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Depressive Symptoms in Extended-Care Employees: Children, Social Support, and Work-Family Conditions

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Abstract

To examine the relation between having a child aged 18 years and under in the home and employee depressive symptoms, we analyzed cross-sectional data from four extended care facilities in Boston, MA ($n = 376$ employees). Results show that having a child is associated with slightly higher depressive symptoms. The strength of this relationship in our models is attenuated with the inclusion of social support at home ($\beta = 1.08$ and $\beta = 0.85$, with and without support, respectively) and may differ by gender. We recommend that future research examine the role of parenting and social support in predicting employee mental health.

The composition of the American workforce has undergone numerous changes in recent decades. Today, nearly 60% of women work outside the home, compared to 43% in 1970. The majority of employed women currently work full-time (Lee & Mather, 2008; US Department of Labor, 2008), and men and women report an equal desire for jobs with high levels of responsibility, regardless of parental status (Galinsky, Aumann, & Bond, 2008). Women's contribution to family income also has increased. In 2008, 78% of the workforce reported living in dual-earner households, with women contributing nearly half (44%) of the family income (Galinsky et al., 2008). Social roles attributed to men and women at home have evolved as well. While the amount of time that women report caring for children and performing household tasks has not changed in the past 30 years (3.8 hours per day), fathers report that they contribute significantly more time today to managing and providing child care as well as performing chores like cooking and cleaning (3 hours per day today, versus 2 hours in 1977) (Galinsky et al., 2008). Thus, shifts in labor dynamics have coincided with related changes in the home, and an increasing number of Americans, both men and women, may now experience work and family demands simultaneously.

The aim of this study is to assess the impact of work-family conflict in relation to depressive symptoms among extended-care employees. Greenhaus and Beutell (1985) introduced the term "work-family conflict" 25 years ago, referring to "a form of interrole conflict in which the role pressures from the work and family domains are mutually incompatible in some respect." This perspective is in the tradition of role strain theory, which perceives the management of multiple roles as inherently difficult and implies that the presence of both work and family demands serves as a source of potential stress (Frone, Russell, & Cooper, 1992). Frone and colleagues further posited that work-family conflict is a bidirectional

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phenomenon (operating work-to-family and family-to-work), presenting itself when efforts to fulfill responsibilities in one realm interfere with the ability to succeed in another (Frone, 2000a; Frone, Russell, & Barnes, 1996). The term “spillover” is often used to describe and test the bidirectional nature of work-family conflict. This term has been defined as the “effects of work and family on one another that generate similarities between the two domains;” (Edwards & Rothbard, 2000, page 180) spillover is conceived to be capable of acting as a positive or negative force (i.e., instill a sense of accomplishment or be perceived as interference) (Edwards & Rothbard, 2000; Kinnunen, Feldt, Geurts, & Pulkkinen, 2006).

Much of the literature suggests that increased work-family conflict is associated with poorer employee health outcomes (Berkman, Buxton, Ertel, & Okechukwu, 2010; Frone, 2000a; Melchior, Berkman, Niedhammer, Zins, & Goldberg, 2007; Roos, Lahelma, & Rahkonen, 2006), and several studies have demonstrated a relation between work-family conflict and mental health outcomes such as depression, anxiety, and mood and substance disorders (Frone, 2000; Frone et al., 1996; Hammer, Cullen, Neal, Sinclair, & Shafiro, 2005; Hughes & Galinsky, 1994; Schieman, Branch McBrier & Van Gundy, 2003). Work-life fit, defined as having a flexible schedule that meets both the employee’s needs as well as coworkers’ needs and having supervisors who are supportive of personal obligations, may have mental health-promoting effects. Among a nationally representative sample of employees, high work-life fit was associated with better mental health and lower levels of stress, compared to employees with low or moderate work-life fit (Galinsky, Peer, & Eby, 2009). It should also be noted that a smaller body of research supports the notion that the work-family interface has the potential to produce health benefits. For instance, it is possible that having multiple roles improves well-being. According to role enhancement theory, participation in multiple roles may lead to energy expansion and, therefore, more opportunities and resources, such as income and self-esteem, to promote health (Barnett, 1998; Barnett & Hyde, 2001; Kinnunen et al., 2006). In addition to examining whether the work-family interface produces negative or positive effects, researchers have hypothesized that the effects of work-life conflict vary by gender, although findings have been largely inconclusive to date (Frone, 2000; Frone et al., 1996; MacEwen & Barling, 1994).

