

Watch them Grow

Unmarried-cohabitant and Solo
parenthood in Ireland

An analysis of the **Growing Up in Ireland** infant cohort data
Waves 1 and 2

Key Findings 4: Child Health and Wellbeing

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2014



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 - ✓ unmarried parents living apart
 - ✓ unmarried parents living together
 - ✓ teen parents
 - ✓ opposite and same sex parents
 - ✓ grandparents and other relatives
 - ✓ those working with unmarried parents and their families.
- Advocates on behalf of unmarried parents and their children.
- Co-ordinates the 11 local **Teen Parent Support Programmes** at national level.

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2. Treoir recognises that all families, including unmarried families have the same rights to respect, care, support, protection and recognition
3. Treoir supports and promotes the rights of all children as outlined in the United Nations Convention on the Rights of the Child
4. Treoir believes that all children have a right to know, be loved and cared for by both parents

Key Findings 4: Child Health and Wellbeing

Introduction

This Key Findings document outlines select findings of interest concerning **Child Health and Wellbeing** presented in Treoir's report on the first two waves of data from the infant cohort (collected at 9 months and again at 3 years) of the *Growing Up In Ireland* (GUI) Study, entitled *Watch them Grow: Unmarried-cohabitant and Solo parenthood in Ireland*.

The report focuses on primary caregivers (PCGs) and their infant children, exploring differences in outcomes across a range of domains, including parental health and parenting, child health and wellbeing, childcare, work and welfare. In doing so, the report employs the tripartite scheme used by Kiernan to distinguish marital status categories as follows (Kiernan, 2005) :

- **Married:** those who were 'ever married' and currently cohabit with a partner
- **Unmarried-cohabitant (UC):** this category comprises only those who indicated they were 'never married' and all of these respondents have cohabiting partners
- **Solo:** this group combines single parents, none of whom cohabit with a partner, whether they were 'never married' or whether they are lone parents who are now separated, divorced or widowed

Complete details of the methodology and findings can be found in the full report which is available for download on the Treoir website at www.treoir.ie. The report was researched and written by Dr Owen Corrigan and generously funded by the HSE Crisis Pregnancy Programme. Other Key Findings documents are also available free to download on the Treoir website covering a range of topics. The complete collection of Key Findings documents covers:

- | | |
|---|--|
| • KF1: Marital Status, Family Transitions and Solo Parents | • KF4: Child Health and Wellbeing |
| • KF2: Childcare | • KF5: Work and Welfare |
| • KF3: Parents' Health and Parenting | • KF6: Crisis Pregnancy |

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Context

A range of factors can impact on child health, from poverty and deprivation (Bradley and Corwyn, 2002), to parental behaviours during pregnancy – such as smoking and drinking alcohol – to parenting habits and practices after pregnancy, including approaches to diet and interaction with health services. It is well established that intrauterine exposure to drugs like alcohol or tobacco is implicated in development deficits in children that can often result in lifelong mental or physical difficulties (Mulder et al., 2002). Tobacco use during pregnancy, for instance, increases the risk of preterm birth approximately two-fold (Goldenberg et al., 2008).

Premature infants generally have been seen to have more problems in a number of developmental areas than their normal birth counterparts, including such areas as: motor/neurologic function, visuomotor integrative skills, IQ, academic achievement, language, executive function, and attention-deficit hyperactivity disorder/behavioural issues (Aylward, 2005). While low birth weight and premature birth often coincide this is not always the case, though it has been suggested that gestational age may be a better indicator of biological maturation than birth-weight (Aylward, 2005; Nixon et al., 2013). Prematurity may also impact on parent-child relationships and interactions. Research has shown that premature babies elicit different parenting responses due to their being more challenging to caregivers (Goldberg and DiVitto, 2002; Nixon et al., 2013). Studies have found that parents rated as significantly more fearful and negatively reactive those children born small for their gestational age, as compared with infants who were an appropriate weight for their gestational age (Pesonen et al., 2006).

