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Mothers' Perspectives on Managing the Developmental Delay of a Child With Considerations for Contextual Influences and Maternal Functioning

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Abstract

Developmental delay in very young children is trending upward. Maternal depressive symptoms are known to negatively impact child development and may also impact family management of the child's condition. Research on family management guided this second phase of a sequential mixed methods study. The purpose of this study was to explore mothers' perceptions of family management of their children's developmental delays. Mothers of very young children who received early intervention services were interviewed. A team-based content analysis approach revealed key findings: (a) views of the child that were not holistic, (b) condition management ability was informed by what the mother thought her child needed, (c) views of condition impact were related to adapting to possible child outcomes and experiences of isolation, and (d) parental/caregiver mutuality was impaired by conflict. Understanding perceptions of family management and influence of depressive symptoms in this context is essential to extend assessment and intervention.

Keywords

mothers; children; developmental delay; depressive symptoms

When a child has a developmental delay, the family is charged with managing the child's health and development while intersecting with multiple systems including health care, local agencies, and early education. In the United States (U.S.), about one in six children are reported to have developmental delays associated with such conditions as autism spectrum disorder, attention deficit hyperactivity disorder, speech pathology, or learning/intellectual

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disabilities (Boyle et al., 2011). Remediation efforts that are increasingly aimed at educating families to support child development could be thwarted, however, when a mother's family management of the child's condition is suboptimal.

The U.S. Individuals With Disabilities Education Improvement Act of 1990 included a mandate for early intervention (EI) services administered through state agencies to improve long-term cognitive and academic outcomes for children with developmental delays (U.S. Department of Education Office of Special Education Programs, 2004). Very young children (<3 years old) who score 1.5 standard deviations below the mean for at least one area of development are typically eligible for EI services, including speech/language, physical, and other developmental therapies. The number of children meeting the criteria for developmental delay and receiving EI services in the U.S. is increasing annually, with more than 350,000 receiving EI in 2016; double the number of children two decades ago (Early Childhood Technical Assistance Center, 2017). Of the recently estimated 2.8% of children who receive EI services (Adams & Tapia, 2013), a widening proportion are from underserved and high-risk families (Rosenberg, Robinson, Shaw, & Ellison, 2013).

Although a long-standing focus has been on the child, the design and recognized value of EI as a collaborative effort involving service providers and parents has varied. As highlighted over the past decade, EI is most effective when parents are positively engaged with the child and incorporate intervention activities into daily life (Barton & Fettig, 2013; Kasari, Gulsrud, Wong, Kwon, & Locke, 2010). Thus, increases in the number and diversity of children substantiate the need to understand how families manage child delays and disabilities, and use services, to ensure positive outcomes. The benefits of EI for the child, however, can be influenced by sociocultural norms, as well as the mother's mental health and child care demands.

The sociocultural norms experienced by a child includes the language spoken in the home as well as expected parental roles. Children in families with less English than another language spoken in the home can be at a disadvantage in English-speaking schools (August & Shanahan, 2006; National Task Force on Early Childhood Education for Hispanics, 2007). In the U.S., Spanish is the most common non-English language spoken in the home (Gonzalez-Barrera & Lopez, 2013). When considering home environments with low socioeconomic resources, being a child in a Hispanic, non-English speaking U.S. household has been associated with increased odds of having possible and probable developmental delays (Simon, Pastor, Avila, & Blumberg, 2013). Although resources are a factor, Spanish-speaking mothers and fathers appear to exert strong, and different influences on how and to what extent a language is used in the home which, in turn, determines English learning opportunities for the child (Branum-Martin, Mehta, Carlson, Francis, & Goldenberg, 2014). Sociocultural norms related to the language spoken in the home, as well as the complexities of parental role expectations could be important since compared with families speaking primarily English, those speaking primarily Spanish perceived that EI was less helpful and reported worse child outcomes (Olmsted, 2010).

Mothers caring for young children are more at risk for poor mental health than women without children (Evenson & Simon, 2005; Nomaguchi & Milkie, 2003). When a mother

cares for a child with special health care needs such as developmental delay, she is vulnerable to encountering depressive symptoms (Churchill, Villareale, Monaghan, Sharp, & Kieckhefer, 2010; Jellett, Wood, Giallo, & Seymour, 2015). A mother's depressive symptoms can pose particular risk to the very young child with developmental delay. These symptoms are known to compromise mother-child engagement and impair the child's neurocognitive, psychomotor, and socioemotional development (Field, 2010; National Research Council and Institute of Medicine, 2009). These areas of development are vulnerable during a child's rapid brain growth during the first years (Drury, Scaramella, & Zeanah, 2016). Thus, the risk factor of maternal depressive symptoms is especially concerning when a family has a child with a developmental delay. A recent study indicated that 34% of mothers with children receiving EI services experienced significant depressive symptoms (Beeber et al., 2017). It has also been shown that mothers of children with later onset of developmental delays experienced more depressive symptoms compared with mothers of children identified at risk for developmental delays at birth (Feinberg, Donahue, Bliss, & Silverstein, 2012).

Family size that includes a child with special health care needs along with siblings, notably siblings with delays, represents risk to mothers for being overburdened with caregiving demands (Brown & Clark, 2017; DeRigne & Porterfield, 2010). When fathers are able to engage as parents, the burden of caregiving demands and negative mental health can be alleviated for mothers (Laxman et al., 2015). Such family dynamics could be particularly relevant since evidence suggests that mothers are more vulnerable to depressive symptoms than fathers. A father's influence on family functioning through engagement in child care and additional support for child development appears to be a potential strength to be assessed (Brown & Clark, 2017).

Countries vary on government services providing screening, assessments, and interventions to support healthy functioning, and more specifically, the same variation was found for screening and referral services focused on maternal depressive symptoms. Screening and referrals for depressive symptoms among mothers over the perinatal time are more common in countries other than the U.S. The Child Health and Parenting Service in Australia and Tasmania includes universal screening for mental health needs with intervention if indicated at no cost to the mother (beyondblue, 2018). The United Kingdom among many European countries, and Canada provide similar but decentralized services, often involving waitlists (Underwood & Frankel, 2012). In the U.S., screening and referrals are provided much less consistently, and the burden of treatment cost is typically shifted to the family. At both the agency and policy levels in the U.S., compromised maternal mental health with the potential to negatively affect child health and development, has recently been recognized as affecting EI (Adams & Tapia, 2013; Alvarez, Meltzer-Brody, Mandel, & Beeber, 2015). Yet in the U.S. or other countries, the systematic incorporation of screening for risks in the family, such as for maternal depressive symptoms, in conjunction with EI programs still appears lacking.

