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The Impact of Socioeconomic Factors and Familial Structure on Pediatric Health: An Analysis of Child Physical and Mental Health Outcomes

The mind and body of a child are some of the most impressionable; the child like a clean slate ready to be written on by their environment in conjunction with the ideas and actions of those around them. The ways which children think about themselves, their families, their peers, and any other individuals they may come into contact with can be strongly influenced by the way they are raised, whether that be in a large family or a small one, in a rich family or a poor one. Not only can the mental health and outward thoughts of a child be affected by the character of their upbringing, but the physical health of the child can also be impacted by their familial structure and socioeconomic background. In other words, both the socioeconomic status and structure of a child's family throughout their upbringing impacts the health outcomes of a child. Children of lower socioeconomic statuses, particularly those from low-income backgrounds, minority racial and ethnic backgrounds, and those assigned female at birth, as well as those children whose families have little structure or adult influence tend to have less positive health outcomes, with higher incidences of both untreated or unrecognized mental and physical health ailments.

When looking at the mental and physical health outcomes of children of various socioeconomic and familial backgrounds, it is important to first establish what is meant by mental health and physical health and methods of measuring levels of both mental and physical

health. Physical health refers to the absence of physical symptoms or a state of physical "wholeness" (Saylor 2004). Physical health or well-being looks at the physical structures of the body, with optimal physical health referring to preserved structure and function of bodily organs and systems (Saylor 2004). Physical health is measured by looking at how an individual's body functions; looking at an individual's symptoms and seeing if these symptoms hinder the bodily structures and day-to-day functioning (Saylor 2004). Symptoms that hinder an individual's ability to function optimally and diagnosis of disease are said to negatively impact an individual's physical health (Saylor 2004). Physical health and wellness as well as physical health symptoms and conditions can be monitored through various forms of testing, like diagnostic or laboratory testing, imaging, and other forms of examination or testing (Saylor 2004). Mental health, on the other hand, is a less concrete aspect of health. Unable to be measured through physical symptoms like joint pain or organ failure, mental health is measured primarily through individual health evaluations which can be used to diagnose mental health conditions (Galderisi et al 2015). Mental health refers to the state of well-being attained through awareness of one's own abilities and productivity (Galderisi et al 2015). Mental health focuses on an individual's ability to modulate their emotions so that they are able to cope with day-to-day stressors while also contributing to society (Galderisi et al 2015). Although there are different descriptions of the symptoms of different mental health conditions in literature such as the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), presentations of mental illnesses vary from person to person (Galdersisi et al 2015). Mental health conditions may differ by factors such as race and sex, as well as on an individual level (Galderisi et al 2-15).

As established above, various socioeconomic factors can impact both the mental and physical health outcomes of children (Cheng and Goodman 2015). The income level at which the

child is raised, the sex of the child, and their race and ethnic background directly relate to the mental and physical health of the child. Income correlates to child health outcome in that familial income can impact the access one has to nutritious food and the access a child has to healthcare, particularly preventative care (Babar et al 2010; Berger 2004; Davenport et al 2017). Financial stress and low income are studied not through measures of absolute poverty, but through measures of relative poverty (Babar et al 2010; Berger 2004; Davenport et al 2017; Foster 1998). Absolute poverty is a figure set forth by the federal government which defines the minimum income or salary required to meet subsistence needs (Foster 1998). Absolute poverty measures do not account for differences in cost of living in different areas, number of dependents, or other factors that could influence the amount of income one can dedicate to meeting their basic needs (Foster 1998). Relative poverty is characterized less by concrete mathematical figures but more so on the inability to meet expenses regardless of how much one makes (Foster 1998). In other words, relative poverty considers more factors, recognizing that cost of living varies by location and the number of dependents in a household can impact the amount of income one can devote towards paying for housing and other necessities (Foster 1998). By considering income and poverty by a measure of relative poverty, greater numbers of individuals are affected, as individuals can be considered poor by relative poverty standards while not being considered poor by absolute poverty standards; because relative poverty standards generally focus on difficulty paying for necessary expenses, greater numbers of individuals can be considered economically disadvantaged (Foster 1998). Low income, looked at through the scope of relative poverty, makes it more difficult for families to obtain nutritious food, and children often do not have enough food to eat or often eat unhealthy fast food and takeout (Babar et al 2010; Berger 2004, Foster 1998). Children from low-income households are more likely to be malnourished, going