The impact of work-family balance on employee mental health may be further complicated by the added role of parent. The fact that three-fourths of American workers reported not having enough time for their children in 2008, up from 66% in 1992 (Galinsky et al., 2009), attests to the challenge of balancing multiple facets of modern life. Research has suggested that parenting may be demanding, even among those not in the labor force. In the United States, research suggests that presence of a child in the home is an important factor in the relation between occupational strain and depressive symptoms (Ertel, Koenen & Berkman, 2008). Similarly, among a cross-sectional sample in Sweden, having children was associated with increased odds of poor self-rated health and fatigue in women, regardless of employment status (Floderus, Hagman, Aronsson, Marklund, & Wikman, 2009). On the other hand, cross-sectional research has shown that paid employment and having children are positively associated with women’s well-being in the Netherlands (Fokkema, 2002), and longitudinal research in the United States indicates that women who undertake multiple roles (such as mother and employee) experience better mental and physical health than women with fewer roles (Barnett, 2004; Barnett & Marshall, 1991; Fokkema, 2002). These findings may not be clear cut, however. Macintyre found that “parents tend to have better health ... though parents of young children and single mothers often have poorer mental health” (Macintyre, 1992, page 460). Similarly, Thorpe identified that mothers with twins experience increased depression compared to mothers of singletons and that close child spacing and having a child with disabilities also correlates with lower maternal mental health status (Thorpe, Golding, MacGillivray, & Greenwood, 1991). Collectively, these findings suggest there is a particular strain in caring for children who require greater

parental inputs. A closer look at the literature reveals nuances in the relationship between parenting status and health outcomes among men and women. Studies of domestic access to health care report that having children offers a protective effect on self-reported health status for men of all ages but poses a burden for women, particularly those under age 40 (Clark, Freeman, Kane, & Lewis, 1987; Hibbard & Pope, 1991). In a sample in Colombia, different work and family factors were associated with poor mental health in men and women. For men, negative perceived quality of work and fathering roles were associated with higher levels of depression, whereas poor quality of marital and work roles predicted depression in women (Gomez, 2006).

The current study is prompted by these inconsistent associations in the literature pertaining to parental status, gender, and health and the importance of understanding these dynamics given that increasing numbers of Americans are balancing work and family demands. In addition, we investigate the role of specific work and home factors, including social support, in order to elucidate the antecedents of depressive symptoms among working parents. The predictors of depressive symptoms among health care employees have been shown to be multifaceted (Firth-Cozens, 1998; Ertel et al., 2008), and it is also possible that work and home factors may each have unique impacts on employee well-being (Byron, 2005). For the general population, factors as diverse as work-to-home and home-to-work spillover, hours worked, job strain, and income/wage have been found to relate to employee mental health (Frone, 2000; Geiger-Brown, Muntaner, Lipscomb & Tinkoff, 2004; Hammer et al., 2005; Kinnunen et al., 2006). Social support, which is believed to promote mental health directly and through the buffering of stressful events (Cohen, 2000; Kawachi & Berkman, 2001), also has been associated with improved well-being among employed individuals, but it is not clear whether social support at home or at work is most influential (Berkman et al., 2010; Ertel et al., 2008). Taken together, it is important that work-family research explore factors beyond having children and gender in order to better understand the myriad predictors of depressive symptoms among working parents.

We have chosen to investigate this issue in the extended-care setting because it represents a particularly emotionally and physically taxing work environment (Geiger-Brown, Muntaner, Lipscomb & Tinkoff, 2004), in which work-family effects may be more pronounced. Despite a recent economic recession, the health care industry and its workforce continues to grow in the US and work-family research in this area offers a unique and salient opportunity to investigate the intersection of occupational and home demands and health. Furthermore, many employees in long-term care earn relatively low wages, which may set the stage for particular stresses when encountering multiple demands.

Specifically, this study examines the following aims and associated hypotheses:

1. Understand the relation between household presence of a child 18 years old or younger and depressive symptoms among employees at extended care facilities. Hypothesis 1: Employees with a child 18 years old or younger will have higher depressive symptoms compared to employees without a child 18 or under in the home.
2. Identify associations between work and family factors and depressive symptoms. Hypothesis 2: Work and family factors, such as spillover (home to work and work to home), job strain, and primary wage earner status, will be positively associated with depressive symptoms in this occupational cohort. Social support at home and at work will be negatively associated with depressive symptoms and may protect against the effects of parental status on depressive symptoms.
3. Examine gender differences in the relationship among depressive symptoms, child status, and other work and family demands. Hypothesis 3: Women will experience

a higher risk of depressive symptoms resulting from work-family demands, compared to men.

Because these workplace and home factors have the capacity to shape an individual's health, this research is founded in ecosocial theory, which posits that employees embody numerous experiences that ultimately accumulate and influence their well-being (Krieger, 1994, 2001). We anticipate that factors in both realms of life as well as parental status, gender, and social support will strongly influence the mental status of employed adults in the extended care setting.

METHODS

Sample and Data Collection

Participants were employees at four extended care facilities in Massachusetts who took part in a cross-sectional survey of employee experiences with workplace policies and informal practices. Trained research assistants administered the survey in English, Spanish, and Haitian Creole between September 2006 and July 2007. All interviews were conducted during employees' work shifts. Interviews required approximately 40 minutes, and debit cards were distributed to all respondents as an incentive to participate. All eligible employees at each work site were invited to participate in the survey ($N = 590$), with a response rate of 76.6% ($n = 452$). Listwise deletion was implemented and complete data for all covariates of interest yielded a total sample of 376 in the current analysis. This method of treating missing data produced no substantial changes to the sample's work, home, or demographic characteristics.

