CIÊNCIAS DA VIDA E DA SAÚDE
LIFE AND HEALTH SCIENCES
CIENCIAS DE LA VIDA Y LA SALUD

millenium

Millenium, 2(Edição Especial Nº17)

en

PERFIL DE SAÚDE DAS FAMÍLIAS COM FILHOS MENORES: ESTUDO OBSERVACIONAL
HEALTH PROFILES OF FAMILIES WITH YOUNG CHILDREN: OBSERVATIONAL STUDY
PERFILES DE SALUD DE LAS FAMILIAS CON HIJOS MENORES: ESTUDIO OBSERVACIONAL

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RECEIVED: 22nd November, 2024
REVIEWED: 20th June, 2025
ACCEPTED: 28th July, 2025
PUBLISHED: 29th July, 2025

DOI: https://doi.org/10.29352/mill0217e.39135

RESUMO

Introdução: A saúde das famílias, influenciada por determinantes sociodemográficos e pelo estado de saúde, desempenha um papel crucial no bem-estar e na qualidade de vida dos seus membros, tornando essencial a compreensão dos perfis de saúde das famílias com filhos menores a seu cargo para o desenvolvimento de intervenções eficazes.
Objetivo: Caraterizar os perfis de saúde das famílias com filhos menores e analisar a relação entre esses perfis e os determinantes sociodemográficos e de saúde.
Métodos: Realizado um estudo quantitativo, observacional, descritivo e transversal com 474 famílias que frequentaram consultas de Saúde Infantil e Juvenil. Os participantes foram selecionados por conveniência, e os dados recolhidos através de um questionário autopreenchido. A análise incluiu a formação de clusters com base no "Rácio Total do Funcionamento Familiar" e utilizou técnicas estatísticas descritivas e inferenciais.
Resultados: Identificaram-se cinco clusters de famílias, variando desde um funcionamento familiar mais equilibrado no cluster 1 até o menos equilibrado no cluster 4, que apresentou os piores resultados em saúde, incluindo menor nível de escolaridade, maior taxa de desemprego e pior perceção da saúde.
Conclusão: O estudo revelou que as famílias monoparentais e com menores habilitações literárias apresentam piores resultados em saúde. O suporte social percebido e o funcionamento familiar são fatores determinantes significativos. Recomenda-se a implementação de estratégias de intervenção para melhorar o bem-estar e a saúde das famílias com base nos perfis identificados.

Palavras-chave: saúde da família; família; determinantes sociais de saúde; indicadores do estado de saúde; cuidados de saúde primários

ABSTRACT

Introduction: Family health, influenced by sociodemographic determinants and health status, plays a crucial role in the well-being and quality of life of its members, making it essential to understand the health profiles of families with young children for the development of effective interventions.
Objective: To characterize the health profiles of families with young children and analyze the relationship between these profiles and sociodemographic and health determinants.
Methods: A quantitative, observational, descriptive, and cross-sectional study was conducted with 474 families attending Child and Youth Health consultations. Participants were selected by convenience, and data were collected through a self-administered questionnaire. The analysis included cluster formation based on the "Total Family Functioning Ratio" and employed descriptive and inferential statistical techniques.
Results: Five clusters of families were identified, ranging from a more balanced family functioning in cluster 1 to a less balanced functioning in cluster 4, which exhibited the poorest health outcomes, including lower education levels, higher unemployment rates, and worse health perceptions.
Conclusion: The study revealed that single-parent families and those with lower educational qualifications experience poorer health outcomes. Perceived social support and family functioning are significant determinants. It is recommended to implement intervention strategies aimed at improving the well-being and health of families based on the identified profiles.

Keywords: family health; family; social determinants of health; health status indicators; primary health care

