LEARNING OUTCOMES

- To list the types of risks for adequate parenting and the sources of those.
- To describe some of the ways the risks can affect parenting and in turn children.
- To summarize sources of resiliency in families.

Child rearing is, at times, demanding, tiring, and stressful. Even under the best of circumstances with plenty of resources at hand, parenting is challenging. These challenges become much more difficult in the face of various risk factors in the child’s environment or due to the parent’s or child’s characteristics. Risk factors are anything that increases the likelihood of problems in adequate parenting and in turn, for a child’s
well-being. Consider individuals with a history of delinquency or drug use. What about the added challenges of rearing a child who has a significant development disability? Adequate child rearing can also be threatened by living in dangerous environments.

This chapter addresses three types of risk factors: parent characteristics, child characteristics, and contextual characteristics. The five parent characteristics are poverty, affluence, adverse childhood experiences, mental health problems, and substance abuse. Child characteristics is best illustrated by children with special needs, such as children diagnosed with autism spectrum disorder (ASD). Finally, examples of the contextual risk to be considered in this chapter include living in a violent relationship, being in a relationship with an incarcerated parent, and living in a war zone or a natural disaster.

PARENT CHARACTERISTICS

Socioeconomic status (SES) is recognized to be one of the most important determinants of parenting (Chapter 5), and it is a widely studied construct in social science (Bradley, 2018). SES is not easily quantified, but it is typically determined on the basis of parental occupation, highest educational degree obtained, and income. SES provides a convenient variable to serve as a proxy to represent a variety of different physical and social experiences. Differences in SES are closely linked to variations in three types of resources that affect children’s development:

- financial capital (money);
- human capital (the availability, involvement, and motivation of other people to promote a child’s development); and
- social capital (access and connections to others in the community, including providers of medical care).

Interestingly, both ends of the financial spectrum put parents and children at risk for problems. We begin with the most obvious case, parents living in poverty.

Parents Living in Poverty

If one had to choose one risk factor with the greatest likelihood for negative effects on parenting and children’s development, it would be poverty, also investigated as low-income or low SES (Bradley & Corwyn, 2002). When a family has inadequate financial resources to meet its daily needs, this condition brings with it a variety of problems. Poverty is clearly harmful for children. It negatively affects brain development; it leads to poor physical, emotional, and behavioral health; it creates achievement gaps; it exposes children to chronic stress, violence, drugs, and other damaging experiences; and it negatively impacts families and the home environment (Murphey & Redd, 2014; Steele et al., 2016).

How is poverty status determined? Globally, one index of poverty is those living on $1.90 per day or less. It is estimated that 385 million children live in extreme poverty (Newhouse, Suarez-Becarra, Evans, & Data for Goals Group, 2016). See Box 12.2 for a brief description of these families. In the United States, the Census Bureau measures
poverty by family income, adjusting the figure depending on family size and composition as well as current inflation. For 2017, the poverty threshold for a two-parent family with two children was set at $29,989 (U.S. Census Bureau, 2019). Despite the affluence and collective wealth of the United States being recognized as an affluent country, currently, about 19% of U.S. children are being raised in poverty. Almost one in five children! That troubling rate varies greatly depending on such variables as race/ethnicity and region of the country (Annie E. Casey Foundation, 2018). Figure 12.1 depicts how the U.S. rates of child poverty differ by child race/ethnicity.

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**BOX 12.1 BABIES’ EXPERIENCES IN DIFFERENT SES GROUPS**

How does SES affect infants? One study compared the experiences of three- to four-month-old African American infants from three SES groups: low (families had an annual income of less than $10,000), middle (incomes in the $35,000 to $55,000 range), and upper (average income above $80,000) groups. The researchers (Fouts, Roopnarine, & Lamb, 2007) observed infants for 12 hours over four days to examine 16 different behaviors, including social interactions, sleeping, smiling, vocalizing, self-play, fussing, and crying.

Although all the infants slept and were talked to for similar amounts of time, higher-SES infants differed from the middle- and lower-SES infants in several ways. They vocalized and fussed less but engaged in more self-play. They also received more verbal affection and soothing responses. Lower-SES infants interacted more with relatives. In this study, it is clear that the lower-SES infants did not experience social deprivation, although they were experiencing a different social environment than the other children. How differences like these subsequently translate into different child outcomes remains to be seen.

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**FIGURE 12.1** Childhood Poverty Rates in Different Racial/Ethnic Groups in the United States

![Graph](image-url)

**Source:** The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org.
What are the ramifications of living in poverty? First, it means living in a poor-quality physical environment (see Photo 12.1). Children in poverty live in toxic environments—both literally and figuratively. Many children raised in poor urban neighborhoods live in “war zones” (Garbarino, Kostelný, & Dubrow, 1991), and are exposed to toxins such as...
lead paint or polluted air and water. These residential areas are often plagued by crime, drugs, and violent gang-related activity. In a multiethnic sample of poor fourth and fifth graders in Detroit, 89% of the children regularly heard gunfire, 66% had seen someone mugged, and 25% had witnessed a stabbing or shooting. Many of the children had themselves been victimized: 65% reported being assaulted, 44% had been threatened, 26% had been chased by gangs, 24% had been mugged, and 21% had been at home when the place was burglarized (Ceballo, Dahl, Aretakis, & Ramirez, 2001).

Gary Evans and Pilyoung Kim (2013) identified three different pathways through which poverty can result in negative outcomes in children. The first trajectory is lack of parental investment. Poor parents may not have the resources or the knowledge to provide their children with appropriate cognitive and language stimulation. Their homes are often bereft of reading materials, toys, and cognitive stimulating objects. Another explanation for neglect is the elevated chronic stress due to low income and life circumstances. Poverty puts families under extraordinary daily stress, which can be exacerbated by substance abuse, mental health problems, or disabilities. That stress and its comorbid problems puts low-income children at a heightened risk for neglect as well as physical abuse. Parents who lack financial resources are more likely to engage in harsh disciplinary practices as well as be less responsive to their children (Conger & Donnellan, 2007).

The evidence is very clear that low income is interrelated with multiple negative contextual and interpersonal characteristics. In addition to the pathways identified by Evans and Kim (2013), there are other hazards to children that accompany poverty. Poor family are also likely to frequently move. Higher incomes allow parents to live in better neighborhoods and provide more cognitively stimulating material (toys, books, computers), provide better nutrition, and receive better health care. In addition, higher-income parents often have more time to devote to child rearing and engaging the child in social relationships with others. In contrast, poor families live in crowded, noisier, more dangerous, and more disorganized and chaotic environments that are often characterized by family turmoil and violence (Evans & Cassells, 2013; Evans & Wachs, 2010). Such families are also more likely to be made up of single parents and members of a minority or immigrant group. For immigrants, they may experience language problems. And, neighborhood childcare and schools options are often substandard (Huston & Bentley, 2010).

