# Operationalisierung der Variablen

HEALTH

|  |  |  |  |
| --- | --- | --- | --- |
| hpcs | physical health score |  |  |
| hmcs | Mental health score |  |  |

EFRTILITY: Parents / Childless

|  |  |  |  |
| --- | --- | --- | --- |
| parents | Having kids | All sorts of kids (bio, foster etc) | 1 , 0 |
| nokids | Having no kids |  | 1, 0 |
| childmrd\_parent\_1 | Parents who lived with 1+ kids | Only parents | 1, 0 |
| cohabs | childless and parents who have lived with a child. | excluding parents never lived with a child | 1, 0 |
| cohabs\_curr | parents who currently live with a child and childless | excluding 118 parents not living with child | 1, 0 |
| cohabs\_bio | parents having lived with 1+ bio child and childless | Excluding other parents | 1, 0 |

FERTILITY: Parity

|  |  |  |  |
| --- | --- | --- | --- |
| nkidsdead | Deceased children | Excluded from analysis | PROBLEM |
| nkidsnonbio | Non biological children | Stay in analysis |  |
| nkidsalv |  |  | 0-10 |
| nkidsalv4 | Kids alive | Scale until 4+ | 0-4+ |
| nkidsalv4\_dum1 | 0 kids alive |  | 1, 0 |
| nkidsalv4\_dum2 | 1 kid alive |  | 1, 0 |
| nkidsalv4\_dum3 | 2 kids alive |  | 1, 0 |
| nkidsalv4\_dum4 | 3 kids alive |  | 1, 0 |
| nkidsalv4\_dum5 | 4+ kids alive |  | 1, 0 |
| nkidsalv4\_parents | Kids alive | Only parents | 1-4+ |
| livk\_all | Sum of cohabition years | Childless = . | 0-x |
| livk\_all\_all | Same | Childless = 0 | 0-x |

FERTILITY: Age at first birth

For reasonable group sizes I made the cut for both genders after 22 and after 34

|  |  |  |  |
| --- | --- | --- | --- |
| age\_fbirth |  | Childless are missing . | x-x |
| agegroup\_fbirth |  |  | x-x |
| fbirth\_dum1 | "Early first Birth - 22" |  | 1, 0 |
| fbirth\_dum2 | "23-26" |  | 1, 0 |
| fbirth\_dum3 | "27-30" |  | 1, 0 |
| fbirth\_dum4 | "31-34" |  | 1, 0 |
| fbirth\_dum5 | "35-43" |  | 1, 0 |
| early\_fbirth | First birth up until 22 | VS all, also childless | 1, 0 |
|  |  |  |  |
| age\_lbirth | Age at last birth |  | x-x |
| late\_fbirth | First birth 35-43 | VS all, also childless | 1,0 |

SOEP

|  |  |  |  |
| --- | --- | --- | --- |
| incnet | Personal income |  | xx-xx |
| hhincnet | Household Income |  | xx-xx |
|  |  |  |  |
| moneystress | Financial Stress | ever had big financial problems, dept, insolvency | 1, 0 |
| yeduc | Years of education |  | 10-20 |
| edu\_high | University degree |  | 1, 0 |
|  |  |  |  |
| employment | Full/half time/self employed |  | 1, 0 |
| siops0 /. isei0 | Occupational prestige |  | 0-xxx |
| migstat | Has migration background |  | 1, 0 |

* Scale HHinc per capita

Age of kid(s)

|  |  |  |  |
| --- | --- | --- | --- |
| hask\_agegroup1 | At least 1 child in agegroup 0-5 | Including childless = 0 | 1, 0 |
| hask\_agegroup2 | 6-10 |  | 1, 0 |
| hask\_agegroup3 | 11-14 |  | 1, 0 |
| hask\_agegroup4 | 15-18 |  | 1, 0 |
| hask\_agegroup5 | 19-30 |  | 1, 0 |
|  |  |  |  |
| nk\_agegroup1 | # of kids in group1 |  | x-x |
| nk\_agegroup2 |  |  | x-x |
| nk\_agegroup3 |  |  | x-x |
| nk\_agegroup4 |  |  | x-x |
| nk\_agegroup5 |  |  | x-x |

Alternative Agegroups: 0-2, 3-6, 7-13, 14-18, 19-25, 26-xxx

Relationship

|  |  |  |  |
| --- | --- | --- | --- |
| relyears | Relationship duration in years | Current relationship? | 0-30 |
| married\_cohab | Being married or at least cohabiting | VS Single or LAT | 1, 0 |
|  |  |  |  |

* Alleinerziehend!!! SEHR WICHTIG
* relationship quality

Lifestyle Factors

|  |  |  |  |
| --- | --- | --- | --- |
| smoking | Currently smoking |  | 1, 0 |
| nsmoking\_all | Intensity of smoking |  | x-x |
|  |  |  |  |
| alc\_often | drinking alcohol at least 3 times per week |  | 1, 0 |
| alc\_int | How often 5+ alcs / month |  | 1-6+ |
| sport1 | Sport at least once/week |  | 1,0 |
| friends1 | Seeing friends at least one/week |  | 1, 0 |
| sleep | Sleeping 6-8 hours per night |  | 1, 0 |
| weight\_high | People with high weight |  | 1, 0 |

Biological Factors

|  |  |  |  |
| --- | --- | --- | --- |
| nkidsnonbio | Non biological children |  | x-x |
| onek\_bfed | At least one kid breast fed |  | 1, 0 |
| nk\_bfed | Number of kids breast fed |  | x-x |
| fem | Gender of parent female |  | 1, 0 |

Prior health conditions / Genetics

|  |  |  |  |
| --- | --- | --- | --- |
| h\_childhood\_good | good or very good health during own childhood" |  | 0, 1 |
|  |  |  |  |

"

Family Policy

|  |  |  |  |
| --- | --- | --- | --- |
| east | currently living in east Germany |  | 1,0 |
| migstat | Migration background |  | 1, 0 |

Parenting Stress and Support

|  |  |  |  |
| --- | --- | --- | --- |
| parentstress | As a parent, worries, burden etc. |  | 1-50 |
| parentstress\_high | high levels of parent stress |  | 1, 0 |
|  |  |  |  |
| parentsupport\_partner\_high | above average support from partner |  | 1, 0 |
| parentsupport\_social\_high | above average support from others |  | 1, 0 |
| childcare\_sat\_avg | Average satisfaction with childcare situation for child 1-10 |  | 1-10 |
|  |  |  |  |
|  |  |  |  |

Make evry scale start at 0???!

Involuntary childlessness

* ? childless people and their attitude? Fertility plans?
* Infertility?
* Unsucessfull fertility treatments

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

Dead children / Physically disabled / special need children

Physical circumstances

Stress

* parent stress
* normal stress
* City / rural ??? (Großstädte über 100.000, städtische Kreise, Ländliche Kreise)

Migrationshintergrund Ja/Nein

Character Traits

Stress Handeling Abilities

Nutrition. for operationlization look for example at kendig 2007, page 1478Obesity / excessive weight gain = ??

The Will to fight disease as a parent

Short birth intervals and multiple births

""

Social Support / Contact from adult children

* having kids over 18 (yes/no)
* quality of relationship with that child / frequency of seeing each other
* regular face-to-face contact
* adult child still dependent on parents?
* Living distance in km

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

[Health factors 2](#_Toc44278237)

[Luftverschmutzung wichtiger als Gene: https://www.br.de/themen/wissen/luftverschmutzung-genaktivitaet-gene-feinstaub-stickoxid-100.html 8](#_Toc44278238)

[Childlessness / Parenthood 8](#_Toc44278239)

[Theory of social Role 10](#_Toc44278240)

[IDEAL NUMBER OF CHIDLREN 14](#_Toc44278241)

[Methods and Interaction Effects 14](#_Toc44278242)

[Covariates 14](#_Toc44278243)

[Parenting Support 15](#_Toc44278244)

[Gender of child 15](#_Toc44278245)

[Biological / Step / Adoptive Child 16](#_Toc44278246)

[Childhood health 🡪 adult health / childlessness 16](#_Toc44278247)

[Infertility 17](#_Toc44278248)

[Childhood Conditions /Education / MArriage🡪 adult health 17](#_Toc44278249)

[THEORIE 19](#_Toc44278250)

[Pivotal age at frist birth 19](#_Toc44278251)

[Theorie zu Life Course 20](#_Toc44278252)

[Nutrition 22](#_Toc44278253)

[Sport and Exercise 22](#_Toc44278254)

[Mental Health 22](#_Toc44278255)

[Studien zu High parity and worse health 23](#_Toc44278256)

[WOMEN! Vs MEN 24](#_Toc44278257)

[Social Context: the 1971-1973 Birth cohort 27](#_Toc44278258)

[EAST vs WEST 27](#_Toc44278259)

[Familienpolitik in Deutschland 32](#_Toc44278260)

[MIGRATION AND PARITY/HEALTH 32](#_Toc44278261)

[EINLEITUNG 33](#_Toc44278262)

[FAZIT 34](#_Toc44278263)

[SINGLE PARENTS 37](#_Toc44278264)

[“ 37](#_Toc44278265)

[STEPPARENTS 38](#_Toc44278266)

[RESTE 39](#_Toc44278267)

[ADULT CHILDREN 41](#_Toc44278268)

[EARLY FIRST BIRTH 41](#_Toc44278269)

[Late FIRST Birth / End of Womens Fertility Phase 44](#_Toc44278270)

[Critical/Sensitive Periods 46](#_Toc44278271)

[IDEAL TIME AT FIRST BIRTH 46](#_Toc44278272)

[IDEAL NUMBER OF CHIDLREN 46](#_Toc44278273)

[MARRIAGE AND HEALTH 46](#_Toc44278274)

[Single Mums 49](#_Toc44278275)

[Vocabular merhode / analyse 49](#_Toc44278276)

# Health factors

z.b. Gesundheitsfaktoren: RIECK

oder

A screenshot of a cell phone

Description automatically generated

<https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model?componentType=health-factor&componentId=12>

Die menschliche Gesundheit wird durch viele Faktoren beeinflusst. Neben den persön-lichen Lebensumständen, Verhaltensweisen und angeborenen Faktoren ist Gesundheit auch ein Resultat umweltpolitischen Handelns.

<https://www.umweltbundesamt.de/sites/default/files/medien/4031/publikationen/umid_umwelt_mensch-informationsdienst-01-2020_0.pdf> p.7

NUTRITION

<https://www.alliedacademies.org/articles/nutritional-complications-and-its-effects-on-human-health-9619.html>, Lap Tai Le and Joan Sabaté) maybe this is partly in the obesity variable, in the west people have a very imflammatory nutrition, 60% of our fiet is made from ultraprocessed food (corn wheat and soy) and the people who eat the most of it are the sickest<https://www.youtube.com/watch?v=kXF5S1QpoG4> bei 38:40 gut issues, diabetes, cancer alzheimers heart disease are all imflammatory dideases. For every 10% of your diet that is ultraprocessed, your risk of death goes up by 14%

SLEEP

!!! = ??? chrnoc sleep dperivation has systemwide effects, cncer cells grow faster the more sleep deprived you are, also tremendous effect on immune response against viruses. 30-40% der erwachsneen haben weniger als 7h schlaf am tag (laut medram corona virus #16)<https://www.cdc.gov/features/sleep/index.html> <https://www.cdc.gov/sleep/publications/publications-by-topic.html> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6400544/pdf/JEM_20181169.pdf> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3256323/pdf/424_2011_Article_1044.pdf>

SOEP

Education in years!? (A five fold classification of educational level (in the year of observation) distinguished those with compulsory (10 years of schooling); lower secondary (11e12 years); higher secondary (13 years); higher (14e17 years); and postgraduate education. The very small proportion (2%) with missing informa- tion on education were grouped into the lowest level category) Grundy 2010

They divided socioeconomic factors into ascribed (age, gender, race/ ethnicity) and achieved (education, occupational status, family income)

FAMILY LIFESTYLE

Marriage disruption / experienced divorce

Or: Marital status – never married / married / widowed / divorced (Current marital status distinguished four groups; the never- married, married, divorced, and widowed. The data do not allow identification of those in non-marital cohabiting unions )

PHYSICAL ENVIRONMENT

„The relationship between elevated air pollution (especially fine particulate matter and ozone) and compromised health has been well documented.[1,2] Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.[1] Long-term exposure to fine particulate matter increases premature death risk among people age 65 and older, even when exposure is at levels below the National Ambient Air Quality Standards.[2] These harmful particles can be directly emitted from sources such as forest fires, or they can form when gases emitted from power plants, industries and automobiles react in the air. Almost 65,000 premature US deaths were related to adverse effects of outdoor fine particulate matter, and minority populations and those living in poverty are more likely to be exposed.[3]“ <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/air-water-quality/air-pollution-particulate-matter>

Luftverschmutzung ist ein gravierendes Umweltproblem, das die Lebensqualität der Menschen direkt beeinträchtigt. Trotz nationaler und internationaler Umweltschutzmaßnahmen und sinkender Schadstoffemissionen nehmen die Gesundheitsschädigungen durch Luftverschmutzung in Städten weltweit zu. **Bis 2050 dürfte Luftverschmutzung zur wichtigsten umweltbedingten Ursache dafür werden, dass Menschen vorzeitig sterben.**Vor allem der Verkehr sowie private Holz- und Kohleöfen sind für die Schadstoffbelastung in städtischen Ballungszentren verantwortlich. Diese wiederum steht in Zusammenhang mit zahlreichen Gesundheitsproblemen, von leichten kurzfristigen Augenreizungen und Störungen der oberen Atemwege bis hin zu chronischen Atemwegserkrankungen, etwa Asthma, oder Herz-Kreislauf-Erkrankungen und Lungenkrebs. Einige dieser Krankheiten müssen stationär behandelt werden und können tödlich verlaufen. Für Kinder und ältere Menschen ist die Gefahr am größten.

Die OECD-Länder überwachen die Konzentration von **Feinstaub PM2.5 in der Luft.** Diese Schadstoffpartikel, die klein genug sind, um in die tiefsten Bereiche der Lunge vorzudringen, können gesundheitsschädlich sein und die Lebenserwartung verringern. In den vergangenen zwei Jahrzehnten **sind die PM2.5-Konzentrationen in vielen Stadtgebieten der OECD-Länder deutlich zurückgegangen. Trotzdem sind in etwa der Hälfte der Länder mehr als 90% der Bevölkerung einer Konzentration ausgesetzt, welche höher liegt als der von der Weltgesundheitsorganisation empfohlenen Richtwertes von 10 Mikrogramm pro Kubikmeter.** Im Durchschnitt liegen die PM2.5 Konzentrationen pro Kubikmeter bei 13,9 Mikrogrammen in den OECD-Ländern. Der *OECD-Umweltausblick bis 2050* prognostiziert, dass im Jahr 2050 weltweit etwa 3,5 Millionen Menschen an Feinstaub sterben werden, Anfang des Jahrtausends waren es noch etwas über eine Million.

**In Deutschland liegt die PM2.5-Konzentration bei 14,0 Mikrogramm pro Kubikmeter** und damit über dem OECD-Durchschnitt von 13,9 µg/m3 sowie dem von der Weltgesundheitsorganisation empfohlenen jährlichen Luftgüterichtwert von 10 µg/m3.

<http://www.oecdbetterlifeindex.org/de/topics/environment-de/>

The WHO sates that for higher income countries air pollution is the main environmental risk. 2,5% of deaths were attributed to urban outdoor pollution in 2004.

<https://read.oecd-ilibrary.org/environment/oecd-environmental-outlook-to-2050_9789264122246-en#page281> page 281

„The most serious types of outdoor air pollution for human health are airborne particulate matter (PM) and ground-level ozone” ebd. P 283

The effects of particulate matter and ozone can range from eye and respiratory irritation, inflamed airways, to cardiovascular disease, lung cancer and result in premature death. … The main sources of ground-öevel ozone and PM pollutanta are: The enry sector, transportation, household burning of coal and wood, animal husbandry and waste water treatment. P284-285

The concentration pf ozone and pm depend on the local emission of these pollutants and on their long-distance air travel ways.285

In general one can say that in Germany

“Nach Berechnungen des Umweltbundesamtes (UBA) können über 40.000 Todesfälle in 2015 in Deutschland auf die Feinstaubbelastung der Außenluft zurückgeführt werden (UBA 2016)” [https://www.umweltbundesamt.de/sites/default/files/medien/4031/publikationen/umid\_umwelt\_mensch-informationsdienst-01-2020\_0.pdf p.17](https://www.umweltbundesamt.de/sites/default/files/medien/4031/publikationen/umid_umwelt_mensch-informationsdienst-01-2020_0.pdf%20p.17) UBA – Umweltbundesamt (2016): Umwelt und Gesundheit systematisch untersucht. https://www.umweltbundesamt.de/themen/gesundheit/belas-tung-des-menschen-ermitteln/umweltbedingte-krank-heitslasten#textpart-1 (Zugriff am: 20.01.2020).

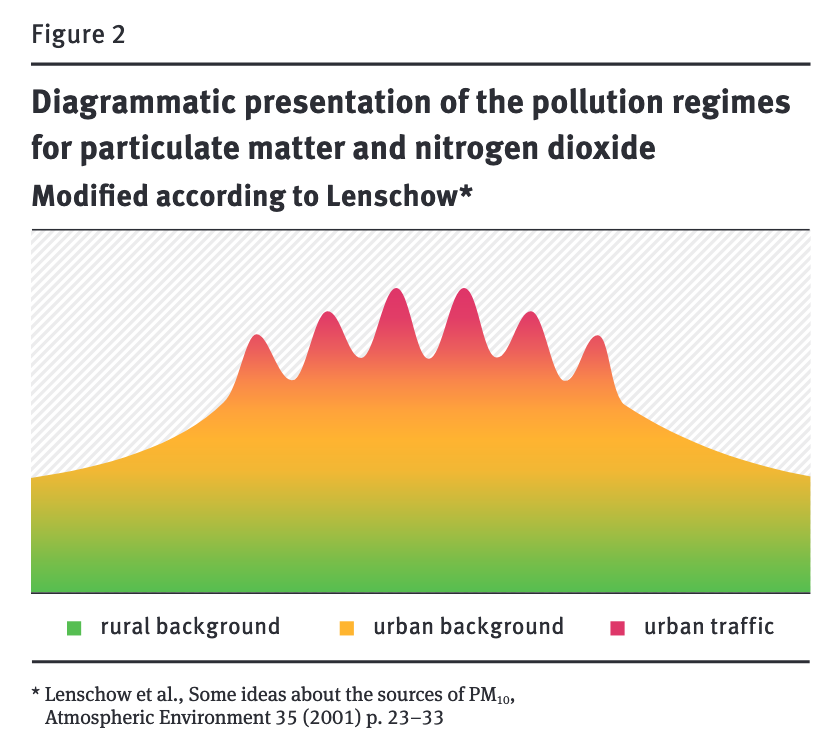
„Die Luftqualität wird deutschlandweit stündlich überwacht. Rund 99 Prozent der Daten stammen von Messstationen der Bundesländer, die der Überwachung der Luftqualität zum Schutz der menschlichen Gesundheit dienen. Im Umweltbundesamt (UBA) werden die aktuellen Messdaten von circa 400 automatischen Stationen zusammengeführt und stehen mit einer Verzögerung von einer Stunde via App und Luftdatenportal auf der UBA-Webseite zur Verfügung. Somit ist es überall und jederzeit möglich, sich über die aktuelle Luftqualität an einer Station der Wahl oder über die Gesamtsituation in Deutschland zu informieren. Die kostenlose und werbefreie Android- und iOS-App „Luftqualität“ des Umweltbundesamtes stellt stündlich Daten für die gesundheitsge-fährdenden Schadstoffe Feinstaub (PM10), Stickstoffdioxid und Ozon zur Verfügung. Ein Luftqualitätsindex informiert zudem auf einen Blick über die Luftqualität an jeder Station und gibt Gesundheitstipps für Aktivitäten im Freien. Auch der Empfang von Warnhinweisen kann aktiviert werden, um bei schlechter Luftqualität schnell infor-miert zu sein.

<https://www.umweltbundesamt.de/sites/default/files/medien/4031/publikationen/umid_umwelt_mensch-informationsdienst-01-2020_0.pdf> p.59“

„Air quality is monitored throughout Germany by the individual federal states and the UBA (German Envi-ronment Agency/Umweltbundesamt). In this respect, air quality is determined on the basis of the amount of air pollutants it contains, which means substances which have a harmful impact on human health and/or the environment. These include, primarily, particulate matter, nitrogen dioxide and ozone.“ “The pollutant concentrations in the air are measured several times a day at over 600 air monitoring stations throughout Germany” [https://www.umweltbundesamt.de/sites/default/files/medien/1410/publikationen/2020-03-20\_hgp\_air-quality-2019\_bf.pdf p.6](https://www.umweltbundesamt.de/sites/default/files/medien/1410/publikationen/2020-03-20_hgp_air-quality-2019_bf.pdf%20p.6)

„The primary sources of the air pollutants are road traffic and combustion processes in industry, the energy sector and households. Agriculture also contributes to particulate matter emissions... The degree of the pollution level is also influenced by the weather conditions.