RESUMEN

Introducción: La salud de las familias, influenciada por determinantes sociodemográficos y por el estado de salud, desempeña un papel crucial en el bienestar y en la calidad de vida de sus miembros, lo que hace esencial comprender los perfiles de salud de las familias con hijos menores a su cargo para el desarrollo de intervenciones eficaces.
Objetivo: Caracterizar los perfiles de salud de las familias con hijos menores y analizar la relación entre estos perfiles y los determinantes sociodemográficos y de salud.
Métodos: Se llevó a cabo un estudio cuantitativo, observacional, descriptivo y transversal con 474 familias que asistieron a consultas de Salud Infantil y Juvenil. Los participantes fueron seleccionados por conveniencia y los datos fueron recogidos mediante un cuestionario autocompletado. El análisis incluyó la formación de grupos basados en el "Índice Total de Funcionamiento Familiar" y utilizó técnicas estadísticas descriptivas e inferenciales.
Resultados: Se identificaron cinco grupos de familias, variando desde un funcionamiento familiar más equilibrado en el grupo 1 hasta un funcionamiento menos equilibrado en el grupo 4, que presentó los peores resultados en salud, incluyendo un menor nivel educativo, una mayor tasa de desempleo y una peor percepción de la salud.
Conclusión: El estudio reveló que las familias monoparentales y aquellas con menores niveles educativos presentan peores resultados en salud. El apoyo social percibido y el funcionamiento familiar son factores determinantes significativos. Se recomienda la implementación de estrategias de intervención para mejorar el bienestar y la salud de las familias basándose en los perfiles identificados.

Palabras clave: salud de la familia; familia; determinantes sociales de salud; indicadores del estado de salud; atención primaria de salud

DOI: https://doi.org/10.29352/mill0217e.39135

INTRODUCTION

Family Health is a multidimensional concept grounded in systemic thinking and a dynamic perspective, promoting the development, functioning, and well-being of family units. This concept encompasses a variety of biological, psychological, spiritual, sociological, and cultural aspects of family system members (Crandall et al., 2020; Kaakinen, 2018). The family is considered the primary context for the development of health and health literacy (Feinberg et al., 2022).

To better understand Family Health, it is necessary to adopt an interdisciplinary perspective that considers various factors influencing family health (Weiss-Laxer et al., 2020). These factors include family functioning, communication and problem-solving skills, the mental and physical health of family members, social and emotional support, economic resources, housing conditions, access to transportation, education, health insurance, family behavioral habits such as diet and physical activity, access to childcare, and external resources. Other important aspects include the family's help-seeking efficacy and use of health services (Crandall et al., 2020; Weiss-Laxer et al., 2020).

Research on Family Health has mainly focused on individual factors related to health and illness, leaving a gap in the study of family and social factors (Demidenko et al., 2018; Lima-Rodríguez et al., 2022). Lima-Rodríguez et al. (2022) emphasize the need for more comprehensive approaches to family assessment to better understand the relationships between family health and its determinants, guiding nurses and other professionals in developing evidence-based best practices.

A health profile, or epidemiological profile, allows for the identification of major health problems or needs within specific population groups. Defined as a set of indicators including demographic and socioeconomic characteristics, health status, risk factors, and the use of health resources relevant to most populations (Institute of Medicine, 1997), the family health profile should integrate both the health of individual members and aspects related to the functioning of the family system (Kaakinen & Hanson, 2015).

Analyzing these profiles enables a better understanding of the health needs and challenges faced by families, considering the complexity of the variables involved and their interactions. This approach contributes to the development of more effective intervention strategies tailored to the specific needs of each family profile.

By considering family health from a multidimensional and integrated perspective, this study aims to provide valuable insights for health professionals, enabling them to adopt evidence-based practices that promote the well-being and proper functioning of families. Studying detailed health profiles is essential to improving the quality of care and supporting family health more efficiently and effectively.

1.METHODS

Data were collected between January and June 2021, and the study received approval from the Ethics Committee of the Local Health Unit. Informed consent was also obtained from all participants.

The sample consisted of 474 families with children under the age of 18 who attended Child and Youth Health consultations at various Primary Care Functional Units (1 Family Health Units and 2 Personalised Healthcare Units) in the Central Region of Portugal. Participation included all parental figures present with their children at the consultations, excluding families where the parental figures were under 18 years old or unable to read and write. The sample selection was non-probabilistic, using a convenience sampling technique. The minimum sample size required was calculated using Fischer's formula as described by Naing et al. (2006), establishing a minimum of 385 participants.

Data were collected through a self-administered questionnaire divided into two parts: the first focused on sociodemographic indicators such as age, nationality, sex, place of residence, educational attainment, employment status, social classification, family type, number of children, average age of children, and perceived social support. The second part addressed health characterization, including self-perceived health, mental health, sleep quality, self-perceived family functionality, and family functioning.

