

Chapter 12.

Family Structure and Mental Health¹

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One of the most significant structural changes in North American societies is the increase in the number of families headed by single mothers, which is due largely to rising rates of marital separation and divorce and an increase in the proportion of never-married single parents. These changes in family structure are more significant given the ever-increasing proportion of women in the labor force (Giele, 1988), a trend that has been especially pronounced among women with children (Bielby & Bielby, 1989). However, despite their labor force participation, a substantial proportion of single mothers suffer from significant socioeconomic disadvantage (Holden & Smock, 1991) largely as a result of being the sole wage earner in the household (McQuillan, 1990). Thus, many single mothers shoulder multiple burdens: At the same time that they assume all or most of the custodial and parenting responsibilities for their children, they frequently live in poverty while still undertaking the obligations of the work role.

It is by no means surprising then that these multiple sources of stress have a wide range of health consequences for single parents and their children. Indeed, there is widespread agreement in the scientific literature that single parenthood constitutes an important risk factor for mental health problems among parents and children. However, without a better appreciation of the web of social and psychosocial processes that surround the association between family structure and health outcomes, it seems unlikely that specific recommendations for preventive interventions can be made with any level of confidence.

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In this paper, I summarize some of the most salient findings from a large study of families, half of which are headed by single mothers. My primary purpose is to draw attention to those social and psychosocial processes that identify promising points of intervention suggested by these findings, specifically, three thematic areas: (1) the links between family structure and exposure to an array of stressors that have significant consequences for health; (2) the pervasive effects of poverty in single-parent families on the health of parents and children; and (3) the roles that individuals' childhood and adolescent experiences play in influencing subsequent family structure and their consequences for current well-being.

Thinking About Family Structure

The study of family structure and its effects on family members' health was stimulated by increases in divorce rates and births outside of marriage in the 1960s and 1970s. Consequently, many early studies of family structure and health focused on the impact of separation or divorce on parents' and children's psychological well-being. Early studies of separated and divorced families clearly established that marital dissolution is often accompanied by increased levels of stress and strain that continue long after divorce (Hetherington, Cox, & Cox, 1979a, 1979b; Wallerstein & Blakeslee, 1989; Wallerstein and Kelly, 1975, 1980; Weiss, 1975). These investigations identified a broad array of financial, work, and childcare strains that have negative consequences for the lives of separated or divorced women and their children. Studies of women who had children outside of marriage have reported similar findings (Furstenberg & Brooks-Gunn, 1986; Rutter & Madge, 1976). Since these landmark studies, other investigations have enriched our understanding of problems encountered by single-parent families (e.g., Furstenberg, Brooks-Gunn, & Morgan, 1987; Furstenberg & Cherlin, 1991; Guidubaldi, Cleminshaw, Perry, Nastasi, & Lightel, 1986; Kurdek & Berg 1983; McLanahan, 1983, 1985; McLanahan & Sandefur, 1994; Peterson & Zill, 1986).

A review of this research reveals a subtle change in the focus of more recent work. Earlier research tended to examine processes of adjustment to the dissolution of a marriage or the adaptation of teenaged women to motherhood. Implicitly, if not explicitly, much of this work treated single parenthood as a transitional status, almost as if it were a temporary social location that was a deviant or at least devalued social identity. By contrast, recent work seems to conceive of single parenthood as one type of family structure, rather than as a temporary or transitional social status.

This shift in focus has important implications for psychosocial and health research. First, it recognizes that single parenthood is simply one type of family structure and directs attention to social processes and experiences that affect all families, rather than to circumstances that are specific to marital transitions. This in turn, allows for comparisons among individuals in different family structures in terms of factors that condition their entry into these structures and those that influence their exposure and response to stressful experiences.

A second implication of thinking about single parenthood as one variation in family structure is that it enables researchers to see it as a product or consequence of the confluence of other particular statuses and roles. The intersection of marital status and parenthood may produce diverse forms of family structure that vary in stability over time. The notion that single parent and two-parent families constitute two kinds of family structures enables researchers to begin thinking about the psychosocial consequences for individuals of these differing social positions. Thus the impact of family structure on stressful experience and its consequences can be examined in the same manner that the sociology of stress has considered the effects of other social roles and statuses. By identifying the factors that influence entries into and exits from marriage and the circumstances that lead to timing of births before or after marriage, researchers can better understand the processes that most affect the lives of single mothers.

This approach to the study of family structure is also consistent with current thinking in prevention. It avoids the pitfalls of thinking of single parenthood as a stigmatized or deviant social status that requires treatment. Instead, the notion that single parenthood is one of many different types of family structure is a reminder that there will be substantial variation in health outcomes among these families just as there are among two-parent families. It is important, then, to document how single-parent families emerge and to trace their social, psychosocial, and health consequences for parents and children. Investigations that do so are likely to identify important opportunities for primary prevention initiatives.

Family Structure, Stress, and Mental Health

Single mothers are at elevated risk for psychological distress and depression. Several studies have documented greater psychological distress among separated and divorced parents than among the married (Furstenberg & Cherlin, 1991; Guidubaldi, Cleminshaw et al., 1986; Hetherington et al., 1979a, 1979b; Kurdek & Berg, 1983; McLanahan, 1983; Peterson & Zill, 1986; Wallerstein & Blakeslee, 1989; Wallerstein & Kelly, 1975, 1980). For these researchers, marital dissolution is a precursor of chronic strains, such as economic hardship and social isolation. These stressors may continue for long periods after the time of separation and may manifest themselves in elevated levels of distress. For example, McLanahan (1983) found that separation and divorce trigger chronic stressors, such as income reduction and housing relocation. Kitson and Holmes (1992) reported that divorced individuals experienced more life events than married people do, particularly negative events involving loss. When children are involved, additional strains may be associated with separation or divorce. The custodial parent, usually the mother, assumes many household, financial, and emotional responsibilities previously shared by two parents (Kitson & Holmes 1992).