Diet is a key component of health for both infants and parents. Key findings from the GUI study team on the health of the infant cohort found that one in four three-year olds were classified as overweight or obese, 19% as overweight and 6% as obese (GUI, 2011). Social class and education were seen in these findings to be important correlates of diet quality. Consumption of unhealthy foods, such as fizzy drinks, crisps and chips, was seen to increase as parental education fell. It has been suggested that improving parent knowledge and reducing child television viewing may constitute important pathways in the effort to curb childhood obesity (Gable and Lutz, 2000).

Maternal stress is linked to a higher risk of depression as well as to negative parenting behaviours which can impact on child socio-behavioural outcomes (Lancaster et al., 2010; Webster-Stratton and Hammond, 1988). Depression itself has also been linked to negative parenting behaviours (Lovejoy et al., 2000). Before birth, depression has also been linked to an increased likelihood of premature delivery (Goldenberg et al., 2008).

Beyond parent effects, a wide variety of factors including sociodemographics and family characteristics have been seen to explain conduct and behavioural difficulties in young children. High levels of maternal stress co-occur with adversity experienced by the mother, such as socio-economic hardship, poverty, overcrowding, poor neighbourhoods etc. (Bradley and Corwyn, 2002; Petterson and Albers, 2001). Socioeconomic status (SES) in terms of income or occupation has been shown to be consistently associated with child development in numerous studies (Bradley and Corwyn, 2002; Brooks-Gunn and Duncan, 1997); see the full report for more citations on this point.

Numerous factors have been posited as potential moderating mechanisms by which low socioeconomic status impacts on child development including: higher maternal stress due to poverty (Bradley and Corwyn, 2002; McLoyd, 1998); difficult home relationships or marital discord (Petterson and Albers, 2001; Repetti et al., 2002); lack of resources and, thus, of stimulating materials for children impacting on cognitive development, and potentially on behavioural development where child boredom or frustration results in strained parent-child relations (Bradley and Corwyn, 2002; Brooks-Gunn and Duncan, 1997); larger families or crowded residences leading to a dilution of parental attention on young children (Downey, 1995).

Socioeconomic status, as well as family structure, has also been seen to impact on how parents go about using medical services. A UK study of the determinants of rates of consulting GP doctors showed that: Higher rates of consultations were found in patients who were classified as permanently sick, unemployed, renting their accommodation, some immigrants, living with a spouse or partner (women only), children living with two parents (girls only), and living in urban areas, especially those living relatively near the practice (Carr-Hill et al., 1996). The most prominent characteristic associated with child injury is family type; children from one-parent homes with more than one child had the highest injury rates across different family types (Williams et al., 2013: 49).

There are a number of supports in Ireland available to parents in the time after the birth of their child under the Maternity and Infant Care Scheme. This entitles mother and baby to two visits to their GP after the baby is born, at 2 weeks and 6 weeks old. At the second visit doctors check the baby's weight, length, head circumference and hips and they discuss the baby's feeding patterns and general health with the mother, and address any concerns she might have. A public health nurse also visits mother and baby at home, generally within 48 hours of birth, for mothers who gave birth in a hospital. They carry out checks at 9 months, 18 months and 2 years, focusing on developmental issues such as eyesight, hearing etc. Public health nurses also offer advice and support to mothers, as well as support groups for breastfeeding and advice on developing a healthy and balanced diet for babies switching to solid food.

