



OPEN ACCESS

# Keeping children safe at home: protocol for a case–control study of modifiable risk factors for scalds

P Wynn,<sup>1</sup> J Stewart,<sup>2</sup> A Kumar,<sup>1</sup> R Clacy,<sup>1</sup> F Coffey,<sup>3</sup> N Cooper,<sup>4</sup> C Coupland,<sup>1</sup> T Deave,<sup>5</sup> M Hayes,<sup>6</sup> E McColl,<sup>7</sup> R Reading,<sup>8</sup> A Sutton,<sup>4</sup> M Watson,<sup>2</sup> D Kendrick<sup>1</sup>

<sup>1</sup>Division of Primary Care, School of Medicine, Nottingham, UK

<sup>2</sup>School of Health Sciences, University of Nottingham, Queen's Medical Centre, Nottingham, UK

<sup>3</sup>Nottingham University Hospitals NHS Trust, Queen's Medical Centre Campus, Nottingham, UK

<sup>4</sup>Department of Health Sciences, University of Leicester, Leicester, UK

<sup>5</sup>Centre for Child & Adolescent Health, Health and Life Sciences, University of the West of England, Bristol, UK

<sup>6</sup>Child Accident Prevention Trust, Canterbury Court (1.09), 1 - 3 Brixton Road, London, UK

<sup>7</sup>Great North Children's Hospital, Research Unit Level 2, New Victoria Wing, Royal Victoria Infirmary, Newcastle upon Tyne, UK

<sup>8</sup>Norfolk and Norwich University Hospitals NHS Foundation Trust, Norwich, UK

## Correspondence to

Dr Persephone Wynn, Division of Primary Care, Tower Building, University Park, Nottingham NG7 2RD, UK; persephone.wynn@nottingham.ac.uk

Received 28 March 2014

Accepted 13 April 2014

Published Online First

19 May 2014



Open Access  
Scan to access more  
free content



CrossMark

**To cite:** Wynn P, Stewart J, Kumar A, et al. *Inj Prev* 2014;**20**:e11.

## ABSTRACT

**Background** Scalds are one of the most common forms of thermal injury in young children worldwide. Childhood scald injuries, which mostly occur in the home, result in substantial health service use and considerable morbidity and mortality. There is little research on effective interventions to prevent scald injuries in young children.

**Objectives** To determine the relationship between a range of modifiable risk factors for medically attended scalds in children under the age of 5 years.

**Design** A multicentre case-control study in UK hospitals and minor injury units with parallel home observation to validate parental reported exposures. Cases will be 0–4 years old with a medically attended scald injury which occurred in their home or garden, matched on gender and age with community controls. An additional control group will comprise unmatched hospital controls drawn from children aged 0–4 years attending the same hospitals and minor injury units for other types of injury. Conditional logistic regression will be used for the analysis of cases and matched controls, and unconditional logistic regression for the analysis of cases and unmatched controls to estimate ORs and 95% CI, adjusted and unadjusted for confounding variables.

**Main exposure measures** Use of safety equipment and safety practices for scald prevention and scald hazards.

**Discussion** This large case-control study will investigate modifiable risk factors for scalds injuries, adjust for potential confounders and validate measures of exposure. Its findings will enhance the evidence base for prevention of scalds injuries in young children.

## INTRODUCTION

Burn injuries in children under 10 years of age are a major cause of death internationally, and are the fifth most common cause of non-fatal childhood injuries.<sup>1</sup> In those under 5 years, scalds are the leading cause of thermal injuries in high, middle and low income countries.<sup>2–14</sup> Scalds accounted for 62% of hospital admissions for thermal injuries in children under 5 years old in the USA between 2003 and 2012,<sup>15</sup> and 63% of such admissions in the same age group in England in 2012–2013.<sup>16</sup> In 2012–2013 over 3500 children aged 0–14 years were admitted to hospital in England with a thermal injury, of which the majority (61%) were scalds.<sup>16</sup> Most scalds in childhood occur at home<sup>12 13 17</sup> and are most commonly caused by hot liquids from kettles, baths, cups or mugs.<sup>17–19</sup>

