All the Single Ladies: Analysis of the Self-Rated Health of SWANS (Unmarried and Childfree Women)

Cassandra Carter

ABSTRACT

Rising rates of singlehood and childfreeness are emergent trends in the United States. Historically, shifts in family composition have always been important, but the increasing number of unmarried and childfree adults is just beginning to gain acknowledgment. Using the Social Determinants of Health and the Sojourner Syndrome Model as a framework, race and family type are used to investigate the emotional well-being of Black and White unmarried, childfree women, termed herein as SWANS (Single Women Alone with No Stabilizers [Husbands or Children]). The frequencies of self-rated health outcomes are analyzed to determine the association between family type, emotional health, and race. Using secondary data from the National Health Interview Series (2015–2018), binary logistic regression (N=3552) results indicate that the main independent variables of race and family type interact to differentiate emotional health outcomes. These findings persist despite adjusting for demographic and socioeconomic characteristics that are known to influence emotional health, such as age, income, education, and insurance coverage status. This study found that Black SWANS have poorer emotional health than White SWANS. Notably, Black SWANS experience the lowest rates of emotional health. These findings persist despite adjusting for demographic and socioeconomic characteristics that are known to influence health. The analysis further underscores the importance of focusing on intraracial variations in marriage and health, and supports feminist arguments regarding the methodological and conceptual challenges to studying women who exist on the margins of society and Black women in general. Taken together, the results move toward examining health and family policies to identify areas for potential policy change.

INTRODUCTION

The prevailing health patterns among Black women living in the U.S. are striking. Research demonstrates that health disparities and the widening health gap between Black and White women continue to grow (Braithwaite, Taylor, & Treadwell 2009; Centers for Disease Control 2004). Unmarried, childfree women between the ages of 18 and 46 remain an unexplored group to analyze for health disparities. This group will be referred to as SWANS (Single Women Alone with No Stabilizers [Husbands or Children]). In recent years, the trend has been for women to remain unmarried for longer periods of time than in previous years (or permanently) (Waite & Gallagher 2001). Unmarried childfree women challenge assumptions about womanhood and femininity (Marsh et al. 2007; Nitsche & Brueckner 2009; Rowland 2007). This research will explore the health status of unmarried, childfree women to understand the interactions of race, marital status, and parenthood on self-rated health.

Research on changing family types suggests many tangible health benefits of marriage (e.g., happiness, better health, economic rewards) (Center for Disease Control and Prevention 2022; Waite 1995; Waite & Gallagher 2001). These studies have investigated the variability in measurable health outcomes to show a direct positive relationship between marriage and health (Waite 1995). Meanwhile, family sociologists consistently demonstrate that the probability of marriage varies by race. This pattern suggests that the benefits of marriage also may vary by race. When childfreeness and single status are considered, how is health influenced for Black and White women; do these groups experience the same or different health patterns? These remain unanswered questions among health and family scholars.

The relationship between race and family type is important; however, another important relationship is that between race and health, especially because Black women's health lags behind that of White women on average (Braithwaite, Taylor, & Treadwell 2009, 51). Over time, the health outcomes among Black women

have worsened, even after controlling for socioeconomic and other background factors (Braithwaite, Taylor, & Treadwell 2009; Read & Gorman 2006). A disproportionate number of Black women have lower income and education levels compared with White women, a pattern which presents overall barriers to good health (Braithwaite, Taylor, & Treadwell 2009; Williams & Collins 1995). Factors such as cultural environments, psychological influences, and sociological influences are used to explain major racial health disparities (Braithwaite, Taylor, & Treadwell 2009; Redding et al. 2000; Williams 1999; Williams & Collins 2001). Although these social health behavior models do explain health variation, the specific contributions of never-married and childfree status have not been fully explored in this context. Health status remains complex; as such, the exploration of health differentials demands a focus on multiple selected variables.

