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The role of the family doctor in the care of single-parent families

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RESUMO

Objective: To understand family doctors' (FD) and family doctor residents' (FDR) perspectives on the health care of single-parent families (SPF).

Methods: A cross-sectional observational study was conducted using a convenience sample. After validation, an anonymous online questionnaire was distributed to FD and FDR between January and March 2024. Two contextual variables were collected, as well as five questions regarding the views of FD and FDR on "The impact of living in a single-parent family" and seven questions about "The medical practice in the single-parent family". Descriptive and inferential statistical analyses were performed. A *n*=31 representative sample was calculated.

Results: For *n*=47, 88.6%, there was agreement that single parents present poorer mental health, and 81.1%, *n*=43, expressed the need for more training on SPF, also agreeing that the formation of an SPF is a moment of increased need for medical attention, *n*=36, 67.9%. FD and FDR, who expressed the need for more training, were more likely to disagree that their medical training was sufficient to provide satisfactory care for SPF, *p*=0.003. Doctors seemed to know when to refer SPF to other qualified professionals, *n*=37, 69.8%.

Discussion: The small sample size and the different inherent biases of self-reported data studies are to be mentioned. No other Portuguese studies exist on this subject; the fulfilment of the FD's and FDR's populational role seems to depend on the skills that are to be learned and practiced in continuous medical knowledge and development. More studies on this topic are needed.

Conclusion: FD and FDR consider it important to intervene in the needs of SPF and do not feel fully prepared to provide satisfactory care for these families.

Keywords: Single-parent families; Family medicine; Family doctor; Medical training.

INTRODUCTION

Single-parent families (SPF) are defined as those composed of one parent, with parent responsibility, and their offspring, and may be caused by several triggers.[1-2] The characteristics of SPF justify their consideration as deserving special medical attention, as most of them undergo a greater number of adjustments during their life cycle, when compared to other types of families.[3]

Several authors have studied the consequences of being raised in an SPF, encountering several problematic health events related to their context, particularly higher frequency of alcohol consumption and drunkenness in adolescence,[4] and higher use of inhalants, amphetamines, and marijuana.[5] Poorer metabolic control in children and adolescents with diabetes has also been associated with growing up in an SPF, along with increased risk for obesity.[6-7] Children from SPF have presented lower sleep efficiency, a concept that objectively measures sleep fragmentation and sleep duration.[8] Finally, being raised in an SPF has been linked to lower bone strength in later adulthood[9] and a higher likelihood of hospital attention due to asthma, a study also revealing lower household income causality.[10]

As for adults in SPF, single mothers, compared with married ones, have presented with a higher likelihood of evidencing depressive symptoms, alcohol-related

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problems, and enhanced levels of recent stress.[11] The perception of single mothers about their physical and mental health has been assessed, revealing more self-reported depressive symptoms, poorer general health, and higher rates of long-standing illness, preventing them from living a perceived normal life, when compared to mothers in nuclear families.[12] For single male-parents, similar conclusions were encountered, but with significantly higher probability of suicidal ideation, suspicious depression and alcohol dependence than coupled parents.[13] A recent longitudinal study found that single, fathers have a higher mortality risk than partnered fathers, as is the case for mothers of SPF,[14] revealing the need for the medical community to pay close attention to mothers and fathers in SPF' health.

As factors for such detrimental health, the birth of an SPF can represent a stressful life event for all family members,[15] resulting in greater susceptibility to disease in general and mental illness in particular.[16-19] Children's susceptibility tends to be greater if parents are not able to process and resolve the situation without conflict, grieving, thus creating an additional source of stress.[20-21] Adults in SPF, often with less support than before, have increased responsibilities and workload after becoming an SPF, seeking more attentive medical care.[3,20]

SPF are exposed to external circumstances contributing to their increased vulnerability to disease, such as lower household income,[10] greater risk of poverty,[22] and significant mental health vulnerability to social support.[23] Socioeconomic conditions affect the well-being of both children and parents in SPF, and are therefore factors that need to be considered.[24]

Family dysfunction is also a relevant topic to account for when regarding SPF' health, associated with worse physical and mental health in a multimorbid patients' study and patients suffering from chronic pain.[25] Family dysfunction was also associated with poorer self-perceived health, more depressive symptoms, and a need for help to take medication correctly.[26]