Although the link between single parenthood and depressive symptomatology or psychological distress has been well documented, relatively little research has examined the consequences of single parenthood for psychiatric illness. Brown and Harris (1978) have clearly documented how many of the social and economic consequences of single parenthood are risk factors for depressive illness. Weissman, Leaf, and Bruce (1987) compared rates of clinical depression between single and married mothers using data from the New Haven site of the Epidemiologic Catchment Area studies. Although they found no significant differences between these two groups in 6-month prevalence rates, among whites, single mothers were almost twice as likely to suffer from depression as married mothers (13.1% vs. 7.7%). To my knowledge, there are no large-scale studies that compare single parents and married parents on rates of alcohol or substance abuse.

Family Structure and Exposure to Stressors

In the mid-1970s and early 1980s, explanations of social differences in mental health outcomes emphasized the differential vulnerability of specific social groups to stressful experience. The idea that individuals occupying certain social statuses might be more likely to suffer stress can be found in Dohrenwend & Dohrenwend (1974) and Brown (1974); who discuss substantial variations in mental health outcomes among individuals experiencing the same stressful event. Examples in the sociological literature include Pearlin and Johnson's (1977) examination of differential responsiveness to stress and Kessler's (1979a, 1979b) explicit examination of the differential vulnerability hypothesis. Just a few years later, research in psychology by Lazarus (1981), Kobasa (1982), and Cohen and McKay (1984) examined such concepts as vulnerability and stress resistance. Since then, vulnerability to stressors has become a dominant theme in stress research across disciplines.

Recent work in the sociology of mental health has challenged the existence of any pervasive group differences in vulnerability, arguing instead that vulnerability effects are specific to the stressors considered, the outcomes examined, and the interaction of acute stressors and chronic strains. This perspective has been argued most eloquently by Pearlin (1989) and Aneshensel (1992); both suggest that social structure has important implications for the kinds of stressors experienced by people, the kinds of mediators that are available to them, and the ways in which stressors manifest themselves. Aneshensel, Rutter, and Lachenbruch (1991) have also argued that a distinctive feature of sociological analyses of stress is a focus on the ways in which social structure gives rise to stress and its various sequelae. In this tradition, sociologists have been interested in how roles generate stressful circumstances.

Although there is ample evidence documenting higher levels of psychological distress among single mothers than among married mothers, I am unaware of any comprehensive tests of the relative power of differential vulnerability and differential exposure in accounting for this pattern. Indeed, although it seems clear that these families are exposed to elevated levels of ongoing stressors, the notion that women in single-parent families are less resilient to stress still seems to persist. However, much of the research in this area has not been based on population-based samples of single-parent families, and there has been a striking absence of any comparison sample of two-parent families. Of those studies that have been able to identify relatively large population-based samples of single-parent and two-parent families, few have collected information on a wide array of different stressful experiences. As well, any studies of family structure and stressful experience have employed very limited inventories of stressors, which severely limits their ability to estimate the effects of exposure on mental health outcomes. Moreover, in estimating the effects of differential vulnerability to stressors, it is important that the same domains of stressors be assessed among single parent and married mothers. Such designs constitute more rigorous tests of differential exposure and vulnerability to stress and avoid attributing unmeasured differences in stress exposure to differences in vulnerability (Turner, Wheaton, & Lloyd, 1995). For those who are interested in selecting among preventive interventions to enhance the well being of single parents, evidence of the relative advantages of reducing stress exposure as opposed to building resilience is crucial information.

Single Parenthood and Poverty

Among the many ongoing stressors to which single parent families are exposed, poverty may be the most pernicious. McQuillan (1992) has shown that increases in the labor force participation rate of married women has led to substantial increases in total household incomes among two-parent families, whereas demographic changes among single mothers have limited their family incomes. The result has been a consistently widening income gap between two-parent and single parent families. Consequently, poverty is substantially more prevalent among single-parent families than among two-parent families.

There can be little doubt about the pervasive effects of poverty on health. Horwitz (1984) has provided a comprehensive review of the literature that documents how socioeconomic disadvantage contributes to psychological distress among adults. More recent studies have reported elevated levels of depression and anxiety among men and women who are exposed to a variety of economic strains (Voydanoff & Donnelly, 1989). As well, there is evidence of significant negative associations between income and marital disruption and conflict (Conger et al., 1990; Liker & Elder, 1983). Although most studies of economic disadvantage and family relations have focused on interactions among spouses, poverty also seems to create difficulties in parent-child relationships.

Poverty erodes children's emotional well being as well. Results from some of the classic studies of children's mental health suggest that rates of emotional and behavioral problems are significantly higher among children from the most severely disadvantaged circumstances (Langner et al., 1974; Rutter, 1973; Rutter, Cox, Tupling, Berger, & Yule, 1975). The perhaps most comprehensive investigations of the association between social disadvantage and children's mental health have been conducted by Offord et al. (1987) in the Ontario Child Health Study.

McLeod and Shanahan (1993) have argued for the need to consider the persistence of poverty in examining the relationship between socioeconomic disadvantage and children's mental health. Their analyses reveal that persistent poverty is associated with deteriorating parenting skills, which in turn contribute to children's emotional problems. Their results call attention to the need to examine the impact of poverty in the context of family processes.

