selective in their involvement in romantic relationships than men: they prefer the stability of marriage to cohabitation (Bumpass, Sweet, & Cherlin, 1999) and are more likely to seek partners who will provide resources and help with rearing offspring (Daly & Wilson, 1983). Thus, the meanings of cohabitation, parenthood, and marriage differ for women and men. Substantial research also documents gender differences in depressive symptoms: Starting in adolescence, girls report higher levels of depression than boys (Petersen, Sarigiani, & Kennedy, 1991). Given these patterns, we examined family transitions separately for women and men.

Control variables consisted of age and ethnicity. Given that the correlates of family transitions are likely to vary as a function of their developmental timing, we included respondent's age. Data showing that the timing of family transitions varies across ethnic groups (Bianchi & Casper, 2000) led to including ethnicity.

Variation in the Implications of Early Family Transitions

Our study is grounded in the premise that some individuals may benefit from early family transitions, whereas others may not. A study of young women at risk who benefited from marriage is instructive in this regard (Rutter & Quinton, 1984). This classic study focused on a group of women who were raised in institutions and a comparison group who resided in the same geographic area. Overall, the psychological development of the institution-reared women was considerably poorer. Nevertheless, a significant number functioned as well in adulthood as those in the comparison group: these were women who had positive educational experiences and a sense of efficacy and, as a result of these attributes, were married to supportive and non-deviant spouses. The authors concluded that a sense of efficacy derived from positive school experiences

mediated the link between institutional upbringing and achieving a supportive marriage relationship, which in turn explained well-being in young adulthood.

A study of unmarried men and women evaluated the extent to which the transition to marriage was associated with changes in depression (Frech & Williams, 2007). Although they did not differentiate between those making early versus on time transitions, findings suggested that the psychological benefits of marriage depended on the respondent's premarital depression: Men and women who were depressed prior to marriage reported greater psychological gains from marriage than those who were not depressed. The study further supports the idea that people at risk may have more to gain from family transitions than less disadvantaged individuals.

Method

This study drew on interviews from Waves 1 and 3 of the National Longitudinal Study of Adolescent Health (Add Health). At the time of the first interview, youth ranged in age from 12-18 years. Wave 3 took place 5 years later when most individuals were young adults. For purpose of this study, family background and risk/protective factors were measured at Wave 1, and family transitions were measured at Wave 3. We used data on depressive symptoms collected at both Waves 1 and 3 to create groups that varied in level and change in depression symptoms.

Participants

The Add Health Study consists of a nationally representative sample of 20,745 middle and high school students who were first interviewed in 1995-96 and for a third time in 2000-01 when they were young adults. Response rates for Waves 1 and 3 were 78.9% and 77.4% respectively. The study over sampled a number of populations, and weighting was used in order to make the sample nationally representative. The number of respondents that had weight values

and that participated in both Waves 1 and 3 was $N = 14,086$. A more detailed description of the study can be found in Bearman, Jones and Udry (1997) and Harris et al. (2003).

Individuals who were close in age to those who typically make the transition to marriage and parenthood (23 to 25 years of age) were eliminated from the sample so that for comparison purposes those making early transitions were in the same age range as those who did not. For the analysis of early transition to cohabitation, those who were close in age to the national average (i.e., 21 and 25 years of age) were eliminated from the analysis. Individuals who made family transitions prior to Wave 1 were also eliminated. The final sample consisted of 8,172 individuals.

The resulting sample included individuals whose average age of making a family transition was below national averages. As shown in Table 1, the mean ages of the women and men in our sample who made family transitions were under 20 years. In contrast, in a U.S. sample of a household population 15-44 years of age (the National Survey of Family Growth), the average age for initiating cohabitation by men was 22.9. (There was no figure available for women.). In a national sample of females ages 10-49, Mathews and Hamilton (2002) estimated that the average age for becoming a mother was 24.9. A comparable figure for first fatherhood is unavailable. Finally, the national estimate for age at marriage for women was 25 and for men was 27 years (Bianchi & Casper, 2000). The final sample made it possible to compare those making early transitions with those who did not and is ideal for exploring the factors associated with making early transitions as well as the consequences of those transitions.

