

2003

## Increased Morbidity and Mortality in Single Parent Families: A Review

Katie Steneroden  
*Iowa State University*

Follow this and additional works at: <https://scholarworks.uni.edu/ijgh>



Part of the [Public Health Commons](#)

---

### Recommended Citation

Steneroden, Katie (2003) "Increased Morbidity and Mortality in Single Parent Families: A Review," *International Journal of Global Health*, 2(2), 44-51.

Available at: <https://scholarworks.uni.edu/ijgh/vol2/iss2/5>

This Research is brought to you for free and open access by the Journals at UNI ScholarWorks. It has been accepted for inclusion in International Journal of Global Health by an authorized editor of UNI ScholarWorks. For more information, please contact [scholarworks@uni.edu](mailto:scholarworks@uni.edu).

# INCREASED MORBIDITY AND MORTALITY IN SINGLE PARENT FAMILIES: A REVIEW

Katie Steneroden, D.V.M.  
Iowa State University  
2170 Veterinary Medicine  
Ames, Iowa 50011

## INTRODUCTION

American families have changed dramatically in composition in recent decades. Increasing proportions of children are being raised in single parent households, reflecting both rising divorce rates, the growing percentage of births to unmarried women and adoption by single parents. As fewer children grow up in traditional families, there is increasing concern about the impact of alternative family structures on children's health and well-being. Many believe that there is a vital connection between family structure and youth well-being, with the nuclear family constituting the optimal structure for fostering "normal" development. Some say the change in the typical nuclear family is one of the most significant demographic and social transformations of recent history.

Connections are now being made between single-family female-headed households and decreased well-being of children. These include lowered academic achievement, increased accidents, psychiatric disorders, emotional and behavioral problems, increased rates of suicide, drug and alcohol related problems and death. Lone parents are also found to have greater levels of psychological distress.

It is a reasonable hypothesis that single-parent children are raised with generally poorer household resources, resulting in negative effects on their health. Also, that economic hardship is the cause of increased psychological distress in single parents. Many studies are purporting to control for socioeconomic status and still find a disparity between single- and two-parent families when it comes to child and parent health. The purpose of this paper was to review the current literature on the epidemiological relationship between single-parent households and decreased child and parent health.

## REVIEW OF STUDIES

A population-based study was conducted in Sweden over a seven-year period using 65,085 children from single-parent families and 921,257 children from two-parent families (1). Information was obtained through Swedish national registers: Swedish Population and Housing censuses (children living in one- or two-parent households), Swedish Total Enumeration Income Survey (welfare and unemployment data), Swedish Hospital Discharge Register (alcohol or drug abuse info), Swedish National Board of Health and Welfare (hospital discharges), National Cause of Death Register (mortality) and National Hospital Discharge Register (morbidity). Diagnosis was based on the doctor's judgment, not a standard diagnostic assessment.

Variables included age of child and parent, number of children, socioeconomic status, welfare status, city dwelling vs. country dwelling, owning or renting a house, alcohol and drug abuse, psychiatric illness and ill health.

Many of the differences in morbidity and mortality between single-parent and two-parent families in this study were explained by the socioeconomic status - lack of household resources. Smaller contributions were made by drug/alcohol addiction and mental illness. The authors claim a significant increased risk remains unaccounted for and speculate that this is due to three confounders: parental absence (because there is only one breadwinner), lack of social support (single parents are more isolated) and family conflict (single parent families largely become so through divorce). They speculate that divorce and continued family hostility create a negative home environment where kids are stressed, unhappy and insecure which may lead to increased morbidity and mortality.

Hospital records reviewed by the authors do not show severity of disease or injury. This is an example of selection bias in that it may be single parents have more hospital visits because they have no opportunity to share responsibility of a sick child and so are more likely to take a child to the hospital than care for them at home. Additionally this study lacked knowledge on shared custody arrangements and lack of information on when a divorce took place. This did not allow researchers to evaluate risk in relation to the length of time since parent separation.

The duration and number of subjects make this an important study. Questions arise about variables and generalizability. In this study it was more common for the single parent to have been born outside of the country. The authors don't elaborate on or explain this factor. They don't use the variables of race or ethnicity so it cannot be determined what "being born outside of the country" means or what affect it may have. It may have none, but it should be explained. Another important factor is that Sweden has subsidized day care making comparability with most other countries difficult, thereby decreasing the study's external validity.