hungry because they do not have enough food to nourish them (Babar et al 2010; Berger 2004). Low-income children are also more susceptible to preventable health conditions like diabetes mellitus because of their decreased access to nutritious foods as well as their decreased access to medical care (Babar et al 2010; Berger 2004). These children are also more likely to develop cardiovascular and musculoskeletal diseases (Ahnquist et al 2012). Economically disadvantaged children are less likely to be consistently attending medical checkups in which diseases like diabetes or other conditions could be prevented or effectively treated (Berger 2004). In addition to their physical health complications, children who come from low-income families also have increased incidence rates of mental health conditions (Berger 2004). Children of low socioeconomic statuses have greater tendencies toward depressive disorders and anxiety, as well as other cognitive or behavioral disorders (Berger 2004). Low parental income is directly correlated with decreased cognitive stimulation and emotional support of their child, which makes them more susceptible to mental health conditions as their needs go unmet (Berger 2004). Low familial income makes it harder for them to seek treatment for mental health conditions, as most therapies are not fully covered by insurance (Berger 2004). Hence, children from low-income families are, through no fault of their own, set up to have poor mental and physical health as they have decreased access to nutrient-dense meals, therapeutic services, and preventative care (Ahnquist et al 2012; Babar et al 2010; Berger 2004; Davenport et al 2017).

The sex a child has been assigned at birth is another aspect of socioeconomic status that plays a role in both the mental and physical health outcomes of a child. While there are negligible differences in physical health outcomes based on assigned sex, mental health outcomes vary based on the sex a child has been assigned at birth (Green et al 1996). Children who are assigned male at birth have greater incidences of externalizing mental conditions and

symptoms, such as aggression or hyperactivity, whereas as children assigned female at birth have greater incidence of internalizing mental health symptoms and conditions like low self-esteem or anxiety (Green et al 1996). Because of this difference in presentation of symptoms where children assigned male at birth tend towards projecting externalized symptoms and children assigned female at birth tend toward internalized symptoms, children who are assigned male at birth are often referred to mental health services like therapy at greater levels (Green et al 1996). This differential presentation of symptoms and the differential recommendation to mental health services leads to a discrepancy in diagnoses of mental health conditions, as external symptomatic presentations are easier to observe and attribute to a diagnosis like anger management disorders and attention-deficit/hyperactivity disorder, or ADHD (Bauermeister et al 2007; Green et al 1996). In the case of ADHD, there is no evidence to suggest that children assigned male at birth are more susceptible to the condition than children assigned female at birth (Bauermeister et al 2007). However, because of the differential presentation of symptoms where children who are assigned male at birth present more outward and disruptive symptoms like impulsivity and aggression and children who are assigned female at birth present more inward symptoms like inattentiveness and depression, children who are assigned male at birth are nearly two and a half times more likely to be diagnosed with ADHD than children who are assigned female at birth (Bauermeister et al 2007). On the other hand, for conditions that present more internalized symptoms like depression, children assigned female at birth are twice as likely to be diagnosed with depression (Salk et al 2017). Though in the case of depression, children that are assigned female at birth are more likely to be diagnosed, general trends in mental health diagnoses and treatment recommendation suggest otherwise. In other words, children assigned female at birth have the same likelihood of mental health ailments as children assigned male at birth, but

children assigned female at birth are less likely to be diagnosed with mental health conditions and are less likely to be referred to mental health services (Bauermeister et al 2007; Green et al 1996).

Just as the sex which is assigned to a child at birth and the income level at which a child is raised can positively or negatively impact both the physical and mental health outcomes of the child, the racial and ethnic background of the child can command a significant role in the child's mental and physical health condition. The majority of studies about the impact of racial and ethnic background on a child's mental and physical health focus on the discrepancies in health outcomes of black and white children. Starting at the beginning of their lives, black children are disadvantaged in that they have lower birth weights than weight children (Edwards and Grossman 1982). Low birth weight is typically used as "a good negative indicator of whether an infant will survive his first year and of his successful future development," which is conducive to mortality rates in black infants and children which are fifty percent greater than those of their white peers (Edwards and Grossman 1982). In a different study comparing the health outcomes of white and black children, of the nearly one hundred seven thousand participants in the survey, nearly ten percent of black children were in poor physical health and seven percent of white children were in poor physical health (Montgomery et al 1996). These negative health impacts are not isolated to physical health, but the mental health of individuals from minority racial and ethnic backgrounds is also impacted. Studies into the correlation of mental health outcomes and racial and ethnic background have a wider scope, looking at white, black, Hispanic, and Native American children whereas physical health comparisons focused on discrepancies between black and white children only. Focusing not on specific mental health conditions but rather the incidence of nonspecific mental health ailments, the study looked at children ages six through

seventeen (Howell and McFeeters 2008). The study broke down incidence of mental health conditions by racial and ethnic background from children in both urban and rural areas (Howell and McFeeters 2008). In the general population in the United States, six and a half percent of white children had mental health problems (Howell and McFeeters 2008). Ten and a half percent of black children and twelve percent of Hispanic children reported mental health issues (Howell and McFeeters 2008). About eight percent of Native American children had mental health issues (Howell and McFeeters 2008).