< Table 1 About Here >

Measures

All scales were unidimensional and reliable at acceptable levels. For each scale, we calculated the mean across all items. Fewer than 5% of the values were missing for any variable except primary caregiver education and per capita household income. For these two variables, approximately 25% of the data were missing because they were obtained from the parental questionnaire which was not administered in all households. Missing cases were replaced with imputed values using the expectation maximization (EM) algorithm (Allison, 2001) in SPSS.

We selected depressive symptoms as the outcome measure because they are associated with many types of adversity such as poor physical health, unemployment, and harsh family relationships (Amato & Booth 1997). Depressive symptoms were indexed as the mean of seven items collected at Waves 1 and 3. For example, respondents were asked if, during the last week, *they were bothered by things that usually don't bother you*, or *felt that you could not shake off the blues, even with help from your family and your friends*. Responses ranged from 0 = *never or rarely* to 3 = *most of the time or all of the time*, with high scores signifying more depressive symptoms. The depressive symptoms scale had an alpha of .81 for Wave 1 and .82 for Wave 3 (see Table 2 for descriptive statistics). In an effort to capture both level and change in depressive symptoms we classified individuals as being high in depressive symptoms if they scored in the top 20th percentile, and we created two classification schemas: First, participants were coded 0 if they were high in depression at both Waves 1 and 3 and they were coded 1 if they were high in depression at Wave 1 but not at Wave 3, indicating a decline in depressive symptomology. Second, individuals were coded 0 if they scored low in depressive symptoms at both Waves 1 and 3, and 1 if they were low in depressive symptoms at Wave 1 but high at Wave 3, signifying an increase in symptomology.

< Table 2 About Here >

Although cutoffs for grouping variables are sometimes arbitrary, we chose a 20% cutoff based on data showing that a little over 20% of the population meet the criteria for clinically significant mental health problems involving depression symptoms (National Institutes of Mental Health, 2006), including mood disorders (9.5% of the population), major depression (6.7%), dysthymic disorder (1.5%) and bipolar disorder (2.6%). Other cutoff points and ways of constructing the depressive symptoms variable were examined, but they all produced similar results.

To measure first birth, respondents were asked how many times they or their partner had had a pregnancy. Then respondents were asked *Next, please indicate the outcome of this pregnancy by selecting the appropriate response*. We restricted our focus to live first births (0 = *never had a live birth*, 1 = *had at least 1 live birth*). In Wave 3 of Add Health, respondents were asked about their pregnancies and births within the context of a history of their romantic and sexual relationships. As such, some respondents failed to report on births in the contexts of cohabitations and marriages that had been reported in an earlier section of the interview. As a result, Add Health's fertility history is incomplete. We used the household roster to check for incompleteness and to add births to the history that had been omitted. A detailed description of the procedure that was used to correct the fertility history is available from the authors. In separate analyses we differentiated births that occurred in a marriage, in a cohabitation relationship, or outside either type of relationship.

To assess cohabitation, respondents were asked "Have you ever lived with someone in a marriage-like relationship for one month or more?" Responses were coded 0 = *no/never* and 1 = *yes/at least once*. Because cohabitations tend to be of short duration and because we expected that relationship instability would be linked to symptoms of depression, we focused on the first

cohabitation and created a measure of cohabitation stability using respondents' answer to the question "*Are you still living together?*"

Marriage was derived from the question "*How many times have you been married?*" Responses ranged from 0 to 3. The number of individuals who had been married more than once was less than 100, so we recoded this variable to 0 = *never married* and 1 = *married at least once*. Given that the total number of marital disruptions in our sample was very small, we did not create an index of marital stability.

The control variables of age and ethnicity were included in every regression. Age was indexed as a continuous variable, measured at Wave 1. Ethnicity consisted of four categorical variables (Black, Hispanic, and Other), with White as the reference category.

