THE INFLUENCE OF FAMILIES ON CHILD HEALTH
Family Behaviors and Child Outcomes
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Because pediatricians routinely see children and their parents together, they can observe the influence of each generation on the other. Pediatric training rarely provides a framework to understand how parents' behaviors, characteristics and circumstances affect children's health and health behaviors, emotional well-being, and social competence, however. Consequently, in the course of patient care, some essential information is not routinely obtained, and inevitably some treatment recommendations are ineffective. Skilled practitioners, schooled through experience, develop an intuitive sense of how families shape children's health, and they tailor their recommendations accordingly.

FUNCTIONS OF THE FAMILY

Understanding the functions that families carry out on behalf of children can help pediatricians organize their approach to family-centered child health care. Family functions can be divided into two main categories: (1) providing material support and supervision; and (2) providing affective and cognitive support, socialization, and education (Ta-

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ble 1). Both are essential for children's health and development. In our society, a multitude of public agencies and social programs can help to assist parents with the first category of functions, but few to assist them with the second. As observers of the private, psychosocial interior of families, pediatricians also have a unique opportunity to assist parents in performing their functions and parenting successfully.

The quality of interactions between a parent and child is key to optimal child development. Characters of high-quality parenting include devoting time, thought and energy; being responsive, sensitive, and empathetic; and having the ability to form intimate relationships. Children whose early primary attachment relationships are satisfying and whose families give them a secure sense of love, support, value, and belonging feel emotionally secure and learn to view themselves as lovable, to expect positive interactions with others, and to value close relationships. Children who experience rejection or harsh treatment come to view themselves as unworthy of love, and they expect and elicit further rejection.

Day to day, parents vary the way that they react to their children's behavior and in the demands they make on them. Pediatricians can identify dominant parenting styles by observing three dimensions of child-rearing: (1) expressions of warmth, pride, affection, acceptance, and enjoyment; (2) openness of communication with children; (3) amount of control exercised, ranging from highly restrictive to highly permissive. Baumrind has organized such dimensions into three parenting styles: authoritative, authoritarian, and permissive. Authoritative parents are controlling and demanding, but also warm, rational, and receptive to the child's communications. Authoritarian parents are controlling, firm enforcers, have high maturity demands, but are detached and less warm than other parents. Permissive parents are noncontrolling, nondemanding, and relatively warm. These styles have different effects on children's emotional and social development.

Children from authoritative homes tend to be consistently more socially competent than other children. Some sex differences are appar-

### Table 1. FUNCTIONS THAT FAMILIES PROVIDE

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<td>Food</td>
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ent; for girls this parental style is associated with purposeful, dominant, and achievement-oriented behaviors, and for boys with friendly, cooperative, and socially responsible behavior. In authoritarian homes, on the other hand, boys tend to be relatively hostile and resistant, socially assertive but not socially responsible, and girls are relatively lacking in independence and dominance. Among children of permissive parents, girls are less assertive and independent, and boys less achievement-oriented; both sexes score well on social responsibility. Of course, the process and outcomes of parenting are more complex than this overview suggests. Each parent has a different parenting style, and each child brings his or her own temperament and capabilities to family relationships. Thus, as with other clinical care, the pediatrician must individualize interventions with families in an attempt to achieve mutually rewarding relations for parents and children.

### FAMILY EFFECTS ON HEALTH

#### Physical Health and Health Behaviors

Family members tend to resemble one another in terms of health status and health behaviors. Similarities reflect familial, genetic predispositions; shared physical, social, and emotional environments; and learned health beliefs and values. Children's use of health services is largely controlled by their parents and, logically, resembles the utilization patterns of their parents. For example, parents generally decide for children which symptoms require medical attention or restriction of activities, although they may establish different thresholds for seeking medical care for themselves. Left to their own initiative, children seek care in the same manner in which their parents have sought care for them.

Health risk behaviors tend to cluster within families, and pediatricians should address these behaviors as family, not individual, issues. Children whose parents smoke, use alcohol or other drugs, or overeat are at higher risk for adopting those habits. Whether children are mimicking their parents' behaviors or are responding to similar social and environmental pressures or inducements is not always clear. Family relationships also can influence children's health risk behaviors. For example, adolescents with weak attachments to their families are more likely to smoke.

