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Public Health

journal homepage: www.elsevier.com/puhe

Original Research

Family structure, social capital, and mental health disparities among Canadian mothers

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ARTICLE INFO

Article history:
Received 2 June 2014
Received in revised form
16 March 2015
Accepted 18 March 2015
Available online 30 April 2015

Keywords:
Single mothers
Self-rated mental health
Social capital
Socio-economic status

ABSTRACT

Objectives: To examine the extent to which inequities in mental health between single and partnered mothers can be explained by social capital, independently and in concert with socio-economic circumstances.

Study design: Cross-sectional study.

Methods: The sample consisted of 2920 mothers participating in Statistics Canada's 2010 General Social Survey. Chi-square and logistic regression analyses were used to investigate the extent to which family structure differences in self-rated mental health, if observed, were mediated by various dimensions of social capital.

Results: Compared with partnered mothers, fair/poor self-rated mental health was more common among previously married mothers (OR = 3.14; 95% CI 2.15–4.59) and never married mothers (OR = 3.01; 95% CI 1.95–4.65). After adjustment for socio-economic and social capital variables, the odds ratio between single mother family structure and fair/poor mental health decreased but remained significant ($OR_{previously\ married}$ = 1.90, 95% CI 1.22–2.98; $OR_{never\ married}$ = 1.90, 95% CI 1.14–3.16).

Conclusion: Single mothers' more limited access to economic and social capital resources partially explain their compromised self-rated mental health. Longitudinal research with multi-item measures of mental health is needed to corroborate these findings and extend their understanding of the relationship between family structure, social capital, and mothers' mental health.

Introduction

Marked changes have occurred in the family structure of Canadians over the last thirty years, with the traditional two-parent family structure becoming much less prominent. Single parent families comprised 16.3% of all Canadian families in 2011, an increase of 8% since 2006 and nearly double the proportion reported in the early 1960s.[1] Of the

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http://dx.doi.org/10.1016/j.puhe.2015.03.023
0033-3506/

approximately 1.5 million Canadian single parent families in 2011, the vast majority, approximately 80%, were headed by single mothers.

A considerable body of research has accumulated, both in Canada [2,3] and in other Western countries,[4,5] indicating that single mothers experience poorer mental health than their partnered counterparts. Research has shown that much, but not all, of single mothers' elevated level of mental morbidity can be explained by their greater socio-economic hardships.[6,7] One of the more recent explanations posited to further assist in understanding differences in the mental health of single and partnered mothers involves the concept of social capital.[8]

Clear and consistent definitions of social capital are difficult to come across in the academic literature, although there appears to be agreement that social capital is a concept that is both multidimensional and complex.[9] The epidemiological literature on social capital draws upon the work of several notable theorists, including Robert Putnam[10] who defines social capital as '*features of social organizations such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit*'. Although Putman's definition clearly positions social capital as a group resource, researchers have extended his work to the study of social capital at the individual level; that is, '*the ability of actors to secure benefits by virtue of membership in social networks or other social structures*'.[11] Different dimensions of social capital have also been recognized.[12] Cognitive social capital focuses on individuals' perceptions of trust, sense of belonging and beliefs of reciprocity. Structural social capital centres on individuals' behaviours, such as contact with family/friends, volunteering with community organizations, and political participation.

A growing body of research has linked higher levels of individual social capital, particularly the cognitive components, to reduced risks of psychological distress, major depression and common mental disorders.[13–15] Although the precise mechanisms remain unclear, social capital has been suggested to enhance/protect mental health through multiple pathways such as decreasing individuals' exposure and/or vulnerability to psychosocial stressors, increasing the likelihood of adopting positive health-related social norms (e.g. regular physical activity), and increasing self-esteem and perceptions of self-efficacy. The positive association between social capital and mental well-being may be particularly pronounced among lower socio-economic groups.[16]

Some limited evidence suggests that mothers in single parent households may experience lower levels of social capital than those in coupled households, as measured by their network size, participation in formal organizations and trust in relation to family, community, and institutions.[8,17] Although the reasons for the link between family structure and social capital have not been fully elucidated, several researchers have speculated that single mothers' levels of social capital may be compromised due to having less time available than partnered mothers to develop and maintain social networks and participate in social activities and organizations. Further, as speculated by Ravanera and Rajulton,[17] for previously partnered single mothers, '*marital dissolution, often accompanied with acrimony and severance of ties with family members, possibly brings about breaking of ties with informal and formal networks and consequently decreases trust in people*'.

Given research linking social capital with mental health outcomes in general population samples, and that connecting single mother family structure with both compromised mental health and possibly, lower social capital, it is reasonable to speculate that social capital may contribute to explaining single mothers' elevated mental health morbidity compared to partnered mothers. Therefore, using a nationally representative sample of Canadian mothers, the purpose of this study was to examine the extent to which any observed inequities in mental health between single and partnered mothers can be explained by individual social capital, independently and in concert with socio-economic circumstances.

Methods

Data source

The 2008 Canadian General Social Survey (GSS) on Social Networks (cycle 22) was the data source for this study.[18] The sampling frame covered 92% of the Canadian population, including households from the ten Canadian provinces but excluding those living in the Yukon, Northwest Territories, Nunavut, and full-time residents of institutions. The survey was conducted using the Computer Assisted Telephone Interview (CATI) method whereby randomly selected households were contacted and one individual over the age of 15 years within the dwelling was asked to participate. The response rate for the GSS cycle 22 was 42.7%.

To address study objectives, participants in this study were restricted to women between the ages of 18 and 59 years with at least one child under the age of 25 living in their household, resulting in a sample size of 2920 (502 single mothers, 2418 partnered mothers).

Measures

The dependent variable was self-rated mental health (SRMH). Participants were asked In general, would you say your mental health is (1) 'excellent' (2) 'very good' (3) 'good' (4) 'fair' or (5) 'poor'; these categories were collapsed into two groups: 1) excellent/very good/good and 2) fair/poor. In a recent validity study, Mawani and colleagues[19] found self-ratings of fair/poor mental health to be moderately associated with multi-item, standardized measures of mental morbidity.

The primary independent variable was family structure and operationalized on the basis of current living arrangement. Partnered mothers were those who indicated living with at least one child (age less than 25 years) in the household and with a partner (married or common-law). Single mothers (i.e. those with children but not living with a partner) were further categorized on the basis of marital history as previously married (separated/divorced/widowed) or never married.

There were three categorical demographic variables: mothers' age (18–39 years, 40–59 years), number of children living in the household (one, two, three or more), and age of the youngest child in the household (0–4 years, 5–11 years, 12–18 years, 19 years+). Four categorical variables were used as indicators of socio-economic conditions: annual household