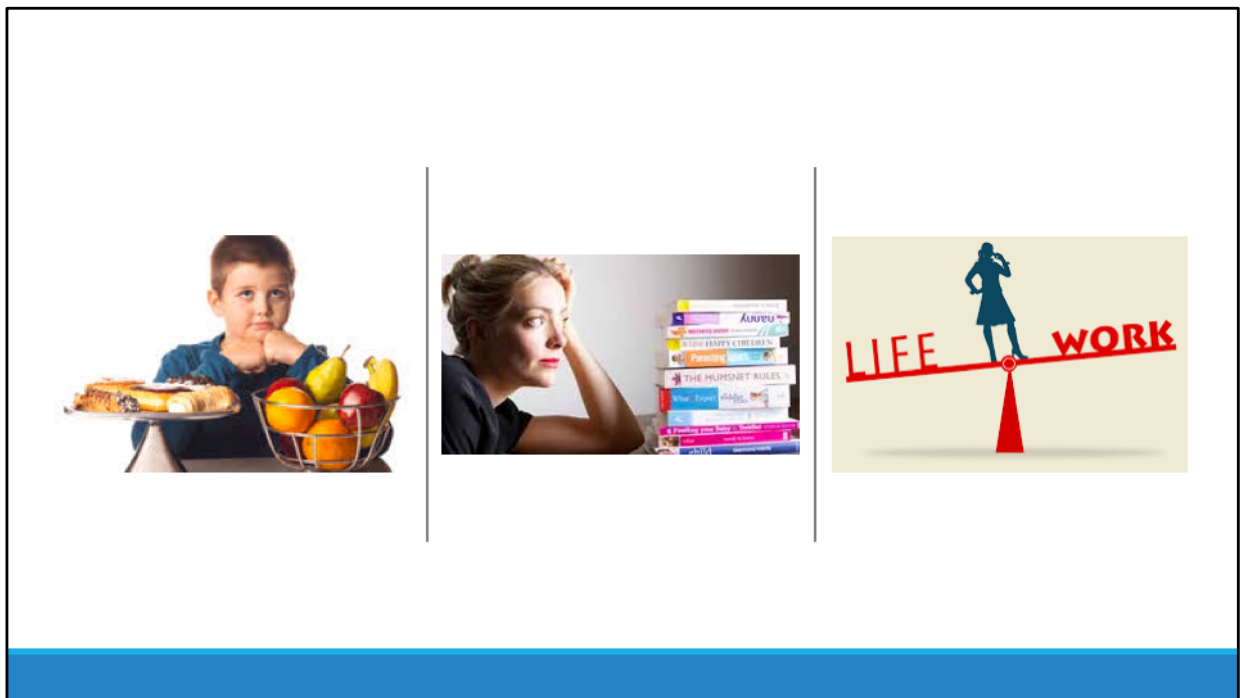
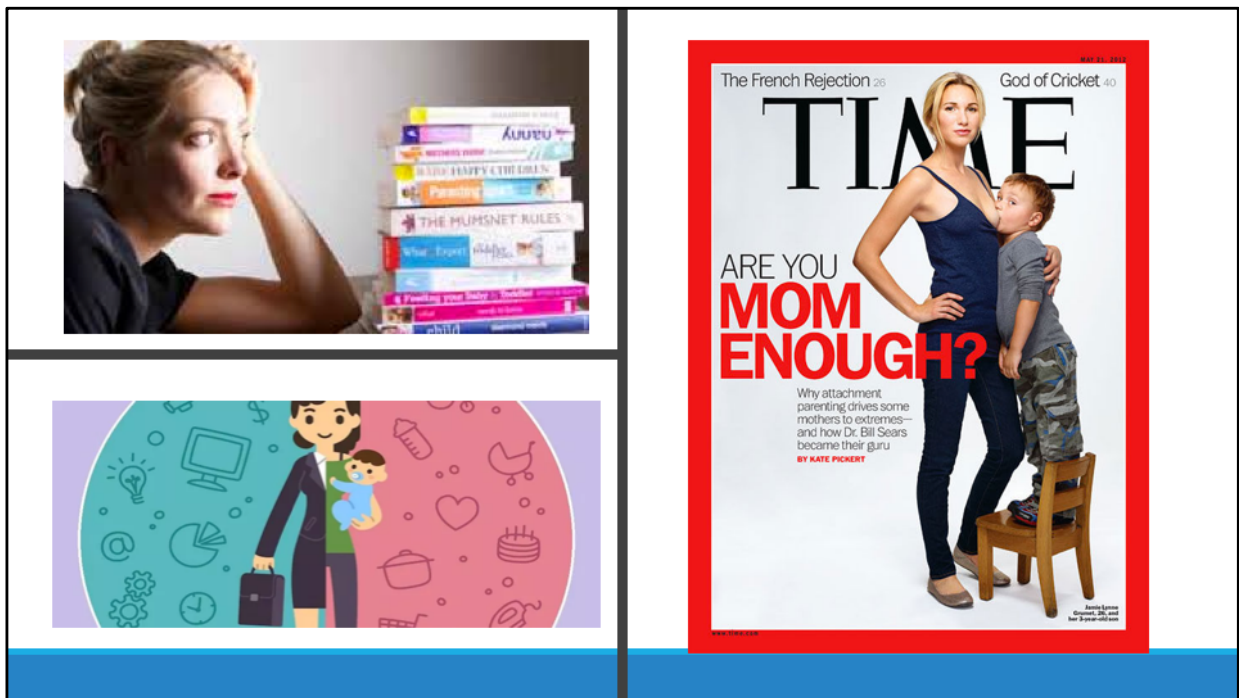


In the Best Interests of Children? The Paradox of Intensive Parenting and Children's Health

