Parenting in Nontraditional Families and Special Populations

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Chapter Preview: True or False?

- In the United States today, more than one third of children are born to single mothers.
- Children raised by gay or lesbian parents are not as well adjusted as children raised by heterosexual parents.
- Unloving mothers drive their children to become autistic.

Nontraditional Families

Most of the research described in the prior chapters comes from investigations of traditional American families. For the most part, that means a two-parent family with a mother and father who are usually 30 to 40 years old, of European descent,
and raising their biological children. Another aspect of the traditional view is that
the mother stays home to rear the children while the father works. However, in 2006, only about 15% of all American families fit this stereotype (Federal Interagency Forum on Child and Family Statistics, 2008).

Both around the world and increasingly in the United States, parenting occurs in nontraditional families. Many of these families are culturally diverse, as is discussed in the next chapter. Can children grow up to be psychologically healthy in nontraditional families? This question will be addressed in the first half of this chapter. The remaining portion of the chapter will address parenting and children’s development in two special parenting populations: when a parent has a serious mental health problem and when a child has a serious developmental disability or other special need.

Although most Americans will reflexively think of a mother and a father when considering a typical family structure, around the world, there are multiple forms of nontraditional family structures and contexts. Consider polygamy—when one person has more than one spouse. Most frequently, this consists of polygyny—a man having two or more wives. This family structure is found in some African countries (such as Ghana, Congo, and Tanzania) and Middle Eastern countries. It’s even discovered occasionally (although it’s illegal) in the United States. See Box 10.1 for a description of polygynous families. Polyandry (a woman having multiple husbands) is far less common but continues to be practiced in some societies in China and Nepal.

**BOX 10.1**

**One Father but Two Mothers: Polygynous Families**

Although outlawed in the United States, polygamy is legal in more than 850 societies around the world (Elbedour, Onwuegbuzie, Caridine, & Abu-Saad, 2002). The most common form of polygamy is polygyny—when a man marries two or more women. This form of nontraditional family structure in the United States made news in the summer of 2008, when officials raided the home of a small religious sect in west Texas. Four hundred and forty children were removed from their parents due to suspicion of child abuse. It turned out that polygyny was being practiced there.

How are children affected by this type of family structure? As reviewed by Elbedour and his colleagues (2002), the research indicates that all is not well in families with multiple wives. A number of potential factors put children’s healthy development at risk. First, polygamous marriages are more likely to be characterized by marital tension and conflict. There is often jealousy among the wives, who are frequently unhappy. The wives also often feel helpless to leave their situation, because they are unemployed. Children in polygynous families are more likely to be exposed to marital violence and father absences than are children in two-parent families. In sum, the available research indicates that this form of family structure is likely to be problematic.
Single Parents

In U.S. society, the most common nontraditional family structure is single parenthood. Although there are exceptions, this state usually occurs for one of three reasons: The parent was never married, the parent has been separated or divorced from the spouse, or the spouse has died. Generally, single parents are mothers. In the United States, 23% of children lived with only their mothers, whereas 3% lived with only their fathers (Federal Interagency Forum on Child and Family Statistics, 2008). Race plays a big role in this statistic: 16% of White children lived with a single mother, compared to 50% of African American children (U.S. Census Bureau, 2005). Divorce often leads to single parenthood; 16% to 35% of marriages end within the first 10 years (when children are likely to be born). The least common cause of single parenthood is death of a parent, most likely the father. Only 1.7% of single parents are widows.

One of the most dramatic structural shifts over time in U.S. families has been the number of unmarried women who become mothers. In 2003, more than one third of births in the United States were to unmarried women. That’s more than 1 million babies (Martin, Kochanek, Strobino, Guyer, & MacDorman, 2005). According to recent statistics, it is increasingly common for single women to decide to have children. In 1960, the percentage of children living in single-parent households was 9.1%. Forty years later, this had risen to 26.7% (Federal Interagency Forum on Child and Family Statistics, 2008). Illustration 10.1 depicts this dramatic change in family structure.

Illustration 10.1  Percentage of All Children (and White and African American) Living in Single-Parent Homes

Unmarried mothers are a diverse group. The main subgroups consist of adolescent single women, older single women, and unmarried women living with a partner (Weinraub et al., 2002). The reasons an unmarried mother is single can affect both the quality of parenting and how children are influenced. Consider the single successful professional woman who deliberately chooses to have a baby in her late 30s. Contrast that situation with the unintended pregnancy of a 15-year-old adolescent with no source of income. In addition, single parenthood is not a static attribute of mothers. Many single parents are legally single but are supported by a partner; women are often in long-term relationships but choose not to marry (see Box 10.2). Some are single for a finite amount of time and then choose to marry or remarry. Many children being raised in single families spend 20% of their time in the presence of their mother and her cohabiting partner (Bumpass & Raley, 1995).