To evaluate the family's social classification, the Adapted Graffar Scale was used (Amaro, 2001; Graffar, 1956). Mental health was assessed using the Mental Health Inventory (Ribeiro, 2001), and sleep health was measured with the Sleep Health Scale (Becker et al., 2018). Perceived social support was assessed using the Multidimensional Scale of Perceived Social Support (Carvalho et al., 2011). Family functionality was evaluated using the APGAR questionnaire (Agostinho & Rebelo, 1988; Smilkstein, 1978), and family functioning was measured with the FACES IV scale (Sequeira et al., 2015).

To describe and analyse the health profiles across the identified clusters, both descriptive and inferential statistical techniques were applied. The *t*-test for independent samples and one-way analysis of variance (ANOVA) were used when it was reasonable to assume that the variables followed a normal distribution.

Additionally, when the distribution of continuous variables did not meet the assumption of normality, non-parametric tests were employed — namely the Kruskal-Wallis test — depending on the nature of the hypotheses being tested. To test hypotheses regarding the independence of categorical variables, the Chi-square test of independence or Fisher's Exact Test was applied, as appropriate. All hypothesis tests considered a significance level of 5%. The analysis was performed using SPSS® v.28.0 software.

DOI: https://doi.org/10.29352/mill0217e.39135

2. RESULTS

The study included 474 parental figures responsible for minors, who were grouped into five clusters. Several clustering strategies were initially tested, involving variables related to individual and family health, such as self-perceived health and family functioning. The combination of both variables did not produce significantly different cluster profiles compared to using self-perceived health alone. Similarly, using the subscales of family functioning resulted in low discriminative capacity, as observed in the centroid values. Ultimately, the clusters were defined using the *Total Family Functioning Ratio*, which proved to be the most discriminative among all analysed variables, producing clearly differentiated mean values across clusters.

Cluster 3 included the largest number of participants (n = 181), whereas Cluster 1 comprised the smallest group (n = 21). Although all clusters presented a *Total Family Functioning Ratio* classified as balanced, Cluster 1 exhibited the highest mean score (M = 2.52; SD = 0.18), while Cluster 4 recorded the lowest (M = 1.06; SD = 0.14). A one-way ANOVA confirmed statistically significant differences between clusters regarding the *Total Family Functioning Ratio* (p = 0.001).

Table 1 - Identification of clusters

	Cluster 1		Cluster 2		Cluster 3		Cluster 4		Cluster 5		p-value[1]
	n=21		n=100		n=181		n=43		n=129		
Family Functioning [Total Ratio, mean (sd)]	2,52	(0,18)	1,99	(0,11)	1,67	(0,08)	1,06	(0,14)	1,42	(0,09)	**<0,001**

Demographic and social determinants of health indicators

Regarding demographic and social determinants, Cluster 1 showed that the respondents' average age is 40 years, with all being of Portuguese nationality. Only 4.8% are male, and the majority (76.2%) reside in urban areas. In terms of education, 76.2% hold higher education degrees (bachelor's, master's, or doctoral), while 9.5% are unemployed. The most common family type is nuclear (61.9%), with an average of one child per family, and the children's average age is eight years. Regarding the social classification of the parental figures' families of origin, middle-lower class predominates (50%).

In Cluster 2, the respondents' average age is 41 years, with most (99.0%) being of Portuguese nationality. Among them, 16.0% are male, 73.7% reside in urban areas, and 66.0% have higher education degrees. Unemployment affects 6.0%. The predominant family type is nuclear (73.0%), with an average of two children per family, and the children's average age is 10 years. The social classification of the families of origin predominantly falls into the middle-lower class (37.9%).

Cluster 3 features respondents with an average age of 42 years, mostly of Portuguese nationality (97.2%), with 16.6% being male. About 66.3% live in urban areas, and 56.4% hold higher education degrees. Only 3.9% are unemployed. The most prevalent family type is nuclear (75.1%), with an average of two children per family, and the children's average age is 11 years. Regarding social classification, middle-class families predominate (43.5%).

In Cluster 4, the parental figures have an average age of 42 years, with the majority being of Portuguese nationality (95.3%). Among respondents, 23.3% are male, and 76.7% reside in urban areas. Regarding education, 55.8% have not completed higher education, and 11.6% are unemployed. The most common family types are nuclear (48.8%) and single parent (41.9%), with an average of one child per family, and the children's average age is 10 years. The social classification of families of origin is predominantly middle-class (51.3%).

