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MODERN FAMILY: THE EFFECTS OF FAMILY INSTABILITY AND PARENTING ON
LOW-INCOME MATERNAL HEALTH

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Abstract

A significant amount of developmental research has focused on the effects of family structure and parenting on children's development. Less research has focused on how family structure and parenting influences adult health and risky health-related behaviors. Among a sample of socio-economically disadvantaged mothers with young children, I examined the association between family structure and parenting practices on maternal health and risky health-related behaviors (n=4,127). Family structure captured maternal stability (stably married, cohabiting, single) or instability (union formation, union dissolution) over a two year period. Parenting practices captured mother's engagement with her child, role strain, and perceived coparenting support from the child's father over a two year period. Maternal health and engagement in risky health behaviors included: poor physical health, depression, and binge drinking. Results indicated that mothers in stable marriages compared to other family structures were less likely to be in poor health; while mothers in unstable relationships compared to those in stable marriages were at an increased probability for experiencing depression or engaging in binge drinking. In addition, higher levels of maternal role strain were predictive of mothers experiencing poor health, depression, and engaging in binge drinking. Further, higher levels of mother involvement and greater levels of perceived coparenting support were also related to mothers less likely being in poor health. Given the growing prevalence of family structure instability, parenting programs and policies should continue to focus on the importance of relationship stability, but also acknowledge that parenting practices are related to maternal health and risky health-related behaviors.

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Chapter One

Introduction

Over one quarter of United States children under the age of 18 live with only one of their parents. At some point in their childhood, approximately half of children in the United States will reside in a single parent family. The majority of these single parents are single mothers. Single mother households are highly correlated with poverty. According to the U.S. Census Bureau data, forty-two percent of single mother households live in poverty compared to 26% of single father households that live in poverty. Poverty is defined as having a household income less than the official poverty standard, approximately \$14,570 for a family of two in 2010 (U.S. Census Bureau, 2010).

Single mothers face many challenges that are associated with poverty. Compared to higher-income women, researchers have found that low-income women were more likely to smoke before or during pregnancy. They were also more likely to be obese, suffer from postpartum depressive symptoms, and have three or more chronic diseases. Researchers discovered that low-income women were also more likely to be uninsured before pregnancy (Bombard et al., 2012). Poverty also increases maternal stress and therefore, it decreases the quality of maternal health by exposing mothers to negative life events such as, job loss, chronic strains, poor housing, dangerous neighborhoods, and conflict with partners (Beeber, Perriera, & Schwartz, 2008). McLanahan (2009) found that unmarried parents come from more disadvantaged populations than married parents, and that unmarried parents experience increased maternal stress and mental health problems. The reduced quality of maternal health and well-being reduces the quality of her parenting and can lead to poor outcomes in children.

Despite there being a multitude of research on the effects of relationship status on maternal physical and mental health, there is less known about the direct effects of parenting on

maternal health. My study aims to discover how both relationship status and parenting practices influence the physical health, mental health, and risky health-related behaviors of socio-economically disadvantaged mothers with young children.

The Fragile Families and Child Wellbeing Study (FFCW) is ideal for studying low-income mothers because it includes an oversampling of “fragile families.” Fragile families are couples who were unmarried at the birth of their child. These couples are often young, economically disadvantaged, and highly unstable (McLanahan & Beck, 2010). Approximately 60% of these couples will split by their child’s third birthday. The majority of mothers will begin a new romantic relationship during the same time period (Osborne & McLanahan, 2007). This prevalent relationship instability has raised concerns about maternal physical and mental health, along with the quality of mothers’ parenting practices.

RELATIONSHIP STATUS

Social stress theory can be used to describe how relationship status affects health and risky health-related behaviors. Specifically, social stress theory maintains that changes in relationships lead to changes in resources and routines (Osborne & McLanahan, 2007). It suggests that those who are married have the greatest likelihood to have the most stable material and social resources, while individuals who experience partnership transitions are most likely to experience changes in material and social resources. Stable material and social resources in married or married-like relationships (i.e. cohabitation) are many times a result of two incomes being pooled, thereby improving the economic well-being of those who marry and remain married (Lerman, 2002). Further, economic stability associated with partner stability has the ability to improve health outcomes by increasing access to health care; it also lowers the stress that is associated with poverty. Further, partner stability has the ability to improve health

outcomes as research has suggested that spouses encourage positive health behaviors (e.g., eating well and exercising) and discourage unhealthy behaviors (e.g., smoking and heavy drinking) (Umberson, 1987).

On the other hand, partnership changes, such as divorce or separation after cohabitation is associated with a decline in economic resources (Avellar & Smock, 2005) and an increase in stress due to income loss and greater residential mobility (McLanahan & Sandefur, 1994). The social stress theory also maintains that “positive” events such as getting married or dissolving a bad relationship can lead to increases in stress. According to this theory, stress increases around the time of the transition and fades away as time passes (Acock & Demo, 1994). Ultimately, experiencing any union instability has the ability to negatively affect health and psychological functioning (George, 1993).

Relationship Status and Physical Health

Researchers have discovered that mothers who are married are in better physical health than those who are unmarried or who are divorced (Kiecolt-Glaser & Newton, 2001). A study conducted by Lorenz, Wickrama, Conger, and Elder (2006) compared trends in physical health for a group of women who were recently divorced to trends for a group of women who were married. The study found that physical health did not differ between those who were divorced and those who were married at the beginning of the study; but by the end of the study, women who remained divorced reported significantly worse physical health than those women who had remained married (Lorenz et al., 2006). This finding shows that there are differences between women who experience marriage stability from women who experience relationship instability and remain single.

Williams and Umberson (2004) used the longitudinal dataset Americans' Changing Lives (ACL) to examine the effects of marital transitions on changes in physical health. For women, the study did not find substantial evidence to indicate that transitions into or out of marriage correlated to changes in self-rated health. It was discovered, however, that transition into a woman's first marriage was associated with a small improvement in women's health (Williams & Umberson, 2004). Another study using the FFCW survey found that compared to mothers who were stably married, mothers who were in stable cohabiting relationships, stably single, who transitioned from cohabiting relationships to marriages, who transitioned into a cohabiting relationship with a new partner, or those who experience multiple relationship transitions reported lower self-rated health (Meadows, McLanahan, & Brooks-Gunn, 2008). In sum, the research demonstrates that being stably married is positively correlated to physical health.