The diversity of single-motherhood situations makes it difficult to summarize how single motherhood affects children. The caregiving quality of single mothers covers the entire range from neglectful and abusive to exemplary parenting. However, due to the nature of a single-parent family’s structure, single mothers

**BOX 10.2**

**No Need to Marry?**

It has already happened in northern Europe and Scandinavia. Increasingly in the United States, parents of children are choosing not to get married. Unmarried partner households have increased by 70%, and over a 10-year period, there has been nearly a 100% increase in the number of children living with their unwed parents. Today, 52% of nonmarital births are to cohabiting couples, compared to 29% of nonmarital births in the early 1980s (Child Trends, 2007). An estimated 4.3 million children were being raised in such families in 1999. According to another estimate, two fifths of all children will spend part of their childhood living with cohabiting parents (statistics cited by Manning & Brown, 2006).

Why don’t the parents marry? For lots of reasons. A common reason is financial. By not marrying, costly weddings are avoided (which average anywhere from $14,000 to $43,000, according to a search of “cost of wedding” sites on the Internet). Some couples put off marriage until it is the “right time.” As one mother told a reporter, “We want to be a little more established. We want to be a little more with the money” (Sege, 2007). Still other cohabiting couples choose not to marry due to their beliefs that marriage is oppressive to women, but cohabitation is progressive.

Based on demographic information, two types of concerns have been raised about unwed families. The first is the instability of the partner relationships. Two years after becoming parents, almost one third (31%) of the unwed parents were no longer together. This compares with 6% of the married couples who had separated or divorced by then (Child Trends, 2007). The other concern about unwed parents is they tend to be less educated and have lower income than married parents. About one fifth (23%) of children living in households with cohabiting, biological parents are raised in poverty (Smock, 2000).
commonly experience excessive demands on their time and, consequently, high levels of stress. Variations in the amount of stress (and the amount of support, which can mitigate stress) influence parental interactions.

Stress for a single mother comes from many sources, including financial problems, troubled relationships, the never-ending demands of parenting, and a lack of time for rest or other self-care tasks. The relation between single parenthood and financial stress is well documented: 43% of children living with single mothers are at or below poverty levels. Compare this to only 8% of children being raised in homes with married biological parents (Manning & Brown, 2006). Poverty often means living in low-income neighborhoods, an environment highly stressful in itself (Kotchick, Dorsey, & Heller, 2005).

Social supports can compensate for the effects of stress; recall Belsky’s model of the determinants of parenting (presented in Chapter 4). Social support includes material and financial help—such as diapers, babysitting, and money. Social support also consists of having someone to talk with about the children, such as a spouse or a friend. Supportive friends provide a mixture of sympathetic listening to frustrations, assistance in solving problems, and encouraging comments (Crnic & Low, 2002).

Interestingly, feelings of satisfaction with social support are more important than the actual amount of social support received. One mother may need to talk only once a week to a friend in order to feel supported. Another mother would like a relative or friend to sit with her baby each day. Social support provides a powerful moderator (buffer) of the adverse effects of stress on mothers. This was empirically demonstrated in a study of low-income African American single mothers and their children. Those mothers who experienced neighborhood stress (violence, gangs, crowding, drug use) had greater psychological distress (anxiety, depression) and were, in turn, less positive in their parenting practices (less monitoring, more lax or inconsistent discipline) than were other mothers. Perceived support from family, friends, and neighbors lessened the negative impact of the neighborhood stress on the mothers (Kotchick et al., 2005). The number of stressors is also linked to children's psychosocial adjustment (as shown in Illustration 10.2). The more risk factors (neighborhood problems, poverty) a single mother experienced, the more likely her children were to have internalizing problems (Jones, Forehand, Brody, & Armistead, 2002). These data illustrate what is called a cumulative risk model.