In the following sections, the concentration values recorded at the individual air monitoring stations are summarised in the form of what are referred to as “pollution regimes”. Pollution regimes group air monitoring stations together with similar environ-mental conditions. The “rural background” regime relates to areas in which the air quality is largely uninfluenced by local emissions. The air monitoring stations in this regime therefore represent the regional pollution level, which is also referred to as the regional background. The “urban background” regime is characterised by areas in which the meas-ured pollutant concentrations can be seen as being typical for the air quality in the city. In this respect, the pollution results from emissions in the city itself (road traffic, heating systems, industry, etc.) and that in the regional background. The air monitoring stations in the “urban traffic” regime are typically located on busy roads. As a result of this, the urban background pollution is joined by a contribution which arises due to the direct road traffic emissions. Figure2 provides a diagrammatic representation of the contributions by the individual pollution regimes, although it only provides the approximate proportions. Another pollution regime relates to measurements in the vicinity of industrial areas, which are used to assess the contribution of indus-trial emissions to the air quality in nearby residential areas.“ p.7

p7

The limit value for the 24-hour PM10 value, which needs to be complied with since 2005, was for the first time not exceeded at any German monitoring station, i.e. none of the about 380 stations measured PM10 24-hour values over 50μg/m³ at more than 35 days in 2019. .....in 2019 the decreasing trend of the mean PM10 pollution continued. 2019 was the year with the lowest level of pollution compared to the considered period since 2000

A screenshot of a cell phone

Description automatically generatedp.8

Pollution is higher in urban areas (pm and no), but not when it comes to ground-level ozone

“The reason for the variation of the peak ozone concentration between the years is the high dependency on the weather conditions. In contrast to particulate matter and nitrogen dioxide, ozone is not emitted directly but formed from specific precursors (nitrogen oxides and volatile organic compounds) and with intensive solar radiation..... Figure13 shows that most cases in which the target values were exceeded occurred in rural areas – in contrast to pollutants such as particulate matter and nitrogen dioxide, which have the highest concentrations in the vicinity of roads, the ozone values in the vicinity of roads are a lot lower. Therefore, ozone is rarely measured at air monitoring stations in urban traffic locations

” p.16

„Air quality in Germany is monitored every hour. ... The app posts hourly updated data on harmful pollutants such as particulate matter (PM10), nitrogen dioxide and ozone. Furthermore, an air quality index (AQI) provides an instant view of the air quality at every station.“ p.20

„The air quality index provides an instant view of the air quality at every station. It is calculated using the measured concentrations of the three pollutants nitrogen dioxide, particulate matter (PM10) and ozone, with the concentration with the poorest individual result determining the total result of the AQI. The AQI is divided in five classes, from “very good” to “very poor” (Table 1). For every AQI class, there is an assessment about whether or not air pollution is harmful to health or if outdoor activities should be avoided (more information)“ p.21

More information: <https://www.umweltbundesamt.de/en/calculation-base-air-quality-index>

# Luftverschmutzung wichtiger als Gene: <https://www.br.de/themen/wissen/luftverschmutzung-genaktivitaet-gene-feinstaub-stickoxid-100.html>

# Childlessness / Parenthood

Hohe Kinderlosigkeit ist ein rein westdeutsches Phänomen: In den neuen Bundesländern sind in den Jahrgängen 1964–1968 11,8 Prozent und im früheren Bundesgebiet (jeweils ohne Berlin) 24,0 Prozent kinderlos

https://www.bmfsfj.de/blob/75090/7a1ebb08b6be4f49607ad3bdbefda302/geburten-und-geburtenverhalten-in-d-data.pdf

Ergebnisse.Frauen der Jahrgänge 1965–1969, die in Deutschland leben, sind zu 21 % kin-derlos und haben im Durchschnitt 1,57 Kinder. Endgültige Kinderlosigkeit ist meistensungeplant und hat primär gesellschaftliche Gründe: Lediglich 6–8 % der jungen Frauenmöchten dauerhaft ohne eigene Kinder leben, unter 4–5 % sind lebenslang infertil. BeiAkademikerinnen und in westdeutschen Großstädten ist die Kinderlosigkeit besondershoch, trotzdem ist der Kinderwunsch bei diesen Frauen nicht geringer. Der Anteil vonErstgeburten nach dem 35. Geburtstag ist in den letzten 10 Jahren um über 40 % gestiegen.Bemerkenswert ist das Ausmaß von spätgebärenden Akademikerinnen.Schlussfolgerung.Die Hauptursache der hohen Kinderlosigkeit liegt in der Zunahme an Le-bensoptionen in Beruf, Freizeit und Partnerschaft sowie brüchigen Erwerbs- und Partner-biographien. Dadurch verschiebt sich die Realisierung des Kinderwunsches oft in ein Al-ter, in dem die Fruchtbarkeit nachlässt. Diese Entwicklung erhöht den Anteil von Risi-koschwangerschaften und die Nachfrage von Frauen ab Mitte 30 nach Kinderwunschbe-handlungen.

<https://www.bib.bund.de/Publikation/2016/pdf/Wie-stark-nehmen-Kinderlosigkeit-und-spaete-Geburten-zu.pdf?__blob=publicationFile&v=2>

Die größten Unterschiede zeigen sich bei der Kinderlosigkeit, während diedurchschnittliche Kinderzahl pro Mutter weniger variiert und meistens bei ca. 2 liegt. Die Stadt-Land-Differenzen sind enorm: In Großstädten ist die Kinderlosigkeit fast doppelt so hoch wie inländlichen Kreisen. Aber auch in Ostdeutschland, bei Migrantinnen, in der Ehe und bei Frauenmit niedrigerem Bildungsabschluss ist die Kinderlosigkeit deutlich niedriger als in der jeweiligenReferenzgruppe. Verheiratete Frauen in ländlichen Kreisen sind nur zu 8,4 % kinderlos, bei Aka-demikerinnen in einer westdeutschen Großstadt sind es mit 35,2 % mehr als 4-mal so viele. DieKinderzahl pro Mutter ist in Ostdeutschland geringer, hier sind Einkindfamilien stärker verbreitet.Generell haben Mütter mit niedriger Bildung am meisten Kinder – durchschnittlich 2,38. Bezogenauf alle Frauen ist bemerkenswert, dass selbst die Gruppen mit der höchsten Geburtenrate –Migrantinnen und niedrig Gebildete – im Durchschnitt weniger als 2 Kinder haben.

(Bujard and Diabaté 2016 p.396)

Kinderlosigkeit.Tatsächlichliegtdie Kinderlosigkeitbeiden1960er-Frauenjahrgängenbei19,7 %,diehöchstehatder1969er-Jahrgangmit22,1 %.BeiAkademikerinnenistdieKinderlosigkeitv.a.inWestdeutschland hoch: Bei den in den 1960er-Jahren geborenen Frauen mit Hochschulabschlussliegt die Kinderlosigkeit bei 29,1 %. Ihr langjähriger Anstieg ist jedoch inzwischen gestoppt [9].

(Bujard and Diabaté 2016 p.395).

MEHR SEHR GUTE ZUSAMMENFASSUNG ZU KINDERLOSIGKEIT: BUjard und Diabete 397ff.

Ursachen von KinderlosigkeitDie hohe Kinderlosigkeit hat sehr unterschiedliche Ursachen: Infertilität, fehlender Kinderwunschund perpetuierender Aufschub der Familiengründung aufgrund der Rahmenbedingungen. Dabeigibt es zwischen diesen GründenInteraktionen: Erstens kann sich der Kinderwunsch im Lebens-verlauf im Kontext von Erfahrungen und Rahmenbedingungen verändern. Zweitens reduziert sichdie Fruchtbarkeit mit zunehmendem Alter der Frau, sodass ein Aufschub des Kinderwunschesauf das Alter von 35 oder 40 Jahren dazu führen kann, dass Frauen aufgrund von Infertilitätdauerhaft kinderlos bleiben [11].InfertilitätZum Teil lassen sich die Ursachen trotzdem quantifizieren: Während die Punktprävalenz vonInfertilität bezogen auf 12 Monate einen Mittelwert von 9 % (Spannbreite: 3,5–16,7 %) hat [12],ist der Anteil von Frauen mit lebenslanger Infertilität deutlich niedriger, einige Autoren nennen5%[13]. Gruppenspezifische Analysen zeigen, dass der Anteil kinderloser Frauen in bestimmtenBevölkerungsgruppen nur bei 4–6 % liegt [9]. Insofern dürfte der Anteil von Frauen, die imgesamten Leben infertil sind, unterhalb der Spanne von 4–5 % liegen. Demnach sind die Ursachender hohen Kinderlosigkeit in Deutschland primär auf motivationale und gesellschaftliche Faktorenzurückzuführen.Fehlender KinderwunschIn mehreren Studien werden Kinderwünsche erhoben. Die Vergleichbarkeit ist allerdings schwie-rig, da sich neben den befragten Altersgruppen auch die Messkonzepte unterscheiden: Zumeinen danach, ob der Kinderwunsch allgemein oder bezüglich einerHandlungsabsicht(z. B.im Generation and Gender Survey [GGS] innerhalb der nächsten 3 Jahre) erfragt wird. Zumanderen, ob nach dem realen oder dem idealen Kinderwunsch gefragt wird. Das Beziehungs-und Familienpanel pairfam („Panel Analysis of Intimate Relationships and Family Dynamics“)operationalisiert denidealen Kinderwunschdurch die Frage „Wenn Sie einmal alle Hindernisseaußer Acht lassen“. Hier liegt der Anteil von Frauen zwischen 15 und 37 Jahren, die lebenslangkinderlos bleiben möchten, bei 6,6 % [14]. Zudem zeigen die Eurobarometerdaten von 2011, dasssich der Anteil je nach Alter erheblich unterscheidet: Bei 15- bis 24-jährigen Frauen geben 4 %an, ihre persönliche ideale Kinderzahl sei null, bei 25- bis 39-Jährigen sind es 8 %, bei 40- bis55-Jährigen 4 % und bei über 55-Jährigen 2 % [15].

Da sich die Kinderlosenquote zwischen gesellschaftlichen Gruppen erheblich unterscheidet,wird im Folgenden geprüft, inwieweit dies auch für die Kinderwünsche gilt. Dafür wird dieStudie Familienleitbilder (FLB 2012) analysiert, bei der 5000 Personen im Alter von 20 bis39 Jahren in Deutschland befragt wurden. Die Daten zeigen den Anteil an allen Frauen bzw.Männern an, die kinderlos sind und keinen Kinderwunsch haben (.Tab.2). Zunächst zeigensichsignifikante Geschlechtsunterschiede, Männer ab 30 sind etwas häufiger ohne Kinderwunschals gleichaltrige Frauen. Die Wahrscheinlichkeit gewollter Kinderlosigkeit nimmt generell mitaufsteigender formaler Bildung ab, bei Männern ist dieser Trend deutlich stärker.Die geringe Zahl von jungen Erwachsenen ohne Kinderwunsch belegt die Bedeutung einereigenen Familie: Die überwiegende Mehrheit, 85 % der 20- bis 39-Jährigen (FLB 2012), erachtet esals sehr wichtig oder wichtig, eigene Kinder zu haben. Nur für einen sehr kleinen Teil der jüngerenBevölkerung ist dies unwichtig. Hinsichtlich des Kinderwunsches existieren keine Unterschiedezwischen alten und neuen Bundesländern. Deutliche Einstellungsunterschiede, die seit Jahrenin diversen Studien repliziert wurden, finden sich hinsichtlich des Geschlechts: Junge Frauenhaben mit 62 % im Vergleich zu gleichaltrigen Männern (45 %) signifikant häufiger einen starkausgeprägten Kinderwunsch.

(Bujard and Diabaté 2016 p.397).

A screenshot of a cell phone

Description automatically generated

(Bujard and Diabaté 2016 p.395).

A screenshot of a cell phone

Description automatically generated

(Bujard and Diabaté 2016 p.397).

Kinderlosigkeit beruht auf einem Zusammenspiel von kulturellen, strukturellen, ökonomischenund partnerschaftsbezogenen Faktoren, die zu einem Aufschub des Kinderwunsches geführthaben, der letztlich häufig in nichtintendierter Kinderlosigkeit resultiert.Eine kulturelle Ursache ist der Wertewandel, der auf säkularen und emanzipatorischen Pfei-lern aufbaut und Selbstverwirklichung sowiepersönliche Freiheitin den Mittelpunkt stellt. ImZuge dieses Prozesses haben sich seit den 1960er-Jahren die Einstellungen gegenüber Sexualität,Partnerschaft, Ehe und Familie fundamental geändert [16]. Ein Zusammenleben mit Partner oh-ne Heirat oder Kinderkriegen wurde normaler Bestandteil des Lebenslaufs und Kinderlosigkeitzunehmend sozial akzeptiert. Gleichzeitig haben sich die Ansprüche an Elternschaft zunehmenderhöht. Beispielsweise sind 84 % der 20- bis 39-Jährigen der Ansicht, dass Eltern bei der Erziehungvieles falsch machen können. Demgegenüber stehen gerade mal 10 %, die der Ansicht sind, dassKinder „von allein“ groß werden [17]. Es wird ein starker sozialer Druck innerhalb der Gesellschaftwahrgenommen, dass Eltern „perfekt“ sein müssen [18].Strukturelle Gründe liegen in der sprunghaft gestiegenen Beteiligung von Frauen am Bildungs-system und Arbeitsmarkt. Für die heutige Frauengeneration ist es selbstverständlich, erwerbstätigzu sein. Auch haben sich die Möglichkeiten in der Freizeit, von Reisen und bei der Partnerwahlerhöht, insbesondere in Großstädten. Die Entscheidung für ein Kind reduziert viele dieser neugewonnenen Optionen. Je größer die Optionen, desto höher ist die Kinderlosigkeit; dies erklärtauch die hohe Kinderlosigkeit bei Akademikerinnen und in Großstädten. Wenn zusätzlich dieVereinbarkeit von Beruf und Familie durch eine aufPräsenzkulturbasierende Arbeitswelt unddurchmangelnde(qualitativhochwertigeundbezahlbare)Ganztagsbetreuungsangeboteerschwertwerden, stehen insbesondere hochgebildete Frauen faktisch vor der Wahl zwischen Karriere undKindern.Ökonomisch lässt sich die Kinderlosigkeit durch die gestiegenen Opportunitätskosten vonKindern bei Frauen erklären [19], die sich mit höherer Bildung und in wissensbasierten Arbeits-märkten maximieren. Zudem kumulieren sie sich dynamisch im Lebenslauf, da familienbedingteErwerbspausen undTeilzeitarbeitdie Gehaltsentwicklung erheblich bremsen. Die Erwerbspausenreduzieren zudem das spätere Rentenniveau von Frauen, zumal sich dieses nur geringfügig ander Erziehung von Kindern, sondern primär an der Erwerbsbiographie orientiert. Dazu kommtdas Phänomen, dass der berufliche Einstieg für die junge Generation mit vielen Unsicherheitenbehaftet ist und sich die berufliche Etablierung in ein immer späteres Lebensalter verschiebt [20]

(Bujard and Diabaté 2016 p.397).

WEST GERMANY: Frauen ohne Abschluss sind zu 18,2 Prozent kinderlos. Das ist auch im internationalen Vergleich ein relativ hoher Wert, der aber deut- lich niedriger ist als der Anteil von 30,9 Prozent bei den Hochqualifizierten. {Dorbritz:2014vc p.256}

Childlessness here is used in its demographic sense describing people who don’t have any own biological children but might have step-, foster or adopted children.

🡪 exclude all foster and step children!!! Sind eh nur wenige!

Israeli researchers found the nulliparous middle-aged women showed overall highest mortality risks compared to older age groups in Israel {Jaffe:2009jc}.

In the U.K and in Austria the excess mortality of childless women compared to women with one or two children is 15 percent {Doblhammer:2000cg p.171}

The excess mortality

of childless women compared to women with one

or two children peaks before age sixty and then

decreases with age. Doblhammer:2000cg 172

9 Albrektsen G, Heuch I, Tretli S, et al. Breast cancer incidence before age 55 in relation to parity and age at first and last births: a prospective study of one million Norwegian women. Epidemiology 1994;5:604–11.

On the downside (certain patterns of) child rearing can raise psychological and economical stress levels, with higher chances of exhaustion and depression {Grundy:2007kz p.271}.

young women facing infertility and older unmarried men

successful career oriented women who delay childbearing until it is too late to have children and then experience distress (Hewlett, 2002).

Koropeckyj-Cox (2002) found that, among the childless (age 50 – 84), negative attitudes toward childlessness were associated with lower levels of well-being (more loneliness and depression),

The Significance of Parenthood and ChildlessnessResearch on families and intergenerational relationships has emphasized the central importance of parenthood, generally equating normative parenthood with biological procreation (see Dykstra & Hagestad, 2007). From a structural-functionalist perspective, parenthood represents a unique relationship that serves as a resource for emotional and instrumental support in midlife and old age and as a buffer against negative stressors (e.g., Bengtson, Rosenthal, & Burton, 1996; Silverstein & Bengtson, 1991).

Culturally and symbolically, parenthood (particularly biological parenthood) is characterized as a normative life experience and social role as well as a source of gratification, close emotional bonds, and the passing of genes and values to the next generation (Connidis, 2001; Morgan & King, 2001; Schoen, Kim, Nathanson, Fields, & Astone, 1997).

Older parents who find themselves functionally or de facto childless because their adult children are absent, unavailable, or no longer living may represent an especially vulnerable but invisible group (Kreager, 2004; Rubinstein, 1987).The life histories of biologically childless adults are also varied (Dykstra & Hagestad, 2007; Kreager, 2004). As marriage has been the traditional prerequisite and expected context for childbearing, the odds of remaining childless among older cohorts have been largely determined by marital history (i.e., never marrying, marrying relatively late, or experiencing marital disruption; Hagestad & Call, 2007).

PARENTHOOD AND OBESITY

Our results suggest that parenthood (compared to childlessness), age at ﬁrst birth, and living with an adult child have similar effects on men and women. Parents gain weight at a more rapid rate than nonparents and, among parents, younger and older age at ﬁrst birth are associated with increasingly accelerated weight gain (with the most stable weight trajectories occurring for ﬁrst birth at around age 27), and living with an adult child is associated with higher baseline body weight. In contrast, parity is positively associated with baseline body weight, with greater effects on women than men, perhaps reﬂecting biological as well as social consequences of multiparous parenthood for women’s weight gain (Weng et al., 2004). Yet living with minor children and having independent adult children is associated with heavier baseline weight only for men. These ﬁndings demonstrate the potential power of parental contexts to have biological consequences (reﬂected in body weight) for men as well as for women. Taken together, the ﬁndings from this study support the concept of “embodiment,” deﬁned as “the sculpting of internal biological systems that occurs as a result of prolonged exposure to particular environments” (Glass & McAtee, 2006: 1655). Our results suggest that it is not the transition into a particular parental status that suddenly reshapes weight trajectories, rather, parenthood seems to shape a long-term, gradual, and cumulative pattern of weight gain and in somewhat different ways for men and women. Moreover, ﬁndings suggest greater weight stability for childless men and women. Weight stability is better for health than is ﬂuctuating or increasing weight (Adams & Schoenborn, 2006), thus, our ﬁndings correspond to recent research showing that childlessness seems to have few costs for long-term health and may even have some beneﬁts (Umberson et al., 2010). Degree of exposure to particular social contexts increases the cumulative effect of those contexts (Glass & McAtee, 2006; House et al., 1994). Certainly, “exposure” associated with parenthood is substantial in societies where parents and children typically live together until children are young adults and often much longer. Moreover, parents and adult children tend to remain closely involved with one another throughout life, even after children (Umberson et al., 2011) p.1329

Recentworkdemonstratesthatobesityrisk“spreads”across social networks regardless of geographicproximity and social distance (i.e., closer network relatedness)trumps geographic distance in promoting the spread of obesityacross networks (Christakis & Fowler, 2007). Parenthood introducessocial constraints and demands that are long-term, difficult toavoid,and have lasting, as well as cumulative, effects on parents’weight.Additionally, given the intergenerational transmission of over-weight and obesity (Jacobson, Torgerson, Sjöström, & Bouchard,2007), family contexts that contribute to parents’weight gain mayalso foster long-term weight gain in their children.Family scholars suggest several reasons that parenthood wouldaffect weight trajectories. We analyzed some of these possibilitiesincluding smoking, physical activity levels,financial stress, andpsychological distress, but these explanatory mechanisms did notexplain the effects of parenthood on weight gain. Future researchshould consider potential mediators that are tied to parenthood,having minor children in the home, parity, and early or latefirstbirth. This work should investigate the interplay of social, psycho-logical, behavioral, and biological processes underlying patterns ofweight gain associated with family contexts and how they differ formen and women. This research is needed in order to betterunderstandhowfamily contexts promote weight gain across socialgroups.