The effects of poverty reach beyond the environment to permeate the quality of parenting. The impact of poverty on parenting has been most extensively documented using the Home Observation for Measurement of the Environment (HOME) assessment, developed by Robert Bradley and Bettye Caldwell (1984). This instrument consists of both a parent interview and observations of the home and parent-child interactions during the interview. The nine subscales of the preschool version of the HOME are listed in Table 12.1.

Researchers using the HOME instrument have documented that poverty affects all the parenting tasks identified by Bradley (2007):

- Ensuring safety and sustenance
- Simulating and instructing
- Giving socioemotional support
### TABLE 12.1  
**The HOME Inventory (Preschool Version): Examples of Subscale Items**

<table>
<thead>
<tr>
<th>I. Learning Stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child has toys that teach color, size, or shape.</td>
</tr>
<tr>
<td>• Family buys and reads a daily newspaper.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Language Stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child is encouraged to learn the alphabet.</td>
</tr>
<tr>
<td>• Mother uses correct grammar and pronunciation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Building appears safe.</td>
</tr>
<tr>
<td>• House is reasonably clean and minimally cluttered.</td>
</tr>
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<table>
<thead>
<tr>
<th>IV. Warmth and Acceptance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parent praises child’s qualities twice during visit.</td>
</tr>
<tr>
<td>• Parent caresses, kisses, or cuddles child during visit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. Academic Stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child is encouraged to learn colors.</td>
</tr>
<tr>
<td>• Child is encouraged to learn to read a few words.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>VI. Modeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parent introduces visitor to child.</td>
</tr>
<tr>
<td>• Child can express negative feelings without reprisal.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VII. Variety in Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child is taken on outings by family member at least every other week.</td>
</tr>
<tr>
<td>• Child eats at least one meal per day with mother and father.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIII. Physical Punishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parent does not scold or derogate child more than once.</td>
</tr>
<tr>
<td>• Parent neither slaps nor spanks child during visit.</td>
</tr>
</tbody>
</table>

**Source:** Bradley & Caldwell, 1984.

- Monitoring and surveillance
- Structuring
- Providing social connectedness
Poverty interferes with or degrades these parenting tasks. Several researchers have described how poverty affects many dimensions of family life and creates widespread environmental inequities for children (e.g., Evans, 2004). Children in poverty receive less social support, and their more-authoritarian parents provide less warmth, cognitive stimulation, and responsiveness. Economic hardship, of course, diminishes a parent’s capacity for supportive, consistent, and involved caregiving, in part because it results in depression (Engle & Black, 2008; McLoyd, Jayaratne, Ceballo, & Borquez, 1994). Children raised in poverty watch more TV, are read to less often, and have less access to books or computers. They are more likely to

TABLE 12.2 Problems Associated With Poverty for Children and Youth

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Social and Emotional Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature birth</td>
<td>Problems with self-regulation</td>
</tr>
<tr>
<td>Birth defects</td>
<td>Low efficacy motivation</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Obesity</td>
<td>Aggression, delinquency</td>
</tr>
<tr>
<td>Asthma</td>
<td>Relationship difficulties</td>
</tr>
<tr>
<td>Increased blood lead levels</td>
<td></td>
</tr>
<tr>
<td><strong>Competence and Achievement</strong></td>
<td></td>
</tr>
<tr>
<td>Attention difficulties (e.g., ADHD)</td>
<td></td>
</tr>
<tr>
<td>Mental retardation</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td></td>
</tr>
<tr>
<td>Poor grades and dropping out</td>
<td></td>
</tr>
<tr>
<td>Lower college attendance</td>
<td></td>
</tr>
</tbody>
</table>
engage in harsh discipline (i.e., corporal punishment) and neglectful parenting (Bøe et al., 2013; Bradley & Corwyn, 2002; Evans & Kim, 2013; Kang, 2013) and less likely to reward their children or be responsive to their needs (Magnuson & Duncan, 2002). No wonder these children are prone to many more problems than their more fortunate peers!

Vonnie McLoyd (1990) developed a model of how poverty affects parenting and, in turn, children. Her model, as tested by Nievar and Luster (2006)—with some adaptations—is found in Figure 12.2. So, there is evidence that poverty affects families and children in multiple ways.

Low-income parents are chronically stressed; poverty takes a large toll on their health and well-being (Magnusson & Duncan, 2002). Poverty also affects parents’ values and goals. Recall from the chapter on determinants of parenting that socioeconomic class helps to explain why parents may have different long-term socialization goals for their children, such as low-resourced parents valuing conformity to authority in contrast to other parents who value autonomy and self-motivation in their children.

The well-being of children in poor families is at risk for a variety of health and behavioral problems. These children have more self-regulatory deficits, attentional problems, maladaptive coping skills (i.e., withdrawal and avoidance), behavior problems, and school failure than their higher-income peers (Brooks-Gunn, Duncan, & Maritato, 1997; Evans & Kim, 2013; Pryor, Strandberg-Larsen, Anderson, Rod, & Melchior, 2019) Many of these problems co-occur. Poor children are 1.3 to 6.8 times as likely to have learning or behavior problems, to become a teen parent, or to be a victim of child maltreatment (Brooks-Gunn, Duncan, & Aber, 1997). Finally, these children are also at risk for neglect and maltreatment, as will be discussed in more detail in Chapter 15. Many of the problems closely linked to poverty are listed in Table 12.2.

Of course, not all parents and child rearing are adversely affected by living in poverty. Some parents respond to this dangerous environment in a variety of ways to try to counteract or at least buffer their children from some of the potentially damaging experiences (Burton & Jarrett, 2000). Positive ways of dealing with the environment include increasing their commitment to their child-rearing role, modifying their parenting practices to protect their children, and seeking out resources and opportunities for their children.

Homeless families represent an extreme case of a lack of material resources. Globally, it is estimated that as many as 2.5 million children experience homelessness each year (Bassuk, DeCandia, Beach, & Berman, 2014). On any single night, as many as 3.5 million people in America and 4.1 million in the European Union are homeless (Fazel, Geddes, & Kushel, 2014). Of those individuals without a home in the United States, 35% (more than 194,000 individuals) are families with children (U.S. Department of Housing and Urban Development, 2016). Sixty percent of these individuals are children. Typically, these families are mother-headed. Homeless families are rarely found on the street. Rather, 32% live temporarily in homeless shelters or with extended family or friends (Henry et al., 2016). And, their homelessness is relatively short-lived. Most of these families (87%) are homeless for fewer than five months.