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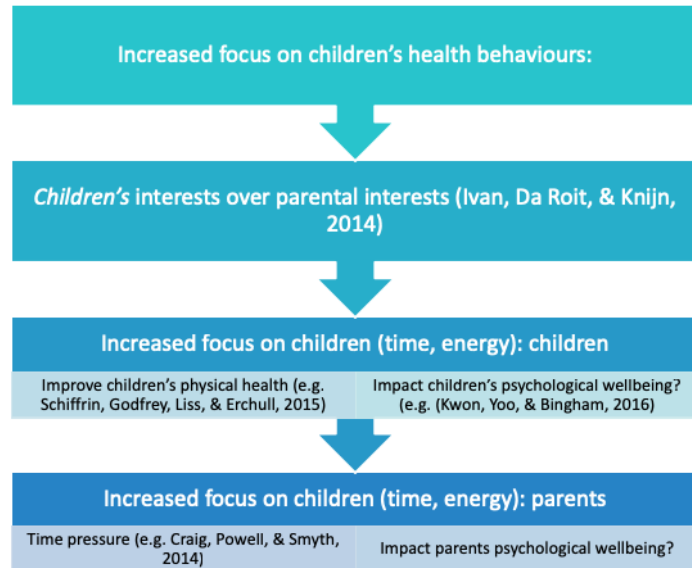
Our initial idea for this paper is different than what I'm presenting here today. I work at the Department of Interdisciplinary Social Science at Utrecht University, where I work with colleagues from a variety of disciplinary backgrounds – primarily psychology, sociology, social policy, public health. During a discussion about common research interests, we started talking about children's and parent's health; in relation to eating behaviours, parental modelling, intensive parenting and work-life balance. These topics mirrored our own research interests and expertise, but also allowed us to look at a modern phenomenon with different viewpoints.



Because in our multiple disciplines, parents – and moms in particular, are under great pressure to be the perfect parents. From a work-family perspective, mothers are attempting to reconcile often competing demands of work, family, their own lives. We know that parents experience significant time pressure in their negotiation of work and family commitments and work-family research, e.g. from Craig, Powell and Smyth (2014) shows that the increased emphasis placed on parents' roles in children's health outcomes adds to the pressures of reconciling work and family (Craig, Powell, & Smyth, 2014).

Additionally, the way in which parents (mothers) reconcile work and family roles, affects parenting styles and the time parents have to invest in parenting, which can also affect health outcomes for children and parents (e.g. parents have less time to engage in health promoting behaviours; see Pagnan, Seidel, & Wadsworth, 2017).

Health paradox?



Our idea is that these concurrent pressures are possibly leading to a health paradox. One in which the increased focus on children's health behaviours and the role of parents in shaping children's health, means that:

Children's interests are taking front seat to parental interests, as a consequence of parents spending more time raising children.

On the one hand, this can have positive effects, for example on children's physical health. But it's not clear whether the increased time spent raising children has positive effects on children's psychological wellbeing. In fact, research from Schiffrin and colleagues (2015) suggests the effect of parental involvement on children follows an inverted U-shape: Children of highly involved parents show higher levels of internalizing problems such as anxiety and depression, and higher levels of externalizing problems when reaching adolescence. At student (college) age, these young people again show higher levels of anxiety and lower levels of coping skills.

At the same time, the increased focus on children can negatively impact parents – leading to increased feelings of time pressure, as well as reduced psychological wellbeing. Our initial idea was to look into these issues concurrently – whether the increased emphasis on parental modelling and intensive parenting positively affects children's physical health, while negatively affecting children and parent's

psychological health. But as often happens with initial ideas, this turned out to be too complex for one paper – so we've split these out. And for now, we're focusing on the possible paradox for children's health, specifically in relation to intensive parenting.

Background to children's health paper

- ❖ Children's health and wellbeing as focal point of social and scientific concern
- ❖ Importance of **family environment** and **parental modelling and guidance** as salient determinants of children's health and wellbeing
- ❖ Shift from identifying to preventing disorders, encouraging protective factors (e.g. secure attachment; see (Bell, McNaughton, & Salmon, 2009; Jackson & Scott, 1999))

- Children's health and wellbeing is a focal point of social and scientific concern.
- Child development professionals, public health experts, paediatricians, and child psychologists increasingly emphasize the importance of the **family environment** (e.g. parents' socio-economic and socio-cultural status, parental support, providing children with autonomy and enabling healthy behaviours) as well as **parental modelling and guidance** as salient determinants of children's health and wellbeing.
- Concerns about children's health and development have moved from identifying disorders to preventing possible disorders and encouraging so-called protective factors (Bell, McNaughton, & Salmon, 2009; Jackson & Scott, 1999). (Example of attachment: secure attachment as a protective factor instead of insecure or anxious attachment as identifiers of a possible disorder).

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Background (II)

- ❖ Growing importance of **'intensive parenting'** ideology and **child (social) investment**

- ❖ Parenting increasingly seen as rational choice; make 'correct' or 'healthy' choices (Jackson & Scott, 1999; E. Lee, Bristow, Faircloth, & Macvarish, 2014).

- ❖ A normative framework for 'good' parenting: 'Good' parents choose to parent intensively = improved health outcomes for children

- ❖ Government-led social investment approach ((Hemerijck, 2017; Morel, Palier, & Palme, 2012)

Emphasis on parents' behaviour as key driver of children's health is reflected in contemporary western parenting styles, dominated by **'intensive parenting'**.

- Parenting is increasingly perceived as a **rational choice** that parents make as 'risk managers', who deliberate about the advantages and disadvantages of various parenting styles, but who are also implicitly expected to make correct or 'healthy' choices (Jackson & Scott, 1999; E. Lee, Bristow, Faircloth, & Macvarish, 2014). For example, the dominance of health education is reflected in parents' reliance (i.e. mothers) on expert advice for analysing, defining and resolving childrearing issues (Edwards & Gillies, 2004; Furedi, 2008; E. Lee, 2014). Parents not only increasingly rely on such expert advice, they are also expected to seek it (Faircloth, 2014; Hopman and Knijn, 2017; Macvarish, 2016; Ramaekers & Suissa, 2012). The emphasis on parental modelling sets a **normative framework for 'good' parenting**. 'Good' parents choose to parent intensively, thereby improving the health outcomes of their children.