Re-analysis of data published in the Childhood Supplement of the Registrar General's Decennial Supplement on Occupational Mortality in England and Wales was reviewed (2). The supplement is put out by the British government and concluded that differences in health status between single-mother families and two-parent families cannot be fully accounted for by socioeconomic status, so further research needs to be done. Judge and Benzeval claim that the findings of the supplement misrepresent the facts and are an excuse for ignoring health inequalities. Their study attempts to show that the method used for classification of children in childhood mortality figures is misinforming.

This study and re-analysis requires some explanation. The supplement classified families into "unemployed" or into "social class's I-V." Unemployed are lowest on the socioeconomic scale, next was social class I and so on to the wealthiest in social class V. It then takes the child mortality figures and only fits that data into the social classes I-V (excluding unemployed). The conclusion by the supplement was that socioeconomic status does not account for most child mortality. Clearly, to be comparable the social class and mortality groups would have to contain all of the same individuals, unemployed up through social class V. This becomes even more important when we realize that single mothers make up 89 percent of those classified as unemployed and their children

accounted for 6 percent of all children (61,445 out of 1,017,379 children total) and 14 percent of observed death. The authors claim this was not just an oversight and that the government has an interest in putting off dealing with the issues of socioeconomic status. By making it a problem with an elusive cause, no one has to try and come up with an answer.

The authors acknowledge the inferences made are speculative, that the evidence is not conclusive but that the implications are profound and need to be addressed. This is clearly an error in data classification and analysis and it is compelling evidence that in this instance socioeconomic status plays a greater role in mortality in children than is reported in England.

The Canadian National Longitudinal Survey of Children and Youth cycle I (NLSCY) is an initiative of Human Resources Development Canada and Statistics Canada to develop a national database on the characteristics and life experiences of children and youth in Canada as they grow from infancy to adulthood (3). In 1994 there were 13,439 families in the study. Parent assessments were collected in the home with a computer-assisted interview. This was a cross sectional study of data collected from the (NLSCY) (1994-95). The study included 9,398 children aged six to 11 years, 8,112 from two-parent families and 1,286 from single-mother families.

This study examines the strength of the association between single-mother families and outcomes of children. It is interesting to note that single-father families were excluded from the study as the economic status of single-father families was similar to couples and so it was inappropriate to include them with single mothers. Also the number of single-father families was so small as to not be statistically significant (n=175).

Sociodemographic variables that were adjusted included age, gender, number of children, income, maternal education and maternal non-employment. Personal variables included social support, family dysfunction, maternal depression, parenting variables and hostile parenting. Child functioning was assessed by social impairment scales, psychiatric problems and math scores.

Findings suggest that children from one-parent and two-parent families develop difficulties for similar reasons. Low income in any type of family is associated with increased child morbidity, except in the area of hostile parenting. Children from single-mother families with hostile parenting style develop greater difficulties than children from two-parent families with hostile parenting.

Because this study relied on maternal reporting, the association between maternal depression and increased child problems may be reporting artifact or recall bias. Do low income or depressed mothers report higher morbidity in their children because everything seems worse to them? Do they believe if they report more problems they may get more financial assistance or more attention paid to their plight?

This was a cross sectional study, a single point in time, so cannot take into consideration temporal changes. The authors point out that no single variable is assessed by multiple methods and consider this a limitation.

Implications of this study are that interventions aimed at improving parenting will benefit both one- and two-parent families, but may be especially helpful in single-parent homes with hostile parenting.



This was a good study but all the complicated talk about child psychiatric problems left the reader with the impression that the authors believe all problems are related to parenting. Some child psychiatric problems, especially some of the more severe problems, may have a genetic or biologic basis and that possibility was never mentioned.

Several surveys were analyzed in a study by Angel and Worobey including the Hispanic Health and Nutrition Examination Survey (Hispanic HANES) and the National Health and Nutrition Examination Survey II (NHANES) (4). The Hispanic HANES survey included 2,781 Mexican children while the NHANES included black children (n=838) and non-Hispanic white (n=3532) children. There was an adult questionnaire, medical history form and maternal depressive effect score measured by the Center for Epidemiologic Studies Depression Scale. Each child was given independent physical exam. The authors utilized the Survey of Income and Program Participation (SIPP) to establish economic status, which was the first wave of a large scale longitudinal panel study that gave detailed information on individual, family and household income and social program participation for approximately 20,000 US households. This sample used 7,216 two-parent and 1,542 female-headed households.

Four variable categories were adjusted for, including culture (language of the interview and use of an acculturation scale), medical (mother's assessment of health, physician's assessment of health and mother's depressive effect score) sociodemographic variables and economic variables.

