



Mothers and Their Children: An Exploration of the Relationship Between Maternal Mental Health and Child Well-Being

D. Crystal Coles¹ · Jamie Cage²

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Abstract

Introduction Psychosocial factors and life stressors have an impact on long-term health effects on mothers and their children. Recent studies examining maternal mental health have predominantly focused on identifying maternal experiences with depression; however, there has been minimal research investigating maternal experiences with psychosocial risk factors and its relationship with child well-being.

Methods Secondary analysis was conducted using data from the Fragile Families and Child Well-Being Study. The study sample includes 2396 adolescents and their biological mothers. Adolescents were between the ages of 14 and 19. We examined primary outcomes regarding mental health (depression and anxiety), life-satisfaction, and substance usage (alcohol and drugs).

Results The association between maternal psychosocial factors and adolescent depression was significant, $F(26) = 5.29$, $p < .01$. Mothers' educational attainment and poverty level significantly predicted adolescent depression; with completion of some college ($B = -0.411$, $p = 0.025$), a college degree ($B = -0.540$, $p = 0.018$), and living at the 300% poverty level ($B = -0.725$, $p = 0.002$) predicting lower levels of adolescent depression.

Conclusion Our study demonstrates that there was a positive relationship between maternal mental health and adolescent mental health. Further, this study demonstrated that maternal mental health and social determinants of health are predictors of adolescent mental health and social functioning, thus indicating an inextricable connection to child well-being.

Keywords Maternal mental health · Child well-being · Depression · Anxiety

Significance Statement

What is known? Despite studies identifying that women are experiencing rates of depression, particularly during the early years of parenting, few studies have examined the interconnectedness of maternal mental health and child well-being. *What this study adds?* There was an association between maternal mental health and child well-being, with an emphasis on comprehending how social determinants of health impact the mental and emotional well-being of mothers and children.

Background and Introduction

Understanding the connection between maternal mental health and child well-being is essential to decreasing health disparities being faced by families. Social determinants of health such as socioeconomic status, educational attainment, employment opportunities, and life satisfaction have an impact on long-term health effects on mothers and their children (Shonkoff et al., 2009). Over the past decade, there has been an increase in awareness as it relates to women's health, specifically to the impact of psychosocial risks as it relates to mothers (Wood et al., 2017; Price & Masho, 2014). Maternal mental health has been extensively studied during and around the time of pregnancy (Author; Price & Masho, 2014), with a primary focus on women experiencing depressive symptoms (Wood et al., 2017; Abrams & Curran, 2010). Maternal depression has been recognized as a public health concern and the implications on women and children, during and around the time of pregnancy, has been acknowledged

✉ D. Crystal Coles
crystal.coles@morgan.edu

¹ School of Social Work, Morgan State University, 1700 E Cold Spring Lane, Baltimore, MD 21251, USA

² School of Social Work, Virginia Commonwealth University, Richmond, VA, USA

(Thompson et al., 2018). For example, maternal and child health programs have enhanced their services by providing behavioral health screens (Price & Masho, 2014); however, while placing a specified emphasis on depression, other psychosocial factors and life stressors are viewed in a separate capacity.

Mothers who experience elevated psychosocial risk factors face challenges related to their mental, physical, and emotional health (Author); however, they are also challenged with ensuring the safety and well-being of their children. Literature has demonstrated a relationship between risk and protective factors for infants and maternal mental health in areas such as stress, depression, and anxiety (Brown et al., 2020; Nelson et al., 2018) and has implications for health outcomes of children and adolescents as they progress developmentally (Berge et al., 2006). Research has demonstrated that one in four women, even ten years after childbirth, report experiencing mental health symptoms (Brown et al., 2020). These symptoms include indicators of post-traumatic stress, depression, and anxiety.