Cluster 5 shows that the respondents have an average age of 41 years, with most being of Portuguese nationality (92.2%). Among them, 20.9% are male, and 66.7% reside in urban areas. Around 50.4% hold higher education degrees, and 7.8% are unemployed. The predominant family type is nuclear (60.5%), with an average of two children per family, and the children's average age is 10 years. The social classification of families of origin is predominantly middle-class (49.6%).

The analysis of the scale measuring perceived social support, with a response range of 1 to 7, shows a general mean score of 6.02 (SD = 0.93). This indicates a high level of perceived social support, meaning that, overall, participants feel highly supported by their social environment. Cluster-specific data reveal that individuals in Cluster 2 perceive the highest social support ($\bar{X}$ = 6.35; SD = 1.29), while those in Cluster 4 perceive the lowest ($\bar{X}$ = 5.15; SD = 1.10). The three subscales also exhibit relatively high mean scores, with the "Family" subscale scoring the highest ($\bar{X}$ = 6.19; SD = 1.00), followed by "Significant Others" ($\bar{X}$ = 6.16; SD = 1.01) and "Friends" ($\bar{X}$ = 5.70; SD = 1.19). These results highlight the family as the primary source of perceived social support for the participants. Cluster-specific analysis reveals that in Clusters 1 ($\bar{X}$ = 6.55; SD = 1.20), 2 ($\bar{X}$ = 6.57; SD = 0.75), 3 ($\bar{X}$ = 6.33; SD = 0.85), and 5 ($\bar{X}$ = 5.95; SD = 1.02), the family is the main source of perceived social support, whereas, in Cluster 4 ($\bar{X}$ = 5.36; SD = 1.19), "Significant Others" play that role.

The key indicators of demographic and social determinants of health are presented in the following table.

DOI: https://doi.org/10.29352/mill0217e.39135

Table 2 - Clusters characterization: demographic and social determinants of health indicators

	Total		Cluster 1		Cluster 2		Cluster 3		Cluster 4		Cluster 5		p-value
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	
Age													0,127[1]
Mean	41		40		41		42		42		41		
dp	7		6		7		6		7		6		
Min	22		28		25		22		26		26		
Max	60		54		54		60		57		57		
n	474		21		100		181		43		129		
Nationality													0,058[2]
Portuguese	456	(96,2)	21	(100,0)	99	(99,0)	176	(97,2)	41	(95,3)	119	(92,2)	
Other	18	(3,8)	0	(0,0)	1	(1,0)	5	(2,8)	2	(4,7)	10	(7,8)	
Gender													0,331[2]
Female	390	(82,3)	20	(95,2)	84	(84,0)	151	(83,4)	33	(76,7)	102	(79,1)	
Male	84	(17,7)	1	(4,8)	16	(16,0)	30	(16,6)	10	(23,3)	27	(20,9)	
Residence													0,449[2]