Findings

Child's health

Child's current health

- Solo parents appear more likely to report that their child is unwell than Married parents or Unmarried-cohabitant parents, however this can be accounted for in terms of Solo parents higher scores on indexes of stress and/or depression
- Parental stress and depression as well as younger gestational age at birth are all implicated in poorer health outcomes for children

Change in child's health over time

- Solo parents are more likely than Married parents to report a decline in their child's health over time, though the association is somewhat weak
- Again, higher scores on indexes of stress and depression were associated with a decline in the child's health over time
- Other factors such as poor general health of the PCG, parental disability, complications in pregnancy, or premature birth were also associated with a perceived decline in child health

Injury requiring hospitalisation

- Injury requiring hospitalisation occurred significantly more frequently for children of Solo parents than for children of UC and Married parents. This finding is in line with previous research; as is the finding that injury occurs more frequently for children in larger families
- Where mothers had experienced crisis pregnancy (a pregnancy that was both stressful and unintended) this was associated with a higher likelihood of the child sustaining an injury requiring hospitalisation, and this effect could not be explained away in terms of differences in parenting style or in stress or depression scores

Use of medical services

Use of medical services, in terms of number of visits to different types of medical practitioner in the preceding 12 months shows clear patterning by medical card usage as would be expected, see Fig. 1. Meanwhile, Table 1 shows the distribution of medical card claimants by type of medical card and marital status at W2. The vast majority of Solo parents are on a full medical card.

Fig. 1

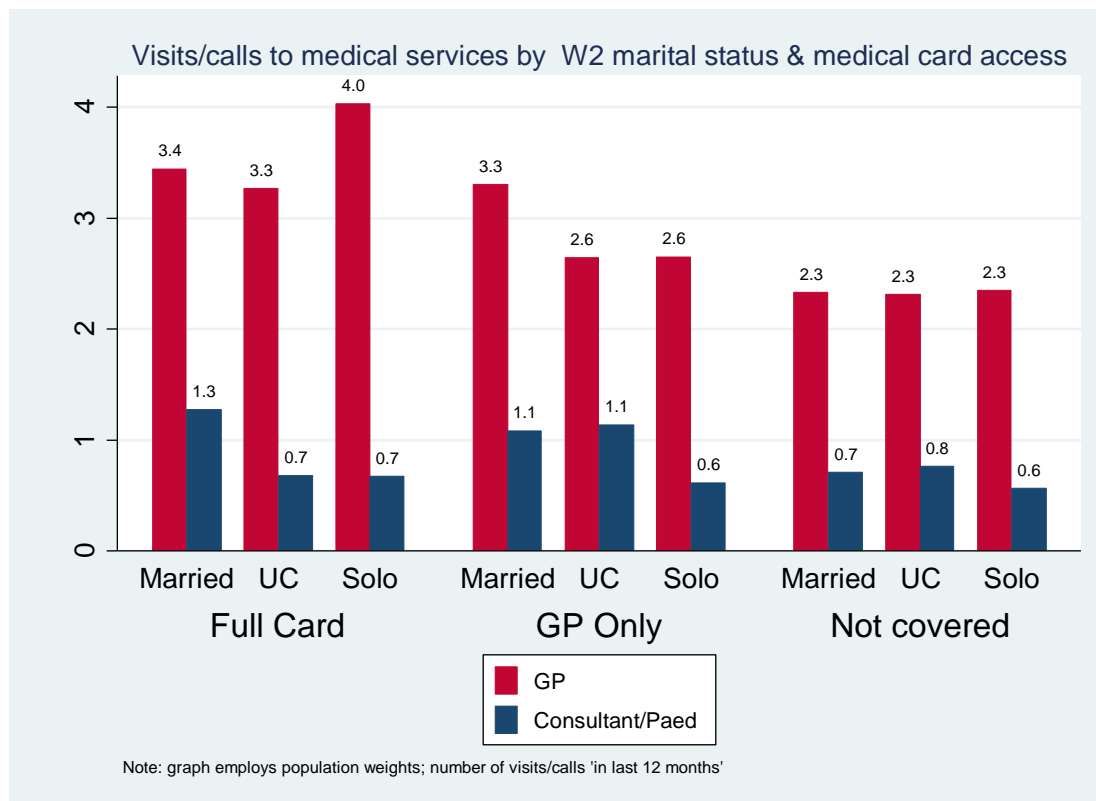


Table 1: Distribution of medical card type by W2 marital status

Medical Card	Married	UC	Solo	Total
Full Card	22	50.3	78.7	33.4
GP Only	4.4	5.3	4	4.5
Not covered	73.7	44.4	17.3	62.1
Total	100	100	100	100