Mothers in homeless families are typically young, minority, jobless, have multiple children, and have been abandoned by the father of their children. In addition, the mothers are often survivors of trauma in their childhoods and intimate partner violence.
as adults. Many homeless parents struggle with substance abuse problems, and approximately one third have serious mental health problems (Bassuk & Beardslsee, 2014; Hinton & Cassel, 2013; Monn et al., 2013; Roze, Vandentorren, van der waerden, & Melchior, 2018).

Homeless parents are at risk for a variety of mental health and parenting problems. Mothers report high rates of stress, depression, and are likely to use harsh and inconsistent discipline (e.g., Holtrop, McNeil, & McWey, 2014; Wu, Slesnick, & Murnan, 2018). However, not all homeless mothers experience high levels of problems. Ann Easterbrooks and Christine Graham (1999) compared 55 homeless mothers and children with 57 low-income (not homeless) mothers and children. They assessed maternal mental health, attachment relations, reported parenting practices, and stressors. Surprisingly, the homeless mothers did not differ reliably from the low-income mothers on any of the variables. That does not mean that either group was faring well. Both groups of mothers evidenced a number of problems and problematic behaviors.

Homeless children are also likely to have high rates of problems due to cumulative risk factors. These children tend to have poor health, behavior problems, educational delays, and poor academic performance. There is evidence that the longer the children are homeless, the more internalizing symptoms (such as depression, anxiety, and social withdrawal) they will have (Buckner, Bassuk, Weinreb, & Brooks, 1999; Monn et al., 2013).

Despite all of the problems the homeless children encounter, there is striking variability within the homeless population. Some homeless children show remarkable resilience despite the risks (Masten, 2011). One source of resilience comes from the quality of the child rearing at least some children receive. High-quality parenting (warm, responsive, consistent discipline, appropriate structure, and positive expectations for the child) can protect the child against some of the negative effects of unstable living situations (Herbers et al., 2011). High functioning homeless parents report various adaptive strategies they use to try to buffer their children from the potentially damaging effects of their living situation. These include: maintain a positive mindset (e.g., discussing how the situation is only temporary); valuing the parental role (recognizing their role in protecting their children); spirituality (using their faith to comfort their children); practical strategies (arranging for family time in a shelter), and support seeking (finding supportive individuals for their children) (Bradley, McGowan, & Michelson, 2018).

**Parents With High Incomes**

At the other end of the SES continuum are affluent families, technically defined as families earning greater than twice the country’s median income (the median income in the United States in 2017 was $57,617). Although material resources are not a problem with these families, and children of affluent families are assumed to be low risk, the evidence indicates this view is not an accurate. A review of the limited literature (Luthar, 2003) identified some of the adjustment problems experience by children from wealthy families. They included anxiety, depression, and substance use (cigarettes, alcohol, marijuana, and other drugs). These children are at risk for various emotional problems (Csikszentmihalyi & Schneider, 2000).
Economically privileged children are believed to be at risk for several reasons: Their parents are less involved and devote less time to them than other parents, they may feel under considerable pressure to achieve (a feeling that may be derived from parents, sibling competition, or themselves), and they may be isolated from their parents (literally and emotionally) (see Box 12.3). Often, children of affluent families perceive their parents as emotionally and physically unavailable—to the same extent as youth raised in poverty. They may lack after-school supervision, which is associated with externalizing problems (Luthar & Latendresse, 2005). High-profile parents may also be reluctant to seek professional help in their efforts to maintain a veneer of well-being. Finally, children of affluence often have the financial means to purchase illegal drugs and alcohol (Lund & Dearing, 2013; Luthar & Latendresse, 2005).

Another cause of youth distress in affluent families is the parents’ excessive focus on materialism. According to Kasser (2002), affluent parents are likely to:

- value money, work, and possessions;
- model consumerism;
- devote time and energy to making money and purchasing items rather than to spending time with the family; and
- reinforce valued child behavior with gifts or money.

Materialism and consumerism are associated with unhappiness because the desire for more and more possessions forces us into a more frantic pace of life, causing stress, strain, and neglected relationships (Kasser, 2002, 2016). Think about the parents-as-guides model of child rearing. What materialistic parents are doing—either intentionally or otherwise—is shaping their children’s values in, perceptions of, and orientation toward the external world. In materialistic families, happiness becomes linked to acquiring fashionable clothes, the latest cell phone, the lightest and fastest computer, and the biggest and most luxurious car.

**BOX 12.3 WORKAHOLIC PARENTS**

Affluent families tend to have one or more parents who are workaholics (or who have a “work addiction”). Workaholism not only negatively affects the parent, who may be working 12-hour days or 100 hours in a week, but it also affects the family system. Family problems include high levels of marital unhappiness and divorce as well as relational and psychological problems (depression, anxiety, obsessive-compulsive tendencies) in the children (Chamberlin & Zhang, 2009; Robinson, Flowers, & Carroll, 2001). Children of workaholic parents resent the lack of physical and emotional availability of the parent. Another type of problem created by the parents’ absence is parentification of the child, when the child is put into the role of an adult in the family. Older children are sometimes put in the position of providing child care for a younger child or emotional support for a parent. When this occurs, the child carries the burden of inappropriate responsibility (Robinson & Carroll, 1999). Youth who perceive parentification as unfair are likely to exhibit mental health symptoms (Jankowski, Hooper, Sandage, & Hannah, 2013).
What research is available does indeed indicate that children and youth from affluent families are at risk for several types of problems. The most commonly documented problems are anxiety, unhappiness and depression, and somatic problems (insomnia, gastrointestinal disturbance) as well as delinquency and substance abuse (Elgar et al., 2013; Luthar, 2003). In a study of affluent girls aged 12 to 17, they reported feeling great pressure to perform, they had narrow views of the meaning of success, experienced stiff peer competition, and their view of their parents’ expectations for them were often inaccurate (Spencer, Walsh, Liang, Mousseau, & Lund, 2018).

Another common child outcome stemming affluence is the development of overly materialistic values (Kasser, Ryan, Zax, & Sameroff, 1995). Parents, as well as peers, can directly influence the development of materialism by modeling, reinforcement, and communicating consumption attitudes. Alternatively, there may be some mediating influences on the development of materialism, according to Chaplin and John (2010). Youth with positive self-perceptions are less materialistic, so parents who are supportive of their children and promote healthy and realistic self-esteem will have adolescents who are less consumer-oriented.