Relationship Status and Depression

Depression is a common illness among impoverished women. The prevalence of low-income mothers who are depressed is high (approximately 40-59%). This rate is four times higher than middle-income mothers (Brown & Moran, 1997). Low-income mothers are more likely to have lower education levels, more hourly work, and higher rates of past exposure to trauma. In addition, they must face challenges such as food insecurity and living in disadvantaged neighborhoods (Doucet, 2003). All of these obstacles make low-income mothers more vulnerable to depression.

In terms of relationship status and depression, it has been consistently found that those who are married are the least likely to be depressed (Pearlin & Johnson, 1977). Brown (2000) used data from the National Survey of Families and Households to discover that cohabitators reported higher levels of depression than their married counterparts. Higher depression levels were

attributed to cohabitators' greater prevalence of relationship instability. It was found that cohabitators' depression scores were exacerbated by the presence of biological and step-children, while the depression scores of those who were married were not affected by the presence of children (Brown, 2000). Meadows, McLanahan, and Brooks-Gunn (2008) found that those who were stably single, those who exited a marriage or a cohabiting relationship, transitioned into a coresidential relationship with a new partner, or experienced more than one transition had more mental health problems one year after the birth of the child than mothers who were stably married.

Relationship Status and Binge Drinking

Binge drinking has also been studied in regards to relationship status. Researchers using the National Longitudinal Survey of Youth (NLSY) have found that women who enter marriage are less likely to binge drink than young adults who do not marry. However, as the marriage continues, the likelihood of binge drinking does not continue to decline. These results were true for both African Americans and for whites, along with those with higher and lower levels of education (Duncan, Wilkerson, & England, 2006).

A similar study conducted by Curran and colleagues found that total alcohol consumption declines more rapidly around the time of first marriage than it does for those individuals who do not marry (Curran, Muthen, & Harford, 1998). Miller-Tutzauer, Leonard, and Windle (1991) also discovered that transition into first marriage is associated with a significant decline in alcohol consumption for both men and women. In terms of cohabitation, Horwitz and White (1998) found that cohabiting women were more likely to binge drink than their married counterparts. In conclusion, the research seems to find that the initial transition to marriage

decreases the likelihood that women will drink, but this finding does not hold true as the marriage progresses.

PARENTING PRACTICES

Role theory argues that certain roles are laden with stress. Stress can arise from the occurrence of new events or from continuous problems (Pearlin, 1989). For instance, role theory states that chronic stress is a common problem for single mothers because they lack the necessary resources to fulfill roles of mother and worker (Avison, Ali, & Walters, 2007). Solo parenting, which is the type of parenting encountered by a single mother, has many burdens, especially when the mother is impoverished. Avison et al. (2007) found that the stress of solo parenting is correlated to the age of the children and the number of children in the household. The younger the age of the child and the more children in the house, the more likely the mother will have harsh exchanges with her children. These mothers have higher levels of psychological distress due to the daily hassles that are exacerbated by poverty (Avison et al., 2007).

Mother Involvement and Health

Mother involvement refers to how engaged a mother is with her child. Researchers have found that mothers who receive emotional support from their baby's father are more likely to engage in activities with their young child (Carlson & McLanahan, 2002). There has not been enough research documenting the effects of mother involvement on physical health. Research that has focused on paternal involvement and physical health suggests that fathers who are more involved with their children report significant better physical health. In addition, socio-economically disadvantaged fathers who increased their involvement with their children are less likely to experience negative changes in their physical health over time (Hernandez, in press). Thus, when considering maternal involvement, it is possible that socio-economically

disadvantaged mothers who are more involved with their children may be less likely to report poor physical health.

Research has not focused on how mother involvement influences depression; instead, it has focused on how depression influences mother involvement. For example, mothers who are depressed are less likely to maintain high levels of involvement with their children compared to nondepressed mothers (Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Research on socio-economically disadvantaged fathers indicates that fathers who increased their involvement over time were less likely to be depressed than fathers who did not increase their involvement (Hernandez, in press). Based on these studies, it may be that socio-economically disadvantaged mothers who are engaged with their children are less likely to be depressed than mothers who are not involved with their children.

Similar to the above, there is a lack of research examining how parental engagement influences binge drinking; instead, research has focused on how excessive alcohol intake is related to parenting practices. Lang, Pelham, Atkeson, and Murphy (1999) discovered that parents who drank alcohol were less likely to listen to or establish eye contact with their child as compared to sober parents. As a result, their parental effectiveness may be reduced. Parents who drank alcohol commanded their children more frequently, but did not respond appropriately when their child executed the right behavior. It was also found that parenting behavior was not consistent when the parents drank (Lang et al., 1999). Based on the above findings, it may be that there is reciprocal relationship between binge drinking and mother involvement, where a decrease in maternal engagement is associated with binge drinking.

Role Strain and Health

Role strain captures mothers' perception of the difficulty of fulfilling her roles as a worker and as a parent. Role strain is related to the concept of parenting stress. Parenting stress refers to when a parent feels that the demands associated with parenting exceed the personal and social resources available to meet those demands (Cooper, McLanahan, Meadows, & Brooks-Gunn, 2009). It has been found that mothers who experience high levels of parenting stress also report greater psychological distress and lower life satisfaction than mothers with low levels of parenting stress (Crnic & Greenberg, 1990). Parenting stress is related to parents' expectations prior to the birth of their child, their personality, aspects of family history, along with child factors, such as temperament and behavior (Cain & Combs-Orme, 2005; Jackson, 2000).

There is very little research documenting the effects of role strain on physical health. Hernandez (in press) examined socio-economically disadvantaged fathers' experience of role strain on their physical health but found no significant relationship. It can be assumed, therefore, that the same finding may be true among a sample of socio-economically disadvantaged mothers.

Similar to physical health, it is difficult to find research describing the influence of role strain on maternal depression. Other researchers have noted the energy and commitment associated with being a parent. Most parents exhibit a "hardy" personality and are able to take on the challenges that accompany this role. However, mothers with low self-efficacy are more likely to focus on relationship problems, have a negative affect, and feel helpless as a parent (Coleman & Karraker, 1998). Thus, these mothers are more likely to experience role strain and may be at an increased risk for depression. Previous studies have not explored this direct link.