Note: population weighted table; p<.000; highest row percentages highlighted

Looking at usage of medical services by marital status and controlling for other relevant factors shows:

- Unmarried-cohabitant parents visited the GP less frequently than Married parents; Solo parents visited with no greater or lesser frequency once other explanations (e.g. income, education) had been accounted for
- Low education, low income, being a younger mother, mother's poor health, complications in pregnancy, or experiencing a crisis pregnancy were all associated with more intensive usage of a range of different medical service providers
- Higher parental stress was associated with more intensive use of services for 6 of 7 service types examined (except Practice Nurses)
- Premature birth predicted significantly more intensive usage of all medical services (except social workers)

Child Wellbeing

Physical abilities

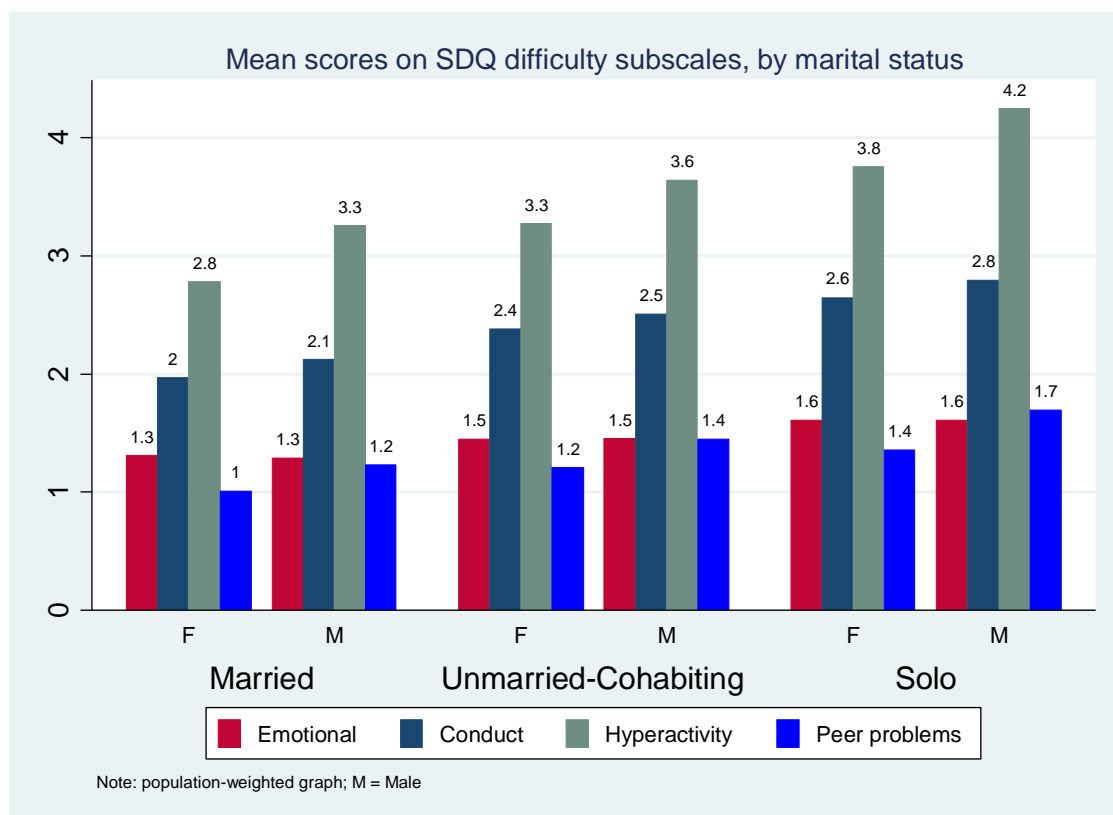
- There was some association of marital status with child physical abilities: children of Solo parents are less likely to be able to throw a ball overhand than children of Married or UC parents. This could not be explained by differences in terms of birth weight, gestational age at birth, parenting style, or parental stress
- Consistent parenting and a positive parent-child relationship were strongly associated with an ability to perform other physical tasks, i.e. standing on one leg, throwing a ball overhand, drawing/copying a vertical line, holding a pencil with the correct grip. Consistency of parenting is seen in the full report to be associated with income and education differences, not with marital status or family type per se
- Complications in pregnancy, low birth weight, premature birth and higher levels of parental stress at wave 2 were all associated with poorer physical developmental outcomes¹

