Maternal Employment, Work Experiences, and Financial Well-Being of Australian Mothers Who Care for Young Children With Special Health Care Needs

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Abstract
The employment and work experiences of mothers who care for young children with special health care needs is the focus of this study. It addresses a gap in the research literature, by providing an understanding of how mothers’ caring role may affect employment conditions, family life, and financial well-being. Quantitative data are drawn from Growing Up in Australia: The Longitudinal Study of Australian Children. The current study employs a matched case–control methodology to compare the experiences of a group of 292 mothers whose children (aged 4-5 years) with long-term special health care needs with those mothers whose children were typically developing. There were few differences between the two groups with regard to job characteristics and job quality. There were significant differences between the two groups with regard to work–family balance. Fewer mothers with children with special health care needs reported work having a positive effect on family functioning.

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Introduction

In the past two decades, the importance of understanding the link between work and family life has been increasingly recognized (Stewart, 2013). However, the concept of work–family balance is often poorly defined and underconceptualized despite its common usage when researching work and family life (Marcus-Newhall, Halpern, & Tan, 2008). The absence of work–family conflict is often used as an indicator of good work–life balance. However, this is unlikely to always be the case. The combined impact of work-related activities may strongly effect family activities and care responsibilities, particularly when a mother cares for a young child with special health care needs (Hauge et al., 2013). It is therefore important that the issues of job quality defined by the conditions of employment are also considered as a related construct contributing to work–family balance when considering mothers who have nonnormative care duties in the home.

Mothers of children who have special health care needs may experience greater work–family strains but also work–family gains (Spiess & Dunkelberg, 2009). For example, work may be detrimental to family functioning because of decreased time available for care of the child. Mothers often find themselves in repeated crises due to the expected and unexpected demands of working and caring for children with special health care needs. This has serious implications for maternal well-being as individuals who experience an imbalance between work and family life report the negative impacts of daily stressors on physical and mental health (Marcus-Newhall et al., 2008). However, mothers may experience work-related gains because of increased financial resources that will contribute to family income and personal satisfaction and social networks provided by employment. In addition, working outside the home may provide respite from caring for young children with special health care needs (Morris, 2012). Therefore, finding a balance between work and family responsibilities in an era when families often require two incomes to provide the basic necessities of family life may be more challenging in families where there is a child with additional health care needs (Wei & Yu, 2012).

As a result, mothers of children with special health care needs may need to seek employment that can accommodate their care and family responsibilities. This may mean fewer hours of paid work outside the home, with non-standard hours, and in less demanding jobs. It may mean a move from...
full-time to part-time work or accepting work that is not commensurate with their experience and professional qualifications (DeRigne & Porterfield, 2010; Gordon, Cuskelley, & Rosenman, 2007; Loprest & Davidoff, 2004; Stabile & Allin, 2012). Some studies have shown that mothers of children with special health care needs work fewer hours, prefer part-time work, and return to work later after the birth of their child (Chung et al., 2012; DeRigne & Porterfield, 2010; Hauge et al., 2013; Wasi, van den Berg, & Buchmueller, 2012).

However, other studies reveal inconsistent results when examining the employment status and employment trends of these women, possibly due to differences in definition and categorization of childhood disability (Baydar, Joesch, Kieckhefer, Kim, & Greek, 2007; Brandon, 2000; Lloyd & Rosman, 2005). In a study of 41 parents (36 mothers) of children who had multiple disabilities that included a serious emotional or behavioral disorder, Rosenzweig, Brennan, and Ogilvie (2002) identified four major themes when focus groups were asked how having a child with high care demands changed their work lives. These included adjustments in their employment responsibilities, need for greater work flexibility, effects on their daily work performance, and the role of coworkers as a source of support to cover their work duties when they were called away on an emergency.

Lower levels of employment by mothers whose children have special health care needs can lead to lower family income and resultant financial hardship which, in turn, has consequences for the family. Negative effects of financial hardship on families have also been found to be a risk factor for delayed developmental outcomes for young children (Hill, Waldfogel, Brooks-Gunn, & Han, 2005). Mothers of children with special health care needs cite the need for higher use of health services for their children and the increased likelihood of absences from work as barriers to employment (Looman, O’Conner-Von, Ferski, & Hildenbrand, 2009). This may also force mothers to accept jobs that have lower pay and part-time or casual positions with resultant economic consequences for the family and for the child.