Binge drinking is not commonly researched in its regards to role strain. There has been research, however, conducted between a concept similar to role strain, parenting efficacy, and

binge drinking. Parenting efficacy measures mothers' perception of her adequacy as a parent. Researchers discovered that mothers who exhibit lower levels of parenting efficacy are more likely to have alcohol problems than mothers who have higher levels of parenting efficacy (Cunningham, Benness, & Siegel, 1988). This finding suggests that mothers who experience greater role strain may also be more likely to binge drink than mothers who do not experience role strain.

Coparenting Support and Health

Coparenting support is a mother's perception of how supported she feels by the biological father of her child. As would be expected, researchers have discovered that mothers who are married or are cohabiting report the highest levels of paternal support compared to mothers who are not romantically involved with the father of her children (Carlson, McLanahan, & England, 2003). There is a lack of research that has focused on the direct relationship between coparenting support and maternal physical health. However, research by Hernandez (in press) on socio-economically disadvantaged fathers suggests that coparenting support is associated with better paternal physical health. Thus, the same relationship may be found when focusing on mothers' perceptions of coparenting support and their own self-report of physical health.

Further, there is a lack of research on the association between coparenting support and maternal depression. Research does indicate that emotional support from the father is associated with lower levels of maternal stress, which in turn, allows the mother to be a better parent (Belsky, 1990). In addition, among socio-economically disadvantaged fathers, it was found that those who experienced a decrease in coparenting support were more likely to be depressed over time (Hernandez, in press). Based on this finding, it may be that greater coparenting support is related to lower levels of depression among socio-economically disadvantaged mothers.

Research on parental problem drinking and family functioning suggests that paternal problem drinking is associated with greater marital conflict and lower parental warmth (Schacht, Cummings, & Davies, 2009). In addition, partner alcoholism is believed to result in increases in marital conflict and overall marital dissatisfaction (Jacob & Leonard, 1994). Although prior studies have not examined the relationship between coparenting support and maternal binge drinking, based on the above studies, it may be that a lack of coparenting support is associated with mothers engaging in binge drinking.

Current Study

The literature review above shows that mothers who are stably married are more likely to be in better physical health, less likely to be depressed, and at the inception of marriage, less likely to binge drink compared to mothers who experience relationship instability or are stably single or in a stable cohabiting relationship. Although many studies have examined how mental health influences parenting practices, very few studies have explored the reciprocal nature of this relationship. For example, there is research showing the relationship between parenting practices and paternal health, but research is lacking on how parenting practices influence maternal physical health, mental health, and risky health-related behaviors. Within a sample of socio-economically disadvantaged mothers with young children, the current study focuses on discovering how relationship status and parenting practices influence maternal physical and mental health, and risky health-related behaviors. The specific research questions (RQ) and hypotheses (H) are below, along with how my study could have implications for policy:

RQ1: How do relationship status and parenting practices affect maternal physical health in a sample of socio-economically disadvantaged mothers with young children?

H1: I hypothesize that mothers who are not stably married will report lower levels of physical health than mothers who are stably married. In addition, mothers who displayed lower levels of mother involvement, and those who received lower levels of coparenting support from the biological father will also demonstrate lower levels of physical health. Based on previous research findings, I hypothesize that role strain will not affect maternal physical health.

RQ2: How do relationship status and parenting practices affect maternal depression in a sample of socio-economically disadvantaged mothers with young children?

H2: I hypothesize that mothers who are not stably married will be more likely to be depressed than mothers who are stably married. Mothers who displayed lower levels of mother involvement, who experience greater levels of role strain, and who receive lower levels of coparenting support from the biological father will be more likely to experience depression as well.

RQ3: How do relationship status and parenting practices affect maternal binge drinking in a sample of socio-economically disadvantaged mothers with young children?

H3: I hypothesize that mothers who are not stably married will be more likely to binge drink than mothers who are stably married. Mothers who displayed lower levels of mother involvement, who experienced greater levels of role strain, and who report low levels of coparenting support from the biological father will be more likely to binge drink as well.

In 2002, the United States Department of Health and Human Services launched the Healthy Marriage Initiative and other marriage and relationship education programs that were

designed to keep couples together by providing them with information and by teaching them communication, problem-solving, and other necessary relationship skills. This effort was the government's attempt at combating issues that single mothers and mothers in unstable relationships may face (Hawkins & Ooms, 2010). There is a great likelihood that the current study will also find evidence of the health benefits of marriage among a sample of socio-economically disadvantaged women. If that is the case, the current study will provide reasoning for funding to continue for the Healthy Marriage Initiative and other relationship education programs, especially among impoverished communities. Last, if positive parenting practices are found to be related to be deterring negative health outcomes, the findings may suggest that the marriage education programs need to take a broader perspective and consider how relationship status and parenting not only influence child development but adult development as well.

Chapter 2

Methods

Data

The study uses data from the Fragile Families and Child Wellbeing Study (FFCW). FFCW is a national longitudinal survey that follows nearly 5,000 children born in 20 large American cities (where population exceeds 200,000) between the years 1998 and 2000. Approximately three quarters of the parents were unmarried at the time of the child's birth. Mothers and fathers were interviewed within 48 hours of their child's birth in the hospital (i.e. year 0) and then when the child was 1, 3, and 5 years of age over the telephone. The analyses below mainly focuses on information received from mothers. For information on sample and design of the study, please see Reichman, Teitler, Garfinkel, and McLanahan (Reichman et al., 2001).

Measures

Dependent Variables.

Three indicators of health were used to measure mothers' well-being at the year 5 survey.

Poor physical health. Mothers reported on their physical health in the past year on a continuous scale with 1=*excellent health* and 5=*poor health*.

Depression. Maternal depression was measured using the Composite International Diagnostic Interview (CIDI). The FFCW project created a dichotomous variable based on mothers' responses to items in the survey regarding depression during the past year. For information on the validity of the CIDI, please see Poutanen, Koivisto, Joukamaa, Mattila, and Salokangas (Poutanen et al., 2007).

Binge drinking. Mothers reported on whether in the past year they had 4 or more drinks in one day. A dichotomous measure was created based on an affirmative response.