Family Structure and Chains of Adversity

Sociological studies of mental health indicate much about how social roles and statuses are associated with a variety of health outcomes and the factors that mediate these relationships. However, as several sociologists have noted, much less is known about the individual psychosocial experiences and the structural conditions that may precede arrival into particular positions or statuses in adulthood (Kessler & Magee, 1994b; Pearlin, 1989).

The vast majority of studies of family structure focus almost exclusively on the sequelae of single parenthood. Substantially fewer studies consider earlier experiences and personal histories that are the pathways to single parenthood. This seems to be a curious omission: It is unlikely that becoming a single parent is any more random an event than getting married, getting a job, or becoming a parent in general. A more complete understanding of the role that family structure plays in the lives of individuals can only be attained by describing the processes that produce different family structures that in turn result in variations in individuals' well being. This approach conceives of family structure as both a social consequence of prior experience and a social determinant of subsequent psychosocial outcomes.

Research on adversity in childhood and adolescence and its impact on the timing of depression provides some clues about possible chains of experience that are antecedents of single parenthood. First, the initial onset of depressive disorder frequently occurs in childhood, adolescence, or early adulthood (Robins & Regier, 1991; Sorenson, Rutter, & Aneshensel, 1991). Second, the vast majority of current cases of major depression among adults are recurrences, rather than first episodes (Kessler & Magee, 1993, 1994a, 1994b). These observations suggest that some of the most important determinants of the onset of depression are experiences in individuals' childhoods or adolescence before their entry into single parenthood. Therefore, focusing only on the stressful consequences of single parenthood may provide only a partial explanation of the determinants of depression among these individuals. Indeed, such an approach neglects the prior experiences that individuals bring into their adult marital and parenting roles; that is, life histories that may either exacerbate or diminish their risk for depression.

Although the processes through which early childhood experiences shape events in later life are multiple, one plausible mechanism is through their impact on mental health. Childhood adversity has been shown to have long-term mental health influences (Turner & Lloyd, 1995). For example, parental divorce and parenting problems seem to be related to depression in adulthood (Tennant, 1988). Other research points to the impact of parental psychopathology as a risk factor for the onset of disorder in childhood (Avison & McAlpine, 1992; Fendrich, Warner, & Weissman, 1990; Gotlib & Avison, 1992). Furthermore, individuals with early onset of affective disorder are more likely to experience separation or divorce than those with later onset or no disorder (Turnbull, George, Landerman, Swartz, & Blazer, 1990).

These considerations make it clear that whether one is a single parent or a married parent may be influenced by a number of social and psychosocial factors in childhood and adolescence. These experiences in one's family of origin condition both the likelihood of experiencing emotional problems and the probability of being a single parent. It seems then that adversity in one's family of origin, early role transitions, current family structure, and one's history of depressive episodes do not exist independently. The nature of their connections, however, continues to be elusive, warranting further attention (Rutter, 1989).

The Single-Parent Family Study

Overview

The data for this study come from a case-comparison study of single parent and two-parent mothers living in London, Ontario, Canada. The target population of single parents was all never-married, separated/divorced, or widowed women who lived with at least one child less than 17 years old.

The sampling frame was generated from a listing of the 1989 London Municipal Assessment File (MAF) containing an enumeration of every household in the municipality. An initial screening of the MAF generated a list of 5,419 households that appeared to include single mothers with at least one child under age 17. We stratified these lists of single-parent families (SPFs) into 13 geographic areas that reflected differences in household income to ensure an adequate representation of SPFs across socioeconomic circumstances. To generate a comparison sample of two-parent families (TPFs) matched by age and gender of the index child and by geographic area, we used a two-stage sampling strategy. First, we selected a random sample of all TPFs from the MAF stratified by the same 13 geographic areas as for the SPFs. In the second stage, we further stratified these families by age and gender of the oldest child. For each SPF, we then randomly selected a comparison TPF from the appropriate age-gender stratum.

Interviews were completed with 518 single mothers and 502 married mothers. The response rate among SPFs was 71.6 percent, and among TPFs it was 60.2 percent, for an overall rate of 65.5 percent. Based on what little information we had about families who refused to participate, we were reasonably confident that there are few biases due to non-response. No particular geographic area had significantly higher rates of refusal, nor was there an indication of any differences between responders and non-responders in maternal age or in the age or gender of the index child.

Eighteen months later, respondents were interviewed a second time. We were able to re-interview 472 of the original 518 single mothers, a retention rate of 91.1 percent. Our success rate for reinterviewing married mothers was 94.8 percent.

Measures

Field staff administered a 2-hour structured interview to mothers in their homes. The interview included measures on a wide range of areas, including socioeconomic circumstances, family history, psychosocial characteristics, life stressors, and mental and physical health.

Maternal mental health. Various dimensions of mothers' mental health were assessed. To measure major depressive disorder and dysthymia, we administered the relevant sections of the University of Michigan version of the Composite International Diagnostic Interview (CIDI; Kessler et al., 1994; Robins et. al., 1988). We assessed psychological distress using the well-known Centre for Epidemiologic study—Depression Scale (CES-D; Radloff, 1977). Anxiety was indexed with an abbreviated version of the trait version of the State-Trait Anxiety Inventory (Spielberger, Vagg, Barker, Dunham, & Westbury, 1980).

Children's mental health. Mothers completed the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), a 113-item list of symptoms of emotional and behavioral problems. Standardized scores (or T scores) on internalizing and externalizing dimensions were constructed for specific age and sex groups according to CBCL algorithms.

