MATERNAL DEPRESSIVE SYMPTOMS AND CHILD BEHAVIOR AMONG LATINA ADOLESCENT MOTHERS AND THEIR TODDLERS: TRANSACTIONAL RELATIONS AND MODERATING PROCESSES

A dissertation submitted to Kent State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

by

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CHAPTER I

INTRODUCTION

Developmental theories (Belsky, 1984; Bronfenbrenner, 1979; Sameroff & Chandler, 1975) and some longitudinal research findings (Hammen, Burge, & Stansbury, 1990; Sameroff, 1995; Johnston & Mash, 2001) suggest that the relation between maternal depressive symptoms and child behavior is transactional, such that they influence each other over time. To date, however, the majority of research investigating transactional relations between these variables used samples of European American adult mothers, and few studies used samples of adolescent mothers or mothers from other ethnic groups. Latina adolescent mothers are one of the least studied groups with regard to maternal depressive symptoms and child behavior. To the author’s knowledge, the only two published longitudinal studies including some Latina adolescents investigated the influence of maternal depressive symptoms on child behavior over time but did not investigate whether the relation was transactional (Leadbeater & Bishop, 1994; Yoshikawa, Rosman, & Hsueh, 2001). Evidence with this population suggests a concurrent relation between these variables (Smith, Grau, Duran, & Castellanos, 2013; Weller, Grau, Quattlebaum & Castellanos, 2008), but inferring the mutual influence is impossible without longitudinal data.
Child gender may moderate the relation between maternal depressive symptoms and child behavior. Research with depressed or dysphoric mothers suggests that boys are more vulnerable early in childhood and show more behavior problems than girls (Cummings & Davies, 1994; Cummings & Davies, 1999; Goodman & Gotlib, 1999). However, child gender differences have rarely been studied with adolescent mothers in general and adolescent Latina mothers, specifically. Research with samples including some Latina adolescent mothers failed to examine child gender as a moderator between maternal depression and child behavior (Leadbeater & Bishop, 1994; Yoshikawa, Rosman, & Hsueh, 2001; Smith et al., 2013). Information on gender differences in this population would inform prevention and intervention efforts.

Several factors indicate the importance of studying Latina adolescent mothers and their young children. First, the birth rate for Latina adolescents (55.7 per 1000 births; 15-19 years of age) is the largest compared to all other groups in the U.S. (51.5 per 1000 births for non-Hispanic blacks; 38.7 per 1000 births for American Indian or Alaska Natives; 23.5 per 1000 births for non-Hispanic whites; 10.9 per 1000 births for Asian or Pacific Islander; Hamilton, Martin, & Ventura, 2011). Second, adolescent mothers face higher risk of experiencing low socioeconomic status, low intellectual ability, and poorer performance in school than their non-parenting peers and adult counterparts (Flick, 1986; Klerman, 1993; Moore, Hofferth, Wertheimer, Waite, & Caldwell, 1981). The difficulties of having low income can significantly increase an adolescent mother’s already high risk for depression (Leadbeater & Linares, 1992). Some research indicates that adolescent Latina mothers display high rates of depression (Colletta, 1983; Leadbeater, Bishop, &
Raver, 1996; Nadeem, Whaley, & Anthony, 2006), further highlighting the need to investigate depressive symptomatology in this population. Lastly, children of adolescent mothers begin to show behavioral difficulties in the second year of life, or the transition from infancy to toddlerhood (Brooks-Gunn & Furstenberg, 1986; Furstenberg, Brooks-Gunn, & Morgan, 1987; Field, Widmayer, Adler, & de Cubas, 1990; Hann, Osofsky, & Culp, 1996). Yet, little research investigating the emotional and behavioral development of these young children exists.

Given the scarcity of research with Latina adolescent mothers and the high risk these young families face, uncovering the contributions of protective factors in this population is imperative. This paper will focus on the potential protective effect of partner child care involvement as partners have emerged in the literature as a primary source of support for Latina adolescent mothers (Contreras, Narang, Ikhlas, & Teichman, 2002). A co-parent or caregiver, such as the mother’s romantic partner, who engages in positive interactions with the child, may supplement the mother’s parenting and protect children against the negative effects of maternal depressive symptoms. Several studies indicate a positive effect of partners and fathers on child outcomes (Amato & Gilbreth, 1999; Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Furstenberg & Harris, 1993). Additionally, two studies with adolescent mothers support a buffering effect of partner involvement – one with primarily African American mothers (Howard et al., 2006), the other with Latina mothers (Smith et al., 2013). However, the literature lacks longitudinal studies using within-group samples of Latina adolescent mothers investigating these relations.
Maternal Depressive Symptoms and Child Behavior

The extant literature investigating maternal depressive symptoms and child behavioral outcomes mainly focused on samples mostly or entirely comprised of adult European American mothers. Findings from cross-sectional studies indicate a concurrent relation between maternal depression or depressive symptoms and child behavioral, emotional, social, and cognitive outcomes (Downey & Coyne, 1990; Koblinsky, Kuvalanka, & Randolf, 2006; Hoffman, Crnic & Baker, 2006). In a review chapter on parental psychopathology, Zahn-Waxler and colleagues (2002) indicated that these outcomes persist throughout childhood and into adulthood for children of depressed parents. Specifically between infancy and toddlerhood, findings indicate that children with depressed mothers face risk for a variety of negative outcomes. Infants of depressed mothers, compared to children of well mothers, tend to have more difficult temperaments and display mood dysregulation (Zahn-Waxler, Duggal, & Gruber, 2002), and they also exhibit lower cognitive and motor functioning and sleep difficulties (Cornish, McMahon, Ungerer, et al., 2005; Downey & Coyne, 1990; Zahn-Waxler, Duggal, & Gruber, 2002). Research also indicates that these infants have less secure attachments than infants of non-depressed mothers (Zahn-Waxler, Duggal, & Gruber, 2002). In one of the few studies with some representation of Latino families (40%), newborns with prenatally depressed mothers displayed higher levels of fussing and crying. Additionally, maternal depressive symptoms at any time related to sleep difficulties in the neonates (Diego, Field, & Hernandez-Reif, 2004).
Into toddlerhood, offspring of depressed mothers tend to react poorly to stress, have ineffective self-regulation strategies, and are less skilled than their peers at interacting socially. Toddlers and preschoolers of depressed mothers are more likely to be aggressive toward, withdraw from, and show inappropriate behaviors toward peers (Zahn-Waxler, Duggal, & Gruber, 2002). These children display emotional and behavioral problems (Downey & Coyne, 1990; Zahn-Waxler, Duggal, & Gruber, 2002). In a sample of 184 mothers and their toddlers, higher maternal depression scores related to higher levels of externalizing and internalizing behavior problems in children (Koblinsky, Kuvalanka, & Randolf, 2006). In another study with a mixed sample including Latina mothers (32.8%, 41.4% African American, 17% European American), Malik and colleagues (2007) found that maternal depression predicted aggression in 2-year-old children. Hoffman, Crnic and Baker (2006) found that, by comparison, 4-year-old children of depressed mothers displayed more dysregulation and behavioral problems than those with non-depressed mothers. Taken together, these findings from samples of adult mothers and their young children highlight the importance of studying the influence of maternal depressive symptoms early in child development.

**Transactional Relations**

The transactional model was first articulated by Sameroff and Chandler (1975) when discussing the phenomenon of children developing into normal-range functioning adults despite being raised in high-risk environments or experiencing some risk factor. This transactional theory was in line with Bronfenbrenner’s (1979) ecological model of child development in which parent and child psychopathology are thought to be
interrelated. Later, Belsky’s (1984) process model of the determinants of parenting also highlighted the mutual influence of parents on children and children on parents. Other theorists echoed the call for an understanding of the transactional relation between children and their environments in research regarding child development (Martin, 1987; Sameroff & Seifer, 1983). The transactional model allowed researchers to conceptualize not only the child as a developing organism, but also the child’s environment as one which changes and is influenced over time (Sameroff, 2009). As such, temporal variations in child behavior, parenting, and parent psychopathology throughout a child’s development could be better understood through the idea that throughout a child’s development both children and parents modify their behavior based on that of the other or that one’s psychopathology could fluctuate with the behavior or psychopathology of the other.

Despite this call decades ago, little research has investigated the mutual influence of maternal depressive symptoms and child emotional and behavioral functioning. One of the first studies to examine this mutual influence suggested that mothers who displayed depressive symptoms when their children were rated with higher levels of behavior problems at 14 months post-partum maintained depressive symptoms at twenty-seven months post-partum (Ghodsian, Zajicek, & Wolkind, 1984). Results were only significant for mothers who reported dysphoria, and mothers with few or no depressive symptoms with children displaying high levels of behavior problems at time one did not develop these symptoms later (Ghodsian, Zajicek, & Wolkind, 1984). The study found some evidence that children with depressed mothers showed behavior problems both
concurrently and at later ages (Ghodsian, Zajicek, & Wolkind, 1984). This study highlights the transactional nature of the relation between behavior problems, or child externalizing, and maternal depressive symptoms.

In a similar study, Hammen and colleagues’ (1990) results were consistent with the transactional model such that maternal functioning and child characteristics mutually influenced one another in a sample of adult mothers and their eight- to sixteen-year-old children. Maternal functioning in this study was operationalized to include maternal depression along with other indicators of functioning. Child characteristics measured in this study included self-concept, age, and observed quality of interactions with mother. In a longitudinal follow-up of the same sample, results indicated that child depressive episodes preceded mothers’ depressive episodes in half of the sample and vice versa in the other half (Hammen, Burge, & Adrian, 1991). These findings indicate a transactional relation between child internalizing and maternal depressive symptoms.

Transactional relations between psychological distress in parents and their adolescent children also emerged in a longitudinal study over three time points by Ge and colleagues (1995). Parental distress and adolescent distress were quantified as a composite of self-reported anxiety, hostility, and depressive symptom scores. The strongest reciprocal effects were found for mother – son pairs and father – daughter pairs. Moreover, results indicated that mothers may experience more negative effects of sons’ distress than sons experience for mothers’ distress (Ge, Conger, Lorenz, Shanahan, & Elder, 1995). Results of this study further point to a transactional relation between internalizing behaviors in children and parental internalizing.
More recently, Gross and colleagues (Gross, Shaw, & Moilanen, 2008; Gross, Shaw, Burwell, & Nagin, 2009) have investigated the transactional relations between maternal depressive symptoms and child disruptive behavior longitudinally from early childhood to adolescence. Results indicated that boys’ disruptive behavior at age 5 significantly predicted maternal depressive symptoms at age 6, and vice versa (Gross, Shaw, & Moilanen, 2008). Results of that study also suggested that these reciprocal effects were present in early adolescence (Gross, Shaw, & Moilanen, 2008). The authors also found that child noncompliance in early childhood was the strongest predictor of later maternal depression (Gross, Shaw, Burwell, & Nagin, 2009). Maternal depression then was a significant predictor of adolescent-reported antisocial behavior, teacher-reported adolescent externalizing behavior, but not teacher-reported adolescent internalizing behavior (Gross et al., 2009). Thus, this study highlights the mutual influence between maternal depression/depressive symptoms and child and adolescent externalizing behaviors.

Other areas of research indicate that child behavior, specifically externalizing behaviors, relates to changes in maternal characteristics. First, treatment studies aimed at lowering problem behaviors in children suggest that maternal depressive symptoms alleviated as child behavior improved (Sanders, Markie-Dadds, Tully, & Bor, 2000; Sanders & McFarland, 2000). Johnston and Mash (2001) also reviewed research indicating that depression levels in parents of children with comorbid ADHD and conduct disorders are elevated. Thus, evidence exists indicating both that maternal depression
influences child outcomes, as reviewed above, as well as that child behavioral and emotional difficulties influence levels of maternal depressive symptoms.

**Child Gender**

Child gender has been identified in the literature as a risk factor for psychopathology. Normative research has indicated that prior to age 4, the rates of adjustment problems in children do not significantly differ for males and females (Achenbach & Rescorla, 2000; Keenan & Shaw, 1994; Maccoby, Snow, & Jacklin, 1984; Prior, Smart, Sanson, & Oberklaid, 1993). Research with depressed or dysphoric mothers and their children, however, suggests gender differences as early as 2 years of age (Zahn-Waxler, Iannotti, Cummings, & Denham, 1990). Research indicates that in early childhood, boys are more vulnerable than girls to develop psychopathology whereas girls become more vulnerable in adolescence (Cummings & Davies, 1999). Additionally, research suggests that some gender differences exist in the type of psychopathology displayed in that boys may show more behavioral problems and girls may show more emotional problems in the face of maternal depression (Cummings & Davies, 1994). Taking into account both the age of vulnerability for each gender and the type of psychopathology displayed, it is reasonable to conclude that, in toddlerhood, boys would exhibit higher rates of behavior problems than girls in the context of maternal depressive symptoms. Given that maternal depressive symptoms may influence boys and girls differently, investigating the interactive effects of child gender and mothers’ symptomatology becomes important.
In samples of adolescent mothers, child gender has never been examined as a moderator of the relation between maternal depressive symptoms and child behavioral outcomes. Some studies have examined gender as a main effect. Hubbs-Tait and colleagues (1996) examined gender and maternal depression as predictors of both child internalizing and externalizing symptoms at 44 months old, and gender was not a significant predictor with maternal depression in the model. In a longitudinal study with a mixed sample including some Latina adolescent mothers and their children (\(M_{\text{age}} = 1.2\) years, range 0-3), Rosman and Yoshikawa (2001) entered gender as a control variable in analyses predicting total behavior problems, and it was significant in the first step such that female gender of child was associated with better behavioral outcomes. However, the authors failed to mention whether gender remained a significant predictor once maternal depression was entered into the model (Rosman & Yoshikawa, 2001). In another longitudinal study with a mixed sample of adolescent mothers and their children (\(M_{\text{age}} = 2.7\) years), a main effect for the interaction of gender by ethnicity was significantly predictive of child behavior problems with maternal depression in the model such that male children of African American mothers were rated with higher levels of behavior problems (Leadbeater & Bishop, 1994). Gender alone was not a significant predictor in this model (Leadbeater & Bishop, 1994). Gender was not significantly related to child internalizing or externalizing in studies of within-group samples of Latina adolescent mothers and their 20-month-old children, and, as such, it was not entered into the model with maternal depressive symptoms in either study (Weller et al., 2008). Taken together, studies including older children found gender differences, whereas those with younger
children did not. However, as none of these studies investigated the interaction of maternal depressive symptoms and child gender as a predictor of child behavior, the moderating influence of this variable is still unknown in samples of adolescent mothers in general and Latina adolescent mothers, specifically. Thus, this variable should be explored further with relation to this population to gain understanding of its potential role as a moderator.

**Latina Adolescent Mothers**

Beyond the high birth rate and risk-factors faced by this population, examining the challenges of the developmental periods of adolescent parents and their toddlers provides more reason for investigating this high-risk sample. Adolescent mothers and their toddlers face difficult developmental tasks. Adolescence is a time of identity and romantic relationship development, and young mothers face these challenges along with the added strain of learning to be a parent. As such, adolescent mothers need to accommodate not only the developmental tasks of adolescence, but their parenting responsibilities as well (Mercer, 2004). Research indicates that young women facing the stressful developmental milestone of parenting during adolescence are at increased risk for psychopathology (Wiemann, Berenson, Wagner, & Landwehr, 1996), which may be due in part to feelings of low maternal competence (Birkeland, Thompson, & Phares, 2005).

Toddlerhood is also a time of increasing autonomy and efforts for children to control one’s behavior and one’s environment. Children of adolescent mothers begin to show behavioral difficulties in the second year of life, or the transition from infancy to

Regardless of ethnicity or age of parent, parents remain influential in the early years of a child’s life as children spend most of their time surrounded by their family of origin. First, the developmental challenges of toddlerhood and adolescence create a difficult developmental context for young mothers and their toddlers. Thus, parenting a toddler as an adolescent may be even more difficult than a more docile period of a child’s development. Second, as discussed above in detail, the context in which Latina adolescent mothers are parenting includes many risk factors, which may increase the impact of a difficult developmental period. Taken together, the above findings highlight the increased risk in Latina adolescent mothers and their children for adverse outcomes.

Despite these findings, a dearth of literature to date has focused on this population.

A handful of research studies have examined the relation between depressive symptoms and child outcomes in samples that included significant proportions of adolescent Latina mothers and their young children. Each of the studies reviewed below utilized self-report measures of maternal depressive symptoms, and all but one used maternal report of child behavior problems. Only two studies have looked at this relation in samples of entirely Latina adolescent mothers. The first studied the relation between maternal depressive symptoms and child behavior and affect in a sample of young mainland Puerto Rican mothers and their 20-month-old children. Findings revealed that maternal depressive symptoms were significantly associated with less child positive affect and more distress in children as observed and coded during a teaching-task
interaction with mothers at the same time point (Weller et al., 2008). The other is the largest study with this population and was conducted with a sub-sample from data from the first wave of the larger longitudinal study on which the current study is based (Smith et al., 2013). In this study of 125 mainly Puerto Rican mothers and their 18-month-old children, maternal depressive symptoms related to mothers’ perceptions of both internalizing and externalizing behaviors in children (Smith et al., 2013). These relations existed above and beyond the effects of financial strain and negative life events.

Limited longitudinal research has focused on Latina adolescent mothers, and the author could find no published studies using within-group samples of this population. To date, longitudinal relations between these variables have only been explored in two samples. In analyses of data on 83 participants collected as part of a longitudinal study of adolescent mothers and their children, Leadbeater and colleagues found that maternal depressive symptoms at several time-points early in the child’s life were significantly correlated with mother-reported total behavior problems in children aged 28 to 36 months (Leadbeater & Bishop, 1994). Concurrent correlations were also significant between these variables (Leadbeater & Bishop, 1994). Further investigation with a smaller subsample in this study found that chronic depressive symptoms over the first year of the child’s life were correlated to mother-reported preschool problem behaviors (Leadbeater, Bishop, & Raver, 1996). Each of these samples consisted of approximately 40% Latina and just over half African American adolescent mothers. Additionally, Yoshikawa and colleagues (2001) found that maternal depressive symptoms in a large mixed sample including 23% Latina (54% African American, 23% European American) teenage
mothers predicted behavior problems in their children. However, neither of these studies reported their results separately by ethnicity; thus, little can be determined about their applicability to Latina adolescent mothers. Although these studies were longitudinal in nature, the transactional relation between maternal depressive symptoms and child outcomes was not investigated. Longitudinal, within-group data are needed to better understand the nature of this relation in Latina adolescent mothers and their children.

