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Does MPF Put Women at Risk?
Theories of Multipartnered Fertility and Health
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Abstract

Though having children with more than one person (a.k.a. multipartnered fertility or “MPF”) has been depicted as a social problem with many negative correlates, research has not clearly demonstrated whether multipartnered fertility has direct effects on well-being or if these negative outcomes result from selection into this family form. I address this puzzle by proposing a thought experiment which holds constant selection effects and other confounders while assessing three theoretical mechanisms by which MPF could negatively influence the health of women, including: Boundary Ambiguity, Social Stress, and Social Support. Assessment of the theories suggest that even if women had identical socioeconomic histories prior to childbearing and the same number of partners and children throughout the life course, women with multipartnered fertility remain at greater risk for mental and physical health problems over time compared to their single partner fertility counterparts. Implications for future work are discussed.

Key Words: boundary ambiguity, life course perspective, multipartnered fertility, multiple partner fertility, social support, stress process
INTRODUCTION

The last four decades have witnessed substantial changes in the way people form and dissolve relationships throughout their lives. As a result of increases in divorce, cohabitation, and nonmarital fertility, the opportunities for adults to have children with more than one person have risen substantially (Ellwood & Jenks, 2004; Hamilton, Martin, & Ventura, 2010). Current estimates suggest that nearly one in five U.S. women have children with more than one man (hereafter referred to as multipartnered fertility or “MPF”) by the time they reach their forties and finish childbearing, and among mothers who have two or more children—when multipartnered fertility is even possible—the rate is even higher, at 28% (Dorius, 2010). To put these numbers in perspective, roughly 4.4 million women have experienced this family pattern by the time they reach middle age. This is particularly true among minority women, with the rates being highest among African Americans (40% of whom have children with more than one man by their mid to late forties, over 1.1 million), then Hispanics (27% report MPF at midlife, around 917 thousand), followed by non-Hispanic Whites (14% report MPF at midlife, about 2.1 million) (Dorius 2010; www.factfinder2.census.gov). Furthermore, estimates of MPF among women who are earlier in their childbearing career suggest this has become a practice embraced by all age groups (Evenhouse & Reilly, 2010), underscoring the prevalence and importance of MPF as a significant family form throughout the lifecourse.

Although research on the consequences of MPF is still in its infancy, most work on this topic indicates that having children with several partners is associated with a host of negative outcomes for women (Klerman, 2007). For example, mothers who experience MPF tend to be socially and economically disadvantaged and report lower levels of education, more time in poverty, and longer stints of unemployment compared to mothers who have their children with the same man (Carlson & Furstenberg, 2006; Dorius, 2010; Guzzo & Furstenburg, 2007;
Manlove, Logan, Ikramullah & Holcombe, 2008; Monte, 2011). There are also important distinctions in the relationship experiences of MPF and single partner fertility women, with MPF women reporting poorer quality intimate relationships and knowing their partner for a shorter period of time before getting pregnant (Carlson & Furstenburg, 2006). Further, evidence suggests that experiencing MPF may lead to greater instability and more partners over time because women who have children with more than one man are less likely to marry, more likely to cohabit, and more likely to engage in a series of short unstable relationships compared to other women (Harknett & McLanahan, 2004). In terms of fertility, women who have children with more than one man report earlier first sexual experiences and childbearing as well as higher rates of non-marital births and more children overall (see Carlson & Furstenberg, 2006; Dorius, 2010; Guzzo & Furstenberg 2007; Harknett & Knab 2007; Manlove, Logan, Ikramullah, & Holcombe 2008).

Despite the growing body of literature on the negative consequences of multipartnered fertility in women’s lives, it remains unclear whether MPF directly effects women’s well-being or if these negative correlates result from selection into this family form. Because having children with more than one man is most common among women who are socioeconomically disadvantaged prior to childbearing it is possible that many of the consequences associated with MPF are actually a reflection of early exposure to poverty and reduced educational opportunities, poorer marriage markets or interaction with the criminal justice system. Furthermore, it may be one of the component parts of multipartnered fertility (e.g., having more children, more partners, or more relationship instability than other women) driving the experiences of these families rather than the culminating exposure to having children with more than one man.

Using this puzzle as a backdrop, this paper constructs a “thought experiment” to test three theoretical mechanisms by which MPF could negatively influence the health and well-being of
women, including: Boundary Ambiguity, Social Stress, and Social Support. I address the issue of selectivity by comparing two women with different MPF histories but identical socioeconomic backgrounds, childbearing, partnering, and relationship instability experiences. The goal of this experiment is to answer the basic questions that have plagued MPF research since its inception: Does multipartnered fertility really matter for understanding individual well-being? And if so, why?

**METHOD**

**Thought Experiment: Introducing Alice and Betsy**

Figure one provides a visual depiction of the thought experiment proposed here, including the relationship and childbearing histories of Alice and Betsy, two fictional women who represent differences among families with single partner fertility (all children born to the same birth partner, hereafter referred to as SPF) and multipartnered fertility (children born to two or more birth partners, also known as MPF). In the first scenario Alice married and divorced quickly, was single for a time, and then later remarried a man with whom she had two children. In the second scenario, Betsy married a man and had one child. After a time, she and her husband divorced, and as a result Betsy was a single mother for a period. Later, Betsy remarried and gave birth to a second child.