Independent Variables.

Relationship status and parenting practices are the two main independent constructs. These constructs were reported by mothers at the year 1 and year 3 survey.

Relationship Status. Relationship status was categorized based on mother's current relationship situation between years 1 and 3. Mothers who reported no change in their relationship status between years 1 and 3 were categorized in stable relationships based on their response: stably married, stably cohabitating, and stably single. Mothers who entered or exited a relationship were placed in categories that reflected this change. Mothers who were single at year 1 but either cohabiting or married at year 3 were considered to have formed a union. In addition, those mothers who were cohabiting at year 1 but married at year 3 were considered to have formed a union. Mothers who were cohabiting or married at year 1 but single at year 3 were considered to have dissolved a union. Those mothers who were married at year 1 but were cohabiting at year 3 were also considered to have dissolved a union.

Parenting Practices. *Mother involvement* measured how engaged mothers were with their child. This measure consisted of 7 items, on a scale from 0=*none* to 7=*every day of the week*. Items included statements such as, "sing songs or nursery rhymes to child," "take child to visit relatives," or "hug and show physical affection to child." The 7 items were averaged at year 1 (alpha = .58) and year 3 (alpha = .60). The average scores at year 1 and year 3 were then summed up and averaged to create a variable that reflected the overall average mother involvement between years 1 and 3.

Role strain was measured based on 4 items that captured how mothers felt about her role as a parent. Items were statements like “Being a parent is harder than I thought it would be,” or “I feel trapped by my responsibilities as a parent.” Mothers responded on a scale that ranged from 1=*strongly disagree* to 4=*strongly agree*. Two average role strain variables were created by taking the averages of responses from the 4 items at year 1 (alpha = .61) and at year 3 (alpha = .63). Next the average scores at year 1 and year 3 were summed and averaged to create a variable that reflected the overall average role strain between years 1 and 3.

The last of the mothering practices was coparenting support. Coparenting support measured mothers’ feelings towards being supported in the parenting role by the father of the child. Coparenting support consisted of 6 items, such as “He supports you in the way you want to raise (child),” or “You can count on father for help when you need someone to look after (child) for a few hours.” These items ranged on a scale from 1=*never* to 4=*always*. The six items were averaged at year 1 (alpha = .86) and at year 3 (alpha = .89). The average scores at year 1 and year 3 were then summed up and averaged to create a variable that demonstrated the overall average coparenting support between years 1 and 3.

Controls

The following covariates were based on mother reports at the year 1 survey with the exception of race and ethnicity, which was measured at the year 0 survey. These variables were taken into consideration when analyzing the data because they are related to the dependent variables (i.e. poor health, depression, binge drinking), and they can influence the independent variables (i.e. relationship status and parenting practices). Therefore, they could affect the results. Child characteristics included: child’s age (measured in months) and child’s poor health, which was coded on a continuous scale from 1=*excellent* and 5=*poor*. Mother characteristics

included the following items. Mother's age was measured in years; race and ethnicity of the mother was based on a series of dichotomous measures that included white (reference), black, Hispanic, or other race. Maternal education was coded on as a series of dichotomous measures: less than high school (reference), high school diploma or GED, and greater than high school. Maternal employment was a continuous variable based on the number of weeks the mother worked in the past year. Maternal health insurance was coded as a series of dichotomous measures that included: private coverage, public (Medicaid) coverage, or no coverage (reference). Household income was constructed by taking into consideration the Federal Poverty Line (FPL), which takes into account household income in relation to the number of members in the household: <100% FPL (poor), 100-299% FPL (working poor), or \geq 300% FPL (not poor). Number of children in the household was constructed on a continuous scale based on the number of children under the age 18 that resided in the household.

Analytic Sample

Starting with the full sample of mothers that participated in the study ($n=4,898$), it was necessary to exclude mothers who had missing data in regards to the dependent variables. By excluding mothers who had missing data on any of the dependent variables, the sample was now uniform across all three dependent variables (771 mothers excluded). Next, the missing values for mothers who dropped out of the study or refused to respond to the items measuring the independent variables and covariates were imputed. To impute these values, mean substitution was used. In other words, missing values were filled in with the average value of the corresponding variable. The final analytic sample consist of $n = 4,127$. See Table 1 and 2 in Chapter 3.

Analytic Plan

Descriptive statistics were performed on each variable in order to assess the means and standard deviations (or proportions) in regards to the analytic sample. The means of each continuous variable were determined, as well as, the proportions of each categorical variable. A correlation table showing the strength of the relationship between the dependent and independent variables was also conducted.

Multivariate regression models consisted of an ordinary least squares (OLS) regression model and two logistic regression models. An OLS regression model was estimated to examine the association between relationship status and parenting practices on poor maternal health, controlling for child, maternal, and household characteristics. Logistic regression models were conducted to examine the associations between (a) relationship status and parenting practices on maternal depression and (b) relationship status and parenting practices on binge drinking. Logistic regression models also controlled for child, maternal, and household characteristics.

Chapter Three

Results

Descriptive analyses consisted of means and standard deviations of the study's independent and dependent variables, along with the covariates. Table 1 describes the means and standard deviations of the analytic sample prior to mean substitution. Table 1 indicates that the range of missing values on the study variables ranged from 0—1519, with the dependent variables (poor health, depression, binge drinking) missing the least number of values and coparenting support missing the most number of values.

