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## "Come pick up your child!" Integrating Work and Family Life for Parents of School-Aged Children with Mental Health Challenges

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**“Come Pick Up Your Child!”:  
Integrating Work and Family Life for Parents of  
School-Aged Children with Mental Health Challenges<sup>1</sup>**

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## Background and Context

Growing numbers of parents of children with emotional or behavioral problems are entering the workforce in the United States. However, due to the demands of caring for a child with mental health challenges, these employed parents find themselves torn between their duties at work and their responsibilities to care for children with high levels of need. When a child is diagnosed with a mental health disorder like ADHD (Attention Deficit Hyperactivity Disorder), the parent is engaged in a long-term process that involves frequent disruptions of family and work life (Kendall, 1998) and that affects family management styles (Kendall & Shelton, 2003).

Work-life integration, or the degree to which people are able to “function and find satisfaction in both work and personal life, independent of the amount of time they actually spend in each domain at different stages of their lives” (Rapoport, Bailyn, Fletcher, & Pruitt, 2002, p. 17), is often difficult to attain for these family members. In fact, parents are often compelled to quit work or are terminated due to their responsibilities to care for a child with emotional or behavioral problems (Rosenzweig & Huffstutter, 2004).

Parents’ capacity to engage in employment also depends on the levels of family support and workplace accommodation that are available in their communities (Rosenzweig, Brennan, & Ogilvie, 2002). When schools can manage disruptive or troubling behavior that occurs during the school day, and when the workplace allows flexibility in work location and schedule, parents may be able to engage in employment even while caring for a child with pronounced mental health needs.

## Research Focus

Our research team sought to discover the factors that lead to the unemployment of parents of children with mental health disorders. Our preliminary analyses and findings are reported in this presentation. We controlled for factors that affect participation in the paid workforce for parents in general: (a) child age, (b) level of caregiver education, and (c) the number of children in the household. We also introduced factors that pertain specifically to families that have children with emotional or behavioral disorders: the level of the child’s internalizing and externalizing symptoms, and the number of child absences from school. Our research was guided by specific hypotheses:

1. The more severe the child’s symptoms, the more days of school the child will miss.
2. The greater the number of child absences, the greater the disruption in the caregiver’s employment.
3. Some caregivers will have to stop working outside the home because of frequent disruptions.

## Methods

We conducted a secondary analysis of data taken from the national evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program (CCMHS; Holden, Santiago, Manteuffel, Stephens, Brannan, Soler, et al., 2003). In this analysis, we used data from 39 CCMHS sites that had data sufficiently complete to be included. Data were collected from families participating in the evaluation between 1998 and 2004. To be included, the child had to be receiving services at the time of entry into the study, be between 5 and 17 years of age, and have attended some form of school within the prior 6 months. Additionally, caregivers had to care for the child in their home and to have answered all of the relevant questions.

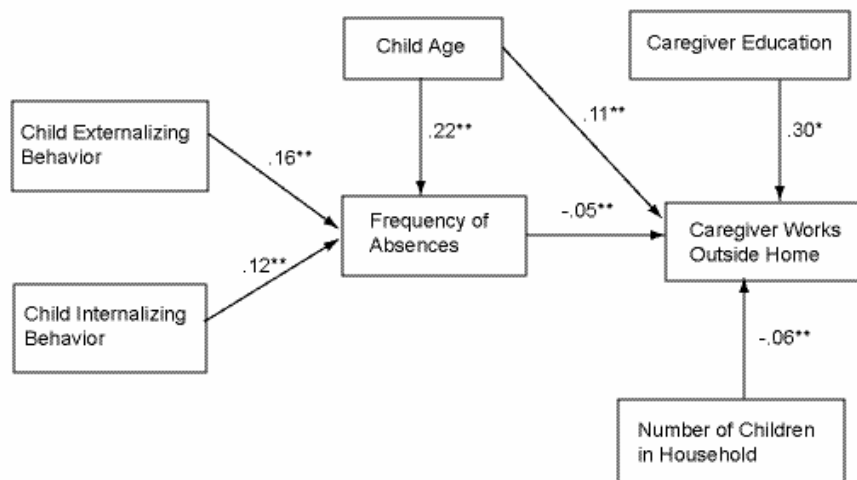
**Sample.** A total of 2,660 children were included in the study; 68.8% were male. The majority of children (53.2%) were between the ages of 10 and 14, whereas 25.4% were between 5 and 9 years of age, and the remaining 21.4% were older than 14. The sample was racially and ethnically

cally diverse: 49.5% were non-Hispanic European Americans, 18.5% were African American, 11% were Hispanic, and 21% were other races or had no ethnicity reported. The children had Child Behavior Checklist (CBCL; Achenbach, 1991) mean scores that were above the clinical cutoff point of 64 for externalizing behavior ( $M = 67.5$ ,  $SD = 10.9$ ) and slightly lower than clinical range scores for internalizing behavior ( $M = 63.0$ ;  $SD = 11.7$ ). Caregivers had a median number of 2 children in their household and a plurality had engaged in education beyond high school (43.1%). A slight majority of the caregivers (52.2%) worked in paid employment.

**Analysis.** We used structural equation modeling to examine the relationships among child symptoms (measured by the CBCL internalizing and externalizing scores), school absences (measured using parent report of school attendance), and caregiver participation in the workforce (obtained by parent report of being employed outside the home or not). The analysis controlled for age of youngest child, number of children in the home, and caregiver education level.

### Research Findings

The model was supported as indicated by the fit indices ( $CFI = .982$ ,  $RMSEA = .028$ ), and individual parameter estimates were found to be significant and in expected directions, as can be seen in Figure 1. Severity of child psychiatric internalizing ( $\gamma = .12$ ,  $p < .001$ ) and externalizing ( $\gamma = .16$ ,  $p < .001$ ) symptoms were significant predictors of frequency of absences, with more child problems being associated with more frequent absences. Frequency of absences, in turn, was negatively related to the likelihood that the caregiver worked outside the home ( $\beta = -.05$ ,  $p < .025$ ); the more frequently the child was absent, the lower the probability that the caregiver worked outside the home. As expected, older child age ( $\gamma = .11$ ,  $p < .001$ ), more caregiver education ( $\gamma = .30$ ,  $p < .001$ ), and fewer children in the household ( $\gamma = -.06$ ,  $p < .001$ ) were positively related to caregivers participating in the paid workforce. The model accounted for a substantial portion of the variance in caregiver workforce participation,  $R^2 = .11$ ,  $\chi^2(3, N = 2,660) = 9.43$ ,  $p = .02$ .



## **Conclusions and Implications**

Our findings confirmed that a higher level of mental health symptoms predicted less frequent attendance at school for children in this sample. They also supported the hypothesis that a caregiver's ability to participate in the paid labor force was negatively affected by the demands of caring for a school-aged child with emotional or behavioral disorders. However, a limitation of our study was that we only tested for a few of the many possible factors affecting a parent's decision to participate in the paid labor force.

Schools and out-of-school care programs need to have additional supports for staff that will allow them to nurture children with mental health challenges and allow parents the time to engage in fulfilling and necessary employment (Brennan, Bradley, Ama, & Cawood, 2003). When caregivers who wish to participate in paid employment are not able to, the potentially ensuing economic jeopardy may cause less desirable outcomes for them and their families. (Brody & Flor, 1998; Costello, Compton, Keeler, & Angold, 2003; Luthar, 1994). Clearly, future studies of the outcomes of mental health services should consider including caregiver workforce participation as a standard measure.

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