Family per capita income was obtained from the parent questionnaire by taking the total household income and dividing by the number of household members. Primary caregiver education was measured by a single item *How far did you go in school?* from the parental questionnaire; responses ranged from 0 = *never went to school* to 9 = *professional training beyond a 4-year college or university*. Family structure was obtained from a household roster at Wave 1 and coded as a dichotomous variable where 0 = *two biological parents* and 1 = *one or no biological parents*.

Mother-offspring relationship quality was measured using a four item scale (e.g., *Most of the time, your mother is warm and loving toward you*). Respondents used a 5-point scale (1=*strongly agree* to 5=*strongly disagree*) to rate how strongly they agreed or disagreed with statements describing their experiences. The scale is coded so that high values signify a positive mother-child relationship, and Cronbach's alpha was .84. Vocabulary Skill was measured using the "Add Health Picture Vocabulary Test" which was an adapted from the "Peabody Picture

Vocabulary Test” administered in Wave 1. School attachment was measured at Wave 1 using a three item scale (e.g., *You feel close to people at your school.*). Items were coded so that higher values indicate higher levels of school attachment, and Cronbach’s alpha was .79. Delinquency was measured using a 14 item measure on which respondents were asked to rate how often they engaged in the past 12 months in a range of activities (e.g., *How often did you deliberately damage property that didn’t belong to you?*) using a 4-point scale (0 = *never or rarely* to 3 = *5 or more times*). Items were coded so that higher values indicate more delinquency, and Cronbach’s alpha was .85.

Results

The results are organized in two steps. First, we compared the risk and protective characteristics and experiences of those who did versus did not report early cohabitation, parenthood, and marriage. Second, we tested whether individuals who did versus did not make early family transitions differed in their patterns of stability and change in depressive symptoms. *How are Family Background and Risk/Protective Factors Linked to Early Family Transitions?*

We conducted a series of logistic regressions to test the probability of making each family transition (cohabitation, birth, or marriage) as a function of control, family background, and risk/protective factors, conducting separate analyses for women and men. In these analyses we used event history person-year files in which each individual has a record per year until he/she experiences a family formation event, and then no longer contributes to the file. Separate person-year files were constructed for first birth, first cohabitation, and first marriage. The resulting sample consisted of 8,172 cases from 1996 to 2002: 53,459 person-years for the birth file, 49,480 person-years for cohabitation, and 54,730 person-years for the marriage file. Event history analysis involves measuring a continuous record over time on a variable, in this case,

length of time until the first family formation event of each type. In this way we take into account two factors: (a) whether the individual had a family formation transition or not, (b) the timing of the transition.

Results are shown in Table 3. With respect to the control variables, we found that those who became a parent or married by Wave 3 were older. Furthermore, compared to Whites, Blacks were less likely to marry and cohabit. In addition, compared to Whites, Hispanics were less likely to cohabit. Finally, those in the “other” category (mostly Asians and Native Americans) were less likely than Whites to cohabit or marry.

< Table 3 About Here >

Turning to family background characteristics, those who made early family role transitions were more likely to come from low *income* families. With the exception of men who married, those who made early transitions were more likely to have parents with lower levels of *education* and were more likely to have lived in a household with one or no *biological parents*. Similar patterns have been reported in prior research (Bianchi & Casper, 2000).

Risk and protective factors also were related to family formation in emerging adulthood. First, women who had poor *relationships with their mothers* in adolescence were more likely to cohabit, but mother-child relationship quality had no association with becoming a parent or with marriage. With the exception of men who married or became a parent, those with poor *vocabulary skills* were more likely to make family transitions. Both men and women who had experienced low *school attachment* were more likely to cohabit, but only the women were more likely to become parents. Both men and women who had reported high levels of *delinquency* in adolescence were more likely to cohabit and become parents, but only the men were more likely to marry.

