

The morbidity of single-parent families

K. J. BOLDEN

Tijdens het vijftiengste internationale congres van de SIMG in Opatija bracht K. J. Bolden verslag uit van zijn met de SIMG-Janssen Prijs bekroonde onderzoek. De tekst van deze voordracht wordt hier vrijwel ongewijzigd weergegeven*. De auteur is huisarts en Senior Lecturer in General Practice, Postgraduate Medical Institute te Exeter.

Introduction

There has been a rapid rise in the number of one-parent families in the population over the past decade and certain studies have been done related to their place in society and the social implications of this growing problem (*Leete*). Between 1971 and 1976 the number of one-parent families in the UK rose from 620,000 to 750,000, an increase of 32 percent. It was also estimated that, in 1975, 650,000 single parents were looking after 1,111,000 children in Great Britain.

There are many reasons for the rapid rise in the number of single-parent families this decade, including:

- the increased break-up of families by separation of the parents and the subsequent rise in the divorce rate;
- the greater acceptance by society of single women keeping their own children rather than having them adopted; this has been paralleled by a fall in the adoption rate.

In view of these growing numbers in the community I decided to study the morbidity of this group in one urban practice over the course of one year to see if any pattern of illness could be identified.

The definition of a single-parent family was: any family consisting of a father or a mother living without a spouse (or not cohabiting in a stable relationship) with his or her dependent children either below 16 or 16 to 19 and undergoing

full-time education. In practice, however, it is not always easy to identify the presence of a stable relationship in an apparently single-parent family.

First it might be appropriate to look at the work of the Finer Committee and a number of other known facts about single-parent families.

The size of the problem**

There is great difficulty in accurately recording single-parent families, as the event in itself is not officially recorded like birth, marriage, divorce or death. Because of this all figures must be estimated and based on a number of sources.

The figures originally used by the Finer Committee (*The Finer Report*) were devised from the 1971 Census report and in addition since then figures have been obtained from the number of single parents drawing supplementary benefits, and also a series of General Household Surveys (GHS) which sometimes indicate the status of the people in the household. The figures have been derived from all three sources.

Single Mothers. In 1971 it was estimated that there were 90,000 single mothers with dependent children. The number of single mothers rose by 30 percent during the four year period 1972-76 and is equivalent to a growth of 39 percent over 1971-76.

It is interesting that during the period 1971-76 there was a slight fall in the illegitimate birth rate.

Married, but Separated. This, as already stated, is a difficult event to estimate because it is not officially re-

corded, but the numbers involved probably rose from 170,000 in 1971 to 185,000 in 1976

Divorced. In 1971 there were 120,000 divorced women with dependent children and various estimates suggest that this figure doubled by 1976 to 230,000.

Widowed. There was a slight fall in the numbers involved from 120,000 in 1971 to 115,000 in 1976.

Lone Fathers. For a variety of reasons this is difficult to calculate, but the number of lone mothers increased by 32 percent from 1971 to 1976 and if you apply the same proportion to fathers it gives an estimated rise from 70,000 in 1971 to 90,000 in 1976 in the number of motherless families.

In 1976 therefore 11 percent of all families had single parents compared with 8 percent in 1971. Nearly 75 percent of the 750,000 adults lived alone and half had two or more dependent children of whom there were more than 1¹/₄ million. Against this background of sociological change in Britain during the decade we will now go on to look at the study itself which attempted to measure the morbidity of these families.

The practice

This study took place in a three-partner urban practice in the City of Exeter in South-West England. It is not a heavily industrialised area, although most of our patients are social classes III, IV and V, and includes non-professional skilled, semi-skilled and unskilled workers. The practice works from a health centre which also comprises one other practice, not involved in this study.

One of the unique features of the British National Health Service is the fact that a patient has to register with a general practitioner who then provides services for that patient. The doctor always knows if patients leave the practice. In this way one has an opportunity to know the morbidity of the population as all patients have to seek medical aid through their general practitioner and cannot go from one doctor to another without control as happens in many other countries.

The total number of patients looked after by the practice on the 1st July 1977 was 7,600 and there is a change in the practice population of about 20 percent per year.

The unusual feature of the practice is that we use a computerised record system as part of the Exeter Computer Project, which is a research experiment funded by the Government. This rec-

(1979) huisarts en wetenschap 22, 423

*Overgenomen uit (1979) *Allgemeinmedizin International - General Practice*, Heft III.