- Further pressure on parents to invest time and energy in children stems from the simultaneous development of a government-led **social investment approach**: policies and interventions centred on improving children's skills, health and life chances (Hemerijck, 2017; Morel, Palier, & Palme, 2012) and breaking the cycle of social inequality.

- In this context, the empirical research does not necessarily support the theoretical claims. While in some cases IP is found to improve children's physical health, more recently, studies suggest it may negatively impact children's psychological wellbeing (e.g. study that shows it has a negative effect on children's locus of control). Little evidence that IP improves children's *psychological* wellbeing. IP could lead to relative loss of freedom and autonomy and more psychological problems later in life.

Intensive parenting

1. The belief that parenting is best done by mothers;

2. The belief that parenting is time intensive in order to meet all the child's needs;

3. The belief that parenting should be guided by expert knowledge;

4. The belief that parenting is expensive in order to organize all kinds of stimulating activities for children; and

5. The belief that children are inherently good, precious and innocent (Hays, 1996; Liss, Schiffrin, Mackintosh, Miles-McLean, & Erchull, 2013).

Intensive parenting is: 'child centered, expert guided, emotionally absorbing, labour intensive and financially expensive' (Faircloth, 2014: 27; Hays, 1996).

Intensive parenting – or more recent terminology such as hoovering, helicopter or snowplough parenting (Gopnik, 2016; Lemoyne & Buchanan, 2011; Ungar, 2009) – is predominantly formed around five “beliefs”:

Taken together, this means that intensive parenting is:

Intensive parenting & children's health

- ❖ Health discourse: family environment the single strongest influence on children's development, including health and wellbeing, until at least the age of 12, at which age peers take on a larger role.
- ❖ Parenting behaviours, such as parental modelling, as well as parental monitoring, support and encouragement, strongly influence children's health behaviours (Bauer et al., 2011; Pearson, Biddle, & Gorely, 2008).
- ❖ Parents rely on general parenting strategies (e.g. parental modelling, monitoring and controlling (as well as invest in building an open and trustful relationship with their children (authoritative parenting styles; e.g. Aunola & Nurmi, 2005; Baumrind, 1997; Darling & Steinberg, 1993).
- ❖ Parents who adopt an intensive parenting style adhere to these general parenting strategies in a rigorous fashion.

Health discourse in which the family environment is seen to be the single strongest influence on children's development, including their health and wellbeing, until at least the age of 12, at which age peers take on a larger role. Parenting behaviours, such as parental modelling, as well as parental monitoring, support and encouragement, strongly influence children's health behaviours (Bauer et al., 2011; Pearson, Biddle, & Gorely, 2008).

Intensive parenting & children's health (II)

- ❖ Evidence suggests clear link between (intensive) parenting and children's physical health.
- ❖ Evidence on intensive parenting in relation to children's *psychological* health not unequivocal.
- ❖ IP: perceives children as vulnerable; lacking agency
 - ❖ Children can experience a relative loss of freedom and autonomy (Wall, 2010)
 - ❖ Children may feel less competent, more anxious and more depressed (Kwon et al., 2016; Schiffrin et al., 2014).
- ❖ Contradicts general developmental psychological theories (e.g., Erikson, 1963, 1974; Marcia, 1980), with emphasis on importance of developing autonomy and self-confidence for healthy psychological wellbeing.
- ❖ Discourses against IP: emphasize importance of unsupervised and risky behaviours or differences in the perception of risks (Bristow, 2014; Shirani, Henwood & Coltart, 2012).

Hypotheses

- ❖ H1: intensive parenting should positively affect children's physical health;
- ❖ H2: No relationship between intensive parenting and psychological wellbeing of children;
- ❖ H3: Intensive parenting ideology (as a parenting style) can be distinguished from less intensive forms of parenting styles;
- ❖ H4: Intensive parenting leads to comparatively better physical health outcomes than other parenting styles;
- ❖ H5: Intensive parenting leads to comparatively worse psychological health outcomes for older children.



Positive effects on children's psychological health may only exist at early stages in life, becoming negative as children grown older. As it is unclear when this possible u-shape occurs, we test the null hypothesis that there is no relationship between intensive parenting and psychological wellbeing of children (H2).

Given an absence of evidence on the variation in the 'intensity' of intensive parenting, we explore the possibility of differentiating among parenting styles, assuming it is possible to distinguish an intensive parenting ideology that differs significantly from other forms of parenting styles (H3)

Data and analytic sample

- ❖ UK Millennium Cohort Study
- ❖ Longitudinal data on 19,519 children born in the UK in 2000-2001
- ❖ Complex sampling structure:
 - ❖ Stratified across ethnic groups and SES
 - ❖ Clustered across electoral wards
- ❖ Parent sample=15,590 (wave 2), 15,246 (wave 3), and 13,857 (wave 4).
- ❖ Children's sample sizes fluctuate between 10,424 and 10,836

We use data from the UK Millennium Cohort Study to compare children's physical and psychological health outcomes among parents who intensively parent against those who do not. The UK Millennium Cohort Study is a longitudinal study of more than 18,000 children born in the UK in 2000-2001 (University of London; Institute of Education; Centre for Longitudinal Studies, 2017). The study follows children and their families from birth through adulthood, offering rich data on children and parental outcomes and the relationships between parents and children. Surveys are administered every two-four years, and currently, six waves of data are available, with children aged 9 months, 3 years, 5 years, 7 years, 11 years and 14 years old. The study relies on a stratified clustered random sample design, with oversampling for disadvantaged (in all 4 countries of the UK) and ethnically diverse (in England) populations. For our analyses, data from wave 2 (child's age 3 years), wave 3 (child's age 5 years), wave 4 (child's age 7 years), wave 5 (child's age 11) and wave 6 (child's age 14 years; the most recent data available) were used. Data from wave 1 (child's age 9 months) was not used because there are no activities that could be clearly classified as 'intensive parenting'.

Children's sample sizes are considerably smaller, in particular given missing data on self-reported health and wellbeing measures. Sample size fluctuates between 10,424

(self-esteem; analyses with combined parent (wave 4) and child (wave 6) data) and 10,836 (general health; analyses with combined parent (wave 4) and child (wave 6) data).