In sum, parenthood appears to steepen trajectories of weight gain for both men and women, particularly for those who become parents relatively early or late in the life course. Certain aspects of parenthood seem to have greater implications for women’s weight patterns and others for men’s and this may result from differences in the impact of parenthood on the social contexts of men and women. Long term, cumulative aspects of parenthood appear to be an operative factor in fostering and sustaining weight gain over time, although the precise mechanisms through which this occurs remain uncertain. These ﬁndings add to a growing body of evidence that family contexts inﬂuence body weight. Our results suggest that social conditions associated with parenthood may contribute to long-term risk for weight gain. Given that even small changes in weight are associated with increased risk for morbidity and mortality (Breeze et al., 2006), and the intergenerational transmission of overweight and obesity (Jacobson et al., 2007), social scientists should further explore how family contexts inﬂuence weight change of all family members throughout the life course. (Umberson et al., 2011) p.1330

# Theory of social Role

The develop- ment of social role and self theories belongs in this tra- dition, and features the writings of sociologist Robert Merton on role sets and reference groups (1968), Morris Rosenberg (1979) on self-esteem, and Urie Bronfen- brenner on socialization (1970), to name a few. (Elder Shanahan 2006: 669-670)

The second column of Figure 12.1 refers to how an indi- vidual’s life pattern is structured by multiple role se- quences and their transitions. These transitions into and out of social roles across the life span entail both social and personal changes in status and identity (Glaser & Strauss, 1971). In their field studies, anthropologists have referred to a patterned role sequence from birth to death as a “life cycle” (Kertzer & Keith, 1984). Changes in major roles, such as from youth to marriage and parenthood, generally represent changes in a social stage across the life cycle. In concept, the life cycle views life organization through social relationships, particularly kin relation- ships, and generational succession. A dominant concept of the life span from the early 1900s up to the 1960s, life cycle generally referred to a sequence of social roles among individuals and families. A more precise social meaning of life cycle is a sequence of stages in parent- ing, from the birth of children through their departure from the home to their own children. The role sequence refers to a reproductive process that always applies to human populations. In a life cycle of generational suc- cession, newborns are socialized to maturity, give birth to the next generation, grow old, and die. The “cycle” is repeated from one generation to the next in a human population (O’Rand & Krecker, 1990). Life cycles as reproductive cycles vary greatly in the pace of their revolutions. Early childbearing, shortly after menarche, accelerates the cycle and shortens the distance between the generations. When the eldest daughter has a child before the age of 13, her mother may become a grandmother before the age of 30 and a great-grandmother before the age of 50. A sequence of early childbearing across the generations weakens the generational and age basis for family authority and social control. By contrast, late childbearing slows the cycle and minimizes age similarities across adjacent generations. In a rapidly changing world, parents, grandparents, and children share less culture and his- torical experience.

The life cycle concept incorporates both socializa- tion and social control processes. The predominant roles of a life stage lock people into a set of normative expec- tations and informal sanctions that provide direction and discipline. Commitments to a line of action arise over time through obligations to significant others (Becker, 1961, 1964). Stable role relationships ensure a measure of personal stability, just as entry into such re- lationships can stabilize a person’s life and minimize involvement in unconventional and dangerous activities. Sampson and Laub (1993) observed, in their sample of men from a low-income urban sample, that adult bonds to conventional figures and lines of activity defined a route of escape from delinquency for a substantial num- ber of men with a childhood history of delinquency and economic disadvantage.

During the familistic post-World War II years, the life cycle became well known as the *family cycle* through the writings of Paul Glick and Reuben Hill; a set of or- dered stages of parenthood defined primarily by varia- tions in family composition and size (Elder, 1978). Major transition points included courtship, engagement, marriage, birth of the first and last child, the children’s transitions in school, departure of the eldest and youngest child from the home, and marital dissolution through the death of one spouse. Family life in this era provided a better fit to this sequence of roles than it does today. Marriage and parenting have been uncoupled to a considerable extent (Bumpass & Lu, 2000). Children are increasingly born prior to marriage or outside of mar- riage altogether. In the United States, the prevalence of divorce has led to multiple families in a person’s life and to the likelihood that most children will experience a single parent household before they enter adulthood.

The life-cycle concept and its family-cycle version usefully knit together the full array of life stages and generations. They also provide insight into processes of socialization and social control over the life span that link the developing person and his or her career. And yet, the life cycle’s focus on reproduction and parenting has limited value as a way of viewing the lives and de- velopmental trajectories of children and adults because it does not apply to never married, nonparent, or di- vorced persons, all of whom have become increasingly common (e.g., Fussell, 2002). The focus on a single ca-

(Elder Shanahan 2006: 672)

reer also ignores the realities of multiple careers, and each person generally occupies multiple roles at the same time (whether spouse and parent or spouse and employee), but these concurrent roles are not part of the life cycle’s scope. Consequently, the life or family cycle did not orient research to the management or coor- dination of multiple roles such as marriage and work. By the end of the 1960s, a prime era for life-cycle re- search, a survey by Young and Willmott (1973) con- cluded that studies of work and family had proceeded along separate paths with no significant effort to exam- ine their interdependencies. This contrasts rather strik- ingly today with the flourishing study (with an emphasis on interlocking trajectories) of work and family relations (Blair-Loy, 2003; Crouter, Maguire, Helms-Erikson, & McHale, 1999; Drobnic, Blossfeld, & Rohwer, 1999; Moen, 2003; van der Lippe & van Dijk, 2002).

On the contrary, the evi- dence suggests that timing matters because social timetables, age norms, and age-graded sanctions influ- ence individuals.

(Elder Shanahan 2006: 673)

Also read:

Childlessness is good for:

Childlessness is bad for:

young women facing infertility and older unmarried men

successful career oriented women who delay childbearing until it is too late to have children and then experience distress (Hewlett, 2002).

Koropeckyj-Cox (2002) found that, among the childless (age 50 – 84), negative attitudes toward childlessness were associated with lower levels of well-being (more loneliness and depression),

Divorced, widowed, and never married men who were childless hadsignificantly higher rates of loneliness compared with women in comparable circumstances; divorced and widowed menwho were childless also had significantly higher rates of depression than divorced and widowed women. (Zhang)

Parenthood is good for:

Parenthood is bad:

Koropeckyj-Cox (2002) found that among parents, worse than expected relationships with adult children were associated with lower well-being

Parenthood Fathers Resdient / Nonresident

Overall, the evidence indicates that the transition to parenthood and the addition of subsequent children primarily transform the organization of men’s lives, especially when they become coresident fathers. Men making the transition to parenthood are most likely to be affected. Fatherhood encourages men to increase intergener- ational and extended family interactions, participation in service-oriented activities, and hours in paid labor—at the expense of spending time socializing. {Knoester:2016fs p.1532}

Social support may affect health through social pathways for ex. Encouragement of appropriate health behaviours may improve health, or it may lower stress and have beneficial physiological effects (Crimmins and Seemann 2004){Henretta:2007eh p.255}

Yet there is reason to believe that fatherhood transforms men’s lives inways that are functional for society. Fathers exhibit more intergenerational andextended family interactions, more frequent involvement in service-orientedactivities, and a greater attachment to the labor force than do nonfathers. Theseassociations are most pronounced for men who live with their own childrenand are involved in their children’s lives (Eggebeen & Knoester, 2001). Tus fathering behaviors may be important not only for their effects on children butalso for their effects on men’s lives {Knoester:2016fs p.1533}

First, the transition to parenthood and subse-quent children may influence men’s psychological and physical health. Onone hand, it is posited that happiness, subjective well-being, and life satisfac-tion will increase among men who become fathers because these aspects ofpsychological well-being are more rooted in the family roles of men than intheir work roles (Pleck, 1985). Furthermore, like marriage (Nock, 1998),fatherhood may civilize men by reducing their involvement in such riskybehaviors as smoking, drinking, drug use, and dangerous hobbies. {Knoester:2016fs p.1535}

On the other hand, fatherhood may have negative effects on men’s feelingsof well-being. Men may become distressed as they adapt to new responsibilities,expectations, and changes in the quality of romantic relationships after the tran-sition to fatherhood (Belsky & Pensky, 1988; Cowan & Cowan, 1992, 1995). Also, recent studiesreport that the transition to parenthood is associated with small declines inmen’s feelings of well-being (Nomaguchi & Milkie, 2003; Woo & Raley,2005). Therefore, we expect the arrival of new children to have small, neg-ative effects on men’s psychological and physical health.

{Knoester:2016fs p.1536}

men may increase their hours in paid laboras they seek to fulfill the needs of their children (Christiansen & Palkovitz,2001). Indeed, fathers evidence greater attachment to the labor force thando nonfathers (Eggebeen & Knoester, 2001; Kaufman & Uhlenberg, 2000;Waldfogel, 1998),

Overall, a transformative perspective of the effects of fatherhood sug-gests that the largest differences in well-being and behaviors should bebetween having and not having children and not among the various types offathers such as fathers living with their own children, stepfathers, nonresi-dent fathers, or fathers of adult children. In other words, once men haveexperienced the challenges and opportunities that fatherhood provides, theyare different in ways that carry forward, even after their fathering experi-ences have attenuated or ended.In addition, this perspective implies that the transition to parenthoodmay be most likely to transform men’s well-being and behaviors, but sub-sequent children may enhance these effects. Each child provides opportu-nities and challenges to one’s self.

{Knoester:2016fs p.1537}

However, when men donot actively occupy fathering roles, the arrival of new children may produceminimal, if any, effects on their lives. One extension of a role occupancy perspective is that fatherhood willhave its most profound effect on men who live with their children. The ideais that fatherhood affects men primarily when its roles are clearly occupied.In situations where role uncertainty may exist or there are structural chal-lenges to embracing fathering roles—such as stepfather or nonresidentfather—the salience of fatherhood roles may be diminished. Subsequently,the experiences of fatherhood may have a lesser impact on men’s lives inthese situations. A role occupancy explanation is consistent with the literature showingthat men’s involvement with their children declines when they are not liv-ing with them and the literature showing that men’s involvement withnonresident children declines even further when men remarry (Amato &Rivera, 1999; King & Heard, 1999). As a result, this perspective predictsthat the strongest effects of fatherhood occur among coresident fathers,whereas nonresident fathers are less likely to experience changes in theirlives. Instead, nonresident fathers are more like nonfathers in their feelingsof well-being, family interactions, social connections, and work behaviors.Of course, the effects of fatherhood roles on men’s lives are moderated bythe degree to which men embrace fathering roles.

{Knoester:2016fs p.1538}

Having at least two new coresident children significantly decreases men’s social activities (*b* –.30, *p* .05). A new nonresident child is associated with increases in men’s feel- ingsofdepression(*b* .27,*p*.05). The magnitude of these effects is relatively small yet significant.

{Knoester:2016fs p.1546}

as their children age, fathers report slight increases in life satis- faction, socializing, family interaction, and the amount of support that they provide to other family members. The effects of a new child are not signifi- cantly altered by controlling for the age of men’s youngest child. Thus, the addition of a new child—not simply the presence of a young child—seems to affect men’s lives. However, these results also provide modest evidence that the effects of the transition to parenthood and subsequent children may be somewhat tempo- rary in that the effects may manifest themselves differently as men and their children develop.

{Knoester:2016fs p.1553}

Background characteristics and changes in men’s lives may affect entry into parenthood, the addition of subsequent children, and men’s well-being and behaviors. Background characteristics that may be associated with the addition of new children and men’s health, interactions with adult and extended family, social connections, and work behaviors include men’s age, education, race, number of children, family income, marital status, and father- hood status (Eggebeen, 2002; Eggebeen & Knoester, 2001; Schoen, Astone, Kim, & Nathanson, 1999). Thus, we also consider the influence of changes in educational achievement, family income, marital status, and fatherhood status in this study. {Knoester:2016fs p.1540}

# IDEAL NUMBER OF CHIDLREN

When asked about the ideal number of children, 53% of allrespondents stated the wish of having two children; 9.5% con-sidered it ideal to have no children. Contrasting the actual andthe ideal numbers of children (Table III) about half of allrespondents who considered one child as ideal, have made thisideal wish become a reality, but only 38% of those whoregarded two children as ideal, actually had two children. STÖBEL RICHTER 2005 2851

# Methods and Interaction Effects

“Tests for interaction by age group showed that the shape of the effect significantly differed among men (P \ 0.001), but not women. An interaction effect for parity 9 educa- tion or parity 9 origin was not significant. ” (Jaffe 2009)

A risk or protective factor mediates the association between exposure and disease when it chronologically follows the exposure and is conceptualised as lying, at least partly, on the causal pathway.

Life course epidemiology requires an explicit temporal theoretical model that distinguishes between mediating factors (post-exposure of interest) and confound- ing factors (conceptualised as prior to and/or tangential to understanding the effects of the exposure of interest). {Kuh:2003vb p.780}.

A risk or protective factor modifies the association between an exposure and disease when the causal effect of the exposure of interest differs across levels of the modifying factor. Investigation of modifying factors provides information about the nature of the causal process. Effect modification is known as interaction—‘‘synergism’’ if the modifying variable enhances the effect of the explanatory variable or ‘‘antagonism’’ if it diminishes it. Interactions are thought to be common features of life course processes and should be investigated where plausible biological, behavioural or social hypotheses exist. Well defined theoretical life course models are needed to interpret the biological or social significance of observed interactions. Empirical assessment of interaction is the source of much debate in epidemiology and needs to be carefully considered in terms of additive or multiplicative risk models.51 53 {Kuh:2003vb p.780}.

# Covariates

Mediators follow the exposure and lie, at least partly, chronologically on the causal pathway between exposure and health outcome, like a partnership disruption, that can influence health very significantly. Confounding factors are located prior to the exposure, like childhood circumstances, and can affect exposure as well as outcome {Kuh:2003vb p.780}.

There is a myriad of these factors that either protect or risk health and they need to be controlled when approaching the association between fertility and health. They will in the following be referred to as simply co-variates.

Early life influences are broadly classified as environmental influences, family influences, and adolescent social and economic circumstances. Region of birth (measured as South versus non- South) is used as a fixed covariate reflecting broad differences in life circumstances. Regional differences in the 1920s and 1930s were important in the extent of urban and industrial development, poverty, education, and disease (cf. Odum, 1936). In addition, Southern birth in this era for blacks marks exposure to the expe- rience of de jure racial segregation, an apartheid system that only began to be dissolved in the 1950s (Woodward, 2002). Infant mortality rates around the time of birth are generally considered a good indicator of the disease and nutritional environment and have been shown to relate with old age mortality (Bengtsson & Lindstrom, 2000, 2003). We consider the median infant mortality rate of the region of birth (South versus non-South) during the year of birth. In addition, we consider national maternal mortality rates in the year of birth, which reflect both the disease environment and the level of maternal/infant health care. Earlier analyses included indicators of 5-year birth cohorts in various comparisons. However, these measures did not uniquely contribute to the analysis and are excluded from the models presented here. Family influences are tapped by examining mother’s education (8th grade or less versus 9þ) as an indicator of early life socioeconomic status and as a proxy for access to nutrition and prenatal care. Adolescent social and economic characteristics come from retro- spective data collected in the baseline interview on the respondent’s family of origin when she was 15 years of age. We use data on family structure (two-parent versus other), type of residence (rural versus other), and mother’s employment (employed versus not).

Educational attainment is a time-invariant covariate measured at baseline in 1967, after which very few women experienced addi- tional schooling. Educational attainment is measured as a series of dummy variables for 1) less than high school, 2) some high school but did not graduate, and 3) high school graduate, compared to women with college education or more.

Adult social, economic, and health characteristics include respondent’s family income (in logged 1983 dollars), employment status (working for pay 1⁄4 1, not 1⁄4 0), housing tenure (respondent owns home 1⁄4 1, does not own home 1⁄4 0), and marital status (never married, widowed, and divorced or separated, with married as the reference category). We also include a dichotomous indicator of region of residence (South 1⁄4 1, non-South 1⁄4 0). Each of these char- acteristics is measured at baseline in 1967 (ages 30–44) to reflect circumstances during prime adulthood and also as a time-varying covariate during the post-reproductive period drawing on data collected between 1982 and 2001.

Health during prime adulthood and the post-reproductive years is controlled in these analyses by the inclusion of a dummy variable for self-rated health at each life course stage. Women were asked ‘‘Would you rate your health, compared with other women about your age, as excellent, good, fair, or poor?’’ Responses were dichotomized into excellent/good and fair/poor with the latter as the reference group. This question was fielded in 1967 and then not again until 1986. Therefore, we include an indicator for ‘‘data not available’’ to account for the gap in data collection during the post- reproductive period.

(SPENCE 2009)

We place particular emphasis on social contexts and how the impact of parenthood on well-being depends on marital status, gender, race/ethnicity, and socioeconomic status. We also consider how recent demographic shifts lead to new family arrangements that have implications for parenthood and well-being. These include stepparenting, parenting of grandchildren, and childlessness across the life course. Umberson 2010

# Parenting Support

Two recent longitudinal studies of new parents found that mothers who perceived more support from their partner were less likely to experience an increase in depressive symptoms following the birth of a child (Smith & Howard, 2008). Women who were ambivalent about their marital relationship and perceived less support from husbands experienced a greater increase in depressive symptoms following the transition to parenthood (Simpson, Rholes, Campbell, Tran, & Wilson, 2003). (umberson p.5)

# Gender of child

When operationalising sex composition as the “number of boys”, coefficients are insignificant in all specifications. However, when considering the three categories “only boys”, “only girls” and “mixed sex”, I find a small but significant disadvantage of having only girls, compared to having at least one child of each sex, for mothers of two or more children. Having only daughters is associated with a mortality disadvantage compared to having only sons for mothers of two children, but a mortality advantage among mothers with four children. Among women who gave birth to their first child as teenagers, those who have only sons have relatively high mortality. I also find an excess mortality both for mothers of only girls and mothers of only boys in the period 1980–1989. (Christiansen 2014)

Number of **care recipients** is steadily increasing, however, this is not especially relevant for middle-aged individuals as care dependency before age 60 is below one percent in Germany {Nowossadeck:2016ta p.7}.