Measures

Depressive Symptoms—The primary outcome of interest, depressive symptomology, was measured using a shortened version the Center for Epidemiologic Studies Depression Scale (CES-D). The full CES-D consists of 20 questions with four response categories and assesses the presence and severity of depressive symptoms in the past week among the general population (Radloff, 1977). In the current study, we employed the Iowa Short Form, which consists of 11 of the 20 questions in the original scale and typically makes use of three response categories (Kohout & Rogers, 1993). While the Iowa Short Form does not offer a clinical cut-point, the revised version demonstrates good reliability among women (Cronbach alphas 0.71–0.88 in six female samples) and encompasses the four main factors in the full CES-D (i.e., depressed affect, positive affect, somatic affect, and interpersonal distress) (Carpenter et al., 1998; Wong-Kim & Bloom, 2005). Internal consistency reliability in this sample was also high (Cronbach alpha = 0.79). Similar to the original CES-D, we maintained four response categories in this study (rarely/never, sometimes, much of the time, and most times), yielding a continuous variable with possible values ranging from 11 to 44 (items reverse coded as necessary) that has been utilized in previous work-family research (Ertel et al., 2008).

Presence of a Child (18 Years of Age or Younger)—To explore the association between parental status and depressive symptoms, a dichotomous variable (yes/no) was derived to capture the presence of a child aged 18 years or younger in the household based on participant responses to questions about the age and relationship of each household member. This age cut-point of 18 is consistent with other studies in the work-family literature (Berkman et al., 2010; Ertel et al., 2008; Frone, 2000). In this analysis, "child" was defined as a biological child, stepchild, and/or foster child, as we assumed that each of these relationship categories necessitated parental input and energy. From this point forward, the term "child" will refer to a biological, step, or foster child in the home 18 years of age or

younger. We also briefly investigated whether caring for children that require greater parental inputs, such as young children and children with disabilities, is associated with parental depressive symptoms using questions that ask about child age and the number of hours per week spent caring for a disabled child, respectively.

Work Factors—We included a number of work factors in our models to understand their independent and collective associations with employee depressive symptomology. The number of hours worked at all jobs was the sum of the respondent's report of hours worked at the extended care facility and at other jobs. Employee pre-occupation with work at home was assessed with one question, derived from recommendations from the Sloan Work-Family Researchers Electronic Network (Macdermid et al., 2000), "Are you preoccupied with work at home?" Response options were "never," "rarely," "sometimes," and "often." Employees who responded "often" were considered to be preoccupied with work at home. Job strain was assessed using survey items about job demands and job control based on the work of Karasek and colleagues (Karasek et al., 1998; Karasek & Theorell, 1990). In response to questions pertaining to physical activity, lifting, and body positions (job demands) as well as degree of skill, task variability, and autonomy (job control) at work, participants strongly disagreed, disagreed, agreed, or strongly agreed (valued 1–4, respectively) that these elements were part of their jobs. Consistent with other research, we calculated the sum of these ordinal responses and dichotomized each measure at the 50th percentile to create four exposure categories (high demand, low control; high demand, high control; low demand, low control; low demand, high control). The low demand and high control category served as the reference. Workplace supportive behaviors also were assessed. We measured family friendly workplace by a count of items for which employees responded that it was not difficult to do: (1) make/take family phone calls at work, (2) decide shift times, and (3) take time off (possible values: 0, 1, 2, 3). Through four questions, social support at work captured employee perceptions about whether colleagues/supervisors offered support and listened to work problems. Values for responses "never," "rarely," "sometimes," and "often" (0, 1, 2 and 3, respectively) were summed to create a measure with possible values ranging from 0 to 12.

Home Factors—We included a variety of home factors in our models to understand their independent and collective contributions to employee depressive symptomology. Based on employee self-report, wage earner status was categorized as primary wage earner or not the primary wage earner (including equal wage earner). Employee preoccupation with home at work was assessed with one question ("Are you preoccupied with home at work?"), with response options of "never," "rarely," "sometimes," and "often;" this question, like the one inquiring into preoccupation with work at home, was derived from recommendations from the Sloan Work-Family Researchers Electronic Network (Macdermid et al., 2000). Employees who responded "often" were considered to be preoccupied with home at work. Social support at home denotes whether an employee could always, sometimes, or not depend on friends and family for emotional support, specific tasks, and financial assistance. Values for these responses (0, 1, and 2) were then summed to create a single measure. Social networks assessed attendance of religious services, participation in social clubs/groups, and possession of more than two close ties. Respondents answered yes or no to each question and received a score of 1 or 0, respectively. Scores for each question were summed to create a composite measure.

