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Test of a Conceptual Model to Explain Television Exposure of Head Start Children

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Abstract

Excessive television (TV) viewing by children can lead to negative health and developmental outcomes. Using structural equation modeling, this study tests a conceptual model to understand social and familial factors associated with TV exposure among a sample of 767 Head Start families with children between the ages of 3 and 5. Fit statistics suggested that the overall model provided an acceptable fit to the observed data. Specifically, significant structural paths suggest that parents' social support impacts child TV exposure. Additionally, lower levels of social support were associated with significantly greater parental stress, which also predicted child TV exposure. Findings suggest that, to combat excess TV exposure among children, physicians and other team members of the patient-centered medical home may benefit from broad-based interventions that address familial factors. Urging parents to turn off the TV could fail to address the underlying causes of child TV intake.

Keywords

television; children; parental stress; social support; head start

Introduction

Many children are exposed to much more screen time than is recommended by the American Academy of Pediatrics (AAP).¹ Excessive television (TV) intake among children is linked to undesirable health behaviors including decreased physical activity² and poor dietary habits.^{3,4} Excessive TV intake is also associated with a host of less-optimal health outcomes for children including poor sleep⁵, decreased insulin sensitivity⁶, increased body fat^{7,8}, and an elevated body mass index (BMI)^{9,10}. These negative effects are long lasting. Children who

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Ethics approval:

This project was approved by the IRB of the University of Arkansas for Medical Sciences as secondary analysis of existing data under an expedited protocol (133672) without consent given that records were record reviewed and de-identified.

Declaration of Conflicting Interests:

Dr. Leanne Whiteside-Mansell and UAMS have a financial interest in the technology discussed in this publication. These financial interests have been reviewed and approved in accordance with the UAMS conflict of interest policies.

watch TV in excess are more likely to become adults with decreased cardiovascular and respiratory fitness, and increased cholesterol and BMI¹¹. Those who experience excessive TV intake in childhood are more likely to continue watching TV into adulthood, and thus continuing the behaviors that affect BMI¹².

Excessive TV exposure is also associated with less-optimal development in the cognitive and socio-emotional realms. Preschool children with elevated TV exposure may exhibit poor language development^{13,14}, increased inattention and hyperactivity^{15,16}, disrupted play¹⁷, decreased cognitive capacity¹⁸, and delayed motor development¹³. One study found that increases in TV watching time at age 29 months were associated with declines in math and vocabulary skills, and may impact a child's confidence and self-assertion, leading to a greater likelihood of victimization in school¹⁹. Early, excessive TV intake may also have long-term negative impacts on socio-emotional outcomes. For example, TV intake in childhood (mean taken from 5, 7, 9, and 11 years old) was related to increased attention problems in adolescence²⁰ and decreased educational attainment in adulthood¹¹.

An array of family and home factors likely impact the use of TV in families with young children including ethnicity, family TV viewing habits, family socioeconomic status, and maternal depressive symptoms^{21,22}. For example, even background TV exposure (i.e., while the caregiver is watching TV or during meals) is associated with poor outcomes in young children, including reduced parent-child interactions and lower reading levels²³. The current study proposes and tests a conceptual model to explore conditions that are associated with excessive television viewing for children. Findings can inform appropriate intervention for families in medical settings.

Conceptual model

Neighborhood quality, social support, and TV—Social capital theory provides a framework to understand the social relations of families in disadvantaged neighborhoods. Specifically, social capital theory purports that families in low-quality neighborhoods are likely to experience decreased quality of social networks and reciprocal relationships compared to families living in higher-quality neighborhoods²⁴. Supporting this theoretical assertion, Turney and Harknett²⁵ found that mothers who moved to less-advantaged neighborhoods reported a significant decrease in support. A potential reason for these lower levels of support is that neighborhood reputation is predictive of social trust²⁶. Consistent with this, higher maternal perceptions of neighborhood collective efficacy is related to less TV viewing for children²⁷. To protect themselves, families residing in unsafe areas may intentionally isolate themselves from other families.