# Biological / Step / Adoptive Child

Prior research has examined whether parenthood is associated with higher levels of well-being among older adults, but definitions of parental status have varied. The authors examine links between parental status and depres- sive symptoms among older adults, comparing biological and social defini- tions of parenthood. The study finds few differences between biological and social parenthood but substantial variation in the relationship between paren- tal status and depressive symptoms by gender and marital status. Biologically and socially childless adults had the lowest predicted levels of depression across all marital status groups. Widowed men averaged higher levels of depression than other men. For women, the highest predicted levels of depressive symptoms were observed among never-married biological parents and formerly married women who had outlived their children. Increased sampling of less common parental subgroups and diverse kinship relations to allow for more precise classifications and the consideration of joint marital–parental statuses in future research. Bures, Loree 2009: 670

Among those who are biologically childless, social parenthood through stepparenting or adoption may provide an avenue for establishing intergenerational ties, but with unique concerns and challenges. Legally, the norms and obligations of adoptive parents are equivalent to those of biological parents, though adoption has remained socially stigmatized compared to biological parenthood (Fisher, 2003; Wegar, 2000). Social surveys, particularly of older populations, rarely distinguish adoptive and biological parenthood.The obligations and relationships related to stepparenthood represent a relatively new area of research (Bornat, Dimmock, Jones, & Peace, 1999; Clawson & ganong, 2002), and the uncertain status of stepparents raises basic questions about definitions of parenthood. The legal status and obligations of stepparents are ambiguous, and the norms that govern ties between stepchildren and stepparents are uncertain, flexible, and voluntary (Clawson & ganong, 2002; Killian & ganong, 2002). Furthermore, as stepparenting may begin at any age and may not be connected with childrearing, obligations within stepfamilies vary and are defined conditionally in terms of relationship closeness and past history (ganong & Coleman, 1999; ganong, Coleman, McDaniel, & Killian, 1998). Stepparenthood is also regarded as contingent on the continued relationship with the biological parent: When a marriage dissolves, ties with former stepchildren become more tenuous or end Bures, Loree 2009: 673)

# Childhood health 🡪 adult health / childlessness

Stu- dien zeigen, dass verschiedene Gesundheitsprobleme, wie etwa Adipositas oder Atemwegserkrankungen, durch pränatale (der Geburt vorausgehende) und frühe postna- tale (nach der Geburt auftretende) Einwirkungen bereits sehr früh geprägt werden *[5–8]*. RKI 2015 complete report 103

*BLANE 2007 p.32: Data from the 1946 cohort at ages 36 and 43 years, for example, demonstrated the importance of childhood illness to adult health; parental social class previously had been shown to influence the incidence of serious illness during childhood, particularly during the first 5 years of life [13]. Illness and disability during childhood, together with parental and adult social class, were found to influence health at age 36 years. Disadvantaged parental social class and low educational qualifications predicted poor diet [14] and obesity [15] at age 36 years, while those with the best health were characterised by both advantaged parental class and high educational qualifications [16]. The same factors, parental social class, adult social class and illness and disability during childhood, independently influenced the chance of physical disability and handicap at age 43 years; with the socio-economic consequences of disability being more severe for manual workers [17]. In a further example from the 1946 cohort, early life factors, including breastfeeding during infancy and physical growth and cumulative socio-economic disadvantage during childhood, influenced the timing of the menopause more strongly than adult factors [18,19]. -- Highlighted 17. Apr 2019*

More generally, poor health may in some cases affect fecundity, otherwise restrict opportunities for parenthood, or lead par- ents to limit their family size (57, 58).  „{Grundy:2007kz p.276f}

# Infertility

Within an individual’s life course, childlessness has most often resulted inadvertently from repeated delays of marriage and/or childbearing (Rindfuss, Morgan, & Swicegood, 1988), with smaller subgroups remaining childless by choice (“childfree”) (672)

Bures et al. / Parenthood and Depressive Symptoms 673or involuntarily childless because of physiological infertility. Recent research has shown that these pathways relate to later psychological well-being in important ways:

Many infertile men and women report distress and regret in later life, even those with stepchildren or adopted children, suggesting that strong cultural preferences for biogenetic parenthood may remain salient for adults who are aging without any biological children (Jeffries & Konnert, 2002; Vissing, 2002; Wirtberg, Möller, Hogström, Tronstad, & Lalos, 2007). (Bures Loree 2009: 673)

# Childhood Conditions /Education / MArriage🡪 adult health

There exists three potential mechanisms whereby the socioeconomic environment in childhood can affect health and disease risk in adulthood. Firstly, experience and socioeconomic environments during early life and at subsequent points in the life course may 'accumulate' to influence adult health and disease risk [[1](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B1)]. Secondly, early life socioeconomic circumstances may have a direct effect on adult health through affecting exposure to causal factors acting during 'critical periods of development'. These may have lasting or lifelong effects on the structure or function of organs, tissues and body systems that are not modified in any dramatic way by later life experience [[2](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B2)]. Thirdly, social and economic factors acting in early life may be important, because they influence later life experiences, opportunities and health indirectly via socioeconomic 'pathways' [[1](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B1),[3](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B3)]. It is the latter that is the focus of this paper. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B1>

CONCLUSION:

Our results suggest that educational attainment is the likely key gateway to socioeconomic trajectories that link childhood SEP and poor adult health, psychological distress and current smoking. Educational attainment is influenced by childhood socioeconomic circumstances and in turn, shapes health through its impact on socioeconomic circumstance in adulthood through better jobs, higher household incomes, and better housing. It is these later socioeconomic circumstances which in turn impact on health. Education might also affect a person's receptivity to health education messages which could have a beneficial influence on their health through health promoting behaviours and lifestyles. This may be especially important in younger people during critical periods when health behaviours such as smoking and drinking patterns are established. Thus, ensuring good access to and quality of education especially for younger people may be the best approach to tackle the transmission of social and economic disadvantage over the life course.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B1

In most countries adult SEP showed stronger associations with self rated health than childhood SEP. There are both gender and national differences in the associations between childhood and adulthood SEP. Policies designed to reduce inequalities in health need to incorporate a lifecourse perspective that is sensitive to different national and gender issues. Ultimately, more cross national studies are required to better understand these processes.

https://pubmed.ncbi.nlm.nih.gov/16973536/

Adult SEP is considered a pathway or mediating variable because it is heavily influenced by childhood SEP and is itself predictive of subsequent health outcomes. For example, parental SEP can constrain later adult SEP by influencing access to social and economic resources during childhood, especially opportunities for education and other learning experiences [[3](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B3)]. Adult SEP in turn can exert an effect on adult health by determining exposure to causal factors in later life such as income or unemployment. Therefore, it is likely that childhood SEP acts through future adult SEP which in turn influences adult health [[3](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B3)].

Studies that have investigated the effects of adjusting for adult SEP, in the association between childhood SEP and life style risk factors in adulthood such as physical activity, smoking and diet [[7](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B7)-[11](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B11)] and subjective measures such as self-rated health [[12](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B12),[13](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B13)] and psychosocial functioning, [[14](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B14),[15](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/" \l "B15)] show that much if not all of the association of childhood SEP with adult health is explained by adult SEP.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110570/#B1

##### SOEP

Obviously health is a multifactorial construct. Besides genetics and physical circumstances, socio-economic position, family lifestyle, social networks and health behavior are having consdiderable impacts on health - and need to be considered as covariated in the analysis - “whereas the more commonly considered factors such as access and use of health care services often have less of an impact.” {WHOWorldHealthOrganization:FNUca2hp, RKIRobertKochInstitut:2015ee}. WIE GROSS ist der EINFLUSS JEWEILS?

Family life and fertility behavior is closely related to the SEP, still it seems to have an (weak) independent direct impact on health - which is the focus in this paper.

Since socio economic factors highly correlate with health itself (XXX), it is by default a controlled mediator across articles.

„The positive correlations among educational attainment, SES, and health and mortality in adulthood have been even more widely reported over a longer period than those between childhood conditions and adult economic and health outcomes (e.g., Elo & Preston, 1996; Mirowsky & Ross, 2003). The predominant explanation for these observations is that human capital accumulation through schooling mediates the effects of social origins. The fundamental argument is that level of education is an achieved status that serves as a proxy for unmeasured factors, such as substantive learning, socialization, and more positive personal outlooks and attitudes toward the management of life course challenges and risks. And the argument is supported by some observations that mar- ginal returns from each additional year of schooling are higher among (Orand 2009: 132) the most disadvantaged populations (Mirowsky & Ross, 2003). Accord- ingly, such asymmetrical returns over time should reduce the disparities in economic, social, and personal resources observed in early life and compensate for adverse social origins.

With respect to health outcomes, education is positively related to better health and mortality at later rather than earlier ages, though House, Lantz, and Herd (2005) argue that education’s effects are stron- gest in predicting the onset of disease, whereas other SES factors, such as income or health insurance, influence the course of disease. These and other mixed findings across studies suggest that educational attain- ment may reproduce (and perhaps amplify) the effects of childhood inequalities under some conditions (or for some status groups based on gender and/or race; see earlier discussion of O’Rand & Hamil-Luker, 2005) and mediate their effects for others.

Education, then, is a pivotal and multidirectional factor in cumula- tion processes; it both reproduces childhood inequalities and provides a means for escaping previous disadvantage. The mechanisms of its effects may include the unmeasured factors proposed by Mirowsky and Ross (2003). But other unmeasured selective factors, such as school quality, curriculum track, competing role demands, and other unknown factors that can perhaps better explain the ameliorative, compensatory or exac- erbating effects of schooling, may be operating as well to affect health trajectories. (Orand 2009:133)

Accumulated evidence demonstrates a stron grelationship between socioeconomic status (SES) and health

„A growing body of life course research strongly suggests that childhood conditions matter for adult health and mortality (e.g., Hayward & Gorman, 2004; Hertzman, Power, Matthews, & Manor, 2001; Preston, Hill, & Drevenstedt, 1998) and contribute to race differences (Warner & Hayward, 2006). „ (Spence 2009)

„In addition to characteristics of the family of origin, education may affect fertility as it competes for women’s time and attention (Barber, 2001). Because of the difficulties often associated with attending school and having children, one may be delayed or forgone for the other. In addition to the causal or selective role that education may play in age at birth, education is an oft cited inde- pendent and relatively strong predictor of mortality (Rogers, Hummer, & Nam, 2000). Like education, labor force participation may affect fertility and mortality independently. Employed women may delay child- bearing to establish careers, resulting in later age at first birth and ultimately lower parity. In addition, women with early and/or more children may be penalized for their absence from the labor force (Budig & England, 2001). Paid employment may have beneficial effects on health through greater material resources, more positive psychosocial resources, and greater social integration (Moen, Dempster-McClain, & Williams, 1992; Sorensen & Verbrugge, 1987; Thoits, 1986), but negative effects are also evident from combining paid and domestic labor (Blane, Berney, & Montgomery, 2001).

Marriage is another important predictor of both fertility and mortality. Although changed sexual behavior along with modern contraception and cohabitation have created variability in this relationship, marriage is important for exposure to the risk of pregnancy, particularly among older cohorts of women where non- marital fertility was rare (Ventura & Bachrach, 2000). Marriage and marital stability can positively impact health and mortality, even controlling the positive health selection of those who marry (e.g., Waite, 1995).

(Spence 2009)

“

THEORIE  
„Findings are interpreted in light of the weathering hypothesis and from a life course framework that views women’s fertility as adaptive to particular social and historical contexts. „ (Spence 2009)

# Pivotal age at frist birth

As defined here, the pivotal age at first birth divides parenthood's likely health liabilities from its likely health benefits. Parents who had children before the pivotal age are less healthy than nonparents otherwise similar to themselves in background factors such as age, sex, race, and family of origin's social and marital status. Those who had children after the pivotal age are healthier than nonparents from similar backgrounds.

There is no direct evidence that a pivotal age at first birth exists or what it might be. However, indirect evidence suggests that, if it exists, this age is above 18, and perhaps near the median age at first birth for women but above that for men. (Mirowsky 320)

Figure 1 illus- trates the model's predictions in the top panel. The figure shows the health predicted for mothers and fathers as a function of age at first birth. It plots the prediction for nonparents at the pivotal age at first birth, which is by definition the point at which the health expected among parents equals that expected among nonparents with otherwise similar background attributes. All the figures reported in this section plot the health predicted for 45-year-old non-Hispanic whites reporting both par- ents with 12th grade educations who remained together during the respondent's childhood. Other combinations of traits would raise or lower the curves but not change the relationships.

(Mirowsky 329)

# Theorie zu Life Course

Überblick bei Mayer 2009

Read: Shanahan et al 2016 Handbook of the lifecourse II

**Does the Body Forget? Adult Health,  
Life Course Dynamics, and Social Change**......................................... 355 Mark D. Hayward and Connor M. Sheehan

**Life Course Lens on Aging and Health** ............................................... 389 Kenneth F. Ferraro

**Mental Health** ........................................................................................ 407 William R. Avison

Shanahan et al 2003: Handbook of the life course

***5.* Parental Identification, Couple Commitment, and Problem Solving among Newlyweds . . . . . . . . . . . . . . . . .** *Irving Tallman*

**6. Family Context and Individual Well-Being: Patterns and Mechanisms in Life Course Perspective . . . . . . . . . . . . . .** *Peter Uhlenberg and Margaret Mueller*

The “life course” is a lifelong manifold phenomenon of intertwining cumulative processes, in which earlier events and expe- (123) riences are consequential for later events and experiences, and their management by individuals (Elder, Johnson, & Crosnoe, 2003). The key consequence of this complexity is the emergence, persistence, and widening or narrowing of inequality in different aspects of well-being— social, economic, physical, and psychological. The central puzzle for researchers is to identify the mechanisms that drive these processes from childhood (if not from the time of fertilization and *in utero*) to adulthood and old age to produce considerable heterogeneity in aging populations. No single mechanism has been identified. Rather, mul- tiple, culmulative components appear to operate in different ways for different aspects of well-being. {ORand:2009vf p.124}

„We used survey data from three countries to examine parental status dif- ferences in late-life health in conjunction with gender and marital status. The findings in old age show outcomes that reflect accumulating life course experiences since childhoods dating back to the early 20th century. „ (Kendig 2007 1479)

„We commend the value of bio-psycho-social and life course perspec- tives (Ryff & Singer, 2005; Sauvain-Dugerdil, Leridon, & Mascie-Taylor, 2006) for further research on the influence of marital status, childlessness, and health as people move through adulthood into late life. A life history framework is especially valuable for identifying the critical influences and possibly enduring effects of family events such as marriage, divorce, and wid- owhood, as well as childbirth, coresident parenting, the departure of children from home, and ongoing interaction with them afterward. With the emer- gence of chronic disease and mental health as major health concerns for the future (World Health Organization, 2005), we need to know more about the “trigger points” and durations of health-risking and health-promoting expo- sures throughout the life course. Understanding family influences on health has potential to identify opportunities and guide actions that can improve health in later life (Kendig, Browning, & Wells, 1998). „ (kendig 2007, 1482)

Life course development is analyzed as the outcome of personal characteristics and individual action as well as of cul- tural frames and institutional and struc- tural conditions (relating micro, meso, and macro levels of analysis, structure, and agency). Lifecourse/cohortanalysisisessentialfor social policies with a paradigm shift from curative to preventive intervention. Mayer 2009: 414

“The life course paradigm assumes that individuals, as human agents, build their future on the basis of the constraints and opportunities experienced in the past (Elder 1994). The process is iterative and cumulative, since initial advantages or disadvantages often are amplified with time (Giele and Elder 1998). In addition, different life domains are strongly interdependent. Elder (1985) observes that a trajectory can also be envisioned as a sequence of transitions that are enacted over time. A transition is a discrete life change or event within a trajectory (e.g., from single to married), whereas a trajectory is a sequence of linked states within a conceptually defined range of behavior or experience. ” {Barban:2013cl p.358}

„According to the life course health development (LCHD) model, health is the result of a continuous process that develops over an individual’s lifetime (Halfon and Hochstein 2002). In the LCHD model, health is a consequence of multiple factors operating in nested genetic, biological, behavioral, social, and economic contexts. These contexts change during the life course. Therefore, health is seen as an adaptive process, composed by multiple transactions between the contexts mentioned above (e.g., genetic, social) and the biobehavioral regulatory systems (e.g., neurological, endocrine) that define human functions (Halfon and Hochstein 2002). In other words, health is not a static phenomenon. It develops over time and changes as a function of experience. The LCHD model suggests that a person’s health takes on a trajectory that results from the cumulative influence of multiple risk and protective factors during life course. Health, in turn, is a multidimensional concept that encompasses a large array of measures, including behavioral, physical, and emotional outcomes. „ {Barban:2013cl p.359}

“From a life course perspective, health outcomes are the result of the cumulative influence of multiple risks and protective factors experienced during the life course (Halfon and Hochstein 2002; Ben-Shlomo and Kuh 2002; Oxford et al. 2006; Harris and Eileen 2010). Under this perspective, it is necessary to take into account the whole life course development in order to study effects on health outcomes. On the other hand, taking the whole trajectory as an input in statistical analysis is not straightforward (George 2009; Amato and Kane 2011). ” {Barban:2013cl p.361}

„A life course perspective directs attention to continuity and change in well-being over the life course and suggests how parenthood and the “linked lives” of parents and children influence trajectories of change in well-being over time (Milkie, Bierman, & Schieman, 2008). A life course perspective also takes inequality into account by emphasizing that individuals vary in their exposure to stressors and resources throughout life. Differential exposure to environmental risks and resources around parenthood can produce increasing disadvantage for the well- being of some and increasing advantage for others (Kendig, Dykstra, van Gaalen, & Melkas, 2007). This approach recognizes human agency and resilience as well as heterogeneity in relationships and life course experiences. Thus, individual choice and a sense of personal control in making decisions about parenthood may play an important role in shaping the effects of parenthood on well-being (Keeton, Perry-Jenkins, & Sayer, 2008). „ (Umberson 2010, 2)

Parenthood and parenting shape life experiences and have significant effects on psychological and physical well-being over the life course. The nature of these ongoing effects and the mechanisms (e.g., stress, support) through which they occur differ depending on the context of parenting as shaped by age of children, family structure, and sociodemographic characteristics. If we compartmentalize individual studies into age- restricted snapshots, we fail to understand how parenthood shapes life trajectories in meaningful and lasting ways, as well as how certain key transitions and contexts may alter life trajectories. The life course perspective offers a way to weave together the many strands of research on parenthood and well-being and to see this cumulative process in an integrated big picture way. In this section, we use key life course concepts to synthesize major research themes of the past decade and to identify important directions for future research on parenthood and well-being. Highly specialized suggestions for future research can also be UMBERSON 12

A life course perspective incorporates three temporal dimensions: individual time, generational time, and historical time (M. Bengtson & Allen, 1993; Macmillan & Copher, 2005). This view of multiple clocks focuses on the intersection of social and cultural contexts, cohort experiences, and individual biographies (M. Bengtson & Allen). From a life course perspective, it is crucial to examine the interplay of age, cohort, and period effects on the experiences of parenthood. Parenthood and parenting shape life experiences and have significant effects on psychological and physical well-being over the life course. The nature of these ongoing effects and the mechanisms (e.g., stress, support) through which they occur differ depending on the context of parenting as shaped by age of children, family structure, and sociodemographic characteristics. If we compartmentalize individual studies into age- restricted snapshots, we fail to understand how parenthood shapes life trajectories in meaningful and lasting ways, as well as how certain key transitions and contexts may alter life trajectories. The life course perspective offers a way to weave together the many strands of research on parenthood and well-being and to see this cumulative process in an integrated big picture way. In this section, we use key life course concepts to synthesize major research themes of the past decade and to identify important directions for future research on parenthood and well-being. Highly specialized suggestions for future research can also be UMBERSON 14

Taking the long view enables family researchers to consider how certain types of parenting stress that occur early in the life course may affect long-term, in addition to short-term, functioning of parents (Booth et al., 2008; Henretta, 2007). The life course concept of cumulative advantage/disadvantage provides away of thinking about and analyzing the impact of parenthood on well-being throughout adulthood. Certainly, research emphasizes that parenting of young children tends to be stressful and that this stress is greater for some parents than others—for example, the unmarried (Evenson & Simon, 2005). Parenthood and parenting could then influence trajectories of increasing advantage or disadvantage for well- being over the life course. The strains of parenting minor children (e.g., time and financial constraints) may create additional disadvantage and increased risk for distress among young parents (MacInnes, 2008) and this increased risk may be carried forward to influence well- being late in the life course (Greenfield & Marks, 2006; Ha et al., 2008). UMBERSON 13

# Nutrition

See Gerontology Book 2007: Chapter 7 The role of Nutrition in the older individual

# Sport and Exercise

See See Gerontology Book 2007: Cahpter 8 Exercise and Aging

# Mental Health

Psychological well-being, psychological dis- tress, and clinical depression are manifestations of mental health studied in relation to social ties and health behavior. Following past research (Gorman & Read 2006, Uchino 2004), UMBERSON 2010

Timing 🡨🡪 Parity Associations

“Finally, having a child at 18 years of age or younger was strongly associated with parity (p<0.00). “ {Pirkle:2014il p.5}

# Studien zu High parity and worse health

Multiple births

BIOLOGY diseases correlating with parity:

Diabetis:

Beral 1985

Green beral moser 1988

Heart disease:

Beral 1985

Ness 1993

Kvale Heuch Nilssen 1994

Cancer:

Beral 1985

Kvale 1994

Madigan 1995

Doblhammer 2000: “Reproductive Histo- ry and Mortality Late in Life: A Comparative Study of England and Wales and Austria.” *Popu- lation Studies*

Smith Mineau Bean 2002: Fertility and Post-Reproductive Longevity.” *Social Biology*

Grundy Tomassini 2005: Fertil- ity History and Health in Later Life: A Record Linkage Study in England and Wales.” *Social Science and Medicine*

Few exceptions:

Muller et al 2002: Fertility and Life Span: Late Chil- dren Enhance Female Longevity.” *Journals of Gerontology Series A: Biological Sciences and Medical Sciences*

Mc Ardle et al. 2006: Does Having Children Extend Life Span? A Genealogical Study of Par- ity and Longevity in the Amish.” *Journal of Gerontology: Medical Sciences*

The role of parity was assessed both as a continuous and dichotomous variable (2 or fewer children and 3 or more children). The cut- off of two or fewer children was selected based on evi- dence that 3 or more children is associated with coron- ary heart disease, stroke, and heart failure [22]. (Prikle 4)

Complications of labor and/ordeliveryOf the 15 reported complications oflabor and/or delivery, 4 were reported at arate greater than or equal to 30 per 1,000

live births in 1995; meconium,moderate/heavy (57 per 1,000), fetal dis-tress (42 per 1,000), breech/malpresen-tation (37 per 1,000), and premature rup-ture of membrane (31 per 1,000)(table 37). For these four complicationsthere were observable variations by raceand Hispanic origin (tables 26and27).Although not frequent, placenta pre-via is a serious complication that occurredin nearly 13,000 births in 1995. Datafrom birth certificates identify increasingage of mother and live-birth order as tworisk factors for this complication (62). (Monthly votal statistics report 1997) p.13f.