According to Richins and Chaplin (2015), there are two different pathways through which parents socialize their children to become materialistic. Warm and supportive parents are likely to provide their children with material rewards. Some parents indulge their children with conditional material rewards (such as buying a smartphone for the child as a reward for accomplishments or good behavior) and other parents may engage in unconditional material rewards (giving the child a desired item without requiring any specific performance). Both manifestations of material rewarding aided in the development of materialism as adults (Richins & Chaplin, 2015).

However, they also identified a second type of pathway toward materialism. That stemmed from an insecurity experienced in childhood. That insecurity could reflect a personal doubt in one’s abilities or a social insecurity centered around a lack of confidence in social relationships. Both could result from parental rejection. Like the reward pathways, evidence was found for both forms of insecurity contributing to adult materialism.

Parents With Adverse Childhood Histories

The majority of Americans and the vast majority of college students are reared in families and communities that are stable and nonviolent. However, many children are not so fortunate. Consider the true case of a child, whom we will call “Donnie.” Donnie was raised in an inner-city apartment in a poor neighborhood of a major city. Drug dealing and gang violence was rampant. He lived with his unemployed mother and three siblings in a small, noisy apartment. But, the worst part of his childhood was his mother. She was a drug addict and prostitute. If she had a boyfriend, he was likely to be abusive to her. Donnie was born addicted to heroin. His mother’s child rearing consisted primarily of yelling, name-calling, and hitting with objects—there were never any expressions of love or affection. At age six, Donnie was sexually abused by a neighbor. He was also subjected to abuse from siblings, including an older brother who eventually went to prison. Donnie finally escaped that toxic environment when he was 15 because he was arrested for selling drugs. A juvenile correction home became his safe house.
Although Donnie represents an extreme case, being raised in unfavorable environments is not. To investigate the effects of childhood environments on adult functioning, the Adverse Childhood Experiences (ACE) study was conducted (Felitti et al., 1998). More than 17,000 middle-class adults enrolled in a health maintenance organization in California participated. They reported on the number of adverse circumstances they experienced in the first 18 years of their lives, as well as their current physical and mental health. Information about 10 adversities forming two categories of adverse experiences: child maltreatment (physical, sexual, psychological, and neglect) and household “challenges” (e.g., parental separation/divorce, drug or alcohol problems, mental health problems). Donnie’s ACE score was 10. See Box 12.4 to calculate your ACE score.

The first surprising result concerned the reported frequency of adversities. Only about a third reported no adverse experiences. Forty-two percent of the adults reported one or two ACEs and 22% reported three or more. Those ACEs where then linked to

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**BOX 12.4 CALCULATE YOUR OWN ACE SCORE**

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? Or, act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? Or, ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least five years older than you ever... Touch or fondle you or have you touch their body in a sexual way? Or, attempt or actually have oral, anal, or vaginal intercourse with you?

4. Did you often or very often feel that... No one in your family loved you or thought you were important or special? Or, your family didn’t look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Or, your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? Or, sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?

Total score is the total number of “yes” answers.

*Source: [http://acestudy.org/ace_score](http://acestudy.org/ace_score).*
multiple physical and mental health problems. The consistent finding is that adverse childhood experiences impact physical health (e.g., heart disease, stroke, cancer, diabetes), mental health (e.g., depression, alcohol or drug abuse, suicide attempts), and behavior (e.g., early initiation of sexual activity, smoking). Furthermore, it has been repeatedly found that the greater the exposure to adversities, the greater the risk for problems (Felitti et al., 1998). There is often a cumulative or dose-response relationship between the number of adversities and individual’s well-being. The likelihood of having a health problem is low with no ACEs but increases dramatically with each additional ACE someone has experienced.

How is parenting affected by adverse childhood experiences? What are the chances that Donnie will make a nurturing father? Researchers using the ACE instrument (or similar ones) have only begun to investigate how childhood adversities can result in problematic parenting. At least three qualities of parenting have been implicated using ACE instruments: stress, harsh punishment, and positive parenting. Parents with higher ACE scores are likely to be more stressed (Lange, Callinan, & Smith, 2018; Steele et al., 2016; Yoon et al., 2019). Similarly, mothers with ACE scores of two or more were more likely to spank their infant or use physical punishment with older children (Chung et al., 2009; Yoon et al., 2019). Third, mothers of preschoolers who had fewer than three ACES had higher oxytocin levels and engaged in more positive parenting (sensitive, supportive guidance, positive affect) than mothers with three or more ACEs (Julian et al., 2018).

The continuing legacy of childhood experiences can be accounted for by a variety of underlying mechanisms, including physiological and neurological, social, emotional, and cognitive (Leen-Feldner et al., 2013; Shonkoff et al., 2012). However parenting is affected by early experiences with ACEs, evidence is accumulating that children are indeed at considerable risk. Some of the likely consequences on children of parents having lived through childhood adversities include: infant health problems (Racine, Plamondon, Madigan, McDonald, & Tough, 2018); developmental delays (Folger et al., 2018); behavior problems (Schickedanz et al., 2018; Yoon et al., 2019); emotional disturbance (Schickedanz et al., 2018); and health problems (Lê-Scherban, Wang, Boyle-Steed, & Pachter, 2018).

**Parents With Serious Mental Illness or Substance Abuse Problems**

One of the adverse experiences that some children live with is when a parent has a mental illness. From time to time, one reads horrific news stories that illustrate this risk. A mother in Houston, Texas, made headlines in 2001 after drowning her five young children in a bathtub. From the time of the birth of her fourth child, Andrea Yates had suffered from postpartum depression, but medication had successfully controlled the problem. When her fifth child was born, she relapsed into severe depression, and the antidepressant drugs were ineffective. Her defense lawyers argued that she was both depressed and psychotic. Before the killings, she said, she heard voices telling her to kill her children to save their souls. In 2006, she was tried for murder, acquitted by reason of insanity, and committed to a state mental hospital.

Fortunately, it is unusual for mentally ill parents to murder their children. However, serious mental illness in adults is not rare: It is estimated that one of five American adults
will experience a mental illness and in any given year, 43.8 million adults experience some type of mental illness, such as an anxiety disorder or depression (National Alliance on Mental Illness, 2019). Some mental health problems, such as postpartum depression, are generally short-lived for many individuals (as mentioned in Chapter 6). However, other serious psychological problems can be chronic.