Social isolation is a potentially important factor in understanding why neighborhood disadvantage is related to increased TV exposure. Studies suggest that TV viewing is sometimes used as replacement for social interaction. For example, Finn and Gorr²⁸ found that social support is negatively related to a social-compensation motivation for TV viewing. Bickham and Rich²⁹ found that children who spend more time watching violent TV programs spend less time with their friends. Conversely, loneliness is positively related to a social-compensation motivation. In a related study, lonely persons reported an increased use of movies and TV, and infrequent engagement in social activities and interactions with

family or friends. People identifying themselves as lonely were also less intentional in their viewing (i.e., plan to watch the news or specific programming), and instead watch TV passively³⁰.

Neighborhood quality, parenting stress, and TV—Parents in low-quality neighborhoods face a unique set of challenges. Factors outside the home are likely to create demands on parents' resources (psychological, financial, etc.), which create stress and impact a parent's involvement with their child³¹. For example, 3-year old children who live in neighborhoods that their mothers perceive as unsafe are significantly more likely to watch >2 hours of TV per day³². Consistent with this finding, a recent study found that girls who perceived their neighborhood to be unsafe had 4.8 more hours of screen time each week than girls who had no neighborhood concerns³³. In fact, neighborhood quality has been identified as an important predictor of TV intake beyond that of parental limit setting³⁴.

In addition, neighborhood disadvantage is related to increased psychological stress^{35–37}, chronic stress symptoms³⁸, and parenting stress³⁹. In the midst of this strain, parents may use TV intake as a parenting strategy to educate, pacify, and/or babysit their children. Stressed adults are also more likely to watch TV themselves^{40,41}, which increases the amount of TV exposure for children in the home. Consistent with these studies Ribner et al⁴² identified a correlation between socioeconomic status, excessive TV viewing, and attributes such as executive function and school readiness – with the association being strongest in low-income children who exceeded the TV watching times suggested by the AAP. Neighborhood quality may help to explain this observed relationship.

Social support and parenting stress—Parenting stress is likely to be exacerbated in the absence of social relations. (For a review on the link between social support and mental health, see Kawachi & Berkman⁴³.) For example, neighborhood disadvantage is *less* likely to lead to depression for people with social support⁴⁴. Social support is also documented as a stronger predictor of mental health than even physical environment⁴⁵. Another study found that higher levels of emotional and instrumental social support are related to decreased psychological distress among African American mothers in low-income neighborhoods⁴⁶. Similarly, immigrant Latina mothers who lack a family support system may be more likely to use TV intake both as a babysitter and as a tool to learn English⁴⁷.

The current study—Given the host of negative psychical and psychosocial outcomes associated with TV exposure for children, medical professionals would be well-served to understand and address factors that impact children and families in this area. The objective of this study is to test a conceptual model examining neighborhood quality, parent social support, and parental stress as potentially important social and familial factors for understanding child TV intake. Figure 1 provides a representation of the proposed theoretical model tested in this study.

Based on extant literature and theory, social interaction and parental stress are hypothesized as mechanisms through which neighborhood quality impacts child TV exposure. It is proposed that parents in unsafe neighborhoods will replace social interactions with TV intake, that increased levels of parenting stress due to neighborhood quality will also result

in more TV exposure in the home, and that parental stress in this context will be impacted by the level of social interaction. No direct path is proposed between neighborhood quality and TV exposure, because the signs of the proposed indirect effects are opposite, which (if appropriate) would coincide with a near-zero direct effect between neighborhood quality and TV exposure⁴⁸.

Materials and Methods

Procedure

The Family Map (FM) interview was adopted by 20 Head Start centers located in an urban area ($n = 53$ classrooms) and in six centers in rural areas ($n = 17$ classrooms). In these classrooms, teachers were trained in the use of the FM during a 2–4 hour session (depending on the training time allotted by each site's administration). Training included information about the intent of the interview questions, the impact of the parenting and home environment on children's learning outcomes, identification of risks to suggest goals for the family, and the use of nonjudgmental interview techniques to avoid influence on participant responses. Teachers also watched videos of interviews to learn proper administration of questions. FM interviews were then conducted during the biannual home visits in the fall and spring. The research team, under Institutional Review Board protocol, conducted a record review of these interviews. Family Maps were scanned using Remark OMR software, stripped of all identifying information, and exported to SPSS software.