Adolescent Mothers

Each year in the United States, about 750,000 15- to 19-year-old females become pregnant, according to the Guttmacher Institute (2006). Most (82%) of those pregnancies are unintended. More than half (57%) of them are carried to term. The other pregnancies end in abortion (29%) or miscarriage/stillbirth (14%). Births to teenage mothers total 11% of the babies born. These days, adolescent mothers are likely to keep their babies; fewer than 5% will be placed for adoption. See Box 10.3 for a discussion of the rates of teen pregnancy in the United States in comparison to those of other developed countries.
Teenage Pregnancy and Childbearing Rates in the United States Compared to Other Developed Countries

How do teenagers in the United States compare with teens in other developed countries on issues related to teen sexuality and childbearing? Not very well, according to reports issued by the Alan Guttmacher Institute, a leading organization specializing in the study of sexual and reproductive health issues. What the institute has found is that teen sexual activity is generally similar across developed countries: By age 18, more than 60% of women in Sweden, Great Britain, and the United States report having had sexual intercourse. Canadian and French women report percentages in the 50s. But by age 20, more than 80% of women in four of the five countries (not Canada) have had sex.

Although the U.S. rate of sexual activity is comparable to other countries, the United States leads all of them in rate of teen pregnancy—almost twice as high as in England and Canada and eight times as high as in the Netherlands and Japan. The United States also has high rates of sexually transmitted infections (STIs), compared with Canada and Western Europe. The United States also has one of the highest rates of abortions among developed nations. A final problem associated with U.S. sexual activity in teens is the birthrate for mothers aged 15 to 17 years (which is more than 20 per 1,000 teens). This rate is two to four times higher than many European countries.

The primary reason for the high U.S. teen rates of STIs, abortions, pregnancies, and childbearing is a lower rate of contraceptive use. Countries performing better in these areas are characterized by social acceptance of adolescent sexual relations. Those countries also provide comprehensive sex education and easy access to contraceptives.
Just as single mothers form a heterogeneous group, so too do adolescent mothers. The married 19-year-old young woman is classified as an adolescent. So is the single 13-year-old eighth grader. Typically, however, when teen mothers are studied, the label refers to young women living without a partner in a socioeconomically disadvantaged situation (Moore & Brooks-Gunn, 2002).

What contributes to adolescent pregnancies? A number of prominent risk factors have been identified: living in poor neighborhoods, experiencing school problems or failure, failing to use contraceptives, and having few or low aspirations for the future. In addition, adolescent mothers are more likely than their peers to have a relative or friend who was also an adolescent parent and to have unrealistic thoughts about how easy it is to be a parent (Holden, Nelson, Velasquez, & Ritchie, 1993; Moore & Brooks-Gunn, 2002).

Do adolescents make adequate parents? In many ways, teenage mothers can provide good child care. When observed by researchers, adolescent mothers can be competent caregivers who are just as warm and responsive as older mothers are. Teen mothers also demonstrate that they can discipline reasonably. However, some researchers have found that adolescent mothers are less likely to talk to and cognitively stimulate their infants (Moore & Brooks-Gunn, 2002). More important, many teenagers experience the pregnancy and parenthood as a crisis. Not only are teenagers unprepared for being a parent, but their own phase of development conflicts with early parenthood as well. For example, the typical adolescent tasks of identity formation and role experimentation are not easily accomplished at the same time as being a parent. Adolescent egocentrism may interfere with developing empathy for the vulnerable and dependent newborn.

Parenting is a 24/7 task with few shortcuts; infants require constant attention, planning, problem solving, sleep disruptions, patience, and giving of oneself. Most teenagers are unprepared to provide these sacrifices. In addition to a lack of personal maturity necessary for effective parenting, the teenage parent often faces an unstable family life, stress, low earnings or reliance on public assistance, relationship problems (including marital disruption if she is married), additional births, and poor health outcomes (such as depression) during and after pregnancy (Furstenberg, 2003). Often, teen mothers have experienced some type of abuse in their childhood (Meyers & Battistoni, 2003). Each of these conditions puts a child at risk when born to an adolescent.

How well adjusted are the children of adolescent mothers? Whether children’s outcomes are negatively affected by their mother’s age appears to be a function of multiple factors, including the mother’s intelligence, her self-esteem, the amount of adversity she faces, and the presence of mental health problems (Weed, Keogh, & Borkowski, 2006). The most commonly found differences between children of teen mothers and those of older mothers are differences in cognitive functioning and psychosocial problems (such as behavior and attachment problems). Children of adolescent mothers have more school problems later (as indicated by grade repetition and truancy, for example), engage in sexual activity at younger ages, and experience more externalizing behavior problems than other children (Levine, Emery, & Pollak, 2007; Moore & Brooks-Gunn, 2002).
Gay and Lesbian Parents

Since the early 1980s, another type of nontraditional family structure has been investigated: one where both parents are the same gender. Based on the 2000 Census, about 33% of lesbian couples and 22% of gay (male) couples live with children under the age of 18 years (Simmons & O’Connell, 2003). Gays or lesbians (sometimes called “lesbigay” parents) become mothers and fathers in various ways. Some bore children in previous heterosexual marriages and continue to rear them either as a single parent or with a same-sex partner. Others become parents through alternative reproductive technologies (such as donor insemination) or adoption.