There are six commonly studied categories of mental health problems in parents:

- Depression
- Anxiety
- Schizophrenia
- Bipolar disorder
- Antisocial personality disorder
- Alcohol or substance abuse

To date, we have an incomplete understanding of how mental illness affects parenting and children’s development. Part of the reason is that research into mental disorders and parenting has focused mostly on mothers. One notable exception is a meta-analytic review of 28 studies examining the effects of depression on fathers’ parenting (Wilson & Durbin, 2010). They found that depressed fathers engaged in fewer positive and more negative parenting behaviors. A more recent review of 12 studies analyzed how opioid use by parents affects the parent-child relationship and child outcomes (Romanowicz et al., 2019). They found mothers who used opioid were more irritable, disinterested, and ambivalent about their children and had greater difficulty in interpreting their children’s cues compared to mothers in a control group. Children of parents with opioid use were more likely to have disorganized attachments, emotional and behavioral problems, poor social skills, academic problems, and be at risk for abuse or neglect.

Part of the reason for the focus on mothers is that they are typically the primary caregivers. But, there is also a long history of mother blaming. Mothers have been accused of causing a variety of problems in their children. Autism—according to male psychiatrists in the 1950s—was the result of cold and unloving mothers. The etiology of childhood schizophrenia was also thought to be due to aberrant maternal behavior called schizophrenogenic parenting. These and other examples of mother blaming (see Box 12.5) are due to an orientation or cultural view that a mother has primary responsibility for the growth, development, and behavior of her children (Caplan & Hall-McCorquodale, 1985).

When considering how mental health problems affect parenting and children’s development, the environmental context needs to be considered; psychological problems do not occur in a vacuum. When a parent has a serious mental illness, there are usually co-occurring problems. For example, individuals with a mental illness often abuse alcohol or drugs and have strained interpersonal relationships. In addition, poverty and violence are found in many of these families. Thus there are two types of multiple problems in these individuals: co-occurrence (two or more problems in the family) and comorbidity (two or more disorders in the individual). Mental health problems can be both a cause...
and a consequence of homelessness (Chambers et al., 2013). It is difficult to sort out exactly which effects can be attributed to particular problems. For research purposes, however, certain statistical procedures (such as partial correlations, covariance, and structural equation modeling) can be used to control for multiple problems.

How is child rearing affected by a parent’s serious mental illness? The answer depends on such considerations as the type of mental health problem, the severity of it, and whether the problem is chronic or acute (with short episodes) (Zahn-Waxler, Duggal, & Gruber, 2002). Mental health problems impede effective parenting in multiple ways. Parents with a psychopathology typically cannot provide the warmth, emotional nurturance, reciprocal interactions, structure and stimulation, appropriate supervision, and discipline that young children need. In addition, when the children get older, mentally ill parents may have difficulty granting increasing autonomy to the child. Mothers with mental illness also report more stress, less social support, and less nurturance than other mothers (Oyserman, Bybee, & Mowbray, 2002).

The mental health problem that has attracted the most attention is depression in mothers and, more recently, fathers (Barker, Iles, & Ramchandani, 2017). The problem is not uncommon; about one-third of women experience depression at some point in their lives. It is also a highly recurrent condition; more than 80% experience more than one depressive bout. Depression affects parenting in various ways. Ted Dix and Leah Meunier (2009), based on 152 studies, identified 13 potential regulatory processes that may be involved when a parent is depressed and thus serve to undermine effective parenting. For example, depressed parents can be less child focused, less attentive, more negative, and more prone to use coercive parenting. A review of 46 observational studies of depressed mothers determined that depressed mothers are significantly more likely

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**BOX 12.5 IT’S THE MOTHER’S FAULT!**

There is a long history of blaming women for a diverse assortment of childbearing or child-rearing issues. King Henry VIII had his wife, Anne Boleyn, executed because she had failed to bear him a son. A more benign attack on mothers has come from those psychiatrists and psychologists who accused mothers of causing a variety of problems in children. “Refrigerator mothers” were thought to cause autism through their cold and aloof behavior. “Schizophrenogenic mothers” elicited schizophrenia in their children. A mother who was “close-binding” and intimate with her son while being dominant and minimizing to her husband was the “classic pattern” for causing homosexuality (Bieber et al., 1962). The list of blameable offenses goes on and on and includes epilepsy, asthma, ADHD, and transgendered children (Caplan & Hall-McCorquodale, 1985; Johnson & Benson, 2014; Singh, 2004).

Subsequent research has refuted all those extreme environmental, Watsonian contents. When differences in maternal behavior are found, they can readily be explained by child effects. For example, children with ASD typically have severe communication problems, avoid eye contact, resist affection, and struggle with reciprocal interactions. It is no wonder that their mothers’ behavior differs dramatically from mothers of typical children! Interestingly, fathers have rarely been accused of causing these types of problems.
than non-depressed mothers to be irritable, negative and to be disengaged or withdrawn from their infants or children. Their disciplinary practices tend to be lax, inconsistent, and ineffective (Lovejoy, Graczyk, O’Hare, & Neuman, 2000). On the other hand, some depressed mothers engage in a different pattern of behavior—that of being highly intrusive and overstimulating their infants (Field, Hernandez-Reif, & Diego, 2006).

Why are children affected when parents have a mental illness? It is impossible to isolate any single cause because multiple processes are at work. Children of mentally ill parents can be affected by genetics and biology; parenting processes (e.g., attachment, child discipline, and modeling); cognitive processes; family interactions; and family characteristics, such as a low income and a lack of social resources (Elgar, McGrath, Waschbusch, Stewart, & Curtis, 2004; Goodman & Gotlib, 1999). If the mentally ill individual is unable to parent adequately, a child’s needs go unmet. The child’s behavior is then affected, and this in turn leads to more problems for the ill parent.

Living with a mentally ill parent certainly represents a risk for children’s development. When a mother has chronic depression, her children are not just at risk for depression and other mental health problems but also for behavioral, emotional, cognitive, academic, and health problems (Downey & Coyne, 1990). Part of the task for a child living in this situation is to understand the fact that the parent is ill. This challenge is captured in the true story presented in Box 12.6.

**BOX 12.6 REARED BY A MENTALLY ILL MOTHER**

Raven had lived with just her mother since she was two, after her parents had divorced. Raven’s mother experienced delusions and hallucinations and acted out in ways that were unusual and unexplainable to the child. But, Raven believed in her mother, to whom she had a strong attachment; she had never had another caregiver. Raven didn’t recognize that her mother had a mental illness. The mother kept her illness hidden, and it was years before she received an accurate diagnosis and treatment.