While the above evidence suggests the longitudinal influence of maternal depressive symptoms on child behavior in samples of Latina adolescent mothers, little is known regarding the influence of child behavior on mothers’ depressive symptoms over time in this population. The literature on the transactional relation between these variables reviewed above indicates that, in other samples, maternal depressive symptoms are affected by child behavior over time (Ge et al., 1995; Gross, Shaw, Burwell, & Nagin, 2009; Gross, Shaw, & Moilanen, 2008; Hammen et al., 1990; Hammen, Burge, & Adrian, 1991). For Latina adolescent mothers, their contexts may influence whether this relation exists in this population. It is possible that, given the risk factors faced by these young families and the developmental context of Latina adolescent mothers, child behavior may not predict adolescent mothers’ level of functioning since it may be less central to the mothers’ self-definition in such a high stress context. However, considering the developmental period of late-infancy to toddlerhood in which children are seeking autonomy in tasks, an adolescent mother may become more stressed as her child becomes more difficult to manage, thus affecting her level of depressive symptoms.

As mentioned by Birkeland and colleagues, adolescent mothers may integrate their
transition to parenting into their self-definition and view parenting difficulties as low parenting competence; which, in turn, could affect their level of depressive symptoms (Birkeland, Thompson, & Phares, 2005). Moreover, the extent to which children of adolescent mothers are predisposed to be more dysregulated and have potentially difficult temperaments due to lack of or delayed prenatal care (Singh, Torres, & Forrest, 1985; Young, McMahon, Bowman, & Thompson, 1989; Stevens-Simon, Roghmann, & McAnarney; Wells, McDiarmid, & Bayatpour, 1990) likely also increases the influence of child behavior on maternal depressive symptoms. Thus, it is reasonable to expect that child behavior problems will predict maternal depressive symptoms over time. Given these possibilities and the lack of research on the impact of child behavior on maternal depressive symptoms over time in this population, longitudinal studies testing this relation are necessary.

**Mother’s Partner: Child Care Involvement**

Whether due to lack of parenting engagement or merely having a strong support network, adolescent Latina mothers may rely on others to perform child care duties in addition to or in replacement of their own parenting tasks. One such individual could be the adolescent’s romantic partner. With regard to Latina adolescent mothers, the influence of partner is especially important to consider. In samples of Latina adolescent mothers, husbands and partners are reported as one of the most important sources of support (Wasserman, Brunelli, Rauh, & Alvarado, 1994; de Anda & Becerra, 1994) and these mothers are more likely to report co-residing or being married to the father of their child than their non-Latina counterparts (Wasserman et al, 1994; de Anda & Becerra,
Research with Latina adolescent mothers has found high rates of participants with partners or husbands (Contreras, López, Rivera-Mosquera, Raymond-Smith, & Rothstein, 1999), and they tend to be involved in longer romantic relationships than their non-Latina counterparts (Moore, Florsheim, & Butner, 2007; Wasserman, et al., 1994). As such, these men are likely to be present and possibly involved in child care. However, little is known about partner child care involvement in this population, and only one study has examined the effects of partner child care on the behavior of children of Latina adolescent mothers (Smith et al., 2013).

Beginning in the 1970s, research in the area of child development widened its focus on parental influences to not only include mothers, but fathers as well. As such, a great deal of literature points to positive associations between father involvement and positive child outcomes in the areas of behavior and emotional adjustment as well as academics, cognitive development, and social interactions with peers (Amato & Gilbreth, 1999; Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000). Research from The Baltimore Study of Teenage Motherhood indicated that children’s strong relationships with their father-figure, whether their father or their mother’s partner, predicted better outcomes in the areas of employment, education, and depression than those who did not (Furstenberg & Harris, 1993), highlighting the importance of a father-figure, not necessarily a biological father. Moreover, the impact of these relationships may be more influential in toddlerhood, as children may show more interest in and interact more with their fathers and father-figures (Lamb, 1987). Given the above reviewed literature on Latina mother’s tendency to remain in longer, co-residing relationships with their
romantic partners, it is likely that the interactions these men have with the toddlers of Latina adolescent mothers are important at this stage of life. As such, the current study will focus on partner child care involvement as a means of measuring the impact of such interactions on child internalizing and externalizing behaviors.

Theories on parenting suggest that presence of a healthy caregiver in the context of having a depressed parent may serve as a protective factor for the child (Belsky, 1984; Goodman & Gotlib, 1999), and literature with adult parents has supported that having a healthy father is directly related to better outcomes for children of depressed mothers (Goodman, Brogan, Lynch, & Fielding, 1993). In the study by Goodman and colleagues (1993), children with a well father and a depressed mother fared better in areas of self-concept, self-perceived peer relation skills, and teacher-rated self-control than children without a well father in the same context. Research with adolescent mothers of primarily AA descent indicates that contact with mothers’ partners can positively impact children (Furstenberg & Harris, 1993; Cooley & Unger, 1991). These findings highlight the beneficial role that healthy partners and fathers can play in lives of children with mothers displaying heightened levels of depressive symptoms.

Although previous literature called for research exploring the buffering influence of fathers and partners, the interaction of maternal depressive symptoms and father or partner child care has rarely been studied, even in samples of adult mothers (Chang, Halpern, & Kaufman, 2007; Mezulis, Hyde, & Clark, 2004). One such study with adult families found that quantity of father involvement impacts child behavior problems, and only found moderating effects of father involvement (composite of quality of
involvement, quantity of involvement, father’s parenting styles, and father’s depression) for internalizing (and not externalizing) behavior problems (Mezulis et al., 2004). Another study indicated a protective effect of child-reported positive father involvement (a composite of items assessing talking over important decisions with child, child’s perception of whether father spends enough time with child, listening to child’s side of argument, child’s perception of closeness to the father, how well the child and father share ideas and talk about important topics, etc.) on both internalizing and externalizing problems for children with depressed and non-depressed mothers, with stronger effects for non-depressed mothers (Chang et al., 2007). Thus, these two studies present a mixed picture.

Moreover, this relation has rarely been tested in samples of adolescent mothers. One study of African American adolescent mothers investigated the buffering effect of father contact (i.e., composite of father’s pre-natal romantic involvement with mother, post-natal contact with child, residential status, financial support, child care assistance, etc.) on the relation between maternal risk (i.e., having a high- or low-risk mother) and child internalizing and externalizing behavior (Howard et al., 2006). Results indicated that father contact related to lower internalizing symptom ratings in children with high risk mothers (e.g., mother with low intelligence, low cognitive readiness to parent, and high internalizing and externalizing problems). For children of low-risk mothers, father contact was not related to internalizing symptoms in this study (Howard, et al., 2006). No buffering effect of father contact was found for child externalizing problems in this study.
In the previous study completed with the first wave of data from the current longitudinal study (Smith et al, 2013) maternal depressive symptoms were less strongly related to child internalizing symptoms at high levels of partner involvement in child care than at low levels of partner involvement, indicating a buffering effect of partner child care. Smith and colleagues measured partner child care involvement including direct didactic, physical play, and care giving behaviors provided by mothers’ partners. Consistent with Howard and colleagues’ findings, results were also only significant for child internalizing, and not externalizing, behavior problems. This study is the only study to the author’s knowledge to investigate the protective influence of partner child care involvement in a within group sample of Latina adolescent mothers. Taken together, the above findings regarding the buffering influence of partners indicate that it would be reasonable to expect a significant interaction between maternal depressive symptoms and partner child care involvement.

The Current Study

The current study used data from a longitudinal study of Latina mothers, of mainly Puerto Rican descent, and their toddlers for which data were collected at two time points, 6 months apart. The first aim of this paper was to assess the longitudinal and transactional nature of the relation between maternal depressive symptoms and child behavior. The findings reviewed above indicate that the relation between maternal depressive symptoms and child behavior is similar in samples of Latina adolescent mothers to samples of adult mothers such that maternal depressive symptoms relates to both internalizing and externalizing behaviors in children. Thus, despite the lack of
literature testing the transactional relation between these variables in this population, I hypothesized that the relation would be transactional in the current sample such that maternal depressive symptoms predicted child internalizing and child externalizing over time and vice versa.

Further, this paper aimed to investigate child gender as a potential moderator of the relation between maternal depressive symptoms and child behavior. Based on the research reviewed above, I hypothesized that maternal depressive symptoms would relate to behavior problems for both males and females, but that this relation would be stronger for males’ externalizing behavior problems than for girls’ externalizing behavior problems. Given a lack of support for this moderating effect of gender to occur at such a young age for internalizing, I did not expect moderation by gender when testing the relation between maternal depressive symptoms and child internalizing. The final aim of this study was to extend the previous study by Smith and colleagues (2013) that used wave one data from this sample to investigate the potential longitudinal protective effect of partner child care involvement on child behavior in the face of maternal depressive symptoms. The model proposed in the study tested both the direct effect of partner child care and the moderating effect of partner child care. Given evidence from the research reviewed in the previous section, partner child care at Time 2 was expected to correlate directly to child behavior variables at Time 2. Following evidence from the Smith and colleagues (2013) study, I also hypothesized that partner child care involvement at Time 2 will interact with maternal depressive symptoms scores at Time 1 to buffer children from the negative, longitudinal effects of depressive symptoms on child internalizing at
Time 2. As such, it was expected that maternal depressive symptoms (Time 1) would be more strongly related to child internalizing symptoms (Time 2) at low levels of partner child care than at high levels of partner child care (Time 2). Figure 1 illustrates the proposed overall model.

The current study followed Smith and colleagues (2013) by assessing partner involvement in a more specific and targeted way, rather than using the global assessments of contact that have been used in the literature. Mothers’ reports of partner involvement in child care in the month prior to Time 2 were used as the moderator of the current study. Using a rich, multi-item measure of partner involvement, the current study assessed the direct care provided to the child by assessing three key aspects of child care for young children (i.e., didactic interactions, physical play, care giving; Cabrera, et al., 2004; Lamb et al., 1987). This measure differs from those used in previous studies in its ability to pinpoint the impact of partners’ involvement in these forms of child care rather than the impact of his financial support to the family or his psychopathology as other studies have done. Additionally, we focused on both non-father partners and father partners by measuring involvement by mothers’ romantic partners consistent with previous literature with adolescent mothers indicating that partners can have positive impacts in the lives of their children (Cooley & Unger, 1991; Furstenberg & Harris, 1993).

Several maternal report measures exist to measure symptoms in young children. For the purposes of this study, the Child Behavior Checklist 1½ - 5 (CBCL; Achenbach & Rescorla, 2000) was used to measure mother-reported child internalizing and
Figure 1. Proposed model of the longitudinal relations between maternal depressive symptoms and child behavior.
externalizing symptoms. The use of maternal-report of child behavior is consistent with previous studies investigating the relation between maternal depressive symptoms and child outcomes (for children under the age of 9) in samples of adolescent mothers and Latina mothers. Moreover, maternal-report of child behavior was used in four of the five studies with Latina adolescent mothers reviewed above. The CBCL/1 ½-5 is available in both Spanish and English and is adequately reliable and valid in samples of Latino parents (Gross, et al., 2006; Weiss, et al., 1999).

Consistent with previous research, maternal depressive symptoms were measured through self-report. Although use of maternal report of all measures is the norm in the current research, it is a limitation of the current study. In an attempt to allay some of the complications from shared method variance, the current study used theoretically-derived Time 2 control variables for both maternal depressive symptoms and the child outcome variables at Time 2. Theory and empirical evidence indicate that mothers’ age, socioeconomic context, and stressful life events relate to their levels of depressive symptoms (Colletta, 1983; Leadbeater, Bishop, & Raver, 1996; Nadeem, Whaley, & Anthony, 2006; Leadbeater & Linares, 1992). As such, maternal age at birth of child and indicators of economic strain and life stress were used as control variables for maternal depressive symptoms. Though theory also indicates that child age may influence symptom levels in mothers and children, child age was not included as a control since children’s ages represented such a restricted age range at each time point that age differences were not expected (Time 1: 18 +/- 2 months; Time 2: 24 +/- 2 months). Also, given that developmental theories and research indicate that child gender may
impact a child’s presentation of behavioral symptoms, child gender was selected as a control variable for both child internalizing and child externalizing problems (Cummings & Davies, 1994; Cummings & Davies, 1999; Goodman & Gotlib, 1999). Additionally, Time 1 scores for each outcome were controlled for in the model in order that Time 2 scores reflected changes in the variables over time. Regardless of these attempts, results should be interpreted with the understanding that mothers were the sole informants for all data points.

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CHAPTER II

METHOD

Participants

Participants for the current study were mothers who participated at both Time 1 and Time 2 of the larger study from which the data were gathered (87.6% of larger sample N = 170). Of these, 2 participants had missing data due to invalid reporting on questionnaires. Thus, 147 mothers and their toddlers comprise the sample for the current study. Analyses were conducted to determine if families who did not participate at Time 2 differed from those who did participate on demographic and study variables. Results indicated that, compared to mothers who participated at Time 2, mothers who only participated at Time 1 were more likely to report that they had moved more than once since the birth of their child by the Time 1 interview.

Mothers’ mean age at time of the child’s birth was 17.93 years (SD = 1.35; range: 14.25 – 19.92), and 82.8% were of Puerto Rican heritage. 46.3% of participants were born outside of the mainland US. Target children’s (53.1% male) mean age was 18.17 months (SD = .99; range: 15.94 – 20.79) at Time 1 and 24.6 months (SD = 1.09; range: 22.40 – 27.48) at Time 2. The majority were the first child (86.4%), and 63.3 were the only child. Most children (92.5%) were born in the mainland US; 69.4% were described by their mothers as of purely Latino origin while the others were reported as mixed
Latino and African American origin (18.4%); mixed Latino and European American origin (9.5%); and mixed Latino and other (2.7%).

One hundred-one (68.7%) of mothers reported having a partner (husband or boyfriend) at time 2; of those partners, 72 were the father of the target child. Over half (55.8%) of the participants reported that their partner was the same partner from the first home visit. Seventy-five (51.02%) of the participants reported living with their partner: of those, 70.6% lived only with their partner and child; 14.6% with their maternal figure, partner, and child; and the remaining 14.6% with their partner’s family, partner, and child. The other 72 participants (48.98%) had other living arrangements: 34 participants (47.2%) with their mother and child; 25% alone with child; and 27.8% other (i.e., with grandparents, siblings, peers, or other). 63.3% of participants did not complete high school, 22.4% earned a high school diploma or equivalent, and 14.2% attended some college or professional training. At Time 2, 23.1% of participants were attending school full-time or part-time. 40.8% of the participants reported being employed full time or part time. 88.4% of participants received one or more forms of government assistance (i.e., food stamps, medical card, Temporary Assistance for Needy Families) at Time 2.

**Procedure**

Most participants (78.9%) were recruited in waiting rooms of pediatric clinics serving Latino neighborhoods in a large Midwestern city. The remaining participants were either referred by friends/relatives or self (14.3%) or by professionals or others in the community (6.8%). As reaching young Latina mothers in the area is difficult (e.g. no service agency is devoted to this population and no specialized High School classes are
provided), mothers were invited to participate at first contact, regardless of child’s age. To establish eligibility (i.e. mother 19 years or younger at birth of child, child under age 20 months, child had no major physical/medical problems at birth), information on the mother’s age and child’s age and birth status was obtained as well as contact information. At this point 253 eligible individuals were contacted; 12 of these women did not agree to be considered for the study on first contact (4.7%). Mothers were then followed until their target child met age criteria (18 ± 2 months). Out of the remaining 241 from whom contact information was gathered, 170 participated (70.5%) in Time 1. Seventy-one individuals were lost because they moved away before their children reached eligible age (18.5%), could not be located after first contact (28%), refused to participate when contacted again (8.5%), or had scheduling problems preventing participation while their children met the age criteria (45%). Results of t-test analyses indicated that non-participating families did not differ significantly from participant families on variables of mother age, mother nationality, child age, or child gender, which were the only data gathered at first contact.

Two female researchers, at least one of whom was bilingual, conducted two home visits, approximately 6 months apart, in either English or Spanish. Home visits included videotaping the child with the mother and interviewing the mother using a computer assisted interview made up of various questionnaires. Interviews were conducted in participant’s preferred language to read (Time 1: 70.1% English; 29.9% Spanish, Time 2: 70.7% English, 29.3% Spanish). Families were compensated with $70 and a small gift for
the child at the end of each visit, and a copy of the videotape was delivered within a few weeks after each visit.

Measures

Translations

For measures for which a Spanish version was not available, items were translated by a bilingual member of the research team and then back-translated and adjusted by a group of bilingual individuals. The reliability of each language version will be calculated for each measure to further examine equivalence between English and Spanish versions.

Demographics

Demographic information about each participant, target child, and partner (if applicable) was obtained through participant self report on a set of fixed-format, computer-aided interview questions. Participants provided information on the following items: their date of birth; ethnicity; target child date of birth; school status; work status; education level; receipt of TANF; living arrangements; marital status; country-of-origin of participant, target child, and partner (if applicable); and, if applicable, length of romantic relationship; partner’s school status, education level, financial support, employment status.

Maternal Depressive Symptoms

Maternal depressive symptoms were measured using the Depression scale of the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1994), a 13-item, self-report scale
assessing symptoms in the past two weeks (e.g., ‘in the past two weeks, how much were you distressed by feeling hopeless about the future?’). Responses range from 0 – ‘not at all’ to 4 – ‘extremely’. Adequate reliability coefficients ($\alpha = .90$) for this scale were found in the normative sample (Derogatis, 1994), and in studies with young Latina mothers (Contreras, López et al., 1999; López & Contreras, 2005). In the current sample, this scale showed an internal consistency reliability of .89 at Time 1 (Time 2: $\alpha = .89$). Reliabilities were .87 (Time 1; Time 2: $\alpha = .89$) and .92 (Time 1; Time 2: $\alpha = .87$) for English and Spanish respondents, respectively.

**Child Behavior**

Child internalizing and externalizing symptoms were measured using the Internalizing and Externalizing scales of the Child Behavior Checklist 1½ - 5 (CBCL 1½ - 5; Achenbach & Rescorla, 2000), a 99-item, parent-report measure assessing child emotional and behavioral problems. Responses range from 0 - ‘not true’ to 2 - ‘very true or often true’. Official Spanish and English versions are available. Excellent validity, internal consistency, and test-retest reliability are reported for these scales (Achenbach & Rescorla, 2000). In samples of Latino parents, the Spanish and English versions of the scales have demonstrated adequate internal consistency, test-retest reliability and concurrent validity between Spanish and English versions (Gross et al., 2006; Weiss, et al., 1999). In the current sample, adequate reliabilities were found for both internalizing (Time 1: $\alpha = .86$; Time 2: $\alpha = .81$) and externalizing (Time 1: $\alpha = .86$; Time 2: $\alpha = .88$), and for English (Time 1: internalizing $\alpha = .85$; externalizing $\alpha = .87$; Time 2: internalizing $\alpha = .79$; externalizing $\alpha = .89$) and Spanish (Time 1: internalizing $\alpha = .86$;
externalizing $\alpha = .84$; Time 2: internalizing $\alpha = .85$; externalizing $\alpha = .87$) versions. Means from the current sample were higher than those of the normative sample at Time 1 and Time 2. Of the entire sample used in this study, 17% of children fell in the clinically significant range of T-scores for internalizing at Time 1, and 12.2% of the children fell in the clinically significant range of scores for internalizing at Time 2. Regarding externalizing, 23.8% of the children’s T-scores placed them in the clinically significant range for externalizing at Time 1, and 19.7% fell in the clinically significant range for externalizing at Time 2. Inconsistent with norms for children this age, gender differences were found for T-scores of child externalizing symptoms in the current sample at Time 2 ($t (145, 2) = -2.80, p = .006; M_{female} = 54.28, M_{male} = 58.65$). No gender differences were found for child internalizing symptoms. To maximize variability, raw scores will be used in analyses.