It is important to note that multipartnered fertility is a gendered experience, and as such it is likely that men and women have a unique set of pathways through which MPF may affect their health and well-being. For example, mothers like Betsy tend to take on the female-specific role of primary caregiver when they break up with or divorce men, which is why her child remains with her after her divorce from her first husband. Conversely, fathers like Bill often become non-resident parents with ongoing financial obligations for children after a relationship dissolves. Though I will address some of the issues MPF fathers may face when describing Bill’s situation,
for conceptual clarity the focus of my assessment will be on Alice and Betsy, with the goal of reflecting the unique experiences of MPF mothers and their children.

As dictated by the needs of the thought experiment, when considering the example of Alice and Betsy one should imagine these women came from the same neighborhood, with families of roughly the same size, producing a similar income, and having a similar level of residential and relationship stability throughout their early lives. As adults, these women made similar choices in terms of their partnering and childbearing: and as seen in the figure the women share the same household level relationship history of marriage → divorce → remarriage, the same number of transitions (3 total), the same number of partners (2 total), and the same number of children (2 total). In most standard research assessments these women would appear identical, so why do some family scholars expect them to have unique outcomes from one another?

**Conceptual Model: Testing the Relationship between MPF & Health Vulnerabilities**

At the core of research on MPF is the belief that regardless of how similar women appear according to traditional measures of family life, if one has children with more than one man they may experience a unique array of life events which may lead to disparities in well-being. The reasons for some of the distinctions between MPF and SPF families can be illuminated by applying the life course perspective (Elder, Johnson, & Crosnoe 2003) to understand how women may be set onto different life course trajectories because of their agency, or the ability to make their own choices about who to partner with and when to have children, the timing of singlehood relative to childbearing which introduces single parenthood into most MPF families, and the interdependency of lives between the mothers, resident and non-resident fathers, and full and half siblings. Further, as each woman encounters her own unique set of life course experiences she may be more or less vulnerable to ambiguity in the family system, an array of
Does MPF Put Women at Risk? Theories of Multipartnered Fertility and Health

Figure 2 illustrates a conceptual model with pathways from multipartnered fertility through these key mechanisms of Boundary Ambiguity, Social Stress, and Social Support onto health vulnerabilities. Note that mental and physical health have been chosen as the outcome of interest in this conceptual model because they are a reflection of general well-being, are relatively easy to assess in most surveys, and tend to act similarly in theoretical and analytical models because they “correlate highly...they share common causes, they affect each other, and signs of one are often are signs of the other” (Ross, Mirowsky, & Goldsteen 1990, p. 1060).

In keeping with the goals of the thought experiment, the model incorporates the reciprocal influence of MPF and social and economic disadvantage, instability, partnering, and childbearing as the foundation for understanding the pathways between multipartnered fertility and women’s mental and physical health. As noted in the leftmost side of the figure, socioeconomic disadvantage and family instability often precede multipartnered fertility, but may also be affected by it over time. These social conditions may also have independent effects on the stress process outside of their relationship with MPF, which may indirectly influence mental and physical health. Similarly, the component parts of MPF, including childbearing, instability, and partnering, precede multipartnered fertility but may also be altered by it over time. They may also have independent effects in the stress process, influencing mental and physical health. Though there are other potential reciprocal relationships among each of the theoretical mechanisms depicted here, this conceptual model is purposefully kept succinct, with the goal of focusing on the main potential pathways between MPF and well-being.
**Figure 1.** Visual Depiction of Selected Multipartnered Fertility and Single Partner Fertility Families with Identical Childbearing, Partnering, and Instability Histories

**Scenario A- Single Partner Fertility:** Alice marries and divorces Alex, then remarries Andy. She has two children with Andy.

**Scenario B- Multipartnered Fertility:** Betsy marries and divorces Bill, then remarries Bob. She has a child with each man.

**Key: Instability, Childbearing, and Partnering Measures For Scenarios A and B**

<table>
<thead>
<tr>
<th>Family Measure</th>
<th>Assessment</th>
<th>Distinctions between A&amp;B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship trajectory</td>
<td>marriage, divorce, remarriage</td>
<td>identical for Alice &amp; Betsy</td>
</tr>
<tr>
<td>Number of transitions</td>
<td>three</td>
<td>identical for Alice &amp; Betsy</td>
</tr>
<tr>
<td>Number of children</td>
<td>two</td>
<td>identical for Alice &amp; Betsy</td>
</tr>
<tr>
<td>Number of partners</td>
<td>two</td>
<td>identical for Alice &amp; Betsy</td>
</tr>
<tr>
<td>Multiple partner fertility</td>
<td>no (A), yes (B)</td>
<td>only Betsy</td>
</tr>
</tbody>
</table>

Alex

Bob

Betsy

Bill

Alice

Andy

Alice Jr.

Andy Jr.

Bill Jr.