Portuguese SPF literature available is scarce. One cross-sectional study found that single mothers were more likely to have an unplanned pregnancy and inadequate use of prenatal care and folic acid supplements.[27] They also presented lower socioeconomic status, higher familial risk, and number of diseases, when compared to other familial structures.[28] Thus, despite the limited evidence, Portugal appears to present a similar context to other countries. The Portuguese 2021 Census found a 20.7% increase in the number of Portuguese SPF since 2011, with this family structure now being 18.5% prevalent in Portugal.[29]

The role of family doctors (FD) and family doctor residents (FDR) in the care of SPF begins within the core definition of this medical specialty, caring for each patient while continuously considering their familiar and community context.[30] This close doctor-patient-family relationship enables FD and FDR to be aware not only of the family structure but also of its functionality, socioeconomic conditions, and stressful events that may affect them, preventing and providing mental or physical medical support, and also referring them to specialized professionals.[3,20]

Assessing Portuguese FD' or FDR' perspectives on the impact of living in a single-parent family and on adequate strategies when caring for these families were the main objectives of this study, which also aimed to understand how these doctors view their training for such care, and when they had had such training.

METHODS

A cross-sectional observational study was performed between December 28, 2023, and March 24, 2024.

A preliminary version of a questionnaire was built from scratch, since no validated instrument was found on this topic after the existing literature review. The questionnaire's first version was sent to ten FD and FDR, retrieving data on response time, relevance of the questions, comprehensibility, and suggestions. Then, taking these reviews into account, the final version of the questionnaire was made, and permission for conducting the study was obtained from the Ethics Committee of the Administração Regional de Saúde do Centro. According to the ethics approval, informed consent was necessary to complete the anonymous and confidential Google Forms questionnaire, distributed online, through specific social networks used by FD and FDR, like MGFamiliar XXI, residents' social networks, and the author's specific ones. All answers were considered valid, since access to the questionnaire was only possible once informed consent was given and ticked on the

initial page of the questionnaire. The only one answer per person option was on no other data than the asked for being obtained.

The questionnaire was divided into three sections: Group I – The impact of living in a single-parent family, with five questions; Group II – The medical practice in the single-parent family, with seven questions; and the last section, Context Variables, with two questions.

Group I – The impact of living in a single-parent family – intended to learn about the general perspectives of FD and FDR regarding the health of SPF, reflecting empathy and the doctor-patient relationship.[30-31] Questions referred to the mental health of parents and children in SPF, and risk of SPF members for developing mental or physical disease in adolescence and adulthood. These five questions were answered using a 5-point Likert scale, ranging from 1 («strongly disagree») to 5 («strongly agree»), with a sum score being used.

Group II – The medical practice in the single-parent family – aimed to understand the perspectives of doctors on the adequacy of their care, and on their skillfulness and management of SPFs' follow-up. In this group, five questions were answered using a 5-point Likert scale ranging from 1 («strongly disagree») to 5 («strongly agree»), a sum score was used, one was answered using a 4-point Likert scale ranging from 1 («definitely no») to 4 («definitely yes»), and the last one was a multiple-choice question.

The last section collected contextual variables: sex and years of clinical practice. As an exploratory study, with no previous data on the matter being known, a sample size of at least 31 respondents was calculated.[31]

SPSS version 27 for Windows Operating System was used for descriptive and inferential statistical analysis. To test for internal validity within Group I and Group II, Cronbach's Alpha was calculated, and to measure dependency within each set of variables, the internal correlation coefficient was calculated. Then, for each group, the Kolmogorov-Smirnov test was applied to determine whether the total score had a normal distribution. Descriptive statistics were performed, and Mann-Whitney U and Kruskal-Wallis tests were used for inferential analysis of each group of variables and cross-data analysis, with a significance level of 0.05.

RESULTS

The preliminary version of the questionnaire revealed a mean completion time of four minutes [3 to 5] by the 10 respondents. The need for questions addressing medical training was reported, leading to the addition of two more contextual questions determining when knowledge about the theme had been obtained and regarding the need for more updated knowledge. The wording of some of the questions was also adjusted to ease their understanding, according to the suggestions.

For internal consistency, a Cronbach's Alpha of 0.843 for Group I and 0.699 for Group II of questions was obtained, as well as intraclass correlation coefficients of 0.682 for Group I and 0.644 for Group II. The Kolmogorov-Smirnov test indicated that both groups' scores followed a non-normal distribution, determining the use of non-parametric tests for inferential statistical analysis of the data. The Spearman correlation between the two groups' scores was positive, very weak, and non-significant (r=+0.095, p=0.498).