Much of the research relating to maternal employment, work experiences, and the financial well-being of mothers who care for children with special health care needs has been conducted in the United States (DeRigne & Porterfield, 2010; Looman et al., 2009). There is less current research exploring the employment and financial experiences of mothers in an Australian context when caring for young children with special health care needs. In addition, very little is known about “work–family balance” for these mothers and their families. Current studies conducted in an Australian context examining recent trends in workforce participation of mothers with young children (Parr, 2012), do not specifically identify trends for women who care for young
children with additional needs. Though the employment rates of Australian mothers with children under 5 years of age increased between the years 2002 and 2008, it cannot be assumed that this is true for mothers of children with special health care needs. While new financial initiatives such as The Better Start for Children with Disability have been introduced in order to help families meet the cost of early intervention services, this funding is restricted to children with sight and hearing impairments, cerebral palsy, Down syndrome, or Fragile X. It remains unclear as to whether such funding packages make a significant difference to the working lives of these mothers (Looman et al., 2009). The very few studies examining the working lives of mothers when caring for children with special health care needs, do so on a categorical basis such as disability with physical limitations (Gordon et al., 2007) or specific health conditions such as asthma (Baydar et al., 2007). These studies also examine children within a broader age span (up to the age of 18 years).

This research can enable a better understanding of parenting children with special health care needs in relation to engaging in employment. The present study considers a broader population of children with special health care needs and who are aged 4 to 5 years. Children are identified as having special health care needs using questions from the Children with Special Health Care Needs Screener (CSHCN; Bethell et al., 2002). This screener does not classify children by specific conditions such as Down syndrome or autism to classify children as having special health care needs. Instead, it uses, as a proxy, the child’s need to access specialized and additional medical, educational, or other services over a period expected to exceed 12 months. In this way, it encompasses children who are affected by a wider range of conditions that may affect maternal employment and financial well-being than those children identified by a condition specific screener only. The CSHCN screener has been found to be sensitive enough to detect chronic conditions in children, whereas not including children with nonchronic or very mild health problems (Youngblade & Shenkman, 2003). The key research question addressed in this study is the following:

**Research Question 1:** Are there differences in employment, work experiences, and financial well-being of mothers whose young children do and do not have special health care needs?

**Method**

This research uses data from the national representative sample of Australian children participating in *Growing Up in Australia: The Longitudinal Study of Australian Children* (LSAC), a study that tracks the development of 10,000
children. This research draws on Wave 1 data recorded for the 4,983 children in the Kindergarten Cohort (4 years old at recruitment). Data are collected and drawn from the Parent 1 Face-to-face Interview or the Parent 1 Self-complete Questionnaire, returned by the respondent parent. This study employs a matched-case control methodology to compare the mothers’ employment experiences, job quality, work–family strains and gains, and financial position. A matched-case control study is a quasi-experimental design. This approach allows comparison between individuals who are exposed to a specific effect with a matched group of individuals who have not experienced “the effect” (Meirik, 2008). In this study, the effect is ex post facto, that is, having a child with a special health care need. The matching process involves a one-on-one matching for each individual in the target group (in this case, children with a special health care need) with an individual (in this case, all other children from the LSAC Kindergarten Cohort). The comparative Kindergarten group can then be considered the control group. Individuals are matched on variables that may have a confounding effect on the dependent variable. Differences between groups are examined, where relevant, using chi-square and t-tests for independent groups, \( p < .05 \). Effect sizes are reported using phi (\( \phi \)) for chi-square and Pearson’s \( r \) criteria for \( t \) tests: small effect = 0.1; medium effect = 0.3; and large effect = 0.5 (Muijs, 2011).