At school, Raven began to exhibit behaviors that concerned her teachers. She shared her “special powers” with friends, but the friends began to withdraw from her, saying she was “strange” and “weird.” They began to avoid her and to make fun of the stories she told. Raven often played alone, and spoke intently to her imaginary friends, the only consistent friends she had ever had. Academically, she was struggling; her reading and writing levels were years behind. The other children noticed this as well, and it was another excuse to tease and belittle her. At times, the young girl was oblivious to the teasing and bullying; at other times, she was very aware that she was being ostracized.

The school situation prompted an investigation by the Ministry for Children and Families, and Raven was removed from her mother’s care. Shortly after being placed in her father’s care, Raven came into the Kids in Control group.

It became clear almost immediately that she had been affected by her mother’s illness. She described unusual situations that she and her mother had experienced. She talked about special powers she had and how she could use her powers. She talked about being afraid of certain people and how the “bad men” were trying to hurt her and her mother. Many of the disturbing stories were obviously a result of things her mother had said to her.
Despite the associations found between parental mental health problems and children's problems, the likelihood that a child of mentally ill parents will develop problems is not high. According to a meta-analysis of 134 different samples of mentally ill parents and children (Connell & Goodman, 2002), the likelihood of children having behavior problems was small. The average effect size (a statistic that can be interpreted similarly to a correlation) is 0.17 for mothers and 0.16 for fathers. These associations vary by the age of the children and the parents' type of mental health problem, but they indicate that it is far from inevitable that a child will develop a serious problem. Given the multiple challenges these children face, it is remarkable how many of them appear to be resilient as they weather their difficult childhood circumstances.

Parents who have mental disorders often abuse substances. It is estimated that about 12.5% of children and youth (amounting to 8.7 million people) in the United States have a parent with a substance use disorder (Lipari & Van Horn, 2017). This disorder is characterized by recurrent use of the substances that result in significant impairments. These include: failing to meet obligations at work, home, or school; poor health; and devoting time to obtaining, using, and recovering from use of the substances. The substances are include marijuana (where illegal), cocaine, methamphetamine (crystal meth), hallucinogens (LSD, ecstasy), inhalants, and opioids such as heroin or fentanyl or oxycodone.

Parents with substance abuse problems are characterized by cycles of relapse and recovery. During recovery periods, the parent may exhibit minimal, if any, child-rearing deficiencies. However, during a relapse, negative effects can emerge. Some of these effects directly affect the quality of parenting while others may have indirect effects on the home (e.g., more chaotic), the child (e.g., unfed), or interactions with others (more partner conflict) (Keller, Cummings, Davies, & Mitchell, 2008).

If the mother used substances while pregnant, the newborn is at risk for having physical, cognitive, and/or behavioral impairments. As the children grow, they are at risk to develop mental health problems if they do not receive adequate care and support.

In an unusual twist of circumstances, I happened to be assigned to work with Raven in a family outreach program. My initial assessment of her concluded that she had experienced trauma while in her mother’s care. She had normalized the incidents, believing that all young people had the same experiences growing up. One of the goals of Kids in Control is to help children recognize that they are not responsible for their parent’s illness. Raven had, in effect, been her mother’s caregiver since a very early age. She truly believed the frightening stories her mother had told her. Affected by the years of fear that had been instilled in her, Raven was afraid to meet or trust new people. And she had difficulty understanding that many of the things her mother had said to her were false and the result of delusions. Somehow the two had survived, depending on one another, and not letting anyone into their lives.

Raven attended the Kids in Control program twice over two years. She gradually learned about mental illness and finally came to her own conclusion that her mother had been in need of medical attention for a very long time. She came to recognize that much of what she had learned about the world from her mother was false.

risk for attachment problems as well as child maltreatment. Parents who are preoccupied with drugs or frequently high are unlikely to provide the warmth or responsiveness to a child but instead rely on harsh discipline (Barnard & McKegancy, 2004). Parents with substance abuse problems are likely to exhibit negative emotions as well as have difficulty controlling their emotions (Conners-Burrow et al., 2013; Haller & Chassin, 2011). Other problems found with substance-abusing fathers who also engaged in intimate partner violence included negative parenting and poor co-parenting relationships (Stover, Easton, & McMahon, 2013).

Children of alcoholic parents are more likely to develop a number of problems, including alcohol and drug abuse, internalizing and externalizing behavior problems, and mental health problems (e.g., anxiety) (Anda et al., 2002; Lipari & Van Horn, 2017; Peleg-Oren & Teichman, 2006). They also tend to have lower academic achievements than other children (Chassin, Pitts, DeLucia, & Todd, 1999). There is evidence that these problems persist well into adulthood, as the children continue to be at risk for substance abuse, depression, anxiety, aggression, low self-esteem, distress, and problematic intimate relationships (Harter, 2006).

CHILD CHARACTERISTICS

We now turn to look at one type of child characteristics that put parenting at risk. That is the demanding task of parenting children with special needs—i.e., a disability or developmental disorder.

Parents of Children With Special Needs

Developmental disabilities can be caused by genetic, chromosomal, prenatal, or perinatal problems. Trauma during the birthing process is likely to produce brain damage and anywhere from minimal to severe mental disabilities. Some newborns appear to be healthy at birth but within a few years show signs of a pervasive developmental disorder, such as autism spectrum disorder (ASD). Other children may be born with or experience a problem that may result in a sensory impairment (blindness, deafness), motor restrictions, communications difficulties, and continuing medical conditions. Approximately 7% of all children age three to 17 years in the United States have a developmental disability, such as ASD, intellectual disability, or a developmental delay (Zablotsky, Black, & Blumberg, 2017). See Figure 12.3 for a depiction of the estimated prevalence of four types of childhood disabilities.

Developmental problems vary on many dimensions, including the degree of physical and mental impairment, the age of onset, and whether other problems are comorbid. Consider ASD, a disorder characterized by impaired social relations; problems with verbal and nonverbal communication; and the presence of repetitive and stereotyped patterns of behavior, interests, or activities. Children with autism generally do not act like other children; they are likely to engage in disruptive behaviors and to have emotional and thought problems. However, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) uses the diagnosis autism spectrum disorder to label the problem because the severity of the condition can range
from extremely severe to relatively mild (as is the case with Asperger’s syndrome). Some individuals diagnosed with ASD function well in society. Four notable examples are Matt Savage, the jazz pianist; Courtney Love, the singer; Dr. Temple Grandin, a university professor and designer of humane livestock-handling facilities; and Dr. Vernon Smith, the 2002 Nobel Laureate in economics.

