

Depression and Quality of Life for Women in Single-parent and Nuclear Families

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This is a cross-sectional study which objectives are 1) to determine the predictors for perceived quality of life and 2) to analyze the differences between women from single-parent families and bi-parent families, about their quality of life, depression and familiar income. We worked with a non-probabilistic sample of 140 women from Monterrey, N.L, Mexico, 107 are from bi-parent families and 33 from single parent families. Some of the results show that women from single-parent families have lower quality of life ($Z = -2.224$, $p = .026$), lower income ($Z = -2.727$, $p = .006$) and greater depression ($Z = -6.143$, $p = .001$) than women from bi-parental families. The perceived quality of life's predictors, using a multiple regression model ($n = 140$) were depression, income and number of children, those variables explaining 25.4% of variance.

Keywords: depression, quality of life, income, women, single-parent, bi-parental

El presente estudio es transversal y sus objetivos son determinar las variables predictoras de la calidad de vida percibida y analizar las diferencias entre las mujeres de familias monoparentales y las de familias nucleares, respecto a su calidad de vida percibida, depresión e ingreso familiar. La muestra no probabilística fue de 140 mujeres del área metropolitana de Monterrey, N. L., México, de ellas 107 pertenecen a familias biparentales (nucleares) y 33 a monoparentales. Algunos de los resultados encontrados fueron que las mujeres de familias monoparentales tienen un menor puntaje en calidad de vida que las mujeres de familias nucleares ($Z = -2.224$, $p = .026$), un menor ingreso ($Z = -2.727$, $p = .006$) y mayor depresión ($Z = -6.143$, $p = .001$). Las variables predictoras de la calidad de vida en el modelo de regresión múltiple con la muestra general ($n = 140$) fueron la depresión, el ingreso y el número de hijos, explicando el 25.4% de la varianza.

Palabras clave: depresión, calidad de vida, ingreso, mujeres, monoparentales, nucleares

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The 20th century was a time of profound transformation in society. The political, economic, social and cultural changes that have been produced, are reflected in the changing face of family, one aspect of which is the growing number of terminated marriages. The high rate of separation and divorce, indicated by both national and international statistics, as well as the prevalence of widows and widowers, are enough to suggest the importance of studying the impact that these phenomena have on family organization, and on living conditions.

Along those lines, Bumpass (1990) stated that marriage is an institution that reflects changes in society. In Mexico, between 1950 and 2002, rates of divorce grew to 7.7 times the former rates, while rates of marriage only grew to 3.5 times the former rate; meanwhile, the total population of the country grew to 3.8 times its former size (INEGI, 1992, 1994, 2003, 2005). On the other hand, while the percentage of the population that are widows and widowers continues to be greater than the percentage that is either separated or divorced, that prevalence, has faded over the last decade. According to INEGI (2002) data from 2000, the number of people who have been separated or divorced in the last decade, between the years of 1990 and 2000, soared from 3.8% to 7%.

All of the aforementioned situations demonstrate emerging cultural patterns, and have contributed to increasing the diversity of family arrangements, and their associated living conditions. The dissolution or termination of a marriage has, among its most obvious results, the onset of “new” ways in which members of a family, or families, live together (Arriagada, 1998; Landero, 2002; Valdés, 2004). This includes the formation of single-parent families that are diverse in configuration, conditions, structure and composition, as well as everyday progress.

Thus, the root and proximal causes of becoming a single parent, according to Barrón (2002) & Landero (2001), would be as follows:

1. Single parenthood beginning with marriage or cohabitation, of a couple living together in a home, whether “nuclear,” “extended” or “composite” that experiences: a) a dissolution or termination of the marriage due to widowhood (the death of a spouse), divorce (legal dissolution of the marriage) or separation (an end to matrimonial cohabitation that does not necessarily end in divorce); b) that involves no dissolution or termination of the marriage (de facto separation), but where there is an absence of the element of cohabitation due to incarceration, hospitalization, or emigration of a spouse.

2. Single-parenthood that takes place outside of marriage (without marriage, living together or cohabitation) on the part of a woman or man by maternity or paternity (whether by deciding to have a child, or not), without cohabitation or marriage (“single mothers” and “single fathers”), or by adoption (maternity or paternity obtained through legal process).

According to authors like Barrón (2002) and Rodríguez & Luengo (2003), the majority of our definitions of *single-parent family*, on the part of both individuals and institutions, consider basically the following aspects: the presence in the home of a sole parent and his or her children, who are single and/or dependents – and sometimes the children’s age is also taken into account; take, for example, minors –. Even if it is true, this definition is limiting in that it only includes single-parent families consisting of a single nucleus, otherwise known as “semi-nuclear,” which excludes single-parent families in which there are other family members present (relatives and non-relatives alike).

The National Institute of Statistics, Geography and Informatics, INEGI in Mexico (1998:90), defines single-parent families as: “those that have only one parent and that one parent’s children, and the possible addition of another relative or non-relative.”