¹ All reduced the likelihood of being able to hold a pencil correctly; complications and prematurity also reduced the likelihood the study child would be able to stand on one leg; stress reduced the likelihood of being able to copy a line.

Socio-behavioural development (SDQ scores)

The Strengths and Difficulties Questionnaire (SDQ) was developed by Goodman (Goodman, 1997). This questionnaire measures children's development in five areas and is used to develop subscales gauging things such as: how children relate to peers (peer problems), how they behave (conduct), how fearful or easily scared they are (emotional), how agitated or fidgety they are in their behaviour (hyperactivity-inattention), and a 'strength' subscale tapping the extent to which they are considerate of other people's feelings (prosocial). Summing the four 'deficit' subscale scores produces a Total Difficulties score. Higher scores mean more difficulties on this scale. Fig. 2 shows mean scores on the difficulties subscales by marital status and clearly shows higher levels of difficulties (higher scores) between genders and between marital status types. For example, three-year old boys in a Solo parent family have the highest mean score on the hyperactivity scale at 4.2 points; compare this to girls in Married families where the mean score is 2.8 points (for boys in Married families the score is 3.3 points).

Fig. 2



Looking at explanations for differences in SDQ scores shows:

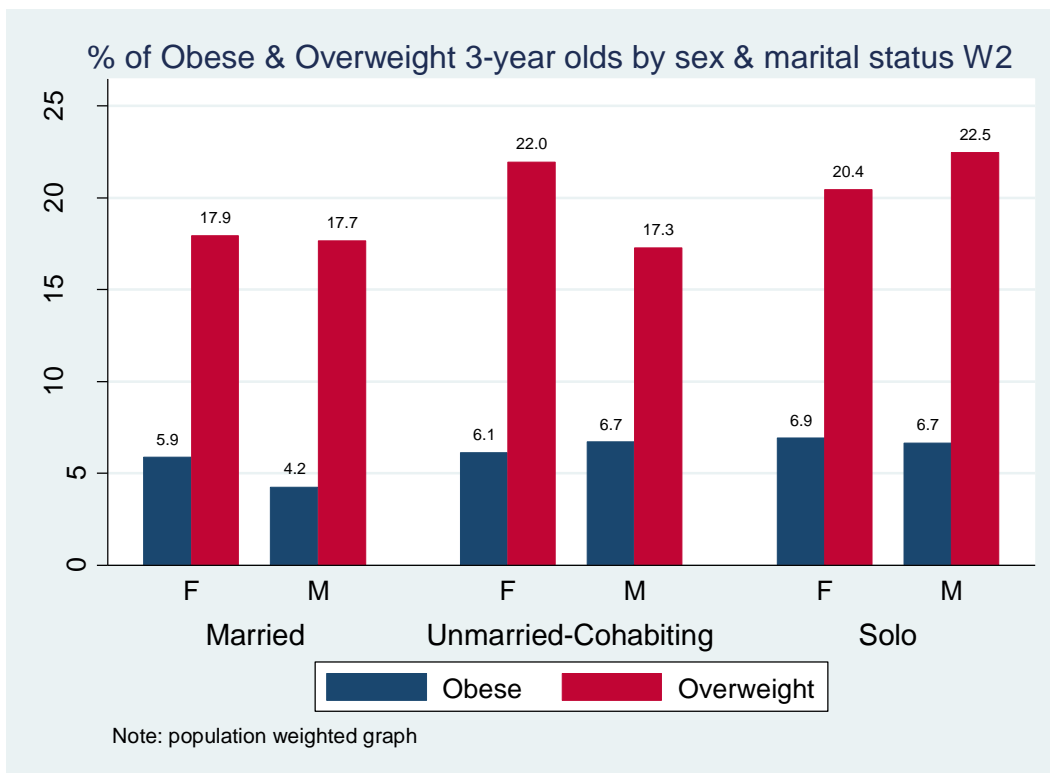
- There was a clear patterning of socio-behavioural difficulties by marital status
- Solo parents' children were seen to have significantly higher levels of social difficulties even controlling for a range of relevant factors
- Children of Solo parents who transitioned into marriage/cohabitancy were predicted to have higher levels of social difficulties than in families which made no such transition
- Smoking while pregnant, the baby being male, and the mother being relatively young or in poor health are all factors that predicted higher levels of socio-behavioural difficulties
- Parenting styles were strongly predictive of higher levels of socio-behavioural difficulties when parents exhibited hostile or inconsistent parenting behaviours
- Change in depression or stress scores of the primary caregiver (increases in scores over time) significantly predicted higher levels of socio-behavioural difficulties for 3 year old infants