Certain developmental disabilities are apparent to everyone because the physical characteristics of it are present at birth—such as the unique facial characteristics of children with Down syndrome. However, the severity of the cognitive impairment is not known at birth and can vary from mild learning disabilities to—in rare cases—profound mental impairment. Although some individuals with Down syndrome have graduated from college, most have cognitive disabilities that limit their educational achievements. For other developmental disorders, such as ASD, the extent of the problem emerges gradually. Although subtle behavioral indicators may be present in the first year of life, the disorder is typically not diagnosed until the child is about three years old. But early identification is important, because early intervention, some which start in infancy, have the potential to dramatically change the course of the disorder (French & Kennedy, 2018).

The presence of a developmental disability comes as distressing news to parents for various reasons. It means that parents have to dramatically alter their expectations and aspirations both for their child and for their own experiences as parents. It also means more stress. Parenting children with serious developmental disorders is much more demanding for many reasons (e.g., Estes et al., 2013; Hartshorne & Schafer, 2018; Rao & Beidel, 2009; Rayan & Ahmad, 2018; Sikora et al., 2013). Parental stress comes from many sources:

Source: Zablotsky, Black, & Blumberg, 2017 [https://www.cdc.gov/ncbddd/cp/index.html].
- Interaction difficulties, such as aggravation and difficulty in controlling the child
- Trying to solve challenging behavior problems
- Interference with typical family functioning and other relationships
- Feelings associated with having a child with special needs
- Financial costs associated with rearing the child
- Concerns about the child’s safety and protection
- Concerns over the child’s future
- Problems encountered when dealing with professional and support services
- Self-stigma

In addition to being more stressful and challenging than rearing a typical child, the task is—for many parents—less rewarding. For example, a child with autism will not reciprocate physical affection in the same way that a typical child does. It’s no wonder that these parents often report high levels of stress, distress, and depression. There is evidence that the relation between maternal distress and children’s behavior problems is circular: Distress leads to increased child behavior problems, which in turn lead to increased maternal distress (Estes et al., 2013). Fifteen studies have confirmed that parents of children with ASD are more stressed than parents of typically developing children (Hayes & Watson, 2013). Stressed parents are more likely to use harsh punishment, as has been found in parents of children with ASD (Lambrechts, Van Leeuwen, Boonen, Maes, & Noens, 2011).

Another problem is parental self-stigma—when individuals accept negative view of themselves. This can occur with parents of children with disabilities, who may sense they are disapproved of or criticized by the public for having the children. These parents may internalize views of self-blame (“My child has the problem because of me”), self-shame (“I am embarrassed that my child has the problem”) or that they are bad parents because of the disability (Eaton, Ohan, Strikzke, & Corrigan, 2019). In a study conducted in Hong Kong, it was found that parents who have greater levels of self-stigma have children who experience more problems (Li, Lam, Leung, & Chung, 2019).

Although parents of children with disabilities—and especially parents of children with autism—are more at risk for having mental health problems than are parents of typically developing children (Estes et al., 2013), stress does not affect all parents in the same way. For example, parents who are resilient, have more parental self-efficacy, or have a greater network of supportive friends, family, or groups are less likely to be adversely affected (e.g., Kuhn & Carter, 2006; Li et al., 2019; see Photo 12.2). Some parents are able to modify their prior expectations about their child and have a positive, affirming parenting experience, as is described in Box 12.7 by a mother of a child with Down syndrome.
Parents in Violent Intimate Partner Relationships

It is estimated that 8.2% of American children witnessed family violence in the last year (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015). In most of these homes, the father is the major perpetrator of the violence, although it is not unusual for the violence to be bidirectional as mothers attempt to defend themselves. Fathers who are violent...
toward their partners are also likely to be authoritarian, angry, controlling, and verbally abusive (Bancroft & Silverman, 2002; Edleson & Williams, 2007). However, not all fathers who engage in violence with their partners are poor parents. For example, in a study comparing 56 interpersonally violent men in a battering intervention program with 39 comparison fathers from the community, only 18% of the violent men were at risk for maltreating their children compared with 3% of the community fathers. However, the violent men who were at risk for child maltreatment differed significantly from the other men on half of the variables assessed. These fathers reported more stress, anger, substance abuse problems, and psychological problems as well as behavior problems in their children than the men who were not at risk for maltreatment (Holden, Barker, Appel, & Hazlewood, 2010).

Mothers living with violent men are also at risk for problematic parenting, often because they are overwhelmed by stress and trying to cope with a violent partner (Radford & Hester, 2001). Mothers who are more traumatized and have poorer psychological functioning are more likely to show poor parenting practices, such as less warmth and more frequent verbal or physical harsh punishment (Holmes, 2013; Levendosky & Graham-Bermann, 2001).

Children living in families where there is intimate partner abuse are at high risk for problems. Many factors contribute to this: the trauma of seeing their parents fight, problematic parenting, and other commonly co-occurring problems (e.g., poverty, child maltreatment, mental health and substance abuse problems). In a meta-analysis of 60 studies of preschoolers through adolescence, those children exposed to intimate partner violence were significantly more likely to have internalizing, externalizing, and trauma symptoms than other children. Boys were especially at risk for exhibiting externalizing problems (Evans, Davies, & DiLillo, 2008).

**When a Parent Is Incarcerated**

The United States boasts the highest rate of incarceration in the world with 2.2 million prisoners (Gramlich, 2018). About 93% of the inmates are male and 92% of the parents in prison are fathers (National Fatherhood Initiative, 2014). This forced family disruption has multiple implications for parenting and burdens vulnerable families. When the incarcerated father goes to prison, the mother at home must transition into the role of the single parent. It often exacerbates or results in a snowballing series of problems, including economic hardships, family and housing instability, unemployment, substance use, and mental health challenges (Geller, Garfinkel, Cooper, & Mincy, 2009; Turney & Goodsell, 2018; Wakefield & Wildeman, 2018). Maintaining positive relations with children is difficult when the father is in prison. Depending on the type of visitation allowed (e.g., video, non-contact, contact), it is difficult or impossible to interact normally with a child.

PHOTO 12.3: An incarcerated mother with her daughter.
Nevertheless, fathers who are able to have regular contact with their children prior to release and have good family support are likely to have positive relations with their children (Visher & Travis, 2011).

It can be more problematic for the child if the mother is in jail. In these situations, there is often more instability in the family (Turney & Goodsell, 2018). Often the child’s grandmother steps in to become the parent. Once released from prison, parents have to transition back into their previous roles. With all the other readjustment problems they face (e.g., employment, re-establishing relationships, etc.), this transition is often difficult and requires effective co-parenting (see Poehlmann & Eddy, 2013).