Empirical studies, gradually accumulating on this topic, address two central questions: Do gay/lesbian parents differ from heterosexual parents in their parenting? And what are the effects on children of having gay/lesbian parents?

Although the research is limited by small and selective samples, the evidence is consistent: there are few significant differences in the reported parenting practices, beliefs, or attitudes of gay/lesbian parents compared to traditional parents (Allen & Burrell, 1996; Kurdek, 2004; Patterson, 2002, 2004; Perrin & Committee, 2002). When differences are found, the most common is that gay/lesbian parents are more likely than heterosexual parents to share child-care tasks more evenly, and they tend to be more satisfied with these arrangements than heterosexual couples (Patterson, 2002). Some investigations reveal benefits of same-sex parenting. Compared to heterosexual parents, lesbian mothers showed more awareness of their children, perhaps because of their concern about raising a child in a nontraditional environment (Flaks, Ficher, Masterpasqua, & Joseph, 1995). In contrast, other findings reveal that this particular type of nontraditional family may face certain hardships. For instance, these families are more likely to report receiving less social support from family members than do heterosexual parents (Kurdek, 2004).

Do children of gay/lesbian parents grow up emotionally damaged? Do these children become homosexuals themselves? On most of the variables investigated, children of homosexual parents are largely indistinguishable from their heterosexual peers; they appear to be typically developing children and youth. In general, studies do not find negative effects from this nontraditional parenting on the children’s psychological well-being as assessed by anxiety and self-esteem, behavior problems, alcohol and drug use, school grades, and sexual behavior and preferences (Golombok et al., 2003; Patterson, 2002; Perrin & Committee, 2002; Wainright, Russell, & Patterson, 2004).

That is not to say that there are no effects from being reared by same-sex parents. Not surprisingly, one difference uncovered is that children with gay/lesbian parents are more open to same-sex relationships. However, children raised in these nontraditional families often face antigay prejudice, teasing, and harassment from peers (Gartrell, Deck, Rodas, Peyser, & Banks, 2005). It is likely that these children develop coping skills, just like children from other nontraditional families or minority groups.

Two reviewers of the subject found evidence that there are indeed negative effects from this type of rearing environment. In a meta-analytic review, Stacey and Biblarz (2001), after reviewing 21 studies on the topic, concluded that researchers
have downplayed findings regarding children’s gender interests and sexual preferences. They also identified significant methodological weaknesses of the research conducted to date, including the nonrepresentative samples used, ambiguity in definitions of sexual orientation, and the lack of developmental research on these children. The investigators argued that future researchers should avoid these problems. In sum, it appears the jury is still out on this topic. Additional research may uncover gender-related developmental problems or subtle effects that result from being raised in this nontraditional parent environment.

**Adoptive Parents**

Each year in the United States, about 500,000 women seek to adopt a child, and more than 125,000 families successfully adopt (Flango & Flango, 1995; Jones, 2008). There are a variety of types of adoption, including domestic (within the country), international, foster care or special needs adoptions, transracial, and kinship (for instance, stepparent) adoptions. Most adoptions come through one of two sources: a private agency or a state child-welfare agency. Adoptions through private agencies typically involve infants. Children adopted through a child-welfare agency are generally older than infants. For example, 46% of international private-agency adoptions
in 2001 were infants compared to 2% of those from child-welfare agencies (U.S. Department of Health and Human Services, 2001). Most parents (more than 80%) who adopt an infant do so because they are unable to have a biological child. In contrast, only about half of the parents who adopt from foster care (child welfare) cite infertility as their reason for adoption (Berry, Barth, & Needell, 1996). Some parents adopt for altruistic reasons completely separate from issues of fertility. Table 10.1 displays the top 10 countries from which American parents adopted children in 2007.