**Partner Child Care Involvement**

A standard series of items adapted from measures of father involvement used in the ECLS-B study (Cabrera, et al., 2004; Cabrera, Shannon, West, & Brooks-Gunn, 2006) was used to assess mother-reported frequency of partner involvement in child care during the past month at each time point. The ECLS-B study used samples of adult parents which included Latinos (Cabrera, et al., 2004; Cabrera, Shannon, West, & Brooks-Gunn, 2006). Two items assessed frequency of didactic child care (i.e., sing songs and read stories); four items assessed frequency of physical play with children (i.e., play with child with toys; tease child to get him/her to laugh; and holding/caressing child); and five items assessed frequency of care giving (i.e., help with bath, diaper
change, and feeding). Responses ranged from ‘0’-never to ‘6’-several times a day’. For the current study, Time 2 scores from all items will be averaged together to provide an overall score of partner involvement in child care. The internal consistency of the scale was adequate (whole sample – Time 1: $\alpha = .87$, Time 2: $\alpha = .75$; English – Time 1: $\alpha = .88$, Time 2: $\alpha = .70$; Spanish – Time 1: $\alpha = .84$, Time 2: $\alpha = .80$).

**Life Stress**

A modified version of the Life Events Survey (Sarason, Johnson, & Siegel, 1978) that was adapted for young minority mothers (Rhodes, Ebert, & Fisher, 1992) was used to assess life stress. Mothers responded to a series of questions regarding stressful events that in the 6 months between Time 1 and Time 2 home visits. Responses ranged from 1 – ‘extremely negative’ to 5 – ‘extremely positive’ for events that occurred to them in the last 6 months or 6 – ‘did not occur in the past 6 months’. Negative event ratings were added together and weighted such that events perceived as extremely negative carried more weight than those that were perceived as merely negative. Adequate test-retest reliability has been found for this questionnaire (Sarason, Johnson, & Siegel, 1978). In prior research with adolescent Latina mothers, scores on this measure significantly related to maternal psychological distress (Contreras, López et al., 1999, indicating construct validity. Weighted scores obtained in the current sample (Time 1: $M = 4.07$, $SD = 3.58$; Time 2: $M = 3.68$, $SD = 2.51$) were similar to scores obtained in another comparable sample of Latina adolescent mothers ($M = 5.4$, $SD = 4.06$; Contreras, 2004).
**Economic Strain**

The Economic Strain Questionnaire (ESQ; Pearlin, Menaghan, Lieberman, & Mullan, 1981), a seven item, self-report measure of financial difficulties, was used to measure economic strain. Participants rated the usual situation in their household by responding to questions like ‘Do you feel your household is able to afford decent housing?’ with responses from ‘never’ (1) to ‘always’ (5). Items were averaged together to create a mean economic strain score. In a previous study with young African American adolescent mothers, economic strain as measured by this scale related to psychological distress (Rhodes, Ebert, & Meyers, 1994). Adequate reliability was found for the total sample (Time 1: $\alpha = .81$, Time 2: $\alpha = .83$), and English (Time 1: $\alpha = .82$, Time 2: $\alpha = .83$) and Spanish respondents (Time 1: $\alpha = .82$, Time 2: $\alpha = .83$).
CHAPTER III

RESULTS

Analysis Plan

First, mean differences across time were explored using paired samples t-tests to determine whether levels of depressive symptoms and child behavior problems varied significantly between Time 1 and Time 2. Bivariate correlations were also computed among all study variables in IBM SPSS Statistics 20 (2011) prior to running path analyses. These correlations along with means and standard deviations for each study variable can be found in Table 1. Next, to assess transactional and moderation effects, a series of path analysis models using maximum likelihood estimation were conducted in MPlus 5 (Muthén & Muthén, 2007). As some relations were expected to differ based on type of child behavior problem, models were run separately for child internalizing behavior problems and child externalizing behavior problems. All models included concurrent correlations between maternal depressive symptoms and child behavior.

Transactional effects were assessed using a series of three increasingly complex models for each outcome variable. The paths in the first model, or the stability model, specified that maternal depressive symptoms and child behavior predicted themselves over time (i.e., direct prediction of Time 1 predictors to Time 2 outcomes). The second model, hereby referred to as the parent—to—child model, contained an additional
Table 1. *Bivariate Correlations Among Study Variables (N = 147).*

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. T1 Mat. Depressive Sx</td>
<td>.73 (.68)</td>
<td>.38***</td>
<td>.35***</td>
<td>.66***</td>
<td>.43***</td>
<td>.44***</td>
<td>-.12</td>
<td>.12</td>
<td>.32***</td>
<td>-.15†</td>
<td>.08</td>
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<tr>
<td>2. T1 Child Internalizing</td>
<td>11.35 (6.98)</td>
<td>—</td>
<td>.57***</td>
<td>.27***</td>
<td>.60***</td>
<td>.37***</td>
<td>.01</td>
<td>.13</td>
<td>.14†</td>
<td>-.10</td>
<td>.05</td>
</tr>
<tr>
<td>3. T1 Child Externalizing</td>
<td>19.03 (8.59)</td>
<td>—</td>
<td>—</td>
<td>.32***</td>
<td>.42***</td>
<td>.64***</td>
<td>-.05</td>
<td>.14†</td>
<td>.14†</td>
<td>-.18*</td>
<td>.03</td>
</tr>
<tr>
<td>4. T2 Mat. Depressive Sx</td>
<td>.61 (.62)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.45***</td>
<td>.41***</td>
<td>-.19*</td>
<td>.20**</td>
<td>.38***</td>
<td>-.10</td>
<td>-.11</td>
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<tr>
<td>5. T2 Child Internalizing</td>
<td>10.68 (6.04)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.60**</td>
<td>-.11</td>
<td>.16†</td>
<td>.13†</td>
<td>-.10</td>
<td>.06</td>
</tr>
<tr>
<td>6. T2 Child Externalizing</td>
<td>18.26 (8.23)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>-.11</td>
<td>.13</td>
<td>.21**</td>
<td>-.18*</td>
<td>.23**</td>
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<tr>
<td>7. T2 Partner Child Care</td>
<td>4.09 (.92)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>-.16*</td>
<td>-.10</td>
<td>.11</td>
<td>.13</td>
</tr>
<tr>
<td>8. T2 Economic Strain</td>
<td>.01 (.64)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>-.05</td>
<td>-.10</td>
<td>-.03</td>
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<tr>
<td>9. T2 Life Stress</td>
<td>2.57 (3.21)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.02</td>
<td>-.09</td>
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<tr>
<td>10. Mother Age</td>
<td>17.93 (1.34)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<td>-.03</td>
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<tr>
<td>11. Child Gender</td>
<td>53.1% male</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</table>

*Note. Mat. Depressive Sx = Maternal Depressive Symptoms
†p ≤ .10, *p ≤ .05; **p ≤ .01; ***p ≤ .001*
third model, or the transactional model, added the final direct pathway between Time 1 child behavior and Time 2 maternal depressive symptoms. The default mode in MPlus is to model correlations among all model variables. Because theory and research indicate no relations between child gender and a family’s economic strain, experience of negative life events, mothers’ age, or mothers’ depressive symptoms, these correlations were fixed at zero in the models. To evaluate model fit, the root mean square error of approximation (RMSEA) and confirmatory fit index (CFI) were used. CFI values between .9 and 1 are considered acceptable (Hu & Bentler, 1999). RMSEA values between .05 and .08 suggest reasonable model fit, and values below .05 suggest good fit (Browne & Cudeck, 1993). Additionally, the results of the models $\chi^2$ tests were evaluated because a nonsignificant $\chi^2$ test suggests that a model fits the data well (Kline, 2005).

In the path analyses conducted, a maximum of 21 parameters were estimated with 36 observations. Thus, the models have more observations than parameters, allowing for model identification (Kline, 2005). The current sample of 147 participants, a medium sample size according to Kline (2005), is considered to be adequate to identify paths for such a model. With 147 participants and a maximum of 21 parameters, the assessed models were stable and had adequate power to detect model fit and significant regression coefficients as they did not reach the lowest participant—to—parameter parameter ratio threshold mentioned by Kline (2005), which is 5:1.

**Mean Differences and Bivariate Correlations**

Paired sample t-tests indicated that mean levels of maternal depressive symptoms differed significantly across time points such that Time 1 mean scores were significantly
higher than Time 2 mean scores ($t (146, 2) = 2.86, p = .005$). Mean scores for internalizing and externalizing problems did not differ significantly across time points. Results of bivariate correlations indicated that maternal depressive symptoms at Time 1 were significantly positively associated with child internalizing and externalizing problems both concurrently and across time points. Mother’s depressive symptoms were also significantly correlated across Time 1 and Time 2. Additionally, child internalizing and externalizing significantly positively related to each other at Time 1 and Time 2, and each child behavior variable significantly positively related to itself across time points. Time 2 partner child care involvement significantly negatively related to Time 2 maternal depressive symptoms, but was not significantly associated with Time 2 child internalizing or externalizing behavior.

Regarding control variables for the endogenous – or outcome – variables, economic strain at Time 2 was significantly positively associated with Time 2 maternal depressive symptoms and negatively associated with Time 2 partner child care involvement, and marginally positively correlated with Time 2 child internalizing behavior. Time 2 life stress concurrently correlated positively with maternal depressive symptoms and child externalizing, and marginally positively correlated with concurrent child internalizing. Mothers’ age was significantly negatively associated with Time 2 child externalizing. Lastly, child gender significantly related to Time 2 child externalizing, such that boys had higher externalizing scores. To further investigate these correlations, t-tests were run investigating the nature of the relations between gender and child externalizing and partner child care involvement. As reported in the Method
section, males had significantly higher mean externalizing scores than females at Time 2 ($M_{female} = 54.28, M_{male} = 58.65$).

**Path Analyses**

Results will be presented in the order of hypotheses listed in The Current Study Section of the Introduction. First, the three-step path analysis models testing the longitudinal and transactional relations between maternal depressive symptoms and child behavior variables will be presented. Fit indices from each step will be reviewed briefly; and the model that presents the best fit to the data will be discussed in detail. Second, results from path analysis models testing the potential moderating effect of child gender will be presented. Lastly, results from path analysis models investigating the potential direct and moderating effects of partner child care involvement will be reported. As all models were tested separately for each child behavior variable, results will first be presented for child internalizing problems and then for child externalizing problems. Fit indices for all path models can be found in Table 2.

**Transactional Path Models: Child Internalizing**

Results of the stability model path analysis indicated that although paths were significant, the model was a poor fit for the data (See Table 2, 1st row, first 5 columns). The stability model explained 35.6% of the variance on Time 2 child internalizing problems and 45% of the variance on Time 2 maternal depressive symptoms. The addition of the direct path between maternal depressive symptoms at Time 1 and child internalizing problems at Time 2, however, resulted in a parent—-to—-child model with
Table 2. *Fit Statistics for Tested Models (N = 147).*

<table>
<thead>
<tr>
<th>Model</th>
<th>Child Internalizing</th>
<th>Child Externalizing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\chi^2$</td>
<td>df</td>
</tr>
<tr>
<td>Stability</td>
<td>21.36*</td>
<td>10</td>
</tr>
<tr>
<td>Parent—to—child</td>
<td>9.83</td>
<td>9</td>
</tr>
<tr>
<td>Transactional</td>
<td>9.82</td>
<td>8</td>
</tr>
<tr>
<td>Child Gender Moderator</td>
<td>16.80</td>
<td>10</td>
</tr>
<tr>
<td>Partner Child Care Moderator</td>
<td>17.31</td>
<td>11</td>
</tr>
</tbody>
</table>

*Note.* CFI = Confirmatory Fit Index; RMSEA = root mean square error of approximation.  
*$p \leq .05$; **$p \leq .01$
good fit (nonsignificant $\chi^2$, CFI = .99, RMSEA = .02; See Table 2, 2\textsuperscript{nd} row, first 5 columns). The parent—to—child model explained 40.8% of the variance on Time 2 child internalizing problems and 48.9% of the variance on Time 2 maternal depressive symptoms.

Results of the transactional model path analysis (see Figure 2) indicated that the addition of the direct pathway from Time 1 child internalizing to Time 2 maternal depressive symptoms did not improve model fit since CFI values remained equal and RMSEA increased (see Table 2, 3\textsuperscript{rd} row, first 5 columns). Moreover, the amount of variance explained on the two outcome variables remained the same between the parent—to—child model and the transactional model. Lastly, and perhaps most importantly, Time 1 internalizing was not predictive of maternal depressive symptoms over time in the model ($\beta$ (SE) = .01 (.06), $p = .91$). Thus, the parent—to—child model is the most parsimonious model with the best model fit and will be used in further analyses investigating the moderating effect of gender and the direct and buffering effects of partner child care involvement.

Figure 3 depicts the results of the parent—to—child model. Child internalizing and maternal depressive symptoms both showed significant stability over time as Time 1 scores were positively significantly predictive of Time 2 scores. Regarding the longitudinal influence of maternal depressive symptoms on child internalizing, maternal depressive symptoms at Time 1 significantly related to increases in child internalizing behavior over 6 months. Both Time 2 economic strain and Time 2 life stress were positively related to Time 2 maternal depressive symptoms, but maternal age was not
Figure 2. Parent-to-child path analysis model investigating the association between maternal depressive symptoms and child internalizing problems over a 6 month period (standard errors within parentheses) (N = 147).

Note. †p ≤ .10, *p ≤ .05; **p ≤ .001
Figure 3. Transactional path analysis model investigating the association between maternal depressive symptoms and child externalizing problems over a 6 month period (standard errors within parentheses) (N = 147).
significantly associated with the outcome. Child gender was not significantly related to child internalizing behavior problems at Time 2.

**Transactional Path Models: Child Externalizing**

Results of the stability model path analysis indicated that though paths were significant, the model was a poor fit for the data (See Table 2, 1st row, second 5 columns). The stability model explained 44.5% of the variance on Time 2 child externalizing problems and 44.5% of the variance on Time 2 maternal depressive symptoms. The addition of the direct path between maternal depressive symptoms at Time 1 and child externalizing problems at Time 2, however, resulted in a parent—to—child model with good fit (nonsignificant $\chi^2$, CFI = .98, RMSEA = .06; See Table 2, 2nd row, second 5 columns). The parent—to—child model explained 49% of the variance on Time 2 child externalizing problems and 48.7% of the variance on Time 2 maternal depressive symptoms.

Results of the transactional model path analysis (see Figure 4) indicated that the addition of the direct pathway from Time 1 child externalizing to Time 2 maternal depressive symptoms did not improve model fit since CFI values remained equal and RMSEA decreased only by .002 (see Table 2, 3rd row, second 5 columns). Moreover, the amount of variance explained on the two outcome variables changed only slightly between the parent—to—child model and the transactional model. The parent—to—child model explained 49.7% of the variance on Time 2 child externalizing problems and 49.3% of the variance on Time 2 maternal depressive symptoms. Lastly, and perhaps most importantly, Time 1 internalizing was not predictive of changes in maternal
Note. †p ≤ .10, *p ≤ .05; **p ≤ .01; ***p ≤ .001

Figure 4. Transactional path analysis model investigating the association between maternal depressive symptoms and child externalizing problems over a 6 month period (standard errors within parentheses) (N = 147).
depressive symptoms over time ($\beta (SE) = .08 (.06), p = .19$). Thus, the parent—to—child model is the most parsimonious model with the best model fit and will be used in further analyses investigating the moderating effect of gender and the direct and buffering effects of partner child care involvement.

Figure 5 depicts the results of the parent—to—child model for child externalizing. Child externalizing and maternal depressive symptoms both showed significant stability over time as Time 1 scores were positively significantly predictive of Time 2 scores. Regarding the longitudinal influence of maternal depressive symptoms on child externalizing, maternal depressive symptoms at Time 1 significantly related to increases in child externalizing behavior over 6 months. Both Time 2 economic strain and Time 2 life stress were positively related to Time 2 maternal depressive symptoms, but maternal age was not significantly associated with the outcome. Child gender significantly positively related to child internalizing behavior problems at Time 2.

**Child Gender Moderator**

Using the parent—to—child path analysis model the potential moderation of the relation between maternal depressive symptoms and child behavior variables by child gender was investigated. A multiplicative interaction term of maternal depressive symptoms and child gender was added to each model, and the direct relation of child gender to the child behavior variable remained in the model.

**Child gender moderator: Internalizing.** Results of the path analysis testing the possible moderating effect of gender on the relation between maternal depressive
Figure 5. Parent—to—child path analysis model investigating the association between maternal depressive symptoms and child externalizing problems over a 6 month period (standard errors within parentheses) (N = 147).
symptoms and child internalizing problems indicated that the model fit the data reasonably well (nonsignificant $\chi^2$ test, CFI = .96, RMSEA = .07; see Table 2, 4th row, first 5 columns). Figure 6 depicts the results of this path analysis model. Control variables of Time 2 economic strain and Time 2 life stress were both significantly associated with Time 2 maternal depressive symptoms ($\beta$ (SE) = .12 (.06), $p = .03$ and $\beta$ (SE) = .20 (.06), $p = .001$, respectively). Maternal age at birth was not significantly related to Time 2 maternal depressive symptoms ($\beta$ (SE) = .01 (.06), $p = .90$), and child gender was not significantly predictive of Time 2 child internalizing problems ($\beta$ (SE) = .09 (.09), $p = .32$). Maternal depressive symptoms showed stability over time ($\beta$ (SE) = .59 (.05), $p < .001$), as did child internalizing problems ($\beta$ (SE) = .51 (.06), $p < .001$). Time 1 maternal depressive symptoms predicted changes in Time 2 child internalizing problems significantly ($\beta$ (SE) = .32 (.23), $p = .15$). Results also indicated that the relation between maternal depressive symptoms and child internalizing problems over 6 months was not moderated by child gender in our sample ($\beta$ (SE) = -.04 (.10), $p = .67$). The pathways specified in this model explained 41.4% of the variance on Time 2 child internalizing problems and 49.8% of the variance on Time 2 maternal depressive symptoms.

**Child gender moderator: Externalizing.** Regarding the possible moderating effect of gender in the relation between maternal depressive symptoms and child externalizing problems, indicators of model fit were mixed. The $\chi^2$ test was significant (indicating poor model fit), CFI was .95 (indicating acceptable model fit), and RMSEA was .08 (indicating reasonable model fit; see Table 2, 4th row, second 5 columns).
Figure 6. Parent—child path analysis model investigating the moderating effect of gender on the association between maternal depressive symptoms and child internalizing problems over a 6 month period (standard errors within parentheses) (N = 147).