Thus, the purpose of the current study was to describe mothers' perceptions of family management of delays in child development when the cause is not yet known in families expected to vary on contextual influences and maternal functioning. The contextual

influences and maternal functioning explored in this study included social experiences and cultural norms within the family, as well as maternal depressive symptoms, and demands met by mothers with or without partner and family support.

Theory on Family Management

The theoretical work that guided this study included the Family Management Style Framework, and dimensions of the Family Management Measure (Knafl et al., 2011; Knafl, Deatricks, & Havill, 2012; Knafl et al., 2013). This framework has offered a valuable explanation of how parents' perceptions of family management reveal a family-level response to child health issues. The related Family Management Measure was developed to capture variation in several dimensions descriptive of a parent's and couple's view of the child, and approach to management of a child's condition. The six scales of the Family Management Measure below represent these dimensions (Knafl et al., 2018):

- Child's Daily Life includes how a parent thinks of the child's identity, and views the child from day to day.
- Condition Management Ability reflects whether a parent thinks s/he can address the needs of the child in a competent manner, how difficult this is, and the inherent philosophy (priorities, beliefs, and values) that inform the parent's management approach.
- Condition Management Effort draws on the parent's determined investment in management based on ideas about the origin, severity, and predictability of the child's condition.
- Family Life Difficulty elicits the parent's evaluation of how challenging or satisfying it is to manage the condition, and also the extent to which treatments or other care have been embedded in the family's everyday routine.
- View of Condition Impact prompts the parent's response on how management will be achieved in the future based on condition severity, as well as how this condition has and will affect the child and family.
- Parental Mutuality is intended for partnered parents caring for the child, and focuses on discerning whether their views of the child are similar, and if the approaches to parenting and condition management are compatible and satisfactory.

Based on a recent examination of the measure, a family-focused pattern of responses characterized parents who integrated care for a child's chronic condition into a daily routine in a way that the condition was not the focal point for the family. This family-focused pattern of family management was also linked with better family functioning and child adaptation compared with a condition-focused pattern (Knafl et al., 2013). Mothers' perceptions of family management of child developmental delays and uncertain trajectories, however, have not previously been considered. With an understanding of family management in this context, it could be possible to enhance assessments of mothers and their families when EI services are provided.

Method

Participants

The findings reported here are based on data collected from a sample of mothers of very young children enrolled in or transitioned out of EI services provided in a southeastern state in the U.S. during the second of a two-phase sequential mixed methods study. Results of the first phase of the study highlighted the scope and severity of depressive symptoms and link to low self-efficacy among mothers in this sample. Description of the original sample, and detailed results from the first phase of the study are reported elsewhere (Beeber et al., 2017). The sample for the second phase of the study was determined by using stratified purposeful sampling of subgroups expected to vary based on key characteristics to facilitate comparisons (Patton, 2002). Sampling characteristics were drawn from the literature primarily regarding risks for compromised maternal functioning and child development, and also informed by data collected during the first phase of this study. These risks included limited English language proficiency as a risk for the child and as a proxy for family sociocultural norms (Brooks-Gunn & Markman, 2005; Catts, Fey, Tomblin, & Zhang, 2002; National Task Force on Early Childhood Education for Hispanics, 2007); maternal depressive symptoms (Albright & Tamis-LeMonda, 2002; Beeber et al., 2017; Cabrera, Shannon, & La Taillade, 2009; Dix & Yan, 2014); and child care demands (Grey, Schulman-Green, Knafl, & Reynolds, 2015). As shown in Figure 1, characteristics based on mothers' reports during the first phase of the study were used for this stratified purposeful sampling approach during the second phase of the study. Mothers were sought based on preferred language. Within each language group, mothers were sought based on quantified scores indicating depressive symptom severity. Within these groups, mothers were sought based on the number of children living in the home under the mother's care. The mothers comprising this smaller sample drawn from the original sample were recontacted for the second phase of the study from May to October 2014. Although recontacting mothers was challenging, most mothers who fit the sampling frame were eventually reached by telephone. When a telephone number was no longer in service, contact efforts involved in-person visits to the family's home. Upon recontact and verification of the mother's interest to continue in the study, a meeting was scheduled for data collection. A separate informed consent was obtained after explaining the study and answering any questions in the mother's preferred language and before data were collected for the second study phase.

Children varied on whether diagnoses related to a developmental delay were confirmed, and the extent to which developmental delay was an ongoing concern. Some mothers and their children were transitioning out of EI services and entering school-based services to address developmental needs. Institutional review board approval was obtained from the University of North Carolina for this study.

Data Collection

Interview.—Follow-up interviews conducted during the second study phase were timed to capture each mother's current experiences and reflections over time regarding how she viewed her child, and managed her child's development along with the needs of the family and herself. The research team members, trained to conduct these interviews, brought

expertise from their professional backgrounds in nursing, psychology, epidemiology, and social work to the study. A guide for the semistructured interview was informed by the literature on family management (Knafl et al., 2011; Knafl et al., 2012; Knafl et al., 2013), and by what was learned about these mothers' experiences potentially related to family management during the first phase of this study. Interview questions were designed to explore family management including contextual influences and maternal functioning by inviting these mothers to share their social, cultural, and emotional experiences, as well as to understand how care providers, specifically EI, might have affected family management. Excerpts from the interview guide are shown in Table 1. Probe questions were used to gain richer descriptions through mothers' examples, and further exploration of their perceptions of how they manage from day-to-day for comparative purposes. Interviews were conducted with mothers in person in their homes in their preferred language of English or Spanish. The audio-recorded interviews conducted in English were transcribed verbatim. Interviews conducted in Spanish were translated and transcribed in English, and all were deidentified for analysis.

Research instrumentation.—Mothers were also asked to complete the Center for Epidemiologic Studies–Depression Scale (CES-D). The CES-D is a 20-item self-report measure intended to capture symptoms of depression (e.g., affective, psychomotor, interpersonal, and somatic) with reliability in general and clinical populations of $\alpha = .86$ and $.91$, respectively (Radloff, 1977). The response options for frequency of depressive symptoms in the past week are on a 4-point Likert-type scale (0 = *rarely/none of the time*, 3 = *most or all of the time*). Although scores range from 0 to 60, scores ≥ 16 are considered clinically concerning and used as the cut-off in this study.