Paediatric scald injuries impose a heavy financial burden on the state. More severe scalds may require intensive care, skin grafts and months or years of

rehabilitation.<sup>2</sup> Studies from England suggest the average cost of treating an uncomplicated minor (<10% total body surface area) paediatric scald in 2002–2003 was £1850<sup>20</sup> while the average cost of acute inpatient treatment of a 'major scald' (30–40% total body surface area) in 2007–2009 in a paediatric burns unit can be as high as £55 000.<sup>21</sup> Socioeconomic disadvantage increases the risk of scalds. Recent research from the UK demonstrates that children living in the most disadvantaged areas have an 82% higher odds of a medically attended scald injury than those in the most affluent areas.<sup>22</sup> This pattern is repeated globally, with socioeconomic differentials between and within countries.<sup>12 13 23</sup>

Systematic reviews and recent meta-analyses have consistently demonstrated that interventions to promote thermal safety in the home can increase safety behaviour and the use of safety equipment to reduce the risk of thermal injuries.<sup>24–31</sup> However, there remains little evidence that they reduce the actual incidence of thermal injuries due to a lack of adequately powered randomised controlled trials or high quality observational studies. Rigorous case-control studies have often provided the best evidence for effective interventions in injury prevention.<sup>32–34</sup> There are few case-control studies investigating prevention practices in the homes of scalded children.<sup>23 35–37</sup> One Canadian multicentre study, exploring risk and protective factors for a range of childhood injuries requiring emergency department (ED) attendance in children under the age of 8 years, failed to find any significant associations between any scald prevention practices and ED attendance.<sup>35</sup> A second study of children of all ages attending EDs in two hospitals in Greece with a thermal injury found a 40% reduction in the odds of injury with a one unit increase in a burn avoidance index which measured four scald prevention behaviours.<sup>36</sup> Another study, of children aged 0–5 years attending an Iraqi hospital with an acute burn injury found a one unit increase in the number of thermal hazards increased the odds of a thermal injury by 32%.<sup>23</sup> Finally a study of children aged 0–4 years attending EDs in 14 Dutch hospitals found that using a vacuum flask rather than cups or mugs, to store hot drinks halved the odds of ED attendance for a thermal injury.<sup>37</sup> These studies were limited by small sample sizes,<sup>36 37</sup> the use of hospital controls,<sup>23 35 36</sup> the use of unvalidated parental reports to measure exposures,<sup>23 36 37</sup> case definitions covering a wide range of injury mechanisms<sup>35</sup> and potential bias from unmeasured confounders.<sup>23 35–37</sup>

The aim of the case-control study described in this protocol is to examine the relationship between modifiable risk factors and scald injuries in

young children. Community and hospital controls will be used and a range of confounding factors will be measured and adjusted for. Parental reported exposures will be validated by home observations in a sample of cases and controls.

METHODS  
Objectives

The objective of this case-control study is to determine the relationship between a range of modifiable risk factors and medic-ally attended scalds in children under the age of 5 years.

Study design

A multicentre case-control study will be carried out within hos-pitals and minor injury units (MIUs) in Nottingham, Bristol, Derby, Gateshead, Great Yarmouth, Newcastle upon Tyne, Norwich and Lincoln, UK. This is one of a series of case-control studies running concurrently in these study centres which employ identical methods and aim to identify modifiable risk factors for different injury mechanisms. The published protocol for the falls case-control study describes the methods in more detail.<sup>38</sup>

Definition of cases and controls

Cases will be defined as children under the age of 5 years who received medical attention for a scald injury which occurred in their home or garden, defined as the address at which they were registered with a family doctor or general practitioner (GP). Scald injuries are defined as ‘thermal injuries caused by hot liquids or steam’. Medical attention is defined as an admission to hospital or attendance at an ED or MIU. Children are not eli-gible to take part if the injury was intentional or suspected to be intentional or if the child lives in residential care. Fatal injuries will not be included to avoid parental distress. Cases are not eli-gible to be included as a control in the study at any time after being recruited as a case.

Controls are defined as children under the age of 5 years who did not receive medical attention for a scald injury on the date of the case’s medical attendance. Children living in residential care are not eligible to participate in the study. Controls are eli-gible for recruitment to the study as a case or as a further control if they are recruited at least 12 months after their first

recruitment. Controls will not be recruited more than twice to the study.