Note. †p ≤ .10, *p ≤ .05; **p ≤ .001
Results of this path analysis model can be found in Figure 7. Control variables of Time 2 economic strain and Time 2 life stress were both significantly associated with Time 2 maternal depressive symptoms ($\beta$ (SE) = .13 (.06), $p = .03$ and $\beta$ (SE) = .18 (.06), $p = .003$, respectively); but maternal age was not ($\beta$ (SE) = .01 (.06), $p = .84$). Similar to results of the parent—to—child model, child gender was significantly predictive of Time 2 child externalizing problems ($\beta$ (SE) = .19 (.09), $p = .03$). Maternal depressive symptoms showed stability over time ($\beta$ (SE) = .60 (.06), $p < .001$), as did child externalizing problems ($\beta$ (SE) = .54 (.06), $p < .001$). Time 1 maternal depressive symptoms predicted temporal changes in child externalizing problems significantly ($\beta$ (SE) = .22 (.07), $p = .001$). Results also indicated that the relation between maternal depressive symptoms and child externalizing problems over 6 months was not moderated by child gender in our sample ($\beta$ (SE) = .05 (.09), $p = .56$). The pathways specified in this model explained 49.4% of the variance on Time 2 child externalizing problems and 49.7% of the variance on Time 2 maternal depressive symptoms.

**Effect of partner child care involvement.** Using the parent—to—child path analysis model, Time 2 partner child care involvement was added as both directly associated to Time 2 child behavior and as a moderator of the path between Time 1 maternal depressive symptoms and Time 2 child behavior problems. To maintain adequate power, the moderating and direct effects of partner child care involvement were tested separately from models testing the moderating effect of child gender.
Figure 7. Parent—to—child path analysis model investigating the moderating effect of gender on the association between maternal depressive symptoms and child externalizing problems over a 6 month period (standard errors within parentheses) (N = 147).

Note. *p ≤ .05; **p ≤ .01; ***p ≤ .001
**Effect of partner child care involvement: Internalizing.** Results of a path analysis investigating the effect of partner child care involvement on the relation between maternal depressive symptoms and child internalizing problems indicated that the model fit the data reasonably well (nonsignificant $\chi^2$ test, CFI = .97, and RMSEA was .06; see Table 2, 5th row, first 5 columns). See Figure 8 for the results of this path analysis.

Control variables of Time 2 economic strain and Time 2 negative life events were both significantly associated with Time 2 maternal depressive symptoms ($\beta$ (SE) = .13 (.06), $p = .03$ and $\beta$ (SE) = .20 (.06), $p = .001$, respectively). Maternal age was not significantly related to Time 2 maternal depressive symptoms ($\beta$ (SE) = .01 (.06), $p = .92$), and child gender was not significantly predictive of Time 2 child internalizing problems ($\beta$ (SE) = .09 (.06), $p = .17$). Maternal depressive symptoms showed temporal stability ($\beta$ (SE) = .59 (.05), $p < .001$) as did child internalizing problems ($\beta$ (SE) = .51 (.06), $p < .001$).

Time 1 maternal depressive symptoms significantly predicted Time 2 child internalizing problems ($\beta$ (SE) = .24 (.07), $p < .001$). Results indicated that partner child care involvement did not moderate the relation between maternal depressive symptoms and child internalizing problems in our sample over a 6-month period as the multiplicative interaction term was not significantly predictive of Time 2 child internalizing problems ($\beta$ (SE) = .14 (.09), $p = .13$). Partner child care involvement was, however, marginally directly associated with Time 2 child internalizing problems ($\beta$ (SE) = -.17 (.09), $p = .06$), indicating a trend that higher partner child care involvement may directly relate to fewer internalizing behavior problems in children. The pathways specified in this model
Figure 8. Parent—to—child path analysis model investigating the moderating and direct effects of partner child care involvement on the association between maternal depressive symptoms and child internalizing problems over a 6 month period (standard errors within parentheses) (N = 147).
explained 41.9% of the variance on Time 2 child internalizing problems and 49% of the variance on Time 2 maternal depressive symptoms.

**Effect of partner child care involvement: Externalizing.** In a path analysis investigating the effect of partner child care on the longitudinal relation between maternal depressive symptoms and child externalizing behavior, model fit indicators were mixed. The \( \chi^2 \) test was significant (indicating poor model fit), CFI was .95 (indicating acceptable model fit), and RMSEA was .08 (indicating reasonable model fit; see Table 2, 5th row, second 5 columns). Figure 9 depicts the results of this path analysis. Control variables of Time 2 economic strain and Time 2 life stress were both significantly associated with Time 2 maternal depressive symptoms (\( \beta \) (SE) = .14 (.06), \( p = .02 \) and \( \beta \) (SE) = .19 (.06), \( p = .003 \), respectively); but maternal age was not (\( \beta \) (SE) = .01 (.06), \( p = .86 \)). Similar to results of the previous models, child gender significantly predicted Time 2 child externalizing problems (\( \beta \) (SE) = .24 (.06), \( p < .001 \)). Both maternal depressive symptoms and child externalizing problems showed stability over time (\( \beta \) (SE) = .59 (.05), \( p < .001 \) and \( \beta \) (SE) = .54 (.06), \( p < .001 \), respectively). Time 1 maternal depressive symptoms significantly predicted Time 2 child externalizing problems (\( \beta \) (SE) = .23 (.06), \( p < .001 \)). Time 2 partner child care involvement did not significantly predict Time 2 child externalizing problems (\( \beta \) (SE) = -.07 (.06), \( p = .23 \)). Thus, partner child care involvement at Time 2 did not directly affect levels of children’s externalizing problems. The pathways specified in this model explained 50.4% of the variance on Time 2 child externalizing problems and 49.4% of the variance on Time 2 maternal depressive symptoms.
**Figure 9.** Parent—to—child path analysis model investigating the direct effect of partner child care involvement on child externalizing symptoms while accounting for the association between maternal depressive symptoms and child externalizing problems over a 6 month period (standard errors within parentheses) (N = 147).

*Note.* *p ≤ .05; **p ≤ .01; ***p ≤ .001
CHAPTER IV

DISCUSSION

Guided by theory and previous research, the current study investigated the longitudinal relations between maternal depressive symptoms and child internalizing and externalizing behavior problems in a sample of Latina adolescent mothers and their toddlers over a six-month time period. Specifically, this study sought to answer the call for research investigating the transactional influence of mothers’ depressive symptoms and child behavior on each other over time. The study also explored whether child behavior problems differed by gender in the context of mothers’ symptoms of depression. Last, the current study investigated the potentially protective influence of child care involvement by mothers’ partners on child behavior problems longitudinally, both directly and in the face of maternal depressive symptoms.

To the author’s knowledge, the current study was the first to investigate these relations in a sample entirely comprised of Latina adolescent mothers with children in their second year of life. Children of adolescent mothers are important to study during this year of development since literature suggests that behavioral difficulties emerge at this time (Brooks-Gunn & Furstenberg, 1986; Furstenberg, Brooks-Gunn, & Morgan, 1987; Field, Widmayer, Adler, & de Cubas, 1990; Hann, Osofsky, & Culp, 1996). As such, the study enhanced the currently sparse understanding of these relations in these
young families and added to the lack of longitudinal and within-group studies with samples from this population. This study also improved upon the methodology used in previous studies by relying on path analysis modeling to test theorized longitudinal models which allowed for inclusion of multiple outcome and control variables.

**Longitudinal Relations between Maternal Depressive Symptoms and Child Behavior**

Though a majority of research has focused on the impact of maternal depressive symptoms on child behavior, theories and literature have also sought to highlight the reciprocal relations between parent and child characteristics. In studying this transactional relation in a sample of Latina adolescent mothers and their toddlers, however, the current study failed to find support for such a bidirectional relation. Instead, this study supports a mother—to—child model of longitudinal transmission of symptoms for adolescent Latina mothers and their toddlers. These findings are consistent with previous research with adult and adolescent mothers (Leadbeater & Bishop, 1994; Leadbeater, Bishop, & Raver, 1996; Yoshikawa, Rosman, & Hsueh, 2001; Gross, Shaw, & Moilanen, 2008, Hammen, Burge, & Adrian, 1991). Importantly, maternal depressive symptoms had a longitudinal effect even when accounting for concurrent relations between maternal depressive symptoms and the respective child behavior variable at both time points. Accounting for these concurrent relations helped to alleviate shared-method variance concerns due to the use of maternal report for all study variables. Taken together, the findings indicated that maternal depressive symptoms impact changes in child behavior relatively early in development for children of adolescent mothers.
Additionally, results suggested that maternal depressive symptoms and child behavior were stable over time, above and beyond concurrent contextual risk factors.

Since the current study did not find evidence of the child—to—parent link, results are discrepant with previous research with older children of adult mothers indicating that both child internalizing symptoms and child externalizing symptoms predict maternal depressive symptoms over time (Ghodsian, Zajicek, & Wolkind, 1984; Hammen, Burge, & Adrian, 1991; Ge et al., 1995; Gross, Shaw, & Moilanen, 2008). Although the reasons for this finding are unclear, some plausible explanations exist given the characteristics of the current sample. First, the existent literature indicates that child behavior impacts parental well-being in samples comprised of parents with children ranging in age from 5 years to adolescence, not toddlers. Therefore, the effect of child behavior problems on maternal depressive symptoms may not emerge until later in child development since mothers would have been exposed to the difficulties of child behavior for a longer period. Further, in order for child behavior to affect levels of maternal depressive symptoms, mothers must view their children’s behavior as problematic. However, mothers of toddlers may not view their children’s behavior in this negative light given the culturally accepted idea of the “terrible twos.” In other words, mothers may believe that their children’s behavior is related more to a developmental phase common to all toddlers rather than to a more stable characteristic of their child and/or their parenting practices. After prolonged exposure to negative behaviors as children get older, though, these behaviors may start to take a greater toll on mothers’ well-being which would result in the child—to—parent link emerging later in child development.
For Latina mothers, specifically, differences in their expectations of young
children’s behavior may also account for the lack of child—to—parent link. Some
research indicates that Latina mothers may parent children under the age of 6 differently
than older children such that they engage in less controlling parenting behaviors with
younger children (see Halgunseth, Ispa, & Rudy, 2006 for a review). Halgunseth and
colleagues’ review of the literature (2006) suggests that this lack of parental control for
infants, toddlers, and preschoolers is related to mothers’ beliefs that their young children
are too cognitively immature to behave intentionally. In other words, evidence implies
that Latino parents view their children as incapable of meeting behavioral expectations at
such as young age. This evidence lends another plausible explanation for the lack of
impact of toddler behavior on Latina adolescent mothers’ depressive symptoms in the
current study.

Regarding adolescent mothers, a few more plausible reasons exist for their
children’s behavior not impacting their well-being. Given the risk factors and
developmental context of young mothers and their children, it is possible that these
factors are more prominent and influential on their levels of depressive symptoms than
their children’s behaviors. An adolescent mother may be developmentally more focused
on building autonomy, romantic relationships, and friendships, with her parenting role
being less central to her identity. Her experience of depressive symptoms, then, may be
more linked to these developmental tasks than difficulties with her child’s behavior.
Adolescent mothers may also be more likely to dismiss or misinterpret their children’s
problem behaviors as literature suggests that they have relatively limited knowledge of
child development (Field, Widmayer, Stringer, & Ignatoff, 1980). As a result, child behavior problems may be less salient to adolescent mothers’ depressive symptomatology. Lastly, adolescent mothers may integrate their contextual stress (e.g., economic difficulties, negative life events) into their sense of well-being more so than their children’s behavior. The current study provided some evidence for this potential explanation since contextual stressors, specifically financial stress and negative life events, were positively associated with mothers’ experience of depressive symptoms.

Thus, the results of the current study suggest that a parent—to—child transmission of symptoms is occurring in these young families. Additionally, results suggest that children’s behaviors at 18 months have little impact on mothers’ symptom levels at 6 month follow-up in this population. Future research should further explore the above potential explanations. Continued multiple time-point investigations spanning several years of child development are needed to determine when, if at all, child behavior influences maternal depressive symptoms. To investigate the potential influences of the processes mentioned above, measures of the centrality of the parenting role and mothers’ understanding of child development should be integrated into future research as potential moderators of the relation between child behavior and maternal depressive symptoms. Lastly, it is also important that research with adolescent mothers continue to investigate these relations accounting for sources of contextual stress related to their depressive symptom levels to identify predictors that explain variance above and beyond such stressors.
**Longitudinal Stability and Change**

As the current study sought to investigate longitudinal relations among all constructs of interest, it was important to also examine their stability and change across time points. Regarding these temporal changes, mean levels and rank order of child internalizing and externalizing behavior problems were similar across time. In contrast, mothers reported fewer depressive symptoms at six month follow-up; but the rank order of these symptoms was stable. These results are consistent with previous research indicating that the rank order of adolescent mothers’ depressive symptoms was temporally stable (Schmidt, Wiemann, Rickert, & Smith, 2005; Milan et al., 2004; Leadbeater & Linares, 1992) and scores decreased steadily throughout the first 2 to 4 years postpartum (Schmidt, Wiemann, Rickert, & Smith, 2005; Leadbeater & Linares, 1992). While the Schmidt and colleagues failed to investigate group-level reasons for this decline, Leadbeater and Linares (1992) found that the decrease in scores over the first year postpartum was due to the overlap in somatic complaints from childbirth and recovery with somatic items on the measure of depressive symptoms used in their study. However, the reason for the decline later in the postpartum period was not investigated by the researchers. These previous studies found a similar trend in the decline of maternal depressive symptoms to that of the current sample such that group means were below the clinically significant level as was the case in the current sample at 18 and 24 months postpartum. Additionally, the group means found in their samples decreased by relatively small amounts across time points, consistent with the findings of the current study. Therefore, changes in the current sample’s group mean do not suggest major shifts.
from high levels to much lower levels of depressive symptoms, but rather a group trend to remain in the sub-clinical levels of depressive symptoms.

One plausible explanation for the difference in mothers’ depressive symptoms from Time 1 to Time 2 could be accounted for by regression towards the mean after repeated administrations of the measure (SCL-90-R). The decline in depressive symptoms over time could also be due to the normative developmental trend for individuals to report fewer symptoms of depression during the transition into adulthood. The SCL-90-R cutoffs for clinical range scores is higher for the adolescent female (<19 years) norm population than for the adult female (≥ 19 years) norm population, indicating that adolescents typically report higher levels of depressive symptoms. This explanation is consistent with previous literature indicating a decrease in symptoms across the period of emerging adulthood (Galambos, Barker, & Krahn, 2006) and across the postpartum period for adolescent mothers (Schmidt, Wiemann, Rickert, & Smith, 2005; Leadbeater & Linares, 1992). One potential reason for such a normative change for adolescent mothers, specifically, is that these young women may be settling into their lives as mothers. Such a trend toward accepting and embracing their lives as mothers may result in a decline in depressive symptoms. Nonetheless, longitudinal investigations with similar samples are needed to investigate potential explanations for the decline in maternal depressive symptoms in the second year postpartum.

Regarding child behavior, the current study found relatively high levels of clinical range scores for both child internalizing (Time 1 – 17%, Time 2 – 12.2%) and externalizing disorders (Time 1 – 19.7%, Time 2 – 23.8%) when compared with CBCL.
$1\frac{1}{2} - 5$ norms (clinically significant t-score = 64; Achenbach & Rescorla, 2000). However, the group means were within the normal range of scores for both child behavior problem areas (t-scores M (SD): Internalizing - Time 1 = 54.53 (8.81), Time 2 = 53.85 (8.60); Externalizing - Time 1 = 57.20 (9.06), Time 2 = 56.60 (9.67)). These results are consistent with research with other samples of low-income, adolescent- and adult-parent families that found rates of clinical range behavior problem as high as 41% (Keenan & Wakschlag, 2000; Spiker, Larson, Lewis, Keller, & Gilchrist, 1999; Black, Papas, Hussey, Dubowitz, et al., 2002; Gross et al., 2006). Taken together, these results indicate that children in the current study were rated similarly on levels of internalizing and externalizing as other children from low-income families.

**Role of Child Gender**

Regarding the impact of gender on the relations of interest in this study, the current study followed the larger literature which suggests that the relation between maternal depressive symptoms and child externalizing behavior varies by child gender (Zahn-Waxler, Iannotti, Cummings, & Denham, 1990). However, little is known about the influence of gender regarding children of Latina adolescent mothers. Whereas no gender differences were present at 18 months in this study, males had significantly higher levels of externalizing problems than females at 2 years of age. These results are inconsistent with normative data suggesting that gender differences do not emerge in child internalizing or child externalizing problems until age 4 (Achenbach & Rescorla, 2000; Keenan & Shaw, 1994; Maccoby, Snow, & Jacklin, 1984; Prior, Smart, Sanson, & Oberklaid, 1993). The current study’s results are consistent, however, with two studies
of adult, primarily European American, middle-class, mothers and their approximately 27-30 month old children which found that boys displayed higher mean levels of mother-reported externalizing behaviors than females (Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001; O’Leary, Slep, & Reid, 1999). Moreover, in a mixed-ethnicity sample of lower- to middle-income adult parents of 2, 3, and 4 year olds, significant mean differences were also found for externalizing on the CBCL 1½ - 5 such that boys had higher mean scores (Gross et al., 2006). However, Gross and colleagues (2006) did not break down mean differences by age group, making it difficult to determine if gender differences were present at all three ages. In contrast, a study by Keenan and Shaw (1994) found no significant gender differences in a low-income sample of children 18 to 24 months old; indicating that early gender differences do not necessarily emerge in children raised in low socioeconomic status households.

The higher levels of externalizing behaviors in boys in the current sample may be related to culturally-derived gender role socialization within the Latino culture. Regarding Latina adolescent mothers, specifically, cultural values could also explain the findings. Some research with Latino families indicates that male adolescent children are given more freedom than females (Raffaelli & Ontai, 2004). Though this research is done with older children, it may be reflective of differential socialization goals of Latino parents for their male and female parents that children may be exposed to from birth. Should child gender elicit differential parenting behaviors in adolescent Latina mothers, child behavior may differ between males and females such that males are less regulated and more impulsive than females. Such a difference should be investigated in future
studies by examining possible differences in parenting behaviors of adolescent Latina mothers with their male and female children. Clearly, results from previous studies are mixed regarding gender differences for children in their 2nd year of life.

Given that gender differences had previously been found in 24-month-old children in the context of maternal depression (Zahn-Waxler, Iannotti, Cummings, & Denham, 1990), it was important to address whether the relation between child behavior and maternal depressive symptoms differed for male and female children. Results from the current study were mixed. First, consistent with expectations, results indicated no moderation by gender regarding child internalizing symptoms. However, the hypothesis that child gender would moderate the relation between maternal depressive symptoms and child externalizing over time was not supported. Though some research suggests that male children of depressed or dysphoric mothers display higher levels of aggression than females (Zahn-Waxler et al., 1990), as mentioned above the current study only found that boys had significantly higher mean levels of externalizing behavior problems than girls, regardless of level of maternal depressive symptoms. As such, maternal depressive symptoms appeared to affect boys’ and girls’ externalizing problems similarly, although boys were reported to display more externalizing problems. It is possible that maternal depressive symptoms do not differentially affect boys and girls until later ages.