Socioeconomic factors such as income, assigned sex, and racial and ethnic background can have much influence on the mental and physical wellness of children (Cheng and Goodman 2015). These factors, however, are not the only factors that can impact the physical health and mental wellbeing of a child. The structure of the child's family, referring specifically to the stability of the home environment and the amount of parental influence in the upbringing of a child, have profound effects on the mental and physical health outcomes of the child (Berger 2004; Dawson 1991). In terms of stability or instability of the home environment, the main factors contributing to instability are the inconsistent presence of a child's parents in their life, serial relocating or often moving from house to house, or constant introduction of new individuals like new caregivers or a parent's new significant other (Dawson 1991). Children from families with constantly changing structure, children from unstable home environments are more likely to fall victim to maltreatment, because with so many moving parts of relocating or introduction of new people, these children may be overlooked (Berger 2004). Focusing on birth to age seventeen, children from unstable family backgrounds, from constantly changing home environments, were more likely to skip routine medical appointments and, in turn, experience accidental injuries or preventable illnesses in greater numbers (Berger 2004; Dawson 1991).

Children from unstable family backgrounds are also at higher risk for frequent and chronic headaches, asthma, and speech impediments like a stutter (Dawson 1991). Instability of family environment is also correlated to mental health issues resulting from insufficient, inconsistent, or absent emotional support and cognitive stimulation (Berger 2004). Because of this decreased availability of parents to promote good mental health and development in their child, children from unstable or poorly structured family environments have greater incidences of emotional disorders like depression and anxiety (Berger 2004; Dawson 1991).

In addition to families in which the stability experienced by a child varies, different families also have varying amounts of adult influence, specifically varying amounts of parent influence. Often in two-parent families, the burden of childcare and homemaking fall disproportionately on one parent, typically the mother or another maternal figure (Garbarski and Witt 2012). In single parent families, however, the full burden for childcare and homemaking is on one parent with that one parent typically but not exclusively the child's mother (Duriancik and Goff 2019; Garbarski and Witt 2012). Because of this burden of care falling onto one parent who must manage all care for their child alone as they also work and tend to the home among other things, children in single parent families may often be overlooked as the parent is swamped by all of their overarching obligations (Berger 2004; Duriancik and Goff 2019). Children growing up in a single parent family, because of the chance that they may be overlooked or a sign or symptom may be missed, are more likely to be diagnosed with preventable conditions like diabetes or high blood pressure (Berger 2004; Duriancik and Goff 2019; Garbarski and Witt 2012). These children are at higher risk musculoskeletal disorders or deterioration which lead to a high prevalence of mobility issues in these children (Ahnquist et al 2012). The likelihood of accidental injuries like broken bones is increased as well (Berger 2004). In addition to

preventable injuries or illnesses, children raised in a single parent household have increased incidence of respiratory disorders or difficulties such as asthma (Dawson 1991). However present physical disorders, disabilities, and deteriorations are in children from single parent families, mental disorders are also more prevalent in these children. Children from single parent families, when compared to children raised in two parent families, had a greater prevalence of insecure attachment styles, scared to leave the only parent they have known whether this may be to go to school or an extracurricular activity (Dawson 1991). Children raised by one parent also have greater incidences of anxiety and depression, which can again be attributed to business of the parent and insecurities on the end of the child (Dawson 1991). Overall, the mental health issues on the end of a child who has been raised in a single parent household are the result of the child feeling insecure or nervous that their parent may leave them behind or may fall victim to injury and the child will be left alone without their parent to care for them and love them (Dawson 1991).

Looking at the mental and physical health outcomes of children by breakdown of race, sex, familial income level, amount of familial structure, and amount of parental influence provides insight into how each of these factors on an individual level can take a toll on the health of a child. Each of these factors alone has a counteractive effect on a child's mental and physical health outcomes, but when looking at the conjunction of factors, it can be seen that the combination of a variety of factors only creates a more negative impact on the health outcomes of the child (Cheng and Goodman 2015). Certain combinations of factors are more common than others, with one of the most prevalent combinations being racial and ethnic background and income level (Cheng and Goodman 2015). Children of minority racial and ethnic backgrounds are more likely to be impoverished (Edwards and Grossman 1982). Hence, the negative mental