Table 1 Proportion or Mean (Standard Deviation) of Variables in Analytic Sample (n = 4127)

	M	SD	Number of Present Cases in Analytic Sample	Number of Missing Cases from 4127
Health Outcomes at Year 5				
Poor Health	2.36	1.03	4127	0
Depression	.17	---	4127	0
Binge Drinking	.11	---	4127	0
Relationship Status Over Time (Average between Year 1 & Year 3)				
Stable Relationships				
Stable Married	.24	---	3655	472
Stable Cohabitation	.13	---	3655	472
Stable Single	.33	---	3655	472
Unstable Relationships				
Union Formation	.05	---	3655	472
Union Dissolution	.10	---	3655	472
Parenting Practices Over Time (Average between Year 1 & Year 3)				
Mother Involvement	5.27	.99	3104	1023
Role Strain	2.21	.59	3103	1024
Coparenting Support	1.94	.22	2608	1519
Covariates at Year 1				

Child Characteristics				
Age (months)	15.00	3.44	3858	269
Poor Health	1.51	.80	3840	287
Mother Characteristics				
Age (years)	26.37	6.04	3866	261
Race/Ethnicity ^a				
White	.21	---	4118	9
Black	.49	---	4118	9
Hispanic	.26	---	4118	9
Other Race	.03	---	4118	9
Education				
Less than High School	.27	---	3862	265
High School Diploma or Equivalent	.28	---	3862	265
Greater than High School Diploma	.38	---	3862	265
Employment (# of weeks)	24.77	21.80	3680	447
Health Insurance				
Private Insurance	.30	---	3853	274
Public Insurance	.54	---	3853	274
No Health Insurance	.09	---	3853	274
Household Income				
Household Income (continuous)	31740.46	34064.25	3866	261
< 100% of FPL	.41	---	3866	261
100– 299% of FPL	.37	---	3866	261
>= 300% of FPL	.16	---	3866	261
Number of Children in Household	2.31	1.23	3634	493

Note. FPL = Federal Poverty Line

^a Measured at Year 0

After mean substitution, the average maternal health score was 2.36 on a scale of 1 to 5, showing that most mothers were in fairly good health (Table 2). Approximately 14 percent of the mothers were depressed. In regards to binge drinking, it was found that approximately 10 percent of the mothers in the study's sample had binged drink in the past year.

The independent variables included relationship status and parenting practices. Around 81 percent of the mothers in the sample were in stable relationship situations between years 1 and 3. In other words, their relationship status did not change during this time. Specifically, twenty-four percent of mothers were stably married between years 1 and 3. Approximately 13

percent of the sample was stably cohabitating, and around 44 percent of mothers were stably single during this time. The remaining 19 percent of the mothers in the sample were in an unstable relationship. For those who were in an unstable relationship, they either entered or exited a union between years 1 and 3. Approximately 9 percent of the sample formed a union, and around ten percent dissolved a union during this time.

In regards to parenting practices, the descriptive statistics indicate that mothers were engaged with their child on average 5.27 days out of 7. The average role strain score was 2.21 (out of 4). An average of 2.21 shows that the majority of mothers disagreed that they felt strained in their role as a parent. Mothers scored an average of 1.94 (out of 4) on the coparenting support measure. An average of 1.94 depicts that many of the mothers in this sample do not feel completely supported by the father of the child.

Table 2 Proportion or Mean (Standard Deviation) of Variables in Analytic Sample after Mean Substitution (n = 4127)

	M	SD
Health Outcomes at Year 5		
Poor Health	2.36	1.03
Depression	.14	---
Binge Drinking	.10	---
Relationship Status Over Time (Average between Year 1 & Year 3)		
Stable Relationships		
Stable Married	.24	---
Stable Cohabitation	.13	---
Stable Single	.44	---
Unstable Relationships		
Union Formation	.09	---
Union Dissolution	.10	---
Parenting Practices Over Time (Average between Year 1 & Year 3)		
Mother Involvement	5.27	.78
Role Strain	2.21	.51
Coparenting Support	1.94	.18
Covariates at Year 1		
Child Characteristics		
Age (months)	15.00	3.33

Poor Health	1.51	.77
Mother Characteristics		
Age (years)	26.37	5.84
Race/Ethnicity ^a		
White	.21	---
Black	.49	---
Hispanic	.26	---
Other Race	.03	---
Education		
Less than High School	.27	---
High School Diploma or Equivalent	.28	---
Greater than High School Diploma	.45	---
Employment (# of weeks)	24.77	20.55
Health Insurance		
Private Insurance	.30	---
Public Insurance	.61	---
No Health Insurance	.09	---
Household Income		
Household Income (continuous)	31740.46	32969.24
< 100% of FPL	.47	---
100– 299% of FPL	.37	---
>= 300% of FPL	.16	---
Number of Children in Household	2.31	1.15

Note. FPL = Federal Poverty Line

^a Measured at Year 0

In order to better understand the sample of mothers in the study, demographic and economic characteristics of the mothers are discussed. In regards to child characteristics, it was found that the average child age was 15 months. In addition, the average for child health was 1.51, showing that most children were in good health. On average, mothers were 26 years of age. The majority of mothers in the sample were black (49 percent). Approximately 26 percent of the mothers were Hispanic, twenty-one percent were white, and around 3 percent were of another race. In addition, most of the mothers in the sample had greater than a high school diploma (45 percent). Twenty-eight percent of the mothers had a high school diploma or equivalent, and 27 percent had less than a high school education. The average amount of weeks of employment was

approximately 25 weeks. When focusing on health insurance, it was found that the majority (61 percent) of the sample had public insurance (Medicaid). Thirty percent had private insurance and 9 percent of the sample had no insurance. On average, mothers had a household income of \$31,740.46. In addition, the majority of the sample was poor (i.e. 47 percent of the sample were <100% of FPL). Thirty-seven percent of the sample had incomes within 100-299% of FPL, and sixteen percent had incomes that were $\geq 300\%$ of FPL. Last, on average, there were over two children under the age of 18 residing in the households.

Before performing regression analyses, a correlation table was conducted (Table 3). The correlation table displayed varying relationship strengths between the dependent and independent variables. It was found that poor health was negatively correlated with being stably married, along with mother involvement and coparenting support. Poor health was positively correlated with stably cohabiting, being stably single, union formation, union dissolution, and role strain. All of these correlations were fairly weak. The strongest relationship was between poor health and role strain (.11).

In regards to depression, it was found that depression was negatively correlated with stable marriage and stable cohabitation. The parenting practices of mother involvement and coparenting support were also negatively correlated with depression. Depression, however, was positively correlated with stable single, union formation, union dissolution, and role strain. The strongest relationship was between role strain and depression (.12); however, none of the correlations were particularly strong.

Binge drinking was negatively correlated with stable cohabitation, stable single, union formation, and coparenting support. It was positively correlated with being stably married, union

dissolution, mother involvement and role strain. Again, all correlations were weak, with the strongest correlation being between binge drinking and role strain (.04).