Several studies have identified child well-being as a holistic approach to understanding the quality of life and functioning of children over domains inclusive of physical, mental and behavioral health; social and emotional health; safety and the physical environment; economic security; and academic and intellectual outcomes (Rushton et al., 2015; Jones et al., 2015; Newman & Holupka, 2015). Child well-being studies have demonstrated that children facing life stressors are at a higher risk for increased levels of depression, anxiety, stress and other behavioral health risk factors (Lugaila, 2003). For example, contributions of familial and environmental factors, such as home instability, can be viewed as an indicator of behavioral health outcomes in children (Wood et al., 2017); while exposure to abuse or neglect can be linked to poor outcomes for child well-being. In other words, the concept of child well-being has expanded from an emphasis on child protection to a holistic view of what encompasses childhood wellness (Raghavan & Alexandrova, 2015). Thus, the promotion of child well-being has long lasting impacts for the child (Rushton et al., 2015).

Literature suggests that health areas related to physical health, mental health, emotional health (Newman & Holupka, 2015) and the family environment are contributors to the overall well-being of children. Evidence has demonstrated that parental psychosocial risks have the potential to contribute to adverse outcomes for children inclusive of social problems, substance abuse, and physical health concerns (Wood et al., 2017; Ringoot et al., 2015; Hernandez et al., 2010). Though these studies have emphasized the necessity of comprehending the psychosocial risks that mothers are experiencing and the implications of behavioral health risks on a mother's overall functioning (Price & Masho, 2014; Author), there has been minimal research

conducted on how maternal mental health and maternal experiences with behavioral health risk factors impact the overall well-being of their children.

The current study aimed to investigate the association between maternal mental health and child well-being. Specifically, this study aims to: 1) identify the primary psychosocial risks (individually and concurrently) experienced by mothers, 2) determine any child well-being mental health outcomes for children with mothers experiencing psychosocial risks, and 3) identify whether or not there was a relationship between maternal psychosocial risks and child well-being.

Methods

Data and Sample

Secondary analysis was conducted using data from the Fragile Families and Child Well-Being Study. Fragile Families is a nationally representative longitudinal study and children and families in the United States. The Fragile Families and Child Wellbeing Study is a new data set that follows a cohort of approximately 5,000 children born between 1998 and 2000 in medium to large U.S. cities for a 15-year period (Reichman et al., 2001). Mothers and fathers were interviewed by telephone when their children were approximately 1, 3, 5, 9 and 15 years old. Baseline response rates were 82% for married mothers and 87% for unmarried mothers. Of the 4,898 mothers who participated in the baseline survey, 89%, 86%, 85%, and 74% participated in the 1, 3, 5, 9 and 15 -year surveys, respectively (Families, 2008). The current study uses data from Year 15 which was collected between 2014 and 2017. This study was exempt from ethical approval because it was limited to publicly available datasets that contained no personally identifiable information. All participants provided informed consent to the Fragile Families and Child Wellbeing Study interviewers before being enrolled within the study.

The study is designed to examine (1) the overall conditions of “fragile families”; defined as “unmarried parents and their children” (Reichman et al., 2001); (2) the outcomes of children born into fragile families; and (3) to examine how ecological factors related to the condition of the primary mothers' relationship, contextual policies, and environmental factors children's parents influence children's outcomes. The study includes six waves of data; coinciding with the year of follow up. Children and their mothers were interviewed at Baseline at Year 1 follow-up, year 3 follow up, Year 5 year follow-up, Year 9 follow-up, and Year 15 follow-up. The current study uses data from the 15 year follow-up. This study sample includes 2,396 adolescents and their biological mothers. Adolescents were between the ages

of 14 and 19 at the year 15 data collection. Families were only included in the study if they had complete data on all study variables in follow-up Year 15.

Adolescent Mental Health

Adolescent mental health well-being was measured from the adolescent's depressive symptomatology and anxiety. Adolescent depression was measured from five-items associated with the Center for Epidemiologic Studies Depression Scale (CES-D). A raw score was created by summing the answers to all four questions. All, but one item (*i feel happy*) was reverse coded so that higher numbers would indicate higher levels of depressive symptomatology. The 5 items were then summed to create a total depressive symptomatology score. Adolescent anxiety was measured from six-items mirroring the Brief Symptom Inventory 18 (BSI 18). A total anxiety score was created by summing the responses of all six-items.

Adolescent Characteristics

Adolescent characteristics include age and race/ethnicity. The adolescent's gender was not reported in the year 15 data. Adolescents self-reported on their demographics. The following categories were used to measure adolescent race/ethnicity: 0 = Non-Hispanic White, 1 = Non-Hispanic Black, 2 = Hispanic, 3 = Non-Hispanic Other.