Bob Jr.
THEORY

Boundary Ambiguity

As women spread childbearing across relationships they have the potential to introduce a tremendous amount of uncertainty into the family system regarding “who, when, and how members participate in family life” (Carroll, Olsen, & Buckmiller, 2007, p. 210). As a result of family relationships being uncertain or misaligned families can experience high levels of stress or dysfunction (Pasley, 1987). Previous work has found that unclear family boundaries are more prevalent among complex families, including cohabiters, people who have remarried, and step-families (Brown & Manning 2009; Carroll et al., 2007; Pasley, 1987) all of which are more common in MPF households. Furthermore, ambiguity in parent-child, mother-father, and sibling bonds can influence the quality of the dyadic relationships as well as the stability of the family system as a whole (Boss, 1977; Carroll, Olsen, & Buckmiller, 2007). For example, because of overlapping and reciprocal ties between family members, when family dyads are in conflict the
tenor of the home is likely to become querulous which may result in more hostility, less warm and supportive behaviors, and ultimately, more family instability (Conger, et al., 1990). One reason ambiguity might be salient among complex families is because each is likely to face unique “problems for which institutionalized solutions do not exist. And without accepted solutions to their problems, families must resolve difficult issues by themselves. As a result, solving everyday problems is sometimes impossible without engendering conflict and confusion among family members” (Cherlin, 1978, p. 642).

An extension of Boundary Ambiguity theory would suggest that along with uncertainty being more prevalent among MPF families, unclear boundaries may be more pronounced as MPF trajectories increase in complexity, as is the case when there are more than two birth fathers, the number of residential partners increases, or when there are multiple relationship transitions. Even in relatively simple scenarios of multipartnered fertility, such as the one proposed in the thought experiment where both women form legal and residential relationships with their partners, there may be considerable ambiguity involved. For a visual representation of ambiguity within simple SPF and MPF family subsystems see Figure 3, which continues to build on the example of Alice and Betsy, who due to their unique SPF and MPF histories have disparities in the type and number of key family relationships. These women illustrate five possible relationship types which are described at the bottom of the figure in terms of their residential statuses, biological ties, and likelihood of ambiguity. Ambiguity is determined by prior research which suggests non-resident fathers have uncertain roles regarding children, ex-partners, new partners, and new children in the mother’s home. Furthermore, new partners often have ambiguous ties to step-children, and half-siblings have ambiguous ties to one another (see Cherlin, 1978; Inger-Tallman & Pasley, 1987; Pasley, 1987). Of the five possible relationship types, Alice’s family experiences three of the forms within six dyadic connections while Betsy’s
family encounters all five types of relationships within ten dyadic relationships. Note that anytime there is a single line linking two people they are biologically related, and whenever there is a dashed line linking two people there is ambiguity in their relationship.

The biggest distinction between the two scenarios presented in Figure 3 is that Betsy is obliged to maintain a relationship with her first partner because she shares a common child. Consequently, every time she re-partners there is a built-in source of ambiguity in her family system. As noted by Inger-Tallman and Pasley (1987),

The presence of children...complicates the lives of all members of a remarried household because children require continued interaction between parents—interaction which is often legally demanded as a part of custody and visitation arrangements. Thus, while divorce represents the end of the marital relationship, it does not mean the termination of the parental relationship. When children are involved, the presence of a former spouse or parent means that custody arrangements, financial support, and visitation schedules must be negotiated (p. 13).

As a result of these ongoing ties to men outside the household, Betsy’s family is characterized by boundaries that are more subjective, volatile, and dependent on the salience of the nonresident bond. And, when women start new residential relationships, it can have a substantial effect on the perception of family roles and responsibilities, often to the detriment of the first child:

Depending on custody and visitation arrangements, children, as well as other family members (e.g. stepgrandparents, stepsiblings), may or may not consider their ‘new’ siblings to be members of the remarried family. While the new siblings may be considered as family members by their biological parent, their stepparent may have some confusion about their membership in the new family. Also, the stepparent and non-residential parent (usually the stepfather and father) may share economic responsibility for the children as well as some degree of parental authority in terms of daily child care, but the legal rights of stepparents are ill-defined or non-existent. Thus, in the remarried family, the family boundary is not clearly defined, particularly where non-residential children from a prior marriage are concerned (Pasley, 1987, pp. 209 - 210).
Given that women often form MPF families with a mixture of cohabiting unions, marriages, dating relationships, and periods of singlehood, the likelihood of ambiguity is even greater for these families compared to those who only marry and divorce (see Manlove et al., 2006; Dorius, 2010), although the same type of ambiguity process should be operating for each of these types of families (e.g. Brown & Manning, 2009).

Even in the simplistic example of Betsy’s MPF family, there is a tremendous amount of role confusion, with over half of the dyadic relationships being ambiguous. Interestingly, the woman with MPF experiences the least amount of relationship ambiguity followed by her second partner and second child, then her first child, and finally, her first partner. The high level of ambiguity among ex-partners may help explain why these men frequently reduce contact with their children when women move in with or marry someone new (Hofferth, Pleck, Stueve, Bianchi, & Sayer, 2002). Moreover, this pattern of ambiguity points to areas of future research, which should consider how multipartnered fertility influences child well-being when controlling for child birth order, given that the first child is particularly vulnerable to family role confusion relative to their sibling(s). Even though Betsy may be better off relative to her children and partners in terms of understanding her own roles within the larger group, the notion of spillover within the family system (Almeida, Wethington, & Chandler, 1999) posits that it is not just the mother’s dyadic relationships that will influence her well-being, rather it is the burden of ambiguity throughout the MPF family system that may influence her mental and physical health.