This study examined the effect of marital status on a mother's perception of her children's health in black, Mexican American and white children six to 11 years of age. They use three ethnic and racial groups because they felt varying cultural norms concerning marriage, motherhood and divorce may influence the well being of single moms and their children. They hypothesize it is possible that single motherhood entails different levels of vulnerability for children's health depending on the culture as well as social class in which it occurs. There is a complex interaction among marital status, economic resources and social resources that effect a mother's interpretation of her child's health.

Because medical sociologists rely heavily on self-reports of health, it is imperative to understand the nature of such subjective information. This study claims that a mother's report of poor health for her child is largely a reflection of her own distress level. Many things can affect the "accuracy" of a mother's assessment. According to this study mother's reports should not be taken at face value. There are several ways in which single motherhood can affect children's health or a mother's perception of and response to her child's symptoms. Poverty may impair health, children in female-headed households may manifest the stresses they experience physically as well as emotionally and complain of more common childhood symptoms. Finally, as a result of her own stress, a single mother may view her child's health as poorer than it is in reality. Single mothers are significantly less likely to report their children's health as excellent. There was a fairly consistent association between low income and reports of poorer health, especially for Mexican Americans. The authors conclude that the stress associated with single motherhood is associated with economic deprivation. Also a significant amount of the less than optimal health reported by all mothers for their children is associated with economic strain.

The strength of this study lies in the independent physical exam, which checked accuracy of the maternal self-reports. The same standard was used for all physical exams thereby minimizing observer bias. The authors could not use statistical analysis to compare the two surveys because of differences in survey type and considered this a limitation. And, as is the case with most of these cross sectional surveys, they cannot assess temporal relationships.

This excellent study brought up some interesting points and potential confounders not mentioned by any other studies. Female-headed households are four times more likely to live in poverty than two-parent households and these new points are extensions of living in poverty. Single mothers are extensively dependent on public programs, which make and keep them vulnerable. Because they are less likely to have private medical insurance they may receive lower quality health care. Young single mothers are more at risk of delivering premature infants who are more likely than full term infants to experience health problems at birth and in the future. And, low birth weight infants born to young mothers suffer more illnesses in general. This generates new confounders of birth weight, age of mother at birth, marital status at birth, reliance on medical assistance and change in public assistance or medical assistance that will hopefully be analyzed in future studies.

A cohort study using the 1958 British birth cohort followed to age 33 was reviewed (5). This cohort is comprised of all children born in England, Scotland and Wales during one week in March of 1958. Data was collected at birth, ages 7, 11, 16, 23 and 33 years. At age 23 there were 12,537 subjects remaining (76 percent) and at age 33 there were 11,405 (69 percent) subjects. Since those with high levels of psychological distress were less likely to respond at age 33, the authors used data from age 23. This eliminated selection bias so as to not underestimated differences in psychological distress between lone and married mothers.

Variables adjusted for include psychological distress as measured by the Malaise Inventory, age of the youngest child in the household and number of children. There were nine variables listed as indicators of hardship: financial (rent/mortgage arrears, being in debt, lack of savings) and housing based measures (housing tenure, access to a telephone, lack of central heating, shared household facilities, household dampness and overcrowding).

This study found that lone mothers were significantly more likely to report psychological distress than married mothers. The majority of the increased psychological distress in lone mothers was related to financial hardship some minor contributions were from social support, employment and number of children, especially when children are younger in age.

The authors were unable to exclude the possibility that psychological distress associated with divorce was an important contributor to psychological distress. Divorced moms had increased levels of stress than those who were never married, but this was claimed to be not statistically significant. This study contributes well to the body of data being gathered on single-parent families. The duration of the subject study and the inclusion of so many variables lend to its generalizability.

An analysis of the British General Household Survey (GHS) was reviewed, which was an annual cross sectional survey of 16,000 households and 25,000 people (6). It was

based on a stratified random sample of private households and has been shown to be representative of the British population, so for the British population, it is generalizable. The survey asked questions about personal and household characteristics, social and economic circumstances, health and health care utilization. This study utilized data from 1992, 1993 and 1994 and was limited to parents with dependent children. It consisted of 16,736 families, 12 percent of which were single parents.

The authors concluded that lone parents, especially lone mothers, have poor relative health status compared to couples. Much of this was accounted for by socioeconomic status, but four confounders remained - lack of a confiding intimate relationship, health selection into lone parenthood, stress regarding route into lone parenthood and finally the stigma of lone parenthood in Great Britain.