Stress. Stressful life events were assessed using a 41-item life events checklist (Avison & Turner, 1988; Turner & Avison, 1992a, 1992b). Mothers also noted when each event occurred and responded to a series of probe questions on each event. For the present analyses, we used a count of events that had occurred to mothers in the past year. Financial strain was measured with a 13-item scale indicating the extent to which respondents had experienced difficulties in meeting financial commitments. Our measure of family caregiving strain consisted of seven questions concerning feelings of role burden or overload in caring for family members. These items were modifications of a scale developed by Pearlin, Mullan, Semple, and Skaff (1990) in their study of caregiving and the stress process. We revised these items so that they were more relevant to mothers' concerns about caring for their children. Work-home role strain among women who were working either part- or full-time at the time of the interview was indexed with five questions assessing the extent to which they experienced role conflicts between home and work.

Psychosocial resources. We focused on three major dimensions of psychosocial resource variables. Mastery was measured with Pearlin and Schooler's (1978) 7-item index indicating the extent to which individuals believe themselves to be in control of their lives. Self-esteem was assessed using Rosenberg's (1979) well-known 10-item scale. A global measure of perceived social support was included in this study to assess generalized perceptions of social support. The Revised Kaplan Scale (Turner, Frankel, & Levin, 1983) consists of eight vignettes describing individuals with various levels of support. Respondents indicated who they themselves most resembled with regard to social support.

Family Structure and Its Impact on Health

Socio-Demographic Characteristics

Table 1 shows a basic socio-demographic profile of the sample of SPFs and TPFs included in the first wave of the study. Single mothers were somewhat less well educated and have slightly fewer children than married mothers. They were also less likely to be employed either full- or part-time, and their household incomes were less than half of married mothers incomes. Never married mothers, in contrast to those who were separated or divorced, were considerably younger, much less likely to be employed, and had extremely low household incomes. They had slightly more education and somewhat smaller families than separated or divorced women.

A word of caution is required concerning the never-married mothers in this sample. Contrary to the popular conception, only 48 of the 116 never-married women were teenagers at the time of the birth of their first child. Rather, most of these women were formerly in common-law relationships and were now separated from their partners. Their low household incomes probably reflected the absence of legal entitlement to child support from their common-law partners.

It is also important to note the community context in which this study was conducted. The number of nonwhite individuals is very small in Canada, except in the major cities. According to 1991 Canadian census data, only 6 percent of the adult population of London, Ontario were members of nonwhite minority groups. This low percentage is reflected in our sample of families in which nonwhite minorities comprised only 7.7 percent of single mothers and 5.2 percent of married mothers.

One other observation deserves mention. During the interviews with separated or divorced mothers, we attempted to determine how long they had been single mothers. The average in our sample was slightly more than 7 years, which is consistent with our assertion that single parenthood ought to be considered more in terms of a relatively stable role set than as a transition status between separation or divorce and remarriage.

Table 1.
Socio-Demographic Characteristics of Single and Married Mothers

Variable	Married mothers	Single mothers	Never married mothers	Separated/divorced mothers
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Age (years)	37.61 (61.9)	36.74 (.85)	32.01 ^b (5.82)	37.92 (6.47)
Education (years)	13.83 ^a (2.72)	12.72 (2.72)	12.97 ^b (2.73)	11.82 (2.48)
Number of Children	2.20 ^a (.85)	1.80 (.85)	1.57 ^b (.75)	1.86 (.87)
Employment ^c	.74 ^a	.60	.41 ^b	.65
Household income (Canadian dollars)	44.95 ^a (17.60)	20.52 (13.16)	14.64 ^b (8.92)	22.04 (13.60)
<i>n</i>	502	518 ^d	116	382

^a Difference from single mothers significant at $F \leq .001$.

^b Difference from separate/divorced mothers is significant at $p \leq .001$.

^c Employed full- or part-time = 1; else = 0.

^d Includes single, never married, and separated/divorced mothers.

Mothers' Mental Health

Table 2 displays differences by family structure on an array of measures of mental health. The CES-D scores of single mothers were almost twice as high as those of married mothers. When we computed the proportion with scores of 16 or higher, a commonly used indicator of elevated risk of depressive disorder, the same pattern emerged. Although these two groups of women differed significantly on our measure of anxiety, the magnitude of difference was considerably smaller than for the CES-D.

From the CIDI, we estimated that 19 percent of single mothers met DSM-III-R criteria for major depressive disorder in the past year compared with only 4 percent of married mothers. Lifetime prevalence of depression was approximately three times higher among single mothers than among the married. In addition, single mothers are more than three times more likely than married mothers to report alcohol or drug abuse; however, the prevalence of substance abuse was still very low. Thus, across a wide array of mental health outcomes, we found convincing evidence that family structure is associated with maternal mental health problems.

No such differences emerged when we compared never-married mothers with separated or divorced mothers. Clearly it is single parenthood rather than the pathway to that social circumstance that is associated with emotional distress and disorder.

Table 2
Differences in Mental Health Outcomes Between Single and Married Mothers

Variable	Married mothers Mean (SD)	Single mothers Mean (SD)	Never married mothers Mean (SD)	Separated/divorced mothers Mean (SD)
CES-D score	7.12 ^a (8.62)	12.84 (11.96)	12.63 (10.07)	12.95 (12.43)
CES-D > 16 (percent)	.14 ^a	.31	.32	.31
Anxiety score	21.08 ^a (6.08)	24.50 (7.16)	24.47 (6.73)	24.55 (7.33)
Major depression last year (percent)	.04 ^a	.19	.22	.18
Major depression lifetime (percent)	.15 ^a	.43	.38	.49
Alcohol/drug abuse lifetime (percent)	.02 ^a	.07	.09	.06
<i>n</i>	502	518 ^a	116	382

^a Difference from single mothers significant at $F \leq .001$.