Participants

Participating Head Start centers adopted the FM as an interview to be used in the federally required, biannual home visits. All parents with a child in the Head Start centers were required to complete the FM interview with their teacher during their fall and spring home visits. Due to program withdrawal, 268 families that were interviewed in the fall could not be interviewed in the spring. In total, 767 primary caregivers completed a FM interview at two time points. See Table 1 for demographics provided from the fall interview. Most frequently, interviews were with the mother or mother figure (86.3%). Centers that were involved in the study served Head Start families in both urban (74.7%) and rural (25.3%) settings of a southern state. Over half of the families were African American (55.7%) with Hispanic (17.8%), White (20.8%), and other (5.6%) ethnicities comprising the rest of the sample. English was the main language spoken in the home for 77.3% of families. The responding caregiver reported being employed 71% of the time. Most caregivers reported having at least a high school education or equivalent (84.6%) and more than half were married or with a significant other (59.9%). On average, there were 2.26 children in the home in addition to the target child. Many families (38.7%) reported moving one or more times in the previous year.

The Family Map

The FM is a semi-structured interview composed of 12 modules that assess key aspects of the family and home environment, which are important for healthy development in 3- to 5-year-old children⁴⁹. The FM aids childcare providers in systematically identifying areas of concern and strength in order to best design interventions and reduce risk conditions for

families (e.g., daily routines, parent mental health, nutrition, safety issues) or promote conditions associated with child well-being (e.g., variety of experiences, monitoring and supervision, family cohesion). Each module consists of survey and observational items that assess risks and target a specific aspect of the family that is impactful for the child. Items in the measure were compiled from a larger pool of existing assessment tools used in national studies of low-income families.

The FM exhibits strong test–retest reliability over a 2-week period when conducted by both teachers and trained research staff⁴⁹. All items implicated in this study exhibit test–retest reliability beyond 0.63. Validity of the FM tool is also supported by risk estimates of the FM, which align with national risk estimates in similar populations to the validation samples^{49,50}. The overlap shown between risks in the subsections of the FM reflects established risk patterns in the extant literature, which provides evidence of convergent validity⁵¹. Constructs in the FM have also been validated by showing strong correlations to direct observations of conditions in the home, and correlation to independent assessments of risk by standard instruments in the field⁵⁰. Four modules of the FM are relevant to this study and are described below.

Neighborhood quality—This module is composed of items focusing on violence and crime exposure in the home and neighborhood. Items were originally developed for the Early Head Start Research and Evaluation Project⁵² and the study of the Fast Track program⁵³. The first item asked of parents: (1) how often they thought of moving to another home because of the safety of their neighborhood (1 = Never, 4 = All of the time). The other two items asked about the seriousness of problems with: (2) the selling and use of drugs (1 = Not Serious, 4 = Very Serious) and (3) muggings, assaults, and burglaries (1 = Never Happen, 4 = Happen Very Often) in their neighborhood.

Social support—This module includes items focused on family social support and integration into the community. These items originated from the national Infant Health and Development study⁵⁴. Participants were asked about how often in the past month they had participated in: (1) a neighborhood or community organization, committee, club, or sports team; (2) church service or other religious club or activity; or (3) hobby or sport with a friend (1 = None, 4 = More than once per week).

Parenting stress—This module had three items relevant to our study originating from the Parenting Stress Index⁵⁵. Caregivers rated their agreement (1 = Strongly Disagree, 4 = Strongly Agree) with items reflecting potential parenting stress. These statements were: (1) “I feel that my child is much harder to care for than most children his/her age”; (2) “When I do things for my child, I get the feeling my efforts are not appreciated”; and (3) “Sometimes the punishment I give my child depends on my mood.”

Television exposure—Families were asked two questions: (1) how many hours per day their TV was on, even if no one was watching it; and (2) about how many hours per day the child watches TV. To also achieve local identification for this construct, these indicators were restricted to be tau equivalent in measurement-model estimation.

Analysis approach

Data were cleaned and prepared in SPSS Version 19⁵⁶ and imported into MPLUS Version 6.12⁵⁷ for model construction. The sample size of 767 satisfied the ideal of 20 cases per estimated parameter ($q = 27^{58}$). Bootstrapping was selected to estimate path parameters and model fit. Bootstrapping is a nonparametric technique with fewer assumptions⁵⁹ than a typical regression or structural equations model. Rather than relying on assumptions about underlying distributions, a sampling distribution is empirically generated from the sample data. The two elements of identification were satisfied: (1) the degrees of freedom for the model were greater than zero; and (2) each latent construct was scaled to a metric⁵⁸. The Unit Variance method⁵⁸ of scaling was selected for this study because (a) the metric of the manifest variables was not meaningful for the exogenous constructs, (b) there was no information to indicate the relative or absolute reliability of the indicators to inform the selection of the reference variable, and (c) standardized regression coefficients were desired for clarity in interpretation. As recommended by McDonald and Ho⁶⁰, the two-step method of model specification was used. First, a confirmatory factor analysis (CFA) confirmed that the proposed measurement model was of appropriate fit. Thereafter, structural relationships were added and fit was assessed again.