** All figures relate to the UK.

ord system enables all patients' records to be stored on a computer with ready access by the partners who have a visual display unit (VDU) in the consulting room. The record itself shows all the usual personal details of the patient plus his or her past medical history, social history and day to day attendances at the Health Centre. It was this computerised system which enabled me to match two-thirds of the single-parent families against a control group of two-parent families within the same practice.

Aims and methods

The aim of the project was to study the morbidity of single-parent families in one British urban practice over a year and to compare this morbidity with that of matched two-parent families. Morbidity in this study was taken to mean doctor/patient contact.

The possible single-parent families were identified by screening the whole practice population using the computer to identify any patient who had a recorded past history of divorce or separation. In addition any adult and child who seemed to be living together without a matching spouse was similarly identified.

Of course quite a number of divorced or separated adults had either remarried or come together again, so these were discarded. In the same way there was sometimes a quite valid reason for an adult and children to be living together without the other parent being identified, the most common reason was that the other parent was being looked after by a different practice and so was not recorded by computer. These families were also deleted from possible identification as one-parent families. In this way the list of single-parent families in the practice was compiled. Having identified the characteristics of the one-parent families, for example, the age and sex of the parent and children, then the computer was used to try and match controls with similar characteristics from the same practice population.

The criteria used for matching single-parent families (SPF) and controls were:

- the adults had to be the same sex and within two years in age of each other;
- the event leading to the lone parent status had to have occurred at least one year previous to 1st July 1977;
- the family size had to match by numbers;

- under the age of 5 years the children had to match within one year;
- between 5-15 years of age the children had to match within two years of each other.
- it was impossible to get enough controls if the sex of the children was taken into account, so it was assumed that all children below the age of 15 years consulted evenly irrespective of sex. This was a reasonable assumption as the *Second National Morbidity Survey* showed that the consulting rates for boys was slightly higher (0-5 years, 4.2; 5-15 years, 2.1) than girls (0-5 years, 3.9; 5-15 years, 2.2). In this sample there are more girls in the single-parent families. The single-parent families and their controls all had their attendances for medical advice from 1st July 1977 to 30th June 1978 recorded together with the details of the consultation. During the year some patients left the practice and others joined, but in the few cases the single-parent family or control was affected they were rejected from the final results so that only patients who were in the practice for a complete year were included.

Although all consultations were recorded for both groups the reason for the consultation was analysed in more detail for five categories. These were consultations for respiratory disease, psychiatric problems (in their widest sense including behaviour disorders), injury (accidental and non-accidental), gynaecological problems and contraceptive advice (tables 1 and 2). In addition, certain features of the past medical

Table 1. Total matched and unmatched SPF consultations analysed in five selected groups.

Reason	Adults	Children
Respiratory illness	37	76
Psychiatric complaints	39	19
Injury	15*	20**
Gynaecological	32	2
Contraception	41	3

* 3 non-accidental
** 1 non-accidental

Table 2. Matched SPF/Control families consultations analysed in five selected groups.

Reason	SPF		Control families	
	Adults	Children	Adults	Children
Respiratory illness	30	57	14	63
Psychiatric complaints	24	16	24	12
Injury	10	17	4	13
Gynaecological	23	-	16	-
Contraception	23	-	19	-

history were noted and compared within the two groups.

About one-third of the single parent families in the practice could not be matched but their morbidity was studied too and the results of the total SPF are shown separately from the matched SPF and controls.

Results

Total practice population at risk 7,600. Total number of SPF, 69 consisting of 68 females and 1 male.

These families had 134 children (47 males and 87 females).

The 69 adults made 307 visits giving a consultation rate of 4.4 visits per year. The 134 children made 294 visits giving a consultation rate of 2.2 visits per year. A visit included consultations in the health centre or at home.

Single-Parent Families and Control Families

Number of single-parent family adults, 46 consisting of 45 females and 1 male.

These families had 87 children consisting of 28 males and 59 females.

Number of control adults, 46 consisting of 45 females and 1 male.

These families had 87 children, consisting of 42 males and 45 females.

The average age of single-parent family adults - 33.4 years.

The average age of control adults - 33.5 years.

The average age of single-parent family children - 10.8 years.

The average age of control children - 10.9 years.

Of the single-parent families, 46 adults made 224 visits, giving a rate of 4.9 visits per year.

Of the controls 46 adults made 136 visits, giving a rate of 3.0 visits per year.

Of the single-parent family children 87 made 188 visits, giving a rate of 2.2 visits per year.