# WOMEN! Vs MEN

Comparing the association between x and y over two centuries in late life, Dykstra and Hagestadt found diminishing differences between mothers and childless women and base this on improved conditions for combining career and children.

.) Die Mehrheit der Frauen und Männer will heute eine **Partnerschaft auf gleicher Augenhöhe**. Frauen und Männer haben für das partnerschaftliche Zusammenleben nicht mehr die hierarchische Vorstellung einer Über- und Unterordnung des einen Geschlechts zum anderen, sondern der Gleichheit und des Anspruchs auf gleiche Chancen. Doch nach der Geburt eines Kindes werden die Aufgaben für die Versorgung und Erziehung des Kindes, für die Erledigung von Aufgaben im Haushalt sowie für den Erwerb des Familieneinkom- mens ungleich auf Frauen und Männer verteilt. Männer reduzieren ihre Tätigkeit im Haushalt auf wenige Tätigkeiten und helfende Unterstützung; Frauen übernehmen die überwiegenden Tätigkeiten im Haushalt, die Versorgung und Erziehung des Kindes.9  
***Diese Retraditionalisierung der Rollenverteilung*** manifestiert sich auch in der Vollzeiterwerbs- tätigkeit, die nach der Geburt eines Kindes bei Frauen und Männern gegenläufig ist: Männer ohne Kinder sind zu 79 % Vollzeit berufstätig; bei Männern mit Kindern im Haushalt ist der Anteil mit 91 % signifikant höher. Bei Frauen gibt es den umgekehrten Trend: Frauen ohne Kinder sind nach der Ausbildung zu 51 % Vollzeit erwerbstätig; dieser Anteil sinkt nach der Geburt des ersten Kindes: nur noch 26 % der Frauen mit Kind(ern) unter 18 Jahren sind Vollzeit berufstätig.10 Im Fall der Geburt eines Kindes sehen Männer sich in der unbedingten Pflicht, hauptsächlich – und allenfalls unterstützt durch die Partnerin – für die Existenz- sicherung ihrer Familie zu sorgen. Tief verankert ist auch in unserer modernen Gesellschaft das (teil-)traditionelle Geschlechterrollenbild, das meist erst nach der Geburt eines Kindes „aktiviert“ wird – allerdings mit großer Kraft: Frauen sehen sich gefordert, dem unbedingten „Normbild der guten Mutter“ zu genügen11; Männer der Rolle des Familienernährers, die auch moderne Männer nach der Geburt des ersten Kindes übernehmen. {Anonymous:2015ur p.14}

* **Frauen** machen in ihrem privaten und beruflichen Umfeld sehr häufig die Beobachtung, dass die Geburt eines Kindes zu einer Retraditionalisierung der Rollenverteilung führt – auch bei Paaren mit gleichgestellter Einstellung und gleichen beruflichen Qualifikationen und Zielen. Nach einer familienbedingten Erwerbsunterbrechung stehen Frauen vor erheb- lichen Hürden bei ihrem beruflichen Wiedereinstieg v. a. bei Unterbrechung von mehr

als zwei Jahren; bekommen oft keine Vollzeitstelle mehr und wollen diese zum Teil nicht, um mehr Zeit für ihr Kind zu haben, um ihrem Partner dessen Karrieresprung nicht zu erschweren. Frauen nach längerer Erwerbsunterbrechung bekommen in der Phase des Wiedereinstiegs weniger Verantwortung, weniger Kompetenz zugewiesen, kurz- und mit- telfristig ein deutlich geringeres Entgelt (v. a. bei einer Teilzeitstelle) und ihre Chancen auf führende Positionen sind erheblich geringer als zu der Zeit vor ihrer Elternschaft.13 Insofern hat ein erheblicher Teil der qualifizierten und ambitionierten Frauen die Maxime, zunächst die beruflichen Rahmungen optimal und strategisch zu gestalten (wie es Männer tun), um dann die Familienplanung anzugehen, wenn die berufliche Architektur stabil steht – und auch eine Erwerbsunterbrechung kein zu großes Risiko für sie darstellt. {Anonymous:2015ur p.15}

So bedeutet vor allem die Geburt des ersten Kindes für viele Paare auch heute noch einen Übergang in traditionelle Rollenmuster *[2, 3]*. RKI 2015 complete report 103

1. ***Bundesministerium für Familie, Senioren, Frauen und Jugend (Hrsg) (2011) Neue Wege – Gleiche Chancen. Gleichstellung von Frauen und Männern im Lebensverlauf. BMFSFJ, Berlin***
2. ***Schulz F, Blossfeld H-P (2006) Wie verändert sich die häusliche Arbeitsteilung im Eheverlauf: eine Längsschnittstudie der ersten 14 Ehejahre in Westdeutschland. Kölner Zeitschrift für Soziologie und Sozialpsychologie 58(1):23-49***

Models estimated for all cancer sites combined showed that, even when marital status is taken into account, parenthood is linked with improved prognosis. The difference was found to lie between the childless and those with at least 1 child. When cancers of the breast and reproductive organs were excluded, the effects were very similar in men and women. A simple and plausible interpretation would be that, for these sites, the effect is purely social. However, one cannot exclude the possibility that the social effect of motherhood actually is sharper than that of fatherhood because of women’s often stronger involvement with children, and that this is outweighed by an adverse physiologic effect. Kravdal 2003 264

Overall, gender dif- ferences were reasonably consistent across the three countries. Women were more likely than men to have difficulty falling asleep, to eat fruit on a daily basis in winter, and to refrain from smoking and drinking.

(kendig 2007, 1481)

In conclusion, a man appears to benefit from having a wife as well as from having children (unless these effects are entirely due to selection). This is less obvious for women, whose entry into marriage is not associated with any survival advantage. For them, it is only childbearing that confers protection, in addition to the avoidance of divorce. kravdal 2003) 265

most evidence is restricted to women!

However, additional analyses failed to supportour hypothesis regarding gender differences inthe association between parenthood and depres-sion. Despite the female excess of depressionamong all types of parents (and nonparents) inour national sample, the association betweenparenthood and symptoms does not significantlydiffer for women and men. These findings arenot only inconsistent with some earlier studies,but they are also inconsistent with anotherassumption of work in this area, which is thatparenthood is more consequential for the emo-tional well-being of women than of men.Although we did not find gender differencesin the associations between parenthood anddepression, our findings clearly show that certaintypes of parenthood are predominantly male,whereas other types are predominantly female.These gendered parenting patterns no doubtreflect contemporary custodial arrangements inthe United States, where mothers are more likelythan fathers to reside with their young biologi-cal and/or adopted children in the event ofnonmarital childbearing, cohabitation, separa-tion, divorce, and remarriage. EVENSON 2005 355

Die Pflegequoten nehmen mit dem Alter zu – von den unter 60­Jährigen ist nicht einmal 1 Prozent pflege­bedürftig, von den 60­ bis 64­Jährigen sind es lediglich 1,9 Prozent. Dieser Anteil steigt über die Altersgruppen hinweg an auf 81,4Prozent in der Gruppe der Personen, die 95 Jahre und älter sind. Ab dem 80. Lebensjahr werden deutliche Geschlechterunterschiede sichtbar: Die Anteile bei den Frauen liegen erheblich über denen der Männer. (DZA p.7)

Women in general are less healthy (XX), more depressed etc, but live longer???

Worldwide, it has been documented that as popula- tions age, women experience worse physical function and greater physical decline than men at similar ages [1,3-8]. Increasingly, there is evidence that the physical function differences between women and men are heterogeneous across settings and these are linked to gender inequality. Countries with the greatest gender inequalities also have the highest odds-ratios for mobility disability in women compared to men [4]. At the individual level, the disability gap between women and men is even more substantial among people with low education and low income [5,9-11]. A number of biological and social explanations are proposed to explain women’s relatively greater burden of physical decline and disability. On the one hand, it may arise from a higher cumulative burden of physiological dysregulation, especially in the postmenopausal period [12,13], as well as a greater risk of diseases (arthritis, osteoporosis and depression) that hamper physical func- tion [6]. On the other hand, the greater burden has also been linked to gender inequality accumulated throughout the life-course [4]. Gendered norms, values and behav- iours contributing to differences in educational attain- ment, physical activity, smoking, diet, childhood hunger, poverty, and body mass index may all predispose women to physical decline and disability [8,14]. However, research on the roles of these factors has been fragmentary and can only explain a fraction of the sex/gender gap [1,8,15]. In contrast, relatively little attention has been paid to the role of women’s reproductive history on physical decline in older age. Women in lower income settings tend to start childbearing earlier, have more children, and face more risks during childbirth [16 {Glasier, 2006 #94]}. Their re- productive histories may partially account for the greater prevalence and earlier onset of physical decline docu- mented in these settings, especially if early childbirth and higher parity affect future life opportunities. {Pirkle:2014il p.2}

In recent decades, fathers have shown slight increases in the absolute and relative amounts of child care and household labor that they perform, but mothers continue to perform the bulk of these responsibilities (Bianchi, Milkie, Sayer, & Robinson, 2000; Pleck, 1997). The largenumber of single-parent families is because of relatively high rates of non-marital childbearing and divorce—both of which appear to constrain the non-resident parent’s involvement in their children’s lives. About one third ofall children are now born outside of marriage, and half of all marriages areexpected to end in divorce. Only 74% of White children, 64% of Hispanicchildren, and 36% of African American children younger than 18 are livingwith two parents (biological, adopted, or stepparents) at any given time.Although the number of single-parent fathers has been increasing, mothersare overwhelmingly more likely to be the primary caretaker if parents do notreside with one another (Teachman, Tedrow, & Crowder, 2000). The largenumbers of nonresident fathers, their low levels of involvement with theirchildren, and the high rates of poverty among female-headed families haveled to increased focus on the challenges of both single mothering and non-resident fathering (King & Heard, 1999; McLanahan & Sandefur, 1994). Infact, some have argued that father absence and inadequate fathering practiceshave led to family decline and increases in social problems such as poverty,crime, and male violence (Blankenhorn, 1995; Popenoe, 1993).{Knoester:2016fs p.1533}

# Social Context: the 1971-1973 Birth cohort

Moreover, the social meaning of parenthood and childlessness has changed a lot in recent decades and psycho-social effects possibly vary across cohorts {Umberson:2010iz p.3}.

Having grown up in very different regimes is still entrenched in fertility and family patterns in former East and West-Germany.

# EAST vs WEST

EAST/WEST WOMEN? Eastern German Women….

Older cohorts of the former East accumulated negative experiences after the transition (Mayer 2009 p.420), whereas younger folks were able to adapt much more smoothly into the new Germany. Anyways, in many sociological Analysis there are still significant differences between the eastern and western countries and it is a standard procedure to control for it.

Theorie: inquiry into the very specific impacts that institutions and policies have on life course outcomes (Mayer 2005, Kohli 2007) Mayer 2019 418

Mayer KU. 2005. Life courses and life chances in a comparative perspective. In *Analyzing Inequality: Life*

*Chances and Social Mobility in Comparative Perspective*, ed. S Svallfors, pp. 17–55. Palo Alto, CA: Stanford

Univ. Press

Kohli M. 2007. The institutionalization of the life course: looking back to looking ahead. *Res. Hum. Dev.*

4:253–571

The hallmark of the life course tradition has been that among its primary topics were changes of life course patterns across histori- cal time and the impact of historical contexts on life course outcomes (period effects). There have been a number of recent contributions in regard to the former concern, with a tendency to use extant data sets to extend the breadth of the periods (Mayer 2009 419)

The very sudden system rupture connected to the transition of former socialist countries has provided a new application and testing ground of life course research in regard to the relationship of lifetime and historical time. Eyal et al. (1998) developed a theory of how the transformation of these countries is processed both at the level of institutions and on the level of individual life courses, families, and house- holds. Mayer (2006, pp. 15–17) has outlined a systematic account of how life courses act as medium, mechanism, and outcomes of these transformations. Sudden system change pro- vides a crucial experiment for several tenets of life course theory: Is the usual assumption of the early fixation of lives born out in the transi- tion to postsocialism? Do the institutional im- prints of the system of origin and the system of destination change lives radically, or are life courses, as shaped by the old system, projected into the new era? In which way do the former lives act as constraints and resources under the new circumstances? Are there age dependencies in the willingness and ability to adapt? Which are the sources for continuity despite major disruptions? Diewald et al. (2006b) have traced the consequences of the transformation of East Germany and have spelled out the implications their findings might have for a general theory of the life course.

Continuous event histo- ries show a much higher degree of turbu- lence than do either cross-section comparisons or panel studies. Former qualifications, skills, gender, and age at the time of the transfor- mation play the strongest role in trajectories after system rupture. Former political capital (party membership and function) did not in- crease the risk of unemployment but led to both upward and downward mobility. The formerly self-employed fared surprisingly poorly after the transition. Prior biographical experiences (e.g., of occupational flexibility) did not pre- dict later work trajectories. Over a 6- to 10-year period, occupation and family ties were highly stable (stability despite or because of turbu- lence). Negative experiences accumulated for those around age 50 at the time of transition, an unexpected example of the possible emer- gence of a distinctive generation even in late adulthood.

The East German experience of unification also provided the context for a study by Sil- bereisen and his associates on the effects of fam- ily income loss on depressive mood and trans- gression among adolescents. Building both on Glen Elder’s work and comparative work in West Germany and Poland, Silbereisen’s study showed that, in contrast to West Germany, a de- cline of family income did not result in depres- sive mood of fathers and, consequently, of chil- dren. Similar to Poland in the 1980s, individuals did not blame economic hardship on themselves but rather on collective circumstances (Forkel & Silbereisen 2001, Silbereisen et al. 2002).

(Mayer 2009 420)

One rare instance in which it was possible to test empirically which role psychological dispo- sitions play in life course processes and whether they are responsive to changing social contexts is the transition of East Germany from a so- cialist society to a market economy. Indeed, psychologists argue that personality character- istics should show most salience in times of sudden change and turbulence (Caspi & Moffitt 1993). In the context of a study of life courses during the transformation of East Germany af- ter the fall of the Berlin Wall, Diewald et al. (1996) examined first how control beliefs, con- trol strategies, and feelings of self-respect var- ied among groups of different age and different occupational experiences before 1989 and be- tween 1989 and 1993. Second, Diewald (2006) tested whether control beliefs had a net impact on unemployment, downward mobility, upward mobility, and occupational shifts between 1989 and 1993. It is noteworthy that control cog- nitions played an important role in preventing unemployment but that they had no significant effects on upward and downward mobility. For the two variables of internal control and fatal- ism, only fatalism showed any effect at all and on only one of the four dependent variables: unemployment. In general, the evidence from these studies points to psychological disposi- tions more often being modified by (in this case, dramatic) life course events than being a strong influence on life course adaptation. At any rate, it is still a long way until the emerging dif- ferential life course sociology will be matched with a similarly differential study of the link- ages between macro social contexts and human development.

(Mayer 2009 421)

Bekannt sind aus früheren Analysen die besondere Situation in Westdeutschland mit auch im internationalen Ver- gleich sehr hohen Anteilen kinderloser Frauen und die deutlichen Unterschiede zu Ostdeutschland. Aus diesem Grund werden die Paritätsmuster in diesem Bei- trag getrennt nach Ost- und Westdeutschland analysiert. {Dorbritz:2014vc p.254}

In den alten Bundesländern ist die Kinder-losigkeit höher, dafür werden häufiger drei und mehr Kinder geboren, in den neuen Bun-desländern ist hingegen der Anteil der Frauen mit einer Geburt höher (Dor-britz/Ruckdeschel 2014: 256).

Im Osten werden nach wie vor mehr (erste) Kinder vorehelich geboren als im Westen (Kreyenfeld et al. 2011: 171-172).

<https://www.bib.bund.de/Publikation/2015/pdf/Kinderzahl-und-Migrationshintergrund-Ein-Vergleich-zwischen-Frauen-tuerkischer-Herkunft-mit-oder-ohne-eigene-Wanderungserfahrung-sowie-Frauen-ohne-Migrationshintergrund-in-Westdeutschland.pdf?__blob=publicationFile&v=1>

What makes the German case interesting is the more recent history since the mid-twentieth century, when Germany was divided into two opposing political systems. In the state-socialist German Democratic Republic (GDR), the centrally planned economy guaranteed stable and predictable employment paths. Furthermore, social and family policies that were often ridiculed in the West as being “pro-natalistic” encouraged early childbearing and the full-time integration of mothers into the labor market. West Germany’s social policies were geared towards the male breadwinner model, and the trade unions adhered to the principle of family wages for male employees. Family poli- cies, in particular the system of joint taxation and the coverage of non-working spouses in the public pension and health care systems, are the key characteristics of a regime that was never seriously interested in the integration of mothers into the labor market. Pro-natalism was rejected in West Germany, not only because it was misused during the Nazi period, but also because the government wanted to take a clear political stance against the pro-natalist orientation of East Germany’s family policies. A statement by the first West German chancellor Konrad Adenauer reflects the attitudes towards family policies that were prevalent among West German politi- cians during that period: “*Kinder bekommen die Leute immer*” (“People will always have children”).

The legacy of having lived under two very different regimes is still deeply entrenched in the fertility patterns and living arrangements that we observe in con- temporary Germany. Compared to West Germans, East Germans are less likely to remain childless, are younger at first birth, and are far more likely to have children in a cohabiting union or as a single parent (Huinink et al. 2012). The correlation between socioeconomic characteristics and childlessness also differs between East and West. In East Germany, there are only small differences in childlessness rates by women’s level of education; whereas in West Germany, highly educated women were far more likely than less educated women to remain childless.

(Childlessess i Europe, 98)

childlessness of the West German female academics has attracted considerable pub- lic and media attention, and was probably an important motivation for recent policy reforms, including the expansion of public childcare and the reform of the parental leave benefit system (*Elternzeit*). However, there is also evidence that behavioral patterns have shifted among the most recent cohorts, and that the educational dis- parities are narrowing for the younger cohorts of West German women.

(Childlessess i Europe, 99)

Cohort effects:

Some Exposures, such as shocks and changes in the natural, social and political environment, affect only certain generations in history. Their impacts can manifest as cohort effects many years later in health and mortality outcomes. Cohort differences can also occur due to variations in behavior and the adoption of habits like smoking. {Kuh:2003vb p.779}. The position of a cohort in national history is important to keep in mind when analyzing several cohorts or cohorts from several countries.

This very distinct example emphasizes the importance to control for major external factors during life.

For the German population the period of the German division (1949-1990) constituted a severe experience with long-term cohort effects on virtually every part of life {:2015ue p.48f.}. A 2013 study by the Berlin Institute for Population and Development sums up how the ‘wall’ is still present in today’s health data: children born in east Germany

The period of age thirteen to sixteen, for example, was found to be a very sensitive period for later physical health in Nigeria. During this adolescent life period the body seems to be much more responsive to external events than at any other age, as a study on women who experienced the Nigerian civil war (1967-1970) has shown. Adult health, measured in body height, didn’t differ much for individuals exposed between the fetal year and age twelve. An average reduction in adult height of 0.75 centimeters relative to unexposed women of the same cohort was found for them, while those exposed at age twelve to sixteen showed a striking 4.53 cm deficit {Akresh:2012bm p.274f.}. The authors explained their findings: “Even if growth is more rapid in early childhood than in adoles- cence, however, the increase in food demand may be greater for adolescents given their larger baseline size.“

Generell liegt die Geburtenrate der Männer in Westdeutschland ungefähr vier, in Ostdeutschland sogar mehr als zehn Prozent unterhalb der Geburtenrate der Frauen. Denn in den Neunziger- und Nullerjahren wanderten vor allem Frauen aus dem Osten ab, so dass sich der Männer- Überschuss erhöhte. Besonders gering war die männliche Geburtenrate in Ostdeutschland im Jahr 1994. Die erstmals ermittelte Geburtenrate von 0,74 Kindern pro Mann stellt für Friedenszeiten einen neuen weltweiten Negativrekord dar und unterschreitet das viel diskutierte Rekordtief der ostdeutschen Frauen, die 1994 eine Geburtenrate von 0,85 Kindern erreichten, noch einmal deutlich.