**Role of Partner Child Care Involvement**

Regarding the influence of partners, results were consistent with previous findings that Latina adolescent mothers are likely to be involved in romantic relationships as the majority of mothers in the sample reported having a partner (Contreras, López, et
al., 1999; Wasserman, et al., 1994). Just over seventy percent (71.3%) of those partners were also the child’s father, consistent with previous research that Latina adolescent mothers are more likely to be in serious relationships with their children’s fathers than European American and African American adolescent mothers (Wasserman et al, 1994; de Anda & Becerra, 1984). Lastly, nearly three quarters (74.2%) of mothers who reported a partner also lived with their partners either alone with their child or with family members indicating that many of the children in this sample were likely around their mothers’ partners on a daily basis. Consequently, it was especially important to investigate the influence of mothers’ romantic partners on their children.

The current study extended research by Smith and colleagues (2013) to investigate the potential longitudinal protective effect of involvement in child care by mothers’ romantic partners. Despite the findings from Smith and colleagues (2013) that a concurrent buffering effect of partner involvement existed at the first data collection point using the same sample, a longitudinal buffering effect of partner child care involvement was not indicated by the current study. Other studies that have found direct or buffering relations in samples of adolescent mothers differed from the current study as they used samples of older and collected data at multiple time points over several years (Howard et al., 2006; Furstenberg & Harris, 1993), and the same is true in studies with adult mothers (Mezulis et al., 2004). Hence, drawing conclusions about whether the current study’s results are consistent with theirs is difficult. However, these studies do point to measurement differences that may influence the current study’s ability to find effects of partner involvement in child care. Since each of the previous studies utilized multiple
data collection points over several years, a composite variable of measures of father and partner contact or closeness was used in each study (Howard et al., 2006; Furstenberg & Harris, 1993; Mezulis et al., 2004). Taken together, the larger literature suggests that composites of involvement over several time points have both direct and buffering effects on child behavior. In the current study, then, perhaps amount of partner involvement at one time point was insufficient to find either type of effect.

Other measurement issues could also account for the current findings. Although this study obtained rich information regarding the mother-reported amount of child care in the month prior to the second home visit, current research suggests that partner-report or observation of the partner child care interactions would produce more reliable independent data (Mikelson, 2008). However, some evidence indicates that mothers are reliable reporters of father involvement (Hernandez & Coley, 2007). Moreover, the current study did not account for the possible effects of grandmothers, extended family, babysitters, or child care centers on child internalizing and externalizing problems. Perhaps controlling for such sources of child care assistance in this study would have increased the likelihood of finding unique effects of child care behaviors provided by partners. While the current study followed previous research which included participants with and without father or partner contact at different time points throughout their studies (Howard et al., 2006; Furstenberg & Harris, 1993; Mezulis et al., 2004), it is also possible that investigating this relation in the entire sample rather than in the subsample of participants with a partner may have affected the results. Post-hoc analyses of the buffering effect of partner child care involvement with the 101 participants with a partner
indicated perfect fit indices when run in the larger path analysis model, which is an indicator of unreliable findings and lack of power. Therefore, separate post-hoc hierarchical linear regressions were run for this sub-sample which failed to suggest a buffering effect of partner child care involvement in the face of maternal depressive symptoms when controlling for Time 1 child internalizing behavior. Importantly, partner child care involvement was marginally significantly associated to child internalizing behavior when the moderator was not present in the model ($\beta$ (SE) = -1.21(.70), $p = .09$), consistent with results from the larger sample.

Taking all of these potential explanations into account, there are several directions for future research on partners, especially given that these men are clearly present in the lives of Latina adolescent mothers and their children. First, further investigations regarding partners’ potential direct influence on children of Latina adolescent mothers are warranted given the marginally significant finding regarding the direct, negative relation between partner involvement in child care and child internalizing problems. Second, integration of multiple data points as well as measures of quality of interactions with mothers’ partners would be important to study. Second, further research with partner-report or observational measures of partners’ child care behaviors would likely provide richer data to test the buffering effect of partner child care involvement. Third, future research should also investigate whether a buffering influence of partner involvement may be found for mothers with partners. Fourth, future research should investigate the influence of partner child care involvement while controlling for other sources of child care to gain a better understanding of the unique influence of partner child care
involvement. Lastly, a growing body of research indicates that partners positively influence maternal psychological well-being as well as their parenting behaviors in samples of Latina adolescent mothers (Contreras, López, et al., 1999; Leadbeater & Linares, 1992). Thus, given their positive effect on mothers’ well-being, it is reasonable to expect that partners would indirectly impact children through influence on mothers’ psychopathology and parenting.

**Implications for Intervention**

An emphasis on early intervention and prevention for young Latina mothers and their children is imperative based on results from the current study. Toddlers in the current study were rated as having high levels of clinical range problem behaviors compared to normative samples. As such, prevention and intervention efforts should focus on reducing these behavior problems. One possible avenue for these efforts would include teaching behavioral parenting skills to help adolescent Latina mothers manage child misbehavior which is one of the most studied and effective forms of treatment for child behavior problems (Kazdin, 2005; Sanders, Markie-Dadds, Tully, & Bor, 2000). Moreover, treatment research indicates that parenting programs aimed at reducing problem behaviors in children also aid in decreasing depression in samples of adult parents (Sanders, Markie-Dadds, Tully, & Bor, 2000; Sanders & McFarland, 2000). Hence, such types of early intervention could aid in reducing mothers’ symptoms which, given the relation between maternal depressive symptoms and child behavior, would help both children and mothers. However, parenting treatment studies on mixed samples indicate non-completion of treatment in individuals of minority status (Lavigne et al.,
Accordingly, treatment efforts specific to the cultural and development needs of Latina adolescent mothers should be formed. Lastly, given the gender differences found in the current study, the development of programs specifically tailored to Latina adolescent mothers with male children for prevention and treatment of externalizing behavior disorders regardless of mothers’ levels of depressive symptoms is necessary. Given the longitudinal influence of maternal depressive symptoms on child behavior, programs should also include regular screening for maternal depressive symptoms during the postnatal period. Also, the influence of financial strain on depressive symptom levels suggests that prevention and intervention programs should work to increase mothers’ access to resources and educate mothers and/or train them for higher paying jobs. Moreover, prevention and intervention efforts should work to reduce life stress by increasing community support and outreach to these women.

**Limitations and Future Directions**

Though the current study enhanced the understanding of Latina adolescent mothers and their children, it also had limitations. First, Latina adolescent mothers of primarily Puerto Rican heritage comprised the current sample, thus compromising the ability to generalize findings to Latina adolescent mothers of other backgrounds or adolescent mothers of other ethnic groups. In order to better understand similarities and differences in subsets of adolescent mothers, further research should continue to investigate these relations in samples of adolescent mothers of all groups and nationalities. Additionally, reliance on mothers as the sole informant likely limits the ability to ensure that these findings are not due to shared method variance. Though, it is
important to note that attempts were made to mitigate this limitation by controlling for concurrent correlations between maternal depressive symptoms and child behavior as well as controlling for variables from the first wave of the study. Regardless, future studies using multi-method assessments of variables would improve the literature. Ratings by other caregivers or observation of children’s behavior could provide a more comprehensive measure of child behavioral and emotional difficulties as mothers’ own symptom levels may influence their ratings of their children’s behavior.

Maternal report has also been used in prior literature regarding the role of the partner. Despite some evidence that mothers are reliable reporters of father involvement (Hernandez & Coley, 2007), current research suggests that getting partner report or third-party observation of the support provided by partners to children would produce more reliable independent data (Mikelson, 2008). As such, future research should attempt to include mothers’ partners and/or children’s fathers as reporters of their own involvement; observations of partner interactions with children would also provide richer data. Using a variety of these multi-method assessments would extend current results and strengthen methodology as each variable would rely on multiple data points rather than one questionnaire or data point.

Studies with larger samples would also allow future research the statistical power to test certain relations in subsamples of adolescent mothers and their children. Specifically, it would be interesting for future research to investigate the influence of partner child care involvement in samples including only participants with partners. Research with larger samples would also have the power to investigate whether effects on
child behavior varied across different subsamples of participants, such as those who maintained the same relationship over time, those who co-reside with partners, those whose partners are also the child’s father, and those who are no longer in a romantic relationship with the child’s father, but the father remains involved with the child. While these variables were measured in the current study, they could not be tested because of insufficient power. Research regarding the impact of these sub-groups of partners and fathers would greatly increase our understanding of potential protective influences in these young families.

Since current findings are mixed regarding gender differences in toddlerhood, another direction for future research would be to continue to investigate these differences. Such efforts could clarify whether these gender differences exist consistently at such young ages. Future research should also include efforts to understand potential reasons for this difference in samples of primarily Puerto Rican adolescent mothers. Specifically, investigating whether these gender differences could be related to differences in gender socialization practices within Latino families would be interesting.

As mentioned previously, in addition to having the highest adolescent birth rate in the U. S. (Hamilton, Martin, & Ventura, 2011), adolescent Latina mothers and their children experience higher rates of numerous vulnerability factors than adult mothers and their offspring. Moreover, the Latino population in this country continues to increase at a rapid rate and is projected to comprise 30% of the total population of the United States by the year 2050 (Census Bureau, 2008), and they are currently overrepresented in low socioeconomic classes (Cauce & Domenech-Rodriguez, 2002). As such, studies
investigating Latina adolescent mothers and their children are imperative. The current study added to our understanding of this population by documenting that maternal depressive symptoms uniquely predicted changes in child internalizing and externalizing behaviors. Additionally, this study found a large percentage of children in the clinically significant ranges for internalizing and externalizing problems. Since the children in this sample were of such a young age, it is essential that intervention and prevention efforts target these young mothers and their children by monitoring levels of mothers’ depressive symptoms and child behavior problems within the first two years of the children’s lives.
APPENDICES
Dear Participants and Parents:

Kent State University in collaboration with MetroHealth Medical Center is conducting a study of the factors influencing the well-being of young Latina mothers and their children. We would like you to take part in this study. If you decide to participate, you will be asked to complete two home visits, one in the near future when your child is approximately 1 and ½ years old, and the other, six months later. The home visits will be scheduled at a time that is convenient to you and will be conducted by two female researchers. During each of the visits, one of the researchers will videotape your child while he/she is administered a developmental test. The researcher will then videotape you while you play with and teach your child. Finally, you will be interviewed individually about your own functioning (e.g., social and personal adjustment, relationships with family members) and your child’s behavior. The visit will take approximately 2 and ½ hours to complete. For your participation, you will receive $70.00, a copy of the videotape, and a small toy for your child at the end of each of the home visits.

All the information gathered through this study will remain strictly confidential within the limits of the law. This means that we are required by law to break confidentiality and report to local authorities if we find evidence of child (including you, if you are less than 18 years old) or elder abuse, or if we learn that you have suicidal or homicidal feelings. To maintain confidentiality, the information you provide to us will be identified only by a participant number (not your name) and...
will be examined only by Dr. Grau and qualified members of her research team at Kent State University. We will schedule the home visit at a time that is convenient to you, so that you can be videotaped and interviewed privately. Also, you will have the choice of responding to interview questions either aloud or by pointing to response options that will be printed in response cards. However, if you have confidentiality concerns because of the presence of a family member or someone else in your home while you are being videotaped or interviewed, we can interrupt the procedures or reschedule the home visit.

Personnel at MetroHealth Medical Center will not have access to the information you provide us. Similarly, Dr. Grau and her research team will not have access to medical or any other information that MetroHealth Medical Center may have about you.

You may experience some discomfort when asked to answer personal questions, but our experience is that this discomfort is, at most, slight and short lived. If you experience more than mild discomfort, we encourage you to contact the Center for Behavioral Health, Child and Adolescent Services at MetroHealth Medical Center (216-778-3745). Alternatively, if you prefer, the interviewer can assist you with the referral.

You are under no obligation to complete this study even if you sign this consent form. You may skip questions or discontinue your participation at any time. You will be presented with another consent form for the second home visit. Participation is completely voluntary and refusing to participate will not affect in any way the services you receive at MetroHealth Medical Center.

If you have any questions regarding the study, please feel free to call Dr. Josefina Grau at (330) 672 3106 or (216) 212-9188. This project has been approved by Kent State University and MetroHealth Medical Center. If you have any questions about Kent State University's rules for research, please call Dr. John L. West at (330) 672-3012. If you have any questions about your rights as a research participant, contact the MetroHealth Medical Center’s Institutional Review Board (which is a group of people who review the research to protect your rights) at (216) 778-2077.

By signing this form I acknowledge that I have read and understand this form, and have had any questions regarding this study satisfactorily answered, and I am voluntarily consenting to participate in this study.

Participant's signature __________________________ Date __________
Parent/Guardian Consent: I give my daughter permission to participate in this study.

Parent or Guardian's Signature __________________________ Date __________

Researcher Signature __________________________ Date __________
(Person obtaining consent)
Latina Adolescent Parenting Project – Consent Form

Page 78 of [2]

HUMAN INVESTIGATION CONSENT FORM
CONSENT FOR PHOTOGRAPHY, AUDIO OR VIDEOTAPING (medical)

Request Type:  □ Photography □ Audiotape   □ Videotape □ Other: ________________________
Photographs of the subjects(s) will be:  □ Clothed  □ Partially clothed □ Undressed
Permission is hereby given to photograph, audiotape, or videotape the following named
person(s) __________________________________ with the understanding that such
photographs, audiotapes or videotapes may be used for the following stated purposes:
□ Medical Necessity/Diagnostic Purposes: Explain: __________________________________________

□ Education: Explain intended purpose: ____________________________________________________

□ Publication in medical and/or scientific journals: ____________________________  Journal Name

■ Inclusion in Research Paper(s): Latina Adolescent Parenting Project

Name of Study

□ Other: _____________________________________  __________________________

Please Specify

The department requesting photos, videos, etc will be responsible for proper storage of
the media as established by The MetroHealth System medical record retention
requirements. Photographs, etc are not to be placed in the patient medical record. The
department requesting photographs, video, etc is ______ Research ______:  
Description of media requested:  Videotaping of 1) mother while she teaches and plays
with her child; 2) child while he/she is administered a developmental test.

Purpose of Request (describe how photographs, audiovisual or videotaped will be
used): Learn about factors influencing the well being of young Latina mothers and their
children.

I, the undersigned, understand that this authorization is valid for a period of 60 days from the date of
completion of this authorization, and may be revoked by me or my legal representative in writing at any
time. However, I understand that if I do so, it will not have any effect on any actions that were taken
before the revocation was received. I understand that for the revocation to be effective, I must do so in
writing and send it to department who originally requested the photographs, etc. The revocation
notices will be filed in the patient medical record after review by the originating department.

I further understand that once the media has been released, re-disclosure of my information by the
recipient which may include protected health information may no longer be protected by law.

Signature of Participant __________________________ Date/Time __________________________
Signature of parent/guardian __________________________ Date/Time __________________________
Name of Photographer __________________________ Date/Time __________________________ Witness __________________________

For non-medical photographs, videotapes or audiotapes for non-medical purposes for use by The
MetroHealth Foundation, Marketing or Media Relations, please refer to the form in Attachment B.
MHS FORM 031047901
4/05
CONSENTIMIENTO

Título del Proyecto: Latina Adolescent Parenting Project

Investigadora: Dra. Josefina Grau, Kent State University

Estimadas Participantes y Padres:

En colaboración con MetroHealth Medical Center, Kent State University está conduciendo un estudio acerca de los factores que influyen en el bienestar de madres Latinas jóvenes y sus hijos/as. Nos gustaría que participes en este estudio. Si decides participar, te visitaremos en tu casa dos veces, una vez en el futuro cercano cuando tu hijo/a tenga aproximadamente 1 año y medio, y la otra vez, seis meses más tarde. Las visitas serán fijadas para el día y la hora que a ti te convenga, y serán conducidas por dos investigadoras mujeres. Durante cada una de las visitas, una de las investigadoras filmará a tu hijo/a mientras le administra una prueba de su desarrollo. Después de eso, la investigadora te filmará mientras le enseñas y juegos con tu hijo/a. Finalmente, te entrevistaremos individualmente acerca de tu propio bienestar (por ejemplo, tu adaptación social y personal, tus relaciones con tu familia y amigos) y acerca del comportamiento de tu hijo/hija. La visita tomará aproximadamente 2 horas y 1/2. Al terminar cada visita, recibirás $70.00, una copia del video, y un juguete pequeño para tu hijo/a.

Toda la información que obtengamos a través de este estudio se mantendrá confidencial dentro de los límites de la ley. Esto significa que no podremos mantener confidencialidad y tendremos que reportar a las autoridades si encontramos evidencia de abuso de menores (incluyendo a ti, si es que eres menor de 18 años) o de ancianos, o si notamos que tienes deseos de cometer suicidio u homicidio. Para mantener la confidencialidad, la información que nos des será identificada solamente mediante un número (no tu nombre) y será examinada solo por la Dra. Grau y miembros calificados de su grupo de investigación en Kent State University. Para que seas filmada y entrevistada privadamente, las visitas serán fijadas para el día y la hora que sean
convenientes para ti. También tendrás la opción de responder a las preguntas de la entrevista en voz alta o señalando las respuestas que estarán escritas en tarjetas al frente de ti. De todos modos, si cuando estás siendo filmada o entrevistada, hay alguien en tu casa que prefieres que no te escuche o vea, podemos interrumpir la filmación o entrevista por un rato, o hacer una cita para continuar la visita en otro momento.

El personal de MetroHealth no tendrá acceso a la información que nos des. Tampoco tendrá la Dra. Grau y su grupo de investigación acceso a cualquier información que MetroHealth Medical Center pueda tener acerca de ti.

Puede que te sientas incomoda cuando te hagamos preguntas acerca de cosas personales, pero nuestra experiencia es que esta incomodidad es, a lo más, leve y breve. Si tu sientes más que incomodidad leve, te recomendamos que llames al Center for Behavioral Health, Child and Adolescent Services en el MetroHealth Medical Center (216 778-3745). Si prefieres, la entrevistadora te puede ayudar a hacer una cita.

Tú no estás obligada a completar el estudio aunque firmes este consentimiento. Puedes saltarte preguntas o dejar de participar en cualquier momento. Te pediremos que firmes otro consentimiento cuando te visitemos la segunda vez. Tu participación es completamente voluntaria y los servicios que puedas estar recibiendo en MetroHealth Medical Center no van a ser afectados si te niegas a participar.

Si tiene preguntas acerca del estudio, por favor llama a la Doctora Josefina Grau al (330) 672-3106 or (216) 212-9188. Este estudio ha sido aprobado por Kent State University y MetroHealth Medical Center. Si tienes preguntas acerca de los reglamentos de investigación de Kent State University, por favor llama al Dr. John L. West al (330) 672 3012. Si tienes preguntas acerca de tus derechos como participante, por favor llama al Institutional Review Board del MetroHealth Medical Center (que es un grupo de personas que revisa las investigaciones para proteger tus derechos) al (216) 778-2077.