The questionnaire was viewed by 54 respondents, one not consent to participate, so a sample of n=53 respondents was studied, of which n=39 (73.6%) were female. Significant differences in the group of years of clinical practice were found (p=0.002), with n=17 (43.6%) women in the up to 10 years group and n=9 (64.3%) males in the 21 or more years group. The distribution across the three groups of years of clinical practice was balanced, with n=18 (34%) in the up to 10 years one, n=18 (34%) in the 10 to 20 years, and n=17 (32.1%) having more than 20 years of clinical practice. For n=43 (81.1%), «yes» or «definitely yes» was the answer regarding the need for more training on the subject of SPF, not significantly different between genders (p=0.302). Knowledge on the topic of SPF has been mainly acquired in the general practice residency for 60.4% of the respondents, not significantly different by sex, according to Table 1.

Table 2 shows the descriptive results for Group I – The impact of living in a single-parent family –, and Group II – The medical practice in the single-parent family. Most of our sample strongly agreed that the formation of an SPF is a moment of increased need for medical attention (n=36, 67.9%). Regarding the mental health of single parents, most respondents agreed (either partially or strongly) that anxiety and depression levels are

TABLE 1. Doctors' years of clinical practice, need for more training, and moment when knowledge on the topic was obtained, according to gender. Descriptive and inferential statistics

		Gender (*)		Total *n* (%)	*p*
		Male *n* (%)	Female *n* (%)		
Group of years of clinical practice in family medicine	Up to 10 years	1 (7.1)	17 (43.6)	18 (34.0)	0.002
	11 to 20 years	4 (28.6)	14 (35.9)	18 (34.0)	
	21 years or more	9 (64.3)	8 (20.5)	17 (32.1)	
Total		14	39	53	
Do you feel the need for more training or information on the subject of single-parent families?	Definitely no	1 (7.1)	1 (2.6)	2 (3.8)	0.302
	I don't know	1 (7.1)	7 (17.9)	8 (15.1)	
	Yes	9 (64.3)	13 (33.3)	22 (41.5)	
	Definitely yes	3 (21.4)	18 (46.2)	21 (39.6)	
Total		14	39	53	
When did you obtain knowledge on the topic?	In under-graduate and general training	1 (7.1)	10 (25.6)	11 (20.8)	0.263
	In the general practice residency	10 (71.4)	22 (5.4)	32 (60.4)	
	As a specialist	3 (21.4)	7 (17.9)	10 (18.9)	
Total		14	39	53	

* Mann-Whitney U test.

higher in SPF (*n*=47, 88.6%). As for children's health, respondents were more likely to answer «partially agree» to the questions "I believe that children from single-parent families will have more symptoms of anxiety and depression" (*n*=19, 35.8%) and "I believe that children from single-parent families are at risk of more physical health problems in childhood and adolescence" (*n*=16, 30.2%). To the question "I believe that children from single-parent families are at risk of poorer health in adulthood", *n*=23 (43.4%) answered «neither agree, nor disagree».

Median, minimum, and maximum scores for Group 1 were 19.0, 11.0, and 25.0, and for Group 2 were 16.0, 10.0, and 25.0, respectively.

There were no significant gender differences in the scores for both groups (*p*=0.292 for Group 1 and *p*=0.113 for Group 2, Mann-Whitney U. No significant differences were found for "Years of clinical practice in family medicine", with *p*=0.062 and *p*=0.059 (Mann-Whitney U), respectively. Again, no differences were found in the need for more training or information, *p*=0.221 and *p*=0.363, Mann-Whitney U, for groups 1 and 2 scores. For the question "When did you obtain knowledge on the topic?", no differences were found for Group 1, *p*=0.621, but for Group 2, significant differences were found, *p*=0.006, according to Table 3.

DISCUSSION

This research aimed to know more about the perspectives of Portuguese FD and FDR regarding the impact in health of living in an SPF, the adequate strategies when caring for these families, the medical training of these doctors on the subject and to understand these professionals' feelings of preparedness to protect and intervene in moments of specific needs of these families.