Das ist unter anderem deshalb von großer Bedeutung, weil diese niedrige Geburtenrate darauf hindeutet, dass in Ostdeutschland bald eine Generation mit verhältnismäßig vielen kinderlosen männlichen Senioren existieren wird, die etwa beim Eintreten von Pflegebedürftigkeit auf staatliche Hilfe angewiesen sein könnten. Zwar entschärft sich diese Situation seit Mitte der 1990er Jahre wieder, doch bis heute liegt die Geburtenrate der Männer im Osten unter der im Westen Deutschlands.

https://www.demografische-forschung.org/archiv/defo1702.pdf

In eastern Germany, fertility dropped to extremely low levels during the post-communist transition crisis of the 1990s but recovered some- what until the 2000s (Goldstein and Kreyenfeld 2011) {Dudel:2016cna p.1554}

Nach der Wiedervereinigung gab es in Deutschland noch beträchtliche Unterschiede in der mittleren Lebenser- wartung bei Geburt zwischen alten und neuen Ländern zuungunsten der neuen Länder (1991/93: Frauen 79,5 bzw. 77,2 Jahre; Männer 73,1 bzw. 69,9 Jahre) *[1]*. Nach der aktuellen Sterbetafel des Statistischen Bundesamts für den Zeitraum 2009 bis 2011 beträgt die Differenz aktuell nur noch 0,2 Jahre bei Frauen und 1,3 Jahre bei Männern. Allerdings gibt es auch weiterhin beträchtli- che regionale Unterschiede in der Lebenserwartung in Deutschland. Die mittlere Lebenserwartung bei Geburt differiert vor allem zwischen ärmeren Regionen mit höherer Arbeitslosigkeit und Armutsrisikoquote und prosperierenden Regionen mit annähernder Vollbe- schäftigung und einer eher wohlhabenden Bevölkerung *[10, 11]*. {RKIRobertKochInstitut:2015ee p.21}

„Results from studies including outcomes other than or in addition to mortality show some variations that may reflect differences in measures, methodologies, and statistical power as well as contextual influences. Analyses of German survey data, for example, found that in Western Germany mothers and fathers of four or more children reported better health, but had no elevation of mortality risk, while in Eastern Germany high parity was associated with increased mortality risks among women, but not with poorer health (Hank 2010). „ (Grundy Read 2015)

After the reunification in 1990 the German East-West mortality difference narrowed rapidly for women, and by late 1990s and early 2000s mortality in the age groups 50-64 had declined below that of the West. This mortality cross-over has been attributed to higher smoking of the West German cohorts. In this study we show that the survival advantage of the East German cohorts is ending, and use demographic forecasting methods to study the implications of the reversing smoking advantage to mortality differentials between the East and West German women. Our results show that the increases in smoking rates among younger cohorts will have a strong impact on the future mortality differentials. East German women between the ages 50 and 64, who currently enjoy a lower mortality than their West German peers, will in the next two decades fall again behind West Germany both in terms of lung cancer mortality and all-cause mortality. Page 10: https://www.demogr.mpg.de/papers/working/wp-2016-004.pdf

The legacy of having lived under two very different regimes is still deeply entrenched in the fertility patterns and living arrangements that we observe in con- temporary Germany. Compared to West Germans, East Germans are less likely to remain childless, are younger at first birth, and are far more likely to have children in a cohabiting union or as a single parent (Huinink et al. 2012). The correlation between socioeconomic characteristics and childlessness also differs between East and West. In East Germany, there are only small differences in childlessness rates by women’s level of education; whereas in West Germany, highly educated women were far more likely than less educated women to remain childless. KREYENFELD 2017: 98

The table shows that childlessness has been rising in West Germany starting with the 1940s cohorts. Of the most recent cohorts, those born in 1965– 1969, 22 % have remained childless, which suggests that childlessness has increased steadily starting with the cohorts born in the 1940s. By contrast, in East Germany female childlessness levels stalled for the 1940–1959 cohorts, and increased only slightly thereafter. Hence, childlessness levels in East Germany are still substan- tially lower than those of West Germany. However, the increase in childlessness among the recent birth cohorts indicates that the differences in the birth patterns of the two parts of Germany have become smaller. KREYENFELD 2017: 102

# Familienpolitik in Deutschland

MIGRATION AND PARITY/HEALTH

*Research on Aging* (Lynch 2008) published a special issue on “Race, socio- economic status, and health in a life course perspective” that represents the state of the art in combining substantive theory, advanced statistical techniques, and longitudinal data. (Mayer 2009:422)

An-dersson (2004: 765-766) zeigt in seiner Untersuchung zur Fertilität von Migrantinnen ver-schiedener Herkunftsregionen in Schweden, dass insbesondere Frauen aus islamisch ge-prägten Herkunftsländern (mit Ausnahme des Iran) in Relation zu autochthonen Frauen paritätsspezifisch eine höhere Zahl an Geburten aufweisen. Dabei ist vor allem die relati-ve Chance für Türkinnen, drei und mehr Kinder zu gebären, deutlich höher im Vergleich zu Schwedinnen (ibd.). Für Frauen aus osteuropäischen Ländern hingegen ist die Chance sogar niedriger als bei Schwedinnen (ibd.).

Andersson, G. (2004). Childbearing after migration: Fertility pattern of foreign-born women in Sweden. International Migration Review, 38, 2, S. 747-775.

Aber auch in den Folgegenerationen bleiben Unterschiedlichkeiten bestehen: Unter Berücksichtigung verschiedener Faktoren zeigt Naderi (2013), dass die Familienerweiterung, also die Geburt weiterer Kinder, Frauen mit türkischem Migrationshintergrund „leichter fällt“ (ibd: 93).

Naderi, R. (2013). Unter welchen Bedingungen bekommen Eltern weitere Kinder? Ein Vergleich zwi-schen Deutschen und Türken unter besonderer Berücksichtigung ökonomischer Abwägungen. Zeit-schrift für Familienforschung /Journal of Family Research, 25, 1, S. 75-95

In diesen Befunden zeigt sich der Einfluss der Herkunftskultur mitunter auch durch die Religionszugehörigkeit und Re-ligiosität. Männer und Frauen mit türkischem Migrationshintergrund gehören zum über-wiegenden Teil muslimischen Glaubensrichtungen an. Zudem weist die Gruppe im Ver-gleich zu Deutschen ohne Migrationshintergrund eine weit höhere Religiosität1 auf, was für Frauen und Männer in nahezu gleicher Weise zutrifft (Gründler 2012: 202).

Gründler, S. (2012). Partnerschaftszufriedenheit von Deutschen und türkischen Migranten. Der Einfluss soziologischer und sozialpsychologischer Determinanten auf Partnerschaften. Wiesbaden: Springer VS

Eine ent-sprechende Hypothese, dass stärkere Religiosität islamischer Prägung häufig mit traditio-nelleren Vorstellungen zu Lebensformen verbunden ist, welche wiederum fertilitätsbe-günstigend sein kann, ist mit dem Mikrozensus nicht überprüfbar.

„In the ‚Turkish case‘, it seems that there continues to be a stronger orientation towards marriage and a higher number of children than is the case among West Germans [...].” (Milewski 2010b: 319)

Milewski, N. (2010). Fertility of immigrants. Berlin & Heidelberg: Springer. Milewski, N. (2010). Immigrant fertility in West Germany: Is there a socialization effect in transitions to second and third births? European Journal of Population, 26, 3, S. 297-323.

# EINLEITUNG

The impacts of reproductive patterns on health and mortality in western societies have been studied a lot in epidemiology, social sciences and medicine. Besides a huge amount of research on children’s health, cognitive abilities and careers see e.g. {see Goisis:2017hr, Winter:2014to, Tearne:2015hr}, in the last two decades an increasing amount of interest is drawn towards parent’s physical and psychological condition in later life (see for an overview:{see Barban:2013cl, Barclay:2016bs, Grundy:2015gz, Kravdal:2012cb, Modig:2017kn, Read:2011cf, Umberson:2010iz} (hier am besten die Metastudien!). In ageing societies, this new focus fits well with the generally growing interest in the impact of life course events on elderly people’s health and healthy ageing.

However, the linkage is not solidly understood yet {Modig:2017kn p. 424; Umberson:2010iz p.16}XX, XX); a variety of positive and negative associations has been observed which accumulate over lifetime. Some findings that apply to one country or cohort and age group do not do so for others {Grundy:2009ix, Umberson:2010iz}. Also, the overall impact of parenting on health, compared to other variables named above, is rather small (parity: Doblhammer 2000, HURT2006:55 / timing: ) but long term implications have been found for both women and men.

Analysis generally indicate that fertility quantum and fertility timing have implications on the parents health and mortality.

“With increasing life expectancy in almost all locations

worldwide, the question of whether the years of life

gained are spent in good health or poor health is

increasingly relevant because of the associated policy

implications, ranging from health-care provisions to

extending retirement ages.”

“This is relevant from a policy point of view. The potential benefits of marriage have influenced, at least in part, several US governmental initiatives in recent years that encourage and support marriage (Lichter et al. 2003; Acs 2007). Consequently, this led to a debate on the effectiveness of pro-marriage policies among the scientific community (McLanahan 2007; Amato 2007; Nock 2005). However, the ‘‘de- standardization’’ of life course led to a large variety of patterns of family formation that goes beyond marriage. The study of family trajectories may highlight disadvantaged situations and it may permit design of appropriate interventions.” {Barban:2013cl p.362}

“Fertility is a central element of the life course for women. The timing of pregnancy and childbirth as well as the number of births are central in shaping women’s opportunities, attitudes, decisions, and behaviors. Recent trends toward later childbearing and increased childlessness have prompted concern over whether and how there might be long-term consequences for women’s later life health and survival. Principles of historical and social contingency are key (Elder et al., 2004), such that patterns and relationships should vary across time, place, and group ” {Spence:2009ha p.1625}

# FAZIT

No parity effect was seen for breast cancer, however, which may signal that the social effect is set off against an adverse physiologic effect of motherhood for this particular cancer. Kravdal 2003: 261Among

*Becoming a parent is both detrimental and rewarding. With the exception of social integra- tion, which is greater for all groups of new par- ents compared with their childless counterparts,*

*#the effects of parental status on adults’ lives vary markedly by gender and marital status. Unmar- ried parents report lower self-efficacy and higher depression than their childless counterparts. Mar- ried mothers’ lives are marked by more house- work and more marital conflict but less depression than their childless counterparts. Parental status has little influence on the lives of married men.*

So, fertility may be a very complex health relevant factor. Like alcohol consumption which is health promoting für bestimmte personengruppen (when consumed in small quantities) but also health schädigend bei erhöhtem Konsum… (gehört in Vortrag Niko Rittenau bei ca 14min: <https://www.youtube.com/watch?v=mCEmjYCs8MA>) „Lakohol ist nicht per se gesund aber wenn leute ein erhöhtes Herzerkrankungsrisiko haben, zeigen Versuche dass ein moderater Alkohol dieses Risiko etwas verringern kann, dafür wird aber das Krebsriskiko erhöht. In Summe, netto ist es also für einige Menschen ein Zugewinn, für andere eher ein Verlust“

Finally, and no less importantly, “unmeasured heterogeneity” (or variables omitted from the analysis) may influence the results observed in potentially sig- nificant but unknown ways. Sample attrition through institutionaliza- tion or mortality or unmeasured indicators of illness in early life, hostile workplaces, hazardous neighborhood environments, poor schools, or the quality of diverse social relationships may contribute to observed cumulative patterns of well-being but typically are unmeasured (or can- not be measured) in surveys. ORand:2009vf p.125

On the analytic side, some scholars have argued that the genetic, physical, and psycho- logical constraints on how people live out their lives and the interindividual variations result- ing from these constraints are not just non- negligible but rather overwhelming compared with the determinants resulting from sociocul- tural differences (Rutter 1997, Shanahan et al. 2003). It is obviously difficult, if not impossible, to assess such relative weights, although one might at least tender the hypothesis that across evolution, social and cultural construction (Mayer 2009: 420)

would tend to increase in their relative weight and internal factors would recede in impor- tance (Mayer 2003). In stark contrast, however, Heckhausen (1999) (see also Schmeiser 2006) argues that psychological modes of regulation of the life course should become more impor- tant than structural or institutional constraints. She makes a distinction between external and internal regulation: External regulation is equated with social conditions such as legal sanctions, group pressure, or organizational rules; internal regulation is equated with rela- tively stable psychological dispositions related to modes of adaptation and coping, or with regard to substantive preferences. Heckhausen (1999, pp. 34–35) claims that “external enforce- ment via societal power has gradually, over centuries, been transformed into internalized rules and norms of conduct and behavior. This process of internalization renders the need for external societal enforcement obsolete.” Heckhausen’s position is consistent with soci- ologists’ claim that life courses have become deinstitutionalized and that cognitive bio- graphical scripts about the normal life course have become more important (Kohli 1985). Mayer 2009: 421)

EINLEITUNG: Potentially adverse effects of parenthood include the stresses of rearing children, the narrowing of opportunities for fulfilment in other roles and potential role overload, substantial economic costs, and, in the case of those becoming parents at young ages, possible disruption of educational and career trajectories (Joshi 2002; Moffit et al. 2002; Evenson and Simon 2005; Pudrovska and Carr 2009; Dariotis et al. 2011; Wolf et al. 2011). The extent and effect of these stresses may vary according to parenting trajectories and other circumstances, for example partnership status and financial resources. Additionally, not all life-style changes associated with parenthood are beneficial and parenthood and higher parity are associated with weight gain and obesity in American and some other populations (Umberson et al. 2011).

(Grundy Read 2015, p.111)

The detrimental effects of low and high parity on mortality among both men and women suggest a non pregnancy-related pathway that is likely mediated by biological and psychosocial factors and other lifestyle characteristics that have long-term conse- quences into older ages. Further research is warranted to examine the effects of parity by specific cause of death. JAFFE 2013 abstract

The impact of a woman’s reproductive history on her life span is small, however, compared to the influence of her level of education or family status. DOBLHAMMER 2000

Maybe the effect becomes visible in old age when when health goes down and the need of family support increases.

„ Taken as a whole, the results provide support, albeit indirect support, for our argument that variation in mental health among parents reflects a myriad of factors affecting different parenting experiences.

we agree with mental health and family scholars that the benefits derived from parenthood may be canceled out or exceeded by the costs associated with the role, “ EVENSON 2005 355

The findings generally show that becoming a parent can entail both great- er costs and higher levels of benefits compared with those who remain childless, depending on the adult’s social position. (Nomaguchi 370)

It is equally important for future research to investigate whether individuals select themselves into—and out of—certain types of parenthood on the basis of their mental health status. EVENSON 2005 355

„Another possibility is that the relationship between fertility and post-reproductive mortality is spurious. The age pattern and level of fertility may reflect background or early life disadvantages (e.g., childhood poverty and disease exposure or underlying health status), which may also influence mortality. It is particularly important to consider social causation and selection in interpreting observed relationships. Background factors and other characteris- tics may vary widely across social groups within the same society, e.g., for blacks and whites in the US. „ (Spencer 2009)

„We commend the value of bio-psycho-social and life course perspec- tives (Ryff & Singer, 2005; Sauvain-Dugerdil, Leridon, & Mascie-Taylor, 2006) for further research on the influence of marital status, childlessness, and health as people move through adulthood into late life. A life history framework is especially valuable for identifying the critical influences and possibly enduring effects of family events such as marriage, divorce, and wid- owhood, as well as childbirth, coresident parenting, the departure of children from home, and ongoing interaction with them afterward. With the emer- gence of chronic disease and mental health as major health concerns for the future (World Health Organization, 2005), we need to know more about the “trigger points” and durations of health-risking and health-promoting expo- sures throughout the life course. Understanding family influences on health has potential to identify opportunities and guide actions that can improve health in later life (Kendig, Browning, & Wells, 1998). „ (kendig 2007, 1482)

**Our findings bringintosharpfocus theideathateconomicandeducationalpolicies thataretargetedat children'swell-beingareimplicitlyhealthpolicies witheffectsthatreachfar intotheadultlifecourse.** {Hayward:2004jm}

The impact of a woman’s reproductive history on her life span is small, however, compared to the influence of her level of education or family status. The results of this study are consistent with the hypothesis that reproduction and longevity are closely related. However, differences in reproductive history do not explain much of the large variability in longevity. The influence of reproductive history on longevity, although statistically significant, is small compared to differences in longevity stemming from environmental factors such as level of education or family status. Among the different patterns of childbearing, giving birth early in life has the largest impact on longevity. It is also the only fertility characteristic that differs between Austria and England and Wales in terms of the extent of excess mortality. Whether the observed relationship between reproduction and longevity among women indicates a physiological trade-off between reproduction and longevity or is the result of social and cultural factors is a question that cannot be answered decisively. For humans, insights will be gained by conducting research using data on individuals that contain full life histories rather than just fertility histories. The analysis of the relationship between fertility and longevity among men will also shed light on this question. {Doblhammer:2010cg}

Results for all men and women (Figures 1 and 2) showed that when all intermediate factors were entered in the model, the direct (unmediated) associations between large family size and limiting long-term illness disappeared. {Grundy:2015gz 130}

“This study provides evidence that adolescent childbirth may increase the risk of developing chronic diseases and physical limitations in older age. Results likely reflect both the biological and social consequences of early childbearing and if the observed relationship is causal, it reinforces the importance of providing contraception and sex education to young women, as the consequences of early pregnancy may be life-long. ” {Pirkle:2014il}

Beruf und Familiengründung folgen keinem festen und verbindlichen Lebenslaufre- gime mehr, sondern sind de-standardisiert und müssen in unserer individualisierten Gesellschaft von den Einzelnen (und Paaren) individuell entworfen und entschieden werden. Die Entscheidung, jetzt (noch) kein Kind zu wollen, gründet meistens in *ratio- nalen* Erwägungen aufgrund äußerer Umstände sowie zur Wahrung von Chancen für die nahe und mittlere Zukunft: {Anonymous:2015ur: p 13} bundesministerium für familie

In sum, recent research emphasizes that the well-being of new parents cannot be fully understood without considering the timing and context of the transition to parenthood. Becoming a parent may be a profound stressor, with negative long-term consequences for some people and an important source of well-being for others. Yet recent studies provide mixed results on the long-term implications of early age at first birth. Emphasis on the contextual nature of new parenthood is consistent with the life course perspective that draws attention to heterogeneity among individuals experiencing the same transition under different circumstances and at different stages of the life course. Emphasis on context is particularly important, given demographic changes in age and marital status at first birth as well as the role of new reproductive technologies that facilitate childbearing at older ages (Friese, Becker, & Nachtigall, 2006; Santelli et al., 2009). Future research should continue to emphasize parenthood within the context of these trends. We now turn to studies that move beyond the transition to parenthood to focus on the effects of young children on parents. (umberson p.5)

Recent research on parenting adult children clearly shows that parenthood is a role that never ends. Studies emphasize the “linked lives” of parents and adult children and reveal multiple ways in which relationships with children remain an important influence on parental wellbeing throughout the life course. Not surprisingly, the quality of relationships with children is positively associated with parents’ mental health. Moreover, the way children turn out and succeed or fail in socially desirable roles is related to parents’ psychological outcomes and self-concepts. This conclusive demonstration of parents’ and children’s interdependent life course trajectories is an important contribution of this decade’s research, although we need to move from studies based on one focal child to research designs that consider multiple children in the family. Attention to parents’ relationships with all their children may shed more light on parental ambivalence, because research consistently shows that intergenerational relationships can entail both positive and negative consequences for parents. Studies of this decade point to the importance of exploring contexts in which parent-adult child relationships are beneficial or deleterious to parental well-being. Race, gender, marital status, living arrangements, and transitions and stressors in the lives of parents and children create diverse contexts in which parent-child relationships unfold, and we cannot understand the influence of parenthood on well-being without understanding these contexts.