With these definitions in mind, as well as gender and family composition, single-parent families may be headed by either a woman or a man. By composition of the family, we refer to whether or not the single parent (or “boss of the house”) lives solely with their own children in a home, which constitutes a *simple single-parent family (or nuclear single parent family)* and that may be headed by either a woman or a man. If in addition to those individuals, other relatives live in the home (for example, grandparents, or even a sibling of the head of the house that is already separated or widowed, and with children) or non-relatives, this would constitute a *single-parent, complex family*. This, too, may be headed by either a woman or a man (cfr. Barrón, 2002; Landero, 1997, 2001, 2005; Rodríguez & Luengo, 2003). For the purposes of this study, in general, only *single-parent families* – simple or complex – *headed by a woman* will be included, and all of the participants interviewed were female “bosses” of their families (Flaquer, 1991). In other words, we refer to single-parenthood beginning in marriage or cohabitation that later comes to dissolve or be terminated, whether because of widowhood, separation or divorce, with children or other relatives living in the home. The previous classification, or taxonomy, attempts to allow for greater specificity and diversity when analyzing single parenthood. It is interesting to keep in mind that this diversity of definition and classification is not acknowledged in the official census. Nevertheless, every idea has its weaknesses, and this one may be disputed by the scientific community.

At the present time in Mexico, there are just over 2 million single-parent families (which accounts for about 10% of all households), which equates to nearly 10 million people living under these conditions, and of those families, approximately 85 – 90% are headed by women (Landero, 2005).

However, the predominant family formation in Mexico, like in other countries, is the nuclear, married family (67.6%), which fell 7.3 percentile points during the period spanning 1990 through 2000. The nuclear family is composed of two parents (who are married) and children. Nevertheless, some

doubt is cast on the subject; within the official statistics, “simple” single-parent families (homes with a single parent, man or woman, living with his or her kids) are included as nuclear, as are couples without children, and as are families in which children who get divorced or widowed, return to their original household. These all factor into the total number of nuclear families, as do single-parent extended and composite families (homes where 2 or more generations, or other relatives, are present) which are counted as *extended* or *composite* households (Landero, 2001, 2005). This lack of differentiation makes it impossible to carry out specific analyses of single-parent families’ characteristics and conditions using official statistics alone.

Men and women alike face difficult times following the dissolution or termination of a marriage (whether by separation, divorce or widowhood). For women, these difficulties extend into the emotional, psychological and economic arenas (Zúñiga & Ribeiro, 2005). The challenges they face as a marriage comes to an end, as well as afterward, are factors that generate stress, depression and other health problems. In other words, they affect living conditions and quality of life. The families that fit within our working definition of single-parent become poor, or at least run a higher risk of poverty, due partly to the loss of the former spouse’s income as a valuable resource. As Madruga (2006) showed, not only single-parent families led by women have a higher probability than other groups of being poor; rather, it is the dynamic of that poverty that is different. For single-parent families, poverty tends to have a longer duration and to be more severe.

The results of the Zúñiga & Ribeiro (2005) study highlight the problematic nature of this situation, with findings that while 66% of the women (separated and divorced) in the sample receive child support from the ex-spouse, 32.7% receive it only occasionally or almost never, and 34% did not receive child support at all. Holden & Smock (1991) showed that in the United States in 1985, of the 61% of women who were separated, divorced or single that had the right to child support, only half received the total they were assigned, 25% received only partial payment and the other 25% did not receive any payment at all. In addition, 57.3% of the women who participated in the Zúñiga & Ribeiro study were faced with serious financial problems, considering that of the women who reported having paid employment (n=118), the majority (83.1%) reported earning less than \$5,000 pesos (Mexican currency) per month. On a related note, Horwitz (1984) has suggested that socioeconomic disadvantage contributes to psychological distress in adults. The women who participated in the Zúñiga & Ribeiro (2005) study reported difficulties ranging from returning to school, to finding work, and with housing. More than half of the women interviewed (61.3%, n=92) experienced a change in residence once separated from their husbands.

Studies of families that experience a separation or divorce have established that marital dissolution is frequently

accompanied by an increase in one’s level of stress, and that that increase continues for some time after the divorce (Hetherington, Cox & Cox, 1979). Authors such as Afifi, Cox & Murray (2006) indicate that unmarried mothers exhibit mental health similar to that of mothers who are married. Meanwhile, mothers who are separated or divorced exhibit a higher incidence of depression and general anxiety than those who stay married. On the other hand, Matud, Guerrero & Matías (2006) found that widows experience significantly more depressive symptoms than single ($p < .05$) or married ($p < .01$) mothers.

On a related note, McLanahan (1983) found that separation and divorce are what are referred to as stressors, as are the associated reduction in income and relocation of the home. Other researchers have also demonstrated that marital “rupture” is one of the most stressful events in life, so much so that it is associated with higher rates of physical and emotional disorders (Bloom, Asher & White, 1978; Verbrugge, 1979). Lamb (1977) what highlights certain social implications of divorce, both for the children and for the former wife. These include a drop in family income, the loss of emotional support for the former wife, and social isolation. These factors are also present in cases of separation. In addition, some studies have produced indices that suggest that individuals with stable partners, friends and family providing them with both material and psychological resources exhibit better health than those with little social contact or whose social life is in crisis (Cohen & Ashby, 1985; Perales, Sogi & Morales, 2003). On a related note, Caimey, Thorpe, Rietschlin & Avison (1999) report that *mothers alone* exhibit twice as much depression as married mothers. Also, Anson (1988) found that female heads of the family are less healthy than women who have a spouse.