Sociodemographic Factors and Other Covariates—Covariates associated with depressive symptoms and work-family demands were included in this analysis: age, gender, marital status, race, education, and income. Age and income were measured continuously. We dichotomized gender (male/female) and marital status (yes/no), and categorized race/

ethnicity (Non-Hispanic White, Non-Hispanic Black, Hispanic, and Other races) and education (less than high school, high school or GED, some college or associates degree, and more than college). Worksite also was included as a covariate, as the four sites exhibited variation in size and location; inclusion of work-site also allows for some control of unmeasured differences across sites.

Statistical Analysis

We examined the bivariate relation between depressive symptoms and employee characteristics and outcomes. Subsequently, we conducted a series of multivariable regressions. To address our primary hypothesis, that employees with children 18 years of age or younger in the home experience significantly more depressive symptoms than those without children, we first modeled this relation controlling only for sociodemographic factors. To explore the impact that work and home factors have on depressive symptoms as well as how they impact the relation between children and depressive symptoms, we conducted step-wise regression analyses for work factors (Models 2 and 3) and, separately, home factors (Models 4 and 5). We then examined a final model with home and work factors combined (Model 6). We also conducted the same multivariable regressions stratified by gender to explore these nuances. In addition, to explore the notion that there is a stronger association between children of younger age and parental depressive symptoms, we replaced the child 18 years of age or younger variable with a series of child age variables (child aged 0–2, child aged 3–5, child aged 6–12, and child age 13–18). There were no associations between any child age group and parental depressive symptoms; however, there were only a small number of employees in many of these groups limiting our statistical power to test this hypothesis. Finally, we briefly investigated whether the hours spent caring for children with disabilities affect depressive symptoms, however, only six participants responded to this question. Ultimately these variables were not included in the models presented here.

RESULTS

Sample Characteristics

This sample consisted of 376 participants employed at extended-care settings (314 women and 62 men) who completed our study survey and had complete data on the aforementioned work, home, and sociodemographic variables of interest (Table 1). As discussed previously, the characteristics of this subsample were similar to those of the entire sample ($N = 452$). Our final occupational cohort had a mean depressive symptom score of 6.64 ($SD = 4.83$, range 0–26). Forty-four percent reported having a child 18 years of age or younger (biological, step-, or foster child) and over half (57%) reported being married. The cohort had a mean age of 41 years and worked an average of 40 hours each week. Fifty-seven percent of respondents reported being the primary wage earner in their household. The majority of the sample identified as Non-Hispanic White or Non-Hispanic Black (47% and 33%, respectively). Some differences in sample characteristics were evident by gender. The mean depressive scores for men and women were 5.89 and 6.98, respectively. Women were, on average, six years older than men in the sample (42 years compared to 36 years). Additionally, a higher proportion of women compared to men reported having a child (48% versus 24%) and identified as Non-Hispanic White (50% versus 28%).

Association Between Depressive Symptoms and Presence of a Child

Employees with a child had slightly higher depressive symptoms compared to employees without a child aged 18 years or younger. With the inclusion of certain work factors (family friendly workplace, total number of house worked, and preoccupation with work at home) in the model, the CES-D score measuring depressive symptoms was roughly 1 point higher for

working parents than non-parents (Model 1, $\beta = 1.09$, $p = 0.04$ in Table 2). When social support at work was added, however, the magnitude of this association was reduced (Model 2, $\beta = 0.94$, $p = 0.07$). In models in which home factors were added step-wise, having a child 18 years of age or under was no longer associated with depressive symptoms and, again, the magnitude of this relation decreased most notably with inclusion of social support at home into the model (Model 5, $\beta = 0.62$, $p = 0.22$), suggesting that social support at home mediates the association between working and having children 18 years of age or under at home. In the final model, with all work and family factors combined, having a child was not statistically significantly associated with depressive symptoms (Model 6, $\beta = 0.60$, $p = 0.24$). We also assessed the role of child age in this final model but found no significant association with depressive symptoms. Given the cross-sectional nature of these data, we are not able to conclude whether there is a causal relation between parental status and depressive symptoms nor the precise mechanism by which social ties may influence this relation. Nevertheless, these findings indicate that household and community support systems may be critical to lowering depressive symptoms experienced by working parents with children at home.

Gender Differences

Gender stratified analyses revealed differences for women and men in the association between work and home variables, including presence of a child 18 years of age and under in the home, on employee depressive symptoms (Tables 3 and 4 for women and men, respectively). For women, social support at work, social support at home and social networks had a consistently protective effect on depressive symptoms, controlling for the presence of a child and other work, home, and sociodemographic variables. Controlling for work factors, presence of a child at home was associated with an increase in depressive symptoms among women ($n = 314$) (Model 1, $\beta = 1.26$, $p = 0.03$, Table 3), but this relation diminished substantially after the addition of social support (Model 2, $\beta = 1.08$, $p = 0.06$). In models with home factors included, there was no association between having a child at home and depressive symptoms (Models 4–6)

Correlates of depressive symptoms appear to be somewhat different for men in this cohort, although the male sample may be too small in this study to draw strong conclusions ($n = 62$). In models with work factors included (Models 1–3), there was no association between having a child at home and depressive symptoms in men. With the addition of home factors, the association between children and depressive symptoms strengthened (Model 4, $\beta = -2.82$; $p = 0.03$) but, again, was reduced with the addition of social support at home (Model 5, $\beta = -2.44$; $p = 0.06$). Unlike with the women in the sample, social support at work, social support at home and social networks were not independently associated with depressive symptoms among men. Preoccupation with home at work and having a high control and high demand job were strongly associated with elevated depressive symptoms (almost 4 points on the shortened CES-D). Additionally, reporting a family friendly workplace was consistently protective of depressive symptoms in the models with work factors but, after controlling for home factors, this relation disappeared.