As modern society is undergoing rapid social change, the impact on certain individuals' health is unknown. Foregoing marriage among women is a new family trend. The unknown social consequences are important for social scientists seeking to make meaning of that change. SWANS, a byproduct of social change, are constructed as a niche social group.

NEVER-MARRIED CHILDFREE WOMEN: UNDERSTANDING HEALTH

Previous work on the health of never-married individuals has drawn varied conclusions. Never-married individuals have not been consistently held to have either good or poor health patterns overall. For example, Jessie Bernard (1975) asserts that marriage is good for men and bad for women, while Waite and Gallaher (2001) build a strong case for the institution of marriage. However, the health and well-being outcomes of this group might have significant social implications. Analyzing how unmarried, childfree Black and White women compare to each other and to their married counterparts on health outcomes, whether parents or childfree, can suggest specific areas of strength and weakness

in health, family, and societal inequalities. Analyzing various race-gender-marital status interactions will also illuminate how Black and White women may experience an important aspect of life—the inequality of their health. Low marriage rates and low probability of marriage suggest the significance of analyzing nonparental singlehood, especially among Black women (Marsh et al. 2007).

Much like the exclusion of women and particularly Black women, never-married singles have been neglected in research. Historically, in U.S. society, singlehood was considered to be temporary or problematic behavior, because fewer support systems, guidelines, or standards existed for negotiating an unmarried lifestyle (Staples 1981). However, modern impacts of remaining single and childfree for prolonged periods of time have not been as central to health research (Lundquist et al. 2009). In fact, "never-married" is often perceived as a transient marital status, occupied by a large number of individuals moving in and out of the status; therefore, the health consequences of singlehood are difficult to study (DePaulo 2006; Staples 1981; Spreitzer & Riley 1974). As the numbers of both never-married and childfree women increase (Taylor 2010), these findings have implications for many areas of research such as health, race, and family. The mainstream media is occupied with Black women's failure to marry, as evidenced by an overabundance of news articles, stories, and blogs (see Table 1). The topics, although all slightly different, focus on the results of prolonged childfreeness and frame unmarried status among Black and White women as problematic.

Table 1. Descriptive statistics for SWANS (N=3552).

Variable Name	Black SWANS (n=5,306)	White SWANS (n=19,073)	P-Value	Relative Difference (B-W)
Self-Rated Health				
Excellent	29.98	40.51	P<.0001*	-10.53
Very Good	33.66	35.18		-1.52
Good	25.61	18.72		6.89
Fair	8.65	4.45		4.20
Poor	2.09	1.14		0.95

Table 1, continued. Descriptive statistics for SWANS (N=3552).

Variable Name	Black SWANS (n=5,306)	White SWANS (n=19,073)	P-Value	Relative Difference (B-W)
Independent Variable				
Age Groups				
18-23	38.22	46.76	P<.001**	-8.54
24-29	24.43	26.01		-1.58
30-35	15.25	13.31		1.94
36-46	22.11	13.92		8.19
Education				
Less than high school	13.48	8.76	P<.001**	4.72
High school	24.59	19.29		5.30
Some college	38.03	39.83		-1.80
Bachelor's degree	17.15	23.64		-6.49
Advanced degree	6.75	8.49		-1.74
Poverty Status				
At or above poverty threshold	77.91	84.15	P<.001**	-6.24
Below	22.09	15.85		6.24
Income				0.00
Less than $15K	57.11	54.71		2.40
$15,000-$24,999	13.78	14.88		-1.10
$25,000-$49,999	20.04	19.24		0.80
Over $50,000	9.07	11.58		-2.51
Home Ownership				
Rent	67.02	50.64	P<.001**	16.38
Own	32.9	45.97		-13.07
Insurance Coverage				
Yes	72.81	78.3		-5.49
No	27.19	21.69		5.50
Region				
North	17.11	19	P<.001**	-1.89
Midwest	17.53	25.33		-7.80
South	55.52	32.34		23.18
West	9.84	23.33		-13.49