Table 3. Total consultation by frequency of visits.

Number of visits	Adults		Children	
	SPF	C	SPF	C
0	2	10	19	31
1	6	8	21	20
2	4	8	13	9
3	6	7	16	12
4	6	2	7	8
5	4	2	5	2
6	7	4	3	1
7	4	2	2	1
8	2	1	1	
9				1
10	1			1
11	1			1
12	1			
13				
14	1			
15	1			
Total	46	46	87	87

Of the control children 87 made 159 visits, giving a rate of 1.8 visits per year.

Therefore taking the total number of visits for SPF with controls (table 3):

Adults

– significantly more visits were made by SPF adults (significant at the 1 percent level, Mann Whitney non parametric test);

– significantly fewer SPF adults made no visits at all (significant at the 1 percent level, $\chi^2 = 4.69$, corrected).

Children

– the median number of visits by SPF children just fails to reach significance at the 5 percent level ($p < 0.08$, Mann Whitney test);

– the number of control children making no visits just fails to reach significance ($p < 0.07$, χ^2 test).

For Selected Disease Groups

(tables 4 and 5)

Adults

– the consultation for respiratory disease by the SPF was significant at the 5 percent level;

– the psychiatric causes were not significantly different ($p > 0.30$);

– the injuries were not significant ($p > 0.40$);

– the gynaecological consultations were not quite significantly different ($p < 0.07$);

– the consultations for contraceptive advice were not significant ($p > 0.30$).

Children

There were no significant differences between the SPF and control groups in any of the disease groups.

Table 4. Distribution of adult visits for five selected disease groups.

Number of Visits	Respiratory illness		Psychiatric complaint		Injury		Gynaecological		Contra-ceptive	
	SPF	C	SPF	C	SPF	C	SPF	C	SPF	C
0	31	39	31	37	42	43	32	40	29	33
1	5	3	10	4	1	2	10	2	11	9
2	6	3	2		2	1	1	1	6	3
3	3		2	4			1	1		
4	1		1				2	1		1
5		1			1			1		
6										
7										
8				1						
Total	46	46	46	46	46	46	46	46	46	46

Table 5. Distribution of children visits for five selected disease groups.

Number of Visits	Respiratory illness		Psychiatric complaint		Injury		Gynaecological		Contra-ceptive	
	SPF	C	SPF	C	SPF	C	SPF	C	SPF	C
0	58	54	78	80	74	77	87	87	87	85
1	17	17	5	4	10	8				2
2	5	9	2	2	2	1				
3	2	4	1		1	1				
4	2		1	1						
5	2	2								
6	1	1								
Total	87	87	87	87	87	87	87	87	87	87

Past Medical History of Adults

Total SPF

16 had past significant psychiatric history with drug treatment of more than 3/12 duration and/or admission to a psychiatric hospital.

8 had taken an overdose of drugs.

8 had termination of pregnancy.

Matched SPF/Controls: table 6.

Table 6. Matched SPF/Controls

	SPF	Controls
Psychiatric history	7	9
Overdose	6	3
Termination of pregnancy	7	
Epilepsy	3	–
Diabetes	2	–

Although twice as many single adults took a drug overdose the numbers were not large enough to be significant. However, a past history of termination of pregnancy in the SPF is highly significant ($p = < 0.01$, Fisher's exact test). Unfortunately the numbers are too small to make a comment about the cases of epilepsy and diabetes.

Reasons for Single Parent Status

Total

24 Divorced (two twice)

3 Widowed

42 Separated or unmarried

Matched SPF

15 Divorced (two twice)

2 Widowed

29 Separated or unmarried

3 controls had been divorced and remarried

Discussion

When compared with national figures the number and distribution of single-parent families in the practice population was about average, 3.3 percent of the total population are single-parent families, and in this study 2.6 percent were.

However, the lower figure can be accounted for by the rigorous criteria used in selection, which means that families who had not been single for a least a year or who were not in the practice for the whole of the year under study were excluded.

In this study morbidity has been measured by the number of doctor/patient contacts and it is possible that relief from the stress of the situation has been through sources other than the doctor. In Britain there are a number of services available to help the patient other than the general practitioner. Within the practice there is the practice nurse (*Bolden* and *Morgan*) and also the health visitor who is employed by the authorities to look after the needs of

families. In the community there are the social services which can be approached directly and are very likely to be involved with this sort of family.