Children's Mental Health

Table 3 presents comparisons of scores on the CBCL of children from SPFs and TPFs. In our design, we obtained maternal reports on the CBCL from all women whose oldest child was at least 4 years old. Where the oldest child was at least 11, we invited him or her to complete the Youth Self-Report form of the CBCL. Thus, for a significant segment of the sample, we have both maternal and child reports on the CBCL. We computed mean scores on the sum scale of internalizing and of externalizing symptoms. In addition, we computed T scores to estimate the number of children with symptom scores in the clinically significant range ($T \geq 63$).

In the maternal reports for all children, there were significant differences in means between children from SPFs and those from TPFs on both internalizing and externalizing scores. These differences were slightly less than half a pooled standard deviation in magnitude. When the percentages of children with clinically significant internalizing and externalizing problems were estimated, differences between SPFs and TPFs were extremely pronounced. On the basis of maternal assessments, over one third of children from SPFs had clinically significant internalizing or externalizing problems compared with approximately one sixth or fewer of children from TPFs. Stated differently, on the basis of maternal reports, children from SPFs were more than twice as likely as children from TPFs to have internalizing problems and were almost three times more likely to have externalizing problems.

Most researchers advocate the use of multiple informants in assessing children's mental health. The lower two panels of Table 3 present comparable data from mothers' reports and Youth Self-Reports for all children aged 11 to 17. Once again, maternal reports revealed substantial differences by family structure. However, children's reports of their own behavior reflected only modest, non-significant differences.

Because of these divergent patterns, it is extremely difficult to conclude from these data that children from SPFs are at significantly greater risk of mental health problems than are children from TPFs. Before such conclusions can be drawn, it will be necessary to rule out the possibility that the higher scores reported by single mothers are not influenced by their own levels of stress and distress.

Table 3
Differences in Children’s Mental Health by Family Structure

	Single-Parent Families		Two-Parent Families	
	Mean (SD) %	N	Mean (SD) %	N
Maternal reports:				
All children age 4–17				
Internalizing	58.3* (9.7)	514	54.1 (8.8)	469
Externalizing	57.6* (10.5)	514	52.9 (9.4)	469
Internalizing $T \geq 63$	35.4	514	16.4	469
Externalizing $T \geq 63$	34.4	514	13.9	469
Children age 11–17				
Internalizing $T \geq 63$	29.3	246	17.0	206
Externalizing $T \geq 63$	27.2	246	12.1	203
Youth self reports:				
Children age 11–17				
Internalizing $T \geq 63$	14.6	246	12.6	206
Externalizing $T \geq 63$	18.7	246	12.6	203

Note. *T*-scores of 63 or greater indicate that the child has scored in the range thought to be clinically significant on the Child Behavior Checklist.

* Significantly different from single-parent families and two-parent families ($p \leq .001$).

Differential Exposure and Vulnerability to Stressors

Table 4 displays mean differences between single mothers and married mothers in their exposure to an array of stressful experiences. Single mothers were more likely than married mothers to have grown up in families where one or both parents suffered from a mental health problem. In terms of chronic stressors, it is not surprising that they reported almost twice as much financial strain as married mothers. In addition, they had significantly higher levels of caregiving strain and problems associated with work-home role conflict. Finally, they reported almost twice as many stressful life events, whether personally experienced or occurring to family or friends.

Table 4
Differences in Exposure to Stressors Between Single and Married Mothers

Stressors	Married mothers	Single mothers	Never married mothers	Separated/divorced mothers
Maternal psychopathology (percent)	21 ^a	31	43 ^b	29
Paternal psychopathology (percent)	26 ^a	36	41	32
Financial strain	7.47 ^a	13.68	14.62	13.48
Caregiver strain	16.00 ^a	18.43	18.13	18.49
Work-home role strain (standard deviation from mean)	-.31 ^a	.20	.34	.18
Stressful life events to self	2.31 ^a	4.26	4.32	4.30
Stressful life events to others	.49 ^a	.94	.75	.99
<i>n</i>	502	518 ^c	116	382

^a Difference from single mothers significant at $F \leq .001$.

^b Difference from separate/divorced mothers is significant at $p \leq .001$.

^c Includes single, never married, and separated/divorced mothers.

Comparisons of never-married mothers to separated or divorced women revealed no such pervasive differences in exposure to stressors. Indeed, the only significant difference that emerged was that never-married women were more likely to have had mothers who suffered from depression or substance abuse problems.

Multiple regression analyses revealed that the main sources of CES-D differences between single and married mothers were chronic strains associated with the caregiving role and work-home role conflict, as well as exposure to stressful life events.

Table 5 shows a decomposition of these effects to estimate how differential exposure to stressors accounts for the difference in CES-D scores between single and married mothers. The entries in the first row display the unstandardized and standardized regression coefficient for the simple (zero-order) regression of CES-D scores on family structure. The CES-D scores of married women were 5.72 points lower than those of single parents. Family structure accounted for approximately 7 percent of the variation in CES-D scores. In the next row, the inclusion of all demographic variables in the regression equation reduced the difference in CES-D scores to 4.76, a difference that remains statistically significant. These differences between single and married mothers in age, education, number of children, and employment reduced the difference in distress between these two groups by 16.78 percent.