* p <0.05; ** p<0.01; *** p<0.001; **** p<0.00

GROUP INTRODUCTION AND CONCEPTUALIZATION: MEET THE SWANS

Race and gender capture a number of interactions that have created a unique and understudied experience among never-married, childfree women. The SWANS are groups of White and Black women who do not have children or a marital partner. Husbands and/or children are viewed as grounding agents in larger society and true markers of adulthood, or as "stabilizing" forces. Similar groups of unmarried Black women have been referred to as the Love Jones Cohort (referring to the 1997 film *Love Jones*) (Marsh et al. 2007) and SaLAs (Single and Living Alone) (Marsh et al. 2007). The Love Jones Cohort is comprised of SaLAs and have been defined and operationalized as Black women between the ages of 25 and 44, living alone, childfree, single, holding high-wage occupations, who have advanced degrees, maintain above-average household incomes, and own their own homes (Marsh et al. 2007, 3).

The term SWANS was first coined by sociology professor Christine Whelan (2006) and was used as an acronym to stand for Strong Women Achievers and No Spouse, from which the expression SWANS in this study was derived. When author Whelan (2006) uses the term SWANS, she refers to a group of women who are unmarried. Of SWANS, she finds that being a high achiever decreases women's chances for marriage (for both racial groups). Whelan's work does not provide an in-depth racial analysis of SWANS; the conceptual framework, when applied to race, is limited. Whelan noted the complexity involved with the racial burden among female high achievers.

BACKGROUND AND THEORETICAL FRAMEWORK

The Pew Center reported one in five (20%) White women ages 40–44 as being childfree in 2008, with 17% of Black women in the same age group childfree that year (Taylor 2010). Rates of childfreeness increased more for non-Whites than Whites between 1994 and 2008. During those same years, the childfree rates for Black

and Hispanic women grew by more than 30%, while rates for White women increased only 11% (Tables 2, 3). The trend among Black women to remain unmarried and childfree has mirrored the overall U.S. decline in marriage and fertility rates (Dickson, Lynda, & Marsh 2008; Lundquist et al. 2009). Little information exists that can be utilized to understand the well-being or social experiences of this group—thus making the goals of this study twofold. While SWANS are a specific population, Marsh and colleagues (2007) suggest that Black unmarried, childfree women are part of the newly emerging Black middle class and are an important demographic group worthy to be studied. Thus, this group's particular experience and demographic profile will contribute to understandings and conceptualizations of singlehood.

Table 2. Contingency table: racial distribution of health factors by family type SWANS only (N=3552).

	Self-Rated Health				
	Fair/Poor		Excellent/Very/ Good		Total
Race Category					
Black	8.18	105	91.82	696	758
White	3.8	62	96.2	2659	2764
					3355
Chi-Square	25.27***				
**P<(0.1)					

MARITAL STATUS AND HEALTH: HAPPY TOGETHER

Although "never married" is the marital status of interest in this study, current understandings about the unmarried are typically viewed from the vantage point of married individuals. Sociologist Peter Stein (1981) studied singles and created a general schema of how individuals arrive at singlehood (see Figure 1). Family scholars continue to focus on married individuals as the group of primary interest. Research demonstrates that married individuals are the healthiest of all marital statuses (CDC 2022;

Table 3. Log-linear model coefficients (odds ratios) SWANS on physical health.

	Model 1	Model 2	Model 3	Model 4
Race[a]				
Black	2.42****	2.21****	1.66****	1.68****
Age[2]		1	1.00**	1.00***
Education[b]				
High school			0.73	0.75
Some college			0.52*	0.52*
Bachelor's degree			0.33*	0.34**
Advanced degree			0.29**	0.30**
Income[c]				
$15,000-$24,999			0.52**	0.52**
$25,000-$44,999			0.44***	0.44***
$45,000+			0.31****	0.30****
Insurance Coverage				
Uninsured			0.58**	1.78**
Region[d]				
South				0.93
Year[e]				
2011				1.17
2012				0.8
2013				0.65
Intercept	-3.24	-4.09	-7.17	-7.13

[a] Reference category is White SWANS; [b] Reference category is Less Than High School; [c] Reference category is Less Than 15K; [d] Reference category is Insured; e Reference category is Year 2010.