In stark comparison to Betsy’s experience of ambiguity is the example of Alice, who has no reason to keep in contact with her first partner and as a result is able to create a family unit that is both biologically and spatially self-contained. According to Pasley (1987), in these types of families “spouses have clearly defined legal ties to their children, and siblings have recognized legal ties to each other because they share the same parent” and as a result, this
family is regarded as having a “physically defined system with fairly impermeable boundaries” (p. 209). Furthermore, in this SPF home there are fewer relationships overall and less room for role confusion and ambiguity to emerge. In fact, among the seven dyadic relationships in Alice’s family, none are overtly ambiguous which means that for each individual, other than Alex who is no longer part of the family system, every person has three dyadic ties to the family, and all of these relationships are thought to be governed by institutionalized roles and norms.

Taken together, the theoretical concept of Boundary Ambiguity and spillover indicate that women with MPF, like Betsy, are much more likely to face confusion and ambiguity within family system compared to SPF women like Alice. And these comparisons are not reliant on differences in SES or prior partnering, childbearing, or instability. Furthermore, this exposure to ambiguity is not likely to be benign for MPF women. Boundary Ambiguity is thought to change the tenor of the home and lead to chronic problems in the family, such as increased stress, dysfunction, and instability, all of which may spillover to the mother and influence her mental and physical health.

**Social Stress**

There are a number of social stress theories which have been widely used in understanding the relationship between family instability and well-being. In fact, much of the empirical work that links health and marriage has been explained with variations on Pearlin’s stress process model (Pearlin & Johnson, 1977) which considers how the chronic stressors, events, and roles one experiences may create a series of stressors or supports that influence well-being overtime. These three approaches will be considered in more detail as potential mechanisms for understanding the relationship between multipartnered fertility and health vulnerabilities.
Figure 3. Visual Depiction of Boundary Ambiguity in Selected Single Partner Fertility and Multipartnered Fertility Families

Note: The lines connecting each dyadic pair indicate whether the relationship is considered ambiguous according to Boundary Ambiguity theory and/or biological. See key below for more details.

Scenario A: Alex, Alice, and Andy

Scenario B: Betsy, Bill, and Bob

Key: Explanation of Dyadic Relationships in Scenario A and B

<table>
<thead>
<tr>
<th>Line Style</th>
<th>Assessment</th>
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<tbody>
<tr>
<td>Solid</td>
<td>Non-ambiguous</td>
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<tr>
<td>Dashed</td>
<td>Ambiguous</td>
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<tr>
<td>Single line</td>
<td>Biologically Related</td>
</tr>
<tr>
<td>Double line</td>
<td>Non-biologically / Part-biologically Related</td>
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A. **Chronic Stress**

Chronic stressors are related to one’s social statuses, social structures, and social situations, and are thought to make people more or less susceptible to the experiences that cause stress (McLanahan, 1983). These can include earned characteristics such as education, employment, or income, or personal physical attributes or even mental attributes like personality or coping strategies. These characteristics are often included as controls in models of family life, but they also represent key theoretical pathways influencing mental and physical health throughout the life course and have been used to examine the relationship between marriage and health for several decades (Coombs, 1991; McLanahan, 1983; Wheaton, 1990). As Thoits notes (2006) the aim of this approach has largely been to demonstrate that health inequalities are “socially produced and are thus explained in large part by social forces” (p. 311), so it is critical to account for the women’s personal attributes when trying to understand how they deal more or less effectively with the problems of everyday life.

Thinking back to the conceptual model illustrated in Figure 2, chronic stressors are a key to understanding the relationship between socioeconomic disadvantage and poorer health. One reason this may be the case is because individuals who are disadvantaged in terms of their education, employment, or income may face a number of chronic strains such as food insecurity or the lack of adequate employment, housing, or personal resources that could help them to maintain a healthy lifestyle or provide consistent access to quality care. There is also a potential direct linkage from MPF to chronic stress, because women with children from more than one man occupy a unique social location wherein they tend to have less economic and social resources, more children, and less consistent partner and kin support, all of which may culminate overtime to make the women less able to seek after and maintain a lifestyle that promotes mental and physical health. As noted by McLanahan (1983), “certain social categories are more
stressful than others and chronic strain has a cumulative negative effect on mental health and well-being” (p. 348), and as a result, it is likely that the pathway from MPF to health is greatly influenced by the chronic stressors these women face on an ongoing basis.

**B. Event Stress**

The stress process related to events includes things that disrupt one’s day-to-day life and often lead to change in social networks (McLananhan, 1983). Implicit in this approach is a belief that the events one experiences can determine the strength and direction of the MPF and well-being association. This view is the backbone to the family literature which finds that discrete events, such as marriage, can create positive support which facilitates well-being, while others events, like divorce or separations, can lead to stress which can harm well-being. This trait-approach implies that event characteristics such as undesirability, unpredictability, and event magnitude drive the strength of the association between well-being and family life so that events that are highly stressful along a range of criteria are more likely to be associated with declines in well-being (Dohrenwend, 1974; Wheaton, 1990).