**Participants**

A subset of 650 children in the LSAC Kindergarten Cohort of 4,983 was first identified as having special health care needs at 4 years of age (Wave 1) using the CSHCN (Bethell et al., 2002). Children had to satisfy the conditions of the CSHCN screener for both Wave 1 (2004) and Wave 2 (2006) when the child was 6 years old. This criterion provides evidence for the persistence of health conditions which have ongoing implications for family and child outcomes (Burton, Lethbridge, & Phipps, 2008). In addition, the primary carer had to be female and the child had to be either the biological or adopted child of the respondent parent. A total of 303 children with long-term special health care needs for whom the primary respondent was the mother were identified. From the remainder of the Kindergarten Cohort, a total of 4,515 children in a comparative kindergarten group were identified. A list of conditions identified for each of the cohorts is provided in Table 1.

Children from the Special Health Care Needs Group \( (n = 303) \) were matched one-on-one with selected cases from the Comparative Kindergarten Group \( (n = 4,515) \) using child gender (male, female), mother’s marital status (married, not married), family socioeconomic position (high, medium, low),
and mother’s employment status (not employed, self-employed part-time, self-employed full-time, employed part-time, employed full-time) as the matching criteria. Two comparable groups of 292 cases: a group of mothers who had children with special health care needs (target) and a group of mothers of children whose children did not have special health care needs (control) were produced from the matching process (using the control variables).

### Procedures

For this study, important aspects of mothers’ working lives examined included: employment characteristics, job quality, work–family balance, and financial position. The variables and their sources used in the analyses are summarized in Table 2. Data on these variables were gathered either in the Parent 1 Face-to-face Interview or the Parent 1 Self-complete Questionnaire using Wave 1 data. A fuller description of each measure is provided in the “Measures and Results” section.

### Table 1. Children’s Specific Special Health Care Needs.

<table>
<thead>
<tr>
<th>Special health care needs group (n = 303)</th>
<th>Comparative kindergarten group (n = 4,515)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Respiratory conditions</td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td>190</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>105</td>
</tr>
<tr>
<td>Asthma</td>
<td>180</td>
</tr>
<tr>
<td>Eczema</td>
<td>85</td>
</tr>
<tr>
<td>Food or other allergies</td>
<td>77</td>
</tr>
<tr>
<td>Other illnesses</td>
<td>74</td>
</tr>
<tr>
<td>Ear infections</td>
<td>60</td>
</tr>
<tr>
<td>Other physical disabilities</td>
<td>48</td>
</tr>
<tr>
<td>Hearing problems</td>
<td>30</td>
</tr>
<tr>
<td>Vision problems</td>
<td>26</td>
</tr>
<tr>
<td>Other infections</td>
<td>24</td>
</tr>
<tr>
<td>ADD or ADHD</td>
<td>23</td>
</tr>
<tr>
<td>Diarrhea or colitis</td>
<td>9</td>
</tr>
<tr>
<td>Frequent headaches</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note. ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder. Frequencies and percentages are not independent across categories.*
Table 2. Summary of Measures of Maternal Employment Conditions and Financial Position.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment characteristics</td>
<td></td>
</tr>
<tr>
<td>Age of child on return to work</td>
<td>1 item</td>
</tr>
<tr>
<td>Main occupation</td>
<td>1 item—Australian Standard Classification of Occupations (Australian Bureau of Statistics, 1997)</td>
</tr>
<tr>
<td>Hours employed when returning to work</td>
<td>1 item</td>
</tr>
<tr>
<td>Number of current work hours</td>
<td>1 item—Labor Statistics Survey (Australian Bureau of Statistics, 2005)</td>
</tr>
<tr>
<td>Evening/night work</td>
<td>1 item—AIFS Family and Work Decisions Study (Australian Institute of Families Studies, 2002)</td>
</tr>
<tr>
<td>Weekend work</td>
<td>1 item—AIFS Family and Work Decisions Study (Australian Institute of Families Studies, 2002)</td>
</tr>
<tr>
<td>Desired work hours</td>
<td>1 item—HILDA (Department of Families, Community Services and Indigenous Affairs, 2002)</td>
</tr>
<tr>
<td>Job conditions and job quality</td>
<td></td>
</tr>
<tr>
<td>Paid leave entitlements</td>
<td>4 items from Australian Workplace Industrial Relations Survey (Crockett &amp; Dawkins, 2008); HILDA (Department of Families, Community Services and Indigenous Affairs, 2002), and 1 item generated for LSAC</td>
</tr>
<tr>
<td>Flexible hours</td>
<td>1 item—National Study of the Changing Workforce (Bond, Thompson, Galinsky, &amp; Prottas, 2002)</td>
</tr>
<tr>
<td>Job control</td>
<td>1 item—HILDA (Department of Families, Community Services and Indigenous Affairs, 2002)</td>
</tr>
<tr>
<td>Job security</td>
<td>1 item—PATH Through Life Project (CMHR, 2005)</td>
</tr>
<tr>
<td>Work–family balance</td>
<td></td>
</tr>
<tr>
<td>Financial position</td>
<td></td>
</tr>
<tr>
<td>Family prosperity</td>
<td>1 item—Brotherhood of St Laurence Longitudinal Study (Taylor, 1991)</td>
</tr>
<tr>
<td>Family hardship</td>
<td>7 items—Early Childhood Longitudinal Study (U.S. Department of Education, 2001), Life Chances Study (Taylor, 1991), ABS Household Expenditure Survey (Bray, 2001)</td>
</tr>
</tbody>
</table>

