Parenting and Child Health:

A Study of Low-Income Hispanic and African American Families

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Low-income families tend to have poorer health, experience more severe chronic health problems, and have higher rates of mortality than children in wealthier families (Aber, Bennett, Conley, & Li, 1997; Case, Lubotsky, & Paxson, 2002; Chen, Matthews, & Boyce, 2002; Hughes & Ng, 2003). Consequently, children in poor health tend to miss more days of school and may develop chronic health problems that interfere with their ability to maintain employment as adults. Health-related factors may therefore help explain the transmission of low socioeconomic status from one generation to the next. As minority families typically represent low economic stratum, African American and Hispanic children are more likely than European American children to be in poor health, even after controlling for socioeconomic status (Flores, Olson, & Tomany-Korman, 2005; Wen, 2007). Understanding child health disparities among low-income, ethnic minority families is thus a crucial endeavor for researchers, policymakers, and practitioners as there is a rapid increase in ethnic minority populations in the United States (Doucet & Hamon, 2007).

A critical component of this effort is identifying what factors may underlie the relations between income, ethnicity, and child health. It is important to first understand how parenting in low-income families may be related to child health. The family stress model and the social-cognitive concept of self-efficacy provide a theoretical framework for understanding this relationship.

Theoretical Framework

We borrow concepts from the *Family stress theory* to study the potential interactions among a stressor event, family resources, and family perception of the stressor result in a process of crisis, adaptation, and reorganization (McCubbin et al., 1980). The family stress model of

economic hardship posits that the influence of economic distress on child outcomes is mediated by its impact on parents (Conger, Rueter, & Conger, 2000). According to the model, stress over financial difficulties creates emotional distress for parents and may lead to parental depression or increased marital conflict. Parental depression reduces the quality of parent-child interaction and may increase harsh parenting, both of which have been found to adversely affect child outcomes (Conger et al., 1992; Conger et al., 1993).

Nonetheless, the impact of the stressors can be alleviated in the presence of certain protective factors and a support network (Conger et al., 2000). One such possible protective factor may be parenting self-efficacy which denotes parents' belief in their competence to meet their children's needs and have a positive impact on their development (Coleman & Karraker, 2000). Parents who are self-efficacious take actions that promote their children's development, such as advocating for their child's needs in the school or health care systems. Parenting efficacy may thus take on a mediating role, intervening between contextual stressors, parental emotional distress, and parenting to minimize adverse effects on child outcomes (Teti, O'Connell, & Reiner, 1996). Although economic hardship may reduce parenting efficacy directly and indirectly through parental depression, maintaining a high sense of parenting efficacy despite these stressors is related to parenting behaviors that minimize risk and promote optimal development (Elder, Eccles, Ardelt, & Lord, 1995).

The concepts of the family stress model have been have been applied in studying the dynamics between economic hardship, parental depression, and disrupted parenting in African American families (Conger et al., 2002; Jackson, Brooks-Gunn, Huang, & Glassman, 2000; Nievar & Luster, 2006) and Mexican American families (White, Roosa, Weaver, & Nair, 2009). Low-income ethnic minority families face additional contextual stressors that may impact

parental depression and parenting behavior. African American and Hispanic families are more likely to live in poor quality, segregated neighborhoods that lack social resources and economic opportunities (Charles, 2003). In impoverished and often dangerous neighborhoods, the influence of parenting efficacy on child outcomes may be even more important because parents must exert more effort to protect and provide for their children (Ardelt & Eccles, 2001). For some Hispanic families, the process of acculturation may produce another source of stress (White et al.). Language barriers and reconciling cultural differences in values and norms may contribute to parental emotional distress and negatively impact parenting. Thus, integrating sociocultural factors into the family stress model demonstrates the critical role of context in understanding family stress and its influence on developmental outcomes.

Purpose of the Study

The purpose of this study is to investigate whether maternal parenting efficacy and depressive symptoms are associated with child health outcomes among low-income minority families. A home visiting program, Home Instruction for Parents of Preschool Youngsters (HIPPY), may also affect parenting efficacy, which in turn may impact child health. This study also explores the contribution of poverty, race/ethnicity, as related to child health in a predominantly low-income sample of African American and Hispanic families.

