

 **Proposed Core Hypothesis**

Families are the epicenters of social environmental influences on children's health and development (Demo & Cox, 2001; McLoyd, Cauce, Takeuchi, & Wilson, 2001; Moen, Elder, & Luscher, 1995). In most studies of children's health and development, family variables are hypothesized to have a direct, mediating, or moderating influence depending on the outcome of interest (e.g., obesity, asthma, mental health). Our review of existing research suggests that the most important domains of familial influences on children's health and development are family characteristics, family interactions (including those with social networks and social institutions), and parenting.

In the context of family characteristics, four factors emerge as critical influences: (1) ***family structure***, comprising attention to parental unions, household composition, and family living arrangements; (2) ***family race/ethnicity/culture***, as they influence equitable access to health care and knowledge and pre-disposes children to certain illnesses and treatment practices; (3) ***family resources***, including income, wealth, health insurance, and human capital and, (4) ***family physical and mental health***, inclusive of parents, children's siblings, and other household members.

The domains of family interaction include: (1) ***family violence***, encompassing both domestic violence and child maltreatment; (2) ***family social networks***, comprising systems of social support and resource exchanges among extended kin and friends; and (3) ***family ties to social institutions***, which concerns families' engagements with neighborhood agencies, child care, schools, and religious organizations.

With respect to parenting, four factors are considered important depending on the health outcome of interest: (1) ***parental socialization*** involving practices relative to gender and health experiences of children; (2) ***parental monitoring*** of children within and across various social environmental contexts (e.g., high risk neighborhoods); (3) ***parental advocacy and help-seeking***, which concerns parents' abilities to acquire resources for their children's health; and (4) ***parenting style***, which encompasses the degree of warmth, affection, communicativeness, and control that parents convey to their children.

We define family as all related individuals in a family household, wherein at least two members are related by blood, marriage, or adoption, one of whom is the householder. Our overall hypothesis is:

*Pathways to specific child health and development outcomes are directly influenced, mediated, and/or moderated by family characteristics, patterns of family interaction, and parenting behaviors that support the healthy functioning and development of children's*

*biological regulatory systems and healthy psychosocial functioning (emotion regulation and social competence) and that meet their basic nutritional, health, and safety needs.*

Sub-hypotheses are:

- ☞ **Sub-Hypothesis 1:** Changes in family structures, including parental unions, household composition, and living arrangements can facilitate or inhibit healthy child outcomes. Multiple changes, over time, in any of these domains compromise children's physical and mental health.
- ☞ **Sub-Hypothesis 2:** The racial/ethnic status of families differentially impacts children's access to health care and parent's access to health care knowledge. Racial/ethnic minority families and their children are likely to have higher morbidity and mortality than whites from the same conditions, in part because they experience greater disparities in health care and acquiring health knowledge. Cultural risk or protective factors associated with minority status (e.g., supports for health-protective behaviors among first-generation immigrants, knowledge and use of alternative medical practices, norms supporting antisocial behaviors or delay of appropriate health care) will contribute to variability in the health experiences of racial/ethnic minorities.
- ☞ **Sub-Hypothesis 3:** The quantity, quality, and allocation of family resources (e.g, income, human capital) influences the health and development of children (*See also the Socioeconomic Status hypotheses*).
- ☞ **Sub-Hypothesis 4:** The mental and physical health of parents affect the quality of parenting that their children receive as well as the parents' abilities to acquire resources (e.g., hold a job) on their children's behalf. Children with less healthy parents are more likely to be less healthy themselves, in part because of shared genetic predispositions but also because of poorer quality parenting and compromised access to resources. In addition to the parents, the more household family members (e.g., siblings) that are in poor health and require substantial family resources, the more likely a child is to experience physical and mental health problems.
- ☞ **Sub-Hypothesis 5:** Children who experience family violence via child maltreatment or witnessing domestic violence are more likely to be victims of severe injury or death and have mental health problems.
- ☞ **Sub-Hypothesis 6:** Families' social networks may have positive or negative influences on child health and development by providing access to instrumental and/or emotional support, placing demands on parents' time for helping others, providing access to information and health-supportive resources, exposing children to positive or abusive relationships, or supporting healthy or unhealthy norms for health-related behaviors. (*See also the Social Network hypotheses*).

- ☞ **Sub-Hypothesis 7:** Families' interactions with and engagement of their children in community institutions, including child care, schools, and religious organizations, influence children's health and development both directly, and indirectly through the formation of supportive social networks. (*See also the Formal Institutions hypotheses*).
- ☞ **Sub-Hypothesis 8:** Parents' differential health behavior socialization of boys and girls will be associated with gender differences in children's injuries, identification and reporting of illnesses, health care seeking behavior, and treatment compliance across the life course.
- ☞ **Sub-Hypothesis 9:** Parental monitoring of and sensitivity to children's activities will influence the prevalence and severity of children's injuries and illnesses.
- ☞ **Sub-Hypothesis 10:** Parental investments in health advocacy and help-seeking behaviors on behalf of their children contribute to better physical and mental health outcomes in children.
- ☞ **Sub-Hypothesis 11:** Parenting styles will differentially impact the health and development of children. Harsher parenting styles will be associated with less positive outcomes for children. However, the variability in outcomes associated with certain parenting styles will be a function of the family's race/ethnicity/culture.

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