DISCUSSION

Poor employee mental health has implications on both the professional and domestic fronts and is an important issue for work-family research to address. Studies indicate that psychiatric disorders are associated with days of work lost, work cutback, decreased hours worked, and lack of job retention (Greenberg, Kessler, Nells, Finkelstein & Berndt, 1996; Kessler & Frank, 1997; Lim, Sanderson, & Andrews, 2000; Wang et al., 2007). At home, depression also has the potential to strain personal relationships and be associated with poorer health for family members. For example, research indicates that individuals who live

with a mentally ill family member report worse physical and mental health and poorer family functioning than family members not living with someone with a mental illness (Gallagher & Mechanic, 1996; Walton-Moss, Gerson, & Rose, 2005). Additionally, parental depression is associated with impaired cognition, behavioral issues, and psychopathology among children (Lyons-Ruth, Wolfe, & Lyubchik, 2000; Nicholson & Clayfield, 2004; Riley, et al., 2009).

With 88% of American families having children and at least one working parent (US Department of Labor, 2010), we sought to understand the role of parenting in mental health among employees balancing work and family demands. While the cross-sectional nature of our study does warrant a cautious interpretation, our results suggest that having a child 18 years of age or younger may be associated with a modest increase in depressive symptoms among employees in extended-care settings. Our findings regarding the role of parents are consistent with other literature that suggests child-rearing responsibilities pose a particular threat to one's mental health status. Evenson and Simon (2005 page 342) suggest that the "emotional benefits associated with parenthood are cancelled out, or exceeded, by the emotional costs associated with the role." Similarly, the Commonwealth Survey, a nationally-representative study in the United States that posed questions to parents about depressive symptoms over the past week and parenting behaviors, found that depression rates increased with increasing numbers of children in the home among women; men who reported being the primary child-care provider reported similar rates of depression as their female counterparts (Lyons-Ruth et al., 2000). While these studies did not address working parents explicitly, the literature indicates that the association between parental status and depressive symptoms applies to employed men and women and is potentially exacerbated by these dual demands (Ertel et al., 2008; Floderus et al., 2009).

Previous literature indicates that children with certain characteristics, such as younger age and special needs, may require additional parenting inputs and, thus, be more strongly associated with parental depression (Macintyre, 1992; Thorpe et al., 1991). We did attempt to investigate these nuances and found that child age was not associated with depressive symptoms in our sample. The nature of our data, however, precluded us from investigating how the number of children in the home, age spacing, or the presence of a child with disabilities affected depressive symptoms among parents working in an extended care setting. We encourage future research to identify data sources that offer this level of detail in order to address how specific child characteristics may impact parental health status.

We considered other work and family factors that may predict poor mental health status among working parents and found that the relation between depressive symptoms and presence of a child persisted with the inclusion of work-related factors in our models, such as family friendly workplace, total number of hours worked, and preoccupation with work at home. There was no relation between having a child and depressive symptoms when we included home factors such as wage earner status and preoccupation with home at work, which suggests that home factors may be more influential than work factors in ameliorating the effects of parenting on depressive symptoms. Still, work factors should be actively considered and incorporated into viable strategies to reduce work-family burden, particularly those that can be changed through workplace policies and informal practices (Pitt-Catsouphe, 2002; Wang, Lesage, Schmitz, & Drapeau, 2008).

Our results also point to the importance of social support, both at home and at work, in potentially mediating the effect of having a child on depressive symptoms. With the addition of social support at work into our models, having a child was no longer associated with depressive symptoms among the entire sample. Similarly, the magnitude of this association decreased with the addition of social support at home. Social support in general has been

hypothesized to buffer the effects of stressful events (Cohen, 2000; Kawachi & Berkman, 2001) and appears to protect against depressive symptoms (Plaisier et al., 2007) and job stress (Oginska-Bulik, 2005) among employed individuals. There is evidence that social support at work may be of particular importance for employee well-being. In this study cohort, Ertel found that social support at work, but not social support at home, buffered the effect of high strain jobs on depressive symptoms (Ertel et al., 2008). In a longitudinal population-based study in Finland, low social support at work (from supervisors and colleagues) and social support in private life were both predictive of depressive and anxiety disorder diagnosis. However, there was a stronger association between support at work and 12-month DSM-IV depressive and anxiety disorders than support at home (Sinokki et al., 2009). The authors of this study posited that support at work buffered the relation between employee stress and poor mental health as well as reduced perceived work-load.