Gender differences surrounding problems like depression may be due in part to the fact that women generally carry a heavier burden of parental and domestic responsibilities (Wu & DeMaris, 1996), which can create a great deal of tension. These responsibilities increase when women are widowed, separated or divorced, while additionally, many are forced to find paid employment that accommodates for their new needs and living conditions (such is the case for female heads of single-parent families).

According to WHO (2002), one in four people (25% of the population) suffers from at least one mental or emotional disorder at some time in their life. Issues in mental health account for five of the ten primary causes of disability worldwide, and almost one third of total, global disability. The most far-reaching of these disorders are considered to be depression, substance abuse, schizophrenia and dementia. A high percentage of people are confronted with depression at some time in their lives, whether transitory or prolonged for as long as months or years. In some cases, it may not affect one’s everyday functioning, but in others, it may manifest itself through numerous physical and psychological

symptoms that do in fact interfere with the person's activities, or that entirely prevent him or her from carrying them out.

The World Health Organization (WHO, 2000) has indicated that it expects depression to become the world's second leading cause of disability in the world by the year 2020, while in 1990 it occupied fourth place among the leading causes. Apparently, of all the different areas of health, research on how to prevent and treat this particular disorder has been heavily prioritized, and still, measures of its prevalence, far from diminishing, threaten to increase over the course of the 21st century.

Depression affects women twice as much as men. One in every five women suffers a major depressive episode at some point in their lives, and that proportion is significantly reduced in men to only one in ten (Torres, 2002). In fact, according to the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2002), the risk of a major depressive disorder occurring during one's life is much higher in women, between 10% and 25%, while it is between 5% and 12% for men. The manual also states that in samples of adults from the general population, the prevalence of depression is found to be between 5% and 9% in women and between 2% and 3% in men.

Based on the information provided by the 2002-2003 National Survey of the Evaluation of Performance, authors like Belló, Puentes-Rosas, Medina-Mora & Lozano (2005) found that the national prevalence of depression in adults in Mexico in 2001 was 4.5% in total, 5.8% in women and 2.5% in men. On the other hand, Castañeda (2004, May 16) has shown that between 5% and 15% of the population, especially women, may suffer from a major depressive episode or period at some time in their lives. Another study that provides data about the greater percentage of women affected by depression than men is the Benjet, Borges, Medina, Fleiz & Zambrano (2004) study of early-onset depression in Mexico. According to the results of that study, 2.8% of Mexican women suffer from an early-onset, major depressive episode at some time, whereas only 1.1% of Mexican men do. With respect to adult-onset depression, the same study suggested that 7.0% of women Mexican women exhibit adult-onset depression at some time, while only 3.3% of Mexican men do.

Along that line of reasoning, it is of no surprise that studies of diverse samples have shown that women score significantly higher than men do on instruments such as the Beck Depression Inventory (Arnau, Meagher, Norris, & Bramson, 2001; Beck, Steer & Brown, 1996). Also, it is of note that depression has a clear relationship with a worse perception of one's quality of life (De Andres, Martin-Arribas, Ferrari & Izquierdo, 2002).

Regarding women's status within the family, McLanahan, Wedemeyer & Adelberg, (1981) showed that studies diverse in epidemiology have shown that single mothers (in other words, those who have a single-parent family status) score higher on scales of anxiety and depression than any other

family status. Also, those authors explain that, proportionally speaking, single mothers are the greatest consumers of mental health services.

Sex differences in the arena of mental health have been studied as a function of men's and women's behavior in seeking help, in their biological differences, social differences, and in terms of their ways of recognizing and coping with exhaustion (WHO, 2000). All of these factors and more may contribute to the fact that rates of depression and psychological problems are higher among women, but the social causes behind that seem to be the most important. For example, women who live in poor social and environmental conditions, with a low level of education and a low income, faced with difficult family and spousal relationships, are much more likely to suffer from mental disorders than any other group (WHO, 2000).

Of all the factors that affect women's lives, and those of their families, the present study will focus on quality of life, which is an aspect of life related to general health as well as depression and household income, of women from single-parent and nuclear (two-parent) families. Those variables will be defined below.

In the WHO constitution, health is defined as a complete state of physical, mental and social well-being, not just the absence of affliction and illness (WHO, 2002). Understanding and assessing quality of life requires one to evaluate several different areas: physical, psychological, social and environmental. Nevertheless, deciding upon a clear and simple definition of the term has not been easy, even for expert researchers on the subject, who all grant that quality of life is inevitably an essentially subjective and multidimensional concept.