Methods

- ❖ Principle component analysis/latent class analysis, comparison of means, and ANCOVA
- ❖ PCA/LCA: assign parents to 'intensive parenting' categories in each wave, and examine the relationships between these categories and children's health cross-sectionally.
 - ❖ PCA (per wave): do different parenting activities load onto a larger, latent factor?
 - ❖ Intensive parenting operationalized by the activities undertaken by the parent (main respondent) to encourage and support their child (cohort member)
- ❖ Are there significant differences in children's physical and psychological health outcomes across parenting styles? Comparison of means/ANCOVA (controlling for key socio-demographic characteristics).



characteristics (gender of parent and child, parent's ethnicity, and parent's age).

Measures

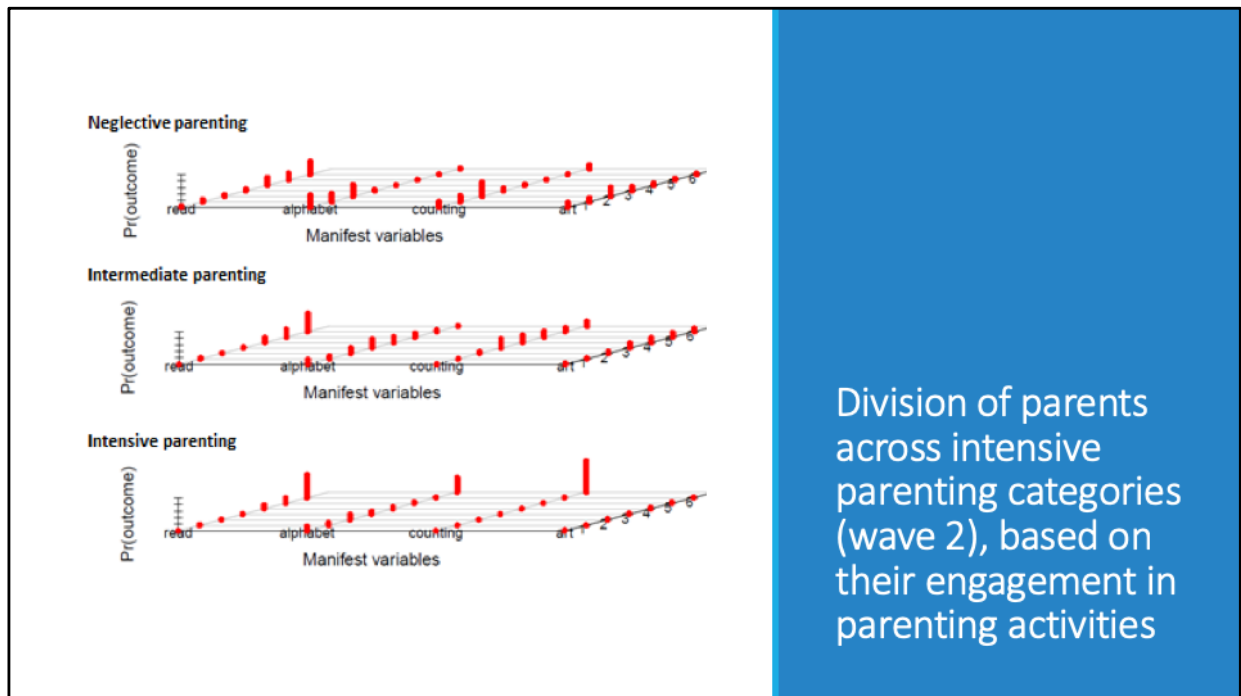
- ❖ Intensive parenting: variety of parenting activity items at each wave, corresponding to children's stage of development
- ❖ Children's health outcomes (wave 6); self-reported data
 - ❖ Physical health : perceived general level of health (Ware & Gandek, 1998) by the child measured on a 5-point scale (5=poor health; 1=excellent health; scale reversed for analyses)
 - ❖ Psychological wellbeing: the Rosenberg Self Esteem Scale (Rosenberg, 1979) and a child-appropriate scale based on the wellbeing grid (Patalay & Fitzsimons, 2016), developed for the BHPS
- ❖ Control variables (wave 6)
 - ❖ Parent: gender, age, ethnicity, education
 - ❖ Child: gender

Psychological wellbeing: In order to measure the psychological wellbeing of children, two measures were used: 1) the Rosenberg Self Esteem Scale (Rosenberg, 1979) and 2) a scale based on the wellbeing grid (Patalay & Fitzsimons, 2016), developed during the 1990s for the British Household Panel Study to measure wellbeing in a manner appropriate to children. All measures were taken from wave 6 and are self-reported data from the child respondent. The former includes five items, such as "On the whole, I am satisfied with myself" and "I feel I have a number of good qualities", all of which were measured on a 4-point scale with 4 being strongly agree and 1 being strongly disagree. The latter includes six items on how happy children are with school, family, friends, schoolwork, appearance and life as a whole. Items were measured on a 7-point scale, with answers ranging from not at all happy (7) to completely happy (1).

Intensive parenting styles?

	Wave 2		Wave 3		Wave 4	
	Item (scale)	PCA loading	Item (scale)	PCA loading	Item (scale)	PCA loading
Items included in LCA	How often does MR read to CM (1-6)	.715	How often does MR read to CM (1-6)	.996	How often does MR read to CM (1-6)	.991
	How often does MR help CM to learn the alphabet (1-7)	.617	How often does MR tell stories to CM (1-6)	.978	How often does MR tell stories to CM (1-6)	.983
	How often does MR try to teach CM to count (1-7)	.794	How often does MR do musical activities with CM (1-6)	.982	How often does MR do musical activities with CM (1-6)	.985
	How often does MR teach CM songs / poems / rhymes (1-7)	.735	How often does MR draw / paint with CM (1-6)	.996	How often does MR draw / paint with CM (1-6)	.997
			How often does MR play physically active games with CM (1-6)	.988	How often does MR play physically active games with CM (1-6)	.985
			How often does MR play games/toys indoors with CM (1-6)	.988	How often does MR play games/toys indoors with CM (1-6)	.987
			How often does MR take CM to park / playground (1-6)	.964	How often does MR take CM to park / playground (1-6)	.978
Eigenvalue		2.06		6.78		6.81
Explained variance		51.6%		96.9%		97.3%
Items not included in LCA	How often does MR take CM to the library (1-4)	.317	How often does MR help CM with reading (1-6)	.407	How often does MR help CM with reading (1-6)	.130
			How often does MR help CM with writing (1-6)	.275	How often does MR help CM with writing (1-6)	.120
			How often does MR help CM with maths (1-6)	.298	How often does MR help CM with maths (1-6)	.103