In the current study, it is possible that support at work may also minimize spillover, a commonly used measure of work-family conflict (Frone et al., 1992), from work to home and buffer against the stress associated with parenting a child 18 years of age or younger. Additionally, as manager flexibility has been found to have positive effects on physical health (Berkman et al., 2010), it is plausible that support at work from supervisors may also offer tangible benefits, such as opportunities to care for ill children without negative work repercussions. While support at home did not significantly alter the association between parental status and depressive symptoms in this occupational cohort, it was independently protective of depressive symptoms. This finding is consistent with the vast literature that indicates that support received at home through quality marital relations offers emotional benefits that promote mental health (Rehman, Gollan, & Mortimer, 2008; Simon, 2002) and that social ties, in the form of friends, family, and the larger community, encourage “belongingness” and psychological well-being (Kawachi & Berkman, 2001; Lin, Ye, & Ensel, 1999). Among individuals balancing work and family demands, the potential benefits of support from friends and family outside the workplace are numerous and may range from having someone to talk to about stress, watch your children while you work, help with household chores, or provide financial support.

As part of our analysis, we assessed gender differences in the relationships among depressive symptoms, child status, and other work and family demands. We found that women who were parents experience more depressive symptoms than women without children, but that men with children experience fewer depressive symptoms than male non-parents. These results are likely due to the roles that men and women assume and how society perceives these roles. Despite increases in female labor participation, women continue to report that they spend more hours caring for children than men (3.8 versus 3.0 hours per day in 2008) (Galinsky et al., 2008) and that hours that men and women spend on household tasks has not changed significantly over time (Bianchi, 2000). Additionally, in the US, women are thought to expend a “tremendous amount of time, energy and money raising children,” referred by some as “intensive mothering” (Hays, 1996; Nomaguchi, Milkie & Bianchi, 2005). Thus, women may not only experience more work-family stressors, but the socially-constructed pressure to fulfill the role of mother may exacerbate these stressors and result in worse mental health status for women with children, compared to men. Similarly, as Barnett and colleagues describe, being a parent may be “less central to men’s sense of self” and may not conjure the same detrimental psychological effects, relative to women. She refers to the widely-accepted view of “man-as-worker” in which men base their worth on their role at the office and see home as a “haven ... to heal the wounds received while on the job (page 358).” In a random sample, longitudinal study, Barnett reveals that men’s psychological well-being may benefit by the role of parenting (Barnett, Marshall, & Pleck, 1992). Similarly, Eggebeen and Knoester (2001) suggest that the role of father may discourage men from engaging in risky behaviors and, therefore, contribute to better health.

Though deciphering the mechanisms that underlie gender differences in the relation between parental status and depressive symptoms are challenging given the cross-sectional nature of our analysis, our findings offer some insights into the specific work and home factors that impact this association and how they differ for women and men. Our results suggest that home factors may have the capacity to buffer against the effect of having a child on elevated depressive symptoms for women and to directly promote mental health among men. Additionally, forms of social support may be more effective mediators of depressive symptoms for women while workplace policies, job type (specifically low control/low demand), and spillover from home to work may have a greater impact of men's depressive symptoms. Understanding these nuances can assist employers and policymakers to conceptualize and implement gender-appropriate strategies to alleviate work-family stress and increase employee productivity.

It is important to note a few limitations in the current study. Our data are cross-sectional; thus we are confined in our ability to draw causal inferences regarding the effect of parental status on depressive symptoms. We cannot determine whether parenting burdens cause depressive symptoms or whether depressive symptoms affect parenting decisions, ability to parent, and/or participate in the labor force. A related issue is that of self-selection. Parents who work outside the home may have identified means of coping with work and family demands and, therefore, may be less likely to experience poor mental health than parents who feel that they cannot work because of home responsibilities. Another limitation of this study is the reliance on employee self-report for the measurement of mental health status and other employee information. In particular, mood-dependent recall may prompt employees experiencing depressive symptoms to report work and family stressors more negatively. However, it is unlikely that our primary exposure of interest—having a child 18 years of age or younger—was reported differently because of mood. Spillover, family friendly workplace, and social support/networks, on the other hand, could plausibly be reported more negatively depending on the mental health status of the employee. The accuracy of such data would be improved if administrative data or objectively-assessed conditions were used to complement or substantiate employee report. Another limitation exists in our data and precludes our understanding of the nuances of the association between having a child in the home and parental depressive symptoms. As other research suggests, it is possible that child spacing and child disability may influence this relation but, unfortunately, we were not able to test the relevance of these child characteristics with the available data. Finally, as this study was administered in the extended-care setting, these results may not be generalizable to individuals working in other sectors. Accordingly, these findings should be considered as preliminary, and future research should focus on establishing temporal sequencing of exposure to work and family stressors and the development of depressive symptoms among men and women balancing work and family responsibilities through longitudinal study design.