Among the proposed definitions of this concept that were considered in the early 1990's, consider those of Schalock & Bogale (1990): Satisfaction with one's lot in life and feeling satisfied with one's experiences in the world. A feeling of personal satisfaction that goes beyond feeling content or happy, yet falls short of finding meaning or fulfillment (Coulter, 1990). General wellbeing, meaning general satisfaction in life, happiness, contentment and success (Start & Goldsbury, 1990). The ability to adopt a lifestyle to satisfy one's desires and needs (Karen, Lambour & Greenspan, 1990).

In another take on defining quality of life, Blatt (1987) emphasizes its temporal, relative and individual nature. Although the majority of authors agree that there is no single, agreed upon definition of quality of life, an excellent definition that may serve as a model is that proposed by the World Health Organization (WHO), one that integrates individual, subjective perception, his or her objective role, and individual contextual factors. Quality of life is an individual's perception of his or her position in life in the context of their culture and the value system in which they live, in relation to their objectives, goals, expectations, interests, standards and concerns (Harper & Power, 1998).

This definition implies that the concept of one's quality of life is subjective and multidimensional, and that it includes not only positive, but also negative elements in evaluation (WHOQOL Group, 1998). At the present, the study and evaluation of quality of life are increasingly considered to be health-related, which may shape the perceptions of the person being evaluated in studies of health (Schwartzmann, 2003). The present study takes the perspective of the WHO (2002), since the instrument we employed was created by them (WHOQOL Group, 1998; Harper & Power, 1998).

On the subject of depression, we maintain Beck's position, who conceived of depression as disordered thinking (Beck, 1976). His position supposes that the signs and symptoms of depression are the consequence of an activation of negative cognitive schemas. The Beck Theory (1963, 1976) established that depression is not an affective disorder, as it may at first seem, but rather a cognitive problem. For depression to occur involves various, specific, cognitive structures that are essential to its development: Beck's cognitive triad and schemas (Beck, Rush, Shaw & Emery, 1979).

The cognitive triad is composed of three cognitive patterns that control ideation: a negative view of oneself, a negative view of the future, and a negative view of the world. Cognitive schemas, it is believed, lead individuals to adopt a system where they mentally filter their experiences to focus on negative aspects and ignore the positive, and to distort their perception and memory; such distortions are referred to as cognitive errors. Beck (1963, 1976) posits that one reason for an individual with a propensity for depression to develop these erroneous cognitive patterns is the experience of a great loss at a time in which that loss was overwhelming to the individual. One such loss could very well be a separation, divorce, or becoming a widow or widower.

Based on the information above, there is no doubting the importance of studies of depression and quality of life across different family compositions, as well as their consequences, in that the results of further research could contribute to the prevention and treatment of an array of grave problems. Also, since treatment is so much more costly than prevention, the focus of study should center on the following: the development of new methods of prevention by identifying causal factors and risk factors (Díaz & Jiménez, 1999) of depression. In light of the above reasoning, the objectives of the present study are as follows: (1) to analyze the differences between women from single-parent families and nuclear families, paying special attention to their perceived quality of life, depression and household income. (2) to determine what variables predict one's perceived quality of life. The first objective is grounded in the following hypothesis: women from single-parent families will show a greater incidence of depression and will report a lower quality of life than women in nuclear families, and their household income will be less than that of women in nuclear families.

Methods

The present is a cross-sectional *study*. The not probabilistic *sample* is comprised of 140 women from the metropolitan area of Monterrey, N. L., Mexico. A total of 33 (23.6%) of those women belong to single-parent families, of which 24 are considered simple single-parent families, and 9 are complex single-parent families, and 107 (76.4%) belong to nuclear families. The sample size, although small, exceeds the national proportion between the two types of families, in which 70% of households hold nuclear families and 10% of households are single-parent (INEGI, 2002). The present study, although limited by its sample size, seeks to explore, and to serve as a basis for further research, because in Mexico, and particularly in Monterrey, remarkably few publications acknowledge and study single-parenthood.

Regarding the civil status of subjects in the sample, of the women from single-parent families, 9 were separated, 19 were divorced and 5 were widows. In other words, their conditions in the study were based on single-parenthood resulting from their marital status. Also, of the 107 women from nuclear families, all but one were married, and that one was involved in a unmarried relationship (cohabitation).

Procedure

Two different sectors of the city of Monterrey were selected to conduct interviews with the participants in their homes that share similar characteristics (lower middle class). Female participants were sought door to door until the minimum quota for participants was met: 100 nuclear families and 50 single-parent families. The inclusion criteria was that participants were mothers with children living in their homes. Due to time constraints, costs, difficulty finding a large number of women in single-parent households to interview, and an overall lack of funding for this study, the quotas were adjusted such that at least 20% of the total sample should be from single-parent homes. The women interviewed were invited to participate on a voluntary basis, at which time the research objectives were explained, and absolute confidentiality of all data was ensured. Last, SPSS was utilized to analyze the sample data.

Instruments

The variables evaluated were depression, perceived quality of life, household income and sociodemographic information.