As shown in Table 2, our principle component analyses indicated that in each wave (after removal of several activities that did not load on the component), the activity variables formed a coherent component. Based on the frequency of parenting activities, it is possible to distinguish three levels of parenting: Parents who generally did not report frequently engaging in the activities are assigned into the ‘neglectful parenting’ category; parents who moderately engaged in the activities are assigned to the ‘intermediate parenting’ category; and parents who frequently engaged in the activities are assigned to the ‘intensive parenting’ category.



Division of parents across intensive parenting categories (wave 2), based on their engagement in parenting activities

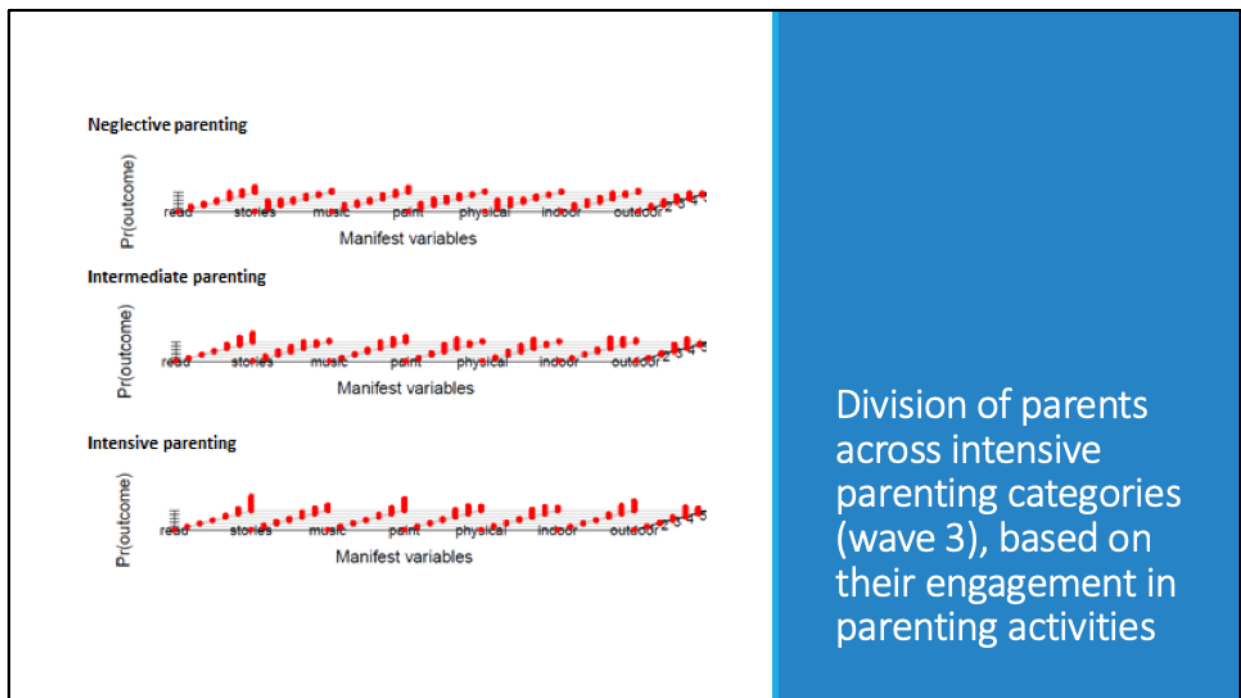
It should be noted, however, that not all activities were sensitive to these different categories (for example, as can be seen in Figure 1, scores on the 'reading' variable in Wave 2 did not vary between the categories).

Sig differences in 'counting', practising the alphabet

With regards to the other items, if you score relatively high in them, you have a greater chance of belonging to the intensive parenting class; if you score relatively low, you are more likely to belong to neglectful parenting, and if you are somewhere in the middle, you will likely belong to the intermediate class.

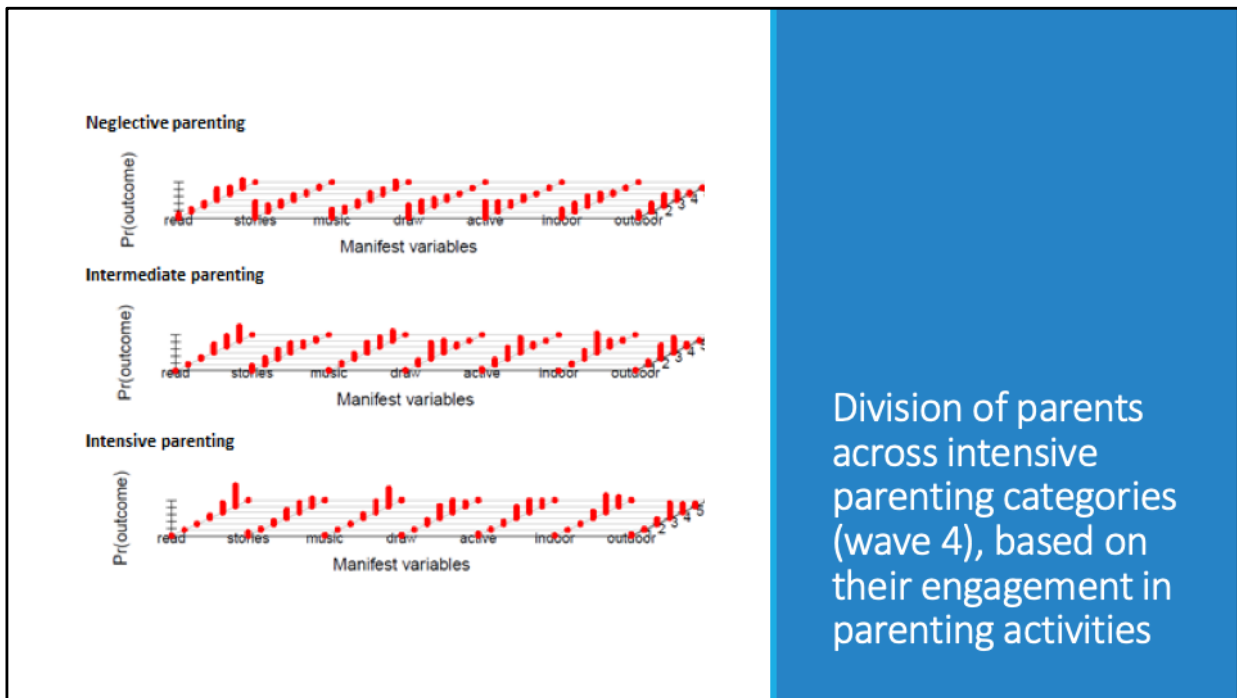
Therefore, we can artificially define the three classes as:

Class 1: neglectful parenting (27.4%) Class 2: intensive parenting (42.5%) Class 3: intermediate parenting (30.0%)



Division of parents across intensive parenting categories (wave 3), based on their engagement in parenting activities

Parents who parent intensively spend more time reading, doing musical activities, playing with a child indoors, and taking children outside (e.g. to a park). (children aged 5)



Division of parents across intensive parenting categories (wave 4), based on their engagement in parenting activities

And again in wave 4, when children are aged 7, parents who parent intensively spend more time reading, doing musical activities, playing with a child indoors, and taking children outside (e.g. to a park).

Latent class analysis on the intensive parenting construct per wave

		Wave 2	Wave 3	Wave 4
Percentage of MR's assigned to each class	Neglectful parenting	27.4%	15.4%	23.0%
	Intermediate parenting	30.0%	44.1%	53.1%
	Intensive parenting	42.5%	39.9%	23.9%

MR=main respondent

The percentages of parents who fell in each of the parenting categories per wave are shown in Table 3. While these findings suggest hypothesis 3 (differentiating among parenting styles) is confirmed, the goodness of fit measurements for this categorization suggest we should be cautious in our interpretation. Additional analyses using factor analysis and the intensity of parenting activities as a continuous variable (in wave 2, for children's outcomes in wave 6) produced similar results. Further research is needed on this point.

Given the exploratory nature of our analyses and the robustness of the findings when using factor analysis, we continued with the comparison of means using these three categories to compare children's physical and psychological health outcomes across parenting styles.

Intensive parenting (age 3) & physical health (age 14)



Intensive parenting predicts general physical health: children at age 14 whose parents intensively parented at age 3 have better self-reported health than children whose parents did not intensively parent. Neglectful parenting has negative effect.

CM:
 $F(2,10581) = 3.52, p = .030$

ANCOVA: $F(8, 16321) = 43.82, p < .001$



Significant differences remain after controlling for socio-demographic characteristics. Gender (of child), education, ethnicity, age (of parents) predictors of children's physical health.

We can see that the only significant difference in children's general health is between intensive parenting and neglectful parenting classes. Children with intensively caring parents at age 3 are more healthy at age 13/14 than those with neglectful parents. However, given the small size of the difference, it is difficult to conclude that parenting styles at children's age 3 have a substantial influence on children's general health at age 13/14.

After controlling for gender, education and ethnicity, age and gender of the child, the influence of parenting styles on general health of children is still significant between neglectful Parenting and Intensive Parenting (which is the reference category). The negative estimate suggests that neglectful parenting has a negative influence on general health of children.

Gender of parents is not a significant predictor (which can be due to imbalanced cases).

Education, age, and children's gender all predict general health: Better education of parents predict better general health; having ethnically-white parents also predicts better health of children; older parents also tend to have healthier children; childGender (being a girl) also seems to predict worse general health.

Intensive parenting (age 5) & physical health (age 14)



Intensive parenting predicts general physical health: children at age 14 whose parents intensively parented at age 5 have better self-reported health than children whose parents did not intensively parent. Intermediate parenting is better for children's health than neglectful parenting.

CM: $F(2, 10833) = 16.61, p < .001$
ANCOVA: $F(8, 16702) = 54.59, p < .001$



Significant differences remain after controlling for socio-demographic characteristics. Gender (of child), education, ethnicity, age, gender (of parents) predictors of children's physical health.

For the comparison of children's general health in relation to intensive parenting activities at age 5, we can see significant differences across all pairs of classes. The largest difference is between intensive and neglectful parenting - despite being only 0.15 (Cohen's $d = 0.16$). This result suggests that parenting styles at age 5 of children may indeed have a (small) influence on the general health of children at age 13/14.

The effect of parenting styles on general health remain significant between all pairs of parenting styles, after controlling for gender, education, age and ethnicity of parents. Higher levels of education (with high education as the reference group) has a positive influence on children's general health. However, so does having ethnically white parents.

Having a male parent has a slight negative influence on children's general health. Being a girl (ChildGender: 0 is male; 1 is female) also seems to have a negative influence on the general health of children.

Intensive parenting (age 7) & physical health (age 14)



Intensive parenting predicts general physical health: children at age 14 whose parents intensively parented at age 7 have better self-reported health than children whose parents did not intensively parent. Neglectful parenting has negative effect.

CM:
 $F(2,10573) = 15.74, p < .001$
ANCOVA: $F(8, 16386) = 53.55, p = .001$



Significant differences remain after controlling for socio-demographic characteristics. Gender (of child), education, ethnicity, age (of parents) predictors of children's physical health.