Recruitment of cases and controls

Participants will be recruited during or after their hospital admission or attendance at the ED or MIU. The initial approach to potential participants will be made by clinical staff, followed by contact from researchers where agreement for this is given. Researchers will contact potential participants during their medical attendance, or by telephone or postal invitation within 72 h of ED or MIU attendance. Postal and telephone reminders will be used if no response is received within 2 weeks. Participants will be given a £5 voucher for local stores to thank them for participation in the study.

Controls will be recruited from the community (matched community controls) and from the hospital (unmatched hospital controls). Community controls will be identified from the GP practice where the case is registered, and matched with the case on age (within 4 months) and gender. If the GP practice where the case is registered does not consent to take part, the GP prac-tice closest to the case’s GP practice will be asked to recruit con-trols. GPs or Primary Care Trust staff will invite, by post, parents or guardians (hereafter referred to as parents) of 10 chil-dren for each recruited case to take part in the study. One reminder will be sent to non-responders (controls and cases) if they have not replied within 2 weeks of initial mailout. Hospital controls will comprise children already recruited as a case to one of the other ongoing case-control studies, that is, these will be children aged 0–4 years attending the ED or MIU with another injury mechanism (fall on the same level, fall from fur-niture, staircase fall or poisoning).

Definition of exposures and confounding variables

Exposures relating to scalds will be categorised into safety (and other potentially risk reducing) equipment use, safety beha-viours and home hazards (see table 1). Cases will be asked about exposures relating to the 24 h (or 1 week for less frequent behaviours) before the scald injury. Controls will be asked about exposures for the 24 h (or 1 week for less frequent behaviours) prior to completing the questionnaire. A range of potential con-founding factors will be measured as shown in table 1.

Table 1 Definition of exposures and confounding variables

<i>Exposure: Safety and other potentially risk reducing equipment use</i>	<i>Potential confounders: sociodemographic</i>
1. Use of safety gates	1. Age
2. Kettles with curly or short cables	2. Gender
3. Play pens (or travel cots)	3. Ethnic group
4. Stationary activity centres	4. Family size and structure
<i>Exposure: Safety behaviours</i>	5. Housing tenure
1. Not drinking hot drinks while holding a child	6. Receipt of state-provided means-tested benefits
2. Not passing hot drinks over a child	7. Single parenthood
3. Keeping hot drinks out of reach of children	8. Adult unemployment in the household
4. Storing kettles at back of work tops	9. Overcrowding
5. Use of back rings on cooker	10. Deprivation (measured using the Index of Multiple Deprivation <sup>39</sup> )
6. Turning saucepan handles away from edge of cooker	11. Distance of residence from hospital
7. Not using tablecloths	12. Use of out-of-home childcare
8. Knowledge of hot tap water/thermostat temperature	<i>Potential Confounders: child and parent measures for health and behaviour</i>
9. Using cold water first when running a bath	1. Child behaviour (infant, early child and child behaviour questionnaires) <sup>40–42</sup>
10. Measuring bath water temperature	2. Child health status (VAS <sup>43</sup> , PedsQL <sup>44 45</sup> )
11. Not leaving child without an adult in the bath or bathroom	3. Long-term health conditions
12. Not having children running baths	4. Parental mental health (Hospital Anxiety and Depression Scale) <sup>46</sup>
13. Teaching children safety rules about hot liquids	5. Parenting daily hassles <sup>47 48</sup>
<i>Exposure: Home hazards</i>	6. Parental perception of child’s ability to reach hot liquids (a series of questions on climbing, reaching, turning on taps, ability to open safety gates)
1. Has baby walker	

PedsQL, pediatric quality of life inventory; VAS, visual analogue scale.

## Measurement of exposures and confounding variables

Exposures and confounding factors will be measured using parent-completed questionnaires, specific to the age of the child (0–12 months, 13–36 months and 37–59 months). The development, piloting and validation of the questionnaires are described in the protocol for the falls case-control study.<sup>38</sup>

## Analysis

The analysis of the validation of exposures has been described in the falls case-control study protocol.<sup>38</sup> Relationships between exposures, potential confounding variables and scalds will be explored using causal diagrams. These will be used to identify the minimal set of potential confounding factors to adjust for when estimating ORs. Exposure and confounding variables will be described using frequencies and percentages for categorical variables and means (and SDs) or medians (and IQRs) for continuous variables as appropriate.