Data Analysis

A team-based and stepwise approach was used for directed content analysis (Hsieh & Shannon, 2005; Patton, 2002). This approach is directed by theory, yet does not disallow consideration or integration of new, related concepts represented in the data. A coding matrix was generated as a working document that accommodated up to three coders for analysis of each transcript (Beebe, 2001). Each matrix displayed the family management dimensions with definitions, related interview questions, records of evidence and representative quotations for each coding category, and additional analytic notes. The initial step for analysis involved two research team members highlighting textual evidence in an interview transcript and using the coding matrix for managing the analysis. After the first six transcripts were coded, the matrix was refined to include contextual influences on family management with coding categories of social experiences, cultural norms, maternal mental health, and child developmental services and related resources.

The next step involved a primary coder for a transcript, followed by a secondary coder who coded the transcript unblinded to coding completed by the primary coder. The secondary coder could agree, refute, question, and/or add additional coding to the transcript. If needed, a tertiary coder facilitated reaching consensus on codes. Coding was completed when the textual evidence was highlighted, and analytic memos and quotations for each category along with additional notes were recorded on the matrix corresponding to each of the 29

transcripts. Iterative with coding, a separate, larger matrix was used to compile and display evidence and quotations for each category across all transcripts. The transcripts and corresponding matrices were used for reference, and the larger matrix was used to identify patterns, rich data, and densely coded categories (Miles & Huberman, 1994). Analytic comparisons and decisions were fostered by the sampling frame, and all documents were used to determine saturation of the four dimensions (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

We designed the study to include all family management scales/dimensions as described by Knafl et al. (2013) that include child's daily life, condition management ability, condition management effort, family life difficulty, view of condition impact, and parental mutuality. As the analysis progressed, however, what we were learning from these mothers about family management that could be of value for clinicians, researchers, and policy-makers, was densely coded in relation to four of the scales/dimensions. Thus, an analytic decision was made to focus on these four, which included each mother's perceptions of her child's daily life, condition management ability, condition impact, and mutuality in the child's care with her partner or family caregiver. The remaining two scales/dimensions, condition management effort and family life difficulty, displayed insufficient data for rich analytic comparisons. Despite the time elapsed (>1 year) as development concerns were first identified, it is possible that the uncertain nature of the delay, and/or maternal depressive symptoms, could have accounted for this limited data. For example, data were lacking in regard to determining short and long-term investment for condition management effort, or maintaining daily routines for family life difficulty. Analysis also suggested that a mother's social experiences and cultural norms, and mental health status might shape her interpretation and management of her child's developmental delay. To guide the latter, more focused analysis, an adapted, study specific theoretical framework was used. As illustrated in Figure 2, the framework depicts the contextual influences on the major theoretical components, four related dimensions, family management style, and functional outcomes (Knafl et al., 2011; Knafl et al., 2012; Knafl et al., 2013).

Findings

The sample was comprised of 29 mothers caring for children who were receiving EI services upon enrollment in the first phase of the study. Five of these mothers were not partnered at follow-up. All of these children were the mothers' biological children, and 17 were boys. The children received EI services due to delays in language, motor, and/or socioemotional development. Those with comorbid conditions, such as hearing impairment or sequelae related to premature birth were not excluded from this study. Of the 29 families, 19 received EI services for one child, whereas 10 families had received EI services for two or more children. Additional demographic details are shown in Table 2.

This sample included seven mothers who had very limited English language proficiency. Clinically concerning depressive symptoms were reported by nine of the 29 mothers at the first phase of data collection with an additional three mothers reporting depressive symptoms just below the threshold. At the second phase follow-up, six of the same mothers and an additional five mothers reported clinically concerning symptoms of depression. Two

of these mothers were previously slightly below the threshold. To provide context for the findings, family characteristics including pseudonyms for each mother, preferred language, CES-D scores, number of children living in the household, and age of child at the second phase follow-up are shown in Table 3.

Interviews lasted approximately 60-90 minutes. Mothers shared a wide range of experiences regarding their child, the developmental delay, as well as family life, and how they managed the positive and negative aspects of the child's condition. Key findings are related to four dimensions of family management: child's daily life, condition management ability, condition impact, and parental/caregiver mutuality.

Child's Daily Life

Views of the child's daily life included the child's identity, and varied substantially across mothers. Mothers reflected on the child's developmental delays, behavioral issues, vulnerabilities, and capabilities, as well as what could be considered normal. The value placed on the services that mothers secured to support child health and development, as well as their own mental health influenced the ways in which they thought about their children.

Most apparent in the interview data were the deficit-focused descriptions of a child which were incongruent with a holistic view. Many of these mothers described their children's development using physical, social, and emotional categories. A mother recalled the difference in her son's size and developmental level had been the concern, "... he was already big and he wasn't talking. Then he wasn't walking. He was very delayed" (Family 15, Marisol). She also explained that her son "learns so quickly" and his development was catching up but that the ongoing issue was inappropriate social behavior. When children had not markedly improved, or when the condition was not well understood or diagnosed, mothers were watching and hoping for progress in certain categories. This mother pointed out that while her son's physical appearance was "normal," he still needed to improve on speech and social skills. Upon visiting a mainstream classroom, she remembered thinking for the first time that her son "didn't belong ... that [he] really was different ... He is an in between" (Family 18, Samantha).

Mothers who expressed incongruent and sometimes distorted views of a child also tended to report concerning symptoms of depression. One such mother, caring for her two children with special needs due to developmental delays, expressed hope but most days she thought, "things'll never get better." She emphasized that her daughter was highly vulnerable, like "a baby" with limitations on mobility and mastering tasks of daily living, and then also described improvements in physical strength (Family 3, Julia). Aside from advocating for development support services, she did not see herself as making a difference for her daughter. Another mother related her history of depression to how she thought about her daughter's behaviors. Beginning after birth, she thought that her daughter was very kind and sensitive, yet also very manipulative, saying "I always thought she was trying to hurt me." This mother was in the midst of addressing her own mental health needs and believed that doing so allowed her to reframe her daughter's intentions and increase her capacity to develop a relationship with her. She explained, "So, realizing that she [daughter] wasn't being vindictive or malicious and actually trying to ruin my life, that was the only way that I

could really cope—once I realized that” (Family 9, Amy). Although reporting elevated depressive symptoms, this mother had recently begun psychotherapy to address her mood disorder, and was beginning to see her daughter as “a whole, brand new kid.”

While some mothers referenced symptoms of poor mental health for how they interpreted and assigned meaning to their lives and views of their children, many mothers did not make these connections. Those who did not report clinically concerning depressive symptoms tended to describe their children more positively, holistically, and without discrepancies.