For the final comparison, intensive parenting activities at age 7, and physical health at age 14, we can see significant differences in children's general health between intensive and neglectful parenting (Cohen's $d = 0.14$), and between intermediate and neglectful parenting (Cohen's $d = 0.13$). However, given the small sizes of the differences, it is difficult to conclude that parenting styles at age 7 of children have a substantial influence on children's general health at age 13/14.

The effect of parenting styles on general health remain significant between all pairs of parenting styles, after controlling for socio-demographic characteristics. Higher levels of education (with high education as the reference group) has a positive influence on children's general health. However, so does having ethnically white parents.

Being a girl (ChildGender: 0 is male; 1 is female) also seems to have a negative influence on the self-esteem of children.

Intensive parenting (age 3) & self-esteem (age 14)



Parenting styles at children's age 3 are not predictive of children's self-esteem at age 14. There are no significant differences in self-reported self-esteem across parenting styles.

CM:
 $F(2,10424) = 1.93, p = .145$

Initially, the comparison of means suggests that children's self-esteem scores at age 13/14 (surprisingly) increase as parenting styles at wave 2 (children's age = 3) become less intensive. However, judging by the raw values, the difference in children's self-esteem scores between classes is not substantial. Fitting an ANOVA shows: we can safely conclude that parenting styles at children's age 3 are not predictive of children's self-esteem at age 13/14.

Intensive parenting (age 5) & self-esteem (age 14)



Intensive parenting predicts marginally better self-esteem: children at age 14 whose parents intensively parented at age 5 have better self-reported self-esteem than children whose parents were 'intermediate' parents. Effects possibly due to sample size.

CM: $F(2,10671) = 3.72, p = .024$
ANCOVA: $F(8, 16522) = 185.2, p < .001$



Significant differences remain after controlling for socio-demographic characteristics. Gender (of child), education, ethnicity, age (of parents) predictors of children's self-esteem.

For intensive parenting activities at age 5, and based on a comparison of means, children's self-esteem scores are highest in the "intensive parenting" categories, and surprisingly, neglectful parenting has higher self-esteem scores than intermediate parenting. However, judging by the raw values again, the difference in children's self-esteem scores between classes is little. If we fit an ANOVA, the difference in children's psychological health scores is only significant between the 'intensive' and 'intermediate' category; however this small but significant effect is likely the result of a large sample size. It is therefore hard to say that parenting styles at age 5 of children have an influence on children's self-esteem at age 13/14.

After controlling for socio-demographic characteristics, the effect of parenting styles on self-esteem do remain significant between intermediate and intensive, and between neglectful and intensive categories.

Higher levels of education (with high education as the reference group) has a positive influence on children's self-esteem. However, having ethnically white parents has a negative influence on children's self-esteem.

Gender of parents is again not significant (likely due to extremely imbalanced groups).

Being a girl (ChildGender: 0 is male; 1 is female) also seems to have a negative influence on the self-esteem of children.

Intensive parenting (age 7) & self-esteem (age 14)



Parenting styles at children's age 7 are not predictive of children's self-esteem at age 14. There are no significant differences in self-reported self-esteem across parenting styles.

CM:
 $F(2,10421) =$
 $2.95, p = .053$

For intensive parenting activities at age 7, and based on a comparison of means, children's self-esteem scores at age 13/14 decrease as parenting styles become less intensive. However, judging by the raw values again, the difference in children's self-esteem scores between classes is not substantial. If we fit an ANOVA, the difference in children's psychological health scores is not significant across classes of parenting styles.

Intensive parenting (age 3) & wellbeing (age 14)



Parenting styles at children's age 3 are not predictive of children's wellbeing at age 14. There are no significant differences in self-reported wellbeing across parenting styles.

CM:
 $F(2,10450) < 1,$
 $p = .457$

Finally, we look at wellbeing, which is measured using the age appropriate scale developed in the BHPS panel study. We can see that children's well-being improves as the parenting style becomes more intensive, despite very small differences. Fitting an ANOVA model shows that we can see the effect of parenting styles on children's well-being is not significant for parenting activities at age 3. Therefore, parenting styles at age 3 of children are unlikely predictive of children's well-being at age 13/14.

Intensive parenting (age 5) & wellbeing (age 14)



Intensive parenting marginally predicts wellbeing: children at age 14 whose parents intensively parented at age 5 have better wellbeing than children whose parents did not intensively parent. Intermediate parenting is better for children's wellbeing than neglectful parenting.

CM: $F(2,10702) = 8.23, p < .001$
ANCOVA: $F(8, 16559) = 68.2, p < .001$



Significant differences remain after controlling for socio-demographic characteristics. Gender (of child), education, ethnicity, age (of parents) predictors of children's wellbeing.

For parenting activities at age 5, and based on a comparison of means, we can see that children's well-being at age 13/14 improves as the parenting style at age 5 of children becomes more intensive, despite relatively small differences. Fitting an ANOVA model shows us that the effect of parenting styles at age 5 of children on children's well-being at age 13/14 is (almost) significant between all pairs of parenting classes, despite the largest difference (between neglectful and intensive parenting) being only 0.13 (Cohen's $d = 0.11$). This result suggests that parenting styles at age 5 of children likely have (only) a small influence on the well-being of children at age 13/14.

The effect of parenting styles on children's wellbeing remain significant between all pairs of parenting styles, after controlling for gender, education, age and ethnicity of parents, and gender of the child.

Higher levels of education (with high education as the reference group), and having older parents has a positive influence on children's wellbeing. However, having ethnically white parents has a negative influence on children's wellbeing.

Gender of parents is not significant.

Being a girl (ChildGender: 0 is male; 1 is female) seems to have a negative influence

on the wellbeing of children.

Intensive parenting (age 7) & wellbeing (age 14)



Intensive parenting marginally predicts wellbeing: children at age 14 whose parents intensively parented at age 7 have wellbeing than children whose parents did not intensively parent. Intermediate parenting is better for children's wellbeing than neglectful parenting..

CM:
 $F(2,10573) = 15.74, p < .001$
ANCOVA: $F(8, 16244) = 67.67, p = .001$



Significant differences remain after controlling for socio-demographic characteristics. Gender (of child), education, ethnicity, age, gender (of parents) predictors of children's physical health.