Beck Depression Inventory (BDI-IA; Beck, Rush, Shaw & Emery, 1979). The present study employed the Beck Depression Inventory, normalized for a Mexican sample by Jurado, Villegas, Méndez, Rodríguez, Loperena & Varela (1998). An article by those authors reported Cronbach's alpha coefficient as being .87, and the results of a factor analysis coincided with the original version. Also concurrent

validity was evaluated using the Zung Self-rating Depression Scale. In a clinical sample and in a sample of students, the correlations were 0.70 and 0.65, respectively. This instrument is one of the most widely used in the world to measure the symptoms of depression in both clinical and non-clinical samples (Beck, Steer & Garbin, 1988; Beck et al., 1979). It consists of 21 items that evaluate the intensity of depressive symptoms through 4 response choices that identify the gravity/intensity of each item. The total score is gathered by summing the values of the responses selected, which range from 0 to 3, in order to obtain a range of scores from 0 to 63 points. The internal consistency of the scale has been studied extensively, showing Cronbach's alpha coefficients from 0.76 to 0.95. The cut-off points that are generally accepted to determine the intensity/severity of depression are: no depression (0-9 points); slight depression (10-18); moderate depression (19-29 points) and major depression (≥ 30 points) (Beck et al., 1988).

WHOQOL-BREF: Quality of life was evaluated using an abbreviated version of this 26-item instrument created by the WHO (WHO, 1996; The WHOQOL Group, 1998) and adapted by Lucas (1996) to create a Spanish version, which was then compared to the English version (WHO, 1996). In Spain, it was validated in a sample from Barcelona, and Cronbach's α coefficient was calculated to measure its internal consistency, which was found to vary from .74 (psychological health) to .80 (physical health). This instrument began as the WHOQOL-100 (WHO, 1997), created in 1991 by the World Health Organization as a project that aimed to create an international, cross-culturally comparable instrument to evaluate quality of life.

The transformed scores on the WHOQOL-BREF generate a profile of quality of life that evaluates 4 areas (physical health, psychological health, social relations and environment). Scores on those 4 areas denote individuals' perceptions of their quality of life in each domain. Also, two items were evaluated separately, 1) How would you rate your quality of life in general? And 2) How satisfied are you with your health? There were 5 response choices for each (1 to 5), where the higher the score, the higher the

quality of life, or the greater the satisfaction (WHO, 1996). The transformed scores range from 0 to 100, where a high score denotes a high quality of life. The reliability measured by Cronbach's alpha coefficient was greater than .65, and the validity of that construct has been confirmed. The WHOQOL-BREF has high discriminant and content validities, and adequate test-retest reliability. Scores on the areas of the WHOQOL-BREF have a correlation of 0.89 with those of the WHOQOL-100 (WHO, 1997; Murphy, Herrman, Hawthorne, Pinzone & Evert, 2000).

With respect to other variables, age was measured as the number of years completed, education was measured as the number of years of education completed, number of children was measured as the number of children living at home with the parent, household size was defined as the number of people residing in the home, and household income was calculated as the sum of the money earned in a given week by all employed family members.

Results

The first step of analysis was to evaluate the internal consistency of the instruments used, which was done using Cronbach's alpha; that found acceptable levels of consistency. Cronbach's alpha coefficient found for depression (BDI-IA) was .84, and for quality of life (WHOQOL-BREF), it was .86.

Table 1 displays the distribution of women in the sample by type of family and status of paid employment (non-domestic work), as well as the mean number of family members who work, expressed as frequencies and percentages. In the nuclear families (107), about half of the women interviewed were employed, and on average 1.5 family members worked, including the woman interviewed, her spouse, and their children. The 33 women in single-parent families, on the other hand, play a greater economic role (78.8%), which is supported by the body of literature on the subject. The economic participation of the members of single-parent families is greater than that of nuclear families, including greater involvement on the part of the children.

Table 1
Description of paid employment by type of family (n = 140)

Type of Family	Paid Employment		Total	Mean	Standard Deviation
	Yes	No			
<i>Nuclear (n=107)</i>	54 (50.5%)	53 (49.5%)	107		
Total number of people employed				1.50	.84
Sons and daughters employed				.18	.56
<i>Single-parent (n=33)</i>	26 (78.8%)	7 (21.2%)	33		
Total number of people employed				1.73	1.15
Sons and daughters employed				.64	1.03

The data presented in Table 2 coincides with that which is widely reported in the literature (INEGI, 1998; Landero, 1997). Women in single-parent families are, on average, 4 years older than women in nuclear families. Nevertheless, on average, they have had fewer years of education, fewer children, fewer children who are minors (younger than 18 years old) and the size of the family (number of family members) tends to be smaller than that of nuclear families. That data supports the data reported by INEGI (2001) for the year 2000, in which the average size of a single-parent family was 3.2 members, while for nuclear families, it was 4.1. Upon comparing these variables by type of family by running a Mann-Whitney U Test, the results show significant differences in education, number of children, number of children who are minors, and household size. However, no difference in age was found ($p > .05$).

In order to satisfy the first objective of this study, next we analyzed the differences between women from single-parent families and women from nuclear families in terms of household income, perceived quality of life, and

depression (Tables 3, 4 and 5). By analyzing the household income variable by type of family using a Mann-Whitney U Test, the results indicate that single-parent families, on average, have a lower weekly income than nuclear families ($p < .05$), approximately 1, 232 Mexican pesos less. That data partly upholds the hypothesis proposed (see Table 3).