Children's health-promoting behaviors resemble those of their parents. Families influence the amount of exercise in which children engage by role-modeling and also by facilitating children's access to facilities, equipment, and opportunities to participate in sports and exercise. Other health-promoting behaviors are affected by family relationships. Children whose families support their autonomy are more likely to feel that their positive health behaviors are being facilitated. Such children are more likely to adhere to prescribed health behaviors, including complying with therapeutic regimens.
Emotional Health

Children's emotional health is related to their parents' sensitivity to them, the developmental appropriateness of their parents' expectations, and the degree and quality of affective support received from their families. Parents need to be able and willing to respond on an emotional level to their children. Appropriate family support can have a continuing influence on children. Children from families who rate high on measures of affective support have higher self-esteem, are better able to cope with stress, and have fewer behavior problems; during adolescence they have less delinquency, depression, and drug use. Conversely, adolescents who experience low levels of family support are more likely to be depressed.

Social Functioning

The social functioning of children consists of two overlapping sets of behaviors: (1) their ability to develop and maintain social relationships; and (2) their ability to carry out their roles as students and as members of a household or social group. The foundation for these abilities is laid early within the child's family. Infants who are securely attached to their parents are able to expand their trust in their caretaker into a generalized trust of people. Such infants are more willing to interact with others, increasing the likelihood that they will have further positive and enriching experiences. As children they tend to be more sociable, and have greater self-esteem, positive affect, assertiveness, empathy, peer competence, and popularity.

Beyond attachment and the reciprocal relationship between parent and child, parents' relationships with one another provide powerful models for their children's interpersonal behavior and can shape children's later choices of friends and partners and their ways of relating to them. Parents' own social functioning and network of relationships are quite predictive of their children's social competencies. Parents with poor or, particularly, deviant social skills are likely to have dysfunctional relationships with one another and with people outside of the family. The models this behavior provides can lead children to learn similar unsuccessful ways of relating to others. Families with poor social functioning tend to find it more difficult to rearrange relationships, roles, and functions; thus, they are less able to adapt to and cope with new situations and stresses.

By selecting and structuring their children's physical and social environments and the time spent in them, parents have some very direct effects on their children's social functioning. Prior to school-age, children's friends are largely a function of where the family chooses to live and with whom their parents arrange for them to play. Supervised young children have better social skills and behavior. Older children and adolescents whose parents monitor their whereabouts, know who their friends are and what activities they are engaged in have lower rates of delinquent behavior.

School is perhaps the key arena in which children's social skills and abilities are tested. Family social support, especially parental warmth and acceptance of their child, contributes to academic achievement and teacher-rated competencies. Active parental involvement in children's schools and education has been associated with both better academic achievement and improved social maturity.

Social Risk Factors for Poor Family Functioning

A number of social circumstances and personal characteristics can have profound impacts on family functioning and thus on child health and well-being. Pediatricians may be unaware that these risk factors are operating or that they are contributing to the problems that their patients present.

Poverty

More than 20% of children in the United States live in poverty, and the rate is nearly 40% for minority children. Being poor and having insufficient resources are the best predictors of poor health outcomes for children. Because families with children are more likely to live in poverty than any other type of family, pediatricians have frequent contact with poor families. Poverty undermines families' ability to carry out their functions. Poor families have more difficulty providing for their children's material needs; they are more likely to engage in health-risk behaviors; they perceive their health as poor; and they feel that they have less control over their health and so may appear to be more fatalistic, less active in addressing health problems, and less adherent to prescribed treatments.

The relationship between poverty and parenting is less clear. Poverty is associated with higher rates of single parenthood, divorce, family violence, and low levels of educational attainment, all of which place children at risk for poor outcomes. In addition, the child-rearing environments of poor families are more likely to lack some of the elements that are fundamental to good child outcomes, such as literacy, stimulation, parental time, toys and books, mature guidance, role models, and high expectations. Middle-class parents tend to be more engaged in their children's day-to-day lives, more respectful of their children, and act in ways to promote their children's cognitive and social development, their sense of self-esteem, and their emotional well-being. Poverty of income should not be confused with poverty of affection, however. Parents of
different social classes differ not in how much warmth and acceptance they feel toward their children, but only in how they express that affection.47

Low Social Support

Social relationships provide emotional support and affection, information and advice, companionship and intimacy, and tangible support.5, 18, 31 Adults and children who feel that they have such resources are better able to function in society and to cope with the stresses they encounter.39 Children report receiving support from parents, siblings, relatives, friends, teachers, and others in their environment. Their preferred source of support depends on the type of support and their developmental stage.16, 31, 58 Family support, however, is qualitatively different from support from other sources22 and has a cumulative and lingering effect on children's subsequent development.61 Adequate social development requires a supportive family environment in which family members have an enduring commitment to the well-being of the child.27 Family support has been related to several child outcomes including academic achievement, psychosocial maturity,70 adolescent risk behaviors,30 psychological adjustment,70, 74 and self-esteem.11 Whereas the absence of a supportive parent-child relationship places the child at significant risk for poor social and emotional outcomes, children who are able to develop a substitute relationship with another adult can effectively compensate for the shortcoming within their families.33, 71 Thus teachers, youth leaders, extended family members, and other adults can play critical roles in the development of children. Where family support seems to be inadequate to meet the child's needs, efforts should be made to direct the child toward additional sources of support.