Mother's Life-Satisfaction

Mother's self-reported on their life satisfaction on a four-point likert Scale: 0 = Very Dissatisfied, 1 = Somewhat Dissatisfied, 3 = Somewhat Satisfied, and 4 = Very Satisfied.

Mother's Education

Mother's self-reported on the highest level of education they completed. Answer choices included 0 = less than high school, 1 = High school or equivalent, 2 = some college or technical school, and 3 = college or graduate school.

Mother's Alcohol Use

Mother's alcohol use was measured by both the mother and the adolescent. Both mothers and adolescents reported on how often the mother drinks alcoholic beverages. Responses ranged from 0 (Never) to 5 (Every day or nearly every day).

Mother's Drug-Use

Drug use was measured from both the mother's report of whether or not she used illicit drugs in the past year, and the adolescent's report of the mother's drug use. Both the

mother and the adolescent responded *Yes* the mother using drugs or *No* to the mother using drugs.

Mother's Anxiety

Anxiety was measured from the mother's endorsement of feeling anxious or worried for at least a month during the past year.

Mother's Depression

FF constructed a variable measuring mother's "liberal scale" of major depression based on the extent to which the adolescent's mother reported experienced symptoms of depression at least half of the day for a two-week period. The constructed variable measures the "probable case" or "non-probable" case of the mother meeting the "liberal scale" of depression.

Household Poverty

Mothers reported on their income in ranges. Income ranges were constructed in official U.S. Census Bureau poverty thresholds.

Data Analysis

Two ordinary least squares linear regression analyses were then conducted to test the relationship between mother's psychosocial factors and adolescents well-being related to their mental health. All variables, except for dummy coded variables showed no indication multicollinearity, as evidenced by highest VIF score being 3.0, and all Tolerance values greater than 0.40 (Allison, 1999). For the regression analysis, dummy codes were created for the adolescent's race (Non-Hispanic Black as the reference group), adolescent's report of maternal alcohol use (never drinking as the reference group), mother's education (less than HS as the reference group), subjective rating of her overall health (poor health as the reference group), satisfaction with life (very dissatisfied as the reference group), maternal alcohol use (never drinking as the reference group), and household poverty level (<49% as the reference group).

Results

Adolescents were 15 years of age, on average (SD = 0.74). Nearly half of the adolescents identified as Non-Hispanic Black (49.3%), followed by Hispanic (24.1%), Non-Hispanic White (18.9%), and Non-Hispanic Other (7.8%). Adolescent depression ranged from 0 to 15 with an average level of depression being relatively low (M = 2.98, SD = 3.01).

Similarly, rates for adolescent anxiety were low with an average depression level of 4.89 (SD = 3.91), rates ranged from 0 to 18. The majority of the mothers did not report experiencing anxiety (79.8%) or depression (81.2%). Descriptive statistics showed that the majority of the adolescents (98.9%) and their mothers (94.7%), reported no maternal drug use. Therefore, maternal drug use was not included in any analyses. Characteristics of the adolescents and their mothers are presented in Table 1.

Table 2 displays the linear regression results of mental health outcomes for adolescents. Model 1, which tested the association between psychosocial factors related to the mother and adolescent depression, was significant, $F(28) = 5.02, p < 0.01$. Mothers educational attainment and poverty level significantly predicted adolescent depression; with completion of college degree ($B = -0.54, p = 0.028$), and living at the 300% poverty level ($B = -0.90, p = 0.000$) predicting lower levels of adolescent depression. Whereas, the adolescent's report of their mother's consuming alcoholic every day or nearly every day ($B = 1.30, p = 0.002$), the mother's report of her consuming alcoholic beverages 1 to 2 days per week ($B = 0.48, p = 0.027$), and the mother's anxiety ($B = 0.39, p = 0.026$) were associated with higher levels of adolescent depression. Additionally, White ($B = 0.29, p = 0.03$) and "Other" race ($B = 0.50, p = 0.03$) adolescents had significantly higher levels of depression than Black adolescents.