* p <0.05; ** p<0.01; *** p<0.001; **** p<0.00

Stutzer &Frey 2006; Waite & Gallagher 1995). Marriage enhances health by providing additional resources, sexual regulation, and self-esteem building (Stutzer & Frey 2006; Waite & Gallagher 1995). Social researchers interested in studying singlehood only have studies on marriage such as the one cited above to rely on, which are not designed very carefully to consider singlehood as a social category. *The Case for Marriage* (Waite & Gallagher 2001) concluded that married people are emotionally, psychologically, and physically healthier than their divorced, bereaved, or single

	Voluntary	Involuntary
Stable	• Open to lifelong single-hood but not looking for marriage	• Actively seeking mates • Not interested at time of study but now looking
Not Stable	• Choose to be single • Opposed to marriage • Cannot get married for any reason • Member of reigious order	• Never-married and for-merly married • Likely to remarry

Figure 1. Typology of Unmarried Individuals Based on Peter Stein's 1987 Singlehood Typology

counterparts. While the book received some serious critique from the research community (DePaulo 2006; Penman 2005), it is one of the most widely cited works regarding marriage and health. In 2007, the Center for Disease Control's National Center for Health Statistics confirmed this conclusion by demonstrating that married individuals were less likely to be limited in daily activities, to smoke, to drink heavily, or to be physically inactive (CDC 2022).

ANALYTICAL APPROACH

The central question that this study aims to address is: Are there racial differences in the health statuses of SWANS? This research utilizes data from the Integrated Health Interview Series (IHIS). The sample number (34,241) at the individual level includes pooled data from 2010 to 2013 in order to increase the number of health events that may occur among a younger aged cohort. Individuals to be included in the sample for this analysis are selected by two main criteria: 1) race—only individuals that identify as Black or White are included in the sample, and 2) sex—only individuals who identify as female are included. The sample derived from the IHIS covers health data from the years 2010–2013. This study utilizes binomial logistic regression to study the impact that the interaction of race, gender, and marital status has on the outcome variable, health.

Health as a variable and concept is complicated, as it is difficult to ascertain all components of health. As a result, several variables exist that are used to create and predict the dependent variable *self-rated health*. This variable is widely used because of its validity and reliability for measurement of individual health status (Idler & Benyamini 1997; Mossey & Shapiro 1982). Many research studies have linked self-rated health to accurate prediction of mortality and morbidity, which demonstrates the overall reliability of the measurement. Self-rated assessments of health status ask respondents to "rate their overall health" within the ordinal frame of "excellent," "good," "fair," "poor," or some other similar Likert Scale variant (Idler & Benyamini 1997). Self-rated health is used to determine the likelihood that an individual reports being in excellent/good health. The variable labeled SELF-HEALTH is dichotomized and recoded to reflect whether a person reports 1=fair/poor health or 0=excellent, very good, or good health.

Race, marital, and family type are the main independent variables. Variables that are a measure of one's social class are the important variables to consider. For this analysis, family size, family type and marital status will be combined to create the main analytical group, SWANS. Social class parameters, namely, education, income, age, year, and region, are included as control variables. AGE is a continuous variable that measures the individuals' age in years. The data contains information for those women aged 18 to 44 in each model. AGE and AGE-squared will be presented. INCOME is divided into four categories ranging from less than $15,000.00 to greater than $47,000.00 per year. EDUCATION is divided into five categories: no high school degree, high school degree, some college, college degree and those with an advanced degree. Five dummy variables are created (less than high school education, high school graduate, some college, college graduate, and advanced degree) to investigate the educational impact on health outcomes (Nitsche & Brueckner 2009).