This study exhibits several strengths as well. Much of the previous literature on parenting stress has not explicitly considered work and family demands together, and the limited work-family literature that has focused on the role of parenting has produced inconclusive findings. Therefore, this study expands the work-family literature by assessing the association between parenting and employee mental health and the potential for other work and home stressors to impact this relation. Additionally, our analyses uniquely explore gender differences in this relation, with the aim of informing gender-appropriate workplace policies to protect against work and family stress. Finally, this research focuses on a working population particularly at-risk for home and work stressors. Our occupational cohort consists of predominantly low-income, racially and ethnically diverse women at extended care facilities, a setting that continues to expand rapidly and has been found to be emotionally and physically taxing (Geiger-Brown et al., 1994) due to the nature of direct

patient care as well as the heavy workload intrinsic to this environment (McVicar, 2003; Phillips, 1996).

The majority of men and women in the United States are currently employed and face demands in multiple realms of life, and it is crucial to identify which work and family stressors contribute to poor employee mental health status as well as the mechanisms by which they operate. In the current study, we found that having a child 18 years of age or younger is associated with slightly higher depressive symptoms among employees in extended-care settings. Additionally, we revealed that social support, particularly support experienced at work, may help to protect against the stressors involved with parenting and that gender differences may exist in the effect of parental status on depressive symptoms. The findings reported here are part of the first phase of the Work, Family, and Health Network Study. Ongoing experimental research, based on these early studies by the Work, Family, and Health Network study, should attempt to confirm our findings and make causal inferences about the impact of parenting and other work-family stressors on the mental health of employees. Additionally, we recommend that future research focus on investigating specific child characteristics such as child age, spacing, and disability as well as the overall impact of parenting for employees working in sectors beyond health care. This area of research has the potential to contribute substantially to the field of work-family research and inform family-friendly, gender-appropriate workplace policy, with the ultimate goal of promoting employee well-being in the workforce.

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TABLE 1

Correlates of Employee Depressive Symptoms: Descriptive Statistics ($N = 376$)

	<i>N</i>	<i>%</i>	<u>Depressive Symptoms</u>			<i>p</i> [*]
			<i>Mean</i>	<i>SD</i>		
Child under 19						0.04
No	209	55.6	6.20	4.41		
Yes	167	44.1	7.21	5.28		
Work Factors						
Family Friendly Workplace ^a						0.11
No	152	40.4	7.13	4.99		
Yes	224	59.6	6.32	4.71		
Number of Hours Worked at All Jobs ^a						0.71
35	100	26.6	6.49	4.78		
> 35	276	73.4	6.70	4.86		
Often Preoccupied with Work at Home						0.13
No	345	91.8	6.53	4.87		
Yes	31	8.2	7.90	4.38		
High Social Support at Work ^a						< 0.01
No	183	48.7	7.61	5.09		
Yes	193	51.3	5.73	4.41		
Job Strain						< 0.01
Low Control, High Demand	86	22.9	8.23	5.07		
High Control, High Demand	97	24.8	6.92	4.73		
High Control, Low Demand	124	33.0	5.19	4.15		
Low Control, Low Demand	69	18.4	6.90	5.19		
Home Factors						
Primary Wage Earner Status						0.02
No	163	43.4	5.99	4.57		
Yes	213	56.6	7.15	4.98		
Often Preoccupied with Home at Work						< 0.01

	Depressive Symptoms			
	N	%	Mean	SD
No	324	86.2	6.36	4.82
Yes	52	13.8	8.42	4.56
High Social Support at Home ^a				< 0.01
No	166	44.2	8.31	5.45
Yes	210	55.8	5.33	3.82
High Social Networks ^a				0.36
No	163	43.3	6.91	4.63
Yes	213	56.7	6.45	4.99
Sociodemographic Factors				
Age ^b				0.36
25	51	13.6	6.80	4.48
26–35	77	20.5	6.62	4.58
36–45	109	29.0	7.28	5.17
46–55	85	22.6	6.39	4.86
56+	54	14.4	5.67	4.77
Gender				0.13
Male	314	16.5	5.81	3.61
Female	62	83.5	6.81	5.03
Marital Status				0.05
Not Married	162	43.1	7.22	4.61
Married	214	56.9	6.21	4.97
Race				< 0.01
Non-Hispanic White	175	46.5	5.72	4.16
Non-Hispanic Black	124	33.0	7.80	5.68
Hispanic	27	7.2	7.93	4.36
Other	50	13.3	6.34	4.37
Education				0.02
Less than High School	50	13.3	6.14	4.66
High School or GED	106	28.2	7.76	5.27

	Depressive Symptoms				<i>p</i> [*]
	<i>N</i>	%	Mean	<i>SD</i>	
Some College	156	41.5	6.48	4.73	< 0.01
College or More	64	17.0	5.59	4.17	
Income ^b					
Lowest Tertile	90	23.9	8.39	5.39	
Middle Tertile	144	38.3	6.30	4.82	0.04
Highest Tertile	142	38.8	5.89	4.21	
Worksite					
1	59	15.7	8.17	5.39	
2	117	31.1	6.79	4.73	
3	96	25.5	6.13	5.03	
4	104	27.7	6.10	4.29	