Missing percentages showed that missingness was <7% for 17 of the 19 manifest indicators. Two indicators for Neighborhood Quality (questions about drugs and muggings) demonstrated the highest missingness at ~20% each; this is possibly due to the sensitivity of these questions. At 20% missingness, full information maximum likelihood (FIML) performs better compared with having complete data, providing accurate estimates when data are missing completely at random (MCAR), or erring on the conservative side of SE estimation when data are missing at random (MAR;^{61,62}). Thus, FIML was used to manage missing data.

Results

Television exposure

In this sample, 67.9% of families reported that their child watched TV for 2 hours per day. Most commonly, families reported that their child watched 1–2 hours per day. An additional 15.6% reported that their child watched 2–3 hours per day. The number of hours reported when the TV was on in the home was greater than the number of hours when children were actively watching. Only 22.8 % of families indicated that their TV was on <2 hours per day. In fact, 42.8% of families had the TV on 4 or more hours per day; 12.2% of the total sample had the TV on for 10 or more hours per day.

Model fit

The CFA exhibited adequate fit indices. The root mean square error of approximation (RMSEA) for the measurement model was 0.02 (CI = 0.00; 0.03); the standardized root mean square residual (SRMR) was 0.03; and the comparative fit index (CFI) was 0.988. The chi-square value was also nonsignificant; $\chi^2(39) = 49.18, p = 0.13$. Standardized factor loadings were 0.59, 0.68, and 0.80 for Neighborhood Quality; 0.59, 0.52, and 0.45 for Social

Support; 0.54, 0.80, and 0.64 for Parent Stress, and 0.44 and 0.83 for TV Exposure. All loadings were significant.

The structural model demonstrated good fit as well: RMSEA = 0.02, CI = 0.00, 0.03; SRMR = 0.03; CFI = 0.99; and $\chi^2(39) = 49.88, p = 0.11$. A significant specific indirect effect was observed from Social Support to Parenting Stress to TV Exposure ($t = -2.32, p = .02$). Paths from Social Support to TV Exposure ($t = -2.70, p = .007$), Social Support to Parenting Stress ($t = -3.92, p < 0.001$), and Parenting Stress to TV Exposure were significant ($t = 2.56, p = 0.01$). However, the total indirect effect between Neighborhood Quality and TV Exposure was nonsignificant. R^2 values indicated that the model accounted for 9.6% of the variance in TV Exposure, 5.9% of the variance in Parenting Stress, and <1% of the variance in Social Support. Figure 2 presents standardized factor loadings, residual variances, and path estimates with significance indicated. Direct, indirect, and total effects for the cross-sectional models are given in Table 2.

Discussion

In this study of low-income parents of 3- to 5-year-old children, parenting factors of stress and social isolation/support were linked to more TV exposure. However, the quality of the neighborhood was not a significant predictor of these parenting factors. Parental social support demonstrated both a direct effect on TV exposure and an indirect effect through parenting stress. That is, availability of a parent's support systems was directly and negatively related to TV exposure for the child. Additionally, a lack of social support was associated with greater parenting stress which, in turn, resulted in more TV exposure. Thus, besides the lack of influence of neighborhood quality, findings were consistent with previous research^{28,40,46,63} on the relationship between social support and parenting stress and the contribution of those factors to excessive TV exposure.

The lack of an association between the quality of the neighborhood and parenting factors suggests a more complicated influence. For example, although other studies have found a link between the parent's perception of the neighborhood and the use of TV, children in some areas (e.g., public housing) were more active, but also watched more TV than low-income children not in public housing²⁷. However, parents may lack social support for reasons that are unrelated to their neighborhood, such as the family poverty status⁶⁴.