In regards to the correlations between relationship status and parenting practices, stable marriage was negatively correlated with role strain and coparenting support. Stable marriage had a positive correlation with mother involvement. Stable cohabitation had a negative relationship with all three parenting practices. Stable single was negatively correlated with mother involvement and coparenting support and positively correlated with role strain. Union formation was negatively correlated with role strain and coparenting support, and positively correlated with mother involvement. Last, union dissolution had a negative correlation with both mother involvement and role strain, and positively correlated with coparenting support. Mother involvement was negatively correlated with role strain and positively correlated with coparenting support. None of the correlations described above were strong.

Table 3. Correlation Table of the Dependent and Independent Variables (n = 4127)

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Poor Health											
2. Depression	.27										
3. Binge Drinking	.04	.10									
4. Stable Married	-.09	-.05	.00								
5. Stable Cohabiting	.02	-.03	-.02	-.22							
6. Stable Single	.05	.02	-.01	-.46	-.32						
7. Union Formation	.03	.02	-.01	-.15	-.11	-.22					
8. Union Dissolution	.01	.03	.01	-.21	-.15	-.30	-.10				
9. Mother Involvement	-.09	-.02	.00	.01	-.00	-.01	.01	-.01			
10. Role Strain	.11	.12	.04	-.03	-.05	.10	-.02	-.01	-.22		
11. Coparenting Support	-.04	-.02	-.00	-.03	-.01	-.02	-.10	.15	.07	-.06	

Regression Analyses

An ordinary least squares (OLS) regression model was conducted for the dependent variable, poor health, as this measure was on a continuous scale. Logistic regression models were conducted for maternal depression and binge drinking, as these measures were on a dichotomy. The following are the results from these regression models (Tables 4-6).

Poor Health

Results indicate that both relationship stability and instability along with parenting practices affect maternal health (see Table 4). In regard to relationship status, it was found that stable cohabiting mothers compared to stably married mothers were more likely to experience poor health ($\beta = .13, p < .05$). It was also found that stably single mothers were more likely to experience poor health than mothers who were stably married ($\beta = .11, p < .05$). In addition, mothers who formed a union between years 1 and 3 were more likely to be in worse physical health at year 5 ($\beta = .17, p < .01$). Also, mothers who dissolved a union between years 1 and 3 were more likely to be in poor health at year 5 ($\beta = .14, p < .05$).

In regards to parenting practices, results suggest that mothers who were more involved with their children were less likely to experience poor health ($\beta = -.06, p < .01$). Results also indicate that mothers who had more coparenting support were less likely to be in poor health ($\beta = -.18, p < .05$). Mothers who experienced more role strain, however, were more likely to experience poor health ($\beta = .14, p < .001$).

Depression

Relationship status and parenting practices were both found to be significant when determining mothers' chances for depression. Specifically, results indicate that union formation, union dissolution, and role strain predict likelihood of depression. Mothers who formed a union

between years 1 and 3 increased their odds of experiencing depression by 72% at year 5 compared to mothers who were stably married (OR =1.72, $p<.01$). Mothers who experienced their union dissolved between years 1 and 3 were 77% more likely to experience depression by year 5 compared to mothers who were stably married (OR =1.77, $p<.01$). It was also found that a one-unit increase in role strain increased the odds of mothers experiencing depression by 85% (OR= 1.85, $p<.001$).

Binge Drinking

Both relationship stability and instability influenced mothers' chances of binge drinking. Mothers who were stably single increased their odds of binge drinking by 46% at year 5 compared to those mothers who were stably married (OR =1.46, $p<.05$). Mothers who formed a union between years 1 and 3 compared to mothers who were stably married increased their odds of binge drinking by 98% at year 5 (OR =1.98, $p<.01$). Mothers who dissolved a union between years 1 and 3 compared to mothers who were stably married were 62% more likely to binge drink by year 5 (OR =1.62, $p<.05$). In regards to parenting practices, only role strain was found to be significant. Mothers who experienced a one-unit increase in role strain increased their odds of binge drinking by 40% (OR =1.40, $p<.001$).

Table 4 OLS Regression Estimates for Predicting Maternal Poor Health at Year 5 (n = 4127)

	B (SE)
Relationship Status Over Time (Average between Year 1 & Year 3)	
Stable Relationships	
Stable Married (Reference)	---
Stable Cohabitation	0.13 (0.06)*
Stable Single	0.11 (0.05)*
Unstable Relationships	
Union Formation	0.17 (0.07)**
Union Dissolution	0.14 (0.06)*
Parenting Practices Over Time (Average between Year 1 & Year 3)	
Mother Involvement	-0.06 (0.02)**
Role Strain	0.14 (0.03)***
Coparenting Support	-0.18 (0.09)*
Covariates at Year 1	
Child Characteristics	
Age	-0.00(0.00)
Poor Health	0.19 (0.02)***
Mother Characteristics	
Age	0.01 (0.00)***
Race/Ethnicity ^a	
White (Reference)	---
Black	-0.12 (0.05)*
Hispanic	-0.09 (0.05)
Other Race	-0.12 (0.09)
Education	
Less than High School (Reference)	---
High School Diploma or Equivalent	-0.03 (0.04)
Greater than High School Diploma	-0.08 (0.04)
Employment	
Health Insurance	0.00 (0.00)
Private Insurance	-0.09 (0.06)
Public Insurance	0.05 (0.06)
No Health Insurance (Reference)	---
Household Income	
< 100% of FPL (Reference)	---
100– 299% of FPL	-0.01 (0.04)
>= 300% of FPL	-0.26(0.06)***
Number of Children in Household	0.03 (0.01)
Constant	2.07 (0.26) ***

Note: FPL = Federal Poverty Line.

^a Measured at Year 0.