Research on the influence of parenting efficacy and maternal depression on child health is sparse with inconsistent findings. For parents reporting more stressful life events, a greater sense of parenting self-efficacy predicted more visits to a primary care professional (Janicke & Finney, 2003). This interaction between parent stressors and self-efficacy explained 11.5% of the variance in primary health care utilization. The authors suggest that efficacious parents are more likely to seek the help they need to overcome stressful life situations. Another study found

that parenting self-efficacy did not mediate the relationship between maternal depression and increased likelihood of stunted growth among low-income children (Surkan et al., 2008). However, this research was conducted in Brazil with an extremely disadvantaged sample, and thus these findings have limited external validity, particularly in the United States.

The association between parenting efficacy and depression is complex. Social cognitive theory suggests that low perceived self-efficacy predisposes an individual to depression (Bandura, 1997). Thus, when parents with a low sense of efficacy are under stress, they may become depressed and feel unable to cope with the additional challenges, such as having a child in poor health. In a study of mothers of children with chronic health conditions, the severity of children's illness-related limitations and low maternal self-efficacy were both associated with higher maternal psychological distress (Silver, Bauman, & Ireys, 1995). These two factors had a significant interaction effect. Mothers of children with the most functional impairment had more psychological distress only when efficacy was low, indicating that the combination of poor child health and low self-efficacy is most detrimental. Thus, interventions that enhance parents' sense of control and self-worth could help mitigate the strain of having a chronically ill child.

It is evident from the literature that socioeconomic disparities exist in children's health. Children from low-income families are more likely to have poor health and suffer from more severe chronic conditions than children from families with higher income (Case et al. 2002). Low-income children from ethnic minority families face additional risk factors for poor health, including racial discrimination and language barriers in health care (Hughes & Ng, 2003). Socioeconomic factors may not fully account for child health disparities, but parenting characteristics and behaviors may help explain the relationship between family income, ethnicity, and child health. Maternal depression and parenting efficacy each show promise as

significant factors influencing child health, yet research in this area is deficient. The present study attempts to fill this gap in the current literature by investigating the dynamic relationship between maternal depression, parenting efficacy, and child health variables in a low-income, ethnic minority sample.

Hypotheses

We expect that maternal depressive symptoms are related to parenting efficacy and both of these factors have an impact on child health. We may predict a specific direction of effects based upon the findings of previous research and presumed theoretical relationships between parent characteristics, children's health status, and children's chronic health conditions. However, the direction of relation is uncertain due to the lack of sufficient research on parent characteristics and emergency room utilization.

1. Parenting efficacy and the absence of depressive symptoms are associated with child's optimal health while suboptimal health status is associated with lower parenting efficacy and depressive symptoms of mothers.
2. Parenting efficacy and maternal depressive symptomatology are predictors of child health (health status, chronic health condition, and utilization of urgent care) while controlling for poverty and related sociodemographic factors.

METHODS

Study Participants

This study was conducted as part of a research project with the Home Instruction for Parents of Preschool Youngsters (HIPPY) program in the Dallas, Texas. HIPPY is a home visiting program for low-income families with children between the ages of 3 and 5 that seeks to improve school readiness and parent involvement among low-income or Spanish-speaking families. The current study includes 311 mother-child dyads living in the Dallas Independent

School District. Of 311 families, 177 were participating in the HIPPY program, and 134 were mother-child dyads from low-income neighborhoods (n = 134) who were eligible for the HIPPY program but did not live in an area where it was available.

Data Collection Procedure

Mothers participating in HIPPY with a child between the ages of 3 and 4 years were contacted by telephone and invited to complete a survey during a meeting at their neighborhood elementary school. In elementary schools where HIPPY was not available, all children attending the school were given a flyer describing the survey and inviting mothers with a 3 to 4 year old child who met qualifications for the HIPPY program to complete a survey during a meeting at their local elementary school. All participants were offered $5.00 and a free gift, such as a book for their child. Trained bilingual research assistants explained the general purpose of the study to the mothers, which was to help them understand the contribution of home intervention programs like HIPPY in assisting mothers to gain positive parenting skills. Mothers were assured that their participation was completely voluntary, and that there was no penalty for refusing to take part in the survey. Each survey was assigned an identification number, and no other personal information was displayed on the survey. Participant personal information was kept separate in a locked file cabinet located in the PI's office.