Building on this idea, Holmes and Rahe (1967) developed a stressful life events scale that provides comparable stress ratings for a number of common life and family events such as death, divorce, pregnancy, vacation, and problem’s with one’s boss. The scale was created by asking people to rate each of the items according to how stressful they thought they were. About 1/3 of all of the items on Holmes and Rahe’s scale are directly tied to family instability and tend to include both positive and negative life events such as the. death of spouse, divorce, marriage, marital reconciliation, pregnancy, gain of new family member, change in responsibilities, revision of personal habits, and change in social activities. An additional 22% of the items are possible latent consequences of instability, such as moving to a new home, changing residences, changing schools, having a child move out, having trouble with in-laws, or changing work hours.
This reinforces the notion that life events, particularly those tied to the relationship formations and dissolutions common in MPF families, may be influential in understanding the amount of stress one experiences, and help explain the direct link between stress and childbearing, partnering, and instability illustrated in Figure 1.

Furthermore, there is likely a strong and direct link between MPF and event stress because, for the majority of women, multipartnered fertility includes an accumulation of event stressors and strains that single partner fertility women, like Alice, do not have to encounter. When a woman’s relationship with a birth father dissolves she is often faced with several emotionally draining events at once, including mourning a failed relationship, gaining full custody of a child, becoming a single parent, and experiencing a severe loss of income. Taken together, the emotional and financial strain may leave MPF mothers like Betsy worse off than their single partner fertility counterparts, like Alice, even net of earlier exposure to socioeconomic disadvantage. Research on family instability suggests that following a union dissolution many women are likely to report internalizing problems such as depression (Simon, 2002), lower income and wealth (Stirling & Aldrich, 2008), a higher risk of wealth disadvantage in old age (Wilmoth & Koso, 2002), and an increased risk of exhibiting health problems (Dupre & Meadows, 2007). In addition to the effects of a single disruptive event, previous research has found that event stress can be cumulative, and that if a person experiences a number of dissolution events over time, they are more likely to become ill or report psychological distress (Barrett, 2000; Cooper, McLanahan, Meadows, & Brooks-Gunn, 2009; Warheit, Holzer, Bell & Arey 1976). Further, if the individual is already under stress because of past events, then a new transition might create higher levels of stress than would otherwise occur (Zhang & Hayward, 2006).
C. Role Stress

A final approach to the stress model looks beyond attributes and events and instead focuses on how a person’s experience in the role being altered by the event influences well-being. This role history can be defined by the level of stress the role creates via demands, responsibilities, inequalities, and uncertainties (Wheaton, 1990). When applied to MPF, the role perspective may help to understand the cumulative effect of ambiguous and conflicting roles that make up the family system, particularly as they are responsible for reductions in social and psychological resources that may impact individuals over time.

Although life events may be influential in understanding the amount of stress one experiences, there is also great conceptual value in understanding how these changes may affect family roles and relationships. In particular, when partnerships dissolve and reform, how are the dyadic relations between mothers and their children and partners affected, and how might this influence the tenor of the home? Family roles are critical to the stress process because they have the potential to reduce an individual’s stress by providing support through increasing the number of social and psychological resources available (e.g. this may include things such as social control or monitoring, social capital, and social integration or isolation), or, conversely, roles can increase stress by reducing these resources. For example, one of the important ways that marriage has been thought to influence a women’s mental and physical health is by providing companionship, emotional support, promoting health behaviors, and increasing socioeconomic resources such as access to better medical care and the provision of homes in safer neighborhoods (e.g. Coombs 1991; Ross et al., 1990; Waite & Gallagher 2000). Further, Umberson (1992) found having multiple roles, such as being in a marital relationship and a parent, were each significantly associated with healthier lifestyle choices such as reductions in fighting, drinking, smoking, risking accidents, inadequate sleep, inactivity, and unhealthy eating.
Thus, the mechanism linking single partner fertility relationships (whether marital or cohabiting) to better well-being may be tied to the ability to consistently receive partner support for a healthier lifestyle as well as the simultaneous enactment of the parenting role.

Conversely, one way that the family roles of multipartnered fertility parents may be negatively related to the stress process is through the absence of social and psychological resources. Social resources may include the social networks and intimate relationships that people enjoy on a regular basis (McLanahan, 1983). When a women experiences MPF it is likely that she will have depleted social resources because of the time she spends in a single parent home between relationships with birth fathers, the fact that at least one child has a nonresident father who is likely to provide fewer material and emotional resources to the child and less co-parenting support to the mother (Cancian & Meyer, 2012; Carlson & Furstenberg, 2006). Psychological resources often include intra-personal attributes such as self-esteem and self-mastery (McLanahan, 1983). Research has consistently confirmed that women, who experience a divorce, or other type of significant relationship disruption, go through periods of depression, anxiety, and have lower appraisals of self-worth (Amato, 2000). While these feelings generally improve over time and when a new partner is brought into the household, women who have MPF are likely to experience periods of reduced psychological resources during their post-break up phase, net of prior SES factors that may help to distinguish MPF and SPF women.