It will come as no surprise that children face cascading problems when one or both parents are incarcerated. Children may be traumatized by the absence of a parent or by exposure to the criminal justice proceedings. In general, children of incarcerated parents are at risk for insecure attachments, behavior problems, poor cognitive or educational outcomes, health problems, delinquency, and psychopathology (Aaron & Dallaire, 2010; Muenter et al., 2019; Murray & Murray, 2010; Turney & Goodsell, 2018; Wakefield & Wilderme, 2018).

**Parenting After Wars or Natural Disasters**

What do wars have in common with hurricanes, earthquakes, floods, and tornados? All of these are community-wide, traumatic, life-threatening, and disruptive of normal activities. Every year hundreds of thousands of families around the world find themselves living in war zones or surviving natural disasters or terrorist attacks. The sequelae often include loss of life of loved ones, displacement from homes, lack of usual resources, and dramatic changes in daily routines.

Survivors of war or natural disasters, or other traumatic experiences, are likely to respond with post-traumatic stress, anxiety, depression, and other mental health problems (Attanayake et al., 2009; Cobham, McDermott, Haslam, & Sanders, 2016; Joshi & O’Donnell, 2003; Kelley et al., 2010). Under such circumstances responsive and appropriate child rearing is at risk for multiple reasons. For one both parents as well as children are impacted by the trauma. So although the parents are preoccupied with the safety of the child, they may have developed posttraumatic stress disorder or at least, be experiencing trauma symptoms (e.g., anxiety, sadness or depression, irritability, insomnia, & difficulty concentrating).

People respond to adversity in different ways. Some parents exhibit maladaptive coping responses (e.g., drug or alcohol use, feeling of hopelessness) and may be likely to use more harsh punishment (Kelley et al., 2010). However, other parents are able to be particularly responsive to their children’s trauma. For example, in a study of Norwegian parents who were on vacation
in Thailand when a tsunami struck, parents reported intentionally engaging in a number of activities to help their children (Hafstad, Haavid, & Jensen, 2012). These included a heightened awareness of potential signs of trauma or distress in their children and using a variety of supportive strategies with their children, including re-establishing a sense of safety, resuming normal roles and routines, and helping their children deal with the trauma (e.g., dealing with nightmares, desensitizing their children to a fear of water, teaching their children about normal psychological reactions to trauma and how to cope with distressing thoughts).

SUPPORT FOR AND RESILIENCE IN AT-RISK PARENTS

As this chapter has made clear, there are many threats to adequate parenting that can jeopardize children’s well-being. These threats can be internal to the family or external. But, consideration of those challenges to parenting needs to be balanced with a recognition that there are multiple sources of support as well as resilience in at-risk parents.

Resilience refers to withstanding or recovering from challenges that are a threat to something, which in this case is competent parenting (Masten & Narayan, 2012). Recall from the ecological systems model that parenting is nested within multiple contextual layers. Support for at-risk parenting that arrives at almost any level can serve to promote competent parenting. That support can come from the relationships within a home, from other adults at work or in a religious institution, or through government programs (Kerr, Capaldi, Owen, Wiesner, & Pears, 2011; Teti, Cole, Cabrera, Goodman, & McLoyd, 2017).

A parent’s exposure to adverse childhood experiences puts them at risk for intergenerational transmission of maladaptive parenting practices such as use of harsh punishment after a childhood history of maltreatment (e.g., Conger, Schofield, & Nepp, 2012; Mulder, Kuiper, van der Put, Stams, & Assink 2018) as well as increased likely of developing insecure attachment with their children (Serbin & Karp, 2004; van Ijzendoorn, 1992). However, there are also many sources of discontinuity—when parents do not repeat the same pattern of behavior they were exposed to as children. For example, if a parent, reared in a family with harsh punishment, had a spouse who engaged in loving and supportive child rearing, then the intergenerational transmission of harsh punishment can be disrupted (Conger et al., 2012).

Parenting interventions also provide an important avenue to address risks and address child-rearing deficits. As a start, recognizing trauma that a child has experienced is an important first step in recovery (Harvey, 2007). Educating and including parents in interventions for children after a disaster helps children recover (Gewirtz, Forgatch, & Wieling, 2008; Grolnick et al., 2018). Many different types of interventions have been developed to address a wide range of problems. These include programs for: parenting children with disabilities (e.g., Overbeek, 2017); depressed mothers (Goodman & Garber, 2017); exposure to intimate partner violence (Johnson, Elam, Rogers, & Hilley, 2018; Jouriles et al., 2018); homeless families (Haskett, Loehman, & Burkhart, 2014);
incarcerated parents (Armstrong, Eggins, Reid, Harnett, & Dawe, 2018); and natural disasters (Gewirtz et al., 2008). Parenting education and interventions will be discussed further in the final chapter.

CHAPTER CONCLUSIONS

There are many threats to successful parenting. Risks can come in many guises, including socioeconomic factors (e.g., poverty, wealth), parent characteristics (e.g., childhood experiences, mental illness), or child factors (e.g., developmental disabilities). Whether the particular risk has an influence on child rearing and, in turn, a child’s developmental trajectory depends on many considerations, such as the type of problem, the severity of it, and the chronicity. Poverty and its many related problems pose a pervasive threat to child rearing. However, most families with low incomes manage to provide “good enough” parenting despite their hardships. Strange as it may seem, wealth can also be a threat to positive child rearing. Parental history plays a large role in influencing child rearing. Parents who had adverse childhood or have mental health or substance abuse challenges are at high risk for maladaptive parenting. Sometimes, the risk to parenting comes from healthy parents who are faced with the challenge of rearing a child with special needs, such as children with ASD or Down syndrome. A key challenge in those cases is for parents to revise their expectations about their children and manage the high level of stress. Natural disasters and war pose another type of threat to providing children with quality child rearing.

Parents who are successful at adapting to the risk can largely mitigate the damage, with the help of social supports and perhaps interventions. Despite all the potential risks to effective parenting, there are multiple sources of support or resilience that help to promote competent child rearing.

Thought Questions

- Do we still blame mothers when children experience problems? What about fathers?
- Compare and contrast the different risk factors. Which ones are more difficult to overcome?
- What other types of childhood adversities should be added to the list?
- Does the emphasis in our society on achievement negatively impact parents of children with special needs? If so, how can this be addressed?
- Think of examples of people who have experienced serious childhood problems and overcame them. What factors contributed to resiliency and better outcomes?