Obesity

Approximately 1 in 4 three-year olds were seen in initial GUI publications on the wave 2 data to be overweight or obese and this was correlated with class. Here we look at the distribution of being overweight or obese by marital status at wave 2. We use age-appropriate cut-off points for infant BMI (body mass index) scores at age 3, drawn from research on standard international definitions of child overweight and obesity (Cole et al., 2000).

- There were gender differences in the determinants of being obese among 3-year old infants
- Female infants of Solo parents were less likely to be obese than females in Married families
- Parental behaviours such as smoking during pregnancy or parenting style (inconsistency) predicted higher risk of obesity amongst female infants
- Higher PCG scores on an index of depression also predicted a higher risk of female infant obesity
- For male infants, income was a major predictor, and there was no effect of marital status or family type when controlling for this and other factors; education level of the parent was also seen to matter
- Male infants from larger families were significantly less likely to be obese than those from smaller families

Fig. 3



Overweight

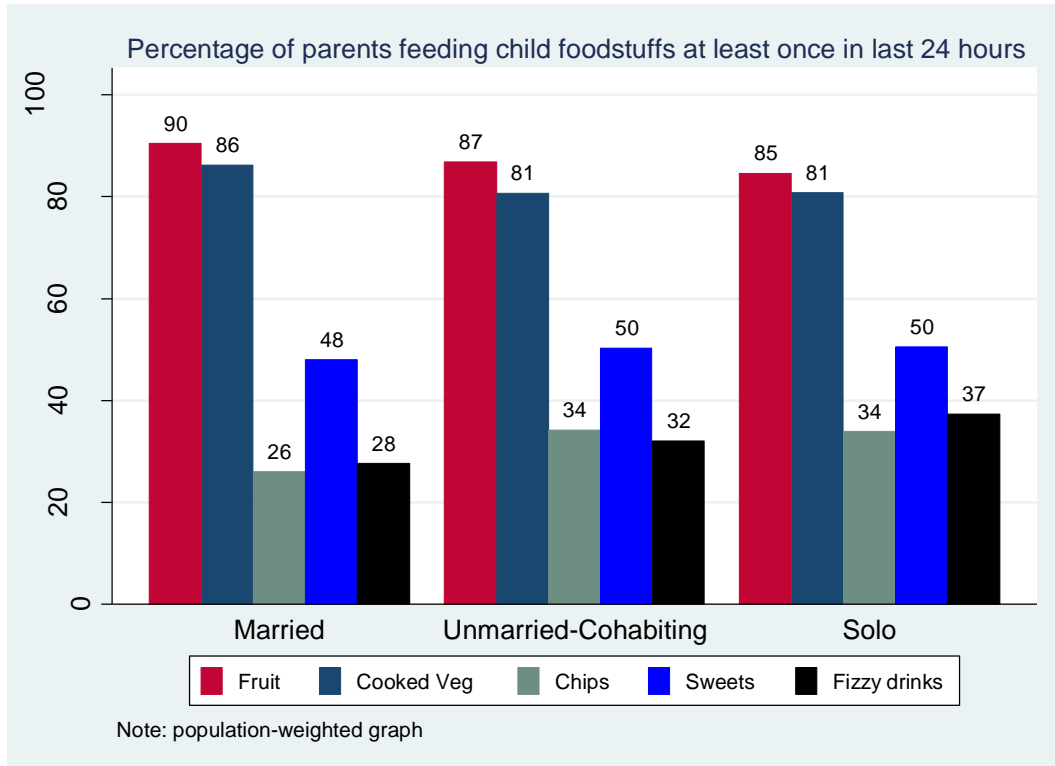
- Inconsistent parenting styles, a family history of poverty, and being born prematurely all predicted a higher likelihood of being overweight for *both* male and female infants
- Higher PCG depression scores were weakly associated with a higher risk of male infants being overweight