The role of health care professionals in decreasing children's TV exposure

Screen for TV Exposure—Consistent with previous research, our study finds that over one-third of children 3 to 5 years old were actively watching TV for >2 hours per day. Further, children in our sample were exposed to high levels of TV even when they were not actively watching. For some children (12.2%), it was likely that the TV is always on in their home. This is consistent with a recent study, which found that parents held a belief that background TV exposure (when the parent viewed or during meals) was of no harm²³. This indicates a need for parent education from health care providers.

In response to concerns about the effects of media on child health and recognizing that many families are impacted by this issue, the AAP has recently updated its media use policy. The

new recommendation places value in unplugged time, hands-on social play, and the development of a media plan that is individualized to each child. The most recent guidance recognizes the complexity of making recommendations to families in a time when “mobile technology is ubiquitous”⁶⁵ (p 503). Specifically, age-based recommendations from the AAP include that media use should be limited to video chatting for children under 18 months and that parents should limit media for children 18 to 24 months of age to that which is high quality and viewed with the parent. Children older than two are advised to limited media to 1 hour per day. Further, all children should avoid media use in their bedrooms, during playtime, one hour before bed, and at meals. Additionally, the AAP recommends that pediatricians should take a detailed media history on children or teens who present with such health issues as aggressive behavior, overweight or obesity, difficulties in school, or use of tobacco, alcohol, or other drugs (Council on Communication and Media⁶⁶).

The AAP directs physicians also to encourage parents to discuss food advertisements (which often focus on unhealthy foods) and proper nutrition with their children⁶⁷. Physicians are encouraged to discuss the importance of “unplugged” play in helping a child to learn to think, solve problems, and develop reasoning skills. Specifically, encouraging families to read together instead of watching TV together is proposed as a meaningful intervention⁶⁸. Given the high levels of TV exposure reported in our study, findings suggest that families may benefit from this information within the context of a broader approach that recognizes underlying reasons for TV use in the home.

Despite these recommendations, most pediatricians seldom spend time educating parents about guidelines for TV intake⁶⁹. Pediatricians’ cite barriers to addressing media use with parents to include a perceived lack of parental motivation and the likelihood of behavior change, which results in a sense of futility for their efforts⁶⁹. Physicians also described a lack of time to address media use along with having to address other recommendations during the visit. However, when implemented, brief office-based counseling has been shown to be effective in decreasing media time for children⁷⁰ and parents were mostly in agreement with the recommendations of limiting media use⁷¹.

Address factors that impact TV exposure—Our study builds on existing recommendations, which suggest that broader psychosocial factors of the familial context may contribute to excess TV exposure. Clinical screening tools designed to measure and inform prevention and intervention efforts should include these important social determinants of health. Potential intervention targets suggested by our model include assisting patients in identifying (a) opportunities for parents to extend their social networks and (b) coping mechanisms for stress.

This possibility may seem daunting, given that providers reported a limited time to even screen for TV exposure. In our study, Head Start families that participated in the FM interview were connected to a set of resources specific to the needs identified in the interview. This is consistent with Head Start’s model of two-generation interventions aimed at increasing child health and well-being through addressing family needs⁷². At present, there are no large-scale implementation or evaluation studies of similar two-generation approaches in a health care setting.

A systematic approach to addressing TV and media intake in primary and preventive care is lacking. Further, there is no anticipatory guidance to caregivers for addressing parent and familial factors during pediatric visits. That is, none of the required standard recommendations during well-child visits include assessment and management of caregiver stress, provision of resources on coping skills, or suggestions for building social support systems in their community. Increasingly, patient-centered medical homes (PCMH) are charged with addressing the needs of the whole patient in the “context of family and community (p 602)”⁷³, and this study underscores the need for such an approach.

The few studies that address broader familial factors through the health care system have shown promising results. For example, studies on the effects of screening for maternal stress and depression have found that this approach was appreciated by mothers and effective in diagnosis and treatment^{74,75}. Gruver et al.⁷⁶ found that a Facebook-based peer group intervention (including posts, videos, and optional meetings) was both feasible and acceptable to low-income mothers who were recruited at urban primary care practices because their infants were at high risk for obesity. This innovative framework permitted other members of the health care team (e.g., care managers, dietary educators, social workers) to assist physicians in educating parents while reducing the burden of these efforts within a clinical visit. Also, children with ADHD in health-care settings with an existing PCMH approach experienced significantly greater improvement in health-related outcomes than children receiving care in settings without a PCMH approach⁷⁷. Strategies to prevent and reduce TV and media exposure that recognize the familial context of children are consistent with such a patient-centered model of care.