When considering the unique role stressors and resources that may be influencing the link between MPF and women’s well-being, it is helpful to visualize some of the common relationships that may be shaping this process. Each of the dyadic relationships between Alice and Betsy and their children and partners are depicted in Figure 4. Note that all of these relationships have the potential to increase or decrease stress (indicated with a + or – sign, respectively) by influencing the availability of social and psychological resources. Because some
of these relationships do both, several relationships have a plus and minus sign, indicating countervailing influences on the stress process. A brief overview of why each relationship is identified as a stressor or support in prior literature is included in Appendix 1. In total, it appears that the net effect of role stress on the women’s sense of well-being is negative for the MPF woman (Betsy) and positive for the SPF woman (Alice) even when holding previous socioeconomic status and family characteristics constant. Part of the negative affect seems to be driven by the sheer number of relationships that must be maintained when MPF mothers add birth partners, resulting in resources being depleted, role stress increasing, and potentially leading MPF women to see reductions in mental and physical health.

### Social Support

A final theoretical mechanism that may be driving the association between MPF and health is social support, also assessed as kin or instrumental support. Harknett and Knab (2007) were the first to test this hypothesis among MPF families and found that the total amount of kin support—in terms of financial, housing, and child-care assistance—tends to be lower than single partner fertility (SPF) families because grandparents provide less instrumental support to blended families, regardless of their son’s or daughter’s current relationship status or income. This suggests that although MPF creates more kin networks from which women might draw assistance, it also promotes weaker familial ties that do not translate to more maternal support, which may lead to less social support and overall declines in well-being. Conversely, in families like Alice’s, where couples have children and remain together, both the husband and his parents are much more likely to provide regular instrumental support for the mother and child (Harknett & Knab, 2007), which is anticipated to have a positive effect on well-being.
In a similar vein of research, Monte (2011) suggests that MPF women lack the same level of access to kin-based childcare as SPF women and this may have substantial influence on their ability to get and maintain jobs. In her sample of low-income mothers, extended family, particularly grandmothers, played an important role in providing childcare while mothers worked. Conversely, women with children from multiple partners were less likely to report
relying on family to care for their children compared to women with children from the same
man, net of family size. In fact, just the opposite was true. Women with MPF, like Betsy, were
more likely to be their child’s sole caretaker, and were more likely to report they lacked ‘enough’
people for whom they could ask small favors compared to SPF women, like Alice, suggesting
that they do not have the same availability of social support as women who have their children
with the same man. This lack of social support has a measurable influence on the women’s lives,
their job prospects, their social relationships, and ultimately, their well-being.

Alternate Specifications for the Thought Experiment

One of the basic goals of the thought experiment was to hold constant the women’s poverty,
education, childbearing, partnering, and relationship instability while we assessed whether
differences emerged between SPF and MPF women. While this was a useful endeavor for
determining that distinctions do arise, even in very simplistic conditions, it was not necessarily
reflective of the realities SPF and MPF women face because of the strict conditions: all families
shared identical relationship histories, had obvious legal and biological ties between each child
and adult, and measured MPF as it was currently occurring. As a result, it is important to
consider how the results might change if alternate scenarios were considered.

According to demographic research on women’s relationship histories from late adolescence
until middle age (see Dorius 2010; ch. 4), about 46% of all births to MPF mothers are nonmarital
and 41% are nonresidential. The most common pattern for these women is to have a first child
with a nonmarital partner and then go on to have a second child within marriage. For SPF
women the opposite is true; these women tend to have 93% of their childbearing within
marriage, and 96% within residential unions. The most common relationship experience for these
women are to get and stay married to the same man throughout their lives (over 50% of women),
although slightly less than half experience relationship instability at some point. As a result, the example provided may work well to describe SPF women like Alice (especially early in their childbearing career), but depicts more marital or residential relationship stability than women like Betsy are likely to encounter. If the thought experiment were based on the more common scenario of marriage→divorce→remarriage for Alice and single→break up→marriage for Betsy, how might the results differ?

Consistent with the boundary ambiguity hypothesis, women with nonmarital unions are likely to experience more ambiguity than married women (Brown & Manning, 2009). As a result, when assessing alternate specifications for the thought experiment that include more cohabiting relationships and periods of singlehood, we can expect to see greater levels of boundary ambiguity among MPF women, likely because the legal and biological ties between children and adults are more prone to confusion than ever before. A similar pattern emerges when considering how singlehood and cohabitation might lead to changes in the stress process. In conditions of stable singlehood for the first birth, women like Betsy might experience less role and event stress because they have fewer residential partners over time, although this would be counterbalanced by ongoing exposure to some of the negative aspects of single motherhood and MPF, including an increase in the chronic stressors of lower income, less consistent tie to the labor market, and lower education than SPF women. Although the total number of relationship events might be less, when the thought experiment is allowed to vary by SES standing, we may expect that MPF women, who tend to be poorer than SPF women, will be more vulnerable to the event stresses they face (Stirling & Aldrich, 2008) leading to a more salient tie between their MPF status and the stress process. Finally, when considering how singlehood and cohabitation might influence the link between MPF and role stress, we uncover few differences between our previous conclusions and the new scenarios, because, as prior research indicates, women with
MPF receive less social support from kin, regardless of their current relationship status, suggesting that they would continue to receive less support whether they were in a marital, cohabiting, or single relationship (Monte, 2011; Harknett & Knabb, 2007).

Overall, it appears that when the thought experiment is allowed to vary in ways that make it more reflective of current family realities, each of the theoretical pathways proposed in the more simplistic scenario continues to hold up. Further, there is no reason to believe that strength or direction of the link between ambiguities, social stress, or social support and health vulnerabilities would lessen in these conditions, indicating that MPF women are more prone to declines in mental and physical health than SPF women, regardless of the scenario addressed.