Rural	145	(30,7)	5	(23,8)	26	(26,3)	61	(33,7)	10	(23,3)	43	(33,3)	
Urban	328	(69,3)	16	(76,2)	73	(73,7)	120	(66,3)	33	(76,7)	86	(66,7)	
Academic Qualifications													**0,035**[2]
Up to 3rd cycle	60	(12,7)	0	(0,0)	7	(7,0)	23	(12,7)	12	(27,9)	18	(14,0)	
Secondary	146	(30,8)	5	(23,8)	27	(27,0)	56	(30,9)	12	(27,9)	46	(35,7)	
Bachelor's degree	208	(43,9)	11	(52,4)	54	(54,0)	78	(43,1)	14	(32,6)	51	(39,5)	
Master's degree and Doctorate	60	(12,7)	5	(23,8)	12	(12,0)	24	(13,3)	5	(11,6)	14	(10,9)	
Employment Status													0,319[2]
Unemployed	30	(6,3)	2	(9,5)	6	(6,0)	7	(3,9)	5	(11,6)	10	(7,8)	
Employed	444	(93,7)	19	(90,5)	94	(94,0)	174	(96,1)	38	(88,4)	119	(92,2)	
Social Classification of the Family													0,144
Lower Middle Class	159	(35,9)	9	(50,0)	36	(37,9)	66	(38,8)	12	(30,8)	36	(29,8)	
Middle Class	191	(43,1)	6	(33,3)	31	(32,6)	74	(43,5)	20	(51,3)	60	(49,6)	
Upper Middle Class	93	(21,0)	3	(16,7)	28	(29,5)	30	(17,6)	7	(17,9)	25	(20,7)	
Type of Family													**0,009**[2]
Nuclear	321	(67,7)	13	(61,9)	73	(73,0)	136	(75,1)	21	(48,8)	78	(60,5)	
Single-parent	111	(23,4)	7	(33,3)	21	(21,0)	30	(1,6)	18	(41,9)	35	(27,1)	
Others	42	(8,9)	1	(4,8)	6	(6,0)	15	(8,3)	4	(9,3)	16	(12,4)	
Number of Children													0,051[3]
Mean	2		1		2		2		1		2		
dp	1		1		1		1		0		1		
Min	1		1		1		1		1		1		
Max	5		2		3		5		2		3		
n	474		21		100		181		43		129		
Average Age of Children													0,072[3]
Mean	10		8		10		11		10		10		
dp	5		5		6		5		6		5		
Min	1		1		1		1		1		1		
Max	21		17		18		21		18		18		
n	474		21		100		181		43		129		
Perceived Social Support from Family													**<0,001**
Mean	6,19		6,55		6,57		6,33		5,25		5,95		
dp	1,00		1,20		0,75		0,85		1,20		1,02		
Min	1,00		1,75		3,25		1,00		2,00		1,00		
Max	7,00		7,00		7,00		7,00		7,00		7,00		
n	465		21		100		176		41		127		
Perceived Social Support from Friends													**<0,001**
Mean	5,70		6,10		6,00		5,82		4,83		5,50		
dp	1,19		1,47		1,12		1,03		1,43		1,16		
Min	1,00		1,00		2,25		1,00		1,00		1,00		
Max	7,00		7,00		7,00		7,00		7,00		7,00		
n	465		21		100		176		41		127		
Perceived Social Support from Other Significant Individuals													**<0,001**
Mean	6,16		6,36		6,47		6,31		5,36		5,92		
dp	1,01		1,35		0,89		0,86		1,19		0,99		
Min	1,00		1,25		2,25		1,00		1,75		1,25		
Max	7,00		7,00		7,00		7,00		7,00		7,00		
n	465		21		100		176		41		127		
Total Perceived Social Support													**<0,001**
Mean	6,02		6,33		6,35		6,15		5,15		5,79		
dp	0,93		1,29		0,76		0,78		1,10		0,91		
Min	1,00		1,33		2,92		1,00		1,75		1,08		
Max	7,00		7,00		7,00		7,00		7,00		7,00		
n	465		21		100		176		41		127		