In cases where an adoption is inspired by fertility problems, the processes underlying the transition to parenthood differ from those of biological families. The transition to parenthood for adoptive families depends on such characteristics as expectations, preparation, social support, and “letting go” of the biological parenthood identity (Brodzinsky & Pinderhughes, 2002). One unusual feature of adoptive parents is that they have to be certified as fit to be parents. In contrast to biological parents, adoptive parents are scrutinized intensely before gaining the approval and endorsement needed to become parents. This evaluation, although stressful, helps to prepare them for parenthood. That screening procedure, along with their positive expectations about parenthood, contributes to reports of positive experiences with their adoptive children (Levy-Shiff, Goldshmidt, & Har-Even, 1991).

Adopting a child raises several unique concerns typically not present with a biological child. Questions must be addressed about the genetic makeup, prenatal environment, and early experiences of the child. Adopted children, particularly those from foster care systems, are more at risk for genetically based psychological problems (Brodzinsky & Pinderhughes, 2002). They also may have experienced prenatal difficulties, such as inadequate nutrition or exposure to teratogens. Once

| Table 10.1 Country and Number of International Adoptions to the United States |
|-------------------------|--------|
| China (mainland)        | 5,453  |
| Guatemala               | 4,728  |
| Russia                  | 2,310  |
| Ethiopia                | 1,255  |
| South Korea             | 939    |
| Vietnam                 | 828    |
| Ukraine                 | 606    |
| Kazakhstan              | 540    |
| India                   | 416    |
| Liberia                 | 314    |


Note: Data come from 2007.
born, the infant may have experienced malnourishment or maltreatment. This is why many adoptive parents are understandably drawn to newborns.

Consider the early experiences of children adopted from developing countries, where overcrowding, inadequate staff, and little stimulation are the norm. Romanian orphans in particular were known to experience severe deprivation. Twenty to thirty infants were kept in cribs in a sterile room with little sensory stimulation. Due to poor caretaker-to-child ratios (one caregiver for 10 to 20 infants), children were left in their cribs, without toys, for 20 hours per day. The children rarely interacted with adults. In one investigation, 46 of these orphans, who had spent an average of 18 months in a Romanian orphanage and were subsequently adopted by Canadian parents, were compared to other Canadian children (Fisher, Ames, Chisholm, & Savoie, 1997). Many differences were found. The Romanian children had a larger total number of problems, as well as more internalizing problems, eating problems, medical problems, stereotyped behavior problems, and relationship problems with peers and siblings.

A prominent aspect of the early experiences of an adoptive child is the attachment process, both before and after the adoption. In adoptions, the attachment process is potentially complicated due to parents’ difficulties in accepting the child as their own, unresolved fertility considerations, lack of family support, or disappointment when the child does not meet parental expectations (Brodzinsky & Pinderhughes, 2002). In addition, when children are adopted past the early infancy period, their prior attachment experiences (or lack thereof) are risk factors for attachment problems. See Box 10.4 for a description of the problem of reactive attachment disorder.

Another common issue associated with adoptions concerns the child’s identity. Beginning in the late preschool or early grade school years, children begin to differentiate biological from adoptive status. Adopted children are curious about their birth mothers and families. Some parents, however, fear that talking about the adoption may confuse the child or negatively affect his or her self-esteem, so they are secretive about the child’s biological status. Investigations into the question, however, find just the opposite: Adoptive families who promote openness in communication about the adoption do not confuse children or lower their self-esteem. Rather, a child’s understanding of the adoption largely mirrors his or her cognitive-development status (Wrobel, Kohler, Grotevant, & McRoy, 2003). During adolescence, a child’s need for identity is especially pronounced, and parents must negotiate the challenges with care. The issues can be even more complex with special needs, transracial, and international adoptions (Brodzinsky & Pinderhughes, 2002).

The types and severity of problems that adopted children have are linked to the type of adoptive group. For example, children adopted from the child-welfare system tend to have higher rates of school problems than do children adopted as infants, children adopted internationally, or children from their birth families (Howard, Smith, & Ryan, 2004). The severity of the problems is often increased when the child has experienced abuse, neglect, or multiple primary caregivers.

Adoption serves a vital function for adults who want to be parents, and it provides a dramatic and powerful intervention for many adoptees. A recent meta-analysis of 62 studies including more than 17,000 adopted children found that
adoptionsignificantly improved a child’s intelligence scores and school performance compared with nonadopted siblings or peers who remained in orphanages or in deprived environments (van Ijzendoorn & Juffer, 2005). So although adopted children do not score as high as nonadopted siblings or peers on school performance or IQ tests, they perform much higher than siblings and peers left behind in subpar environments.