Note. AIFS = Australian Institute of Family Studies; HILDA = Household Income and Labour Dynamics in Australia; LSAC = Longitudinal Study of Australian Children; PATH = Personality and Total Health.
Main Occupation. Mothers’ occupation was measured by one item: “In the main job held last week, what was your occupation?” Responses were categorized into 17 subcategories in accordance with the Australian Standard Classification of Occupations Second Edition (Australian Bureau of Statistics, 1997). The results are summarized and reported for both groups of mothers in Table 3.
The nature of the jobs that mothers held was similar across the two groups. Eighty-two (28.1%) mothers who had children with special health care needs and 85 (29.1%) of mothers whose children were typically developing held professional positions as their main occupation. In the category of tradespersons/clerical workers slightly more mothers who had children with special health care needs (61, 20.9%) compared with mothers whose children did not have special health care needs (53, 18.2%) held a position in this category.

**Current Hours Worked.** A single item from the Labour Statistics Survey (Australian Bureau of Statistics, 2005) measured the total number of hours mothers worked per week that the parent usually worked in all jobs, including any paid or unpaid overtime. The overall average of hours worked per week across groups was comparable. Mothers of children who had special health care needs worked an average of 21.5 (SD = 14.16) hours per week. Mothers who do not have children with special health care needs worked an average of 22.4 (SD = 14.44) hours per week. No statistically significant difference was found between the two groups with regard to current total hours worked per week.

**Nonstandard Work Hours.** Mothers were asked about nonstandard work hours using two questions. First, one item taken from the AIFS Family and Work Decisions Study asked if the parent ever worked after 6 p.m. or overnight? The response option was yes or no. Second, one item taken from the AIFS Family and Work Decisions Study asked if the parent ever worked on Saturdays or Sundays. The response option was yes or no. There were similar percentages across groups for mothers who worked either after 6 p.m., overnight, or weekends. Approximately, half of all working mothers worked nonstandard work hours. There were no statistically significant differences between groups.

**Preferred Work Hours.** One item modified from the National Health Survey (1994) and the Household Income and Labour Dynamics in Australia (Department of Families Community Services and Indigenous Affairs, 2002) was used to measure mothers’ desired work hours. The item asked: “If you could choose the number of hours you work each week (and taking into account how that would affect your income) would you prefer to work.” Responses options on a 3-point Likert-type scale were: 1 (fewer hours than you do now), 2 (about the same hours as you do), and 3 (more hours than you do now). Results were similar across groups. The majority of mothers (48% in each group) preferred the work hours they were currently working. There was no statistically significant difference between groups with regard to preferred work hours.
Job Quality

Items were used to explore mothers’ employment conditions: paid leave entitlements, flexibility in hours, job control, and job security. These items, listed below, are used to construct an overall Job Quality Index to examine differences between groups for mothers who do and do not care for a child with special health care needs.