Interaction terms were computed (gender X risk variable) for all of the predictor variables listed in the table and added to regressions examining the factors that have the potential for being associated with making an early transition (not shown). Of all *gender differences* reported in Table 3, five were statistically significant with respect to factors that influenced family transition decisions. Women who had a poor relationship with their mother were more likely to cohabit or become a parent compared to men in such a relationship. Similarly, women who had been involved in delinquent behavior were more likely to cohabit than men with a history of delinquent behavior. Finally, women who had poor verbal ability or lived with one or no biological parents, compared to men in these categories, were more likely to become a parent. In summary, there is a slight tendency for women with potential risk factors to make early transitions more than for men to do so. It is important to note, though, that the data on men's transition to parenthood are less reliable than the data for women.

What are the Links between Early Transitions and Patterns of Change in Depression Symptoms?

As a preliminary step, we examined overall patterns of change in depressive symptoms by family transition status. Table 4 shows the mean scores at Wave 3 as a function of level, change group, and family formation event. Consistent with prior research (e.g., Petersen et al., 1991) females reported higher levels of depression symptoms than males. *T-tests* indicated that gender differences in depression symptoms were statistically significant at Wave 1 and at Wave 3. Nevertheless, as indicated in Table 2, there were no gender differences in patterns of change in depression symptoms: Although men and women had different levels of depressive symptomatology, they showed similar patterns of change.

< **Table 4 About Here** >

Approximately two thirds of the respondents had consistently low levels of depressive symptoms, and similar proportions experienced decreases and increases in symptoms (i.e., out of or into the top 20%) over a five year period spanning from adolescence to early adulthood. Less than 10% were in the high depressive symptoms group across the period of the study. Also, levels of depression symptoms seem to be generally similar across transition type and whether or not any transition was made. To test whether or not making a family transition was linked to an increase or decrease in depressive symptoms or made no difference in symptoms, we conducted a series of logistic regression analyses separately for women (Table 5) and men (Table 6) and for each type of transition. In addition, because we expected that depressive symptoms would be lower in the context of stable relationships (i.e., ongoing versus terminated cohabitations; parenthood in the contexts of marriage) we examined the depressive symptom change patterns for these subgroups versus those who did not make a transition. For each analysis, the comparison group was those who made no family transition. Coefficients expressing the association between early family transition experiences for women whose depressive symptoms were high initially and stayed high or decreased are shown in the first three columns, and for those who were initially low and stayed low or increased depressive symptoms in the second three columns. The coefficients without family background and risk/protective variables in the equation are shown in the first column. The second column includes coefficients after family background variables are added to the equation, and the third column shows coefficients when both family background and risk/protective variables are in the equation.

< Tables 5 & 6 About Here >

Results shown in Table 5 indicated that women who cohabited early were less likely to be in the decreasing depressive symptom group and more likely to be in the increasing

depressive symptom group as compared to women who made no family transition. After the inclusion of the risk and protective variables, the chance of remaining in the depressed category was no longer statistically significant. Verbal ability accounted for the largest decline in statistical significance (analysis not shown). Comparison with women who were in a stable cohabitation versus an unstable one revealed that, although increases in symptoms and remaining depressed were more common for women who had experienced unstable cohabitation, women who experienced stable cohabitation did not differ in their pattern of stability and change in symptoms from those who did not cohabit.

Compared to women who did not experience a transition, those becoming a parent were no more likely to experience a change in depressive symptoms, regardless of whether the birth was inside or outside of a union. Also, there was no evidence that women who married differed from those who did not with respect to stability and change in depressive symptoms.

For men, compared to those who made no family transition, cohabitation was linked to a lower chance of decline in depressive symptoms but not to a greater chance of increasing depressive symptoms when the relationship was unstable. Those who experienced an unstable cohabitation (row 3) were more likely to show an increase in symptoms. Once school attachment and delinquency were in the equation, the latter coefficient was no longer statistically significant. Like women, being in a stable cohabiting relationship was not linked to change in symptoms compared to those who did not make a transition. The key to understanding the link between cohabitation and depressive symptoms was whether the relationship was stable: Those in a stable cohabitation relationship were no different from those who were not in terms of change in depression symptoms. Approximately half of women and men who cohabited had a stable relationship.