Conditional logistic regression will be used for the analysis of cases and matched controls to estimate ORs and 95% CIs, unadjusted and adjusted for confounding variables. All models will a priori adjust for deprivation and distance from hospital. Unconditional logistic regression will be used for the analysis of cases and hospital controls. All models will a priori be adjusted for age, gender, deprivation and distance from hospital, in addition to other potential confounding variables, as described for the matched analysis. Effect modification will be investigated by adding interaction terms to models and where present ( $p < 0.01$ ), stratified results will be reported. Results will also be stratified by the type of service used (child treated in ED or admitted to hospital vs no treatment required) as a proxy for injury severity.

## Sample size

Based on data on the prevalence of exposures and the amount of missing data obtained from analysis of the first 428 controls recruited across all the ongoing case-control studies, 259 cases and 1036 matched controls are required to detect an OR of 0.64 (equivalent to an OR of 1.56 for a risk factor), with 80% power, a 5% significance level, a correlation between matched cases and controls of 0.1 and an average of four controls per case.

## Ethics committee and regulatory approvals

Ethical approval was provided by the Nottingham 1 Ethics Committee (reference number: 09/H0407/14). Approval has been obtained from National Health Service research and development departments providing research governance to participating hospitals and MIUs.

## DISCUSSION

This large, multicentre case-control study will investigate modifiable risk factors for scald injuries in the homes of children under the age of 5 years. The study will attempt to address some of the limitations of previous studies and will use multiple methods to minimise a range of biases. Cases and community controls will be matched on age and gender, and hospital and community controls will be used. A wide range of exposures will be measured, using, where possible, previously validated questions to help minimise misclassification bias. In addition, a concurrent study validating self-reported exposures will enable quantification of under-reporting or over-reporting of exposures by cases and controls.<sup>38</sup> Further efforts to reduce misclassification bias include restricting measures of exposure to a short

time period (maximum of 1 week) prior to the injury for cases, and prior to questionnaire completion for the controls. Data will be collected on a wide range of confounding factors using validated tools wherever possible. The findings from this study should provide evidence to inform scald prevention policy and practice, with implications for child health surveillance programmes and home safety equipment schemes. Our findings should also inform the advice provided during home safety assessments and other child health promotion contacts.

**Acknowledgements** The authors would like to acknowledge the contributions to the study design, methodology and comments on drafts of this paper from members of the Keeping Children Safe Study Group: Joanne Ablewhite, Penny Benford, Ben Young, Clare Bryan from the School of Medicine, Division of Primary Care, Tower Building, University Park, Nottingham, NG7 2RD, UK; Philip Miller from Nottingham University Hospitals NHS Trust, Queen's Medical Centre Campus, Nottingham, NG7 2UH, UK; Elizabeth ML Towner, Trudy Goodenough, from the Centre for Child and Adolescent Health, Health and Life Sciences, University of the West of England, Bristol, Oakfield Grove, Bristol BS8 2BN, UK; Gosia Masjak-Newman, Lisa McDaid from Norfolk and Norwich University Hospitals NHS Foundation Trust, Norwich, NR4 7UY, UK; Adrian Hawkins, Paul Hindmarch from Great North Children's Hospital, Research Unit Level 2, New Victoria Wing, Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne, NE1 4LP, UK.

**Funding** This paper presents independent research commissioned by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research funding scheme (RP-PG-0407-10231). The views expressed in this paper are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

**Competing interests** None.

**Ethics approval** North Nottinghamshire Research Ethics Committee.

**Provenance and peer review** Not commissioned; internally peer reviewed.

**Open Access** This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 3.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: <http://creativecommons.org/licenses/by/3.0/>