Condition Management Ability

Condition management ability in regard to the child’s development was reflected in a mother’s knowledge of what needed to be done, and whether she could manage the situation competently. Informed by the mother’s goals, priorities, values, and beliefs, manageability involved perceptions of who could make a difference in the child’s development, and related strategies including a routine to handle the child’s and family’s needs every day.

Perceptions about what or who most affected child development differed among mothers. One mother raised the notion that time and maturation alone could be responsible for child development. Yet others considered who could best support developmental progress. There were mothers who believed that the EI providers and therapists, as experts, were primarily the ones to affect progress. One mother described being an advocate by seeking out experts to work with her daughter, and at the same time being at a loss for how to help her child develop self-care skills. There was particular concern with a gap in services, and she emphasized,

I’m trying as her mother, but I don’t know ... how to manipulate her hand to do [certain movements]. You know, there are people that are specialized to do these things, that I’m not. I’m not qualified to do that, I don’t know. All I can do is hold her hand and try to [show the movement]. Hopefully, she’ll mimic me. (Family 3, Julia)

Along with her worries about securing developmental support for her daughter, this mother shared her struggles with depression.

Other mothers described EI providers and therapists as valuable, as well as their own abilities for supporting their children’s daily needs for development. Reflecting on her management ability, this mother explained how she needed to care for her youngest child compared with her older typically developing children. She also shared how she needed to take care of herself to preserve her mental health.

He takes—he is all day, every day. I mean, he’s a huge amount of work, but it’s good. It’s just the way he is. It’s diapering and getting his milk and putting on his orthotics and stretching him and making sure he’s walked and making sure you spent time on cognitive skills. You know, I have two typical children. I know what typical children are like to raise. He’s triple the amount of work, and it’s not bad. It’s just the way it is ... by me taking care of myself, it’s helping him. (Family 4, Brenda)

This mother emphasized keeping a balance to maintain her management ability.

Another mother detailed her abilities and use of many resources for advancing her son's development, especially his social development. She created a "schedule wall" for purposes of structuring and updating the daily routine, completing the tasks of the day, and also to keep her husband informed and involved. Emphasizing the time and effort required for this process, this mother also voiced concerns about whether she could sustain it. She explained her worries about managing her depressive symptoms and avoiding being overwhelmed, "It's so much more than just eat, sleep, and just learn some things—It's starting to get to be a much wider range" (Family 8, Heather). Although demonstrating competence in managing her child's condition through daily developmental support, compromised mental health increased her uncertainty and fears.

Many of the mothers in the sample explained how attending to their personal mental health and self-care needs were of equal or higher priority compared with the child's developmental goals. Problems arose with condition management ability when mental health was not attended to. This mother explained the negative impact of her depressive symptoms on her own and her child's well-being, she said, "... it was something that I did wrong as a parent, that she was delayed in speech and delayed in development. I wasn't being a top-notch parent, like I should have. So that was a struggle" (Family 1, Jessica). The regret and guilt expressed by this mother about her ability to manage her child's condition were heard predominantly among those mothers who had been dealing with depressive symptoms.

Tenacity and resilience were key to maintaining and improving condition management ability. Simply being the mother could be enough at times to keep a sense of self-worth and persevere in managing her child's condition, as this mother poignantly explained, "Sometimes, I feel like a little animal that the whole world steps on. Then I think about my kids. I think about how I am important to them and am worth something" (Family 15, Marisol). This mother needed to cry once in a while, and find time to be alone and rest to regain her ability to deal with and manage "what is happening" with her child and family.

There also seemed to be a broader continuum for management ability from acceptable to the ideal. The ideal approach was particularly challenging with perceptions of instability, uncertainty, and unpredictability of their children's conditions. As routines could be difficult, even impossible to achieve, striving for flexibility, settling for trial and error, and rejecting rigid schedules were recounted as essential for managing the high stress of daily life with the mental energy available. As one self-forgiving mother dealing with depressive symptoms said, "I'm not good at staying calm, but good at starting over" (Family 5, Michaela).

Mothers who did not report compromised mental health or were recovering and experiencing less severe depressive symptoms tended to describe forming relationships with EI service providers and other therapists that benefited their children and themselves. Describing engagement during her child's developmental stages, a partnership with EI service providers, and then active participation in her child's transition to the classroom setting, this mother compared her own and son's experiences. "The person that transitioned

was me, not [my son]" (Family 22, Iliana). With her competent management ability that ensured the necessary attention and appropriate intervention, she believed that her son was well supported by her and many others to make steady and seamless progress.

View of Condition Impact

The view of condition impact includes the mother's interpretations of how serious the developmental delay or disability was and what it could mean for her child's, her own, and her family's future. Mothers' views of the condition impact also involved considerations of the emotional costs and feelings of isolation related to the child's condition.

The seriousness of the condition could be left unexplored, or not considered, as some mothers referred to a time of denial. For most children, the delayed development was uncertain. Both denial and uncertainty were linked with the fear experienced by these mothers in everyday life. For some, there were concerns about whether autism was the appropriate diagnosis, and problems with receiving services to support development were sources of stress. Yet mothers worked to have optimism about the condition impact, albeit a guarded optimism, as suggested by this mother:

[I take] life—one day, and one step at a time, one month at a time, no more than that. Looking too far into the future sometimes can be overwhelming based on what's currently happening. But looking back, and seeing all his growth and everything that he's done, is much more encouraging than trying to look to the future and not know what's gonna happen. (Family 13, Natasha)

Rather than looking into an uncertain future, this mother described finding encouragement in looking back on her child's progress; a strategy common among mothers in our sample. She also shared her ambivalence regarding a confirmed diagnosis. The diagnosis could make a fear a reality, or label the child. Moreover, a confirmed diagnosis did not necessarily make family life any better, as this mother emphasized, "Even though [the diagnosing clinicians] had given us the autism diagnosis, it didn't really make us feel any better because we were still dealing with this child that we didn't know what to do with" (Family 13, Natasha).

Mothers and their partners needed to face losing the child they thought they had, their perfect child, after months or years. As this mother explained through her tears:

... it was hard for me, but it was super hard for him [husband]. Because you think you have a—your kid is physically perfect so you think they're going to be mentally perfect, and that's not the case. But you don't find out until he's two. (Family 1, Jessica)

This same mother went on to explain struggling with the emotional costs that went beyond what is typical for raising a child, "I do what needs to be done for him regardless of what it costs me. I guess that's a quick way to say it ... At one point he had five therapies a week. And that sucks" (Family 1, Jessica). Similar to other mothers in this sample, this mother reported dealing with emotional costs that could manifest as depressive symptoms.