Men who married early were no more likely to experience a change in depressive symptoms than those who made no family transition. Men who became parents were less likely to experience a decrease in depression symptoms over time. When per capita income was included in the equation, they were no more likely to be depressed than those who had not experienced a family formation event. We did not explore union status at the time of birth for men because of the limited number of cases.

In summary, those who made early family transitions in young adulthood differed little from those who did not with respect to changes in depressive symptoms. The only exception is that women who experienced the dissolution of a cohabiting relationship, compared to women who did not, were less likely to experience a decrease in depressive symptoms and more likely to experience an increase in symptomology. The same finding applies to men, but the effects were weaker.

A possible explanation for these findings is that certain family background or risk/protective factors may keep individuals from exhibiting increases in depressive symptoms over time. These effects could be misinterpreted as resulting from positive consequences of a family formation event. For example, having a warm mother-child relationship could offset the negative effects of low family income, and the lack of an increase in depression could have nothing to do with family formation. As a final step in the analysis, therefore, we examined whether adolescent risk and protective factors moderated the link between making family transitions and symptoms of depression. Here we tested whether the effects of early transitions on young adults' depressive symptom change varied as a function of family background or adolescent risk.

We explored this possibility by creating an interaction term for each type of transition and each risk/protective variable (transition X risk/protective) and entered the term into an

equation in which depression symptom change (high and decrease or low and increase) was regressed on type of transition, risk/protective variable, and the interaction term along with the controls of age and ethnicity. This involved 112 regressions (2 indicators of depression X 8 types of transitions X 7 risk factors) for females, but only 70 for males because of the unreliability of the fatherhood data. Only one interaction term was statistically significant for males, while six were significant for females. Because this number of interactions would occur by chance, we concluded that the risk characteristics that characterized many of those who made transitions did not moderate the associations between early family transitions and depressive symptom changes.

Discussion and Conclusions

Some research and theory suggests that making family transitions-- to cohabitation, parenthood, and marriage— in early adulthood may be linked to poorer well-being. We argue, in contrast, that for some individuals, family transitions during this period may be beneficial or at least benign. Although early assumption of adult roles and responsibilities may limit opportunities for identity exploration in the domains of work/education, individuals may take on family roles because they represent possibilities for positive change in other ways. Analysis of data from the National Longitudinal Study of Adolescent Health confirmed that individuals who made early family transitions were more disadvantaged with respect to family background and risk/protective characteristics. In spite of these disadvantages, individuals who made early family transitions were rarely different from those who did not with respect to stability and change in their depressive symptoms from adolescence through early adulthood. The vast majority (86%) did not differ from those who did not make a transition with respect to changes in symptoms. The exceptions were women and men who became involved in unstable cohabiting unions. That many individuals who make early family formation decisions come from less advantaged

backgrounds but do not differ in their depressive symptoms from those who do not make transitions, may mean that early transition decisions can be rational and sound.

It is worth noting that there was a tendency for women with risk characteristics to report early transitions more so than men with such characteristics: Women, more than men, who had problematic relations with their mothers were more likely to cohabit and become mothers; women who were delinquent were also more likely than delinquent men to cohabit. In addition, women with poor verbal ability and those who did not live with both biological parents were more likely than men with these characteristics to become parents. The reasons are not clear, but may be attributed to the fact that women generally make family transitions at a younger age than men. Importantly, most of these gender differences involve parenthood transitions, and data on early fatherhood are less reliable than data on early motherhood. As such, the role of gender in the links between risk and protective factors and early family transitions requires further study.

This study is not without limitations. First, the analyses would have benefited from longitudinal data on the risk and protective indices so that we could examine how changes in these were linked to changes in depression symptoms. More detail on family transition experiences, including individuals' reasons for their choices and subjective evaluations of their family formation experiences also would have allowed us to better understand the conditions under which early family formation is advantageous or disadvantageous to individual well-being. Finally, as we suggested, problems with the data on births with respect to men mean that our findings on this family transition must be viewed with caution.