## REFERENCES

- 1 World Health Organization 2012, Burns Fact Sheet No. 365, <http://www.who.int/mediacentre/factsheets/fs365/en/> (accessed 24 Oct 2013).
- 2 Kai-Yang L, Shi-Hui Z, Hong-Tai T, *et al.* The direct hospitalisation costs of paediatric scalds: 2-Year results of a prospective case series. *Burns* 2009;35:738–45.
- 3 Gupta M, Gupta OK, Goll P. Paediatric burns in Jaipur, India: an epidemiological study. *Burns* 1992;18:63–7.
- 4 Sadeghi-Bazargani H, Mohammadi R. Epidemiology of burns in Iran during the last decade (2000–2010): review of literature and methodological considerations. *Burns* 2012;38:319–29.
- 5 Sierra-Zúñiga M, Castro-Delgado OE, Caicedo-Caicedo JC, *et al.* Epidemiological profile of minor and moderate burn victims at the University Hospital San José, Popayán, Colombia. *Burns* 2013;39:1012–17.
- 6 Al-Shaqsi S, Al-Kashmiri A, Al-Bulushi T. Epidemiology of burns undergoing hospitalization to the National Burns Unit in the Sultanate of Oman: A 25-year review. *Burns* 2013;39:1606–11.
- 7 Zhu L, Zhang Y, Liu L, *et al.* Hospitalized Pediatric Burns in North China: a 10-year epidemiologic review. *Burns* 2013;39:1004–11.
- 8 Wesson HKH, Bachani AM, Mtambeka P, *et al.* Pediatric burn injuries in South Africa: a 15-year analysis of hospital data. *Injury* 2013;44:1477–82.
- 9 Alaghebandan R, Sikdar KC, Gladney N, *et al.* Epidemiology of severe burn among children in Newfoundland and Labrador, Canada. *Burns* 2012;38:136–40.
- 10 Wasiak J, Spinks A, Ashby K, *et al.* The epidemiology of burn injuries in an Australian setting, 2000–2006. *Burns* 2009;35:1124–32.
- 11 Chipp E, Walton J, Gorman DF, *et al.* A 1 year study of burn injuries in a British Emergency Department. *Burns* 2008;34:516–20.
- 12 Peden M, Oyegbite K, Ozanne-Smith J, *et al.* *World report on child injury prevention*. In: Peden M, ed. Geneva: World Health Organisation, UNICEF, 2008:232. [http://www.who.int/violence\\_injury\\_prevention/child/injury/world\\_report/](http://www.who.int/violence_injury_prevention/child/injury/world_report/)
- 13 Delgado J, Ramirez-Cardich ME, Gilman RH, *et al.* Risk factors for burns in children: crowding, poverty, and poor maternal education. *Inj Prev* 2002;8:38–41.
- 14 Vloemans AFPM, Dokter J, van Baar ME, *et al.* Epidemiology of children admitted to the Dutch burn centres. Changes in referral influence admittance rates in burn centres. *Burns* 2011;37:1161–7.