Mi firma indica que yo leí y entiendo este formulario, que mis preguntas acerca del estudio han sido contestadas satisfactoriamente, y he decidido participar voluntariamente en este estudio.

_________________________________________________________________________________________________________________
Firma de la Participante Fecha
Autorización del padre/madre: Le doy permiso a mi hija para participar en el estudio.

Firma del Padre/Madre Fecha

Firma de la investigadora Fecha
(Individuo que obtuvo el consentimiento)
HUMAN INVESTIGATION CONSENT FORM

The MetroHealth System
2500 MetroHealth Drive, Cleveland, Ohio 44109-1998

CONSENTIMIENTO DE FILMACION

Tipo: ☐ Fotografía ☐ Grabación de voz/sonido ☐ Video tape ☐ Otro: ____________
Las fotografías de las participantes se tomarán: ☐ Vestida ☐ Parcialmente Vestida
☐ Desnuda
Doy permiso para que mi hijo/a y yo, ________________________ seamos filmados
con el entendimiento que el video tape puede ser usado para los siguientes propósitos
☐ Necesidad médica/diagnostico: ________________________________

☐ Educación: Explique: _________________________________________

☐ Publicación en revistas profesionales: _____________________________ Nombre de la Revista
☐ Para reportes de investigación: Latina Adolescent Parenting Project ____________________________
☐ Otro: ________________________________________________________ Nombre del Estudio

Especifique

El departamento que esta pidiendo el video va ha ser responsable de salvaguardarlo de acuerdo a los requisitos de MetroHealth System. Estos no serán puestos en la ficha médica del paciente. El departamento que esta pidiendo el video es ____________________________.

Descripción del video que se solicita: Filmación de 1) la madre mientras le enseña y juega con su hijo/a; el/la hijo/a mientras se le administra una prueba de su desarrollo.

Razón para la solicitud: El video será usado para aprender acerca de los factores que influyen en el bienestar de madres Latinas jóvenes y sus hijos/as.

Mi firma indica que yo entiendo que esta autorización es válida por 60 días, y puede ser revocada por mi o mi representante legal por escrito en cualquier momento. Entiendo que si revoco el permiso esto no tendrá ningún efecto en las acciones que se tomaron antes de recibir el pedido de revocación. Entiendo que para que la revocación sea efectiva, yo debo hacerlo por escrito y mandarla al departamento que pidió el video. La nota de revocación será puesta en la ficha médica después de ser evaluada por el departamento.

También entiendo que una vez difundida, puede que nuevas revelaciones de mi información, que puede incluir información médica que es protegida, ya no sea protegida por la ley.

Firma de la participante ____________________________ Fecha ____________________________
Firma del Padre/Madre de la participante ____________________________ Fecha ____________________________
Nombre de la persona tomando el video ____________________________ Fecha ____________________________ Testigo

MHS FORM 031047901 4/05
APPENDIX B

MATERNAL QUESTIONNAIRE
APPENDIX B

MATERNAL QUESTIONNAIRE

2. Language

(CHECK ONLY ONE ANSWER)

|___| 1. 1. English
|___| 2. 2. Spanish

8. With whom do you currently live?

<CHECK ALL THAT APPLY by moving the highlight bar to an answer and then PRESS THE SPACE BAR to toggle a check mark on and off>

(CHECK ALL THAT APPLY)

|___| 1. 1. Live with child
|___| 2. 2. Live with child's father
|___| 3. 3. Live with boyfriend/husband (not the child's father)
|___| 4. 4. Live with mother
|___| 5. 5. Live with father
|___| 6. 6. Live with siblings
|___| 7. 7. Live with paternal grandparents
|___| 8. 8. Live with maternal grandparents
|___| 9. 9. Live with boyfriend/husband's parents
|___| 10. 10. Live with members of the boyfriend/husbands' family
|___| 11. 11. Live with friends
|___| 12. 12. Other <SPECIFY> (GO TO QUESTION 9)
|___| 13. 13. DON'T KNOW
|___| 14. 14. REFUSED

9. <ENTER SUBJECT'S ANSWER FOR WITH WHOM SHE LIVES>
14. How far have you gotten in school?
<READ LIST> 3:42-43
(CHECK ONLY ONE ANSWER)
|__| 1. 1. Less than seventh grade
|__| 2. 2. Seventh grade
|__| 3. 3. Eighth grade
|__| 4. 4. Ninth grade
|__| 5. 5. Tenth grade
|__| 6. 6. Eleventh grade
|__| 7. 7. Twelfth grade
|__| 8. 8. High school diploma/GED
|__| 9. 9. Partial college
|__| 10. 10. College graduate
|__| 11. 11. Other <SPECIFY> (GO TO QUESTION 15)
|__| 12. 12. DON'T KNOW
|__| 13. 13. REFUSED

15. <ENTER SUBJECT'S ANSWER FOR HOW FAR SHE HAS GOTTEN IN SCHOOL> 3:44-73

17. Are you in school now? 3:75
(CHECK ONLY ONE ANSWER)
|__| 1. 1. No (GO TO QUESTION 18)
|__| 2. 2. Yes, part time/night school
|__| 3. 3. Yes, full time
|__| 4. 4. DON'T KNOW
|__| 5. 5. REFUSED

19. <ENTER SUBJECT'S ANSWER AS TO WHY SHE IS NOT IN SCHOOL DUE TO PREGNANCY> 4:3-42

20. <ENTER SUBJECT'S ANSWER AS TO WHY SHE IS NOT IN SCHOOL> 5:1-40
22. Now, I'd like to find out a little bit about how you support yourself. Are YOU working at a job right now?

(CHECK ONLY ONE ANSWER)

|__|  1. 1. Yes, full time
|__|  2. 2. Yes, part time
|__|  3. 3. No  (GO TO QUESTION 25)
|__|  4. 4. DON'T KNOW  (GO TO QUESTION 25)
|__|  5. 5. REFUSED  (GO TO QUESTION 25)

23. Where do you work?

___________________________________________________________

___________________________________________________________

___________________________________________________________

24. What do you do at your job?

_______________________________________________________________________________________________

_______________________________________________________________________________________________

25. Do you receive any welfare benefits?

(CHECK ONLY ONE ANSWER)

|__|  1. 1. No
|__|  2. 2. Food stamps only
|__|  3. 3. Medical card only
|__|  4. 4. Monthly check
|__|  5. 5. Money for day care
|__|  6. 6. Two or more of the above
|__|  7. 7. DON'T KNOW
|__|  8. 8. REFUSED

26. What do you see as your main means of financial support right now?

(CHECK ONLY ONE ANSWER)

|__|  1. 1. Parents/guardians
|__|  2. 2. Other relative(s)
|__|  3. 3. Boyfriend/husband
|__|  4. 4. Child's father (not boyfriend/husband)
|__|  5. 5. Job (myself)
|__|  6. 6. My job and my partner's job
|__|  7. 7. Welfare
|__|  8. 8. Other <SPECIFY>  (GO TO QUESTION 27)
|__|  9. 9. REFUSED

SKIP TO QUESTION 28
27. <ENTER SUBJECT'S ANSWER FOR WHAT IS HER MAIN MEANS OF FINANCIAL SUPPORT.> 6:43-72

28. How would you describe the place where you live? <READ LIST> 6:73

(CHECK ONLY ONE ANSWER)

|____| 1. Public housing
|____| 2. Subsidized housing
|____| 3. Rented apartment or house
|____| 4. Own apartment or house
|____| 5. Shelter
|____| 6. Other <SPECIFY> (GO TO QUESTION 29)
|____| 7. DON'T KNOW
|____| 8. REFUSED

SKIP TO QUESTION 30

29. <ENTER SUBJECT'S ANSWER FOR THE KIND OF PLACE WHERE SHE LIVES.> 7:1-20

51. What is your marital or relationship status? 9:22-23

(CHECK ONLY ONE ANSWER)

|____| 1. Never married / no current partner
|____| 2. Never married / has a current partner
|____| 3. Married, live with husband / child's bio father
|____| 4. Married, live with husband / not child's bio father
|____| 5. Married, separated from husband / no current partner
|____| 6. Married, separated from husband / has partner who is not husband
|____| 7. Divorced / no current partner
|____| 8. Divorced / has current partner
|____| 9. Widowed / no current partner
|____| 10. Widowed / has current partner
|____| 11. DON'T KNOW
|____| 12. REFUSED
52. Do you maintain any type of contact with your child's father?  

(CHECK ONLY ONE ANSWER)  

<table>
<thead>
<tr>
<th></th>
<th>1. Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td></td>
<td>3. DON'T KNOW</td>
</tr>
<tr>
<td></td>
<td>4. REFUSED</td>
</tr>
</tbody>
</table>

53. In general, how satisfied are you with your relationship with your child's father?  

<SHOW "SATISFACTION" CARD>  

(CHECK ONLY ONE ANSWER)  

<table>
<thead>
<tr>
<th></th>
<th>1. Very satisfied</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>2. Somewhat satisfied</td>
</tr>
<tr>
<td></td>
<td>3. Somewhat dissatisfied</td>
</tr>
<tr>
<td></td>
<td>4. Very dissatisfied</td>
</tr>
<tr>
<td></td>
<td>5. REFUSED</td>
</tr>
</tbody>
</table>

54. How often do you see him?  

(CHECK ONLY ONE ANSWER)  

<table>
<thead>
<tr>
<th></th>
<th>1. Once or twice a year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Less than once a month</td>
</tr>
<tr>
<td></td>
<td>3. Once a month or more</td>
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<td></td>
<td>4. Once a week</td>
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<tr>
<td></td>
<td>5. Several times a week</td>
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<tr>
<td></td>
<td>6. Daily</td>
</tr>
<tr>
<td></td>
<td>7. Live with him</td>
</tr>
<tr>
<td></td>
<td>8. Has contact only through mail, email, or phone</td>
</tr>
<tr>
<td></td>
<td>9. REFUSED</td>
</tr>
</tbody>
</table>

55. How often does the father of your child provide financial support for his/her care?  

<SHOW "FREQUENCY" CARD>  

(CHECK ONLY ONE ANSWER)  

<table>
<thead>
<tr>
<th></th>
<th>1. Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Sometimes</td>
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<td></td>
<td>3. Most of the time</td>
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<td>4. Always</td>
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<td></td>
<td>5. Don't know</td>
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<td></td>
<td>6. Refused</td>
</tr>
</tbody>
</table>
56. What is the ethnicity of the father of your child?  

(CHECK ONLY ONE ANSWER)

1. Hispanic / Latino
2. European American
3. African American
4. Native American
5. Asian American
6. Other <SPECIFY>  (GO TO QUESTION 57)
7. DON'T KNOW
8. REFUSED

SKIP TO QUESTION 58

57. <ENTER ETHNICITY OF CHILD'S FATHER>

58. Where was the father of your child born?  

(CHECK ONLY ONE ANSWER)

1. Mainland USA
2. Puerto Rico
3. Dominican Republic
4. Mexico
5. Other <SPECIFY>  (GO TO QUESTION 59)
6. DON'T KNOW
7. REFUSED

SKIP TO QUESTION 60

59. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY>

60. How old is your child's father?  

<ENTER AMOUNT IN YEARS WITH DECIMAL POINT>

1.  

65. Is the father of your child also your current partner/boyfriend/husband?  

(CHECK ONLY ONE ANSWER)

1. No  (GO TO QUESTION 66)
2. Boyfriend/partner
3. Husband
4. DON'T KNOW
5. REFUSED
66. Do you currently have a boyfriend/partner/husband? 10:24
(CHECK ONLY ONE ANSWER)

|   | 1. No   (GO TO QUESTION 98)
|   | 2. Boyfriend/partner
|   | 3. Husband
|   | 4. DON'T KNOW
|   | 5. REFUSED

67. How far has your current boyfriend/husband gotten in school? 10:25-26
(CHECK ONLY ONE ANSWER)

|   | 1. Less than seventh grade
|   | 2. Seventh grade
|   | 3. Eighth grade
|   | 4. Ninth grade
|   | 5. Tenth grade
|   | 6. Eleventh grade
|   | 7. Twelfth grade
|   | 8. High school diploma/GED
|   | 9. Partial college
|   | 10. College graduate
|   | 11. Other <SPECIFY> (GO TO QUESTION 68)
|   | 12. DON'T KNOW
|   | 13. REFUSED

SKIP TO QUESTION 69

68. <ENTER THE SUBJECT'S ANSWER FOR PARTNER EDUCATION> 10:27-46

69. Is your current boyfriend/husband in school now? 10:47
(CHECK ONLY ONE ANSWER)

|   | 1. No
|   | 2. Yes, part time/night school
|   | 3. Yes, full time
|   | 4. DON'T KNOW
|   | 5. REFUSED

70. Is your current boyfriend/husband working at a job right now? 10:48

(CHECK ONLY ONE ANSWER)

|   | 1. No
|   | 2. Yes, part time
|   | 3. Yes, full time
|   | 4. DON'T KNOW
|   | 5. REFUSED
71. What is the ethnicity of your current boyfriend/husband? 10:49

(CHECK ONLY ONE ANSWER)

|___| 1. Hispanic / Latino
|___| 2. European American
|___| 3. African American
|___| 4. Native American
|___| 5. Asian American
|___| 6. Other <SPECIFY> (GO TO QUESTION 72)
|___| 7. DON'T KNOW
|___| 8. REFUSED

SKIP TO QUESTION 73
=================================================================

72. <ENTER ETHNICITY OF CURRENT BOYFRIEND/HUSBAND> 10:50-69

=================================================================

73. Where was your current boyfriend/husband born? 10:70

(CHECK ONLY ONE ANSWER)

|___| 1. Mainland USA
|___| 2. Puerto Rico
|___| 3. Dominican Republic
|___| 4. Mexico
|___| 5. Other <SPECIFY> (GO TO QUESTION 74)
|___| 6. DON'T KNOW
|___| 7. REFUSED

SKIP TO QUESTION 75
=================================================================

74. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY.> 11:1-20

=================================================================

75. How old is your partner?

<ENTER AMOUNT IN YEARS WITH DECIMAL POINT> 11:21-23

|___|___|___|___|
76. How long have you been together with your current boyfriend/husband? <NOTE THAT THIS COULD BE THE CHILD’S FATHER WHO IS ALSO CURRENT PARTNER OR CURRENT PARTNER WHO IS NOT THE BIOLOGICAL FATHER OF THE CHILD> 11:24

(CHECK ONLY ONE ANSWER)

____ 1. 1 month or less
____ 2. 1 to 6 months
____ 3. 6 months to 1 year
____ 4. 1 year to 2 years
____ 5. 2 years to 3 years
____ 6. 3 years to 5 years
____ 7. 5 or more years
____ 8. DON’T KNOW
____ 9. REFUSED

86. How often does your current boyfriend/husband help with the care of your child? <NOTE: IF SHE DOES NOT HAVE A CURRENT BOYFRIEND/PARTNER, JUST MARK (13) NOT APPLICABLE> 11:34-35

(CHECK ONLY ONE ANSWER)

____ 1. Never (GO TO QUESTION 98)
____ 2. Once or twice a year (GO TO QUESTION 98)
____ 3. Less than once a month (GO TO QUESTION 98)
____ 4. Once a month or more
____ 5. Once a week
____ 6. Several times a week
____ 7. Once a day
____ 8. 2 to 3 times a day
____ 9. 4 to 5 times a day
____ 10. 6 or more times a day
____ 11. DON’T KNOW
____ 12. REFUSED
____ 13. NOT APPLICABLE (no current partner)

(GO TO QUESTION 98)

87. Now I am going to ask you a few questions about the activities your current boyfriend/husband has done with your child during the past month.

How often did he..... - sing songs to your child. 11:36

(CHECK ONLY ONE ANSWER)

____ 1. Never
____ 2. Less than once a week
____ 3. Once a week
____ 4. Several times a week
____ 5. Daily
____ 6. Several times a day
____ 7. Don't know
____ 8. Refused
88. tell or read stories to your child?  

(CHECK ONLY ONE ANSWER)  
___ 1. 1. Never  
___ 2. 2. Less than once a week  
___ 3. 3. Once a week  
___ 4. 4. Several times a week  
___ 5. 5. Daily  
___ 6. 6. Several times a day  
___ 7. 7. Don't know  
___ 8. 8. Refused

89. play with your child with toys?  

(CHECK ONLY ONE ANSWER)  
___ 1. 1. Never  
___ 2. 2. Less than once a week  
___ 3. 3. Once a week  
___ 4. 4. Several times a week  
___ 5. 5. Daily  
___ 6. 6. Several times a day  
___ 7. 7. Don't know  
___ 8. 8. Refused

90. try to tease your child to get him/her to laugh?  

(CHECK ONLY ONE ANSWER)  
___ 1. 1. Never  
___ 2. 2. Less than once a week  
___ 3. 3. Once a week  
___ 4. 4. Several times a week  
___ 5. 5. Daily  
___ 6. 6. Several times a day  
___ 7. 7. Don't know  
___ 8. 8. Refused

91. play physical games such as chasing, taking your child for a ride on his shoulders or turning your child upside down or tossing him/her in the air?  

(CHECK ONLY ONE ANSWER)  
___ 1. 1. Never  
___ 2. 2. Less than once a week  
___ 3. 3. Once a week  
___ 4. 4. Several times a week  
___ 5. 5. Daily  
___ 6. 6. Several times a day  
___ 7. 7. Don't know  
___ 8. 8. Refused
92. held or caressed your child?

(CHECK ONLY ONE ANSWER)
___ 1. 1. Never
___ 2. 2. Less than once a week
___ 3. 3. Once a week
___ 4. 4. Several times a week
___ 5. 5. Daily
___ 6. 6. Several times a day
___ 7. 7. Don't know
___ 8. 8. Refused

93. Put your child to bed?

(CHECK ONLY ONE ANSWER)
___ 1. 1. Never
___ 2. 2. Less than once a week
___ 3. 3. Once a week
___ 4. 4. Several times a week
___ 5. 5. Daily
___ 6. 6. Several times a day
___ 7. 7. Don't know
___ 8. 8. Refused

94. Wash, give your child a bath, or help get your child dressed?

(CHECK ONLY ONE ANSWER)
___ 1. 1. Never
___ 2. 2. Less than once a week
___ 3. 3. Once a week
___ 4. 4. Several times a week
___ 5. 5. Daily
___ 6. 6. Several times a day
___ 7. 7. Don't know
___ 8. 8. Refused

95. Change your child's diaper or help the child with the toilet?

(CHECK ONLY ONE ANSWER)
___ 1. 1. Never
___ 2. 2. Less than once a week
___ 3. 3. Once a week
___ 4. 4. Several times a week
___ 5. 5. Daily
___ 6. 6. Several times a day
___ 7. 7. Don't know
___ 8. 8. Refused
96. Prepare meals or bottles for your child?