In analyzing different family members' contributions, it was found that in nuclear families, the mean contribution of employed women was only 20% of the total household income; meanwhile, the spouse's income represented a higher percentage of the income. In single-parent families, the average contribution of employed women was 45.2% of the total household income, the rest of which is contributed primarily by adult family members (siblings) that live in the home, and through children's employment.

As for the quality of life variable, the results indicate that women from single-parent families tend to score lower than women from nuclear families, and that difference is significant (Table 4). Nevertheless, it is a difference of 5.2 points on a scale from 0 to 100. In order to obtain more

Table 2
Description of demographic variables by type of family (n = 140)

Variable	Family	Mean	S.D.	Mann-Whitney U
Age	Nuclear	39.28	8.27	Z= -1.460, p= .144
	Single-parent	43.18	12.73	
Education	Nuclear	12.14	3.60	Z= -2.231, p= .026
	Single-parent	10.24	3.31	
Number of Children	Nuclear	2.36	.92	Z= -2.428, p= .015
	Single-parent	2.00	1.17	
Number of Children that are Minors*	Nuclear	1.71	.98	Z= -4.008, p= .001
	Single-parent	.94	.75	
Household Size	Nuclear	4.34	.93	Z= -4.534, p= .001
	Single-parent	3.42	1.50	

* Children that are less than 18 years old; in nuclear families, 88% of children are minors, while in single-parent families, 70% are.

Table 3
Description of income by type of family (n = 140)

Type of Family/Income	Mean	Standard Deviation
Nuclear (n=107)		
Household Income ¹	3253.59*	2483.93
Income of Woman Interviewed	643.08	1054.69
Income of Spouse	2610.50	1963.89
Single-parent (n=33)		
Household Income ¹	2020.88*	1208.99
Income of Woman Interviewed	913.91	875.18
Income of Other Family Members	1106.97	1278.02

¹ Household income is the sum of the weekly economic contributions of all employed family members.

* There is a significant difference between nuclear and single-parent families in household income.

precise information about the differences between the types of families studied, we additionally analyzed the dimensions (domains) of the quality of life variable. Although the scores on the 4 domains of quality of life are apparently a bit higher for women in nuclear families, the results of a Mann-Whitney U Test show no significant differences in three of the four (Physical, Psychological, Environmental), but it does show a significant difference in the Social Relations ($p < .05$) dimension. It seems that the strong difference in the *social relations* domain (personal relationships, social support, sexual activity) is what really causes their scores of general quality of life to differ. It is important, therefore, to consider that *social relations* is one of the areas that most easily deteriorates after the dissolution or termination of a marriage.

On another note, scores on the two independent items of the quality of life scale were compared by type of family; they were: (1) In general, how would you rate your quality of life? And (2) How satisfied are you with your health? In this case, a higher score meant a better quality of life or a greater level of satisfaction. The results of a Mann-Whitney U Test indicate that there is a significant difference between types of family on item 1 ($p < .05$), but not for item 2. To put it another way, the test showed that women from single-parent families perceive themselves as having a lower quality of life than their nuclear family counterparts, which coincides with the data pertaining to the analyzed variable (Table 4).

Table 5 describes depression by type of family, percentage of women with and without depression, and by

the level of depression according to the criteria established by Beck, Steer & Garbin (1988). 81.8% of participants in single-parent families were found to be afflicted with depression, whereas only 24.3% of participants from nuclear families were depressed. Nevertheless, the scores of depression in both groups were low in terms of severity, considering that their mean scores (14.64 and 13.76) fall into the category of *slight depression*, defined as falling between 10 and 18 points on the scale. The participants found to be depressed were then classified according to their scores into their respective levels of depression (slight, moderate, major). It was found that of the 24.3% of women with depression in nuclear families, 20.6% were slightly depressed and 3.7% were moderately depressed. On the contrary, of the depressed women in single-parent families, 66.7% were slightly depressed, 12.1% were moderately depressed and one participant's depression was classified as major.

A comparison of participants' total scores of depression revealed a significant difference between the types of families studied ($p < .05$); this comparison was done by running a Mann-Whitney U Test. Women from single-parent families had higher scores of depression than women from nuclear families.

In order to determine what variables predict quality of life (objective #2), a step-wise regression analysis was employed, which found that in the overall sample ($n=140$), depression, household income and number of children were predictor variables, and age was not taken

Table 4
Description of quality of life subscales by type of family ($n = 140$)

	Variable	Mean	Standard Deviation	Mann-Whitney U*
Nuclear	Quality of life (overall)	65.35	11.71	$Z = -2.224, p = .026$
	D1: Physical	67.59	12.86	$Z = -.857, p = .391$
	D2: Psychological	65.62	13.89	$Z = -.813, p = .416$
	D3: Social relations	68.93	17.68	$Z = -2.859, p = .004$
	D4: Environmental	59.26	13.38	$Z = -1.288, p = .198$
Single-parent	Quality of life (overall)	60.14	10.85	
	D1: Physical	65.80	16.54	
	D2: Psychological	63.13	14.06	
	D3: Social relations	56.82	19.81	
	D4: Environmental	54.83	12.77	
	Overall, how would you rate your quality of life?			
	Nuclear	3.68	.886	$Z = -2.700, p = .007$
	Single-parent	3.21	.857	
	How satisfied are you with your health?			
	Nuclear	3.45	1.084	$Z = -.299, p = .765$
	Single-parent	3.42	1.001	

* This is the difference in quality of life between types of families.