Whether or not depressive symptoms were linked with the emotional costs, some mothers developed self-care strategies that included seeking counseling. Counseling was valued by

all the mothers who received these services. One of the mothers who did not report concerning depressive symptoms emphasized the motivation needed to attend counseling, saying “I did seek out a counselor for myself. I did that recently. But finding the time for yourself—and you don’t do it because you put your kids first. And it was hard finding the time to see [the counselor]” (Family 12, Emma). Counseling was helping her with the emotional costs, yet not fully alleviating the despair; explaining that after counseling appointments, “my stomach is still upset, but I am not crying my eyeballs out anymore” (Family 12, Emma).

Feelings of isolation were recounted by mothers along with their descriptions of how family members ignored problems with child development, did not understand that there was a problem, or explicitly discounted the need for outside help. These mothers described little attention to their abilities to manage the condition, and lack of support for the child’s need to complete a daily routine of therapeutic tasks. Within some families, there were cultural expectations that the mother should be the only primary caregiver and responsible for the child’s health and development. In other families, differences were marked by maternal and paternal sides of the family, as exemplified by this mother: “My husband’s family, they don’t talk about it, they don’t acknowledge it. They pretend that nothing is wrong, that he doesn’t need therapy, that he doesn’t need to go to school. That—That is what they do” (Family 1, Jessica). Although this mother relayed her experience of isolation along with her depressive symptoms, feelings of guilt, and marital difficulties, she emphasized the importance of socially connecting with other mothers of children with similar developmental delays. Most of these mothers described talking to other parents or engaging in support groups in person or online. Yet even in these social circumstances, isolation was experienced as simply feeling alone. Feeling alone was considered a prominent condition impact, as this mother said, “I really feel alone ... even at the park with other moms, they will talk about ‘Oh, he likes the swing,’ and there is no depth to it” (Family 8, Heather). She stressed how having a son with socioemotional delays was becoming more difficult for her because she wanted him to be able to communicate with others, and also with her about playing with other children and the events of the day.

Parental/Caregiver Mutuality

Parental mutuality, considered for those who were partnered, involved the mother’s reflections on shared or discrepant views, and support regarding how she and her partner were managing their child’s condition together. We learned from these mothers that the father and/or the child’s grandparents could be primary caregiving partners. There were also situations in which the father or other caregiving partner in the family who the mother wished to involve, formally or informally, did not engage in supporting child development. For these reasons, we expanded this dimension to include the father and caregiving partners within the family.

Sharing similar or encountering discrepant views with the child’s father and/or other primary caregiving partners in the family was described by nearly all of the mothers. Sharing views on how to best to manage child delays was appreciated—as one mother emphasized, “we are on the same page” (Family 22, Iliana). Managing the child’s condition tended to go well

when a mother could see how she and the father or other primary caregiving partner brought their strengths to the daily routine. This mother highlighted the value of combining points of view when she said, “I like for him [husband] to be involved too because he notices different things as well. I tend to notice from a more emotional spot, and he tends to notice from a more intellectual spot” (Family 8, Heather).

Most mothers, however, reported having discrepant views, especially with the child’s father. One mother told about how the child’s father saw his work outside the home, and her work within the home, which included the work with the EI service providers. She recalled,

The first three years of parenting sent us in a very opposite direction from each other, which is not good when you’re trying to be a team and you’re trying to be united. It caused so much strain, that is still there, and I don’t know if we’ll come back from it or not. But it’s still daily. We are not recovered. (Family 5, Michaela)

This couple had been seeking to improve their relationship, yet the mother acknowledged that difficulties remained.

While descriptions of families on the verge of breakdown did emerge among some mothers with depressive symptoms, far more common were experiences of discrepant views and unresolved conflict. These mothers explained how they expended valuable energy to draw in fathers, form a mutually agreeable parenting style, and problem-solve on a daily basis. According to one mother, she and the child’s father struggled to share a similar view on managing their son’s behaviors related to his developmental delays:

I tell him [child’s father] that he has to learn how to help me but it goes in one ear and out the other ... as a couple we don’t agree on a lot of things. When we talk about it [differing disciplinary approaches], it seems like we have solved something but then an hour later it’s back to how it was. (Family 15, Marisol)

Their discrepant views and ongoing conflicts were recognized by others, including EI service providers. This mother went on to say “the problem is that we aren’t being good parents.”

Some fathers could be very involved, however, and offered support for condition management in several ways. Most commonly fathers were engaging with their children, taking on tasks of the daily routine to promote child development, and acknowledging and securing the time for mothers’ renewal needs. A mother recounted the dedication of the child’s father, she said, “He gets involved. He helps with the continuity of the new word that is being taught ... Sometimes he comes home late from work, but he is definitely involved” (Family 22, Iliana). She also appreciated that her child’s grandmother and other family members worked on promoting development, saying,

My mom helps me quite a bit ... The whole family has worked together ... we have seen that all of us together can support one another along with the teaching professionals to support [child’s] complete growth. (Family 22, Iliana)

Although the father’s employment outside the home often influenced their views on the management approach, mothers emphasized the different ways each parent supported the

child, and the family. This mother highlighted the strengths that she and the child's father brought to the daily routine with the father involved with the active and physical aspects of home therapy:

All the high impact that the [occupational therapist] wanted us to do—He [child's father] comes home from work and does it. He will drag them on a blanket across the floor, he will throw them into the couch, he will wrestle with them. He enjoys it, and I am like, I am exhausted. (Family 12, Emma)

She also explained, however, that the father could be emotionally guarded about an autism diagnosis, and did not want to acknowledge or discuss this possibility. Thus, parenting together was not always smooth, and this mother had to articulate clearly the need for his support.