Indicators of health status determinants

An analysis of the participants' self-perceived health revealed that 45.1% consider their health as "good," while 29.1% rate it as "very good" or "excellent." The highest proportion of individuals perceiving their health as "fair" or "poor" was observed in Cluster 4 (55.8%). The differences in health self-perception across clusters were statistically significant ($p < 0.001$).

Regarding mental health, participants exhibited good averages in the dimensions of Positive Well-Being (X = 60.17; SD = 16.27) and Distress (X = 70.67; SD = 15.39), with an overall mental health score of X = 66.76 (SD = 14.23). Cluster 4 had the lowest scores in Positive Well-Being (X = 47.34; SD = 14.29) and overall mental health (X = 53.13; SD = 13.54), whereas Cluster 1 achieved the highest scores (X = 75.10 and X = 78.42, respectively). These differences were statistically significant ($p < 0.001$).

DOI: https://doi.org/10.29352/mill0217e.39135

Sleep health, assessed on a scale from 0 to 30, showed a good general average ($\bar{X}$ = 21.30; SD = 5.13), with 71.9% of participants sleeping 7–9 hours daily and 61.9% reporting satisfaction with their sleep. Cluster 1 reported the best sleep health ($\bar{X}$ = 23.43; SD = 4.27), while Cluster 4 had the poorest sleep health ($\bar{X}$ = 19.60; SD = 5.13), with statistically significant differences (p = 0.029).
In terms of family functionality, 87.1% of participants perceived their families as highly functional. Family dysfunction perception was more prevalent in Cluster 4 (48.8%) and least prevalent in Cluster 2 (3.0%). These differences were also statistically significant (p < 0.001).
In the subscales of the FACES IV, most participants scored high on balanced subscales and low on unbalanced subscales, with elevated ratios of Cohesion ($\bar{X}$ = 29.32; SD = 3.46) and Flexibility ($\bar{X}$ = 26.67; SD = 3.44), indicating perceived family functionality. Cluster 4 stood out for its lowest Cohesion ($\bar{X}$ = 24.02; SD = 4.53) and Flexibility ($\bar{X}$ = 22.35; SD = 4.41) scores and highest family dysfunction scores, with higher values in the subscales of Disengaged ($\bar{X}$ = 20.86; SD = 4.74), Enmeshed ($\bar{X}$ = 21.51; SD = 4.47), Rigid ($\bar{X}$ = 22.81; SD = 5.03), and Chaotic ($\bar{X}$ = 22.84; SD = 4.85).
In the Communication and Satisfaction subscales, Cluster 4 registered the lowest scores: $\bar{X}$ = 34.42 (SD = 6.73) and $\bar{X}$ = 23.49 (SD = 6.40), respectively. Overall ratios of Cohesion ($\bar{X}$ = 1.76; SD = 0.38) and Flexibility ($\bar{X}$ = 1.56; SD = 0.36) were high, except in Cluster 4, which recorded the lowest scores for Cohesion ($\bar{X}$ = 1.15; SD = 0.21) and Flexibility ($\bar{X}$ = 0.98; SD = 0.14).
Statistically significant differences were found in all subscales and ratios across the five clusters (p < 0.001).
The health status determinant indicators for each cluster are presented in Table 3.

Table 3 - Characterization of Clusters: Indicators of Health Status Determinants

	Total		Cluster 1		Cluster 2		Cluster 3		Cluster 4		Cluster 5		p-value
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	
Self-Perception of Current Health													**<0.001[2]**
Poor/Fair	122	(25.7)	5	(23.8)	25	(25.0)	37	(20.4)	24	(55.8)	31	(24.0)	
Good	214	(45.1)	8	(38.1)	40	(40.0)	91	(50.3)	14	(32.6)	61	(47.3)	
Very good/Excellent	138	(29.1)	8	(38.1)	35	(35.0)	53	(29.3)	5	(11.6)	37	(28.7)	
Self-perception of Family Functioning													**<0.001[2]**
Dysfunctional family	61	(12.9)	1	(4.8)	3	(3.0)	11	(6.1)	21	(48.8)	25	(19.4)	
Highly functional family	413	(87.1)	20	(95.2)	97	(97.0)	170	(93.9)	22	(51.2)	104	(80.6)	
Mental Health													**<0.001[3]**
Mean	66.76		78.42		71.68		68.44		54.13		62.89		
dp	14.23		13.64		12.29		12.76		13.54		14.11		
Min	10.11		36.17		36.70		34.04		20.74		10.11		
Max	100.00		100.00		100.00		95.74		81.38		95.21		
n	474		21		100		181		43		129		
Positive Well-Being													**<0.001[3]**
Mean	60.17		75.10		65.97		61.22		47.34		56.05		
dp	15.39		13.78		12.75		13.85		14.29		15.70		
Min	8.57		44.29		27.14		20.00		21.43		8.57		
Max	100.00		98.57		100.00		95.71		74.29		92.86		
n	474		21		100		181		43		129		
Distress													**<0.001[3]**
Mean	70.67		80.39		75.07		72.72		58.16		66.96		
dp	15.12		14.75		13.58		13.62		15.51		15.00		
Min	11.02		31.36		29.66		27.97		19.49		11.02		
Max	100.85		100.85		100.85		100.00		87.29		96.61		
n	474		21		100		181		43		129		
Sleep Health													**0.029[3]**
Mean	21.36		23.43		21.97		21.22		19.60		21.33		
dp	5.13		4.27		5.41		5.26		5.13		4.71		
Min	6.00		11.00		6.00		6.00		9.00		6.00		
Max	30.00		30.00		30.00		30.00		29.00		30.00		
n	474		21		100		181		43		129		