Model 2 examined the association between the mother risk factors and the adolescent's anxiety. This model was also significant, $F(28) = 2.89, p < .01$. In this model, the adolescent's race was significantly associated with anxiety. With White ($B = 0.48, p = 0.04$) and Hispanic ($B = 0.59, p = 0.004$) race adolescents having higher levels of anxiety than Black youth. The adolescent reporting that their mothers consumed alcoholic beverages every day or nearly every day ($B = 1.43, p = 0.010$) was associated with higher levels of adolescent anxiety. Additionally, the mother's level of depression ($B = 0.47, p = 0.047$) was significantly associated with higher levels of adolescent anxiety.

Discussion

Child well-being is a multifaceted concept that is inclusive of health areas related to the physical, mental, and emotional health (Newman & Holupka, 2015). This study places an emphasis on a collective and cumulative understanding regarding the impact of depression, substance use, anxiety and social determinants of health such as education, income level, and overall life satisfaction as a mechanism to understand maternal mental health and child well-being. Our study demonstrates that there was a positive relationship between maternal mental health and adolescent mental

Table 1 Characteristics of the sample ($N = 2396$)

Variables	N/%	M (SD)
<i>Adolescent characteristics</i>		
Adolescent age		15.54 (0.74)
Adolescent race		
Non-hispanic White	452 (18.9%)	
Non-hispanic Black	1181 (49.3%)	
Hispanic	577 (24.1%)	
Other race	186 (7.8%)	
<i>Report of maternal substance use</i>		
No	2369 (98.9%)	
Yes	27 (1.1%)	
<i>Report of maternal alcohol use</i>		
Never	1032 (43.1%)	
1–3 Days per month	945 (39.4%)	
1 or 2 days per week	289 (12.1%)	
3–4 days per week	70 (2.9%)	
Every day/Almost every day	60 (2.5%)	
Adolescent anxiety		4.89 (3.91)
Adolescent depression		2.98 (3.01)
<i>Maternal and household characteristics</i>		
Maternal education		
Less than high school	376 (15.7%)	
High school or equivalent	435 (18.2%)	
Some college or technical school	1087 (45.4%)	
College or graduate school	498 (20.8%)	
Household poverty level		
<49%	313 (13.1%)	
50–99%	394 (16.4%)	
100–199%	677 (38.3%)	
200–299%	342 (14.3%)	
300%	670 (28.0%)	
Maternal substance use		
No	2270 (94.7%)	
Yes	126 (5.3%)	
Maternal alcohol use		
Never	732 (30.6%)	
1–3 Days per month	1189 (49.6%)	
1 or 2 days per week	341 (14.2%)	
3–4 days per week	86 (3.6%)	
Every day/Almost every day	48 (2.0%)	
Maternal health		
Poor	65 (2.7%)	
Fair	403 (16.8%)	
Good	788 (32.9%)	
Very good	755 (31.5%)	
Excellent	385 (16.1%)	
Maternal satisfaction with life		
Very dissatisfied	35 (1.5%)	
Somewhat dissatisfied	192 (8.0%)	
Somewhat satisfied	1055 (44.0%)	

Table 1 (continued)

Variables	N/%	M (SD)
Very satisfied	1114 (46.5%)	
Maternal anxiety		
No	1911 (79.8%)	
Yes	485 (20.2%)	
Maternal depression		
No	1945 (81.2%)	
Yes	451 (18.8)	

health. Specifically, we demonstrated that maternal mental health and social determinants of health, are predictors of adolescent experiences of anxiety and depressive symptoms.

Social determinants of health, life stressors, and adversities shape and influence maternal mental health. In congruence with previous studies, findings from this study demonstrated that social determinants of health such as income level, education, and overall life satisfaction undergird maternal mental health and adolescent mental health. For instance, previous literature has identified that life stressors and struggles with mental health decreases adult capacity to care for their children which recent advancements