After obtaining informed consent, participants completed a survey containing standardized measures specifically chosen to collect data relevant to the study. The survey was offered in both English and Spanish languages. Child care was provided onsite. If a participant had difficulty reading, a research assistant read the survey to the participant and pointed to the responses so that the mother could choose her response. No other family or friends were allowed to help mothers complete the survey. Mothers who were unable to attend the group data

collection meetings were contacted again by telephone to arrange individual meetings at their convenience. Two trained research assistants, at least one of whom spoke the language of the participant, travelled to the participant's home or another location, i.e., fast food restaurant or friend's home. Researchers followed the same protocols and procedures in obtaining informed consent and administering the survey as described above for group meetings.

Measures

The following measures from the survey will be examined in this paper: Parental Involvement and Efficacy (Diener, Nievar, & Wright, 2003), Center for Epidemiological Survey – Depression (Radloff, 1977), health status questions, and socio-demographic characteristics.

Child Health outcome variables

Health status. Parents were asked to rate the general health of their child on a 4-point scale (Poor, Fair, Good, and Excellent). Parent rating is one of the most frequently used measures of child health status. It has been shown to correlate with alternative measures of child health (Case et al., 2002) and with children's actual health as determined by a physician (Roberts, 1973). In keeping with previous work on child health disparities, child health status was dichotomized to represent optimal child health and suboptimal child health (Flores, Bauchner, Feinstein, & Nguyen, 1999; Perez, Fang, Inkelas, Kuo, & Ortega, 2009). Parent rating of "excellent" was categorized as "optimal" while all other levels were considered as "suboptimal."

Chronic condition. This is a dichotomous variable (yes/no) representing whether or not the child has a chronic health condition. The item asked, "Has a doctor or other medical professional ever told you that your 3-year-old child has a condition or illness that may restrict

your child's activities or interfere with his/her development?" If parents responded yes, they were prompted by an open-ended question to specify what condition or illness their child has.

Emergency room utilization. This question assessed how frequently families had recently utilized acute health care services. The question asked, "In the last 6 months, how many times has your 3-year-old child needed to visit an urgent care clinic or hospital emergency room for any of the following reasons?" The reasons included receiving medical treatment for a recent illness, a chronic condition, or an injury as well as an option to explain another reason. Parents were asked to indicate the number of times the child had been to the emergency room for each type of visit. This variable was dichotomized to represent whether or not (none vs. one or more times) the child had been to the emergency room in the past 6 months.

Parent Measures – Predictor variables

Maternal Depression

The Center for Epidemiological Survey – Depression scale (CES-D; Radloff, 1977) was used to assess maternal depressive symptomology. This instrument is not intended to make a clinical diagnosis but is frequently used in research and as a screening tool. This self-report measure contains 20 items asking about the frequency of depressive symptoms experienced during the previous week. Example questions include "I felt sad," "I felt everything I did was an effort" and "My sleep was restless." Response categories range from 0 ("Rarely/None of the time/1 day") to 3 ("Most/All of the time/5-7 days"). Four items related to positive affect were reverse-coded, and then all items are summed. A higher total score indicates more depressive symptoms. A score of 16 or more indicates clinically significant depressive symptomology

(Eaton & Kessler, 1981), and in some analyses the CES-D was dichotomized at this cutoff score. The CES-D showed good reliability with this sample (α = .85).

Maternal Parenting Efficacy

The Parental Involvement and Efficacy (PIE) scale is a self-report measure that assesses how mothers perceive their self-efficacy as parents (Diener, Nievar, & Wright, 2003). The scale includes 18 items measuring parent beliefs about their influence over children's learning, development, and health. Parents indicated their level of agreement with each statements on a 5-point Likert scale, with anchors of "1=Strongly Disagree" to "5=Strongly Agree." Six items were reverse coded so that a high mean score on this scale reflects a high sense of parenting efficacy. The reliability of the PIE with this sample was .80.

Demographic Variables

Participants also reported basic demographic information on their race and ethnicity, country of origin, household income, maternal age, marital status, household size, educational level, and current employment status.

Race and Ethnicity. For the initial race and ethnicity question, categories included: White/ Non-Hispanic, Black/African American/Non-Hispanic, Hispanic/Latino, Asian/Pacific Islander, and Other. Individuals who responded "Hispanic/Latino" were prompted to select a more specific subgroup that matched their ethnic identification from the following list: Puerto Rican, Cuban, Cuban American, Mexican, Mexican American, Latin American, Anglo American, South American, Central American or "some other group." In order to determine country of origin and approximate immigrant status, an open-ended question asked, "In what state, territory, or country were you born?"