**Job Quality Index.** The Job Quality Index (Strazdins, Shipley, & Broom, 2007) is constructed using the four job condition variables: access to paid leave, flexible hours of work, job security, and job control. To construct the index, response categories on the above variables were recoded. To create the access to paid leave variable, a positive response was required on at least one of the four paid leave items. This response was then recoded as 1 = *access to any paid leave*. If a negative response was given to all items in the set, then this was coded as 0 = *no access to paid leave*. Responses on the job flexibility item were reverse scored and recoded into three categories being: 3 (*flexible hours*), 2 (*some flexibility*), and 1 (*non-flexible hours*). The flexible hours variable was recoded from *non-flexible hours* as 0 = unfavorable hours. The remaining two responses, *some flexibility* and *flexible hours*, were recoded as 1 = favorable work conditions. Responses on the job control item were recoded into three categories: *Strongly disagree* and *disagree* are recoded into 1 = low control; *neither agree or disagree* is recoded into 2 = neutral; and *agree* and *strongly agree* are recoded into 3 = moderate/high control. The job control variable was recoded from low control as 0 = *no control*. The remaining two responses of neutral and moderate/high control were recoded as 1 = *job control*. Responses for job security were reversed scored and recoded into two categories of *very insecure* and *insecure* into the category *insecure* (0 = insecure) and the remaining responses into the category *secure* (1 = secure).

An index is calculated by summing the presence or absence of a work condition so that “0” represents an absence of a condition and “1” represents the presence of the condition. For the four items, a total score of 4 is possible that represents high job quality: 0 to 1 (*poor job quality, none or one positive condition*), 2 (*two out of four positive conditions*), 3 (*three out of four positive conditions*), and 4 (*optimal, all four positive conditions*). The frequencies and percentages for the number of conditions available to each group of mothers are presented in Table 4. The mean score for the Job Quality Index for the mothers of children who have special needs was 2.39 (*SD = 0.78*) and for the mothers of children without special needs 2.35 (*SD = 0.78*). There was no statistically significant difference between groups on the Job Quality Index.
Balancing Work and Family Life

Work–family balance was measured by using a 10-item version of the 13-item Work and Family Strains and Gains Scale (Marshall & Barnett, 1993). The scale items have a 5-point Likert-type scale with options ranging from 1 (strongly agree) to 5 (strongly disagree). There are four subscales on this measure for which a mean score is derived. For the Work–Parenting and Work–Self subscale, higher scores indicate the positive effect work has on parenting and self. For the Work–family and Family–Work subscales, higher scores indicate that work has a negative effect on family and that family has a negative effect on work. An overall score for work–family balance measure is calculated using the mean for the 10 items and for which items from the Work–family and Family–Work scales are reverse coded. In this way, higher scores indicate more positive work–family balance.

Means and standard deviations for the two groups on the subscales on the Work and Family Strains and Gains Scale are presented in Table 5. There were no statistically significant differences between mothers who had children with special health care needs and mothers whose children were typically developing on any of the four subscales: effect of work on parenting, effect of work on self, effect of work on family, and effect of family on work. However, there was a significant difference between groups on the overall score for Work and Family Strains and Gains Scale. Mothers of children with special health care needs had lower mean scores ($M = 3.43$, $SD = 0.63$) than mothers whose children were typically developing ($M = 3.60$, $SD = 0.61$). The difference was statistically significant, $t(278) = .074$, $p = .025$. This result showed a small effect size, $r = .05$. Thus, mothers of children with special care needs indicated more strain and fewer gains in combining work and family life. This effect was not evident on the subscale scores, most likely due to the limited numbers of items on the scales.
Family Financial Well-Being

Family Prosperity. One item is used in the LSAC Parent 1, Self-complete Questionnaire to assess parents’ perceived family financial situation. This question has been used to determine the level of perceived social disadvantage in the Brotherhood of St Laurence Longitudinal Study of families (Taylor, 1991). The item asks the mother: “Given your current needs and financial responsibilities, how would you say you and your family are getting on?” Responses are recorded using a 6-point Likert-type scale: 1 (prosperous) to 6 (very poor). When comparing the mean scores of the item using a t-test, there was no statistically significant difference between mothers with a child with special health care needs ($M = 3.28$, $SD = 0.84$) and mothers whose child was typically developing ($M = 3.22$, $SD = 0.83$).