^{*} Overall *p*-value for difference between categories

^a Modeled with additional categories in the analysis

^b Modeled continuously in the analysis

TABLE 2
Summary of Regression Analysis for Variables Predicting Employee Depressive Symptoms ($N = 376$)

Variable	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)
Child under 19	1.09*	0.54	0.94§	0.52	0.91§	0.53	0.82	0.53	0.62	0.52	0.60	0.51
Work Factors												
Family Friendly Workplace	-0.48*	0.23	-0.30	0.22	-0.27	0.23					-0.13	0.22
Number of Hours Worked at All Jobs	0.02	0.02	0.02	0.02	0.02	0.02					0.001	0.02
Often Preoccupied with Work at Home	1.78*	0.87	1.50§	0.85	1.44§	0.85					1.26	0.82
High Social Support at Work			-0.43**	0.10	-0.41**	0.11					-0.32**	0.10
Job Strain: Low Control, High Demand					0.95	0.77					0.98	0.74
Job Strain: High Control, High Demand					1.17§	0.62					1.27*	0.59
Job Strain: Low Control, Low Demand					0.64	0.76					0.32	0.73
Home Factors												
Primary Wage Earner Status							0.52	0.54	0.38	0.51	0.47	0.53
Often Preoccupied with Home at Work							1.23	0.70	1.05	0.67	1.08	0.66
High Social Support at Home									-0.87**	0.15	-0.76**	0.15
High Social Networks											-0.74*	0.32
R^2		0.13		0.13		0.11		0.19				0.23

§ $p < 0.10$;

* $p < 0.05$;

** $p < 0.01$

All models adjusted for age, marital status, race, education, household income, and worksite.

TABLE 3
Summary of Regression Analysis for Variables Predicting Female Employee Depressive Symptoms ($N = 314$)

Variable	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)
Child under 19	1.26 [*]	0.59	1.08 [§]	0.58	1.04 [§]	0.59	1.08 [§]	0.59	0.85	0.57	0.76	0.57
Work Factors												
Family Friendly Workplace	-0.32	0.27	-0.07	0.27	-0.04	0.27					0.07	0.26
Number of Hours Worked at All Jobs	0.02	0.02	0.01	0.02	0.01	0.02					-0.002	0.26
Often Preoccupied with Work at Home	1.96 [*]	0.97	1.62 [§]	0.94	1.58	0.95					1.46	0.92
High Social Support at Work			-0.54 ^{**}	0.12	-0.53 ^{**}	0.12					-0.43 ^{**}	0.12
Job Strain: Low Control, High Demand					0.65	0.89					0.82	0.86
Job Strain: High Control, High Demand					0.86	0.70					1.10	0.67
Job Strain: Low Control, Low Demand					0.34	0.88					0.10	0.85
Home Factors												
Primary Wage Earner Status							0.20	0.62	0.08	0.60	0.26	0.61
Often Preoccupied with Home at Work							0.99	0.79	0.80	0.76	0.95	0.75
High Social Support at Home									-0.84 ^{**}	0.17	-0.75 ^{**}	0.17
High Social Networks R^2											-0.93 ^{**}	0.36

[§] $p < 0.10$;

* $p < 0.05$;

** $p < 0.01$

All models adjusted for age, marital status, race, education, household income, and worksite.

TABLE 4
Summary of Regression Analysis for Variables Predicting Male Employee Depressive Symptoms (N = 62)

Variable	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6	
	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)	B	SE(B)
Child under 19	-1.83	1.39	-1.88	1.39	1.87	1.33	-2.82*	1.28	-2.44§	1.28	-2.03	1.23
Work Factors												
Family Friendly Workplace	-0.85*	0.43	-0.89*	0.43	-1.04*	0.43					-0.61	0.41
Number of Hours Worked at All Jobs	0.04	0.05	0.04	0.05	0.04	0.05					0.06	0.05
Often Preoccupied with Work at Home	0.18	1.89	0.47	1.91	-0.28	1.94					-1.80	1.81
High Social Support at Work			0.20	0.19	0.27	0.19					0.29	0.17
Job Strain: Low Control, High Demand					1.65	1.51					0.90	1.39
Job Strain: High Control, High Demand					3.61**	1.33					3.45**	1.22
Job Strain: Low Control, Low Demand					0.75	1.32					-0.45	1.24
Home Factors												
Primary Wage Earner Status					0.66	1.06			0.82	1.04	-0.25	1.02
Often Preoccupied with Home at Work					3.65**	1.33			3.44**	1.30	4.18**	1.37
High Social Support at Home									-0.52§	0.31	-0.55§	0.30
High Social Networks											0.77	0.58
R ²		0.14		0.14		0.22		0.21		0.24		0.37

§ $p < 0.10$;

* $p < 0.05$;

** $p < 0.01$

All models adjusted for age, marital status, race, education, household income, and worksite.