REGION is coded as a series of dummy variables (SOUTH, NON-SOUTH), with SOUTH as the reference category. Due

to the concentration of Black females in the southern states, the high rates of religiosity, and the "culture of marriage" pervasive in the south, I expect to find the effect of race and marital status on health to vary across regions, such that individuals residing in southern states will have higher rates of marriage than those who reside in the northeast, west, and midwest.

INSURANCE, or medical coverage, is included as an independent variable and is measured as insured or uninsured. The goal of this study is to interpret the health consequences of race and family type, focusing on childfree singlehood. Descriptive statistics of the specified variables are presented, paying special attention to the percentage distribution of family type and each individual variable (for conceptual framework see Figure 3 below). To build a more accurate analysis of child-free unmarried adults, the descriptive tables show the sample distribution including age, race, and education of unmarried childfree women. Bivariate analysis between the dependent variable(s) and each of the explanatory variables is presented. Chi-square tests are used to detect if family types differ significantly on various health outcomes. Using the Chi-square results, the association and strength of association, between the independent and dependent variables can be determined.

DISCUSSION

The social demographic characteristics of SWANS are of interest, especially when compared to married parents, the prototype of American families. As shown in Table 1, most SWANS possess a bachelor's degree or advanced degree (36.17% and 32.33% respectively), with fewer SWANS achieving only lower levels of education, such as a high school diploma or less than high school. This positive education association is one that we will revisit. More than a third of SWANS, 37.34%, reside in the south, compared to the majority, who are located across the remaining 3 U.S. regions (62.66%). SWANS are relatively younger than married women in the sample, with the average age of SWANS being 29.21 years, compared to the average age of married parents (36.24 years)

and married childfree couples (34.35 years). The majority of married childfree women earn over $45,000 compared to SWANS or married parents, and SWANS are slightly less likely than married parents to earn $45,000 or more per year. Single parents, as expected, are most likely to earn the lowest income, less than $15,000 per year (41.62%). SWANS, however, are more likely to earn below $15,000.00 than married parents and married childfree women (33.48%, compared to 26.52% and 18.09%, respectively). Table 1 presents the educational levels of family types and reveals education patterns of SWANS relative to married women. SWANS report lower levels of attainment of bachelor's degrees and advanced degrees than married parents (36.17% compared to 41.03%).

Overall Findings

Because SWANS, unmarried and childfree women, are an understudied population, it is difficult to completely discern or predict their health patterns relative to White women. The descriptive analysis provides some support for the overall notion that unmarried, childfree women may, in some cases, demonstrate better overall well-being in comparison to the married, if not better. The sociodemographic indicators of income and education present an interesting picture of the economic realities of being unmarried. A third of all SWANS (33%) report belonging to the lowest income category (earning less than $18,000), while a little over half of SWANS report yearly earnings of $25,000.00 to $45,000.00. Considering the youthfulness of the sample, as well as the educational status (see below), SWANS are making great financial gains. Educationally, SWANS are making a great deal of social advancements and are attaining advanced and bachelor's degrees on par with married households. The huge difference in obesity status among both Black and White SWANS could suggest a possible health benefit for Black SWANS; White SWANS are nearly twice as likely to report obesity compared to Black SWANS. This issue of body size, race, weight, and marriage should be further explored.

While the results from the descriptive display of health-related variables revealed racial differences in health and other social and demographic categories, some racial similarity exists among the relationships among race, family type, and health.

For the first set of tables that test the SWAN relationship, all models report the odds ratios or race alone as the first independent variable; Model 2 introduces the other main independent variables in a stepwise regression procedure; Model 3 shows the effect of the main independent variable of race, plus the control variables added to family type. The results of the regression models and associated equations simultaneously support race as a major social determinant of health.