Grandparents as Parents

Increasingly in the United States, grandparents are becoming the surrogate parents of children. About 5% of children in the United States are under the care of their grandparents (Annie E. Casey Foundation, 2007); 3.7 million children live in their grandparents’ homes (U.S. Census Bureau, 2008b). This practice is particularly common in African American families, with rates twice as high as Hispanic families and more than three times as high as European American families (Fuller-Thomson & Minkler, 2000). As many as 13% of children in single-parent homes also live with a grandparent (U.S. Census Bureau, 2005).

BOX 10.4

Reactive Attachment Disorder

Orphanages and institutions have been raising children in the United States since the 18th century (Mintz, 2004). Today, few children are raised in institutional care in the United States, but the practice continues to be common in developing nations. Although many children who come from institutions are physically and mentally healthy, some exhibit serious problems with forming new relationships and show extensive deficits in social-interaction skills.

Reactive attachment disorder (RAD) refers to a syndrome of developmentally inappropriate behavior with regard to interpersonal relations. It begins prior to age five. Typically, such children are excessively inhibited, hypervigilant, or ambivalent in their responses (frozen watchfulness, resistance to comfort, etc.). Children with RAD do not have a preferred adult as a source of comfort when distressed, they don’t respond to comforting when offered, they don’t show social or emotional reciprocity, and they have difficulties with emotional regulation.

This disorder, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000), is a result of serious neglect or repeated changes in caregivers that precluded forming a stable, secure attachment. In one of the largest empirical assessments of the disorder, it was found that among 94 seriously maltreated preschoolers in foster care, 38% met the criteria for a diagnosis of RAD (Zeanah et al., 2004).

What is the prognosis for a child with RAD? Indiscriminant attachment behavior can last for years, and some children have persistent and serious developmental problems. Fortunately, children with RAD who are adopted into a good environment are able to develop attachments, and many of these attachments are secure ones (e.g., O’Connor & Zeanah, 2003).
Parenting styles of grandparents appear to depend on the age and personality of the individual. Older individuals (more than 65 years) tend to adopt a formal parenting role, compared with the “fun-seeker” grandparents who are younger and maintain informal and playful relations with their grandchildren. A second group of younger grandparents can be characterized as having benevolent but distant relationships (see review by Thomas, Sperry, & Yarbrough, 2000). Involved grandparents can serve as positive influences on children’s lives. In one study of European American single mothers, living with both a single mother and grandmother was associated with positive child development. In particular, children received more cognitive stimulation and had higher reading scores compared to children in homes with a single mother but no grandmother (Dunifon & Kowaleski-Jones, 2007).

Although caring for grandchildren is good for the children and can be rewarding for the grandparent, it is also taxing. Grandparents who are surrogate parents react with anger and resentment at their adult child for putting them in this situation (Glass & Huneycutt, 2002). Not surprisingly, they are more likely to report mental health problems (e.g., depression) than noncaregiver grandparents (Fuller-Thomson & Minkler, 2000; Thomas et al., 2000). Financial strains and physical problems are other difficulties commonly experienced by grandparents who are surrogate parents (Thomas et al., 2000).

Summary

Four types of nontraditional family structures have been discussed: single parents (including adolescent parents), gay/lesbian parents, adoptive parents, and grandparents. There are other types of nontraditional families, including foster families (to be discussed in Chapter 12), group homes, and commuter families (where one parent works in—and may live in—a different location from the rest of the family). The research evidence makes clear that the structure of the family, the sexual orientation of the parents, and the biological status of the children are not nearly as important as how the family members interact. We next turn to two types of special parenting populations: when one or both parents have a psychological problem and when a child has a serious developmental disorder.
Parenting in Special Populations

What happens when adults who have or develop a serious mental health problem are also parents? How well are they able to rear their children? More important, how are the children affected? A different set of issues is raised when a psychologically healthy person is parenting a child with a serious developmental disability, such as autism.

Parents With Serious Mental Illnesses

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 4% to 7% of American adults have at least one episode of a diagnosable mental illness over the course of a year (U.S. Department of Health & Human Services, 1999). In addition, about 40% of adults will experience a diagnosable disorder during their lifetime. 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. In addition, certain problems affect a significant portion of society. It is estimated that more than 9% of children (more than 6 million) in the United States live with a parent who has abused or been dependent on alcohol or an illicit drug (Substance Abuse and Mental Health Services Administration, 2004).