The positive and very weak correlation between both groups reflected the different purposes of the two sets

TABLE 2. Group I – The impact of living in a single-parent family, and Group II – The medical practice in the single-parent family. Its description

The impact of living in a single-parent family

Question	Answer	Total *n* (%)
I consider the formation of a single-parent family (in the case of divorce, separation from an unmarried couple, or death of a parent) to be a time when medical attention is most needed	Neither agree, nor disagree	1 (1.9)
	Partially agree	16 (30.2)
	Strongly agree	36 (67.9)
Total		53 (100)
I believe that in single-parent families there will be higher levels of anxiety and depression in parenting	Partially disagree	1 (1.9)
	Neither agree, nor disagree	5 (9.4)
	Partially agree	28 (52.8)
	Strongly agree	19 (35.8)
Total		53 (100)
I believe that children from single-parent families will have more symptoms of anxiety and depression	Strongly disagree	1 (1.9)
	Partially disagree	8 (15.1)
	Neither agree, nor disagree	14 (26.4)
	Partially agree	19 (35.8)
	Strongly agree	11 (20.8)
Total		53 (100)
I believe that children from single-parent families are at risk of more physical health problems in childhood and adolescence	Strongly disagree	7 (13.2)
	Partially disagree	7 (13.2)
	Neither agree, nor disagree	14 (26.4)
	Partially agree	16 (30.2)
	Strongly agree	9 (17.0)
Total		53 (100)
I believe that children from single-parent families are at risk of poorer health in adulthood	Strongly disagree	7 (13.2)
	Partially disagree	7 (13.2)
	Neither agree, nor disagree	23 (43.4)
	Partially agree	11 (20.8)
	Strongly agree	5 (9.4)
Total		53 (100)

(continues)

of questions and the different premises from which questions for each group were constructed.

Regarding the formation of an SPF, this sample consensually considered such a moment to be worthy of increased medical attention. Thus, our results suggest that the views of FD and FDR on this topic are in line with the current literature, which considers these to be stressful life events that doctors should be attentive to.[15,20,32]

There was agreement that SPF have poorer mental health, once again according to previously published

TABLE 2. Group I – The impact of living in a single-parent family, and Group II – The medical practice in the single-parent family. Its description *(continued)*

The medical practice in the single-parent family

Question	Answer	Total *n* (%)
I consider my follow-up on single-parent families to be generally adequate	Partially disagree	3 (5.7)
	Neither agree, nor disagree	18 (34.0)
	Partially agree	25 (47.2)
	Strongly agree	7 (13.2)
Total		53 (100)
I feel that I have sufficient scientific knowledge to care for single-parent families	Strongly disagree	2 (3.8)
	Partially disagree	13 (24.5)
	Neither agree, nor disagree	17 (32.1)
	Partially agree	19 (35.8)
	Strongly agree	2 (3.8)
Total		53 (100)
I know when to refer a single-parent family to other qualified professionals	Strongly disagree	1 (1.9)
	Partially disagree	11 (20.8)
	Neither agree, nor disagree	4 (7.5)
	Partially agree	31 (58.5)
	Strongly agree	6 (11.3)
Total		53 (100)
I feel that my medical training is sufficient to provide satisfactory care for single-parent families in general	Strongly disagree	4 (7.5)
	Partially disagree	21 (39.6)
	Neither agree, nor disagree	9 (17.0)
	Partially agree	17 (32.1)
	Strongly agree	2 (3.8)
Total		53 (100)
In situations where I consider the family to be at greater risk, and in initial consultations, I apply standardised family assessment tools	Strongly disagree	12 (22.6)
	Partially disagree	10 (18.9)
	Neither agree, nor disagree	7 (13.2)
	Partially agree	21 (39.6)
	Strongly agree	3 (5.7)
Total		53 (100)

research.[11-13] Still, present results suggest that this is not necessarily how doctors feel about children raised in SPF, nor about the physical health of these children. Given that our questions referred generally to SPF and did not address family functioning, one reason for these results may be that respondents consider the negative consequences of being raised in an SPF to be dependent on family functioning.[4-10]

TABLE 3. "When did you obtain knowledge on the topic?" for "The medical practice in the single-parent family" score group: median, minimum and maximum values

	In under-graduate and general training (*)	In general practice residency (*)	As a specialist (*)
n	11	32	10
Median	13.0	18.0	16.5
Minimum	10.0	10.0	11.0
Maximum	19.0	24.0	25.0

(*) p=0.006, Kruskal Wallis.