Evidence of differential vulnerability to stressful experience can be obtained by comparing the rate at which stressors translate into distress for single mothers and married mothers. Analytically, this rate can be assessed by estimating statistical interactions between family type and each stressor on CES-D scores. When we computed these regression effects, the only significant difference in regression slopes occurred for caregiving strain. The significantly stronger coefficient among single mothers indicated that their levels of distress were more affected by this stressor than is the case for married women.

Table 5
**Decomposition of Difference of Means on the Center for
Epidemiologic
Studies—Depression Scale Between Married and Single Mothers**

Variables in Equation	Family type coefficient			Percentage accounted for
	<i>b</i>	<i>B</i>	<i>R</i> ²	
Zero-order	-5.72	-.26***	.07***	6.76
Demographic variables	-4.76	-.22***	.10***	16.78
CONTROLLING FOR DEMOGRAPHIC VARIABLES				
Family Psychopathology	-4.60	-.21***	.11***	2.80
Chronic stressors	-1.44	-.07*	.29***	58.05
Life events	-2.14	-.10**	.20***	45.81
All stressors	-.24	-.01	.34***	76.23

Note: *b* = unstandardized regression coefficient; *B* = standardized regression coefficient.

- $p \leq .05$. ** $p \leq .005$. *** $p \leq .001$.

Thus, differences in family structure were associated with variations in exposure to ongoing stressors or strains and the experience of psychological distress. The elevated levels of distress reported by single mothers are largely a function of this differential exposure to stressors. Indeed, these analyses provide very little support for the contention that distress among these women is attributable to some kind of greater reactivity or vulnerability to stressors.

What roles do psychosocial resources play in mediating or moderating the stress-distress relationship among single and married mothers? Elsewhere, I have reported that differences in both family structure and employment status are also associated with variations in levels of psychosocial resources (Avison, 1995; Avison & Thorpe, 1993). The results reported here indicate that mastery, self-esteem, and social support buffer the effects of chronic strains on psychological distress. These moderating influences, however, do not seem to operate similarly.

Although mastery and self-esteem both moderate the effects of all types of stressors on distress regardless of family structure and employment status, the buffering effects of social support are quite different. Perceived social support moderates the effects of caregiving strains on distress only among employed women. Further, social support buffers the impact of work strain on distress only among married mothers. Thus, in the absence of the protective buffering effects of social support, it is not surprising that unemployed single mothers exhibit such high levels of distress.

It is also important to emphasize that household structure and employment status are significant determinants not only of stressful experience but also of individuals' psychosocial resources. Given the findings that these resources moderate the stress-distress relationship for all women in the above study, it seems important to understand the factors that produce variations in these psychosocial resources.

Table 6 presents some preliminary results that demonstrate how individuals' positions in the social structure and exposure to stressors affect their sense of mastery and self-esteem. Married mothers' mastery scores averaged 1.85 units higher than those of single mothers. Although better-educated women have significantly higher levels of mastery, this finding does not explain away the difference associated with family structure. Somewhat surprisingly, employment status had no significant effect on mastery. In the final regression equation, each of the three measures of chronic strain had a significant negative impact on mastery. Moreover, the inclusion of these stressors explained away the difference due to family structure. Of these three types of chronic strain, the measure of problems in the caregiving role had the most important effect. It is also noteworthy that the impact of education on mastery persisted even when chronic strains were controlled.

Table 6
Regression Scores of Mastery and Self-Esteem on Structural Variables and Strains

		Mastery							
		I	II	III	IV				
Variable		b	B	b	B	b	B	b	B
Family Structure ^a		1.85**	.17	1.46**	.14	1.44**	.13	-.33	-.03
Age				-.00	-.00	-.01	-.01	-.06	-.07
Education				.34**	.18	.33**	.17	.27**	.14
Employment status ^b						.31	.03	.80	.07
Financial strain								-.12**	-.16
Caregiving strain								-.41**	-.36
Work-home role strain ^c								-.23**	-.11
Constant		23.88		19.9		20.0		33.4	
			8		9		6		
R ²		.03**		.06*		.06*		.27*	
			*		*		*		
		Self-esteem							
		I	II	III	IV				
Variable		b	B	b	B	b	B	b	B
Family Structure ^a		3.08**	.21	2.62**	.18	2.50**	.17	.52	.04
Age				.07	.06	.05	.05	.00	.00
Education				.36**	.14	.31**	.12	.24*	.09
Employment status ^b								2.42**	.16
Financial strain								-.05	-.05
Caregiving strain								-.66*	-.42
Work-home role strain ^c								-.25**	-.09
Constant		37.15		30.5		31.0		47.7	
			0		0		3		
R ²		.05**		.07*		.08*		.29*	
			*		*		*		

Note. *b* = unstandardized regression coefficient; *B* = standardized regression coefficient.

^a 0 = single-parent family, 1 = two-parent family, ^b 0 = not working, 1 = working, ^c Measured as deviations from the mean of employed women

* $p \leq .01$

** $p \leq .005$

In the lower panel of Table 6, similar analyses were computed with self-esteem as the dependent variable. Once again, married women and those with higher education levels had significantly higher levels of self-esteem. However, unlike the results for mastery, employment status also had a significant effect on self-esteem. With the inclusion of the chronic strain measures in the equation, the effect of family structure again disappeared, whereas the coefficient for education remained significant. Moreover, when the effects of chronic strains were controlled, the effect of employment status actually increased. Of the three chronic strain indexes, only caregiver strain had a substantial impact on self-esteem. The impact of work-home role strain was significant but modest, and financial strain was non-significant.