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. With relatively few exceptions (e.g., Connell & Goodman, 2002; Nicholson, Nason, Calabresi, & Yando,
1999), researchers have ignored the role of a father's mental illnesses and how it affects the children's development. Part of the reason for this is the long-standing proclivity for 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 aberrant maternal behavior called “schizophrenogenic” parenting. These and other examples of mother blaming (see Box 10.5) 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 often other problems in the family. 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). For example, parents who are alcoholic are also likely to have other forms of mental illness and to live in a dysfunctional family. Mentally ill mothers are sometimes homeless, a problem described in Box 10.6. Thus, it is often difficult to sort out exactly which effects can be attributed to particular problems. For

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**BOX 10.5**

**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 blamable offenses goes on and on and includes epilepsy, asthma, and ADHD (Caplan & Hall-McCorquodale, 1985; Singh, 2004).

Subsequent research has refuted all those extreme environmental, Watsonian contentions. When differences in maternal behavior are found, they can readily be explained by child effects. For example, autistic children often have communication problems, avoid eye contact, and resist affection and 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.
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. Mentally ill individuals 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. 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

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**BOX 10.6**

**No Place to Go: Parenting Without a Home**

It is estimated that somewhere between 1.1 and 1.6 million mothers and children are homeless each year in the United States. That figure represents about 15% of the homeless population (Haber & Toro, 2004). These mother-headed families are rarely found on the street. Rather, they live temporarily in homeless shelters or with extended family or friends. And their homelessness is relatively short-lived. Most of these families (87%) are homeless for fewer than five months. The mothers are likely to be young (adolescents), survivors of sexual abuse and/or intimate partner violence, members of a minority group, and struggling with substance abuse problems. About one third have serious mental-health problems.

Assessments of parenting among the homeless are limited. One exception was a study by Ann Easterbrooks and Christine Graham (1999), who compared 55 homeless mothers and children with 57 low-income but not homeless mothers. 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 samples revealed a number of problems and problematic behaviors.

Indeed, studies of homeless children find high rates of problems. These children tend to have poor health, behavior problems, educational delays, and poor academic performance. There is some evidence that the longer the children are living as homeless, the more internalizing symptoms (such as depression, anxiety, and social withdrawal) they show (Buckner, Bassuk, Weinreb, & Brooks, 1999).
in various ways. For example, a review of 46 observational studies determined that depressed mothers are significantly more likely than nondepressed mothers to be irritable and negative and to be disengaged or withdrawn from their infants or children. Their disciplinary practices tend to be lax, inconsistent, and ineffective (Elgar, McGrath, Waschbusch, Stewart, & Curtis, 2004; Lovejoy, Graczyk, O’Hare, & Neuman, 2000; Zahn-Waxler et al., 2002). On the other hand, some depressed mothers engage in a different pattern of behavior—that of being highly intrusive and overstimulating with 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 et al., 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). This challenge is captured in the true story presented in Box 10.7.

Children of alcoholic parents are more likely to develop alcohol and drug problems, internalizing problems (such as depression), externalizing behavior problems (such as lack of control), and mental health problems (such as anxiety). They also tend to have lower academic achievement than other children (Chassin, Pitts, DeLucia, & Todd, 1999). There is evidence that these problems continue well into adulthood, as the children continue to be at risk for such difficulties as substance abuse, depression, anxiety, aggression, low self-esteem, distress, and problematic intimate relationships (Harter, 2006). Part of the task for a child living in this situation is to understand the fact that the parent is ill.

Despite the associations found between parental mental health problems and children’s problems, the likelihood that a child 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 .17 for mothers and .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 childhoods.

**Parenting Children With Serious Developmental Problems**

In Chapter 6, we discussed chromosomal abnormalities in children, but this is just one type of serious developmental difficulty some children face. Trauma
Reared by an 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.

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.

during the birthing process can produce brain damage and lead to mental retardation. Some children appear to be typical newborns at birth but—within a year or two—show signs of a pervasive developmental disorder such as autism. Other children may be born with or experience a problem and consequently develop a sensory (blindness, deafness) or physical disability (Meadow-Orlans, 2002). See Table 10.2 for a list of the estimated prevalence of seven developmental problems.