This study strongly suggests that FD and FDR feel the need for more training or information on SPF. Accordingly, our respondents did not seem confident about the adequacy of their follow-up of SPF, despite knowing how to identify the situations that fall outside of their competence and require referral to other qualified professionals. This need for more training and information seems to stem from the feeling of not being able to provide satisfactory care on this topic. The doctors who expressed the need for more training and knowledge seem to be aware of the challenges faced by both adults and children of SPF. Thus, an important line of investigation will be to understand doctors' difficulties in the follow-up of SPF.

In this study, female FD or FDR were more dissatisfied with their training and knowledge on SPF; however, male doctors were significantly more experienced, so the greater need for training and information among female FD and FDR may reflect fewer years of clinical practice. However, their real need cannot be excluded.

The answers to the question regarding the use of family assessment tools suggest that this is not a generalized practice for all FD and FDR, even in the situations in which the literature on family medicine recommends it.[20] Being unaware of the family risk of SPF can reduce the ability to intervene and prevent future health problems. However, this question referred to two different situations in which family assessment instruments can be applied, so respondents who only apply these tools in one of these situations, beginning of follow-up and in at risk-situations, may have disagreed partially on the statement. In the situations in which doctors do not apply these instruments, time constraints in consultations are a possible contributing factor, so further clarification on this topic is deemed necessary.[33-34]

Some limitations of this study exist, namely the small sample size, information bias associated with the use of questionnaires and self-reported data, and social desirability bias. Further research is needed, particularly into the feelings of SPF members about the care they receive.

Our study suggests that, despite recognizing the importance of intervening when SPF need it, FD and FDR do not feel entirely prepared to protect them and prevent their future health problems. So, knowledge of social, psychological, economic, or even financial supports or resources seems necessary for the medical professionals.

CONCLUSIONS

Portuguese FD and FDR seem to believe that being a single parent has a negative impact on mental health.

Additionally, they reflect referring SPF to other qualified professionals as an important strategy and seem confident in knowing when to do so. However, they do not seem confident that their follow-up on SPF is adequate.

FD and FDR perceive their training on the care of SPF during their medical education as insufficient to provide satisfactory care for these patients.

Thus, there seems to be a need for continuous medical education and training in the subject of caring for SPF.

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AUTHORS CONTRIBUTION

Conceptualization, CB, and LMS; methodology, CB, and LMS; software, CB;

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CONFLICT OF INTERESTS
Non to declare.

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ABSTRACT

O PAPEL DO MÉDICO DE FAMÍLIA NO CUIDADO DAS FAMÍLIAS MONOPARENTAIS

Objetivos: Perceber as perspetivas de médicos de família (MF) e de médicos internos de formação específica (MIFE) nos cuidados de saúde a famílias monoparentais.
Métodos: Estudo observacional transversal por questionário anónimo, especificamente construído, aplicado *online* a MF e MIFE entre 28 de dezembro/2023 e 24 de março/2024, recolhendo-se duas variáveis de contexto e as opiniões acerca do "Impacto de viver numa família monoparental" (cinco perguntas) e da "Prática médica em famílias monoparentais" (sete perguntas). Efetuou-se a análise estatística descritiva e inferencial dos dados. Calculou-se como dimensão amostral um n=31.
Resultados: Para n=47 médicos, 88,6% concordaram que os pais de famílias monoparentais apresentam pior saúde mental. Além disso, 81,1% (n=43) manifestaram sentir necessidade de mais formação sobre estas situações, concordando ainda que o acompanhamento destas famílias representa um momento de maior necessidade de atenção médica (n=36, 67,9%). Os MF e MIFE que expressaram a necessidade de mais formação discordaram mais de que a sua formação médica fosse suficiente para prestar cuidados satisfatórios às famílias monoparentais (p=0,003). Os médicos revelaram saber quando encaminhar estas famílias para outros profissionais qualificados (n=37, 69,8%).
Discussão: A reduzida dimensão da amostra e os diferentes vieses associados à utilização de dados autorreportados foram algumas limitações deste estudo. Não havendo outros trabalhos portugueses nesta temática, o desempenho da função assistencial dos médicos com famílias monoparentais parece depender de conhecimentos e treino a obter em formação médica e desenvolvimento médico contínuos.
Conclusão: MF e MIFE consideram importante intervir nas necessidades das famílias monoparentais e não se sentem totalmente preparados para prestar cuidados satisfatórios a estas famílias.

Palavras-chave: Famílias monoparentais; Medicina geral e familiar; Médico de família; Formação médica.