and physical health outcomes of children from either poverty or minority racial or ethnic background have a synergistic effect, making the child not only at greater risk of malnourishment, diabetes, cardiovascular diseases, musculoskeletal diseases, anxiety, depression, and emotional or behavioral disorders but these children are also experiencing higher mortality rates and lower birth weights as well as greater incidences of mental health issues (Ahnquist et al 2012; Babar et al 2010; Berger 2004; Davenport et al 2017; Edwards and Grossman 1982; Howell and McFeeters 2008; Montgomery et al 1996). Another typical combination factors which negatively impact mental and physical health of a child results from the trend of impoverished families have a less concrete familial structure (Cheng and Goodman 2015). Children from families that are impoverished and have little to no concrete structure experience the combined negative effects of both factors, having increased vulnerability to accidental illnesses and injuries, a higher risk of asthma, speech impediments, and chronic headaches, greater incidences of anxiety and depression, greater opportunity for diabetes and malnourishment, musculoskeletal and cardiovascular diseases, and emotional and behavioral disorders (Ahnquist et al 2012; Babar et al 2010; Berger 2004; Davenport et al 2017; Dawson 1991). The final highly frequent combination of factors is racial and ethnic background and being raised in a single parent family, as minorities are less likely to marry and more likely to be single parents (Cheng and Goodman 2015). The combination of conditions or disorders resulting from a minority racial or ethnic background single parent includes higher mortality rates, lower birth weights and predicted future success, and greater incidence of mental health issues, as well as greater prevalence of preventable illness or injury, respiratory disorders, musculoskeletal disorders, anxiety, depression, and insecure attachment (Berger 2004; Dawson 1991; Duriancik and Goff 2019; Edwards and Grossman 1982; Garbarski and Witt 2012; Howell and McFeeters

2008; Montgomery et al 1996). In any case or combination of factors, children are at an even greater deficit than they would be had they only been affected by one socioeconomic factor or one factor impacting familial structure (Cheng and Goodman 2015). Children impacted by a combination of factors fall victim to various comorbidities, having a detrimental effect on both their mental and physical health outcomes (Cheng and Goodman 2015).

Children from various walks of life, from various socioeconomic backgrounds and from various familial circumstances, have different inherent impacts on health. Children from low socioeconomic statuses or from families with little structure or parental influence experience negative effects on their health through no fault of their own. These children, whether their parents have chosen to live in a certain way or have fallen victims to circumstance, should not fall victim to serious health conditions that are out of their control, either because their parents do not realize they or sick, cannot afford preventive care, or for whatever reason may be the case. Children ought to be afforded the same opportunity to be healthy, regardless of the color of their skin, or how much money their parent makes, or what sex they are, or because of the family structure their parent has or parents have chosen. Children from these various walks of life should all get the same access to healthcare and nutritious food, but this is easier said than done. It is easy to recognize the gap in health outcomes between children of various sexs, races, income levels, and familial backgrounds, but it is difficult to begin trying to bridge the gap. Solutions proposed in effort to bridge the gap often target the flaws of the healthcare system and not the society that reinforces these discrepancies. One proposed solution is implementing universal healthcare in the United States. By implementing universal healthcare, the United States could help to alleviate the financial burden of seeking medical care of disadvantaged populations, making it easier for these populations to seek preventive care and better mind their

mental and physical health (Ahnquist et al 2012; Berger 2004). Another potential solution aimed at bridging the gap in health outcomes and healthcare experienced by these children is to increase the medical services offered to underserved communities, specifically in the form of clinics. By increasing the prevalence of clinics, particularly in underserved communities, individuals will be able to access healthcare more readily, not having to take days off or drive long trips to see a medical provider under their insurance (Ahnquist et al 2012; Berger 2004). In other words, by increasing the prevalence of healthcare facilities available to underserved communities, one can alleviate the burden of care while also creating jobs in the community to bridge the gap in health outcomes and access to healthcare experienced by children. A final proposed solution to the discrepancies in health outcomes experienced by children from various backgrounds includes their parent or parents. Educating and empowering parents so that they understand the importance of preventive care can be very beneficial to a child, as parents who understand the necessity for preventive care will be more likely to see preventive care for their child (Ahnquist et al 2012; Berger 2004). Furthermore, parents who understand the necessity of preventive care may also be empowered to recognize signs and symptoms of certain conditions like diabetes in their children, allowing them to seek medical care earlier, being more proactive at the benefit of their child's mental and physical health outcomes (Ahnquist et al 2012; Berger 2004). The bottom line is that children, through no fault of their own, are experiencing negative health impacts, both physical and mental, and there are proposed methods to rectify these discrepancies, so why has nothing substantial been done? When action be taken to ensure that children of all racial and ethnic backgrounds, sex identities, income levels, and familial backgrounds can have an equal opportunity to be mentally and physically healthy?

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