Table 2 Hierarchical regression analysis of adolescent depression and anxiety

	Model 1 adolescent depression			Model 2 adolescent anxiety		
	B	SE	β	B	SE	B
Adolescent age	0.10	0.08	0.02	-0.06	0.11	-0.01
Adolescent Race/White ¹	0.39*	0.18	0.05	0.48*	0.24	0.05
Adolescent Race/Hispanic ^a	0.30	0.16	0.04	0.59**	0.21	0.06
Adolescent race/"Other" ^{aa}	0.50*	0.24	0.04	0.48	0.31	0.03
A_1-3 Days/month ^b	0.02	0.14	0.00	0.21	0.19	0.03
A_1-2 days/week ^b	0.16	0.22	0.02	0.44	0.28	0.04
A_3-4 days/week ^b	0.45	0.39	0.03	1.12	0.51	0.05
A_Every day ^b	1.30**	0.42	0.07	1.43**	0.56	0.06
Mother HS ^c	-0.11	0.21	-0.01	-0.35	0.28	-0.04
Mother some college ^c	-0.35	0.19	-0.06	-0.23	0.25	-0.03
Mother college ^c	-0.52*	0.24	-0.07	-0.31	0.31	-0.03
50-99% Poverty level ^d	-0.14	0.23	-0.02	0.33	0.30	-0.03
100-199% Poverty level ^d	-0.45*	0.21	-0.07	-0.05	0.27	-0.01
200-299% Poverty level ^d	-0.35	0.24	-0.04	-0.42	0.32	-0.04
300% Poverty level ^d	-0.90***	0.24	-0.13	-0.72*	0.31	-0.08
1-3 Days/month ^e	0.08	0.15	0.01	0.02	0.20	0.00
1 or 2 days/week ^e	0.48*	0.22	0.06	0.05	0.29	0.01
3-4 days/week ^e	-0.02	0.36	-0.00	-0.17	0.48	-0.01
Every day/almost every day ^e	-0.30	0.47	-0.01	-0.75	0.62	-0.03
Maternal health: fair ^f	0.06	0.40	0.01	-0.75	0.53	-0.07
Maternal health: good ^f	-0.02	0.39	-0.00	-0.66	0.52	-0.08
Maternal health: very good ^f	-0.32	0.40	-0.05	-1.01	0.53	-0.12
Maternal health: excellent ^f	-0.41	0.42	-0.05	-1.04	0.55	-0.10
Life_somewhat dissatisfied ^g	0.29	0.54	0.03	-0.16	0.72	-0.01
Life_somewhat satisfied ^g	-0.17	0.51	-0.03	-0.11	0.68	-0.01
Life_very satisfied ^g	-0.53	0.52	-0.08	-0.34	0.68	-0.04
Maternal anxiety	0.39*	0.18	0.05	0.34	0.23	0.04
Maternal depression	0.16	0.18	0.02	0.47*	0.24	0.05

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

^aAdolescent's race Dummy Code: Non-Hispanic Black as the reference group

^bAdolescent's report of maternal alcohol use Dummy Code: never drinking as the reference

^cMother's education Dummy Code: Less than HS as the reference group

^dHousehold poverty level Dummy Code: <49% as the reference group

^eMaternal Alcohol Use Dummy Coded: Never drinking as the reference group)

^fMaternal subjective rating of health Dummy Code: poor health as the reference group

^gMaternal satisfaction with life Dummy Code: very dissatisfied as the reference group

in neuroscience demonstrate have lasting implications for child health and well-being (Anda et al., 2007; Shonkoff, 2010; Shonkoff et al., 2012). Campo-Arias and De Mendieta (2021) argue that psychological well-being and social inequalities, such as poverty, must be considered concomitantly to fully address syndemic impacts to the mental health of women.

Consistent with previous literature, maternal mental health significantly predicted adolescent mental health. Interestingly maternal depression predicted adolescent anxiety but not adolescent depression, and maternal anxiety predicted adolescent depression but not anxiety. Our findings are somewhat consistent with previous literature that found maternal depression was consistently linked to adolescent anxiety but not depression (Halligan et al., 2007). In their prospective longitudinal study examining the mental health outcomes of adolescents whose mothers experienced postnatal depression, Halligan and colleagues (2007) found that maternal depression was only linked to adolescent depression if mothers experienced depression both during their postnatal stage and in another episode. However, maternal postnatal depression was linked to adolescent depression despite subsequent episodes of depression. These findings may coincide with research suggesting that maternal depression negatively impacts parenting abilities and responsiveness to their children, often resulting in more anxious attachment responses from children (Brenning et al., 2012). Anxiety associated with attachment may have a longer effect on children and adolescents than depressive symptoms that may be momentarily.