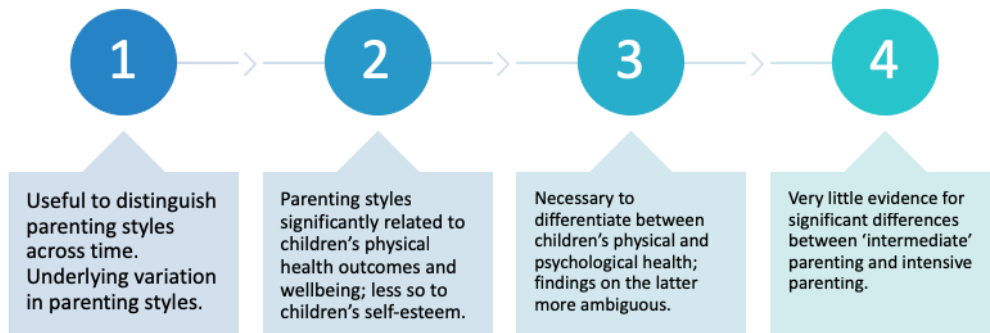
For intensive parenting activities at age 7, and based on a comparison of means, we can see that children's well-being at age 13/14 improves as the parenting style becomes more intensive, despite relatively small differences. Fitting an ANOVA model tells us that the effect of parenting styles on children's well-being is significant between two pairs of parenting classes (i.e., neglectful & intensive, neglectful & intermediate), despite the largest difference being only 0.10 (Cohen's $d = 0.09$). This result suggests that parenting styles at age 7 of children likely have a later influence, but only a small one, on the well-being of children at age 13/14.

The effect of parenting styles on children's wellbeing remain significant between two pairs of classes (neglectful and intensive), after controlling for gender, education, age and ethnicity of parents and gender of the child.

Higher levels of education (with high education as the reference group), and having older parents has a positive influence on children's wellbeing. However, having ethnically white parents has a negative influence on children's wellbeing. Gender of parents is significant; having a male parent has a negative influence on children's wellbeing. Being a girl (ChildGender: 0 is male; 1 is female) also seems to have a negative

influence on the wellbeing of children.

Conclusions



We find that the intensity of parenting activities differs in significant ways as children age, suggesting it can be useful to distinguish not only intensive parenting, but also 'intermediate' parenting and 'neglectful' parenting. These parenting categories are significantly related to children's physical health outcomes and wellbeing, but less so to children's self-esteem. The extent to which parenting matters for children's health outcomes differs dependent upon the developmental stage at which parenting activities are undertaken, suggesting that as children mature other factors come into play (e.g., peers, education) that may cancel out the significant effects on general health earlier in the child's life. At the ages of 3 and 5 for instance, intensive parenting predicts better general health outcomes than the other two styles of parenting. At age 7, however, significant differences were only found for neglectful parenting. Additionally, after controlling for gender, education and ethnicity, the influence of parenting styles on general health of children is no longer significant. Our findings also suggest it is necessary to differentiate between the effects of parenting style on children's physical and psychological health, as findings on the latter present a rather ambiguous picture. Intensive parenting does predict (better) wellbeing for children later in life, but only from wave 3 onwards, once children have reached the age of 5. Differences between 'intermediate' parenting and intensive parenting are however marginal or non-existent. In regards to self-esteem, intensive

parenting only affect self-esteem of children later in life at wave 3, again when children are 5 years old. Surprisingly and contradicting general conceptions of parenting, no significant differences were found between intensive and neglectful parenting. In general however, we find very little evidence for significant differences between 'intermediate' parenting and intensive parenting. This is most likely due to the fact that scientific evidence on the effects of parenting usually focus on ways in which neglectful parenting activities (or responsibilities) may affect children's health outcomes. An example of this can be found in research by DiClemente et al. (2001). In this case, a lack of parental monitoring results in unhealthy sexual behaviour among adolescents. While parental monitoring may improve sexual health outcomes for adolescents, it does not mean that *intensive* variants of monitoring would improve sexual health outcomes *even more*. In a similar vein, while undertaking parenting activities aimed at improving children's development may lead to positive outcomes for children's health, doing these activities *even more* may not lead to even better health outcomes. The opposite might be true for psychological health, whereby overparenting can be particularly detrimental later in life if continued into emerging adulthood (Kwon et al., 2016).

Limitations

- ❖ Data limitations: no full exploitation of longitudinal data.
- ❖ Unclear whether parenting activities are best seen as underlying categories.
- ❖ Data not collected as part of a study on intensive parenting: reflect actual practice of intensive parenting?
- ❖ Measures:
 - ❖ Unable to incorporate 'seeking support', a key element of intensive parenting.
 - ❖ Wellbeing vs. self-esteem
 - ❖ Quantity (of IP) vs quality
- ❖ Too early to tell? Negative effects of intensive parenting are found when children are young adults (Kwon et al., 2016; Schiffrin et al., 2014).

k kan me wel voorstellen dat we nu met het meten van kwantiteit (frequenties van bepaald opvoeders gedrag) niets zeggen over de "kwaliteit" van dat gedrag, en dat de psychologische druk van "bonding" veel meer nadelige effecten heeft dan sec de kwantiteit. Dus bijvoorbeeld in ons geval: niet zo zeer hoe vaak je voorleest maar of je voorlezen ook "afdwingt" als het kind niet wil; niet zozeer hoe vaak je praat met het kind maar hoezeer je openheid en gesprekken afdwingt (en daarmee privacy van kinderen ontnemt). Zoiets?

Moving forward

Focus on role of parents for children's health, but intensive parenting only negligible effects.

Parenting that's 'good enough' (i.e. not neglectful) may be emphasized more to lessen the pressure on parents.

Exploratory study, but underscores the complexity of the relationship between intensive parenting and children's health outcomes.

Nuanced research with attention for both children's physical and psychological health

Variation in parenting style.

Thank you!

Questions or comments?