Developmental problems vary on many dimensions, including the degree of mental and physical impairment, the age of onset, and whether other problems are comorbid. Consider autism, 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 DSM-IV-TR diagnostic manual (American Psychiatric Association, 2000) uses the term 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 autism spectrum disorders function well in society. Three notable examples are Matt Savage, jazz pianist; Dr. Temple Grandin, university professor and designer of humane livestock-handling facilities; and Dr. Vernon Smith, 2002 Nobel Laureate in economics.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Estimated Prevalence</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Psychopathology(^1)</td>
<td>158 in 1,000</td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability(^2)</td>
<td>12 in 1,000</td>
<td>Rate includes some of the other problems listed below</td>
</tr>
<tr>
<td>Autism Spectrum Disorders(^2)</td>
<td>4.5 to 9.9 in 1,000</td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy(^2)</td>
<td>3.1 in 1,000</td>
<td></td>
</tr>
<tr>
<td>Vision Impairment(^2)</td>
<td>1.4 in 1,000</td>
<td></td>
</tr>
<tr>
<td>Down Syndrome(^3)</td>
<td>1.3 in 1,000</td>
<td>6,000 born each year; rate depends on age of mother</td>
</tr>
<tr>
<td>Hearing Impairment(^2)</td>
<td>1.2 in 1,000</td>
<td></td>
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</tbody>
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Sources:
Certain developmental disabilities are apparent to everyone because they are associated with particular physical characteristics present at birth—such as the 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 are 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 intervention provided before age three has shown a much greater positive impact than that started after age five (Woods & Wetherby, 2003).

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 (Ivey, 2004). Parental stress comes from many sources:

- Interaction difficulties, such as difficulty in controlling the child
- Interference with typical family functioning and other relationships
- Feelings associated with having a child with disabilities
- 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

In addition to being more stressful and demanding than rearing a typical child, the task is—for many parents—less rewarding. For example, a child with autism will not reciprocate the 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 (Hastings, Daley, Burns, & Beck, 2006).

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 (Yirmiya & Shaked, 2005), stress does not affect all parents in the same way. For example, parents who are naturally resilient or have a greater network of supportive friends, family, or groups are less likely to be adversely affected. Some parents are able to modify their prior expectations about their child and have a positive, affirming parenting experience, as is described in Box 10.8 by a mother of a child with Down syndrome.
Illustration 10.5  Rearing a child with a disability can be stressful but also rewarding.

Source: © 2009 Jupiterimages Corporation.

BOX 10.8  Parenting a Child With Down Syndrome

In between the umpteen medical tests and examinations at the hospital, the idea of having a child with a disability started to sink in. I said to my husband “I don’t know if I can do this.” He lovingly said, “We have to.” After her birth, we experienced all stages of grief. We talked to a lot of people. We did a tremendous amount of research. Our emotions went back and forth in opposition: It seemed when one of us was feeling low, the other was there to provide encouragement. We started to see a small glimpse into how our lives were forever changed.

Slowly, but very surely, a transformation began and we found that we were becoming very attached to our little girl. She cooed, she cried, she made those gaseous smiles so typical of a newborn—“Did you see that? She smiled at me!” We cuddled, cried, sang, slept and talked to each other. She was our baby and had all the same needs as any other baby. It was then that we began to see what the future might hold . . .

(Continued)
Chapter Summary

There are many kinds of family structures and characteristics, and each nontraditional family has unique issues that characterize its functioning. Ironically, only about 15% of U.S. families fit the stereotype of “traditional” families. It is difficult to make broad generalizations about single parents or adolescent mothers, because both groups are heterogeneous, and their functioning depends on many considerations. Nevertheless, they are at risk for high levels of stress and financial difficulties. Adolescent mothers must bear the additional burdens of going through their own developmental issues while facing the demands of parenting. A strong social-support network can greatly reduce the troubles these mothers face. Other nontraditional parents, including gay and lesbian, adoptive, and grandparents each face particular issues.
Some parents have serious mental illnesses, such as depression, that can affect their child rearing and their children's development. Whether the illness has an influence on the children depends on such considerations as the type of problem, the severity of it, and the chronicity. On the other hand, healthy parents sometimes have the challenge of rearing children with developmental disabilities, such as autism spectrum disorders and Down syndrome. The primary common denominator of those cases for the parents is high levels of stress. Nevertheless, many parents of children with disabilities are able to adapt and manage in ways they never expected.

Thought Questions

• What do you think about the labels “traditional” and “nontraditional” to describe families? Given that only 15% of American families can be described as “traditional,” is this label outmoded or misleading?
• How does the political debate about the legal definition of marriage (between a man and a woman) potentially affect children in nontraditional families?
• Does it surprise you to learn that research shows children of gay/lesbian parents to be virtually indistinguishable from children of heterosexual parents in terms of various indices of adjustment? Do you think there may be effects on children that have not yet been investigated? What might those be?
• Mothers have often been blamed for their children’s problems. Why is this? Do we still blame mothers when children experience problems? What about fathers?