Although our findings are aligned with some literature, they are incongruent with previous literature that has shown direct relationships between maternal depression and adolescent depression (e.g., Monti & Rudolph, 2017; Hammen & Brennan, 2003). The difference in our findings from previous literature may be explained by methodological differences. Some research has grouped adolescent anxiety and depression, measuring them together under the broader umbrella of internalizing behaviors (e.g. Ahun et al., 2018; Goodman et al., 2011). As indicated by our findings, results may differ when anxiety and depression are examined as individual constructs. Additionally, although research has shown a link between maternal depression and anxiety to adolescent mental health outcomes, research does not regularly examine how one form of maternal mental health predicts adolescent outcomes while controlling for another mental health concern. Our study controlled for the other mental health concerns of the mother, and therefore may be contributing to the difference in our findings. Additionally, our study controlled for maternal alcohol and life satisfaction, two factors that are associated with maternal mental health.

Research has indicated that adolescents experience higher rates of depression and anxiety in stressful home

environments (Turney & Wildeman, 2016). More specifically, they are five times as likely to have experiences with anxiety, six times as likely to have behavioral problems, and seven times as likely to experience depression. As a result, adolescence may experience high rates of internalized problems (i.e. depression, anxiety, etc.) that can impact social functioning inclusive of: problems with peers, interactions in school/work, relationships with peers, and identified friends (Vis et al., 2016). In other words, when behavioral and cognitive functioning are prevalent, social functioning can be problematic for youth. Our current study showed that maternal mental health and social determinants of health are predictors of adolescent mental health and social functioning, thus indicating an inextricable connection to child well-being.

Limitations

The strengths of this study are rooted in its approach to assessment and evaluation of two populations that are inextricably connected; yet often studied in silos. Despite the implications of maternal mental health on the ability to function in a parental role, often times, maternal health and child well-being are studied independently, despite the interrelationship of each population. However, this study has several notable limitations. First, due to the nature of secondary data analysis, the study is limited to the variables that existed within the dataset. As such, the authors were not able to account for other maternal factors that have been shown to be associated with adolescent mental health. For example, mother's traumatic experiences like domestic violence were not able to be examined as a part of this study. Mother's anxiety was limited to a dichotomous variable. The presence or absence of anxiety does not allow for an examination of severity, and results may differ by based on severity of anxiety. Therefore, future research would benefit from using more nuanced scales to measure the mother's level of anxiety. Lastly, due to the cross-sectional nature of the study we are not able to examine onset and duration of adolescent mental health. Further studies could also benefit from an analysis of multiple time points with two or more occurrences of depression/anxiety on adolescent outcomes. Such information provides an opportunity for future research to examine. Being able to identify when and how long will be necessary for prevention and intervention efforts.

Conclusion

A primary purpose of the study is to increase comprehension regarding a health culture that promotes wellness within the family through the lens of health interconnectedness.

The examination of the well-being of children within the context of health and mental health has been rarely studied in conjunction with the health and well-being of the maternal parent. Literature demonstrates that there was a relationship between parental mental health and child health (Berge et al., 2006); thus, understanding the interconnectedness of child well-being and maternal child health must be addressed. Maternal child health programs and practice models typically include supportive home-based services meant to enhance client well-being (Price & Cohen-Filipic, 2013). However, these maternal child health programs have barriers to effective mental health screening and treatment; thus, limited attention gets paid to connections among psychosocial and behavioral risk factors and linkages between maternal mental health and adolescent mental health, (Price & Masho, 2014). Maternal child health practice models need to be more flexible and inclusive of adaptable interventions based on contextual needs both unique to and across parents and children. Although it is commonly believed that maternal mental health can impact a child during and around the time of pregnancy, there has been minimal evidence about the relationship between maternal mental health and child well-being. Therefore, diagnosis, interventions, and outcomes need to be transitioned to focus on these aspects of care from an interconnected space. This new evidence suggests that maternal mental health may be a prominent predictor of child well-being throughout adolescence and should be considered within the maternal child health domain.

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