Level of Family Financial Hardship. A family financial hardship scale is constructed from seven items available in the LSAC data. Mothers were asked to indicate the kinds of hardship that their families had experienced in the past 12 months due to shortage of money. The items asked if there were: financial limits on food bought, bills could not be paid on time, something was pawned or sold, assistance was received from welfare services, mortgage could not be paid on time, and family were unable to pay to heat or cool their home. The items were sourced from the Early Childhood Longitudinal Study, Birth Cohort (U.S. Department of Education, 2001); the Life Chances Study (Taylor, 1991); and the Australian Bureau of Statistics Household Expenditure Survey (Bray, 2001). A response of yes or no is required for each items with

<table>
<thead>
<tr>
<th></th>
<th>Mothers of children with special health care needs</th>
<th>Mothers of children without special health care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Effect on work on parenting scale (3 items)</td>
<td>3.44</td>
<td>0.84</td>
</tr>
<tr>
<td>Effect of work on self scale (3 items)</td>
<td>3.78</td>
<td>0.82</td>
</tr>
<tr>
<td>Effect on work on family scale (2 items)</td>
<td>2.91</td>
<td>1.01</td>
</tr>
<tr>
<td>Effect of family on work scale (3 items)</td>
<td>2.74</td>
<td>1.01</td>
</tr>
<tr>
<td>Total score</td>
<td>3.43</td>
<td>0.63</td>
</tr>
</tbody>
</table>

Table 5. Work–Family Balance.
the option of don’t know and refused available. The yes responses are summed to provide a score from 0 to 7.

Relative little financial hardship for families was indicated by mothers in either group. The mean score on the scale for mothers who had children with special health care needs was 1.08 (SD = 1.40) and for mothers who had children who are typically developing was 0.95 (SD = 1.27). There was no statistically significant difference between groups for the mean scores on the financial hardship measure.

**Discussion**

The aim of this study was to examine maternal employment experiences such as current work participation, work conditions and job quality, family and work life balance, and financial well-being. There is an assumption that maternal labor force participation is negatively affected by having a child with special health care needs, either chronic health conditions or developmental disabilities. However, many studies have produced inconclusive results or even contradictory findings in relation to that assumption (Powers, 2003; Spiess & Dunkelberg, 2009). This may be due to the differences in data sets used; the different national contexts in which the research has been conducted and thus different levels of family support by government; and the different populations of special needs studied. Overall, the current study has shown that there are more commonalities than differences between mothers’ employment experiences across the groups studied in this research.

**Employment Status and Job Conditions**

Mothers who have children with special health care needs have been reported as being underemployed. They may not have jobs that are commensurate with their qualifications or experience (Hauge et al., 2013; Morris, 2012; Shearn & Todd, 2000). They may take part-time work often in lower paid, less skilled jobs due to increased care duties and costs. Alternatively, they may only seek jobs with less responsibility and less stress (Chung et al., 2012; DeRigne & Porterfield, 2010; Morris, 2012). This study indicated that there was no significant difference in the current occupational status of mothers who had children with special health care needs and mothers whose children did not have special health care needs. The most common occupational classification for both groups in this study was professional work. Managers and professionals, regardless of care duties, are more likely to have greater work–family conflict than other occupations (Pocock, Skinner, & Ichii, 2009). Working long hours has been found to have negative outcomes for
women with regard to work–life balance when caring for young children (Pocock et al., 2009).