Reminding him of that [autism spectrum-related behaviors and therapy], and then things really, have to really, get emotional for things to finally sink in. Like, 'I need some help. I need it yesterday,' and then he will step up and then things get better. (Family 12, Emma)

Despite his time away at work, this father reportedly was able to offer the necessary support, and the couple gained mutuality in their views. This was not the case for other families, as another mother explained:

He [child's father] works most of the time. So the time that he has for us is sometimes little. And when he gets back from working, he is tired. So this has also sometimes been hard for me, to include him in [our child's] activities. (Family 14, Nerita)

This mother's depressive symptoms were in the concerning range at follow-up. Many others who identified taking on the primary or sole responsibility for child development reported depressive symptoms that were elevated or at the threshold. A mother with symptoms at the threshold initially and at follow-up, described how the child's father did not share her view of the condition or provide support for condition management, and said, "I felt like I was alone, and had to do it by myself. I knew that he cared, but he wasn't really supportive because he didn't want to face the fact that [our daughter] had something wrong" (Family 10, Laura). She also explained her process for identifying and understanding her postpartum depression, how the depressive symptoms continued for 2 years after birth, and how both her mothering and marriage suffered. Like this mother, nearly all the mothers in this sample reflected on the previous months and years, and shared accounts of how they managed their child's condition in the context of needing to care for themselves, including managing their own mental health, as well as their relationships and expectations within the family.

Discussion

This study appears to be the first to describe mothers' perceptions of family management in the context of caring for a child with a developmental delay. These findings offer three main insights that could be especially relevant in the clinic and EI settings. These insights include context-specific variation in how mothers perceived their family management approaches,

the influence of the child's father and family members on management, and how mothers considered their child's developmental needs along with their own mental health needs.

Context-Specific Variation in Mothers' Family Management Approaches

Variation was found among mothers in regard to the dimensions represented by each of the four family management scales.

Child's daily life.—Mothers shared views of the child's daily life in a manner that was deficit-based, incongruent, or holistic. Our findings suggest that a mother's depressive symptoms could negatively influence the view of her child. This is not a surprising finding since evidence, in large part represented in the distortion model (Richters, 1992), has accrued for years regarding associations between maternal symptoms of depression and anxiety and inaccurate interpretations of child personality and behavior. Most recently, examination of mothers' and fathers' symptoms of depression and anxiety in relation to their views of child behavior suggested that symptoms experienced by one parent could shift the parent partner's view of the child (Clark, Durbin, Donnellan, & Nepl, 2017). Moreover, in families where mothering was compromised by depression, fathers demonstrated less sensitive and more intrusive parenting styles compared with families without mental health issues (Vakrat, Apter-Levy, & Feldman, 2017). Thus, when a child is in need of additional support for development, parents' mental health status could be a crucial factor in how a child is viewed within the family and how parent-motivated EI interventions are enacted in a daily routine (Beeber et al., 2014).

Condition management ability.—Mothers perceptions varied; that it was time passing that made the most difference for the child, it was up to the qualified experts to help the child, or it was a combined effort between the family and EI providers and therapists that would lead to the best outcomes. These perceptions might parallel the natural growth versus concerted cultivation approaches in parenting (Lareau, 2011). Natural growth, a parenting style associated with families with low socioeconomic status, involves less scheduling and minimal supervision, and more free play for the child. Concerted cultivation, commonly observed among families with moderate to high socioeconomic status, consists of regimenting a child's day with activities and frequently supervising the child. Although approaches in parenting have been well studied, assumptions should yield to a careful consideration of a mother's perceptions of her condition management ability. Understanding these perceptions could potentially reveal how necessary she sees her own role in fostering her child's developmental progress.

View of condition impact.—The view of condition impact was not determined by those mothers who described being in denial for a period of time, or among those who were especially uncertain about the child's condition. Isolation for these mothers was a common experience. Similarly, descriptions of early parental experiences when a child's developmental delay or disability is first suspected has included a period of mourning and consequent mental health challenges (Seligman & Darling, 2007). The mental health challenges following diagnosis of a child can involve acute and sometimes prolonged stress and depressive symptoms for parents, which can interfere with a healthy adaptive process.

Identifying and addressing these mental health challenges early on has the potential to offset negative effects on the child and family (Beeber et al., 2017).

Parental/caregiver mutuality.—Variation was also found in parent and caregiver mutuality. Regardless of whether a mismatch in family management was related to a time of denial, discrepant views were a main source of strain within the couple, caregiving dyad, and in the family. For some, discrepant views were a source of conflict. Our findings also provided insights into the how a mother's approach to family management might be influenced by the child's father and other family members.

Influence of the Father and Family Members on Management

A mother's approach to family management was influenced by the child's father and other family members in relation to the view of the child, and related experiences of conflict, as well as management ability linked to the levels of parent-child engagement. Our findings could also contribute to an understanding of the influences of social experiences and cultural norms on family management in this context.

Child's daily life.—For those mothers who described discrepant views of the child within the family, conflict often resulted. Such conflict led to counseling for some couples, but problematic issues remained for others. These findings are concerning because conflict within a couple is known to negatively impact child outcomes (Brock & Kochanska, 2016; Grych, 2001), which could further complicate management for families already dealing with child developmental delays. Differing views of the child within families, and related conflict, seemed to be linked with low levels of engagement between father and child.

Management ability.—Addressing the needs of a child in a competent manner involves the quality and quantity of parental engagement with the child; a crucial variable in child development. Low father engagement with the child (e.g., not reading books, not singing songs) has been shown to negatively influence a child's cognitive and social behaviors indirectly through maternal-child interactions (Cabrera, Fagan, Wight, & Schadler, 2011). It is also clear that in the context of limited English language proficiency, the quality of parent-child interactions in English language and literacy activities are especially important for school readiness (El Nokali, Bachman, & Votruba-Drzal, 2010; Espinosa, 2001; Pan, Rowe, Singer, & Snow, 2005; Wood, 2003).

Our findings also match particularly well with one of five themes presented in a review of fathers' contributions to the management of their children's long-term health conditions, which included cancer, diabetes, kidney disease, asthma, and Down syndrome (Swallow, Macfadyen, Santacroce, & Lambert, 2012). Similarly represented in the theme on the impact of father's involvement on family functioning, the mothers in our study offered candid and often negative narratives on intra-couple discrepant views and conflict regarding the child's development and unsatisfactory roles in caring for the child. They also explained how fathers' employment and work schedules either improved or detracted from family life, and the ways in which fathers' efforts to share tasks and stay involved with daily management enhanced family adjustment to the child's uncertain development. Such positive adaptations

that involve fathers' sensitive, nonintrusive, and engaging behaviors with their children on a socioemotional level can compensate for some of the negative impact of maternal depressive symptoms (Vakrat et al., 2017). Thus, these findings offer valuable information about family functioning in the context of management of a child's developmental delay.