The odds of reporting fair/poor health for Black SWANS are about 2.42 times greater than those for White SWANS. The result is statistically significant at the 0.001 level, thus we reject the null hypothesis; the hypothesis that Black SWANS will report fairer/poorer health than White SWANS is supported. For Model 2, the question arises what happens to the model when we add a very important demographic variable, age, which has a tremendous impact on health conditions. When holding age and age-squared at a fixed value, the odds of reporting poor health are still greater (2.21) for Black SWANS, and the result is statistically significant. With Model 3, when we add SES indicators such as education, income, and insurance coverage, the impact of race on reporting poor health decreases, but still the odds of reporting poor health for Black SWANS are 1.66 times greater than those for White SWANS despite holding the impact of age and SES factors at a fixed value. Although it is not statistically significant, the odds of reporting poor health are the greatest for the high school graduates among other educational categories; as the educational level goes up, the odds of reporting poor health significantly decrease.

Similarly, the odds of reporting poor health decrease as income levels increase. Those who earn more than $45,000 are more likely to report good health. For the uninsured, the odds of reporting poor health versus reporting good health increase

by a factor of 0.58 compared to the insured. With Model 4, when we add the effects of region and time, the odds of reporting poor health for Black SWANS slightly increases compared to those for White SWANS. There is not a very noticeable change in the effect of income and education; however, the odds of reporting poor health for the uninsured significantly increase from 0.58 to 1.78. After controlling for various SES variables, race remained a consistent and significant predictor of health, with Black SWANS being more likely to report negative health conditions than White SWANS.

CONCLUSION

The Sojourner Syndrome Model directly addresses the paradoxical situation of Black SWANS. Because of the many social identities of Black women, a focus on health should be addressed by considering various distributions of resources, privilege, and power so that a comprehensive picture of health emerges (Andersen & Collins 2006; Hurtado & Stewart 1997; Mullings 2005; Weber & Fore 2007). The family ranking systems for White women show more of a reward for marriage and motherhood than for Black women. Due to the multiplicative oppression of race, class, gender, and now family type, there is not an equal system of rewards for Black women. This systemic differentiation has revealed race as a master status that overrides any advantages that marriage has for health. In American society, Whiteness is considered the status quo, and there are discriminate advantages of marriage and parenthood. These benefits are contrasted to the disadvantageous situation of Blacks, who collectively display poorer health outcomes than White women.

According to the Sojourner Syndrome Model, oppressive life circumstances among Black women cause their health decline (Kelly 2014; Lekan 2009; Mullings 2005). The use of an intersectional framework is needed to interpret the key findings. Race alone or parental status alone are too restrictive in what they reveal about the Black unmarried-childfree experience. When

additional contextual factors such as race, parental status, and marital status are incorporated in the concept of family experiences, a more comprehensive understanding of health is possible. Recent studies on Black women's health propose that racism, structural discrimination, and social inequality are all associated with physiological changes, and are also somewhat responsible for their adverse health conditions (Williams et al. 1997). Despite major progress in the overall health of all Americans, African Americans experience a complex and diverse range of health problems at a much greater rate compared to Whites. For both racial groups, findings here are consistent with the Social Determinants of Health Model and demonstrate the severity in racial health gaps. Blacks are more likely than Whites to live in poverty, to be uninsured, and to be out of work resulting from disabling health conditions (Braithwaite, Taylor, & Treadwell 2009; Williams et al. 1997). African American women ages 45 to 54 have three times the rate of diabetes, increased levels of breast cancer mortality, and have a 60% greater likelihood of death than White women in the same age group (Holden et al. 2012; Taylor & Holder 2001). HIV/AIDS, cancer, diabetes, and hypertension are just a few of illnesses that plague Black women at a higher rate.