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

Table 5 Logistic Regression Estimates for Predicting Maternal Depression at Year 5 (n = 4127)

	OR (95% CI)
Relationship Status Over Time (Average between Year 1 & Year 3)	
Stable Relationships	
Stable Married (Reference)	---
Stable Cohabitation	1.07 (0.77, 1.51)
Stable Single	1.29 (0.98, 1.69)
Unstable Relationships	
Union Formation	1.72 (1.22, 2.44)**
Union Dissolution	1.77 (1.27, 2.48)**
Parenting Practices Over Time (Average between Year 1 & Year 3)	
Mother Involvement	1.02 (0.91, 1.14)
Role Strain	1.85 (1.57, 2.19)***
Coparenting Support	0.86 (0.54, 1.36)
Covariates at Year 1	
Child Characteristics	
Age	1.01 (0.99, 1.04)
Poor Health	1.21 (1.09, 1.34)***
Mother Characteristics	
Age	1.00 (0.99, 1.02)
Race/Ethnicity ^a	
White (Reference)	---
Black	0.66 (0.52, 0.83)***
Hispanic	0.53 (0.41, 0.69)***
Other Race	0.58 (0.35, 0.96)*
Education	
Less than High School (Reference)	---
High School Diploma or Equivalent	1.07 (0.85, 1.35)
Greater than High School Diploma	1.11 (0.88, 1.40)
Employment	0.99 (0.99, 0.99)*
Health Insurance	
Private Insurance	0.86 (0.61, 1.21)
Public Insurance	0.99 (0.73, 1.33)
No Health Insurance (Reference)	---
Household Income	
< 100% of FPL (Reference)	---
100– 299% of FPL	1.02 (0.83, 1.25)
>= 300% of FPL	0.82 (0.59, 1.15)
Number of Children in Household	0.99 (0.91, 1.07)

Note: FPL = Federal Poverty Line.

^a Measured at Year 0.

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

Table 6 Logistic Regression Estimates for Predicting Maternal Binge Drinking at Year 5 (n = 4127)

	OR (95% CI)
Relationship Status Over Time (Average between Year 1 & Year 3)	
Stable Relationships	
Stable Married (Reference)	---
Stable Cohabitation	1.12 (0.76, 1.65)
Stable Single	1.46 (1.07, 2.00)*
Unstable Relationships	
Union Formation	1.98 (1.33, 2.94)**
Union Dissolution	1.62 (1.09, 2.41)*
Parenting Practices Over Time (Average between Year 1 & Year 3)	
Mother Involvement	0.96 (0.84, 1.10)
Role Strain	1.40 (1.14, 1.72)***
Coparenting Support	1.04 (0.59, 1.80)
Covariates at Year 1	
Child Characteristics	
Age	1.00 (0.96, 1.03)
Poor Health	1.12 (0.98, 1.27)
Mother Characteristics	
Age	0.96 (0.94, 0.98)***
Race/Ethnicity ^a	
White (Reference)	---
Black	0.23 (0.18, 0.31)***
Hispanic	0.51 (0.39, 0.67)***
Other Race	0.42 (0.24, 0.74)**
Education	
Less than High School (Reference)	---
High School Diploma or Equivalent	1.51 (1.14, 2.00)**
Greater than High School Diploma	1.13 (0.85, 1.51)
Employment	1.00 (1.00, 1.01)
Health Insurance	
Private Insurance	0.85 (0.58, 1.27)
Public Insurance	0.93 (0.65, 1.31)
No Health Insurance (Reference)	---
Household Income	
< 100% of FPL (Reference)	---
100– 299% of FPL	1.12 (0.87, 1.44)
>= 300% of FPL	2.06 (1.44, 2.95)***
Number of Children in Household	1.00 (0.90, 1.10)

Note: FPL = Federal Poverty Line.

^a Measured at Year 0.

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

Discussion

Chapter Four

The purpose of the current study was to examine how both relationship stability and parenting practices affect maternal physical and mental health, and risky health-related behaviors in a sample of socio-economically disadvantaged mothers with young children. An ordinary least squares regression model indicated that poor maternal physical health was affected by both relationship status and parenting practices. Compared to stably married mothers, mothers who were stably cohabiting, stably single, or in unstable relationships (i.e. union formation or union dissolution) were more likely to be in poor physical health. In addition, mothers who were less involved with their child, who experienced greater levels of role strain or who reported lower levels of coparenting support were also more likely to be in poor physical health. A logistic regression model found that union formation, union dissolution, and role strain all predicted the likelihood of depression. In addition, mothers who were stably single, formed a union, and dissolved a union were more likely to binge drink compared to mothers who were stably married. Mothers who experienced role strain were more likely to binge drink, as well. Below I discuss the results in more detail as well as limitations and implications.

Relationship Instability

As hypothesized, compared to socio-economically disadvantaged married mothers, mothers who were stably single, stably cohabiting, had formed a union, and those who had dissolved a union reported worse physical health. Previous research supports these findings. As Kiecolt-Glaser and Newton (2001) discovered, mothers who are married are in better physical health than those who are unmarried or divorced. The current study's analyses considered a

greater number of relationship statuses, but the findings remain the same: those who are married fare better. Applying the social stress theory to the current findings, it may be that those who are married are in better physical health due to stable material and social resources that are associated with marriage, along with increased access to health care, and an available spouse who encourages positive health behaviors (Lerman, 2002; Umberson, 1987). It is important to keep in mind, however, that the results above are limited to a two year period. With this specific sample, it is unknown what the effects of relationship status on maternal physical health would be in the long run for those who continued to experience relationship instability or remain single or in a cohabiting relationship. However, research conducted by Lorenz, Wickrama, Conger, and Elder (2006) discovered that those who remained married fared much better in the future than those who remained divorced.

Depression in the current study was influenced mainly by measures of relationship instability. In line with my hypothesis, it was found that those who formed or dissolved a union were more likely to experience depression than those who were stably married. This is consistent with research conducted by Brown (2000). Contrary to my hypothesis, however, those who were stably single and those who were stably cohabiting were not more likely to experience depression than those who were stably married. Thus, experiencing a partner entering or leaving a relationship (and not relationship stability) was related to depression. Previous studies have found that relationship instability exacerbates depression in the presence of biological and step-children, while those who are married are unaffected in terms of depression by the presence of children. Therefore, I did additional descriptive work by calculating the average number of children present in each household by type of relationship status. My thinking behind this was that the mothers who experienced relationship instability may have greater number of children in

their household; and thus, it may be a mechanism for further investigation. However, in the current study, it was found that the number of children that resided in the household did not differ by relationship status. These differences may be due to the nature of the samples present in both studies. The sample in the Brown (2000) study was a national sample that contained low-income families, but by no means, contained an over-sampling of low-income families like the FFCW study. As a result, it may be that those in the FFCW study who were in unstable relationships were influenced by other factors that are unique to poverty conditions; perhaps for low-income mothers the presence of children is secondary compared to other factors that are threatened in the face of poverty. In sum, my results stand consistent with past research in depicting that relationship instability is associated with maternal depression.