Table 5
Description of scores of depression, level of depression and family ($n = 140$)

	Classification and type of family		Scores of depression	
	Frequency	Percentage	Mean	Standard Deviation
<i>Nuclear</i>			6.66*	4.79
Without depression	81	75.7	4.38	2.22
With depression	26	24.3	13.76	3.48
Level				
Slight	22	20.6	12.62	2.31
Moderate	4	3.7	20.02	1.40
Major	—	—	—	—
<i>Single-parent</i>			13.50*	5.73
Without depression	6	18.2	8.39	.80
With depression	27	81.8	14.64	5.74
Level				
Slight	22	66.7	12.51	2.23
Moderate	4	12.1	20.75	.96
Major	1	3.0	37.00	—

* There are differences between families on total scores of depression ($Z = -6.143$, $p = .001$).

into account in the model ($t = -.158$, $p = .87$). Likewise, the education variable was eliminated from the model because it was not significant in the overall sample ($t = 1.89$, $p = .06$, and $Beta = .151$). The explained variance of these three variables was 25.4% (R^2_{aj}). The model indicates that the depression and number of children variables negatively influences quality of life, while income positively affects it. In other words, less depression, fewer children and more income signify a better quality of life (Table 6a).

A regression analysis was done by type of family to determine whether or not that variable was a predictor, and the results were the following: for women in nuclear families, only two variables entered into the model, depression and education, which explained for 23.4% of the variance, while the other variables were not found to be statistically significant (age, $t = -.739$, $p = .46$; number of children, $t = .340$, $p = .73$; income, $t = 1.362$, $p = .176$). Depression was negatively correlated with the dependent variable, while education was positively correlated with it (Table 6b).

Table 6a
Regression analysis of the overall sample ($n = 140$)

Quality of life (VD)	B	Beta	T
Constant	71.126		28.702***
Depression	-.842	-.421	-5.713***
Household Income	1.048E-03	.207	2.791**
No. of Children	-2.210	-.188	-2.549*

* $p < .05$. ** $p < .01$. *** $p < .001$. $R = .519$, $R^2 = .270$, $R^2_{aj} = .254$ $F = 16.75$, $df = 3$, $p < .001$.

Table 6b
Regression analysis of nuclear families ($n = 107$)

Quality of life (VD)	B	Beta	T
Constant	59.455		15.382***
Depression	-.861	-.377	-4.373***
Education	.866	.267	3.088**

* $p < .05$. ** $p < .01$. *** $p < .001$. $R = .498$, $R^2 = .248$, $R^2_{aj} = .234$ $F = 17.16$, $df = 2$, $p < .001$.

Table 6c
Regression analysis of single-parent families (n = 33)

Quality of life (VD)	B	Beta	T
Constant	69.374		20.059***
Depression	-.850	-.579	-4.252***
Household Income	4.044E-03	.451	2.976**
No. of Children	-5.215	-.564	-3.799**

* $p < .05$. ** $p < .01$. *** $p < .001$. $R = .705$, $R^2 = .497$, $R^2_{aj} = .445$ $F = 9.55$, $df = 3$, $p < .001$.

Last, a regression analysis determined that, for women in single-parent families, the variables that predict the dependent variable were depression, number of children and household income, and that those accounted for 44.5% of the variance in the dependent variable (Table 6c), while the other variables were not found to be statistically significant (age, $t = -.155$, $p = .87$; education, $t = -.544$, $p = .87$).

It has been observed that depression is the common variable in both the overall sample and in each type of family, and it is also the one with the most influence (Beta), because the other variables differed between nuclear and single-parent families. This shows us that the living conditions of nuclear and single-parent families differ, and differentially influence quality of life.

Discussion

The present study has focused on variables such as quality of life, depression, household income and sociodemographic information for women in single-parent and nuclear families. Before discussing the results obtained and presenting our conclusions, it is important to consider certain limitations which we ourselves recognize in this study. First of all, the sample size obtained is limited, and second, the difference in size between the groups constitutes a vital limitation. This suggests that we ought to consider these results as preliminary data that serves to direct future research, not to be generalized to the population. However, although the hypothesis stated early in this paper was supported by the results, bear in mind that the results could very well only be applicable to the analyzed sample.

The overall results obtained about family composition highlight certain significant differences in quality of life, depression, income, education and number of children, where women from single-parent families score higher on measures of depression, and lower on measures of quality of life, income, education and number of children, the veracity of which has been confirmed in other studies (McLanahan, Wedemeyer & Adelberg, 1981; Caimey, Thorpe, Rietschlin & Avison, 1999; Anson, 1988; Verbrugge, 1979; Lamb, 1977).