Family scholars now recognize marriage as no longer compulsory, a necessity, or having the same utility as the past. Family scholar Susan Brown, co-director of the National Center for Family and Marriage Research (NCFMR) at Bowling Green State University, comments on the change in marriage: "It is just one of array of options. Increasingly, many couples choose to cohabit, and still others prefer to remain single" (Bowling Green State University 2013). Decreasing marriage rates are not limited to Black communities but are found in society overall, which is explored in detail by family scholars such as McAdoo (2007) and Cherlin (2005). Andrew Cherlin's social-scientific projections in 1993 regarding how increasing educational rates among women would impact marriage rates have come to pass. In fact, well over 20 years later, Cherlin does his best to explain why his predictions

came to pass. In *The Marriage-Go-round*, Cherlin (2010) illuminates the precarious state of the nuclear family as a "war" of cultural ideas. While personal choice and individualism are part of the American ethos, many institutions continue to cater to married individuals in ways that are ultimately beneficial to their health, yet little consideration for unmarried women exists.

Future research should expand the discussion of SWANS' experiences or stimulate a conversation concerning marriage and nonmarriage, always calling into question the role of institutions in creating these divides. Future research should also analyze the SWANS experience among multiple racial groups. Many cultural, social, and religious customs reject the idea of singlehood. Alternative questions of health outcomes and the cultural impact of singlehood can be compared across various racial, social, and religious groups.

REFRENCES

Andersen, Margaret L., and Patricia Hill Collins. 2006. *Race, Class, and Gender: An Anthology*. 6th ed. Belmont, CA: Wadsworth Publishing.

Bernard, Jessie. 1975. *Women, Wives, Mothers: Values and Options*. Chicago: Aldine.

Bowling Green State University. 2013. "Marriage Rate Lowest in a Century." July. https://www.bgsu.edu/news/2013/07/marriage-rate-lowest-in-a-century.html.

Braithwaite, Ronald L., Sandra E. Taylor, and Henrie M. Treadwell, eds. 2009. *Health Issues in the Black Community*. Hoboken, NJ: John Wiley & Sons.

Centers for Disease Control and Prevention (CDC). 2022. "FASTSTATS - Marriage and Divorce." March 25. https://www.cdc.gov/nchs/fastats/marriage-divorce.htm.

Cherlin, Andrew J. 2005. "American marriage in the early twenty-first century." *The Future of Children* 15: 33–55.

Cherlin, Andrew J. *The Marriage-Go-Round: The State of Marriage and the Family in America Today*. New York: Vintage, 2010.

DePaulo, Bella. 2006. *Singled Out: How Singles Are Stereotyped, Stigmatized, and Ignored, and Still Live Happily Ever After*. London: Macmillan.

Dickson, Lynda, and Kris Marsh. 2008. "The Love Jones Cohort: A New Face of the Black Middle Class?" *Black Women, Gender & Families* 2(1): 84–105.

Idler, Ellen L., and Yael Benyamini. 1997. "Self-rated Health and Mortality: A Review of Twenty-Seven Community Studies." *Journal of Health and Social Behavior*. 21–37.

Holden, Kisha B., Stephanie P. Hall, Maryam Robinson, Sharra Triplett, Dolapo Babalola, Valens Plummer, Henrie Treadwell, and L. DiAnne Bradford. 2012. "Psychosocial and sociocultural correlates of depressive symptoms among diverse African American women." *Journal of the National Medical Association* 104(11–12): 493–504.

Hurtado, Aida, and Abigail J. Stewart. 1997. "Through the Looking Glass: Implications of Studying Whiteness for Feminist Methods." *Off White: Readings on Race, Power, and Society*: 297–311.

Kelly, Ursula A. 2014. "Military Sexual Trauma and Nursing Practice in the Veterans Administration." In *Philosophies and Practices of Emancipatory Nursing*, pp. 285–297. Oxford: Routledge.

Lekan, Deborah. 2009. "Sojourner Syndrome and Health Disparities in African American Women." *Advances in Nursing Science* 32(4): 307–321.