**Alternate Specifications for the Conceptual Model**

Along with considering changes to the conditions of the thought experiment, it is useful to reflect on how the conceptual model might be altered to understand the experience of other family members, including men and children. As mentioned previously, the process of MPF is highly gendered, and there is reason to believe that MPF may be linked to well-being in male- and female-specific ways. For men, it may be particularly important to add an additional pathway between MPF and health vulnerabilities that goes through resource depletion, because of men’s primary role as a financial provider to nonresident and resident children. But how might men respond to the same set of conditions tested here?

Overall, it appears that model works quite well for understanding the experiences of MPF men whether they are nonresidential ex-partners or current partners. As demonstrated in Figure 3, both resident and nonresident fathers in MPF families are likely to experience a high degree of boundary ambiguity. In fact, when ambiguity within all dyadic relationships is identified one sees that nonresident fathers experience the most ambiguity, followed by the first child, and then
the resident father, suggesting that men in these types of families may be particularly prone to issues of role confusion. Further, when considering how MPF men experience stress, there is no reason to believe that gender would affect the process. When men have relationship formations and dissolutions it is likely to increase their stress in similar ways to women. And like MPF women, these men tend to be poorer, spend more time unemployed, and face educational disadvantages compared to their SPF counterparts, indicating that chronic stressors are likely to be an important predictor of mental and physical health. In terms of role stress, both the nonresident and resident fathers are likely to see declines in their available social and psychological resources, as depicted in Figure 4. Finally, regardless of one’s gender, adults with MPF report less access to instrumental support (Harknett & Knab, 2007) than SPF adults, and these disparities in support may eventually lead to declines in health.

In terms of children, the model works well to describe the residential living conditions they will face throughout childhood, as well as some of the unique pathways that may affect their own well-being. Building on the findings presented in Figures 3 and 4, we see important distinctions in ambiguity and role support resources for SPF and MPF children. Being raised in homes with more ambiguity and role confusion, higher levels of stress among parents, and fewer kin resources from which to draw will likely lead to substantial disparities in well-being among SPF and MPF offspring. Future work should test these connections in greater detail. Further, the findings in Figures 3 and 4 also point to clear distinctions between MPF siblings themselves. Future research should consider how first born children (pre-MPF) fare compared to second born children (after MPF), given that they are likely to experience radically different home lives during childhood. Based on the current demographic trends, the first child tends to experience a relationship breakup, period in single parent home, and time with a step-father while the second child will most likely live with a biological father in a marital relationship. Though the
conceptual model was upheld for adults, it may be that the real strength behind the study of MPF and disparities in well-being will be found in assessing how being raised in home prone to ambiguity, stress, and a lack of social support influences children within and between MPF and SPF families.

**Figure 5.** Conceptual Model of Multipartnered Fertility as a Key Pathway in the Intergenerational Transmission of Poverty

CONCLUSIONS

Like a clock with several gears, multipartnered fertility has many moving and interconnected parts, including multiple children, multiple fathers, and relationship instability. Given the number of key components that define MPF it is difficult to assess why women who have multipartnered fertility may fare worse than their counterparts. Is it due to their relationship instability, the juggling of fathers between households, or the strain of additional childcare responsibilities? Or, is it because women who have MPF tend to be poorer and less educated than other women, or even have personal characteristics that make them less likely to form and
maintain lasting relationships with partners over time? These unanswered questions have left gaps in the extant literature and has made it difficult to parse out whether multipartnered fertility has independent effects (both theoretical and practical) on well-being above and beyond those associated with the social and economic disadvantage, instability, partnering, and childbearing practices that frequently characterize women who have children with more than one man.

The focus of the current research is to address this theoretical gap in the literature by developing a more nuanced understanding of how the having children with more than one may influence the lives of millions of American women. This was accomplished by conducting a thought experiment which held constant many of the elemental parts of this family forming behavior while we assessed the consequences MPF may have on women’s well-being above and beyond those associated with selection or other confounders. As part of this, three theoretical mechanisms were identified that proved to be useful for linking MPF to health including social stress, boundary ambiguity, and social support. All of this was done to provide answers to two key questions: Does multipartnered fertility really matter for women’s well-being? And if so, why?

After assessing the potential mechanisms outlined in the conceptual model (Figure 2), I conclude that MPF does, in fact, have the potential to significantly influence a women’s mental and physical health through the pathways of increasing ambiguity in the family system, increasing event, role and chronic stressors, and decreasing access to social support. When taken together it appears that women with MPF are likely to face a number of disadvantages that other women do not encounter, even if they share a similar partnering, childbearing, and instability histories. These comparisons were also made while holding the women’s socioeconomic backgrounds constant, indicating that when women are similar on key traits related to income, education, race, and family background, differences in well-being are likely to still emerge.
Should the models be allowed to vary based on other specifications such as increased time in poverty, lower education, and more instability, it is very likely that MPF will continue to be linked to health vulnerabilities via the same causal mechanisms, generally because women with more complex histories are likely to experience an even greater amount of stress, ambiguity, and lack of social support than MPF women who have clear legal and biological ties between children and fathers. Further, men and children are likely to respond to similar theoretical mechanisms described here, though work on men should also consider the role of resource depletion in linking MPF to health vulnerabilities.
References


Appendix A. Rationale for Dyadic Relationship Valences Suggested in Figure 4

NOTE: Each item below is associated with a dyadic pathway found in Figure 4. Number one, for example, describes the pathway marked ‘1 -’ between the non-residential father Bill and the residential father Bob. The minus sign indicates the valence of this relationship is understood to be negative based on the published research described under point one below.