(CHECK ONLY ONE ANSWER)

|   | 1. 1. Never
|   | 2. 2. Less than once a week
|   | 3. 3. Once a week
|   | 4. 4. Several times a week
|   | 5. 5. Daily
|   | 6. 6. Several times a day
|   | 7. 7. Don't know
|   | 8. 8. Refused

97. Help your child with eating or give your child a bottle?

(CHECK ONLY ONE ANSWER)

|   | 1. 1. Never
|   | 2. 2. Less than once a week
|   | 3. 3. Once a week
|   | 4. 4. Several times a week
|   | 5. 5. Daily
|   | 6. 6. Several times a day
|   | 7. 7. Don't know
|   | 8. 8. Refused

151. Next, I'm going to read to you a list of things that sometimes happen to people. FOR EACH OF THE EVENTS ON THIS LIST THAT HAPPENED TO YOU IN THE LAST YEAR, give the response that best describes how it affected you...

- Got married.

<USE "IMPACT" CARD>

(CHECK ONLY ONE ANSWER)

|   | 1. 1. Extremely bad
|   | 2. 2. Somewhat bad
|   | 3. 3. Neutral
|   | 4. 4. Somewhat good
|   | 5. 5. Extremely good
|   | 6. 6. Did not happen in the last year
|   | 7. 7. REFUSED

152. Began a relationship.

<REMIND SUBJECT TO ONLY CONSIDER EVENTS WHICH OCCURRED IN THE PAST YEAR.>

<USE "IMPACT" CARD>

(CHECK ONLY ONE ANSWER)

|   | 1. 1. Extremely bad
|   | 2. 2. Somewhat bad
|   | 3. 3. Neutral
|   | 4. 4. Somewhat good
|   | 5. 5. Extremely good
|   | 6. 6. Did not happen in the last year
|   | 7. 7. REFUSED
153. Broke-up with someone.

<USE "IMPACT" CARD>

(CHECK ONLY ONE ANSWER)

___  1. 1. Extremely bad
___  2. 2. Somewhat bad
___  3. 3. Neutral
___  4. 4. Somewhat good
___  5. 5. Extremely good
___  6. 6. Did not happen in the last year
___  7. 7. REFUSED

154. Separated from husband.

<USE "IMPACT" CARD>

(CHECK ONLY ONE ANSWER)

___  1. 1. Extremely bad
___  2. 2. Somewhat bad
___  3. 3. Neutral
___  4. 4. Somewhat good
___  5. 5. Extremely good
___  6. 6. Did not happen in the last year
___  7. 7. REFUSED

155. Got divorced.

<USE "IMPACT" CARD>

(CHECK ONLY ONE ANSWER)

___  1. 1. Extremely bad
___  2. 2. Somewhat bad
___  3. 3. Neutral
___  4. 4. Somewhat good
___  5. 5. Extremely good
___  6. 6. Did not happen in the last year
___  7. 7. REFUSED

156. Close friend or family member moved away.

<USE "IMPACT" CARD>

(CHECK ONLY ONE ANSWER)

___  1. 1. Extremely bad
___  2. 2. Somewhat bad
___  3. 3. Neutral
___  4. 4. Somewhat good
___  5. 5. Extremely good
___  6. 6. Did not happen in the last year
___  7. 7. REFUSED
157. Someone else moved in or out of household.
<REMIND SUBJECT TO ONLY CONSIDER EVENTS WHICH OCCURRED IN THE PAST YEAR.>
<USE "IMPACT" CARD> 13:12

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED

158. YOU moved in or out of household.
<USE "IMPACT" CARD> 13:13

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED

159. Robbery or attempted robbery of home.
<USE "IMPACT" CARD> 13:14

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED

160. Pregnancy.
<USE CARD "IMPACT"> 13:15

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED
161. Birth of a child.
<REMIND SUBJECT TO ONLY CONSIDER EVENTS WHICH OCCURRED IN THE PAST YEAR.>
<USE CARD "IMPACT"> 13:16
(CHECK ONLY ONE ANSWER)
|___| 1. 1. Extremely bad
|___| 2. 2. Somewhat bad
|___| 3. 3. Neutral
|___| 4. 4. Somewhat good
|___| 5. 5. Extremely good
|___| 6. 6. Did not happen in the last year
|___| 7. 7. REFUSED

162. Miscarriage.
<USE CARD "IMPACT"> 13:17
(CHECK ONLY ONE ANSWER)
|___| 1. 1. Extremely bad
|___| 2. 2. Somewhat bad
|___| 3. 3. Neutral
|___| 4. 4. Somewhat good
|___| 5. 5. Extremely good
|___| 6. 6. Did not happen in the last year
|___| 7. 7. REFUSED

163. Abortion.
<USE CARD "IMPACT"> 13:18
(CHECK ONLY ONE ANSWER)
|___| 1. 1. Extremely bad
|___| 2. 2. Somewhat bad
|___| 3. 3. Neutral
|___| 4. 4. Somewhat good
|___| 5. 5. Extremely good
|___| 6. 6. Did not happen in the last year
|___| 7. 7. REFUSED

164. YOU experienced a serious illness, injury, or hospitalization?
<USE CARD "IMPACT"> 13:19
(CHECK ONLY ONE ANSWER)
|___| 1. 1. Extremely bad
|___| 2. 2. Somewhat bad
|___| 3. 3. Neutral
|___| 4. 4. Somewhat good
|___| 5. 5. Extremely good
|___| 6. 6. Did not happen in the last year
|___| 7. 7. REFUSED
165. Your HUSBAND/PARTNER experienced a serious illness, injury, or hospitalization?

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

<table>
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<tr>
<th></th>
<th>1. Extremely bad</th>
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<tr>
<td></td>
<td>2. Somewhat bad</td>
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<tr>
<td></td>
<td>3. Neutral</td>
</tr>
<tr>
<td></td>
<td>4. Somewhat good</td>
</tr>
<tr>
<td></td>
<td>5. Extremely good</td>
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<tr>
<td></td>
<td>6. Did not happen in the last year</td>
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<td>7. REFUSED</td>
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</table>

166. One or both of your PARENTS experienced a serious illness, injury, or hospitalization?

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

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<tr>
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<th>1. Extremely bad</th>
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<tr>
<td></td>
<td>2. Somewhat bad</td>
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<tr>
<td></td>
<td>3. Neutral</td>
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<tr>
<td></td>
<td>4. Somewhat good</td>
</tr>
<tr>
<td></td>
<td>5. Extremely good</td>
</tr>
<tr>
<td></td>
<td>6. Did not happen in the last year</td>
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<td>7. REFUSED</td>
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167. Your CHILD experienced a serious illness, injury, or hospitalization in the past year?

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

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<th>1. Extremely bad</th>
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<tr>
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<td>2. Somewhat bad</td>
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<tr>
<td></td>
<td>3. Neutral</td>
</tr>
<tr>
<td></td>
<td>4. Somewhat good</td>
</tr>
<tr>
<td></td>
<td>5. Extremely good</td>
</tr>
<tr>
<td></td>
<td>6. Did not happen in the last year</td>
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<td></td>
<td>7. REFUSED</td>
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</table>

168. Some other CLOSE RELATIVE experienced a serious illness, injury, or hospitalization in the past year?

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

<table>
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<th></th>
<th>1. Extremely bad</th>
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<tr>
<td></td>
<td>2. Somewhat bad</td>
</tr>
<tr>
<td></td>
<td>3. Neutral</td>
</tr>
<tr>
<td></td>
<td>4. Somewhat good</td>
</tr>
<tr>
<td></td>
<td>5. Extremely good</td>
</tr>
<tr>
<td></td>
<td>6. Did not happen in the last year</td>
</tr>
<tr>
<td></td>
<td>7. REFUSED</td>
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</tbody>
</table>
169. Death of a: Husband or partner.
<REMIND SUBJECT TO ONLY CONSIDER EVENTS WHICH OCCURRED IN THE PAST YEAR.>
<USE CARD "IMPACT”> 13:24

(CHECK ONLY ONE ANSWER)
___ 1. 1. Extremely bad
___ 2. 2. Somewhat bad
___ 3. 3. Neutral
___ 4. 4. Somewhat good
___ 5. 5. Extremely good
___ 6. 6. Did not happen in the last year
___ 7. 7. REFUSED

<USE CARD "IMPACT”> 13:25

(CHECK ONLY ONE ANSWER)
___ 1. 1. Extremely bad
___ 2. 2. Somewhat bad
___ 3. 3. Neutral
___ 4. 4. Somewhat good
___ 5. 5. Extremely good
___ 6. 6. Did not happen in the last year
___ 7. 7. REFUSED

171. Death of a: Child.
<USE CARD "IMPACT”> 13:26

(CHECK ONLY ONE ANSWER)
___ 1. 1. Extremely bad
___ 2. 2. Somewhat bad
___ 3. 3. Neutral
___ 4. 4. Somewhat good
___ 5. 5. Extremely good
___ 6. 6. Did not happen in the last year
___ 7. 7. REFUSED

172. Death of a: Close relative/friend.
<USE CARD "IMPACT”> 13:27

(CHECK ONLY ONE ANSWER)
___ 1. 1. Extremely bad
___ 2. 2. Somewhat bad
___ 3. 3. Neutral
___ 4. 4. Somewhat good
___ 5. 5. Extremely good
___ 6. 6. Did not happen in the last year
___ 7. 7. REFUSED
173. Started work.
<USE CARD "IMPACT">
13:28

(CHECK ONLY ONE ANSWER)
| 1. 1. Extremely bad
| 2. 2. Somewhat bad
| 3. 3. Neutral
| 4. 4. Somewhat good
| 5. 5. Extremely good
| 6. 6. Did not happen in the last year
| 7. 7. REFUSED

174. Quit or was laid off from work.
<USE CARD "IMPACT">
13:29

(CHECK ONLY ONE ANSWER)
| 1. 1. Extremely bad
| 2. 2. Somewhat bad
| 3. 3. Neutral
| 4. 4. Somewhat good
| 5. 5. Extremely good
| 6. 6. Did not happen in the last year
| 7. 7. REFUSED

175. Change at work (demoted, promoted, etc.).
<USE CARD "IMPACT">
13:30

(CHECK ONLY ONE ANSWER)
| 1. 1. Extremely bad
| 2. 2. Somewhat bad
| 3. 3. Neutral
| 4. 4. Somewhat good
| 5. 5. Extremely good
| 6. 6. Did not happen in the last year
| 7. 7. REFUSED

176. Change of schools.
<REMIND SUBJECT TO ONLY CONSIDER EVENTS WHICH OCCURRED IN THE PAST YEAR.>
<USE CARD "IMPACT">
13:31

(CHECK ONLY ONE ANSWER)
| 1. 1. Extremely bad
| 2. 2. Somewhat bad
| 3. 3. Neutral
| 4. 4. Somewhat good
| 5. 5. Extremely good
| 6. 6. Did not happen in the last year
| 7. 7. REFUSED
177. Started school/vocational training.
<USE CARD "IMPACT"> 13:32

(CHECK ONLY ONE ANSWER)
|___| 1. Extremely bad
|___| 2. Somewhat bad
|___| 3. Neutral
|___| 4. Somewhat good
|___| 5. Extremely good
|___| 6. Did not happen in the last year
|___| 7. REFUSED

Maternal Questionnaire 1

178. Graduated from school/vocational training.
<USE CARD "IMPACT"> 13:33

(CHECK ONLY ONE ANSWER)
|___| 1. Extremely bad
|___| 2. Somewhat bad
|___| 3. Neutral
|___| 4. Somewhat good
|___| 5. Extremely good
|___| 6. Did not happen in the last year
|___| 7. REFUSED

179. Dropped out of school/vocational training.
<USE CARD "IMPACT"> 13:34

(CHECK ONLY ONE ANSWER)
|___| 1. Extremely bad
|___| 2. Somewhat bad
|___| 3. Neutral
|___| 4. Somewhat good
|___| 5. Extremely good
|___| 6. Did not happen in the last year
|___| 7. REFUSED

180. Had major problems in school/vocational training.
<USE CARD "IMPACT"> 13:35

(CHECK ONLY ONE ANSWER)
|___| 1. Extremely bad
|___| 2. Somewhat bad
|___| 3. Neutral
|___| 4. Somewhat good
|___| 5. Extremely good
|___| 6. Did not happen in the last year
|___| 7. REFUSED
181. Detention in jail or youth facility.

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED

182. Other problems with the law.

(REMIND SUBJECT TO ONLY CONSIDER EVENTS WHICH OCCURRED IN THE PAST YEAR.)

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED

183. You were mugged or robbed.

(USE CARD "IMPACT")

(CHECK ONLY ONE ANSWER)

|   | 1. Extremely bad
|   | 2. Somewhat bad
|   | 3. Neutral
|   | 4. Somewhat good
|   | 5. Extremely good
|   | 6. Did not happen in the last year
|   | 7. REFUSED

184. Have you experienced any other significant events in the past year?

(CHECK ONLY ONE ANSWER)

|   | 1. No
|   | 2. Yes (GO TO QUESTION 185)
|   | 3. REFUSED

SKIP TO QUESTION 187
185. Which was the MOST significant of these other events? [14:1-40]
___________________________________________________________
___________________________________________________________
___________________________________________________________

186. Which of the following responses best describes how #185 affected you?
"USE CARD "IMPACT"

(CHECK ONLY ONE ANSWER)
|   | 1. 1. Extremely negative
|   | 2. 2. Somewhat negative
|   | 3. 3. Neutral
|   | 4. 4. Slightly positive
|   | 5. 5. Extremely positive
|   | 6. 6. REFUSED

8. Now I am going to ask you a few questions about your ethnic background.
What is the ethnicity of your child? [1:60]

(CHECK ONLY ONE ANSWER)
|   | 1. 1. Hispanic / Latino
|   | 2. 2. Mixed ethnicity - Latino & African American
|   | 3. 3. Mixed ethnicity - Latino & European American
|   | 4. 4. Mixed ethnicity - Latino & other
|   | 5. 5. REFUSED

9. In what country was each of the following persons born?
In what country was your child born? [1:61]

(CHECK ONLY ONE ANSWER)
|   | 1. 1. Mainland USA
|   | 2. 2. Puerto Rico
|   | 3. 3. Dominican Republic
|   | 4. 4. Mexico
|   | 5. 5. Other <SPECIFY> (GO TO QUESTION 10)
|   | 6. 6. DON'T KNOW
|   | 7. 7. REFUSED

SKIP TO QUESTION 11
=================================================================

10. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY.> [2:1-20]
11. In what country was YOUR MOTHER born?  

(CHECK ONLY ONE ANSWER)
|__| 1. Mainland USA  
|__| 2. Puerto Rico  
|__| 3. Dominican Republic  
|__| 4. Mexico  
|__| 5. Other <SPECIFY>  (GO TO QUESTION 12)  
|__| 6. DON'T KNOW  
|__| 7. REFUSED  

SKIP TO QUESTION 13

12. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY.>  

13. In what country was the MOTHER OF YOUR MOTHER born?  

(CHECK ONLY ONE ANSWER)
|__| 1. Mainland USA  
|__| 2. Puerto Rico  
|__| 3. Dominican Republic  
|__| 4. Mexico  
|__| 5. Other <SPECIFY>  (GO TO QUESTION 14)  
|__| 6. DON'T KNOW  
|__| 7. REFUSED  

SKIP TO QUESTION 15

14. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY.>  

15. In what country was the FATHER OF YOUR MOTHER born?  

(CHECK ONLY ONE ANSWER)
|__| 1. Mainland USA  
|__| 2. Puerto Rico  
|__| 3. Dominican Republic  
|__| 4. Mexico  
|__| 5. Other <SPECIFY>  (GO TO QUESTION 16)  
|__| 6. DON'T KNOW  
|__| 7. REFUSED  

SKIP TO QUESTION 17
16. <ENTER PARTICIPANT’S ANSWER FOR COUNTRY.> 3:1-20

___________________________________________________________

___________________________________________________________

___________________________________________________________

17. In what country was your FATHER born? 3:21

(CHECK ONLY ONE ANSWER)
|___| 1. 1. Mainland USA
|___| 2. 2. Puerto Rico
|___| 3. 3. Dominican Republic
|___| 4. 4. Mexico
|___| 5. 5. Other <SPECIFY>  (GO TO QUESTION 18)
|___| 6. 6. DON’T KNOW
|___| 7. 7. REFUSED

SKIP TO QUESTION 19

===========================================================

18. <ENTER PARTICIPANT’S ANSWER FOR COUNTRY.> 3:22-41

___________________________________________________________

___________________________________________________________

___________________________________________________________

Maternal Questionnaire 2  Page 5

19. In what country was the MOTHER OF YOUR FATHER born? 3:42

(CHECK ONLY ONE ANSWER)
|___| 1. 1. Mainland USA
|___| 2. 2. Puerto Rico
|___| 3. 3. Dominican Republic
|___| 4. 4. Mexico
|___| 5. 5. Other <SPECIFY>  (GO TO QUESTION 20)
|___| 6. 6. DON’T KNOW
|___| 7. 7. REFUSED

SKIP TO QUESTION 21

===========================================================

20. <ENTER PARTICIPANT’S ANSWER FOR COUNTRY.> 3:43-62

___________________________________________________________

___________________________________________________________

___________________________________________________________
21. In what country was the FATHER OF YOUR FATHER born? (CHECK ONLY ONE ANSWER)

|___| 1. Mainland USA
|___| 2. Puerto Rico
|___| 3. Dominican Republic
|___| 4. Mexico
|___| 5. Other <SPECIFY> (GO TO QUESTION 22)
|___| 6. DON'T KNOW
|___| 7. REFUSED

SKIP TO QUESTION 23

22. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY.>

23. In what country were YOU born?

|___| 1. Mainland USA
|___| 2. Puerto Rico
|___| 3. Dominican Republic
|___| 4. Mexico
|___| 5. Other <SPECIFY> (GO TO QUESTION 24)
|___| 6. DON'T KNOW
|___| 7. REFUSED

SKIP TO QUESTION 25

24. <ENTER PARTICIPANT'S ANSWER FOR COUNTRY.>

79. Now, I am going to read you a list of problems and complaints that people sometimes have. Please let me know how much discomfort each of these problems has caused you during the last TWO WEEKS.