Household income- income-to-poverty ratio. Annual household income for the previous year was measured categorically. Response categories started at "$4,000 or less" and initially increased in $2000 intervals ("$4,001 to $6000"). As income increased, the interval categories became wider (i.e. "$10,001 to $15,000" and "$20,000 to $30,000") with the highest category being "More than $80,000." Income-to-poverty ratios were calculated for each household by taking the mid income value for the income range reported and dividing it by the federal poverty guideline for that household size. Federal poverty guidelines are used to determine eligibility for certain government programs and are updated yearly (U.S. Department of Health and Human Services, 2009b). A family is considered to be in poverty if the income-to-poverty ratio is below 1.00.

RESULTS

Sample description

The majority of the participants are Hispanic/Latino (83%, n = 257), followed by African American (12%, n = 47), and the remaining mothers are from other racial/ethnic groups. More than two-thirds (69%) of the families are from Mexico. Mean maternal age was 30.87 years (SD = 5.7), 47% of the mothers had at least a high school diploma or GED and nearly one half (46%) were stay home mothers, 25% were working full- or part-time, 28% were unemployed or not working for other reasons (e.g., in school). Most mothers were married or living with a partner (68.3%) and nearly 85% of are dual-parent households. Eighty-six percent of families had an annual household income under $30,000, and the majority (80%) of the families is in poverty considering income-to-poverty ratio below 1.00.

Nearly one half of the mothers (48%) reported that their three-year-old is in suboptimal health, nearly one quarter (24.4%) had taken their child to the urgent care in the past 6 months

and nearly 36 parents (12%) reported that their child has a condition/illness that may restrict activities/development. Some of the conditions noted were asthma/bronchitis (*n* = 19), autism/speech delay (*n* = 3), sickle cell (*n* = 2), various handicaps (*n* = 3), and other (e.g., cancer, seizures).

Data Analysis

All analyses were conducted using Predictive Analytic Software (PASW®) Statistics, Version 17. Mean scores and standard deviations were calculated for continuous measures while frequencies are reported for categorical data. Group differences based on the health status of the child used independent *t* tests for continuous measures and chi-square test of independence for categorical measures. An alpha significance level of .05 was used for all statistical tests. For multivariate analyses, logistic regression models were run for each of the three child health variables regressing on maternal efficacy, depression controlling for sociodemographic variables.

Significant associations were detected between the three health conditions: general health- suboptimal health status is significantly associated with having a chronic condition, χ^2 (1, 306) = 9.56, *p* =.002, but not significantly associated with emergency room utilization, χ^2 (1, 306) = 1.73, *p* = .23. However, children with chronic conditions were significantly more likely to have been to the emergency room in the past 6 months, χ^2 (1, 306) = 17.62, *p* = .001.

Maternal characteristics

Families in the HIPPY intervention group had higher parenting efficacy scores (*n* = 177; *M* = 76.41, *SD* = 7.94) compared with mothers in the non-participant group (*n* = 134; *M* = 74.68, *SD* = 7.33), *t* = 1.967, *p* = .05). No difference was observed in depression scores between mothers in these two groups.

Mean scores indicate that most mothers had a high sense of parenting efficacy (M = 4.24, SD = 0.41). Nearly 17.7% mothers (n = 55) had clinically significant depressive symptomology (score 16 or higher) (M = 10.5, SD = 8.2). There was a significant difference in parental efficacy between those who had reported clinical depression and those who did not, with a higher efficacy score among non-depressive mothers, $t(309) = -2.1$, $p = .032$.

A t-test comparing optimal and suboptimal child health groups revealed that the parenting efficacy scores are significantly higher in mothers with children in optimal health (M = 78.03, SD = 6.82) compared to mothers with children in suboptimal health (M = 73.05, SD = 7.817), $t(308) = -5.957$, $p = .001$. Additionally, maternal depressive symptomology scores are significantly higher in mothers with children in suboptimal health (M =11.73, SD=8.31) compared to mothers with children in optimal health (M = 9.27, SD = 7.98), $t(307) = 2.649$, p = .008. There was no significant difference in parenting efficacy scores between groups of mothers of children with a chronic health condition (M = 74.39, SD = 8.31) and mothers of children without a chronic health condition (M = 75.88, SD = 7.655), $t(304) = - 1.08$, $p = .278$. Maternal depressive symptoms were, however, significantly higher in mothers with children suffering from a chronic condition (M = 13.94, SD = 11.12) compared to mothers with children in optimal health (M = 9.92, SD = 7.64), $t(304) = 2.794$, p =.006). No significant differences were found between parenting efficacy scores of mothers with children who used urgent care (M = 7.969, SD =.914) and mothers with children who did not use urgent care (M = 7.648, SD = 0.499); $t(309) = - 0.714$, $p = .476$). However, maternal depressive symptoms scores were significantly higher in mothers with children that used urgent care (M = 8.78, SD = 1.01) compared to mothers with children who did not use urgent care (M =7.87, SD = 0.51); $t(308)$ = 3.047, $p = .003$).