Dietary habits

- There were indications that Solo parent family types were more likely to engage in unhealthy dietary habits or to allow unhealthy eating practices such as eating when bored
- Solo parents were more likely to give their child unhealthy foods (fizzy drinks), as were Unmarried-cohabitant parents who transitioned into Solo parenthood, though this latter association was somewhat weak, see Fig. 4

- UC parents were less likely to give their children healthy foods (vegetables), and those who transitioned into marriage over time may also be less likely to do so
- These differences remained even accounting for differences in income, education, and parenting styles, however some of the associations were weak in a statistical sense and so further research may be needed
- Higher levels of education and consistent and positive parenting styles predicted healthy dietary habits and eating practices
- Regular contact with grandparents was (for some indicators) associated with more healthy dietary practices and habits
- Parental stress – and to a lesser extent higher scores on the depression index – was associated with unhealthy dietary practices
- Experience of Crisis pregnancy was implicated in some unhealthy dietary habits, and this could not be explained by differences in income, stress or other factors

Fig. 4



Policy Implications

- Policies aimed at helping parents who are at higher risk for stress and/or depression seem likely to have positive consequences for child health, physical development, socio-behavioural development and diet. Targeting of any such policies at Solo parents, a group at higher risk for these difficulties, may be justified
- The implication of prematurity in poor health outcomes is well established in the literature and the findings here support this. Advice, information, support and guidance to all parents to highlight the linkages of certain behaviours such as smoking with the risk of premature delivery and/or other development impacts on the child will continue to be important in light of this. Targeting of messages aimed at those more likely to engage in such behaviours, e.g. Solo parents' higher likelihood of smoking while pregnant, may be warranted
- Children of crisis pregnancy were more likely to encounter undesirable outcomes such as sustaining an injury requiring hospitalisation, or having poorer dietary habits, and these effects could not be explained away in terms of differences in parenting style, stress or other background characteristics. While no clear policy implication as such arises from these findings it may be that further research to clarify the linkages between crisis pregnancy and undesirable health outcomes is needed
- Educational programmes may help to improve the dietary habits of certain groups of parents, and low education in general was correlated negatively with dietary outcomes.
- Those undergoing transitions to new family types appear to be at some risk of negative outcomes including engaging in or allowing less healthy dietary habits, and higher levels of socio-behavioural difficulties for their children. The availability of advice or support at such a potentially disruptive time may be beneficial
- The issue of childhood obesity is a pressing issue for policymakers, with 1 in 20 Irish 3-year olds now classified as obese. The issue was seen to cut across family types in this analysis, with the results underscoring the importance of education and income as well as parental behaviours and parenting styles

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