Several programs across the country, like the WE CARE project⁷⁸ and the Health Leads program⁷⁹ have shown that a multi-disciplinary team-based PCMH approach can be effectively used to screen and address the social determinants of health. Garg et al.⁸⁰ discuss several strategies including colocating community-based resources, utilizing home visiting programs and designing and integrating multi-disciplinary primary care initiatives to address these social determinants.

Also, providers and their PCMH staff can be educated on (1) the association between the social determinants and TV viewing, (2) guidelines and processes to screen for media use, parental stress, social support and neighborhood quality and (3) the availability of community resources. Such training has been shown to result in increased referrals and more parental discussion of these topics⁷⁹.

Further research is needed to study implementation and to document effectiveness of other innovative health care-centered efforts to address TV exposure and also important social determinants of health, such as parental social support and stress. The screening and referral process used through the FM tool in our study could inform that work. Several options for clinical screening of social determinants of health are emerging⁸¹.

Limitations

Our model is only one possible model representation of how social factors may impact child TV exposure. Future studies should test alternative models and test this model in different

settings. On average in this sample, 9% of the variability in TV exposure was accounted for by our model. For individual families, the importance of these factors may be more or less related to TV exposure in their home. Further, our main focus was on TV exposure. It is clear, however, that other types of media time (including cell phones, tablets, and computers) have similar propensities for negative health outcomes in young people—even preschool children. The AAP has noted that producing useful guidelines that keep pace with digital innovations, such as apps designed specifically for young children, is difficult⁸².

The cross-sectional nature of this study does not allow for the temporal progression between measurement occasions that would be needed to demonstrate causal mediation processes⁸³. As such, findings should be interpreted with caution. Future studies should gather multiple waves of these constructs to estimate their associations over time while controlling for prior levels. The theory-implied relationships should be studied longitudinally.

Finally, an additional limitation is the nature of the measurement of neighborhood quality in this sample. A wider family income range may have resulted in a greater variance in neighborhood quality. This may help to understand the overall weaker link found between neighborhood and TV exposure than was found in previous studies. Causal validity in future studies could be improved by studying families who have experienced a recent move⁸⁴. Restricting the sample in this way would increase the chances that changes over time in stress and social support were related to the neighborhood (i.e., provide a natural experiment).

Conclusion

Consistent with recent research on the value and need to address social determinates of children's health⁸¹, the current study suggests that effective efforts to reduce child TV exposure may need to go beyond simply screening for and educating families about the ill-effects of TV. Broad-based efforts are needed, which include clinic-based assistance by social workers and counselors, along with referrals to community-based programs that focus on nutritious food, safe and affordable housing, and programs that provide healthy exercise and educational assistance for children. By partnering with families to reduce TV exposure, health care professionals can contribute to a decreased obesity risk and improved health for children^{85–87}. The patient-centered medical home team (including pediatricians and family medicine physicians) is well situated to work with parents to ensure that children's TV exposure is kept at a manageable limit.

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Figure 1.
Conceptual model of child television exposure

Figure 2.
Model estimates
** $p < .01$. Standardized estimates are shown.

Table 1

Caregiver demographics

	Total, % (N = 767)
Ethnicity	
African American	55.7
White	20.8
Hispanic	17.8
Other	5.6
Education	
No HS diploma/no GED	14.8
HS graduate/GED	36.0
Some post-secondary or vocational ed	49.1
Primary caregiver employed	71.1
Respondent is female	85.4
Primary caregiver has partner/married	60.2
Urban	70.4
Target child is female	51.9

Table 2

Effect estimates

From, To	Direct effect (SE)	Indirect effect (SE)	Total effect (SE)
Neighborhood Quality, Parent Stress	0.04 (0.06)	0.02 (0.02)	0.06
Neighborhood Quality, Social Support	−0.07 (0.07)		−0.07 (0.07)
Neighborhood Quality, Television Exposure		0.03 (0.02)	0.03 (0.02)
Parent Stress, Television Exposure	0.17 (0.06) **		0.17 (0.06) **
Social Support, Television Exposure	−0.24 (0.09) **	−0.04 (.02) *	−0.20
Social Support, Parent Stress	−0.25 (0.06) **		−0.25 (0.06) **

Unstandardized path coefficients (with SE) provided.

*
 $p < 0.05$;

**
 $p < 0.01$.