- 15 ABA National Burn Repository. *National Burn Repository 2013 Report*. Chicago, USA: American Burn Association, 2013.
- 16 HESonline. Hospital Episode Statistics. England. <http://www.hscic.gov.uk>: HSCIC, 2012/13. (accessed 05/11/2013).
- 17 Kemp AM, Jones S, Lawson Z, *et al*. Patterns of burns and scalds in children. *Arch Dis Child* 2014;99:316–21.
- 18 Drago DA. Kitchen scalds and thermal burns in children five years and younger. *Pediatrics* 2005;115:10–16.
- 19 Sambrook Research International. *Burns and scalds accidents in the home. Government Consumer Safety Research*. London: Department of Trade and Industry, 1999.
- 20 Griffiths HR, Thornton KL, Clements CM, *et al*. The cost of a hot drink scald. *Burns* 2006;32:372–4.
- 21 Pellatt RAF, Williams A, Wright H, *et al*. The cost of a major paediatric burn. *Burns* 2010;36:1208–14.
- 22 Shah M, Orton E, Tata LJ, *et al*. Risk factors for scald injury in children under 5 years of age: a case-control study using routinely collected data. *Burns* 2013;39:1474–8.
- 23 Othman N, Kendrick D. Risk factors for burns at home in Kurdish preschool children: a case control study. *Inj Prev* 2013;19:1884–190.
- 24 Bass JL, Christoffel KK, Widome M, *et al*. Childhood injury prevention counseling in primary care settings: a critical review of the literature. *Pediatrics* 1993;92:544–50.
- 25 DiGiuseppi C, Roberts IG. Individual-level injury prevention strategies in the clinical setting. *Future Child* 2000;10:53–82.
- 26 Dowswell T, Townner EML, Simpson TG, *et al*. Preventing childhood unintentional injuries—what works? A literature review. *Inj Prev* 1996;2:140–9.
- 27 Kendrick D, Smith S, Sutton AJ, *et al*. The effect of education and home safety equipment on childhood thermal injury prevention: meta-analysis and meta-regression. *Inj Prev* 2009;15:197–204.
- 28 Kendrick D, Young B, Mason-Jones AJ, *et al*. Home safety education and provision of safety equipment for injury prevention. *Cochrane Database Syst Rev* 2012;(9): CD005014.
- 29 Townner E, Dowswell T, Jarvis S. Updating the evidence. A systematic review of what works in preventing childhood unintentional injuries: part 1. *Inj Prev* 2001;7:161–4.
- 30 US Preventative Services Task Force. Guide to Clinical Preventative Services. 2nd Edition. Report of the U.S. Preventative Services Task Force. In: Wilkins WA, ed. Baltimore: US Preventive Services Task Force, 1996:671–4.
- 31 Waters E, Shield J, Nolan T, *et al*. Evidence-Based Health Promotion: No. 4 Child Injury Prevention. Public Health: Victorian Government Department of Human Services. Melbourne, Victoria, 2001.
- 32 Fleming PJ, Gilbert R, Azaz Y, *et al*. Interaction between bedding and sleeping position in the sudden infant death syndrome: a population based case-control study. *BMJ* 1990;301:85–9.
- 33 Runyan CW, Bangdiwala SI, Linzer MA, *et al*. Risk factors for fatal residential fires. *N Engl J Med* 1992;327:859–63.
- 34 Thompson RS, Thompson DC, Rivara FP, *et al*. Cost-effectiveness analysis of bicycle helmet subsidies in a defined population. *Pediatrics* 1993;91:902–7.
- 35 LeBlanc JC, Pless IB, King WJ, *et al*. Home safety measures and the risk of unintentional injury among young children: a multicentre case-control study. *CMAJ* 2006;175:883–7.
- 36 Petridou E, Trichopoulos D, Mera E, *et al*. Risk factors for childhood burn injuries: a case-control study from Greece. *Burns* 1998;24:123–8.
- 37 van Rijn OJ, Bouter LM, Kester AD, *et al*. Aetiology of burn injuries among children aged 0–4 years: results of a case-control study. *Burns* 1991;17:213–19.
- 38 Kendrick D, Maula A, Stewart J, *et al*. Keeping children safe at home: protocol for three matched case-control studies of modifiable risk factors for falls. *Inj Prev* 2012;18:e3.
- 39 Department for Communities and Local Government. *The English Indices of Deprivation 2010*. London: Communities and Local Government, 2011 (accessed 30 Jan 2014).
- 40 Putnam SP, Gartstein MA, Rothbart MK. Measurement of fine-grained aspects of toddler temperament: the Early Childhood Behavior Questionnaire. *Infant Behav Dev* 2006;29:386–401.
- 41 Putnam SP, Rothbart MK. Development of short and very short forms of the children's behavior questionnaire. *J Pers Assess* 2006;87:102–12.
- 42 Gartstein MA, Rothbart MK. Studying infant temperament via the Revised Infant Behavior Questionnaire. *Infant Behav Dev* 2003;26:64–86.
- 43 Brunner HI, Maker D, Grundland B, *et al*. Preference-based measurement of Health-Related Quality of Life (HRQL) in Children with Chronic Musculoskeletal Disorders (MSKDs). *Med Decis Making* 2003;23:314–22.
- 44 Varni JW, Seid M, Kurtin PS. PedsQL(TM) 4.0: reliability and validity of the Pediatric Quality of Life Inventory version 4.0 generic core scales in healthy and patient populations. *Medical Care* 2001;39:800–12.
- 45 Varni JW, Seid M, Rode CA. The PedsQL: measurement model for the pediatric quality of life inventory. *Medical Care* 1999;37:126–39.
- 46 Bjelland I, Dahl AA, Haug TT, *et al*. The validity of the Hospital Anxiety and Depression Scale: an updated literature review. *J Psychosom Res* 2002;52:69–77.
- 47 Crnic KA, Booth CL. Mothers' and fathers' perceptions of daily hassles of parenting across early childhood. *J Marriage Fam* 1991;53:1043–50.
- 48 Crnic KA, Greenberg MT. Minor parenting stresses with young children. *Child Dev* 1990;61:1628–37.