Financial income is directly related to the social conditions of life in a given population and at once, to both health and quality of life. Income reflects one's ability to

purchase goods and serves to satisfy the needs of one's family, which is decisive to the subsistence of women, and of single-parent families. Earning an income has been possible for the women in this study's sample, who are also the female "bosses" of their families, by becoming incorporated into the world of non-domestic work. One piece of data that aptly reflects that tendency is the percentage of the women in the sample who are employed (78.8%); this supports the results of a study in Mexico by Zúñiga & Ribeiro (2005). Furthermore, these women work out of their own, sheer economic necessity (Landeró, 2002; Ribeiro, 1993), and that of the other members of their families (siblings and children of the participants that reside in the same home). Earning an income through employment allows women to confront any family "economic crises" that may arise, but this work may also leave women with a double load when there is no one else to assist with domestic needs.

The increase of mothers into the labor market began in Mexico in the 1990's (INEGI, 1998) and there have been social implications to simultaneously fulfilling both roles (family and professional). These have included: the creation of new strategies to raise and care for children, changes in the family dynamic, economic independence, and changing reproductive patterns, among others (De Barbieri, 1984, 1996; García & Oliveira, 1994).

The relationship found in the present study between number of children and quality of life echoes the results of other studies (Cavalcanti, Sampaio, de Fátima & Brito, 2006; Caraveo- Anduaga, Martínez, Rivera & Dayan, 1997). With regards to the difference in quality of life scores according to type of family, this was due to the difference in one particular domain of quality of life: social relations (personal relationships, social support and sexual activity). As we mentioned previously in this paper, *social relations* are one of the aspects that most easily deteriorate after the dissolution or termination of a marriage. Some of the social implications of divorce (and separation) for children and mother alike, according to Lamb (1977), go beyond the resulting loss of income from the spouse, the loss of emotional support, and isolation.

Russel & Cutrona (1991) report that a deficit in quantity – and quality – of social support is associated with an increase in depressive symptoms, and that people who have a greater number of interpersonal relationships are less

vulnerable to the effects of stress, and at critical moments in their lives. In a study by Zung, Broadhead & Roth (1993) of 75,858 patients of primary care physicians in the United States, it was found that the condition of being married was a factor that protected women from developing depression.

Last, the difference in income between the two family types is due primarily to the significant contribution paid by a woman's spouse in nuclear families. To lose a spouse's income as a consequence of "marriage termination or separation," is to experience a significant loss of household income (Lamb, 1977). In other words, families with a single parent become poor, or at-risk of becoming poor, and that poverty tends to be quite severe (Zúñiga & Ribeiro, 2005; Madruga, 2006).

With respect to the difference found on item one of the quality of life variable, women from single-parent families perceived their quality of life as being lesser than that of women in nuclear families. The very fact that single mothers exhibit more depressive symptoms may well reflect their condition of having a worse quality of life (De Andres et al., 2002).

In the overall sample, it was found that the factors that predicted the dependent variable were income, depression and number of children. Income showed a positive correlation with quality of life while depression and number of children were both negatively correlated with quality of life.

Differences were found in the variables that predicted quality of life in the regression model for each type of family. In nuclear families, the predictors were depression and education, education being a factor that is related to depressive symptoms in women (Matud et al., 2006). Income was not a predictor, presumably because income is higher in nuclear families than in single-parent families. The data on single-parent families showed that the predictors of quality of life were income and depression, same as the overall model.

Conclusions

Mental health, an aspect of both overall health and quality of life, has been one of the most neglected areas of health in our country, which has delayed research, as well as the development of treatments and preventative measures. Aside from the fact that only meager resources are dedicated to this area of study, the fields of psychiatry and psychology on the whole are distrusted and undervalued (Lara & Salgado, 1994). It is for this reason that it is especially important to continue to analyze these and other variables such as social relations and social support, and their effect on the health and quality of life of female heads of families. Particular emphasis must be placed on depression as one such variable (Cfr. WHO, 2001) because of its prevalence. This is especially true for simple and complex, single-parent families, in part because of the limited research conducted

on their behalf in Mexico, particularly in the state of Nuevo Leon, and partly because without analyzing the circumstances in which women and children live together in alternative family compositions, politics and health programs will be unsuccessful at fulfilling their needs. Gender inequality is another aspect that should be taken into consideration as it is crucial to improving women's health (Castro & Bronfman, 1995).

Although the results of the present study cannot be generalized to the population because of its restricted sample size, we believe that these results may be of great use in guiding future research related to themes of family, quality of life and depression. Identifying and modifying the social factors that influence women's mental health could enable early prevention of certain mental disorders (WHO, 2000).

Last, we would like to suggest some future directions for research that stem from this study. We believe it is important to continue analyzing the variables that we have addressed here, and their effects on quality of life, physical and mental health, and the social condition of being a woman, particularly in the context of simple and complex, single-parent families, in order to yield a greater wealth of information about their specific characteristics and their differences from other samples.

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