This study has made no attempt to measure the use of these other resources and indeed it would be very difficult to do this as they are so diverse. However, the results of the doctor/patient contact do show some interesting features. The clinical impression that single-parent families are high users of medical services was strikingly emphasised by the adult consultation rate being almost double that of the controls. However despite anxieties expressed, particularly in the *Finer report* about the effects of single parentage on children, the difference in consultation rates between the two groups of children is much smaller than that between the parents and fails to reach statistical significance.

When the specific consultations are studied it is seen that far more SPF adults consult for respiratory disease. Whether this is because they actually get more respiratory disease, is related to smoking more or to a lower tolerance to minor illness, it is impossible to say, but might merit further study.

Despite an assumption that more stress is either created by becoming, or being, a single parent there is no significant difference in either the current consultation or past medical history of psychiatric problems. This applies to both adults and children.

The number of injuries in this group was not significant and these were looked at because of the possibility of a higher incidence of non-accidental injury in the adults and children in single-parent families.

There is some suggestion from the distribution of consultation frequency that lone females may be consulting more for gynaecological reasons than the controls. The figures are not quite significant but may point to anxiety about sexuality or problems with several partners. However, considering that to be defined as a single parent there had to be no known evidence of a stable two person relationship within the family setting, it is interesting that the demands of both groups for contraceptive advice was equal. This suggests that

even in the setting of a lone parent a great many are still sexually active.

Following this theme it is not particularly surprising that termination of pregnancy which has become relatively easy to obtain in the UK, is significantly higher amongst the single parent adults ($p = <0.01$). It may also mean that contraception services are still inadequate or not readily available for this group of patients.

The average age of the single parent was 33.4 years and child 10.8 years, so the traditional concept of the single parent being a young girl with an illegitimate baby is far from the truth. The breakdown in marriages which has led to a doubling of divorces in the past six years and the separation of parents without a formal divorce are the main causes of single-parent families in our society today.

The morbidity that results from this may, of course, be due to other causes than the actual marital separation itself. For example, adults who separate may be inherently more morbid or they may have undergone such strain that this itself induces morbidity. Nevertheless, the sociological implications of this are grave, with well over a million children growing up with a background of marital disharmony and strained interpersonal relationships upon which to develop their own standards of future behaviour.

While doing this study I could not help but be struck by the catalogue of unhappiness and disaster which seems to plague some families and there seems to be no evidence that this trend will decline.

Conclusion

This study has emphasised the fact that most single parents consist of a woman in her thirties with one or two children, their average age being 10 years.

The morbidity resulting from the lone parent status falls mainly upon the adult, who shows almost twice as many consultations per year as the controls. While the attendance for medical advice of the children is increased this is not significantly raised and there is no evidence in either adult or child of an increase in psychological illness as a

result (or cause) of single-parent family status.

Injuries, including non-accidental ones, are not raised in this group but for some reason, not obviously apparent, the adult lone parents presented with respiratory illness twice as frequently as the controls. This may be to their smoking habits and might be worth investigating further.

The attendances for gynaecological and contraceptive reasons were the same in both groups, with no indication that there is any reduction in sexual activity as a result of being a lone parent. Perhaps as a result of this, or possibly because the pregnancy came during the break-up of a relationship, there is a much higher incidence of termination of pregnancy in the past history of single parents. This would support the recommendation of the Finer Committee that this group should be encouraged to use family planning services. This study was initiated to see if any morbidity trends could be identified in the single-parent families. What it has done for me is emphasise how great the problem of breakdown of relationships now is amongst our families. To some extent it has reassured me about the medical and psychological effects on the children in these circumstances, but gives me cause for concern about future implications for the society in which we live.

Bolden, K. J. and D. C. Morgan. Moving to a health centre, the effect on workload and patients. (1975) *J. roy. Coll. gen. Practic.* 25, 527-531.

Finer, The, report 1974. HMSO.

Leete, R. One parent families - Numbers and characteristics. *Population trends*, 13, Autumn 1978.

Second National Morbidity Survey 1970-71. Office of Population Census and Surveys. HMSO.

Acknowledgements

I wish to thank SIMG and Janssen Ltd., for the award to make this study possible. In addition I would like to thank my partners Drs. J. R. Edwards and J. K. Lloyd for their permission to use their case records and my colleagues in the Department of General Practice for their constructive criticism and advice. D. Price, D. Mahoney and Ruth Cole from the Exeter Computer Project were most helpful in matching the families and collating computer data and Mr. J. Gowers of the Institute of Biometry, University of Exeter provided valuable statistical advice.