



Effects of child health on parents' social capital[☆]

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ABSTRACT

This paper adds to the literature on social capital and health by testing whether an exogenous shock in the health of a family member (a new baby) affects the family's investment in social capital. It also contributes to a small but growing literature on the effects of children's health on family resources and provides information about associations between health and social capital in a socioeconomically disadvantaged population. We use data from the Fragile Families and Child Wellbeing study, a longitudinal survey of about 5000 births to mostly unwed parents in 20 U.S. cities during the years 1998–2000. Both parents were interviewed at the time of the birth and then again one and three years later. The infants' medical records from the birth hospitalization were reviewed, and poor infant health was characterized to reflect serious and random health problems that were present at birth. Social interactions, reported at three years, include the parents' participation in church groups, service clubs, political organizations, community groups, and organizations working with children; regular religious attendance; and visiting relatives with the child. Education, employment, wages, and sociodemographic characteristics are included in the analyses. The results suggest that infant health shocks do not affect the parents' social interactions.

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Introduction

There is considerable evidence of a positive association between health and social capital. Researchers have presented cogent arguments for why social capital would promote health at both the individual and the community levels, and the literature has produced numerous empirical findings consistent with those hypotheses. At the same time, it is acknowledged that causality could run in the other direction—that health could affect social interactions, and therefore, one's investment in social capital. Because health and social capital are both forms of human capital and are affected by many of the same factors, and because it is difficult to identify a “shock” that may have a direct impact on one but not the other, it has been difficult to ascertain both causality

and directionality. The purpose of this paper is to add to the literature on social capital and health by testing whether an exogenous shock in the health of a family member (a new baby) affects the family's investment in social capital. As such, it will provide evidence, in a specific context, of whether there are effects of health on an individual's social capital. Additionally, this paper contributes to a small but growing literature on the effects of children's health on family resources, which can have implications for the health trajectories of all family members.

We use the baseline and third waves of the Fragile Families and Child Wellbeing (FFCWB) study—a longitudinal survey of about 5000 births to mostly unwed parents in 20 U.S. cities during the years 1998–2000. Both the mothers and fathers were interviewed at the time of the birth and then again one and three years later. Poor infant health is measured in alternative ways using data from multiple sources to reflect both serious and random health conditions that were present at birth. Social interactions include the parents' participation in church groups, service clubs, political organizations, community groups, and organizations working with children; regular religious attendance; and visiting relatives with the child, as reported in the mothers' and fathers' three-year follow-up interviews. Data on education, employment, wages, and sociodemographic characteristics are included in the analyses.

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Because the FFCWB study oversampled non-marital births, the sample consists of adults who are relatively young and economically disadvantaged. Few studies in the social capital and health literature have focused on young adults or disadvantaged populations, which are important groups to study for several reasons. First, young adults have the potential to benefit more (i.e., for a longer period of time) than their older counterparts from investments in social capital. Second, economically disadvantaged individuals have fewer financial resources that can buffer the effects of adverse life shocks, and social capital may provide a means for overcoming such difficulties. Much previous research has found that social capital is highly associated with socioeconomic status (SES) (e.g., Saffer, 2008), but few studies of social capital and health have focused on economically disadvantaged populations. Third, economically disadvantaged men have high rates of crime and poor health, both of which can confer substantial private and social costs. Thus, social capital—if in socially desirable forms (i.e., not stemming from gang-related activity or negative peer influences)—can be an important asset for poor men, who represent an understudied group in terms of both social capital and health.

Background

Social capital has been characterized as a combination of social organizations, social networks, and civic participation that can improve the efficiency of society by facilitating coordinated actions (Putnam, 1993) and has been identified as a factor explaining variation in a wide range of public health measures. An observed relationship between social capital and health dates back over 100 years when Durkheim, in his classic study of suicide, noted that social integration can enhance well-being. Bourdieu (1980, 1985) highlighted the benefits to individuals from participating in groups, the importance of creating such interactions, and the concept that building social networks requires investment in group activities (see Portes, 1998 for an extensive review of other contemporary contributions to the social capital literature). Recent interest in socioeconomic determinants of health has resulted in numerous studies linking social capital with various aspects of health and well-being (see Lomas, 1998 for a review).