In this study, there was no statistically significant difference between the two groups for flexibility in work hours, job control and/or job security. However, only one third of mothers (in both groups) reported that they received paid maternity leave or had freedom to decide how to manage their work. The issue of maternity leave has now changed for all Australian women through the introduction in 2011 of paid maternity leave entitlements (Gillard, Swan, & Macklin, 2009). In this study, when data were collected in 2004, many women in both groups stated that they felt that their jobs had flexible hours and were secure. The lack of significant difference between groups for flexible work hours and job control is of particular interest. Mothers of children with special health care needs require jobs that will allow them to attend medical appointments and school meetings. Mothers also often use their sick leave to care for children. Having autonomy over how work is performed and flexibility in work hours is important to mothers with children who have special health care needs. These flexible work conditions allow mothers to balance more adequately their work and family life. It also reduces parenting stress and enhance mothers’ health and well-being (Alexander & Baxter, 2005; Mora, 2008).

Women who have children with special health care needs have been found to have longer career breaks and work fewer hours on their return to work than women whose children do not have special health care needs (Burton et al., 2008; Chung et al., 2012; Hauge et al., 2013). These previous findings are not supported by the results of this study. There were no statistically significant differences between mothers who have children with special health care needs and mothers whose children did not have special health care needs, nor were there differences in the proportion of mothers who did or did not return to work after the birth of their child. This is not surprising given that approximately two thirds of Australian women return to work early, primarily for financial reasons (Whitehouse, Hosking, & Baird, 2008). The consequence is that work then reshapes the nature of work and motherhood as women continue to work while having children (Pocock, 2006).

There were no significant differences between the groups of mothers in this study regarding their engagement in nonstandard work hours. However, approximately, half of all women in both groups worked nonstandard work hours. This is a high proportion. This may be due to the increase in trading hours across Australia that sees many women in service positions working weekends and evenings. It has been reported that mothers working nonstandard hours have less optimal family functioning, more depressive symptoms, and less effective parenting (Strazdins, Clements, Korda, Broom, & D’Souza,
Working nonstandard hours has also been associated with marital problems and divorce (Strazdins, Korda, Lim, Broom, & D’Souza, 2004). However, most mothers in this study also indicated that they were happy with their current hours and work arrangements.

**Balancing Work and Family Life**

This study found that the level of gains and strains across work and family life was similar between the two groups of mothers. Both groups were comparably affected with respect to finding some work–life balance. This may be because most mothers of young children have to adjust their employment schedules to accommodate family responsibilities (Leiter, Krass, Anderson, & Wells, 2004). However, differences may occur in the intensity and frequency in which mothers whose children have special health care needs experience family-related dilemmas such as managing complex arrangements in accessing services while still fulfilling employment obligations (Halfon & Newacheck, 2010; Leiter et al., 2004; Looman et al., 2009).

While there were no differences in the various subscales on the measure that examined work–family balance (potentially due to the small numbers of items on the subscales), the overall score on the measure indicated that mothers of children with special health care needs were less positive about their work–family balance. Less than optimal work–family balance for mothers of children with special health care needs not only affects the mother’s well-being but also the family, child, employer, and ultimately the wider community (Baxter & Alexander, 2008; Halfon & Newacheck, 2010; Leiter et al., 2004; Looman et al., 2009; Shearn & Todd, 2000; Stewart, 2013).

**Financial Well-Being**

The severity of a child’s health condition has been found to be a consistent predictor of higher financial costs accruing to families (Looman et al., 2009; Lukemeyer, Meyers, & Smeeding, 2000; Stewart, 2013). In previous studies, it has been found that children with special health care needs are more likely to live in poorer households than children who are typically developing (Parish & Cloud, 2006). Mothers whose children have more severe conditions are more likely to report more financial and employment problems directly related to the child’s condition (Gordon, Rosenman, & Cuskelly, 2007). This study did not find significant differences between the groups of mothers studied with regard to current financial prosperity. Neither were there statistically significant differences between the two groups on the financial hardship index. In Australia, the financial burden of caring for young
children with special health care needs is eased by families receiving packages such as Better Start and Helping Children with Autism. These benefits entitle the family to receive funding for early intervention services. However, these benefits are terminated when the child reaches the age of 7 years. This may be a time when the mother needs to seek employment to compensate for the loss of income and adds pressure on the mother to adopt the dual role of income earner and carer (Gordon, Cuskelly, & Rosenman, 2008).