When considering binge drinking, my hypothesis expected mothers who experienced relationship instability would more likely experience binge drinking compared to stable married mothers. In addition, I believed that those who were stably single and stably cohabiting would also be more likely to experience binge drinking compared to stably married mothers. The results, however, demonstrated that only mothers who were stably single between years 1 and 3 and those who dissolved and formed a union during that time period were more likely to experience binge drinking than those who were stably married. As discussed in the social stress theory, any sort of transition in relationship increases stress (George, 1993). The stress associated with the nature of transitioning into and out of relationships could be contributing to binge drinking. In other words, socio-economically disadvantaged mothers may be using alcohol as a coping mechanism for their unstable relationships. In addition, it has been shown that single mothers are more at risk for adverse conditions (Beeber et al., 2008). These adverse conditions and living environments may contribute to their likelihood of drinking. Furthermore, single

mothers do not have a stable partner to take care of them and to encourage healthy behaviors such as mothers who are married. Thus, binge drinking may be a way of coping with their difficult lives.

Parenting Practices

In terms of parenting practices, I hypothesized that mothers who experienced greater levels of role strain would be more likely to be depressed and to binge drink. Based on previous research findings examining fathers' experience of role strain (Hernandez, in press), I did not believe that those who experienced role strain would report lower levels of physical health. Contrary to my hypothesis regarding role strain and physical health, it was found that role strain was the dominant predictor. Specifically, role strain was related to socio-economically disadvantaged mothers having worse physical health, in addition to experiencing depression and engaging in binge drinking. The current results parallel findings by Crnic and Greenberg (1990) who found that mothers who experience more parenting stress are more likely to report greater psychological distress and lower life satisfaction than mothers with low parenting stress. The findings also support role theory. As explained by role theory, certain roles are laden with stress (Pearlin, 1989), and the stress associated with these roles is exacerbated in the presence of poverty. It may be that socio-economically disadvantaged mothers who experience greater levels of role strain find the role challenging and have less time and energy to focus on taking care of themselves. As a result, these mothers appear to have worse physical health, be more likely to be depressed, and may turn to binge drinking as a way to cope with the multitude of problems they face in their role as mothers.

Mother involvement and coparenting support were not as strong predictors of maternal health compared to role strain as I had hypothesized. Among a sample of socio-economically

disadvantaged mothers, mothers who displayed greater maternal involvement and coparenting support were less likely to be in poor health. Besides the likelihood of being in better physical health, mother involvement and coparenting support did not affect maternal depression or binge drinking. These variables were collected within a short span of time of two years, and it may take a longer period of time for mother involvement and coparenting support to have an effect on maternal mental health and risky-health related behaviors, such as binge drinking. For example, the lack of coparenting support that mothers experienced may take a longer period than two years to perpetuate a negative health outcome.

Limitations

There are limitations that are associated with this current study. For instance, the study sample was based on socio-economically disadvantaged, urban mothers with young children. Therefore, the findings of this study are restricted to this specific sample. Specifically, poverty places these mothers at an increased risk for negative life events such as job loss, chronic strains, poor housing, dangerous neighborhoods, and conflict with partners (Beeber, et al., 2008). The increased risk of negative life events further places these women at greater risk for negative physical health, mental health problems, and engagement in risky health-related behaviors (McLanahan, 2009). The confluence of risk factors among the sample influenced the study's results.

The sample also contained a considerable amount of missing or invalid data. As a result, I chose to substitute the missing data values with mean averages. Although this method is better than listwise deletion, there are better (and more advanced) techniques of handling missing data, such as multiple imputation.

In addition, this study relied on self-report measures of physical health and binge drinking; therefore, reporter biases in the measures are present. Physical health was measured by one question and relied on the mother's perception of her own health (rather based on professional consultation from a doctor). For instance, mothers who were depressed may have reported lower physical health, when in fact their physical health is better than what they perceived. Further, mothers may have underreported their responses regarding binge drinking in an attempt to decrease scrutiny. Thus, these two measures are considered less reliable and valid compared to measures that are directly assessed based on standards and norms. On the other hand, the Composite International Diagnostic Interview (CIDI), which was used to measure maternal depression rates, is considered reliable and valid (Poutanen et al., 2007).

Programmatic and Research Implications

Policies such as the Healthy Marriage Initiative and other marriage and relationship education programs should continue to be promoted by the government. These initiatives recognize the benefits of marriage and encourage couples to gain access to marriage education services, which help them maintain a healthy marriage (U.S. Department of Health and Human Services, 2010). The current study mirrors what previous studies (e.g., Cox & Shirer, 2009; Blanchard, Hawkins, Baldwin, & Fawcett, 2009; Hawkins, Carroll, Doherty, & Willoughby, 2004) have found in that healthy marriages are essential for positive maternal health behaviors, along with maintaining child wellbeing.

Future research studies should continue to examine the importance of role strain when considering the health of mothers with young children. It would be important for future studies to differentiate between parental and work strain, in addition to parental strain regarding children from multiple partners. This type of differentiation is necessary in order to gain a deeper

understanding regarding the association between role strain and maternal health. It may be that work strain is a greater “stressor” than parental strain for socio-economically disadvantaged mothers. If this is the case, greater work related support for low-income mothers is needed.

Implications for My Career as an Occupational Therapist

As a result of my thesis, I will enter the professional world with a newfound respect for research. Analyzing this data has not only given me an appreciation for a different side of academia, but it has also provided me with a richer way of understanding and appreciating people. As an occupational therapist, I will interact with patients from all sorts of backgrounds. The results from my study highlight the various factors that influence different facets of life. For example, my thesis has taught me to consider factors such as a patient’s socio-economic background, the quality of the support the patient receives from others, and the strain he or she may feel as a parent. In addition, it is essential to take into consideration the stability of patient’s relationships. If his or her relationships are fraught with transitions, I must realize that this has the potential to interfere with a patient’s health. My thesis has led me to an appreciation and a greater understanding that the roles that we hold dear (e.g., mother, spouse, worker) have the power to affect our health. They are essential to our well-being.

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