In this regard, Turner and Roszell (1994) have argued that the psychosocial resources that may be the most important for individuals' mental health are those linked to their positions in the social structure. They remind us of the importance of social status in the stress process. Not only do differences in social position expose individuals to greater or fewer numbers of stressful experiences, but these differences may also condition the development of psychosocial resources that enable individuals to cope with such stressors. This observation is a distinctive contribution of the sociological perspective to the stress process (Pearlin, 1989). To ignore the ways in which social status influences the experience of stressors and their mediation is to assume that human experience is considerably more homogeneous than may be the case (Avison & Gotlib, 1994).

Family Structure, Poverty, and Mental Health Outcomes

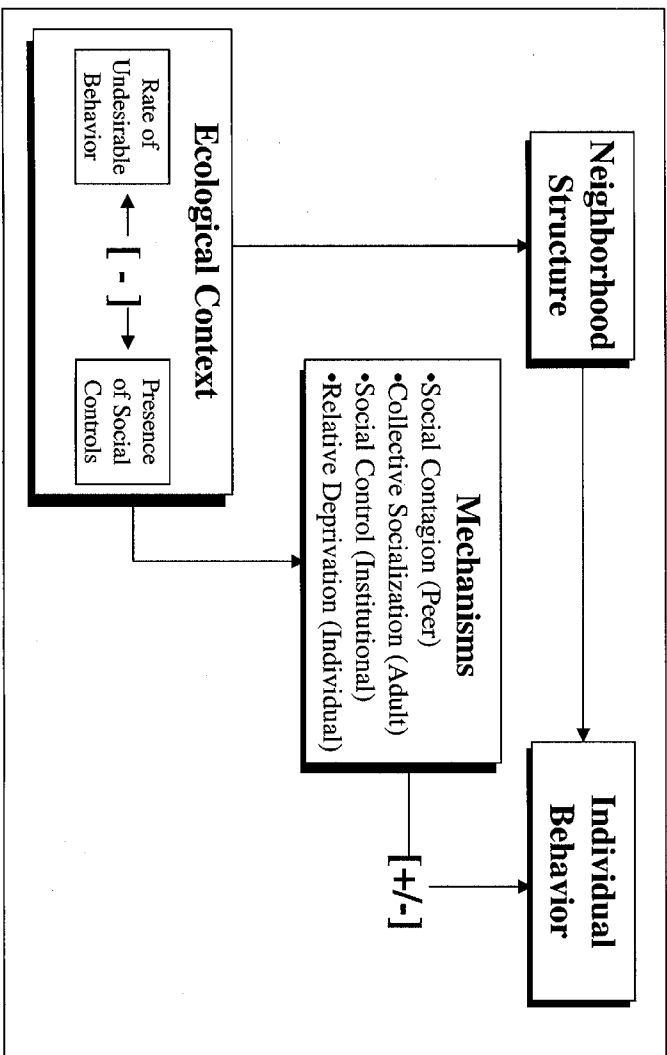
Poverty is a particularly important challenge to the well being of single-parent families. This study clearly indicates the inextricable link between family structure and socioeconomic disadvantage. Based on annual cost-of-living estimates, Statistics Canada determines the amount of money needed to keep a family above the poverty line. Using the 1990 criteria on the sample in this study, of the 278 families in poverty, 250 were single-parent families, and only 28 were two-parent families. Thus, we estimated the prevalence of poverty among single-parent families in our study to be 48.3 percent compared with only 5.6 percent among two-parent families.

It is important to understand the extent to which poverty exerts direct effects on various factors and the extent to which the impact of poverty on mothers and children is mediated by various factors. Evidence of important mediating factors may suggest important points of intervention or targets for health promotion initiatives.

Figure 1 is a rudimentary path diagram that specifies the links among poverty, family stressors, mothers' psychosocial resources, maternal depression, and children's behavioral and emotional problems. This model is based on several a priori assumptions. First, psychosocial mediators (mastery, self-esteem, and social support) intervene between family stressors and child outcomes. There are several alternative specifications that are also plausible, and there is substantial evidence that some important part of the causal sequence runs from stressors through psychosocial factors to distress (Aneshensel & Huba, 1984; Lin & Ensel, 1984; Turner, 1981, 1983; Turner & Noh, 1988). Moreover, one of the most comprehensive tests of alternative specifications (Ensel & Lin, 1991) presented strong evidence attesting to a similar causal structure. Second, the model does not include stress-amplifying effects or possible buffering effects of psychosocial mediators because tests of these interactions produced no significant results. Third, it assumes a simplistic causal ordering of variables in a recursive model.

Figure 1 clearly illustrates the wide-ranging effects of poverty on the lives of family members. Economic disadvantage increases families' exposure to stresses and strains, threatens mothers' sense of self, and ultimately manifests itself in psychological distress and parenting problems among mothers and mental health problems among children. The observation that so many adverse events are the consequences of poverty clearly substantiates the need to trace the effects of social structure and social experience on peoples' lives.

Figure 1: Mechanisms Linking Neighborhood Structure to Individual Behavior



An important implication of these observed relationships is their consistency with one of the original tenets of the stress process formulation developed by Pearlin, Lieberman, Menaghan, and Mullan (1981): Stressors may generate other ongoing stressful circumstances. This idea has been developed more explicitly by Pearlin (1989) in his consideration of primary and secondary stressors. In the context of this study, poverty exposes individuals to an array of other stresses and strains that, in turn, create additional emotional problems. This proliferation of stress throughout the lives of socioeconomically disadvantaged individuals is an issue that deserves further investigation.