UMBERSON 12

Whereas our analysis showed statistically significant effects of parental status on adults’ lives, the explained variance of the models is relatively small, and the mean differences be- tween new parents and those remaining child- less are minimal. NOMAGUCHI 371

SINGLE / MARRIED PARENTS

“Adults and children in single-parent households are at risk for adverse health outcomes, including mental illness (e.g. substance abuse, depression, suicide) and unhealthy behaviors (e.g. smoking, excessive alcohol use, food insecurity).[1-4] Self-reported health has been shown to be worse among lone mothers than for mothers living as couples, even when controlling for socioeconomic characteristics.[5] Mortality risk is also higher among lone parents.[6] Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households.[7]”

<https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors/family-social-support/children-in-single-parent-households>

A screenshot of a cell phone

Description automatically generated

<https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model?componentType=health-factor&componentId=12>

A major theme of recent research is that parenting of minor children is more stressful in some social structural contexts than others. In particular, parenthood is associated with higher levels of distress for the unmarried than the married (Evenson & Simon, 2005), and unmarried women are at greater risk than unmarried men (Hughes & Waite, 2002). Hughes and Waite analyzed Health and Retirement Survey data and concluded that single women with children (compared to married women and men living with or without children) were more disadvantaged across a range of health outcomes, including depressive symptoms, self- rated health, mobility limitation, long-term disability, and chronic conditions. Avison, Ali, and Walters (2007) found that single mothers were more distressed than married mothers over time largely because unmarried mothers were exposed to higher levels of stress across several life domains. In particular, single mothers faced more stress associated with caregiving for family members, finances, and work-home balance. Avison and colleagues suggest that policy initiatives aimed at encouraging marriage to enhance the well-being of single mothers would be better directed toward reducing the structural disadvantage and higher levels of stress that single mothers confront in their daily lives.

Single father families, virtually nonexistent before 1970, constituted more than 18% of all single-parent households in 2003 (Fields, 2003). Single fathers may encounter unique stressors and use coping strategies specific to those stressors (Cole, 2009). Future research should begin uncovering how and why these father-only families are formed, because the context of single fatherhood—in addition to the status itself—has important implications for fathers’ well-being. UMBERSON 6

In summary, although the evidence is somewhat difficult to interpret due toconfounding factors, full-term pregnancy appears to have a protective effect on the riskof ovarian, endometrial and breast cancer but a small increased risk of cervical cancer

RIECK 237

Among men, both marriage and parenthood were associated with a good prognosis. Married male cancer patients with children had mortality one-third lower than that among the childless and never-married. Women who had never married did not have the same disadvantage. Kravdal 2003: 261

# STEPPARENTS

Roughly one fourth of all families with minor children include stepchildren, and about half of stepfamilies have nonresidential stepchildren (Stewart, 2005) with nearly a third of U.S. children spending some time in a stepparent household (Ganong & Coleman, 2004). Stepfamily characteristics are highly diverse, with shifting relationship types (stepsiblings, half siblings, stepgrandparents), relational dynamics, and living arrangements (Ganong & Coleman). When children are young and require continuous parental care, stepparenthood may be associated with elevated parental strain that is often exacerbated by marital conflict, role and boundary ambiguity, and incomplete institutionalization of stepfamilies (Stewart). Stepparenting may be especially stressful for step*mothers* (Stewart). Because of traditional gender dynamics in stepfamilies, stepmothers tend to assume primary responsibility for relationships with minor and adult stepchildren and act as kinkeepers in the blended family (Schmeeckle, 2007). Yet Kohler, Behrman, and Skytthe (2005) found that having stepchildren in the home reduced self-reports of well-being for men but not women. For stepparents who remained married over time, Stewart found that the stress of boundary ambiguity declined with union duration (for marital and cohabiting unions). Most research on stepfamilies focuses on wellbeing of children rather than parents. A recent exception, relying on cross-sectional data, indicated that adults living with minor stepchildren were no more distressed than their childless peers (Evenson & Simon, 2005). Future research should consider whether selection processes play a role in that individuals who become stepparents and remain married may be those who feel more open to the parenting role.

Given the significant number of adults who stepparent at some point in their lives, it is important to consider how stepchildren affect well-being later in the life course. Evenson and Simon (2005) reported that having nonresidential adult stepchildren was associated with elevated levels of distress, relative to the childless and relative to other parents, but their study is limited by a cross-sectional design. Pudrovska’s (2009) longitudinal analysis showed that having a stepchild does not compromise mental health of middle-aged and older adults and that the psychological implications of stepparenthood do not differ by gender. Whereas women may be more affected by enduring parental strains in young and middle adulthood, the effect of stepparenthood may be similar for mothers and fathers in later life when men’s and women’s parental roles tend to become more similar. At this point, research evidence is mixed, and generalizations cannot be drawn. This heterogeneity points to the importance of context in which the stepparent role unfolds, including characteristics of parents and children as well as the quality of family relationships. Parents who have both stepchildren and their own children may face unique stressors associated with parenting children with different biological relatedness, contributing to greater psychological distress. Moreover, the experience of stepparenthood may depend on timing in the life course—with different effects for those who become stepparents of a young child, an adolescent, or an adult child. Future research should explore how the effects of stepparenthood are shaped by the joint life course trajectories of stepparents and stepchildren. UM BERSON 7

# RESTE

Another causal link could be a higher **will to fight** for survival of those with offspring when faced with a disease and mortality {Kravdal:2003ee p.264}.

Early life health influence: “Taken together,these results support the hypothesis that childhood health influences health and economic status throughoutthe life course. ” {Case:2010va p.1}.

Some papers define childlessness for women at the age of 45 as permanent {Bujard:2016uu}; In official statistics the cohort fertility of 50+ women counts as their final number of children {Destatis:2012uh p.24}.

In England early parenthood and larger family size are associated with less wealth and poorer health behaviours and this accounts for much of the association with health. At least part of this operates through stress-related physiological dysfunction (allostatic load). {Grundy:2015gz}

The ideal number of children is typically higher than the realistically aspired and completed fertility in western societies, where it lies arounf two children are considere to be optimum

{Peter:2015um p. 24;, Nauck:2010kl p.227}. (while the opposite is true in developing countries like India or Palestine)

{Peter:2015um p. 24;, Nauck:2010kl p.229}.

Disabled children: A diary study of parents with autistic children found that parents’ coping strategies influenced the degree to which daily parenting stressors affected their well-being (Pottie & Ingram, 2008). Parents who used more problem-focused, social support, positive reframing, emotional regulation, and compromise coping experienced higher levels of well-being. This study points to personal resources that may buffer parents from the effects of parenting stress. A few studies point to the importance of linked lives across three generations in providing support for children with disabilities (for a review, see Mitchell, 2007). For example, S. Green (2001) found that secondary assistance from grandparents helps parents of children with disabilities to have a positive outlook and avoid physical exhaustion. Future research should consider how personal and social resources that may influence well-being are distributed across social groups. UMBERSON 9

PARENTING STRESS: Studies clearly establish that parenting stress adversely affects parents’ well-being. There is general consensus that parental stress is greater as individuals make the transition to parenthood and when children are young (Kluwer & Johnson, 2007). Moreover, individuals in certain social contexts—for example, unmarried, women, lower socioeconomic status— are more likely to experience parenting as stressful because they encounter more life strains around parenting (Crouter & Booth, 2004). In turn, parental stress mediates the impact of minor children on parental well-being. Next, we consider how the strains and rewards of parenting may change as parents and their children age. Disabled children: A diary study of parents with autistic children found that parents’ coping strategies influenced the degree to which daily parenting stressors affected their well-being (Pottie & Ingram, 2008). Parents who used more problem-focused, social support, positive reframing, emotional regulation, and compromise coping experienced higher levels of well-being. This study points to personal resources that may buffer parents from the effects of parenting stress. A few studies point to the importance of linked lives across three generations in providing support for children with disabilities (for a review, see Mitchell, 2007). For example, S. Green (2001) found that secondary assistance from grandparents helps parents of children with disabilities to have a positive outlook and avoid physical exhaustion. Future research should consider how personal and social resources that may influence well-being are distributed across social groups. UMBERSON 9

# ADULT CHILDREN

In a review of 1990s research on families of later life, Allen, Bliezner, and Roberto (2000) concluded that research on the effects of adult children on parents was an important yet

understudied area. The past decade witnessed advances in this area with two basic assumptions driving research. First, relationships with children remain salient and important to parents’ well-being throughout life. This is reflected in frequent contact between parents and adult children and in their mutual exchange of support and affection (Knoester, 2003; Mandemakers & Dykstra, 2008). Second, the quality of intergenerational relationships matters for parents’ well-being (Koropeckyj-Cox, 2002; Milkie et al., 2008). Studies consistently show that emotionally close and supportive ties with adult children enhance parents’ well-being, whereas strained and conflicted relationships with children undermine well-being (Knoester). Relationships with adult children are more likely to be characterized by support than strain, but the strained aspects of relationships appear to be more salient for well-being (Knoester). Most survey research on relationships with adult children has been based on questions about one focal child or on global reports about relationships with all of one’s adult children, but recent studies have shown that a strained relationship with any one child in a family can undermine parental well-being even if relationships with other children are generally positive (Ward, 2008). Like research on parenting minor children, research on parenting adult children shows that the experience and consequences of parenting for wellbeing are shaped by social structural contexts of parenting, perhaps particularly marital status and gender. Studies have shown that divorced fathers have more distant and strained relationships with adult children, whereas divorced mothers may experience closer and more supportive relationships with adult children (Shapiro, 2003). It appears that strains with adult children have stronger adverse effects on unmarried parents (Greenfield & Marks, 2006), whereas support from adult children may be particularly beneficial to widowed parents (Ha, 2008; Ha, Carr, Utz, & Nesse, 2006). One would further expect the experience and consequences of having adult children to vary depending on whether or not parents share a residence with children. UMBERSON 10

A review of the caregiving literature is beyond the scope of the present review (see Silverstein & Giarrusso, this volume, for a review); however, it is important to recognize that adult children are a potential resource for impaired parents. This is especially the case for unmarried parents who may not have access to other informal caregivers (Pinquart & Sorenson, 2007). Although adult children may be an important resource for aging parents, studies have shown that parents are more likely to give than to receive support from adult children and that parents who provide financial and instrumental assistance to their adult children exhibit fewer depressive symptoms than other parents (Byers, Levy, Allore, Bruce, & Kasl, 2008; Silverstein, Conroy, Wang, Giarrussso, & Bengtson, 2002). UMBERSON 12

# EARLY FIRST BIRTH

The findings show, that 45 per cent of the teenage mothers in

our sample succeeded to reach financial independence from social welfare. Economic

well-being among teenage mothers is mainly influenced through attachment to the labour

market, as well as being in a stable relationship lasting more than five years. Both

variables show a significant direct effect to avoiding dependence on social benefits. The

findings highlight the importance of both employment as well as the quality of intimate

relationships in shaping successful adult transitions. The two factors could work

independently, where teenage mothers either succeed to establish themselves in the

labour market, or in finding a supportive partner - or the two factors operate in

conjunction, where early mothers share responsibility with their partner in providing

economic and emotional support for their family. In our sample of teenage mothers we

found 29% single mothers; 9% of mothers living in a relationship where no partner was

employed; 22 % were in a single breadwinner household; and 39% living in a household

where both partners were working.

Generally the findings highlight the importance of intimate relationships in

supporting successful development.

<https://www.researchgate.net/publication/225304835_Pathways_to_Economic_Well-Being_Among_Teenage_Mothers_in_Great_Britain>

Results from tobit models indicate that obesity, especially when experienced early in life, is consistently related to lower-body disability. The results also show that obesity has long-term health consequences during adulthood, altering the life course in an enduring way. FERRARO Abstract

A birth before age 20 significantly increases the mortality

risk late in life in both populations but in the

English/Welsh data-set excess mortality is nearly

three times as high (26 per cent) as in the Austrian data-set (9 per cent). DOBLHAMMER 2000 172

Die Untersuchung zeigt, dass es zum Haupttrend des aufgeschobenen Kinderwunsches den Gegentrend bei einer Minderheit von **ca. 20 % der Frauen und Männer** gibt, die sich bereits **im Alter von 18 bis 22 Jahren ein Kind wünschen und trotzdem lange kinderlos blei­ ben**. In traditionellen Milieus der Ober- und Mittelschicht („Traditionelle“, „Konservative“) sowie in Milieus am unteren Rand der Gesellschaft mit relativ kurzer Schul- und Ausbil- dungszeit („Benachteiligte“, „Hedonisten“) ist eine frühe Elternschaft vor allem für Frauen normal und auch eine normative Erwartung in dieser Phase des Lebensverlaufs: Mutter- schaft als Symbol für Erwachsensein, Angekommensein und Zugehörigkeit. {Anonymous:2015ur p.13}

Analyses of associations between age at childbearing and later health consistently show disadvantages for women, and in a few studies men, who embark upon parenthood at an early age (Doblhammer, 2000; Grundy & Holt, 2000; Grundy & Kravdal, 2008; Grundy & Tomassini, 2005; Henretta et al., 2008; Mirowsky & Ross, 2002; Spence, 2008). These may reflect consequences of early parenthood, such as disruption of educational and occupa- tional attainment (Sigle-Rushton, 2005), and adverse childhood circumstances, propensities for risk taking and other factors asso- ciated both with early entry to parenthood and poor health (Henretta et al., 2008; Hills et al., 2004; Schmidt, 2008; Sigle- Rushton, 2005). Grundy et al 2010

*p* 0.04 (table 1). Similar to Westendorp and Kirkwood we find a tendency that the 29% of female peers who gave birth before their 20th birthday experience an increase in late-life mortality of 22% ( *p* 0.11). We do not find a mor- tality advantage for late mothers (at least one birth after age 40). DOBLHAMMER OEPPEN

Furstenberg (2007) found no or only moderate negative consequences of early childbirth for a group of unwed mothers 40 years later, after controlling for selectivity.

„Histor- ical and social contexts of the transition to motherhood likely shape women’s childbearing strategies (Elder et al., 2004). Because weathering implies a younger optimal age at childbearing for black than white women, it may be that these strategies will vary by race „ (SPENCE EBERSTEIN 2009)

„We find early childbearing to be associated with higher mortality among whites, while later childbearing is associated with higher mortality among blacks. The effect of age at first birth on white women’s mortality is explained by background and mediating social, economic, and health related factors, but this effect remains robust for black women. „ (SPENCE EBERSTEIN 2009)

“The importance of age at first birth was checked in models restricted to parous women. No significant effects appeared for either gender (Table II). Effects have been seen for breast cancer patients in some previous studies but did not show up here. ” kravdal 2003

Kroman *et al.*12 reported significantly better breast cancer prog- nosis among women who had their first child in their 20s than among those who entered motherhood as teenagers. There were also indications of relatively poor survival among those who started childbearing late. However, in Canadian18 and American16 studies, age at first birth was not found to affect prognosis. Effects were not found in Norwegian4 and Australian5 studies of colorectal cancer survival either. In the present study, age at first birth did not have an effect in any model, not even for breast cancer patients. This indicates that future research perhaps should focus less on this and more on other reproductive variables. kravdal 2003 265

“Generally, childless young adults report better well-being than parents (Nomaguchi & Milkie, 2003), although one study found that childlessness in young adulthood may be stressful in the context of thwarted fertility intentions, especially for women with lower family income (McQuillan, Greil, White, & Jacob, 2003). (Umberson 2010, p.2)

”

The transition to parenthood is a pivotal life course transition (Knoester & Eggebeen, 2006), and many studies in the 2000s focused on the *timing* of this transition in the life course. Demographic research on childbearing and the timing of first births has long employed a life course perspective to reveal how socioeconomic antecedents and consequences of early childbearing create life course trajectories of cumulative disadvantage for parents. Early transition to parenthood, particularly during the teen years, has been associated with truncated educational and work opportunities and increased marital instability (Hofferth, Reid, & Mott, 2001)—all factors that might undermine well-being in the short and long term (Booth, Rustenback, & McHale, 2008). Early transition to parenthood is a contemporary concern given the recent upturn in teenage pregnancy after nearly a decade of teenage pregnancy decline (Santelli, Lindberg, Diaz, & Orr, 2009).

A few recent studies consider the impact of early parenting transitions on mental health, with a focus on young adulthood. Booth and colleagues (2008) analyzed a longitudinal sample of young adults and found that, although socioeconomically disadvantaged adults were more likely to make early transitions to parenthood, they were not at increased risk for depression 5 years later. The authors concluded that early transitions “can be rational and sound” (p. 12) for certain individuals. This upbeat conclusion dovetails with Edin and Kefalas’s (2005) qualitative (in-depth interview) study on early parenthood for poor women. Although they did not focus on well-being, they concluded that poor women (age 15 to 56, average age 25) often viewed parenthood as a way to find meaning and purpose amidst limited life chances (notably, this study does not compare young mothers to their childfree peers or those who delayed parenthood). Knoester and Eggebeen (2006) considered the effects of transition to fatherhood for men (age 19 to 65) with a national longitudinal sample and, similar to Booth and colleagues, found no significant effect on men’s psychological well-being. Taylor (2009), using the Wisconsin Longitudinal Study (WLS), compared the psychological well-being of midlife adults who had children before and after the age of 20 and also found no significant effects of early childbirth on men’s or women’s psychological well-being.

In contrast to these studies, Mirowsky and Ross (2002) analyzed a cross section of individuals age 18 to 95 and concluded that early transitions to parenthood are associated with increased risk for depression. They found that men and women who have their first child prior to age 23 are more depressed than their childless peers but that, after age 23, those who have a child are less depressed than the childless. This suggests that later or on- time transition to parenthood might actually benefit well-being. Men experienced a monotonic increase in benefits the longer they delayed their first child. Women experienced increased benefits from age 23 to 30, but not beyond this age. These findings may contrast with the Booth and Eggebeen studies because Mirowsky and Ross considered long-term life course effects of early parenthood on depression rather than short-term effects of the transition experience among young adults. Although the Mirowsky study relied on cross- sectional data, it is unlikely that retrospective reports of age at first birth are biased. Adverse effects of early parenting transitions were also reported by Henretta (2007), whose longitudinal analysis showed that age at first birth was associated with increased mortality

(umberson p.4)

risk for women who gave birth prior to age 20. Similarly, Taylor (2009) found that, at midlife, those who became parents before the age of 20 had worse self-rated health than those who became parents after the age of 20, and Spence (2008) found that early transition to parenthood was associated with more depression and activity limitations in late life.

(umberson p.5)

# Late FIRST Birth / End of Womens Fertility Phase

Menopause occurs between the ages 45 and 55 (average 51) but fertility is expected to end 5 to 10 years before menopause, for most women sometime in their mid-40s. The loss of fertility happens because of age-related and genetically disposed declining quantity and quality of female eggs. By age 40, the chance to get pregnant is less than 5% per cycle and this also holds true for conception using fertility treatments. However, even young women can lower their reserve of healthy eggs through unhealthy behaviour like smoking. Smokers appear to experience menopause on average 0,75 years earlier than non-smokers (Yang *et al.* 2015). Poor ovarian reserve and eggs of lower quality, i.e. either too few chromosomes or too many, do not result in pregnancy or lead to miscarriage, so these women have a lower chance of becoming pregnant than other women of their age group (Medicine 2012).

For men, their sperm quality starts deteriote much later in life which generally does not become a problem before age 60. And some men, especially those who maintain good health, do not experience any significant changes in reproductive functioning over their life course (Medicine 2012).

As the age at Menopause onset correlates with health status (XX) and mortality (Quellen (53–55).), Age at menopause seems to be a predictor or a result of health.

54. Jacobsen BK, Heuch I, Kva ̊le G. Age at natural menopauseand all-cause mortality: a 37-year follow-up of 19,731 Nor-wegian women. Am J Epidemiol 2003;157:923–9.

In a cohort of 19,731 Norwegian postmenopausal women, the authors analyzed relations between the age atnatural menopause and all-cause mortality. A total of 18,533 women died during the 37 years of follow-up from1961 to 1997. An inverse relation was found between the age at menopause and the all-cause mortality rate(p = 0.003). The strength of the association was moderate, however, with 1.6% (95% confidence interval: 0.6, 2.7)reduced mortality per 3 years’ increase in age at menopause. The impact appeared to be stronger in women withan attained age of less than 70 years (3.7% reduction in risk) than in women aged 80 years or more (1.0%). Theinverse relation could not be explained by extreme mortality rates in women with very early (<40 years) or late(>55 years) menopause or by possible confounding variables like birth cohort, place of residence, occupationalcategory (own or husband’s occupation), body mass index, age at menarche, and first and last delivery or parity.The smoking prevalence was low in the underlying population, and the use of hormone replacement therapy wasvery rare. The authors conclude that age at natural menopause is inversely related to all-cause mortality.

55. Snowdon DA, Kane RL, Beeson WL, et al. Is early natural menopause a biologic marker of health and aging? Am JPublic Health 1989;79:709–14.