3. DISCUSSION

The findings of this study highlight marked differences between clusters in terms of educational attainment, employment status, social support, family structure, and health outcomes—both physical and mental. Cluster 4 consistently emerged as the most vulnerable, combining lower education and income levels, higher unemployment, reduced social support, and poorer health indicators, in contrast with Cluster 1, which reflected more favourable socioeconomic and health conditions.
The results for the Demographic and Social Determinants of Health indicators reveal that 43.9% of the sample held a bachelor's degree, while 12.7% had a master's or doctorate. Cluster 1 had the highest proportion of individuals with higher qualifications (76.2%), while Cluster 4 showed the lowest percentage (44.2%). Studies such as Monteiro & Peixoto (2020) indicate that higher education levels are associated with better health outcomes, as individuals with more education tend to adopt healthier behaviors.
Health literacy also has a significant impact, particularly on child health. Parents with low health literacy tend to adopt less healthy behaviors, resulting in poorer health outcomes for their children (Feinberg et al., 2022). According to Macedo (2017), parental education levels directly influence children's health. Lima-Rodríguez et al. (2022) reinforce that low educational levels among couples are negatively associated with family health, increasing economic vulnerability and job instability. Indeed, Cluster 4, characterized by lower education levels, also has the highest unemployment rate.

DOI: https://doi.org/10.29352/mill0217e.39135

Regarding employment, 93.7% of participants were employed, aligning with the findings of Cancian & Haskins (2014), which highlight changes in family structures due to increased female workforce participation. However, Cluster 4 recorded the highest unemployment rate. In terms of social class, middle-class families predominated, followed by lower and lower-middle classes, reflecting Portugal's poverty rate (17.2%) and lower purchasing power compared to the European Union (European Observatory on Health Systems and Policies [OECD], 2021).

Regarding family structure, 67.7% of participants belonged to nuclear families, most represented in Cluster 3, whereas single-parent families were more prevalent in Cluster 4. This distribution aligns with contemporary changes in family dynamics, such as the rise of single-parent and single-person households (Guimarães & Cafieiro, 2018). Cancian & Haskins (2014) also highlight declining marriage rates and increasing births outside of marriage, contributing to greater family complexity and instability.

In terms of social support, participants reported high levels of perceived support, primarily from their families. Cluster 2 recorded the highest levels of social support, while Cluster 4 had the lowest. Lima-Rodríguez et al. (2022) confirm that social support positively correlates with family health. Providing support, whether familial or external, is crucial for addressing daily challenges and improving general health.

Self-perceived health revealed that 45.1% of participants rated their current health as good, while 29.1% considered it excellent. However, Cluster 4 had the highest proportion of individuals with negative health perceptions, consistent with Lindemann et al. (2019), who associated worse health perceptions with unemployed women and individuals with lower education levels. These findings underscore the importance of socioeconomic and family factors in shaping health perceptions.

Regarding mental health, positive well-being was highest in Cluster 1 and lowest in Cluster 4, reflecting a correlation between family cohesion and better mental health. Sleep health also varied significantly across clusters, with Cluster 1 showing the best sleep indicators. Studies by Feinberg et al. (2022) and Palimaru et al. (2022) confirm that sleep health is influenced by family factors, including cohesion and functioning.

Finally, while most participants (87.1%) perceived their families as functional, Cluster 4 exhibited the highest proportion of dysfunctional families. Olson & Gorall's model (Olson & Goral, 2003) emphasizes that balance in cohesion and flexibility is essential for healthy families, with imbalances in these dimensions linked to family dysfunction. These results highlight the importance of strengthening family functioning to optimize the physical and mental health of its members.

CONCLUSION

This study identified five health profiles among families with young children, exploring the relationship between these profiles and sociodemographic and health status determinants. Cluster 4 showed the worst health outcomes, associated with lower education levels and higher unemployment. Single-parent families also exhibited poorer family health and lower perceived social support. Furthermore, social and economic inequalities appear to negatively influence health. Self-perceived health was more negative among single-parent families with worse socioeconomic conditions. Mental health and sleep quality were better in healthier family environments.

The study also emphasized the importance of scientific research in clinical practice, despite limitations such as a regional and non-probabilistic sample. Nonetheless, it provides valuable contributions to Family Health Nursing and recommends future studies in other regions to expand the diversity of the sample and explore significant differences between groups.

AUTHORS' CONTRIBUTION

Conceptualization, I.F., Z.C., and H.F.; data curation, I.F.; formal analysis, I.F.; investigation, I.F., Z.C., and H.F.; methodology, I.F., Z.C., and H.F.; project administration, I.F., Z.C., and H.F.; resources, I.F., Z.C., and H.F.; software, I.F.; supervision, Z.C. and H.F.; validation, Z.C. and H.F.; visualization, I.F.; writing-original draft, I.F., Z.C., V.M., J.M., J.D., J.R. and H.F.; writing-review and editing, I.F., Z.C., V.M., J.M., J.D., J.R. and H.F.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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