Future research should re-examine the notion that early family formation decisions have negative consequences in the long term. It may be that for women and men who come from less advantaged backgrounds, some family formation choices may take them out of harsh or

unsupportive living environments and have positive consequences. An important question is whether benefits stemming from early family transitions are sustained long term among those with fewer resources and opportunities. Future work also should be directed at identifying the early characteristics and experiences that distinguish those who make early transitions and stay on positive trajectories from those who do not. These represent important questions for research on an understudied population: women and men in early adulthood.

To stay “even” with those who did not make early family transitions, given differences in family backgrounds and risk/protective characteristics and experiences, is consistent with results of research focused on low income women showing that parenthood can be a source of validation, companionship, sense of accomplishment, identity and meaning (Edin & Kefalas, 2005), although not always less depression (Evenson & Simon, 2005). Our findings also are consistent with research showing that marriage can be especially beneficial for the psychological well-being of disadvantaged individuals (Frech & Williams, 2007; Rutter & Quinton, 1984). More generally, our study highlights the importance of studying early family formation *in context*, that is, of examining choices about marriage, parenthood, and cohabitation in light of the range of opportunities open to an individual. Emerging adulthood has been described as an important period for exploration for women and men in modern industrialized societies, but most research on this developmental period has been conducted with college students (Arnett, 2000). Add Health data provided an opportunity to study the experiences of individuals who have quite different life trajectories from the typical college student; our findings suggest that the post high school experiences of individuals in the U.S. are diverse, and that their implications are best understood in the context of individuals’ pre-existing resources and constraints. Early family transitions may be a viable and productive option for some young adults.

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Table 1

Descriptive Statistics on Family Formation for Men and Women

	Men (<i>n</i> = 3,418)			Women (<i>n</i> = 4,057)		
	Cohabitation	Birth	Marriage	Cohabitation	Birth	Marriage
<i>N</i>	899	307	273	1,379	933	608
% Making Transition	26	9	8	34	23	15
Mean Age at Transition (<i>SD</i>)	18.6 (1.25)	19.3 (1.53)	19.8 (1.35)	18.5 (1.24)	19.1 (1.62)	19.6 (1.36)

Note: Data from Add Health

Table 2

Descriptive Statistics for Control, Family Background, and Risk and Protective Factors

	Men (<i>n</i> = 3,418)		Women (<i>n</i> = 4,057)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age (W 1; <i>Range</i> = 12 – 20)	14.69	1.12	14.65	1.15
Black (W 1; <i>I</i> = <i>Black</i>)	.14	.34	.14	.35
Hispanic (W 1; <i>I</i> = <i>Hispanic</i>)	.07	.26	.07	.25
Other (W 1; <i>I</i> = <i>Other Race</i>)	.10	.30	.09	.29
Per Capita Family Income (W 1; <i>Range</i> = 0 – 100,000)	14475.3	11407.1	15164.7	12123.9
Caregiver Educ. (W 1; <i>Range</i> = 0 – 9)	5.55	2.17	5.52	2.16
Family Structure (W 1; 0 = 2 <i>Bio parents</i>)	.41	.49	.40	.49
Mother-Child Relationship (W 1; <i>Range</i> = 0 – 5)	4.38	.58	4.24	.07
Vocab. Skill (W 1; <i>Range</i> = 17 – 146)	102.49	14.08	100.9	14.09
School Attachment (W 1; <i>Range</i> = 1 – 5)	3.80	.81	3.84	.84
Delinquency (W 1; <i>Range</i> = 0 – 3)	.32	.39	.25	.31
Depression Decrease (<i>I</i> = <i>Decrease</i>)	.59	.49	.61	.49
Depression Increase (<i>I</i> = <i>Increase</i>)	.18	.38	.18	.38

Note: W 1 = Wave 1

Table 3

Odds Ratios for Effects of Control, Family Background, and Risk and Protective Factors on Family Transitions for Men (M) and Women (W)