1. Relationship 1 is not well defined but it is generally understood to be hostile, ambiguous, and marked by sexual jealousy (Edin & Kefalas, 2005). On the other hand, Marsiglio and Hinojosa (2007) have demonstrated some instances when supportive partnerships have developed among these men.

2. The mother-ex-partner relationship is assumed to be an ongoing source of stress because it was problematic enough to dissolve in the first place. Nevertheless, because of the common child, the relationship cannot be dissolved. “Following a divorce, there is a growing social and legal expectations that couples with children will maintain a civil (meaning both “civilized” and “legal”) relationship until the children reach a minimum age of 18. This socially and legally mandated continuity asks a lot of people who could not tolerate living together. Thus it is not surprising that divorce is initially stressful and has continuing stressful consequences (Kitson & Morgan, 1990, p. 916).”

3. In situations where an MPF woman is currently in a relationship with the second birth father, there may be countervailing forces at play. On the one hand, when the woman re-partners with the second birth father it may be an opportunity to create a new and stable relationship that will promote nurturance and economic resources for the woman and her children (Amato, 2000). Furthermore, women who re-partner often ‘trade up’, especially poor women who experience a nonmarital first birth (a common occurrence among MPF mothers) (Edin & McLanahan, 2007). On the other hand, these women do not do as well as women who have not experienced MPF. Harknett and Knab’s (2007) work indicates that this union does not provide equitable levels of instrumental support from either set of parents when women re-partner. And, while social fathers may help with childrearing, they will do less than the biological fathers in SPF families (Hofferth & Anderson, 2003).

4. When moms are single, father involvement tends to be greater which provides needed social support (Hofferth et al., 2002). Conversely, when mothers remarry or cohabit with a new partner the contact between nonresident fathers and their children declines and mothers receive less social support (Hofferth et al., 2002). Furthermore, if the biological father goes on to have children with a new partner, his childrearing responsibilities will be spread among multiple households, making it increasingly difficult to meet the financial obligations of parenthood (Cancian & Meyer 2012). The resulting lack of paternal financial and emotional resources may be associated with declines in child well-being (Carlson& Furstenberg 2006).

5. Because modern MPF is characterized by disruption, the mother and child relationship will include time spent in a single-parent family, which can have a host of negative attributes such increased time in poverty, exposure to negative parenting practices, and changes in adult time available to children, including less time investment and contact (see Amato & Galbraith’s 1999 meta analysis).

6, 7. According to evolutionary psychologists, children who live with both biological parents have a survival advantage over step-children because of differential resource distribution and the decreased possibility of violence. Kenrick and Trost (1997, p. 154) elaborated reasons for which parents may place priority on biological children, including: a natural tendency to
support gene replication, which is accomplished by protecting, sharing resources, and being more interested in, those who share your genetic makeup. As a result, biological children are given priority over step-children.

8. Resource dilution theory suggests that as the number of siblings increase the number of available resources declines, thus family stress increases (Pinquart & Silbereisen, 2005). Alternately, half sibling relationships are often characterized by boundary ambiguity (Pasley, 1987).

9. Step-children may be disadvantaged relative to biological children because violence is more likely to occur in relationships where people compete for resources, but do not share ‘blood’. Not only are step-fathers more likely to be violent with their step-children than their biological children, the violence is reciprocal, as step-children are more likely to have homicidal fantasies toward their step-parents than biological children (Kenrick & Trost 1997). Kenrick and Trost (1997, p. 170) suggest that the differences in violent actions and motivations “reveal evolved coercive impulses in genetically important situations” such that non-blood family members have less evolutionary pull to protect one another, but rather view each other as a drain on possible resources. Buss and Shackelford (1997) also alluded to several reasons for which step-children may be disadvantaged in a family. Namely, the disadvantage would stem from a lack of evolutionary preference to protect the progeny of another man, and second, unequal resource distribution. Because men have evolutionary drives to horde resources that they can offer women to guarantee fidelity or increase the number of children they can father, they are more likely to share resources to their own progeny, and withhold resources from those who do not share their genetic makeup. Buss suggests that this might occur because when resources are being used by a step-child, it does not further either of the man’s deeply held goals. Finally, counselors who deal with the step-father and child relationship note that additional problems may arise in situations like the one depicted here because children have an ‘escape’ option where they can “avoid confrontation, conflict, and accountability for their actions in one parent’s household if they have a second home in which they can turn” (Ihinger-Tallman & Pasley 1987, p. 14). While this might be beneficial if the step-parent and child relationship is particularly hostile, it may be negative for the family unit because it undermines parental authority and makes the establishment of bonds more difficult over the long-run.

10. Little is known about this relationship, but it appears to be an ambiguous relationship with no clear rules governing how these two should interact.
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