Lundquist, Jennifer Hickes, Michelle J. Budig, and Anna Curtis. 2009. "Race and Childlessness in America, 1988–2002." *Journal of Marriage and Family* 71(3): 741–755.

Marsh, Kris, William A. Darity Jr, Philip N. Cohen, Lynne M. Casper, and Danielle Salters. 2007. "The Emerging Black Middle Class: Single and Living Alone." *Social Forces* 86(2): 735–762.

McAdoo, Harriette Pipes, ed. 2007. Black Families. Thousand Oaks, CA: Sage.

Mossey, Jana M., and Evelyn Shapiro. 1982. "Self-Rated Health: A Predictor of Mortality among the Elderly." *American Journal of Public Health* 72(8): 800–808.

Mullings, Leith. 2005. "Resistance and Resilience: The Sojourner Syndrome and the social context of reproduction in Central Harlem." *Transforming Anthropology* 13(2): 79.

Nitsche, Natalie, and Hannah Brueckner. 2009. "Opting Out of the Family? Social change in racial inequality in family formation patterns and marriage outcomes among highly educated women." *American Sociological Association*. (August 2009). Retrieved from http://www.yale.edu/ciqle/Nitsche_brueckner_Executive%20summary.pdf

Penman, Robyn. 2005. "Current Approaches to Marriage and Relationship Research in the United States and Australia." *Family Matters* 70: 26–35.

Read, Jen'nan Ghazal, and Bridget K. Gorman. 2006. "Gender inequalities in US adult health: The interplay of race and ethnicity." *Social Science & Medicine* 62, 5: 1045–1065.

Redding, Colleen A., Joseph S. Rossi, Susan R. Rossi, Wayne F. Velicer, and James O. Prochaska. 2000. "Health Behavior Models." In *International Electronic Journal of Health Education*.

Rowland, Donald T. 2007. "Historical trends in childlessness." *Journal of Family Issues* 28(10): 1311–1337.

Spreitzer, Elmer, and Lawrence E. Riley. 1974. "Factors associated with singlehood." *Journal of Marriage and the Family*. 533–542.

Staples, Robert. 1981. *The World of Black Singles*. Westport, CT: Greenwood Press.

Stein, Peter J., ed. 1981. *Single Life: Unmarried adults in social context*. New York: St. Martin's Press.

Stutzer, Alois, and Bruno S. Frey. 2006. "Does Marriage Make People Happy, or Do Happy People Get Married?" *The Journal of Socio-Economics* 35(2): 326–347.

Taylor, Paul, ed. 2010. "The Decline of Marriage and Rise of New Families." *Pew Research Center*.

Taylor, Sandra E., and Kisha Braithwaite Holden.2001. "The Health Status of Black Women." *Health Issues in the Black Community*: 44–61.

Waite, Linda J. 1995. "Does Marriage Matter?" *Demography* 32,(4): 483–507.

Waite, Linda J., and Maggie Gallagher. 2001. *The Case for Marriage: Why Married People Are Happier, Healthier, and Better Off Financially*. New York: Crown Publishing Group.

Weber, Lynn, and M. Elizabeth Fore. 2007. "Race, Ethnicity, and Health: An intersectional approach." In *Handbooks of the Sociology of Racial and Ethnic Relations*, pp. 191–218. Boston, MA: Springer.

Whelan, Christine B. 2006. *Why Smart Men Marry Smart Women*. New York: Simon and Schuster.

Williams, David R., and Chiquita Collins. 1995. "US Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology: 349–386.*

Williams, David R., Yan Yu, James S. Jackson, and Norman B. Anderson. 1997. "Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination." *Journal of Health Psychology* 2(3): 335–351.

Williams, David R. 1999. "Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination." *Annals of the New York Academy of Sciences* 896(1): 173–188.

Williams, David R., and Chiquita Collins. 2001. "Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health." *Public Health Reports* 116(5): 404–416.

Cassandra Carter, Booz Allen Hamilton