These results also attest to the intergenerational impact of poverty and of stressors generally. Menaghan (1994) has presented an interesting account of the impact of parental work stress on children's mental health outcomes. Her findings are consistent with other studies that have documented how parental risk and resistance factors influence their children's emotional health (Amato & Keith, 1991; Gotlib & Avison, 1993; Grych & Fincham, 1990).

Family Structure, Adversities, and Mental Health

A more complete understanding of the significance of family structure for women's mental health requires consideration of the dense web of causation that links experiences of childhood and adolescence with family structure and mental health. These considerations generate several predictions:

1. There will be higher 1-year prevalence rates of major depressive disorder among single parents than among married parents.
2. The majority of recent depressive episodes experienced by subjects in our study will be recurrent episodes.
3. Both childhood adversity and the current levels of stressors will explain the elevated levels of depression among single parents. The impact of childhood adversity will be largely indirect, through early onset of depression and through single parenthood. The effect of single parenthood will be largely indirect through current stressors.

In a recent paper, detailed findings were presented that confirm these patterns (Avison, McAlpine, & Davies, 1995). This path diagram reveals several interesting patterns. Childhood adverse events have multiple indirect effects on recent depression, principally through their impact on early onset of depression, but also through single parenthood and operant stress (the sum of the standard scores of four dimensions of stress: stressful life events, financial strain, work-home role strain, and family caregiving strain). The model also depicts the impact that early onset of depression has on recent depression, both directly and indirectly, by increasing the probability of single parenthood and the experience of operant stress. In addition, the elevated rates of depression among single mothers are due primarily to the increased levels of operant stress to which these women are exposed. Taken together, all of the variables in this model account for 23 percent of the variance in recent depressive illness among the women in this study.

Our findings are consistent with a growing body of research that emphasizes the importance of early experience in defining life trajectories. Both Rutter (1989) and Elder and Caspi (1988) have written extensively on these issues. More recently, systematic research efforts have clearly demonstrated that traumatic or adverse experiences in childhood have distal mental health consequences (Davies, Avison, & McAlpine, in press; Kessler & Magee, 1993, 1994b; Turner & Lloyd, 1995). These results provide some understanding of the pathways that link these early adversities with the experience of depressive episodes that may occur as much as three or four decades later.

Implications for Intervention

Although several important implications emerge from these analyses, I focus here on those related to prospects for health promotion and primary prevention. Many scientists have argued that health promotion and primary prevention programs are the most appropriate responses to these problems (Price, Cowan, Lorion, & Ramos-McKay, 1988; Rapoport, 1985). Indeed, given recent epidemiologic estimates of the prevalence of mental health problems among both adults (Kessler et al., 1994; Robins & Regier, 1991) and children (Offord et al., 1987) and the extremely large numbers of cases that go untreated, it seems clear that any attempt to deal with this substantial problem through traditional treatment approaches is likely to fail for lack of sufficient resources. Therefore, research on the impact of various risk and protective factors on mental health problems provides clues for effective intervention strategies.

Clearly the effects of single parenthood on the lives of family members are wide ranging. Economic disadvantage increases families' exposure to stresses and strains, threatens mothers' sense of self, and ultimately engenders distress among mothers and mental health problems among children. A closer examination of these results reveals at least three critical observations that are important in considering primary prevention. First, the higher levels of psychological distress experienced by single mothers are related more strongly to their greater exposure to stress and strain than to personal deficits in social competence or resilience. Thus, single parenthood should be conceived more accurately as a risk factor for exposure to stress than as an indicator of personal vulnerability. Second, there is an especially important connection between single parenthood and poverty that cannot be ignored. Third, a significant number of single mothers have frequent adverse experiences that threaten their mental health. Therefore, interventions that focus solely on factors that occur after entry into single parenthood may fail to address a major source of stressful experience.

These observations clearly demonstrate that family structure has consequences for stress and distress. However, as McLanahan and Sandefur (1994) have pointed out, the problems of single parents are not substantively different from the problems of other families: They may simply be exposed to more of these difficulties or to greater levels of challenges. Thus, consideration of single parenthood in the context of family structure facilitates thinking in terms of processes that affect all families. In this context, intervention programs that address the needs of families in the community are preferable to interventions that target specific types of families because they address the entire social and community context in which families live. Such programs attempt to reduce exposure to life stress and improve family members' social and personal well being indirectly by changing the social systems or the social and economic conditions in which they live. This approach recognizes that individuals' social competence, their ability to learn, and their social and emotional well being are influenced greatly by their experiences at home, at school, and in their neighborhood (Durlak, 1985; Rapoport, 1985; Woodhead, 1988).

Until recently, few of these ecological or community-based programs had been tested carefully for their effectiveness. In recent years, however, there have been several reviews of a variety of ecological or community-based primary prevention initiatives (Hawkins & Catalano, 1990; Institute of Medicine, 1994; Ontario Ministry of Community and Social Services, 1989; Yoshikawa, 1994). These reviews clearly indicate that certain kinds of primary prevention interventions have considerable promise if they address multiple risk factors, focus on multiple settings (the school, family, and neighborhood), and target neighborhoods or communities with high needs (areas with high percentages of single-parent families, low-income families, or cultural minorities). Such interventions encourage families and neighbors to work together to reduce their exposure to the more stressful aspects of their lives, especially those that affect children and that seem to have long-term effects on their lives. They also assist individuals and families in building stronger social relationships that may enhance their feelings of social support and sense of self. In short, the promise of ecological prevention programs is based primarily on their ability to intervene at multiple points in the stress process. The sociology of mental health can identify these points of intervention and specify the ways in which social structure has consequences for individuals' stressful experience and their psychological well being.

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