The parents', particularly the mother's, own perceived support strongly influences child-rearing and thus has an important impact on children.17, 72 Parents' social networks can make them feel more competent,19 help them deal with stress,23 offer alternative ways to interact with children, and perhaps most importantly can share parenting responsibilities.63 Good parenting is fostered by good marital relationships. Mothers who feel adequately supported seem to enjoy their children more31 and act more competently toward them.35, 63 Mothers with the least support have the highest levels of distress and are less emotionally available to their children,10 which can have consequences for the children. For example, in one survey, children living with a formerly married mother were three times more likely to have had an emotional problem during the previous year than were those living with both biologic parents.25

Parents' social networks can directly influence their children by providing cognitive and social stimulation beyond that which the family may provide, by substituting for parents' emotional and material support, by offering alternative models of behavior, and by enlarging the social arena in which children can participate.17

FAMILY RISK FACTORS FOR POOR CHILD OUTCOMES

There are several family structures and circumstances that presumably place children at risk for poor outcomes. Among these are families in which parents are divorced or remarried, use violence as a conflict resolution strategy, abuse alcohol or other drugs, have low literacy skills, or have a homosexual sexual orientation. These topics are covered elsewhere in this issue. The following parenting circumstances also could conceivably put children at risk.

Working Mothers

Most mothers are employed. Approximately half of mothers of babies and preschoolers, and over 70% of mothers of school-age children, work outside of the home. Their income usually is not discretionary, but is necessary to the family, regardless of whether there are two parents in the household. Certainly, for the increasing number of single mother-headed households, the mother's income is essential, although the mean income for mother-headed households is only about 40% of that of two-parent households, accounting for more than half of single-mother families living in poverty.

There has been considerable debate and some ambivalence about the consequences of maternal employment on children. In an April, 1992, Harris Poll of 1251 adults, 71% of respondents and 63% of women who worked full-time said it is better for the child if one parent does not work. But only 36% of the respondents whose own mothers worked when they were children thought their childhoods would have been better if she had not worked.

Conditions of the mother's workplace and job have emotional repercussions which color her interactions at home, and thereby influence her children's health and well-being.31 Working generally has a positive effect on mothers' well-being, especially if the woman wants to work and enjoys her work. Earned income enhances self-esteem and provides a sense of mastery; however, less-valued, lower-paying jobs with low levels of autonomy and little demand or opportunity for substantively complex work are associated with lower self-esteem, self-efficacy and personal control than higher-status jobs. In addition, the positive effect of work on women's well-being is modulated by the extent of the husband's sharing of family tasks. In general, working mothers bear the lion's share of the responsibilities for housework.

Maternal employment affects the use of child health services. Women who work full-time take their children for health care for routine and mild illnesses less frequently,2, 75 but when children have a serious illness, their use of health care services does not differ from that of nonworking mothers.15 Several studies have concluded that maternal employment alone has few, if any, adverse effects on children,30 and that it is neither good nor bad for children.41
It is difficult, however, to untangle the relationship between maternal employment and child outcomes from a number of other related factors. Employment per se may not be a critical factor, but only one among many factors, i.e., family income, the presence of another adult in the household, mother’s working hours, the marital relationship, and the availability and quality of child care, that can influence the developmental and behavioral outcomes for children of employed mothers. Employment related aspects of family life are powerful influences on parents’ ability to carry out their functions on behalf of their children.

Parental Retardation

That mentally retarded parents have difficulty with successful child-rearing is not surprising. Mentally retarded parents (IQ 35–70) have significant difficulty with simple aspects of parenting, such as establishing bedtime and mealtime routines. Some retarded parents have such limited knowledge and skills that their children’s health and safety is in jeopardy. Even when these basic skills are present, the chance for parenting failure is high. Effective parenting is, in part, a complex cognitive task that requires appropriate contingent responses to unforeseen events and behaviors, yet these are precisely the behaviors with which retarded parents have difficulty. The mother–child interactions of mothers with IQs below 70 tend to be less varied, less reinforcing, and more punitive and directive than those of other mothers. Mentally retarded mothers may not know either how or what to reinforce among their children’s behaviors. Further interfering with child-rearing are the associated poverty and physical and sensory handicaps that are prevalent among retarded adults.