	Cohabitation		Birth		Marriage	
	M	W	M	W	M	W
Age	.97	.86**	1.16*	1.27***	1.47***	1.52***
Black	.54***	.45***	1.13	1.15	.48*	.30***
Hispanic	.46**	.61*	1.41	.78	.99	1.16
Other	.42***	.61*	.92	.72	.51*	.42**
Income	.99	.99***	.99*	.99**	.99*	.99**
Education	.87***	.91***	.84***	.89***	.95	.92**
Fam Structure (<i>0 = 2 Bio parents</i>)	1.41*	1.93***	1.54*	2.04***	1.38	1.34*
Mother - Child Relationship	.92	.72***	1.25	.88	1.16	1.04
Vocabulary Skill	.99**	.99*	.99	.97***	.98	.99*
School Attachment	.82**	.81***	.93	.86*	1.00	.90
Delinquency	1.70***	2.59***	1.72**	1.83***	1.52*	.92
Total Person-Years	21,401	24,156	23,075	25,578	23,234	26,764

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4

Means^a for Men's and Women's Depression Symptoms at Wave 3 by Family Transition and Depression Change Group

<i>MEN</i>	No Fam Form	Cohabitation	Birth	Marriage	Any Transit.	% by Cat.
Constantly High	1.11	1.11	1.21	1.09	1.13	7%
Decrease	0.33	0.31	0.29	0.31	0.33	12%
Constantly Low	0.24	0.23	0.25	0.21	0.24	66%
Increase	1.02	1.10	1.02	0.99	1.07	15%
<i>WOMEN</i>	No Fam Form	Cohabitation	Birth	Marriage	Any Transit.	% by Cat.
Constantly High	1.28	1.37	1.30	1.34	1.33	8%
Decrease	0.38	0.38	0.38	0.36	0.38	14%
Constantly Low	0.29	0.34	0.34	0.32	0.34	64%
Increase	1.29	1.20	1.16	1.19	1.21	14%

^a *Scores can range from 0 – 3*

Table 5

Odds Ratios for Effects of Family Transitions on Decreases (0 = Stable/High, 1 = Decrease) and Increases (0 = Stable/Low, 1 = Increase) in Depressive Symptoms Women With and Without Family Background and Risk/Resilience Characteristics

	Depression Decrease			Depression Increase		
	FF Only	W/Family Backg.	W/Backg. and R&R	FF Only	W/Family Backg.	W/Backg. and R&R
Cohabitation ^a	.64*	.63*	.66	1.77***	1.59***	1.35*
Stable Cohabitation ^a	.94	.91	.96	1.13	.99	.89
Unstable Cohabitation ^a	.50**	.50**	.51**	2.55***	2.31***	1.92***
Birth ^a	.68	.69	.69	1.28	1.13	.98
Birth within a Cohabitation ^a	.50	.47	.49	1.67	1.43	1.25
Birth within a marriage ^a	.90	.89	.84	.86	.75	.73
Birth outside any union ^a	.74	.77	.79	1.18	1.05	.91
Marriage ^a	.79	.82	.84	1.24	1.12	1.04

Note: R&R = Risk & Resilience. Controls for Age and Race/Ethnicity included in all regressions.

^a The reference group is no Family Formation

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 6

Odds Ratios for Effects of Family Transitions on Decreases (0 = Stable/High, 1 = Decrease) and Increases (0 = Stable/Low, 1 = Increase) in Depressive Symptoms for Men With and Without Family Background and Risk/Resilience Characteristics.

	Depression Decrease			Depression Increase		
	FF Only	W/Family Backg.	W/Backg. and R&R	FF Only	W/Family Backg.	W/Backg. and R&R
Cohabitation ^a	.48**	.48**	.54**	1.14	1.08	1.03
Stable Cohabitation ^a	.91	.92	1.04	.74	.68	.65
Unstable Cohabitation ^a	.30***	.28***	.28***	1.44*	1.4*	1.34
Birth ^a	.55*	.57	.58	1.34	1.24	1.20
Marriage ^a	.59	.63	.65	.97	.90	.87

Note: R&R = Risk & Resilience. Controls for Age and Race/Ethnicity included in all regressions.

^a The reference group is no Family Formation

* $p < .05$. ** $p < .01$. *** $p < .001$.