82. (In the past TWO WEEKS how much were you distressed by...)
Loss of sexual interest or pleasure?

|___| 1. Not at all
|___| 2. A little
|___| 3. Some
|___| 4. A lot (very)
|___| 5. A huge amount (extremely)
|___| 6. REFUSED
85. (In the past TWO WEEKS how much were you distressed by...) 
Feeling low in energy or slowed down?  
<SHOW "AMOUNT" CARD>  
(CHECK ONLY ONE ANSWER)  
[ ] 1. 1. Not at all  
[ ] 2. 2. A little  
[ ] 3. 3. Some  
[ ] 4. 4. A lot (very)  
[ ] 5. 5. A huge amount (extremely)  
[ ] 6. 6. REFUSED  
5:33  

86. (In the past TWO WEEKS how much were you distressed by...)  
Thoughts of ending your life?  
<SHOW "AMOUNT" CARD>  
(CHECK ONLY ONE ANSWER)  
[ ] 1. 1. Not at all  
[ ] 2. 2. A little  
[ ] 3. 3. Some  
[ ] 4. 4. A lot (very)  
[ ] 5. 5. A huge amount (extremely)  
[ ] 6. 6. REFUSED  
5:34  

88. (In the past TWO WEEKS how much were you distressed by...)  
Crying easily?  
<SHOW "AMOUNT" CARD>  
(CHECK ONLY ONE ANSWER)  
[ ] 1. 1. Not at all  
[ ] 2. 2. A little  
[ ] 3. 3. Some  
[ ] 4. 4. A lot (very)  
[ ] 5. 5. A huge amount (extremely)  
[ ] 6. 6. REFUSED  
5:36  

89. (In the past TWO WEEKS how much were you distressed by...)  
Feelings of being trapped or caught?  
<SHOW "AMOUNT" CARD>  
(CHECK ONLY ONE ANSWER)  
[ ] 1. 1. Not at all  
[ ] 2. 2. A little  
[ ] 3. 3. Some  
[ ] 4. 4. A lot (very)  
[ ] 5. 5. A huge amount (extremely)  
[ ] 6. 6. REFUSED  
5:37
92. (In the past TWO WEEKS how much were you distressed by...) Blaming yourself for things?

<SHOW "AMOUNT" CARD> 5:40

(CHECK ONLY ONE ANSWER)

|__| 1. 1. Not at all
|__| 2. 2. A little
|__| 3. 3. Some
|__| 4. 4. A lot (very)
|__| 5. 5. A huge amount (extremely)
|__| 6. 6. REFUSED

94. (In the past TWO WEEKS how much were you distressed by...) Feeling lonely?

<SHOW "AMOUNT" CARD> 5:42

(CHECK ONLY ONE ANSWER)

|__| 1. 1. Not at all
|__| 2. 2. A little
|__| 3. 3. Some
|__| 4. 4. A lot (very)
|__| 5. 5. A huge amount (extremely)
|__| 6. 6. REFUSED

95. (In the past TWO WEEKS how much were you distressed by...) Feeling blue?

<SHOW "AMOUNT" CARD> 5:43

(CHECK ONLY ONE ANSWER)

|__| 1. 1. Not at all
|__| 2. 2. A little
|__| 3. 3. Some
|__| 4. 4. A lot (very)
|__| 5. 5. A huge amount (extremely)
|__| 6. 6. REFUSED

96. (In the past TWO WEEKS how much were you distressed by...) Worrying too much about things?

<SHOW "AMOUNT" CARD> 5:44

(CHECK ONLY ONE ANSWER)

|__| 1. 1. Not at all
|__| 2. 2. A little
|__| 3. 3. Some
|__| 4. 4. A lot (very)
|__| 5. 5. A huge amount (extremely)
|__| 6. 6. REFUSED
97. (In the past TWO WEEKS how much were you distressed by...)
   Feeling no interest in things?
   <SHOW "AMOUNT" CARD> 5:45

   (CHECK ONLY ONE ANSWER)
   |__| 1. Not at all
   |__| 2. A little
   |__| 3. Some
   |__| 4. A lot (very)
   |__| 5. A huge amount (extremely)
   |__| 6. REFUSED

106. (In the past TWO WEEKS how much were you distressed by...)
    Feeling hopeless about the future?
    <SHOW "AMOUNT" CARD> 5:54

    (CHECK ONLY ONE ANSWER)
    |__| 1. Not at all
    |__| 2. A little
    |__| 3. Some
    |__| 4. A lot (very)
    |__| 5. A huge amount (extremely)
    |__| 6. REFUSED

112. (In the past TWO WEEKS how much were you distressed by...)
    Feeling everything is an effort?
    <SHOW "AMOUNT" CARD> 5:60

    (CHECK ONLY ONE ANSWER)
    |__| 1. Not at all
    |__| 2. A little
    |__| 3. Some
    |__| 4. A lot (very)
    |__| 5. A huge amount (extremely)
    |__| 6. REFUSED

116. (In the past TWO WEEKS how much were you distressed by...)
    Feelings of worthlessness?
    <SHOW "AMOUNT" CARD> 5:64

    (CHECK ONLY ONE ANSWER)
    |__| 1. Not at all
    |__| 2. A little
    |__| 3. Some
    |__| 4. A lot (very)
    |__| 5. A huge amount (extremely)
    |__| 6. REFUSED
APPENDIX C

SOCIAL SUPPORT NETWORK QUESTIONNAIRE (SSNQ)
APPENDIX C

SOCIAL SUPPORT NETWORK QUESTIONNAIRE (SSNQ)

The Social Support Network Questionnaire

The Social Support Network Questionnaire (SSNQ) is a structured face-to-face interview that has been designed to assess social support and social strain in adolescent mothers' relationships. The SSNQ is a modification and extension of the Arizona Social Support Interview Schedule (Barrera, 1981) and it is administered with the aid of a laptop computer. The following document lists instructions to interviewers and questions asked of participants. If you would like a copy of the program files and variable dictionaries, please contact Jean Rhodes (jean.rhodes@umb.edu) or Christina Gee (cgee@gwu.edu).

INTRODUCTION

NOTES:
Instructions to the interviewer are in bold type and enclosed within brackets; interviewer dialogue is italicized.

[READ TO THE PARTICIPANT]

I would like to spend the next 25 to 30 minutes talking with you about the people who are important to you in a number of different ways. To begin with, I am going to ask about the people you turn to for different kinds of help and support. You can give me just their first names or their initials if you wish. These people might be friends, family members, ministers, teachers, doctors, or anyone else you know. If you're not sure you understand the question, please tell me and I will try to make it clearer.

SECTION ONE: SOCIAL SUPPORT

QUESTION # 1a [EMOTIONAL SUPPORT] If you wanted to talk to someone about something personal or private, who would you talk to--for instance, if you had something on your mind that was worrying you or making you feel down?[PROBE] Is there anyone else who you can think of?

[NOTE: Participants can nominate up to 40 people on their network list]
QUESTION # 1b During the past month, how often did you actually talk to each of these people about something personal or private?
[GET RATING FOR EACH PERSON NOMINATED IN QUESTION 1a]
1=Less than once per week
2=Once or several times per week
3=Daily

QUESTION # 1c How did you feel about the way things went the times you talked about personal concerns this past month?
[GET RATING FOR EACH PERSON NOMINATED IN 1a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very Good

QUESTION # 1d During the past month, would you have liked more opportunities to talk to people about your personal feelings and concerns, less opportunities, or was it about right?
[RECORD AMOUNT FOR EACH PERSON NOMINATED IN 1a]
1=About Right
2=Less
3=More

QUESTION # 2a [TANGIBLE ASSISTANCE] Who of the people you know would lend or give you something you needed or pitch in to help you with something you needed to do? These would be people who would run an errand for you, lend you money, food, clothing, or drive you somewhere you needed to go.
[PROBE] Anyone else?
[Note that participants can add individuals to their network list at any time.]

QUESTION # 2b During the past month, how often did each of these people actually loan you something you needed or helped you out with things like providing transportation, running errands, or helping you do a chore you needed to get done?
[GET RATING FOR EACH PERSON NOMINATED IN 2a]
0=Never
1=Once of twice this month
2=About once a week
3=More than once a week
QUESTION # 2c Overall, during this past month, how good was the practical help you got from the people you listed-- how well did it meet your needs? [GET RATING FOR EACH PERSON NOMINATED IN 2a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very good

QUESTION # 2d During the past month, would you have liked people to have given you more practical help such as lending you things, providing you with transportation, running errands, or helping you with other things you needed to get done? Less practical help? Or was it about right? [GET RATING FOR EACH PERSON NOMINATED IN 2a]
1=About Right
2=Less
3=More

QUESTION # 3a [COGNITIVE GUIDANCE] Who would you go to if you needed advice or information-- for example, if you didn't know where to get something or how to do something you needed to do? Remember, you can name the same people that you mentioned before, or you can name new people. [PROBE] Is there anyone else you might go to for advice or information?

QUESTION # 3b During the past month, how often did each of these people actually give you information or advice? [GET RATING FOR EACH PERSON NOMINATED IN 3a]
0=Never
1=Once or twice this month
2=About once a week
3=more than once a week

QUESTION # 3c This past month, how did you feel about the advice and information you did get? [GET RATING FOR EACH PERSON NOMINATED IN 3a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very Good
QUESTION # 3d During the past month, would you have liked more advice, less advice, or was it about right?
[GET RATING FOR EACH PERSON NOMINATED IN 3a]
1=About Right
2=Less
3=More

QUESTION # 4a [POSITIVE FEEDBACK/SOCIAL REINFORCEMENT] Who are the people that you can expect to let you know that they like your ideas or the things that you do? Remember, you might have listed these people before or they can be new people.
[PROBE] Is there anyone else?

QUESTION # 4b During the past month, how often did each of these people actually let you know that they liked something you did or said?
[GET RATING FOR EACH PERSON NOMINATED IN 4a]
0=Never
1=Once or twice this month
2=About once a week
3=More than once a week

QUESTION # 4c During the past month, how did you feel about the way things went the times the people you mentioned told you that they liked your ideas or something that you did?
[GET RATING FOR EACH PERSON NOMINATED IN 4a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very Good

QUESTION # 4d During the past month, would you have liked people to tell you that they liked your ideas or things that you did more often, less often, or was it about right?
[GET RATING FOR EACH PERSON NOMINATED IN 4a]
1=About Right
2=Less
3=More

QUESTION # 5a [SOCIAL PARTICIPATION] Who are the people you get together with to have fun and relax? These could be new names or the ones you listed before.
[PROBE] Anyone else?
QUESTION # 5b During the past month, how often did you actually get together with each of these people?
[GET RATING FOR EACH PERSON NOMINATED IN 5a]
0=Never
1=Once or twice this month
2=About once a week
3=More than once a week

QUESTION # 5c During the past month, how good did you feel about your experiences the times that you got together with people to have fun and relax?
[GET RATING FOR EACH PERSON NOMINATED IN 5a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very Good

QUESTION # 5d During the past month, would you have liked more opportunities to get together with people to have fun and relax, less opportunities, or was it about right?
[GET RATING FOR EACH PERSON NOMINATED IN 5a]
1. About Right
2. Less
3. More
[IF PARTICIPANT IS PREGNANT, ASK 6a-6d; OTHERWISE SKIP TO 7]

QUESTION # 6a [PREGNANCY RELATED ASSISTANCE] If you wanted to talk to someone about being pregnant or get some other type of help related to your pregnancy--a ride to the doctor, clothes for the baby-- who would you go to? These could be people you've already mentioned or new people.
[PROBE] Anyone else?

QUESTION # 6b During the past month, how often did each of these people actually talk with you about being pregnant or help you with your pregnancy in some other way?
[GET RATING FOR EACH PERSON NOMINATED IN 6a]
0=Never
1=Once or twice this month
2=About once a week
3=More than once a week
QUESTION # 6c How did you feel about the help with your pregnancy you received from the people mentioned during this past month?
[GET RATING FOR EACH PERSON NOMINATED IN 6a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very Good

QUESTION # 6d During the past month, would you have liked more help and support with your pregnancy, less help and support, or was it about right?
[GET RATING FOR EACH PERSON NOMINATED IN 6a]
1=About right
2=Less
3=More

[IF PARTICIPANT HAS ONE OR MORE CHILDREN ASK 7a-7d; OTHERWISE SKIP TO QUESTION 8]

QUESTION # 7a [CHILD CARE ASSISTANCE] Who could you go to for help in taking care of your child/children? For instance, who could you rely on to watch your child/children in an emergency or if you just needed a break?
[PROBE] Anyone else?

QUESTION # 7b During the past month, how often did each of these people actually help you with your child/children?
[GET RATING FOR EACH PERSON NOMINATED IN 7a]
0=Never
1=Once or twice this month
2= About once a week
3=More than once a week

QUESTION # 7c During this past month, how did you feel about the help with child care you did receive?
[GET RATING FOR EACH PERSON NOMINATED IN 7a]
1=Bad
2=Not too good
3=OK
4=Good
5=Very Good
QUESTION # 7d During this past month would you have liked more help taking care of your child / children, less help, or was it about right?
[GET RATING FOR EACH PERSON NOMINATED IN 7a]
1=About Right
2=Less
3=More

QUESTION # 8 [OVERALL SATISFACTION] How good did you feel about the way things went the times this person tried to help or support you during the past month?
[GET RATING FOR EACH PERSON NOMINATED IN 7a]
1=Not too good
2=OK
3=Very Good

QUESTION # 9 [OVERALL NEED] During the past month could you have used more help and support from ________? Less help and support? Or was it about right?
[GET RATING FOR EACH PERSON NOMINATED IN 7a]
1. About Right
2. Less
3. More

QUESTION # 10 [IMPORTANCE] How important to you is the help and support you get from this person?
[GET RATING FOR EACH PERSON NOMINATED IN 7a]
1=Not too important
2=Somewhat important
3=Very important

QUESTION # 11a [NEGATIVE INTERACTIONS] Who are the people you can expect to make you angry or hurt your feelings? These would be people you argue with or upset you in some other way. These could be new names or names you listed before.
[PROBE] Anyone else?

QUESTION # 11b During the past month, which of these people actually made you angry or hurt your feelings?
[GET RATING FOR EACH PERSON LISTED IN 11a]
Angry or hurt feelings?
1=Yes
2=No
APPENDIX D

CHILD BEHAVIOR CHECKLIST/1½ -5
APPENDIX D

CHILD BEHAVIOR CHECKLIST/1½ -5

CHILD BEHAVIOR CHECKLIST FOR AGES 1½-5

Boy Girl

TODAY’S DATE
Mo. ____ Day ____ Year ______

CHILD’S BIRTHDATE
Mo. ____ Day ____ Year ______

Please fill out this form to reflect your view of the child’s behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2. Be sure to answer all items.

For office use only
ID #

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www.ASEBA.org 7-28-00 Edition

Be sure you answered all items. Then see other side.
Please print. Be sure to answer all items.

Below is a list of items that describe children. For each item that describes the child now or within the past 2 months, please circle the 2 if the item is very true or often true of the child. Circle the 1 if the item is somewhat or sometimes true of the child. If the item is not true of the child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to the child.

0 = Not True (as far as you know)
1 = Somewhat or Sometimes True
2 = Very True or Often True

0 1 2 1. Aches or pains (without medical cause; do not include stomach or headaches)
0 1 2 2. Acts too young for age
0 1 2 3. Afraid to try new things
0 1 2 4. Avoids looking others in the eye
0 1 2 5. Can’t concentrate, can’t pay attention for long
0 1 2 6. Can’t sit still, restless, or hyperactive
0 1 2 7. Can’t stand having things out of place
8. Can't stand waiting; wants everything now
9. Chews on things that aren't edible
10. Clings to adults or too dependent
11. Constantly seeks help
12. Constipated, doesn't move bowels (when not sick)
13. Cries a lot
14. Cruel to animals
15. Defiant
16. Demands must be met immediately
17. Destroys his/her own things
18. Destroys things belonging to his/her family or other children
19. Diarrhea or loose bowels (when not sick)
20. Disobedient
21. Disturbed by any change in routine
22. Doesn't want to sleep alone
23. Doesn't answer when people talk to him/her
24. Doesn't eat well (describe): ______________________________
25. Doesn't get along with other children
26. Doesn't know how to have fun; acts like a little adult
27. Doesn't seem to feel guilty after misbehaving
28. Doesn't want to go out of home
29. Easily frustrated
30. Easily jealous
31. Eats or drinks things that are not food—don't include sweets (describe): __________________
32. Fears certain animals, situations, or places (describe): ______________________________
33. Feelings are easily hurt
34. Gets hurt a lot, accident-prone
35. Gets in many fights
36. Gets into everything
37. Gets too upset when separated from parents
38. Has trouble getting to sleep
39. Headaches (without medical cause)
40. Hits others
41. Holds his/her breath
42. Hurts animals or people without meaning to
43. Looks unhappy without good reason
44. Angry moods
45. Nausea, feels sick (without medical cause)
46. Nervous movements or twitching (describe): ________________________________
0 1 2 47. Nervous, highstrung, or tense
0 1 2 48. Nightmares
0 1 2 49. Overeating
0 1 2 50. Overtired
0 1 2 51. Shows panic for no good reason
0 1 2 52. Painful bowel movements (without medical cause)
0 1 2 53. Physically attacks people
0 1 2 54. Picks nose, skin, or other parts of body (describe): __________________________
0 1 2 55. Plays with own sex parts too much
0 1 2 56. Poorly coordinated or clumsy
0 1 2 57. Problems with eyes (without medical cause) (describe): _______________________________
0 1 2 58. Punishment doesn’t change his/her behavior
0 1 2 59. Quickly shifts from one activity to another
0 1 2 60. Rashes or other skin problems (without medical cause)
0 1 2 61. Refuses to eat
0 1 2 62. Refuses to play active games
0 1 2 63. Repeatedly rocks head or body
0 1 2 64. Resists going to bed at night
0 1 2 65. Resists toilet training (describe): ________________________________
0 1 2 66. Screams a lot
0 1 2 67. Seems unresponsive to affection
0 1 2 68. Self-conscious or easily embarrassed
0 1 2 69. Selfish or won’t share
0 1 2 70. Shows little affection toward people
0 1 2 71. Shows little interest in things around him/her
0 1 2 72. Shows too little fear of getting hurt
0 1 2 73. Too shy or timid
0 1 2 74. Sleeps less than most kids during day and/or night (describe): __________________________
0 1 2 75. Smears or plays with bowel movements
0 1 2 76. Speech problem (describe): ________________________________
0 1 2 77. Stares into space or seems preoccupied
0 1 2 78. Stomachaches or cramps (without medical cause)
0 1 2 79. Rapid shifts between sadness and excitement
0 1 2 80. Strange behavior (describe): ________________________________
0 1 2 81. Stubborn, sullen, or irritable
0 1 2 82. Sudden changes in mood or feelings
0 1 2 83. Sulks a lot
0 1 2 84. Talks or cries out in sleep
0 1 2 85. Temper tantrums or hot temper
012 86. Too concerned with neatness or cleanliness
012 87. Too fearful or anxious
012 88. Uncooperative
012 89. Underactive, slow moving, or lacks energy
012 90. Unhappy, sad, or depressed
012 91. Unusually loud
012 92. Upset by new people or situations (describe): ________________________________
012 93. Vomiting, throwing up (without medical cause)
012 94. Wakes up often at night
012 95. Wanders away
012 96. Wants a lot of attention
012 97. Whining
012 98. Withdrawn, doesn’t get involved with others
012 99. Worries
012 100. Please write in any problems the child has that were not listed above.
012 ________________________________
012 ________________________________
012 ________________________________

Please be sure you have answered all items.
Underline any you are concerned about.
REFERENCES


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