A screenshot of a social media post

Description automatically generated

(Bujard and Diabaté 2016 p.401)

Einstellungen zum idealen ErstgebäralterDie Befunde belegen eine große Diskrepanz zwischen Wunsch und Wirklichkeit (.Tab.3): DasidealeGebäralterfürFrauenwirdimAltervon26,9Jahrengesehen,alsoknapp3JahrejüngeralsdastatsächlichedurchschnittlicheErstgebäraltervon29,5Jahren.MitsteigenderformalerBildungsteigtdasIdealalterfürdieersteGeburtleichtan:BefragtemiteinerniedrigenBildungsehenalsIdealalter26,3 für Frauen an. Bei den Hochgebildeten, die ihre Kinder auch tatsächlich später bekommen,sind es 27,7 Jahre. Jedoch sind die Unterschiede nach Bildungsgruppen weniger ausgeprägt alsdie tatsächlichen Zahlen für das Erstgebäralter. Insofern besteht bei Akademikerinnen eine nochstärkere Kluft. In den neuen Bundesländern, in denen bis vor einigen Jahren die Kinder nochsehr früh geboren wurden, wird dementsprechend das Idealalter für Frauen niedriger beziffertals im früheren Bundesgebiet.Bei der Betrachtung der prozentualen Verteilungen zeigen sich weitere Anhaltspunkte fürein Leitbild des idealen Erstgebäralters:Teenagerschwangerschaftenwerden nahezu von allenjungen Erwachsenen abgelehnt. Jedoch auch die sehr späte Geburt von Kindern, nämlich nachdem 35. Lebensjahr, wird nicht als ideal bewertet. Lediglich 1,7 % der Befragten sehen diesenZeitraum als ideales Erstgebäralter für Frauen an. Betrachtet man die Männer, so denken 8,8 %,dass es ideal sei, nach dem 35. Lebensjahr eine Familie zu gründen (nicht in Abb. gezeigt). Späte Vaterschaft wird deutlich eher akzeptiert als späte Mutterschaft. Für Frauen sehen 62,1 % dieAltersphase zwischen dem 25. und 29. Lebensjahrals ideal für die Geburt des ersten Kindes an.In der Leitbildstudie wurden auch die Bedingungen erhoben, die erfüllt sein sollten, bevor einPaar Kinder bekommt: Nur eine Minderheit (16,1 %) ist der Ansicht, dass ein Paar verheiratet seinmuss, um Kinder zu bekommen. Jedoch halten 79,1 % der jungen Erwachsenen die finanzielleAbsicherung für eine zentrale Bedingung, um eine Familie gründen zu können. Auch sieht eineMehrheit (60,4 %) die Voraussetzung als zentral, dass die Frau im Beruf Fuß gefasst haben muss,unabhängig davon, ob ihr Partner arbeiten geht.

(Bujard and Diabaté 2016 p.401)

In today’s society, age-related infertility is becoming more common because, for a variety of reasons, many women wait until their 30s to begin their families. Even though women today are healthier and taking better care of themselves than ever before, improved health in later life does not offset the natural age-related decline in fertility. It is important to understand that fertility declines as a woman ages due to the normal age-related decrease in the number of eggs that remain in her ovaries. This decline may take place much sooner than most women expect. P.3

As women age, fertility declines due to normal, age-related changes that occur in the ovaries. Unlike men, who continue to produce spermthroughout their lives, a woman is born with all the egg-containing follicles in her ovaries that she will ever have. At birth there are about one million follicles. By puberty that number will have dropped to about 300,000. Of the follicles remaining at puberty, only about 300 will be ovulated during the reproductive years. The majority of follicles are not used up by ovulation, but through an ongoing gradual process of loss called atresia. Atresia is a degenerative process that occurs regardless of whether you are pregnant, have normal menstrual cycles, use birth control, or are undergoing infertility treatment. Smokers appear to experience menopause about 1 year earlier than non-smokers.P.4

A woman’s best reproductive years are in her 20s. Fertility gradually declines in the 30s, particularly after age 35. Each month that she tries, a healthy, fertile 30-year-old woman has a 20% chance of getting pregnant. That means that for every 100 fertile 30-year-old women trying to get pregnant in 1 cycle, 20 will be successful and the other 80 will have to try again.

<https://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/Age_and_Fertility.pdf>

and a positive association between late age at first birth and breast cancer (Harvard Report, 1996). These associations are assumed to largely reflect hormonal and other physiological changes triggered by pregnancy or lactation, which may also affect risks of developing other cancers (Harvard Report, 1996; Kabat, Miller, & Rohan, 2007). Grundy et al 2010

Associations between late parenthood and subsequent health or all-cause mortality are less clear. Some studies suggest advantages for those having children relatively late in life (Grundy & Kravdal, 2008; Grundy & Tomassini, 2005; Perls, Alpert, & Fretts, 1997; Yi & Vaupel, 2004), but others the reverse (Alonso, 2002; Cooper, Baird, Weinberg, Ephross, & Sandler, 2000; Spence, 2008). Grundy et al 2010

Women who have their first full-term pregnancy after age 35 or who never carried a pregnancy to term have a higher risk of ovarian cancer.

https://www.cancer.org/cancer/ovarian-cancer/causes-risks-prevention/risk-factors.html

Grundy and Kravdal 2010 Cancer

Für statistische Analysen wird angenommen, dass das gebärfähige Alter zwischen 15 und 49 Jahren liegt. RKI 2015 complete report 103

“Older age at first birth was generally associated with lower risks of antidepressant purchase. ” {Kravdal:2015jp}

“By these ages, estimates of fertility–mortality relationships are not biased by the inclusion of women whose fertility may not be complete or by maternal mortality. ” (Spence 2009)

“Late first births are associated with higher mortality risks among blacks (Table 5 and Fig. 1). In contrast, whites who begin childbearing early face higher odds of post-reproductive mortality controlling for age and characteristics of early life (Models 1 and 2 in Table 4, and Fig. 2). ” (spence 1628)

“A very different pattern of relationships is suggested among black mothers. As in Table 3 for all women (including the childless), we see in Table 5 a similar protective effect of 4 or more births that seems to wear off with age. In addition, timing of first births is important. Late first birth (ages 25 or older) is associated with a sixty-nine percent higher odds of death during the post-repro- ductive period (OR 1⁄4 exp(.525) 1⁄4 1.69), compared to having a first child between ages 17–24. This relationship is robust, even with controls for all the variables in the analysis. Although there may be important selection processes, these data suggest that the fertility– ” (spence 1628)

”

“Others, employing more rigorous statistical methods and a wider range of controls, find that women with later first births do not live longer (Mueller, 2004; Smith et al., 2002). ” (spence 2009)

Nulliparity and late childbearing are associated with higher risks of breast cancer (Kvale et al. 1994; Madigan et al. 1995; Grundy and Kravdal 2010). (Grundy Read 2015, p.110)

while late childbearing (after 40) was sometimes found to be associated with lower mortality, sometimes not

Whereas old age at first birth (that is 40+ in most studies) is associated with lower mortality for women {Grundy:2005ca}, lower risks of antidepressant purchase {Kravdal:2015jp},

“Late childbearing (after age 39) was associated with lower mortality. ” {Grundy:2005ca}

“Results for age at last birth showed, again consistent with results for all births, an advantage for mothers whose last birth was at age 40 or over. ” Grundy2005

“Late motherhood (>35) was associated with better cognitive function.” {Read:2016cq}

Placenta presia bei >34

<https://www.ncbi.nlm.nih.gov/pubmed/12820840>

„restricted the study population to women aged ]/40 years or provided stratified estimates for this age group. We excluded data on younger women because they might not have completed their childbearing, and because their mortality might have been directly linked to pregnancy. Mortality during and shortly after pregnancy is known to be associated with parity, with mortality highest during the first preg- nancy and at higher pregnancy orders (AbouZahr and Royston 1991), and we were concerned that these parity-specific patterns in mortality in younger women might mask a longer-term effect of repro- duction on survival. We defined women who had completed their childbearing as women aged 40 and over, since age-specific fertility is very low after this age (Macfarlane and Mugford 2000). „ (Hurt 2006)

Nulliparity and delayed childbearing are associated with an increased breast cancerrisk for oestrogen-receptor-positive rather than receptor-negative tumours.116,117Theevidence is conflicting however since a Norwegian study indicated that up to 45years, nulliparous women have a lower breast cancer risk than ever-parous women.118A French cohort study of 100 000 women with 1718 cases of breast cancer showedfurther evidence that the overall risk increased with increasing age at first birth and lowparity. Age at first full-term pregnancy had an effect on both pre- and postmenopausalbreast cancer risk, with risk increasing each year of increasing age. A first full-termpregnancy over the age of 30 years conveyed a risk of 1.63 (95% CI 1.12–2.38) and 1.35(95% CI 1.02–1.78) in the pre- and postmenopausal groups, respectively. RIECK 237

The risk of cervical cancer is higher in parous women and increases with number ofbirths. Among parous women the risk tends to increase with later age at last birth.113Data from Danish and Swedish registries indicate higher rates of cervical canceramongst women having children with two or more partners.114,115 RIECK 237

# Critical/Sensitive Periods

<https://www.diw.de/en/diw_01.c.504995.en/press/diw_roundup/health_consequences_of_childhood_and_adolescence_shocks_is_there_a_critical_period.html>

During critical periods of development exposures have effects on the body, that – together with later stressors - lead to disease much later in life. Induction and latency periods may be very long but, which makes it difficult to detect the causal agents of a disease {Kuh:2003vb p.780}.

“The elderly and children – from in utero through adolescence – are particularly susceptible to environmental pollution. Worldwider, the per-capita number of helathy life years lost to environmental risk factors is about five times greater in children under five years of age than in the total population (Prüss-Üstün and Corvalan, 2006)”

<https://read.oecd-ilibrary.org/environment/oecd-environmental-outlook-to-2050_9789264122246-en#page282> page 282

Doch nicht alle Entwicklungen, die zum späteren Kinderkriegen beigetragen haben, seien nur positiv. Einen deutlichen Einfluss schreibt Geis-Thöne der Unterhaltsrechtsreform von 2008 zu. „Frauen müssen sichergehen, dass die Partnerschaft belastbar ist, bevor sie sich für den Nachwuchs entscheiden“, glaubt der Ökonom.

„Im Falle einer Trennung hat die Frau jetzt keinen langfristigen Unterhaltsanspruch mehr“ – das führe zu Ängsten auf Seiten der Frauen. „Denn wenn es schiefgeht, geraten sie schnell in eine wirtschaftlich sehr ungünstige Situation“, bedauert Geis-Thöne. Der Effekt mache sich jetzt noch bemerkbar, weil Frauen im Bekanntenkreis Trennungen erlebten, die sie abschrecken könnten.

https://www.welt.de/wirtschaft/article199638854/Geburtenstatistik-Warum-Zehntausende-Frauen-erst-ueber-40-Mutter-werden.html

# IDEAL TIME AT FIRST BIRTH

Regarding the age when ideally the first child should be born,two trends were found in the sample of those who haveremained childless so far: 38% of all respondents articulatedthe wish to have their first child between the ages of 25–29years. Another 38% wanted to fulfil their wish of having achild between the ages of 30 and 35 years; the first child wasdesired at a mean age of 29.9 years. With increasing age, theideal age for the first gravidity also increased. STÖBEL RICHTER 2005 2851

# IDEAL NUMBER OF CHIDLREN

When asked about the ideal number of children, 53% of allrespondents stated the wish of having two children; 9.5% con-sidered it ideal to have no children. Contrasting the actual andthe ideal numbers of children (Table III) about half of allrespondents who considered one child as ideal, have made thisideal wish become a reality, but only 38% of those whoregarded two children as ideal, actually had two children. STÖBEL RICHTER 2005 2851

# MARRIAGE AND HEALTH

Zweitens greift die Konzentration, insbesondere der US-Forschung, auf Gesund- heitsvorteile Verheirateter zu kurz. So hat die Prävalenz nichtehelicher Lebensfor- men in Europa über die vergangenen Dekaden stark zugenommen und zu einer Pluralisierung von Lebensformen geführt (vgl. Brüderl 2004), weshalb Vergleiche z. B. zwischen Ledigen und Verheirateten der real existierenden Diversität von Partnerschaftstypen zunehmend weniger gerecht werden. Daher stellt sich immer dringender die Frage nach den relevanten Vergleichsgruppen, also den zu analysie- renden Lebensformen (Carr und Springer 2010, S. 748): Zumindest wären gesund- heitliche Outcomes Verheirateter wohl mit denen nichtehelich Zusammenlebender (NEL, nichteheliche Lebensgemeinschaften), partnerschaftlich gebundener, aber nicht zusammenlebender Personen (in einer bilokalen Partnerschaft) sowie partner- loser Individuen (Singles) zu vergleichen. die Befunde deuten, insbeson- dere bei in Trennung oder Scheidung lebenden Singles, auf eine temporäre Abnahme nach Partnerschaftsbeginn bei generell steigendem Trend des psychischen Distress hin. Eine Wiederheirat nach einer Scheidung oder Verwitwung scheint auch in anderen Studien mit geringeren gesundheitlichen Verbesserungen einherzugehen als eine Erstheirat (Barrett 2000; Johnson und Wu 2002

BECKER 2017

Marital status was included in these models. Otherwise, about 6% sharper effects of childbearing would have been seen for men, while estimates for women would have been largely the same (not shown). Never-married male cancer patients had a 16% higher mortality than the married, and the divorced or separated had an 11% higher mortality. Both differences were significant. The es- timates suggested a high mortality also for the much smaller group of widowers, but this was not significant. Smaller differences were seen among women. A significant 10–12% excess mortality was kravdal 2003) 262

found for those who were divorced or separated, while there was no excess mortality for the never-married and widowed.

Effects of never being married (but not of being formerly married) would have been sharper in the absence of reproductive variables in the models. These simple models revealed excess mortality of 1.45 [95% confidence interval (CI) 1.34–1.59] for never-married men and of 1.14 (95% CI 1.06–1.23) for never- married women (not shown). (Except for the very high mortality among never-married men, the effects of marital status in these models were of the same size as those found in the previous Norwegian study, which was based on a larger number of some- what older women followed only up to 1991.2)

Combined effects of marital status and parity were also esti- mated (not shown). Most interestingly, married men with children had a mortality one-third lower than that of the childless and never-married. kravdal 2003) 264

“Studies on the United States highlight the positive association between marriage and a various range of health outcomes for both men and women. Married adults are less likely to die in any given period than the unmarried (Lillard and Waite 1993; Dupre et al. 2009; Rendall et al. 2011), they also appear to have better mental health than their counterparts (Lamb et al. 2003; Horwitz and White 1998; Soons and Kalmijn 2009; Meadows 2009) and they are less likely to engage in unhealthy behaviors (Duncan et al. 2006).” “Most studies examine health differences by marital status in order to identify the causal effect of marriage. Generally, they compare health outcomes of married men and women versus unmarried (or cohabiting) people or they examine the effect of changes in marital status across life course (Nock 1981).”{Barban:2013cl}

„A large number of works demonstrate that married people are healthier, happier and less likely to engage in health threatening behaviors (for a review, see Wood et al. 2007; Schoenborn 2004) In the literature, the benefits associated with marriage are generally called the ‘‘protection effects’’ of marriage (Waldron et al. 1996). In their review, Musick and Bumpass (2006) suggest four possible explanations: institutionalization, social roles, social support, and commitment. Marriage is an institution where spouses have defined social roles both inside and outside the household (Gove 1972; Ferree 1990). Moreover, marriage is a source of social support. Spouses provide intimacy, companionship, and daily interaction. At the same time, married people are connected to a larger network (e.g., friends, kin). This enlarges the social capital from which spouses can draw in case of need. Last, the public nature of marriage strengthens commitment and facilitates joint long-term investments, including financial, role specialization, and time spent in the care of young children. Commitment strengthens bonds between partners and serves as a barrier to exit. It is not clear, however, if these benefits are unique to marriage or whether they can be extended to other intimate relationship, particularly cohabitation. Evidence is mixed: Wu and Hart (2002) find no health effects of entering into marriage or cohabitation in Canada. Horwitz and White (1998) find differences in happiness, but no disadvantages in terms of depression. Musick and Bumpass (2006) examine several dimensions of wellbeing including psychological health, social ties, and relationship quality and they do not find significant differences between married and cohabiters. In comparative research using data from 30 european countries, Soons and Kalmijn (2009) find that the cohabitation gap (with respect to marriage) in wellbeing is associated with the degree of acceptance of non-marital unions in the society.

„ {Barban:2013cl p.360}

t age 30 very few women are single (because they did not enter a union, or because of a disruption)

“Table 2 shows differences in self-reports of physical health, adjusted for age and years of education. Across the three countries, few consistent dif- ferences were observed regarding the reports of poor (including “fair”) self- rated health. In Australia and Finland, formerly married childless men were most likely to report poor health, whereas in the Netherlands they were least likely to report poor health. In the Netherlands, never-married childless men were most likely to report poor health, whereas this group reported favorably about their health in Finland. Among Finnish women, the never- married childless and currently married mothers were least likely to report poor health. ” {Kendig:2007ja 1473}

“Never-married childless men were least likely to perceive they were fitter than their peers. Among women, cur- rently married childless women were least likely to report they were fitter than their peers. This question was not in the Finnish survey. Only Netherlands and Australia” {Kendig:2007ja 1474}

“We turn next to our measures of mental health. As Table 3 shows, diffi- culty falling asleep was clearly more frequent among women than men. This pattern was observed in each of the three countries. In Australia and in the Netherlands, never-married childless women were less likely to report sleeping problems than women in other marital and/or parental status cate- gories. In Finland, formerly married childless men were most likely to report difficulty falling asleep, whereas formerly married childless women in the Netherlands were the most likely to report sleep problems. ” {Kendig:2007ja 1475}

“Being formerly married was associated with a greater likeli- hood of depression in all three countries. Consistent parental status differ- ences and gender differences were not observed. Although never-married men were least likely to report depressive feelings in Finland, they were highly likely to do so in Australia. Formerly married childless men in Finland and formerly married childless women in Australia were also highly likely to report feelings of depression. Finally, currently married Dutch men, regard- less of parental status, were unlikely to report depression. ” {Kendig:2007ja 1477}The first indicator of positive health behavior was the daily consumption of fruit in winter (see Table 4), included in the Australian and Dutch but not the Finnish survey. In the Australian and Dutch data, a clear gender differ- ence emerged: Men were less likely to eat fruit daily than women. In both countries, formerly married fathers were least likely of all to consume fruit on a daily basis in winter. In the Netherlands, never-married men were also unlikely to eat fruit daily. {Kendig:2007ja 1477}

Each survey included information on smoking behavior. Gender and marital status differences were found in Finland and the Netherlands but not in Australia. Overall, Australians were least likely to report being cur- rent smokers. In Finland and the Netherlands, men were more likely to be current smokers than women, and the unmarried were more likely to be cur- rent smokers than the married. In both countries, parenthood differences in the likelihood of being a smoker were observed; however, the pattern dif- fered by gender. In Finland, childless men were more likely to be smokers than fathers, whereas in the Netherlands, childless women were more likely to be smokers than mothers. In all three countries, the likelihood of being a current smoker was highest among never-married childless men. {Kendig:2007ja 1477}

In each country, women generally were less likely than men to walk outdoors; however, there were variations by parental and/or marital status. Finnish and Dutch formerly married men were less likely than currently married men to walk outdoors, particularly if they were childless. In Finland and the Netherlands, currently married mothers were most likely of all groups of women to walk outdoors. In the Netherlands, a high likeli- hood of walking outdoors was also observed for never-married women.

Australian men were more likely to report being physically active than Australian women, with the exception of never-married childless men who were particularly unlikely to engage in sports. A gender difference was not observed in Finland or the Netherlands; instead, parenthood rather than gender or marital status accounted for differ- ences in physical activity. Finnish and Dutch formerly married childless men were unlikely to engage in sports or physical exercise. Among the Dutch, this was also the case for never-married men. Childless women in the Netherlands were less likely to engage in physical exercise than mothers. In Finland, this was so for ever-married childless women, not for the never married.

{Kendig:2007ja 1479}

This positive image is further supported by cross-national data showing that never married childless women had high levels of social activity (Wenger, Dykstra, Melkas, & Knipscheer, 2007) and were more highly educated than other groups of women (Koropeckyj-Cox & Call, 2007).

# Single Mums

From a policy point of view, we are interested in detecting what subgroups of population are at risk of experiencing poor health, for example, single motherhood (Furstenberg 2005, 1998, 1976). Previous studies show lower levels of health among single mothers, in particular mental health (Cairney et al. 2003), propensity to smoke (Francesconi et al. 2010), and also higher level of mortality (Mirowsky 2005). Therefore, it is relevant to study the consequences of different patterns in family formation. {Barban:2013cl p.376}

# Vocabular merhode / analyse

Table 1 shows that the estimated correlation coefficients