The authors recognized that the GHS may be a poor source of information in terms of social relationships and it cannot get the ideal level of detail for every researcher. It can't establish how long since subjects last cohabitated so length of time since separation can't be identified, another case of cross sectional survey not being able to show temporal relationships.

The study was a very informative analysis with an extensive introduction, background and literature review. This study utilized a self-report of health, which has been shown in previous studies to not always be the most accurate assessment of health in the parent or the child. Some of the authors' comments, such as, "Lone parenthood should not be seen as a totally negative experience." were questionable.

## CONCLUSIONS/SUMMARY

The hypothesis stated in the introduction to this paper is true — that is, single parents and single-parent children are more likely to live in poverty, which has a negative effect on their health. It is very clear that if one wants to improve the health of single mothers and their children, improving socioeconomic status is step one. And step one is so important that step two might not even be measurably important. It would be of great benefit to see a cohort study that improved the socioeconomic status of single-parent households and compared it to controls. While other factors should be explored, why not use the information we have and do some good for the majority of poor single mothers? Do we have to stop, do research, surveys and studies to look for other elusive causes when the largest contributor to childhood morbidity and mortality is staring us in the face? Every study reviewed found socioeconomic status to be THE biggest contributor to health inequalities in lone parents and their children. Do we need more evidence that enforcement of child support payments is crucial to the wellbeing of children? That poverty exists? That social programs geared towards women and children are crucial to the future health of our nation?

### *Other areas for consideration:*

*Study type:* The almost exclusive use of cross sectional designs has resulted in flawed research in the area of single-parent families and health issues. Social science issues are just too complicated to fit into the neat method of cross sectional study design.

*Divorce/parental conflict:* The length of time since divorce is important to ascertain. The stress and sadness of the breakup of a family unit undoubtedly has an effect on health, short and long term. The level of hostility involved in the breakup is also an important confounder. A growing body of evidence points to an inverse relationship between parental conflict and self-esteem. It has been demonstrated that parental harmony is closely related to psychosocial adjustment. Several studies show kids are better off in single-parent families with low stress than in a two-parent family with high stress. These are more reasons why the circumstances of single parenthood and continued hostilities are important variables.

*Who is doing the reporting:* The reviewed articles remind us to look closely at who is giving the assessment of health. It seems to be a common occurrence that poor single parents report decreased health for themselves and their children, which may or may not be corroborated by independent medical exams.

*Value-laden ideas of family that guide the entire question:* My interest in this subject is as a single parent. The stigma of single parenting has at times left me with a vague feeling that my child will suffer a multitude of disadvantages, that there is something inherently and/or morally wrong with growing up in a single-parent family. Through these readings I saw a bigger picture – that of a context steeped in a biased value system. Most all of the research into families, single or otherwise, has embedded within it a nuclear family bias that informs the questions, hypothesis, research and interpretation. Non-nuclear families are a deviation from the norm. Nuclear-family bias was a consistently neglected topic in all articles analyzed (excluding the article cited below). That the nuclear family is the optimum structure in fostering the well-being of children is a value judgment and needs to be re-examined. Are there possible beneficial effects deriving from different family forms? The issue is far more complex than researchers have been willing or able to entertain. In every area of child development and well-being that has been investigated to date there are no unequivocal answers. Certainly there are no answers that would indicate an indisputable link between departures from the nuclear family structure and negative consequences for the children involved (7). It might even be time to entertain the null hypothesis – that there are no differences in the effects of differing family structures so we can get on with learning what will help our children to grow up healthy and happy no matter what their family type.

## REFERENCES

Mortality, severe morbidity and injury in children living with single parents in Sweden: a population based study. *Lancet* 361(9354) 25 January 2003,

Judge K, Benzeval M. Health inequalities: new concerns about the children of single mothers. *British Medical Journal* 306(6879) March 13, 1993, 677-80.

Lipman, E, Boyle, M, Dooley, M, Offord, D. Child Well-Being in Single Mother Families, *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(1) January 2002 75-82.



Angel, R. and Worobey, J. Single Motherhood and Children's Health. *Journal of health and Social Behavior* Vol. 29 March 1988, 38-52.

Hope S, Power C Rodgers B. Does financial hardship account for elevated psychological distress in lone mothers? *Social Science and Medicine* 49(12) December 1999, 1637-49

Benseval M. The self-reported health status of lone parents. *Social Science and Medicine*. 46(10) 20 March 1998, 1337-1353.

Edwards J. Changing Family Structure and Youthful Well-Being, Assessing the Future. *Journal of Family Issues*. 8(4) Dec. 1987, 355-72.