Much research has examined the relationship between social capital and health at both the community and individual levels. Kawachi, Kim, Coutts, and Subramanian (2004) reviewed 31 empirical studies investigating the relationship between social capital and health that were conceptualized at the community-level or utilized a multi-level framework to incorporate both individual- and community-level factors. They found, with few exceptions, a consistent association between social capital and health outcomes.

Particularly relevant to the current analysis are studies that have examined social capital and health or developmental outcomes within the family. Runyan, Hunter, and Amaya-Jackson (1998) used longitudinal data to study the impact of social capital on child maltreatment. They constructed a total social capital score that included the following measures: two-parent family, maternal social support, number of children in family, neighborhood support, and church attendance. Child well-being was measured using the Batelle Developmental Inventory Screening Test and Child Behavior Check List. The authors concluded that social capital plays a crucial role in determining developmental and behavioral well-being in families with low levels of financial and educational resources. McNeal (1999) found positive effects of parental involvement in schools on their children's educational outcomes using the National Educational Longitudinal Study. Kana'iaupuni, Donato, Thompson-Colon, and Stainback (2005) used data from the

Health and Migration Survey in Mexico to study the relationship between child well-being (health status as reported by mother) and social networks (network size, kinship roles, interaction, and provision of financial and emotional support). They found that networks with more extended kin and co-resident ties offer greater support resources to mothers with young children, particularly among the poorest families. They also found that social support and interactions with extended kin help sustain children's health.

Relatively few studies have evaluated the effects of exogenous measures of child health (e.g., health measures that are independent of social capital) on social capital investment by parents. Kazak and Wilcox (1984) found that mothers and fathers of children with spina bifida have small social networks compared to parents of healthy children. They also found that families with disabled children have higher-density networks, as measured by the extent to which members of the social network know and interact with one another. A study of parents with children diagnosed with phenylketonuria had a similar finding (Kazak, Reber, & Carter, 1988), although the differences in network size between families with disabled children and those without were not large in either study. Overall, the findings from these studies suggest that families with children in poor health or with disabilities are not socially isolated. The advantage of these two studies is that they focus on disabilities that were diagnosed at birth and are not believed to be related to prenatal or other parenting behaviors. The disadvantage is that they focus on only one type of disability and therefore may not be generalizable to a broader group of children with serious health conditions.

Some studies have investigated the effect of poor child health more generally on social interactions of the parents, but this research has not focused on health problems that are known to be exogenous. For example, using data from the Wisconsin Longitudinal Study, Seltzer, Greenberg, Floyd, Pettee, and Hong (2001) found that parents with disabled children had lower rates of social participation (as measured by participation in social organizations and frequency of visits with friends and relatives) than parents without a disabled child. In a more recent review of studies (generally qualitative analyses of small samples) describing how families cope when a child has kidney failure, Aldridge (2008) found themes of social isolation and distress. The disadvantages of this literature are that the severity of the child's health problems may be due, in part, to the intensity with which parents have invested in the child's health and that the factors affecting parental investments in the child's health may be the same as those affecting the parents' investments in their own social capital. Thus, the causal direction is not clear and it is possible that unobserved factors underlie the observed associations between child health and parental social capital.

It is important to consider the point in the life course when examining the effect of poor child health on parental social interactions. The initial reaction to the diagnosis of a disability in a child can be devastating, and parents' adaptations to the reality of raising a child with a disability are a life-long process (Hauser-Cram, Warfield, Shonkoff, & Krauss, 2001), making it difficult to predict how parents may change their behavior as their children grow. Costigan, Floyd, Harter, and McClintock (1997) found that family patterns, routines, and expectations are disrupted by the birth of a child with a disability, but that over time most families regain equilibrium in their family relationships and well-being. Gallimore, Coots, Weisner, Garnier, and Guthrie (1996) found that although parents make accommodations for their disabled children at all ages, the intensity of those accommodations remains stable between the ages 3 and 7 and then decreases between ages 7 and 11.

In summary, while there appears to be significant evidence suggesting a strong relationship between stocks of social capital

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