Social experiences and cultural norms.—Through our study, we also learned about how the social experiences and cultural norms of the family shaped expectations for the mother (e.g., how parenting should be done and by whom), and child (e.g., whether support for development was needed). With the recognition of persisting cultural and linguistic gaps in early childhood care and services, partnering with these mothers, and targeting interventions to successfully support child development is crucial (Banerjee & Luckner, 2014; Verdon, McLeod, & Wong, 2015). It is also likely that vulnerability to suboptimal child outcomes is increased when mothers experience isolation and guilt along with depressive symptoms. Therefore, providing support for child development in the context of a meaningful partnership with the mother could necessitate evaluation of her mental health, and potentially referral for treatment.

Child's Development and Mother's Mental Health Needs

In this sample, the mothers who were able to attend to their own needs, especially mental health needs, described their own engagement with the child, and how they interacted with family members, EI providers, and therapists as partners to support child development. In contrast, mothers who experienced depressive symptoms tended to have a compromised view of the child, and negative perceptions of management abilities.

Child's daily life.—Some mothers thought that their depressive symptoms compartmentalized and distorted the view of the child, with a heightened focus on negative child behaviors and developmental deficits. Such views, potentially due to compromised mental health, could contribute to a condition-focused, rather than child-focused management approach. A child-focused management approach fits well with promoting a child's socioemotional and cognitive development. Yet this approach hinges on a parent's accurate perception of the child, and interpretations and responses that are appropriate and sensitive to child behaviors (Landry, Smith, Swank, & Guttentag, 2008; Merlo, Bowman, & Barnett, 2007).

Management ability.—Some mothers in this sample emphasized that taking care of themselves was necessary to be healthy and effective enough to competently manage the child's condition. This description offers evidence of the bidirectional relationship between individual outcomes of mental health and management style. It is important to note, however, that depressive symptoms reported by some mothers were at or very near to the threshold over time, and might have contributed to the lack of attention to and/or ongoing low engagement with the child, and related suboptimal management ability. These findings are of concern because mothers' depressive symptoms are associated with less adaptive parenting behaviors characterized by low responsivity to, and negative interactions with the child (Beardslee, Versage, & Gladstone, 1998; Goodman & Gotlib, 1999; Lovejoy, Graczyk, O'Hare, & Neuman, 2000).

It is now realized that depressive symptoms in both parents, mothers and fathers, negatively impacts the quality of parenting and child behaviors (Bagner, Pettit, Lewinsohn, Seeley, & Jaccard, 2013; Goodman et al., 2011; Wilson & Durbin, 2010). Although potentially overlooked by early interventionists, the quality and extent of parental attention to child development could bolster or jeopardize the home environment. Such parent attention, integral to family management, appears to be essential for optimal child outcomes. Moreover, the effectiveness of EI could be reduced when negative maternal affect is an issue, and/or when there is low parent-child engagement, or family members hold discrepant views of the child, have conflict. Thus, it is possible that either a mother's or father's mental health status could represent an important modifiable variable of individual functioning related to family management.

Strengths and Limitations of the Study

The two main limitations of this study resulted from the challenges of recontact for the second phase of the study and heterogeneity of child developmental delay. The mothers in this follow-up provided a rich data set. It should be recognized, however, that some mothers who fit the sampling frame, particularly those who had limited English language proficiency, could not be reached due to relocation or interrupted phone service associated with low socioeconomic status. Although variation in the sample was expected at follow-up, the developmental trajectories of the children differed substantially, from nearly resolved to confirmed diagnoses (e.g., autism spectrum). It is possible that for some mothers, developmental outcomes were more uncertain than a known chronic condition, and thus their perceptions of family management dimensions (e.g., condition management effort, family life difficulty) were not fully formed.

Implications for Practice and Research

Practice implications.—The study findings have implications for practice that include the need to screen for compromised maternal mental health that could affect the family, and a call to shift to a family-focused approach in the primary care setting. There is also potential value in providing care for the family unit through a nurse-EI service provider collaborative link. It is clear that family management of children with developmental delay is complex, and mothers can face many challenges, especially in regard to mental health. Evidence suggests that when mothers are referred for assessments and care for substantial mental health needs, family counseling by specially trained registered nurses or advanced practice psychiatric nurses can lead to improved outcomes (Beeber et al., 2013). Still, many mothers are not screened or appropriately referred for additional assessments and care. Left unaddressed, depressive symptoms negatively impact the mother, her child, and her family in the short and long term (Goodman et al., 2011; Letourneau et al., 2012; Letourneau, Tramonte, & Willms, 2013). With ample evidence available, it is now that nurses must spearhead system changes that include screening of maternal depressive symptoms in multiple settings, including screening as a component of EI services locally. At a policy level, nurses who advocate for these families should collaborate with key stakeholders and direct efforts to implement screening by EI services nationwide.

As a child's developmental delays are often identified through the primary health care setting, these patients, especially those most vulnerable for poor outcomes, need family-focused nursing care (Denham, Eggenberger, Young, & Krumwiede, 2016; Friedman, Bowden, & Jones, 2003). Using a family-focused approach, nurses could work effectively with the mother as well as the father by treating the family as the unit of care. From within the primary care setting, case management or advanced practice nurses in particular, must set out to partner with these families, assess the complex and changing needs reflected in the study findings, and provide tailored, supportive care. In regard to child developmental delays, necessary discussions should center on family expectations regarding support for the child, and work toward satisfaction with family management. This implication of study findings contributes to the larger call for family-focused nursing care in primary care and other settings.

Beyond the primary care setting, nurses interface with numerous service agencies including EI services. Considering the practice gap among EI service providers related to engaging fathers (McBride et al., 2017), a collaborative link between these providers and nurses who use a family-focused approach represents as a timely initiative. Findings from the current study along with evidence of enhanced family functioning resulting from improved fathering abilities for young children (Vakrat et al., 2017), suggest that caring for the family as a unit could have a positive impact. Nurses in collaboration with EI services could bolster parent support of child development by helping parents, both mothers and fathers, develop insights and strategies to balance mental health needs with child development needs. Considering the feelings of isolation, and that social support might be lacking for some families, both nurses and EI service providers could help parents articulate this common experience and how to cope with it. Echoed by the findings, culturally sensitive care for Latino families in the U.S. is particularly needed, and must include more than translating materials and having Spanish speakers deliver them (Valdez, Stege, Martinez, D'Costa, & Chavez, 2017). A family-focused approach ensures tailored and holistic care; care that could augment EI providers practices to help families identify, navigate, access, and use resources that best fit their needs from a socioeconomic and cultural standpoint. The nurse-EI service provider link to provide care for the family as the unit of care holds promise, yet requires additional evidence for system change.