Multiple regression analyses – Predictors of health condition

Logistic regression models were run to test whether parenting efficacy and maternal depressive symptoms are predictors of child health condition (optimal versus suboptimal health and utilization of urgent care) while controlling for poverty and related sociodemographic factors. Odds ratios were estimated for the independent predictors and are reported in Table 1. A second regression model (Step Two) was run to test for additional effects of home visiting on child health. After controlling for demographic variables, parental efficacy predicted optimal child health status beyond the presence of a chronic condition. Home visiting participation predicted optimal child health, even when controlling for other predictors. A final regression, displayed in Table 2, indicated that a chronic health condition was a significant predictor of urgent care utilization.

DISCUSSION

In order to expand on previous research, this study examined how maternal depression and parenting efficacy may be related to child health. A theoretical framework that integrated parenting efficacy into the family stress model was used to hypothesize about associations among contextual stressors, parent characteristics, and child health. As hypothesized, parenting efficacy is associated with better child health outcomes while maternal is associated with poorer child health. Mothers whose child had a chronic health condition were more likely to report depressive symptoms. The results of the study provide some support for the utility of this theoretical perspective for understanding parental influences on children's overall health status. Interestingly, the home visiting intervention also positively impacted children's health status, perhaps through improvement of parental efficacy. However, demographic characteristics such

as education and income were not associated with the presence of a chronic condition in the child or utilization of emergency care services.

Qualitative research in this area would help to determine how a child's chronic illness impacts parents' well-being. As the Silver et al. (1995) study demonstrates, it is not merely having a child with a chronic illness that matters, but rather the severity of the child's impairment is the factor associated with lowered self-efficacy and increased psychological distress. A qualitative study would reveal what types of health limitations cause the greatest stress for parents as well as show how parents cope with these challenges.

Mothers of children who had been to the emergency room in the past 6 months did not differ on parenting efficacy or maternal depression from mothers of children who had not been to the emergency room. Previous research found maternal depression was associated with emergency room utilization, but this was only true when mothers reported depressive symptoms shortly after their child's birth (Minkovitz et al., 2005). Depression when children were 3 years old was not related to prior health care utilization, and thus the findings of this study are in line with prior research. As for parenting efficacy, Janicke & Finney (2003) found an association between parents' sense of efficacy and utilization of pediatric primary care services when parents were under stress. It seems possible that a similar association would exist for acute care services because efficacious parents would be more likely to take proper steps to address serious child health concerns. An alternative, though, is that parents with low parenting efficacy may delay preventative care and thus utilize emergency services more because they wait until health problems are severe before seeking medical care.

Limitations

We did not attempt to validate all aspects of the family stress model, which posits causal relationships and mediation effects. The aim was merely to establish whether the predicted relations between variables even existed for the developmental outcome of child physical health. Thus, although some findings lend support to the utility of this theoretical framework, further research is needed to establish whether parental depression and parenting efficacy actually operate as mediators between contextual stress and child health. Initially, we did not expect any associations between the home visiting program and child health. The home visiting program prepares children for school, and previous studies have not tested for effects on child health. There are, however, group meetings and additional information outside of the home visitor curriculum that often encourage positive health practices. Future research will investigate other effects of the home visiting program within this data set.