Limitations

Due to the quasi-experimental nature of the methodology employed in this study, causality cannot be established between the independent variables and the dependent variables based solely on the design. While this is a restriction, quasi-experimental designs do control for a variety of variables so are able to establish plausible relationships that can form the basis for a causal argument (Creswell, 2005).

One of the possible disadvantages of utilizing a matched-case control methodology is that as the number of matching variables increases, the target and control become more alike with respect to the variables of interest (Grimes & Schulz, 2005). However, as this study only matched on four variables, a small percentage of the total available, this was not considered a problem.

While the CSHCN screener identifies those children who require more medical and health services over an extended period of time as opposed to other children, it does not identify any specific subsamples of children, for example, children with disabilities such as Down syndrome and autism (Dillon-Wallace, McDonagh, & Fordham, 2014). It may be argued that these children require a higher level of care and have a larger impact on mothers’ employment conditions and experiences, and financial well-being. The fact that the percentage of these children cannot be identified within the subsample of children with special health care needs introduces a measure of uncertainty as to how different conditions and their representation in the sample might affect the results.

The measurement of a number of constructs in the LSAC data employed ordinal scales. In these analyses, these are treated as continuous measures if the Likert-type response scales have at least five response scale data points. In educational research, it is acceptable to treat ordinal data as interval scales as long as the number of intervals is five or greater and the response distribution does not depart markedly from normality (Norman, 2010). The $t$ test has been shown to be very robust if these conditions are met.

With respect to external validity, this study shares the same restrictions as that of the wider LSAC database. Furthermore, this study is concentrated on
mothers who have children with special health care needs in an Australian context. Care should be exercised when extrapolating the findings of this study outside of this demographic (Dillon-Wallace et al., 2014).

**Future Research**

This study indicates that mothers who have children with special health care needs have a lower level of effective work–family balance than those mothers whose children do not have special health care needs. Further research needs to reevaluate role gains and role strains in order to evaluate how this influences mothers’ work–family balance when caring for children with special health care needs. Although research typified by that of Pocock et al. (2009) sheds light on the general population, specific models need to be developed to theorize the employment of mothers who care for dependent children.

Economic models of labor supply have rarely been applied to households with children with disabilities (Gordon et al., 2008). Such models explore the influences on the family decision-making processes on meeting the financial demands of raising a child with a disability. These models should take into account the trade-offs between work and other sources of income (such as benefits). Changes in benefit systems continually impact on the decisions mothers make regarding their participation in paid employment (Looman et al., 2009; Parr, 2012). Research that develops explanatory/predictive, economic models for families who care for children with special health care needs, may inform government of the changing financial needs of families who care for children with high care costs and allow a dynamic needs based allocation of resources.

**Conclusions**

It has been widely claimed that there are financial and employment implications for families who have children with special health care needs. Financial impacts may include reduced opportunities for employment as well as greater financial demands on the family as a result of having a child with special health care needs. There are also economic costs to the wider community when families require significant support from welfare and health services (Brennan & Brannan, 2005; Nepal, Brown, Ranmuthugula, & Percival, 2009). In this study, there were few differences between the two groups studied with regard to their employment characteristics and job quality. However, there were significant differences between the two groups with regard to overall work–family balance. Fewer mothers with children with special
health care needs reported that work had a positive effect on family functioning. Much of the published research referencing work–life balance in an Australian context targets the general population. In contrast, this study specifically focused on the group of mothers who have children with special health care needs and for these mothers work–family balance was considered less positive than for mothers whose children did not have children with special health care needs.

There were also few differences between mothers who had children with special health care needs and mothers of children who did not have special needs with respect to how mothers reported on how their family was managing financially and the level of financial hardships they were encountering. While this is different from previous research, much of that research has been conducted in the United States and does not reflect the Australian experience. While in Australia there are significant inequalities for some groups in the population, there are also overall more universal social support systems and services in place to help families. There are also much stronger controls, overall, with respect to workplace entitlements and conditions.

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