Research implications.—Most families of children enrolled in the EI program receive one or more in-home visits by providers to support child development. As mothers become accustomed to home visits and lack resources for child care, they might perceive home visits as a convenient setting to address issues of family management and depressive symptoms. The acceptability of additional assessments and mental health screening during home visits for this population requires further study. More studies are also needed to determine whether including trained nurses to intervene with mothers in the clinic or home setting after screening would be more cost-effective and produce desired health outcomes.

Finally, this study was designed to learn about family management from a sample of mothers with key characteristics for comparison. Latina mothers living in the U.S. often experience stress due to low socioeconomic status, undocumented immigration status, and limited English language proficiency. Caring for children with developmental delays

presents even more challenges for these mothers. Given the barriers to accessing appropriate resources including mental health services, more study is needed to gain a complete picture of family management through the lens of Latino parents. Such research can lead to assessments and interventions that are culturally tailored to the needs and life context of these particularly vulnerable children, and their mothers and families. Moreover, by design, mothers who identified as primary caregivers comprised the initial pool of participants, and thus, fathers and other family members were not participants for follow-up. Future studies should include the mother's spouse or partner, and/or other primary caregiving partner (e.g., child's grandmother).

Conclusion

The findings from this study provide an understanding of mothers' perceptions of family management when a child needs support for progressing developmentally. Approaches to family management varied widely, were influenced by the child's father and the family, and often involved mothers addressing their own mental health needs. Variation in family management was found in mothers' views of their children, perceptions of management ability, considerations of condition impact, and the experiences of mutuality. A mother's accurate and holistic view of the child appeared to be negatively affected by her depressive symptoms, and potentially those of the child's father. Condition management ability could have relied on what the mother believed her child needed from her: unstructured passage of time for natural growth, or specified and supervised activity for cultivation of development. Determining condition impact appeared to be integral to how the mother was adapting to the delay, as well as her experience of isolation and preference for looking back on child progress or imagining the future. Mutuality in family management between the mother and the child's father as well as between the mother and other primary caregiving family members was often problematic. Conflicts that arose from discrepant views of the child, low levels of engagement between the father or caregiver and child, and unrecognized needs of the mother and child by the family interfered with mutuality. A mother's depressive symptoms appeared to be a pervasive negative influence on family management. Findings highlight the crucial need for a family-focused nursing care approach to understand the holistic nature of care indicated for these families. This approach could incorporate evidence-based assessments of family management and mental health screening to inform tailoring of care, appropriate referrals to other resources and collaboration with EI service providers. With additional study, an extended family management framework could serve as a guide to support optimal child development outcomes.

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Biography

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Figure 1. Stratified purposeful sampling frame representing key characteristics for comparison during the second phase of this sequential mixed methods study.

Note. CES-D = Center for Epidemiologic Studies–Depression Scale.

Figure 2.

Framework incorporating theory on family management style (Knafl et al., 2012) and specific family management dimensions (Knafl et al., 2011) to understand the experiences and challenges of mothers caring for children with developmental delays.

Source. Adapted from Knafl et al., 2012 and Knafl et al., 2011.

Note. EI = Early Intervention.

Table 1.

Excerpts From the Interview Guide.

Types of questions/ statement	Examples
Invitational statement	Parents can have a range of experiences as they support a child's development. We would like to learn more about your experiences, and the experiences you have had with early intervention services. When we last visited you, (child's name) was (no of months old). Since that last visit, tell me about how you and your family have been doing.
Interview questions	You've seen (child's name) grow and develop in many ways, what do you think that s/he can do well? What sorts of things do you think (child's name) is still needing to accomplish? Tell me what addressing your child's developmental needs looks like in your family. Does your partner help with (child's name)? Tell me about that. On top of a child's developmental needs, parents also have to juggle their own needs. How have you been managing this? We are especially interested in helping mothers who experience symptoms of depression. If you have experienced this, what have you found helps you? What kind of things can get in the way of working on the routines or goals that early intervention service providers suggest you do with (child's name)? How do you see (child's name) doing in the future?
Probe questions	Can you give me some examples? How does it affect your [time, routine, energy]? When did you feel the [worst, best]? What helps you [manage your time, your children's needs, your well-being]?
Closing question	What thoughts would you like to add that I haven't asked about?

Table 2.

Sample Demographics at Follow-Up.

Characteristic	<i>n</i> = 29
Age	
20-25	4
26-30	7
31-35	10
36-40	4
41	4
Relationship status	
Married	18
Partnered	6
Single	5
Highest level of education	
High school	9
Some college	7
Undergraduate degree	9
Graduate degree	4
Household income ^{a,b}	
<30,000	10
30,000-49,000	5
50,000-69,000	7
70,000-89,000	4
90,000-109,000	1
>110,000	1
Number of children living in household	
1	7
2	11
3	8
4 or more	3

^aOne mother reported income as unknown.^bHousehold income is reported in U.S. dollars.

Table 3.

Family Characteristics at Follow-Up.

Family/mother	Mother's preferred language	Depressive Symptoms ^a		Number of children living in household	Affected child months of age at follow-up ^b
		T1	T2		
1. Jessica	English	20	28	1	41
2. Kristie	English	37	22	2	47
3. Julia	English	14	23	3	43
4. Brenda	English	15	11	3	43
5. Michaela	English	22	21	3	43
6. Maria	Spanish	6	13	2	43
7. Jackie	English	8	6	2	38
8. Heather	English	25	28	1	33
9. Amy	English	14	25	1	39
10. Laura	English	17	9	1	37
11. Nicole	English	3	3	1	45
12. Emma	English	7	7	2	49
13. Natasha	English	8	3	2	48
14. Nerita	Spanish	2	16	3	43
15. Marisol	Spanish	27	40	2	35
16. Rita	Spanish	0	6	2	32
17. Zoe	English	1	0	2	40
18. Samantha	English	16	13	4	49
19. Ashleigh	English	13	13	3	43
20. Raquel	English	46	16	3	45
21. Grace	English	7	5	4	44
22. Iliana	Spanish	4	1	2	43
23. Danita	Spanish	0	3	2	43
24. Ariela	Spanish	6	34	3	42
25. Becky	English	3	3	2	45
26. Tayla	English	2	1	2	40
27. Jasmine	English	16	8	6	38
28. Hannah	English	8	10	1	39
29. Jade	English	8	17	1	39

^aCenter for Epidemiologic Studies-Depression Scale (CES-D) scores at the time of data collection during the first phase of the study (Time 1 = T1), and the time of follow-up data collection during the second phase of the study (Time 2 = T2), with clinically concerning scores 16.

^bRounded to nearest month of age.