Second, the data are cross-sectional, and causality should not be inferred from the associations reported. The directionality of the observed associations may differ from what was predicted. It is possible that having a child in suboptimal health may lead parents to feel more depressed and less efficacious in their parenting. Research with parents of children with chronic conditions lends support to this alternative explanation. Children's level of functional impairment, which is presumably related to the severity of their pre-existing health condition, has been associated with greater psychological distress and lower efficacy in mothers (Sllver, Bauman, & Ireys, 1995). On the other hand, even with chronic conditions, it is possible that parental depression and low parenting efficacy may negatively impact parents' caregiving behaviors in ways that influence children's health. Parents who are depressed due to economic strain may not have the energy or motivation to ensure their children adhere to the health care

regimens that chronic illnesses typically require. Longitudinal research that examines parents' actual health-related behaviors is needed to fully understand the associations among parental depression, parenting efficacy, and child health.

Another limitation of this research is the reliance on parental self-report for each measure. This is problematic because significant findings may partially result from shared method variance rather than valid associations among study variables. Also, unlike other studies that have linked parental depression and parenting efficacy to specific caregiving behaviors (e.g. Teti & Gelfand, 1991), this study does not measure parent behaviors that may directly impact child health. The associations discussed here are meant to draw attention to the possible role of the parent characteristics in understanding child health, but it remains unclear exactly how parental depression and parenting efficacy might operate on child health outcomes.

A related limitation may be the use of parent report of child health status. Although this is a widely used measure, it is not clear how parents from different socioeconomic statuses and cultural backgrounds respond to this question. The factors that parents take into consideration when asked to rate their child's general health could differ systematically between groups. Parents from some cultures may perceive health differently than others, and relying on parent ratings could lead to under- or over-reporting of health problems in some populations (Burgos et al., 2005). It is important to recognize that this indicator is a measure of parents' perceptions of their children's health and may not correspond perfectly to the child's actual physical health. Future studies of child health would benefit from qualitative investigations of how parents evaluate the health of their child and, if necessary, the development of a more culturally valid indicator of child health status.

Conclusions

The persistence of disparities in children's health is a national public health concern that has its roots in socioeconomic and racial inequality (Fiscella & Williams, 2005; Huges & Ng, 2003). Child health disparities are evident in the present study of primarily low-income, African American and Latina families from one urban community. These findings are important because poor health in childhood can have far-reaching consequences for adult health and economic well-being (Case, Lubotsky, & Paxson, 2002).

A key objective of this study was to understand why some children maintain optimal health despite the negative influence of economic hardship and minority status. The results suggest that parental depression and parenting efficacy may provide part of the explanation. Future research needs to investigate how parental depression and parenting efficacy are related to specific parent behaviors that impact children's health. Professionals who work with low-income and minority families should focus on interventions that support parents and empower them to enhance their children's lives. Apparently, the HIPPY home visiting program is making some strides forward in this regard. Though more work will be necessary in the years to come, this study proposes a starting point for alleviating the chronic problem of health disparities among America's children.

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Table 1

Predictors of health status

Variable	B	*SE*	Wald	*OR*
Family Predictors				
Poverty	-.706	.370	3.640□	.493
Maternal work status	-.610	.342	3.191□	.543
Partners work status	-.218	.337	.419	.804
Married	-.403	.312	1.672	.668
Maternal education	-.074	.273	.074	.928
Household type	.211	.383	.304	1.235
Clinical depression	.461	.358	1.656	1.586
Parental efficacy	.095	.019	24.030*	1.100
Chronic condition	1.290	.448	8.308*	3.633
Family Predictors and Home Visiting				
Poverty	-.701	.376	3.467□	.496
Maternal work status	-.550	.345	2.545	.577
Partner's work status	-.189	.342	.306	.828
Married	-.451	.317	2.022	.637
Maternal education	-.064	.275	.054	.938
Household type	.306	.388	.620	1.358
Clinical depression	.539	.367	2.153	1.714
Parental efficacy	.093	.020	22.614*	1.097
Chronic condition	1.331	.453	8.633*	3.787
Home visiting	.610	.279	4.784*	1.840

□$p < .10$. * $p < .05$

Table 2

Predictors of urgent care utilization

Variable	B	*SE*	Wald	*OR*
Poverty	-.279	.395	.501	.756
Maternal work status	-.462	.367	1.585	.630
Partner's work status	-.272	.360	.572	.762
Married	.079	.334	.057	1.083
Maternal education	-.107	.297	.131	.898
Household type	-.558	.378	2.179	.572
Clinical depression	-.028	.017	2.955□	.972
Parental efficacy	.022	.010	1.226	.978
Chronic condition	1.274	.394	10.440*	3.577

□$p < .10$. * $p < .05$