Children born and raised by retarded parents are at significant risk for cognitive delay; 30% to 40% of them score in a mental retardation range on intelligence testing. Their verbal IQs and vocabulary tend to be lower than their performance IQs. Their parents’ cognitive limitations and often impoverished circumstances also place children of mentally retarded parents at increased risk for neglect and abuse. Risk for abuse is increased when the higher intelligence of a child creates a mismatch between them and their parents. In one sample of children of mentally retarded parents, 45% had been removed from their home by child welfare agencies. It is important not only to closely monitor the development of these children, but also to ensure that the parents have adequate social and family supports.

Teenage Parenthood

In theory, teenagers, who themselves are not fully mature and are dealing with important and difficult developmental tasks, should make poor parents. Even the decision to become a parent reflects many of the age-specific cognitive and emotional limitations of adolescents; however, the relative importance of age to the acquisition and application of parenting skills remains unresolved. Teenage childbearing is highest within poor communities, and much of the risk status of the children of teenagers rests on other factors associated with poverty, especially low maternal educational attainment, nonstimulating environment, lack of preventive health care, poor nutrition, and the possibility of low social support. In general, becoming a mother during adolescence is associated with reduced scholastic attainment, increased labor force participation but at lower-paying jobs, and increased likelihood of living in poverty and requiring welfare assistance.

Teenage parents are more likely than older parents to be poor and less educated, to have lower self-esteem, to have more conflicted relationships in their own family of origin, and to lack the stable support of a husband. They also tend to lack knowledge about child development, to have unrealistic expectations of their child, and to place other needs above those of their children. Although they tend to be impatient with their children and to have low levels of verbal interaction, teenage mothers demonstrate considerable warmth and affection toward them. Many teenage mothers remain within their family home, and the support afforded them by another adult is an important protective factor for their child.

Children of teenage parents are at risk in terms of health outcomes, cognitive development, academic achievement, and behavior. These children begin school with some cognitive delays, but more importantly, their academic status worsens over time. In addition, while the behavior of young children of adolescents is equivalent to that of their peers’ during their own adolescence more behavioral problems seem to emerge; however, by no means will all children of adolescent parents have poor outcomes, and when teenagers are adequately supported, successful parenting is the likely outcome.

FAMILIES, CHILDREN, AND THE PEDIATRICIAN

There is no single family type that necessarily will succeed or fail in raising healthy, happy, and socially competent children. Neither parental income, education, employment, marital status, age, or sexual orientation is, by itself, predictive of successful child development. It is essential that children’s material, emotional, social, and educational needs (see Table 1) are met.

Families who are able to carry out their requisite functions tend to be cohesive, adaptable, and have good internal communication. In addition, the qualities of parenting that are associated with good child outcomes include warmth and affection, sensitivity, appropriate responsiveness (both in terms of development and situation), and consistency; good parenting also provides firm guidance and clear expectations. These behaviors are likely to occur when parents are physically func-
tional, have good emotional well-being and a sense of self-confidence, and are functioning well in terms of their social roles and relationships. Good functioning requires that parents have adequate resources, such as time, energy and material goods available to them. Most importantly, just as children must have their needs for social support met, so must their parents. Parents who feel unloved or who are socially inept, not a part of a group characterized by shared and open communication and values, or socially isolated will be severely handicapped in making their children feel loved, competent, valued, and supported.

To be effective in promoting children's health, pediatricians need to be familiar with the circumstances of the families for whom they provide care. Care will necessarily be incomplete when such information is absent. Because of the complexity of family functioning, assumptions about families based on clinical impressions are likely to be erroneous. Physicians must collect family data in a structured way, even though some of the information may be perceived as sensitive and difficult to obtain. Establishing a family data base at the first visit, perhaps by using a patient questionnaire, should be a routine part of child health supervision. Some essential information that should be obtained includes:

- Household composition: age, sex, relation
- Parental marital or relationship status and satisfaction
- Parental employment, occupation, and job satisfaction
- Family income
- Parental educational attainment
- Primary language and language spoken in the household
- Primary child care provider
- Household moves, length of current residence, adequacy of housing
- Physical environment: health and safety
- Alcohol, tobacco, and other substance use by family members
- Recent life events and stressors
- Social support and conflict: familial and extra-familial
- Physical and emotional health status and functioning of each family member
- Religious affiliation and attendance

That data base should be updated at least annually. In addition, some screening or "trigger" questions should be used at each visit to elicit information about changing family circumstances. These screening questions include:

- How are things going at home?
- Have there been any unexpected changes or stresses in your family since your last visit?
- Do you feel you have someone to turn to or confide in when you need help?
- Are you satisfied with how well you are doing as a parent?
- What sorts of things does your family do together?

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